SMA news

For Doctors, For Patients

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WAR ON DIABETES

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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.

So many things have happened in the medical landscape in the past weeks – so much that I cannot decide which to comment on. After serving on the SMA Council for more than ten years, I know that few readers grasp the spectrum of matters that we (as volunteers, mind you) grapple with. But recent events have left even "old-timers" shaking their heads in disbelief.

This issue was originally intended as a call to arms, to join in the waging of the "War on Diabetes". Though still important, this has been overshadowed by the shocking cyberattack on Singapore Health Services' (SingHealth) database that has left 1.5 million patients (me included) personally affected.

I have long been a supporter of the National Electronic Health Record (NEHR). Those of us in the restructured hospitals find it very useful for tracing patients' results from years ago or from other institutions. In preparation for a **compulsory** nationwide implementation of the NEHR, the Ministry of Health has held meetings in recent months to seek the opinions of the professional bodies, including SMA. Three recurring concerns I heard raised were of: surrendering personal control of individual privacy; replacing patient confidentiality with generic "authorised access"; and an instinctive feel that no security system, however comprehensively designed, can be invulnerable. Speaking only of those meetings I attended, I do not recall anybody claiming the system's security would be invincible. I also do not recall anybody elaborating on the consequence of a successful hack – ie, that when (not "should") one happens, all exposed content would be open to reading, copying or alteration. In retrospect, this raises an interesting point about the NEHR: If security can never be immortal, surely a patient should surrender his/her current rights to privacy and confidentiality of his/her personal data, only after a process of informed consent meeting the Montgomery test standards.

Back to the present. The official reaction to the loss of personal data was short and brief. The SMS notification said: "Your name, IC, race and birthdate were accessed but not altered… No action needed." This reassurance seems different from an independent website that advised that my name, IC and birthdate are all that is necessary to steal (or clone) my identity. This point was not dismissed upon direct enquiry, but neither was any advice offered on how to reduce the risk. Talking to learned friends, and a quick online search, produced some useful advice which I have implemented. If you had been affected by the SingHealth database hack, I hope you have taken steps to protect yourself too.

I want to end by saying: I am just a simple doctor. I am here to look after patients. I need support from trained non-medical colleagues to concentrate on my job. I can't do it well if I have to simultaneously worry about IT, financial, legal and other non-medical problems as well. A heartfelt appeal to the authorities: It helps tremendously when we know that you listen, and that you take our points to heart when we voice our concerns. It matters hugely that you do not dismiss us so casually. Please, listen. And thank you for doing so. ◆

PS: Due to the time constraints in producing this newsletter, we were not able to cover more aspects of telemedicine in this issue. We do have one in the works, so keep a lookout for it in the coming months – a young entrepreneur is developing an app for personal medical records, which allows each individual to limit the access as he/she wishes. I'm sure this would be of great interest to doctors and patients.

WAR ON DIABETES

Where Are We Now?

Text by Dr Wong Tien Hua,
SMA Representative on the MOH Diabetes Prevention & Care Taskforce

Dr Wong is the 1st Vice President of the 59th SMA Council. He is a family medicine physician practising in Sengkang. Dr Wong has an interest in primary care, patient communication and medical ethics.

Minister for Health Mr Gan Kim Yong declared a "War on Diabetes" in his budget speech in parliament on 13 April 2016. To declare war on a chronic disease is remarkable because it has not been done before. As I had written in the May 2017 edition of *SMA News* (http://bit.ly/2LshIZx), the US had previously declared war on drugs and war on cancer, with similar declarations in other healthcare systems against tuberculosis (an infectious disease) and tobacco (a carcinogen).

These other "wars" tend to be agent- or disease-specific. Diabetes, on the other hand, is an invisible disease with multifactorial causes and is thus difficult for patients and the public to visualise and understand. Compared to pictures of a heroin-filled syringe, an ulcerating tumour, a lit cigarette or an infective microbe, diabetes is an abstract illness.

The factors that can lead to diabetes include genetic predisposition, diet and lifestyle. These are notoriously difficult issues to manage especially in the perspective of population health. Take for example, dietary factors and the problem of sugar and carbohydrates. The public has long been aware that sweetened soft drinks are high in sugar and therefore bad for health, but recent attention has shifted to the role of refined carbohydrates in the diet,

such as that in white rice and white bread. These refined carbohydrates have a high glycaemic index, which means that they are rapidly absorbed into the blood stream and could cause sugar spikes associated with the development of diabetes. Singaporeans typically consume a few portions of white rice a day; it's a cultural heritage that has been passed down the generations.

Changing such deeply ingrained habits is no doubt a challenging task. In 2016, the Health Promotion Board (HPB) highlighted white rice as a concern in the fight against diabetes, which was reported in our local press.[1] A follow up story seemed to suggest that this led to some alarm in the community, reporting that targeting white rice "has created a storm of protest from rice lovers".[2]

An urgent problem

Minister Gan reported in his 2016 budget speech that about 400,000 Singaporeans are diabetic and the lifetime risk of developing diabetes is 30%. Of the Singaporeans who have diabetes, one in three has not been diagnosed. And among those diagnosed, one in three has poor control of the condition. Additionally, we hold the unfortunate distinction of having one of the world's highest rates of lower extremity amputations. There are projections that estimate that close to one million Singaporeans may suffer from diabetes by 2050. Singapore's diabetes prevalence rate (10.5%) is higher than those in Japan (5.7%), Finland (6.0%), Taiwan (8.4%) and Hong Kong (8.0%).[3]

The Diabetes Prevention and Care Taskforce is a high-level inter-ministerial committee that was set up in June 2016 to spearhead efforts to address diabetes in three key areas: healthy living and prevention, screening and follow-up, and disease management.

You would recall that Prime Minister (PM) Lee Hsien Loong, during his National Day Rally on 20 August 2017, singled out diabetes as one of three key long-term issues for Singapore. This underscores the importance of diabetes in a whole-of-nation effort to tackle the disease and further emphasises the urgency and seriousness of the problem.

Key initiatives thus far

Early screening

Early screening is a key initiative of particular relevance to primary care doctors who are the points of first patient contact. It is necessary because diabetes onset is insidious and asymptomatic at the early stages. Patients may not volunteer themselves for early screening especially if there is no incentive to do so.

GPs will by now be familiar with the enhanced Screen for Life (SFL) programme that was rolled out by HPB on 1 September 2017.

This programme enables eligible Singaporeans to screen for five conditions: hypertension, hyperlipidaemia, diabetes mellitus, cervical cancer and colorectal cancer. HPB has sent letters to the patients' homes and recommended a visit to a nearby participating clinic for health screening. These active reminder letters help to create awareness and encourage at-risk individuals to go for screening tests early at a highly subsidised rate, before the onset of symptoms.

However, diabetes screening under SFL applies only to individuals aged 40 years and above. For those below this cut-off age, screening should be considered at an earlier age if other risk factors are present, such as obesity and a family history of diabetes.

In response to this, HPB has also rolled out the Diabetes Risk Assessment (DRA) tool for those aged 18 to 39 years old. The tool comprises a set of five questions including the respondent's age, gender, height and weight, BMI, family history of diabetes and history of hypertension. Based on the information, the online tool tabulates the risk level for diabetes. Singaporeans found to be at risk of diabetes through the tool can enjoy the same subsidised rate of S$5 for diabetes screening and one follow-up consultation at the participating GP clinic.

Encouraging exercise

The National Steps Challenge is another initiative by HPB to leverage

on the smartphone and wearable technology to encourage Singaporeans to be more physically active. Fitness trackers measure the number of steps taken and reward the wearer when they reach certain defined physical activity milestones. Participants are encouraged to walk at least 10,000 steps a day and stand to redeem shopping and grocery vouchers. The third season of the challenge that concluded in April 2018 reached out to more than 690,000 individuals.

Preventing diabetes

The Taskforce has been exploring measures to reduce sugar in sugar-sweetened beverages. PM Lee mentioned in his National Day Rally that some countries impose a sugar tax in a bid to reduce the intake of dietary sugar. Other measures being considered include warning labels and advertising restrictions. This route may be a bit hard for consumers to swallow, but it certainly goes to show how far perceptions toward sugar have shifted – it is as if sugar has become the "new tobacco". The Taskforce is also negotiating with industry players to dial down the percentage of sugar in sweetened drinks. Channel NewsAsia reported that seven major soft drink manufacturers have agreed to reduce the sugar content in all their drinks in Singapore to 12% and below by 2020.[4]

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Another way to change habits is to provide drinking water freely across the country. Public consultation and feedback has called for a "drink plain water" campaign. The feedback panel asked for more water coolers to be installed in public areas, such as within community centres. Minister Gan announced in June 2018 that plain water will be provided at all Government and People's Association functions. Drinking points will also eventually be made available freely in public areas, such as hawker centres, parks and even bus stops.

Healthier food choices

The Ministry of Education and HPB have been running the Healthy Meals in Schools Programme since 2011, serving healthier meals with less fat, sugar and salt, with a serving of fruit in schools. The Taskforce has extended this concept to demonstrate a whole-of-Government commitment, by implementing the Healthier Catering Policy (April 2017) and Healthier Drinks Policy (November 2017) as the default in Government premises and at Government-organised events. Under the policy, caterers must provide wholegrains and plain water, use healthier oils for all food preparation and limit the number of deep-fried items per order. Lower-sugar drinks will also be the default in government premises, while freshly prepared hot coffee and tea must be served with no added sugar. You will notice that sugar and syrups are now provided as a side option.

The range of Healthier Choice Symbol (HCS) products has seen an increase in recent years. This distinctive red pyramid symbol stamped on packaged food products indicates that they are the healthier options to help consumers to make informed choices during grocery shopping.

Food products awarded the HCS are generally lower in fat, saturated fat and/or trans fat, lower in sodium, lower in sugar, higher in calcium and higher in dietary fibre. The number of such products has grown steadily from an initial 300 in 2001 to 2,500 across 70 food categories today. ◆

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2. The Straits Times. Fighting diabetes: Why the target is white rice. 12 May 2016. Available at: http://bit.ly/2uHl6IL.

3. International Diabetes Federation. Age-adjusted prevalence (20 – 79 years) estimates for 2015. In: IDF Diabetes Atlas 7th Edition (2015).

4. Channel NewsAsia. 7 major soft drinks manufacturers in Singapore to reduce sugar content in drinks. 22 Aug 2017. Available at: http://bit.ly/2NYmWxR.

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Legend

1. All freshly prepared drinks are now served with no added sugar at hospital canteens

2. Drinks with the Healthier Choice Symbol, with some containing no sugar

A NATIONAL CAMPAIGN, A NATIONAL EFFORT

Text by Dr Lee Yik Voon

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.

A national campaign

In 2016, the Ministry of Health (MOH), led by Minister for Health Mr Gan Kim Yong, declared a War on Diabetes. We had about 400,000 diabetics then; one in three diabetics did not know that they have the disease and for those who knew, one in three had poor control of their chronic disease.

This is no ordinary health campaign nor is it like any other health campaigns we have had in the past. When we declare war on a disease that affects a large number of people, every Singapore citizen should be committed to the war effort. To date, we have already committed more than 1 billion SGD a year to our war (against diabetes). This year, prediabetes has been included as one of the chronic conditions in our Chronic Disease Management Programme (CDMP) that is covered by the Community Health Assistance Scheme (CHAS) and Medisave.

We all recall many national campaigns, such as Save Water, the National Courtesy Campaign, the National Family Planning Campaign (Stop at Two), and Keep Singapore Clean, but none of them have been on such a large scale and hence its term "War on Diabetes". The Diabetes Prevention and Care Taskforce is made up of inter-ministerial committee members to coordinate our war efforts in the other aspects of our economy other than healthcare. Just as in any war, we need to mobilise the public, who are often the victims, to get them to achieve a healthy state so as to not be susceptible to the onslaught of hyperglycaemia. We need to gather the resources which would normally be employed elsewhere, to be allocated to focus on our war. I recall seeing frequent running commercials on the Pioneer Generation campaign, but the current television advertisements on diabetes look more like snippets from a Chinese kung fu movie. Perhaps the advertisement for diabetes-prevention is more erudite but I think I would have preferred to have kept it simple and easy to understand, so that it would improve retention with the requisite repetition of the campaign message to our citizens.

Nationwide efforts

This is not just a Government campaign though; we need to round up our Government agencies, private sector, healthcare personnel, patient advocacy groups, caregivers and case managers to fight this war. We need to make lifestyle changes and we need to persist till preventing diabetes is a way of life. For those who are already afflicted, we need to educate them to prevent their condition from further deterioration and to treat complications early. We also hope to see more media and propaganda messaging, as these are vital to motivate and educate our public, to empower them to be less dismissive and ignorant, and to reduce their susceptibility to the attack of diabetes.

There have been many other ideas from the community, such as the Running Society's mass run every weekend with the involvement of Residential Committees, and the Health Promotion Board's introduction of exercise programmes in parks and malls on weekends. Perhaps we could extend the ActiveSG funds to create a better environment for cycling and get students to do Community Involvement Programmes associated with these activities as well, instead of selling flags. Could we extend the Individual Physical Proficiency Test to all gender and ages, beyond reservist liability, with incentive of more subsidies if they achieve gold standard? Making bus stops further apart could be helpful, so people will choose to walk more; and more shelters to encourage walking under all weather conditions. The use of information technology and the Internet of Things to manage wearable devices should also be considered.

The war against diabetes also involves our allied health professionals, like physiotherapists, occupational therapists, podiatrists and medical social workers. As for the doctors, it is not just the responsibility of endocrinologists or diabetologists; every doctor is involved as diabetes is a multi-systemic organ disease. The complications are devastating and reach into every nook and cranny of our bodies. Diabetes can result in coma, stroke, blindness, heart disease, kidney disease, limb amputation and mental illness, as well as lead to inflated healthcare costs with spirals into poverty and bankruptcy.

Tools of war

The good news is that, of late, we have better armamentarium to fight this war – we have new drugs that not only control diabetes but also the complications of diabetes such as those that damage the heart and our vital organs. The bad news, however, is that our medical colleagues are still battling the usual problems in managing our patients, such as ignorance, poor awareness and poor insight leading to poor compliance.

Who should we set as a target group and when do we institute the recommended changes? We know that with the elderly group and their years of neglect, it is difficult as it may seem like a lost cause. We need to focus on our younger citizens. In fact, we should start with pregnant women and maybe even earlier at the preconception stage. After delivery, we should continue our efforts for both mother and child. The mothers will need to understand that gestational diabetes is an early warning signal for them to pursue preventive measures. For the children, we should start them early, guiding them by various means to achieve a healthy lifestyle. More health education efforts should be put in place in schools and for school-going children. There was even a suggestion to make it compulsory as part of Primary School Leaving Examination scores.

There are talks of legislation to curb the sugar intake and sugar tax. Punitive measures and negative reinforcements should not be a standalone. We should incentivise and give positive reinforcement to encourage correct behaviour. However, when our existing healthy food choices are considerably more costly to consume than junk food, we need to set it right so that the flow in behaviour will go along the correct gradients. Instead of gourmet holidays, we could change them to trail-walking and camping vacations. Instead of massive buffet feasts when we gather, we should have simple refreshments. Families should be getting together for activity-based events and perhaps the zoo and Sentosa could offer cheaper entrance fees on certain days to promote outdoor activities.

Another target to achieve is the prevention of complications. I believe more public education in the print media, social networks and public outreach can reduce the onset of complications. We know that many conditions, such as microalbuminuria and prediabetes, can be reversed early on through a healthy diet and lifestyle.

The War on Diabetes is a very good opportunity for us doctors to practise team-based holistic care. It is good to know that chronic disease management is not our burden to carry alone; we have multiple healthcare partners to bear the load and share their expertise to better manage our patients.

We hope to catch those with complications early so that there is a chance of reversal. We hope to catch those who are susceptible at an early stage to prevent them from contracting diabetes and to encourage a general healthy lifestyle among our citizens. We hope to move our patients away from the hospitals and back into their community. We aim to look beyond healthcare and instead into the health of our citizens.

After that, we still need to constantly ask ourselves these questions:

1. Are we fighting a limited war or a total war? Have we mobilised enough of our nation?
2. Who else has the public authority in this war? Certainly, it is not only our MOH?
3. If this is intended to be a long-drawn war, what are the key sustainability objectives for the nation?
   a. Quality-adjusted life year;
   b. saving health dollars; or
   c. not to bankrupt the nation?
4. Are the current communication and outreach methods enough? If they are enough, has the community been influenced? If so, how do we secure the commitment of the citizens, employers, National Trades Union Congress, food and beverage sectors, and more?

After all, we are not only for doctors but indeed, we are for our patients. ◆

SMA's Letter and MOH's Reply on

DOCTORS' DUTY TO REPORT UNFIT-TO-DRIVE CASES

In October 2017, SMA received feedback from members regarding Fitness to Drive, specifically on how a doctor can highlight unfit-to-drive cases to the Traffic Police, especially in scenarios where the patient refuses consent for disclosure.

The SMA Council deliberated and sent a letter to the Ministry of Health (MOH) in November 2017, highlighting that:

1. there was no mechanism to report unfit-to-drive cases to the relevant authorities;
2. there was no means to require a second (or specialist) opinion on continuing fitness to drive; and
3. there was no assurance of absolution from a breach of patient confidentiality, if a doctor unilaterally reports an unfit-to-drive case.

MOH responded via email in November 2017, indicating that it was collating responses from the Traffic Police, Land Transport Authority and other stakeholders.

In March 2018, MOH provided an official response on the matter. Both SMA's letter and an extract of MOH's official response are reproduced below.

Via email & post

SMA's letter to MOH

14 November 2017

A/Prof Benjamin Ong
Director of Medical Services
MINISTRY OF HEALTH

Dear A/Prof Ong,

Fitness to Drive: duty to report/warn

Doctors have the responsibility of certifying persons as fit to drive at intervals required by relevant Acts or Regulations. However, in the interval between such statutory examinations, we sometimes encounter patients who because of specific acute conditions, have become unfit to drive with immediate effect.

Examples are previously-well patients upon suffering their first epileptic seizure or their first episode of severe psychosis, or diabetics whose remaining good eye had acutely deteriorated from retinopathy so much that safe driving can no longer be assured.

Such patients are clearly a hazard to themselves and to other road-users, and should be prevented from driving with immediate effect, i.e. even before their next statutory examination. While some such patients would voluntarily stop driving following medical advice, others remain in denial, lack sufficient insight to comply or simply refuse outright. At the present there is no mechanism by which doctors can alert the relevant authorities to revoke the driving license of those unfit to drive, and in fact no assurance of absolution from a breach of patient confidentiality if he unilaterally takes either measure.

Although we have identified this gap that results in public hazard, the SMA has no authority with which to bridge it. We therefore bring this to the attention of your Ministry for consideration of any necessary action. Doctors would greatly appreciate a single point of contact to inform the relevant authority, as well as the assurance of absolution from breach of patient confidentiality when doing so, as they support public safety by identifying drivers no longer able to do so safely.

Yours sincerely,
Dr Wong Tien Hua
President,
Singapore Medical Association

MOH's Reply [Extract]

There was no mechanism (e.g. single point of contact) by which doctors can alert the relevant authorities to revoke a patient's driving license;

MOH's response: MOH has followed up with [Ministry of Home Affairs] MHA and Traffic Police (TP) on this point. To facilitate ease of voluntary reporting, TP has agreed for SMA to publish the email address, SPF_TP_Medical@spf.gov.sg, in SMA's guidelines. This email will be in addition to the postal addresses and fax numbers in SMA's current medical guidelines on fitness to drive.

There was also no policy to require a second (or Specialist) opinion on continuing fitness to drive;

MOH's response: Currently, as indicated in the SMC's Ethical Codes and Ethical Guidelines (ECEG), it is the doctors' clinical and ethical responsibility in providing appropriate advice to patients on their medical conditions and implications of the conditions. SMC's ECEG A3(4) also states that: "If you cannot provide services that are necessary for your patients, or most beneficial for your patients, you must offer to refer them to other doctors or institutions which can provide the most appropriate service."

Lack of assurance of absolution from a breach of confidentiality if the patient who refused to stop driving was reported even when this was done in the interest of public safety.

MOH's response: Although there are no expressed provisions in the Road Traffic Act (Cap. 276) related to protection for the doctor in reporting patients fitness status to drive, there are the following legal provisions and guidelines, on the grounds of public interest, to protect doctor in the event that a patient reports confidentiality breach:

(a) First, section 17(3) of the Personal Data Protection Act (PDPA), read with the Fourth Schedule, provides exceptions for disclosure without consent. The Fourth Schedule, paragraph 1, states that: "An organization* **may disclose personal data about an individual without the consent of the individual** in any of the following circumstances: … (g) the disclosure is to a **public agency** and such disclosure is **necessary in the public interest.**" (*"organization" is defined in the PDPA to include individuals.)

(b) Second, the SMC ECEG provides guidance on the circumstances related to defensible disclosure without consent. C7(5) of the ECEG states that "**Disclosure without consent is generally defensible** when it is mandated by law, it is necessary in order to protect patients or others from harm, when the involvement of parents and legal guardians is beneficial to minors or **where such disclosure is in patients' best interests.**"

(c) Furthermore, if the patient brings a civil suit against the doctor for breach of confidentiality, the doctor can rely on a **defence of public interest** if there are clear facts to indicate that the patient had posed a danger to the public. ◆

Forging Ties across the Causeway

Text and photo by Dr Wong Tien Hua

The Malaysian Medical Association (MMA) was formed in 1959 and seeks to represent all doctors, as well as medical students, in Malaysia. It is interesting to note that both the MMA's and SMA's crests bear the same motto of "Jasa Utama" or "Service before Self".

Being a large country, it is logistically challenging to bring all its members together at once. As such, the MMA holds an annual national convention together with its annual general meeting and annual dinner, providing a platform to bring together continuing medical education, networking and social events.

This year, the National MMA Convention and Scientific Congress was held from 28 to 30 June 2018 at Royale Chulan Kuala Lumpur hotel in the heart of the city, within a stone's throw of the iconic Petronas Twin Towers at Suria KLCC.

The culmination of the three-day event was the gala dinner held on the evening of 30 June. The dinner was graced by the Sultan of Perak, Sultan Nazrin Muizzuddin Shah, and his wife Raja Permaisuri Tuanku Zara Salim.

The guest of honor was Dr Dzulkefly Ahmad, a toxicologist by training, who was named the Health Minister in the new Cabinet of Prime Minister Tun Dr Mahathir Mohamad in May 2018. In his speech, Dr Dzulkefly stated that he wanted to address the "toxic work culture" of healthcare practitioners, put an end to bullying and look into ways to reduce the workload of his Ministry's staff, especially for the junior doctors. He also spoke of bolstering public-private partnerships in the healthcare system and of looking into the provision of universal health coverage.

Finally, the newly minted MMA president, Dr Mohamed Namazie Ibrahim, also delivered a speech in which he requested for quicker placements of housemen and a revision of the medical fee schedule.

We would like to thank the MMA for their hospitality and for the insights gained during the convention and congress. We wish the MMA all the best in their endeavours to improve the nation's healthcare landscape. ◆

Photo: Malaysian Medical Association

Legend

1. Dr Wong with foreign guests at the MMA annual dinner in Kuala Lumpur

Dr Wong is the 1st Vice President of the 59th SMA Council. He is a family medicine physician practising in Sengkang. Dr Wong has an interest in primary care, patient communication and medical ethics.

Honouring Excellence

The 59th SMA Council warmly congratulates our Members who are recipients of the National Day Award 2018.

The Public Service Star (Bar)

Dr Kee Wei Heong
Chairman
Drug Rehabilitation Centre
Review Committee (2)

Member
BOVJ & BOI

The Public Administration Medal (Silver)

A/Prof Aymeric Lim Yutang
Physician-in-Chief and Group Chief Human Resource Officer
National University Health System

Dean
Healthcare Leadership College
MOH Holdings

A/Prof Mabel Yap Mei Poh
Director
Professional Training and Assessment Standards Division
Ministry of Health

The Public Administration Medal (Silver) (Military)

COL (DR) Edward Lo Hong Yee
Chief Army Medical Officer
Headquarters Army Medical Command
Singapore Armed Forces

The Public Administration Medal (Bronze)

A/Prof Tan Suat Hoon
Director
National Skin Centre
National Healthcare Group

Prof Wong Peng Cheang
Senior Consultant
National University Hospital
National University Health System

A/Prof Koo Wen Hsin
Senior Consultant
National Cancer Centre Singapore

Chairman
Division of Medicine
Sengkang General Hospital Pte. Ltd.
Singapore Health Services

The Commendation Medal

Dr Eugene Shum Jin-wen
Chief Community Development Officer
Corporate Development
Changi General Hospital
Singapore Health Services

The Commendation Medal (Military)

LTC (NS)(DR) Jonathan Choo Tze Liang
Chief Physician
192/193 Squadron
Republic of Singapore Navy

LTC (NS)(DR) Tang Chien Her
Deputy Commanding Officer
1 Medical Squadron
Republic of Singapore Air Force

The Long Service Medal

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Regional Health System
Singapore Health Services

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Singapore General Hospital
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Senior Consultant
Changi General Hospital
Singapore Health Services

This list may not be exhaustive. If we have inadvertently omitted the name of any recipient, we sincerely apologise for the oversight. ◆

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.

SMA office relocation

We would like to inform our Members and partners that the SMA office has relocated to the following address with effect from 3 August 2018.

2985 Jalan Bukit Merah
#02-2C, SMF Building
Singapore 159457

Our telephone: (65) 6223 1264 and email: sma@sma.org.sg remain unchanged. However, our fax is discontinued temporarily.

The three professional bodies (PBs), ie, SMA, Singapore Dental Association and Pharmaceutical Society of Singapore, were informed by the Alumni Association (AA) of a rent hike upon the expiry of the lease at 2 College Road on 2 August 2018. Protracted negotiations between the three PBs and AA extended into the middle of July 2018 and the three PBs were unable to afford the new rent demanded by AA (ie, $4.80 psf for a three-year lease, with $4 psf for the first three months). On 17 July 2018, AA informed the three PBs that a Notice to Quit would be served and upon failure of the three PBs to vacate the premises, AA would proceed to impose a default rate of two times the existing rental rate.

That being the case, SMA informed AA on 25 July 2018 that it will vacate 2 College Road by 2 August 2018. Members who are interested in the events that led to our decision to move out of 2 College Road are urged to visit http://bit.ly/2LAWHjp to access the summary of events and important documents between the three PBs and AA, as well as with the relevant authorities.

SMJ impact factor rises to 1.08

We are pleased to announce that the *Singapore Medical Journal* (*SMJ*) has improved in its impact factor for the 2017 citation year, from 0.67 (2016 citation year) to 1.08, and now ranks 100 out of 154 journals under the "Medicine, General and Internal" category of the 2018 Journal Citation Reports.

The SMA Council would like to extend our heartiest congratulations to Editor-in-Chief A/Prof Poh Kian Keong, the *SMJ* Editorial Board and the secretariat for achieving this notable milestone. We wish the journal every success as it aims to expand the body of scientific knowledge in medicine and improve patient care through publishing impactful high-quality papers.

Joint survey on NEHR

SMA, Academy of Medicine, Singapore and College of Family Physicians Singapore collaborated and funded a survey to study the public's understanding of the National Electronic Health Record (NEHR) and collate relevant feedback. The survey also approached specific groups of individuals who may not routinely access social media, various media platforms or public feedback mechanisms via face-to-face interviews, to solicit their opinion and thoughts. The report is published in this month's *SMA News* (see page 15). Preliminary results and findings were shared with the Ministry of Health who also took the opportunity to provide their response on the survey in a companion statement. ◆

JOINT SURVEY ON THE

Public Sentiments towards the National Electronic Health Record

by College of Family Physicians Singapore,
Academy of Medicine, Singapore and Singapore Medical Association

"Singaporeans are generally supportive of the NEHR, and want more control over their data."

In early 2018, in reviewing the proposed Healthcare Services Act (HCSA), and the implications for the nationwide implementation of mandatory contribution to the National Electronic Health Record (NEHR), the College of Family Physicians Singapore, the Academy of Medicine Singapore and the Singapore Medical Association agreed to conduct a joint survey on the public sentiments towards the NEHR.

The objectives of the survey were to:

- ☑ Evaluate the general public's sentiment and awareness of the NEHR;
- ☑ Understand the perceptions and misconceptions of the public towards the NEHR; and
- ☑ Identify any concerns they might have.

This survey was carried out over a six-week period from 9 March 2018 to 15 April 2018. A total of 2,100 responses were collected, comprising 2,000 online submissions and 100 face-to-face interviews. The face-to-face interviews were done to reach out to non-IT-savvy respondents aged 60 years and above, with these respondents being recruited in the town centres, key districts and heartland areas.

The subject pool comprised 90.4% (1,899 of 2,100) Singapore citizens, with 79.8% (1,676 of 2,100) living in public housing. 58.0% (1,217 of 2,100) were females, with the ethnic distribution being representative of the Singapore population (see Figure 1).

The summary of the results of the survey is as follows:

- ☑ We found that 1,936 of 2,100 (92.2%;"Somewhat Support"/"Support"/"Strongly Support") of the study cohort were supportive of the NEHR (see Figure 2).

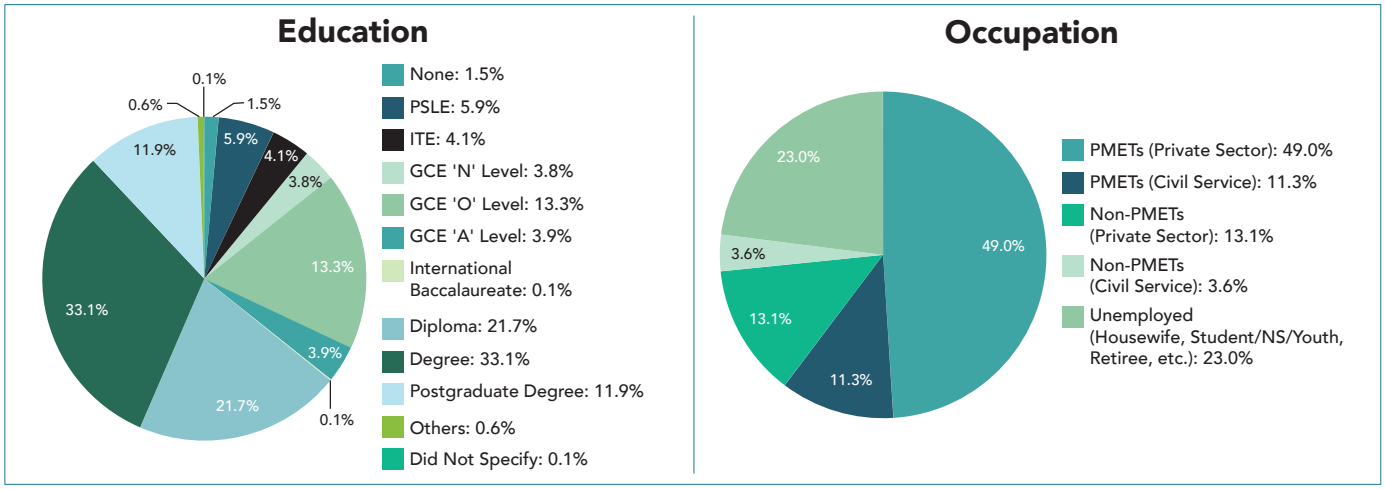


Figure 1

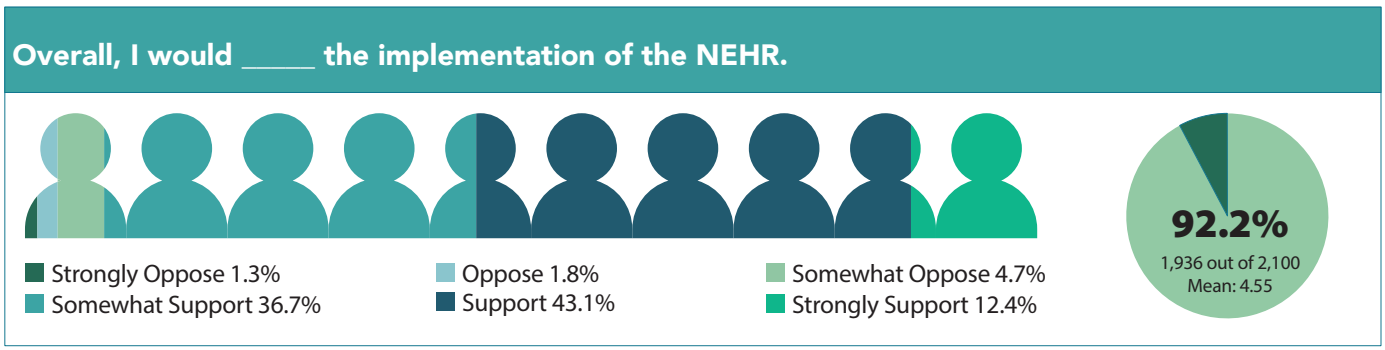


Figure 2

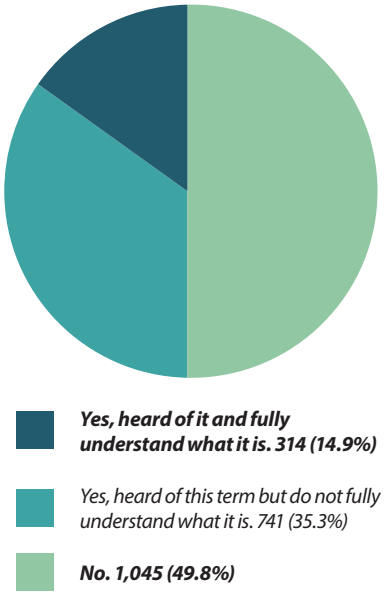
- ☑ 581 of 2,100 (27.7%) definitely wanted to have their records maintained in the NEHR.
- ☑ 1,175 of 2,100 (56.0%) would like their records maintained in the NEHR but did not want any healthcare provider to access it without their explicit consent except during emergencies (see Figure 3).
- ☑ 314 of 2,100 (14.9%) were fully aware of the NEHR, and 1,045 of 2,100 (49.8%) had not heard of it at all. Awareness of the NEHR was lowest amongst those aged 21 to 29 year olds (62 of 170; 36.5%) and those above 60 years old (141 of 320; 44.1%) (see Figure 4).
- ☑ 1,979 of 2,100 (94.2%) of the respondents felt that their doctors would be able to make better informed diagnoses and decisions with the NEHR, and it would also raise patient safety (1,993 of 2,100; 94.9%) (see Figure 5).

Which of the following best describes your intention towards the NEHR?	%
I would ***definitely like*** to have my records maintained in the NEHR.	27.7
I would ***like*** to have my records maintained in the NEHR **BUT** do not want any healthcare provider to access it without my explicit consent except during emergencies.	56.0
It ***does not matter*** to me whether my records are in or out of the NEHR.	5.0
I would like to ***opt out*** of the NEHR presently, **BUT** still have my records uploaded in the NEHR (with access blocked for now) so that they can be viewed in the future should I choose to opt in again.	6.0
I would like to ***opt out*** of the NEHR presently **AND** do not want any records stored in the NEHR. Should I change my mind and opt in in the future, I accept these permanent gaps in my record.	3.3
I would like to ***opt out*** of the NEHR and am unlikely to opt in in the future. I would not want to store my data in the NEHR at all.	2.0

Note: *This analysis was based on all respondents, n = 2,100.*

Figure 3

Have you heard of the National Electronic Health Record (NEHR)?

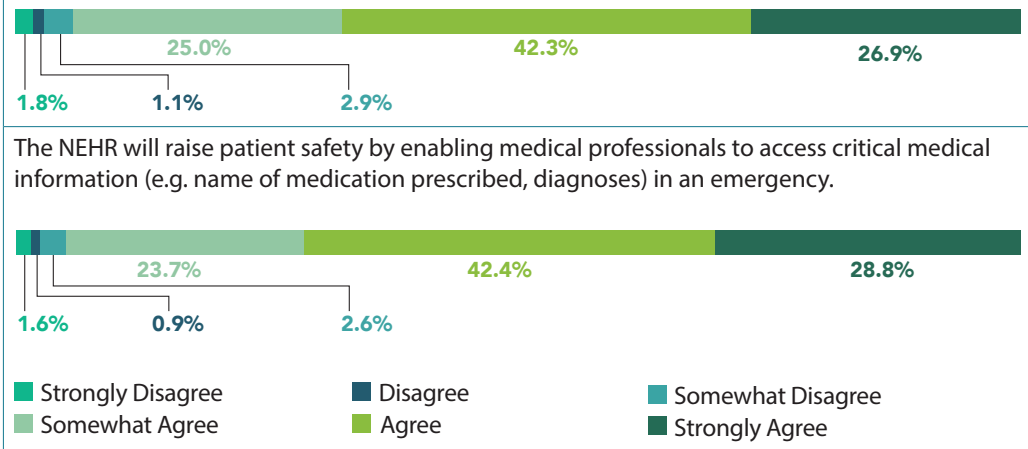


Where have you heard / received information on the NEHR?	n	%
Printed media *(e.g. Straits Times)*	325	30.8
Television	222	21.0
Online news	210	19.9
Word-of-mouth *(e.g. friends, families, relatives)*	184	17.4
Ministry of Health (MOH) website	174	16.5
Social media	114	10.8
My GP / Doctor	92	8.7
Online Search Engines	84	8.0
Radio	77	7.3
Others *(e.g. Workplace, Hospitals)*	58	5.5
Flyers / Brochures	50	4.7
Exhibitions / Roadshows	22	2.1

Note:
1. *This analysis was based on all respondents, n = 2,100.*
2. *Analysis on "Where have you heard / received information on the NEHR?" was based on all respondents who answered "Yes" for the question "Have you heard of the National Electronic Health Record (NEHR)?", n = 1,055.*

Figure 4

On a scale of 1 to 6, where 1 means "Strongly Disagree" and 6 means "Strongly Agree", please rate your extent of agreement with the following statements.	n	Mean	Top 3 Boxes (%)
With the NEHR, my doctor(s) will be able to make better-informed diagnoses and decisions for the best course of treatment to improve my health.	2,100	4.86	94.2
The NEHR will raise patient safety by enabling medical professionals to access critical medical information (e.g. name of medication prescribed, diagnoses) in an emergency.	2,100	4.90	94.9



Note: *This analysis was based on all respondents, n = 2,100*

Figure 5

- ☑ Majority of the respondents were willing to disclose general information, such as doctor's general diagnoses (1,719 of 2,100; 81.9%), allergies (1,661 of 2,100; 79.1%) and general medication history (1,629 of 2,100; 77.6%).
- ☑ However, when it came to "sensitive" information, the support was lower [medication history (1,061 of 2,100; 50.5%), laboratory and radiology results (946 of 2,100; 45.0%), doctor's more specific diagnoses (914 of 2,100; 43.5%) and operation/ procedure notes (876 of 2,100; 41.7%)] (see Figure 6).
- ☑ 77.5% (1,627 of 2,100) of the respondents were confident that their data in the NEHR was secure, and 70.8% (1,487 of 2,100) were confident that their data would not be misused by others (see Figure 7). Nevertheless, there were specific concerns:

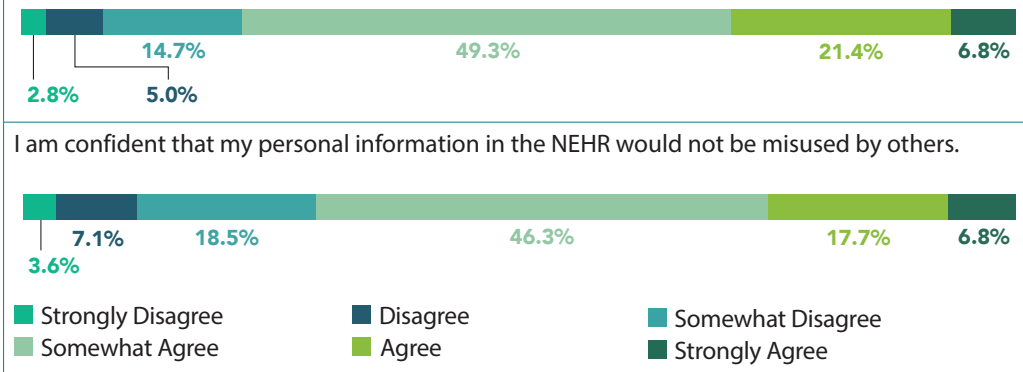
1. 70.9% (1,489 of 2,100) were concerned about their medical information being uploaded onto a cloud (secured online storage).
2. 82.9% (1,741 of 2,100) were concerned that their medical information would be used for matters of public interest by the Ministry without their consent.
3. 81.7% (1,715 of 2,100) were concerned that the NEHR is not subjected to the requirements of the Personal Data Protection Act (PDPA) (see Figure 8).

Given a choice, which of the following type of personal data would you be willing to make available in the NEHR?	
Doctor's Diagnosis – General	81.9%
Allergies	79.1%
Medication History – General	77.6%
Vaccination History	71.5%
Laboratory and Radiology Reports – General	69.8%
Operating Theatre Notes and Procedures – General	60.8%
Hospital Discharge Summary	59.0%
Visit History	56.0%
Medication History – Sensitive	50.5%
Laboratory and Radiology Reports – Sensitive	45.0%
Doctor's Diagnosis – Sensitive	43.5%
Operating Theatre Notes and Procedures – Sensitive	41.7%
Others (e.g. Dental Records)	3.1%

Note:
1. This analysis was based on all respondents, n = 2,100.
2. Percentages may not add up to 100% as this is a multiple response question.

Figure 6

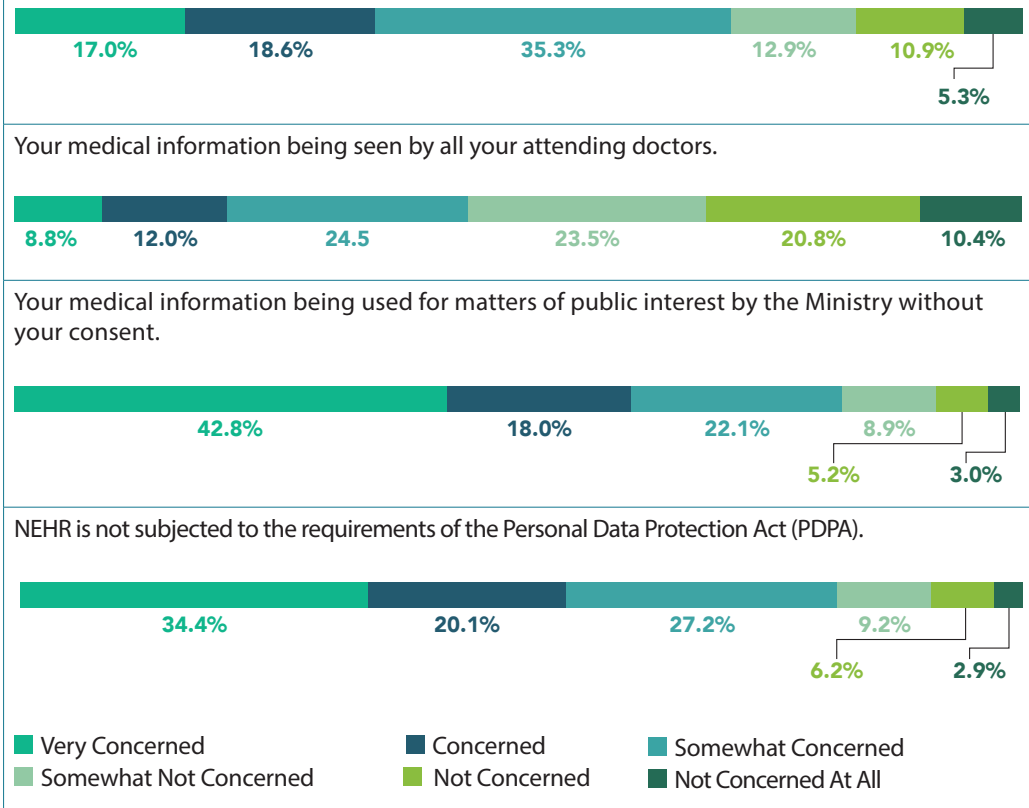
On a scale of 1 to 6, where 1 means "Strongly Disagree" and 6 means "Strongly Agree", please rate your extent of agreement with the following statements.	n	Mean	Top 3 Boxes (%)
I am confident that my data in the NEHR is secured.	2,100	4.02	77.5
I am confident that my personal information in the NEHR would not be misused by others.	2,100	3.88	70.8



Note: *This analysis was based on all respondents, n = 2,100*

Figure 7

On a scale of 1 to 6, where 1 means "Very Concerned" and 6 means "Not Concerned At All", how concerned are you with the following statements:	n	Mean	Bottom 3 Boxes (%)
Your medical information being uploaded into a cloud (i.e. secured online storage).	2,100	2.98	70.9
Your medical information being seen by all your attending doctors.	2,100	3.67	45.3
Your medical information being used for matters of public interest by the Ministry without your consent.	2,100	2.24	82.9
NEHR is not subjected to the requirements of the Personal Data Protection Act (PDPA).	2,100	2.41	81.7



Note: *This analysis was based on all respondents, n = 2,100*

Figure 8

In conclusion:

1. About half (1,055 of 2,100; 50.2%) of the respondents were aware of the NEHR, with 14.9% (314 of 2,100) "fully understanding" what NEHR is.
2. More than 90.0% of the respondents agreed that with the NEHR, "their doctor(s) would be able to make better-informed diagnoses and decisions for the best course of treatment to improve their health" (1,979 of 2,100; 94.2%) and that "the NEHR would raise patient safety by enabling medical professionals to access critical medical information (e.g. name of medication prescribed, diagnoses) in an emergency" (1,993 of 2,100; 94.9%).
3. Most of the respondents were confident that their data in the NEHR was secure (1,627 of 2,100; 77.5%), and that their data would not be misused by others (1,487 of 2,100; 70.8%). Nevertheless, there were still concerns with data confidentiality with regard to their "medical information being used for matters of public interest by the Ministry without their consent" (1,741 of 2,100; 82.9%) and that "NEHR is not subjected to the requirements of the PDPA" (1,715 of 2,100; 81.7%).
4. In a nutshell, while 92.2% of the respondents supported the implementation of the NEHR to varying extents, about a quarter of all the respondents (581 of 2,100; 27.7%) mentioned that they "would definitely like to have their records maintained in the NEHR". More than half of the respondents (1,175 of 2,100; 56.0%) "would like to have their records maintained in the NEHR but do not want any healthcare provider to access it without their explicit consent except during emergencies".

The survey results have helped us to better understand the public perceptions of the NEHR, and the sensitivities regarding the privacy and confidentiality issues of personal medical records that concern the members of the public. With this insight, we hope that it will help to shape how the NEHR will develop especially in the light of the forthcoming HCSA. ◆

MINISTRY OF HEALTH'S STATEMENT ON THE

Joint Public Sentiment Survey on NEHR by AMS, CFPS and SMA

The Ministry of Health (MOH) would like to thank the Academy of Medicine, Singapore (AMS), College of Family Physicians Singapore (CFPS) and Singapore Medical Association (SMA) for providing additional valuable feedback on the National Electronic Health Record (NEHR).

The survey validates much of the feedback that we had gathered during MOH's public consultation sessions in early 2018 from various stakeholders, including current and prospective licensees, professional bodies, and members of the public.

The survey indicates broad support for the NEHR as an enabler to facilitate care continuity as patients move across healthcare settings. We are also heartened that respondents agreed that the NEHR will raise patient safety by enabling medical professionals to access critical medical information during emergencies.

The survey findings reiterate concerns similar to those raised during the public consultation, such as patient confidentiality and data security. MOH plans to enact legislations to protect patients' healthcare data and usage in NEHR.

As patient confidentiality is of utmost importance to us and in view of the recent major cyberattack on SingHealth's database, MOH has directed the Integrated Health Information Systems (IHiS) to conduct a thorough review of the robustness of the cyber safeguards of our key IT systems. These include the NEHR, which is different and separate from the affected system at SingHealth. While we conduct this review, we will take a pause on our plans on mandatory contributions of healthcare information to NEHR. This will allow us to review and strengthen our cybersecurity measures where necessary before proceeding.

MOH recognises that doctors and dentists, as future users of NEHR, play a critical role in ensuring that electronic medical records are used safely, effectively, and ethically for the benefit of our patients. We thank AMS, CFPS, and SMA once again for sharing their survey findings with us. ◆

WEIGHT LOSS

A VIABLE WAY TO MANAGE AND REVERSE TYPE 2 DIABETES MELLITUS?

Text by Dr Tan Tze Lee, Deputy Editor

Diabetes mellitus has always been a major health challenge for Singapore, and it has become such a big problem in recent years that our Government declared war on diabetes in 2016. As of 2014, there were already 440,000 Singapore residents aged 18 years and above who had diabetes, and this figure is projected to increase to 1,000,000 by 2050. The cost to treat diabetes would thus become even more astronomical, from costing $940,000,000 in 2014 to a projected $1.8 billion in 2050! From previous surveys, one in three diabetics was also found to have poor control of their diabetes.

Conventional medical wisdom has long regarded type 2 diabetes mellitus (T2DM) as a chronic disease, capable of amelioration alone. For many, their experience would be of a steady increase in blood sugar with no cure in sight. Beta-cell function correspondingly declines inexorably over time, associated with a steady decrease in beta-cell mass. After ten years of T2DM, 50% of such patients would require insulin in order to maintain good glycaemic control.

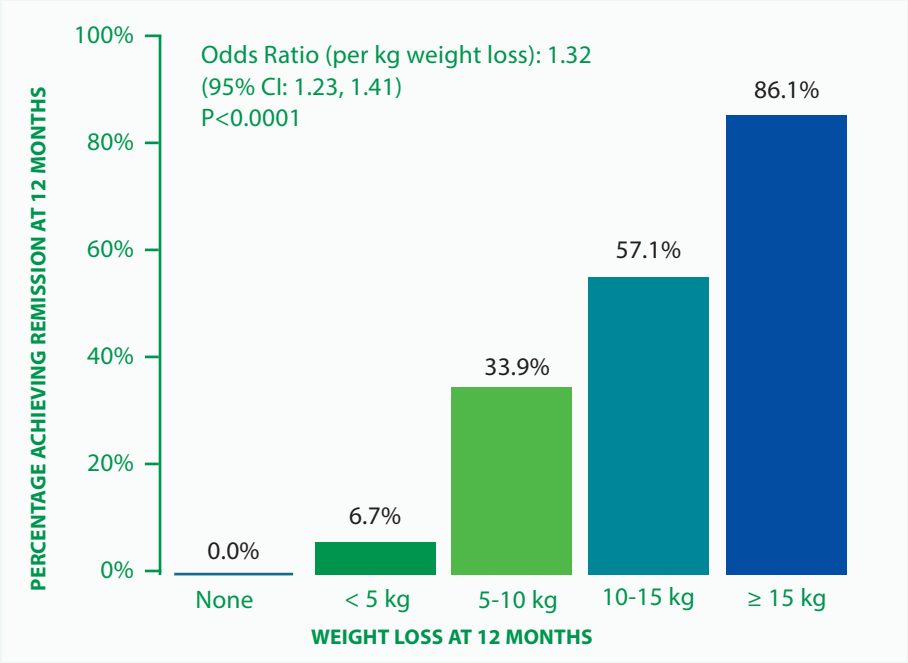
However, evidence has begun to emerge of the potential reversal of T2DM in patients undergoing bariatric surgery, with normalisation of blood glucose levels within days of the procedure long before any major weight loss had occurred. There was also evidence that moderate energy restriction could lead to improved blood sugar control.

In light of this, a group of researchers in Northern England hypothesised that the effect of profound negative energy balance on the metabolism leads to the post bariatric surgery effect. By decreasing intracellular fatty acid concentrations in the liver, the consequent lower export of lipoprotein triacylglycerol to the pancreas allows beta cell recovery by a reduction of the chronic inhibitory effects of excess fatty acid exposure. This hypothesis culminated in a preliminary study published in 2011 that demonstrated for the first time that pancreatic beta cell function and insulin resistance could be normalised by acute negative energy balance alone. After a week of dietary restriction, fasting glucose had reduced from 9.2+/-0.4 mmol/l to 5.9+/-0.4 mmol/l ($p=0.003$). The first-phase insulin response increased from 0.19+/-0.02 mmol/min/m2 to 0.46 +/-0.07 mmol/min/m2 ($p<0.001$). Insulin suppression of hepatic glucose output improved from 43+/-4% to 74+/-5% ($p=0.003$). Hepatic and pancreatic triacylglycerol both decreased from 12.8+/-2.4% and 8.0+/-1.6%, respectively, to 2.9+/-0.2% and 6.2+/-1.1%, respectively.

In conclusion, this study showed that by eating very much less, (in this case, 600 kcal per day for eight weeks), diabetes mellitus could be reversed.

Although the results of this study were very striking, it had clear limitations, not least that it only had 11 subjects matched to eight controls. However, it sets the stage for subsequent studies to follow.

In December 2017, the same research group published an article reporting on a much larger study they had conducted on 306 subjects



Adapted from Lean MEJ, Leslie WS, Barnes AC, et al. (6)

in 49 primary care practices in Northern England and Scotland. The subjects were between 20 and 65 years old, diagnosed with T2DM in the previous six years, with a body mass index of 27-45 kg/m2 and were not on insulin. In this open-label, cluster-randomised Diabetes Remission Clinical Trial (DiRECT), participating practices were randomly assigned to provide either a weight management programme (intervention) or best practice by guidelines (control). Intervention comprised of withdrawal of anti-diabetic and antihypertensive drugs for the intervention group participants. The participants were put on a very strict total diet replacement of around 825 to 853 kcal per day formula diet for three months, followed by a two- to eight-week food reintroduction, structured support for long-term weight loss maintenance thereafter and monitored over 12 months. The aims were to achieve weight reduction of 15 kg or more and remission of diabetes (defined as having a HbA1c of less than 6.5% after at least two months *without* diabetic medication). Acute weight loss and low energy formula diets are associated with an acute drop in blood pressure, hence the withdrawal of the antihypertensives. Antihypertensives are reintroduced only if the systolic blood pressure exceeds 140 mmHg.

The results of this large primary care-based study were quite astonishing. After 12 months, 24% of the participants achieved weight loss of 15 kg or more. Overall, 46% of the participants achieved diabetes remission. Remission depended very much on the amount of weight loss, with 7% in those with 0 kg to 5 kg loss, 34% in those who lost 5 kg to 10 kg, 57% in those who lost 10 kg to 15 kg, and 86% in those who lost 15 kg or more. Almost 50% of those who participated in their study achieved remission to a non-diabetic state and were off anti-diabetic medication, and 68% of the intervention group also remained off antihypertensive drugs at 12 months. The authors concluded that remission of T2DM should become a practical aim for primary care.

DiRECT clearly demonstrated that T2DM of up to six years' duration could potentially be reversed. Furthermore, it showed that weight loss of sufficient magnitude for remission could certainly be attainable by individuals in a non-specialist primary care setting manned by primary care staff.

More research, of course, needs to be done on this. Meanwhile, for those of us working in primary care, we need not tarry, and should take this as ample encouragement for us to try to do the same for all our diabetic patients. ◆

Notes

1. Extrapolation based on National Health Survey 2010, Ministry of Health, Singapore.

2. Projection done by Saw Swee Hock School of Public Health, Singapore.

3. Ministry of Health, Singapore.

4. Poor control is defined as having HbA1c ≥ 8%.

5. Lim EL, Hollingsworth KG, Aribisala BS, et al. Reversal of type 2 diabetes: normalisation of beta cell function in association with decreased pancreas and liver triacylglycerol. Diabetologica 2011; 54(10):2506-14.

6. Lean MEJ, Leslie WS, Barnes AC, et al. Primary care-led weight management for remission of type 2 diabetes (DiRECT): an open-label, cluster-randomised trial. Lancet 2018; 391:541-51.

Dr Tan is a family physician in private practice in Choa Chu Kang. A GP at heart, he believes strongly in family medicine provided by family physicians embedded in the community.

PROFESSIONAL ACCOUNTABILITY

[PART 2]

Text by Dr Peter Loke

This is the second instalment of a two-part series. The first instalment was published in the July 2018 issue of SMA News (http://bit.ly/2Mn2vte).

Professional accountability and the law

While professional self-regulation as enforced by the Singapore Medical Council (SMC) is empowered by legislation (the Medical Registration Act [MRA]), the law also has a direct role in enforcing accountability on the medical profession. This is separate and administered differently from the SMC disciplinary process. While disciplinary matters in the SMC are ultimately judged by a Disciplinary Tribunal, matters in relation to law are decided by the courts of the land. The penalty also differs; the SMC can fine or suspend a doctor, or revoke his/her licence, whereas the remedy in legal cases in tort is a claim for damages (money), and in contract in the medical context would commonly be money. A licenced doctor can potentially face a complaint in the SMC and a lawsuit for the same matter. A simple way of looking at them is that they are two parallel, separate systems of answerability and administration.

Two areas in law that a medical professional can be held accountable for are breach of contract or tortious negligence. When a patient pays a doctor for medical services, the essential elements of a contract are fulfilled; the doctor offers the medical service, the patient accepts this offer with the consideration of the fees (money) and there is an intention to create the relationship. The doctor has an implied duty to exercise reasonable care and skill, and falling below this can be construed as a breach of contract. The remedy for breach of contract is to place the "innocent party" in a position as if the contract had not been breached. There is no need for harm to have resulted to the patient. A doctor can also be held to a breach of contract if a specific outcome is promised for a treatment (eg, this treatment is guaranteed to deliver 10 kg of weight loss in two weeks) and the outcome is different from what is promised.

In reality, the principle area in law that the medical professional is held accountable for is the tort of negligence. In this context, quantifiable harm that directly results from falling below the minimum standard of care expected in law is actionable against the doctor. There are three key elements that must be fulfilled for the tort of negligence to occur. There must be a duty of care (a "given" in the normal doctor-patient relationship), breach of this duty and quantifiable harm that directly flows from this breach. The restitution for this harm is damages in the form of money, which is paid to the person harmed. The test to determine minimum standards is different for diagnosis and treatment (Bolam-Bolitho test),[1] for provision of information and advice (Hii Chi Kok test)[2] and for SMC cases when the charge is professional misconduct (Low Cze Hong test).[3]

The Bolam test: The test is the standard of the ordinary skilled man exercising and professing to have that special skill; it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.

The Bolitho addendum: A defendant doctor cannot escape liability for negligent treatment or diagnosis simply because he leads evidence from a number of medical experts who are genuinely of the opinion that the defendant's treatment or diagnosis accorded with sound medical practice, because what is required is that the practice must be accepted as proper by responsible, reasonable and respectable professionals, and the court must be satisfied that the exponents of the body of opinion relied upon can demonstrate that such an opinion has a logical basis.[4]

The Bolam-Bolitho test (summary): The minimum standards are not breached if a respectable, responsible and reasonable body of professionals considers the practice as proper, so long as this opinion is able to withstand the scrutiny of logic, is internally consistent and has taken account of recent advances.

The Hii Chii Kok test: Also known as the modified Montgomery test, this entails

three stages or questions for the plaintiff to succeed in a claim against the doctor:

1. Patient must show that the information the doctor failed to disclose was:
   a. information that would be relevant and material to a reasonable patient situated in the particular patient's position; and
   b. information that the physician knows is important to the particular patient in question.

   This is the "Reasonable Patient" test.
2. If patient succeeds at the first stage, the Court will then determine whether the doctor was in possession of that undisclosed information, and if not, why so.

   This is judged by the Bolam-Bolitho standard.
3. If the doctor was in possession of that undisclosed information, the doctor must then show that in all the circumstances, he was justified in withholding the information. Eg, waiver by patient ("I don't want to know any more"), emergencies/principle of necessity or therapeutic privilege.

The Low Cze Hong test: Professional misconduct can be made out in at least two situations: first, where there is an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency; or second, where there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.

Potential for criminal charges

Negligence leading to grievous harm or death can constitute a criminal offence. Under section 304A of the Penal Code, whoever causes the death of any person by doing any negligent act is punishable with imprisonment. Under section 338A of the Penal Code, whoever causes grievous hurt to any person by doing any act so negligently as to endanger human life or the personal safety of others is punishable with imprisonment, or a fine, or with both.

The hurt designated as "grievous" is defined in section 320 of the Penal Code as such: emasculation; death; permanent privation of the sight of either eye; permanent privation of the hearing of either ear; privation of any member or joint; destruction or permanent impairing of the powers of any member or joint; permanent disfiguration of the head or face; fracture or dislocation of a bone; any hurt which endangers life, or which causes the sufferer to be, during the space of 20 days, in severe bodily pain, or unable to follow his ordinary pursuits; or penetration of the vagina or anus, as the case may be, of a person without that person's consent, which causes severe bodily pain.

While a doctor has not to date been found guilty of criminal negligence arising from medical care, other healthcare professionals have been. In the case of Siah Kah Ying, a pharmacist was fined $6,000 for negligently causing the death of a 78-year-old diabetic lady who was prescribed ten times the dose of her diabetic medication.

In Lim Poh Eng v Public Prosecutor, a practitioner of traditional Chinese medicine was convicted under section 338 of the Penal Code for having caused grievous hurt by negligently failing to attend to the patient's complaints adequately after administering colonic washout treatments and failing to refer her to the hospital for treatment. These omissions gravely endangered the patient's life and she lost her rectum.

The difference in criminal as compared to civil cases is the standard of proof required; criminal cases must be proved beyond reasonable doubt, whereas the standard for civil ones is the balance of probability.

Summary

In summary, professional accountability in its strict sense is entrusted to and administered by the SMC, largely delineated by the statements in the SMC Ethical Code and Ethical Guidelines and the principles that underlie them. Law applies to society at large, but ones such as the MRA, Mental Capacity Act, Infectious Diseases Act, Penal Code and some common law concepts in Negligence, Confidentiality and Contract, are particularly pertinent to or specifically for the medical profession. Consideration should be made whether the adversarial approach to settling disciplinary issues should be utilised significantly more judiciously. ◆

References

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3. *Low Cze Hong v Singapore Medical Council [2008] 3 SLR 612; [2008] SGHC 78.*
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Dr Loke is an adjunct senior lecturer in Centre for BioMedical Ethics, National University of Singapore; faculty member of the SMA Centre for Medical Ethics and Professionalism; and a partner of Resolvers Pte Ltd, a dispute prevention and resolution company. He is a partner in Mint Medical Centre, a family medicine clinic, and Regional Medical Adviser for Syngenta Asia Pacific Pte Ltd.

HOLISTIC CARE FOR SINGAPORE'S VULNERABLE POPULATION

Interview with Dr Goh Wei Leong

Dr Goh Wei Leong is a GP who has been running a general health clinic in Chinatown for 30 years. He is also the co-founder of HealthServe, a charitable organisation set out to bring healthcare, dental services and care to the migrant community here in Singapore. In recognition of his and HealthServe's tremendous efforts and work, Dr Goh was named Singaporean of the Year in 2017. One year on, we speak with Dr Goh to understand more about his vision for HealthServe, as well as the impact the award has had on him and the organisation.

Please tell us more about yourself and how you first got involved in volunteerism.

Growing up, I had always wanted to be a GP, so it's no surprise that I am now a GP with a practice at Chin Swee Road, on the outskirts of Chinatown. I serve a very colourful multi-ethnic community of those living in one-room rental flats, homeless families, the elderly poor, and people from the lower strata of society. Because we are in a commercial building, my patients also include lawyers, businessmen and traders. I enjoy my practice, and these varied communities helped shape me.

Legend

1. Dr Goh posing for a wefie *with some of HealthServe's beneficiaries*

2. Dr Goh attending to a migrant worker

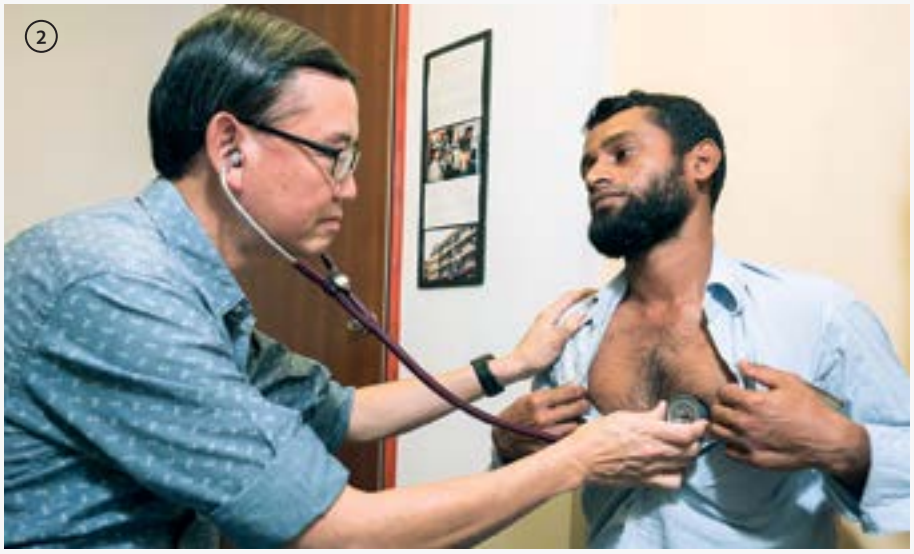
I was first introduced to the world of volunteerism some 20 years ago, when I went to Mongolia to conduct medical checks for NGO workers in 1995. Seeing how they served the common humanity, bringing relief and expertise while also learning from the locals, opened up my world; it also challenged and reframed my Christian worldview. It was a beautiful picture and I wanted to be a part of that – it became my inspiration. When I started visiting India in 1996, I was further challenged. I was confronted with issues of the world that I had been sheltered from and had no experience with in the context of my Chin Swee clinic. Going to India and Mongolia opened my eyes to all these issues in a bigger way. I later also got involved in crisis and disaster relief, and was confronted by the mass devastation and human helplessness brought on by the super cyclone that hit Odisha, India, in 1999.

In 2000, I met Dr Simon Mahendran, who had opened the Karunya Community Clinic for migrant workers in Little India, at a conference in Taipei. Being a dentist, he was lacking a medical network, and I was introduced to the migrant community in Little India. This was perfect since I already had experience from my trip to India and had an understanding of the South Indian community. I was typically a networker. For me, the idea of volunteerism has always been that it is a shared platform for collaboration and friendships, bringing people together to share their medical expertise, talents and passion for a greater cause. The opportunities I had to meet people involved in the NGO, relief and volunteer world helped established the networks that I now have, eventually culminating in HealthServe and the volunteer work that I now do.

Reaching out to the migrant community

What was your motivation in setting up HealthServe?

While helping out at the Karunya Community Clinic, I realised strongly that there was a lack of efforts in social justice among the marginalised communities around me, especially for the migrant workers. Recurring world and local issues, such as poverty in its different forms, propelled me to action.



Within my role as a doctor, I also felt a sense of detachment where running a clinic well does not extend beyond the medical prescription. The social contexts of our patients are conveniently overlooked. Perhaps a holistic approach to medicine was simply assumed. I wanted to change that and effect a cultural shift in thinking and approach.

How has HealthServe grown since its establishment?

It started out as a clinic in 2007 with a small team consisting of one clinic manager and five volunteer doctors. In the course of learning about our beneficiaries and surrounding community, we gleaned that more had to be done to achieve whole-person/holistic care, beyond just dispensing treatment or medicine. The care needed includes psychosocial support for those who experience deep despair or display symptoms of anxiety and helplessness. I also saw and heard for myself their revealed needs for basic food provision, transport costs and even dental care.

We are blessed to be able to operate in the migrant dormitories now. We have a total of three community clinics providing medical and dental services, a Welcome Activity Centre in the Tai Seng industrial area, as well as two case work offices, in Geylang and Little India, respectively, where many low-wage migrants live. These clinics are supported entirely by donations and a large team of committed volunteers who go the distance to serve regularly despite their hectic schedules. Across our centres, we have 431 active volunteers as of July 2018, comprising 151 doctors, 28 dentists and 46 nurses.

We also partner with corporate groups like Changi Airport Group, and healthcare systems like Singapore Health Services and National Healthcare Group, to reach out to workers who may not come to our doorstep and to increase awareness among medical personnel.

We have also been given opportunities to be involved in educating both the youth and adult learners, through our collaboration with institutions such as Ngee Ann Polytechnic, Nanyang Polytechnic, Temasek Polytechnic, Singapore University of Social Sciences, Singapore Management University and National University of Singapore.

We are also involved in advocacy through the communicative exploration of social injustice themes in the arts. For example, in May this year, as part of our fundraising efforts and awareness agenda, we engaged Pangdemonium! and had donors and supporters come together to watch a play which featured migration and its challenges as its central theme. During the Saturday matinee show, we even had a dialogue with Adrian and Tracie Pang on the topics of social justice and migration.

What challenges have you encountered and how did you overcome them?

On a personal level, I am continually confronted with new situations. Being exposed to new facets of medical work in HealthServe deeply challenged my own presuppositions.

At the community level, I was introduced to communities that were very different from the one I had known. The community I was familiar with – the professional community – had its own set of expectations and high-minded solutions. However, upon implementation, we realised that we needed to be more sensitive to the voices and needs of those we serve. Thus, the migrant and the professional came face to face with cross-cultural difficulties impeding our understanding of one another. For example, we gave out Panadol for headaches, but the workers' needs sprung from more complex issues that required listening, which were perhaps better served by a counsellor. Now, as we learn to be active listeners rather than quick advisers who try to "fix" these people, our methods continue to

be sharpened and shaped by the broader perspectives across communities.

At the national/policy level, I found that as comprehensive as our national policies are, realities on the ground are quite different. Active engagement has helped us overcome some of the challenges of making these policies understood and positively contextualised. For example, we have found workers without insurance coverage even though this is required by law, owing to non-compliant employers. This poses a huge problem when the worker is injured. Hence, we act as a bridge between the workers and the Ministry of Manpower, so that the existing policies protect and provide for the vulnerable worker/patient.

On a cultural and global level, migration is a tremendously complex issue especially with increasing xenophobia and fear of the "alien" in our midst. How can we work towards a major cultural shift? This is something that I am still working on, and I have noted that the ongoing rhetoric in the social media needs to be counter-balanced with positive humane stories of reciprocal friendships and a celebration of common humanity. Our land and selves have been shaped by the migrant worker, and vice versa.

What are some improvements that you most want to see happen for migrant workers here in Singapore?

I want to see their inherent dignity recognised by all who come to interact with them. Doctors are at the forefront and we can influence our colleagues to make this difference in the life of a fellow human being. For example, migrant workers should have the freedom to rest when they need it, such as when they are injured. They should also have space for themselves and all the simple entitlements accorded with human dignity.

As doctors, we often view these workers through the diagnostic lens of searching out medical problems to identify solutions. However, these workers are often also breadwinners, and sons and daughters from struggling families who anticipate their safe return.

Recognition

How did it feel to be awarded the Singaporean of the Year 2017?

It has been extremely humbling. I enjoy serving and the little that I have been involved in has borne fruit far surpassing my imagination. The people who are part of this team, be it staff, donors, supporters or volunteers, have done so much more in unison than what I could have ever done on my own, and they all deserve the same honour. I also see the contributions of our migrant beneficiaries on a daily basis – they are our heroes too, and this has shaped HealthServe's work and given it the flavour that it has today – one of diversity, generosity and an inclusive community.

Has receiving the award made any difference for you and HealthServe's work?

Yes, we now have more opportunities to share our perspectives with curious onlookers. HealthServe is an open-learning platform, and we find millennials and retirees coming to us for meaningful and engaging opportunities to serve. **Central to our communal efforts is our vision of a society where every migrant worker leads a dignified life.**

There is an inherent danger of being put on the pedestal, which has increased as well. How do we retain simplicity and integrity as we develop deeper and further? Thus, as much as possible, I try to give the migrant workers an opportunity to speak for themselves, rather than have me as the object of attention.

Personal thoughts

What are your visions and hope for volunteerism?

I hope to see greater generosity, creativity, innovation and learning cultivated through role reversal. For example, our migrant worker beneficiaries are empowered when they are invited to teach visiting medical students their values, hopes, life lessons and practical skills, such as cooking.

We want to nurture reflective practitioners who are deeply sensitive to the environment and society that is constantly changing. Generosity and a willingness to learn from those we serve will strengthen our community.

How can our medical colleagues get involved in the work that you do?

Simply by viewing and respecting every worker in your own practice as a unique and precious human being, you would already be doing your part in this work. We welcome volunteers at our clinics as well, especially orthopaedic surgeons and dentists. We are also looking at creating a list of HealthServe-friendly doctors and specialists who would be keen to partner HealthServe by providing subsidised care for those who are struggling to pay. This will go a long way in serving the most vulnerable in our society.

Remember to swing by our clinic in Geylang when you are having a meal in the vicinity; the food in this area is wonderful and we can provide you with the latest culinary advice in exchange for some meaningful volunteer hours! ◆

Legend

3. Chinese dumpling is one of the dishes our migrant worker beneficiaries have taught medical students

Photos: HealthServe volunteers

SMA Seminar

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TOPICS INCLUDE

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- Employment Act and Central Provident Fund (CPF) Act obligations
- Pay and incentive packages – common practices
- Questions and answers

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READY, LET'S GOLF!

Text by Sylvia Thay, Assistant Manager

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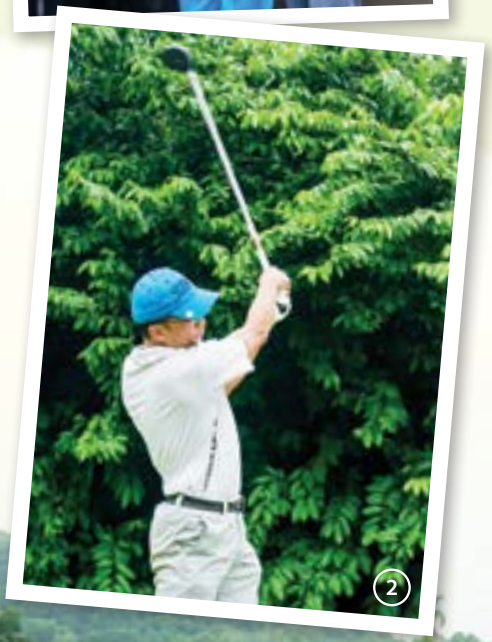

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From as early as 12 pm, golfers began streaming in to Raffles Country Club (RCC) in high spirits despite the gloomy weather. Thunderstorms had been frequent in the week leading up to the SMA Annual Golf Tournament on 27 June 2018, but participants were eager and determined to play the course for it was likely the last opportunity to do so before RCC closed its doors for good.

At the sound of the shotgun, all 78 golfers headed out in their assigned flights, vying for the numerous trophies and awards that awaited them, especially the very attractive hole-in-one prize – a Mercedes-Benz E 200 AVANTGARDE. Despite the drizzle at the beginning of the tournament, many golfers commented that the weather was good (perhaps thanks to the chilli and onion spotted along the course) and that the well-maintained course was a pleasure to play on.

As the tournament came to a close, the participants freshened up and gathered in RCC's Stamford Suite, in anticipation of the dinner and prize presentation ceremony ahead. Dr Chan Kwai Onn, this year's convenor, delivered a short welcome address where he thanked our generous sponsors before announcing the commencement of dinner.

As the golfers chatted over the scrumptious buffet dinner, many regular faces were spotted, such as those of Drs William Verhoeven and Yvonne Soong. The couple has been participating in the tournament for well over ten years and this year was no exception. Always keen to spend an afternoon with friends and experience the camaraderie exuded, Drs Verhoeven and Soong would often encourage friends and colleagues to register for this yearly affair together.

Golfers also took advantage of the dinner break to visit the three booths put up by SMA eMarket, Singapore Medical Group and Bizmann System (S) Pte Ltd. Through visiting the booths, our participants learnt more about the convenience accorded to SMA Members via the SMA eMarket platform, where Members can purchase medical products from the comfort of their clinics or homes; Singapore Medical Group's

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"I have been participating in the SMA Annual Golf Tournament since 1967, when there were only about two dozen players. I have rarely given it a miss since, because it is a good opportunity for us to associate with fellow doctors and it is where my love for both my profession and golf can come together."
– Dr James Chang Ming Yu, Trophy Sponsor

revolutionary CardioScan; and the power of digitalisation, complete with a short presentation by Ms Michelle Ang of Bizmann System (S) Pte Ltd.

Moments later, the prize presentation took place amid much cheer and excitement. Our youngest and first-time SMA Annual Golf Tournament participant, Dr Jen Chi Loong, bagged awards for the longest drive and for coming in second place in the Stableford "A" Division. When approached, he shared that attending the tournament has given him the opportunity to not only experience the golf course at RCC, but has also connected him with other members of the profession, especially the new friends he made within his flight and over dinner. Perhaps not unexpectedly, with the many excellent GP representatives bagging the top prizes, the GP team emerged the winner of the Best Team award for the third consecutive year!

The day soon came to a close after the final lucky draw prize, a Wilson D300 Driver, was won by Dr Sim Kwang Soon. We look forward to another great afternoon of golf, fun and laughter next year with both our regular participants like Drs Verhoeven and Soong, and new friends like Dr Jen! ◆

Congratulations to the Winners!

Best Gross:
Dr Gary Chee

Best Stableford:
Dr Leslie Kuek

Best Nett:
Dr Adrian Tan Yong Kuan

Best Senior Golfer:
Dr Lee Yew Chung, Peter

Best Senior Lady Golfer:
Dr (Mrs) Chang Li Lian

Best Lady Golfer:
Dr Soh Joo Kim

Best Team (GP vs Specialist)

Winner: GPs
Dr Adrian Tan
Dr Gary Chee
Dr Chong Tat Chong
Dr Soh Joo Kim
Dr Chen Sze Sin

Runner-Up: Specialists
Dr Tan Jee Lim
Dr Edward Foo
Dr Chan Kwai Onn
Dr Tay Jam Chin
Dr Chua Yang

Friends of SMA

Winner:
Mr Andrew Ng

Runner-Up:
Mr Alfred Ting


5


6

Legend

1. Golfers undeterred by the rain

2. Tee off in action

3. Drs William Verhoeven and Yvonne Soong (first two from left) with their friends in the same flight

4. Dr James Chang presenting the lucky draw prize to his wife and fellow participant, Dr Chang Li Lian

5. Watch out for the crocodiles!

6. Marking the spot

7. Dr Jen Chi Loong (first from left) posing for a group shot with his flight mates

Acknowledgements

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A PURPOSEFUL AND FUN-FILLED DAY

COMBINED EFFORT FOR HOSPICE PATIENTS

Text by Tan Si Qi and Joshua Tan | Photos by Jacy Mok (LKCMedicine)

The Lunar New Year may have come and gone, but for patients at the HCA Day Hospice Centre, the fun and festivities continued as students from all three local medical schools – Duke-NUS Medical School (Duke-NUS), Lee Kong Chian School of Medicine (LKCMedicine) and NUS Yong Loo Lin School of Medicine – paid a visit on 6 March 2018. The students spent an afternoon with the patients, baking pineapple tarts and making handcrafted cards together.

A common goal

Over the past few years, our healthcare system has evolved in many ways, including the inception of new medical schools to meet the needs of our population. This HCA Day Hospice event was special as it was the first, but certainly not the last, community service collaboration between the three medical schools. This initiative started when the three schools' community service directors met up and agreed that there should be more opportunities for medical students to serve the community while getting to know our future colleagues better.

As it stands, there are many different projects running across the three schools, from health screening projects to those that target migrant workers, people with special needs, the elderly and the terminally ill. We wanted to kick-start with an event that was not too intensive, so that it could be an enjoyable way for the students to meet one another while doing something in line with the festive season for the community.

Thus, when HCA Hospice Care (HCA) offered us the opportunity to set up an afternoon of activities at their day hospice centre, we readily accepted.

HCA is a home hospice programme in Singapore that provides care for palliative patients who have prognoses of six to 12 months. Patients receive care via both the home and day hospices, which offer singing and music therapies, free haircuts, art and crafts, pet therapies, physiotherapies and outings.

On the event day, 27 of us headed to HCA Day Hospice Centre to set up the two stations for the day's activities. Each patient was then paired up with a student buddy for the day.

Engaging activities

Soon, the patients were all gloved up to roll their own homemade pineapple tarts which were baked on the spot and could be brought home to share with their families. Although it was a simple process of wrapping each ball of pineapple tart filling with a disk of pastry dough, many of them took the opportunity to get creative and have fun. Some included sesame seed decorations

"Making pineapple tarts and scrapbooking with the patients at the HCA Day Hospice Centre was a fun and meaningful experience for me. The patient with whom I was partnered told me that he doesn't usually do much, so I'm happy that we managed to bring some joy and excitement to these patients' lives. I was especially touched when the patients applauded us at the end of the activity. It was also heartening to see how the dedicated staff at the Centre had established great rapport with the patients and even knew their individual mannerisms by heart. Additionally, it was a good opportunity for us to interact with our future colleagues from other medical schools." – Justin Lim, M1, LKCMedicine

to "mark out" their exact tarts, while others experimented with different shapes, including 3D animal designs. It was certainly heart-warming to see some of the physically disabled patients engage in this activity with a bit of aid. One of them even mastered rolling pineapple tarts with one hand!

While the pineapple tarts were in the oven, the patients got started on scrapbook making and calligraphy. On top of providing art materials, we also took Polaroid photos of them with their friends, both old and new, as mementos of the day. A student from LKCMedicine conducted the calligraphy lesson. In fact, even the student volunteers expressed their interest in learning from her as well. The day's activities ended just in time for an afternoon tea break of hot drinks and fresh pineapple tarts.

The healthcare landscape is changing, and as we shift from a hospital-centric to a community-based model of care, our community service projects must also adapt to remain relevant and innovative. Moving forward, we will make a greater push to integrate students across the different healthcare-related faculties in our various projects, encouraging inter-professional partnerships from an early stage of their career, even as they give back to society.

Since our inception in 2013, SMA Charity Fund has been actively engaging various stakeholders through four strategic initiatives: providing financial assistance to needy medical students through the SMA Medical Students' Assistance Fund (SMA-MSAF), advocating volunteerism by promoting and supporting meaningful student-led healthcare projects, supporting learning exposure by sponsoring underprivileged students for overseas learning conferences, and recognising mentorship by acknowledging exemplary medical educators.

Legend

1. Justin and his buddy with the cards they made and the Polaroid they took together

2. Nicole, medical student from Duke-NUS, working with two of her newfound friends as they roll the dough to the right size for baking!

3. The student volunteers who took the afternoon off to be with the patients at HCA Hospice Day Activity Centre

Si Qi and Joshua are medical students and heads of Community Service programmes at Duke-NUS Medical School and Lee Kong Chian School of Medicine, respectively.

CONNECTING SENIORS TO SOCIAL AND HEALTH SUPPORT IN THE COMMUNITY

By Agency for Integrated Care

Overseen by the Ministry of Health and the Agency for Integrated Care, the Community Networks for Seniors (CNS) programme brings government agencies and community partners together to bring "ABC" – **A**ctive Ageing, **B**efriending, and **C**are and Support to help our seniors age gracefully. The CNS will be progressively expanded to achieve nationwide coverage by 2020.

Silver Generation (SG) Ambassadors actively reach out to all Singapore Citizens aged 65 and above to share with them activities and services under CNS. They are trained to identify the needs of seniors and will link vulnerable seniors to social and health community partners, so that they receive timely help.

THE "A, B, C"s OF AGEING WELL

WELL SENIORS

Active Ageing:
Encourage seniors who are well to stay active, healthy and socially engaged by participating in active ageing activities

LONELY SENIORS

Befriending:
Connect seniors who are lonely or at risk of social isolation with volunteers within the neighbourhood

FRAIL SENIORS

Care & Support:
Ensure frail and vulnerable seniors get health and social support services

ACTIVE AGEING:

There are regular Active Ageing Programmes (AAPs) conducted in more than 360 neighbourhoods today. Over 7,000 seniors have also attended functional screening sessions to have their eyesight, oral health and hearing checked.

Health Screening

- **Functional Screening:** Eyesight, hearing and oral health checks for Singapore citizens aged 60 and above.
- **Health Coaching:** Seniors can visit Community Health Posts and consult health coaches on how to adopt a healthier lifestyle.

Exercises

- Seniors can join a range of different exercise classes, including Resistance Band Exercises, Low Impact Aerobics, Line Dance, Qigong and Taichi in the community.

Social Activities

- **Seniors Health Curriculum:** Seniors can attend workshops to learn about healthy ageing, such as tips on healthier lifestyle choices.
- **Healthy Cooking Classes:** Seniors can attend cooking classes to learn how to prepare healthy dishes.
- **Social Activities:** Seniors can join activities such as Karaoke and Cafe Corner and make new friends.

BEFRIENDING:

CNS connects lonely seniors to befrienders and neighbourhood volunteers who help to keep an eye out for these seniors.

CARE & SUPPORT:

CNS assists seniors with complex health/social needs by referring them to community and government partners to render holistic and integrated assistance.

NEIGHBOURHOODS WITH CNS:

1. Aljunied GRC
2. Holland-Bukit Timah GRC
3. Ang Mo Kio GRC
4. Bishan-Toa Payoh GRC
5. Chua Chu Kang GRC
6. East Coast GRC
7. Jalan Besar GRC
8. Jurong GRC
9. Marine Parade GRC
10. Marsiling-Yew Tee GRC
11. Nee Soon GRC
12. Pasir Ris-Punggol GRC
13. Sembawang GRC
14. Tampines GRC
15. Tanjong Pagar GRC
16. West Coast GRC

If you wish to refer seniors to CNS services indicated above or sign up as Silver Generation Ambassadors, please call the Singapore Silver Line 1800 650 6060

Recipes FOR THE Home Cook

As we continue on our journey towards a healthier nation, home-cooked meals are surely a step in the right direction. Below are three delightful recipes that Dr Soh Poh Choong, Dr Alex Wong and Dr Tan Tze Lee have personally crafted for your consumption. Do feel free to share these recipes with your colleagues, friends and patients!

Dr Soh is a principal resident physician in Ng Teng Fong General Hospital Emergency Department. She spends much time doing community work, that includes cooking demonstrations, and giving talks on anti-smoking and the benefits of drinking water. She hopes to empower as many students and their parents as possible, with the knowledge to lead a healthy lifestyle.

Low Carbohydrate Grain Crackers

Recipe and photo by Dr Soh Poh Choong

Ingredients

- ½ cup sunflower seeds
- ½ cup pumpkin seeds
- ¼ cup flax seeds
- ¼ cup sesame seeds
- ½ cup chia seeds
- ¼ cup buckwheat cereal
- 1 cup filtered water
- 1 to 1¼ tsp of salt (depends on how salty you like your cracker to be)

**Duration of bake may vary with ovens. When ready, the cracker should be crispy when cooled to room temperature.*

Cooking method

1. Rinse the sunflower, pumpkin, flax and sesame seeds, and allow to air dry.
2. Pour 1/3 of the above into blender, pulse it a few times till most of it is crushed.
3. Pour in all remaining ingredients and mix thoroughly.
4. Allow mixture to stand for at least 30 minutes.
5. Pour mixture onto a piece of parchment paper, cut to the size of your tray.
6. Line another piece of parchment paper above it and roll the mixture till it is flattened evenly to the preferred thickness.
7. Remove the top parchment paper and place the flattened mixture with the bottom parchment paper into the tray.
8. Bake in pre-heated oven (approximately 150 degree Celsius) for 35 minutes.
9. Remove tray from oven and line the top of the cracker with a fresh piece of parchment paper.
10. Turn the cracker over and remove the used parchment paper.
11. Cut the cracker using a pizza cutter into bite-sized crackers.
12. Place the cracker back in the oven to bake for another 35 minutes.*
13. Remove tray from oven and cool the cracker thoroughly before storing in containers.

Cherry, Nut and Goat Cheese Salad

Recipe and photo by Dr Alex Wong

Ingredients

- 300 g fresh greens
- ½ cup fresh cherries (or any similarly sweet and crunchy fruit)
- ½ cup chopped cashews or pecans
- 150 g goat cheese (or a strong cheddar or gouda)
- 2 large sliced red onions
- 2 large eggs

Balsamic vinaigrette dressing

- ¾ cup olive oil
- 3 tbs balsamic vinegar
- 2 tsp minced red onion
- ½ tsp dried oregano
- ½ tsp salt
- ¼ tsp pepper

Cooking method

1. Boil and slice eggs.
2. Combine all salad ingredients in a large bowl.
3. Mix dressing; drizzle on salad and toss.

Mussels with White Wine and Tomato

Recipe and photo by Dr Alex Wong

Ingredients

- ¼ cup olive oil
- 3 cloves garlic, chopped
- 2 brown onions, chopped
- 1 stalk leek, sliced
- 4 large plum tomatoes
- 2 cups white wine
- 1 capful whisky
- 2 cups chicken stock
- ¼ cup chopped fresh basil
- ¼ cup chopped Chinese parsley
- 2 stalks lemongrass
- Salt and pepper (to taste)
- 24 mussels

Cooking method

1. Wash mussels in several changes of cold water.
2. Using a sharp knife, remove beards.
3. Soak mussels for about 30 minutes in cold water containing a handful of salt and flour.
4. Heat oil in heavy saucepan, add onion and saute till translucent.
5. Add garlic and leek and saute until soft and aromatic but not brown.
6. Add tomatoes, parsley, basil and lemongrass.
7. Deglaze with whisky and white wine.
8. Add chicken stock. Bring to a boil till all alcohol has boiled off.
9. Simmer for about 15 minutes to evaporate half the remaining liquid.
10. Just before serving, add the mussels, cover and simmer for 3 to 5 minutes to allow the mussels to open. Discard any that don't.
11. Add salt and pepper to taste.

Dr Alex Wong is a private practitioner of medicine. He believes that ethical private practice is possible but accepts that he has delusional views at times and writes in an effort to try and distinguish these from reality. Occasionally, these ramblings spill out into actual articles, which should always be read with a large spoonful of salt, 200g of char-grilled beef and a spot of freshly squeezed lime juice.

Dr Tan is a family physician in private practice in Choa Chu Kang. A GP at heart, he believes strongly in family medicine provided by family physicians embedded in the community.

Turmeric and Ginger Fish Head

Recipe and photos by Dr Tan Tze Lee

Ingredients

- 1 thumb length blue root ginger, diced
- 1 thumb length old root ginger, diced
- 3 to 4 sticks lemongrass, diced
- 4 large red onions, diced
- 2 cloves garlic, diced
- 4 dried chili, diced
- 1 thumb length turmeric root
- 4 tbs turmeric powder
- 4 tbs peanut oil
- 1 large brinjal, cut to bite-size
- 2 medium tomatoes, cut to bite-size
- 500 g ladies' fingers, cut to bite-size
- 1 large fish head (1 to 1.5 kg)
- Salt and fish sauce to taste
- 1 large fresh red chilli
- Fresh coriander

Cooking method

1. Put diced blue root and old root gingers, lemongrass, onions, garlic and dried chili into a blender and blend till smooth. Remove and put in a mixing bowl, add turmeric powder and stir to a paste.
2. Heat oil in pan and gently fry the paste until aromatic. Be careful not to let it burn.
3. Add cut brinjal, tomatoes and ladies' fingers to the frying paste. Add small amounts of water until the sauce covers the vegetables. Slowly simmer for 30 minutes.
4. Put the fish head in a steaming dish and steam with a pinch of salt, 1 stick of lemongrass and some diced old root ginger for 20 minutes.
5. Put steamed fish head in a serving dish and pour the sauce on top of the fish.
6. You may wish to sprinkle a dash of fish sauce for seasoning. Serve with coriander and cut fresh red chilli.

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*For enquiries, please contact Denise or Jasmine at tel: **6223 1264** or email: **OPG_LPA@sma.org.sg**. For more information on the LPA, please visit the Office of the Public Guardian's website at **https://www.publicguardian.gov.sg**.*

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