SMA news

For Doctors, For Patients

VOL. 49 NO. 11 | NOVEMBER 2017 | MCI (P) 034/01/2017

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SMA news
Vol. 49 No. 11 | 2017

PUBLISHER
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UEN No.: S61SS0168E

DESIGN AGENCY
Oxygen Studio Designs Pte Ltd

PRINTER
Sun Rise Printing & Supplies Pte Ltd

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SERVICE before SELF

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

Tina Tan
Deputy Editor

More likely than not, each of us encounter individuals who stand out as exemplary upholders of the public service ethos of our profession. This includes those who volunteer amid their busy schedules, those we look up to as our teachers and mentors, and those who serve in the community in various ways. No matter how disillusioned or cynical we may be, it can be argued that the vast majority of us are in this profession because there is some part of us that wants to help those who can't help themselves. Remember those medical school motherhood statements you used to say to yourself before reality hit?

Thus, this month, we bring you an interview with Dr Marcus Tan, a psychiatrist who runs a practice in the heartlands with two of his colleagues, Dr Thong Jiunn Yew and Dr Seng Kok Han, the latter of whom I've had the pleasure of working with some time ago as a resident. The goals of Dr Tan and his colleagues have been to increase the ease of access for mental health patients and reduce the stigma of seeking help.

We also feature an article by Dr Roy Joseph, who is no stranger to many of us in the field of medical ethics. He relates his experience in public service and his journey towards serving as Chairman of the National Medical Ethics Committee.

A/Prof Daniel Fung shares his enriching experience volunteering with the Singapore Association for Mental Health and recounts how he started volunteering. He also makes a case for why doctors make great volunteers.

I now move on to another subject featured in this issue: generalists. It's the latest new-old term being used by the Ministry of Health and has, as expected, started a nice debate about the roles of specialists versus that of generalists. A/Prof Cheong Pak Yean and his colleagues ask questions about whether such a distinction should even be made. This is especially relevant given the Government's repeated calls for young doctors to choose generalist disciplines, in response to changing population needs.

Prof Helen Smith writes about the importance of research in the primary care setting and how it can help drive the development of primary care in Singapore. Dr Wong Tien Hua also adds to the discussion in his monthly column, about the increasingly crucial role of GPs in Singapore.

As you can see, this month's issue covers a variety of topics, touching mainly on public service and primary care, including the Government's hottest new topic on generalists. As for the latter, I hope that the articles featured will spur further conversation and submissions from my fellow SMA Members. Keep calm and please write in. We'd love to hear from you. ◆

Bringing Affordable Psychiatric Care TO THE HEARTLANDS

Interview with Dr Marcus Tan

Introduction

Drs Marcus Tan, Thong Jiunn Yew and Seng Kok Han run a community-based psychiatric practice, operating out of two clinics. The three of them got to know each other during their National Service days more than a decade ago, where they served in succession at the Singapore Armed Forces Ward, Alexandra Hospital. There, they ran both the inpatient psychiatric ward and day centre for distressed servicemen. We are glad to speak with **Dr Marcus Tan** to find out more about their vision of bringing psychiatric care to the heartlands.

Legend

1. L to R: Dr Seng Kok Han, Dr Marcus Tan and Dr Thong Jiunn Yew

Could you tell us more about your psychiatric practice?

Jiunn Yew and I started the practice in 2010, while Kok Han joined us in our fifth year of practice. Each of us brings to our practice some 18 to 20 years of clinical experience.

Despite us having rather different personalities, we became close friends and discovered that we share the same vision and passion for the work we do. Understanding each other on a personal level has been really helpful in allowing us to anticipate each other's practice requirements, needs and goals. I think this understanding is essential to form the stable foundation necessary for a working partnership that endures, much as we are still a relatively young practice compared to our seniors in more established practices.

Our flagship clinic is situated at Ang Mo Kio Avenue 10, nestled in an aged neighbourhood precinct populated by a mix of old- and new-school hair salons, hardware stores, itinerant fortune tellers on makeshift tables, mom and pop Chinese grocery shops, a wet market and food centre, a Taoist shrine, traditional Chinese medicine physicians and several GP clinics.

This location holds personal meaning to me. I grew up in Ang Mo Kio and this was one of those places my friends and I hung out at in our teens. The neighbourhood has changed a lot, obviously, but this remains a place that most locally born Singaporeans can relate to. We wanted our practice to be situated in the community, in a place where we live and work, and I could not think of a more ideal spot. With the occasional wafts of fried salted fish mixed with the buttery aroma of kopitiam coffee, and strains of Hokkien songs playing from the HDB flats above our shophouse clinic, it does not get more heartland-like than this.

Our other clinic operates out of Novena Medical Centre, which is more centrally located to serve our patients working near or in town. They visit us on their way to or from work, and sometimes during their lunch hours.

What motivated you to go into the heartlands?

The phenomenon of hidden morbidity is well recognised in psychiatry. Through the course of our work in public institutions, we came to know of the need for greater accessibility to psychiatric services. Apart from the unfortunate stigma attached to being diagnosed with a psychiatric illness and seeing a psychiatrist, persons afflicted with psychiatric conditions can be apprehensive to seeking treatment due to the perceived costs involved in the private sector.

I recall that in the year 2007 or 2008, I had the opportunity to see a pair of parents who were in acute grief after losing their child to suicide. Part of their anguish was that while they knew that their child needed help, they were unsure of how to go about doing so. They had not been keen to approach public institutions as they feared that their child would be left with having "an official record" that would affect his future. While this fear is really quite unfounded given strict guidelines on medical confidentiality, this is a worry that is real and continues to be present for many. Over the course of my work with them, it became apparent that we can do more to provide timely access to psychiatric services for those in the community who are in need.

Instead of waiting for patients to show up at the doorsteps of psychiatric departments of general hospitals and the Institute of Mental Health (IMH), we decided that the way forward in combatting mental illness is to bring our services to the heartlands, where most of us live and work. In addition, a presence in the community will likely go some way to help our efforts in de-stigmatisation. Doing so also avails us opportunities to link up with GP clinics, as well as community mental health and social resources – all of which are important components of a comprehensive mental wellness service.

The concept of establishing a psychiatric service in the heartlands is not new; some of our seniors have also done so, mostly on an ad-hoc basis, before we did. IMH has also established outpatient clinics in polyclinics, but waiting times for appointments can be long.

The opportunity came along when we were approached to join private practice. At that time, we were offered several locations in private hospitals to choose from for our clinic. We managed to state our case for a community-based, heartland practice to serve the needs of the local population.

And here we have been, for the last eight years.

Could you share with us the working model of your practice?

Our practice is focused on providing affordable, financially sustainable and accessible psychiatric care at a one-stop location. To do so, we try to keep consultation rates as low as possible. We also take care to practise judicious prescribing and avoid polypharmacy as far as we can. The latter helps contain treatment cost.

The main challenge we face, like any other private clinic in Singapore, is that the cost of medications are significantly higher than what public institutions obtain them for. The other challenge is rental which, I believe for other clinics too, is an escalating cost over time.

We do what we can to minimise the cost of goods and overheads. We source for the most affordable alternatives for medications, order in bulk to leverage on the economics of scale and constantly review our work processes to reduce wastage. Office products are "recycled" and at times "repurposed". Savings are then passed on to patients.

To further help defray the cost of running the clinics, we also take on teaching assignments and involve ourselves in employee assistance programmes and external contracts for on-site consultation.

We are proud to note that the average cost of care at the practice is contained below $10 per day – around the price of a meal from the food court – for the majority of our clients. This also gives us some bandwidth for pro bono work with selected cases.

To ensure that quality of care is not compromised by the patient volume we manage, we cap the maximum number of patients seen per session to

"When lost or in doubt, always remember to do right by your patients. The rest will follow."

ensure that sufficient time is allocated for each consultation. To enhance accessibility, we also have to ensure that our clinics open long enough to minimise first appointment waiting time. To accommodate patients who prefer to see us after work or during weekends, we run evening clinics on most weekday evenings till late and back-to-back sessions on Saturdays into the afternoon. This in turn has translated to rather long working hours. Apart from ward rounds which are done before and/or after clinic hours, we run as many as 13 sessions per week. Weekends are seldom protected time off and it is not uncommon for us to work some 70 hours per week.

One feature of our practice is that we work alongside our GP partners to co-manage stable patients on maintenance treatment. Once the patients are stable, they are returned to their GPs who continue care, until the time when they are well enough for treatment to be discontinued or when unwell. For the latter, we will take over management until the patients are stable enough to be returned to the GP or be discharged. Anytime an opinion or sounding board is needed, we are just a phone call away from our GP colleagues.

Apart from attending to our patients from referral and walk-in sources, we also offer what we term "transitional care" for patients who already have appointments from the outpatient departments to public hospitals, but are unable to wait. For this group, we provide earlier assessments and initiation of treatment where we manage the patients until they see our public sector counterparts. This helps to moderate the cost of care for them too. I believe that this initiative to promote early intervention has made a difference, especially for those who are in crises.

Administratively, we look after different aspects of the practice. Jiunn Yew takes charge of the day-to-day operational and logistical issues, Kok Han manages the staffing, while I look into our liaison with the community and professional partners. I also work on charting the practice's focus and overall direction. Having said so, most issues that arise are discussed, with a consensus reached before decisions are made.

What keeps you going when dealt with challenges/difficulties?

Being in the community, we do not have the benefit of support from a multi-disciplinary team that can help to share the workload. Some cases can be rather difficult – not just from a biological point of view, but a psychosocial one as well. When faced with challenging cases, we confer mini "grand ward rounds", or peer review learning as it is called now, to discuss the case and bounce ideas for treatment off one another. I am glad to note that the staunch peer support that we have cultivated in the practice over the years has helped sustain us. While we may differ in opinions at times over operational and clinical decisions, we have always managed to resolve our differences.

On a personal level, we are also good friends who play well together. Despite our schedule, we make it a point to meet regularly for dinner to catch up. When possible, we also travel together for conferences and leisure.

I have to admit that the engaging nature of the practice and the often hectic day-to-day routine takes a toll in more ways than one, at a cost to our personal lives. The people around us may not always understand why we do what we do. This is also when we turn to each other for support.

At this point, I am glad to say that we are blessed to have understanding families and supportive partners who appreciate the nature of our work.

Are there any memorable patients/ incidents in your years of practice?

The accessibility of our location, to some extent, avails us to patients from all walks of life. Over the past eight years, we have had some really interesting cases. We have diagnosed clusters of folie à deux or delusional disorder by proxy, treated cases of psychosis initially attributed to paranormal causes, and exposed doctor-hopping benzodiazepine abusers – in one case, a patient tried to impersonate her twin!

Being in the heartlands also allows us to leverage on our surroundings for therapy. I recall how I used to take buses with patients to help them habituate the anxiety they feel. I have also utilised coffee shop toilets for exposure and response prevention therapy for some of my patients with obsessive-compulsive disorder. Some years back, I had a young patient who had a phobia of trees after seeing his family home get demolished by a falling tree during a typhoon. He would get really nauseous and throw up while on his way to school. To overcome his fear, we took to climbing trees at one point. Although that helped his condition, it did not end well for me.

Of course, it is not always all rosy. We have had to contend with threats and even some rather "colourful" letters from anti-psychiatry individuals. It's all in a day's work. What matters is that we do our best so we can go home and sleep easy.

What lessons do you have to impart to our younger colleagues just starting out?

Private practice is not as easy as how it may look from the other side. It comes with its own set of challenges. Contrary to what some may think, the main driver for most of us moving out from the public sector is to have the control to shape the practice we want.

Some do hit the big time, but most of us just get by.

No matter what, don't lose yourself. Work for your passion for the art and be prepared to work very hard. Take time out when you need to. Don't burn out. While it may get lonely at times, you know that support, in the form of colleagues, is always only a call away.

When lost or in doubt, always remember to do right by your patients. The rest will follow. ◆

GENERAL PRACTICE RESILIENCE: SOLO IS NOT SILO

Text by Dr Wong Tien Hua

Deciding to go into general practice has never been an easy choice. In earlier days, general practice was sometimes a default vocation that doctors slipped into when they could not specialise. Family medicine was not well defined and the skill sets and competencies required were not adequately covered in medical school.

GPs were true generalists who had to learn how to handle whatever cases that came their way. They had to develop the clinical skills and acumen to treat patients spanning the demographics of age, illness and social status – including patients from the very young to the very old, patients presenting with both physical and mental ailments, as well as patients suffering from both acute and chronic diseases.

The GP also has to contend with the business and management aspects of running his/her clinic. Most GP clinics are run by solo practitioners who own their practice, typically operating with long opening hours. They have to hire and train their clinic assistants, manage the logistics of a pharmacy, and attend to accounts and legal matters. There is also the additional burden of handyman tasks such as electrical work and plumbing, and nowadays with the increasing use of computers, having to troubleshoot information technology (IT) matters as well. It is like having the roles of the chief executive officer, clinical services, human resources, legal, accounts, property management and IT departments all rolled into one.

All the extra tasks may sound daunting and will certainly take time to master, but I suspect most GPs will not trade that away for the professional autonomy that they currently enjoy, and the ability to practise medicine in a setting where they can make a difference to the community. Running one's own practice allows the doctor absolute freedom to do whatever he/she chooses within legal and ethical boundaries. "Being your own boss" means that there is no one to report to and that you are able to be the captain of your own ship.

The *Straits Times* recently ran a feature on Dr George Khoo,[1] possibly Singapore's oldest practising GP at the age of 89, who has been practising at his solo clinic at Rochor Centre since 1963. In the article, he described his experience treating patients from the nearby brothels and opium dens back in the days. He has even treated not just three, but four generations of family members. One can imagine the immeasurable long-term impact Dr Khoo has made to the health of the community in Rochor, where his practice has been embedded in for more than 50 years!

Roles of the family practitioner

The concept and practice of family medicine, and the operations of general practice that we see in Singapore today, have indeed come a long way.

The clinical skills required to perform in a primary care setting is now well documented. The World Organization of Family Doctors (WONCA) published a good description of the special characteristics and roles of general practice and family medicine (see page 10). It includes not only factors of good clinical care but also takes into account the social, psychological and even philosophical aspects of holistic care.

The training of family medicine starts from medical school with the necessary curriculum in family medicine, as well as exposure and attachment to primary care services. After graduation, residency for family medicine is available to train doctors towards the Master of Medicine (Family Medicine) degree. Doctors can also opt to sign up for the two-year Graduate Diploma in Family Medicine course conducted by the College of Family Physicians Singapore. The Register of Family Physicians was set up in July 2011 and serves to recognise medical practitioners who have relevant qualifications and set the standards of practice for family medicine.

Solo but not silo

Many commentators have long hailed the demise of the solo practitioner, given the rapid changes in Singapore's healthcare landscape. The fact is that the majority of private GP clinics are still operated by solo GPs today, the percentage of GPs in group practices has not increased in the past decade. The Ministry of Health's Primary Care Survey 2014 showed that only 27% of GP clinics considered themselves in a group practice (two or more clinics).[2] The figure was 27% and 26% in 2010 and 2005 editions of the survey, respectively. The difference is in the groups; the number of clinics in group practices has grown, with a significant increase in group practices that have 40 to 59 branches.

Because medicine is becoming more complex, no single doctor can effectively manage the wide range of cases that present in primary care. Hence, there is now a bigger focus on a team-based approach.

Government polyclinics are excellent examples of multi-disciplinary primary care setups, providing high-quality care and services all under one roof. The latest new generation polyclinics look like private establishments, with modern furnishings and the latest technology such as self-registration, electronic records and remote medication collection.

Family Medicine Clinics (FMCs) were introduced in 2011 as a response to the shifting need for team-based approaches in primary care. FMCs are managed by a group of like-minded GPs who work together to provide comprehensive team-based care for patients, especially those with chronic diseases.

The **business environment** has also been getting harsher and more unforgiving. Gone are the days of cheap rental, low wages and low cost supplies. Operating costs for clinics have been on the rise, with rental and staff salaries now accounting for a large percentage of expense. The cost of drugs and equipment has seen year-on-year increases; yet professional fees have not changed much over the past decade. Because of smaller volume, solo GPs find it hard to take advantage of economies of scale; they therefore need to constantly operate under maximum efficiency in order to survive.

Regardless of these external pressures, I still believe that there is a unique role for solo GPs despite the rapid changes in our healthcare system, and I also believe that solo GPs are more resilient than most would estimate. Because the fundamental unit of healthcare boils down to the doctor-patient relationship, the solo GP who provides personalised healthcare and who is accessible to the community will continue to be sought after by patients and families. Patients seek that *one* family doctor whom they can relate to personally. If you look at the roles and competencies of the GP as described by WONCA, there is nothing listed that a solo GP cannot do, and nothing that cannot be overcome with some support and technology.

The singleton GP today may be *solo in makeup, but no longer silo in function*.

Advances in technology mean that doctors can be well connected. For example, doctors can join in a physician network to consult with other colleagues, use electronic records to access investigation results and

Illustration: Dr Kevin Loy

Dr Wong Tien Hua (MBBS[S], MRCGP[UK], FCFP[S], FAMS[Fam Med]) is President of the 58th SMA Council. He is a family medicine physician practising in Sengkang. Dr Wong has an interest in primary care, patient communication and medical ethics.

procedures done, and enlist and refer patients to allied healthcare workers that are available in the community. The advent of the smartphone and mobile apps has allowed doctors to join virtual chat rooms where clinical conundrums are discussed. The National Electronic Health Record is being refined and will eventually be widely available to primary care physicians, allowing them to tap into the public hospital database.

Technology also enables solo GPs to purchase drugs and equipment through cooperatives and online markets where collective bulk purchase can achieve lower costs. SMA just launched our **SMA eMarket** at the recent FutureMed 2017 event.

The SMA eMarket seeks to become a common procurement platform for private medical clinics and healthcare institutions to access basic medical supplies, equipment and services.

The Ministry of Health announced the scaling up of **Primary Care Networks** (PCN) at the Committee of Supply Debate 2017. The PCN pilot had shown that private GPs could operate very effectively with good outcomes as long as there was adequate support that enabled them to handle complex diseases. In PCN, solo GPs and small group practices will be organised into virtual networks to deliver care through a multi-disciplinary team approach. Counsellors and diabetic screening services will be provided on-site at the GP clinics to assist in managing chronic diseases.

The European definition of General Practice/Family Medicine[3]

The role of the GP includes:

- being the point of first medical contact within the healthcare system, providing open and unlimited access, for all health problems both acute and chronic;
- coordinating care within the healthcare system;
- practising patient-centredness in the context of family and community;
- enabling patient empowerment;
- focusing on a long-term doctor-patient relationship and continuity of care;
- making clinical decisions taking into consideration the prevalence of illness in the community;
- managing undifferentiated illnesses at presentation;
- ensuring health promotion and community health; and
- dealing with all aspects of health in their physical, psychological, social, cultural, and even existential dimensions.

WONCA also defined six core competencies that are essential for the GP.

These include:

1. Primary care management such as dealing with undifferentiated illness.
2. Person-centred care including respecting patient autonomy.
3. Specific problem-solving skills to guide decision-making in primary care settings where sophisticated tools are not available.
4. Comprehensive approach to care including acute and chronic problems, health promotion and preventive health.
5. Community orientation emphasising on what the patient presents in the context of family and social settings.
6. Holistic approach.

Antifragility in general practice

The concept of antifragility was proposed by Nassim Nicholas Taleb in his 2012 book, *Antifragile: Things That Gain From Disorder*. **Fragile** systems break down under stress and tension while **resilience** allows systems to resist shocks and to recover from failure. However, the opposite of fragility is not resilience, because resilience maintains or returns the system to the same/prior state. Taleb coined the word "antifragility" to describe a system that goes beyond resilience or robustness. Antifragile systems not only recover but *improve* under stress. An example in biology is the necessity of constant exercise and bearing of weights to stress and hence strengthen bones and muscles; the removal of which results in atrophy.

Based on the above description, **I think that general practice is antifragile**. In the face of rapid change and constant challenges, general practice remains not only resilient but adaptive as well. New policies and schemes have come and gone. GPs have seen through different partnerships, engagements, funding plans and business practices, and have continued to adapt, consolidate and thrive amid all these.

Finally, to the solo GPs who sometimes feel that their existence is being threatened, I quote the German philosopher and existentialist Friedrich Nietzsche who so eloquently said: "That which does not kill us, makes us stronger." ◆

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HIGHLIGHTS

FROM THE HONORARY SECRETARY

Report by Dr Lim Kheng Choon

Dr Lim Kheng Choon is the Honorary Secretary of the 58th SMA Council. He is currently an associate consultant at Singapore General Hospital.

Developments in mental capacity assessment for PWIDs

As part of our ongoing efforts to increase awareness on and to train more doctors to perform mental capacity assessment for persons with intellectual disabilities (PWIDs), SMA Centre for Medical Ethics and Professionalism (CMEP) worked with the Ministry of Social and Family Development (MSF) to develop a Mental Capacity Assessment Tool and an online training module to educate and guide doctors.

In addition, SMA CMEP, in collaboration with MSF, organised its first seminar "Mental Capacity Assessment for PWIDs" on 30 September 2017. More than 50 doctors participated in the event which was conducted by Dr Bhavani Sriram, Dr Wei Ker-Chiah and Dr Giles Tan. Highlights included a practical demonstration of the Mental Capacity Assessment Tool via a video interview with a patient with Down syndrome. The session concluded with a panel discussion comprising healthcare and legal professionals involved with PWIDs. The next seminar is scheduled for April 2018. Do look out for it.

MOH Primary Care Survey 2014 results

On 10 October 2017, several SMA Council Members met with representatives from the Ministry of Health (MOH) to discuss the findings of the 2014 MOH Primary Care Survey. The report can be found here: https://goo.gl/mo9SNs.

In feedback, SMA asked for more financial data to be presented in future reports, as financial sustainability is one of the major concerns facing primary care clinics. We also provided suggestions on encouraging more doctors to participate in future surveys. SMA urges Members to participate in such surveys, as these represent an important source of feedback to policymakers and can potentially influence policies.

SMA eMarket Portal

From October onwards, SMA Members can embark on a new purchasing experience with SMA eMarket (https://www.smaemarket.sg). This portal connects Members with potential suppliers, such as medical device companies and clinic-related service providers, enabling them to procure services and products. It provides seamless communication and real-time order tracking features to improve the productivity for all parties. It allows Members to engage, discuss, place orders, set up delivery, and receipt goods and invoices with the suppliers.

SMA Members can access the portal with their member ID and the user guide can be retrieved at https://goo.gl/wKndHu.

Retention period for medical records

SMA recently received several queries from Members relating to medical records. We wish to take this opportunity to remind Members on two MOH documents relating to medical records:

1. National Guidelines for Retention Periods of Medical Records (Dated 28 Jan 2015)
2. Specific Licensing Terms and Conditions (LTCs) on Medical Records for Healthcare Institutions (Dated 06 Aug 2015)

Members can download the documents from the MOH webpage at this URL: https://goo.gl/5yoSgp. ◆

END-OF-LIFE MATTERS

32ND CMAAO GENERAL ASSEMBLY

Text by Dr Chong Yeh Woei

Photo: CMAAO

I always look forward to the annual Confederation of Medical Associations in Asia and Oceania (CMAAO) meetings in September, and this year it was hosted in Tokyo by the Japan Medical Association (JMA). Tokyo has always been special to most of us who have been there, and it is especially so because of the food. The quality of the sushi and sashimi, the delicacy of tempura, the elaborate courses of kaiseki, and the delicious sake and local beers have enthralled all of us with gastronomic delight.

Our meeting was held in Odaiba; to the uninitiated, that is the new part of the city bordering the Tokyo Bay. The hotel held a beautiful view of the bay with its Golden Gate Bridge lookalike – the Rainbow Bridge. The national medical associations (NMAs) present at the meeting included 20 member associations and an invited guest from the Israeli Medical Association. It is amazing how the 21 countries in attendance represented some 3.8 billion people.

The guest of honour was the first female governor of Tokyo, Yuriko Koike. She delivered her speech in perfect English and, in line with the topic of the meeting on end-of-life issues, spoke rather intimately about care giving and looking after her 88-year-old mother before she perished last year from dementia.

Updates from each NMA

The meeting commenced with the usual presentation of country reports where we learnt about problems relating to the respective NMA's populations, health systems, governments, disasters and epidemics.

Australia talked about getting its federal governments to reinstate the inflation-linked payments to its GPs, where a freeze on payments with regard to inflation has been in effect for the last few years. Bangladesh and India reiterated their problems with violence against doctors and healthcare workers. Japan continues to struggle with its super-ageing population, and Korea talked about the Fourth Industrial Revolution and on how artificial intelligence like IBM's Watson is impacting medical practice. Myanmar made us smile when we learnt that they launched a support group for elderly doctors above the age of 70. Nepal talked about the recent calamitous events of earthquakes, floods and landslides. Taiwan gave us insights into their concerns on medical indemnity insurance and Thailand reported its success on tobacco control. Pakistan, a founding member of CMAAO but had not been attending for many years, attended this meeting seeking to re-join the organisation and was warmly welcomed by all.

We had our symposium, "End-of-Life Questions", on the second day. The background to the selection of the topic had its origins in the

active euthanasia (AE) and physician assisted suicides (PAS) occurring in North America and certain parts of Europe. In Switzerland, PAS is legal, while both AE and PAS are legal in Belgium, Luxembourg and Holland. In the US, certain states allow AE and PAS, and Canada has recently passed legislation to allow PAS.

The World Medical Association's (WMA) stand on both AE and PAS is that they have no place in medicine. However, with such legislations being passed in North America and Europe, there is pressure building up on the organisation to take a second look at its stand. Hence the WMA council has asked the various regions such as Asia/Oceania, Africa and South America to compile the stands of the regional medical associations on end-of-life issues.

Time to review our stand

The JMA had circulated questionnaires to the individual member NMAs of CMAAO regarding their nations' stands on matters pertaining to AE, PAS, advance medical directives (AMDs), withholding or withdrawing life-sustaining treatments, palliative care and end-of-life care for the super-aged. We heard the various NMAs present their individual country's stand on the various questions.

All nations had no legislations on AE and PAS, though Australia and New Zealand had several parliamentary bills that were defeated in the past. Several countries have AMDs and doctors do talk to their patients about "do not resuscitate" scenarios and on appointing a legal representative with regard to such scenarios.

In half the countries represented, there are legislations or court decisions that support withholding or withdrawing life-sustaining care. Most medical associations support the withdrawal of life-sustaining care in futile situations and such decisions must be made on clinical grounds.

In the questions regarding palliative care, most countries do have some form of palliative care for the terminally ill, ranging from rudimentary to very comprehensive programmes. All countries agree that religion plays an important role in these programmes. There was also a question on the use of opioids in palliative care that was to assess if there are restrictions on use of opioids that hinder its use in palliative medicine. Countries were also asked if palliation was available to patients other than the terminally ill and the majority highlighted that it was available to patients with serious illnesses and/or those in distress.

In the final question, Japan highlighted its problem with the "super-aged" patients who have lost their mental capacity to make decisions, have no advance care planning or legal representatives, coupled with the absence of advanced directives in Japan. The Japanese are looking at some form of guardianship legislation to solve the problem while most countries have addressed the problem with advance directives and advance care planning.

In the final analysis, the consensus was that countries in Asia and Oceania, with the exception of Australia and New Zealand, have no significant desire to move in the direction of AE and PAS. Most countries in this part of the world have support from their religion, family, extended family or clan, and palliative care plans, and therefore have no great desire for AE and PAS. I daresay that when there is great clamour for AE and PAS, it is actually a problem of societal breakdown of family structures and the medical fraternity is trying to solve a difficult problem that society itself cannot do so. ◆

Legend

1. Group photo of CMAAO office bearers, councilors and delegates with guest of honour, Tokyo governor Yuriko Koike

2. Dr Chong with Tokyo governor Yuriko Koike

Photo: Dr Chong Yeh Woei

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

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BASIC HEALTH LAW COURSE

Text by Jasmine Soo, Executive, Event and Committee Support

The Basic Health Law Course, a collaboration between SMA and Singapore General Hospital Postgraduate Medical Institute, was held at Academia over the span of three Saturdays – 2, 9 and 16 September 2017. The course covered the following topics:

- Introduction to Health Law and Legal Responsibilities of Medical Practitioners
- Understanding the Elements of Medical Negligence
- Professional Accountability and Misconduct

The course saw a turnout of 42 participants on Day 1, 45 participants on Day 2 and 38 participants on Day 3. Those in attendance were healthcare professionals from various specialities, such as general medicine, ENT, neurology and gastroenterology. The course was delivered by SMA Centre for Medical Ethics and Professionalism core faculty, which comprised both doctors and lawyers.

During the first session held on 2 September, Adj A/Prof Lee See Muah, Senior Consultant, Occupational Medicine, Ng Teng Fong General Hospital, presented the attendees with the basics of health law. Ms Kuah Boon Theng, Director, Legal Clinic LLC, then provided an elaborate "Introduction to Health Law and The Singapore Legal System" and stressed on how the practice of medicine is founded on honour and integrity. Adj A/Prof Seow Wan Tew, Senior Consultant, Neurosurgical Service, KK Women's and Children's Hospital, then spoke on "Key Statutes and Laws that Apply to Healthcare Practice" and "Introduction to Health Law and Legal Responsibilities and Discussion".

The second session held on 9 September started off with Dr T Thirumoorthy, Immediate Past Executive Director, SMA Centre for Medical Ethics and Professionalism, giving the participants an "Introduction on Medical Negligence", followed by Mr Edmund Kronenburg, Managing Partner, Braddell Brothers LLP, sharing on the topic of "Understanding the Elements of Medical Negligence" with his inputs and experience from a lawyer's point of view. Prof Kumaralingam Amirthalingam, Professor, Faculty of Law Chair, NUS Teaching Academy, National University of Singapore, then spoke on the "Failure to Inform/Advise – the Law on Informed Consent". A case discussion followed, which participants complimented as "objective and robust".

During the third session held on 16 September, Dr Peter Loke, Regional Medical Advisor, Syngenta Asia Pacific Pte Ltd, spoke on "The Medical Registration Act and Professional Accountability" and elaborated on the "Role and Powers of Singapore Medical Council (SMC) and the Importance of the SMC Ethical Code and Guidelines". He also talked about the "Difference between Law, Professional Regulation and Ethical Reasoning". Mr Christopher Chong, Senior Partner, Dentons Rodyk, then concluded the last session of the course with his sharing on "Singapore Medical Council Disciplinary Process and Management of Risk".

Throughout the course, participants were supplied with useful information from both the medical and legal points of view. The course ended with positive feedback from participants, with the weighted average (out of 5) being 4.31, 4.48 and 4.14 for Days 1, 2 and 3, respectively. Participants provided feedback such as "The talks by the lawyers are good! We doctors want to know the legal aspects from medical lawyers." and "Summarised notes and relevant cases were provided to us, and there was good discussion with legal input."

We would like to take this opportunity to thank all speakers and participants for setting aside their time on three Saturdays to attend this course. ◆

Legend

1. Participants being involved in and enjoying Dr Peter Loke's session

Professionalism in Medical Education

WHAT MAKES FOR AN EFFECTIVE STUDENT-FACULTY RELATIONSHIP?

Text by Dr T Thirumoorthy

Introduction

There is significant literature on professional ethical codes of conduct, charters and declarations on the doctor-patient relationship both in clinical care and medical research, but relatively few in medical education on the student-faculty or resident-faculty relationship.

There is ample evidence in the education literature that when students are actively engaged with their teaching faculty while they are in school, they achieve academic success, personal development and career success upon graduation. Conversely, disengaged students who isolate themselves from the school community and do not develop meaningful relationships are more vulnerable to academic failures and poor adaption to working life as professionals. Medical students are more significantly influenced by positive role models in the faculty than what is taught in the classroom.[1]

This article aims to discuss the professional and ethical principles that influence the student-faculty relationship in the education of doctors and other healthcare professionals.

The student-faculty relationship

The fiduciary nature of the relationship

A fiduciary is someone who has undertaken the task of acting for and on behalf of another in a particular matter in circumstances which gave rise to a relationship of trust and confidence. A student is dependent on a teacher in more than one way. The teacher has a duty to offer knowledge, skills and advice that the student needs. At the same time, the teacher is responsible for academic evaluation and the student's academic grades. It is important to recognise the imbalance of knowledge, experience and power that makes the relationship unequal and the student vulnerable to abuse and exploitation. To correct the imbalance, the primary goals of this relationship are the student's academic progress and welfare; this must be upheld above the interest of the teacher and other parties involved.

Managing conflicts of interests and boundaries

The faculty in most medical schools hold only part-time or adjunct roles and may have other obligations which can often cause conflicts with the education of the student. Such obligations include patient care, research, personal academic advancements and administrative duties. Although teachers should not use students to forward their research or academic progress, there are overlapping interests in many situations. Individual, independent and system levels of managing these conflicts of interest should be in place and monitored such that the student's interest and the medical education mission are not sidelined.

There is also a fine balance to be achieved in managing boundaries in the student-faculty relationship. Too rigid an approach to managing boundaries would lead the teacher to be unapproachable, distant and unavailable for emotional support. Conversely, when boundaries are too loose, the initial purpose of the relationship of mentoring, coaching and counselling would be lost in a friendly social relationship. Teachers must be aware of their own mental and emotional state, as this would impact the quality of the teacher-student relationship and risk of blurring of boundaries. Even the best of faculty can unknowingly be drawn into situations of inappropriate self-disclosure, exchanging of gifts, forming intimate or romantic relationships, gossiping about other students and faculty, or inappropriately favouring a few students over others. Faculty needs to be trained and supported by a learning community to grow into healthy role models as mentors, coaches, counsellors and professional colleagues.

Principles of fairness and justice

By recognising one's own biases and prejudices, faculty must be aware not to inadvertently discriminate students based on gender, age, ethnicity, religion,

political affiliation, sexual orientation or socio-economic status. The faculty should provide equal access of educational opportunities to all students under his/her assignment.

Commitment to effective educational methods

Using intimidation, shaming and other invalidated methods of motivating students to learn by fear leads to significant moral distress among students. The "name, blame and shame" culture should be replaced with a safe learning environment that has a system of progressively increasing challenging work for the student with a decreasing intensity of supervision. This allows students to gain the skills and confidence to achieve entrustable professional activities.

Good educational governance should put in place a credentialing process to ensure the evaluation and continuous improvement of teaching skills of faculty.

Commitment to effective management of moral distress in medicine

When a medical student is uncertain about the appropriateness of the behaviour of any other person involved in patient care, faculty must be available to discuss the matter. Any student who feels that he/she has been subjected to unfair treatment because of a refusal to do something that seems to be wrong should seek advice from faculty.

Students struggle with ethical issues in clinical situations, and in research and education. They are fully aware of their lack of knowledge and experience, face pressure to conform to hierarchy and professional culture, and fear jeopardising academic progress and evaluation.

Students should be encouraged to raise ethical issues with the faculty throughout their training and not just when a specific issue arises. Teachers should be receptive of ethical dilemmas or problems that students face and seek to explain the ethics involved, or change the circumstances so that students are not ethically compromised and ensure that patients are respected. Moral distress is described as a silent epidemic that undermines the efforts to promote professionalism and compassion.[2]

Commitment to maintaining professionalism in an educational environment

Lapses in professionalism, such as medical errors and diagnostic errors, are common and inevitable, but some are preventable. The extent of frequency and severity of lapses in professionalism has not been proactively researched and documented. What is clear is that the faculty and medical leadership do not have effective ways of managing professional lapses and continue to tolerate them until they deteriorate into formal complaints.[3] As a profession, we can learn from experience of patient safety governance and culture, that in dealing with lapses of professionalism, there are a combination of systems, contextual factors and individual factors. Faculty must be enabled and the institutional governance must be sufficiently rigorous to analyse, learn from and deal effectively with violations of professional standards and conduct by students, residents and faculty.

Appropriate supervision and delegation

It is important that students should ask for supervision and faculty be readily available to provide supervision when necessary. Faculty must take responsibility not only for the care they provide to patients but also for the care they direct and supervise. The degree or nature of the supervision would depend on the competence, readiness and experience of the student involved. The training system must ensure that students and residents are not pressured to take on clinical responsibilities for care of patients beyond their experience and competence. An effective student-faculty relationship thus can ensure that faculty are keenly aware of the developmental stage of the trainees so that appropriate delegation can take place.

Confidentiality

Faculty and students must respect the confidentiality of information that is given in confidence in the learning environment and the student-faculty relationship, unless there are strong ethical or legal reasons not to do so. Earning trust and confidence in any relationship requires the appropriate confidentiality measures to be applied. Issues that may override the confidentiality promise would include considerations of patient safety, the interest of other students or the school, and public interest.

Conclusion

Going back to our Hippocratic traditions, before the development of medical universities, the teacher-apprentice or guru-disciple relationship was deep and elaborate.[4] Although many old traditions may not be relevant today, it behoves us to reflect the critical factors of the student-faculty relationship of the past, to meet today's challenges such as high levels of burnout in the profession and leadership.[5] A reaffirmation of the professional values in the student-faculty relationship can help in developing positive role modelling habits in the faculty and be an effective way for students to engage the faculty in a more meaningful approach. ◆

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EXTENDING A DOCTOR'S REACH THROUGH PUBLIC SERVICE

Text by Dr Roy Joseph

The Singapore Medical Council's (SMC) Physician's Pledge begins with: "I solemnly pledge to: dedicate my life to the service of humanity; give due respect and gratitude to my teachers…" The Ethical Code in SMC's 2016 Ethical Code and Ethical Guidelines (ECEG) lists 22 directives, all of which, when complied, results in service of the highest order to the sick and the healthy. All physicians become aware of this imperative very early in their training, often within the first year of medical school. A quick look at the membership and leadership of organisations with a strong public service ethos will reveal a disproportionately high number of medical practitioners.

My entry into public service

I was led to this noble activity from young: at home by my parents; in school by my Cub and Boy Scout Masters; in church by pastors; in medical school by my teachers; and as a practising physician, by the numerous opportunities that my seniors, our health system and its administrators have made available. However, physicians are often so caught up in caring for individual patients that the needs of other patients, the healthcare system and that of society, are either not recognised, ignored or seen as someone else's business. The practice of my subspeciality of neonatal paediatrics is unique; because in almost every encounter with a baby who is sick, the doctor has to serve the needs of at least two others: the parents. Paediatric practice hence is a crucible from which the value and imperative of serving others becomes internalised and valued.

My service with the National Medical Ethics Committee (NMEC) began in 2005 as a member and from 2009 as its chairman. This was after a period of serving on the National University Hospital Clinical Ethics Committee. The NMEC was appointed by the Director of Medical Services to advise the Ministry of Health (MOH) on prevailing and projected ethical issues in public health and medical practice. An additional responsibility is to participate in the development of ethical codes of conduct for doctors practising in Singapore. The duty was quite formidable and soon, neonatal books in my library were being replaced by books on ethics. A week-long intensive course in clinical ethics at the Imperial College brought some confidence. My mentor in this endeavour was Prof Alastair Campbell, our first professor in medical ethics.

The experience was an eye-opener as it was the first time that I had to work with others who are not medical doctors to deliberate on matters, especially when their effects on an

individual patient were not immediately apparent. The intense discussions were stimulating. The multitude of perspectives present for each situation taught me the critical need for exercising patience, active listening and the art of ethical reasoning, and it enabled the development of skills in facilitating discussion, distinguishing positions taken from values held, negotiating, mediating and the forging of consensus. The mutual learning that took place among members and the camaraderie that developed were precious and memorable. However, much of this was accomplished "after hours" and with the sacrifice of personal free time.

As our referrals came from MOH, we obtained a ringside view of the issues that confront our administrator colleagues, the diligence and comprehensive manner in which these needed to be addressed, the urgency with which some situations needed to be ethically evaluated and the need for perspectives to be provided. Unlike interventions provided to a patient where the effects are immediately apparent, the opinions we provide often have a long but legitimate gestation period before its effects are visible through enactment into policy, regulations and operational changes that bring quality to our healthcare system. The joy and sense of being part of this change is immense and an important driver of continued public service. Equally vital is the understanding, acceptance and support that I receive from my clinical department and family members.

The scope of medical ethics

The spectrum of situations that we have had to evaluate is wide and usually ends with the offering of a view, recommendation of positions to be taken or the development of guidelines. Some that come to mind are: the remuneration and compensation of subjects of clinical trials; physicians' consent for their patients to participate in research; communication in advance care planning; medical futility; end-of-life decision-making; physician-assisted suicide; surrogacy; cryopreservation of oocytes; multiple fetal pregnancy reduction; in vitro fertilisation mix-ups; posthumous extraction of sperms; living and deceased organ donation; clinical decision-making in collaboration with patients; hospital ethics committees; public funding of high cost treatment of rare diseases; the practice of aesthetic medicine; the practice of psychosurgery; and the separation of conjoined twins.

Though the core of medical practice – the therapeutic relationship that we establish and develop with our patients – remains the same, the environment in which the practice takes place and the forces that will drive it are constantly changing and threatening the relationship. This is best described in SMC's introduction of their new ECEG: "… medical practice in Singapore has evolved to become more complex, with advanced technology, innovative communication means, new modalities of treatment, a wide range of organisational as well as business models…"

These new and evolving relationships and situations require careful and regular ethical evaluation. Physicians need to commit to this domain of public service and in so doing, share the ethical values of the medical profession with members of the public, help to strengthen society, and restore and promote individual health. ◆

Dr Roy Joseph is currently an associate professor in NUS Yong Loo Lin School of Medicine's (NUS Medicine) Department of Paediatrics, emeritus consultant in National University Health System's Department of Neonatology and acting director of the NUS Medicine's Centre for Biomedical Ethics. He also serves on the Singapore Medical Council's (SMC) Working Committee for the review of the SMC Ethical Code and Ethical Guidelines.

THE POWER OF PRIMARY CARE RESEARCH TO INNOVATE CARE

Text and photos by Prof Helen Smith

Think of research and images of technology-cluttered laboratory benches and white coated researchers in the hospital wards immediately come to mind. These are not unreasonable images to have as traditionally, most health-related researches have been conducted in the pathology-rich arena of hospitals. In contrast, relatively little research has been conducted in the primary care setting, and even less among those in the community who are unwell but do not seek professional healthcare.

Yet it is in primary healthcare where all minor illnesses can be treated, where most chronic illnesses (including hypertension, diabetes, asthma and depression) can be managed and where most preventative healthcare is delivered. In a strong primary care system, where all these come together, we see lower mortality rates and fewer premature deaths. So we have an anomaly: the healthcare setting where the majority of management and care can be provided hosts the least research.

Much of the information used to reach clinical management decisions in general practice is still derived from observations in the hospital setting, but such evidence is rarely generalisable and can lead to over-investigating and over-treating patients. Taking headache as an example, 70 per cent of the population experience a headache in one month, and 50 per cent of those who present to their family physician describe their pain as severe. If family doctors were to use hospital-derived evidence, most patients reporting severe pain would be sent for a scan to rule out intracranial disease. We all recognise that this would be completely inappropriate, but the scenario illustrates how evidence derived from studies of selected populations in secondary or tertiary care cannot be applied to the undifferentiated patient population we see in primary care. Family medicine (FM) needs its own evidence because the benefits and costs of diagnostic and therapeutic activities vary with the severity and prevalence of disease and with the patients' behaviour. Thus, decisions about effective management strategies in primary care must be derived from studying the patients who are cared for in this setting. We have a large armamentarium of research methods at our disposal and many of them are adaptations of classical research methods that have been modified to enable us to answer the research questions emerging from the consulting room in general practice. For example, the double-blind randomised controlled trial is the gold standard for assessing efficacy of antibiotics, but when we want to understand the optimal prescribing strategy for patients presenting with sore throat, the comparison is not between "active drug" and "placebo", but rather between immediate prescription of antibiotic, no antibiotic or the offer of prescription if the symptoms do not resolve spontaneously after three days. To generate this evidence, a three-armed open trial that is pragmatic and reflects behaviour in normal clinical practice is required.

Developing primary care's full potential

While the public healthcare sector undergoes restructuring into three regional clusters, the field of primary care and FM – both public and private – has a unique opportunity to influence healthcare delivery and policy. To harness the power of primary care, the Lee Kong Chian School of Medicine (LKCMedicine), together with the National Healthcare Group Polyclinics, has established the Centre for Primary Health Care Research and Innovation. This Centre will evaluate

Legend

1. Prof Smith with the students at the launch of the student special interest group in family medicine

2. LKCMedicine and NHG sign an MOU to launch the new Centre for Primary Health Care Research and Innovation at the Singapore Health & Biomedical Congress 2016

new technologies and innovative ways of delivering high-quality FM, especially to patients with chronic and multiple diseases. Recognising the important role of informal caregivers, and the impact caring can have on the carers' own health, the Centre will also focus its research in this area. Through research training and mentoring, the Centre will contribute to expanding the cadre of FM researchers for Singapore.

Alongside the Centre, LKCMedicine, with the support of the College of Family Physicians Singapore, plans to spearhead a Primary Care Research Network (PCRN) for family physicians and other primary care professionals with an interest in research. The Network will provide members with opportunities to enhance their research involvement through research advice and training, invitations to collaborate in multi-practice studies and opportunities to develop their own research ideas into funded studies. Initial outreach to private GPs has been positive, with many keen to support research projects that are relevant to their routine clinical duties and that can be undertaken without interrupting patient care.

There has been much experience in developing family practice or PCRNs in Europe, Australia and North America. I have previously set up three research networks in the UK, advised on network development in the Netherlands, Canada, Thailand and Australia, and established an international federation of networks.

The contribution to the evidence base that such networks have made is significant. For example, the study of safety and effectiveness of nurse consultation in out-of-hours primary care conducted by the Wessex PCRN informed the reorganisation of out-of-hours care for the National Health Service in the UK. PCRN research has informed prescribing strategies for common acute conditions including childhood otitis media, adult urinary tract infection and cough.

Summarising the totality of the impact of PCRNs is challenging in a short article, but their portfolio spans prevention and health promotion, disease management, palliative care and the organisation of services. In the early days of networks, there were some sceptics who wondered about the generalisability of research hosted by network-affiliated practices. But we have evidence to confirm that despite differences in practice characteristics, patients are representative of the general population. As well as generating evidence, networks can also support the development of research careers; in the UK, we have many examples of the transition of novice researchers to full professors in less than a decade.

Reflecting on over twenty years of involvement with PCRNs, the characteristics of the most successful research networks are strong ownership of the research questions by the participating practitioners, sufficient academic expertise and support, and mechanisms for reimbursement of the practitioners' time. It has been documented that networks develop their own momentum, often starting with simple descriptive studies and soon progressing to larger complex and collaborative projects as members grow in competence and confidence.

In addition, the underlying changes in demographics require us to develop a larger and stronger FM workforce for the future. To inform, enthuse and engage more LKCMedicine students about the opportunities and challenges of FM in the run up to the World Family Doctor Day 2017 celebrations, a special student interest group was launched. I enjoy supporting this group of students in their future careers in FM by helping them develop their ideas for research projects, career talks, lectures and community outreach activities.

Looking to the future

For the continued development of the discipline of FM, it is essential to evaluate the needs of patients and the effectiveness of primary care, and to develop evidence to guide our clinical practice. Primary care is a relatively young research discipline, and I hope that the initiatives I am developing with my colleagues will help swell the research activity and the evidence that underpins patient care in Singapore. ◆

Helen Smith is professor of Family Medicine and Primary Care at the Lee Kong Chian School of Medicine. She has dual accreditation in general practice and public health medicine and has worked in academic, hospital and general practice settings. She was the foundation professor of Primary Care at Brighton and Sussex Medical School. For more details about the Primary Care Research Network, please contact Prof Helen at h.e.smith@ntu.edu.sg.

SPECIALISTS AND GENERALISTS: BRAVING A NEW COMPACT

Text by A/Prof Cheong Pak Yean, A/Prof Goh Lee Gan and Dr Ong Chooi Peng

The call has gone out to young doctors to train in generalist disciplines.[1] Residency places for family medicine (FM), advanced internal medicine (IM) and geriatric medicine have increased in recent years while intake for the traditionally less generalist disciplines have shrunk.

This is a good time to ask ourselves some questions. What makes a specialty? Who is a generalist? If I am not a generalist, am I a specialist? What, exactly, is a specialist? Is everything a dichotomy?

Training as a requirement for specialisation

A medical specialty is a branch of medical practice. It is characterised by participation in advanced professional study and by passing an examination administered by senior members of the specialty.[2]

In 1987, the Senate of the National University of Singapore recognised FM as a medical discipline. In the ensuing years, a framework which encompassed a defined training curriculum and structured assessment with practice, training and research components was developed. This framework spans from undergraduate through advanced postgraduate levels.

The various post-MBBS qualifications in FM are pegged[3] to different levels of mastery on the Dreyfus model of skill acquisition.[4] This model describes skill development along a continuum from novice to expert. The Graduate Diploma in Family Medicine, the Master of Medicine, and the Fellowship, following advanced postgraduate training, are set at "competency", "proficiency" and "expert" levels, respectively. Since 2014, fellows of the College of Family Physicians Singapore have been admitted as fellows of the Academy of Medicine, Singapore. One could say that FM meets the definition of a medical specialty.

Until recently, doctors who were specialists and doctors who were non-specialists formed two neat groups demarcated by the Specialist Accreditation Board (SAB). The Singapore Medical Council (SMC)

lists 35 accredited specialties and five accredited subspecialties.[5]

FM is not listed as an accredited specialty. Ironically, FM is an accepted feeder discipline into three of the five subspecialties, viz. aviation medicine, sports medicine and palliative medicine.

Who is a generalist?

The SMC does not define a generalist.

What is generally accepted, however, is that the generalist is the doctor who is not organ-defined; hence the general physician, the geriatrician and the family physician. Clearly, these doctors have undergone structured training and appropriate assessment to get to where they are, and they practise with a clear ethos of their chosen discipline. IM and geriatrics are recognised specialties, and we have seen that FM is de facto a specialty too.

Perhaps it is time to recognise that the old dichotomy is flawed. The generalist is not distinct from the specialist. The generalist, dedicated to the whole person, rightly is distinct from the doctor who focuses his practice on specific organs or body systems.

What makes a specialist?

Does training in a discipline and passing the prescribed examinations make one a specialist? This has been the traditional view. In Singapore, we have the added assumption that the training is focused on specific organs or body systems, or specific skill sets, for example, respiratory medicine or orthopaedic surgery.

In 2011, Singapore embraced the American residency system. New terms entered our lexicon: core competencies, milestones and competency-based training. (Note that competency here refers to the ability to do something, and differs from Dreyfus' competency, which describes a stage in skill acquisition.) Today, a doctor successfully exits residency when he has demonstrated that he has fulfilled the core competencies and passed the relevant examination.

For some residencies, the five or six years of training are divided into basic residency and advanced residency. For example, IM residents complete their basic training in three years, following which they embark on a further period in other training such as renal medicine, cardiology or advanced IM. They may then apply for accreditation by the SAB and registration under their specialty by the SMC.

FM is a three-year programme, following which the doctor may embark on training in palliative medicine, sports medicine or aviation medicine, or the two-year advanced programme in FM. If one trains in any of the first three subspecialties, one may then apply for accreditation by the SAB and registration under the subspecialty.

We propose that the Dreyfus model of skill acquisition may be a useful reference. For FM, the doctor who completes advanced training has been trained to the expert level. It is cogent to consider the family physician with advanced training the equivalent of a specialist in FM.

Quo vadis?[a]

Beyond the specialist-generalist discussion lies other questions.

Jonathan Glass reminds us that medicine, for much of its history, has been about the pursuit of excellence.[6] Today's paradigm is the pursuit of competency in medical education. Perhaps technology, statistics and complexity have so irreversibly altered our landscape that competency alone can deliver the number and skills that we need. Is this the age of the medical technocrat?

What makes the true expert? Intuitively, we recognise genuine mastery as a combination of training and experience. Long practice and faithful application cannot be easily fitted into five or six years. This may be especially true when a specialty is not limited to a body system, but encompasses the whole person. Let us be careful lest we produce many doctors who are qualified generalists or specialists, but who fall short of wisdom. ◆

Note

a. Latin for "where are you going?"

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Pak Yean, Lee Gan and Chooi Peng are family physicians and colleagues at the National University Health System Family Medicine Residency Program. From time to time they enjoy gathering to ponder contemporary family medicine issues.

Fostering Stronger Support for MENTAL HEALTH

By **Agency for Integrated Care**

Guest of Honour Mr Amrin Amin, Parliamentary Secretary, Ministry of Home Affairs, Ministry of Health emphasised the importance of primary care in tackling mental health issues and encouraged GPs to take a more active role.

"Primary care is the first point of contact for people to access care. Integrating mental health services will allow more to access these services in an environment with less stigma and discrimination. This reduces the barriers to seeking treatment and provides opportunities for early identification and verification."

Mr Amrin Amin,
Parliamentary Secretary, Ministry of Home Affairs, Ministry of Health

Held on 8 and 9 September at Singapore Expo's MAX Atria, this year's Singapore Mental Health Conference (SMHC) focused on "The Art and Science of Wellbeing and Happiness". Jointly organised by the Institute of Mental Health (IMH), Health Promotion Board (HPB), Agency for Integrated Care (AIC), and National Council of Social Services (NCSS), it attracted more than 1,000 professionals from the healthcare, social service and community care sectors.

The conference kicked off with an opening address by Guest of Honour Mr Amrin Amin, Parliamentary Secretary, Ministry of Home Affairs, Ministry of Health. Aimed at fostering conversations on how to improve the nation's mental health, the event showcased mental health programmes and services from various organisations, such as Ang Mo Kio Family Service Centre, Club Heal and AIC. Attendees also got to practise what they learnt through experiential sessions, like laughter therapy and stress management through craft making.

The event was well-received by many of the GPs in attendance. Dr Mark Yap, Cashew Medical & Surgery commented, "It was very useful for a GP like myself, who deals with common mental health disorders at the ground level." Dr Rose Fok, Drs Koo, Fok & Associates Pte Ltd concurred, saying, "It's good to learn of new models of care and how they work, as well as community resources."

Attendees had a first-hand look at the mental health programmes and services from Agency for Integrated Care.

The conference prominently featured the Mental Health GP Partnership Programme, which aims to support the General Practitioners (GPs). Under this programme, GPs are networked to enhance their management of new and existing patients with stable mental illnesses, including those right-sited from Restructured Hospitals (RHs) and identified from their own clinics. Today, more than 130 GPs have joined as partners.

Long-time GP partner Dr Alvin Lum, Shenton Family Physician, Shenton Family Medical Clinic (Bukit Gombak) shared his experience with the programme. Having joined since its inception in 2003, he affirmed that primary care can effectively manage patients with stable mental illnesses — this includes the top three mental health conditions managed by GPs: anxiety/stress, sleep disorders and

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> It was very useful for a GP like myself, who deals with common mental health disorders at the ground level.
>
> **— Dr Mark Yap, Cashew Medical & Surgery**

depression*. Thus far, his involvement enables him to provide holistic and accessible care in a less stigmatising way, as well as early interventions.

The Invaluable Role of GPs

An integrated primary care network helps to provide strong support for patients with mental health conditions. Given that 14.3%** of adults with chronic conditions develop mental health issues, GPs are ideal as the first point of contact, as patients tend to be more familiar and comfortable with them, and have a strong potential for intervention. The easy accessibility of services within the GP clinic setting also mitigates stigma, hence facilitating early detection and treatment.

Collaboration with other community providers was another highlight of the conference. Mr Pathma Thanapallam, a Senior Case Worker for the Singapore Association for Mental Health (SAMH), spoke about the Community Intervention Team (COMIT) and the importance of providing complementary psycho-social care. As part of COMIT, he and his team work closely with GPs to ensure that patients remain compliant to their pharmacological treatments, and that their social issues are looked into. This is important as such problems are common among patients with mental illnesses.

Another notable segment was the talk on the emerging role of polyclinics in supporting mental health cases by Dr Winnie Soon. As a Consultant for National Healthcare Group Polyclinics (NHGP), she talked about how a multidisciplinary team works closely to identify and treat the early onset of co-morbid physical and mental health conditions in patients. Such treatments range from supportive counselling to pharmacotherapy.

Health management is a complex issue, encompassing an individual's biological, social and psychological aspects. It takes a collaborative effort by various professionals to effectively manage a patient with mental illnesses. While significant developments have been made in mental healthcare, ongoing initiatives continue to be put in place to strengthen the network and improve the quality of care.

Is the Mental Health GP Partnership Programme for You?

Join the Mental Health GP Partnership Programme today and receive comprehensive support to enhance your care for patients with mental illnesses.

- Affordability of treatment through various schemes
- Coordination support to facilitate patient referrals amongst various services i.e. RHs, COMIT and your clinic
- Regular Continuing Medical Education (CME) talks and case discussion platforms for skills enhancement enhancement

To find out more about Mental Health GP Partnership Programme and other mental healthcare initiatives, email AIC at gp@aic.sg or call 6632 1199.

The conference provided ample opportunities for attendees to learn and discuss the latest developments in mental healthcare.

MARKETING MEDICAL PRACTICE

FOR NEW PRIVATE SPECIALISTS

Text by Dr Desmond Wai

Marketing is often a new word to doctors practising in public hospitals as there are always more than enough patients in public service. However, marketing is commonly done in private practice, especially by new doctors.

Over the last ten years in private practice, I have been exposed to different kinds of marketing media and I wish to share them with newcomers. If you are running a busy practice, you can skip my article as you probably won't need marketing. But if you are new (or going to be new) in private practice, you may find what I share useful.

What is marketing?

Marketing refers to communicating with referring doctors, as well as current and future patients, to increase the profile and value of the doctor/service, and to induce behavioural changes in referring doctors and/or future patients.

Legal and ethical issues

Before you start marketing your new clinic, you ought to be aware that we are bound by common laws as well as the Singapore Medical Council (SMC) Ethical Code and Ethical Guidelines (ECEG).

Some pitfalls are listed below:

(1) "Only the doctor's name, registered field of practice and place of practice may be mentioned in such instances."[1]

We should not provide too much details of our practice as it may be seen as encouraging potential patients to consult us through public speaking, broadcasting and writing.

(2) "…information in the public domain must meet the following standards: factual, not sensational, not laudatory, not comparative…"[1]

Hence, you should avoid using comparative words like *first*, *better*, *best* and *only* in your marketing materials. By saying that you are better, you are implying that your colleagues are not as good. Unless you are absolutely sure, saying that you are the first to perform a certain surgery may be regarded as misleading.

(3) "…the website may not have on its web pages or provide hyperlinks to, *testimonies from satisfied patients or other doctors*."

I know colleagues who have received warning letters from the Ministry of Health with regard to patients writing complimentary remarks on their clinics' websites and Facebook pages. Testimonies from patients, even if authentic, are not permitted on the clinic's website.[2]

(4) "…photographs or video clips showing results of surgery, consultations taking place or operative procedures being conducted when these are related to identifiable doctors or patients either directly or by inference, are not allowed."[2]

Many slimming centres use before and after photos of celebrities to entice the public to join their programme. For doctors, this may be deemed as laudatory and we should be careful.

(5) "…the doctor['s] participation does not occur in such a way as to appear to *endorse* such products, or to persuade patients or members of the public to use the products."[1]

Doctors ought to be careful not to promote a particular medical product even if the pharmaceutical or device company sponsors your marketing activities.

(6) "Organisations may collect, use, or disclose *personal data only with the individual's knowledge and consent*."[3]

It is not a good idea to contact your former public hospital's patients to inform them of your new private practice unless you have their consent.

It will also be embarrassing if you post a letter to the wrong address, or if your patients' family members were not aware of his/her medical conditions. Always seek consent before you send an invitation letter to your patients for a public forum.

Traditional ways of marketing

(1) *Print media* including newspapers, general magazines (eg, Her World), or health magazines (eg, SHAPE, Singapore Health).

Some contain invited articles where journalists call and ask the doctor specific questions on a medical topic. Others are paid articles whereby the doctor pays the publisher to get his article published. Charges can be up to S$10,000 for four issues of magazines, in which the paying doctor writes articles on medical conditions that he is familiar with.

(2) *Radio and television interviews* including news or health programmes (eg, Body and Soul, Body SOS).

This is usually by invitation only, although I understand one can also pay the producer to make an advertorial programme on the doctor and the medical practice for broadcast on radio or television.

(3) *Public health talks* being held at hotel ballrooms or hospital seminar rooms. I know of some specialists who hold talks in their clinics.

Television and radio stations also organise public talks for doctors. They add daily advertisements on the television or radio station in addition to the talk. I am aware of one such seminar, where they included three weeks of daily on-air advertisements, costing close to S$200,000.

(4) *Continuing Medical Education (CME)* talks which can be for GPs or other fellow specialists. CME talks can be organised by doctors, clinics, hospitals, societies, or even pharmaceutical companies.

New ways of marketing

With the revolution of the Internet and start of a new economy, many new ways of marketing have emerged.

Google marketing

Doctors can improve their practices' online presence by utilising Google AdWords campaigns. However, it can be costly when many others bid for the same keywords. For example, the phrase "back pain" may be bid on by orthopaedic surgeons, physiotherapists, rheumatologists, chiropractors, spas, mattress retailers and ergonomic chair manufacturers.

Search engine optimisation (SEO)

Google's search engine uses a complex set of algorithms and formulas that produce the best web results for the words or phrases being searched. Ideally, the most relevant and appropriate websites would rank highly and appear on the first page of search results.

There are also Internet marketing companies that claim to know the algorithm to optimise your websites so that they would appear among the top results on Google search.

Facebook

Facebook targets advertisements towards users with specific demographics and preferences. There was once I asked my Facebook friends to recommend a hotel for my holiday in Bintan. After a while, many advertisements featuring hotels in Bintan appeared on my Facebook feed! Facebook knows what I need and provides these opportunities to advertisers.

Credit card promotions and e-commerce platforms

Many service providers, such as hairdressers, spas and art schools, often offer promotional rates in collaboration with credit card companies or e-commerce platforms (eg, Groupon). The idea is to use a promotional entrance fee to attract a patron to try their services, in the hope that the patron will like the service and sign on as a regular customer.

However, doctors ought to be aware that under the Private Hospitals and Medical Clinics (Publicity) Regulations 2004, healthcare institutions are not allowed to give souvenirs, promotional coupons and vouchers.

Internet platform marketing

There are Internet platforms that group many clinics together and advertise/optimise views within one website. They also help patients to book clinic appointments. The cost per clinic is generally lower as it is shared by all participating clinics. However, many of such service providers charge a percentage of the doctor's professional fees in addition to monthly retainer fees, which may be against the SMC ECEG.

Nitty-gritty of medical marketing

Marketing is not cheap

The costs of marketing can go up to more than S$100,000 per year for a clinic. Most of us are not trained in business or marketing; thus we ought to be careful before we spend such big sums of money.

Be clear about your target markets and audience

If you are giving a public seminar on colon cancer at a community centre, your audience would mainly be "heartlanders". If you are giving a talk to a group of private banking clients, you get a different crowd. Choose your target audience carefully.

Your marketing activities are public

Beware that among the audience of your marketing activities, some may be patients of other specialists and some may even be colleagues in the same specialty. If you bear in mind that any audience member could make a complaint to the SMC, you will prepare your activities properly.

Don't try to induce the audience to see you

Remember that we are not supposed to induce or coerce patients to consult us.

Don't tell an audience member that if he has constipation, he may have colon cancer and can die from it, and that he should go to you for a colonoscopy the following morning. Instead, explain the various causes of constipation and encourage the public to consult the appropriate doctors.

Don't transform your marketing activity into a personal consultation

It is common for audience of marketing activities, such as public talks, radio talk shows or live television phone-in shows, to call in and seek medical advice on their personal conditions.

The ECEG clearly states that a doctor is expected to conduct good history-taking and physical examination before forming an opinion. Transforming a question and answer session into a medical consultation would be risky.

It is thus safer to just offer general information to the enquirer, and advise him/her to seek proper medical opinion.

Stay an arm's length from sponsors

The pharmaceutical and device manufacturing industries often spend huge amounts on sponsorships for public and medical education. Under the Singapore Association of Pharmaceutical Industries, sponsored events must give balanced and diverse views on medical knowledge.

While we should show gratitude to the sponsors, we ought to give an independent lecture to the audience.

Set pragmatic expectations

In business, people often talk about key performance indicators and return on investments. But we are doctors and not businessmen. Our aim should be to enhance the knowledge of our patients and the public.

Setting commercial goals may cause your marketing activities to be too commercial, which will eventually change your perspective and attitude towards your audience. Most of us became doctors not to make money, but to do good to mankind.

The wool comes from the sheep

The cost of commercial marketing eventually draws from the revenue of the medical practice, which comes from patients. My anecdotal experience is that clinics that spend a lot on marketing tend to charge more as well.

Final thoughts

Be very good at your work

When I started my private practice ten years ago, a senior specialist told me that he did not believe in marketing and advertising. "If you are good, patients will look for you. You don't have to look for patients," he explained.

I have realised what he said is very true. Marketing can only bring patients to see you once; the rest depends on your level of expertise.

Harness word-of-mouth marketing

When I asked my Facebook friends for recommendations on Bintan hotels, all my friends suggested one particular hotel. Thus, the choice was clear. Word-of-mouth marketing is the most important form of marketing. Patients are more likely to believe their trusted friends than any form of marketing media.

To get good word-of-mouth recommendations from patients, you must be very good at your work, and be very caring and emphatic. You also need to have super passionate patients who are not shy to recommend you to others.

Consider the externalities

Externalities refer to the consequences of an activity which affect other parties.

A year ago, a local newspaper published an article on "flat polyps", which may be more aggressive than the traditional pedunculated polyps in turning into colon cancer. Though the marketing was done by a gastroenterologist at a restructured hospital, other gastroenterologists benefitted as well.

After the news was out, I suddenly saw many new patients consulting me for screening colonoscopies. This should be our mindset: through our marketing, educate the public to take better care of themselves. In doing so, the whole profession can benefit.

Understand that nothing works forever

Ten years ago, the second page of a major local newspaper always featured the same advertisement: "Lasik surgery: S$999 per eye."

I understand from informal sources that it was highly successful at that time but today, you will no longer find that kind of advertisements. Be clear that no single successful marketing strategy works regardless of the times.

Know that nothing works for everyone

Among those who advertise on Google, there are more surgeons and procedurists than physicians. One reason for this is that for each patient who goes for a surgery or a procedure, a large sum, which can help offset the cost of marketing, is charged. However, for physicians, the consultation fees collected may not cover their cost of advertising.

Have the right mindset

I have seen many new specialists being disappointed with their marketing efforts. Despite spending money and personal time on marketing, they don't yield any immediate return.

To me, the aims of marketing to the public are firstly, to educate the public and fellow doctors. Secondly, to allow fellow doctors know what your strengths are, and thirdly, to let them know how to reach you if they require consultation or referrals.

You won't be disappointed if you have the right mindset.

Conclusion

When you enter private practice, many people will offer you various marketing ideas. Beware that many businesses are trying to make money from you. Do read the law and SMC ECEG carefully, and have the right mindset when marketing your practice. If in doubt, ask your friends/colleagues for advice. ◆

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Dr Desmond Wai is a gastroenterologist in private practice. Like other medical colleagues, he is struggling to balance family and work. Desmond believes that sharing our thoughts and experiences is important in moving our profession forward.

Don't Wait

Dr Tan Su-Ming graduated from the National University of Singapore in 1990. She is married with a daughter and runs her own general practice.

Text by Dr Tan Su-Ming

I was once looking for a quote to scribble in a birthday card and found this one:

"Every birthday is a gift. Every day a gift." –Aretha Franklin

The birthday celebrant, the grandmother of a buddy, was turning 102 and I found the quote apt. This quote came to mind again recently.

I lost a patient last week; I had been treating her for 20 years. She had been doing poorly over the last two years, going through the revolving doors of the hospital due to heart failure.

I last saw her only a month ago. Although it grieved me to learn that she had passed on (peacefully), I felt a certain degree of comfort in the thought that our last encounter was good. I remember the consultation being unrushed. We went through the management plan for her a few times to be sure she understood it. I let her repeat her questions several times without feeling or acting impatient, as I usually do. It was kind of surreal. I don't know, but maybe I had sensed that it might be the last time we would be seeing each other.

Yesterday, I took an afternoon off from work and took my father out for lunch. After dad and I said goodbye, I learnt from a text that my friend's father had passed away the night before. As I drove to the Singapore Casket building where the wake was held, I cried all the way, because I felt my dad's own mortality acutely.

The time I just shared with him earlier suddenly seemed even more precious. No one knows the hour of our own departure, or that of another person.

But if there was a way to know, to sense it, how would it change my behaviour?

Say "yes" to that invite for a meal?

Say "this meal is on me"?

Say "keep the change" to the taxi driver?

Give the nice waiter a generous tip?

Waive the fee for this consultation?

Stop everything I'm doing to really listen to someone?

So here's another quote for you:

"You cannot do a kindness too soon, for you never know how soon it will be too late." –Ralph Waldo Emerson ◆

LEGACY GIFTS

Text by Ho Li Shan, Assistant Manager, SMA Charity Fund

Many of us work and slog through each day to better provide for our family members and loved ones. The passion for work comes when there is a purpose and to most medical doctors, the purpose is clear: to serve and save lives. Thus, doctors often work tirelessly, be it in the form of researching on new drugs, engaging in day-to-day rescue work, and/or supporting those in need in their respective specialties.

There are many unsung heroes who have contributed towards building the future of local medicine. Here we share two examples of how legacy gifts continue to encourage medical students in their medical education journey.

Dr Michael Toh

"Beyond my appreciation for the bursary granted by Dr Toh's family, I am deeply thankful for their good value of life-long commitment to helping and benefitting the lives of others. I look forward to helping others someday just as they have helped me."

– Mr Lau Lagarfeld, M2 student, Lee Kong Chian School of Medicine

Dr Michael Toh was born in 1945 and passed away in 2015. He had firsthand experience as a medical student burdened with financial struggles. His father had passed away in his first year of medical school, but he was able to complete his education thanks to a close family friend's assistance which he never forgot. He was inspired to be a good doctor and was constantly paying the good deed forward.

In 1973, Dr Toh went on to complete his postgraduate radiology training on the back of a scholarship to the UK. He returned to Singapore in 1974, served at the Singapore General Hospital till November 1977, and joined Mount Elizabeth Hospital as consultant radiologist and the first head of the Radiology Department. In 1982, Dr Toh went into private practice and worked as a consultant radiologist and the founding partner of Radiologic Clinic Pte Ltd. He later served as head/chief radiologist and/or medical director in multiple companies, and was last a visiting consultant at Changi General Hospital and a clinical physician faculty member of the Diagnostic Radiology SingHealth Residency Program.

Dr Toh cared deeply for medical education and contributed to the training of residents even in his last days. He volunteered his scans for use in teaching future radiologists, so that they may benefit from learning about the subtlety of his condition.

In keeping with his vision of paying it forward, the Estate of Dr Toh would like to pass on this narrative to medical students from less privileged backgrounds. The SMA-Dr Michael Toh Kok Kuan Medical Students' Assistance Fund is the inaugural joint named bursary between his Estate and SMA Charity Fund (SMACF), created in loving memory of Dr Toh. With the help of this bursary, recipients can better focus on medical education and community service without financial burdens. The Estate passes on Dr Toh's legacy of reaching out to all in love and charity, and to bring hope and health to those in need.

Dr Wong Yu Yi

In early September this year, the medical profession lost Dr Wong Yu Yi, a dedicated family physician and a loving and supportive wife and mother. Dr Wong passed on peacefully in pursuit of her passion for diving in Blue Lagoon, Bali.

Dr Wong graduated in 1993 and had undergone stints of training in paediatrics, obstetrics, gynaecology and primary care. She had practised medicine in various establishments and was a warm and caring doctor to the elderly at Orange Valley Nursing Home. Her last area of practice was as an aesthetic-focused doctor in CSK® clinics where she applied her love for beauty and creativity through her work.

In memory of Dr Wong, the National University of Singapore (NUS) Faculty of Medicine Class of 1993 set up an online campaign on behalf of those who knew Dr Wong, in support of SMACF. We are heartened to share that the campaign reached its target of $20,000 within 24 hours and has continued to gain momentum.

SMACF is honoured to be the appointed beneficiary for the campaign and we would like to thank the following donors for their contributions toward our beneficiaries. The collective effort of the medical community can truly make a difference! The amount may only be a fraction of what you have but it is a turn of fate for the students who receive it.

"Staff members remember Dr Wong as a warm and helpful doctor whom they liked and respected. Patients remember her as caring and gentle, always with a warm smile and greeting."

– Orange Valley Nursing Home

Wall of Appreciation

"In Memory of Dr Wong Yu Yi" Campaign

A/Prof Chai Ping
A/Prof Chen Yu Helen
Mr Chew Zheng Hao
Dr Chng Soke Miang
Dr Selina Ho Kah Ying
Dr Koh Yin Ling
Dr Lam Pin Min
Dr Lee Tzu Hooi
Dr Lim Hui Ling
A/Prof Lim Wan Teck Darren
Dr Lim Wei Kian
Dr Low Chin Howe Robin
Dr Ng Wai Chong
Dr Peng Yeong Pin
Dr Sin Wen Yee
A/Prof Tan Choon Kiat Nigel
Dr Tan En Yu
A/Prof Tan Hui Ling
Dr Tong Pei Yein
Dr Anna Wong
Dr Wong Nan-Yaw
Dr Wong Tien Hua
Dr Andrew Yam Kean Tuck
~
NUS Faculty of Medicine Class of 1993
~
Other anonymous donors

Visit the campaign website at https://goo.gl/qavCM5 and join Dr Wong Yu Yi's friends and family co-build the legacy for future generations of doctors through the spirit of giving.

From Dr Wong Tien Hua, on behalf of NUS Faculty of Medicine Class of 1993

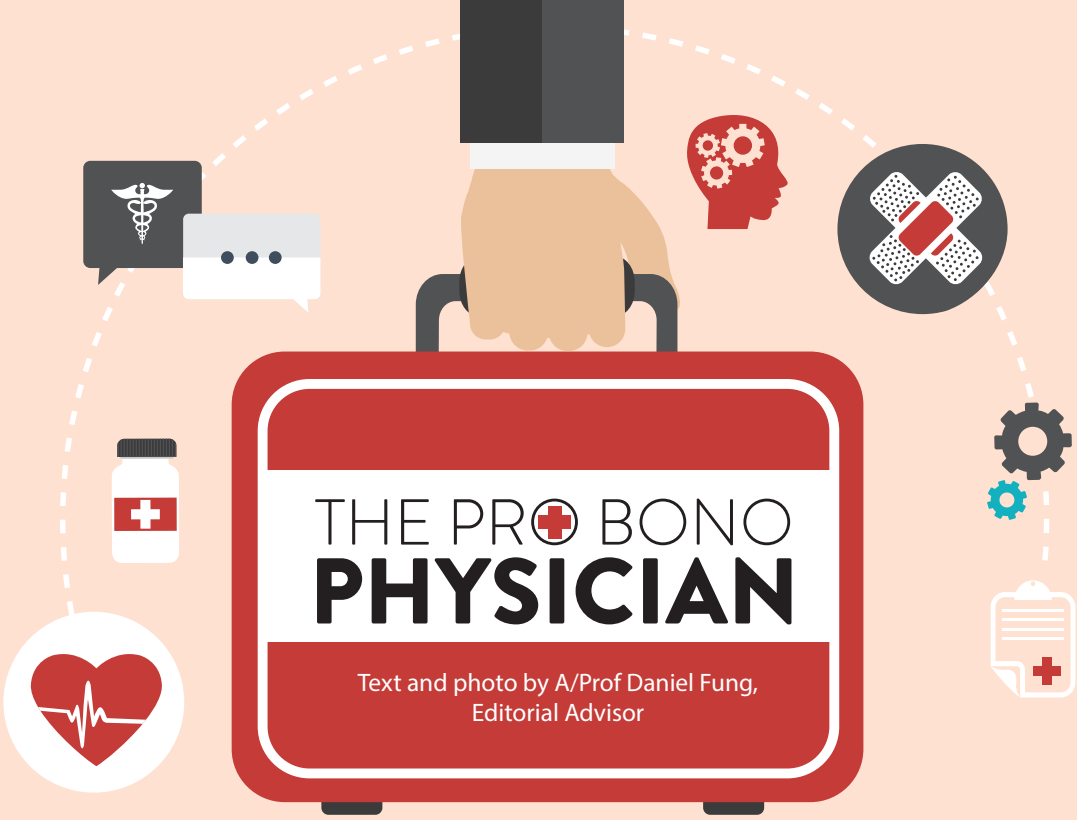
The NUS Faculty of Medicine Class of 1993 lost a dear sister on 6 September 2017. Yu Yi passed on doing what she loved: diving off the beaches of Bali. She was my bench-mate during biochemistry laboratory and anatomy classes in medical school. She was a quiet person who studied hard and was kind to share her knowledge with others.

We graduated more than 24 years ago and many of us have moved to our own fields of practice in Singapore and abroad. Some of us had not heard from each other since we graduated.

When we heard of Yu Yi's passing, news rapidly spread and within 24 hours, a class chat group was formed, connecting us from all over the world. Apart from remembering Yu Yi in our thoughts and prayers, we wanted to go beyond that and started raising funds for charity. The response was overwhelming and I sincerely thank everyone who has contributed to our cause.

If you wish to explore giving as a tribute to your beloved one(s) in support of SMACF and its beneficiaries, please drop us an email at smacharity@sma.org.sg.

Donations of $50 and above made to SMACF are eligible for 250% tax deduction and will go directly towards supporting the works of SMACF. Other than funding the basic living expenses of underprivileged medical students to give them more time to concentrate on their studies, it also helps to provide overseas learning exposure, recognition of mentorship and the promotion of volunteerism among the medical profession. ◆



THE PRO BONO PHYSICIAN

Text and photo by A/Prof Daniel Fung,
Editorial Advisor

The term "pro bono" is shortened from the Latin phrase "pro bono publico" which literally means "for the public good".

I am not a natural born volunteer. I grew up in an era where, unlike today, volunteering was not something that schools taught or inculcated as part of the co-curricular activities. We had no idea what Community Involvement Programmes (CIPs) were. CIP was launched in 1997 by then Director-General of Education, Mr Wee Heng Tin. The initiative was originally intended to be part of compulsory National Education and aimed at building social cohesion and inculcating civic responsibility in pupils of all levels from primary to pre-university.

My volunteering journey

In fact, there were very few examples or opportunities for volunteer work outside of the church I attended. It was only after I started university education did I gradually start seeing opportunities for giving my time to helping others as a meaningful pursuit. One particularly memorable instance of my rude introduction to volunteering was when we tried to raise funds for a trip to Hong Kong in 1988. We went to a clinic in Mount Elizabeth to see a famous pioneer nephrologist. Instead of getting a donation, we received an erudite lecture on working for the poor and helping the less fortunate. From then on, I decided that aside from work, I would try to be involved in causes that make a difference in larger ways while still placing focus on what we as doctors do well in helping everyone, one person at a time.

Between 1990 and 1995, I helped out in church in various ways. What I really enjoyed was being involved in a study class that was held within the church grounds during the examination period. It allowed me to meet young people, speak to them (between the studying) about their hopes and aspirations, and provide guidance as a "big brother". In fact, those voluntary experiences contributed to my decision to choose psychiatry as a specialty.

Since then, I have volunteered in various capacities over the last 20 over years. I have been involved in several voluntary start-ups, such as the Child Abuse Action and Research Team (CARAT). CARAT was affiliated to the Society Against Family Violence (SAFV) and was formed by a few social workers and one aspiring psychiatrist to help with the follow-up of children who had been abused. This was in the 1990s, when child abuse was still largely an under-the-carpet occurrence with only the Singapore Children's Society (http://www.childrensociety.org.sg) doing most of this work in the voluntary sector. Last year, I started an enterprise helping adult survivors of sexual abuse (http://www.yakin.org). Besides working directly with those in need, I have also helped by being part of the governance structure of several voluntary welfare organisations (VWO) which is something that I must say have been quite eye opening to me.

As I am someone who looks for value in things – and by value, I mean the quality of the work in relation to the amount of monies spent – I apply this same principle to my volunteer work. Value, when translated to volunteering, means that the time spent (which is cost) should be commensurate with the benefit for the cause. For example, if we volunteer for an organisation that supports those with a chronic disease, our time should translate into actual support for those suffering from that disease. For that to happen well, there is a need for an efficient management system to channel the volunteers and their energies in the right direction, with maximum benefit for the cause and what it stands for. That can only happen when the mission of the cause is well defined and the VWO is performing its role with proper governance. Most of the time, we are concerned with financial governance but there is also a need to make sure that the work done is relevant to the cause.

My work with SAMH

My experience with the Singapore Association for Mental Health (SAMH; http://www.samhealth.org.sg) has been exciting to say the least. In 2001, my mentor and friend Prof Leslie Lim asked me to join SAMH and share my experiences in working with children.

This was during a period of change in the charity sector and we were some years from the problems faced by the National Kidney Foundation. I was quite green to doing governance work and was more interested in the daily running of the charity rather than how it was run and the value it was giving to people suffering from mental illness.

As I started to understand the mechanics of running a charity, I realised that management committees were really volunteers helping to administer the charity. It was only when we started to have committee retreats, with staff relooking at our vision and mission, that it became evident that we were missing the big picture. The composition of the management committee was mainly mental health professionals. We had little in terms of diversity and a quick look at our history suggested that the VWO was almost on the brink of running out of monies at some stage in the 40 years of its existence. Together with Leslie, we started to build a more diverse board and we added legal and finance expertise to the management committee.

We now have a president who is not a psychiatrist and a very diverse board bringing with it experiences from different sectors. We were awarded the inaugural Charity Governance Award in 2012 and we saw our annual operating budget rise to over $5 million as we were operating ten centres with an emphasis on psychiatric rehabilitation and recovery.

Doctors and volunteerism

There are many past examples of doctors volunteering in various capacities in Singapore. I have no direct data of doctors volunteering, but in an editorial published in the December 1997 issue of the *Singapore Medical Journal*, well-known paediatrician Dr Kenneth Lyen suggested that doctors as volunteers are found in many charities and many hold leadership positions. However, that was 20 years ago. Today, as we turn to the 138 health charities (of which 83 are classified as Institutions of Public Character), how many have doctors leading these charities? Perhaps many are invisible volunteers working hard behind the scenes; I certainly hope so. Are there reasons why doctors don't volunteer as much today? Could it be that they have become too materialistic or that in balancing work and life, there is precious little time that the doctor has for volunteerism? Perhaps more are volunteering overseas which may seem more glamorous?

I believe that doctors would make great volunteers because of three good reasons:

(1) Volunteering is our baby. Volunteering is defined as an altruistic activity in which an individual provides services for no financial gain to the benefit of others. The first volunteers included doctors and the volunteer spirit is one of the tenets of our profession – public service – and is the essence of the Latin translation of pro bono. Funny how this term is used more often in legal service than in medical service these days.

(2) Volunteering is in our blood. Our ethical mandate is a commitment to compassion and charity. Many of the hospitals and medical schools were built on the volunteering spirit. Today, free medical clinics still exist because there are doctors who have the heart to help the poor and less fortunate. I will always remember my consultant who gave money to a patient when he was hungry.

(3) Volunteering is in our brain. The physician is often seen as leaders in many societies. In Singapore, doctors are among the brightest and best of their cohorts. We should have the opportunity to use our heads to alleviate suffering in the heartlands of our society.

SMA is now actively developing a volunteering and charity mission to get doctors to do more for the less fortunate (https://www.sma.org.sg/smacares) and has started a charity fund in 2012 to help the less fortunate. *SMA News* runs regular columns on volunteer opportunities and experiences, and also provides free publicity space for charitable causes. I strongly encourage all doctors to consider volunteering. If you are not sure of what capacity you would like to volunteer in, you could take a look at the National Volunteer and Philanthropy Centre's volunteer page (http://www.giving.sg/volunteer) for some inspiration. ◆

SMA and the SMA Charity Fund support volunteerism among our profession. *SMA News* provides charitable organisations with complimentary space to publicise their causes. To find out more, email news@sma.org.sg or visit the SMA Cares webpage at https://www.sma.org.sg/smacares.

Legend

1. SAMH representatives A/Prof Fung and executive director Ms Rajeswari receiving the inaugural Charity Governance Award from Minister Lawrence Wong in 2012

A/Prof Daniel Fung didn't volunteer to be a father of five children when he uttered his wedding vows but does not regret any moment of it especially after he saw his eldest daughter Grace get married. Among his other voluntary work, he is involved with Paya Lebar Methodist Girls' School, Singapore Association for Mental Health and Singapore Children's Society.

THE NEWTON SCIENCE SHOW

Text and photos by
Dr Tan Yia Swam, Editor

Being a mother to three young boys, I find that I don't indulge myself much anymore; instead, I indulge the kids!

When we celebrated my older boy's fifth birthday in May, he was in a science craze. His teachers at Learning Vision have taught the class concepts like recycling and reproduction; he liked watching *Nina and the Neurons* on cable TV and followed up by searching for relevant videos on YouTube. He could even tell me about how tornadoes are formed and the hunting habits of great white sharks.

Therefore, I thought to organise a science-themed party for his birthday. Google turned up a few relevant results and I decided to engage The Newton Show. From what I gathered, they have had eight years of experience in Europe and came to Singapore early this year. Their website is easy to navigate and provides details, as well as photos and videos, of previous events. There are recommended packages depending on the age group of the children you want to cater to. I sent in an enquiry and was promptly attended to. Arrangements were made via text messages and emails, and a deposit of 20% of the final fee was transferred. The remaining 80% was paid only after the event.

Actual day

The birthday party was held in our condominium's function room with a buffet lunch (which was essentially adults eating while the kids ran around like mad chickens), followed by the show. It's an hour-long programme for up to 30 kids with no limit on the number of adults. The only set-up required from us was a table and an electrical socket.

The show was conducted by "Professor Neon" (a young Indian lady whom my friend identified as a host from local television channel Vasantham). She was very good at engaging the kids! We had 12 kids whose ages range from three to seven years, three toddlers/babies in arms and close to 30 adults.

They conducted ten to 12 mini experiments with the kids, which were all crowd pleasers! The birthday boy was appointed the main assistant and had first dibs at most of the stuff, but all the kids present were given a chance for hands-on.

Professor Neon used various "simple" chemical and physics principles to put on a spectacular show. These included the use of dry ice, volcano foam and a "smoke" gun for shooting zombies. Everyone, including the adults, could also borrow diffraction glasses, enabling us to see a spectrum of colours in the flames when she set her hand on fire (I kid you not). She also taught the children some scientific terms and safety tips (eg, to always handle dry ice with gloves), and emphasised that none of this involves magic, but science.

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I fully endorse the show; it was great fun for both kids and adults. It was safe, interactive and visually captivating. Most important of all, there was no mess to clean up!

Additional items were available at a price. These items include laboratory coats and protective goggles for up to 30 children during the show, "disco with bubbles" (a bubble machine to produce loads of bubbles), "volcano cake", as well as "rocket launch" and "cola-gaser" (to be demonstrated outdoors). Goody bags were also available at $15 each, comprising seven items: a pair of diffraction glasses, a 3 cm bouncy ball, a quail-sized hatching dinosaur egg, a 2 cm by 2 cm compass, a small chocolate coin, a small box of Smarties and a party blower.

Areas of improvement

It was not without problems though, and those encountered were all minor but recurring.

Perhaps due to them being new in Singapore, there seemed to be a language barrier despite our communication being in English. The main contact person was a lady called Yulia. My first message to them indicated that it was a birthday party, but it was misunderstood to be an expression of interest in their science camp. There were repeated queries on the number of kids, venue and date, in both WhatsApp and email correspondences.

Other problems include an email correspondence that invited me to choose a science-themed invitation card, with no subsequent follow-up. We had requested for orange-coloured goody bags, but the final ones received were blue. Finally, I had requested for the performance to start at 1 pm, and agreed when they requested to come later at 1.30 pm. However, they were late by more than half an hour (citing heavy traffic). As the kids were getting restless, we brought forward the cake-cutting and a few guests had to leave before the show started. Luckily, the guests were all close friends who were very understanding.

Despite the hiccups, I would still recommend this show for kids' parties. Everyone enjoyed the programme and the older ones were still excitedly talking about it in the weeks that followed. ◆

Disclaimer: I paid for the show in full, without any benefits or perks, and received no incentive for this review.

Legend

1. "Look out! It's going to blow!"

2. Professor Neon demonstrating a dry ice experiment

3. The kids were captivated by the scientific tricks

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