SMA news

For Doctors, For Patients

VOL. 48 NO. 2 | FEBRUARY 2016 | MCI (P) 052/01/2016

PROTECT OUR CHILDREN:
Recognise Child Sexual Abuse

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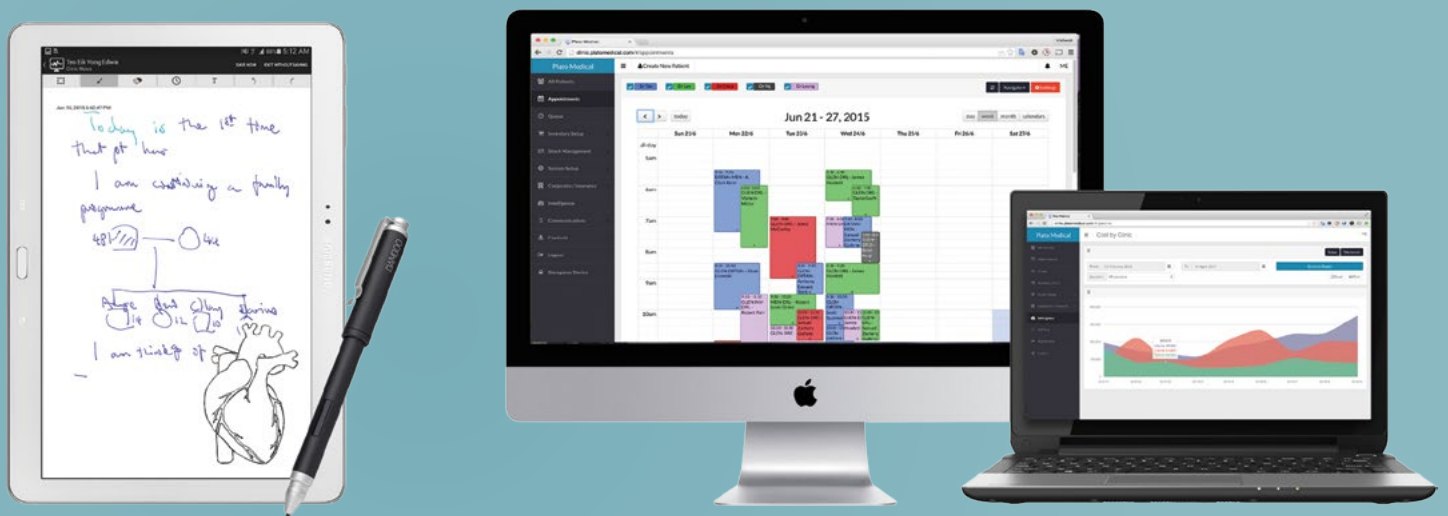

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- Dr. Lee Chee-Wei (Director) & Likar Leong (Clinic Manager), Nexus Surgical

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- Dr. Ben Ng Jen Min, Arden Endocrinology

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THE EDITOR'S MUSINGS

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

Yia Swam
Editor

FOR PATIENTS...

In this February feature, I am honoured to have Ms Eirliani Abdul Rahman, a child rights campaigner and co-founder of Youths, Adult survivors & Kin in Need (YAKIN), write for us. Her piece on how to recognise the signs of sexual abuse in a child and what we can do is relevant even if we don't see paediatric patients. Survivors of such abuse may become our patients for any condition. Sexual abuse may be an area that we don't feel comfortable discussing, which makes it all the more important for us to learn how to identify such patients and refer them to get the help they need.

Our other contributors have also made a difference for patients. Dr Chua Wei Chong, one of my esteemed seniors and former colleague at Tan Tock Seng Hospital's Department of General Surgery, writes on his passion for trauma care and his involvement in locoregional collaborations. "GP Matters" columnist, Dr Leong Choon Kit, shares his views on how hospitals and GPs can better coordinate the post-discharge care of patients. Dr Desmond Mao, an emergency physician, introduces the app by Singapore Civil Defence Force, myResponder, which serves to inform users of nearby cardiac arrest cases that might benefit from cardiopulmonary resuscitation. I have downloaded the app and I find it very user-friendly.

FOR DOCTORS...

Ms Mak Wei Munn and Jasmine Tham are lawyers from Allen & Gledhill LLP who share pointers on how to take informed consent and discuss recent developments in shared decision-making. Another important medico-legal issue that should concern our readers, especially the "junior" ones, is that of medical indemnity. During the course of your training, you should be covered under a group insurance by your respective hospital. Do you know exactly what you are covered for? Will you be covered if you changed cluster? How about an incident that took place three years ago, when you were a house officer, before you paid off your bond and started working as a locum? Dr Lee Pheng Soon and Dr Bertha Woon wrote a piece on the basics of medical indemnity in November 2014 (https://goo.gl/gRXFyK) and in the coming issues, we will be bringing you more insight pieces on this topic.

This month's "Indulge" article combines music and travel. Dr Chang Tou Liang (who should be a very familiar name for all musicians!) recounts his musical pilgrimage to Husum, where he attended a piano festival featuring rarely played pieces. Music lovers among us will be inspired to catch the next such event!

ON THE SHOULDERS OF GIANTS...

Our medical students continue to be very active in humanitarian work. Congratulations to Project Sa'Bai for accomplishing ten years of medical volunteerism! Tricia Chew and Cassandra Ang, the heads of Project Sa'Bai 2015, report on last year's outreach. We hope that succeeding batches of students will continue this fine work.

Jeremy Teoh reports on the WHB-SMACF Outstanding Mentor Awards 2015, where students pay tribute to doctors who have coached them on clinical research. I am glad that the teachers among us are given more recognition, as clinical medicine is a mentorship and we can never just learn from textbooks alone.

As a youngish doctor myself, I admit to some ignorance of our own local medical history. Dr Cuthbert Teo's ongoing series provide a reference into the beginnings of medicine in Singapore. I am also thankful that Dr Jerry Lim (co-founder of Dover Park Hospice) has kindly given my team so much of his time to speak with us about his batch of pioneer doctors. Sadly, one of our pioneers, Dr Moses Yu, passed away on 30 December 2015. He was the first locally trained clinical microbiologist and was Head of Pathology from 1972 to 1985. Dr Jipson Quah and Dr Jerry Lim pen a eulogy in memory of him.

Let us never forget those who came before us and who laid down a strong foundation upon which we build, and let us in turn build a strong structure to support our future doctors. ◆

3 SIGNS A CHILD IS SUFFERING FROM SEXUAL ABUSE

Intro by A/Prof Daniel Fung, Editorial Advisor

Doctors have a role to do more than just identify, treat and manage illness. Child abuse borders on social and health domains. It is social because the definitions of child abuse are based on the society's view of the acceptable ways to handle children, which changes across time and populations. It is a medical issue because its effects have physical and emotional outcomes that need medical assistance. Overt sexual abuse in which a child is engaged in sexual intercourse is easy to recognise and there are few who will dispute the need to prevent, identify and help such children. But more subtle forms, such as exposing children to inappropriate materials, may be harder to pinpoint. All doctors have the duty to understand child abuse better and the article by Ms Eirliani is a good primer. Besides this ethical responsibility, doctors also have legal requirements as child sexual abuse is a crime under the Children and Young Persons Act (CYPA). Although we do not have mandatory reporting of child abuse under the CYPA, there are legal frameworks for which such crimes should be reported. The Ministry of Health, along with the police, has given advisory notes for hospitals to report such crimes. Identification of sexual abuse is thus both an ethical as well as legal responsibility for doctors. By doing so, you can also prevent untoward physical and emotional consequences.

IMPACT OF CHILD SEXUAL ABUSE

Child sexual abuse (CSA), including incest, may have a profound impact on how a child experiences his/her world as a victim and later, as an adult survivor. The short-term effects of CSA can include fearfulness, acute stress disorder, hostility and aggression, depression, low self-esteem, guilt and shame, eating and sleeping disorders, acting out, cognitive disability, developmental delay and inappropriate sexual behaviour. The long-term effects are generally similar, with an impact on the survivor's sexual and reproductive health, increasing the risk of re-victimisation. As adults, survivors may display a tendency to compartmentalise their feelings, and/or not know how to express their emotions in a healthy fashion. They may find it difficult to accept their bodies and frequently push themselves emotionally and/or physically, have addictions to alcohol and/or drugs, are bulimic or anorexic, and/or find it hard to create and maintain healthy relationships. Survivors may also be uncomfortable around children and/or may be confused about crossing the line between good and bad touch.

As a member of the medical profession, you stand at the front line in our collective efforts to put a stop to CSA You are in a position to assess children who have come to you for medical treatment for signs of sexual abuse. Children, depending on their age, may not be able to warn you of what is happening to them, often lacking the vocabulary and/or the understanding. The parents or guardians of child abuse victims may also not be aware of the presentation of the possible signs of abuse. The underlying premise is that early detection and intervention will attenuate the severity of the ensuing symptoms following abuse. It is also important for the child victim to have the support of a non-offending adult who affirms his/her experience of the abuse, if the child chooses to disclose it.

THE GROOMING PROCESS

How does abuse happen?

CSA can either take place through a process called "grooming", or it may

be opportunistic in nature based on access to the child. Grooming is a long process of trying to win a child's trust. It may take months, even years, before any sexual abuse actually takes place. Such adults will try to identify with the child and be the "only one" who can understand the child's needs. They will display common hobbies and interests with the child, such as football, music or video games. They will present gifts frequently to the child and speak to the child via SMS, email or social media without the parents' knowledge. Such adults will try to test a child's boundaries by telling inappropriate jokes which are sexual in nature, roughhousing, tickling or playing games. To desensitise the child, the adult may move to "accidental" sexual touch, done frequently so that the child becomes familiar with the touch and does not become threatened by it. It will then move on to sexual touching.

It is not uncommon for abusers to tell their victims that they, the children, are somehow at fault for the abuse. The child under your care may have been led to believe that his/her "nasty" or "seductive" behaviour caused the abuse. In many cases, child victims develop negative thoughts and attribute blame to themselves, which may perpetuate symptoms of post-traumatic stress disorder and depression. One survivor who is in her early thirties told me: "When I realised what was happening, I wanted to kill myself. I cried a lot and prayed a lot." She was just 12 years old at the time of abuse.

TELL-TALE SIGNS OF SEXUAL ABUSE

What are the three signs to watch out for?

First, the child shows physical signs of abuse such as bleeding, itching and/or swelling in the genital area and may have difficulty in standing or walking. The child may also suffer from frequent yeast or urinary infections. His/her underclothes may also be bloodied, stained or torn.

Second, the child displays behaviour inappropriate for his/her age, for instance, regressive behaviour such as bed-wetting or thumb-sucking for an 11-year-old. He/she may also have advanced sexual knowledge that is not expected for his/her age group. In usual cases, a child up to four years old may show curiosity about private body parts. Between the ages of five to nine years, the child may talk about private body parts while understanding the need for privacy. From ages 10 to 12 years old, a child may display interest in changes in puberty and may ask about sexual behaviour and/or relationships. Teenagers aged 13 years and older may start dating, using sexual language and/or talking about sex with their friends.

Third, if you have prolonged access to a child patient over a period of time, you may notice that he/she is displaying radical mental and/or emotional changes. He/she may suddenly withdraw from company, show fear towards a particular family member or family friend accompanying him/her to your practice and/or suffer from depression. He/she may start to lose weight or suddenly eat a lot. The child may also bathe excessively or display poor hygiene. He/she may self-mutilate, suffer from night terrors and/or shrink from physical contact.

If your child patient is presenting a combination of any of the symptoms above, it is possible that he/she may have been sexually abused. It may be best to speak to his/her parents or guardians to ascertain this. However, if you suspect that the parents or guardians may be involved in the abuse, speak to your child patient in private about whether anyone, including family members and friends, has touched him/her in their private areas. Explain that even if this makes them feel good, it is not right and only those who have been entrusted with bathing him/her or helping him/her clean up after himself/herself is expected to touch his/her private parts.

DISCLOSURE

If your child patient has indeed been abused, reassure him/her that he/she is not to be blamed and is not in any form of trouble. Based on my

experience working with survivors, it is very important to respect what your child patient wants you to do, and it is also incumbent upon you to first explain to the child any decisions that you make. What is essential now is that those involved in his/her welfare must work doubly hard to rebuild the child's sense of safety and boundaries, and ensure that he/she can trust and lean on his/her carers.

To illustrate this, I draw upon the experience of a survivor who had told her teacher about her abuse when she was a child. She was nine years old at the onset of abuse, and wanted the abuse to be kept confidential. However, her teacher chose to report the matter to the authorities and she was not informed of the decision. To this day, the survivor finds it difficult to reconcile with the fact that she was suddenly removed from her parental home and placed in a home for children and then later, in foster care.

At the same time, other survivors have told me that the single most difficult thing that they have had to endure — other than the abuse itself — was to be discounted when they chose to disclose as children, precipitating depression and a lower sense of self-esteem. Children may also be too young to understand what is happening. There was a case where a four-year-old was taken to the doctor's after complaining of persistent stomach ache. It was then discovered that she had been raped. The child did not know the right name for her genitalia.

Should your child patient choose to disclose his/her abuse, tell the parents or guardians to ensure that the person that their child/ward has named as the perpetrator no longer has access to the child. Report the abuse to the police or the Child Protective Service helpline at **1800 777 0000**, which operates Mondays to Fridays from 8.30 am to 5 pm, and on Saturdays from 8.30 am to 1 pm. Ensure that your child patient is kept apprised of the developments, every step of the way.

If you see possible signs of abuse, do not look away. Protect your patient's childhood. ◆

AS A MEMBER OF THE MEDICAL PROFESSION, YOU STAND AT THE FRONT LINE IN OUR COLLECTIVE EFFORTS TO PUT A STOP TO CHILD SEXUAL ABUSE.

PROFILE

TEXT BY

EIRLIANI ABDUL RAHMAN

Eirliani is the co-founder of Youths, Adult survivors & Kin In Need (YAKIN), a Voluntary Welfare Organisation. In 2015, she campaigned against child sexual abuse in India alongside Nobel laureate Kailash Satyarthi, reaching over 16 million people. She won the BMW Foundation Responsible Young Leaders Award in 2015. A former diplomat, Eirliani served in Berlin and Delhi.

PROFILE

TEXT BY

DR WONG TIEN HUA

Dr Wong Tien Hua is President of the 56th SMA Council. He is a family medicine physician practising in Sengkang. Dr Wong has an interest in primary care, patient communication and medical ethics.

Illustration: Dr Kevin Loy

INFORMED CONSENT (PART 2) — SHARED DECISION-MAKING

Informed consent is about helping patients make the right choices for their medical treatment.

The Singapore Medical Council's Ethical Code and Ethical Guidelines exhorts doctors to ensure that their patients are adequately informed and are able to participate in the decision-making process.

"It is a doctor's responsibility to ensure that a patient under his care is adequately informed about his medical condition and options for treatment so that he is able to participate in decisions about his treatment. If a procedure needs to be performed, the patient shall be made aware of the benefits, risks and possible complications of the procedure and any alternatives available to him."

I wrote about the problem of having too much choice in the November 2015 issue of *SMA News* (https://goo.gl/5LLNL2). In the modern era of advancing technology, the treatment options for any medical condition are innumerable and can be bewildering. Patients not only receive information from doctors, but from many different sources as well, including both print and social media, and the Internet. How does a doctor ensure that a patient is able to comprehend all "the benefits, risks and possible complications of a procedure and any alternatives available"?

In this issue of *SMA news*, we have a timely article by Ms Mak Wei Munn and Ms Jasmine Tham (see page 18) on the legal aspects of informed consent, including some recent developments in Singapore.

Informed consent is where the patient makes the choice or agrees to undergo treatment without coercion. The role of the doctor is to provide information and to educate the patient, while patients need to actively participate in the process in an open manner. Getting the context right is important and the doctor must take into account the patient's social, occupational and family circumstances. This means that the process of informed consent is one that is **individualised**. Different patients have varying threshold for risk and would respond to their options for medical intervention accordingly.

From a legal perspective, what was deemed acceptable practice in informed consent is now shifting. The previous gold standard that "as long as it was acceptable by a body of doctors" (Bolam), has now shifted to one that makes it imperative to take into account individual, patient-centric preferences (Montgomery).

SHARED DECISION-MAKING

Atul Gawande's book *Being Mortal: Medicine and What Matters in the End* has been making its rounds in the medical community's list of must-reads recently. Gawande is a surgeon working in Boston and he wrote about the harsh realities of ageing and confronting mortality, the harm of over-medicalisation, the depersonalisation of institutional confinement and the hard conversations with one's loved ones in order to understand what their true wishes were at the end of their lives.

The book also carries an insightful discussion on shared decision-making where the author wrote about the challenges his family faced after his father was diagnosed with cancer. Even though both he and his parents were doctors, they found it difficult to follow the discussion with his father's oncologist. They were presented with all the data by the expert and were asked to make a choice, but there were simply too many options and each had its set of risks and benefits to consider. He lamented that the conversation never got to what his father really cared about, which was to maintain a life that was still worthwhile.

This tendency of doctors to do more was perhaps unsurprising. In Gawande's opinion, "the only mistake clinicians seem to fear is doing too little" but they don't realise that doing too much could be devastating as well. There is clearly a need for doctors to have a deeper understanding of what their patient's goals are, and to be able to work out the best course of action together with the patient.

GUARDIAN, TECHNICIAN, COUNSELLOR, FRIEND

Gawande referred to the work of medical ethicists, Ezekiel and Linda Emanuel, who proposed four models of the doctor-patient relationship.[1] They described these models as paternalistic, informative, interpretive and deliberative, echoing the earlier classic works of Eric Berne's transactional analysis model describing the parent, adult and child ego states.

The paternalistic model of care is the traditional model with the doctor as the guardian of medical knowledge and whose authority cannot be challenged, as he knows what is best for the patient and therefore makes the critical decisions. The doctor has the obligation to place the patient's best interest above his own, and the patient has to trust and even be thankful for the decisions made on his behalf.

The informative model of care is one where the doctor is a technical expert who provides the facts, data and options, but leaves the final decision to the patient. This shift to the other extreme reflects the rising trend of a consumerist culture where patients are deemed as clients and doctors as providers. Patients are given the information, the freedom and the control.

The interpretive model of care is one where the doctor acts as a counsellor to guide the patient in their medical journey and help the patient determine what is in their best interest based on their individual values. The patient may be confused and conflicted at first and it is up to the doctor to assist the patient in realising his or her own goals, leading to self-understanding. The choice of treatment is aimed at realising these values.

The fourth model is the deliberative model of care where the doctor acts as a friend, not only to provide information and guide the patient, but also to educate and provide his or her own insights and values during the decision-making process. Not only does the doctor indicate what the patient *could* do, the doctor advises what the patient *should* do, based on his intimate knowledge of the patient's values. These four models operate in the doctors' daily interaction with their patients and may be used for different patients in different settings, based on the situation. However, medical paternalism is roundly criticised and best avoided, as it does not support the notion of patient autonomy and self-determination in medical ethics. It is easy for patients to blame doctors when something goes wrong, especially when they were not consulted prior to a procedure.

The informative model can be employed for straightforward uncomplicated consultations where the patient has maximum choice and is knowledgeable enough to make decisions about their own care. The interpretive and deliberative models apply when the subject matter is more complex, with treatment results that may be unpredictable. Patients may feel confused and conflicted, and may appear vague and unable to express their goals during the consultation process. When this occurs, the doctor needs to spend time to elicit the patient's ideas, concerns and expectations, and then guide the patient towards a decision best suited for his individual circumstance.

This process of open discussion and understanding, with the exchange of ideas and values where both parties contribute and collaborate, is the process of shared decision-making. ◆

SUMMARY

- Informed consent is not about asking the patient to sign a form. It is a process.
- Informed consent is not about explaining every option. It is individualised and contextualised.
- Informed consent is about getting to know the patient.
- Informed consent is shared decision-making

References

1. Emanuel EJ, Emanuel LL. Four models of the physician-patient relationship. Jama 1992; 267(16):2221-6.

HIGHLIGHTS FROM THE HONORARY SECRETARY

PROFILE

REPORTED BY

DR DANIEL LEE

Dr Daniel Lee Hsien Chieh (MBBS [S'pore], GDFM [S'pore], MPH [Harvard], FAMS) is Honorary Secretary of the 56th SMA Council. He is a public health specialist and Deputy Director of Clinical Services at Changi General Hospital.

FEEDBACK ON MEDICAL APPOINTMENT WEBSITES

SMA received several member queries on third party medical appointment websites. Concerns on inaccurate information and wrongful portrayal of medical clinics and doctors were raised. SMA wrote to the respective companies to request that only the information of clinics and doctors that had provided consent should be placed on the websites. SMA has also provided feedback to the Advertising Standards Authority of Singapore on this matter. We are currently consulting our honorary legal advisors on the next steps to address this matter.

QUERY ON DRUGS THAT MAY RESULT IN POSITIVE URINE TEST

An SMA member who is a family physician wrote in to seek guidance in responding to queries by the Central Narcotics Bureau (CNB) on whether the medications prescribed by the doctor could give rise to the subject's urine being tested positive for controlled drugs. We noted the concern, that without a standardised list of controlled drugs tested and the corresponding medications that may result in a false positive, it will be difficult for a doctor to be definitive in his declaration to the CNB. SMA wrote to the CNB to seek clarification and will be meeting with CNB officials to explore ways to assist doctors in responding to such information requests.

DISCOUNTED STETHOSCOPE PRICING FOR SMSANZ STUDENTS

In support of local medical students under the Singapore Medical Society of Australia and New Zealand (SMSANZ), SMA provided to them a special discounted rate for the purchase of 3M Littman stethoscopes. SMSANZ members, like their counterparts in our three local medical schools and the Singapore Medical Society of the United Kingdom, enjoy complimentary SMA Student Membership. This is part of SMA's focus to reach out to more Singaporean and Singapore Permanent Resident students studying not just in local medical schools but overseas as well.

RE-APPOINTMENT OF SMJ CHIEF EDITOR

A/Prof Poh Kian Keong is re-appointed as Editor-in-Chief of the *Singapore Medical Journal* (SMJ) for a second term, for the period 2016 to 2017. The SMA Council thanks A/Prof Poh for his contributions and valuable efforts as the Chief Editor of the SMJ.

RE-APPOINTMENT OF SMA REP FOR WSHC (HEALTHCARE) COMMITTEE

Dr Wong Sin Yew is re-appointed as SMA's representative to the Workplace Safety and Health Council (Healthcare) Committee, for a further term of two years, ending 31 March 2018. The SMA Council thanks Dr Wong for his hard work and continued efforts to promote safety awareness in the healthcare environment. ◆

56th SMA ANNUAL GENERAL MEETING

Please mark your calendar

Date : Sunday, 17 April 2016
Time : 2 pm–4 pm (Buffet lunch will be served from 1 pm)
Venue : Alumni Auditorium, Level 2 Alumni Medical Centre, Singapore 169850

E-Annual Report: The SMA Annual Report 2015-2016 and audited Financial Statements ending 31 December 2015 will move from print to electronic platform as part of SMA's ongoing efforts to support environmentally sustainable practices by reducing our carbon footprint. Members can access and read the Annual Report and Audited Financial Statements from the SMA website. A downloadable PDF version will be made available online, for members who wish to print a hardcopy for your own reference.

Members who prefer to receive a printed copy may submit your request by returning the AGM Response Slip to the SMA Secretariat via **fax: 6224 7827** or **email: gekeng@sma.org.sg**, or **respond online: https://www.sma.org.sg/agm** by **1 March 2016**. A limited quantity will be printed for mailing to members upon request.

In summary, please submit the following documents to **the Honorary Secretary by 12 noon on 1 March 2016 (Tuesday):**

1. Your letter, if you wish to propose Resolutions and Constitution Amendments [Article XI Section 1(iii) and Article XII Section 2, SMA Constitution]
2. The Nomination Form if you wish to nominate candidates to fill the ten vacancies in the 57th SMA Council [Article VIII Section 3a, SMA Constitution]. The Form is circulated with the Notice of AGM in the January mailbag.
3. The Response Slip (which is also circulated with the Notice of AGM in the January mailbag) to
   (a) Request for a printed copy of the Annual Report
   (b) Confirm your attendance for AGM and to sign up for AGM lunch. ◆

DR DANIEL LEE HSIEN CHIEH
Honorary Secretary
56th SMA Council

CALLING ALL *WRITERS*

Do you have inspiring medical stories, insight and expert opinions regarding the local healthcare system, unusual encounters with patients, or beautiful images of faraway exotic lands to share with our readers?

If your answer is "**Yes**" to any of the above, and you would love to put to words your thoughts, wait no more. **Send in your written article to us at news@sma.org.sg today!**

IN MEMORY OF DR MOSES YU

Dr Jipson Quah sits down for a chat with Dr Jerry Lim, founder of Dover Park Hospice and long-time friend of Dr Moses Yu, to learn more about Dr Moses Yu's life.

- Born 31 January 1934 and passed away on 30 December 2015
- Former Head of Pathology Department, Singapore General Hospital (SGH)
- First UK-trained Diagnostic Bacteriologist in Singapore
- Former Assistant Director of Medical Services in the Ministry of Health (MOH)
- Founding Medical Director / Advisor, Dover Park Hospice
- Founding Member of the Chapter of Pathologists
- Former Chairman of the Alumni Association Southern Branch Singapore
- Former Commanding Officer of the second Combat Support Hospital and retired with the rank of Lieutenant-Colonel
- Pioneer batch of medical volunteers in 1970 under COL (Ret) Vol Dr Kwa Soon Bee's leadership

1

Dr Moses Yu graduated from the Faculty of Medicine in Singapore and joined the Department of Pathology in the early 1960s. He was sent to Manchester by the Government, where he attained the Diploma of Bacteriology in 1965. In 1971, he was promoted to Senior Pathologist and worked in the position for 14 years. During his headship, he started the Virology lab as a separate section from Bacteriology under Dr M Doraisingham and saw this lab designated as the National Influenza Centre. He also convinced MOH to acquire the first electron microscope in Singapore, and it became essential in the diagnosis and study of renal diseases. Later, he was appointed to the position of Assistant Director of Medical Services at MOH in 1985 and was also a key medical advisor at Dover Park Hospice.

Dr Jerry, you and Dr Yu were great friends for over 50 years, worked on numerous projects and served in the Singapore Armed Forces (SAF) together. Could you tell us more about him?

Dr Yu was born in China, where his father worked as a water engineer and his mother delivered him by the reservoirs, hence the name Moses Yu. He received his early education in China and Malaya, and attended the Anglo-Chinese School (ACS) in Penang, which has recently honoured him for his achievements.

He later transferred to ACS in Singapore where his presence is still fondly remembered by many of his colleagues today. Dr Yu was an ardent scout and distinguished himself in many leadership roles.

He entered the Faculty of Medicine, back then known as the University of Singapore, and was married to Mrs Ovidia Yu nee Iau Kuo Fong while pursuing his undergraduate studies. He was a devoted and loving husband and had a long and happy marriage with Mrs Ovidia Yu, who was a beloved and celebrated teacher in Methodist Girls' School.

After his housemanship, Dr Yu joined a general practice in Wisma Atria, Orchard Road. But alas, his tenure lasted exactly 24 hours! He then reapplied to the late Dr Eddie Ho, then Director of Medical Services, MOH, and his career commenced in the Pathology Department. Many years later, he was appointed as Head of Department and Consultant Bacteriologist when Dr Tan Kheng Khoo retired.

How was Dr Moses Yu as a doctor and a friend?

Dr Yu was the most humble, affable, kind and generous person I ever met and he ran a happy and efficient Pathology Department in SGH. I recently met one of his staff, Mr Ow Ah Kit, who was under Dr Yu's wing for 60 years before becoming the Chief Laboratory Technician for the whole of Singapore. He told me that Dr Yu never spoke an angry word to any of his staff and patients. He was always kind-hearted and generous in offering his money and services

to anyone who needed help. He was loved by everyone who came into contact with him.

As a doctor, he helped to look after the medical needs of many VIPs and as testimony to that, Prime Minister (PM) Lee Hsien Loong has written Dr Yu's children a most touching and kind letter of condolence, where he thanked Dr Yu for his contributions to the national healthcare landscape and described him to be "always ready with a gentle word, carefully explaining his diagnosis and what he was doing to his patients." PM Lee also mentioned Dr Yu's role in the founding of Dover Park Hospice, where he took on the role of Medical Director and Advisor on a pro bono basis. He would always promptly direct the MOH pay cheque towards the funds of Dover Park Hospice.

Are there any interesting anecdotes and memories of Dr Yu you'd like to share?

Dr Yu was an avid golf fan and was known to hit over 200 balls in his youth. His aim at billiards and golf was supreme and as he was monocular, he was a sharpshooter on the SAF rifle and pistol firing ranges as well. He often invited us to play "National Service Golf" with the late Dr Goh Keng Swee, who was a keen golfer especially in his retirement. Dr Yu was well known for his generosity to his caddies and he enjoyed buying expensive golf clubs to present to his friends as gifts or to persuade them to take up the sport.

Dr Yu was great company when he was with his friends and related many interesting anecdotes to which he also delightfully added a multitude of his various theories that we have fondly dubbed as "YUisms".

Dr Yu was a great friend to many and he always gave himself selflessly to help others. Nothing to him was too much trouble. His humility, kindness and generosity were his greatest virtues as a person and we shall miss this great doctor-soldier-administrator of Singapore. ◆

Dr Moses Yu is survived by his daughter, Ovidia; his son-in-law, Richard; his son, Peter; his daughter-in-law, Victoria; and his two grandchildren, Samuel and Jane.

Legend

1. Dr Moses Yu with his golfing buddies, Dr Jerry Lim and Dr Giam Choo Hoo
2. Dr Moses Yu's 80th birthday with Ovidia and Peter
3. Dr Moses Yu on the piano

ADVERTORIAL

DELIVERING HEALTHCARE IN CHINA'S FASTEST GROWING CITIES

Perennial Real Estate Holdings Limited ("Perennial"), listed on the Singapore Exchange mainboard, is an integrated real estate owner, developer and manager with a focus on large scale mixed-use developments. In China, Perennial is developing an extensive portfolio of healthcare and retail hubs within its integrated developments in several fast growing Chinese cities. These developments are in close proximity to major transportation hubs with an extensive catchment beyond their immediate precincts.

With the government-driven liberalisation of the healthcare industry (worth US$ 1 trillion by 2020)[1] to both private local and foreign operators, the Chinese healthcare market, growing at an annual rate of 12.5%, is attracting keen interests from healthcare operators, doctors and investors from Southeast Asia, USA and Europe.[2]

Foreign companies are allowed to hold majority share in medical related businesses and qualified doctors from the Commonwealth countries, USA, Canada, Eastern Europe and South America are able to practise on yearly renewable practice licences. It is expected that the Chinese government may further streamline the registration process for foreign doctors practicing in China in anticipation of the needs of China's growing consumer wealth.

To better capitalize on the growth in private healthcare in China, Perennial has established a joint-venture with Guangdong Boai, one of the largest private healthcare organizations to acquire and manage hospital/medical services in China. Perennial has a 40% stake in Guangzhou Modern Hospital, a leading tumour cancer hospital in China with plans to further develop specialty hospitals throughout China.

Perennial is developing China's first integrated healthcare, retail and lifestyle hub, Perennial International Medical and Health Hub, at Chengdu East High Speed Railway Integrated Development. It is located in Chengdu (population: 14.7 million), the provincial capital of Sichuan (population: 81.4 million). It has secured Parkway Pantai as an anchor tenant to establish a 350-bed multidisciplinary general hospital of no less than 500,000 sqft. Other specialty hospitals include a 200-bed rehabilitation hospital, a post-natal confinement centre, a TCM hospital, a plastic surgery and aesthetics hospital. Additionally, there are 118,400 sqft of available space for lease to medical suites or offices. Perennial International Health and Medical Hub is expected to be ready for occupation by end-2016 with the total development area about 3.01 million sqft.

Chengdu East HSR Integrated Development comprises 3-, 4- and 5-star hotels with over 645,000 sqft of Meetings, Incentives, Convention and Exhibitions (MICE) facilities; a 6,000-bed elder care and retirement home; service apartments and residences; 2 56-storey Grade 'A' offices and a retail podium. The hotels are slated to open next year while the others will progressively commence operations over the following 3 years.

Perennial International Medical and Health Hub is adjacent to and directly connects to the Chengdu East High Speed Railway Station which serves over 250,000 commuters a day through its 28 tracks. Within a 2-hour travel radius, it is accessible to a population of over 100 million. The train station is well-supported by subway line 2 and upcoming line 7, long- and short-distance bus routes and taxi ranks.

Being the commercial gateway of the West, Chengdu's economy is consistently ranked number one, with its 2014 GDP ranked eighth nationally at RMB1,005 trillion at 8.9% increment over the last preceding year. The disposable income per capita in 2014 grew 9% to RMB32,665, stimulated mainly by service, industrial and construction sectors. Over 50% of the World's Fortune 500 companies have presence in Chengdu and the city has been especially well known for its logistics, aviation and software development in recent years.

The introduction of healthcare real estate within well-designed integrated developments creates synergy among the various components further defines these developments as landmark one-stop destinations. Fully supported by an in-house professional real estate business and specialised healthcare team, Perennial will continue to expand in high growth cities and acquire assets in close proximity to major transportation hubs.

[1] "Health care in China: Entering 'uncharted waters'", McKinsey Report, November 2012.

[2] World industry outlook: Healthcare and pharmaceuticals, The Economist Intelligence Unit, May 2014.

PERENNIAL INTERNATIONAL HEALTH AND MEDICAL HUB

L3/L4 The Wellness Connection

International Confinement Center | International Plastic Surgery and Aesthetics Hospital | Rehabilitation Hospital | Traditional Chinese Medicine Hospital

L1/L2/L2M The Retail Connection

Healthcare Equipment | Convenience Stores | Cafes and Bistros | Drugstores | Florists | Organic Fruit and Juice Bars Eyewear | Traditional Flagship Chinese Medicine Pharmacy | SPA | Organic Health Food | Bookstore | International Specialist Medical Centre

B1/B2 The Convenience Connection

Medical Equipment and Supplies | Gifts and Novelties Food Street | Supermarket | Specialty Grocers Seafood Wholesaler | Digital and Electronics | Fast-foodServices

About Perennial Real Estate Holdings Limited

Perennial Real Estate Holdings Limited ("Perennial") is an integrated real estate owner, developer and manager listed on the Mainboard of the SGX-ST. Headquartered in Singapore, Perennial focuses strategically on large-scale mixed-use developments and has a presence in the People's Republic of China ("PRC"), Singapore, Malaysia and Ghana with a combined portfolio measuring over 45 million square feet in gross floor area. Perennial's business also extends into the healthcare industry in the PRC, through the acquisition, development and management of medical, eldercare and senior housing services and assets.

Perennial is a dominant commercial developer with sizeable integrated developments in the PRC, of which two are the largest high speed railway commercial hubs in the country, being Chengdu East High Speed Railway Integrated Development and Xi'an North High Speed Railway Integrated Development. Other landmark projects in Perennial's portfolio include the Beijing Tongzhou Integrated Development, the Shenyang Longemont Integrated Development and the Zhuhai Hengqin Integrated Development.

In Singapore, Perennial is invested in and manages prime and iconic properties located predominantly in the Downtown Civic District, Central Business District and Orchard Road precinct, such as CHIJMES, Capitol Singapore, AXA Tower, TripleOne Somerset, House of Tan Yeok Nee and Chinatown Point mall.

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DEFENSIVE MEDICINE

— THE NEED FOR RE-IMAGINATION OF OUR MEDICAL LITIGATION PARADIGM

PROFILE

TEXT BY

DR T THIRUMOORTHY

Executive Director, SMA Centre for Medical Ethics & Professionalism

Dr Thirumoorthy has been involved in the SMA CMEP for the last 15 years and has been Faculty at Duke-NUS Medical School since 2007. His teaching responsibilities include subjects on clinical skills, professionalism, medical ethics, communications and healthcare law. He has been practising medical dermatology at Singapore General Hospital since 2002.

Defensive medicine has been in the news with Chief Justice Sundaresh Menon proposing a review of the medical litigation paradigm to a less adversarial process in order to reduce the practice of defensive medicine, during his speech at the opening of the legal year on 11 January 2016.[1] In this paper, we attempt to understand the "whats" and "whys" of defensive medicine and the need for a less adversarial system of medical dispute resolution.

WHAT IS DEFENSIVE MEDICINE?

Defensive medicine is a deviation from sound medical practice that is induced primarily by a fear of medical malpractice (medical litigation in the courts and threat of legal action by licensing boards). The deviation in practice aims at reducing adverse outcomes, deterring patients from filing malpractice claims or complaints and persuading the legal system that the standard of care was met. Defensive medicine is primarily focused to help avoid and protect the physician from liability rather than to substantially further the patient's diagnosis or treatment.[2]

The practices in defensive medicine are classified as **assurance practices** and **avoidance practices**. **Assurance practices** involve the use of more investigations, more medications and more referrals than would be normally indicated. Assurance practices intend to reassure patients and their relatives concerning the quality of care and also offer psychological reassurance for the physicians.

Avoidance practices involve restriction of practice, including eliminating procedures prone to complications and avoiding patients who have complex medical problems or are perceived as litigious. Avoidance behaviours reflect physicians' efforts to distance themselves from situations of high legal risk. Obstetricians are known to limit their practice only to gynaecology and tend to retire early. Orthopaedic surgeons tend to avoid spinal work.[3]

The prevalence of defensive medicine is high in the US with reports as high as 90%.[2,3,4] There are no local studies measuring the prevalence of defensive medicine. Speaking to practising clinicians, both specialists and generalists, many are convinced that defensive medicine has been fully incorporated into daily medical practice. The extent may vary according to legal risk in that specialty.

Defensive practice correlated strongly with respondents' lack of confidence in their liability insurance cover, perceived high financial burden of insurance premiums and experiences of being dropped by insurers in the past.[2]

THE NEED TO REVIEW MEDICAL LITIGATION PROCESSES

Moving away from the adversarial model of medical dispute resolution would definitely reduce the sting of litigation from the medical profession and pave the move away from defensive medicine.

Physicians feel vulnerable to malpractice suits because claims often do not involve medical error or negligence and physicians have been sued despite practising within the standard of care. The strongest reason for review and reform is the inefficiency of the current adversarial malpractice system — neither is it beneficial to the plaintiff nor in terms of improving the patient's safety. There is minimal correlation between negligent acts that harm patients and adverse outcomes that prompt lawsuits.[5] There is no evidence that the deterrence of lawsuits does anything beneficial in reducing the prevalence of medical errors. Leaders in the field of patient safety and quality improvement view the blaming and shaming of individual physicians as a largely counterproductive strategy for improving patient safety.[6,7]

Legal commentators critical of the US tort system have gone on to claim that it is harder to design a more inefficient system of just compensation in medical malpractice. If one were to deliberately try to design a bad system for compensating the victims of medical errors, it is difficult to show how the present system could be exceeded.[8, 9]

Reducing the adversarial nature of the litigation process by encouraging mediation creates a safe space for open disclosure, expression of empathy and apology and reconciliation of the doctor-patient relationship. A judge-led inquisitorial process lends to a more efficient finding of the facts. "Hot-tubbing" of experts and neutral medical assessors in complex cases allows for effective use of medical expert advice.

DEFENSIVE MEDICINE TO PATIENT-CENTRED MEDICINE

Defensive medicine often leads to altered clinical judgement, defensive communication and finally, the deviation from good clinical practice. It distorts the doctor-patient relationship where the physician is committed to serve the patient's best interest. In addition to reforms in the litigation process, doctors should upgrade their knowledge on medico-legal matters so that they can act from a position of knowledge rather than have a fear of medical litigation.

We should return to our humanistic mission of building strong therapeutic relationships with our patients and their families based on mutual respect and trust. In patient encounters, doctors should elicit patient's expectations, seek to understand their illness perspective and engage them in shared decision-making.

When our patients suffer an adverse event, doctors and hospitals must have in place policies, practices and expertise that will enable engagement in open and truthful communication, empathise always, apologise when appropriate and develop systems for early and just compensation.

Doctors should work collaboratively with hospitals and other stakeholders to reduce medical errors, improve patient safety and be committed to optimise use of healthcare resources.

Moving from defensive medicine to the delivery of safe, effective, efficient and affordable patient-centred medical care is the best way to reduce medical malpractice and its unwanted effects. ◆

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SHARED DECISION-MAKING:
CONSENT AND RECENT DEVELOPMENTS

WHAT IS CONSENT AND WHY IS IT IMPORTANT?

"Respect for autonomy is not a mere ideal in healthcare; it is a professional obligation. Autonomous choice is a right, not a duty of patients."
— Beauchamp and Childress

Consent is an agreement, approval or permission as to some act or purpose and is given voluntarily by a competent person. The concept of consent given in the medical setting is one that recognises patient autonomy, that patients have a right to freely make decisions about their health without coercion. The role of doctors and healthcare providers is to provide an environment within which the patient can make an autonomous choice, by educating the patient and providing information that may be relevant to the patient in making an informed decision.

Obtaining (informed) consent from patients is also important for doctors and healthcare providers, as properly obtained consent protects them from liability, be it criminal liability for trespass to person, civil liability for medical negligence, or professional misconduct.

SHARED DECISION-MAKING

The phrase "shared decision-making" begets the question of *who* should be involved in the decision-making process.

Ill health impacts not only the individual, but also his family and people in his sphere of influence. Do third parties have a right to participate in medical decisions for the individual? Or should the treating doctor with greater understanding of the patient's medical condition and treatment options be allowed to make medical decisions for the patient?

The Singapore Court commented on this issue in the case of *Re LP (adult patient: medical treatment)*.[1] In *Re LP*, the patient required amputation of both legs to manage her infection and to save her life. However, the patient was in a comatose state and consent could not be taken. The patient had no known relatives except for her 16-year-old son (a minor). Prior to being in a comatose state, but at a time when there was no danger of death, the patient had verbalised to her doctor her wish that they "*save her legs at all costs*".

The Singapore Court commented that a person is entitled to give or withhold consent to any medical treatment and that **doctors are to respect that person's decision. No one else, however close by reason of kinship or friendship, is legally entitled to make that decision for the patient**. However, the Singapore Court ultimately did not accept that the patient had clearly and expressly refused her consent to the amputation, given that her wish to "*save her legs at all costs*" was expressed in the absence of knowledge that an amputation was the only treatment which could save her from impending death.

The concept of shared decision-making is thus not about other persons "sharing" in the medical decisions of the patient, but rather the patient taking on a more active and participative role regarding his treatment decisions. Instead of the patient simply being given information about treatment by the doctor and then making a decision to give or withhold consent, the patient and doctor are expected to have more open and interactive communications. The doctor offers all reasonable options to the patient, including no treatment, and then discusses with the patient the advantages and disadvantages of the options. The doctor then invites the patient to provide input on factors that would affect his decision on treatment, such as the patient's job and its requirements, family's expectations, personal risk threshold and religious considerations. Based on a better understanding of the patient's unique background and concerns, the doctor advises and recommends, and the patient and his doctor have an open dialogue to answer the patient's queries to help him come to a decision on what treatment option is most suitable for him.

The challenge for medical practitioners today is in determining how this shared decision-making and the discussion that it must entail can be implemented in a busy clinic.

BOLAM AND RECENT DEVELOPMENTS ON CONSENT

The test that has been applied in Singapore in determining whether satisfactory consent has been obtained from the patient is the Bolam test, defined in the English case of *Bolam v Friern Hospital Management Committee*[2] — that is, satisfactory consent is considered obtained if the doctor had "*acted in accordance with a practice accepted as proper by a responsible body of medical men in that particular art*" when obtaining consent. The Bolam standard was adopted into Singapore law through the seminal case of *Khoo James v Gunapathy d/o Muniandy*[3] and has to date been maintained (in Singapore) as the gold standard.

Notwithstanding having originated from the UK, the Bolam test is no longer being employed in the UK in relation to the obtaining of consent. The UK Courts departed from Bolam in the recent 2015 case of *Montgomery v Lanarkshire Health Board*.[4]

In *Montgomery*, the patient, who was pregnant and diabetic, had concerns about vaginal delivery. The doctor involved failed to warn her about a 9% – 10% risk of the baby suffering from shoulder dystocia during vaginal delivery, believing that the risk of grave injury to the baby was very small, and if advised, the patient would opt for a Caesarean section, which was (in the doctor's opinion) not in the patient's interest. During the vaginal delivery, the baby suffered hypoxia and developed cerebral palsy, and also suffered a brachial plexus injury, which resulted in paralysis of his arm. It is not disputed that had the patient been warned of the risks of vaginal delivery, she would have opted for Caesarean section and the baby's injuries would have been avoided.

The UK Supreme Court heard evidence from expert witnesses, and had the Bolam standard been applied, it may be argued that the doctor's decision to omit mentioning the risk of shoulder dystocia to avoid unnecessarily alarming the patient may be in "*accordance with a practice accepted as proper by a responsible body of medical men in that particular art*". However, the Supreme Court held that the doctor's duty is to "*take reasonable care to ensure that the patient is aware of any **material** risk involved in any recommended treatment, and of any reasonable alternative or variant treatment*", and that a risk is considered material if "*in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that **the particular patient would be likely to attach significance to it***". The Supreme Court's rationale for departing from Bolam is that patients are now more capable of understanding medical matters and are generally more well-informed, thus able to decide on the risks to their health that they would be prepared to undertake.

PROFILE

TEXT BY

MAK WEI MUNN

Wei Munn is a Partner of Allen & Gledhill LLP. She has over 13 years of medico-legal work experience and acts for hospitals, clinics and doctors across a range of specialist disciplines in a variety of cases involving civil claims, disciplinary proceedings and inquiries. She is on the Teaching Faculty of the Singapore Medical Association Centre for Medical Ethics and Professionalism.

TEXT BY

JASMINE THAM

Jasmine is an Associate at Allen & Gledhill LLP. She graduated with an LLB (First Class Honours) from the University of Exeter in 2012 and was called to the Singapore Bar in 2014. She is part of the Firm's litigation practice and has a special interest in medical negligence litigation.

WHAT DOES THAT MEAN FOR SINGAPORE?

In light of the change in judicial sentiment in the UK and other Commonwealth countries (for example, Australia and Malaysia have adopted a more patient-centric test) there can be no assurance that the Bolam standard will continue to remain the prevailing standard of care for doctors in Singapore. We need to proceed with an awareness that given a climate of increasing patient involvement in treatment decisions, better education in a generation of patients who have access to information around the clock, and changing approaches to patient care, the law will seek to keep pace with these developments. While in pre-*Montgomery* cases such as *D'Conceicao Jeanie Doris v Tong Ming Chuan*[5] and *Tong Seok May Joanne v Yau Hok Man Gordon*,[6] the Singapore High Court had resolutely dismissed the idea of a patient-centric test to replace the Bolam standard, in the first post-*Montgomery* case of *Chua Thong Jiang Andrew v Yue Wai Mun*,[7] the Singapore High Court acknowledged the shift in the position in the UK, but did not address *Montgomery* directly, citing that it was unnecessary to deal with *Montgomery* given that the results (of that case) would have been the same on the application of the Bolam test.

PRACTICAL SAFEGUARDS ON HOW CONSENT SHOULD BE TAKEN

For doctors in Singapore, the uncertainty lies in the fact that the manner in which you take consent today may be scrutinised by a different standard in the future, should the law in Singapore change. In this regard, we suggest some good practices in relation to how consent should be taken:

- Consider the nature of the treatment or procedure;
- Ascertain and consider the motives of that particular patient for undergoing the procedure. Is the procedure an emergency or elective procedure?
- Disclose information that a reasonable and competent doctor might think necessary in the same circumstances;
- Disclose information that the patient specifically asks about;
- Disclose (i) key known risks;
  (ii) any substantial risk of minor adverse consequences;
  (iii) any remote risk of grave adverse consequences;
  (iv) in appropriate cases, even remote risks of minor consequences;
- Consider and discuss alternatives with the patient. If a non-standard procedure would be relevant to the patient's specific circumstances, they ought to be considered and discussed with the patient; and
- Discuss limitations of the procedures. ◆

THE CHALLENGE FOR MEDICAL PRACTITIONERS TODAY IS IN DETERMINING HOW THIS SHARED DECISION-MAKING AND THE DISCUSSION THAT IT MUST ENTAIL CAN BE IMPLEMENTED IN A BUSY CLINIC.

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For Doctors, For Patients

SMA Seminar: Tax Obligations on Medical Practice

Date: 09 April 2016, Saturday
Time: 1 pm – 4.30 pm
Venue: M Hotel, Level 10
CPE Points: Max 2

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Clinic owners (especially new owners and those not represented by tax agents), and representatives who are responsible for the preparation and filing of the Income Tax Return and other corporate tax matters.

1 pm	Registration (Lunch will be provided)
2 pm	Tax Obligations of a Medical Practitioner *Mr Shajahan, Senior Tax Auditor, (Individual Income Tax — Ruling & Compliance Branch), Inland Revenue Authority of Singapore (IRAS)*
2.30 pm	Productivity and Innovation Credit (PIC) Scheme — Find out what's new! *Ms Elyn Hong, Senior Tax Officer (Individual Income Tax — Self-Employed Branch), IRAS*
3.15 pm	Budget 2016 and its Implications *Ms Koh Puay Hoon, Partner, Tax Services, RSM Chio Lim*
3.45 pm	Questions & Answers
4 pm	Tax Planning *Mr Stephan Chew, Principal Consultant, Summit Planners Pte Ltd*
4.20 pm	Closing

Please return this slip for *SMA Seminar: Tax Obligations on Medical Practice* to **Carina Lee, Singapore Medical Association, 2 College Road, Level 2, Alumni Medical Centre, Singapore 169850.** Tel: 62231264, fax: 62247827 or email: carinalee@sma.org.sg. A confirmation email will be issued to all applicants.

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BE RELEVANT, STAY RELEVANT

In the last six months, I have been approached by a few long-time friends from different institutions for advice on their GP engagement programmes. I felt greatly appreciated by their invitations as it shows that they recognise what I have been trying to do in the last decade. At the same time, I feel flattered though I'm sure I still have much to learn.

REFLECTION

These invitations got me reflecting on the reasons why the previous programmes have not seen much success. I am sure the previous programmes are all sound and good, and are based on good principles and focused on lightening the national healthcare burden. Many of these programmes are well funded too. Of course, there are some existing policies that cannot be changed overnight but, by and large, there are ways to circumvent them.

Some of the programmes also have very dynamic and enthusiastic managers. These executives spare no effort in visiting GPs, tirelessly explaining to the GPs how their schemes work. While not all patients are happy to leave tertiary care, enough of the public are keen to try out the new schemes.

So what exactly is the problem? Why is it that these schemes do not see any success?

BAD EXPERIENCES

Not too long ago, a GP colleague shared with me his frustration and anger when he discovered that his faithful patient was directed to a family medicine clinic for follow-up after attending the emergency department of a public restructured hospital. This happened despite the patient telling the attending physician that he had a regular GP. Before we conclude that the patient is unhappy with my GP friend, the truth is the exact opposite. In reality, the patient wanted to schedule his follow-ups with my friend, which was why he brought along the neatly typed letter to show my friend.

This is not an isolated event. Not long after, I was told by another GP, whose clinic is in the northern part of Singapore, that his patient was referred to a private GP group after visiting the polyclinic near his house.

Whenever GPs meet, I hear of various negative accounts. Strangely too, whenever the same GPs meet with our colleagues and leaders from the Ministry of Health, they do not bring up any of these woes. I guess GPs are generally nice people.

HOW GPS SURVIVE

The conditions in the private world are harsh. Many younger GPs find the going tough. Some will surrender early while others may seek alternative means of survival. We know that many GPs went into aesthetic practices out of need. Let's face it, there are bills to pay and aesthetic services bring in the much needed cash fast enough for survival.

Older GPs survive through the years often with niches in which they excel. We know of some who "specialise" in company contracts, some offer mainly screening programmes and house call services and others offer health services specifically for men.

Whether it is aesthetics or others, all these "specialisations" are dividing the fraternity, deskilling the well-trained GPs and adversely affecting the public and country. And that would be an interesting topic that deserves a special write-up another time.

The positive lesson here, however, is that GPs have learnt to stay relevant and focused on the needs of their potential clientele to survive and thrive.

APPLICATION

Applying this lesson in the programmes for right-siting patients, I realised quickly that current GP engagement programmes are not relevant to both the public and GPs. No wonder they will not take off.

It is a near impossible task to convince the public to choose visiting

GPs over polyclinics, Specialist Outpatient Clinics (SOCs) and emergency departments, when the latter's charges are much lower. Similarly, the same medicines are available at these places at only a fraction of the price of those purchased from GPs and retail pharmacies. With that in mind, a little wait and the clinics being slightly out of the way is no deterrent to the almost free services and medicines.

It is well known too that the public will risk being scammed and sometimes even their own lives by buying medicines online. Others may just brave the crowd and long lines entering our neighbouring countries to buy cheaper medicines.

Additionally, engagement programmes are driven by administrators and medical leaders in the institutions who do not have personal experience in the private and GP industry. Simply put, GPs do not need these programmes.

The GPs have learnt to survive and thrive without them. On the other hand, the institutions are the ones suffering from the ever increasing load. The institutions need the GPs much more than the GPs need them.

On top of that, conditions such as fixing consultation charges, drug charges, restricting access to only those who attend "extra" training and so on, put a damper to the programme.

Understanding this helped me realise very quickly the root cause to the lack of success.

SOLUTION

In my humble opinion, maybe we should let the private GPs take the lead. Let them feedback to the institutions on what they need to attend to their patients, how they should be remunerated and the role they require the public institutions to play. Maybe we still have a chance.

We should think out of the box and for once, let the private world or the GPs take the lead. I am sure the Ministry has already missed the boat since many older GPs have comfortably adapted. But all is not lost. Maybe our Ministry could pin their hopes on the younger GPs while accepting guidance from the older ones.

Finally, we need to listen to the public. They are the ultimate key to success. If the programmes are not conducive for them to switch doctors, they will not. And if that's the case, we will be back to square one regardless of what we do. ◆

PROFILE

TEXT BY

DR LEONG CHOON KIT

Editorial Board Member

Dr Leong Choon Kit is a GP in the private sector. He is an advocate of the ideal doctor which is exemplified by one who is good at his clinical practice, teaching, research and leadership in the society. His idea of social leadership includes contributing back to society and lending a voice to the silent.

Disclaimer:
The author has been very active in helping MOH, GPs, professional bodies, pharmaceutical companies and patients come together to improve our healthcare system.

A Passion for Trauma Care

PROFILE

TEXT BY

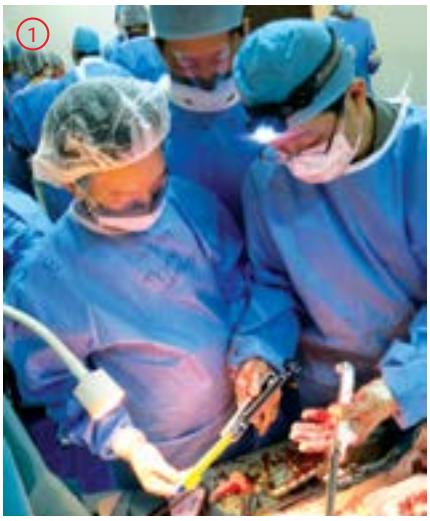
DR CHUA WEI CHONG

Dr Chua Wei Chong is a consultant general and trauma surgeon at Tan Tock Seng Hospital (TTSH). He is also the Director of TTSH Surgical Sciences Training Centre, member of the TTSH Clinical Board and Honorary Treasurer of the College of Surgeons, Singapore. Prior to joining TTSH, Dr Chua led a distinguished career in Singapore Armed Forces, completing his final tour as Chief Army Medical Officer and Commander, SAF Medical Training Institute. He was awarded the Public Administration Medal (Bronze) (Military) in 2011.

Trauma is a global epidemic, the leading cause of death in people below 40 years old in developed countries. In Singapore, trauma is the number one cause of emergency department admissions in all hospitals and the fifth cause of death across all ages. During my training years as a general surgeon, I saw how injuries, often resulting from accidents, could completely change the lives of both the injured and their loved ones. Even if a life was saved through timely surgery, the subsequent morbidity often adds to the burden of the family and society. My interest in this field of surgery was further cemented through my interactions with local and overseas mentors, all of whom, I noticed, possess an innate passion for saving lives emergently.

TIME IS LIFE IN TRAUMA CARE

In many industries and businesses, time is money. In trauma care, time is life. There are very few fields in medicine where time is such a critical factor. The term "golden hour of trauma" was coined to define life-saving procedures that must be done within the first few hours of trauma to prevent death. Notably, the three most common preventable causes of death are pneumothorax, haemorrhagic shock and loss of airway. If these conditions are diagnosed and treated early, precious lives could be saved. Beyond these initial emergency management skills, a robust hospital trauma system is necessary to prioritise and treat the different injuries in order to achieve the best possible outcome for a polytrauma patient.



An important but uncommonly known role of a trauma surgeon is that of leading and coordinating the care of the critically injured patient. There is no room for a "fog of war" scenario in the resuscitation bay, where the emergency physician, general surgeon, orthopaedic surgeon, neurosurgeon and nurses have to determine the best course of action to take when every injured

organ is in urgent need of repair. Teamwork, mutual understanding and trust among the various specialists have to be built over years under the umbrella of the trauma service, so that once a decision is made, the team is aligned and will proceed with the plan together. I have always felt a sense of fulfilment and camaraderie while standing together with my colleagues in the intensive care unit discussing the next steps to take for a trauma patient.

Communicating and empathising with the loved ones of patients can sometimes be trying because of the emotionally charged atmosphere. An avenue for the family's grief, especially when not all patients will survive, needs to be provided. One of the greatest challenges is breaking the bad news to family members that their loved one is unlikely to survive from severe trauma, while supporting both the patient and the family in the last leg of their journey. These cases further strengthen my resolve to always do my best in providing optimal care for my patients.

REACHING FAR AND WIDE

In 2013, I made my first visit to hospitals in Phnom Penh, Cambodia, with my hospital's trauma director. I was moved by how keen the Cambodian doctors were to acquire more skills to manage trauma despite the lack of hospital resources. We felt that the best way to contribute to the country was to impart our knowledge and skills to them. Fortunately, we were able to obtain support from an official in the Cambodian Ministry of Health for a partnership with Calmette Hospital, a public tertiary hospital in Phnom Penh, to provide training for local doctors and nurses. After much planning, a memorandum of understanding was signed between Tan Tock Seng Hospital and Calmette Hospital in January 2014, and the first Skills in Trauma and Resuscitation (STAR) course was conducted. Since then, we have sent teams to conduct basic, intermediate and advanced STAR courses at Calmette Hospital three times a year, and medical personnel from other local hospitals have also benefitted from attending the course.

In April 2015, I was informed that a young man who had sustained a serious head injury in a motorcycle accident was evacuated to Calmette Hospital. I was truly moved to know that the patient's life was saved partly because of the training and skills received by the Cambodian ER doctors. All the hard work and late nights put in to develop the STAR programme have been worthwhile; the sense of hope given to the patient's family is immeasurable. In order for such a collaboration to be effective in the long run, a sustainable presence in Cambodia is needed to continue this training journey and to nurture the next generation of life-savers.

Nine years ago, I was part of a small group of trauma surgeons who organised the first Singapore Trauma Conference. We had the privilege of having world-renowned experts share about trauma care, and the conference has steadily gained prominence as a regional trauma conference attended by doctors and nurses in the Asia Pacific region. Today, Singapore's advancement in trauma care is recognised by many countries, thanks to Singapore Trauma, the work of the National Trauma Committee, and Singapore's comprehensive participation in international trauma-related events.

In the last three years, I have travelled to a number of countries to conduct talks and courses, such as the International Advanced Trauma Life Support Provider course in Myanmar and Mongolia. While I continue to provide trauma care to hospital patients, I believe that by sharing my knowledge and skills with my counterparts in the region, I will be able to help even more people. Although every trip presents different challenges and experiences, there is always one constant: the desire to save the life of a fellow human being. Verbally, we may speak different languages, but our hearts speak the same language. ◆

Legend

1. Dr Chua conducting the Advanced STAR Course in Cambodia, focusing on operative damage control surgery
2. The Memorandum of Understanding Ceremony between Tan Tock Seng Hospital and Calmette Hospital in January 2013
3. Dr Chua teaching airway management at the inaugural Advanced Trauma Life Support (ATLS) Provider Course in Mongolia in 2015

SMA

Annual Dinner

2016

Guest of Honour

Dr Vivian Balakrishnan

Minister for Foreign Affairs

14th May 2016 (Saturday)
Dunearn Ballroom, Raffles Town Club
1 Plymouth Avenue, Singapore 297753

Cocktails will be served from 6.15 pm
All guests to be seated by 7.15 pm

Non SMA members' rate
$1,300 nett per table ($130 nett per person)
SMA members' exclusive
$1,100 nett per table ($110 nett per person)

Please note that alcohol will not be provided at the dinner.
You may bring your own bottle of wine as there is complimentary corkage waiver for bottles of duty-paid hard liquor, wine and champagne.

For enquiries, please contact Ms Mellissa Ang
Tel: 6223 1264 Email: dinner@sma.org.sg

MyResponder Mobile App:
EXTENDING THE REACH OF THE CPR-TRAINED COMMUNITY

TIMELY HELP PRODUCES THE BEST OUTCOMES

One day in the early months of 2014, Nurse Amanda Tan witnessed her mother, Mdm Mary Lee, faint with uprolling of eyes. With help from the Singapore Civil Defence Force (SCDF) 995 phone dispatcher, Amanda ascertained that her mother had suffered from a cardiac arrest. Despite her initial panic, Amanda was able to administer timely cardiopulmonary resuscitation (CPR), which helped save her mother's life.[1]

While Mdm Lee was fortunate to have had a trained nurse by her side when she required CPR, many have not been as lucky. Despite efforts to train the public in CPR over the last ten years, only 22.4% of all arrests had CPR applied by a bystander.[2] It is postulated that the proportion of people trained in the population is still not large enough to appreciably increase the chances of a trained bystander being on scene when a cardiac arrest occurs.[2]

SMARTPHONE APP THAT MAKES A DIFFERENCE

While we may not be able to train everyone in CPR, we can enhance the reach of CPR-trained community first responders through smartphone technology.[3]

As shown in Mdm Lee's case, SCDF 995 dispatchers play a crucial role in identifying out-of-hospital cardiac arrest patients. Through the myResponder app, SCDF 995 dispatchers would be able to activate volunteer first responders located within 400 m of the cardiac arrest case. First responders in the community are able to render life-saving CPR in the precious minutes before SCDF paramedics arrive on the scene.

Importantly, community first responders are under no obligation to respond when activated and need to render help only when able to.

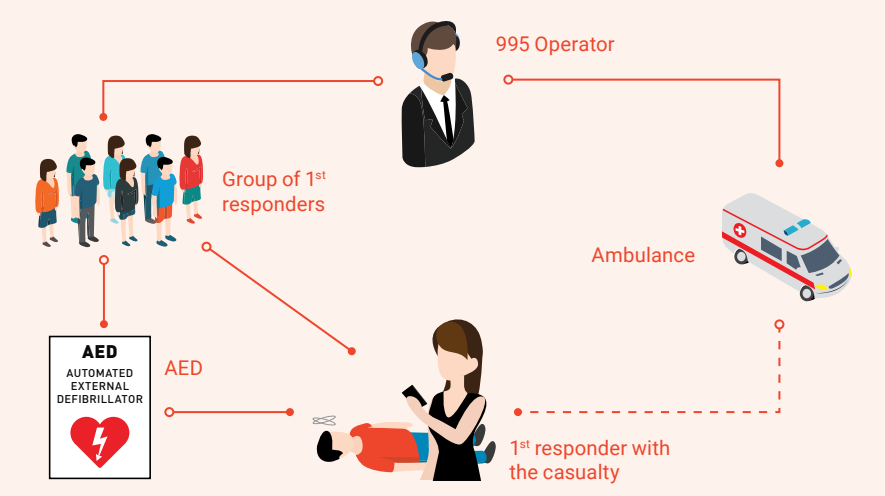
Another feature of this app is its ability to identify nearby automated defibrillators to improve defibrillation timings. Patients or bystanders in an emergency can also make use of the geolocation function of the app to help SCDF pinpoint their exact location.

DOCTORS AS FIRST RESPONDERS

With this app, doctors in Singapore are in a key position to make a real difference. As most doctors are trained in CPR and we can handle sick patients better than the general public, this app gives us a great opportunity to help patients in their moments of crisis.

In the words of our late Prime Minister Lee Kuan Yew, "This is not a game of cards. This is your life and mine." We appeal to doctors to lead the way in CPR. Download the app and be a volunteer first responder today!

Feedback on the app or this article can be directed to mao.desmond.r@alexandrahealth.com.sg. ◆



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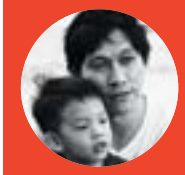
1. Cheong K. CPR Helpline a real life-saver. My Paper 5 September 2014; A2.
2. Lai H, Choong CV, Fook-Chong S, et al. Interventional strategies associated with improvements in survival for out-of-hospital cardiac arrests in Singapore over 10 years. Resuscitation 2015; 89:155-61.
3. Ringh M, Fredman D, Nordberg P, Stark T, Hollenberg J. Mobile phone technology identifies and recruits trained citizens to perform CPR on out-of-hospital cardiac arrests victims prior to ambulance arrival. Resuscitation 2011; 82:1514-8.

PROFILE



TEXT BY

DR DESMOND MAO

on behalf of Unit of Prehospital Emergency Care

Dr Desmond Mao is an associate consultant at the Acute and Emergency Care Department, Khoo Teck Puat Hospital.

STANDING ON THE SHOULDERS OF GIANTS

THE WHB-SMACF OUTSTANDING MENTOR AWARDS 2015

Sweaty palms. Bounding pulses. Feeling trapped in one's stuffy blazer. The niggling desire to adjust one's tie (is it still slanted?) for the 17th time. This cacophonous orchestra of anxiety is one memory we would vividly remember about our research conference debuts. As we reflect on our baptisms by fire, our thoughts invariably wander to those who have guided us through the flames and fought blazes alongside us — our beloved research mentors.

These giants were duly recognised at the second Wong Hock Boon (WHB) Society Symposium, held at the National University of Singapore last November. The WHB Society Symposium provides a platform for medical student researchers to showcase and defend their work against an expert panel, thereby allowing them to gain valuable experience through the presentation of their projects. The symposium is an annual event organised by the WHB Society, an undergraduate student research society within the NUS Yong Loo Lin School of Medicine (NUS Medicine). The society is named after the eponymous Father of Paediatrics in Singapore whose wide-ranging contributions to paediatric practice, including the widespread use of rice water to alleviate diarrhoea in children and the prevention of kernicterus in newborns, was also accompanied by his unflagging guidance and research mentoring to medical students and junior paediatricians.

Sharing the day's spotlight are doctors who have selflessly imparted their wisdom and shared their enthusiasm with budding researchers. The event saw student presenters and attendees from all three medical schools in Singapore, as well as eight mentors who were nominated by their student mentees and honoured with the Outstanding Mentor Award. The SMA Charity Fund has been supporting the award since its inception.

Our guest of honour, A/Prof Lau Tang Ching, spoke of Daniel Pink's model of motivation, as described in his book *Drive*. A/Prof Lau shared how the trinity of giving students the autonomy to explore, training their mastery of the subject matter and instilling a sense of purpose in their efforts are vital to their research success. In the anecdotes that follow, it is clear how our mentor awardees have practiced this as embodiments of poet Robert Frost's vision of education: "I am not a teacher, I am an awakener."

HEARING FROM THE MENTEES

Cai Mingzhe, a Phase IV medical student at NUS Medicine, shares with us the generosity of his mentor Dr Stefan Mueller: "No single instance can fully describe how wonderful mentor Dr Stefan has been to me. He has gone to great lengths to nurture me both in the heart and mind. Our meetings typically run overtime — for which I often feel bad — because of my never-ending list of questions and Dr Stefan's ever-enduring patience. His counsel to me goes beyond our research project and spans clinical knowledge, specialty interests, extracurricular advice, my father's health, life aspirations, values and professionalism."

Alvona Loh, who is also a Phase IV student at NUS Medicine, describes how her mentor, A/Prof Gerald Koh's role was pivotal in her research journey: "When I set out to conduct a study on the motivations, outcomes and perceived barriers of global health aid, as well as their corresponding potential solutions, it was instrumental that someone with experience in these areas supervised me. A/Prof Koh was the perfect mentor for this."

"A/Prof Koh taught me to envision this study as more than just a student project, but one that contributes meaningfully to global health aid and medical education. We worked closely to conduct the study in a way that is sufficiently rigorous and meticulous for publication on an international platform. I learnt from him the importance of open-mindedness to the findings of a study, receptiveness to constructive feedback during the research process and having acquired critical analytical skills to systematically process data, which are very useful qualities of a researcher."

FINAL THOUGHTS

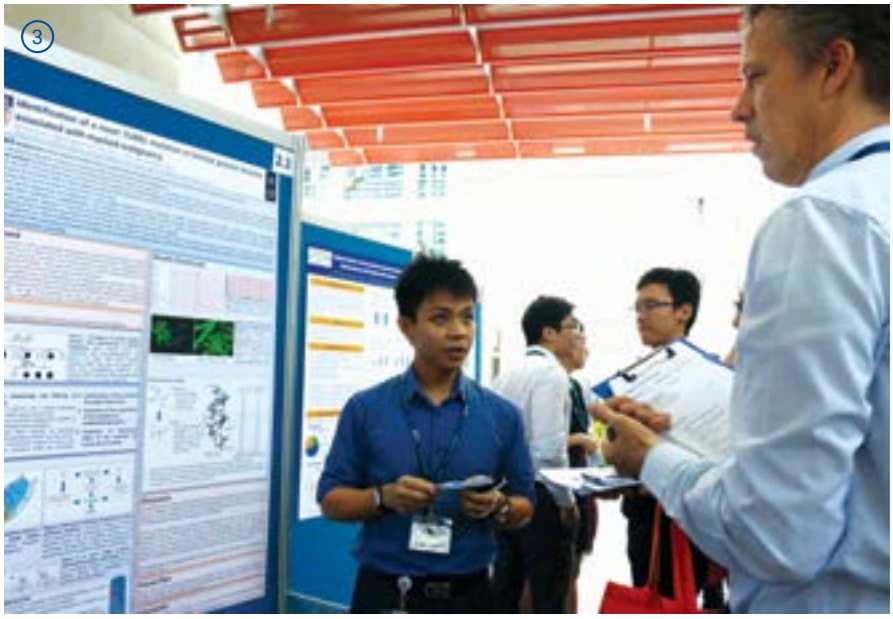
While we continue to make little forays into the vast unknown on the edges of human medical knowledge, let us not forget our mentors who have tenderly

placed the map and compass in our hands and taught us how to read the constellations to find our own path in the vast wilderness. Fittingly, the great medical educator and physician William Osler reminds us of the beauty and promise of teaching the next generation: "In the hurly-burly of today, when the competition is so keen and there are so many seeking the bubble reputation at the eye-piece and the test-tube, it is well for young men to remember that no bubble is so iridescent or floats longer than that blown by the successful teacher."

As you look into the mirror adjusting your attire for your next big presentation, or even the ward rounds of the day ahead, we hope that you too will remember fondly the moments your teachers and mentors have invested in you to shape the person in the mirror whom you see today. ◆

RECIPIENTS OF THE OUTSTANDING MENTOR AWARDS 2015

Dr Alfredo Franco-Obregon
A/Prof Bettina Lieske
Dr Delicia Ooi
A/Prof Koh Choon-Huat Gerald
A/Prof Poh Kian Keong
Dr Ridzuan Farouk
Dr Stefan Mueller
Dr Vu Duc Thang



PROFILE

TEXT BY

JEREMY TEOH

Jeremy is a third year medical student at the National University of Singapore and is the co-director of the second Wong Hock Boon Symposium, alongside Ang Ting Yao. When he's not struggling to read X-rays or ECGs in the wards, he enjoys reading on rainy days with a cuppa in hand.

Legend

1. Guest of honour (GOH) Prof Lau Tang Ching delivering the opening address
2. GOH Prof Lau and Outstanding Mentor Award recipient Dr Stefan Mueller
3. Student researcher Tan Yong Chuan presenting his project to expert judge Prof Mikael Hartman
4. Alvona, Prof Gerald Koh and his son Max at the WHB Symposium

Photos by Low Zhi Xuan

SMA EVENTS MAR – MAY 2016

DATE	EVENT	VENUE	CME POINTS	WHO SHOULD ATTEND?	CONTACT
CME Activities					
15 March Tuesday	Mastering Your Risk	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
19 March Saturday	Medical Expert Witness Training	Academia	TBC	Doctors	Denise Tan 6223 1264 denisetan@sma.org.sg
20 March Sunday	BCLS	SMA Conference Room	2	Family Medicine All Specialities	Shirong or Huda 6223 1264 cpr@sma.org.sg
22 March Tuesday	Mastering Difficult Interactions with Patients	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
23 March Wednesday	Mastering Your Risk	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
30 March Wednesday	Mastering Professional Interactions	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
2 April Saturday	Mastering Shared Decision Making	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
6 April Wednesday	Mastering Professional Interactions	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
9 April Saturday	Medical Expert Witness Training	State Courts	TBC	Doctors	Denise Tan 6223 1264 denisetan@sma.org.sg
9 April Saturday	SMA Seminar: Tax Obligations on Medical Practice	M Hotel	2	Doctors and Healthcare Professionals	Carina Lee 6223 1264 carinalee@sma.org.sg
18 April Monday	Achieving Safer and Reliable Practice	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
19 April Tuesday	Achieving Safer and Reliable Practice	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
23 April Saturday	Mastering Adverse Outcomes	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
24 April Sunday	BCLS	SMA Conference Room	2	Family Medicine All Specialities	Shirong or Huda 6223 1264 cpr@sma.org.sg
25 April Monday	Achieving Safer and Reliable Practice	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
27 April Wednesday	Achieving Safer and Reliable Practice	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
30 April Saturday	Medico-Legal Seminar on Mental Capacity	Academia	2	Doctors and Healthcare Professionals	Carina Lee 6223 1264 carinalee@sma.org.sg
3 May Tuesday	Achieving Safer and Reliable Practice	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
4 May Wenesday	Mastering Adverse Outcomes	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
5 May Thursday	Achieving Safer and Reliable Practice	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
7 May Saturday	Achieving Safer and Reliable Practice	Novotel Singapore Clarke Quay	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
14 May Saturday	Mastering Adverse Outcomes	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
Non-CME Activities					
9 April Saturday	SMA Dance Spring Celebration	Alumni Medical Centre	NA	SMA Members and Guests	Rita 6223 1264 rita@sma.org.sg
14 May Saturday	SMA Annual Dinner 2016	Raffles Town Club	NA	SMA Members and Guests	Mellissa Ang 6223 1264 mellissa@sma.org.sg

The SMA Medical Students' Assistance Fund

In 2007, SMA, in joint collaboration with the NUS Yong Loo Lin School of Medicine (NUS Medicine) and with the support of the NUS Development Office, started the SMA Medical Students' Assistance Fund (SMA-MSAF) to help needy medical students with their living expenses during the course of their medical education at NUS Medicine.

Beyond meeting the needs of our medical students in NUS Medicine, the SMA Charity Fund (SMACF), an entity with Institute of a Public Character status, has also been working very closely with Duke-NUS Medical School and Lee Kong Chian School of Medicine to ensure that the needy medical students there are able to enjoy peace of mind while pursuing their medical education. The SMA-MSAF programme now comes under SMACF. At the start of each academic year, medical students who are in need of further assistance to support their living expenses may apply to SMACF for bursary assistance.

The bursary is made possible by our stakeholders, most of whom are medical professionals who believe in maintaining a tradition of giving back to the community and through doing so, shaping the future of healthcare for the benefit of everyone. It is a scarce resource and the Board reviews all applications thoroughly to ensure that the award is given out fairly to these needy medical students, allowing them to focus on what is important — training to be a good medical doctor!

DID YOU KNOW?

1) From 1 February 2016 onwards, Giving.Sg has replaced the old donation site at sggives.sg. With the new site, donors are able to do more to support programmes by the SMACF. Support SMACF at www.giving.sg/smacf.

2) Our programmes include supporting the learning exposure of needy medical students, advocating volunteerism and recognising mentorship.

3) The tax deduction benefit has reverted to 2.5% from 1 January 2016.

4) The quantum for each bursary award is currently set at S$5,000 and the amount is given directly to the students to support their living expenses.

5) Ad hoc application for the bursary is open to medical students throughout the year. Medical students who are caught in unforeseen emergencies that put a strain on their family's financial status can contact SMACF for assistance. The quantum of such awards will be assessed on a case-by-case basis.

THE BURSARY APPLICATION PROCESS

Medical students apply for assistance through the SMACF website at the start of each academic year

↓

Staff in charge review applications with all necessary supporting documents provided

↓

Shortlisted bursary applicants attend an interview by the Board of SMACF where required

↓

Approval by Board of SMACF for successful applicants

↓

Applicant to receive and return the Letter of Acceptance of Bursary Award

↓

Disbursement of funds to recipient

PROFILE

TEXT BY

JENNIFER LEE

Deputy Manager, SMA Charity Fund

PROJECT SA'BAI: 10 YEARS IN SERVICE

Legend

1. Couldn't have accomplished a great clinic day without the help of our Cambodian Wing from the University of Puthisastra!
2. Testing out the portable water filters which were given out to a random sample of villagers in Phum Chreh
3. Our alumni doctor and translator working together during one of the consults at Teuk Thla School
4. A focus group discussion with the villagers during one of our Participatory Learning for Action sessions

WHAT WE DO

In 2015, Project Sa'Bai, an Overseas Community Involvement Programme under the National University of Singapore (NUS) Medical Society, celebrated its tenth year of service. Project Sa'Bai has offered free clinics and health screenings for thousands of patients in Cambodia, many of whom consider our clinics to be their only source of healthcare.

Over the course of two weeks in December last year, Project Sa'Bai screened a grand total of 2,238 patients in Cambodian schools and villages, sent out 24 external investigations and referred 121 external care cases to our Cambodian healthcare partners.

In recent years, we have seen an increase in the need for a solution to provide year-round healthcare to help patients manage their chronic conditions more effectively. As such, Project Sa'Bai pioneered the Referral System in 2012, which has grown from working with one-man non-governmental organisations (NGOs) to forming partnerships with the largest Cambodian hospitals in Phnom Penh. Our partners include the Rose Eye Clinic, which offers free cataract surgery, and the Khmer Soviet Friendship Hospital, one of the largest Cambodian hospitals catering to the healthcare needs of the underprivileged. Our commitment towards developing an extensive referral system has helped reintegrate our patients back into their local healthcare systems.

OUR 2015 FOCUS

Among the aims for each trip was identifying gaps in healthcare knowledge and needs through population studies. During Project Sa'Bai 2015, we forsook the usual surveys in favour of Participatory Learning for Action, an open-ended discussion method introduced to us by Dr Sri Chander, the Asia-Pacific Regional Health Advisor of World Vision from 1987 to 2014. Our conversations with the villagers brought to our attention the prevalence of gastrointestinal illnesses due to poor hygiene habits and water quality. In order to enhance the water quality, our pioneering committee led the change of water filters in Don Bosco School in Phum Chreh and distributed new portable membrane filters to nearby villages.

Our team also focused on **improving the sustainability of our project** by further developing our exit plan. In 2014, we established our Sa'Bai Cambodian Wing, which consists of five medical students from the University of Puthisastra. As Cambodians themselves, they are in a better position to serve their fellow citizens, navigate the healthcare facilities and provide more comprehensive clinics for the underprivileged communities. Last year, the Cambodian Wing worked closely with us in creating educational materials, liaising with Cambodian healthcare organisations and procuring pharmaceutics and logistics. Over the next few years, we hope to ease them into taking over the existing clinics while the Singaporean Wing moves on to new locations to identify other underprivileged communities in need of our help.

Yet another initiative was the reviewing of the schools' health

education syllabus to keep it relevant. Our health education team has put in great effort to sustain the students' interest over the past year by ensuring that the content is different yet effective in filling the gaps in health knowledge. Other efforts by the team included the use of donated soft toys to teach kindergarten children how to dress their wounds, in a bid to make health education lessons more interactive and interesting for the younger ones.

IN RETROSPECT

Planning this project has given us a more holistic view on healthcare delivery, beyond what we are exposed to as medical students. Through the experience, we realised the meticulous coordination involved between various stakeholders and the immense operational requirements needed to deliver free healthcare to our patients in Cambodia. At the same time, we also saw that there was a need to inspire a change in how the Cambodians take care of their own health through targeted health education efforts in order for us to make a lasting impact on their health.

This trip also taught us the importance of having a well-governed and coordinated healthcare system. We faced many difficulties in referring our patients to their local hospitals, which has imbued in us a deeper appreciation for our own healthcare system considering its efficiency, access to state-of-the-art technology and heart for the people.

Providing referrals for our patients who needed more advanced health services beyond the capabilities of our clinic proved to be a huge challenge. Due to the overwhelming number of patients needing referrals, as well as the limited funds and resources available, we were forced to make the difficult decision on which patients were given priority. As a group of unqualified medical students, we faced situations where the patients' conditions were far too severe for us to do anything substantial to help, and those with less severe yet more treatable conditions had to be "chosen" over those with more painful conditions.

Unfortunately, some patients whom we could treat turned down treatment for reasons that would seem insignificant to us yet crucial to them, such as needing to be home to feed their children, not being able to afford the transport for follow-up, or simply due to fear which stems from the stigma associated with surgery.

Despite all these limitations, we took comfort in knowing that we have at least provided them with support and help while we were there to serve their medical needs. Our shared experiences will serve as the bedrock of encouragement in our lives as future healthcare professionals.

OUR THANKS

To end off, the Project Sa'Bai team would like to thank Drs John and Priscilla Lee for their unwavering support throughout the course of our project term and we are grateful for their kind mentorship. Our project owes its success to the support of our local community and we would like to extend our sincere gratitude to all volunteers and sponsors who made Project Sa'Bai 2015 possible. As we prepare for the next project, we hope to continue receiving support from the local medical community. If you would like to support Project Sa'Bai in any way, or to find out more about our project, please contact us at projectsabai@gmail.com. ◆

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PROFILE

TEXT AND PHOTOS BY

TRICIA CHEW LI TING

Tricia Chew is a second year medical student at NUS. She loves meeting new people and getting to know what makes them tick. Often, she relaxes by reading, exercising, drawing and playing the piano.

TEXT AND PHOTOS BY

CASSANDRA ANG YANG XUAN

Cassandra Ang is a second year medical student at NUS. She enjoys a variety of hobbies such as cooking, singing and exercising. She likes to lead an active lifestyle by dancing and going on hikes.

PILGRIMAGE OF A PIANOPHILE:

Four Days in Husum, the Mecca of Piano Music Lovers

PROFILE

TEXT AND PHOTOS BY

DR CHANG TOU LIANG

Dr Chang Tou Liang is a family physician. From 2004 to 2008, he was the artistic director of the Singapore International Piano Festival. He is presently Singapore's most prolific classical music reviewer, having contributed over 1,900 articles to the *Straits Times*. He is married to Janet, has a 14-year-old son Shan Ming and owns 12 cats.

Muslims go to Mecca and Roman Catholics to Lourdes. For the *pianophile*, or lover of piano music, the place to be is Husum, a little town on Germany's North Sea coast. Better known to the Germans as a summer seaside getaway, Husum hosts the world's most unique piano festival, *Rarities of Piano Music*, at the Schloss vor Husum. The festival specialises in presenting works for the piano that are rarely performed or heard of. Pieces by obscure composers and forgotten works by great composers are celebrated as if they were the true classics.

Husum is located two hours by train from Hamburg's Altona Station, a pleasant journey through vast and flat expanses of greenery, dotted by thousands of modern windmills, the energy collectors of wind farms. The train crosses over the mighty Kiel Canal, a man-made waterway that connects the North Sea to the Baltic Sea. Husum's sleepy station beckons and the market square is a short six-minute amble away. The clock tower of Marienkirche (St Mary's Church) dominates the low skyline, and its carillons, heard from my loft at the welcoming Wohlert Hotel, reminded me that it was six in the evening. The piano recital would commence in an hour and a half.

The festival takes place every year over eight evenings in late August, when the sun sets late and the air is balmy. The setting of the Knights' Hall in the 16th century castle, Schloss vor Husum, is special. A Steinway grand piano stands proudly in a small but intimate space which seats 200 comfortably. The castle's ferrous oxide red bricks and its imposing clock tower, encircled by a moat slightly overgrown with rushes, is a sight! When the concert began, the audience sat with rapt attention, but no one informed the moat's ducks and migratory birds, whose calls provided a

Legend

1. Pianist Martin Jones acknowledges the applause in the Knights' Hall of Schloss vor Husum
2. Market day in Husum square
3. Husum's inner harbour in low tide
4. Reflections of the 16th century Schloss vor Husum

surreal but natural counterpoint to the piano music.

My first evening was in the company of Welsh pianist Martin Jones. Not exactly a household name, he has nevertheless amassed an impressive discography covering large swathes of French and Spanish repertoire, and the complete piano works of Brahms, Mendelssohn, Szymanowski and Percy Grainger. He is a natural for the festival, as every note of his Czerny, Mompou, Gal, Guastavino, Nin and Grainger is unknown to me, even for an inveterate *pianophile* like me.

He addressed the audience in English, offering interesting anecdotes and insights into the composers and the music he performed. It was in this informal and unstuffy atmosphere that music connected the composer, artist and audience, with nary a dull moment. There was still light during the intermission and many headed out into the castle's formal gardens for a taste of wine, while others scrutinised the festival's photographic exhibition on piano literature in the elaborately decorated rooms. I contented myself with rummaging through a "pasar malam" of piano CDs on sale at a concession booth.

The music continued, and when the recital ended, there was a clamour for the pianist to perform encores. This practice is *de rigeuer*, and many find it the most intriguing part of a concert, where surprises can spring up like a welcomed Christmas gift. Jones generously obliged the audience with not one but four impromptu performances, and was duly rewarded with a standing ovation. I was informed that such accolades are not common practice in Germany, but the warmth of the response to Jones's encore performance was palpable. This fuzzy feeling continued late into the evening when the piano party moved en masse to a nearby watering hole where beer and North German home-cooked food was served.

What did I do during the intervening stretches of day between the evening recitals? Sightseeing is the obvious option. The state of Schleswig-Holstein is unlike the rest of Germany; instead, it resembles the Netherlands, with its low-lying countryside and architecture, and neighbouring Denmark, which is only a half-hour's drive away.

Husum is a quiet town that comes alive on market days, when farmers' produce and cottage industry handicrafts are carted in, and families and pets throng the streets, giving it a carnival atmosphere. Husum's picturesque inner harbour is a kilometre away from the sea and the tide rises and ebbs, leaving boats grounded on dry land. Ice cream parlours do roaring summer business and seafood restaurants offer hearty soups and broths at reasonable prices. Within walking distance are the Maritime and North Sea Museums, which document the rich history of Husum's seafaring communities. Seven minutes away by train is the town of Friedrichstadt, which was founded by Dutch remonstrants fleeing religious persecution. Its well-planned streets, bisected by a system of canals, centuries old churches and a townhouse, resemble a miniature version of Amsterdam.

In between, I found the time to interview Peter Froundjian, a Berlin-native of Armenian extraction in his sixties, who is the founder and artistic director of the Rarities Festival. According to Froundjian, the inspiration for the festival came to him during a posting as head of music at the castle school during the 1980s. He pondered, "There is so much good piano music that is unknown, so why do we stick to a narrow perspective when it comes to concert repertoire?" The castle's rustic setting seemed appropriate and the first festival took off to critical acclaim in 1987. This year, the festival celebrates its 30th edition, which promises to be a gala event.

The second and third evenings featured excellent recitals by Briton Jonathan Plowright and the French-Cypriot piano wizard Cyprien Katsaris. The latter was slotted in as an eleventh hour replacement for a pianist who called in sick and it was an unexpected reunion of sorts. In 2007, when I was the artistic director of the Singapore International Piano Festival, Katsaris was invited as a marquee artist in the theme "Lisztomania: The Art of Virtuosity", where he performed the music of Franz Liszt. "The doctor from Singapore!" he exclaimed when we met after his stupendous showing at the recital. It was time to catch up and reminisce.

Four days seemed an all-too-short sojourn into an arcane world of piano esoterica in a friendly atmosphere, but time flies when one is having fun. Further visits to Husum are imperative, if only I can just find more time.

For more information, visit the festival website at http://www.raritaeten-der-klaviermusik.de. ◆


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THANK YOU TO SINGAPORE'S PHPCs FOR SUPPORTING THE 2015 HAZE SUBSIDY SCHEME!

By Agency for Integrated Care

The transboundary haze crisis that affected Singapore in the second half of 2015 was one of the worst on record. Singapore's air quality deteriorated drastically, with several 24-hour Pollutant Standards Index (PSI) readings registering in the unhealthy range.

Thankfully, we had the assistance of our Public Health Preparedness Clinics (PHPCs).

As part of the Ministry of Health's (MOH) efforts to provide subsidised treatment for haze-related conditions to eligible Singaporeans, the PHPCs were activated on 16 September 2015 to administer the Haze Subsidy Scheme. Under this scheme, eligible Singaporeans could get subsidised treatment for haze-related conditions, namely allergic rhinitis, asthma, bronchitis, chronic obstructive pulmonary disease (COPD), conjunctivitis and upper respiratory tract infections (URTI).

As the nature of the scheme is dependent on the 24-hour PSI readings, PHPCs were only given less than 24 hours to prepare their clinic operations upon scheme activation. Despite such short notice, the PHPCs responded promptly to the SMS activation, took on their roles readily and administered the scheme swiftly.

We would like to thank the PHPCs for rising to the occasion of a health emergency, going beyond their duties to ensure a high standard of healthcare in Singapore.

Dr Adrian Koh from The Balmoral Clinic, one of the PHPCs, commented that even though he and his staff had to react fast, they were able to roll out the scheme smoothly. "The announcements from AIC were clear, so we had all the information we needed and there were not many hiccups at all," he said.

In addition to being quick to act, PHPCs also willingly put in extra hours to ensure proper administration of the scheme and to submit the manual claims to MOH, promoting the spirit of volunteerism.

Dr Alan Ho from Kai Clinic, another participating PHPC, revealed that his clinic encountered a number of teething problems, but managed to overcome them quickly. "When the scheme was first activated, the staff in my clinic were unsure of how to submit claim forms and on a few occasions made mistakes in our claims," he said. "But my staff and I took time out of our schedules to familiarise ourselves with the procedure and to understand our roles and responsibilities."

"The PHPC scheme meant more work for my staff especially during the period of haze, but I'm glad it benefitted patients who needed it," remarked Dr Koh.

In comparison to Haze Subsidy Scheme 2013, which recorded 18,500 haze attendances, this number increased threefold last year. By the time the scheme was deactivated on 23 November 2015, more than 630 PHPCs had participated in the scheme and managed over 70,000 attendances, providing Singaporeans with affordable treatment for haze-related conditions.

We are also grateful to the PHPCs for building closer working relationships with us, helping to act as gatekeepers of the utilisation of the Haze Subsidy Scheme, and giving us continuous feedback to refine processes and improve policies in the future. We hope that the PHPCs, MOH and AIC will continue the spirit of teamwork in the community, supporting each other for the care of Singaporeans during such crises.

What to Expect When a Clinic Signs Up to be a Public Health Preparedness Clinic

The PHPC scheme is an MOH initiative to support the management of public health emergencies in a primary care setting. Support includes the following:

- Up to 12 weeks' supply of PPE (Personal Protective Equipment) for staff of the participating clinic
- Supply of medications and vaccines for staff and patients of the participating clinic
- Guidelines, e-learning courses and workshops to enable doctors to build up skill sets and maintain skills currency
- As a single point of contact for all PHPC-related queries

For more information, please visit the Primary Care Pages (www.primarycarepages.sg > Primary Care Initiatives)

For Community Health Assist Scheme (CHAS) Clinics:

Sign up for PHPC by writing to us at **gp@aic.sg**

For Non-CHAS Clinics:

We strongly encourage you to sign up for CHAS and PHPC to become part of this nationwide effort to improve patient care. Please contact us at **6632 1199** or **gp@aic.sg** and we will guide you through the sign up process for both schemes.

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PHPC

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Date	Course	Early bird dateline
5 March 2016	Cosmetic Botulinum Toxin	By 12 February 2016
2 April 2016	Intense Pulsed Light Therapy	By 2 March 2016
16 July 2016	Dermal Fillers	By 16 Jun 2016
17 September 2016	Chemical Peels	By 17 August 2016
8 October 2016	Laser Hair Removal	By 8 September 2016

Time : Saturday, 2pm to 6 pm
Venue : National Skin Centre
Fees : Early Bird Registration $450.00 / Normal Registration $500.00

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Please mail your application form and cheque (payable to Dermatological Society of Singapore) to Ms Jenny Folk, Dermatological Society of Singapore, c/o National Skin Centre, No 1 Mandalay Road, Singapore 308205 or email to dss.secretariat@gmail.com.

Please refer to DSS website (www.dermatology.org.sg) or NSC website (www.nsc.com.sg) for further details.

Registration is open to fully registered medical practitioners from PGY2 onwards only. DSS reserves the right to request for proof of medical license during application.

For enquiries, please call Ms Jenny Folk, Dermatological Society of Singapore at Tel: 9129-4583 or National Skin Centre Training Department @ Tel: 6350-8477, Fax: 6253-3225

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- Good interpersonal skills
- Good team player

Kindly email: **steve_tan@parkwayshenton.com** or call **9670 0472** for a friendly discussion.

www.parkwaypantai.com

LIFESCAN IMAGING
Management Team and Staff Welcome

Dr John Huang
Radiologist
Mb ChB (Hons) (Glasgow, UK)
MRCP (UK)
FRCR (UK)

Dr John Huang graduated with honours from the University of Glasgow, U.K. and has 18 years of clinical experience. After training in internal medicine and obtaining membership in the Royal College of Physicians, he embarked upon radiology specialist training and obtained fellowship of the Royal College of Radiologists in 2003.

While at the Singapore General Hospital, he was awarded a HMDP (Health Manpower Development plan) fellowship in cardiac CT and MRI at Emory University, Atlanta, U.S.A.

During this time he was also a visiting consultant to the National Heart Centre and a clinical tutor for the National University Hospital. He was also an adjunct instructor for the Duke-NUS Graduate Medical School, a role for which he received an Outstanding Educator award. He continues to be involved in the post-graduate training of radiologists at the Singapore General Hospital.

He has spoken and participated in numerous local and regional conferences and workshops, particularly on cardiac CT and MRI. He is the author of several journal publications, book chapters and poster presentations. He has also been an invited reviewer for some local and international medical journals.

An avid photographer and traveller, he enjoys roaming around the world with camera in hand.

Dr Kenneth Sheah
Radiologist
MBBS (London) FRCR (UK)
MMed (Diagnostic Radiology)
Cert Pain Mgmt (UCSF)
Former research fellow Massachusetts General Hospital/Harvard Medical School

Dr Kenneth Sheah is a consultant radiologist with an interest in musculoskeletal radiology. He qualified at Charing Cross and Westminster Medical School. He completed his radiology training in Singapore and was a research fellow at Massachusetts General Hospital/Harvard Medical School where he worked on upper limb injuries in high-performance baseball athletes.

He teaches musculoskeletal radiology courses on MRI of the wrist, hand, elbow and shoulder. His work involves evaluation of upper limb pain (including ultrasound of the nerves and tendons of the hand and wrist), and ultrasound-guided injections.

Dr Sheah has presented research findings at international meetings, including the Radiological Society of North America Annual Scientific Meeting and received the Young Radiologist Award at the Singapore Radiological Society Annual Scientific Meeting in 2001. The Singapore Medical Journal awarded him a Distinguished Reviewer Award in 2010.

Dr Sheah was involved in drafting the radiology curriculum for the Duke-NUS Graduate Medical School in Singapore and was an adjunct clinical tutor at NUS Medical School. He served on the Singapore Radiological Society website, the College of Radiologists, Singapore, and the organizing committee of the 2009 SRS Annual Scientific Meeting.

He is a co-opted council member of the Pain Association of Singapore (2010 and 2011) and ran a workshop on percutaneous intervertebral disc interventions. He organised the first Singapore Orthopaedic Radiology-Surgery Symposium (2008), and was an invited speaker at the International Congress of Emergency Medicine (2010). He has co-authored chapters on X-ray physics, and CT and MR imaging of the shoulder, and published research in peer-reviewed journals since 2001.

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- **Possess a valid practicing certificate from the Singapore Medical Council**
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- **Good team player**

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Human Resource Division
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- A personal statement regarding stated goals and plans.

Medical Affairs (HR) Department
National University Health System Pte Ltd
1E Kent Ridge Road
NUHS Tower Block, Level 6, Singapore 119228
E-mail: medical@nuhs.edu.sg

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