SMA news

For Doctors, For Patients

VOL. 48 NO. 4 | APRIL 2016 | MCI (P) 052/01/2016

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Sichuan Healthcare 2014 Market Landscape

Total Outpatient Visits: 445.11 Million

Annual Outpatient Spending: RMB 103.3 Billion

Annual Inpatient Spending: RMB 164.9 Billion

Total Inpatient Stays: 15.07 Million

Fast Facts about Chengdu

GDP per Capita: **RMB 70,338** (2015)

Average Income: **RMB 48,358** (2015)

Annual income of above RMB 300,000: **1,070,000 individuals**

Middle class income: **1,020,000 individuals**

The above figures are derived from Sichuan Provincial Bureau of Statistics Yearbook and the official website of the Sichuan Provincial Planning Commission.

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SMA NEWS

Vol. 48 No. 4|2016

PUBLISHER
Singapore Medical Association
2 College Road
Level 2, Alumni Medical Centre
Singapore 169850
Tel: (65) 6223 1264
Fax: (65) 6224 7827
Email: news@sma.org.sg
URL: http://www.sma.org.sg
UEN No.: S61SS0168E

DESIGN AGENCY
Oxygen Studio Designs Pte Ltd

PRINTER
Sun Rise Printing & Supplies Pte Ltd

CORRECTION
In the March 2016 issue Interview article on page 12, the list of medical officers in the pioneer batch should have been "Drs Lo Hong Ling, Richard Hin Yung (Obstetrics and Gynaecology), Lim Kuang Hui, Arthur Lim (Ophthalmology), Cheong San Thau (Surgery), William Chew Loy Soong, Chan Swan Tong, Richard Chin Keng Huat, Wong Yuen Poh, Lee Soo Choo, Chew Chin Hin, Moses and myself [Jerry Lim]." We apologise for the error.

PHYSICIAN, HEAL THYSELF

Dr Tina Tan is a psychiatry senior resident with National Healthcare Group. She obtained her medical degree from Duke-NUS Graduate Medical School (Class of 2011). She also has a bachelor's degree from the University of California, Berkeley.

Tina Tan
Deputy Editor

A while back, a doctor I knew committed suicide. It was sudden and tragic. There were no warning signs; everything seemed to be going perfectly for this colleague. Yet, on hindsight, there probably were clues that things weren't as rosy as they seemed.

The truth is that we are as human as the patients who consult us. The same qualities that make a good doctor increase the likelihood of mental illness — we can be perfectionists with high expectations of ourselves and others, with a correspondingly low tolerance for uncertainty. That combined with work factors, such as long hours or lack of support, all increase the likelihood of physical and mental illness in doctors.

Psychiatric problems in doctors are complicated with no easy answers due to the ethical issues involved. Dr Tor Phern Chern explains why doctors are prone to depression and how to seek help for a colleague in need and Dr G Kandasami covers an equally hushed-up topic — dependence and addiction in doctors.

Our "Feature" article, therefore, focuses on how we can maintain our physical and mental well-being. Dr Chong Yeh Woei shares his insights about "walking the talk" that we always like to nag our patients about. Our "Indulge" article looks at unique and healthy ways some doctors have found to unwind and stay fit at the same time. Still have a dearth of ideas? Miss Ralene Sim shares her heart-warming experience of volunteering with Project Yangon last year, reminding us that altruism may well be the medicine that we need.

So what happens when a doctor does fall sick? No doubt that stigma exists. Doctors who are willing to share their perspective of needing medical treatment are few and far between. Beyond the worry of time taken away from our busy work schedules, is the worry that news of our ailments will get around. So much is at stake — our careers, our livelihoods. It is little wonder that doctors don't seek help when they need it, nor do they want to talk about it thereafter. Thus, it is with sincerity that our Editor, Dr Tan Yia Swam, shares her heartfelt experiences as a patient to encourage our readers not to remain silent but to seek help for their problems. In addition, our "GP Matters" column includes a call for the medical profession in Singapore to provide resources for fellow physicians in need.

On the lighter side of things, A/Prof Cuthbert Teo continues his series on the history of medicine in Singapore, showcasing humorous medical student memories from the 1930s and 40s. It proves that even our oldest professors were once medical students who weren't always on their best behaviour.

In his article about scholarship, A/Prof Cheong Pak Yean shares his passion for convivial learning and teaching. It's the presence of that merry and mentally stimulating atmosphere that keeps us refreshed from the daily drudgeries of our work, both for the teacher and student.

Dr Hsu Li Yang provides a timely and much needed commentary on the Zika virus, including a reminder of the key question to ask our patients — their travel history.

We also report here the latest news from the SMA Centre for Medical Ethics and Professionalism, and an article by Dr Hairil that teases out the unique ethical issues anaesthetists face. They may be behind the screens but their responsibility as healthcare providers is as crucial as that of a patient's primary physician.

On a final note, I want to announce that *SMA News* will be providing more exclusive online content, such as articles ahead of print, videos and audio clips, for our members.

Keep calm, and read your issue of SMA News! ◆

Doctors, Your HEALTH Matters Too

We always hear the old adage "Physician, heal thyself"! Personally, I think it to be true but with a caveat: it should not be "heal" but rather along the lines of "prevent".

A DOCTOR'S HEALTH

We are in the trade but we often take our own health for granted. In the early parts of our career, we tend to push our body and mind to the limit. Those houseman calls that start from 8 am and last till the afternoon of the next day with little or no time to rest are really punishing. One thing to note is that when one has little or no rest, there is a potential risk of making mistakes like prescribing a wrong drug, missing out a drug allergy or giving an injection via the wrong route (intrathecal or intravenous). An interesting thing I learnt when renewing my car insurance was that doctors are classified as high-risk drivers. That is because there have been a number of accidents, fatal or otherwise, where the doctors involved were sleep deprived. If you have relatives, friends or children who are doctors in training, please impress on them that sleep deprivation and driving do not mix well.

Entering into our thirties, we often take our bodies for granted. We experience a lot of stress and the reaction to that could be eating excessively, imbibing lots of alcohol, smoking more than we should and sometimes getting into various forms of gambling. Gambling could well be in the casinos, "punting" in the turf club or leveraging up in equities, derivatives and futures.

In my experience in the private sector, quite a number of my colleagues ended up working long hours with little time to spare for family and friends. A handful of them also ended up with visceral fat due to irregular meal times coupled with seeking solace in food.

Recognising the pitfalls and scenarios that cause us to get into difficulties is the first step. The second is to act on them by shifting ourselves out of a passive mode and actively taking charge of our lives. As we head in to the second half of our lives, we must remember that life expectancy is taking us into the eighties. This to me is longevity and the idea is then to have the best quality of life, hopefully till the very end before we make a quick and painless exit from this planet. What we really do not want or need is a premature event such as a massive heart attack or a stroke. Such events that could leave us as a cardiac cripple or bedridden for decades before our eventual demise form a very frightening prospect.

MEASURES TO TAKE

It is therefore important to make sure we do not put ourselves at risk of chronic diseases such as diabetes. We often counsel our patients about their body mass index, whereas a number of us have knowledge deficits about the calories in the food that we consume. The knowledge of the calories present

in hawker food is particularly important as the majority of our patients do eat out. Over the years, I have noticed that all the endocrinologists whom I know in private practice have lost weight and attained their ideal body mass index. I think it is because they make it a point to talk to their patients, especially those with diabetes and hyperlipidaemia, about food intake and they have ended up "walking the talk". I wonder if that is the case for endocrinologists in the public sector as well! Sending your patient to a dietician or nutritionist is a good idea but better yet, educate yourself about food intake, glycaemic indices and calories of common foods to effect a change in your own diet.

Having lost quite a bit of weight myself over the years, I would say that exercise has a role to play but your eating habits remain as the main driver. Nevertheless, a brisk walk thrice weekly with a decent heart rate pounding away is effective. Having a wearable device on your wrist and clocking ten thousand steps daily is yet another possibility for the long haul. I tell my patients who take public transport to alight a train stop earlier or forego the feeder bus and take a brisk walk home. That would be the exercise needed for the day! My personal take is that a slow but long jog is very effective for weight loss.

Yet another aspect to think about is the loss of muscle mass. It has been estimated that upon hitting our forties, we lose a pound of muscle annually. At this age, testosterone levels in men slowly decline at a rate of one percent annually, while for women, there's the dreaded menopause and its associated symptoms. That is why muscle work is important; but I am not about to ask you to pump iron at the gym. The reality is that gym work is mostly about the muscles that you can see and look good on the outside: in your chest and arms. The muscles that you cannot see are those in your back, glutes and thighs; these are the biggest muscles in your body. To work these muscles and to get them to ache is not easy. Yet it is the aching muscles that burn your calories and you can work them hard with Pilates, yoga and ballroom dancing. Besides, pumping iron can lead to injuries that will take seemingly forever to heal when you are at a certain age. One more benefit is that strengthening the core muscles can lead to good posture and stability, translating to fall prevention.

Finally, please avail yourself to medical technology and have your blood work done regularly. I do mine annually around the time of my birthday, as your birthday is always a good reminder of mortality. Please don't forget your colonoscopy when you reach 50 years of age! There are prominent members of our profession who have not followed this important guideline only to find advanced metastatic colorectal cancer a few years later. Cardiac imaging or functional cardiac testing is also important to prevent premature cardiac events. For my female colleagues, please find a good radiographer that does your mammogram with little or no pain! Do ask your female radiologist colleagues for the heads-up.

CONCLUDING WORDS

If you have to take your statin, so be it. If you want to do your MRI stroke screen or carotid imaging, please go ahead. I would like to leave you with the lessons learnt from the Harvard study on happiness. Some of you may be aware that this study was ongoing for 75 years and the cohort included a US president, several senators, and captains of industry. The first lesson gleaned is that love is the key and it is important to cope with life through mechanisms that do not push love away. What this means is that it is important not to be negative, prickly and nasty; and not to be labelled as a curmudgeon. Finding contentment in your work is critical and as doctors, we are way ahead of the curve in terms of goodwill and gratitude from our patients.

It is important to have a group of professional colleagues to fall back on. Keeping in touch with fellow doctors helps to foster friendships, trigger discussions on difficult cases and also provides the opportunity to learn from each other on matters outside of medicine, from managing businesses to investment decisions. Sometimes, running a solo practice can be insular and it allows withdrawal from society to creep up on us without us even realising it.

Strong relationships with your spouse, friends, family, children and colleagues are important and remember to invest in friendships with people a whole generation younger. It can be really sad to reach longevity when all your friends in your cohort have perished. Finally, how we cope with challenges in a mature way and maybe even through creative expression (eg, art, music, dancing or writing) is paramount to attaining that elusive better quality of life. I wish all my readers success in their journey to reach that holy grail of happiness, longevity and contentment. ◆

PROFILE

TEXT BY

DR CHONG YEH WOEI

Dr Chong was SMA President from 2009 to 2012 and is a member of the 56th SMA Council. He has been in private practice since 1993 and has seen his fair share of the human condition. He pines for a good pinot noir, loves the *FT Weekend* and of course, wishes for world peace...

HOME ISN'T THE BEST CLINIC

Why Doctors Should Avoid Treating Family Members and Themselves

During festive gatherings, the doctor in the family is often faced with the prospect of being asked to dispense all sorts of medical advice. Once that distant uncle whom you have not seen in ages starts the inevitable line of questioning, a small circle soon forms and various ailments and alarming symptoms are pitched at the family's doctor — you. A growing lump, a painful bump, from acne to Zika; nothing seems to be off limits. On one occasion, I was personally asked to advise a relative who had a roaring cardiac murmur which I could hear just by placing my ear on his chest.

They come to us for quick advice in the hopes of reassurance; oftentimes they want to hear comforting words such as "it is benign" or "there's nothing to worry about". Unfortunately, bar the most obvious spot diagnosis, the setting and context of such social consultations are far from ideal.

Firstly, the fact that the "patient" is relating his history in a room with other people listening means that the account is likely to be condensed, lacking in details and incomplete. Intimate information that may be crucial in some cases cannot possibly be conveyed. Secondly, there is a lack of proper equipment at hand. Additionally, lighting is suboptimal and the physical examination that we rely on to exclude relevant conditions cannot be performed. Finally, there is also the lack of proper documentation. Once the doctor is unable to record the problem, findings and advice given, any follow-up would not be possible until the next social gathering, typically a year later. These conditions set the doctor up for misunderstanding, providing inappropriate advice and, worse of all, giving false reassurances leading to a missed diagnosis.

DOWNSIDE RISK

Some years ago, I met a senior neurologist at a social event and asked her about my son's frequent headaches. I was seeking the same reassurance that headaches in children was a common phenomenon and that there was nothing to worry about. However, she refused to offer any comfort and instead advised that I bring my son in for an assessment in case of serious pathology. I wasn't too happy with that conversation then but on hindsight, I realised that the doctor had much wisdom in her years of practice. I was a parent asking about vague symptoms for a child who was not even present at the time and I wanted the doctor to give me reassurance, a responsibility that the doctor should not have been asked to bear. If things went well, there would be little thanks to the doctor for giving charitable advice, but what if an insidious pathology was missed? Therefore, in such a scenario, the wisest option for the doctor is to insist that the patient be brought in for a proper assessment.

In the context of treating family members in social settings, missing a diagnosis or giving the wrong advice would be a painful affair that not only affects the two parties, but involves the other family members as well.

DOUBLE-EDGED SWORD

There are more complex issues at play when treating family members. The doctor is emotionally involved with family and this will inevitably affect professional judgement, which often demands a certain amount of detached objectivity. Obligation is a double-edged sword that cuts both ways. Sometimes, doctors may feel obliged to advise and treat immediate family members well beyond their own field of expertise. Family members who are being treated will also feel a sense of obligation towards the doctor, and this can interfere with health-seeking behaviour. For example, a persistent symptom such as chronic cough could be downplayed because the patient is unwilling to seek assistance early for fear of causing undue trouble to the busy doctor and preferring to wait for the next opportune family gathering. This may result in delayed diagnosis and treatment of progressing pneumonia. Patient autonomy is also compromised because the sense of obligation and fear of offending the doctor in the family restrict their choice to see other doctors and to seek a second opinion.

Ethical guidelines are quite clear in advising against the treatment of family members except during an emergency (American Medical Association Code of Medical Ethics Opinion 8.19 - Self-Treatment or Treatment of Immediate Family

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.

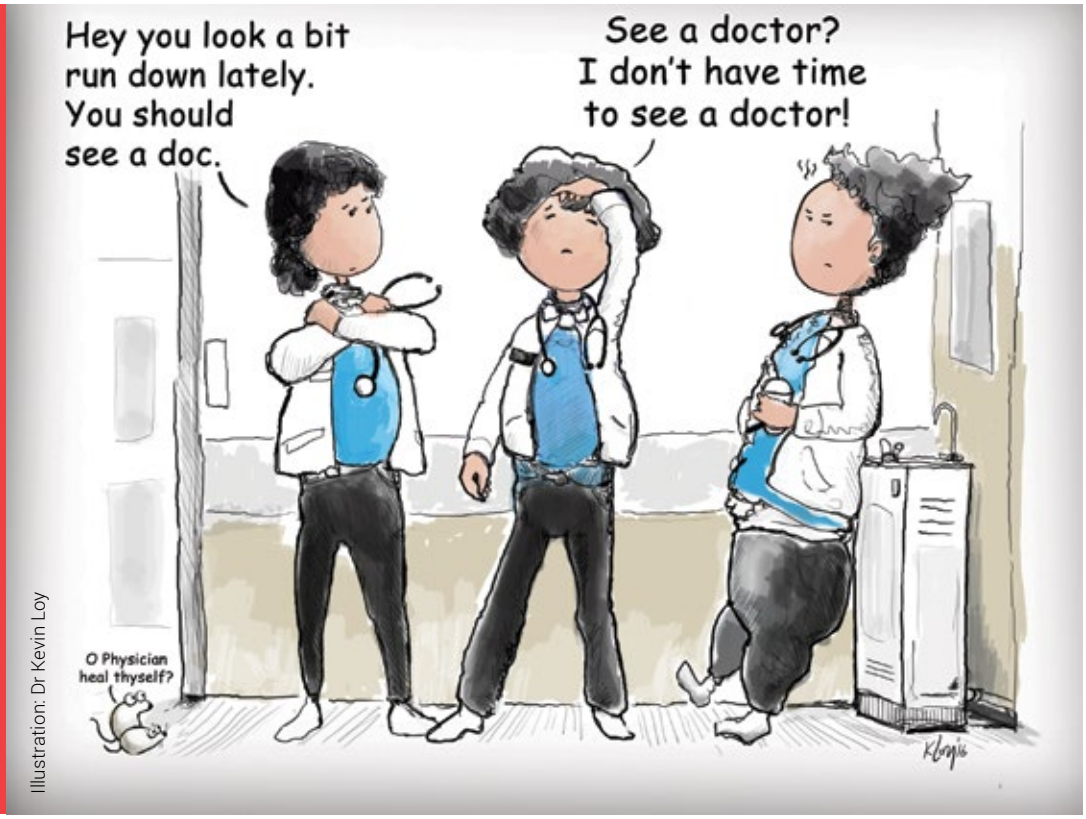

Illustration: Dr Kevin Loy

Members). The doctor should certainly not provide chronic care for immediate family members over an extended period of time. Disease progression can be very subtle and even clinically astute physicians will miss these changes occurring in front of their eyes in their daily encounters with family.

SELF-TREATMENT

Physician self-treatment and treatment of family members are usually addressed together in ethical guidance. This reflects the duality of psychological roles that a doctor plays when he attempts to treat himself: there is tension between his embedded "medical self" and the unfamiliar role of being sick. Their professional roles are deeply ingrained in doctors from the time they enter medical school. They learn to look after and treat "the patient", who is someone sitting on the other side of the consultation table, lying on the hospital bed or undergoing a procedure on the operation table. The patient and the doctor are two entirely separate entities, each with its expected role in the doctor-patient relationship. When a doctor falls ill and requires treatment, it is no wonder that he will feel intense conflict. The same problems with regard to treating family members would apply if the doctor is unable to exercise detached objectivity when he attempts self-treatment.

DOCTORS MAKE BAD PATIENTS

It has been said that doctors make the worst patients. Delay in seeking treatment is often the norm and the opportunity to treat diseases that may benefit from early intervention may be lost. This could be due to the doctor's heavy schedule and clinical demands as the long hours spent in the wards leave little time for self-care. It seems ironical that medical services can be hard to access even though doctors work in a hospital. I suspect that many doctors do not even know where the hospital staff clinic is located, much less make use of its services when they are ill. When symptoms of illness appear, they tend to be ignored or downplayed.

Studies have identified personality traits that make doctors resistant to seeking help early. Doctors can be perfectionists, obsessive-compulsive and may have a fear of failure. Many of us practise various forms of self-denial, where the patient's needs override our own needs. It is not easy to accept the notion that we will one day fall ill just like any other human being.

Finally, there is the stigma attached to illness among the medical fraternity, especially with regard to mental health issues. The medical community in Singapore is small and concerns of maintaining medical confidentiality may prevent early treatment of mental health problems.

Doctors need to be reminded that we can claim no special status in our own susceptibility to illness and disease; we are not immune to affliction or addiction and we too will one day fall sick and require help. We should not walk this path alone. We should seek help early. ◆

HIGHLIGHTS FROM THE **HONORARY SECRETARY**

MEETING WITH MPS

SMA President, Dr Wong Tien Hua and several SMA council members met with the CEO of Medical Protection Society (MPS), Mr Simon Kayll, and its representatives on 1 March 2016. Issues pertinent to medical indemnity were discussed. In conjunction with the visit, MPS organised several workshops on informed consent for MPS members in Singapore.

MEETING WITH NTUC INCOME

SMA President, Dr Wong Tien Hua, met with Mr Soon Gud Voon, Senior Manager & Head, Property & Casualty, NTUC Income, to discuss various medical indemnity issues. Ideas were discussed with a view to reinforce the partnership between the organisations, and to improve and expand the benefits to our members.

TIE UP WITH 3M TO OFFER STETHOSCOPE TRADE-IN

In collaboration with 3M Littmann Stethoscopes, SMA will be facilitating a trade-in exercise to allow for an upgrade of the stethoscopes used by our members. Members will get to enjoy discounted prices from the trade-in, as well as a 3M goodie bag arranged exclusively for SMA members for this exercise.

CHANGE OF SMA CMEP EXECUTIVE DIRECTOR

Dr T Thirumoorthy, who completed a second term as the Executive Director of the SMA Centre for Medical Ethics and Professionalism (CMEP), stepped down on 31 March 2016. A/Prof Gerald Chua, previously Designate Director, CMEP, has taken on the reins from 1 April 2016. The SMA Council thanks Dr Thirumoorthy for his stellar contributions and valuable efforts as the Executive Director and Board Member of the SMA CMEP since its formation in 2002. Under the leadership of A/Prof Gerald Chua, SMA CMEP will continue to support the profession to, in the words of Dr Thirumoorthy, "Stay competent, stay compassionate, stay service-ful". ◆

PROFILE

REPORT 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.

Legend

1. Group photo of SMA and MPS representatives at the meeting on 1 March 2016

1

For Doctors, For Patients

Introductory Course in Health Law

In collaboration with JurongHealth

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Please return this slip for *SMA Introductory Health Law Education Series* 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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A. **SMA Member:** ☐ Yes ☐ No

B. **JurongHealth Employee:** ☐ Yes ☐ No

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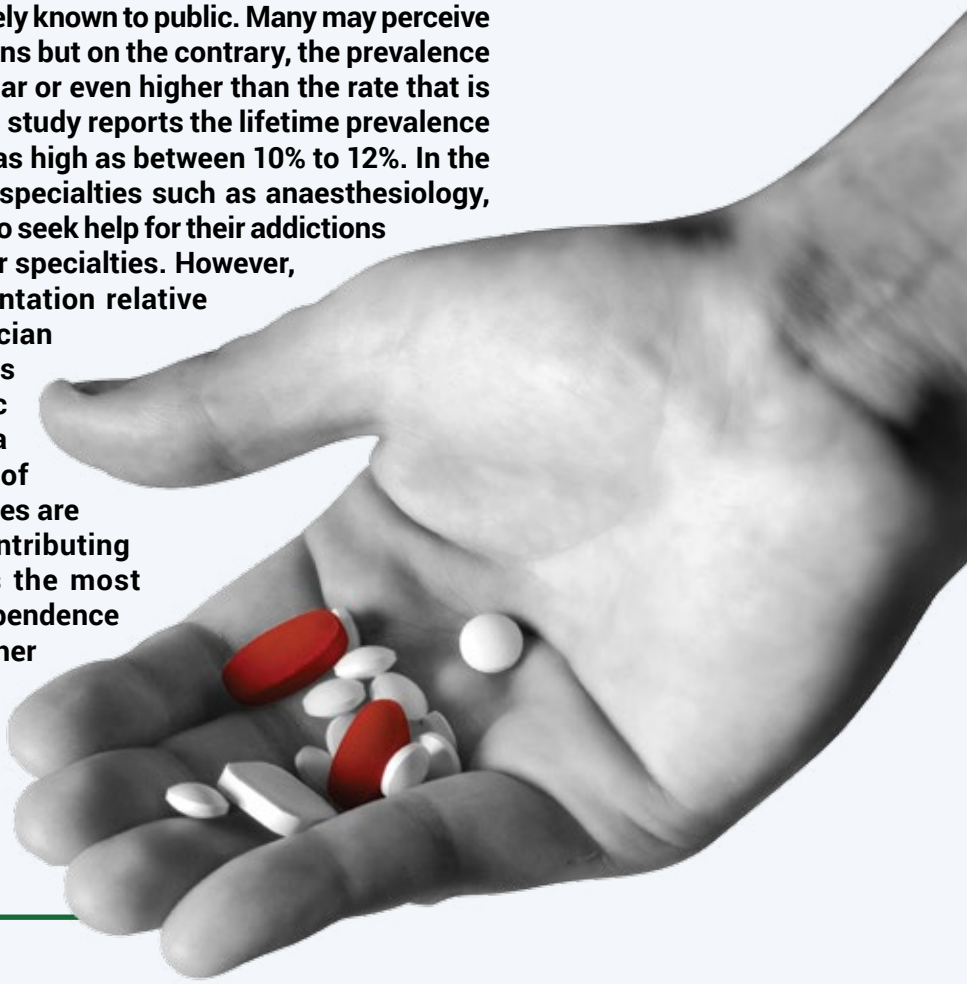
Substance Addiction

Among Physicians

Generally, the problems physicians face because of addiction to substances are not well reported in the media or widely known to public. Many may perceive that physicians are immune to addictions but on the contrary, the prevalence of addiction among physicians is similar or even higher than the rate that is seen in the general population. One US study reports the lifetime prevalence of addictions among physicians to be as high as between 10% to 12%. In the West, the number of physicians from specialties such as anaesthesiology, emergency medicine and psychiatry who seek help for their addictions is slightly higher than those from other specialties. However, this could be due to an over-representation relative to their numbers in the overall physician pool. Work-related stress, ready access to narcotics and other psychotropic drugs in the workplace, and also a possible selection bias in the type of physicians who choose these specialties are reported to be some of the other contributing risk factors. Alcohol dependence is the most common presentation, followed by dependence on opioids. Abuse of stimulants and other substances is also reported and among those who seek help, more than half are reported to be abusing multiple substances. There is no scientific data available in Singapore on addiction among physicians.



FACTORS AFFECTING THEIR HELP-SEEKING BEHAVIOUR

The problems caused by their substance abuse may first appear at home or in their social circumstances before becoming obvious in their workplace. By the time the symptoms appear in the hospital setting, their substance abuse would often have been active for a long period of time. One study found that the mean duration which physicians took to seek treatment for substance-related problems was six to seven years. It is not surprising that physicians seek treatment very late during the course of their substance use disorder and by that time, the symptoms are likely to be in an advanced stage. The key reason for the delay in seeking treatment may be due to their efforts to keep workplace performance and reputation intact. Physicians fear that the disclosure of addiction will affect their affluent social status and they may risk losing their licence to practise medicine. Lastly, it has also been commonly observed that the help-seeking process can be delayed due to the physician's family members and co-workers' efforts to hide the addiction, in order to protect the family, the medical practice and staff who are employed by it.

SIGNS AND SYMPTOMS

The earliest signs of addiction may include: neglect of physical appearance, weight changes, sleep impairment, lethargy in work or tiredness, smelling of alcohol while at work, or skin changes such as bruises and needle marks. Physicians are reported to be good in concealing their substance use and thus, these signs might be subtle and not easily detectable.

When the symptoms become severe, one might see significant deterioration in the quality of their work. They may repeatedly come late for meetings and appointments, show long-term absences at work, seek special considerations, or may have poor working relationships with staff and patients. They may show irregularities in their prescribing practices and may not promptly attend to their calls during their on-call duty hours. The presence of these signs should raise suspicion for addiction issues and warrant further investigation. However, these warning signs alone are not sufficient to confirm the presence of a substance use disorder.

ASSESSMENT

Once a suspicion of addiction is raised, the relevant authorities in the workplace should review policies and notify the appropriate people in the management to proceed with further investigation. If a discreet investigation is carried out and enough evidence is available to confirm the initial suspicion, the physician should be asked to undergo a proper clinical assessment. Evaluation of addiction issues in physicians would require a multidisciplinary team with experience in working with this population. The assessment could become very difficult because the physicians may show exceptional rationalisation, denial and resistance to cover their substance use habits. In the US, physician health programmes, which are available in most states, would provide such expertise to facilitate independent assessments and support for the struggling physicians and offer guidance to hospital administrators on treatment and monitoring.

Routine clinical assessment of addiction should involve eliciting a thorough history suggestive of loss of control over the use of substances, development of tolerance and/or withdrawal symptoms, cravings and the physician's own attempts to reduce or stop using substances. The physical, psychological, legal, social and interpersonal complications that might be substance-related should be explored in detail. Any information on observed negative changes at work such as allegations of stealing of samples, diverting medicines from patients, colluding with patients to share prescriptions, writing fraudulent prescriptions or seeking internet-based prescriptions must be thoroughly investigated. Consent should be sought from the physician under investigation to gather more collateral information from friends, family, co-workers and pharmacies to support the diagnostic evaluation, while careful steps should be taken to protect confidentiality.

The positive signs elicited in the history should be supported with laboratory investigations such as urine tests for drugs and blood alcohol levels or breathalyser tests for alcohol. The results of the investigations should be thoroughly scrutinised as they can act as a means for helping the clinician to refute the false allegations or claims. Therefore, extreme care should be taken to avoid false positives as physicians may face serious professional and legal sanctions if a test result indicates drug use.

TREATMENT

Once there is reasonable clinical evidence to establish a substance use disorder, an intervention should be provided

without further delay to help both the physician in question and his or her patients. Very few studies have been published on appropriate treatment methods for clinicians. Usually, residential treatment programmes which offer individual and group therapy, medications or attendance at Alcoholics Anonymous or Narcotics Anonymous meetings are recommended. The main focus is to achieve complete abstinence from drugs and alcohol.

Generally, treated physicians show very good recovery in the range of 75% to 80%. The high success rates are attributed to very structured treatments offered in physician health programmes that are available in countries like the US. The high cost of failure such as loss of income and public embarrassment, and the positive influence of staying in the medical practice also helps to maintain sobriety. However, there is also a high risk of relapse soon after treatment. Therefore, it is recommended to impose restrictions on employment with clear instructions to the recovering physician about the consequences of a relapse or failure to comply with any of the return-to-work conditions.

ETHICAL AND LEGAL CONSIDERATIONS

Healthcare organisations are required to report a physician to the licensing board if there is reasonable suspicion that the physician is struggling with a substance use disorder. Ethically, physicians have a primary duty to respect the autonomy of others, but when a fellow clinician is suspected of abusing drugs for their psychoactive properties, he or she can potentially harm patients and family members. Therefore, it is advised to seek an opinion from the hospital ethical committee if such dilemmas arise when reporting the suspected abuse to the authorities. In many parts of the US, recovering physicians are not legally allowed to self-prescribe or prescribe medications for their other family members except in true emergencies, to reduce the potential for wrong-doing or abuse. Physicians should be allowed to have their legal counsel handle various legal issues that can arise during the entire process, starting from the initial assessment period to the point when they are deemed to be safe to return to work.

CONCLUSION

Early recognition of the substance use disorder and prompt initiation of treatment is the key to successful recovery. It is vital that written policies and procedures are in place throughout the whole process, as faithful adherence to the policies can help to prevent disastrous clinical and legal consequences to all the parties concerned. It is better to prevent substance misuse before it begins. Therefore, physicians should engage in healthy lifestyle activities to reduce the risk of falling victim to psychoactive substances. They should seek immediate help for their medical or psychiatric problems. Healthy physicians create and maintain better working environments for themselves and those around them. In Singapore, the National Addictions Management Service at the Institute of Mental Health provides specialist addiction treatment for the general population and can offer expert advice and support for physicians who are concerned about their alcohol or drug habits. ◆

PROFILE

TEXT BY

DR GOMATHINAYAGAM KANDASAMI

Dr Kandasami is a consultant psychiatrist, chief at the National Addictions Management Service at the Institute of Mental Health. He holds an academic appointment with NUS Yong Loo Lin School of Medicine and Duke-NUS Medical School. He has been a core faculty for the National Psychiatric Residency Program for psychiatry.

Further readings

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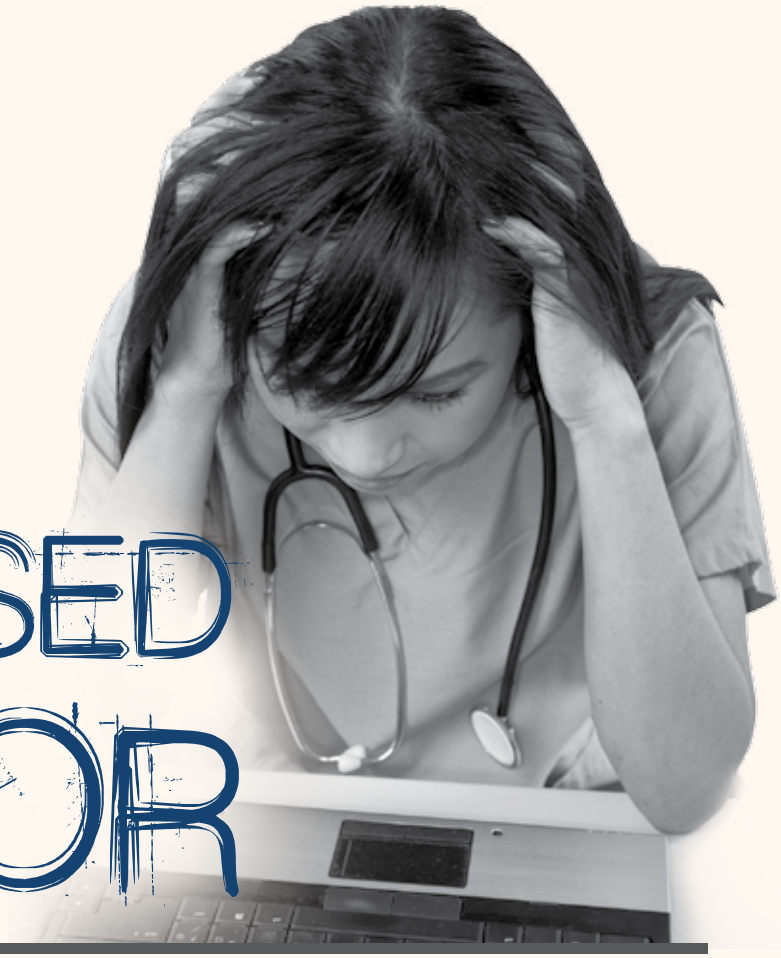

THE DEPRESSED DOCTOR

DEALING WITH DIFFICULT DECISIONS

"These are the duties of a physician: First… to heal his mind and to give help to himself before giving it to anyone else…"
— Monument to Serapion circa 220AD

ARE DOCTORS MORE LIKELY TO BE DEPRESSED?

Depression is a psychiatric condition that afflicts up to 5.8% of the Singapore population. It is a syndrome that includes abnormally low mood, anhedonia and somatic symptoms like insomnia and fatigue. Doctors appear to be at higher risk of having depression than the average person. A landmark Harvard study by Vaillant et al[1] prospectively followed Harvard sophomores for 30 years and found that doctors were consistently more likely to use drugs and alcohol heavily, have poor marriages and obtain psychotherapy. Doctors apparently endorse more depressive feelings in response to personal and professional stressors than even lawyers! Female doctors in particular appear to have a higher rate of depression in comparison to other females with similar educational levels and are far in excess of population levels of depression (39% vs 23.9%). Higher rates of depression are apparent, even for students, with up to 34% of medical students endorsing depressive symptoms that persist throughout training, showing little accommodation to the demands of training.

WHY ARE DOCTORS MORE DEPRESSED?

One explanation for the high rates of depression is the high stress nature of the job. This entails long working hours, regular rapid and high stake decision-making, while facing unpleasant and taxing illnesses with the constant requirement to keep up-to-date with increasing amounts of information. The typical personality of a doctor may be a predisposing factor as well. It is believed that the average doctor is smart, driven, competitive and has difficulty relaxing or acknowledging personal limits or vulnerabilities.

There is also some evidence that people with a predisposition to illnesses like depression, self-select into medicine. One study[2] showed that medical students, compared to controls, were more likely than law students to have experienced a serious medical illness in their family

of origin and the fear of death at a younger age. Selecting the medical profession may be an unconscious reflection of the desire to combat fears of powerlessness from close contact with serious illness or obtain the care that was lacking due to ill parents. Unfortunately, many doctors who enter the profession to "conquer illness" soon find that they are only human and have little power over many serious conditions.

WHAT IS THE PROBLEM WITH DEPRESSED DOCTORS?

The American Medical Association defines the impaired physician as one who is unable to fulfil professional or personal responsibilities due to psychiatric illness, alcoholism or drug dependency. Many depressed doctors are likely to initially have personal problems, such as marital or familial interactional problems, which can progress to the abuse of alcohol to "manage" these problems. Eventually, this can progress with difficulty in coping with clinical duties that can manifest in poor record-keeping, lapses in administrative duties, withdrawal from social activities and compensatory behaviour like rounding at odd hours. The most serious outcome of depressed doctors is suicide, which is four times more likely to occur in female doctors than the general population.

WHAT CAN OTHER DOCTORS DO TO HELP?

The first step is to recognise that something may be amiss. This is often reflected in problems related to the personal life of the doctor and if clinical performance is affected, the situation is often quite severe. A useful first step is corroboration with other colleagues to determine if your concerns about the doctor are shared. If confirmed, the next step could be a private chat with the affected doctor, to ask about the recent changes in mood, behaviour and general situation. However if there are issues of clinical competency, a more expeditious approach involving the programme director (for students) or head of department may be warranted. Referral to the hospital staff support programme or a certified mental health provider may be useful at this stage.

IS IT THAT SIMPLE?

Studies have shown that only one third of doctors who suspected a colleague to be impaired reported them. Common reasons include uncertainty about actual impairment or harm to patients, the general reluctance to criticise colleagues and the lack of protection of whistle-blowers. These are very real and practical issues when trying to get our colleagues the appropriate help.

A useful ethical framework should aim to prevent harm to patients, execute our professional obligation at self-regulation (as stated in the Singapore Medical Council [SMC] guidelines) and most importantly, help our impaired colleague. The best way to do this will vary from institution to institution but it is often wise to avoid treating a colleague, unless the relationship is purely clinical. The concerns about confidentiality and loss of licence to practice are very real for any impaired doctor. Locally, the SMC does not have a category of licensing that allows doctors to practise with restrictions, making fitness to practise an all-or-nothing situation. This could potentially make it more challenging to identify and treat impaired physicians.

ROUNDING UP

Medicine is a rapidly advancing field that has the potential to reduce suffering, extend life and improve our quality of life. The demands of this profession are high and take a toll on its members. We should be mindful of the first duty of doctors: to heal thyself. ◆

PROFILE

TEXT BY

DR TOR PHERN CHERN

Dr Tor is a psychiatrist working in the Mood Disorder Unit in the Institute of Mental Health. He has a special interest in treating patients with electricity and magnetism. In a previous life, he spent his time treating stressed young men in uniform.

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A Glimpse into the Past

MEDICINE IN SINGAPORE (PART 6)
1930S TO 1940S: MORE STUDENT ANTICS AND MEMORIES

This is the sixth instalment of a series on the history of medicine in Singapore.

In 1936, Dr JC Tull was succeeded as Professor of Pathology by Dr JA Cowan, who held the position briefly until 1937. Dr HO Hopkins was the next Professor, and he held the position from 1937 to 1941.
In 1938, the Dental Clinic Building was completed at the present site of the Singapore General Hospital (SGH) and served as a teaching department. At around the same time, the Dental School comprised one professor (EK Tratman), one lecturer (JW Softley), two tutors in dental surgery (Henley Wong and Tay Teck Eng) and one instructor in dental mechanics (GH Stephens). Tan Sri Dr Tay later became Chairman of the Council of the University of Singapore and the Singapore Cancer Society.
In preparation for the war, a maxillofacial unit was set up at the Kandang Kerbau Hospital (KKH).

In 1936, Col (Dr) John William Scharff was appointed Lecturer in Public Health and he introduced a health and sanitary survey of rural villages as part of the curriculum. In 1937, doctors were just beginning to understand the aetiology of cardiac beriberi (a vitamin B1 deficiency). Prof ES Monteiro described how thiamine chloride was first used in Singapore as a cure and as proof of the aetiology.[1]

Dr Ng Ek Khiam described some of his fellow students in the late 1930s.[2] "I remember a string of names: Baptist, Ding Ee, Siew Choh, Oon Teik, Danasamy, Parampalam, Lum Choon, Duriaretnam and Frank Dourado, who played the funeral march on his flute when conducted to the bath tub for the immersion ceremony in scented water. I was quartered at Room 33 of the then Federated Malay States Hostel (FMS Hostel) on top of a hill, facing the sisters' quarters. Japanese telescopes were selling at ten cents apiece and most students were equipped with one. I came to the College with a reputation as a sportsman, but could not do much because I had a knee injury, which took me in and out of hospital. During one of these hospital episodes, just before I was put under traction for a year, I loved to wander from room to room to visit the other patients, especially fellow students. One fine day, I came upon a final year medical student whom I shall not identify for obvious reasons. Mournfully, he told me that another capable final year student had kindly done a circumcision for him, but that septicaemia had set in. Hence, despite the loss of face, he had to make a clean breast of things to the professor, who had ordered hospitalisation to avoid possible amputation. This unfortunate student was a very old friend of mine, against whom I had played in inter-school games in North Malaya. Our schools were 'enemies' but personally, we were good friends. How could I leave him alone to let fearful self-pity eat into his very soul? So filled with love and charity, I used to pay him regular visits to cheer him up with funny stories. But even Bob Hope would have run out of funny stories, so my stories graduated to the sublime. I showed him pin-ups and debauched him with 'nice' stories. You can picture a man tensed with passion. You can picture a man tensed with pain. But can you picture a man tensed with both?"

Based on a tongue-in-cheek account[3] given by Dr Chee Phui Hung (who was among the first batch of MBBS graduands from the University of Malaya, Singapore), medical and dental students were a rambunctious lot in the 1930s: "We remember the good old days

when we sang songs to 'dirty' lyrics, got drunk on a potent cocktail of gin, whisky, brandy and beer from the Kay-Mouat cup after an inter-college victory, smelled the nurses when we advanced from morbid anatomy classes to clinics, gambled the night away in hostel corridors and suffered 'air raids' when our rooms were turned upside down. We recall too, getting pelted by rotten eggs in the former FMS Hostel's quadrangle, hopping on to goucho's cowboy lorry to 'barrack' at our Raffles College counterparts throughout the year; conducting panty raids at Eusoff Hall, the ladies hostel; dowsing the chief medical officer when he dared to invade the hostel and defying the police with bugle calls." Upon graduation, Dr Chee worked briefly in the Department of Bacteriology of the Faculty of Medicine before going into private practice. In his later years, Dr Chee devoted his time to the Alumni Association, where he was known as "the Agong" (apparently in reference to him being the "King of Raggers").

Dr JJ Murugasu was in the second batch of students after the war. He entered Tan Tock Seng Hostel in October 1946 and later transferred to FMS Hostel. This was how Dr Murugasu described daily life as a student.[4] "Every morning, the College provided transport in the form of a military truck driven by a fellow called ['goucho'] because he had a big hat. It was the truck that took us first to Holne Chase to pick up the girls, then to Raffles College for physics and chemistry lectures. In the afternoon, we had biology at the College of Medicine Building before returning to our hostel. When I came back to our third floor room, I would always announce my arrival by throwing my shoes up in the air so that they landed noisily on the wooden floor. Seah Cheng Siang, who stayed in the room below, eventually got fed up and bought a big wooden pole. This, he banged on the ceiling to tell me to stop making so much noise."

In 1964, Dr Omar bin Hamid wrote an account of what life was like for "northerners" who came to the College of Medicine in Singapore in the late 1930s.[5] "The first pioneers from the north were Salma and Sutan. Through no fault of his own, (Sutan) took the slow boat to graduation, and if the College had issued any decorations, he certainly would have been awarded the Long Service Medal. Bakar was another stalwart at games, but whenever he scored wide off the goal, he would swear as angrily as he would throw a rotten mah-jong card. In academic studies, these boys took things easy. Why worry! They had a good scholarship and there was a whole year to relax, and they could always do some frantic reading just before the exam. But to satisfy their conscience, they carried Jamieson with them to the picture hall or whenever they patronised the mee stall behind the ronggeng stage at Happy World. Among themselves, they formed the Radio Club. They just parked themselves around the radiogram in Harrower Hall after dinner with Gray's or Samson Wright's on their laps ostensibly with the idea of doing some earnest reading. Bakar and I were constant partners in the labs, just because nobody else wanted to partner us. Both of us occasionally slipped out of the gynaecology lectures at KKH after the attendance had been taken, in order to go to the pictures at the Rex Theatre close by. I also achieved the record of being the only student in the history of the College to be asked by Dr Balasingam to repeat the one-month post mortem course just because I was honest enough not to copy the post mortem notes from the technician, Nalpon, as so many others did. The College was a real melting pot to which came students with different backgrounds, outlooks and eccentricities. There were people who had come from the wilderness and there were city folks who thought that *padi* grew on trees. There were people with plenty of dollars and other[s] with plenty of sense. There were sloppy students and those who dressed with sartorial correctness. There were clowns and fuddy-duddies, and there were paragons of virtue and others who were a little salacious, and there were adventurers, ideologists, romanticists and students. This motley crowd melted in the Medical College Union (which was re-formed in 1922 from the Student's Recreation Club) pot, out of which emerged the good Alumni we all are today." ◆

PROFILE

TEXT BY

A/PROF CUTHBERT TEO

Editorial Advisor

A/Prof Cuthbert Teo is trained as a forensic pathologist. The views expressed in the above article are his personal opinions, and do not represent those of his employer.

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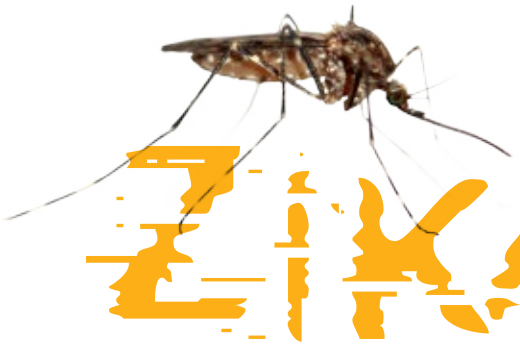

An Update on the ZIKA VIRUS

The Zika virus epidemic in the Americas, and in particular its association with subsequent development of microcephaly in the newborn of infected pregnant women, has resulted in considerable public and medical interest. Will it come into Singapore and what are the implications if it does?

PROFILE

TEXT BY

DR HSU LI YANG

Dr Hsu Li Yang is currently based in the private sector, with part-time appointments at the Singapore's first school of public health as well as the oldest medical school.

ABOUT THE ZIKA VIRUS

First, a brief introduction to the virus itself. The Zika virus is a member of the flavivirus family ("flavi" actually translates to "yellow" in Latin and the family is so named because of its most famous member in history: the yellow fever virus), which also includes dengue, Japanese encephalitis and West Nile viruses. Scientists working at the Yellow Fever Research Institute (currently Uganda Virus Research Institute) discovered the virus serendipitously in 1947, in a sentinel monkey set up in the Zika Forest near Entebbe, Uganda. Other than Africa, the Zika virus is also present in Asia, having been described in orangutans in Sabah as well as in travellers from Indonesia, Cambodia and Thailand.

It is maintained in its sylvatic cycle by primates and is transmitted primarily by a variety of *Aedes* mosquitoes, including the two major strains of *Aedes* mosquitoes in Singapore — *Aedes aegypti* and *Aedes albopictus*. The virus can also be transmitted via blood transfusion and in a recent curious discovery, via sexual intercourse (at this point, although we are clear that men can transmit the virus to their partners, as the virus can be found in semen, it remains uncertain whether women can transmit Zika through sex). The incubation period after being bitten by an infected mosquito is "a few days" (variously described as somewhere between two and 12 days). Incubation periods after blood transfusion or sexual transmission are unknown, but likely to be just as brief, if not more so.

As with dengue, up to 80% of infected persons will be asymptomatic. The clinical disease the virus causes is Zika fever, which is often described as a "mild dengue". This is an acute syndrome comprising fever with various combinations of other symptoms such as headache, joint aches, muscle aches, maculopapular rash and non-purulent conjunctivitis. Not many clinicians or researchers were particularly interested in this mild viral illness until the first ever epidemic of Zika occurred on the Micronesian island of Yap in 2007; and even after that, there was little mainstream interest. However, the virus spread inexorably eastward through Micronesia, French Polynesia (2013), Cook Islands (2014) and Easter Island (2014), to finally reach the Americas in 2015. Brazil was the first country in South America to report the Zika epidemic in April 2015 and researchers have postulated that the virus arrived during the 2014 FIFA World Cup held in that country. Since May 2015, the virus has spread throughout most countries of tropical South America, Mexico and parts of

Central America. The virus has also been exported episodically from the Americas as well as Asia since then.

COMPLICATIONS OF THE VIRUS

The huge number of infections in Brazil and other South American countries has unveiled two rare but terrifying complications of the infection. The first is Guillain-Barré syndrome (or, specifically for neurology wonks, the acute motor axonal neuropathy phenotype of Guillain-Barré syndrome) — an immune-mediated neurological condition presenting as progressive paralysis over a period of days to weeks. Researchers have since uncovered strong evidence of its association with prior Zika infections even in the French Polynesian outbreak, although the mechanism by which it happens remains unknown, as the usual auto-antibodies have not been detected. A very small proportion of patients (up to 0.24 per 1,000 Zika-infected persons) may be affected, which explains why the association was not made until fairly recently. It is important to note that asymptomatic infection may also result in Guillain-Barré syndrome, albeit at far lower rates compared to symptomatic Zika disease, according to current evidence.

The second, and much worse, complication is the association of viral infection in pregnant women with grave outcomes for the pregnancy. Microcephaly in the newborn was the first and most obvious manifestation, leading to a sudden surge of public interest in Zika and the enormous public pressure to confirm the association, as well as to "do something about it". The subsequent studies and events have been depressing, demonstrating that the association is likely true and Zika is a cause for fetal complications including microcephaly:

- The Zika virus has been shown to infect and kill neural stem cells in cell culture experiments (ie, biological plausibility).
- The virus was found in the brain of an aborted fetus in Slovenia. The mother had been infected with Zika at Week 13 of pregnancy and had elected to abort the fetus after confirmation of microcephaly and intrauterine growth retardation at Week 32.
- Among nine pregnant travellers to the US, with evidence of Zika infection, there were two fetal deaths and one newborn with microcephaly.
- In a Brazilian cohort of 42 women infected between Weeks 6 and 35 of pregnancy, there were two fetal deaths (4.8%) and 12 with abnormal fetal ultrasound scans (28.6%), including four (9.5%) with microcephaly.

These resulted in travel advisories for countries with ongoing Zika transmission: pregnant women and those actively seeking to get pregnant should not travel to these areas and should either abstain from sex or get their male partners to use condoms if they are in these areas, in addition to minimising the risk of mosquito bites. Several South American governments have urged women to delay pregnancies until the Zika outbreak is over, a recommendation which is unlikely to be helpful. This outbreak has also refuelled the debate on legal abortions and contraception in these highly Catholic nations.

ZIKA IN SINGAPORE?

Will Zika be imported into Singapore? The answer is very likely yes. We have tourists and returning travellers from both South American and Asian countries where Zika is endemic. In addition, it is unlikely that the Zika epidemic in Brazil will be under control by the 2016 Summer Olympics in August, which a fairly large contingent of athletes and other personnel will be attending.

How can we diagnose Zika infections? A travel history is important here, as the disease manifestations are very similar to dengue (with perhaps the exception of conjunctivitis, which is not always present) and can result in false-positive dengue antibody tests (being a related member of the flavivirus family). Of note, the dengue antigen test (usually positive between Days 2 to 9 of dengue infection) will be negative. The only laboratory tests available locally at this point in time are based on the polymerase chain reaction, detecting the presence of absence of the virus directly (and therefore will only be positive from blood samples for the first few days of disease; although it might be positive for a longer duration in urine or semen, the latter might be difficult to collect in a clinic setting), and can be done at either the National Public Health Laboratory or the Environmental Health Institute.

What can we do about it here? It is obviously impossible to quarantine all visitors and returning travellers from countries with ongoing Zika transmission until they are tested negative for the virus. On top of that, the majority of Zika infections are asymptomatic but can potentially spread the disease if bitten by *Aedes* mosquitoes. The key question then is whether a Zika outbreak in Singapore will behave like chikungunya (with less than 200 cases a year and only 42 cases in all of 2015) or dengue. Most local experts currently believe it will be more like the former, partly because our vector control is good (some of us might find this difficult to believe, but it is true) and largely because Zika — unlike dengue — is not rife in the surrounding countries.

There is no Zika vaccine available commercially and the current vaccine candidates will take several years more to be tested, licensed and commercialised. There is also no specific treatment for the infection. Better diagnostic tests, especially more specific serological tests, may be helpful in certain instances, such as the testing of pregnant women who may have potentially been exposed to the virus (either in countries with ongoing Zika transmission or in the scenario where there is an outbreak in Singapore). The only real way forward is continued investment in improving vector control, which has the side benefit of reducing the transmission of a number of other diseases such as dengue and chikungunya. ◆

Being in a Convivial Learning Compact:

To Add Zest to Life, Teach

This article was triggered by a* Medscape Journal *article written by Dr Julian L Seifter after he attended a grand round in Brigham and Women's Hospital (BWH), Boston. Dr Seifter's article titled "Don't Abandon the Case Report in the Race for Big Data"[1] was highlighted in the National University Hospital System (NUHS) family medicine (FM) residency weekly bulletin of 4th December 2015, as the case studies approach he espoused is also valued in the residency teaching programme. This article was also inspired by the Ministry of Health's (MOH) call to train more doctors in a letter to the* Straits Times Forum *on 7 December 2015.[2] A/Prof Cheong recounts his inchoate passion for scholarship as a young doctor, his positive experience as a medical teacher and concludes with an exhortation to colleagues to add zest to life by teaching.

As an internal medicine (IM) resident (1976-1979), I studied the Clinico-Pathological Conference (CPC) proceedings in the *New England Journal of Medicine* (NEJM) religiously and honed my clinical reasoning skills from it. There was no internet then and the costly subscription to this premier journal mailed weekly to my home kept me current for the IM examinations.

I decided to go on a grand tour of the United States after my chest medicine posting and MRCP examination in Edinburgh. A high point of the trip was my visit to Boston, where I surreptitiously crept into the amphitheater of Massachusetts General Hospital (a Harvard affiliate of BWH) one afternoon. I had expected to be lost in a big crowd of learned doctors holding court in the CPC. To my surprise, there was only a handful of doctors present in that cavernous room that had hosted decades of scholarly discussions. The stark room was ringed with wooden benches, once occupied by some whose names are immortalised by eponymous diseases. Even the 35 mm slide projector was passé compared to those we had in Singapore at that time. There was an ungainly lantern projector with a microscope attachment that was later used for projecting pathology glass slides. It made a lot of noise when switched on but the projection was bright and clear. The air was still, musty even, but it was autumn and comfortable. I took a seat in the far corner.

I was quickly lost in the case presentation and discussion that followed, too enraptured to worry about being discovered. Thankfully, I did not have to put my rehearsed apology to use and the event ended on the hour. No doubt, the scribe would then rush to write it up for publication in one of the next editions of NEJM. What struck me was that a handful of persons sitting in a nondescript room had such a great impact on the medical world — a testament to the power of scholarship and publication. I was privileged to witness one presentation before it was published!

I gave up that weekly scholarly ritual after a few years in practice. It wasn't until almost a decade after that I published my first academic paper. A/Prof Goh Lee Gan, my co-author, will attest to the many nights spent in the old Department of Community Occupational and Family Medicine (COFM) offices in National University Hospital (NUH) revising and revisiting the drafts. With

his encouragement, I persevered sometimes past midnight — that is the power of a learning compact.

I am happy now to be in another learning compact in the NUHS FM residency. I see young enthusiastic doctors presenting interesting cases and discussing them. In debrief after clinical sessions, learning gems picked up are shared. Around the patients' beds in their inpatient postings, cases are discussed from both inpatient and FM perspectives. In the FM grand rounds, residents share cases, diligently documented and researched under the guidance of the FM faculty and invited experts. Some cases are presented in external medical conferences and a few even made it to prestigious refereed medical journals. An example is a report[3] in *Osteoporosis International* (impact factor 4.24). However, it is the scholarship process and learning camaraderie that really matter. Getting it to print is just an external validation.

Best of all, the interactions are convivial, happening in a friendly, lively and enjoyable learning atmosphere. As I happily teach, I also joyfully learn. In an outpatient consultation, a resident was puzzled why post-prandial glucose (PPG) home monitoring was ordered for the patient as he was accustomed to only ordering fasting and pre-prandial glucose (FPG) monitoring during his hospital postings. We discussed and agreed that for our patient, PPG was preferred because she had near-normal FPG but persistently high HbA1c. Moreover, a drug targeting PPG was just added. A subsequent literature search supported our clinical decision.[4] We are wiser for it and the two residents have written these insights as a portfolio-based case record for our online FM tabletop companion.

Doctors in practice do seek conviviality in groups outside medical practice. Such groups develop from kinship and revolve around mutual interests. I belong to an informal group also called SMA (Singapore Makan Association), whose members are bound by a love for good food. Doctors' social lives also revolve around sports, hobbies or spiritual pursuits. Involvement outside the confines of medicine adds spice to life and recursively, zest to our medical practice.

Conviviality can flourish in healthy academic and scholarly groups too. Looking at it from a family system approach, the health of such groups is revealed by its sub-systems viz. Relatedness, Order, Agency, Development and Self-Identity (ROADS in short). How diverse members reverently *relate* to one another engenders collegiality. Having good administrative support *orders* the learning milieu. Active *agency* drives intellectual pursuits and scholarship. Road-maps to *develop* high academic standards harness energies and the cultivation of *self-identity* within the professional group identity opens common space. Conviviality naturally flourishes in a healthy learning compact such as the NUHS FM Residency, just as positive emotions and joie de vivre effuse from a healthy mind and body.

The MOH made a clarion call for more medical teachers in a letter to the *Straits Times* on 7 December 2015. I connect that to my past scholarly pursuits as a young doctor as well as positive experience learning from and teaching fellow doctors and medical students thence. For colleagues who feel jaded by the ennui of medical practice, I vouch that conviviality can be found in scholarly and teaching compacts within medicine too.

You can add zest to life. Teach. ◆

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PROFILE

TEXT BY

A/PROF CHEONG PAK YEAN

A/Prof Cheong Pak Yean teaches medical students at the NUS Yong Loo Lin School of Medicine, FM residents in the NUHS FM programme and sees patients at his private IM and FM clinic. He wishes to thank his learning compact, in particular, Ong Chooi Peng (Core Faculty member) and Grace Chiang (Chief Resident) for shaping this essay. A/Prof Cheong is a past president of the Singapore Medical Association, College of Family Physicians and chairman, Chapter of Family Medicine Physicians, Academy of Medicine Singapore.

WHEN A DOCTOR BECOMES A PATIENT

I have been to the doctor's only a few times in my life. The childhood memories are somewhat blurred by time; while recent memories are a mix of joy, fear, anger and sadness. If you watched the animated movie *Inside Out*, all my experiences with doctors are those swirly balls of golden yellow, with specks of burning red and streaks of blue and purple.

I remember seeing my neighbourhood GP, Dr Chong Ah Lek, for chicken pox and the occasional bad cough during my childhood. He was always kind and gentle. I also remember the antiseptic smell of the clinic and how I was fascinated by the tiny scrawls on the little yellow flashcard that served as my notes. Another fond memory was the sweet taste of the pink syrup, the chemical bitterness of the pills and the reverence in which I held a medical certificate (MC), stamped and signed for which a school absence was permitted.

At the Primary Six school health screening, I received a referral for scoliosis. I recall my parents worrying about my "crooked" spine and parroting the doctor's advice that I must stretch and swim, and carry my heavy schoolbag on alternate shoulders to even out the imbalance. They were respectful of the advice and thankful that I didn't need surgery. Once, I saw a polyclinic doctor for a pain in my right knee — I was 19 years old and had just started medical school. I couldn't describe the symptoms and to me it was just "painful"; like there was something moving inside my knee and that it would suddenly give way while walking down the stairs. The doctor did quite a thorough examination (which I appreciated only a few years later) and concluded it was nothing serious. I remember vaguely my feelings of dissatisfaction; while it was not serious, the pain did bother me. Anyway, the right knee is still a problem to this day.

After starting work as a doctor, my own health took a back seat. Early rounds, night calls, post-calls, examinations… it just became an endless merry-go-round of catching up with work and sleep. There were occasional visits to GPs or staff clinics to get an MC. By then, it had become something embarrassing and shameful. *How can a doctor be sick? What would my registrar/consultant think of me?* This lasted for years, until a few years ago when some major life events happened. That was a wake-up call for me to look after myself and my family first.

Without going into medical details, what I can share is: it s*cked to feel so d**n helpless.

FAMILY CRISES

Bad things often happen without warning. There was a sense of unease when we looked at the scan images, followed by cold sweat, fear and the feeling of impending doom. The trained eye had seen what the heart refused to believe. A detached, clinical part of me maintained a calm and professional demeanour when discussing diagnosis and management options, as if it was just another grand ward round discussion (a tribute to years of training to be "Dr Tan"). The real "me" was dazed and reeling in shock and disbelief. Even close friends and the doctors managing our problems never quite saw the depth of emotions we experienced. One commented: "How are you feeling? You seem to be taking this well." My reply went along the lines of: "We have to. Enough tears have been shed at home. No point crying now." We knew we were in good hands and it was time to take on the role as a patient and trust the doctor to do what's best.

I wish to put on record my deepest thanks to Drs Mary Rauff, Cindy Hia, Shankar Sriram, Winn Maung Maung Aye, Su Lin Lin, Lim Tian Jin, Ms Jacqueline Kong and Nurse Diana. I have thought long and hard about whether I should list down these names — it doesn't take a genius to figure out why we needed to see these particular doctors and I trust that readers will respect my privacy and not pry. In the end, I decided that I needed to shout out, loud and clear, how much these people have done for me. My apologies to all the other doctors and nurses who have looked after us; I might not remember you now, but at that point in time, your presence and care was deeply appreciated and you made a difference. Too often, healthcare workers only get complaints and a bad rap in the press. There's a lot of good work being done that should be acknowledged as well. Another point of sharing is to hopefully encourage more doctors to share their own patient journeys as we are uniquely placed to appreciate our doctors.

ON A LIGHTER NOTE

In my most recent hospitalisation stint for delivery, the ward nurses asked me how I wanted to be addressed. I responded with a confused "huh?" and they clarified: "Shall we call you Dr Tan?" I told them: "No need! I'm not working. Just call me Yia Swam/Mdm Tan/Auntie/Miss… whatever you are used to." Therefore, my ward's label simply stated "Yia Swam". When passing report, the nurses always mentioned that I was a medical doctor. Among the medical staff, only my consultants knew who I was. One of the junior doctors was a student of mine and recognised me. He swore that he would protect my confidentiality — I reassured him that I trust him to be professional and not to ever discuss ANY patient. Anyway, I hardly needed to keep the birth a secret, people knew I was pregnant! At least, I assumed they did… or maybe they thought I put on ten kilograms from eating too much but were just too polite to comment.

Every time a new doctor came into the ward, be it to draw blood or conduct a basic examination, the husband and I had our fun. The husband would point out which vein is better for venipuncture and helpfully apply the tourniquet while I would present my own history in the standard format and then pre-empt them in the physical examination steps. There was always a look of surprise, followed by a look of suspicion from the new doctors who didn't know who I was…

Moral of the story: Read *SMA News*. ◆

PROFILE

TEXT BY

DR TAN YIA SWAM

Editor

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.

A HELPING HAND FOR GPs

PROFILE

TEXT BY

DR LEONG CHOON KIT

Editorial Board Member

Dr Leong Choon Kit is a GP in the private sector. He feels strongly about doctors contributing back to society and ministering to fellow doctors in trouble. As a result, he tries to lend a voice to the silent majority in every issue he has come across, particularly those in healthcare, educational and other social concerns.

"Hey, Choon Kit, do you have a moment? I've just received a letter from a management company and I am disturbed by the new clauses they have added in. Can you help?" — SMA News, July 2015

"How many of us actually check our blood sugar, blood pressure and cholesterol levels?" — A question I posed to fellow GPs in our WhatsApp chat group recently.

It has been half a year since I last wrote about this and I am still receiving requests for help from fellow doctors. The various requests usually fall into a few broad categories: medical, social, financial, practice, patient complaints and matters relating to health.

It is commendable that the College of Family Physicians Singapore has organised a skills course on physician self-care earlier this year. Looking at the categories outlined above, it looks like there is still a lot of work to be done. Mental health and physician burnout is only a small portion of the many problems we face as doctors.

We still do not have a framework or structure to administer care to doctors who are suffering. We will need a point of contact, a hotline or a one-stop centre for doctors to call — one which is effective, efficient, timely and confidential.

Looking beyond ministering to doctors in trouble, we will need to move into prevention mode. The organisation of courses or talks may help doctors build up their arsenal to withstand any stressors life throws at them, or even to help minister to fellow colleagues who are suffering.

ONE-STOP CENTRE

Physician self-care is important to all doctors. It is not peculiar to GPs or to those of us in private practice.

With that in mind, I feel that the ideal professional body to establish such a system and run the one-stop centre should be the SMA. With a single hotline or email address, any physician facing any trouble can get in touch with physician volunteers at the SMA.

It would be ideal if all doctors belong to the SMA; however, membership is purely voluntary. Despite having many privileges that come along with SMA membership, some of us still prefer to stay out until we get into trouble. Maybe with the idea of a physician self-care centre as the latest incentive, more would be persuaded to take up SMA membership.

Much like buying insurance, it would be money we need to spend but hopefully never have to utilise the "payouts". It is a paradox we must get used to; paying our annual dues to our professional bodies.

PRINCIPLE

The main principle governing physician self-care should be that of cooperation and self-support: one where camaraderie is paramount.

In the July 2015 issue of *SMA News*, I shared in the "GP Matters" column about the fishermen's cooperative I chanced upon during my trip to Phillip Island in Melbourne a few years ago. They run a restaurant to earn money for fishermen who are too ill to go to sea and offer job opportunities in the restaurant. That is the type of model we should aim for. Other important principles we should embrace are those of prevention, empowerment and strengthening.

Not only must we cater to those colleagues in trouble, but we should also help them with prevention. We must regularly pre-empt the possible stressors and invite experts to share their experiences with us.

We should also keep a lookout for one another. We can create social groups to engage fellow doctors or be whistle blowers to warn one another of potential dangers. Often, we are not aware even when we are in trouble. There is a Chinese saying: "当局者迷，旁观者清", which means that those who are amid trouble are clouded, while bystanders are clear.

One example is in legal and business matters. For instance, a friend was approached by the police with regard to a patient he saw a while ago. As there was no official charge from the court, my friend was not clear what his role and responsibility was at that time. Hence, I sought the help of my friend, a lawyer, for him.

In another instance, managed care companies want to start charging a percentage of the fee charged to patients by doctors in private practice. Similarly, some mall management also calculate the rental for clinic based on a fixed sum with an additional percentage of the clinic's gross takings. My friends were stressed out as they were unsure if it bordered on the organisation receiving kickbacks from the practitioners. It is obvious that my specialist friends would not like to run afoul of the Singapore Medical Council's ethical code by unwittingly offering kickbacks.

STRUCTURE

There are many things in our lives and practices that can stress us out. We are only doctors and are certainly not specialists in life affairs. However, I am confident that we can share best practices and life lessons with one another but we will need a structure to facilitate that.

In areas where we cannot find any experts among ourselves or in situations when we should not rely on our amateurish experience, we could engage other professionals to help us.

I can think of two examples. One instance would be in the counselling of fellow doctors. While we may know a lot more about our own trade and stressors, we may also be too familiar with our colleagues for us to confide our deepest thoughts and anxieties with one another. Counsellors from non-medical organisations would serve us well here.

Another instance would be in the area of submitting income tax returns. Some of us engage accountants for help, while others prefer to do it on their own. SMA has done well in organising seminars touching on income tax returns and related matters each year. I recall many of the speakers being accountants, as well as senior tax officers from the Inland Revenue Authority of Singapore.

I only serve in the SMA as an editorial board member and I am neither privy nor able to influence any of the ideas I outlined above. I pray that these ideas will come into fruition soon, so it can cater to many physicians who are facing ever increasing stressors from all quarters. ◆

THE SMA HAS THE FOLLOWING PLATFORMS AVAILABLE FOR OUR MEMBERS:

Ethics consultation — request for opinion on practice issues you are faced with

SMA forum — discuss issues and get suggestions from fellow forum users

SMA CMEP resources and courses — access archived information on medical ethics, health law and professionalism or be updated through a seminar/conference

Medical practice management courses — gain insight through our courses in 2016, including a tax seminar, a private practice seminar and a workplace and health seminar

Access to the above information could require you to log in to the membership portal. Other resources available via our website (**https://www.sma.org.sg**) include past position statement and advisories on areas such as Managed Care Contracts and medical fee splitting. You may also raise your queries via our **online contact form**, phone: **6223 1264** or email: **sma@sma.org.sg.** However, due to the nature of the Council and Committee being formed by volunteers and supported by a non-medical secretariat, it may require some time for a formal response to be given to your query.

PROFESSIONAL RESPONSIBILITIES OF THE ANAESTHESIOLOGIST

As an anaesthesiologist with an interest in professional and clinical ethics, I have always been fascinated by the ethical labyrinth that we navigate in our daily practice. We are clinicians to the patients, service providers to the surgeons and stakeholders to the operating room management team. Anaesthesiologists thus have ethical responsibilities to their patients, medical colleagues as well as the healthcare facilities in which they practise.

PROFESSIONAL RESPONSIBILITIES TO THE PATIENTS

The framework for the care of our patients is rooted in the principles of patient welfare and respect for their autonomy. The main challenge is the difficulty in establishing an anaesthesiologist-patient relationship. This is primarily due to the fact that anaesthesiologists are not the primary physicians for the patients under their care. Surgical patients do not come to the hospital seeking anaesthesiologists, but they will inevitably need one to participate in their management. Many patients think of their anaesthesiologists as just the person behind the mask — the person who puts them to sleep and wakes them up when it's over. They often do not realise the comprehensive medical care the anaesthesiologist provides preoperatively and beyond.

Our professional duty begins preoperatively. Anaesthesiologists carry the responsibility of providing preoperative evaluation, optimisation and also the facilitation of informed decision-making, especially with regard to the choice of anaesthetic technique.

Oftentimes, we find that the contact time with patients while they are awake ends up being very brief. This then forms an imbalance in the trust and depth of relationship between the patient and their anaesthesiologist, and with their surgeon. By the time patients are presented to the anaesthesiologist for assessment and risk discussion, they would have been through multiple sessions with surgical colleagues and are then understandably more focused on the surgical risks. It can be difficult for patients to grasp the concept of a separate set of risks for a single surgery, and that the risks of anaesthesia may sometimes be higher than those of the surgery itself. This may lead to downplaying of the anaesthesiologist's risk discussion and estimation with the patient. It is also challenging to assess if the patient is really able to understand, retain and process all the complex information given within that short preoperative assessment visit.

A dedicated outpatient pre-anaesthetic evaluation clinic allows anaesthesiologists to be able to spend time interacting with their patients in a comfortable environment, weeks before the surgery. This could help to enhance the patient's understanding of the discussion, build rapport and trust with the anaesthesiologist, and act as mitigation against the last minute rush to assess patients the night before, or even morning of, the surgery. One can even arrange for further follow-up or revisits for truly complex cases. This would be an improvement from the traditional workflow of visiting patients the night before their surgery. To further strengthen this understanding, general conversation and dissemination of information on the anaesthetic process could even be started earlier at the surgeon's office. After all, it is in the best interest of our patients that the surgeons and anaesthesiologists work as a team to care for each patient.

On the part of the anaesthesiologist, offering a full risk-benefit discussion in the best interest of the patient would require an understanding of their values, medical and surgical condition, as well as prognosis and healthcare access. This should also be placed into a wider context beyond the aim to get the patient through one surgery. Anaesthesiologists should resist the temptation to use medical jargon to restrain or coerce patients who have adequate decision-making capacity.[1] The patient's right for self-determination in the presence of informed consent should be respected. In challenging circumstances, multiple engagements over time or seeking the help of surgical colleagues may be better options.

Intra-operatively, the major professional and ethical consideration would be that anaesthetised patients are extremely vulnerable. Ethical practice should motivate us to step up as the patient's advocate and care for the patient's physical and psychological safety, comfort and dignity. Examples are wide-ranging — from protecting the anaesthetised patient's modesty to ensuring that the patient's consent and wishes are respected. This would again require anaesthesiologists to know their patients well enough while they are awake so that a custodial relationship can be forged. Anaesthesia training programmes should not only focus on producing anaesthesiologists with good clinical competence, but also those who are aware of surrounding ethical and professional issues.

THE ANAESTHESIOLOGIST AND CONSCIENTIOUS OBJECTION

Invocation of conscientious objection does not exonerate physicians from duties to their patients. Hence, disclosure of personal ethical beliefs to the institution might be needed for the purpose of ensuring the availability of cover. Anaesthesiologists should not abandon or compromise the care of patients whose beliefs clash with their own, but instead arrange for a transfer of care. In an emergency, the patient's safety and best interest would be paramount. Arrangement for another anaesthesiologist could be carried on concurrently with life-saving measures which should be provided without prejudice.

PROFESSIONAL DUTIES TO OTHER MEDICAL COLLEAGUES

With the patient's best interest in mind, anaesthesiologists should also bear the responsibility of promoting a cooperative and respectful relationship with other professionals involved in their care. One should strive to maintain an environment where good quality management can be given. This can be challenging especially when there are differing professional opinions, which can be common when dealing with medically complex cases that require multidisciplinary input. Portraying another colleague in a bad light or allowing disagreements to become apparent in front of the patient would erode the patient's trust in medical providers and their ability to work together.

The anaesthesiologist-surgeon relationship can often be strained in the face of disagreements, especially over the extent of medical interventions in medically challenging cases. When an anaesthesiologist finds the surgeon's decisions to be in conflict with his or her own moral or professional beliefs, there should be an attempt to reconcile these differences diplomatically, which may include escalation of the issue to a higher level or getting a second opinion from a neutral colleague. If the situation is irreconcilable, the anaesthesiologist should withdraw in a non-judgemental fashion and provide an alternative for care in a timely fashion.[2] However, if an anaesthesiologist finds certain intervention decisions to be in conflict with the accepted professional standards of care, ethical practice or institutional policies, the anaesthesiologist should then voice such concerns and present the situation to the appropriate institutional body. In no instance however, should a patient be inconvenienced or have his or her care compromised due to unresolved differences between the anaesthesiologist and the surgeon — patient care should always be at the forefront of any professional interaction. Maintaining a healthy collegial relationship is the responsibility of all physicians caring for their patients.

CONFLICTS OF INTEREST IN ANAESTHESIOLOGY

Most anaesthesiologists in private practice are dependent on surgeons to provide patients for anaesthesia and it is rare for patients to request for an anaesthesiologist unless they have positive experiences from a previous surgery. As such, the anaesthesiologists may end up beholden to the surgeon, which can lead to conflicts of interest — pitting

patient advocacy against loyalty to the referring surgeon. Furthermore, as service providers, the practice of financial kickbacks, undercutting and price-fixing are always a temptation. Those who participate in fraudulent business practices often do so due to ignorance rather than intent. Hence, it is our ethical obligation to learn and understand the various forms of inappropriate business practices in order to avoid becoming unintentionally implicated.

THE ANAESTHESIOLOGIST AND PRACTICE-BASED IMPROVEMENT

Anaesthesiologists throughout the world have established themselves as leaders in patient safety and quality improvement. I know of many anaesthesiologists who serve within hospital or specialty committees. Much of our training revolves around patient safety and acute care; hence, using our skill set to help develop departmental or hospital guidelines as well as reviewing the practice of colleagues, in good faith, are part of our ethical responsibility. Cooperating with both clinical and administrative colleagues to improve the quality, effectiveness and efficiency of the care given would only serve to improve the patient's outcome. This may consist of being present and taking part in the surgical safety checklist, as well as taking lead in patient safety issues in the operating theatre.

As an acute care physician, we are also ethically obliged to be present during emergencies in our institution when contracted to do so, and to ensure that we are able to handle such emergencies. This would include measures to maintain our state of readiness, such as attending continuous medical education sessions and refresher courses.

Due to our unique role which requires the personal handling of controlled and dangerous drugs, we also carry the responsibility of keeping these substances safe from abuse and illicit use. We should be vigilant about the signs of possible substance abuse among our colleagues and learn how to handle such cases discreetly and ethically.

CONCLUSION

Every specialty will have its own unique ethical responsibilities and challenges. Anaesthesiologists, being clinician service providers, encounter many. These are obviously on top of the myriad of ethical responsibilities which are common among all physicians. It can be a daunting prospect to try and keep within ethical parameters. However, as long as we practise in the best interest of our patients and keep to the common pillars of medical ethics — we should be secure in the knowledge that we are on the right track. ◆

PROFILE

TEXT BY

DR HAIRIL RIZAL ABDULLAH

Teaching Faculty, SMA Centre for Medical Ethics and Professionalism

Dr Hairil is a consultant in the department of anaesthesiology, Singapore General Hospital and currently heads the Preoperative Evaluation Clinic. He holds a special interest in medical ethics as well as clinical systems improvement. He has a passion for scuba diving and marine conservation, and tries his best to dive as often as possible during his free time.

References

1. American Society of Anesthesiologists, Guidelines for the ethical practice of anesthesiology. 22 October 2008.
2. American Society of Anesthesiologists, Ethical guidelines for the anesthesia care of patients with do-not-resuscitate orders or other directives that limit treatment. 16 October 2013.

SMA CMEP Appreciation Dinner 2016

PROFILE

TEXT AND PHOTOS BY

DENISE TAN

Senior Executive, SMA Centre for Medical Ethics & Professionalism

Legend

1 and 2. CMEP Board of Directors and Teaching Faculty mingling before dinner begins
3. A/Prof Gerald Chua presenting a token of appreciation to Dr T Thirumoorthy

On 3 March 2016, the SMA Centre for Medical Ethics and Professionalism (SMA CMEP) held its annual appreciation dinner at Moghul Mahal Restaurant in Novotel Singapore Clark Quay. A sumptuous buffet of Indian cuisine was laid out as attendees mingled and enjoyed the night with glasses of wine in hand. It was attended by SMA's President, Dr Wong Tien Hua, SMA CMEP's board of directors, as well as current and newly on-board teaching faculty.

The dinner commenced with an opening speech by Dr Wong, thanking everyone for their attendance and for their continuous support rendered to the seminars that were organised in 2015 and the years before. Dr Wong also announced that Dr T Thirumoorthy will be stepping down and A/Prof Gerald Chua will be taking over the position as the Executive Director of the SMA CMEP. He thanked Dr Thirumoorthy, the founding director of SMA CMEP, for playing a significant role in paving its growth.

The night ended with A/Prof Chua giving out tokens of appreciation, specially prepared by the SMA, to the board and faculty as recognition for their hard work over the years. Lastly, A/Prof Chua presented a special gift to Dr Thirumoorthy for his dedicated years in SMA CMEP.

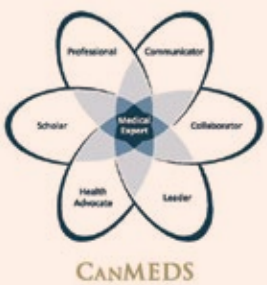
We would like to thank Dr T Thirumoorthy for his leadership, dedication and effort as SMA CMEP's Executive Director over the past four years.

"My vision for SMA CMEP is that we enable a learning platform to assist doctors in their quest to continually develop in the multiple roles (CanMeds 2015 Physician Competency Framework) that the practice of medicine in Singapore requires.

Dr Thirumoorthy urges us to "stay competent, stay compassionate, stay service-ful." To that, I add a call to refocus on three core attributes of our profession: Love, Servitude and Humility.

***Love** others more than ourselves;*
***Serve** the interests of our patients before our own; and remembering always, the*
***Humility** of wisdom"*
– A/Prof Gerald Chua, Executive Director, SMA CMEP (since April 2016)

We look forward with confidence for the continued growth of SMA CMEP under the leadership of A/Prof Gerald Chua.



SCS-SMA Cancer Education Seminar Series 2016

Jointly Organised by:

SINGAPORE CANCER SOCIETY

SINGAPORE MEDICAL ASSOCIATION
For Doctors, For Patients

Date: 7 May 2016, Saturday
Time: 1 pm – 5 pm (Lunch will be provided)
Venue: Health Promotion Board Auditorium
(3 Second Hospital Avenue)
Number of CME Points: Pending approval from the Singapore Medical Council
To register, visit https://www.sma.org.sg/academy or fill in the form below

TOPIC: LUNG CANCER

Lung cancer is the second most common cancer among Singaporean men and the third most common cancer among Singaporean women. As a GP, you can advise, encourage and empower your patients to take ownership in adopting healthy lifestyle practices for cancer prevention. Sign up for the SCS-SMA Cancer Education Seminar Series to learn how you could be a life changer for the patients you care for. Early detection saves lives.

Time	Programme
1 pm	Registration (Lunch will be provided)
2 pm	Introduction to SCS–SMA Cancer Education Series 2016 *David Fong, Chief Operating Officer, Singapore Cancer Society*
2.15 pm	Epidemiology of Lung Cancer
2.25 pm	Lung Cancer Screening
2.45 pm	Video-Assisted Thoracic Surgery in Lung Cancer Treatment
3.05 pm	Stereotactic Body Radiotherapy in Lung Cancer Treatment
3.30 pm	Advanced Lung Cancer — Optimism In Nihilism
3.45 pm	Question & Answer
4.15 pm	Closing Address
5 pm	End

GENERAL PRACTITIONERS ARE THE FIRST LINE OF DEFENCE AGAINST CANCER.

Supported by:

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Please return this slip for *SCS-SMA Cancer Education Series* 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.

Name: _____ Handphone no.: _____
Email: _____ Profession/Specialty: _____
MRC no.: _____ SMA Member: YES / NO *(please circle accordingly)*

Registration (inclusive of GST) ☐ SMA member: complimentary
☐ Non-member: $120

Mode of Payment

☐ Credit Card
VISA/ Master Card no.: _____ - _____ - _____ - _____
Expiry date: _____ / _____ CVV2/CVC2 no.: _____

☐ Cheque (*payable to Singapore Medical Association*)
Bank: _____ Cheque no: _____
Signature: _____ Date: _____

By registering for this event, you consent to the collection, usage and disclosure of personal data provided for the purpose of this event, as well as having your photographs and/or videos taken by SMA and its appointed agents for the purpose of publicity and reporting of the event.

ION SUPPLY DRINK

POCARI SWEAT

Otsuka

RUN

POCARI SWEAT RUN SINGAPORE 2016

LET'S RUN TO THE MOON!

POWERED BY LUNAR DREAM CAPSULE PROJECT

23 JULY 2016 | THE FLOAT @ MARINA BAY | NIGHT RUN

The journey to the moon is estimated to be 380,000km. In our past 4 editions of POCARI SWEAT RUN, all our runners have covered a total distance of about 300,000km. With a remaining distance of about 80,000km, we'll need all of your support to complete this mission together!

POCARI SWEAT Singapore will donate $5 to the SMA Charity Fund (SMACF) for every SMA Member who signs up for the race. The SMACF supports underprivileged medical students through the SMA Medical Students' Assistance Fund.

Thank you for your support towards the SMACF. Registered SMA runners will receive information about POCARI SWEAT RUN 2016's race pack collection from the SMA Secretariat at a later date.

Please visit www.pocarisweatrun.com for more information.

The SMA Promo Code, reserved exclusively for the first 500 SMA Members, will expire on 30 April 2016. SMA Members who register from 1 May onwards will have to pay the full published rate.

SINGAPORE MEDICAL ASSOCIATION

For Doctors, For Patients

SMA Charity Fund

Project Yangon
Love, Live, Learn

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

Are you interested in making a difference by reaching out to a community that is largely neglected medically? Are you willing to take part in a pioneering effort to bring first-rate healthcare to people who lack regular access to a healthcare provider? Do you seek to gain experience in another community through an overseas healthcare volunteer trip? Your clinical expertise will be greatly valued and will go a long way in improving the lives of many. Please email the Project Yangon team at projectyangon2015@gmail.com or contact Ralene Sim at 9711 2590 if you would like to join us on our health screening trip from **27 to 30 May 2016** or make donations of drugs, equipment or funds. Any form of sponsorship would be most welcome.

Although we had been thoroughly informed of the Burmese people's immense warmth and hospitality, nothing could have prepared us for the kindness and friendliness that we experienced during this trip in May 2015.

What was intended to be a health screening conducted for their benefit turned out to be the embodiment of the spirit of kindness which touched our hearts greatly. We felt genuine warmth that was not forged for the sake of tourism and it was evident in both the young and old.

AN EAGER HELPING HAND

I will always remember the day I was busy preparing the equipment for the glucometer station during a health screening session as the village kids scampered around in excitement and curiosity. Amid the chaos, I noticed an older boy watching my actions intently and shushing the kids around him, attempting to get them to quieten down.

The boy, whom I later learnt was named Aung Kyaw Moe, gestured to the equipment beseechingly before thumping his chest enthusiastically. To my surprise, I realised that he wanted to help me. I shook my head, but he wouldn't take no for an answer. After I performed the blood glucose test on the first villager, he put on a pair of gloves and assisted me seamlessly without any prior instructions. He helped by removing the plasters from their wrappers and placing them on the villagers' fingers. He even took the initiative to guide them to the next screening station.

What really touched my heart was how he whipped out a makeshift fan and began fanning everyone, even though he too was sweating profusely from the heat.

MEETING HEALTHCARE NEEDS

Translated into English, "Yangon" means "the end of strife". However, for many of the villagers, including little Aung Kyaw Moe, life is a constant struggle to move on from the devastating past. He was one of the villagers who were relocated from Hlaing Township to Shwe Pyi Thar with virtually nothing after a fire

wrecked their homes. They had to rebuild everything from scratch and needless to say, higher education and healthcare is a luxury that they cannot afford.

Many village children have no choice but to discontinue school after Primary Six or even earlier to bring in extra income, despite being bright, inquisitive and deserving. Health wise, all parents want the best for their children, regardless of their circumstances. However, circumstances do dictate prognosis and it is unfortunate that there is a severe lack of healthcare facilities where they are located.

One of our Project Yangon doctors, Dr Samuel Lim, encountered a breathless and febrile 14-year-old boy from the village who presented with asthma that was difficult to treat. His mother didn't need to convey her worry to us in words — it was evident, with her hand constantly over her son's shoulder and the creases on her forehead. A clinical examination revealed coarse crepitations consistent with bronchiectasis; in the local context, it was most probably from tuberculosis.

Fortunately, there was a happy ending for both mother and child. We managed to connect them with some local doctors who assured us that they would follow up on the boy. Dr Lim explained: "It gave us a sense of achievement knowing that we helped find the right diagnosis and, more importantly, connected him to a local healthcare system that could provide treatment for children like him."

There was also a two-year-old suffering from developmental delay and failure to thrive. "His mother told us that as a baby, he was diagnosed with heart problems but no further work-up was done. She then gave us a clinical history consistent with tet spells while cardiac examinations supported the diagnosis of possible tetralogy of Fallot," recalled Dr Lim. "After much negotiation, we managed to get local doctors on site to refer him to a local charity clinic which had special funds to refer the child to a tertiary centre. It would be most ideal if we had set aside funds to help such children get the care that their own healthcare system can actually provide but their social standing cannot afford," he added.

ALL IN ALL

The trip went by in a whizz due to the flurry of work that engulfed us every day, but one thing was clear — nothing was more uplifting than the villagers' warmth and gratitude which dispelled our weariness and returned the spring to our steps. During this trip to Myanmar, the reward for trudging off the beaten track was that of an endless repository of stories and smiles to light our souls for the entire trip and beyond. Will you be the reason for someone's grateful heart? Or will you be the recipient of gratitude-eliciting acts of genuine kindness? Why not achieve both by volunteering with Project Yangon? ◆

PROFILE

TEXT BY

RALENE SIM

Ralene Sim is a second-year medical student who feels privileged to be part of the Project Yangon family. Having helped out last year, she will be embarking on a trip again this year together with other medical students who share the same passion for reaching out to the less fortunate in developing countries. She feels that the villagers' unrelenting spirit of genial hospitality and immense gratitude made every minute put into planning for the project worthwhile.

Legend

1. The kids of Shwe Pyi Thar dressed in their school uniforms after school
2. Aung Kyaw Moe, the boy who brought smiles to everyone with his industrious spirit and kind heart during health screening
3. Our valued doctors who are part of our Project Yangon family, all ready to take on health screening with their smiles and equipment
4. Dr Samuel Lim caught in action during our health screening

Photos by Project Yangon

STAY FIT, BE ACTIVE!

With long working hours and heavy responsibilities, many physicians hardly have energy to spare for themselves at the end of a work day. However, three physicians show us a glimpse of the benefits from committing to the fitness activity of their choice.

Dr Jeanne Ong is a second year resident at the National University Healthcare System. She graduated from NUS Yong Loo Lin School of Medicine in 2012. Her weekly fitness regime aside from pole dancing often includes yoga and CrossFit. The studio she pole dances at is Ecole De Pole Singapore and she has participated in Amateur Competitions in Singapore and Hong Kong.

When I first started pole dancing in 2012, I never would have expected it to become such a big part of my life, or that I would end up in dance. Yet now, I am at the pole studio at least three times a week and on some days, I am not sure I want to leave. Over the past three years or so, the pole studio has been my little solace from a crazy world at the end of a long day, where I am among a loving community and can lose myself a little bit in dance.

Pole dancing, or pole fitness as some people like to call it, has become a prominent and almost ubiquitous form of alternative fitness all over the globe. There are countless competitions held worldwide, as well as instructors who make a living by travelling the world attending competitions, teaching workshops and performing. For me, it all started with watching a video and the strength, flexibility and athleticism exhibited appealed to me instantly. I started midway through my housemanship year and as they say, the rest is history.

Apart from its health benefits, what amazes me most is that pole dancing has an empowering effect on women: in a world where one is so used to criticising others for their looks or physique, you can walk into a class where judgement is left at the door and anyone can learn to dance regardless of shape, size, age and fitness. Beyond the fun, the challenges and the benefit of getting fit, pole fitness also changes people's perspective of body image; women learn to accept their bodies for what it is capable of rather than how it looks.

"IT IS NOT EASY TO SUSTAIN A FITNESS REGIME WITH OUR BUSY WORK SCHEDULE BUT A LITTLE DISCIPLINE SEEMS TO GO A LONG WAY."

It is not easy to sustain a fitness regime with our busy work schedule but a little discipline seems to go a long way for me, along with finding a fitness regime that works for my lifestyle. Once I started work, running for long distances was no longer an option as my legs always felt fatigued. I am glad that I found pole fitness as an alternative — a fitness activity with so much fun; I sometimes forget that I am trying to exercise!

Dr Foo Chek Siang is a general surgeon in private practice. He is striving to achieve the optimum work-life balance, without forgetting social and corporate responsibilities, having been so inspired by mentors in France and Australia.

Every weekend, as one heads off to the early weekend clinic or ward round, there is a high chance of meeting the local cycling community; mostly pacing alongside the roads and occasionally around the neighbourhood cafe. Take a closer look and one might spot a familiar face in the peloton or breakfast crowd, donned in Lycra trimmings rather than in surgical scrubs.

Enter the Mamil (acronym standing for "middle-aged men in Lycra"), as defined in the landmark 2010 BBC news article, with its newer described variant: the Muddy Mamil, who favours the muddy trails over the tarmac, from the 2016 publication of the *Telegraph*, albeit of lower impact factor. Road cycling is a retirement sport for me, having shifted gears out from triathlons; dozens of triathlon races, with two ironman-distances, does take a toll on the body.

Endurance sports have always complemented a busy clinical work schedule, as a sort of mental escape and relaxation for the tired soul. To perk it up, the caloric negative nature of cranking the bike does bode better for a bon vivant lifestyle than a flashy sports car.

If road cycling were the official Mamil religion, the weekend ride is the weekly service. An alarm call at 4 am is the invitation to the morning coffee before a slow warm-up to the old Longhouse — the de-facto meeting place for most cycling groups. Cycling is such a serious affair that the riders of the Joyriders, one of the larger cycling groups that gather at the Longhouse, even appoint noms de guerre for its members (Dr Chickenblood, I was). After a quick morning prayer, the group regularly scuttles off at 5 am promptly, taking on the sleepy island of Singapore in its many permutations (mainly westwards or eastwards).

"LIFE IS LIKE RIDING A BICYCLE. IN ORDER TO KEEP YOUR BALANCE, YOU MUST KEEP MOVING."

Road cycling in Singapore offers the different aspects of Singapore not fully appreciated in other forms — a whiff of fresh grass (with the occasional piquancy from dung) along Kranji Countryside, the morning mist along Hort Park and sunrise along the Esplanade. Road cycling also offers great opportunities beyond our shores, being a year-round recreation that is arguably safer than skiing.

Cycling has been a great leveller: it narrows social schisms, inspires conversation and has taught me patience. It has had its harrowing moments and sacrifices, but as a wise man once said: "Life is like riding a bicycle. In order to keep your balance, you must keep moving".

Seeking fun riding up an active volcano — Mount Ijen in East Java

4C on the summit of Col du Tourmalet, during a yearly pilgrimage to the hallowed mountains of cycling

Fresh air up at Col d'Aspin in the French Pyrenees

Dr Magdalene Liau obtained her medical degree at University College Dublin in Ireland, in the year 2011. Since then, she has moved back to Singapore to be closer to home and family. She is currently pursuing the field of medical aesthetics, hoping to make it her eventual career path.

Top to Bottom

Photo taken with the trainers at a popular fitness facility known as Unit-27 in Phuket, Thailand

Group photo with friends after completing Singapore's first Spartan race event in November 2015

In Phuket, Thailand at a famous Muay Thai training camp, Tiger Muay Thai

I took up Muay Thai three years ago, learning from someone who has lived and fought in Thailand with ten professional fights under his belt. What initially piqued my interest was the gracefulness in which the fighters moved and the intensity of the sport.

Muay Thai may seem brutal to some: two guys in a ring pummelling the heck out of each other, hoping to come out of it intact. Yet in reality, you start with the basic techniques, working on the bags and pad work with a trainer. You'll also do countless push-ups, sit-ups and various other bodyweight exercises designed to leave you a trembling wreck. This, I speak from personal experience.

With all that said, I was hooked from the moment I started. My current fitness regime involves a combination of Muay Thai, circuit training and weightlifting four to five days a week. I also frequently travel to Thailand, the mecca of Muay Thai, to learn more on the art from the locals in dedicated training camps.

Contrary to what some people may think, I dislike running and thus, Muay Thai is the perfect form of cardiovascular exercise for me. It is a physically demanding full body workout that burns plenty of calories. Besides the cardiovascular benefits, it also improves mental sharpness as you are required to react quickly to instructions or to block kicks from your trainer, which has improved my coordination and reflexes tremendously.

To me, I think stress relief is one of the most important benefits that Muay Thai has offered. Due to the nature of our jobs as doctors, we accumulate a fair amount of stress during the day and having an outlet for that stress is fantastic. Let's face it, it feels good to vent and hit something after an upsetting day at work. Additionally, you can't occupy yourself with worry while training. Otherwise, you'll get hit in the face or mess up the drill you're working on in this fast-paced sport. I also believe that regularly doing an activity that detaches you from the daily grind helps you to be a happier and more carefree person.

"NEVER GET SO BUSY WITH MAKING A LIVING THAT YOU FORGET TO LIVE FOR YOURSELF."

From a girl who has mitral valve regurgitation and who used to repeatedly fail her 2.4 km run to someone who is able to do ten strict pull ups — I think I'm doing alright. I'm proud of how far I've come and the invaluable friends I've made along the way.

My two cents' worth for fellow colleagues is that life is about balance. Never get so busy with making a living that you forget to live for yourself. Pick up a hobby and get excited about life outside of work. You'll find that you'll be a better doctor for your patients.

Doing bent-over rows with weights

SMA EVENTS MAY – JUN 2016

DATE	EVENT	VENUE	CME POINTS	WHO SHOULD ATTEND?	CONTACT
CME Activities					
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
7 May Saturday	Cancer Education Series 2016 — Lung Cancer	Health Promotion Board Auditorium	TBC	Doctors	Carina Lee 6223 1264 carinalee@sma.org.sg
14 May Saturday	Mastering Adverse Outcomes	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
24 May Tuesday	Mastering Difficult Interactions with Patients	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
25 May Wednesday	Mastering Shared Decision Making	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
28 May Saturday	Achieving Safer and Reliable Practice	Orchard Hotel	2	Family Medicine All Specialities	Margaret Chan 6223 1264 margaret@sma.org.sg
29 May Sunday	BCLS	SMA Conference Room	2	Family Medicine All Specialities	Shirong or Huda 6223 1264 cpr@sma.org.sg
4 June Saturday	CMEP Health Law Seminar	Ng Teng Fong General Hospital Auditorium	TBC	Doctors and healthcare professionals	Carina Lee 6223 1264 carinalee@sma.org.sg
Non-CME Activities					
8 May Sunday	42nd SMA-Eagle Eye Centre Inter-Hospital Soccer Tournament	Home United Youth Football Academy	NA	SMA Members and Guests	Azliena Samhudi 6223 1264 liena@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

THANK YOU, OUR GP PARTNERS, FOR SUPPORTING CHAS!

By **Agency for Integrated Care**

To recognise and thank our General Practitioner (GP) partners for their continuing support for the Community Health Assist Scheme (CHAS), Agency for Integrated Care (AIC) and the Ministry of Health (MOH) jointly organised a CHAS Appreciation Lunch & Continuing Medical Education (CME) event on 5 March, 2016 at the Furama Riverfront hotel.

Into its third year, this year's theme was "Fostering closer working relations between GPs and Specialists". In line with the theme, the event aimed to encourage more collaboration with our GP partners in order to provide healthcare at the appropriate setting. A psychiatrist and two respiratory physicians from Tan Tock Seng Hospital (TTSH) not only shared clinical updates but also their experiences and efforts in right-siting care. A rheumatologist and a family physician also paired up to share case studies on co-managing a common group of patients.

To further show appreciation to the CHAS GPs this year, a special tribute video capturing CHAS GPs at work and their dedication in caring for CHAS patients was screened.

The event was graced by Guest of Honour Associate Professor Benjamin Ong, Director of Medical Services (DMS) at the MOH, as well as special guest Associate Professor Kenneth Mak, Deputy Director of Medical Services (DDMS).

In his opening address to the 100 GPs present, DMS affirmed the crucial role GPs play on the front line of Singapore's healthcare system, making them well placed to identify those at risk and follow up with regular consultations. "Primary care transformation is a major focus of the Ministry of Health, and rightly so," he announced. "GPs are key partners in this journey of care transformation, and CHAS is an integral part of our effort to help patients get under GPs' care for chronic disease management."

As CHAS complements the Chronic Disease Management Programme (CDMP), which offers CHAS subsidies to patients with chronic conditions, the scheme has made consistent and continuous care a lot more accessible, especially for the lower- to middle-income patients.

Introduced by the Ministry of Health in 2012 to make healthcare affordable and accessible for everyone, CHAS subsidises medical and dental treatments for lower- to middle-income Singaporeans, as well as Pioneer Generation (PG) citizens, at participating GP and dental clinics across the island. As of April 2016, there were more than 1,500 CHAS GP and dental clinics and about 1.4 million CHAS and PG beneficiaries.

But it is not only patients who benefit from CHAS.

According to Dr Toh Khai San of SATA CommHealth, CHAS has helped his organisation to be more deeply involved in eldercare. "We have a Doctors-on-Wheels programme, where we go to Senior Activity Centres to see patients on a regular basis," he explained. "Almost all of them are under CHAS. This makes our programme more sustainable because the government defrays some of the cost. It's very much welcome."

When asked if he would encourage other GPs to join CHAS, Dr Toh replied, "Yes, definitely. CHAS is very relevant, especially for those staying in housing estates and the suburbs. And also because of our demographic changes with the aging population."

Although many GPs in attendance readily agreed that they would recommend CHAS to fellow doctors, some who joined last year commented that it was an initially daunting process that was quickly made much easier by

Information booth set up by Tan Tock Seng Hospital at the event.

The CHAS team is always ready to assist you with your queries

the proactive assistance of the CHAS team. "There was a lot of paperwork, but the CHAS team actually came over and taught us the whole system. They're very responsive," remarked Asia HealthPartners Clinic's Dr Chong Yeang Chern, who joined CHAS in 2015 to better serve her PG patients.

For Dr Ow Boon Hin of Universal Medical Clinic, it was such an event that motivated him to sign up for CHAS. "What was really memorable was the networking. I got to talk to fellow GPs who had joined CHAS, which allowed me to clarify my doubts," he explained.

The event was also an excellent opportunity for the 100 CHAS GPs who attended to be kept updated about the various primary care initiatives. TTSH, Health Promotion Board and the Community Health Centres had information booths at the event to publicise their schemes and to sign interested GPs up for their programmes. Meanwhile, AIC had a booth to promote Primary Care Pages, Community Care- GP Partnership Training Award and the Mental Health GP Partnership Programme.

The GPs expressed their enjoyment of the event and shared that they found it useful. "Of course I would like to see this event happening again next year," said Dr Ow when asked if he would attend it again. Many other GPs also found the talks enriching, requesting for more material on various schemes. Within the day, TTSH received 18 leads from GPs who expressed a keen interest to tie up with the hospital.

Although CHAS has come a long way since 2012, AIC believes there is much more to be done, and will strive to get more GPs on board. AIC would like to express our appreciation to our GP partners for supporting CHAS over the years and for working closely with us to provide affordable and accessible healthcare to the community.

Special thanks to our distinguished speakers:

Dr Puah Ser Hon
Associate Consultant, Tan Tock Seng Hospital for the presentation on Updates on Asthma Management

Dr Albert Lim
Senior Consultant, Tan Tock Seng Hospital for the presentation on Updates on Asthma Management

Adjunct Assistant Prof Jaspal Singh Dhaliwal
Consultant, Tan Tock Seng Hospital for the presentation on Managing Depression in Primary Care

Dr Anita Lim
Senior Consultant, National University Hospital for the presentation on Managing Inflammatory Arthritis

Dr Tan Tze Lee
Senior Physician, The Edinburgh Clinic for the presentation on Managing Inflammatory Arthritis

What to Expect When Clinic Sign Up for CHAS

The CHAS team provides a hand-holding experience to each and every clinic, which means guidance every step of the way for a seamless integration of CHAS:

- A dedicated account manager to assist clinics in the CHAS application process
- On-site training for doctors and clinic assistants on the use of the CHAS Online portal for claims submission
- Regular information sessions on CHAS updates
- Support for any CHAS-related query through the CHAS hotline (6632 1199) during office hours

Contact us at **gp@chas.sg** if you would like to sign up as a CHAS clinic, or if you have any further enquiries

• SALE/RENTAL/TAKEOVER •

34 sqm Paediatric clinic for lease from June 2016. Shared overheads negotiable. Please call Ms Prunella 9626 7607.

SCM: Buy/sell clinics/premises: Takeovers: (1) D14, ind/HDB; (2) D21, High Turnover. Rental: (i) Holland, former 40 year HDB clinic space; (ii) Chai Chee ind, 1045 sq ft; (iii) D21, share with specialist, MRT. Sale: Mall Shop, D14. Kok Yein 9671 9602.

Clinic for rent. Prime next to lift, #06-01 Gleneagles Medical Centre. Immediate. 656 sq ft. Renovated. SMS 9680 2200.

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Abel Soh
Diabetes, Thyroid and Endocrine Clinic

Dr Abel Soh Wah Ek
MBBS (S'pore), MRCP (UK)

Dear Friends and Colleagues,

I have commenced private practice at Mount Elizabeth Medical Centre. I was previously consultant endocrinologist at Singapore General Hospital (SGH) as well as at Raffles Hospital.

I graduated from National University of Singapore (NUS) in 2000 and obtained MRCP (UK) in 2006. I pursued advanced specialist training in endocrinology and obtained my specialist accreditation in 2010. I was awarded the SingHealth HMDP Fellowship in Diabetes in Pregnancy at Joslin Diabetes Centre, USA, in 2010. In 2012, I received the Singapore Health Quality Service Gold Award.

Prior to leaving for private practice, I was actively involved in undergraduate and postgraduate teaching at SGH. I served as Adjunct Assistant Professor in Medicine at Duke-NUS Graduate Medical School and Clinical Senior Lecturer at Yong Loo Lin School of Medicine, NUS. I was also in the Core Faculty of the SingHealth Internal Medicine Residency program. In 2011, I initiated the pre-Ramadan counselling program for Muslim patients with diabetes in SGH. I am currently the Vice-President of the Singapore Association for the Study of Obesity (SASO).

Besides seeing patients with diabetes mellitus, thyroid disorders, lipid abnormalities, calcium and vitamin D disorders, osteoporosis, adrenal and pituitary disorders, and obesity, I subspecialise in managing women with endocrinological problems during pregnancy (e.g., gestational diabetes mellitus, thyroid disorders). I can perform ultrasound scan of the thyroid and ultrasound-guided fine needle aspiration biopsy of thyroid nodules for patients as well.

I look forward to working with you to provide comprehensive endocrine care for your patients.

Abel Soh Diabetes, Thyroid and Endocrine Clinic
Mount Elizabeth Medical Centre
3 Mount Elizabeth, #12-11, Singapore 228510
Tel: 6262 2008, Fax: 6262 2278
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On 16th March 2016, Farrer Park Hospital was officially opened by Minister for Health Gan Kim Yong. This occasion marks another milestone in the illustrious history of the area, Farrer Park.

Inpatient suites were displayed for guests to experience the machine-washable beds, the hotel chef and hospital nutritionist inspired patient meals and our Smart, Mobile and Interactive Table (SMIT) devices which allow patients to select their meals from a menu already customised to their dietary conditions. It also allowed them to do in-room shopping that will be delivered within 3 hours or items on Krisflyer that foreign patients can pick up planeside as they go home.

We were honoured to have Minister Gan speak about affordability in his speech as it mirrors Farrer Park's philosophy on value.

Farrer Park Hospital is officially opened on 16 March 2016.

A specially crafted 3-course brunch from our halal hospital kitchen gave guests a sampling of the food patients enjoy. Guests were brought on a 'tour' of our facility while seated in the ballroom. As Farrer Park Hospital was built with education in mind, fibre optic cabling and streaming capabilities allowed the seminar rooms, operating theatres and hotel cooking studio to be beamed live.

"Farrer Park Hospital provides a fertile environment to reimagine private healthcare, so as to enhance medical care, service quality, professional integrity and value." Professor Maurice Choo, Chairman of Farrer Park Hospital

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To check on your eligibility and queries for the Cashless service, please contact Parkway East Hospital Admission / Business Office at (65) 6340 8600.

^ Figure drawn from article: Salma Khalik, 'Health coverage: Are you overinsured' (The Straits Times, Jan 23, 2014), yourhealth.asiaone.com

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