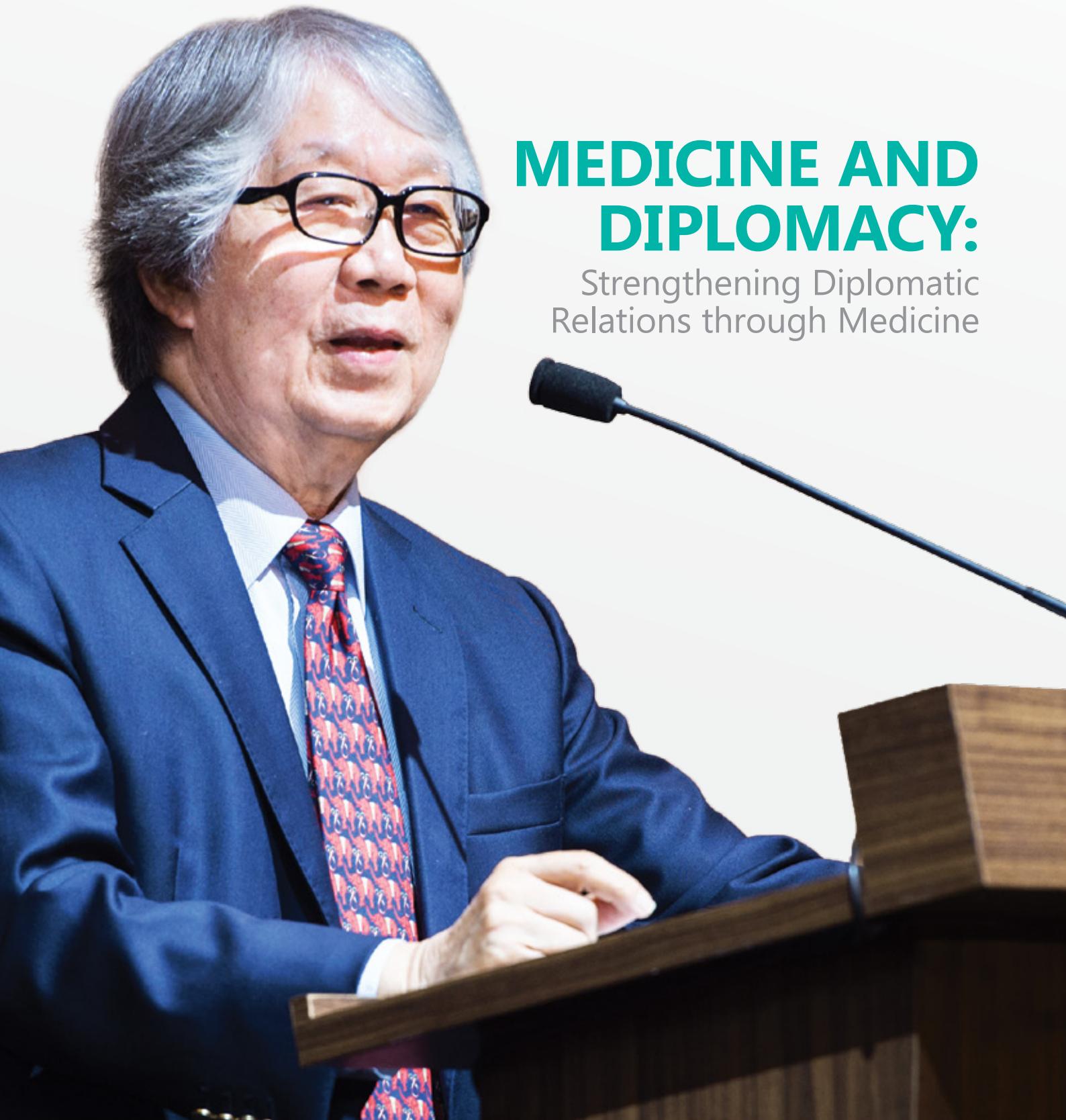


SMA NEWS



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MEDICINE AND DIPLOMACY:

Strengthening Diplomatic
Relations through Medicine

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Li Li Loy

Denise Jia

Tel: (65) 6223 1264

Email: adv@sma.org.sg

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>

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diplomacy

noun; di•plo•ma•cy / dɪˈplɒməsi /

The art of dealing with people in a sensitive and tactful way

This issue focuses on Medicine and Diplomacy. All of us could probably fill reams of pages with anecdotes of instances where we had to use the full force of our “diplomatic prowess” in our day-to-day work. Some of us do it better than others, that’s for sure. But diplomacy in medicine goes beyond nicely asking our colleague to do something for us, or smoothing out tensions between us and our patients, fellow healthcare professionals or the admin people upstairs.

Prof Tommy Koh summed it up aptly in the SMA Lecture given on 7 November 2015: “You can’t be a good doctor or a good diplomat if you don’t like people”. How else could we, whose very profession centres on the care of people, be doctors?

For those who missed the lecture, the full script of Prof Koh’s lecture on Medicine and Diplomacy, as well as the citation for Prof Koh delivered by Prof Cheah Jin Seng, can be found in this edition of the *SMA News*. On a related note, the President’s Forum by Dr Wong Tien Hua also touches on the reasons doctors should partake in providing humanitarian aid to the needy.

In Council News, Dr Daniel Lee reports on the World Medical Association meeting in Moscow, which focused on Medical Education. This issue also contains highlights of the well-received Medico-Legal Seminar on Mental Capacity held on 17 October 2015. Continuing with part 2 of his article on Family Medicine Clinics, Dr Leong Choon Kit makes a thoughtful argument on the need for GP super clinics and the current barriers our local healthcare system needs to overcome to make the concept a reality.

As part of our issue’s theme, we feature an opinion piece from an anonymous Patient X, who details his admission experience with delicate honesty – a key component of diplomacy, I must say. We also include a professionalism article by Dr Lee See Muah and Dr Seow Wan Tew, on informed disclosure by different healthcare providers.

This being the Christmas season, and to take our minds off the more serious topics, we feature an Indulge article by Dr Tan Su-Ming on her travels to Mongolia and a humorous guide to growing a medical beard by Dr Pinakin V Parekh. Read on to find out more.

I wish each and every one reading this issue a delightful Christmas and a wonderful 2016.



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
Editor

SMA LECTURE



2015

PROFILE

TEXT BY

SYLVIA THAY

Editorial Executive

What do a plate of chicken rice, writer Joseph Conrad and the Russian Kremlins have to do with SMA Lecture 2015? Apparently, they all contributed to spice up Professor Tommy Koh's lecture on Medicine and Diplomacy, held on 7 November 2015 at One Farrer Hotel & Spa.

The afternoon's programme commenced with the welcome address delivered by Dr Wong Tien Hua, President of SMA, to an audience of close to 100 doctors and healthcare professionals. In his speech, Dr Wong introduced the exhibition, *Humanity in Medicine – A Look at the Past and Forward to the Future*, put up by Lee Kong Chian School of Medicine at the hotel foyer, before sharing his take on the importance of participation in humanitarian missions. Following the welcome address, Prof Cheah Jin Seng, Emeritus Consultant Endocrinologist from National University Hospital and a long-time friend of Prof Tommy Koh, delivered the citation for Prof Koh (see page 7).

Prof Tommy Koh started his lecture with a humorous story of how he came to be the SMA Lecturer, after accepting an invitation to a "free" lunch of chicken rice. This drew laughter from the audience, who quickly warmed up to our lecturer, attesting to his exceptional diplomatic skills. In his lecture, Prof Koh shared several personal

anecdotes, including his close encounter with the Russian Kremlins and how the plaque to honour the Polish writer Joseph Conrad came to be installed at Fullerton Hotel, to illustrate the five main thrusts of his lecture. He concluded by reiterating the important role that doctors play in promoting Singapore's good relations with our ASEAN neighbours and the world. (For the full text of Prof Tommy Koh's lecture, please refer to page 9.)

Following the lecture, a panel consisting of Prof Tommy Koh, Dr Benjamin Seet, Executive Director of the Biomedical Research Council, A*STAR, Dr Vivien Lim, a Specialist in Endocrinology from Gleneagles Medical Centre, and moderator Dr Toh Han Chong, took to the stage for a Q&A session.

During the panel discussion, many thought-provoking and interesting questions were raised, to which the



Legend

1. Dr Wong Tien Hua delivering his welcome address
2. Dr Toh Han Chong, emcee and moderator for the afternoon
3. The Humanity in Medicine — A Look at the Past and Forward to the Future exhibition
4. Group photo of SMA Council members with Prof Cheah and Prof Koh
5. Dr Tan Lai Yong offering his opinion during a query
6. The panellists for the afternoon's discussion
7. Dr Geh Min raising a query during the panel discussion
8. Participants listening attentively during the lecture



panellists discussed with enthusiasm and candour. One concern raised was the management of diversity in local healthcare and the allocation of places for foreigners in our medical schools, to promote cross-cultural relations. In Prof Koh's opinion, it is beneficial to maintain diversity in our healthcare environment. However, he also admits that it is challenging to maintain an optimal ratio of local and foreign students in institutions of higher learning amid growing pressure from Singaporean parents.

On the trade-offs and risks associated with participating in overseas humanitarian missions, Dr Benjamin Seet shared that,

although some have viewed his decision to join the public service as career suicide, he has no regrets, for he has had the opportunity to see the world and pursue his desire to serve on medical missions with the SAF Medical Corp. He opined that the few years one gives up is insignificant in light of the longevity (60 to 70 years) of one's medical career, to which Dr Vivien Lim wholeheartedly agrees. Dr Lim further shared that she has been fortunate to have supportive colleagues who held the fort in Singapore while she was on her numerous overseas mission trips. Both Dr Seet and Dr Lim also assured the audience that they had never been exposed to dangerous situations

during their overseas missions, as the organisations they served with place high priority on the safety of their volunteers and medical teams.

By 5 pm, the panel discussion drew to a close with a final comment from Prof Tommy Koh on the potential of Singaporeans as a whole to do good and to triumph over evil, not only in our society, but also in our world.

The SMA Council thank Prof Tommy Koh, Prof Cheah Jin Seng, our panellists and participants for making SMA Lecture 2015 a successful and enriching one. ♦

DIPLOMAT EXTRAORDINAIRE

CITATION FOR PROF TOMMY KOH



It gives me great pleasure to read this citation for Prof Tommy Koh, a trusted friend of many years. I prepared this citation by first reading his CV, supplied by the organiser of this lecture; it was far too long to fit a 15-minute citation. Next, I googled for information on Prof Tommy Koh; it turned out to be far longer than his official CV. Finally, I consulted some of the books that Tommy has published: one of his latest books *Over Singapore* (2015) provided me with a helpful summary of his credentials.¹

Prof Tommy Koh was born in Singapore in 1937. He attended Raffles Institution and received an Entrance Scholarship to study Law at the University of Malaya, Singapore. In 1961, he graduated with an LLB (First Class Honours) degree from the University of Malaya. He served his Law Pupilage with the famous lawyer David Marshall.

His diplomatic career began in 1968 when he was appointed Singapore's Permanent Representative to the United Nations, New York, USA.

Professor Koh is currently Ambassador-at-Large, Ministry of Foreign Affairs; Professor of Law, National University of Singapore (NUS); Chairman of the Governing Board of the Centre for International Law and Rector of Tembusu College at NUS. He is also Co-Chairman of the China-Singapore Forum, the Indian-Singapore Strategic Dialogue and the Japan-Singapore Symposium.¹ His current CV lists many other positions that he holds.

Prof Koh was Singapore's Permanent Representative to the United Nations

in New York for 13 years. He was Ambassador to the United States of America for six years. He was the Dean of the Faculty of Law of NUS. He was also the President of the Third UN Conference on the Law of the Sea. He chaired the Preparatory Committee for and the Main Committee at the Earth Summit. He has served as the UN Secretary-General's Special Envoy to Russia, Estonia, Latvia and Lithuania. He was also Singapore's Chief Negotiator for the US-Singapore Free Trade Agreement. He has chaired two dispute panels for the World Trade Organization.

In 1984, Prof Koh was conferred the Yale University Honorary Degree of Doctor of Laws. He received the Elizabeth Haub Prize for Environmental Law in 1996 and was made a Champion of the Earth by the United Nations Environment Programme (UNEP) in 2006. He also received the Great Negotiator Award 2014 from Harvard University on 10 April 2014.

He has been decorated by the Government of Singapore with the Public Service Star (1971); the Meritorius Service Medal (Pingat Jasa Gemilang) (1979); the Distinguished Service Order (Darjah Utama Bakti Cemerlang) (1990) and the Order of Nila Utama (First Class) (2008).

For his services in international diplomacy, he has been decorated by several Heads of States and Governments: he was appointed Commander in the Order of the Golden Ark by HRH Prince Bernhard of the Netherlands (1993); awarded "the Commander, First Class, of the Order of the Lion of Finland" by the President of Finland (2000); conferred the rank of Officer in the Order of the Legion of Honour by the French President (2001); bestowed the Encomienda of Isabella la Catolica by King Juan Carlos of Spain (2004), etc.

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While Professor Koh's brain is that of a diplomat, his heart belongs to a medical doctor; he married Siew Aing in 1967. Siew Aing graduated MBBS from NUS. Behind a successful man is a successful woman: Prof Koh acknowledged that his wife had helped diplomatically when he was Singapore's fourth ambassador to the USA.²

Prof Koh's interest in medicine began early. In the 1960s, he led a debating team against a team led by Prof Tow Siang Hwa (my teacher in Obstetrics & Gynaecology at NUS) on the motion, "Therapeutic Abortion should be adopted as a method of Population Control".³ Prof Koh lost the debate but he was voted the best speaker. Prof Tow wrote: "Prof Koh is 'Singapore's best known overseas representative' and 'his hospitality caused even the winter snow to melt'".³

The very successful and happy life of Prof Koh as a career diplomat and family man is based on eight principles, which guided his life: Love Singapore; Love the World; Love Family; Make Friends for Life; Do Not Worship Money; Be Kind; Be Loyal and Be Healthy, and Be Rich Culturally.⁴

I hope I have convinced my audience that Prof Tommy Koh is not only a renowned diplomat extraordinaire but also a doctor "at heart". He is thus in a unique position to deliver this 2015 SMA Lecture on "Medicine and Diplomacy". ♦

PROFILE

DELIVERED BY

PROF CHEAH JIN SENG

*Emeritus Consultant,
Endocrinologist,
National University
Hospital*

Legend

1. Prof Cheah Jin Seng, Prof Tommy Koh and Dr Wong captured during the presentation of token of appreciation

MEDICINE AND DIPLOMACY

DELIVERED BY PROF TOMMY KOH



SIMILARITIES BETWEEN DOCTORS AND DIPLOMATS

I shall begin with my first point, which is that doctors and diplomats share some common traits and values. You can't be a good doctor or a good diplomat if you do not like people. To succeed in our professions, we must have empathy for people. We must have an open mind and be willing to treat people of different races, colours, religions and cultures with respect and as fellow human beings. To be a good doctor, you have to establish a rapport with your patient and gain his trust and confidence. The doctor-patient relationship becomes dysfunctional when the patient dislikes his doctor or has no confidence in him. I have no empirical evidence to support

my hypothesis that a patient's positive attitude towards his doctor contributes a significant percentage to the success of the healing process. My hypothesis is that a patient's trust in his doctor is a key to recovery.

In a similar way, a good diplomat is able to establish a rapport with his interlocutor. He should try to raise the level of their relationship to one of friendship, based upon mutual trust and confidence. I have undertaken many negotiations on behalf of Singapore and the United Nations (UN). In all cases, I had tried to establish a warm relationship with my counterpart or interlocutors. This was particularly challenging when I was chairing the UN Conference on the

Law of the Sea (1981 to 1982) and the Earth Summit (1990 to 1992), because they involved so many participating countries. However, I could not have pushed through some very tough decisions if I had not gained the trust of the conference participants.

Breakthrough in Moscow

Diplomats, unlike doctors, are a pretty cynical group of people. They have become cynical because they have seen so much evil and unprincipled policies and actions by states. Also, unlike doctors, diplomats are professional nomads and have to relocate themselves and their families every few years to a different country. In view of these facts, it would be reasonable to conclude that diplomats do not make good friends. This is, however, not the case.

Ambassador Tom Pickering

I want to tell you a story that I have never told in public before. In 1993, the then UN Secretary-General, Dr Boutros Boutros-Ghali, had appointed me as his Special Envoy to undertake a peace mission to Russia, Estonia, Latvia and Lithuania. Towards the end of my mission, I called on an old friend in Moscow, Ambassador Tom Pickering of the United States. I briefed him on my discussions in Moscow, Vilnius, Riga and Tallinn. He told me that, in Moscow, power was concentrated in

the Kremlin and it was essential for me to have access to someone on the personal staff of President Boris Yeltsin. I told Ambassador Pickering that I had made a request to do so through the UN and the Singapore Embassy but was unsuccessful. He told me that he would help me, and he did. As a result, I was able to meet with a senior member of the President's staff inside the Kremlin. I briefed him on my meetings in the four capitals and the compromises that I intended to propose in my report to the UN. I then requested him to convey my respect to President Yeltsin and pleaded for his support.

REGIONAL MEDICAL CENTRE

I want to go on to my second point, which is Singapore's role as the medical centre of the region. No one could dispute the fact that Singapore is the most advanced medical centre in Southeast Asia and perhaps, the whole of Asia. A few years ago, a good friend from Iran, who lives in Hiroshima, needed surgery for a medical condition. Her Japanese doctor in Hiroshima recommended that she should seek treatment either in the US or Singapore for her condition. She chose to come here.

Many of our region's leaders come to Singapore for their annual medical check-up. When they fall ill, many of them have chosen to come here for treatment rather than go to the West. The high standing of our doctors and hospitals and the excellent care and services that they provide to patients in the region bring credit to Singapore. It adds to our brand equity and soft power. It is good for our diplomacy with the region. We must never allow our love for money to undermine our reputation for integrity and trustworthiness.

SINGAPORE AND WHO

Thirdly, I want to talk about Singapore's relationship with the World Health Organization (WHO). WHO is the UN's specialised agency for global health. In the year 2000, WHO ranked Singapore 6th out of 191 countries on overall health system performance. WHO has designated ten of our institutions as WHO Collaborating

Centres, one of the highest in the Asia-Pacific region. These are research institutes belonging to universities or academies that have been designated by WHO to carry out activities in support of its programme.

SARS

In 2003, Singapore and several other countries in the region were hit by SARS. Singapore worked closely with WHO and the Centre for Disease Control of the United States to overcome the crisis. The two big lessons we learnt from that crisis were the importance of transparency and international cooperation. In 2006, Singapore was elected to the Executive Board of WHO for a three-year term. My dear friend and colleague, the late Dr Balaji Sadasivan, was elected chairman of the board from 2007 to 2008. His untimely passing from colon cancer was a great loss to Singapore.

Other Singaporeans, such as Dr Vernon Lee and Mr David Ho, have also made significant contributions to the work of WHO. Dr Lee is currently the Head of the Singapore Armed Forces (SAF) Biodefence Centre. From 2007 to 2008, Dr Lee was a medical epidemiologist working on avian influenza response and pandemic preparedness in the WHO office in Indonesia. From 2010 to 2012, he worked with WHO in Geneva, leading its work on global health collaborations and pandemic preparedness. I will not talk about Mr David Ho's work because he is not a doctor.

HUMANITARIAN MEDICAL MISSIONS

Fourth, I want to refer to the fact that many Singaporean doctors, dentists, nurses, therapists and other allied professionals regularly go abroad on humanitarian medical missions. I was privileged to have been invited to deliver the keynote speech at the inaugural international conference on Humanitarian Medical Missions, held on 30 October 2014, at the Singapore General Hospital.

In my speech, I praised the work of four of our institutions, namely the

Singapore International Foundation (SIF), the SAF, the Singapore Red Cross Society and Mercy Relief. To date, SIF has undertaken 76 healthcare projects in 14 countries. SAF has a tradition of sending medical teams to help in emergency situations. The Singapore Red Cross Society and Mercy Relief have also despatched volunteer medical teams to help in humanitarian emergencies.

I am proud to say that our public hospitals also support volunteerism as part of their corporate social responsibility. Members of the staff are encouraged to volunteer their time in both local and international projects. A staff member is allowed to take 14 days of volunteer leave if it is to participate in an approved project. In 2011, KK Women's and Children's Hospital (KKH) won the award for the Public Sector Volunteer of the Year, given annually by the National Volunteer and Philanthropy Centre.

Champion volunteers

In that same speech, I also praised four of my doctor friends who are champion volunteers. They are Prof Lee Seng Teik of SGH, Prof Anantharaman Venkataraman (Prof Anantha) of SGH, A/Prof Annette Jacobsen of KKH and Dr Tan Chi Chiu, a private practitioner.

Prof ST Lee is a highly skilled plastic surgeon and educator. In the past 22 years, he has led or participated in 22 volunteer missions to ASEAN countries and China. In recognition of his contributions, he received the SIF Award from President SR Nathan in 2006.

Prof Anantha is another veteran volunteer. He was the leader of a highly successful SIF project to enhance emergency medical services in Malang, Indonesia. The project lasted seven years and involved 96 volunteers from Singapore, who visited Malang on 17 training visits. The project benefited the Faculty of Medicine of the Saiful Anwar Hospital, the Faculty of Medicine of the Brawijaya University and the Provincial Health Department of East Java. Prof Anantha is currently leading a team from SingHealth, on a

two-year project, to set up a Disaster Medical Training System in Makassar, Sulawesi, Indonesia.

A/Prof Anette Jacobsen is a paediatric surgeon at KKH. In 2001, she went on her first volunteer mission to Cambodia and was hooked. Since then, she has been on over 20 missions to four ASEAN countries. She volunteers with SIF, the Temasek Foundation and the Tzu Chi Foundation of Taiwan.

Dr Tan Chi Chiu is an eminent gastroenterologist in private practice and a former director of SIF. He is one of our most experienced volunteers. Between 1986 and 2013, he participated in 14 humanitarian medical missions, in 12 of which he was the leader or medical director. Dr Tan believes that Singapore can do more and should benchmark itself against Japan and South Korea. He proposes the creation of a national network and resource of medical volunteers, which could then support the relief missions of all organisations that need medical teams.

People-to-people diplomacy

What is the significance of medical volunteerism to Singapore's diplomacy, especially with the ASEAN countries? We live in a world that is full of misunderstanding and suspicion. Medical volunteers help to promote better mutual understanding between Singaporeans and the peoples of other countries. The work that our doctors, dentists, nurses, therapists and other allied professionals do on medical missions is invaluable. Action speaks louder than words.

FRIENDSHIP BETWEEN CHINA AND SINGAPORE

Fifth, and finally, I want to talk about the contributions of three Singapore doctors to friendship between China and Singapore. The three doctors are the late Prof Arthur Lim Siew Ming, Prof Lim Yean Leng and Dr Tan Lai Yong.

Prof Arthur Lim was an eminent ophthalmologist, a visionary and a man of action. He was the founding director of Singapore National Eye

Centre. In the 1980s, he led a major campaign in China to control mass cataract blindness. He advocated the use of intraocular lens implant to restore sight. He founded the International Intraocular Implant Training Centre in Tianjin, which, in 1986, became the Tianjin Medical University Eye Centre. Prof Lim established the Xiamen Eye Centre in 1997. He also established eye centres in three other provinces: Shandong, Gansu and Ningxia. In 1996, the Chinese Government conferred on Prof Lim the Friendship Award, which is the highest award presented to a foreign national.

Prof Lim Yean Leng is an eminent cardiologist and the former director of the National Heart Centre in Singapore. In 1995, he was invited to visit Xiamen by his mother's primary school classmate. At that time, Xiamen University, which was founded by Singaporean Tan Kah Kee, had no medical school. As they say, one thing led to another and Prof Lim was appointed as the Dean of Xiamen University's new Medical College, as well as Head of the Heart Centre. The new medical school opened a year later, in 1996. Prof Lim served as the Dean for five years, setting up the Medical School, Heart Centre and Emergency Centre. He leaves behind a proud legacy. Today, the medical faculty of Xiamen University is one of the largest and most comprehensive medical schools in China. There are 1,500 undergraduates and 200 postgraduate students at the school.

Fujian-Singapore Friendship Polyclinic

Before moving on from Xiamen, I want to record the fact that due to the vision and leadership of our former Consul-General in Xiamen, Ms Tee Bee Lock, we have the Fujian (Xiamen)-Singapore Friendship Polyclinic. The polyclinic was co-funded by donations from the Singapore private sector and the Xiamen Municipal Government. An eminent Singapore architect, Liu Thai Ker, designed the building on a pro bono basis. The Temasek Foundation funded the training of 110 medical personnel from Fujian,

on a "train the trainers" programme. The polyclinic has successfully incorporated and implemented Singapore's health management strategies in its operation.

The third doctor I want to refer to is Dr Tan Lai Yong. In 1996, Dr Tan accepted a one-year assignment to join a commune in Yunan province, to train its ethnic minority community in basic medical practice. His one-year assignment became a 15-year epic. He and his family lived humbly with the local people and won their hearts. He treated the poor, the orphaned, the disabled and the leprosy. In addition to treating the locals, Dr Tan also began a tree-planting programme, started a mobile library for children and spearheaded other projects to benefit the people he lived with and served.

In 2004, the Government of China conferred on Dr Tan the Friendship Award. In 2007, Yunan TV conferred on him the Good Citizen of Kunming Award. Dr Tan is now back in Singapore and inspiring the students of the College of Alice and Peter Tan at NUS.

CONCLUSION

I shall conclude. As doctors, you are probably unaware that, directly or indirectly, many of you have been helping to promote Singapore's good relations with our ASEAN partners or the wider world. You do so when you do a good job in treating a foreign patient. You do so when you go on a humanitarian medical mission. You do so when you work with WHO or other kindred institutions. You do so if you, like Prof Arthur Lim, Prof Lim Yean Leng and Dr Tan Lai Yong, use your knowledge, expertise and network to help the people of another country, such as China. ♦



Illustration: Dr Kevin Loy



**HUMANITARIAN AID –
WHY WE SHOULD
GO OUT OF OUR WAY
TO HELP OTHERS**

I was very delighted to have attended Prof Tommy Koh's SMA Lecture entitled "Medicine and Diplomacy" on 7 November 2015 at One Farrer Hotel & Spa. Prof Koh spoke highly of the work that individual doctors do when they go on humanitarian missions, and gave real-life examples of members from our medical community. As doctors, our individual actions matter to the collective effort, sometimes in unexpected ways. By seeking excellence in our own fields of practice, we can enhance Singapore's diplomatic efforts through medicine – as a form of soft power.

The theme of the SMA Lecture is part of SMA's contribution to the SG50 celebrations and a fitting conclusion to this year's activity-packed calendar for the Association. As we enjoy the year-end festivities and take time off from our busy schedules, it is perhaps timely to think about how we can use our skills and expertise for the betterment of people in need who are beyond our own horizons.

Doctors enjoy one of the highest levels of job satisfaction among professionals, and it is not difficult to understand why. We help people directly, whether to cure, care or comfort. The ability to see someone through from illness to health, relieve suffering and build deep relationships with patients is unique to the medical profession. It gives doctors the energy and impetus to deal with a lifetime of challenging work.

There is no shortage of work for doctors in Singapore. Our society is ageing rapidly; our patients fall ill, grow old and frail, and develop chronic diseases that require medical expertise. Indeed, there is much demand for medical care and services within our healthcare system, as well as in community hospitals, charity institutions and voluntary welfare organisations.

Given the great need on home soil, why would doctors desire to venture to distant shores, into difficult or hostile terrain while risking personal safety, to render medical assistance under suboptimal conditions? Are

some of us akin to adrenaline junkies looking for the next level of medical high when we seek to treat patients in a disaster zone?

I know many friends and colleagues who have gone for humanitarian missions and their reasons are anything but that. Some do it to challenge their personal limit, others have an altruistic desire to help the neediest of the needy in times of crisis, while some see these missions as opportunities to make a visible difference in the lives of others.

The act of responding to such calls for urgent help in times of crisis is an articulation of the moral obligation to do that which is *good* and *right*.

Morality and moral actions fall under the branch of philosophy known as ethics. In this sense, our exposure to medical ethics supports the concepts and endeavours of humanitarian missions. As doctors, we understand and hold dearly the primacy of patient autonomy – to treat each patient as an individual worthy of self-determination. We believe that every life has intrinsic value and is worth saving. We act in the best interests of our patients, vow to do no harm and to seek justice for all. Therefore, all patients deserve the same level of care regardless of where they are situated.

When doctors reach out beyond the comforts of our society to go on humanitarian missions, they transcend physical and societal boundaries, and acknowledge that humanity as a whole is one global family.

Finally, the common thread that links the experiences behind every medical mission is not just what the doctors give of themselves, but what they gain personally from the experience.

In the May 2015 issue of *SMA News*, second year Yong Loo Lin School of Medicine student, Hargaven Singh Gill, described his experience of helping HIV-positive children when he was in Nepal in December 2014. He wrote, "Sometimes it was hard to put ourselves in their shoes, because

we couldn't comprehend the pains and rejections they faced from their society. ... It's the reason for what we do that provides us strength, and it is in the middle of these people, that I regained some understanding of my purpose in the medical profession."

In the October 2015 issue of *SMA News*, LTC (Dr) Adrian Tan described his experience of leading the SAF medical mission to Nepal after the devastating earthquake in April of the same year. He wrote, "While we go on a mission to render assistance, often the mission leaves us richer from the experience. The very people we helped also taught us lessons in resilience, courage and generosity."

The purpose of humanitarian aid is to save lives, reduce suffering and show respect for human dignity. There is no better person trained to do this than the medical professional. In the course of this work, doctors, through their acts of compassion, sympathy and love for humanity, ultimately learn to become better doctors. ♦

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.



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66TH WMA GENERAL ASSEMBLY

The World Medical Association (WMA) is an international organisation representing physicians, and their mission is to serve humanity by endeavouring to achieve the highest international standards in medical education, medical science, medical art and medical ethics, and healthcare for all people in the world. There is a total of 112 members in the WMA comprising national medical associations (NMAs) and constituent bodies, including the SMA.


The 66th WMA General Assembly and the 201st/202nd Council Sessions of the WMA were held from 14 to 17 October 2015 at the World Trade Centre, Moscow, Russia. Delegates from close to 60 NMAs attended the meeting. One of the issues discussed was medical education, where Prof David Gordon, President of the World Federation for Medical Education, presented observations on the global trends of medical education. He explained that the number of medical schools has been increasing, according to records by the World Directory of Medical Schools, but there has been a mix of both well-planned and chaotic growths in different regions. He opined that the use of standards to accredit medical schools is of high importance, thereby

sparking discussions on the role of national governments and agencies in accrediting medical schools in their respective countries.

Prof Sir Michael Marmot, Director of the Institute of Health Equity at University College London and former President of the British Medical Association, presented the social determinants of health and championed the notion that every sector is a health sector; he gave an example where level of education is associated with higher life expectancies, lower obesity levels, less smoking and less early childhood developmental disorders.

At the General Assembly, Prof Sir Michael Marmot was installed as president of the WMA for 2015/2016. In addition, the WMA's policy on the Social Determinants of Health was retitled the Declaration of Oslo on Social Determinants of Health. The 66th General Assembly also adopted the WMA Resolution on the Bombing of the Hospital of Medecins Sans Frontieres in Kunduz, Afghanistan, the WMA Resolution on Global Refugee Crisis, and the WMA Resolution to Stop Attacks Against Healthcare Workers and Facilities in Turkey. In addition, the WMA called

PROFILE



TEXT BY

**DR DANIEL
LEE HSIEN CHIEH**

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.

for a series of measures to improve physicians' well-being. The medical profession often attracts highly driven individuals with a strong sense of duty and who are subject to high expectations from patients and the public. These expectations can contribute to physicians prioritising the care of others over that of self, and inadvertently developing feelings of guilt and selfishness for managing their own well-being. The WMA urged for better wellness promotion and prevention strategies, and earlier intervention to help lessen the severity of mental and physical illnesses among practising physicians and physicians in postgraduate education. ♦



Photo: WMA

PROFILE



TEXT BY

**DR DANIEL
LEE HSIEN CHIEH**

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.

HIGHLIGHTS

FROM THE HONORARY SECRETARY

**MOH GUIDELINES ON
PROVISION OF EST**

On 5 March 2015, the Ministry of Health (MOH) sought feedback from SMA regarding the draft Licensing Terms and Conditions (LTCs) on the Provision of Electrocardiography Stress Testing (EST). SMA consulted with several senior cardiologists and provided the feedback from our members on 5 May 2015. The concern raised was on the liability of doctors who do not proceed with EST based on pre-test probability scores, in accordance with the LTCs, only to have the patient suffer adverse outcomes (eg, major heart attack) that might have been picked up during EST.

MOH replied via email on 10 June 2015 that it will support the doctor who acted in compliance with the LTCs, in the scenario as stated in our feedback. The LTCs were recently amended as Guidelines and SMA received the latest draft Guidelines on 12 October 2015.

SMA reiterated our members' feedback in a reply on 5 November 2015.

**FITNESS TO DRIVE –
HEAVY VEHICLE DRIVERS**

Since July 2014, the Traffic Police and MOH have sought consultation with SMA on the certification of heavy vehicle drivers for fitness to drive. SMA met with MOH on 6 October 2015 and after several rounds of consultation, our final recommendations were submitted to MOH on 12 November 2015.

**FEEDBACK ON MANAGED
CARE SUBMITTED**

Following feedback from SMA members, SMA wrote to Central Provident Fund Board, Life Insurance Association (LIA), Monetary Authority of Singapore and MOH to highlight concerns relating to the market conduct of a managed care organisation and an insurance company. LIA has responded with an explanation from the insurance company. LIA and SMA are also proceeding with further stakeholder discussions on related matters. ♦

SMA EVENTS JAN – APR 2016

DATE	EVENT	VENUE	CME POINTS	WHO SHOULD ATTEND?	CONTACT
<i>CME Activities</i>					
24 January Sunday	BCLS Course	Alumni Medical Centre	TBC	Family Medicine and All Specialties	Lin Shirong 6223 1264 shirong@sma.org.sg
19 March Saturday	Medical Expert Witness Training	Academia	TBC	Doctors	Carina Lee 6223 1264 carinalee@sma.org.sg
9 April Saturday	Medical Expert Witness Training	State Courts	TBC	Doctors	Carina Lee 6223 1264 carinalee@sma.org.sg



MEDICO-LEGAL SEMINAR ON MENTAL CAPACITY

TEXT BY

CARINA LEE

Executive, Centre for Medical Ethics & Professionalism (CMEP)

Legend

1. Posing for a group photo after the event

Do you find medical report writing and legal jargons challenging? On 17 October 2015, more than 100 medical practitioners cleared their doubts by attending the Medico-Legal Seminar on Mental Capacity – Assessment & Report Writing for Doctors.

The Mental Capacity Act (MCA) was passed by Parliament in 2008 and came into effect in 2010. This is an area where the practices of law and medicine are required to work together in serving the person's best interest. Generally, doctors find medico-legal work burdensome, as this is an area of educational deficit in the regular medical education, both in the undergraduate and postgraduate medical education.

Speakers with extensive amount of experience in both medical and legal areas helmed the day's topics and imparted valuable content to the participants. Topics covered included "Overview of Mental Capacity Assessment for Doctors", "Understanding the Family Court Workings" and "The Medical Reports – A Practical Exercise", conducted by A/Prof Goh Lee Gan, Dr Colin Tan and Ms Lim Hui Min, respectively.

Based on feedback from participants, the highlight of the seminar was the medical report writing exercise. Many lauded the "innovative and effective" teaching style and found the exercise "useful and informative". The segment was strategically planned to encourage participants to apply what they have learnt from the seminar. They were tasked to write a medical report after watching a video clip of the enactment of a medical consultation. Thereafter,

model answers and tips were shared during an interactive discussion. The participants were also given a step-by-step tutorial on how to fill in the medical report for MCA application. Additionally, they were provided with specific examples on the different types of mental assessment tests and how to give evidence to support medical conclusions.

The seminar concluded with a panel discussion on "Mental Capacity Act, Lasting Power of Attorney (LPA) Certification and Mental Capacity Assessment", chaired by Dr T Thirumoorthy. The panellists consisted of A/Prof Goh Lee Gan, Dr Colin Tan, Ms Lim Hui Min, Ms Sumytra Menon and Dr Ooi Chun How. Intriguing queries were raised for the panel, stimulating an engaging examination of issues pertaining to mental capacity. Questions raised included "How do you assess the mental capacity of a patient who is born without full mental capacity?", "Should the doctor be the one who ensures there was no coercion leading to making an LPA?" and "In what ways

is making a will the same or different from the MCA and LPA?".

The responses from the panel covered both legal and medical considerations. As such, participants were able to understand the gravity of the issues from the perspectives of both a doctor and a lawyer. Quoting Dr T Thirumoorthy, "Medicine is filled with ambiguity and uncertainty. Hence, obtain as much information as possible to help make a decision. Weigh the facts before making your medical judgement and defend the decision with written reasons in your medical report."

The overwhelming participation rate and positive feedback are very reassuring; it affirms that the content taught is relevant and useful for medical practitioners. This is another milestone for the SMA CMEP as we continue to strive along our motto – "For Doctors, For Patients." ♦



PROFILE

TEXT BY

JENNIFER LEE

*Deputy Manager,
SMA Charity Fund*

Legend

1. Dr Lim Kheng Choon
2. Dr Noorul Fatha As'art
3. Maria Noviani with her poster presentation at the 11th International Congress On Systematic Lupus Erythematosus

2015

SMACF YEAR IN REVIEW



It has been a momentous year for SMA Charity Fund (SMACF). We are truly heartened by the support received from the medical profession thus far. This year, we anchored several key programmes, and some of our bursary recipients have completed their medical studies and are moving on to the next phase in their pursuit of medicine.

In 2015, SMACF received full National Council of Social Service membership and inclusion into the Care & Share movement by Community Chest, the latter allowing for approved donations to be matched by the Government. These memberships have enabled SMACF to partner other stakeholders to enlarge our social impact and further our causes. We also appointed two new directors, Dr Lim Kheng Choon and Dr Noorul Fatha As'art, as directors of the SMACF Board in July this year. This appointment will ensure that there is continuity and succession planning for SMACF. Both Dr Lim and Dr Noorul also serve on the SMA Council.

SMACF has a long journey ahead as we strive towards developing compassionate professionals. With your relentless support, our goal is certainly attainable!

EMPOWERING A DREAM

The SMA Medical Students' Assistance Fund (SMA-MSAF) continues to be one of our core programmes. Since 2007, SMA-MSAF has disbursed more than half a million dollars in financial

assistance, empowering many needy medical students to pursue their dream of becoming doctors. In 2015, the fund was disbursed to 40 needy medical students from Duke-NUS Graduate Medical School (Duke-NUS), Lee Kong Chian School of Medicine (LKCMedicine) and Yong Loo Lin School of Medicine (YLLSoM).

The gift of a bursary is important to medicals students dealing with financial challenges. The costly fees and expenses of a medical education is often a huge burden for underprivileged medical students, pushing many to seek part-time work to lighten their families' financial load.

To better understand the needs of our medical students in today's changing environment, we revisited the Medical Student Living Expenses survey, with YLLSoM in the lead and assistance from LKCMedicine and Duke-NUS. The collated findings will enable SMACF to better strategise our bursary programme in order to help more medical students fulfil their aspirations.

PROVIDING EQUAL OPPORTUNITIES

SMACF also supports underprivileged medical students in their research and further education pursuits. This comes in the form of sponsorship for participation in medical conferences or elective postings overseas. Such sponsorships provide equal opportunity for

underprivileged students to extend their medical knowledge beyond the local context, exposing them to different medical systems, spectrums of diseases and patients. One such recipient this year is Ms Maria Noviani, a Doctor of Medicine student from Duke-NUS, who presented her research findings on "Breastfeeding Practice in Patients with Systematic Lupus Erythematosus" at the 11th International Congress on Systematic Lupus Erythematosus in Austria, with a partial learning grant from SMACF.

INCULCATING COMPASSION

Besides supporting medical students, SMACF also aims to benefit the community through healthcare projects, with the aim of inculcating the values of compassion and service among the medical professionals and students. One of the flagship projects we supported, Public Health Screening 2015, held in October this year, saw an increase of over 50% in volunteering hours rendered over the two-day event. The event brought basic health screening programmes to the heartland, creating greater health awareness among citizens above 40 years old. Project Legacy is another supported programme that encourages medical students to help palliative care patients to

celebrate their lives by leaving keepsakes for their loved ones. Additionally, SMACF supported two new projects of YLLSoM and LKCMedicine, the Freshmen Orientation Camp Community Involvement Programme, which seeks to inculcate in freshmen the value of giving to the society.

RECOGNISING THE MENTORS

The making of our future medical professionals falls on the shoulders of inspiring educators and mentors today. The Wong Hock Boon-SMACF Outstanding Mentor Award was presented to eight medical educators this year, to recognise their commitment towards educating and shaping our future medical professionals. ♦

Donations to SMACF can be made online at the SG Gives website (<http://www.sggives.org.sg/smacf>). The 300% tax deduction for donations made to SMACF will end on 31 December 2015. All donations are to reach SMACF by 31 December to enjoy the enhanced tax benefits.

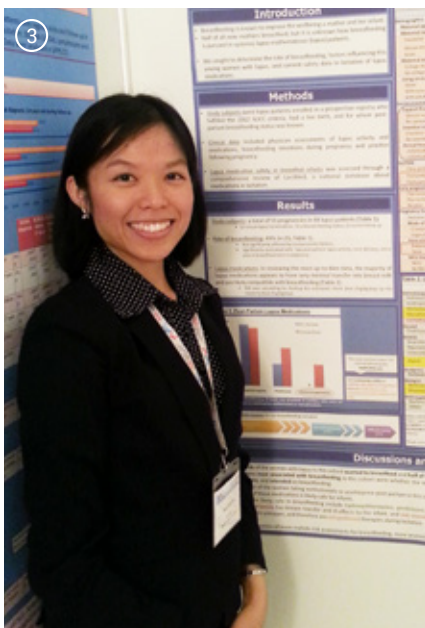
The SG Gives website will be transiting to the new Giving platform (<http://www.giving.sg>) from 1 January 2016 onwards. More details will be released on our website in December 2015.

YOUR SUPPORT IS IMPORTANT!

Your support towards the Fund has far-reaching impact on the future of healthcare. SMACF is happy to announce a total receipt of \$250,000 in donations from January to October 2015, including the pledged matching grant from the Care & Share Movement and donations from SMA. SMACF extends our sincere thanks to the following donors for their generosity toward the Fund:

- Dr Ang Xin Yu, Alicia
 - Dr Noreen Chan
 - Charles Toh Clinic Pte Ltd
 - A/Prof Cheong Pak Yean
 - Mr Chew Kwee San
 - Dr Chu Siu Wen
 - Dr Chua Seng Chew
 - Dr Dohadwala Kutbuddin
 - Dr Fareed Husain Yusuf Kagda
 - Dr Goh Boon Cher
 - Integrated Marketing Solutions Group Pte Ltd
 - Intertrust (Singapore) Ltd
 - Dr K Gunasegaran
 - Dr Lee Lay Tin
 - Dr Lew Yin Choo, Laura
 - Dr Lim Hwee Leng
 - Dr Lim Juay Yong
 - Dr Lim Yu Her
 - Dr Loh Kia Ee, Sheila
 - Prof Low Cheng Hock
 - Mr Mohamed Baisal S/O Abdul Nassar
 - Dr Ng Lee Beng
 - Dr Ng Swee Cheng
 - Dr Ong Cheng Choon
 - Dr Ong Chiou Li
 - Dr Ong Choo Phaik, Caroline
 - Dr Ong Eng Cheng
 - Dr Ong Eng Kang
 - Dr Oon Chiew Seng
 - Dr Peh Lai Huat
 - Mr Ian Phoon
 - Pocari Sweat Singapore (Pocari Sweat Run 2015)
 - Dr Raut Pradeep Prakash
 - Safer Wireline Operations Research & Development (SWORD) Pte Ltd
 - Singapore Medical Association
 - Dr Tan Cheng Lim
 - Dr Tan Wu Meng
 - Dr Tay Sok Hoon
 - Dr T Thirumorthy
 - Ms Claryn Wong
 - Mr Mildred Yong Lu De
- All other donors who wish to remain anonymous

The list may not be exhaustive. If we have inadvertently omitted the names of any donors, we apologise for the oversight.





• GROWING A • MEDICAL BEARD

REASON FOR STUDY

A difficult question was being repeated at work a few months ago. I had anticipated and prepared for it, but my rehearsed answer always came out garbled. I face the same problem whenever people ask me why I became a doctor. While I have given many altruistic reasons, I think I sounded cliché most of the times. The straight truth is it's cool to be a doctor. There was no real reason as to why I wanted to keep a beard. I just thought it was cool to have one. Even Hippocrates had one!

CONCLUSIONS DRAWN

Retrospectively, it had been a great social experiment on human behaviour. I learnt that change in any form is hard to accept, and all I had done was altered the way I looked. A further observation was that one man's meat is truly another man's poison. People had commented how incredibly militant it was, but on the flipside, an equal number

had marvelled at how *GQ Magazine* cover-worthy it looked. And yes, we all suffer from selective hearing. That's why it had remained on my face for six interesting months. Or rather, my face was under it.

METHODOLOGY

It's no surprise that one of the preliminary requirements is that of having the potential for enough hair. A good status gauge is what happens after a night call. If there is stubble from the maxilla down, you are probably the gifted one. On the contrary, if there is some just on the tip of your chin, I suggest you bow out gracefully and respect the magnitude of a full-grown beard. The teenage days are long over.

The first four to six weeks of growing out the beard is the most challenging. In its infancy, the beard looks utterly messy. The growth sprouts in all angles and perimeter lines are not defined. Almost all self-help beard

community websites advocate starting one while you are on a holiday, as most beards are killed early because of negative comments from colleagues. I recall having someone ask me why I had pubic hair growing on my face. I perpetually had flu during those early days. A surgical mask provided a perfect illusion that nothing was happening on the sly. Sometimes, it's just easier to unveil the finished product.

DEFINITION

The next step is to carve out a shape. An exhaustive literature search found, to my dismay, that there was no consensus on the definition of the different types of beard. I got a little lost without official guidelines and statements from governing bodies. The simplistic way to characterise one is based on famous people who have sported them (and it comes together with their associations). For example, there is The Lincoln (patriotism), The Wolverine (aggression), The Bin Laden (negativity), etc.

Intriguingly, Mr Narendra Modi, a fellow Gujarati, was elected Prime Minister of India during my journey with the beard. The world was fixated on his talent. He had something more to offer. The Modi would be the ideal medical beard. It was well-kempt and nonintrusive, and had already proven its efficacy in office.



Making sure that the left and right halves were symmetrical was tough. An uneven beard is extremely annoying. That's when good social support is useful. My wife had the glorious task of assessing it every morning, providing input on where to nick in order to balance both sides. She showed another aspect of love: doing the task with conviction, although she hated the beard down to the last strand.

DISCUSSION

Be prepared to look more than your true biological age. I was told that I looked at least ten years older. This was a double-edged sword. Patients followed my advice more readily in the clinics. I could appease angry relatives in a shorter time. Juniors thought twice before calling me. The problem was when patients equated the beard with seniority during morning ward rounds and almost all my consultants were beardless.

Keep the length in check regularly. A long, grisly beard gives an impression that they are overworking you. Residency is a busy period and the last thing on my mind after a long day was to drop by Little India to get it nicely trimmed. Although a handheld beard trimmer helped mitigate the time issue, my perpetual paranoia was the razor running amok and accidentally shaving a big patch

away! Think all those hirsute men going for electrocardiograms and the aftermath of the nurses' shaving when the leads don't stick.

The beard makes a good prop for "thinking in progress". Difficult questions asked during tutorials are hard to negotiate. Confessing that you don't know exposes your lack of background reading. Looking away at the ceiling or at the floor is rude. But twirling the ends of the moustache or finger-combing the goatee downwards looks like second nature and gives the nonverbal cue that you are a thinker. My beard was my saviour.

However, I need to be honest. While I have talked about the benefits, one cannot negate the side effects. The beard is incredibly itch-inducing. The discomfort is mainly from the ends of the bristles curling inwards and poking the skin. Antihistamines are the houseman's solution. Lasting effects can be seen when effort is taken to soften the hair. Dedicated shops selling moustache wax, beard oil and beard balm offer relief over multiple follow-ups. Unfortunately, these are non-standard items that are available only at a hefty premium.

LIMITATIONS

Apparently, life dictates that all good things must come to an end. After numerous months, the novelty of the new look had ceased. Daily exposure had desensitised everyone. It was no longer a talking point. The black sheen, which had been another source of pride, was taken away from me — without warning one day, a crop of resistant white hair strands had infiltrated an otherwise clean field. I had

been robbed of my youth! My wife showed caregiver fatigue because of my obsession. My daughter developed transient erythema on her face whenever I showered her with goodnight kisses. Finally, I silently succumbed to the stressors and killed the beard.

FUTURE TRIALS

It is speculative to say for now that the beard has been infectious and that more in the medical field are keeping it. The occasional few that I have noticed while changing postings could have been just a random occurrence. As I mentioned earlier, change is always hard to accept. An easy question is being repeated these days: What happened to the medical beard?

I left it at home. ♦

PROFILE



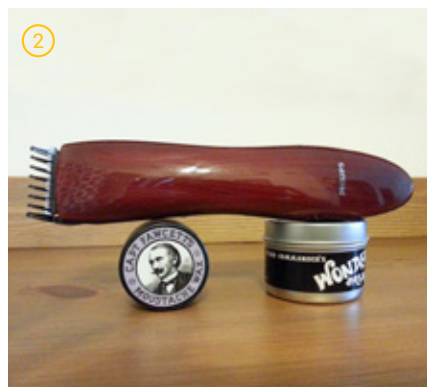
TEXT BY

DR PINAKIN V PAREKH

Pinakin is a final year cardiology senior resident in Singhealth. He will grow back his medical beard once he clears the exit exams. Till then, he first needs to grow his medical knowledge!

Legend

1. The beard in all its glory!
2. Tools of the trade



GOING THROUGH

A Learning Experience



Singapore can be proud of its healthcare system, which has been lauded as one of the world's best, with an important target to limit over-utilisation of healthcare. However, do we simply rest on our laurels or should we seek to improve it? I was admitted to a restructured hospital for surgery as a full paying patient in a class A1 room, and would like to share my experience and perspectives. Much as my observation may sound discouraging to the hardworking

healthcare personnel, it is not in any way meant to trivialise their excellent care. While I am grateful for the care I received, this article is targeted at hospital administration, operations and healthcare workers, in the hope that it will be helpful to their efforts in delivering what they preach and promise. We teach soft skills such as empathy, care and concern to medical students, but those involved in healthcare should also put themselves in the shoes of the patient, so as to realise how simple,

inexpensive things can improve the experience for each patient.

WAITING FOR SURGERY

It was decided that I needed elective surgery, but it could only be done slightly more than a week later. Reasons included the surgeon's lack of operating days and a lack of theatre slots. As it did not make sense to be operated on as an emergency patient (in which case theatre space was available), I accepted it without hesitation, as operative risks and

A SURGERY

ence

TEXT BY PATIENT X



complications are lower in elective surgery. There was also no issue with regard to availability of anaesthetists. The questions that have to be asked: are surgeons given enough operating days or is it an issue with a lack of elective operating theatres? Perhaps, it is a matter of cost-effective, maximal utilisation of theatres that prevents surgeons from operating as soon as indicated. There appears to be some lessons on cost-effectiveness and efficiency that we can learn from the private sector.

The aims of the healthcare system are to minimise hospitalisation and encourage same day admission for surgery — at least that is what is propagated to healthcare personnel. I was initially advised that I needed to be admitted on the day of surgery. However, this advice was changed to “better come one day earlier, so we can guarantee you a bed after surgery”. This meant that I had to occupy a room for an additional day (approximately 24 hours) at my own expense, and also increased the bed occupancy unnecessarily. In all honesty, I cannot fault the surgical team, who were admirably gaming the inefficiencies of the system for the benefits of their patients. The system has not achieved what it sets out to do, which is to prevent unnecessary admissions and increase same day surgery admissions.

THE STAY

The nurses were polite and kind, reminding me repeatedly ad nauseam to be careful, to call them for help and not to injure myself (I had a tag with “fall precaution”). I was particularly peeved by the numerous monitoring. I had no hypertension, respiratory problems or fever, yet my parameters (pulse, temperature, blood pressure and oximetry) were measured every four hours. I am fully aware that these tests do not come cheap. As an otherwise healthy patient, other than my requirement for surgery (which had nothing to do with fever, blood pressure or oxygen saturation), it perplexes me to see that such routines have crept into our healthcare system. Perhaps it was a Joint Commission International requirement, or everyone was



just being cautious, or maybe the junior doctor who requested them was unsure of or unsupervised on the need and value of such tests. Not only did they add to my hospitalisation bill, but they also interrupted my sleep and rest. These interruptions were in addition to the medication, meal, change-of-shift introduction of nurses and pain score assessment times. It dawned on me that, day or night, you are not going to get a reasonable period of rest in a hospital bed, even if you are in a relatively good state and do not have an incessant number of visitors.

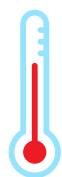
The first night of my stay enlightened me a lot. A house officer came to check on my progress or deterioration at approximately 2 am. Apparently, it was a routine to ensure that I had not worsened during my immediate stay, probably an “early warning system” to pick up on a patient’s changing conditions. More interestingly, after I had slept for about one and a half hours after the previous doctor’s examination, another “very hurried” and shabbily dressed doctor rather rudely barged into the room and gave some specific instructions to examine me. Perhaps he felt that his junior had not examined something important, but he left saying nothing except “okay.” I was bewildered and annoyed as to what he was trying to accomplish, not to mention his lack of introduction, manners, tact and above all, professionalism, which we endeavour to instil in all our doctors. I stayed in a single room that came with a single bed, a sofa and multiple chairs among its facilities. The bed costs a few thousand dollars, but sadly, the mattress, being either too old or used, was very uncomfortable, contributing further to my aches and pains. Even one of my surgeons agreed that the bed is one of the least comfortable. I was also told by other colleagues that one of the most common complaints of hospitalised patients is the quality of the mattress. On the other hand, the sofa in my room was heavenly compared to my bed. I wondered if it was meant for my visitors who were there for a short

while, or to get me to move out of my bed whenever possible. If the comfort level of the bed is a repeated issue, shouldn't it take priority?

The room had a huge wardrobe-sized mirror to the side of the bed. I was once told that, according to Chinese customs, one should not sleep with the mirror visible to oneself. While whoever designed the room took care of that concern, they forgot to look at the utility of the huge mirror in the room. I remain unconvinced about the purpose of such a huge mirror in the room, since there is another large toilet mirror.

The call bell system was intriguing to me. The bed had some switches, which suggested that they could be used to call, but they were dysfunctional. Instead, the call bell, which was tied to my bed rails with a string that not too infrequently got dislodged, had a separate connection to the sockets cephalic to my head.

A few days after admission, I found out by chance that broadband was available free of charge through a USB laptop plug-in, "if one asked for it". I duly got mine after asking. But nowhere in my introduction to the ward, its amenities or in any of the brochures was this indicated, although I was probably being charged for it.



The air conditioner in the room was another mystery to me. I was freezing even when the air conditioning was set to the warmest. I became apprehensive that perhaps I had unrecognised hypothyroidism, but it was soon laid to rest, as almost every visitor had the same complaint. Yet if I switched off the air conditioner, the room felt stuffy and warm. Perhaps it would have been better if I had the choice of switching the air conditioner on and off myself, but this was not to be, because the switch was a significant distance away from the bed (remember, I was on fall precaution) and the air conditioner was apparently

centrally controlled. The nurses were extremely nice when called to help with switching off the air conditioner, but it made me dependent on them and it also felt awkward to get help from them for something other than their professional skills or training.



The toilet is of interest to any patient. To bring a wheelchair in unaided was a struggle. I was very impressed by the rails, call bell system and the shower chair. At last, I saw something that was well thought through. However, my delight turned to disappointment when I realised the bidet switch was completely hidden and inaccessible when using the commode. The flush system also required a fairly mighty strength to be functional; two of my visitors thought the flush was non-functional.

Coordination was rather disordered. I needed a few imaging modalities conducted at several places that were away from the ward but within close vicinity of each other, and all were requested at the same time. However, the poor health attendant had to repeatedly wheel me a considerable distance back and forth from the ward purely because of poor coordination. Also, during admission, I was told that I needed some imaging, which could not be done over the weekend, so I had to wait till it was completed before I went home on a Monday. This was told to me at around noon on a Friday, which meant that I had to pay for two days of hospitalisation just to wait for imaging.

BILLING

I was in a very fortunate situation where I could afford my hospitalisation. Prior to my admission for surgery, I was asked to fork out a huge deposit despite having a letter of guarantee from my institution. I tried not to quibble over it; I guess if I did, my surgery would have been delayed. What was more fascinating was that

more than four months after my discharge, I had not received the significant amount of refund due to me. Institutions seem to have very deep pockets when it comes to returning due money. Perhaps a lesson from the Inland Revenue Authority of Singapore (IRAS), which deals with the entire nation's income tax, may provide useful tips. I have experienced the efficiency of IRAS where excess payments were returned within a fortnight.

I was charged more than \$500 per day for "consumables", in addition to the daily room charge (more costly than a deluxe room at Marina Bay Sands Hotel, Singapore), a treatment fee of more than \$100 per day, and nearly \$100 per day for a category mystified as treatment services, investigations and medication. Computation of charges seems to lack clarity and transparency. I can only guess that consumables include electricity, water, urinals, pyjamas, bedsheet, dressing changes and maybe even my "must ask" internet access, and more.

POSTOPERATIVE CARE

Having had surgery, I was rather surprised that the rehabilitation aspects were not well thought of in advance. Rehabilitation, which lasted less than half an hour, was only started two days prior to discharge. I was not allowed to attempt rehabilitation on my own ("in case I fell"). More interestingly, I was not given any further review on rehabilitation upon discharge. Maybe it was felt to be premature or the value of rehabilitation was underestimated, or maybe there was just some breakdown in communication.



My surgical wound dressing remains a mystery. While originally told that I needed to return a week later for wound inspection, the review time was changed to "three weeks" by the surgical team. With my sweaty self, I asked, "Don't I need to change the dressing at all?" and was promptly

advised, "No, just make sure it doesn't get wet during showering; it will be changed on review."

I confess I defied nursing orders and got a close relative to regularly change my dressing until the review date. The fear of bugs thriving in a moist sweaty "op-site-covered" environment gave me the jitters. I pondered over the additional cost I could have incurred if I had not defied the orders to not change the dressing, and developed a wound infection as a result. A check with nursing colleagues in other institutions led to agitations and disbelief among them: "Are you sure they told you that?" and "That's not what we teach or practice!" Fortunately, they believed me, for I think I am still some distance from the age of dementia.

REQUEST FOR FEEDBACK

Hospitals get patient feedback to, hopefully, act on them. Startling, however, is the methodology of obtaining feedback. The feedback I gave was not confidential, as it was written on a card that I was supposed to hand back to the person who served me. In this instance, I had no issue with giving positive feedback. It did cross my mind though — what if I had negative feedback? If I knew that the person receiving the feedback was going to read it, I would likely hesitate to be negative. Maybe this is a nice way to get more positive feedback!



My worse experience with the feedback gathering process was in the wards. Less than 24 hours after my surgery, while I was on drip and medication to reduce my pain, an "official" from customer service came into my room unannounced, and after the usual greeting and introduction, requested my feedback. I could only guess that the person was unaware that this was my immediate postoperative day and had not checked with the nurses before

entering my room. My relatives and visitors, however, had a different interpretation. They coyly remarked, "Better to get the feedback early so that fewer negative things will come to light."

CONCLUDING THOUGHTS

I am glad that the surgery made me much better. Surgery was an ordeal I had to go through (by no means my first), and I had experienced the best and the worst of healthcare. I have learnt how to treat my patients better. I will educate my juniors to put themselves in the patient's shoes and will keep emphasising professionalism at all times.



I hesitated a lot in writing this article, but in the interest of good general patient care, I felt that sharing this experience with a wider audience can only serve to improve what we are doing, as well as open the eyes of administrators, operations staff, hospital planners, builders, engineers, doctors, nurses and other healthcare personnel to the fact that it does not take much additional resources to improve a patient's experience in the hospital.

Much as we talk about satisfaction in healthcare and look at survey results conducted regularly, there must be a process to systematically look at making the experience of patients better and safer, not necessarily at higher costs. If systems and coordination issues had been carefully controlled, I am convinced that my hospitalisation cost would have been lower and my experience more pleasant. Those involved and holding a stake in healthcare can work towards relooking at patient experiences and then learn to adapt and modify accordingly.

The Irish novelist, CS Lewis, has these wise words to say: "Experience: that most brutal of teachers. But you learn, my God do you learn." ♦

SINGAPORE CAN BE PROUD OF ITS HEALTHCARE SYSTEM ... DO WE SIMPLY REST ON OUR LAURELS OR SHOULD WE SEEK TO IMPROVE IT?



DISCLOSURE INVOLVING MULTIPLE HEALTHCARE TEAMS

PROFILE

TEXT BY

DR LEE SEE MUAH
DR SEOW WAN TEW

*Teaching Faculty,
SMA Centre for
Medical Ethics &
Professionalism*

Medical professionals have a primary duty to inform patients of any medical information that would be important or material to the patients in making medical decisions for the present and future. Discussing significant adverse medical events with patients and people close to them is seen as an ethical norm. Such discussions would usually include acknowledgement and expression of regret over the adverse event. Patients should be assisted and supported compassionately through their illness.

Healthcare providers have a duty of candour; this enables patients to make decisions based on informed disclosure. Whether the information at hand is complete or not is immaterial; such disclosures should include admissions about uncertainties, apologies for any errors, recognition of feelings and emotional responses towards the event, and a plan forward.

We describe herein a case of disclosure involving two different health care teams from two different centres caring for a single patient with the same condition. We examine the position in law and ethics regarding the disclosure of an adverse event and the boundaries of ethical behaviour. We conclude by suggestion of a way forward to manage such disclosures.

FACTS

Mdm X has been receiving treatment for the past two years at a government treatment centre ("A" centre) for chronic cough. She is otherwise well. Chest X-ray result was reported as normal. She later developed backache and sought consultation at the emergency department of "B" hospital. Investigations showed metastatic lesions of the spine. A review of the same chest X-ray done by "A" centre showed a cancer lesion, which appears to have been missed in the reporting 18 months ago. The conclusion was that the primary lesion responsible for the metastasis was lung cancer.

DISCLOSURE

If the patient were to ask, "B" team would be obliged to state their impression of the chest X-ray findings as findings of fact. This is not a contended point.

However, if not asked, does "B" team have an obligation to disclose their impression of the chest X-ray done 18 months ago by "A" team? Doing so adds clarity for the patient with regard to the time frame of the illness. The inference of "A" team having missed the earlier diagnosis would be inescapable, but one which "B" team would be ill-advised to elaborate on because the patient was not under their care when the chest X-ray was ordered and taken. With this in mind, "B" team decided to go ahead with a voluntary disclosure, but not before a discussion had taken place with "A" team.

"B" team's intention and extent of disclosure, even if unasked, was made known to "A" team, who would then have to decide whether to hold further discussion with the patient. In any case, it was jointly decided between the two teams that "B" team would make the offer for an open disclosure with the "A" team about the chest X-ray findings and the care given at that time, on behalf of "A".

The offer was subsequently not taken up by the patient for reasons that were not pursued.

DISCUSSION

There is no duty in law to incriminate oneself in wrongdoing. From this view, the decision to not offer a disclosure, especially when we can let sleeping dogs lie, is tempting. On the other hand, the risks of being found out and having to face the allegation of concealment because of a self-serving interest, even if not legally damning, or even if there was no intention to conceal — "you did not ask, I did not tell", which arguably may not amount to concealment — would be ethically problematic.

From an ethics perspective, it would be reasonable to expect that the patient would have an interest in knowing this information. A decision based on best interest must be one that is based on the autonomy of the patient to decide on what she wants done subsequent to being informed.

There is a duty of cooperation and collegiality between doctors. This duty in collegiality, of working in cooperation and collaboration with colleagues, is for a common purpose of upholding the primacy of the patient's welfare. This duty does not stand alone and is underscored by the requirement of acting in the best interests of the patient. As such, the two duties do not come into conflict. Conceivably, "A" team would have more to lose if a case of negligence is made out, but this is a secondary consideration.

One study has established that 50% of litigation was initiated following comments made by other healthcare professionals. Never underestimate the power of a raised brow or frown, or the insinuation of the spoken word implying substandard care by

colleagues. Comments about care given by colleagues, when perceived as negative, become opinions of expertise, which one should refrain from making unless one is also prepared to do so in an official capacity (eg, as an expert witness for the court). Concerns about the safety of patients should be communicated through other channels.

The line between giving an opinion and stating a factual account is not always discernible. This can be challenging in open disclosure involving two parties who are caring for the same patient, one of whom might have come to know that the patient had suffered a detriment under the hands of the other party.

An account consisting of facts known should be disclosed to the patient, but the speculative nature of why and what the circumstances of care are of another party should not be attempted. This is the limit of disclosure. An open disclosure is not a forum for giving a second opinion about the care provided by another clinician, especially when the other clinician is not present.

TAKE HOME MESSAGE

- Support the patient.
- Disclose the facts of the case.
- Where the disclosure of facts involves other carers, it is highly recommended that all healthcare teams be briefed on the extent of disclosure.
- Do not speculate.
- If necessary and agreed upon, make an offer for discussion with the patient and the other healthcare team whose care has supposedly resulted in the adverse outcome.
- If agreed upon, a discussion with the patient in the presence of the different healthcare teams may be proposed. ♦

Further reading

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2. General Medical Council (UK). Openness and honesty - the professional duty of candour. Available at: http://www.gmc-uk.org/Joint_statement_on_the_professional_duty_of_candour_FINAL.pdf_58140142.pdf. Accessed 14 August 2015.

SUPER CLINICS:

THE WAY TO GO?

— PART 2



PROFILE

TEXT BY

DR LEONG CHOON KIT*Editorial Board
Member*

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

*Disclaimer:
The above article is a reflection
of the author and not as a result
of owning or running any of
the FMC.*

"You know what? We should get our private GPs together and share as much resources as we can, especially good locum doctors who can cover us when we need a break." A senior GP mentioned to me at a lunch hosted by the Ministry of Health (MOH).

His views are not new and many of us share the same thought. Some have tried to do it by forming small private groups. Others have tried applying the MOH concept of Family Medicine Clinics (FMC), which is similar to the Australian "super clinic" model.

Regrettably, I have yet to see any success in the last decade. Why is it so difficult to see FMC take flight here when countries like Australia and New Zealand are able to pull it off?

OUR UNIQUENESS

Singapore has some unique features that pose challenges to the FMC model. Firstly, although we are a very small country, our healthcare facilities are abundant and easily accessible in terms of distance, cost and standards. The abundance of choices creates such stiff competition that it is impossible to save cost by size. Instead, the

institutions have to be small and nimble to remain cost-effective and cost-efficient.

Secondly, our financing model is confusing and varied. The public can pay for healthcare services through a variety of means. They can utilise their company medical benefits, healthcare services supported by insurance companies and managed care companies, subsidised public healthcare, subsidised private healthcare at GP clinics, or pay out of their own pocket for services at private GP clinics.

The different permutations a GP clinic offers only add to the confusion. The lack of uniformity ultimately causes the public to choose healthcare services based on their out-of-pocket payment amount. This makes it difficult for GPs to come together.

Thirdly, GPs are individuals with different motivations. Those who work in the public sector may choose to work there because they like the regularity and predictability of the practice. It is also attractive for those who prefer a career path with advancements in terms of teaching and research. The private GP can

either be employed or self-employed. Those who chose to remain employed might have an entirely different motivation from those in public sector and those who are self-employed. The self-employed, on the other hand, have to find all means to stay afloat. It is a matter of sink or swim for them daily.

INGREDIENTS FOR SUCCESS

There are many factors to address before any chance of GPs coming together will materialise.

PUBLIC PERCEPTION

The most important factor is the public's perception of GPs. The public must regard GPs as their first doctor to call and the clinic as their first port of call whenever they require any medical advice.

Public policies and health promotion can further improve the positioning of GPs. Our current health system is confusing to the public. As a result, they cannot differentiate between primary and tertiary care, and their often inaccurate perception may cause them to shun GPs.

Public understanding of tertiary and emergency care is equally inaccurate, resulting in patients who seek care that they do not need or face difficulties addressing their problems. This frustration has to be managed before super clinics can succeed.

MOTIVATING FACTOR

Another factor is the operators themselves. The super clinics should ideally run on a self-employed model. The attitude and approach to issues can be very different between an employer and an employee. Personally, I am more willing to work and try harder as a self-employed GP than when I was a locum or in public service. The threat of failure for a self-employed acts as an excellent motivator.

CONDUCTIVE INFRASTRUCTURE

Additionally, our present infrastructure does not support building larger clinics. In order for the

FMC model to be viable, doctors will need bigger units. Currently, most available Housing & Development Board (HDB) commercial units are around 500 square feet. A small super clinic comprising two to three doctors will likely need a space of 3,000 square feet. Thus, the HDB will need to allocate larger units for future clinics if they take this into consideration. A cheaper alternative would be to convert current void decks into larger clinic spaces.

FINANCIAL FUNDING

Our current public funding policies do not favour consolidation. There is no incentive to merge. Finance can change the way doctors practise and the way the public seek healthcare services. It is a powerful enabling tool, but it can also be a hindrance if applied improperly.

For instance, if money is granted too easily, it will take away the desire to work hard for success. On the contrary, when money is withheld most of the time, GPs will give up.

It is interesting to note here how the Australians clinch it. I was told by my classmate who had migrated down under, that the Australian government buys over solo private GP practices at market rate before relocating them into these super clinics, which the GPs now co-own. It is a very bold, innovative and attractive policy indeed.

ADMINISTRATORS' MINDSET

The mindset of our public health administrators also has to change. It is very important to impose clinical governance. But bringing it to the extreme will not be attractive to existing private GPs. There can be more collaboration between the tertiary hospitals and super clinics, where they adopt a shared care and co-operation concept. With that, they can better sort out the patients and direct them to the appropriate care facility.

FUTURE GPs

We also need to make it attractive to the next generation of GPs. The super clinics must embrace teaching and nurturing of the younger residents.

I would go to the extent of saying that our public institutions must help and bless our young family physicians when they tender their resignation to start their own practice. It is obvious that when the young GPs starting their practices receive help with no strings attached, they will remain a friend. The converse is true. The more negative the parting, the worse the rivalry. Why make an enemy out of a friend?

LASTING TRUST AND RELATIONSHIP

Last but not least, we need to trust one another. The best way to build trust is to genuinely care for one another, especially when one is in need. Everyone should take the initiative to make the first move to reach out. Action often speaks louder than words, and not everything can be bought with money or programmes.

Care for physicians' welfare is lacking here. We can start with this. The super clinic, with its multi-doctor practice, might help us to look out for one another; a topic we should touch on more. It is definitely worth the effort to consider using the super clinic to care for fellow GPs.

So, are we ready? ♦

THE PUBLIC MUST REGARD GPs AS THEIR FIRST DOCTOR TO CALL AND THE CLINIC AS THEIR FIRST PORT OF CALL WHENEVER THEY REQUIRE ANY MEDICAL ADVICE.

MONGOLIAN

Horse Riding Adventure

PROFILE



TEXT AND
PHOTOS BY

DR TAN SU-MING

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

Legend

1. View of Lapis Sky Camp (photo credit Peter Danelo)
2. At *Naadam*, dressed in our Sunday best in *Deels*
3. High Ho, Brownie! Away!

July this year, I joined a Mongolian horse trek organised by National Geographic and had the adventure of my life. Although there were many Mongolian horse riding tours available, I chose the tour by National Geographic as their website stated "no riding experience is required".

With six hours of horse riding lessons under my belt, I boarded a plane to Ulaanbaatar, the capital of Mongolia. From there, I joined 13 other adventurers on a 400-odd km bus ride to Lapis Sky Camp, which was located in a protected area in the Bulgan *sum* (district) of the Arkhangai *aimag* (province) in the mountain steppes of Outer Mongolia.

We got off the bus, picked up our backpacks and started to descend into the valley. As our campsite came into view, I teared up, moved by the beauty of the place.

"Okay, folks," our guide, Thomas Kelly, said. "We are officially off the grid."

For the next seven days, there would be no electricity and Internet or phone connection, except via the satellite phone meant for emergencies. We would live among the nomads, like the nomads, who rely on solar panels to power their television and lamps and charge their electrical devices. Our bathing and part of our drinking water would come from the river that flowed next to our campsite, sterilised via boiling, and our *ger* (a traditional Mongolian

tent) would be warmed up by wood stoves. The daytime temperatures ranged from 20 to 30 degrees Celsius and could drop to 0 degrees at night. I heard it has even snowed there before in the middle of summer.

"Great," one of my group mates said. "Now we can argue all night." What he meant, though, was that with no Internet, arguments would be won by logic, and not settled abruptly by someone checking the facts on the Web.

We were soon introduced to our horses, brought from the nearby valleys by their horsemen who would take care of us over the next week. Mine was a chestnut gelding. Like the rest of the Mongolian horses, he was small, sturdy, strong and fearless. He reminded me of an English butler: he was professional and did his job but didn't fraternise



with me. Over the next seven days, my respect and affection for this horse grew. I marvelled at how he carried me over mountain passes, rivers and streams, nary missing a step or slowing, his ankles never turning, and never complained.

My travel mates joked that he was the overachieving horse with an underachieving rider. Not feeling really confident about riding at the start of the trip, I was sort of cantering by default by the end of it. Brownie, which was what I decided to name him (Mongolian horses are usually not given names), didn't like being at the back of the pack or separated from the rest of the herd because of his slow rider (namely me), so he would fly and I would hang on. My heart would be in my throat, but, that was truly one of the most joyous, exhilarating experiences of my life. On the last day of our ride, when I knew I would probably never see my steed again, I asked Dawanyam, my horseman, for

a memento of Brownie. He yanked a few strands of hair from Brownie's tail for me. Holding those strands now is a tangible reminder that it wasn't all a dream.

On some mornings before we rode, we would visit the nomads who lived in the valley. Although their work is endless, herding and milking the yaks, mares and goats several times a day, they would warmly welcome us into their *gers* if we came a-knocking. We would be offered *airag* (fermented horse milk) and *aaruul* (dried curds), or a treat of *khailmag* (caramelised clotted cream). A bowl of *arkhi* (homemade moonshine) with an alcohol content of 3% to 12%, made by distilling the *airag*, would then be passed around three times. Each guest is expected to sip, or better yet, empty the bowl, which will be promptly refilled. Singing then follows. The nomads love to sing and we each took turns after drinking. We visitors felt a little shy, even after the alcohol, but were

gently coaxed into rendering a tune, from *God Save the Queen* by Fiona from England to the Hwa Chong Junior College school song sung by my Singaporean travel mate, to loud applause for the exotic sounding Chinese song. What a lovely way to start the day.

We were so lucky to be in Mongolia in July, when the festival *eriin gurban naadam*, which translates to "the three games of men", or *naadam*, is celebrated, as it has been for centuries. The three games are archery, Mongolian wrestling and horse racing. On that day we rode 10 km from our valley to the nearest town to witness the celebration. We were all given *Deels* (traditional Mongolian clothes) to wear and it felt very festive donning the outfit. Initially, two of the young men in our group wanted to sign up to participate in the wrestling, but later changed their minds. We realised the wisdom of this when we saw the heft of the competitors upon our arrival at the festival grounds; our guys might have been creamed.

Another treat for our group was the chance to meet and speak with a shaman, a religious figure who is supposed to have the ability to communicate with the souls of the ancestors. Since recovering from Soviet domination after the 1990s, a period when the Communists wiped out many of Mongolia's records and physical traces of its past, the shamanic practices allow Mongolians to communicate with the spirit of their distant ancestors and hear fragmented stories about their lives in the past.

Occasionally I still dream that I am there, waking to the sound of a yak munching grass outside my *ger* or walking to the outhouse in the middle of the freezing night under a blanket of stars.

Do visit Mongolia before too long. Mongolia's vast steppe is home to the world's last surviving nomadic culture, and I sense fragility to that timelessness. ♦



LIFE IN PIXELS

SMA NEWS PHOTO COMPETITION



WINNING PHOTO

SEPTEMBER THEME:
"NATION BUILDING"

**GARDEN CREATION
THAT MADE SINGAPORE
ICONIC INSTANTLY!**

Dr Low Cze Hong



Taken with
an iPhone 5s

JUDGES' COMMENTS

"Modern structure created using the latest technology, synonymous with nation building."

"Embarking on transforming our nation green, our late MM started tree planting campaign. The Supertree symbolises that."

"Building a tree out of metal is symbolic of our City-Garden; how we merge nature and technology. This relatively new addition to our landscape and list of attractions is part of nation building as we continue to progress with the times."

HONOURABLE MENTION

**IN THE FACE OF MODERN DEVELOPMENT,
HISTORY STILL STANDS TALL AND PROUD**

Dr Deshawn Tan



VOTE FOR YOUR FAVOURITE PHOTO!

Congratulations to the **4 winners and 4 honourable mentions** of the Life in Pixels SMA News Photo Competition 2015! One of them now stands the chance to walk away with a **DSLR EOS100D kit**, sponsored by **Canon Singapore Pte Ltd**.

From 5 January to 12 January 2016, simply visit <https://www.sma.org.sg/lifeinpixels> to view all participating entries and vote for your favourite photo! Two lucky voters for the winning photo will walk away with a **Crumpler camera bag** and a **Canon Digital Ixus lanyard with a 16GB thumbdrive**.



Authentic learning environment –
Role play on giving oral evidence in Court

Medical Expert Witness Training

A Collaboration between the Academy of Medicine, Singapore (AMS), The Law Society of Singapore (LSS), Singapore Academy of Law (SAL), Singapore Medical Association (SMA) and State Courts of Singapore (State Courts)

COURSE OBJECTIVES

- A. To acquire the knowledge and skills in writing medical expert reports.
- B. To be aware of the skills and pitfalls in giving oral evidence in court as an expert witness.
- C. To acquire practical skills by being directly observed and coached in providing oral evidence in court.

Day 1 (19 March, Saturday)

Venue: Academia, L1-S3,
20 College Road, Singapore 169856

1 pm	Registration (Lunch will be provided)
1.30 pm	Opening Address
1.50 pm	Course Overview
2 pm	MCQ Quiz (Part 1)
2.15 pm	Seminar 1: In General – Medical Expert
2.45 pm	Seminar 2: Instructions and Writing an Expert Report, Preparing for Court and Professional Issues
3.25 pm	Tea Break
3.45 pm	Seminar 3: Testifying in Court – What to Expect and Courtroom Skills
4.15 pm	Question & Answers
4.45 pm	MCQ Quiz (Part 2)
5 pm	Assignment & Instructions: Drafting an Expert Report
5.15 pm	End of Day 1

Day 2 (9 April, Saturday)

Venue: State Courts,
No. 1 Havelock Square, Singapore 059724

8.30 am	Registration
9 am	Course Overview
9.10 am	Seminar: Common Pitfalls in Writing Expert Reports
10 am	Morning Tea Break
10.20 am	Roleplay: Giving Oral Evidence in Court
2 pm	Lunch
2.30 pm	Closing Remarks/Debrief
3.30 pm	End of Day 2

CME Points: Max. 6 (pending approval from SMC)

Limited to 60 doctors.

30 participants will be given the opportunity of being directly coached by judges and lawyers in giving oral evidence in court
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Please return this slip for *Medical Expert Witness Training* to Denise Tan, **Singapore Medical Association, 2 College Road, Level 2, Alumni Medical Centre, Singapore 169850. Tel: 62231264, fax: 62247827 or email: denisetan@sma.org.sg.**
A confirmation email will be issued to all applicants.

Name: _____ MCR no.: _____ Year of graduation: _____
Contact no.: _____ Email: _____
Mailing address: _____

Please tick the following:

- A. SMA member: ☐ Yes ☐ No
B. AMS member: ☐ Yes ☐ No
C. ☐ GP ☐ Specialist (please include specialty: _____)

Registration fee: \$450* (Inclusive of GST) *For SMA/AMS members (in good standing), \$350 will be refunded upon completion of the training

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Pioneer GPs and medical students gathered at the Grand Copthorne Waterfront Hotel for the SG50 Appreciation Dinner for Pioneer GPs.

HONOURING PIONEER GPs

By Agency for Integrated Care

When West Coast Clinic and Surgery's Dr Yeo Kwan Ching started working as a General Practitioner (GP), primary care was not widely practised in Singapore. Young doctors were well versed in their areas of specialisation such as neurology or obstetrics and gynecology, but these were too narrow to provide primary care for families and children.

However, primary care has grown dramatically in the last couple of decades, and is now commonplace. "Medical students these days have to go through an entire Family Medicine module that covers all disciplines. I think young doctors in Singapore today have much more exposure, and are definitely better equipped as GPs than the previous generation," Dr Yeo explained during the SG50 Appreciation Dinner for Pioneer GPs on 30 October 2015. More than 150 pioneer GPs were honoured for the critical roles they played in the growth of Singapore's healthcare sector over the years.

The dinner — jointly organised by the Agency for Integrated Care (AIC), the College of Family Physicians Singapore (CFPS), and the Ministry of Health (MOH) — was held at the Grand Copthorne Waterfront Hotel, and was graced by Minister for Health Mr Gan Kim Yong as well as Special Guest, Minister of State for Health Dr Lam Pin Min.

About 50 medical students — from Nanyang Technological University's (NTU) Lee Kong Chian School of Medicine, as

well as the National University of Singapore's (NUS) Yong Loo Lin School of Medicine and Duke-NUS Graduate Medical School — also attended. They were there to pay tribute to the pioneer GPs and learn from their journey as doctors.

With a string quartet playing in the background, students and pioneer GPs mingled at a cocktail reception preceding the dinner. While many of the pioneer GPs were happy to catch up with ex-schoolmates and other doctors, some also reached out to the students, engaging them with stories about their careers and what being a medical student was like back in the day. Students and GPs continued their lively interactions even after taking their seats in the ballroom.



Pioneer GPs and medical students engaging in lively interactions over dinner.

Doctors and guests enjoying the presentations given by guest speakers.



In his welcome speech, Minister Gan highlighted the importance of the GP's role in the healthcare system. "GPs have a unique doctor-patient relationship that enables them to empower their patients to make good lifestyle choices," he asserts. "The trust and familiarity GPs enjoy with patients and their family members allow them to advocate for their patient's wellbeing. The family doctor's holistic understanding of patients' needs is the essence of good family medicine. It is also key to keeping our care cost-effective and sustainable in the long run."

Minister Gan also thanked the pioneer GPs for being on Singapore's frontline, safeguarding the nation's health in times of crises, especially during the SARS and H1N1 outbreaks as well as the current heavy haze. "We salute the healthcare teams and GPs who played a key role in successfully containing the outbreaks. And we remember our colleagues who sacrificed their lives in saving others," he said.

As the attendees tucked into a sumptuous eight-course Chinese feast, presentations were given by veterans of the primary care sector. CFPS President Associate Professor Lee Kheng Hock reviewed the Primary Care landscape over the past 50 years, tracing it back to its inception in 1969. Ex-president of CFPS, Associate Professor Goh Lee Gan and pioneer GP Dr James Chang shared their life stories and experiences in academia and private healthcare respectively.

Both doctors and students were full of praise for the event. Dr Mary Wee of Rochor Centre Clinic commented, "I really appreciate the thought put into this event to thank us pioneer GPs. It was also great that the young and old could come together to share ideas and experiences."

Yeo Wei Ren, a first-year student from the Lee Kong Chian School of Medicine, also enjoyed the dinner thoroughly. "I found the event very well organised. Although there is much literature documenting the growth of healthcare in Singapore over the years, the presentations and anecdotes from the pioneer GPs made it all come alive," he said.



Dr Chang sharing his experiences in the healthcare sector with attendees.



AIC will continue to engage GPs and involve them in events and new initiatives.