SMA news

For Doctors, For Patients

VOL. 54 NO. 2 | FEBRUARY 2022 | MCI (P) 077/12/2021

HEALTHCARE LEADERSHIP

INSPIRING INNOVATION AND CHANGE

Leading Innovation and Change – **DDMS A/Prof Dan Yock Young**

Bearing Good Fruits: **The Healthcare Leadership College**

We invite Family Medicine Physicians, Resident Physicians and Generalists to join the medical team at Jurong Community Hospital.

The Post-acute & Continuing Care (PACC) team at Jurong Community Hospital (JCH) comprises physicians with postgraduate training in family medicine, geriatric medicine or internal medicine, providing inpatient care to patients that require sub-acute care or rehabilitative care after an acute illness or surgery. The incumbent will work with a multi-disciplinary team of nurses and allied health professionals to provide holistic care to JCH patients. The incumbent will also work in close partnership with community health service providers to enable care-reintegration into the community.

REQUIREMENTS

Candidate must possess a basic Medical Degree and postgraduate qualifications registrable with Singapore Medical Council. Those who have MMed (FM), FCFPS or MMed (Int Med) or other postgraduate qualifications recognised by College of Family Physicians Singapore (CFPS) or Specialist Accreditation Board (SAB) will be considered for Senior Physician or Specialist positions.

JurongHealth Campus is a part of the National University Health System (NUHS) group, serving the community in the western region.

JurongHealth Campus comprises the integrated 700-bed Ng Teng Fong General Hospital (NTFGH) and 400-bed Jurong Community Hospital (JCH) which were designed and built together from the ground up as an integrated development to complement each other for better patient care, greater efficiency and convenience. NTFGH and JCH were envisioned to transform the way healthcare is provided, and together with the National University Hospital, National University Polyclinics, Jurong Medical Centre, family clinics and community partners, to better integrate healthcare services and care processes for the community in the west.

To find out more, please write in with your full resume to:
Medical Director
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Email: **JHCampus_medicalcareer@nuhs.edu.sg**

For more information, visit:
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We regret that only shortlisted candidates will be notified.

Ng Teng Fong General Hospital

Jurong Community Hospital

SMA news
Vol. 54 No. 2 | 2022

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Email: news@sma.org.sg
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UEN No.: S61SS0168E

DESIGN AGENCY
Oxygen Studio Designs Pte Ltd

PRINTER
Sun Rise Printing & Supplies Pte Ltd

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The EDITORS' MUSINGS

Dr Tina Tan

Editor

Dr Tan is a psychiatrist with the Better Life Psychological Medicine Clinic, and a visiting consultant at the Institute of Mental Health. She is also an alumnus of Duke-NUS Medical School. Between work and family life, she squeezes time out for her favourite pastimes – reading a good (fiction) book and writing.

The ability to transform and adapt healthcare and its systems to ever-changing times is something that was rarely taught in medical school. How do you incorporate and teach the wealth of knowledge that comes from delving deep into an organisation, and mould it into that final envisioned product? Well, by ensuring that such experiences are shared. By having students and younger doctors learn from the lessons of their seniors in such a journey.

In this issue, we feature comprehensive articles from a diverse group of individuals on healthcare leadership and healthcare of the future. We hope that this will be educational to all our readers, especially those who wonder what weighs on our bosses' minds and those overseeing various components of our local healthcare system.

In addition, Dr Desmond Wai's article on his Vaccinated Travel Lane travels will provide some much-needed vicarious travelling as well as his personal insights on the downsides of travelling during a pandemic.

Happy reading.

Dr Clive Tan

Guest Editor

Dr Tan is a public health specialist. He is also Director for Integrated Care Planning in the National Healthcare Group, where he and his team are planning for new ways of health service design and delivery that will promote better health for all, reach out to underserved populations and respond more effectively to patients with complex health needs.

"A leader is best when people barely know he exists, when his work is done, his aim fulfilled, they will say: we did it ourselves." – Lao Tzu

Throughout the two years of the COVID-19 pandemic, we have seen strong leadership in Singapore's healthcare sector emerge at every level. These leaders have stepped up to the mantle, risen to the occasion, and carried many heavy decisions. Our Director of Medical Services, A/Prof Kenneth Mak, is one stellar example of a stoic leader who has led us well and been there with us throughout the entire campaign. There are also many leaders who have toiled behind the scenes, responding to emergent situations, preventing the next crisis, or even just keeping the ship afloat amid these rough seas.

In this issue, we are glad to be able to share a few stories from our healthcare sector leaders on their leadership journeys in their respective roles. For every story shared, there are hundreds that may go untold. But like the boy that is picking up starfishes from the beach and throwing them back into the sea, we hope that these few stories will be meaningful to you and also bring you some joy. ◆

LEADING INNOVATION AND CHANGE AT THE HEALTH SYSTEM LEVEL

Interview with DDMS A/Prof Dan Yock Young

Interview by Dr Clive Tan, Editorial Board Member

***SMA News* spoke with Deputy Director of Medical Services (DDMS) (Health Services Group) A/Prof Dan Yock Young to hear about his work in leading healthcare transformation, and his thoughts and perspective about some of the ongoing planning work for the healthcare system.**

Dr Clive Tan – CT: Hi Prof Dan, thank you for agreeing to this interview with *SMA News*. To start things off, could you share with us who the role models and mentors you looked up to early in your career were, and what was it about them that inspired you?

A/Prof Dan Yock Young – DYY: This question alone will take the whole afternoon if I start talking about *all* my mentors. (*laughs*) I subscribe to the Chinese saying "三人行，必有我师" (idiom from Confucian Analects meaning there is always something to learn from other people). So in life, we will meet many potential teachers; the question is whether we take the opportunity to learn from them. One of my professors once told me, "There is no such thing as a bad teacher; even if you learn nothing useful from them, you'll learn not to be like them." There were many teachers in my journey, and a few true mentors in my training career who left an indelible mark.

When I was a house officer, I was posted to Singapore General Hospital's Medical Unit III; we called this the "hell posting" at that time. The head of department then was Prof Ong Yong Yau – *the* great YY Ong. There was one evening at about 6 pm when we were still fervently clerking cases. He came by to do his evening round and saw that many cases were still unclerked. Prof Ong rolled up his sleeves and began clerking the cases, taking blood and setting IV plugs. We all went, "Eh, Prof is clerking cases," and quickly ran over saying, "Prof, we'll do this." He said to us, "Why? This is a patient here lying in need, I am the doctor whom he needs, so why should I not be doing anything – I'm just doing my job." Perhaps because I was very young in my career then, it struck me that that was the simplest and most basic form of doctoring, a doctor responding to a patient's needs. And that has always reminded me, even many years on, that the first and most fundamental duty of a doctor is to the patient. Even though we may belong to a system and there are hierarchies and so on, our first responsibility has to be to the patient. That experience left an indelible mark.

Moving to gastroenterology, I've had many teachers and mentors as well. I was very lucky that I had Prof Lim Seng Gee, Prof Yeoh Khay Guan and Prof Lawrence Ho, whom I call my mentors. I always tell the people that you do not need to confine yourself to just one mentor. In fact, I count myself very lucky to have three "foster parents" who constantly looked out for me, who would reach out and pull me along whenever there was a need. So these are some of my role models. There are many more, but I will not mention all of them, or we will be here till tomorrow.

CT: Thanks, Prof Dan. Over the span of your career, you have also taken on a lot of different leadership roles. Do you recall which role was your most challenging?

DYY: I think the most unforgettable role so far was my involvement with the Joint Task Force response at the

Ministry of Manpower, where I had the good fortune of meeting you [Dr Clive Tan] and many good and able men and women. That was the time when we had a COVID-19 outbreak among the migrant workers, and we were trying to bring it under control. I suppose what was unforgettable about it was that when we first went in, the virus was still very much unknown. The task given to us was mammoth and at times, there were no good solutions. The situation was volatile and there were times when there is no certainty that our strategies will turn out as we had planned it, and that added to the complexity of the situation.

What I found most challenging about the experience was having to give the orders to our various healthcare clusters, workers and volunteers to go into the dormitories. As you would remember, the working conditions there were tough – it was hot, staff had to be all gowned up in personal protective equipment and safety was a priority. We had to share the logic and rationale clearly and convince the staff as to why they needed to go in; and they were fantastic – they lived up to their duty, their calling, and they did their job.

But the toughest part, I think, was lying in bed wondering whether, despite what we have done, the migrant workers were truly safe in their dormitories; whether we would see the light at the end of the tunnel; and whether all the sacrifices of our front-line workers were in vain or not. So when everything did come through and we managed to bring the spread under control, there was a huge sigh of relief. Going through it was a very challenging and humbling experience that I will never forget.

Shifts in the healthcare landscape

CT: The challenges within the healthcare sector are getting more complex now. Some have suggested that in healthcare, there is a shift from having a strong leader to strong leadership teams. What are your views on this?

DYY: I think of that in two ways. Firstly, leaders in the past also had great teams – Alexander the Great won campaigns with teams and the late Lee Kuan Yew also had a fantastic team to help build Singapore. We should not use it as an excuse that "I do not need to be a perfect leader; I have a team and I can take less responsibility." Having said that, society and life are tougher now, and there are many facets of leadership that a single leader may not be able to achieve on his/her own.

Within healthcare, systems have gotten more complicated and more challenging. There are uncharted territories, unknowns and multiple areas to oversee, so you really do need a good team.

CT: On leading and driving healthcare transformation at the national level, what are some of the major issues or challenges that you and your team are grappling with?

DYY: I will share from my personal perspective. To me, the biggest challenge is that nobody has gotten it right. Yes, we always want the system to be cheaper, better, faster – but when you throw in the aspiration for people to live longer and healthier, and have ready access to good care, there is an inherent tension that makes it very challenging for a healthcare system. Singapore has done very well for its healthcare system; our system is highly efficient. We achieved that through pushing our tertiary services and specialists in a way that make them accessible and affordable to most people. But I think society has come to a point where that model may not be able to hold up to the challenges of the future.

The concept of the "Three Beyonds", in a way, is an effort to bring healthcare out of the hospital to the community, to re-centre on health and place more focus on value. However, I think we are at the point where we can go further to build a whole health ecosystem around the individual. It is a concept where we put the patient at the centre, then layer on the primary care and all the allied health services to support him/her in living a healthy life, and then finally building the secondary and tertiary care as the backup when the patient needs it.

Now, to achieve that goal, we really have to change peoples' mindset. The first thing we need to do is to paint that vision and picture for everybody to see what our healthcare system can be like. That is the grand plan; getting there is the tough part. I think that is the opportunity for us to really make a difference now.

Developing the future pillars

CT: Thanks, Prof Dan, for sharing on this future that we are working

A/Prof Dan Yock Young and Dr Clive Tan during the interview

towards. Turning the focus to our young doctors, nurses and allied health colleagues – how do you think we should infuse some of these values and concepts a bit earlier in their training, to groom the next generation of thinkers and leaders?

DYY: This question touches on what is most existential for university education. I often joke that medical school robbed me of my education, because in professional training you are taught certain skillsets and protocols, but yet the true essence of a university is really to teach people to disagree with what they have been taught, to unlearn what they may have been indoctrinated with, and to challenge and redesign the future. That is what I think university education hopes to achieve.

In that sense then, we need to train our people to be more flexible and creative. The world is moving at a very fast pace. What has worked before in the past may not be good enough for the future. As the saying goes – "If you don't change course, you will end up exactly where you're going". The question is, "Are you satisfied with where you're going?" Therefore, to really be one step ahead of the curve, you need to leverage on the opportunities that are available to you.

Today there's artificial intelligence, revolutionary medical technology, and all these new care models. We need to teach our young generation to be flexible and creative. We have always said that the solutions for their generation have not yet been thought of by us, and so it is up to them to chart their own paths. What we can try to do is to give them the background knowledge, skillsets and more importantly, the thinking process and framework, so they may leverage on what is being developed to build their own world.

CT: Thank you, Prof Dan. That really resonated with me. You mentioned the next generation of leaders in the healthcare sector – I think this would be useful for our younger readers, the aspiring leaders of the healthcare sector in their late 20s and 30s, to learn about. What do you think are some of the attributes that our future healthcare sector leaders should have?

DYY: Well, I think despite the rapid changes in medicine, the base attributes of a healthcare leader have not changed. The ethos, the public-mindedness and integrity, those will continue to be fundamental. People need to see leaders as being principled and upright; they need to have a mind for the public good and a heart for public service. But to be able to build the future, we also need nimbleness, creativity and the courage to dream of novel ways of doing things. Only then can we leverage and capitalise on the opportunities that are available to us. I would encourage the young generation to learn and use what has been taught to you as a foundation, but do not let yourself be restricted by it. Instead, strive to break through and create new possibilities.

Riding the wave of change

CT: Looking back at the last ten to twenty years, healthcare has undergone many waves of transformation, and it sounds like we're going through a wave of important systemic changes right now. With any change, I think there will be some doctors who may feel like they are not in control, that they are being caught up in this wave. I was wondering if you have any advice for these doctors, on how to be better prepared for this future?

DYY: The rapidly changing world will mean that everyone, doctors included, will have to be adaptable and dynamically agile to keep up with the times. Although doctoring in its basic sense – the traditional doctor-patient relationship – has not changed, the approach, emphasis and the operating tools will shift quite significantly. Fortunately, it usually does not require a complete makeover but a pivot to embrace the new opportunities that come along. After all, the science of medicine is by nature unassuming and ever-ready to embrace new evidence and chart new directions. An open-mindedness to learn, try, and evolve along the way will help tremendously. At the heart of our trade, our relationship, responsibility and trust with our patients will not change.

I think in the future, with the world evolving so quickly, we will have to be more deliberate about paying attention to the end-to-end transformation process. This is what the Civil Service alluded to in the three core steps of transformation: dare to dream, clarity of plans, and effective execution. We are generally quite good with the first two stages – we do dream a little bit and are very good at drawing policies and plans, but the execution is always the most challenging part. And in healthcare, we know we have lots of models, lots of pilots and ideas, but execution could possibly be faster, and more focused on scaling up for maximum impact. So I think to achieve that, we require more than just knowledge and skills – it also requires relational factors, to be able to convince, excite and bring people with you along this journey.

CT: Some have likened this change management issue for the healthcare system to shifting a very big ship, which would take a really long time. Is that your opinion as well?

DYY: Yes, changing the healthcare system is a huge endeavour, just like you said. People have described the healthcare system to be fundamentally complex. The analogy of healthcare is like a geometric game where every point must stay equidistant with the other two. Shifting one point will shift everything else along with it, and movement will continue for a long time because everything is in relation to each other.

I think those are the sort of fundamental challenges in healthcare, which is why it has been so difficult to tinker with it at the edges. But once we set the vision of where we want to go, it gives us a better chance of being able to move the whole system.

CT: What you mentioned sounds like complex adaptive systems and healthcare systems are indeed a well-known example of it. People who have to manage complex adaptive systems need to be trained to look at things differently, and to intervene differently because of the nature of such systems. In that sense, how are our healthcare leaders doing in terms of changing this complex system?

DYY: I think you brought up a very good point. We need to start getting the younger generation to think like this. Many in my generation, in our old school ways, may tend to have a "this is how it has always worked" attitude; we take a spanner and tighten or loosen a screw here and there. In complex systems however, you cannot do that because then, either nothing happens or the whole system becomes destabilised. So I think it will require a whole new mindset and skillset. This has to be included as part of our leadership development process, so that our young people have that ability to take on the challenges of the future, rather than use a very old toolbox that they were brought up with.

Learning from the pandemic

CT: From your experience and vantage point, how did this pandemic crisis transform our healthcare leaders, especially since everyone in healthcare was involved in the response in one way or another?

DYY: COVID-19 has been called the great divider. Because of its many unknown aspects, people hold very strong differing views of what should be done. In a way, COVID-19 issues touch on some of the very fundamental tensions in society – the individual versus common society; being conservative versus being pragmatic; being consistent versus being nimble and flexible to change. Those are the sort of polemics that can cause a lot of angst, and in a big way it has changed how healthcare leaders think and imagine how we can get some of those policies through. Because they say policy is what you plan, but the impact is what you are able to effect. We need effective implementation – and that is where we need leaders who not only can come up with good ideas but are able to persuade people to follow those ideas.

Throughout this COVID-19 pandemic, I felt that our healthcare leaders have had the opportunity to sharpen the trust and relationship with the fraternity to align everyone in the same direction. Even amid the initial confusion, the whole healthcare fraternity and ecosystem have never been more aligned. A lot of things that we had previously thought impossible have also been made possible and accelerated by COVID-19. For example, we took years to develop telehealth, and COVID-19 gave us the opportunity to fully implement it. I think we have gotten more nimble, and more aware of the multiple facets of policy decision-making. Good things have been borne out of COVID-19 – we should leverage and learn from these opportunities to sharpen ourselves. People have said that the biggest mistake of COVID-19 would be to wait for things to go back to normal and go back to our old ways.

CT: You mentioned a lot about gains. There is an ongoing conversation about how we must actively lock in these gains, so we do not retrograde from where we are at now. Do you have any advice on how, as a healthcare system, we can lock in these gains?

DYY: I think there are two levels to it. The first is that COVID-19 allows us to look at the problem from very different perspectives. Naturally, when we are caught in the humdrum of the pandemic, we are only seeing parts of an elephant. Yet in our response planning, COVID-19 forces us to take a step back and consider the other perspectives and overall implications. It has forced us to be more circumspect, more insightful and learn to develop a more holistic, big-picture view of the situation. The second thing we need to learn from COVID-19 is that in complex unpredictable scenarios, we have to be dynamically agile to plan, appraise, glean lessons and quickly re-strategise. The next challenge may or may not be another infectious agent. It is not what we have set up as standard operating procedure but whether we have distilled the principles we can draw and learn from it.

Staying mentally and physically healthy

CT: Prof Dan, tell us a bit about your work-life balance. There's so much demand on time, and work is also quite relentless, so how do you balance all these needs?

DYY: So I have had people ask me how I balance all these multiple parts, and my response is that I do everything badly. (*laughs*) Having said that, I don't think my time demands are tougher than the average Singaporean. What is important is that we make every minute count. Every minute that you have, you want to make sure that you make the best of it. For example, whatever time you have for unwinding with your family, you make sure that it is focused quality time. And you learn to reduce the time that you waste or not do anything with. To be fair, I think to be able to strike a good balance also requires the good fortune of having a very independent and supportive family. I am by nature also very low maintenance, so that helps. (*laughs*)

CT: So how do you unwind or destress?

DYY: I try to run, though my physique does not really show it. Not to sound too superficial, but I feel that one thing I learnt about running is that when you are gasping for life after a run – it is the closest to a feeling of being alive. So that is my way of de-stressing. Although I have not been too successful at it because of increasingly limited time.

Final thoughts

CT: Prof Dan, as we reflect back at your own journey, from a clinician, to going into research, teaching and your current post as DDMS, how would you describe your journey in medicine and leadership?

DYY: I feel extremely fortunate and privileged to have met some excellent people in my life. Whether they are my mentors, my teachers, my mentees, people I work with or people who have helped and supported me, it has been a tremendous experience and they have defined me. And it is such a privilege to work and interact with people – that helps fuel the energy that drives me on. I often say that I do not know which is more exciting – having come so far together, or having so far more to go. So I look forward to working with more people and learning from them – colleagues, juniors, students, friends and patients – for they enrich my life and I am so thankful for them.

CT: 50 is the new 30, right? (*both laugh*) Thank you so much for your time and for sharing your thoughts with our readers. ◆

For the full interview transcript, please visit https://bit.ly/5402-Feature.

Bearing Good Fruits

THE MISSION OF THE HEALTHCARE LEADERSHIP COLLEGE TREE

Text and photo by Prof Aymeric Lim

Prof Lim is the CEO of the National University Hospital. With almost 30 years of experience, he is an internationally recognised hand and reconstructive microsurgeon at the National University Hospital and a professor with the Department of Orthopaedic Surgery, National University of Singapore. He was the founding Dean of the Healthcare Leadership College from 2012 to 2021.

The symbol of the Healthcare Leadership College (HLC) is a tree. Good trees have solid roots; they have strong trunks with sturdy branches and healthy leaves, and they bear good fruit.[1-3] Trees maintain a deep bond with each and every one of us, no matter the country, conviction or culture. And this is exactly why the tree – from a sapling to a mighty giant – is emblematic of the HLC.

More than a decade ago, it was noted that healthcare in Singapore had been growing the wrong way. The focus had shifted from treating the patient to treating the disease. Altruism was withering, and this trend needed to be stemmed. Ms Yong Ying-I, the then-Permanent Secretary of Health, set up the HLC in 2012 to rejuvenate the true ideals of our mission, and to reinject humanism into our profession and healthcare in general.

Values

The very *first mission* of HLC was to re-establish the importance and visibility of **values**, which form the core and the roots of HLC. Core values are similar across all our public institutions.[4-6] They are built around compassion. True compassion is altruistic; it demands excellence and is expressed through service. Any organisation that holds to this for its own staff will display the same compassion for its patients.

Values define the organisation; just like the ten commandments were inscribed on stone for posterity, so too must values be made visible for all to see across time. The problem with values though, is that they must be held to even when it is hard. This requires an inner strength of conviction called moral courage. Moral courage is the primary enabler of our values; it is a sine qua non for leadership.

Moral courage

Perhaps there is no better description of moral courage than that of General William Slim's (1891-1970).[7] William Slim, described by Admiral Louis Mountbatten as the finest general World War II produced, said of moral courage: "You must have moral courage. Moral courage is a *much rarer* thing than physical courage. Moral courage means you do what you think is right without bothering very much what happens to you when you are doing it."[8]

This description is perfect for healthcare. **Moral courage** mandates that doing the right thing takes primacy over doing things right. There will be times when doing the right thing may come at some personal costs, and the choices will be made by an authentic leader's innate moral compass.

Sources of leadership wisdom

There is a paradox in healthcare. While failures of leadership have severe consequences for patients, the consequences for the leaders themselves are usually not direct, nor immediate.

In business, the consequences for leaders are direct. The business will go bankrupt and leaders will be replaced. In the military, the immediate consequences of failure are defeat and death for the soldiers, and often for the commanders.

I therefore think that it is the military leadership literature that is truly tried and tested, and the most valid. It can and should be applied to healthcare, and there is no better example than the COVID-19 pandemic. During these past two years, our intelligence was always changing, our plans always appeared to be less than perfect and upon execution of these plans, the reality looked very different.

One of the greatest military classics is the multi-volume treatise *On War* by Carl von Clausewitz (1780-1831),[9] a Prussian general.[10] He wrote these volumes after Prussia had been crushed by France in the Napoleonic wars. He says of plans, intelligence and reality: "Many intelligence reports in war are contradictory; even more are false, and most are uncertain", "The enemy of a good plan is the dream of a perfect plan", and "Everything takes a different shape when we pass from abstractions to reality."

Policies

If values are the roots of our tree, then the trunk is formed by sound healthcare **policies**. Strong national values and philosophies lead to good policies. They form the backbone of any healthcare system. If they are weak, the system will crumble.

I think that the central policy, that of *accountability* on the part of patients as well as the system, was established by Lee Kuan Yew. He stated in his memoirs that: "The ideal of free medical services collided against the reality of human behaviour, certainly in Singapore. My first lesson came from government clinics and hospitals. When doctors prescribed free antibiotics, patients took their tablets or capsules for two days, did not feel better, and threw away the balance. They then consulted private doctors, paid for their antibiotics, completed the course, and recovered. I decided to impose a charge of fifty cents for each attendance at outpatient dispensaries."[11]

Our COVID-19 response and policies were values-driven. The first duty of the government is to protect its people, and this is what Singapore has done. Prime Minister Lee Hsien Loong stated in 2020:

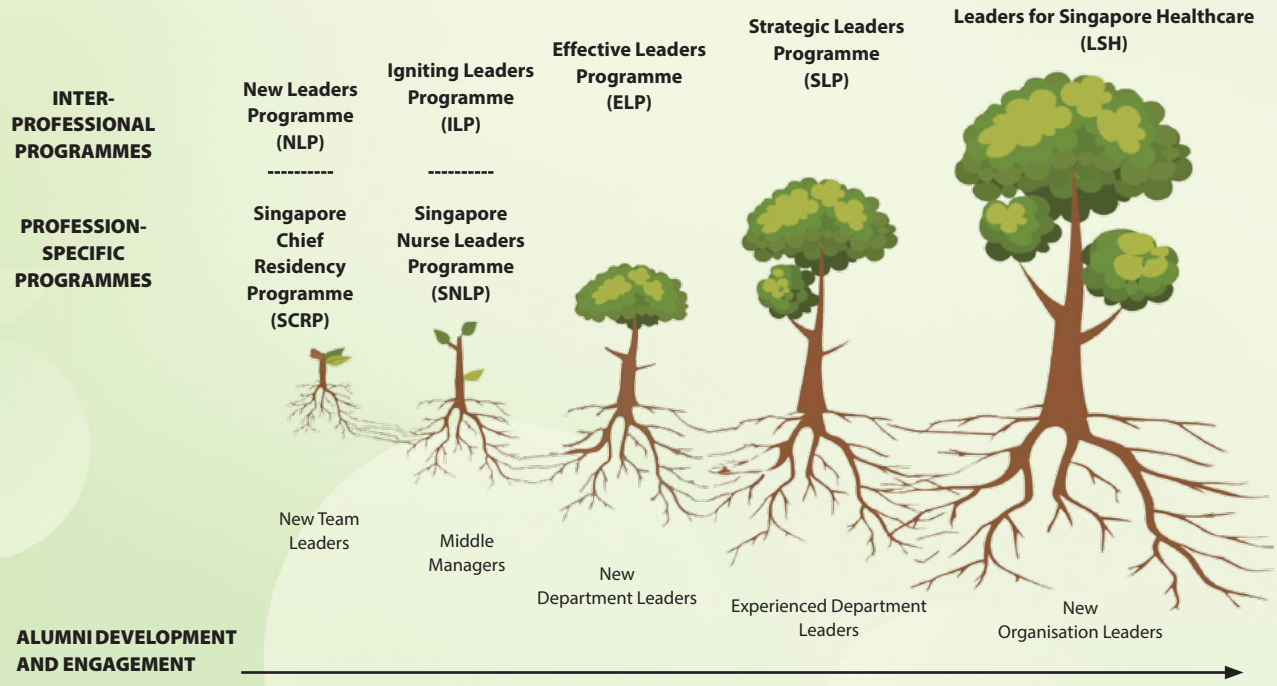

Figure 1 HLC Milestone Programmes Trees

"We will keep on doing our utmost to protect every Singaporean from COVID-19. Many people have been working tirelessly for the past two months. Our nurses and doctors, our contact tracers and healthcare staff. We thank them all for their efforts and sacrifices. Now we are all enlisted to join them on the frontline."[12]

He demonstrated the role of humanism in medicine when he promised to deliver healthcare to foreign workers in the country: "If any of their family members watch my video, let me say this to them: 'We appreciate the work and contributions of your sons, fathers, husbands in Singapore. We feel responsible for their well-being. We will do our best to take care of their health, livelihood and welfare here, and to let them go home, safe and sound, to you.'"[13]

If we as a nation had not chosen this course of action for our migrant workers, there would have been damaging effects to our national character.

Execution

Policies have little use unless they are paired with well-articulated and well-executed strategies; these branch out from values-based core policy. Neither articulation nor **execution** is easy. They require a simplicity of intent, a clarity of logic and diligent determination. Stephen Bungay puts it very well:

> "Having worked out what matters most now, pass the message on to others and give them responsibility for carrying out their part in the plan. Keep it simple. Don't tell people what to do and how to do it. Instead, be as clear as you can about your intentions. Say what you want people to achieve and, above all, tell them *why*. Then ask them to tell you what they are going to do as a result."[14]

Programmes at the HLC are designed on three interlacing principles:

1. Thinking up – having a sound understanding of policy.
2. Thinking across – across our institutions and the professions.
3. Thinking ahead – planning the future of healthcare delivery.

Three strategic manoeuvres were used in planning the future of healthcare in Singapore:

1. Rationalising healthcare into three clusters – combining the dual juxtaposed strengths of consolidation and competition.
2. Developing the "Three Beyonds" – Beyond Healthcare to Health; Beyond Hospital to Community; and Beyond Quality to Value.
3. A mindset recalibration from tribal-think to a systems-based approach of thinking for the good of the patient, the good of the healthcare system and the good of the nation.

We need to remember that there is no greater obstacle to successful execution than micromanagement.[15]

Outcomes

The fruits are the raison d'être of the HLC. These are the excellent men and women that HLC has trained: leaders that execute well-laid and well-conceived plans, based on values-driven policy, with the moral courage to do the right thing. The leaders we produce at HLC work for the good of all patients, their families, and both society and nation.[16]
These leaders understand that the enemy may be the disease, but the ones that need the healthcare are the patient and the nation. After all, 下医医病, 中医医人, 上医医国 (the mediocre doctor treats the disease, the common doctor treats the patient, and the best doctor solves the problems of the country). ◆

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Changing the Face of Healthcare

One Step at a Time

Text by Dr Tan Yia Swam

"There are few things wholly evil or wholly good. Almost everything, especially of government policy, is an inseparable compound of the two, so that our best judgment of the preponderance between them is continually demanded."

–Abraham Lincoln[1]

Healthcare leadership

February's heavyweight issue carries articles by various leaders from different sectors of healthcare, sharing both current developments and future plans. Having a vision is important, followed by a good team and real-life implementation with regular feedback for refining and adjustments.

This month marks the completion of my first year serving as a Nominated Member of Parliament (NMP). The personal growth has been tremendous, in learning about how a country is run, and even a bit about Singapore's participation on the global stage. At my core, I remain a simple *heartlander* (referring to one who lives in the heartland), comparing prices between Sheng Siong, Giant and NTUC FairPrice. Some days during Parliament sittings, I feel overwhelmed, much like how I used to feel as a houseman in a Morbidity and Mortality meeting with complex discussions flying over my head! Perhaps the one area I am most confident in is the clinical practice of medicine, especially my own subspecialty. Another area in which I can hold intelligent discussions would be on the local healthcare system – in-depth conversations to ruminate, debate and (hopefully) reach consensus on difficult issues.

In my 16 years of volunteer service on the SMA Council, I have heard so much about the problems that plague those in private practice, such as difficulties with private healthcare insurers (in Integrated Shield Plans [IPs] and Employees' Benefits plans), third-party administrators (TPAs) and medical concierge services. These last two arose out of an apparent need to bridge gaps in services, and as like any other businesses, they charge a fee. But how do they charge, who do they charge and who regulates them?

In my capacity as an NMP, I have raised questions about these,[2,3] and have received some answers. But the devil is in the details. An article written in 2016 made mention of some changes to how TPA fee arrangements should be disclosed.[4] But what has truly changed since then? I know that the Singapore Medical Council Ethical Code and Ethical Guidelines[5] has clearly stated that fee-splitting is wrong, but that applies only for doctors. The onus is on us to be aware of the fees, and to not fall afoul of our ethical code. But are the contracts transparent? Do we understand market forces?

I have heard that one simple solution is for doctors to refuse to sign any TPA agreement. But is it really that easy for a doctor to refuse to sign with any TPA?

Healthcare makeover

The time may be right for Singapore healthcare to have a makeover. COVID-19 is a worldwide threat, and now more than ever before, precious healthcare resources need to be allocated wisely. More people, even among the public, are sensitive to the need for appropriate usage of precious resources such as ICU beds, and the practical limitations of laboratories, trained personnel and even something basic like sheer human endurance. Working endlessly for 24 months, under stressful conditions, without a break takes its toll. Even if the budget is infinite, the time needed to train a healthcare worker is years in the making.

More than ever before, **right-siting of care** is essential. Education is also key, such as educating the public in basic first aid, basic health knowledge and knowing how to access the healthcare system. Some important questions to address include: What is the role of primary care? What is the difference between a GP and a polyclinic doctor? When should one head

to a hospital's emergency department? How should subsidised healthcare be utilised? When should one go to a private doctor? How much does one's medical insurance cover? I had started a blog to address some of these issues, but alas, I do not have the time to maintain it!

At the risk of sounding self-serving (now that I am also in private practice), **a robust private sector will help reduce the stresses on the restructured hospitals**. In 2012, the then-Minister for Health Mr Gan Kim Yong[6] presented the roadmap for Singapore's "Healthcare System 2020". I draw attention to his emphasis on the development of primary care, the introduction of models of care to tap on the capacity of private GPs to provide accessible, affordable and high-quality care, and the acknowledgement that the private sector has the capacity to help ease the burden of national healthcare needs.

In these past nine years, indeed much has been done. The unity of the various healthcare sectors in rising up to the unprecedented challenge of COVID-19 is a matter of public record. I believe the SMA, together with our sister professional bodies, will continue to help in integration and support through even stronger representation for doctors, in particular the private sector, and doctors in training. With medical doctors as office holders within our Government, perhaps we can help to tackle the problems plaguing primary care, as Minister for Manpower Dr Tan See Leng mentioned in his reply to my Supplementary Question in Parliament;[7] much as how the Multilateral Healthcare Insurance Committee was set up to address the problems faced with the IPs.

Healthcare representation

In having multiple roles and portfolios,[8] my challenge on the personal front is having work-life balance. My poor kids see less of me, and some of you would have seen them barging in on Zoom meetings! Professionally, I stay aware of the different hats I wear, and take care to differentiate them. When I make a comment, I need to know if I am making it in my personal capacity, or in the role of a public figure.

Being mindful of the intent of what I say and the audience I am speaking to is essential, or I run the risk of being taken out of context! I follow one simple rule of thumb: when all is in alignment, I am confident it is the right way. And when they are at odds, I need to ponder more on why I cannot commit to a single view.

In treading through the complexity of the healthcare system, there is no one simple answer, and it will take a group of like-minded people to achieve a fair ecosystem.

As I end, allow me to share three visions:

1. My vision for the future of private healthcare: good quality care, timely access, seamless processes and fair payments for all parties. After two years in the private sector, I have an inkling of what it means to run a business. Businesses should be profitable. But healthcare should **NEVER** be **profiteering** off people's suffering. That is my personal ethos. If one wanted to be ultra-rich, one should not have entered healthcare.[9]
2. My vision for the SMA: to be the bridge between doctors and patients, doctors and insurers, and doctors and Government; to achieve an equitable healthcare ecosystem **for doctors, and for patients**. Hence, SMA decided to support Health Connective, an initiative by the lead technology providers, namely Smarter Health, Assurance Technology and Health Catalyst, which aims to be one of the ways for increased transparency, accountability and affordability in private healthcare (read more at https://bit.ly/3Hjr6v1).
3. My vision for Singapore (and even the world): to be kinder, sensible and tolerant of differences. Even as the world becomes divided over race, nationalities, vaccination status, etc – **as individuals, let us be kind**. Learn more about the Singapore Kindness Movement,[10] and practise it in our daily lives. Everyone is going through their personal hardships, which we may never fully understand.

In this year of the tiger, I wish all readers "虎虎生威" – to brave the year ahead with the strength and vitality of the tiger! ◆

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Dr Tan is a mother to three kids, wife to a surgeon; a daughter and a daughter-in-law. She trained as a general surgeon, and entered private practice in mid-2019, focusing on breast surgery. She treasures her friends and wishes to have more time for her diverse interests: cooking, eating, music, drawing, writing, photography and comedy.

SMA Charity Auction

Giving through Art

Text by Dr Ng Chew Lip

Centenarian Cultural Medallion winner, Mr Lim Tze Peng, has generously donated a piece of his iconic artwork to support the publication of an artbook by SMA and writer/artist Mr Josef Lee on Singapore's fight against COVID-19. All nett proceeds from the book will go towards the SMA Charity Fund to support medical students in need.

Born in 1921, Mr Lim is one of Singapore and Southeast Asia's most celebrated living artists. He was awarded the Cultural Medallion in 2003 and is also Singapore's highest-selling living artist, with a painting auctioned for HK$1.25 million (S$215,226) at Christie's in December 2021. A largely self-taught artist, his calligraphy was profoundly influenced by Kang Youwei, a master calligrapher, politician and reformist of the late Qing dynasty, and his paintings by painter and art theorist Huang Binhong. His iconic muddled words (糊涂字), often portrayed against colourful backgrounds and paintings of shophouses along the Singapore River, are highly sought after by collectors.

At 100 years of age, Mr Lim continues to paint and write daily. At a recent launch of a book about Mr Lim's life and philosophy on art, guest of honour Prime Minister Lee Hsien Loong said, "From his streetscapes and kampung scenes in our early nation-building years, to his iconic paintings of Chinatown and the Singapore River through the decades, they offer a vivid glimpse of the colour of everyday lives in Singapore – still within living memory, but fading into the past year by year. His life's work captures the atmosphere of the changing times, as our country developed and urbanised. It opens a window into our nation's soul, while enriching our heritage, and helping to form an emerging national cultural identity."

This iconic calligraphic piece (97 cm by 89 cm), titled 孝 (filial piety), was completed in December 2021. It demonstrates strong brush strokes with masterful 飞白 (white spaces within the black ink), with Mr Lim's iconic harmoniously colourful background painted with ink specially sourced from Japan. It is signed off with 百岁林子平, which means "Lim Tze Peng at 100 years old". At 100 years old, his works have a special auspiciousness and meaning due to an association with his longevity, and are crystallisations of the century-long practice of his craft. This artwork will make a pleasing centrepiece in a home or clinic; it harbours deep meaning and will make a delightful conversation piece. It will also be exhibited at our book launch for public viewing in mid-2022. This piece comes unframed, with a letter of appreciation and authenticity from SMA.

SMA is pleased to open bidding to Members, beginning from $8,000 (excluding GST). Please submit your bids via email to sma@sma.org.sg before 20 March 2022. We will announce the winning bid by 31 March 2022. ◆

The SMA Charity Fund (SMACF), an independent charity arm of the SMA, is an Institution of a Public Character (IPC) and charity in Singapore. SMACF endeavours to develop a compassionate medical profession that contributes towards better healthcare in Singapore through providing financial assistance to needy medical students; advocating volunteerism among the profession; supporting learning exposure for medical students; and recognising mentorship. Both SMA and SMACF believe in giving back to society and encourage SMA Members to do the same.

HIGHLIGHTS

From the Honorary Secretary

Report by Dr Ng Chew Lip

Dr Ng is an ENT consultant in public service. After a day of doctoring and cajoling the kids at home to finish their food, his idea of relaxation is watching a drama serial with his lovely wife and occasionally throwing some paint on a canvas.

2021 SMA Members Appreciation Giveaway

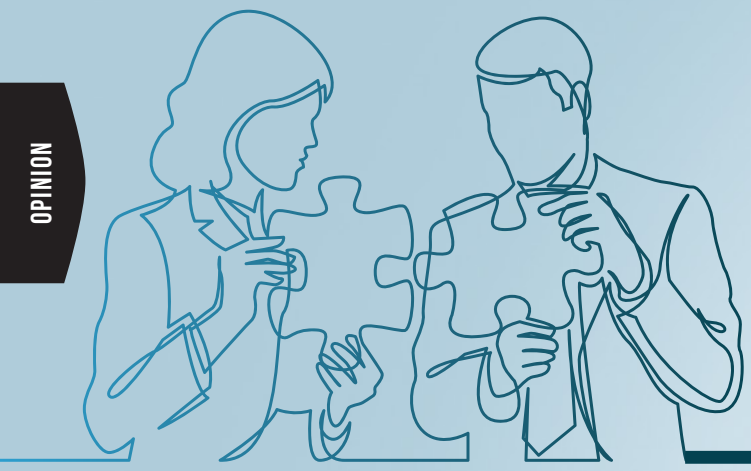
We wish to thank Members for making the giveaway an overwhelming success, with all 300 pairs of Golden Village movie e-vouchers redeemed in a short period of time.

We also encourage Members to consider whitelisting sma@sma.org.sg in your email system, to prevent SMA emails from going into your spam folder and missing out on receiving timely updates and information on events organised by SMA.

We look forward to your participation in our future events. ◆

Calling all house officers *past and present!*

SMA News invites you to share your house officer experience and how it shaped you as a doctor. Whether your housemanship took place in 2022, 1992 or 1972, send in your stories to **news@sma.org.sg** and let us share them with the generations of doctors to come.



Bringing Together the Heart of a New Campus

Text by Dr Nicholas Chew, Dr Rochelle Kinson and Yvonne Ng

Woodlands Health (WH) employed its first staff in 2014. Since then, we have been progressively hiring staff in preparation for our opening in 2023. Without a staging site for hospital operations, our staff have been nested in nearly all public hospitals in Singapore and have not had the opportunity to work together as intact teams (eg, team leaders and team members are sometimes physically sited in different locations). Work processes, identity, culture and behavioural norms have been heavily dependent on the staffs' previous work environments and their current nesting sites. It is therefore a continuous challenge for WH to form an identity and culture of our own.

Creating our culture

In 2018, WH created a framework to drive identity formation and enhance joy in work. Our aim was to create an environment in which our leaders could learn and practise collective leadership in order to develop an engaged and empowered workforce.

We identified three goals through conversations with staff about the culture they hoped to see in the future WH. These were (a) alignment of meaning and purpose, (b) development of psychological safety and trust, and (c) encouragement of participative management. We then strategised to intervene at three levels of the system, namely (1) developing skills to enable collective leadership, (2) engaging in team conversations, and (3) implementing pulse surveys to continually sense our progress.

Skills to enable collective leadership

WH leveraged on preceding work done by the National Healthcare Group in developing a framework for collective leadership. We created a curriculum to develop skills in using tools that enabled individuals (intrapersonal) and teams (interpersonal) to raise individual awareness, enhance collaboration and distribute power through collective leadership. This was introduced to leadership and senior staff across all family groups and further distilled for junior staff to better contextualise the skills to their work settings. Bite-sized content was incorporated into the WH orientation programme and service training. We further enabled the application of these skills by curating a reference toolkit for team leaders. The WH Organisation Development team was at hand to coach and assist in the process.

Team conversations

Team conversations took on two forms: programmatic and purpose designed.

We began by working with willing teams to co-create team conversations around topics such as why they joined WH, what would bring meaning to the work they do, specific requests they may have, the challenges they faced and their offers to work through the challenges together. Requests that were made to the organisation were then surfaced to WH leadership and a closed loop was created with the team leader. Check-ins with the team leader were done every three to four months to review progress and assess the need for further team conversations.

As we engaged with teams over a period of time, it became clear that their needs evolved. Team sizes were growing rapidly, the dynamics in nesting sites changed and WH development requirements grew. In addition, the impact of COVID-19 operations and opening delays led to new emerging needs. With this in mind, we began to purpose-design team conversations to address these changing needs. Figure 1 is an example of how the team conversations for a WH team evolved over time.

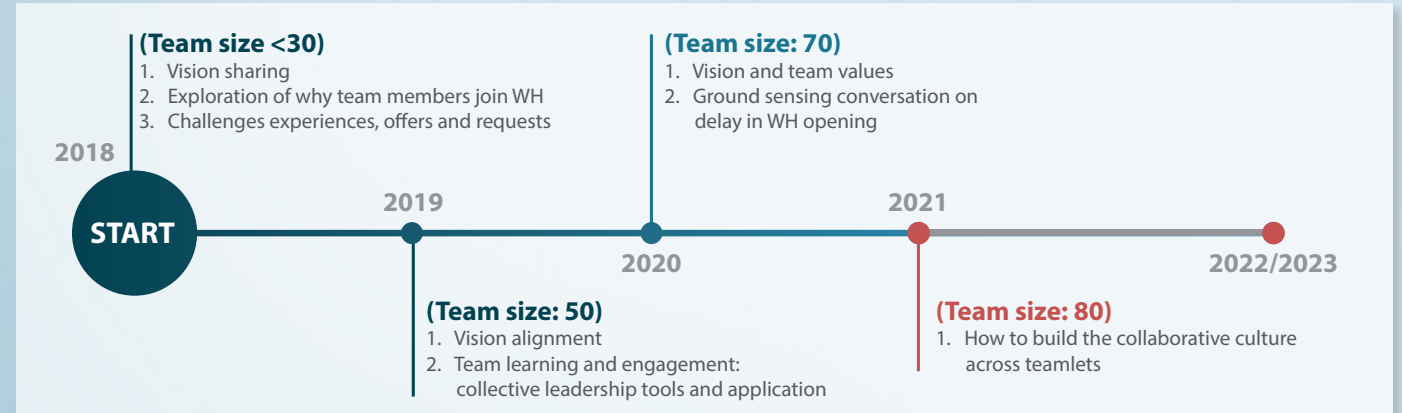


Figure 1 Evolution of team conversation designs over time

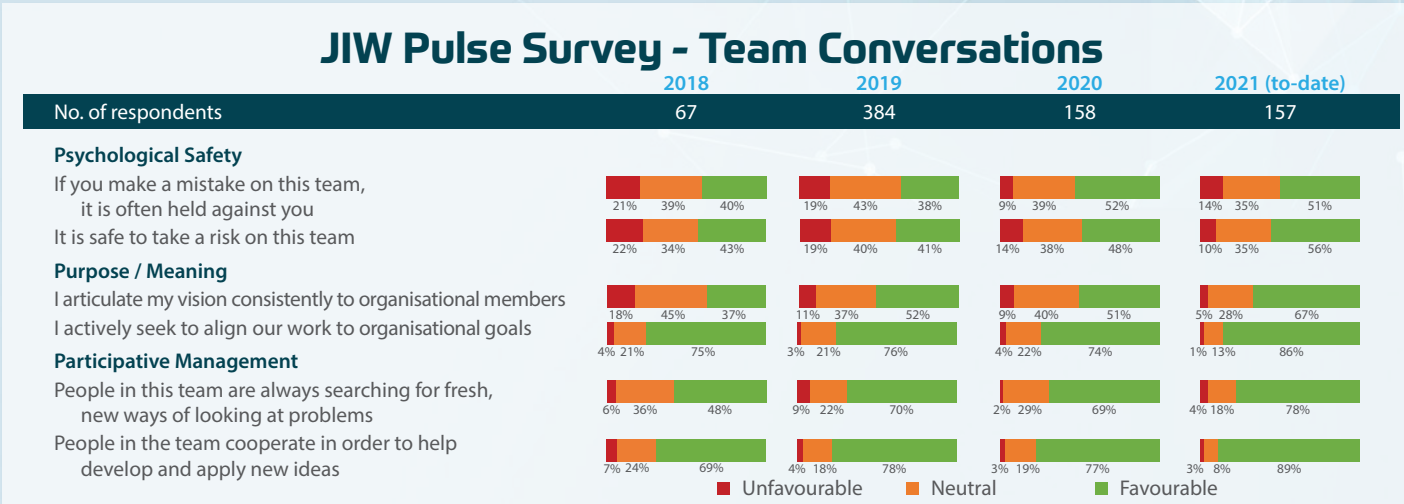


Figure 2 Cumulative pulse survey data across time

Pulse surveys

The team recognised the importance of collecting data in order to monitor and sense the progress we were making in our efforts to drive towards our three goals. We crafted an anonymous six-item pulse survey with two questions each on psychological safety, purpose and meaning, and participative management. This was administered to new staff at the point of orientation and again when staff participated in team conversations. The same survey was also administered to randomly selected employees of WH who had not had any prior team conversations as a control.

We tracked the global changes in scores over time to monitor our progress. Figure 2 shows a sample of how the pulse survey was tracked. Cumulative data across the organisation has demonstrated positive shifts in all three domains measured. Similar patterns were observed in teams that have engaged in multiple team conversations.

Insights

WH is uniquely positioned to explore new ways of delivering healthcare and with it, a shift in perspective on how to take care of our workforce. A key strength in our efforts was engaging in the work needed to systematically care for our workforce as early as six years prior to the official opening of WH, and adopting a flexible approach to absorb changing needs with progressive milestones.

We did this by adopting a simultaneous educational and intervention-based strategy to ensure that the teams engaged with these new skills and applied them in a cognisant manner. With this approach, we endeavoured to ensure that, with time and guidance, teams became self-sufficient in designing their own future conversations, thereby ensuring sustainability.

A data-informed foundation was fundamental in keeping the work tightly related to team needs. We found that it also created a meaningful team conversation starter on the missing elements and how best to reach their aspirational state. Tracking team cumulative data year-on-year was a useful way to do a large scale check-in on the other elements that the system needed to take care of.

Conclusions

The WH development journey presented both opportunities and constraints. The absence of a staging site for our staff necessitated building culture and leading teams in a very different way. We purposefully designed a framework to systematically enable our team leaders to engage staff and build relationships, teams and networks.

We envision that WH collective leadership manifests when our leaders proactively:

1. Connect with their teams and connect their teams with WH's vision, mission and values;
2. Align expectations and norms of how work is done with their teams and with each other as leaders;
3. Engage their teams for participative management;
4. Constantly challenge their team and themselves to creatively address the needs of our patients, the community and our healthcare family; and
5. Collaborate within and across the network to create this future state. ◆

Acknowledgements

We thank the WH Organisation Development team for their creativity and perseverance, without which this work would not have been possible.

Dr Chew is a senior consultant psychiatrist and the Chairman Medical Board of Woodlands Health. He previously held the position of Group Chief Education Officer, National Healthcare Group.

Dr Kinson is a senior consultant psychiatrist and Head of Medical Psychiatry of Woodlands Health. She is a certified shared leadership team coach and supports the Organisation Development team.

Yvonne leads people and organisation development in WH. As a certified shared leadership team coach, she leads her team to build the foundation for the WH model of care – trust, psychological safety and collective leadership.

NAVIGATING THE CHANGES IN PRIVATE HEALTHCARE SECTOR

Text by Dr Melvin Heng

The healthcare industry at the start of the 21st century is going through an accelerated phase of transformation. The intersection of digitisation, computing power and the Internet has brought about the democratisation of information and sparked new waves of innovation. These shifts are changing the way we deliver healthcare. Easy access to knowledge and greater demands for transparency are changing the relationships and expectations between patient, provider and payor.

In the face of all of these changes, navigating the healthcare landscape becomes seemingly more complex. The private sector faces many challenges as companies will consistently need to calibrate and trim their sails to adjust to the prevailing conditions, to ensure that they are able to continuously deliver safe, efficient and effective healthcare while balancing commercial interest.

There are many development themes that underpin these tectonic shifts and this article hopes to discuss some of them.

Digitalisation of healthcare

Many industries such as banking, logistics, and food and beverage have had their turn in the area of digital transformation. It would seem to many that the healthcare sector has fallen behind in this process, but akin to the waking of a sleeping giant, it is clear that we are well into the cycle of healthcare digitalisation and the impact will be great. The recent COVID-19 pandemic has only accelerated the take-up of healthcare digitisation in areas of healthcare delivery, where the demand for offline to online experience has increased.

Driven by influences from other industries, the new health consumer is now more discerning – translating experiences like QR code scanning, biometrics, online "check-in" and e-appointment booking to their expectations when consuming healthcare services. The healthcare sector has to pivot to serve these demands while ensuring that the principles of data protection, closed-loop ordering and information integrity are not compromised.

In order to meet these expectations, an entity would have to embark on strategies to increase core capabilities and digital infrastructure. An analogy to this would be in the construction of a building by first ensuring the "back-end" foundations and supporting structures are in place. In time, the "front-end" externalities may be added easily when required, building upon the existing infrastructure that has already been put in place.

Other areas of digitalisation can be found in the integration of new innovations, such as machine learning, algorithms and artificial intelligence, into current medical processes and products, giving rise to new applications. For example, conventional drug discovery processes starting from lead identification to clinical trials are severely costly and may take several years. The recent advent of computation models has given rise to in silico approaches that have attracted much interest, as they accelerate the drug discovery process by reducing the uncertainty through eliminating or selecting drug compounds more efficiently, thereby reducing the investment in time, labour and cost.

In another example, blockchains are increasingly used to provide a trust layer to medical reports and diagnostic results. A recent widespread application is the verification of COVID-19 vaccination statuses for air travel. Other applications can be found in clinical trials, medical insurance and medical records. Furthermore, with the addition of smart contracts, the ability to create decentralised autonomous processes that govern and direct the flow of information, services and monies will eventually also transform the way we interact with the multiple stakeholders in healthcare.

Public-private partnerships

The lines between public and private healthcare will become increasingly blurred due to the increased interaction between both sectors. Traditionally, the engagement of the public sector with private healthcare might incorporate elements of financing, design, facilities, maintenance, operations (eg, information technology, environmental services) and delivery of clinical and clinical support services. There is scope for the expansion of these interactions.

The increasing demands on the public healthcare system will push for greater cooperation between the two provider buckets. While the current models of collaboration revolve around the continuum of specialists, ancillary services, diagnostics, inpatient and emergency care, there will be opportunities to expand these partnerships to wellness, pre-hospitalisation (eg, preventative and primary care) and post-hospitalisation services (eg, rehabilitation, home care, palliative care).

These partnerships might help rebalance the priorities of healthcare delivery – cost, quality and access. These pillars need not be mutually exclusive and will be best achieved through collaborative models.

In order to prepare for these partnerships, private healthcare organisations ought to participate with public healthcare service provision projects, increasing their involvement incrementally. Private healthcare organisations might have to reorganise their care models to accommodate elements of public health deliverables that might not traditionally have been a priority. Some of these concepts – value-based healthcare, gatekeeping, bundle payments and capitations – have to be addressed in order for such collaboration to occur. By building such capabilities internally while maintaining commercial viability, private organisations can then pivot to successful and sustainable public-private partnerships.

Value-driven outcomes

The previously discussed trends of digitalisation, democratisation of information, and transparency have contributed to a better appreciation of healthcare outcomes. With the healthcare consumer being more discerning in such matrices, the providers will be incentivised to signal and deliver quality by demonstrating data that show consistent, reproducible and superior results in areas of processes, clinical quality and patient experience.

Value-driven outcomes will lead to further segmentation of procedures and standardisation of raw materials required to deliver such a service. Unless counterbalanced with case-mix selection, there will be a risk of "cherry-picking" – selecting choice patients that will only perform well in order to reduce the cost of service.

Organisations might have to prepare for these value expectations by aligning practices with international (or local) standards and selecting appropriate indicators for benchmarking. With the continuous cycle of checking, executing and optimisation, organisations will be able to appreciate and prepare for this trend more fully.

Human resourcing

The recent COVID-19 pandemic has brought significant paradigm shifts in the way we work and the environment we work in. Coupled with a new generation workforce that is familiar with on-demand, remote and digital platforms, the healthcare company of the future will need to make changes in human resource policies to attract and retain their staff. There will be a greater emphasis on moving usual paper-based processes onto digital platforms and stronger demand for flexible working hours, with performance tied to productivity rather than presentism. Healthcare companies will have to engage their workforce beyond the traditional tenets of salary or job scope; the importance of culture, purpose and sustainability become increasingly important criteria in employee participation and talent retention.

With a greater emphasis on human resources, there will be upskilling and higher expectations on productivity and value from each employee. Tasks considered repetitive and manual will constantly be required to be right-sited or eliminated – whether by process change, automation, robotics, outsourcing, or digitalisation. Companies who are investing in these areas will be ahead of the curve in ensuring that the right people are in the right place and engaged in doing the right jobs.

Knowledge workers

The pace of information creation is relentless and inevitable. More data is created and synthesised into knowledge daily. These occur in all major areas – clinical quality and outcomes, patient experience and service delivery, operations and process engineering and lastly, leadership and organisation structure.

There is a constant need for a business unit to train and retrain our workforce to cope with the innovations and changes to care delivery. On-the-job-training will have to become more structured and intentional; less rudimentary than "see one, do one, teach one".

The process of such learning will also change; it is of high opportunity cost for organisations and individuals to take large chunks of time off to pursue formal month- or year-long courses. Continuous learning will be bite-sized and will require less time off work. Udemy, Coursera and LinkedIn Learning, to name a few platforms, are becoming widely accepted and recognised as evidence of self-improvement and upskilling. In juxtaposition to the full-time, on-site and lengthier courses, these bite-sized programmes are being seen as an ideal alternative – delivering similar knowledge and outcomes without the disadvantage of opportunity cost and long absences from work.

Environmental, social and governance

The healthcare industry generates a large amount of waste, has the advantage of being able to arbitrage on information asymmetry and holds significant responsibilities as outcomes are measured not just in dollars and cents, but human lives and clinical outcomes.

There is a palpable emphasis on the importance of sustainable organisations that do business in a responsible way. Shareholders and investors will place greater emphasis on responsible behaviour, good governance and environmental consciousness, applying these non-financial factors as part of their analysis process to identify material risks and growth opportunities.

Apart from shareholders, consumers are also making purchasing decisions based on such factors. Companies will need to constantly interrogate their processes with this environmental, social and governance lens, and develop relevant capabilities by assigning both human and financial capital accordingly.

Concluding thoughts

The factors listed above are but a few diverse key developments. They represent the multiple tensions that exist in the marketplace. Healthcare businesses are not immune from such forces and companies that operate in these areas will constantly need to calibrate and optimise resource allocation in these areas to effectively navigate the healthcare landscape. ◆

Dr Heng is a physician and healthcare executive with first-hand experience in hospital management, primary and specialist clinics, medtech and aeromedical businesses. He is currently the CEO of Gleneagles Hospital.

Certifying a Lasting Power of Attorney under the Mental Capacity Act (2008)

30 April 2022, Saturday | 12.30 pm to 4.30 pm

The Lasting Power of Attorney (LPA) allows a person to voluntarily appoint someone to make decisions and act on their behalf if they should lose mental capacity one day. Professionals who are certificate issuers of an LPA assessing mental capacity have a duty to perform their assessments to a reasonable standard. This webinar, jointly organised by the SMA Centre for Medical Ethics and Professionalism, the Law Society of Singapore and College of Psychiatrist Singapore, Academy of Medicine, Singapore, will introduce the basic concepts as well as explore the subtleties of the assessments required for the certifying of an LPA, and will be conducted by doctors, lawyers and other professionals experienced in this area of work.

Time	Programme
12.30 pm	Polling Begins
12.50 pm	Opening Address
1.10 pm	Introduction
1.15 pm	Legal Nuts and Bolts for LPA Certificate Issuers – Being an LPA Certificate Issuer isn't as simple as you think!
1.35 pm	Understanding the Medical Issues in Certifying an LPA
1.55 pm	Clearing Up Misconceptions of LPA Certificate Issuers – Duties of care and potential liabilities of LPA CIs
2.15 pm	Medical Red flags and Pitfalls in Certifying an LPA
2.35 pm	Break
2.45 pm	Panel Discussion and Q&A
4.15 pm	Concluding Thoughts
4.30 pm	Webinar Feedback End of Webinar

Scan QR code to register
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For enquiries, please contact Jayanthi at cme@sma.org.sg

Jointly organised by:

THE LAW SOCIETY OF SINGAPORE

Singapore Medical Association
For Doctors. For Patients

SMA CMEP Centre for Medical Ethics & Professionalism

Tay Syndrome

In Memory of Dr Tay Chong Hai (1932–2022)

Text by Dr Kenneth Lyen
Photos by Tay Guan Hin and Dr Tay Guan Yu

Dr Tay Chong Hai was born in 1932 and graduated from medical school in 1959. He obtained his postgraduate medical degree from the Royal College of Physicians in Glasgow in 1963, and became a Fellow of the Academy of Medicine, Singapore in 1967. Subsequently, he became a Fellow of the Royal College of Physicians in Glasgow in 1972, and a Fellow of the Royal Australasian College of Physicians in 1982.

He later subspecialised in rheumatology, and was appointed consultant physician at the Singapore General Hospital in 1971. This was soon followed by becoming head of the Department of Medicine at Changi Hospital. In 1978, he left for private practice as a consultant physician and rheumatologist, opening his clinic at Mount Elizabeth Medical Centre.

Dr Tay was the first Singaporean physician to have a disease named after him. In 1971, he was referred a young brother and sister who had dry, scaly and itchy skin with painful cracks and fissures on their palms and soles. Their hair was short and so brittle that it broke with the slightest rubbing against a pillow or combing with a hairbrush. They had red skin at birth that remained sensitive to sunlight. The siblings were short in height and were intellectually challenged. Another brother had died earlier from intestinal obstruction at the age of two months. Their parents were first cousins. Dr Tay looked at the siblings' hair under a polarising light microscope and saw bands running across the shaft, which he described as "tiger stripes". Tay Syndrome was confirmed to be a new disease – a rare autosomal recessive genetic condition (trichothiodystrophy), and the name has appeared in dermatology textbooks since 1975.

Dr Tay has also been involved in other medical issues. He identified arsenic poisoning in some Chinese medicines, including the Sin Lak asthma medicine. He also alerted the authorities to some Chinese medicines that were adulterated with Western medicines, and that steroids like cortisone was being misused. His actions led to the tightening of Singapore laws regulating traditional medicines.

In 1972, he was involved in the first Singapore outbreak of hand, foot and mouth disease, and he helped differentiate this condition from the other diagnoses that were being made, such as Steven-Johnson Syndrome and chickenpox. He also discovered another new disease – eosinophilic arthritis, an acute arthritis affecting mainly the large joints with elevated eosinophil count.

Dr Tay authored more than a hundred medical articles. He established the National Arthritis Foundation in 1984, and was its chairman for 14 years. In 1988, he was conferred the Life Fellowship of the American Academy of Dermatology. His hobbies included playing golf, and he published a book of his poetry, *The Birth of a New Day*, in 1977. Colleagues describe him as a friendly person with a good sense of humour.

Dr Tay was one of Singapore's outstanding doctors, and is survived by two sons, their wives and five grandchildren.

Rest in peace. ◆

The SMA Council expresses our heartfelt condolences to the family of Dr Tay Chong Hai on his passing on 1 January 2022. Dr Tay was a Life Member of SMA.

Further readings

1. *Lim J. A Pioneering Spirit. SMA News 2013; 45(6):30-2.*
2. *Aboud AA. Chong Hai Tay and the syndrome which bears his name. Our Dermatol Online 2013; 4(1):105.*
3. *Dr Tay Chong Hai. Mount Elizabeth Hospitals. Available at: https://bit.ly/3tuZH5E.*
4. *Chong Hai Tay. Whonamedit? Available at: https://bit.ly/3rgA0DI.*

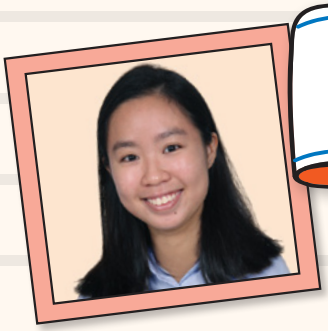
Legend

1. *Dr Tay and the late President S R Nathan*
2. *Dr Tay smiling for the camera*
3. *Dr Tay and his clinic staff*

Mid-Year Check-In

Lessons Learnt and Goals Ahead

SMSUK members at Wicked *the musical*



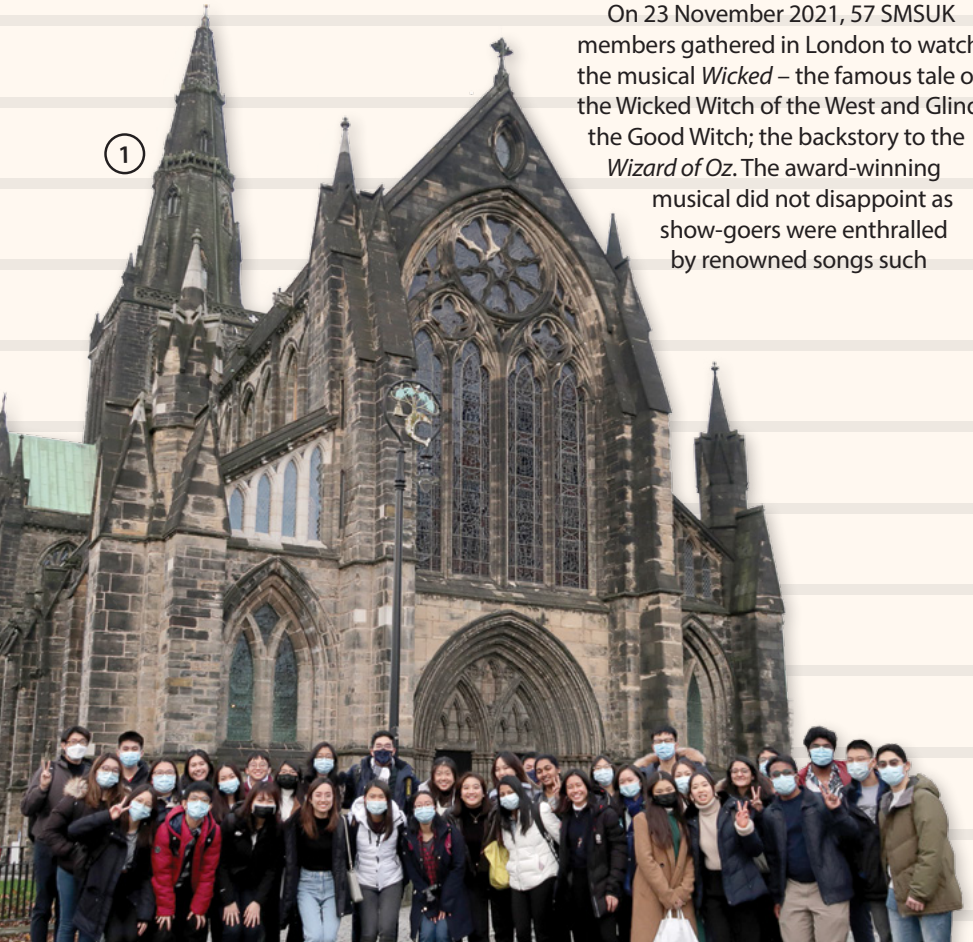
Chin Sue-Kay
Editor, SMSUK

With our Singapore Medical Society of the UK (SMSUK) members spread across 25 different UK medical and dental schools, opportunities for everyone to meet and connect can be sparse, especially during the pandemic. During the past two months however, SMSUK held our first in-person events since COVID-19 began in March 2020.

On 23 November 2021, 57 SMSUK members gathered in London to watch the musical *Wicked* – the famous tale of the Wicked Witch of the West and Glinda the Good Witch; the backstory to the *Wizard of Oz*. The award-winning musical did not disappoint as show-goers were enthralled by renowned songs such as "Defying Gravity" and "For Good". Following that, our SMSUK congregation headed to Lime Orange, a Korean restaurant just round the corner, for a delicious set meal. We were thankful that the entire restaurant had been booked out as we were boisterous!

For our members outside of London, we held a "Wider UK Trip" in Glasgow, Scotland, voted as "one of the world's friendliest cities". Blessed with unexpected sunny weather in otherwise often gloomy Scotland, participants visited famous sites such as the Glasgow Necropolis, Glasgow Cathedral and the Kelvingrove Art Gallery and Museum. The trip ended with a taste of home at a Chinese restaurant and members singing their hearts out at karaoke. We hope that our members have enjoyed the in-person social events and we thank all participants for their time, enthusiasm and responsibility in following our COVID-19 safety measures.

As we are fast approaching the midway point of our members' academic year, we asked some of them to reflect on their medical school experience thus far and their hopes and goals for the new year, two of which are shared here.



Legend

1. *SMSUK Members at the Glasgow Cathedral*

Text by Saranya Siva

To say that the past one-and-a-half years have been a whirlwind of emotions would be an understatement. I was in my third year of medical school when the pandemic began and now, I am in my final year. Looking back, it has been an extraordinary albeit (occasionally) tumultuous journey. I remember commencing medical school being all bright-eyed yet terrified of what laid ahead of me. It was my first time living abroad and I had so many concerns on my mind; from academics to living independently, and even maintaining my ties back home. It is a lot easier said than done and being in the middle of a pandemic has not made it easier.

If I could offer a piece of advice, it is to stay in the present and trust the journey you are on. That was my biggest takeaway from the last couple of years. Initially, everything may seem daunting and out of control. However, one should treasure the moment instead of worrying about what comes next.

For instance in 2020, I was seeing fewer patients and a good chunk of my learning was done online due to COVID-19. I worried if the clinical exposure I had would suffice. Despite the futility of doing so, I spent time worrying about my situation instead of enjoying my placements, which in retrospect were well planned given the circumstances.

Thus, in my final year, I am going forth with a more positive outlook. I am prioritising my physical and mental health, which took a dip last year. I am also ensuring that I spend time with my loved ones while balancing the hectic revision preparation. Although the situation this year has not improved significantly in terms of restrictions and reduced clinical exposure, I am enjoying it a lot more and have been making full use of the resources available. My goals for the new year are to continue taking care of my health, graduate university and enjoy a well-deserved break with my friends and family. All the best to everyone for the upcoming year, and thanks for reading!

Saranya is a Year 5 medical student at the University of Manchester.

Text by Gabriel Kwok

As I write this from my East London home, the falling autumn leaves mark another changing of the seasons. Exactly one year ago, I was back home in Singapore, streaming tutorials over 10,000 km of nebulous aether at midnight, while crouched behind my new blackout curtains. Even though induced deliberately, delayed sleep phase syndrome proved quite the challenge indeed, saliently enhancing the presyncopic effect of lectures.

Suffice to say, my first year was far from my finest performance, although it was probably the best I could manage, given the circumstances. COVID-19 aside, I struggled for some time with the sheer volume of ostensibly piecemeal information I was expected to memorise. Here, my school's spiral curriculum became a double-edged sword. With the spiral, the idea is to cover the entire human body twice in the first two preclinical years, circling back to the same concepts in different contexts and with greater detail. This approach is sensible, but it does sacrifice depth in favour of breadth when first starting out. Many concepts must be understood in their wider pathophysiological contexts, but I was still learning only half that very context!

Emerging into my second tour of the body, I found myself relieved to have that physiological context in the bag. Although the volume of knowledge is occasionally still a problem, I am now often wrestling with how to organise these oft-disjointed ideas into clinically relevant frameworks. Recently, this led to an interesting conversation with a senior, who dismissed an entire lecture series as patently useless in a clinical context, because it was not explicitly part of any clinical reasoning chain. Now, he certainly had a point about clinical practicalities, and I am aware of how little I have seen from my current vantage point, but this nonetheless struck me as disingenuous. While I have certainly not needed every tiny little detail from past lectures, many things would have made a lot less sense this year without that previous round of diligent study. I am still elucidating the fine lines between mere knowledge and wisdom, but I am beginning to suspect it looks something like this: knowledge is memorising the full glycolytic cascade, while wisdom is explicitly knowing just the controlling irreversible steps, retaining a proximate scaffold to fill in pro re nata.

I very much suspect I might be proven at least partially wrong in the coming years, but as any good methodologist would say, post hoc analyses are only hypothesis-generating, at best! ◆

Gabriel is a Year 2 medical student at Barts and The London School of Medicine and Dentistry.

Oesophageal Cancer Awareness Month Campaign

Singapore Medical Association
For Doctors. For Patients

UPDATE ON *Oesophageal Cancer*

DATE
9 APRIL 2022, SATURDAY

TIME
2 PM TO 5 PM

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2 CME points (pending Singapore Medical Council's approval)

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For more information, please contact Denise at **cme@sma.org.sg**.

2 pm	Welcome
2.10 pm	Endoscopic Diagnosis and Management Dr Stephan Tsao *Senior Consultant, Department of Gastroenterology, Tan Tock Seng Hospital (TTSH)*
2.40 pm	Surgical Management Dr Aung Myint Oo *Senior Consultant, Department of General Surgery, TTSH*
3.10 pm	Role of Chemotherapy/Immunotherapy Dr Choo Su Pin *Medical Oncologist, Curie Oncology*
3.40 pm	Role of Radiotherapy Dr Ivy Ng *Associate Consultant, Department of Radiation Oncology, National University Cancer Institute, Singapore*
4.10 pm	Perioperative Nutrition Serene Chew *Senior Dietitian, TTSH*
4.40 pm	Closing

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Living and Dying Well

Review by Dr Tina Tan, Editor

In *The Matrix*, Morpheus offers Neo two pills to choose from. "You take the blue pill… you wake up in your bed and believe whatever you want to believe. You take the red pill… you stay in Wonderland, and I show you how deep the rabbit hole goes… all I'm offering is the truth."

In *Being Mortal*, Dr Gawande presents us with a harsh reality – how do you want to age, and how do you want to die? He even includes the red pill/blue pill analogy to illustrate different models of the doctor-patient relationship, and how that can impact the way we have this difficult conversation with our patients on the topic of dying.

The first few chapters are about living well in old age, and they include a history of the origins of nursing homes and assisted living facilities. By the time I was through with the first half of the book, one thought ran repeatedly through my mind – that every healthcare administrator and policy maker should read *Being Mortal*, especially chapter 2. In that chapter, Dr Gawande describes how a university's division of geriatrics was closed due to "financial losses", despite research showing that patients under geriatric care had better morbidity and depression rates.

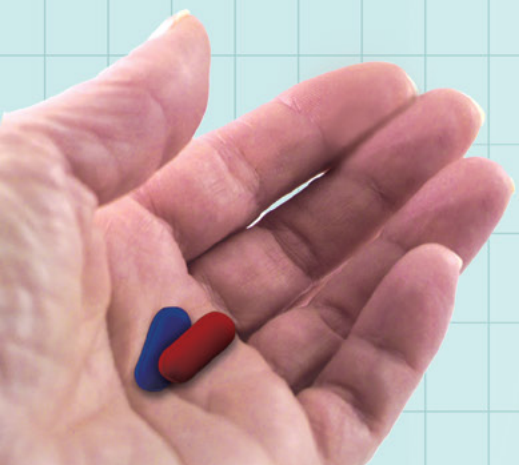
I was flabbergasted, yet not very surprised. Geriatrics, which overlaps significantly with my subspecialty of geriatric psychiatry, is somewhat of a pariah in medicine. The elderly patient just doesn't recover from illness the way an adult or child does. They almost seem like dead ends (forgive the awful pun), and not everyone has the patience for it. As a result, in my line of work, I've encountered one-too-many situations where patients are given suboptimal care or are not properly right-sited, due to inadequate resources, strict adherence to exclusion criteria or simply "because it's protocol". And it is, in the end, the patient who suffers. This is the complete antithesis of patient-centred care.

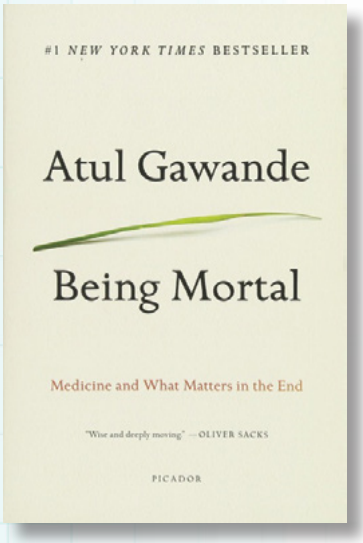
The second half of the book is about dying well and what that means for each of us. Dr Gawande highlights the growing need for doctors to have such conversations with patients, and included the poignant example of doing so with his own father. The irony was that despite he and his father being doctors, Dr Gawande struggled to find out what his dying parents wanted at the end of their lives, and it is easy to identify with that feeling of inadequacy. A decade's worth of medical and specialty training does not necessarily prepare us to initiate such conversations, and we are often limited by the lack of time and the patient volume in our local setting.

However, that is no excuse. Dr Gawande describes being mortal as a "battle to maintain the integrity of one's life… sickness and old age make the struggle hard enough. The professionals and institutions we turn to should not make it worse." He calls on doctors and administrators to think long and hard about the type of medicine and care we want to give to our patients at the end of their days. It would be so much easier to ignore the problem, but that's exceedingly impossible as our population ages. Ask yourself, at life's end, what would you want for your loved one or for yourself?

Would you rather have the blue pill or the red pill?

By the way, Neo took the red pill.





Title: *Being Mortal: Medicine and What Matters in the End*

Author: *Atul Gawande*

Number of pages: *282*

ISBN: *9780805095159*

Type of book: *Hardcover*

Publisher: *Metropolitan Books, USA*

Year of publication: *2014*

Dr Tan is a psychiatrist with the Better Life Psychological Medicine Clinic, and a visiting consultant at the Institute of Mental Health. She is also an alumnus of Duke-NUS Medical School. Between work and family life, she squeezes time out for her favourite pastimes – reading a good (fiction) book and writing.

BOARDING PASS

VTL TRIP TO THE US

WHAT YOU NEED TO KNOW


1


2

Text and photos by Dr Desmond Wai

Like many people, I had not had a break from work since the pandemic began in 2020. And so, I was particularly excited when the Vaccinated Travel Lane (VTL) with the US opened in October 2021. My wife, our 12-year-old boy and I decided to spend two weeks in the US on a self-driving trip.

I share our experience below in hopes that it may aid other Singaporeans in deciding and planning for similar trips.

Preparing for the trip

Securing a **return air ticket on a designated VTL flight** was the foremost priority. We could take any flight to the US, but returning on a designated VTL flight was necessary. Once the flight was confirmed, I booked our **pre-departure COVID-19 tests** at a designated clinic, as well as the **on-arrival PCR tests** at Singapore Changi Airport. Different countries may require different pre-departure tests. For the US, a supervised ART at a designated centre was sufficient.

Next up was travel insurance. I bought travel insurance that **covered COVID-19-related loss**, such as flight cancellation and additional expenses in the US should our trip be prolonged by a positive pre-departure test.

Singaporeans can visit the US without a visa, but there is a new scheme called the **Electronic System for Travel Authorization** (ESTA). It took about ten minutes for online application and approval was granted within three working days. Singaporeans must have ESTA approvals before being allowed to board the plane to the US.

I then went to the Automobile Association of Singapore to apply for the **International Driving Permit** (IDP). One must bring their Singapore driving licence along with the IDP to be allowed to drive in the US.

I also printed out our **COVID-19 vaccination certificates** via the HealthHub app. The airport checkpoints in both Singapore and the US would need to see proof of vaccination before we were allowed to board the plane.

We arrived at Changi Airport three hours before departure, to ensure that we had sufficient time for all the extra procedures. Indeed, the check-in staff took much time to verify our ESTA approvals, vaccination certificates and pre-departure ART results.

The plane was less than a quarter filled, and had been sanitised before we boarded. Extra alcohol swabs were provided to clean the seats and tables on board. Mask-wearing was also compulsory, except during mealtimes. Only two meals were served during our 15-hour flight, apparently to reduce mask-down time during the flight. The airline crew wore both goggles and N95 masks.

When we arrived at the Los Angeles International Airport (LAX), we cleared immigration smoothly, and on-arrival COVID-19 tests were not required.

The return trip

A negative **pre-departure COVID-19 test result** within 48 hours of departure was required to board the VTL return flight. The Singapore Airlines website provides a list of approved COVID-19 test centres in LA, but details like pricing, queueing systems, booking of appointments and turnaround times were not available.

We had our pre-departure tests done at LAX, as the results would be available just three hours after via email. The price was reasonable at US$125 (S$169) per person. We made an online booking for the tests a day before, and travelled all the way to the airport for swabbing.

The staff at the swabbing station were professional and efficient. There was no queue at all and the whole process was completed within 15 minutes. Our PCR results were emailed to us and fortunately, all of us tested negative.

On the day of departure, we arrived at LAX four hours before departure time. The check-in process was longer than usual, as the staff had to check our vaccination certificates and pre-departure test results. The staff recognised our vaccination status displayed on our **TraceTogether app**.

We also had to submit an **Electronic Health Declaration** before we boarded the return flight. In it, we declared that we stayed within the VTL country during the trip, and had no contact with COVID-19 patients, nor had any symptoms of COVID-19 infection. We were advised **NOT to patronise the shops or restaurants at the arrival hall** after disembarking from the plane.

At the Singapore immigration counter, we showed our **boarding pass**, which confirmed we returned on a VTL flight, to the officer and were each given **a green sticker** after clearance. The sticker was important as without it, we would not be allowed to leave the arrival hall.

After collecting our luggage, we were escorted to the swab centre outside the arrival hall to have our **on-arrival COVID-19 swabs** done. This was the worst swab test I have ever had, as we were swabbed in our throat and both nostrils. We were given strict instruction to return home immediately after the swabs. Results would be available about six hours later, and we had to isolate at home until our test results returned negative.

We took a nap once we arrived home, but I was woken up by a call from **the Immigration and Checkpoints Authority (ICA)**. The caller checked my NRIC number and requested that I showed him my surroundings via a WhatsApp video call. I suppose they wanted to be sure that I was at home, as required by law.

We received our on-arrival test results through both the **TraceTogether and HealthHub apps** about seven hours later. We heaved sighs of relief when our swab results turned out negative. The isolation process was over and we were free to roam around.

Travel costs

Cars, hotel stays and even meals in the US were affordable. Most of my hotel rooms for my family of three cost between US$100 and $200. Some only charged US$80 per night. My seven-seater rental car cost about US$120 per day. The cost of petrol was about US$4 per gallon, which is cheaper than Singapore.

Travelling in pandemic times did impose additional costs. **Prices of VTL return flights** are high and continually rising; thus, booking the tickets early is important. I booked my VTL return flight two weeks before my trip. I paid S$2,400 for a seat in Premium Economy Class. The price increased to S$3,400 just two days later.

The price of the pre-departure COVID-19 ART at the designated clinic was SS$30 per person. Pre-departure COVID-19 tests in LA and Singapore were US$125 and S$160, respectively. The price of an ESTA application was US$14 per person.

The total additional fixed cost was about S$350 per person per trip. As the cost of COVID-19 testing was fixed regardless of how long the holiday was, it made more sense to have a long trip. Hence, I chose to go on a 14-day holiday.

Managing risks

The risk of contracting COVID-19 on a plane was low, as most passengers were vaccinated and had a negative pre-departure test. But **children below 12 years of age** were not vaccinated, and children below three years of age did not need a pre-departure test. Most COVID-19 infections in children are mild and/or asymptomatic, which may not be picked up via symptom questionnaires or temperature checks. I guess children could possibly be a concern, as they could contract and spread the virus on board.

There was no monitoring app like TraceTogether in the US, so entering and leaving any premises was easy.

The US Centers for Disease Control and Prevention recommended mandatory mask-wearing in indoor places. We did not need to wear masks in open spaces. Hotels, restaurants and shops would request customers to wear a mask. But from what we saw, the **adherence rate of this rule was not 100%, and the vaccination rate in California was only about 62%**.

We were still mindful of contracting the virus in enclosed indoor places, so we travelled in our own vehicle and visited mainly outdoor attractions. We wore masks whenever we entered any enclosed spaces.

We were also mindful that should a pre-departure test return positive, we would not be allowed to board the plane and would have to extend our stay for an additional 14 days. Sometimes, **test results could be equivocal** (ie, neither positive nor negative). A retest would then be done. It is better to have any pre-departure test done early in case extra time is needed for any additional tests.

If a Singaporean is admitted to a hospital in the US for COVID-19, **medical costs would be substantial**. One US study estimates medical costs to be approximately US$42,200 per person.

Lastly, **rules change all the time** so travellers must accept such uncertainties. One example is when Denmark imposed a minimum four-day quarantine and an additional COVID-19 PCR test for all arrivals from Singapore on 9 November 2021, despite VTLs.

Final thoughts

Most of us want an overseas break. But travelling during a pandemic does impose extra costs and procedures, and it comes with much uncertainties. The risks of contracting the virus while on a plane or overseas, though low, are real with serious consequences. It is important that we continue to follow safe management measures while overseas, and make our own risk assessments.

Despite all this, my family and I had a great time on our much-needed overseas break. We had a wonderful time in California and Arizona, visiting places like the Grand Canyon, Antelope Canyon, Lake Powell, Monument Valley, and the great beaches along the Pacific Coast Highway. The canyons were beautiful, and I particularly feel refreshed after the trip. To me, the benefits outweighed the costs and the risks. ◆

Information accurate as at time of writing.

3

Legend

1. Horseshoe bend

2. Grand Canyon

3. Antelope Canyon

4. Collecting the appropriate stickers after swabbing, so as to leave the airport

4

Dr Wai is a gastroenterologist in private practice. He enjoys writing about life as a doctor. He strongly believes that doctors must share their experience and knowledge with one another to raise the standard of the medical profession.

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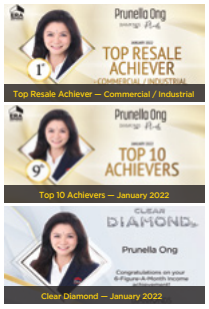

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- MBBS registrable with the Singapore Medical Council
- Preferably with MMED or Postgraduate qualifications in Internal/Family/General Medicine or Psychiatry. Those with relevant training and experience will be considered for senior positions
- Have worked in psychiatric inpatient setting
- At least 5 years post housemanship experience

FULL TIME / PART TIME / CONTRACT TERMS AVAILABLE

Interested applicants may submit their applications to: **careers@imh.com.sg**

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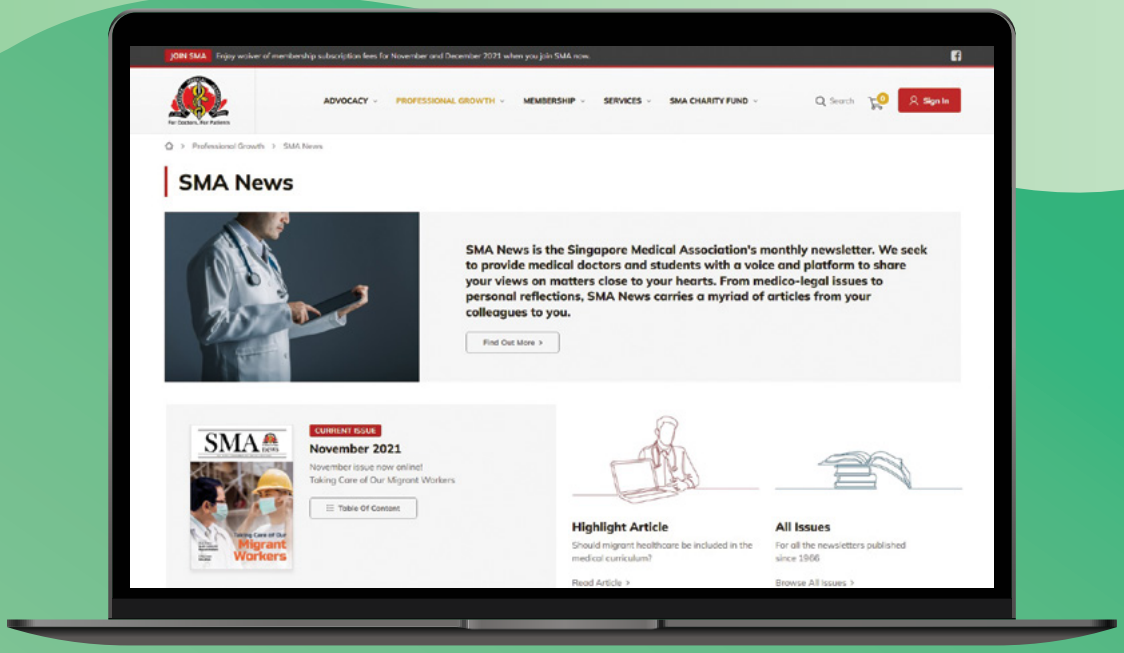

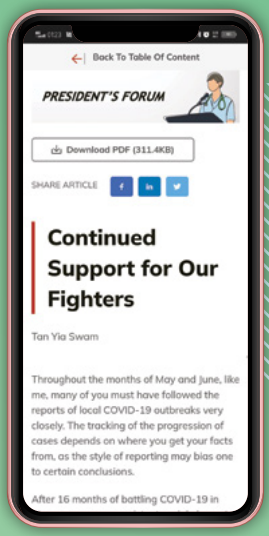

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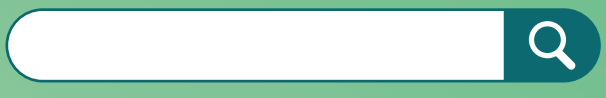

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GRADUATE DIPLOMA IN MENTAL HEALTH

Mental Health Course for General Practitioners and Family Physicians

Doctors in primary care are often the first source of help for persons with mental health issues. With heightened mental health awareness due to the COVID-19 pandemic, more people are likely to seek help.

More than 180 doctors have completed the **Graduate Diploma in Mental Health** since its launch in 2010. Feedback from past participants include how the course has enhanced their expertise to assess, identify and treat common mental health conditions and enabled them to provide more holistic care for their patients.

Government subsidy is available (subject to terms and conditions).

The next run of the course opens for registration from

28 March 2022 to 4 July 2022.

This one-year programme is jointly offered by the Institute of Mental Health and the Division of Graduate Medical Studies, National University of Singapore.

For more details,
visit **www.imh.com.sg/GDMH**
or email: **gdmh@imh.com.sg**

Organised by:

INSTITUTE of MENTAL HEALTH
National Healthcare Group

NUS National University of Singapore
Division of Graduate Medical Studies
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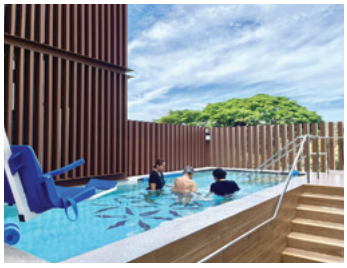

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