SINGAPORE MEDICAL ASSOCIATION

NEWSLETTER

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At the crossroads

Now in its 23rd year, the Singapore Medical Association is bogged down by polemics that threaten its very survival as a thriving professional body.

SMA President, DR. N. K. YONG, examines the underlying causes and reaffirms his faith in the future directions of the 1,600-strong association.

IT is almost platitudinous to say that nothing is permanent and that change is at the heart of life and evolution. The S.M.A. is at the crossroads in its 23rd year of existence and the course it now takes will determine whether it becomes an association for all seasons or an anachronism.

The recent controversy within the profession over the issue of signboards and nameplates generated more heat than light and regrettably, perhaps, led to rather acrimonious exchanges. But it has also uncovered a grave deficiency in the present structure and organisation of the SMA, and in so doing it has provided a timely warning to the Association.

I do not see the current misgivings and dissatisfaction as indicative of a crisis which threatens to splinter the profession and therefore the Association. I prefer to see it as a challenge to all of us – a challenge to take a good, hard and long look at what is wrong, as well as what is good about the Association, and to take appropriate preventive and corrective steps.

The single most important lesson that we have learnt from the recent controversy is that the present structure and organisation of SMA, and hence the conduct of its business, does not provide for adequate representation of the views and needs of all the different sections of the medical community which it represents.

The organisation and administration of the Association is simply not structured to do so. Its composition and the method of election to council are subject to individual whims and fancies or to the efforts of pressure groups. The group with the loudest voice or the greatest voting power can dominate Council composition, and decisions of the Annual General Meeting. The obvious result is that in critical issue, minority views and interests can be swept aside, as has happened all too often in the past.

The result is as plain as the noses on our faces - in the present situation the private medical specialists complain vehemently, and with some justification, that their views are not given due consideration and therefore are not represented in official communications. It is a complaint which cannot be ignored. The way in which the A.G.M. or E.O.G.M. of the Association is conducted allows only one method of decision making by a simple majority.

It is too naive to expect, or even to hope, that members could be mindful of the different needs of their colleagues as well as their diametrically opposite viewpoints. The result is the polarisation which I have tried to avert.

Clearly, very clearly, this state of affairs cannot be allowed to continue. Hence my earlier statement, that I see this as the challenge which confronts the Association, rather than as a crisis.

We now have a move to form a society of private medical specialists. I do not see this as undersirable provided that this new grouping operates within the framework and structure of the S.M.A. i.e. as an affiliate of the S.M.A.

But rather than a new grouping, what is urgently needed is a complete overhaul of the S. M. A. Its basic structure and organisation, and the way it functions and attends to the affairs and needs of the members must be re-examined, and, where necessary, totally revised so that it will be representative of all sections of the profession.

No one section by virtue of overwhelming numbers should be permitted to dominate decisions and resolutions of the Association. Any minority group, however small, must have its interests considered and its voice heard.

If we can bring about this re-organization, the Association can then truly be said to be fully representative of the profession. Then, and only then, will SMA be able to speak with a loud clear voice, - and it will have to be listened to.

The Constitution Review Committee of Council has already begun its work on the re-structuring and re-organization of the Association with the objectives I have laid out above in mind. We welcome submissions whether in writing or verbally by any member.

Forecast of manpower needs by DMS

THE Director of Medical Services, Dr Andrew Chew, made a speech at a banquet during the 16th Singapore/Malaysia Congress of Medicine Meeting on July 23, 1982.

The highlights of his speech are:

- An estimate of 648 medical trainees need to be selected for specialist training in order to meet the projected requirements of 532 specialists by the end of the decade. This takes into account that about 227 of these trainees will eventually leave for the private sector.
- For the current financial year, a budget of $1.22 million has, for the first time, been set aside for health manpower development.
- There is no longer the need for doctors to sit for the Royal College examinations concurrently, as our M. Med has standing. This practice is to be discouraged, and the message must reach all graduates who intend to train as specialists.
- Local training must be supplemented after acquiring the M. Med, with a period of six to 12 months overseas.
- Doctors who remain in the service should update themselves every five years, to keep abreast of the times.
- Private specialists from abroad have been invited to contribute one to two weekly sessions in our hospitals. At the moment, there is a list of 12 names of specialists from the UK, USA and Australia.
- There are 2,176 doctors on the medical register. Of these 752 are higher qualified; 34 per cent acquired their training locally.

Inside

Legal aspects of medical practice in Singapore

WITH the increasing sophistication of the Singaporean population, coupled with the influx of non Singaporeans seeking medical treatment, the practitioner of today has to equip himself with new medical technology, and keep abreast with advances in treatment.

However, with this expansion of skills, most if not all practitioners wonder if the likelihood of litigation has been increased. Except for the Hippocratic oath (ironically, quite a few medical students and doctors do not know what it is) the medical curriculum does not inform about the legal aspects of medical practice.

In this article, 3 experts have given us their viewpoints based on extensive experience, on some important questions faced by the medical practitioner.

MISADVENTURE V. NEGLIGENCE

Dr Chao Tzee Cheng in his article "Legal Implications of Medical Practice" published by the Medico-Legal Society of Singapore 1981, offered some guidelines as to when a mistake in patient management would be considered a **misadventure** versus **negligence.**

Quoting from Lord Denning in Roe v. Ministry of Health (1954) 2 W.L.R. 915-926: "We should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist in due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure".

The key words are "due care for the patient at every point". But care alone is insufficient.

The doctor must be knowledgeable and skilful in his work, Dr Chao wrote. Quoting from R.V. Bateman (1925) 94 L.J.K.B. 791: "The law requires a fair and reasonable standard of care and competence. If the patient's death has been caused by the defendants indolence or carelessness, it will not avail to show that he had sufficient knowledge, nor will it avail to prove that he was diligent in attendance if the patient has been killed by his gross ignorance and unskilfulness. As regards cases where incompetence is alleged, it is only necessary to say that the unqualified practitioner cannot claim to be measured by any lower standard than that which is applied to a qualified man."

A correct diagnosis is essential to proper treatment, and the doctor should always carry out a thorough and careful examination. Where more than one diagnosis is possible, the doctor must perform additional tests and examinations to distinguish one condition from the other. The general legal rule in the USA states "It is one of the fundamental duties of a physician to make a properly skilful and careful diagnosis of a patient and if he fails to bring to that diagnosis the proper degree of skill or care, and makes an incorrect diagnosis he may be held liable to the patient for the damage thus caused just as readily as he must answer for the application of improper treatment."

Negligence

Should a patient die during an investigational procedure, the question of negligence will depend on the indication and necessity of carrying out such an investigation; whether the test was carried out with the usual precautions; and when the patient collapsed, was resuscitation immediate and proper. In a local case, where a patient died from a haemopericardium due to a marrow aspiration, coroner's inquiry revealed that examination of the marrow was necessary for diagnosis of a suspected blood disorder, and hence treatment. The necessary precautions were taken during the procedure and resuscitation was immediate and adequate when the patient collapsed. Further, it was shown that this was a known complication of marrow aspiration. A verdict of misadventure was returned.

Another important situation raised by Dr Chao was "Can a doctor be held responsible for the negligence of another?" The Law is quite settled that a doctor is liable along with his partners for acts of malpractice committed by any of the partners. Responsibility may also arise from a number of other business relationships. A doctor is liable for the negligence of another doctor who is his employee on the theory of respondent superior. A doctor who hires a locum tenens to cover his practice during his vacation can be held liable for the malpractice of his locum. Thus it is essential that you select your partner and locum with care and ensure they perform their duties well. Further if a doctor is found to be the agent of another, who acts on his behalf during his absence and with his approval, he may be held liable for the acts of his agent doctor.

Finally, an appeal for the proper signing of death certificates. It is the law in Singapore that all unnatural, violent, sudden and unexpected deaths must be reported to the coroner. The doctor must not be pressurised into signing death certificates that are not valid and proper, or this would cause inconvenience and trouble for the relatives and the doctor. Fortunately, no damages suit has been brought up yet.

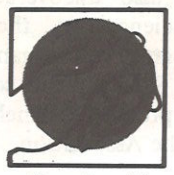
Thus it is well established in law that if a doctor examines his patient with thorough care, establishes his diagnosis with reasonable grounds, considers the differential diagnosis by performing additional tests that are necessary, treats his patient along well established regimes, keeps adequate notes of the progress, knows what he is doing, resuscitates immediately and adequately when things go wrong, he would not be held liable for what is only a mistake.

SOME ASPECTS ON THE DISCLOSURE OF CONFIDENTIAL INFORMATION

Dr Brian Rhodes, the Deputy Secretary, Secretary in Australia of the Medical Defence Union was asked to clarify on the obligation of practitioners to disclose confidential information at the request of members of the legal profession.

(continues on page 10)

PROSTAGLANDINS
—the link between pain inflammation & drug action in arthritis



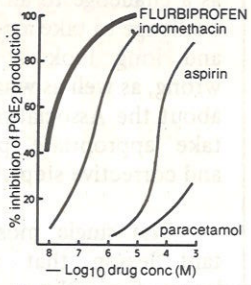
Prostaglandins & pain

Prostaglandins are synthesised from C_{20} fatty acids in almost all cells of the body. In man they produce local pain when injected intramuscularly and headache when injected intravenously. Accumulating evidence suggests that their main function is to sensitize pain receptors to pain producing stimuli and chemical mediators. Froben inhibits prostaglandin synthesis and relieves pain.

Prostaglandins & inflammation

Prostaglandins are present in exudates from inflamed areas. They produce dilatation of blood vessels and increase capillary permeability. Prostaglandins can produce an inflammatory response directly and by augmenting the action of other inflammatory mediators such as histamine. Froben inhibits prostaglandin synthesis and relieves inflammation.

Inhibition *in vitro* of microsomal PG synthetase from human rheumatoid synovia.[2]



Froben a specific inhibitor of prostaglandin biosynthesis.

The ability of flurbiprofen (Froben) to inhibit prostaglandin (PG) synthesis at the site of action has been confirmed by Bacon, *et al.*[1] Their experiments using microsomal fractions from human rheumatoid synovial tissue suggest flurbiprofen is one of the most powerful of the anti-inflammatory drugs. The *In vitro* studies of Crook, *et al.*[2] indicated that the molar potency of flurbiprofen for 50% inhibition of PGE_2 synthesis is some 5000 times that of aspirin and 20 times that of indomethacin. It is now widely accepted that the inhibition of prostaglandin synthesis explains the varied pharmacological effects of non-steroidal anti-inflammatory agents.

Drug		Relative molar potency for 50% Inhibition of PGE_2 synthesis *in vitro*.[2]
	Paracetamol	<0.01
	Salicyclic acid	<0.02
	Aspirin	1
	Phenylbutazone	2.7
	Ibuprofen	22
	Naproxen	45
	Indomenthacin	257
	Flurbiprofen	5610

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In patients with severe symptoms or disease of recent origin, or during acute exacerbations, the daily dose may be increased to 300mg in divided doses. Since Froben has been shown to be well tolerated by the majority of patients it would appear to be particularly well suited for patients intolerant to the side-effects of high dosage aspirin, phenylbutazone or indomethacin and those whose present long standing treatment no longer provides adequate relief.

Froben "One of the most powerful of the anti-inflammatory drugs in inhibiting the action of prostaglandin synthetase."

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1 Acta Paediatrica Scand. 1979; 68: 351-5, 441-2, 813-17.
2 Codex Alimentarius Commission Joint FAO/WHO food standards programme. Recommended international standards for foods for infants and children. CAC/RS 72/74 – 1976. Rome: Secretariat of the joint FAO/WHO food standards programme, 1976.
3 American Academy of Pediatrics. Committee on Nutrition. Commentary on breast-feeding and infant formulas, including proposed standards for formulas. Pediatrics 1976; 57: 278-85.

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Medical intelligence — a review of medical literature

By P. H. Feng

Advances in Medicine — The Good and the Bad

A glimpse of the American medical scene reveals the following good tidings.

1) 12,000 Americans have reached 100 years of age or more and one of every four babies born this year will reach the age of 85.
2) Of about 50 heart transplants done in the world each year, 50% are done in the U.S. and 50% of the recipients live at least 5 years.
3) More than 250,000 people in the U.S. are wearing cardiac pacemakers without which they might be disabled or dead.
4) 64,000 Americans are beneficiaries of renal dialysis and transplantation.
5) The new PETT (positron emission transaxial tomographic) scanner can detect and measure abnormality or injury in body tissues quite accurately and is poised to replace the CAT scanner.

However all these technological advances have created enormous economic dilemmas. The 1980 health care bill as estimated by the American Medical Association is US$245 billion which is about six times what it was in 1965. At the present rate of increase the cost is expected to go up to US$758 billion by end of this decade. Other relevant figures are as follows:—

1) In 1972 there were 11,000 cases on renal dialysis and transplantation costing US$239 million. By 1979 the number had risen to 56,000 costing US$1 billion and in 1980 to 64,000 costing about US$1.5 billion. By 1990, the cost is anticipated to be US$6 billion!
2) One PETT scanner at present costs about US$2 million. At the present moment there are 1,500 CAT scanners in the U.S. and if these were to be replaced by PETT scanners a bill of US$3 billion in today's dollars will ensue.
3) At present about 100,000 coronary bypass operations are done in U.S. per year at an average cost of US$15,000 per case, total cost US$1.5 million. With non-invasive investigatory screening tools like the PETT scanner and the knowledge that about 25% of individuals over 45 have significant coronary arteriosclerosis one can identify more than 10 million potential candidates for bypass! If the cost of the operation were to remain at current cost, the total bill would be US$150 billion!
4) The ultimate in organ replacement is the heart. If one overcomes the organ shortage and rejection problems it is estimated that about 32,000 Americans can benefit from a heart transplant per year. At US$100,000 per case this amounts to US$3.2 billion per year at current costs.

Factor

How then can one reconcile the run-away medical costs with economic realities. One basic factor is that there is an ever-increasing tendency to rely on x-ray, laboratory and other anxillary reports to make a diagnosis. Tests are extremely valuable but they should only supplement as necessary, not supplant, clinical acumen. It is pertinent to recall what Franz Ingelfinger, the late respected editor of New England Journal of Medicine said "If all available procedures are used, doctors can now diagnose illness with close to 100% accuracy. Patients will still die but they rarely die undiagnosed!"

This increase reliance on technical procedures is encouraged by several factors. Patients are often more impressed by doctor action than by doctor thinking, by the number of tests ordered than by the questions asked in the history, by the medications prescribed than by the advice given, by the number of x-ray films taken than by the amount of thought behind their requisition. Also services and decision making are rewarded at a lower rate than tests and procedures. An all-night vigil by a physician managing a case of diabetic acidosis is rewarded at a disproportionately low figure compared with a 10-minute endoscopy often performed for flimsy reasons.

It seems clear therefore that rationing in some form is necessary as mounting costs consume resources needed for other essential goods and services. Formal rationing is already imposed by the government. Ultimately the utilization of health care is best regulated by the physician. It is a difficult responsibility especially traditionally the doctor-patient relationship makes us instinctively focus our concern on the patient's getting well and exclude thoughts about cost. Unfortunately, in to-day's world, accepting such responsibility is necessary for failure to accept it allows the responsibility to go to others who may be strongly motivated but are certainly less knowledgeable in the comparative importance and value of cost and quality of care. Therefore the medical profession must include cost consideration in our decisions on patient care. However cost containment must not be used as an excuse for cutting down necessary expenditure to upgrade goods and services. This will be the burning issue of the 1980s and beyond.

Technologic advances in Medicine. The good news and the bad. Postgraduate Medicine 1982 Jan p 11 — 16.

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Report of 4th SMA/MMA Games held in Singapore on 4 Aug 1982

41 SMA and 42 MMA members participated in this year's games which involved the same four games as in previous years, namely badminton, golf, squash and tennis. All games were played at Singapore Island Country Club (SICC) except for badminton which was played at Delta Sports Complex. This year, SMA again emerged as overall winner, winning in all the four games.

BADMINTON: (Acting Convenor – Dr Teh Kong Chuan)

Ties	SMA Team	MMA Team	Results
1st Singles	Dr Tan Kheng Kooi	Dr Lee Gek Hui	Won 15-3/15-3
2nd Singles	Dr Chan Kum Khung	Dr Ammis Ahmad	Won 15-1/15-3
1st Doubles	Dr Oon Chong Hau Dr Chiang See Ping	Dr Minder Singh) Dr Wong Sai Hou)	Won 15-2/15-4
2nd Doubles	Dr Tan Kheng Kooi Dr Yeow Yew Khim	Dr Lim Gek Hui) Dr Ammis Ahmad)	Won 15-9/19-9
3rd Doubles	Dr Roger Pang Dr Thng Hooi Leong	Dr Wong Sai Hou) Dr Thilla Kannu)	Won 15-4/15-3

Overall Result: SMA won 5-0 (Challenge trophy donated by MMA)

GOLF: (Convenor – Dr Thomas Sim)

Pairs	SMA Team	MMA Team	Results
1.	Dr Goh Tiow Seng Dr Harold Chan	Dr Amir Abbas Dr Fong Wah Onn	Won
2.	Dr Wong Yik Mun Dr Benny Loo	Dr Teoh Boon Hooi Dr Chow Chong Yew	Won
3.	Dr Thomas Wong Dr Yeoh Kean Seng	Dr Paramarajah Dr Joginder Singh	Lost
4.	Dr Thomas Sim Dr Giam Choo Keong	Dr K. L. Lim Dr Chin Jeck Soon	Lost
5.	Dr Lian Ho Peng Dr Lim Whye Geok	Dr Lim Yew Hock Dr Lim Kah Pean	Won
6.	Dr Ang Hong Beng Dr Neo Eak Chan	Dr Dicky Tan Dr Chandrasekharan	Lost
7.	Dr Chan Kai Poh Dr Chan Kah Poon	Dr Andrew Choo Dr Tan Bock Hay	Won
8.	Dr Yang Chien Pai Dr Leong Kwong Lim	Dr Leong Sik Hoong Dr Balakrishnan	Won
9.	Dr Harry Ho Dr Martin Ng	Dr Ting Ing Keat Dr Patau Rubbis	Won

Overall Result :
SMA won 6-3 (Challenge trophy donated by Dr Yeoh Ghim Seng, SMA)

The following doctors participated in the social matches:

Dr Hia Kwee Yang	Dr Thomas Lim
Dr Edmund Kwee	Dr Ong Theng Kwee
Dr Kwok Weng Fai	Dr Tan Thian Hwee
Dr Willie Lee	Dr Tan Soon Kiam

SMA hosted our Malaysian guests to a buffet lunch at the Bunker Room, SICC. A dinner and prize presentation was held at the Golden Phoenix Restaurant, World Trade Centre. The dinner was also attended by SMA and MMA Council members. MMA was again victorious in the beer-drinking contest. MMA President Dr Lim Say Wan proposed that future games be held in conjunction with the Academies of Singapore and Malaysia Congreses. The next SMA/MMA Games to be hosted by MMA in 1983 will probably be held in Malacca.

I wish to record my sincere appreciation to the SICC for the use of their facilities, all the sponsors, games convenors, their sub-committee members and the SMA Secretariat for their assistance. I accept responsibilities for any oversights or mistakes which may have occurred in the organisation of these games.

Dr Giam Choo Keong
Hon. Secretary, SMA and Chairman
SMA Sports & Games Committee 1982

SQUASH: (Convenor – Dr Peng Chung Mien)

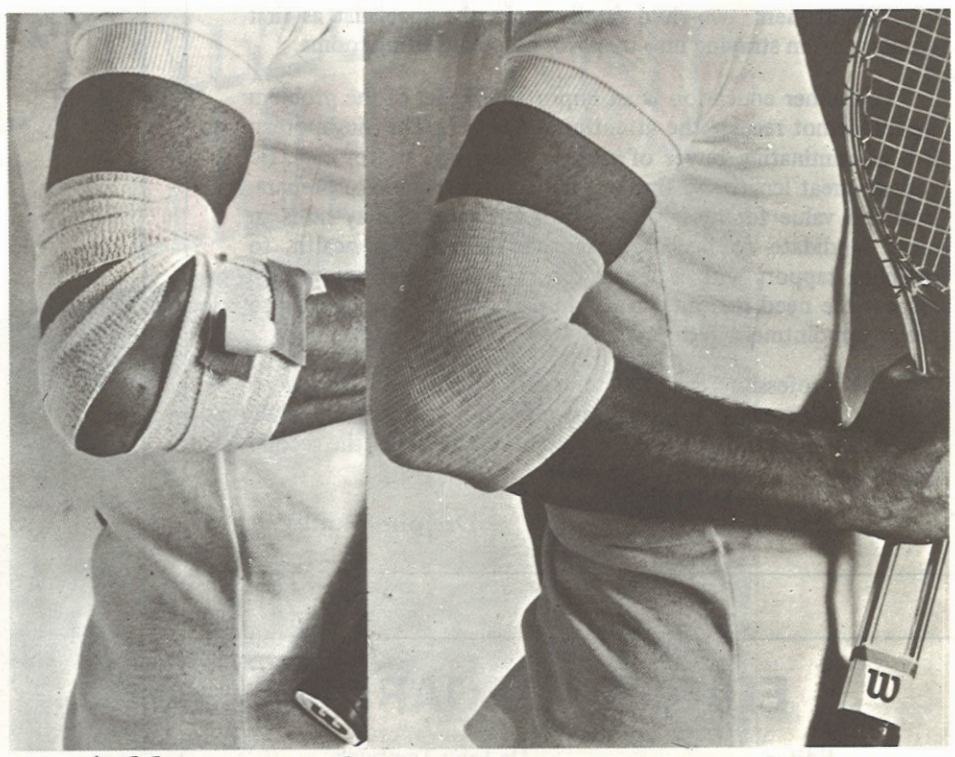
Rubbers	SMA Team	MMA Team	Results
1st	Dr Ranjodh Singh	Dr Lim Say Wan	Won 3-0
2nd	Dr Wong Ee Kong	Dr Doraisamy	Won 3-0
3rd	Dr Chong Kwang Peck	Dr Abdul Hamid	Won 3-0
4th	Dr Peng Chung Mien	Dr Alfred Tan	Won 3-1

Overall Result : SMA won 4-0 (Challenge trophy donated by MMA)

TENNIS: (Convenor – Dr Willie Lee)

Ties	SMA Team	MMA Team	Results
1st Singles	Dr Ong Leong Boon	Dr V. K. Pani	Won 9-6
2nd Singles	Dr Lee Kheng Hin	Dr M. Krishnan	Lost 6-9
1st Doubles	Dr Willie Lee Dr Ong Leong Boon	Dr Lau Soo Chuan) Dr J.B. Tan)	Won 9-8
2nd Doubles	Dr Chow Shen Jung Dr James Khoo	Dr Rahim Omar) Dr Abu Bakar)	Won 9-2
3rd Doubles	Dr Albert Wee Dr Wong Teng Kim	Dr Andrew Choo) Dr Tan Bock Hay)	Won 9-2

Overall Result : 4-1 (Challenge trophy donated Dr N K Yong, SMA)



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EDITORIAL

THE FIRST OPINION

THE pre-occupation with a second opinion in recent times has detracted from the value of a good first opinion and this may be an opportune time to reflect on the current status of the first opinion in Singapore.

The average outpatient doctor in Singapore, working in one of our government-run clinics, is given a quota of 70 patients to see between 8.30 am and 1 pm and 50 patients between 2 pm and 4.30 pm. This works out to 3.8 minutes per patient in the morning and 3 minutes in the afternoon!

The doctor has to greet courteously (mindful of the current campaign), obtain a history, examine the patient, establish rapport, explain the nature of the illness, prescribe, prognosticate and finally give a friendly wave of goodbye in three point something minutes! The busy HDB practice is no different. There is no appointment system at most points of first contact. First come, first served.

The problem is complex, with many facets to consider. Are there practical solutions? Nurse practitioners may reduce the load in "routine pill prescribing". Rules to limit supplies of medication prescribed compound the numbers attending for more tablets. Minor problems clamour for attention amidst life-threatening situations. The system is too accessible in many instances. Singapore must be one of the few places in the world where it is easier to obtain the services of a doctor than those of a plumber, painter or mechanic and often at lower rate of fee for service!

The affluent two-child family seeks the specialist as first opinion, often straying into inappropriate consulting rooms.

Consumer education is an important aspect of the problem that does not receive the attention it deserves. The Singaporean is a discriminating buyer of clothes, food and motor cars. He goes to great lengths to find out the contents, mode of preparation and value for money in shark's fin soup. Surely he is an ideal candidate to become interested in his own health, to establish rapport with a doctor for a life-time first opinion, to respect the need for time to obtain that opinion and to learn to use an appointment system.

The profession can update itself, update its attitude to patients as people with problems, fears and anxieties and then perhaps, the quality of the first opinion will make the second redundant.

Dr John Tambyah

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CONGRATULATIONS

A. NATIONAL DAY HONOURS 1982

The Public Administration Medal

(Gold) – Dr Poh Soo Chuan
(Silver) – Dr Lenny Tan Kheng Ann
(Bronze) – Dr Giam Choo Keong

Commendation Medal (Gold) (Military)

LTC (Dr) Cheong San Thau
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The Public Service Medal

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Dr Yip Chin Ling
Dr Yong Fong Min

C. RESULTS OF EXAMINATIONS

Royal Australasian College of Surgeons Part I Fellowship Examination: July 1982

Dr Chew Khet Kuen
Dr Foo Toon Hiong
Dr Goh Min Yih, Peter
Dr Lee Bee Lan
Dr Ng Sok Hoon
Dr Sim Chiang Khi
Dr Yong Fok Chuan

Primary Master of Medicine (Anaesthesia) Examination August 1982

Dr Chong Yeen Yoong
Dr Lee Joo Ee, Evelyn (Miss)
Dr Lee Shing Cheung
Dr Tan Hsiao Ming (Miss)

Final Master of Medicine (Surgery) Examination: August 1982

Dr Kee Sue Gee
Dr Lee Soon Tai
Dr Wong Ho Poh

News from Council

HEALTH COUNCIL:

SMA Council has sent to Dr Andrew Chew, Director of Medical Services, Ministry of Health, a letter of congratulations on the formation of the Health Advisory Council. We have also requested the Health Ministry to include official representation from SMA on this Health Advisory Council.

FEES:

Together with the Consumers' Association of Singapore (CASE) and the Association of Private Medical Practitioners of Singapore (APMPS), Council will be issuing a joint statement to the news media, advising doctors and patients to discuss the issue of fees chargeable for medical consultation, investigation or treatment.

The need for this joint statement has arisen in view of recent allegations by patients of overcharging by the medical profession.

A survey questionnaire on "Guideline on Fees for Doctors in Private Practice in Singapore" has been revised to facilitate analysis by computer and was sent out to members on 15 August 1982. Council hopes you responded to it as it wishes to know your views before putting up recommendations.

SMA/MMA GAMES:

Forty-two of our Malaysian colleagues and their families came down to Singapore during the National Day weekend to participate in the 1982 SMA-MMA Games.

The SMA Team won all the four games but lost in the Beer Drinking Contest!

NURSING PRIZE:

SMA donated $200/- to the Singapore Nursing Board towards book prizes for their most outstanding graduands.

DONATION :

SMA's interest in the community is also reflected in Council's decision to donate at least one dialysis machine costing some $35,000/- to the National Kidney Foundation.

The money will be raised from an appeal to SMA members, with SMA matching dollar-for-dollar, up to a maximum of half the cost of one machine.

Please donate generously to this worthy cause. All donations will be tax-exempt.

SMA members have also been requested to pledge their organs for donation and encourage their friends and patients to do the same. Details have been sent to all SMA members on 1 September 1982.

TALK:

Make a date with SMA on Wednesday 13 October 1981, when Dr P G T Ford, Deputy Secretary of the Medical Protection Society, will be giving a talk to SMA members and the NUS Medical Society.

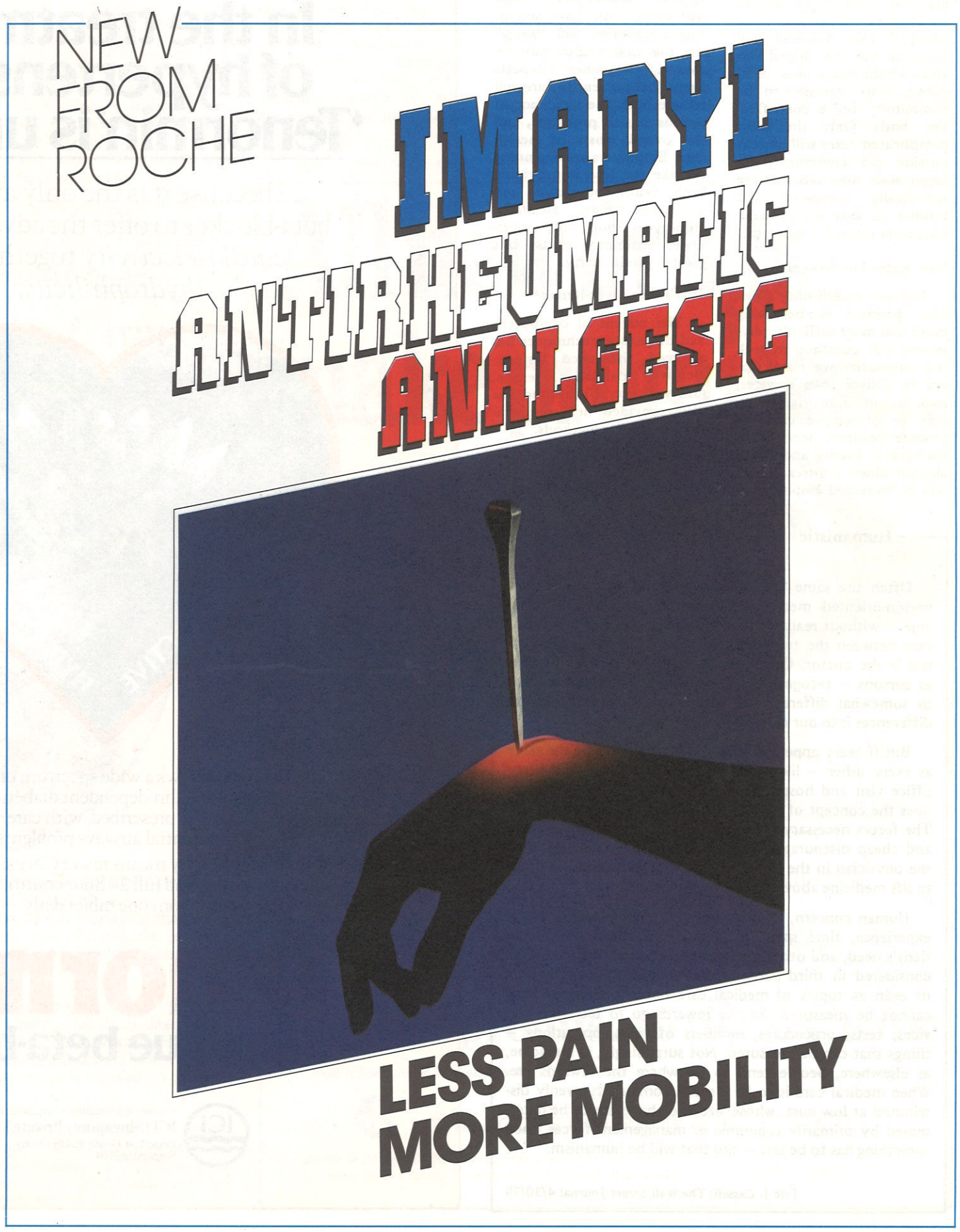
MASEAN:

The Medical Association of Southeast Asian Nations (MASEAN), in conjunction with the Regional Institution of Higher Education and Development (RIHED), is organising a Workshop on Postgraduate Medical Education in December 1982 in Bangkok.

Dr Low Lip Ping, a member of the SMA Medical Education Committee, will be SMA's representative to this workshop session. Other members of the Singapore delegation are Drs Feng Pao Hsii, Teoh Peck Chuan, Wong Hock Boon and a representative from the College of General Practitioners.

CONVENTIONS:

SMA's 14th National Medical Convention and the SMA Annual Dinner will be held at the Shangri-la Hotel over the weekend of 16 and 17 April 1983. More details will be released soon.



A.M.I. looks at health care in the next ten years

AMI (American Medical International) believes that the health care system in U.S.A. is changing. Today the system is increasingly responsive to consumer needs and economic realities. This will be the basis for a quite different health care delivery system in the 1990's.

The New Role For Hospitals

Sophisticated health care will come closer to the patient's home. New, noninvasive diagnostic technologies are now available to smaller community hospitals. The 100-250 bed hospital will come to rely on shared services which make new technology more accessible to the community on a cost-effective basis. Only the most complicated cases will be sent outside the community to larger scale hospitals that are specifically organized and funded to take on unusual, long-term esoteric treatment.

New Roles For Physicians

Because establishing a private practice is becoming more and more difficult, physicians will continue to seek out alternative ways and places to deliver their services, such as in industrial medicine or preventive care, or provide contract services to emergency rooms and drug/alcohol abuse centres. There will be increased emphasis on the treatment of the elderly (a fast growing segment of the population) and chronically ill, and an increase in the number of hospices.

Controlling Rising Costs

The current pressure on hospitals to hold down costs will continue. Third party payers will continue to look for ways to control costs. Co-payments and higher deductibles will be standard features of most health insurance plans. Protection against catastrophic illness will come from government. The consumers will "shop" for the best health care resource. Insurance experts agree that preventive care will reduce both the incidence of serious health problems, and the overall costs of health care. Employers are beginning to take the lead in providing both health education and preventive care. Healthier employees not only mean lower insurance costs, but greater productivity.

If It's New, Is It Better?

The advent of computerized diagnostic techniques has reduced the need for expensive, risk-laden, exploratory surgery. Ultrasound has also provided new noninvasive diagnostic methods.

The problem with technology is that it can be costly, and is often beyond the range providers can afford. To make it more accessible and affordable takes ingenuity. AMI is already providing mobile CAT scanners, which many can share.

The breakthroughs in pharmaceutical research are just as startling. Medicines are encapsulated in synthetic tissue containers that release precise dosages automatically through the skin. The costs of developing these new drugs and technologies are staggering.

The Consumer In The 1990's

The consumers in the future will be better educated and will understand more about the technology and techniques of proper health care delivery. They will know more about the costs of that care. And they will make choices as to how and where they utilize the skills available to them. The more they know, the more they can help make the health care system responsive.

Extracted from AMI literature.

by DR. C.Y. KHOO

Humanistic vs. Commodity Medicine

Often the same people who want a more humanistic person-oriented medicine also want a commodity medicine — without realizing that there is an inherent contradiction between the two views. If the patient is a person, so too is the doctor. Only persons can take care of persons as persons — recognizing all the things that make each of us somewhat different and consequently, introducing the differences into our care when we are sick.

But if every appendectomy is considered to be the same as every other — like a mass produced table — and every office visit and hospital consultation are the same, where does the concept of the doctor as a person fit in with that? The forces necessary to keep every medical service identical and cheap discourage the intense personal involvement by the physician in the patient's care that is required in order to lift medicine above the merely technical.

Human concern, clinical judgment, knowledge born of experience, time spent in listening, understanding a patient's need, and other personal acts of medicine cannot be considered in third party regulations, fixed fee schedules or even as topics of medical care research, because they cannot be measured. So the rewards go to technical services, tests, procedures, numbers of visits, operations — things that can be measured. Not surprisingly, in medicine, as elsewhere, people tend to go where the rewards are. When medical care is to be a social commodity evenly distributed at low cost, whose size and shape are to be determined by primarily economic or management forces, then something has to be last — and that will be humanism.

Eric J. Cassell; The Wall Street Journal 4/30/79

In the treatment of hypertension 'Tenormin' is unique

...because it is the only available beta-blocker to offer the advantages of *cardioselectivity* together with *hydrophilicity.*

Cardioselectivity allows a wide spectrum of patient selection. Appropriate in insulin-dependent diabetics, preferable in smokers, and can be prescribed, with care, to patients with potential airways problems.

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the unique beta-blocker

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Fees: To fix or not to fix

By Dr Earl Lu

IT would seem that some members of the medical profession are overcharging the public, or the question of a fixed schedule of fees would not arise. As a young doctor, I was for a short time a general practitioner in a rough part of Sydney called Newton. We had a fixed schedule of fees, which I liked. A consultation paid me 1½ Australian dollars, and only one dollar for pensioners, which the government promptly paid. There was no need to haggle about fees, and there were few bad debts. Over the years, these fees, which covered nearly all medical and surgical services, have risen many times. I understand a GP consultation is now about A$30/-.

The question naturally arises whether a fixed schedule of fees benefits patients and doctors. Yes and no. This passage appeared in one of the daily papers in March this year when I was in Sydney. It concerned health fund problems. "In the light of the government guess-timate that about 900 doctors are defrauding $100 million each year, this is costing the contributors plenty. Fraud is not easy to detect. Most of the big (fund) companies employ economists or computer experts to check through their systems for suspicious claims. Overservicing by doctors is the most prevalent offence."

System

It seems that, whatever the system, there will be a number of wise guys out to beat it. I think it is fair to say that at this moment, the prestige of the medical profession across the seas has suffered somewhat.

The question remains: what is fair return for a doctor's services. My guess is that he will aim for an upper middle class professional man's income. What he achieves will depend on the economic environment of his practice, his qualifications, his skills, his years of experience, his dedication, his business sense and his skill for public relations. An older doctor should feel morally obliged to charge more than his younger colleagues, to give them a sporting chance.

A doctor should bear in mind that idealism is built into his profession by tradition. His patients' welfare must come first, and he must expect sometimes to work for no pay. However, a doctor is also the product of his own community, and a merciless community must not expect too many merciful doctors.

I think a doctor is right to charge the rich more than the poor, if only because the rich are much more demanding. But he must be sensitive to financial distress in his patients, especially if unexpected complications gave rise to unexpected expenses. In some ways a doctor is supplying an essential service like water, electricity and housing, and like these services, the rich subsidise the poor.

Life

He must accept the fact that saving a life may not pay much, but losing that same life through negligence may cost him his last penny. He must realise that his livelihood is as vulnerable as his state of health, and a heart attack, a stroke or a bad tremor may render him unmarketable.

Perhaps the central point about fees is that the patient has a right to know, as near as possible, what his total financial commitment is likely to be, and every effort must be made to keep it within that range.

It is better for a doctor to suffer occasional financial loss for wrong assessment, than to start an unseemly argument over fees. When a patient feels he is victimised, there should be a panel of trusted doctors and laymen to act as arbitrators.

To sum up, there is no perfect system where fees are concerned. Sound medical ethics is paramount. The patient should know what his financial commitments are likely to be. There should be an arbitration panel.

** Talk given at the 13th SMA Convention*

New Coat of arms for N.U.S.

THIS is the new coat of arms adopted by the University. It shows a full-faced walking lion on the white ground of the shield. The lion is from the State Arms, signifying that it is a national institution. On the upper part of the shield, in a blue background, there is the open book on the right and on the left three white circles.

The new coat of arms, incorporating the former University of Singapore and Nanyang University symbols, is designed by the College of Arms in London. The College was approached by the University in March last year, after attempts to search for a suitable design for the University's emblem failed to produce any satisfactory result.

A University flag bearing the new coat of arms is currently being designed and the University wishes to acknowledge the valuable advice received from the Ministry of Culture and the assistance rendered by Mrs Evelyn Lip, Senior Lecturer in the School of Architecture, in preparing the artwork.

All new drugs make promises...

Brufen keeps them

The promise of relief from inflammation and pain...

fulfilled by more than seven years' use in all types of practice. Over 8,000,000 arthritic patients have been treated with Brufen. It is now prescribed in more than 90 countries throughout the World.

The promise of an exceptionally well tolerated drug...

clearly demonstrated in large numbers of patients unable to tolerate other antirheumatic agents. Side-effects of any nature have been remarkably few with Brufen.

The promise of effectiveness in long-term use...

confirmed by extended studies in clinical practice. Every feature of Brufen, including its value in long-term therapy, has been fully discussed in some 250 published articles and papers.

BRUFEN (ibuprofen)

keeps its promise to the arthritic

Full information is available from

THE BOOTS COMPANY (F.E.) PTE. LTD.

Roche Building, 30 Shaw Road, Singapore 1336. Tel: 2854222
34, Jalan Telawi Lima, Taman Bungsar Baru, off Jalan Maarof, KL, Tel: 941507, 944557.

LEGAL ASPECTS OF MEDICAL PRACTICE

continues from page 2

He has written that "if a request for confidential information is not accompanied by a firm statement that the solicitor is acting for his client, the doctor's patient, no disclosure should be made until the patient's wishes in the matter have been checked."

Also "if a request for confidential information is not accompanied by facts which show valid reason for disclosure, the practitioner is urged to be cautious". For example, the lawyer may be acting in relation to a road accident, industrial injury or a marital dispute. Even in such cases, circumspection is desirable in disclosing information in order to save embarrassment to the patient and criticism of the doctor.

Where such facts are not forthcoming, then the doctor must beware of the "fishing expedition" process, a procedure designed to tempt the doctor to divulge and/or allow scrutiny of material by those seeking a possible basis for litigation. This usually takes the form of a request for a report.

A doctor who is in doubt as to the validity of a solicitor's request for information will be well advised to seek guidance from his defence organisation.

Report

In summary, a doctor is not obliged to give a report merely on the request of lawyers, furthermore his obligation to give a report does not extend to the disclosure of the contents of his personal case notes, or copies thereof. On the other hand a doctor who is unduly obstructive or who otherwise seeks to impede the customary and accepted co-operation between medical and legal professions is likely to impair the best interests of his patients.

SOME LEGAL ASPECTS OF MEDICAL INSURANCE

Although medical insurance is still in its infancy in Singapore, the trend in the 80's will surely be to follow the experience in industrialised nations.

Dr Mying Soe, a well known local barrister was asked to highlight areas in medical insurance where there will be difference in opinions between the health insurers and doctors who have treated the insured.

The areas of dispute will usually be with regard to the special conditions, and the exclusions imposed in the policy.

By **special conditions** Dr Soe refers mainly to conditions precedent to liability. Certain examples are given:—

1. In most of the medical insurance policies, it will be stated that notice of injury or of sickness on which the claim may be based and which is covered by the policy must be given to the company within 30 days after the occurrence or commencement.

2. Affirmative proof of sickness must be submitted to the company at the expense of the claimant.

3. If there is other insurance covering the injury or sickness, the company shall not be liable for a greater portion of such injury or sickness and the amount applicable under the policy.

4. No action can be brought after 2 years within which proof of claim is required by the policy. All these special conditions will give trouble.

Claim

For example, a person may be in hospital abroad with no relatives. He may be there for several weeks. He may be in a serious state. In such a case it is quite likely that he will forget to make any claim within 30 days of the occurrence or commencement of the injury or sickness.

In such a case, it will seem that his claim is finished. Secondly, trouble can arise over the phrase "affirmative proof of injury or sickness". What is proof to the insured may not be proof to the insurers. In such a case, further proof is asked for. It may not be available especially when the claimant has been hospitalised in a foreign country where the system may be quite diffferent from the system in Singapore or in England.

Thirdly, most insured do not know the way co—insurance works or affects them. In fact, even some lawyers who deal with insu—rance may not be familiar with the effect of co-insurance.

Lastly, the limitation period is another snare. In fact, this is a very unfair provision because few who are insured know about it and some lawyers may well overlook it. This is because in the general law, any suit for liability for breach of contract or in tort (except where the tort involves personal injury) can be filed within six years.

The limitation clause in a policy should be in a special colour (red for example) so that insurers will not take advantage of technical provisions.

Opinion

Certain **major exclusion clauses** have given trouble from time to time. Almost all medical or health policies will not cover pre-existing illness, congenital condition or deformity, or treatment for a nervous breakdown or disorder. But medical opinion may differ as to what is a pre-existing illness, what constitutes a congenital condition or deformity (except in the obvious like harelip, clubfoot), or a nervous breakdown (except where psychiatrists or Woodbridge are involved).

Hence, problems arise in insurance policies because of interpretation of definition.

It is hoped that this trilogy will advise doctors on some legal aspects of practice. As the topic is very vast, we would like to invite questions so that aspects not covered can be dealt with in later articles, subject to the response.

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756 Upper Serangoon Road, Singapore 1953. Tel: 2804718

Guardian Centrepoint Basement, Cold Storage Centrepoint, 176 Orchard Road, Singapore 0923. Tel: 7374835, 7374222 ext 42
Guardian Mount Elizabeth 1st Flr, Blk A, 2.10, Mount Elizabeth Medical Centre, Singapore 0922. Tel: 7344824/5
Guardian Jelita 1st Flr, Cold Storage Jelita, 293 Holland Road, Singapore 1027. Tel: 4690700, 4693877 ext 34
Guardian Katong 123, 1st Flr, Katong Shopping Centre, Mountbatten Road, Singapore 1543. Tel: 4403945

Field day for golfers

Everyone knows that golf is a game which requires 90% Mental concentration and 10% Physical prowess. This was truly proved when Dr Chia Boon Hock "psyched" himself into becoming the 1982 SMA Champion at the Singapore Island Country Club New Course on Sunday, 9th May 1982.

Seventy persons including 8 ladies (6 wives and 2 lady doctors) participated in this year's championships which were held in conjunction with the 13th National Medical Convention. A new feature was also introduced this year with a game between dcotors in the Public and Private sectors. Dr Foo Chee Guan, our "Grand Old Man" of golf generously donated a trophy for this match.

In groups of 3 and 4, the players teed off from 12.30 to 2.20 pm and there were the usual slicings, hookings, OB's 3-puttings etc. Even a threatening downpour, which miraculously did not materialise, did not dampen the spirits of the golfers.

At the 9th hole, Dr Alfred Chee landed his ball just 9" from the hole (and thus missed special "hole-in-one" prizes of a Nissan Sunny car and a Honma Graphite driver by those 9 inches!) He was awarded the "nearest-the-pin" prize while Mrs Beatrice Foo won a similar prize among the ladies.

At the 18th hole, all braced themselves to hit the longest drive and it took the power and rhythm of Dr Goh Tiow Seng to belt the ball close to 300 yards. Not to be outdone by the men, the ladies too had their longest driver in the person of Dr Susan Lim.

After the game, it was time for drinks and food at the New Swimming Pool Complex. Of course, this was interspersed with lies and gossips about their missed putts, fluffed shots and unfortunate OB's. The day was climaxed by the Prize Presentation with congenial Dr Harry Ho as the compere and SMA President, Dr Yong Nen Khiong who presented the prizes. Dr Foo Chee Guan was also at hand to present his trophy to the captain of the Private Sector team, Dr B K Sen.

Dr Thomas Sim
SMA Golf Convenor

RESULTS

Best Lady Golfer

(Dr Oon Chiew Seng Trophy)

Winner	:	Dr Susan Lim
Runner-up	:	Mrs Lucy Sheng
3rd	:	Mrs Beatrice Foo
4th	:	Mrs L K Wong
5th	:	Mrs Aileen Chong

Senior Golfers

(Dr Chan Ah Kow Trophy)

Winner	:	Dr Khoo Boo Kwee (2nd year in succession)
Runner-up	:	Dr Ng Chee Chai
3rd	:	Dr Harold Chan
4th	:	Dr Sheng Nam Chin
5th	:	Dr Yeoh Siang Aun
6th	:	Dr Ong Swee Law

Best Gross

(Dr Choo Jim Eng Trophy)

Winner	:	Dr B K Sen
Runner-up	:	Dr Charles T C Lim
3rd	:	Dr Lim Whye Geok
4th	:	Dr Lim Cheng Hong
5th	:	Dr Chen Yeu Wah
6th	:	Dr Chew Beng Keng

Best Stableford

(Dr Heah Hock Thye Trophy)

Winner	:	Dr Robert C K Loh
Runner-up	:	Dr Goh Tiow Seng
3rd	:	Dr Wong Yik Mun
4th (A & B Division)	:	Dr Thomas Wong
(C & D Division)	:	Dr Michael Loh
5th (A & B Division)	:	Dr Philip Ling
(C & D Division)	:	Dr Hia Kwee Yang
6th (A & B Division)	:	Dr Thomas Sim
(C & D Division)	:	Dr Chan Kah Poon

Best Nett (Dr Yeoh Ghim Seng Trophy)

Winner (SMA Champion)	:	Dr Chia Boon Hock
Runner-up	:	Dr Oh Siew Leong
3rd	:	Dr Leong Kwong Lim
4th	:	Dr Yang Chien Pai
5th	:	Dr Steven S E Ong
6th (A & B Division)	:	Dr Lian Ho Ping
(C & D Division)	:	Dr Ong Teng Kwee
7th (A & B Division)	:	Dr Yeoh Kean Seng
(C & D Division)	:	Dr Giam Choo Keong
8th (A & B Division)	:	Dr Moses Yu
(C & D Division)	:	Dr Chow Kye Kheong
9th (A & B Division)	:	Dr Benny H P Loo
(C & D Division)	:	Dr M K Chin
10th (A & B Division)	:	Dr Lim Kim Leong
(C & D Division)	:	Dr Ho Cheong Hock

Special Prizes

Nearest-the-Pin (9th hole)

Men	:	Dr Alfred Chee
Ladies	:	Mrs Beatrice Foo

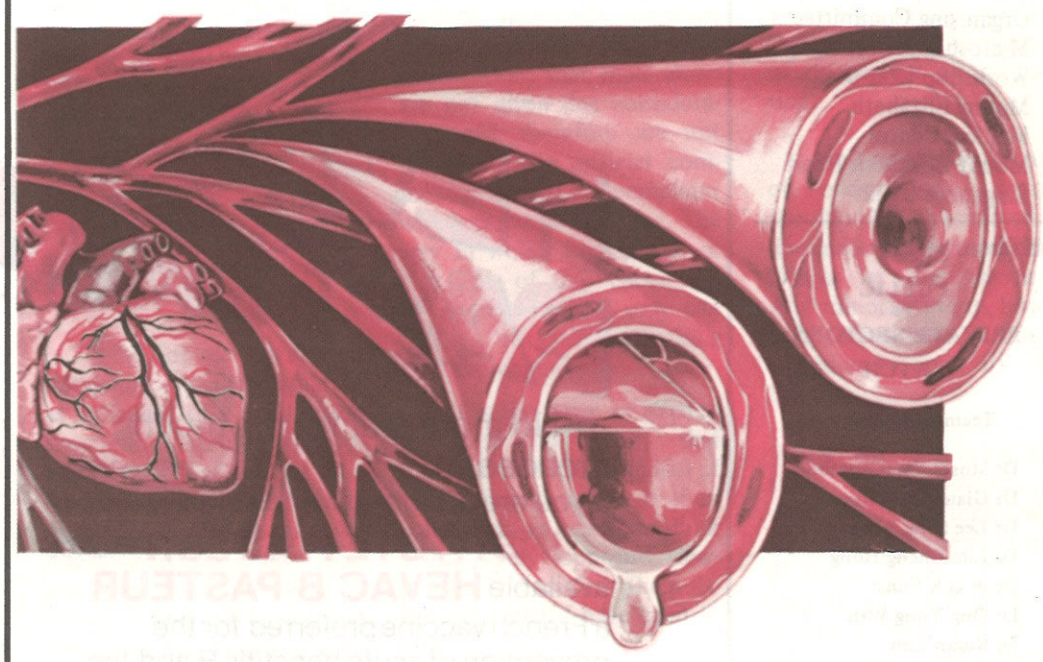
Longest Drive (18th hole)

Men	:	Dr Goh Tiow Seng
Ladies	:	Dr Susan Lim

(See pg 12)

new Minizide*

Effective in blood pressure control particularly in mild to moderate hypertension with once daily dose.



- Dual action of reducing total peripheral resistance and plasma volume giving the preferred hemodynamic response
- Convenient dosage schedule encourages patient compliance
- Minimum side effects which are generally mild, transient and occur early
- Provide significant benefits for both the patients and the physician

Pfizer

*Trademark

Announcements

THE Annual Convention of the Royal Australian College of General Practitioners (incorporating the 25th A.G.M.) will be held from October 17 - 22, 1982 at the Lennons Plaza Hotel, Brisbane, Australia.

The theme will be 'Update for the 80's'. For more information, write to:

Executive Officer
R.A.C.G.P. (Queensland Faculty)
P.O. Box 37, Toowong 4066
Australia

THE 16th Annual Combined Surgical Meeting takes place from November 19 - 21, 1982 at the Mandarin Hotel.

This is organised by the Academy of Medicine (Chapter of Surgeons) and the Singapore Surgical Society.

For more information write to:

The Scientific Chairman
Organising Committee
16th Annual Combined Surgical Meeting
Academy of Medicine
4A College Road
Singapore 0316

A WORKSHOP on microsurgical teaching will be held on March 18 and 19, 1983 in conjunction with the Ninth Congress of the Asia-Pacific Academy of Ophthalmology in Hong Kong.

For more information write to:
Dr Arthur Lim
Chairman,
Organising Committee
Microsurgical Teaching
Workshop Unit 0609.
Mount Elizabeth
Medical Centre
Mount Elizabeth Road
Singapore 0922

THE Singapore Cardiac Society and the Academy of Medicine will jointly organise the Asean symposium on cardiac rehabilitation.

This will be held from March 4 to 6 at the Mandarin Hotel. Guest speakers will be Professor Nanette Wenger from the Emory University School of Medicine, USA; Professor Herman Hellerstein from the University Hospitals of Cleveland, USA; and experts on the subject from the Asean countries.

For further information, write to Dr Oon Chong Hau, Organisingg Secretary, Academy of Medicine, 4A College Road, Singapore 0316.

COMMONWEALTH MEDICAL ASSOCIATION
CODE OF MEDICAL ETHICS

THE doctor's primary loyalty is to his patient. His vocation and skill shall be devoted to the amelioration of symptoms, the cure of illness, and the promotion of health.

He shall respect human life, and studiously avoid doing it injury.

He shall share all the knowledge he may have gained with his colleagues without any reserve.

He shall respect the confidence of his patient as he would his own.

He shall by precept and example, maintain the dignity and ideals of the profession, and permit no bias based on race, creed or socio-economic factors to affect his professional practice.

LAST WORDS:

YOUR stethoscope may be stifling some creative steak in you.

Let is surface. The SMA Newsletter would like to hear from those who are hobbyists in painting, sculpturing, photography and may be bird encounters of the feathered kind!

This is part of the Newsletter's efforts to feature regular profile stories of doctors who are also personalities outside the consulting room.

And if cartoons and caricatures are your forte, you will find the Newsletter a lucrative avenue. Write to:

The Editor
SMA Newsletter
Singapore Medical Association
4A College Road
Singapore 0316.

The Editor also welcomes letters expressir opinions on relevant issues, or suggestions on improving the Newsletter.

Golf (from pg 11)

PUBLIC vs PRIVATE SECTORS MATCH

Teams – Public :

Dr Moses Yu (Captain)
Dr Giam Choo Keong
Dr Lee Siew Khow
Dr Lim Cheng Hong
Dr W G S Fung
Dr Ong Yong Wan
Dr Susan Lim
Dr M K Chin

Private :

Dr B K Sen (Captain)
Dr Ang Hong Beng
Dr James Chang Ming Yu
Dr John Y C Chong
Dr Lian Ho Ping
Dr Yeoh Kean Seng
Dr Leong Kwong Lim
Dr Goh Tiow Seng

Stableford Points
(Best 7 out of 8)

Public sector – 209 points
Private sector – 225 points

Winners
(Dr Foo Chee Guan Trophy)

Private Sector Team

Dr Thomas Sim
SMA Golf Convenor

HEVAC B PASTEUR

No more fear for the much dreaded **HEPATITIS B,** especially if you are a 'high-risk' individual.

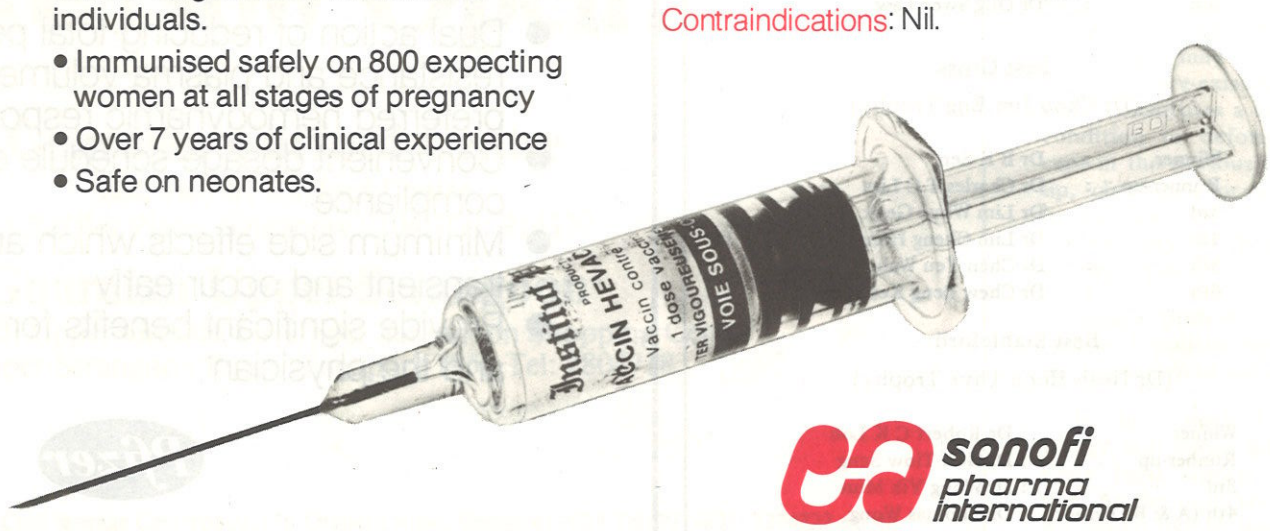
INSTITUTE PASTEUR makes available **HEVAC B PASTEUR** a French vaccine preferred for the prevention of acute hepatitis B and the carrier stage in non-immunised individuals.

- Immunised safely on 800 expecting women at all stages of pregnancy
- Over 7 years of clinical experience
- Safe on neonates.

Chronic HBV infection is known to be associated with a higher risk rate for Hepatocellular carcinoma and is also associated with various forms of chronic hepatitis and occult cirrhosis. Age decade studies in Singapore have shown that the exposure to infection by Hepatitis B viruses increases with age, so that by the age of 60, nearly 100% of the population have been infected. In other studies on HBV-carrier mothers in Japan, Taiwan and UK, infections of such babies are detected from 5 days to 3 months post-natally.

Treatment of Hepatitis B is a challenge of this decade. Ultimately, prevention by vaccines against HBV infections will be required.

Presentation: Disposable, unidose, syringe of one ml. of vaccine.
Contraindications: Nil.



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