SMA news

For Doctors, For Patients

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GLP-1 Agonists for Obesity

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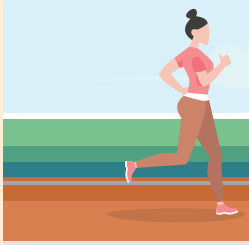


The Editors' Musings

DR TINA TAN

Editor

Dr Tan is a psychiatrist in private practice and an alumnus of Duke-NUS Medical School. She treats mental health conditions in all age groups but has a special interest in caring for the elderly. With a love for the written word, she makes time for reading, writing and self-publishing on top of caring for her patients and loved ones.

At risk of sounding like a health magazine, we have curated several articles this month with focuses on (1) developments in the realm of obesity treatment, and (2) extreme diets that are trending these days, which our patients may turn to in the absence of medication or surgery.

This is relevant because our patients often learn of such matters and trends from their friends, family and the social media. They then consult Doctor Google, before approaching an actual doctor. For me, such conversations usually start off at the *end* of a consultation and would typically go, "Oh, and by the way, Dr Tan, have you heard of...?" or "*Ah*, before I leave, Dr Tan, what do you think of...?"

Thus, I direct you to Dr Rasminder Kaur and Dr Tham Kwang Wei's informative article on anti-diabetes drugs that have recently been approved for use in obesity treatment. Dr Chie Zhi Ying has also written an insightful piece on the various extreme diets that her patients have been on, and the resultant impact such regimes have on a person's health and their overall control of their medical conditions.

On a lighter note, Dr Lim Baoying has written about her enjoyment of running, both as a way to keep fit (in her case, *athletically* fit) and to relieve stress. Naturally, we cannot forget that in the pursuit of physical well-being, we should not ignore our emotional well-being too (as a psychiatrist, I feel obliged to say so, though I acknowledge that it is not always easy living up to my own advice!).

With that, stay fit and stay healthy.

DR CHIE ZHI YING

Deputy Editor

Dr Chie is a family physician working in the National Healthcare Group Polyclinics. She also holds a Master of Public Health from the National University of Singapore and is a designated workplace doctor. She enjoys freelance writing and writes for Chinese dailies *Lianhe Zaobao, Shin Min Daily News* and health magazine *Health No. 1.* She can be contacted at chiezhiying@gmail.com.

With ready access to calorie-dense food and leading a sedentary lifestyle revolving around electronic devices for work and entertainment, global obesity rates are steadily rising and has been termed the "obesity pandemic". In Singapore, we have in place the Healthier SG movement, a national initiative focusing on preventive health, which also includes promoting a healthy lifestyle.

The fundamental thing about maintaining a healthy weight is balancing the energy intake from one's diet against the energy expenditure from physical activity and exercise. Those who are more health-conscious put in great effort and commitment to maintain a certain diet and exercise regime, allowing themselves to indulge on occasion. There are various diets and exercise regimes that one can choose from to keep fit and healthy, but sustaining these healthy habits is a great challenge.

In this issue focusing on health and fitness, we are excited to have Dr Rasminder Kaur and Dr Tham Kwang Wei give us their insights into the use of diabetes drugs for obesity treatment. I am happy to share about some of the common but extreme health diets that my patients have tried in their bid to lose weight, in an effort to optimise their control of their chronic diseases. Additionally, get inspired by Dr Lim Baoying as she shares with us how she keeps healthy and fit with her zest for physical training and exercise.

As the old saying goes, "Health is wealth". No matter how busy we are with the demands of life, let us continue to keep health as our top priority so that we can give our all in achieving our goals.

GLP-1 Agonists: Anti-Diabetic Medicine for Obesity

Text by Dr Rasminder Kaur and Dr Tham Kwang Wei

Dr Kaur is a family physician currently based in the Department of Endocrinology, Tan Tock Seng Hospital (TTSH), where she is part of the TTSH Weight Management Service.

Dr Tham is a senior consultant endocrinologist in Woodlands Health. She is the president of the Singapore Association for the Study of Obesity.

"Hi doctor, could you prescribe me that once-weekly injection for weight loss? It can work for my diabetes too, right?" Mr T asks during one of his regular reviews.

If you have not already faced this scenario, there is a good chance that you will someday soon. Thanks to the weight loss effect of once-weekly incretin-based therapies such as semaglutide and tirzepatide, a disease-centric approach to the management of type 2 diabetes mellitus (T2D) has now become more attainable, and patients are initiating requests for these therapies. This well-established approach recognises that the physiological mechanisms behind obesity and T2D are inextricably intertwined, and thus recommends treating obesity not merely as a risk factor but as the primary therapeutic target in T2D. This is all well and good for people with obesity (PwO) who also have diabetes, but what if Mr T had obesity without diabetes? Should that undermine the treatment of his obesity?

Incretin-based therapies

The year 2021 welcomed a game changer in the form of semaglutide for treatment of T2D in Singapore: Once-weekly subcutaneous (SC) semaglutide 1 mg (Ozempic®) and daily oral (PO) semaglutide (Rybelsus®). It was not until February 2023 that once-weekly SC semaglutide 2.4 mg (Wegovy®) was approved for obesity treatment, and in the following month, tirzepatide (Mounjaro®) received approval for the treatment of T2D. Most recently on 8 November 2023, the US Food and Drug Administration approved through an expedited process the use of tirzepatide (Zepbound®) for chronic weight management in adults with obesity, reflecting the urgent need to address gaps in obesity treatment.

These newer incretin-based therapies are revolutionary in combining superior glucose-lowering effects with unprecedented weight loss (see Tables 1 and 2). This contrasts with conventional T2D therapies like sulphonylureas, insulin and thiazolidinediones, which induce weight gain as a by-product of treatment. Essentially, glucagon-like peptide-1 (GLP-1) receptor agonists (RA) and glucose-dependent insulinotropic polypeptide (GLP-1/GIP) dual RA target the fundamental pathophysiology that underpins both T2D and obesity. This is achieved by virtue of their metabolic effects and reduction of body weight through their central actions of increased satiety and reduced food intake (see Figure 1), thus rendering them highly effective therapies. In addition, they only require once-a-week dosing and have mild side-effect profiles. It is no wonder that more patients like Mr T are now taking the initiative to request these treatments.

Influence of social media (over doctors'!)

Semaglutide's skyrocketing popularity has been fuelled by social media. On TikTok for example, the hashtag #Ozempic has garnered over 1.3 billion views while #Mounjaro boasts an impressive 819 million views since its recent launch in 2022. Social media influencers have been enthusiastic in sharing their personal experiences with semaglutide, and the pervasiveness of their influence has had real implications on drug availability across the globe. Such unregulated and non-discriminatory word-of-mouth marketing gives it legitimacy in the eyes of the public and has broken down barriers to the use of these medications, as such forms of messaging are seen as more relatable than clinical trials. While we physicians need to repeatedly present our patients with scientific data to convince them to

Table 1: Mean HbA_{1c} and weight changes in patients with T2D treated with semaglutide and tirzepatide

Parameter	SC semaglutide 1 mg (Ozempic®)[1,2,3,4]	PO semaglutide 14 mg (Rybelsus®)[2,3]	SC tirzepatide (Mounjaro®) 15 mg*[4]
Mean HbA_{1c} lowering	1.5%–1.9%	1.2%–1.7%	2.3%
Mean weight loss (kg)	5.7–6.5	4.5	11.2

**Weight loss of 15.7% seen in another study, SURMOUNT 2.[5]*

Table 2: Weight loss in patients with obesity (without T2D) treated with semaglutide and tirzepatide

	SC semaglutide 1 mg (Ozempic®)[6]	SC tirzepatide (Mounjaro®) 15 mg[7]
Mean total weight loss (%)	16.9**	22.5**

***Trial product/efficacy estimand*

adopt even the most effective of medical treatments, social media upstages us with a fraction of the effort.

Controversies and consequences

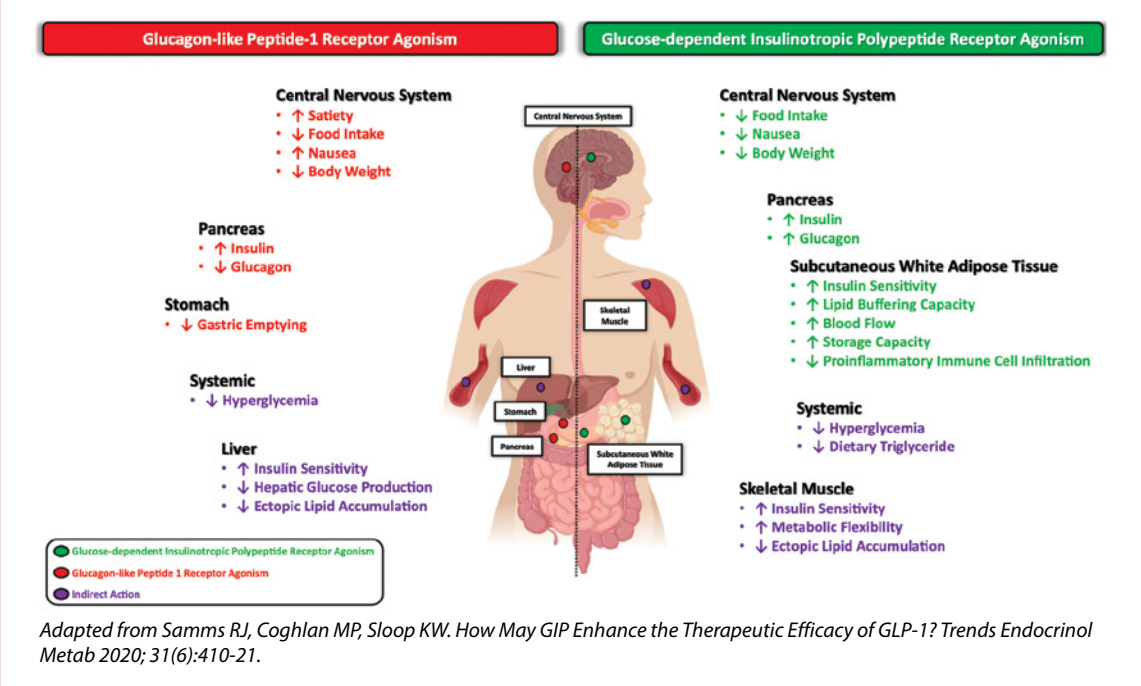
In most parts of the world including Singapore, Wegovy® is not available for clinical use due in part to a global supply shortage. The surge in demand for semaglutide has channelled the off-label use of Ozempic® and Rybelsus® for weight management, further straining the supply of these medications for use in T2D. In the US alone, prescriptions for incretin-based treatments for obesity (Ozempic®, Mounjaro®, Rybelsus® and Wegovy®) rose approximately 260% from 2021 to 2022, and 25% of these were in patients without diabetes.[8]

Some have argued that such off-label use deprives patients with T2D of essential treatments. The counter-argument may be that patients with T2D have more therapeutic options, some of which have proven additional mortality and cardiorenal benefits.[9,10] Additionally, some proponents for the use of Wegovy® for obesity treatment posit that it is essentially the same medication as Ozempic®, just in a different pen device which allows for delivery of higher doses. For example, the up-titration of semaglutide 2.4 mg (Wegovy®) requires patients to receive 1 mg of semaglutide (ie, Ozempic® doses) for at least four weeks and this may be an adequate dose for some patients.

Furthermore, our obesogenic environment poses an insurmountable obstacle to weight loss without professional support for most PwO. More than four in five PwO have made a serious attempt at weight loss but less than half of them would have lost 5% of their body weight over three years, and 70% of those that do are expected to regain their losses.[11] This illustrates that regardless of the drivers of obesity, PwO are in an established state of pathological energy homeostasis that requires intensification of treatment beyond foundational lifestyle changes, and which often requires the use of anti-obesity medications (AOMs).

In particular, PwO with severe obesity-related complications (ORC), such as heart failure or fibrosis from steatotic liver disease, should not have their treatment delayed. Expedited and substantial weight loss, which often necessitates AOM, is required to halt disease progression, improve the severity of symptoms or even send some of these ORC into remission. Unfortunately, the history of AOM has been fraught with the abrupt withdrawal of several medications due to adverse effects (eg, sibutramine, lorcaserin, rimonabant and fenfluramine-phentermine). Though we have effective AOM in our armamentarium, such as phentermine, extended-release naltrexone and bupropion, and liraglutide, their more modest weight loss (mean total 4% to 8%)[1] and/or side-effect profiles often preclude their use. On the other hand, semaglutide has been shown in clinical trials to be well tolerated, safe and highly beneficial to patients with established cardiovascular disease,[12] heart failure[13] and other ORC, but without T2D.[1] SC semaglutide is thus a potentially life-saving drug for PwO even in the absence of pre-existing T2D.

What is absolutely not acceptable is the off-label use by people who do not meet the clinical criteria for AOM. Some have resorted to unregulated sources to get a quick fix without consulting a healthcare professional trained in obesity management, with no screening of eligibility and contraindications, and without monitoring for efficacy or side effects. Doctors have at times been accomplices by recklessly offering prescriptions for these medications with minimal or no patient assessment and support. Such practices have opened the gateway for considerable potential for abuse.



Adapted from Samms RJ, Coghlan MP, Sloop KW. How May GIP Enhance the Therapeutic Efficacy of GLP-1? Trends Endocrinol Metab 2020; 31(6):410-21.

Figure 1: Pleiotropic effects of dual GIP/GLP-1 RA

Semaglutide's popularity in the media has proven to be a double-edged sword. It was inevitable for it to start making headlines for the wrong reasons: from reports of gastroparesis, suicide attempts and critical supply shortages to unflattering excess skin after weight loss. While the actual numbers reported with these "serious" medical side effects are small and not currently substantiated, these reports have caused a media frenzy. The fear of these exaggerated side effects could lead to treatment aversion in PwO who truly need it. Judicious use of semaglutide through appropriate patient selection and vigilance can mitigate some of its more serious side effects such as serious gastrointestinal symptoms, gallstone pancreatitis and exacerbation of depression. Proper public and patient education on the holistic management of obesity, complemented with the appropriate use of AOM, is needed to counteract the unscientific media sources.

Perhaps the biggest controversy stems from the perception we – doctors, healthcare professionals, policymakers and the general public – have of obesity. When faced with a shortage of semaglutide, some countries have opted to prioritise treatment of T2D, resulting in the delay or discontinuation of the treatment for PwO. This is despite the evidence that semaglutide is effective in both conditions; its effect on glucose metabolism is equally strong as its appetite-modulating effect. Discontinuing GLP-1 RA leaves our patients unsupported in their battle against the inevitable weight regain that occurs as a consequence of physiological forces, such as an increase in appetite and reduction in metabolic rate. Such policy decisions ignore the pathophysiology of obesity. Thus, the decision to view semaglutide primarily as a "diabetic medication" goes beyond just semantics – it reveals our subtle biases and has tangible downstream implications.

Treatment of obesity leads to the prevention of metabolic, mechanical and psychological obesity complications, and not to mention, also leads to an improvement in patients' quality of life and a reduction in healthcare spending and mortality. So why are we putting the cart before the horse by not prioritising the treatment of obesity? Why is it then that when push comes to shove, PwO must "sacrifice" a treatment which has greatly benefitted their health or forgo one that could be life-saving? Beyond the weight regain experienced with cessation of effective anti-obesity treatment, PwO will experience a worsening of health with the relapse or deterioration of obesity-related complications, the deepening of weight stigma and a reduced quality of life.

Final thoughts

The superior efficacy of GLP-1 RA and newer incretin-based therapies on glycaemic control in T2D and weight loss in obesity is undeniable, and there are many more promising therapies on the horizon. Recent phase two studies of retatrutide, a GLP-1/GIP/glucagon triple RA, showed a similar glucose-lowering effect,[14] but an even greater weight loss effect (24.2% at 48 weeks) than tirzepatide.[15]

It is not our intention to advocate the use of AOM, in particular GLP-1 RA, for every patient with obesity. The cost of the newer GLP-1 RA runs high in countries where they are available. Since treatment of obesity as a chronic disease would require long-term AOM use in many individuals, the cost-effectiveness of this approach has yet to be established and such an approach, while clinically recommended, may potentially put a strain on health systems. At present, obesity prevalence is predicted to rise to impact about one in four of the world's population in 2035. We urgently need to implement a framework of risk stratification which goes beyond the use of body mass index cut-offs, prioritising people with more severe ORC in the treatment paradigm who would benefit the most from efficacious AOM like incretin-based therapies and in whom we expect treatment to be more cost-effective. This priority system should be on par with the priority we allot to people with T2D.

Formalised and updated education on the scientific paradigm of diabetes and obesity will help more to understand the pathophysiology of these two diseases. A better understanding is urgently needed to address the root cause of obesity stigma, which manifests in our misperceptions of obesity.[16] This understanding must lead to definitive actions that provide equality to the treatment of obesity within a chronic disease framework, one in which PwO will not be discriminated against and will be equally supported.

With more novel therapies targeting both obesity and T2D in the pipeline, this is only the beginning of our discussion. Once we acknowledge obesity as a disease in and of itself – a pathophysiological condition – we will move beyond having to make justifications for the use of efficacious AOM for PwO. The earlier we intervene on the precursor disease of multiple diseases, the less PwO need to suffer from the burdensome sequalae of obesity and the better the quality of life our patients with obesity can have. ◆

Disclosure: Dr Tham reports receiving honoraria for speaking engagements for Novo Nordisk, iNova, EuroDrug Laboratories and DKSH, and engagement in scientific committees and advisory boards for Novo Nordisk and DKSH.

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Singapore Medical Association

For Doctors, For Patients

Adjusted SMA Membership Fees

As per the constitutional amendment passed at the 2023 SMA Annual General Meeting, SMA's Ordinary Membership Fees will be increased from $200 to $250 (before GST). With effect from 1 January 2024, the new Membership Fees are as follows:

ORDINARY MEMBER	Year of Graduation	TOTAL AMOUNT (Including 9% GST)
1st year after graduation	2024	$68.13
2nd year after graduation 3rd year after graduation 4th year after graduation	2023 2022 2021	$136.25
5th year after graduation 6th year after graduation 7th year after graduation	2020 2019 2018	$204.38
8th year onwards	2017 or before	$272.50
OVERSEAS MEMBER Flat Rate	–	$187.50
SPOUSE MEMBER Complimentary	–	$0.00
STUDENT MEMBER Complimentary	–	$0.00

For more information regarding our Membership fees and privileges, visit https://www.sma.org.sg/member-privileges. If you have any queries, please email membership@sma.org.sg.

Third-Party Administrators
A CALL FOR FEEDBACK

Text by Dr Ng Chee Kwan

Third-party administrators (TPAs) have been a feature of the local corporate healthcare landscape since the 1990s. Oftentimes, companies may purchase healthcare coverage for their employees from TPAs. Doctors under TPA panels are contracted to see patients at pre-determined rates, which are usually at a discount compared to the doctors' usual fees. The TPAs reimburse doctors accordingly after deducting administrative fees (charged by TPAs).

In recent years, TPAs have also played an increasingly prominent role in the personal health insurance landscape by providing panel management services for many Integrated Shield Plan (IP) insurers.

Managing healthcare through TPAs reduces costs for both companies and insurers. Many doctors, especially those new to private practice or those in group practices, sign up with TPAs in the hopes of boosting patient volume, despite the restrictions in payments.

However, doctors have given negative feedback about TPAs since the early 2000s.[1] SMA conducted managed care surveys in 2003 and 2015 – both showed a high rate of dissatisfaction with TPAs,[2] with a 56% dissatisfaction rate in the 2015 survey.[3]

One common complaint about TPAs is that the fee and drug restrictions imposed by the TPAs put patients at risk of poor outcomes.[4] At the same time, the Singapore Medical Council's Ethical Code and Ethical Guidelines require doctors seeing TPA patients to provide them with the expected standard of care regardless of financial constraints or pressures.[5]

Another reason for dissatisfaction is that TPAs remunerate doctors substantially below fair market rates. For example, the consultation fee could be as low as S$2 to S$10 for GPs after the TPA's administrative fees are deducted.[4] Similarly, for specialists, surgical procedure fees are consistently below the lower bound of the Ministry of Health (MOH) Fee Benchmarks.

Arguably, TPAs function like medical entities. In addition, TPAs collect patients' health information, including details of diagnoses and treatments. With TPAs now providing management services for both corporate employees and patients with IPs, the amount of patients' health information that they collect has also increased. As with all personal data collected by any organisation, there is a risk of data leakage.

Despite the widely known issues with TPAs, many doctors have few options but to sign on with TPAs, so as to keep their practices viable.

There have been multiple calls for MOH to regulate TPAs.[1,4,6] A regulatory framework for TPAs would ensure that restrictions on patient care are reasonable and do not compromise quality of care, that patients' healthcare information are properly safeguarded, and that the doctors' practices are sustainable. MOH stated in May 2021 that "if there is evidence of patient risks, [MOH] will look further into how TPA should be regulated".[6]

SMA will continue to advocate for doctors and patients with regard to TPAs. Your Membership gives us a mandate to represent you and we welcome any feedback on TPAs, especially regarding potential patient risks. If you have any comments or feedback, please email us at sma@sma.org.sg. ◆

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Dr Ng is a urologist in private practice and current President of the SMA. He has two teenage sons whom he hopes will grow much taller than him. He has probably collected too many watches for his own good.

SMA Feedback on Medishield Life Claims Management

Dear SMA Members,

The Ministry of Health (MOH) Claims Management Office was set up in 2022 to develop Medishield Life (MSHL) claims rules and conduct claims adjudication.

MOH issued a press release on 10 October 2023 detailing the new initiatives to strengthen governance over MSHL claims. The press release and its annexes can be viewed at the following links:

1. Press release: https://bit.ly/492uKbh
2. Annex A: https://bit.ly/3M3HhS0
3. Annex B: https://bit.ly/48ZcYFN

We are glad to note that some of SMA's feedback to MOH have been taken on board following an earlier briefing on 3 October 2023, where MOH briefed SMA on the new initiatives and sought the SMA Council's feedback.

Please see below a summary of SMA's feedback and comments on the initiatives shared.

1. The SMA Council was briefed by MOH on 3 October 2023 regarding the new MSHL claims management initiatives.
2. We were briefed that:
   (a) MOH would formalise a framework to guide and govern appropriate claims behaviours. These included claims rules to provide doctors greater clarity on what is appropriate to claim MSHL for, and claims adjudication to allow independent assessment for claims appropriateness by medical peers.
   (b) MOH may initiate claims adjudication in cases suspected of overservicing, misuse of surgical codes to claim for higher fees and claims for cosmetic procedures that should not be claimed from MSHL.
   (c) Enforcement would be tiered, and suspension of Medisave and MSHL accreditation would be for egregious cases (such as fraud) or for doctors with repeated or multiple non-compliances.
   (d) Cases involving fraudulent claims may be prosecuted under Singapore law, and cases involving professional misconduct may be referred to the Singapore Medical Council.
3. We pointed out that the interpretation of surgical codes could be subjective, and that doctors usually submit surgical codes based on their interpretation of the codes and their assessment of the work that they did. For example,
   (a) There may not be an existing surgical code for a new and approved procedure, so the doctor submits the closest equivalent surgical code.
   (b) There may not be a surgical code for a bilateral procedure, hence the doctor submits two separate unilateral surgical codes.
   (c) These would be isolated cases.
4. We made the following recommendations to MOH regarding the framework:
   (a) The doctor who is unsure of the appropriate surgical code(s) should be given the opportunity to notify MOH to review his/her submission. In this situation, the doctor should not be considered as non-compliant.
   (b) The framework should be targeted at the small minority of doctors who are suspected of egregious claims behaviour.
   (c) The framework should allow for doctors who commit unintentional errors to be educated rather than have the error counted as one strike against them.

(d) The doctor who is suspended from Medisave and MSHL accreditation should be given the right to appeal against the suspension.

(e) The duration of suspension of Medisave and MSHL accreditation should be specified.

(f) The rectification process should be kept simple; eg, the format for submission could be the same as that of the Letter of Certification.

5. Last but not least, we opined that with the claims management process in place, insurers could be assured that the number of inappropriate claims would be reduced. This should give insurers the confidence to open up their panels and allow more specialists to join panels.

6. We are glad that MOH will be taking our feedback into consideration and will continue to work with the professional bodies, including SMA, to see how to review and streamline the processes further, including developing educational materials and sharing case examples with professionals and the public.

7. We will support MOH by circulating the relevant MOH announcements to our Members, and by featuring articles on appropriate claims behaviour in *SMA News*.

8. We understand that Members may be concerned about these measures, and we will continue to engage with MOH on this. We would appreciate it if Members would feedback their concerns to us.

Members can submit their feedback to the SMA Secretariat via email to szeyong@sma.org.sg. ◆

Singapore Medical Association

HIGHLIGHTS

From the Honorary Secretary

Report by Clinical Asst Prof Benny Loo Kai Guo

WSH Council guidance on slips, trips and falls

Slips, trips and falls (STFs) have consistently been the top cause for major and minor workplace injuries. STFs can happen when there is a lack of safety measures, such as failure to install non-slip flooring or not having workers adorn proper personal protective equipment.

SMA is a member of the Healthcare Committee within the Workplace Safety and Health (WSH) Council. The WSH Council has compiled bite-sized guidance materials to help companies reduce STF risks at their workplaces and provide workers with a safer work environment.

The guidance documents can be found at the following link: https://bit.ly/45Wy7Pb. ◆

Dr Loo is a paediatrician in public service with special interest in sport and exercise medicine. He serves to see the smiles on every child and athlete, and he looks forward to the company of his wife and children at the end of every day.

Strategies to Improve Vaccine Confidence

Professor Heidi Larson, anthropologist and the founding director of The Vaccine Confidence Project™, discusses the current state of vaccination worldwide and factors influencing vaccine uptake. Additionally, she advocates a shift from using the phrase "vaccine hesitancy" when discussing challenges faced in vaccination to "vaccine confidence". This enables vaccine confidence to be discussed in a positive light.

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The onset of vaccine hesitancy and its significance in recent years

Vaccine hesitancy has been around since the introduction of vaccines. However, in the last two decades, the landscape has transformed due to the rise of new social and digital media. Previously localised concerns have gained widespread traction.

The United Nations Children's Fund (UNICEF), an agency of the United Nations responsible for providing humanitarian and developmental aid to children worldwide, recently published their 2023 State of the World's Children report which has a chapter on Vaccine Confidence which includes the Vaccine Confidence Project's pre- and post COVID-19 vaccine confidence study which reveals a significant drop in confidence during the COVID-19 pandemic.[1]

A recent study revealed that top reasons for vaccine hesitancy are cultural concerns, perceived lack of need for vaccination and concerns over vaccine safety. Cultural concerns (related to COVID-19 vaccine hesitancy) were related to vaccine contents i.e., porcine component, fears of sterility and trust in natural remedies among others. Those who felt the lack of need for vaccination believed that infectious diseases were uncommon, had doubts about vaccine effectiveness, and had a lack of knowledge regarding diseases and vaccines. Those concerned about side effects were afraid of minor and potential undisclosed side effects of vaccines. Some reported unease due to previous adverse reactions to vaccinations.[2]

Politics interfering with the acceptance of vaccines

Presently, the world is facing complex geopolitical issues leading to a surge in societal distrust and polarisation between people of different political ideals. Vaccine programmes, including childhood immunisation and COVID-19 vaccination, are typically orchestrated as top-down, government-driven, and regulated endeavours. Therefore, persons whose political ideals do not align with the ruling government may reject vaccine recommendations made by the government of the day. This situation shows that sometimes people's choices are influenced by societal and political influences instead of vaccine effectiveness and safety.[3,4]

During the COVID-19 pandemic, the COVID-19 vaccine was not mandated in Singapore.[5] Instead, restrictions on unvaccinated persons entering eateries and public establishments were recommended by the government.[6] Many chose to undergo vaccination as a means of returning to normal i.e., going about daily activities such as dining in and shopping.[7]

Partners needed to improve vaccination uptake

The recent pandemic revealed the need for novel partnerships in immunisation. These collaborations cover a diverse group—from religious groups to educators, with a particular focus on respected figures within local communities.[8]

In the US, African American barbershops emerged as pivotal advocates. Frequented by patrons who had cultivated trust over time, these establishments played a crucial role in endorsing vaccination, even among those harbouring government distrust.[9]

In East London's Bangladeshi community, restaurant owners took up the cause by posting vaccination selfies, emphasising the significance of immunisation for both their community and their businesses.[10] Urban restaurants, such as those in Singapore, not only serve as dining venues but also serve as vital social and community hubs and can help bolster vaccine confidence. These examples suggest the possibility of using non-traditional allies to further bolster vaccine acceptance in the future.[8]

Avoiding vaccines leads to poorer public health consequences

Failing to address the issues leading to vaccine avoidance can lead to significant problems. The recent decline in measles vaccination during the COVID-19 pandemic, even after the pandemic's peak is a clear example of this issue.[11] Consequently, fostering confidence in the vaccine system could generate a positive ripple effect, enhancing trust across various aspects of healthcare.[12]

Technology and malicious intent drive vaccine hesitancy

Several factors have shaped present-day vaccine hesitancy. Recent technological advances in social media applications played a pivotal role by enabling the rapid spread of concerns and misinformation.[3]

One notable historical event is Andrew Wakefield's 1998 publication linking the measles, mumps, and rubella (MMR) vaccine to autism. This coincided with the emergence of Google, which unwittingly provided a platform for his alternative narratives. Despite flaws in his research and subsequent retraction of his study, the serendipitous timing of his paper's publication and the launch of a search engine giant allowed his ideas to gain traction and continues to influence vaccine hesitancy today.[13,14]

Avoid jumping to conclusions when it comes addressing vaccine confidence

Addressing vaccine hesitancy requires a subtle, context-specific approach instead of rushing in with preconceived plans. There is no one-size-fits-all solution, but rather a selection of strategies. The first step is understanding the root causes, which can vary widely between communities, followed by selecting the right approach from a menu of

options.[15] For instance, in some cases, what appears to be a religious issue could be gender preferences in who administers vaccines. In other instances, deeply held beliefs, such as a preference for natural remedies over modern medicine, drive hesitancy.[16,17] It is essential to find allies within these belief communities to bridge the gap between these convictions and vaccination.[8]

It is crucial to listen to people's concerns and tailor responses to their specific needs or it may backfire.[16] An example is Indonesia's experience with a measles-rubella campaign disrupted by religious concerns.[18] Learning from this, when implementing the COVID vaccination programme, stakeholders sought approval from regulatory bodies and also the leaders of the Muslim community.[19] This approach harmonised technical evidence with respect for cultural and religious values, a model worth emulating. These lessons hold promise in supporting future vaccination efforts and other immunisation programmes.

The vaccine situation in Singapore and her neighbours

In Singapore, there is a growing focus on adult vaccination. Childhood vaccines benefit from well-established systems and frequent health system interactions, making them relatively easier to administer.[20] With older adults, challenges arise as vaccination is not mandatory and there are no scheduled healthcare interactions. The COVID-19 pandemic led to drops in older adult vaccination rates for other vaccines such as pneumococcal vaccine.[21]

Globally, adult vaccination rates lag behind those for children, especially in a region like Asia which is experiencing demographic shifts towards an ageing population. In research conducted in Hong Kong and Singapore, looking at areas with varying levels of vaccine hesitancy, some insights emerged—some feared vaccine side effects, particularly when living alone; there was misinformation from smartphone sources; and misconceptions about mRNA vaccines.[22,23]

These insights underscore the urgent need to develop targeted strategies for older adult vaccination in the face of changing demographics and evolving healthcare landscapes. Addressing these concerns will require tailored approaches and effective communication, even among well-educated populations.

Shift the narrative from vaccine hesitancy to confidence

Locally and globally, it is crucial to shift focus from "vaccine hesitancy" to "vaccine confidence". This will encourage a more positive perspective on the topic. Instead of measuring hesitancy as ranging from a little to a lot, there should be a refocusing of emphasis on varying levels of confidence and trust in vaccines' effectiveness and safety, and the delivery systems.[24]

Recommendations to tackle the commonest reasons for vaccine avoidance

To combat vaccine hesitancy that arises from lack of trust in vaccines, the public can be provided information that emphasises the nature of vaccines and the size of clinical trials from trusted sources rather than pharmaceutical companies directly. As mentioned, cultural and religious safety concerns are widespread but vary by location and culture, necessitating a targeted approach. Those who perceive vaccines to be ineffective or unnecessary may be coaxed to be vaccinated if they believe they are putting others at risk with their behaviour. The fear of unknown side effects can be circumvented by helping the individuals assess vaccination's actual risks and benefits, potentially using psychological approaches to win them over.[2]

KEY MESSAGES

1. Geopolitical challenges and growing distrust within societies can influence vaccine acceptance. Vaccine programmes, whether for childhood vaccines or COVID-19, are often government-driven, and those who are unaligned with the government or its political affiliations can reject vaccines.
2. The rise of social and digital media has significantly amplified concerns and misinformation surrounding vaccines. This trend has contributed to a decline in vaccine confidence, as evidenced by studies conducted during and after the COVID-19 pandemic.
3. The COVID-19 pandemic underscored the importance of forming partnerships with a wide array of entities, including religious groups and trusted community figures, to promote vaccination.
4. There is impetus to replace the term "vaccine hesitancy" with "vaccine confidence." This shift in language encourages a more positive and comprehensive approach to discussing challenges related to vaccination.

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MME Webinar 1: Professionalism	3 Feb 2024	SMA Members in good standing: Complimentary Non-Members: $100/webinar
MME Webinar 2: Informed Consent	6 Apr 2024	
MME Webinar 3: Ethics Analysis	6 Jul 2024	
MME Webinar 4: Medical Records	7 Sep 2024	
MME Webinar 5: Privacy and Confidentiality	2 Nov 2024	
MME Distance Learning Programmes (SMC Category 3B: video/online readings and quiz) | 1 MME core point per module		
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Medical Professionalism – How the Law and Ethics Regulate Our Practice		
Understanding Consent – The Key Elements Which Protect Patients and Doctors		
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The Art of Medicine

Text by Natalie E Yam

This article was adapted from one of Natalie's end-of-posting assignments from the NUS Yong Loo Lin School of Medicine.

I cannot help but envy my classmates whose reflections tell stories which are not their own. As they embarked on their palliative care posting, my family embarked on a ferry to lay my grandfather's remains to rest at sea.

I sometimes wonder if there was any point at all in studying medicine. After all, doctors are but mere mortals – what can we do but acquiesce when God calls our patients home? And if modern medicine is unable to reverse death, then what role do doctors play in the denouement of their patients' lives?

When my grandfather went for a check-up at Tan Tock Seng Hospital, his abnormal liver function test results prompted the medical team to order an MRI of his liver, revealing extensive metastases originating from the pancreas. My grandfather had Stage 4 pancreatic cancer – with just weeks to live.

While the diagnosis was a huge blow to us all, it also enabled us to make the necessary preparations. The palliative care team organised family conferences with us and worked closely with the hospice team to fulfil my grandfather's final wishes – to die peacefully and painlessly at home, surrounded by his loved ones.

And so, after intensive coordination and logistical preparations, a terminal discharge was arranged for my grandfather. We all agreed on the plan in the event that his symptoms worsened (eg, calling 995 and subjecting him to CPR was an absolute no-go) and we learned how to administer fentanyl to manage his pain.

An hour before he passed away, my grandfather surfaced briefly from his fog of hyperbilirubinaemia. I happened to be the first person he saw when he opened his eyes; just as well, for I have always been his greatest pride and joy. As our eyes met, he smiled widely, and I was overwhelmed by a flood of emotion.

His tachypnoeic breathing eventually transitioned to slow, gasping breaths, the interval between each breath lengthening until the next breath never came. As I felt his pulse fade beneath my fingers and his hands grew cold in mine, I reflected on what a privilege it was to be able to share this final moment with him in the intimacy of our own home.

Even in the midst of my sorrow and bitterness, even as I resented the limitations of modern medicine – still so ineffectual in the face of death after decades of innovation – I was thankful for this precious moment.

This precious moment of intimacy and humanity made possible by a team of dedicated doctors who cared enough to find out what mattered most to their dying patient and his family.

It has often been said that the journey matters more than the destination. Death remains the final, inevitable destination for all of us, but medicine has the power to alter the journey, the memories we make along the way and ultimately, our life's narrative. The doctor's responsibility, therefore, extends far beyond merely prolonging life; first and foremost, it is to empower his/her patients, even within the constraints of their failing health, to live life to the fullest and achieve their aims.

And this art of medicine, I believe, is something worth dedicating a lifetime of study to master. ◆

To my grandfather:

Thank you for sharing your love for reading and writing with me. After three years of your nagging, I finally decided to send my work to SMA News *for the first time. This article is dedicated to you: to celebrate your life, to honour your memory, and to offer consolation to those learning to live with loss.*

Natalie is a Year 4 medical student at NUS Yong Loo Lin School of Medicine. In her free time, she takes martial arts classes, explores parks and plays the piano. She also enjoys reading, writing and gardening.

Extreme Dieting: A WEIGHTY AFFAIR

Text by Dr Chie Zhi Ying

With the global prevalence of obesity rising rapidly in both developed and developing countries, obesity has become a pandemic. We are familiar with the complications of obesity, like our "three highs" (type 2 diabetes, hypertension and hyperlipidaemia), as well as cardiovascular disease, non-alcoholic fatty liver disease, cholelithiasis, osteoarthritis, sleep apnoea and even colorectal cancer.

The meat of the matter

Extreme diets have gained popularity in recent years as they frequently promise rapid weight loss, but they remain controversial in terms of the health benefits they bring and the sustainability of the diet. It is no wonder that as consumers, we are constantly bombarded with media messages promoting such diets.

In my practice, I have come across patients who shared with me their attempts at adopting extreme diets to achieve rapid weight loss and thereby optimise the control of their chronic conditions, such as diabetes. But what exactly are in these extreme diets and what are the possible side effects of taking them? This article is not meant to be an academic discussion on extreme diets but to share some anecdotes based on my patients' experiences.

Juice-only diet

The first extreme diet is the "juice-only" diet which involves consuming only fresh fruit and vegetable juices. It purportedly helps to detoxify and cleanse the body, and the diet regime typically lasts from three days to a week. You can make your own juices or buy commercially prepared juices (aka cold-pressed juices). Whether one chooses to take some solid foods with the juices or not, it is usually very restrictive in terms of caloric intake. This diet lacks the usual nutrition from carbohydrates, fibres, fats, protein and minerals like iron and calcium which are essential for our bodily function, and such deficits can lead to blood glucose spikes. While one could possibly reduce his/her weight rapidly with this diet since caloric intake is strictly restricted, I have heard from one of my diabetic patients that he constantly felt hungry and giddy, and his blood glucose level was fluctuating so wildly that he had to stop and return to his normal diet. To him, it was simply not sustainable, especially since he also did not have the energy to exercise because of the caloric restriction.

Ketogenic diet

The ketogenic or "keto" diet is another popular diet that is a low-carbohydrate, fat-rich eating plan. The diet consists of exceptionally high fat content, typically 70% to 80%, though with only a moderate intake of protein. The typical food consumed in this diet can be high in saturated fat (eg, fatty cuts of meat, processed meats, lard and butter) and can also be sources of unsaturated fats (eg, nuts, seeds, avocados, plant oils and oily fish). Again, similar to the juice diet, the resultant carbohydrate restriction that might last for days to weeks can cause hunger, fatigue, low mood, irritability, constipation, headaches and brain fog. In addition, there is a potential risk of one's body going into ketoacidosis, which is fatal if left untreated. Following a very high-fat diet can be challenging to maintain, and my patient who was on

> **Ultimately, there is no one-size-fits-all formula and one has to exercise discretion and wisdom to find the best solution to maintain a healthy weight.**

the ketogenic diet would usually take some carbohydrates on and off to satisfy the cravings.

Paleo diet

The next diet is the paleo diet which involves following the so-called hunter-gatherer-style diets of our ancestors during the Paleolithic period. It includes taking fruits, vegetables, lean meats, fish, eggs, nuts and seeds. Foods excluded from the diet are beans, legumes, starchy carbohydrates, starchy vegetables and dairy products. In more extreme cases, paleo diet supporters may also opt for a totally raw diet. Similar to the above two diets, patients can develop symptoms from carbohydrate restriction, such as giddiness, fatigue, headache, weakness and irritability.

Fast 800 diet

Lastly, there is the Fast 800 diet which restricts the eater to an 800-calorie daily eating plan. This includes taking a relatively low-carbohydrate Mediterranean-style diet with lean protein sources and vegetables, or taking milkshakes that are high in protein, fibre and healthy fats as meal replacements. The eater is supposed to follow it for at least two weeks and no more than 12 weeks. This is similar to the very low-calorie diet used in many weight loss programmes. Again, the side effects are like those of the above diets and from what my patients have shared, they end up feeling weak, giddy and listless, and suffer from constipation.

One size does not fit all

In the latest health trend, intermittent fasting has quickly gained traction and several of my patients have already tried it. There are various ways to use intermittent fasting for weight loss. For example, one might try eating only during an eight-hour period each day and fast for the remainder of the day. One could also choose to eat only one meal a day for two days a week. Whichever combination one chooses, one should tweak it until one is able to adjust to the new way of eating. From the experience of my patients, most were indeed able to lose weight and achieve better glycaemic control. They shared with me that they would sometimes have "cheat days" where they reward themselves by indulging in small snacks so that they could sustain this diet.

As you can tell from the above extreme diets, there are definitely health concerns regarding the lack of nutrition, the side effects of calorie restrictions, as well as the difficulty of sustaining such diets and promoting long-term weight loss.

Adopting an extreme diet may help you achieve rapid weight loss, but as soon as you return to a slightly more normal diet, your weight may rebound equally fast. The age-old formula of eating well with a reduced calorie count (following the recommendations of the My Healthy Plate from the Health Promotion Board) and leaving enough energy for one to exercise would seem to be a more gradual and safer way of achieving long-term weight loss.

As the old Chinese saying goes, 民以食为天 (Chinese for "food is the first necessity of the people"). Whether you are a foodie who lives to eat or you simply eat to live, food is as much a necessity for survival as it is an indulgence. Without eating sufficiently to stave off hunger and enjoy tasty foods, one misses the opportunities to indulge in the basic pleasures of life and get a timely morale boost. Not having a sufficient calorie intake would also mean that one will not have enough energy to participate in exercises, so while you might able to lose weight in a short amount of time, you might not look fitter without workouts. Ultimately, there is no one-size-fits-all formula and one has to exercise discretion and wisdom to find the best solution to maintain a healthy weight. ◆

Dr Chie is a family physician working in the National Healthcare Group Polyclinics. She also holds a Master of Public Health from the National University of Singapore and is a designated workplace doctor. She enjoys freelance writing and writes for Chinese dailies *Lianhe Zaobao*, *Shin Min Daily News* and health magazine *Health No. 1*. She can be contacted at chiezhiying@gmail.com.

ACP for Persons with Cognitive Impairment

Text by Dr Philip Yap and Dr Chen Shiling

Dr Yap is a senior consultant in the Department of Geriatric Medicine, Khoo Teck Puat Hospital. He has special interests in dementia, long-term care and end-of-life care.

Dr Chen is a physician with special interests in dementia and intellectual disability. She is the founder of Happee Hearts Movement and practises in IDHealth and Khoo Teck Puat Hospital.

Population ageing, accompanied by a tandem rise in neurocognitive disorders such as dementia and stroke diseases, as well as adults with intellectual impairment, have fuelled the rise in the number of persons with cognitive impairment (PCIs) today. As cognitive competence is a necessary prerequisite for advance care planning (ACP), PCIs may lack the mental capacity to meaningfully engage in care planning. However, as enunciated in the Mental Capacity Act (MCA), cognitive impair-ment does not per se equate to a lack of mental capacity, and a person is assumed to have mental capacity unless proven otherwise. Mental capacity pertains to the ability to understand, retain and weigh information to enable informed decision-making and ultimately communicate the decision. This article proposes relevant practice points that can facilitate ACP for PCIs.

Optimising conversations

For a start, as neurodegenerative conditions are progressive, ACP should be conducted as early as possible in the illness trajectory when the person first presents with cognitive concerns before mental incapacity sets in. In dementia for example, where the prodromal stage of mild cognitive impairment (MCI) is a recognised clinical entity, the MCI phase would be the ideal time to engage in ACP conversations. Furthermore, con-versations and decisions pertaining to care planning should be conducted under optimal conditions as there can be fluctuations in cognitive competence. Delirium is a case in point, and conditions such as Lewy body disease characteristically present with fluctuations in mental state. Hence, it is important to time ACP conversations to coincide with the patient's optimal mental state.

Table 1: Strategies to approach ACP with the four possible profiles.

	High desire	Low desire
High ability	**High ability, high desire** • Validate the importance and value of ACP and explore any potential barriers. • Explore and plan for losses that can occur across the illness continuum, from mild to severe cognitive impairment (eg, driving, finances, navigation, custodial needs and end-of-life issues such as enteral nutrition and other life-sustaining treatments). • Proceed to formal ACP documentation and Lasting Power of Attorney if ready.	**High ability, low desire** • Pace accordingly and provide information with nudges and reminders along the way. Explore PCI's goals, values, preferences, concerns and worries in general. • Explore PCI's understanding of illness and the value of ACP. Elicit any possible barriers to ACP. • Tailor to specific barriers encountered, such as: ◦ Passivity/avoidance: Provide example of conflict situations among family members in the absence of ACP, inspire with stories of how ACP has helped others, offer to show videos (eg, from the Agency for Integrated Care ACP website). ◦ Reluctance to document ACP: Position care planning as conversations, include family or trusted associates.
Low ability	**Low ability, high/low desire** • Adopt a general rather than illness-specific approach to ACP. • Explore understanding of ACP, any barriers encountered and if he/she appreciates the value of ACP. • Target specific barriers identified. • Elicit goals, values, preferences, worries and concerns in general. • Involve family or trusted associate in conversations. • Pace accordingly with nudges and reminders.	

PCIs can be assessed on their (1) **ability** to appreciate the impact and prognosis of their illness and (2) **desire** to enter into ACP conversations. There are four possible profiles that can emerge (summarised in Table 1), and the approach to ACP should be tailored to each profile specifically.

High ability, high desire

This is the ideal scenario where the PCI possesses a good understanding of his/her condition and appreciates the value of ACP. Hence, it might be possible for ACP to be pursued with greater depth to encompass not only issues surrounding end-of-life care, but also a stage-specific plan that explores the deficits experienced at the different stages of the illness. For example, issues pertinent to mild to moderate dementia such as giving up driving, allowing the caregiver to manage medication and finances, and the use of Global Positioning System trackers can be discussed.

High ability, low desire

PCIs may have adequate mental capacity to comprehend the prognostic ramifications of their progressive illness but remain hesitant about ACP. For those who have not given much thought to the matter, information on the importance of ACP can be provided while pacing alongside and accompanying the PCI, and providing him/her with nudges and reminders along the way. If the PCI adopts the acquiescent stance of entrusting future decisions to loved ones, one can provide examples of real-life scenarios where families find themselves in a quandary, having to make difficult decisions on behalf of the person, or when conflicts arise due to differing opinions.

There may also be those who opine that there is no need to make formal care plans as they have casually shared their preferences with those they trust, or may express reservations about the need for formal ACP. Positioning care planning

as conversations would be appropriate in such instances, as is the involvement of family members or trusted relatives and friends. The emphasis should be on understanding the PCI's goals, values, priorities and concerns. By building rapport and trust, one can attempt to draw out the PCI's desires and fears, while concurrently seeking out what is important to him/her with the aim of helping him/her live well in the present while also thinking about and planning for the future.

Low ability, high or low desire

Persons under this category are usually more advanced in their cognitive deficits and are characterised by their lack of mental capacity to engage in meaningful discussions. Although intellect and mental capability are compromised, PCIs may still retain the ability to share their personal perspectives, which are often founded more on subjective feelings, long-standing values and preferences. As such, adopting a general approach to care planning might still be possible if they are assisted in the process. Through the personal narratives expressed by the PCI, one can better appreciate his/her life goals, concerns and what matters to him/her, thereby assisting the PCI to navigate care planning. With his/her consent, it would be appropriate to involve surrogate decision-makers during ACP conversations so that they can be privy to the PCI's thoughts and preferences. Having these conversations over time would help to engender trust and familiarity, and ultimately allow care professionals and surrogates to make shared decisions in the best interest of the PCI.

Facilitating ACP

As cognitive deficits may render it challenging for PCIs to articulate their thoughts, assisting them with prompting and paraphrasing can help. Communication strategies such as motivational interviewing and negotiation can also be employed to facilitate conversations. It is important to be intentional in engaging PCIs and to find means to communicate in a manner that works for them. This can include using visual aids and speaking in familiar languages to assist them in their understanding and expression. Deficits in short-term memory may constrain the ability of PCIs to hold information in their minds long enough to allow adequate processing and decision-making. Hence, assisting with "memory prostheses" by way of repetitions and re-presentations of the same information can be utilised as means of bolstering PCIs' mental capacity, to enable them to make and express a choice. If the person is able to consistently make the same choices with these aids, it may be construed that the choices are indeed what the person desires. These practices are aligned with the MCA wherein medical professionals are called upon to undertake practicable steps to help the PCI make informed decisions.

Today, there is growing consensus that ACP should be process-oriented rather than a one-off transaction in completing checkboxes and forms. Research has shown evidence of increased rates of ACP completion through efforts at continued education and conversations over time.[1] Direct and regular one-to-one engagement promotes receptiveness while fostering rapport and trust in pacing alongside the PCI. As ACP is a multi-stage process, patience is crucial and one should move to the next stage only when the PCI is ready.

As a key objective of ACP is to prepare individuals for the end of life, it is even more critical that practitioners are sensitive and mindful in the conduct of ACP. It has been found that PCIs often lack an adequate understanding of dementia and its prognosis.[2] Furthermore, there may be communication gaps between patients and their physicians, and between patients and their family members. Therefore, ACP conversations can help to clarify and deepen patients' understanding, and allow them the opportunity to share their values, priorities and concerns with both their physicians and families. In particular, in pacing with patients and revisiting discussions as the disease progresses, the process of ACP may allow patients to become more prepared to discuss their end-of-life care preferences over time.

In an oriental setting like Singapore, having time to prepare and engage families is especially important. Family members generally play a pivotal role in ACP discussions, given the culture of familial and collective decision-making. The presence of trusted family members during ACP conversations will enable them to hear and appreciate what matters to the PCI, which would in turn incline them to honour his/her preferences and make decisions in his/her best interest when the PCI loses mental capacity in the future, notwithstanding changing circumstances.

Finally, even as we involve families, surrogate decision-makers and care professionals to assist the PCI in decision-making, the ethical imperative demands that we elicit what matters to him/her, uphold the primacy of his/her wishes and make every effort to respect him/her. We would do well to avoid being paternalistic in imposing our opinions and wishes on the PCI who is ultimately vulnerable. ◆

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As we conclude this campaign, we would like to express our heartfelt gratitude for your enthusiastic participation. Remember, keeping your information current will ensure you continue to receive vital updates, exclusive Member giveaways and other valuable information from SMA. It is our way of thanking you for being a part of our family.

Thank you for your participation, dedication and continued support. Stay tuned for more exciting updates and events from SMA. Until then, take care and stay connected!

Congratulations!

We are pleased to announce the final group of 80 lucky draw winners who have won $5 Grab e-vouchers.

Winners will be notified by email

MCR/Matriculation numbers of winners

1. M00060D	17. M08186H	33. M14272G	49. M63579J	65. MP3617D
2. M01509A	18. M08256B	34. M14696Z	50. M63929Z	66. MP3758H
3. M02003F	19. M08750E	35. M14800H	51. M65093E	67. MP3820G
4. M03030I	20. M08930C	36. M15249H	52. M65668B	68. MP4204B
5. M03248D	21. M09172C	37. M15507A	53. M65836G	69. *****405H
6. M04870D	22. M09401C	38. M16745B	54. M65949E	70. *****348E
7. M05041E	23. M09501Z	39. M16848C	55. M66025F	71. *****042E
8. M05498D	24. M09523J	40. M17136J	56. M66463D	72. *****776N
9. M05901C	25. M10694A	41. M17391F	57. M66571A	73. *****783X
10. M06109C	26. M10942H	42. M17568D	58. M66692J	74. *****628Y
11. M06609E	27. M11500B	43. M17593E	59. M67076F	75. *****907X
12. M07022Z	28. M12476A	44. M17678H	60. M67589Z	76. *****180M
13. M07375Z	29. M13059A	45. M18565E	61. MP0725E	77. *****398R
14. M08038A	30. M13090G	46. M60825D	62. MP0934G	78. *****010J
15. M08064J	31. M13966A	47. M60951Z	63. MP2500H	79. *****290A
16. M08125F	32. M14174G	48. M61597H	64. MP3140G	80. *****901L

For further enquiries, please contact membership@sma.org.sg

Primary Care Network support for patient referrals to Active Ageing Centres and Intermediate Long-Term Care Services

by the Agency for Integrated Care

Patients may require other health and social care services to supplement the care provided by their family physicians, and this is where the Primary Care Network (PCN) headquarters and community partners come in.

The Role of Primary Care Coordinators (PCCs) at the PCN headquarters

PCCs play an important role supporting the work of clinics within their PCNs. Prior to the launch of Healthier SG, PCCs have been coordinating and scheduling ancillary service appointments for PCN patients, including appointments for Diabetic Retinal Photography, Diabetic Foot Screening, and others. This helps ensure that patients are completing the required care components to manage their chronic conditions.

Contact your PCN HQ if you require support and call AIC to find out more about PCNs and AACs if you are not in a PCN yet.

With the launch of Healthier SG, PCCs will also be helping patients to adhere to exercise and lifestyle goals in their health plans by providing them with information about exercise and lifestyle programmes organised by community partners such as People's Association, Health Promotion Board and SportSG, as well as services and programmes organised by Active Ageing Centres.

What are Active Ageing Centres?

Active Ageing Centres (AACs) are drop-in social and recreational centres that seniors within a geographical area can visit for their social and health-related matters. These centres provide an avenue for seniors to build strong social connections, participate in recreational activities and contribute to the community in meaningful ways, which can be greatly beneficial to their social, mental and physical well-being. Certain Active Ageing Care Centres also provide care services such as day care and community rehabilitation.

Active Ageing Centres serve Singapore citizens and Permanent Residents aged 60 years and above regardless of social-economic status and housing type.

What are the services offered by an Active Ageing Centre?

Active Ageing for Well and Active Seniors

- Provide and/or refer seniors to active ageing programmes.
- Promote volunteerism and/or microjobs.

Befriending & Buddying for Seniors with No or Limited Social Networks

- Provide support to seniors through home visits and phone calls.

Information and Referral to Care Services

- Provide information on relevant schemes, grants, and support and/or conduct referrals for seniors to care services.

Social Connector for Social and Lifestyle Interventions

- Connect seniors to lifestyles and social interventions (as recommended by doctor).

Community Screening

- Assist seniors with measuring vitals (as recommended by doctor).

For patients who are unable to navigate these services on their own, clinics may contact their PCN HQ with the patients' health plan, postal code and other information. The PCN HQ will locate a suitable AAC, refer the patient and provide the clinic with further updates.

Referrals to Intermediate and Long-Term Care Services

In some cases, patients may require additional medical help or care. Services that may be suitable for such patients may include home-based services such as Meals-on-Wheels, Medical Escort and Transport, Home Personal Care, Home Medical, Home Nursing, Home Therapy and Home Palliative Care, or centre-based services such as Maintenance Day Care, Dementia Day Care and Community Rehabilitation.

PCN HQ teams have been trained to support their PCN clinics by using the Integrated Referral Management System (IRMS), a one-stop online referral portal for all intermediate and long-term care referrals, thus relieving clinics of this administrative burden. Clinics are therefore encouraged to reach out to their PCN HQs should their patients be in need of such services.

Consent for Data Sharing

Clinics are required to seek consent (verbal or written) from patients for sharing their personal data with the PCN HQ, AIC and relevant service providers to conduct further assessments for referrals/ applications. For verbal consent, family doctors should document the consent in their case notes for records.

All referrals or applications for intermediate and long-term care services are subject to further assessment and time taken to assess referrals/applications may vary for different services. Once referrals/applications are approved and matched with relevant service providers, availability of services may be subject to the current available capacity of the service provider. PCN HQs will work closely with their clinics to keep them updated on the status of applications/ referrals.

Running with Vim and Vigour

Doing the run leg of Challenge Roth 2017, an Ironman distance triathlon

Text and photos by Dr Lim Baoying

I first took up running in secondary school when I was tasked to be the physical training instructor in my extra-curricular activity (ECA), the National Police Cadet Corps. Running in those days was usually a few rounds around the fenced school compound and assembly ground in my sleeveless Nanyang Girls' High School top, PE shorts and canvas shoes. I would go straight off to attend school assembly before the school day started. It did not contribute to my love of running, but the discipline required by my ECA set the foundation for my endurance pursuit.

Running competitively

Running really became part of my life only during my junior college (JC) years when I joined the school's cross country and middle- and long-distance running athletic teams (800 m and 3,000 m). The key figure in my journey was my running coach, Mr Leong Chee Mun, and I have had the great fortune of being able to repay him in recent years when I treated his multiple physical ailments as a doctor. My countless overuse injuries and ankle sprains combined with the frequent visits to the physiotherapist also contributed to my eventual career choice in sport and exercise medicine. I completed my first full marathon (42.195 km) at the end of JC year one as a 17-year-old, even though the minimum age of participation was 18 years. That was in 1999 – nobody checked.

I continued to run throughout my time in medical school and had good standings in cross country and 3,000 m track events for the National University of Singapore. I even dabbled in kayaking and sport climbing, till I realised I probably needed to spend more time on my books rather than hours at the rock wall, and that the resulting finger stiffness might harm any prospects I had of being a surgeon. Running stayed a constant in my life until I purchased a road bike in year two while recovering from a bad bout of iliotibial band friction syndrome. Very soon, I became competitive in road cycling, and became a successful one as well since there were not many female road cyclists in those years. I even took the title of female National Road Cycling Champion in my last year of medical school at the brutal circuit set in Nanyang Technological University.

Cycling took over running for a few years as it allowed me to train while commuting in my junior years as a medical doctor. But the call of running came again from multi-sport events, specifically the duathlon (run-bike-run format) when the 24th Southeast Asian Games of 2007 listed it as an event. I was one of the best qualifiers in the local trials, but my quest sadly came to an end due to a stress fracture of the pubic ramus. Many more good years of competitive running, followed by duathlons and triathlons (swim-bike-run format) kept me sane as I progressed in my career as a medical doctor – although one might question how training for three events in a triathlon helps a sleep-deprived individual. But it is always with pride that I can call myself a multiple-time Ironman triathlon finisher (an event comprising swimming 3.8 km, biking 180 km and running 42 km), and patients in my current practice know that I walk the talk.

A way of life

Having taken a long journey to finally exit as a sports physician in sport and exercise medicine earlier in August 2023 – even though I have been working at the Singapore Sport and Exercise Medicine Centre at Changi General Hospital since 2011 – running plays a key role in motivating me and relieving my stress. Many times, when it was tough juggling my work and study load, I just had to remind myself that it was a long journey I had committed to. Short, frequent breaks from my work and study to go for a run or other physical activities helped to clear my foggy brain and inject fresh vigour into the mundane.

I currently run about 60 km to 80 km a week over five to six sessions, undergo strength training once a week and use the bike trainer once or twice a week. Waking up early and attempting to sleep early is a challenge in order to get the morning training session in, especially if it follows an evening training session the night before. However, keeping your activity and energy levels high while working full time is possible once a routine is set in place. Your body and health will also thank you for the investment you put in.

Physiological and chronological age discrepancy can be quite pronounced, especially when I compare myself as a lifelong athlete to a sedentary person of the same chronological age. Of course, I cannot deny that overuse and degenerative joints and tissues are becoming limiting factors in how hard I can push myself. This is the future challenge for myself as I continue to stay physically active for my sanity and health, and as a good example for my family, patients and colleagues.

Dr Lim is a sports physician who walks (runs) the talk. If she is not in the clinic talking or treating patients, you will probably find her on the road or pavement running and testing one of the many pairs of running shoes she has in her possession.

In the swim-bike-run routine in Metasprint Triathlon 2017

Receiving the trophy as the female National Road Cycling Champion in 2005, final year of medical school

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Lucky Plaza shop for lease. 825 sq ft. Prime central location. Right beside escalator, good crowd and traffic. Partially fitted. Water point and pantry. Available immediately. Asking $8250 negotiable. Call Cheryl 9159 2383 to view.

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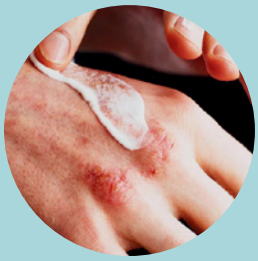

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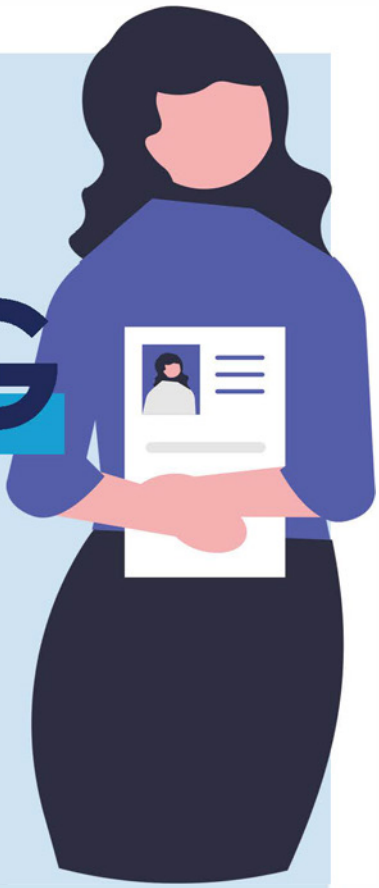

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  - Discuss and guide patient accordingly based on expert's opinion.
  - Continuously monitor and evaluate patients' progress and provide appropriate medical guidance and education.
- Cooperate with Medical Directors and Care Coordinators in quality and service improvement initiatives.
- Deliver remote advisory services, including but not limited to Expert Medical Opinion, Health Advisory, Chronic Disease Care, Coaching/Education and Referral.

Skill Requirements/Preferences

Professional Experience

Required:

- Medical degree from an accredited university/institution
- Registered with an active medical license with Singapore Medical Council

Desirable:

- Graduate Diploma of Family Medicine or any other relevant specialty

Languages

- Proficient in English. Being able to communicate in Mandarin will be a competitive advantage.

Others

- Excellent communication and interpersonal skills to establish rapport with patients and effectively collaborate with remote healthcare teams.
- Commitment to staying updated on telemedicine advancements, industry standards and professional development opportunities.

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Graduate Diploma in Sports Medicine Programme

Application Period: 1 January 2024 – 30 April 2024

In partnership with Singapore Sport & Exercise Medicine Centre @ Changi General Hospital (SSMC@CGH), Lee Kong Chian School of Medicine is offering a Graduate Diploma in Sports Medicine (GDSM) programme aimed primarily at doctors. The programme will equip them with the knowledge and skills needed to confidently perform pre-participation screening, for sport and exercise, manage general and sports-related musculoskeletal injuries in the primary care setting and to provide medical support for sports programmes and events, among other skills.

Sports Medicine Theory Course

Application Period: 15 September 2023 - 10 December 2023
Course Dates : 1 January 2024 to 30 June 2024

In partnership with Singapore Sport & Exercise Medicine Centre @ Changi General Hospital (SSMC@CGH), Lee Kong Chian School of Medicine is offering a Sports Medicine Theory Course (SMTC) for medical doctors and allied health professionals who would like to have a fundamental understanding of sports medicine. Participants (only applies to medical doctors) who have successfully completed the SMTC and subsequently sign up for Graduate Diploma in Sports Medicine (GDSM) programme will be entitled to a 30% discount from the GDSM tuition fee.

Living Well with Common Joint Pain

Course Dates: 10 January 2024 - 12 January 2024

This course is designed to improve participants' skills in caring for joint pain using physiotherapy and tuina approaches. Aligned with recent healthcare initiatives in Singapore, such as Healthier SG and the Action Plan for Successful Ageing, the course content will address the needs of Singapore's ageing population.

Care and Prevention of Common Sport Injuries

Course Dates: 10 January 2024 - 12 January 2024

Through this course, participants will gain valuable practical skills in providing first aid and develop a strong understanding of how to effectively manage a variety of sports injuries, including open wounds, strains, sprains, and chronic injuries. Upon completion, learners will have the exciting opportunity to enhance their knowledge and abilities by enrolling in the 'Sports Trainer' certification course offered by Sport Singapore (Sport SG).

Living Well with Diabetes Mellitus

Course Dates: 24 January 2024 - 26 January 2024

Participants will gain a comprehensive understanding of diabetes management, including the crucial role of exercise and nutrition in disease management. They will also acquire the necessary skills to provide effective patient-centered care, significantly improving the health and overall well-being of those under their care.

Living Well with Hypertension and Hypercholesterolemia

Course Dates: 24 January 2024 - 26 January 2024

This course is a formal training programme aimed at enhancing the competencies of allied healthcare professionals, nurses, and other health-related workers who provide care for elderly individuals with chronic diseases, such as hypertension and hypercholesterolemia.

Living Well with Arthritis

Course Dates: 28 February 2024 - 1 March 2024

The course focuses on mitigating and managing osteoarthritis and rheumatoid arthritis, equipping professionals to guide and support senior citizens in prevention and management. It emphasises medication compliance and lifestyle modifications including exercise, diet, pain management, biomechanical adjustments, and movement aids.

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