SMA news

For Doctors, For Patients

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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.

My daughter was a peer support leader in her secondary school days, and she once asked me a question that most of us who work with adolescents would have encountered: what if a peer/friend of hers was struggling in terms of their mental health but refuses to inform their parents for some reason? Could this person seek help on their own without anyone else being informed?

I must admit, I had no simple solution for my daughter, who was asking this on behalf of real people in her life.

It is timely for me then that this issue features two articles on the broader topic at hand – an adolescent's ability to make their own treatment decisions. One article has been coauthored by our former SMA Centre for Medical Ethics and Professionalism director, the esteemed Prof Thirumoorthy, and the other by a respected colleague of mine, A/Prof Daniel Fung.

The gist of the answer to my daughter's question seems to be this: protect the individual's confidentiality as far as possible, always ask what is in the patient's best interests, and have ongoing conversations that will enable family to be involved to provide the adolescent with the care they need.

DR LIM ING HAAN

Deputy Editor

Dr Lim is the first female interventional cardiologist in Singapore. She is an early adopter of new technology and is a key opinion leader in international cardiology conferences. She shares a clinic with her twin, Dr Lim Ing Ruen, an ENT surgeon at Mount Elizabeth Hospital. Both believe in the power of food, travel, laughter and loyalty in forming strong family bonding.

This issue highlights two thought-provoking articles – one on adolescent decision-making by Prof T Thirumoorthy and the other on adolescent autonomy by A/Prof Daniel Fung. Both offer valuable insights into the complexities surrounding young people's capacity to make healthcare decisions, which I found particularly enlightening.

In Singapore, the age of majority is 21 under the common law, and physicians are obligated to act in the patient's best interests. Challenges arise when adolescents under 21 with mental health, sexual health or substance abuse issues wish to exclude their parents from healthcare decisions. Although they may be capable of making informed decisions, they remain below the age of legal consent.

I recall a 16-year-old patient referred to me for hypertension who later confided his wish for gender reassignment, requesting confidentiality from his parents. Understanding the social stigma associated with sex change, I advised him to focus on completing his examinations before making any major decisions. At a subsequent visit, he agreed to let me broach this sensitive topic with his father, which allowed us to address concerns related to his upcoming National Service. Fortunately, I was able to encourage him to seek psychiatric support to better navigate the decisions ahead. In my view, he needed time to develop psychological and emotional maturity before making significant decisions, in line with the concept of Gillick competency.

This case underscores the physician's role as a first point of contact for adolescents. By upholding confidentiality and building trust with my patient, I was able to facilitate parental involvement. Ultimately, doctors must balance acting in the best interests of minors with respecting their growing autonomy, recognising that they will eventually assume full decision-making upon reaching adulthood. ◆

The Best Interest and Gillick Competence Principle

Application in Adolescent Health

Text by Darius Lim Xiang Wen and Dr T Thirumoorthy

Darius is a first-year medical student at NUS Yong Loo Lin School of Medicine. In his free time, he enjoys running, catching up with friends and exploring new experiences together.

Dr Thirumoorthy currently holds the position of Adjunct Professor in the Office of Academic Medicine at Duke-NUS Medical School. He has been with the SMA Centre for Medical Ethics and Professionalism (SMA CMEP) since its founding in 2000.

Opening vignette

John is a 16-year-old boy who is currently schooling and preparing for his upcoming national examination. He is known to place unrealistically high expectations on himself, and his stress is made worse by parental expectations. John is currently experiencing severe anxiety from academic stress and has trouble sleeping. He visited a clinic recently to seek medical advice and was referred to the psychiatry department, where he was diagnosed with generalised anxiety disorder. John is keen to start treatment with oral anxiolytics. During the consultation, John specifically requested for the doctor to not inform his parents as they would not understand, inferring that they are part of the problem. The psychiatry team has several concerns regarding his request: (a) whether John, an adolescent, has the capacity to give consent on his own; and (b) whether involving his parents without his consent would be in his best interest.

Introduction

In medical practice, the legal basis permitting doctors to provide any form of medical intervention is informed consent. Every adult patient of sound mind has the right to self-determination. Medical interventions with a person's body are unlawful battery unless the patient has voluntarily given informed consent.[1] The age of majority is the age at which an individual is legally considered an adult with full legal rights. In Singapore, that age is 21 years old under the common law. An adult aged 21 and above, barring any physical or mental incapacity, is legally empowered to provide consent or refuse medical treatments.[2]

However, for those below 21, Singapore has no statute law that defines the legal age for medical consent.[3] Under Singapore law, there is no presumption of capacity for adolescents, and most hospitals have consent processes that involve parents or guardians for adolescents.[4] However, with the rising incidence of mental health disorders in adolescents, they may not want to involve their parents in the consultation process for such sensitive and stigmatising matters.[2] This presents a conundrum for healthcare professionals (HCPs) when adolescents do not wish to involve their parents: whether to respect the adolescent's wishes, involve the parents nonetheless, or act according to what the HCPs believe is in the adolescent's best interest.

There are also scenarios where relying on parental authority for consent may be impractical or undesirable: parents may be uncontactable or may make treatment decisions against the best interest of the adolescent; or the

adolescent may have concerns they wish to keep confidential from their parents. Hence, this article aims to outline the perspectives of various stakeholders involved in adolescent medical decision-making, as well as ethical and legal considerations in accordance with statutes and professional ethical codes and guidelines. This article has relevance for doctors, clinicians, parents, adolescents, as well as policymakers. Let us first understand the background and perspective of the main stakeholders in adolescent health.

Stakeholder perspectives

The key stakeholders involved in adolescent medical decision-making are the adolescent, the parent and the healthcare professional.

1. **The adolescent**: The key underlying principle is that adolescents have an evolving capacity to participate, and naturally, they should be supported as active participants in decisions about their health. However, an adolescent should have a certain level of maturity and understanding so as to avoid making decisions that risk harming themselves and to participate constructively in making medical decisions.
2. **The parent**: Parents have an obligation of beneficence to optimise the welfare of the adolescent. In order to exercise this responsibility, they must be given certain authority and access to information, because society expects them to be responsible for their child's welfare. Traditionally, parents are expected to make treatment decisions on behalf of minors.[5] However, parental authority is not absolute and is subject to the "best interest" standard. The general presumption is that parents, as caregivers of the minor, would know what is best for their child and would act in the child's best interest. The courts retain the authority to intervene when a parent or guardian fails to protect the interests of the adolescent.[5]
3. **Healthcare professionals**: HCPs have a duty to act in the best interest of the minor and to safeguard their welfare, respecting their views and upholding their desire to participate in decisions about their health. Where it is in the adolescent's best interests, HCPs would involve both the parent and the minor in making medical decisions. While consent for minors is typically obtained from a parent or legal guardian, as outlined in the professional ethical codes and guidelines, HCPs should still inform the minor about their medical condition and give due consideration to their views.[5]

Although there is no specific legal age for minors to give consent, an adolescent under the age of majority (21 years) can independently consent to treatment if they are "Gillick competent" and demonstrate sufficient maturity and understanding. Under routine circumstances, HCPs should be able to assess the capacity and maturity of the adolescent. In complex cases where there is uncertainty in assessing an adolescent's level of maturity, HCPs should seek guidance from a senior colleague, psychiatrist or psychologist.[5]

The "best interest" principle

Rather than just defaulting to parental authority in adolescent medical decision-making, the starting point for minors should be the "best interest" principle. This overarching legal principle, as written in the Children and Young Persons Act, states that the minor's welfare, care and protection must be the first and paramount consideration.[6] When deciding what is in the best interest of an adolescent, the decision-maker must not rely solely on the minor's age, appearance, or assumptions drawn from an aspect of the minor's behaviour.[7] Best interest can be defined as a comprehensive evaluation that takes into account the adolescent's medical, psychological, emotional, moral, religious and overall well-being in both the short and long term.[4] Taking corollary from the Mental Capacity Act, in applying the "best interest" principle, reasonable consideration must also have been given to the past and present wishes, as well as the views of the parent or legal guardian and significant others, in so far as they have been involved in the adolescent's care.[7] This approach is often called the "Checklist and Balance Sheet" method, where the checklist refers to the collection and collation of data and the balance sheet refers to the weighing of the benefits and harms to the minor's best interests.[8]

In practice, pursuing the adolescent's best interest should involve a collaborative care model that emphasises open communication, active listening and negotiation between all stakeholders: the adolescent, the parent and the HCP. The collaborative care model is more likely to produce better clinical outcomes and build lasting trustworthy relationships.[9] In this collaborative care model, more skills and effort are necessary, as adolescent medical decision-making can be complex and contested due to diverging stakeholder interests and power asymmetries. The adolescent phase is marked by an evolving sense of autonomy and identity, which begins a change in the doctor-adolescent-patient relationship.[10] Adolescents who are on the verge of legal adulthood have a growing desire to express autonomy and self-determination, which may be inevitably encroached by parental responsibility seeking to protect them.[10]

Where the adolescent, the parent and/or the HCP hold differing views, a third party (such as an ethics committee, a senior colleague, or a judge) may be called upon to determine an appropriate course of action. Before referring to the third party, HCPs must make a structured effort to understand the perspectives and interests of the stakeholders so as to harmonise and reach a consensus. In such cases, it is essential to understand the principles, interests and point of contention of all stakeholders involved in adolescent medical decision-making.

Legal basis of Gillick competency

Gillick competency is an English Law concept from the House of Lords Decision in *Gillick v West Norfolk and Wisbech Health Authority* [1986], which addressed whether girls under the age of 16 could obtain contraceptive advice or treatment without parental knowledge or consent.[11] In its judgement, the court found that under certain provisions, the adolescent may be legally competent to give valid consent independently: the adolescent

must be able to understand the doctor's advice and weigh the benefit and risk; identify and distinguish important relevant information from non-factual, inaccurate misrepresentations; and have a level of maturity and intelligence that enables him/her to arrive at an informed and reasoned conclusion.[11] Maturity can be defined as psychological or emotional development which involves several criteria: self-awareness and understanding one's own thoughts and emotions; self-regulation and managing emotional reactions; and ability to decide on the best approach to cope with challenging situations.

The level of maturity required to be Gillick competent depends on the gravity of the specific medical decision in question and the context in which it is made. An adolescent may be capable of making minor decisions independently, while major decisions (such as consenting to heart surgery) may require external support.[12] Furthermore, the level of maturity and understanding varies widely between adolescents depending on age, the presence of physical or psychological comorbidities, as well as the support system available to the adolescent. An adolescent is not Gillick competent simply because he/she has reached a certain age threshold. Rather, Gillick competence is an assessment of the adolescent's maturity, intelligence and ability to make an informed medical decision.

The legal precedent in Singapore concerning Gillick competence is not extensive. Singapore's first judgement came in 2021, where a disagreement between parents about whether their 16-year-old daughter should receive the COVID-19 vaccination was resolved in court. In deciding whether the vaccine was in the adolescent's best interests, the court gave "full weight" to the daughter's preferences after finding her Gillick competent and sufficiently mature to make an informed decision about being vaccinated. The court's recognition that Gillick-competent adolescents can consent to treatment represents a constructive development in Singapore statute, yet there remains no general legislative guidance on consent to medical treatment by adolescents under 21.[4]

Professional basis of Gillick competency

The ethical ethics basis of adolescent medical decision-making rests on the principles underpinning the doctor-patient relationship: primacy of patient's welfare, respect for persons, duty of care, non-abandonment and confidentiality. Involving the adolescent in decisions about their health is necessary to respect their need to know about their medical conditions, to be heard, and to participate in decisions regarding their care.[13] According to the Singapore Medical Council (SMC) Handbook on Medical Ethics, HCPs should give due consideration to the opinions of minors who are able to understand and decide for themselves.[5] It also recognises Gillick competence as an ethical matter, stating that young children may have the capacity to understand medical information sufficiently to make their own decisions about their care.[5]

Professional practices for consent in adolescence

In clinical practice, HCPs should encourage adolescents to involve their parents or caregivers in medical decisions. If they refuse, HCPs should explore why, and if appropriate, discuss how they could help inform their parents or caregivers. If they remain resolute about not involving their parents or legal guardians, the Gillick principle and Fraser guidelines should then be considered.

The assessment of capacity in adolescence is not far different from that used in adults. HCPs can gain a better understanding of the adolescent's intellectual and emotional maturity by asking open-ended questions and observing their responses. These include, but are not limited to:

- The adolescent's understanding of the medical issue, relevant information and alternatives.
- The adolescent's ability to weigh and evaluate the benefits and risks of treatment, both in the short and long term.
- The adolescent's ability to reason, consolidate and come to a reasoned conclusion.
- The adolescent's ability to clearly communicate and express their decision.
- Whether the adolescent is under any undue external influence or pressure that is affecting the their decision.

HCPs can use the teach-back technique to assess if the adolescent has correctly understood the information and advice given. They can also use the ICE tool (Ideas [and beliefs on their illness], Concerns and Expectations) during the consultation to elicit and better understand the adolescent's knowledge, understanding, values and preferences. HCPs should clearly document the assessment process, including the adolescent's responses, thought processes and decision-making ability.

In addition, HCPs can make use of a modified Fraser guidelines process to determine if it is appropriate to give such advice and treatment to adolescents without parental knowledge or consent.[14] The criteria include:

- The adolescent remains adamant about not involving their parents or guardians despite the doctor's attempts at persuasion.
- The adolescent has a sufficient level of maturity and intelligence to understand the medical advice given.
- The adolescent's physical or mental health is likely to suffer unless they receive the advice or treatment.
- It is in the adolescent's best interest to receive the advice or treatment without parental knowledge or consent.
- The adolescent is at high risk of complications if mental health treatment is withheld.

The primacy of the best interest principle

In all medical decisions, whether the adolescent is Gillick competent or not, or when decisions are made by parents, the overarching principle of the best interest of the minor – welfare, care and protection – must be upheld. In some cases, a Gillick-competent adolescent may make a medical decision that is against their best interests, such as refusing a

life-saving or beneficial treatment due to emotional distress, lack of understanding of the consequences or undue influence of peers. In the same vein, parents may end up making a decision that does not serve the adolescent's best interests. HCPs should be aware that the rights of Gillick-competent adolescents and their parents to make medical decisions on behalf of the minor are not absolute, and are subject to the "best interest" standard.[3] In order to fulfil their duty to prevent unnecessary harm and act in the adolescent's best interest, HCPs may apply to the ethics committee or the courts to overrule any decision they assess to objectively not be in the adolescent's best interest.[5]

Medical confidentiality and trustworthy relationships

HCPs also regularly struggle with issues of confidentiality surrounding adolescents. While it is generally in a minor's best interest for parents or guardians to be involved, adolescents are more likely to discuss private health matters (such as mental health, contraceptive advice, drug use and sexually transmitted infections) if they believe their confidentiality will be respected.[2] According to the SMC Ethical Code and Ethical Guidelines, HCPs are obliged to maintain the medical confidentiality of minors (the same as adults), except when it is in the minor's best interests for their parents or guardians to be informed and involved.[5]

Parents may also make a request to doctors to not inform the adolescent of their condition, especially if they suffer from a life-threatening illness or the prognosis is bleak. On the one hand, HCPs may be hesitant to share information with the adolescent to prevent emotional pain or helplessness. On the other hand, withholding information risks compromising the adolescent's understanding of the illness and treatment, thus decreasing the level of trust in the doctor–patient relationship.[15] HCPs and parents may also disagree as to what information should be provided to the adolescent. In these cases, HCPs would do well to engage in discourse to encourage disclosure.[10]

Box 1. Important questions for HCPs to consider on involving parents

1. Does the adolescent want to involve parents or legal guardians?
2. Is the adolescent Gillick competent?
3. Is it in the adolescent's best interest for parents to be involved?

Box 2. Best interest checklist questions for HCPs

Questions that HCPs can use to determine adolescents' best interest:

Medical indications and benefits

1. Is there good evidence that treatment will improve the medical condition?
2. Does benefit outweigh side effects or harm?
3. What are the alternatives to the proposed treatment?
4. Is the proposed treatment the least intrusive intervention?

Emotional and psychological well-being

1. Will the treatment reduce psychological suffering or distress?
2. What are the long-term impact of having the treatment?
   (a) Does it impact future autonomy outcomes?
3. Will quality of life be enhanced or impaired in daily functioning?

Social, cultural and other factors

1. Will the treatment support the social health and family relationships of the adolescent?
2. What is the impact on other relationships, schooling and culture?
3. Have the cultural, religious and social factors been considered, respected and balanced with the treatment and care needs?

Views of the stakeholders

1. Were the views of the adolescent supportive of the treatment?
2. Were the views of the parents supportive of the treatment?
3. Are the views of the parents consistent with the child's welfare?
4. Were the views of the members of the healthcare team supportive of the treatment?

Box 3. Possible scenarios and appropriate responses

1. The adolescent does not want to involve their parents and is assessed to be Gillick competent. However, it is also in their best interest for their parents to be involved.
   (a) In order to fulfil their duty to act in the adolescent's best interest, HCPs can inform the minor of their intention and reasons for involving parents, nonetheless.
2. The parents refuse consent for a beneficial and necessary treatment. The treatment is assessed to be in the adolescent's best interest. The adolescent is assessed to be Gillick competent and offers their consent.
   (a) HCPs can obtain valid consent from the Gillick-competent adolescent and proceed with treatment if urgent.
   (b) In elective situations, HCPs should continue to engage the parents and seek consensus or refer to the clinical ethics committee.
3. The parents refuse consent for a beneficial and necessary treatment. The treatment is assessed to be in the adolescent's best interest. The adolescent is assessed to not be Gillick competent.
   (a) In order to act in the adolescent's best interests, HCPs may need to involve the ethics committees or the courts to get support and sanction to proceed with life-saving treatment.
4. The adolescent is assessed to be Gillick competent and refuses treatment. The treatment is considered to be in the adolescent's best interest. The parents are involved and provide consent for treatment.
   (a) In accordance with the best interest principle, HCPs may treat the adolescent with valid consent from the parent.

Conclusion

Adolescent medical decision-making in Singapore is complex and contested, as existing medical laws and regulations do not specify a legal age for individuals under 21 to provide independent, valid consent. The overarching legal standard guiding such decisions should be the "best interest" principle. A collaborative care model emphasising dialogue among all stakeholders – including the adolescent, parent and HCP – can help achieve a satisfactory outcome.

However, determining what constitutes an adolescent's best interest would be best done using the "Checklist and Balance Sheet" tool.

For adolescents lacking capacity, parents with legal authority are expected to act in their child's best interest. Decisions that go against the minor's best interest can be overruled in the courts. Moreover, the assessment of Gillick competence is patient-centric, context-specific, and may be conducted by a doctor or a child representative appointed by the courts. ◆

Take-home messages

1. In Singapore, the age of majority, which is the age at which an individual is legally empowered to provide valid consent or refusal for medical treatment, is 21 years old. Consent for adolescents under 21 is usually taken from parents or legal guardians.
2. Adolescents under 21 who demonstrate sufficient maturity and intelligence to understand the doctor's advice and weigh the benefit and risk may be deemed Gillick competent. Gillick-competent adolescents may independently consent to medical treatments but may not refuse beneficial treatment that is in their best interest. The assessment of Gillick competence by a HCP is patient-centric, context-specific, and based on the adolescent's level of maturity.
3. Medical decisions and consent for adolescent health, whether obtained from a Gillick-competent adolescent, parents, or legal guardians, must adhere to the best interest standard. HCPs can use the "Checklist and Balance Sheet" tool to determine the adolescent's best interest. HCPs can apply to the ethics committees or the courts to overrule a decision not in the adolescent's best interest.
4. Pursuing the adolescent's best interest in medical decision-making should involve a collaborative care model that emphasises open communication, active listening, and negotiation between all stakeholders: the adolescent, parent and HCP.

Closing vignette

The first step is to recognise that John, who is 16 years old, is under the age of majority. Therefore, the treating team must determine whether John is Gillick competent and able to sufficiently understand the nature and consequences of the medical decisions at hand. A psychiatrist should conduct a proper assessment of John's level of understanding by asking open-ended questions to elicit his understanding, maturity and ability to appreciate the consequences of his decision. The second step is to assess if disclosure to his parents would be in John's best interests. To assess this, the psychiatrist should engage with John to elicit his thoughts and rationale for not wanting to involve his parents. Involving his parents may be in his best interest, particularly if it helps create a supportive and conducive healing environment for his mental health recovery. If so, attempts should be made to persuade John to involve his parents. If John is assessed to be at risk of suicide, the medical team may break confidentiality in his best interest to protect him from self-harm. Throughout the consultation process, the medical team should uphold John's welfare as the first priority.

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An Experience of a *Lifetime*

Text by Dr Ng Chee Kwan

As I come to the close of my appointment as President of SMA, I reflect on my experience with gratitude.

I am glad to have presided over a three-year period during which we increased our Membership representation to 59% of all registered doctors in Singapore. I believe our commitment to providing Members with mandatory medical ethics (MME) continuing medical education (CME) modules led many doctors to join SMA. Much credit for this goes to our team at the SMA Centre for Medical Ethics and Professionalism, who put up an excellent programme that helped our Members fulfil their MME CME point requirements.

Speaking up for issues that matter

I am glad that SMA has continued to advocate for issues that matter to doctors. We consistently advocated for Integrated Shield Plan (IP) panels to be open to all private specialists and more recently, spoke up for measures to limit the turnover of specialists on panels to ensure better continuity of patient care. We asked that insurers who steer patients to preferred hospitals make such arrangements fully transparent to policyholders, so that patients can make informed decisions on their choice of IP provider.

Since SMA started its advocacy efforts on IP insurance (some of which predate my presidency), there have been observed improvements in the implementation of IP panels. The majority of insurers have increased the number of specialists on their panels, from between 300 and 400 specialists per insurance panel at the beginning of 2021 to between 600 and 800 specialists in 2024.[1,2] There have also been improvements in terms of transparency – the Ministry of Health (MOH) now publishes a yearly comparison of the number and turnover rate of private specialists on each insurer's panel on their website.[2] Recent panel specialist contracts no longer have clauses that oblige panel specialists to use preferred hospitals. I acknowledge that this is a work in progress and trust that SMA will continue advocating for specialists with regard to panel issues.

During this time, we provided feedback to MOH regarding the Health Information Bill (now Act) and suggested that cybersecurity and data security requirements be simplified to reduce the burden on healthcare providers. We also suggested that healthcare providers be given adequate funding support to defray the costs of implementation. We are glad that MOH has taken our feedback seriously and has undertaken to work with and support healthcare providers.

Connecting with fellow professionals

During my term, I have had the privilege and honour of engaging with leaders from MOH, Academy of Medicine, Singapore, College of Family Physicians Singapore and the local medical schools. I have also met with representatives from the Medical Associations of South East Asian Nations and enjoyed their camaraderie. These interactions have broadened my perspectives on the medical profession and the practice of medicine, far beyond the confines of my daily clinical practice, and I am grateful for all these opportunities. My three years as SMA President has truly been an experience of a lifetime.

It has not all been smooth sailing and there have been numerous stressful moments during my term. One such moment occurred in 2024, when SMA was the subject of a cybersecurity attack following a phishing email. We were fortunate that there was no exfiltration of data, and we have since fortified our cybersecurity measures.

Concluding my term

My term as President will come to an end in April 2026. It will be time to take a

step back and refocus on other priorities, such as my own medical practice and family. However, I will remain in the SMA Council to continue offering my help and support as needed.

I could not have done my job without the strong support of the SMA Council members, and I would like to extend my deepest gratitude to my fellow Council members for their invaluable advice and guidance. I am also grateful to the Secretariat for the smooth execution of the Council's plans, and for organising Members' events and educational activities.

Last but not least, I would like to thank my friends, colleagues and Members of the SMA who have supported and encouraged my efforts as President of the SMA over the past three years. ◆

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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.

HIGHLIGHTS

From the Honorary Secretary

Report by Clinical Asst Prof Benny Loo Kai Guo

Disclosure of patient medical records to insurers

SMA's comments regarding patient medical records were included in a 26 January 2026 article in *The Straits Times*. Key points are shared below.

SMA President Dr Ng Chee Kwan told the *Straits Times* that, beyond submitting medical reports to insurers with patient consent, panel doctors may also be bound by contract to allow insurers to review patients' medical records, usually for audit reasons.

He noted that while such audit provisions are widespread, actual requests for audits are rare based on SMA's knowledge.

Dr Ng also said that although preparing separate medical reports for insurers takes additional time and effort, doctors generally prefer this approach over sharing their clinical notes in order to protect patient confidentiality.

In line with the Ministry of Health (MOH) circular, he added that SMA recommends that insurers revise their audit clauses to comply with MOH guidelines.

Members may read the full article at https://bit.ly/3Ms76yI.

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.

Guidelines on the use of NRIC numbers

MOH has issued a circular on 2 February 2026 on ceasing the use of NRIC numbers for authentication, with sector-specific guidelines and frequently asked questions to assist providers in distinguishing between identification and authentication scenarios. The document also provides practical guidance on implementing appropriate authentication measures for various healthcare use cases (eg, patient registration, updating personal particulars, accessing digital services, release of medical documents and teleconsultations).

The circular and its two annexes can be viewed at https://bit.ly/4akp2V5.

Any queries relating to these documents may be addressed to moh_nric_enquiries@moh.gov.sg. ◆

A Cute Appendix and Other Ruminations

Text by Dr Jared Ng and Dr Lo Hong Yee

The grid iron incision for open appendicectomy, first described by Dr Charles McBurney in 1894,[1] is fast fading into history. Once a rite of passage for the surgical trainee, it was often the first real abdominal operation a young surgeon performed. For decades, generations of surgeons gained their early confidence by mastering this familiar cut.

But the field has changed. Laparoscopic appendicectomy has become the standard in most hospitals. Unlike open cholecystectomy, which still has a place in certain complex gallbladder cases, the grid iron incision is nearly obsolete. In difficult appendicitis cases where laparoscopy fails, many surgeons now prefer a midline incision for better access and flexibility.

Evolution of surgical techniques

This evolution has improved patient care in clear ways. Smaller incisions mean faster recovery, less pain and fewer wound-related complications.[2] The long hospital stays and large scars that were once part of appendicitis management have been replaced by day surgeries and nearly invisible marks.

Yet, progress comes with trade-offs. The familiar scar in the right lower abdomen once served as a visible clue to a patient's surgical history. Today, these signs are subtler. We must look carefully for the small, well-healed puncture marks – a reminder that medicine often moves forward quietly.

However, surgery has never been only about tools or techniques. It is about relationships – between patient and surgeon, between teacher and trainee, and between our sense of competence and our tolerance for uncertainty. Each operation, no matter how routine, carries a chance of success or failure. And when complications happen, no amount of technical progress can protect us from the burden of responsibility. There is a "little cemetery" that every surgeon carries with them.[3] A place where they visit in quieter moments, to reflect and to temper, to remember and to learn.

When complications happen

In the OT, the weight of our work is measured not just by what we remove or repair but by the lives we touch.

I (Dr Lo) once treated an 88-year-old man for acute cholecystitis. He was independent and in good health before he fell ill. After antibiotics, we planned an interval laparoscopic cholecystectomy. The surgery itself was smooth and unremarkable. Two weeks later, he returned with fever and sepsis; imaging showed a large biloma collection. Despite repeated drainage, antibiotics and many days in intensive care, he developed one complication after another. After two months in hospital, he died.

Over those weeks, I got to know his family well. They were gracious and patient, even as the setbacks piled up. When he passed, they thanked me for trying my best. Their kindness somehow made the guilt sharper. I kept questioning whether I had made the right decision to operate or whether I should have done anything differently. I doubted my judgement and my hands.

In moments like these, many of us visit the "little cemetery" within. It is the place in our minds where we keep the memories of patients we could not save. No amount of experience makes that burden lighter. These memories are not just about failure. They also teach us humility. They remind us to hold ourselves to the highest standards, far beyond what is expected by law or policy.

The invisible scars of psychiatry

If surgery leaves visible scars, the wounds in psychiatry are often hidden. The outcomes are harder to measure, and the harm less visible. Yet the weight of caring can be just as heavy.

Some years ago, I (Dr Ng) cared for an elderly man who struggled with depression. He had made some progress in treatment. He seemed to be improving, and there were plans made for the future. Then one afternoon, I received a call from his son – he had taken his own life.

I asked for permission to attend the wake. I prepared myself to face anger and blame. Instead, the family greeted me with warmth. They thanked me for looking after him. I felt relief that they

did not hold me responsible, which was mixed with guilt that I could not prevent what happened.

Suicide prevention has become a central focus in mental health care in Singapore. This is a necessary and positive shift, but it also brings new pressures. Patients sometimes feel afraid to speak honestly about suicidal thoughts because they fear involuntary measures or being sent to hospital. Families feel they must stay constantly alert, watching for signs of decline. This atmosphere of vigilance can strain relationships and add stress to already fragile situations.

As psychiatrists, we walk a narrow path. We are bound to act when risk is high. But we must also create space for patients to share their distress without fear of overreaction. Sometimes, we have to choose between preserving trust and taking protective action. Even when our decisions are justified, they can damage the therapeutic relationship.

In our efforts to prevent death, we must not forget our purpose is also to help people live fully. Safety is essential, but so are dignity and autonomy.

The second victim

Whether in surgery or psychiatry, when a patient dies or suffers harm, the clinician is often the second victim. The concept of the "second victim" describes the emotional impact on healthcare professionals involved in adverse events. It may feel callous to talk about the impact on the doctor when it is the patient and their family who are suffering physically, but the emotional trauma faced by the healer is not insignificant.[4]

Tan HK and colleagues have done important work summarising studies on this phenomenon and examining its impact in Asian contexts, including in Singapore.[5,6] Their research challenges the comforting belief that those who remain in the profession simply grow stronger. In reality, many continue to struggle with guilt, shame and self-doubt. Some develop maladaptive coping patterns. Others leave the profession altogether.

Their findings also highlight that the medical culture in Asia often expects stoicism and composure. We are taught to compartmentalise, to keep going and to appear unaffected. Over time, this silence takes its toll. It can erode confidence, increase burnout and harm patient care.

In many hospitals, there is still an unspoken belief that seeking help is a sign of weakness. This idea is outdated and unhelpful. Emotional health is not separate from professional competence – it is part of it.

A call for change

We dedicate our lives to healing others. But the price can be high. We need to build a culture where asking for support is accepted, even encouraged.

In some places, peer support programmes have made a difference. After critical incidents, structured debriefings and confidential counselling can help clinicians process their experiences. Some hospitals in Singapore have also introduced peer support initiatives, though many clinicians remain unaware of them or feel hesitant to access help.

More can certainly be done. Institutions in Singapore can normalise discussions on emotional impact. Leaders can model openness by sharing their own struggles. Medical training can include preparation for coping with complications and loss, not only the technical aspects of care.

To colleagues in medicine, surgery and mental health: you are not alone. Struggling does not mean you are any less skilled or committed. You are human; you have limits, and that does not diminish your worth.

To policymakers and healthcare leaders: invest in systems that make it easier for clinicians to seek help without fear of judgement. Psychological support, mentoring and protected time for reflection are not luxuries; they are essential parts of a safe healthcare system.

In acknowledging our vulnerability, we affirm our humanity. As we move past outdated surgical techniques, let us also set aside the idea that clinicians must carry these burdens alone. The future of medicine depends not only on skill and innovation but on our ability to care for ourselves as we care for our patients. ◆

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Dr Ng is a psychiatrist in private practice in Singapore. In 2009, he and Dr Lo Hong Yee were deployed to Afghanistan, where they quickly realised that one of them was better with a scalpel and the other with talking about feelings. They have been friends ever since.

Dr Lo is a general surgeon at Tan Tock Seng Hospital. He was classmates with Dr Jared Ng and they served in Afghanistan in 2009 as part of Singapore Armed Forces' Operation Blue Ridge.

The Dilemma of Adolescent Autonomy

Text by A/Prof Daniel Fung, Editorial Advisor

Early in my career as a child and adolescent psychiatrist, I encountered a case that has stayed with me in the many years since. A 15-year-old girl was referred to me with severe depression and suicidal thoughts. She had recently discovered that she was pregnant. Her parents were devastated and had threatened to disown her. The girl felt ashamed, frightened and utterly alone. She also refused antidepressant medication. Everyone involved in her care felt stuck. Her doctors were worried about her safety; her parents were angry and heartbroken; and the young girl herself had lost hope that things could improve. I asked to meet the girl and later her parents. The conversations were difficult, with tears, anger and long silences. But slowly, something started to shift. The parents began to hear their daughter's fears. The daughter began to understand the depth of her parents' disappointment and pain. Eventually, her mother agreed to support her during the pregnancy and help care for the baby after birth. In the end, she recovered without needing medication. The moment that remains most vivid to me came when her father finally told her that, despite everything that had happened, "I still love you".

In situations like these, doctors are sometimes tempted to focus on the clinical problem in front of them. But adolescent care is rarely just about symptoms and treatment plans. It is about relationships. For that family, healing did not come from a prescription. It came from rebuilding trust.

Cases like this illustrate the complexity of caring for young people. Adolescents often come to doctors with concerns that they do not want their parents to know about. These may involve mental health struggles, sexual health issues, substance use or deeply personal questions about identity. When this happens, doctors face a difficult question: how much autonomy should a young person have in decisions about their own health?

Extent of a young person's autonomy

The concept of Gillick competence offers some guidance. Originating from a landmark British case in 1986, it recognises that adolescents may have sufficient maturity and understanding to participate meaningfully in decisions about their care, even though they are not yet legal adults. In Singapore, the Children and Young Person's Act defines a child as a person under the age of 14 years, while a young person is defined as someone aged 14 years or older but below 18 years old. 21 years is the formal "age of majority" where individuals gain significant commercial and personal rights of adults (see Table 1 for further elaboration).

Table 1: Developmental timelines

Autonomy develops progressively during adolescence. In Singapore, young adults between 18 and 21 already assume many legal responsibilities such as contractual obligations, driving, and criminal liability, yet full legal authority for independent medical consent begins at 21. Clinicians therefore often balance developing autonomy with the best interests of the young person when making healthcare decisions. In Singapore, care has been differentiated to basic care, psychotherapeutic care, and psychiatric diagnosis and medical care. Guidelines are being formulated and clinicians are advised to refer to them when available.

Phase	Childhood	Early Adolescence	Mid Adolescence	Late Adolescence	Young Adult
Age	0-10	11-14	15-17	18-20	>=21
Healthcare	• Decisions primarily made by parents • Limited ability to understand medical risks • Doctor communicates mainly with parents	• Beginning participation in health discussions • Developing understanding of illness and treatment • Parents remain primary decision makers	• Increasing maturity and reasoning • Possible **Gillick competence** depending on maturity • Confidential consultations may occur in specific circumstances	• Increasing participation in medical decisions • However full legal medical autonomy in Singapore begins at 21	• **Full legal autonomy for medical decisions**
Societal	• Full parental responsibility	• Increasing independence in school and social life	• Developing independence and decision-making • Criminal responsibility can be attributed at age 16	• May enter many legally binding contracts • Can sue or be sued • Marriage (with parental consent) • Eligible to drive and consume alcohol • Treated as an adult in the criminal justice system	• Full legal majority

But Gillick competence is often misunderstood. It does not mean that teenagers can simply make medical decisions on their own, nor does it mean that parents should be excluded from care. Instead, it reminds doctors that young people themselves have voices that deserve to be heard.

At the same time, clinicians have a duty to act in the best interests of the young person, and this remains the guiding principle in caring for minors. Balancing these responsibilities requires discerning judgement rather than rigid rules.

When confidentiality is requested

One of the most challenging situations arises when an adolescent asks a doctor to keep information confidential from their parents. A teenage girl may request emergency contraception but insist that her parents must not be informed. Another young person may seek treatment for a sexually transmitted infection while fearing severe punishment in the event the family finds out about it. A depressed teenager may ask for counselling while refusing parental involvement. If doctors insist on parental consent in every situation, many adolescents will simply avoid seeking help altogether. Worse, they may seek help through illegal means, and that outcome serves no one. Yet automatically granting confidentiality without careful consideration can undermine the family relationships that often support recovery. The most important question therefore becomes: why does this young person want confidentiality?

Understanding the reasons behind the request often reveals more than the request itself. Sometimes, the fear is rooted in embarrassment or misunderstanding. Other times, it reflects genuine family conflict or cultural stigma. There is another ethical principle that is especially useful in these situations: "the least detrimental alternative". Described in the book *Beyond the Best Interests of the Child* by Joseph Goldstein, Anna Freud and Albert Solnit, this principle was proposed as a more realistic and urgent replacement for the "best interests of the child" standard. Sometimes, every option carries risk. Informing parents may damage trust and discourage the adolescent from seeking future help. Maintaining confidentiality may limit family support that could be beneficial. The role of the doctor is not simply to apply rules but to choose the course of action that is least likely to harm the young person overall. Often this means trying to bring parents into the conversation gradually rather than abruptly breaching confidentiality. Doctors frequently work with adolescents to find ways of sharing information safely with family members. The goal is rarely to exclude parents permanently. Instead, it is to preserve trust long enough for a healthier dialogue to emerge.

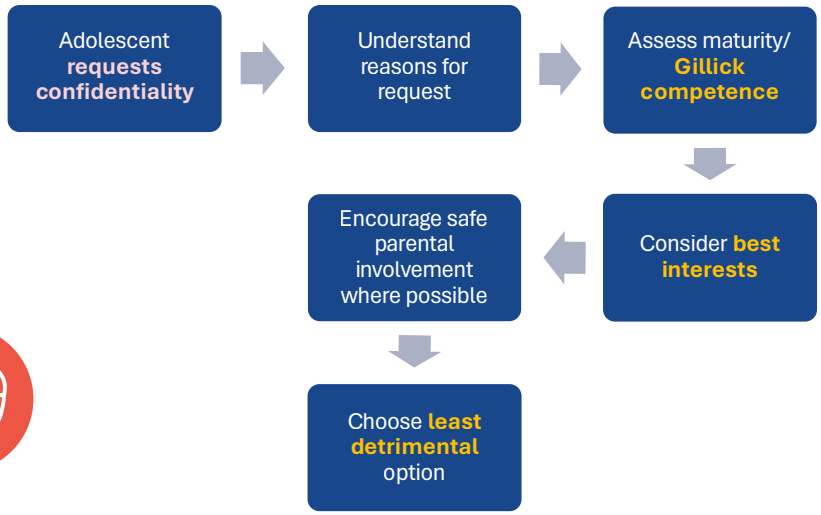
Complex decisions in modern adolescent care

Adolescent healthcare today presents a growing range of complex decisions. One example is gender dysphoria and gender-affirming treatment, which has attracted significant attention worldwide. These decisions can involve psychological assessment, social transition and medical interventions. Such issues require careful multidisciplinary evaluation and, wherever possible, the involvement of families.

Another dilemma arises in the treatment of depression in adolescents. Psychotherapy is recommended as the first-line treatment. Yet occasionally an adolescent may request antidepressant medication while asking that their parents not be informed. Should medication be prescribed without parental knowledge? Would psychotherapy alone be acceptable in such circumstances?

Figure 1: Responding to adolescent requests for confidentiality

Clinicians often approach adolescent confidentiality through a structured process that balances autonomy, safety, and family involvement.



Emerging therapies create additional questions. New evidence-based approaches such as non-invasive brain stimulation and nutritional supplementation are increasingly explored in youth mental health.

Each intervention carries its own level of risk and uncertainty. Decisions about consent therefore depend not only on the maturity of the adolescent but also on the nature of the treatment.

Learning to make decisions

It is also worth remembering that decision-making is part of development. Young people make choices every day as they navigate friendships, school and social life. Some of those decisions will inevitably be bad ones. Parents and teachers recognise that learning from mistakes is part of their development, and overprotection can sometimes prevent young people from gaining the experience they need to mature.

Healthcare decisions however often carry more serious consequences. Doctors therefore have a responsibility to guide adolescents through these decisions while ensuring their safety. In many cases, the best approach is neither to grant complete independence nor to insist on parental control. Instead, the aim is to create a space where adolescents can speak openly while gradually involving the people who care for them most.

Conclusion

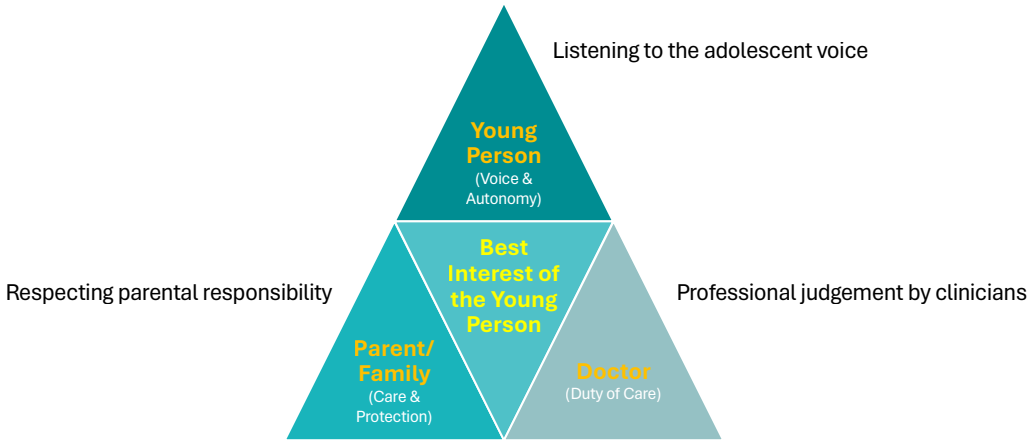
I often think back to the young girl I met early in my career. If her doctors had simply insisted on medical treatment, we might have missed the deeper crisis unfolding within her family. If confidentiality had been handled poorly, the fragile trust needed to bring her parents into the conversation might never have developed. What ultimately helped her recover was not a legal concept or a treatment protocol, but a willingness to listen, to understand and to create space for reconciliation. When her father finally told his daughter that he still loved her despite everything that had happened, it changed the course of that family's story.

In adolescent medicine, we often talk about autonomy, competence and consent. But sometimes the most powerful intervention is simply helping families rediscover the bonds that were there all along. ◆

A/Prof Fung is a father of five and grandfather of five, which are experiences that have taught him to live with stress, uncertainty and joy in equal measure. A lifelong supporter of Tottenham Hotspur, he has learnt resilience and the discipline of hope. His tenure as CEO of the Institute of Mental Health prepared him well for his current role as chief wellness officer at NHG Health.

Figure 2: Triangle of adolescent decision-making

Adolescent healthcare decisions often require balancing three perspectives: the young person, the parents, and the healthcare professional. The best interest of the young person remains the central guiding principle.



Unlock Prosperity in the Year of the Horse!

Text by Joanne Ng, Deputy Manager, Membership Services

SMA hosted a complimentary Chinese New Year talk titled "Unlock Prosperity in the Year of the Horse", in collaboration with Standard Chartered Bank, on 30 January 2026. About 70 participants (including Members and their guests) attended the event at the Connect Zone, Level 21, Marina Bay Financial Centre.

The evening featured a talk by Master Terelyn, a renowned expert in Chinese metaphysics, who shared insights on harnessing the power of the Year of the Horse for financial success. Master Terelyn, with over 13 years of industry experience, has spoken for over 120 leading multinational corporations and is a trusted voice on Mediacorp LOVE 972 and CAPITAL 958 radio stations. Her unique approach makes Chinese metaphysics relevant, practical and results-focused for today's corporate audience.

The programme kicked off with a buffet dinner and champagne at 7 pm, followed by an opening speech by Liana Lau, Executive Director, Affluent Client, Standard Chartered Bank. Master Terelyn then took the stage, sharing valuable insights on wealth and investment, career, love and relationships, health and more. Attendees also learnt about lucky colours, foods, crystals and activities to boost prosperity in the coming year.

Additionally, the event featured a session on "Building Additional Income for Retirement" and a priority banking onboarding segment. Attendees enjoyed ample opportunities to network with fellow doctors and guests, making the most of the relaxed atmosphere.

The event was part of SMA's efforts to provide Members with unique opportunities for personal and professional growth while fostering connections within the medical community. ◆

Legend

1. Gathering for a prosperous year ahead!

2. Food for thought (and belly) at our Chinese New Year event

3. Smiling faces and abundant blessings

4. Good company, good vibes, good feng shui

5. Master Terelyn sharing prosperity tips with participants

Passing the Torch: Succession Planning and Local Art Showcase

Text by Joanne Ng, Deputy Manager, Membership Services

On 9 January 2026, SMA hosted a rerun of the succession planning talk for doctors at the AIA Wealth Centre, generously sponsored by Precepts Trustee and RISE (representative of AIA). The first run of the talk took place on 19 September 2025 and drew many requests for a rerun. This second session focused on helping doctors safeguard their practice and prepare for the future with confidence.

41 attendees gained valuable insights on succession planning, including how to make sound long-term decisions that will support both their professional and personal goals. The talk emphasised the importance of forward planning, with speakers sharing practical strategies, such as the use of standby trusts to ensure seamless clinic succession, minimise disruption and provide peace of mind.

The highlight of the evening was a series of real-life case studies, which brought the topic to life and illustrated the complexities of succession planning in practice. These examples offered relatable scenarios and gave participants a clearer sense of how to structure their own succession plans.

The session also addressed pressing questions many practitioners face, including:

- What happens to my clinic if I pass away unexpectedly?
- Can I pass my clinic to non-doctor children and have them engage a medical professional to continue operations?

Beyond the insights, the evening was also a chance for fellowship. Guests enjoyed a buffet dinner with champagne and the opportunity to reconnect with friends and fellow colleagues they had not seen in some time. The blend of practical learning and warm camaraderie made the event both thought-provoking and enjoyable.

The event also featured a curated display of local artworks by renowned artists such as Cheong Soo Pieng, Chen Wen Hsi, Ong Kim Seng, Lim Tze Peng, Tan Choh Tee and Ang Ah Tee, adding a touch of local culture to the evening. The art showcase complemented the talk well, providing attendees with a unique opportunity to appreciate Singapore's rich artistic heritage while networking with peers.

A bonus segment featured AIA sharing wealth solutions tailored for high-net-worth individuals, helping doctors build, grow and preserve multi-generational wealth.

The event was well received, and SMA extends its heartfelt thanks to Precepts Trustee and AIA for their generous support. Their contributions made it possible for Members to gain valuable knowledge, practical insights and fresh perspectives on succession planning and legacy protection.

Appreciating local art and planning for the future

Getting ready to unlock the secrets of succession planning

HAIG Mentorship Programme Concludes with *Appreciation Dinner*

Text by Joanne Ng, Deputy Manager, Membership Services

The SMA Health Administrators Interest Group (HAIG) wrapped up its mentorship programme with a heartwarming appreciation dinner on 22 January 2026. Established in July 2025, the mentorship programme aimed to pair experienced healthcare leaders with budding professionals, fostering growth and knowledge sharing. Over the past six months, a total of three mentors and five mentees were matched based on their interests and career goals, engaging in regular check-ins and discussions.

The three esteemed mentors, Dr Wong Chiang Yin, Adj Prof Raymond Chua and Dr Foo Chuan Kit, generously shared their expertise and insights with the mentees. At the dinner held at Fu Lin Men Grandeur at Novotel Singapore on Kitchener, mentors and mentees finally gathered to close the 2025 mentorship programme with an appreciation dinner.

Mentees took the opportunity to express their gratitude for the opportunity to learn from their mentors. Dr Steven Shen thanked the organising team comprising Dr Roland Xu, Dr Smily Lock, Dr Janise Lee and Dr Yeo Jia Xuan for organising the programme, and said to the mentors: "Really appreciate all the mentors for investing your time in us and sharing your experience and wisdom." Dr Daniel Lim also shared his appreciation: "Big thank you to the organising team and thank you to the mentors (especially to Prof Raymond) for the advice and insights!" Dr Lim also added: "It was great meeting with everyone for dinner; food was good and conversation even better!"

The dinner marked the successful conclusion of the 2025 mentorship programme, strengthening relationships and laying the groundwork for future collaborations. HAIG extends its sincerest gratitude to Dr Wong, Prof Chua and Dr Foo for their dedication and mentorship, which has undoubtedly made a lasting impact on the next generation of healthcare leaders.

For those interested in joining HAIG, please reach out to membership@sma.org.sg. ◆

THE ANNUAL NATIONAL MEDICO-LEGAL SEMINAR

THE LAST DECISIONS: MEDICO-LEGAL PERSPECTIVES ON END-OF-LIFE CARE

17 to 18 Oct 2026

One Farrer Hotel

Day 1: 4 MME/CPE/CPD Points
Day 2: 2 MME/CPE/CPD Points
Max 5 MME points

Day 1 – 17 October 2026

Time	Programme
8.30 am	**Registration**
9 am	**Opening address**
9.05 am	**Introduction** Adj A/Prof Vishal G Shelat | Organising Chairperson, ANMLS 2026; Associate Director, SMA Centre for Medical Ethics and Professionalism (SMA CMEP); Senior Consultant, Tan Tock Seng Hospital (TTSH)
PLENARY	
9.10 am	**(A) End-of-life decision-making: Clinical realities and legal standards** Prof Richard Huxtable | Director and Professor in Medical Ethics and Law, Centre for Ethics in Medicine, University of Bristol
9.40 am	**(B) Artificial nutrition and hydration at the end of life: Obligations, limits, and liability (terminal cancer or advanced dementia case)** Prof Choo Wee Jin, Philip | Emeritus Consultant, TTSH
10.20 am	**Tea break**
CORE DOCTRINES IN END-OF-LIFE CARE	
10.40 am	**Palliative sedation vs medical euthanasia: Ethical, legal and communication boundaries** Prof Lalit Kumar Radha Krishna | Senior Consultant, National Cancer Centre Singapore
11.15 am	**Communicating end-of-life matters: Truth-telling, conflict management and cultural realities** Dr Hum Yin Mei, Allyn | Centre Director (Palliative Care Centre for Excellence in Research and Education), TTSH
11.45 am	**Panel discussion: Core doctrines in end-of-life care** Moderator: Prof Chin Jing Jih | Deputy Group Chief Executive Officer (Clinical & Academic Development), NHG Health Panellist: All speakers
12.05 pm	**Lunch**
MEDICAL FUTILITY DEBATE	
1.15 pm	**Medical futility debate: Should doctors ever provide treatment they believe to be non-beneficial?** Judicator: Edmund Kronenburg | Managing Partner, Braddell Brothers Proposition: • Prof Chin Jing Jih • Prof Richard Huxtable Opposition: • Dr Michael Dunn | Associate Professor and Director of Education, Centre for Biomedical Ethics (CBmE), National University of Medicine (NUS) • Mr Melvin See | Senior Partner, Dentons Rodyk
2.25 pm	**Floor debate** All speakers

**The organisers reserve the right to make changes to the programme. Any updates will be communicated as necessary.*

Day 1 – 17 October 2026 (cont.)

Time	Programme
2.45 pm	**Tea break**
	INTERPROFESSIONAL MULTIDISCIPLINARY DISCUSSION OF END-OF-LIFE ISSUES
3.15 pm	**Multidisciplinary discussion of end-of-life issues** Adj Asst Prof Neo Han Yee | Chair (Programme Evaluation Committee (PEC), Palliative Medicine Residency Programme), TTSH Ms Lin Jingyi | Principal Medical Social Worker, TTSH Ms Fionna Yow Chunru | Advanced Practice Nurse, TTSH Ms Ruby Lee | Co-Director, Pro Bono Centre (PBC), Yong Pung How School of Law, Singapore Management University
4.20 pm	**Panel discussion** Moderator: A/Prof Devanand Anantham, Executive Director, SMA CMEP Panellists: All speakers
4.45 pm	**Closing**
5.00 pm	**End of seminar**

Day 2 - 18 October 2026

Time	Programme
8.30 am	**Registration**
8.55 am	**Introduction** Ms Mar Seow Hwei | Senior Partner, Dentons Rodyk
9 am	**End-of-life care in the perspective of primary care and public policy: Taking the experience in Hong Kong** Prof Albert Lee, Emeritus Professor of Public Health and Primary Care, The Chinese University of Hong Kong; Senior Research Fellow, Centre for Medical Ethics and Law, University of Hong Kong; Vice President (Asia), World Association for Medical Law
9.50 am	**Risk management in end-of-life care: Documentation that helps or hurts** Ms Vanessa Yong | Director, Legal Clinic LLC
10.30 am	**Tea break**
10.50 am	**Ethical stewardship in end-of-life care: The nursing perspective** Sister Geraldine Tan | Provincial Leader, Canossian Daughters of Charity
11.20 pm	**Artificial intelligence and prognostic tools in end-of-life decision-making** Dr Voo Teck Chuan | Head, Office of Ethics in Healthcare, Innovation and Research Advisor, SingHealth Duke-NUS Medical Humanities Institute
12.00 pm	**Closing**
12.15 pm	**End of seminar**

**The organisers reserve the right to make changes to the programme. Any updates will be communicated as necessary.*

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The Final Tapestry

Text by Christic Moral

Christic is a second-year medical student at King's College London and is the Editor of the 31st SMSUK executive committee.

As the end of the year slowly comes into sight, we often wonder how time seems to be so fleeting. It feels like it was mere moments ago that we were finding our footing amid everything new, with a myriad of encounters waiting to shape us. Like the threads on a loom slowly taking shape and revealing their picture, we begin to mould our identity, strengthening our resolve for what comes ahead. The challenges that come will call our progress into question and test our dedication. Even with everything we have learnt, it is natural that uncertainty about the future persists. As I reflect on these thoughts, the lyrics of Fleetwood Mac's "Landslide" come to mind:

Can I sail through the changin' ocean tides?

Can I handle the seasons of my life?

As spring approaches and flowers begin to bloom, we too begin to show the fruits of our growth. Alongside our personal growth, our community continues to create moments of connection, offering both support and space for us to flourish, reminding us that growth can also come through other means. Our weekend trips to Tenerife and Vienna gave members a much-needed time to rest and enjoy each other's presence. Keeping true to our commitment to learning, we also held our Annual Summit in collaboration with Malaysian Medics International UK and the Hong Kong Medical Society of the UK, offering workshops to both challenge and develop our members' medical knowledge and skills. These experiences, woven into our tapestry, give us a little more certainty, reminding us that we have a community to lean on and a matured sense of purpose. In this edition of Letters from the UK, Carolyn shares with us the strength that she found throughout the year and the resilience that keeps her going.

Text by Carolyn Por

Carolyn is a first-year medical student studying at University College London.

The journey through my first year of medical school in the UK has been one of the most meaningful experiences of my life – the excitement, the adrenaline and the deep sense of privilege that comes with studying medicine. Yet there have also been moments of doubt, low mood and exhaustion when the six-year journey ahead feels long and demanding. However, as the saying goes, "When the going gets tough, the tough get going." These moments have taught me resilience and reminded me of the strength that emerges through adversity.

When times get difficult, the community around me becomes a powerful source of motivation. I am privileged to have a close group of friends in medical school who understand the pressures and intensity of the course, which helps ward off the sense of isolation. Simple moments, such as sharing meals together, allow us to unwind, ease our stress and support one another. We openly talk about our uncertainties, encourage each other academically and emotionally, and reassure one another, especially before

assessments. I fondly recall a time when a friend offered some words of encouragement, as well as academic help, when I was feeling overwhelmed before a test. To relieve my nerves, she offered to have revision sessions together, where we could check each other's understanding and build on each other's knowledge. This truly helped me consolidate my learning and, more importantly, feel less alone in facing this challenge. We also uplift each other by looking forward to meaningful moments beyond academics. For example, planning a visit to Winter Wonderland after our first assessment gave us something to look forward to and reminded us to celebrate small milestones. Beyond academics, these friendships provide reassurance and stability, especially since we are far from home. They remind me that university life is not defined solely by academic achievement but also by the meaningful relationships we build along the way. This sense of belonging transforms challenges into opportunities for growth.

When the demands of studying feel overwhelming, what motivates me is the opportunity to grow through challenges. Medicine is demanding, and there are moments when the volume and complexity of material can feel daunting. However, after seeing real patients, I realised that these challenges, significant as they are, pale in comparison to the struggles faced by many patients. With a greater understanding of this profession, I decided to see these challenges as part of the learning process rather than obstacles. Each difficult concept understood and each assessment completed builds my confidence and resilience. Over time, I have learnt to trust that persistence and consistent effort will gradually turn uncertainty into understanding. This growth mindset helps me stay motivated, reminding me that the skills I am developing to overcome challenges will not only be useful in medicine but also in many other aspects of life.

Although I am far from home, the support of my family remains an unwavering source of strength. Sharing a close bond with them reassures me that I am never alone in this journey. Even from afar, their words of encouragement bring warmth, comfort and renewed motivation. Knowing that they believe in me gives me the strength to continue, even during difficult times.

While there is still a long journey ahead, my experiences in the UK have reassured me that challenges provide opportunities which can shape me into a stronger and more resilient individual. This journey is not only about gaining knowledge but also about growing as a person, creating meaningful memories and ultimately becoming a compassionate and competent healthcare professional. ◆

Legend

1. Enjoying the scenic views after a morning hike up Montana Chayofita in Tenerife

2. SMSUK members gather for a photo at the fountains of the Vienna State Opera

3. Getting ice cream after our first formative examination

Photo: SMSUK

Photo: SMSUK

Photo: Carolyn Por

Opportunities for Exploration: Bringing Care to Patients Outside the Hospital

Dr Joseph and his new friend exploring Gardens by the Bay

Text and photos by Dr Koh Jun Rui Don

This article was first published in the Jan - Jun 2025 issue of MSKSC Newsletter, available at https://bit.ly/421vVWm. Reproduced with permission.

On 8 November 2024, Changi General Hospital's (CGH) Orthopaedic Surgery Department partnered with Cerebral Palsy Alliance Singapore (CPAS) for a community outreach event at Gardens by the Bay. The initiative brought together medical professionals and children with cerebral palsy for a day of meaningful connection outside the hospital.

The birth prevalence of cerebral palsy is estimated to be 1.4 to 2.2 per 1,000 in high income countries. This condition is found to result from early childhood brain damage, leading to symptoms ranging from permanent movement disorders to intellectual disabilities. Many of these children face daily challenges such as mobility limitations and communication barriers. Families of the affected are likewise involved in continuous medical and therapy follow-ups.

CPAS was established in 1957 with the vision of empowering those affected with cerebral palsy or multiple disabilities to realise their full potential, as well as lead fulfilled and dignified lives. CPAS currently serves over 800 clients, ranging in age from infancy to 55 years, through the provision of early intervention, special education, rehabilitation and vocational training services.

Against the backdrop of the iconic Supertrees and lush gardens, volunteers from CGH as well as children and members of CPAS enjoyed an exciting day of interaction. The event began with members from both sides being paired up and getting acquainted before embarking on a route which brought them through the Flower Dome and Cloud Forest. The fun-filled day concluded with a delicious meal together at the Jurassic Nest Foodhall.

The event, partially sponsored by Dr Low Boon Yong, Emeritus Consultant at CGH Orthopaedic Surgery, was first conceived as a way to extend care to patients beyond the scope of clinical practice. It created profound moments of joy while reinforcing the belief that every child deserves opportunities for exploration regardless of their physical limitations. Dr Andy Yeo, Head of CGH Orthopaedic Surgery, emphasised that similar outreach programmes could be implemented across other hospital departments. "We hope this will spark thinking about how we can give back to the community beyond providing clinical care," he reflected.

The department plans to make this a regular event, with the next outing scheduled for 2026. Other means of community outreach in the works include planning for roadshows for degenerative conditions such as osteoarthritis, which is gaining relevance due to Singapore's ageing population.

This initiative showcased how simple, thoughtful gestures can transform lives. By breaking the routine of hospital visits, both patients and clinicians experienced a day filled with laughter and sensory exploration. As healthcare evolves, initiatives such as these remind us that healing happens beyond hospital walls – as doctors, we treat people, not just conditions. Through empathy and understanding, medical professionals can create experiences that acknowledge the whole person, emphasising the critical importance of emotional and social support in comprehensive patient care.

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

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Volunteers from CGH Orthopaedic Surgery enjoying a day out with CPAS clients and members

Dr Koh is currently an orthopaedic surgery resident with Singapore Health Services. He enjoys organising and participating in community outreach programmes in his free time.

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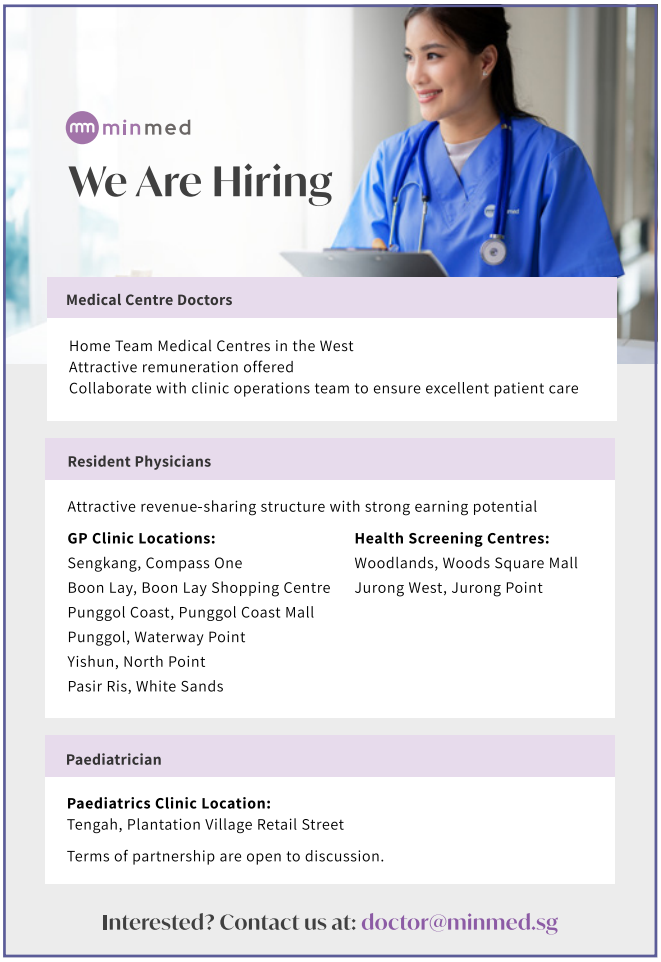

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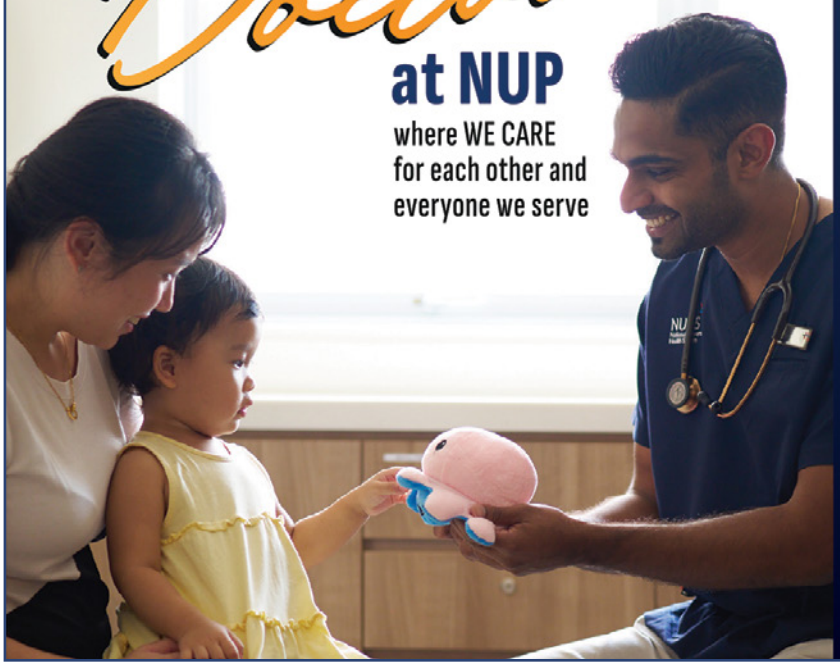

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