SMA news

For Doctors, For Patients

VOL. 58 NO. 7 | JULY 2026 | MDDI (P) 057/04/2026

SCAN TO READ ONLINE

Creating Symphony:
Pursuing Musical Passions

Mental Capacity
Assessment for LPAs

DukeNUS
Medical School

Training that truly shines

"Duke-NUS training truly shines in the practical knowledge not found in textbooks. Through hands-on workshops, I learned the realities of patient care and teamwork. Beyond clinical skills, what sets 'Dukies' apart is our diverse backgrounds. We each bring a unique past life to the table, using those different perspectives to strengthen our medical teams and better serve the wider healthcare community."

Dr Wharton Chan
House Officer
SingHealth Postgraduate Year 1
Duke-NUS Class of 2025

SingHealth DukeNUS
ACADEMIC MEDICAL CENTRE

Chart your path in medicine.
Explore Duke-NUS' graduate-entry
MD programme today.

SMA news
Vol. 58 No. 7 | 2026

PUBLISHER
Singapore Medical Association
166 Bukit Merah Central
#04-3531 Eagles Center
Singapore 150166
Tel: (65) 6223 1264
Email: news@sma.org.sg
URL: https://www.sma.org.sg
UEN No.: S61SS0168E

DESIGN AGENCY
Oxygen Studio Designs Pte Ltd

PRINTER
Midas Asiapac Pte Ltd

CONTENTS

Editorial
04 The Editors' Musings
Dr Tina Tan and Dr Lim Ing Ruen

Feature
05 Creating Symphony: Pursuing Musical Passions
Dr Ellie Choi and Dr Bertha Woon

Council News
09 Highlights from the Honorary Secretary
Adj A/Prof Ng Chew Lip

Event
10 A Fruitful Evening of Networking and Insights
Joanne Ng

SMA CMEP – Medical Ethics
11 Ethical and Professional Duty for Appropriate MC Issuance in Telemedicine
Dr Vishal G Shelat

SMA CMEP – Medical Practice
14 Mental Capacity Assessment for LPAs: A Practical, Process-Driven and Proficient Approach
Dr Nurul Ibrahim, Dr T Thirumoorthy and Dr Giles Tan Ming Yee

AIC Says
18 New Tools, Stronger Partnerships for Better Outcomes
Agency for Integrated Care

Eulogy
22 Commemorating Dr Henry C Lee
A/Prof Cuthbert Teo, A/Prof Stella Tan Wei Ling and Dr Shawn Lee

24 In Memoriam: Dr Chew Beng Kheng (1933–2026)
Dr Kanwaljit Soin

Reflections
25 Kindness to Children
Dr Tan Su-Ming

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.

Did you know that there is a musical group called Meditunes? Or that Gleneagles Hospital was home to the Singing Doctor's Society? Neither did I.

This month's offerings feature two of our musically talented colleagues, Dr Ellie Choi and Dr Bertha Woon, who each share about their skills beyond medicine and how they nurture their artistic sides. Dr Choi's write-up, in particular, contains tongue-in-cheek advice for doctors attempting to nurture the same talents in their children and themselves.

We have also included a variety of other topics – from a childhood reflection by Dr Tan Su-Ming to heartfelt commemorations of two medical giants who, for various reasons, have left a profound impact during their illustrious careers. Then, there are also the thorny subjects of medical certificates in telemedicine and durian parties (I absolutely intend the pun).

Enjoy.

DR LIM ING RUEN

Guest Editor

Dr Lim is an otorhinolaryngologist and rhinologist with fellowship training from the Hospital of the University of Pennsylvania (UPenn). She runs a private practice in Mount Elizabeth Medical Centre. Other than being on the Operating Room Committee and the Proton Therapy Tumor Board, she is also into art appreciation.

July marks the start of the second half of the year when most people have returned from a relaxing mid-year holiday. In tune with this light-hearted period, this issue features doctors who are multitalented in both the rigorous field of medicine and the ritualistic field of performance arts.

The performing arts are a powerful form of communication. They are dynamic art forms ranging from theatre to dance to comedy to music. Artists weave a dramatic narrative with their voices, bodies or instruments. One might think that dramatic communication and the practice of medicine are two polarising ideas. However, that is far from being the truth. Medicine is both a delicate art and a hard science. The accomplished physician hones the art of showmanship with a practised tone, body language and active listening skills. Effective communication is the cornerstone of compliance and successful delivery of treatment.

Performing artists are also sensitive listeners. History abounds with famous musician-doctors. Dr Rene Laennec (1781–1826), French physician and flautist, was the inventor of the stethoscope and the father of clinical auscultation. Dr Leopold Auenbrugger, Austrian physician and composer, discovered in 1754 that percussion of the chest could reveal hidden fluids or tumours. Dr Theodor Billroth (1829–1894), German surgeon and musician, is widely regarded as the father of modern abdominal surgery (famous for pioneering the Billroth I and II gastrectomy procedures) and was a close confidante of composer Johannes Brahms, who dedicated his two *Opus 51* string quartets to Billroth. Tao Hongjing (456–536), courtesy name Tongming, was a Chinese alchemist, astronomer, calligrapher, military general, musician, physician and pharmacologist during the Northern and Southern dynasties period. A good listener makes a good doctor. A sensitive listener makes an exceptional doctor.

With this issue, we celebrate our talented, musically inclined physicians among us. ◆

Creating Symphony: Pursuing Musical Passions

Our colleagues have many passions and pursuits beyond their medical practice. In this Feature, *SMA News* invites Dr Ellie Choi and Dr Bertha Woon to share about their experiences in the performing arts, how they developed a passion for their musical craft and how it has enriched their lives.

Text and photos by Dr Ellie Choi

Dr Ellie is a consultant dermatologist. She plays the harp and keyboard alongside a group of healthcare professionals in a band called Meditunes, which most commonly performs at healthcare, charity and community events. She was the principal harpist in the NUS Symphony Orchestra and is now part of the NUS Alumni Orchestra.

What does it take to become musical? I was invited to write about being a harpist, but since the harp ranks low on practical concerns, I have instead highlighted tips for picking up an instrument. Whether it is for yourself or your child, I hope you will find this helpful.

Consider noise pollution

In the early stages, "practice" sounds nothing like music and more like misplaced ambition with volume. As the adage goes, choose your suffering wisely. Some instruments are more beginner friendly, including fixed pitch instruments like the guitar or piano that you simply pluck or press to release a note. In contrast, most string and wind instruments require precise finger placement, mouth position and breath control before a stable note emerges.

Volume is also another consideration – higher-frequency instruments like the violin and flute are particularly screechy and brutal compared to deeper and more resonant instruments such as the cello and saxophone. Drums and brass instruments also tend to rumble through an entire apartment.

1

Transferable music skills

The upside of suffering through a variable pitch instrument is that it trains the ear and forces the player to calibrate as he/she plays, leading to early pitch discernment.

Music reading-wise, the piano, organ, harp and harpsichord are the only instruments reading both the treble and bass clefs simultaneously, building theory and a broader understanding of harmony and structure that transfers well into learning a second instrument. Other instruments tend to read only the treble or bass clef, and the viola is the sole user of the alto clef.

Solo value and public appeal

Many parents – much to their children's chagrin – would like a resident home performer. If you have just one child to press into service, instruments covering

both melody and accompaniment like the piano and Chinese instruments like the guzheng and yangqin are best. If you are lucky (or to some, unlucky) enough to have more children, or willing company to play with, then the world opens up. A looping pedal can also allow instruments like the violin and cello to layer phrases in real time, forming your own ensemble.

For public engagements, an unusual instrument like the harp can compensate for mediocre skill. Vocals, keyboard and guitar are popular preferences, but they also dominate mainstream music, and the average listener will be more discerning.

Orchestras

There is a particular joy to playing in an orchestra. 50 individuals sharing the stage, no longer producing individual sounds but a single rich body of music that envelops you in true surround sound and stirs you from deep within. That said, orchestral practice was when I wished I had picked a more common instrument like the violin. Many pieces have no harp parts and I spent much of our rehearsals not playing. Even pieces that featured the harp were punctuated by long stretches of rest where I would count 60 bars of silence.

Other practical considerations

Instruments are financial, spatial and logistical commitments. Apart from the cost of the instrument, space and portability should be considered too. A piano needs sizable space in a home while a flute needs only a drawer. Instruments with mouthpieces may potentially affect dental or jaw development. Wind instruments build lung capacity, but be careful of the self-inflicted Valsalva manoeuvre and raised intrathoracic pressure.

My musical journey

Now, did I consider any of this? Of course not. As a 16-year-old, I simply did not want to walk to the MRT alone after school, so I followed a friend to the harp ensemble co-curricular activity open house during orientation week. Peer pressure did the rest.

Having learnt the piano prior made learning the harp faster, and friends made it enjoyable. This was vastly different from the tearful, dreaded piano lessons of childhood. You do not need to love music to start playing it. I certainly did not – and still have no strong love for music in the abstract.

Perhaps that is the real gift of learning music. Not talent, nor taste, nor some grand love. But the chance to grow into something through the simple act of returning to it regularly. The learning came first. The appreciation came later. And somewhere along the way, what began as peer pressure became something worth keeping.

Legend

1, 3. Harps come in various sizes ranging from the standard concert harp (47 strings, pedal operated) to lap and floor harps (20-40 strings, lever operated)

2. Making music accessible through community

4. Meditunes is a music group made up of healthcare professionals (non-cluster specific) who perform for hospital, charity and community events

Text and photos by Dr Bertha Woon

Dr Woon is a breast and general surgeon in solo practice at Gleneagles Hospital for the last 21 years. She helps her patients get their troubles off their chests. She is in the process of becoming minimalist. In her free time, apart from music, she volunteers and does Tai Chi.

I started learning music (piano and the Electone) around three years old. At nine years old, my piano teacher's professor felt that I was gifted and wrote me a recommendation to study music at the University of Edinburgh. My parents declined because they thought I needed to at least have my PSLE. However, they took his advice to nurture a gifted student seriously and supported me to study five instruments (piano, Electone, pipe organ, oboe, cor anglais), composition and arrangement. I had a total of 12 excellent music teachers.

As a musician, I peaked at 18, playing first oboe in the Singapore Youth Orchestra (SYO). Just as my teacher applied to the Munich Conservatory for me, I was informed that I got a place at NUS Medicine. My oboe teacher, Lei Rong, advised me that I could be a doctor who played the oboe and people would clap for me to give me face because I am a doctor. However, the reverse would not happen. His classic line "傻孩子！如果有其他路可走，就别走音乐这条路" ("Silly child! If you have another path to take, do not choose music.") echoes in my memory to this day, especially when wind musicians were unable to perform much during the COVID-19 pandemic.

Music or medicine?

In medical school, for the first six months, I kept dreaming that I was at orchestra rehearsals and woke up during tacet.[a] I questioned if I had made a wrong choice. I had difficulty playing my oboe for years during medical school due to the irregular class schedule and issue of finding other musicians to play with. My reeds (organic mouthpieces) wore out often and needed regular replacement. Furthermore, one can only play oboe on an empty stomach and after brushing and flossing our teeth.

Meanwhile, I played piano and organ for church services and as a church choir accompanist. Altogether, I played for various churches from age nine to just before the COVID-19 pandemic. Part of my reason for stopping piano was a wrist injury sustained after retracting a 1 kg breast during a skin-sparing mastectomy. My physiotherapist, who happens to be a clarinettist, told me to choose between my career and my hobby. Musculoskeletal injuries of the upper limb are common amongst musicians and can be career-crippling. Thankfully, I have recovered and can continue in my career as a surgeon.

Blending work and play

My oboe playing resumed when I started private practice 21 years ago. I had time to visit the Loree Paris oboe workshop to overhaul my instrument and fix the springs, warped cork joints and leaky key pads. I co-founded the Singing Doctors Society based at Gleneagles Hospital. We performed charity concerts at the Istana for the late President SR Nathan and at the Esplanade for the late Mrs Lee Kuan Yew. This Society was dissolved last year.

For SG50 in 2015, my conductor, cultural medallion winner Ms Vivien Goh, and my fellow SYO alumni got together to rehearse for the SG50 concert at Victoria Concert Hall. This concert (featuring Tchaikovsky's *Symphony No. 5* and songs by Liang Wenfu) triggered another wave of practising and performing. Some videos of this concert can be viewed at the following links:

1. https://youtu.be/xERbTpvyVI8
2. https://youtu.be/EIRLDtCWPjE
3. https://youtu.be/9B7AwfeUZvU

After that, I continued to play oboe with SYO and the Singapore National Youth Orchestra alumni at their rehearsal studio on Bencoolen Street and at the Esplanade. I also play oboe for Gleneagles Hospital now and then – I composed and performed the Gleneagles Hospital 65th anniversary song, and also performed for Mount Alvernia Hospital's Nurses' Day two years ago. For Prof Low Cheng Hock's 80th birthday, Dr Denis Cheong and I composed and performed his birthday song. Sometimes I jam with friends at the piano at the Singapore Botanic Gardens pavilion near Gleneagles Hospital as well.

My latest performance was on 13 June 2026 with D'Nightingales and Friends at Gleneagles' 67th anniversary. I played the instrumental for "You Raise

Me Up" and sang Teresa Teng's "The Moon Represents My Heart".

At work, for operations under local anaesthetic, the top playlists my patients request for are by JJ Lin, Stefanie Sun, Jay Chou, Jacky Cheung, Taylor Swift and Ed Sheeran. When I do mastectomies under general anaesthesia, I prefer listening to oboe or cello concertos. I use the pieces as time markers. For example, by the end of the first movement, I should have completed the sentinel node dissection, and by the second movement, the flaps should all be raised. By the time the concerto is over, I ought to have completed the mastectomy.

Over the last few decades, I have evolved from being a perfectionist musician to a more laid-back one who plays for fun with friends. I have to accept that without regular practice, I will never be at my original performance level. ◆

Note

a. Tacet (pronounced /ˈtæsɪt/ or /ˈteɪsɪt/) is a Latin musical term that translates to English as "(it) is silent". It is primarily used in sheet music as a performance direction instructing a particular instrument or vocal part to remain silent for an entire movement or a substantial section of a piece.

Further reading

1. Wong SM, Goh V. Rehearsal for Life: Singapore Youth Orchestra 1980-1990. Singapore: Word Image Books; 2015.

Legend

5. From left: Bertha Woon, Fong Chong Suan, Chen Zhijian in the Singapore Youth Orchestra, 1991

6. Performing "You Raise Me Up" at the 67th anniversary of Gleneagles Hospital

7. Encouraging my cousin Christina to play the piano

8. My Loree Cabart oboe in my BAM case. Double reeds being soaked

9. Singapore National Youth Orchestra alumni at the Esplanade Concert Hall

HIGHLIGHTS

From the Honorary Secretary

Report by Adj A/Prof Ng Chew Lip

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

SMC scam alert – impersonation of doctors

The Singapore Medical Council (SMC) has warned of scammers posing as SMC-registered doctors, using forged Certificates of Registration and electronic Practising Certificates to fraudulently offer medical services. Such impersonation is a criminal offence carrying a fine of up to $100,000, up to 12 months' imprisonment, or both.

Members are reminded to verify any individual's registration status via SMC's online register. Do not share personal information or make payments to unverified practitioners.

The SMC announcement can be viewed at: https://bit.ly/4y5jNT2. ◆

Calling all artists!

Do you prefer expressing your thoughts through sketches and cartoons instead of words? If you would like to add a splash of colour to *SMA News* in the form of topical illustrations and/or comic strips, reach out to us at **news@sma.org.sg** today!

A Fruitful Evening of Networking and Insights

Text by Joanne Ng, Deputy Manager, Membership Services

On 17 April 2026, SMA Members gathered at Plume Singapore at Singapore Flyer for an evening that blended two things close to Singaporeans' hearts: good durian and good conversation. The Durian Night and Wealth and Legacy Talk, co-hosted with Standard Chartered, brought together 80 Members for a relaxed night of networking, learning and durian indulgence.

Held at Plume Singapore along Marina Bay, the event kicked off at 6.30 pm with registration, light refreshments and the first wave of durians on the table. The casual setting made it easy for Members from different specialties to catch up, swap stories and meet new faces outside the clinic and hospital corridors.

The programme shifted focus at 7.20 pm with the Wealth and Legacy Talk delivered by Standard Chartered. The session addressed practical considerations for doctors at different career stages, from managing personal finances to planning for long-term legacy and wealth transfer. It was a timely reminder that financial well-being is part of holistic well-being, especially for busy clinicians balancing demanding schedules.

Following the talk, Members learned about Standard Chartered's Priority Banking Onboarding Rewards Programme. At about 8 pm, the main durian service began, with platters of premium Mao Shan Wang and Black Pearl served to all Members. The rich, bittersweet Mao Shan Wang and the creamy, slightly bitter Black Pearl were a hit, sparking lively discussions on taste, texture and personal favourites as everyone dug in.

The event wrapped up at about 9 pm, as Members left with both full stomachs and new connections. SMA thanks Standard Chartered for sponsoring this exclusive Members-only evening. With limited spots and high demand, the night underscored how much Members value opportunities that combine professional insight with genuine social connection.

Our events reflect SMA's commitment to supporting Members beyond clinical practice, fostering community and creating spaces for meaningful engagement. We look forward to seeing you at the next event! ◆

Legend

1. Our Members enjoying the king of fruits together!

2. Mao Shan Wang vs Black Pearl – the ultimate showdown! Which team are you?

Ethical and Professional Duty for Appropriate MC Issuance in Telemedicine

Text by Dr Vishal G Shelat

Dr Vishal is a hepatobiliary and pancreatic surgeon with interests in medical education, healthcare quality and bioethics. He is a senior consultant at Tan Tock Seng Hospital and a faculty member of the SMA Centre for Medical Ethics and Professionalism. He holds an MA in Healthcare Ethics and Law and has completed the CHESS Fellowship in Surgical Ethics at Washington University in St Louis.

Medical certificates (MCs) are a familiar but consequential part of clinical practice, extending beyond the doctor-patient relationship into occupational, social and legal domains. Following appropriate clinical assessment, a medical condition may render a person temporarily unfit for work or require restrictions on particular duties. In the workplace context, the MC issued by a practitioner certifies medical unfitness and the expected duration of any necessary, foreseeable absence. Appropriate sick leave supports recovery and may reduce the risks associated with presenteeism, including workplace transmission of infectious disease.[1] Issuing an MC is a professional privilege and reflects societal trust in the medical profession. This trust may be challenged when patient expectations conflict with professional judgement. Accordingly, MC issuance should be grounded in clinical assessment, functional capacity and any material risk to third parties. Employer preferences, payment arrangements and non-medical benefits must not determine the decision. The Ministry of Health's (MOH) 2024 findings concerning a telemedicine licensee including ultra-short consultations, repeated MC issuance and question-able documentation warrant professional reflection.[2]

Under the Employment Act, eligible employees are entitled to paid sick leave when certified unfit for work by a registered medical practitioner or dentist, underscoring practitioners' responsibility to issue MCs based on accurate health evaluations. However, the issuance of MCs is frequently influenced by factors far beyond purely clinical considerations. The same diagnosis or procedure may justify different periods of absence because functional capacity depends on the clinical course, recovery, commuting requirements and the actual demands and risks of the job. The relevant question is therefore not the diagnosis or procedure alone, but whether the

Table 1: Potential non-clinical influences on MC decision-making

Domain	Illustrative influences
Patient and occupational context	Job demands, commuting requirements, financial or caregiving pressures, expectations, uncertainty about recovery
Clinician	Time pressure, fatigue, clinical uncertainty, relationship bias, defensive practice, conflicts of interest
Organisation and system	Workload, commercial incentives, employer policies, continuity and availability of follow-up

patient's symptoms and functional limitations are compatible with the actual demands and risks of the job. Requests for a particular duration of leave may reflect the patient's symptoms, expectations, fear about recovery, workplace circumstances or other non-clinical considerations. Where the requested duration appears inappropriate, the clinician should explore the underlying concern and negotiate a safe plan rather than reflexively accept or reject the request.[3]

MC issuance must follow an appropriate clinical assessment, including the relevant history, functional and occupational context, and any examination or investigation that is clinically necessary and feasible. Patient preferences should be heard and considered, but certification remains the doctor's independent clinical decision. External pressures may favour either shorter or longer certification, but employer preferences should not determine the clinical decision. Thus, physicians need to manage conflicting interests by upholding the fundamental principle of medical professionalism: the primacy of patient welfare.[4] Observations highlighting the myriad factors influencing MC issuance are shown in Table 1. One should note that these illustrative and non-exhaustive factors should prompt reflection but must not substitute for clinical assessment or independently determine MC issuance or duration.

MC issuance standards in telemedicine

With the widespread adoption of technology, telemedicine has improved convenience and timely access to medical care, but it may provide less clinical information than an in-person encounter. The professional standard should not fall because the consultation is virtual; rather, the means of meeting that standard differ. Patient-assisted observations and home measurements may supplement assessment, but findings such as palpation and conventional auscultation may remain unavailable. Where clinically material uncertainty cannot be resolved remotely, the appropriate response is to arrange an in-person assessment rather than lower the threshold for MC issuance. Healthcare organisations should therefore establish clear protocols, train clinicians and ensure identity verification, informed consent, contemporaneous records, secure technology and appropriate follow-up. The National Telemedicine Guidelines 2015 provide foundational guidance, while the Singapore Medical Council (SMC) Ethical Code and Ethical Guidelines (ECEG) require doctors to endeavour to provide the same quality and standard as in-person care.[5,6]

Subsequent regulatory guidance has made these expectations more explicit. MOH Circular No. 30/2024 highlights excessive MC issuance without proper clinical assessment and repeated issuance without appropriate reassessment or follow-up.[7] Joint MOH-HSA-SMC Circular No. 87/2024 ordinarily requires real-time two-way video for patients consulting the licensee for the first time, prohibits teleconsultations from being conducted solely through self-service and text-only questions, and places active review obligations on telemedicine licensees.[8] These governance expectations were subsequently formalised in the modified licence conditions for remote provision of outpatient medical services, effective from 17 October 2025, including requirements for adequate assessment before MC issuance, escalation of repeated MCs and documented internal review.[9] MC issuance is not a standalone transaction but part of the duty of care within the doctor-patient relationship. MC decisions should not be influenced by who initiated or paid for the consultation or by non-medical benefits to the patient. Remote consultation alone

Table 2: Dos and don'ts of MC issuance

Dos	Don'ts
1. Must be issued to patients only on proper medical grounds arrived at through good clinical assessment.	1. Must not post-date or backdate the date of issue. The period covered may begin before the issue date only when the preceding absence is consistent with the clinical presentation.
2. Must be issued by the practitioner who provided care and conducted the clinical assessment; electronic generation does not transfer responsibility away from the issuing practitioner.	2. Must not amend the particulars on the MC issued by other doctors.
3. Must state the issuing practitioner's name and registration number.	3. Must not state the diagnosis on the MC, unless with the patient's consent.
4. When certifying restricted or light duties, must ascertain, as far as reasonably possible, that the workplace can accommodate the stated limitations.	4. Must not be sent directly to an employer without the patient's request or consent.

should not preclude MC issuance, but its assessment limitations must be considered. Table 2 summarises the dos and don'ts.[6,7,8,10]

Factors that may compromise appropriate MC issuance

Concerns about inappropriate MC issuance predate telemedicine. Remote delivery may amplify existing risks when assessment, documentation or follow-up is inadequate. Current professional and regulatory guidance therefore emphasises appropriate assessment, escalation and organisational review.[6–9] These risks illustrate why telemedicine should be evaluated not only for technical effectiveness but also for its ethical and social implications.[11]

First, requests for MCs often arise near the end of a consultation, when time pressure, fatigue or high-throughput workflows may encourage premature closure. These pressures do not excuse inadequate assessment, but they are foreseeable clinical governance risks. The clinician should document the medical grounds, functional impact and duration of certification, while the licensee should review patterns such as unusually brief encounters and repeated MC issuance. Second, a request for a particular duration may create interpersonal pressure to acquiesce. Continuity and familiarity can improve contextual understanding but may also introduce relationship bias. Clear explanation, explicit professional boundaries, safety-netting and an accessible route for follow-up can help preserve both the therapeutic relationship and independent clinical judgement.

Patient-reported symptoms are legitimate clinical evidence and should be assessed in context rather than regarded as either automatically sufficient or inherently suspect. The physician should consider their severity, functional impact, associated red flags and whether examination or investigation is required for safe care. Where remote assessment is insufficient, an in-person assessment should be arranged. The SMC ECEG requires doctors providing telemedicine to "endeavour to provide the same quality and standard of care as in-person medical care".[6]

Conclusion

MC issuance serves employee well-being and workplace safety but remains vulnerable to non-clinical pressures from patients, employers, clinicians and platforms. Telemedicine can improve access, yet its convenience must not convert certification into a transactional endpoint. Responsible practice requires appropriate patient selection, adequate assessment, clear documentation and escalation to in-person care when remote assessment is insufficient. Appropriate MC issuance requires professional judgement that is clinically grounded, occupationally informed and independent of extraneous pressure. The doctor remains accountable for each certificate, while the telemedicine provider must create systems that support safe assessment, follow-up and review. Protecting the integrity of MCs ultimately protects patients, employers and public trust in the profession. ◆

References

1. Widera E, Chang A, Chen HL. Presenteeism: a public health hazard. J Gen Intern Med 2010; 25(11):1244-7.

2. Ministry of Health. Issuance of Medical Certificates Following the Provision of Outpatient Medical Service. MOH Circular No. 60/2024. Available at: https://bit.ly/4wZbBm3. Accessed 13 July 2026.

3. Kravitz RL. Negotiating with patients about tests, referrals, and treatments. JAMA 2025; 333(17):1538-9.

4. Thirumoorthy T, Shelat VG. Understanding medical professionalism. Singapore Med J 2025; 66(2):114-8.

5. National Telemedicine Guidelines 2015. In: Ministry of Health. Available at: https://bit.ly/4bHYIDR. Accessed 24 March 2026.

6. Singapore Medical Council Ethical Code and Ethical Guidelines 2016. In: Singapore Medical Council. Available at: https://bit.ly/4rHcXhX. Accessed 24 March 2026.

7. Ministry of Health. Issuance of medical certificates following the provision of outpatient medical service. MOH Circular No. 30/2024. Available at: https://bit.ly/4wFUmWA. Accessed 13 July 2026.

8. Ministry of Health, Health Sciences Authority, Singapore Medical Council. Joint MOH-HSA-SMC Circular on Regulations and Professional Standards for Telemedicine Services and Advertisements. Joint Circular No. 87/2024. Available at: https://bit.ly/3Rg3IsS. Accessed 13 July 2026.

9. Ministry of Health. Notice of Modification of Licence Conditions for Remote Provision of Outpatient Medical Service under the Healthcare Services Act 2020. MOH Circular No. 64/2025. Available at: https://bit.ly/44upV9N. Accessed 13 July 2026.

10. Ministry of Health. Amendment of the Healthcare Services (General) Regulations 2021 on Additional Requirement on Medical Certificates. MOH Circular No. 76/2024. Available at: https://bit.ly/4w0GHJC. Accessed 13 July 2026.

11. Kaplan B, Litewka S. Ethical challenges of telemedicine and telehealth. Camb Q Healthc Ethics 2008; 17(4):401-16.

Mental Capacity Assessment for LPAs:

A Practical, Process-Driven and Proficient Approach

Text by Dr Nurul Ibrahim, Dr T Thirumoorthy and Dr Giles Tan Ming Yee

Under the auspices of the Office of the Public Guardian and Ministry of Social and Family Development, in partnership with SMA Centre for Medical Ethics and Professionalism, College of Psychiatrists, Academy of Medicine, Singapore, and Singapore Academy of Law, a webinar titled "Medical, Legal, and Ethical Perspectives on Mental Capacity Assessment for Lasting Powers of Attorney (LPAs)" was organised to equip certificate issuers (CIs) of LPAs with lessons learnt from recent court cases and to increase confidence in conducting mental capacity assessments for LPAs. A total of 4,383 attendees, consisting mainly of doctors and lawyers, participated in the session on 18 April 2026. Through case studies and multidisciplinary discussion, the webinar explored how medical and legal practitioners can navigate complex certification scenarios, ethical dilemmas and medico-legal risks in LPA work.

This article summarises the practical approaches, legal lessons and clinical principles shared during the webinar, translating them into a structured framework for doctors involved in LPA certification.

Growing importance of LPA assessments

The use of LPAs in Singapore has increased significantly over the years alongside greater public awareness of advance care planning and future decision-making. At the same time, disputes involving LPAs have become increasingly visible in the courts. Questions surrounding mental capacity, voluntariness, family influence, poor process and improper witnessing are now appearing more frequently in legal proceedings.

Against this backdrop, the role of the registered medical practitioner (RMP) acting as a CI has become increasingly important. Doctors are not merely witnessing signatures or completing administrative paperwork. In many ways, we function as one of the key safeguards protecting patient autonomy within the Mental Capacity Act (MCA) framework.[1]

Recent Singapore court judgements have also highlighted an important reality: the CI can inadvertently become the weak link in the LPA process if assessments are superficial, rushed, poorly documented or procedurally flawed. Conversely, where assessments are careful, contemporaneous, independent and well documented, the courts have demonstrated willingness to uphold LPAs even in elderly donors or patients with cognitive impairment.

The role of the CI

The responsibilities of the RMP acting as a CI extend far beyond deciding whether a patient "has capacity". Broadly, the doctor must assess three key domains: capacity, voluntariness and proper execution.

First, the doctor must assess whether the donor has the mental capacity to make the specific decision relating to the LPA. Second, the doctor must assess whether the decision is truly voluntary and free from undue influence or pressure. Third, the doctor must ensure proper execution of the LPA, including personally witnessing the signing process.

These domains are separate but interconnected. A donor may have mental capacity but still be acting under coercion. Likewise, capacity and voluntariness may both be present, but the LPA may still fail because of improper witnessing or process failures.

This is why LPA certification should never be approached as a mere form-signing exercise. It is fundamentally a medico-legal assessment requiring due diligence, independent judgement and careful documentation.

Mental capacity is functional

One of the most important concepts under the MCA is that mental capacity is functional, decision-specific and time-specific.[1,2]

Capacity is not determined solely by age, diagnosis, educational level, appearance or socioeconomic status. A diagnosis of dementia, schizophrenia, stroke, intellectual disability or mild cognitive impairment does not automatically mean a person lacks capacity. Likewise, advanced age alone should never lead to presumptions of incapacity.

The real clinical question is: "Can this patient make this specific decision at this specific time?" This distinction is extremely important in LPA work. Many patients with mild cognitive impairment or early dementia may still retain sufficient understanding to appoint a donee. The law does not require perfect cognition. Instead, it requires the ability to make the relevant decision at the material time. Importantly, frailty, advanced age, hearing impairment, slow speech, repetition or the need for more time should trigger better support and fuller documentation – not automatic assumptions of incapacity.

At the same time, doctors should not assess capacity in isolation from the wider clinical picture. Prior records, collateral

history, fluctuating cognition, previous assessments and evidence of progressive decline may all provide important context in interpreting the patient's presentation during the consultation.

The two-step test under the MCA

In practice, mental capacity assessment follows the statutory two-step test under the MCA.[1] The first step asks whether there is an impairment or disturbance of the functioning of the mind or brain. The second step asks whether, because of that impairment, the individual is unable to make the relevant decision.

A person is considered unable to make a decision if he/she cannot:

- Understand the relevant information;
- Retain that information long enough to make the decision;
- Use or weigh the information as part of the decision-making process; or
- Communicate the decision.[1,2]

These four abilities form the practical structure of the clinical interview.

When a patient explains what an LPA is, the doctor is assessing understanding. Revisiting the same concept later in the consultation provides informal assessment of retention. When the patient explains why a particular donee was chosen, the doctor is assessing the patient's ability to weigh information and appreciate consequences. Finally, the patient must be able to communicate a decision consistently. The assessment therefore becomes less about administering a rigid checklist and more about observing how the patient reasons through the decision in real time.

Capacity and voluntariness must be assessed separately

One of the clearest lessons emerging from recent Singapore cases is that mental capacity and voluntariness are separate concepts. A donor may have sufficient mental capacity to execute an LPA and still be acting under undue pressure or influence. This distinction is critical because the presence of capacity alone does not automatically validate the LPA.[4–8] Practically, this means the assessment cannot stop once the patient demonstrates understanding. Doctors must also explore whether the decision truly belongs to the donor.

Simple but revealing questions include:

- "Whose idea was it to make this LPA?"
- "Why did you choose this donee?"
- "Would you feel comfortable choosing someone else?"
- "Is anyone pressuring you to do this?"

These conversations should ideally occur with the patient alone. Even well-intentioned family members may unintentionally influence responses or inhibit honest disclosure.[2,3]

Doctors should also pay attention not only to what the patient says but how the patient says it. Hesitation, guardedness, fearfulness, inconsistent answers, unusual compliance or obvious rehearsed responses may all be subtle indicators of undue influence. Importantly, voluntariness assessment should not feel interrogative or confrontational. Calm reassurance and neutral questioning often facilitate more genuine responses than aggressive probing.

Why LPAs fail

Many challenged or revoked LPAs share recurring themes. Common pitfalls include superficial capacity assessments, ignored red flags, family pressure or coercion, poor documentation and improper witnessing procedures.

From a practical perspective, LPAs often fail at three levels: capacity failure, coercion or voluntariness failure, and process failure. Understanding these three domains helps doctors structure both the assessment and their documentation.

Lessons from recent court cases

Recent Singapore judgments offer valuable practical lessons for CIs.[4–8] One major lesson is that courts place significant weight on contemporaneous assessments. The court is primarily interested in the donor's functional ability at the material time – that is, when the LPA was executed.[5,8]

This means that even patients with dementia or cognitive decline may still validly execute an LPA if they retain sufficient decisional capacity at that specific point in time. Conversely, prior negative assessments or documented cognitive concerns should never be ignored or taken lightly. A recent refusal or doubtful opinion from another doctor is a major red flag.[8] Before proceeding, the CI should understand why the earlier assessment was negative and whether current findings genuinely overcome those earlier concerns.

Another important lesson concerns witnessing. Singapore courts have repeatedly emphasised that witnessing is not a clerical formality but a substantive safeguard.[5] The donor must execute the LPA in the personal presence of the CI. Doctors should never certify retrospectively, rely on pre-signed forms or accept assurances from family members that signing occurred earlier. Physical presence, identity verification, direct interaction and personal witnessing are part of the safeguard itself – not bureaucratic hurdles to bypass.

Recognising red flags in practice

Red flags do not automatically mean the patient lacks capacity or that certification must be refused. Rather, they are signals to slow down and assess more carefully. Examples include:

- Family members speaking on behalf of the donor.
- Relatives controlling the consultation.
- Excessive urgency ("Doctor, we need this done today").
- Pre-signed forms.
- Previous refusals by another doctor.
- Evidence of "doctor shopping".
- Parroting memorised phrases without real understanding.
- Fearful, hesitant or guarded behaviour.

Another important red flag is a mismatch between the donor's presentation and the decisional complexity of the document. For example, a donor may repeatedly state "I trust my son" but be unable to explain what powers are being granted, when the donee's authority begins or what would happen if family disagreements arose. These situations do not necessarily mean the donor lacks capacity, but they warrant deeper exploration.

A practical three-stage approach

One practical way to operationalise due diligence is to structure the assessment into three stages: before, during and after the consultation.

Before the assessment

The patient should be physically present and his/her identity should be verified using identifiers such as NRIC, date of birth and address. Relevant medical history should also be reviewed, particularly any history of dementia, cognitive impairment, psychiatric illness, stroke or prior concerns regarding decision-making ability.

Communication barriers should also be addressed early. Hearing aids, visual aids, interpreters, simplified language or slower pacing may all be necessary to optimise communication. Importantly, interpreters ideally should not be close family members whenever feasible.

Doctors must also ensure there is no conflict of interest. The CI must remain independent and should not have relationships that may compromise or appear to compromise objectivity.[2,3]

During the assessment

During the core assessment, the donor should ideally be seen alone. This is an important safeguard to allow the doctor to assess the donor independently, minimise the risk of undue influence and ensure the donor can speak freely without pressure or prompting from others.[2,3]

Communication style matters greatly during mental capacity assessments. Doctors should adopt a calm pace, use plain language and focus on one concept at a time. Teach-back techniques are particularly useful. Rather than relying on yes/no answers, patients should be encouraged to explain concepts in their own words.

Core questions commonly include:

- "What is a Lasting Power of Attorney?"
- "Who is your donee?"
- "What can your donee do for you?"
- "When will he/she be able to make decisions?"
- "Why did you choose this person?"

Open-ended questions are especially valuable because they allow doctors to evaluate reasoning quality rather than rote memorisation. Further questions may include:

- "What kinds of decisions might your donee make?"
- "Would this include decisions about your money or property?"
- "Would this include decisions about where you live or your medical care?"
- "Is there anything you do not want your donee to do?"

These questions help assess whether the patient appreciates the practical implications and scope of the LPA.

Witnessing: process matters

Witnessing is also a legally essential process, not merely administrative.[3,5] The CI must personally witness the execution process live, whether physical or digital. Pre-signed forms should never be accepted. Likewise, doctors should not certify execution retrospectively based on family assurances that the donor had already agreed earlier.

After the assessment: documentation matters

Good documentation is one of the strongest safeguards for both patient welfare and medico-legal defensibility.[5,8] Simply documenting "patient has capacity" is inadequate. It records only the conclusion, not the reasoning process behind it.

Strong documentation should include:

- The patient's own explanations of the LPA.
- Evidence demonstrating understanding.
- The patient's reasoning for choosing the donee.
- Assessment of voluntariness.
- Documentation that the patient was seen alone.
- Observations relevant to communication and consistency.

The key principle is simple: document not only the conclusion but also how the conclusion was reached.

Knowing when to decline

Equally important as knowing when to certify is knowing when to decline certification. Declining is not a failure. It is part of responsible clinical judgement.[2,3] Doctors should consider declining or deferring certification when:

- Significant doubt remains after assessment;
- Red flags remain unresolved;
- There are unresolved concerns regarding coercion; and/or
- Previous negative assessments cannot be satisfactorily reconciled.

The law does not expect perfection from doctors. However, it does expect careful and independent clinical reasoning. When in doubt, it is often safer to pause, seek further assessment or decline certification rather than rush through uncertainty.

Conclusion

LPA certification occupies a unique intersection between medicine, law, ethics and patient autonomy.

Singapore courts have consistently shown that superficial assessments, ignored warning signs, rushed processes and poor documentation may undermine the validity of LPAs. At the same time, the courts have also demonstrated clear respect for careful and independent clinical judgement when assessments are structured, contemporaneous and well documented.

Importantly, doctors should not become fearful of participating in LPA work. Not every assessment requires maximal scrutiny or prolonged consultation. Many patients are familiar to their GPs, demonstrate clear understanding, provide consistent reasoning and present with no significant red flags. In such situations, the process may be relatively straightforward.

What matters is proportionality – the degree of scrutiny should match the level of concern.[1,2] Straightforward cases may proceed efficiently, while cases involving cognitive impairment, family conflict, doctor shopping, rehearsed answers or coercive dynamics require a slower and more detailed approach.

Ultimately, the role of the CI is both valuable and meaningful. Doctors are not

merely signing forms. We are helping to preserve patient autonomy while serving as one of the key legal safeguards within the MCA framework. ◆

References

1. *Singapore Statutes Online. Mental Capacity Act 2008 (Cap 177A, 2010 Rev Ed) Available at: https://bit.ly/3rYAfSf. Accessed 20 May 2026.*
2. *Office of the Public Guardian. The Code of Practice. Available at: https://bit.ly/4uXVdks. Accessed 20 May 2026.*
3. *Office of the Public Guardian. Lasting Power of Attorney Certificate Issuer Guide. Available at: https://bit.ly/4uXVdks. Accessed 20 May 2026.*
4. *Law Society of Singapore v Sum Chong Mun and another [2017] SGHC 80.*
5. *Law Society of Singapore v Yeo Poh Tiang (Yang Baozhen) [2025] SGHC 136.*
6. *XYF v XYG and XYH [2026] SGFC 9.7. XYF v XYG and XYH [2026] SGFC 9.*
7. *ULP and others v ULS [2021] SGHCF 19.*
8. *WLR and another v WLT and another and other matters [2023] SGHCF 24.*

Dr Nurul, MB BCh BAO (RCSI), MRCPsych (UK), is a GP with MD Family Clinic. She previously worked in a psychiatric department across multiple subspecialties and has a special interest in mental capacity assessment. She serves on the SMA Mental Capacity Assessment and Practice Committee.

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.

Dr Tan is a neurodevelopmental psychiatrist at the Institute of Mental Health, Associate Director of SMA Centre for Medical Ethics and Professionalism, and President of the College of Psychiatrists at the Academy of Medicine, Singapore.

26 SEPTEMBER * WEBINAR * 2 MME POINTS

NAVIGATING MENTAL CAPACITY: TWO CASES, MANY LESSONS.

SCAN QR CODE TO REGISTER

26 September 2026 | 2 pm to 4.15 pm
Webinar via Zoom | 2 MME points
Complimentary for SMA Members and Fellows of the College of Psychiatrists, AMS

- Case presentations and multidisciplinary team discussions
- Managing Patient's Best Interests Without LPA: Challenges in Progressive Stroke and Care Planning
- Regaining Capacity After Deputyship: Clinical and Legal Dilemmas

Organised by SMA Centre for Medical Ethics and Professionalism and College of Psychiatrists, Academy of Medicine, Singapore

AIC SAYS

New Tools, Stronger Partnerships for Better Outcomes

by the Agency for Integrated Care (AIC)

Primary care continues to evolve as Singapore responds to changing population needs, with General Practitioners (GPs) remaining at the forefront in providing care close to home.

As healthcare needs grow more complex, greater integration and coordination across the system are needed. Therefore, the next phase of transformation under Healthier SG aims to help GPs deliver enhanced care in the community through improved information sharing, stronger digital infrastructure and new technology-enabled tools.

Building a Shared Information Ecosystem

Effective shared care depends on timely access to relevant patient information. From early 2027, the Health Information Act (HIA) will take effect, laying the foundation for community-based and shared care through more comprehensive health information sharing.

All licensed healthcare providers will be required to contribute key health information to the National Electronic Health Record (NEHR), and ensure secure and appropriate use of health data, including timely reporting of cybersecurity incidents and data breaches.

Strengthening Continuity of Care

Since 18 May 2026, Healthier SG clinics can schedule appointments for enrolled patients through the Health Appointment System (HAS). With HAS, GPs can seamlessly arrange First Health Plan consultations and annual check-ins for their enrollees, as well as flu vaccinations for those aged 65 and above. Patients will then receive an MOH-approved SMS with a secure link to confirm or manage appointments, enabling regular follow-ups and better continuity of care.

Click or scan the QR code to book your patient's next appointment on HAS

Overview of the Health Information Act (HIA)

Under this Act, healthcare providers must:

Contribute
Ensure accurate, timely and complete contribution of key health information to NEHR.

Protect and Appropriate Use
Ensure a secure connection to NEHR and protect health information; appoint only authorised individuals and maintain this access list regularly; and implement policies and practices to ensure appropriate access, collection and disclosure of NEHR information.

Report
Notify MOH of confirmed cybersecurity incidents and data breaches in a timely manner.

What should be submitted to NEHR?

Required

Key health information on services provided at medical clinics to Singaporeans, Permanent Residents and FIN Holders only. These include:

- Visit details
- Reason for visit/diagnosis
- Allergies
- Vaccinations given
- Medications prescribed/dispensed
- Referral letters
- Surgical procedures*
- Cardiac reports

Other types of service providers will be required to submit specific data types relevant to their services, e.g. dental clinics will be required to submit Dental Notes.

**Required at a later date*

Not Required

Clinics are not expected to:

- Convert and contribute all historical data
- Contribute their detailed progress notes
- Submit Laboratory/Radiology reports as these will be contributed by the Laboratories/Radiology clinics

Leveraging Technology and AI

To support more meaningful health plan conversations, a Health Plan AI beta feature will be launched on HealthHub from 27 July 2026. Leveraging generative artificial intelligence (AI), the feature develops personalised exercise plans based on an enrollee's health plan, demographics and preferences. This tool will be available as a pilot for six months for eligible enrollees who do not have any chronic conditions.

From early 2027, the Assisted Chronic Disease Explanation using AI (ACE-AI) tool will be rolled out to help GPs identify individuals at higher risk of developing diabetes and/or hyperlipidaemia within the next three years. Using anonymised health data, the tool supports earlier intervention and preventive care, reducing the risk of downstream cardiovascular events and long-term healthcare costs.

Continued Support for GPs

Delivering person-centred care at scale requires more than individual effort. These latest initiatives reflect a coordinated effort towards a more connected, data-enabled and preventive model of care.

As the primary care landscape continues to evolve, AIC remains committed to supporting GPs in meeting our community's healthcare needs over the long term.

Resources and contacts for GPs

Primary Care Pages
Stay updated on the latest developments and initiatives by MOH and AIC:
for.sg/primarycarepages

Healthier SG Playbook
Access an overview of national primary care schemes: for.sg/hsgplaybook

Further support
AM Finder
- Reach out to your PCN HQ for access to your PCN care team
- Contact your AIC Account Manager: for.sg/amfinder
- Call the AIC GP Hotline: 6632 1199
- Email: gp@aic.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) Dying matters: Law, ethics, and the end(ing) of life** 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**
1.05 pm	**Medical Protection Society (MPS) — Topic to be confirmed**
MEDICAL FUTILITY DEBATE	
1.25 pm	**Medical futility debate: Doctors should be allowed to provide life-sustaining treatment even where it does not improve the patient's condition.** Judicator: Mr Edmund Kronenburg | President, Medico-Legal Society of Singapore; Managing Partner, Braddell Brothers Proposition: • Prof Chin Jing Jih • Prof Richard Huxtable Opposition: • Assoc Prof 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
2.35 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
2.55 pm	**Tea break**
INTERPROFESSIONAL MULTIDISCIPLINARY DISCUSSION OF END-OF-LIFE ISSUES	
3.20 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.*

JOINTLY ORGANISED BY SMA AND MEDICO-LEGAL SOCIETY OF SINGAPORE

SUPPORTED BY

YOUR GATEWAY TO ANMLS 2026 STARTS HERE:

SPONSORED BY

FOR ENQUIRIES, PLEASE CONTACT: CME@SMA.ORG.SG

COMMEMORATING DR HENRY C LEE

Text and photos by A/Prof Cuthbert Teo, A/Prof Stella Tan Wei Ling and Dr Shawn Lee

Dr Henry Chung-Yu Lee (李昌钰), a towering figure in the field of forensic science, passed away peacefully at his home in Henderson, Nevada, US on 27 March 2026, at age 87. Dr Lee was interviewed by A/Prof Cuthbert Teo for a Feature in *SMA News*,[1] where he talked about his life and career. His book *Cracking More Cases* (with Thomas W O'Neil) was reviewed in the same issue.[2]

The forensic expert's beginnings

Dr Lee was born on 22 November 1938 in Rugao (如皋), Jiangsu (江苏) province, China. His parents were wealthy business owners. His family moved to Shanghai in 1942, where they lived at 1384 Xinchang Road (新长路). They then moved to Taiwan in 1945 when he was six. The transition was fraught with turmoil and tragedy. The Second Sino-Japanese War had just begun in 1937, and the Chinese Civil War in 1945. His father died while travelling separately to Taiwan, when the ship he was aboard, *SS Taiping*, collided with a cargo ship and sank. In Taiwan, the Lee family was in financial ruin, and his mother was left raising him and his 12 siblings. His mother taught her children discipline and resilience and insisted that they achieve the highest academic standards possible.

After secondary school, Dr Lee joined the Central Police College (now Central Police University, 中央警察大学), where he graduated with a Bachelor of Arts in Police Administration in 1960. Dr Lee said he chose this path because it was the only academic path he could afford, the tuition being free. He then joined the Taipei police department. When he became a captain at age 22, he was the youngest person then to have risen to that rank. In 1964, Dr Lee moved to Sarawak briefly with his wife Margaret Soong Meow Lee (married 1962), who was originally from Sarawak and whom he met while she was studying at National Taiwan Normal University. In Sarawak, Dr Lee worked as a newspaper reporter/editor. To continue his interest in forensic work, he and his wife relocated to New York, US in 1965. Margaret Lee passed away on 1 August 2017. Dr Lee later married Angel Xiaping Jiang, an entrepreneur, in December 2018, in Connecticut.

Dr Lee studied at the John Jay College of Criminal Justice at the City University of New York, where he worked multiple jobs (medical technician, waiter, and teaching martial arts which he had learned at the police academy) to pay his tuition fees and to support his family. He eventually graduated with a Bachelor of Science in Forensic Science in 1972, a Master of Science in 1974, and a PhD in Biochemistry from New York University in 1975.

An expert and public servant

Dr Lee joined the University of New Haven in 1975 and thus began his illustrious career which spanned five decades. Dr Lee transformed the university's forensic science programme, then in its infancy, into a renowned centre for forensic education. He founded the Henry C. Lee Institute of Forensic Science in 1998, a facility that serves as a bridge between academia and law enforcement.

Dr Lee worked on many high-profile cases throughout his career. His career was highly respected, but not without controversy. Dr Lee was also a dedicated public servant. From 1998 to 2000, he served as the commissioner of the Connecticut Department of Public Safety, overseeing the state police and emergency services.

Dr Henry Lee with A/Prof Stella Tan's son, Ethan, at different ages.

A mentor to all

Dr Lee frequently shared his knowledge around the world. He worked with and coached the Singapore Police Force on shooting reconstruction and pattern analysis. One notable case involving his expertise was the Kovan double murder trial, where he gave a scene reconstruction report that was submitted to the Court.

The forensic science programme at the National University of Singapore (NUS) was refined and vetted by Dr Lee. He provided advice about the methods and content of the courses.

Dr Lee was a good friend of the late Prof Chao Tzee Cheng. He gave

public lectures at NUS as part of the Chao Tzee Cheng Professorship Programme. In 2007, he first gave the lecture as part of the NUS forensic science programme. During his lectures, he shared his experiences and takeaways from his cases, and about developments in the forensic sciences. His public lectures were always packed, bringing together experts and enthusiasts alike.

In 2024, during his last lecture at NUS on the topic of crime scene investigation, Dr Lee said, "Life is a crime scene; there is only one chance, and once you miss it, it's gone." Dr Lee was supposed to return to Singapore in September 2026 for another lecture.

Just like a family member

To his students, Dr Lee was not just a teacher; he was family. He loved interacting with his students, learning more about them, going for meals together and meeting their families. Over the years, he proudly watched his students blossom into leaders in their fields and watched their children grow up. This closeness went both ways, where students of his were also introduced to his family.

Dr Lee also created a platform for learning and collaboration among his students. For example, NUS students had the opportunity to learn and do research with Prof Chen Chun-Chieh from the Central Police University in Taipei.

His lasting legacy

Dr Lee's significant contributions in forensic science have been documented in crime investigation videos, such as in the series *Trace Evidence: The Case Files of Dr. Henry Lee*. These videos (which include the Helle Crafts case, the Ian Tracy case and the Ken Mathison cases) have been used for case discussions in the NUS forensic science classes.

In his talks, Dr Lee emphasised that forensic science is an ever-developing field. He taught that forensic science practitioners should not work in silos, and that the different fields should work together to speak one uniform truth. He also emphasised that it was very important that forensic scientists are impartial; to let the evidence speak for itself.

During lectures, Dr Lee often shared his favourite adage "Make the impossible possible", encouraging his audience to work hard in pursuit of their goals.

Dr Lee's life was a journey from a war-torn childhood to the pinnacle of international forensic science. His influence will be felt for generations to come, through the work of the thousands of students he mentored, and the rigorous standards he set for a profession that sits at the intersection of law, life and death. ◆

References

1. Teo C. Uncovering the Truth – Interview with Dr Henry Lee. SMA News 2008; 40(3):1-8.

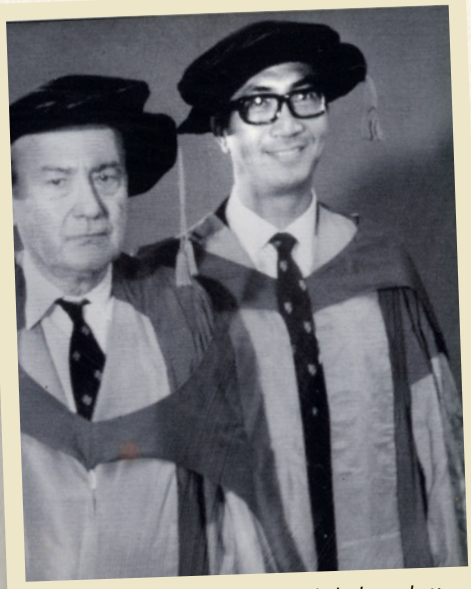
2. Jen OO. Cracking More Cases by Dr Henry C. Lee, with Thomas W. O'Neil. SMA News 2008; 40(3):14,22.

Dr Henry Lee with former students, A/Prof Stella Tan (right) and A/Prof Eugene Lee (left), 2025.

Dr Henry Lee at a dinner hosted by the Singapore Police Force (SPF), 2010. A/Prof Cuthbert Teo (standing first from right); A/Prof Stella Tan (sitting first from left); A/Prof Eugene Lee (standing first from left); Dr Wee Keng Poh, forensic pathologist (standing second from left). Other attendees are senior police officers

In Memoriam:
Dr Chew Beng Kheng
(1933–2026)

Text by Dr Kanwaljit Soin



Dr Chew Beng Kheng (right) with the legendary Sir Gordon Arthur Ransome

It is with profound sadness that we mourn the passing of Dr Chew Beng Kheng (1933–2026), a distinguished physician, dedicated mentor and tireless philanthropist.

Born in Terengganu, Malaysia, Dr Chew was one of five children raised in a family that ran a textiles business. Dr Chew was the top student at his school in the 1950s. A scholarship paved the way for his medical studies.

Following his graduation from the University of Malaya in Singapore in 1958, he travelled to England, where he served as a senior house officer at the Royal Salop Infirmary in Shrewsbury. He then furthered his medical expertise by conducting research on liver diseases at the University of London and Yale University.

His career was marked by consistent clinical excellence. In 1961, he was awarded Master of the Royal College of Physicians of Edinburgh (RCPE). Upon returning to Singapore, he worked under Prof Yeoh Ghim Seng and Prof Gordon Arthur Ransome at Outram Hospital (now Singapore General Hospital [SGH]). During his tenure in public service, he also imparted his knowledge to the next generation as a lecturer in the Faculty of Medicine at the University of Singapore. In 1970, he became a Fellow of the RCPE – distinguishing himself as one of the youngest to achieve this milestone in both Singapore and Malaysia.

To me, Dr Chew was far more than an esteemed senior colleague: he was a formative and fondly remembered teacher. I had the distinct privilege of being his student in the clinics of SGH in 1965. I was part of a tight-knit group of four female medical students – alongside my dear friends Margaret Teo, Tan Wee Khin and Grace Tan – who attended his clinical sessions. We were all struck by his approachable and friendly demeanour. I vividly remember how patiently he taught us to use our stethoscopes to discern heart sounds, making a complex lesson feel effortless. We were not only impressed by his exceptional teaching but also by his commanding presence – he was a tall, strikingly handsome man with a remarkably warm and engaging smile and a loud friendly laugh that put everyone at ease.

Beyond the hospital wards, our paths crossed again in the heart of the community in the late 1980s. We served together on the Cairnhill Community Centre management committee during a period of active grassroots work. With Dr Wong Kwei Cheong serving as the grassroots adviser, Dr Chew led the committee with great dedication as its chairman and I had the privilege of serving as a volunteer under his leadership. This period reinforced what I had learned from him earlier: that the duty of a doctor extends far beyond treating illness to truly uplifting the society around us. His wider contributions to the workforce and society were later formally recognised when he received the Friend of Ministry of Community Development and Sports Award and the Service to Education Gold Award.

Our professional relationship continued to deepen as we navigated the private sector. Dr Chew opened his private practice, Chew Da Costa Pte Ltd, in 1977. As my own career moved into private practice, our dynamic evolved from teacher and student to collaborative colleagues. We frequently referred patients to one another; he entrusted me with his patients who suffered from upper limb and hand problems, while I sent him patients requiring complex internal medicine care. Through these exchanges, I continued to learn from his immense clinical wisdom in a deeply collegial manner.

Dr Chew was also a prominent leader in the wider medical community. He served as the Honorary Secretary of SMA from 1972 to 1974. In 1973, he

headed a 22-person SMA study tour to China. During this trip, the delegation toured hospitals, acupuncture clinics and medical centres, exchanging views with Chinese doctors and witnessing global medicine firsthand.

Dr Chew lived by an ethos of uplift-ment, cementing his legacy through immense generosity. Remembering his roots, he established the Chew Beng Kheng Bursary in 2011, open to both Singaporean and Malaysian medical students, with priority given to those from his home state of Terengganu. In 2012, he funded the Gordon Arthur Ransome Gold Medal and Prizes in Internal Medicine in memory of his former mentor.

Continuing this spirit of giving, his children established the Chew Beng Kheng Scholarship in honour of his 80th birthday in 2013 to support financially needy undergraduates at NUS Yong Loo Lin School of Medicine.

Outside of medicine, his boundless energy found a home in the sporting world, where he contributed significantly as vice-president of the Singapore Badminton Association and honorary treasurer of the Asian Badminton Confederation.

Dr Chew Beng Kheng's legacy is one of clinical excellence, steadfast generosity and an unyielding dedication to human welfare. He will be deeply missed, but his spirit will live on in the countless patients he healed, the colleagues he inspired and the community he so faithfully served. ◆

Kindness to Children

Text by Dr Tan Su-Ming

I was at the petrol station today when I saw an elderly, urbane-looking gentleman in the queue ahead of me. He was buying ice cream for two young boys who looked like brothers, still in their school uniforms. Initially, I had assumed he was their grandfather, but as the conversation between the man and the cashier continued, and at the sound of the children's foreign accents, it became clear to me that he was their chauffeur.

After the trio left, the cashier told me that the chauffeur often bought the children treats and paid for them out of his own pocket. He did not seek reimbursement because his boss was good to him, and because the children – who were foreigners – did not have a mother.

That gave me a flashback to when I was five years old and attending kinder-garten. Some children had parents or grandparents waiting to pick them up after school. But I commuted each day on a school bus with many bullies.

I cannot remember the exact circumstances now – but one day after school, I was waiting alone by the school gate, and the school bus was late. There was an ice cream truck, and I remember looking longingly as other children's parents bought them icy treats. Money was alien to me then; I was never given money to bring to school.

Suddenly a kind-looking man, who looked like someone's grandfather, smiled at me. He had bought his grandchild an ice cream cone. Without asking if I wanted one, he handed me a cone. I do not remember whether I thanked him, but I hope I did. What I do remember was feeling overwhelmed – overwhelmed with joy.

The gentleman has likely passed on by now, as more than 50 years have elapsed. But that young child still remembers his act of kindness to this day. ◆

Dr Tan is a GP and graduated from the National University of Singapore. She is married, and mom to a daughter.

• SALE/RENTAL/TAKEOVER •

Keen to build your own clinical practice? We are looking for full-time anchor and locum Family Physicians and GPs to be part of our team. Come partner us in our young healthcare group! Email your CV to hello@ultimed.com.sg.

Singapore Clinic Matters Services: Singapore's pioneer clinic brokers and clinic succession planners. We buy and sell medical practices and premises. We also specialize in Legacy & Estate Planning for doctors and clinic owners. Yein – 9671 9602. https://singaporeclinicmatters.com.

Haig Road HDB shophouse next to market for rent/sale. Suitable for clinic. Please contact 9111 8587 if interested.

HDB shophouse, 1,335 sqft for sale/rent. Ground floor commercial + upper floor living (convertible). Established clinic. Prime Hougang Village — road frontage, wet market, coffeeshops, supermarket, F&B nearby. 10-min walk to Hougang MRT (major interchange NEL/CRL by 2030). Call/WhatsApp 8673 3055.

12 year old clinic 850 sqft in Jurong West Street 51 next to market/hawker center for rent. Faces main road and ample parking. Please WhatsApp 9841 3023.

81,119 sqft at Beauty World Plaza. Next to MRT for rent/sale. Currently a tuition center. Previously a clinic. Good for Physio or Aesthetic. Call/WhatsApp Mr Lim 9666 3343.

beCuriou

Travel Design | Events | Concierge

Some experiences aren't advertised.
They're shared through trusted relationships.

Relationships with the leadership behind the world's finest hotels, lodges and travel experiences create exceptional access. One dedicated expert manages your trip start to finish. Far fewer clients per specialist.
Independent advice. The privileges that come with the relationship.

Visit us at Raffles Place, or we'll come to you.

+65 3158 5168 | info@becuriou.com | www.becuriou.com

Singapore | Oslo | London | Zürich

Chosen by private clients, family offices and corporate leaders since 2013

INSURERS TYPICALLY COVER A WIDE VARIETY OF INDUSTRIES.

WE SPECIALISE IN ONLY ONE: HEALTHCARE.

Most healthcare insurance providers don't specialise – they spread themselves over a wide range of industry sectors. Our sole focus is supporting, protecting and defending healthcare professionals.

As the world's leading medical defence organisation, we have been trusted by doctors in Singapore for over 50 years.

GET THE FACTS

medicalprotection.org
Always there for you

Medical Protection

2508266778 02/26