SMA news

For Doctors, For Patients

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A/Prof Goh Lee Gan

The Case for
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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.

I wonder how many of us entered medicine without realising just how expansive and protean healthcare can be. Perhaps as medical students we had some vague idea that healthcare is... a lot. Or perhaps we had no clue what it was really like and only felt that vastness when we joined the proverbial trenches.

If there is anything this month's slew of articles has shown me, it is that medicine is not just about treating an illness or making someone feel better. Fundamentally, that is what medicine is about. But doctors do not practise in isolation. We are cogs in a massive and complex machine that only works if we understand it. How does everything come together? What do we want this machine to do? What can it *not* do? How do we maintain it to prevent breakdowns? How do we fix the parts that are not working so well? Who do we need to keep it going? Who pays for all this?

As you peruse this issue, consider that you are indeed a part of this complicated machine called The Healthcare System. Before you are pioneers who steered the direction of medicine with wisdom. Ahead of you, newly minted doctors with their own perspectives and innovative insights.

Where do you fit in?

For the record, I took a cue from the article on creative facilitation by Phylaine Toh and A/Prof Anantham Devanand, and I thank them for asking the question about body parts.

DR CHIE ZHI YING

Deputy Editor



Dr Chie is a consultant family medicine specialist working in NHG Polyclinics. She also holds a Master of Public Health from the National University of Singapore and is a Fellow of the Royal Society for Public Health. She enjoys freelance writing and has written for Chinese dailies *Lianhe Zaobao*, *Shin Min Daily News* and health magazine *Health No. 1*.

The Global Wellness Institute defines wellness as the active pursuit of activities, choices and lifestyles that lead to a state of holistic health. While one can choose to go to wellness centres to enjoy various therapies and activities, simple things like practising mindfulness, physical exercises and setting aside time to "unplug" from the digital world are also good ways for urban dwellers to relax and enjoy peace.

In this issue, we are honoured to interview A/Prof Goh Lee Gan, widely regarded as the pioneer (or the "midwife", as he prefers to call himself) of family medicine (FM) in Singapore. In this interview, he shares his personal journey in medicine, how FM has evolved over time, establishing postgraduate FM training and personal reflections.

On the topic of enhancing patient care, Dr T Thirumoorthy and Darius Lim Xiang Wen share on the intricacies of doctor-patient encounters and how our communication as doctors goes a long way in building trust and rapport with patients.

Dr John Thng, founder of NUS HealthX, a platform ecosystem designed to bring together disciplines such as medicine, engineering, design and information technology, discusses how the platform helps reimagine healthcare innovation and interdisciplinary collaboration. We also have Foo Chuan De and Woon Ting Hui, final-year medical students, sharing their perspectives and reflections on Healthier SG, our national preventive health strategy.

Last but not least, on the topic of wellness, we are delighted to have Ms Phylaine Toh and A/Prof Anantham Devanand share about creative facilitation, a structured pedagogy for guiding groups to surface reflection, emotion and collective meaning in participants from diverse professional and social backgrounds through making artworks and encouraging reflections.

As doctors, we must not forget that we are also human beings who need to take care of our health and wellness so that we can better help others achieve theirs. With that, I hope you enjoy the read and have fun "unplugging"! ◆

Paving the Way for Family Medicine

Interview with A/Prof Goh Lee Gan

Interview by A/Prof Daniel Fung, Editorial Advisor and Dr Chie Zhi Ying, Deputy Editor



A/Prof Goh Lee Gan is a family physician and a well-known figure in Singapore's medical landscape. Often nicknamed the "midwife of family medicine" for his role in pioneering family medicine training in the 1980s, A/Prof Goh has guided many batches of medical students to becoming full-fledged doctors. With the recognition of family medicine as a specialty in November 2025, **A/Prof Daniel Fung (DF)** and **Dr Chie Zhi Ying (CZY)** speak with **A/Prof Goh Lee Gan (GLG)** about his experiences in establishing and elevating the discipline of family medicine over the past decades, as well as about his good friend, the late A/Prof Cheong Pak Yean.

Journey into medicine

DF: Thank you for meeting with us, A/Prof Goh. Could you tell us about your journey into medicine, and how you became so passionate about family medicine?

GLG: I was in the science stream in Anglo-Chinese School's Pre-University Science Class B. At the time, there were two choices of study for us: engineering or medicine. I chose medicine because I thought it would be easier to study.

DF: Medicine is easier than engineering?

GLG: I was really scared of mathematics! [*laughs*] Hence, I applied for medicine, went for the interview and received a letter saying I had been accepted. I told my mother, "Mum, I got a place in medicine." And the rest, as they say, is history. The medical course at the University of Singapore was normally six years long, but those of us with good grades could skip the first year and enter as "super fresh". Of course, that meant the seniors ragged us more severely: "You think you're very smart, is it? Super fresh?"

DF: Did you stay in a hostel?

GLG: No, I was not a "hostelite". I completed my five years of study, graduated in 1971 and joined Government service from 1971 to 1976. I thought it would be good to stay there for a while.

Serving the nation and postgraduate years

DF: What about National Service at that time?

GLG: Compulsory enlistment applied to those born from 1948 onwards. I was born in 1946, so I was exempt from the usual National Service for males, but I had to join under what was called a Specific Term of Engagement. This was deferred until I had completed my medical studies. The basic medical training lasted three months and we were posted to the army camps for two and a half years. I was posted to an artillery battalion as a battalion medical officer.

CZY: Did you have a bond to serve after graduation?

GLG: I had taken a bursary of about $800 a year for my medical studies and there was a bond for five years.

DF: Tell us about your housemanship.

GLG: My first housemanship posting lasted six months in KK Women's and Children's Hospital (KKH). After my KKH posting, I went to Thomson Road General Hospital, the predecessor of Toa Payoh Hospital, which later closed in 1997. Then, for my postgraduate training, I chose internal medicine because it was such a broad specialty. I wanted to know something about everything. Internal medicine covers the body systems in adult medicine, whereas other specialties concentrate on particular organs. I wanted that breadth, and I was happy with my choice.

DF: Did you take the Membership of the Royal College of Physicians (MRCP) besides the local Master of Medicine (Internal Medicine)?

GLG: I took and passed the local Master of Medicine (Internal Medicine) examination. I attempted the MRCP but did not succeed.



A/Prof Goh Lee Gan (left) with A/Prof Cheong Pak Yean (right) and Dr Wong Heck Sing (centre) at the 1997 SMA Lecture

DF: Then you moved into general practice.

GLG: I joined Shenton Medical Group around 1976 and stayed with the group until 1987. It was a good arrangement. My background in internal medicine helped me manage the more difficult cases. Then in 1987, I was approached to join the University of Singapore, the forerunner of the present-day NUS, to teach family medicine as an undergraduate medical discipline.

Developing family medicine in Singapore

DF: Was that when the Community, Occupational and Family Medicine (COFM) Department was formed?

GLG: Yes. The Department was previously called Social Medicine and Public Health, but was renamed COFM to include family medicine. I was the first person to lead family medicine there.

DF: Where does family medicine sit in the University today?

CZY: COFM no longer exists as a combined department.

GLG: Family medicine has its own department today in the NUS Yong Loo Lin School of Medicine (NUS Medicine), led by Prof Jose Maria Valderas. There is also a Department of Family Medicine in Duke-NUS Medical School as well as the Lee Kong Chian School of Medicine.

CZY: How did you begin building family medicine?

GLG: It was Prof Chee Yam Cheng who asked me to kickstart family medicine as a discipline. We developed a collaboration among the three institutions of the Ministry of Health (MOH), NUS Medicine and the College of Family Physicians Singapore, which I think was a very good arrangement. My first task was to design a curriculum. Drawing on my experience with internal medicine, I organised the syllabus into eight modules, each lasting eight weeks. Half of them focus on population groups, such as adults and children, while the other half focuses on organ systems, such as cardiovascular, respiratory and gastrointestinal medicine.

CZY: Was this the basis for the Graduate Diploma in Family Medicine (GDFM) modules? I remember thinking they were very well structured.

GLG: Yes, it was the same framework that laid the foundation for the Graduate Family Medicine Programme.

DF: Which graduate qualification came first: the Master of Medicine in Family Medicine (MMed [FM]) or the GDFM?

GLG: MMed (FM) came first, and it was awarded by the Division of Graduate Medical Studies, NUS starting in 1993. That was our first step in postgraduate family medicine accreditation. We later launched the GDFM in 2000.

DF: As of November 2025, family medicine has become recognised as a specialty. How do the Academy of Medicine, Singapore (AMS) and the College fit into that picture?

CZY: AMS formed the Chapter of Family Medicine Physicians in 2014 and has a register of family medicine specialists.

GLG: It is a tripartite arrangement. MOH is involved in residency training; the University awards the MMed (FM) and GDFM; and the College provides training for the Fellowship of the College of Family Physicians Singapore (FCFP[S]) as well as the Family Practice Skills Course, which is the College's family medicine continuing education programme.

CZY: To clarify, the University awards the GDFM and MMed (FM), while the College runs the FCFP(S).

GLG: Yes.

DF: How do you encourage doctors to keep learning without making every stage another examination?

GLG: Continuing medical education (CME) offers one way to do that. You continue learning through CME rather than repeatedly sitting examinations. As long as you practise, you need that continuing component.

DF: In disciplinary tribunals, we often focus on sanctions for ethical or clinical failings. But what happens afterwards? How do we help a doctor learn and practise safely again? Could the Colleges provide that kind of rehabilitation?

GLG: You are right, Daniel. There should be two parts: punishment and repair. Rehabilitation is the repair. Someone who has made a mistake may face a penalty, but there should also be a way to help that person improve.

DF: At present, we can sometimes recommend a course, but we could also develop training that responds to particular gaps in practice. It could help doctors who have faced disciplinary action and others who recognise that they need to strengthen their skills.

GLG: That is worth thinking about. Once a doctor has paid for a mistake, can we help prevent it from happening again? The response should depend on the seriousness of the case. But where rehabilitation is appropriate, we should ask what would actually help the doctor change.

DF: Such courses could benefit many of us. In psychiatry, for example, we regularly ask how to help doctors practise better and avoid foreseeable risks.

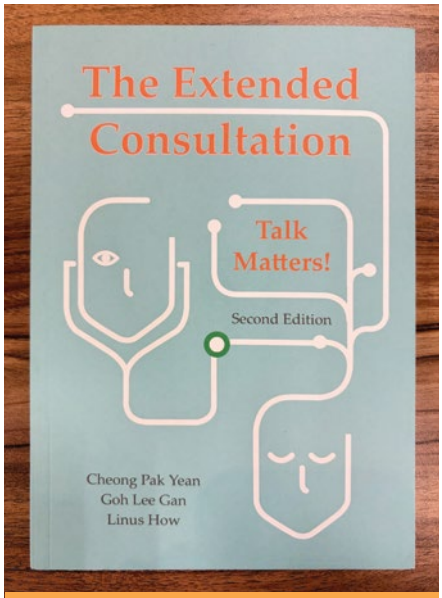
GLG: CME can help doctors practise better and avoid mistakes.

A legendary duo

DF: Let us talk about the late A/Prof Cheong Pak Yean, with whom you have been called a legendary duo. Both of you co-wrote a book titled *The Extended Consultation*.

GLG: Cheong Pak Yean developed the idea of the extended consultation. He saw that some acute problems could be addressed fairly directly, but also that other patients had deeper difficulties: problems in their relationships, family life or daily living. A consultation had to make room to recognise those problems. That thinking led us to write *The Extended Consultation* together, the first edition of which came out in 2017 and a second edition in 2024. It describes several approaches to helping patients with problems of living: pattern, problem, presence and positive.

DF: Family doctors often have limited time, whether in a polyclinic or private practice. How can they make room for an extended consultation?



The Extended Consultation *(second edition), written by A/Prof Goh and the late A/Prof Cheong Pak Yean*

GLG: Rather than ask every doctor to spend a great deal more time on each patient, *The Extended Consultation* offers a framework for thinking. First, you recognise that a patient may be struggling with a problem of living. Then you consider how to help. With the pattern approach, for example, you may notice that the patient responds in the same way whenever he/she feels unable to cope. You can ask about that pattern and explore what is going through his/her mind. This framework gives the doctor a set of strategies that are still useful even when consultation time is limited.

DF: Does "extended" mean that the appointment itself must be longer?

GLG: Not necessarily much longer. In the course we run, we use scenarios to show how a doctor can apply the approaches in a short consultation.

DF: How long is a typical consultation these days? About ten minutes?

CZY: It may be ten, or perhaps 15 to 20 minutes long for a more complex family medicine consultation.

DF: Then perhaps what is extended is the doctor's way of thinking: taking into consideration social circumstances and other factors affecting health. Continuity also gives a family doctor more than one opportunity to help. When I read the book, I wondered about support beyond the GP's room too. Could other people and services help carry that work forward?

GLG: The doctor can begin within an ordinary consultation by recognising the problem and choosing an approach. Positive psychology, for instance, may help someone who lacks confidence. We teach these approaches in a course that Cheong Pak Yean cared deeply about.

DF: Who continues to teach the course now that A/Prof Cheong is gone?

GLG: Several of us, including Asst Prof Ong Chooi Peng and me, with other colleagues. The course is offered under the College's Family Practice Skills Course as CME.

DF: It sounds as though doctors learn counselling skills and ideas from positive psychology. That seems very useful.

GLG: We should invite you to speak the next time we run it.

DF: Welcome to do that.

GLG: We also have a postgraduate course called CCC: Communication, Consultation and Counselling. The opportunity is there; the question is how widely doctors take it up.

CZY: It is compulsory in the GDFM. MMed (FM) trainees also learn these skills, though they are embedded in the programme.

GLG: In the undergraduate medical curriculum, we have a Communication with Patients course for second-year undergraduates, which I used to teach many years ago.

CZY: That teaching is now part of the clinical skills foundation.

GLG: The postgraduate CCC course grew out of that work too.

Personal life and closing reflections

DF: Tell us a little about your family.

GLG: We have one son, who is now a plastic and reconstructive surgeon. He is married and has three children.

DF: What else occupies your time these days? What are your hobbies?

GLG: I serve as a medical director at nursing homes with Methodist Welfare Services, which has a hospice and long-term care services at Bukit Batok and Woodlands. I visit once a week to see patients whom the resident physicians would like me to review. A doctor might ask me to review a persistent rash, for example. In an older patient, we would consider possibilities such as fungal infection or eczema. That is the sort of clinical work I still do.

About hobbies, I like gardening and keeping Japanese koi. Unfortunately, because my residence is near the sea, the sea otters would come and make away with some of the koi once in a while. Thankfully, the last assault was three years ago, and I lost three out of my ten koi in that attack.

DF & CZY: Thank you for your time, A/Prof Goh!

GLG: Thank you both too, and the News team as well. ◆

RECONNECTING AND LEARNING ACROSS THE REGION: CMAAO 2026

Text by Clinical Asst Prof Benny Loo Kai Guo
Photos by Korean Medical Association

Clinical Asst Prof Loo is a paediatrician in public service with a 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.



SMA participated in the 40th General Assembly and 61st Council Meeting of the Confederation of Medical Associations in Asia and Oceania (CMAAO), held from 2 to 4 September 2026 in Seoul, South Korea. SMA was represented by Dr Chong Yeh Woei, CMAAO Chairman, and Clinical Asst Prof Benny Loo Kai Guo, CMAAO Councillor and SMA Council member.

Hosted by the Korean Medical Association (KMA), the meeting brought together delegates from Hong Kong, Indonesia, Japan, Malaysia, Myanmar, Nepal, the Philippines, Singapore, South Korea, Taiwan and Thailand. Beyond the formal programme, the gathering was a welcome opportunity to reconnect with colleagues from across the region and build on friendships developed through previous exchanges.

For the SMA delegation, this included a reunion with colleagues from the Malaysian Medical Association and the Hong Kong Medical Association who had visited Singapore last year, as well as a chance to catch up with a former Indonesian colleague from the Junior Doctors Network. These personal connections are an important part of such international meetings, helping national medical associations maintain open channels for collaboration and the sharing of ideas.

Learning from different health systems

The country report session offered a broad view of the work being undertaken by medical associations across Asia and Oceania. Delegates shared updates on initiatives to engage their members, the wider medical profession, the public and their respective health services.

The presentations also highlighted the diversity of health systems and governance structures across the region. Each country faces its own combination of workforce pressures, healthcare financing issues, regulatory responsibilities, changing public expectations and the need to maintain trust in the profession. While the specific circumstances differ, many associations are working through similar questions about how best to represent doctors, contribute to health policy and support improvements in patient care.

Importantly, the reports were candid about challenges and work still in progress. This allowed delegates to learn from successful programmes and also the different approaches being tested and refined across the region. Clinical Asst Prof Loo presented Singapore's country report on behalf of SMA, giving a concise overview of SMA's work in professional advocacy, member engagement, support for junior doctors, medical ethics education and academic development.

What does professional autonomy mean today?

The main theme of the meeting was "Professional Autonomy in Medicine". The 23rd Taro Takemi Memorial Oration included presentations by Dr Otmar Kloiber, former Secretary-General of the World Medical Association (WMA), and Dr Ahn Ducksun, Professor Emeritus at Korea University Medical College and Director of the KMA's Research Institute for Healthcare Policy.

Dr Kloiber discussed the WMA's definition of professional autonomy and clinical independence, described



CMAAO 2026 delegates

as the processes that allow individual physicians to exercise their professional judgement in caring for patients without undue or inappropriate influence from external parties. At the same time, such autonomy remains bounded by professional standards, the available evidence and the realities of healthcare systems and resources.[1]

Dr Ahn shared about the historical background of the KMA and discussed its role as both a statutory professional body and a trade association representing doctors. His presentation explored the challenge of balancing responsibilities to the public and the profession, including the KMA's roles in professional standards, self-regulation and the collective representation of doctors.[2]

During the symposium, Clinical Asst Prof Loo presented Singapore as a case study of professional autonomy within an accountable healthcare system. He emphasised that autonomy does not mean unrestricted freedom for doctors. Rather, it is the ability and responsibility to exercise sound clinical judgement, advocate for patients and explain decisions within appropriate ethical, legal, organisational and resource boundaries.

The discussions show that professional autonomy is shaped differently in each country, depending on their respective healthcare systems, regulatory framework, financing arrangements and relationships between the profession and the state. Nevertheless, doctors from the various nations share a common interest in preserving appropriate clinical judgement while maintaining accountability, patient partnership and public trust.

Moving forward

A key moment during the General Assembly was the handover of the CMAAO presidency from Dr Anil Bikram Karki of Nepal to Dr Kim Taeg Woo of South Korea, who is now the 43rd President of CMAAO.

The meeting was also attended by senior WMA leaders. Dr Jacqueline Kitulu, WMA President, delivered a congratulatory message, while Dr Ramin Parsa-Parsi, WMA Secretary-General, presented the WMA Strategic Plan 2026–2030.

This meeting in Seoul was a useful reminder that despite the differences between national health systems, medical associations across the region share many of the same concerns. Just as importantly, it provided the opportunity to renew friendships, establish new connections and continue learning from one another. ◆

References

1. WMA Declaration of Seoul on Professional Autonomy and Clinical Independence. In: World Medical Association. Available at: https://bit.ly/4iPKxle. Accessed 18 September 2026.

2. Ahn D. Improving the Korean Medical Association's organizational strength and partnership for physicians. J Korean Med Assoc 2020; 63(6):304-6.



Clin Asst Prof Benny Loo with Dr Chong Yeh Woei as SMA representatives to CMAAO

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.

SMA Council Retreat 2026

On 29 August 2026, the SMA Council came together to reflect on the Association's past, assess its present position and chart its future direction.

Assisted by an external facilitator, the Council and Secretariat heads of department participated in a series of workshop exercises to identify potential priorities for SMA.

Five key objectives emerged from the discussions:

- To support doctors at every stage of their careers;
- To be known to the public as an advocate for patients;
- To shape healthcare discussions by being a trusted voice and key opinion leader;
- To grow our membership; and
- To strengthen our financial sustainability.

These objectives will help guide SMA's priorities and initiatives over the coming years. As we move forward, the Council remains committed to strengthening the Association's role in supporting doctors, advocating for patients and contributing to the wider healthcare landscape.

HIA Implementation Guide Version 2.0

In August 2026, the Ministry of Health published version 2.0 of the Health Information Act (HIA) Implementation Guide for Healthcare Providers, which provides essential information to help healthcare providers meet HIA requirements. Members are advised to review the updated document, especially Table 5 from page 15 onwards, which provides a summary of cybersecurity and data security requirements.

The guide can be viewed in full at: https://bit.ly/4zoYjjO. ◆

The Doctor-Patient Encounter:

Understanding the Communication Processes from Introduction to Trust



Text by Dr T Thirumoorthy and Darius Lim Xiang Wen

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.



Darius is a second-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.



It is often assumed that in a medical consultation, the doctor is the interviewer who gathers information, while the patient is simply the interviewee who provides it. In reality, the medical interview is a dynamic two-way process that profoundly shapes how patients experience their doctors. As the doctor interviews and takes medical history, patients and family members (if present) are continuously interacting with and observing the doctor during each stage of the clinical encounter, creating impressions and making judgements. From the moment the doctor enters the room, patients begin to form impressions (consciously and subconsciously) based on both verbal and non-verbal behaviours. The patients assess not only what is said but how it is said, and what these behaviours signal about what matters most for them. These include whether patients feel they know the doctor and his/her role in their care, whether they like the doctor, whether they believe the doctor genuinely cares about them, whether the doctor is clinically competent and, ultimately, whether they decide to trust the doctor. Medical interviews continue to be one of the most essential and most frequently used tools in clinical practice. Empirical work on patient-centred communication shows that these interpersonal processes are not peripheral; they are central determinants of patient satisfaction, adherence, safety and even health outcomes.[1,2]

A clinical introduction therefore is not a mere social nicety. It is the first step in a relational and communicative trajectory that can either strengthen or weaken patients' impression of their doctor, with important consequences for diagnostic accuracy, shared decision-making and treatment effectiveness.[1] Understanding this trajectory can help clinicians act deliberately in applying appropriate communication and behavioural skills, rather than leave such impressions to chance. This article outlines a staged model of how patients commonly move from initial acquaintance to durable trust – "I know this doctor; I like this doctor; this doctor cares about me; this doctor is competent; I can trust this doctor" – and identifies the specific communication skills that support each stage.

The stages of impression formation in the doctor-patient encounter

Knowing the doctor: orientation and clarity

The first task in any consultation is to enable the patient to know who the doctor is and why he/she is present. Patients may encounter multiple professionals in a brief time, and without

clear orientation, they can easily become confused or disengaged. A structured introduction – stating the clinician's name, role and purpose clearly – reduces uncertainty and frames the encounter as being organised and professional.

Key communication techniques at this stage include:

- A warm greeting, clear self-introduction of name and designation, explanation of the clinician's role in the team, and a brief statement of the purpose and structure of the consultation; and
- Asking how the patient would like to be addressed and checking that the patient is comfortable to start the consultation (and/or if he/she would like any family members to be present), conveying respect and supporting patient autonomy.[3]

These simple behaviours provide the direction for the patient's first conclusion: "I know who this doctor is and what they are doing here."

Liking the doctor: warmth and respect

Once the patient gets to know who the doctor is, the next impression is largely affective: whether the patient experiences the doctor as likeable, friendly, approachable and respectful. This impression is strongly shaped by non-verbal behaviours such as eye contact, facial expression, posture, a smile where appropriate and the sense that the doctor is genuinely interested and focused rather than distracted or uninterested.

Key communication techniques that foster liking include:

- A warm but professional tone of voice and an unhurried opening;
- The deliberate use of positive non-verbal cues like sitting at eye level, leaning slightly forward, maintaining appropriate eye contact as well as an appropriate soft smile; and
- Using open-ended questions at the start of the consultation and avoiding early interruption, signalling that the patient's perspective is heard.[4]

These behaviours lead patients to feel that the doctor is approachable and respectful, which is often summarised in their minds as "I like this doctor."

Perceiving that the doctor cares: empathy, issues, concerns, illness experience, expectations and person-centeredness

The next impression patients reach is whether the doctor genuinely cares about them as a person, and not only as "another clinical case". Genuine empathy has been conceptualised as understanding the patient's perspective of illness experience and feelings, communicating that understanding, and then acting on it in a helpful way.[5] Patients infer caring when they perceive this empathic process in consultation.

Specific communication techniques include:

- Active empathic listening; use of minimal encouragers to speak; accurate summarising of the patient's story; and explicit empathic statements such as, "It is understandable that you are worried given how suddenly this started".
- Attending to emotional cues by noticing affect, exploring feelings and validating the patient's experience, demonstrating that the doctor is not focused solely on disease but also on the person living with the illness.
- Seeking clarification, doing a summary and checking if the doctor has the facts right, following up on a previously expressed concern and including "what else needs to be discussed" questions, which further reinforce the impression that "this doctor is interested and really cares about me".
- Deliberate elicitation of the patient's own perspective on his/her illness, which is a central expression of both caring and competence. This includes the patient's beliefs and ideas about what is happening, his/her specific concerns or fears, expectations of the consultation, and the illness' impact on his/her daily life.
- Asking open, non-judgmental questions such as "What do you think is going on?", "Is there anything you are particularly worried about?" and "What were you hoping we could do today?" before reflecting and negotiating a shared understanding.

The widely used "Ideas, Concerns, Expectations" framework offers a practical structure for this exploration and has been associated with better patient satisfaction, more appropriate prescribing[6] and more effective shared decision-making.[7]

Anthropological work on explanatory models further highlights the value of exploring patients' beliefs about the cause, meaning and appropriate treatment of illness, particularly across cultural contexts.[8] When doctors take the time to understand and respectfully integrate the patient's illness narrative with the biomedical concept of disease, patients experience both empathy ("this doctor cares about me") and cognitive competence ("this doctor understands what is important and relevant for my life").

Judging the doctor as competent: clarity, structure and transparency

Perceived clinical competence is influenced not only by technical decision-making but also by how the doctor communicates knowledge and reasoning. Patients judge competence through the use of clear and simple non-jargon language, organisation of the information sharing and transparency of explanations as well as the doctor's ability to explain uncertainty in a calm, confident and honest manner.



Key communication techniques include:

- Providing structured explanations in plain language, signposting the stages of the consultation, and linking diagnostic reasoning explicitly to the patient's narrative and findings.
- Using teach-back to check understanding ("Could you tell me in your own words what you understand about the plan?") which improves comprehension and signals conscientiousness.
- Transparent discussion of uncertainty and risks: explaining what is known, what is not yet known and the rationale for investigations, strengthening perceptions of competence.
- Safety-netting advice on risk mitigation, including clear guidance on red-flag symptoms and follow-up arrangements, further reinforcing the impression that the doctor is thorough, organised and clinically skilled.[2]

Arriving at trust: reliability, solidarity, and partnership

Trust is the integrative outcome of the patient's belief that the doctor is not only competent and caring but also dependable, honest and committed to acting in the patient's best interests. Higher levels of patient trust are associated with better adherence, continuity of care and self-reported health outcomes.[9]

Beyond perceptions of competence and compassion, patients also look for signs that the doctor will stand with them over time – that the relationship is not merely transactional but one of solidarity in the face of illness. Recent ethical scholarship describes solidarity in healthcare as a commitment to share burdens and pursue health-related goals together with patients, recognising our interdependence and common vulnerability.[10]

In communication, this is conveyed through the language of partnership ("We will work through this together"), explicit attention to the patient's long-term journey, advocacy within the health system, and a stable presence at key transitions of care. When doctors acknowledge the weight of illness, help navigate structural barriers and frame decisions as a shared project, patients experience trust and confidence that the doctor will not abandon them when circumstances become difficult. This experiential sense of solidarity is often what transforms episodic trust into a durable therapeutic alliance.

Communication behaviours that build trust therefore include:

- Reliability and follow-through (keeping promises, doing what one has promised), explicit partnership and shared decision-making.
- Openness and honesty about errors or system limitations and clear protection of confidentiality.
- Inviting patient preferences, exploring values and goals and negotiating plans together, signalling respect for autonomy and reinforcing the sense of a trustworthy therapeutic alliance.

When trust is established, patients are more willing to disclose sensitive information, accept advice, find consensus in treatment plans and are more accepting of unexpected events.

Conclusion

From the patient's perspective, a clinical encounter is far more than a technical exercise in diagnosis and management. It is a complex social interaction in which the patient is continuously and often silently evaluating the doctor: "Do I know you? Do I like you? Do you care about me? Are you competent? Can I trust you?" These judgments are built cumulatively through the doctor's introduction, non-verbal behaviours, empathic responses, clarity of explanation, eliciting of the patient's perspective and reliability over time. Each phase of the encounter offers opportunities either to strengthen or weaken these developing impressions.

For doctors, making these largely implicit processes explicit is crucial. Communication skills are not just innate traits, but competencies that can be taught, observed, practised and refined through feedback and reflective learning.[11] Understanding how patients move from initial acquaintance to durable trust enables clinicians to use specific communication techniques purposefully rather than relying on personality or habit alone. Doing so not only enhances patient experience and clinical outcomes but also aligns with professional values of respect, compassion, humility, solidarity and accountability. In an era marked by increasing complexity, uncertainty and time pressure, skilful patient-centred communication remains one of the most powerful instruments a doctor can possess. ◆

References

1. Levinson W, Lesser CS, Epstein RM. Developing physician communication skills for patient-centered care. Health Aff (Millwood) 2010; 29(7):1310-8.

2. Street RL Jr, Makoul G, Arora NK, Epstein RM. How does communication heal? Pathways linking clinician-patient communication to health outcomes. Patient Educ Couns 2009; 74(3):295-301.

3. Makoul G, Zick A, Green M. An evidence-based perspective on greetings in medical encounters. Arch Intern Med 2007; 167(11):1172-6.

4. Marvel MK, Epstein RM, Flowers K, Beckman HB. Soliciting the patient's agenda: have we improved? JAMA 1999; 281(3):283-7.

5. Hojat M, Maio V, Pohl CA, Gonnella J. Clinical empathy: definition, measurement, correlates, group differences, erosion, enhancement, and healthcare outcomes. Discov Health Syst 2023; 2(1):8.

6. Matthys J, Elwyn G, Van Nuland M, et al. Patients' ideas, concerns, and expectations (ICE) in general practice: impact on prescribing. Br J Gen Pract 2009; 59(558):29-36.

7. Murtagh GM. A critical look at ideas, concerns and expectations in clinical communication. Med Educ 2023; 57(4):331-6.

8. Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. Ann Intern Med 1978; 88(2):251-8.

9. Thom DH, Hall MA, Pawlson LG. Measuring patients' trust in physicians when assessing quality of care. Health Aff (Millwood) 2004; 23(4):124-32.

10. Kim DT, Ranganathan B. Why should one care? An ethics of solidarity in the patient-physician relationship. Discov Med (Singap) 2024; 1(1):156.

11. Thirumoorthy T. Core Communication Skills in the Medical Interview. SMA News 2016; 48(11):34-5.

Navigating migraine prevention and acute care strategies in primary care



Clinical insights from **Dr Zhao Yi Jing**
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Mount Elizabeth Hospital, Singapore



The clinical and economic burden of migraine

Migraine is an under-recognised and underdiagnosed neurological disorder characterised by recurrent, typically unilateral and throbbing headaches of moderate-to-severe intensity lasting 4 to 72 hours, often accompanied by nausea, vomiting, photophobia, phonophobia, movement sensitivity and reduced functioning.[1,2] In Singapore, the lifetime prevalence of migraine is reported to be 8.2%.[1] The estimated total economic burden of migraine in Singapore was SGD 1.04 billion in 2018, comprising direct healthcare costs and indirect costs associated with missed workdays and productivity losses.[2]

The crucial role of early acute migraine management

Acute migraine treatment is a vital component of care. It typically involves the use of over-the-counter (e.g., paracetamol) or prescription medication (e.g., triptans or ergotamine derivatives).[2] Delayed or inadequate treatment may allow migraine attacks and associated symptoms to intensify, potentially predisposing patients to chronification; a state where migraines become increasingly frequent, severe and refractory. Early and effective treatment can provide symptom relief, restore normal functioning, reduce the burden of migraine attacks and preserve workplace productivity, particularly if such treatment can be provided in a primary care setting.

Conversely, ineffective acute management may contribute to prolonged attacks, including status migrainosus, a debilitating migraine attack lasting over 72 hours (or 3 days) that may require escalation of care, including emergency care or hospital-based treatment. Optimising acute treatment strategies may help reduce attack-related disability, treatment burden and healthcare utilisation.

The vicious cycle: ineffective treatment and medication overuse

When acute therapies for migraine are ineffective, patients may increase their self-medication, potentially contributing to medication overuse headache (MOH), a secondary headache disorder associated with increased disease burden, healthcare utilisation and costs, as well as impaired quality of life. MOH is diagnosed in patients with headache occurring on 15 days (or more) per month, in the context of regular overuse of acute therapies for more than 3 months.[3]

Shifting the paradigm: from acute management to migraine prevention

While effective acute treatment remains essential, acute therapies alone do not address the underlying pattern of recurring migraine attacks or reduce the risk associated with frequent use of medication. In patients with frequent or chronic migraine, particularly those with MOH, inadequate preventive control may make it difficult to reduce reliance on acute medications. Additionally, patients may also perceive migraine as an episodic condition that can be managed solely with acute treatment, potentially delaying consideration of preventive therapy.

The primary goals of migraine prevention are to reduce migraine frequency, severity and disability, prevent progression to chronic migraine, and improve quality of life and daily functioning. Without appropriate preventive treatment, some patients may progress from infrequent migraine (<4 days/month) to low frequency episodic migraine (4–8 days/month) and high frequency episodic migraine (9–14 days/month). Early initiation of preventive therapy may help reduce migraine frequency and disability, support restoration of normal functioning and reduce reliance on acute medications.

Patients who are at risk of MOH or migraine chronification, or who experience highly disabling attacks despite acute treatment should be assessed for preventive therapy as part of a comprehensive management plan.

Dr Zhao's clinical analogies for migraine chronification and prevention

"I always use the fire analogy. When the fire is small, you can put it out quickly with just one pail of water. But if it's left to spread, it becomes a full-blown bushfire. With migraine, you take painkiller, the pain subsides briefly, but you wake up to another headache; creating a vicious cycle."

"If painkillers are fire extinguishers, preventive therapies are like fireproofing. You cannot just use extinguishers during a bushfire; fireproofing simultaneously provides synergistic control while reducing pill burden."

Overcoming barriers to prevention in primary care

Migraine prevention remains underutilised in primary care, partly owing to resource limitations. Traditional oral preventive medications (OPMs), such as propranolol and amitriptyline, may require gradual dose titration, monitoring for adverse effects and individualised dose optimisation.

Novel oral calcitonin gene-related peptide (CGRP) receptor antagonists (gepants), such as rimegepant, provide an additional preventive treatment option. Favourable tolerability and oral administration may facilitate the incorporation of CGRP-targeted preventive therapies into primary care. Moreover, according to Dr Zhao, when appropriate patients are initiated on such newer-generation preventive therapies, reductions in monthly migraine days (MMDs), attack frequency and migraine-related disability may be achieved, potentially reducing reliance on acute

medications and improving quality of life. As Dr Zhao noted, newer-generation oral preventive therapies may offer greater flexibility in clinical practice. Over the coming years, she anticipates that primary care physicians may become increasingly familiar and comfortable with initiating preventive therapies such as rimegepant.

Supporting clinical evidence from rimegepant's phase 4 trials

Rimegepant can be used for both the acute and preventive treatment of migraine, with the dosing regimen determined by the treatment objective. Recent phase 4 clinical trials demonstrated superior efficacy versus placebo and a comparable tolerability profile in both settings: as a single dose for the acute treatment of migraine in adults unsuitable for triptans, and as every-other-day (EOD) dosing for the preventive treatment of episodic migraine in patients with inadequate response to 2–4 prior traditional OPMs.[4,5] These findings highlight the potential of rimegepant to address unmet treatment needs in patients who are unsuitable for or have responded inadequately to conventional therapies.[4,5]

Acute management	Preventive treatment
Ashina et al. evaluated a single 75 mg dose of rimegepant orally disintegrating tablet (ODT) in adults with migraine unsuitable for triptans due to previous lack of efficacy, intolerability or contraindication. Rimegepant demonstrated superiority over placebo for 2-hour pain relief (55.9% vs 32.7%, p<0.0001). All 10 prespecified key secondary endpoints met statistical significance (p≤0.0005), including 2-hour pain freedom (22.7% vs 7.4%), 2-hour return to normal function (28.9% vs 12.7%) and avoidance of rescue medication within 24 hours (82.0% vs 53.8%). Adverse event rate was comparable to placebo (12.5% vs 12.1%).[4]	Pozo-Rosich et al. evaluated rimegepant 75 mg ODT EOD in adults with migraine and inadequate response to 2–4 OPMs. Over 12 weeks, rimegepant achieved a significantly greater reduction in MMDs versus placebo (–2.1 vs –0.5 days, p<0.0001, **Figure 1**). Key secondary endpoints also favoured rimegepant, including the proportion of patients achieving a ≥50% reduction in moderate-to-severe MMDs (34.0% vs 13.8%, p<0.0001, **Figure 2**), and improvement in Migraine-Specific Quality of Life Questionnaire (MSQ) scores (+21.1 vs +14.6 points, p<0.0001). Adverse events were comparable between rimegepant and placebo (56.7% vs 54.9%).[5]

Figure 1

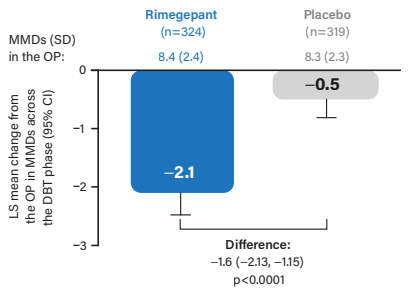


Figure 2

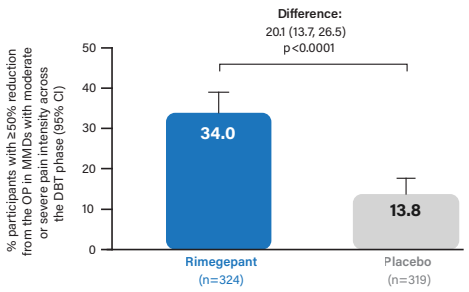


Figure 1 shows the primary endpoint: mean change from the OP in MMDs across the DBT phase, while **Figure 2** demonstrates the key secondary endpoint: percentage of participants with ≥50% reduction from the OP in MMDs with moderate or severe pain intensity across the DBT phase.[5]
CI, confidence interval; **DBT**, double-blind treatment; **LS**, least-squares; **MMD**, monthly migraine day; **OP**, observation phase; **SD**, standard deviation.

Real-world experience with patients receiving appropriate migraine prevention

Dr Zhao shared the following real-world clinical experiences:



Case 1: One time-poor businessman who frequently travelled by plane between cities had experienced severe migraine attacks whenever he flew, affecting his sleep quality and productivity. Following treatment initiation with newer-generation oral/injectable CGRP-targeted therapies, his pain improved substantially, allowing him to resume his work and frequent travel with less disruption.



Case 2: A young woman experienced severe menstrual migraines that caused her to miss work for 3 to 5 days during each menstrual cycle. She started taking rimegepant as a situational preventive, identifying her premonitory symptoms such as yawning or mild discomfort, and taking the medication every other day for 2 to 3 doses during her period. This approach effectively prevented her migraine attacks during menstruation, allowing her to maintain her usual activities and quality of life.

Key takeaways for general practice



- Consider preventive therapy early in appropriate patients, rather than waiting for migraine frequency or disability to increase, or for MOH to develop.
- Optimise both acute and preventive treatment: use effective acute therapy to extinguish individual attacks while applying appropriate preventive strategies to reduce the overall migraine burden; aiming for "fireproofing" while also extinguishing the fire.
- Rimegepant has demonstrated efficacy and favourable tolerability for both acute and preventive migraine treatment, including in patients with unmet needs from conventional therapies.[4,5]

References: 1. Jeyagurunathan A, et al. *Soc Psychiatry Psychiatr Epidemiol* 2020;55:33-43. **2.** Ong JJ, et al. *Cephalalgia Reports* 2020;3:1-11. **3.** AlQuliti KW, Alhujeily RM. *Neurosciences (Riyadh)* 2023;28:13-18. **4.** Ashina M, et al. *Cephalalgia* 2025;45:1-12. **5.** Pozo-Rosich P, et al. *Cephalalgia* 2025;45:1-13.

The Case for Creative Facilitation

Text by Phylaine Toh and A/Prof Anantham Devanand
Photos by SingHealth Duke-NUS Medical Humanities Institute



The Womb, *Clinician Participant*

During a recent hospital retreat, the Singapore Health Services (SingHealth) Duke-NUS Medical Humanities Institute (SDMHI) facilitated a creative session using an approach that blended open-ended reflection, arts-based narratives and structured idea generation to invite deeply embodied engagement. We began by posing a metaphorical question: "If your hospital were a body, what part would you be?"

The participants paused, hands hovering over preserved foliage and found materials, tools curated to spark organic creativity. They had been invited to work with a curated selection of natural and found materials, including foliage, moss and organic objects in varying states of preservation – some freshly moist to the touch, others dried or preserved – chosen to engage the senses and support metaphor-based reflection.

What began as silence soon turned into excited chatter as participants began shaping "organs" with repeating, branching forms, stepping away from the familiar cadence of ward rounds, administrative work and budget reviews into a space where metaphor became a language for meaning making in clinical care. Participants were not instructed to represent specific ideas or metaphors; instead, they worked intuitively with the materials and reflected on what emerged through the making process.

We witnessed hearts weighted with patient narratives. We saw lungs designed to hold the collective breath of teams operating under chronic pressure. One clinician reflected, "Our team is the immune system: repairing damage before anyone realises something is wrong." Another held up a pair of sculpted hands: "These heal even when cure is no longer possible. They hold families together till the end."

One participant shaped a form initially read by others as a heart but described it instead as a womb: a first home characterised by warmth, protection and strength. In the participant's reflection, this inner space came to represent what they hoped healthcare ought to provide: the place where care begins. It was at this point that many participants began to realise this was far more than a simple arts and crafts exercise. By visualising the organisation as a living body, they surfaced forms of tacit knowledge that may not have emerged through dashboards or engagement surveys.

By slowing the pace of discussion and engaging participants through material and embodied processes, creative facilitation allowed lived clinical experience to come into view. These insights shaped by sensation, memory and practice are not always readily accessible through verbal reasoning alone, and can support clearer identification of shared priorities and tensions, enabling more aligned and thoughtful decision-making.[1]

Importantly, the use of material, metaphor and making also altered the usual dynamics of group discussion. When participants worked with their hands rather than speaking from their titles, verbal dominance was softened and professional hierarchies receded into the background. Metaphor created a shared language that did not privilege any single discipline or rank, allowing junior and senior clinicians alike to contribute meaningfully. In this way, creative facilitation offered a practical method for amplifying voices that might otherwise remain unheard in conventional meetings.

What is creative facilitation?

Creative facilitation, as practised within established medical humanities programmes, is not an aesthetic add-on or an icebreaker at meetings. It is a structured pedagogy for guiding groups to surface reflection, emotion and collective meaning in participants from diverse professional and social backgrounds. Creative facilitation is especially suited where the stakeholders may hold different values and world views, where the system in which they are embedded is complex and where problems being tackled require adaptive solutions. Its value lies not in "being engaged" or "being entertained" but in creating the conditions for clinicians to stay with uncertainty long enough to respond wisely rather than reactively. Such facilitation integrates experiential considerations with cognitive objectives in the design of teaching sessions and meetings. From an educational perspective, there is the benefit of engaging the audience not only intellectually but also emotionally, facilitating resonance with what is being communicated. Creative facilitation is therefore oriented towards outcomes beyond informational exchange, including insight, culture change and innovation.

The versatility of creative facilitation enables teams to mix and match facilitation techniques based on setting and topics. Facilitation techniques at

SDMHI span poetic medicine, visual thinking strategies based on art from the National Gallery Singapore, forum theatre, mindfulness training for flourishing in medicine, narrative medicine as well as sessions facilitated by our creative therapists from art and music therapy. Facilitation has also been used in undergraduate and postgraduate education, clinical meetings and leadership retreats. The range of medical topics covered include physical examination skills, communication techniques, empathy, patient safety, wellbeing of healthcare professionals, coping with death and dying, and interprofessional training. Creative methods transform conventional facilitation based on discussion and verbal output into an experiential activity that additionally utilises visual and embodied methods.



Non-verbal communication training in the "Gestures of Care" project at the National Heart Centre

Refill to Regift

In a separate creative facilitation workshop focused on nurturing healthcare worker wellbeing, a participant shaped a small clay pinch pot titled *Refill to Regift*. The piece captured a familiar truth: when practitioners are required to pour endlessly from an empty cup, it eventually requires refilling. The creative facilitation prompted interoceptive awareness – the sensing of the body's internal state. While clinicians are rigorously trained to observe patients, far less attention is given to recognising signals from one's own nervous system. Interoception plays a critical role in emotional regulation, decision-making and resilience.[2] Relational care depends on practitioners who can recognise when they themselves are running thin, not just those who are technically proficient.[3]

Creative facilitation offers a practical way of cultivating these capacities within healthcare teams by helping clinicians reconnect with tacit knowledge, bodily awareness and shared purpose. When thoughtfully integrated into meetings, teaching sessions and retreats, such approaches support collective sense-making and enable teams to engage complexity without prematurely narrowing it.

So, if your clinic or department were a body, which part would you be? ◆



Refill to Regift, *Clinician Participant*

All artworks and reflections are shared with participants' consent. Identifying details have been included or withheld where appropriate and reflections have been paraphrased to preserve confidentiality.

References

1. Bleakley A. Medical Humanities and Medical Education: How the medical humanities can shape better doctors. Routledge, 2015.

2. Craig AD. How do you feel? Interoception: the sense of the physiological condition of the body. Nat Rev Neurosci 2002; 3(8):655-66.

3. Epstein RM, Krasner MS. Physician resilience: what it means, why it matters, and how to promote it. Acad Med 2013; 88(3):301-3.

Phylaine, MA AThR, leads the creative facilitation programme as a core faculty member of the SingHealth Duke-NUS Medical Humanities Institute, and contributes to institutional wellbeing at Singapore General Hospital. Drawing on her background in clinical art psychotherapy and narrative medicine, she explores how creative practices can contribute towards more connected, inclusive and equitable healthcare.



A/Prof Devanand is the director of the SMA Centre for Medical Ethics and Professionalism as well as director of the SingHealth Duke-NUS Medical Humanities Institute.





NUS HealthX

Building Bridges for Interprofessional Collaboration in Healthcare Innovation

Text and photo by Dr John Thng

The practice of medicine is evolving rapidly. Beyond clinical expertise, the doctors of tomorrow must also be fluent in technology. Digital literacy has become a new frontier of continuing medical education.

Clinicians capable of harnessing technology can elevate care delivery, manage complex systems and meet evolving healthcare needs with greater efficiency and independence. This shift comes with new baselines: healthcare professionals must be technologically literate and able to work seamlessly in multidisciplinary teams that now include design, engineering and computing specialists.

Yet our training and practice environments often remain behind this curve. Faculties are siloed, leaving little intersection between the problems clinicians face and the technical expertise that could generate solutions. For healthcare trainees, the focus remains firmly on developing clinical acumen, with few pathways for meaningful exposure to innovation and technology.

This critical gap became the starting point for us to build HealthX – a platform ecosystem designed to bring disciplines together and reimagine healthcare innovation and interdisciplinary collaboration.

HealthX: a bridge between worlds

At HealthX, our vision was to build an ecosystem where technical disciplines collaborate directly with healthcare professionals, learning side by side. We aim to catalyse change by connecting future doctors and allied health professionals with researchers from design, computing and engineering disciplines. United by a shared passion for healthcare innovation, we created a space where learning, collaboration and meaningful problem-solving can thrive.

Our broader vision is to nurture multidimensional clinicians and future problem-solvers who not only build strong clinical acumen but also develop the perspective and confidence to harness technology in addressing real-world challenges – supported by foundational know-how and ecosystems with the technical capabilities to back them.

Our beginnings and growth

Our first starting point for HealthX was to create structured opportunities for multidisciplinary conversations and a spectrum of entry points for students. This ranged from simple networking sessions, learning workshops and hackathons, to even leading the development of prototypes.

Our philosophy has remained simple – start small, stay agile and focus on execution. Each event or workshop served as a testbed for interdisciplinary interaction, from ideation nights to hackathons. With every cycle, we refined our approach, documenting what worked and scaling successful models.

In the past year alone, we have significantly expanded our digital reach, engaged hundreds of students through workshops and programmes, incubated several medical innovation prototypes, and established both local and international collaborations. Our leadership team has also grown, with new cohorts stepping up to sustain and further these efforts.

Highlights of 2025: Partnerships and impact

2025 has been particularly fruitful. HealthX has grown into a platform recognised not just within the National University of Singapore (NUS) but also by international partners. Here are some of HealthX's accomplishments over 2025.

- **Design for Medicine module:** The Design for Medicine module was launched by our HealthX advisor and team in collaboration with the NUS Division of Industrial Design (DID) and the Centre for Healthcare Simulation (CHS). The programme provided a structured platform for medical and design students to work under clinician mentorship to co-develop medical hardware prototypes addressing real-world clinical challenges. Several prototypes were successfully produced and later showcased to the CEO of National University Hospital, as well as the dean and vice-dean (education) of NUS Yong Loo Lin School of Medicine, receiving strong encouragement for further development.
- **International Medical Innovation Hackathon with King's College London:** In collaboration with King's College London (KCL), the King's College Entrepreneurship Society and the MedTech Society, HealthX co-organised a transcontinental hackathon featuring leading medical technology (medtech) ideas from Singapore and the UK. The event spotlighted differences in healthcare systems, surfaced diverse needs and examined how each system approaches innovation. The collaboration reinforced the

importance of global perspectives in addressing complex health-care challenges.

- **Workshops and learning platforms:** HealthX has also hosted a series of workshops designed to lower the entry barrier to healthcare innovation. Covering both emerging and practical themes, these sessions have explored artificial intelligence in healthcare, panel discussions with medtech entrepreneurs, technology showcases at tertiary hospitals, design thinking for medicine, medical 3D printing and regenerative medicine. Together, they provided accessible entry points for students to gain exposure, learn from experts and build connections across disciplines.

Lessons from the journey

Reflecting on our progress, several lessons from the year stand out.

Innovation is accessible. It is not confined to seniority or titles. Anyone – whether a student on the wards or a seasoned clinician – can identify pain points, inefficiencies and gaps in clinical processes. The act of noticing and questioning "why" is often the first spark of meaningful innovation.

Multidisciplinary collaboration is essential. No single discipline can solve healthcare's challenges alone. Effective innovation requires perspectives from medicine, design, engineering, computing and beyond. Collaboration across these fields is not optional; it is a skill that must be intentionally cultivated to transform ideas into viable, real-world solutions.

Doctors as translators. Clinicians have a unique responsibility in the innovation process: to frame healthcare needs in a way that technical experts can act upon, and to guide co-creation so that solutions remain clinically relevant. Their role ensures that new ideas are not only functional but also compatible with real-world workflows and regulatory requirements.

Innovation is not always disruptive. While breakthrough technologies often capture attention, incremental improvements can be just as impactful. Small but well-executed changes – streamlining existing pathways, improving scalability, or making care more accessible – can meaningfully improve patient outcomes and healthcare delivery.

Looking ahead

These lessons shape our path forward. The vision for HealthX remains clear: to nurture a sustainable ecosystem of student-led healthcare innovation and become a launchpad for future talent and ideas. We look ahead to expanding our collaborations, deepening our impact, and empowering the next generation of clinician-innovators.

As its founder and chairman, it has been a privilege to witness HealthX grow from an idea into a community that champions innovation and empowers students to create solutions that advance healthcare.

Moving ahead, healthcare challenges will only grow in complexity. But I believe that by learning and building together, we can create solutions that outlast today's problems.

A word of thanks

Our progress this year was only possible with the support of many. We extend our heartfelt thanks to our advisor, A/Prof Dinesh Kumar Srinivasan, whose guidance and support played an important role in the founding and growth of HealthX.

We also extend our thanks to our partners and collaborators, including Prof Prashanth Jha (KCL), Prof Yen Ching Chiuan (DID), Dr Gene Chan, Dr Alexander Ng, Dr Cheryl Woo (CHS), and many others who have contributed to our journey.

Finally, to the existing and incoming HealthX Executive Committee – Harpreet Singh, Nicholas Lee, Nadia Yap, Jarrett Tan, Zhou Xinyan, Joel Tang, Darren Ho, Pranav Rao, Guang Shian, Marcus Lee, Kong Kei-Lyn, Jayden See and Avishi Gupta. Thank you for your belief in our shared mission and for journeying alongside me to build what HealthX stands for today.

Dr Thng has since graduated from the NUS Yong Loo Lin School of Medicine and is currently working as a junior doctor. As the founder of NUS HealthX, he now serves as its chairman, mentoring successive generations of student leaders and supporting them in driving the organisation's continued growth and development.





HealthX Design for Medicine Workshop

Healthier SG

Medical Students' Perspectives on a National Policy in Motion

Text by Foo Chuan De and Woon Ting Hui

Chuan De is a final-year medical student at Duke-NUS Medical School and a research fellow at the NUS Saw Swee Hock School of Public Health. His academic interests lie at the intersection of population health, family medicine and health policy research.



Ting Hui is a final-year medical student at Duke-NUS Medical School who has a keen interest in population health and Traditional Chinese Medicine. In her free time, she enjoys running.



As third-year medical students, we chose to write a *Lancet Regional Health – Western Pacific* Viewpoint article about Healthier SG (HSG)[1] because we found ourselves repeatedly asking: how do we sustainably stem the unrelenting influx of patients to tertiary hospitals? While higher patient volumes may offer broader clinical exposure for medical students, they also reveal an unsettling reality: an increasing burden borne by healthcare professionals at the front-lines and an overstretched hospital-centric model.

This catalysed our interest in HSG: a national policy pivoting the locus of care from reactive treatment in tertiary institutions to proactive, preventive care in the community. We were privileged to be mentored by experienced clinicians embedded in the three Regional Health Systems (RHS), whose perspectives grounded our observations in pragmatic realities. Their insights illuminated both the promise and the perils of this transformation.

A timely policy for a growing chronic burden

Like many developed nations, Singapore is experiencing a demographic shift towards an ageing population and a rising chronic disease burden. HSG was introduced as a system-wide response to this transition. As Prof Jose Maria Valderas, Head of the Department of Family Medicine in the National University Health System (NUHS), reiterated to us, "HSG aims to turn healthcare upside down. Instead of waiting for people to fall ill and then fixing the problem, it focuses on keeping every person healthy before trouble starts. This is a bold vision for fundamental change – decisively shifting the balance of care by placing primary care, health promotion and disease prevention at the very heart of the system." At its core, this policy empowers GPs to act as gatekeepers of care, ensuring that individuals are guided through a more preventive, coordinated and person-centred healthcare journey longitudinally.

Under HSG, individuals are softly empanelled to a GP of their choice to facilitate continuity of care. These GPs are responsible for the management of chronic illnesses, preventive screenings and the delivery of services across a wider biopsychosocial spectrum, including mental health counselling, health coaching and vaccinations. For these community-based, preventive healthcare initiatives to happen, the health system building blocks must already be in place and functioning. However, fostering a conducive environment for system change and adaptation is imperative.

Indeed, as A/Prof Jason Yap, programme director of NUHS' National Preventive Medicine Residency Programme aptly remarks, "Population health management is not engineering but gardening. We prepare the ground, plant the seeds, ensure the right sun and water, pull out the worst weeds – but complex adaptive systems must be allowed to grow from within."

Partnership, participation and power

For a policy of this scale to succeed, robust cross-sectoral partnerships are indispensable. Traditionally, many private GPs in Singapore operated as solo practitioners. Now, they are expected to engage with RHS institutions, the Ministry of Health and various community partners. Unlike prior top-down healthcare reforms, HSG has adopted a more participatory governance approach. GPs are now actively invited to town halls and engaged in technical working groups alongside policymakers, enabling a more inclusive and iterative process of policy co-design.

Yet, genuine collaboration requires more than consultation – it demands parity. In every multi-stakeholder initiative, the spectre of power asymmetry often looms large. Trust cannot flourish in an ecosystem where decisions are perceived as predetermined or unequally influenced. For HSG to thrive, all stakeholders – especially GPs on the ground – must feel that their voices carry weight. Without meaningful inclusion, confidence in policy longevity wanes.

Business models, burnout and burgeoning costs

Crucially, transformation must also be financially sustainable. Without viable business models, even the most well-intentioned reforms can falter. GPs, especially those operating in high-rent locales, face immense operational pressures. Coupled with the administrative burden of HSG – including referrals, health plan formulation and HSG-required parameter inputs – many GPs find themselves stretched thin.

While there are ongoing efforts to harmonise medication pricing between private GPs and public polyclinics – such as adjustments in Community Health Assist Scheme subsidies and medication price lists – these measures may not be enough if overall financial and infrastructural support remains insufficient. Even though one-off grants are available for electronic medical record (EMR) system upgrades, adoption remains uneven. Some GPs struggle with the digital transition and, without targeted support, risk being sidelined from the broader HSG vision.

Avoiding unintended consequences

It is imperative to ensure that the pursuit of measurable targets does not come at the cost of holistic care. As HSG metrics become embedded in clinical workflows, there is a risk of reducing population health to a series of checkboxes. This could inadvertently lead to cherry-picking behaviours and compromise the equity and comprehensiveness of care, where GPs preferentially enrol lower-risk patients to meet indicators with minimal effort to generate revenue, especially with rising costs. Moreover, issues like the chronic disease medication whitelist – a subject deserving its own in-depth discussion – highlight the policy complexities GPs navigate.

Silver linings: digital health and social prescribing

Despite these challenges, several bright spots have emerged. Digital platforms such as HealthHub and Healthy 365 have markedly improved public engagement with preventive health services. These apps enable individuals to seamlessly access vaccination schedules, screening results and health promotion activities. From the GP's perspective, such platforms facilitate more efficient data exchange, patient follow-up and health coaching.

The EMR grant is another positive step, though appropriate support should be rendered while considering individual technological literacy of GPs and the unique operational constraints of smaller practices. Without this, digital tools – though potentially transformative – could exacerbate existing disparities among providers.

Importantly, HSG is also attuned to the social determinants of health. By integrating social prescribing into care plans and working with community care organisations, the policy acknowledges that wellbeing is not merely a medical outcome. As Singapore ages, strategies that enable older adults to age in place, supported by both medical and social ecosystems, are indispensable.

Reflections from the frontlines of learning

Our budding medical student perspectives are shaped not only by academic inquiry but also by lived experience. Having previously trained at the NUS Saw Swee Hock School of Public Health, I (Chuan De) bring a public health lens to this policy. To me, HSG represents both a culmination of long-standing systemic pressures and a hopeful reimagining of care delivery.

My co-author and fellow medical student, Ting Hui, brings the unique vantage of prior training in Traditional Chinese Medicine (TCM), which emphasises preventive care and holistic healing. The increasing willingness to explore synergies between biomedicine and TCM within the HSG framework is an encouraging sign that diverse paradigms of health are being considered in policy conversations.

Through our rotations, we have seen the ground realities: high hospital admission volumes, long outpatient waiting times and overburdened acute care teams. While HSG is a step in the right direction, thoughtful attention must be given to the policy's operationalisation. Potential pitfalls must be identified and mitigated early to achieve a durable health system reform.

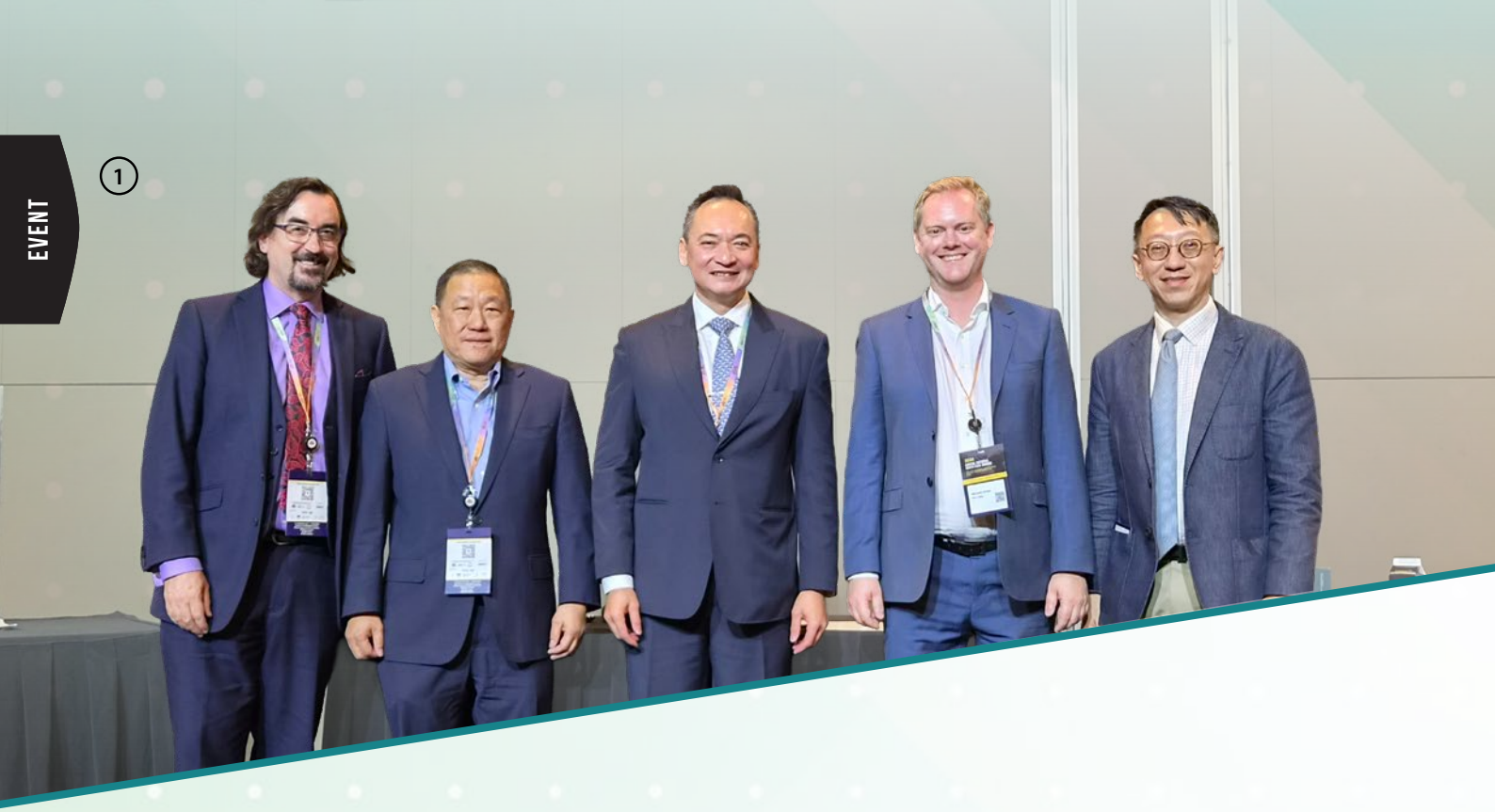
From our years of volunteering before medical school, we have also witnessed how the most vulnerable are often left behind. Future iterations of HSG and other prospective policies will need to wear in a more equitable lens, to ensure that all Singaporeans are safeguarded. To quote Dr Teo Ken Wah, associate consultant in public health at Singapore General Hospital: "HSG is in full swing, and our healthcare clusters, GPs and com-munity care organisations have made tremendous strides. Looking ahead, our strategies must increasingly focus on the most vulnerable populations and high-frequency healthcare users to systematically improve population health."

From an educational standpoint, we are heartened by the growing emphasis on family medicine within our medical curriculum. As Singapore transitions to a primary care-led model, the need for skilled, community-based gatekeepers will only grow. But clinical skills alone will not suffice. We strongly advocate for integrating health policy, governance and health economics into medical training. Our generation of physicians must be equipped not only to treat but to lead, design and evaluate health systems.

In many ways, HSG embodies the adage of "crossing the river by feeling the stones". This slow, cautious and context-sensitive approach to reform is emblematic of Singapore's policy ethos. Whether HSG will achieve its ambitious aims of reducing healthcare costs and improving population health remains to be seen. But as aspiring physicians, we remain cautiously optimistic. ◆

Reference

1. Foo CD, Woon TH, Chia HX, et al. Healthier SG: a gateway for evolving public-private-population partnerships in population health. Lancet Reg Health West Pac 2025; 60:101606.



THE LAST DECISIONS – Annual National Medico-Legal Seminar 2026

Text by Benjamin Ong, Editorial Executive



Over the weekend of 17 and 18 October 2026, more than 200 doctors and lawyers gathered at One Farrer Hotel to share and discuss the complex and challenging matters surrounding end-of-life care at the Annual National Medico-Legal Seminar (ANMLS) 2026, jointly organised by the SMA Centre for Medical Ethics and Professionalism (SMA CMEP) and the Medico-Legal Society of Singapore (MLSS). This year's focus was on "The Last Decisions: Medico-Legal Perspectives on End-of-Life Care", and speakers covered a wide variety of topics including conflict and cultural management, doctrines surrounding end-of-life care and the ethics of life-sustaining treatment.

Adj A/Prof Vishal G Shelat, Organising Chairperson of ANMLS 2026 and SMA CMEP Associate Director, opened the seminar with a brief address, and

Prof Richard Huxtable began the day with a broad exploration on "dying matters", covering the four topics of advance decision-making, withdrawing treatment, relief of symptoms and assisted dying. Other speakers for the day presented on topics such as artificial nutrition and hydration, what can be learnt from palliative cases across the globe, and communication surrounding end-of-life matters. Prof Lalit Kumar's sharing on six personal palliative cases he encountered across his career was especially poignant and drove home the point that palliative sedation is fundamentally about the patient's dignity, not about shortening their lives.

Panel discussions invited plenty of audience engagement, with audience members posing many interesting questions drawn from their own experiences. However, the highlight of the first day was a structured debate on medical futility surrounding the motion: "Doctors should be allowed to provide life-sustaining treatment even where it does not improve the patient's condition." Arguing the proposition were Prof Chin Jing Jih and Prof Richard Huxtable, while A/Prof Michael Dunn and Mr Melvin See argued the opposition. The lively debate was adjudicated by Mr Edmund Kronenberg, MLSS President, who also crafted the debate motion. After the debaters concluded their impassioned speeches, Mr Kronenberg shared that he intentionally included a great deal of ambiguity within the motion to facilitate a deeper discussion for all.

The second day of ANMLS was furthered by sharing of end-of-life cases in Hong Kong, discussion surrounding documentation of advance care planning, the role of nurses in end-of-life care, and the use of artificial intelligence technology in prognostic tools for end-of-life decision-making. In his closing address, Dr Aung Myint Oo @ Ye Jian Guo, Vice President (Medical) of MLSS and SMA CMEP teaching faculty, thanked participants for their attendance and enthusiastic contribution to the seminar.

We would also like to express our thanks to all speakers and participants, our main sponsor, Medical Protection Society, as well as our other sponsors for the success of the Annual National Medico-Legal Seminar 2026. ◆

Legend

1. MLSS President Edmund Kronenberg (centre) with the Day 1 debators

2. Perspectives from allied health professionals and lawyers help to build a holistic understanding of end-of-life care

3. Panel discussions elicited insightful and incisive dialogue with audience members



3

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13 February 2027, Saturday 1.30 pm	Ethical Considerations in the Use of AI Scribes	A/Prof Anantham Devanand
24 April 2027, Saturday 1.30 pm	Disciplinary Procedures for Doctors	Mr Lek Siang Pheng
24 July 2027, Saturday 1.30 pm	Abuse and neglect: When to report?	Asst Prof Crystal Lim
2 October 2027, Saturday 1.30 pm	Treatment Decision-Making in the Competent Minor	Dr Kumu Rajasegaran and Dr Oh Jean Yin

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SCAN



Members enjoying an intimate viewing session at the Boucheron boutique

An Afternoon of Elegance: Discovering Boucheron's Lierre de Paris

Text by Joanne Ng, Deputy Manager, Membership Services

On 14 October 2026, SMA hosted Discover Lierre de Paris: An Exclusive Champagne and Wine Experience with Boucheron, in partnership with CIMB Preferred Banking and Maison Boucheron. The exclusive event welcomed SMA Members across three intimate sessions comprising ten attendees each at the Boucheron boutique in The Shoppes at Marina Bay Sands.

The afternoon offered Members a unique opportunity to step into the world of Boucheron, the renowned French jewellery maison founded in 1858. Through an introduction to the Maison's rich heritage, Members discovered the inspiration behind its creations and the exceptional craftsmanship that has defined the brand for generations.

A key highlight was the presentation of Lierre de Paris, a collection inspired by ivy, a symbol of freedom, resilience and bold creativity. Drawing inspiration from the natural world, the collection reflects Boucheron's distinctive approach to jewellery design, transforming the beauty and character of nature into exquisite creations. Members had the opportunity to view selected pieces up close and appreciate the artistry and intricate details behind the designs.

Complementing the jewellery showcase was a curated champagne and wine tasting, accompanied by canapes and beverages. The relaxed and elegant boutique setting provided a welcoming atmosphere for participants to exchange views and build new connections with fellow SMA Members, and engage with Boucheron and CIMB Preferred Banking representatives. The programme also included a sharing by CIMB Preferred Banking, offering attendees an opportunity to learn more about its banking services and wealth management offerings.

Beyond the appreciation of fine jewellery, champagne and wine, the event reflected SMA's continued commitment to providing Members with exclusive lifestyle experiences and meaningful networking opportunities. The collaboration with CIMB Preferred Banking and Maison Boucheron also highlights the value of partnerships in bringing distinctive experiences to the medical community.

Through initiatives such as this, SMA continues to enrich the membership experience by connecting Members with premium brands, unique experiences and opportunities to build lasting relationships beyond their professional practice. ◆



A close-up of Boucheron's exquisite jewellery on display

AIC SAYS

Making Diabetes Care a Team Effort

by the Agency for Integrated Care



Managing diabetes requires more than clinical treatment alone. The reality is that social determinants of health and the socioeconomic realities that patients face outside the clinic dictate up to 80% of their chronic disease control, while clinical interventions account for just 20%.[1]

Yet many of these influences can be difficult to address during a typical GP consultation.

"In primary care, we all operate within finite time and dispense medical advice and therapy in time blocks. We cannot expect dramatic outcomes from short clinical encounters," Dr Roy Teow, Family Physician and Clinical Lead of SingHealth Delivering on Target (DOT) Primary Care Network (PCN), reflects.

"Lifestyle and social prescribing can help bridge that gap and facilitate an ongoing action-reflection cycle," Dr Teow shares. "While nurse counselling sessions are similarly time-constrained, we aim to improve our patients' mindsets through incremental encounters."

"Acknowledging this limitation may drive a shift away from our traditional, solo practice-centric GP model toward a more well-rounded, sustainable and scalable team-based care model," he continues.

In conjunction with World Diabetes Day, Dr Teow and Ms Teo Rui Ying, a Nurse Counsellor with SingHealth DOT PCN, share how team-based care helps patients turn treatment plans and lifestyle recommendations into lasting changes that support better diabetes control.

A partnership beyond the GP consultation

"Time and cost are our biggest constraints as a GP. Trying to deliver a comprehensive education package at the exact point of diagnosis almost always leads to information overload for the patient, and it severely disrupts a busy clinic schedule," Dr Teow shares.

"The PCN care team helps me deliver complex care without bottlenecking my clinic operations," he continues. "The nurses take over the time-intensive therapeutic education that we cannot fit into the same consult."

To make support more accessible for patients while minimising disruption to clinic operations, Dr Teow suggests: "We try to bundle nurse counselling with Diabetic Retinal Photography (DRP) and Diabetic Foot Screening (DFS) appointments. I would also refer patients to group diabetes counselling sessions conducted over Zoom, where lifestyle education can be broken down into digestible parts."

Nurse counsellors can also use social prescribing to connect patients with resources such as Active Ageing Centres (AACs), community exercise programmes, and Community Mental Health Intervention Teams (COMIT), depending on their needs.

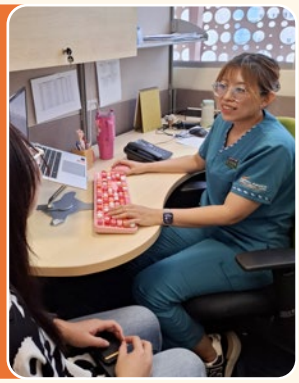
"From the patient's perspective, it can be experienced as one unified care plan even though the appointments take place on different dates," Dr Teow added.

Turning advice into action

Within this model, the GP and nurse counsellor work together to help patients turn care plans into action.

"GPs prescribe the treatment plan, and nurse counsellors help patients make that plan work in their everyday lives. Together, we're not just managing chronic diseases; we're empowering patients to live healthier and more meaningful lives."

- Ms Teo Rui Ying, Nurse Counsellor, SingHealth DOT PCN



Communication is key. Clinical information from the GP helps Ms Teo tailor her counselling, while insights gained during counselling can uncover barriers that might otherwise go unnoticed.

"After we complete our reports, we send them back to the GP with updates on the patient's progress, challenges and goals. This helps ensure that we are communicating the same messages," Ms Teo says.

This creates an action-reflection cycle. Patients test strategies discussed during counselling and return to reflect on what worked and what did not.

While patients who engage in counselling may already be more motivated, Dr Teow observes a notable change in how they approach their care: "They shift from being passive to now active partners in their own health outcomes."

Understanding the person behind the condition

Ms Teo notes that many patients may already know what to do to manage their condition but struggle to put that knowledge into practice. Counselling provides a safe space where patients feel supported rather than judged or lectured.

She remembers a patient, Mr Tan (not his real name), who was referred by Dr Teow for nurse counselling. Despite years of medication adjustments and regular follow-up, the patient's diabetes remained poorly controlled. He was initially guarded and saw little value in counselling.

Use HealthierSGEventsGoWhere to help your patients find suitable Community Lifestyle Activities

[1] Magnan S. Social Determinants of Health 101 for Health Care: Five Plus Five. NAM Perspectives. 2017. https://nam.edu/perspectives/social-determinants-of-health-101-for-health-care-five-plus-five/

"After spending time listening to him, I learnt that his challenge was not a lack of knowledge about diabetes. However, he had recently retired and was struggling with the loss of routine and purpose. He shared that one of his biggest fears was becoming a burden to his children," Ms Teo recalls.

"I think this is a concern for many older people. They worry not only about their own suffering but also about the effect on the whole family," Ms Teo reflects. "Instead of focusing solely on maintaining his blood sugar, we tried to add a bit of social prescribing around maintaining his independence and being able to enjoy time with his family."

By connecting health goals to what mattered most to him, self-management became more relevant and achievable. Following the counselling, the patient became happier and more motivated to manage his health.

Making healthy habits stick

Ms Teo believes that lasting behaviour change is more likely when patients choose goals that are meaningful and achievable within the context of their own lives. Her approach reflects the principles of Lifestyle Medicine, which focuses on helping patients build sustainable habits that fit naturally into their daily routines.

Ms Teo recalls another patient, a widow who struggled with motivation after losing her husband. Through their conversations, Ms Teo learnt that the patient used to enjoy walking in the park with her late husband. Together, they then set small yet meaningful goals as a start.

"She started with a few short walks each week in a place that held memories of her husband, creating a positive association with exercise," Ms Teo says. "Over time, she shared that her walks had become more regular and she felt happier. Eventually, she joined a walking group."

Dr Teow admits that long-term change is difficult unless the patient genuinely buys into the process and repeats it daily.

"One concept we try to teach is habit stacking," Dr Teow shares. "Instead of carving out an entirely new block of time for lifestyle change, we look for ways to attach a small adjustment to a routine the patient already has, such as doing a quick stretch after taking their morning medication or choosing to take the stairs instead of the lift when heading home."

Starting early for better outcomes

"I would encourage more referrals for nurse counselling, particularly early referrals for newly diagnosed patients. The earlier we engage them, the greater the opportunity we have to correct misconceptions, build trust and support meaningful improvements in diabetes or chronic disease management," Ms Teo encourages.

Over time, Ms Teo sees patients become more confident in managing their health: "They are no longer making changes only because the doctor or nurse told them to. They want to make the changes for themselves. That is patient empowerment."

For Dr Teow, how GPs position the service matters. While a small co-payment may increase resistance to enrolment, it can also strengthen patients' commitment to follow through on agreed goals.

"We recognise that the GP does not control the whole picture. However, our recommendations often carry the most weight with our patients. We should therefore frame nurse counselling not as an optional add-on, but prescribe it as a medical necessity," Dr Teow suggests.

Case Study: Team-based Care in Action



Patient Profile: Mr Tan

- Has Type 2 diabetes
- Overweight
- Retired and struggled with loss of routine and purpose

GP Review

During a routine review, Dr Teow noted that Mr Tan's diabetes and weight remained suboptimal. Dr Teow then referred Mr Tan to the PCN nurse for lifestyle counselling and social prescribing support.

Nurse Counselling

The nurse explored Mr Tan's lifestyle habits, challenges and understanding of his condition. Together, they set goals to:

- Reduce sugary drinks
- Walk 30 minutes, 2-3 times weekly
- Achieve gradual weight loss

Social Prescribing

To support these goals, Mr Tan was linked to community exercise programmes through the Healthy365 app. Mr Tan also discussed challenges adjusting to retirement. Strategies were explored to help him establish a structured daily routine and engage in meaningful activities.

Follow-Up with PCN Nurse

During follow-up sessions, the nurse reviewed Mr Tan's progress, reinforced goals and addressed barriers to lifestyle change. Updates on Mr Tan's progress were shared with Dr Teow to support coordinated care.

Follow-Up by the GP (3 months later)

At the follow-up, Dr Teow reviewed Mr Tan's clinical progress alongside updates from the nurse.

After three months, beyond the clinical improvements and gradual weight loss, Mr Tan reported healthier eating habits, a more active lifestyle and greater confidence in managing his condition, demonstrating how coordinated support can help patients translate health goals into sustained lifestyle change.

"By embracing this team-based model, we acknowledge that while our clinical time is finite, our impact does not have to be. We must build stronger partnerships between healthcare and community resources. We are equipping our super-ageing population with the exact tools and community support they need to maintain their health and independence outside of our clinic walls."

- Dr Roy Teow, Family Physician and Clinical Lead of SingHealth DOT PCN



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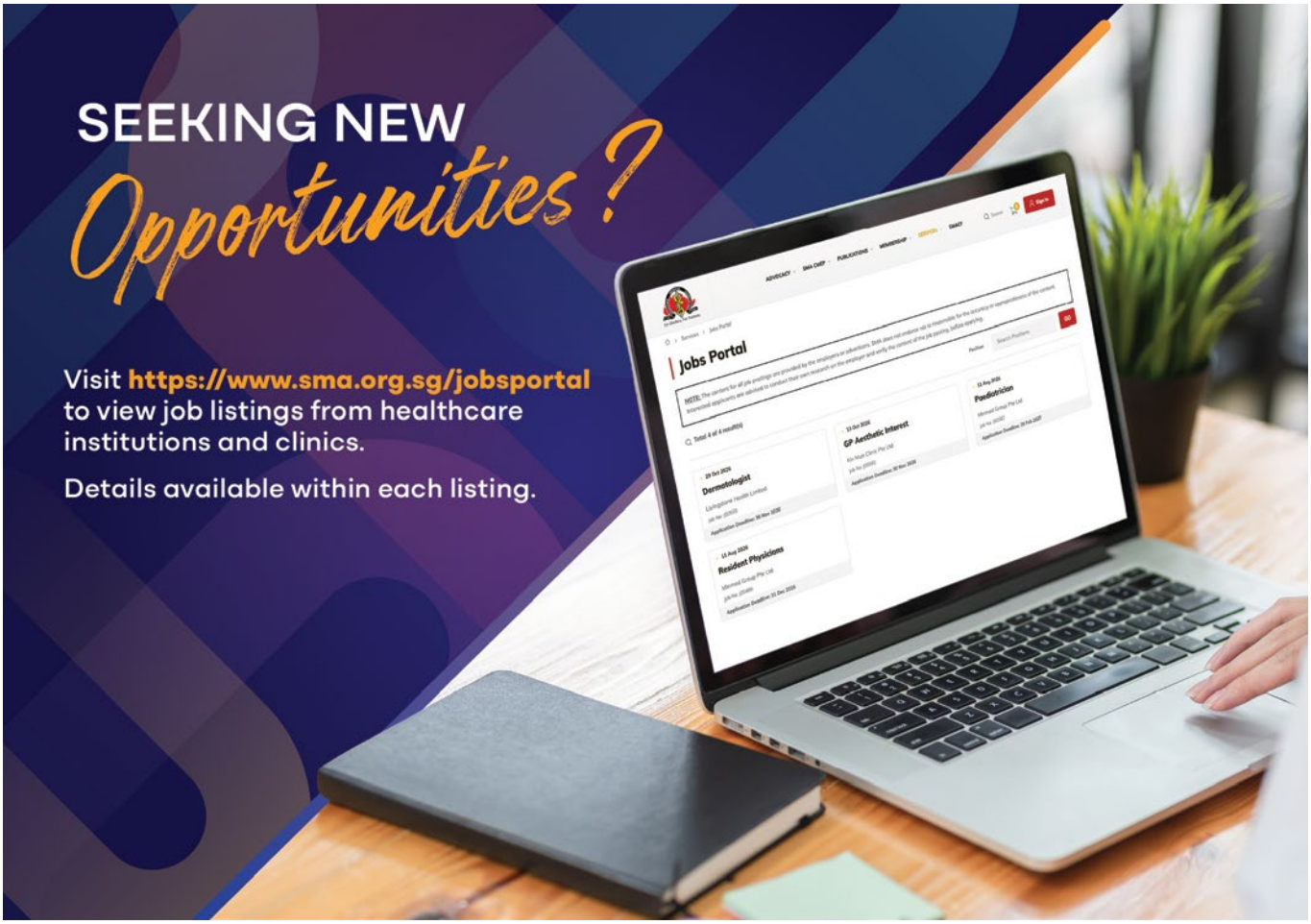

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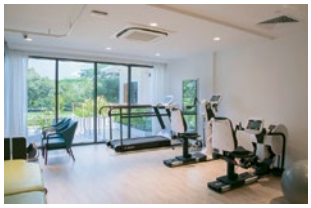



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