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GPs, read on!
TIME FLIES. It’s a cliche, I know, but I continue to be amazed by how fast the days have passed – we were just getting ready for Christmas, then we had to take down the tree. Next was the countdown to 2015, followed by Valentine’s Day, and then the Year of the Horse crossed into that of the Goat just like that. Maybe it’s me getting older, maybe it’s the fact that we see the sick and dying in our line of work – but I have never been more aware than ever to SLOW DOWN and appreciate life and those dearest to me.

In this issue, we focus on the human aspect of medicine. When it comes to the crunch, we are all humans. Not counting the minor ailments that I consulted polyclinic doctors for, I have been a patient five times. It is distinctly disconcerting to be on “the other side”. Long ago, I decided that when I became a patient, I would jolly well be a model one and not interfere with medical treatment. It helps that we have had a great team of doctors, nurses and allied health professionals who inspire nothing but trust, and I entrusted myself and my family into their hands.

Dr Audrey Looi tells a deeply personal story on how she set up a charity, iC2 PrepHouse, to help children (and their families) with significant eye conditions that cause impaired vision. Dr Ivan Lin writes about his travails with a major illness, and the life lessons he has learnt. I thank both of them for sharing their journeys and heartaches – that when “bad things” happen, there’s just no way to sugarcoat it. Side effects, abnormal scans, risks, prognoses: we know. It’s only by reaching out to each other as fellow humans in suffering, that the pain gets easier to bear.

Of course, we don’t just connect in times of grief and tragedy – there are many happier occasions when we come together to celebrate as well. Prof Foo Keong Tatt reflects on his great experience as a mentee, and then as a mentor to others. Dr Tu Tian Ming describes life after welcoming the newest addition to his family. We also report our first-ever session to meet writers and contributors, in my term as Editor. The event was also a good occasion to present Dr Alvin Lum with the grand prize for winning the inaugural Life in Pixels photo competition. I’m pleased to announce that we have a great line-up of themes this year to celebrate SG50, with prizes sponsored by Canon.

I anticipate a fruitful year ahead; our News team will carry on with sourcing for, and presenting articles of interest to our members. I look forward to your continuous support.

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Dr Tan Yia Swam is now an associate consultant at the Breast Department of KK Women’s and Children’s Hospital. She continues to juggle the commitments of being a doctor, a mother, a wife, and the increased duties of SMA News Editor. She also tries to keep time aside for herself and friends, both old and new.

55th SMA Annual General Meeting

Date: 12 April 2015, Sunday
Time: 2 pm - 4 pm
Venue: Arthur Lim Auditorium*, Level 2, Alumni Medical Centre, 2 College Road, Singapore 169850
*Lunch will be served at the auditorium from 1 pm.

To confirm your attendance, please send your response to SMA via fax: 6224 7827 or email: sma@sma.org.sg. You can also register online at https://www.sma.org.sg/agm. To assist us with catering arrangements, do indicate if you will be coming for lunch as well. For more information, please contact the SMA Secretariat at 6223 1264.
In Memoriam

Lee Kuan Yew
1923 - 2015

The SMA Council, Members and Secretariat convey our deepest condolences to the family of the late Mr Lee Kuan Yew, SMA Honorary Member 2012 and the country’s first Prime Minister.
SMA News catches up with Dr Alvin Lum (left, with his sons), a GP in private practice, to find out more about his passion for photography. Dr Lum’s image of water droplets (facing page) was voted as the overall Grand Prize Winner of the Life in Pixels 2014 photo competition.

What was the inspiration for your winning photo?
I saw a similar photo in a magazine, and it captured my attention immediately. I was intrigued and wanted to know if I could produce an equally eye-catching photo. I experimented with different methods of dripping water to produce the drops. Eventually I found that by using an expired intravenous drip set, I was able to control the drops to my liking.

How did you start this hobby of photography?
I have always been fond of photography since young, hence it naturally became a hobby of mine.

How do you find time to pursue your hobby?
I do not set aside a specific time to shoot – I do so when I can. However, I do wish that I had more time to shoot.

What are your favourite photographic subjects?
My family! Nothing is more valuable than memories of my family captured in photos.

How do you continuously improve your skills?
My wife (Chu Cheng) and two boys (Aaron and Abner) will give me comments on my photos. They are my strongest supporters and main source of motivation. Their honest comments make me strive to improve. I try to read photography magazines and books to find out how to take better photos. The winning photo was taken after I had read up on the basics of taking such photos. With some experimentation and adaptation, I was finally able to achieve the photo.

Could you share a secret tip you use when taking photos?
No real secret – just enjoy the photography! There are photo opportunities everywhere, you just have to look out for them.

How would you advise those who intend to pick up photography?
Definitely try it out, and have fun! Meet up with like-minded folks for shoots, get ideas and discuss your photos. This way you make good friends, enjoy your photography and have great photos to accompany your good memories.

Any other thoughts?
I would like to thank all my family and friends, as well as everyone else who voted for my photo! A big thank you to SMA for organising this photo competition too!
CONTINUING THE spirit of showing appreciation to SMA’s members and volunteers (who were the focus of this publication’s December 2014 issue), SMA News decided to host an inaugural Thank You Session for our article contributors from the second half of last year. The event was also intended as a platform for the SMA News editorial board members and staff to discuss ideas with and obtain feedback from these writers. The cozy meetup, held on 23 January 2015 at the SMA Secretariat conference room, eventually saw 20 doctors, medical students and staff gathered over light refreshments.

Editor Dr Tan Yia Swam welcomed the guests with a simple speech, thanking them for setting aside time to join us for the occasion, and writing for this newsletter. She also expressed her hope for their continued support in the coming years. In another highlight of the evening, Dr Tan presented a Canon EOS 1200D camera (sponsored by Canon Singapore Pte Ltd) to Dr Alvin Lum, whose image of water droplets was voted as the overall Grand Prize Winner of the Life in Pixels 2014 photo competition. To view all participating entries, visit http://www.sma.org.sg/lifeinpixels. (Turn to page 6 to read more about Dr Lum’s photography.)

The two-hour gathering also served as the perfect setting for a casual networking session, with many of the attendees engaging in both deep conversations and light-hearted banter throughout the evening.

Here, we wish to express our gratitude to the writers who were able to join us for the Thank You Session. We would also like to take this opportunity to call out to all readers who are interested in contributing to SMA News. Submit your stories or ideas to the team at news@sma.org.sg!
THE MEDICAL Protection Society (MPS), a UK-based medical defence organisation (MDO), recently announced changes to professional indemnity for doctors practising obstetrics in Singapore, producing quite a jolt in the local medical community. MPS is the largest provider of medical indemnity in Singapore, covering about 10,000 registered medical practitioners here. Tremors from their decision to switch obstetricians and gynaecologists (O&G) who manage pregnancies after 24 weeks’ gestation from occurrence-based to claims-made cover, were felt beyond the O&G community. Many doctors from other specialties wondered if they would be next in line for the axe. Many questions were asked as doctors sought to understand this sudden and drastic change.

History of medical indemnity
Perhaps the current changes can only make sense when we examine the history of medical indemnity, and have a better understanding of what the risk-pooling business is all about in the context of professional liability.

Professional indemnity began in 1885 in England, when the Medical Defence Union (MDU), the world’s first MDO, was formed in response to the medical community’s outrage over the case of Dr David Bradley. He had been wrongly sentenced to two years of hard labour in 1884 for sexually assaulting a woman who suffered erotic delusions during and after epileptic seizures. Dr Bradley served eight months in prison before he was eventually granted a pardon. The case raised awareness among medical practitioners then on the risks involved in medical practice, and the need to pool resources together in order to defend doctors’ reputation and livelihood against a rising tide of patient-initiated medical litigation. In addition to offering legal advice and defence, MDU was also established to promote honourable practice, to prosecute unauthorised practitioners, and to take positions for or against legislative measures that might benefit or adversely affect medical practice, respectively.

Over the next century, more MDOs like MDU came on board in England and other Commonwealth countries, each with a large membership base. These MDOs were formed as not-for-profit mutual organisations with member-owned assets, offering legal advice and assistance for doctors in response to complaints or claims after adverse events.

From my recent conversations with fellow doctors, I realised that many have only a superficial understanding of the different types of medical indemnity, including the particular type of coverage that they themselves have. A key fact to appreciate is that in many of these adverse incidents leading to complaints or claims, there is usually a lag time between the event occurrence and subsequent discovery and claim against the doctor. Whether a doctor is covered for an event depends on the type of coverage his plan provides – whether it is one based on when the incident occurred or one which depends on when the claim or complaint was made.

Traditionally, many MDOs are mutual organisations which offer “occurrence-based discretionary cover”. Such coverage is “occurrence-based” because the MDO will assist the doctor in any complaint or claim against him, as long as the adverse event happened during the period of paid membership or premiums. This is regardless of when or how long later the discovery and therefore the claim for the incident are made (this can be years after the doctor has ceased practice and stopped paying premiums). Therefore, doctors on occurrence-based plans do not need to make any further arrangements for long term protection (“run-off protection” or “tail cover”) after contract cessation. Many such plans are “discretionary”, because in contrast to cover under an insurance contract, the MDO may exercise discretion on whether or not to grant assistance to a doctor member; this assistance, once granted, may not have a limit to the cover offered.

Claims-made cover, however, provides indemnity coverage only for claims made during the period of cover.
paid for. This is not unlike an insurance-based cover which ends when the contract ends. In such schemes, doctors would have to purchase run-off (or tail) cover to remain protected for any claims made after the period of cover has ended. Run-off cover can be purchased from another provider, though it is probably more practical to do so from the same one. In general, the annual premiums for claims-made cover are lower than occurrence-based ones, but the difference is offset by the additional amount needed to purchase tail cover.

MPS announced that it will no longer cover obstetricians under an occurrence-based scheme, but will instead provide only claims-made cover, with an option for tail cover purchase, in blocks of five years. If one were familiar with the recent turbulent history of medical indemnity, particularly the 2001 collapse of United Medical Protection (UMP), then the largest MDO in Australia, it would not be surprising that the obstetricians were the first to be hit.

The first case that accelerated the medical indemnity storm was an obstetrics one in Australia. In November 2001, after a nine-year legal battle, the New South Wales (NSW) Supreme Court awarded Calandre Simpson, then 22, A$14 million (reduced on appeal to A$11 million). Ms Simpson was born in 1979 with severe athetoid cerebral palsy, and as a result became severely disabled. Her mother was given Syntocinon as part of labour induction, and five attempts at forceps delivery were made before she was finally delivered by caesarean section. The court ruled that her brain injury was caused by negligence by the obstetrician Dr Robert Diamond during the delivery.

This large payout was instrumental in catalysing UMP’s demise. What was significant about this case was firstly, the quantum was twice that of the next highest payout, as it factored in the costs of future care for the disabled claimant. Secondly, and perhaps more importantly, the claim was allowed 22 years after the incident had occurred, because it was held that the true impact of an obstetric case on brain injury might not be clear or discoverable until the age of maturity. This resulted in a hyperinflation of the estimated sum of incurred but not reported (IBNR) claims (about A$455 million) which UMP would be expected to pay over the subsequent 20 years. UMP was then already under severe financial stress from increasing claims and progressively huge payouts awarded by the Australian courts.

With its reinsurer’s collapse and a spike in claims in anticipation of tort reforms to cap payouts, the worst finally happened when in April 2002, UMP applied to the Australian court to appoint a provisional liquidator. As UMP was one of the two MDOs serving Singapore doctors, doctors under its cover were not spared the impact of this indemnity tsunami from Australia. To make matters worse, the guarantee of cover provided by the Australian federal government was not extended to UMP members in Singapore, who had to scramble for tail cover provided by both MPS and NTUC.

### Challenges in providing cover for obstetrics

In its announcement, MPS stated that the main reason behind its change in its professional protection for O&G specialists was due to the “challenges and risks associated with obstetric claims and obstetric litigation globally”. Key to this is the length of time between a birth injury and the settlement of an obstetric claim, which can be 20 years or more, compared with an average of five years for non-obstetric claims. MPS cited uncertainty in legislation and claims environment as reasons why it would be difficult to estimate the value of future obstetric claims, and hence the accurate pricing of obstetric risk now.

It is important in this discussion to appreciate that mutual insurance is an instrument of equitable risk distribution, where a group of doctors come together and agree to share their total estimated risk based on historical claims data, and then redistributing this risk among members. In contract insurance, a doctor hedges against the risk of loss from a professional liability claim by purchasing insurance coverage from an insurer through premium payments. Both forms of risk management use an actuarial science model which applies mathematical and statistical methods to assess risk. Basically, to sustain such a model, payouts should not exceed the sum of all paid-up premiums, and the premium quanta can be reasonably estimated from known claims data.

It is easy then to see the challenges faced in providing occurrence-based cover for a specialty like obstetrics. The specialty has an intrinsically long run-off period, and a tendency to face high (and still rising) quota of claim payouts, resulting in a potentially large sum of IBNR claims that is risky and unmanageable. With such a profile, occurrence-based cover will be unsustainable due to high premiums needed to sustain the system. And more importantly, in such an environment, the difficulty in estimating the quota of future payouts many years later during the run-off period makes it almost impossible to predict, with reasonable accuracy, the appropriate premiums to be paid now. This probably explains why MPS, in offering tail cover (“extended reporting benefits”), has indicated that its tail cover is available in five-year blocks, thereby enabling it to price coverage more accurately with five-yearly adjustments. Above all, the risk of insurer collapse in providing occurrence-based cover to such doctors becomes more than just a theoretical possibility. With hindsight from the Australian indemnity crisis, MPS explained on its website that “as a responsible organisation”, it “must make changes in order to … continue providing affordable and sustainable professional protection to obstetricians”.

For the same arguments above, it would be fair and logical to expect the same changes to soon affect other specialties that treat or operate on young children. Besides the inevitable contact in neonatology and general
paediatrics, specialties that are involved in providing high risk interventions in young children, particularly paediatric neurosurgery, may be next. The only reason why that has yet to happen is probably because payouts for claims in these specialties have yet to reach untenable quanta. But given the increasingly litigious climate in first world countries, this day may not be far away.

**Solutions for this crisis**

Is there a concrete solution to this? Some have advocated that having more insurers may help by providing choice and competition, thereby reducing monopoly by one major provider. However, no matter how many providers we have, none can run away from the realities of actuarial science mentioned above. In fact, the reduction of doctors covered by each insurer works negatively for the economies of risk pooling, and may again make the calculated premiums unbearably high.

Increasing premiums is possible but only a temporising measure, as they will soon reach a prohibitive sum. As one Australian obstetrician told the Australian Broadcasting Corporation in 2002 – he used to only need to deliver one baby to pay his premiums in 1982, but by 2002, he had to deliver 100 babies to pay for his insurance. In some countries, this has resulted in doctors relocating to states with more affordable premiums. In Singapore, I suspect while a few may do this, some may decide to retire, while many may consider practising only gynaecology.

This indemnity crisis cannot therefore be a problem of only the medical profession, but also of wider society, because any O&G specialist can decide to practice only gynaecology, where the risks of litigation are more manageable with a lower risk of IBNR. Now if most local O&G specialists decide to abandon obstetric practice, then obstetric care costs will escalate to a prohibitive level by a simple demand-supply principle. Even those who intend to retire from practice completely may be discouraged from quitting by the staggering tail cover that they need to pay to cover IBNR cases in their careers. Society may have no choice but to regress to less costly options like nurses and midwives. In complicated pregnancies, the lack of specialist medical management can potentially result in higher risks to mother and fetus. Some citizens may even find the obstetric care costs so prohibitive that they decide to not have any children altogether. In the worst case situation, if obstetric practice is unable to obtain insurance cover, many will likely stop practice. While these are presently just speculative scenarios, their likelihood is not insignificant. For a country that is trying very hard to improve its birth rates, this can be a serious setback.

Obstetric practice is also being influenced where caesarean sections are known to be popular among obstetricians despite the absence of clear contraindication to normal delivery, as a way of lowering professional risk related to brain injury and other problems associated with a complicated vaginal delivery, particularly when instrumentation is needed. But caesarean delivery is not a problem-proof alternative either, as it has its own risks not usually present in normal vaginal delivery. Another way of defensively managing risk would be to cherry-pick straightforward cases, with few keen to take on complicated pregnancies. Doctors are not trained to evade challenging cases, but if the blame-and-sue culture leads one day to the prevalence of an unforgiving and harsh practice environment, then defensive medicine will unfortunately rear its ugly head.

The most likely solution that will bend the curve can possibly be found in tort reform. In 2002, Australia tackled its medical indemnity crisis by subsidising doctors subjected to high premiums and introducing a number of tort reform measures. For example, NSW law was amended to require doctors and others defending personal injury claims to show only that they took reasonable care, to set upper limits to damages, to hold lawyers personally liable for costs if they instigate “unmeritorious” public liability insurance claims and to limit access to courts. Then NSW Chief Justice James Spigelman pleaded to his fellow judges to adopt a principle-driven reform, which includes rationally moderating the scale of their damages awarded. While the Singapore judiciary has thus far been very reasonable and balanced, one cannot be certain that the same crisis in Australia and the USA in the last decade will not happen here. Now may be an opportune time for us to consider similar tort reforms that will provide more definitive and durable solutions, ultimately benefiting patients and Singaporean society.

While local healthcare services are generally safe and well regarded, adverse incidents can still arise from medical care despite the best of efforts, especially with complex cases or frail patients. In these cases, there is no denying that medical indemnity plays a vital role in protecting both doctors and patients. Therefore, it is also time for the regulators to consider making medical indemnity cover mandatory for all medical practitioners. It takes away unnecessary anxiety in both patients and doctors, leaving no one in a lurch when adverse events occur.

The soaring cost of medical indemnity cover today is certainly a national problem. It is time, perhaps, for us to consider tort reform as a more definitive and long-lasting solution that will benefit both doctors and patients.

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A/Prof Chin has been President of SMA since 2012. He is a geriatrician in Tan Tock Seng Hospital with an interest in ethics, professionalism and systems of care.
Thank you for updating your information with SMA. The lucky draw winners* for three iPad Mini 3 16GB Gold with Wi-Fi Access each worth $548 are A/Prof Shantha Amirth, Dr Chua Tee Lian and Mr Aloysius Loo. Congratulations! Read what SMA means to these three lucky winners and their hopes for the Association below.

*A 74-year-old SMA Life Member was initially one of the three winners. However, he gave up the iPad Mini 3 as he felt that someone else would have better use for it than him. SMA would like to thank him for his generosity.

“SMA has strived to remain relevant in helping doctors, in public and private institutions, to enrich themselves professionally. I would like to see SMA evolve into a prominent platform for members of the medical fraternity to debate on current and contentious issues.”

– Dr Chua Tee Lian

“I have been an SMA member since the mid-80s. Through the years, I have watched SMA develop with an all-encompassing role of representing the medical fraternity of Singapore. I have also published some of my papers in the Singapore Medical Journal (SMJ). I appreciate SMA’s efforts for medical education, especially the courses on medical ethics.”

– A/Prof Shantha Amirth

“SMA is the face and voice of the local medical profession. Being a student member, I get to enjoy up-to-date information about the local medical landscape from SMJ. I hope that SMA will continue to protect my interests and provide me with career improvement opportunities.”

– Mr Aloysius Loo

SMA Photography Courses
SMA, in collaboration with Canon Singapore Pte Ltd, will be conducting a series of photography courses that are aligned with the themes of the Life in Pixels SMA News Photo Competition 2015. Limited spaces are available for these photography courses, so find out more about them on the SMA website at http://goo.gl/6Wg3mv now as registration for the first run (for members only) is open.

**Date:** 11 April 2015 (Saturday)  
**Time:** 1.30 pm to 4 pm  
**Venue:** Alumni Medical Centre  
**Price:** $20

**Topic:** Basic photography course with a focus on people (aligned with the 2015 SMA News Life in Pixels Photo Competition’s SG50 themes)
Working in a Clinic: More Hazardous than You Thought?

Text and photos by Dr Wong Tien Hua

This is part of a series on workplace safety and health for healthcare institutions.

Mochi is a delicate sticky rice cake, usually filled with sweet red bean paste and eaten as a dessert in Japan. Although it is available in the country throughout the year, it is most often served during the New Year. Mochi might be a soft, sweet and lovely treat, but it is also a deadly health hazard.

Every year, several people choke to death after consuming mochi in Japan. I found out about this interesting fact when I came across a report in a local newspaper, which said that nine people choked and died in January this year. This food has caused a fair bit of concern with the folks at the Tokyo Fire Department, as they had to respond to almost 100 emergency calls of choking every year in the Japanese capital alone. In response, they even put up a webpage on the choking hazards of mochi, complete with uniquely Japanese kawaii cartoon figures doing the Heimlich manoeuvre.

Since this article is about workplace safety and health, I bring up this reference because it illustrates three important characteristics of workplace health hazards:

1. Hazards occur so infrequently that they are easy to ignore, but they can happen even in seemingly innocuous situations.
2. When accidents occur, they can be unexpectedly dangerous and even fatal.
3. Awareness and simple preventive steps alone can prevent most accidents (in this case, please cut mochi into smaller pieces, eat mochi slowly, chew mochi carefully and enjoy the taste).
ergonomics is a major hazardous risk factor that we simply cannot afford to overlook. Used incorrectly, ergonomics is the silent killer that will slowly and insidiously lead to chronic debilitating conditions such as lower back pain, neck strain, tension headaches, eye strain, frozen shoulders, and wrist strains – to name only a few. Such musculoskeletal disorders are a result of mismatch between the worker, the equipment, and the task.

For doctors, inferior ergonomics means adopting poor posture in the sitting position for long periods. During consultation, patients are often seated on one side of the desk, while the office computer is located on the opposite side, causing doctors to make frequent twisting spinal movements. The increasing use of electronic records means that doctors frequently need to type and click on the computer, often thrusting the head forwards to glare at the monitor, resulting in problems with the cervical spine and musculature.

For the nurses and clinic assistants, ergonomics come into play with long hours of standing and sitting at the counter, retrieving medical records, carrying stores, and physically handling patients.

Prolonged duties at the registration counter lead to static posture and repetitive movements of the upper limbs. This increases the risk of neck and lower back pain as well as strains of the wrist and shoulders. The answering of phone calls is a common cause of musculoskeletal strain from poor posture especially when the handset is grasped between the neck and the shoulders.

Handling of stocks and movement of stores are part of the clinic staff’s duties, but many are not properly trained to handle large cartons of drugs that can be very heavy (e.g., those containing glass bottles filled with liquids). Stocks may have to be lifted onto high shelves and cabinets for storage. This introduces the risk of overstretching of the upper limbs when trying to reach heights above the shoulder level, while the use of ladders to reach higher shelves may result in accidental falls from elevated heights.

Ergonomic risk is increased when patients are handled improperly and repetitively. Some common situations to note are: staff adopt an awkward position while helping patients, use too much force, and attempt to do the task alone without assistance from others.

Having identified ergonomic risk factors, suitable control measures need to be established. Using a comfortable chair with adequate back support and smooth swivel, and adjusting the desktop workflow such that the computer is at a comfortable distance and height, will pay off in the long term. Staff need to be aware of possible hazards, shown the correct postures, taught proper lifting techniques, and given appropriate tools (such as trolleys and stepladders) to ease the physical demands of the job.

Physical hazards

Physical hazards, ubiquitous and intrinsic to the physical world that we occupy, lie in wait for us to lower our guard in a moment of carelessness to cause injury and pain. Doctors as employers and team leaders have a responsibility to walk through their clinic premises to record physical hazards that are present. Sharps such as needles and surgical blades are the most obvious physical hazard because they carry infectious risk as well. Most healthcare workers are trained and aware of these dangers when handling and disposing of sharps.

Hazards in the clinic premises are apparent as soon as one opens the main glass door. If there are no stickers or markings, people can walk into clear glass panels. Steps at the front entrance need to be clearly marked to prevent trips. In the waiting area, take note of sharp corners on furniture and defective seats that may cause injury. Some water dispensers have a hot water tap and these must be marked and kept away from children. Coffee machines, televisions and other electrical appliances present risks of electrical shock if the wires and sockets are exposed. Wires running along the floor have to be secured and covered. Carpets and floor tiles must be smooth and flat to prevent tripping. Filing cabinets and drawers must be closed as soon as users have assessed the contents.

Equipment hazards

Clinic staff not only need to be trained on how to properly operate clinic equipment but also know the possible hazards present. Common equipment include ECG machines, autoclave machines, and cardiac defibrillators.

Most defibrillators installed in outpatient clinics today are automated external defibrillators (AEDs). They are generally safe for the operator as they adopt a “hands-off” approach, and do not require manual firing of the electrical current. However, risks of electrical burns and electrical shocks still exist if the equipment is not used correctly. Faulty ECG machines also have the potential to cause electrical shocks.

Any defective electrical equipment or appliances may cause electrical fires. Clinic premises are required by legislation to have smoke detectors and fire extinguishers. These must be placed in visible areas and clearly marked. Some premises also have hose reels and sprinklers installed. All staff must be trained to operate the fire extinguishers and other firefighting equipment in the premises.

Conclusion

It should be clear by now that every type of work carries occupational hazards and healthcare is no exception. As healthcare workers, we sometimes pay too much attention addressing the healthcare needs of others while neglecting to look into our own needs and safety.

Having a good workplace safety policy at your clinic is good for both your staff and patients. Awareness of physical and equipment hazards is the first step in planning a workplace safety policy. Since every practice is different and unique, with different premises and equipment used, we must conduct our own risk assessment based on our local configurations.

The following procedure is a useful guide to adopt:

1. Identify hazards – conduct a walk-through and see the clinic from the perspective of the staff or patients.
2. Evaluate risks and existing control measures in place – what is the likelihood of injury and if it occurs, how serious could it be?
3. Evaluate the tolerability of residual risks – even with control measures in place, accidents can still happen.
4. Identify any other risk control measures – the hierarchy of controls (with the most preferred first) being:
   a. Elimination – remove the physical hazards entirely.
   b. Substitution – use safer equipment.
   c. Engineering and administrative controls – isolate hazards and restrict usage and access to hazards.
   d. PPE – use these when risks are still present.
5. Evaluation and feedback – close the loop and provide a mechanism for continuous improvement.
“A baby will make love stronger, days shorter, nights longer, bankroll smaller, home happier, clothes shabbier, the past forgotten, and the future worth living for.”
– Anonymous

New Beginnings

Text and photos by Dr Tu Tian Ming
PARENTHOOD IS a life-changing experience. Cliched as it may sound, nothing prepares you for this path no matter how much homework you have done prior to the big day. We even attended prenatal classes to steady ourselves for the daily grind. And with my limited paediatric knowledge from medical school, I thought I was all ready to take on the new job title of “Daddy”.

Days shorter and nights longer
Night calls during housemanship were long. The endless changes, continuous beeping of the pager, countless patient reviews and serial ECGs (yes, I still had to do ECGs as a houseman... that's how old I am) kept me up the whole night. Nevertheless, at 8 am, bad things always came to an end. Post-call (when possible) was something I looked forward to for a recovery snooze.

Then came registrarship. Emergent decision-making took place throughout day and night. There were endless consults and admission reviews, and post-call was non-existent. Nevertheless, once again, at 5.30 pm the following day, I could pack up and go home to crash in bed.

However, daddy duties never end. This is a daily routine after working hours. My better half would perform a handover to me at 6 pm, marking the beginning of my call... I meant my after-hours parenting role. Bathing and putting Marianne to bed are my current core responsibilities. Cradling her in my embrace at 2 am and seeing her staring back with her big innocent eyes, I can only attempt to sedate her with my limited repertoire of bedtime songs and rocking motions. The Z monster often conquers me briefly, and Marianne will then promptly remind me – with a resounding wail – that the boss of the house is still awake. I will eventually be rescued from the quicksand by my ever dependable wife, and a short nap is all I am allowed before the next working day begins. The cycle repeats itself daily and this has become the circadian rhythm I have gotten accustomed to. Uninterrupted sleep is indeed a premium!

Bankroll smaller and clothes shabbier
Overseas holidays, fine dining, musicals and movies are a thing of the past. Our home has been invaded by boxes of diapers, packets of baby wipes and cartons of baby cereals. Mess is now a norm, but there is always order in the chaos. The living room has been converted to a play area, the study room has morphed into a storeroom, and our bedroom is now triple sharing. Never have I better appreciated space management! Self-care is limited to maintenance of personal hygiene and fashion is limited to what is most convenient.

Home happier and love stronger
Despite the sweat, blood and tears, something strange has happened: there is a continuous yearning to return to the chaos; recurrent longing thoughts about Marianne occur throughout the day while I am at work. The desire to hold her close, kiss her chubby cheeks and hear her laughter is ever present. The joy of cuddling my little girl after returning home makes the day truly worthwhile.

Despite leading a simpler life now, joy fills up the household and has made us feel richer than ever before. Parenthood has also made me even more appreciative of my immensely capable wife! Being a superwoman, she single-handedly cares for and nurtures Marianne during the day so that I can work in peace. The love Mummy showers on Marianne is immeasurable. Nothing I am able to provide can commensurate with the amount of dedication given by my wife.

Future worth living for
Marianne took a long time to arrive into this world. After she finally greeted us with a resounding hello, I held her dearly in my arms. She was so small and precious.

Days have gone by and Marianne is different all the time! She learns a new trick, a new skill or even a new babbling word every day. I will always remember her first smile, her first laugh, her first solid meal, and even her first flying poop. There were many other firsts in our lives with Marianne. Our first vaccination visit, our first meal out in a restaurant, our first overseas trip... I will be looking forward to her first steps, her first words and her first day in school!

At this point, I am only at the beginning of this long journey. Many seasoned parents have told me that the challenges will evolve as years pass, and troubles will be inevitable. The going will get tough yet nothing will be insurmountable with an awesome teammate in life. Happiness doesn’t come easy, but I would not trade this adventure for anything else in the world!
A Beautiful Journey

By Dr Ivan Lin
IT HAS been five years; nevertheless, the pain remains. I still cry alone at night in bed; I still recall my leukaemia.

Time might have passed, but I will never forget. I was diagnosed with acute lymphocytic leukaemia back in March 2010, and became a patient. Nobody knew me. I wasn’t anyone famous. I hadn’t won any awards. I was just a junior doctor. Quietly, I took the pain. I went through the chemo, because I wished to show everyone it was possible. As a doctor, I wanted to set a good example for my patients; I wanted them to believe in the medicine.

Nobody said life would be easy. There was so much pain, yet I didn’t give up. Even if I were to die, I wanted to die knowing that I have done my best. I wanted to have no regrets. Every moment was precious, and I was happy for each day I had.

Even today, I am grateful. So many people have come up to me, and encouraged me. They had found out about my story, and they wanted me to live. I was truly touched by the love I received. I have never felt so loved before.

Deep inside me, something has changed. I am no longer the man I used to be. I have learnt to accept that I am human, and I am humbled by my fragility. Even doctors die, and they die quietly, fading away into the distant past.

Some time back, my story was made known to the late Prof Lam Khee Sien. We kept in touch, and he wrote to me:

Hi Ivan,

Sorry to take some time to reply to you. Thank you for your sharing. Both of us shared the same experience.

I am Dr KS Lam, senior orthopaedic surgeon from Changi General Hospital and in KK Women’s and Children’s Hospital. I was doing well, and successful and happy in my career. My whole life and priorities suddenly and dramatically changed. My career and wealth were no longer the desires of my heart. My God and my family became the most important things in my life.

I was devastated like you when I learnt that I had advanced stage transitional cell carcinoma of my right lower ureter with metastases to the pelvic and para-aortic lymph nodes in June 2009. I had a right nephrectomy with right ureterectomy done and subsequently had six cycles of chemotherapy. I was cleared of metastases.

It was different to be at the other end of the table – being a patient. It helps me to be more understanding, compassionate, sensitive and caring when dealing with patients and relatives.

Praise God and I was able to continue where I left off. However, I had a relapse after 1.5 years with metastases to the pelvic and abdominal lymph nodes, liver, left lung and left supraclavicular lymph nodes.

Like you, I will never give up. I will never give up.

No one lives forever. I have seen death, and I know death. Prof Lam passed away on 18 May 2013 from ureteral cancer. He had touched my heart while he was alive, because he made me realise that we are all the same. Regardless of what kind of doctors we are, we are human.

There were others as well. I remember a friend once shared with me about a kind and helpful registrar he had come across during his houseman posting. The registrar’s name was Dr Ng Tsong Haur. While I didn’t know Dr Ng personally, I had heard about the good deeds he had done. He was kind to his juniors, and was always willing to render his services.

He too, has left us, on 25 July 2009 – barely a few weeks after he was diagnosed with terminal gastric cancer.

Sometimes it is not easy. Nonetheless, I will carry on. Good people do die, but they leave us with memories of their kindness. And I want to always remember the kindness I have received.

Life is a journey. There are challenges, yet there are beautiful moments too. I have grown so much since my leukaemia, and my life will never be the same again. Many people have supported me, which warms my heart. I want to keep going; I want to make a difference. It is because I am happy to be alive.

Someone once told me I was very special. My buddy even stated that I was, and will always be, an inspiration to everyone around me. It is difficult for me to believe.

I was never in the Dean’s List. I don’t have any accolades. I haven’t published any papers in any journals. I am neither a trainee nor a specialist. But I am a doctor.

I am Dr Ivan Lin.

References

Dr Ivan Lin is still on follow-up for his cancer. He will live life to the fullest, and make his dreams come true. He can be contacted at ivan.lin.xiaohui@gmail.com.
This article was adapted from a speech Prof Foo gave during the Symposium on Panel on Teaching through Mentoring at the Singapore General Hospital (SGH) Annual Scientific Meeting 2013.

Introduction

In the Greek epic poem, the Odyssey, Mentor was the name of the wise counsellor whom Ulysses entrusted to bring up his son, Telemachus. According to Wikipedia, a mentor is defined as someone who imparts wisdom to and shares knowledge with a less experienced colleague. Someone who has the welfare of his mentee at heart: a true friend.

Medicine: both art and science

I learnt from Prof Wu Jieping, considered the father of urology in China, that we do not treat diseases, rather, we treat patients. Treating diseases is a science and treating patients is an art. Whatever we do should be in the interests of patients. We should treat patients as a whole, treating them irrespective of class or creed.

To improve our care of patients, mentoring should impart both the art and the science. We should treat with competence and care with compassion. To enhance our care, we need to conduct research and teach the next generation.
Why the need for mentoring?

Good clinical practice should not only be evidence-based, but also a balanced application of the knowledge in real-life practice, for the best interests of patients. This necessitates a good understanding of the natural history of disease and the correct attitude.

Balance is the key – in nature, in our lives as well as in management of diseases. The way is not straight, but full of twists and turns. That is why in Eastern philosophy, the symbol for balance is the yin and yang. We need to balance the high tech and the high touch; the hardware and the heartware. We must keep to the middle. However, balancing is not easy, as it requires experience and wisdom, and not just knowledge. That is why mentoring is necessary.

What makes a good mentor?

Over the years, I have been blessed with good mentors, who helped to shape my life and philosophy. In 1968, I was among the first batch of surgical trainees at the newly opened University Hospital in Kuala Lumpur. There, I had the good fortune to come under Prof Yong Nen Khiong, who cared not only for his patients but also his trainees. He taught me that “we do not give our best, but the best to patients”. This is because our best may not be good enough and that we should refer patients to the best available.

After my fellowship in 1972, I joined the University Department of Surgery at SGH as a lecturer under Prof Ong Siew Chey. He was yet another good mentor who emphasised proper diagnosis and also pre- and post-operative management, instead of just operating. Also we were reminded to “be one step ahead of the complications, if not the patients may be one step beyond!”

In 1978, Prof Foong Weng Cheong took over as head of the University Department, and I learnt from him not only surgical techniques but also the importance of understanding the natural history of diseases. He used to comment that our then new technique, transurethral resection of the prostate (TURP), was incomplete compared to his open surgery for prostate and we disputed that. But he was proven right 30 years later, that our conventional TURP was indeed incomplete, as many patients returned with haematuria and other symptoms due to recurrent adenoma. As we now have a better understanding of the disease’s natural history, we have improved the procedure by changing to enucleation and resection of the prostate transurethrealy.

Three decades ago, I was given the opportunity, under the university sabbatical leave scheme, to specialise in urology with the Smith & Nephew Fellowship. I learnt how to conduct TURP from my mentor Dr Robert Whitaker. He was approachable and friendly, and I managed to learn much from him. Up till today, we still keep in touch to exchange ideas in science and art (we share a mutual interest in watercolour painting).

A good mentor is accessible and patient, and a friend for life. A good mentor also teaches the fundamentals and practises what he teaches. He walks the talk.

What makes a good mentee?

With the Internet, knowledge can be easily acquired, but its application to real-life practice requires guidance from mentors. Skill is not just knowledge, but the application of knowledge with awareness of the fundamentals.

A good mentee must be committed to the core purpose in medical practice and be humble like the bamboo, resilient but hollow to absorb new experiences. He also needs to follow the master in the art yet at the same time, think for himself in the science.

Conclusion

In summary, mentoring is important to help society or an institution to progress, with commitment by the mentors and mentees to improve the care of patients.
“JAMES, please stop fooling around. The sooner we get this done, the sooner we can head to the funfair,” I urged impatiently. It was a Saturday morning, and I had stopped by Singapore National Eye Centre (SNEC) to get my then eight-year-old son’s refraction done. Both his Mandarin tutor and sister had been commenting for a few weeks that he tended to read with his books really close up. My initial presumption was that he needed glasses to correct myopia, a common enough problem among Singaporean children. I was not at all expecting to deal with a more serious diagnosis.

As it turned out, his slowness in response to the optometrist’s queries heralded a tough time for our family – which surprisingly, led my husband Beng Ti and me to discover a public-spiritedness that we never knew we had.

The electroretinography tests conducted that morning confirmed the clinical suspicion of a cone rod dystrophy. A visiting expert later refined the diagnosis to Stargardt’s macular dystrophy, an autosomal recessive disorder that is characterised by gradual progression of bilateral visual loss. I doubt I will ever be able to describe the devastation I felt that day. As an ophthalmologist, I knew immediately the grave prognosis. There is, to date, no widely recognised treatment for this condition. Sure, there is current research into gene therapy and stem cell therapy. But the work is rudimentary and no clear treatment looks to be available any time soon.

As there was nothing to be done, we proceeded on to the funfair in a bit of a daze, and took refuge in the comforting words of friends we met there. Over the next few weeks, we looked around desperately for the specialised support that James would need to cope with his macular dystrophy. Given his single disability and level of low vision (completely blind children learn through Braille and may be better supported in a school for the blind, or in designated schools with resource teachers who teach in Braille), he could and should continue to study in a mainstream school. We also
needed to understand how the support would change as his vision worsened with time. So we checked with the existing institutions in Singapore that dealt with visual impairments, and were shocked to find that there were no professionally structured programmes designed to assist children with low vision. I am no psychiatrist but am sure I was depressed for a short while back then. We even thought of emigrating to the UK.

The turning point

Thankfully, things got better after I met two very inspiring individuals. The first was Lee Lay Hong, a teacher who studied for her Master in Special Education (specialising in visual impairments) in Sydney to better support her two children who both have a similar condition as James. She had to embark on this further education as she had made the painful realisation that there was no one in Singapore who was formally trained to support children with low vision. She had also suffered the suspicions and irritation of teachers and principals who did not understand how a parent could not properly discipline a child who professed not to see well, yet was able to go outside and play catching! This is easily explained by the fact that in some children with low vision, there is mainly central visual loss with relative sparing of peripheral vision. What this translates into, functionally, is that while their reading is affected early on, orientation and mobility can remain relatively intact for a long time.

Lay Hong’s journey had begun a decade earlier. By the time I met her serendipitously through an informal support group that she had set up, she had become quite an expert in both the specialised assessments designed for children with low vision, as well as in the customised instruction of affected children. You can only imagine the load that came off my shoulders when I realised that with Lay Hong’s aid, we would finally be able to help James manage his disability.

The other amazing individual was Wong Meng Ee. I first knew him as the chairman of the Retinitis Pigmentosa Society Singapore – a support group for patients with retinitis pigmentosa which held regular meetings at SNEC. He was kind enough to share with me his personal experience. Like James, he had begun losing his vision in primary school; and now, in his 40s, he had lost most of his vision. Despite that, armed with the requisite skills that he acquired in the UK where he received his post-primary education, he had gone on to become an assistant professor in special education at the National Institute of Education. If that was not enough to impress, I have to mention that he is also a regular marathoner and biathlete!
So, really, although the disability is severe, if others have the strength of character and steadfastness to work through the difficulties and achieve much, then the least I could do was to cheer up, roll up my sleeves and work on providing the necessary support to James, with Lay Hong’s help.

Her weekly instruction in using the video magnifier/ closed-circuit television and the Braille lessons led to a warm friendship between the two families. It really is a small world – her husband turned out to be an endocrinologist whom my husband knew. I was truly grateful for her expertise and could not understand why there were other parents who had complained of the nominal fee she charged (approximately $30 to $40 per hour, mainly to cover transport costs). This woman knew her stuff yet she was being questioned not only by some parents, who felt her support should be provided free, but also by school authorities because they viewed her as an overly anxious parent instead of a trained professional.

**Taking the plunge**

One day, Lay Hong asked if I would help her set up a school or centre that would better cater to the needs of children with low vision. I remember telling her right away that what she envisioned could not be provided by an educational centre but by a charity proper. How else could one cover the overheads when families, already grappling with the disability in their children, are unwilling to pay for specialised assessments and instruction? As we discussed what needed to be done, I have to confess that I struggled between taking the easier way out of just carrying on with Lay Hong’s support, and the more difficult job of setting up and running a charity. I had heard of charities that were poorly run and was concerned whether we had the wherewithal to make this succeed. My husband had his reservations as well. His neurosurgeon duties and research work leave him little time as is for the family. But, our personal painful experience could not allow us to turn away from a job that needed to be done.

Thus, we took the first leap of faith and met up with then Minister for Community Development, Youth and Sports, Dr Vivian Balakrishnan, who, as luck would have it, was my ex-medical director at SNEC. He was aware of the local low vision scene and kindly pledged his support. I had heard of charities that were poorly run and was concerned whether we had the wherewithal to make this succeed. My husband had his reservations as well. His neurosurgeon duties and research work leave him little time as is for the family. But, our personal painful experience could not allow us to turn away from a job that needed to be done.

Thus, we took the first leap of faith and met up with then Minister for Community Development, Youth and Sports, Dr Vivian Balakrishnan, who, as luck would have it, was my ex-medical director at SNEC. He was aware of the local low vision scene and kindly pledged his support. He introduced us to the folks at the National Council of Social Service and we began our journey to set up iC2 PrepHouse. We formed a board comprising Meng Ee as chairman, Beng Ti and myself. We later roped in Lynette Shek (our old friend and an associate professor in paediatrics) and Jennifer Chia (recommended by another wonderful and supportive old friend Stefanie Yuen-Thio; both Stefanie and Jennifer are corporate lawyers with TSMP Law Corporation and have provided tremendous legal and governance support for iC2). Lay Hong came on board as a vision teacher, and we also were fortunate to recruit another passionate teacher, Mary McPherson, who had approached me for a position when she heard through the grapevine that we were setting up iC2.

Looking back, I am constantly amazed by how all the pieces came together neatly like a jigsaw puzzle. To cut the long story short, I am glad to report that since its official opening in November 2012, iC2 has reached its two-year milestone and supported over 50 families. We have also started training more vision teachers, to ensure that there will always be a local pool of professionally trained instructors who can support children with low vision in Singapore to achieve their maximal potential in mainstream schools. James, incidentally, performed well in the Primary School Leaving Examination two years ago and is now studying at Anglo-Chinese School (Independent), supported by iC2.

In conclusion, I would like to share my personal opinions about work and of giving back to society. I have always been grateful for the myriad opportunities to help our many patients. Nothing beats the delightful experiences with good clinical outcomes, especially when dealing with challenging diseases. All doctors are familiar with that feeling. Not all of us, however, have experienced the joy and satisfaction of giving back in other ways. The first step is the most difficult, given the unfamiliar territory and the necessary demands on one’s time. But I would encourage you to do so. There are many charities that could do with a doctor’s healing touch.

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Dr Audrey Looi is a senior consultant at SNEC and heads the Department of Oculoplastics. She has served as vice president of the Asia-Pacific Society of Ophthalmic Plastic and Reconstructive Surgeons. Her husband, A/Prof Christopher Ang Beng Ti, heads the Department of Neurosurgery in Singapore General Hospital.

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SMA and the SMA Charity Fund support volunteerism among our profession to make a positive difference in the lives of the less fortunate. SMA News provides charitable organisations with complimentary space to publicise their causes. To find out more, email news@sma.org.sg.

For more opportunities to give back, visit the SMA Cares webpage at http://www.sma.org.sg/smacares/index.aspx?ID=82.
Calling all photography enthusiasts! Life in Pixels is back for 2015! To celebrate Singapore's 50th year of independence, we're releasing a series of themes which reflect the richness of life on this little red dot.

### Themes

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<tr>
<th>Theme</th>
<th>Closing date</th>
<th>Release of results</th>
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<td>1. <strong>“One United People”</strong> – people of different races and different cultures at work or at play</td>
<td>27 April</td>
<td>End May</td>
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<td>2. <strong>“Nation Building”</strong> – a play on words: members of the pioneer generation and buildings of historical significance</td>
<td>28 June</td>
<td>End July</td>
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<td>3. <strong>“Singapore by Night”</strong> – capture the bright lights of our city after the sun goes down</td>
<td>23 August</td>
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<td>4. <strong>“Culinary Heritage”</strong> – the best local gastronomic delights that are a feast for the eyes</td>
<td>25 October</td>
<td>End November</td>
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*SMA will be holding relevant photo workshops in conjunction with each of the four themes. For more info, go to [http://goo.gl/6Wg3mv](http://goo.gl/6Wg3mv).*

The winner of each theme will take home a Crumpler camera bag and a Canon Digital Ixus lanyard with 16GB thumbdrive. The winning entries will also be featured in the pages of SMA News.

Send us your best photos along with your name and MCR/matriculation number at [lifeinpixels@sma.org.sg](mailto:lifeinpixels@sma.org.sg), with the name of the theme as email subject. All images must be in JPEG format, and sized to at least 2,480 x 3,508 pixels. Include a short descriptive legend (maximum 20 words) with each picture.

This contest is open to SMA members in good standing only. Before submission, check out the contest details at [http://www.sma.org.sg/lifeinpixels](http://www.sma.org.sg/lifeinpixels).
Principle of Primacy of Patient Welfare
– The Fundamental Principle in Medical Professionalism and Practice

By Dr T Thirumoorthy, Executive Director, SMA Centre for Medical Ethics & Professionalism

This paper was originally delivered as a National University Hospital grand round presentation on 17 October 2014.

THE COMMITMENT to the primacy of patient welfare is a longstanding historical and fundamental principle held across all healthcare professionals. It embodies the internal core of clinical medicine, that is: a fellow human, who is distressed by disease and unable to resolve the distress (both physical and psychological), decides to seek the help of another human who professes to have the knowledge, skill and motivation to help. Medicine is basically an enterprise rooted in human welfare, relieving of suffering and healing traditions. Medicine has, in its foundation, an overwhelming social and ethical dimension in its goals.

The principle demands acceptance of holding the interest of the patient above that of the clinician’s. Market forces, societal pressures, and administrative exigencies must not compromise this principle. Today’s medicine is marked by for-profit medicine, medical entrepreneurship, investment in and ownership of medical facilities by clinicians. This brings altruism and the patient’s welfare in direct conflict with the financial interests of clinicians and hospitals.

The principle underlines the fiduciary nature of the professional relationship and the virtue of altruism in developing trust and confidence which is essential in achieving the goals of medicine. It alludes to the inherent imbalance of power in the doctor-patient relationship. It recognises the vulnerability and dependency of the patient when undergoing the illness experience. Illness can be viewed as an assault on the patient’s autonomy to move, choose, carry out her vocation and pursue her life’s goals. The assaults are of the threat or actuality of death, permanent disability, pain, shame, discomfort and limitations of a chronic illness. The patient is thus vulnerable to exploitation and abuse, which this principle aims to protect her from.

Scope of the principle

In upholding this principle, the clinician is committed to maintain and improve his clinical competence. Without clinical competence, the goals of improving the patient’s welfare would not be reached, and the patient potentially harmed in the process of care. The scope of this principle also encompasses the principle of fidelity and non-abandonment. The virtue of altruism and fidelity marks the clinician’s commitment to provide care beyond the contractual model with acceptance of reasonable risk and inconveniences to him.

It is a commitment to maintaining trust by appropriately managing conflicts of interest. The scope of the principle requires a commitment to preserve the professional boundaries and not violate them by the clinician’s interest. This principle also embodies the legal duty of care owed to the patient based on due diligence, care, skill, knowledge and sound judgement.

What is necessary to effect this principle is the development of capacity for compassion, humility, conscientiousness, wisdom (discernment) and integrity on the part of the clinician and the healthcare profession and organisation.

In fact, this principle alone renders the clinician to be committed to maintaining all professional responsibilities and guard against any abuse of professional privileges (see Table). The scope is wide and so is the challenge for the clinician to uphold this principle.

Professional autonomy and judgement

The practice of medicine is complex, full of uncertainties and demands a high level of commitment and effort on the practitioner. Developing appropriate responses to the challenges, complexities and uncertainties in medicine calls for good professional judgement, which includes clinical and ethical competence. Professional judgement would require the clinician to make things black or white, when many areas of medical practice are grey, so the treatment plan can be executed. Inappropriate delays or indecision can harm the patient’s welfare.

The clinician needs discretionary space, time, support and resources to enable the exercise of good clinical and ethical decisions and judgement in serving the principle of primacy of patient welfare. Professional autonomy is about meeting the professional standard of care and the ethical and legal duty of care.1

Healthcare organisations can support or destroy the development of good professional judgement by their policies, protocols and ethics. Healthcare financiers can support or destroy professional discretion in upholding the principle of primacy of the patient welfare.2 Professional regulators can support or destroy professional autonomy in upholding this principle. Overregulation, legalisation of medical practice, bureaucratisation of healthcare services and its financing can all compromise the development of good medical judgement in the clinic and at the bedside.
Do the regulations and the ethical codes facilitate or restrict the professional autonomy and the exercise of responsible professional discretion? Are the regulations and the ethical code guiding or dictating medical practice? These are questions that the profession must be engaged in regularly, to create the discretionary space and to protect professional autonomy, in order to uphold the principle of primacy of patient welfare.

**Counter-instinctive nature of professional obligations**

Essential factors for enabling the clinician to uphold the principle of primacy of patient welfare includes lifelong professional education, clinical training and experience. Placing another person’s interest above one's own is counter-instinctive. Demonstrating calmness and professional demeanour in an overbooked clinic, crowded hospital ward or highly provoked emotional situations is counter-instinctive. Displaying compassion and empathy when one is deprived of sleep and food, and when physically and emotionally exhausted, is counter-instinctive.

Self-interest and self-preservation are instinctive. Fight, fright and flight responses in stressful situations are instinctive. Denial, discounting and distancing are common behaviours of all humans when unexpected adverse outcomes arise. Liking and being compassionate to people who are like ourselves is a naturally instinctive behaviour. Upholding the principle of primacy of patient welfare does not come naturally to the human predicament. Learning counter-instinctive behaviours and habits requires a transformative learning process.

**Transformative learning journey**

Acquiring the skills and demonstrating professionalism is achieved by incremental development in a transformative learning journey, shaped over a lifetime of care. It involves a process of modelling and remodelling by knowledge, experience, reflection and metacognition. It is a process of redefining our beliefs and learning new skills. Time is required for internalising and imbibing values. The clinician needs to be mentored, coached, and where necessary, counselled.

Transformative learning comprises a multistage and multistep cognitive, emotional and intuitive learning process. It involves a psychological transformation by developing self-awareness, self-examination, skills in situational awareness, and critical reflection on experience and oneself. It also involves a convivial change and paradigm shifts of personal beliefs and values to professional values and habits. Additionally, it involves a behavioural transformation of conscious change of unhelpful behaviours to developing new habits and behaviours. Role modelling is an essential component of transformative learning.

The professional education requires the development of self-awareness and training in self-management. Self-awareness involves recognising the warning signs of stress (somatic, emotional and cognitive) and responding appropriately to them. At the same time, there is a need to develop social and cultural awareness of others. Mindfulness or mindful practice comprises an acceptance of one's own imperfections and a willingness to audit and improve one's own ideas, behaviour and performance. Becoming a medical professional requires the acquisition of skills in building therapeutic relationships and appropriate dispute resolution.

Acquiring the skills and demonstrating professional behaviour necessary to uphold the principle of primacy of patient welfare needs a transformative learning process. Transformative learning must be supported by a community of self-motivated lifelong learners. Becoming an effective professional requires a professional collegial enterprise and effort.

**Conclusion**

Upholding this principle of primacy of patient welfare is essential to preserve the humanistic core and the healing nature of medicine. As medicine is a complex system, the upholding of this fundamental principle is a function of the entire medical community. There has to be a willing assumption of ownership of this principle by all stakeholders in medicine, namely the medical profession, the public, the press and media, policy makers, regulators, healthcare organisations, politicians and patients.

**References**


Dr Thirumoorthy has been an associate professor in the Education Programme at Duke-NUS Graduate Medical School since 2007. His teaching responsibilities include subjects on professionalism, medical ethics, communications, and healthcare law. He has been practising medical dermatology at Singapore General Hospital since 2002.
DOCTORS IN TRAINING

Registry-Based Research – A Dream Come True
By Dr Kaavya Narasimhalu

The author, who is currently a third year SingHealth internal medicine resident, recalls her time at Karolinska Institute in Stockholm. She was there from September 2010 to September 2011.

IT WAS 3 pm on a Wednesday afternoon, but it wasn’t as if I could tell the difference anyway. Deep in my office in the basement of my department’s building, the only window I had was completely obscured by the three feet of snow on the ground.

I was attached to the Department of Medical Epidemiology and Biostatistics at Karolinska Institute, as part of my Swedish exposure while pursuing a PhD in Genetic and Molecular Epidemiology. This was a joint programme between the National University of Singapore (NUS) and Karolinska, and entailed coursework and projects in both Singapore and Sweden.

At that point I was technically on leave of absence from Duke-NUS Graduate Medical School, and formally a PhD student in both NUS and Karolinska. In reality, I still had to complete all the requirements of the MD programme in time to graduate with my Duke-NUS cohort, including taking and passing the United States Medical Licensing Examination Step 1.

I was about six months into my Svenska experience, and the thrill of working 100 metres from where the Nobel Prize is announced was starting to wear off. Why? Because I was living through what I had been told was the harshest winter in the last 100 years.

By then, I had been through weeks of sub-30 degree Celsius weather, trudging to work in Gore-Tex boots, wrapped in so many layers that I lost count, and attempting not to fall while navigating the last steep icy ten metres to the door of my apartment building (I had already fallen twice!). While Swedish glogg (spiced wine that tasted like heaven in the
middle of winter) and endless Scandinavian salmon took some of the edge away. I had started to crave Singapore’s sweltering heat. Sweden may have 17 months of parental leave per child to be split by its parents until it reaches seven (their solution to what used to be one of the lowest birth rates in the world) and virtually free healthcare, but I could not imagine spending the rest of my life in a place where I would be unable to see the sun four months in a year (although I later realised that houseman year wasn’t much different).

It was only three more months until I had to move back to Singapore, and I had just become cognizant of the fact that what I thought would be the last of the four papers in my thesis was not going to work.

For the first two papers in my thesis, I had used data from a stroke study at Singapore General Hospital to show that even after accounting for traditional risk factors, having mild cognitive impairments after a stroke predicted for more dementia, death, vascular events, and dependency. The results of the third paper (that I was staring at), showed me that in the general Swedish population, while mild cognitive impairment increased the risk of dementia, death, and dependency, it didn’t affect vascular outcomes at all. The planned fourth paper, an analysis of how genes and environment explain the associations between mild cognitive impairment and vascular events (by using twin modelling), was now moot!

There was only one way out. Fika time!

Germinating a great idea

The fika is the quintessential Swedish experience. It’s a short coffee or tea break in the midmorning and/or midafternoon to catch up with colleagues or friends. I messaged a fellow student: “Study 4 isn’t going to work! Fika now please!”

And in minutes, I was explaining to her how the results of my earlier study were making the planned final study obsolete. As I was talking, it suddenly hit me that the larger plan of the third paper (that I was staring at), showed me that in the general Swedish population, while mild cognitive impairment increased the risk of dementia, death, and dependency, it didn’t affect vascular outcomes at all. The planned fourth paper, an analysis of how genes and environment explain the associations between mild cognitive impairment and vascular events (by using twin modelling), was now moot!

There was only one way out. Fika time!

1. Death registry – hmmm, I’ve already used this one...
2. Inpatient registry – I guess I could come up with more hypotheses here to test...
3. Outpatient registry – only clinics next to academic institutions are involved, so there’d be a huge bias... possible, but let’s keep looking...
6. Wait. Back up. The prescription registry is complete?! Every prescription filled in all of Sweden is traceable. Really? That is sooooo cool!

The dork in me instantly came alive! I already knew who died and who eventually became demented, and could now figure out how all my predemented patients were treated. Should I concentrate on looking at anticholinesterases and memantine? Should I look into antidepressant use? Or tackle the whole Alzheimer’s-has-a-probable-vascular-pathology angle and look at cardiovascular medications? Decisions, decisions!

Before I knew it, the clock struck 10 pm! (Not that it mattered as it was already completely dark outside at 4 pm and -15 degrees outdoors regardless of whether it was night or day.) The sheer amount of data that was available for me to play with was overwhelming. Even after whittling the database down to the cardiovascular medications in the twins that we had reliable cognitive data on, the computer still took half a minute to tell me how many observations there were.

I did a little happy dance as I realised there were so many questions that I had and could actually answer. With a sweetener – I could answer them now! I didn’t have to plan a prospective study and track patients for years before I got my results (I couldn’t yet anyway, without a medical licence). Sure, it wasn’t a randomised clinical trial, and these studies were going to have their limitations, but I had complete data on every single prescription that had been filled in Sweden. How cool would it be if we could do this in Singapore too? The possibilities of what I could study were endless.

As the adrenaline wore off, I decided that I was too drained to do any more that day. But there was a plan. My life had emerged from the mess it was in eight hours ago. It was going to be hard, but definitely possible; and I was going to enjoy doing it! I glanced at the clock and thought that if I left then, I could just catch the last bus home (instead of slipping and sliding on the ice/slush/snow walking back). As I exited the office, a refreshing blast of cold air hit my face and I could not help but smile – this was definitely what I wanted to be doing for the rest of my life.

The author is currently a third year SingHealth internal medicine resident. She enjoys travelling a lot and is always planning her next escapade. She likes to combine cuisines from the countries she has visited, into fusion pieces for the enjoyment of her colleagues and family.
Sakura Heaven
– Cherry Blossom Festival in Tokyo

Text and photos by Dr. Oh Jen Jen
EVEry spring, thousands flock to the Japanese capital to view its breathtaking sakura, which can only be enjoyed for two weeks of the entire year. The eagerly anticipated pink flowers herald the end of the harsh winter, but also symbolise clouds due to their nature of blooming en masse. The transience of the blossoms – strikingly beautiful prior to a quick death – is also associated with mortality and an enduring metaphor for the ephemeral nature of life. There are more than 100 cherry tree varieties in the Land of the Rising Sun, the most prevalent being the cultivated Somei Yoshino, which is light pink with five delicate petals.

Timing one’s trip to coincide with the peak bloom period can be challenging, requiring a combination of educated guesses and plain good luck. Every year, the Japanese Meteorological Agency and the public track the sakura zensen (cherry blossom front) as it moves northward, but final confirmation may not be possible until mid-March, and foreign visitors cannot afford to wait as flights tend to sell out quickly. The year I visited, it was indeed fortuitous that I made a correct prediction. In fact, the day I joined a local sakura viewing tour, we landed right in the middle of the peak bloom period, and practically overdosed on the exquisite beauty which greeted us.

There are many famous viewing spots in Tokyo, but our tour focused on four main areas. The first stop was Tokyo Tower, a white-and-orange skyscraper modelled after the Eiffel Tower. It has two observatories which offer panoramas of the city, but our interest was more directed towards the nearby Shiba Park, where streets were lined by cherry trees bursting with vibrant colour, and locals partook in hanami – the centuries-old practice of picnicking under a blooming sakura tree. Remember to point your camera skyward to capture a memorable photo of the tower with a cluster of blossoms in the foreground.

Next was a cruise along the Sumida River, which snakes through the city. During a previous trip in November, the landscape was a monotonous dull grey and the weather was dreary. This time, however, we were greeted by a clear azure sky and 1,000 blooming cherry trees which flanked the waterway on both sides. As it was early afternoon on a Sunday, massive crowds thronged the area on foot and via ferry. We disembarked at Sumida Park, where thousands of locals celebrated beneath the flowers. There were quite a few major productions involving portable barbecue grills and hotpots, but despite the tight squeeze, it was still relatively easy to stroll around, snap pictures and soak in the festive atmosphere.
The highlight was definitely Chidorigafuchi, a moat adjacent to the Imperial Palace, with a few nearby parks. In spring, the 700-metre-long pedestrian path is canopied by 260 cherry trees of different species, creating a spectacular efflorescent tunnel and a truly magical ambience. At certain spots, the blooms hung at eye level, and we couldn't resist breathing in their sweet yet subtle fragrance. As we made our way towards the boat pier at the end of the path, we passed numerous young couples taking romantic boat rides, and I wondered how many marriage proposals had taken place here.

Our last stop was the Meguro River. Approximately eight kilometres in length and flowing through the Meguro, Setagaya and Shinagawa wards, its banks are extensively landscaped and serve as an urban green space. We were brought to a stretch near the Nakameguro residential neighbourhood at sunset, where sakura were bathed in the soft orange hues of twilight, complemented by rows of beautiful lanterns swaying among the branches. At the conclusion of a long and tiring day, we paused, spellbound, to appreciate the tranquil scene before us.

Aside from cherry blossom viewing, don't miss the countless sakura-themed product tie-ins, from pastries, mochi and ice creams, to jewellery, key chains and umbrellas. My favourite items? A range of perfumes and body shampoos from Pola (a renowned Japanese cosmetics brand), and a necklace from Mikimoto.

After the festival, Tokyo returns to its colourless state and the population's mood shifts back to serious mode, so the spring season is a rare opportunity to see the city and its people completely transformed. I'm no fan of human congestion, but the Japanese are disciplined and unfailingly polite, not to mention hyperexcitable upon learning you're a tourist. It is a country that is dear to my heart.

If you decide to make the trip, the ideal period falls between late March and early April. And to quote a famous line from The Hunger Games: may the odds be ever in your favour.

Dr Oh Jen Jen is a consultant at the Department of Emergency Medicine, Singapore General Hospital. When not battling endless patient queues at the hospital, she spends way too much time in front of the TV. An avid blogger since 2002, she also hopes to write a screenplay or novel someday – if she manages to survive her three-monthly episodes of job burnout.

Photos
1. Tokyo Tower
2. Chidorigafuchi
3. Somei Yoshino cherry blossoms
4. Boat pier, Chidorigafuchi
5. Sumida Park
6. Meguro River
We don’t know what lies ahead but we can prepare for what may come. Help your patients plan ahead, through the Lasting Power of Attorney (LPA), so that their interests will be protected should they lose mental capacity.

For enquiries, please contact the SMA Secretariat at tel: 6223 1264 or email: OPG_LPA@sma.org.sg.

Successful applicants who pass the quiz will be notified of their application outcome by the Office of Public Guardian (OPG). For more information on the LPA, please visit the OPG website at: http://www.publicguardian.gov.sg.

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NHG Mobile CHC Increases Access to Care for Chronic Conditions

Located within neighbourhoods, Community Health Centres (CHCs) aim to provide accessible nursing and allied health services for patients referred by general practitioners (GPs) in the community. Patient convenience is now taken a step further with the first mobile CHC by National Healthcare Group (NHG).

The NHG Mobile CHC was launched on 7 February 2015 at Kovan Hub. This launch was held in conjunction with Aljunied Cluster & National Healthcare Group Community Carnival 2015, which was graced by guest-of-honour, Health Minister Mr Gan Kim Yong. As part of the event, a CME lunch talk for the GPs on the new DRP Screening programme was also held at Paya Lebar Kovan CC.

The NHG Mobile CHC is the latest addition to five other CHCs located in Tampines, Bedok North, Bedok South, Jurong East and Tiong Bahru.

A 24-seater bus retrofitted with medical equipment, the NHG Mobile CHC provides diabetic retinal photography, diabetic foot screening, and nurse counselling services for chronic conditions such as diabetes, hypertension.
and high cholesterol. It allows patients to get screenings done even closer to home, reducing the need for travel to a hospital or polyclinic.

The new initiative extends CHCs’ reach by acting as an additional screening option for those who may be physically challenged, such as 73-year-old Madam Sarasvathy d/o Rama Panicker, a diabetic patient who has difficulty travelling long distances alone. “With the Mobile CHC at the Community Centre near my home, I can walk to the location for my screening. I feel more independent,” she says.

Based in central Singapore, the NHG Mobile CHC will support more than 300 GPs. GPs will be able to refer patients who will be seen on an appointment basis. The Mobile CHC will make monthly stops at 17 different locations including Community Clubs and HDB car parks in various towns such as Bishan, Toa Payoh and Hougang. It will also be available to residents from the Institute of Mental Health as well as nursing homes and satellites care centres in future. Patients covered by the Community Health Assistance Scheme and Pioneer Generation Package can receive its services at subsidised rates.

Private GPs such as Dr Angela Lim and Dr Wong See Hong have found CHCs highly beneficial in improving patient care. “We are very happy that the NHG Mobile CHC is here to give our patients faster access to diabetic care. This initiative also helps elderly patients regain some independence by attending diabetic screenings themselves,” Dr Lim says.

Dr Wong appreciates that the CHC works closely with primary care providers by sending back test results in a timely manner for his review and patient follow-up. “The report turnaround time is also fast and this helps me care for my patients better. I hope to refer more patients for screening in the coming months.”

**Locate your nearest CHC today!**

![NHG Mobile CHC](image)

**Eastern CHC (Bedok North)**
Blk 201A Bedok North Street 1 #01-563
Singapoor 461201
Tel: 6446 7200 Fax: 6446 7207

**Operating Hours:**
Mon to Fri: 8.30am – 12.00pm
1.00pm – 5.00pm
Sat: 8.30am – 12.00pm
Sun & PH: Closed

![Jurong East CHC](image)

**Jurong East CHC**
Blk 220 Jurong East Street 21
#01-701 Singapore 600229
Tel: 6665 1290 Fax: 6896 1832

**Operating Hours:**
Mon to Fri: 8.30am – 12.00pm
Sat: 8.30am – 1.00pm
Sun & PH: Closed

![Toronto CHC](image)

**Toronto CHC**
Blk 18 Jalan Membina, #01-24 Singapore 163019
Tel: 6376 0168 Fax: 6271 7239

**Operating Hours:**
Mon to Fri: 8.30am – 12.00pm
1.00pm – 5.00pm
Sat, Sun & PH: Closed

![Eastern CHC (Bedok South)](image)

**Eastern CHC (Bedok South)**
300 Bedok South Ave 3, #01-04 Singapore 469200
Tel: 6419 5419 Fax: 6243 8916

**Operating Hours:**
Mon to Fri: 8.30am – 12.00pm
1.00pm – 5.00pm
Sat, Sun & PH: Closed

*Health Assist & PG cardholders enjoy subsidised rates for services at CHCs*

FOR MORE INFORMATION ON CHC, VISIT HTTPS://WWW.PRIMARYCAREPAGES.SG/CHC/
## SMA EVENTS APRIL - JULY 2015

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<thead>
<tr>
<th>DATE</th>
<th>EVENT</th>
<th>VENUE</th>
<th>CME POINTS</th>
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<th>CONTACT</th>
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<td><strong>CME Activities</strong></td>
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<td>1 April</td>
<td>Mastering Adverse Outcomes</td>
<td>Sheraton Towers Singapore</td>
<td>2</td>
<td>Family Medicine and All Specialties</td>
<td>Margaret Chan 6223 1264</td>
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<td>18 April</td>
<td>A Medico-Legal Seminar: SMC Disciplinary Proceedings</td>
<td>Camden Medical Centre #09-08</td>
<td>TBC</td>
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<td>12 April</td>
<td>55th SMA Annual General Meeting</td>
<td>Alumni Medical Centre</td>
<td>NA</td>
<td>SMA Members</td>
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<td>9 May</td>
<td>41st SMA Inter-Hospital Soccer Tournament B-a-Side</td>
<td>Home United Youth Academy</td>
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<td>Doctors, Dentists and Pharmacists</td>
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<td>SMA Annual Dinner 2015</td>
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For enquiries please contact Li Li Loy/Denise Jia
Email: adv@sma.org.sg • Telephone: 6223 1264