

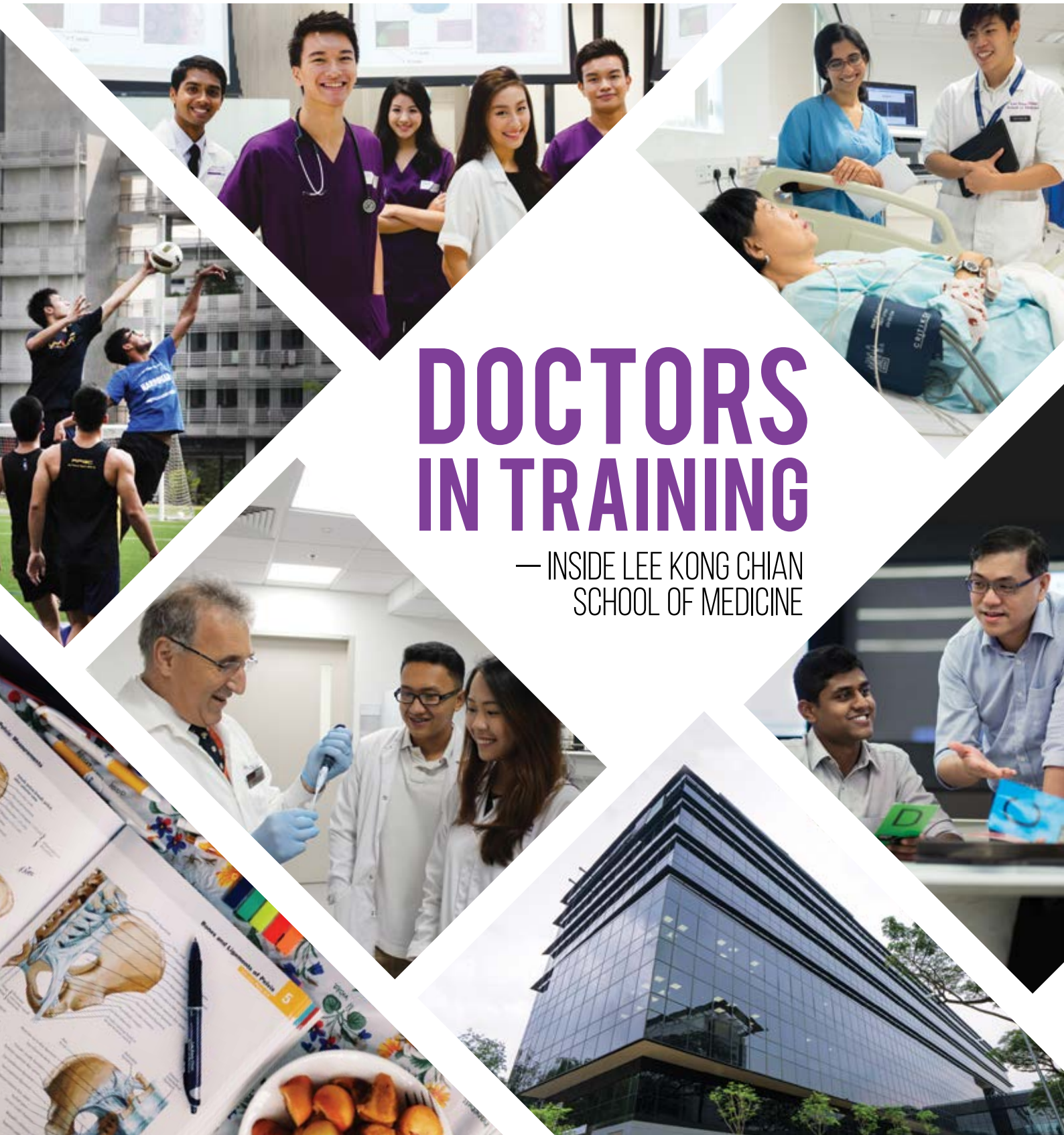


For Doctors, For Patients

news

DOCTORS IN TRAINING

— INSIDE LEE KONG CHIAN
SCHOOL OF MEDICINE



REGISTER by
12 August 2016

MEDICINE UPDATE 2016



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Email: news@sma.org.sg

URL: <http://www.sma.org.sg>

UEN No.: S61SS0168E

DESIGN AGENCY

Oxygen Studio Designs Pte Ltd

PRINTER

Sun Rise Printing &

Supplies Pte Ltd

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THE EDITOR'S MUSINGS

For this year's Doctors in Training issue, allow us to unveil the mystery of the Lee Kong Chian School of Medicine (LKCMedicine)! (*Cue Harry Potter opening theme*)

On a more serious note, it is my pleasure and honour to have this collaboration with LKCMedicine. I must thank A/Prof Tham Kum Ying, a senior colleague and friend from the Tan Tock Seng Hospital (TTSH), who has given us this opportunity for an insider's look, beyond the official press releases. We have an interview with the school's dean, Prof James Best, as well as a range of articles from staff and students, sharing their love and appreciation for the school.

Some spoilers: wonderful melting pot of talents, integrative use of the latest technologies and the House System! Almost made me want to be a student again with them, except, I doubt I can qualify for entry.

Aside from that, Mr Michael Griffiths of Aon Singapore explains occurrence-based versus claims-made malpractice medical protection, as part of our on-going series of articles on indemnity. Meanwhile, Dr Lee Pheng Soon gives his take on the indemnity issue and urges all doctors to review their own cover.

We hope you will be entertained and educated by the *SMA News*. Enjoy~



Dr Tan Yia Swam is 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.

Yia Swam
Editor

AN INSIDE LOOK AT LKCMEDICINE

"Good is the enemy of great." – James C Collins, author

LKCMedicine doesn't want to just be another good medical school. It is greatness that LKCMedicine aspires to achieve: greatness not only in how we measure ourselves but how others – patients, colleagues and stakeholders – assess us.

After three years of preparation, the School welcomed its inaugural class of 54 students in 2013. This class – the Class of 2018 – is currently

completing their Year 3 studies and will graduate to become PGY1 doctors (also known as postgraduate year 1 or house officers) on 2 May 2018. The invitation from the *SMA News* to feature LKCMedicine in the July 2016 issue is therefore timely and much appreciated.

LKCMedicine has two parents: Nanyang Technological University (NTU) Singapore and Imperial College London (Imperial). Being the newest medical school in Singapore coupled with such parentage surely raises



A/Prof Tham Kum Ying is assistant dean for Year 5 and lead for emergency medicine at LKCMedicine. She is also education director and a senior consultant at TTSH. A passionate educator and active volunteer, A/Prof Tham has been recognised with numerous awards for her dedication and excellence in teaching.

Kum Ying
Guest Editor

the curiosity quotient. Hence, Prof James Best, dean, will share through his interview an overview of the School; touch on how LKCMedicine addresses Singapore's healthcare needs and how our students contribute to the School and to patient care; and elaborate on the opportunities a new medical school provides for multidisciplinary research that transcends boundaries (see page 6). Vice dean for education, A/Prof Naomi Low-Beer, shares her insights into the making of this new medical school, introduces the School's Team-Based Learning pedagogy and bespoke e-learning ecosystem, and the enduring partnership between NTU and Imperial. A/Prof Wong Teck Yee, assistant dean, Year 4 and family medicine, and senior consultant family physician at TTSH, reflects on the curriculum, highlights the

sustained early patient contact that begins in Year 1, the multidisciplinary faculty that teaches our students and how these impact student communication and interpersonal skills in their clinical years.

To give voice to our students, three of them have written about various aspects of student life. Leon Tan, third year student, pauses in the middle of his busy schedule to take stock of the year – during which the initial baby steps towards a medical career become firmer – and explains how the early years have facilitated the transition. With the recent conclusion of the 2016 admission exercise, Rebekah Lee from Year 2 articulates the factors she based her choice of medical school on. We have also invited Edlyn Tay from the Class of 2020 to recall how the House System

has added colour and vibrancy to the year, during which fun and games were interspersed with meetings and chit chats with caring and supportive house tutors, and the tutorials, tips and tricks from seniors.

The privilege to start a new medical school happens once in a career-time. For those of us tasked with making LKCMedicine a reality, it has been an enriching and humbling experience. Our students, faculty – scientists and clinicians, researchers, administrators and leaders are united in our aspiration that our graduates will be: "The doctors you and I would like to have caring for us." And to our colleagues – the readers of this newsletter – we hope that when you exclaim: "So, you graduated from LKCMedicine!" it will be because the doctor has surpassed your expectations. ♦

SMA EVENTS AUG - OCT 2016

DATE	EVENT	VENUE	CME POINTS	WHO SHOULD ATTEND?	CONTACT
<i>CME Activities</i>					
6 August Saturday	CMEP Health Law Seminar	Ng Teng Fong General Hospital Auditorium	2	Doctors and healthcare professionals	Carina Lee 6223 1264 carinalee@sma.org.sg
3 September Saturday	CMEP Health Law Seminar	Ng Teng Fong General Hospital Auditorium	2	Doctors and healthcare professionals	Denise Tan 6223 1264 denisetan@sma.org.sg
24 September Saturday	SCS-SMA Cancer Education Seminar Series 2016 (Breast Cancer)	Health Promotion Board, Auditorium	2	Doctors	Carina Lee 6223 1264 carinalee@sma.org.sg
1 October Saturday	Core Concepts in Medical Professionalism	Ng Teng Fong General Hospital, Tower A	TBC	Doctors and healthcare professionals	Carina Lee 6223 1264 carinalee@sma.org.sg
8 October Saturday	SMA Seminar: Workplace Safety and Health for Medical Practice Owners	M Hotel Singapore	TBC	Doctors and healthcare professionals	Carina Lee 6223 1264 carinalee@sma.org.sg
22 to 23 October Saturday to Sunday	The Annual National MedicoLegal Seminar 2016	Raffles City Convention Centre	TBC	Doctors, lawyers, healthcare and legal professionals	Carina Lee 6223 1264 carinalee@sma.org.sg
<i>Non-CME Activities</i>					
August to October	Inter-Professional Games 2016	Various Venues	NA	SMA Members	Azliena Samhudi 6223 1264 liena@sma.org.sg
3 August Wednesday	SMA Annual Golf Tournament 2016	Tanah Merah Country Club	NA	SMA Members and Guests	Azliena Samhudi 6223 1264 liena@sma.org.sg
22 September Thursday	Annual Lawyer-Doctor Networking Session 2016	Audi Centre	NA	SMA Members and Guests	Rita 6223 1264 rita@sma.org.sg

INSIDE LKCMedicine

AN INTERVIEW WITH PROF JAMES BEST

This year's Doctors in Training issue focuses on Singapore's newest medical school – the Lee Kong Chian School of Medicine (LKCMedicine). *SMA News* took the opportunity to interview Prof James Best, the School's dean, to have a closer look at what makes LKCMedicine special and the challenges the School faced to make it what it is today.

Prof Best is a distinguished medical leader, educator and researcher who has dedicated his career to improving treatments for diabetes and kidney disease. Prior to joining LKCMedicine, Prof Best was the Head of Medical School at the University of Melbourne in Australia – an institution he served for 25 years.

During this career, Prof Best has taught extensively, especially on the topic of diabetes and metabolism, as well as on the medical interview. His research has involved physiological and molecular studies of glucose disposal, as well as studies of lipid biochemistry and epidemiological and clinical studies of risk factors for cardiovascular disease in diabetes. His current research is predominantly in healthcare delivery for diabetes prevention and management.

The author of more than 200 publications, **Prof James Best (JB)** is a Fellow of the Royal Australasian College of Physicians, Royal College of Pathologists, Royal College of Physicians of Edinburgh and has an Honorary MD from St Andrews University. In June, he was appointed an Officer of the Order of Australia in the Queen's 2016 Birthday Honours.



THE MEDICAL SCHOOL

Was it challenging to take over a brand new school of medicine that has ambitiously incorporated some of the best learning practices from around the world?

JB: Yes, it was, but I was excited to embark on this new challenge because there is a wealth of opportunities for new collaborations, partnerships and innovative academic approaches. I have joined a School that has a dedicated and talented team, which in turn is supported by hundreds from Nanyang Technological University (NTU) Singapore, Imperial College London (Imperial), National Healthcare Group and other healthcare organisations. I hope to leverage further on the strengths of these institutions as the School moves towards fulfilling its ambitious goals to redefine medicine and transform healthcare; in particular through our collaboration with Imperial in education and our joint medical research programme.

My immediate goal is to produce the first cohort of LKCMedicine graduates in 2018 who will be great doctors for Singapore and light the way for subsequent graduating classes. We have a huge responsibility towards these students and we will make sure that they graduate as highly competent and caring doctors for Singapore. In research, my goal is for the School to be recognised as a major contributor to medical research, both in Singapore and internationally, particularly by linking scientists and engineers with clinicians.

What are some teething problems you and/or the School encountered before accepting its first batch of students, and now, as

the School prepares to welcome its fourth batch of students?

JB: I joined the School in 2014, just in time to welcome our second cohort of students. As a new medical school, we had the benefit of a blank slate when we started. This meant that we could address in advance the challenges many institutions encounter over the years, such as the planning of space or updating of teaching facilities. We have built teaching venues large enough to hold more than 200 students in one sitting, in addition to our smaller seminar rooms. Our custom-designed and built technology infrastructure is incorporated into the design of our learning facilities. Of course, we have to remain adaptable and open to innovation, so the challenge for us now is to stay at the forefront of innovation in medical education.

Having two of the world's finest universities as parent institutions – NTU and Imperial – has also given us access to a network of highly experienced and world-renowned scientists and clinical educators. Together with our excellent local faculty, we have come together across continents and time zones to create an innovative curriculum that is fit for the 21st century. At times, the scheduling was difficult and the School's progress is a tribute to those who led the curriculum development.

Apart from ensuring that the School was ready for its students, what other challenges were there?

JB: The other major task we faced was to develop a strong research strategy for the medical school. NTU is one of the leading universities in the world for engineering and computer science. Using the expertise in clinical research and health systems within our medical school and bringing in colleagues from NTU, we can collaborate with health services in Singapore to improve healthcare outcomes. Just a few examples of research areas that can benefit from this multi-disciplinary approach are infectious diseases, rehabilitation, aged care and diabetes. However,

we have another very important link – our joint medical research programme with Imperial. It is the responsibility of any world-class medical school to advance medical knowledge and we have the advantage of two very accomplished research-intensive universities as our parents, plus a talented and experienced faculty.

We are taking an integrated approach to cover everything including lab-based discovery research, clinical research, health services research and population health research. If we can successfully link these different research elements and researchers with diverse backgrounds, we can transform how we treat diseases such as dengue, diabetes, heart disease and Parkinson's disease.

What is unique about LKCMedicine's teaching and learning style?

JB: One of the great advantages of starting a new medical school is that we were able to infuse best practices from around the world into our curriculum to produce medical graduates who will be prepared for medicine of the future. We hope that a future with personalised medicine will become a reality and that our students can be the agents of change in the way healthcare is delivered and medicine is defined.

In 1950, it was estimated that medical knowledge doubled every 50 years; by 1980, it doubled every seven years, by 2010 it doubled every three-and-a-half years and by 2020, it will be doubling every 73 days.

This is why when we developed our teaching approach, we adopted a flipped classroom, Team-Based Learning (TBL) approach that teaches students how to access the facts they need, how to analyse that information and how to apply it appropriately in caring for patients.

To ensure that students master relevant basic medical science knowledge, we introduce them early on to the professional and clinical

aspects of their future world. Students regularly spend time in a polyclinic where they practise their clinical and communication skills with the help of simulated patients. They also interact with their future colleagues and other healthcare professionals, who join them as content experts in TBL lessons and instructors for practical sessions. We also want our students to see and experience the healthcare system through the patients' eyes. That's why students spend one week each in a polyclinic and a hospital during the first two months of their studies. They also have a Long-Term Patient Project, during which they follow a patient over the course of two years to see how their condition affects their lives and their families.

To prepare our students for what might be a career of 50 years, we emphasise the importance of lifelong learning. Therefore, it is important that they are familiar and comfortable with research. To help instil an appreciation of the research process, we've introduced a six-week Scholarly Project module which all students undertake at the beginning of Year 4. I saw the impact of this approach at the Melbourne Medical School, where every student does a research project which helps them understand the research process and appreciate how new knowledge in medicine arises. Students need to be engaged in research through hands-on experience, so they can learn to evaluate new knowledge for themselves. Research also teaches them how to ask relevant questions, which is very important in the practice of evidence-based medicine.

These elements are combined in our curriculum and students are taught in a way that emphasises critical thinking and problem-solving over excessive memorising of facts. We also have a major emphasis on professional development with strong elements of ethics and the responsibilities that come with being a doctor.

What are the strengths of LKCMedicine that would sway an undergrad student to apply for studies here?

JB: We may be a young medical school, but we draw on a strong tradition and many exceptional medical educators. Our outstanding clinician educators come from Singapore's finest hospitals, including Tan Tock Seng Hospital (TTSH) and the primary care sector, particularly the polyclinics.

Complementing our experienced clinician educators, our students benefit from the world-class curriculum developed by Imperial, which has been customised for the Singapore context. They also benefit from other extensive links with Imperial, including student exchanges and research opportunities.

Given that all medical schools are highly regulated by the Ministry of Education and the Ministry of Health (MOH), our students are assured of a quality education. So the decision should be a personal one – where would I be happier and where would I learn best?

Let us not forget that our students graduate with a joint degree issued by NTU and Imperial, a qualification that will be highly regarded around the world.

How do we integrate the LKCMedicine students with those from the other local medical schools?

JB: During the clinical years, our students work at healthcare sites across Singapore alongside students from the National University of Singapore Yong Loo Lin School of Medicine (NUS Medicine) and Duke-NUS Medical School, and a great spirit of collegiality has already developed. For example, when our inaugural cohort started on their clinical years, the NUS Medicine students extended a helping hand, even sharing the much treasured MedBear notes!

They've also come together in friendly sporting competitions, such as the Med-Nurse Games, and the three medical societies are working on plans to create more opportunities for students to meet up and interact.

MOH is convening a series of meetings involving the three medical schools to ensure cooperation and coordination in clinical placements and in the core medical school curriculum.

What type of doctors do you hope your graduates will become?

JB: Our goal is to produce doctors equipped to advance the science and practice of medicine for the good of humanity. Through an innovative medical education of the highest international standards, we guide our students to become competent and confident doctors who put society and patients at the heart of what they do, while being at the forefront of medical advances in patient care.

STUDENT COHORT

What student initiatives have been started by your current students?

JB: Our students have had the unique opportunity to co-create the student experience at LKCMedicine. The School gave them structures such as the House System, which acts as a mentoring and guidance system, as well as a vehicle that brings together students across the year groups. Our students have filled the House System with activities and life. Each House is developing its own identity, which is driven by the students; they have designed the House crests, mottos and defining features. One student from the inaugural cohort even drew portrait sketches of the medical luminaries after whom the Houses are named. Each year, the Houses compete in a championship that runs throughout the year.

Beyond this, students have been busy setting up new traditions, such as developing the medical society, designing freshmen orientation programmes, holding jamming sessions and initiating Overseas Community Involvement Projects – the first of which was to Batam, Indonesia. Students now go to Batam four times a year to provide health education to villagers. The students have also set up annual projects that are further afield in India, Nepal, the

Philippines, Sri Lanka and Cambodia. Our faculty provides assistance and support where necessary, but we leave it to the students to develop the projects and they have been very resourceful!

When interviewing applicants, what are the traits that you look for in potential students?

JB: At LKCMedicine, we aim to nurture doctors you and I would like to have caring for us, so when we interview, those are the attributes that we look for – communication skills, compassion, integrity and empathy.

How are your students currently unique, different or similar to other Singapore medical students?

JB: Like their peers in the other medical schools, our students are among the brightest in Singapore. I think during our early years, we perhaps attracted students who are more pioneering and entrepreneurial, because it can be daunting going to a school where there are no seniors and no traditions. However, as we add cohorts to our student body and we become more established, this point of differentiation diminishes.

Another aspect that makes our students stand out – to me at least – is their dedication to the community, whether that's here in Singapore or further afield. With more than 80% of our student body actively involved in one or more volunteering programme, I feel that we do truly attract students with a heart to serve.

PERSONAL

What are your thoughts on the residency programme?

JB: The current residency programme was introduced quite recently and follows the US system. With the design of our curriculum, we aim to prepare our students for a seamless transition to the internship year and then to the residency programme. We are placing a strong emphasis on clinical competency and understanding of the health system and the practical skills required.

With our growing student numbers, we are extending our network of healthcare partners to range from TTSH and KK Women's and Children's Hospital in central Singapore to the Eastern Health Alliance in the east, Ng Teng Fong Hospital and National University

Hospital in the west, Khoo Teck Puat Hospital in the north and Singapore General Hospital in the south, so that our students benefit from the rich expertise of the whole hospital community.

What hobbies do you have?

I enjoy swimming and of course have come to the perfect country for this purpose. Once I get into the right freestyle (once known as the Australian crawl!) rhythm, I feel relaxed and some of my best ideas arise when I am swimming. I also enjoy reading novels or books by travel writers about places I visit and I do like listening to music, from opera to country music. ♦

For the full transcript of this interview, please visit <https://goo.gl/2RhD1p>.

Legend

1. Prof James Best with students

Photos by LKCMedicine



HELPING STUDENTS IN NEED: MATTHEW'S CUMULATIVE ADVANTAGE AND MARK'S CLARION CALL

A study examining class stratification in schools was recently conducted and was reported in the *Straits Times* on 1 June 2016.

The study found that children from higher socio-economic backgrounds are more likely to attend secondary schools with Integrated Programmes (IP) and their affiliated primary schools, as well as primary schools that offer the Gifted Education Programme (GEP).

The study looked at families with a monthly household income that exceeded \$10,000, families that lived in private homes and families who had at least one parent with university education. Based on the results, children from such families were more likely to get into GEP primary schools and IP secondary schools. For secondary schools, almost 41% of "elite" IP secondary school students came from families with a monthly household income that exceeded \$10,000, compared to 7% in government schools. About 31% of IP secondary school students lived in private homes, compared to 2% in government schools. About 54% of IP secondary students had at least one parent with university education, compared to 17% in government schools.

Research advisor Dr Cheung Hoi Shan was quoted: "the observation from many news reports... does point to some form of social stratification in our schools; so in elite schools you tend to have families represented by higher socio-economic status

(SES) and in neighbourhood schools you tend to have the reverse." SES differences were seen in secondary schools even though entry was supposed to be determined by performance in the primary school leaving examinations (PSLE); in other words, by merit, rather than through alumni affiliation or distance from home. Dr Cheung added: "... it may point to a perpetuation – if you started off with a high SES, chances are because you have more resources, you are better prepared for PSLE..."

Studies like this are important to better understand the downstream effects on medical practitioners in Singapore, in particular the selection of students that enter our medical schools. Every year, thousands of graduates from these IP schools apply to study medicine in the NUS Yong Loo Lin School of Medicine (NUS Medicine) and the Lee Kong Chian School of Medicine (LKCMedicine), vying for the limited places available (NUS Medicine had 300 students and LKCMedicine had 90 students in their 2015 intake). The medical schools select the crème de la crème; bright students with likely near perfect scores, who are strong in core curricular activities with some social enterprise or overseas community projects on the side, and who then shine during the interview process that tests their level of compassion, communication skills and ethical judgement.

We do not have similar studies to look into the SES of medical students, but the findings from the secondary

school study serve to validate what many of us in the medical profession had long suspected and witnessed personally. Indeed, there is no doubt that many of our young doctors come from affluent and well-to-do families.

CUMULATIVE ADVANTAGE — THE MATTHEW EFFECT

Malcolm Gladwell, in his 2008 book *Outliers*, talks about the effects of cumulative advantage that is a key factor for success in society. We are often fascinated by successful individuals who seem to be able to rise to the top of their leagues through sheer talent, intelligence and effort. Autobiographies of successful personalities in business, sports and politics occupy large dedicated sections of the bookstore and often hog the best seller lists for months. It was as if there were some special skills or abilities that we too can learn and emulate. Gladwell challenges this assumption of innate ability as misleading, arguing that individuals are more often than not "the beneficiaries of hidden advantages, extraordinary opportunities and cultural legacies".

The fact is that one's upbringing and where one is born matters. The effect of cumulative advantage is such that children with better opportunities are able to turn small differences in their childhood into huge advantages later on in life. Indeed, children from families with high SES have a head start, with more opportunities to learn and try out different interests such that their talent is identified



Illustration: Dr Kevin Loy



TEXT BY

DR WONG TIEN HUA

Dr Wong Tien Hua is President of the 57th SMA Council. He is a family medicine physician practising in Sengkang. Dr Wong has an interest in primary care, patient communication and medical ethics. His two nephews are named Mark and Matthew.

early. Shortfall in academic subjects can be made up for through extra lessons outside school. Students who perform well get into these "elite" schools with higher performing classmates and teachers, translating into a significant advantage when competing with others of the same cohort in the national examinations.

This phenomenon of accumulative advantage has been coined "The Matthew Effect" and is taken from the biblical passage found in the Book of Matthew, chapter 25 verse 29:

"For unto every one that hath shall be given, and he shall have abundance: but from him that hath not shall be taken even that which he hath."

This month's column firstly serves as a timely reminder for those of us in medicine to appreciate the fact that we did not get into medical school by our own innate abilities and talents. No doubt the process of medical studies and training is long, tough and difficult, requiring mental resilience and hard work, but we

have to appreciate and be thankful for the contributions from our family and the society that allowed us the opportunity and environment to achieve success.

Secondly, an important lesson, especially for medical students, is that their cohort of students in medical school is not representative of society in general. Students in medical school need to be cognizant of their privileged background and learn to develop a sense of humility in their attitude towards others, in particular for their teachers and above all, for their patients. When they eventually start to interact with patients in the wards and in the community, they need to empathise and connect with people from the poorest, most underprivileged groups in society. For such patients, they need to learn to treat them as equals, to be their strongest advocate and not let social standing get in the way of their duty of care.

Thirdly, we as a medical community must look out for the less privileged

among us and ensure that medical students who come from difficult financial backgrounds will not be disadvantaged in their quest to fulfil their calling in medicine.

LEVELLING THE PLAYING FIELD — THE MARK EFFECT

The idea that inequalities in opportunity should be addressed through reallocation of resources is known as "The Mark Effect" and is taken from the biblical passage found in the Book of Mark, chapter 10 verse 31:

"But many who are first will be last, and the last first."

The Mark Effect counters the Matthew Effect by giving those with less more resources to level up, by giving the weaker competitor a better chance to compete and, specifically in this case, it is a calling to help underprivileged students so that their situation will not further dampen their aspirations to do well in medical school.

With the rising costs of living in Singapore and of medical education in particular, such students may have to resort to part-time employment to help reduce the financial burden on their families.

In the domain of charitable giving, the neediest are first in line for assistance.

THE SMA CHARITY FUND

One of the stated objectives of the SMA Charity Fund (SMACF) is to provide bursaries and financial assistance to underprivileged medical students from all three local medical schools; that remains the mainstay of SMACF's charitable outreach. In 2015, a total of 40 full bursaries of \$5,000 each were awarded to underprivileged students.

In 2014/2015 work year, there were 15 student recipients whose gross

family income per month was less than \$1,000. There were four student recipients with gross family incomes less than \$2,000 per month. This figure was three students and four students respectively for 2015/2016 work year. The majority of needy students come from families with only one breadwinner at home.

One such student was Dr T, whose father passed away when she was 13 years old. Her mother had to take on a job to support her and her younger siblings. To support herself through medical school, Dr T took on part-time jobs and often skipped classes because of her work commitments. Her burden was lightened when she received bursary support from SMACF and was also awarded financial support for her research project presentation at an international medical conference.

She is currently pursuing residency training.

Altogether, some \$395,000 in financial assistance was disbursed since SMACF's inception in 2013. The funds set aside to help underprivileged students remain accessible throughout each year to allow students with unforeseen financial difficulties to apply for assistance. Two such awards were given out to Duke-NUS Medical School students in 2015.

SMACF continues to grow from year to year, through support from the public as well as members of our own profession. It is heartening to note that the spirit of collegiality, where doctors contribute to the next generation of medical practitioners, remains a strongly rooted tradition. ♦

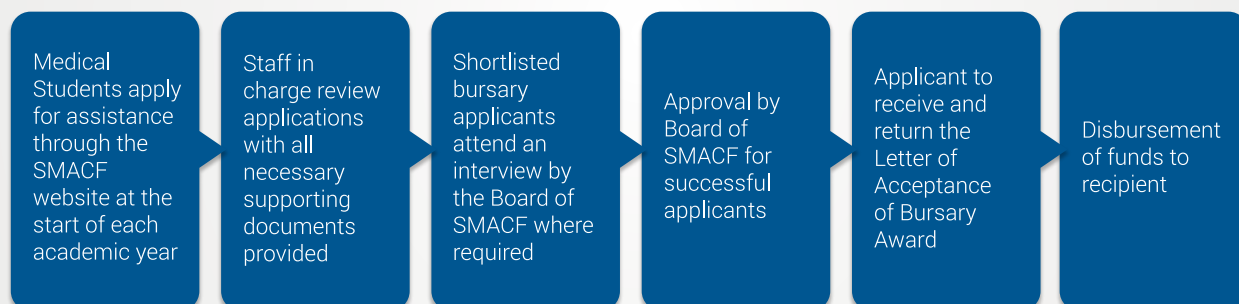
ANNOUNCEMENT

From AY2016/17, medical students from the Lee Kong Chian School of Medicine will be able to apply for the SMA Medical Students' Assistance Fund (SMA-MSAF) even after receiving other bursaries from the school.

What you need to know as a bursary applicant:

1. The SMA-MSAF is a needs-based bursary
2. Application for the bursary can be done online at <https://www.sma.org.sg/smacades>
3. All new applicants are to register for an account on the system before they can proceed with the bursary application
4. The complete application is to reach the SMA Charity Fund (SMACF) by 15 September 2016

The bursary application process:



For further enquiries, please contact the SMACF at bursary@sma.org.sg.



For Doctors, For Patients

Save the date!

5 November, Saturday

1 pm – 5 pm

Grand Copthorne Waterfront Hotel Singapore

Galleria Ballroom, Level 3

Max 2 CME points

SMA LECTURE 2016

HEALTH AND HUMAN RIGHTS

Prof Sir Sabaratnam Arulkumaran

Professor Emeritus, Obstetrics and Gynaecology, St George's, University of London



Prof Sir Sabaratnam Arulkumaran's research and clinical interests are in understanding and improving the quality of life for women and newborn babies. He has been in clinical practice for 37 years and in research and teaching for 25 years. He joined St George's, University of London as a professor and head of Obstetrics and Gynaecology in 2001. Previously, he held posts at a number of high-profile institutions including the National University of Singapore (NUS) and the University of Nottingham. He is a past president of the Royal College of Obstetricians and Gynaecologists, British Medical Association and the International Federation of Obstetrics and Gynaecology.

After obtaining membership of the Royal College of Obstetricians and Gynaecologists and fellowship of the Royal College of Surgeons by examination, he obtained his MD and PhD by research from NUS. In June 2009, he was appointed as Knight Bachelor by Her Majesty the Queen of England for his services rendered to medicine and healthcare in the UK.

Please return this slip for SMA Lecture 2016 to **Denise Tan, Singapore Medical Association, 2 College Road, Level 2, Alumni Medical Centre, Singapore 169850. Tel: 62231264, fax: 62247827 or email: denisetan@sma.org.sg.**

A confirmation email will be issued to all applicants.

Name: _____

Handphone no.: _____

Email: _____

Profession/Specialty: _____

MCR no.: _____

SMA member: YES / NO (please circle accordingly)

Registration (inclusive of GST):
Complimentary for all healthcare professionals

By registering for this event, you consent to the collection, usage and disclosure of personal data provided for the purpose of this event, as well as having your photographs and/or videos taken by SMA and its appointed agents for the purpose of publicity and reporting of the event.

PROFILE



REPORT BY

DR DANIEL LEE

Dr Daniel Lee Hsien Chieh (MBBS [S'pore], GDFM [S'pore], MPH [Harvard], FAMS) is Honorary Secretary of the 57th SMA Council. He is a public health specialist and Deputy Director of Clinical Services at Changi General Hospital.

HIGHLIGHTS

FROM THE HONORARY SECRETARY

INTERVIEW ON ADVANCE MEDICAL DIRECTIVE

According to data from the Ministry of Health, more than 20,000 people in Singapore have signed the Advance Medical Directive (AMD), with more than 3,000 people signing it in the past year. On 4 June 2016, Channel 8's *News Tonight* featured a short interview with SMA Council Member A/Prof Chin Jing Jih. A/Prof Chin shared that doctors can assist patients with terminal illnesses to have a better understanding of palliative care and treatment to make the right choices based on their own values, via Advance Care Planning. A/Prof Chin also mentioned that the law has been in force for 20 years and that the Government may consider a review and public consultation to simplify the AMD procedures. Details of the interview are available at <http://goo.gl/2pjHaC>.

have been charging doctors administrative fees for patient referrals, which may be a variable percentage of a doctor's professional fees. The majority of affected doctors are those in private practice.

SMA President, Dr Wong Tien Hua, expressed concern on how this and other factors could have an effect on the patients' best interests, and advised that patients and clients of these agents should be aware that such fees are being paid. Dr Wong also mentioned that SMA is seeking clarification with the Singapore Medical Council on this matter. Details of the report are available at <http://goo.gl/HCPorq>.

DOCTORS CRY FOUL OVER "UNFAIR" PRACTICES OF THIRD-PARTY AGENTS

On 10 June 2016, the *TODAY* newspaper reported that practices of third-party administrators may not be fair and ethical to both doctors and patients. These third-party administrators, also known as managed care companies,

SMA-LEE FOUNDATION AWARDS

At the Duke-NUS Graduation Dinner on 3 June 2016, Dr Wong Tien Hua presented the SMA-Lee Foundation Achievement Prize to the top scorer at the Duke-NUS Exit Exam, and the SMA-Lee Foundation Teamsmanship Award to five graduating students who have demonstrated exemplary team values. In 2009, SMA and Lee Foundation jointly established the two awards to mark SMA's 50th anniversary. Lee Foundation kindly contributed a donation of \$200,000 towards the awards.

17TH MASEAN CONFERENCE 2016

The 17th Medical Association of South East Asian Nations (MASEAN) Conference was held from 11 to 12 May 2016 at Dusit Thani Hotel in Pattaya, Thailand. This year's meeting was hosted by the Medical Association of Thailand and attended by delegates from all ten ASEAN medical associations: Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, the Philippines, Singapore, Thailand and Vietnam.

The SMA delegation comprised Dr Wong Tien Hua, A/Prof Mahesh Choolani, Dr Lee Yik Voon, Dr Daniel Lee and Dr Tammy Chan.

OPENING CEREMONY AND HANDOVER OF CHAIRMANSHIP

The meeting commenced with the opening remarks delivered by Dr Wong Tien Hua, welcoming the delegates and thanking the Medical Association of Thailand for hosting this year's conference. Having been the chairperson of MASEAN for the past two years, he thanked members of MASEAN for their support and in particular, the Brunei Medical Association for hosting the 16th MASEAN Mid-term Meeting in 2015.

After which, Prof Saranatra Waikakul, president of the Medical Association of Thailand, was installed as the new chairperson of MASEAN. After receiving the customary MASEAN gold medallion from Dr Wong, Prof Saranatra delivered his welcome address and thanked Dr Wong for his leadership as the chairperson for the past two years. He also expressed gratitude to Dr Lee Yik Voon and SMA for being the secretariat of MASEAN. With the

recent advancement of medicine, he highlighted the importance of relying on the medical community and sharing of knowledge, which links to this year's topic of "How to Boost the Collaboration of our Medical Journals: Basic, Offers, Needs".

The highlight of the opening ceremony was the 4th Dr MK Rajakumar Memorial Oration, delivered by Prof Somsri Pausawasdi, chief executive officer of the Medical Association of Thailand, titled "Creating a Successful Inter-professional Collaborative Organisation".

CONFERENCE HIGHLIGHTS

The conference proper started on Day One afternoon, chaired by the MASEAN secretary general, Dr Lee Yik Voon.

Each of the national medical associations (NMAs) presented their country report, which highlighted the important issues that each of them face. There were issues shared which were relatable to that of the other NMAs, such as medical education, indemnity and the doctor-patient relationship.

The scientific symposium on "How to Boost the Collaboration of our Medical Journals: Basic, Offers, Needs" started on the morning of Day Two. This year, the session was a round-table discussion, moderated by Prof Saranatra Waikakul and Dr Wonchat Subhachaturas, past president and senior advisor of the Medical Association of Thailand. An Agreement of Cooperation was signed by all NMAs to strengthen the academic exchange and educational cooperation in the development of medical journals in terms of the sharing of articles, peer reviewers, journal assessment and citations.



PROFILE

TEXT BY

DENISE TAN

*Senior Executive,
International Relations*

Legend

1. Dr Wong Tien Hua presenting a token of appreciation to Prof Saranatra Waikakul, president of Medical Association of Thailand for hosting the 17th MASEAN Conference
2. A photo with all the MASEAN delegates

Following the scientific symposium was the business meeting, where the minutes and position statement of the 16th MASEAN Mid-term Meeting, held last year, were both confirmed. The newly revamped MASEAN website (<http://masean.net>) was also presented.

NEXT MASEAN MEETING

We would like to thank the Medical Association of Thailand for hosting this event and we look forward to the next meeting — the 17th MASEAN Mid-term Meeting to be held in Malaysia in 2017. ♦



HEALTHCARE

AT THE FOREFRONT

The Australian Medical Association's (AMA) National Conference was held from 27 to 29 May in Canberra. This year, the conference took place amid the federal election campaign primarily between the incumbent Liberal-National Coalition and the Labour Party. The main issue in the election, according to the polls, is healthcare, followed by the state of the economy. Reason being that their universal Medicare spending that dispenses payments to doctors has been frozen.

The freeze amounted to no increments for inflation in the last three years and the current government intends to continue the freeze for another three years. A couple of GPs who depend primarily on such payments shared that medical inflation and salary increments have eroded their margins and they face a dire situation, especially if the freeze carries on for three more years.

AMA has since started a poster and prescription pad campaign in GP practices to inform patients about the consequences of the freeze. Currently, 84% of GPs in Australia do not charge patients any copayments and "bulk bill" the fees to the government. If the freeze carries on, patients will need to copay an amount to help GPs defray their costs; thrusting the healthcare issue into the forefront of the election campaign.

In local context, many of our GPs are still seeing private patients with an increasing number attending to those on managed care plans, the Community Health Assist Scheme and Medisave for Chronic Disease Management Programme. The "nationalisation" of primary care will be complete when these patients eventually form the bulk of our income streams.

The conference had many interesting policy sessions. The panel on physician-assisted dying was chaired by a famous journalist who was so well prepared that I thought he was a doctor. The discussion centred around a more palatable view that the likely legislation in the future would involve doctors writing a prescription to hasten death but not actively participating in the "act" itself. This was described as a "halfway house" whereas participating actively in the act was described as the "full house" or the "full monty". There was also discussion on the "double effect" of prescribed drugs or treatments that would primarily relieve pain but may have a secondary effect of hastening death. The intention of the discussion was to update the position paper of the AMA on doctors' role in end-of-life care.

Another interesting session that reflected the politics of the day was the session "Health Policy in an Election Year". Five top health journalists discussed the various issues on healthcare and we learnt that despite the repeated change of governments over the decades, AMA has kept to its mantra of talking about only health- and patient-related issues instead of taking sides. This has given the association huge cachet and influence on the government of the day. I suppose some principles are common to all national medical associations (NMAs) and we need to keep our eyes on the "lighthouse" of the patient's interests as we sail our NMAs through stormy seas.

Yet another hot topic involved bullying and harassment. I was surprised when the president of the Royal Australasian College of Surgeons, Dr Philip Truskett, disclosed that the issue of discrimination, bullying



PROFILE

TEXT BY

DR CHONG YEH WOEI

Dr Chong was SMA President from 2009 to 2012 and is a member of the 56th SMA Council. He has been in private practice since 1993 and has seen his fair share of the human condition. He pines for a good pinot noir, loves the *FT Weekend* and of course, wishes for world peace...

and sexual harassment (DBSH) was so dire that the Attorney General (AG) met with him and told him that training privileges of the college will be suspended if actions were not taken. The expert advisory group formed then published a "damning" report and the college accepted all of the group's recommendations.

I spoke to our local residency programme directors who said that our local residency programme deals with DBSH in a firm manner and any "old habits" are slowly dying a natural death.

Other policy sessions included the role of private insurers, closing the gap on aboriginal health and interestingly, the association took position on the social ills of smoking, alcohol abuse, and issues such as climate change and the state of health of asylum seekers in detention. I always see the AMA National Conference as a crystal ball of sorts; the issues they face would eventually wash up on our shores in the not-so-distant future. ♦



SMA Seminar: Workplace Safety and Health for Medical Practice Owners

Date: 8 October 2016, Saturday
Venue: M Hotel, Level 10

Time: 1 pm – 5 pm
CME Points: Max 2

Who should attend?

Clinic owners and clinic assistants who are responsible for workplace safety matters.

Did you know?

You are required to possess general knowledge of Workplace Safety and Health which may be tested during the application/renewal of clinic licensing.

Safe & Healthy Workplace



Happier Employees



1 pm	Registration (Lunch will be provided)
2 pm	Opening Address <i>Dr Wong Sin Yew, Infectious Disease Physician, Infectious Disease Partners Pte Ltd</i>
2.15 pm	Risk Assessment for the Ambulatory Care <i>Ms Moon Loh, Consultant, Centre for Safety, Health, Environmental and Quality (SHEQ), ST Electronics (e-Services) Pte Ltd</i>
3 pm	Handling Aggressive and Violent Patients <i>Dr Adrian Wang, Consultant Psychiatrist, Gleneagles Medical Centre</i>
3.45 pm	Infection Control Considerations in the Family Physician Clinic <i>Ms Moon Loh, Consultant, SHEQ, ST Electronics (e-Services) Pte Ltd</i>
4.30 pm	Questions & Answers
5 pm	End of Seminar

Supported by:

ST Electronics (e-Services) Pte Ltd

Booth Partner:



Please return this slip for SMA Seminar: Workplace Safety and Health for Medical Practice Owners to **Carina Lee, Singapore Medical Association, 2 College Road, Level 2, Alumni Medical Centre, Singapore 169850. Tel: 62231264, fax: 62247827 or email: carinalee@sma.org.sg.** A confirmation email will be issued to all applicants.

Name: _____ MCR no.: _____ Specialty: _____

Contact no.: _____ Email: _____

Mailing address: _____

I would like to (inclusive of GST):

- ☐ Register myself for the seminar (SMA member: complimentary, non-member: \$80)
- ☐ Register my staff to attend on my behalf (SMA member: complimentary, non-member: \$80)
- ☐ Register both myself and my staff for the seminar (SMA member: complimentary, non-member: \$100)

Mode of payment

- ☐ Credit card
VISA/MasterCard: _____ - _____ - _____ - _____
Expiry date: _____ / _____ CVV2/CVC2 no.: _____

- ☐ Cheque (payable to Singapore Medical Association)
Bank: _____ Cheque no.: _____

Signature: _____ Date: _____

By registering for this event, you consent to the collection, usage and disclosure of personal data provided for the purpose of this event, as well as having your photographs and/or videos taken by SMA and its appointed agents for the purpose of publicity and reporting of the event.



For Doctors, For Patients

Singapore
Medical
Association

SMA ANNUAL GOLF TOURNAMENT 2016

Date: 3 August 2016, Wednesday

Time: 12 pm (shotgun will start at 1.30 pm)

Venue: Tanah Merah Country Club

This year, the SMA Annual Golf Tournament 2016 will be held at the Tanah Merah Country Club's challenging 18-hole Tampines course.

With the generous support of sponsors, you can look forward to:

- The GP versus Specialist Competition (*top 5 + 1 [lady] scores from each group*)
- The "Friends of SMA" trophy (for non-doctors)
- The chance of winning the hole-in-one prize:
 - Mercedes-Benz CLA Shooting Brake
- Exciting prizes for winners and lucky draw
- A sumptuous dinner
- Goodie bags with attractive door gifts
- Last but not least, enjoy a day of golfing with friends

To register, please visit **<https://www.sma.org.sg/golf>**. Registration closes on 29 July 2016. Do sign up early and encourage your doctor friends to join us at the SMA Annual Golf Tournament 2016.

Looking forward to seeing you there!

Yours sincerely,

DR TAY JAM CHIN

Convener

SMA Annual Golf Tournament 2016

Main Sponsors:

Hole-in-one Sponsor:



UNDER THE FLOODLIGHTS

The past SMA annual inter-hospital soccer championships were all fought for under the scorching sun. The organising team led by Chairperson Dr William Kristanto received feedback from players that they would prefer a night tournament this year, as it would place a greater emphasis on skills and less on fitness. Hence, in our attempt to level the playing field, the 42nd SMA-Eagle Eye Centre Inter-Hospital Soccer Tournament was held on the evening of 8 May at the Home United Youth Academy (HYFA).

The eight participating hospital and private practitioner teams' players started streaming into the HYFA fields at 4 pm for their warm up to conquer four hours' worth of soccer matches. At 5 pm, the first two matches kicked off with the Khoo Teck Puat Hospital team competing against the Singapore Armed Forces (SAF) team, while the National University Hospital players were up against their Tan Tock Seng Hospital counterparts. After each team

completed three matches under their respective groups amid cheers from supporters along the sidelines, the SAF team topped the Group 1 table while the Singapore General Hospital (SGH) team came in with the most match points in Group 2.

As the SAF, SGH, SingHealth HQ (SHHQ) and Private Practice 1 (PP1) teams vied for a spot in the finals against the setting sun, raindrops started to fall. However, the players' fighting spirit was not put out by the rain and they fought strong and hard for a closer chance at the championship. The SAF and SGH teams eventually won their places in the much anticipated finals.

A mixture of fatigue and fiery determination were clearly written on the SAF and SGH players' faces as they stepped onto the pitch at 8 pm for the last 20 minutes of the game to obtain the coveted championship. It was a close match and the ball was deflected numerous times by both team's defence

players as they struggled to maintain possession and to send it to the opposite team's goalpost. The SGH team eventually scored three goals that sealed the game, and they were crowned as the champions of the 42nd SMA-Eagle Eye Centre Inter-Hospital Soccer Tournament!

We would like to thank Eagle Eye Centre for their strong support and sponsorship for this year's tournament. ♦



PROFILE

TEXT BY

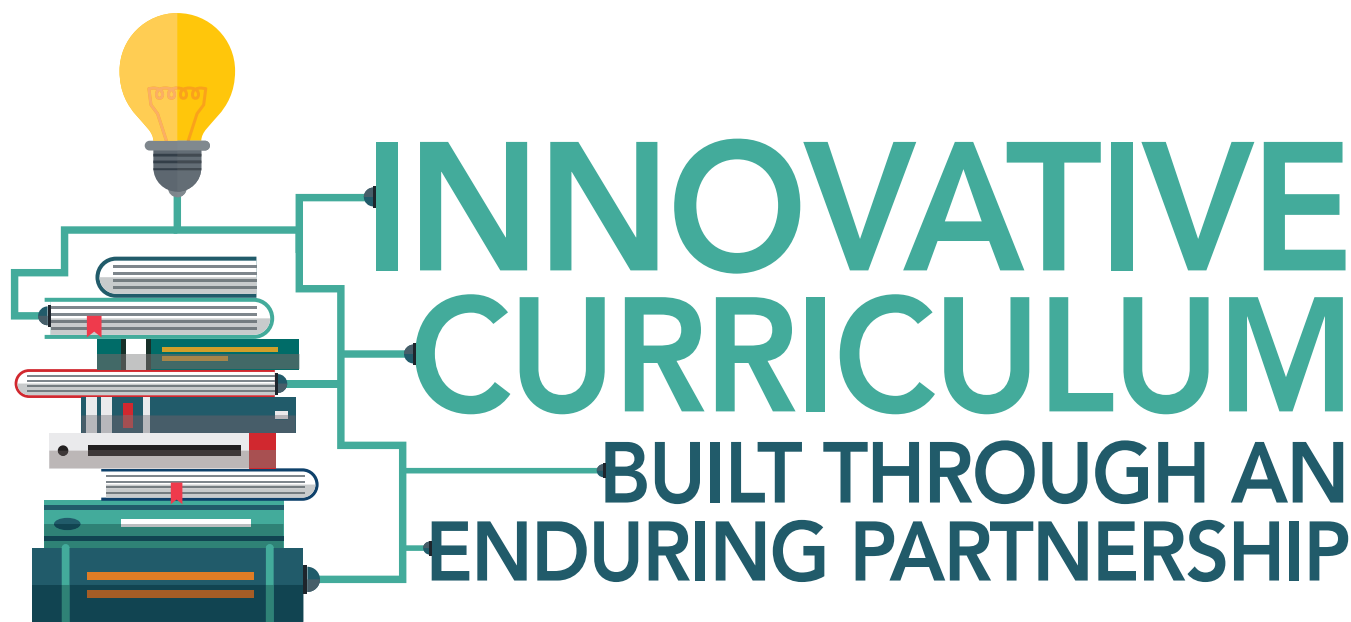
MELLISSA ANG

*Senior Executive,
Membership Services*

Legend

1. The SGH team were all smiles after winning the championship

2. A PP2 player sliding in for a tackle against his SHHQ counterpart



When I was approached in December 2010 to head a team of medical educators at Imperial College London (Imperial) for a new medical school “project” in Singapore, I was curious to know what the expectations of the new curriculum would be. Would we deliver a replica of the highly successful Imperial curriculum? Doing that would surely be a missed opportunity. However, by the time of my first visit to Singapore in early 2011, it was clear that all stakeholders were committed to a school that would approach medical education in a very different way. This would be a bespoke curriculum for Singapore.

Many medical schools worldwide are collaborations between universities, but the Lee Kong Chian School of Medicine (LKCMedicine) is – dare I say it – unique. From the start, teams in London and Singapore set about developing collaboratively all parts of the MBBS programme – from admissions to curriculum, assessment and student welfare – combining the very best from Imperial with innovative educational approaches. Our mission then, as now: to train the very best doctors for Singapore; doctors who advance the science and practice of medicine for the good of humanity.

BUILDING TEAMS

At that time, based in London as the curriculum development lead, a position that I combined with my role as consultant gynaecologist, I was responsible for a talented team of

medical educators based at the London office of LKCMedicine, working closely with more than 90 faculty and staff across Imperial. I regularly updated Prof Jenny Higham, then director of education at Imperial, who led the project from the start, and was in daily contact with Prof Martyn Partridge, our then senior vice dean in Singapore. Prof Partridge, a highly regarded respiratory medicine physician from Imperial, worked tirelessly to gain deep insights into Singapore’s evolving healthcare landscape. He was instrumental in establishing and communicating the vision and mission of the School through broad engagement with the Singapore medical and university communities. A highly committed team in Singapore was established, including very experienced clinician educators from the National Healthcare Group, who are renowned for their medical expertise and teaching excellence.

MEETING SINGAPORE’S HEALTHCARE NEEDS

We recognised that the new curriculum must prepare graduates for the future and for Singapore’s healthcare context. Singapore’s changing demographics, with a population ageing faster than anywhere else in the world and growing numbers living with complex chronic conditions, were driving changes in healthcare delivery; a shift in the balance between hospital and community practice and a greater emphasis on teamwork and integrated care. Furthermore, patient

expectations were changing, with calls for more holistic care. These changes, coupled with the veritable explosion in medical and scientific knowledge and innovative technology, posed challenges and exciting opportunities for the medical educator teams designing the curriculum.

Our graduate outcomes started to take shape. Being caring, knowledgeable and competent doctors was a given, but what would be distinctive about LKCMedicine graduates? Firstly, they would be “pluripotent” – able to excel in all medical careers, from primary care to surgery to medical research. Secondly, they would be team players with excellent communication skills, a patient-centric approach and the highest standards of professionalism. Finally, they would have the scientific rigour, lifelong learning skills and resilience to remain competent and up to date, responding to and shaping the future practice of medicine.

DESIGNING THE NEW CURRICULUM

With our planned graduate outcomes established, we took stock of the latest international practices and innovations in medical education. In London, the curriculum team embarked on a thorough review of the Imperial curriculum to identify its most successful elements. Meanwhile, in Singapore, with the core clinician educator team established, there was a commitment to leverage on the

strengths of Nanyang Technological University (NTU) Singapore, with broad engagement of faculty across the campus. This was a true international partnership at work.

So what did the Imperial curriculum bring to LKCMedicine? From the outset, we identified early patient contact courses that were subsequently enhanced and contextualised, and have become popular and innovative courses in Singapore. These include the Integrated Clinical Practice course and the Long-Term Patient Project, both of which emphasise patient-centric care early in medical training. We identified many high-quality Imperial lectures, delivered by some of the world's finest scientists. A decision had to be made about how to deliver this content. In keeping with modern educational practice, we recognised the need for an active learning pedagogy that embraced critical thinking, teamwork and integration of scientific knowledge with clinical experience.

TECHNOLOGY MEETS TEAM-BASED LEARNING

The experience of Duke-NUS Medical School, which had already implemented Team-Based Learning (TBL) in Singapore with great success, was an important influence. But would TBL work for undergraduates in larger classes across multiple years of curriculum? Extensive consultation, including with Prof Larry Michaelsen, the "founding father" of TBL, a visit to Sharjah (home to one of only a few undergraduate medical schools in the world with experience of TBL), and a review of the medical education literature all convinced us that it would.

Our approach to TBL is unique in being implemented across five years of curriculum, most intensively in Years 1 and

2, where it has completely replaced lectures. Furthermore, the seamless integration of our e-learning ecosystem into all aspects of student learning – including the TBL classes – is highly innovative. This enables our educators in the classroom to monitor student progress more efficiently and get a sense in real-time whether they are on track.

AN ENVIRONMENT TO FLOURISH

With LKCMedicine's TBL pedagogy planned and ready, and our faculty training programme in place, we also needed the right systems, spaces and people to create an environment in which our students would flourish. Our House System was going to be at the heart of this endeavour, with a dedicated team of house tutors on hand to nurture and support our students. The House System would also foster an ethos of community service and professionalism, while at the same time ensuring the students had a lot of fun!

A MATURING MEDICAL SCHOOL

Since opening our doors to our inaugural cohort in August 2013, LKCMedicine has matured into a thriving community of talented students and committed faculty with a curriculum fully mapped over five years. Having relocated to Singapore in December 2014 to take up my full-time position as vice dean of education, I see the School growing in size and stature as key elements of our pedagogy are established, new bespoke facilities are in place and our students have transitioned to the wards and clinics, where they have impressed many with their energy, enquiring minds and professionalism.

AN ENDURING PARTNERSHIP

How will the partnership with Imperial evolve? LKCMedicine is an

autonomous school of NTU, jointly managed by NTU and Imperial, with its own leadership team. We often refer to LKCMedicine as having two proud parents with high expectations. With our high-calibre medical educators, these expectations are being met every step of the way and our students are in the very best hands. Imperial continues to play an important role in assuring the quality of the curriculum and supporting its delivery. Exciting new initiatives to make the Imperial partnership more meaningful to our students are underway. These include exchanges, elective placements and student collaborations. The partnership with Imperial remains an enduring one and like LKCMedicine itself, it is going from strength to strength. ♦

PROFILE



TEXT BY

A/PROF NAOMI LOW-BEER

A/Prof Naomi Low-Beer is vice dean for education at LKCMedicine, responsible for the development and delivery of the School's innovative MBBS programme. Having previously combined a medical leadership role at Imperial with clinical practice as consultant gynaecologist, she relocated to Singapore in December 2014 in order to focus full-time on LKCMedicine.

Legend

1. Students learn in teams and benefit from a fully integrated e-learning ecosystem that ensures all materials and resources are just a swipe away

Photo by LKCMedicine



TRAINING DOCTORS FOR TOMORROW'S HEALTHCARE CHALLENGES



The Lee Kong Chian School of Medicine (LKCMedicine) was officially signed into existence on 29 October 2010. This is a unique partnership between Nanyang Technological University (NTU) Singapore and Imperial College London (Imperial). The collaboration is not just a "lift and shift" of Imperial's curriculum, but provided the new School with an opportunity to build a curriculum that takes in high-quality content from Imperial, tailor it to Singapore's needs and underpin it with the latest technology. The outcome? A five-year MBBS programme that uses technology-enhanced Team-Based Learning (TBL) and incorporates three themes that cut across the years – the scientific basis of medicine, clinical management and patient-centred care, and healthcare delivery and professional standards, delivered in bespoke state-of-the-art teaching facilities at NTU's main and Novena campuses.

This is a significant milestone for medical education in Singapore. For many of us, there was only one choice

when it came to studying medicine locally. When the new medical school was announced, I signed up as I wanted the opportunity to experience something different and to implement novel ideas and programmes that would have been difficult to incorporate in an existing system.

Our vice dean for education, A/Prof Naomi Low-Beer, sums it up like this: "We developed a medical curriculum that is fit for purpose in the 21st century. By creating an active learning environment, we nurture a spirit of inquiry and a higher level of thinking. We prepare our students for the challenges of modern medical practice across the spectrum of medical careers, with an emphasis on patient-centred care, teamwork, scientific rigour and technological innovation."

While the LKCMedicine curriculum retains the pedagogical approaches associated with medicine, such as being split into pre-clinical and clinical years (where the latter are spent at hospitals and healthcare sites across Singapore), we infuse our curriculum

with three key features to reflect the changing nature of how and where patients access care: early patient contact; exposure to the full spectrum of medical settings from the bedside to the home; and exposure to different healthcare professionals. We infuse these elements by sending our students to different clinical sites and by involving patients, scientists, nurses, medical social workers, pharmacists and other allied health professionals early on in their curriculum.

EARLY PATIENT INTERACTION

Through the early contact with patients, we encourage students to focus on understanding patients' journeys through the healthcare system, which oftentimes do not follow a linear process. At the onset, it teaches them to build rapport and to understand the challenges individual patients face while seeking healthcare. We do this through the Hospital and Polyclinic Weeks, which are timetabled during the first two months after matriculation. During Polyclinic Week, our students engage with relatively well patients by talking to them as they wait to be seen.

This is reinforced through the Long-Term Patient Project, which is an adaptation of a course that Imperial offers. This project spans the first two years of the MBBS programme, during which students follow a patient in the community to observe how care is delivered, how the patient lives and the challenges he or she faces in accessing care. Students process these experiences through reflective writing on their interactions and learnings from the encounters. We hope that this appreciation for the patient's perspective is something that they carry with them throughout the years and into their professional lives.

LEARNING WHERE HEALTHCARE IS DELIVERED

Throughout the first two years, students visit the polyclinic once a week to train their clinical and communication skills. They not only practise their skills with simulated or volunteer patients, they also practise

them in an environment that comes as close to a clinical setting as possible.

This gives us an opportunity to show students that the practice of medicine depends on the setting in which a doctor practises. Vice dean for clinical affairs, A/Prof Pang Weng Sun, explains: "The majority of patients with chronic illnesses are seen in primary care clinics – polyclinics and GP clinics. So it is important for our students to learn how to diagnose, investigate, treat and manage such patients in the community."

To achieve this, students are exposed to the fast-paced care of a hospital setting, as well as the care delivered in the polyclinic, at step-down care facilities and even at home.

There is one other key setting that we believe our students should be exposed to, namely the world of biomedical and clinical research. Working alongside world-renowned scientists in metabolic medicine, neurosciences, infection, dermatology, and health services outcomes research, we want to nurture a spirit of inquiry in our students. While many students seek out such opportunities on their own, we have also introduced a six-week Scholarly Project in Year 4, so that all students get this opportunity. Students can choose from a wide array of projects (eg, medical education, clinical research, basic research, translational research) through which they acquire an appreciation and understanding of scientific research.

INTER-PROFESSIONAL TEACHING

Throughout the curriculum, we involve other professionals in the teaching of our students. Having different professionals with different perspectives train our students can provide our students with a greater appreciation of the various roles we play and how all of us can work together in the future as effective and competent teams. Our research faculty teach basic medical science alongside clinical experts; clinicians, nurses and allied health professionals act as content experts and teachers for TBL sessions and clinical skills.

HIGH-TECH, HIGH TOUCH

Not only do we expose our students to a wide range of healthcare settings, healthcare professionals and, most importantly, different types of patients, we also expose them to a wide range of technologies that have been harnessed to enhance all aspects of their learning. Using iPads, all curriculum materials are just a swipe away; using our custom-built e-learning environment, faculty can track student performance in real time, adjusting the lesson to suit the class. Using the latest simulation technologies, including the Anatomage Table and plastinated specimens that are used in our anatomy teaching, we augment their learning experience. Through this exposure, we train our students to be comfortable with new technologies and incorporate them into their practice without these technologies replacing them. Complemented by our TBL pedagogy, which nurtures lifelong learning and teamwork, our students are already making a positive impression in their clinical years, distinguishing themselves with their inquisitiveness and situational awareness.

Our students will continue to hone these skills and attributes during their clinical years. To ensure that they are fully job-ready once they graduate, we are introducing the Student Assistantship Programme, where students will learn to interact and work alongside their future colleagues as part of the healthcare team.

LKCMedicine remains a work in progress. I look forward to 2018, when I can proudly work alongside my new colleagues – the first graduates of LKCMedicine. ♦

PROFILE



TEXT BY

A/PROF WONG TECK YEE

A/Prof Wong Teck Yee is assistant dean for Year 4 and Family Medicine at LKCMedicine. He is also a senior consultant family physician practising at Tan Tock Seng Hospital. Prior to that, he has held appointments with the National Healthcare Group Polyclinics and National University Health System. He has an MMed (Family Medicine), Masters in Public Health and Health Professions Education.

Legend

1. Vice dean for education A/Prof Naomi Low-Bear regularly meets students to hear their feedback on the curriculum and their experiences at LKCMedicine
2. LKCMedicine students are taught by some of the School's top-name research faculty

Photos by LKCMedicine



OCCURRENCE-BASED OR CLAIMS-MADE:

WHICH MEDICAL MALPRACTICE PROTECTION IS RIGHT FOR YOU?

No indemnity model is perfect. They differ in characteristics and features such that individual doctors need to decide which would be the most suitable for their type of practice. To provide SMA members with generic information on indemnity models, the article, "Your Medical Practice Protection: Know Your ABCDEs before Something Goes Bump in the Dark" was published in the November 2015 issue of *SMA News* (<https://goo.gl/PvrE1J>). Following that, Dr Benny Loo, representing doctors in training in the SMA Council, conducted an interview with Dr Teoh Ming Keng, a medico-legal advisor in the Medical Protection Society (MPS), in a bid to address the many queries from doctors on how changes in the medical indemnity landscape could affect them. The interview was published in the March 2016 issue of *SMA News* (<https://goo.gl/kXJoul>).

SMA invites Mr Michael Griffiths, Regional Director, Healthcare, Aon Singapore, to provide insights on occurrence-based and claims-made indemnity covers. Michael has more than 20 years of experience in managing medical malpractice insurance, professional indemnity insurance, directors' and officers' liability insurance, and other specialist classes for major hospital groups, clinics and individual healthcare practitioners. He also has substantial experience in risk management, risk retention programmes and captive management in the Australian market.

Comment from the Editor: Malpractice indemnity is a difficult and complex topic. In the article published here, the author writes mainly about claims-made indemnity cover. Some readers, commenting on the "Ahead of Print" release of this article, said that it is not always clear which parts are about claims-made indemnity in general, which are about individual policies, which are about group cover arrangements and which apply to specific arrangements in current use (ie, the MOHH-Aon-MPLC programme that covers the majority of our young doctors).

In 2015, MPS announced they were making important changes to the medical malpractice protection offered to obstetrician members in Singapore. MPS was replacing the traditionally offered occurrence-based solution with a claims-made solution. At short notice, obstetricians in Singapore were forced to consider the type of protection that they carry against medical malpractice claims, and were immediately faced with an array of unfamiliar concepts and terminology: claims-made, claims-occurring, occurrence basis, run-off cover, nose cover, etc. In the inevitable confusion that followed, letters were written to newspapers, Government officials were lobbied and some even referred to a looming "indemnity crisis". In this article, we address issues that surround claims-made and occurrence-based protection to provide Singapore doctors the knowledge that will help them make informed choices.

In order to understand the nature of occurrence-based and claims-made protection, we need to consider the sequence of events that leads to medical malpractice claims. There are two important dates: the date when the patient was treated and the date when the patient brought their claim against the doctor. These two dates may occur close to one another or, as under Singapore law, may be as far apart as 24 years. Given that a doctor may have changed between different insurance or indemnity providers in the intervening period, it is necessary to determine which protection will respond: the protection that was in place on the date of the treatment or the protection that was in place on the date that the claim was brought?

The answer to this seemingly innocuous question reveals the key

difference between occurrence-based and claims-made protection. Under occurrence-based protection, it is the policy in place at the time of the treatment that responds. Under claims-made protection,¹ it is the policy in place at the time the claim is brought against the doctor that responds. Simple enough, but the implications can be material.

First, let us consider the case where a medical malpractice claim is brought against a doctor with occurrence-based protection. The doctor will need to determine the date or dates of the treatment and then identify the provider of indemnity or insurance at the relevant time. So long as the provider is still operating, the doctor will be able to lodge the malpractice claim, which will then be managed in accordance with the insurance policy terms and conditions, or in the case of a discretionary mutual, at the discretion of the mutual.

If the cover is claims-made, the doctor will lodge the malpractice claim with the current provider at the time of the claim. Such a claim will, depending on the type of protection, be managed either in accordance with the insurance policy terms and conditions or at the discretion of the mutual.

The mechanics of claims management for occurrence-based and claims-made protection are not significantly different.

One point to highlight is that where occurrence-based insurance protection is taken out, the impact of inflation can be significant. If a long period elapses between the time of the treatment and the time of the claim, medical or litigation inflation could lead to material increases in the

PROFILE

TEXT BY

MICHAEL GRIFFITHS

Regional Director,
Healthcare,
Aon Singapore

settlement amount of a malpractice claim. Under an occurrence-based insurance protection, the claim will go back to the insurance policy that was in place at the time of the treatment and the amount of cover available will depend on the limit of indemnity chosen at that time.

For this reason, doctors who take out occurrence-based insurance protection need to make allowances for future inflation when selecting their limit of indemnity. Doctors who take out claims-made protection have the opportunity to select insurance protection limits based on current-day litigation trends.

An important difference between occurrence-based and claims-made protection comes to light when a doctor retires or ceases practice. For a doctor who has carried occurrence-based protection throughout his or her career, there is no need to purchase further cover in retirement. Any claims brought against that doctor in retirement will be covered by the protection in place at the time of the treatment. The important proviso here is that the occurrence-based protection provider at the time of the treatment must still be in business at the time the claim is brought. By contrast, doctors who have carried claims-made protection throughout their career must make arrangements to ensure continuing cover in retirement. This type of cover is known as run-off or tail cover and is typically purchased in multi-year blocks.

So which of these two types of cover is better? The key to answering this question is to consider the doctor's employment status. The majority

of doctors practising in Singapore do so as employees of either the public sector institutions or the larger private healthcare providers. For employee doctors, the primary defence against medical malpractice claims is not insurance or indemnity from a medical defence fund but the indemnity provided by their employer. It is the employer who is ultimately liable for the actions of their employees. In Singapore, employers of doctors currently adopt one of two strategies in order to protect themselves and employees against liabilities arising from the actions of their employee doctors:

1. Employers take out protection for each individual employee doctor. This protection acts as the first line of defence, shielding the employer from having to offer indemnity to the employee doctor.
2. Employers take out a group protection for claims brought against either the employer or its employees.

From the point of the employee doctor, it makes little difference whether the protection that their employer arranges is occurrence-based or claims-made. Individual protection is available on both occurrence and claims-made basis, while group protection is typically only offered on a claims-made basis. But in either case, it is the employer who bears ultimate responsibility for the actions of employee doctors both during the period of employment and after they resign or retire.

There is a difference for doctors acting as independent consultants in the private sector, or employed by a small clinic they have set up alone or in partnership with other

doctors. In such cases, there is no protection available in the form of indemnity from their employers and so a personal, occurrence-based protection will, if available, be selected by independent consultants due to the cover that it offers in retirement.

Finally, we need to consider the case where doctors' circumstances change during their career, requiring a move from one type of protection to another. Moving from an occurrence-based protection to a claims-made protection is straightforward. The occurrence-based protection will continue to cover future claims arising from date of treatment "prior" to the change of protection. The claims-made protection will provide cover for future claims arising from treatment "after" the change of protection.

Aon is opining on the theoretical distinction between claims-made and claims-occurring. It should be noted that there are situations with claims that can straddle the transition which can challenge and complicate this theoretical distinction.

Moving in the other direction, from claims-made to occurrence-based protection, is a little more complicated.

If a doctor moves from claims-made protection to occurrence-based protection, it will be necessary to take one of the following steps:

1. For employed doctors (and leaving to one side the legal question on sources of indemnity) to obtain a

confirmation from their employer of ongoing availability of indemnity and insurance for future claims that might arise from treatments given during the time of their employment.

2. For independent doctors, to ask the new occurrence-based provider to cover treatments in the past that will give rise to future claims.

Singapore doctors currently have a choice of three providers of malpractice claim protection: Medical Protection Society, NTUC Income and Aon Singapore Medical Indemnity. Genuine competition between providers is the best guarantee of access to the required protection at a reasonable price. It is important that doctors make informed choices when selecting their provider. We recommend that advice is sought from a licensed insurance intermediary specialising in medical malpractice protection in Singapore so that cover purchased is appropriate for the doctor's specific circumstances and needs. ♦

Note

1. We are aware of a Singapore-based protection provider referring to claims-made protection as "claims-occurring" protection.

SMA urges you to take this article only as general education. For information about, and terms applying to, your specific indemnity cover, you must refer back to the programme's specific terms and conditions. If you are in any doubt about any point, you should contact your indemnity provider for clarity.

SCS-SMA Cancer Education Seminar Series 2016



SINGAPORE
CANCER
SOCIETY



For Doctors, For Patients

Date: 24 September 2016, Saturday

Time: 1 pm – 5 pm (Lunch will be provided)

Venue: Health Promotion Board Auditorium, Level 7
(3 Second Hospital Avenue)

Number of CME Points: Max 2 (Pending approval from the Singapore Medical Council)

To register, visit <https://www.sma.org.sg/academy> or fill in the form below.

**GENERAL
PRACTITIONERS
ARE THE FIRST
LINE OF DEFENCE
AGAINST CANCER.**

TOPIC: BREAST CANCER

Breast cancer is the most common cancer among Singaporean women. As a GP, you can advise, encourage and empower your patients to take ownership in preventing, coping with and surviving breast cancer. Sign up for the SCS-SMA Cancer Education Seminar Series to learn how you could be a life changer for the patients you care for. Early detection leads to better survival outcomes.

Time	Programme
1 pm	Registration (Lunch will be provided)
2 pm	Introduction to SCS-SMA Cancer Education Series 2016 <i>Ms Athena Wang, Head, Strategic Development, Singapore Cancer Society</i>
2.10 pm	Introduction to Singapore Society of Oncology <i>Dr Ravindran Kanesvaran, President, Singapore Society of Oncology</i>
2.15 pm	Breast Cancer in Families <i>Dr Joanne Ngeow, Consultant, Division of Medical Oncology, National Cancer Centre Singapore (NCCS)</i>
2.35 pm	Breast Cancer Screening – the Never-Ending Controversy <i>Dr Raymond Ng, Senior Consultant, Division of Medical Oncology, NCCS</i>
2.55 pm	How Not to Miss Breast Cancer – Understanding Breast Imaging and Diagnostics <i>Dr Felicity Pool, Consultant, Department of Diagnostic Imaging, National University Hospital</i>
3.15 pm	Breast Surgery and Reconstruction – Getting Back to “Normal” <i>Dr Tan Kik Mien Veronique, Consultant, Division of Surgical Oncology, NCCS</i>
3.35 pm	Questions I Dare Not Ask My Oncologist <i>Melanie Tan, Assistant Nurse Clinician, NCCS</i>
3.55 pm	When Breast Cancer Treatment is Over – The Survivors <i>Dr Tan Sing Huang, Senior Consultant, Department of Haematology-Oncology, National University Cancer Institute, Singapore</i>
4.25 pm	Closing

Supported by:



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Please return this slip for SCS-SMA Cancer Education Seminar Series to **Carina Lee, Singapore Medical Association, 2 College Road, Level 2, Alumni Medical Centre, Singapore 169850. Tel: 62231264, fax: 62247827 or email: carinalee@sma.org.sg**. A confirmation email will be issued to all applicants.

Name: _____

Handphone no.: _____

Email: _____

Profession/Specialty: _____

MCR no.: _____

SMA member: YES / NO (please circle accordingly)

Registration fees (inclusive of GST)

☐ SMA member: complimentary

☐ Non-member: \$120

By registering for this event, you consent to the collection, usage and disclosure of personal data provided for the purpose of this event, as well as having your photographs and/or videos taken by SMA and its appointed agents for the purpose of publicity and reporting of the event.

Mode of payment

☐ Credit card

Visa/MasterCard no.: _____ - _____ - _____

Expiry date: _____ / _____ CVV2/CVC2 no.: _____

☐ Cheque (payable to Singapore Medical Association)

Bank: _____ Cheque no.: _____

Signature: _____ Date: _____



PROTECTING JUNIOR DOCTORS THROUGH GROUP COVER

Recent issues of *SMA News* covered two indemnity models that doctors can choose from as individuals, namely occurrence-based and claims-made cover. In recent weeks, three-way communication between the SMA, doctors and MOH Holdings (MOHH) demonstrated the need to briefly discuss a third model: group indemnity. Knowing how this may differ from individual cover is very important to doctors currently covered under such an arrangement. As most of them will be under the MOHH Junior Doctors' Medical Malpractice Insurance Programme and this is the group indemnity plan of greatest current interest, I have used points gleaned from the above-mentioned communications to illustrate this short summary.

WHY GROUP INDEMNITY?

What is group indemnity? It is a good way for an employer-organisation to address vicarious liability. After all, "it is the employer who bears ultimate

responsibility for the actions of the employee doctors during the period of employment and after they resign or retire" (see article on page 24). In essence, it means that the employer is liable for whatever damages resulting from a doctor's treatments, which he himself cannot pay. For self-protection, an employer will therefore do one of the following: (i) refuse to employ any doctor who does not have his own individual protection, (ii) buy protection for individual employees, or (iii) arrange for group protection designed to cover claims brought against either the employer or employee.

GROUP INDEMNITY VS INDIVIDUAL PROTECTION

How does group indemnity differ from individual protection? I have listed some points and illustrated them with quotes from communication surrounding the MOHH programme mentioned above:

- a. **Group indemnity is usually purpose built.** "[It] is not some [commercial off-the-shelf] (COTS) product. Aon had designed and brokered this programme for MOHH..."
- b. **It is likely to have been designed based more on employer's (rather than employee) requirements.** "... based on our [ie, MOHH's] specific requirements as an institution purchasing insurance coverage for our employees."
- c. **Its terms of cover are individualised to these requirements rather than generic.** "It is therefore wrong to put together information taken from Aon's general website and pass it off as the terms of the MOHH programme."
- d. **Its coverage may include or exclude specific aspects of work.** These may be important (or not) to specific individuals.

The cover offered by the MOHH programme includes at least: clinical negligence, Singapore Medical Council enquiries, disciplinary procedures, guidance for preparation for inquests, and Good Samaritan Acts (except in the US and Canada). However, it probably excludes locum work outside MOHH. Other group indemnity arrangements may offer either more or less and it is critical that the doctor being covered reads the “fine print”.

- e. **It may, or may not, cover the doctor after he leaves this employer.** The MOHH programme specifically continues to cover the doctor after leaving “... provided that such adverse events are reported and notified during the period of employment... For adverse events that were not reported, cover will be discretionary on a case-by-case basis.”
- f. **Such cover may be only for a limited duration, or may meet the doctor's full needs for tail cover.** The MOHH programme in effect provides full tail cover, ie, “[it] includes tail cover for whatever duration based on the relevant statutes of limitations... regardless of subsequent employment status of our doctors...”; “... we structure our insurance programme such that individual run-off cover is not required, as future renewals of the policy by MOHH will include run-off cover for claims from past acts and for former employees.”
- g. **Such tail cover may continue undisturbed even if the employer changes insurers in the future.** For example, even if MOHH changes insurers in the future, the employee is assured that “... avoiding gaps in cover is a simple matter of ensuring that the policy terms and conditions of the former policy are mirrored in the new one.”

Note: The above quotes and examples are based on the author's understanding of emails and other communications between SMA (and doctors) with MOHH. It is used only to illustrate the characteristics of a group policy which

an employee should be aware of. If any of these details have been wrongly understood, the author apologises and requests for MOHH's clarification and correction for print in SMA News.

ITEMS TO CONSIDER

I emphasise that **other group indemnity plans may differ significantly from the MOHH programme illustrated above.** If you are covered by your employer's group indemnity plan, SMA strongly urges you to:

- a. **Realise that group indemnity is different from personal indemnity.** Even if both are administered by the same insurer, you cannot assume that what is on the website will apply to both personal and group indemnity alike. You must clearly understand what you are covered for, and what not, under your group's plan. While most doctors may feel that their group plan meets their current and future needs, others may wish for different characteristics in their cover.
- b. **If you feel you need something not offered by your group's plan (eg, occurrence-based cover), you must know that presently, neither the Medical Protection Society nor NTUC Income will accept you for their individual malpractice indemnity plans while you are covered by a group plan.** You therefore need to clearly confirm that one of them will cover you before you enquire if you can opt out of your (free) group plan to buy individual (self-paid) cover.
- c. **You must have a clear understanding on whether you will still have tail cover after stopping employment with the group.** You must also know who will provide this (ie, the insurer or the employer, as the assurance that this entity will be around when you need help in years to come may differ). You need to evaluate the likelihood of the group existing in its current form and continuing to buy insurance that includes tail cover for you and other employees who have left, annually for the next 24

years. If there is any reason for doubt, when you leave and seek individual cover, you must ask your new indemnity provider for tail cover — ie, tell them that you need cover for treatments in the past (when you were covered under this group's claims-made scheme) that may give rise to future claims. *(Note: at present, SMA is not aware of any indemnity provider who offers such tail cover when you join as an individual.)*

This may sound like a lot of work, but it is unavoidable. After all, if you do not take steps to secure your future, nobody else will do it for you. Safety in the future truly starts with the actions and choices you make today (within the limits allowed by your employer). ♦

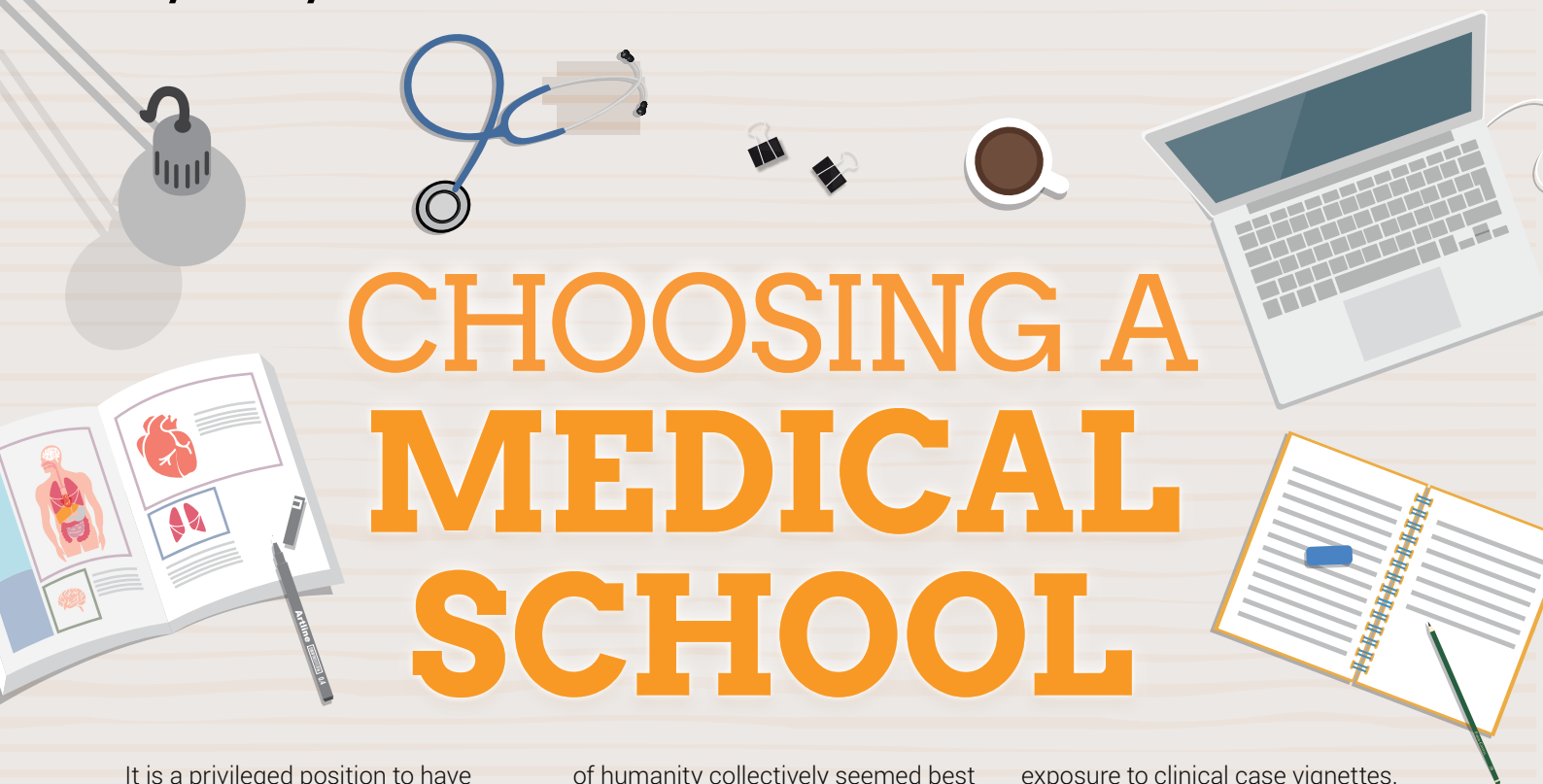
PROFILE



TEXT BY

DR LEE PHENG SOON

Dr Lee is the Chairman of the Professional Indemnity Committee of SMA. Dr Lee has a Fellowship in Pharmaceutical Medicine from the UK Royal Colleges of Physicians and an MBA from Warwick University, UK. He works part-time as a consultant in industry and part-time as a GP.



CHOOSING A MEDICAL SCHOOL

It is a privileged position to have a choice of medical schools. This was one of the most challenging and life-changing decisions I had to grapple with. I chose medicine because I could not conceive of another profession in which science and humanity converge in such a spectacular fashion. This coalescence of contrarities resonates strongly with who I am and it was not by chance that this was also the basis on which I chose my medical school, the Lee Kong Chian School of Medicine (LKC Medicine).

DECISION-MAKING PROCESS

It was a difficult decision. I spoke at length with my parents and seniors, but no two people experience medical school in the same way. So I pondered over what I wanted from my medical school experience and what kind of doctor I hope to become. I wanted to be an articulate thinker, with a sharp mind and the respectful means to speak it. I also wanted to be a keen team player and a humble leader because team-based medicine is the patient's best hope. I asked myself what it would take to make my life one that is well lived, and in reply, I just wanted to touch lives. Pulling these threads together, LKC Medicine's curriculum, pedagogy and mission to advance the science and practice of medicine for the good

of humanity collectively seemed best poised to help me make my goals and dreams a reality.

HANDS-ON TEACHING PEDAGOGY

Humanity in medicine is emphasised from day one. Through various programmes, such as the fortnightly Integrated Clinical Practice sessions, where we learn to communicate with patients, the Hospital Week where we experienced a patient's journey and the Long-Term Patient Project (LTPP), where we followed a patient over two years, I have learnt much about the idiosyncratic human aspect of medicine from our patient encounters. *No two patients suffer in the same way. Empathy is a deliberate, concerted effort we make to get into the patient's state of heart or mind.* Notably, of all the lessons I have learnt, my LTPP patient taught me that with courage, hope and passion for something that is greater than ourselves, we may yet make a meaningful existence.

The rigour of Team-Based Learning (TBL) provides a robust system for learning. During TBL sessions, we are constantly engaged. Multiple checkpoints throughout each session help us to build a good foundation of pre-clinical concepts and give us early

exposure to clinical case vignettes. This goes a long way in helping us to understand and remember the concepts better. Through the range of questions we encounter in TBL, we are constantly pushed to think critically and articulate clinical reasoning. This is intentionally so, to help us become thinking doctors in the future. In this way, we are not just going through the motions – we truly understand and learn.

Furthermore, systems-based teaching provides us with a clear, coherent understanding of each body system. I am not an educator, but from a student's perspective, everything ties in very well when we learn by systems. This fuller, richer picture allows us to appreciate the interplay of different disciplines – anatomy, physiology, pathology – within a system, and its clinical implications.



FLEXIBLE LEARNING ENVIRONMENT

Our timetable, in the pre-clinical years, is very flexible. We enjoy latitude and independence in scheduling our own pre-TBL preparation study time, accommodating students with different learning styles and speeds. We can study at our own pace, which allows us to pause and rewind, or look up any concepts that we are confused about. This ensures that we understand the concepts properly before moving on so that we do not postpone our learning, as students are wont to do when hurried through a series of lectures. Medicine is a steep learning curve, so it is imperative that we really learn, and in a less stressful environment to boot.

This flexibility also grants us time and space to pursue other interests alongside our medical education. Whether our interests lie in community service, sports, the arts or research, we have ample time to explore and enjoy these activities. As a new school, students have plenty of opportunities to develop new initiatives and see their ideas set in motion. The only limit is our imagination and the willingness to turn dreams into plans.

On the other hand, medicine can be heavy going, so I appreciate the space and freedom to take a proper break and balance studying with an equal measure of rest. Personally, I often balance out a heavy morning's worth of studying with a casual evening at the Singapore Botanic Gardens or

a lunch with friends. It is no secret that medical studies is a long and challenging journey. But with kind friends enduring it with me, patient seniors guiding me and wise house tutors advising me, I have come through two demanding but meaningful years, with a stronger love for medicine.

CONCLUSION

At the heart of it, I chose LKCMedicine because I wanted to be brave. Although mine was a thoughtful and considered decision, it still took no small amount of courage to take the road less travelled. As I have taken up the challenge myself, I now challenge prospective students to choose a medical education that will help them grow as a person and develop into a thinking and compassionate doctor. This holistic, integrated learning experience has indeed challenged me intellectually, mentally and emotionally. Every aspect of the LKCMedicine curriculum is designed to humanise medicine. I am constantly reminded that my patients and I share in a common humanity, yet remain aware of the distinctiveness of each individual patient. When I look around me, these are the future doctors that I would like caring for me. Like many of my peers, I had a choice; I chose LKCMedicine and I have not regretted it. As it is in life, there is no way of knowing what could have happened had I taken another path any more than I can predict the future. But right here and now, I am in the best place to help me become the kind of doctor I want to be. ♦

PROFILE



TEXT AND PHOTOS BY

REBEKAH LEE

Rebekah Lee is an LKCMedicine Class of 2019 student who is thankful for the privilege of living her dream. Be it history, literature or medicine, books are her best companions. From Steinbeck to Harrison's, she endeavours to think critically, feel deeply and get a glimpse of why and what we are.

Legend

1. Studying in our medical library in the LKCMedicine heritage HQ building, adjacent to Tan Tock Seng Hospital
2. The Class of 2019
(Source: Project Purple and Silver video, produced by the introDOction 2015 Publicity Committee)





"You won't see the clinical relevance until you've seen patients yourself. It is from the experience of meeting patients that you truly learn, integrate knowledge and make sense of things in a way that is personal and memorable for you."

This was the mantra we heard from the doctors who taught us over the course of our pre-clinical years at the Lee Kong Chian School of Medicine (LKCMedicine). Back in 2013, as a freshly-minted medical student reciting my pledge, I never could have imagined what these three years would be like.

In just three years, I found myself transiting from having only a basic knowledge of science from my junior college days to having a deeper understanding of the core principles and science in medicine in my pre-clinical years and being able to piece together a clinical picture of a real patient by my first clinical year. The transition from Year 2 to Year 3 is traditionally a difficult one and I am thankful that LKCMedicine's teaching pedagogy allowed for a smoother transition.

EXPERIENCING CLINIC LIFE

Right from the get go, our faculty drummed into us the importance of being "clinical", as knowing just the hard science and facts is not enough to make us good doctors. The School

incorporated a Polyclinic and Hospital Week during our fourth and sixth week in Year 1, respectively, where during the latter, we were assigned to different departments at Tan Tock Seng Hospital (TTSH) to shadow a team of doctors and get our first taste of clinical life. The purpose of this was to let us know that the theory we were going to learn in the next two years will one day ferment into reality and clinical application. It also served as a reminder that in five years from then, we would be out in the various hospitals as junior doctors and be at the frontline of patient care. Hospital Week was an amazing experience. My team was supervised by Dr Terence Huey (consultant general surgeon at TTSH), a great role model who taught us that there is something new to learn every day. With this mantra in mind, I approached learning with the mindset that I wanted to learn as much as I could, so that I can be the best doctor possible for my future patients.

The teaching pedagogy at LKCMedicine allowed for that to happen. Team-Based Learning (TBL) forms the core of our learning model and introduced application exercises with clinical relevance right from Year 1, training us to think like clinicians. Learning was innovative; gone were the days of lecture theatres and tutorials with worksheets to fill in. Instead, we were each given an iPad on the first day of school, which

would go on to serve as our "lecturer", "worksheet" and study tool. Pre-recorded lectures from Imperial College London are uploaded onto various internet platforms for us to access in our own time, allowing us to study and prepare at our own pace before going for TBL sessions. When we are in class, we have the privilege of having clinicians from various departments teaching and showing us the clinical relevance of each theoretical point. Application exercises required us to have some basic understanding of our medical sciences for the discussion to be fruitful; thus, many of us prepared before each session to identify gaps in our knowledge that we could clarify in class. This helped to develop an inquisitive and independent learning culture at school.

PRE-CLINICAL YEARS

The highlights of my pre-clinical years were the Integrated Clinical Practice (ICP) sessions. Almost every week, we would head to Bukit Batok Polyclinic where we interacted with simulated patients under the supervision of a clinical tutor, to practise our history-taking skills and physical examinations. We were also taught practical skills such as venipuncture and suturing in a safe environment. I found this early practical exposure extremely useful as we had two entire years to hone these skills which would serve as fundamentals for our daily

jobs as junior doctors in the future. I remember that day in August 2015 when I stepped into the hospital ward to obtain a history from my very first patient, as a third year medical student. That encounter turned out to be surprisingly smooth and I managed to obtain a salient history while covering the most important bits. It was at that point that I realised how important a strong foundation in history-taking is, as it gives us — the students — the confidence to approach any patient.

One unique thing about LKCMedicine's ICP approach is that even though there was a framework taught to us (eg, presenting complaint, past medical history, etc), there was a huge emphasis on obtaining the patient's "ideas, concerns and expectations". In this way, we could learn how to be a caring doctor who is able to empathise and see medicine in totality — not just the medical aspect, but also a social and functional element that makes up the entire care experience.

MAKING STEADY PROGRESS

My first clinical year has been extremely memorable. We still have TBL sessions in Year 3 to prepare us for our clinical postings, which are split into three major blocks — a 14-week-long medicine posting, a 14-week long general surgery and orthopaedics posting and six short postings of two weeks each, covering ophthalmology; otolaryngology; anaesthesia; rheumatology, allergy and immunology; dermatology; and infectious diseases. The TBL sessions were fully "application exercises" in Year 3, and our clinical faculty taught us important principles and concepts through these high-yield sessions that

we have all come to appreciate a lot. Besides the excellent clinical teaching provided at TTSH, the highlights of my first clinical year are the patients themselves. Getting to talk to them on a personal level, understanding their concerns and learning about various medical conditions from their histories and physical presentations really helped me understand my core content better. Another highlight was my general medicine attachment with TTSH general medicine consultant Dr Ranjana Acharya's team for two weeks during my ward embedment days. I participated in ward rounds by taking charge of a few patients, clerking and presenting the patients to the team during morning rounds. In the process, I learnt first-hand how to manage patients. As the saying goes, "You learn best when you personally do it" and I am extremely thankful to have had this experience so early on in my third year.

The highlight of this year is my learning experience with TTSH's internal medicine team, where I spent 14 weeks learning the principles and key concepts of general medicine from various medical subspecialties. I am also excited about the upcoming paediatric posting in Year 4 as it will be an entirely new experience working with children.



Come May 2018, we, the first batch of LKCMedicine students, will graduate and start work in various hospitals in Singapore. The School has put in a lot of effort to set up a unique and engaging curriculum for us and I hope that we will do our School proud. ♦

PROFILE



TEXT AND PHOTOS BY

TAN YUAN RUI LEON

Leon Tan is from the pioneer batch of LKCMedicine. With a passion for music, he composes in his free time. The Victoria Junior College and Anglican High School alumnus strives to do his best to serve through leadership roles in various executive committees, including secretary to the LKCMedicine Students' Medical Society's second executive committee.

Legend

1. In the first month of my medical school life with my first clinical team (Y1 TBL9, 2013-2014) — with our clinical mentors during hospital week at Tan Tock Seng Hospital
2. Overseas community involvement programme in Sri Lanka on Chronic Kidney Disease of Unknown Etiology; photograph taken with the first team of 12 LKCMedicine members and our friends from Rajarata University



BUILDING FAMILY MEDICINE

-Nurturing The Next Generation

"Dear Dr Leong,

I am Josiah, a Year 5 medical student from the NUS Yong Loo Lin School of Medicine (NUS Medicine). We met last year along with my fellow student Jonathan, where you and Belinda helped us find contacts for our elective trip to the Philippines.

On behalf of the Family Medicine Extravaganza Committee, I would like to extend a warm invitation to you to be a speaker for the third instalment of the Family Medicine Extravaganza..."

My friends know me as one who doesn't say no; especially not to invitations where I get to share my vision with the young doctors-to-be. I would never let a chance like this slip and so, I gamely responded without even checking my schedule.

INFLUENCING MEDICAL ELECTIVES

Many medical students have heard that some of us are active in medical missions and they would approach us for insights into how real world medicine would be like during their electives. Among these students, few will finally meet us in person and fewer will make the trip.

I remember very clearly that I had invited a couple of students to a thanksgiving dinner in my mission. I had not expected any of them to turn up; after all, it might have been

awkward for them since I was a total stranger to them and they did not know anyone else.

Yet to my surprise, Josiah turned up and even stayed on to spend the rest of the night listening to senior medical students and doctors involved in medical mission share their war stories. To cut the long story short, Josiah went on to lead a team of his classmates, including Jonathan, and spent their electives with my Filipino counterpart, Dr Vicky Ang, in St Luke's Medical Centre in Manila. Their hearts were torched and fired up.

INFLUENCING PRE-MED STUDENTS AND PARENTS

Every year, there will be many requests from parents and high school students who wish to sit in at my clinic as they want to have a taste of what a GP's life is like. I suspect

some are forced by their parents to sit in while some may think they stand a higher chance of getting into medical school after it. I had to tell them that even my own son did not get into our local medical schools.

Some of them came, sat in, got into medical school, went on to do family medicine training and now work as GPs. Others did not foresee themselves having a career as a doctor and went on to pursue other meaningful jobs. They return years later as my patients and share a deep respect for GPs.

INFLUENCING MEDICAL STUDENTS

Many of us are also involved in undergraduate training as clinical tutors. Through the two-week attachment period, our students catch a glimpse of what general

practice is all about. They learn about ideas, concerns and expectations (ICE) and they learn to sharpen their communication skills. Even though not all chose family medicine residency, I am confident that our posting will help them be better specialists.

SIDE BENEFITS OF TEACHING

One of the side benefits of taking students in at our clinics is the immense respect and admiration our patients showed us. I remember when my partners and I started our clinic; patients did not always trust us. We could see their lack of confidence through their facial expressions and body language. However, as our clinic was the only clinic in the neighbourhood, they had little choice.

My partner, Dr Lee-Oh Chong Leng, and I then started doing our family medicine training. As part of our training, we were expected to take medical students in at our clinics. I still remember vividly the surprised looks on our patients' faces when we introduced the students to them. Their respect for and trust in us were evidently elevated.

Not only that — as young GPs, we were often challenged by the patients on our "higher" consultation fees. We had to take time to explain that we followed good family medicine principles and practices which add value to the consultation.

Their doubts immediately evaporated when the patients saw and heard how we explained their conditions to our students and advised our students on the approach to the various conditions and complaints. After that, few disputed our "higher" consultation charges.

INFLUENCING FAMILY MEDICINE RESIDENTS

Some of us are also involved in family medicine residency with the institutions and patients are less surprised that we have residents

and students sitting into the clinics. However, what is surprising now is that some of those who did not bother too much about GPs in the past are now keen to be teaching subjects for our residents. The perception of the public can certainly change when we carry out our teaching duties well.

WHAT'S NEXT?

The annual World Family Doctor Day came and went, this year with less fanfare compared to previous years. In fact, many of our GP colleagues are not even aware that there is such a day. It sets me reflecting on what more we should do to help GPs play the pivotal role in primary care.

I think we have done reasonably well in nurturing the next generation of medical students, doctors, as well as the public. However, I feel that somehow we still lack a strong leader who has the vision and the ability to unite the fraternity. Adding to the difficulty in uniting the primary care physicians is the diverse nature of general practice. There is almost no common ground for all of us to identify with one another.

We need a family medicine gospel — one where we can find common grounds, values and philosophies. A primary care system which is understood by the public and the practitioners will certainly benefit our society well.

The Ministry of Health organised a town hall meeting for GPs on 9 July at Suntec Convention Centre. I feel that such an event may be a good place to start.

The founder of a mission agency once said: *"Win the campus today, win the world tomorrow"* and started a strong student Christian movement in the fifties. I would like to paraphrase it: *"Win the young today, we will bless our world tomorrow"*. ♦

PROFILE



TEXT BY

DR LEONG CHOON KIT

Editorial Board Member

Dr Leong Choon Kit is a GP in the private sector. He is an advocate of the ideal doctor which is exemplified by one who is good at his clinical practice, teaching, research and leadership in the society. His idea of social leadership includes contributing back to society and lending a voice to the silent.

PUBLIC HEALTH ETHICS



Public Health Ethics are the principles and values that guide professionals in what they do to promote health and prevent injury and disease in the population. The general medical ethical principles of beneficence, non-maleficence, justice and respect for autonomy are well known and they assist clinicians in decisions for individual patients. These same principles are applicable also for the Public Health practitioners, but their application becomes more complex because they have to consider not just the individual patient's interests, but also those of the general public.

On one hand, individuals have certain rights to make their own decisions and to privacy and confidentiality; but on the other hand, the community demands their partnership and citizenship in achieving communal health, safety and security. The individual may not be just patients but also the apparently well persons utilising healthcare services, healthcare professionals and other stakeholders. This balancing act must be guided by society's ethical values and legal procedures and norms.

PUBLIC HEALTH LAWS

Public Health laws support the deliberate and measured societal implementation of this balance, in the control of infectious diseases like sexually transmitted infections, HIV and tuberculosis; environmental and occupational health issues like workplace safety and health; health and healthcare systems including

the ensuring of access to resources and services; and the role and ethical bounds of research in Public Health.

Legal prescriptions in the form of statutes, regulations and case laws guide the public health authorities (eg, the Ministry of Health and the Health Sciences Authority) in how they may protect, preserve and promote the health, safety, morals and general welfare of the population. These efforts may at times restrict the interests of individuals, albeit within limits, to achieve these communal benefits.

These restrictions on personal and organisational behaviour and the informational, physical and business environment may at times be controversial as people disagree on the extent to which coercive interventions empowered by law may restrict individual choice and liberty.

PUBLIC HEALTH LAWS IN ACTION

The plainest example of such laws for clinicians would be the Infectious Diseases Act, which requires that they notify the health authorities of cases of specific infectious diseases. The consent of the patient is neither required nor sought. While the patient's confidentiality is technically breached, the breach is limited in that firstly, the recipients are bound by the same Act to keep the information confidential and secondly, the data is used only for contact tracing and surveillance – both of which benefit the society at large.

People in some occupations or with specific exposure to such diseases may receive special attention. For example, surveillance (eg, health checks) and responsive action are required for food handlers in order to prevent outbreaks of food-borne diseases.

During the SARS crisis, people who might have been exposed to the disease were issued quarantine orders that confined them to their own homes, as they could potentially spread the infection to others in the community. This was obviously an infringement on their personal freedom to move about. Some protested that they would be risking transmission to their own family members, which is undeniably true even if one could argue that their family members might have already been exposed.

Such restrictions may be imposed even on the community at large. While we respect each person's right to choose or refuse treatment under the principle of respect for autonomy, the state may nonetheless impose a penalty if beneficial treatments like vaccinations are refused because their refusal has an impact on the health of the community.

Even when the consequence of harm is greatest for themselves, the right to choose is not unlimited. Under the Mental Health Act, for example, the state has the right to detain and treat mentally unwell persons who could harm themselves. There are limits to

the duration of such detention and independent reviews are required, in order to keep the balance between the rights of the individual and those of the community.

PUBLIC HEALTH PROGRAMMES

To what extent then can the authorities implement Public Health programmes intended for the good of the many at the cost of the few? In a seminal article¹ in the *American Journal of Public Health*, Nancy Kass proposed a six-step framework for the evaluation of such programmes. She asks for such programmes to answer the following questions:

1. What are the public health goals of the proposed programme?
2. How effective is the programme in achieving its stated goals?
3. What are the known or potential burdens of the programme?
4. Can burdens be minimised? Are there alternative approaches?
5. Is the programme implemented fairly?
6. How can the benefits and burdens of a programme be fairly balanced?

The questions above, while relevant and vital for every programme, are made within an ideological and paradigmatic milieu that is much influenced by politics and policies, the healthcare ecology and economy, and personal and social biases and convictions. Not everyone would have the same answers, but better that these questions are asked than not considered at all.

GUIDING PRINCIPLES OF PUBLIC HEALTH LAWS

Laws guide many but not all situations and each physician must be able to weigh multiple factors to choose sound and balanced actions. Often, the difference is not in the courses of action but in how the actions are executed. As such, some guiding principles are useful.

Effectiveness

The measure taken should be, and be known to be, effective. To impose a restriction on an individual for the sake of the community requires that there is credible evidence that the restriction actually has such a beneficial effect.

Conjecture and speculation should play little part.

Necessity

The intervention should be clearly necessary and alternatives with possibly lesser infringements must be considered. The choice should not only simply be based on the efficacies of the possible approaches; their differential infringements on the individual's rights are necessary factors in the decision.

Proportionality

The infringement must be proportional to the benefits of such interventions. An overly draconian execution of an appropriate intervention could be unfair to the individual while the opposite extreme of an overly lax implementation is ineffective. A respiratory infection like SARS may necessitate a home quarantine but patients with HIV do not need to be so confined as the mode of transmission is wholly different.

Minimal infringement

Wherever possible, one would choose the least amount of restrictions. If information must be shared, then it should be the minimum set for the action to be taken. If identifiers are not needed (eg, if the purpose is only for surveillance), they should not be collected, even as a just-in-case.

Reciprocity

The burden imposed on individuals for the sake of the community should be mitigated by the community. Persons who are detained for treatment under the Infectious Diseases Act are given free treatment, which compensates somewhat. Subsidies for childhood immunisations should be given not only to incentivise their uptake but also because society shares, and therefore should also invest, in the benefits.

Public justifications

Lastly, and sometimes most importantly because of the inequality of parties, decisions that consider the balance between community and individual rights and benefits should be transparently discussed both in general society (including social media) and in the legislature. There must be the openness of decisions and outcomes, responsibilities and accountabilities,

PROFILE



TEXT BY

A/PROF JASON YAP

*Teaching Faculty,
SMA Centre for
Medical Ethics and
Professionalism*

A/Prof Jason Yap is a public health physician who's been around a bit. He is currently a practice track faculty in the Saw Swee Hock School of Public Health, and the Program Director for the National Preventive Medicine Residency Program. He helps out with various abbreviations like AMS's CPHOP, SMA's CMEP, NHG's DSRB F1, and IFIC.

for good Public Health decisions that can bear the scrutiny of society and history.

CONCLUSION

Doctors make clinical judgements each time they approach a patient. In our increasingly complex healthcare delivery system, it is no longer sufficient for the doctor to just be good clinicians for each individual patient. They must now also have a sense of, and the common sense to deal wisely with, aspects of Public Health Ethics that will invariably intersect with their clinical practice. ♦

Reference

1. Kass NE. An ethics framework for public health. *Am J Public Health* 2001; 91(11):1776-82.



The students of the Lee Kong Chian School of Medicine (LKCMedicine) are no strangers to the House System. Upon starting school, every student is sorted into one of the five Houses named after esteemed individuals in the medical field – Marie Curie, Alexander Fleming, Lim Boon Keng, William Osler and Wu Lien-Teh. Personal tutors are allocated to individual students within each House to provide guidance and lend a helping hand by ensuring that students are progressing in and coping well with their academic studies, as well as to ascertain their well-being; with the aim of giving students the maximum opportunity to succeed. Each House is also a platform for interaction between students across different years of the MBBS programme, nurturing friendships that transcend merely the academic and the segregation between different batches of students, ultimately growing into a genuine and multi-faceted support system for each individual.

We are each part of a “House family”, with every family there to support

its members through little acts of encouragement like preparing welfare packs before examinations or academic support such as tutorial and revision sessions conducted by seniors to aid their juniors through a difficult teaching block. The House families form the cornerstone of bonding and networking between House members of different school years.

We also bond across Houses. One key activity that brings all the Houses together is the House Cup or Inter-House Championship, which serves as a platform for members of each house to interact and deepen their friendships.

THE HOUSE CUP

The House Cup consists of five competitive events – Inter-House Sports, Inter-House Unsports, Inter-House Brawl, Inter-House Mania and Inter-House Remix. These events cover all grounds, allowing all students – whether they are athletically inclined, more drawn to the arts or more well-read and knowledgeable – to participate. The House Cup



allows students to take a break from their books, unwind and enjoy the Wednesday afternoons, which we have all timetabled off, with their House mates – seniors and juniors alike. Every student's participation serves as a tangible means by which we contribute to our House, fostering a sense of ownership and belonging.

Beyond the competitive element that is brought to the table, the Championship supports bonding within each House, creating opportunities for interaction that go beyond those related to work. The Houses compete, laugh and cheer together, building a sense of camaraderie that contributes to the building of the LKCMedicine school spirit.

As the House Cup covers a spectrum of interests and talents – from sporting and gaming to trivia and the arts – the AY2015/16 edition attracted the participation of different groups of students for each event. Playing to their strengths, the five events saw the victories and defeats alike for the Houses.

THE BATTLE BEGINS

The House Cup kicked off on a sunny November afternoon, as the three cohorts of medical students and their house tutors got together for the opening House Cup event at the lower field of Nanyang Technological University for Inter-House Sports. The Houses competed in a variety of games, namely soccer, captain's ball, Frisbee and dodgeball, to showcase their sporting talents. After battling it



out, we eventually had a tie between Marie Curie House and Lim Boon Keng House, who took the early lead.

But this didn't last long, because Alexander Fleming House made up for lost chances by bagging top spot in the next three House events – Inter-House UnSports, Brawl and Mania, leading the standings from January through to May! They impressed with their flair for words, sharp wit and considered wisdom at UnSports, where they came out on top after a series of games, spanning from Mario Karts, Saboteur and Space Team to Psych, Boggle and an intense round of Pictionary which featured childhood, movies, characters, television shows and of course, medicine as categories.

Alexander Fleming House extended its lead with the Inter-House Brawl, where Houses needed all their muscle and best strategic thinking to earn points; and then some more with Inter-House Mania, which featured challenges including our own edition of “Don't Forget the Lyrics” and “Minute to Win It”.

Despite their winning streak, Wu Lien-Teh and Marie Curie Houses remained in the race, making the final event a real showdown. Inter-House Remix challenged the Houses to beat each other at singing, dancing, acting, drawing and modelling. The Houses put on highly entertaining dance performances and it was fascinating to discover the hidden fashionistas! It was at this event that Marie Curie

House outshone the other Houses, radically altering the standings in the league table and eventually emerged as this year's sole champion.

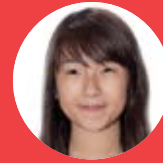
MEMORIES TO LAST A LIFETIME

Over the course of the Championship year, each House forges its own invaluable and unforgettable memories – be it in the heat of a sporting event in the lower fields, in the ensuing cheers after your fellow House mate steers his Mario kart to victory, or in the crafting and execution of an otherwise spontaneous skit centred on a wayward adolescent-turned law enforcer. Celebrating every victory and loss together, each House has created for its members a set of unique experiences.

The House Cup is not built solely on the time and effort of the house representatives, but that of the entire student body of LKCMedicine. The House Cup was never about winning the championship trophy, but rather about giving one's best in every event and enjoying the process. Our Houses form an indispensable support system – one that has seen LKCMedicine students through academic rigour and light-hearted fun with friendships that last well beyond.

As we mark the end of the third House year, we are pleased to realise that every House has had its turn in winning the House Cup, recognising the diverse spread of talented individuals in each of the five Houses. ♦

PROFILE



TEXT AND PHOTOS BY

EDLYN TAY

Edlyn Tay is an LKCMedicine Class of 2020 student and the M1 house representative of Alexander Fleming House, who has helped to organise all the Inter-House events together with the other house representatives. She believes strongly in the House System.

Legend

1. Students give their House mates tips on how to win a bridge game
2. All the participants after the final House Cup event, Inter-House Remix, where Marie Curie clinched the title
3. In addition to the House Cup, students also bond through other events such as the Senior/Junior games



COMMUNITY CARE STARTS AT HOME



By Agency for Integrated Care



Photo credit: Thye Hua Kwan Moral Charities

Dr Lai Junxu on a house visit, extending care to the community

Governments all over the world are increasingly facing the challenges of increased longevity. By 2050, the world will have about twice the number of elderly as today.

Globally, different ways to care for the elderly are being studied. Hong Kong's administration for example, promotes a policy of "ageing in place" for a senior population that is expected to rise from 15 percent in mid-2014 to 32 percent in mid-2041. The concept aims to empower seniors to live at home with the proper support with institutional care exercised as a secondary option. Denmark also encourages its elderly to age at home and promotes community care over institutionalised care through a long-term care system, which includes free home care.

Singapore's white paper on population reported that the population of 440,000 senior citizens is projected to increase to 900,000 by 2030. More importantly, the number of seniors in Singapore living alone has risen. The General Household Survey 2015 showed that 41,200 seniors live by themselves, up from nearly 21,500 seniors documented in 2005.

With such a large elderly population, Singapore is making a concerted effort to care for seniors at home.

PREPARING FOR THE SILVER WAVE

One crucial way Singapore is preparing for the growing ageing population is to involve the country's general practitioners (GPs) in addressing the different needs of seniors.

Seniors generally require a higher level of medical and nursing care, especially after discharge from public hospitals. Home care, for example, is an important care option for clients that are bed-bound or require palliative care towards the end.

In addition, home care can reduce unnecessary hospital readmissions and save on healthcare costs. The wider availability of home care resources also lessens the burden and stress on live-in caregivers, such as family members.

For these reasons, the Community Care — GP Partnership Training Award supports and encourages interested GPs to further their work in the community care sector.



Handmade gifts of appreciation from a patient to Dr Lai

A scheme introduced in partnership between the Agency for Integrated Care (AIC) and the Ministry of Health (MOH), the Award funds graduate diplomas in studies related to the care of our seniors. Course fees are co-funded by the Award. AIC will link interested GPs to Community Care institutions to whom they will provide services to after completing their training. This gives them an opportunity to apply their knowledge and serve a larger pool of patients in need.

PUTTING LESSONS INTO PRACTICE AT HOME

Dr Lai Junxu is one awardee who has found helping elderly patients in their homes greatly rewarding. After receiving his Graduate Diploma in Palliative Medicine, Dr Lai joined the Home Care team of his sponsoring institution, Thye Hua Kwan Moral Charities.

"Studying palliative medicine has helped me understand how to help patients on their last journey (both the young and the old). Through this course, I have been equipped with the practical knowledge on how to care for palliative cancer and end-organ disease patients at home. I have

also learnt how to manage psycho-geriatric issues in palliative patients which have some overlap with a frail elderly patient. This is especially useful for end-of-life care for patients who have requested maximum home care," says Dr Lai. He is also the director of OmniMed Healthcare (www.omnimedhealthcare.com), a healthcare service and clinic that offers house calls around the clock.

Dr Lai's newly acquired knowledge was put to the test when he was caring for a patient with end-stage chronic obstructive pulmonary disease. The patient had developed stage-four laryngeal cancer. "It was challenging managing the palliative aspect of end-stage organ disease and end-stage cancer. In addition, my patient had multiple comorbidities, most significantly of which was diabetes," says Dr Lai.

The patient chose to live out his life being cared for at home. "Unfortunately, the family felt they would not be able to care for the patient at home sufficiently and sent the patient to the hospital where he passed away," recounts Dr Lai.

With this experience in mind, Dr Lai is a strong supporter of the scheme. With more GPs stepping forward to offer their services in the community, seniors and their caregivers will have more home care options and services to choose from.

"Home care will be a key service required in the future as the population ages," he stresses. "Previously, home care was for the rich who could afford to pay for house calls. We need more GPs in to grow the availability of subsidised home care as well as nursing home medical support. Only then can we bring care to the doorstep of the poor, or to patients with mobility issues," he says.

WHAT DO YOU GET FROM THE COMMUNITY CARE-GP PARTNERSHIP TRAINING AWARD?

70% of your course fees will be funded if you are enrolled in any of these courses and are sponsored by an eligible Community Care institution:

Graduate Diploma in
Palliative Medicine (GDPM)

Graduate Diploma in
Geriatric Medicine (GDGM)

Graduate Diploma in
Family Medicine (GDFM)

The list of institutions which have sponsored GPs for the CCGPTA are:

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Singapore Cancer Society
Thye Hua Kwan Moral Charities Limited
Orange Valley Nursing Homes Pte Ltd
TOUCH Community Services Ltd
Dover Park Hospice

Metta Welfare Association
All Saints Home
Home Nursing Foundation
Ren Ci Hospital
St. Andrew's Community Hospital

Applications for the FY16 Community Care-GP Partnership Training Award are open till 31 December 2016. AIC will be able to assist you in linking up with potential sponsoring institutions. To register or find out more, visit www.primarycarepages.sg or email AIC at gp@aic.sg.

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Based in Singapore, you will be part of team of dedicated doctors and clinical staff rendering healthcare and providing comprehensive care to our patients. You will also play a key role in the maintenance of clinical standards and the delivery of a service experience for our patients.

Requirements:

- Basic medical qualification registrable with Singapore Medical Council
- Possess Graduate Diploma in Family Medicine/ Master of Medicine in Family Medicine*
- Postgraduate medical qualifications are an advantage
- Possess a valid practicing certificate from the Singapore Medical Council
- Relevant experience is an advantage
- Good oral and written communication skills
- Good interpersonal skills
- Good team player

For position 1 and 2, kindly email: gilbert_yeo@parkwayshenton.com.

For position 3, kindly email: kok_chuan@parkwayshenton.com.

For position 4, kindly email: rodney_bay@parkwayshenton.com.

Please state "Position – Your Name" in the subject header of your email application.

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Gleneagles JPMC™

A PARKWAYHEALTH CARDIAC CENTRE
JERUDONG PARK BRUNEI

Cardiac Anaesthesia / Intensivist (2-Year Contract) Career Level: Associate Consultant

Gleneagles JPMC Cardiac Centre is a premier world-class tertiary Cardiac Centre located in Brunei Darussalam. The Centre is a joint venture between The Brunei Government and Parkway Pantai, one of the region's largest integrated private healthcare groups with a network of 20 hospitals and more than 4,400 beds throughout Asia, including Brunei, Singapore, Malaysia, India, China and Vietnam.

The Centre is staffed by leading Cardiologists and Cardiac Surgeons trained and educated in some of the most renowned global institutions and is supported by a team of international nursing and paramedical staff. It is supported by advanced technology with clinical results comparable to the best cardiac centres in the world.

This is an opportunity to join a single site specialist heart hospital as an associate consultant in cardiothoracic anaesthesia and intensive care, reporting to the Chief Executive Officer and Chief of Medical Services. The hospital performs all types of cardiac interventional procedures and surgeries such as PCI, electrophysiology & ablation, TAVI, CABG, valve repair/replacement, aneurysm surgery, paediatric cardiac surgery and implantation of heart assist devices.

Responsibilities:

- Run a cardiac surgical list
- Manage patients in the intensive care unit
- Perform call duties, which are scheduled 6 to 8 times each month

Requirements:

- Basic medical qualification registrable with the Brunei Medical Board
- Degree or accreditation in anaesthesia from a recognised university, eg. The Fellowship of the Australian and New Zealand College of Anaesthetists, Fellowship of the Faculty of the College of Anaesthetists of Ireland, Master of Medicine (Anaesthesia) of the National University of Singapore, Fellowship in Anaesthesia of the Royal College of Physicians and Surgeons of Canada or equivalent
- At least 3 years of experience in cardiothoracic anaesthesia and intensive care
- Excellent Interpersonal and communication skills
- Competency in transoesophageal echocardiography will be an advantage

The Contract:

A 2-year contract is being offered with an attractive remuneration package which will include return travel and accommodation. Interested applicants are invited to submit their comprehensive resume, contact number, expected salary via our career portal, <https://www.parkwaypantai.com/careers/overview/> then click on **Available Positions** and select "Brunei" under **Country**.



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Dialogue Session.
**I was encouraged
when 2 agents
came up to thank me for sharing.**



9626 7607

ERA Senior Marketing Director
CEA No.: R026368D

Prunella Ong Lay Foon

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We are looking for suitable patients to participate in Post-Herpetic Neuralgia Trial

招募合适的志愿者参加带状疱疹后遗神经痛的临床研究

Are you suffering from **Pain** after Shingles?

您是否在带状疱疹, 俗称「皮蛇」, 发作之后感受到疼痛?

***Sharp pain**
***刀割痛**

***tingling pain**
***刺痛**



***throbbing pain**
***跳痛**

***burning pain**
***灼痛**

Purpose of the research

You are invited to take part in this study because you have post-herpetic neuralgia (PHN). The main purpose of this study is to collect information about a new drug to treat your disease.

研究目的

您被邀请到这个本研究 是因为您患有带状疱疹后遗神经痛 (PHN)。本研究 的主要目的是为了收集一种新药物的资讯来治疗带状疱疹后遗神经痛 (PHN)。

Key enrolment criteria

- Age \geq equal or more than 21 years
- Pain present for more than 3 months after eruption of skin rash.

重要入选条件

- 年龄 21 岁及以上
- 在皮疹发作之后, 疼痛持续已超过3 个月

Any benefits

Subjects treated with this Investigational Product may experience reduction in pain.

You need to return to the site at different time points for the required procedures. Please contact the study team for the details.

有何益处

接受治疗的受试者, 疼痛可能会有所改善。

您需要定时回到研究中心履行必要的研究规程。请联系研究团队进一步了解该临床研究。

If you fulfill the above criteria, please contact us at any hospital below:

如果您符合以上条件, 请联系研究团队进一步了解该临床研究。

1. Singapore General Hospital (新加坡中央医院)

Contact Person/Department (联系人/部门): **Clinical Trials Resource Centre** Phone Number (电话号码): **+65 6321 3652**

2. National Skin Centre (新加坡全国皮肤中心)

Contact Person/Department (联系人/部门): **Research Department** Phone Number (电话号码): **+65 6350 8505**

3. National University Hospital (国立大学医院)

Contact Person/Department (联系人/部门): **Department of Dermatology** Phone Number (电话号码): **+65 9776 0476**

4. Raffles Hospital / Pain Management Centre (莱佛士医院)

Contact Person/Department (联系人/部门): **Clinical Trial Unit** Phone Number (电话号码): **+65 6311 2030**

Audrey Hii
Medical Social Worker

Janie Chua
Senior Dietitian

Mah Siew Chung
Psychologist

Ng Soh Mui
Senior Nurse Clinician

Dr Franco Wong
Family Physician
Associate Consultant

Chia Hui Shan
Senior Pharmacist

We care
for you with
our different
skills and
expertise

We work together
as a seamless team
to support your
healthcare needs

Take the Lead. Break Away from Traditional Models of Care.

Join NHGP, a Family Dedicated to Keeping the Community Healthy.

Family Physicians

As a Family Physician with NHGP, you will lead and work together with a team of healthcare professionals at the new polyclinic in Pioneer to provide better coordinated care for patients with acute, chronic and non-morbid conditions. You will also have the opportunity to provide training and guidance to junior doctors, nurses, Allied Health Professionals and other members of the healthcare team.

If you share the same passion as us in being one of the forerunners of advancing family medicine and transforming healthcare and have a heart for the community, we want to hear from you.

Job Requirements

- Basic medical degree with Master of Medicine (MMed) or Graduate Diploma in Family Medicine (GDFM)
- Accredited with the Family Physicians Register
- Good clinical skills and management
- Good interpersonal skills and rapport with patients
- Willingness to continually update professional knowledge and skills
- Flair for teaching and imparting knowledge to junior doctors and other members of the healthcare team

Our new polyclinic in Pioneer is NHGP's latest primary care facility and is part of the Ministry of Health's Healthcare 2020 Masterplan to expand the national healthcare capacity to meet the needs of Singapore's growing and rapidly ageing population by delivering more accessible, affordable, integrated and quality care to all. By 2017, this new development will offer residents in Jurong West convenient access to quality primary care services.

At this new polyclinic, the care delivery model will focus on patient empanelment to a care team, comprising Family Physicians, Care Managers, Care Coordinators and Allied Healthcare Professionals, working closely together to support patients' care needs. The enhanced care team model will help the team better understand patients' medical history and family environment to better engage them and manage their care plans holistically.



To apply or to find out more about these positions, log on to
www.nhgp.com.sg/joinus.aspx

We regret that only shortlisted candidates will be notified.



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