SMA news

For Doctors, For Patients

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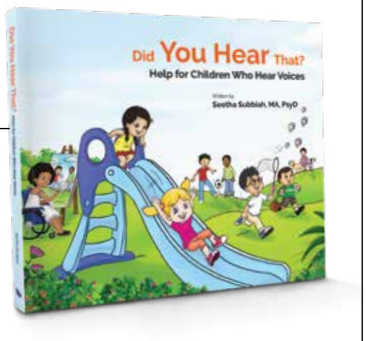


CARING FOR OUR Treasured Ones

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

Dr Chie Zhi Ying enjoys freelance writing and singing. She writes for Lianhe Zaobao, Shin Min Daily News and Health No. 1. She can be reached at chiezhiying@gmail.com.

Chie Zhi Ying
Guest Editor

It is my great pleasure to welcome Zhi Ying to the *SMA News* team and with her being the youngest doctor (I'm guessing here!) on the Editorial Board, I think it is most fitting for her to be my co-editor for this month's themed issue on children.

We were all children once and all of us have had interactions with children in some ways or another — be it bringing up our own, playing with your friends' kids, looking after paediatric patients, or maybe just glaring at a misbehaving child on a plane! Whatever the circumstances, children impact us (and our future). We, as the adults in their lives, will definitely have a significant impact on them. Thus, remember to look after them, teach them well and teach them right.

I have many fond memories of my primary school's Children's Day celebrations. As kids, we eagerly looked forward to this special day each year, where our teachers showered us with all kinds of gifts. Best of all, the Children's Day school concert was always a festival of arts put up *by* the children *for* the children.

As I was penning the Editorial this Mid-Autumn Festival, children carried brightly lit lanterns around our neighbourhood under the full moon, filling the air with their peals of laughter. I would have loved to join them, if not for the fact that I'm way past that age. Nevertheless, I had great fun lighting my very own traditional lanterns in the comfort of my house (who says adults cannot relive childhood fun?). How I missed those carefree days!

Hence, it is my great pleasure as the Guest Editor of the October issue of *SMA News* to bring you through the many articles centred on children and childhood.

For our Feature article, we are privileged to have Prof Doris Young from the University of Melbourne offer her insights into adolescent health, a topic many of us find unfamiliar yet commonly encountered in our day-to-day clinical practice.

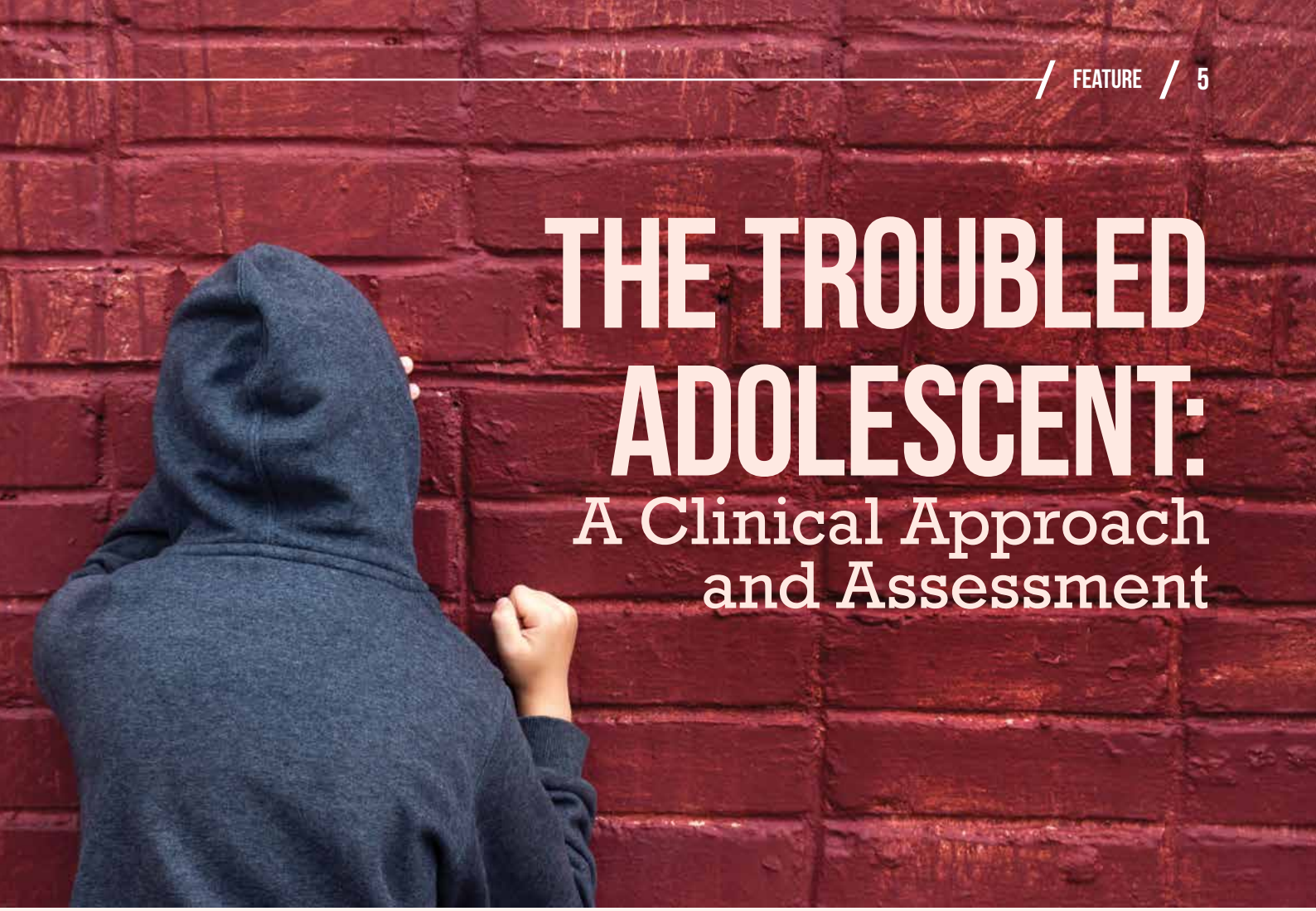
Talking about the field of paediatrics, what would be better than to hear from our paediatric colleagues themselves? We are delighted to have Prof Ho Lai Yun and A/Prof Marion Aw share with us their joys and challenges working with young patients.

For some, childhood may be a daunting and even traumatic experience, especially for victims of family violence. Here, Dr Tan Su-Ming and Ms Lim Hui Min provide some clear, practical tips on recognising and helping victims of family violence. You will also hear from Dr Seetha Subbiah, clinical psychologist and author of *Did You Hear That?: Help for Children Who Hear Voices*, who has helped to raise awareness on how to recognise auditory and visual hallucinations in children through this concise pictorial book.

For those of you who are parents, making your child(ren)'s childhood a happy and healthy one is certainly one of the greatest priorities in life. As you flip through these pages, you will also get to read of doctors' unique experiences of parenting.

For the Indulge column, we bring to you the personal childhood experiences of four doctors as they recall distinct events in their lives that proved to be life transforming. Lastly, find out more about helping underprivileged children as Dr Ho Xin Qin tells us about her latest overseas mission work. Hopefully these stories will inspire future generations of doctors to continue the good work.

As Nobel Laureate Nelson Mandela aptly puts it, "Children are our greatest treasure. They are our future." With this, sit back and I hope you enjoy the read! ◆



THE TROUBLED ADOLESCENT:
A Clinical Approach and Assessment

Engaging the adolescent is the key to a successful therapeutic "doctor-patient relationship". Using the adolescent development screening framework HEADSS[1], followed by a sensitive physical examination, forms an important therapeutic baseline. An understanding of the concerns and developmental tasks of adolescence is vital in order to detect abnormal behaviour. Knowledge of local youth resources and early referral for more complex problems is advisable.

The Lancet recently commissioned a report on global adolescent health and well-being in May 2016 and it states: "During adolescence, an individual acquires the physical, cognitive, emotional, social and economic resources that are the foundation for later life health and well-being".[2] The report calls for more global investment into adolescent health and well-being programmes, better awareness of young peoples' health needs and training for health professionals to address these needs.

Adolescents or young people (ten to 24 years of age) usually enjoy good physical health but have to bear a host of psychological and emotional stresses in this developmental phase. During this period, they have to deal with the conflicting pressures presented by society, their family members and their peers, at a time when they are self-conscious and self-centred.

Coupled with these pressures is an inner conflict that seems to be a prerequisite for growing up — a necessity to assert independence, together with a continuing need to rely on parental support. Any obstacle or family dysfunction that impedes the achievement of developmental tasks (Table 1) will exaggerate the conflict and result in maladaptive behavioural problems such as acting out, school truancy, sexual promiscuity, substance abuse, etc. Moreover, the brain development also undergoes changes during adolescence. Studies in adults suggest that most mental disorders begin before 25 years of age, most often between 11 to 18 years.[3] Therefore, it is important for clinicians to distinguish between "normal" and "abnormal" adolescent

Table 1: Developmental tasks of adolescence

1. Establishing identity and self-image
2. Separating from the family
3. Establishing an adult sexual role
4. Making career and vocational choices

behaviours. What are normal mood swings and puberty blues, such as angst, defiance and moodiness, versus persistent anxiety, depression and anti-social behaviours? When is dieting to lose some weight a normal behaviour rather than an early sign of an eating disorder such as anorexia nervosa or bulimia nervosa? Is a mono-syllabic adolescent male patient lacking eye contact just being quiet and shy, or exhibiting features of autism spectrum disorder (ASD) and disconnectedness?

In order to assess the adolescent appropriately, physicians need to firstly engage with them during the consultation and then proceed to discuss the presenting problems. After which, when a physical examination is performed, extra sensitivity needs to be put in place as the adolescent is often very conscious about his/her developing body and body image.

ENGAGING WITH THE ADOLESCENT PATIENT

Empowering young people and building trust begins in the waiting room. It is important to greet the adolescent patient first before greeting their parents. It is also important to be friendly, respectful and non-judgemental, in order to gain his/her trust. Often, relating to parents is also a challenge during consultation and the physician should be tactful in his/her approach to ensure that the needs of both the adolescent and his/her parents are being met. It is preferable to see them together first to observe their interaction before seeking an opportunity to spend some time alone with the adolescent. The common practice is to first see them together, then ask their permission to see the adolescent alone for a short period, before inviting the parents back in for feedback after assessment. However, some adolescents may choose to have a parent present in the room throughout the consultation and that wish has to be granted. It is advisable to seek another opportunity to see the adolescent alone during follow-up visits. The physician is the advocate for the adolescent patient and provides the care that he/she needs.

Confidentiality is a key issue when seeing the adolescent alone so that a trusting relationship is built between the physician and the patient. Exceptions to this obligation must be explained from the outset that if the adolescent reveals self-harm, suicidal intent, being subjected to physical/sexual abuse and/or intent to harm others, then the physician has to notify others in their best interests to keep them safe. The physician should always try to encourage the adolescent to share sensitive information with their parents, as their support often helps in their well-being, and will help them cope in the future. Once trust and confidentiality are agreed upon, the consultation can then commence. The physician should listen and take the adolescent's distress seriously.

ASSESSING THE TROUBLED ADOLESCENT

When assessing a troubled adolescent with features of abnormal behavioural problems, be it emotional, social or psychological, the physician must take into account the severity and chronicity of the problem, and the adolescent's development. These relate to their independence, body image, relationship with peers, school performance and perceived identity. Using the HEADSS framework (Table 2), a comprehensive assessment of the adolescent's total environment will provide much needed information in distinguishing normal adolescent adjustment reactions versus abnormal behaviours that require more comprehensive and complex assessment and management. Often, mental health problems such as depression, anxiety, eating disorders and ASD can be identified and appropriate referrals can be made.

Two challenging clinical presentations will now be discussed to illustrate the approach for each "troubled" adolescent patient: excessive dieting in a female adolescent, and assessing and detecting ASD in a disengaged young male.

NORMAL DIETING VS AN EATING DISORDER

When a thin adolescent female patient who is accompanied by her mother presents to the physician because she is losing weight and refusing to eat, one has to have an index of suspicion that an eating disorder may be present. Apart from excluding a physical cause for the weight loss by taking a comprehensive medical history, performing a thorough physical examination and ordering appropriate basic laboratory tests, it is essential to take a dietary history, and eating and exercise patterns since the onset of the weight loss. A history of preoccupation with food and calories, bingeing and self-induced vomiting and excessive exercise despite weight loss, points to an eating disorder. Using the HEADSS assessment, the physician would also be able to detect the progressive withdrawal from peers and other social activities with the family, and the onset of depression. Once the diagnosis is confirmed, the management starts with a clear explanation of the illness to the patient and her family members.

Management techniques in counselling adolescents with eating

Table 2: The HEADSSS approach

H	**Home**
E	**Education/employment/eating/exercise**
A	**Activities/peers**
D	**Drugs/cigarettes/alcohol**
S	**Sex/sexuality (abuse)**
S	**Suicide/depression screening/other symptoms**
S	**Safety/spirituality**

disorders require tact and sensitivity. It also depends on the training and competence of the physician and the severity of the problems. Often, individual and family therapy are required, and referrals to the psychologist/psychiatrist and a multidisciplinary team that includes a dietician will ensure optimal outcome and recovery. The physician maintains a liaising role, monitors the physical conditions of the young person and provides support for the family.

ADOLESCENTS WITH ASD

The diverse expressions of the symptoms of ASD pose diagnostic challenges to clinicians. Individuals with ASD may present at various times of development, including adolescence, as symptom expression may vary over the course of development. Some of the symptoms of ASD can include disconnection with others and inappropriate emotional outbursts, which can be similar to normal adolescent rebellious defiant behaviours. There are also psychiatric co-morbidities associated with ASD, such as depression, anxiety, schizophrenia and obsessive compulsive disorders. Hence, when a male adolescent presents with "behavioural" problems, it is important to exclude ASD using the adolescent development screening HEADSS framework first to distinguish between normal and abnormal behaviours. The lack of engagement and eye contact, history of social isolation, poor school performance, repetitive ritualistic habits and lack of emotional responses would alert the physician to the presence of ASD and refer the adolescent for further assessment. As the diagnosis of ASD in an adolescent is often challenging, there are specific screening tools developed by the National Institute for Health and Care Excellence and the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, among others. These will not be discussed further in this article.

The primary care physician who has the index of suspicion that the adolescent has ASD ought to refer the adolescent to experienced clinicians for a more comprehensive assessment. This often involves a multidisciplinary team of health professionals, including clinical psychologists and psychiatrists, who will assess the young person based on their own assessments. The observations of teachers and parents in various contexts of the young person's growth and development will also help with diagnosing ASD. After the diagnosis, the primary care physician often provides comprehensive whole person care to the patient for other healthcare needs. Parental support is vital as family members usually encounter major stresses and family dynamics are often disrupted.

HEALTH SERVICES INTERVENTIONS

Adolescents have special healthcare needs and in order to deal with the emerging health issues that they face, health services ought to respond to the challenges of providing appropriate care for them. Youth-friendly clinics have been established in some countries to care for young people as they find most medical clinics more suited to children or older adults. Others provide a multidisciplinary service model for at-risk youths with substance abuse or psychological/behavioural problems.

In order to encourage young people to seek medical assistance when they are distressed, all healthcare providers need the knowledge and skills to respond to the complex health issues as they go through adolescence.

In summary, the key to successfully identifying problems in the troubled adolescent lies in the initial doctor-patient relationship and the physician's awareness of the developmental issues in adolescence. At the same time, the physician has to win the confidence and approval of the parents to avoid sabotage. Counselling and working with adolescents is one of the most challenging and rewarding experiences in medical care. ◆

PROFILE

TEXT BY

PROF DORIS YOUNG

Prof Doris Young (MBBS, MD FRACGP) is professor of general practice, Melbourne Medical School, University of Melbourne, Australia. She has been extensively involved in educating and training medical students, registrars, GPs and other health professionals in adolescent medicine, general practice and primary care research. She moved to Singapore two years ago and is currently research advisor to the National Healthcare Group Polyclinics.

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2. Patton GC, Sawyer SM, Santelli JS, et al. Our future: a Lancet commission on adolescent health and wellbeing. Lancet, 2016; 387:2423-78.
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CLINICAL DECISION-MAKING (PART1):

UNCERTAINTY, INTUITION AND BIASES

In last month's issue of *SMA News*, I wrote about the role of mentors in the practice of medicine and how they help younger doctors navigate and deal with uncertainty in clinical practice. Medicine remains an "uncertain art" despite advances in technology and the development of evidence-based medicine in an attempt to improve the predictability of diagnosis and clinical outcomes.

We are familiar with modern methods of clinical decision-making, such as the use of clinical algorithms, decision trees and practice guidelines. These guidelines are useful, if not essential, in providing a high standard of care for patients and are applicable for the majority of problems that a doctor encounters, as they are backed by statistically proven data. Guidelines set a standard of expected care and thus help to maintain consistency of quality, improve treatment outcomes and ensure patient safety.

There are of course limitations to the use of guidelines — they do not cover each and every clinical situation, they do not take into consideration the individual patients in context, and patients themselves may often present with undifferentiated and vague problems, or complain of multiple interconnected symptoms.

INTUITION

The ability to rapidly assess a given situation, identify the problems and come up with a provisional diagnosis to make a decision is what we call clinical intuition. A *heuristic* is a "mental shortcut", "rule of thumb", "gut feeling", or a rapid insight that clinicians develop to help them cope with essentially uncertain situations. Doctors commonly use heuristics in clinical decision-making. In emergency situations, being able to rapidly size up a situation and make clinical decisions can be a matter of life and death.

Intuition is certainly useful to enable quick decisions, and mostly serves its purpose in conserving mental energy since most patients present with common symptoms and cases, even if uncertain, can be fairly straightforward. This is especially true in primary care, where family physicians are called upon to make clinical decisions for patients who present with early and undifferentiated symptoms, under the twin pressure of high patient load and shortage of time.

Primary care doctors develop an acute sense of observation that kicks in as soon as patients enter the consultation room, using framing techniques to fit patients into categories, each with certain expected symptoms and outcomes. Through literally thousands of patient encounters, the primary care doctor is able to refine his decision-making skills and develop a sense of the expected outcomes of common diseases. Once a patient does not fit into a recognisable pattern, the difference stands out.

DETECTING ZIKA

The detection of the first locally transmitted cases of Zika virus infection in Singapore in August 2016 was an excellent example of the role that primary care doctors have as the first line of defence in emerging infectious disease outbreaks. It also showed how pattern recognition and intuition played a part in clinical decision-making.

Doctors at Sims Drive Medical Clinic had noticed an unusual spike in patients with fever, joint aches and rash in the community. This unusual "pattern" was noticed by the team of three doctors practising there, and when coupled with the negative test results for dengue, measles and rubella, it triggered the alarm for them to report the cases to the Ministry of Health.

This combination of pattern recognition, clinical experience, high index of suspicion, concern for the welfare of the community, and a network of colleagues that allowed information exchange all came together to enable the cases of Zika infection to be detected.

There was no definitive clinical guideline for Zika detection at that time; the patients presented with vague

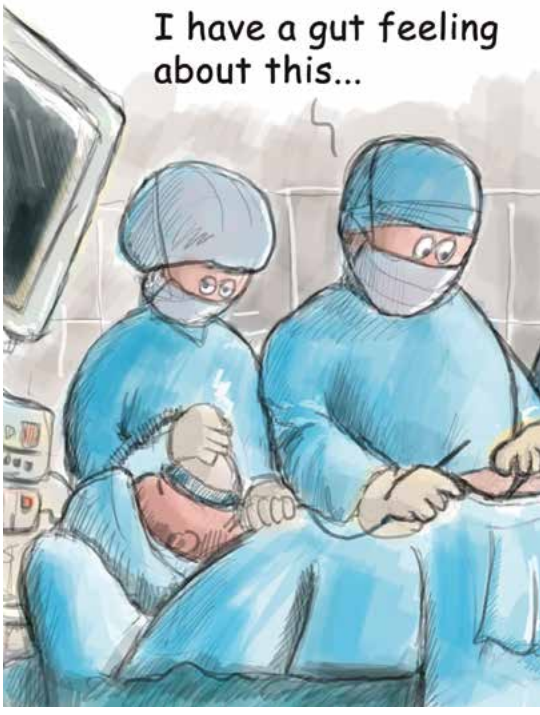


Illustration: Dr Kevin Loy

symptoms and the doctors were all uncertain about the problem. Yet, their intuition told them that something was wrong — the pattern did not fit a usual outbreak of viral fevers.

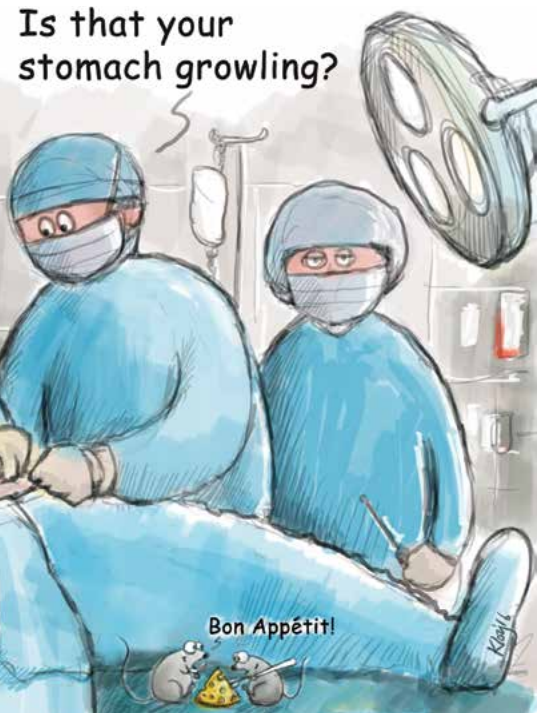
BIASES

Intuition is refined and improved through a process of observation, practice and feedback. It is a learning process honed through years of clinical experience.

Clinical intuition is widely employed by doctors even if they are not aware of it. I became interested in behaviour and cognition pertaining to doctors when I first read Jerome Groopman's book, *How Doctors Think*. It led to reading about theories of cognition and intuition, which in turn led to a wide field on the study of cognitive errors.

Indeed, intuition can be fallible. Authors of books on intuition are divided on whether it is something that is reliable or misleading. Doctors often make wrong decisions, as heuristics are double-edged swords that can make them fall short on predictions when applied wrongly. Doctors therefore need to be aware of such pitfalls and biases.

Here are some common types of cognitive biases that operate in clinical decision-making. The list is non-exhaustive; interested readers can refer to the book references at the end of the article.



Attribution errors involve negative stereotypes that lead clinicians to ignore or minimise the possibility of serious disease.

Example: Dismissing "malingerers" as medical certificate seekers and missing a serious pathology. A "heartsink" patient who presents for multiple visits often has symptoms ignored or played down.

Anchoring heuristic occurs when physicians are overly influenced by initial pieces of information, leading to biases in subsequent judgements. Once an anchor is set, physicians cling to that initial diagnostic impression despite new information that points to the contrary.

Example: A doctor makes an diagnosis of acute appendicitis in a patient and subsequently dismisses a positive urine culture as a contaminated specimen.

Belief perseverance refers to the tendency to cling to one's belief even after receiving new information that contradicts the basis of that belief. Once an impression is anchored in the mind, the doctor holds on to it. Doctors need to be aware that they can make rapid decisions but should not be trapped with their personal beliefs.

Example: A doctor may have a firm belief that food allergy is the cause of many underlying diseases such as rhinitis, gastroenteritis and dermatitis, even when clinical evidence of another aetiology is present.

Confirmation bias ("seek and ye shall find") is a tendency to search for or interpret information in a way that confirms one's preconceptions, leading to decision errors. It compounds an anchoring error when the physician "cherry picks" available data to fit his initial impression.

Example: In history-taking, doctors can sometimes ask leading questions in an attempt to "confirm" their initial first impressions. Once they are satisfied that a conclusion is reached, they end the interview.

Availability heuristic occurs when doctors are influenced by what they have seen recently or what comes to mind easily. Overestimation of probability occurs when the doctor had witnessed a dramatic and eventful case, or is influenced by exposure in a recent lecture or through the media.

Example: The surge of suspected cases of Zika infection being referred for testing because it is constantly reported in the media. On the flip side, public health authorities can use availability bias to saturate the media with information on a disease, so as to improve detection rates during epidemics.

Representativeness heuristic is when clinicians use shortcuts to arrive at a diagnosis based on what is common in their area of practice. This may lead to errors if the *base rate* in the population changes, such as overestimating a patient's disease based on certain clinical features, despite the rarity of the disease in the population.

PROFILE

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.

Example: A medical officer who has just finished a respiratory posting may think that the rate of lower respiratory infection is high based on what he observes in the respiratory ward, leading to overestimating cases of pneumonia when he gets posted to a primary care facility.

Illusory correlation is the phenomenon of perceiving a relationship between variables even when no such relationship exists.

Example: Doctors often believe that their drugs work (eg, antibiotics to treat upper respiratory tract infections) based on personal experience, when in fact most minor ailments are self-limiting. Doctors tend to take too much credit for such self-limiting conditions.

Framing effect refers to drawing conclusions based on how the information is presented. Clinical decision becomes biased by subtle changes in language, perception of risk, and benefit.

Example: The doctor can present a procedure as having a ten percent chance of mortality or a 90% chance of survival, eliciting different decisions from the patient.

INTUITION VERSUS RATIONALITY

Kahneman and Tversky (2011) proposed that the cognitive mind operates in two modes — system 1 is fast and intuitive, while system 2 is slow and rational. How this influences clinical decision-making will be the topic of another article.

Watch this space. ◆

Further readings

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HIGHLIGHTS FROM THE HONORARY SECRETARY

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.

MEETING WITH MINISTER OF STATE AND DMS

On 8 August 2016, SMA President Dr Wong Tien Hua, 2nd Vice President A/Prof Tan Sze Wee, and Council Members Dr Anantham Devanand and Dr Wong Chiang Yin met with Minister of State Dr Lam Pin Min and Director of Medical Services A/Prof Benjamin Ong. Issues discussed included the Singapore Medical Council Ethical Code and Ethical Guidelines, and managed care. A follow-up meeting was held on 26 August 2016 together with Minister of State Dr Lam, the Academy of Medicine, Singapore and the College of Family Physicians Singapore, to further discuss issues on managed care in Singapore.

ADDITION TO SMA HONORARY LEGAL ADVISORS

Mr Matthew Saw, an established lawyer with Lee & Lee, has joined SMA's panel of honorary legal advisors. He joins Ms Kuah Boon Theng (Legal Clinic LLC), Mr Lek Siang Pheng (Dentons Rodyk) and Mr Edwin Tong (Allen & Gledhill) as honorary legal advisors on our panel.

SMA'S CONTINUED EFFORTS TO ENGAGE FOREIGN-TRAINED MEDICAL STUDENTS

SMA has been actively supporting the Singapore Medical Society of the UK (SMSUK), Singapore Medical Society of Ireland (SMSI) and Singapore Medical Society of Australia and New Zealand (SMSANZ) in various ways over the past years. SMA sponsored the venue for SMSUK's Freshers and Members Gathering event held in August 2016, and obtained discounted prices for 3M Littman Stethoscopes made available to SMSUK, SMSI and SMSANZ members. All foreign-trained medical students from the three overseas medical societies continue to enjoy complimentary SMA Student Membership, which usually costs $20, as part of SMA's effort to reach out to more medical students locally and abroad. ◆

SMA's Advocacy Efforts on MANAGED CARE

The SMA closely monitors the business environment in Singapore and is particularly concerned with business arrangements that have an impact on the practice of medicine here.

Managed care has been a feature of our healthcare business landscape for many years and a number of third party administrators (TPAs) have come and gone. SMA thought that this was a matter of sufficient concern and dedicated our 37th annual national convention in 2006 to the topic of managed care (https://goo.gl/vz2Q63). SMA also conducted surveys on managed care in 2003, 2006 and 2015, with the latest survey results published in the May 2016 issue of *SMA News* (https://goo.gl/k6E28F). The August 2016 issue (https://goo.gl/QiYQpM) was also dedicated to the discussion of various aspects of managed care.

On 23 February 2016, the SMA Council wrote to seek the Singapore Medical Council's (SMC) guidance on the business practices of certain managed care companies and TPAs that inevitably involve registered medical practitioners (ie, doctors). SMA is concerned about companies deducting excessive administrative fees from participating doctors, because it sets up a system whereby patient interests may not be best served when they are preferentially directed to panel specialists, even when their insurance plans allow them more options. We wrote to SMC to clarify if, firstly, such an arrangement is considered "fee-splitting", and secondly, if doctors who allow deduction of excessive administrative fees may be considered as having induced companies to refer patients to them.

In general, SMA is of the opinion that a flat or fixed fee should be charged for each patient episode, rather than a percentage of the bill. This fee paid to the managed care company and TPA must also have a bearing on the work done in facilitating the referral.

Though we understand that the regulation of managed care companies and TPAs do not come under the ambit of the SMC, the Association feels that doctors in Singapore need guidance from SMC on whether they can participate in such practices, or if engagement in such practices would constitute unethical behaviour or professional misconduct.

We reproduce below SMC's reply, and a Parliamentary Question and Answer on managed care companies which was first published on the Ministry of Health website (https://goo.gl/MpAUu0).

SMC's Letter to SMA

8 September 2016

Dear Dr Wong,
RE: Fees Charged by Managed Care Companies and Third Party Administrators

1. We refer to the letters of the Singapore Medical Association dated 23 February 2016 and 22 March 2016.
2. The role of the Singapore Medical Council (SMC) under the Medical Registration Act is to regulate the doctors' professional standards and behaviour.
3. In an earlier draft of the revised SMC Ethical Code and Ethical Guidelines (ECEG), the Working Committee for the review of the ECEG had labelled such percentage fees as "fee-splitting" and was of the view that it should not be allowed. What followed in the first consultation was feedback from stakeholders, including SMA members that SMC should not to interfere with business arrangements, especially when such fees are not deemed to be "fee-splitting" in some jurisdictions (extracts of SMA members' collated feedback are appended below).

Date	Name	Feedback
28 Nov 2014	SMA (collated responses from individual members of SMA)	It is better to state the broad ethical dilemma of fee-splitting. Private medical service providers do make it a business to source for patients and refer doctors. How can SMC tackle such behaviour if they have no jurisdiction to control these for-profit companies? The business methods and ways of charging can vary and there are many ways of creatively side stepping any rules that SMC may impose. Does SMC have any idea how the Managed Care systems and the Insurers and Third Party Administrator system works? Almost all insurance claims have to be through TPA who charges an administrative fee as a percentage of the total fees. If SMC is to make this work, SMC would have to work with the insurers and TPAs to sort out this issue, and ban such administrative fees imposed on the doctors. Otherwise, such agreements will always exist, doctors will be tempted and "PUT THEM AT RISK OF UNETHICAL BEHAVIOUR"
28 Nov 2014	SMA (collated responses from individual members of SMA)	Summary points, bullet 2: *"If you have decision-making responsibilities in your practice or company or benefit directly from such disallowed dealings, you will be held professionally accountable."* Intruding on Companies Act.
28 Nov 2014	SMA (collated responses from individual members of SMA)	summary points, bullet 4 *"Administrative fees of amounts commensurate with the real cost of administration may be paid to third parties such as managed care organisations, but it must not be based on a proportion of fees, charges or bill size as this would be fee-sharing."* Managed healthcare organisations perform bill collection on behalf of panel doctors. They routinely charge percentage of doctors' bills as administrative costs. While this can be termed as fee-splitting, it has been an exempted from the general ban on fee-splitting in the State of Illinois. It is a convenient system which allows doctors the leeway to keep their fees low if they wish, as the admin fee will be proportionately low. The system is not perfect but it is logical. Usually charges are already capped by the managed healthcare organisation so risk of overcharging is low and the range of admin fees is limited. The alternative would be to charge a fixed administrative fee, but this has its own moral hazards. If this fee is set too high it will encourage the doctor to over-service the patient and charge more in order to recover back the costs. http://virtualmentor.ama-assn.org/2009/05/hlaw1-0905.html http://dermatologytimes.modernmedicine.com/dermatology-times/news/modernmedicine/modern-medicine-now/can-outsourced-billing-be-considered-illeg?page=full
28 Nov 2014	SMA (collated responses from individual members of SMA)	*i) You shall not share your fees (sometimes called "fee-sharing" or "fee-splitting"), make payments or offer gifts or any other consideration for patients referred to you from any source.* This statement is too general. But I agree we should prohibit paying percentage referral fee to licensed clinics and agents. These sources do not place a restriction on doctors' charges and the temptation is to over-service and overcharge the patient in order to recover the referral fee. The referral fee has no upper limits and bears no correlation to the amount of work done by the referring source.
28 Nov 2014	SMA (collated responses from individual members of SMA)	Para (iv): *"You are not allowed to pay a percentage of professional fees, total charges or bill size to any third party payer (e.g. managed care organisation or insurance company) for the privilege of receiving patients referred by them. Administrative fees may be paid, but this must be a reasonable, pre-determined, fixed sum for each patient, commensurate with the real cost of administration, and fees must not vary with your charges, fees or bill size, otherwise you will effectively be 'fee sharing' or 'fee splitting' with a party who has not rendered a commensurate part of the services."* As this is well entrenched, any changes cannot happen overnight. 3rd party payers should be engaged in the discussion. In the meantime, we should not pre-judge them.

4. The SMC agrees with you that the regulation of these managed care companies and third party administrators (TPAs) does not come under the ambit of SMC. Neither can SMC identify business patterns that are of such high risk to professionalism that they ought to be prohibited on grounds of medical ethics, since the range of options is wide and there will always be creative ways to circumvent specific prohibitions.

5. The approach and SMC's stand on this are as follows:
   (a) Doctors who participate in managed care or TPA contracts must not allow any financial constraints or pressures inherent in such schemes to influence the objectivity of their clinical judgment in managing patients, such that the required standard of care is not provided. Should doctors be challenged as to whether they provided appropriate care, it is not a defence that the contracts they have entered into did not allow them to provide the necessary standard of care. Patients should not get differential treatments just because they are from companies which are involved in such contracts with doctors.

   (b) Paying of fees is in and of itself not necessarily disallowed, provided in general, the sums reflect the actual work of the managed care companies or TPAs in handling and processing patients and that such fees must not be based primarily on the services doctors provide or the fees they collect from patients. SMC would deem unethical the sharing or splitting of fees with a referring doctor, merely for the privilege of being referred a patient, with no commensurate work done justifying such fees. Both doctors would then have behaved unethically. If a doctor splits fees with a third party who is not a doctor and has done nothing commensurate with the payment, the doctor would be deemed to have behaved unethically.

   (c) Doctors must not pay fees that are so high as to constitute "fee-splitting" or "fee-sharing", or which impact their ability to provide the required level of care. Therefore, doctors need to give due consideration to any contract before signing. Where the boundary is between a reasonable fee and "fee-splitting" is a matter for judgment.

   (d) If doctors pass such fees onto patients, doctors ought to be transparent about this with their patients and disclose this to them.

6. SMC is of the view that patients' best interests are compromised when:
   (a) Patients are sent to doctors inappropriate to their needs, due to the doctors agreeing to pay fees to managed care companies or TPAs;

   (b) Doctors under-treat patients due to financial pressures;

   (c) Doctors over-treat patients to make higher revenues to cover the fees they must pay; and

   (d) Doctors grossly over-charge patients in order to redeem high business costs due to such fees.

7. SMC understands why SMA prefers a "fixed fee", but is of the view that however fees are constructed, what is important is that the fee paid must not be based primarily on the services doctors provide or the fees they collect from patients. We believe this addresses the problem sufficiently without a need to specify how the fee should be derived.

8. We encourage SMA, as the profession's advocate, to engage the industry to bring about fairer practices as well as engage and educate doctors on how to handle such contracts without breaching their obligations to patients.

Thank you.
Yours sincerely,
Prof Tan Ser Kiat
President
Singapore Medical Council

Parliamentary Q&A on Managed Care Companies

13 September 2016

Mr Desmond Choo
MP for Tampines GRC

Question No. 583

To ask the Minister for Health (a) whether the Singapore Medical Council is aware that some managed care companies require doctors to pay administrative fees for the "'referral" of patients and, if so, what is their response; and (b) whether this practice will result in patients having to pay more.

Written Answer

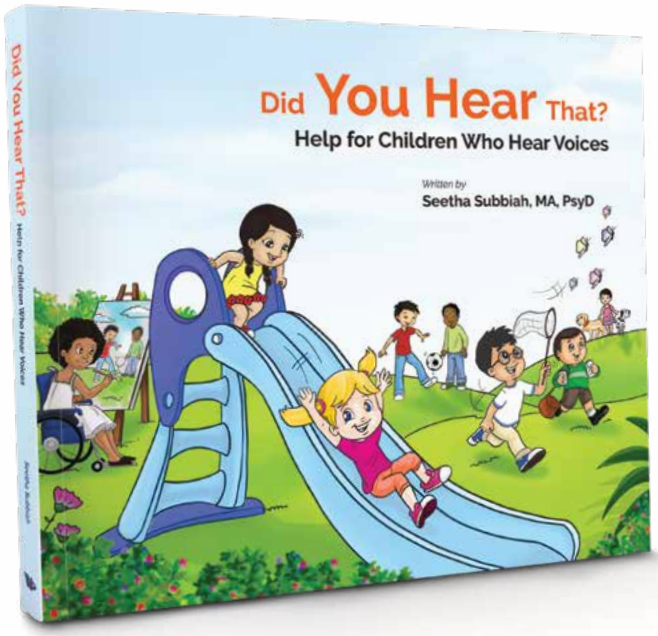
1 Managed care has been a feature of our healthcare landscape for many years. Managed care companies serve to provide intermediary services to various stakeholders such as insurers, corporations, healthcare providers and patients.

2 In recent months, the Ministry of Health (MOH) and the Singapore Medical Council (SMC) have received feedback from individual doctors and the Singapore Medical Association (SMA) regarding managed care companies, or third party administrators (TPAs), entering into contracts with doctors, where the doctor would commit to pay a fee for each patient referred by the TPA.

3 This raises concerns that TPA's decisions on patient referral may be influenced by the fee arrangement rather than the interest of the patients. The doctor may in turn pass on the cost of the referral fee to the patient through higher charges. In some cases, the patient may not be aware of this, especially if his bills are fully covered by his insurance plan or employee benefits. It is of particular concern if the fee is determined as a percentage of the doctor's charges, without relation to the actual services rendered by the TPA.

4 The SMC is revising its current Ethical Code and Ethical Guidelines, which already addresses fee-sharing between doctors, to also address fee-sharing between doctors and TPAs. The revised guidelines will explicitly state that doctors must not allow financial arrangements in managed care to lead to any compromise in the care of the patient.

5 MOH is also working with the medical professional bodies and associations to raise doctors' awareness of appropriate arrangements with TPAs. We will continue to work with the Life Insurance Association to remind the Integrated Shield Plan (IP) insurers to ensure that their appointed TPAs, if any, should not have any conflict of interest and should disclose to policyholders any financial arrangements they have with the doctor. ◆



Children Hearing Voices

When I was asked to review *Did You Hear That?: Help for Children Who Hear Voices* as a paediatric psychiatrist, my first impression was that it is a really big book which is well illustrated. Colourful pictures and words fill each of its 160 pages. As I started to read it, it gave me the feeling that this was another book written from a Western viewpoint that didn't consider the cultural diversity that was relevant to Singapore. I was rather sceptical that this book could address the complex issue of children who hear voices, but was pleasantly surprised as I read through the examples of Susie, Carlos, Selma, Chang and Lala.

For our gentle readers, let me give you some background on the issue. Hallucinations are typically described as when one has an external perception that does not exist. These perceptions can be auditory (in things we hear), visual (in things we see) or even olfactory (in smells) and kinaesthetic (in things we touch and feel). Auditory hallucinations are the most common and unfortunately, doctors have been taught to consider this psychopathology as the hallmark of psychosis — a serious mental illness. This may indeed be the case when we deal with adults, but children may hear voices for a number of reasons. Trauma and adverse childhood experiences are common sources of these hallucinations. This review is not long enough to give you a thorough thesis on hallucinations versus imagination, but taken at face value, hallucinations are experienced much like real perceptions and not just thoughts in the mind.

In this sense, Dr Seetha (who holds a doctorate in clinical psychology) has made the concept easy for children to understand and also provided good scaffolding for parents, therapists and other professionals working with children to broach the subject. It helps to clarify the notion of the subjective experience of a child in a non-threatening manner and also provides some common examples. One notable story missing would be on sexual abuse, that may also result in hallucinations. The supplementary questions on the bottom of some pages help to introduce talking points for adults to discuss with the child. In this sense, this is an excellent couch side book for working with children who complain that they are hearing voices, and I would recommend it to all my colleagues at the Child Guidance Clinic. My only regret is that we did not participate in the writing of this much needed addition to the global child mental health resources. ◆

Title: Did You Hear That?: Help for Children Who Hear Voices
Author: Dr Seetha Subbiah
Number of pages: 160
ISBN: 978-981-3144-15-6
Type of book: Softcover
Publisher: World Scientific Publishing
Year of publication: 2016

PROFILE

REVIEW BY

A/PROF DANIEL FUNG

Editorial Advisor

A/Prof Daniel Fung is the Chairman Medical Board at the Institute of Mental Health and an adjunct A/Prof with all three medical schools. He is married to Joyce and has five children and hopes to be a grandfather one day in the not too distant future.

The Heart and Tool to Help

— Interview with Dr Seetha Subbiah

Dr Seetha Subbiah (SS) is a licensed clinical psychologist with about 22 years of experience in providing emotional and behavioural healthcare services to multicultural children, adolescents, adults, couples and families in Singapore, and in other countries such as the USA, Japan, India, Sri Lanka and Nigeria. Her special interest is in children, adolescents and families and her expertise is in trauma, sexual, physical and psychological abuse, and conditions that fall within the more severe end of the diagnostic spectrum.

She received her clinical training at the University of California, Berkeley (Bachelor's degree in Psychology), and the Illinois School of Professional Psychology, Chicago Campus (Master's and Doctoral degrees in Clinical Psychology), USA.

In May this year, Dr Seetha published her book ***Did You Hear That?: Help for Children Who Hear Voices***, which seeks to help children with hallucinations. *SMA News* is glad to have the opportunity to speak with her about her inspiration and hope for the book.

Please tell us more about your experience in child psychology.

SS: Over the years, I have provided therapy services, clinical consultation, presentations, workshops, trainings and programme development in a variety of settings, including general hospitals, specialised children's hospitals, private clinics, schools, community mental health centres, non-profit organisations and non-governmental humanitarian organisations.

I have also served as a Human Diversity Expert to the California Board of Psychology and Mental Health Advisory Board Member to the National Asian Women's Health Organisation, USA, and I was admitted to the California and Illinois Boards of Psychology, USA, in 2005 and 2006.

What inspired you to write this book?

SS: The impetus to write this book was, primarily, frustration.

It is a commonly held belief and perspective in the field of psychology and psychiatry that the phenomenon of hearing voices or seeing things that are not there is, almost always, indicative of schizophrenia or pre-schizophrenia. In my clinical work with child clients who hear voices, it was evident that the root cause for the phenomenon was not always organic in nature and did not always require pharmacotherapy.

There are many reasons why one might hear voices. Besides trauma, other root causes of hearing voices can include grief, physical/sexual/psychological abuse, substance

abuse, personality disorders, reactions to certain drugs, and medical conditions like seizure disorder. It is also not an uncommon coping mechanism that the brain employs to parcel out unacceptable or difficult to deal with emotions, feelings, thoughts and experiences that could take the form of auditory voices or surface as visual forms that are not there.

In my work, I found success in treating clients without medication or with the minimal use of drugs. With appropriate talk therapy treatment, children earmarked as likely to be on medication for life started appearing like average kids, and were able to reach much higher levels of functioning and even their full potential.

Prior to 2005, I frequently looked for clinical tools and information to assist and aid in my work with clients. However, appropriate resources were very hard to find. Research on the topic was limited and gave little direction on how to tailor or provide treatment for this population, other than to rely primarily on pharmacotherapy.

The final push to write the book came in 2005 when I came to discover that the Food and Drug Administration in the US had approved the use of anti-psychotic medication with children as young as two years old.

The cumulative frustration that resulted from (i) knowing how this population had been poorly served, reflected by the limited research attention it had received and the lack of treatment resources; (ii) my difference in opinion with colleagues and peers that the voices did not always indicate schizophrenic conditions, and pharmacotherapy alone was not always the ideal treatment methodology; (iii) having witnessed clients' emotional turmoil and psychological suffering associated with the phenomenon; and (iv) my discovery that anti-psychotic drugs were approved for use in children too young to even determine the presence of psychosis, propelled me to pen down what I understood and discovered through my clinical work. Ie, possible causes for the phenomenon and the fact that voice hearers are not "doomed for life" and can indeed live effective lives with the appropriate assistance.

In 2006, I completed the first version of my book. In its unillustrated, Microsoft Word document format, it was used as a treatment tool for child clients and as a training resource for interns and practicum students in the intensive outpatient programme at EMQ FamiliesFirst (currently known as Uplift Family Services) — a community mental health service provider in California. After two years, the feedback from therapists who used the book with child clients was very positive. Over the next few years, I continued to fine-tune it to make it a dynamic, interactive and informative tool to help mental health providers such as psychologists, psychiatrists, psychotherapists, counsellors and clinical social workers in their work with child clients of diverse backgrounds.

Pressure to formalise the book came from peers who used it and believed that more people could benefit from it.

I hope that by having published this book, the information within reaches and assists as many children who may be suffering in silence or in isolation as possible. By reducing the incidence of false positive diagnoses of psychosis in children, the unnecessary use of anti-psychotic medication can be reduced and instead, appropriate clinical treatment can be rendered to help them understand, accept, master and cope with the voices.

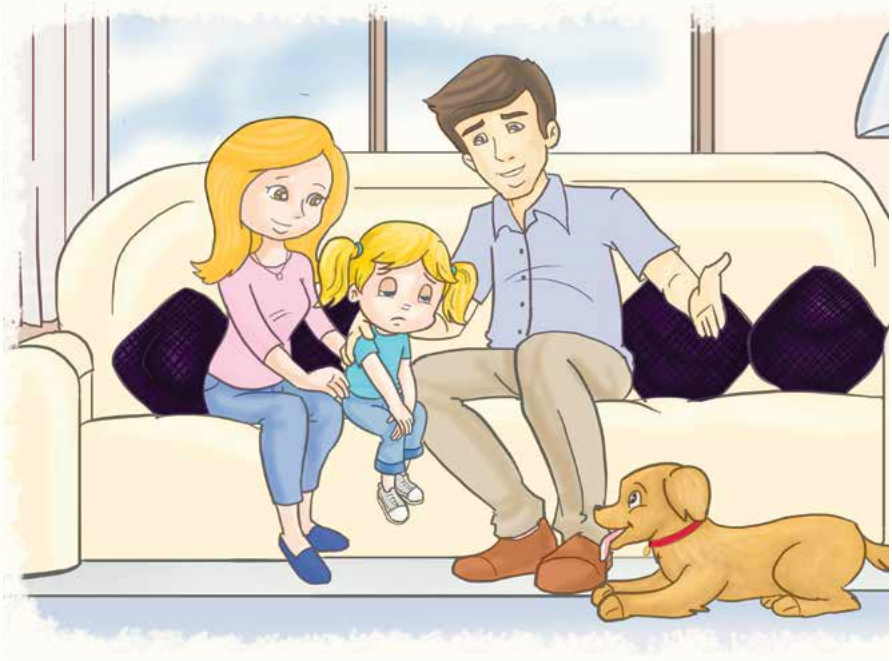
Who can benefit from reading this book?

SS: Designed as a therapeutic storybook, it is a practical tool for psychologists, psychiatrists and mental health practitioners treating children with the voice-hearing phenomenon.

Written in very simple terms, child clients who may hear voices and/or see things that are not there will find it easy to understand. Mental healthcare clinicians can read this book to younger clients while older ones can read it themselves.

The book also doubles up as an informational tool and user-friendly guide for concerned parents, teachers, medical doctors and allied healthcare professionals (eg, speech therapists, occupational therapists), probation officers, lawyers and other carers of child clients.

Although the original intent was not for the following populations, I have received feedback that it has helped (i) non-voice-hearing school children better their understanding and increase their empathy for classmates who struggle with the phenomenon and (ii) adult voice hearers who find the illustrated format a less-threatening way of addressing painful



material and the jargon-free language easier to understand.

How do parents get their child to confide in them for such problems? Are there any simple advice parents can give before bringing the child to visit a doctor?

SS: At a very young age, children pick up from society and media (ie, cartoons and movies) that one is "cuckoo, strange or a witch" if he/she hears voices. Thus, it is very common for children who struggle with this phenomenon to suffer alone and/or in silence because they fear others judging them as "weird".

The following is general advice for parents to help them keep the communication channel with their children open at all times in order for their children to feel comfortable approaching them with anything that ails them or concerns them, as and when necessary. This includes when they are struggling with voices too. Parents need to actively work toward building a framework of trust in their parent-child relationship. This takes time to develop and requires the parents to be consistent, emotionally available, honest and empathic in their interactions with their children. By ensuring that the child feels there are no taboo topics for discussion, and that anything they speak about will not be chided, minimised, mocked, ignored and/or negated, parents can be sure that their child will confide in them, if and when the need arises.

Specifically, if a child shares with his/her parents about hearing voices, it would be important for parents to validate the experience and normalise it. They could ask questions to understand the nature of the phenomenon. Questions that start with, "when, where, what, who, how and how often" would be useful to not only get the conversation going but also show the child that you are taking it seriously and are interested. This approach also helps a child sift through a possibly scary experience to gain a better understanding of the phenomenon and gain a sense of mastery over it.

If professional assistance is required, depending on what the child has heard about or has garnered from society and media about what it says about a person who requires the assistance of a mental health professional, the introduction of the topic may be sensitive. It would be useful to assure the child that the visit is not to "sort out" the child, but for the entire family's benefit, including parents, to learn how to become better at helping the child. This perspective helps children feel that the finger is not being pointed at them or they are being told that there is something "wrong" with them. Equating the upcoming visit to that of a regular visit to a dentist or physician for dental and physical health could further normalise the experience. This should allay a child's fears of seeking help. As an added resource, parents could use Chapter 1 of the book as a tool and guide to help them broach the topic with their child.

How can adults help to integrate these children within their schools (ie, acceptance and understanding from teachers and students)?

SS: Children spend a significant amount of time in school and various experiences in school can trigger the voice-hearing phenomenon as well. So, garnering the support of school staff would be a very important part of helping a child who hears voices. Increasing awareness in teachers handling voice-hearing children would be key as this will help them (i) understand what is going on with the child; (ii) realise that reprimanding or mocking a child's wavering attention and concentration may not necessarily assist the child to improve on this shortcoming; and (iii) as and when necessary, support the child during school hours by helping the child be more engaged at school by, for example, giving timely reminders to use pre-determined coping strategies to revert their focus to school-related activities.

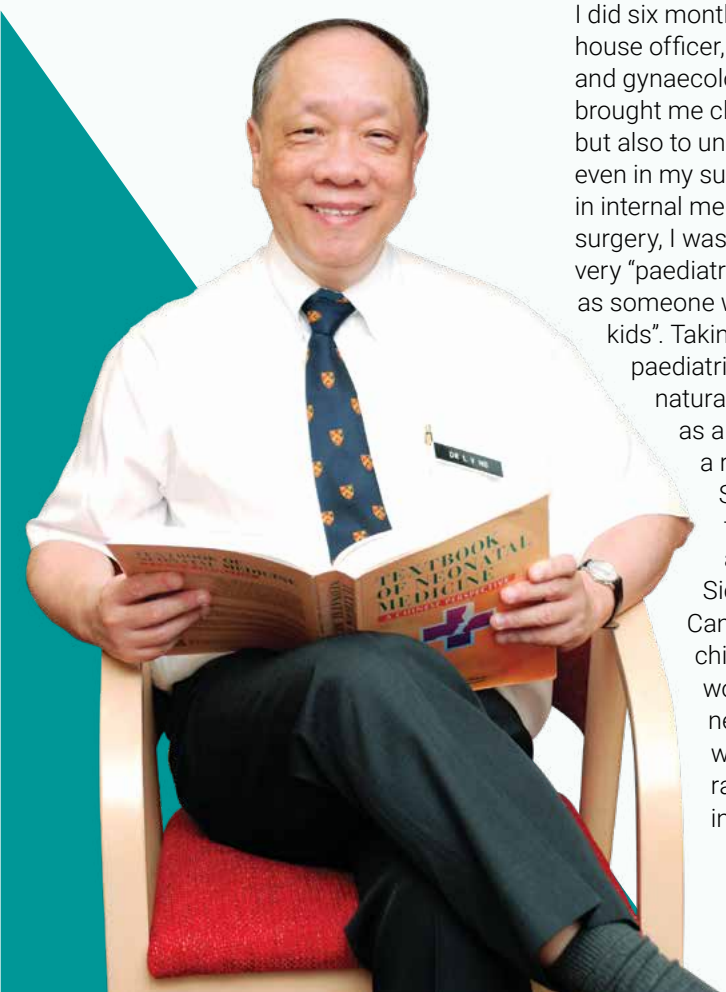
Note should be made that it may not always be healthy, useful or necessary for every single person at school to be informed about all details relating to a child's condition. Thus, it should be thought through as to who should be notified and what details should be shared.

In general, teachers and school counsellors play a key role in helping children in the classroom develop compassion and empathy toward others' challenges, including the challenge posed by voices for children. This book has been successfully used by teachers, independently and upon the recommendation by parents, in classrooms to educate and increase awareness of this condition among students. ◆

Impacting the Future

— Interview with Prof Ho Lai Yun and A/Prof Marion Aw

In this issue focusing on the young ones, *SMA News* took the opportunity to interview two established and experienced practitioners in the field of paediatrics. In this interview, Prof Ho Lai Yun (HLY) and A/Prof Marion Aw (MA) offer a better understanding of their personal and professional journeys as paediatricians.



Prof Ho Lai Yun

What inspired you to specialise in paediatrics?

HLY: During my undergraduate days, the most inspiring teachers were in paediatrics at Mistri Wing. I did six months of paediatrics as a house officer, followed by obstetrics and gynaecology — which not only brought me close to newborn babies, but also to unborn ones. Since then, even in my subsequent postings in internal medicine and general surgery, I was labelled as being very "paediatric" and considered as someone who "has a way with kids". Taking up a traineeship in paediatrics thus seemed to be a natural course. During my time as a registrar, I was awarded a rare Commonwealth Scholarship to undergo training in neonatology at The Hospital for Sick Children, Toronto, Canada — the biggest children's hospital in the world. In the early 1980s, neonatal intensive care was an evolving and rapidly advancing field in paediatrics.

In your opinion, how has the practice changed since your trainee days?

HLY: Advances in medicine and technologies have revolutionised our practices. As young doctors, we used to perform two to three exchange transfusions on babies with severe neonatal jaundice per night call. There were usually at least ten calls per month and each procedure would last between one-and-a-half to two hours. The nurse assisting the procedure in the middle of the night would wake us up when we became sleepy doing the monotonous job. The introduction of phototherapy has almost wiped out the need for exchange transfusion. Our current trainees hardly even have the chance to witness one being performed.

We could also spend the whole night trying to set drips on the scalps of babies with severe diarrhoea, using metal "butterfly" needles that needed to be sharpened and sterilised for each use. During the gastroenteritis seasons, doctors doing ward rounds would be seen using long sticks to lift up the covers of the bins by the cot side containing cloth diapers stained with stools. It was like doctors "playing golf" in the gastroenterology cubicles!

What were some of the interesting things you've experienced in your course of work?

HLY: In paediatrics, we have the unique opportunity to grow up with our young patients. There are many heart-warming stories, but there are sad ones too. On several occasions in my clinic, elderly ladies accompanying their pregnant daughters for antenatal check-ups would approach me and remind me that the lady was the sick little one whom I had taken care of when I was a young doctor.

As a solemniser, it is also not unusual that after I have united the couple in matrimony, the mother of the bride or groom would take out a well-kept health booklet of her child to point out my signature in the record. I have also met up with some of the children who have gone through very traumatic

childhood experiences of abuse. They come back with touching stories of resilience and achievements under adversities, and vow that the cycle of violence would stop at them.

One of my most memorable encounters was when I met this family in the airport departure lounge. They were going on a holiday with their daughter who has spastic diplegia and was in a wheelchair. As a young, innocent and naive doctor at that time, I had the urge to offer some words of apology and comfort. But before I could do that, the parent informed me that the girl had drastically changed their outlook in life and the family bond had never been stronger. This incident changed my perspective on disability forever.

What do you think are some of the challenges the field of paediatrics and child health faces?

HLY: In UNICEF's report on "The State of the World's Children 2015"[1], Singapore was ranked first, together with Japan, Sweden and Switzerland, for the lowest infant mortality rates and under-5 mortality rates in the world.

Childhood mortality rates in Singapore have fallen to very low levels and are now associated mainly with conditions that modern medical care cannot affect. Other population-based indices must be developed to enable proper evaluation of "how we are doing" as a community in the provision of holistic care to mothers and children.

A number of "new morbidities" have been identified to pose major challenges to child health in the next few decades. They are chronic medical illnesses; developmental disabilities; learning problems; injuries and neglect; behavioural disturbances and disorders; sequelae associated with unhealthy lifestyles; and social and emotional disorders. These are known in developed countries as "modernity's paradox". As multiple causal factors are involved, medical and other health interventions may not always be the most appropriate and effective means of providing care to these children.

The basic needs of young people are universal: a healthy start in life, an ongoing relationship with positive role models, safe places to learn and to grow, a marketable skill through effective education, and a stake in the well-being of their communities. Looking after the developmental health of the children will ensure the nation's wealth in the future. A concerted national effort is required to promote the children's capacity to achieve their potentials, and to avoid poor outcomes in health, education, behaviour and crime, and their huge costs to society.

What is your hope/advice for young doctors who aspire to be paediatricians?

HLY: There are new challenges in paediatrics and child health. The management of sick children is becoming more complex. Subspecialisation in paediatric care is inevitable. While our young doctors should be encouraged to scale the "ivory towers", it is important for them to remain competent in taking care of a child as a whole and not compartmentalised into different organs and systems. They must remain deeply rooted in general paediatrics. Paediatric subspecialties can only grow and develop from a sturdy common trunk.

Regardless of the subspecialty they venture into, they must take it as their responsibility and mission to bring the knowledge of improved care from one that is hospital-based to the community. For example, we may have the best team in the hospital in diagnosing and treating children who have been abused, but all these efforts would go to waste if the environment the child is returning to remains hostile to him. Therefore, our next generation of paediatricians must be ready to go beyond their comfort zone in medicine to advocate for the welfare and well-being of the child in the community, and to influence effective policy changes in the best interests of the child. These will require them to lead in the collaboration with primary healthcare, education, legal, and social and community services.

What do you do in your spare time? Do you have any particular hobbies?

HLY: I used to play table tennis, but I retired as the unbeaten champion at the Singapore General Hospital (SGH) by the age of 50. My study room at home is filled with novels and I intend to go through every one of them when I retire! I had no opportunity to learn any musical instrument when I was younger, but I was courageous enough to do a solo singing performance at one of the SGH Formal Dinners! I also enjoy classical music — both traditional and contemporary. I have a good collection of Rach 3 performed by different pianists and even by the same pianist at different stages of his or her performing life! I am still an active volunteer at the Singapore Children's Society, Society for the Physically Disabled and National Council of Social Service. I also spend quite some time in fulfilling my duties as a Justice of the Peace. However, the top priority is to be with my family.

Prof Ho Lai Yun is emeritus consultant, paediatrician and neonatologist at Singapore General Hospital. He is the founding head of the Child Development Unit, KK Women's and Children's Hospital and continues to be the senior consultant of the Department of Child Development. He is chairman, Residency Advisory Committee (Paediatrics) and past master, Academy of Medicine, Singapore.

A/Prof Marion Aw

What inspired you to specialise in paediatrics?

MA: There were a number of things that drew me to paediatrics.

Firstly, it was the realisation that it was quite enjoyable (even fun!) to communicate with kids through play — it meant that play could be part of my official daily work life. Secondly, it was the relative lack of mortality in paediatrics (compared to internal medicine). I recall being quite stressed as a house officer, getting frequent calls to attend to near collapsing adult patients I knew nothing about. Last but not least, the excellent role models in paediatrics whom I've encountered as a student and intern have inspired me to want to walk the same path! To watch Prof Yap Hui Kim or Prof Lee Bee Wah in action was to witness medical problem-solving at its inspirational best.

In your opinion, how has the practice changed since your trainee days?

MA: Three changes in particular come to mind:

The first is advancement in the management of complex conditions. For example, viral myocarditis in the not so distant past was almost a death sentence — we would watch helplessly as these children fade away despite intensive care unit management and inotropic support. Now, with extracorporeal membrane oxygenation, these children can be supported through their most critical period, to recover fully and walk out of the hospital!

Similarly, liver transplantation has changed the outcome for children with acute liver failure or end-stage liver disease. I was a trainee when the National University Hospital performed the first living-related liver transplant in 1996. Since then, we have done over 100 transplants in children.

Consultant-led care is emphasised a lot more now. When I was a trainee, the registrars more or less "ran" the wards. I don't think we provided any less quality care for our patients and our consultants were certainly around to be "consulted" whenever we needed them. However, the sense of responsibility for patients under our care certainly made us step up much faster.

Finally, information technology (IT) is a great boon when it comes to receiving timely updates from the wards, pulling results or even accessing reference materials on the go.

I recall having to wait daily at 4 pm for the ward's fax machine to "spit" out all the blood tests results for the patients of the day as a trainee. We would then faithfully chart all the relevant and important results into the patient's case notes. Doing department presentations also meant doing research physically in the library, writing our presentation on clear plastic sheets and presenting using overhead projectors — something I hardly encounter nowadays!

However, with IT and the ease at which we get information at our fingertips, we need to be careful not to have the mindset that committing important information to memory is a thing of the past because of Google, PubMed and Wikipedia!

What do you think are some of the challenges the field of paediatrics and child health faces?

MA: There are several, but I would highlight two.

Firstly, having appropriate resources and seeing the need to invest in child health and well-being. There is evidence that early life influences and nutrition have long-lasting effects that impact health outcomes of a population 30-40 years later. So while we may not see the impact of these investments or interventions now, we would certainly reap the rewards many years later. Paying attention to the mental well-being of children is another important aspect of paediatric care.

Secondly, while we have the capability to push diagnostic and therapeutic boundaries, we would need to have

the wisdom to know when to stop or at least pause to think about the appropriateness of our actions. For example, it could be something very personal to the patient or his family — the question of how much technology we want to use to sustain the life of a child, when all we could be doing is prolonging death from occurring.

On the other hand, it could be something with potentially far-reaching consequences such as policies regarding genetic manipulation and selection, either for treatment of disease, prevention of disease, or simply for the selection of a "healthier" individual.

What is your hope/advice for young doctors who aspire to be paediatricians?

MA: I would advise them to constantly return to the core elements of our profession. Healthcare is about human relationships. The trust that our patients place in us is sacred — it must always be cherished and never taken for granted. In practical terms, this means never forgetting the human story behind each condition in order to manage the whole person better; and in paediatrics, this is not only the child but his or her family as well.

In addition, the human relationship is one that involves not just our medical colleagues but also nursing and allied healthcare colleagues. We work as a team and we learn from each other.

What do you love about your work?

MA: I am grateful for the opportunities given to me to impact the lives of those I come into contact with in many different ways. As a paediatrician — to care for my patients and their families; as a teacher — to be a guide and role model, hopefully to inspire students and trainees, and challenge them to be the best that they can be; and as a colleague — to support and encourage my fellow co-workers to do their best for their patients.

Lastly, I love being given the opportunity to learn all the time, from patients, students and colleagues.

What do you do in your spare time? Do you have any particular hobbies?

MA: Realistically, I don't have a lot of spare time! My work at the National University Health System and National University of Singapore keeps me fairly busy.

I ring fence time for various activities. I try to exercise regularly — usually in the form of brisk walking on a treadmill three to four times per week.

Family is very important and I spend a number of evenings a week with both my husband's and my side of the family. This takes place in the form of dinners on the weekends and a Sunday lunch with my family after church. I also make it a point to catch up with old friends from secondary school and medical school — usually during the June and December school holidays.

I'm also an action movie fan and I'm always ready to indulge in a bit of escapism by parking my brains at the cinema door, but I would bring along a jacket to hide behind whenever there are tense moments! ◆

A/Prof Marion Aw is a consultant in the Department of Paediatrics, National University Hospital. Her area of clinical expertise is in paediatric gastrointestinal and liver disease. Her other passion is in medical education, where she is actively involved in both undergraduate and post-graduate teaching. Marion also currently serves as the president of the College of Paediatrics and Child Health, Singapore.

Legend

1. A/Prof Aw and a group of paediatric residents at their residents retreat

Sleep Faker

PROFILE

TEXT BY

DR TAN SU-MING

Dr Tan Su-Ming graduated from the National University of Singapore in 1990. She is married with a daughter and runs her own general practice.

My husband was very strict about afternoon naps when our child was very young. I recall when she was about five years old, my husband told me that our daughter sometimes pretended to sleep. My husband is not a doctor, so I told him how doctors sometimes check to see if a patient is truly in a coma or faking it.

"If I raise the patient's arm above his face, and the arm falls directly onto his face when I let go of his arm, it's likely to be genuine," I continued, "but if on letting go of the arm, the arm falls nicely into place beside the patient, avoiding the face, it may be a put-on."

My husband said he would try this out on our sleeping child. When he returned, he laughed and said, "She's the ultimate faker!" "How did the test go?" I inquired.

"When I lifted up her arm, it stayed straight in the air!" ◆

SEND IN YOURS TODAY!

Have you recently experienced an interesting patient encounter or a heartfelt moment that you're eager to share? Perhaps you enjoy putting your thoughts to doodles and illustrations instead of words? Whether it's a short anecdote, poem, cartoon or a comic strip, send them in to us at **news@sma.org.sg** today!

OVERCOMING THE LAST MILE ON DIABETES

PROFILE

TEXT BY

DR CLIVE TAN

Dr Clive Tan is a public health physician in the public sector. He recently returned from a posting to the World Health Organization and is busy getting re-acquainted with the local food scene (eating healthily of course!).

TEXT BY

DR KWONG SEH MENG

Dr Kwong Seh Meng is a general practitioner in private practice. He has a strong family history of diabetes.

ARTWORK BY

DR NGIAM XIN YING

Dr Ngiam Xin Ying is a paediatrician in private practice.

Legend

1. Screenshot from Dr Kwong's Facebook post

Here's the situation. You're sitting at the dinner table with your extended family. Your cousin, who just turned 40 years old, asks you, "My GP told me last week that I have diabetes and I must take daily medications… What is diabetes? Can it be cured?"

What do you do? Do you…

A. Jump at this opportunity to segue into your well-rehearsed ten-minute monologue on the pathophysiology of diabetes, expound on the latest research reports and impress upon your cousin the importance of a healthy diet and regular exercise;
B. Take his rice bowl away and tell him to eat less white rice; or
C. Welcome him to the club and show him the medications you are taking?

If you chose option A (which many of us would have done at some stage of our lives), you might receive several responses:

1. "Huh? Too much information! If I just pop the white pill every morning and eat less, I'll be okay, right?"
2. "Cannot cure *ah*! Die *lah*, die *lah*… Is it too late to buy insurance?"
3. "So what you are saying is that my pancreas isn't secreting enough hormones to break down the sugars in my blood, and if my blood glucose level becomes too high, it can damage my eyes, kidneys, skin, blood vessels and nerves. Okay, sounds straightforward!"

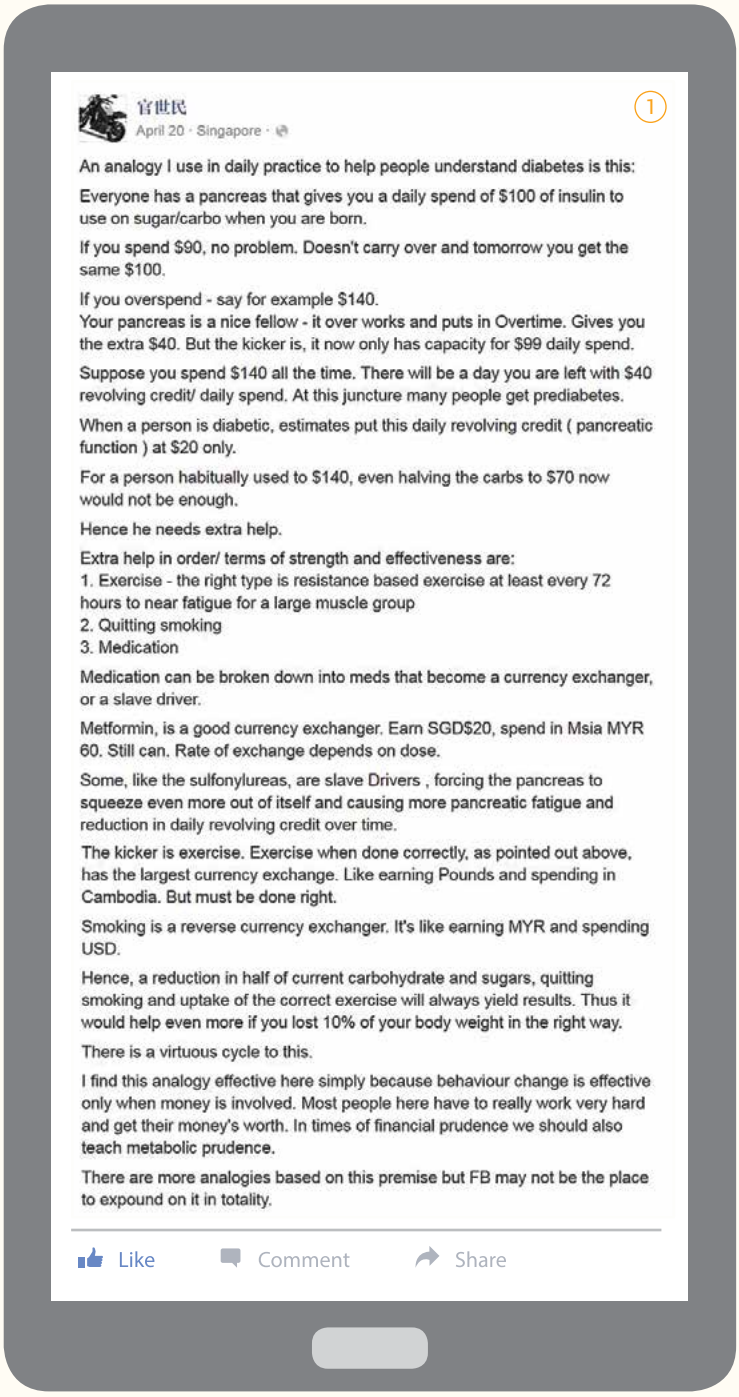
While improving health literacy and promoting self-management have been identified as critical factors for patients to better manage their diabetes, the practice is challenging. As shown by the example above, the level of readiness in both the healthcare professional and patients (and their families) need to correspond, and they need to journey together towards better patient knowledge of the health condition and the ability to self-manage.

Perhaps there can be better ways to share this health information with patients and their families, in a way that makes sense to them and is "sticky".

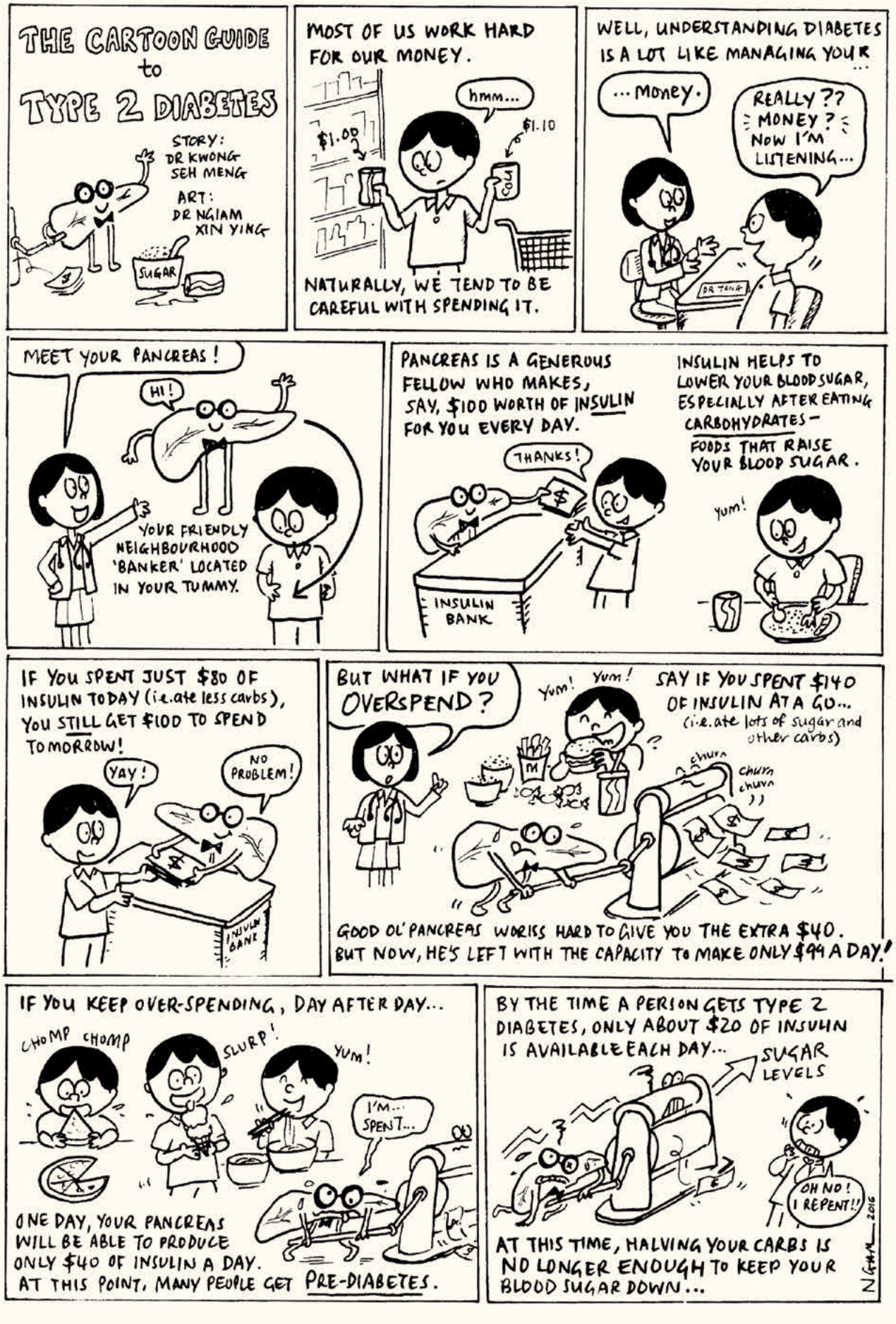
However, knowledge does not always translate into behavioural change. Tobacco cessation is a fine example. Yet, knowledge and awareness are critical enabling factors for changing behaviour; knowledge of how the condition can threaten one's current way of life, and knowledge and skills in how the condition can be controlled and managed.

The government's war on diabetes has gone some ways in generating awareness on the condition, and it promises to restructure services to be more people-centred. Technologies and medicines that support the prevention and treatment of diabetes will also become more accessible. But the doctor's office and the patient's home is where the battlefield for overcoming the last mile on diabetes truly takes place.

There can be many reasons why health literacy is low in a country where literacy is almost 100%, but the important takeaway here is the huge potential for improving health literacy, since we are starting from such a low baseline. As shown in the Facebook screenshot, crafting health messages that can appeal to the masses and are "sticky" is an innovative way to help patients and families better understand and manage their medical conditions. ◆

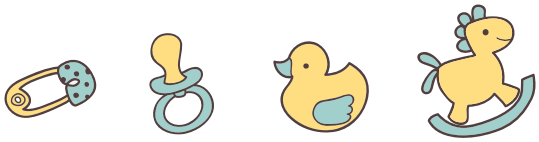


> "In the doctor's office and in the patient's home is where the battlefield for overcoming the last mile on diabetes takes place."


THE CARTOON GUIDE to TYPE 2 DIABETES
STORY: DR KWONG SEH MENG
ART: DR NGIAM XIN YING
SUGAR
MOST OF US WORK HARD FOR OUR MONEY.
hmm...
$1.00
$1.10
COLA
NATURALLY, WE TEND TO BE CAREFUL WITH SPENDING IT.
WELL, UNDERSTANDING DIABETES IS A LOT LIKE MANAGING YOUR ...
... MONEY.
REALLY?? MONEY? NOW I'M LISTENING...
DR TANG
MEET YOUR PANCREAS!
HI!
YOUR FRIENDLY NEIGHBOURHOOD 'BANKER' LOCATED IN YOUR TUMMY.
PANCREAS IS A GENEROUS FELLOW WHO MAKES, SAY, $100 WORTH OF INSULIN FOR YOU EVERY DAY.
THANKS!
INSULIN BANK
INSULIN HELPS TO LOWER YOUR BLOOD SUGAR, ESPECIALLY AFTER EATING CARBOHYDRATES — FOODS THAT RAISE YOUR BLOOD SUGAR.
YUM!
IF YOU SPENT JUST $80 OF INSULIN TODAY (i.e. ate less carbs), YOU STILL GET $100 TO SPEND TOMORROW!
YAY!
NO PROBLEM!
INSULIN BANK
BUT WHAT IF YOU OVERSPEND?
YUM! YUM!
SAY IF YOU SPENT $140 OF INSULIN AT A GO... (i.e. ate lots of sugar and other carbs)
M
CHURN CHURN
GOOD OL' PANCREAS WORKS HARD TO GIVE YOU THE EXTRA $40. BUT NOW, HE'S LEFT WITH THE CAPACITY TO MAKE ONLY $99 A DAY!
IF YOU KEEP OVER-SPENDING, DAY AFTER DAY...
CHOMP CHOMP
SLURP!
YUM!
I'M... SPENT...
ONE DAY, YOUR PANCREAS WILL BE ABLE TO PRODUCE ONLY $40 OF INSULIN A DAY. AT THIS POINT, MANY PEOPLE GET PRE-DIABETES.
BY THE TIME A PERSON GETS TYPE 2 DIABETES, ONLY ABOUT $20 OF INSULIN IS AVAILABLE EACH DAY...
SUGAR LEVELS
OH NO! I REPENT!!
AT THIS TIME, HALVING YOUR CARBS IS NO LONGER ENOUGH TO KEEP YOUR BLOOD SUGAR DOWN...
NGHAM 2016


BUT WHAT ELSE CAN I DO - BESIDES CUT DOWN ON CARBOHYDRATES?
① EXERCISE
② STOP SMOKING
③ MEDICINES
"currency exchangers"
"slave drivers"
HAVE NO FEAR! HELP IS AT HAND.
LET'S TALK ABOUT MEDICINES FIRST.
"CURRENCY EXCHANGERS" LIKE METFORMIN HELP YOU GET MORE BANG FOR YOUR INSULIN BUCK.
(in doctor-speak, it's "lowering your insulin resistance")
OOH, LIKE SHOPPING IN JB!! S$1 = RM3!
YEAH!
SALE
SALE
ON THE OTHER HAND, "SLAVE DRIVERS" LIKE SULPHONYLUREAS (eg. glipizide, glibenclamide) FORCE THE PANCREAS TO PRODUCE MORE INSULIN.
FASTER!?
gulp!
EVENTUALLY, THIS BACKFIRES AS THE POOR PANCREAS GETS FATIGUED & ITS CAPACITY TO PRODUCE DECREASES OVER TIME.
SMOKING IS NOT A GOOD IDEA FOR DIABETICS. IT'S A "REVERSE CURRENCY EXCHANGER" — LIKE EARNING IN RINGGIT AND SPENDING IN BRITISH POUNDS. (doctor-speak — 'increasing insulin resistance')
£1
WHAT?!! THAT'S RM5.50!!
THAT'S IT! I'M QUITTING SMOKING!
EXERCISE IS THE BEST CURRENCY EXCHANGER (when done correctly)! LIKE EARNING IN BRITISH POUNDS & SPENDING IN INDONESIAN RUPIAH!!
YEAH! GO! GO! GO!
I FEEL RICHER ALREADY!
200 KCALS BURNT
WITH WISE CURRENCY EXCHANGE PRACTICES - AND REDUCING SPENDING - YOU CAN REALLY STRETCH YOUR INSULIN DOLLAR.
BEST GLYCEMIC CONTROL AWARDS
1
AH! NOW I CAN RELAX A BIT!
YOUR PANCREAS WILL THANK YOU FOR IT.
SO... DO YOU NOW KNOW SOME GOOD WAYS TO MANAGE TYPE 2 DIABETES?
EASY!
① CUT CARBS/ SUGAR BY HALF
② EXERCISE
③ QUIT SMOKING
④ TAKE MEDICINES AS PRESCRIBED
DR TANG
VERY GOOD!
SO, JUST AS WE SHOULD BE WISE WITH OUR MONEY...
WE SHOULD BE CAREFUL WITH OUR "INSULIN SPENDING" TOO!
HEAR, HEAR!
NGIAM 2016
THE END

THE FIRST OF FOUR?



PROFILE

TEXT BY

DR JONATHAN TAN

Editorial Board Member

Dr Jonathan Tan is currently an orthopaedic resident at the National University Health System. A dwarf in a department of giants, his hobbies include falling asleep while studying, resubmitting rejected journal articles and trying to not stutter during morning teachings. He is grateful for the opportunity to pursue his dreams and hopes to become a good orthopaedic surgeon and help educate future trainees. He is thankful for the love and support of his parents and wife, without which none of this would be possible.

We had always agreed that four was the magic number. I have two siblings and my wife has four, so we compromised and agreed we'd have four kids. I have always loved children and had at one point wanted to be a paediatrician. That was until I attended my first paediatric nephrology round and realised that I didn't quite have the brainpower or calculating skills needed, so I decided to pursue a different path.

However, one does not simply promise multiple grandchildren at one's wedding without being constantly reminded about it, and I knew my wife and I had a lot to live up to. Babies, however, were the furthest thing from my mind when I returned home a month after our wedding. It had been a long day in a heavy lead gown and I did not expect my wife to greet me at the door with a surprise. Perhaps X-rays really are bad for brain cells, because I did not quite grasp what the strange plastic device with the red lines meant. It was not until I saw the tiny pair of shoes next to it that the penny finally dropped: I was going to be a father. My wife likes to claim that I teared up at the thought of being a father, while I'd like to believe that it was the onset of a previously undiagnosed adult allergy that brought the tears to my eyes.

The first trimester was hard on the both of us. While she had to juggle running a busy psychiatric ward, her examinations and a baby with an amazing knack for causing morning sickness, I had my own bout of adjustment disorder. I had never had problems with my working hours before or any doubts that this was what I wanted to do for the rest of my life; but for the first time, doubt crept in. *Did I really want to be closing up a wound at 9 pm, miss dinner with my wife and not know how she and the baby were doing? What else would I miss in the future?* Needless to say, I was not my most cheerful or enthusiastic self for those few months.

However, there were happy moments too, like the first time I heard my child's heartbeat on the ultrasound, and that magical moment when he began to take on a discernibly humanoid appearance on the screen. The adjustment disorder improved as the morning sickness of the first trimester was replaced by the glow of the second, and I gained a different perspective. Usually, I'd be asking my bosses how to fix fractures or write papers, but for the first time, what I really wanted to know was how they managed to juggle being a good father, surgeon and researcher/educator. It made for some good and some awkward conversations, but it gave me hope that I could put my family first and still be a good surgeon at the same time.

Of course there was still the small matter of finding out if the baby was a boy or girl. Unfortunately, the baby decided to use his femurs to hide his gender from the earlier ultrasound and it wasn't till Father's Day, deep in the second trimester, that I found out he was going to be a boy. At the risk of sounding like an MCP (not metacarpophalangeal joint, but male chauvinist pig), I'd always hoped that my first child would be a boy. Finally, someone just like me but better; maybe he'd win a rugby gold medal for my alma mater; maybe he'd become a prefect like his grandfather had wanted; or maybe he'd publish in *Cell* or *Nature* one day and not write non-peer-reviewed articles like his father. Of course, my wife, being more sensible (and well-read in child psychiatry), advised me that this was far too much pressure to place on the shoulders of a little boy, and I scaled down my expectations to him being a happy, filial and kind human being. Although I did ask her why he couldn't be all of the above at the same time…

And now, the countdown to his birth day begins. I wonder each day if each kick is a harbinger of contractions. The cupboard is packed with tiny baby clothes and his room with a cot, a pram and boxes full of diapers and wet wipes. I'd always thought that becoming a doctor was pretty cool, but I had not realised that there was a job even better than that — and so my watch begins. ◆

FORMING MEMORIES WITH CHILDREN

A few years after I graduated from Fellowship, I met up with one of my co-fellows, Dr BF, at a conference in San Diego. We shared details of our lives, and invariably talked about our families and finances. Like most American doctors fresh out of Fellowship, Dr BF had a six-digit tuition debt. In spite of this, his spouse had insisted that they go for a good vacation every year. She felt that it was important to develop fond memories with their children.

That got me thinking — Emily and I had three very young children at that point, and traveling on a plane for a "holiday" sounded more like a major combined air, land and sea operation. Thus, being the ever pragmatic, hassle-free Singaporean, I opted to do nothing. However, after reflecting on both Dr BF's words and my own childhood experiences, I realised that there is merit in having annual vacation trips with the children — I will always remember the coach trips to Malaysian towns with my family, my first flight to Bangkok, and playing on the beaches of Pattaya with my sister…

And so, the moment my youngest child was self-propelling, I planned for not one but two trips at once. Our first destination was Seoul, South Korea. The flight was an adventure in itself, but with my kids being slightly older, they handled themselves well and thoroughly enjoyed the plane ride. The other adventure was when we struggled with food orders at little eateries, in our attempt to savour the local cuisine — all because we were much influenced by *Jewel in the Palace*.

On our trip to Japan, we flew in to Kobe and travelled to Osaka to see the city. It was a real adventure negotiating the railways and subway lines. (Foreign visitors can sign up for the Kansai Thru Pass and avail themselves to unlimited travel on certain railways and subway lines.) We then visited Kyoto before finally ending up in Kobe again. There, we visited the Kobe Earthquake Memorial Museum and the children learnt to be prepared for an earthquake.

With that success, we have been going on trips at least once a year. In 2013, we made a long journey to the US where we embarked on the quintessentially American vacation — a road trip. We visited friends in Cincinnati and Cleveland, and the walk through the wintry landscape in the Cleveland Metroparks reservation when the first snow had just fallen was an unforgettable experience. We wound up our holiday in New York City during Thanksgiving week. Standing around the block in Times Square waiting for Toys"R"Us to open on Black Friday, having a turkey dinner in the hotel, and fidgeting about in the bitter cold for Macy's parade are some of the all-American memories deeply etched in my memory. The following year, we travelled to Melbourne, Australia. The children learnt much about the unique animals of Australia. We also visited Sovereign Hill, an old gold mining town in Ballarat, where they enjoyed wearing the wide brim leather hats as miners.

When I look back on the last few years, the kids have grown up really fast. The eldest is now taller than Emily and they will someday leave for college and get on with their own lives. In the end, there is nothing more meaningful in our lives except the friends and families we have, and the memories we all share. And in these memories we live forever. ◆

PROFILE

TEXT BY

DR JIMMY TEO

Editorial Board Member

Dr Jimmy Teo is an associate professor in the Department of Medicine, NUS Yong Loo Lin School of Medicine and senior consultant in the Division of Nephrology at National University Hospital. He is the Division of Nephrology Research Director and an active member of the Singapore Society of Nephrology.

Legend

1. First snowfall in Metroparks, Cleveland, Ohio, USA

PROFILE

TEXT BY

DENISE TAN

Assistant Manager, SMA Centre for Medical Ethics and Professionalism

INTRODUCTORY COURSE IN HEALTH LAW

Legend

1. A doctor clarifying his doubt during the question and answer segment

The Introductory Course in Health Law, a collaboration between SMA and JurongHealth, rounded up its last session on 3 September 2016 at the Ng Teng Fong General Hospital, Tower A, Auditorium. The course was held over the four first Saturdays from June to September, covering the following topics:

- Introduction to Health Law and Legal Responsibilities of Medical Practitioners
- Understanding the Elements of Medical Negligence
- Professional Accountability and Misconduct
- Medical Experts and Report Writing

On average, close to 80 doctors and hospital administrators attended each session. The course covered the basic concepts of health law, which is relevant to all practising doctors and of greater value to medical leaders and teachers, especially for those who have had no previous education in this area.

The course was delivered by the SMA Centre for Medical Ethics and Professionalism's (CMEP) regular core faculty which consisted of doctors and lawyers.

Participants gave feedback stating that the course is an "excellent series for doctors", has "interesting topics" and is a "good session where valuable knowledge [was] gained".

Introduction to Health Law and Legal Responsibilities of Medical Practitioners

The first session, held on 4 June, was covered by Ms Rebecca Chew, deputy managing partner of Rajah & Tann Singapore LLP, and A/Prof Seow Wan Tew, head of the Department of Neurosurgery and deputy medical director of Academic Affairs at National Neuroscience Institution. Ms Chew gave an introduction to the law relating to healthcare professionals. A/Prof Seow then dealt with the relevant statutes that have major impact on medical practice.

1

Understanding the Elements of Medical Negligence

The second session, held on 2 July, saw Mr Edmund Kronenburg, managing partner of Braddell Brothers LLP, speak about the concepts of medical negligence and the elements of negligence: duty, breach and damage. A/Prof Lee See Muah, senior consultant at Ng Teng Fong General Hospital and adjunct associate professor at Saw Swee Hock School of Public Health, talked about the ethical and legal perspectives of informed consent.

Professional Accountability and Misconduct

The third session, held on 6 August, was led by Mr Lek Siang Pheng, senior partner of Dentons Rodyk and Davidson LLP, and Dr Peter Loke, regional medical advisor of Syngenta Asia Pacific Pte Ltd. They looked at critical issues on the Medical Registration Act and the Singapore Medical Council Disciplinary Proceedings, as these affect the performance of individual doctors and medical practice.

Medical Experts and Report Writing

In the fourth and final session held on 3 September, Ms Kuah Boon Theng, director of Legal Clinic LLC, and Dr T Thirumoorthy, immediate past executive director of SMA CMEP, discussed the roles of and what to expect as a medical witness, and gave tips on writing a medical report. The audience also clarified their doubts about the Bolam and Bolitho tests, issues of determining the professional standards, and disclosure of risk as a professional competency during the question and answer section.

We would like to thank speakers from the SMA CMEP core faculty for their time and effort, and JurongHealth for providing the venue and food. ◆

The Conundrum of Resource Allocation

When Much is Not Enough

Healthcare is a bottomless pit. No matter how resources are obtained or distributed, demand will always exceed supply. In historical times, when medicine, such as there was, was much less successful at prolonging life or relieving suffering, it mattered less that the best healthcare was available only to the relatively affluent. Life was "nasty, brutal and short" for most, even the privileged.

Healthcare is much more capable today. Lifespans have lengthened, mostly because of environmental improvements such as better sanitation, water supply and nutrition, but also because medicine can simply do more. Where once patients suffered and died, today they could be cured sometimes, cared for often, but always comforted,[1] as they live longer lives so afforded. All of these consume resources.

RESOURCE ALLOCATION

When demand exceeds supply for any goods, there must necessarily be some mechanism to decide who gets and who goes without, as any Economics textbook would explain. It is not possible to provide every healthcare service of potential benefit to everyone who needs (or merely wants) them. This is especially so with the ageing and multi-morbid population, increasing medical capabilities and concomitant costs, inherent and sometimes intractable wastage and inefficiencies, and local and international competition for consumers, professionals and providers.

Resource allocation is subject to the Iron Triangle of Access, Quality and Cost: "Who gets what quality and at what cost?" Allocation can be at what is known as the *macro* level (or the systems level; eg, how much for healthcare compared to other sectors), the *meso* level (or the organisational level; eg, how much for which providers) and the *micro* level (or within the care delivery process; eg, what does each patient get and not get), based on a mix of competing principles of equality, equity, rights, outcomes and the ability to pay. The conversation is complicated by the different weights, and even different definitions, that people give to these principles.

Ultimately, when there are insufficient resources to accommodate all needs, some will be denied. Healthcare rationing

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.

is "a conscious decision or the adoption of an explicit policy that excludes certain persons with known medical need from treatment that might save, prolong or significantly enhance the quality of their lives."[2] The paradigmatic example of rationing in healthcare is the triaging of casualties on the battlefield, but this will occur at all levels and in all situations. There is thus a need for clear, fair and publicly acceptable institutional and professional policies to ensure that such decisions are transparent and defensible and to avoid arbitrary "bedside" rationing. If the clinician is unsure of their institution's policy and practices, it is important that they ask for guidance.

Resource allocation in the public sector is especially critical, being subject not just to economics but to politics, society and nationhood as well. It is an increasing challenge to balance the obligations to current and potential patients under the care of one doctor, one department, one hospital, one cluster and at the national level. Serving one patient can mean depriving another, if not of actual material resources, at least of the professional's time and attention. More resources for healthcare may compromise other national priorities like education, housing and national defence, and ultimately national economic survival.

Resource allocation in the private for-profit sector balances between the need to do the best for each patient and the sustainability and profitability of the business. The obvious danger here is over-servicing, to provide any service so long as the patient can pay. Higher prices are one way to increase profit, but there are constraints to how much prices can be raised before the payers push back, so increasing volume and frequency is an alternative.

Profits are revenues less expenditure, so another less obvious temptation is to under-provide resources to control costs. For example, where optimal resourcing for best operational efficiency and clinical effectiveness might recommend a particular surgical device in each of three operating theatres and an additional spare in the storeroom to minimise risks and maximise throughput, an organisation more concerned for its capital outlay would have just one for all three theatres and none in the storeroom.

HEALTHCARE FINANCING

The allocation of healthcare resources ultimately rests on the foundation of the financial organisation of a country's healthcare. There are many national models for healthcare financing because they can differ on how resources are gathered (eg, general taxation, social and community insurance, charity, fee-for-service), governed (eg, central direction, legislative direction, commissioning, through employers, free market), risk-pooled (eg, as governmental budgets, through various types of insurance, through families and communities), and finally distributed (eg, through public, private and charity organisations) in many configurations.

Singapore has elements of many of the above, and emphasises free choice of services, self and family accountability, and reliance on

free market competition, with the Government as the provider of last resort. There is a two-tier system within the public sector which on one level provides access to decent subsidised healthcare, and on the other, competes directly with the private for-profit sector without societal subsidies. The so-called "public sector" is operating very much in the private sector space.

It is not easy to specify what a "decent minimum" in healthcare is. Would this prefer the therapeutic to the enhancement, or life-saving to improving quality of life? There can be compromises on the ground to both the access and quality of healthcare if healthcare organisations focus on their business interests, and there is thus a need for institutional or organisational ethics (which will be the subject of another article).

THE CLINICIAN'S ROLE

What is the clinician to do in practice amid such complexity? Every clinician, no matter how august or powerful, is still only one cog in a vast machinery. Many, if not most, resource allocation decisions that affect an individual doctor's care delivery are beyond their control.

McKneally et al[3] point out that the clinician's goal is to provide optimal care within the circumstances that pertain to the situation, including any unavoidable or imposed limits. The clinician should therefore:

- Choose interventions known to be beneficial on the basis of evidence.
- Minimise the use of marginally beneficial tests or interventions.
- Seek the tests or treatments that will achieve the goal for the least cost.
- Advocate for one's own patients but not manipulate the system to gain unfair advantage.
- Resolve conflicting claims for scarce resources justly and on the basis of morally relevant criteria (like need and benefit).
- Inform patients of the impact of cost constraints, but do so in a sensitive way without blaming others and increasing anxiety.
- Seek resolution of unacceptable shortages at the appropriate levels.

It can be a challenge for the clinician to handle this complexity at the bedside, especially in conversation with distressed patients and anguished relatives. It may be true that a particular resource (eg, an intensive care unit bed) is in high demand and that one patient's occupancy deprives another perhaps needier patient, but it would be disastrous to speak too plainly. People do understand that other people need care as well and can sympathise with the clinician's dilemma, but are less receptive when it appears that other people have apparently higher priority or preference. While they accept that other patients also need as much appropriate attention, they would not like to feel that they themselves are receiving less.

It would also be counterproductive to blame the administration or, in the public sector, the government. This only aggravates the distress and angst of the patients and their families and adds little to the therapeutic environment. It implies that "more could be done, if only…", leading to more guilt, anger and dissatisfaction.

Some might argue that such a course of action is not only unprofessional of the clinician, but also cowardly to thus deflect responsibility to others if the objective is only to direct anger and angst away from themselves. We are all part of the same healthcare system. Of course, the clinician is not to blame if resources are insufficient, but neither are the hospital administrators nor the government who have their own challenges to make supply meet demand.

Ultimately, the focus needs to be on the healing and caring of the patient. Clinicians must advocate for their own patients and act in their best interests within the limits imposed on their capabilities by the circumstances, understanding that even if more resources were available, the demand would simply ratchet up to create the next gap.

CONCLUSION

Doctors trained to do the best for every patient will inevitably find limits to what they can do. Sometimes it is just the current state of the art. Sometimes it is the patient who comes too late or who does not cooperate with treatment. The doctor learns to deal with these, but when a resource, possibly available to others or just within arm's reach, is denied because of allocation rules, it can be hard to swallow. The art and science of medicine today extends beyond managing just the patient. ◆

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1. Variously attributed to Hippocrates, Benjamin Franklin, Edward Trudeau and others.
2. Priester R, Caplan AL. Ethics, Cost Containment, and the Allocation of Scarce Resources. Investigative Radiology 1989;24:918-26.
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DEALING WITH

INTIMATE PARTNER VIOLENCE

THE GP'S ROLE

Over the last 20 years that I (Su-Ming) have been practising as a GP, I can count with my fingers the number of times where women (and one man) presented themselves at my clinic, telling me that they had been abused by their spouse or partner.

After my research for this article, including what I have learnt from my co-author (Hui Min), I now understand that they had probably suffered for several years before they mustered the courage to seek help from me — their doctor. A straw had broken the camel's back and a line had been crossed before they decided to do something to change their circumstances.

There are many barriers, both for the abused person and the GP, in the reporting of and dealing with intimate partner violence (IPV). (*Note: Although men may also be victims of IPV, I will refer in this article primarily to the woman as the victim since statistically, more women than men experience it.*[a]) The woman may believe that physical or psychological abuse is normal in a marriage, feel too ashamed to talk about it, blame herself for it, or even doubt that anything can be done about it. In my opinion, my index of suspicion as a GP might have been too low and I might have been too awkward and unsure to ask the question, or felt diffident about my ability to intervene and what effect it would have had.

I now know that I may often be the first contact that a woman suffering from IPV makes with a "formal" agency (ie, a professional person or body) when she is seeking help, and my attitude and approach during that initial visit could make all the difference between her going on to seek further help to change her circumstances or retreating back into her shell.

Without intervention, the violence usually escalates and continues in frequency and severity. She may present not with injuries (which she hides) but with symptoms like anxiety or insomnia and/or, depression or somatisation.

Research shows that an abused woman may be waiting for her doctor to ask her if she has been abused. And if a woman has not been abused, she would not take offence at being asked.

WHAT CAN GPS DO?

These are some things that I believe we can do as health professionals to help detect IPV earlier so that it can be stopped, for the sake of the woman and any children in the family. With that, the perpetrator of the violence will also have a chance to be reformed sooner.

1. **Consider the possibility.** Have a high index of suspicion about family violence. Search actively for the early presentation of IPV, which may not be in the form of an obvious physical injury. She may have repeated "accidental" injuries or may describe the "accident" in an embarrassed or evasive way. The extent of injury may be inconsistent with the explanation by the patient. There may be an inexplicable delay between the time of injury and presentation for treatment. The patient may present with physical symptoms (eg, headache, nausea, stomach ache) for which no physical explanation can be found. This may be particularly common among women whose first

language is not English and who may find it hard to express their feelings and suffering. Also note if the partner accompanies the patient, and insists on staying close and answering all the questions.

2. **Ask the question.** The patient will not mind being asked directly if she has suffered abuse from her partner/spouse if the doctor is sensitive, respectful and non-judgemental in his or her approach and if the patient's confidentiality is assured.
3. **Document.** If she has visible physical injuries or any non-bodily evidence (eg, torn clothing), document them meticulously. Your notes may be essential for use as evidence in court proceedings.
4. **Assess the present situation.** Is there any present danger of further IPV that needs immediate attention/referral to social services?
5. **Provide resources.** Be aware of all the social service agencies that are available to help the abused person so that you can make the necessary referrals.
6. **Remember — it's her decision.** Offer her realistic choices but respect her decision if she decides not to do anything yet. It may take a very long time for a woman, demoralised by years of violence, to find the confidence and courage to choose a different life for herself and her children.

If you provide her with a contact number where she can seek help, she will keep it until she feels ready to make a change to her circumstances.

WHO CAN HELP?

Family violence specialist centres

These centres provide specialist family violence intervention work, including assistance with applying for a Personal Protection Order (PPO) (see "Legal Framework for IPV"). Refer your patient to these centres if you think the IPV is serious and the patient is very emotionally distressed or ambivalent about getting help.

PAVE (http://www.pave.org.sg)
Block 211, Ang Mo Kio Avenue 3,
#01-1446, Singapore 560211
Tel: 6555 0390
Email: admin@pave.org.sg

TRANS SAFE Centre
(http://www.transfamilyservices.org.sg)
Block 410, Bedok North Avenue 2,
#01-58, Singapore 460410
Tel: 6449 9088
Email: transsafe@trans.org.sg

Care Corner Project Start
(http://www.carecorner.org.sg)
Block 7A, Commonwealth Avenue,
#01-672, Singapore 141007
Tel: 6476 1482
Email: projectstart@carecorner.org.sg

Family service centres (FSCs)

These centres offer a broad range of services to the public, including help with financial, parenting and marital difficulties. Refer your patient to an FSC if she prefers going to a place near her home. There are 47 FSCs located in Housing and Development Board towns around Singapore. To find out which is the most convenient FSC for the patient to visit, you can call 1800 222 0000 or check online at http://www.msf.gov.sg/fsclocator.

WHAT SORT OF HELP IS AVAILABLE?

Counselling

- Assists the abused woman in processing her experiences, and helps her make a decision on how to move forward and help herself.
- Provides support to child witnesses of family violence.
- Helps break the cycle of IPV through showing perpetrators of violence alternative ways of expressing themselves and to challenge their beliefs which contribute to the use of violence.

PROFILE

TEXT BY

DR TAN SU-MING

Dr Tan Su-Ming graduated from the National University of Singapore in 1990. She is married with a daughter and runs her own general practice.

TEXT BY

MS LIM HUI MIN

Ms Lim Hui Min is currently the Director of Legal Aid. She has published numerous articles on civil and family procedure and family law, and edited and contributed to a number of books in these areas. In 2014, she published her first book, *Juvenile Justice*, on youth law in Singapore.

Disclaimer:
The views expressed in this article are solely the authors' own, and not the views of the Legal Aid Bureau or the Ministry of Law.

Safety planning; places of safety

- The abused woman can be assisted with making a safety plan on what to do if the IPV recurs (eg, to keep important documents and personal belongings packed in a suitcase in a safe place, so she can leave the family home quickly if necessary).
- She can also be referred to a crisis shelter if she urgently needs a place for her and her children to stay, to escape the IPV.

Financial and practical help

- The abused woman can be given/referred for financial and other practical help (eg, food rations, cash, employment assistance).

Legal help

- The abused woman may need legal help not just on family violence issues, but on divorce, custody and access to children, maintenance and other matters. She can be referred to legal clinics run by organisations such as the Law Society or to the Legal Aid Bureau.

LEGAL FRAMEWORK FOR IPV[b]

PPO application and process

The victim can apply to court for a PPO against her abusive spouse or ex-spouse. This is a restraining order which forbids the perpetrator to commit family violence[c] against the person named in the order. After the application is made, the court will serve the perpetrator the court papers and fix a date for both parties to attend court. At the court hearing, the PPO can be made if the perpetrator agrees to it. If he does not agree, there will be a trial on the matter. In addition to police reports filed by the abused woman, the GP's medical report on the injuries suffered by the victim will be important to support the PPO application and court proceedings.

Expedited order, counselling and DEO

At the time the PPO application is made, if the court is of the view that the victim is in imminent danger of further family violence, the court can also make an expedited order, which is a temporary "emergency" PPO. This provides protection to the victim pending the court hearing.

When granting a PPO, the court can also order that:

- the perpetrator and the victim (as well as their children) are to attend counselling at a social service agency; and
- a Domestic Exclusion Order (DEO) be made, where the perpetrator is forbidden from staying in the matrimonial home, or from entering certain areas of the matrimonial home (eg, the bedroom where the victim sleeps), for a certain period of time.

Penalty for breach of PPO/DEO

If the perpetrator commits further violence despite the PPO, or breaches the DEO, the victim may call the police, who can arrest the perpetrator without a warrant. The penalty for breaching a PPO/DEO is a fine of up to $2,000 or imprisonment for a term of up to six months, or both, for a first offence; and for a second or subsequent offence, a fine up to $5,000 or imprisonment for a term of up to 12 months, or both.

Note: IPV between partners who are not legally married do not fall within the legal framework described above. However, there are other civil and criminal remedies available for such persons, which are beyond the scope of this article. For such cases, you can refer the patient to the social service agencies set out above, which can link them to the organisations which can provide them with legal advice. ◆

Acknowledgement

The authors are grateful to Dr Sudha Nair (Executive Director, PAVE), Beulah Li (Assistant Director, Legal Aid) and Tan Rou'en (Assistant Director, Legal Aid Bureau) for their help with this article.

Notes:

a. A study conducted by the then Subordinate Courts on family violence cases between 2003 and 2004 revealed that 82% of all PPO applicants were female. Information is taken from page 13 of the October 2009 issue of *Protecting Families from Violence – the Singapore Experience*, a publication by the Rehabilitation, Protection and Residential Services Division, Ministry of Community Development, Youth. Available at https://app.msf.gov.sg/Portals/0/Summary/research/Protecting%20Families%20from%20Violence_The%20Singapore%20Experience_2009.pdf.
b. Please see Sections 65 and 66 of the Women's Charter.
c. This includes threats of violence, confinement against one's will and continual harassment (See Section 64 of the Women's Charter).

Further readings:

1. Management of Family Violence. The Singapore Family Physician. Available at http://cfps.org.sg/publications/the-singapore-family-physician/article/127.
2. Heath I. Domestic Violence: The general practitioner's role. Available at http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/Domestic-violence.ashx.
3. Hattery A, Smith E. The social dynamics of family violence. Colorado: Westview Press, 2012.
4. Ministry of Social and Family Development. Protecting families from Violence. The Singapore experience. Available at https://app.msf.gov.sg/Portals/0/Summary/research/Protecting%20Families%20from%20Violence_The%20Singapore%20Experience_2009.pdf.
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6. Global Family Doctor. Why we need an special interest group on family violence. Available at http://www.globalfamilydoctor.com/site/DefaultSite/filesystem/documents/Groups/Family%20Violence/reasons%20SIG%20family%20violence.pdf.

Preparing our doctors for public health emergencies

The seasonal haze might come to Singapore often, but the Public Health Preparedness Clinic scheme (PHPC) will give participating General Practitioners (GPs) a leg up in dealing with any such public health emergencies

About the PHPC scheme

Introduced in early 2015, the PHPC scheme provides support to GPs during public health emergencies such as flu pandemics and severe haze. It provides GPs with:

- Medication for staff prophylaxis
- Training support
- Access to the national stockpile for medications and/or vaccines relevant to the public health emergency
- Personal protective equipment (PPE) (such as N95 masks, examination gloves, isolation gowns and surgical masks)
- Access to government subsidies for treatment(s) relevant to the public health emergency through the **Haze Subsidy Scheme (HSS)**

Online claims submission for the Haze Subsidy Scheme (HSS) is now available

The claims submission for the Haze Subsidy Scheme (HSS) can now be made online, similar to the Community Health Assist Scheme (CHAS), and does not require submission of hardcopy claim forms. The submissions will be made via a new module on the existing **CHAS Online** platform. Upon scheme activation, participating clinics can access the module. All existing admin features in CHAS Online will also be extended to HSS claims, such as the tracking of claim status and extraction of claim report.

Please note that clinics can only see the **"PHPC Download" tab when the scheme is activated.*

Easy Administration in just 3 steps

1) You will receive an SMS and email notification at least 24 hours before the HSS implementation

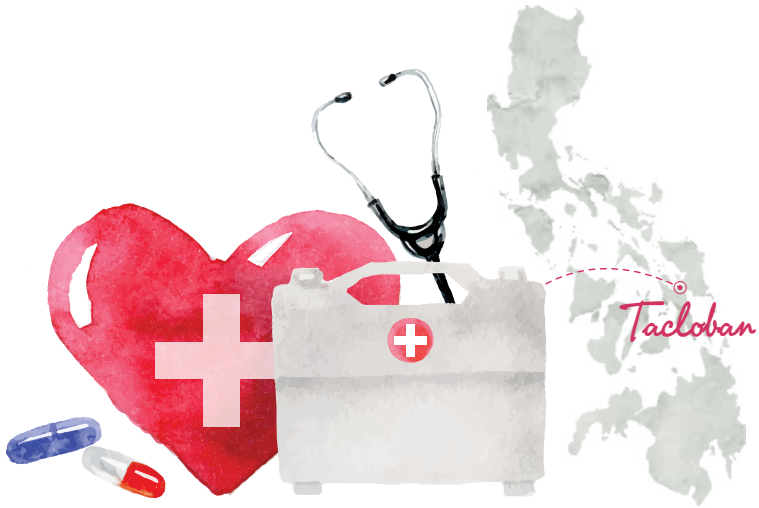
2) Acknowledge the SMS and refer to the MOH circular on your email

3) Upon activation of HSS
- Put up the Haze Poster
- Fill in the activation date
- Administer the scheme

For those who are interested to join the PHPC scheme, simply write in to **gp@aic.sg** with:

- Your full name
- Clinic name
- Mobile number
- Email address

You will receive a token of appreciation upon sign up. For more information, visit the **Primary Care Pages** at **www.primarycarepages.sg** or call our GP Hotline at **6632 1199**.



ADDRESSING HEALTH NEEDS

— Medical Mission to Tacloban

5,414 patients benefitted from the 214th Buddhist Tzu Chi Foundation (Tzu Chi) medical mission held in Tacloban in the Philippines from 5 to 7 August 2016, organised by the Philippines Tzu Chi office. I had the honour to be part of the 124-member volunteer team from Singapore, which consisted of 54 medical professionals including physicians, surgeons, nurses, dentists, dental assistants, audiologists and Traditional Chinese Medicine practitioners from the Tzu Chi International Medical Association (TIMA), and 70 non-medical Tzu Chi volunteers.

In November 2013, Typhoon Haiyan caused massive destruction in Tacloban. During the TIMA conference held in Singapore in March 2015, I learnt about how Tzu Chi helped rebuild Tacloban and assisted the residents in recovering from the disaster. Mr Alfredo Li, the chief executive officer of Tzu Chi's chapter in the Philippines, was one of the first to arrive at the disaster area. During the conference, he shared with us how volunteers from Tzu Chi painstakingly gathered nearly 300,000 disaster victims in a massive clean-up of the debris and how they managed to successfully bring their homeland "back to life" within 19 days under the "cash-for-work" relief programme.

It was also moving to learn about the collaboration between Tzu Chi and the Catholic Church in Tacloban in reconstructing the badly damaged Santo Niño Parish Church.

THE WORK BEGINS

Upon reaching Tacloban City on the morning of 5 August 2016, I was pleasantly surprised by the scene of a bustling city with no evidence of damage from the mega typhoon that struck three years ago. I cannot help but be filled with wonder at how resilient the residents were.

We headed straight to Leyte Progressive High School, where the medical mission clinics were held. There, we were greeted by rows of local residents, some of whom had arrived in the wee hours of the morning, forming queues that extended beyond the school premises. The fatigue from ten hours of overnight travelling quickly dissipated at the sight of hundreds of patients. However, our fatigue paled in comparison to the efforts of the "early departure team". Volunteers in this team worked late into the night to transform the ordinary school into a "hospital" with fully functional operating theatres, clinics, pharmacy, etc, all prior to our arrival.

Just before the free clinics started, we were informed that additional manpower was needed to run the paediatric clinic as two paediatricians from Manila were unable to attend the mission. Despite having undergone internal medicine training and not having treated children since my housemanship, I volunteered to join the standby doctor in running the clinic. Thinking back, perhaps being surrounded by patients waiting for us expectantly had left me no room for hesitation.

Even though paediatrics is not a specialty I favour, I quickly felt at ease running the clinic and even found it quite enjoyable. I was in awe at how well behaved the children were, queuing up for their turn to be examined (it was not uncommon to see parents with four or more children). These little angels kept absolutely still during the consultations and out of more than a hundred children that we saw, only two cried!

I was also greatly reassured by the presence of fellow TIMA doctors, who were ever so patient in offering their guidance for more complicated cases. My brilliant local teenage translator, who sacrificed her weekend for the medical mission, also deserves special mention. She was such a natural that she eventually asked for the bulk of the patients' histories and presented them to me after. There were also many dedicated Tzu Chi volunteers who made their rounds; they offered snacks to us a few times a day and

made sure that we drank sufficient water. It was these kind gestures that distinguished this medical mission from other medical duties that I have been involved in before.

A DIRE NEED

I vividly recall a toddler who was brought to me while lying in her mother's arms. She presented with the typical history of acute respiratory symptoms like the other children, but she was visibly unwell — the child was in respiratory distress. Memories of my paediatric posting in medical school came to mind: my clinical group was gathered around a cot in the general paediatric ward at the National University Hospital, staring at a sleeping baby. "Do you notice anything that is not right?" asked my professor. We stared hard but remained clueless for a good five minutes. "Breathing!" someone finally blurted out and my professor smiled. Since then, I cautioned myself never to miss the signs of respiratory distress in a child.

The first thought that came to my mind while looking at the breathless toddler in front of me was: "How could her parents seek medical attention only now? Did they not notice that their child was ill?" It was only later into the consultation that I realised my folly. The young mother in front of me had brought her breathless child to the local hospital that very morning, only to be told to return the next day as there was no bed available. No medicine was prescribed.

My heart immediately went out to this family and the countless patients who live in areas with scarce medical resources. There is truly a dire need for medical care in these places but sadly, there is a limit to what medical missions can do. Having said that, giving our very best for every patient we come across is the little difference we can make to patch the gap. Having been cynical about the impact of overseas medical missions before, I am now convinced of its value.

THE PURPOSEFUL TRIP

The unexpected opportunity to see paediatric patients during this medical mission has proven to me the importance of a holistic medical training and of gaining experience in various specialties in the early years of medical practice. Taking part in overseas medical missions has its challenges, but with an open heart and a dedicated team, I believe that there is nothing that cannot be overcome. ◆

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

PROFILE

TEXT AND PHOTOS BY

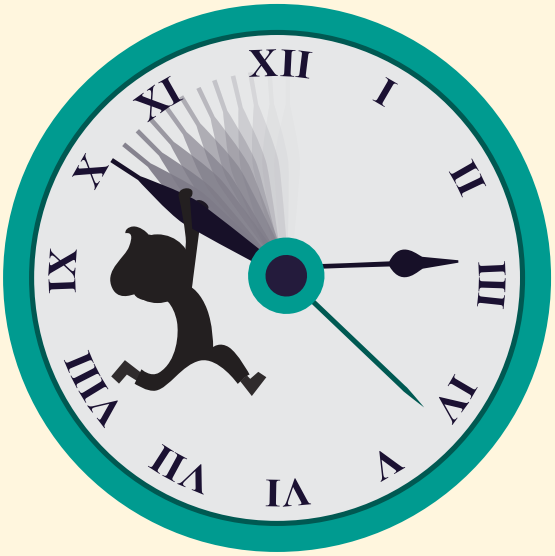
DR HO XIN QIN

Dr Ho Xin Qin started internal medicine residency training after completing housemanship, which included a posting in paediatric medicine. She is thankful for the opportunity to be part of the Tzu Chi International Medical Association team to provide medical care to the residents of the Tacloban City in the Philippines.

Legend

1. A large-scale and well-organised medical mission in Tacloban, the Philippines
2. Having fun with local children with fellow volunteer nurse and TCM physician
3. Running a paediatric clinic for the first time

Travelling Back in Time



During our childhood, we form many unforgettable memories that we carry through our lifetime on earth. In this series, we invite four doctors to each share distinctive events that occurred during their formative years which have impacted their lives in one way or another.

Dr Chie Zhi Ying

Dr Chie Zhi Ying enjoys freelance writing and singing. She writes for *Lianhe Zaobao*, *Shin Min Daily News* and *Health No.1*. She can be reached at chiezhiying@gmail.com.

My twin sister and I (on the left) at Chinese Garden, Singapore, when we were three years old

"It's double the giggles, and double the grins, and double the trouble if you're blessed with twins." — Anonymous. My family and I would totally agree with this.

My twin sister and I were delivered through caesarean at Mount Elizabeth Hospital at 36 weeks and a few days of gestation. It ended days of dizzying anticipation and apprehension, but this was to be the start of another tumultuous journey.

At birth, I weighed a mere 1.9 kg and looked as frail as a small kitten. Mum broke down into tears — how she wished she was cuddling a healthy chubby baby! My younger sister fared better, weighing 0.6 kg heavier, and was much healthier than me.

I spent that first month in the incubator with all kinds of tubes imaginable plugged in me and it was not until I could feed on my own that I was discharged. Growing up as a child, my appetite was always poor and Mum had a really tough time coaxing me to eat. My prematurity and poor feeding caused me to fall sick ever so easily. Seeing our family doctor became a "favourite" pastime. I remember myself wailing and shaking my head frantically as Mum tried to feed me a nasty concoction of medications from our doctor. I was nursing a fever or flu every now and then and those disgusting medications became my "staple". It didn't help that being unwell, I was irritable and my parents had to buy me a new toy each time I saw the doctor.

Those were trying times for my parents, particularly because it was their first time (and the only time) at being new parents. Despite that, they were very doting, patient and supportive. As I grew up, things got better and my dreaded visits to the doctors reduced. My sister and I enjoyed a carefree childhood where we spent our days watching television and playing at parks, playgrounds and beaches. My twin sister is my best playmate and confidante, and there is nothing we don't share with each other.

Fast forward twenty-something years on, that preemie fraught with ill health is now a young doctor. Whenever I see premature babies in my clinic, my heart goes out to them and their parents, knowing how onerous it is for the parents to bring them up. But at the back of my mind, I find comfort knowing that life has its own plans and it is up to us to live it to the fullest. ◆

In the early 1960s, when I was still in primary school, my parents and I visited my uncle (from my mother's family) during Chinese New Year. His name was Dr Choo Jim Eng ("Jimmy" to his friends, I eventually learnt) and he lived in a small, neat bungalow on the grounds of the Thomson Road Hospital. His house was adjacent to the small traffic circle on top of the hill, which could only be accessed by a small road (Toa Payoh Rise) that began from Thomson Road near Marymount.

I was very impressed because there were only two such bungalows. The first was occupied by the then medical superintendent (do I remember somebody saying "a white man"?), and the second was occupied by my uncle. Each bungalow had a small grass garden in the front, with its own private hedge. Without realising that my uncle was the Head of Surgery at that time, I thought to myself, "How well the government treats its doctors!"

I returned to the hospital for postings as a medical student in the late 1970s, and as a houseman in 1982. My uncle was still there in Surgery, by then with Prof Raj Mohan Nambiar. He had long been joined by another uncle (this one was from my father's family), Prof Lee Yong Kiat, who was simply called "Prof" and was Head of Medicine, ably assisted by Dr Chua Kit Leng (of "tropical sprue" fame) and Prof Fock Kwong Ming. Funnily enough, I don't remember seeing the bungalows any more by then, though I must have driven past that location every day on my way to work.

The individuals whom I have mentioned above were obviously gentlemen and experts in the science and art of medicine and surgery. As a houseman, I was surrounded by them and learnt a lot, both by example and by osmosis down a steep concentration gradient. They also served the medical profession well. Dr Choo Jim Eng was president of the SMA for three terms, he and Prof Lee Yong Kiat were both SMA Honorary Members, and Prof Raj Mohan Nambiar and Prof Fock Kwong Ming were Masters of the Academy of Medicine, Singapore. However, early memory is a funny animal. While I was surrounded by great men who are very well respected and well loved by our profession, it is that bungalow on the hospital grounds that I remember first. It is, to me, symbolic of how much society could value doctors in days past. ◆

Dr Lee Pheng Soon

Dr Lee Pheng Soon 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.

I remember the first magic show I watched at the Singapore Indoor Stadium: *A night with David Copperfield*. That was just after I had completed my Primary School Leaving Examination. During the show, there were countless effects, with each of them more astounding than the one before. It started off with close up effects such as melting a cigarette through a coin and progressed to large-scale effects with motorcycles appearing and people vanishing and reappearing. Everyone was amazed.

Eventually, it ended off with David Copperfield performing a flying stunt. It was dream-like. I remember watching with wonder and awe, just like all the other kids around me. It was stunning. He even carried a member of the audience and with seemingly no effort, he lifted his feet and took off. He was flying, and carrying a lady as he did so. It was truly exhilarating!

From then on, I was greatly inspired to pick up magic and hone it as a craft. During my secondary school years, I started learning how to throw cards, manipulate cards and execute sleight of hand. This passion fuelled my inner desire to learn more about magic. I went from performing close-up card tricks to performing on stage as a part-time professional. Now, it has also become a means of giving

Dr Sin Yong

Dr Sin Yong (Dr Syros) believes in magic with a message of hope and love. He seeks to use magic to encourage and inspire others around him to develop the same passion in helping the less privileged. Together, he believes we can create a wonderful world using what we have.

back to society as performances are used to raise funds for the needy. These performances are also themed with a message of hope and love to encourage and inspire the audience. Performing magic is not just about the effects, but also about the underlying message that makes the experience magical and worthwhile.

Never would I have imagined that I would someday be the one performing on stage, inspiring the next generation of youths. Now, looking back, each and every one of my experiences has helped to shape the effects I perform for my audience. It was truly a touch of magic from Copperfield and I hope to pass it on.

A charity magic show was also held last month to raise funds for the National University of Singapore Medical Society - Christine Chong Hui Xian Bursary, which serves to alleviate the financial burdens of needy medical students during their course of study to become a doctor. An act of kindness from you can mean the world to someone in need. More details on how to donate to this cause-worthy fund are available at http://www.magicofkindness.org. ◆

Dr Syros creating a snowing experience

Dr Bertha Woon

Dr Bertha Woon is a full-time general and breast surgeon at her own practice, Bertha Woon General and Breast Surgery, at Gleneagles Medical Centre. She is an advocate and solicitor of the Supreme Court of Singapore, an associate mediator at the Singapore Mediation Centre, and one of the four Associates of the Medical Protection Society in Singapore.

I spent most of my childhood in Bandar Seri Begawan with my maternal kin. Every day was filled with fun because I had numerous cousins to play with and many different relatives' houses to visit. My mother also took me to the beach every Friday and Sunday. The beaches in Brunei were different from Singapore's. In my memory, the sand was fine and silvery. There, I collected a wide variety of seashells, along with a collection of beautiful pebbles polished by the waves. We used to build sandcastles and catch baby crabs. There were no ships at all on the horizon and in fact, very few people on the beach.

However, I came back to Singapore during the September school holidays and discovered that Singapore had **Plaza Singapura**, which to me was the greatest thing since sliced bread as Brunei had no shopping malls at that time. Plaza Singapura had a space where parents paid $1 an hour to leave their children there while they went shopping. I loved the place because there was a ball pit (like the one in Ikea) to jump in, cartoons playing on a colour television (Brunei only had black and white television, and not many cartoons at all), crayons for colouring and ice slush in orange and grape flavours. In addition, the basement of the mall had a shop where I got my bento box lunches with tempura udon, shaped rice with pink fish floss and black sesame seed garnishing, carrots cut into the shape of flowers, plus *Anpan* bun for dessert. I loved grocery shopping in Yaohan. The best thing in the basement though, was the wide selection of coin-operated rides that were available in airplanes, helicopters, trains and animal models. I really loved the rides.

I told my parents that I will not return to Brunei. My grand plan was to stay in Singapore to play every day. My father had to scramble to apply for a Primary One spot for me while I gave up places in three schools in Brunei. I got enrolled in Raffles Girls' Primary School, where I had to repeat Primary One because I was underage and also because we studied Malay and traditional Chinese in Brunei, whereas Singapore uses simplified Chinese. This one decision changed the entire course of my life. ◆

This is last photo taken before mum went back to Brunei and I stayed behind in SG because I refused to take the plane back. I said if I missed mum, I'd just look at this photo

A photo taken with my cousins in Brunei

• SALE/RENTAL/TAKEOVER •

Serviced clinic for rent at Mount Elizabeth Novena Hospital. Fully equipped and staffed with IT support. Immediate occupancy. Choice of sessional and long term lease. Suitable for all specialties. Please call 8668 6818 or email serviced.clinic@gmail.com

Clinic space (650 sq ft) for rental at shopping mall in a mixed dev at 1 West Coast Drive. Suitable for GP, dental, O&G and Paediatric. Please call: 9738 0548.

Connexion 915 sq ft clinic for Specialists, bare condition rental only S$4500 per month (subject to GST). Conveniently located with sheltered walk-way to Farrer Park MRT station. Walking distance to City Square Shopping Mall & plenty of eateries. Angeline 9436 1098.

Gleneagles Medical Centre room for rent. Newly renovated. Please call 9438 7367. No agents please.

Buy/Sell clinics/premises: Takeovers: (1) D14, industrial/ HDB area; (2) D21, high net-worth patients; (3) D14, established practice, good human traffic. Rental: (a) D21, share with specialist, near MRT. (b) Various other places. Hp: 9671 9602.

Gleneagles Medical Centre clinic for rent. 400 sq ft. Waiting area, reception counter and consultation room. Immediate. SMS 9680 2200.

GP Practice in North-East for takeover/sale. Large clinic with thriving practice within shopping mall. HDB, landed and condo catchment with industrial estate nearby. Large space, stable rental, large pool of patient records. Contact singapore6421@gmail.com or 9175 0889.

• POSITION AVAILABLE/PARTNERSHIP •

Medical Group in the West is seeking full time doctor with full medical registration. General consultation, conduct medical check-up/health screenings and clinical treatment at GP level. Able to communicate in simple Mandarin. Interested applicants, please email your CV to ptklsh@gmail.com

medical clinic®
laser + aesthetics + hair removal

Does being part of Singapore's Largest Multi-Award Medical Aesthetic Group sounds like a great opportunity for you to build your career, prospects & add value to your medical credentials? If you're an experienced aesthetic doctor who's passionate and enthusiastic about helping men and women to transform, discover how you can get rewarded with attractive remuneration package. Send in your resume to info@onlyaesthetics.sg

TLC lifestyle has positions for visiting Ophthalmologists for co-management of periorbital conditions for our patients. Please write to hr@tlclifestyle.com to express your interest.

CUTIS
MEDICAL LASER CLINICS

We are looking for enthusiastic aesthetic doctor to join our practice part-time or full-time Extensive and continuous training will be provided. Registered doctor with Certificate of Competence for laser and injections. Please send resume to hello@cutislaserclinics.com

Medical Aesthetic Doctor with experience? We are an Aesthetic Clinic in town looking for an experienced Aesthetic Doctor to join our team. Attractive remuneration for candidates with aesthetic experience. COCs are required. Candidates please contact us at 9175 0889 or recruitha1@gmail.com

Manager /regular locum +/- partner treasured. Geylang clinic. Able to do some nights. Please enquire at 9724 6410 or 9689 5505 during daytime. Confidentiality ensured.

• SMA JOBS PORTAL •

Date Posted	Position/ Job Title	Organisation	Application Deadline	Job No
28/09/2016	Aesthetic Doctor	1st Company Pte. Ltd	30/11/2016	J00123
28/09/2016	Associate Consultant	Hospital Authority	18/11/2016	J00121
28/09/2016	Service Resident	Hospital Authority	18/11/2016	J00122

RafflesMedical

We are looking for doctors who wish to pursue family medicine as a career to join our growing organisation. Local and overseas graduates from recognised universities may apply.

We provide fulfilling work environment where you can work, learn and deliver care to your patients with our team of nurses, healthcare managers, specialists and family physicians.

As an approved Learning Institution, we provide opportunities for you to learn, grow and develop your career as a family physician, physician leader or as a healthcare manager. Remuneration is attractive and competitive and being a key member of the Raffles team, you will participate in the employee share option scheme of Raffles Medical Group.

Exciting career opportunities are available in the following positions:

1) Family Physicians / General Practitioners
2) Health Screening Physicians
3) Medical Officers with A&E experience

Both full and conditionally registered doctors may apply, full time or part time.

Please send your full CV to:
Dr Michael Lee | Email: lee_michael@rafflesmedical.com
Dr Wilson Wong | Email: wwong@rafflesmedical.com
Tel: **6311 2276** | www.rafflesmedical.com

1st COMPANY

We are looking for enthusiastic aesthetic doctor to join our practice part or fulltime. Extensive and continuous training will be provided. Registered doctor with Certificate of Competence for laser and injections.

Please send resume to **careers@1st company-singapore.com**, Tel: **9772 7711** Fax: **6221 4098**

AESTHETIC DOCTOR

Requirement:

1. A medical degree from a recognised university and fully license by MOH to practice privately in Singapore.
2. At least 1 year of experience in the medical aesthetic field with experience in handling incostestable and lasers
3. Able to work as a team with the Group's management team to develop the medical division at rapid pace.
4. Self-driven individual for success
5. Strong interpersonal communication skills
6. well-groomed with pleasant personality

Benefits:

1. Training in Japan will be provided
2. Training centre has recognised and certified by Japan Society of Plastic & Reconstructive Surgery

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ERA REAL ESTATE

ERA approval : AP8636/110515/30K/ID

As Featured on The Straits Times, Paid SMA News, Property Guru, Facebook and many more

Transacted Many Clinics Sale/ Leasing.

So Many Satisfied Medical Practitioners Can't Be Wrong!

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Prunella Ong Lay Foon

ERA Senior Marketing Director

CEA No.: R026368D

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Parkway Pantai

Parkway Pantai Limited (PPL) is the largest private healthcare provider and operates Mount Elizabeth Novena Hospital, Mount Elizabeth Hospital, Gleneagles Hospital and Parkway East Hospital - all accredited by Joint Commission International (JCI).

Our Accident and Emergency department / 24 hour clinics provide first-line treatment for a full range of medical conditions, including management of critical and life-threatening emergencies, to the treatment of walk-in patients 24 hours a day.

All our medical and surgical specialists are well-trained and ever–ready to support the handling of emergencies effectively and efficiently. By adopting a team approach towards the management of emergencies, we ensure the smooth and expedient management of all patients.

We invite dedicated individuals who are passionate and driven to join us as:

Resident Physician (A&E/ 24 hours Walk-In Clinic)

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

At Parkway, we provide sponsored postgraduate training opportunities in addition to a comprehensive suite of benefits. Join us for a challenging career and opportunities for personal development.

Requirements:

- Basic medical qualification registrable with Singapore Medical Council
- Possess a valid practising certificate from the Singapore Medical Council
- At least 3 years of clinical experience post-housemanship.
- Postgraduate medical qualifications and relevant experience are advantages
- Good oral and written communication skills
- Good interpersonal skills
- Good team player

Kindly email: **steve.tan@parkwaypantai.com** or call **9670 0472** for a friendly discussion.

www.parkwayshenton.com

Yona 月华

Senior Director

MBA, FCHFP & AFC,

Court of the Table, Top of the Table

Representing Manulife Financial Advisers, part of Manulife (Singapore) Pte. Ltd.

Please Call 97271702

or email: yona@manulifefa.com.sg

DEAR MEDICAL SPECIALISTS

Sucessful Individuals Like You Deserve Only the Best!

- You will have access to a wide range of solutions from Manulife Financial Advisory as well as other trusted partners.

• OUR UNIVERSAL LIFE •

The answer to your legacy (in US Dollars and Singapore Dollars) and retirement planning needs

• OUR READY PROTECT •

- Ready Protect covers against 21 infectious diseases – Dengue & Zika Virus, Insect Bites, Hand, Foot and Mouth Disease, and many others
- An affordable amount of SGD$2.55 a day for comprehensive coverage

Disclaimer:

Buying a life insurance policy is a long-term commitment. An early termination of the policy usually involves high costs and the surrender value payable (if any) may be less than the total premiums paid. This promotional material is not a contract of insurance and is not intendedd as an offer or recommendation to the purchase of the plan. The specific details applicable to this insurance plan are set out in the policy contract. This promotional material is for general information only and does not have regard to your specific investment objectives, financial situation and any of your particular needs. You may wish to seek advice from a financial adviser before making a commitment to purchase the plan. In the event that you choose not to seek advice from a financial adviser, you should consider carefully whether this plan is suitable for you."

This plan is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for the plan is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact us or visit the LIA or SDIC websites (www.lia.org.sg or www.sdic.org.sg).

醫院管理局
HOSPITAL AUTHORITY

The Hospital Authority is a statutory body established and financed by the Hong Kong Government to operate and provide an efficient hospital system of the highest standards within the resources available.

1. Associate Consultant (AC) Positions for Experienced Doctors without Full Registration

(Anatomical Pathology / Obstetrics & Gynaecology) *(Ref: HO1609023)*

2. Service Resident (SR) Positions for Experienced Doctors without Full Registration

(Anaesthesia / Anatomical Pathology / Emergency Medicine / Family Medicine / Intensive Care / Internal Medicine / Obstetrics & Gynaecology / Orthopaedics and Traumatology / Paediatrics) *(Ref: HO1609024)*

The Hospital Authority invites applications from experienced doctors who are not fully registered with the Medical Council of Hong Kong (MCHK) and yet have acquired relevant postgraduate qualifications set out in the Requirements to serve the community of Hong Kong. For details, please visit **http://www.ha.org.hk** (choose English language, click Careers → Medical).

APPLICATION

Application should be submitted on or before
18 November 2016 (Hong Kong Time)
via the HA website **http://www.ha.org.hk**

ENQUIRIES

Please contact Ms. Wing LAU,
Hospital Authority Head Office at **+ 852 2300 7394**
or send email to **lwy584@ha.org.hk**

MW AESTHETIC & MEDICAL CLINIC

M & W Aesthetic Clinic is the pioneer clinic of an aesthetic and beauty group and chain, which is currently looking for the following positions:

Resident Aesthetic Physician

Job Description:

- To provide a comprehensive menu of aesthetic treatments to patients
- To engage in aesthetic training for self-improvement (both local and overseas)
- To lead the medical team in providing professional and comprehensive medical care to our clients

Requirements:

- Certificates of competence for lasers, botox, fillers
- Good team player, excellent inter-personnel skills
- Previous aesthetic experience is a bonus

Both job openings promises good job remuneration and benefits.

Full aesthetic training, local and overseas, is also be provided – including botox, fillers, lasers, threads etc.
Interested applicants should send their resume to
hr@mwaesthetic.com
with a recent photograph.

MindChamps® Medical Clinic

MEDICAL DOCTOR
(FULL TIME / PART TIME)

Responsibilities

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

Requirements

- Basic medical qualification registrable with Singapore Medical Council
- Postgraduate medical qualifications are an advantage
- Possess a valid practising certificate from the Singapore Medical Council
- Good oral & written communication skills
- Good interpersonal skills
- Good team player

Additional information

If you would like to take advantage of this exciting opportunity, we would love to meet you. Please e-mail your detailed resume with a recent photograph, stating your availability, current and expected salaries to **hr@mindchamps.org.**

For more information about MindChamps Medical, please visit **http://mindchamps-medical.com**

We regret that only shortlisted candidates will be notified.

For Doctors, For Patients

SMA MEMBERSHIP
PRIVILEGES AT A GLANCE

SMA's efforts to enhance the local healthcare landscape can only come to fruition with the support of every medical professional in Singapore.

❖ SMA Membership Cards ❖

The SMA eMembership Card represents your affiliation with SMA and can be used to enjoy benefits offered by our partners. Download it via your SMA Membership account.

The UOB-SMA Visa Platinum Card, which doubles up as your SMA Membership Card, allows you to enjoy perpetual fee waiver, dining privileges and other benefits.

❖ SMA's Work ❖

SMA Courses

Receive complimentary or subsidised rate for courses as an SMA Member.

SMA Events

Mingle with other members and source good deals from our partners at SMA events such as the Annual Lecture in November.

SMA Publications

Read about the latest healthcare news and topics in monthly issues of the SMA publications.

❖ SMA's Promotional Partners ❖

Great Eastern

Jitron® Biomedical & HealthCare SINGAPORE www.jitron.com

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SavioStaff Travel

THE PEAK

To find out more about the SMA Membership or to register, please visit http://www.sma.org.sg. Remember to use your Membership Portal to enjoy the uniquely SMA privileges as well as sign up for courses and events!

COMING SOON!

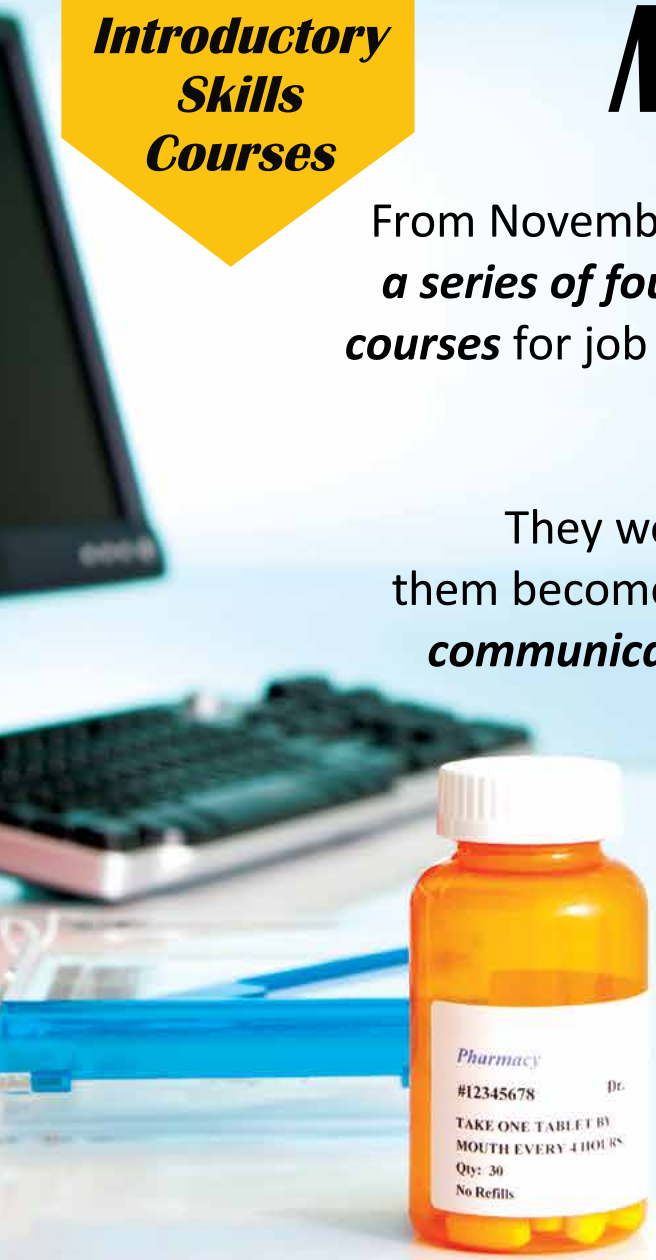
New SMA Clinic Assistant Introductory Skills Courses

THE PERSON BEHIND YOUR CLINIC COUNTER *MATTERS!*

From November 2016 onwards, SMA will be organising ***a series of four-day clinic assistant introductory skills courses*** for job seekers who are interested in working in a healthcare clinic environment.

They would learn essential skills that would help them become a better ***medical technician, dispenser, communicator and administrator*** for your practice.

If you have any job vacancies for clinic assistants, please visit https://www.sma.org.sg/trainandplace to register your interest in interviewing and choosing from a ready pool of SMA-trained personnel!



SMA Members submit clinic assistant job vacancies

Job seekers complete *SMA Introductory Course for Clinic Assistants*

SMA Members interview course graduates on the last day of the course

SMA Members arrange additional interviews with course graduates via the SMA website

Supported by: e2i
Better Jobs For Life
Employment and Employability Institute

Participation in this programme is provided free of charge to SMA Members and their clinics

SMA Members' Appreciation Nite 2016

ROGUE ONE

A STAR WARS STORY

15 December 2016, 6.30 pm*
Golden Village
Great World City

$10 nett for a pair of tickets**
(inclusive of one popcorn and drink combo set)

Following our successful premiere screening of *Star Wars Epsode VII: The Force Awakens* last year, we are organising an exclusive movie premiere of the latest Star Wars movie just for SMA Members again this year.

To register for this movie event, please visit http://goo.gl/QC28Uf.

*Timing to be confirmed by GV in December
**Terms and conditions apply