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# SMA NEWS



King's College, Cambridge

## Interview with Professor Patrick Sissons

*The University of Cambridge features one of the oldest medical schools still in existence today. Its teaching of medicine dates back to 1540 when Henry VIII endowed the University's first Regius Professorship of Physic (as in 'Physician'). Appointed by the British Crown and announced by the UK Prime Minister's Office, the Regius Professorship's history is entwined with that of medical education in the UK: office-holders include George Paget (brother of James Paget), who introduced assessment of bedside clinical examination in the Bachelor of Medicine finals – these were the first ever to be carried out in UK hospitals. Today, the Regius Professor provides strategic leadership of the Faculty of Medicine and School of Clinical Medicine at the University of Cambridge, and oversees its relationship with*

*the UK National Health Service, industrial partners and major research foundations such as the Wellcome Trust and MRC.*

*Prof Patrick Sissons, the current Regius Professor, joined Cambridge in 1988, where he pioneered the establishment of an Infectious Disease Service and an academic division of Infectious Diseases. His research interest is in the biology of cytomegalovirus and other herpesviruses, with over 90 publications to his name.*

*Prof Sissons recently visited the Yong Loo Lin School of Medicine in early February 2006. Our Editorial Board Member Dr Tan Wu Meng, a recent Cambridge alumnus, spoke with him during his visit to Singapore.*



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*Published by the Singapore Medical Association, Level 2, Alumni Medical Centre, 2 College Road, Singapore 169850.  
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URL: <http://www.sma.org.sg>*

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**TWM:** Welcome to Singapore. What are your impressions of Singapore Medicine, coming from a British perspective?

**PROF SISSONS:** Although it would be presumptuous for me to make a judgment based on such a brief exposure, my impression is that overall the quality of healthcare in Singapore is high, and of course it attracts people from much of Southeast Asia to come here for treatment. I am particularly impressed that this quality is achieved on the basis of what I understand is an expenditure of 3.5% of GDP on healthcare, and I very much doubt there is anywhere else in the world where equivalent healthcare is provided for such an expenditure of GDP – although I understand that a considerable amount of primary care and other care is provided by the private sector, so that 3.5% may not be an accurate reflection of total healthcare expenditure. Nevertheless, it's impressive and it's clearly spent in a sensible way by the government with the polyclinics in the community as well. So overall I think the quality of healthcare is very high and would compare favourably to that in the UK.

**TWM:** Having presided over the establishment of the Cambridge MB/PhD programme, what advice would you offer to institutions just starting their own clinician-scientist training programmes? Are there pitfalls to avoid?

**PROF SISSONS:** MB/PhD programmes have been going on for many years in the United States. In Cambridge we were the first medical school in the UK to start a MB/PhD programme, which has now been going on for more than a decade. As you yourself have experienced, our model has trainees combine their undergraduate medical training with the PhD. However many, and indeed most, doctors who go into academic medicine do their PhD subsequent to qualification, often integrated with their higher clinical training, and there still is a very definite place for that. So I think there isn't a one-size-fits-all model – one wants to be able to offer a range of opportunities. The programme at the medical school here (I gather) is encouraging people to move in the direction of doing their PhD immediately after graduating, which is – if you like – yet a third model, which I shall watch with interest. We have many similarities, and of course we've got a number of students from Singapore who've come to the MB/PhD programme in Cambridge besides yourself.

The nurturing of people through to the clinician-scientist stage is critical. Of course

doctors have to go and do their general professional and higher clinical training: I think having funded fellowships which allow clinicians to come back after three to four years of clinical training into research – and integrate that with their higher clinical training – is very important, and requires that those fellowships provide them with some technical support and funding to continue the research. Also it's unrealistic to allow people to do that fellowship in isolation. There has to be an environment into which they can embed their research so that when they're doing their clinical training there's a resource back in the laboratory, and that they're part of a group that's going to foster their science and help them get through that really critical period – the clinician's postdoc [that is, the training period after doing a PhD], which is what the clinician-scientist fellowship is all about. It's very difficult for a physician to do a PhD and then go directly into research as an independent investigator – indeed it's probably unrealistic, and so that clinician postdoctoral period is really critical.

**TWM:** Part of your background is in infectious diseases, and that's obviously quite an exciting topic these days, especially in Southeast Asia. What do you see as the major challenges in ID in the coming decade or two?

**PROF SISSONS:** Obviously there is great emphasis at the moment on the so-called 'emerging infectious diseases', and nowhere in the world are those more important than in Southeast Asia. Of course the origins of a number of them, particularly those mediated by the mutable RNA viruses, are in Southeast Asia. So there is great emphasis on H5N1 flu at the moment, and SARS very recently affected Singapore in a major way. I think there are clearly going to be more of those sorts of viruses, probably originating in this part of the world, and I think it will be very important to have both the clinical and research facilities to deal with them. This will require some prior thought and investment, for example establishing the containment facilities for handling both the patients, but also to do the research.

When I was a medical student, the impression given to us was that infectious diseases were probably a thing of the past, and that they were unlikely to form a major part of our professional experience as doctors in the UK. We now know how wrong that was. It's also true that infectious diseases are responsible for a number of syndromes, which we wouldn't have thought at all to be infectious. I think

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I would have failed my exams had I told my professors that peptic ulcers were caused by an infectious disease, in my medical student days. We've now realised that infections will always be with us, and that bacteria, viruses and the other micro-organisms causing infectious diseases are always going to be playing the game of outwitting us and the therapies we throw at them. So we will always have to maintain our alertness, and that's going to be very important for Singapore. For example, you've got great research opportunities here, such as the Novartis Institute co-located with Biopolis, and I was impressed to hear yesterday about what's going on there.

**TWM:** With the rise of criteria- and protocol-driven clinical practice, what role do you see for the skill known as clinical judgement? Is it likely to become a dying art as the evidence base proliferates, and with it the plethora of protocols?

**PROF SISSONS:** Well, you're right to raise it, because there's a risk of that – but it's absolutely critical that clinical judgement doesn't become a dying art. As you say, we are increasingly – and to a considerable extent quite rightly – driven by protocols in what we do. It's very difficult for an individual doctor to carry in their head all the literature pertaining to the correct management of a particular syndrome in front of them, so we need guidelines and protocols. On the other hand, as most of us know, when you look at the patient sitting in front of you, the odds are that they won't precisely fit the trial or the protocol or the guidelines from which the information to provide treatment was derived. Many patients – increasingly as we see older patients (currently perhaps not so much here, but this will increasingly be a feature in Singapore healthcare too) – have multiple diseases and may be on other therapies, so skilled clinical judgment in the application of guidelines to the individual patient is still going to be critically important. It would be a very sad day for medicine if clinical skills were to atrophy in the face of all the guidelines and protocols.

**TWM:** Many healthcare environments over the years have become more and more litigious. Looking back on your decades of clinical experience, what are your thoughts on how this has affected the practice of medicine in the UK? Are there any lessons we can draw from this in Singapore?

**PROF SISSONS:** As you say, it is a trend. I think that in part this reflects something positive,



Professor Patrick Sissons

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namely that in the past doctors probably didn't reflect enough – and weren't always careful enough – about all the possible complications of the therapies they were recommending for individual patients. I think making doctors more aware of the implications for their patients' lives of the decisions they take as doctors is a good thing. On the other hand, we all know there has been a downside. I think it is true that – even in the UK – one does see an increasing tendency to practise so-called defensive medicine, which takes account of the possibility of litigation, sometimes against the instincts of the physician for what is best for the patient. That applies particularly in the use of invasive and expensive investigations despite a low probability that they will show something – which also bears on the issue of health economics.

Anecdotally, when I qualified as a doctor, my subscription to the Medical Defence Union was £5 [S\$15] a year. I need hardly say that that's not the case now: indeed the subscriptions rose so much that negligence insurance had to be



taken over by the health service, because it was uneconomic for individual doctors to purchase medical insurance. I don't think this is a trend that is going to go away.

I think one thing that – although many doctors were initially apprehensive about it – could actually be a guard against things getting (if you like) worse is to involve lay people more in the process of regulation and decision-making and the drawing up of guidelines (which you were referring to earlier), because they will then appreciate the complexity of the decisions that healthcare professionals have to make. So there's actually a lot to gain from encouraging lay people to be more involved in the whole process – not for defensive reasons – but to show them the complexity that's involved in making decisions in medicine.

**TWM:** In medical schools today, there is an emerging trend to combine the teaching of basic sciences and clinical practice. For instance, instead of a two- to three-year period of pure basic sciences followed by pure clinical teaching, there is a trend to combine them together with an emphasis on application rather than the pure sciences. Some say that has 'dumbed down' the basic sciences element of training, while others feel it enhances the quality of learning. What is your perspective on this?

**PROF SISSONS:** The General Medical Council, which regulates medical education in the UK, is in favour of more integration between pre-clinical and clinical teaching. I think it's important that students of medicine do appreciate during their pre-clinical teaching how what they're learning has relevance to clinical medicine – they need to see the importance of what they will learn. But you're right, at worst it can lead to the diminution of teaching, particularly in traditional physiology, biochemistry and anatomy, to the extent that it may subsequently be difficult for doctors to understand the basis for therapies or for the pathogenesis of disease. In Cambridge, as you know, we have a relatively non-integrated course – in fact we have probably the most heavily science-based pre-clinical course of just about any medical school in the UK. We've introduced more integration in terms of early exposure to patients, but in the Clinical School in Cambridge, none of us have any desire to impair the high quality of the science-based course. I think it would be a mistake to impose a one-size-fits-all type of medical teaching throughout medical schools:

there should be a place for medical schools which deliver a particularly intensive pre-clinical science-based course, and which also gives students time for thought and a research project, as the Part II [third year undergraduate] course in Cambridge does. That's becoming increasingly unusual, but I think it's particularly valuable to give students exposure to personal biomedical research at a relatively early stage in their teaching.

**TWM:** It is the trend in many healthcare systems to have increasing sub-specialisation. In fact, in many tertiary hospitals, the concept of a general medical firm/team is changing as patients are increasingly triaged to sub-specialties. What role do you see for the general medical physician in the coming decades, in an era when sub-specialties appear to be on the rise?

**PROF SISSONS:** I think there is a role for the general physician – perhaps most obviously in primary care. There is an increasing trend in the UK to move chronic disease management back into primary care from hospitals, although I don't think we've yet arrived at an equilibrium, and there is an ongoing debate about how far that should go in the UK. However the general physician as someone in a hospital-based setting, who would manage the patient throughout the course of their admission even if that turned out to be an extended admission for a defined condition – well, that's going, and I think rightly so. If it's clear that the main problem is within the field of an organ-based specialty, then it makes sense for management to be handled by that specialty, which will have competency in all the associated procedures and the necessary experience. What's happening in the UK is an increasing tendency in hospital medicine to have emergency admissions unit based physicians who [in a short stay ward] will make diagnoses and then triage patients to whichever firm is necessary – there's a place for that too. It's also sometimes said in the UK that those involved in medicine for the elderly are the last generalists: those of us who aren't geriatricians feel that's perhaps laying it on a bit thick, but one understands what they mean.

However, if there are fewer roles for generalists, there is a continuing need for the specialist to maintain competency in general medicine, particularly in the face of co-morbidity. As populations age, it will be increasingly the norm to see people who have not one, but two or three conditions – and I think nothing can be worse than to see a patient being passed around from specialist to specialist, each of them taking only a narrow view of their own area of interest in



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the patient, without considering the consequences of their therapies and interventions for that disease on the other co-existing diseases. So all of us will have to remain to some extent competent in general medicine. There will definitely remain a role for the general physician in primary care and at the point of entry into hospitals, and it's critical that co-morbidities and management of multiple conditions in the patient are handled in the best interests of the patient.

**TWM:** While on the topic of needing to maintain competency in general medicine or otherwise, do you see a role for revalidation? Should a specialist endocrinologist or cardiologist need to revalidate himself or herself? Certainly in the USA the trend for revalidation seems to be proceeding apace.

**PROF SISSONS:** I don't know about Singapore but I think we'll see that in the UK too. I think revalidation in general medicine will certainly be necessary for those who are stated as – if you like – specialists in general medicine, such as those working in admissions units.

We will see revalidation for specialties. I hesitate to say that every specialist should have to be revalidated in general medicine as well, but there may be a place for demonstrating that one is maintaining continued medical education in general medicine, for example by having been seen to attend grand rounds and general medicine meetings, and maintaining a level of reading in general medicine.

**TWM:** Thank you for your time, Professor Sissons. Wishing you all the best with your travel back to the UK.

**PROF SISSONS:** Well thank you, I hope I'll be back in Singapore. And I should say that I and the Dean will be exploring possible areas of collaboration between Cambridge and NUS. It's interesting that in January a meeting was held here in Singapore to launch the International Alliance of Research Universities – which comprises 10 universities, including Cambridge and NUS. That will provide a framework for our collaboration, which will probably be particularly in the area of graduate student involvement in collaborative research projects. ■