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August saw the successful conclusion of the inaugural Singapore Medical Week organised by SMA, which was held at the Marina Bay Sands. The three-day conference saw various stakeholders of the healthcare industry coming together to discuss hotly debated health topics and future health trends, as well as provided a unique platform for healthcare experts to share the latest innovations and developments in healthcare. With our healthcare industry moving towards providing patient-centred care, I find it apt to introduce our October issue of SMA News on palliative care.

What comes to your mind when one talks about palliative care? To me, it is about patients and their loved ones coming together with their medical team to talk about a topic that is often considered taboo – death. Dealing with death can be a nerve-wrecking and agonising experience, and that’s where palliative care comes into the picture – to meet all the needs of the patient as an individual while alleviating suffering and maximising their quality of life. In essence, it is about adding life to days and not days to life.

I had a patient, a middle-aged gentleman, who was diagnosed with metastatic gastric cancer a few months ago. The diagnosis was like a bolt of lightning out of the clear blue sky. Knowing that his days were numbered, he put a stop to his hectic work life (he was a self-confessed workaholic) at once and spent his time with loved ones instead, pursuing activities he had always wanted to do. In his words, he was reliving his life all over again and had never felt so carefree before. He passed on peacefully one month later. Since death knows no time and age, his story is now a constant reminder for me to not get caught up in the never-ending rat race of modern life.

As you browse through this issue, you’ll find doctors sharing their thoughts on palliative care. We are privileged to have A/Prof Goh Lee Gan’s insightful interview with Prof Anne Merriman, founder of Hospice Africa Uganda, on her dedication in bringing affordable palliative care to Africa and beyond. Dr Yang Sze Yee, palliative physician from Tan Tock Seng Hospital, gives us some tips on counselling terminally ill patients.

We also invited Dr Kenichi Sato, a family physician who has relocated from Japan to Singapore, to share his experience caring for patients in Japan and with palliative care. Renowned American professional golfer Walter Hagen once said: “You’re only here for a short visit. Don’t hurry, don’t worry. And be sure to smell the flowers along the way.” With this, enjoy the read.

Welcome on Board!

Hello to all readers! I would like to thank the Editor for inviting me to join the SMA News Editorial Board. It has been an honour and a privilege to contribute to this newsletter and I hope to be able to continue in the years to come.

Working with written media seems to have been firmly tied to each phase of my life, whether I was scribbling for ACS Press in secondary school, editing the school’s newsletter in junior college or doing layout for a varsity magazine – where I eventually met my wife. Writing remains for me a unique form of expression; the written word has a quiet dignity that defies all the pomp and glamour of modern media.

Through writing I hope to be able to continue to explore social issues afflicting both doctors and patients. I firmly believe that the rights of patients and doctors are inextricably tied together and explaining this relationship clearly will help build trust in the medical community.

I look forward to many exciting and meaningful exchanges in the articles to come.
Singapore Medical Week 2017 is SMA’s first ever all-in-one event comprising multiple programmes such as FutureMed 2017, an international medical and technology conference and expo; the 47th SMA National Medical Convention; and the 1st SMA National Medical Students’ Convention. The event took place from 24 to 26 August 2017 at the Sands Expo and Convention Centre. Focusing on international advancements in medical technology, the event saw more than 1,800 visitors including local and international speakers, exhibitors, medical professionals and medical students for three days of education, discussion and networking.

To kick-start the event, Day 1 began with a welcome reception where attendees gathered for the welcome address by A/Prof Nigel Tan, Chairman of FutureMed 2017, during which he shared how FutureMed 2017 was a pipe dream brought to reality. He attributed the realisation of this event to Singapore’s reputation of being a health hub and a technology leader, as well as the strength of our healthcare and health technology professionals. Dr Wong Tien Hua, SMA President, also took to the stage to deliver his opening address, which highlighted that major technology advancements could eventually be a norm in future medical practice and patient interaction.

**FutureMed 2017**
As part of SMA’s endeavour to highlight recent advancements in medical technology, a three-day exhibition space was set up with 15 exhibitors showcasing the latest products and innovations in the region, alongside the two-day conference presenting interesting and relevant topics by eminent guest speakers. Throughout the event, attendees had the chance to interact with the exhibitors and even try their hand at various smart products and devices.

**Future of Healthcare**
The first speaker to deliver his keynote on Day 1 of the conference was Dr Ogan Gurel, Visiting Distinguished Professor from Daegu Gyeongbuk Institute of Science and Technology. In his talk, entitled “Technology Revolutions: Past, Present and Future”, Dr Gurel delved into the ways healthcare has revolutionised over the years, and how the paradigm shifts and implications of technology revolutions have affected modern medical care.

Our second keynote speaker, Dr Paul Grundy, Chief Medical Officer, Global Director, Healthcare Transformation, IBM Healthcare and Life Sciences, spoke on “General Practice (Patient-Centred Medical Home) Foundation for Population Health Management that Works for Singapore”. Dr Grundy gave attendees insights into the importance of patient-centrism in future healthcare transformations and how that can be achieved with data-driven, team-based strategies.

The morning session concluded with a lively panel discussion moderated by SMA Council Member, Dr Chong Yeh Woei, with the two keynote speakers making up the panel.

The afternoon sessions continued after a sumptuous buffet lunch. First, A/Prof Chew Ling, Director (Insights, Innovation and Planning), Health Promotion Board (HPB), spoke on “Using Technology for Better Health Choices”. Next, Prof Russell Gruen, Director at Nanyang Institute of Technology in Health and Medicine, Nanyang Technological University, offered insights into “The Future Roles of Doctors”. The final speaker for the day was Dr Zubin Daruwalla, Director and Healthcare Lead, PwC South East Asia Consulting, who presented on the topic “Global Healthcare Trends and the Transformative Future of the Industry”.

The three speakers were then invited to be part of a panel discussion moderated by SMA Council Member, Dr Toh Choon Lai.
Interesting questions were raised by members of the audience, especially with regard to what artificial intelligence (AI) really means and whether it could possibly replace doctors in the future.

**Big Data and Health**

The second day of the conference began with keynote speaker Ms Farhana Nakhooda, Director, Healthcare and Social Services, IBM Asia Pacific, who gave an eye-opening talk on “Cognitive Computing and Big Data Analysis”. She touched on the differences between programmatic systems and cognitive systems, and how the latter is designed to augment clinical intelligence through the understanding of contexts. She also introduced Watson, an AI-based “question answering machine” developed by IBM.

The panel discussion that followed the three talks focused mainly on the implications of data sharing, especially in the healthcare setting. Some concerns raised included the breach of patient confidentiality/privacy and cyber security issues.

The afternoon session, helmed by HPB representatives, comprised three talks that focused on harnessing the power of health technology on a national level. Dr Mathia Lee, Assistant Director of Analytics & Insights, introduced “The National Steps Challenge”, while Ms Dzurina Zainal, Deputy Director of Digital Marketing, talked about “HealthHub: Your Personal Digital Health Companion”. Ms Steffiana Wijaya, Manager at Student Health Centre, focused on how her team has been “Leveraging Technology to Modify Lifestyle Habits in Children and Youth”. All three speakers then fielded a variety of questions from the floor.

To mark the end of the two-day conference, A/Prof Nigel Tan delivered his closing remarks, thanking all speakers and conference-goers for their participation. All attendees were ushered to the main exhibition hall for light refreshments and complimentary wine sampling, courtesy of The French Cellar.

When asked about how the conference topics would be helpful in daily practice, Dr Mark Chew, a family physician, commented, “They are informative and insightful, and have helped to keep me updated on the latest global trends in the healthcare industry.” Another physician also commented, “As a doctor, besides knowing how technology helps in my practice, I also need to know what information has been given to my patients, and how I, as a GP, should act if my patients are on such programmes.”

The soft launch of the SMA eMarket also took place over the first two days of the expo. More than 20 representatives from health device and medical consumable companies were in attendance. The launch provided interested parties with information on the portal’s functions, how to sign up and market their products via the portal, as well as how to tap on the available funding to cover associated setup costs. The SMA eMarket is a portal designed exclusively for SMA Members to purchase medical products for their professional needs. Members are now able to access the portal using their SMA membership ID.
The third and final day of the Singapore Medical Week consisted of the 47th SMA National Medical Convention: Embracing the Future of Medicine, a full day packed with symposiums with both the public and the medical professional in mind; and the 1st SMA National Medical Students’ Convention.

Public symposium

First up was the public symposium, which drew more than 200 members of the public on an early Saturday morning.

Dr Charles Tan, Chairman of the 47th SMA National Medical Convention, delivered the welcome address. Referencing the 1985 movie Back to the Future, Dr Tan drew attention to how much technology has advanced since Marty McFly (Michael J Fox) was transported to the year 2015. He quipped that many of the futuristic technologies seen in the film have now been realised, further underscoring the fact that the future is already here. He then introduced the topics that would be covered during the public symposium before handing the time to Dr Wong Tien Hua, who introduced the Singapore Medical Week, its programme, activities and objectives to the audience.

The Convention’s keynote speaker, Dr Ogan Gurel, then took to the stage to speak on “The Logic of Medicine: How Doctors Think”. Dr Gurel covered a few key points in his speech, which looked at the art of communication, how doctors start with a general study before specialising, the importance of history-taking, the dualities of thinking, the option of a medical or surgical route, and a final reminder that medicine is both a science and an art. Throughout his session, Dr Gurel used analogies and stories to illustrate his points and avoided medical jargon to keep the content simple for our public audience to digest. Following a tea break, the audience broke up into two groups to attend either the English or Mandarin talks.

Colorectal health and treatments

Dr Ng Chee Yung, a senior consultant colorectal surgeon from Mount Elizabeth Novena Hospital, and Dr Lai Jiunn Herng, a general surgeon from Lai Endoscopy & Colorectal Surgery, covered the topic of colorectal health in English and Mandarin, respectively. They explained how technology has allowed much advancement in colorectal surgery, and showcased real-life scope videos on how such minimally invasive surgeries are performed nowadays – through both non-robot- and robot-assisted methods. Cancer prevention was also briefly touched on and it was stressed that having relevant knowledge on colorectal health, maintaining a healthy diet and going for regular colonoscopies are the best means of prevention and early detection.

Cancer treatment and advances

Cancer is an illness feared by many and some people may even regard it as an untreatable disease. For the second session, Dr Shang Yeap, a specialist in medical oncology at Novena Cancer Centre and Dr See Hui Ti, a medical oncologist at Parkway Cancer Centre, were the English and Mandarin speakers, respectively. Both doctors touched on the currently available methods of treatment, such as chemotherapy, immunotherapy and targeted therapy – with immunotherapy being the backbone of future cancer treatments. Specifics of the Human Genome Project and Next Generation Sequencing, as well as the innovation of liquid biopsy where cancer could possibly be detected early via blood tests, were also discussed. Finally, the speakers urged the public to monitor their personal sugar intake, weight and exercise, to ensure that they do what they can against preventable cancers.

Cardiology – coming soon to a clinic near you

Unlike cancer, heart diseases are slow-moving conditions, and treatment does not take place only upon a heart attack. Instead, the treatment could be a long-term process. Dr Ong Yean
Yee, a senior consultant cardiologist at Cardiac Solutions Medical Centre and Mount Elizabeth Novena Specialist Centre, and Dr Chuang Hsuan-Hung, a consultant cardiologist and intensivist at Gleneagles Hospital and Mount Elizabeth Hospital, were our third English and Mandarin speakers, respectively, for this topic.

The speakers spoke about the demographic trends that are directly related to the intake of food products that are high in cholesterol and also elaborated on treatment methods, such as stenting, stem cell therapy and heart transplants, with an emphasis on the importance of harnessing these technological advances without abusing and misusing them. Various challenges of alternative methods of cardiology care, such as the lack of heart donors, the high costs of mechanical transplants, and the ethical challenges of xenotransplants, were also brought up.

**Bright eyes, clear vision**

The final session for the public symposium placed emphasis on eye care, and it was delivered in English by consultant ophthalmologist, Dr Por Yong Ming from Eye Surgeons at Novena, and in Mandarin by eye specialist, Dr Loh Boon Kwang from My Eye Specialist & Retina Surgeon.

Some of the topics covered by the speakers included issues with lenses and cataract, such as the various kinds of inlays; an introduction to macular degeneration and its treatment methods; and the causes and treatment options of various eye diseases, including cataract and glaucoma. The speakers employed interesting analogies, such as comparing the retina to wallpaper when explaining the condition of retinal detachment, to help participants better grasp the medical concepts. The sessions ended with the simple reminder that the best way to care for our eyes is through taking care of our health.

The respective sessions’ speakers were then invited on stage and the participants had the opportunity to ask them questions relevant to their specialities and presentations. Many queries came pouring in on topics such as the benefits of consuming probiotics, the risks of using robotics in surgery and the likelihood of technical failure, and the risks associated with prolonged use of eye drops. The speakers addressed each query with care and patience, ensuring that their responses were simple yet comprehensive for laypersons.

It was evident that the attendees took home valuable insights that would allow them to be more aware of their personal health and well-being. Mr Ng Ah Leong, a retiree who attended the English track of the public symposium, commented: “The members of the audience were quite involved in the programme and the speakers were very professional. Their illustrations were also direct and detailed.”

**Lunch symposium**

The lunch symposium saw Ms Kuah Boon Theng, one of SMA’s legal advisers, take the stage to discuss a topic relevant to every practising doctor – “Informed Consent and Advice”.

She began her session by providing an overview of the three aspects of medical care – diagnosis, advice and treatment – before elaborating on the implementation of the new modified Montgomery test used in court. Ms Kuah also enlightened the participants on the stages of the
Mandarin public symposium speakers addressing participants’ concerns

Participant clarifying her doubts with speakers

Montgomery test and provided tips on what doctors should look out for during consultations. Her final advice to the participants was to be conscientious in note-taking, to practise robust documentation, and to consider recording their consultations. The lunch symposium concluded with a question and answer segment, where several doctors raised queries and requested clarifications on the recording of consultations by both patients and doctors.

Medical symposium

The final segment of the Convention, the medical symposium, commenced shortly after lunch, with three speakers lined up: Dr Charles Tan who spoke on “Advances in General Surgery”, Dr Jacob Cheng who looked at the “Advances in Ophthalmology”, and Dr John Chia who discussed the “Convergence in Ovarian Cancer Rx – Genomics and Immunotherapy”.

Dr Charles Tan, a general surgeon with 20 years of clinical experience, talked about the conveniences that advancement in surgical techniques have brought to both doctors and patients. In his presentation, he highlighted several techniques/treatments that had seen major advancements in recent times, and emphasised the need for practitioners to “re-learn” anatomy in order to tie up with technology, listing keyhole surgery for the treatment of hemia as an example. Despite the many advantages, Dr Tan also mentioned that not all advancements are for the best, and it is thus crucial for doctors to decide on the best and most helpful option for the patient they are treating.

Dr Jacob Cheng, consultant surgeon in cataract and comprehensive ophthalmology, was our next speaker. Using cataract treatment as an example, he explained how surgeries in the past involved making big incisions and cuts going up to ten millimetres, leaving patients with big wounds, stitches and delayed recovery. However, with modern technology, smaller incisions (2.65 to 2.75 mm) can now be made, resulting in the ability to conduct day surgeries. Aside from surgical treatments, Dr Cheng also highlighted advancements in lenses, eyesight correction methods and non-invasive treatment techniques, such as LASIK.

The final speaker for the afternoon, Dr John Chia, consultant medical oncologist at Onocare Cancer Centre, began his segment with the question: “Is ovarian cancer one, five or a million diseases?” After giving the participants some time to ponder over it, Dr Chia offered his personal opinion that ovarian cancer is probably between 15 to 20 diseases due to mutations. He then proceeded to look at the pathway of ovarian cancer and the various studies conducted on the condition, elaborating on relevant topics such as preventive measures against gene mutation, genomic tests, platinum resistance and immunotherapy drugs.

After the delivery of the three topics, participants raised queries pertaining to the three topics and a fruitful discussion ensued. One of the participants expressed his appreciation for the symposium: “Thank you to all the speakers for the very interesting topics. I benefitted a lot from them.”

1st SMA National Medical Students’ Convention

The inaugural SMA National Medical Students’ Convention took place on the third day of the Singapore Medical Week, concurrently with the Medical Symposium, with over 100 medical students in attendance. Jointly organised by SMA and the Tri-Medsoc Charter, the students’ convention brought together students from all three local medical schools under one roof, to share an afternoon of networking and collegiality.

The convention began upon the arrival of Guest-of-Honour A/Prof Benjamin Ong, Director of Medical Services, MOH. Mr Ivan Low, Chairperson of this edition of the students’ convention and president of the National University of Singapore’s (NUS) Medical Society, took to the stage to deliver his welcome address. He thanked all for their attendance and reminded his fellow medical students of the importance of creating a medical community that sticks through
thick and thin, and a culture of collaboration and sharing of medical knowledge. Dr Wong Tien Hua then delivered his opening remarks, stressing on how collegiality is essential as doctors are now required to work in teams. He reminded everyone that collegiality needs to begin in medical school and that the students “may be from different medical schools, but from the same medical profession”.

A/Prof Benjamin Ong then proceeded to deliver his keynote titled “The Future of Singapore Healthcare and What It Means to Medical Students Today”, where he compared the healthcare system of the past and present. He also touched on some of Singapore’s healthcare challenges, as well as key shifts for a future-ready healthcare system.

Next, Prof Low Cheng Hock gave a talk on “Good Patient Care – What Roles Medical Students Play”, where he discussed the needs and wants of patients, and how it is essential to keep professionalism and ethical principles alive in this changing world of business.

The final speaker, Dr Kumaran Rasappan, indulged the student attendees with stories of his mountain climbing endeavours and his goals of giving back to the Nepalese Sherpa community. He shared anecdotes of his experiences in making a difference in the lives of Sherpas (eg, education and medical attention), and highlighted some of the many difficulties that they have yet to overcome. Dr Rasappan ended with words of encouragement for the students, reminding them to press on even in the face of adversity.

This was followed by a question and answer session with panellists Prof Low, Dr Rasappan, and medical students Wharton Chan, Goh Xin Rong and Tan Xin Yang, and moderated by A/Prof Jason Yap, associate professor at Saw Swee Hock School of Public Health. The panel and medical students engaged in a lively discussion on AI and its capabilities, the legal responsibility involved in the use of technology, and the importance of the human touch in patient care.

The students’ convention came to a close after president of Lee Kong Chian School of Medicine’s Medical Society, Mr Richard Chan, delivered his closing remarks, in which he espoused the need for medical students to work together as one, and thanked everyone present for making the inaugural medical students’ convention a success.

**Conclusion**

Both doctors and medical student participants proceeded to network over some refreshments and wine sampling after the respective conventions. After three fulfilling days, the Singapore Medical Week 2017 came to a successful close with 90% of the feedback received expressing positive reviews of the event.

The SMA and the organising committees would like to thank all our speakers, guests and participants for taking time off from their busy schedules to contribute to our inaugural Singapore Medical Week’s programme. Special thanks to all our sponsors and partners who made this event possible: Health Promotion Board, Tote Board, Duke-NUS Medical School, Lee Foundation, Lee Kong Chian School of Medicine, NUS Yong Loo Lin School of Medicine, Pocari Sweat, Advagen Pte Ltd, EP Plus Group (S) Pte Ltd, Mundipharma Pte Ltd, Pharmline Marketing Pte Ltd, Servier (S) Pte Ltd, Steward Cross Pte Ltd, Association of Medical Device Industry, Asian Hospital & Healthcare Management, Pharma China Online and PharmaAsia.
Regarding Each Other as Brothers and Sisters

Text by Dr Wong Tien Hua

The SMA hosted our inaugural National Medical Students’ Convention at Marina Bay Sands Convention Centre on 26 August 2017, as part of the Singapore Medical Week, in a bid to encourage our medical student members to participate in SMA activities. We were honoured that Director of Medical Services A/Prof Benjamin Ong was able to grace the occasion and give his opening address to the gathering of students from all three local medical schools.

During my time, there was only one medical school at the National University of Singapore (NUS), with 160 medical students in my cohort. Being in the same school meant that each batch of students would have contact with their seniors four years ahead and their juniors four years after them – which works out to be about 1,300 medical students gearing to be future doctors.

Medicine used to be small community. Ten years ago in 2007, there were a total of 7,400 doctors registered to practise medicine in Singapore. Today, we have approximately 13,000 registered doctors in Singapore, and our third medical school, Lee Kong Chian School of Medicine, was officially opened recently by Deputy Prime Minister Teo Chee Hean on 28 August 2017. The three medical schools will be producing some 500 doctors a year.

There was a good chance that these graduates from NUS Medicine would know many of their medical colleagues when they eventually obtained their qualifications. This was important when it came to being part of a small network of medical professionals after graduation. The medical officers and seniors were likely to be familiar faces – doctors whom freshly minted house officers could relate to in the stressful and sometimes harsh hospital environment.

Now that we have three medical schools and many more doctors per...
graduating cohort, it is no longer possible for students to get to know everyone within the medical community, and it is likely that they will someday be working with colleagues hailing from different schools, each with unique cultures.

In my address to the audience of students at the medical students’ convention, I talked about the importance of forming good relationships within the medical profession early – to learn to regard each other as professional brothers and sisters.

**Collegiality**

Collegiality within the medical profession is about treating one another with professional courtesy and respect, being able to learn from one another, and having an eagerness to help and serve one another in a common purpose.

The Singapore Medical Council’s Physician’s Pledge is a compulsory vow that all physicians must take before they can become fully registered medical practitioners. One of the items that physicians declare is the pledge to “Uphold the honour and noble traditions of the medical profession; and to respect my colleagues as my professional brothers and sisters”.

Respecting our fellow colleagues is an important part of professionalism. The practice of medicine is a collaborative endeavour now more than ever, with doctors being required to work in teams. If the common purpose is to do the best for our patients and to ensure the best possible outcomes, then collegiality promotes harmony within the team, and encourages open communication and consensus, and the sharing of skills and experience.

Respecting each other means that we intrinsically believe that all members of the team have something to contribute to the care of the patient. Junior doctors should value and respect the experience and clinical intuition of their senior colleagues, while senior doctors should possess the humility to accept constructive suggestions, be willing to pass on their knowledge to others in the team, and act as positive role models. I think that respecting each other is one facet of professional courtesy, and also the basis of the timeless but unwritten tradition in the medical profession – that doctors do not charge one another for professional services.

Collegiality is also about communication. When faced with a challenging problem in our clinics or ward rounds, this collegial relationship allows us to pick up a phone to call, or nowadays we can text a colleague, and consult one another to benefit our patients. In fact, the sharing of such medical information with colleagues in order to benefit the care of the patient can be regarded as an ethical obligation.

In recent times, the mutual respect among doctors seems to be eroding, with disputes and conflicts becoming more visible through social media. But of particular concern, and perhaps even more commonly experienced, are the incidences of disparaging and negative remarks made by doctors about their colleagues, especially to patients.

Some examples are:

“It is very fortunate that you came to the hospital, your GP should have referred you earlier!”

“You should not undergo this treatment; those doctors practising...
in private are out of touch with the latest advances."

“These extra tests done by that doctor are useless and unnecessary.”

Doctors are urged to refrain from making such remarks especially when they do not know the context of the case. These “casual remarks” are extremely erosive to a patient’s trust in the doctors being blamed, and it also reflects badly on the entire profession. Needless to say, trust is a critical component in maintaining the public’s confidence in the medical profession.

Patients often consult us to obtain our professional opinion about the appropriateness of treatment plans recommended by colleagues. During such second opinions, we may find that we do not agree with the suggested course of management previously recommended. When this happens, it is important to take extra care with how we communicate this to the patient. We can acknowledge the patient’s concerns, inform them that we do not have the full facts of the prior consultation and encourage the patient to speak to the previous doctor to clarify.

Collegial behaviour needs to be inculcated early and it is best to start in medical school. Our medical students are rigorously selected from the top of their cohorts and are inevitably products of a highly competitive educational environment. We need to “rewire” them and mould them from highly competitive individuals to cooperative team-based doctors. One example of SMA’s efforts to encourage team-based values is the SMA-Lee Foundation Outstanding Teammanship prize that was jointly established in 2009 by SMA and Lee Foundation for graduating Duke-NUS students, to mark SMA’s 50th anniversary. The award serves to honour five students who have demonstrated exemplary team values.

The importance of networking among students from all three medical schools is absolutely essential, and gatherings like the recent medical students’ convention should be the platform to stress the importance of teamwork, better communication and mutual collaboration, and encourage the exchange of ideas. 

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### SMA EVENTS

**NOV–DEC 2017**

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<td>4 Nov</td>
<td>SMA Lecture 2017</td>
<td>Grand Copthorne Waterfront Hotel Singapore, Riverfront Ballroom</td>
<td>2</td>
<td>Doctors</td>
<td>Denise 6223 1264 <a href="mailto:denisetan@sma.org.sg">denisetan@sma.org.sg</a></td>
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<td>2</td>
<td>Family Medicine and All Specialties</td>
<td>Shirong 6223 1264 <a href="mailto:cpr@sma.org.sg">cpr@sma.org.sg</a></td>
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**Non-CME Activities**

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<td>SMA Members’ Appreciation Nite (Star Wars: The Last Jedi)</td>
<td>GV Great World City</td>
<td></td>
<td>SMA Members and Guests</td>
<td>Rita 6223 1264 <a href="mailto:rita@sma.org.sg">rita@sma.org.sg</a></td>
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Feedback on managed care practices

The Ministry of Health (MOH) and Singapore Medical Council (SMC) invited the three professional bodies – Academy of Medicine, Singapore; College of Family Physicians Singapore; and SMA – to provide feedback following the implementation of the new SMC Ethical Code and Ethical Guidelines, Guidelines H3(7), relating to payment of fees to managed care companies that came into force on 1 July 2017.

After collating feedback, the three professional bodies provided a comprehensive response which included the following observations:

- A sizeable number of doctors have since terminated at least one, if not all, of their existing contracts with managed care companies/third party administrators (TPAs).
- Some members still feel that the current guidelines and advisories do not provide sufficient clarity on what are acceptable arrangements, which could potentially expose them to formal complaints.
- TPAs should collect fees from organisations that engage them, not from doctors whose primary responsibility should be towards the care of patients.

MOH should directly regulate TPAs as these are essentially healthcare entities involved in the provision of healthcare for their clients.

Keeping in touch with medical students

SMA recently partnered with National Healthcare Group, National University Health System and Singapore Health Services during their residency open houses to engage local and returning overseas medical students. The SMA Membership Committee also organised information and sharing sessions with the three local medical schools to share SMA’s advocacy work and membership activities. More than 250 students signed up for the complimentary SMA student membership.

SMA representative as CMAAO chairperson

Dr Chong Yeh Woei, one of SMA’s former Presidents and a current Council Member, was recently elected as the chairperson of the Confederation of Medical Associations in Asia and Oceania (CMAAO) for a two-year term at its 32nd General Assembly held in Tokyo. Dr Chong had been serving as CMAAO vice-chairperson since 2011 and has played a key role in improving SMA’s relationship with our neighbouring medical associations. We wish him all the best in his new role.
Text by Sylvia Thay, Senior Executive

The 2017 edition of the SMA Annual Golf Tournament was an eventful one for the 143 registered SMA Member and guest golfers. Unlike past years, this year’s tournament took place over two Wednesdays – 5 July and 30 August.

On 5 July, many participants arrived as early as 11 am at Seletar Country Club (SCC) in anticipation of the afternoon of golf ahead. However, as the golfers were enjoying the buffet lunch, the sky began to darken and soon the lightning alert was sounded. Still, everyone hoped for the best and many were convinced that the game could proceed. As the suspension continued to be extended, it was soon apparent that the game could not be played that day and participants were visibly disappointed. Nevertheless, the participants made the most of the afternoon and took the opportunity to catch up and mingle with fellow golfers instead.

Dinner commenced in SCC’s Seletar Room promptly at 6 pm with this year’s convener, Dr Chong Tat Chong, delivering his welcome speech. He thanked the golfers for their support despite the poor weather and proceeded to thank the various sponsors for their efforts and sponsorships. Amid the words of appreciation, Dr Chong also persuaded one of our Hole-in-One sponsors, ASA Holidays, to offer the return air ticket to Hong Kong as a lucky draw prize for the dinner guests instead!

Tokens of appreciation were then presented to our valued sponsors, before Ms Michelle Ang, representative from the main sponsor Bizmann System (S) Pte Ltd, took to the stage for a short presentation on their firm’s services. She also took the opportunity to introduce everyone to the SMA eMarket portal, an SMA initiative that allows our members to purchase medical products easily and conveniently.

Dinner continued and the participants enjoyed the delectable dishes and wine while they awaited the highlight of the evening – the lucky draw segment.

Many participants were eager to hear their numbers being called out, for there was a generous range of prizes that included various electronic products, shopping and dining vouchers, and even four bags of premium durians! The evening then concluded with the presentation of the much anticipated lucky draw prize – the return air ticket to Hong Kong – which was won by Dr Goh Swee Heng.

The dinner soon came to a close, but that was not the end of this year’s event as Dr Chong announced that the golf tournament was postponed to 30 August and encouraged the participants to return for their shot at winning the trophies and prizes.

On 30 August, 136 excited golfers streamed in from 11.30 am onwards and were looking forward excitedly to the tee off scheduled for 1.30 pm. With a clear sky and bright sunlight, the shotgun sounded promptly and the golfers set off for the greens. Unfortunately, as evening drew near, the weather took an unexpected turn and the lightning alert was sounded once again. This caused the tournament to come to an abrupt end for many golfers who were still giving their best out on the course.

Nevertheless, the participants returned to the clubhouse and washed up in preparation for the prize presentation. Convener Dr Chong Tat Chong took to the stage, as participants enjoyed some light refreshments, to commence the prize presentation with a short welcome address. Since the 18-hole course was not completed, Dr Chong announced that the Best Gross and Best Nett positions were undeterminable, before proceeding to award the rest of the prizes.
This year, a new trophy – the Best Senior Lady Golfer: The Goh Swee Heng Challenge Trophy – was included in the list of prizes and it was won by none other than Dr Goh herself! When she received the trophy and prize on stage, Dr Goh explained that she had sponsored this trophy to encourage more senior women golfers to join the tournament. She also shared that it is a precious opportunity for GPs and specialists to spend an informal afternoon networking, especially with the younger participants.

The event came to an end with loud applause and cheers from the golfers in support for the tournament. We look forward to seeing both familiar and new faces in next year’s SMA Annual Golf Tournament!

Congratulations to the Winners!

**Best Stableford**
Dr Chan Kwai Onn

**Best Senior Golfer**
Dr Leslie Kuek

**Best Senior Lady Golfer**
Dr Goh Swee Heng

**Best Lady Golfer**
Dr Howe Wen Li

**Stableford Men’s Division**
First: Dr Gary Chee
Second: Dr Chong Tat Chong
Third: Dr Bernard Lim Yon Kuei
Fourth: Dr Tan Jee Lim

**Stableford Ladies’ Division**
First: Dr Yvonne Soong
Second: Dr Soh Joo Kim

**Senior Men’s Division**
First: Dr Lim Chong Sian
Second: Dr Wong Teck Sin

**Best Team (GPs versus Specialists)**
**Champion:** GP Team
Dr Gary Chee
Dr Chong Tat Chong
Dr Peck Ming-Hsin Stanley
Dr Adrian Tan Yong Kuan
Dr Howe Wen Li

**Runner-Up:** Specialist Team
Dr Chan Kwai Onn
Dr Bernard Lim Yon Kuei
Dr Tan Jee Lim
Dr Charles Tan Tse Kuang
Dr Goh Swee Heng

**Friends of SMA**
Men’s First: Mr David Soh
Men’s Second: Mr Xavier Tay
Men’s Third: Mr Thean Tsin Piao
Ladies’ First: Ms Gillian Sim
Ladies’ Second: Ms Vicky Zan
Ladies’ Third: Ms Wendy Soh

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**Legend**
1. Swinging for the win
2. Gleeful jump shot before golfing
3. Fellow golfers and friends gather for a time of collegiality
4. Dr Goh Swee Heng (right), lucky winner of the return air ticket to Hong Kong, receiving the prize from convenor Dr Chong Tat Chong
5. Dr Chia Yih Woei (left) presenting the Ling Chaw Ming Challenge Trophy to Dr Leslie Kuek
6. Golf ‘kakis’ posing for a group shot during the game
Acknowledgements

Main Sponsor:  

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Dr James Chang Ming Yu  
Dr Goh Swee Heng  
Family of the late  
Dr Heah Hock Thye  
Family of the late  
Dr Ling Chaw Ming  
Dr Lo Hong Ling  
Dr Oon Chiew Seng  

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Mr Goh Kong Beng
MONTGOMERY AND BOLITHO
IS THERE A PRACTICAL DIFFERENCE?

Text by Colin Liew and Tham Lijing

Part 1 of this series can be found in the September 2017 issue of SMA News (https://goo.gl/bPXaRz).

This is the second of two articles about the Montgomery test for medical negligence. In the first article, it was explained that the Montgomery test applies only to the provision of medical advice. The Montgomery test does not apply to the doctors' duties to diagnose and treat the patient. In those two areas of medical practice, the Bolam test continues to apply.

Under the Montgomery test, doctors must strive to ensure that they do not unilaterally decide what treatment would be in the patient's best interests, and omit to inform the patient about the full risks and alternatives. Ultimately, doctors must remember that it is the patient who decides and bears responsibility for the choice of treatment. Therefore, doctors must give their patients enough information to allow their patients to properly bear that responsibility. Is there any practical difference between the Montgomery and Bolam tests? That is the question this article seeks to answer.

Practical concerns

One large concern with the Montgomery test is that its adoption would result in "defensive medicine", where doctors provide excessive amounts of information to patients in order to avoid charges of professional negligence.1 The application of the Montgomery test is largely common sense. The ultimate question is whether a doctor has failed to take reasonable care in his relationship with his patient. If, as a matter of common sense, a doctor has given his patient such relevant and material information which the doctor ought to have known his patient would reasonably have wanted, the doctor is unlikely to have been negligent on the Montgomery test.

At the same time, such a doctor is also unlikely to have been negligent under the Bolam test, since it is likely that a responsible body of doctors, using their common sense, would have done the same thing. Indeed, in Hii Chii Kok, the Court of Appeal reached the conclusion that the doctor in question had not been negligent, whether the Bolam test or the Montgomery test was applied.

Practical differences

In some cases, however, the Bolam test and Montgomery test could lead to different outcomes. Two examples are given below.

Example 1

In the case of Montgomery itself, the doctor had failed to advise the patient, who was of small stature, diabetic and pregnant with a larger-than-usual baby, of a substantial 9% to 10% risk of shoulder dystocia involved in vaginal birth. While the doctor accepted that the risk was high, she stated that her practice was not to discuss such risks in detail (if at all) because her assessment was that the risk of a grave problem resulting from shoulder dystocia was small, and that if she disclosed such information, her experience was that most women would elect to undergo a caesarean section, but, in her view, it was not in the "maternal interest" for a woman to have a caesarean section. In the event, the risk of shoulder dystocia materialised, and the patient's baby was born with severe disabilities.

The doctor produced several expert witnesses who supported her approach, and as their opinions could not be shown to be illogical, the Bolam test was met and the doctor was held not to have been negligent by the lower courts. The UK Supreme Court, however, applied the Montgomery test and held the doctor to have been negligent in failing to advise the patient of the risk of shoulder dystocia.

Example 2

Say a patient is diagnosed by an oncologist of having early Stage 2 Non-Hodgkin Lymphoma. The oncologist advises the patient to undergo CHOP chemotherapy. In the oncologist's professional opinion, CHOP chemotherapy is well established, has a high success rate in such cases, and he is confident that in the present case, CHOP chemotherapy is likely to achieve a complete remission. The oncologist is aware that radiation therapy is available as an alternative, but since he is less experienced with radiation therapy, which is less widely available in Singapore and might even require the patient to go to Australia for treatment,
the oncologist does not tell the patient of that alternative. The patient agrees to CHOP chemotherapy, which does not work. The cancer spreads.

Assume that the doctor’s decision not to mention radiation therapy is supported by many of his colleagues. Under the Bolam test, the doctor would not be negligent. But things would be less clear under the Montgomery test: (a) the existence of the alternative of radiation therapy would be relevant and material to the patient, and (b) the doctor knew of the alternative. So Stages 1 and 2 of the Montgomery test are met. The key issue then becomes whether the doctor can persuade the court that he was justified not to advise the patient on radiation therapy (ie, Stage 3 Montgomery test). In our view, the doctor’s lack of experience with radiation therapy and its relative lack of availability in Singapore per se are unlikely to be sufficient justification.4

Areas of uncertainty

The shift from the Bolam test to the Montgomery test raises many new issues for medical professionals and doctors to consider. Two of them are highlighted below.

Diagnosis, advice, or treatment

Clinical practice does not rigidly demarcate diagnosis, the provision of advice, and treatment. In practice, and as the Court of Appeal recognised, the three aspects of diagnosis, advice, and treatment can sometimes overlap.

For example, a proper diagnosis might first require invasive procedures or exploratory surgery, the nature and risks of which the patient needs to be informed and advised about in order to understand. Similarly, the administration of a course of drugs (treatment) might form part of an initial diagnosis, the preliminary nature of which the patient should be advised of.

It can therefore be quite arbitrary whether a material event is characterised as diagnosis, advice or treatment. Take, for example, the case of an obstetrician who notes that a foetus is larger than average, attempts a vaginal delivery and dystocia occurs.5 The obstetrician takes emergency measures but the baby is born with a brachial plexus injury to the right arm. Does the Bolam test or the Montgomery test apply?

On one hand, the issue could be framed as negligent diagnosis/treatment – the obstetrician failed to recognise that a caesarean section delivery was indicated in the circumstances. Under this characterisation, the applicable test for determining whether the obstetrician was negligent would be the Bolam test. On the other hand, the issue could also be framed as negligent advice – the obstetrician failed to advise of the risk that shoulder dystocia increases in large foetuses, which resulted in the patient being deprived of the opportunity to opt for delivery by caesarean section. Under this characterisation, the Montgomery test would apply.

Until further guidance from the courts, medical professionals are likely to have to live with this uncertainty of characterisation.

Further modifications to the Bolam test

The Court of Appeal in Hii Chii Kok left open the question of whether, in applying the Bolam test, the court ought to take into account the experience and/or special expertise of the doctor.6 This could, possibly, mean that the standard of care expected from a doctor with special expertise in a field may be higher than one without that special expertise.

For example, an experienced and expert oncologist defending his diagnosis/treatment might have to show that there are oncologists of similar experience and expertise who support his diagnosis/treatment. In the same vein, a GP might not be judged by the standards of a specialist (unless the GP was negligent in not recognising that the matter ought to be referred to a specialist).

Conclusion

The decision in Hii Chii Kok represents a landmark change in the law of medical negligence. Medical professionals should be prepared to involve their patients to a greater extent when advising possible therapies or discussing treatment plans. Care should also be taken to record what the patient’s particular concerns are, and what medical advice and information has been imparted to the patient as a result. ▶

References

1. Hii Chii Kok v Ooi Peng Jin London Lucien [2017] SGCA 38 at [84].
3. Hii Chii Kok v Ooi Peng Jin London Lucien [2017] SGCA 38 at [139].
4. Although it may be that the patient would have made the same decision even if told of that alternative – ie, the negligent advice may not have caused any harm.
5. To borrow an example referred to in the Attorney-General’s Submissions to the Court of Appeal in Hii Chii Kok dated 30 November 2016.

Colin Liew graduated from the University of Oxford with a First Class Honours, and has in the course of his practice acted in a wide range of disputes before the State Courts, the High Court and the Court of Appeal.

Tham Lijing has two First Class degrees from Oxford. He specialises in dispute resolution and acts for multinational corporations, state institutions, and individuals.
Prof Anne Merriman (AM) focuses on ensuring that palliative care reaches the poorest people in the world. After working in Ireland, Nigeria, the UK, Malaysia, Singapore and Kenya, she founded Hospice Africa in 1993 and, through their model, the Hospice Africa Uganda (HAU), which has worked with over 20 countries in Anglophone and Francophone Africa.

Prof Merriman attended the 12th Asia Pacific Hospice Conference in July this year, and A/Prof Goh Lee Gan (GLG) took the opportunity to speak with her on the work she did in Singapore at a time when both geriatric and palliative care were in their early years of development. They also discussed her work on palliative care development in Africa. Prof Merriman lived in Singapore from 1984 to 1990.

GLG: Hello Anne, welcome back to Singapore. How has Singapore changed since you last visited us in 2011? What do you find good about Singapore?

AM: For me, coming back to Singapore in 2017 is like landing on a different planet! The buildings are higher and people are more numerous. However, the people are just as welcoming and helpful as ever. You have a caring and compassionate community in Singapore. With regard to my special interest – palliative care – it has moved faster here than in any other country. I noted that in Singapore today, 70% of cancer patients receive some form of palliative care in the disease trajectory. Services are multi-faceted and available at all levels of specialty and practice. Communities are providing care and facilities in both the Housing and Development Board estates and other housing areas.

Singapore should be very proud of her level of palliative care, and even more so of how the experience in Singapore has spread to the rest of the world – not only in Southeast Asia but in Africa as well!

GLG: Tell us more about your work with HAU.

AM: At 82, I am long past my sell by date! But I remain the director of International Programmes (IP) at HAU. Our department is small with four team members – two for Anglophone and two for Francophone Africa. My role is to coordinate our training programmes that are held twice a year for those initiating new services in African countries. We then follow students into their countries of choice, on invitation, to support them in setting up clinical services that can grow to have teaching programmes at all levels – from village carers to postgraduate and undergraduate doctors.

The annual Anglophone and Francophone programmes consist of a five-week schedule. The first two weeks are classroom-based, where they learn the basics of African Palliative Care (APC) while sharing their experiences in their own countries. Over the following two weeks, they go on mobile rounds to the homes to learn how to manage those too weak to attend clinics, how to assess home environments and to meet with the families. The last week consists of the training of trainers so that they can train others upon their return home. Upon completion of the programme, these initiators, consisting of doctors, nurses, pharmacists and social workers, become part of our alumni, and we keep in touch online.

IP takes up only a portion of my time. I am also sought out for advice regarding our running of this “model”, especially as we have had several different chief executive officers (CEOs) since I first handed over the leadership in 2003. Our present CEO is Dr Eddie Mwebesa, a home-grown palliative care physician, who is a great teacher, speaker and clinician. He is now learning the hard way on how to be a manager and we all assist him together.

Receiving up to 100 emails a day has been a challenge and I am not always able to keep up. I have been asked by...
our foundation to ensure that legacy documents are written, for when I “pop my clogs”. Thus, I am working closely with Autumn Fielding, an advisor and legacy document writer. Autumn helped me in the writing of my book Audacity to Love in 2010. She also provides support for the foundation and the foundation’s website (http://www.annemerrimanfoundation.org).

All this, plus speaking at conferences to promote our ethos, attending board meetings, and bringing advocacy to donors and fundraisers, keep me very busy.

APC first started in 1989. I was still in Singapore when I was asked to take the post of medical director at the new Nairobi Hospice. When I visited Nairobi, I found that the hospice provided its services in a wooden hut and had only three dedicated staff. The poor patients were given only paracetamol for pain control, whereas the rich, who could afford to pay, sometimes had access to codeine. I could not join them unless we had affordable oral morphine, as what we had made in Singapore. Six months later, they wrote to tell me that they had the government’s permission to import oral morphine powder. Thus, the affordable formula from Singapore got to Africa!

While in Nairobi as the medical director, I wrote an article describing our work, for an edition of Contact. Edited by Dame Cicely Saunders herself, my article described one of the many patients whom we had helped and demonstrated the difference that we were making. Letters came in from seven different countries in Africa asking me to help them with the suffering in their own countries. Realising that it was not just Nairobi but all African countries that needed palliative care, I left Nairobi Hospice to start an organisation with the vision to provide palliative care for all in need in Africa. We started by selecting an African country in which a model that was affordable and culturally adaptable could be developed from, so that it might reach all of Africa.

Hospice Africa UK commenced in 1993 and HAU, the model, began the same year, following a feasibility study in four countries. The vision of HAU was, and still is, “to bring peace to the suffering of Africa, through providing and facilitating affordable, accessible and culturally appropriate care in Uganda and other African countries”.

This was the beginning of APC and our goal to follow our vision. When HAU was established in 1993, we were only the fourth of 53 African countries (now 54) to have palliative care. The initial two were in the richer countries, Zimbabwe and South Africa, followed by Nairobi Hospice ten years later, in 1988, through the vision of Ruth Wooldridge. Now in 2017, 37 countries have supportive palliative care in some parts of their country, while only 20 have affordable oral morphine.

The importation of morphine is still being blocked by governments, but a solution has been found; morphine for all in need in Africa is made at HAU in Kampala. The formula is one that was devised in Singapore in 1985 and this has opened the gate to palliative care in the poorer African countries.

The Palliative Care Association of Uganda commenced operations in HAU in 1999, and in 2003, the seeds of the African Palliative Care Association (APCA) were sown in HAU. In 2005, APCA became independent and registered. Both of these organisations work together with us in Uganda and other African countries.

The teaching of undergraduate and postgraduate doctors commenced in 1994 in Makerere University, and has completely changed the attitudes of healthcare professionals. In 2008, after two years of intensive advocacy work and planning by HAU, the Palliative Care Unit was commenced under the Department of Medicine at Makerere University.

Our Institute of Hospice and Palliative Care in Africa (IHPCA) has grown since 1993. IHPCA continues training programmes in all of Africa, up to the degree level, and plans to commence Master degree programmes in 2018.
GLG: I remember you first came to Singapore in 1984. Tell us more about that part of your experience in geriatric care in that era.

AM: I was invited to join the Department of Social Medicine & Public Health in the National University of Singapore (see historical note) by Prof Phoon Wai-On because of my experience in geriatric medicine, coupled with my recent Master’s degree in International Public Health. I am a clinician at heart and was frustrated to be restricted to working without patients. But I soon made up for that! With ongoing research into Parkinson’s disease and incontinence among the elderly, I was able to have weekly clinics. The support I received from colleagues to help the elderly at that time was invaluable.

Working with St Joseph’s Home in Jurong and other homes run by religious organisations brought about a new perspective on how having good institutional care was possible in Singapore. I also visited some of the private homes for the elderly and although some were good, there were also some that were really bad.

This led to me writing a book on international geriatric medicine that was published by PG Pub in 1989, with the forward written by Dr Lee Suan Yew. The second edition was promised by a wonderful young lady doctor working in geriatric medicine then. Sadly, she died after I moved on from Singapore and the next edition never came to fruition.

GLG: You are one of the pioneers in hospice care in Singapore. Share with us that part of your life.

AM: The Singapore nurses, headed by Sisters Geraldine and Mary Tan of St Joseph’s Home, and a few dedicated volunteers, including Cher and Siew Kim Florence, first came to me after a meeting in 1985, and asked for some form of home care for cancer patients who were not responsive to treatment and had gone home to await death. When we followed these patients home from the hospitals, we found that pain was no longer being controlled.

Yet from Dame Cicely, we learnt that there were simple methods to control pain so that the patient could stay comfortable till the end of life. This meant taking pure oral morphine regularly, titrated against the pain. Thus, holistic care for patients and their family members was possible when the terror of experiencing severe pain – now considered akin to torture – and it being witnessed by the family, was removed.

Morphine powder was already being imported into Singapore for making the “Brompton Cocktail” which contained not only morphine powder, but also sedatives (eg, chlorpromazine) and other additives. Also added occasionally was the local tipple such as whisky or gin. The trouble with this was that when the patient became drowsy, it was difficult to tell if it was due to the alcohol, sedative or morphine! Also, sedated patients were still in pain, and a drowsy person cannot function normally.

We asked the pharmacists at National University Hospital (NUH) to make us a pure morphine solution. This was when the formula for affordable pure oral morphine was first produced here in NUH. Oral morphine had only three ingredients: morphine powder, water and a preservative.

Before I left in 1990, we used this on more than 400 patients in the community, with no addiction or diversion observed. Over this period, we taught doctors, nurses, patients and family members how to use it. Gradually, the myths and fears of using morphine were dispersed.

After the Hospice Care Association was established in early 1990, I left Singapore in the hands of a very dedicated team headed by Prof Cynthia Goh who had joined us early in 1985, and she has since led Singapore to the forefront of palliative care in the world.

GLG: Yes, indeed. Prof Cynthia Goh has carried on your good work and taken palliative care in Singapore to where it is today. She also contributed a lot to the development of the Asia Pacific Hospice Palliative Care Network. Based on your professional experience, what message do you have for the world with regard to hospice care?

AM: The difference between palliative medicine and other specialties is obvious. The words “hospice” and “hospitality” both come from the same origins of hospes (Greek) and hospitium (Latin) that mean “hospitality,” hospices still reflect hospitality in addressing all the needs of each patient, and see each patient not just as their illness but as people with a life, family and community.
Hospital patients are often stripped of their dignity in order to fit in with the strict bureaucracy of health services and the busy schedule of doctors and health professionals. Hence, there is little hospitality. Shortcuts are taken to ensure that patients fit into a time frame and health professionals must hit the goals dictated by officials, often to make or save more money. This, to me, is very sad.

My message to the world is to ask each carer to be reminded of the aspirations that they had when they joined the caring community. The hospice ethos has three guiding values and those who follow these values form the caring community.

The three guiding values are:

1. **Care for the patient and family**
   Everything – in decisions, in care and in changing the environment for the patient – must be done with this question in mind: “How will this affect the patient?” This question needs to be asked by those in high positions within international organisations, such as the World Health Organization and International Narcotics Control Board, which make decisions and recommendations that directly affect patients, families and communities throughout the world. Additionally, this should be considered by those in the government sectors, carers, consultants, cleaners and those supporting all that we do. We as carers must recognise and address both the pathology of the body and spirit, as well as other areas of life that affect our bodily health.

2. **Care for each other**
   We should care for each other within our teams, our colleagues and those whom we work with at any level. This brings peace and harmony within teams, enabling the spirit of hospitality to be extended to all patients, families and even strangers. This enables us to go out in peace to provide comfort for the very sick.

3. **Support partner organisations**
   We should recognise that no man is an island. None of us can heal without the support of other organisations, specialties and support services. It is important that we respect and not put each other down in our seeking funds for our own work, and recognise that our patients have many needs and we need one another.

**GLG:** Thank you, Anne, for sharing with us your work and insights of the time. We look forward to you visiting us again.

**References**

1. **African Palliative Care** is palliative care that is adaptable to economies, cultures and needs of different African countries, tribes, etc. It is based on “African solutions for African challenges”.


**Historical note:** The Department of Social Medicine & Public Health, NUS was set up in 1948 and renamed in 1987 to Department of Community, Occupational & Family Medicine (COFM) when family medicine was included as a formal discipline in NUS and taught by COFM. The Department of COFM was next renamed Department of Epidemiology and Public Health (EPH) in 2009 with the departure of family medicine to join the Department of Medicine, NUH as the Division of Family Medicine. Since 2015, the Department of EPH has become the Saw Swee Hock School of Public Health.

**Legend**

1. Prof Merriman and A/Prof Goh Lee Gan during the dinner interview
2. Bottled oral morphine solutions for Uganda manufactured at HAU
3. Mah-jong group at Day Care Centre in HCA, Singapore, 2017

**A/Prof Goh Lee Gan** is currently a senior consultant and Professorial Fellow in the Division of Family Medicine, University Medicine Cluster, National University Health System. He was a colleague of Prof Anne Merriman in the Department of Community, Occupational, and Family Medicine from 1987 to 1990.
Quality of life for patients with advanced illnesses includes emotional, spiritual and social well-being. Patients and their family have informational needs that vary at different stages of their illnesses. There are opportunities for counselling throughout the illness. In cancer cases, psychological/spiritual distress peaks at diagnosis, disease recurrence and the terminal phase of the illness. Most patients/families would like to receive information regarding the illness, prognosis and future symptoms, and any information that will aid decision-making regarding treatment options at each particular stage of illness. The topics, especially prognosis, should be broached in a sensitive manner. Patients’ and caregivers’ informational needs should be assessed individually. As the illnesses progress, caregivers need more information especially with regard to the dying process, possibly so that they can be mentally prepared and to feel more confident in providing the required physical and emotional support. Meanwhile, patients may prefer less detailed information about prognosis or other end-of-life issues.

Understanding their needs
Illness trajectories provide a framework for physicians to address patient and family expectations with regard to anticipated progression in advanced disease. The disease trajectories in patients with advanced illnesses differ broadly between three different illness groups. Patients with cancer, especially those with solid tumours, maintain their function till several months before death when they experience a steep decline. Patients with dementia/frailty experience a gradual deterioration of cognitive and physical disability over several years. In organ failure, most typically represented by late stage heart, respiratory or renal failure, there are episodes of exacerbations that may result in death. If the patient survives the episode, his/her health and functional status may have deteriorated.

Recognising family dynamics and addressing family members’ emotions is crucial in assisting the integration of advanced illness into family dynamics. There should be preparation for any discussion, including negotiating who should be present during family meetings.
As perspectives may differ from member to member in the same family, it is important for the physician to use open-ended questions to elicit views from the family and to listen carefully in order to understand the different views. Each individual’s informational needs and level of understanding should be clarified in order to tailor the informational content. Checking the individual’s understanding of the health condition and goals is an ongoing process as the situation may change during the course of the illness. Patients and their caregivers should be given the option of not hearing the prognosis.

**Addressing their needs**

Advance Care Planning is an opportunity to engage both the patient and his/her family and should be performed early. It includes discussing preferences, values and contingencies at the end of life. As the illness progresses, changes in the patient’s and family’s preferences in response to the situation should be acknowledged and plans should be modified. In patients lacking mental capacity, the physician can encourage family members to think about what the patient would want for himself/herself, based on the patient’s values and beliefs.

Strong emotions such as anger, sadness and fear in response to a deteriorating health condition are common in patients. Family caregiving can also strain family bonds and affect personal well-being. Counselling skills support patients/families in finding solutions to their problems, and build a trusting relationship between the physician and the patient/family. These include 1) recognising and validating common feelings to let people know that they are heard; 2) normalising feelings to ensure that patients/families know that their feelings are common and they are not alone; 3) reframing perspectives – helping patients/families see their situation from a different and more helpful perspective; and 4) educating by providing factual information which helps give patients/families some control over their situation. Other communication strategies include summarising what has been said to capture the essential meaning and emotion, making concrete plans when needed and offering follow-up.

Home is the preferred place of care for most palliative patients as there is a degree of autonomy and dignity that is not easily reproduced in an institution. The caregiver plays a central role in providing medical/nursing assessment and services. This can be an overwhelming responsibility for a caregiver with no healthcare training. Specific information such as the following are required:
1) expected natural history of the patient’s illness; 2) emergencies that may occur; 3) present and future care needs; 4) options for alternative care arrangements; 5) administration of medications; and 6) indications and process of accessing professional advice 24 hours a day. Training in nursing care is also essential. The success of the home care plan depends on the relationship established between the healthcare team and the patient’s caregiving network.

When a loved one is dying, the family would like to know about the dying process so they can be prepared. There is a common pathway regardless of the underlying cause. It is normal for the patient to be less concerned about his/her surroundings. There is a decreased need for food and drink. The patient will also spend more time sleeping. Physical changes in skin colour, body temperature, consciousness, breathing pattern and respiratory secretions may occur. Families would also like to know the signs indicating death and the procedures required after death, including issuance of the death certification. Once the patient has lost mental capacity, the physician plays a proactive role in providing medical guidance to the family.

A trusted healthcare professional who shows empathy will clarify each individual’s informational needs and level of understanding in the discussions, and also encourage questions that are most valued by patients/family members. Referrals are indicated when the physical and psychosocial needs of patients/families exceed the level of current care being provided. The options include the hospital palliative care team, inpatient hospice or the community hospice team, depending on the most appropriate site of care.

Dr Yang is a palliative medicine consultant in Tan Tock Seng Hospital. She has an interest in hospice home care and is currently the consultant in charge of Dover Park Home Care.
When I was a trainee in family medicine back in Japan, I observed that many doctors seemed to consider their role as one who treats and cures patients' diseases as fast as possible. Hence, they paid less attention to palliative care and some even felt that palliative care was not part of a doctor's job scope.

To tell the truth, this is still a reality in Japan despite the percentage of cancer-caused deaths reaching 30%. As many doctors are trained as specialists with the purpose to save patients' lives, it may be reasonable for them to argue their case as such.

However, when it comes to a situation where patients are in the progressive states of illness and there is nothing much more to be done, the change in their doctor's attitude towards treatment may come to them as a shock, and patients may be disappointed with such attitude and complain that their attending physicians have given up on them.

Things do not end there. Given that the role of doctors is to perform the surgery as part of treatment, once the doctor considers the patient's lesion as unsuitable for the operation, or that chemotherapy or radiation therapy is not suitable for the patient's condition, they lose their role.

Aspects of palliative care

Recently, many health professionals have emphasised on the importance of a multidisciplinary approach to providing patients with appropriate healthcare and welfare intervention. However, doctors working in a hospital are generally less interested in this aspect and would leave this responsibility to allied health workers and community doctors.

After seeing such situations during my home visits for a terminal stage patient, I elected to do two months of training in a palliative care ward, aiming to provide better palliative care to my patients and to teach it to our juniors.

As you may have realised, family medicine and palliative care share a high affinity with each other. For example, family physicians in Japan usually use patient-centred clinical methods during the consultation (see Figure 1). This is because when it comes to health problems, we take not only the disease aspect (eg, biomedical points of view such as history, physical condition and laboratory testing) but also the illness aspect (eg, feelings, ideas, function and expectations) into consideration.¹

The consultation by a specialist is usually approached from the disease aspect, so they value history-taking, physical examinations, and laboratory tests and imaging. Of course, such an approach is important for all doctors and is necessary for all consultations.

However, regardless of the degree of their symptoms, many patients showcase the aspect of illness, such as a fear of, a pessimistic or optimistic view on, and excessive expectations of their condition. These feelings are easily wavered and affected not only by tiny changes in their condition but also proximal contexts (eg, family or relatives) and distal contexts (eg, cultures or habits of their region).

After understanding the illness aspect and how it affects a patient's emotions, family physicians can propose the type of end-of-life care that is acceptable to the patients and their family members. Sometimes, not just the patient but the family member may also request for something beyond what is expected.

Instead of declining such wishes and passing them off as unrealistic, we should dig deeper into the hidden meanings behind the requests, seek common ground and find feasible solutions through collaboration with a multidisciplinary team.
What is most important is that these patients and their family members only have very little time left to share. Once they miss the opportunity, they can never again afford it. This is why health professionals should have the ability to respond promptly to such requests.

When it comes to palliative care, many doctors tend to focus on pain control, symptom control and counselling. However, the role of doctors who work at hospices or palliative care wards differs from doctors who see patients with palliative care need in a community. Compared to the hospitals, medical resources in the community may be lacking. Therefore, family members have to play the roles of health professionals all day long. Besides counselling patients, evaluation and support to ease the burden of care of family members is important during home visit by family physicians.

Another characteristic of palliative care by family physicians is the continuity of care. Because family physicians do not only see patients who need palliative care, they have the opportunity to see also their family members or relatives during the process of building patient-doctor relationships. Such a wide range of continuity of care is one of the attractive points of being a family physician and is a precious experience for us.
Editor Dr Tan Yia Swam’s note:
Dr Wong has sent in a very heartfelt and personal article on his view of cancer. He shares his observations on the link between emotional and/or spiritual health, and the physical ailment known as cancer. While there is no strong scientific evidence for these, there is a small body of work associating emotions to biomarkers and health statuses. We will have to wait and see how science catches up with these anecdotal cases. I would also define “demon” here as “something insidious or harmful”, rather than the religious/mythical creature of evil. For those of us who rely on science to manage cancers, this is a reminder that we should also take into account the overall well-being of the patient – emotionally and spiritually, not just physically – and perhaps incorporate this into our daily practice (eg, referring to psychologists and/or psychiatrists; gently suggesting for stronger family or religious support as per the patient’s faith).

In 2016 alone, six of my very close buddies passed on – each struck down mercilessly by the ravaging cancer which had consumed them totally, rendering them defenceless and hapless. There are among us, courageous and inspiring cancer survivors, as well as languishing cancer-stricken patients – many of whom are just waiting for the final curtain to fall.

There is already much research into cancer, so I won’t go into the purely scientific explanation of this demon – this all-consuming evil that has caused so much pain, suffering and misery to so many people, many of whom were apparently in “perfect” health.

A game of roulette?
Is cancer purely a roulette game of chance that strikes anyone with sheer abandon? Or is it a diabolical evil and a devious demon lurking in all of us, waiting for a chance to gain control and devour us?

Or is it a form of punishment for us? Neither I nor my fellow professionals have the answer.

I was talking to a breast cancer survivor and she told me in hushed tones that she believed that the cause of her cancer was the emotional baggage she had carried all her life – the anger, depression, unresolved conflicts, unforgiving hurt, irreconcilable guilt, and her revengeful and vindictive behaviours. She confessed that all these chronic emotional feelings lingered on until she was struck down by cancer! Her mentor (and saviour) came to her rescue and guided her on letting go of the emotional baggage she harboured. She was taught how to release all her anger and guilt, and to seek forgiveness and acceptance. She was convinced that her mentor has saved her life.

After a successful surgery and a course of chemotherapy, she now lives a very peaceful and reclusive...
life, spending her time in quiet prayer and meditation. It has been ten years since her diagnosis. She is now emotionally “cleansed” with no hang-ups. No torments and no worries. And best of all, no cancer.

**Emotional stress and trauma – a cause of cancer?**

Wars, natural disasters, the loss of a loved one, domestic abuse, financial destitution, emotional upheavals, emotional guilt, irreconcilable conflicts, a cancer diagnosis, tragic childhood events – these and so many more situations can cause the “bottom to fall out” of our lives. They can also leave us with medically diagnosable psychological disorders such as post-traumatic stress disorder. However, the relationship between such life events and cancer is weak.

All of us have had some form of emotional traumas in our life, but not all of us have developed cancer. Personally, I believe it is not the traumas themselves that lead to cancer, but that unresolved negative emotions from the traumatic event, and the way one handles emotional stress or trauma might be the precipitating trigger. If, as a result of an emotional event, one becomes an emotional bully, cheat, aggressor and/or self-centred liar, cancer might grow like a creeper in you. I believe that the more emotional guilt one has, the higher the chances that cancer will develop.

There are several ways chronic emotional stress can lead to cancer: activation of inflammatory responses; inhibition of immune responses; inhibition of programmed cancer cell death or apoptosis; reduction in the cytotoxic function of natural killer cells; inhibition of DNA repair; stimulation of cancer cell blood vessels growth or angiogenesis; or the activation of epithelial-mesenchymal transition which can lead to cancer. All these have been reported and demonstrated. (Editor’s note: Studies have showed altered immunological responses in humans under stress, but are not able to show direct casual relation to cancer, yet.)

From anecdotal observations, I would say it takes around two years for cancer to appear when one has such emotional traumatic guilt and unwholesomeness. There is a tendency to internalise intense emotional reconciliation and emotional conflict which results in a drastic change in the personality: “Cancer Personality Profile” is the result. Sometimes, you look at a person and you can spot diagnose cancer! “He looks so worried and so anguished – and cachectic.” The intense emotional upheaval shows.

**Preventive and therapeutic measures**

I have read about some preventive and therapeutic modes of healing. Meditation and visualisation techniques to heal traumatic and guilty emotions have been suggested. Healing deep emotional wounds with hypnosis therapy is another modality of therapy. Emotional Freedom Techniques (EFT), or Meridian Tapping, have also been advocated to free the emotionally trapped person.

Exercise can prevent and possibly even cure cancer!

Exercise should be done mindfully though. Some incorporate prayers and meditation into their exercise regime. Some even chant a mantra while they are out taking a slow walk in the park. Exercising also helps you to detach from the stressful physical world. In other words, you learn to let go of, detach from and release your emotional guilt or pain. You give yourself some space and some privacy to heal the emotional wounds within you. Look inwards and seek peace and reconciliation.

Another way to alleviate any emotional guilt or stress is to accept, repent and redeem in your own way. It can be done through your religious belief or any other forms of spiritual practice. Cast away your guilt or trouble and let God settle it for you. Yes, pray, repent and seek forgiveness. Forgiveness is a very potent tool – it is self-healing and it heals others too. It removes anger and hatred – the two powerful toxins that will trigger the cancerous process. This will also release you from the emotional bondage that is stifling you.

Do all these before cancer strikes! The key word is **prevention**! If you have suffered an emotional guilt, do not be afraid to admit, repent, redeem and seek forgiveness. Release yourself from any form of emotional stifling that will trigger the cancerous process.

**What are emotional guilt and stifling?**

What is emotional guilt? It can be something personal – an irreconcilable relationship that becomes a chronic thorn and a daily stressor; an unwise or unethical financial transaction that keeps haunting you; or a sinful religious transgression committed for selfish and self-centred reasons. Any form of unwholesome behaviour that keeps haunting and plugging you with guilt could trigger the events that will lead to cancer formation. So know yourself and see where your emotions are driving you.

The choice is yours. Control your emotions. Avoid anger and fury. Display loving kindness, compassion and magnanimity. Repent, redeem and seek forgiveness. Detach, let go and free yourself from any form of emotional guilt and hurt. Do not let your mind be a storehouse of toxins. And keep the “demon” out of your life… Good luck!

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**References**


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Dr Wong Sin Hee is a family physician doing sessional work for clinics and medical groups.
A joint initiative by the Ministry of Health (MOH) and the Agency for Integrated Care (AIC), the Primary Care Networks (PCNs) anchor effective chronic disease management within primary care, providing holistic and coordinated care for patients with chronic conditions such as diabetes, hypertension and hyperlipidaemia. Currently, two PCNs have been established, one led by Frontier Healthcare Group and the other set up by National University Health System (NUHS).

Frontier PCN
- Pilot ed in 2012 with 9 GP clinics
- Now has 39 GP clinics that manage over 9,000 patients
- Taps on the Diabetic Society of Singapore and Community Health Centres for patients’ diabetic foot and eye screening tests

NUHS PCN
- Kick-started with 8 clinics in April 2017 and had since expanded to 23 clinics
- Makes multidisciplinary team-based care possible through shared care between the PCN GPs and NUHS Specialists to better manage patients with complex conditions

To encourage more GP clinics to work in networks, an inaugural application call for PCN proposals ran from 1 April 2017 to 31 May 2017. The response has been positive, with a total of 14 applications involving more than 200 interested GP clinics. Successfully awarded PCNs are targeted to commence from early 2018.

Dr Tan Tze Lee, Family Physician
The Edinburgh Clinic – Frontier PCN

“Through periodic follow up, close monitoring at the clinic and lifestyle modification advice from the PCN nurse counsellor, some patients’ blood sugar was so well controlled that their initial therapy had been reduced by more than two-thirds.”

Dr Tan has seen 47-year-old Ms Lim Yee Wah since 1992. Thanks to PCN, she enjoys individualised and dedicated dietary and lifestyle counselling from a nurse counsellor, as well as the convenience of mobile eye and foot screening services at Dr Tan’s clinic. She values the continuity of care and long-term relationship with Dr Tan.

Dr Mark Yap, Family Physician
Cashew Medical & Surgery – NUHS PCN

“Through imparting adequate knowledge such as meal planning to the patients through the PCN nurse counsellor, we are empowering patients to make informed and important choices that could impact their health conditions.”

Dr Yap has been seeing Mr Ong Keng Cheong, 68, for the past 15 years for his diabetes. With PCN, Mr Ong has benefitted by having more holistic team-based care with regular diabetic eye and foot screening, as facilitated by the PCN care coordinator and health counselling by the nurse counsellor.

To learn more about PCN and how you can be a part of it, contact AIC at gp@aic.sg or 6632 1199.
Since the inception of the SMA Clinic Assistant Train and Place Programme in November 2016, more than 100 SMA Members and their clinic managers have interviewed our graduates as a viable avenue to boost their staff strength. As a result, more than 40 SMA-trained clinic assistants have successfully found employment in SMA Members’ clinics over the past year.

From the November 2017 intake onwards, SMA Members can assess a job seeker’s fit for a clinic assistant position first-hand by participating in the work trial programme. The work trial programme for the November 2017 intake took place between 11 and 19 October 2017. You and your clinic manager can still interview our participants for employment opportunities during the November course from 2 to 4 November 2017.

Submit or update details on your clinic’s vacancy on the SMA Train and Place portal at https://www.sma.org.sg/trainandplace and indicate your preference for employment interviews. If you’re unsure about your membership login details or have any queries about the programme, please email Mellissa Ang (mellissa@sma.org.sg) or call her at 6223 1264.

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Do Doctors Have Hobbies, Still?

Text and photos by Dr Tomas Xu

Introduction

Medical paper writing has become part and parcel of a doctor’s training journey. Publication in reputable peer-reviewed journals has become a requisite to career progression and promotion. To some, it gives them a sense of achievement and recognition for the effort put in to write a good article. Having published two articles recently, I now understand the time and effort taken and it makes me wonder whether doctors still have their own personal time to do the things they like. Do doctors still enjoy or even have time for their hobbies? I have been asked to contribute an article on the topic, but instead of the usual standard abstract, let me go ahead with something that is less formal and hopefully I will provide some form of entertainment for our readers. Please pardon my writing as I talk about my hobbies: cars and anime.

Car enthusiast

It is indeed a privilege to be able to own a car in Singapore. The convenience of being able to move from point A to B almost without any delays, except when you are caught in a massive traffic jam, provides a smooth daily transition from my home to the workplace. I was extremely lucky to be able to own my first car, a silver Mazda 6, when I graduated in 2006 – the time when the Certificate of Entitlement rate was at a record low. The car was a gift from myself for passing the MBBS, even though the down payment essentially wiped out 99% of my savings account! While it served its core purpose of conveniently allowing me to reach my workplace at 6.15 am to do my pre-rounds, it also led to my discovery of my love for cars. In car enthusiasts’ terminology, the “poison” was seductive and the first step was to make “aesthetic” modifications: adding a rear spoiler, upsizing and changing to forged rims, and changing the front bumper. After the “aesthetic” enhancements came the “sensorineural hearing loss-inducing” exhaust modifications.

Dr Xu is currently a senior staff registrar working in the Department of Family Medicine, Sengkang Health. He is also an assigned assistant supervisor for MMed (FM) College Programme. He is currently undergoing the Fellowship Programme from the College of Family Physicians Singapore.
exhibit. Seeing the 18-metre tall Gundam RX78-2 was a dream come true for many Gundam fans but alas, it was removed on 5 March 2017. Thankfully, Bandai had great news for us and announced that a 24-metre tall RX-0 Unicorn Gundam will be the replacement! Another excuse to visit Japan again!

Conclusion
Life as a doctor will never be easy. The constant need to improve our medical knowledge, the amount of time spent on preparing for various post-graduate examinations and the never-ending medical paper writings, will often take up a large portion of our free time. To my fellow colleagues, do take a break at times to do the things you enjoy and do not abandon your hobbies!

Put in as much heart and soul to everything: hobbies, examinations, family. Let me end by quoting this phrase I learnt from the anime Attack on Titans: 心臓を捧げよ! (Japanese for “devote your heart”)

The poison didn’t end there and eventually came down to “palpitations” – inducing turbo-modification of the engine. So when the poison finally reached its maximal dose, it was time to change the car! I guess too much “poison” to the mind and wallet led me to my next phase of discovery: convertibles. A two-seater sports car, satisfying the need for speed and audio-visual pleasure, came in the form of a Mercedes SLK 200 with a full AMG Body Kit and 18-inch AMG rims. The pleasure of driving top down, feeling the breeze and getting the desired dose of Vitamin D, can unfortunately be hampered by unexpected showers and the yearly Southeast Asian haze. The convertible journey ended along with news of my wife expecting our first child. Reverting to the convenience of a sedan, my current F80 fulfils all the requirements of any car enthusiast; the 3.0L S55 straight six Twin Turbo with the 7-speed M-DCT transmission gives the acceleration akin to 00 Gundam Raiser Trans-Am mode, the aesthetic beauty of its exterior and interior and the sensorineural hearing loss-inducing exhaust sound when driving in the M-mode.

Japanese anime
That brings me to my other hobby. Japanese anime has always been a part of my life. It was during my secondary school days that I watched my first anime: Record of the Lodoss War. A typical teenager’s dream and fantasy: a heroic knight fighting goblins and dragons to save his elf princess from the evil wizard. The artwork of Japanese anime was so mesmerising that I was drawn to it like a moth to a flame. From its mystical fantasy to science fiction genres, anime provided me with a welcomed break from the intensive studying and examination preparations throughout my educational journey. Somehow, the Gundam Series became my first-choice anime over the years. I began collecting Gunpla (Gundam models) and the process of building each Gunpla was as exciting as modifying a car. From the simple assembly of the various parts to the airbrush finishing that gives the Gunpla the realistic look, the excitement and joy of completing the Gunpla and displaying them in my glass cabinet ignited the fire within my soul! The ultimate experience was my visit to DiverCity Tokyo Plaza in Odaiba to view the life-sized Gundam RX78-2 exhibit. Seeing the 18-metre tall Gundam RX78-2 was a dream come true for many Gundam fans but alas, it was removed on 5 March 2017. Thankfully, Bandai had great news for us and announced that a 24-metre tall RX-0 Unicorn Gundam will be the replacement! Another excuse to visit Japan again!

Legend
1. One of my early car modifications – the SLK 200 18-inch AMG rim
2. Just a few of my Gunpla collection
3. The life-sized Gundam RX78-2 at DiverCity Tokyo Plaza, Odaiba
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Dr Heng Siok Kheng graduated from National University of Singapore (NUS) in 1987 with MBBS (Bachelor of Medicine, Bachelor of Surgery), went on to obtain her postgraduate degree in 1993, and became a Member of the Royal College of Physicians (United Kingdom). She is a Fellow of the Academy of Medicine, Singapore and has obtained Specialist Accreditation as a Neonatologist in 2011. She has 30 years of experience as a doctor and 24 years of experience as a paediatrician.

Prior to her practice at Thomson Medical Centre and Mt Alvernia Hospital, she carried out her paediatric training at the previous Paediatric Department at Tan Tock Seng Hospital and later at Kandang Kerbau Women’s and Children’s Hospital. She has experience in dealing with newborn problems, treating common childhood illnesses as well as dealing with more serious problems needing hospitalization care.

With a personal interest in respiratory illnesses and having seen the evolution of medical care in Singapore in the last three decades, she is constantly seeking to fine-tune her medical practice to give her patients the best of care.

Dr Heng Siok Kheng
Paediatrician
MBBS, MRCP (Paed)
Children’s Clinic
Bld 177 Toa Payoh Central #01-163 Singapore 310177
T. +65 6334 8362 E. napeyosh@kidsclinic.sg
W. www.kidsclinic.sg

Dr Oh Meng Choo
Paediatrician
MBBS, MMed (Paed), MRCPCH (UK)
Kids Clinic @ Bishan
Bld 116 Bishan Street 12 #01-28 Singapore 570116
T. +65 6346 8005 E. bishan@kidsclinic.sg
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SHARE WITH YOUR PATIENTS ABOUT LASTING POWER OF ATTORNEY (LPA) TODAY!

3 Simple steps to complete our online module!

1. Visit the SMA website (https://www.sma.org.sg) and click on the respective module banners.
2. Register by filling in your particulars and clicking “Submit”.
3. Log in to the online portal and complete the module!

2 Online modules

**LPA Accreditation Programme**
As a prerequisite to being accredited, the medical practitioner (non-psychiatrist) has to undergo a familiarisation course on their roles for issuing an LPA certificate.

**Assessment of Mental Capacity under the MCA**
- Understanding the principles of MCA
- Assessing mental capacity
- Writing a Mental Capacity Assessment Report

1 Non-Core CME point for each online module

**MEDICAL REPORT FOR ACTIVATION OF LPA**
Doctors may use this medical report to assess the mental capacity of the donor. *This form can be found at https://www.publicguardian.gov.sg.*

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

For more information on LPA, please visit the Office of Public Guardian website at https://www.publicguardian.gov.sg.
COPD: Stay Updated!

Primary Care CME Series

Accredited for 2 Family Medicine Core CME points

Date: 18 November 2017
Time: 1 pm – 5.30 pm
Venue: Sheraton Tower Level 2
39 Scotts Road
S(228230)

Please send your name, MCR number, and email address through fax to 6223 9789 or email at pgmi.gpcme@sgh.com.sg

Pre-registration is required for CME points

In collaboration with:
The Chronic Obstructive Pulmonary Disease Association (Singapore)

Sponsored by:

AstraZeneca

Boehringer Ingelheim

NOVARTIS

1.00 pm Registration & Buffet Lunch

2.00 pm Welcome Address
Adj Asst Prof Tan Tze Lee
President of the COPD Association

COPD in 2017: Gold in the Guidelines
Dr Ong Thun How
Programme Director, SingHealth
Respiratory Medicine Residency

2.30 pm Spirometry: How to do it and what it means
Dr Adrian Chan
Director, SGH Pulmonary Physiology Lab

3.00 pm Smoking Cessation: Motivational Interviewing and Beyond
Dr Kalvanasundaram Ganesh
Assoc Consultant, Dept of Respiratory & Critical Care Medicine, SGH and SKH

3.30 pm Exercise therapy for COPD: What works & what does not
Dr Ong Hwee Kuan
Senior Principal Physiotherapist, SGH

4.00 pm Case Studies on COPD Management
Dr Jessica Tan
Director of SGH COPD Clinic & Consultant SKH

4.30 pm Quiz with Mystery Prize & Closing Address
Dr Phua Ghee Chee
Head, Dept of Respiratory & Critical Care Medicine, SGH

Followed by break-out sessions for hands on training on inhaler techniques and performing effective spirometry