SMA news

For Doctors, For Patients

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TELEMEDICINE

A GAME CHANGER IN HEALTHCARE DELIVERY?

Reimagining gout care

The **Electronic MC**

We invite Family Medicine Physicians and Resident Physicians, to join the medical team at Jurong Community Hospital.

The Post-acute & Continuing Care (PACC) team at Jurong Community Hospital (JCH) comprises physicians with postgraduate training in family medicine, geriatric medicine or internal medicine, providing inpatient care to patients that require sub-acute care or rehabilitative care after an acute illness or surgery. You will work with a multi-disciplinary team of nurses and allied health professionals to provide holistic care to JCH patients. You will also work in close partnership with community health service providers to enable care re-integration into the community.

REQUIREMENTS

Candidate must possess a basic Medical Degree and postgraduate qualifications registrable with Singapore Medical Council. Those who have MMed (FM), FCFPS or MMed (Int Med) or other postgraduate qualifications recognised by College of Family Physicians Singapore (CFPS) or Specialist Accreditation Board (SAB) will be considered for Senior Physician or Specialist positions.

JurongHealth Campus is a part of the National University Health System (NUHS) group, serving the community in the western region.

JurongHealth Campus comprises the integrated 700-bed Ng Teng Fong General Hospital (NTFGH) and 400-bed Jurong Community Hospital (JCH) which were designed and built together from the ground up as an integrated development to complement each other for better patient care, greater efficiency and convenience. NTFGH and JCH were envisioned to transform the way healthcare is provided, and together with the National University Hospital, National University Polyclinics, Jurong Medical Centre, family clinics and community partners, to better integrate healthcare services and care processes for the community in the west.

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Ng Teng Fong General Hospital
Jurong Community Hospital
Jurong Medical Centre

Members of the NUHS

We regret that only shortlisted candidates will be notified.

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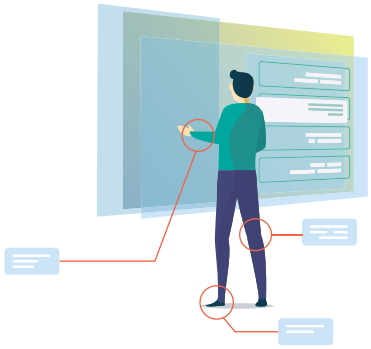

The EDITOR'S MUSINGS

Jimmy Teo

Guest Editor

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

Medical practice has changed significantly over the last 20 years with increasing digitalisation and computerisation, among other technological advances. The work habits of doctors have also changed with the adoption of these technologies. When I started as a medical student, Kodak and Fujifilm reigned supreme and radiographs were actual films; there was the "leisurely" pace of ordering X-rays or scans and ending the afternoon in the "bowels" of the hospital to review them (for some reason, almost all radiology departments are located at the basement level). By the time I started as a house officer in the National University Hospital, the first computers for viewing radiology reports were being installed. The sound of dot-matrix printers ripping out lab results at a furious pace was soon replaced by laser printers and electronic medical records.

Rather than with a big bang, small incremental steps were taken to change the way we did things. When I started internal medicine residency at Case Western Reserve Medical Center in Cleveland, Ohio, US, I had to get used to computerised ordering of laboratory tests and viewing discharge summaries on a computer. When I crossed over to the Wade Park Veterans Affairs (VA) Hospital in 2000, the hospital was already 100% computerised for all inpatient and outpatient electronic medical records nationwide – all 50 states! I remember this with awe because I was seeing a patient who was recalling his medical history, which I could not find in the system. He then advised me that he had just moved to Ohio from Hawaii. So I called the information technology department of the hospital where I got connected to an actual live person who was seated two floors down from me. His exact words were: "Doc, no problem, we will download it and you should get it by 2 pm. No consent for release of information is needed, as the VA is one system." More importantly, the VA hospital had a well-honed down-time requisition process, and you could do everything you'd do electronically in a manual fashion if it had to go stone-age for a while.

By the time I got to fellowship at the Cleveland Clinic, I was involved in the adoption of Epic in outpatient and inpatient electronic medical records. There were doctors who were power users, constructing their clinic work habits around them, and some doctors who retired the day the password mailer came in. Nonetheless, my experience has shown that change is the only constant – we have to continually reconstruct our professional services to work with newer tools. Overall, electronic medical records have increased our efficiency and productivity while reducing the cost of storing and retrieving paper medical records.

Similarly, we have to develop new work protocols and structures to fit newer technologies into clinical practice. One problem that people encounter when they attempt to adopt newer technologies in a doctor's work is the failure to recognise that the model of practice is a professional one. Assuming professional responsibility necessitates developing deep protocols and structures, including adequate reimbursement, or else any new proposed model will fail.

Instead, the technology proponents, designers and end users must first understand the professional model and adjust the offerings to strengthen the primary doctor-patient relationship in the first instance. If any attempt is made to undercut or weaken the professional relationship, doctors will not be able to support that platform as it would be a violation of the professional code of conduct or ethics. Thus, although new technologies appear to cost more, they may save money for patients and families in the long run, or improve timely access to care. These costs must be added onto facility charges and are part and parcel of long-term improvements in the way care is delivered.

Many of us are now grappling with the development of telemedicine. In this issue of the *SMA News*, we hear from doctors in a variety of settings facing new trials and tribulations in developing telemedicine. Let us learn from them and prepare ourselves for a brave new world.

TELEMEDICINE: BENEFITS AND DRAWBACKS

Text by Dr Kenneth Lyen

Wikipedia defines telemedicine as "the use of telecommunication and information technology to provide clinical health care from a distance." It is particularly effective in helping patients who face difficulties physically accessing direct medical contact.

A brief history of telemedicine

You could say that telemedicine started with the invention of the telephone and one could consult a doctor via a mere phone call. Some of you might remember carrying a pager – once a phone number appeared on the screen, you had to scramble around looking for a land line to return the call. All this changed with the invention of the mobile phone, but the earlier models could only communicate voice messages. Later phone models could transmit text messages and photographs. As the speed and volume of transmissible information increased, you could send larger files which carried greater clarity, send videos and do videoconference calls. Then came cloud storage, enabling everybody to store and simultaneously view and alter materials sent into the cloud.

Techniques of telemedicine

Telemedicine is generally practised from a hub, where a distant practitioner delivers service and advice through a telecommunications system. Current communication devices include mobile phones, computers and teleconferencing webcams. Currently, nearly all medical, nursing and allied health professionals are incorporating telemedicine into their operations.

Wireless networking (eg, Wi-Fi) using mobile phones is probably the most popular data transmission system used in telemedicine. Devices with sensors can emit signals that are transmitted to the mobile phone and in turn sent to distant healthcare facilities. Such sensors are getting increasingly sophisticated, allowing greater accuracy and a wider range of measurable parameters. Currently, the more popular devices in medical use include devices that measure heart activity (eg, the Holter monitor), blood pressure, oxygen saturation and temperature, as well as noninvasive skin glucose patches, global positioning sensors (for Alzheimer patients), activity/step trackers, and sensors embedded into pills that can check if you are adhering to prescribed medication. The list of health-related technological advances lengthens every year. I am intrigued by a new wearable device developed by Takeda Pharmaceutical Company and Cognition Kit that can sense psychological depression and is currently on trial. If this device really works, suicide rates could be reduced.

Benefits of telemedicine

The march of technology is unrelenting and, like it or not, we are powerless to resist or ignore it. On the positive side, the improved communication between doctor and patient can benefit patients, especially those who live in remote areas, and those who have difficulty with mobility, such as the elderly and disabled.

Reduces travelling time

Currently, telemedicine is used for patients who have received or are receiving treatment by a doctor – either recently discharged inpatients or regular outpatients with chronic diseases like diabetes or hypertension. The monitoring of blood pressure, ECG, oxygen saturation and blood glucose can be done at home, and medical consultations can be carried out via videoconferencing, preferably

on a secure network. Follow-up consultations conducted remotely at home save the patient from making extra trips to the clinic or hospital.

Allows initial management of emergencies

Some acute emergencies require prompt management, especially when rescue services take too long to arrive. Using videoconferencing to instruct patients or bystanders on basic first aid could make a difference between life and death.

Facilitates opinion-seeking

Telemedicine can be used to manage unusual disorders, especially if the pertinent subspecialists are not available. These include rare dysmorphic or genetic disorders, certain congenital heart diseases, atypical skin conditions and unusual movement disorders, among others. Even some common disorders can be managed using telemedicine. For example, I occasionally receive a photo or video sent to me by a patient who is travelling in a country that does not have good medical services, and I am asked to give an opinion. I always preface my remarks by saying that looking at a photograph or video is never as good as seeing the patient in the flesh, and therefore my diagnosis may be subject to a degree of error. Another scenario that I have encountered is when I have a patient with a difficult diagnosis or management issues; I can now discuss the problem online (without divulging the patient's identity) with a close colleague whom I know has the appropriate specialist knowledge. This is an extension of the old hospital corridor consultation, except that now it is a more distant consultation.

Minimises cross-infection

During the Severe Acute Respiratory Syndrome (SARS) epidemic in 2003, there were 238 reported cases, of which 33 patients died. Other regular patients were frightened to visit a doctor. I received numerous phone calls from patients seeking medical advice. Some of the patients sent me photos of their child's skin rash or diarrhoeal stools. I made diagnoses and gave medical advice on the phone, where appropriate and within my capacity.

Enhances medical education

Several medical schools, including the NUS Yong Loo Lin and Lee Kong Chian Schools of Medicine, videotape their lectures and allow students to watch the lessons using mobile phones or computer tablets. These schools also conduct their assessments and tests online. Medical books can be downloaded for reading on tablets and mobile phones, and YouTube is a great resource for video instructions on medical topics and surgical procedures. Students find these additional sources of information extremely useful, and some have stopped attending lectures and instead watch the recorded videos at home. Even interviews for some overseas medical school admissions are conducted via Skype.

Photo: Philips

1

In summary, telemedicine has many benefits, including reduced doctor visits, reduced waiting time at clinics, access to subspecialist opinions, avoidance of catching infectious diseases, home monitoring of several medical parameters, and enhanced online learning. The bottom line is that there is overall improved quality of healthcare and medical education, and ultimately it has reduced overall costs of healthcare.

Problems and limitations of telemedicine

However, even with all the benefits mentioned above, something is missing when doctors and patients do not meet face to face.

Underlying conditions

Let me illustrate this with a personal example. A mother brought her three-year-old son to see me because of a slight cough and runny nose. There was no fever and thorough physical examination was normal. I then asked the mother if there was anything else on her mind. She then told me about her worries about her son's development – that he was only saying a few single words, and he was not playing with the other children in his playgroup. The boy turned out to be on the autism spectrum, and her suspicion was the main reason why the mother brought him to see me. Quite often, the ostensible reason for consulting a doctor may not be the real reason. It is only with direct contact that the real reason for the consultation surfaces.

Overlooked diagnoses

Once, while examining a one-year-old baby boy who had diarrhoea, I noticed that he had squint eyes and an undescended testis. Both of these conditions would have been missed if his mother had only communicated with me over the phone or via the Internet. The consequences of missing these diagnoses include amblyopia with loss of visual acuity, and a risk of future testicular cancer. Direct human contact may be vital in the diagnosis of some medical conditions.

Clinical judgement

Another reason why direct contact with patients can be extremely

important is in the evaluation of the severity and urgency of a condition. Assessment of pain is a good example. I have had patients who are extremely sensitive to what I consider to be mild pain, and I have also seen the opposite where a rather stoic patient can withstand severe pain without batting an eyelid. The art of medicine is the art of judgement. This includes the ability to judge the gravity of an illness, and to discern a "phoney" patient looking for a medical certificate from a genuine patient. A balanced judgement assessing what is the optimum management strategy is best made through direct interaction with the patient.

Bad news

One of the grave duties that we have to perform as a clinician is the breaking of bad news. This is a serious moment when a great deal of sensitivity is needed. We need to assess whether or not the person to whom we are breaking the news fully understands the gravity of the information. There may be denial, guilt, anger, tears and depression, and one needs to deal with each of these reactions delicately and diplomatically. The road to acceptance may take a long time and sometimes more than one session. By listening and talking, we try our best to help the patient or his/her relatives weather the sadness. I think this is where the personal touch of face-to-face interaction transcends remote telemedicine.

Medico-legal issues

Consulting patients from a distance using mobile phones or the Internet is not the same as face-to-face evaluation of a disease, and potential errors in diagnosis and treatment could arise. Who is to blame if things go wrong? If the doctor and patient are residing in different countries; how does international law view legal disputes? What if the overseas doctor consulted has a medical degree not recognised by the country from which the patient is seeking advice?

It is often claimed that a patient's online information is secure, but the recent hacking of hospital medical records reveals that there is no such thing as absolute security in computer technology. Who takes the blame for the breach of patients' confidentiality?

While it is inevitable that telemedicine will continue its march into the healthcare domain, it is important to remember its limitations. While technology allows you to do distance monitoring of blood pressure, ECG and oxygen saturation, there are still areas in which humans can do better. These include palpating for swellings and lumps, examining a crying baby, and the early detection of subtle signs. Moreover, medicine must address not just the physical, but also the emotional aspects of disease. We must not forget that we also have a duty to be healers of the mind.

The future of telemedicine

Artificial intelligence

The future of telemedicine is already here. Some of my patients try to self-diagnose on the Internet. There are several online self-diagnosis programmes, including the Mayo Clinic Symptom Checker, WebMD, Isabel Symptom Checker, Symptomate and many others.

Some computer programmes can even more accurately differentiate skin conditions (eg, benign and malignant melanomas) as compared to human dermatologists.

Robotic surgery

The advent of robotic surgery opens another door for telemedicine. A surgeon does not need to be operating in the same hospital, or even in the same country!

Conclusion

Telemedicine is rapidly increasing its foothold on all aspects of medical practice and education. We have no choice but to embrace it. However, we do not wish to displace the human interaction baby by filling the bathwater with high technology. The evolution of medicine obligates us to use telemedicine and technology with intelligence and wisdom.

Acknowledgements

I would like to thank Dr Oliver Chen of Telemedicare and Dr Robert Kwok of Mount Elizabeth Medical Centre's Radiologic Clinic for valuable discussions and for insights into current advances in telemedicine. ◆

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Legend

1. Patient using a tablet to monitor his blood pressure and other vital health statistics in the comfort of his own home

Dr Lyen is a consultant paediatrician at Mt Elizabeth Hospital Orchard and a visiting consultant at the Health Promotion Board, Ministry of Health. He founded the Rainbow Centre, which manages three special schools for disabled and autistic children. He has co-authored 14 books on paediatrics, parenting, creativity and education. Website: http://kenlyen.wixsite.com/website.

HONOUR THE PAST EMBRACE THE FUTURE

Text by Dr Lee Yik Voon

Dr Lee is a GP practising in Macpherson. He is also a member of the current National General Practitioner Advisory Panel. He is a pet lover at heart who is the proud owner of a dog, and regularly feeds neighbourhood community cats. He also enjoys playing online war games and thinks that playing Pokemon Go is a good form of exercise.

60 years old.

That is how old our national medical association will be this year. After coming such a long way, how should we celebrate this monumental milestone?

While we ponder this thought, we should look back at some of the milestones we have achieved along the way. I recall the dark days when we helped our nation battle SARS. At short notice, we had to source for N95 masks, draw up standard operating procedures for clinics to demarcate their spaces to handle suspected cases, and gather doctors in batches, all dressed in personal protective equipment, for training on how to handle the crisis. We had a "déjà vu" experience when the H1N1 epidemic happened and we continue to think about how to prepare our doctors for future epidemics and pandemics.

We also remember the Guideline on Fees (GOF) that we started upon the request of the late Dr Kwa Soon Bee, then Permanent Secretary for Health and Director of Medical Services. We remember the anguish we felt when we were told that the GOF could be deemed anti-competition and we had to withdraw the guideline. The GOF has recently been reincarnated as the benchmark of surgical fees published by the Ministry of Health.

One of our annual events is the SMA Lecture. We have, over the years invited learned speakers, including non-doctors, to be our SMA Lecturer. Some examples include Chief Justice Sundaresh Menon, Mr Ngiam Tong Dow, Mr K Shanmugam and Prof Tommy Koh. They were invited because they have made significant contributions to the field of medicine and the community. The former Dean of NUS Yong Loo Lin School of Medicine, A/Prof Yeoh Khay Guan, delivered the SMA Lecture last year on the Future of Medical Education. How will we top what has come before, for this year's SMA Lecture?

Leaving the topic of milestones that the SMA has achieved, I would like to focus on directions in which I think the Ministry and the healthcare professional community should partner to move our country towards.

On the primary care front, I was told that primary care doctors would be busier this year as compared to previous years, as more measures would be implemented to improve the health of our citizens. We are already fighting the war on diabetes, managing dementia and mental problems in the community and helping our population age gracefully.

In the coming months, there will be more focus on moving patients under acute hospital care back to the community. The intent is to get our patients to receive appropriate care in the community instead of crowding our acute hospitals. Various initiatives are in place to empower our GP colleagues to do more for our patients at the primary care level, instead of sending them back to the tertiary centres due to a paucity of capabilities in the community. The Primary Care Network is one such move, bringing nurses and case managers together to help our GP colleagues provide team-based care and further enhance the capabilities of GP clinics. Diabetes foot checks and diabetic retinal photography services are also deployed to the community for better accessibility and better care in our war on diabetes.

Our medical students should also have their training set in the community instead of focusing on the more exotic cases seen in acute hospitals. They should be trained to manage the bread-and-butter medical conditions faced daily by our community.

Our primary care colleagues who have interests in mental health should also upskill themselves to manage psychiatric patients in the community. Those of us interested in providing care for geriatric and demented patients should also upskill ourselves.

From healthcare to health

We have talked about healthcare, but in reality, we need to emphasise on the health of the population. We need to go back to the old adage of "prevention is better than cure". So, in moving beyond healthcare to health, we will be revisiting preventive measures such as healthy lifestyles, exercise, proper diets, smoking cessation and limiting alcohol consumption. Proper washing of hands and wearing of face masks to cut down transmission of infections should be emphasised. We can reduce vector diseases by doing our part in the eradication of mosquitoes.

In addition, we may also attempt to prevent diabetes and kidney diseases through early detection of pre-diabetes and early kidney changes like microalbuminuria. It is possible to reverse these chronic diseases with proper evidence-based intervention. Health screening programmes, such as the enhanced Screen for Life, are useful for early detection of chronic diseases. This should be combined with motivation for behavioural change and maintaining the desired changes in our patients.

Sweep your decks clean and be prepared for more changes in the coming months. Keep your spirits up, go with the flow and ride the wave; when you encounter difficulties, you have a friend in SMA. We may not be able to solve every one of your problems, but at least we will help to set your sails in the right direction.

Happy 60th anniversary, SMA! We have come a long way and we have more challenges ahead; some will be new while others are revisits from our old friends and foes. How many of those in our fraternity can I count on to face such future challenges as brothers and sisters in arms? ◆

WORLD HEALTH CONFERENCE 2018

世界健康大会

Text and photos by Dr Daniel Lee

On 29 July 2016, Dr Margaret Chan, then Director-General of the World Health Organization (WHO), met with Mr Jack Ma, Special Advisor to the United Nations Conference on Trade and Development and President of the General Association of Zhejiang Entrepreneurs, in Beijing and they proposed the organisation of a conference that will be the global platform to drive the reform of world health, transform cooperation among governments and private enterprises, and promote sustainable and integrated development in health and healthcare. The first World Health Conference (WHC) was held in December 2017.

The second WHC was held from 19 to 21 October 2018 in Hangzhou, China, with the theme "Health and the Human Community". The conference focused on, among other things, the impact of innovative healthcare technologies and globalisation on human health. SMA representatives, Dr Lee Yik Voon and I, attended last year's WHC at the Chinese Medical Association's (CMA) invitation. Dr Lee, President of the SMA, kicked off the closed-door meeting and spoke on the role of medical associations in influencing healthcare legislation and policy, drawing examples from the work of the SMA in Singapore.

There were numerous presentations by keynote speakers and opinion leaders at the WHC. The plenary speaker, Dr Margaret Chan, who was the Director-General of the WHO from 2006 to 2017, is a medical doctor and alumnus of the National University of Singapore, where she obtained her master's degree in public health. Dr Chan revealed that although the medical field of public health was considered unglamorous at that time, she chose to specialise in the field initially out of love (ie, to be with her now husband) but eventually fell in love with the specialty when she was able to treat health systems through the use of policy, regulatory and financial levers at various levels. Dr Chan delivered her entire speech at the WHC in mandarin, recalling fondly how she was impacted by what Chinese Premier Li Keqiang once said, "我们不能让一个人生病，全家人倒下" (translated: we must not allow the illness of a single person to result in the breakdown of the entire family) and discussing how doctors must move beyond treating diseases and patients to building sustainable preventive health systems.

Other notable speakers included Dr Ada Yonath, a 2009 Nobel Laureate in Chemistry and an Israeli crystallographer best known for her pioneering work on the structure of ribosomes. She shared her research into novel antibiotic binding sites on pathogen ribosomes, which could lead the way for the design of next-generation species-specific antibiotics. Dr Yonath also shared that the rampant use of non-biodegradable broad-spectrum antibiotics that find their way into irrigation systems contributes significantly to the global antibiotic resistance phenomenon occurring across species. She further explained the potential of species-specific biodegradable antibiotics targeting novel binding sites on pathogen ribosomes, and called upon the government and industry leaders to double efforts in this area.

Ms Judith Faulkner, Chief Executive Officer and founder of Epic, shared how she started the healthcare software company in 1979 in the basement of an apartment house with US$70,000 start-up money and just two part-time

assistants. Hospitals that use its software held medical records of about 64% of the patients in the US and 2.5% of patients worldwide in 2015. At the WHC, Ms Faulkner shared that the mission of Epic is "Do Good. Have fun. Make Money (in this order)." Epic remains a privately held company today. As with the adage "culture eats strategy for breakfast", she emphasised the foundational importance of culture in a successful organisation and gave examples of how personnel introductions in Epic are made without the use of titles, and how colleagues convey "congratulations" to one another rather than "thank you" for jobs well done, where appropriate.

The conference concluded with site visits to the Shulan (Hangzhou) Hospital and Alibaba Group hosted by CMA for delegates of invited medical associations. Shulan (Hangzhou) Hospital is a 1000-bed JCI-accredited tertiary teaching hospital purpose-built about three years ago on a site where a hotel and retail mall used to stand. It specialises in liver and kidney transplant surgeries in China, among other things. At Alibaba Group, we caught a glimpse of the strength of her corporate culture and saw how a relentless focus on human capital and teamwork can be pivotal to an organisation's continued success.

We thank the CMA for inviting us to the WHC, and will continue to broaden and deepen ties with medical associations worldwide for the benefit of doctors and patients in Singapore. ◆

Legend

1. Mr Jack Ma officiates wedding ceremonies for Alibaba Group's employees

2. Dr Daniel Lee and Dr Lee Yik Voon with CMA Vice-President and Secretary-General Dr Rao Keqin (fourth from left) and CMA representatives

3. Dr Margaret Chan, Director-General of the WHO from 2006 to 2017, speaking at the WHC

Dr Lee (MBBS [S'pore], GDFM [S'pore], MPH [Harvard], FAMS) is an SMA Council Member. He is a public health specialist by training and Senior Director of Operations (Hospital Services) at Thomson Medical.

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HIGHLIGHTS

FROM THE HONORARY SECRETARY

Report by Dr Lim Kheng Choon

Dr Lim is the Honorary Secretary of the 59th SMA Council. He is currently an associate consultant at Singapore General Hospital.

Feedback on draft clinic regulatory standards

SMA submitted recommendations and comments to the Ministry of Health, relating to draft clinic regulatory standards that may be proposed under the proposed Healthcare Services Bill. Our preliminary comments for the draft cover areas on Basic Cardiac Life Support training, automated external defibrillator training and financial counselling, among others.

Member's query on residency posting evaluation

SMA responded to a member's request for advice on his/her residency posting evaluation. An SMA Council member has contacted the member and provided verbal advice and tips. Members who require assistance may email sma@sma.org.sg and SMA will endeavour to assist where possible.

SMA comments on Telemedicine on Channel 5's "Talking Point"

Dr Lee Yik Voon, SMA President, was interviewed on Channel 5's television programme, "Talking Point", which featured a segment on telemedicine. Dr Lee highlighted some challenges of telemedicine; for example, the lack of a face-to-face consultation could potentially compromise the standard of care provided and lead to a misdiagnosis.

A joint advisory by the College of Family Physicians Singapore and SMA on participation in Telemedicine and Online issuance of Medical Certificates, published in the January 2018 issue of *SMA News* (http://bit.ly/2CglEun), was also highlighted in the programme.

The episode is available on Toggle (http://bit.ly/2EqdoJJ) and the telemedicine segment starts from the 14 minutes 53 seconds mark.

SMACF's IPC status renewed for another two years

SMA Charity Fund's (SMACF) Institution of Public Character (IPC) status was renewed for a two-year period from 27 December 2018 to 26 December 2020. The SMACF is SMA's independent charity arm. Its work includes the managing of the SMA Medical Students' Assistance Fund that helps underprivileged medical students of all three medical schools. Donations to the SMACF will enjoy 250% tax deduction benefits. For 2018, SMA has contributed $20,000 as its annual pledge to the cause. You can donate to the SMACF at https://www.giving.sg/smacf. ◆

Keen to share where your wanderlust has brought you? Or perhaps you've discovered a fun activity that few know about? Maybe you've recently picked up a new hobby that you feel more people should consider?

We welcome all this and more. Send us your story at news@sma.org.sg today!

Ethical Issues around MEDICAL CERTIFICATES

PART 01

Text by Dr Neeta Satku

Medical certificates (MCs) are issued by doctors as evidence that their patient is unfit for work for a specified period of time, ensuring paid sick leave for employees covered under the Employment Act.[1] Doctors should be mindful of the importance of MCs in protecting both individual patients and public interest, and of the potential ethical pitfalls involved.

This article will discuss the Singapore Medical Council's (SMC) guidelines on the issuance of MCs, as well as the types of medical leave that can be specified in an MC. A second article will follow on the role of MCs in safeguarding public interests in matters of workplace safety and in limiting the spread of contagious disease, as well as the possible need for uncertified medical leave.

SMC ECEG regarding MCs

The SMC Ethical Code and Ethical Guidelines (ECEG) 2016 cautions doctors to consider medical factors when they issue an MC, and to guard against allowing the interests of other stakeholders to affect their actions.[2] In particular, doctors may be under pressure to alter the duration of an MC for non-medical reasons, such as requests from employers, financial incentives or workplace benefits for the patient. Patients also often request for MCs to be issued for a slightly longer or shorter duration, which may be granted when medically reasonable.

Doctors should respect confidentiality by writing a diagnosis on the MC only with the patient's consent.[2] For the same reason, the MC should be given directly to the patient unless he/she (and not his/her employer) requests otherwise. For civil servants, consent should be sought before electronic MCs are uploaded to the Government's Medical Billing System from registered clinics.[3]

The date of issue of the MC and the dates for which the patient is certified unfit for work must be clearly and accurately indicated on the MC.[2] If the doctor is reasonably certain that the patient would have been unable to work for a number of days prior to the consultation, the MC may be written to cover those days. However, the date of issue must **not** be backdated.

MCs should also be personally signed to ensure professional and legal accountability.[2] Doctors should not change the details on MCs written by their colleagues, and should instead write a new MC if they feel that there are medical reasons to do so. It is good practice to document in the clinical notes the reasons for such amendments.

In a recent case,[4] a doctor was fined $15,000 for activities that included multiple violations of the ECEG's guidelines for writing MCs. The SMC Disciplinary Tribunal also noted that they would have recommended suspension of 36 months, had the doctor been registered at the time of sentencing. These violations included backdating the date of issue on an MC, writing an MC for himself without medical grounds, and attempting to give the impression that the MC was written by another doctor. This case serves as a reminder that the ability to issue MCs is a serious responsibility.

Types of sick leave

A doctor should specify on an MC whether the patient requires hospitalisation leave or outpatient sick leave, based on the patient's medical condition (rather than on request).[2] Hospitalisation leave certifies that the patient's illness is severe enough to warrant hospitalisation.[5] He does not necessarily have to be hospitalised, however, and may recuperate at home if it is medically safe to do so.

Sometimes, a patient can return to work with certain limitations on the type of activities he can perform, in which case he is certified fit only for "light duties". The ECEG states that it is the doctor's responsibility, because of his/her medical expertise, to ascertain "to the best of [his] ability… that appropriate light duties are in fact available to the patients at their place of work".[2] This can present a challenge in practice, as doctors are allowed to rely on their patients' assessment of the availability of light duties.[6] Non-governmental organisations concerned with migrant worker rights have, however, suggested that there is a risk that this assessment may be influenced by pressure from employers.[7]

The Ministry of Manpower (MOM) encourages employers to grant paid sick leave if no option for light duty exists, but does not mandate this.[5]

As the system evolves, a more detailed document, perhaps resembling the fit note issued by doctors in the UK,[8] could be used to specify the type of light duties appropriate for the individual patient. This would allow employers to take greater responsibility for their employees' well-being, instead of allowing the burden to fall solely upon doctors.

Leave for appointments

The question often arises as to whether employees can use MCs to take paid leave to attend a medical appointment. The MOM website addresses this with the statement that an employee is entitled to paid sick leave as long as they are given an MC.[5] The doctor is thus at liberty to decide, based on medical factors,[2] when this is appropriate.

Alternatively, a "time chit" may be issued as evidence of a patient's

attendance at a clinic or hospital. The MOM, however, does not compel employers to accept time chits. This system may disadvantage low-wage workers who are less likely to be granted uncertified time-off, and shift workers who may resort to scheduling clinic appointments on their rest days to avoid losing pay.

When appropriate, and with the patient's consent, it may also be helpful to communicate with employers or to remind patients of their rights under the Employment Act. ◆

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Dr Neeta spent several years as a resident physician in anaesthesiology and clinical ethics. She is now a clinical tutor with the Centre for Biomedical Ethics and is eternally optimistic about the next generation of doctors.

SMA EVENTS
FEB–MAR 2019

DATE	EVENT	VENUE	CME POINTS	WHO SHOULD ATTEND?	CONTACT
CME Activities					
17 Feb Sun	BCLS+AED	SMA Conference Room	4	Family Medicine and All Specialties	Shirong/Terry 6223 1264 cpr@sma.org.sg
17 Mar Sun	BCLS+AED	SMA Conference Room	4	Family Medicine and All Specialties	Shirong/Terry 6223 1264 cpr@sma.org.sg
19 Mar Tue	Building Resilience and Avoiding Burnout	Sheraton Towers Hotel	2	Family Medicine and All Specialties	Margaret/Terry/Shirong 6223 1264 mpsworkshop@sma.org.sg
20 Mar Wed	Mastering Your Risk	Sheraton Towers Hotel	2	Family Medicine and All Specialties	Margaret/Terry/Shirong 6223 1264 mpsworkshop@sma.org.sg
23 Mar Sat	SMA CMEP Health Law (Basic)	SMF Building	2	Medical Practitioners, Lawyers, Nurses, Allied Health Professionals and Healthcare Administrators	Jasmine 6540 9196 jasminesoo@sma.org.sg
30 Mar Sat	Tax Obligations on Medical Practice	Novotel Singapore Clarke Quay	2	Aspiring and Current Practice Owners, Clinic Managers and Staff	Denise 6540 9195 denisetan@sma.org.sg

THE ELECTRONIC MC

Text by Dr Alex Wong, Editorial Board Member

Dr Wong is a private practitioner who talks too much. This occasionally leads him to write strange things, eat strange foods, travel to strange places and attend strange weddings/funerals that he doesn't necessarily always want to be at. He thinks this is fun and what life should be about.

"Why travel? Why wait?" screams a mobile application advertisement in bright and bold orange font. Another says, "No more travel time, no more waiting rooms and no more long lines."

Practice of telemedicine and electronic medical certificates (MCs) are on the rise in Singapore. It's easy and simple. Get online, talk to your doctor and get an electronic copy of your MC. It provides a great boon to patients by eliminating the need to walk to and queue at the nearest GP clinic. It's also a lot cheaper than arranging a house call which can cost hundreds of dollars.

It's fast, cheap and good!

Any child growing up here in the 1980s knows this concept. If it's fast and cheap, it can't be good; if it's good and fast, it can't be cheap. It's a concept I learnt as a child, wandering around the wet market behind my mother's knee while she haggled with the wet market fishmonger in Cantonese. "No such thing as *peng leng zeng (cheap, good and fast) lah,* aunty!" the fishmonger used to say.

Telemedicine and its good buddy, the electronic MC, however, has proven my mother's fishmonger wrong. Now, it's possible for medicine to be good, cheap and fast; telemedicine and the electronic MC have taken centre stage in the world of medicine. Virtual platforms offering health consultation and electronic MCs have sprung up in Singapore like mushrooms after a proverbial summer rain. A half dozen or so companies now practise telemedicine within the Ministry of Health's (MOH) regulatory sandbox, which allows healthcare providers to "introduce new healthcare models or evolve their models in a safe manner, in partnership with MOH to come up with best practices for the new technology".[1]

Sounds like a great idea.

The disabled physician

Except – of course – that it isn't a new idea.

Doctors have had the tools to conduct some form of telemedicine for years now. The telephone allows us to "hear", and so we've typically used the telephone to play blind doctor and communicate with

> **However, a physician who can see and hear, but cannot feel, auscultate, percuss or assess vital signs, is still a severely disabled physician.**

colleagues and patients for all sorts of reasons.

Typically, we have done so very cautiously because as health professionals, we understand that only so much information can be communicated via the phone. These have traditionally been restricted to consults with other trained health professionals and minor follow-up questions patients may have after going home. Such phone conversations are not uncommon, but they inevitably always end with the words: "Okay, but if you're not getting better, please come back and see me."

The advent of high definition video now allows the doctor to "see" as well, and the gain of this new virtual sense has spurred a wave of new companies clamouring to take advantage of this. However, a physician who can see and hear, but cannot feel, auscultate, percuss or assess vital signs, is still a severely disabled physician.

We didn't start the fire

One could argue that the application of telemedicine in the world is hardly a new thing and that there is significant online literature supporting the use of telemedicine. One would be correct to some extent.

However, the vast ream of online literature supports the use of telemedicine – in the chronic and follow-up care settings. The remainder of the literature supports the use of teleconsultations in rural areas where there is a lack of specialised medicine in conjunction with a primary care provider. There is precious little literature to support the use of telemedicine in an acute setting within an urban environment, and certainly not in Singapore where there is literally a GP practice on every street corner.

A legal document

The argument, of course, is that Singapore is different in its requirement of its denizens to produce an MC when they are absent from work. Therefore, it is logical that most patients are able to self-diagnose minor ailments and duly "report" their sickness to the doctor without much medical risk to the patient and legal risk to the doctor. That's certainly a logical argument, but not a very convincing one when you're in front of a lawyer who is cross-examining you for medical negligence. It also severely underestimates the value of the MC – a legal document enshrined in statutory law as a certificate only to be issued by a "medical officer" (defined as a practitioner recognised by the Singapore Medical Council [SMC]) who has "examined" the patient and is sufficiently satisfied that the patient in front of him/her is truly ill. The difficulty of properly examining a patient over a video call need not be elaborated on, and one can only speculate as to how the law would choose to interpret the word "examine" should a test case ever come to pass.

Recent events have already shown us that the SMC does not take the issuing (or withholding) of MCs lightly, and it would seem reasonable to assume that physicians who issue MCs in a laissez-faire manner do so at their own peril.

A ruling of criminal negligence

In the absence of a local test case, let's perhaps turn our attention to other shores. A recent case in India, involving the death of a patient after a teleconsultation, has resulted in a conviction of criminal negligence.This has given the Indian Medical Association pause to seek clear guidelines from their own medical council due to concerns that the ruling seems to be against the practice of telemedicine.

In the meantime, our own SMC remains fairly clear. According to SMC Circular No. 2/2018, "In summary, diagnosis, prescription of medicine and issuance of MCs via telemedicine… is subject to doctors' professional judgement and the precise circumstances of each presenting case."[2] That is to say that telemedicine is allowed, but only on your own professional judgement held to a standard of care delivered no differently compared to when you physically see patients in your own clinic.

That makes me think that perhaps I'd prefer to just see patients in my clinic. ◆

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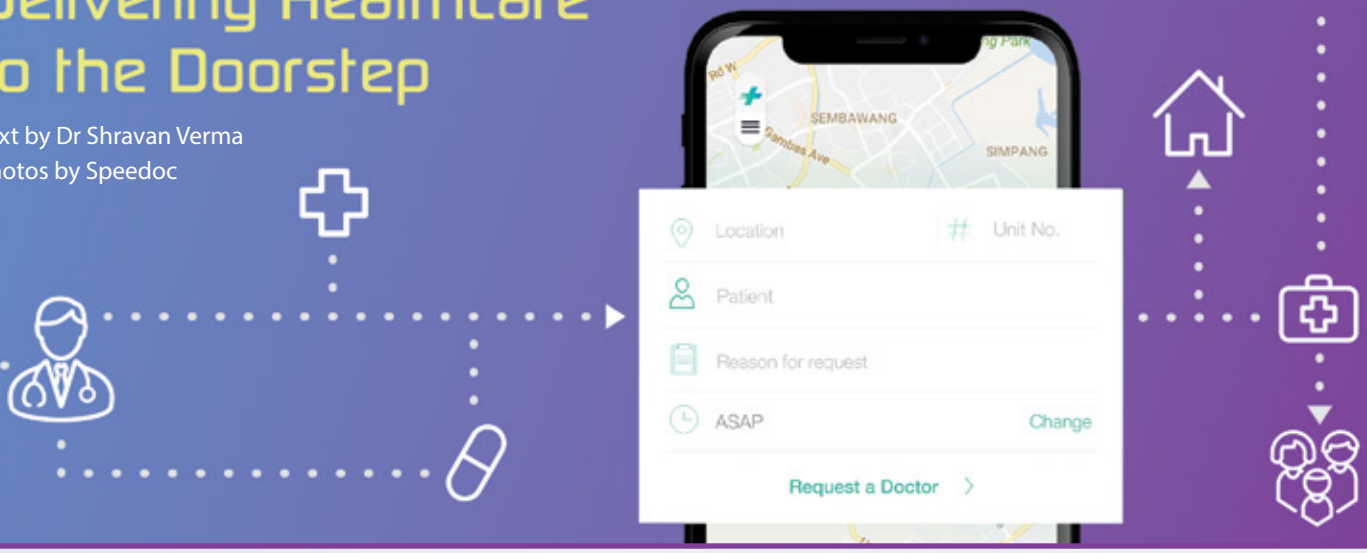
MOBILE MEDICINE

Delivering Healthcare to the Doorstep

Text by Dr Shravan Verma
Photos by Speedoc



Having always been interested in using technology to impact medicine, I decided to pursue biomedical engineering, alongside electrical engineering, at Duke University for my undergraduate studies. At that time, I saw my studies as a gateway to working on the research and development of medical devices, which fascinated me endlessly. Upon graduation, however, I came to the realisation that it was very important to have the knowledge, understanding and skills as a clinician to get to the root of some of the problems before working to solve them. I then enrolled in Duke-NUS Medical School and made my way to Singapore, where I graduated with a Doctor of Medicine (MD).

While rotating through the restructured hospitals, I noticed how the hospitals' emergency waiting rooms were overcrowded, often with patients who were suffering from non-critical conditions that could have been easily treated in the community. Yet, due to the time of day, lack of proper triaging, or even cultural factors, these patients were in the emergency waiting room for hours before they got the medical attention they needed.

The birth of Speedoc

It wasn't long before I started wondering if there was a way to distribute healthcare resources more efficiently. The idea of a mobile healthcare delivery platform came to me in a time of need. I had injured my shoulder during a game of soccer, and could not sleep due to the pain of bursitis and the need for prescription painkillers. I did not live near a 24-hour clinic and knew that it would be a long wait in the A&E if I chose to go. I ended up waiting until morning to visit the clinic downstairs, and in the long, painful hours of that night, I started putting together what was to become the platform we now have.

What if, I wondered, instead of having patients travel to hospitals and waiting there, we could use technology to enable skilled medical professionals to reach patients as soon as possible in a decentralised manner? What if this could in turn reduce the patients' need to go to the hospital and enable them to get the medical care they needed sooner? What if primary care providers took on a bigger role of triaging and, along with added professional medical advice, provided more value by allowing non-critical patients to be treated in the community?

I had a firm conviction that the answers to the aforementioned questions lay at least partially within the premise of mobile medicine.

Of course, there were challenges in setting up a new and loosely defined healthcare model in an industry which is heavily regulated. While there were house call providers in the market, most were stand-alone doctors or small companies. In 2016, the Ministry of Health announced that service-based licencing would be introduced under the upcoming Healthcare Services Act in 2020. They also launched a regulatory sandbox in 2018, allowing healthcare businesses and innovators to test new care models and services in a controlled environment. Among the services that were listed was mobile medicine. The time was ripe. I soon left the public healthcare system and started up Speedoc.

I envisioned an app where people could request medical attention in their own homes. People were already ordering food delivery through apps like Deliveroo, or transportation through Grab. People should be able to get medical care at the touch of a button. With the current trends of

technology and medical devices, it seemed a natural progression towards a decentralised, technology-enabled service with skilled providers carrying out medical care on par with that of a clinic.

Ensuring appropriate patient care

With the public perception of mobile medicine bent towards urgent care, patient safety had to come to the forefront of all that we did. One of the first things we did was to establish a strong triage protocol to ensure that patients did not present with any time-sensitive critical conditions or suffer from conditions that were unsuitable for house calls. Before each visit, the attending doctor or nurse made calls to the patients to understand more about their conditions. Under the triage protocols, patients deemed unfit for house calls were advised to visit a hospital or call an ambulance, where appropriate.

There were patients who called in presenting with a sudden onset of full-body numbness and weakness, and some who called in having difficulty breathing. These were clear-cut cases that we quickly escalated.

There were also cases that weren't so clear-cut, such as elderly patients who were gravely ill, but who had decided not to return to the hospital, wanting to remain home for the rest of their days. There were cases where the patient was deemed fit for a house call, but upon arrival of the doctor, was quickly found to require hospital-level care or treatment.

In each case, the doctor was able to establish an understanding with the patient and family about the different options of care, the risk levels of escalation or lack of escalation to the hospital and, when required, the ceiling of care for each patient. If the decision was to escalate, an ambulance and safe transfer of the patient was arranged to any of the suitable hospitals.

Uprising of similar services

Our app is not alone. Similar solutions are found in countries such as the US, UK, Australia and Malaysia, and they are all still in the nascent stage. With the nature of healthcare twisting and unfolding before our eyes at the turn of the decade, it remains anybody's guess what the healthcare system will be like in ten or 20 years' time. One thing remains certain – medical care must continue to be patient-centric and it will do all providers good, us included, to ensure that medical care remains accessible, affordable and timely. ◆

Legend

1. Dr Shravan Verma seeing a patient in her home

Dr Shravan graduated in biomedical and electrical engineering from Duke University, US, and with an MD from Duke-NUS Medical School. Entering medicine with a goal of bridging technology and healthcare, he started Speedoc to provide a platform for overall improvement in access to healthcare.

1

SMA Members' Appreciation Nite 2018

THANK FOR ANOTHER GREAT YEAR!

A big thank you to all who joined us on 20 December 2018 for the SMA Members' Appreciation Nite held at Golden Village Great World City. It has been a wonderful year of change, learning and networking, and we are ever so grateful for the support of our Members and volunteers. In the coming year, SMA will continue being a voice for doctors and medical students, and advocate for matters that impact the profession.

We hope that you have enjoyed the premiere screening of *BumbleBee: The Movie* and that 2019 will be a year of positive changes and transformation (pun intended)! ◆

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REIMAGINING GOUT CARE:

OUR DIVISION'S FORAY INTO TELEMEDICINE

Text by Dr Amelia Santosa

The incidence of gout is increasing in all parts of the world. As societies become more affluent, lifestyle changes seem to favour the development of this disease, which used to be dubbed the "disease of kings". The need for a structured programme for gout patients has long been recognised, due to the multifaceted treatment approach that is required to control the condition and its associated cardiovascular diseases.

The need for change

There exists a wide variability in the way gout is managed worldwide, likely due to differences in the perceived urgency for which uric acid (UA) levels should be controlled, physicians' comfort level with the traditionally feared complications of urate-lowering therapy (ULT), and the strong influence of patient preferences that determines the successful management of this condition. A 2008 clinical practice improvement project aiming to optimise UA control, conducted by our colleague Dr Anita Lim, demonstrated that target UA (<6 mg/dL; the solubility threshold of UA crystals) can be attained through a concerted multidisciplinary effort. The median time taken to achieve target UA was nine months at that time. On average, it took 2.5 clinic visits and active ULT dose titration during these visits for a patient with gout to achieve the target UA level. Some patients, however, needed up to nine visits during the timespan of this project to achieve the target. Post hoc analysis further revealed that during this period, 15% required admission to hospital with a gout flare prior to their successful achievement of target UA.

These figures illustrate the significant burden of managing gout; to the patient, who has to take many days off work to attend the many visits it takes to attain their target UA, and to the healthcare system, which has to be able to create sufficient capacity to see these patients. In addition, the interval between clinic visits should not be too far apart because this will prolong the time it takes for the patient to reach target UA, which will in turn lead to a higher risk of gout flares, to the further detriment of patients' work productivity and healthcare resource utilisation. However, clinic resources are finite and patients may not be able to take time off work at such close intervals. Our division was therefore interested to trial a new care model in gout management.

In 2016, our division embarked on another clinical practice improvement project, this time conducted by Dr Frank Tay. Its focus was to shorten the time to achieve target UA levels. In order to attain this sustainably, various aspects of gout care needed to be addressed. This included a continued emphasis on patient disease education (including flare management strategies) and a more deliberate attention to patient adherence. Our main intervention, though, involved the provision of ULT titration through telemedicine. We called this clinic the gout VMC (virtual monitoring clinic). In brief, we worked with physician extenders (in this case a rheumatology nurse) to deliver a protocolised, rheumatologist-supervised telemedicine programme to assist gout patients in achieving target UA levels in a safe and timely manner. Patients did laboratory investigations

at pre-specified time intervals at a location and time convenient to them. The rheumatologist would prescribe a ULT dose escalation after reviewing the laboratory results, and the nurse would inform the patient of the new dose telephonically. Patients then had the option to physically collect medications at their convenience or engage a courier service to have them delivered. Safety calls were embedded into the programme, to ensure that any adverse reactions were picked up early; these calls served the additional purpose of reminding patients to adhere to medications and clarifying any doubts. Face-to-face visits with physicians were required at the initial consultation to ensure accurate diagnosis and ascertain patient suitability; at any point that the patient or rheumatology nurse deemed necessary; and in our subsequent protocol enhancement at every fourth visit to ensure appropriate patient progress.

The median time taken to achieve target UA was a much shorter period of five months in this programme. Moreover, while gout flares were reported by a third of the patients, none required unscheduled clinic visits or hospital admissions, suggesting that patients were well equipped to manage their gout flares. Satisfaction among patients and rheumatologists with the programme was high. The programme also allowed us to generate clinic capacity for other patients, by reducing the number of physical clinic slots taken up for gout ULT titration.

Lessons learnt and next steps

Anchoring of the VMC by *physician extenders* allowed us to create clinic capacity while providing patients with more flexible communication touchpoints. Since the initial phase, we have now incorporated pharmacists into the gout VMC to assume the doctor's role in escalating ULT. A structured training programme with clearly defined objectives was designed to ensure that the nurses and pharmacists have a strong knowledge base. A well-defined VMC protocol further helped to streamline treatment and follow-up plans. We empower our nurses/pharmacists to escalate any patient to doctors for further input, if required. The National University of Singapore's newly launched National Collaborative Prescribing Programme may be particularly beneficial for physician extenders practising in a telemedicine programme. Going forward, we hope that we will have the opportunity to enrol our nurses and pharmacists into the course to strengthen their clinical foundation.

Appropriate *patient selection* was crucial in ensuring that patients benefit from the programme. As ULT – while mostly safe – can be associated with adverse effects, the initial face-to-face visit was important for the physician to exclude higher risk patients, such as those with limited cognitive ability and advanced renal impairment (eGFR<30 mL/min). Patient cooperation was very important, as they had to be able to communicate issues such as flares or symptoms of potential drug allergies to us during the VMC calls.

Patients were satisfied with the *flexible timing* for laboratory investigations and medication collection, which allowed them to have more regular titration of their ULT without having to miss work or other commitments. We were privileged to have been able to collaborate with primary care in the provision of laboratory services at various locations within our institution's catchment area. Such options helped to improve the accessibility of the gout VMC programme to our patients.

Conditions which rely heavily on physical examination are probably not suited for a telemedicine programme, while gout is a condition which we felt was amenable to tele-management through a clearly defined protocol. In our setting, the next group of patients whom we plan to incorporate into a VMC care model are those with inflammatory arthritis during their disease-modifying anti-rheumatic drug (DMARD) titration phase. As with our gout VMC, we will continue to *incorporate face-to-face visits at regular intervals* to ensure that any change in the patient's condition is picked up.

Most importantly, we were able to deliver holistic *multidisciplinary care* to our gout patients. The strengths brought to the table by the nurses and pharmacists, as well as the added benefit of regular telecommunication with the patients, have translated to not only more expedient care of gout, but also greater patient empowerment, as shown by their self-efficacy in managing gout flares and medication adherence, and staff satisfaction. ◆

Dr Santosa is a consultant at the Division of Rheumatology, National University Hospital (NUH). She currently serves as Clinical Services Director of the University Medicine Cluster and Division of Rheumatology, NUH.

HOW SHOULD YOU PREPARE FOR COURT APPEARANCES?

Text by Dr Bertha Woon

When you entered medical school, did it ever cross your mind that you may have to appear in court one day? Chances are, probably not. Does the thought of appearing in court fill you with a sense of fear, dread or apprehension? When you are called upon to appear in court, do you wish you could pass the "honour" to someone else?

The point is, sooner or later, you may be called to court as a witness of fact or as a court expert/medical expert witness. Being a witness of fact is relatively straightforward. It requires you to recount factually what happened during the incident in question, what role you played and what you did. As long as you are logical, reasonable and clinically sound, this should be a walk in the park.

I shall thus focus on preparing to appear in court as a medical expert witness, since this is potentially more trying. I shall also take this opportunity to encourage you to attend the Medical Expert Witness Training (MEWT) course that will take place over three days on 4 May, 29 June and 6 July 2019, where you will get to role play in a real court setting with real judges and lawyers.

Think of the court appearance as preparing for a distinction viva or a concert performance. As far as possible, fix the date and time slot that you are required to appear on, so that you can close your outpatient clinic and get another doctor to cover for your patient appointments. Do not allow lawyers to give you an open-ended duration and have you on standby to appear at any time of a certain week. Make sure the lawyer agrees to your fees charged before agreeing to attend. If your medical expert witness report has been very thoroughly prepared, and has already been tendered to court, you only need to appear in court for clarification and cross-examination. This will usually, at the most, take half a day.

The scenario and the scene – pre-trial preparation

Mental preparation

Before you agree to be a medical expert witness, make sure you have the appropriate level of expertise in the matter at hand and that you can afford the time to be involved in the matter. A healthy self-awareness is key.

Pre-trial preparations involve reviewing your expert report, refreshing your memory on the issues of contention, and confirming that the references backing up your opinions are up to date. It is good to discuss issues that the opposing lawyer may raise in cross-examination and how to approach the reply. Your instructing lawyer cannot coach you on what to say, but he/she can discuss with you generally what you intend to say and help you to express it better. You cannot bring any extra notes onto the witness stand because only the agreed bundles (documents that both sides have) are allowed on the witness stand.

If you discover that you have made an error, highlight it to your instructing lawyer so that he/she can correct it in court soon after you take the witness

stand. While you cannot discuss the matter with the other experts who are testifying in the same case; you can most certainly ask colleagues who have been expert witnesses before for tips. Treat it like a rehearsal for a play, in which you are the lead actor. Some people find it helpful to practise speaking in front of the mirror to observe their own demeanour, mannerisms and speaking speed.

Physical preparation

If you have never been to court, a trip to the public gallery to watch an on-going case in the court in question can be an adventure. Take note of where you would be seated in relation to the judge and lawyers. Most of the time, people find the air conditioning in the courtroom to be very cold, so do dress warmly. Men usually just have to wear a suit and tie to be warm. Women tend to have more considerations. Make sure that whatever you wear is comfortable, neat, professional and not distracting. Layering is a good idea.

Be familiar with the bundles of documents that will be placed before you at the witness stand. They are always lettered and numbered. Make sure you know where to turn to in the course of your testimony. You will appear confident if you know exactly where to find relevant material in the bundles to support yourself when you answer questions on the witness stand.

The performance – taking the witness stand on the day of the trial

By this time, you will already know all the material very well. When you are called to the witness stand, the standard procedure is to take the oath or affirmation, state your name, address and designation, and identify your affidavit of evidence-in-chief ("AEIC"), conditioned statement, and the attached expert report and confirm that those are your statements and reports.

When giving evidence, there are three parts: examination-in-chief ("EIC") conducted by your instructing lawyer; cross-examination by the opposing lawyer; and re-examination by your instructing lawyer.

> Remember that you have no vested interest in this matter and you should conduct yourself professionally with dignity and integrity. **Your job is to assist the Court to get to the truth and come to a fair decision.**

The EIC and re-examination should be friendly processes. It is meant to support the case and allow you, the medical expert witness, to answer your instructing lawyer's questions to supplement your evidence (if lacking) or to respond to new evidence that the opposing lawyer has submitted.

The cross-examination is where the opposing party's lawyer asks you questions to test your evidence, evaluate the truth of your testimony,or seek concessions on the statements or opinions already given. Most doctors get intimidated by lawyers who are particularly fierce, loud, rude or confrontational.

Do not be afraid. Hold your ground. My recommendations are to be confident but not cocky, and do not be intimidated or riled up. Usually, if the opposing lawyer is rude and intimidating, it means that his/her case is weak. Do not take it personally and keep your cool. Treat the belligerent lawyer as you would a difficult patient's relative and you will feel much better. Listen carefully to what is being asked and ask for clarifications if you are not sure of what the lawyer is asking. Pause to think and reply clearly without rushing. Be specific in your answers and be prepared to explain your reply. Sometimes, the opposing lawyer may try to force you to answer yes or no, even when the question cannot be answered with a yes or a no. Be firm that you need to answer properly. If you make a mistake, correct yourself. Do not volunteer information that was not asked of you. When replying, look at the judge at all times. Stop speaking if the judge interrupts or your lawyer is making an objection to a question that the opposing lawyer asked you.

Make sure you speak audibly, because there is a court transcriber who has to transcribe every word you say verbatim. Often, the judge will be writing down what you say in long-hand as well, so there is no need for you to rush at all. Do not use body language because that cannot be transcribed.

Lastly, remember that you have no vested interest in this matter and you should conduct yourself professionally with dignity and integrity. Your job is to assist the Court to get to the truth and come to a fair decision.

With that, I wish you good courage to go ahead and be a medical expert witness. ◆

Dr Woon practises at Bertha Woon General and Breast Surgery, Gleneagles Medical Centre. She is an advocate and solicitor of the Supreme Court of Singapore, an associate mediator at the Singapore Mediation Centre, and an associate of the Medical Protection Society. She co-chairs the Medical Experts Training Committee.

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3 lucky draw prizes worth more than $600 each to be won!*

Thank you for your support and membership as we continue advocating for doctors and patients in 2019. You can now pay your 2019 SMA Membership fees online through your membership portal!# All SMA Members who are in good standing by 15 February 2019, regardless of their mode of payment, will be eligible for this lucky draw. Good luck!

A novita AirCare Supreme™ Air Ionizer NAI9000
(worth $699)

B Apple iPad 9.7" 6th Generation Wi-Fi + Cellular 32GB - Silver
(worth $698)

C SMA eMarket Vouchers
(worth $600)

*Only SMA Members in good standing will be eligible.

#Your Member ID for the membership portal at https://www.sma.org.sg is the email address that you indicated upon your membership sign up. Please email us at membership@sma.org.sg if you have any queries.

Photos used are for illustrative purposes only

HEALTH LAW

BASIC & INTERMEDIATE

WHO SHOULD ATTEND?

Medical Practitioners, Lawyers, Nurses, Allied Health Professionals and Healthcare Administrators

BASIC HEALTH LAW

23 March 2019 **1 pm to 5 pm**

2 CME Points

Basic Understanding of Singapore Law

- Common Law
- Breach of Statutory Duty
- Breach of Professionalism

Statutes Regulating Doctors and Medicine

- The Private Hospitals and Medical Clinics Act
- Other Key Statutes

Doctors and Duty of Care

- Accountability
- Ethical and Legal Obligations

Legal Duty to Report

- Section 424 – Criminal Procedure Code
- When Should You Report?

INTERMEDIATE HEALTH LAW

13 April 2019 **1 pm to 5 pm**

2 CME Points

Professional Accountability and Negligence

- Roles, Powers and Importance of the Singapore Medical Council (SMC)
- The Elements of Medical Negligence: Duty, Breach and Damage

Medical Registration Act and SMC Proceedings

- Key Aspects of the SMC Disciplinary Process

Note: Topics are subject to change

DID YOU KNOW

You can track the SMA courses you have attended when you log in to your membership portal?

For more information, please contact Denise Tan or Jasmine Soo at email: courses@sma.org.sg or tel: 6223 1264, or visit https://smacmep.org.sg.

SMA CMEP Centre for Medical Ethics & Professionalism

OVERCOMING VISUAL IMPAIRMENT

Text by Lee Lay Hong

Lay Hong is a founder of iC2 PrepHouse and currently works as a vision teacher in the organisation.

Legend

1. Fingers reading Braille, an important learning medium for the visually impaired

2. Reading with magnification using a desktop magnifier

3. Joshua Babol (third from left) participating in the 2018 POSB PAssion Run with his family

When Joshua Babol started losing more of his sight towards the end of his Primary 4 and early Primary 5 days, his family was concerned about how he would be able to continue his education in a mainstream primary school. In 2016, Joshua was diagnosed with Leber hereditary optic neuropathy and referred to iC2 PrepHouse by Adj A/Prof Sharon Tow of the Singapore National Eye Centre.

At iC2 PrepHouse, he was taught skills that enabled him to continue his education without disruption; he learned how to use a desktop electronic magnifier which allowed him to magnify his reading materials to an accessible size, to touch type and to use screen magnification with voice. He also learnt to use the cane which helps him to move about safely. Additionally, iC2 PrepHouse worked closely with Joshua's school, Montfort Junior School, to help him adapt to using a scribe and reader, as well as the JAWS screen reader program to prepare him for his Primary School Leaving Examinations.

With the support garnered from iC2 PrepHouse and his school, Joshua achieved an aggregate score of 212, with an "A" in Science and "B" in both English and Mathematics. His school also awarded him with numerous awards such as the Best in Conduct Award, Exemplary Montfortian Award and Star Pupil Award. Joshua is currently in the Secondary 1 Express stream at Montfort Secondary School. He also participates actively in activities organised by iC2 PrepHouse and has even represented iC2 PrepHouse in the Singapore Kindness Run and POSB PAssion Run for Kids.

There are many children like Joshua who present with vision loss at a young age and struggle to find appropriate services to enable them to live life independently. While we have excellent medical resources to identify and treat children with sight disorders, there are still some who continue to present with low or no vision. Families of children with vision loss have few support services to fall back on.

Providing specialised support

Dr Audrey Looi and I set up iC2 PrepHouse as a charity organisation in 2012 to address this gap in service provision for children with vision loss. Being parents with children who are visually impaired, we understood all too well the importance of early intervention. The lack of structured services here prompted us to start iC2 PrepHouse, with the vision that all children with visual impairment will receive appropriate intervention to live a confident and fulfilling life.

To do so, iC2 PrepHouse first seeks to impart the necessary skills and knowledge to visually impaired individuals, such as visual efficiency skills, skills in the use of assistive technology and general concept development and learning in very young children. This will empower and enrich the lives of those with visual impairment, enabling them to lead independent and fulfilling lives.

iC2 PrepHouse works collaboratively with schools and institutions to ensure that visually impaired children are fully supported and included in the curriculum. Regular conversations are held either in person or via email to address concerns and queries. We also advise schools on the appropriate access arrangements for the children so that they have equitable access to national examinations.

Building social relationships

Parenting a child with visual impairment can be extremely isolating. A key part of our programme is to educate and support parents as they journey through life with their children. Various functions and activities are organised throughout the year to allow parents to come together to share with and learn from each other.

iC2 PrepHouse also organises and takes part in events to promote social interaction with persons of varying abilities. Our programmes reach out to both private and public institutions to create awareness of visual impairment and promote opportunities for greater social inclusion.

While it is difficult to remove the challenges that visual impairment imposes on the child and his/her family, iC2 PrepHouse seeks to mitigate the impact through various support programmes.

Joshua is currently working towards his goal of doing well in his GCE O-Level examinations. A firm believer of trying his best in whatever he does, Joshua believes that one should not give up in the face of adversity but instead continue moving towards success. ◆

iC2 PrepHouse Limited is a resource centre that caters to the needs of children and youth with visual impairment. To find out more about iC2 PrepHouse and the services we provide, please visit our website at https://www.ic2.com.sg.

2

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

TESTIMONIAL BY

Adj A/Prof Sharon Tow

Head and Senior Consultant, Singapore National Eye Centre Neuro-Ophthalmology Department, MBBS (Sydney), FRCS(Ed), FAMS

Through the services and helpful support of the staff at iC2 PrepHouse, the young patients with visual impairment whom I have sent to iC2 PrepHouse have benefitted in various ways, including learning how to cope with their vision issues and regaining their self-confidence. There are various activities in which the children can actively participate and experience a sense of being part of the community. This centre is a valuable resource for all young children who suffer from vision loss.

3

AIC SAYS

MANY HELPING HANDS TO SUPPORT AGEING-IN-PLACE FOR YOUR PATIENTS (PART TWO)

By Agency for Integrated Care

Besides physical health needs, senior patients often need support for their mental and social needs as well. In the last issue, we shared about Community Care services for senior patients using walking aids or wheelchairs, to keep their minds and bodies healthy and functional. In this article, we share about additional Community Care services for bedbound patients and their caregivers, as well as the financial schemes available to support care at home.

Senior bedbound patients and their families require as much support, if not more, than senior patients using walking aids or wheelchairs. As such, GPs who wish to render holistic support for bedbound patients may refer them to the relevant Community Care services (See Table 1).

Also, given that one of the most stressful concerns for patients and their families is working out the financial cost of caregiving, GPs may wish to share about the eldercare subsidies they may tap on, depending on their eligibility (See Table 2).

Table 1. Schemes available for bedbound seniors.

Type of Care	Bedbound Seniors
Taking a break from Caregiving	• Nursing Home Respite Care
Care Cost	• Caregivers Training Grant (CTG) • Seniors' Mobility and Enabling Fund (SMF) • Foreign Domestic Worker (FDW) Grant • Foreign Domestic Worker (FDW) Levy Concession for Persons with Disabilities • Pioneer Generation Disability Assistance Scheme (PioneerDAS) • Interim Disability Assistance Programme for the Elderly (IDAPE)[1]
Care at Home	• Interim Caregiving Service • Home Medical • Home Nursing • Home Therapy • Meals-on-Wheels • Hospice Home Care[2]
Residential Care	• Nursing Home

Care Cost

[1]Interim Disability Assistance Programme for the Elderly (IDAPE)

If your patient did not qualify for Eldershield when it launched, they can receive a monthly cash payout of between $150 and $250.

Care at Home

[2]Hospice Home Care

If your patient has advanced or progressive health conditions that are expected to progress in weeks or months, arrangements can be made for them to be cared for at home.

Table 2. Eligibility criteria for financial schemes.

<table>
<tr><th>Eligibility Criteria</th><th>Caregivers Training Grant (CTG)</th><th>Seniors' Mobility and Enabling Fund (SMF)</th><th colspan="2">Foreign Domestic Worker (FDW) Grant</th><th>Foreign Domestic Worker (FDW) Levy Concession for Persons with Disabilities</th><th>Pioneer Generation Disability Assistance Scheme (PioneerDAS)</th><th>Interim Disability Assistance Programme for the Elderly (IDAPE)</th></tr>
<tr><td>Patient's Nationality</td><td>Singapore Citizen or Permanent Resident</td><td>Singapore Citizen</td><td>Singapore Citizen</td><td>Permanent Resident</td><td>Singapore Citizen</td><td>Pioneer who became a Singapore Citizen before 1987</td><td>Singapore Citizen</td></tr>
<tr><td>Patient's Age/ Date of Birth</td><td>65 years old and above or certified to have a disability</td><td>60 years old and above</td><td>Not Applicable</td><td>65 years old and above</td><td>16 years old to 64 years old</td><td>Born before 1950</td><td>Born on or before 30 Sept 1932
OR
Born on or between 1 Oct 1932 and 30 Sep 1962, with pre-existing disabilities as of 30 Sept 2002</td></tr>
<tr><td>No. of Activities of Daily Living (ADL) that patient needs permanent help with</td><td>65 years old and above: Not Applicable
Below 65 years old and with physical disability: 1</td><td rowspan="3">Not Applicable</td><td colspan="2">3</td><td>1</td><td>3</td><td>3</td></tr>
<tr><td>Caregiver Requirements</td><td>Either a family member or an FDW</td><td>Not Applicable</td><td>FDW Employer must be a Singapore Citizen</td><td rowspan="2">Not Applicable</td><td rowspan="2">Not Applicable</td><td rowspan="2">Not Applicable</td></tr>
<tr><td>Caregiver Training</td><td>Caregiver must complete the training</td><td colspan="2">Caregiver must have attended an AIC-approved FDW Grant caregiver training course</td></tr>
<tr><td>Household Monthly Income[1] per Person</td><td rowspan="2">Not Applicable</td><td>$1,800 and below</td><td colspan="2">$2,600 and below</td><td rowspan="2">Not Applicable</td><td rowspan="2">Not Applicable</td><td>$2,600 and below</td></tr>
<tr><td>Annual Value (AV) of home for households with no income</td><td>$13,000 and below</td><td colspan="2">Below $13,000</td><td>$13,000 and below</td></tr>
<tr><td>Remarks</td><td></td><td>Approval for grant is subject to assessment by a qualified assessor to determine type and suitability of assistive devices or home healthcare items</td><td colspan="5">[1] Household monthly income per person = Total gross household monthly income / total number of family members

[2] Annual Value (AV) is assessed by IRAS. An AV of up to $21,000 covers all HDB Flats and some lower-value private residences.

[3] Activities of Daily Living (ADLs) are:
• Bathing
• Dressing
• Eating
• Toileting
• Walking or moving around
• Transferring</td></tr>
</table>

To find out more about these schemes,
contact your AIC Primary Care Engagement team at gp@aic.sg or call 6632 1199.

Zi Char Conquest!

Text and photos by Dr Leslie Tay

These food reviews were first published on ieatishootipost.sg, and have been shortened and collated for SMA News *by the author.*

There are plenty of hidden (and not so hidden) treasures in Singapore when it comes to *zi char* food. Here are 12 stalls which are worth checking out in the New Year (not in order of ranking)! More details about each stall can be found on my website.

May you find something worth spending your calories on!

1 Keng Eng Kee

Blk 124 Bukit Merah Lane 1, #01-136, Singapore 150124

Our first stop is Alexandra Village where we visit Chef Wayne for his Moonlight *Hor Fun* (月光河). If there is ever a dish to order to gauge the chef's wok skills, it has got to be *hor fun*. This very simple dish of rice noodles, fried with lard and dark sauce topped with an egg, is simply irresistible when the chef has managed to capture the breath of the wok (*wok hei*)!

KENG ENG KEE

2 Kok Sen Restaurant

30-32 Keong Saik Road, Singapore 089137

Kok Sen is one of those venerable zi char stalls that have served three generations of Singaporeans. They have a couple of signature dishes, but if I were to order just one, it would have to be their yong tau foo. They make their own stuffing from squid and prawns, and the items are braised in a wonderfully moreish sauce so tasty that you would break your low-carb diet and order a bowl of rice to go with it!

KOK SEN

3 Quan Ji

Amoy Street Food Centre, 7 Maxwell Rd, Singapore 069111

A French cook might be whacked over the knuckles if the surface of the omelette turns brown, but the Chinese won't have any of that. The best way to cook an omelette is with lots of lard at high heat, so that the eggs become really puffy and develop that nice crust on the outside. Then all you need is a bit of fish sauce and you would realise how tasty eggs can be! It's even better when it's served atop a mound of eggy noodles! This old school dish isn't easily found anywhere else, making it well worth the trip.

4 Sik Bao Sin

592 Geylang Road, Singapore 389531 (between Lorong 34 and 36)

I have been enjoying Desmond's wok skills ever since he was still cooking at his father's restaurant, **Sik Wai Sin**, which has been around for almost five decades. Desmond has gone on to open his own eatery just down the road at **Sik Bao Sin**. My must-order dish here is the tofu prawns, which is one of those dishes that is really bad when you are on a low-carb diet, because the sauce truly begs for a big bowl of rice!

5 Eastern House of Seafood Delicacy

46 Geylang Lorong 23, Singapore 388375

Also in Geylang is **Eastern House of Seafood**, which has recently relocated from Chai Chee. With the relocation, they have introduced the lobster *hokkien mee*, which is much like our usual hawker version except better, as it comes adorned with the crimson shell of a live (cooked by then) Boston Lobster! Their smoked chicken is also very unique and definitely worth a try!

JB AH MENG

6 JB Ah Meng

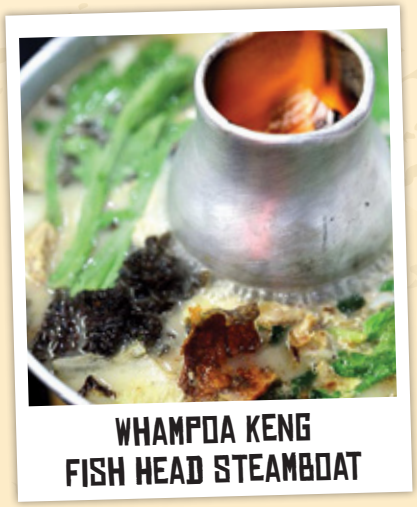
534 Geylang Road,
Singapore 389490

Yet another *zi char* stall in Geylang is one that stays open till the wee hours of the morning. It is the haunt for many chefs who come here for supper after closing their own restaurants! The white pepper crabs here are really tasty and so is their *san lou bee hoon*! This is the red light district, so try not to wander down the even-numbered *Lorongs* (small streets) on the left side of the main road!

7 Whampoa Keng Fish Head Steamboat

116/118 Rangoon Road,
Singapore 218394

It's a shame that fish head steamboat isn't usually mentioned in the same sentence as chicken rice or chilli crabs when it comes to iconic local dishes. Most of the time, it is relegated to the "B" list of foods to try in Singapore. But this dish is well loved by the locals and the stall that I find myself going back to the most is Whampoa Keng. The soup is very tasty and I also like the *san lou hor fun* which has got that *wok hei*.



WHAMPOA KENG FISH HEAD STEAMBOAT

8 Ocean Curry Fish Head

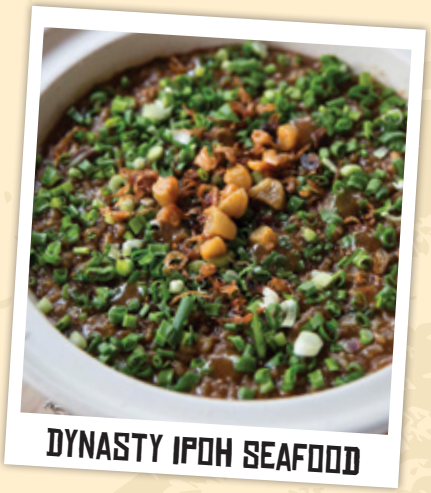
Blk 92 Toa Payoh Lorong 4,
#01-264, Singapore 310092

Fish head curry was invented by an Indian man who wanted to attract a Chinese crowd to his curry stall. I am not kidding! It's true! Anyway, there are many places where you can enjoy fish head curry, but the one that stands out from the rest is **Ocean Curry Fish Head**. The gravy is very nicely balanced and you can get really good quality wild-caught fish there if you request for it.

9 Dynasty Ipoh Seafood

Blk 151 Bishan Street 11,
#01-195, Singapore 570151

This stall in Bishan sells fried porridge. Yes, you heard that right. Fried porridge! How does someone actually come up with the idea of fried porridge? I don't know. How does it taste? Well, there is only one way to find out! They also have a very good Kuala Lumpur *hokkien mee* that is worth a try!

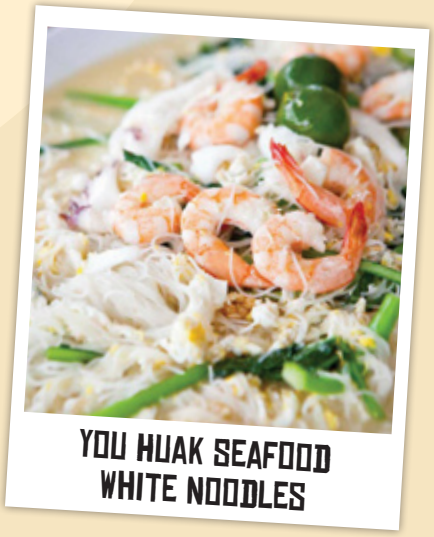


DYNASTY IPOH SEAFOOD

10 Hao Kee Seafood Deluxe

Blk 203 Toa Payoh North,
#01-1097, Singapore 310203

Hao Kee's deep fried kailan with pork floss is the perfect way to introduce kids (and adults who won't eat veggies) to start enjoying vegetables. It isn't exactly health food, but it is quite tasty. The *zi char* stall is helmed by a young Singaporean chef who really knows how to catch the breath of the wok, and his *chye poh hor fun* and *chao tar bee hoon* are always well worth ordering!



YOU HUAK SEAFOOD WHITE NOODLES

11 You Huak Seafood White Noodles

22 Jalan Tampang,
Singapore 758966 (opposite Sembawang Shopping Centre)

When I first wrote about You Huak's white *bee hoon* in 2011, they were just about the only ones famous for the dish. Since then, seafood white *bee hoon* stalls have opened up all across Singapore. Nevertheless, I still think that You Huak serves the best version of the dish.

12 Zai Shun Curry Fish Head

Blk 253 Jurong East Street 24,
#01-205, Singapore 600253

Zai Shun is the best place in Singapore for steamed fish. Not only is the fish fresh, the prices are also very reasonable. They even have fish like empurau and humpback grouper, which are not easily found elsewhere! Make sure you order the salted egg bitter gourd omelette while you are there! ◆

Dr Tay is currently practising as a family physician at Karri Family Clinic. When not at the clinic, he is looking for good food and writing about it on his blog, http://ieatishootipost.sg and social media sites. He has authored two books on Singapore Food and is widely regarded as an expert on local food.

• SALE/RENTAL/TAKEOVER •

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

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

Fully furnished clinic room with procedure room for rent at Mount Elizabeth Novena Hospital. Suitable for all specialties. Please call 8318 8264.

Buy/sell clinics/premises: Takeovers (1) D02 near Chinatown, MRT (2) D10 Bukit Timah, established (3) D20 Ang Mo Kio, with shophouse (4) D19 HD heartland practice (5) D27 Yishun, high turnover (6) D20 Bishan, HDB practice (7) D16 near MRT, mixed catchment (8) O&G practice, established, no takeover fees. Clinic spaces (a) Serangoon Central, HDB shop (b) Novena Medical Centre, 451 sq ft (c) Peninsula Plaza, town, 400+ sq ft. 9671 9602 Yein.

Established busy family practice in Central District. Well equipped, fully computerized, good ground floor location, very near to MRT, shopping and food centres. Looking for seriously interested party for prospect of takeover. For enquiries, please SMS 9687 3701.

Brand new, tastefully renovated clinic/rooms for rental at Royal Square Novena. Auspicious unit number, high 18th floor, available from January 2019. Please contact Regina 6235 0660.

Clinic consultation room to co-share with existing orthopaedic surgeon at Parkway East Medical Centre, Joo Chiat Place. Interested, call 6440 1566 to leave name and contact number.

Well established, fully furnished GP clinic in Tiong Bahru area with 50 years' history for takeover. Pool of existing patients, 2 consultation rooms, fully equipped, newly renovated, fully computerized with ClinicAssist software for CHAS, Pioneer Generation and TPAs. Good location and frontage, near market and human traffic, near MRT, auspicious unit number. Immediate. Terms negotiable. Please SMS 9818 3232 or email donlau@amda.sg.

• POSITION AVAILABLE/PARTNERSHIP •

Medisave approved O&G clinic of 36 years in Katong looking for partner with eventual takeover. Close to future Paya Lebar Quarter. Email: umtofamily@hotmail.com.

Rapidly growing medical group seeks GPs to join our health screening team in Orchard and Novena. Provide general health screening services, lifestyle-based screening services, comprehensive men's and women's health and corporate healthcare services. Submit detailed resume to hr@smg.sg.

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Full-time GP wanted by Stamford Medical Group Pte Ltd. 5-1/2 days work. Pay and leave negotiable. WhatsApp +65-9750 0678 (Loo).

Established busy family practice in Orchard Road looking for motivated junior doctor to work as associate with possibility of profit sharing in the future. Please write in with CV to fempract@gmail.com.

• MISCELLANEOUS •

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• SMA JOBS PORTAL •

Position : GO

Positions Available:

Click on each position's link for a detailed job description.

Date Posted	Position/ Job Title	Organisation	Application Deadline	Job No
07/01/2019	Doctor	GEO Aesthetics	28/02/2019	J00306
03/01/2019	Resident Trainees and Specialist Doctors with FULL Registration	Hospital Authority	13/02/2019	J00232
28/12/2018	General Practitioner	Stamford Medical Group Pte Ltd	15/02/2019	J00305
12/12/2018	Doctor	Dore Aesthetics Pte Ltd / Dore Clinic Pte Ltd	31/01/2019	J00285
11/12/2018	Doctors	O Medical Clinic by The ONLY® Group	15/03/2019	J00304

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Staff Registrar
Resident Physician

Requirements

- Possess a basic Medical Degree registrable with the Singapore Medical Council and/or
- A recognised post-graduation qualification such as Masters in Medicine in Family Medicine / Internal Medicine / MRCP

For interested applicants, please email your full resume together with relevant documents to schrecruitment@singhealthch.com.sg.

We regret that only shortlisted candidates will be notified.

Join us in shaping the way we deliver care beyond the hospital to the community, to achieve health goals with our patients.
For more information, visit https://www.singhealthch.com.sg.

Sheares HMO is a Health Maintenance Organization that provides corporate clients with one-stop healthcare solutions, focusing on convenience and sustainability. By incorporating modern technology with our 24/7 response team, prompt healthcare services are easily available. We have a presence throughout the Asia Pacific region, including China, Indonesia, Laos, Malaysia, the Philippines and Vietnam, where we work with reputable healthcare providers that have been hand-picked by the team.

Sheares HMO provides a comprehensive set of healthcare solutions, from health screening and telemedicine to corporate urgent care. In order to provide suitable healthcare solutions for everyone, Sheares HMO streamlines workflow for all stakeholders, ensuring smooth healthcare delivery processes for overall increase in productivity.

At Sheares HMO, we recognize the importance of every stage in the healthcare delivery process, from early detection to treatment and finally, recovery. Hence, we provide Executive Health Screening packages for early detection; specialist and inpatient care for treatment; and rehabilitation care such as physiotherapy.

Our carefully selected healthcare providers are experts in their own fields and in providing the most appropriate advice and services for our clients.

GENERAL PRACTITIONERS

Responsibilities
· Provide virtual care services for patients with acute and chronic conditions through online video consultations
· Provide primary care services
· Conduct health screening, including tests, consultations and reviews

Requirements
· Fully registered with the Singapore Medical Council
· Private practice experience preferred
· Able to commit long term, with a desire to grow with the company
· Innovative and adaptable

Benefits
· Profit-sharing

CONTACT
Name Jenifer Goh
Email jenifer.goh@sheareshealth.com
Phone 9022 8129
1 Pemimpin Drive #02-06 Singapore 576151

SHEARES HEALTH

JAPAN GREEN CLINIC

Japan Green Clinic has 35 years of history in Singapore providing general medical services in Japanese and English, to meet the medical needs of both Japanese expatriates and residents of other nationalities.

Supported by its medical facility, including X-ray and clinical laboratories and in coordination with specialists and medical centres in the vicinity, Japan Green Clinic offers general and comprehensive health screenings.

Japan Green Clinic is currently recruiting a
GASTROENTEROLOGIST
who is willing to take a leading role in this specialty.

Responsibilities
- Consultation, examination and treatment in the doctor's own specialty on a full-time basis
- Supervision of doctors with conditional registration

Requirements
- Accredited by the Specialists Accreditation Board
- Full registration with the Singapore Medical Council as a specialist for at least five years
- Actively involved in gastroscopy and colonoscopy for the past five years
- Good communication and interpersonal skills

Benefits
- Employee medical benefits
- Language-learning subsidy

Please send your full resume to:
Ms Doris Tan | jghsec@japan-green.com.sg | Tel: 6734 6577
Visit our website at: **https://www.japan-green.com.sg/english/**

UNITED MEDICAL

We are looking for two positions to run our new clinic at Novena Medical Centre:

DERMATOLOGIST

GENERAL PRACTITIONER
(with special interest in dermatology)

REQUIREMENTS
- MBBS or postgraduate qualification registrable with the Singapore Medical Council
- Relevant experience is an advantage
- Good interpersonal and communication skills
- Good professional ethics

BENEFITS
- Comprehensive benefits
- Attractive remuneration package including bonus
- Profit sharing

For interested applicants including foreign-trained doctors, please email your full resume to: **hr@unitedmedical.sg.**

10 Sinaran Drive #11-05 Novena Medical Centre, Singapore 307506
For more information, please visit http: //unitedmedical.sg.

HCA hospice care

HCA Hospice Care is the largest home hospice provider in Singapore and is a registered charity since 1989.

Our multi-disciplinary team of specialists makes about 37,000 home visits a year and serves an average of 3,500 patients annually.

As we continue to grow our clinical teams and set new benchmarks in palliative care excellence, we invite doctors who are passionate about making a difference in end of life care and share our values of Compassion, Professionalism and Respect to join us as:

Resident Physicians & Consultants (adult and paediatric medicine)
You will work alongside hospice nurses, medical social workers and other allied health specialists in the compassionate support of patients and families in the home and day care setting. This involves holistic patient assessments, care planning and ongoing reviews using a family centred model.

Learning and development to serve our beneficiaries better is always a priority. Hence local and overseas training opportunities are widely available, in various formats and at diploma and specialist levels. Research, education and quality improvement are other aspects within the anticipated scope of work.

Requirements:
- MBBS Degree registrable with the Singapore Medical Council
- At least two years of clinical experience as a doctor
- Post-grad qualifications or prior experience in other related disciplines e.g. Family Medicine, Oncology, Internal Medicine, Paediatrics or Geriatrics will be useful

Interested applicants are invited to submit a detailed curriculum vitae with a recent passport-size photograph to humanresources@hcahospicecare.org.sg

HOME IS WHERE THE CARE IS

Woodlands Health Campus
National Healthcare Group

SHAPE THE FUTURE OF CARE WITH US

Woodlands Health Campus will open progressively from 2022. Our 1,800-bedded facility will comprise a fully integrated Acute and Community Hospital, Specialist Outpatient Clinics and Long-Term Care facility.

We are already **serving patients in our pre-operations wards** located at the Yishun Health campus. Be part of a team providing **person-centric, quality care** that employs **practical technology** to improve the lives of our patients, community and healthcare family.

We are looking for motivated doctors to pursue a career in medicine with our fast-growing family.

As a **Resident or Staff Physician (Full time / Part-time / Locum)**, be responsible for the overall management of patients, under the supervision of senior doctors. We want individuals who can take comprehensive histories, perform thorough physical examinations, formulate differential diagnoses, investigations and treatment plans. Collaborate with other healthcare professionals to provide holistic care for our patients.

Career Path

Resident Physicians → Senior Resident Physicians → Principal Resident Physicians

Email careers@whc.sg to apply. We regret that only shortlisted candidates will be notified.

Asia Pacific's leading healthcare exhibition and congress

ASIA HEALTH CONFERENCES

DAY 1 26 March	DAY 2 27 March	DAY 3 28 March
Patient Safety Asia NEW Quality session	Patient Safety Asia NEW CSSD session	Patient Safety Asia NEW Antimicrobial Resistance session
Biotech Forum NEW	Oncology	
	Healthcare Procurement	

MEDLAB ASIA CONFERENCES

DAY 1 26 March	DAY 2 27 March	DAY 3 28 March
Laboratory Management	Clinical Chemistry	Haematology
Clinical Microbiology	Molecular Diagnostics & Genetics	Laboratory Informatics
Roundtable Discussions: NEW • Quality control • Body Fluid evaluation • Method Validation • Role of Lab in patient safety • Reference Intervals • Lab Administration	Anatomic Pathology NEW	Point of Care Testing

PLAN YOUR ATTENDANCE

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