# SMA news

For Doctors, For Patients

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Illustration: Dr Kevin Loy

# The EDITOR'S MUSINGS

Tan Yia Swam

*Editor*

Dr Tan is a consultant at the Breast Department of KK Women's and Children's Hospital. She continues to juggle the commitments of being a doctor, a wife, the *SMA News* Editor and the increased duties of a mother of three. She also tries to keep time aside for herself and friends, both old and new.

In the past weeks, two prominent events were highly featured on my social media feed: the death of Mr Aloysius Pang while on Operationally Ready National Service reservist, and a $100,000 fine.

Like most people, I was saddened and shocked by Mr Pang's death, especially in the wake of the other training-related deaths, and I await the results of the official inquiry with great vested interest. My three boys are still young, but they will be serving National Service in the years to come and I want to know how such tragic events could be avoided.

The $100,000 is another life-changer, at both a professional and national level. A lot has been said on this – some learned, some not so much. We carry an adapted version of the Hobbit's article in this issue. With her usual insights and bluntness, she gave a critical analysis of the event right after the news broke. There have been many developments; meetings, parliamentary questions and answers. The Singapore Medical Council (SMC) held a meeting with key appointment holders of the Academy of Medicine, Singapore (AMS), College of Family Physicians Singapore (CFPS) and SMA to clarify the processes that resulted in the $100,000 fine. Dr Lim Kheng Choon gives a brief report (see page 13). There is ongoing discussion on the problems that this has caused. The medical fraternity awaits proper guidance.

Social media is powerful and can create social unrest if used inappropriately. But it can also be used well to inform and educate. The petition with more than 6,000 signatures seems to have triggered a wave. Clicking a button is easy, but one wonders how much real change it can do. The professional bodies are not as ineffective or gormless as some of my acquaintances think. Real change happens when there is a meeting of like minds and real life action in slow gradual steps.

I appeal to the disgruntled keyboard warriors to step up and join committees in the professional body of their choice and be the change they want. There are the SMC, SMA, CFPS, AMS, and Alumni Association. Take your pick, or set up your own if you really feel that none of the above meets your needs.

Onto more light-hearted updates – the Lunar New Year and Valentine's Day have always been about family, friends and loved ones for me. With a family theme in mind, we have brothers – Drs Reuben Soh and Benjamin Soh, and twins Drs Keith Liang and Kevin Liang – share their thoughts about brotherhood in medicine. (Off hand, we didn't know of many sisters in medicine; if you are keen to share your stories, I'd love to hear from you!) Dr Tan Tze Lee and his wife run a clinic in the north where they have managed their practice successfully while raising their kids over the past 20 years. He shares pearls of wisdom on maintaining a harmonious partnership in work and life.

While loving and looking after others, don't neglect yourself either – self-care is important, be it in the form of food, drinks, rest, meditation or exercise. One of my favourite restaurants is Pasta J, and I've invited John, the owner, to tell us more about it. I love the food and it's a great meeting place, especially if you have fur babies.

Going full circle back to death, Dr Tina Tan reviews the book *When Breath Becomes Air*. How would you face your own mortality? Would you live your life any differently if the end date is brought forward?

It is not too late for New Year resolutions. Rethink your personal life; rethink your professional life. Are you the person you want to be? Are you the doctor you want to be? Take back ownership of the doctor-patient relationship. ◆

**18 February 2019**

# Called to the Same Profession

## Brothers in Medicine

Medicine is more than just a profession; it is a calling – to serve and do good together as a united profession. But have you ever wondered what it's like having a sibling who shares the same calling? In the following pages, hear from two sets of brothers who reflect on the ups and downs (mostly ups) in their common pursuit of medicine.

Text by Dr Benjamin Soh

My brother and I have always been quite different. For one, we grew up ten years apart with no siblings in-between (no, I'm not an accident), so I often felt like we grew up in different times; his – the era of SEGA, ICQ and dial-up modems (remember when your internet got disconnected every time someone called your house phone?) and mine – the era of the first Xbox, MSN Messenger and broadband. He grew up athletic, representing the school in track and field, while I took a liking to more artistic interests, joining debate and later the drama and photography clubs.

It is perhaps curious that we both ended up in medicine and coincidental that we both took an interest in musculoskeletal medicine. While I can't say for sure how much influence my brother had on my joining medicine, thanks to our large age gap, I had a pretty decent personal idea of the road ahead of me.

In particular, I have often been asked why I chose to do family medicine (with a view to do sports medicine) instead of orthopaedics, given that my brother was already in the field and could mentor me. For that, the answer was clear – I saw the intense

Reuben & Benjamin

Dr Reuben Soh is a consultant in the Department of Orthopaedic Surgery, Singapore General Hospital. He tries to juggle teaching, performing spine surgeries, spending time with his wife and three daughters, and his occasional sporting pursuits.

Dr Benjamin Soh is currently a final-year resident in the SingHealth Family Medicine Residency Programme who hopes to further his interest in sports medicine after completing residency. When not stressing out over his MMed (FM) preparations, he can usually be found lifting weights in the gym.

rigours of surgical life and decided that it wasn't for me! My brother worked in pre-residency times and I would often meet him going home at 7 to 8 pm on a regular day – the one day I met him going home at 5 pm, he was doing post call! As someone who struggled to stay awake after post-call rounds, I couldn't imagine another six to ten years of surgical training of that nature.

At the same time, I must say that the benefits of having an older brother in medicine are amazing – from MBBS tutorials (my clinical group got a three-hour "everything you need to know for orthopaedics during the MBBS" tutorial from my brother), to smooth integration with seniors (mainly in my orthopaedics posting, but also during National Service [NS]), to having a first-hand alternative perspective as a junior doctor of the benefits and challenges that consultants may face.

If it seems like there aren't many (if any) downsides, that would be because my brother is who he is – an ultra "*chiongster*" who juggled work and examinations, served NS, raised three children and ran triathlons, and yet was still one of the first in his batch to pass his exit examinations. Not only that – he is also a kind and nurturing teacher who won the Dean's Excellence Awards thrice, and rarely ever scolds his junior residents. Perhaps the only downside is thinking how I will ever match such an amazing roster of achievement!

Ultimately, I do feel that my brother and I have gotten closer from being in the same profession. We once grew up in different times, but now we share similar amusing stories from clinical practice; we once had our own mutually exclusive circles of friends, but now we know many of the same people from the SingHealth circles; we once had differing relationships with our relatives, but now just give them free medical consults!

Text by Dr Reuben Soh

*Passion is the fuel that drives medicine.*

Reflecting on my journey into medicine, I see the many lighthouses that guided my path. Two significant ones shine particularly bright. My mother worked as a staff nurse and often had many interesting stories of the hospital. Those stories intrigued me. How and why do doctors make decisions that impact the patient so profoundly? More importantly, why did they ask for a patient to be served meds stat near 3 pm, causing my mum to come home late, resulting in me missing my favourite television programme?

In junior college (JC), I was fortunate to get an observership in anaesthesia and that one week certainly helped me understand what life is like in the operating room. I saw the same surgeon, who performed a hernia repair, hemicolectomy and an appendicectomy in the day continue to work through the night, with several abscesses and more appendicectomies. However, what struck me was how he continued to have a cheerful disposition even in the wee hours of the morning as he proceeded to debride the groin and thigh of a patient with necrotising fasciitis. It was certainly inspiring to see how many patients he impacted during those 36 hours.

While I am sure there were other events that shaped my decision to pursue medicine, those two particularly stand out. However, I never actually related these to my brother as I did not want to overtly influence him in his career decision. You see, Ben was always better than me in his grades. With his International Baccalaureate score, he could have easily secured a course anywhere else and be in the running for many prestigious scholarships.

At his crossroads of JC and university, I told Ben that a life in medicine is tough. I was then a first-year orthopaedic registrar and being in a small unit, was frequently on call. I suppose, given that he has seen me falling asleep on the couch post-call, falling asleep on the floor after Chinese New Year reunion dinners and appearing chronically tired, it would have been evident to him that doctoring was certainly not for the faint-hearted. Nevertheless, it dawned upon me one day that he must certainly have the passion for medicine, especially since he could clearly see what lay ahead.

Being born ten years apart, it was interesting to have the chance to give orthopaedic tutorials to his class. It was always funny to hear whispering towards the end of tutorials, to which my query often drew the reply: "We can't quite agree which features you share with Ben Soh!" Recently, a smile appears whenever my residents or medical officers (Ben's classmates) introduce me to others as the brother of the Hulk/Silver Surfer, or as the brother of Singapore's strongest doctor.

Throughout his undergrad days, I saw many parallels in our interests in being part of Playhouse (an inter-batch play competition), building props for rag day, as well as being part of the freshmen orientation committee. Certainly, I think that our "true" age gap has lessened over the years as we have many fun sessions chatting about the dynamics of our workplace or grumbling about the challenges of residency. Thankfully, despite having hectic work schedules and being on call, we have gotten better over the years at participating in family meals especially during the festive season. Family meals continue to be peppered with stories of what happened in the operating room or polyclinic, and I'm sure that my daughters are eavesdropping, perhaps catching a spark of the same passion that drives Daddy, Mummy, Uncle Ben and Aunty Charmaine.

Dr Kevin Liang is a senior resident in the Department of Paediatric Medicine at KKH.

Dr Keith Liang is a senior resident in the Department of Paediatric Medicine at KKH.

# Kevin & Keith

Text by Dr Keith Liang

Being wrongly called over the phone by fellow colleagues, nurses and pharmacists; being greeted in the lift by strangers and seeing their embarrassed reactions shortly after; facing bewildered parents of patients who cannot believe their eyes when they encounter us one after the other – these are just a few examples of a day in the life of a pair of twins at KK Women's and Children's Hospital (KKH).

The good old twin jokes and questions somehow just never get old in the department. Kevin and I have been working together in KKH for about six years now, and every now and then we still face the usual barrage of questions we've been answering since we were young. From time to time, there's even that little game of "spot the difference".

Having a twin brother in the same profession and residency programme is a privilege that I deeply treasure. I entered medical school one year later than Kevin as I failed to get in the first year I applied. That was naturally tough, given that we had been in the same class almost every year since primary school. It was also humbling as my younger (by one minute) brother was now one step ahead of me in the journey of medicine. However, I knew that it was part of God's plan and although I probably haven't said this enough, I have always looked up to Kevin during this journey. I have relied heavily on his tips and advice throughout these years; whether it was choosing which microbiology notes to use, preparing for the final MBBS examination or surviving housemanship – I always held his advice in very high regard. Embarrassing as this may sound, he even walked me to my ward a number of times during my initial months in KKH as a new house officer!

Years down the road, Kevin is not only my lunch buddy but also my study partner, a source of support and my lifeline at work when the going gets tough. I know that I can always count on him to help me review a new admission in my ward or help with a difficult intravenous plug. I will always remember the bittersweet memories of studying and practising together for the MMED examination, failing it together (with the exact same score), and then subsequently passing it together and celebrating the fruit of our labour. To put it plainly, we just can't get enough of each other at work, and our colleagues often joke about how ridiculously close we are. Call it separation anxiety if you like, but you can't blame us considering that we've spent most of our lives (plus 36 weeks in the uterus) together!

My journey in medicine would never be the same without my dear twin and I certainly wouldn't have it any other way. God has blessed us with this privilege that only few have, and I look forward to many more years of "twinning" together in this journey.

Text by Dr Kevin Liang

I never dreamt that I would be in this profession, let alone be working alongside my twin brother in the same hospital and department. Our father had passed on when we were still in our early teenage years and due to financial constraints, we did not entertain the thought of this career path. However, God provided for us financially through our granduncle and grandaunt who saw us both through medical school.

My initial journey in medicine started off on a bittersweet note. When I received my acceptance letter from NUS Yong Loo Lin School of Medicine, I was elated. However, this joy was short-lived as I soon found out that my twin had not been granted a place. Throughout my first year of medical school, I hoped and prayed that Keith would one day join me on this journey. Well, he eventually did, and for that I am so thankful to God.

In God's divine plan, He allowed both Keith and I to be accepted into the SingHealth Paediatrics Residency Programme at KKH, where we have worked alongside one another since graduation. The opportunity to pursue paediatrics together as a career has indeed been a huge blessing for us and one that we are really grateful for.

Looking back, it has been a real privilege to have a twin brother! Growing up, Keith and I have never been far apart. For most part of our lives, we've been attending the same classes and training in the same tennis team. From a tender age, we had learnt to look out for one another, take care of each other and even stand up for one another when the need arose. This spirit, I'm proud to say, has not changed one bit over the years.

Having the opportunity to work together in the same hospital and department has certainly been an answer to our prayers. This has allowed us to support, encourage and help one another, especially during busy night calls. It's always heartening to know that we've got each other's back (and tummy) at work. Till today, we're still one another's faithful lunch, study and work companion. Some even say that we have started to develop separation anxiety!

The fact that we look identical also brings about an interesting twist to daily work. Our peers, consultants, juniors and even patients mistake us for each other almost on a daily basis! As a result, we have trained ourselves to respond promptly when called by either name and to smile or wave to anyone who greets us, whether we recognise them or not.

Being together in the same profession and hospital has definitely helped to strengthen our bond with each other. This journey has been such a special and meaningful one for us and I would not want to have it any other way! I'm thankful for this blessed opportunity and I look forward to the road ahead, serving others alongside my dear brother. ◆

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SMA eMarket

# Passion AND Compassion

Text by Dr Lee Yik Voon

February is here again and both Valentine's Day and the Chinese Valentine's Day fall in the same month this year. Both days are about passion and romance.

In our profession, we too often talk about passion in what we do. When was the last time you looked back and reflected on the reasons why you embarked upon this journey to be a healer? Was it because of your passion for this noble profession? Do you have enough compassion for your fellow human beings? Many of us wanted to be doctors because we care about others. We believed that our passion to study medicine was to fulfil our ambition. When we graduated and became house officers, reality hit us and became a wake-up call for many.

Ideally, we should know our patients inside out. It is a human failing for us to take advantage of them when we know so much about them. We are expected to not develop romantic feelings for our patients or even more so enter into relationships with them. Our calling and passion is the practice of medicine based on compassion for our patients and their sufferings, not to take advantage of them. Our code of ethics and professionalism continually reminds us of this.

## Passion for medicine

What is passion for medicine? Year in and year out, I see many of us toiling long hours in clinics, doing research, conducting home visits or volunteering on overseas mission trips. Personally, I feel good solving the medical problems of my patients, helping them see what their problems actually are and coming up with practical solutions that they can adopt.

Although most of us end up practising clinical medicine, a smaller number gave up clinical medicine and realised their calling after graduation. You may have met medical doctors fulfilling their calling in non-medical or non-clinical fields, like in politics, health administration, clinical and medical management in pharmaceutical companies, banking and manufacturing.

When I speak to the different subsets of our medical fraternity, I am often surprised to see many disillusioned doctors. They now realise that medicine is not how they envisioned it. Some are exhausted from the heavy and demanding workload, actual or perceived, and have lost their joy in what they are doing.

Does embarking on a journey to pursue the study and practice of medicine require such a huge sacrifice that we need to forsake everything else? There are many examples of both extremes but I think it is about what you really want in life and the trade-offs that you are willing to accept. Take for example a friend of mine, who got so tired of the medical scene in Singapore, he emigrated to Canada and worked as a factory worker in an assembly plant. He sells *bak kwa* as a side business. But medicine is still his calling and in his blood. He ended up taking the local medical examinations there and passed it. He is now working as a GP in a Canadian Chinatown and is more matured in the way he handles similar

medical practice issues that he used to face in Singapore. I suppose this is an example of a growing up process faced by a fraternity member.

We have numerous female doctors who are able to strike a balance between serving as a wife and mother, and working as a medical doctor. I am sure they have to make sacrifices but they are able to come to terms with their decisions.

## Sustaining our passion

I previously aspired to be a paediatrician and even sat for my MRCP entrance examinations. After passing that, I left the service to join the pharmaceutical sector to gain exposure to the corporate world. After five years of jet setting, I stopped as I dearly missed clinical work. I then worked as a part-time locum, but that did not satisfy my calling as I needed to feel ownership of my patients.

Now, after more than twenty years of running my own private practice and trying out all sorts of schemes run by private entities and the Ministry of Health, and the restructured hospital system that GPs in Singapore get exposed to over the years, I still feel the adrenaline rush when solving challenging problems for my friends and patients. Will this passion and longing die out in the years to come? Will I end up like those who burn out and no longer find clinical work exciting?

One of the reasons that we end up in this state is that when we were younger, we felt that we should push ourselves hard because we believed that we will become more resilient with time.

Will we regret when we fall and can no longer look after our patients? As doctors, we need to look after ourselves so that we can do our best for our patients. Will patients be forgiving when we slip up due to tight work schedules or insufficient sleep or when we are fatigued? Or will patients prefer that we love ourselves so that we are in better shapes to take care of their medical problems?

We also need to extend collegiality to our fellow brothers and sisters in the profession. We are one big family and yet we are guilty of pointing fingers when things go wrong. We need to inculcate a positive spirit so that we can groom future generations of doctors with the right values and in the right manner. After all, we need to have a good succession plan so that we can be better taken care of when we grow older and become patients ourselves.

At the end of the day, for some of us, when we hang up our stethoscope and seek what we have been yearning for all along – that is our real passion in life – only then will we be truly happy until we grow old and fade away.

Till death do you part, but for me, I see medicine riding with me as I gradually disappear into the sunset. ◆

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.

# 2019 AGM

Please mark your calendar for SMA's upcoming Annual General Meeting (AGM). The details are as follows:

**DATE**
14 April 2019, Sunday

**TIME**
2 pm to 4 pm
*(Lunch served from 1 pm onwards)*

**VENUE**
2985 Jalan Bukit Merah,
SMF Building, Singapore 159457
*(meeting room details to be confirmed)*

**MAP**
https://goo.gl/maps/K7Wz4QGWU192

Please send an email to **szeyong@sma.org.sg** if you wish to:

1. Confirm your attendance (for both the AGM and lunch);
2. Submit resolutions and/or proposed constitution amendments; or
3. Submit nominations to fill the ten vacancies in the SMA Council.

Do also take note of the following sections from SMA's constitution:

**Article XI, section 1, sub-section (iii)**

Any member desirous of moving any resolution at the Annual General Meeting shall give notice in writing thereof to the Honorary Secretary not less than thirty (30) days before the date of such Meeting.

**Article XII, section 2**

The proposed amendments to the Constitution and Rules shall be made in writing to the Honorary Secretary at least thirty (30) days before the date of the Annual General Meeting.

Members are invited to submit nominations of candidates to fill the ten vacancies in the Council, in accordance with Article VIII Section 3a of the SMA Constitution.

Nominations must be signed by two Ordinary/Life/Spouse Members and contain a consent to act, if elected, signed by the person nominated.

All completed forms should reach us by 12 noon on 15 March 2019.

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*For more information on LPA, please visit the OPG website at* ***https://www.publicguardian.gov.sg.***

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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.

### SMA seeks clarification from SMC following the Grounds of Decision of the Disciplinary Tribunal Inquiry for Dr Lim Lian Arn

When the Grounds of Decision for this case were published, SMA Council wrote a letter to Singapore Medical Council (SMC) on 24 January 2019 to share comments expressed by its Members about its implications. Following the letter, the SMA Council met with SMC on the evening of 25 January 2019 to better understand the reasoning behind the judgement and penalty, and to discuss practical implications to clinical practice that now arise in consequence. A second meeting, also with the SMC presenting, was held on the evening of 31 January 2019 together with the leaders of the Academy of Medicine, Singapore and College of Family Physicians Singapore.

At both meetings, SMA and other participants pointed out to the SMC that given that the complications experienced by the patient from the minor procedure were neither permanent nor debilitating, and as the harm which ensued was limited in nature and extent, the penalty of $100,000 seemed disproportionate. Questions were also posed to the SMC about their views on what the appropriate benchmark sentence(s) for failure of informed consent cases ought to be.

Regarding minor procedures, three very important points of everyday practice now needed clarification: First, precisely which minor procedures could be done just under implied consent; second, how comprehensive was the information that needed to be communicated, including under implied consent; and finally, whether documentation in the case-notes was now mandatory (as opposed to merely good practice), including for cases done under implied consent. Unless definitively clarified, such uncertainty would only encourage the practice of defensive medicine, which would not be in the interest of either doctors or patients.

We also pointed out the current ambiguity and resultant practical difficulties facing the junior doctors over consent taking for minor procedures, and how, without proper guidance, the time required for defensive medical practice would eat into what was presently available for routine patient-care. This was summarised in the letter to the Straits Times Forum on 11 February by the Chairman of SMA's Doctors-in-Training Committee, Dr Benny Loo. The letter can be found at http://bit.ly/2DvdrBJ.

Other issues discussed included how some members of the Complaints Committee and Disciplinary Tribunal might benefit from more formal training in aspects relating to how to consider expert opinions and how to judge fellow doctors. An offer by the SMA Centre for Medical Ethics and Professionalism to work together with the SMC was accepted for consideration.

The SMA Council will continue to engage with the SMC and to advocate for greater clarity and guidance on consent taking. We will keep Members updated as new information becomes available.

### SMA committee against harassment

SMA recently formed a committee to look into the issue of harassment at work. As a start, the committee plans to publish a series of articles in *SMA News* on this matter. We also look forward to engaging external stakeholders to organise activities and initiatives. We hope to raise awareness regarding harassment and help reduce the occurrence of such incidents in the workplace.

### Predatory publishing

The issue of predatory publishing was highlighted by the *Singapore Medical Journal (SMJ)* Editor-in-Chief, A/Prof Poh Kian Keong, in his January 2019 issue's editorial. Predatory publishers typically ask for high upfront publication fees without providing robust peer review or editorial services. There have been several cases where *SMJ* had to decline submitted manuscripts which have been published in predatory journals without the authors' knowledge. We encourage readers to find out more about predatory publishing and avoid the pitfalls. The full editorial can be found at http://bit.ly/2tdxmQR. ◆


Text and photos by Dr Tan Tze Lee, Deputy Editor

The town was dusty and the air hung heavy with the scent of fresh cement and diesel fumes. The bus interchange, the centre of public transportation in Choa Chu Kang, was operating at a furious pace. The MRT line also ended precipitously there, the extension still in the distant future. The train emptied at Choa Chu Kang, with commuters big and small, young and old, pressing for space on the myriad feeder buses serving the region.

We walked several times around the new town centre. It was empty – bereft of shops and facilities. A lone coffee shop stood empty and forlorn at the edge of the interchange. *Fabulous! We must bid for the shop space opposite!* Two months later, we were the proud owners of the 99-year lease space from the Housing Development Board. We could finally start on our journey as family doctors in a new town.

We now had a shop space, but how do we maximise the space? Ideas and suggestions streamed in from all corners. We took on board many of the suggestions, distilled them and presented them to an architect friend. A design was proposed, the tender was awarded and eight weeks later, we had a complete clinic space outfitted with the then latest in clinic innovation.

## An equal partnership

I couldn't have done all this on my own. My better half, L, hovered in the wings with a watchful eye, whispering pearls of wisdom during the discussions, dotting the i's and crossing the t's. We have an equal partnership in every way. We voice out our ideas, concerns and expectations (*Yes, we do that too!*) to each other and always try to come up with a final decision that takes all the ICEs into account.

We have faced many challenges over the years. Hand, foot and mouth disease, bird flu, SARS and H1N1 – all this happened on our watch. They gave us a real fear in our belly doing the work we had dedicated our lives to. For the longest time, doctors on our fair shores worked in relative safety, but the last 20 years have been a roller coaster for the medical profession. For the first time in decades, going to work could mean getting an infectious disease, carrying the agent home, infecting all and sundry, with the very real risk of succumbing to the illness.

SARS was a game changer for many. At the time, L and I had the feeling that it was going to be really bad for us. Little did we know how accurate we were. Many of the cases originated from our wee town and many of the families who worked in the wholesale market in Pasir Panjang lived in Choa Chu Kang. There was a real and present danger going to work every day; the worry that we could bring the dreaded agent to our family was very real. Yet we couldn't just abandon our patients who had trusted us for so many years. L felt the same way and we decided together to continue the clinic's operation as usual. It wasn't easy; with us decked out in our personal protection equipment (PPE), breathing and working was a real effort. Our staff

also followed our examples – none took a leave of absence; everyone came diligently every day, put on their PPEs dutifully and served the patients as best as they could.

## Growing together in close proximity

Whenever people find out that L and I work in the same practice, they are very often surprised that we are able to work so closely together in the same "office". The usual comment is that if they and their spouses were working in the same office, they would fight every day! For us, it is quite the opposite. As we went through those difficult times together, we discovered deep strengths in each other. We are indeed more than the sum of our parts when we are together, and are truly thankful for the relationship and partnership that we have.

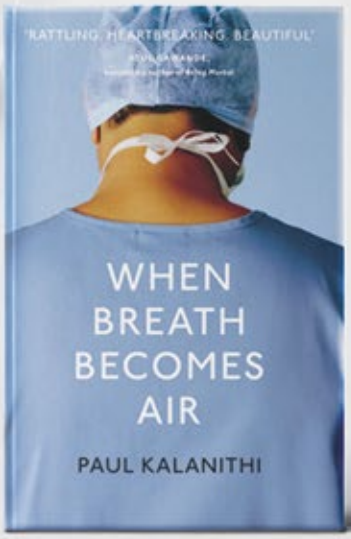
Showing respect for and taking time to listen to each other is so important. Many times, on the drive to and from work, L will share with me things that are on her mind, and vice versa. I have come to deeply appreciate that time together, and the discussions we have had range from the mundane to the very profound. This has strengthened how we manage the practice and the family.

In every partnership, the partners have to be likeminded, with the same aims and goals. Although L and I have very different characters, we are almost always on the same page when it comes to the fundamentals. L always has her eye on the affordability of our clinic charges, and in this I always defer to her better judgement. We decide on the services we are going to provide and we interview for new staff together. We also decided on the hours we are going to work together, as we try to balance the needs of our young family and the needs of our professional service. Very early on, it was clear that we needed to spend more time at home with our young children. We jointly decided that L should spend more time with the kids and we set out to recruit doctors to help us with our growing practice. We made the needs of the family and the practice paramount in our decision making, and always strove to find the middle ground that we can both accept.

If we have the right values and support each other in achieving what holds true, the sky is truly the limit! For we can achieve anything we set our hearts on. ◆

Dr Tan is a family physician in private practice in Choa Chu Kang. A GP at heart, he believes strongly in family medicine provided by family physicians embedded in the community.

# Time WAITS FOR No One




Review by Dr Tina Tan, Deputy Editor

I heard about this book when it was published in 2016. But what struck me when I finally read the book was that Paul – the author – was a surgeon with a literary flair. I'm not saying surgeons can't be closet poets, but the sheer amount of time and energy that surgical training (in fact, almost all medical training) takes might not leave one much time for the humanities. Therefore, Paul's account of medical school and residency has a certain heightened awareness and sensitivity that he was able to call forth and display.

The visage of death hovers throughout the entire book; it was present in the author's description of the cadaver dissection during anatomy class, in his quotation of the Scripture, and in seeing his own patients die before him. The book was also a touching and brief recollection of his journey to medicine, through medical school and residency. And it was when he was on the cusp of completing his residency (on the very day of graduation), that he was hospitalised following a massive chemotherapy-related infection. Paul alluded the experience to climbing to the top of the proverbial mountain and seeing the Promised Land. But what is tragic is that the reader never knows whether he thought he'll ever reach it, and what it meant to him.

Paul's relationship with his oncologist, Emma, is to be admired. She encouraged him to find meaning in his life, refused to discuss Kaplan-Meier survival curves, and also offered to "just be his doctor". My oncology colleagues, no doubt, grapple with such issues on a daily basis. In fact, at one point or another, we will face such situations: the patient seated before us is a fellow physician, or that we become patients ourselves. How much do you let this doctor-patient of yours make treatment decisions? Where does the balance of control lie?

The book concludes with Paul's heartbreaking account of his final day of residency, his prolonged hospitalisation, and his struggle with what to do with the time he had left. The latter is made all the more poignant because at the time of his writing, he truly had no idea how much time he had remaining.

This book is a must-read for medical students and those of us who have "seen too much". If I could paraphrase this book into a sentence, it'd be: "When a doctor with a literature degree becomes a patient". Of course, given the prominent absence of a literature background in my case, my paraphrasing destroys the poetic title. But hopefully, it doesn't take away from the meaning of the book – how each of us face death and what we make of the time that is given to us. ◆

**Title:** When Breath Becomes Air
**Author:** Paul Kalanithi
**Number of pages:** 228
**ISBN:** 978-0812988406
**Type of book:** Hardcover
**Publisher:** Random House
**Year of Publication:** 2016

Dr Tan is an associate consultant at the Institute of Mental Health and has a special interest in geriatic psychiatry. She is also an alumnus of Duke-NUS Medical School. Between work and family life, she squeezes time out for her favourite pastimes – reading a good (fiction) book and writing.

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# About That $100,000 FINE for an Injection


*This article was adapted from The Hobbit's article originally published at http://bit.ly/2CMqa2I.*

*Editor's Note: Since the online publication of The Hobbit's original blog post, the Singapore Medical Council has met with key appointment holders of the Academy of Medicine, Singapore, College of Family Physicians Singapore and SMA to clarify the case. For updates on the meeting, please refer to page 13. We will continue to provide more updates on this matter.*

So, this is how the practice of medicine, as we knew it, dies in Singapore.

Not quietly or softly in the arms of compassion and empathy, but throttled inadvertently by a $100,000 fine.

## Interesting points

There are many interesting points about the case.

**Firstly, the patient** who complained against Dr Lim Lian Arn. The H&L injection was administered on 27 October 2014 but the patient only complained against Dr Lim on 11 January 2016, some 14 months later. Especially when she was purportedly unhappy with the adverse effects which were quick to surface and temporary: pain and inflammation, discolouration, paper-thin skin, and loss of fat and muscle tissues. What took her so long to complain?

**Secondly, the Singapore Medical Council (SMC) lawyer** asked for a five-month suspension for Dr Lim. This is mightily interesting. The ill effects suffered by this patient are far less serious than the ones in the Eu Kong Weng case, in which the patient suffered serious complications. Dr Eu was suspended for three months and he appealed to the Court of Three Judges. The Judges commented that had the law provided for less, a shorter period would have sufficed, but they upheld the minimum three-month period since they felt a suspension was indeed warranted. If so, on what basis did SMC's lawyer ask for a five-month suspension? This Hobbit does not understand. I hope the SMC President, Registrar and members understand, at least retrospectively.

**Thirdly, the doctor and his lawyer.** Faced with the SMC lawyer asking for a five-month suspension, this Hobbit speculates that their priority is to avoid a lengthy suspension. They pleaded guilty at first instance and offered to pay the maximum $100,000 fine or take the minimum three-month suspension. This is perfectly understandable; a successful senior orthopaedic surgeon in private practice probably makes that amount in three to five months. A five-month suspension would mean that he has no income and still has to bear the fixed costs of running a clinic.

A secondary concern is that should they offer something low, like $5,000 or $10,000, and the SMC Disciplinary Tribunal (DT) accepts it, there is no guarantee that the SMC lawyer will. He may instead choose to appeal to the Court of Three Judges. In other words, to avoid what they deem as undesirable consequences, Dr Lim has to make a generous-enough offer that *both the DT and the SMC lawyer* will accept. In his self-interest, Dr Lim did as he was supposed to do. Perhaps this Hobbit would have done the same too.

**Fourthly, we go on to the DT.** Faced with an offer of a $100,000 fine, they had three choices – they can accept or lower the fine, or suspend Dr Lim. Thankfully and rightly, they decided that Dr Lim should not be suspended. It would look very strange if they decided to lower the fine since the defendant already offered $100,000, even though the DT thought the closest comparison to this case was that of Dr Eric Gan, in which Dr Gan was fined $5,000. So, as expected, they decided to fine Dr Lim $100,000, the amount that *he offered*. This Hobbit does not think the DT did anything questionable up to this point.

What is questionable is the appropriate standard of care that this DT promulgated for taking an informed consent for an H&L injection. They said that for the patient to give an effective informed consent, she should have been told of:

(a) post-injection flare, in particular, that:

  (i) the Complainant may experience increased pain and inflammation in the area injected that can be worse than the pain and inflammation caused by the condition being treated;

  (ii) the onset of the post-injection flare is usually within two hours after the injection and typically lasts for one to two days;

(b) the post-injection flare can be treated by rest, intermittent cold packs and analgesics;

(c) change in skin colour including depigmentation, hypopigmentation and hyperpigmentation;

(d) skin atrophy;

(e) subcutaneous fat atrophy;

(f) local infection; and

(g) tendon rupture.

To me, this is the kind of "information dump" that the Judges said should be avoided when they formulated the Modified Montgomery (MM) test for Singapore in 2017.

**Fifthly, the MM test** – now obviously applied in full force. The MM test replaced the Bolam-Bolitho (BB) test because the five judges (in the Hii Chii Kok vs London Lucien Ooi case) felt that in the provision of medical advice (which includes getting an effective informed consent), the process must be patient-centric rather than doctor-centric.

A few doctors, when faced with disciplinary proceedings and medical negligence suits, relied on the BB test in their defence, almost to the point of abusing it. They would nominally come up with a few friendly "expert" opinions to justify their actions and pass the BB test.

This was the weakness of the BB test, but it also had its strength – it provided for a reality check. The BB test required one to ask what was practised on the ground by doctors and took reference to such common practices.

This element is somewhat missing in the MM test. So, the DT accepted an information dump checklist as the required standard of care in giving medical advice when practically no one does this. The only reality check the DT was seen to undertake was accepting that it was not universal practice to get a written consent for an H&L injection.

Dr Lim was charged under the 2002 version of the SMC Ethical Code and Ethical Guidelines. Many respected orthopaedic surgeons have been on the SMC Council since 2002. In fact, at least one of the current members is an orthopaedic surgeon. All the DT had to do was ask these SMC members if they routinely gave *ALL* such information to patients going for H&L injections, and documented as such in the case notes, to know what the reality on the ground is. This Hobbit is confident that practically all of them will fail this simple test. It's just that none of their patients complained, unlike Dr Lim's.

There is nothing in the published Grounds of Decision that suggests they did such reality checks; the MM test does not include such an element except suggesting that expert opinion could be taken into account when appropriate. The test of materiality (in deciding what information needs to be given) is solely from the patient's perspective and nothing about what was being practised on the ground. Nonetheless, the standard of care stated in the Grounds of Decision of the DT is *Medico-Legal Reality*.

## What's next

Let's get back to the procedure itself: an H&L injection. This is a cheap, effective and common procedure done in the specialist and GP setting. But no more in the post-$100,000 fine era. This Hobbit would like to differentiate by calling the past the pre-LLA era and the current period as post-LLA era. (*Dr Lim deservedly gets naming rights to such a momentous incident.*)

Ask any business school professor and he/she will tell you to price in the risk. Here is how you do it:

Pre-LLA era price for an H&L injection by a GP: $50 to $150; $100 as a reference price.

Number of H&L injections given before a patient complains: 100

Number of successful complaint cases (where you pay a fine of $100,000): one in three

Estimate: 300 cases will result in three complaint cases, of which one will be successful

Economic cost: one $100,000 fine **and** estimated $200,000 (about $70,000 a case) for the emotional distress, time lost and effort in preparing for the complaints, etc.

Total risk premium: $300,000 for 300 cases

Risk premium: $1,000 a case

New price for one H&L injection: $1000 + $100 = $1,100

**Conclusion 1: price of H&L injection by a GP in the post-LLA era: $1,100 (up from $100).**

Of course, these numbers will only be significantly higher in the specialist setting. An H&L injection by a hand or orthopaedic surgeon may now cost $2,000 to $4,000, after taking into account their own risk premiums.

Many patients in the heartlands cannot afford a thousand-dollar jab and the GPs know this. Most of these patients will then be treated conservatively with brace and medication, resulting in unnecessary pain or suffering by the patient (which may cost between $100 and $1,100), or referred to the public sector. This is not to say that the public sector doctors can do a better job with better outcomes and attract fewer complaints. It is just a simple transfer of the risk premium to the public sector, where much of the costs are subsidised by taxpayers. The richer patients will be referred to the private specialists because they can afford to pay the higher charges, and the private specialists may refer their poorer patients to the public sector.

The patients that will complain to the private GP sector will also likely complain to the public or private specialist sector. In the former, the state/taxpayer takes up the risk and in the latter the risk premium is covered by higher private specialist fees.

Incidentally, fee benchmarks currently do not cover office procedures like H&L injections.

**To summarise** – there will be little demand for a $1,100 H&L injection in the HDB estates, and GPs are also unwilling to take up this new risk premium. In simple economic theory, the demand and supply curves do not cross and there will be few or no transactions (ie, no volume of work). Consequently, the standard of care given in the Grounds of Decision of the DT, while now is *Medico-Legal Reality*, will also in all likelihood become *Virtual Reality* in the HDB Heartlands. How interesting.

**Conclusion 2: in the post-LLA era, not many heartland GPs will offer H&L injections. H&L injections will go the way of dodo bird in the heartlands.**

The expected repartee from people who are out of touch is that this is not about risk premium but about good consent-taking and documentation.

Frankly, not many doctors are interested in this spiel anymore. After the Eu Kong Weng case, no doctor is really sure what will be deemed effective informed consent-taking under the scrutiny of SMC or the Courts. If I were to take this kind of risk for a $100 job, I'd rather refer to someone else to take the job (and the risk).

This is probably the outcome that will take place in the next few months, if it has not taken place already. Please do not call this defensive medicine. As this Hobbit has said before, it is called *survival medicine*. It's the only practical way to survive. For me at least.

But it's not just about H&L injections. How about other simple everyday office procedures like speculum examination, proctoscopy or ear syringing? The same principle applies and a heartland GP will transfer the risk premium to the public sector or the private specialists through referrals.

**Conclusion 3: in referrals we trust (to avoid taking on insufferable professional risks).**

## How it came to be

You may ask how we got to this situation. It is because everyone behaved in a way expected of them.

The judges wanted to move from a doctor-centric to a patient-centric process where medical advice is provided. They promoted patients' rights to autonomy through promulgating the MM test.

The lawyer wanted to do a good job by pushing for a deterrent five-month suspension. He is defending the patient-complainant's rights to autonomy, as well as promoting patients' rights in general.

The SMC DT wanted to be seen defending/promoting patients' rights by accepting Dr Lim's offer of a maximum $100,000 fine. They also want to send a signal to all doctors that the standards as prescribed by the MM test are well in force when they promulgated that long list of potential complications and side-effects for an H&L injection.

Dr Lim Lian Arn acted as he should, by offering to pay $100,000 or be suspended for only three months.

The patient-complainant is probably satisfied too that the doctor was fined $100,000. Whether she proceeds on to a civil suit or not, we don't know.

Every party got what they wanted: The patient, doctor, SMC lawyer, judges and SMC DT.

But this Hobbit cannot help but wonder if Singapore society deserves more.

Because the *Likely End-Result* is that patients will either find the H&L injection less accessible or have to pay significantly more for it. Same goes for other common, cheap and effective office procedures. A situation of either scarcity of service providers and higher prices will result, leading to unnecessary higher healthcare expenditure.

Society will have to pay for this in the long run. Unless the politicians and senior civil servants step in soon with some form of tort reform for medico-legal cases, the practice of medicine, as we knew it, has truly died. And the biggest losers are the patients collectively and society. Not the doctors. I just earn a few hundred less a month, but I'll live. Don't worry. ◆

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|---|---|
| 1:00 PM | Registration and Lunch |
| 1:30 PM | Opening Address |
| 1:50 PM | Course Overview |
| 2:00 PM | **Seminar 1:** In General – Medical Expert |
| 2:30 PM | **Seminar 2:** Instructions and Writing an Expert Report, Preparing for Court & Professional Issues |
| 3:00 PM | **Seminar 3:** Testifying in Court – What to Expect and Courtroom Skills |
| 3:30 PM | **Seminar 4:** Common Pitfalls in Writing Expert Reports |
| 4:00 PM | **Assignment & Instructions:** Drafting an Expert Report |
| 4:15 PM | Questions & Answers |
| 4:45 PM | End of Day 1 |

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| DAY 2 (29 June 2019, Saturday) Furama City Centre Hotel | |
|---|---|
| 8:00 AM | Registration and Breakfast at Furama City Centre Hotel |
| 8:45 AM | **General Session:** Reviewing The Assignment and Common Errors Made |
| 9.30 AM | Movement to Family Justice Courts |
| **Family Justice Courts** | |
| 9:45 AM | **Roleplay Session 1:** Giving Oral Evidence in Court |
| 1:00 PM | End of Day 2 |

| DAY 3 (6 July 2019, Saturday) Family Justice Courts | |
|---|---|
| 8:30 AM | Registration |
| 9:00 AM | **Roleplay Session 2:** Giving Oral Evidence in Court |
| 12:15 PM | Movement to Furama City Centre Hotel |
| **Furama City Centre Hotel** | |
| 12:45 PM | Buffet Lunch at Furama City Centre Hotel |
| 1:00 PM | Debrief, Closing Address and Presentation Ceremony |
| 2:00 PM | End of Day 3 |

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# Ethical Issues around MEDICAL CERTIFICATES

## PART 02

Text by Dr Neeta Satku

This is the second article in a two-part series on medical certificates (MCs). The first (http://bit.ly/2UvPukQ) discussed the guidelines for writing MCs responsibly, with attention to accountability and confidentiality, as well as the types of certified sick leave available.

This article will address the importance of issuing an adequate duration of sick leave, and the advisability of providing limited uncertified sick leave.

### Workplace safety

The issue of giving inadequate medical leave following work-related injuries has recently received much attention in the press.[1,2]

The Workplace Health and Safety Act requires that employers notify the Ministry of Manpower (MOM) of work-related accidents that result in workers being given more than three days of sick leave,[3] so that an investigation can be made following any significant work-related injuries. Such investigations may be inconvenient or expensive, leading employers to occasionally request for shorter MC durations to avoid triggering them, sometimes even suggesting that the doctor's contract with the company hinges on his/her acquiescence.[4,5] Employers may also request for MCs specifying that the patient is fit for light duties, rather than unfit to work at all, as these do not have to be reported to MOM.

These requests can also come from the patient him/herself. Ordinarily, although doctors should consider only medical factors when issuing MCs,[6] they may allow their patients some say in the MC duration, such as issuing fewer days when a patient would like to return to work earlier after an illness, as long as it presents no risk to himself/herself or others. However, in the setting of a workplace injury, such requests from patients may be a result of coercion from employers rather than a genuine desire to return to work early. Coercion can take the form of promises to allow the employee to rest with pay or assurances that compensation will be paid even without medical certification, or in the form of threats of repatriation.[4] These promises may not be kept, leaving the worker unpaid and unprotected.

This is an important reason for doctors to reject requests to shorten medical leave or prescribe light duties for work-related injuries. Doctors should also be aware that adequate medical leave is given not merely for the benefit of the individual patient in this case, but because it plays a role in maintaining workplace safety for other employees through the reporting system.

It is uncomfortable for professionals who are trained to be compassionate and respectful towards

their patients to be caught between individuals and policy. Using MC duration as an indicator of worksite safety is an imperfect mechanism, placing an undue burden on the doctor and potentially jeopardising employees' welfare.

Unfortunately, until such time as a more reliable reporting system is in place, it seems doctors must view work-related injury MC issuance partly as a duty to the public. As stakeholders, and as a profession with an interest in protecting the vulnerable, we must also continue to urge reviews of the system.[7]

## Preventing disease transmission

Taking adequate medical leave also plays a part in preventing the spread of infectious diseases.[8] During the SARS outbreak of 2003, taking sick leave became an obligation rather than a luxury for doctors because of the potentially serious consequences of disease transmission. Similarly, in outbreaks of gastrointestinal or respiratory disease, such as influenza, adequate medical leave allows for the relative isolation of unwell persons.

Some employers discourage MC-taking by rewarding perfect attendance. They may offer outright rewards for a period of perfect attendance, or make it clear that sick days will be considered negatively during performance appraisals. This unfairly penalises those afflicted with illness, rewards the often-unearned good fortune of health, and encourages "presenteeism", as unwell employees try to preserve their attendance records.

Childcare centres also rely on the duration of medical leave advised to indicate when it is safe for children to return to school after episodes of infectious diseases (such as hand, foot and mouth disease or chickenpox).

## Considering uncertified paid sick leave

There has been much debate in the last few years about the possibility of allowing paid uncertified sick leave.[9] At present, the Employment Act allows an employer to require an MC before granting paid sick leave,[2] although some employers do allow a limited number of days of paid uncertified sick leave.

Labour laws in Hong Kong[10] and Australia[11] are similar, while UK law requires employers to allow seven days of uncertified paid sick leave per year.[12] The US has no federal law mandating paid sick leave, although some states do.[13]

It seems reasonable to trust employees to not abuse a system of uncertified paid sick leave, and to recognise that abuse of the system can take place even when MCs are procured. The requirement for MCs involves clinic visits that have financial costs to employers and eat into the employee's rest time. It also burdens the primary healthcare system with patients who could otherwise manage uncomplicated illnesses with rest and over-the-counter medicine.

The requirement for MCs may also encourage employees to attend work while they are ill, resulting in reduced productivity and potentially spreading contagious illnesses to other employees.[10]

The concept of taking a "mental health day" to help employees manage stress and avoid burnout is also gaining traction in the discussions of workplace health. Encouraging this by allowing the occasional paid absence without an MC may benefit individuals and increase productivity.

Clearly, there are a number of potential ethical dilemmas involved in the everyday practice of issuing MCs. An awareness of these issues will allow doctors to act in their patients' best interests, and hopefully minimise the moral distress of balancing conflicting principles. ◆


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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.


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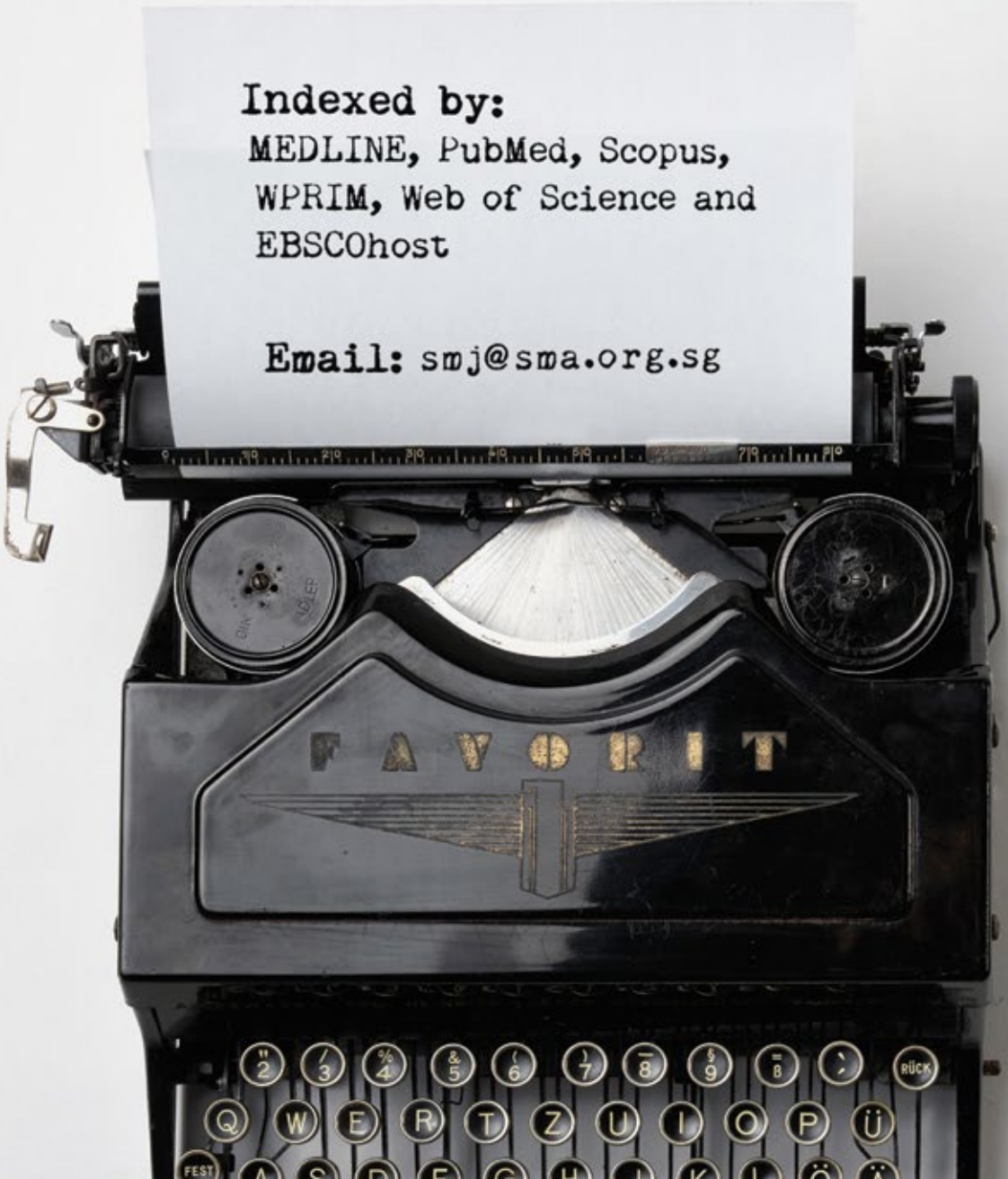

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| **CME Activities** | | | | | |
| 17 Mar Sun | BCLS+AED | SMA Conference Room | 4 | Family Medicine and All Specialties | Shirong/Terry 6223 1264 cpr@sma.org.sg |
| 19 Mar Tue | Building Resilience and Avoiding Burnout | Sheraton Towers Hotel | 2 | Family Medicine and All Specialties | Margaret/Terry/Shirong 6223 1264 cpr@sma.org.sg |
| 20 Mar Wed | Mastering Your Risk | Sheraton Towers Hotel | 2 | Family Medicine and All Specialties | Margaret/Terry/Shirong 6223 1264 cpr@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 |
| 4 Apr Thu | Building Resilience and Avoiding Burnout | Novotel Singapore on Stevens | 2 | Family Medicine and All Specialties | Margaret/Terry/Shirong 6223 1264 cpr@sma.org.sg |
| 13 Apr Sat | Mastering Adverse Outcomes | Novotel Singapore on Stevens | 2 | Family Medicine and All Specialties | Margaret/Terry/Shirong 6223 1264 cpr@sma.org.sg |
| 13 Apr Sat | SMA CMEP Health Law (Intermediate) | SMF Building | 2 | Medical Practitioners, Lawyers, Nurses, Allied Health Professionals and Healthcare Administrators | Jasmine 6540 9196 jasminesoo@sma.org.sg |
| 16 Apr Tue | Achieving A Safer and Reliable Practice | Sheraton Towers Hotel | 2 | Family Medicine and All Specialties | Margaret/Terry/Shirong 6223 1264 cpr@sma.org.sg |
| 21 Apr Sun | BCLS+AED | SMA Conference Room | 4 | Family Medicine and All Specialties | Shirong/Terry 6223 1264 cpr@sma.org.sg |
| 24 Apr Wed | Building Resilience and Avoiding Burnout | Sheraton Towers Hotel | 2 | Family Medicine and All Specialties | Margaret/Terry/Shirong 6223 1264 cpr@sma.org.sg |
| 4 May, 29 Jun and 6 Jul Sat | Medical Expert Witness Training 2019 | Academia, Furama City Centre Hotel, Family Justice Courts | 6 | Doctors | Mr Roland Lim 6593 7884 mewt@ams.edu.sg |
| 7 May Tue | Mastering Adverse Outcomes | Sheraton Towers Hotel | 2 | Family Medicine and All Specialties | Margaret/Terry/Shirong 6223 1264 cpr@sma.org.sg |
| 11 May Sat | Mastering Difficult Interactions With Patients | Novotel Singapore on Stevens | 2 | Family Medicine and All Specialties | Margaret/Terry/Shirong 6223 1264 cpr@sma.org.sg |
| 16 May Thu | Building Resilience and Avoiding Burnout | Sheraton Towers Hotel | 2 | Family Medicine and All Specialties | Margaret/Terry/Shirong 6223 1264 cpr@sma.org.sg |
| 25 May Sat | Privacy Awareness | Novotel Singapore Clarke Quay | 2 | Medical Practitioners, Aspiring and Current Practice Owners, Clinic Manager and Staff | Denise 6540 9195 denisetan@sma.org.sg |
| **Non-CME Activities** | | | | | |
| 4 May Sat | SMA Annual Dinner 2019 | Regent Hotel | NA | SMA Members and Guests | Mellissa/Azliena 6223 1264 dinner@sma.org.sg |
| 5 May Sun | 45th SMA Inter-Hospital Soccer Tournament 2019 | The Cage Sports Park @ Turf City | NA | SMA Members | Rita 6223 1264 membership@sma.org.sg |

# NEIGHBOURHOOD HEALTH SERVICE

## The Nation's First Integrated, Community-Based, Holistic Health Screening

Text by Benjamin Tan Kye Jyn and Koh Ying Ying | Photos by Darryl Low Wei Jie

*This article was adapted from an article by the same writers, first published in the November 2018 issue of* MediCine.

In 2007, a small group of enthusiastic medical students found a gap in the healthcare system that they believed they could help bridge. They pooled what little resources they had, garnered the support of their teachers and introduced Singapore's pioneering student-led health screening and follow-up programme.

Twelve years later, the Neighbourhood Health Service (NHS) has grown to become the National University of Singapore (NUS) Yong Loo Lin School of Medicine's flagship community service project. Gifted with the dedication of our mentors and seniors, NHS has grown to become the only student-led school project with nationwide reach, having partnered all three Regional Health Systems to serve close to 6,000 residents in ten different districts island-wide.

Today, our interdisciplinary, inter-school student committee and volunteers hail from all three medical schools in Singapore, as well as the nursing, social work and physiotherapy faculties at NUS, Nanyang Polytechnic and the Singapore Institute of Technology. While many things have changed since 2007, one thing has not – our core ethos of serving the underprivileged. Our research found that lower-income residents living in Housing Development Board rental blocks are four times less likely than the average Singaporean to go for regular health check-ups, hence our mission to reach out to them at their doorsteps.

### Uniting key players in healthcare delivery

For the first time last year, NHS pioneered an eight-way partnership, involving the Ministry of Health, SingHealth, National Healthcare Group, Health Promotion Board (HPB), Agency for Integrated Care, Singapore Eye Research Institute (SERI), National Dental Centre Singapore (NDCS) and Singapore Cancer Society.

This novel collaboration saw the key players in healthcare delivery – each with their own screening programmes – come together to organise a one-stop holistic health screening. By synergising our efforts, we improved upon the conventional practice of holding separate screenings for different aspects of health, saving residents a significant amount of time.

Bringing the key players on board also meant that the holistic health screenings were well-aligned with nationwide screening efforts such as HPB's Project Silver Screen.

Residents were assessed via multi-level tests through a "one-stop shop" screening covering:

- Chronic diseases (diabetes mellitus, hyperlipidaemia, hypertension and obesity)
- Functional abilities (vision, oral health and hearing)
- Fall prevention (screening and education)
- Cancer (colorectal, cervical and breast)
- Mental health (dementia and depression)
- Social assistance (financial, social and psychological)

Through the efforts of more than 600 student and professional volunteers, NHS reached out to over 8,000 selected


1

households at their doorsteps and screened 863 residents at Kampong Glam and Queenstown (Leng Kee) in September and October last year.

Notably, both basic and advanced screenings for vision and oral health were conducted within the same visit at NHS, enabled by the strong support of our long-time partners, SERI and NDCS. In most other screenings, the practice is to arrange separate follow-up screenings at community-based mobile clinics, but for the elderly residents of rental blocks who live alone without caregivers, streamlining the process could help to encourage timely follow-up.

## Cost-effective door-to-door screenings

Many years back, NHS devised the unique approach of door-to-door publicity, health screenings and follow-ups. Healthcare students equipped with the relevant logistics would visit residents, especially the immobile, to conduct screenings in the comfort of their homes.

As our long-term goal is to evolve into a replicable and scalable healthcare model, NHS partnered NUS Business students in 2015, under A/Prof Albert Teo's guidance. The team conducted a social return on investment analysis to evaluate the cost-effectiveness of our labour-intensive approach. Interestingly, they found that for every $1 invested in NHS over a five-year cycle, $2.29 in social returns was generated yearly on the average. This shows, perhaps counter-intuitively, that the door-to-door approach is in fact cost-effective.

## Follow-up care driven by research

Since its inception, NHS has followed up with residents via phone calls and house visits (in more complex cases) post-screening. The aim was not to replace primary care, but to motivate these residents to follow up with their family doctors on their screening results.

Every year, NHS also engages in population health research, guided by our chief academic advisor A/Prof Gerald Koh and research mentor Dr Ian Wee Liang En. In the past, NHS found that only 11% of rental block residents preferred to approach Western-trained doctors, while 30% preferred alternative medicine. Another 53% preferred "self-reliance".

Our findings spurred the continuous expansion of our follow-up programme. In 2017, a record number of more than 300 residents (30% of those screened) with abnormal chronic disease screening results were selected for follow-up. To improve our follow-up counselling, NHS collaborated with the National University Health System Department of Family Medicine and NUS Medical Society to train our student committee in motivational interviewing techniques. We were ecstatic to see improvements, with 64% of residents successfully reconnected to the healthcare system – quite a good number considering the many socio-economic barriers which rental block residents face in seeking healthcare!

## A note of gratitude

It has been a humbling experience to represent our schools, professions and generation of youths in serving our community. We are also sincerely grateful for our mentors' excellent guidance and our schools' unwavering support. Along with A/Prof Gerald Koh, mentors who provided invaluable support in this run of the NHS include A/Prof Tay Sook Muay (who gifted us with energy, encouragement and enthusiasm) and Dr Sue-Anne Toh (who has truly been a pillar of support)! Last but not least, we are deeply grateful to Dr Ian Wee, Dr Chiong Yee Keow (who also initiated our newly launched sister project last year – NHS Kids!) and many other NHS alumni who continue to dedicate their time and hearts after so many years!

The team would also like to thank all students and healthcare professionals who generously gave their time, as well as partners and sponsors for their unwavering support. In particular, we would like to thank the generous donors of the SMA Charity Fund (SMACF), without whom we would not have had the means to serve our residents! Little deeds of kindness over the past 12 years have inspired countless generations of students and created a lasting culture of community service at our schools. We sincerely hope that our story inspires you to support NHS and other ground-up community initiatives through the SMACF. To find out more about NHS and its initiatives, visit https://www.neighbourhoodhealthservice.com.

The next committee, like the ones before, will continue to improve and adapt amid the changing landscape, driven by our common passion to make a positive difference in our community! ◆

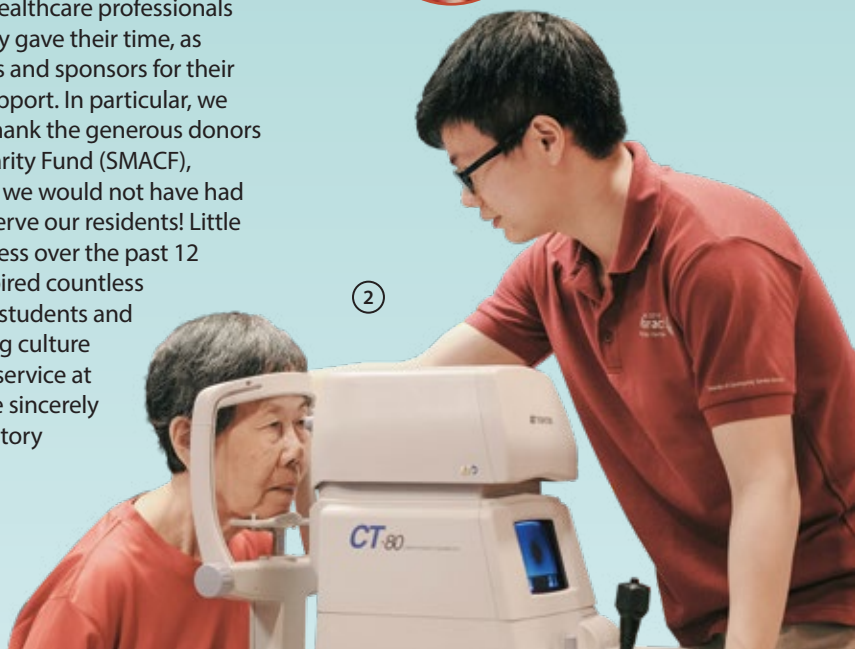
SMA and the SMA Charity Fund support volunteerism among our profession. *SMA News* provides charitable organisations with complimentary space to publicise their causes. To find out more, email news@sma.org.sg or visit the SMA Cares webpage at https://www.sma.org.sg/smacares.

***Legend***

*1. NHS 12th Committee at our Kampong Glam Health Screening*

*2. NHS Advanced Eye Screening Station in partnership with SERI*

Benjamin and Ying Ying are the outgoing directors of the NHS and represent a committee of 70 students across the four schools – NUS Medicine, NUS Nursing, NUS Social Work and NTU Medicine. Rarely, when they are not attending to their duties at NHS, they are also Year 2 medical students at the NUS Yong Loo Lin School of Medicine.




2

# HOLISTIC PREVENTIVE CARE PLAN FOR YOUR PATIENTS IN 2 STEPS!

By Agency for Integrated Care and Health Promotion Board


## Step 1: Screening and Follow-up

Screen for Life (SFL) is the national screening programme by the Health Promotion Board (HPB) that aims to encourage Singapore Citizens and Permanent Residents to go for regular screening and follow-up sessions. Under SFL, eligible applicants above the age of 40 may go to GP clinics for subsidised screening tests for chronic diseases (cardiovascular risk), cervical cancer or colorectal cancer.[1]

Currently, over 900 Community Health Assist Scheme (CHAS) GP clinics offer enhanced SFL subsidies, and the scheme has benefitted more than 30,000 Singaporeans as of February 2018.

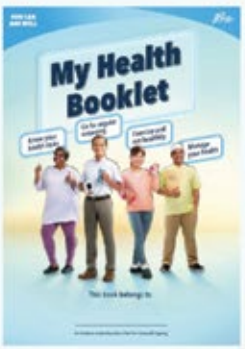
The scheme enables early detection, long-term follow-up and continuity of care for chronic conditions. In addition, SFL clients can tap on subsidised schemes and programmes for affordable screenings and care management. These include subsidies via CHAS for follow-up consultations at GP clinics, and subsidised referrals to Specialist Outpatient Clinics (SOCs) for clients with abnormal cervical cancer or colorectal cancer test results.

## Step 2: Intervention Programmes to Monitor

To complement medical advice given to clients, GPs may also refer them to the following intervention programmes initiated by HPB:

- Health coaching at Community Health Posts (CHPs)
- Lifestyle intervention programmes such as 'Lose to Win' and 'I Quit'

[1] Eligibility for colorectal and cervical cancer tests is further dependent on age and gender - please refer to Primary Care Pages (PCP) for more details.




# COMMUNITY HEALTH POST (CHP)

- CHPs offer SFL clients an avenue for lifestyle-related coaching and follow-up programmes.
- Trained in health promotion and coaching, a health coach works with the client to set lifestyle goals to maintain or improve their health through nutritional, physical activity, mental wellbeing and/or smoking habit intervention. The coach may also share other health topics the client is interested in, such as sleep hygiene or ergonomics, or community health programmes happening around the estate.
- Primary target audience includes SFL clients (typically above the age of 40) with borderline stage diagnosis or who have been diagnosed with chronic diseases.
- Through a referral to CHPs, GPs help to ensure regular lifestyle follow-ups as well as personalised lifestyle tips and goals for clients. Depending on their suitability, clients may be referred to the 'Lose To Win' or 'I Quit' programmes.
- For more information, please call HealthLine at **1800 223 1313**, and refer to HealthHub for a full list of CHPs and their addresses.

# LOSE TO WIN®

- Lose to Win® is a free 12-week weight management programme that aims to help clients manage their weight through regular exercise and healthy eating.
- Clients enjoy free unlimited workout sessions for 12 weeks, which are guided by professional trainers at a progressive intensity.
- Primary target audience includes clients aged 21 to 64 years with a BMI range of 23 to 37.4kg/m2.
- Through client referral to Lose to Win®, GPs can expect a safe, structured and supportive environment that encourages patients to live healthily and better manage their weight. With regular participation, clients can expect potential improvement in their health markers.
- For more information, please visit **www.losetowin.com.sg**, email **hpb_losetowin@hpb.gov.sg**, or call HealthLine at **1800 223 1313**

# I QUIT

- I Quit is a SMS-based intervention designed to assist smokers to quit smoking by sending them motivational text messages daily for the first 28 days.
- Research has shown that a 28-day smoke-free cycle increases one's chances of quitting by five times.
- Also, clients can access other resources such as QuitLine tele-counselling, an online community at **www.facebook.com/iquitclub**, quit-smoking tips on HealthHub, and over-the-counter pharmacist advice (including Nicotine Replacement Therapy information).
- Upon completion of the programme, clients may book an appointment to receive attractive incentives in addition to better health.
- Primary target audience includes Singaporeans and Permanent Residents who are smokers.
- Through referral to I Quit, clients receive support from well-trained counsellors and will potentially see improvement in their health markers.
- For more information, please visit **www.healthhub.sg/iquit**, email **hpb_smoking_control@hpb.gov.sg**, or call QuitLine at **1800 438 2000**

**Please contact the Primary Care Engagement team at gp@aic.sg or 6632 1199 if you would like to offer this holistic preventive care plan to your patients.**

# THE STORMY SEAS OF A BUDDING RESTAURATEUR

1

Starting up and running a restaurant isn't all glitz and glam. We know from various reality shows that the culinary industry can be cutthroat, and it can pose its own set of challenges especially for one who enters without experience and formal training. However, with a strong desire to present and share good food, John Chan – founder of Pasta J – has persevered through the many tribulations and kept on serving good quality food from his restaurant nestled in the suburbs.

## Introduction

**When and how did you first start getting interested in cooking?**

Experimenting with food and flavours came to me naturally. Even before I was ten years old, I loved adding all kinds of condiments to my instant noodles – Tabasco sauce, soy sauce, oyster sauce and even fish sauce. Yeah, I like strong and salty flavours.

**Why the name "Pasta J"?**

Honestly, because I couldn't think of any other name! I wanted to go with Pasta Sano at first, but I found a local brand using that name so I had to quickly think of something else. "Pasta J" was what came to mind.

## Behind the scenes

**Tell us about your core team.**

Frankly, creating food like mine with no credentials (experience/training) makes it very tough to gain acceptance from staff and customers alike. Add to that a very steep learning curve and constant evolution, it has led to high turnover in my restaurant in an industry already notorious for high turnovers. Thus, I would say that our core team is me, my wife and, in the past three years, our only service staff – Xena.

**What are some of the challenges the establishment has overcome in its years of operation?**

There are simply far too many to list, but one main issue is definitely finding good staff. This is a problem common with all restaurants, at all levels, but more so for us because I do expect a lot from my staff. However, since we do not sell ourselves as an authentic Italian restaurant, and being located in the suburbs, customers are less willing to spend as much as they would in town, even if the quality of the food deserves it.

With time, though, our frequent customers have realised the quality we offer, despite our lack of pedigree.

With that said, I think the real challenge is probably our lack of experience. We've had to learn very quickly, through a lot of trial and error, about how to operate a restaurant. Over time, we also came to understand the kind of operation we should run that would best suit the high quality and standards that we offer through our food. It has been a slow and very painful journey.

## The food served

**With the name "Pasta J", do diners expect traditional Italian cuisine? What are some of the must-try dishes when one visits you?**

Well, over the years, we have gone way past being pasta-centric. Our current focus is on meats and lobsters instead.

Some of our must-try dishes include the Salted Fish Burratina – burratina served with salted fish and honeycomb on a bed of dense homemade focaccia, the Wagyu Tomahawk (we have three types), the Live Boston Lobsters served with Kombu Sauce and, with prior notice, the Squid Ink Lobster Stock Risotto that uses lobster stock prepared from 10 kg

John was previously an emcee, events manager and associate lecturer (Republic Polytechnic). He loves dogs, especially Schnauzers, Chinese food and action movies. He loves to create – dishes, fancy event props and even doghouses, once.

worth of lobster heads reduced to just one kilogram – costing me about S$100 per batch.

**Where do you get your ideas for your menu?**

I always go back to my Chinese roots – the flavours I had growing up, which I incorporate into my dishes. Other Asian flavours are not forgotten either, as Singapore *is* a melting pot.

I don't set out to be creative though. I set out to cook something delicious. Creativity is secondary. I also don't set out to use the finest ingredients, as I believe that that is not the key duty of a chef. A chef works with whatever ingredients available to make it as delicious as possible. Focusing on just the ingredient is something anyone with money could do. That is, if one could afford it, one could use any ingredient he/she wants. Why would you need a chef to do that?

There is a deviation towards these two aspects of cooking these days though, ie, being creative and being ingredient-centric. I call it a deviation because they are not part of a chef's key duty, as I see it; I am sure you have had at least one meal that was very creative and prettily plated, maybe even using some very expensive ingredients, but was unremarkable in terms of taste.

**One of your menu items caught our attention: break-up steak. What is the story behind this dish?**

It is basically an upgrade of our previous steak in terms of cut and weight. My meat supplier had asked me to try the cut and upon the first bite, I thought to myself, "Oh my, this can heal any broken heart." So if you are going through a break-up and desire some "healing", order this steak.

## Going forward

**Where will you be going from here?**

My plan is to eventually retire Pasta J. This is mostly because it doesn't represent what we do anymore and has stopped doing so for some time. We have evolved over the years.

Many current dishes will remain but their format will change – all to be found under a new name. Aside from launching new dishes, we intend to produce more of our own ingredients through fermentation, brining, curing, ageing and even cultivation.

We also plan on opening in areas closer to town and are in talks with interested parties. Stay tuned for more updates! ◆

***Legend***

*1. Pork Collar Chops with Caramelised Portobello Mushrooms*

*2. Sanchoku Wagyu Tomahawk in Truffle Sauce*

*3. Squid Ink Lobster Stock Risotto with Tiger Prawns & Scallops. Live Boston Lobster optional*

## • 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 HG heartland practice (5) D27 Yishun, high turnover (6) D16 near MRT, mixed catchment (7) 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. Call 9671 9602 Yein.

**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.

**Two adjoining clinics** each 900+ sq ft at Farrer Park Hospital for rent at S$3/sq ft ono. Interested, sms or call 8858 6735 for discussion.

**D19 ground-floor shop** at Simon Plaza, 2-min to Kovan MRT. 968 sq ft with water point, toilet and 3-phase wire. Within private condominium and landed property enclave. Immediate occupancy, carpark available. Suitable for GP/Specialist clinic. Please call 6348 1680.

**33-year medical/dental clinic** in Bukit Gombak neighbourhood centre for take-over. Both the practice and the rental of the shophouse. Tenancy from HDB at prevailing attractive rate. Proximity to MRT station. Options open. Dr Wong 9684 6939.

**Gleneagles Medical Centre** clinic for rent. Approx. 500 sq ft. Comes with reception, waiting area and 2 consult rooms. Immediate. Please contact 9382 5939.

**Well furnished and** tastefully decorated clinic for takeover. In Upper Paya Lebar area. Prospect for growth. No nearby clinic within 800m radius. Please contact Cindy at 9008 8178 for further details.

**Any proposed price** will be considered: Medical unit at Farrer Park Hospital, 24-hr link to shopping mall/hotel/MRT and hospital. Best before mid-March. 807 sq ft/750 sq ft/1500 sq ft for lease and sale available. Contact Diana Kok at HP: 9767 9390. Act fast!

## • POSITION AVAILABLE/PARTNERSHIP •

**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.

**Minmed Group invites** doctors to anchor our clinic located in Pasir Ris. Ideal commitment to be 40-50 hr/week with Saturday am and 2-3 nights preferred. Nice work environment with good remuneration, bonus and profit sharing. Call/WA 9009 2899.

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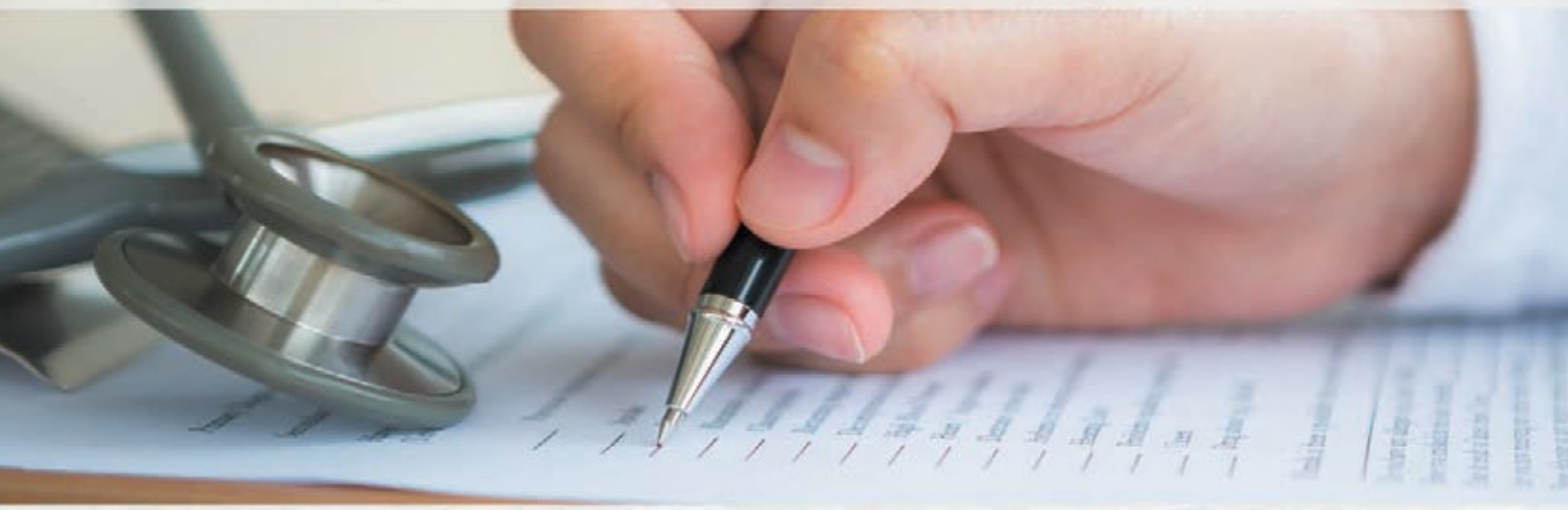

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| | Healthcare Procurement | |

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