SMA news

For Doctors, For Patients

VOL. 51 NO. 10 | OCTOBER 2019 | MCI (P) 083/12/2018

Role Reversal

Doctors as Patients

Some Insights
from the Other Side

When I was
the Patient

We invite Family Medicine Physicians, Resident Physicians and Generalists 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.

To find out more, please write in with your full resume to:
Medical Director
Jurong Community Hospital
1 Jurong East Street 21
Singapore 609606

Email: **JHCampus_medicalcareer@nuhs.edu.sg**

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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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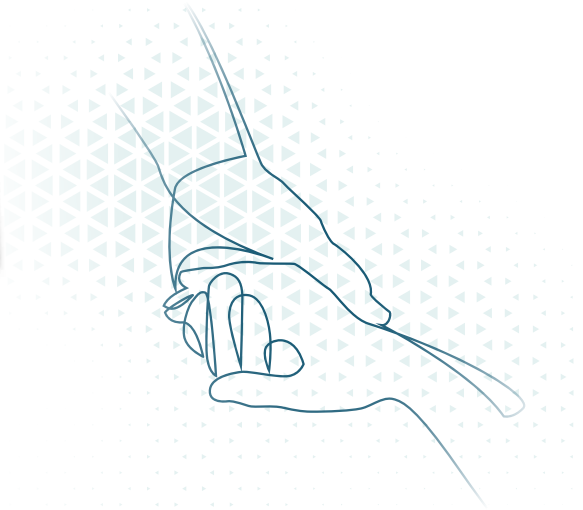


The EDITORS' MUSINGS

Tan Yia Swam

Editor

Dr Tan is learning new skills and stretching new boundaries in her private practice. Meanwhile, she still juggles the commitments of being a doctor, a wife, the *SMA News* Editor, the Vice-President of the SMA and a mother of three. She also tries to keep time aside for herself and friends, both old and new.

I remember learning in medical school that the incidence of schizophrenia is around 1% of the general population. Some people joked that it means two in my class of 200 will be diagnosed with schizophrenia.

We were young and foolish as we had little life experience. Now, two decades later, we have gone through our own various life events – the death of our parents, loss of a child, battles with cancers and major illnesses, and the loss of friends to sudden deaths or suicides.

I believe that those of us who have been through such events emerge emotionally stronger, more mature and probably more empathetic – qualities which I hope will make us better doctors.

Despite the bad press surrounding our profession, I still believe that patients come to us for genuine help. We should humble ourselves and step into their shoes. What do you want from a doctor? And how can you deliver that kind of care?

Tan Tze Lee

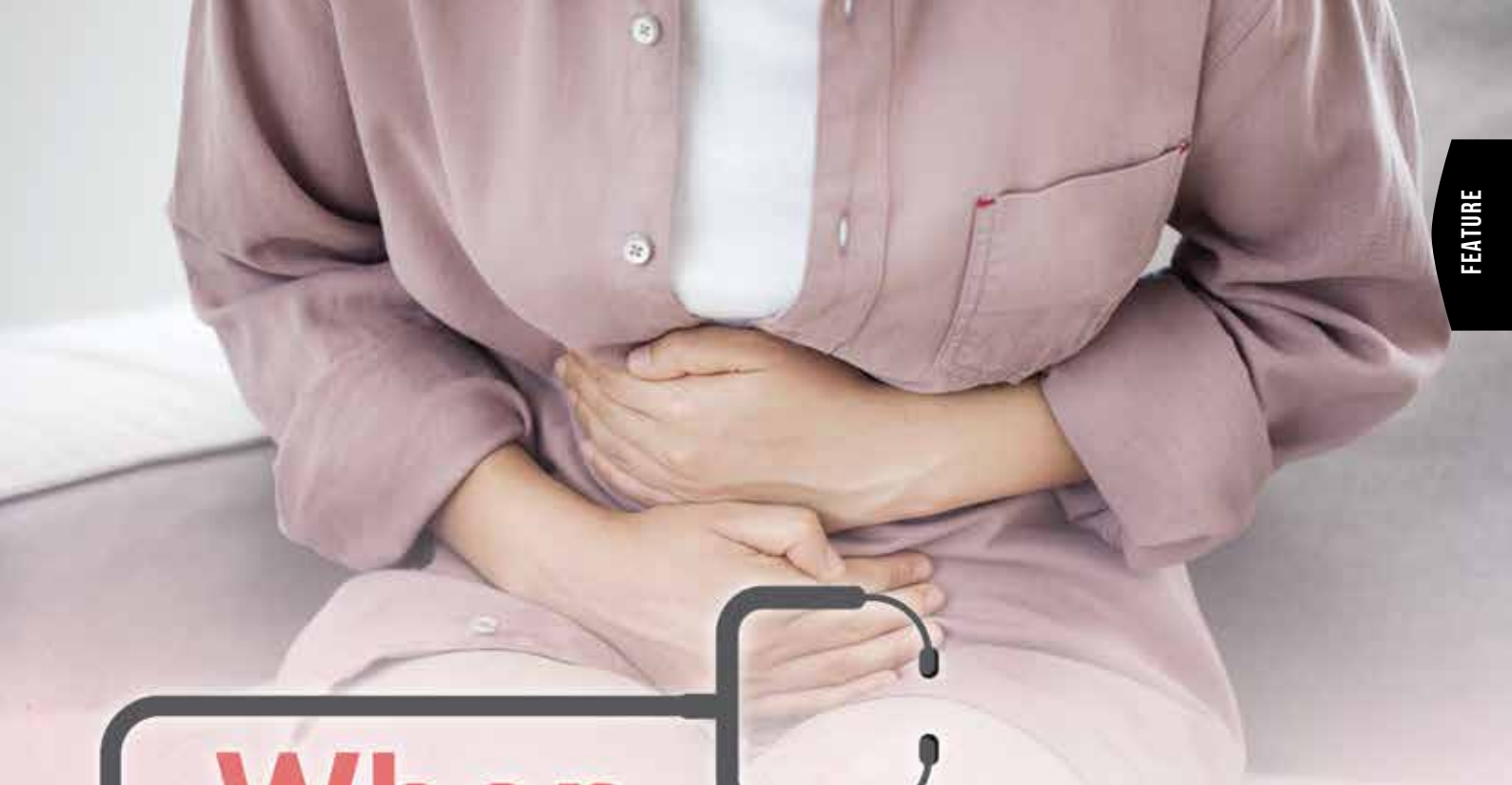
Deputy Editor

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.

As doctors, we are so busy taking care of our sick patients that we often do not spare a thought for our own health. That is why when illness comes knocking at our door, the first reaction is often disbelief and bewilderment – "It can't happen to me!"

This issue deals with the doctor who becomes ill, and the articles trace the journey of the doctor taking on the role as a patient. Dr Audra Fong's article gives us useful advice on how to choose a doctor or a surgeon for our health needs. Dr Bertha Woon looks in from the opposite side, and explores the difficulties and pitfalls of treating colleagues. The article by Dr Foo Swee-Sen and Prof C Rajasoorya explores the challenges of caring for the dying, and gives us a rare insight from an Asian perspective. We also have personal accounts from fellow doctors of their encounters with illness, giving us that rare glimpse of their experiences as patients. We do not value health as much when we are well; only in sickness and when health is gone do we miss it.

As Gandhi said, "It is health that is real wealth and not pieces of gold and silver." Absolutely. ◆



When Doctors Become Patients

Some Insights from the Other Side

Text by Dr Audra Fong

Dr Fong graduated from the National University of Singapore medical faculty in 1998 and is an ophthalmologist in private practice. She is happily married to her life-saving doctor spouse and has two children and a humanised Golden Retriever. Despite missing quite a few organs, she is an avid cook and Japanese language student, and hopes to run a private dining facility one day upon retirement.

It has been 26 years since I first entered medical school, bright eyed and bushy tailed, eager to answer what I believed was my calling in life. Till today, the immense privilege to be given a patient's trust to heal their ailments still humbles me greatly, and I am mindful of that with each and every consultation sought. Sometimes, however, there are challenging cases and situations that arise beyond my scope of expertise, and I would then have to advise patients that perhaps another opinion should be sought, for greater clarity of options available, aiming for the best ultimate outcome. I know that not all doctors subscribe to the notion of recommending their patients to seek second or even third opinions. This is sometimes viewed as an admission of ignorance or fallibility, which may be a pride issue for some, or a loss of face for others. I do not value personal pride or face as such because I strongly believe, for reasons that I shall elaborate on later, that not one doctor can ever profess to know it all, and that sometimes, another medical opinion may just save one's life.

But what happens when we, as healers, fall sick? What do healers do when they are in need of healing?

A doctor in need of a healer

I have had a few close encounters with death. Externally, I look pretty much intact, but truth is, I have had a few left-sided organs removed in the last decade or so! The closest (and most frightening) encounter began right in the middle of moving into our first home about 15 years back. Everyone knows that moving house comes as a close second to divorce or the death of a loved one in terms of ranking on the stressfulness scale, and it was in the middle of this intense life event that I began spotting. Insidiously, persistently and painlessly, I spotted for a week. At the time, this was more of an annoyance than anything to a busy young wife and mother of an active toddler, who was juggling medical officer calls and traineeship demands. A week dragged into nearly two, till finally, while having a short breather post-call one day, I decided to check in with my then O&G physician, Dr S.

Dr S had been a great tutor back in medical school, highly respected for her skill and knowledge, yet somewhat feared for her strictness and "no nonsense air". Not too long before, she had effortlessly and competently delivered my rather large firstborn safely, with nary a hint of perineal destruction in its aftermath (for which I was eternally grateful). I do apologise for the excessive information here for some, but this is purely to emphasise just how much I trusted Dr S in so many ways with my "woman issues" – totally unquestioning and with full trust in her professional judgement and capabilities.

Dr S diagnosed the stressed out and spotting me as having dysfunctional uterine bleeding, most likely brought on by the harrowing logistics of moving house. This was based purely on normal gynaecological anatomy on ultrasound. I accepted her diagnosis without question, was given some progesterone pills to take back home, and thought nothing more about the spotting. At that point, I did not even think about whether a urine pregnancy test (UPT) should have been done – hey, she was Dr S, after all, and I was just a second year eye trainee, with O&G pretty much left in the murky recesses of my preoccupied mind.

A few days later, in the middle of having dinner, I felt a sudden intense implosion within my abdomen, associated with a strange light-headedness, unlike anything I had experienced before. Being a doctor (and also coincidentally married to one), we naturally rationalised the few possible differential diagnoses – gas build-up from the curry dinner, possible early gastroenteritis or maybe even a dramatic mittelschmerz? However, within minutes, the pain intensified sufficiently to worry me, and I called Dr S's emergency hotline for a quick phone consult. Her advice was simple: "not to worry... only period pains" and to "take a Panadol and sleep it off." Again, unquestioningly, I dragged myself upstairs, dutifully took the analgesics and laid down. Doctor spouse popped in about twenty minutes later and stared at me, almost clinically, before starting to palpate my abdomen. When he reached my left iliac fossa, I winced as there was rebound tenderness and weirdly, shoulder tip pain as well – odd for supposed menstrual cramps, and *ominous*.

"This isn't menstrual cramping. Let's get you to A&E now."

Vulnerable and hurt

In the car, a million thoughts filled my clouded mind: my little son's worried face as I kissed him goodnight, my half promise to him that mummy would be home soon, whether he would be okay with the helper the next day as I had not had the time to make his overnight porridge stock… The intense gnawing colicky pain was both distracting and distressing at the same time. I had absolutely no idea what was going on inside me at that point, and running to the emergency department somehow seemed such a hassle then.

The triage nurse on duty was professional and efficient. After taking a brief history of my presenting complaint and checking my vital signs, she whipped out a small foil pack. "Doc, I will need you to go and pass urine in this, and return it back to me after." By then, I was getting rather lethargic, but did as I was told. "I can't be pregnant... *no way*!" I thought foggily, but complied nonetheless.

The UPT was positive.

And it suddenly dawned on me that I had a ruptured ectopic pregnancy, and would die if nothing was done, soon.

The rest of the night passed in a frantic blur after that. Dr S ended up performing my emergency salpingectomy that night, but not before chiding me as I slipped under general anaesthesia for being "too lazy to do a UPT". I fell into a deep and dreamless sleep after those hurtful words were uttered.

I woke up hours later, one fallopian tube and one child less, totally anaemic and giddy as a goose. Of course, I was immensely grateful to have even woken up at all. I kept wondering how I – a doctor – had missed this deadly diagnosis to the point that I could have gone to bed and found myself at the Pearly Gates upon waking.

The answer to that was simply this – I had placed my complete trust in Dr S, and her alone. I never once questioned her opinion or plan of management, not even when my ectopic had ruptured and I was in incredible pain. Thank goodness I had obeyed the laws of fraternity inbreeding and married a fellow doctor, who knew what referred pain and rebound tenderness meant.

Postoperatively, I developed an infected pelvic collection, a complication which prolonged my misery and time off work. Coupled with the fact that I had lost a child (albeit in embryonic stage, but still my child, nonetheless) and one of my tubes, adding to concerns that I would be rendered secondarily subfertile after the harrowing events, I was a sad miserable soul. Dr S's words to me on one of the outpatient reviews hit me particularly hard. "Here is the histology

> I have learnt to always try to put myself in the patients' shoes, to feel as they do, to see things from their perspective, and to choose my words mindfully without succumbing to pure technical jargon sans empathy."

report. Nothing more than POC, as expected." I wanted so badly to scream at her. It was NOT *just* a product of conception (POC); it was my *baby* that exploded in me, and that I nearly *died* as a result of the whole saga because I only listened to her, *because I trusted her completely*. I broke down into shuddering sobs outside the consultation room.

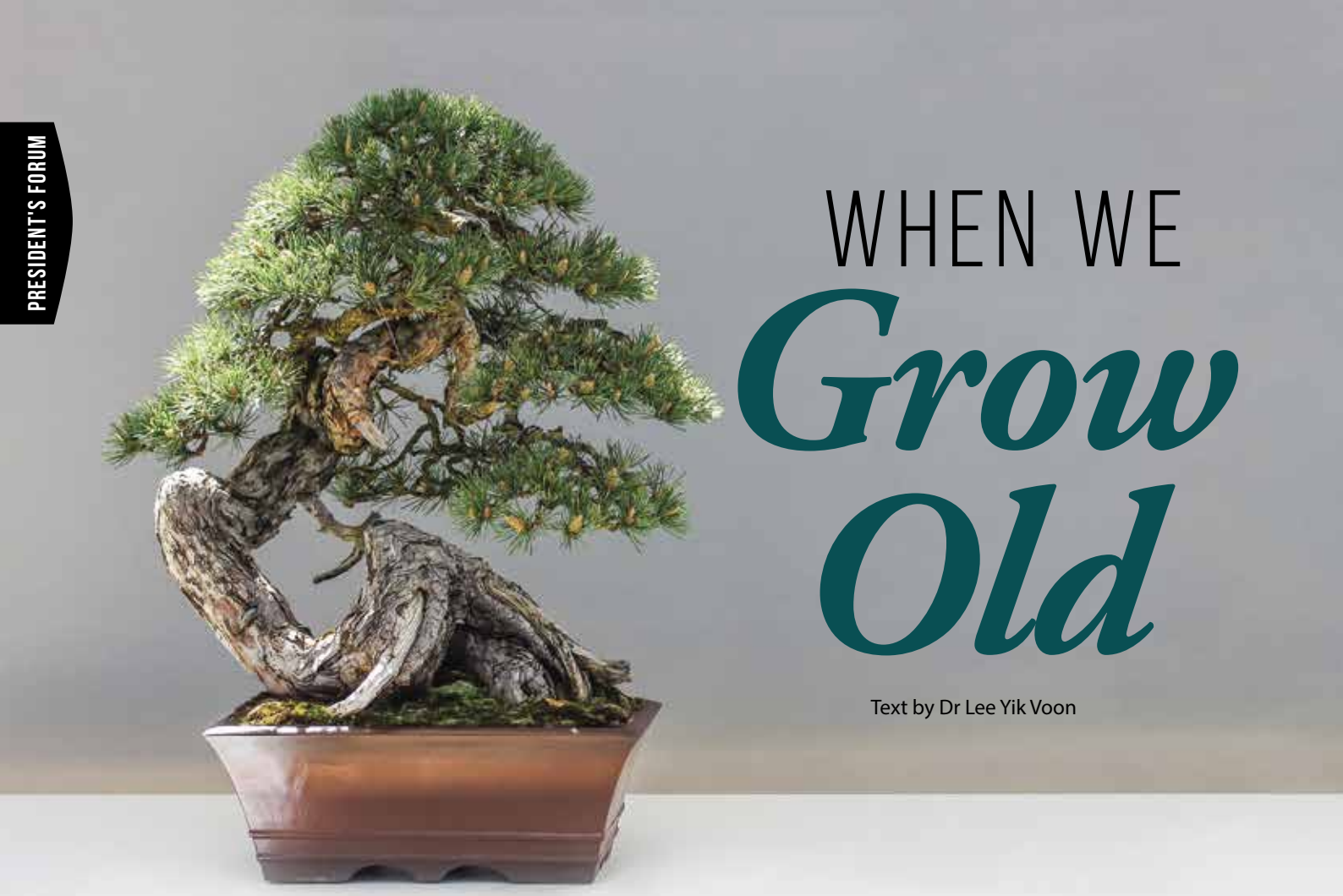
Would it have been different?

Dr S never once admitted that she had made mistakes in my management, perhaps in fear of litigation. The words, "oh, it would not have made a difference anyway" when I asked her if doing a UPT on my first visit would have helped, greatly disturbed and saddened me. I was worried that another patient of hers would suffer the same ordeal as I did, but might not be so lucky to make it through alive. Yet, I would never have brought Dr S to the courts (believe me, many flabbergasted friends advised me to do so, both medical and non-medical persons alike). The reason was simply because I believed (and still believe) that our profession was (and still is) one where most times the best intentions are there, but we, as doctors, are all still human and are not infallible. I learnt the hard way that second or third opinions could be helpful, sometimes even life-saving, as not one doctor can ever truly profess to know it all.

Perhaps if I had seen another doctor, I would not have had such a close shave with death. Perhaps if I had not been a doctor to begin with, things would have been different as there would not have been assumptions about what I ought to have known or known to do. The list of what-ifs could go on and on.

The above has been but one of a few harrowing accounts in my fairly dramatic existence thus far. Having been a patient myself, and having faced the rollercoaster of emotions, fears and uncertainties from "the other side", it has deeply humbled me and granted me precious insights. I have learnt to always try to put myself in the patients' shoes, to feel as they do, to see things from their perspective, and to choose my words mindfully without succumbing to pure technical jargon sans empathy. This first-hand experience has also changed the way that I now seek medical advice for myself and my family, and how I handle my own limitations as a healer. Ultimately we, as doctors, do want the best outcomes for our patients, but sometimes we need to set aside personal pride to help them achieve just that.

Finally, when mistakes have been made or when complications have arisen despite our best intentions, we need to be strong and walk alongside our patients through their time of darkness and pain, remembering that it was *they* who placed their faith and trust in *us* in the first place, and the last thing we should do is to abandon them when things go wrong. Much easier said than done, given the current hostile litigious climate that we work in, but to do the converse would be akin to cowardice and a betrayal of our calling. ◆



WHEN WE Grow Old

Text by Dr Lee Yik Voon

The Chinese song "当你老了" ("When you are old") by Karen Mok reminds me to ponder about life as I age.

Declining pool of familiar doctors

In my younger days as a practising GP, I had my preferred network of specialists whom I usually refer my patients to. I knew who could handle what sort of patients. For instance, patients who require doctors with high EQ, patients who like "no nonsense and cut straight to the chase" doctors, or patients who have mental and financial constraints needing colleagues who will do pro bono work.

As some of us approach the statutory retirement age, we may find our network of specialists dwindling as many would have retired from practice or have passed on. How many of them can we seek help from when we are struck down by illness ourselves?

Similarly, when we retire and no longer practise medicine, who do we see for our primary care needs? Will we think that our younger colleagues are still "wet behind the ears" and not experienced enough to look after our relatives and us?

If you look at the number of titles that our younger colleagues display, it would seem that they have undergone more rigorous training. Titles such as Graduate Diploma in Family Medicine (GDFM), Master of Medicine (MMed), Fellowship in the College of Family Physicians (FCFP) and Fellow, Academy of Medicine, Singapore (FAMS) – you name it, they have it. But will they have the practical experience, or the ability to interpret medical conditions and results in the right context? I have a younger colleague who is a good friend of mine. He has been a professor for many years and being humble, he told me that he is just a paper tiger. Can paper tigers deliver the healthcare that will meet the expectations of our loved ones?

Unlike laypersons, we have more domain knowledge, more medical information and more insights to have a better understanding of whatever "Dr Google" throws up. However, we have our inherent biases and blind spots that will give us subjective impressions that could form very non-objective assessments of the medical conditions of our loved ones and ourselves.

Alternatively, would you prefer an older GP who has worked beyond his/her retirement age? Would he/she be on cruise mode and just collecting tons of continuing medical education (CME) points and attending many CME lectures, or really keeping in touch with the latest advancements in medical science and technology and still able to maintain his clinical skills and acumen?

If we were to refer patients to our senior specialists, would their hands still be as nimble and deliver the same results expected of them? Many would have stopped operating and be more involved in a supervisory role to younger surgeons. Their years of

> We eat, sleep and breathe medicine... Retirement would be a massive change in our lives for us to adapt to."

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.

invaluable experience make them a rare and precious commodity in the current medical community, especially when many of our younger specialists are now trained in the sub-specialties.

The young specialists have received advanced training from top medical centres all over the world. Would they be a better choice than our elderly specialists for ourselves and our loved ones?

However, overseas training comes with challenges in extrapolation. The overseas patients are different in race and ethnicity. Their cultures, habits and lifestyles are also different from ours. Even their healthcare systems are different.

Facing our retirement

I will now like to take a step back and think about our own retirement.

What is retirement to you? What would you do in your retirement? Or would you do nothing at all? Sitting around doing nothing may be a sure way of leading to dementia.

What are your plans for retirement? Most of us, I presume, have walked the straight and narrow path of practising medicine. We eat, sleep and breathe medicine. We have barely spent time on anything else other than our family and medicine. Retirement would be a massive change in our lives for us to adapt to.

In our retirement, those of us who have pastimes and hobbies may no doubt spend more time on these activities. Or maybe we will adopt new hobbies like travelling to places we have not been to and perhaps do social work in needy communities, here and abroad. We may also try our hand at sports we have never had time to pick up or invest time in, or projects we scarcely had time for or to think about previously but had always wanted to embark upon.

In doing all these, one must not forget to check with oneself if these pursuits will make us happy. Are we as satisfied as we were when we were practising medicine? Will we have the same fervour as when we were running our own medical practice? Or are we just making ourselves busy so that we will not miss practising medicine?

One would also need to consider our physical and mental health when we retire. Will we age gracefully and be ambulant to travel all over the world or will we be suffering from chronic debilitating illnesses that will rob us of quality of life and our ability to practise medicine? Will we lose mobility and sanity and be stuck to a wheelchair or worse – be bed-bound?

As for me, I will be practising medicine until I can do it no more. I believe that as a medical doctor, I would forever be one in this lifetime. However, that does not mean I will not be spending time on other things and people, like family, friends, hobbies, other projects and my pet.

As Karen Mok's love song reminds us to carry on loving when we age; I would like to remind us to keep our love of our craft forever. ◆

HIGHLIGHTS

FROM THE HONORARY SECRETARY

Report by Dr Lim Kheng Choon

Dr Lim is the Honorary Secretary of the 60th SMA Council. He is currently an associate consultant at Singapore General Hospital.

SMA feedback on LIA standard pre-authorisation form

We provided feedback on a standard pre-authorisation form by the Life Insurance Association Singapore (LIA). **SMA is currently unable to support the latest version of the LIA pre-authorisation form.**

A key issue involves a section in the form which requires doctors to provide information of the patient's co-morbidities.

SMA reiterates that information collected in a pre-authorisation form should be for the current admission of the patient and not for the possible construction of his/her medical profile.

For details of the issues highlighted and SMA's recommendations, please refer to this link: http://bit.ly/313PEmh.

SMA response to Raffles Health Insurance's action to recover fees from clinics

SMA recently responded to a *Lianhe Zaobao* (联合早报) media query regarding Raffles Health Insurance (RHI), which is reportedly taking action to recover from its panel clinics medical fees that water treatment firm Hyflux failed to pay for staff medical treatment.

SMA's comments were included in a *Lianhe Zaobao* article titled "垫付凯发员工医药费拿不回钱 莱佛士医疗保险向诊所索讨诊金", published on 26 August 2019. Our full response is as reproduced below.

"Hyflux's financial woes have been in the news for some time now, but the full extent of risk would be clearest only to its business partners. In this instance, it would be fair for RHI to assume the credit risk for continuing to require their panel of doctors to serve the employees of Hyflux, when only they knew that Hyflux would have problems paying their dues to RHI.

As doctors, our first priority is the healthcare needs of our patients. Small clinics do not have the expertise to monitor the financial health of the employers of their patients, and would need to rely on the knowledge of upstream partners like RHI.

Moreover, as panel clinics of RHI, they do not have the right to reject patients visiting them, even if doctors feel uncomfortable about the stability of their patients' employers.

They have honoured their part of the contractual agreement and thus cannot be responsible for the losses which could have been pre-empted by RHI. They could have stopped seeing such patients on credit terms immediately had RHI instructed them accordingly."

SMA's input on possible misleading health information

SMA 1st Vice President Dr Tan Yia Swam was recently interviewed on a Channel 8 television programme, *Morning Express* (晨光第一线), aired on 27 August 2019. In it, Dr Tan advised patients to seek proper medical advice from doctors, avoid buying unknown health/medical products, and to be wary of misleading health claims and alternative therapies found online or shared by friends/relatives via social media. ◆

EFFECTIVE COMMUNICATION

THE KEY TO HAPPY DOCTOR-PATIENT RELATIONSHIPS

Text by Jasmine Soo, Executive, Event and Committee Support

Organised by the SMA Centre for Medical Ethics and Professionalism, the Communication Course was held on 27 July 2019 (Saturday) at Camden Medical Centre. It was attended by 23 professionals from a wide range of specialties from both the public and private sectors, including general practice, neurosurgery, haematology, paediatrics, patient service department and more.

Effective communication goes beyond just an exchange of information. When done properly, communication fosters understanding, strengthens relationships and builds trust among people. Very often, complaints from patients and the arguments, tension or misunderstandings between doctors and patients arise due to the breakdown of communication. Learning the right communication techniques will help to reduce the risk of patients' complaints and workplace stress.

This course provided participants with the techniques and skills helpful in improving their communication process with patients and patients' families, which can also be applied in their daily work in clinics and/or hospitals. Roleplay sessions were also part of the curriculum, allowing participants to practise the skills taught during the course. It also served as a platform for participants to share with one another the issues they have faced in their own workplaces.

We would like to thank our speakers – Dr Habeebul Rahman, Dr Lambert Low, Dr Syed Harun and Dr Liew Jun Wen – for taking time to conduct this course and share their expertise with our participants. We also thank Camden Medical Centre for the sumptuous lunch and comfortable venue, making the smooth execution of this event possible.

Legend

1. Role-play discussions among doctors from different specialties

Topics covered:

Basic Communication Skills	Advanced Communication Skills	Application of Skills Learnt
• Listening and Observing • Posture and Body Language • Language • Dialogue Skills	• Picking up Cues • Weaving It In • Signposting • Zooming Out • Sidestepping • Mirroring • Escaping the WIB (Whining, Ifs and Buts)	• Breaking Bad News • Handling Difficult Patients and Families • Role-play Sessions

Medicine and Ethics

Preparing the Young Minds

Text by Sylvia Thay, Assistant Manager

What lies ahead for young medical students and doctors, as they watch multiple medico-legal cases unfold before their eyes?

The third SMA National Medical Students' Convention (NMSC) held on 31 August 2019 sought to tackle the current medico-legal climate worries with the theme, "Sailing the Seas of Medical Ethics and Law: Navigating the Winds of Ethico-Legal Changes".

Eager-eyed students from the three local medical schools congregated at the Lee Kong Chian School of Medicine's Learning Studio for the day's activities, purposefully put together to educate and guide the doctors of tomorrow. Mr Ng Ding Yi, programme director of the SMA NMSC, opened the Convention before elaborating on its purpose and theme. Following which, Dr Lee Yik Voon, SMA President, took to stage for his welcome address where he thanked Dr T Thirumoorthy for setting aside time to share his wealth of knowledge and industry experience with our medical students. In his address, Dr Lee also expounded on the four pillars of ethical medical practice: Autonomy, Justice, Beneficence and Non-Maleficence, setting the stage for the keynote address.

What every medical student needs to know

An increasingly common term being thrown around these days is "defensive medicine", and this was what Dr Thirumoorthy sought to address in his keynote message titled "The Current MedicoLegal Climate – What Every Medical Student Needs to Understand". He talked about the current medico-legal climate, the negative impact defensive medicine can have on doctors and patients, and how doctors are held accountable to the professional standards of medicine.

Dr Thirumoorthy reminded the students to aim to understand the issues at hand and ask themselves at the end of each work day if "their actions have indeed met the standards". He also inspired the students to practise leadership at the different levels (ie, individual/team, hospital and national policy) to effect change and move from a "blame and shame" culture to a fair and just one.

In closing, Dr Thirumoorthy left the students with an important reminder: "What we say and what we do must complement what we think".

Further discussions

Following the keynote address, a panel discussion was scheduled to provide a platform for students to seek advice from the panellists. Concerns brought

up included issues surrounding professional accountability: whether it extends beyond medical work to the doctors' personal lives; what doctors can do if they observe senior doctors potentially practising defensive medicine; and future expectations on professional accountability.

Working in teams

For the team-based learning session, the students were sorted into teams and proceeded to read through and discuss the two case studies provided for the session.

Ms Yang Lishan, together with Dr Thirumoorthy, then led an invigorating discussion based on the teams' response to the case studies. The facilitators motivated the students to think a step further and reconsider the scenarios in depth to avoid making assumptions. Both students and facilitators voiced their questions and opinions with fervour, leading to much sharing on the different beliefs and understanding of the laws and circumstances.

Inter-school debate

Proposition team:
Cowan Ho, Clarissa Cheong, Thirrisha Murugan and Mo Jiahui

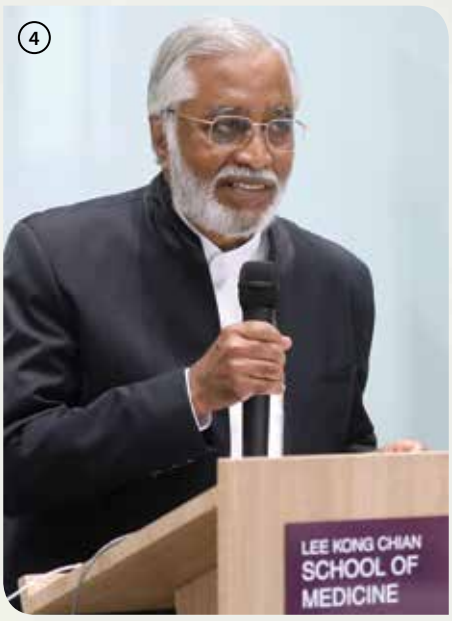
Opposition team:
Lee Hong Jing, Lim Lig Chuan Sean, Tan Ying Kiat and Marco Lizwan

The highlight of the day was the inter-school debate on the motion "Burnout among medical students is the responsibility of the individual".

Speakers from both the proposition and opposition teams took their turns and delivered their respective points and counters, garnering nods and murmurs of agreement for both sides of the coin. Was the onus truly on the individual, as the proposition team defined, since they are best placed to assess and eliminate the causing issues as doctors, or should the underlying systemic issues be resolved and managed by higher authorities? Both teams put up such convincing arguments that the audience soon looked conflicted about which side to support. One can't help but think that perhaps these students would do just as well as lawyers!

After some discussion, the judges, Dr Thirumoorthy, Dr Bertha Woon and A/Prof Marion Aw, announced the opposition team as the winner! Each team member received a 3M™ Littmann® Cardiology IV™ Stethoscope kindly sponsored by 3M Singapore and certificate from Dr Woon, while A/Prof Aw presented the certificates of participation to the proposition team members.

As the participants streamed out to lunch, many were still caught up in bunches comprising students from different schools, discussing the day's rewards and the various conundrums raised. It was an exhilarating day of learning for everyone indeed. We look forward to the next run of the SMA NMSC, and hope to see you there! ◆



Much thanks are to be given to the many esteemed guests who set aside their precious time to make this Convention a success.

Keynote speaker

- Dr T Thirumoorthy, Founding Director, SMA Centre for Medical Ethics and Professionalism

Panel discussion

Panellists:

- Dr T Thirumoorthy
- A/Prof Chin Jing Jih, Chairman, Medical Board, Tan Tock Seng Hospital; Past President, SMA
- Dr Bertha Woon, Associate, Medical Protection Society of Singapore
- Ms Kuah Boon Theng, Managing Director, Legal Clinic LLC

Moderator:

- Dr Norman Lin, Past President, National University of Singapore Yong Loo Lin School of Medicine's (NUS Medicine) Medical Society

Team-based Learning

- Ms Yang Lishan, Assistant Director, Team-based Learning Facilitator, Education Development, Office of Medical Education, Lee Kong Chian School of Medicine, Nanyang Technological University

Debate judges

- Dr T Thirumoorthy
- Dr Bertha Woon
- A/Prof Marion Aw, Assistant Dean of Education, NUS Medicine

Legend

1. Students focused on their reading for the team-based learning session

2. The debaters pose for a group photo with the judges

3. Mr Ng Ding Yi as he delivers the opening address

4. Dr T Thirumoorthy, the keynote speaker for NMSC 2019

Treating FELLOW DOCTORS

Text by Dr Bertha Woon

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.

In the Singapore context, everyone has the freedom to choose which doctor to see when they fall ill. This is no different for doctors who become patients. This freedom of choice may be lost in an emergency situation such as a road traffic accident. However, in an elective situation, a doctor-patient may have to think hard about whom he/she trusts and what to do when he/she meets the physician again in a social/professional setting. When I was asked to write about this topic, I felt it was a trick question of sorts because there is actually no difference whether the patient is a doctor or not. **The usual issues of ethics, confidentiality, privacy, autonomy and beneficence apply.**

There are a few scenarios that come to mind:

1. General conditions for which a doctor seeks treatment from another doctor because he/she has already tried self-treatment and failed;
2. A doctor from a different specialty sees a relevant specialist because he/she is not familiar with his/her own condition;
3. A surgeon/proceduralist sees another surgeon/proceduralist for a surgical/procedural problem because he/she cannot operate/perform a procedure on himself/herself;
4. Doctor-patient and the doctor are friends;

5. Doctor-patient and the doctor are strangers;
6. Doctor-patient requires treatment in an emergency situation;
7. Doctor-patient seeks treatment in an elective situation (benign); and
8. Doctor-patient seeks treatment in an elective situation (malignant).

Just another patient

Although one may assume that the doctor-patient has good understanding of the condition, one should put aside any assumptions and take as detailed a history as usual. The same goes for physical examination.

It is a safe thing to double check what the doctor-patient's baseline understanding is on the condition and explain the investigations, differential diagnoses and possible management plan as clearly as needed. One should not assume that the doctor-patient knows everything, especially when the doctor-patient is from another specialty with respect to the presenting medical condition. It is prudent to allow all patients, whether doctor-patient or not, to ask as many questions and discuss the possible options/outcomes as he/she finds necessary to allay his/her anxiety.

Sometimes, it is not easy to set boundaries, especially if the doctor-patient is not just a colleague, but also a friend. Knowing the context of the doctor-patient's social history and life is often part and parcel of one's history-taking process and could be helpful in better patient management. When proposing the surgical plan, it is good to advise the preferred option as well as the other alternatives for the doctor-patient to consider. It is also prudent to give cooling time to the doctor-patient to make decisions, do the literature check and seek another opinion. Where needed, involve their family members and/or caregivers in the decision-making.

In this era of "Dr Google", it is not unusual for patients to want to drive the medical care, whether they are doctors by profession or not. As a result, one should get used to having very detailed discussions about options before making a shared decision.

For the relationship between doctor and patient to work, good communication and trust are essential. If there is anything that jeopardises it, it is better for one to gently suggest that the patient sees someone else. If the doctor-patient decides on a treatment that one is not comfortable with giving, it is proper to refer to another physician for a second opinion. It is important to maintain a good relationship with the patient and there is absolutely no shame in sending the patient for a second opinion. If one thinks that there is a better physician for his/her doctor-patient, it is alright to refer onwards. Always have the patient's best interest at heart, regardless of who he/she is.

My personal take

Personally, if a doctor opts to see me voluntarily, I take it as a great honour that he/she chooses me to be their physician. I would treat him/her as well as I treat any other patient. As with any other patient, our rapport is important. In most cases, I would extend professional courtesy as my senior doctors had taught me long ago – we do not charge for consultation. However, if the doctor-patient has insurance, then I would charge as usual. In any case, one's professional liability kicks in whether or not the patient is a doctor.

Given that my specialty is gender-sensitive, my patients are mostly women. And since I am in private practice, the patients I see would have come to me out of his/her own free will. After all, if he/she did not trust me, he/she would not have turned up for the consultation.

However, I am also aware that doctors in the restructured hospitals often do not have the luxury of being able to choose the patients they see. Assignments of patients to doctors are usually by the administrative clerks or by "luck of the draw". Most of the time, doctor-patients are reasonable and there would not be any issues. Outpatient difficulties, such as personality clashes, can be easily resolved by referring the patient to someone else on the spot in the case where there are objections. However, problems that arise when a doctor-patient is involuntarily admitted in a restructured hospital due to the severity of the condition or emergencies would be tougher to resolve. In the situation where there is a loss of choice, the difficulty of the doctor-patient assuming the sick role, trust issues and non-compliance issues can be challenging. Statements such as, "I don't trust you"; "I know better than you"; "I'm more senior than you"; "What do you know?"; "I don't agree with your diagnosis, investigations, management and treatment plan"; or "I won't do what you say" can erode the doctor-patient relationship from the get-go.

What can one do in such a situation? I think the better option would be to treat the patient as you would any other and to not let professional issues get in the way of your better judgement. Remember that it is normal for people to be difficult when they are not feeling well. Cut them, and yourself, some slack and do your best for the doctor-patient while bearing in mind *ethics, confidentiality, privacy, autonomy* and *beneficence*. ◆

When I was the Patient...

Being a doctor is a calling, as many would say, to care, treat and comfort those in need. However, doctors too are humans and there may come a time in life when doctors themselves need some medical attention.

Here, two doctors share their experiences as a patient and how being a doctor had an impact on their respective encounters.

Text by Dr X

It was an uncanny experience looking at my own heart in motion on the fluoroscopy monitor as I underwent an emergency angioplasty for an acute coronary event. In that situation, prior medical knowledge of what to expect throughout the procedure certainly helped.

Looking at my own cardiac movement and continuous electrocardiogram, I could estimate that I had several seconds to say a desperate prayer before losing consciousness, and also to harmonise my soul with the Divine should I not regain earthly awareness.

I also understood without questioning the rationale for the attending radiologist's instruction for me to cough as hard as possible when he gave the order (which thankfully proved unnecessary). I suppose the pre-emptive action was meant for the event of ventricular fibrillation – to hopefully abort it without the attending staff having to thump my chest or start cardiopulmonary resuscitation.

On the flip side, the prevenient knowledge was not helpful when I saw a cardiothoracic surgeon colleague of mine peeping into the fluoroscopy suite while I was undergoing angioplasty. I knew in an instant that he was called to be on standby for emergency open-heart surgery should complications arise. (*I would not have chosen that surgeon to perform it if I had a choice.*) Thankfully, the angioplasty went smoothly and here I am, able to pen this short reflection today.

Text by Dr Chie Zhi Ying, Editorial Board Member

As a clinician, regardless of where and what you may be practising, you are always the one being consulted by patients. It is a great privilege as well as a humbling experience to be sitting in the consultation chair, listening to the woes of patients and trying your best to help them. And when the occasion arises where a doctor, like any fellow human being, falls ill and becomes a patient, the role is reversed and it becomes quite an interesting encounter.

I recall one such morning when I was busy seeing patients in my consultation room. I had felt a little unwell the night before but decided to work anyway. As the morning wore on, I felt chills and rigour with a stuffy nose and terrible body aches. It came to a point where I felt as if I was in the freezing cold Arctic, feeling goosebumps and chills all over; I stood up and switched my room's air conditioner off. The very next patient came in and as I went through her laboratory results for her chronic conditions, she casually remarked, "Doctor, how come your room so hot and stuffy? Never on air con, is it?"

I gave her a sheepish and apologetic look, inched painfully towards the air conditioning panel on the other side of the room and switched it on reluctantly. After the consultation, I took my own temperature and realised I was having a high fever. I decided that it was high time to see my colleague for my self-diagnosed viral upper respiratory tract infection.

The first obvious benefit of seeing your colleague, especially one working at the same institution, is convenience. I simply called up a senior colleague before I popped over to his room on the other side of the level for a quick consultation.

The second good thing about seeing a fellow colleague is the familiarity and trust already present. As the doctor that fellow colleagues often turn to for advice on handling patients' issues, this senior colleague of mine was naturally the person of choice when it came to seeking a physician.

After confirming my earlier self-diagnosis, I was prescribed medicine and quickly packed off to rest. Being as unwell as I was, I was grateful for an efficient consultation and of course, some tender loving care and advice from my colleague. Hearing comforting words and getting gentle care from one's doctor can really make your day, reminding me to always be a caring doctor to all my patients.

On the other end of the spectrum, I can imagine doctors feeling hesitant to see another doctor if the consultation pertains to sensitive issues (ie, psychological issues, gender-based medical problems). After all, it is human nature to fear embarrassment and stigmatisation. However, at the end of the day, we doctors are also humans. Being in the patient role is a stark reminder of our own vulnerability as a human being but more importantly, our responsibility to the greater humanity as physicians. ◆

Dr Chie is a family physician working in the National Healthcare Group Polyclinics. She enjoys freelance writing and singing. She writes for *Lianhe Zaobao*, *Shin Min Daily News* and *Health No.1*. She can be contacted at chiezhiying@gmail.com.

SAYING Goodbye

Text by Margaret E Perry

Margaret was a dietitian in the National Health Service (UK) before becoming a journalist. She moved to Singapore in 2000 and worked as a health reporter at the *Straits Times* and *Channel NewsAsia* for ten years. Margaret has worked in public healthcare communications since 2010 and is currently with SingHealth.

In July 2018, I experienced my first "real" death where I finally had to face life's only certainty. Until then, the subject of dying had always been a taboo for me and best avoided at all costs. My beliefs around death were formed from watching television; seeing people drop dead from heart attacks and old ladies move seamlessly from their beds to their coffins in one swift scene change.

No doubt some people do die sudden and dramatic deaths, but that wasn't what I witnessed in my father's final days. Dying was a journey that began long before he took his last breath, and so too was my goodbye.

My father retired at 65 years old and two years later he was diagnosed with Parkinson's. At the start, it had little impact on his life. He took a couple of pills a day and kept busy. He was a volunteer secretary of the local Parkinson's UK branch, played the piano, was the main driver, mowed the lawn when nagged, and every year, he and my mum flew to Singapore to visit me and my family.

Preparing for the end

I had heard of Parkinson's and knew there was no cure, so I read up on the disease and pondered dad's future. It felt like we were staring into the headlights of a distant oncoming train that would eventually shatter my father's life. The clock had started to tick and I needed to make the most of the good years he had left. Living overseas, I wasn't able to visit every weekend so I made a conscious effort to spend more quality time with him and my mum when I saw them. Every time they came to Singapore, my father and I attended a concert by the Singapore Symphony Orchestra and we went to midnight mass together when we were together for Christmas.

Dad had always been averse to being "poked around" by doctors, yet treatments such as feeding tubes were a future possibility as the disease often affects swallowing in the advanced stages. At that time, I was working in the communications department of a public hospital in Singapore that was actively promoting advance care planning for patients and their caregivers.

Not knowing what the future held for my father, I decided to document his care wishes while he was still healthy. I downloaded the advance care planning forms and brought them with me to the UK during a visit to my parents' home. My mother could see the need but didn't

want to take part in the conversation, so she left my father and me to it. I was nervous and a little awkward at the start, but my father's pragmatism and desire to have his wishes respected allowed us to talk openly. It helped that he was still active and relatively well, so some of the questions were hypothetical, beginning with "if you…", rather than "now that you…". The conclusion was that he would only agree to tubes being poked in his body if it meant that he could continue to be independent and contribute to the family and society.

Very slowly, the disease started to rob my father of his abilities and sense of self. He lost his appetite when he could no longer smell, his striding walk became a halting shuffle, his quick wit slowed as he struggled to keep up with conversations and, for the first time in his life, he lacked confidence as he started to fall. My mother began to do his "jobs" such as driving, which was usually to visit friends nearby or to a cafe for a cup of tea and a piece of cake.

Earlier in 2018, my dad shared with an old friend that he felt he was "running on empty". The effort of thinking through even the simplest of movements was physically and mentally draining. His falls became more frequent and eventually landed him in his local hospital in Hull, East Yorkshire, at the end of May. Fortunately, he didn't suffer any broken bones, but his low blood pressure needed to be sorted out before he could go home.

Turning his face to the wall

This was his second hospital admission in six months, but my mum noticed his attitude was very different this time. Previously he had been desperate to go home, whereas this time he didn't mention it. He seemed more withdrawn and ate very little. My mum has never been one to bother people, so when she said it might be good if I visited, I booked my flight to the UK and took a week's leave.

I hoped for the best but prepared for the worst. When my children asked if Grandpa would get better, I said I hoped so, but his body and soul were very tired from fighting Parkinson's so he might not have the strength to continue. The truth hurt and all I could do was to wipe away their tears and hug them. They wrote letters for me to bring along, each showing their love for him in their own way. My son knew his Grandpa didn't like being in hospital, so his included jokes to cheer him up. It worked, because when I read the letter to my father, he laughed. My daughter's letter was more poignant and made him tear.

When I first saw him in his hospital bed, I started to have hope that he would recover. He seemed pleased to see me; we talked and when I showed him a photo from his school days he was able to name several of the boys whom he hadn't seen for more than 60 years. But he also had hallucinations that made him very anxious, such as when he believed that my daughter's life was in danger. When I tried to brush it off, he became angry and demanded that I leave immediately to sort it out. I left his bedside, upset that he didn't want me there and bought a cup of tea from the canteen. I sat in the tiny garden at the front of the hospital, sent a message to my husband back in Singapore to double check that all was fine at home, and gradually calmed down. When I went back up to the ward, I presumed that my father would have forgotten about it but he was still concerned and demanded to know how my daughter was. I held his hand, looked him in the eye and said I had checked and she was definitely safe, at home and tucked into bed. After repeating it several times, he looked relieved and more settled.

Other times, my father's mind was crystal clear and he was determined to be in control of his care. He was painfully thin from eating only mouthfuls of food and the consultant suggested putting in a temporary feeding tube to build him up. His answer was a resolute "no". She spent an hour with him, discussing his care wishes and options, but he didn't waver once. The doctor, my mother, brother and I respected his decision, but accepting it was a little harder because we knew there would be only one outcome. It felt wrong and unfilial to "allow" my father to make a decision that wouldn't prolong his life. I questioned whether I should have tried to persuade him to have the tube feed. Yet his decision was consistent with the advance care wishes he had expressed several years ago when he had been well. Who was I to override his wishes when his Parkinson's was getting worse and a tube feed wouldn't enable him to lead an independent life?

My father also refused to take his medication. He became expert at tucking his pills near his gums, then spitting them out when no one was looking. After a while, he simply clamped his mouth shut whenever someone tried to give him his pills. He was starting to get weaker, and three days after I had arrived, the doctor asked us to meet her for a family discussion. She shared what we already knew – that my father's time was limited. She said it was impossible to say how long he had left, but we should start thinking about where he would want to spend his final days.

Our priority was for dad to be as comfortable as possible. We considered bringing him home, but he was so frail and thin that we were worried he would suffer from pressure sores because of our caring inexperience. We also wanted to make sure he could receive treatment to relieve any symptoms should the need arise, so we opted for the local hospice. His doctor started making the arrangements, but when we arrived the following morning, we felt it was too late to move him. His condition had deteriorated overnight, and the last thing we wanted was for dad to pass away in the back of an ambulance.

Dying with dignity

The staff moved him from a four-bedded bay to a single room, with a sweeping view that stretched for miles. The nurses told us we were welcome to visit anytime, and they provided a camp bed for my brother and his wife to sleep on, as they volunteered to stay with him at night. The staff said their job was to keep my father, and us, as comfortable as possible, so if we wanted anything or

had any concerns, we should just ask. It was a Tuesday, and looking at him with my untrained eye, I thought he wouldn't live for more than a day.

There were no beeping monitors or blood tests. The only medical care given was tenderness, respect and the touch of experienced hands checking his pulse and the temperature of his hands and feet. The nurses turned him regularly to prevent pressure sores and took care of his personal hygiene needs, keeping him clean shaven to ensure he looked his best despite his gaunt appearance. They taught us how to keep his mouth clean and moist using sponges on sticks, dipped in water or fruit juice. The palliative care team visited him every day to check on his condition and wrote a prescription so the nurses could give him medication to make him comfortable, if necessary.

My father lay in bed, staring straight ahead, but he was still able to hear. We talked to him about things that were happening and asked him if he was in any pain or discomfort. He held one of our fingers and answered with a squeeze for yes and no response for a no. The nurses put him on a low-dose morphine pump, enough to ease his discomfort while still able to hear what we said.

Over the days, his cheeks became more sunken and his mouth remained open all the time. But his breathing remained regular and the nurses were surprised he was "holding his own". By Thursday I was in a dilemma – should I fly back to Singapore the next day on my booked flight or stay with him until he passed on? I had heard nurses say before that the dying often choose who they want with them when they go. Sometimes they wait until a loved one leaves the room to spare them from seeing their last breath. I spoke to my mother and brother, and with their blessing I decided to leave it in my father's hands. Before I went back to my parents' house on Thursday night, I told him I was going to catch the train at 11 am the following morning. I would see him in the morning before I left, or anytime in the night should things take a turn for the worse.

Dad survived the night and Friday morning I said my last goodbye, knowing I would never see him again. I thanked him for loving me and my family, for sharing with us his love of music and for teaching me to speak up when I felt that something was wrong. For the first time in my life, I told him I loved him and would miss him, before giving him a last kiss on the cheek and leaving the room in floods of tears.

The sense of loss was staggering. On the journey back to Singapore, I numbed the pain watching mindless movies, unable to accept reality. I checked in with my mum and brother as soon as I landed in Singapore and continued to message them throughout the night.

He passed away mid-morning the following day, with my mother and brother at his side. The nurse had warned them that his breathing had changed and they said their final goodbyes. My mum said he then gave one small gasp and slipped peacefully away. It was Father's Day and I was with my family when the call came. I was able to break the news to my children and my husband was there to comfort all of us.

A father until the end

The funeral was held two weeks later, in the first week of the school term. Education is important, especially for my son whose Primary School Leaving Examination was just months away, but sometimes family must come first. My husband and I took the children out of school for a week to attend the funeral so they could say their goodbyes, grieve with the family and learn more about their Grandpa from people who had known him at different stages of his life.

I've always hated funerals and was dreading my father's send-off. I cried, but unlike my usual uncontrollable sobs at previous funerals. Instead, I felt a sense of calm sadness but also pride in listening to the moving eulogy and address read by my brother and one of my father's oldest friends. They shared his achievements and his unique qualities, both the good and the bad. There was a raw honesty to the service – a quality my father held dear throughout his life. He was an Anglican priest and the service was held in a church, but the passage his sister read came from Homer's *The Iliad*, a tribute to the years he spent in his youth studying ancient classical literature and his love of language:

Then Zeus that gatherer of the clouds spoke to Apollo

Go, dear Phoebus, and take Sarpedon out of the range of the darts,

and cleanse the black blood from him, and thereafter bear him far away,

and bathe him in the streams of the river, and anoint him with ambrosia.

And clothe him in garments that wax not old, and send him to be wafted by fleet convoy,

by the twin brethren Sleep and Death, that quickly will set him in the rich land of wide Lykia.

[There will his kinsmen and clansmen give him burial, with barrow and pillar, for such is the due of the dead].

– The Iliad Bk 16. ll.666-673.

The days following the funeral have been a time of reflection. Remembering the times I spent with my father brings me happiness and pain, as I know I can no longer see him or ask him for his advice. I hold the life lessons he taught me dearly, and I hope that one day I will be able to accept his greatest and his last: to acknowledge my mortality, be at peace with myself and my loved ones, and when the time comes, to meet death with courage, grace and humility. ◆

Requiescat in pace

D.W. PERRY

1942 – 2018

Looking Beyond Life, Death and Dying

An Asian Perspective

Text by Dr Foo Swee-Sen and Prof C Rajasoorya

The poignant reflection by Margaret (see page 18) strikes a familiar chord with many of us who deal with the terminally ill. The reflection is a collective narrative of the issues we face in our daily lives in dealing with death, including dilemmas in care, extent of care, conflicts within us, and pain and sorrow, among others. More importantly, the narrative brings the patient with illness to the centrepiece of discussions. Such discussions then affect our decisions and their downstream implications.

Many a time, we provide aggressive care and treatment truly with the belief in its appropriateness and consistency with our own values. Sometimes, however, we are influenced by fear of litigation, guideline recommendations, peers' practice, our own religious and cultural alliances, the financing model and insurance coverage. We are indoctrinated to think that doing everything we can do within our means for the patient is the way. In the process, we sometimes ignore the paradoxical outcome in which our best intentions may not be congruent with the patient's values, preferences or goals. Balancing futility with quality of life remains difficult impasses we encounter, however much we believe our medical training helps us. As physicians, we may like to take heed of Atul Gawande's warning: "We've been wrong about what our job is in medicine. We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being."

As glowingly illustrated in these candid revelations – life and death are not just distinct entities in itself, but represent a spectral journey punctuated by a "dying process". We hold many conversations with family members and carers on end-of-life care in the course of our practice, but this beautifully written reflection from a loved one's perspective helps us to truly understand and shift our focus to pertinent issues on the dying, death and the care we

provide for our patients and their loved ones. We'd like to highlight some of these below.

Stigma of death and conversations on ACP

The reluctance to discuss death stems from a variety of motives with roots from our cultural and social value system: our unpreparedness to discuss about uncertainties, not wanting to traumatise our loved ones, fear of a consequential family dispute, yielding to unaccomplished desires, or even feeling bad about delegating unfinished work to the living relatives. As much as it seems easier to avoid discussion on these issues, it is worth reminding ourselves that non-discussion can make issues after death even more complex if the important contribution of the patient is left out of the equation. The Institute of Medicine has identified good clinician-patient communication as well as effective shared decision-making as components of a high-quality end-of-life experience.

Advance care planning (ACP) was introduced in Singapore in 1996, represented by the Advance Medical Directive Act. It is a continual process as values, wishes and conditions may change with time. It serves as a guide rather than the rule of the thumb. It also serves as a portal for patients to come to terms with their declining health and death. Studies have suggested that most patients with serious illness do not fully appreciate its progressive nature and incurability.[1,2] Prior to ACP and the discussion of goals of care, it is imperative that the patient/caregiver appreciates the extent of illness and the likely progression trajectory.

ACP is a tool to engage the patient in deeper conversations and remove the stigma of talking about death. It also allows the family members to understand the values and wishes of the patient, removing the burden of decision-making and second guessing.

Paternalism vs mutualism

The doctor-patient relationship has shifted the pendulum from paternalism to one that places emphasis on patient autonomy and acknowledging that every patient has the right to choose the treatment he/she wants, as an informed decision. A mutualistic approach to discussions on death and dying has significant benefits for the entire family and community at large. To leave dealing with death entirely in the minds of physicians or in the hands of patients and/or their relatives is unfair. A mutualistic approach offers a good balance where the physician shares the burden of decision-making with his patient, through careful deliberation and collaboration.

With our population growing older and with multiple co-morbidities, it is inevitable many will grow old with deficits, disabilities and limitations. Early initiation of conversations on one's wishes will help their loved ones significantly, while accepting that they are given the right to change their minds at any point in time – provided that the decisions are medically sound and relevant to the patient's condition. We are seeing a shift from the paternalistic approach to a more mutualistic and consultative relationship. Either way, we continue to uphold the medical oath – protecting our patients from harm, benefiting them and guiding them in their decision-making.

No doubt, physicians have the continuing dilemma of precisely defining what "futile care" is. Patients and/or their relatives may have different perceptions of futility from medical professionals, leading to profound disagreements and conflicts. McCabe and Storm[3] have suggested addressing three major issues that include goals of treatment, likelihood of achieving the goals, and risk benefits and alternatives of treatment options. They also suggested that discussions on these should be initiated early and there should be ongoing communication with careful attention paid to not mislead the patient. Despite the best communication efforts, disagreement may linger. As recommended by the American Medical Association, where conflict resolution fails, it would be prudent to bring issues to the institutional ethics committees.[4]

Feeding vs dying hungry

Feeding has always been a concern for families of patients with advanced conditions, such as dementia or malignancy, although most patients don't feel hungry at the end of their lives. Anorexia can be extremely agonising for loved ones to cope with. The cultural belief that we cannot "die hungry" causes distress to many families. Historically and culturally, food has often been paired with love, care, hospitality and support. Sharing the natural progression and the futility of artificial nutrition in some circumstances may require multiple conversations and discussions. Reassurance that there is no scientific evidence that food provides prolonged or qualitative life improvement in terminally ill patients, and that stopping eating is a natural event that is part of the normal dying process, would be useful for the caregiver. Sharing details on how tube feeds and parenteral nutrition can contribute to patient discomfort and possible need for restraints can also help allay anxieties. Involving the patient him-/herself in the conversations when he/she is mentally composed helps greatly in easing the fear and anxiety.

Filial piety vs keeping alive at all cost

In an Asian society, we struggle with the conflict between filial piety, translated to keeping parents or loved ones alive at all cost, and quality of life. It does not help when inexperienced healthcare workers dumbfound caregivers with the

dreaded question of whether they want the ill relative resuscitated. Almost instantaneously, the instinctive affirmative response is given, no doubt clouded by a lack of sufficient details and a very prevalent misconception that "non-resuscitation" equates to "non-care". In a similar vein, the uninformed public tend to associate symptom management with doing nothing else, and avoiding an intensive care admission is tantamount to giving up.

Much as it takes soft skills (currently emphasised in all undergraduate curriculum), patience and tact, it is prudent for physicians to realise that a lack of aggressiveness, from a caregiver's perspective, may be misconstrued as a lack of care. The emphasis should perhaps be that care and quality are not mutually exclusive. Doing everything does not mean offering every patient intubation and intensive care, but what is medically appropriate; failing which, it is to ensure death will not be painful for the individual.

More for the patient vs more to the patient

Patients and relatives must be fully aware of the purpose of the tests, treatment or procedures to be performed, including the benefits, limitations and, more importantly, the risks. In dealing with the issues of death, physicians must be prudent to have an honest discussion with the patient, especially if these will make a difference to his/her lifespan and quality of life. Physicians should take particular pains not to investigate at the expense of their patients just to satisfy their intellectual curiosity.

The other common dilemma we face is on the extent of investigations and treatment in patients with advanced disease or age. We have found it useful to ask ourselves three probing questions. Firstly, will the investigations or treatments be keeping with their goals of care or aid in their management? Secondly, am I doing more for the patient or to the patient?

Lastly, what would the medical and psycho-social burden of investigations on this patient be? One of us had the pleasure of having a lovely, well-loved 90-year-old lady with dementia under our care. She would come to the clinic in a wheelchair, beautifully groomed by her family members, despite requiring help with all daily activities and mobility. She had presented with weight loss but was otherwise asymptomatic and was found to have iron deficiency anaemia. Despite supplementation, she continued to lose weight. We made a joint decision with the family not to proceed with invasive evaluations and opted for expectant management. The difficult decision was made with all the more conviction when the family (and physician) recognised that she would not want or tolerate any intervention if needed.

Life remains a journey and the outcome of this journey is death. We tend to forget that the implications of what we offer in the patients' death and dying can be significant for their loved ones when they carry on their journey beyond the patient's passing. But as physicians caring for our patients holistically, we have to ask ourselves if we want to uphold our patients' dignity and lives free from pain and discomfort with proper closure, or continue the anxiety and suffering to both our patients and their loved ones. Margaret's perspective of her father's life, death and the dying process best captures the entire journey and our mutual roles. ◆

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Dr Foo is a senior consultant from Sengkang General Hospital. Her specialty is geriatric medicine with a special interest in orthogeriatrics and falls in older persons.

Prof Rajasoorya is a senior consultant physician and endocrinologist from Sengkang General Hospital with an interest in integrating the science and art of the practice of clinical medicine that incorporates the patient in the care process.

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NOT JUST SKIN DEEP
THE WORLD CONGRESS OF DERMATOLOGY

Text and photos by Lim Gim Hui

The World Congress of Dermatology (WCD) is held once every four years and holds a prestige equivalent to the "Olympics" of dermatology conferences.

This year, the 24th WCD was held in Milan, Italy, from 10 to 15 June 2019, and I was most privileged to have my poster selected by the conference authorities for presentation at the world conference. My poster presents the data for Phase I of the research project conducted with the National Skin Centre (NSC) during my third year in medical school.

I am also happy to share that this year's conference was made extra special for the NSC team when their hard work came to fruition, winning the bid to host the 25th WCD here in Singapore in July 2023.

A brand new experience

This was my first time attending and presenting at an international conference overseas. It was a very large-scale conference and it was impressive to note that there were over 16,000 participants and over 6,000 projects presented at the conference.

During the conference, some of the most memorable sessions included presentations on humanitarian dermatology, where people from around the world shared how the use of tele-dermatology can tackle problems in areas like rural Nepal, where there are limited dermatologists. Some examples shared include how the care for HIV patients was done in Africa to ensure compliance to highly active antiretroviral therapy (HAART) treatment and how health education and awareness programmes were conducted in Fiji for patients with vitiligo, among others. These experiences resonated with me, as I found myself inspired that there are also opportunities for dermatologists to play a part in humanitarian missions.

Over the few days in Milan, I made new friends from around the world and learnt more about their culture and the way dermatology is practised in their country. We even got to mingle with one another and tour the city of Milan in the evenings after the conference proceedings.

Overall, the conference was a very enriching experience for me. After my poster was selected for the conference, I was initially hesitant to attend the conference because of the high cost required. I am very thankful to Duke-NUS Medical School and the SMA Charity Fund for helping to defray the cost of attending the conference. It was with their support and encouragement that I decided to go ahead. I am very thankful that I managed to attend such an important conference to learn more about dermatology and even made some friends along the way.

Thank you for your support and for making the trip possible.

Legend

1. Prof Roy Chan, Head of the Singapore Bidding committee for the WCD, addressing the congress attendees after Singapore won the bid

2. Me and the poster I presented at the conference

Gim Hui recently returned inspired after an opportunity to serve in Project DOVE, an overseas medical mission trip in Vietnam with Duke-NUS Medical School. He is thankful for these opportunities and hope that these experiences will help him to better serve patients in the future. He is currently a fourth year medical student.

AIC SAYS

STRENGTHENING LONG-TERM CARE FOR ALL SINGAPOREANS

Singaporeans are living longer; while this is good news, improved life expectancy comes with an increased risk of disability, especially towards the end of life. To strengthen long-term care for Singaporeans, MOH introduced the Home Caregiving Grant (HCG) in Oct 2019 and will implement CareShield Life in mid-2020.

In addition, to ensure more Singaporeans are able to receive the support they need, MOH has revised the assessment framework to provide assessors with more guidance on aspects to take into consideration if an individual is suspected to have cognitive impairment.

Patients who wish to make a claim under any severe disability scheme will have to visit an MOH-accredited assessor to obtain an Assessor's statement. Assessment fees have been increased from $50 to $100 for clinic-based assessments and from $150 to $250 for house-call assessments. For other disability schemes, patients can visit any GP to obtain a Functional Assessment Report[1].

With the new schemes and enhancements, MOH anticipates there will be a marked increase in assessments required. GPs like you have always been AIC's invaluable partner in ensuring patients are able to access quality care. Coming onboard as an assessor for severe disability schemes will further strengthen this partnership and help more severely disabled patients receive the support they need.

SCHEMES FOR PATIENTS WITH SEVERE DISABILITY

1 CareShield Life (for CareShield Life policyholders only[2]) — NEW

- Cash payout of at least $600/month for as long as patient is severely disabled
- No means-testing required

2 ElderFund[3] — NEW

- Cash payout of $250 or $150/month for as long as patient is severely disabled
- For patients who are not CareShield Life or ElderShield policyholders[4]
- For patients with a low income and low MediSave balance

3 MediSave Withdrawals for Long-Term Care[2] — NEW

- Cash withdrawals of up to $200/month
- From patients and/or their spouse's MediSave
- No means-testing required

4 ElderShield 300 and ElderShield 400 (for ElderShield policyholders only[4])

- $300 or $400/month for up to 60 or 72 months respectively
- No means-testing required

5 Interim Disability Assistance Programme for the Elderly (IDAPE)

- Cash payout of $250 or $150/month for up to 72 months
- For patients who were not eligible for ElderShield in 2002
- Means-testing required[5]

[1] Patients also applying for any of the Severe Disability schemes do not need to obtain the FAR. They should visit a MOH-accredited severe disability assessor instead to obtain an Assessor Statement.
[2] Scheme will be rolled out from mid-2020
[3] Scheme will be rolled out from Jan 2020
[4] Patients who wish to check if they have ElderShield may login to their account on www.cpf.gov.sg and select "My Messages" followed by "Healthcare"
[5] No additional step is required in applications for schemes requiring means-testing. Patients who previously opted out of means-testing will be contacted by AIC for more information.

SCHEMES FOR PATIENTS WITH MILD OR MODERATE DISABILITY

Mild Disability

Foreign Domestic Worker (FDW) Levy Concession for Persons with Disabilities (PWD)

- Levy concession of $60/ month for duration of FDW employment
- For households hiring a FDW to care for a patient
- No means-testing required

Moderate Disability

Home Caregiving Grant (HCG) NEW

- Cash payout of $200/month for life
- For patients being cared for at home
- Means-testing required[5]

Pioneer Generation Disability Assistance Scheme (PGDAS)

- Cash payout of $100/month for life
- For Pioneers
- No means-testing required

LEVELS OF DISABILITY

The long term care schemes are only applicable for patients who always require assistance with or are unable to perform the Activities of Daily Living (ADLs) - Feeding, Bathing, Toileting, Dressing, Moving, and Transferring.

Mild Disability	Moderate Disability	Severe Disability
Always require some assistance with at least 1 ADL	Always require some assistance with at least 3 ADLs	Unable to perform at least 3 ADLs

TRAINING FOR GPS WHO WISH TO BECOME ACCREDITED ASSESSORS

Why Is Training Necessary?

- Ensures consistent experience and assessment outcomes for individuals undergoing severe disability assessments through standardized training and a MCQ accreditation test

Enhancements To Support Assessors

- **Training made easier:** use of e-learning has enabled us to reduce the classroom training segment from 2 days to half a day
- **Revamped curriculum for holistic assessments:** assessors will learn how to better account for the impact of cognitive impairment on functional abilities

---

What Will Training Entail?

E-learning:

The e-learning modules will take an average of 2.5 hours to complete, and must be completed prior to attending the classroom training.

Classroom Training:

Trainer: A/Prof Ng Yee Sien
Senior Consultant, Rehabilitation Medicine, Singapore General Hospital
A/Prof Ng has worked with a group of experienced healthcare professionals to develop the course.

CME points will be awarded to doctors who complete the training. The next wave of training sessions will be held in early 2020. GPs who wish to attend these sessions may indicate your interest via Primary Care Pages.

Indicate interest via Primary Care Pages
(www.primarycarepages.sg > "Contact Us" > "Indicate interest to be a severe disability scheme assessor")

For more information on the disability schemes and assessor training, please contact the AIC GP Engagement team at gp@aic.sg or 6632 1199.

FROM Vineyards TO Tables

Text and photos by Shalom Chin

Many of us enjoy drinking some wine every now and then, especially during celebrations and social events. However, how many of us have truly devoted time and effort to understanding the roots of each bottle of wine we drink? *SMA News* speaks with Shalom Chin, a certified sommelier and wine distributor, who shares how his deep connection with wine developed over the years.

Could you share with us how your journey with wine began?

My vinous journey began when I was 17. I came across a bottle of Chardonnay when I was at a supermarket and wondered what "Chardonnay" meant. Little did I know then that it was the name of a grape. I paid for it at the counter without getting my age checked. Turns out, I enjoyed it so much that I decided to research more into it, and that was what opened up my life to the world of wine.

From then on, I started to keep accounts of the wines I bought and even recorded my tasting experiences. During my university days, I spent a lot of my pocket money attending tasting events and eventually developed an appreciation for the nuances that can be found in wines made in different regions of the world.

To formalise my knowledge, I studied to be a Certified Sommelier from the Court of Master Sommeliers in the US and further obtained a Wine and Spirits Diploma from the Wine and Spirit Education Trust programme. My interest in food also took me to do a Master in Food Culture and Communications at the University of Gastronomic Sciences in Pollenzo, Italy. My master's thesis was about boutique wineries and how a different type of marketing and distribution strategy could benefit their sales.

I was really enamoured with the idea that the culture of a people and the identity of a region could be embodied in a bottle. I also enjoyed understanding how vines grow and react to their environment. I started sharing bottles of not-so-well-known but impressive wines that I collected during my visits to small wineries with friends and colleagues of family members, borne out of my desire to share the craft of these passionate winemakers with people outside their network and to bring some attention to what they were doing. Over the years, it evolved into a business.


1

What have you done since to further your interest?

In my life, I have had the rare opportunity to visit 13 wine-making

countries and most of their regions to understand more about their grapes and soil. I also did a harvest and wine-making stage in Austria, Australia and Italy. Additionally, I have worked in the industry organising wine events and also in a wine export company.

So what are you working on these days?

A few years ago, I took my company B°NU from a physical space to the digital space by transforming it into an e-commerce store. Since then, the business has stabilised and I am free to work full-time on my second passion – technology. I am now in the fintech sector.

What do you see your company's future to be?

I think more could be done to take my company digital. With today's existing technology and services empowered by technology, there is no reason why we can't transform the wine import business to become more service oriented and cost effective for consumers. If more people can band together to do combined orders, these organised efforts can significantly bring down the cost for both importers and consumers. My dream is to combine the orders of many consumers to get wines at a better price. Instead of marking up the price per bottle, I would charge on a service fee basis per bottle dependent on the time taken to process the shipping and alcohol tax. No storage cost would be included if delivery could be on the same day as arrival.

We all know to pair wine with steak and seafood, but is it okay to drink wine with steamboat?

It is more than okay to drink wine with anything, as long as you understand the basic principles of wine and food pairing. The three key things to take note of when pairing wines with food is the 1) method of cooking, 2) ingredients used and 3) sauces. For steamboat, the method of cooking is boiling. The ingredients could be an assortment of meat and seafood. If pig liver were used, then there will be a stronger, gamier taste. For sauces, it could range from a standard soy sauce with sesame oil to a chicken rice chili sauce. Putting all this information together, I would recommend a wine that is versatile for all sorts of ingredients, high in acidity to whet the appetite and yet not so heavy that it overwhelms the delicateness of the boiling method. Some suggestions would be Rieslings from Germany, Verdelho from Spain and Beaujolais Cru from France. ◆

Legend

1. Doing a barrel tasting at Weingut Sommerach

2. Me with winemaker Tal Pelter of Pelter Winery in Israel

Shalom is a certified sommelier with a Diploma in Wines and Spirits and a Masters in Food and Communications. After working for an Italian wine export company, he founded B°NU (pronounced BE-NU), a food and wine lifestyle company that sources, promotes and distributes premium limited-edition wines crafted by the finest artisan producers.

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If you have any queries, please contact Rita or Priyah at
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*Terms and conditions apply

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We'll always be with you. No one's ever really gone.

In view of SMA's 60th Anniversary, the Association will donate all proceeds collected from this event to the SMA Charity Fund (SMACF) which supports needy medical students in their living expenses. To find out more about SMACF, visit http://bit.ly/AboutSMACF or scan the QR Code.

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Contact Jenifer Goh
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Requirement:

- Fully registered with the Singapore Medical Council
- At least 1 year of post-housemanship experience
- Training will be provided

RESIDENT PHYSICIAN, OPHTHALMOLOGY

The Clinical Services department is seeking candidates who are highly motivated and willing to join us for a fulfilling career as Resident Physician. The incumbent will be responsible for the daily running of clinics and any other ad-hoc duties assigned by his/her Supervisor or Head of Department.

Requirement:

- MBBS or postgraduate qualification registrable with the Singapore Medical Council
- At least 3 years of ophthalmology practice experience
- Must be able to do call
- Please note that the role does not have surgical privileges

CLINICAL ASSOCIATE

The Clinical Services department is seeking candidates to join us on a short-term contract basis doing general clinic and ward duties. No eye experience is required as on the job training will be provided. This two-year stint will not come with night calls.

Requirement:

- MBBS registrable with the Singapore Medical Council
- Completed 1 year housemanship
- Doctors who are bonded need to seek permission from their funding body before application

Interested applicants, please email your curriculum vitae including details of work experience, qualifications, present and expected salaries to Ms Chong at: ***chong.kai.xian@snec.com.sg****.*

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- Developing clinical programs for paediatric radiation therapy and leading the development of clinical policies and procedures using evidence-based radiation services
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- Training and mentoring fellow clinical professionals

In addition, you will have full participation in teaching, audit and research.

Requirements:

- Basic and Postgraduate Medical Degree
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- Experience in Proton Beam Therapy would be especially welcomed

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Please apply by **31 December 2019**

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DOCTORS DON'T NEED A WILL?

BASED on various estimates, as high as 87% of Singaporeans do not have a Will written. There's a good chance that the number is even higher amongst doctors and healthcare professionals. Here are the top 3 reasons that they give:

1. *It's too expensive*
2. *I have no time to visit the lawyer's office*
3. *I need more time to think about how I want my estate distributed*

Dr Chow U-Jin M.B.B.S (SINGAPORE)
Founder and Principal Consultant of Finhealth

Despite dealing with illness and death daily, Doctors tend to neglect their own legacy planning needs. Here's what could happen if you do not have a Will in Singapore when you pass on. Contrary to popular belief, your spouse will not automatically inherit everything after your passing.

A. Your assets may not be distributed according to your wishes, regardless of what you discussed with your spouse/children when you were alive. Some loved ones may not be catered for, including: elderly parents, special needs siblings, illegitimate children, unmarried parents, charity etc.

B. Settlement of your estate may take a much longer time and cost more

C. Guardianship of your children will be uncertain should both you and your spouse pass away at the same time

CASE STUDY

A 50 year old surgeon in private practice passes away without a Will, leaving behind 3 properties for his spouse and 2 children. As his death wishes were not captured in a Will, his 3 properties will be distributed according to the Intestate Succession Act, resulting in

- Spouse owning 50% of all 3 properties
- Each child owning 25% of all 3 properties

This arrangement would clearly not have been the wishes of the deceased surgeon. To redistribute the properties amongst his family members after his death, stamp duties will have to be paid, incurring significant unnecessary cost.

Writing your FIRST Will doesn't need to be expensive or time consuming, neither do you need a lawyer. Just **10 minutes** will get you a fully legally compliant Will.

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WSHCOUNCIL

Tripartite Alliance for
Workplace Safety and Health

A LONG ROAD TO RECOVERY

Madam Zaleha's vibrant personality and energy make her perfect for her role as a Resident Care Associate at the Salvation Army. Her regular work activities involve taking care of the residents, going on excursions and participating in outdoor recreational activities with the residents.

All this changed on 31 December 2017. During a routine fire drill at work, she slipped and fell. The fall caused a fracture of her right hip and she immediately felt the pain when she tried to get up. Her road to recovery was equally painful — Madam Zaleha underwent hip surgery and subsequently went through nine months of rehabilitation at the hospital.

Thankfully, Madam Zaleha found a friend in her occupational therapist — who is also a coordinator for the Return To Work (RTW) programme at Tan Tock Seng Hospital, where she sought treatment after her surgery.

An initiative by the Ministry of Manpower and Workplace Safety and Health Council, the RTW programme helps workers who suffer from traumatic work injuries and work-related musculoskeletal injuries to make a smooth transition back into their workplaces. The programme provides early intervention to help injured workers retain their long-term employability and continue to be productive in their jobs. The RTW programme is available in seven public hospitals in Singapore.

The RTW coordinator worked with Madam Zaleha and other healthcare professionals in setting goals to help Madam Zaleha regain her mobility and carry out daily activities at home. At the same time, the coordinator had constant discussions with Madam Zaleha's doctor and employers on how she could get back to work safely, proposing readjustments to her work duties. When Madam Zaleha returned to work in November 2018, she was given light administrative duties and exempted from outdoor physical activities with the residents.

Despite the changes in her work duties, Madam Zaleha still works selflessly to take care of the residents' well-being. She teaches the residents arts and crafts, as well as gardening, and keeps a watchful eye on them while they engage in outdoor activities.

Today, Madam Zaleha is still on her road to recovery but is slowly gaining more self-confidence. She credits the RTW programme for her progress and for granting her a smooth transition back to a fulfilling life at work. She is very appreciative of the programme and how it can help to boost workers' spirits, giving them assurance on returning to work after an injury.

She shares this advice with fellow workers, "Be mindful of your environment and take extra measures to ensure safety at all times. Do not be afraid to approach your supervisor on any issues relating to your safety and health at work."

HAPPY TO BE BACK AT WORK

Mr Peh Chee Beng is a cleaner with Summer Pond & Landscaping Pte Ltd. In January 2018, Mr. Peh's big toe was crushed by a drain cover. There was a deep cut diagonally across his toe and he suffered a fracture. After going through surgery and physiotherapy at Tan Tock Seng Hospital, his doctor recommended him to undergo the Return To Work (RTW) programme.

As part of the RTW programme, the RTW coordinator conducted a workplace visit with Mr Peh and his supervisor. During the visit, the coordinator went through Mr Peh's work environment and identified potential safety risks. Mr. Peh was given modified work duties, advice on correct body postures and wore proper footwear. Mr Peh returned to work six weeks after his injury.

"The RTW programme played an important part in my recovery journey. The RTW coordinator helped me greatly by checking with my doctor on my condition, liaising with my employer on my job scope, (and) identifying the potential risks or barriers for me to return to work. With these interventions, I was assigned light duties when I first went back to work. My supervisor was supportive and urged me to pace out my work, so that I have sufficient breaks throughout my shift. I'm happy to be able to go back to my job and continue working after I have recovered," shared Mr. Peh.

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References:
1. Hayden FG et al. N Engl J Med 2018; 379: 913-923.

XOFLUZA® (baloxavir marboxil) – Abbreviated Prescribing Information
Before prescribing XOFLUZA®, please consult the full local prescribing information.

THERAPEUTIC INDICATIONS: XOFLUZA is indicated for the treatment of uncomplicated influenza in patients aged 12 and above, who have been symptomatic for no more than 48 hours. **POSOLOGY AND METHOD OF ADMINISTRATION:** The recommended dose of XOFLUZA is an oral dose of 40 mg in patients with body weight of 40 kg to <80 kg, oral dose of 80 mg in patients with a body weight of ≥80 kg. **CONTRAINDICATIONS:** XOFLUZA is contraindicated in patients with a known hypersensitivity to baloxavir marboxil or any of the excipients. **USE IN SPECIAL POPULATIONS:** No effects on fertility were observed in animal studies performed with baloxavir marboxil. XOFLUZA should be avoided during pregnancy unless the potential benefit justifies the potential risk to the fetus. The safety and efficacy of XOFLUZA in paediatric patients (<12 years of age) and geriatric patients have not been established. The safety and efficacy of XOFLUZA in patients with renal impairment or severe hepatic impairment has not been studied. A change in dose is not required for patients with renal impairment, or mild to moderate hepatic impairment. **UNDESIRABLE EFFECTS:** The overall safety profile of XOFLUZA is based on data from 1318 subjects in 14 clinical trials receiving XOFLUZA. No adverse reactions have been identified based on pooled data from 2 placebo-controlled clinical studies in adult and adolescent patients, in which a total of 910 patients have received XOFLUZA.

SAFETY REPORTING FOR POTENTIAL UNDESIRABLE EFFECTS: *Please report any adverse events to the local Roche Adverse Event email at singapore.drugsafety@roche.com or call (65) 6735 0550. This will enable Roche to better understand the safety of XOFLUZA and to provide appropriate information to health authorities, healthcare providers and patients.*

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xofluza® (baloxavir marboxil)