SMA news

For Doctors, For Patients

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MEDICO-LEGAL UPDATES

for the Singapore doctor

Defensive **Medicine**

Court-Appointed **Medical Assessors**

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We regret that only shortlisted candidates will be notified.

Ng Teng Fong General Hospital

Jurong Community Hospital

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PUBLISHER
Singapore Medical Association
2985 Jalan Bukit Merah
#02-2C, SMF Building
Singapore 159457
Tel: (65) 6223 1264
Fax: (65) 6252 9693
Email: news@sma.org.sg
URL: https://www.sma.org.sg
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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 hope readers are keeping track of the developments in recent high-profile medico-legal cases. I also hope that you are not just repeating what the general media reports, but reading through judgements and discussing critically with colleagues.

The field of medical ethics and professionalism is a complex one, and some of us strongly feel that there should be on-going continuing medical education in this area. In fact, it should be taught almost like a specialty.

The SMA Centre for Medical Ethics and Professionalism has been conducting advanced subspecialty training/residency courses for exit specialists, and other courses for those interested in additional training. Articles in this issue have also been curated to provide a more holistic understanding of current medico-legal practices.

The future months and years will bring some changes and challenges to the way we self-govern. I hope that more concerned doctors will step forward to contribute their opinions and give their time and expertise to tighten our own processes.

In this issue, various authors give their take on medico-legal issues.

In his speech at the opening of the Legal Year 2016, Chief Justice Sundaresh Menon said that medical assessors (MAs) will be appointed to help judges understand cases.[1] At the Annual National Medico-Legal Seminar 2016, Justice Judith Prakash, Judge of Appeal, outlined the role, responsibilities and essential skills of court-appointed MAs.[2] In this issue, Dr Winston Woon, who had taken part in a case as an MA in 2016, gives us some insights into the role of an MA.

It is no longer enough for doctors to just learn from their mistakes. Doctors need to take preventive measures to safeguard themselves against negligence allegations. Doctors may potentially respond to the threat of increased litigation by practising defensive medicine. In their article, Drs Ng Shu Li and T Thirumoorthy tell us that "a professional and systems approach is necessary to build a healthcare system that empowers medical practitioners to become competent, compassionate and trustworthy to promote patient safety and defend against defensive medicine."

The rise of defensive medicine not only erodes the doctor-patient relationship, but more importantly indicates a crisis of the doctor-society relationship. It is a scourge that causes doctors to behave

Cuthbert Teo

Guest Editor

A/Prof Teo is a forensic pathologist by training. The views expressed in the editorial is his personal opinion.

opportunistically, rather than in the patient's best interest. There is an urgent need to slow down this global epidemic. To reduce the practice of defensive medicine, doctors will need to make time for patients, and reaffirm evidence-based clinical reasoning. Healthcare institutions need to have a systems approach to preventing medical errors and supporting both patients and healthcare professionals who experience adverse events. Society may need to examine whether it would be worthwhile to have a system that tries to prevent, identify and correct errors, instead of a blame-and-punish system.

Fault-based negligence compensation is not cost-effective and negatively impacts the doctor-patient-society relationship. Society should seek a holistic inquisitorial facilitative dispute resolution process. ◆

References

1. *CJ seeks to ease doctors' fears of malpractice suits. The Straits Times 12 January 2016. Available at: http://bit.ly/2MONstT.*

2. *Prakash J. The role, responsibilities and essential skills of a court-appointed medical assessor. SMJ 2017; 58(12):678-80.*

A FINAL MANY WORDS ON THE LLA CASE

Text by The Hobbit

This article was first published at http://bit.ly/2lH1KTV on 21 August 2019.

And so, it has come to pass, on appeal from the Singapore Medical Council (SMC) against its own Disciplinary Tribunal (DT), our wise Judges have ruled that Dr Lim Lian Arn (LLA) is not guilty of professional misconduct.[1] Everybody has to pay their own costs, including Dr Lim and SMC's lawyers. Other than the lawyers and the DT, everyone lived happily ever after. And so the story comes to a happy ending.

Not quite.

Learning points from the C3J Judgement of the LLA case

First, a few learning points can be gleaned from the Judgement that was issued on 24 July 2019 by the Court of Three Judges (C3J):

One key point was that the SMC's position to call for a five-month suspension of Dr LLA was "wholly unwarranted" and that the "DT also fell into error by too readily accepting Dr LLA's submission (made in response to the five-month suspension) that the maximum fine of $100,000 would be appropriate" (para. 63). This Hobbit couldn't agree more. To me, it means that how a sentence is called for by the SMC must be dependent on the specific facts of the case, and that the several calls (at least in four previous cases), before the LLA case by the C3J, for harsher sentences and sentence re-calibration against doctors must be taken in their specific contexts on these occasions and not to be interpreted as "general instruction" for all cases. This is helpful.

Personally speaking, the most helpful information in the Judgement is it makes out clearly how professional misconduct is to be proven (summarised for brevity and not necessarily for high fidelity):

- Establish what the applicable standard is;
- Establish whether there is departure from this standard; and
- Prove whether this departure is serious enough to constitute professional misconduct. With respect to negligence, it must be "serious negligence" and departure from standards must be "serious disregard" or "persistent failure" to meet the standards set out under the SMC Ethical Code and Ethical Guidelines (ECEG).

The Judges took effort to state that the lawyer for LLA "was mistaken" when he regarded that a breach of a "basic principle" in the ECEG amounted to professional misconduct. They also stated that "there must be a threshold that separates relatively minor breaches and failures from the more serious ones that demand disciplinary action. Were it otherwise, doctors would find it impossible to practise in a reasonable way" (para. 30). *Hurray*.

The extent and coverage of expert evidence was also elaborated on. The Judgement stated that it was not enough for an expert to merely state what he/she thinks how things should be done. The expert must also present "the underlying evidence and the analytical process by which the conclusion is reached" (para. 43) for the expert opinion to hold sway.

On the subject of informed consent, the Judgement reiterated essentially the basic requirements of the Modified Montgomery (MM) test:

- Establish what relevant and material information to the patient is.

Materiality of a risk or complication is generally determined by its severity and likelihood and "largely a matter of common sense" (para. 50).

- Establish that the doctor possesses this information.
- Establish whether the doctor can justifiably withhold this information from the patient.

On the subject of defensive medicine, the Judgement defined or described it as "the situation where a doctor takes a certain course of action in order to avoid legal liability rather than to secure the patient's best interests". The Judges said that it is a mistake to classify "information dumping" (ie, doctors overwhelming patients with a deluge of information in order to protect themselves legally) as defensive medicine because "giving too much information will not avoid legal liability" (para. 54).

Informed consent

As this Hobbit has said before, in our local context, "**just follow law**". Whatever the Judges have said is case law and therefore has to be adhered to. But perhaps in my senescence and folly, please allow this old coot to blabber a few irrelevant and immaterial things about three points – informed consent, defensive medicine and information dump.

MM test

The MM test is largely a matter of common sense. As my professor (now emeritus professor) once said to me when I was a medical student, "common sense is uncommon". Were it not so, it would not have been necessary to introduce the Bolitho Addendum to the Bolam test. The Bolitho Addendum is essentially an addendum to require common sense when applying the Bolam test. The MM test essentially requires even more common sense than the Bolam-Bolitho (BB) test because it demands the doctor to establish what is material and relevant to the patient.

Don't get me wrong, I think being patient-centric is good. How to achieve this is already cast in legal stone (case law – MM test), even though I am still trying to grapple with implementing this in my clinical practice. To this Hobbit, essentially, the MM test ignores a basic dimension of existence: time.

For one, a three-step test doesn't quite work for me when I see 40 patients a day and I prescribe hundreds of medications and investigations. Secondly, what is relevant and material to the patient changes with time – his/her circumstances changes and his/her memory fades. For the same procedure, what is of concern to him/her one month before the procedure can often be quite different from when it is one week or a day before the procedure. And all this could be quite different one month post-operation, when his/her concerns are quite different from pre-operation. As one doctor wisely said, "Often the only relevant risk or complication is the one the patient develops post-operation".

Also, there are scientific studies to prove that a patient's retention of information or advice given to him/her by the doctor is really quite limited and diminishes with time. You may have told patients to your best effort what you think is relevant and material, but they may have forgotten or ignored what you said and then turn around to sue you.

Another smaller issue about the MM test is the severity and likelihood matrix. As advocated, you should tell the patient the risk if it is more serious, even if it is unlikely. The most serious risk is, of course, death. Another doctor also said "once you mention 'death', the patient's mind goes blank thereafter". But the patient still signs the consent form and undergoes the procedure usually. And then he/she may also turn around and sue you later.

There is little doubt that the MM test brings increased uncertainty to the practice environment and doctors generally don't like it. However, that doesn't mean doctors are against being more patient-centric. It is an argument of **false dichotomy** to say that just because many doctors are uncomfortable with the MM test, it suggests that the medical profession is not supportive of being patient-centric.

Defensive medicine

We now come to the difficult subject of defensive medicine.

Let us return to the Judgement delivered on 12 May 2017 by the Chief Justice and four Judges of Appeal in the Hii Chii Kok vs London Lucien Ooi case (a civil suit and **not** an SMC case). This was when the MM test was introduced as case law. Here are excerpts from paras. 84, 85 and 87 under "The argument for full retention [of Bolam and Bolitho]". The portions I wish to emphasise are in italics.

> **84** What of the view that the Bolam test and Bolitho addendum should not be interfered with to any degree, even as regards advice? *The strongest argument in favour of that view is the contention that if the Bolam test and Bolitho addendum were abandoned in favour of a standard that placed greater emphasis on the interests and perspective of the patient, it would spark an unacceptable increase in medical litigation. This would, it is said, have two deleterious effects: first, it would drive up the cost of medical malpractice insurance, and thus increase the costs of healthcare to the public, and second, it would increase the pressure on doctors to adopt what is commonly referred to as "defensive medicine".* …
>
> **85** It cannot be denied that the cost of healthcare and the practice of defensive medicine (which also feeds into the cost of healthcare to some extent) are both real concerns. However, we do not accept that they provide sufficient reason for the court to shut the door to reform entirely. In the first place, *it has not been distinctly established that any departure from the Bolam test would in fact have the consequences of more medical litigation, higher insurance premiums and greater healthcare costs.* …Furthermore, we note that certain factors which have driven up the cost of medical professional insurance in the US – the jurisdiction in which

such concerns have been perhaps the most prominent – are not present in Singapore. *The US legal system features jury awards which often would, in Singapore, be considered highly inflated; allows contingency fee arrangements (encouraging opportunistic negligence suits); and does not follow a "loser pays" principle of costs (thus reducing the disincentive for litigants or law firms to bring weak or speculative claims). In the absence of such factors in Singapore, we see no reason to believe, without clear evidence, that a carefully calibrated shift in the standard of care is likely to lead to a drastic increase in the frequency and value of medical negligence lawsuits in Singapore.*

87 The problem of defensive medicine falls more squarely within the ambit of the court's inquiry, since it directly implicates the question of whether the proposed standard will fortify or hinder the medical profession's fulfilment of its duties to its patients. In that regard, we note that unlike a wholesale rejection of the Bolam test and Bolitho addendum, which the court in Gunapathy rightly warned against (at [144]), reform of *the more limited nature being considered appears unlikely to contribute significantly to the practice of defensive medicine. The implications of Montgomery are limited to advice, whereas the concerns in defensive medicine pertain mainly to diagnosis and treatment…We therefore do not think the spectre of defensive medicine is a strong reason to shy away from reform in the area of advice specifically.*

Paras. 84 to 87 in the 12 May 2017 Judgement on the Hii Chii Kok case was given as consideration on why a departure from Bolam and Bolitho can be seriously countenanced; the promulgation of the MM test then took place later in this Judgement. To summarise:

- The fear of a rise in malpractice costs and increase in practice of defensive medicine are important considerations as to whether one should depart from the BB test.
- But these fears (as at 2017) were unproven and theoretical at best (ie, not "distinctly established").
- Even if we depart from the BB test, Singapore does not have the pre-existing conditions (like in the US legal system) for a drastic increase in frequency and value of medical legal lawsuits, which in turn will lead to defensive medicine taking root quickly – contingency fees (ie, loser pays) and high jury awards.
- Defensive medicine doesn't quite extend to the realm of medical advice (of which informed consent is a part of) and is limited to diagnosis and treatment.

Departure from BB test

In a study commissioned by the College of Family Physicians Singapore and SMA to examine the effect of the SMC Judgement in the LLA case on doctors' behaviour[2] earlier this year, it has been proven that these fears are clear and present, and very real.

- The number of doctors surveyed who provided an H&L injection decreased by 14.6%.
- The median price for the injection increased from the $0 to $100 band to >$100 to $200 band.
- The number of surveyed doctors who charged more than $1,000 went up eight-fold from eight to 65.

This study therefore documents a quantitative increase in the practice of defensive medicine and healthcare costs when the BB test was departed from. It can be argued that the LLA outcome came about from a botched implementation of the MM test, but it is a departure from the BB test nonetheless.

The "free" SMC process can lead to defensive medicine taking root quickly

The next point that Singapore does not have the pre-existing conditions that the US legal system has is interesting. It is true that Singapore doesn't have high jury awards and contingency fees. But these advantages apply only to civil suits. For SMC complaints, the environment may be just as favourable for an increase in medico-legal complaints as the US – it is practically **free** to the complainant (no financial risk) to embark on an SMC complaint! The whole SMC disciplinary process may be no less frightening and painful to the doctor than a civil suit (if not more); hence the flight to defensive medicine in Singapore may be no less quick and intense as in the US. So this assumption that Singapore's legal system has a more agreeable climate to doctors is correct when applied mainly to civil suits. The doctor does not only flee towards defensive medicine out of fear of being sued in a civil case and paying hefty damages, but also out of fear of getting involved in the SMC complaints and disciplinary process, which is free to the complainant.

Defensive medicine is not static – it goes where the attack is targeted

Lastly, the point on defensive medicine being limited to diagnosis and treatment and not extending to medical advice needs some discussion. Let's break down the words "defensive" and "medicine" for a start.

The practice of medicine is dynamic and ever-evolving. That is why we need to gain 50 continuing medical education points every two years, to keep us up to date with the changes in the practice of medicine. The practice of defensive medicine is no different; it is also evolving with the times. It is not static. Just because the practice of defensive medicine has been limited to diagnosis and treatment does not mean that it will always remain so.

The word "defensive" has military roots, as in "defence" and "attack". Any Singapore Armed Forces serviceman will tell you that defence is not static either. You prepare a robust, in-depth defence where you think the attack will most likely target. High-profile cases involving senior doctors accused of not getting informed consent send a strong signal that patients (and lawyers) are focusing their efforts in this area. These well-known cases include Dr Eu Kong Weng, Dr Ang Peng Tiam, Dr Leslie Lam and this LLA case. It doesn't matter if the

complainants were successful or not; just the pain and trauma of responding to a complaint is sufficient motivation for doctors to focus their defensive efforts to prevent more complaints in this area.

Defensive medicine is divided into avoidance and assurance defensive medicine. Ordering more and unnecessary tests and investigations is a classic example of assurance defensive medicine because a doctor is afraid that he/she will be complained against or sued for a missed diagnosis. Similarly, an information dump carried out because a doctor is afraid he/she will be complained against or sued in the area of medical advice, is in the opinion of this Hobbit, a new form of assurance defensive medicine. The medical profession should not rigidly limit ourselves to what was previously described – that defensive medicine only exists in diagnosis and treatment. Defensive medicine will occur where the doctors think they will be attacked, be it in the areas of diagnosis, medical advice or treatment.

Information dumping

That brings us to the statement that information dumping is not defensive medicine because "giving too much information will not avoid legal liability" by our learned Judges. The judges are of course absolutely correct since from where they sit, what is inefficacious in avoiding legal liability in the courtroom or a disciplinary trial should not be considered as defensive medicine.

But as practising doctors, I suppose, we have to look at things more upstream. As the age-old saying goes, "prevention is better than cure". What is inefficacious in a disciplinary trial or the courtroom is an inefficacious or useless cure. But it may still work as a **preventive measure**. This is because it is human nature to take comfort in numbers or quantity. There are so many examples of this. We usually feel better when we write a longer answer to an examination question when compared to a shorter one (the test scores, of course, may have no correlation to the length of answer). We take psychological refuge in buying a thicker textbook than a thin one (whether we actually finish reading the textbook or understand what's written inside is another matter altogether).

It is for the same reason that our consent forms are getting longer and longer. A longer consent form looks formidable and gives us psychological security. Remember the days when we could combine both the surgical and anaesthesia consent-taking into one page? Those days are gone. And if they still do exist, many would wonder – will such a short form suffice?

Due to information asymmetry, the buyer of a service also derives satisfaction and gauge quality by substitute measures of quantity (even though there is little correlation between quality and quantity). An inpatient given a lengthy discharge summary which is no more than a "cut-and-paste" job may think the medical officer has been diligent, while a medical officer who has assiduously prepared a concise one-page discharge summary may be less appreciated. For about the same amount of money, a patient given five different drugs for common cough and cold often thinks he has been given quality treatment and may consequentially conclude that the other doctor who gave him only two drugs earlier was tardy.

So, both doctors and patients derive comfort and satisfaction from quantity. This is just simple human nature. If that is so, we will also believe that with more information engendering more comfort and satisfaction, complaints are therefore less likely to occur. It is therefore no surprise that information dumping will be adopted in an attempt to prevent complaints from occurring, even though it is inefficacious in avoiding legal liability.

This psychological comfort derived from quantity is accentuated when there is greater uncertainty, as is the case with the MM test when compared with the BB test. The greater uncertainty arises because it is extremely difficult for a doctor to **titrate accurately** the exact amount and nature of information that is material and relevant to a particular patient in a particular context under the MM test. This Hobbit thinks most doctors believe it is more likely that a patient is dissatisfied with less information than more. As such, most doctors will intuitively also believe that it is probably easier to prove that a lack of informed consent arose from insufficient information rather than excessive information.

It should therefore come as no surprise that a doctor will give more information than what is actually needed.

Conclusion

After this long spiel of about 3,300 words, what are the take-home messages? It's still more of the same. We are a law-abiding profession in a society that enshrines the rule of law. Whatever is law, be it legislation or case-law, **must be followed**. There is no other way. Whatever this Hobbit rambles or blabbers about, is irrelevant and immaterial.

In the area of medical advice, this Hobbit will still give substantially more information than he previously did in the BB test era. This is my form of Survival Medicine.

The answer to the question of when and how a generous amount of information limps across the line and qualifies as information dump is best left to minds that are far more brilliant and incisive than this Hobbit, who admittedly suffers from a little lack of this precious commodity called common sense. This lack may be a result of the imperfect Hobbit condition that I am born into. ◆

References

1. Singapore Medical Council v Dr Lim Lian Arn [2019] SGHC 172.

2. Wong CY, Surajkumar S, Lee YV, Tan TL. A descriptive study of the effect of a disciplinary proceeding decision on medical practitioners' practice behaviour in the context of providing a hydrocortisone and lignocaine injection. Singapore Med J. 30 Jul 2019. https://doi.org/10.11622/smedj.2019086. [Epub ahead of print].

For Doctors, For Patients

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**From 1 June 2019, in accordance with the Singapore Resuscitation and First Aid Council's protocol, all Basic Cardiac Life Support courses need to include the AED component as it will no longer be offered as a stand-alone topic*

MEDICO-LEGAL Thoughts

Text by Dr Lee Yik Voon

I was invited to open the Annual National Medico-legal Seminar 2019. I was glad to see many enthusiastic participants, many of whom were new and young faces. It is indeed heartening to see that our younger generation of doctors are interested in this subject.

This triggered me to think about various issues facing medicine today, such as defensive medicine. Is offering our patients a less risky choice of treatment a form of defensive medicine? Or is that how medicine should be practised in the first place? That, I guess, will depend on what constitutes playing safe.

It is a fine line. We may order all sorts of tests or accede to patients' and their family members' requests to protect ourselves legally and avoid complaints and lawsuits. Or we could do the right thing by ordering just enough to be fair to the patients so that we cover sufficient grounds to confirm the diagnosis, so that treatment will be appropriate for our patients.

We may sometimes hear that a particular treatment may be better than nothing. Or we may use such an argument to justify the services that we provide for our patients. But is that enough? Is it a spectrum of decreasing severity of negligence when we compare doing nothing, doing something, doing enough and doing almost everything (otherwise known as over-servicing)?

Is returning to Bolam-Bolitho better than using the current Modified Montgomery test? Is facilitating doctors so that they can do their work as important as reassuring that patients' welfare is taken care of? It is not true that the old ways are absolutely paternalistic and patients have no say at all. We must not forget that the doctor-patient relationship is prime.

Is standard of medical practice an absolute and distinct line which we must all cross and not breach? Or do we have a range for our standards of medical practice? What then defines grave departure from the standard of medical practice? And at which point are we considered to have crossed over to unprofessional conduct?

Is it a direct and absolute comparison? Or is it a relative comparison with common standards across specialties and regions? How then are the various ways of approvable actions considered a normal behaviour and normal medical

considerations? Or at which point does it cross into a massive departure of acceptable norms?

Do we consider common mistakes as a departure? But to err is human.

Or should we be judged and prosecuted only for severe negligence of duty? Is that fair to the public and patients?

How can we practise medicine if everything is held at perfection and at aspirational standards that are modelled after the best practitioner under the most ideal condition?

Relevance to telemedicine

It is interesting to apply all these arguments to the newest kid on the block – telemedicine. Telemedicine has generated a lot of interest recently because it is seen to be:

a. a source of revenue to stakeholders;

b. cost savings for the public and patients;

c. convenience to patients who do not need to step out of the comfort of their homes and queue at a clinic with strangers;

d. a disrupter of traditional modern medicine – a face-to-face model that requires a physical presence; and

e. filling up gaps in-between consultations in real time and person.

We are well aware of the weaknesses and dangers of telemedicine. It not only lacks direct face-to-face interaction, but also does not allow any physical examination at all. Detractors may argue that devices and sensors are available to bridge those gaps. However, current devices are still experimental and unreliable.

When these devices are introduced into telemedicine, we have to grapple with the accuracy, reliability, sensitivity, acceptability and cost of these equipment.

Is what you see on the screen the same as what you see with your naked eye? Often, an image captured by the handphone today can make one look better than in real life. The camera could also be unkind and make one a lot less similar to the real life image.

Is the doctor at the end of the camera a real bona fide doctor? How would anyone know and be able to verify? Could it be a chatbot? Could it be a simulation using artificial intelligence or could it be an imposter?

Is the doctor locally registered and familiar with local medical conditions, epidemiology, patterns of antibiotic resistance and cultural nuances and cues? What about the expectations of local patients and their acceptance?

When a patient is unhappy with the doctor's service and standard, can the public approach the local authority for mediation or complaints? Should the doctor be an imposter, a foreign-registered doctor or a chatbot, what recourse does the public have? How will the insurance company view this? How will the employers view this?

How sure are we about safeguarding the privacy of the users? How is patient confidentiality maintained? Are you sure you are really alone with your doctor? Or is there an irrelevant person to the consult with him/her outside the view of the camera during the teleconsultation? How sure are you that there will be no one else eavesdropping or walking into the room during the consultation?

Telemedicine can be a useful option for those of us with overseas patients. How do we ensure we receive the fees due to us? How can the public be assured that the payment is received by the doctor? How do we settle any dispute should it arise?

One may think that this is a self-selected group of patients and it is very unlikely to have any severe problems that require closer medical attention. Some quarters have shown data that there have been no cases of missed diagnosis with severe consequences.

There are too many "what if's" and often users and patients might not even have thought about them. This is a brave frontier where regulations are not yet set and cast in stone. Many potential issues are still unknown.

Are we ready to face a test case? When that happens, will our patient suffer severely in the short term or worse, have a prolonged period of suffering with nasty complications and consequences? As practitioners, we need to abide by the relevant laws and our Singapore Medical Council Ethical Code and Ethical Guidelines. Are we able to satisfy all the requirements when we engage in telemedicine now?

Hence, telemedicine is housed in a regulatory sandbox. Although it is convenient and disruptive, its safety and framework are not mature enough to be released for use in real life like a face-to-face consultation. It is still very much a work in progress and we can only hope that this will lead us towards a robust form of telemedicine.

Telemedicine is not something entirely new. We have been using it to follow up on our patients since the telephone was invented. We use the telephone to check with our patients if treatment and management are effective, whether they are encountering any side effects or complications of our treatment, if they are compliant to our management plan, and whether they understand, register, agree with and have retained all the instructions and explanations that we have told them.

Companies and start-ups looking to venture into telemedicine are not going to sit still and take all the criticism lying down. They are moving quickly into other areas where there are gaps, such as house calls and tele-monitoring. If one looks carefully, one will realise it is not telemedicine, but doctors themselves who are implementing and driving it forward. As long as medical professionals are behind it, we will have to address the medico-legal requirements and issues behind this. ◆

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.

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 a consultant at Singapore General Hospital.

Advisory to Members to re-evaluate the original motivations for establishing their organisational structures

SMA has issued an advisory to Members regarding the use of corporate structures by members of the medical profession in the running of their medical practices.

While SMA wishes to remind its Members not to establish artificial or contrived structures with a blatant or primary purpose of avoiding or reducing taxes, SMA also notes that the use of a company as a business vehicle by itself has been a common practice since time immemorial.

The advisory can be found at http://bit.ly/2Wv7vBQ.

Feedback on LIA pre-authorisation form for Integrated Shield Plans

The Life Insurance Association Singapore (LIA) recently announced the use of a standard pre-authorisation form for all Integrated Shield Plan insurers that offer pre-authorisation services.

Prior to this, LIA approached SMA on 29 May 2019 for comments regarding the initiative and the form. SMA responded on 18 July 2019, to seek clarifications and also provide feedback.

In the ensuing formal exchanges that followed, SMA reiterated several issues on the form which remain unresolved. As such, SMA is unable to support the latest version of the LIA pre-authorisation form. The details of these issues and SMA's recommendations can be found at http://bit.ly/2okskn8 (Member login is required).

A key issue involves a section of the form that requires doctors to provide information of the patient's comorbidities. Unless these comorbidities require additional specialist inpatient review, this information is not relevant for pre-authorisation.

SMA reiterates that information collected in a pre-authorisation form should be for the current admission and not for the possible construction of the medical profile of the patient. To date, SMA has not received assurances from LIA on this. LIA has also not adopted our suggested amendments to request only relevant co-morbidities that require additional specialist inpatient review.

SMA advises all Members that they should exercise discretion and only give information that they deem is necessary for pre-authorisation and not inadvertently provide more information than necessary. Members should always put patients' interests first, not just for the current admission but also for future possible admissions, since it is uncertain if information collected now will be utilised later for other purposes not directly related to the current admission. If the information about co-morbidities is not relevant for pre-authorisation, Members may consider indicating "not relevant for pre-authorisation" in the appropriate section of the form.

SMA Members should also not commit to matters that are beyond their usual decision-making limits, such as other doctors' treating fees.

SMA supports the concept of pre-authorisation and the standardisation of the pre-authorisation form. We urge LIA to keep the form as brief as possible so that it can be completed in a timely manner. The medical information requested should also be readily available at the time of consultation and limited to what is necessary for pre-authorisation. The pre-authorisation should be processed expeditiously, ideally within 24 hours, to avoid unnecessary delays to patient care. Hopefully, with the issuance of fee benchmarks by the Ministry of Health (MOH), this will be made possible and will reduce the need for appointed panels.

SMA and LIA representatives met on 22 October 2019 to further discuss and clarify the contents of the pre-authorisation form. We will inform Members when updates are available.

SMA nominates representative to MOH committee on ethics capability

The MOH is forming the Healthcare Ethics Capability Committee (HECC), which will carry on the work of the current National Ethics Capability Committee.

SMA has nominated Dr Anantham Devanand to be SMA's representative to the HECC. We wish him all the best in this new appointment. ◆

34th CMAAO General Assembly

GOA

Text by Dr Chong Yeh Woei | Photo by Confederation of Medical Associations in Asia and Oceania (CMAAO)

It was my first time in India; the Mumbai airport was new, sparkling and worthy of the crown that cosmopolitan Mumbai desires of herself. During my four-hour transit, I left the airport building to head to Starbucks for a coffee, and I realised that the airport, like India herself, was still under siege. There were soldiers armed to the teeth with live rounds and a machine gun post outside the building. The shadow of the 2008 terror attack still hangs over the city. Later on during the security and luggage clearance, the soldiers themselves did the personal pat-downs and manned the X-ray machines. You can be sure that personalised service was far from their minds.

I landed in Goa at nearly 4 am and got into a car that brought me to the conference venue – a resort 50 km from the city centre. The road was winding and mostly unlit; the skilled driver had to navigate the small road with headlights and the "cat's eye" reflectors on both sides of the road. It did not help that the drive was interrupted by huge brightly lit trucks from out of state and the occasional cow that would wander onto the road.

Commencing the meeting

It was always good to see familiar faces at the conference – secretary general Dr Mari Michinaga of the Japan Medical Association (JMA), treasurer Dr Alvin Chan of the Hong Kong Medical Association, Dr Yoshitake Yokokura of the JMA and our generous host Dr KK Aggarwal of the Indian Medical Association, among others. As chairman of the council, it was my pleasure to welcome 13 national medical associations (NMAs) and their presidents and councillors.

On our agenda is always a country report by all the NMAs. This is where we learn from each other about the problems we face, the solutions we have found,

the lessons learned from our successes or mistakes, and how we handle our respective governments. A commonality we found was that the problems faced by the NMAs of the developed world were potential problems the NMAs of the less developed world would eventually face. I recall going to the Australian Medical Association meetings to hear them speak frankly of their problems and issues, only to see Singapore eventually face the same issues years later. Listening to the country reports of the First World NMAs was like peering into a crystal ball.

"The Path to Wellness"

This year's Taro Takemi Oration, named after the JMA's former president of 25 years and one of the founding fathers of CMAAO, was delivered by Dr Ketan Desai, who gave us an insight into wellness according to the Vedic Literature. I must admit that we are so caught up in the medical world of diagnostics and therapeutics that wellness may seem alien to most of us. In a nutshell, subscribing to wellness would require us to observe social, environmental, nutritional, behavioural, psychological, spiritual, occupational and even financial aspects. I personally find wellness more of a concept, ideal or goal that we should all aspire towards.

Exploring Goa

On the last day, our host brought us to the Basilica of Bom Jesus, the oldest church in Goa built in 1594. It also houses the mortal remains of St Francis Xavier who died in 1552 in China. The city has elements of Portuguese influence and architecture reminiscent of nearby Malacca. The Portugese had ruled the city since 1510 till it was annexed by India in 1961. The food in Goa is unique and I had a great fiery vindaloo the first day I arrived. Thankfully, we are well trained in Singapore when it comes to spicy food! ◆

Legend

1. Dr Chong with outgoing CMAAO president Dr Ravindran Naidu of the Malaysian Medical Association

Dr Chong is in his fifth decade and trying to decide what is important going ahead for the last leg. Is it leaving a legacy, drinking good Pinot noir, reading the good stuff, keeping an active lifestyle, or just enjoying the good company of his friends? He would like your honest opinion!

The Current Medico-Legal Climate and Defensive Medicine

Text by Dr Ng Shu Li and Dr T Thirumoorthy

Dr Ng is currently a Senior Manager in Clinical Services at Woodlands Health Campus. She has a keen interest in health administration, global health and medical ethics.

Dr Thirumoorthy has been with the SMA Centre for Medical Ethics and Professionalism (SMA CMEP) since its founding in 2000 and most recently been given the responsibility of being the SMA CMEP Academic Director.

Over the last 60 years, medicine has grown from a cottage industry into a complex multi-dimensional, international, humanitarian, biomedical, business and political enterprise. As medical practice becomes more complex, there is a natural increase of regulations of medical practice and practitioners. Medical practitioners are being called to be accountable for their performance not only by the medical licensing board, but also by the hospitals they practise in, patients and their families, insurance payors, and not to mention complaints to mainstream and social media. There has been a significant shift from accountability to only one's patients and colleagues, to accountability to many different stakeholders.

In recent times, there has been a consistent and progressive increase in complaints and claims, fines and payouts at the medical council and the courts. There has been a progressive increase in the premiums of medical malpractice indemnity coverage in response to the cost of malpractice defence. There has also been a recent surge in legal cases against medical practitioners to the court of appeal perpetuated by appeals on judgements from patients, doctors and even the medical council.

Medical practitioners, whose education has been focused on the biomedical scientific aspects of disease, diagnosis and treatment, know little about the current legal and professional disciplinary systems. Doctors are ill-equipped to navigate this new medico-legal climate, and this has led to confusion and quandary about judgements of the professional disciplinary tribunal and a prevailing smog of confusion, apprehension, fear and paranoia within the profession. The doctors feeling besieged, unaware of how to mount a legal defence and not confident that they would have a fair hearing, tend to go for guilty pleas with the hope of a lighter sentence. The

besieged doctor just wants to get over these unwelcomed obstacles and get back to his/her daily clinical practice.

Defensive medicine

Another consequence of harsh disciplinary penalties is the emergence of defensive medicine. Many have started or increased their practice of defensive medicine.[1] A survey among doctors in the UK showed that 78% reported practising some form of defensive medicine.[2]

Defensive medicine is a deviation from good, accepted medical practice and is induced primarily by a threat or fear of professional legal liability.[3] The aim of this practice is to reduce adverse outcomes, deter patients from filing malpractice claims, as well as attempt to persuade the legal system that the standards of care were met. Defensive medicine can manifest in an assurance behaviour or avoidance behaviour.

Assurance behaviour

Assurance behaviour is where the medical practitioner orders additional tests and therapies that may not normally be required.[4] The practitioner attempts to exceed the accepted standard of care in order to reassure patients that they have been thorough and that the quality of care is better. There are increased unwarranted referrals to other medical specialists. Assurance behaviour seems to provide medical practitioners with psychological reassurance that the behaviour will reduce their legal risk.[5]

The consequences of assurance behaviour include increased inappropriate investigations and therapeutic procedures. The inappropriate investigations put patients at risk of harm and false positive tests that may entail more invasive investigations. Patients also have to bear the cost of these unnecessary tests.[6] For those covered by medical insurance, there is a resulting increase in premiums. Inappropriate referrals to other medical specialists impede good decision-making and reduce the time available to other patients who may truly require the referral.

Avoidance behaviour

Avoidance behaviour is where the medical practitioner intentionally avoids any beneficial investigations or therapy that may carry risk, and avoids or refuses access to care of patients with chronic complex medical problems. They would also demonstrate defensive communication and behaviour with extensive inappropriate documentation. This behaviour is aimed to avoid potential adverse events that could result in complaints or medico-legal action.

The impact of avoidance behaviour on patients and medical practitioners is the denial of beneficial therapy and increasing refusal of access to care for patients with complex medical problems. Patients who are perceived as litigious by virtue of their history, family members or profession may be denied care, which is a form of discrimination. Avoidance behaviour not only impedes good clinical judgement, but also reduces trust and confidence in the doctor-patient relationship and the profession.

Professionalism vs defensive medicine

Defensive medicine raises a professional ethical dilemma – whether it is an acceptable risk-management strategy or an unprofessional practice. The fundamental principle of medical professionalism is the primacy of the patient's welfare. While professionalism is based on professional principles, values and knowledge, defensive medicine is based on fear and anxiety. While professionalism encourages respectful, empathetic communication, defensive medicine only propagates defensive, guarded communication.

Professionalism cultivates the practice of delivering good quality care in the best interests of the patients. The main focus is on addressing the concerns and expectations of the patients. Time and energy are directed towards making a good holistic clinical judgement in order to add value to care.

On the contrary, defensive medicine breeds an unhealthy focus on the phobia of complaints, claims and medical malpractice liability. Time and energy are wasted on searching for ways and means to bolster defensive practices. This distracts from patient care and adds to the complexity and cost of the process.

Defensive medicine that is carried to its far end erodes professionalism. It distorts good medical practice, causing improper medical reasoning, poor decision making, and poor quality of care; these are the factors that ironically increase the risk of law suits. This then begs the question of why defensive medicine remains so prevalent.

Factors that promote defensive medicine

Defensive medicine practices are inevitable when there is high intensity and cost of professional accountability, coupled with lack of clarity, transparency and consistency of professional regulation policies and disciplinary processes. Furthermore, the lack of a systematic professional skills development programme in the post-specialist training period, and poor institutional support for a work environment that enables the attainment of professional standards, leads the doctor towards defensive medicine. The poor development of a just and safe professional and organisational culture for continuous learning from errors, adverse events and experience is a contributing factor to defensive medicine.

The effects of an adversarial professional accountability system

An adversarial "name, blame and shame" process creates fear and stress, and destroys relationships. It is wasteful of both resources and time. The adversarial nature of the disciplinary and legal systems impedes development of patient safety and results in withdrawal of services. It increases the cost of medical indemnity insurance and causes stress to medical practitioners. This has been documented in various forms as "litigation stress syndrome" and "second victim syndrome".[7] Second victim syndrome is the emotional

turmoil experienced by healthcare practitioners who are involved in patient tragedies or medical errors that result in patient morbidity or mortality.[8,9] It has been likened to post-traumatic stress disorder where the healthcare practitioner undergoes feelings such as guilt, distress, fear and loss of self-confidence. There is often neglect and lack of institutional support for these healthcare practitioners.[10] Defensive medicine is a maladaptation and inappropriate response to the adversarial process.

A systems approach against defensive medicine

There needs to be a just and transparent system-level solution to manage the perils of defensive medicine. Effective leadership and skilful management must work at all levels. At the macro level (or societal/national level), there is a need for coordinated strategy for timely and effective medical dispute resolution. Healthcare systems that involve patients and all stakeholders in building a fair and just healthcare culture need to be created.

At the meso level (involving the hospital and healthcare system), there is a need to develop a safe culture that promotes patient safety as a top priority and a culture of continuous learning and improvement. There should be an effective and timely system in place to investigate all adverse events, as well as a system for medical disputes resolution with open disclosure and early settlement.

At the micro level (involving the healthcare professionals, teams and departments), healthcare teams should continuously strive to build collaborative therapeutic relationships with patients and their families. Healthcare professional education should involve understanding the law around medical malpractice and the reasons why patients and their families sue medical practitioners and hospitals. Healthcare professionals must be equipped with the appropriate strategies for legal risk prevention and reduction.

Building a fair and just culture in healthcare

Complex systems, such as hospitals, are inherently unsafe. Despite best practices, errors can and do occur. The professional governance system should move towards a fair and just culture. There needs to be an environment of trust, fairness and transparency in the process, to encourage a system of safe reporting of errors, near-misses and adverse events to allow the profession to learn from individual and system traps, flaws and errors.

There needs to be a clear distinction between true human error in complex systems and intentional unsafe acts of an individual. Individuals should be held accountable for intentional unsafe acts as per current practice. Good analytic skills and tools will help to identify and differentiate an intentional individual unsafe act from human factors and systems errors. A fair and just culture is critical to enable learning from errors and adverse events to improve medical practice. Continuous improvement invariably leads to better clinical outcomes and patient experience. Patient safety and good quality clinical outcomes lead to patient and public trust and confidence in the medical profession and the healthcare system. Leadership and a just culture are the keys to patient safety.

Conclusion

We need to develop strategies, knowledge, skills and professional behaviours that preserve trust and confidence in medical practitioners, even in the advent of unexpected adverse outcomes. A professional and systems approach is necessary to build a healthcare system that empowers medical practitioners to become competent, compassionate and trustworthy to promote patient safety and defend against defensive medicine. ◆

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Medical Malpractice Indemnity Solutions

The Differences between Discretionary Indemnity and Insurance

Text by Rachel Ong and Joel Tng (Marsh-JLT Specialty)

Editor's note: SMA Members would have heard by now that Jardine Lloyd Thompson (JLT) is the third and newest addition to the list of medical malpractice indemnity providers endorsed by SMA. As JLT offers their services as an insurance broker, SMA has asked them to pen an article to help SMA Members understand the differences between insurance-based and (the much more familiar) discretionary-based products.

This following article reflects the opinions of JLT and not necessarily those of the SMA. Past articles from the SMA Professional Indemnity Committee, and another provider of medical indemnity, can be found at http://bit.ly/2PSFpPO and http://bit.ly/33lDw1U, respectively.

Dear doctors of Singapore,

It has been almost three years since MOH Holdings moved all 9,000 of their public sector doctors onto a then new medical malpractice insurance solution. While the transition was smooth, we are still receiving queries from doctors regarding the differences between a Medical Protection Society (MPS) membership and an insurance solution.

We write to you today, in our capacity as insurance brokers, in response to the calls for an objective comparison between discretionary indemnity and insurance in Singapore. We will address the salient differences and suggest the areas a doctor should focus on when choosing between the different options in the market.

Discretionary indemnity

One of the benefits of joining mutual defence organisations, such as MPS, is having discretionary indemnity. As the name suggests, when a claim is made against a doctor, assistance will be provided solely at the discretion of the defence organisation.

Contractual indemnity: insurance solution

Doctors can purchase an insurance product, commonly known as "medical malpractice insurance", for contractual indemnity. The terms of the contract define the scope of cover, establish the maximum amount covered for, and spell out situations that will not be covered by the policy (otherwise known as exclusions).

Understanding the differences

There are unique features for discretionary indemnity and insurance solutions, and understanding them vis-à-vis your professional needs will allow you to choose the right option.

Wording/contract

By its nature, discretionary indemnity is not governed by a policy contract and, in some situations, can be more flexible in the manner with which the organisations can assist their doctor-members. However, if assistance is withheld, members will have limited recourse.

Insurance, on the other hand, is bound by a policy contract, which is a legal document binding both doctor and insurer to its clauses. While it may mean less flexibility, doctors who purchase insurance have contract certainty based on the terms and conditions within the policy contract.

Domicile/regulatory oversight

The UK's Department of Health and Social Care is studying the need to regulate discretionary indemnity providers. While there is no outcome yet, considerations for the regulation stem from the need to provide adequate cover for healthcare

professionals – to ensure that indemnity providers hold adequate reserves to pay for claims and for patients to have access to appropriate compensation.

Discretionary indemnity organisations trading in Singapore are neither registered nor regulated as insurance companies or financial institutions by the Monetary Authority of Singapore (MAS). Since they are not regulated as such, they are not obliged to fulfill the reporting requirements required of a registered insurance company or financial institution.

Insurance, on the other hand, is regulated by the MAS or their respective country's regulators. An insurer will have to comply with a minimum level of capital reserves in the country that they transact in. This reserve is illiquid and is there to ensure that the insurer has funds ready to honour their claims obligations. While having regulatory oversight provides insured doctors with additional assurance, it will come at a cost that will be passed on to the insured doctors through premiums collected.

Policy limit

Most times, discretionary indemnity, as its name suggests, does not have a concept of policy limit. While this creates greater uncertainty, confidence in its ability to meet members' needs is typically obtained from the historical experiences of the members of the organisation. This is in contrast to an insurance policy where limits are clear and defined, and its ability to meet policy payouts is dependent on its reserves, which are regulated by local authorities. Under an insurance policy, a doctor will select a limit and pay its commensurating premium, with a higher limit naturally drawing a higher premium.

Policy structure

In general, most discretionary indemnity providers are set up on an occurrence-based structure that provides cover for practitioners as long as they have an active occurrence-based indemnity/policy when the medical incident occurs. **This means that coverage depends on the timing of the medical incident.**

Insurance providers in Singapore offer both occurrence-based and claims-made covers. Claims-made covers protect practitioners from claims that are made against them during the indemnity period, regardless of when the medical event occurs. **This means that coverage depends on the timing of the claim.**

The discretionary indemnity model lends itself to an occurrence-based structure. However, an insurance model with a stated policy limit on an occurrence-based structure might see a doctor locked into a limit that is adequate at the point of purchase but may prove to be too low when a claim is brought against them several years later due to medical and legal inflation.

For an insurance coverage with a claims-made structure, it is important to review the availability of a run-off solution (commonly known as "tail cover") for when a doctor retires from practice. A run-off cover would provide protection from claims brought against doctors in their retirement years for medical work done in the past. This would also provide doctors with the opportunity to increase their policy limit protection (in their last year of practice) to cater for medical and legal inflation on a claim brought against them in the future.

This is a simple summary of the differences. You should clarify with your insurance/indemnity provider and/or employer regarding the type and the extent of your cover. It is also extremely important that you obtain a letter of good standing (also known as a case history letter) from your incumbent indemnity provider before you switch providers. This letter will provide you with a record of all your previous claims history (if any) and may also be a requirement for purchasing indemnity from certain providers. At the same time, and for prudence, do conduct a thorough check of your clinical practice history and make any circumstance/claims notification for any matter that might have previously been unnotified.

Further considerations

When choosing between indemnity models, a doctor's key considerations can be broken down into the three following points.

Claims support

In our experience as insurance brokers, the most important aspect of any indemnity is the support rendered when there is a claim. At its core, indemnity solutions are promises to assist and support doctors when they need it. Your indemnity providers must return your calls for help with timely answers backed with high levels of technical expertise. It is important that:

1. Your medical indemnity broker/insurer/provider is responsive and able to quickly triage the severity of the claim matter. After the diagnosis, the correct measure must be taken to address the claim – whether to recommend mediation or immediately move things forward with legal representation.
2. An experienced panel of medico-legal lawyers supports the programme. Doctors need to have access to specialist legal advice and representation covering a range of professional issues, such as clinical negligence claims and disciplinary hearings. Your medico-legal lawyers should be focused entirely on your defence.
3. Your insurer or indemnity provider must be forthcoming in paying claims and swift to assist you in resolving matters to enable you to continue with your practice without having to worry about the claims.

Credibility and longevity

Ideally, your medical indemnity provider should remain in business while you are practising medicine and continue to thrive even after you have retired. They should hold good

standing among the medical community and the protection they offer should be credible and sound. The provider should be vetted for solid business fundamentals and be adequately capitalised for the long term. This is important to ensure that you are protected through and beyond your career as a physician. The history and outlook of your indemnity providers must be thoroughly reviewed.

Coverage

Coverage analysis should be conducted based on the breadth and depth of protection. Breadth considers whether the scope of cover is adequate for the work that the doctor performs and depth considers the sufficiency of the limit of liability.

The traditional breadth of protection required in Singapore is coverage against medical negligence claims, legal representation costs in the event of a disciplinary inquiry and coverage for the clinical staff working for the doctor. To take a longer-term view, the breadth must be broadened to encompass new modes of treatment like telemedicine.

The limit of liability required is a rather subjective consideration. Insurance or indemnity is a shield and not a sword. It is meant to restore individuals to their initial level of utility. This means that the doctor will be defended only up to the level of cost imposed on the doctor by the claim's financial obligation. Being under-insured will, therefore, be disastrous, as the insurance limit will not be high enough to cover the payout, but being over-insured, or having a "sky is the limit" level of coverage, is also an unnecessary expenditure. It is thus important to consider both the highest and the average payout for your specialty.

Concluding thoughts

Insurance or indemnity is, at its core, a financial tool that allows doctors to practise medicine with peace of mind. We hope that the points set out in this article will help you to make an informed decision before you purchase your indemnity.

Both indemnity models have their respective strengths and weaknesses, but from a macro perspective, it is good that the pseudo-monopoly of the past is now more of a free market, such that doctors now have a choice of different medical malpractice indemnity providers.

The choice of your medical malpractice indemnity is an important one – it is protection for your livelihood and whichever model you choose must protect you in both the present and the future. ◆

With best regards,

Marsh-JLT Specialty
FINPRO Healthcare Team

My Journey as a Court-Appointed MEDICAL ASSESSOR

Text by Dr Winston Woon

As clinicians, we always want to provide the best care for our patients. With the rampant emergence of medico-legal issues in the news and on social media, many of us have started to look a little deeper into this area. I was given the privilege to be a medical assessor (MA) in the Supreme Court in 2016, and I share below what I have learnt from this valuable experience. Do keep in mind that I had no formal training as an MA, although the judge and his clerk (who is also a qualified lawyer) did give me several "dos and don'ts" along the way.

The role of an MA

An MA is not an expert witness, but more of a medical advisor to the judge. The MA is almost like the judge's walking medical dictionary to explain medical terms (eg, "what is ascites?", "what is pleural effusion?", "what is a gastrojejunostomy?"). Occasionally, the judge might also ask the MA what he/she would have done in certain circumstances. Questions may be asked both in and outside the courtroom. One might think that the MA facilitates and gives the judge a holistic understanding of the case involved.

After reviewing the case notes and laboratory and radiology reports, I had my own opinion on how the case could have been managed. When we review cases retrospectively, I am sure most of us would pick up areas where management could have been improved or where certain interventions could have been done to possibly improve the outcome. However, I believe that as an MA, it was not my role to influence the case in any manner. Unlike an expert witness, whose role is to give their opinion, an MA's role is to be neutral and provide the judge with medical facts and possibly the gold standards of medical care.

The importance of early preparation

Months before the court date, I was given a DVD to review. I casually looked through the disc and saw a few folders, and carefully kept the disc in a locked drawer in my office. It was only a few days before the court hearing that I formally looked through the disc. To my surprise, there were thousands of pages of clinical progress notes and laboratory and radiology reports to look through. The disc also included the affidavit of each witness, which again

contained hundreds and thousands of pages to read. The learning point here is to look through the documents way in advance.

The experience

From a social perspective, it was quite an interesting experience – I got to hang out with the judge and his team. Occasionally, we'd go for lunches together and talk about life in general. On the other hand, the defendant and plaintiff lawyers involved were not supposed to interact with me while the case was ongoing.

During the court hearing, I was seated beside the judge on the judges' bench. I saw familiar faces on the floor, and those in front of the bar tried to make eye contact with me and even attempted a smile. I put on a poker face; to reciprocate with a smile might perhaps cause some uneasiness towards the defendant or the plaintiff.

The lawyers from both sides traded information, argued over medical papers and terms, and attempted to unsettle the witnesses and medical experts. This was a rather exciting learning experience for me. I also realised that the lawyers had to dump in as much (favourable) information as they could for the case so that it could be formally recorded in the transcripts. This is because when either party wants to challenge and appeal against the decision (in the Court of Appeal), they are only permitted to use information that was previously presented and recorded in the courtroom.

Last but not least, the judge told me that the "burden of proof lies with the plaintiff". In other words, if the plaintiff is unable to show proof that the defendant has done anything wrong, the defendant may choose to remain silent in court and still be declared innocent.

In conclusion

Being an MA does take up quite a bit of time, but the experience is invaluable. Currently, I understand that the Singapore Medical Council has a formal selection process for doctors to be MAs. Every case is different and I am sure that we will all learn something new from the experience. ◆

Dr Woon is a fellow of the Royal Australasian College of Surgeons. He was the head of the hepatopancreaticobiliary surgical unit in Tan Tock Seng Hospital from 2010 to 2018. His main interest is in minimally invasive surgery. Currently, he is in private practice and his main clinics are located in Gleneagles, Mount Elizabeth Novena and Parkway East Hospital.

SMA EVENTS
DEC 2019–FEB 2020

DATE	EVENT	VENUE	CME POINTS	WHO SHOULD ATTEND?	CONTACT
CME Activities					
12 Dec Thu	BCLS + AED	SMA	4	Family Medicine and All Specialties	Alif 6540 9197 cpr@sma.org.sg
5 Jan Sun	BCLS + AED	SMA	4	Family Medicine and All Specialties	Alif 6540 9197 cpr@sma.org.sg
10 Jan Fri	BCLS + AED	SMA	4	Family Medicine and All Specialties	Alif 6540 9197 cpr@sma.org.sg
Non-CME Activities					
19 Dec Thu	SMA Members' Appreciation Nite *(Star Wars: The Rise of Skywalker)* FULLY BOOKED	GV Great World City	NA	SMA Members and Guests	Rita 6540 9193 appreciationnite@sma.org.sg

ANGELS ARE NOT PERFECT

CAN HUMAN DOCTORS BE?

Text by Dr Chuang Wei Ping

The opinions expressed in this article belong to the writer and do not reflect the views of the Singapore Medical Council or SMA. This article was submitted to SMA News *on 1 October 2019 and accepted for print on 14 October 2019.*

When angels are not perfect, how can human doctors be?

While the patient has the right to the most appropriate and sensible medical treatment, it is not possible to achieve this ideal treatment all the time. The doctor's interest is broadly in alignment with that of the patient – to achieve the best result possible.

Recently, there have been publicised cases where doctors were severely punished beyond what was considered just. This has led to petitions and mass protests by doctors to have such punishments reviewed.

Perhaps it is time to start a narrative about the interests of doctors. There appears to have been too much emphasis on the rights of patients. It is time the pendulum swung back to a sensible position.

A quasi-criminal justice system

When the Singapore Medical Council (SMC) is dealing with the reputation, livelihood, and indeed the very life of a doctor and his/her dependants, the standard of conviction must be "beyond reasonable doubt", which is the standard required by the criminal justice system. While the SMC is not yet wholly a part of the criminal justice system, it is quasi-criminal and shares the same standard of proof as that of the criminal justice system. To that extent, it should operate very much like the criminal justice system.

As in the criminal justice system, there can only be a conviction when there is mens rea (a guilty mind). Examples of a guilty mind and deliberate premeditated behaviours include:

- Cheating through the Community Health Assist Scheme;
- Illicit selling of cough syrup;
- False certification;
- Doing a procedure mainly for financial gain or self-interest; or
- Gaming the system (eg, deliberately issuing a two-day medical certificate after a major operation to avoid the causative injury to be a reportable industrial accident).

Nulla poena sine lege (Latin for "no penalty without a law"): there is no punishment without a crime. From time immemorial, a crime meant that it has to be premeditated, with malice aforethought, with an intentional guilty mind. For instance, breaking each of the Ten Commandments requires a guilty mind. Crimes are deliberate and not accidental.

"Intentional, deliberate departure" from standards would be mens rea, such as recommending in bad faith your specialty as the best treatment, as in *Ang Peng Tiam v SMC*.[1] Intentionally misdiagnosing a case would be criminal, not negligence, as in *Chow Dih v Public Prosecutor*.[2]

In medical negligence cases, conduct so outrageous that it falls far from an acceptable standard of care and becomes crimes against the state can be gross or criminal negligence.[3] Willes J famously observed that gross negligence is just negligence with a vituperative epithet.[4] Nevertheless, gross negligence, with a jury finding of recklessness, has led to cases being labelled criminally negligent in the UK. These cases were frequently those which led to death.[5,6,7,8]

Gross negligence is also a concept found in the Singapore context, although in terminology, "serious negligence that objectively portrays an abuse of the privileges which accompany registration as a medical practitioner" is more often used.[9]

Straightforward negligence, such as wrong diagnosis, treatment or advice should fall under the Civil Law. The writer argues and presses for civil negligence to be outside the jurisdiction of the SMC.

Civil or criminal

The writer argues that civil cases which can be redressed by compensation and do not amount to crimes against the state or seriously undermine public confidence in the medical profession must be outside the jurisdiction of the SMC. The SMC and its committees should be very clear about what forms a purely civil case and one deserving of punishment by the SMC. A rapid test of gross negligence could be to use the test of St Thomas Aquinas (1225–1274), the medieval philosopher whose writings still form a large part of the bedrock of Catholic Church theology. Aquinas' test of repugnance is *statim, modica consideratione*[10] – immediately, with little thought. The writer suggests that unless the elements of the complaint satisfy the simple test of "repugnance", it should not be sent to the Disciplinary Tribunal (DT). Of the 165 cases before the SMC in 2018, 46 were for professional negligence, 19 for missed diagnosis, and 20 for inappropriate treatment (ie, 85 out of 165); the majority should have originated as civil cases, with only few describing "serious negligence", or drastic or extremely egregious misconduct.

"Beyond reasonable doubt" has a lot of similes defined by different judges over time. This simply means that the DT must be "nearly 100%

sure", "absolutely sure", "firmly convinced", or "sure" before they convict. There is a great number of formulae in words which shed little light on "beyond reasonable doubt".

Perhaps it is better to express it in numbers. In a 2009 Institute of Criminology paper, the University of Cambridge suggests a threshold figure of being 91% sure.[11] This test takes on a significance in assessing mens rea as the guilty act(s) comprising the "actus reus" would usually be agreed upon in a deemed "Statement of Facts" before trial. 91% to 100% sure is very far from the standard required for a plaintiff to prove in a civil case against a doctor, which is to cross the 50% threshold, called "a balance of probability". The patient wins if the civil court tips just 51% to his favour. At 50%, the patient still loses.

Clearly, to score more than 9/10 in an SMC case is a very stringent requirement[12] compared to needing only more than 5/10 in a civil court. Ideally, there should be a final screening check before the case is referred by the Complaints Committee (CC) to a DT. This should preferably be at the Review Committee (RC) stage, which should oversee CC referrals to the DT. This is not possible under current law, but a good practical alternative is to ensure that the CC first satisfies defined stringent requirements before a case is allowed to go to trial by the DT. The RC must lay down the stringent requirements which must be satisfied before a case is sent to the DT. The SMC President must ultimately be the goalkeeper and give the green light before any case is sent to the DT, with the RC ensuring that all stringent requirements are met.

Screening a case before it even gets to the CC stage may not serve much useful purpose, as the CCs at present seem adequately adept at detecting frivolous and vexatious cases. The 2018 SMC Annual Report statistics show that of the 192 cases reviewed by the CC, 109 were dismissed. Before sending a case to the DT, alternatives such as mediation or a warning should be considered.

Why be selective?

The first reason for the SMC to be more selective is that cases which are purely civil in nature and can be settled between parties should be given the fullest consideration before being sent to the DT.

The second reason is that there is now talk of a Conditional Fee Agreement, which means lawyers can take on cases on a no-win, no-fee basis. Champerty and champertous agreements used to be illegal and were strictly banned in the UK and Singapore, as it increased speculative litigation. Now, even the UK is accepting no-win, no-fee for medical negligence litigation. Singapore may also consider giving a statutory exemption for the medical profession. Patients may then be encouraged to compose their Statutory Declarations to imply and presuppose a prima facie case. This can oblige the DTs to do all the tedious work while the patient's lawyer may not need to do any work except to gamble on a multiplicity of DT verdicts, and then use any adverse DT verdict as a cash cheque (eg, as brawny leverage in obtaining more favourable terms from the Medical Protection Society).

SMC committees should be wary or in medical parlance "have a high index of suspicion" for civil cases dressed up as quasi-criminal ones. In cases of an alleged breach of the SMC Ethical Code and Ethical Guidelines (ECEG), great care should be taken to distinguish between "such disregard for life and safety of others as to amount to a crime against the state and conduct deserving punishment"[4] or "egregious misconduct"[13] and civil cases where "the relation of rules of practice to the work of justice is intended to that of handmaid rather than mistress."[12]

The third reason stems from the Judgement of the Court of Appeal in the case of Dr Lim Lian Arn.[13] The Court held that in deciding whether the doctor was negligent it was necessary to (a) establish a benchmark standard; (b) establish a departure; and (c) find the departure sufficiently egregious. The logical corollary would be that if a case does not show a prima facie case of egregious behaviour, SMC committees should not send the case to the DT. A warning should be sufficient to highlight and underscore displeasure. Good policing does not mean that every prima facie case has to go to trial. *De minimis non curat lex* – the law does not bother with minor matters. There are alternative sanctions in place which register disapproval of occasional minor departures from the ideal benchmark standards. These sanctions lower the threshold for sending a similar case to the DT should the infraction be repeated.

The fourth reason for the SMC to be selective is to avoid a blunderbuss approach which leads to imprecise results. The recent imbroglio has diminished the reputation of the SMC. It takes a great deal of perceived injustice for a normally staid profession to collectively protest DT rulings. We should be cognisant of our police force being very selective in prosecuting cases with a resulting high conviction rate and public confidence, leaving civil cases to be settled between parties.

Expert opinions

The SMC should be cautious in its reliance on external "expert reports". The expert has the benefit of having all the information from the beginning, through the progress of the case and to the final result. His report with 20/20 hindsight typically

surfaces a few weeks or months later with the possible benefit of deliberation, aided by reference to textbooks, journals and discussions with colleagues. The expert may present the ideal solution, with care not to incriminate himself in any way. The expert report may bear all the hallmarks of defensive medicine.

Retrospective "expert reports" have little correlation to real-time situations. A suggested approach would be to provide the expert with all the information until just before the point of contention. The expert is then asked to provide all acceptable management options from just before the alleged material act and also what are contraindicated. The expert would not be told of what the respondent doctor actually did. Whichever form the expert opinion takes, common sense is still needed in weighing it.

For a civil case, opposing parties start on equal footing (50-50) and it is for the authority to decide whom to believe. For a criminal or egregious negligence case, the respondent doctor starts with a 100% advantage, as he is presumed innocent until proven guilty.[14] The difference between a civil and a quasi-criminal matter ought to be inculcated into our CCs, DTs, and indeed the SMC itself and the medical profession at large.

Final thoughts

Many doctors live in dread of a registered letter from the SMC. This must change. A DT must not find a doctor guilty of negligence unless "there has been an intentional, deliberate departure from the standards observed or approved by members of the medical profession who are of good repute and competency",[1] ***OR*** "there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner."[9]

Doctors must not practise and live in fear. ◆

Dr Chuang is a family practitioner and an Advocate and Solicitor of the Supreme Court. The Chief Justice appointed him to the Law Society's Inquiry Panel. He has been Chairman of several Disciplinary Committees judging complaints against lawyers. He has an honours Divinity degree from the University of London.

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2. Chow Dih v Public. Prosecutor [1990] 1 SLR(R) 53.

3. R v Bateman [1925] 28 Cox Crim. Cas. 33, also (1925) 19 Cr App R 8, per Lord Hewart, Chief Justice.

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7. R v Prentice [1993] 4 All ER 935: two junior doctors without training or experience told under protest to do lumbar puncture on leukaemia patient. Criminal conviction quashed on appeal. Hospital may be criminally liable.

8. R v Holloway and Others [1993] 4 Med LR 304: Hypoxia from anaesthetist's failure to notice signs of disconnection.

9. Wong Meng Hang v Singapore Medical Council [2018] SGHC 253. Liposuction death. In all the cumulative circumstances, the Court of Appeal held that "we find it difficult to conceive of a worse case of medical misconduct" para. 92. The test of "such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner," in Wong Meng Hang was used verbatim from Low Cze Hong v Singapore Medical Council [2008] 3 SLR(R) 612 at para 37.

10. Boyle J. Natural Law and the Ethics of Tradition. In: Robert P. George ed. Natural Law Theory: Contemporary Essays. Oxford: Oxford University Press, 1992: 11. Also in St Thomas Aquinas (the "Angelic Doctor"), Summa Theologiae, I-II, 100.1

11. Arts and Humanities Research Council. Beyond Reasonable Doubt. Available at: http://bit.ly/2IP17jl.

12. Dictum of Collins, Master of the Rolls, in the Court of Appeal case of Coles v. Ravenshear [1907] KB 1.

13. Singapore Medical Council v Lim Lian Arn [2019] SGHC 172. The Court of 3 Judges at paragraph [28] criticised the DT for holding Dr Lim culpable when he merely departed from the ECEG. The DT must go further and hold the departure egregious, or serious.

14. For "Beyond Reasonable Doubt", the writer prefers to use a figure more familiar with the medical profession, which is $p<0.05$ where there is over 95% correlation between the act and guilt. If the correlation can be disproved by any alternative reason, then the accused should be given the benefit of the doubt. Two Standard Deviations=95.45%. For SMC's internal use, 95% should be the standard. Repugnance can be up to 3SD or 99.73 or $p<0.01$.

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Medical Humanities

Connecting Science and Art

Text and photos by Dr Rayan Alsuwaigh and Dr Anantham Devanand

The Singapore General Hospital Annual Scientific Meeting, held on 12 and 13 April 2019, was launched in unique fashion by a medical-humanities-themed performance from the doctors of the Division of Medicine. Before an audience that included the guest of honour, Mr Gan Kim Yong, Minister for Health, there was a poetry recital and a rendition of Andra Day's inspiring "Rise Up". These pieces were chosen to call attention to the growing incidence of burnout among doctors and how resilience can be fostered by mutual support.

Burnout is characterised by the triad of cynicism, emotional exhaustion and sense of loss of personal accomplishment. Despite increasing restrictions on resident duty hours, burnout persists, resulting in jaded doctors who can no longer empathise or tend to the sick. Increasing litigation and professional regulation, as well as over-reliance on electronic documentation and data, has led to a sense of loss of professional autonomy. The rights of patients appear to overwhelm the professional duties that are owed, as well as our ability to care. Data published in the *Singapore Medical Journal* in 2018 suggests that our residents have lower empathy and higher prevalence of burnout compared to counterparts in the US,[1] where the rates are already reaching epidemic levels. Besides the drain on medical manpower by those leaving the profession, there are also proven adverse effects on the quality of care through medical errors.

While systemic issues need to be addressed to resolve the complex problem of burnout, the medical humanities offer alternative solutions. The humanities, in many ways, serve to complete the practice of medicine by complementing the sciences.

The humanities can help restore our practices from only the diagnosis of symptoms to *concern* for the sick, and from merely treating the disease to *caring* for the person. It restores belief in the aspirations of caring for people – aspirations that brought us into the profession. This is the vision of the Office of Medical Humanities, established in Medicine Academic Clinical Program at SingHealth Duke-NUS by A/Prof Chow Wan Cheng.

Amar Vaswani's stirring poem "Unity in the Body" and Amanda Lam's soaring vocals helped remind the audience that while we were at a scientific meeting to share knowledge, we should not forget to connect with the roots of our profession and with each other. What is special about doctors engaging in the humanities is that they bring the experience of clinical reality and sensibility to the performance. To this end, a full concert and art exhibition titled "A Night to Remember" has been scheduled for 13 December 2019. As the music faded, the lyrics that lingered at our scientific meeting were:

"All we need, all we need is hope;
And for that we have each other."

The practice of medicine is tough but we don't have to travel this road alone. We do have each other. ◆

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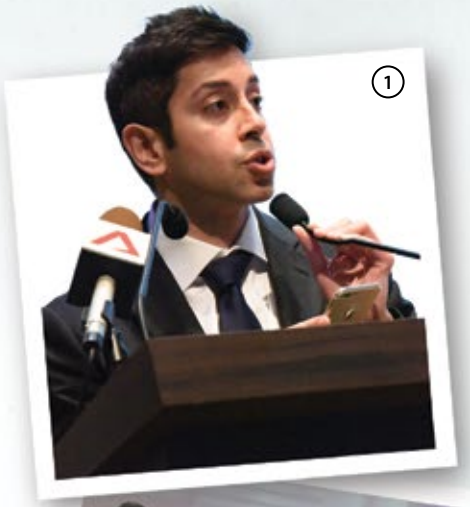
Legend

1. Dr Amar Vaswani addressing the audience
2. Backing vocalists for "Rise Up" (L to R: house officer Dr Daniel Lim, advanced practice nurse Joanna Phone Ko and senior resident Dr Cheong Li Anne)



Dr Rayan is a senior resident in the SingHealth Respiratory Medicine Residency Programme and the director of "A Night to Remember".

Dr Devanand is director of Medical Humanities at the SingHealth Duke-NUS Medicine Academic Clinical Programme.

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THE TURMOIL OF A TRAINEE

Review by Dr Tina Tan, Deputy Editor

One can argue that since this book is set in the UK and was published in response to the National Health Service crisis of 2016 (which is still ongoing), there wouldn't be much relevance to reading it in our local Singaporean context.

However, the feelings evoked by this book – the emotions, the situations and the people – were so much like what I had experienced as a house officer and during my training years that it gave me flashbacks. I suspect many who read this book would agree as well. It will bring laughter (or tears) to those who can empathise with and relate to Adam's thoughts. And as the saying goes, it will open the eyes of those who have no idea what it's like "on the ground".

Written in a blunt, honest fashion with deadpan humour, even the appendices, which were written by Adam to explain certain medical terms, are funny.

What's less funny is the situation that Adam was operating under as he went through his training years – severe manpower shortages and doctors working while exhausted, all while juggling examinations, family and relationships. And the heartbreaking ending – the incident that finally caused him to throw in the towel. Evidently, this book highlights the need to ensure adequate resources are available for junior doctors – not just in terms of manpower, but also in terms of support and guidance especially when bad things happen (because they do).

The book ends with an open letter to Britain's Secretary of State for Health. It won't take much to figure out who this particular Secretary is (apparently, he's famous for all the wrong reasons). I especially appreciate the sentiment reflected here: "You and your successor… should have to work some shifts alongside junior doctors. Not the thing you already do, where a chief executive shows you round a brand-new ward that's gleaming like a space station… I defy any human being, even you, to know what the job really entails and question a single doctor's motivation."

While this isn't the platform to get political or rant at "the system", it is good to know that there are other people, in other countries, who face the same issues as we do – manpower shortages, adverse events, or being misunderstood by the public, politicians and/or journalists. This is a refreshing and easy read that touches the heart with its brutal honesty.

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

Title: This Is Going to Hurt: Secret Diaries of a Junior Doctor

Author: Adam Kay

Number of pages: 267

ISBN: 9781509858651

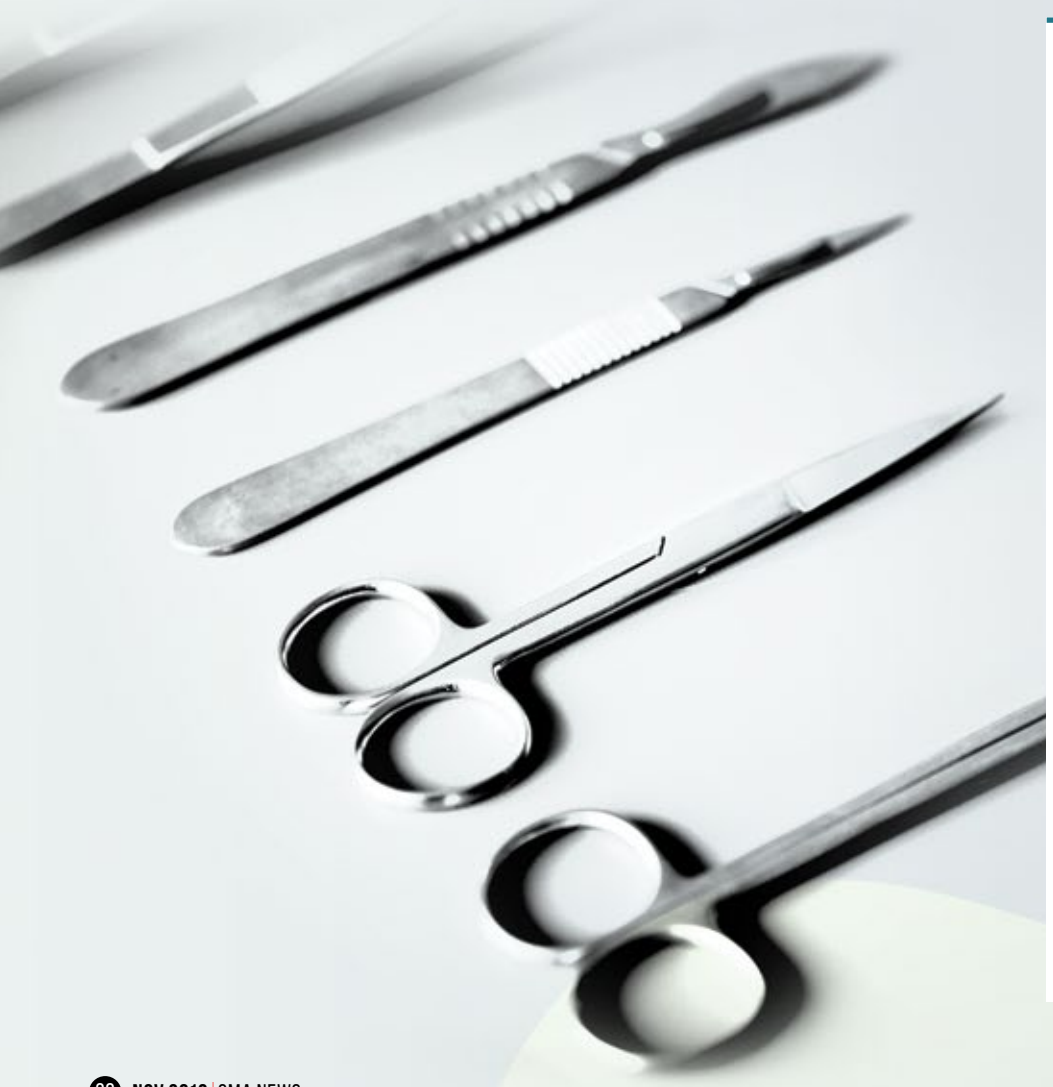
Type of book: Paperback

Publisher: Picador (GB)

Year of publication: 2017

At the Heart of DISSECTION ELECTIVES

Text by Faye Ng Yu Ci



Standing over the silent mentor prepped in my blue gown, gloves and goggles, scalpel and forceps in hand, I was at a loss of what to do. My hands had been taught the basics: how to load the blade into the scalpel holder, hold and position the scalpel against the body, and make the first incision. My mind knew the anatomy: I could name the muscles of the forearm, state their origins and insertions, and explain the ulnar paradox. Yet, in the face of a real body, still and embalmed, I realised how unprepared I was to handle the gravity it represented – its flesh and bone, its nuances and variations. For all that we have learnt over the course of our first year in medical school, we remain at the tip of the iceberg; the blue underneath is unending. Besides, having the knowledge is one thing and putting it into practice is another.

Similar to historians who study the past to reimagine the future, medical students and doctors study the dead to save the living, hoping to glean experience and expertise by carving through muscles, organs and vessels. Through dissection, we study

features and relations in close detail, training our dexterity and hand-eye coordination, fumbling around before we gradually figure things out.

In the beginning, it was difficult getting used to the idea of the cadaver. In our largely traditional and conservative society, death and dead bodies remain taboo topics we shy away from. Before entering medical school, most of us rarely, if ever, had candid and meaningful conversations about these weighty subjects. It is only as doctors-to-be that we start to approach and understand our eventual fragility and fatality, confronting our fears and preconceived notions of what death and dying looks like.

The notion that the human body is fundamentally sacred and sacrosanct is a timeless and revered one. The act of dissection hence feels like an infringement of personal space and autonomy, even when justified on the grounds of medical education. This explains the medical student's initial hesitance, along with his or her guilt and unease, which gradually fades but is still evoked from time to time. Despite being awed by the human body's intricacies and complexity, a part of us remains opposed to cutting through a corporeal body in order to be privy to its logic. Such are the contradictions we will have to continuously grapple with as we progress through our medical journeys and encounter various ethical dilemmas.

The first cut

The first cut is always the hardest. From there, the dissection unfolds. After overcoming our inertia to put blade to skin, the process of cutting along skin markings was swift, with ten or so of us working on different regions of the body. The blade was unnervingly sharp, the skin of the silent mentor parting easily as our scalpels skimmed horizontally across his chest. Clearing out the subcutaneous fat proved more tedious, due to the neurovascular structures embedded within that we had to work carefully around to keep intact. The nerves, which were thin and blended easily into the surrounding tissue, were especially hard to preserve. Often, we learnt caution through trial and error, by inevitably cutting a few structures ourselves.

After peeling away skin, clearing out fats, reflecting away muscles and cutting through ribs, we finally opened up the anterior wall of the chest and abdomen. It was illuminating seeing how the body is put together by elucidating the relationships between organs and structures with our own hands. Previously, in our anatomy halls, we studied prosected specimens by individual regions, including the head and neck, abdomen, and lower limb, prepared for us by our professors. Dissection electives was our first time performing hands-on procedures on the silent mentors, where we reviewed textbook knowledge through application and let passive facts take on newfound meaning and significance. At the same time, the process of dissection taught us patience, as we sat through mornings and afternoons cutting through the layers, the smell of formaldehyde no longer as pungent as we grew accustomed to it, our hands working intently to clear away fat and fascia, revealing the underlying structures.

The silent mentors we were working on all had unique causes of death: metastatic breast cancer, gallbladder cancer, cardiac arrest, cerebrovascular stroke... My group's silent mentor, Mr G, for example, died of pneumonia and ischaemic heart disease. Upon looking at his organs, we found that his heart was visibly enlarged with thickened muscular walls, while his lungs had a firm and elastic texture, with areas of consolidation. All these correlated with his medical conditions and causes of death, exposing us to pathology before we were formerly taught. Through our silent mentors' bodies, we also glimpsed the everyday lives they led. The black spots on Mr G's lungs indicated that he was a smoker and the thick layer of fatty deposit underneath his skin suggested he enjoyed fatty and oily food.

Thankful for the experience

These precious weeks of dissection electives helped me to revise and reinforce my anatomical knowledge learnt over the past year and gave me a prelude to surgical postings in Year 3. Moreover, they made me appreciate how mortal and human we all are – both the silent mentors and us wide-eyed, incorrigibly curious students. In our own ways, we are fallible and make mistakes, but we also possess the potential to contribute and be a part of something greater than ourselves.

In the anatomy hall, I experienced excitement and adrenaline, frustration and ennui. Yet most of all, I experienced gratitude – for the unspoken selflessness shown to us by our silent mentors, who gave us the opportunity to learn using their bodies, as well as for the kindness of their family members, who granted us the grace of their loved ones. The immensity of their sacrifice reminds us of the many people who have given without expectation and supported us in our journey to become doctors, reminding us to serve with both our minds and hearts. As one of our professors said: "Even with advancements in technology and artificial intelligence, a heart can only be trained by another heart; a heart can only be touched by another heart." ◆

Faye is a second-year student at NUS Yong Loo Lin School of Medicine. In her free time, she writes poetry and frames light into verse. Her works can be found in the *Quarterly Literary Review Singapore* and *Cha: An Asian Literary Journal.*

PARTICIPATE AND ANTICIPATE: A FUTURE-READY COMMUNITY CARE SECTOR

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By Agency for Integrated Care

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Keynote Speaker

- **Professor Ichiro Kawachi**, John L. Loeb and Frances Lehman Loeb Professor of Social Epidemiology, Harvard TH Chan School of Public Health, United States of America

Distinguished Speakers

- **Professor Jenny Billings**, Professor of Applied Health Research, Centre for Health Services Studies, University of Kent, United Kingdom
- **Professor Philip Sloane**, Distinguished Professor, Director of Academic Advancement, University of North Carolina, United States of America
- **Professor Sheryl Zimmerman**, Distinguished Professor, Associate Dean for Research and Faculty Development, University of Illinois, United States of America

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However, prolonged periods of stressful caregiving can lead to caregiver burnout and even depression. GPs and care staff can play a part in supporting your patients and their caregivers by raising awareness on services and programmes available for caregivers.

In conjunction with the Community Care Conference 2020, AIC and NCSS present the Caregiver Public Forum 2020 happening from 9:00am to 12:30pm on 15 February 2020 at Suntec Singapore Convention & Exhibition Centre.

Encourage your caregivers to sign up for the Forum. This learning platform seeks to raise awareness on family caregiving by:

- providing insights into family roles and managing family dynamics
- getting to know the available support and resources available in the community
- knowing how they can plan the care ahead.

This event is open to the general public especially caregivers or anyone who is keen to understand more about caregiving

For more information on Caregiver Public Forum 2020, visit *www.aic.sg/cg-forum2020*.

Scan the QR code or call 6831 1319 to register by 12 January 2020. Free admission. Seats are limited.

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If you need assistance in signing up for the Community Care Conference, or have any other questions, please contact the AIC GP Engagement team at gp@aic.sg or 6632 1199, or visit Primary Care Pages (www.primarycarepages.sg).

Doctors or Musicians

Why Not Both?

Text and photos by Dr Hirantha Ariyadasa

Note: This article was submitted to both SMA News *and* The College Mirror. *It has since been published in the September 2019 issue of* The College Mirror.

Medicine is a rather stressful and demanding profession to be in and music has always given me an avenue to de-stress as well as to channel my creativity. It's not always that you get to simultaneously pursue two entirely different paths that you are passionate about and bring a smile to someone's face. I'm fortunate to be able to do that in both medicine and music.

Let me share more about my band – The Missing Link. Dr Suran Kuruppu and Dr Gananath Dassanayaka, both medical doctors by profession, are my other band members. Suran is a resident physician at Changi General Hospital's Department of Anaesthesia and Surgical Intensive Care, while Gananath is a family physician by training. He is currently based in Sri Lanka as the Head of Quality Assurance at the Asiri Group of Hospitals.

Suran and I have been friends since we were in secondary school. We used to spend a lot of time singing and playing music together after school and it was then that we realised that our voices and guitar playing blended very well. We met Gananath during our first year of medical school and it turned out that he made a great addition to the team.

What started out as a simple pastime quickly became a passion for the three of us. In 2006, we took this passion a step further and started playing as a band at various venues back in Sri Lanka. It was unexpected to see three medical students pursuing music but we were very well received by our audience at the time.

The band members

All three of us had been introduced to music at a very young age with formal training and it has been an important part of our lives growing up. This is probably the main reason why we continued to pursue it even after becoming medical professionals.

I started my musical career as a violinist and vocalist when I was 11 years old. Later on, I developed an affinity towards percussion instruments and learnt to play the acoustic drums and the cajon on my own. Suran had been trained in western classical guitar and the two of us had even been in the same choir at one point. Gananath started out as a vocalist and a jazz saxophonist, and he specialises in old school jazz music.

Suran and I have always been very fond of American folk and country music. We both value the tunes that originated during the 1960s to1980s; Simon and Garfunkel, James Taylor, Cat Stevens, and The Beatles are some of our musical heroes. Gananath, on the other hand, is a fan of old school jazz music. Frank Sinatra is his biggest inspiration.

Over the years, we have played at numerous venues – from pubs, cocktail parties and weddings to corporate events and even five-star hotels overseas. These venues were where we got our exposure to professional performances, and how we got to really understand the audience and entertain them with our musical skills. With the amazing reviews and responses that we got, our confidence was boosted and we took live performance to the next level. Since then, we have participated in many more performances and even held our own concert in Sri Lanka in 2011, which was a tremendous success.

We were also able to individually gain performance experiences and achievements. With Gananath's special interest in old school jazz music, he plays with another jazz band that has had five sell-out concerts, while Suran has played back up for many live television shows. These experiences have helped us to elevate our performance today as a band.

Ongoing music making

The band likes to feature people with different musical talents that may complement what we do as musicians. This helps us to provide our audience with something different and vibrant each time we play. We usually charge a nominal performance fee and all our gig proceeds are donated to charities.

We also enjoy experimenting with music from other cultures and different genres. Music is an infinite creative process and experimenting helps us to creatively explore different dimensions influenced by the vibrancy of different cultures. I believe this will help us to continuously evolve as musicians and deliver something new and fresh to our audience. ◆

Dr Hirantha is a medical doctor who works as a resident physician at Bright Vision Community Hospital, Singapore. He is also a trainee in the Master of Medicine (Family Medicine) programme at the College of Family Physicians Singapore.

• SALE/RENTAL/TAKEOVER •

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

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

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

Buy/sell clinics/premises: Takeovers (1) D10 Bukit Timah, 1300 sq ft (2) D2 Chinatown, mall practice, 560 sq ft (3) D20 Ang Mo Kio, heartland practice, with shop (4) D20 Bishan practice, with shop, high turnover (5) D20 Bishan practice, good revenue (6) D14 Sims Place clinic space with/without practice (7) D03 Bukit Merah, high potential (8) D08 health screening practice, with shop (9) D09 O&G, Orchard, high turnover. Clinic spaces (a) D01 Raffles Place, fitted, 300 sq ft (b) D02 Oxley Tower, 321 sq ft, bare (c) D07 Parklane, 345 sq ft, fitted (d) D22, Biz Park, 1000 sq ft, (e) D08 4-storey aesthetic fitted space. Yein 9671 9602.

Clinic for rent. 1119 sq ft. Upper Bukit Timah. Good frontage next to Beauty World MRT Exit A. One operating theatre with two recovery beds. Suitable for aesthetic, plastic, cardiology or share specialists' clinic. Call Mr Lim 9666 3343.

Rent at Royal Square @ Novena. Cheap rental! 517 sq ft, 15th floor. 103 Irrawaddy Road next to Novena MRT. Suitable for medical/dental clinics, TCM, research lab X-ray clinic. Free rental for 3 months. Monthly rental $3800. Contact 9389 3178 Mary.

• POSITION AVAILABLE/PARTNERSHIP •

Primary healthcare group looking for energetic and enterprising doctors to join us as anchor doctors and family physicians. We provide acute and chronic care in the community, with special interests in family medicine, aesthetic medicine, pathology and sports medicine. We offer a competitive remuneration package with bonuses/profit-sharing for successful doctors. Ideal for colleagues who want more flexibility and creativity in their practice. Please email admin@mayfairmedical.com.sg or call 9672 0473.

CAAS
Civil Aviation Authority of Singapore

The Civil Aviation Authority of Singapore's raison d'etre is to develop the air hub and aviation industry in Singapore, expanding Singapore's links to the rest of the world. We enable opportunities through aviation, making connections, opening doors and enabling choices in people's lives.

The Civil Aviation Medical Board (CAMB), a division of the Civil Aviation Authority of Singapore (CAAS) is responsible for the medical fitness assessment and certification for flight crew and air traffic controllers in Singapore, as well as regulatory oversight of medical related matters pertaining to aviation safety and human performance.

REGISTRAR (CIVIL AVIATION MEDICAL BOARD)

You will be working closely with the senior medical staff to provide aviation medicine consult services at the CAMB. You will be primarily responsible for monitoring health trends of our clientele and staffing health promotion initiatives that would help flight crew and air traffic controllers maintain their health and fitness throughout their career. The work will involve close professional interactions with the clinical partner of the CAMB as well as flight crew, air traffic controllers and industry partners. You will also be assisting the senior medical staff in providing guidance to the panel of Designated Medical Examiners and perform oversight activities to ensure that they maintain a high standard of practice and compliance in performing their roles and responsibilities pertaining to their designation by the CAAS.

Requirements
- Medical qualification registered with Singapore Medical Council
- Possess a valid practising certificate
- Completed primary specialist training in Family Medicine, Occupational Medicine or Internal Medicine
- Interest in pursuing sub-speciality training in Aviation Medicine

Please send full resume to: Sherry_SIM@caas.gov.sg

KWONG WAI SHIU HOSPITAL
廣惠肇留醫院
Since 1910

Kwong Wai Shiu Hospital is a charitable organisation, established to provide healthcare services to the sick and poor in Singapore regardless of race, language or religion. Our vision is to be a leading community healthcare hub in Singapore.

We provide a continuum of care ranging from in-patient (transitional care, long-term care, chronic sick care), out-patient home care, rehabilitation therapy and Traditional Chinese Medicine services. We invite dynamic individual to join us as:

RESIDENT PHYSICIAN / SENIOR RESIDENT PHYSICIAN

Responsibilities
The Resident Physician will be responsible for providing medical care to inpatients and outpatients. This includes:
- Patient assessment, care planning, treatment and monitoring progress of patients
- Involvement in community care, telehealth services
- Working closely with nursing, allied health professionals, other healthcare providers, within and outside KWSH healthcare hub
- Involvement in continuing education, training and research

Requirements
- Medical Degree registrable with the Singapore Medical Council (SMC)
- Graduate Diploma in Family Medicine / Geriatrics preferred for senior resident physician
- Minimum 2 years post-housemanship experience for resident physician
- Minimum 5 years in Family Medicine / Post-acute care for senior resident physician post

Interested applicants, please email your resume with recent photograph indicating your current/last drawn and expected salary to:

Kwong Wai Shiu Hospital • 705 Serangoon Road Singapore 328127 • Email: HR_Dept@kwsh.org.sg

Singapore National Eye Centre
SingHealth

The Singapore National Eye Centre (SNEC) is the national centre for ophthalmology in Singapore and an internationally recognised tertiary centre for eye care. We offer a broad spectrum of subspecialties and ambulatory services to our patients.

Visit our website at **www.snec.com.sg** for more information.

ASSOCIATE CONSULTANT, MYOPIA CENTRE

Singapore holds one of the highest rates of myopia in the world. 20% of children in Singapore are myopic by 7 years old. Over 80% of Singaporeans in their 20s to 40s are myopic. People who are highly myopic are at a greater risk of developing early cataract, glaucoma, macular degeneration and retinal detachment in their mid to late adulthood.

To address this global and Singapore myopia epidemic, SNEC formed the Myopia Centre to provide care and treatment for myopia, educate the public on preventive measures and early detection for myopia, as well as collaborate with relevant stakeholders to advance clinical research.

The Associate Consultant will be involved in clinical, teaching and research-related activities in our Child and Adult myopia clinics in SNEC main centre and at SNEC Eye Clinic @ Bedok.

Requirements:

- Accreditation by the Specialist Accreditation Board, Ministry of Health, Singapore, and specialist registration with the Singapore Medical Council in Ophthalmology
- Strong teaching and research abilities with a track record of publications is beneficial

Duration: 2-year contract (renewable)

Interested applicants, please email your curriculum vitae including details of work experience, qualifications, present and expected salaries to Ms Liow at: liow.xiu.hui@snec.com.sg

醫院管理局
HOSPITAL AUTHORITY

The Hospital Authority is a statutory body established and financed by the Hong Kong Government to operate and provide an efficient hospital system of the highest standards within the resources available.

1. Associate Consultant Positions for Experienced Doctors without Full Registration

(Anaesthesia / Anatomical Pathology / Cardiothoracic Surgery / Nuclear Medicine / Obstetrics & Gynaecology / Ophthalmology / Otorhinolaryngology / Radiology)

(Ref: HO1904001)

2. Service Resident Positions for Experienced Doctors without Full Registration

(Anaesthesia / Clinical Oncology / Emergency Medicine / Family Medicine / Intensive Care / Internal Medicine / Nuclear Medicine / Obstetrics & Gynaecology / Ophthalmology / Orthopaedics & Traumatology / Otorhinolaryngology / Paediatrics / Pathology - Anatomical Pathology / Pathology - Chemical Pathology / Pathology - Clinical Microbiology and Infection / Pathology - Haematology / Psychiatry / Radiology / General Surgery / Cardiothoracic Surgery / Neurosurgery / Plastic Surgery)

(Ref: HO1904002)

The Hospital Authority (HA) invites applications from experienced doctors who are not fully registered with the Medical Council of Hong Kong and yet have acquired relevant postgraduate qualifications set out in the Requirements to serve the community of Hong Kong. For details, please visit http://www.ha.org.hk (choose English language, click Careers → Medical).

Application

Application should be submitted **on or before 31 March 2020 (Hong Kong Time)** via the HA website **http://www.ha.org.hk**.

Enquiries

Please contact **Ms. Melanie TAM**, Hospital Authority Head Office at **+ 852 2300 6542** or send email to **tml128@ha.org.hk**.

NKF50 | Giving Life & Hope Together

Director, Medical Services

The successful candidate will spearhead the Medical Services and Allied Health Services teams of The National Kidney Foundation and cultivate a culture of high quality care in delivering holistic, quality and safe dialysis treatment to patients for optimal clinical outcomes and population care management.

Main Responsibilities:

- Provides strategic oversight to the teams and collaborates with both internal and external partners to roll out a holistic care model in support of the Foundation's push for integrated service delivery and partnerships with external stakeholders.
- Leads and drives quality improvement and patient safety initiatives/ programmes in accordance with the Foundation's directives and/or external regulatory requirements, in addition to implementing patient care management programmes and providing oversight to the infection control practices/standards.
- Active participation in educational and academic activities like conference presentation and scientific publication.
- Provides training/mentorship to the clinical teams on Patient Management and advises on medical matters to other departments.

Requirements:

- Degree in Medicine from a recognised University.
- Membership of the Royal Colleges of Physicians (MRCP) or American Board Certified qualifications or equivalent qualification registerable with SMC.
- Certificate of Specialist Accreditation in Renal Medicine.
- At least 10 years of clinical nephrology practice (clinical management of ESRD patients) including 3 years of supervisory experience.

Submit your application to cynthia.chua@nkfs.org by 31 December 2019 www.nkfs.org

NOVENA VITILIGO MEDICAL CENTRE

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

DERMATOLOGIST | **RETIRED DERMATOLOGIST**

REQUIREMENTS

MBBS and postgraduate qualification registrable with the Singapore Medical Council

Relevant experience is an advantage

Good interpersonal and communication skills

Good professional ethics

BENEFITS

Comprehensive benefits

Attractive remuneration package including bonus

Profit sharing

For interested applicants including foreign-trained doctors, please email your full resume to: hr@vitiligo.com.sg or contact or WhatsApp Mr Wu at 9062 9077

10 Sinaran Drive #11-05 Novena Medical Centre, Singapore 307506
For more information, please visit www.vitiligo.com.sg

Tan Tock Seng HOSPITAL

National Healthcare Group

Tan Tock Seng Hospital (TTSH), established in 1844, part of the National Healthcare Group, is one of Singapore's largest multi-disciplinary hospitals, providing holistic and integrated patient care. With a strong quality culture steeped in patient safety, TTSH constantly challenges itself to provide high quality cost-effective care for patients. In recognition of its commitment to excellent patient care and its comprehensive range of quality healthcare services, TTSH has been awarded the ISO 14001 and OHAS 18001 certification.

The Department of Anaesthesiology, Intensive Care and Pain Medicine is looking for passionate and experienced doctors who aspire to make a difference to people's lives. The department is a national leader in Neuroanesthesia and Neurocritical care, Surgical Intensive care as well as Regional Anaesthesia. We provide anaesthestic services to 24 operating theatres (OT) in the hospital as well as the endoscopy and radiological suites.

Applications are now open for the following positions:

Resident Physician / Senior Resident Physician

The Resident Physician/ Senior Resident Physician will work closely with the senior medical staff of the department to provide clinical care to patients during the perioperative period. You will have the opportunity to handle complex cases in the operating theatres and guide the junior doctors working in the department. Outside the operating theatre, you will be expected to participate in acute pain rounds. There are also opportunities to manage patients in the surgical ICU. You will also be required to perform night duties according to the operational requirements of the department.

Requirements for Resident Physician/ Senior Resident Physician

Candidate must possess a recognised basic medical qualification or equivalent that is registrable with the Singapore Medical Council (SMC). Candidates whose basic medical qualification is not registrable with the SMC can apply if they possess recognised postgraduate qualifications such as M Med and FANZCA or its equivalent that is registrable with SMC. Candidate must be in active clinical practice and attained a minimum of 3 years of local post-housemanship working experience OR 5 years of post-housemanship working experience at a reputable local/overseas hospital.

Clinical Fellow

The Department of Anaesthesiology, Intensive Care and Pain Medicine offers Clinical Fellowship Programmes in the following sub-specialties:

Regional Anaesthesia Fellowship: This is a 1 year training programme with hands-on experience. You will be guided by a team of forward looking and highly skilled specialists in regional anaesthesia. You will have the opportunity to perform both basic and advanced ultrasound guided nerve blocks for patients in the operating room. You will be able to experience how an independent mobile block service is organized in the department.

Neuroanaesthesia Fellowship: The department is a leader in providing perioperative care to neurosurgical patients. This 1 year hands-on training programme will provide the opportunity to have clinical exposure to a wide variety of neurosurgical cases in the operating theatre. Complex spine surgery, skull base surgery, awake craniotomy and functional neurosurgery are some of the procedures you can expect to be involved in. You will be able to participate in the care of patients undergoing intraoperative neuromonitoring including Evoked Potentials as well as cerebral oximetry and EEG monitoring.

Pain Medicine Fellowship: TTSH has an established Acute Pain and Chronic Pain Service. In this 1-year hands-on fellowship, you will have the opportunity to learn about acute and chronic pain management in a multi-disciplinary setting. You will also be exposed to a variety of pain procedures, both fluoroscopically and ultrasonographically guided. The fellowship will prepare you well for a future in pain medicine.

Requirements for Clinical Fellow

Candidate must possess a basic medical qualification from an accredited medical university or medical school and must be in active clinical practice with a minimum of 3 years post-housemanship or post-internship experience as a medical officer (or equivalent) or have a medical postgraduate qualification.

Interested applicants are invited to write in with full personal particulars including educational qualifications, work experience, present and expected salary, contact number and email address to:

Chairman, Medical Board
c/o Human Resource
Tan Tock Seng Hospital
11 Jalan Tan Tock Seng
Singapore 308433
Email: med_career@ttsh.com.sg
Fax: (65) 6357 8625
Website: www.ttsh.com.sg

Seven Keynote Presentations

Prof. Gerald Pollack
Water: its physical properties in new approaches to health, energy and recycling

Dr. Ron Ehrlich President ACNEM
The basis for nutritional, environmental and integrative medicine: the Australian perspective.

Keynote Speech Prof. Dean Radin
Real Magic? Are spontaneous remissions based on conscious intent and are there any physical-material bases of explanation? Institute for Noetic Sciences (IONS)

Keynote Speech Prof. Atsuo Yanagisawa
The Integrative Medicine Approach: The Japanese Perspective

ACNEM Workshop

Covers topics such as:

- Gut Health & Hormones-microbiome factors in cancer.
- Toxicity in the mitochondria, impact on redox and metabolism
- Endocrine disrupting chemicals
- Learn from biological dentists how oral health affects the rest of the body
- Liquid biopsy and personalised testing for determining treatment options
- When is intravenous vitamin C appropriate and how to fit it in a treatment protocol?
- Metabolic nutritional management
- Lifestyle factors, exercise and trauma support
- and more....


Professor Gerald Pollack
Professor of Bioengineering
Founding Editor-in-Chief of WATER


Professor Ian Brighthope
Founding President ACNEM

Four Plenary Sessions

Plenary Session Ia
Cancer aetiology from an integrative medicine perspective

- Genes, epigenetics and nutrigenomics factors: the current paradigm
- Environmental factors, the strength of evidence for lesser known chronic exposure to contaminants
- Metabolic dysfunction as a possible candidate
- Is there an oral link to CVD and cancer?

Plenary Session Ib
The role of nutrients and water in immune support and cancer prevention

Plenary Session II
Cancer aetiology and spontaneous remissions

Plenary Session III
The future: Evidence-based integrative cancer prevention and support and the role for structured water, nutrients and lifestyle factors.


Professor Atsuo Yanagisawa
Professor in Clinical Medicine & Clinical Cardiology
President ISOM

For more information visit
https://singaporelifestyleintegrativemedicine.com/

CME points pending application - ACNEM is an Australian accredited RACGP QI & CPD training provider for the 2017 - 2019 Triennium with 40 'Category 1' points allocated to most training programs. ACRRM, RNZCGP and CPD/CME points from other professional organisations may also be available.

ACNEM
Australasian College of Environmental Medicine

ISOM
International Society for Orthomolecular Medicine

Organised by:
Clinical Bionomics Pte. Ltd
+65 65928553