SMA news

For Doctors, For Patients

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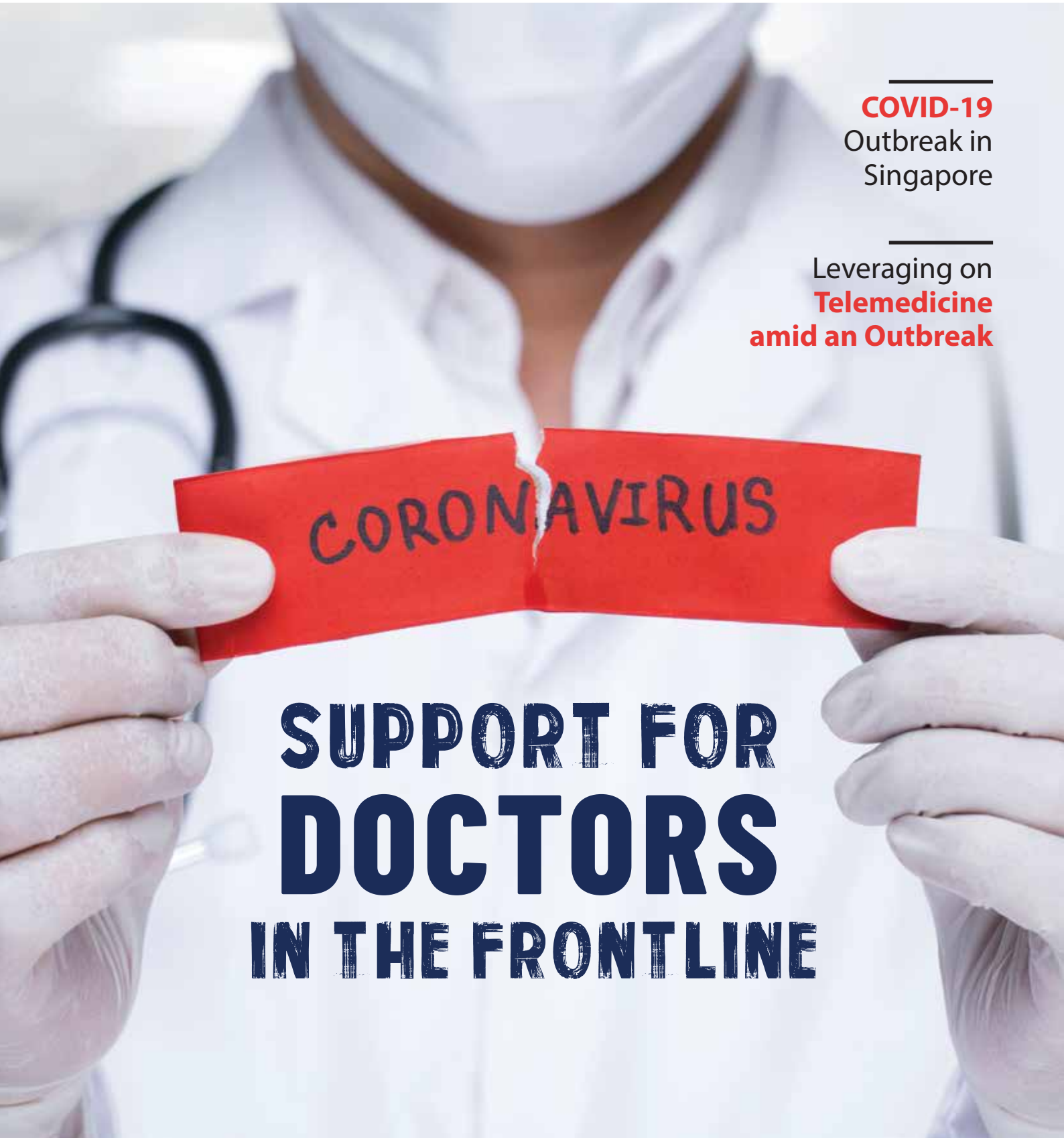

COVID-19 Outbreak in Singapore

Leveraging on **Telemedicine amid an Outbreak**

SUPPORT FOR DOCTORS IN THE FRONTLINE

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

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

REQUIREMENTS

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

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

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

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

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

For more information, visit:
www.juronghealthcampus.com.sg

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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

Tina Tan

Deputy Editor

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

Tan Yia Swam

Editor
1st Vice President, 60th SMA Council

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.

This issue was meant to be a lighthearted one and it was almost ready to be published. But January rolled around with ominous developments about the 2019 novel coronavirus (COVID-19) from Wuhan, bringing unwanted flashbacks of SARS and with it, much fear and trepidation. Several of our intended articles have thus been delayed until a more appropriate time. However, certain last-minute changes could not be made, and I hope that our readers understand that we've done our utmost given the evolving situation.

In that same spirit of response, SMA's leadership has spent the past few weeks collaborating with the Ministry of Health and College of Family Physicians Singapore to ensure that our colleagues (SMA Members and non-members alike) are provided with timely and practical information, as well as much-needed support. Media interviews were also given. A week after the Lunar New Year weekend, SMA published a special news bulletin *(SMA e-News)* with a focus on the COVID-19 outbreak, comprising tips and practical resources for doctors, and a timeline of events (http://bit.ly/2SjO5hT). In particular, the timeline highlights what SMA did to ensure that our colleagues on the ground were empowered with relevant information and sufficient supplies of personal protective equipment. This issue of *SMA News* features the contents of the *SMA e-News*, if you haven't already perused it online. It is thanks to the dedicated staff, Council and various Members that SMA was able to respond promptly to the ever-changing situation on the ground.

Experts have been talking about the need to strike a balance between containing an outbreak and allowing life to go on. Our country's leaders have warned us to be prepared for the long haul. It is hence timely to hear what our telemedicine colleagues have to say about the benefits of a robust system of remote medical consultations, especially during an epidemic.

Another weighty matter is the subject of gender equity. These days, it's probably unheard of that a medical school would impose a quota to limit the number of women enrolling. But it wasn't that long ago when the quota existed for various, probably outdated though well-meaning, reasons. That's changed for the better, thanks to the hard work of the Association of Women Doctors (Singapore) (AWDS). However, local news media recently published results of a Ministry of Manpower study that showed women earning 6% less than men, even with national efforts to close the gap in wages. As I look around my place of work, I wonder if my male peers are truly earning 6% more than I am. And this begs the question: why? I have no easy answers, but I hope that our articles from Dr Gayathri Nadarajan, and A/Prof Gan Yunn Hwen and A/Prof Sophia Archuleta, can throw some light on the issue of gender equity in our local medical scene, and what can be done to continue advocating for this half of the medical profession.

It is encouraging to note that despite the many unknowns in the COVID-19 situation, people are stepping up to help in whatever way they can. Yes, there is fear and apprehension, and human nature is inevitably rearing its ugly head, but all of us in the medical profession must be united in this new frontier. The men and women behind SMA have stepped up their efforts, and will continue to do so.

With that, stay safe everyone, and remember to wash your hands frequently.

COVID-19 OUTBREAK IN SINGAPORE

In view of the recent outbreak of the 2019 novel coronavirus (COVID-19, formerly known as 2019-nCoV), *SMA News* had put together a special news bulletin *(SMA e-News)* to provide our Members and fellow doctors with a succinct overview of key events, websites and ground tips. Reproduced below are the key contents of the bulletin.

EPIDEMICS IN PERSPECTIVE

Text by Dr Paul Yang Ing Woei and Dr Tan Yia Swam • Reviewed by Dr Leong Hoe Nam

Background

Epidemics are not new to human history and modern epidemics are well documented on websites of healthcare organisations, such as the Centers for Disease Control and Prevention, and the World Health Organization.

Key comparisons

⚠ Spanish flu (1918)

- Infected 500 million people, almost one third of the world's population then. Lasted two years and caused 50 million deaths.
- Worldwide spread, but called the "Spanish flu" as Spain had no censorship then and published the first public reports of the epidemic.

⚠ SARS (2003)

- Infected 8,069 people. Lasted nine months and caused 774 deaths.

⚠ Seasonal influenza

- Causes three to five million cases of severe illness per year and about 290,000 to 650,000 respiratory deaths. Milder illness may not be tested and documented.

⚠ Current COVID-19

- Coronavirus has been with humankind since humans domesticated animals many eons ago.
- With modern modes of transportation, it has gone intercontinental.

In the bigger scheme of things, influenza is still the king. It does not light up the public imagination because it keeps visiting repeatedly like clockwork. It has become routine, like the seasons. In temperate countries, it occurs once a year during the colder months. In countries near the equator, like Singapore, Indonesia and Malaysia, it occurs throughout the year.

As doctors, we have the sacred duty to protect the public not only from viruses but also to hand-hold them through these challenging times. In such times, the public looks to us for **solutions** and **reassurance**.

There is no doubt that as professionals we will all rise to this occasion as we did during every epidemic in this century.

Further readings

1. World Health Organization. Emergency preparedness, responses. Disease Outbreak News. Available at: https://www.who.int/csr/don/en/.

2. Centers for Disease Control and Prevention. CDC Current Outbreak List. Available at: https://www.cdc.gov/outbreaks/index.html.

TIMELINE OF EVENTS

Compilation by Dr Tina Tan and Dr Tan Yia Swam

Government Releases in Singapore		SMA and CFPS's Response and Actions
• Situation update on COVID-19 in China by Ministry of Health (MOH), including notification and identification of suspect cases of COVID-19 (MOH Circular 12/2020)	**21 Jan 2020**	• Email reminder to Members on MOH licensing terms and conditions on maintaining a supply of personal protective equipment (PPE)
• MOH set up a multi-ministry taskforce	**22 Jan 2020**	
• First confirmed case in Singapore • Revised suspect case definition (MOH Circulars 19/2020 and 19A/2020)	**23 Jan 2020**	• MOH, College of Family Physicians Singapore (CFPS) and SMA met to discuss support for the private primary care sector; MOH agreed to release stockpile of N95 masks for sale • MOH's N95 mask stock arranged for delivery to SMA office • CFPS agreed to man hotline for doctors who are unsure of procedures
• Second and third cases confirmed • Temperature screening for land and sea checkpoints	**24 Jan 2020** (Lunar New Year Eve)	• Supply of N95 masks delivered at 9 am • SMA Secretariat mobilised to sell N95 masks from 10 am to 2 pm with support from CFPS
• Fourth case confirmed	**25 Jan 2020** (Lunar New Year Day 1)	
	26 Jan 2020 (Lunar New Year Day 2)	• MOH, CFPS and SMA met again to discuss current situation and further support for doctors in the private sector
• Fifth case confirmed • Compulsory leave of absence announced	**27 Jan 2020** (Lunar New Year Day 3)	• Decision made to continue N95 mask sale on 28 January • SMA Secretariat prepared for the sale of N95 masks
• Sixth and seventh cases confirmed	**28 Jan 2020**	• SMA requested for additional stock of N95 and surgical masks from MOH • Two batches of N95 masks approved and collected for sale • Sale of N95 masks from 9 am to 4 pm
• Eighth, ninth and tenth cases confirmed	**29 Jan 2020**	• Sale of N95 and surgical masks from 9 am to 4 pm • The *Straits Times Forum* published a letter penned by SMA 1st Vice President Dr Tan Yia Swam (http://bit.ly/2UdPhpo)
• Three new cases confirmed; total tally 13 • Surgical mask distribution to Singaporean households announced	**30 Jan 2020**	
• World Health Organization declares outbreak an international emergency • 16 confirmed cases	**31 Jan 2020**	
	1 Feb 2020	• Provided input and comments for interview with *TODAY* (http://bit.ly/391b2wP)

TIPS FOR DOCTORS

Compilation by Dr Alex Wong • Material adapted from doctors' chat group

Editor's note: The following are only suggestions for fellow medical practitioners and are not meant to constitute a guideline for management. I am heartened that experienced doctors have generously shared their personal experiences and tips on overcoming day-to-day challenges on the ground. Do keep track of official news releases and updates. Stay safe and keep up the good work!

General instructions

1. Consider converting the waiting area to an open-aired space and turning off the air conditioner.
2. Ensure that all staff have been fit-tested for N95 masks.
3. Brief staff on personal hygiene:
   a. All staff are to do daily temperature checks.
   b. Ensure that staff are versed on the proper way to wear masks.
   c. Discard masks after use.
   d. Remind staff not to touch their faces and to wash their hands before touching their faces. ("Your face is sacred; don't touch it" – Dr Leong HN)
   e. No handphone use during clinic hours except during emergencies. Keep it in a ziplock bag.
4. Put up notices outside the clinic informing patients to notify clinic staff regarding travel history (see Annexe A for travel advisory in Mandarin).
5. Remove all but two to three pens for patients to use at registration.
6. Disinfect non-metallic surfaces with diluted bleach (see Annexe B for guidance on bleach dilution).
7. Metallic surfaces have to be wiped down with alcohol wipes.
8. At the end of each session, before unmasking and ungloving, wipe down the computers and/or pens. Also wipe down all the doorknobs, tabletops, counters, telephones and stationeries (staplers, pens, etc) in the dispensing area, as well as outside and inside consultation rooms.
9. Doctors to wipe stethoscope and blood pressure cuff after each patient consultation.
10. Screen patients at clinic entrance.
    a. When two staff are on duty, one will be the triage nurse. The triage nurse should be wearing a surgical mask. Suspected cases should be managed in an N95 mask or full PPE.
    b. Doctor should be wearing a surgical mask. Consider an N95 mask or full PPE for procedures that may aerosolise viral particles (eg, nebulisation and nasogastric tube insertion).
    c. Re-using of N95 masks is not recommended. Visit: http://bit.ly/3b8BWVD.
    d. You must not remove your mask during the entire work session. Wash your hands before touching your face.
    e. Discourage patients from waiting in the clinic.
    i. If time permits, allow patients to book via phone and call them when it is their turn. For busy clinics where calling is not feasible, send patients home and give them an appointment time to revisit the clinic.
    ii. For those who insist on waiting, separate them by asking patients with upper respiratory tract infections to wait outside and non-infectious patients to wait inside.
    iii. Chronic patients who are well can repeat their medicine for one to two months. These patients can enter the clinic and should be attended to by the non-triage nurse.
    iv. If the triage nurse picks up a patient who fulfils criteria for the COVID-19, isolate the patient and keep in view the transfer to Tan Tock Seng Hospital (see Annexe C for management of suspected cases).
11. 14-day leave of absence
    a. From 31 January, all returning from mainland China regardless of which sector they work in must take 14 days of leave of absence starting from their date of return from China. This is a form of quarantine. There is no need to see a doctor for a medical certificate. This will minimise exposure to persons returning from China. They should monitor their health closely for two weeks upon their return to Singapore. If unwell with fever or respiratory symptoms, they should wear a mask and seek treatment. ◆

ANNEXE A. TRAVEL ADVISORY IN MANDARIN

1. 如果您患有肺炎的病徵及病狀，或有严重的呼吸系统感染而导致呼吸困难，而在病发前14天内曾经前往或居住在中国大陆。或是
2. 患有任何呼吸系统疾病，无论情况轻重，的病患者，而在病发前14天内:曾经前往或居住在湖北省(包括武汉市)或浙江省(包括杭州市)，或是曾经去过中国大陆的任何一家医院或医疗设施，或与2019冠状病毒疾病感染病患者有过接触，或在工作上与近期(14天内)曾经前往中国大陆的旅客有经常或密切接触，都请马上向服务人员索取口罩，并立刻戴上它才登记求诊。

凡被怀疑有2019冠状病毒疾病感染病患者，本诊所会安排救护车，转送到陈篤生医院急诊（成人）或竹脚医院儿科急诊（儿童）接受详细检验。请在诊所外等候。感谢您的合作和无私之举。

The advisory in brief

It advises that any patient who had been to mainland China, especially Hubei and Zhejiang; or visited any hospitals or medical facilities in mainland China; or been in contact with any COVID-19 patient; or contact with travellers from mainland China is to immediately retrieve and put on a surgical mask before registration. It also states that the clinic will arrange for ambulance transport for suspect cases to the A&E of Tan Tock Seng Hospital (adults) or KK Women's and Children's Hospital (children) for further tests, and asks that patients wait outside the clinic.

ANNEXE B. GUIDANCE ON BLEACH DILUTION

Bleach as a disinfectant (usually 5.25% or 6% to 6.15% sodium hypochlorite depending on manufacturer) is usually diluted in water at 1:100.

Approximate dilutions are 1/4 cup of bleach in a gallon of water for a 1:100 dilution (~600 ppm).

1 cup = 240 millilitres

1 gallon = 3.785 litres

Things to note

- Do not mix bleach with other cleaning agents.
- Do not mix bleach with hot water.
- Bleach degrades over time if left at room temperature.
- Store bleach in a cool dark place and use freshly produced/purchased bleach.
- Bleach can corrode metals and damage painted surfaces.
- Avoid touching the eyes. If bleach gets into the eyes, immediately rinse with water for at least 15 minutes and consult a physician.
- If using diluted bleach, prepare fresh diluted solution daily. Label and date it, and discard unused mixtures 24 hours after preparation.
- Organic materials inactivate bleach; clean surfaces so that they are clear of organic material.

ANNEXE C. MANAGEMENT OF SUSPECT CASES OF COVID-19

Case definition (correct as of 5 February 2020)

1. A person with clinical signs and symptoms suggestive of pneumonia or severe respiratory infection with breathlessness **AND** travel to mainland China within 14 days before onset of illness; or
2. A person with an acute respiratory illness of any degree of severity who, within 14 days before onset of illness had:

   Been to Hubei Province (including Wuhan city) or Zhejiang Province (including Hangzhou city), China; **OR**

   Been to a hospital in mainland China; **OR**

   Had close contact with a case of COVID-19 infection; **OR**

   Had frequent or close contact during work with recent travellers from mainland China (travel history in the last 14 days).

Proposed workflow for a suspect case

1. Managing staff/doctor to wear N95 mask, gown and gloves.
2. Do not allow the patient to enter clinic.
   a. Seat patient outside clinic and away from others.
   b. Put a face mask on patient and a squirt of hand sanitiser.
   c. Record the time of registration, name and contact details of patient AND any accompanying person.
   d. Inform doctor immediately. Doctor to see the patient at a designated area outside the clinic.
3. Once doctor confirms that the patient is a suspect case,
   a. If unstable, call **995** and notify operator of suspect case of COVID-19;
   b. If stable, call 6220 5298 for dedicated ambulance transport.
4. Doctor to submit MD131 via the Communicable Diseases Live & Enhanced Surveillance (CDLENS) system.
5. If patient absconds, inform Surveillance Duty Officer of Communicable Diseases Division at 9817 1463.
6. After patient leaves,
   - Wipe down tablet/pen and all surfaces, knobs and equipment the patient may have contaminated.
   - Unmask, unglove and wash your hands.
   - Double bag all cleaning materials into black garbage bags.
   - Spray diluted bleach into garbage bags and tie up garbage bag.
   - Wash hands with soap and water.
   - Remask and wear gloves.
   - Call back other patients.

HELPFUL RESOURCES

Compilation by Dr Ganesh Kudva

Website	URL
Singapore Government's Factually website	https://www.gov.sg/factually?topic=Health
Ministry of Health Singapore's website	https://www.moh.gov.sg/covid-19
Gov.sg WhatsApp channel	http://bit.ly/36FW9i1
Lancet	https://www.thelancet.com/coronavirus
New England Journal of Medicine	https://www.nejm.org/coronavirus
MOH Alerts (accessible only via Internet Explorer)	https://mohalert.moh.gov.sg/welcome.do
Primary Care Pages	https://www.primarycarepages.sg
Channel NewsAsia	http://www.cna.asia/wuhan-virus
8world News (8视界新闻)	http://bit.ly/37JuE8z
The *Straits Times*	https://www.straitstimes.com/coronavirus
Lianhe Zaobao (联合早报)	http://bit.ly/2Ubmf9W

Information provided are accurate as at time of print.

FAREWELL TO A FOREVER FRIEND

Text by Dr Lee Yik Voon

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

"My Bobo lies over the ocean

My Bobo lies over the sea

My Bobo lies over the ocean

Oh, bring back my Bobo to me"

Bobo was a five-year-old Cairn terrier abandoned by his previous owner when I first met him. I brought Bobo home after two failed attempts at adopting a dog from the Society for the Prevention of Cruelty to Animals (SPCA). Both times, I was way at the bottom of the wait list. The third time, I rushed down with my son during lunchtime to be first in queue. Bobo seemed to be telling me to choose him and give him a chance to be my friend forever. I did, and we were so happy that day. Good things come to those who wait.

The initial challenges

Getting the basic needs was the first challenge. Feeding was easy – we just stuck to what SPCA did. Although after a while, he got bored with kibbles and welcomed more fresh food. He liked softer food and refused hard stuff – almost like a human who prefers to be managed in the correct way with the right expectations.

Training him to pee and poo was the key initial challenge. Should we train him to do it at home or outside? After some training, he started to pee and poo only when he was brought to the grassy areas. Whoever walks him has to carry a poo bag to pick the poo up after him for proper disposal. Seemingly, it is not only the dogs who need to be trained; the humans who walk the dogs also need to have better civic mindedness. We need to set good examples to our young and other pet owners.

My time with Bobo

I often thought that he was the best dog because he attacked only his toys. He left everything else alone. He is unlike what I have heard about other dogs who destroy furniture, slippers and shoes. He liked to befriend other dogs by wagging his tail furiously and would react violently when other dogs try to bully him. He was not attention seeking and would wait patiently for me to complete my work and give him a tummy rub every night. He appreciated tummy rubs by kicking his legs in the air.

Every Thursday after clinic, I brought Bobo to Marina Barrage for his late-afternoon walks. He received lots of attention from students. They would volunteer to walk him but he would always walk them back to me. He was mine and I was the only one in his life. Meanwhile, we caught lots of Pokemon at Marina Barrage despite him urging me to move on while I had to stop to "catch them all". Similarly, in life, we have competing interests and often we will have to make difficult decisions.

At the age of 11, he developed symptoms of cough and retching phlegm. I brought him to see two veterinarians. One told me that there was nothing wrong with him while the other told me that he was just getting old. Do we do that as medical practitioners as well? Do we

try hard enough to come up with a working diagnosis or just attribute it to ageing or an overreaction to simple symptoms?

In loving memory

Bobo passed on abruptly one night while waiting for me. He only managed to wait for my son to get home to see him one last time. I went home late that night as I had to attend our Council meeting.

I have another regret as I read from anecdotes by veterinarians that dogs are afraid of dying alone. He was my best buddy for the last six years and I was not there for him in his last moments. The next day was spent looking for the pet crematorium; somehow I took many hours to find the place despite having the address and the help of the GPS.

Everything that is sad went with him. Only he can trigger off any more sadness. What used to be and have been are no longer there. Promises from others are no longer that important when he is gone.

My moods lifted somewhat six months later. Although I got a new puppy a few months after I lost Bobo, she is not a replacement. I see her as someone to keep my mind distracted. I see Bobo's urn every day as I have placed it in my living room to remind me of my closest buddy.

How many true friends can you expect in your lifetime? A handful or less is all we would expect to have. I have anecdotes from my patients who find it so difficult to make friends that they can trust. That is because they were disappointingly tricked and cheated time and again.

Bobo is selective of his human company and people who are shunned are upset. Why is it wrong if we behave like that? Can't we have our own preferences for company and not have to be inclusive? Why can't we have flaws? Why can't we accept that or must we be socially acceptable and politically correct all the time?

Run free, my boy; I know that you will be waiting for me at Rainbow Bridge when my time comes. ◆

HIGHLIGHTS

From the Honorary Secretary

Report by Dr Lim Kheng Choon

COVID-19 outbreak response

With the escalating novel coronavirus COVID-19 (formerly 2019-nCOV) situation in late January 2020, SMA and the College of Family Physicians Singapore (CFPS) coordinated with the Ministry of Health (MOH) to release their N95 stockpile for sale to doctors. The secretariat staff worked hard to organise the first sale of N95 masks on 24 January 2020, the eve of Lunar New Year. Subsequent sales of N95 masks were organised on 28 and 29 January to meet demands. Surgical masks were also offered for sale to clinics on 29 January to alleviate the shortage they were facing.

SMA would like to thank the staff from MOH and CFPS for their help in coordinating the sale at such a short notice.

A Joint SMA-CFPS Circular regarding 2019 Novel Coronavirus was issued to Members on 27 January 2020, highlighting the process for handling suspect cases, the need to stock up on personal protective equipment, and misinformation circulating on social media.

SMA also contributed through various means of media, including a letter in the *Straits Times Forum* published on 29 January 2020, titled "Medical profession more prepared for outbreaks after Sars experience", and input to the *TODAY* article on COVID-19, titled "The Big Read: 17 years on, S'pore puts SARS lessons to the test in fight against Wuhan coronavirus". Additionally, we also published an *SMA e-News* on 3 February 2020 titled "Updates in view of the 2019-nCoV".

To read the above-mentioned documents or to find out more about SMA's efforts, please visit https://sma.org.sg/covid19.

2020 AGM

The SMA's upcoming Annual General Meeting (AGM) has been confirmed as detailed below. Do mark your calendars and join us for the afternoon.

Date: 19 April 2020, Sunday

Time: 2 pm to 4 pm
(Lunch served from 1 pm onwards)

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

Map: https://goo.gl/maps/K7Wz4QGWU192

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

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

Members who wish to move any resolution or raise amendments to the Constitution and Rules at the AGM, are to give notice in writing to the Honorary Secretary, by 12 noon on 20 March 2020, in accordance with SMA constitution Article X, section 1, sub-section (iii) and Article XII, section 2, respectively.

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

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

All completed forms should reach us by 12 noon on 20 March 2020.

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

HSA requirement for two separately drawn blood samples for pre-transfusion testing

As of 1 January 2020, the Health Sciences Authority (HSA) now requires doctors of private hospitals and clinics who use their pre-transfusion cross-match service to provide two separately drawn blood samples. SMA has clarified with HSA on the rationale for the above decision.

The requirement was instituted to reduce "Wrong Blood in Tube" errors which can potentially lead to devastating outcomes. HSA has assessed this measure to be useful for the safety of patients here. It is also in line with recommended international best practices and guidelines. Details of HSA's clarification, as well as a Frequently Asked Questions section, are available on the SMA website using your membership login details, at http://bit.ly/2uOLnZn.

Facilities that are not yet ready to implement this requirement can contact HSA Blood Services Group Crossmatch Laboratory to request for an extension of the deadline. ◆

Leveraging on TELEMEDICINE during an Infectious Disease Outbreak

Text by SMA Telemedicine Workgroup

SMA Telemedicine Workgroup

Chairperson
Dr Tan Yia Swam, 1st Vice President, SMA

Members
Dr Branden Seow, Cluster Head Clinical Services, Doctor Anywhere

Ms Dawn Lum, Head of Sales and Marketing, Doctor World

Dr Jipson Quah, Editorial Board Member, *SMA News* and Medical Director, Diagnostic Development Hub (DxD)

Dr Kevin Kok, Chief Operating Officer, Doctor Anywhere

Dr Matthew Lee Yee Song, Director of Clinical Operations, MyDoc

Dr Warren Ong, Medical Director for Corporate and Digital Health, Alliance Healthcare

Ethics Reviewers
Prof T Thirumoorthy, Adj Associate Professor, Duke-NUS Medical School and Academic Director, SMA Centre for Medical Ethics and Professionalism (SMA CMEP)

Dr Devanand Anantham, Head, SingHealth Duke-NUS Lung Centre and Director of Medical Humanities, and Deputy Executive Director, SMA CMEP

This Workgroup was brought together through my personal contacts in the past weeks with the aim of establishing a unified presentation for the potential use of telemedicine, specifically in the context of this current novel coronavirus (COVID-19, formerly known as 2019-nCoV) outbreak.

This Workgroup is not meant to be exclusive; it was assembled out of necessity and serendipity. Speed was essential. If you are a telemedicine provider, or if you have contacts who are interested in contributing to the Workgroup, do reach out to us. We would be very happy to have more people on board to assist our community. As technology advances, this Workgroup believes that there will be more opportunities for the appropriate use of telemedicine in other situations.

Current users of the commercially available platforms are welcome to use this advisory as a guide.

Doctors who have never used telemedicine are strongly encouraged to read the list of additional resources below to understand what telemedicine entails, before trying any of the following:

(1) Use telemedicine in their practice and exercise the same duty of care;

(2) Sign up with any of the ten commercial platforms known to us currently.

Additional resources:

1. National Telemedicine Guidelines. Available at: http://bit.ly/33QArGL.
2. Singapore Medical Council Ethical Code and Ethical Guidelines. Available at: bit.ly/2AxPyYU.
3. Visitor Resource Pamphlet, February 2020.

I wish to acknowledge the input and guidance from the SMA CMEP, as well as other professional bodies, in the preparation of this working guide.

Regards,

Dr Tan Yia Swam
1st Vice President, SMA
Editor, *SMA News*
General surgeon

Introduction to telemedicine

Telemedicine can be broadly categorised into four domains: tele-collaboration (ie, between healthcare professionals), tele-consultation (ie, between patient and healthcare professional), tele-monitoring (ie, remote vital signs monitoring) and tele-support (ie, administrative support). For the purpose of this advisory, we will be focusing on tele-consultation between a doctor and a patient.

Telemedicine involves the exchange of information for clinical purposes between doctors and patients/caregivers via telephone, text-messaging (SMS), messaging platforms and platforms with video capabilities. Telemedicine modalities today enable the delivery of care to patients remotely, beyond providing merely general advice and follow-up phone calls to check in on patients.

Telemedicine can play an important role in long-term chronic disease management and in limited acute conditions. In recent years, more doctors are leveraging on purpose-built telemedicine platforms with video capabilities to carry out video consultations (VC). Through VC, doctors can better assess key visual cues (eg, patient expression, pallor and breathing) and inspect specific body areas (eg, the throat, eyes and skin). Some telemedicine platforms that are coupled with tele-monitoring capabilities (eg, blood pressure, temperature, heart rate, pulse and oxygen saturations) can be useful in ensuring more timely clinical intervention and care coordination by the care team in chronic disease management. This can result in better delivery of healthcare and optimisation of patient outcomes.

What to take note of when starting a telemedicine service

It is important that doctors familiarise themselves with and adhere to the Singapore Medical Council (SMC) Ethical Code and Ethical Guidelines (ECEG – A6)[1] and the National Telemedicine Guidelines[2] when providing telemedicine services.

Doctors must be aware that there are limitations with telemedicine. These include (i) the inability to perform a physical examination, (ii) lack of visual and other cues of the patient's condition when compared to an in-person consultation, and (iii) technological limitations (eg, image quality, transmission lag and data breach). Therefore, not all medical conditions can be diagnosed or treated through tele-consultation. When tele-consulting, it is important to consider the following to mitigate these limitations:

i. **Assess the patient's profile for suitability**, including age (considering the needs and ability of the elderly and young), education level, social support, functional abilities (including cognitive) and technological capabilities. The patient must be comfortable and willing to use this modality, and escalation protocol should be in place for patients who require further evaluation;

ii. **Advise on limitations of telemedicine service before obtaining consent to proceed.** This may include limitations ofvideo resolution, potential for data breach, etc;

iii. **Recognise the challenges and limitations** in evaluating the patient's symptoms and conditions without a physical examination;

iv. **Take reasonable steps to verify patient identity prior to proceeding with consultation.** These steps taken should form part of clinical documentation;

v. **Take a thorough and comprehensive history** to better understand the circumstances of the patient;

vi. **Be reasonably confident that any physical examination of the patient is unlikely to add critical information** that could change the opinion or course of clinical management. If it may change the opinion, providers should direct the patient to an in-person consultation;

vii. **Be aware of the clinical "red flags"** which may trigger the need for a referral, an in-person consultation or urgent medical attention (ie, there should be clear escalation procedures without unduly alarming the patient); and

viii. **Clinical documentation for tele-consultation should be maintained at the same standard** as an in-person consultation (ie, documentation in their medical records or clinic management system) and the mode of consultation should also be documented in the case of a tele-consultation.

Doctors are advised to consider the above and develop protocols for medical conditions that they wish to manage via tele-consulting prior to providing the service.

In the setup of a telemedicine service, doctors should also consider the following components:

i. VC platform

- To safeguard the privacy of the consultation, doctors should use VC platforms with end-to-end encryption. These include the common consumer platforms in use today.
- Reasonable steps should be taken to confirm the identity of the person on the other end of the consultation.
- A chaperone should be present if the patient is undressing in front of the camera.

ii. Laboratory tests and vital signs monitoring

- Where required to manage patients over tele-consultation, doctors should consider the arrangements for laboratory, diagnostics and vital signs monitoring.
- This may include workflows for mobile phlebotomy and identifying registered, suitable and inter-operable vital signs medical devices.

iii. E-payment system

- A payment method, preferably electronic, should be set up to allow patients to pay for consultations and/or medications remotely.

iv. Medication delivery (optional)

- For the provision of medications following the consultation, doctors can consider the following options:
  - Request for patients or their family members to collect medications from the clinic
  - Work with logistics service providers (ie, delivery partners) to provide medications delivery from clinics
  - Partner with retail pharmacies to supply and deliver medications to patients
- Whether medication is supplied or delivered from the clinic or pharmacy, doctors and pharmacists should comply with the Singapore Standards for the Supply and Delivery of Medication (SS SDM 644).

Use of telemedicine in the current COVID-19 outbreak

Besides playing a crucial role in chronic disease management, telemedicine can also be a supplementary tool at doctors' disposal for fights against infectious disease pandemics to limit spread and exposure.

As mentioned in the *Straits Times Forum* on 29 January 2020,[3] telemedicine

has been identified as a possible method to manage patients in the community during infectious disease outbreaks and to prevent further spread of the disease. As we fight the spread of COVID-19, telemedicine can allow patients to contact their doctors remotely and receive immediate medical attention without physical contact, where appropriate.

The golden rule of stopping any infectious disease outbreak is to break the chain of transmission. This can be achieved by isolating patients who have the disease and quarantining close contacts or people who have been exposed to the communicable disease.

It is possible for patients who are on leave of absence or in quarantine to be managed in situ via monitoring. However, there is a need to align the triggers with the latest Case Definition and to ensure that these can be reasonably assessed over telemedicine. This will reduce the burden on the healthcare system and resources can be diverted to patients who have more severe symptoms.

All doctors should refer to the Ministry of Health (MOH) website for the up-to-date Case Definition of a COVID-19 suspect case.

Considerations to setting up telemedicine services for clinics

The Workgroup advises patients who are feeling unwell (excluding emergency medical conditions) to contact their family doctor via a telephone consultation first. Based on the prevailing Case Definition, doctors should then exercise sound clinical judgement to determine whether an in-person consultation or a VC is necessary to help them determine the next course of action (ie, escalate as a suspected case or to continue with standard management).

Doctors currently with no VC capabilities can either (i) refer patients to a telemedicine provider with VC capabilities, (ii) sign on with an existing telemedicine provider or (iii) purchase a telemedicine platform with VC services (as indicated above). Telemedicine providers should make their contact details available to all doctors for easy referral, and to the public through various social media or Internet platforms.

Process of tele-consultation specific to the current COVID-19 outbreak

Patient registration/verification

- Refer or escalate patients with serious conditions requiring urgent in-person management (eg, chest pains and respiratory distress)
- Request for name, date of birth, NRIC number, gender, residential address, allergy status, past medical history and existing medications
- Ascertain current location of patient – to direct emergency services if necessary

History-taking (for upper respiratory tract infection [URTI])

Screen for COVID-19 suspect criteria

(refer to the latest update of MOH Suspect Case Definition for COVID-19 for further details)

- Review travel history (recent travel history to China within 14 days before onset of illness), exact location of travel and/or any hospital visits
- Any close contact* with patients diagnosed with COVID-19
  - Including occupational risk factors as defined in the prevailing Case Definition
- Fever
- Cough
- Breathlessness
- Generalised malaise
- Myalgia
- Nasal congestion and discharge
- Sneezing
- Sore throat or hoarseness
- Watery and/or inflamed conjunctivae
- Others: Headache, diarrhoea, nausea, symptoms possibly suggestive of pneumonia (eg, shortness of breath, delirium, chest pain, wheezing)
- Onset/course/duration of symptoms, characteristics of discharge/sputum
- Review allergens, seasonal problems, exposure to irritants/smoke
- Review history of respiratory disease (eg, asthma, bronchitis)

**Close contact defined as: anyone who provided care for patient, including healthcare worker or family member, or who had other similarly close physical contact, or anyone who stayed at the same place as a case.*

Patient examination

- Patient examination will be limited to what you are able to see or hear during the VC
- Temperature using home thermometer (any antipyretics taken?)
- Blood pressure, heart rate, respiratory rate at home
- Observe general appearance (well/comfortable vs unwell/toxic)
- Visualise patient's respiratory effort (look for signs of respiratory distress, including nasal flaring, usage of accessory muscles and inability to complete sentences)
- Inspect
  - Eye: Note "allergic shiners", tearing, redness and eyelid swelling
  - Nose: Note any nasal discharge, redness/swelling
  - Throat: Guide patient through opening their mouth and positioning their opened mouth in front of camera. May require external light source
  - Skin and mucous membrane: Check for cyanosis
  - Ear: Ask patient to turn head to right and left to observe for any swelling/redness over mastoid process
- Palpation: instruct patient to self-examine head and neck for enlarged or tender lymph nodes

NB: *In the event the doctor notes that there are suspicious signs of pneumonia that require a physical examination with auscultation of the lungs, the doctor should ask the patient to seek an in-person consultation.*

Management of high-risk cases (ie, patients who meet the Case Definition)

- All suspect cases of COVID-19 are to be isolated and admitted
- Call ambulance on behalf of patients
- Submit MD131 through online CDLENS portal or fax, under "Other significant disease: 2019 novel coronavirus"
- Conveyance of patients:
  - If patient is medically stable, send to hospital via the dedicated ambulance service at 6220 5298 (available 24/7):
    - Persons aged 16 years and above (including pregnant women) will be sent to the National Centre for Infectious Diseases
    - Children below the age of 16 years will be sent to Children's Emergency Department, KK Women's and Children's Hospital
  - If patient is medically unstable (ie, breathless, hypotensive), call for Singapore Civil Defence Force ambulance at 995:
    - Inform the ambulance operator that you are referring a suspect case of pneumonia with relevant travel history (aligned to the prevailing Case Definition)
- While waiting for ambulance, advise patient to:
  - wear a surgical mask at all times
  - practise self-isolation and avoid contact with others

Management of other cases (ie, patients who do not meet the Case Definition)

- Standard URTI treatment protocol
- Encourage patient to wear a surgical mask and practise precautionary measures to prevent the spread of disease
- Encourage patient to isolate himself/herself until the symptoms are resolved
- Encourage patient to monitor symptoms and to call back if symptoms deteriorate (ie, breathlessness, worsening cough, chest pain)
- Provide patient with a medical certificate of appropriate duration

Management of patients with symptoms suggestive of severe respiratory disease, but do not meet COVID-19 suspect criteria)

- Escalate patient to the emergency department
- Encourage patient to wear a surgical mask and practise precautionary measures to prevent the spread of disease

For patients who know that they meet the COVID-19 infection suspect criteria, screening and escalation via minimally a phone consultation is encouraged. Both doctors practising in physical clinics and telemedicine providers should call the MOH dedicated hotline for the patient accordingly.

For general URTI management, text-only, phone-only, or text and phone-only consultations are unlikely to meet the required professional standard as outlined in the SMC ECEG. Doctors should either escalate the patient to a VC or an in-person consultation. This is to ensure that visual cues are considered prior to diagnosing and prescribing treatment.

Telemedicine for patients with chronic diseases condition(s)

During this period, we understand that patients with chronic disease conditions need to continue with their regular follow-up with their doctors. As such, doctors may consider the use of telemedicine to follow up with their patients during this period to limit their patients' exposure to the infectious disease.

Doctors should ensure that patients are able to provide their recent readings (eg, blood pressure, glucometer readings and recent blood tests if available) during or prior to the tele-consultation so that the doctor can make the necessary changes to their medication dosing regimen.

Cost of telemedicine

Doctors should be explicit about the itemised cost of their telemedicine services, including information on medication costs, delivery charges and prevailing taxes, if applicable. ◆

For the accompanying Continuing Medical Education quiz on telemedicine, which will contribute to the core points on Ethics and Professionalism, please visit https://www.sma.org.sg/CMEQuiz.

References

1. *Singapore Medical Council. SMC Ethical Code and Ethical Guidelines (2016 Edition). Available at: http://bit.ly/2AxPyYU. Accessed 5 February 2020.*

A6 Telemedicine

1. If you engage in telemedicine, you must endeavour to provide the same quality and standard of care as in-person medical care. This includes ensuring that you have sufficient training and information to manage patients through telemedicine. Otherwise, you must state the limitations of your opinion.

2. You must give patients sufficient information about telemedicine for them to consent to it. You must also ensure that your patients understand any limitations of telemedicine that may affect the quality of their care in relation to their specific circumstances.

2. *Ministry of Health, Singapore. National Telemedicine Guidelines. 2015. Available at: http://bit.ly/33QArGL. Accessed 5 February 2020.*
3. *Dr Lee PS. Forum: Telemedicine can help prevent local outbreak. The Straits Times 2020. Available at: http://bit.ly/2vjyO8K. Accessed 5 February 2020.*

AWDS – Standing Up for Women Doctors

Text by Dr Gayathri Nadarajan
Photos by Association of Women Doctors (Singapore)

Gender quota in medical school

A medical class filled with more female than male students. A residency programme with an equal number of male and female trainees. These are scenarios we take for granted these days.

Let us journey back through time to the 1980s and 1990s when most industries, including medicine and dentistry, had a gender quota. The rationale was that ladies would eventually get married, have babies and leave; hence it was deemed futile to invest in training the female workforce.

Even when I went for an interview in 2002 to secure a grant for my medical school fees, I was told that I should not be too "gung-ho" about doing medicine because eventually, as per societal expectations, I would have to run the family and bear children, which may result in me leaving the workforce. The interview panel even persuaded me not to take up medicine. I still recall clearly my feelings of disbelief and dumbfoundedness.

Even meritocratic Singapore was not spared from the issues of gender inequality. The existence of many organisations under the Singapore Council of Women's Organisations (SCWO) tells the stories of the struggles faced and battles fought. One of such groups is the Association of Women Doctors (Singapore) (AWDS), an organisation that represents women doctors and dentists in Singapore.

Understanding the historical context behind the formation of the AWDS will give us a better perspective of its current role and the future it can help build for our community.

Organisations to promote gender equity

Besides the AWDS, there are over 50 organisations under the SCWO, including the commonly featured organisation, the Association of Women for Action and Research (AWARE). SCWO was established in the 1980s as the national coordinating body of women's organisations in Singapore, at a time when gender inequity was prevalent. At a national and international level, it represents the Singapore female population on various pressing issues. As the medical fraternity, we are indeed honoured that the current president of SCWO is Dr June Goh, an

1

anaesthetist from SingHealth and an ex-president of the AWDS.

The birth of the AWDS

Realising that there was a lack of a platform for female medical professionals to gather and brainstorm on issues they faced, a group of women doctors got together to set up the AWDS. In July 1998, after over a year of discussions, the association was officially set up and registered. Dr Kanwaljit Soin, orthopaedic surgeon and the first female Nominated Member of Parliament; Dr Jennifer Lee, ex-chief executive officer of KK Women's and Children's Hospital (KKH) during its transformation to a paediatric hospital; Dr Lucy Ooi, a social activist and advocate for the arts and mindfulness; and Dr Myra Elliot, dentist and maxillofacial surgeon active in global health, were the founding members of AWDS. Following which, dentist Dr Yeo Siang Khin, radiologist Dr Anne Tan Kendrick and paediatric neurologist A/Prof Choong Chew Thye, formed the backbone of the AWDS as its first core members.

Dr Yeo Siang Khin reminisces the association's humble beginnings: "The year was 1998 and I was a young mother looking to make new alliances with like-minded women dental and medical professionals. I walked into the KKH auditorium and next thing I knew, Dr Myra Elliot had put my name to be selected into the executive committee – and I was in. During those times, I was in charge of producing a newsletter and one must remember that during this early era, the dwindling twilight years of the nineties, many did not own mobile phones or even computers. Fortunately, I had access to an office computer, a printer and a Xerox machine in my dental clinic back then, and using a 'cut-and-paste' method, many newsletters were churned out that way, usually in the wee hours of the night."

AWDS started as a "go-to" centre for female doctors and medical students, and eventually evolved to be the body that represents Singapore female doctors and dentists at a national and international level. Over time, its role expanded such that the expertise within AWDS was harnessed to benefit the community through collaborations, public education and fundraising events.

Lifting of the medical school gender quota

From 1979 to 2002, females were only conferred one-third of the places in the only medical school then – the National University of Singapore (NUS) Medical Faculty (now NUS Yong Loo Lin School of Medicine). This led to "less qualified" male students being given a place instead of the "more qualified" female candidates. For many years, the core members of AWDS voiced their views against this practice of inequity, writing countless letters to the *Straits Times* and politicians.

Dr Anne Tan Kendrick looks back on this: "The AWDS committee was the backbone for me when I was president from 2000 to 2004 and fighting the gender quota. Kanwaljit and I flew to Japan to attend a conference held by the Convention on the Elimination of Discrimination against Women. I drafted several letters to the *Straits Times* with their approval. We met and debated with several members of parliament."

AWDS conducted a survey and presented data showing that the attrition rates between male and female were similar. This was presented to the ministers with support from the Singapore Nurses Association and AWARE. After numerous dialogue sessions, the quota was finally lifted in 2002. Without this victorious battle, many of us may not be reading this article as SMA Members.

Community work, well-being and advocacy

Following this, AWDS expanded their work beyond advocating for doctors and dentists, to the community. In its early days, AWDS worked with the Family Courts to have member doctors volunteer their services to help women filing for a Personal Protection Order (PPO) after being assaulted, saving them the trouble of visiting multiple places just to get a PPO. In appreciation, the Family Courts dedicated a plaque to AWDS on its Family Justice Tableau.

Dr Lucy Ooi, who was elated to find that the plague still remains on a wall in the Family Court building at Havelock Road, recalls: "They gave us a clinic space adjacent to the Family Court, which at that time was at Paterson Road, where we provided medical services to examine women who were victims of violence. These were women who wanted PPOs. We would examine them and record their injuries and the stories they told us."

AWDS also runs fundraising events for various organisations, such as the NUS Medical Society Community Involvement Projects, Sanctuary House and Pledge It Forward. The myriad of talents among the AWDS members is a

> *"Through AWDS, we hope to inspire and motivate women doctors and women in general to do more for themselves and for the betterment of others. We would like to help reshape how women perceive themselves. To have gender equality, you first have to firmly believe and know that you are just as capable and deserving, if not much more so."*
>
> – **Dr Ho Ching Lin**
> President, AWDS

strong catalyst for such advocacy, fund raising and health-related public events.

Workshops are organised for both the public and healthcare professionals, with the aim of community engagement and empowerment. For example, together with the Dispatcher-Assisted first REsponder (DARE) programme, a basic CPR course was held for those from the SCWO, which was well received by the females and their spouses. Recognising that today's professional women face challenges managing the various "hats" they wear and responsibilities they hold, we also organised a series of signature talks in 2019 targeting at equipping working women with life skills that will be helpful to them.

Wellness is something that AWDS strongly advocates for as well. We have to be kind to ourselves – allowing us to feel rejuvenated to take care of our patients and family. Annually, besides the Christmas event, there are various events promoting personal well-being as we recognise that while always putting our patients and responsibilities first, self-care is often neglected by healthcare professionals.

Collaboration with other professions is unique and highly valued in AWDS. We frequently organise events in collaboration with other societies, such as the Singapore Association of Women Lawyers, where we get to meet and learn from dynamic women from various fields. One of the most powerful stories I have heard was from Dr Sudha Nair, a social worker and the founder of Centre for Promoting Alternatives to Violence. She shared with us some of the heart-wrenching stories of domestic abuse, which can be emotional rather than physical – such as the spouse who overly controls, is constantly suspicious and refuses to give his wife their house keys.

Our next big project, with the support of SCWO, is a book describing the biopsychosocial approach to women's health. We hope that this book will help to empower women and increase health literacy, and we welcome anyone keen to contribute to it through AWDS.

Looking into the future

The challenges women face today are different and they come in various forms. To move forward as a meritocratic and successful society, we have to look out for each other. As the body representing women doctors, AWDS hopes to effectively address issues faced by doctors, dentists and the community. We also aim to help our members grow and develop in their areas of interest and expertise. Most importantly, we hope to impact the community through our various initiatives and collaboration with other organisations. ◆

Legend

1. Group photo taken with our guest speaker and founder, Dr Kanwaljit Soin, during our 20th Annual General Meeting in 2018

2. Past AWDS president, Dr Lucy Ooi, pointing to the plaque appreciating AWDS for their services at the Family Court

Dr Gayathri is a consultant at the Department of Emergency Medicine, Singapore General Hospital. She is also a pre-hospital doctor at the Unit of Pre-Hospital Emergency Care with a special interest in Global and Community Health. She currently serves as the secretary of the AWDS and pursues her community health interest through collaborative efforts with other organisations.

Vision and Mission of the AWDS

"The Association of Women Doctors (Singapore) aims to enhance the professional development and well-being of its members in the medical and dental profession by providing a social platform for networking and communication. The society serves as a voice for women's health issues and an advocate for the advancement of women in practice. The society serves to provide information on career guidance and mentoring, and is also active in organising seminars, forums and workshops relating to health concerns, particularly those pertaining to women and families."

Please scan the QR code or visit http://bit.ly/2Ph4hzq to respond to a short survey by AWDS on the issues female doctors face and how the association can help.

To find out more about the AWDS and their work, visit https://www.awds.org.sg.

Holding Up HALF THE SKY

WOMEN IN SINGAPORE MEDICINE

Text by A/Prof Gan Yunn Hwen and A/Prof Sophia Archuleta

A/Prof Gan is an associate professor at the Department of Biochemistry and the Assistant Dean for Equal Opportunities and Career Development at the NUS Yong Loo Lin School of Medicine. She is a scientist working on infectious diseases.

A/Prof Archuleta is the head and senior consultant of the Division of Infectious Diseases at the National University Hospital. As a clinician educator, her clinical expertise and primary interest, is in the care of people living with HIV and its associated conditions.

Mao Tse-tung's famous saying reflected his appreciation of the critical role that women played, and continue to play, in China's national growth, progress and development. Decades later, Mao's conviction would be echoed by Michelle Obama at the Summit of the Mandela Washington Fellowship for Young African Leaders in July 2014: "No country can ever truly flourish if it stifles the potential of its women and deprives itself of the contributions of half of its citizens."

Women hold up half the sky in Singapore too – they raise children, care for the elderly at home, and many also hold down jobs at the same time. In healthcare, women now figure prominently across the range of roles, from administrators to nurses and from allied health professionals to doctors.

Despite the critical and diverse roles and responsibilities undertaken by women here, their economic status, corporate status and progress show a disturbing picture. Like their counterparts in many countries, Singaporean women still lag behind men in terms of income and career progression in many professions. According to a *Straits Times* report,[1] women's pay has not improved in the last ten years, with men earning 20% more.

The report cited a study by consumer research firm ValuePenguin, which reviewed data from the Ministry of Manpower (MOM). The information indicated that in 2006, the median gross monthly income of men was about $2,452, approximately 19% higher than the $2,053 for women.

In 2016, the median monthly income for Singaporean male workers rose to $3,991. This was 18% higher than the median for women, which was $3,382. Encouragingly, the report added that wage gaps narrowed in health and social services, as well as in manufacturing, public administration and education, information and

CLASS OF 1947

Tan Sri Dr Salma binti Ismail

The late Tan Sri Dr Salma was born on 19 December 1918 in Alor Setar, Kedah. She received her early education at the Kampung Bahru Girl's Kedah, passing her Junior Cambridge in 1934 and Senior Cambridge in 1935, the latter with distinction. She then continued her education at the King Edward VII College of Medicine in Singapore in 1936 under a scholarship by the State Government of Kedah. She was conferred a degree in Medicine in 1949, making history as the **first Malay woman to qualify as a medical practitioner in Malaya**. Dr Salma practised in Kedah and Selangor and died of old age in Malaysia.

CLASS OF 1955

Tun Dr Siti Hasmah Mohamad Ali

Tun Dr Siti Hasmah has set an example of personal and professional achievement for women in her country, campaigning tirelessly for women's health, family planning, drug abuse control and adult literacy.

Often a pioneer in her profession, Tun Dr Siti Hasmah was one of the first Malay women to enrol for a medical course at the King Edward VII College of Medicine in Singapore after the war.

In 1955, she graduated as a medical doctor from the Faculty of Medicine, Universiti Malaya, Singapore, and joined the government health service. Ten years later, she became the **first woman to be appointed medical officer** in the Maternal and Child Health Department and, in 1974, became the first woman to be appointed the State Maternal and Child Health Officer.

Tun Dr Siti Hasmah is the author of several articles on family medicine and the socio-economic factors associated with pregnancy and childbearing in Malaysia and has held a number of posts. She has served on various associations, including being the patron of the Malaysian Association of Maternal Health and Neonates. She has also been active in efforts to educate young people about the dangers of drug abuse.

Her decades of public service, voluntary work and leadership in the fields of public health, literacy and drug abuse control saw her honoured on numerous occasions, including awards from Malaysia's Yang Di Pertuan Agong, as well as the sultans of Selangor and Kedah.

communications, and financial and insurance services.

Two years later, things have not made much progress. According to another *Straits Times* article,[2] research conducted by jobs website Glassdoor found that women are still earning 13% less than their male counterparts. Among high-paying jobs, the MOM found that the largest pay gap was in specialist medical practitioners, with women specialists making only about 49.7% of their male colleagues' median wage.[3]

Various reasons for under-representation

The disparities are most visible at leadership levels in the professional and occupational areas, with women under-represented in leadership ranks relative to their overall numbers and qualifications, compared to other developed countries.[4]

There are various reasons to explain this continuing gulf between the genders – chief of which are societal norms and values. These biases in structures, systems, policies and processes throughout our society could be subconscious, meaning our behaviours, choices and practices are shaped by underlying assumptions and attitudes without us even realising.

These have been cited as reasons for women being assigned disproportionate responsibility for family caregiving and "softer" roles such as nurturing or welfare-supporting functions that are generally accorded less value in organisations. This, together with inadvertent effects of government policies, hold women back from making the same sort of progress marked by men. It is a development that could put women at greater risk of financial hardships in old age especially when women live longer than men; the same *Straits Times* article reported that women aged 60 years and older had Central Provident Fund (CPF) balances that were 69% of the average men's balance, while females aged between 55 and 60 years had CPF accounts that were 84% of their male counterparts'.[4]

Women in Singapore healthcare

What is beyond debate, however, is the participation and crucial roles that women around the world have played in healthcare, which first gained significance in the 1800s with the work of Florence Nightingale and the International Committee of the Red Cross.[5] The preponderance of women in nursing reflected the historical dominance of men in medicine – a situation that was also replicated in Singapore. The country saw very few women enrolling in medical school; the second graduating class of the Straits Settlements Medical School (the forerunner of the National University of Singapore [NUS] Medical School) in 1911 included just two women – E Nunes and JS Lee.[6]

Modest beginnings notwithstanding, the list of early women doctors in

Singapore includes the late Tan Sri Dr Salma binti Ismail, Tun Dr Siti Hasmah Mohamad Ali, Prof Low Poh Sim, Prof Chay Oh Moh and Prof Leo Yee Sin. (Read more about their achievements in their respective panels.)

Despite their historical and early active involvement in medicine and healthcare through the centuries, women today are still not as well represented in leadership roles, such as heads of department and assistant or vice-chairs of medical boards, as their male counterparts. At the National University Health System, 2019 figures show that women hold 21.2% or 41 out of 193 senior leadership posts, and out of a clinician population of 1,700, women make up 39.1%, or 664. At the NUS Yong Loo Lin School of Medicine (NUS Medicine), 33.3% assistant professors, 28.6% associate professors and just 10.1% tenured full professors (as of 2019) are women.

At the National Healthcare Group, women occupy 32 of 117 senior leadership posts in 2019. Out of the clinician population of 1,512, women comprise 42%. Over at SingHealth, 48% of the 2,393 clinicians are women and they hold 76 out of 272 leadership positions.

More women in medical practice today

The 1979 quota capping female enrolment in medicine at NUS to just a third has been identified as a major contributing factor to this imbalance in gender representation.[7] In the intervening years, Singapore's steadily ageing population, higher immigration flows, as well as the attrition of doctors leaving for the private sector, led to an increase in demand for healthcare services, which translated into a need for more medical staff. The growth of Singapore's biomedical research and development sector that added to the growing demand for more doctors also helped to convince the Government to abolish the policy in 2003. The decision was well-received universally and "served to rectify the anomaly in which 'less qualified' male students were preferentially admitted to NUS Medicine over 'more qualified' female students, many of whom went overseas to study medicine and never returned to Singapore."[8]

Five years after the quota was removed with the strong support of the Remaking Singapore Committee's Group on Women's Issues, the Association for Women Doctors (Singapore) and Members of Parliament Dr Lily Neo and Mr Charles Chong, [9] women made up nearly 49% of enrolment in 2008 for the NUS Medicine undergraduate degree programme. In 2018, the intake of females comprised at least 55% of the freshman cohort entering NUS Medicine. In the same year, the percentage of females enrolled in Duke-NUS Medical School made up at least 53% of the incoming cohort, while they comprised between 30% and 40% of the students in the Lee Kong Chian School of Medicine's first four intakes.[10] The female students from NUS Medicine are at the forefront of student leadership, helming projects and initiatives such as large-scale public health screening campaigns, as well as community service programmes here and even in neighbouring countries.

Working towards a better tomorrow

We are hopeful that women will eventually fill more leadership posts in the coming years but this requires

CLASS OF 1974

Prof Low Poh Sim

Senior Consultant, Division of Paediatric Neurology, Khoo Teck Puat-National University Children's Medical Institute

National University Hospital Professor, Department of Paediatrics, NUS Medicine

Prof Low is a senior consultant paediatrician and is one of Singapore's leading specialists in paediatric neurology.

Her long and distinguished career of 40 years has seen her hold key appointments, including being Chairperson at the Khoo Teck Puat-National University Children's Medical Institute, National University Health System (NUHS); Head of Department of Paediatrics at NUS Medicine and the National University Hospital (NUH); as well as Associate Dean at NUH. She has also been Head of the Division of Paediatric Neurology and Developmental Paediatrics and is a member of several medical advisory panels.

As Head of the NUH Division of Paediatric Neurology, Prof Low led her team to develop greater capabilities in clinical services and oversaw the development of new and essential clinical services and programmes in the area of paediatric neurology, as well as the development of the Child Development Unit at Jurong Medical Centre.

Over the years, Prof Low has also nurtured and mentored countless young paediatricians, many of whom are now established paediatricians and leaders in the profession. She has been appointed by the NUS as the Chief Examiner for the Master of Medicine in Paediatrics, a post she has served faithfully in for the past 20 years. With the introduction of the residency programme for post-graduate training in Singapore, Prof Low continued to play a seminal role in maintaining national training and assessment standards as a member of the Residency Advisory Committee and the Chief Examiner for Paediatric Medicine.

Prof Low's sustained involvement in and commitment to the area of clinical care and student development runs alongside her research work, which has resulted in the publication of several scientific papers in high-impact peer-reviewed journals.

CLASS OF 1976

Prof Chay Oh Moh

Senior Consultant, Department of Respiratory Medicine, KK Women's and Children's Hospital

Prof Chay is a senior consultant in the Department of Respiratory Medicine Service of the KK Women's and Children's Hospital (KKH). She is also the Associate Designated Institutional Officer of SingHealth Residency, Campus Director of KKH, and Professor in Paediatrics, Duke-NUS Medical School and NUS Medicine.

For more than 20 years, Prof Chay has been an outstanding mentor and educator par excellence, making significant contributions to the professional initiation and development of innumerable medical students and residents in the areas of paediatrics and paediatric respiratory medicine, with her teaching, training and mentorship.

As the first Academic Chair of the SingHealth-Duke NUS Paediatric Academic Clinical Programme, she established a robust framework that has effectively cultivated strong mentor-mentee relations across all levels of doctors at KKH, as well as in SingHealth. She was awarded the National Outstanding Clinician Mentor Award, National Medical Excellence Awards 2014.

CLASS OF 1983

Prof Leo Yee Sin

Director, Institute of Infectious Diseases & Epidemiology

Clinical Director, Communicable Disease Centre

Senior Consultant, Department of Infectious Diseases, Tan Tock Seng Hospital

Clinical Professor, NUS Medicine

Prof Leo proved her mettle during one of the worst health crises to hit Singapore in recent times: the 2003 SARS virus outbreak. She has also participated in the fight against Chikungunya and pandemic influenza virus outbreaks during the late 1990s and 2000s. While heading the Institute of Infectious Diseases and Epidemiology at Tan Tock Seng Hospital, Prof Leo was also involved in various research in dengue, influenza, HIV and emerging infections. Singapore's evolution from developing to developed country has led to changes in the disease landscape.

intentional efforts by institutions and individuals to recognise, acknowledge and address the issues. Since 2017, the National University Health System's (NUHS) Women in Science & Healthcare (WISH) has been working closely with the NUHS leadership to raise awareness, facilitate access and promotion for women, as well as address misperceptions and unconscious biases in the clinical and medical sciences. More recently, the creation of the Equal Opportunities for Career Development Office within NUS Medicine in 2019 seeks to plug the leaky pipeline of women in academic medicine and aims to offer both men and women equal opportunities and rewards in academia. We look forward to embracing a future where more women can fulfil their full potential as they continue to make their mark in medical thought and practice, and help shape the course of health-care in this country and beyond. ◆

Disclaimer: All figures cited in the article were contributed by the relevant parties.

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Care and Support Planning Conversations in Diabetes Management

Text by Dr Yew Tong Wei, Dr Tan Wee Hian, Dr Victor Loh, Dr Choong Shoon Thai, Prof Doris Young and Prof Tai E Shyong

Introduction

Patient-centred care is care that is "respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."[1] It has been associated with better adherence and quality of care, as well as improved health outcomes for long-term conditions (LTCs), leading to lower healthcare utilisation and cost.[2,3] The ideals of patient-centred care require the holistic healthcare professional (HCP) to skirt at least two complex tasks within the confines of a consultation: (1) understanding patients as holistic persons with preferred values and goals and (2) providing medical expertise that will improve the patients' clinical outcomes. Both are necessary to improve a patient's long-term health.

Is our current ambulatory model of care able to achieve this? The short answer is: not always. Most healthcare systems around the world have to deal with patients with acute episodic conditions, which usually respond predictably to the prescribed treatment (often medication or a surgical procedure) and go away once the treatment is completed. The typical consultation, where an HCP might address a presenting complaint, perform a focused clinical examination and prescribe appropriate therapies based on evidence-based guidelines, may be extremely effective for the management of acute illnesses. By building on this model, Singapore's healthcare system has become one of the most efficient in the world. However, the typical model may not work so well for people living with LTCs.

The unique challenges of LTCs

Unlike acute illnesses, LTCs such as diabetes, hypertension and hyperlipidaemia, once established, stay with a patient for the rest of their lives. As they live their lives, our patients make decisions and choices every day that impact these LTCs. These include choosing what food to eat, whether to take the bus or a cab, or whether they take their medication. In turn, these choices are affected by other factors in their lives, such as the stressors they face, personal preferences, jobs, friends and family members.

Patients see their HCPs for an average of three hours per year (and that's being generous).[4] LTCs wax and wane as their lives wax and wane. Sometimes, the LTCs impact their lives; at other times, their lives impact their LTCs. Seldom do these cycles follow the regular scheduled visits through which we provide care. This means that at most times, we are not there when a patient really needs us. This makes it particularly important to build partnerships with our patients to develop a care plan that enables them to make decisions about goals, therapeutic options and self-care behaviours for reasons that matter to themselves. Patients are then more likely to assume responsibility for these care plans and live more effectively with their LTCs.[5]

Besides the limited time that we have with patients, the relentless drive for efficiency and measurable outcomes may also work against us. We have all been in a situation where patients are queueing outside our door, complaining about the waiting time, while we are trying to get our clinics finished so that we can take a short break for a meal before we begin again. We just want to assess the situation, identify the right treatment, prescribe it and move on. We simply do not have time to think about why a patient does not want to take particular medications or is not able to engage in regular physical activity. Nor are we able to have discussions about more general issues in their lives that, although not appearing to be directly related to their LTCs, might be the only stumbling block to living well with the condition.

Our healthcare practitioners who were trained by the YoC UK team to facilitate care and support planning conversations

As a consequence, the prescribed goals may not align with the patient's own goals and they may not follow through with the plans. If the prescribed goals are not met, patients may (rightly or not) perceive themselves as being judged by their HCPs, particularly with the emergence of terms such as "non-compliance", "non-adherence", or even "lazy" and "naughty" used to describe our patients (we've all said this, so there's no point denying it). In the wake of patients perceiving themselves as a "failure", frustration and resignation may follow, which results in a vicious cycle that ultimately leads to poor outcomes for both the patients and the healthcare system.[6]

We know that this is happening in our healthcare system. As part of a design thinking work stream under the War on Diabetes, our Ministry of Health (MOH) conducted a number of in-depth discussions with patients living with diabetes who received care across a broad spectrum of care contexts. When asked about their experience with diabetes care, some patients brought up what they perceived to be the judgemental, unfeeling attitude of some HCPs:

> "This guy, he whack me, you know – the way he talk. I just sit there and let you whack. You are right *lah*, I am wrong. Talk to you no point, I just get my medication [and] go off. He ridiculed me."
>
> "The nurse is very scary also… she told me am I cheating my readings, am I like faking it… she said for this type of reading, you should have some symptoms… which I don't have… And then it's like you don't believe me. What's the point I show you?"

Asked to describe their ideal care experience, the patients mentioned aspects such as being heard and respected by their care team; having goals that were realistic and important to them; and having specific assistance when they had difficulty adjusting their diet and exercise, or managing their complications and treatment side effects.

A Citizen's Jury, comprising 76 members of the public, was subsequently convened by the MOH, in collaboration with the Institute of Policy Studies in 2018. It identified priority areas for improving diabetes care, including the empowerment of patients and caregivers in order to make better care decisions; closing the gap between patients' and HCPs' goals; and enhancing the manner of communication by HCPs, as exemplified by the principles of motivational interviewing, in order to better facilitate the attainment of patients' needs and goals.[7] In other words, they wanted care to be more patient-centred.

These concepts are not new. As clinicians, we are taught about effective communication in medical school, and many of us have long recognised the importance of patient engagement. The MOH also urges Singaporeans to take individual responsibility for our own health. Our Minister for Health recognised that healthcare is a partnership between providers and patients when he said, "When we replace 'I' with 'We' and we do it together, 'Illness' can become 'Wellness.'"[8]

This is not something that can be applied only to a few "difficult" patients. Previous studies have emphasised that care planning conversations need to be incorporated into routine clinical care rather than part of a side programme.[9] As providers, the challenge we face is how we could achieve this while meeting the demands for efficiency and sustainability placed on our healthcare system by an ageing population that suffers from an increasing burden of chronic, non-communicable disease.

Year of Care model of patient-centred care

The Year of Care (YoC) patient-centred care programme was initiated in England in 2007. Modelled partly after Wagner's Chronic Care Model,[10] the YoC programme envisaged care delivery in a healthcare system organised to enable partnership between "engaged" or "activated" patients and their HCPs. The ultimate goal is to facilitate patient self-management.

The "House of Care" figure depicts this model. Central to the YoC model of care is the collaborative Care and Support Planning (CSP) conversation. It is the platform on which an engaged patient (left wall) discusses what matters to the patient with the HCP (right wall). In collaborative CSP conversations, both patients and the CSP-trained HCPs work collaboratively to identify areas of need, set goals and decide on specific actionable plans that the patient agrees to undertake to achieve these goals. Barriers to achieving the goals and contingencies, should these arise, are discussed. Commissioning by the healthcare cluster (information technology support, training and health service delivery) forms the base of the house, and organisational processes (electronic medical records, results letter sending and so on) form the roof. Using this framework, YoC UK has been able to improve patients' self-care behaviour and experience of care, as well as enhance teamwork, productivity and job satisfaction among HCPs.[11]

We discuss some of these aspects in further detail in the following description of a pilot programme that we have undertaken in Singapore.

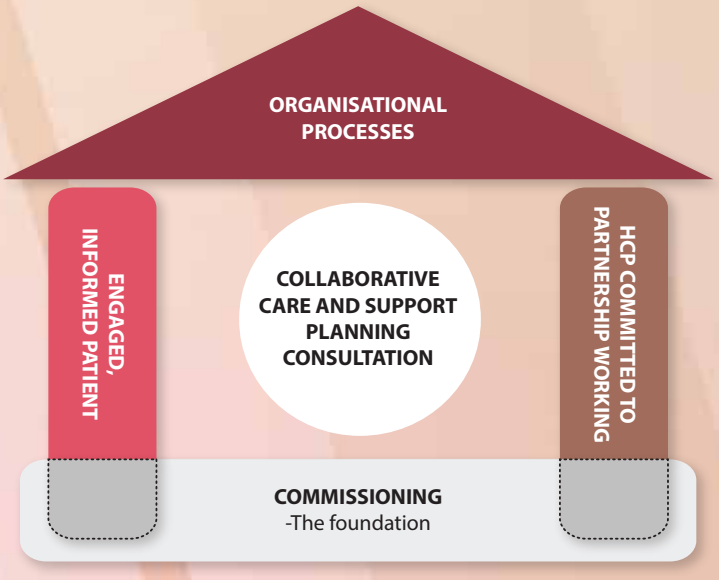

Figure 1. House of Care Framework of the YoC model
Reproduced with permission from Year of Care Partnerships

Bringing the YoC model to Singapore

Learning from the YoC UK team

While on attachment to Ninewells Hospital in Dundee, Scotland, from August 2014 to July 2015 on an Academic Medicine Development Award (AMDA) scholarship, Dr Yew Tong Wei experienced first-hand how Scotland adopted the YoC model of care. He was involved in the organisational changes required to enable the model and learnt how to conduct CSP conversations. In doing so, he experienced both the effort involved and the overwhelming benefits of CSP conversations on enabling patient self-care for LTCs. On his return, he found like-minded colleagues at the Division of Endocrinology, National University Hospital (NUH), who realised that this way of delivering care may provide an opportunity to bring patient-centred care to the healthcare system and address some of the implementation challenges we have described. With support from the National University Health System and the Kewalram Chanrai-Enpee Group Research Fund in Diabetes, the team embarked on a plan to implement a YoC-like programme in Singapore, starting with the NUH diabetes clinic.

In July 2017, YoC trainers Drs Lindsay Oliver, Nick Lewis-Barned and Yvonne Doherty travelled to Singapore to train 30 endocrinologists, GPs, nurses, pharmacists and dietitians in facilitating CSP conversations. They focused on several key principles, including approaching patient care as a collaboration between two experts – the patient as an expert in their own lives and the HCP as an expert in treating disease. The trainers shared techniques for uncovering patients' true motivations and goals, as well as tools for working together with patients to develop a plan of action to support them in their self-management and help them achieve their goals.

Implementation at NUH

Arming our HCPs with skills and knowledge alone was not sufficient. Implementing the CSP conversations in the clinical workflow required a redesign of many aspects of care.

The first, and perhaps greatest, challenge, was to make time for CSP conversations in a schedule that barely allows most HCPs time to breathe, never mind to indulge in long conversations with their patients.

To start with, it was determined that CSP conversations would only be carried out once a year, at the time that the patient undergoes his/her annual diabetes screening tests, thus limiting the impact on the HCP's schedule. In order to allocate time for the CSP conversations (20 minutes vs ten minutes for a usual consultation) in packed clinic schedules, the endocrinology team settled on a strategy to start clinics earlier in the day, for example at 8.40 am instead of 9 am to incorporate one CSP session, or at 8.20 am to incorporate two CSP sessions.

Secondly, the team realised that, in a typical consultation, a disproportionate amount of time may be spent on explaining test results to patients. In addition, when the results are sub-optimal, the patient does not have time to process the information and engage in a productive conversation about the possible reasons behind the results, or to discuss the next steps that could be taken. To address this, an easy-to-understand results letter (see Figure 2) was designed, incorporating input from patients to ensure that it would be easily understood. In the redesigned workflow, patients were asked to come earlier for their annual tests and complications screening, and the results in the form of a completed results letter were sent to them ahead of their appointments. This reduced the need to communicate results during the consultation, creating space for the collaborative conversation to take place.

The prior communication of the results to patients also provided an opportunity for them to better prepare for the CSP conversation. Prompts in the results letter were designed to help prepare patients for the CSP conversation by encouraging them to reflect on their aspirations, needs and concerns prior to the CSP conversation (see Figure 2) and document them, so that the time in the CSP conversation could be more effectively used.

In October 2017, the pilot YoC Singapore programme was launched at the NUH diabetes clinic. Two clinical coordinators were hired for the programme and patients were recruited. In January 2018, the first CSP conversation was held. To date,

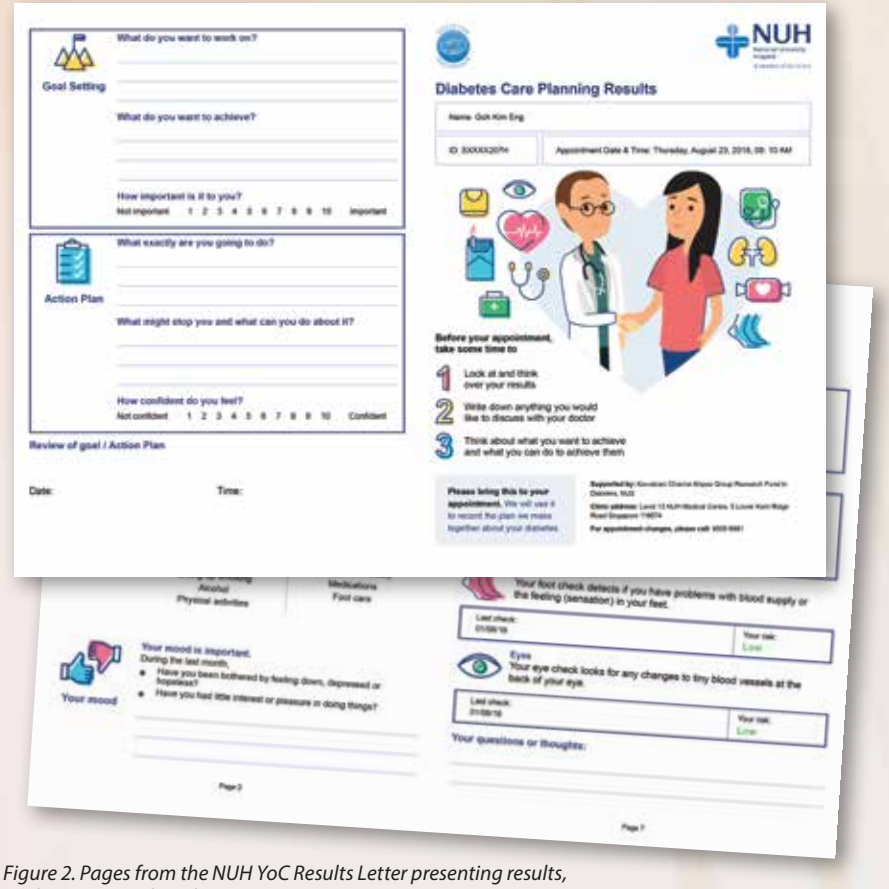

Figure 2. Pages from the NUH YoC Results Letter presenting results, explanations and goal-setting prompts

176 patients living with diabetes have been enrolled in the programme and 158 have completed at least one CSP conversation. Out of these 158 patients, 59 have completed their first and second CSP conversations. For the most part, both patients and HCPs have responded favourably to the new format.

Implementation challenges

There was a steep initial learning curve for most HCPs. It required them to be skilful in encouraging patients to talk about very personal things, such as their feelings, motivations and fears. This meant adopting a communication style that encouraged patients to surface their goals and concerns and occasionally providing on-the-spot responses to patients' concerns. With practice, the HCPs became more skilful in facilitating CSP conversations.

"It wasn't easy at the start. I found myself reverting to old habits of jumping in and 'lecturing' the patients. This is called the 'righting reflex' – an urge to want to 'make things right' whenever we see a problem," recalled Dr Yew. "It required me to be very mindful, but with practice I can now communicate in a collaborative manner more naturally."

As we have moved into our second CSP visits with our patients, we find that patients also became more effective at articulating their needs and aspirations and working with their HCPs to set goals. Thus, over time, the time required for a CSP becomes shorter, allowing more CSPs to be conducted within the context of our usual practice. This gradual implementation to allow HCPs to adapt is a key part of the process and we would advise any healthcare system considering implementing a similar programme to adopt a staged approach. We are also applying these and other learnings in our patient-centred care study in primary care, called Patient Activation through Community Empowerment/Engagement for Diabetes Management (PACE-D).

We think we can finish here by saying that the challenge of LTCs is far from solved. Implementation needs to be carried out at all levels, including the smallest unit of healthcare delivery – the solo practitioner. But we believe that programmes like YoC offer a glimpse of what is possible, and are a starting point for our journey towards patient-centred care. Whatever we implemented is likely to require future iterations to continuously improve the process, so as to optimise benefits not only in the lives of our patients, but also in the lives of our HCPs. We are delighted to have the opportunity to share some of our early experiences with you as we take this long journey together.

Acknowledgements

The authors would like to acknowledge Dr Khor Ing Wei for her assistance in the writing of this article; the Year of Care Partnerships, National Health Service UK, for training and advice; and the Kewalram Chanrai-Enpee Group Research Fund in Diabetes for funding this programme. ◆

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Dr Yew is a consultant in Endocrinology at NUH. He leads the YoC pilot at NUH and is passionate about helping patients live well with diabetes.

Dr Tan is a consultant family physician and Head of Pioneer Polyclinic, National University Polyclinics.

Dr Loh is a senior consultant at National University Health System (NUHS) and education director of family medicine at the National University of Singapore (NUS). He trains primary care practitioners in care and support planning.

Dr Choong has been a family physician at Jurong Polyclinic since 2003. He was introduced to the YoC programme in 2017 and became a trainer for the PACE-D programme in 2019.

Prof Young is the head of the Department of Family Medicine at NUHS and a professor of family medicine at the NUS Yong Loo Lin School of Medicine.

Prof Tai is a senior consultant in endocrinology at NUH and the director of the Centre of Excellence for Chronic Disease Prevention and Management at NUHS. Patient-centred care is one of his passions.

A New Chapter Begins with *Thank You*

– SMACF's Appreciation Dinner

Text by Sara Kwok, Executive, SMA Charity Fund

"Enter this new year with a gratitude for this new chance to create your dreams" – Avina Celeste

There is no time more fitting to express our gratitude to the main drivers of the SMA Charity Fund (SMACF) – the group of people operating behind the scenes – than during this jolly New Year season. On 8 January 2020, SMACF's Board Members celebrated the beginning of 2020 with a dinner held at a local restaurant, hosted by SMA's 1st Vice President, Dr Tan Yia Swam. The dinner was organised in appreciation of the former's service in 2019. Attended by SMA Executive Committee Members, as well as the deans of two medical schools, the event saw people from different backgrounds gathered because of their belief in a single worthy cause.

In her speech, Dr Tan, representing SMA, thanked SMACF's Board Members for their selfless giving of time and unwavering support, without which we would not have been able to achieve our mission of helping needy medical students from the three medical schools by disbursing a record of 57 bursaries worth $285,000 in 2019. This was the highest number of bursaries awarded since SMA started the ball rolling in 2007 with the SMA-Medical Students' Assistance Fund at the National University of Singapore Yong Loo Lin School of Medicine. Dr Chong Yeh Woei, Chairman of SMACF, also took the opportunity to propose a toast in appreciation of SMACF's board members, for their contribution and support.

The chemistry prevalent at this gathering of like-minded and passionate group of givers was a joy to witness as they shared ideas on how we could do more to propel and inspire the next generation of physicians to give of themselves in kind and in deed for their patients, the community and those in need. As the evening unfolded, there was a strong sense of camaraderie and generosity which augurs well for all of us as we look forward to another year of meaningful collaboration and support for our beneficiaries.

The evening ended with a group photo as a representation of our renewed commitment to work together in support of our beneficiaries – the needy medical students in our schools.

Once again, we thank each and every one of those present for their passion, contribution and efforts. We would also like to take this opportunity to thank donors for your continuous support – thank you for believing in us. It has been a privilege for SMACF.

And now, let us welcome the New Year. Let new adventures begin! ◆

Legend

1. SMA ex-officios, SMACF Board Members and guests at the appreciation dinner

SMC Ordered to Pay Costs

JUSTICE SERVED?

Text by Dr Mona Tan

The recent judgement of the Court of Appeal where the Singapore Medical Council (SMC) was ordered to pay a plastic surgeon's legal fees evoked a sense of conflict within me. On the one hand, I rejoiced with my colleague's triumph that the Court had upheld the Disciplinary Tribunal's (DT) decision against the patient. At the same time, I felt dismayed that SMC is now required to pay the costs of the surgeon's legal fees. Eventually, that cost would be transferred to me as a registered doctor. When divided among all the medical professionals registered with SMC, it would probably be a small quantum for this episode, but if more of such instances were to come, it could add up to a significant amount. This would inevitably lead to an increase in our SMC registration fees which have been rising steadily over the years.

I note that the DT found this patient to be a "sophisticated, capable and highly educated professional" whose complaints were "vexatious and baseless", her allegations false and that she had lied in other areas. This is startlingly similar to what Lord Bannatyne said of Nadine Montgomery in her suit against the Lanarkshire Health Board. He assessed her to be a highly intelligent person, who appeared to be "rewriting history in the light of the outcome", with a "pattern of overstatement and exaggeration".[1] This is also consistent with studies which show that 48% of patients imagine or misconstrue what was said to them during a medical consultation,[2] an occurrence not uncommon in my experience.

Unfortunately, the Scottish Supreme Court overruled Lord Bannatyne's judgement without re-examining Mrs Montgomery as a witness and awarded her £5.25 million in damages. Sadly, this case formed the basis for the standard of informed consent.

It is evident that, as a consequence of the Montgomery case, more patients are emboldened to submit complaints to SMC when unfavourable treatment outcomes occur, disputing the validity of their documented consent. It is troubling that the SMC Complaints Committee sought to escalate this case and convene a DT. It is distressing that an "innocent party" like me would now be called upon indirectly to pay for SMC's legal fees. The complainant in this case was found to have lied and is therefore possibly guilty of perjury. Has justice truly been served if she is exempted from paying costs arising from her baseless complaint? ◆

Dr Tan is a breast surgeon in private practice, who enthuses professionally about breast conservation treatment and personally about organising trips which allow time away from work. However, since the second requires resources from the first, she reluctantly continues with her career to provide funding for her breaks.

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Through the Eyes of a Medical Student:

LIFE AT KING'S COLLEGE HOSPITAL

Text by Han Shu Xin

Week 1

Team – together, everyone achieves more

It was my first day at the Emergency Department (ED). I was pretty lost. I recall trying to get from the card collection office back to the ED, which had me take a few detours down different corridors, only to find myself time and time again back at the same spot. I marvelled at the wide array of patients I walked past as I was doing so – the dark-skinned, blonde and blue-eyed – along with the occasional chatter in British English. This was all a whole new world to me. Eventually, I managed to stumble back to trauma nurse Iona Polson's office, with the help of the staff at the information desk. I also made it a point to geographically map the locations of the different departments in my head so that I will never be lost again.

I was assigned to Max, the Emergency Nurse Practitioner (ENP) on duty at the Urgent Care Centre (UCC) that day. The UCC was completely packed, and yet the ENPs remained calm, treating each patient with utmost care. The occasional grumble by patients who had been waiting in line for a long time were met by helpful nurses who kindly assured them that they were next in line, or suggested that they have a light tea break if a long wait was expected. The

phlebotomist was busy trying to calm an anxious patient to take some blood for tests.

Despite the flurry of activity going on, communication between staff and fellow staff or patients remained friendly at all times with "thank you very much", "I appreciate that" and "no problem at all", and were met by exchanges of smiles from both parties. It was only after a week that I noticed that this was but commonplace. Everyone was willing to help each other out; junior doctors could easily approach senior doctors for help regarding any patient, regardless of apparent complexity or complaint. Doctors and nurses alike looked out for patients who were upset or in pain, making sure that their pain was addressed with paracetamol, appeasing squabbles between patients waiting in line, and giving directions to those who looked lost. This made the busy ED a happier place to work and be in, with patients leaving satisfied with their care and filled with gratitude.

Week 2

The vulnerable individuals – of toxins and poisons

When I entered the cubicle, there laid a middle-aged gentleman – brows furrowed, with hints of despair behind his frightful, tired eyes, clearly anxious. Just the night before, he had been ingesting G (gamma-Hydroxybutyrate) – a colourless, odourless liquid commonly known as a "date rape drug" – as a sexual stimulant and was now experiencing the withdrawal effects of it. He was honest and frank about its abuse and that he had been using it for a long time now, together with methamphetamine, which helps to complement its effects.

While this was a first for me, Dr T explained to me that she had seen tons of cases similar to this during her public health rotation, where there were plenty of drug abuse cases. Vulnerable individuals – the homeless, poor and shunned, and the physically and emotionally abused – were particularly prone to drug abuse.

This gentleman shared with us his worries – he was tired of being at the mercy of drugs. He understood that it was a huge financial burden, costing him his relationship with his family and essentially his life; he wanted to get his life back on track. Prior attempts at doing so were futile – he had relapsed after a year of being off drugs. But this time, he wanted to change for good. Dr T expressed her genuine willingness to help and did so promptly by engaging the drug team on-call that day. Soon, one of the staff came to enrol him in their rehabilitation programme. He expressed his gratitude.

However, basic blood tests needed to be taken. We knew that this was going to be a tricky task – he was acutely dehydrated and most of his veins had collapsed or fibrosed from the overuse of intravenous drugs. Dr T tried her best to find a suitable vein but alas, trials at pricking him with the needle failed again and again. He winced at every trial. The pain was so unbearable that he yelled for a stop after multiple trials. Eventually, the registrar was called in and a plug was successfully set with the help of some handy lignocaine, a smaller needle and a keen eye for a suitable vein.

Coming from a place where drug laws are extremely strict, I have had little experience with patient admissions for illicit drug use in Singapore. I am fortunate to have the privilege of meeting some of these individuals here. Be it the haggard looking intravenous drug abuse lady, hair dishevelled and teeth discoloured with brown stains, who beamed at me when I passed her a new gown upon noticing the blood stains from her prior venipuncture, or the aggressive alcoholic who was subsequently escorted out by the big, burly security personnel upon name-calling and upsetting a fine dark-skinned gentleman passing by, these individuals helped me to gain an insight into a world beyond what I had previously known.

Week 3

Life on the brink of death

King's College Hospital is one of the major trauma centres in the region. It receives patients by walk-ins, ambulance and air (the helicopter). On a busy day, one can hear the ongoing ambulance sirens in the neighbourhood whizzing past the traffic, and see the ED parking lot decked in yellow and green, patients being pushed in stretchers by ambulance personnel eager to send in the sick for further treatment. Paramedics are well equipped and trained to carry out emergent procedures ranging from simple face masks to complex intubations en route before being received by the ED.

An elderly gentleman, in his 60s, was wheeled through the doors of the Resuscitation Department. He was unconscious, with a Glasgow Coma Scale of 6. Fortunately, he was breathing spontaneously. From his body emanated an unpleasant and distinct smell akin to rotting flesh. He looked very ill indeed. His arm was stiff and rigid, and his bum sustained a huge, 7 cm by 10 cm open wound that was black and foul smelling. He was living alone and had been found unconscious, for what seemed like three days based on when he was last seen, by neighbours who felt something was amiss when they noticed the foul-smelling odour coming from his home.

A quick head-to-toe assessment was done – Airway, Breathing, Circulation, Disability and Exposure. He was then whizzed over to the CT head scanner. The doctor kept close by during the wait outside the room, watching out for signs of desaturation. We called out to the patient every time he had closed his eyes for a long time, and heaved a sigh of relief when we realised he was just snoozing. We propped him up onto the CT machine using the Patslide. CT images revealed a grim prognosis – a

large left-sided basal ganglia bleed. The doctor told me he was unlikely to last very long. Neurosurgeons were called in.

Throughout the process, however, despite being in an unconscious drowsy state, he was constantly being addressed by name and informed of the various steps along the way – of being changed out of his clothes, transferred and moved from place to place. The effort towards upholding patient respect and dignity even in their most vulnerable states was, what I felt, commendable. What may be bread and butter in the department – major trauma, bleeds and strokes – is actually of utmost significance and has lifelong impact on the individuals and their loved ones.

As for the patient, I didn't have the opportunity to follow up with him. All I know was that he was eventually admitted to the wards and was in a state of recuperation.

Week 4

Mental health is wealth

> " …. I am nobody; I have nothing to do with explosions.
> I have given my name and my day-clothes up to the nurses
> And my history to the anesthetist and my body to surgeons.
>
> They have propped my head between the pillow and the sheet-cuff
> Like an eye between two white lids that will not shut.
> Stupid pupil, it has to take everything in.
> The nurses pass and pass, they are no trouble,
> They pass the way gulls pass inland in their white caps,
> Doing things with their hands, one just the same as another,
> So it is impossible to tell how many there are.
>
> My body is a pebble to them, they tend it as water
> Tends to the pebbles it must run over, smoothing them gently.
>
> They bring me numbness in their bright needles, they bring me sleep…"
>
> – Sylvia Plath

American poet and Pulitzer Prize winner, Sylvia Plath, described in her famous poem "Tulips", about her lifelong struggle with depression, between the oblivion of death and the responsibility of life, to help us gain an insight into the world she lived in. Her struggle eventually led to her unfortunate suicide by putting her head in the oven and turning up the gas.

The hospital, as much as it is associated with life and living, is very much the place of frailty and death. Suffering from mental health disorders is a plight that many of our patients face, some unfortunately stigmatised by the very community they reside in, and it is up to us clinicians, through our interactions with these patients who entrust us with their painful secrets, to offer a listening ear and, as much as possible, a helping hand.

I was tasked to take a medical history from a patient who had been referred for suicidal ideations by her GP. I met Ms A, a small-framed and thin-built elderly lady who had been suffering from a kidney infection for months – it was truly unpleasant, as she described the foul-smelling urine and painful sensation upon voiding. She had tried antibiotics for months but to no avail. She was fed up of being in pain – physically, emotionally and mentally.

As she spoke, her fierce tearful eyes meeting mine, she recounted stories of her partner's passing, of being cast out by her family, of being a victim of identity fraud and of being stripped of her finances. All these were compounding her own physical pain. She broke down, face cupped gently in her palms, and I briskly handed her some napkins for her tears.

She had also been experiencing significant weight loss down from a dress size of 14 to 4, but she couldn't care less if cancer struck, for "I would rather be dead than living", a phrase she brought up multiple times throughout the conversation. Her sheer helplessness at her own situation was heart-breaking.

She was eventually seen by the psychiatric team and sent home with medications for her urinary tract infection. As part of the ED team, we did what we could and wished her well. It reminded me that behind every patient lies a story, that it is up to us as physicians to cure sometimes, to relieve often, and to comfort always.

This care towards our patients extends to our fellow colleagues and peers. More recently, the World Health Organization meeting in Geneva included "burnout" as an official occupational phenomenon in its latest revision of the International Classification of Diseases. The nature of our work, caring for the health of others, can be a demanding and exhausting feat. It is then up to every individual – whether medical student, junior doctor, allied health member or senior doctor– to treat one another with the love and respect we all deserve.

Thank you

I would like to thank all the doctors, ENPs, phlebotomists and patients that I've come across and interacted with. Each has taught me lessons in more ways than one. ◆

Shu Xin is a Year 5 medical student from National University of Singapore Yong Loo Lin School of Medicine. She enjoys having hearty conversations with *ah mas* she meets at the hawker centre and laughing with her friends and family. Her idea of a perfect day would be having a dip in the pool, eating freshly baked bread and indulging in 99% cocoa dark chocolate.

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Updates on LPA:

- The LPA Form has been revised. You may refer to the Office of Public Guardian's (OPG) website for the latest LPA Form.
- From 1 August 2019, all new LPA certificate applicants will receive a softcopy LPA certificate from OPG through their e-services portal, accessed using SingPass.
- Since 31 December 2019, the Ministry of Social and Family Development, including the OPG, has ceased payment collection via cheque. This is in line with the Public Sector Transformation to build a Digital Government.

**For more information on the above updates, please visit OPG's website.*

For enquiries, please contact Alif/Denise/Jasmine at tel: **6223 1264** or email **OPG_LPA@sma.org.sg**.
For more information on LPA, please visit the OPG website at **http://www.msf.gov.sg/opg**.

WORKING HAND IN HAND FOR MENTAL HEALTH CARE

By Agency for Integrated Care

Through the Mental Health GP Partnership Programme (MHGPP), General Practitioners (GPs) become part of an integrated healthcare network and are able to lean on community partners like Community Intervention Teams (COMIT) to provide support to patients with mental health needs, GP Dr Mark Yap from Cashew Medical & Surgery, and social worker Ms Lee Soo Chin from Montfort Care, share with us on their roles and how they work together to support clients in their recovery journey.

Dr Mark Yap
from Cashew Medical & Surgery

Ms Lee Soo Chin
from Montfort Care

What is the role of COMIT?

Soo Chin:

Our teams are made up of counsellors, occupational therapists, psychologists, nurses and programme coordinators. We provide counselling, psychotherapy, coordinate care and support caregivers of those with mental health conditions. In this way, we complement the care provided by GPs in managing clients with mild to moderate mental health needs so that they can continue to live well at home and in the community.

GPs are usually the first point of contact for many patients. How do you work together to manage a patient's condition?

Dr Yap:

I have been working with the community intervention teams since 2014. I see about four to eight clients a month who may have anxiety, depression and schizophrenia. If they need more support such as counselling, I will contact the Agency for Integrated Care (AIC) via **careinmind@aic.sg** with the client's details, medical background and condition for referral to the community intervention team for their follow up.

Soo Chin:

While GPs are the first to identify the condition, our team provides social and emotional support for the clients and their caregivers to better manage their condition. For instance, if the client is confused about how to take their medication, we can explain it to them during our home visits. During such visits, we will also evaluate their condition and with their caregivers, develop or review their care plan.

How do you provide support for patients?

Dr Yap:

People usually feel more comfortable talking to their family doctor. As a GP in the Mental Health GP Partnership Programme, I can also assess and diagnose patients with mental health conditions. When my patients tell me how they feel unwell, I will also check if their symptoms may be due to an underlying mental health condition. If they are, I will refer them to the community intervention team for further support while I continue seeing them for the condition and provide medication if needed.

Soo Chin:

When AIC sends us information on the clients for follow up, we will go down to their homes to evaluate their condition and develop or review their care plan with their caregivers. We also educate the clients about their conditions so that they can better manage it. Besides partnering AIC, we also work with other community partners like grassroots organisations and hospitals to support their residents or patients with mental health needs.

Dr Yap:

As for me, I often keep in touch with the community intervention team to stay up to date with my patient's condition. If I notice that someone has not returned to my clinic for follow ups or medication, I will also contact the team to see if my patient is doing okay.

Why is it important for different partners to work together?

Soo Chin:

By working together, we can provide care in a more well-rounded manner to the client.

Dr Yap:

Their team and I will also share information as patients may tell different people different issues about themselves.

GP and COMIT in collaboration

Mdm A was diagnosed with anxiety after she experienced weight loss, high blood pressure and sleeping problems due to work stress. In August 2018, Dr Yap referred Mdm A to a community intervention team. Soo Chin's team took up her case. Over two to three sessions, Mdm A's condition improved.

How did both of you work together to help Mdm A manage her anxiety?

Soo Chin:

We provided counselling sessions at her home and taught her how to better understand and manage her condition. Now that she is better, we continue with home visits to help her manage her condition. For instance, we set different goals for each session such as supporting her in overcoming her daily anxieties.

Dr Yap:

Besides being more aware of her condition, the counselling sessions also made Mdm A realise that her health comes first. With medication and a break from work, she overcame her condition. Should the need arise again, she now knows who to turn to for support.

If you would like to be part of the Mental Health GP Partnership Programme, please contact the AIC GP Engagement team at gp@aic.sg or 6632 1199, or visit Primary Care Pages (www.primarycarepages.sg).

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Application
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Enquiries
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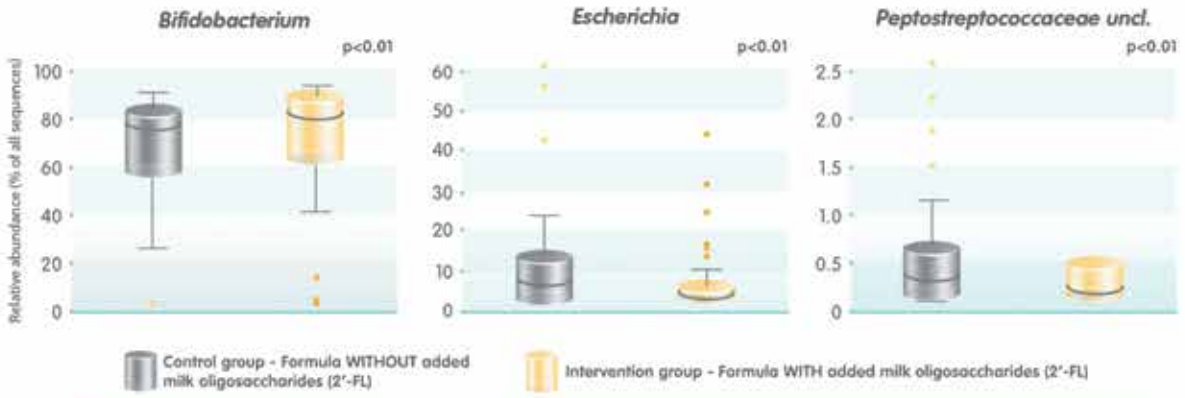

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