SMA NEWS

Vol. 47 No. 11 November 2015
MCI (P) 154/01/2015

SMA NEWS
Vol. 47 No. 11 | 2015

PUBLISHER
Singapore Medical Association
2 College Road
Level 2, Alumni Medical Centre
Singapore 169850
Tel: (65) 6223 1264
Fax: (65) 6224 7827
Email: news@sma.org.sg
URL: http://www.sma.org.sg
UEN No.: S61SS0168E

DESIGN AGENCY
Oxygen Studio Designs Pte Ltd

PRINTER
Sun Rise Printing & Supplies Pte Ltd

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DOCTORING WITH SKILL & PEACE OF MIND

In this November issue, the SMA President shares his thoughts on informed consent and why having too many choices can sometimes be a hindrance. Dr Lee Pheng Soon and Dr Bertha Woon present us with a simple but thorough breakdown of the different aspects of medical practice safety and protection — a much needed and important read for those of us with minimal or zero knowledge of the topic! Dr Peter Loke concludes his two-part series on ethics in medicine.

This year's CMAAO meeting, held in Yangon, Myanmar, was another fruitful meeting where like-minded colleagues from the Association of Southeast Asian Nations met to discuss and provide updates on local and regional healthcare issues. Prof Cuthbert Teo continues his in-depth narrative on the development of clinical teaching in the early 1900s in part IV of his history of medicine article.

As a continuation of last month's military issue, Dr Koh Choong Hou offers his insights on the physician-warrior with its myriad and changing roles, while A/Prof Cheong Pak Yean enthralls with two interesting anecdotes of his army doctor days in the 70s, depicting situations that I imagine are hardly seen nowadays! Dr Yue Wai Mun explains why he served NS beyond the "compulsory" years. He is truly an inspiration, and I salute him and all who continue to serve beyond their call of duty.

Last but not least, our Indulge column expands beyond travel and food to bring us a bit of the arts and culture. Dr Terence Tan interviews Ms Adelene Khoo, who has a rare and unusual occupation; something to delight those of us who are bibliophiles!

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

Yia Swam
Editor

Your Medical Practice Protection:

KNOW YOUR ABCDEs BEFORE SOMETHING GOES BUMP IN THE DARK

PROFILE

TEXT BY

DR LEE PHENG SOON

Chairman of the Professional Indemnity Committee of the SMA

Dr Lee has a Fellowship in Pharmaceutical Medicine from the UK Royal Colleges of Physicians and an MBA from Warwick University, UK. He works full-time in industry and part-time as a GP.

TEXT BY

DR BERTHA WOON

Vice Chairman of the Professional Indemnity Committee of the SMA

Dr Woon is a full time General and Breast surgeon at her own practice, Bertha Woon General and Breast Surgery, at Gleneagles Medical Centre. She is an advocate and solicitor of the Supreme Court of Singapore, an associate mediator at the Singapore Mediation Centre, and one of the four Associates of the Medical Protection Society in Singapore.

Here are two true stories to start you thinking about insurance. A medical student drove her father's car and rear-ended a stationary Porsche. Suspecting how expensive it might be to fix the bumper and rear-light cluster, her father was glad that his car's insurance policy would pay for all repairs after the first $500 (the excess). However, he was unaware that, as his daughter was both young and a newly qualified driver, this excess would automatically jump to several thousands of dollars — a condition written in his policy.

A 65-year-old type 2 diabetic patient, well controlled on low-dose oral hypoglycaemic agent, had a stent inserted in Tan Tock Seng Hospital (TTSH) as an emergency procedure for acute myocardial infarction (AMI). Upon discharge, she found that her insurance company rejected her hospitalisation claim, as the AMI was deemed a known possible complication of her diabetes mellitus, a pre-existing condition.

UNDERSTANDING INSURANCE

What point are we trying to make? Having insurance but not being familiar with the actual terms can result in rude shocks. We would argue that many doctors in Singapore are similarly naive about their personal protection against medical malpractice. Junior doctors are especially at risk, as many have left it to "what the Human Resource department has arranged as group cover" for years. An A&E registrar from TTSH did not even know that her cover provider had changed from Medical Protection Society (MPS) to Aon Singapore over the last month or two — we wondered who she would have called for emergency advice had she needed it; probably the SMA.

In this short guide, we have listed some key considerations that each of us should bear in mind when we ask the question, "Am I covered when something goes badly wrong?" (Note the use of "when", not "if".) Because doctors sometimes work, rather than sleep, at night; they cannot dismiss "things that go bump in the night" as a bad dream like many other professionals might. The "bump" could be the sound of an incoming complaint or malpractice claim landing in the mailbox. It is thus better to be prepared for adverse events, being fully aware of the limitations of whichever cover we have chosen, however carefully we continue in our daily medical practice. The features vary among the three major providers of practice protection cover in Singapore (namely MPS, NTUC Income and Aon), and perhaps a fourth, yet unnamed, insurance provider that might be negotiating to offer group cover to your hospital. Readers, you are urged to read on and reflect, especially on your own needs. A disclaimer here: The points we will make are for generic information — they are not meant to suggest that any one provider or model of malpractice cover is preferable, nor should the comments be read as such. Some basic principles of medical practice protection are outlined below.

A IS FOR...

ASSISTANCE

When something goes wrong, you may need up to four kinds of assistance. Good **immediate assistance** (advice on what to, or not to, do or say) can prevent things from getting worse, either medically or legally. Professional **post-crisis assistance** in explaining to the patient and family soon after the immediate phase can sometimes avoid the escalation of an incident to a legal event, simply by preventing misunderstanding of what you have done or said. If things unfortunately progress further, you will need **assistance in legal defence**. Finally, if damages are awarded (or a fine imposed), you will need **assistance to meet the resultant financial liability**. As you can see, the total cost for any one unfortunate case can be very high. Practice protection, whether

obtained by joining a medical defence organisation (MDO) or buying an insurance policy, should offer confident access to all of the above, starting preferably with 24/7 access to both immediate and post-crisis assistance.

ASSOCIATION

In UK and British Commonwealth tradition, doctors formed associations to pool, and thus better manage, practice risks and the necessary protection. They were sometimes called MDOs and were also referred to by older doctors as "mutuals". Of course, the assistance offered by such self-help groups can never be unconditional — to keep premiums reasonable, assistance must be restricted to medical malpractice, and when granted, the interests of the doctor seeking help balanced against the interests of other co-members, if necessary, by a board decision. A second approach is for the doctor to buy an insurance policy. The insurance provider would directly meet some of the doctor's initial needs for assistance, and finance the remainder (eg, legal fees for defence and costs of damages awarded) when the need arose.

ASPECTS OF THE COVERAGE YOU CAN RELY ON

There are three aspects you must clearly understand about the nature of any cover you settle for, be it an MDO or insurance. The first is "Occurrence vs Claims-made", the second, "Discretionary vs Contractual" and the third is "Specified or Unspecified Limit to claim".

Occurrence-based coverage is traditionally offered by MDOs. You could apply for assistance for *claims arising from incidents that occurred while you were a member*. The actual time that claims arose and were filed is not relevant — it could even occur after you had left the MDO or retired. The only thing that matters is whether you had been a member at the time of occurrence of the incident. *In effect, occurrence-based cover offers permanent coverage for incidents that occur during the membership period*. This arrangement is expensive. Generally speaking, MDOs now prefer to offer fewer new occurrence-based arrangements. In 2015, MPS announced that, moving forward, new occurrence-based obstetrics and gynaecology cover would no longer be offered, though all other categories would remain.

Claims-made coverage is traditionally offered through insurance policies. Even if the unfortunate event occurred during the time insured, the company *would only pay those claims that arose and were filed during the "reporting period"* specified in the policy. This may be the policy year itself or longer as specified (eg, "the policy year plus the next two consecutive years"), or even "as long as you keep renewing your policy with us" (continuity with the same company being the key). But for such insurance policies, sooner or later, a time will come when it becomes "too late to file a claim". This limited reporting period of claims-made protection is unsettling for some doctors who have heard of cases where claims arose years, even decades, after the incident, or who point to diseases (eg, neurodevelopmental delay or silicosis) where clinical signs take years or decades to manifest — when a request for assistance could no longer be made.

Some insurance companies sell a separate and different policy to partially cover this concern. This is called an "extended reporting period (ERP) cover", otherwise known as "tail cover" or "run-off cover". A doctor buys the *right to extend the time within which he can file a claim*, by the period of the ERP cover (typically a further three or five years). Other insurance companies offer discretionary incidence-based cover after the initial contractual claims-made cover is over.

Discretionary coverage means that help offered, including the extent of help, is decided not by the contract (as in an insurance policy), but by the discretion of a Board convened to decide on these claims. Needless to say, the historical performance of organisations offering discretionary cover is very important when choosing between different types of coverage. In contrast, the conditions under which an insurance policy will offer assistance are specified and *contractual*; if you feel that you did not get what you were promised, you can appeal to the Insurance Commissioner at the Monetary Authority of Singapore.

Finally, insurance policies typically state a limit to the claims that will be paid on a single policy, while MDOs usually do not, leaving it instead to the discretion of the Board discussing that specific incident.

BASIS UPON WHICH ASSISTANCE IS PROVIDED

The six "aspects" of your coverage, namely occurrence basis vs claims-made basis of claims, contractual vs discretionary assistance and limited vs unlimited claims benefit, have been explained above. It is critical for you to know which three of these form the basis of your assistance should you encounter trouble. The first, occurrence basis vs claims-made basis, is the most difficult to grapple with and to recall under stress. We therefore share an example below.

Think in terms of car insurance. Following an accident, you would know, within a day or two, how much it would cost to repair the damage, so a claims-made insurance cover would have been enough. Both car insurance and claims-made cover start with "C". On the other hand, a neonatologist attending to an infant at delivery might be shocked to receive a claim for damages many years later, when developmental delay became obvious. He would have needed occurrence-based cover, paid up during the time of delivery. Alternatively, if he had chosen insurance over an MDO, he would need uninterrupted renewal of his claims-made policy with the same insurance company till the claim arrived, assuming this insurance company allowed that method of extending the reporting period. And if

he had left the insurance company for another protection scheme, or retired, he needed to have bought run-off cover for enough years to meet this day of need.

C IS FOR...

CATEGORY OF COVER

Whether you buy insurance cover or join an MDO, you must subscribe to the correct category of cover that reflects your clinical practice. For example, family practice and aesthetic medicine carry different risks, and thus, each requires payment of different premiums.

CONFLICT OF INTEREST

Many of us have heard of instances where a patient simultaneously sued not only the doctor and his assistants, but also the hospital. Some doctors derive comfort from the thought that MDOs are owned and operated by, and exist for, the interests of doctors (ie, members), and so would always put the interests of the doctor first. Others may express concern that any defence scheme they rely on (be it insurance or MDO) may prefer to reduce expenses by an early out-of-court settlement, refusing to fund a costlier trial that might, if successful, preserve the reputation of the doctor. Where an insurance scheme covers both the hospital and its employed doctors, some doctors may wonder if the insurance company would offer them assistance that puts their interests first, ahead of those of the bigger customer, the hospital. Our advice is to ask whether your insurer or MDO covers your hospital, when covering you. If you sense a potential conflict of interest, use the past behaviour of your insurer or MDO as a guide. For example, whether the organisation had stood up for doctors in the past (eg, supporting appeals to a higher court that subsequently cleared the doctor's reputation) is a useful indication.

D IS FOR...

DURATION OF COVER YOUR MEDICAL PRACTICE WILL NEED

Some of us think that we need cover only from the start of housemanship to the day of retirement from practice. Unfortunately, adverse consequences of our medical work may be alleged even decades after we had seen our last patient. The minimal duration of cover you need is, therefore, the time you begin practice till the time unexpected complaints are no longer "likely" or "possible" (which of these two words is more applicable to you depends on your appetite for risk). "Possible" varies according to specialties. Doctors dealing with infants need, in theory, to be prepared for more than 20 years of possible claim. Understandably, doctors who need security for a longer term would usually prefer an arrangement that offers occurrence-based cover.

DURABILITY OF THE DEFENCE ORGANISATION AND YOUR RELATIONSHIP WITH IT

Older doctors will be able to name insurance companies and MDOs that had come to serve Singapore or our neighbouring countries, which then quietly left. Older SMA Council members will tell you of bad times in the past, when the SMA had to scramble to seek a provider of tail cover for doctors in Singapore left in a lurch after such exits. Before you settle on a specific organisation, ask about the track record of the organisation — both in terms of how long it has been in Singapore and its performance in the other countries it had served.

Durability of your relationship with an organisation is a more difficult topic. Sometimes, one simply cannot continue in the old relationship any longer, whatever one's preferences, and asking "NOW WHAT?" at this stage is too late. This might affect doctors whose employer or institution provides them "Group Cover" or some other "Institution Contract". You need to be very sure that this organisation will sell you ERP cover (tail or run-off cover) in at least three situations: (1) when the employer changes to another provider of group cover; (2) when you change to a new employer (even when old and new have the same provider of group cover); and (3) when you leave the institution (eg, to start private practice or retire). It is not good enough to have saved enough money to buy tail cover, if you find out later that the relevant organisation does not sell it. Thus, you should discuss with your potential employer or institution the availability of ERP cover upon exit *at the time you think about joining it*. To answer the obvious question, "Can I buy my own personal protection and take it with me wherever I go?" This option is not available in Singapore. There is no organisation willing to sell you protection "a second time" when you are already covered "a first time". It is irrelevant that this "first-time cover" (ie, the group policy of your employer) has covered you without your active consent.

E IS FOR...

ECONOMICS

An insurance policy that only considers claims filed within the year of cover (ie, basic claims-made insurance cover) will obviously cost less than its incidence-based MDO counterpart that offers permanent claims cover. If the insurance scheme allows you to extend claims-reporting by renewing your policy in subsequent years, it will need to fund additional claims risks on the second and subsequent years. The annual premium will likely increase till the fifth year, before it plateaus at around the premium of incidence-based coverages. Unless you know this simple truth based on the fundamentals of economics, you may mistakenly select a scheme just because it offers a lower annual premium. Make sure you compare similar offerings — claims-based with claims-based, incidence-based with incidence-based. You will otherwise lose any initial savings later when you need to buy an ERP coverage.

A hospital calling for bids for group cover is subject to the same economic fundamentals. New claims-made bids will always be more attractively priced than current incidence-based costs. The chooks come back to roost only when the hospital administrator wants to exit the insurance scheme (perhaps because he realises that it is claims-made and understands this weakness) and finds out that he now has to buy ERP cover on exit — or worse still, that such cover cannot be had for love or for money. That is why individual doctors need to be clear on how they can buy their personal ERP cover when they exit, before they join a hospital with group cover. In the event of a legal suit, the doctor who is not covered is responsible for both his own legal defence as well as any subsequent financial liability awarded against him.

EDUCATION

Many organisations run classes to teach their members how to reduce their risks of unintentionally doing or saying the wrong things. The SMA runs classes and courses on professionalism and ethics. Sign up and learn. When something goes bump in the night, whether your first words help or aggravate the situation is not dependent as much on your instincts as it is on whether you have bothered to learn and practise what to do and say in such difficult situations. Experts say that a large proportion of problems come from miscommunication or misunderstanding. Learn how to reduce the risk of both.

ET CETERA

Many organisations offer special services that most of us are not aware of, because they are seldom needed. For instance, if you should need advice on answering questions from the Coroner, your defence organisation might be able to help. If you need advice on how to conduct yourself in Court as an expert witness or how much detail you can safely provide to a family pressing you for information about your patient, you might similarly find help there. What about coverage for overseas postings, especially in the US, or for voluntary work in a third-world country? Many of us think of our MDO or insurance provider as an umbrella, simply occupying space until a rainy day. Our advice is this — at least know how to open the umbrella without having to struggle with it in a downpour. At the very minimum, keep in your wallet the name and telephone numbers of the medico-legal hotlines established to help you, should something go wrong unexpectedly. Medicine is a very satisfying calling, but it seems to suffer more rainy days than many of us are prepared to admit.

SUMMARY

Medical practice is one of the more complex professions. We deal with humans who are unwell and families that are stressed. We rely on their understanding our goodwill and assume that they will extend theirs to us. Sometimes things do go wrong, whether from malpractice or miscommunication, or both. When you choose your partner in medical defence, you need to think carefully about the kind of assistance you will eventually need, and match the features offered by each provider with your need. At the minimum, you should be clear about whether you might need this assistance on an occurrence or claims-made basis, and have asked about the track record and reputation of the partner you choose. It would be unwise to choose your partner purely based on the small difference in premiums quoted in the different websites, because schemes that offer you less in their service package can also quote lower premiums.

Similarly, you cannot rely on the group cover provided by your employer or institution unless you fully understand what it covers when you are employed and what you must do to guarantee your extended reporting rights when you leave. If you really do not know or your seniors evade your questions, you might do well to speak with your SMA Council members. We may be able to offer you a perspective that may help, or at least ask your hospital administrator questions in words he cannot duck. Remember, when push comes to shove, you either are adequately covered, or will need to personally cover the costs of defence and awarded damages. ◆

INFORMED CONSENT (PART 1) — THE PROBLEM OF CHOICE

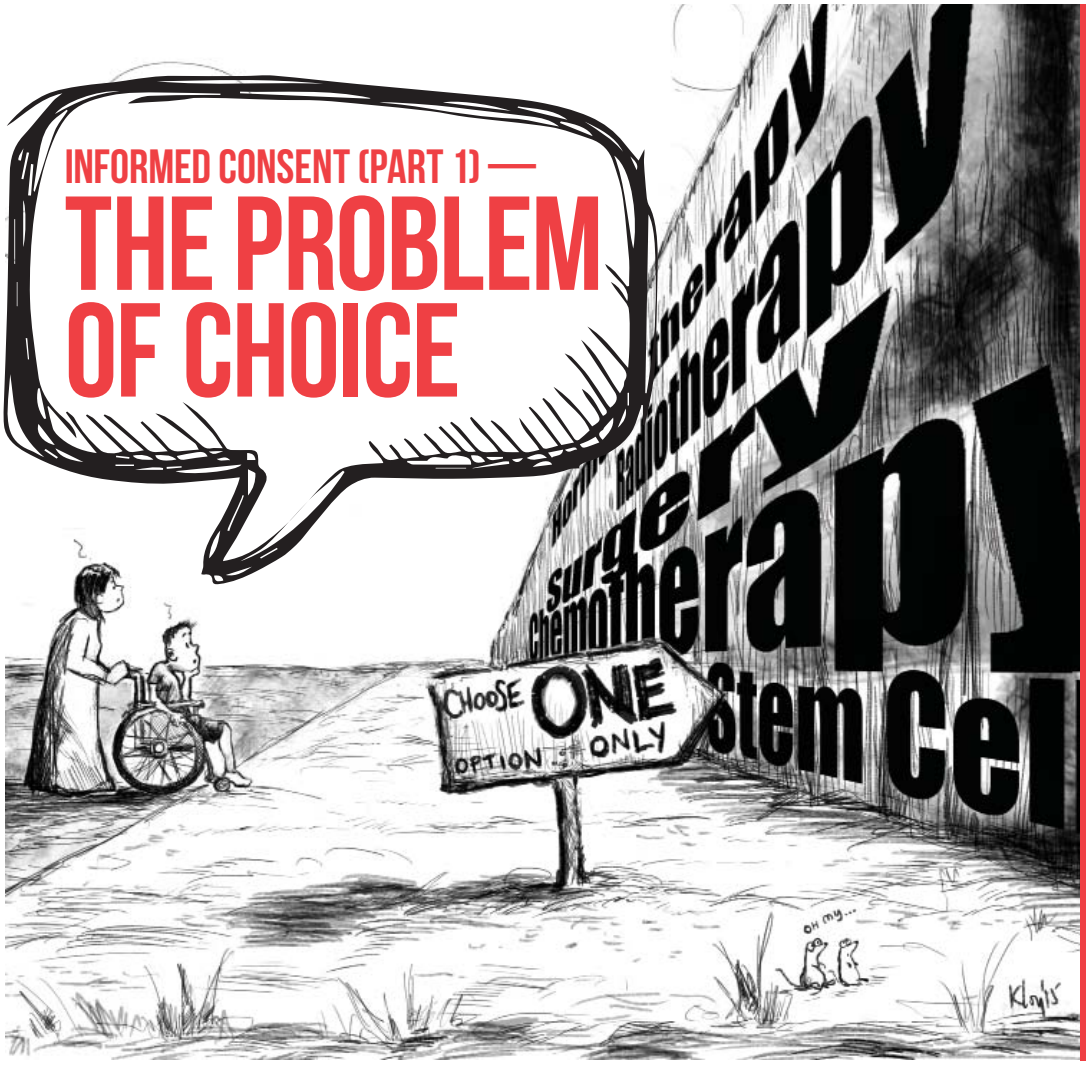

Illustration: Dr Kevin Loy

PROFILE

TEXT BY

DR WONG TIEN HUA

Dr Wong Tien Hua is President of the 56th SMA Council. He is a family medicine physician practising in Sengkang. Dr Wong has an interest in primary care, patient communication and medical ethics.

Informed consent is a process that takes place between the doctor and patient, where the patient gains an understanding of his condition, receives an explanation of the management options available, including an assessment of the expected risks, side effects, benefits and costs of each option, and is thereby able to give consent via an informed choice for the treatment option that best suits him. The process of making an informed consent is also about making the right choices.

CHOICE IS GOOD

Nobody can deny that having choices is a good thing. Being able to choose is an expression of one's autonomy, the exercise of one's free will and the demonstration of one's desire for self-determination.

Under the Mental Capacity Act, a key ethical tenet expressed through the provisions of the Act is the principle of respecting the autonomous right of persons with the capacity to make decisions for himself, ie, the right for him to choose.

We make choices all the time, both consciously and subconsciously. However, the kinds of choices we make vary, from simple daily choices that have low consequences to important decisions that carry high stakes.

TYPES OF CHOICES

Going to the supermarket to buy groceries is a common activity that involves choosing from a wide variety of products that assault our senses as soon as the automatic doors swing open. Most shoppers depend on a fixed habitual buying pattern to overcome the stress of making too many small decisions. However, we do occasionally select novel items or products to try out, based on recommendations, clever advertising or attractive packaging. Such choices are easy to make because the products are relatively inexpensive and the goods will eventually be consumed; therefore, such mistakes carry a low consequence. We then learn through experience and avoid products that we dislike.

Choosing a handphone is not an uncommon activity, but unlike grocery shopping, it occurs infrequently. It is also of a different magnitude of complexity. We probably need to buy a new handphone once every few years to replace an obsolete model or when our telco offers discounts on handsets with contract renewal. We cannot rely on our experience with an old model,

as new handphones always carry more advanced features and technology. The selection process thus becomes more complicated, as market research and investment of time would be required. The stakes are higher because one has to live with the consequences of one's choice, which is more expensive and lasting in this case.

In the practice of medicine, the choices that doctors and patients make also involve differing levels of complexity.

On the one hand, medical conditions such as the common cold, gastric flu and tension headaches occur frequently enough among patients that they have the benefit of experience. Choosing to see the family doctor for symptomatic relief and treatment of non-life-threatening conditions are decisions with low consequences. The doctor recommends a largely expected course of treatment and the patient is usually quite clear on the options available. From the benefit of experience and a relationship built up over time, the family doctor knows which course of treatment best suits the patient, and thus having the patient agree with the management plan is straightforward.

Medical conditions that are more serious or less common and procedures that are more complicated or require expert management will involve complex decision-making processes. In such cases, there is no absolute guarantee of success or "money back" once the commitment is made, and patients cannot rely on past experience. The consequences of making a wrong decision are very serious. Such choices therefore require patients to devote substantial time, energy and emotion, which may lead to stress and anxiety. A patient may even feel caught between a rock and a hard place, where none of the options seems to be good enough.

TOO MANY CHOICES

Nowadays, we have the luxury of choice even when satisfying our craving for a bowl of wonton noodles. A quick search of the local food portal will reveal a list of "Top 10 wonton noodle stalls in Singapore", with no fewer than 55 stalls taste-tested and ranked for our convenience. Arriving at one of these stalls after travelling halfway across the island, you will likely find, to your dismay, a snaking queue of like-minded hungry patrons all seeking the same experience. After all that time spent travelling and waiting in line, I often wonder whether the $5 bowl of noodles that would be polished off within minutes was worth the trouble, even if it was marginally superior in taste.

Having options is good, but having more options may not be better. This is the idea behind psychologist Barry Schwartz's 2004 book, *The Paradox of Choice: Why More Is Less*. Schwartz challenges the notion that more choices will lead to more happiness. He argues that the converse is true — that the overwhelming options facing consumers today leads to more anxiety, more time wasted and less overall satisfaction. He also quoted studies demonstrating that if too many options are available, the effort of trying to decide overwhelms the enjoyment of the experience. In an example involving shoppers, some people decide *to not decide* when faced with too many competing offers and put off making a purchase.

It seems that medical practice is not spared from this problem either. Schwartz wrote that "when it comes to medical treatment, patients see choice as both a blessing and a burden." Indeed, when faced with a life-threatening illness such as cancer, surveys show that cancer sufferers prefer their doctors to make the decisions for them.

What makes medical decisions increasingly difficult? Firstly, the options for treatment have increased tremendously with technological advancements. Slightly more than a century ago, someone with an infected leg wound faced gangrene and certain death, unless he had the courage to go through a brutal amputation in the absence of anaesthesia. Today, even in an acute illness like appendicitis, patients can choose to be treated with antibiotics followed by an interval appendectomy, or choose to undergo either a laparoscopic and open appendectomy. The patient obviously cannot rely on any past experience to choose the best treatment. This creates an information asymmetry that puts the burden of knowledge on the doctor who is advising the patient. Even in such acute illness, the doctor must be careful to discuss and explain the options available such that the patient fully understands and can make an informed decision. Information asymmetry becomes more significant in complex procedures, and the burden of making a decision becomes heavier for patients undergoing elective treatment as they have to weigh the benefits and risks carefully.

Secondly, the roles of doctors and patients are changing. It was not too long ago that doctors made decisions on behalf of patients in a paternalistic model of care. Patients did as they were told and were not privy to important information about their treatment. In the present era, the model of care has shifted to that of giving patients the responsibility and freedom to make decisions about their care. If we take this far enough, we simply present patients with all the viable options and let them decide what is best for themselves. This scenario, however, may turn out to be confusing, difficult and counterproductive for patients.

MAKING THE RIGHT CHOICES

Informed consent is about helping the patient make the right choices. The difficulty lies in how to encompass all the possible options and whether it is even possible to have a truly informed patient.

Doctors are not technicians who rattle off from a long list of options for the patient without any intellectual input. They are expected to weigh the pros and cons of each option before making treatment recommendations. Patients should not be making decisions by themselves.

The process of arriving at the right choice, one that is best for the patient, is an interactive and contextual one. Indeed, informed consent is about shared decision-making, which will be the topic of another article. Watch this space.

HIGHLIGHTS FROM THE HONORARY SECRETARY

SMC PRACTISING CERTIFICATE RENEWAL

SMA recently wrote to Singapore Medical Council (SMC) to highlight feedback from members regarding the recent announcement on Practising Certificate (PC) renewal. In response, SMC has extended the deadline and advised doctors to submit their applications by 30th November 2015 to ensure that their PCs are renewed in time. We thank SMC for the positive reply. SMC's response is found on our website at **https://goo.gl/LBm00R.**

SMA COLLABORATES WITH CFPS AND SHRI

SMA and College of Family Physicians will conduct a survey on managed health organisations (MHOs) and the managed care environment in November 2015. Spearheaded by the SMA Private Practice Committee, this initiative aims to refresh a similar survey that was conducted in 2006. We encourage our members to participate in the survey so as to help us better understand Singapore's managed care environment. SMA will also collaborate with Singapore Human Resource Institute to conduct a survey of human resource practitioners to find out their views on MHOs and the managed care environment.

SMA SUBMITS FEEDBACK ON DRAFT ECEG

The SMA submitted its feedback to the SMC on 20th October 2015. In our letter, we reiterated our view that the current 2002 Ethical Code and Ethical Guidelines is fundamentally sound as a professional code, although it may need more regular updates to keep abreast with the changing practice of medicine. We also shared our concern that the proposed revision will do little to champion the spirit of professional ethics in the practice environment but may inadvertently have a negative effect on patient care in Singapore.

SMA COUNCIL HOSTS LUNCH FOR MINISTER FOR HEALTH AT THE SMA

The SMA Council hosted lunch for Minister Gan Kim Yong at the SMA on 23rd October 2015. Candid and fruitful discussions ensued on topics such as the ethical code for doctors, professional indemnity, training and assimilation of foreign trained doctors and the primary care landscape. The two-hour lunch ended with the celebration of SMA Honorary Treasurer Dr Tammy Chan's birthday, a sweet ending to a meeting that has now become a regular affair.

PROFILE

REPORTED BY

DR DANIEL LEE

Dr Daniel Lee Hsien Chieh (MBBS [S'pore], GDFM [S'pore], MPH [Harvard], FAMS) is Honorary Secretary of the 56th SMA Council. He is a public health specialist and Deputy Director of Clinical Services at Changi General Hospital.

SMA WORKS WITH MEMBER TO RECOVER OUTSTANDING LOCUM PAYMENTS

SMA received a request for help to recover locum payments owed. We acted on behalf of our member by writing to the clinic. The issue was resolved quickly and the fees were subsequently received by the member. ◆

SHINING THE SPOTLIGHT ON FOOD SAFETY

– THE 30TH CMAAO GENERAL ASSEMBLY

The Confederation of Medical Association in Asia and Oceania (CMAAO) has been in existence since 1956. The organisation was founded by Dr Taro Takemi, a visionary doctor and President of the Japan Medical Association for 25 years. We attended the 30th general assembly in Yangon, Myanmar, hosted by the Myanmar Medical Association.

The membership of CMAAO comprises 18 national medical associations, including our Association of Southeast Asian Nations neighbours and countries from East Asia, including Japan, Taiwan, Hong Kong, Macau and Korea. Australasia is represented by Australia and New Zealand, while South Asia is represented by India and Bangladesh.

FOCUS ON FOOD SAFETY

The conference programme included an opening ceremony, the inauguration of a new president, a plenary session and an academic programme. This year, Food Safety was the theme of the scientific session, which included the Taro Takemi Memorial Oration, named after the late president of the association, and a scientific seminar.

It was enlightening to learn that food safety is not just about the prevention of transmission of bacteria, parasites and viruses in food, but also encompasses chemicals, organic toxins, heavy metals, and organic pollutants such as dioxins, which accumulate in humans and disrupt endocrine function.

We learnt that the widespread use of antimicrobials in human and veterinary medicine has resulted in resistant bacteria entering the food chain through animals (eg, salmonella in chickens). We also discovered that the jury is still out on the long-term safety of genetically modified foods. Today, food chains, from production to consumption, span borders and have

PROFILE

TEXT BY

DR CHONG YEH WOEI

Dr Chong was SMA President from 2009 to 2012 and is a member of the 56th SMA Council. He has been in private practice since 1993 and has seen his fair share of the human condition. He pines for a good pinot noir, loves the FT Weekend and of course, wishes for world peace...

Legend

1. Old friends include Dr Rai Myra, CMAAO president from Myanmar, Secretary General Dr Masami Ishii from Japan and Treasurer Dr Alvin Chan from Hong Kong

2. Shwedagon Pagoda at sunrise

3. Japan Medical Association delegates

4. Banners of the member medical organisations of CMAAO

Photos by Dr Tammy Chan

become longer and more complex. Furthermore, urbanisation, travel and changes in consumer habits have led to an increased number of people buying and eating food prepared in public places. In light of these current developments, maintenance of high food safety standards is of crucial importance to health.

LEARNING FROM OUR COUNTERPARTS

We have always found the presentation of country reports to be an interesting aspect of the assembly. We have gained much from hearing about the issues that our fellow colleagues faced when dealing with their respective governments, civil society and the public at large.

Our Bangladeshi colleagues revealed that harassment and assault of doctors by hooligans is rampant in their country, in part due to a tradition that originated from the previous authoritarian regime where thugs are hired to do its bidding. We heard the concerns from Malaysia on the ramifications of the Trans-Pacific Partnership (TPP) agreement that our governments are negotiating. These concerns include the extension of patent periods and patent protection of diagnostic, therapeutic and surgical techniques, both of which could result in doctors having to pay royalties for the use of these patented techniques. However, an interesting aspect is the exclusivity of data imposed by the TPP, which would delay the introduction of generic drugs once the patents on these drugs expire.

The Philippines reported on their fight against the legalisation of cannabis on compassionate grounds, while our Hong Kong colleagues informed the assembly of lead contamination in potable water in their public housing estates. Indonesia reported on the effects of the country's anti-corruption drive on the medical sector. The Japanese reminded us of the massive "super ageing" problem faced by their society. Our Korean colleagues recounted their crisis with MERS-CoV, during which I must confess that I had a post-traumatic flashback to the dark days of our SARS crisis in 2003.

Myanmar updated us on the floods in July 2015 and their disaster relief activities, which included 22 projects funded by United Nation bodies and international agencies to bring medical care to underdeveloped regions in the remote areas of the Shan, Kachin and Rakhine states. The Nepalese alerted us to the plight of violence against their doctors, while the Taiwanese reported on the disaster involving the ignition of flammable powder in a water park that resulted in burn injuries to 498 youths. The Australians spoke about the budget cuts under the Abbott/Turnbull government and how cigarette companies are suing the government for introducing plain packaging for cigarettes.

FINAL THOUGHTS

At the CMAAO meeting, we gained knowledge and wisdom from the lessons learnt by our colleagues in the region, during the various sessions and in the midst of interacting with old friends and new ones.

Yangon is a city that is reminiscent of Singapore under the British colonial rule — the atmospheric calm of the two-millennium-old Shwedagon pagoda at sunrise, the waft of fragrant Burmese curries, salads and desserts, and the afternoon tea at the Strand Hotel, opened by our own Sarkies brothers of the Raffles Hotel fame. I would strongly recommend a visit to this beautiful country before the winds of change spoil its serene beauty. ◆

MAKING A DIFFERENCE

One Life at a Time

Dr Tan Si Heng is an orthopaedic resident with National University Hospital who graduated from NUS Yong Loo Lin School of Medicine (YLLSoM) in July 2015. She was a bursary recipient of the SMA Medical Students' Assistance Fund (SMA-MSAF) and was also supported by the SMA Charity Fund (SMACF) for a podium presentation at the European Orthopaedic Research Society (EORS) meeting in Nantes, France, from 2 to 4 July 2014. Her podium presentation was on her team's study, "Atypical Fractures of the Ulna and Bisphosphonate Therapy: A Case Report and Systematic Review of Published Case Reports".

It had been a trying journey for Dr Tan who lost her father to colorectal cancer in 2004, when she was 13 years old. She then took on part-time jobs to support her family financially, contributing to household expenses and paying off some of her late father's medical bills. Driven by external circumstances, Dr Tan often had to miss classes during her five years at YLLSoM.

HER TESTIMONY

I took on various jobs, starting with being a cinema staff at Golden Village and waitressing at a restaurant. Later on, I took on tuition assignments because I could not cope with the long working hours of the first two. While still providing tuition, I also became involved in organising children's birthday parties with science themes. It was a challenge juggling work and studies. I worked till 10 pm almost every day and that made it difficult to concentrate on my studies. I really appreciate the way SMA-MSAF works. Instead of paying for school fees, the bursary gives the money directly to needy students to assist with our daily expenses. We can thus work shorter hours and concentrate more on our studies. I really regretted missing classes in my first few years of medical school and I sincerely hope that this bursary can benefit more people like me, so that we can become better doctors in the future.

The trip supported by SMACF was one of the rare opportunities where I was able to learn from experts worldwide, and it has inspired me to continue doing research with the aim of making some changes to better the lives of my patients.

Now that I've graduated, I will continue to pursue my passion in medicine and be a good doctor. The road gets difficult sometimes, but I really hope to be a doctor who is patient-centred and can bring good to patients' lives. I hope that with my research, I can also better the lives of future generations. Thank you SMACF, for making a difference in my life!

SMACF would like to express our heartfelt appreciation to all donors who share our vision of developing a compassionate profession that impacts healthcare! ◆

Donations towards SMA-MSAF can be made online via the SG Gives website at **https://www.sggives.org/smacf** or by cheque or credit card donations. The donation form is available on our website at **https://www.sma.org.sg/smacares**. All donations to SMA Charity Fund will qualify for tax deductions benefits of three times the donations made between 1 January and 31 December 2015. SMACF will also receive matching donations from the Government under the Care and Share Movement.

PROFILE

TEXT BY

JENNIFER LEE

Deputy Manager, SMA Charity Fund

Legend

1. Dr Sharon Tan Si Heng feeling thankful for the support she has received from SMACF back during medical school

MEDICINE, LAW, PROFESSIONAL REGULATION AND ETHICS

— PART 2

ETHICS & PROFESSIONALISM

Medical practice is probabilistic; it is an imperfect science, based on complex, vast yet evolving knowledge carried out in teams, and subject to communication lapses and individual biases. Each patient is also unique. Laws, regulations and practice guidelines cannot provide mechanical solutions, but provide a framework for sound decision-making in practice.

Healthcare professionals should deliver care that stands up to legal and professional regulatory scrutiny, and is of high ethical and conscionable standards. The application of ethical deliberation coupled with clinical competence assists in achieving this by providing a systematic objective method of analysis and reasoning.

Ethics articulates desirable conduct, ideals and virtues, delineating moral standards. Ethical deliberation employs philosophical ethical theories, as well as ethical principles and tools as part of the reasoning process of coming to a sound medical decision. Ethical reasoning sometimes underpins decisions in law, and ethical deliberation can occasionally even result in revision of the law.

PHILOSOPHICAL REASONING

Philosophical approaches in ethical reasoning include consequentialism, deontology and virtue ethics. Consequentialism is a school of thought that is "outcome based", looking to achieve greatest good or happiness for the greatest number, and maximise "total benefit", and not at the distribution of benefits and burdens. Utilitarianism is one form of this.

Deontology is, on the other hand "rule based", where certain actions are considered "universal wrong" (for example, a human being must never be treated as a means to an end but as an end in itself), and not based on the consequence of the action.

Virtue ethics emphasises the role of one's character and the virtues that one's character embodies as determining or evaluating what ethical behaviour is.

Decisions that have a higher policy level impact, for example, whether human organ trading or active euthanasia should be allowed, often benefit from deliberations based on such theories.

ETHICAL GUIDELINES

Professional ethical guidelines, which for the medical profession is the Singapore Medical Council (SMC) Ethical Code and Ethical Guidelines, are strictly speaking more of a regulatory instrument that sets out minimum standards (rules as determined by the profession) for the profession. It is effectively intra-profession "pseudo-law". While it is largely based on ethical reasoning, it is not ethics per se, but rather sets out the minimum standards expected of an ethical professional. They remain good professional aspirational statements, references and sources of ethical standards.

CASUISTRY OR CASE-BASED REASONING

Practice-oriented tools for ethical deliberation are largely for day-to-day clinical decision-making. The

four principles approach[1] balances the principles of beneficence, non-maleficence, autonomy and justice to enhance clinical decision-making. In the four boxes approach,[2] the clinician is offered a framework of collecting and collating information into the four boxes, namely — medical indications (questions on medical beneficence), quality of life (questions on beneficence, non-maleficence and autonomy), patient preferences (questions on autonomy) and contextual features (questions on justice and fairness) are weighed up to facilitate sound clinical decision-making.

Case-based ethical deliberation requires a clear understanding of both medical and non-medical information for the issues to be properly weighed up in each individual case. Take the case of a moderately demented 70-year-old lady with fractured neck of femur for example. She expresses the wish to walk again, yet refuses any operation in the face of active persuasion. Important medical information relevant to this case include decision-making capacity, patient's diagnoses, prognosis flowing from the different treatment options, baseline physical function and, if mentally competent, the baseline mental function.

In the face of an unwise decision in such a patient, it is appropriate to consider whether she lacks mental capacity to make this decision. Here, the 2-stage test which section 4 of the Mental Capacity Act (MCA) calls for should be applied. Is the person suffering from an impairment of, or disturbance in the functioning of the mind or brain? In this case, the answer is "yes" (dementia). The follow-on question is whether the impairment or disturbance causes the person to be unable to make a decision when she needs to.

This requires application of section 5(1)(a)-(d) of the MCA; whether she can understand information relevant to the decision, retain that information, use or weigh that information as part of the process of making the decision and to communicate her decision (whether by talking, using sign language or any other means). If all the limbs for this particular decision are satisfied and she is mentally competent, the law is that her wishes must be respected.

If a four boxes approach is undertaken, and review of the contextual features shows that the patient worries that cost of surgery results in excessive financial strain for her main caregiver daughter, but further reveals a wealthy son whom she thought to be prodigal but is actually willing to pay "whatever it takes" for the welfare of his mother. The patient then becomes receptive to surgery and changes her mind. Her best interest is now achieved.

This simplified illustration demonstrates how a methodical ethical review of a case, where a superficial application of law might indicate a different course of action, results in a better outcome for the patient and the healthcare team.

CONCLUDING REMARKS

The practice of medicine today is highly regulated. We all need to acquire the knowledge and skills to enable strong professional accountability. A separate body of knowledge to that for clinical competence is required for ethical reasoning. Supervision and mentoring then help develop the skill to apply the appropriate ethical principles in problem-solving.

Deficits in ethical reasoning as well as understanding of the law and professional standards relevant to medical practice must be addressed to enable sound clinical decision-making. Decisions should be based on both clinical and ethical reasoning, while conforming to the law and ensuring legal and professional standards are met. The clinician needs a combination of knowledge in medicine, medical law and professional regulations, ethical analysis and judgment together with strong interpersonal and communication skills. ◆

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1. Beauchamp TL, Childress JF. Principles of Biomedical Ethics, 7th ed. Oxford: Oxford University Press, 2012.
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PROFILE

TEXT BY

DR PETER LOKE

Teaching Faculty, SMA Centre for Medical Ethics & Professionalism

Dr Peter Loke is a partner in Mint Medical Centre (Family Medicine), and Resolvers (private mediation and alternative dispute resolution). He is an adjunct senior lecturer in the Centre for Biomedical Ethics, National University of Singapore; and Regional Medical Adviser for Syngenta Asia Pacific Pte Ltd. He is also a Fellow of Chartered Institute of Arbitrators, and Fellow of Singapore Mediation Centre.

TEXT BY

DR T THIRUMOORTHY

Executive Director, SMA Centre for Medical Ethics & Professionalism

Dr Thirumoorthy has been involved in the SMA CMEP for the last 15 years and has been Faculty at Duke-NUS Graduate Medical School since 2007. His teaching responsibilities include subjects on clinical skills, professionalism, medical ethics, communications and healthcare law. He has been practising medical dermatology at Singapore General Hospital since 2002.

CHASING DRAGONS AND EXORCISING DEMONS:

Strange patient encounters of an army doctor

A/Prof Cheong Pak Yean remembers fondly his days as an army doctor in a recruit camp in the 1970s. He led a carefree life, interrupted only by strange encounters with patients, two of which he vividly recalls.

CHASING DRAGONS

Heroin addiction was endemic in Singapore then. In every intake of about two thousand recruits, I tended to a few who were down with "shakes, shivers, sniffles and shits" for cold turkey treatment. Using antihistamines, kaopectate, paracetamol and lots of blankets to ameliorate the withdrawal symptoms, I tided my patients through. I had not been taught how to treat drug addiction in medical school, but after a while, I felt I was coping well. My patients suffered less. Or so I thought.

Home then to me was a large room at the corner of the second floor where the sick bay was. One early morning, answering the call of nature, I went to the adjacent sick bay toilets instead of the officer's toilet downstairs.

When I entered the toilet, I saw a faint glow of light from the gap under a closed cubicle and flickering rays dancing on the ceiling above. Sensing something amiss, I stealthily perched on a stool to peer into the cubicle. Through the opening, I saw a gyrating figure crouched on the floor over a minuscule flame. The recruit was inhaling the bittersweet wisp emanating from the molten heroin he was cooking. He was lost in time, gingerly swirling the molten mass in a cigarette foil to keep it from coalescing. I witnessed first-hand what addicts called "chasing the dragon", in pursuit of the ultimate high. I dramatically kicked the cubicle door open and seized the evidence from the surprised recruit before he could flush it away. The military police was then summoned.

I was not so clinically adept after all! The sick bay returned to the "shakes, shivers, sniffles and shits", which I had to cope with using my limited armamentarium. For the record, I was never assaulted by drug pushers in reprisal. I was never commended either. After all, it never happened. Narcotic abuse never existed in an army camp.

EXORCISING DEMONS

What began as a ripple of piquant interest in the camp soon turned into disquiet. The camp commandant summoned me to his office.

A new recruit had gone into a trance during the morning parade. Dressed in his crisply starched Number 4 uniform, the young man pranced around the parade square in the animalistic movements resembling the "Monkey God", evoking awe and bewilderment in the assembly. A quick-witted National Service officer herded the recruit to his bunk.

The Monkey God (*Sun Wukong*) from the 16th century novel *Journey to the West* is the mischievous monkey incarnate who protected the Tang dynasty Buddhist monk, Xuanzang, on his journey to India. As a kid, I had watched, elated, the scenes of *Sun Wukong* plucking hairs from his body and with magical puffs, transform them into his clones to win cosmic battles against demons.

Words then spread that the recruit was a potent medium (a "*tangki*" or spiritual intermediary) from a famous temple. To the camp commander's dismay, some officers had even prayed to and sought 4D lottery "lucky numbers" from the recruit, believing that the audacious display attested to his supernatural power.

When I arrived at the commander's office, he instructed that the next recruit who entered into a trance be confined to the medical centre instead. I had not encountered such patients in medical school but recalled how patients in status epilepticus were treated. Soon after, another apparently dissociated recruit was forcefully brought in by burly military policemen.

With the patient prancing around like a lion dance performer and literally wrecking my consultation room, I summoned reinforcement to restrain him. I expediently jabbed the patient with intramuscular paraldehyde and monitored his vital signs. I was neither superstitious nor demon-fearing. After the morning sick parade, I reviewed the patient with a phalanx of medics.

Then I did something out of the box. Speaking in *pasar* (market in Malay) Hokkien, I interrogated the recruit who was just out of sedation and demanded that he identify the deity that he was possessed with. I then ostentatiously addressed the deity by name, ordering it never to intrude the camp again because the "crown hat", gesturing to the embossed crest of the Singapore Armed Forces, was almighty in this territory. I also warned that if the deity were to possess the recruit again, they would "both" be thrown into the guard house.

I must have improvised from the famous scene in the 1973 American horror movie, *The Exorcist*, where two priests conducted an exorcism ceremony on Regan, a possessed 12-year-old girl. No new sighting of supernatural phenomena was reported in the camp after that. The impressed medics got it out that even "deities" obeyed the primacy of the crown.

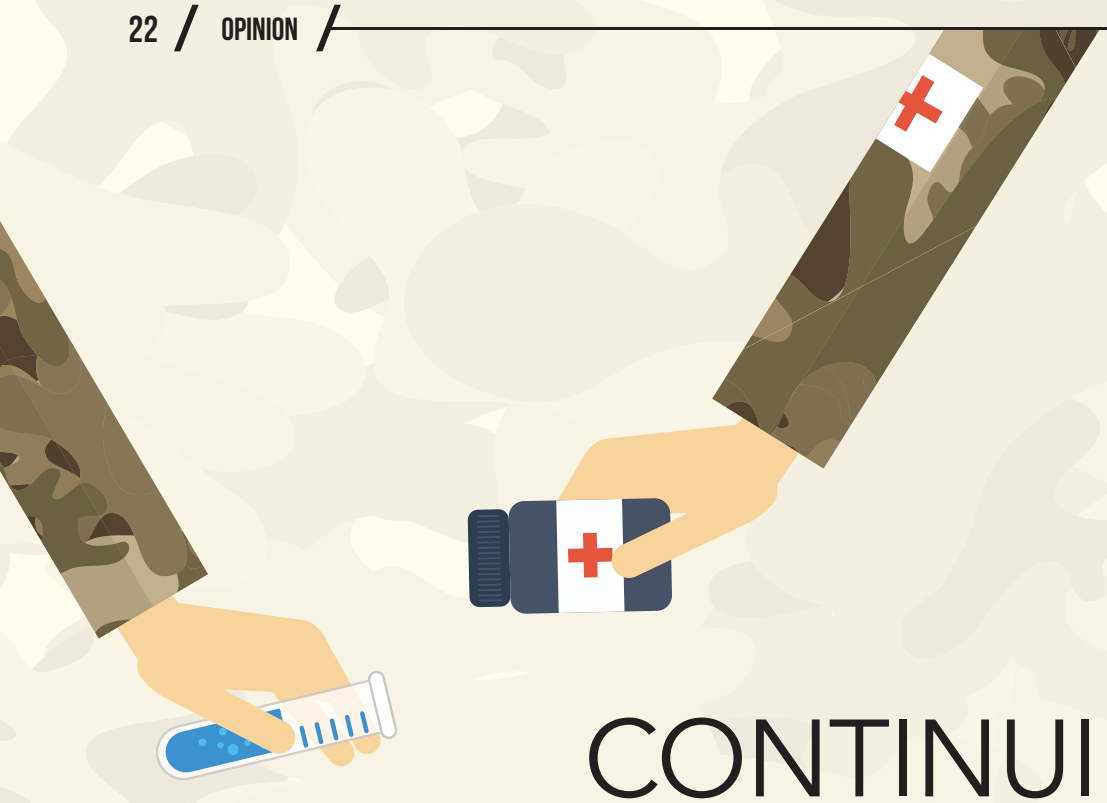
Forty years on, I wonder if the second recruit was just masquerading for secondary gains and if the outcome of the ritual would have been different if I had "commanded" the first patient's "deity" to stop its visitation instead. In the movie, *The Exorcist*, alluded to earlier, the cornered demon devilishly screamed and leaped from the possessed girl onto one of the priests. The possessed priest then rushed to the open window, threw himself out and died. Exorcising demons, I belatedly found out, is dangerous business. ◆

PROFILE

TEXT BY

A/PROF CHEONG PAK YEAN

A/Prof Cheong loves being a teacher and seeing patients. When possessed with a compulsion to decant salient memories, he writes.



CONTINUING TO SERVE

"You must be very young!" My patient exclaimed when I told him that I had been away for In-Camp Training (ICT) last year. Such comments would normally make one feel good, but I had also received a sobering reminder a few days earlier when a young man at the gym addressed me as "uncle".

I have been asked many times why I was still serving as a National Serviceman (NSman) and when I will complete my National Service (NS) cycle. Honestly, for a long time, I did not track how long I had been on the Reservist On Voluntary Extended Reserve Service (ROVERS) scheme. However, earlier this year, after 29 years, I have officially completed my NS and is now on the MINDEF Reserve (MR) instead. While serving full-time NS as a staff officer at Headquarters Medical Corps, I certainly did not imagine that I would continue to be in service 20 years later, albeit in a different capacity as Deputy Commander of a logistics support group. Looking back, it must have been the events, people and experiences that I encountered along the way that led to this decision.

A SENSE OF MISSION

In 1996, I received a rude shock when I was posted to a Guards Battalion as a medical officer (MO), having completed NS in a relatively sedentary posting. In this new posting, several events that occurred during our long and punishing marches served to change my perception of NSmen.

On one occasion, we were trekking through a jungle towards a military objective on the pitch-black night. Suddenly, we saw a deep, wide ditch marked with fluorescent paint. While we had to abruptly slow down to avoid the ditch, none of us fell in. Two days after the exercise, a corporal reported sick to the medical centre. He had a grossly swollen and bruised ankle that appeared to be broken. When asked how he injured himself, he replied that during reconnaissance two nights ago, he had fallen into a ditch while navigating the path for the battalion in the jungle. He also confirmed that he was the one who marked the ditch so that no one else would fall into it.

On another occasion, an officer who works overseas but returns each year for ICT was having morning coffee with me in the camp canteen when he asked, "Excuse me, sir, I'm just wondering whether this is a problem?" He proceeded to remove his boots and socks to show me his feet. To my surprise, the skin of his soles was chafed and his feet were swollen, bare and inflamed. It must have been extremely painful. Again, this occurred after a military exercise the night before.

The third occasion happened at 4 am, towards the end of a three-day field exercise. Exhausted, we were waiting for transportation to take us back to camp when the radio crackled in the silence and an urgent message came through. Another MO in the battalion had called to say that he was treating a soldier suffering from an acute asthmatic attack. The soldier had dropped his inhaler and my colleague had used up his stock on other patients. Two medics jumped up immediately and ran with me over two hills to get to the soldier in question. This was after a particularly long exercise that covered about 40 km. These two medics were overweight and could not usually pass the Individual Physical Proficiency Test no matter how hard they tried. I could hardly expect them to walk properly at that stage, let alone run.

On each occasion, I had asked the four NSmen why they did what they did. I could have certified them sick or excused them from carrying on, yet all of them gave essentially the same reply: "Sir, I've been given a mission. I must complete it so that those who depend on me are not let down." I have been fortunate to serve with these men, and I am sure there are many more out there in other units. *It is the sense of mission.*

BEYOND THE CALL OF DUTY

I have also made many friends, not all of whom are doctors or officers. They come from all walks of life — teachers, lawyers, bankers, construction workers, businessmen, car mechanics, locksmiths and even a goldfish farmer. They have taught me a lot, especially about life outside of the hospital and scientific conferences, and I have found them to be loyal friends. However, I did not fully realise this until last year when I received personal messages of encouragement from many of my military acquaintances when I was going through a professional crisis.

Once, I remember asking one of my officers if he would like to be excused from a particular call-up, as he had already attended a three-week military-related course. He emphatically replied, "No, sir! Of course not! I don't want to miss meeting up with my friends — I see them only once a year." *It is for our friends.*

PROFILE

TEXT BY

DR YUE WAI MUN

Yue Wai Mun is an orthopaedic surgeon who has just left for private practice, after 22 years in public service. He is busy building his new practice while trying not to miss watching his four children grow up.

On a personal note, I have found that being in active military service, especially as a leader, is a good reason to maintain my physical fitness. In no other organisation is the axiom, "Leadership by Example", held so dearly. When I ask those under me to keep fit, I have to show them that it can be done despite our busy work and family lives. This is also true for many other aspects of leadership. *It keeps me honest about myself.*

Overall, it has been a privilege, not a liability, to continue serving NS, and I am grateful to the men whom I have been privileged to lead over the years. ◆

IN NO OTHER ORGANISATION IS THE AXIOM, "LEADERSHIP BY EXAMPLE", HELD SO DEARLY.

THE PHYSICIAN-WARRIOR:

MOVING BEYOND THE CONVENTIONAL MILITARY MEDICINE PARADIGM

This article was submitted to Pointer magazine as part of the "Chief of Defence Force Essay Competition".

Military medicine[1] has been in existence in various forms since the earliest wars were fought — be it on-site care by fellow comrades or established medical units dedicated to provide battlefield support — and has been an integral part of troop support and morale in all major battles.

A key component in the combat medical support structure is the physician. Traditionally, physicians are recognised as healers, practitioners who shun conflict and provide solace and support to the ill and dying. Transposed onto the battlefield, the physician now has to morph into a warrior-like mode — to not only participate in the prosecution of the war, but also prepare the fighters under his charge, both physically and mentally. As warfare and its accompanying ideologies and concepts evolve, so does the raison d'être of the physician-warrior. This article discusses the changing paradigm and emerging challenges that military medicine practitioners face.

SHIFTING SANDS, CHANGING FACES

The conventional thinking that underpins military medicine is frontline casualty care. However, as most armed forces and their medical units are geared largely for deterrence and their daily routines revolve around peacetime training and performance optimisation, this facet of combat support has gradually receded in stature. Instead, peacetime efforts on training and force sustenance are now focused on translational programmes to maximise the human performance envelope (especially for special forces and unique vocationalists such as divers, aircrew, controllers and gunners); enhancement of cognitive processes and responses to generate rapid sense and decision-making (especially for ground commanders); and channelled resources in combatant healthcare and health administration.

The need for the military physicians to double- or even triple-hat these responsibilities meant that they now require exposure to a wider breadth of operations and academic training in order to maintain the edge over their adversaries. This ensures that the troops under their care will be better prepared to fight any conflicts when the need arises. Dedicated training for frontline combat support has consequently transited to a background role.

Beyond that, the military medicine landscape has also evolved significantly since the turn of the 20th century. While first responder and field medical care for the physically wounded and mentally afflicted remain a priority, there have also been leapfrogging advancements in other subspecialties such as aviation medicine, hyperbaric and diving medicine, sports and tropical medicine, infectious diseases and human systems protection. These fields have proven to be critical in supporting an armed forces that is potent and medically well poised to engage the enemies, by training selected combatants to best fit their combat roles. In addition, even the doyens of clinical medicine with military ties, such as clinicians who don military uniforms full time or as part of the medical reserves, have chosen to scope their niche specialisations to those intimately relevant to combat operations and training. These specialties include trauma, psychiatry, tropical medicine, infectious diseases and rehabilitation, among others.

Besides, a military physician will need to develop a distinctly different mindset from his peers who work in the civilian sector. Other than being clinically competent, administratively able and well versed in the combat medicine subspecialty of his calling, he must also be able to transit mentally from a bedside clinician to that of a warrior as war preparations escalate in any impending conflicts. To do that, he must already be embedded in the operations culture on a day-to-day basis so that he is intimately acquainted with operational concepts, technology, behaviour and training pedagogies. He must also have a keen sense and knowledge of operational medicine such as contingency planning (for mass casualties and triage during disaster scenarios, and biochemical warfare countermeasures); consequence management; business continuity and get-well plans; force medical protection and force health; and aeromedical and hyperbaric rescue operations.

A sensitive topic relating to military medicine is the moral obligation of all physicians — *primum non nocere*[2] (first, do no harm). In a fluid war situation and under the caveat of the "fog of war", things develop dynamically and the demands placed on the ground commanders to ensure a "swift and decisive victory" may position the physician in a dilemma. It is thus not surprising that wars have produced battlefield situations in which suspending patient-centred medical ethics has seemed reasonable, at least to the military commanders.[3] To regenerate troopers in the thick

of battles to continue in the war campaign in light of limited medical supplies and manpower, decisions must be made to channel medical response to the "hopeful" (those with minor injuries who can quickly return to the battlefield), rather than the "hopeless" (those with critical injuries who will not last without definitive medical care). To make such a "sacrilegious" decision, the physician must walk out of the boxed-in mental framing of saving "all and sundry" at the expense of operational demands. Whether that is right or wrong remains fiercely debated till this day, but the fact is that such ethical dilemmas exist and in the heat of battle, the medical officer must make that call.

INCREASING OPERATIONAL RELEVANCE

As mentioned earlier, even clinical doyens need to be selective when choosing the appropriate medical or surgical subspecialty that is applicable to the military. To serve the military intent, one must then map the chosen field of clinical practice and crossmatch it to conflict- and combat-related domains. To illustrate this, some examples are listed below.

Surgical fields

This is traditionally thought to be the most applicable to warfare as it encompasses damage control surgery at the frontlines, gunshot wound management, advanced haemorrhage control techniques and kits, trauma orthopaedics (including prosthesis management), reconstructive plastic surgery and burns management.

Psychiatry

Mental health was often overlooked in the past, but has come to the forefront during recent conflicts (Operations Iraqi Freedom for the Iraq conflict and Enduring Freedom for the war on terror in Afghanistan). Subfields comprise niche specialisations and focus


2

on combat stress, combat fatigue, post-traumatic stress disorders, veteran mental and psychological well-being and in-zoning for war preparations. Others include prisoner-of-war psychiatric management, as well as clinical management for survivors' guilt or traumatic near-death experiences.

Occupational and service-oriented specialties

These cover underwater medicine, aviation medicine, sports and rehabilitation medicine, community and occupational medicine, and public health. Increasingly, the doctor has a greater role in combatant selection, training and safety management. Special military vocations demand that the applicants undergo and pass a battery of medical, fitness and psychological tests. Military physicians are now increasingly thrust into the realm of designing and scoping these tests, to ensure that standards are maintained and the right applicants selected. After that, they assume the role of trainers, in which they supervise and monitor specific areas of military training that require medical oversight. Some examples include bounce dives, hypobaric and hyperbaric chamber exposures, and centrifuge training.

Finally, the military doctor also has to immerse himself in human systems protection and performance maximisation. As we stride into the 21st century, the human operator is now the limiting factor in operating war machines. As such, we now begin to visualise the man-in-the-loop as a weapon system and design programmes to enhance and protect this unique weapon system. This is an ever-expanding field that covers a myriad of considerations — the physician needs to come up with plans (such as heat countermeasures, acclimatisation and monitoring) to help the operator overcome environmental stressors and threats (biochemical, radiological or thermonuclear), and even entraining the war fighters to extended nocturnal operations. In addition, there is the need to surpass cognitive limitations and raise reactive or projective thresholds in the human operator; such areas encompass situational awareness training, uncertainty management, and even the OODA (Observe,

Orientate, Decide, Act) loop thinking process. Thus, military doctors need to collaborate closely with clinical psychologists to achieve these aims. Last but not least, the onus is on the physician to devise equipment and implement survival training and know-how for troopers, working in conjunction with the survival trainers in the force.

The scope of the military physician does not end with the roles described above. He also features prominently in accident and/or incident investigations and analysis, providing a slice of medical insight into the overall dissection of the event and giving input on the likelihood of medical conditions or human errors contributing to the incident.

THE PHYSICIAN OPERATOR

The military doctor dons multiple hats and is a vital cog in the machine that is the military organisation. He has to understand key military operations and doctrines in order to design the appropriate combat support plans and be deeply knowledgeable about operator behaviour in order to train operators to the suitable level of competence and safety. He also has to be dynamic in applying himself in order to utilise existing technological advances to achieve the above-mentioned aims (such as designing information technology systems or capabilities to ensure a robust and flexible medical support structure that provides seamless support across the peace-war continuum). He is thus no longer just a doctor, but a fellow military operator and a practitioner of medicine deeply knitted in the battlefield tapestry.

Moving ahead, the military medicine community is also increasingly being leveraged in the larger geopolitical sphere. In the event of an armed conflict, post-war resolution would require the services of medical teams, largely from the military, to defuse tensions in the civilian community either in the form of direct healthcare services to the affected public, or humanitarian aid or disaster relief to occupied areas. This paints the picture of a benevolent force that cares for the people on the ground, thus enhancing civil-military relations.

CONCLUSION

The practice of military medicine is no longer restricted to battlefield casualty care. Its scope has increased dramatically over the years. The footprint and importance of its contribution will certainly increase in the coming years, and it is the establishment's prerogative to ensure the sustained attraction and retention of the brightest minds to maintain this intangible edge. Regardless of its transformation and criticality, military medical practitioners must never forget the mandate to "seek, save and serve" because this is the duty we were called to carry out in the first place. ◆

Notes

1. Extracted from www.wikipedia.org. The term "military medicine" has several potential connotations. It may mean: (1) a medical specialty, specifically a branch of occupational medicine attending to the medical risks and needs (both preventive and interventional) of soldiers, sailors and other service members; (2) the planning and practice of surgical management of mass battlefield casualties, and the logistical and administrative considerations of establishing and operating combat support hospitals; (3) the administration and practice of healthcare for military service members and their dependents in non-deployed (peacetime) settings; or (4) medical research and development specifically bearing upon problems of military medical interest.

2. From the Hippocratic Oath undertaken by all physicians.

3. Annas GJ. Military medical ethics — physician first, last, always. New Engl J Med 2008; 359:1087-90.

PROFILE

TEXT BY

LTC (DR) KOH CHOONG HOU

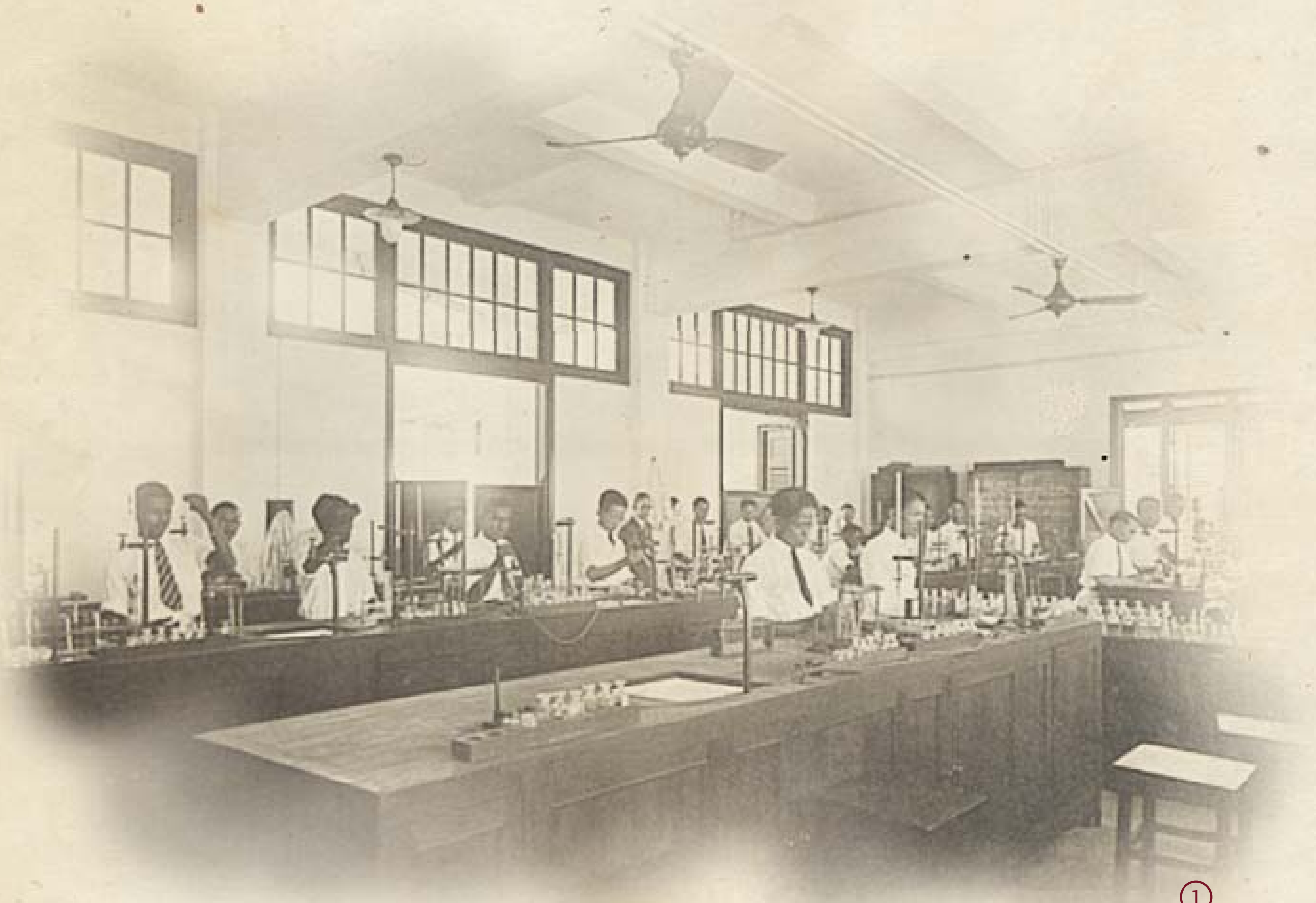
LTC (Dr) Koh Choong Hou "Walli" is an Associate Consultant in Aviation Medicine from the Republic of Singapore Airforce. He is currently pursuing further specialist training in cardiology. He is a veteran of Operation Blue Ridge — Singapore's contribution to the reconstruction efforts in Afghanistan. Unlike fighter pilots, his favourite attack manoeuvre is photo-bombing.

Legend

1. An SAF medical personnel interacting with the International Security Assistance Force counterpart and an Afghan patient

2. SAF medical personnel undergoing in-theatre combat refresher training

A Glimpse into the Past



1

MEDICINE IN SINGAPORE (PART 4)

1906 TO 1912: CLINICAL TEACHING, TRAINING AND EVOLUTION

This is the fourth instalment of a series on the history of medicine in Singapore.

In 1906, the Medical Student's Recreation Club was set up at the site of the former railway station to offer sport facilities. In 1907, introductory classes in clinical medicine and clinical surgery were held at the General Hospital (GH), and a new lecture theatre with 120 tiered seats was built in the school. In the same year, students began to learn practical pharmacy at the Government Outdoor Dispensary at Kandang Kerbau Hospital (KKH) and gynaecology at two wards meant for prostitutes. The Government Analyst's laboratory was also shifted to Sepoy Lines that year.

In 1908, students began attending clinical medicine at the GH and minor surgery at Rumah Miskin in Balestier, the latter being better staffed and under the charge of Dr GA Finlayson, the Government Pathologist from 1905 to 1926. Ophthalmology was taught by Dr FW Moore at Tan Tock Seng Hospital (TTSH) and clinical surgery by Major EM Pilcher. There was a good deal of surgical training at TTSH; by 1910, 583 operations had been performed, with the technique of spinal anaesthesia and iodine disinfection of the skin being practised during operations.

On 3 February 1909, Dr Gerald D Freer was transferred to Selangor as Senior Medical Officer. Before he left, the medical students presented Dr Freer with a farewell scroll contained in a beautiful silver cylindrical scroll-holder, measuring 10.5 inches in length and 3 inches in diameter. Made in Canton, China, the holder was beautifully chased with magpies among prunus blossoms and branches. An undated inscription on the silver scroll-holder reads: "To/ Dr GD Freer/ From the Students/ Medical School/ Singapore".[1] The current whereabouts of the scroll is, however, unknown.

In February 1909, Dr Robert D Keith succeeded Dr Freer as Principal, while Dr SM Livesey succeeded Dr Keith as Physiologist and Assistant Pathologist. Dr Livesey obtained the Fellowship of the Royal College of Surgeons of Edinburgh in 1911, but resigned in January 1912, as the school had no Chair of Surgery. In June 1912, Dr J Gray, the resident medical officer (MO) at TTSH was appointed to the newly created post of Surgeon to the Singapore hospitals. In June 1913, Dr Gray was appointed Surgeon to the Penang hospitals. Dr ED Whittle, who had been appointed MO in Penang in December 1909, took over as Surgeon to the Singapore hospitals, Lecturer in Surgery to the Medical School and Visiting Surgeon to TTSH. The MO in charge of TTSH was Dr JR McVail, who also officiated as Surgeon of TTSH because the post was not officially created until 1914, when it was taken up by Dr CJ Smith, who was transferred from the Federated Malay States Medical Service.

In 1914, 1,853 operations were performed at TTSH (1,443 in 1913 and 941 in 1912). At the GH, 261 operations were performed in the first-, second- and third-class wards, while 861 operations were performed in the native ward. At the women's hospital at KKH, 78 major and minor operations had been performed by then. At the medical school, the surgical subjects taught included surgical anatomy by Dr TD Kennedy; anatomy and osteology surgery by Dr ED Whittle; clinical surgery by Drs ED Whittle, CJ Smith and

PROFILE

TEXT BY

A/PROF CUTHBERT TEO

Editorial Advisor

A/Prof Cuthbert Teo is trained as a forensic pathologist. The views expressed in the above article are his personal opinions, and do not represent those of his employer.

Legend

1. Biochemical Laboratory, College of Medicine

2. King Edward VII College of Medicine

3. Opening of the new King Edward VII College of Medicine

Photos by SGH Museum

2

JR McVail; and ophthalmology by Dr FW Moore. By this time, the principal of the medical school said that the teaching of surgery and clinical surgery "is now greatly improved by the establishment of a highly efficient permanent surgical staff". Unfortunately, Dr Whittle and his wife were tragically killed in January 1915 during the Sepoy Mutiny in Singapore.

In May 1910, the first batch of seven medical students (known as the "Magnificent Seven") graduated from the Straits Medical School with a Licentiate in Medicine and Surgery (LMS). Among them were Drs SR Krishnan from Seremban; John Ganaparagasam from Selangor; Chen Su Lan, Mark W Chill and Edwin Williborod de Cruz from Singapore; John Scott Lee from Ipoh and William F Carnegy from Penang.

In a 1973 Alumni Association newsletter,[2] Dr EW de Cruz gave an account of his experience, written in a steady handwriting, which was the joy of nurses and dispensers: "... In all, I spent four years in Malacca, 20 years in Singapore and 13 years in Penang, serving the government. ...All through my life, I endeavoured to live up to the principle which Dr Finlayson had inculcated in the first batch of students. 'If you want to take up medicine,' he said, 'don't do it for gain. Do it for good.'" Dr de Cruz, who died in March 1974, was the last surviving member of the first batch of seven doctors who graduated in 1910.

Dr Teh Lean Swee, who was admitted into the College in 1910 as the fifth batch (before any one had graduated) and graduated in 1914, wrote about Dr RD Keith in a 1969 Alumni Association newsletter:[3] "... he did put his heart and soul to reorganising the LMS (Licentiate in Medicine and Surgery) curriculum with a few professors as lecturers. But unfortunately, sarcoma of the rectum forced him to retire early to Scotland before achieving success. However, through the untiring efforts of his successor, Dr MacAlister, the Singapore LMS was

at last recognised. ... The memory of Dr RD Keith has aroused in me a sense of gratitude and honour, and to pay tribute to my alma mater, especially to the teaching staff, whom I still vividly remember..."

By 1915, there were 59 graduates, 117 by 1920 and 233 by 1930. In 1916, the LMS was recognised by the General Medical Council of the United Kingdom (GMC). At that time, local graduates of the Medical College could only look forward to careers as assistant apothecary, hospital dresser and sub-assistant surgeon. They could not become MOs, a post reserved only for Europeans. The locals were called "Asiatics" by the Europeans.

In 1911, the new Tan Teck Guan Building was added to the medical school. It was built from funds donated by a Chinese benefactor, Mr Tan Chay Yan, in memory of his father, Mr Tan Teck Guan (sometimes spelt as Tan Teck Gein). This building served as the administrative block, containing the Principal's and clerk's offices, a new medical library, reading room, lecture room and pathology museum.

In 1912, the medical school received a large donation ($120,000) from the King Edward VII Memorial Fund started by Dr Lim Boon Keng in 1905, for the founding of the Medical School. On 18 November 1913, the name of the school was changed to King Edward VII Medical School. In 1919, the GMC warned the college of possible de-recognition if standards of teaching and examination were not maintained. Thus, the government in Singapore contributed more resources to the school, and professors were soon being appointed. In 1921, the name was changed again, to King Edward VII College of Medicine, to reflect its academic status. ◆

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1. Cheah JS. Approaching 100 Years of Medical and University Education in Singapore. (Editorial). Singapore Med J 2003; 44:1-4.

2. de Cruz EW. Reminiscences. In: Lim KH, ed. At the Dawn of the Millennium: 75 Years of Our Alumni. Singapore: Singapore University Press, 2000: 393-6.

3. Teh LS. From an early alumnus – why come to a reunion? In: Lim KH, ed. At the Dawn of the Millennium: 75 Years of Our Alumni. Singapore: Singapore University Press, 2000: 397-9.

SUPER CLINICS: THE WAY TO GO? — PART 1

"Hi, how are you and your shared practice with your partner?" This common greeting evoked an interesting response from my ex-classmate during a recent conversation. "Oh, thanks for asking. My practice is fine now. My partner and I have split, but we continue to practise in the same clinic."

Germaine is a GP who was practising in a two-doctor practice in an older part of Singapore. She and a friend had bought over the clinic about a decade ago, and the clinic had been doing fine since. However, in the past few years, Germaine noticed that her partner had gone into a "hibernation" mode while she attended to most of the patients. After a few confrontations, Germaine and her partner decided to part ways, but instead of tearing down the set-up, they decided to split accounts. Now, they each own a consultation room at their two-doctor practice — an interesting development.

A similar arrangement was seen at the recent opening of the Hougang Family Medicine Clinic (FMC) @ Ci Yuan Community Club. It gives us a glimpse of what a "super clinic", as the Australian GPs call it, can achieve for the fraternity and the public. The FMC tries to replicate the Australian model, where each doctor employed is an individual owner of his or her practice, but everyone is supported by a common team of administrators and allied healthcare workers.

The main difference between the FMC and Germaine's clinic is that the former started as a deliberate plan to attain the same success enjoyed by our overseas colleagues, while the latter was born out of a need for an ingenious plan to save her practice.

EVER-CHANGING HEALTHCARE LANDSCAPE

The Singapore healthcare landscape is rapidly changing. There are new schemes and policies being implemented every few months. All these are in an attempt to solve the over-burdened public institutions.

PROFILE

TEXT BY

DR LEONG CHOON KIT

Editorial Board Member

Dr Leong Choon Kit is a GP in the private sector. He is an advocate of the ideal doctor which is exemplified by one who is good at his clinical practice, teaching, research and leadership in the society. His idea of social leadership includes contributing back to society and lending a voice to the silent.

Disclaimer:
The above article is a reflection of the author and not as a result of owning or running any of the FMC.

I REMAIN CONFIDENT THAT THE SUPER CLINIC CONCEPT IS THE IDEAL MODEL FOR THE FUTURE OF PRIMARY CARE.

In the private sector, our colleagues are also experiencing their own set of challenges. These include new policies arising from Managed Health Care companies, evolving expectations from a newer generation of Singaporeans shaped by the new policies, and ever increasing rental and drug prices, among others.

Dealing with these challenges has taken a toll on many GPs. Looking forward, the FMC or Germaine's model could well be the eventual GP model here. So, what are some of the potential benefits of this model?

ATTRACTIVENESS OF THE SUPER CLINIC

MAINTAIN DOCTORS' AUTONOMY

The super clinic concept allows doctors to retain their autonomy in their practice. They are able to see the same patients and continue their practice in a manner that they are accustomed to, such as prescribing the same medications.

BETTER PATIENT MANAGEMENT

With better administration support in place, patients can be tracked and organised according to an appointment system, which reminds them to attend reviews and go for various necessary tests. The patient's condition can also be closely tracked and monitored by fellow medical colleagues.

OPTIMAL FINANCIAL MANAGEMENT

With a more efficient administrative system, cash flow will likely improve, too. For instance, more modes of payment can be made available to patients and outstanding payment can be better managed. Submission of claims will also be more timely and efficiently.

WELL-STOCKED DISPENSARY

A super clinic with a consolidated management and dispensary can capitalise on their economy of scale to enjoy better drug prices. Some medicines that are seldom used can be expensive to stock up, but with a consolidated practice, keeping this stock becomes possible. Ultimately, the public will enjoy a larger repertoire of treatment options.

ADOPTION OF INNOVATION

With a larger set-up, the super clinic is also more likely to adopt innovative ways of running the clinic and managing the patients. With the smart nation initiatives, these clinics may also be able to participate in some trials to enhance the quality of life among the segment of the population who are elderly but well. All these will allow the GP to truly practise family medicine from cradle to grave, from preventive care to clinical care.

FREE UP DOCTORS' TIME

All the above improvements will also free up doctors to do things they enjoy. With extra time, GPs can choose to see more patients and earn more, or spend more time with their family, travel the world, train for their favourite sports, perhaps even win the elusive Olympic gold medal for Singapore! They can also choose to teach residents and undergraduates, embark on research that they could not previously find the time and resources to do, or maybe even pursue an altruistic dream to help the world through mission trips.

ADOPTING FOR SUCCESS

Admiring the super clinics from down under, I believe the primary care landscape can gradually evolve into something similar. I have never run an FMC before and am still waiting for the opportunity to run one. Despite my many failed attempts at bidding for an FMC, I remain confident that the super clinic concept is the ideal model for the future of primary care. In order to achieve this, the principle and philosophy behind human motivation must be considered. We shall explore some of the essential ingredients for success in the next instalment. ◆

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SMA Members can now enjoy unique offers from our growing group of promotional partners, register for SMA courses and events fuss-free, and even pay your 2016 SMA membership fees online via PayPal or credit card through your **membership portal*** at https://www.sma.org.sg!

**Your Member ID for the membership portal is the email address you indicated upon your membership sign up. You can reset your password on the SMA website. Email membership@sma.org.sg if you have any queries.*

LIFE IN PIXELS

SMA NEWS PHOTO COMPETITION

Calling all photography enthusiasts! To celebrate Singapore's 50th year of independence, we have released a series of theme which reflect the richness of life on this little red dot.

Theme	Closing date	Release of results
Nation Building a play on words: members of the pioneer generation and buildings of historical significant	15 November	End November

The winner of each theme will take home $50 in CapitaVouchers, a Crumpler camera bag and a Canon Digital Ixus lanyard with 16GB thumbdrive. The winning photos will also be featured in the pages of SMA News and on the Life in Pixels website. What's more, winners of each theme are eligible for a finale readers' voting contest and stand to win the grand prize, a DSLR EOS100D Kit sponsored by Canon!

Wait no more and send us your best photos along with your name and MCR/matriculation number at **lifeinpixels@sma.org.sg**, with the name of the theme as email subject. All images must be in JPEG format and sized to at least 2,480 x 3,508 pixels. Include a short descriptive legend (maximum 20 words) for each picture.

This contest is open to SMA members in good standing only. Before submission, check out the contest details at **https://www.sma.org.sg/lifeinpixels**.

Organised by Singapore Medical Association — For Doctors, For Patients

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In celebration of SG 50

THE CRAFT OF BOOKBINDING

Many of us have had books fall apart after a couple of reads. But some books have withstood the passage of time, passing down the joy of reading through the generations. What is the difference between a machine-made book and an expertly crafted leather-bound one? Dr Terence Tan speaks to Adelene Koh, whose love for the ancient craft of bookbinding led her to give up her career to pursue it as a profession.

1

Could you share with us what bookbinding is and how you got into this profession?

Bookbinding is an age-old craft that has been around for a long time. Books, as we know today, are mainly a thing of utility where information is passed, a form of quiet entertainment, or even simply to prop up a table. However, this form as we know it has evolved in many ways to what it is today. Bookbinding brings together many components, such as the work of the author, illustrator, paper maker, printer, leather tanner, and so many others. It is the final part of creating the theatre that sets the mood and tone to how the content of the book is presented to you.

I learnt simple bookbinding in art college. I loved it so much that I taught my sister the craft, too. Soon, we were making handmade journals for friends as birthday gifts. However, I left this hobby behind after graduation and did not pick it up again until 2011 when I was in Brooklyn. There, I met a bookbinder at the New York Book Art Fair and realised that bookbinding is a profession — a real job. I decided to quit my job and dove into full-time bookbinding.

Do you think bookbinding is still relevant in today's market where e-books are becoming more popular?

It is the same as asking whether vinyl records are relevant today. Digital music is readily available, but there are still people who love the motion of putting a vinyl record into the turntable and setting the pin gently down onto the record, and they enjoy every part of that process. It is the same with books. Even though e-books are readily available, many people still love the smell, feel and touch of a beautifully leather-bound book, and enjoy listening to the sound of the paper pages being turned. I would say that many people are keen to own a beautifully made book that has evolved from something that is simply utilitarian to something that is a luxury to have. It is an all-sensory experience when you read such a book.

Could you bring us through the process of binding and the skills it takes to be a master bookbinder?

The many processes of bookbinding vary across different cultures and eras. There are also certain types of books that require more time to process than others. In the past, one has to be an apprentice for a minimum of five years and work as a binder for more than 20 to 30 years before he or she can be considered a master bookbinder. I am still at the infancy of my journey. I think a craft has to be honed over years of experience and not something that

2

4

one can simply tick off a checklist and be considered a master when the list is complete.

What are some memorable projects you've worked on?

I have fond memories of all the books that I've made or restored. Regardless of whether it was an old book that needed restoration after being loved for many generations or a new book that I made, every book has a different "life" story to tell. Before preparing a book for my customers, I usually spend time chatting with them, listening to their personal stories and understanding what they have in mind for the book. I then create a one-of-a-kind bespoke journal based on my experience with them and their stories. As for books made for competitions, I draw inspiration from its content and then create a visual representation of the book on its covers, doublures and endpapers. Even the way I sew it may be influenced by how I relate to the story.

3

Recently you were in the UK for a project but encountered some problems with funding. Can you tell us more about it?

Yes, I was in the UK for the Society of Bookbinders Education and Training Conference. It is a biannual conference where many master bookbinders gather for three full days of lectures, demonstrations and workshops. I was very privileged to be able to attend the conference and met with many like-minded people. After the conference, I spent a month with my mentor in London to create my design binding for an annual bookbinding competition. During that time, I also applied for the Certificate of Competence by the Society of Bookbinders.

However, pursuing a bookbinding certification has always been a struggle. Bookbinding has become a very niche craft and not many people know about what I do. Because many things have been mechanised or computerised, most books these days are machine-made and hand bookbinding is not commonly heard of in Singapore. Thus, my recent attempt to seek funding from a local council was unfortunately declined again and I turned to crowd-funding instead. I am very grateful for the many people who have come forward to support me.

What's next on the horizon for you?

There is so much, really. At the conference, I was one of the younger people among experienced bookbinders who had been binding for at least 30 or 40 years. One of the oldest and most respected binders there is 90 years old this year. So I would say that I look forward with great anticipation to improving my bookbinding skills. One day, I hope to be the grand old lady in Singapore who has an abundance of interesting stories to tell through the books that I have made. ◆

PROFILE

TEXT BY

DR TERENCE TAN

Dr Terence Tan is a full time locum. He has a strong interest in the arts and publishes a guitar and a ukulele magazine with the time that he has outside of work and family. Feel free to contact him at terence@guitarbench.com.

Legend

1. Customised full leather journal with leather onlays of cats for a fund pledger of Adelene's UK trip in August 2015
2. Breakfast at Tiffany's by Truman Capote bound by Adelene. This received the "Highly Commended Certificate" in The Bookbinding Competition 2015 by Designer Bookbinders UK
3. Mark Cockram, Adelene's mentor and tutor, in London, sharing the joys at the Prize Presentation Ceremony and Exhibition for The Bookbinding Competition 2013 & 2014
4. Display of entries for the The Rubáiyát of Omar Khayyám

Photos by Louis Kwok

GUIDING YOU THROUGH CHAS AUDIT: A QUICK REFERENCE

We understand the challenges GPs face daily, juggling patient care and CHAS administration. In a two-part series, we will share a quick reference covering the do's and don'ts of CHAS claims submissions.

PATIENT CONSENT FORM (PCF)

Patient consent should be obtained at the patient's first visit to your clinic, and the original PCF must be kept either with the case notes or in a separate file.

COMMUNITY HEALTH ASSIST SCHEME ("CHAS")
PATIENT CONSENT FORM

PART I: PARTICULARS OF PATIENT

PART II: AUTHORISATION & DECLARATION BY PATIENT FOR INFORMATION DISCLOSURE

PART III: DOCTOR'S/ DENTIST'S CERTIFICATION

Please ensure all fields are correctly filled, according to patient's NRIC. If you require postal code information, please go to http://tinyurl.com/streetindexsystem[1]

If the patient is below 18 years old, a parent/guardian must sign on the patient's behalf. Please indicate the parent's/guardian's name.

If the patient is illiterate, a thumbprint can be taken.

Please ensure all fields are correctly filled. You may use your doctor's name stamp for convenience. The GP signing the PCF would need to be Medisave-accredited. To check your Medisave accreditation status, please go to: https://www.mediclaim.moh.gov.sg/mmae/Overview

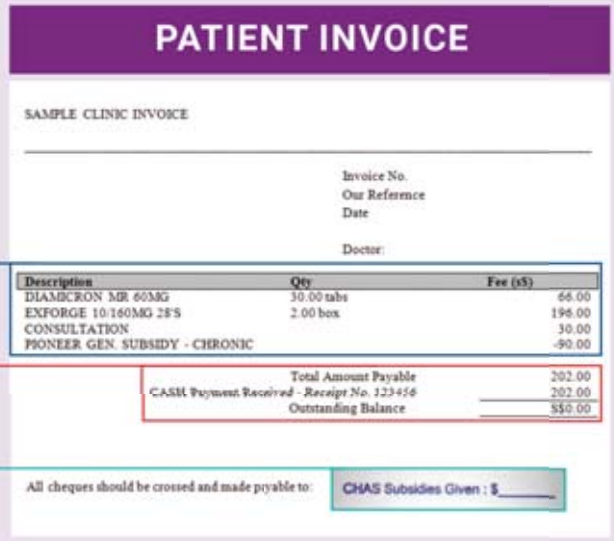
Ensure all existing and new CHAS patients sign the latest version of the Patient Consent Form, dated 1 January 2014.

PATIENT INVOICE

The breakdown of consultation, medication (as well as procedures such as wound dressing and ear-syringing), and investigation (e.g. X-ray, blood tests) for claim submission must correspond with the supporting documents, i.e. patient invoices and case notes. Please provide patients with an itemised invoice/receipt at the end of their visit.

The receipt number must correspond with that submitted through CHAS Online.

GPs can use the CHAS subsidy stamp to record the subsidy amount claimed. If your clinic needs one, please contact AIC below.



SAMPLE CLINIC INVOICE

Invoice No.
Our Reference
Date

Doctor:

Description	Qty	Fee (s$)
DIAMICRON MR 60MG	30.00 tabs	66.00
EXFORGE 10/160MG 28'S	2.00 box	196.00
CONSULTATION		30.00
PIONEER GEN. SUBSIDY - CHRONIC		-90.00

Total Amount Payable 202.00
CASH Payment Received - Receipt No. 123456 202.00
Outstanding Balance $0.00

All cheques should be crossed and made payable to:

CHAS Subsidies Given : $_____

Look out for our January 2016 issue on clinical notes documentation. If you have a question on CHAS which is not covered above, kindly contact **AIC** at **gp@chas.sg** or **6632 1199**

[1] This webpage will redirect you to sis.pa-apps.sg/NASApp/sim/AdvancedSearch.jsp, hosted by pa.gov.sg