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"the duty of confidentiality may become an enigma in the age of information technology, but so long as law and morals are still central to the application of science and medicine, and are justly and morally administered, the computer will not take over, but function only to serve our needs and enhance the quality of our lives."
– Mr Choo Han Teck

THE 1999 SMA ETHICS CONVENTION AND SMA LECTURE

The 1999 SMA Ethics Convention was held on 28 October 1999 at the College of Medicine Building. The theme of this year's Convention was "Patient Confidentiality". The annual Convention aims to equip doctors with knowledge and skills on health law and ethics, especially in this rapidly evolving medical practice. Like previous years, the Convention comprised of 3 events, starting with the Mini Course on Ethics, the 1999 SMA Lecture entitled "Confidence & Confidentiality – Aspects of the Law" by Judicial Commissioner, Mr Choo Han Teck and ending with a Public and Professional Symposium on the same theme.

Mini Course on Medical Ethics

The Chairman, Dr T Thirumoorthy started the Course by explaining the systems that govern human social behaviour. He defined Ethics as a systematic application of values and Medical Ethics is applied ethics concerning medical practice. He went on to outline the principles in Medical Ethics and finally, he reminded doctors their responsibilities with regards to Medical Ethics.

Next, A/Prof Goh Lee Gan touched on the focus of the Course, ie. the issue on Medical Confidentiality. The concept of confidence and confidentiality as well as the 4 principles of confidentiality, ie. (1) in the course of care of the patient (2) with the patient's consent (3) under statutory compulsion (4) in situations with strongly countervailing public interest were explained. A/Prof Goh proceeded to with pointers on the actual practice of confidentiality in the course of care of patient. Case studies were used to illustrate the different situations where the medical confidentiality could be breached and how doctors could safeguard the patient's interest in these situations.

We invited A/Prof Chia Kee Seng of the Department of COFM, NUS, Dr Wong Yue Sie of Ministry of Defence, Mr Venu Nair of NTUC Income and Dr David Chan of Department of Philosophy, NUS to present their perspective on medical confidentiality at the panel discussion. The doctors participated actively, some of whom shared their personal experience. The participants went home with much food for thought. So long as the patient confidentiality is not forgotten, we will be on the right track.

1999 SMA Lecture

A/Prof Goh Lee Gan presents the Gold Medal to 1999 SMA Lecturer, Mr Choo Han Teck.

In line with the theme of the Ethics Convention, Judicial Commissioner Choo Han Teck, the 1999 SMA Lecturer addressed the topic of "Confidence & Confidentiality – Aspects of the Law". Mr Choo concluded that "the duty of confidentiality may become an enigma in the age of information technology, but so long as law and morals are still central to the application of science and medicine, and are justly and morally administered, the computer will not take over, but function only to serve our needs and enhance the quality of our lives." The SMA Lecture is published in full on Page 726. Dr Lim Teck Beng gave a citation of the Lecturer, which is printed in N7.

SMA Ethics Essay Award

This is the first SMA Ethics Essay Award. The Award aims to encourage tertiary students in Singapore to research and review important aspects of medical ethics. The Award is open to two categories, medical undergraduates and non-medical undergraduates. Nine entries were received, out of which 7 essays came from the medical category and 2 from the non-medical category. A/Prof Chong Kim Chong, Head of Department of Philosophy, Prof Feng Pao Hsii and Dr John Tambyah were tasked to judge the 9 entries. The winner of the medical category is Mr Tor Phern Chern, a fourth year medical student from NUS. The title of his essay is "New Challenges facing the Doctor-Patient Relationship the

▶ N7

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NEW MILLENNIUM, NEW YEAR, NEW ASPIRATIONS

The December issue of the SMJ and the SMA News under Prof Kua Ee Heok is always a special one I look forward to. For one thing, he brings along a group of peers each year to reflect on a theme. This year it is on future challenges in medicine. This is an appropriate juncture in time to reflect on this topic as the world races to a new millennium.

For another thing Prof Kua Ee Heok brings to the cover of the journal a holiday look. After all this is holiday time after a year of toil. Hopefully, it has been a fruitful year or a year of growth. Never mind if it has not. We can always look towards the new year.

Hope springs eternal. For in hope, we will live another day, another month and another year. This is the time of the year that each of us should make a review of ourselves, our relationships, our goals and our challenges. Amidst the holiday cheer and light heartedness, may each of us find the quiet time to reflect and set our goals for the coming year.

For your reflection too, Prof Kua has rushed out the SMA Lecture 1999 by Mr Choo Han Teck who is a Judicial Commissioner. Those of us at the Lecture have enjoyed it. Amongst the goals let us not forget the goal to be a doctor. Let us resolve to strive everyday to be a better doctor whose mission is to cure, to care and to comfort. Let this goal be the fountain of energy that will keep us professional and caring, wherever we are, whatever we may be doing through the years.

But for a while, let us relax, put on the music and bring out the gifts.

May I wish you happy holidays and a happy new year. ■

A/PROF GOH LEE GAN

A Visit from ST. NICHOLAS: The Next Generation

(A Star Trek version of Twas the Night Before Christmas)

'Twas the night before Christmas, when all through the ship
Not a circuit was buzzing, not one microchip;

The phasers were hung in the armory securely,
in hopes that no aliens would get up that early.

The crewmen were nestled all snug in their bunks
(Except for the few who were partying drunks);

And Picard in his nightshirt and Bev in her lace,
Had just settled down for a nice face to face...

When out in the halls there arose such a racket,
That we leapt from our beds, pulling on pants and jacket.

The bridge Red Alert lights, which flashed through the din,
Gave a luster of Hades to objects within.

When, what, on the viewscreen, should our eyes behold,
But a weird kind of sleigh, and some guy who looked old.

His sleigh grew much larger as closer he came.
Then he zapped to the bridge and addressed us by name:

"It's Riker! It's Data! It's Worf! and Jean-Luc!
It's Gordi! and Wesly, the genetic fluke!

"To the top of the bridge! To the top of the hall!
Now float away! Float away! Float away all!"

As leaves in the autumn are whisked off the street,
So the floor of the bridge came away from our feet,

And up to the ceiling our bodies then flew,
As the captain called out, "What the...is this, Q?!"

The prankster just laughed and expanded his grin,
And snapping his fingers, he vanished again.

As we took in our plight and were looking around,
The spell was removed, and we crashed to the ground.

Then Q, dressed in fur from head to his toe,
Appeared once again, to continue the show.

"That's enough!" cried the captain, "You'll stop this at Once!"
And Riker said, "Worf! Take aim at this dunce!"

"I'm deeply offended, Jean-Luc," replied Q,
"I just want to celebrate Christmas with you."

As we scoffed at his words, he produced a large sack,
He dumped out the contents and took a step back.

"I've brought gifts," he said, "just to show I'm sincere.
There's something delightful for everyone here."

He sat on the floor and dug into his pile,
And handed out gifts with his most charming smile:

"For Counsellor Troi, there's no need to explain,
Here's Tylonol-Beta for all of your pain.

For Worf I've some mints as his breath is not too great,
And for Geordi Laforge, and inflatable date.

For Wesley, some hormones, and Clearasil-Plus;
For Data a Joke Book, for Riker, a truss.

For Beverly Crusher, there's sleek lingerie,
And for Jean-Luc, the thrill of just seeing her that way."

Then he sprang to his feet with that grin on his face,
And clapping his hands, disappeared into space.

But we heard him exclaim as he dwindled from sight,
"Merry Christmas to all, and to all a good flight!"

By William Schwab

CONFIDENCE ON CONFIDENTIALITY – SOME CURRENT ISSUES

The doctor-patient relationship is based and built on trust – and confidentiality of information provided is a cornerstone of this relationship. For the most appropriate medical care to be provided, patients must be confident that they can freely disclose information to their doctors. Uncertainty about confidentiality erodes confidence in the healthcare system.

The 1999 SMA Lecture[1] by Mr Choo Han Teck, Judicial Commissioner, examined the legal aspects of medical confidentiality and the philosophical basis of rights and duties of the individual and society. It provides a ethical framework to reflect on some current issues of confidentiality confronting the medical profession – issues arising from the pervasiveness of commercial forces, burgeoning healthcare technologies and the increasing demand for healthcare information from third parties for audit and research.

These current issues are discussed under the four principles governing confidentiality – that information should not be disclosed unless in the course of care of the patient, with the patient's consent, under statutory compulsion, and in situations with strongly countervailing public interest.

In the course of care of the patient

The increasing use of integrated electronic medical records (EMR) and the ownership of and access to physical records by persons other than the patients' own providers are two issues that need to be studied.

The concern that a nation-wide integrated EMR in Singapore, called 'central healthcare database infringes privacy' was the subject of a Straits Times reader's letter published on August 19 1999. The Ministry of Health assured in a reply on the 28 August 1999 that 'various pertinent issues including the ethical, security and legal aspects as well as patient confidentiality are being looked into before the system is implemented'.

The proposed system in Singapore aims to achieve closer integration between the EMR of the primary care providers and the hospitals to provide 'better healthcare for all'. There is however the inevitable trade-off brought on by such aggregation of information viz. between ease of access versus security of the record, between timeliness in situation when expressed consent is not possible, versus the need for consent based on specific needs/time period. Thirdly there is also the utility of keeping only clinically significant records versus the temptation of accumulating detailed data from all sources.

"Doctors and advocates of patients must collectively grapple with the implications of the new economics and technologies on the ethics of medical practice and preserve this confidence on confidentiality."

Until these issues regarding confidentiality are ironed out, it may be prudent to implement integrated EMR on a limited basis on critical information, like drug allergies, and comprehensively only on an 'opt-in' bases to benefit those with complex medical conditions. A submission on the same subject by the American Medical Association in 1997 to a subcommittee of the US National Committee on vital and health statistics provides a good overview of these issues[2].

Though Information technology wizardry and legal reforms may provide best-fit solutions to some of the above problems, the medical profession must also keep its house in order. Rind et al[3] cautioned that the most common threat to confidentiality is the inappropriate accessing of information by authorised healthcare providers. It is onerous to audit the legitimacy of access for contextual patient care. Also as many institutions would be participating, the prevention, detection and punishment for cross-institution violations would have to be agreed.

Confidence in the reliability and veracity of information in the EMS is crucial. In an editorial in the Annual of Internal Medicine, 'Reduction of Medical Verbiage: Fewer Words, More Meaning'[4], Voytovich cautioned that the tradition of physicians relying heavily on a larger, less precise terminology (than say air-traffic controllers) could diminish the benefits of integration across institutions with different practice cultures.

There is a need to ensure that the computer axiom of "GIGO", garbage in, garbage out, do not visit these records. A central research and pedagogic authority like the Reed Institute funded by NHS in Great Britain should be considered in Singapore to standardise terms and codes, to educate users and to monitor the system.

Aside from EMR, the ownership and trusteeship of physical medical records also impacts on confidentiality. Our healthcare system allows for non-doctors and commercial organisations to own medical establishments and therefore, the paper in paper-based records and the physical media in which EMR are stored.

They may have a legal but not the same ethical obligation as doctors to patients on confidentiality. An English High Court ruled in May 1999 that doctors and pharmacists who sell information about doctors' prescriptions to a database company for commercial use would breach patient confidentiality even though the information was anonymised[5].

The ethical constraints of using such data may not apply to non-doctor entities. There is a need to work out explicit rules about disclosure and release of such records and punishments for violation if the information is used for commercial gains or in an unauthorised manner.

With the patient's consent

A member of the public wrote to SMA on 3 February 1999 regarding her "Hobson's Choice" on medical benefits when she joined a multinational company. She was asked to sign a statement that read as follows, "I hereby authorise my doctor, medical practitioner, hospital or clinic by whom or where I have been observed or treated, to give particulars about my whole medical history to the company's benefits service centre. A photo copy of this authorisation shall have the full effects of the original authorisation"[6].

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Explicit consent for disclosure is legally given if that document is signed under non-coercive and informed circumstances. However in this particular case, the patient was asked to sign the document before a mandatory pre-employment medical examination as a condition for employment. Should the medical profession therefore take stewardship to ensure that the balance be in the patient's best interest and garnered the support of consumer advocates, civil rights groups and employee's unions against such 'unfair' practices?

Third party payers also exert pressures on doctors. A doctor lamented on 14 January 1999 to SMA that "it has now become common practice for third party payers and insurance companies to demand that diagnosis be stated on the claim form before the amount claimed can be approved and paid to the medical practitioner submitting the claim. The patient's consent is not specifically sought. Doctors "want to do the right thing, only to find themselves shut from the 'contracts'".

It would be a pity if patients in third party payer schemes do not have the choice of seeing doctors who opted out because they are unwilling to compromise patient's confidentiality. Would pragmatists see these 'conscientious objectors' as being out of touch with the times and unnecessarily inflexible?

While there are legitimate needs for defined information by third-party payers, employers and healthcare managers, to ensure a well managed system, unfettered and unauthorised access can lead to intrusion into privacy of patients and discriminatory profit-driven practices. An alliance of consumer advocates employees unions and the medical profession is needed to check the excesses. It would be a 'tragedy of the commons' if all concern groups look away and pretend that only doctors are involved.

Under statutory compulsion

Confidentiality is not absolute in the eyes of the law. A court can order a doctor to breach the confidentiality of his patients and there are laws in most countries enacted in public interest to compel disclosure and notification of certain infectious diseases.

In Singapore, the Private Hospital & Medical Clinics (Amendment) Act of 1999 passed recently empowered the Director of Medical Services to compel healthcare establishments to furnish such information relating to 'the condition, treatment and diagnosis of any person... notwithstanding that the prior consent of such person has not been obtained.'

When the Ministry conducted a 'survey on antibiotic prescribing practices in general practices' in June 1999 by mandating the submission of photocopy of the daily dispensing register, some doctors were uncertain it would be unethical to provide the information as the register also contains patient's personal particulars. The Ministry assured concerned doctors, through the President SMA on 25 June 1999, that personally identifiable medical information would not be included in the data set and that the concerns on confidentiality is noted.

A request for de-identified data would skirt the ethical issue. The providers can easily remove identifying information in EMR. However, the exercise to segregate such data in paper-based records is laborious, if not impossible. Whether the doctor can be found unethical in providing information not de-identified in complying with this Act (should a breach of confidentiality ensures) still remains to be clarified.

While accepting the vital role that research and audit can play for the overall health of the system, the tenuous balance between patients privacy and access to data in the public interest must still be maintained even if greater cost and effort is needed.

Strongly countervailing public interest

Professor of Law in Manchester University, Margaret Brazier believed that 'wider public interest may come before issues of confidentiality'[7]. She argued that the wider public interest in preventing harm to others and preventing crime could exceptionally outweigh both the private and public interest in confidentiality. However, "there must be a real and serious risk of some other person or persons suffering harm if the confidence is not broken. Breaking confidence must be shown to the only effective means of avoiding or minimising that harm.

This appeared to be the rationale for the 1999 amendment in Singapore to "The Infectious Disease Act" section 20D. While the traditional breach of confidentiality pertains only to the statutory requirement to notify the authorities in the list of gazetted infectious diseases, it is now amended in the case of patients who are HIV positive. The amendment allow doctors to inform spouse, former spouse and contacts of HIV infected persons if the doctors reasonably believe that there is significant risk of infection to such persons and the HIV infected person has refused to inform or consent to inform these people despite due counseling. The doctor may also apply to the Director of Medical Service if he was unable to counsel the HIV positive patient.

Confidence on Confidentiality

Doctors and advocates of patients must collectively grapple with the implications of the new economics and technologies on the ethics of medical practice and preserve this confidence on confidentiality. Reaffirmation of the medical profession commitment in our ethical codes can renew the patient's faith in his doctor.

Editorial Note: This commentary is based on A/Prof Cheong's presentation at the SMA Ethics Convention Seminar on Patient Confidentiality which was held on 28 November 1999, after the 1999 SMA Lecture. The full report of the seminar will be published in subsequent issue of the SMA News. ■

A/PROF CHEONG PAK YEAN

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LISTEN, LEARN, LIVE!

1999 WORLD AIDS CAMPAIGN WITH CHILDREN AND YOUNG PEOPLE

Joint United Nations Programme on HIV/AIDS
UNAIDS
UNICEF • UNDP • UNFPA • UNDCP
UNESCO • WHO • WORLD BANK

The 1999 World AIDS Campaign – Listen, Learn, Live!
– focuses on communication with children and young people. It builds on the momentum generated by two years of advocacy through the 1997 Campaign, which featured Children Living in a World with AIDS, and the 1998 Campaign, which highlighted young people as a Force for Change.

Listen, Learn, Live! has two main objectives. The first objective is to raise awareness about the need to listen to children and young people in order for AIDS prevention and care efforts to be effective. The second objective is to strengthen AIDS programmes with children and young people in ten action areas.

It is imperative that we:
Listen to children and young people, hear their views and concerns, and understand what is important in their lives.
Learn from one another about respect, participation, support, and ways to prevent HIV infection.
Live in a world where the rights of children and young people are protected and where those living with HIV/AIDS are cared for and do not suffer from discrimination.

Ten Action Areas to Strengthen AIDS Programmes with Children and Young People

1. National policies that protect children's and young people's rights and reduce their vulnerability to HIV/AIDS.
2. Participation of children and young people in making decisions and supporting and educating their peers.
3. Communication to challenge the social norms that increase children's and young people's risk for HIV infection.
4. Quality dialogue between adults, young people and children.
5. Economic opportunities and vocational training to reduce children's and young people's vulnerability to HIV infection.
6. Quality lifeskills, sexual health and HIV/AIDS education in and out of schools.
7. Child-friendly and youth-friendly health services.
8. Support and care for children and young people living with, affected or orphaned by HIV/AIDS.
9. Reduction of stigma and discrimination surrounding HIV/AIDS.
10. Prevention of mother-to-child transmission of HIV.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together seven UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the United Nations Educational, Scientific and Cultural Organisation (UNESCO), the World Health Organization (WHO) and the World Bank. UNAIDS both mobilises the responses to the epidemic of its seven cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners – governmental and NGO, business, scientific and lay – to share knowledge, skills and best practice across boundaries.

UPDATE ON HIV/AIDS SITUATION IN SINGAPORE

For the first nine months of this year, another 150 Singaporeans were found to be HIV infected. This brings the total number of HIV infected Singaporeans to 1,080 as at 30 Sep 99. Among them, there were 468 asymptomatic carriers, 251 with full-blown AIDS and 361 have died.

Mode Of Transmission of HIV Infection Among Singaporeans

Sexual transmission remained the main mode of transmission among Singaporeans accounting for 96% of all reported cases (1,040 out of 1,080 cases). The remaining HIV infected Singaporeans contracted the infection through intravenous drug use (21), the perinatal route (11), renal transplant overseas (5), and blood transfusion (3).

Hetrosexual transmission was the most common mode of HIV transmission among Singaporeans since 1991, accounting for 72% of all reported HIV infected Singaporeans. Most of these cases contracted the infection through unprotected casual sex and sex with prostitutes in Singapore and overseas.

Profile of HIV infected Singaporeans

The major (954 cases) of the HIV infected Singaporeans were males and 126 were females giving a male to female ratio of about 8:1. Two-thirds (65%) of the cases were between the ages of 20 – 39 years at the time of diagnosis. About 83% were Chinese, 7% were Malays, 6% were Indians and 4% Others.

60% of the reported cases were single. Among the males, 65% were single while among the females majority (70%) were married. Since 1991, there has been an increase in the number of married persons among HIV infected Singaporeans from 14% in 1991 to 38% in 1998. For the first nine months of this year, 39% of the reported cases were married.

MINISTRY'S ADVICE

The ministry would like to emphasise that the only way to avoid AIDS is to remain faithful to one's spouse and to avoid casual sex and sex with prostitutes. A HIV infected person looks and feels normal during the early stage of the infection. It is therefore not possible to tell if a person is infected by looking at his/her appearance.

The Ministry would also like to remind those who are at risk of being infected with the HIV virus not to donate blood. They should see their doctors for HIV screening. All women who are pregnant are encouraged to be screened for HIV infection so that measures to prevent transmission from mother to infant could be taken early. The Ministry would like to assure that the identities of persons who come forward for testing and those who are found to be HIV positive will be kept strictly confidential. ■

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World's Apart Series

If you are wondering whether you should consider psychiatry as a potential specialty to train in, read on ...

10 REASONS WHY I DO NOT WANT TO BE A PSYCHIATRIST

I do not like to be associated with mental illness

Mental illness is perhaps among the most misunderstood diseases in medicine, both by the layman as well as doctors. The stigma in psychiatry is often heightened by movies which make every psychiatric illness a violent and dangerous one, and every psychiatrist strange and often unethical. The most prominent is perhaps the mad psychiatrist, Dr Hannibal Lector. Even serious movies paint a bleak picture of psychiatry such as "One Flew over the Cuckoo's Nest". The truth of the matter is mental illness and the mentally ill need to be understood better. In my practice, 90% of the patients I see are not violent or aggressive but they may have behavioural and emotional difficulties which need care, concern and professional help.

I do not like to practice holistic medicine

As medical students, we study progressively the basic sciences, to the study of the lower forms of life, finally ending in studying the human body and the diseases that afflict it. This is a material approach that makes it easy in physical illness to ignore the person and concentrate on the pathology. Holistic medicine emphasises that such scientific study must be combined with a genuine concern of the patient as a fellow human being. Psychiatry is the medical specialty that deals with diseases of the mind. As such, there is often a need to consider all aspects of the person. For example in schizophrenia, we have not only to treat the neurotransmitter abnormalities, but we have to understand the impact this illness has on the social and psychological functioning of the person.

I do not like to deal with my patients in depth or develop a good therapeutic alliance

In dealing with a patient with a mental disorder, psychiatrists have to understand the patient's background in great detail. Psychiatric history taking may take well beyond 30 minutes, delving into aspects of the patient's early life, his relationships, his hobbies and interests, his responses to numerous crises and stress as well as his feelings and attitudes. The psychiatrist has to deal in depth with the patient's life story.

The basis of the practice of psychiatry is the development of a good doctor-patient relationship and the understanding that improvement in the patient's problems lie not in the doctor's skill alone but also in the patient's own self belief. Psychiatry emphasises the need for doctor and patient to work hand in hand.

I do not believe that disease may have non medical causes

Psychiatry considers the medical model only as one of several models of illness. How illness is also determined by the other factors such as psychosocial situations, the personality and make up of the patient is always a consideration. A patient with depression may need some correction in his brain Serotonin but this may also be the result of the loss of the loved one whom he has had no opportunity to grief over, just as he missed seeing his father pass away from cancer when he was 12 years old.

I do not like to work with other healthcare professionals

Psychiatrists work in a multidisciplinary environment in which he is the leader of a team that may consist of the nurse, the psychologist, the social worker as well as the occupational therapist. The multidisciplinary concept is even stronger in child psychiatry where the team may also include teacher and educational psychologists. Besides working in a mental health setting, psychiatrists often liaise with their medical colleagues from other disciplines in a general hospital setting.

I do not like to listen to my patients

Psychiatrists spend inordinate amount of time listening to their patients and their life story. As a result, their patients may develop a relationship with their psychiatrist which can form the basis for helping their patients understand themselves better.

I do not like to work with my patients and their families

Part of the problems that patients have is their place in the family. The psychiatrist realises that the family is a complex system that needs to maintain an equilibrium but in doing so may cause pain and suffering to some members in the family. For example, a child refuses to go to school because his parents quarrel often and the mother is depressed. His school refusal was due to his fear and concern for his mother. Dealing with the child alone would not treat the main problem which was the marital conflict.

I do not like to treat my patients with non medical means

Psychiatrists do give medications and electroconvulsive treatments. These are but some of the tools that the psychiatrist is armed with. Psychotherapy is a form of talking cure that helps patients understand themselves and find ways to deal with their own difficulties. Psychiatry requires the doctor to explore the life story of his patient and to develop competencies in a number of related disciplines like neurology or medicine and to think across disciplines.

I do not believe that the practice of medicine is an art as well as a science

Psychiatrists are scientific in their approach to mental illness but also learn interpersonal skills to handle their patients. The psychiatrist also spends time learning about the basis of human behaviour and how these behaviours can be changed. The training of psychiatrists in Singapore involves 3 years of basic training culminating the Master of Medicine examinations. Three further years of advance training in the form of an apprenticeship under a senior supervisor will complete the training process. Trainees will be rotated through all aspects of psychiatric including child and adolescent psychiatry, geriatric psychiatry, forensic psychiatry as well as liaison psychiatry. Psychiatry is as much a science as it is an art.

I do not want to understand myself better

Psychiatrists need to understand themselves better in order to be effective in helping others. Thus the psychiatrist has to consider his or her own personality problems, foibles and ways of coping with stress in order to gain a fruitful insight into himself or herself. Most psychiatrists gain this through working with their patients and discussing their work with senior doctors. A readiness to work through his or her own hang ups is an essential part of the training.

If any of the above reasons fit you, psychiatry is not the specialty you would want to consider. ■

DR DANIEL FUNG

CITATION OF MR CHOO HAN TECK, JUDICIAL COMMISSIONER, SMA LECTURER 1999

I am indeed honoured to read this citation for Judicial Commissioner, Mr Choo Han Teck, who is the SMA Lecturer for 1999.

Mr Choo is a friend of the medical profession. It has been said that as a result of his getting to know doctors in the course of his legal work, he liked what he saw and proceeded to find a wife who is a doctor. That was how he came to marry Lucy.

Mr Choo graduated with a law degree from the University of Singapore in 1979. He started his legal career in 1980 with the local law firm of Murphy & Dunbar. It was there that he got his first taste of medico-legal work. Murphy & Dunbar was already then acting for one of the medical defence organisations.

Mr Choo joined the Law Faculty of the National University of Singapore in 1984. He obtained his Master of Laws from Cambridge University in 1986 and proceeded to obtain the diploma in Trial Advocacy Teacher Teaching from Harvard University the same year.

He left the Faculty of Law in 1988 to join the law firm of Allen & Gledhill. He became involved in medico-legal work again. He left to be one of the founding members of Helen Yeo & Partners in July 1992. While back in private practice, Mr Choo has represented doctors, nurses and hospitals in various types of medico-legal cases, ranging from Coroner's inquiries, civil suits to professional disciplinary inquiries.

Dr Lim Teck Beng

Throughout his career, Mr Choo has served in an honorary capacity as legal adviser to various medical organisations. He was the honorary legal advisor to the Association of Private Medical Practitioners of Singapore from 1984 to 1994, the Singapore Medical Association from 1992 to 1995 and the Singapore Nurses Association from 1992 to 1995. He gave of his time and legal expertise freely.

Mr Choo has also lectured on various medico-legal subjects to the Faculty of Medicine, NUS and the College of General Practitioners. The subjects included "Professional Negligence" and "Professional Confidentiality". He will be speaking on the latter topic today.

Mr Choo was also involved in various capacities in the postgraduate Practice Law Course, which is the course that all aspiring lawyers in Singapore have to go through.

He was the Acting Director and also Chief Examiner in 1984. He was a lecturer and examiner in criminal procedure from 1985 to 1990.

In April 1995, Mr Choo was appointed as a Judicial Commissioner of the Supreme Court. He is currently in his 5th year as a Judicial Commissioner.

While a Judicial Commissioner, Mr Choo was somehow still involved in medico-legal matters. He was the judge in 2 significant cases involving Singapore Medical Council proceedings.

The first case (in October 1997) involved an appeal by a doctor whose name was removed by the Medical Registrar after a SMC inquiry. One of the charges involved the doctor's failure to provide an appropriate treatment. Mr Choo upheld the decision of the SMC on the sentence.

The second case (July/August 1999) involved a challenge by a doctor against the procedure in SMC disciplinary proceedings. Important issues were raised about the powers and duties of the Complaints Committee. As the case is pending before the Court of Appeal, I shall speak no further on it on this occasion.

Mr Choo has been in both private practice and the teaching profession. He is now a judge. He is uniquely qualified to speak on today's topic of "Confidence & Confidentiality – Aspects of the Law".

The SMA Council is grateful that Mr Choo has accepted their invitation to be the 1999 SMA Lecturer. May I on their behalf, call upon him to now deliver his lecture. ■

DR LIM TECK BENG

◀ N1 'The 1999 SMA Ethics Convention and SMA Lecture'

A/Prof Chong Kim Chong gives away the Award and the Plaque to Mr Tor Phern Chern, winner of SMA Ethics Award.

next Millenium". The winner of the other category is Mr Christian Chin Fei Loong, who is currently sitting for the Bar examination wrote on "Medical Ethics". A/Prof Chong Kim Chong presented the Award in the form of $1000 and a plaque to the winners. The two essays, and other selected ones will be published in subsequent issues of the SMJ.

Public & Professional Symposium on Patient Confidentiality

This symposium focused on patient confidentiality from the lay perspective. Mr Stephen Loke, Chairman of the CASE Consumer Affairs Committee used the word "CONFIDENTIAL" as the acronym for the considerations doctors should observe before "breaching" patient confidentiality. He emphasised the importance of maintaining trust or confidence. He added that "Clearly unless the trust element is created and build up between doctor and patient, there may be little confidential information to speak of to begin with..."

Mr Venu Nair, Underwriting Manager, Group & Health Department of NTUC Income said that "medical information on the insured is usually sensitive and therefore needs to be received in confidence." He assured that written consent of the insurers is sought before confidential medical information is released. Furthermore, Life Insurance Association (LIA) maintains a LIA Substandard Risk Register which serves as an "alert" to the member company's underwriter to seek more information regarding the proposed insured. He said that "In this way, insurers are safeguarded to some extent against frauds and anti-selection on the part of the insured which will directly be against the interest of the insurers and indirectly, the interest of the general body of policyholders."

Speakers at the Symposium on Medical Confidentiality, (L-R) Mr Stephen Loke (CASE), Mr Venu Nair (NTUC Income) and A/Prof Cheong Pak Yean (SMA).

Finally, A/Prof Cheong Pak Yean reiterated the 4 situations where confidentiality has to be "breached" from the medical practitioner's point of view. He concluded that doctors and patients need to grapple with the issues of confidentiality in the age of the new economics and technologies. The Commentary of this issue is written by A/Prof Cheong based on his presentation at this Symposium.

We will feature the full report of the Mini Ethics Course and the Public Symposium on Medical Confidentiality in subsequent issues of SMA News. ■

Reported by
A/PROF GOH LEE GAN and MS TAN HWEE PING

■ FOR SALE/RENTAL

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For a no-obligation discussion of your clinic's renovation (new or existing), please contact Mr Michael Lee or Mr Ronald Koh at Telephone number 894 8944. Pager : 9500 5683.

Quotable Quotes from the SMA Lecture 1998

"Whatever in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge as reckoning that all should be kept secret"
– Moses Maimonides

"Rights trump policies and rules"
– Ronald Dworkin

"Public interests served by preserving the anonymity of both classes of informants are analogous; they are of no less weight in the case of the former than in that of the latter class."
– Lord Diplock

"The end justifies the means"
– Machiavelli

"The truth is out there ... somewhere."
– X-Files

World Health Network

World Health Network is in the process of establishing regional headquarters in Singapore, Australia and North America, with each of these centres of excellence responsible for market expansion within their respective regions.
The organisations' primary functions are to provide a news indexing service of daily and practical use of unparalleled quality, along with a secure communications system for healthcare professionals. This exciting and ambitious project seeks to create the de-facto global health intelligence exchange forum for the dissemination and sharing of medical knowledge.
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World Health Network Singapore Pte Ltd
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Singapore 039190

Website: www.healix.net

We regret that only shortlisted candidates will be notified.

UNITED MEDICAL PROTECTION

1 December 1999

Dear Colleague

It is now three months since Professor Goh Lee Gan and his Council invited UNITED Medical Protection to offer the doctors of Singapore a new choice in professional indemnity. In that short time we have been gratified by the warm welcome that you have extended to us. We are also delighted that so many of you have already made the choice to join UNITED. We are reassured that you have joined us not only for the immediate benefits which membership can offer, but also for the promise to partner us in our longer term goal to assist the Singapore medical profession develop and manage its own medical indemnity operation.

I am also pleased to advise you that our proposal to participate in continuing medical education in Singapore was well received at a meeting with leaders of the Singapore medical profession that I recently had to privilege to attend. I expect that in the year 2000 Singapore will see examples of how UNITED's Professional Development Program will work in support of local initiatives.

To help you gain a deeper understanding of the UNITED vision, and how it is put into action for mutual benefit of all members, we are pleased to be forwarding to you shortly a copy of UNITED's 1998 – 99 Annual Review for our Australian operations. The Review contains extensive information on our financial performance, membership services, and the implementation of our Professional Development Program over the most recent financial year.

I would like to take this opportunity to thank Professor Goh, his Council and the officers of the SMA for their cooperative and supportive approach. The open and productive relationship now established between UNITED and the SMA allows us to share information and insights that will help us develop the indemnity products and services best suited to your needs.

We look forward to welcoming more SMA members each month. If you have not already taken up UNITED membership and would like more information, please contact the SMA office on 223 1264.

At this time of year, I would like to extend the very warmest of festive greetings, and may the New Year be a rewarding and fulfilling one for you and your families.

Yours sincerely

Richard Tjiong

Dr Richard Tjiong
MBBS (SYD), FRCS Ed, FRACS, Dip Law (BAB)
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