SMA news

For Doctors, For Patients

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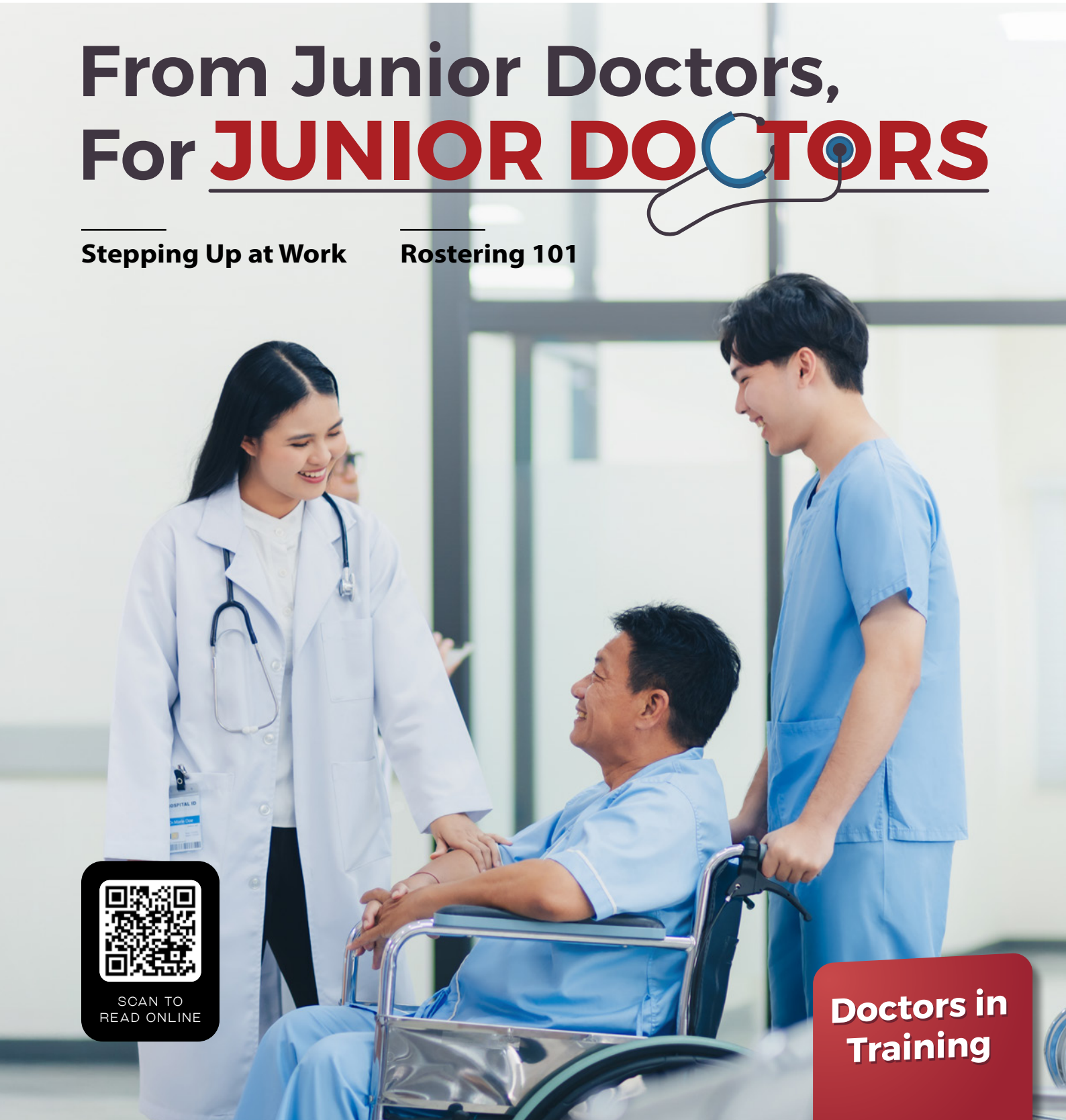
From Junior Doctors, For JUNIOR DOCTORS

Stepping Up at Work

Rostering 101



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The Editors' Musings

DR TINA TAN

Editor

Dr Tan is a psychiatrist in private practice and an alumnus of Duke-NUS Medical School. She treats mental health conditions in all age groups but has a special interest in caring for the elderly. With a love for the written word, she makes time for reading, writing and self-publishing on top of caring for her patients and loved ones.

Our 2025 Doctors-in-Training (DIT) issue is a robust one, prepared in conjunction with the SMA DIT Committee chaired by Dr Ivan Low. We have featured a range of topics, from the Hospital Clinician scheme (which I never even knew existed until I read about it), to manpower planning (roster monsters, anyone?), to the role of food and superstitions in the lives of junior doctors.

SMA has played an active part in advocating for trainees and junior doctors over the years and continues to do so through the dedicated efforts of Dr Low and his team. More information about what the DIT Committee has been doing these few years can be found in Dr Low's Feature article.

While older readers may think, "Junior doctor issues are not relevant to me anymore", here is something to mull over: someday, these same juniors will be taking care of us. Let us continue to care for them too.

And to junior doctors reading this: we are trying. I hope you know this and appreciate it, and return the favour to your juniors in the future.

DR IVAN LOW

Guest Editor

Dr Low is a Navy medical officer and A&E senior resident. He is an SMA Council member, and has a passion for public health, community outreach and medical education. In his spare time, he can be found relaxing at the park with his loved ones, his dog, and a cup of *kopi c peng* (*siew siew dai*).

Our early years in this profession are often marked by long hours, steep learning curves, and the constant balancing of professional and personal demands. The pressures of clinical work and training – whether as a house officer, medical officer, resident or hospital clinician – are compounded by manpower constraints, evolving patient expectations and the need to adapt quickly to new systems of care. It is in these formative years as a junior doctor that support, mentorship and thoughtful organisational practices make the greatest difference.

This issue of *SMA News* is dedicated to the challenges and opportunities junior doctors face today. We begin with a guide to stepping up at work, offering practical insights on taking responsibility and developing leadership skills. Recognising that rostering is often a pain point, we also feature tips for departments on optimising medical manpower, with suggestions that balance service needs with training and well-being.

Looking outward, we explore global trends and affairs, from workforce migration to improving health literacy among our patients, and how these impact junior doctors in Singapore. Closer to home, we highlight new career pathways such as the Hospital Clinician scheme, giving junior doctors a clearer view of the options available to them as they stand at the crossroads.

Our reflections on housemanship across generations provide a poignant reminder that while the context of practice has changed, the spirit of perseverance and camaraderie remains timeless. Finally, we shine a light on the softer but no less important aspects of culture – food traditions to be aware of on a night call, and related rituals that sustain us through the toughest hours.

We hope that this collection of articles from the SMA DIT Committee not only resonates with junior doctors but also inspires the wider profession to continue shaping a supportive, resilient and forward-looking medical community. ◆

On Stepping Up *at Work*

Text by Dr Ivan Low, Chairperson, SMA Doctors-in-Training Committee

I recall one particular day that took place some years back, when I was serving as a medical officer (MO) in the ICU. A patient had desaturated in the general ward and was intubated before being brought in. It seemed like just another day, until I met a tearful house officer (HO) trailing behind the patient. Before I could take the handover, the HO asked, "Was it my fault?"

I distinctly remember feeling taken aback by the abruptly posed question and perhaps paused a little too long before I responded with somewhat awkward words of comfort. Truth be told, nobody really teaches us how to handle our colleagues' emotions at work, and when giving feedback, it is often hard to tread the line between being falsely reassuring and being perceived as patronising.

This was one of many moments in my last eight years of working in public hospitals that highlighted how stepping up at work was not just a good-to-have habit, but an essential practice. Yet we hardly talk about this, and every year, approximately 800 HOs are bestowed a new MCR number, unceremoniously "becoming" MOs overnight without so much as a formal brief on their newfound roles and responsibilities.

But fret not! In the SMA Doctors-in-Training (DIT) Committee's quest to ease difficult transitions for doctors in training, we have sought to distil the wisdom of generations of seniors who have walked the path before us. To our fellow doctors assuming new roles at work and prospective "black tags", this is for you. Introducing… the DIT 3-2-1 Step Up Model!

D – Define, delegate, and do not forget the little things

Define clearly

The fundamental first step is to know our scope of work. This comprises the "official" terms of reference (eg, important legal responsibilities such as death certification), as well as the "unofficial" duties we are expected to undertake (eg, ensuring our HOs do not skip their meals). Importantly, the process of defining our scope helps us to prepare and remain accountable for our work.

Delegate thoughtfully

As we gain seniority, it is inevitable that we will need to delegate tasks to juniors in the team. When doing so, it is

important that we do so with intention, be it as a deliberate learning opportunity or to stretch our juniors and showcase their potential, among other reasons. When tasks are delegated, we should give our juniors a degree of autonomy to complete the task, while remaining accessible to them should help be requested or required.

Do not forget the little things

Little things carry a big impact when managing a team. Learn people's names, find out more about what they do outside of work, show an interest in their growth as fellow human beings. Help your juniors, answer a question they might be fumbling with during the ward round, step in and speak up if you witness non-collegial behaviour. Remember to say thank you for even the simple things, like a timely escalation or a well-curated management plan.

I – Invest in yourself and in others

Investing in yourself

We must dedicate a portion of our time toward personal mastery, lest we fall prey to the Dunning-Kruger effect. Beyond clinical knowledge and skills, we should remain cognisant of and actively work on our deficiencies in communication and documentation, information gathering and synthesis, decision-making and task prioritisation, time and resource management, and systems-based practice. I find Broadwell's Stages of Competence to be a helpful framework to help me assess my degree of competence in any given domain. Many of us find that asking for feedback supplements our reflective learning process as well – this includes feedback from our juniors, nurses, allied health professionals, and even our patients.

Another crucial aspect of investing in ourselves is ensuring that we have downtime to rest, recharge and rejuvenate. Stretching ourselves out too thin ultimately comes at the expense of patient safety.[1] Even as we rise through the ranks, we must know our limits in order to practise safely, and remember that there are always seniors and trusted colleagues to whom we can turn to seek help or escalate situations to.

Investing in others

Mentorship is a core tenet of our profession. Junior doctors must recognise that they play a pivotal role as near-peer mentors at their workplace.

Most of us would agree that the bulk of our medical practice, especially soft skills such as communicating with patients and other professionals, is invariably learnt through role modelling.[2] It is therefore important for all of us to exemplify the good practices and behaviours we hope for our juniors to emulate. It also helps to verbalise our thoughts when we assess patients to facilitate this learning process.

The clinical environment, while at times unforgiving in pace and workload, is rife with teaching moments. We must leverage these teaching moments and make learning visible to our juniors (ie, make explicit what we want them to learn from a specific task or experience). In giving feedback, we should aim for it to be constructive, specific, timely and actionable, and to this end, useful feedback models include Pendleton's Rules and the One-Minute Preceptor.

T – Take a step back

It is oftentimes all too easy to get caught up with the hustle and bustle of everyday life in the wards, and we end up forgetting to take a step back to see the big picture. A key aspect of stepping up at work is seeking to understand the overarching system at play that ultimately influences how patient care is delivered and how we are resourced. Only with this understanding can we begin to challenge the status quo and design solutions to improve the system, beyond improving the care of our patients.

Junior doctors occupy a rather unique position in this regard, having accumulated ground experience while not being completely entrenched in the way things work. This engenders within them a natural inclination to think out of the box – in identifying opportunities to address pain points at their workplaces and potential growth areas in their respective fields of practice.

Closing thoughts

Admittedly, stepping up at work is not always intuitive. By virtue of our vocational training, many physicians value and place our focus on honing our clinical skills, sometimes at the cost of neglecting our development in the leadership domain. We hope to bring to light this critical component of the "hidden curriculum", and encourage junior doctors to continue taking the initiative in stepping up at work – as mentors and team leaders, and as advocates for change. Our patients will be better off for it. ◆

About us

The SMA DIT Committee advocates for junior doctors and medical students, and runs a wide range of initiatives to support them in becoming competent, confident and compassionate healthcare professionals.

The Committee has spoken up and provided recommendations on working hour caps, night call allowances and the float system, leave for National Service call-ups, postgraduate training opportunities, the process for full registration, and junior doctor engagement.

In addition to these advocacy efforts, the Committee operates an "Ask Me Anything" channel, publishes the DIT 101 digital pocketbook, conducts "starter pack" workshops for junior doctors, and organises events for the Medical Association of South East Asian Nations Junior Doctors Network as well as the SMA National Medical Students' Convention.

Join our DIT Telegram channel @helpourjuniordocs and follow our Instagram page @jrdocs.sg to stay up to date regarding our various initiatives. If you are keen to get involved with SMA DIT efforts, please write in to us at ilj@sma.org.sg.

Follow our Telegram Channel: @HelpOurJuniorDocs

Further information

Dunning-Kruger effect

The Dunning-Kruger effect refers to a cognitive bias where people with limited competence in a particular domain overestimate their abilities in that domain. When we fall prey to the Dunning-Kruger effect, we risk stunting our personal growth by failing to develop the areas in which we are weaker. It is thus important to be able to evaluate your own competencies as accurately as possible.

Broadwell's Stages of Competence

Broadwell's Stages of Competence is a model that classifies the learning process into four stages: (1) unconscious incompetence, (2) conscious incompetence, (3) conscious competence, and (4) unconscious competence. In the first stage, the learner is unaware of his/her own deficit in competence. The learner progresses to the second stage when he/she becomes aware of his/her incompetence in the skill (similar to overcoming the Dunning-Kruger effect). The third stage is attained when the learner is competent in the skill but requires heavy conscious involvement when executing the skill. Finally, the fourth stage is reached when the skill is "second nature" to the learner and can be performed easily.

Pendleton's Rules

Pendleton's Rules comprise five rules intended to guide feedback conversations. They are as follows:

1. The feedback provider (FBP) asks the feedback receiver (FBR) to mention two or three points that went well.
2. The FBP shares two or three points that went well.
3. The FBP asks the FBR to mention two or three points that can be improved.
4. The FBP shares two or three points for improvement and discusses strategies based on the input on closing the gap.
5. The FBP or FBR summarises the most important points from the conversation.

One-Minute Preceptor

The One-Minute Preceptor is a teaching model that comprises five micro-skills to help facilitate clinical teaching. The five micro-skills are:

1. Get a commitment: Ask the learner to articulate his/her own diagnosis or plan.
2. Probe for supporting evidence: Evaluate the learner's knowledge or reasoning.
3. Teach general rules: Teach the learner common "take-home points" that can be used in future cases, aimed preferably at an area of weakness for the learner.
4. Reinforce what was done well: Provide positive feedback.
5. Correct errors: Provide constructive feedback with recommendations for improvement.

Further readings

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c. Pendleton D, Schofield T, Tate P, Havelock P. The Consultation: An Approach to Learning and Teaching. United Kingdom: Oxford University Press, 1984.

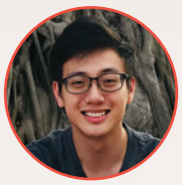
d. Irby D. The One-Minute Preceptor. Presented at: The annual Society of Teachers of Family Medicine Predoctoral meeting; February 1-4, 1997; Orlando, Florida, USA.

References

1. Garcia CL, Abreu LC, Ramos JLS, et al. Influence of Burnout on Patient Safety: Systematic Review and Meta-Analysis. Medicina (Kaunas) 2019; 55(9):553.

2. Benbassat J. Role modeling in medical education: the importance of a reflective imitation. Acad Med 2014; 89(4):550-4.

Dr Low is a Navy medical officer and A&E senior resident. He is an SMA Council member, and has a passion for public health, community outreach and medical education. In his spare time, he can be found relaxing at the park with his loved ones, his dog, and a cup of *kopi c peng (siew siew dai)*.



> ***Mentorship is a core tenet of our profession. Junior doctors must recognise that they play a pivotal role as near-peer mentors at their workplace.***

The Cost of Providing Mandatory Medical Ethics Education

Text by Dr Ng Chee Kwan

In order to renew one's practising certificate, doctors are required to acquire mandatory medical ethics (MME) continuing medical education (CME) points. SMA has been providing MME CME activities since January 2024, and our MME programme in 2025 includes 17 modules, comprising five webinars, seven online distance-learning programmes and five articles. These activities are open to both SMA Members and non-Members, but are complimentary for Members.

These programmes have been put together by the SMA Centre for Medical Ethics and Professionalism (SMA CMEP). Personally, I have found the MME programmes to be of extremely high quality, and I am quite frankly amazed at the SMA CMEP teaching faculty's depth of knowledge. In 2024, I acquired sufficient MME points to renew my practising certificate. However, I am still attending the MME webinars organised by SMA in 2025. I find it beneficial to have my knowledge refreshed, and there are always new things to learn.

For example, I found the webinar held in July 2025 on using the four-box method for ethical analysis to be well worth attending. The lecture was clear and concise, and served as a great introduction to one of the most common approaches to ethical analysis.

A great amount of effort has been put in by the SMA CMEP faculty into producing MME content. The SMA Secretariat also puts in additional hours to host the webinars, each of which is typically attended by more than 1,000 doctors. After the webinars are over, the Secretariat spends more time and effort in order to submit doctors' particulars to the Singapore Medical Council (SMC), so that MME points can be appropriately awarded.

In addition to webinars, the online distance-learning programmes allow doctors to fulfil MME CME requirements at their convenience. In order to host these programmes, SMA subscribes to a learning management system at considerable cost.

As you can see, there is a financial and time cost in providing MME CME activities. We believe that it is worth the while, and it resonates with our objective of supporting a high standard of medical ethics and conduct. It is a service that SMA intends to continue to provide for as long as we are able.

As this issue of *SMA News* is focused on doctors in training (DITs), it would be remiss of me not to mention that our MME CME programmes are as relevant to DITs as they are to the rest of the medical profession. SMC has also expanded the 2026 MME CME curriculum to include many issues not touched upon previously. Moving forward, I hope that all Members, including those who are DITs, will continue to avail themselves of our programmes for their MME CME education. ◆

Dr Ng is a urologist in private practice and current President of the SMA. He has two teenage sons whom he hopes will grow much taller than him. He has probably collected too many watches for his own good.

Scan the QR code to learn more about SMA's MME CME activities.

HIGHLIGHTS

From the Honorary Secretary

Report by Clinical Asst Prof Benny Loo Kai Guo

Dr Loo is a paediatrician in public service with special interest in sport and exercise medicine. He serves to see the smiles on every child and athlete, and he looks forward to the company of his wife and children at the end of every day.

Practice guide for Tiered Care Model for mental health

The Inter-agency Taskforce on Mental Health and Well-being has developed a practice guide for mental health service providers across different sectors.

The practice guide can be downloaded at the following link: https://bit.ly/4n2rYZU.

Workgroup to Support the Registration and Practice of Doctors with Psychiatric Conditions

In the wake of the COVID-19 pandemic, growing awareness of mental health in the workplace has spurred efforts to improve mental health support for healthcare workers. The SMA Doctors-in-Training (DIT) Committee, together with specialists from the College of Psychiatrists, Academy of Medicine, Singapore (AMS) and the College of Public Health and Occupational Physicians, AMS, formed the Workgroup to Support the Registration and Practice of Doctors with Psychiatric Conditions in January 2025.

The workgroup was formed to assess the needs of doctors with psychiatric conditions and to develop guidelines outlining considerations for conducting fitness to practise assessments and recommendations targeted at departments and institutions to better support mental health in the workplace. The SMA DIT Committee is supporting the workgroup as its secretariat and has been involved in needs assessments (such as conducting qualitative interviews with doctors with psychiatric conditions), conducting literature reviews and crafting the proposed guidelines. The guidelines are planned to be published by early 2026.

Doctors who are facing mental health concerns may seek help from various channels listed in the table for reference. ◆

Public institution staff wellness resources

Singapore Health Services (SingHealth)

Type	Organisation	Contact
Hospital peer support networks	SingHealth Postgraduate Year 1 BLUES (Burnout, Listening, Understanding and Emotional Support) Programme	pgy1blues@singhealth.com.sg
	Singapore General Hospital SAFE (Support Action for Employees)	8879 3342 (office hours) sghpeers@sgh.com.sg
	Changi General Hospital (CGH) PEER Network	8125 8452 peernetwork@cgh.com.sg
	KK Women's and Children's Hospital Carer's Support Programme	8181 7655
	Sengkang Hospital PALS (Peers Actively Lending Support)	pals@skh.com.sg
Hospital staff counselling	CGH Staff Counselling Service	9299 0041 clinical_counselling@cgh.com.sg

National University Health System

Type	Organisation	Contact
In-house counselling service		Schedule appointments via internal "Bookwhen" link 9784 7629
Crisis helpline		3163 1813
Consultation at hospital staff clinics	National University Hospital Staff Health Clinic	6772 2167
	Jurong Community Hospital Clinic C11	6908 2222
	Alexandra Hospital Cocoon Clinic	9129 2198 (call for tele-consultation or appointment)

NHG Health

Organisation	Contact
Tan Tock Seng Hospital Staff Support Staff programme	9720 8515 (office hours) ttsh.staff.support.staff@nhghealth.com.sg
Khoo Teck Puat Hospital/Yishun Community Hospital Peers Around Lending Support programme	9647 0462 (office hours) ktph.ych.pals@nhghealth.com.sg
Woodlands Health WellCARE Helpline	9835 2973 (office hours) wh.wellcare@nhghealth.com.sg
Institute of Mental Health Staff Support and Assistance Programme	imh.ssap@nhghealth.com.sg

National resources

Brahm Centre (Counselling)	9766 0000 assist@brahmcentre.com
National MindLine 1771	1771 (24-hour hotline)
Samaritans of Singapore	1767 (24-hour hotline) or 1800 221 4444
Singapore Association for Mental Health (Counselling)	1800 283 7019
TOUCHline (Counselling)	1800 377 2252

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20th MASEAN Mid-Term Meeting

Text by Denise Tan, Deputy Manager, International Relations
and Dr Maxz Ho, Member, SMA Doctors-in-Training Committee

The 20th Medical Association of South East Asian Nations (MASEAN) Mid-Term Meeting, graciously hosted by the Medical Association of Thailand (MAT), was held from 17 to 19 July 2025 at the Amari Bangsaen Hotel in Chonburi, Thailand. The event was held in conjunction with the International Seminar for Authors of Medical Journals from MASEAN Countries, organised by MAT and the MASEAN Group of Journals (GOJ).

The SMA delegation comprised the following members:

- Adj A/Prof Ng Chew Lip, SMA Treasurer; Secretary General of MASEAN
- Prof Mahesh Choolani, Chairperson, MASEAN GOJ
- Dr Calvin Tjio, Vice Chairperson, SMA Doctors-in-Training Committee
- Dr Maxz Ho, Secretary, MASEAN Junior Doctors Network (JDN)
- Ms Krysania Tan, Ms Denise Tan, Ms Lee Xin Yi and Mr Spencer Soh, SMA Secretariat

Harmful inhalational volatile substances

Delegates from the national medical associations of Brunei, Indonesia, Laos, Malaysia, Myanmar, the Philippines, Singapore, Thailand and Vietnam convened over three days, joined by special guests from the medical associations of Australia and Nepal, to share insights on the positive developments and challenges related to this year's theme: "Harmful Inhalational Volatile Substances, with Special Reference to E-cigarettes and Cannabis".

Delegates shared insights on the current situation and legislative frameworks concerning the use of harmful substances in their respective countries, with a particular focus on the growing global public health impact of electronic cigarettes (e-cigarettes) and cannabis. Recognising the increasing prevalence of e-cigarette and cannabis use, especially among youth, and their strong association with tobacco use and other substance use disorders, and expressing concern over the detrimental health effects linked to these substances, the delegates reaffirmed their collective commitment to uphold the highest standards of healthcare and to advance a coordinated regional approach in addressing these escalating public health challenges.

> ***As a regional network, the MASEAN Group of Journals plays a vital role in strengthening academic publishing within Southeast Asia. We bring together a diverse and dedicated group of editors, each working to raise the standards and impact of their respective journals. This meeting offers us a valuable opportunity to reflect on our progress, address common challenges and more importantly, to launch new initiatives that will help us move forward together.***
>
> ***– Dr Azizan Abdul Aziz, Chairperson, MASEAN***

MASEAN GOJ

The Seminar for Authors of Medical Journals from MASEAN Countries drew 208 participants. During the business meeting, Prof Mahesh Choolani, Senior Deputy Editor of the *Singapore Medical Journal*, concluded his two-year term as chairperson of the MASEAN GOJ and formally handed over the role to A/Prof Maria Christina H Ventura, Editor-in-Chief of the *Journal of the Philippine Medical Association*.

The MASEAN GOJ Board also held a strategic meeting on 17 July to discuss key developments and chart new initiatives.

MASEAN JDN

The MASEAN JDN, chaired by Dr Loke Xi Mun from the Malaysian Medical Association, also convened a business meeting on 17 July. The meeting brought together junior doctor representatives from Brunei, Malaysia, Singapore, Indonesia and Thailand, reflecting the network's commitment to regional solidarity.

The MASEAN JDN remains dedicated to strengthening regional collaboration through ongoing dialogue, active engagement and meaningful exchange of ideas among junior doctors across the ASEAN region. Its key advocacy areas include safe and supportive working environments, clear and equitable career progression, and fair and improved remuneration.

We extend our deepest appreciation to MAT for their warm hospitality, and we look forward to the 21st MASEAN Conference, which will be hosted by the Philippine Medical Association in Bohol, the Philippines in 2026. ◆

Legend

1. Delegates of 20th MASEAN Mid-Term Meeting

2. SMA President Dr Ng Chee Kwan presenting a token of appreciation to Medical Association of Thailand President Prof Prakitpunthu Tomtitchong

3. Strategic meeting of the MASEAN Group of Journals Board

4. Members of the MASEAN Junior Doctor Network

Exploring the Hospital Clinician Pathway

Interview by Dr Aaron Goh

The Hospital Clinician (HC) scheme is a relatively new career pathway in Singapore's healthcare system and is often viewed as an alternative to the traditional residency programme. Its flexibility, structured training and opportunities for growth make it a compelling mainstream option for junior doctors seeking a fulfilling career. To shed light on this pathway, **Dr Aaron Goh (AG)** spoke with **Dr Shawaf Farmanullah (SF)**, a senior HC in the Department of General Surgery, National University Hospital (NUH), and **Dr Aaron Chong (AC)**, an HC in the Department of Emergency Medicine at Woodlands Health. Their insights reveal the HC scheme's unique advantages and its potential to redefine medical careers.

AG: Could you briefly introduce yourselves and your current roles? What inspired you to pursue the HC pathway?

SF: I have been a HC for two years. I recently passed the diploma examination and was promoted to senior HC. During my medical officer (MO) postings, I explored various surgical specialties such as cardiothoracic and colorectal surgery but had difficulty choosing a single specialty. The HC scheme's broad-based exposure across departments, including medicine and anaesthesia, was therefore attractive to me. It also offered the potential to engage in leadership opportunities, which aligned with my interest in healthcare administration.

AC: I have been a HC since January 2025. After cycling through my MO Posting Exercise postings, I decided that I wanted more focused experience in critical care. The HC scheme at Woodlands Health offered a chance to gain directed training in emergency medicine and other relevant specialties like orthopaedics and general surgery. It provided a structured path to explore my clinical interests while staying in a familiar hospital environment.

Day-to-day experience

AG: Could you describe a typical week in your life as a HC?

SF: Most of my week is spent in the surgical high dependency unit, functioning at the level of a registrar. I manage critical care patients and coordinate plans with surgical teams. Furthermore, I am undergoing training in colonoscopy, with the eventual goal of independently leading my own elective lists. I also teach rotating residents and MOs on critical care topics such as point-of-care ultrasound (POCUS). The role also allows flexibility to pursue quality improvement projects and healthcare administration/leadership.

AC: As a relatively new HC, I am currently rotating through required postings which include general medicine, emergency and surgical specialties. In the emergency department, I am rostered to attend to the patients, just like any MO would. While in general medicine, I participate in ward rounds and multidisciplinary meetings. The role includes opportunities for audits and peer review, with flexibility to explore specific clinical interests like POCUS or toxicology.

AG: How does the HC role integrate with the broader healthcare team?

SF: As a senior HC, I function at the registrar level and administer care to patients across all surgical disciplines. When there are complex patients requiring the input of multiple surgical subspecialties, I help to coordinate care across the various teams. I also provide the first line of acute care when patients deteriorate, especially if residents or consultants are in clinic or OT. Eventually, when I become a principal HC, I will be expected to function at the level of a consultant and will be the primary attending physician for patients under my care.

AC: As junior HCs, we perform the same duties as any MO, but with greater responsibilities and expectations as we are familiar with the workflows and protocols of our home department. This also prepares us to take on more senior responsibilities in the future.

When posted to other departments, we draw on our emergency medicine experience to support the team, especially in procedures and protocols they may be less familiar with. There are also ongoing efforts to involve HCs in residency teachings, aligning our development more closely with emergency medicine residents.

AG: What are the most rewarding aspects of working as a HC?

SF: The flexibility to customise my role is key. As an HC, you have the autonomy to focus on your specific clinical interests. The permanency of working in my chosen department, rather than rotating through potentially unwanted postings, is also a huge plus. The programme also offers a set career path and much room for growth.

AC: I echo what Shawaf said about being able to direct your own learning. Additionally, working in a single hospital allows for greater familiarity with the processes and systems, and helps build better working relationships with the staff there. It has also been nice to receive mentorship from the HC programme directors.

AG: What are some challenges of being a HC, and how do you manage them?

SF: The scheme's newness means that many may not fully understand the HC role. In the initial stages, I often found myself explaining my role to many people, though this has lessened as I became more familiar to the department. Another challenge is the lack of HC programmes in niche specialties like cardiothoracic surgery, but this may change as the scheme grows.

AC: It is true that we spend a lot of time explaining our role to others – not just to the teams that we work in but even our family and friends! As a new scheme, the HC's place between the MO, resident and consultant roles is still not fully established. Moreover, while there are lots of opportunities as a HC, a lot of the scheme is very self-directed. I would advise having a clear sense of direction and to know what you would like to gain from the programme for those interested.

Contrasting HC, residency and RP

AG: What are some of the key differences between the HC pathway, the residency programme and the Resident Physician (RP) scheme?

SF: Residency focuses on specialisation over a period of five to six years, while the HC scheme is a two-year, competency-based programme emphasising broad-based skills. Unlike the RP scheme, where roles are department defined, HCs have more autonomy to shape their scope of practice.

AC: The HC scheme is also shorter than RP progression with a diploma examination taken at the end of two years. The diploma provides you with the necessary qualifications to take on senior roles within a shorter timeframe.

Appeal and viability

AG: Why is the HC pathway a viable and attractive career option for junior doctors?

SF: Its shorter duration, opportunities for non-clinical work like administration or research, and flexibility to tailor your career make it appealing. The ability to switch disciplines without being locked into a single specialty is also attractive.

AC: The scheme provides certainty in rotations and a clear career goal with fixed timelines. It is ideal for those seeking directed training in a chosen field, with the promise of a position in the department of your choice at the end of it.

AG: What opportunities for personal development or leadership exist within the HC programme?

SF: I am exploring healthcare administration, with my institution supporting further education like a Master of Business Administration or Master of Public Health. My department and programme director have been quite supportive of my interests and have tried to involve me in various high-level meetings and quality improvement projects.

AC: One thing I was struck by was the level of mentorship from our clinical supervisors. The monthly check-ins with them are helpful in navigating our clinical careers. The Woodlands Health HC scheme also offers opportunities for audits and research, similar to residents and RPs. The departments are generally supportive of HCs pursuing further education in areas that are relevant to their job scope.

Advice for junior doctors

AG: What advice would you give to junior doctors considering the HC pathway?

SF: Keep your options open and talk to current HCs to better understand the role! Even if you feel it does not work out for you, you can still pursue residency if needed. The HC scheme is a good option for those seeking a fixed department while exploring career paths.

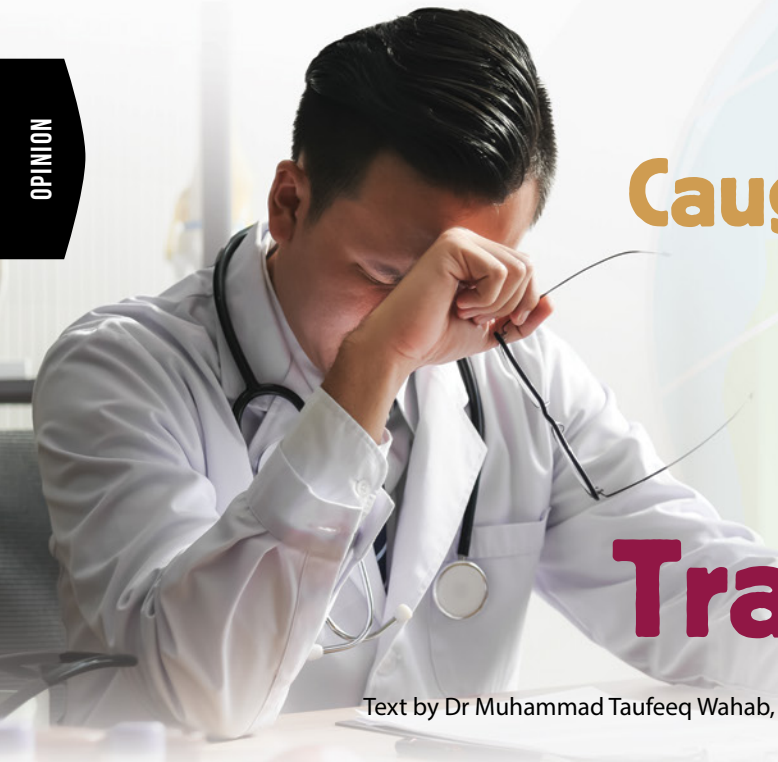
AC: You have a long career ahead of you – it is good to explore around to find out what you really want to do. Being in the HC programme helps you gain confidence in your clinical practice, which will be beneficial no matter where you practise in the future.

AG: Where do you hope the HC pathway will go in the next five to ten years?

SF: I hope to see the success stories of principal HCs who have been through the system, demonstrating that the pathway leads to independent, consultant-level roles. This will prove the HC scheme as a viable alternative to specialisation.

AC: I envision a robust HC workforce that brings strong clinical competencies, offering a fresh perspective on medical careers and supporting the junior manpower pool. ◆

Dr Goh is a medical officer and member of the SMA Doctors-in-Training Committee. Outside of work, he enjoys hiking, music and catching up with loved ones over a good conversation.



Junior Doctors Caught in the Current: Navigating Healthcare Transformation

Text by Dr Muhammad Taufeeq Wahab, Dr Christina Png and Dr Lim Ther (Lawson)

When asked about work-life balance, many junior doctors respond with a knowing smile and a change of subject. This silence speaks volumes, not of satisfaction, but of a complex web of challenges that extend far beyond the traditional rigours of medical training and defies simple answers. As Singapore's healthcare system evolves to meet unprecedented demographic and technological demands, junior doctors find themselves navigating an increasingly turbulent landscape.

In public healthcare, the junior doctor workforce is the foundation of the clinician corps. They are at the forefront of patient care – through managing the wards, organising the patient lists, supporting senior clinicians on call – yet they are often absent from the forefront of our minds. In recent years, medical circles in Singapore have been abuzz with pressing healthcare issues: healthcare workers' compensation, the ageing population, rising insurance premiums, artificial intelligence (AI), and pandemic preparedness. But rarely have we paused to examine the junior doctor psyche and the evolving challenges they face.

In South Korea, 19 February 2024 marked the start of what has been described as "one of the world's longest medical strikes". In a dramatic turn of events, thousands of junior doctors submitted their resignations, escalating into a massive walkout the next day. While media coverage has rightfully focused on the issue of junior doctors' concerns about inadequate pay in essential specialties, long working hours and a highly litigious medical malpractice environment, we believe the root of the problem runs deeper. At its core, there is a fundamental disconnect between the presence of a dynamic epidemiological landscape (due to an ageing population, worsening lifestyle habits, etc) against a static healthcare landscape whose policies have not caught up with global trends. This highlights the importance of putting the challenges that junior doctors face at the forefront of our policy and advocacy efforts, so as to identify and address issues early before they boil over. Thus, we reflect below on some of the global trends we consider to be particularly pertinent to the challenges and experiences faced by junior doctors today.

Technology: A double-edged scalpel

The phrase "ageing population" is often cited as a looming challenge in healthcare, but what does it truly mean for junior doctors? In a word, workload.

Singapore stands at a critical demographic juncture. The nation is projected to become a "super-aged" society by 2026, with 21% of the population aged 65 years and above. This transformation has significant implications for healthcare workforce planning as our old-age support ratio is projected to decline from 3.5 as of 2024 to 2.7 working age adults for every citizen aged 65 years and above by 2030. Healthcare workers already struggle with higher workloads and stress, with risks of fatigue, burnout and attrition. These in turn multiply the remaining workers' workloads, perpetuating a vicious cycle. The implications extend beyond mere numbers as older patients typically require more complex and time-intensive care.

In response, technology has been positioned as the solution to this "soon-to-be overwhelmed" healthcare system. Economically, technology promises improved productivity by enabling fewer employees to produce more healthcare services. But for junior doctors, this promise is proving to be a wolf in sheep's clothing.

In reality, junior doctors' well-being or workloads are often overlooked during the implementation of new technologies. Junior doctors may be expected to support pilot projects that inadvertently increase their workload instead of alleviating it. These projects, while well-intentioned, may siphon away manpower from clinical duties, further straining already stretched teams. The result is a mismatch between what junior doctors expect technology to bring and its actual impact on their present workload.

The irony is stark: we deploy cutting-edge AI for patient diagnostics while

junior doctors still navigate painfully manual processes for roster planning, call claims and other administrative workflows. While there is hope on the horizon that AI may simplify routine tasks such as documentation and administration in the future, such benefits have yet to reach most junior doctors in their daily practice. For now, the more visible gains of such technological initiatives are often higher in the clinical hierarchy (eg, surgical technology, latest oncology drugs). As with all promises of progress, the proof of the pudding is in the eating.

Globalisation of the medical workforce

Among junior doctor circles, questions such as "Should I join residency?", or "How long more before I serve out my bond?" are frequently discussed. Finding the optimal career path that provides work-life balance is a concern for some junior doctors. In recent years, the available career options have expanded from residency, becoming a resident physician, and joining a GP clinic, to joining the new and highly publicised Hospital Clinician scheme. However, with more choices comes choice paralysis. Many may find themselves needing more time and clarity to make these pivotal career decisions.

To add another "differential" to this expanding list, the global junior doctor job market is becoming increasingly permeable. Medical licensure is increasingly transferable, with international examinations and credential recognition enabling greater mobility of junior doctors across international borders. This may present exciting opportunities to those who find local options limiting, but it also fuels competition and uncertainty. For some junior doctors, overseas training pathways can offer better alignment with both their professional and personal aspirations. However, this could signal a troubling shift that the current system is losing its ability to retain top talent.

These shifting dynamics raise questions about the kind of medical careers offered in Singapore. Is it one where doctors feel empowered, valued and invested, or is it one where early burnout and disenchantment are normalised as rites of passage? Instead of having systems that disincentivise emigration, can systems be designed to incentivise retainment instead?

The weight of societal change

Today's patients arrive with unprecedented access to medical information and misinformation. The traditional monopoly doctors once held over health knowledge has been democratised through Internet access and now AI-powered "health advisors". This empowerment is undoubtedly a positive development for population health, but it also fundamentally alters the dynamics of clinical practice, particularly for junior doctors.

As frontline healthcare providers who frequently interact with patients and families, junior doctors often grapple with the realities of increased patient empowerment and health literacy. This information abundance paradoxically increases rather than decreases the communication burden on junior doctors as patients and families search deeper to reconcile conflicting information sources. It is not unheard of for junior doctors to be doing "7 pm communication rounds" where they go around updating patients and families until the late evening. With greater empowerment of patients and caregivers also comes greater fear of litigation. This creates the dangerous cycle of fear fuelling the practice of defensive medicine. In such an environment, are we inadvertently engineering a more distant, less relational cohort of junior doctors? This also begs the question, have we done enough to equip junior doctors with the skillsets and support they need to navigate this increasingly empowered patient landscape?

Looking ahead

Healthcare transformation must not come at the expense of those who sustain it. Much importance has been placed on healthcare expenditure, hospital systems and research, but these rarely capture the perspectives of junior doctors in planning, funding, services and human resource transformation. This needs to change. Junior doctors are not just workers; they are leaders, educators and architects of the future of healthcare, and they need to be a part of the equation and given a voice.

We do not claim to have all the answers, but we believe in the power of recognition and open dialogue. By surfacing these less-discussed patterns, we hope to inspire readers to observe, question and ultimately contribute to conversations that place junior doctor perspectives at the forefront of healthcare transformation planning. This conversation continues through your engagement. Share your thoughts with the SMA Doctors-in-Training Committee through our Instagram page (@jrdocs.sg) and learn more about what we do by joining our Telegram group (t.me/helpourjuniordocs). Your participation can surface ideas to help shape a more sustainable and supportive journey for junior doctors. ◆

Dr Taufeeq is a senior resident in the National Preventive Medicine Residency Programme under the National University Health System. He has been a member of the SMA Doctors-in-Training Committee since 2021 and contributes to the workgroup on junior doctor mental health and well-being, as well as the outreach track.

Dr Png is a junior resident in the National Preventive Medicine Residency Programme under the National University Health System. She has been a member of the SMA Doctors-in-Training Committee since 2025 and leads the workgroup on workforce planning.

Dr Lim is a senior resident in the National Preventive Medicine Residency Programme under the National University Health System, currently posted to Khoo Teck Puat Hospital and Yishun Community Hospital Corporate Development. An SMA Doctors-in-Training Committee member since 2024, he contributes to the outreach track and the workgroup on workforce planning.

Rostering 101

Text by Dr Hoe Pei Shan and Dr Calvin Tjio

Roster planning, or rostering, in healthcare is not simply about allocation of teams, calls and the dreaded duties on public holidays (PHs) or weekends. Challenges include the variation in work duties each day, high manpower turnover rates, varying levels of work experience and prevention of burnout.

Effective rostering can and should strive to achieve fairness, optimised productivity and better healthcare delivery. Fairness applies to manpower distribution, including fair distribution of the daily workload and work on PHs, weekends or calls. Departments should consider prioritising leave according to certain principles (eg, prioritising training leave for doctors taking examinations that determine progression in residency, or time off for the Singapore Medical Council Physician's Pledge Affirmation Ceremony).

In striving for optimised productivity, it is important to remember that healthcare manpower is not just numbers on paper. Other considerations include identifying strengths and weaknesses of teams and individuals, so as to leverage on certain skillsets, or intentionally developing a particular skill further. Departments should also be able to support those who are struggling (eg, by buddy-pairing them with colleagues who can help, or by allocating them to teams that can help them learn).

To have an overall better healthcare delivery, a fair, optimised roster should provide adequate rest for healthcare workers, which hopefully reduces burnout and improves decision-making each day.

We provide below six suggestions for roster planners and their teams on factors that should be considered when planning the roster. These suggestions are based on a brief literature review, an informal surveying of past and present roster planners, and anecdotal experiences shared by healthcare workers in Singapore.

Be transparent and systematic

Transparency can go a long way in assuring people that work is being distributed fairly. It also enables systematic rostering and helps build trust among colleagues in the same department.

For rostering of work beyond one's regular weekday office hours (eg, PHs, weekends, nights and calls), planners can consider factoring in a transparent point system, where points are allocated based on an agreed weightage. For example, this could involve recognising that having a call on a Thursday is not the same as a call on a Friday, Saturday, Sunday or PH. With that in mind, a possible point system could value a weekday call from Monday to Thursday at 1 point, while a Friday call could be worth 1.5 points (because the rostered person loses some of his/her weekend post-call), and all weekends and PHs could be worth 2 points. Transparent tabulation of points allows everyone to keep track of the duties they have been allocated, and helps avert any suspicion of unbalanced rostering.

Departments could consider enhancing transparency in the application and approval process for leave, call or shift requests. The department rules for these should be made known well in advance, and requests should be able to be seen by all (eg, by using platforms such as Google Sheets or Workforce Optimizer). Having leave projections submitted earlier than the typical one month in advance may also be helpful. If the nature of the leave application is sensitive, there should also be appropriate privacy regarding the reason of request. This provides the opportunity to deconflict requests early on, if it becomes clear that too many

people are requesting leave for similar dates. Early approval and allocation helps ease stress for those involved, as does transparent decision-making.

Impartiality + accountability = credibility

Roster planners in healthcare have been called "roster monsters" for various reasons, which can be unfair at times. Some wonder if the roster is planned for the planner's own interests and those of their friends, and may be wary of the perceived power that roster planners wield over the lives of others. This can occur even if the roster planner means well, and even despite his/her best attempts to roster fairly.

Ideally, a roster planner should be more senior to the group and not be involved in the roster plan himself/herself, to better avoid conflicts of interests. But in departments where this is not the case, there should still be senior oversight regarding roster planning. Senior support for roster planners should be provided, while ensuring seniors do not unfairly influence the established systems (eg, consultants making requests to the roster planner to avoid being assigned juniors whom they consider less competent).

Roster planners should be individuals who have the bandwidth to take on what is essentially extra work, and have good principles to roster fairly in everyone's interests. All roster planners should be able to report to a more senior colleague who checks in regularly, but not in an overbearing or micromanaging way. This oversight should be balanced with providing roster planners sufficient autonomy and independence to function efficiently. Impartiality and well-balanced oversight together can help produce a credible, reliable rostering team.

Maximise rest

Those whose leave days are being approved should have priority for being assigned post-call or post-night shifts leading into the start of their leave, giving them sufficient time to reset prior to their leave. There should also be consideration to block out adjacent weekends when combined with weekday leave requests. Sufficient rest is also important between calls and other longer shifts such as emergency department night shifts. Insufficient rest can translate into numerous negative outcomes such as fatigue, poorer decision-making and compromised patient safety.

Teamwork makes the dream work

Day-to-day rostering takes time and effort. Do not rely on one person to do all the work as everyone, including roster planners, needs rest and off days. Build a solid team (eg, with at least three people) as healthcare chugs on 24/7 and people may call in for sick leave at any time on any day. This means that the rostering team needs to be constantly on standby to be able to re-juggle manpower in the event of unforeseen changes.

Enable efficiency and upskilling

Roster planners should have a good grasp of basic spreadsheet skills and/or be given free access to tools that will allow them to learn and use the basics. Rostering for an entire department can be a nightmare otherwise, both for the planners as well as those trying to interpret their roster. More complex tools such as Microsoft Copilot and other artificial intelligence-driven rostering models can also be explored, though not at the expense of the roster planners' welfare or rest. Any upskilling undertaken should ideally be funded for the roster planner, as they are putting these skills to the benefit of their workplace. Likewise, time taken to upskill could also be considered under training leave, so that roster planners may be given the time off to learn.

Recognise and reward good rostering work

Rostering is not an enviable job. It is tedious, time consuming and can be thankless. The good work put in this area needs to be recognised. Some departments have used various ways to recognise and reward roster planners, including giving them an additional day off each month (ie, providing roster planners an administrative off-in-lieu day) and adding their rostering work to their achievements in performance assessments for consideration in their posting grade. Rewarding good work helps incentivise more good work, including fair rostering. Roster planners should not be self-serving, but neither should they be expected to be wholly altruistic and selfless.

Closing thoughts

In closing, strategic approaches to rostering can help better its effectiveness and in turn improve the quality of healthcare for our patients. We hope that these recommendations serve to help roster teams develop systematic, fair and productive rosters that can better support our healthcare workers and patients. ◆

Dr Hoe was a roster planner for house officers and medical officers (MOs) at two institutions last year. A Woodlands Health Campus emergency department MO at the time of writing, she is part of the SMA Doctors-in-Training Committee, advocating for healthcare workers' welfare and education.

Dr Tjio is an SMA Council member and is the vice chairperson of the SMA Doctors-in-Training Committee. He is a resident in diagnostic radiology at National University Health System and was a roster planner during his housemanship.

What I Wish I Knew

Housemanship is a journey common to local doctors, but it has certainly seen its share of evolution over the years. In this article, three doctors of varying seniority share their thoughts on their housemanship and what they wish they knew in the early days of their journey.

Dr Elizabeth Teo, new house officer

That first day I stepped into the wards was filled with a mix of fear, anticipation and excitement. Bright-eyed, riding on the high of passing my Bachelor of Medicine and Surgery after what seemed like years of endless studying, and yet somehow I felt completely unprepared for the year ahead. The adjustment from medical school to house officer (HO) life is a big one – gone were the days of dozing off midway through a recorded lecture playing at double speed in the background.

Now, our words hold weight and our actions have real consequences. Working life comes with responsibilities, and unfortunately, such responsibility demands conscientiousness. It is a terrifying weight to bear but one we must learn to shoulder. Being a doctor is more than a nine to five – in fact, it is usually even longer than a five to nine – and our weekdays or public holidays are no longer our own. But even so, in the midst of busy calls and non-stop changes, one must stop to take a breath and remember why we chose this career in the first place. It is easy to lose yourself in the system, and burnout is so prevalent among junior doctors. So, despite the responsibilities of work and the inevitable adjustment disorder, you must protect your time and personal space. Before we can properly care for others, we have to learn to take care of ourselves and be intentional in finding joy in the little things in and out of work!

Dr Rajit Soni, new senior resident

1. Patients are our best teachers. It is hard to find the motivation to study and improve amid the demands of work, but I find it much easier to have that drive when there is a real patient whose management I am unsure of. Even if I lack time to read on the day itself, I take note of the questions I had on these patients and look into them with that specific patient in mind when I get the chance to. Over time, this helped me develop algorithms in my head for various situations.
2. Compassion matters. Work is tough, and burnout can happen. When it is hard to find meaning in work, what keeps me going is talking to patients. Hearing their stories, their anxieties and fears, and sometimes being able to relieve these concerns is a heartwarming feeling. Even when stretched for time, spending those five minutes with a patient who needs it gives me a fresh lease of motivation to get through the day.
3. Do not take things personally. As humans, we make mistakes. And as juniors, there will be times when a senior is upset with us, but that is often more related to their mood than our actions. I have noticed myself and colleagues to be unnecessarily curt on days we are stressed, swamped or poorly rested. We should all strive to be kinder to each other, but as a junior, it is often better for our mental health to avoid taking things personally.

Dr Joanna Chan, consultant

Firstly, remember that all patients assigned to the team are the whole team's responsibility. Counter-check to ensure that all actions and changes have been done for all patients by lunch and exits.

Secondly, allow yourself to be kind to patients. My worst experience during the plug-setting learning curve involved repeated attempts to insert a plug for intravenous Augmentin on call for a patient with difficult veins when, despite repeated SOS, my medical officer (MO) was too busy to help. The patient was stable and not septic. My current self would advise my then HO self to stop attempting after I failed twice, and escalate to another available MO. Sometimes as juniors, we think we need to get the job done "at all costs". We are right to question our judgement – sometimes the task is truly of paramount importance – but not all tasks are equal.

Lastly, do not struggle on your own with a sick patient or a difficult task – get senior help (as above). Ask another senior if one party does not respond. ◆

SMA's Inaugural Durian Party: A Fruitful Success!

Text by Joanne Ng, Deputy Manager, Membership Services

SMA recently hosted its first-ever Durian Party, an exciting and flavour-packed afternoon made possible with the generous sponsorship of HSBC Bank. Held on 19 July 2025, the event welcomed 50 SMA Members and their guests to Ms Durian, a popular air-conditioned cafe among durian aficionados.

Guests spent the afternoon networking and bonding over the "king of fruits", creating a lively and convivial atmosphere. The event kicked off with two engaging talks: an exclusive HSBC session from 2.30 pm to 3 pm, followed by a property insight sharing from 3 pm to 3.30 pm. Both sessions sparked thoughtful discussion and provided practical takeaways.

Naturally, the highlight was the durian feast. Members indulged in creamy, top-grade Mao Shan Wang and Red Prawn durians alongside a refreshing spread of tropical delights such as longans, lychees and mangosteens. Complementing the fruity treats were hearty sandwiches, crispy samosas and thirst-quenching coconut water served straight from the fruit. *Luo han guo* herbal drinks also added a cool and soothing touch to the mix.

The vibe was upbeat and welcoming, with guests who attended solo leaving with new-formed connections. Feedback for the party was overwhelmingly positive, with attendees expressing strong interest in future events of a similar nature.

SMA extends heartfelt thanks to HSBC for their kind support, and to Ms Durian for the wonderful hospitality and exquisite spread.

Looking ahead, Members can look forward to an exciting lineup of events, including a golf simulation and test drive party with Audi and a mortgage talk in October, our annual SMA Members' Appreciation Night movie screening in December, and a rerun of the Succession Planning talk for doctors in January 2026 due to popular demand.

This Durian Party was a sweet reminder of SMA's commitment to offering vibrant, meaningful experiences to our Members. We cannot wait to welcome you to the next event! ◆

Legend

1. Durian delight on every face!

2. Tasty treats to complement the king

3. Beyond durians, insights on smart banking

4. Durian love is in the air

1

TEE-RRIFIC TURNOUT AND CAMARADERIE IN FULL SWING

Text by Sylvia Thay, Deputy Manager

Orchid Country Club was bustling with activity on the morning of 30 July, with 102 golfers gathered for a day of golf, fun, and friendly competition. Following a scrumptious lunch spread and a group photograph, the shotgun tee-off marked the beginning of the SMA Annual Golf Tournament 2025 and 26 flights of golfers headed onto the green. This year's Tournament saw 13 first-time participants, who managed to snag the highly sought slots despite an overwhelming response.

Thanks to good weather throughout the day, the Tournament proceeded smoothly with an optional dessert break for golfers who stopped by the ice-cream booth which offered traditional cut ice cream in a cup or sandwiched between their choice of bread or wafers. Before long, the golfers returned to the main building with big smiles on their faces, as they got ready for dinner.

The Emerald Suite was filled with the chatters of excited golfers and choice music played by the deejay. Convenor Dr Bernard Lim took to the stage to welcome everyone and expressed his gratitude to all involved, including golfers, sponsors and SMA staff, and the dinner commenced! Much to everyone's delight, the ballroom's atmosphere was further livened as emcee-entertainer Happy Fei Fei began the evening's programme with an energetic greeting and plenty of jokes. Time passed quickly amid the series of games as well as a sharing by Platinum Sponsor Summit Planners, and the room was soon filled with applause and cheers as the results of the day's game were announced.

To both their surprise, first-time participants Dr Benedict Peng and Dr Angela Hwee bagged the Best Nett prize and Best Lady Golfer prize, respectively. When speaking with them, Dr Hwee shared that they were eager to participate in the tournament to meet fellow enthusiasts as they had only recently started golfing more seriously. Having had a great day, she praised the event for being well-organised with a fantastic course, good food and most importantly, great company. "Come join the Tournament, you won't regret!" was what Dr Hwee answered when asked what she would say to golfers who have not participated in the Tournament before.

Yet another pleasant surprise for the evening was the tie for the Best Team award, with both teams scoring 183 points each. The final winner was thus determined with a coin toss and as luck would have it, Team Specialist brought home the trophy for 2025! The evening's programme continued in a boisterous mood until all 51 lucky draw prizes were given out. Golfers then bid fond farewell to old and newfound friends, departing Orchid Country Club in high spirits, stomachs filled and hands full with goodie bags and prizes.

SMA thanks Dr Bernard Lim and all participants for their strong support of our Golf Tournament, and we look forward to organising more of such events for Members to meet and connect with colleagues and friends with similar interests. If you are keen to find out more about SMA's Special Interest Groups' games and activities, please reach out to us at membership@sma.org.sg.

Dr Bernard Lim first joined the SMA Golf Tournament in 2017. Back then, he had just picked up golf and excitedly registered for the Tournament after finding out about it through the newsletter. Eight years later, we speak to him as the convenor of the SMA Annual Golf Tournament 2025 to find out about the experience.

Q: How has your experience as the Golf Tournament's convenor been?

A: Although I was taken aback when tasked to organise this year's Tournament, I have found it to be a pleasure and honour to do so for fellow golf enthusiasts. I am thankful for the strong support provided by the organising committee (including SMA staff) and the sponsors in the process of putting together this event. It is especially heartwarming to have so many doctors join us today. This is a good event for doctors to network with colleagues from both private and public sectors, as well as an opportunity for everyone to let our hair down outside of work. The turnout today is very encouraging.

Q: Do you have any advice for the next convenor?

A: I would urge the next convenor to continue and build on this momentum for the Golf Tournament. My hope is for the event to increase in scale and participation, and possibly even move out of its comfort zone. I believe that this is possible with the strong support of the SMA team and fellow doctors! ◆

Congratulations to all the winners of SMA Annual Golf Tournament 2025!

Best Gross: Dr Charles Tan Tse Kuang

Best Stableford: Dr Tay Jam Chin

Best Nett:
Dr Benedict Peng Chan Wearn

Best Senior Golfer:
Dr Chong Tat Chong

Best Senior Lady Golfer:
Dr Goh Swee Heng

Best Lady Golfer:
Dr Hwee Peik Hum Angela

Best Team (GP vs Specialist)

Winner: Specialist

Dr Tay Jam Chin

Dr Charles Tan Tse Kuang

Dr Ngiam Shih Kwang Kelvin

Dr Ng Chee Yung

Dr Goh Swee Heng

Runner-up: GP

Dr Adrian Tan Yong Kuan

Dr Chee Hsing Gary Andrew

Dr David Tan Yew Weng

Dr Chee Yew Wen Ewen

Dr Hwee Peik Hum Angela

Friends of SMA

Winner: Mr Ke Yam Cheong

Runner-up: Mr Clinton Ang

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3

4

Legend

1. United we swing, united we conquer

2. Ace couple on and off the course: Dr Benedict Peng Chan Wearn (Best Nett score) and Dr Hwee Peik Hum Angela (Best Lady Golfer)

3. Congratulations to our lucky draw winner, Mr Marcus Song!

4. Unforgettable moments with unforgettable friends

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ZAPPY
Your Personal Bodyguard

Convenor: Dr Bernard Lim Yon Kuei

Advisor: Dr Chan Kwai Onn

SMJ Editorial Fellowship:

A Firsthand Experience of Editorial Decision-Making

Text by Dr Fong Jie Ming Nigel

In the past year as a *Singapore Medical Journal* (*SMJ*) Editorial Fellow, I have had the opportunity to peer review submissions, participate in *SMJ* editorial meetings where publication decisions are made, pen an editorial titled "Chronic Kidney Disease is no longer a 'nontraditional' cardiac risk factor: a call to action for Cardio-Kidney-Metabolic Health", and write a guide to the peer review process. Even as a junior specialist, I had a front-row seat to witness journal editorial decision-making and a chance to participate in the process and contribute to decisions made. I also gained access to a longitudinal mentor during the fellowship, who has been a great source of wisdom and inspiration.

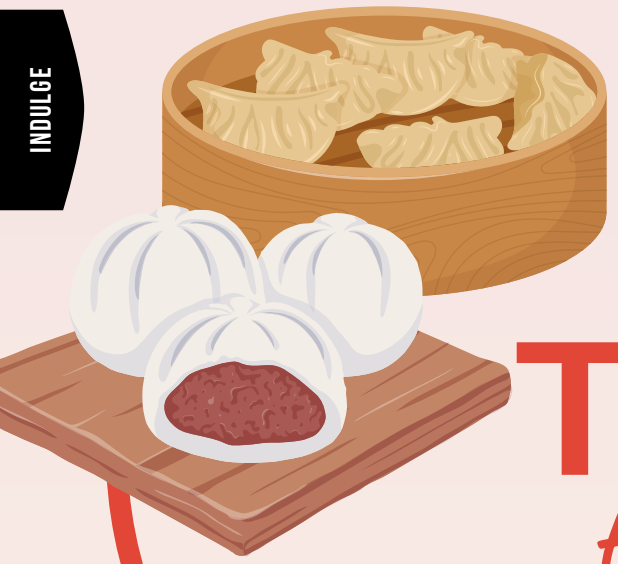
Having now been on the other end of submitting papers to journals and waiting with bated breath to see if my article would be accepted, I better understand the many – and sometimes opposing – factors that go into an editorial decision whether to accept or reject a submission. Beyond principles of evidence-based medicine, such as the presence of a well-framed hypothesis, appropriate study methodology, mitigation of potential biases, and accurate and fair result analysis, the journal must also consider questions of novelty, impact on the scientific field, and in the case of *SMJ*, implications for the local healthcare landscape and policy-making. A good peer review and editorial process not only selects appropriate articles worth publishing, but also provides constructive feedback that improves the final published product.

I have also come to realise that it is in the interest of our medical community and research ecosystem to have a strong local journal, which improves the standing and visibility of local research, amplifies the impact of local and regional work, and flies the Singapore flag high. A journal is defined by the articles it is able to attract and chooses to publish. While metrics such as impact factor are important, this singular statistic over-simplifies many complex nuances and is not to be blindly worshipped. Behind any journal is a committed team of section editors and reviewers with diverse areas of expertise – all of whom receive no remuneration apart from the shared vision of contributing to the journal, and more broadly to medical progress and ultimately our patients.

As the 2026 Editorial Fellowship applications open, I encourage senior residents and junior specialists who desire to gain insights into the peer review and editorial processes to apply. A basic grasp of evidence-based medicine and/or experience with simple research will be helpful, and a dose of intellectual curiosity is essential. The expected time commitment includes approximately one hour-long meeting a month, plus a peer review about every other month, which should be manageable for busy clinicians (except perhaps senior residents taking their exit examinations in the same year, whom I would advise to focus on studying first). I trust that it will be an enriching and meaningful journey, just as it has been for me. ◆

Scan the QR code to learn more about the *SMJ* Editorial Fellowship.

Dr Fong is a renal physician at Sengkang General Hospital with clinical interests in peritoneal dialysis, glomerulonephritis and tubules/electrolytes. He is also heavily involved in medical education and has authored two books, *Algorithms in Differential Diagnosis* and *A Strategy to and Worked Practices for the MRCP PACES*.



Time for Dinner?

Text by Dr Daniel Lim

As doctors, we are trained to practise evidence-based medicine. The investigations we order are based on guidelines, the drugs we prescribe are backed by trials, and our dietary advice is drawn from data.

And then we go on call, and suddenly we believe in "call luck" – a complex fusion of superstition, anecdotal experience and dialect-based wordplay.

Food traditions on call

Passed down like a secret oral tradition, the rules to follow are rarely written but universally known. Do not say "It's been a quiet call." Do not take the last lift or staircase. And definitely do not wear red unless you want to summon more of it.

Food-based rituals are especially colourful. Drink Coke Zero for zero admits. For the same reason, don't drink 100PLUS or, worse still, POKKA Lemon 1000. Chrysanthemum tea invites floral serenity. *Shuǐ jiǎo* (Chinese for dumplings) help you *shuì jiào* (Chinese for sleep). Beware the bao, lest you have to *bao ga liao* (Hokkien for "settle everything"). I have seen grown adults back away from a *char siew bao* (barbecued pork bun) as though it were radioactive.

There is also a food delivery ordering hierarchy. A senior medical officer calls the shots at night for the call team – sometimes magnanimously polling everyone, other times issuing a unilateral order with the efficiency of a wartime general.

Meanwhile in the day, the house officer (HO) stresses out while taking drink orders: "One *kopi o siew dai*, one *kopi c kosong*, one *teh peng*, one Milo dinosaur..." One must come back with everything ordered correctly or risk exile. These beverage orders can sometimes feel more sacred than the laboratory orders put in during rounds.

But beyond these quirks lies a deeper story of how food shapes our call culture. Amid all the weariness, food becomes more than just sustenance. It turns into a symbol of support.

I still remember going on my first call – I was overwhelmed, "under-slept" and desperately flipping through my "Called to See Patient" handbook. Then came a simple, "Need a drink?" from a fellow HO, handing me a vending machine packet drink (which was, you guessed it, Yeo's chrysanthemum tea). That small act pulled me out of my despair. I suddenly realised that I was not the only one on call, and that I had help around me.

On another call, after a particularly intense resuscitation, I overheard one senior whisper to another, "What should we eat later ah?" I remember laughing internally. It was oddly comforting – a reminder that all storms would pass, and we would all eventually sit down and eat.

I have had nights in the ICU where, surrounded by patients recovering from cardiac arrest, I found myself sheepishly ordering an upsized McSpicy meal with the rest of the team – aware of the irony, but hungry for some comfort food.

Over time, I have come to realise that these food moments meant more than just calories. They were gestures of care. They were how we showed concern and solidarity. They were how we said, "You're not alone."

Closing thoughts

As I move further along in my career, I carry these food stories with me not just as funny anecdotes, but as reminders of what truly fed me in my early years: the seniors who bought me food without asking, the coffee runs with teammates during lull periods, and the warmth of a shared meal amid a long night's fatigue.

I hope we carry on these quiet traditions – not just the rules about what can or cannot be consumed, but the deeper instinct to look out for those around us. Because sometimes, the simplest way to say, "I've got your back", is still, "Eh, time for dinner?" ◆

Dr Lim is a member of the SMA Doctors-in-Training Committee and works in the community care sector, primarily with nursing homes and hospices. Although getting older than he cares to admit, he still hopes to better the lives of junior doctors around him.

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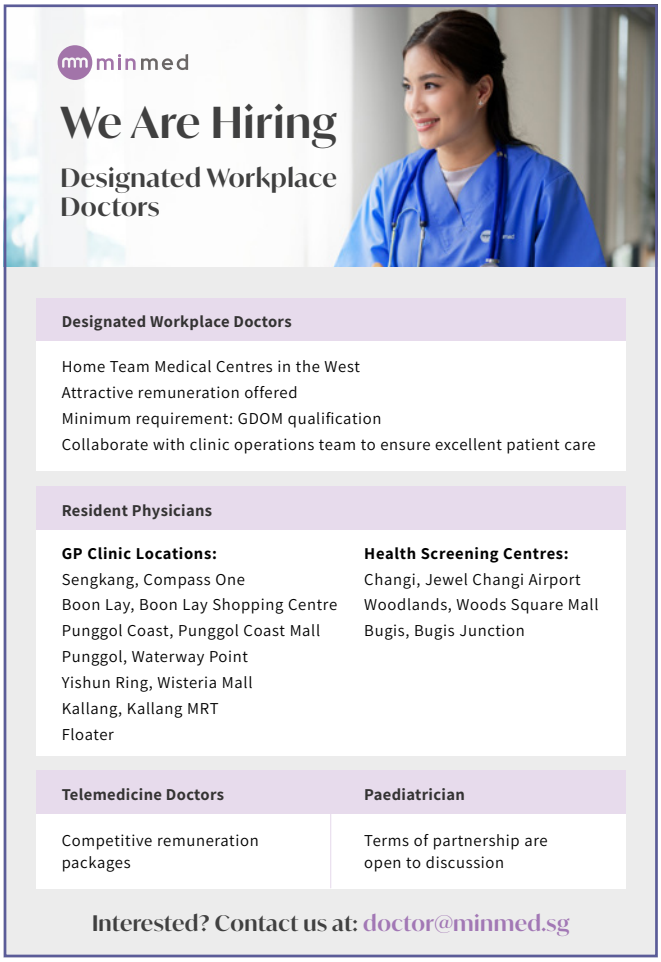
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