

SMA



For Doctors, For Patients

news

VOL. 59 NO. 2 | FEBRUARY 2026 | MDDI (P) 022/12/2025

Reel Medicine, Real Reflections



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and Reality

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URL: <https://www.sma.org.sg>
UEN No.: S61SS0168E

DESIGN AGENCY

Oxygen Studio Designs Pte Ltd

PRINTER

Midas Asiapac Pte Ltd

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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.



In his contribution this month, Prof Toh Han Chong reminisces about the medical show *ER*, stating that, "As a busy internal medicine resident, I did not watch *ER* much as I did not want to relive my day job after work."

For the same reason, I generally avoid books or shows that heavily feature medicine, especially those with a focus on mental illness and psychopathy. Nevertheless, the crime and thriller genres are peppered with these elements and, while I am at it, let me throw in my own recommendation of *The Silent Patient*, if anyone has a few hours to spare to binge a book.

Like it or not though, my social media algorithm knows that I am in healthcare and continues to show me clips from clever series like *House* and *The Good Doctor*. I must admit, there is something about these shows

that hooks you, when it is done well. Admittedly, *House* remains my favourite Western medical drama.

February being what it is, we wanted to focus on something lighter, thus the spotlight on medicine in reel life. While not strictly about the medical treatment of diseases (that is what medical school, residency training and conferences are for), medicine in reel life showcases the less quantifiable aspects of being in the profession – the art of medicine, the heartaches, the dynamics, the crushing constraints of different healthcare systems and the fact that we are, fundamentally, flawed individuals working with other imperfect human beings. Anyone who thinks otherwise is probably living a reel life themselves.

DR CHIE ZHI YING

Deputy Editor

Dr Chie is a consultant family medicine specialist working in NHG Polyclinics. She also holds a Master of Public Health from the National University of Singapore and is a Fellow of the Royal Society for Public Health. She enjoys freelance writing and has written for Chinese dailies *Lianhe Zaobao*, *Shin Min Daily News* and health magazine *Health No. 1*.



Medical drama is in a unique genre of its own, not merely serving as a source of entertainment but also spurring reflections and soul searching on matters of life and death. From the likes of Western dramas such as *Grey's Anatomy* and *ER*, to Chinese dramas like *The Heart* and *Healer of Children*, and Korean dramas such as *Hospital Playlist* and *Resident Playbook*, medical dramas blend in high-stakes, emotional and tear-jerking storylines with healthcare professionals often struggling with ethical dilemmas and their own fair share of personal woes in fast-paced hospital scenarios.

As the audience remains on tenterhooks seeing how doctors and nurses in these shows resuscitate patients in emergency rooms, undertake complex emergency surgeries and other procedures to save lives, we are also constantly touched by the kindness, compassion and professionalism that healthcare professionals have for their

patients, as well as the resilience, camaraderie and friendship that the healthcare team have forged in the most challenging of all times.

Although life in reality as a healthcare professional may not be as dramatic as what is often portrayed on screen, the values and spirit exemplified by these characters are certainly highly relatable and are what we frequently see among peers in real life.

In this February issue of *SMA News* on "Reel Medicine, Real Reflections", we are excited to hear from a few of our Editorial Board members their thought-provoking, witty and humorous commentaries on medical series and shows. We also have Dr Chong Yik Yan sharing her reflections on the TV series *Inside Crime Scene*, in which our Editorial Advisor A/Prof Cuthbert Teo was one of the experts featured.

So, as you sit back and read this issue, I hope you have fun watching your own favourite medical drama series as well! ♦

MEDICINE, MEDIA AND REALITY



Medical shows are enjoyed by people of all ages and all walks of life, including those in the medical profession. These shows may serve as entertainment, reminders and even lessons for students and doctors alike in their pursuit of medicine. *SMA News* invites three Editorial Board members to share their personal reflections and commentaries on medical shows that have impacted them on their journeys thus far.

Behind the Scenes: Drama and Reality ▶▶▶

Text by Wong Shi Hui, Student Correspondent

From dramatic resuscitations to breaking bad news, medical dramas have shaped the way many of us view healthcare.

As I reflected on what to write, numerous dramas flashed through my mind. Should I choose Western series such as *House MD*, *The Good Doctor*, *Grey's Anatomy* and *The Pitt*? Or should I turn to Korean dramas like *Doctor John*, *Hospital Playlist*, *Ghost Doctor*, or perhaps Chinese productions such as *The Hippocratic Crush* and *Big White Duel*?

Many of these dramas share similarities with what healthcare workers witness daily – the chaos, pressures and demands of a healthcare system serving society. Yet each genre also highlights differences in medical practice, often shaped by cultural contexts. Whenever I watch a medical drama, I look out for one key thing: how accurately does it reflect our work? *Hospital Playlist* resonated deeply with me because of its realistic depiction of each character and the working life I aspire to pursue.

Hospital Playlist follows the lives of five doctors, each specialising in a different field, working in the same hospital. What stood out most to me was their friendship that continued to blossom years after their graduation. Though they are now professors feared by their fellow residents, they retain their playful and cheeky dynamics as though they have not aged since their medical student days. Their friendship keeps their spirits

young amid gruelling work schedules and the many stressors of life. Despite their busy schedules, they still find time to have meals together, celebrate milestones and even revive their band practices. It highlights how small acts can go a long way.

While watching *Hospital Playlist*, I found myself relating to many scenes: being quizzed as a medical student, attending multidisciplinary ward rounds, caring for patients and their families, and juggling commitments and hobbies outside of medicine. One of the joys of watching a drama is the spectator view that allows us to appreciate the heartwarming stories from both the patient's and the healthcare team's perspectives. I enjoyed watching the doctors go above and beyond to provide holistic care for their patients. As we hone our professional skills, we inevitably become more critical and efficiency driven. While expertise and competence come with experience, humility is what keeps us grounded and prevents complacency.

One particular scene that stood out to me featured Lee Ik Jun, a hepatobiliary surgeon who is friendly with everyone in the hospital: the cleaners, the optometry shop owner, the emergency medical services helicopter pilot and the gardeners. Running a hospital requires far more than just healthcare professionals, and this scene skilfully honoured the many service providers who support the system behind the scenes.

Another appealing aspect of *Hospital Playlist* is that it does not glorify medicine as a career where doctors are portrayed as invincible. Instead, it explores their realistic struggles – both medical and personal. For dramatic effect, one resident fell victim to a scam and suffers significant financial loss. While fictional, the portrayal of doctors juggling multiple commitments mirrors reality closely. Medical students and doctors are constantly “hustling” – some with research, others with hobbies or side businesses. In *Hospital Playlist*, Chae Song Hwa, a neurosurgeon, exemplifies this balance: in addition to her clinical duties, she mentors her residents, supervises their research papers, attends band practices, and still finds time to go camping on her days off.

Perhaps we share more similarities with these characters than we realise. Drama may not be so far removed from reality after all. As we persevere in our medical journeys, I hope readers find comfort and respite in your hobbies as you strive for work-life balance. May the friendships you forged in medical school – or at any point in your career – serve as a strong support system during difficult moments. I am deeply grateful for the kindness I have received thus far, and I hope readers will carry the same spirit of kindness and passion as we continue writing our own life stories.

Shi Hui is a student correspondent (Singapore) at *SMA News* and a fourth-year medic at the National University of Singapore. She is an advocate for wellness, equality, inclusion, diversity and volunteerism. Beyond academia, Shi Hui finds joy in teaching and writing, and indulges her passion for running during moments of respite.



Still from *Hospital Playlist* (*Egg is Coming* and *CJ ENM*, 2020–2021)

Sherlock: A Medical Drama Disguised as a Detective Series ▶▶▶

Text by A/Prof Daniel Fung, Editorial Advisor

I have always thought that *Sherlock* is misunderstood. It is described as a crime or mystery series, but at its heart, it is a medical one. Not in the sense of wards and white coats, but in how it thinks about the human condition: observation, diagnosis, pattern recognition, the brain-body connection and the cost of suffering when meaning is lost.

This is not accidental. Sherlock Holmes was created by Sir Arthur Conan Doyle, who was himself a physician. Holmes was famously modelled after Doyle's surgical professor, Joseph Bell, a man known for diagnosing patients by observing how they walked into the room. Long before MRI scans, Bell taught that the body tells a story, if only one learns how to read it. That is medicine in its purest form.

Seen through this lens, *Sherlock* is not just a whodunnit. It is about how we know what we know.

At its best, the series celebrates clinical observation. Holmes notices the stain, the tremor, the pause before a sentence. Doctors are trained to do the same. In a healthcare system increasingly seduced by tests and technologies, *Sherlock* offers a reminder, almost a parody, that the diagnosis often begins before the first investigation is ordered. The patient's story, posture, affect and context still matter.

Then there is John Watson, a doctor who embodies the mind-body link more convincingly than many textbooks. A war injury leaves him with pain, post-traumatic stress disorder and a loss of

purpose. His recovery is not linear or neat. It unfolds through relationships, work and meaning. Watson shows us that trauma does not sit only in the brain or only in the body. It lives in both. This is mental health literacy quietly delivered, without slogans.

Sherlock himself is an exaggerated case study in psychosomatic medicine. When bored, his mind decays and his body follows – insomnia, agitation, substance use. When engaged, both sharpen. The show may dramatise this, but the principle is sound. Mental states shape physiology, and bodily states shape cognition and emotion. The idea that we can neatly separate “mental” from “physical” illness is biologically convenient and clinically wrong.

Even Sherlock's restless movements matter. He paces, shoots walls, plays the violin. His thinking is embodied. Cognition does not float free from muscle, breath, sleep, hormones or inflammation. The brain is an organ in a body, not a software update. If more people understood this, our conversations about health would be far more grounded.

But *Sherlock* also miseducates.

The playful label of a “high functioning sociopath” is witty television and poor psychoeducation. It blurs personality, neurodiversity and mental illness into a single caricature. Worse, it implies that emotional detachment is the price of brilliance. In real medicine, empathy is not a weakness. It is a diagnostic tool. You do not need to be cold to be clever.

Addiction fares no better. Sherlock's drug use is stylised, selective and strangely consequence-free. In clinical reality, addiction is harmful. It damages organs, relationships and futures. Romanticising it may make good drama, but it undermines health literacy.

Then there is the lone genius myth. Sherlock outpaces systems and teams with disdainful ease. Entertaining, yes. Accurate, no. Modern medicine is a team sport. Safety and care come from collaboration, not savants. Media narratives matter because they shape expectations of healthcare, often unconsciously.

Which brings us to the real lesson. Popular media is an informal medical curriculum. For many people, *Sherlock* is where ideas about trauma, addiction, intelligence and the brain-body connection are first encountered. Viewers may forget the plot, but they remember the attitude.

That is why *Sherlock* matters. It invites curiosity about how minds and bodies work together. It also reminds us that stories shape health beliefs as powerfully as prescriptions do.

In that sense, Doyle's medical legacy lives on. Sherlock Holmes is not just solving crimes. He is practising a stylised, flawed and fascinating form of medicine. And for health literacy, that may be the most enduring mystery of all.



Still from *Sherlock* (Hartwood Films, BBC Wales and WGBH, 2010–2017)

A/Prof Fung is a father of five and grandfather of five, which are experiences that have taught him to live with stress, uncertainty and joy in equal measure. A lifelong supporter of Tottenham Hotspur, he has learnt resilience and the discipline of hope. His tenure as CEO of the Institute of Mental Health prepared him well for his current role as chief wellness officer at NHG Health.



My Desert Island Choice of TV Medical Drama Across the Years ▶▶▶

Text by Dr Toh Han Chong, Editorial Advisor

Hands down, the defining medical TV drama of my youth was *M*A*S*H* – short for Mobile Army Surgical Hospital. Younger generations of doctors would mostly be unaware of this multi-award-winning timeless TV show; an offshoot of the original Robert Altman's 1970 masterpiece film, *M*A*S*H* – widely considered one of the greatest films ever made, and winner of the Grand Prix du Festival International du Film (now known as Palme d'Or) at the Cannes Film Festival.

An anti-war movie that paid tribute to the medical support for the Vietnam War, with one of the most iconic original songs in both the movie and TV series, *M*A*S*H* follows the military medical team at the 4077th Army hospital based in the village of Uijeongbu, South Korea, during the Korean War. The colourful characters showed viewers the grace, humour, humanity, horror, pain, pathos, courage and compassion of medical first responders on the frontline of war. US President Barack Obama has said that he learnt many life lessons from *M*A*S*H*, as did many of us. The 1983 TV series finale was the most watched in television history at the time with over 106 million viewers. I was then deciding whether to apply to medical school, and *M*A*S*H* must surely have subliminally nudged me towards wanting to be a doctor.

My next desert island medical TV drama is also likely not known to many – the BBC TV series *Cardiac Arrest* (1994 to 1996). Screened at a time when I was a medical resident preparing for the MRCP examination, it was very relatable. *Cardiac Arrest* goes deep into the heart, brain and bowels of a National Health Service British hospital revolving around the trials, tribulations, triumphs, travails and sleep-deprived Sisyphean stresses of Andrew Collin – a bright-eyed, idealistic house officer – and his strong, sisterly mentor, medical officer Claire Maitland – battle-wise, protective, pugnacious and poised with equanimity. Our very own Ivan Heng, artistic founding director of Wild Rice, played a nurse in this gritty, hard-hitting TV series given two thumbs up by most British doctors then.

Cardiac Arrest lets us see the grit, dilemmas, dedication and sweet light moments of medicine. But it also showcases the open wounds of junior doctor burnout, racism, misogyny, gender inequality, sometimes toxic culture, brutal confrontations and self-harm (which led to the tragic loss of a bullied surgical junior doctor in the series).

Rewatching *Cardiac Arrest* on YouTube recently was nostalgic. I qualified in medicine in the UK and as final-year medical students, we often had to function like house officers. It brought me back to a time of quintessential English bedside manners, stiff upper lip fortitude and Dunkirk spirit in the trenches, taking medical notes with pen and paper, reaching for the *Oxford Handbook of Clinical Medicine* (as no Internet or Google was available then), constantly buzzing pagers and ringing landline phones.

During my time as a medical resident at Tan Tock Seng Hospital, one of the most successful medical TV series, *ER*, hit our screens between 1994 and 2009, taking home 128 awards. Helmed by a suave young George Clooney, Anthony Edwards, a younger Noah Wyle, and Julianna Margulies, this groundbreaking high-adrenaline drama follows up close the unfolding in a chaotic Chicago hospital emergency room. As a busy internal medicine resident, I did not watch *ER* much as I did not want to relive my day job after work.

Thirty years on, a way more mature, tougher and wiser Noah Wyle, no longer the doe-eyed, sometimes blur medical student he played in *ER*, is now an emergency room attending physician in a Pittsburgh hospital in the current hit TV medical series born out of the COVID-19 pandemic – *The Pitt*. Already garnering five Emmy awards, it accurately portrays first responders rendering acute medical care with real, raw, realistic, immersive power and empathy. It also shines a light on American healthcare today – strong in so many ways yet dysfunctional and broken in parts. In the US, overall life expectancy is now lower than in 2010.

Still from *MASH* (20th Century-Fox Television, 1972–1983)



Still from *Cardiac Arrest* (World Productions, 1994–1996)



Finally, there is the Korean drama (Kdrama) spread and my top pick is *The Trauma Code – Heroes on Call*. This fun, fantastical and action-packed webtoon-inspired Kdrama follows the adventures of mission-possible macho ex-military oppa (Korean for “older brother”), super trauma surgeon Dr Baek Kang Hyuk at the fictitious Hankuk National University Hospital. I mean, how many doctors have you seen jump out of a helicopter, fight bad guys with all guns blazing, charge through a conflict zone in a motorcycle, decompress a cardiac tamponade in designer suit and slick hair in place, all while flexing his muscled bod and six-pack? Yes, Singapore has tough selfless heroic doctors out in war zones with Medicins Sans Frontieres and other humanitarian organisations, but I doubt they perform amputations looking this stylish while dodging bullets and exploding bombs.

On another note, the Hobbit is retiring – marking the end of an era. If the furry one is willing, I would be happy to work with Hobbit on a dramatised oral history of Singapore medicine right through two pandemics and beyond. Like Agatha Christie's Hercule Poirot in her famous mystery stories, the Hobbit should narrate. ♦

Dr Toh is a senior consultant medical oncologist and deputy ceo (strategic partnerships) at the National Cancer Centre Singapore. He was a former Editor of *SMA News*. In his free time, Dr Toh enjoys eating durians and ice cream, reading, writing, rowing and watching films. Thankfully, the latter four are not fattening.



Closing the Loop on the Quest for Office Space

Text by Dr Ng Chee Kwan

SMA is currently renting premises at 166 Bukit Merah Central and it is indeed a very comfortable and pleasant office space for our staff. However, our lease is guaranteed only up to 2028. In my August 2024 column, I wrote that the SMA Council had embarked on a quest to purchase an office space which could house our Secretariat staff as well as serve as a meeting venue. The impetus for doing so was that we have had to relocate twice in the last ten years. By securing a permanent office unit, we would be less vulnerable to rising rents, leasing uncertainties and recurrent set-up costs.

At the same time, we anticipated that the returns on our investment funds, which were mostly in fixed deposits and T-bills, would diminish as interest rates were trending lower. We could make better use of our investment funds by purchasing a commercial property that could be rented out for income, and which could also serve as our office should the need arise.

There were several criteria to be met. Our proposed office space needed to be reasonably priced so that we did not overextend our finances. It had to be big enough to house our Secretariat staff comfortably, as well as provide enough space for a meeting room for

Council members and visitors. It had to be centrally located and accessible by public transport. As an investment, it had to have a sufficiently long remaining lease and, last but not least, it should have a reasonable rental yield.

Over the course of six months, we conducted an extensive search for suitable properties, and considered shophouses, newly launched commercial office properties and existing commercial office spaces. Further time was required for us to confirm the availability of bank loan facilities. After much deliberation, we decided to purchase two adjacent office units in Paya Lebar Square, and the purchase was completed on 27 October 2025.

Paya Lebar Square is part of a mixed-use development right next to Paya Lebar MRT. The two office units combined yield 2,680 square feet of space and are currently leased to a single tenant. The property carries a 99-year leasehold, with 84 years remaining. To maintain financial flexibility, we financed 50% of the purchase through a loan from DBS Bank, even though we had sufficient reserves available to fund the property in full. The full details of the purchase will be available at the upcoming Annual General Meeting.

I am happy that our vision to secure an office space has come into fruition within my term as SMA President. Having our own office space will provide SMA with more operational long-term stability, so that we can continue to serve our Members better. ♦

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.



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.



Fitness to Drive – TP-LTA combined medical examination form

Over the years, SMA has assisted the Traffic Police (TP) and Land Transport Authority (LTA) regarding Fitness to Drive matters, producing the SMA Fitness to Drive guidelines to help doctors in assessing a driver's fitness to drive a vehicle.

The TP and LTA recently developed the Harmonised Medical Examination Report, a digital form that enables doctors to submit reports for vocational licence holders and recreational drivers to both authorities at one go. SMA sent an email blast to Members on 27 January 2026 highlighting a feedback survey conducted by TP and LTA on the Harmonised Medical Examination Report.

A virtual question and answer engagement session was also jointly hosted on 10 December 2025 to address direct questions from medical doctors. It was a fruitful session with many pertinent questions and useful feedback for TP

and LTA to review. We thank SMA Members for their active participation.

We also wish to inform that the new submission process is now live, with effect from 2 February 2026.

For more details, please refer to the LTA press release at <https://bit.ly/4rxRUP5>.

Guidance on disclosure of patient medical records to insurers

The Ministry of Health (MOH) has issued a circular on 9 January 2026. The circular provides guidance on the appropriate disclosure of patient medical records to insurers, to facilitate legitimate insurance processes while safeguarding medical confidentiality.

Please refer to this link for the circular: <https://bit.ly/3Orfe39>.

For queries regarding this circular, please contact MOH at HCSA_Enquiries@moh.gov.sg. ◆

Disaster Preparedness and Response

CMAAO Meeting 2025



Text by Dr Chong Yeh Woei | Photos by Nepal Medical Association

Every year when September comes along, it marks that time of the year when we get together with colleagues from National Medical Associations (NMAs) from across the Asia-Pacific region for serious discussions and sharing on what we are doing for our constituents, our patients and our nations.

A delayed meeting

This year was no different and we were to be hosted by the Nepal Medical Association. However, the meeting in mid-September was derailed by the 2025 Generation Z (Gen Z) protests. We were shocked by videos that showed the five-star Hilton hotel in Kathmandu gutted by fire. Fortunately, that hotel was not our venue for the conference. The meeting was nevertheless postponed and we convened on 12 December 2025 at a resort hotel in the suburbs of Kathmandu. We were warmly welcomed by Dr Anil Bikram Karki, the current president of the Confederation of Medical Associations in Asia and Oceania (CMAAO) who was installed in a Zoom meeting conducted earlier in the year.

Twelve NMAs attended the meeting, with seven joining in person and the

rest online in a hybrid meeting, where the theme was “Disaster Preparedness, Response and Management”. The guest of honour was the Nepal Minister for Health and Population, Dr Sudha Sharma Gautam, who was a past president of the Nepal Medical Association. She was very much at home when she graced our meeting, and I asked her about the situation on the stability of the country. She was appointed to the role by the interim leader Sushila Karki, who was a former Chief Justice, after the Gen Z protests. The Gen Z protests were triggered by a shutdown of all social media platforms on 4 September 2025, a response to a social media trend focusing on nepotism among the children of the ruling elite. The situation had calmed down by the time we met in December, and the nation’s focus was on rebuilding and the elections due in March 2026.

We always have the Taro Takemi oration lecture at our CMAAO meetings and this year was no exception. Dr Taro Takemi was the president of the Japan Medical Association for 25 years from 1957. He was instrumental in establishing CMAAO in 1956 and he also served several terms as the president of

CMAAO. At the 1977 CMAAO general assembly, Dr Taro Takemi highlighted issues such as ageing of the population, seriousness of pollution and its impact on the environment, and was also concerned about the impact of medical progress and soaring medical costs due to ageing that will put a strain on national finances. Indeed, he was a visionary and prescient about the issues that are facing many of our nations today. Hence in 1991, the Taro Takemi Memorial Oration lecture series was established with donations from the Japan Medical Association and the Takemi family.

The speaker of the oration lecture this year is Dr Kenza Bennani who works for the World Health Organization in Nepal. She is a Moroccan epidemiologist and her talk on disaster preparedness was most illuminating.

National response to disasters

Those of us in Singapore have often taken for granted the safety and security we enjoy and the lack of natural calamities. However, we have in recent



years had disasters in our fellow CMAAO member nations including typhoons in the Philippines and Myanmar, earthquakes in Nepal, floods in Pakistan, and tsunamis and earthquakes in Japan and Indonesia. CMAAO had in recent years donated funds for disasters to the NMA of the affected nations.

During the meeting, member NMAs presented on how they handled disasters. In particular, I was very impressed with the Japan Medical Association's (JMA) disaster response where they organise volunteer Japan Medical Association Teams (JMATS) that comprise a physician, two staff nurses and a coordinating staff member. During the Great East Japan earthquake and tsunami in 2011 that we all remember vividly, JMA dispatched close to 8,000 volunteers organised into JMATS. These volunteers came from JMA membership as well as the various prefecture medical associations that are part of the JMA umbrella. The deployment of these teams was sustained over several months.

As part of the camaraderie during our meetings, we get updates from different nations as to their domestic situation. The Korean Medical Association gave us the latest update on the strike by the young residents and interns in South Korea that has since ended in December 2025. The Hong Kong Medical Association gave us the latest information on the fire that had engulfed Wang Fu Court in Taipo that had resulted in 161 deaths. They also shared how they sent medical volunteers to help with the disaster, especially for the displaced and to give psychological support for those who have lost their loved ones. A quiet discussion with my

Myanmar colleagues gave me an insight into the ongoing civil war between the junta, hill tribes and the population. The Thais gave us information on the border war between Cambodia and themselves.

The meeting also gives me the unique flavour of being in a mini United Nations with all the various inputs on the state of the NMAs and the challenges they face. We have country reports by various participating NMAs and we do not hesitate to disclose the hard truths of what is going on in the leadership's thinking of each NMA and how the NMAs relate to their respective governments.

For my part, I presented the preparedness of Singapore's society on disaster response with regard to our civil defence and medical community on mass casualties with hazardous materials and civil emergency response exercise. We also highlighted the measures that were involved in the COVID-19 pandemic as well as our public system of warning sirens, the MyResponder app, and the recent establishment of the Communicable Diseases Agency.

At the end of the reports presented and the robust discussions that followed, we sought to hammer out a CMAAO Kathmandu declaration on Disaster Preparedness, Response and Management.

Other than the discussions, we also found time to renew our ties. I have been the chair of the CMAAO Council since 2017 and it is always a pleasure to see my colleagues from all the nations. There will always be meals shared together and a common activity is the karaoke singalong usually initiated by our Japanese and Korean colleagues and very often there

will be folk dancing sessions as cultural shows are always a must for the host nations. A benefit of this solidarity is that the CMAAO delegation to the huge World Medical Association meetings, comprising a hundred nations or more, have a united voice and some say in international matters.

Till the next meeting

Our next meeting will be held in Seoul, hosted by the Korean Medical Association and I look forward to our next meeting with a meal of bibimbap washed down with *soju*. Meanwhile I leave everyone with a beautiful photograph of the Annapurna mountain range at sunrise! ◀

Legend

1. Dr Chong receiving a token of appreciation from the Nepal Medical Association
2. Delegates posing for a group photo
3. The beautiful Annapurna mountain range at sunrise

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





STRENGTHENING SUPPORT FOR DOCTORS: MOHH HMD × SMA DIT Forum

Text by Dr Ivan Low Jinrong and Dr Calvin Tjio

Dr Low is a Navy medical officer and A&E senior resident. He is an SMA Council member and the chairperson of the SMA Doctors-in-Training Committee. He 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*).



Dr Tjio is a resident in diagnostic radiology at the National University Health System. He is the vice chairperson of the SMA Doctors-in-Training Committee and an SMA Council member. He is interested in medical education, quality improvement and artificial intelligence.



The annual MOH Holdings (MOHH) Healthcare Manpower Division (HMD) × SMA Doctors-in-Training (DIT) Forum, held in October 2025, provided a valuable platform for open dialogue on issues affecting our junior doctors. The meeting was attended by SMA DIT Committee members, MOHH officials and student leaders from the various local medical societies.

We share here a summary of the discussions that took place during the meeting.

Establishing guidelines for department manpower planning

One of the concerns raised during the National Wellness Committee for Junior Doctors discussions was the varied manpower planning practices across departments. SMA DIT Committee's assessment is that a set of overarching guidelines, formulated together with MOHH HMD, could help establish common manpower planning principles for departments to align with. Such

guidelines would help MOHH HMD's manpower distribution principles to be percolated down to and felt by the ground, promoting fairness among department manpower deployment. The guidelines will be formulated based on a review of existing literature and best practices, similar to prior SMA guidelines such as the SMA Guideline on Fees for Doctors in Private Practice in Singapore, and the SMA Medical Guidelines on Fitness to Drive.

Enhancing support for IMGs

SMA and MOHH both shared about the initiatives each has put in place to help junior doctors. For example, the SMA DIT Committee currently conducts annual workshops for house officers and medical officers. These workshops, along with resources such as the SMA DIT 101 digital pocketbook, are accessible by all SMA Members and have historically supported a significant number of international medical graduates (IMGs). In parallel, MOHH currently works with hospitals to provide workshops for

returning IMGs and is considering a standardised orientation programme. Discussions were held regarding how to better support our junior doctors and the potential for future collaboration.

Exemption of pregnant doctors from night duties

Inconsistent practices regarding the exemption of pregnant doctors from overnight calls and night shifts were raised as a concern. While some departments provide automatic exemptions during a certain stage of pregnancy, others require memos from the treating physician, resulting in differing treatments and additional administrative burden on pregnant doctors. SMA DIT Committee recommended that MOHH HMD issue guidance for a reasonable timepoint from which pregnant doctors can be exempted from night duties, from which hospital departments could take reference while retaining flexibility in implementation.

Improving the health status declaration process

A key concern raised was the phrasing of the health status declaration in MOHH's employment form, which could be misconstrued as discriminatory and/or discourage doctors from declaring their health conditions. SMA DIT Committee provided suggested amendments to the MOHH health status declaration. The suggested amendments aim to: (1) clarify the intent of the declaration to be to plan postings/rotations more effectively; (2) reassure doctors that their health information would be treated with utmost confidentiality; and (3) ensure that MOHH's work practices remain fair and within the legal limits of Singapore Law (see Workplace Fairness Act 2025, part 3, paras 15–16 and part 4, paras 17–18).

Ensuring compliance with transport claim policies

One of the concerns raised was that some departments imposed additional limits on transport claims, in contravention of

MOHH's policy. This has resulted in doctors in certain departments being unable to claim for transport despite them needing to start work before 6.30 am in view of the heavy clinical workload. SMA DIT Committee suggested for MOHH HMD to identify errant departments and to issue a reminder for departments to comply with MOHH's transport claim policy.

Clarifying timelines for work-related claims

SMA DIT Committee was informed through engagements on feedback regarding the timeline for the processing of work-related claims. The main concern was for rejection of claims that could be due to factors outside the doctor's control (eg, delayed approval by department claims approver). MOHH gave reassurance that doctors will not be held liable for delayed claims due to factors beyond their control, and that an appeals process existed for these circumstances. SMA DIT Committee

suggested for MOHH HMD to include this important clarification into the MOHH handbook for employees.

Improving accessibility of pre-employment grant interviews

Finally, feedback from IMGs highlighted logistical challenges in attending pre-employment grant interviews in Australia. Some cited difficulties in flying across the country for interviews. Consideration for conducting interviews in more locations was suggested to improve accessibility and reduce travel burden.

The discussions at the forum underscore the importance of continued engagement between stakeholders to address structural issues thoughtfully and collaboratively. SMA DIT Committee remains committed to advocating for practical, fair and doctor-centred manpower policies, and looks forward to working closely with MOHH HMD to translate these discussions into meaningful improvements for MOHH employees. ♦

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 (smadit101.glide.page), 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 supports the SMA National Medical Students' Convention.

Join our DIT Telegram channel [@helpourjuniordocs](https://t.me/helpourjuniordocs) and follow our Instagram page [@jrdocs.sg](https://www.instagram.com/jrdocs.sg) to stay up to date regarding our various initiatives. If you are keen to get involved with SMA DIT Committee's efforts, please write in to us at ilj@sma.org.sg.

Where Evidence Comes Alive: *Inside Crime Scene*

Review by Dr Chong Yik Yan

Picture this. It is 10 pm at night, and you have just attended a dinner party. What are your options for the journey home?

Many times, I find myself opting for public transport to save money, even though it includes a ten-minute walk home from the bus stop. The fact that I can include public transport as one of my options at night speaks volumes of the sense of safety that we feel in Singapore. In a 2024 survey by Gallup,¹ Singapore ranked safest in the world for the 12th consecutive time, boasting 98% of surveyed Singaporeans reporting feeling safe walking alone at night.

But what did it take to bring us to this state? What were the incidents in our history that played pivotal roles in improving our security?

Inside Crime Scene is a short series of 11 episodes packaged in two seasons, exploring iconic crimes from Singapore's past. It offers an immersive look into the world of crime investigation from the Singaporean perspective, dissecting local cases with a multidisciplinary approach. Cases come to life through the lenses of the various stakeholders – police, forensic scientists, forensic pathologists, forensic psychologists, journalists and even the victims themselves. In this piece, I write about three episodes that struck a chord with me.

S1E2: In Cold Blood – Geylang Bahru Murders

Something cold

Decades ago, Singapore saw its fair share of violent crimes. Yet nothing could prepare Singaporeans for the morning where four young children were slain in cold blood.



Still from *Inside Crime Scene* (August Pictures, 2022)

A regular weekday morning, school bus driver Tan Kuen Chai and his bus attendant wife Lee Mei Ying set off for work early in the morning at 6.35 am as usual, reminding their eldest child to wake the rest of his three siblings for school. At 7.10 am, Mei Ying dialled three wake-up calls home and requested a neighbour to check in on the children, all yielding no response. When the couple returned home at 10 am, the four children, ages 10, 8, 6, and 5, were found lifeless, with multiple slash wounds each, and stacked on top of each other in the unit toilet.

Details of the case were illustrated with vivid detail through interviews and reenactments of the scene. The police investigator repeatedly described the scene as one of the worst he has seen. The heart-wrenching discovery of the slain children and the subsequent public outrage was palpable as various neighbours recalled the incident. The fear was further highlighted by a neighbour with young children of similar ages, who recounted how her children used to play with the Tan family and how she thought it was a near miss that her children were temporarily living elsewhere when the murders happened.

To aid understanding of the case, a walkthrough of the crime scene was used to explain the investigation that

followed, with models depicting the house layout, allowing the viewers to visualise the macabre scene that greeted the Tan parents. Current forensic scientists were invited to weigh in on key points of the crime scene, and to expand further on how different the case might have been if investigated with current available technology. Till today, the case remains a cold one.

Another important stakeholder interviewed in this episode is the Crime Library Singapore – a non-profit organisation working on public crime awareness and prevention. They religiously broadcast and publicise the case on its anniversary, hoping that people with information can come forward to help solve the crime. Ultimately, when the evidence is scarce, we resort to the old-fashioned way of investigative journalism, continuing to hold on to the hope that the case may be solved one day.

S1E5: Guns and Violence

Something resolved

Gun violence is virtually unheard of in Singapore these days. But did you know that the Arms Offences Act was only enacted in 1973, a little over 50 years ago? This episode explored Singapore's history with firearm crimes – most rampant in

the post-war era, and most frequently used in kidnapping and robberies. Through interviews with the then law enforcers, era-appropriate re-enactment of the crimes, and an exploration of the regional history, viewers can get a better understanding of what Singapore was dealing with fifty years ago.

A highlight of this episode was the baffling case of seamstress Chan Chee Chan, who was shot to death while walking along Queenstown in 1972. The source of the shot was unknown, but there were three main hypotheses – (1) a sniper shot taken from a nearby HDB block, (2) a bullet accidentally discharged by flying fox hunters returning home from a night out, and (3) a stray bullet from a nearby shooting range. This was against the background of an era where gangs ran rampant, shootouts were common and citizens could hold firearms easily.

This episode was a reflection on the importance of severe punishment and strict enforcement in the maintenance of order in Singapore. Although the Act was enacted in 1973, gun violence was still common, and many citizens still possessed firearms. The situation improved only after the penal code was amended in 1974, to include the death sentence for firearm discharge without a need to prove intent to shoot. Moreover, with strict gun control laws, gun crime is largely resolved, with the most recent gun injuries sustained only in the course of law enforcement.

S2E5: Burden of Proof

Something relevant

With advancements in technology, crime in Singapore has also shifted to

the digital world. Something closer to home would be white collar crimes such as scams and credit fraud. In 2024, cases of scams and cybercrime continued to increase, up 10.8% from 2023.² Appropriately, an episode in this series is dedicated to such crimes.

A good example from the episode would be that of serial fraudster Jerald Low who was involved in a variety of scams, including that of property, telco and job scams. One of his victims was Terrence, his ex-classmate from secondary school. This is a story that may even sound familiar to any viewer – an old friend approaches you and speaks to you about a business opportunity, requiring a small financial investment with minimal effort for substantial returns. Despite feeling suspicious about the circumstances, Terrence decided to trust Jerald and proceeded to invest in six mobile phone lines, ultimately losing up to ten thousand dollars in telco termination penalties without getting anything in return.

Hindsight is always 20-20. The setting of the stories mentioned in this episode remind us that such scams can happen to anyone. Even young, seasoned digital surfers may be caught in a moment of weakness and fall prey to such schemes.

Conclusion

In summary, *Inside Crime Scene* offers an intimate look at local crimes that many Singaporeans may not be aware of. The series was both educational in creating awareness of events that have passed, and thought-provoking in evaluating the response and subsequent management of the aftermath. By interviewing people who were originally involved in the case,

the emotional weight of the crimes was well balanced with fresh perspectives and hypotheses brought in by present-day forensic scientists.

For medical professionals and learners, it sheds light on how the various sciences come into play, and how medical knowledge is used in the setting of law enforcement. For anyone curious to learn more about crime investigation with a Singaporean twist, *Inside Crime Scene* is an immersive watch to learn more about our past and to explore the techniques shaping the future of forensic investigation. ♦

References

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Dr Chong is a medical officer with a keen interest in forensic science and medicine. She enjoys bridging medical knowledge and science with real-world applications, particularly in the realm of healthcare and crime investigation. When not working, she enjoys true crime media such as podcasts and documentaries.



Still from *Inside Crime Scene* (August Pictures, 2022)



Still from *Inside Crime Scene* (August Pictures, 2022)

SMA MEMBERS' APPRECIATION NIGHT 2025

SMA is pleased to host our many Members, volunteers and friends at the SMA Members' Appreciation Night on 19 December 2025, where we screened the movie *Avatar: Fire and Ash*.

Prior to the screening, SMA President Dr Ng Chee Kwan took the opportunity to address those in attendance, sharing the advocacy efforts of SMA in the year of 2025. It is also SMA's joy to now be representing 59% of Singapore doctors and we encourage more doctors to join us as SMA Member.

Aside from the movie itself, we hope that everyone who joined us for the evening enjoyed the complimentary popcorn and drink combo set, the instant photography booth services and the chance to meet up with friends and colleagues in a casual setting. Thank you for your support through the years and we look forward to continuing our advocacy efforts in 2026! ▶





Good Medical Records: Standards and Challenges

Text by Dr Gerald Chua and Sophie Chua



Gone are the days of handwriting paper notes and the arduous, time-consuming task of deciphering the illegible doctor scrawl. We now practise in the era of electronic medical records, a tool that has undeniably transformed and improved the way clinical information is documented, accessed and used in modern healthcare.

Despite technological advancements, the fundamental pillars underpinning medical practice and professionalism remain unchanged. These pillars – competence, altruism and a commitment to ethical practice – continue to guide our work. Likewise, our core professional duties – to diagnose, to advise and to treat – persist. Together, these principles are reflected in the actions we perform instinctively on a daily basis, acting as cogwheels in a coordinated manner. These might be described as the three Ts: to think, to talk, and to type. We **think** through our differentials, the advice we intend to give to our patients and our treatment plans; we then **talk** with our patients, and sometimes with their next-of-kin as well, to communicate the details of our management plan; and finally, we **type** (or write) into our records to create a visible, durable footprint of our findings, thought processes and discussions with our patients.

Medical records as a footprint of our care must extend beyond the account of what is found, said and done. They must convey our delineation of the clinical facts, the weighing up of the options, and the thought process underpinning

our clinical decision-making. Our records must also serve as a clear and accurate guide for the next healthcare professional attending to the patient to aid the quality of continuing care, especially when team-based care is provided.

The aspects of a good medical record can be summarised under the following seven Cs.

Content

The SOAP (subjective, objective, assessment, plan) note for recording our ward rounds and clinic encounters is a tried-and-tested method of documentation. It serves its purpose for most routine encounters. However, on occasions when the clinical interactions and decision-making is non-routine and more complex, the simplicity of the SOAP note may be inadequate. An alternative method to record the content of our patient interaction is **FOR-DEC**, a structured decision-making framework that originated in the aviation industry in the 1990s.

Facts: What is known about the patient?

Options: What are the diagnostic and/or treatment choices ahead?

Risks: What goes for and against the application of the different options?

Decision: After weighing the above with the patient, what is the plan?

Execute: The plan – to be executed by whom and when by?

Check: How will the patient's progress be monitored?

This documentation framework is particularly applicable when the clinical plan entails a necessary deviation from the usual practice, there is clinical equipoise, or existing practice evidence and/or guidelines are not extrapolatable to a set of unique clinical circumstances. Documenting the content of our clinical plans in this manner promotes clarity, states uncertainty and complexity where it exists, and enhances continuity of care.

Context

In any narrative, viewing and interpreting the content within the context it sits in is important. Particularly in situations filled with complexity (see the below section), documenting both clinical and situational contextual facts enables subsequent healthcare professionals to accurately interpret the note and understand the rationale for decisions made.

Contextualised records enhance clinical reasoning transparency, medico-legal defensibility and patient-centred care by demonstrating that decisions were informed by the full clinical situation rather than isolated data points.

Complexity

The acronym VUCA was first used by the US Army to refer to volatile, uncertain, complex and ambiguous state of the world in a post-Cold War era. Robert Johansen, a leadership consultant, built upon this in his proposed behavioural leadership model **VUCA Prime** – vision, understanding, clarity and agility, as a way of counteracting the challenges of VUCA.

The lack of **VUCA Prime** attributes can alert us to the potential complexity of a patient interaction.

- Lacking **vision**:
The patient is unable to appreciate the management path and/or longer-term goals ahead beyond the immediate next steps.
- Lacking **understanding**:
The patient is unable to fully comprehend the plans.
- Lacking **clarity**:
The current plans, because of disease-/patient-related factors, are necessarily not fully determined.
- Lacking **agility**:
The patient has rather rigid ideas of how clinical management is to be executed.

Even the most health literate of our patients can find themselves mired in complexity, beset by the conditions as described above. This is more commonly encountered when a multitude of treatment options exist, or there are many stakeholders involved in the care. Under such circumstances, good record-keeping becomes all the more crucial.

Concision

With the rise of content-importing technology in electronic medical records, a new phenomenon of “note bloat” has emerged. The ease of being able to copy-paste, import templates and autofill speeds up documentation, but inadvertently often results in the accumulation of redundant information.

Critical changes in symptoms, assessment or plan can be buried beneath copied text. This increases the risk of errors and miscommunication, and compromises patient safety. Over time, note bloat impairs the usefulness of the medical record as a clear and concise clinical communication tool to the next provider, turning it into a repository of recycled text rather than an accurate reflection of the patient’s present state and care.

To remedy this habit, the notion of **SOAP v2.0** is proposed – the idea that every clinical note should be **succinct, original, accurate** and **problem-oriented**.

Clinical entries, particularly one read at 3 am by the junior doctor on-call or

the night-shift nurses encountering the patient for the first time, must convey with clarity and efficiency the patient’s key problems and critical facts. Well-constructed notes allow all team members to rapidly achieve shared situational awareness, ensuring that any patient care in the moment or planned for the future is effective and unhindered. To support problem-oriented documentation, most electronic medical record systems include a “Problem List” tab, enabling clinicians to encode problems as they arise and organise their notes around the patient’s active clinical issues.

Check

In our increasingly fast-paced practice, we are reminded of the need to pause and check that our clinical documentation is accurate. If records are made on our behalf by team members, we must take reasonable steps to ensure that the quality of the records meets the required standard.

A reasonable attempt to check the clinical facts contained in a patient’s existing medical records should also be made at each encounter, and more thorough attempts at checking made when complexity is anticipated/encountered, or when pivotal clinical decisions need to be made.

Conversation

The C of conversation is a reminder that even amid the needed attention paid to clinical documentation, we need to be present for and engage with our patients. Taking a good history involves conversing with our patients, not just a careful perusal of the content of the existing medical records.

The Four-Box Method for ethical analysis (medical indications, patient preference, quality of life, contextual issues) developed by Jonsen, Siegler and Winslade can also be used as a framework to guide our conversations with our patients.

Consent

The final C of good medical records revolves around specific records of the consenting process. Once the

conversation with our patients on what matters (materially) to them has taken place and its elements clearly documented, meeting the standards of giving medical advice (for informed consent) as laid out in the Civil Law Act Section 37 will not be difficult.

Taking a step back, we remind ourselves of the three pillars of informed consent: capacity, voluntariness and disclosure. A record of how the three pillars are present/upheld should be made.

In conclusion

Accurate and thorough medical records are the backbone of high-quality health-care. We keep good clinical records not just for medico-legal purposes, but because they aid sound clinical decision-making, promote continuity of care and facilitate good team-based care.

Ultimately, a well-kept record ensures that our patients’ health stories are clear, accessible and readily actionable, which directly improves our care and their clinical outcomes. ♦

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Sophie is a Year 5 medical student at the University of Bristol.



HIRING AN ASSOCIATE



Text by Dr Wai Chun Tao, Desmond

Nowadays, it is a common practice for private specialists to expand their practice by hiring additional doctors, who may be partners, employees or associates. When I left public service in 2006, I first joined a private group as an employee, before leaving the group in 2011 to start my own practice as the sole practice owner.

I have been considering hiring an associate to expand my practice but so far, I remain a solo practitioner. There are both advantages and challenges associated with this, which I share in this article.

Advantages of expanding a practice

Providing more comprehensive service

No one specialist knows everything in their specialty. In the case of gastroenterology, it is generally divided into luminal gastroenterology and hepatology. There are further sub-specialisations like liver transplantation, inflammatory bowel disease and advanced endoscopy.

My own Health Manpower Development Plan training was in hepatology and liver transplantation. While I do general endoscopy and gastroenterology work, I refer patients who need advanced endoscopy procedures such as endoscopic submucosal dissection or endoscopic ultrasound to other doctors.

It will thus be logical for me to hire an associate who can cover this shortfall and provide more comprehensive gastroenterologist services within the clinic.

Enabling holidays coverage

When I go on leave or overseas travels currently, my clinic is closed. It is a waste of resources as I continue to pay for my clinic staff, rental and other overheads

despite being closed. My patients may also seek out another doctor if they need such services while I am not around.

It will certainly be better if an associate can continue to run the clinic and attend to patients when I am unavailable.

Expanding clinic footprint

I currently run clinics at two separate hospitals on different days in a week. With an associate, we will be able to run clinics in two more locations, hence expanding the coverage. The clinic can also get onto more Urgent Care Centres' (UCCs) calls rosters and possibly receive more inpatient referrals from specialists within those hospitals.

Lowering cost per doctor

Certain clinic operating costs are fixed, such as fees for accountants, secretary, electricity, clinic facilities, administrative staff, etc. With more doctors practising at a clinic, the running costs per doctor will be lowered.

This is especially so for specialties that require expensive clinic equipment, such as LASIK machines, exercise treadmills and echocardiogram setups.

Improving economy of scale

Clinics with more practising specialists can offer improved services. Some groups are able to have their own ultrasonographic machines, FibroScan machines, physiotherapists, dietitians, pharmacists, etc, within the premise due to having a pool of doctors.

However, as a solo practitioner, it is not economical hiring a digestive dietitian or purchasing my own FibroScan machines as they will be underutilised. These costs will be relatively lower if the staff or equipment is shared with more doctors. In addition,

pharmaceutical companies that supply medications to clinics often charge less per tablet if a larger quantity is ordered. Tapping on the economy of scale will help improve profitability.

Being better target for opportunities

Many private equity firms have been actively acquiring medical groups for further merger or initial public offer (IPO).¹ My observation is that they typically acquire groups with three or more doctors, rather than solo practices. One multidisciplinary specialist group was purchased at S\$109 M.² That is an opportunity that solo practices like mine will not qualify for, unless I expand my practice to three or more gastroenterologists.

Although it sounds good to have a group, being able to sustain and grow a group requires much management and leadership skills.

Challenges of hiring an associate

Finding the associate with the right skill

This is **THE** most difficult part. I will need someone with skills that complement mine, and can do things that I cannot, such as endoscopic ultrasound and endoscopic submucosal dissection. However, gastroenterologists who are good at these can easily set up their own practice. It means that I will need to find one and also convince him/her to join me.

Hiring the associate with a compatible attitude

Some doctors would put in time and energy to give marketing talks to the media the public and GPs to advertise their skills and services. They do not mind receiving calls at odd hours or during holidays when there are patients to be seen. Their main reason going into

private practice is to see more patients and to earn more.

On the other hand, some go into private practice to have more time for themselves, their hobbies and families. Their priorities are to have total control of their time and better work-life balance. They do not mind earning less as long as they are happier.

Thus, finding one with the attitude that matches mine is important.

Setting a fair compensation package

I will need to derive a package that is fair to both the new hire and me. While the associate must be paid well enough to entice him/her to leave public service, I also need an incentive system that will encourage him/her to work hard for the clinic. I would not want the associate to receive a high salary and become less motivated to bring in more patients.

The new hire might be wary that it could take up to several months or years for him/her to build up the patient load, meaning that his/her initial income would be low. However, he/she would also have financial commitments like housing and car mortgages, and children's education to worry about.

As such, most packages will have a fixed, guaranteed component, as well as a profit-sharing formula. This is to ensure that the associate's take-home is guaranteed during the initial stage. When he/she is established and brings in more revenue, he/she can then get a share of the profit. Ideally, the associate will eventually make more than what he/she gets in public service.

Setting the guaranteed amount, as well as the profit-sharing formula, however, is a major task that no one has the magic formula for. Additionally, the formula needs to be adjusted as the associate matures in private practice.

Getting patients for the new hire

As I am giving a guaranteed basic pay for the new hire, I need to ensure that he/she sees enough patients. He/She will likely have to enrol onto panels of various Integrated Shield Plan (IP) providers, as well as third-party administrators (TPAs).

It is hard for private practitioners (GPs and specialists alike), especially new ones, to survive without being on any panels.

I am personally not a big fan of TPAs, as their fees are lower than that of IP

providers. Additionally, TPAs typically require their panel clinics to issue medication to patients first, then bill the TPA after. My personal experiences with several TPAs have not been pleasant especially when they have taken up to several months to disburse payment.

But things are different when I have a new hire. My task is to find him/her enough work such that he/she makes enough to cover the basic salary. One thing to note is that many IP providers may not be accepting new specialists on their panel and thus, getting my new hire onto IP panels could be an uphill task.

Marketing the new hire

It is important to let the public, GPs and fellow private specialists know about the new hire's skills. I will thus have to find ways to introduce the new hire via social media, GP talks and hospital continuing medical education talks.

I may also have to tap on my experiences and connections with various media outlets to arrange for public appearances on television, public events and newspapers for the new hire. It is also essential to convince my existing patients that he/she is good and that they can see him/her when I am not available.

Departure of the new hire

No group sticks together forever. The associate could leave during any of the different stages of his/her private practice journey.

Some leave private practice after a short stint. Not all enjoy private practice, where patients are more demanding, UCCs call you at odd hours, and ward nurses call you at all times with no junior doctors as buffer, etc.

Some leave when they persistently fail to earn more than their basic pay. Others prefer the leave benefits in public service, such as the 20 days of annual leave, 28 days of conference leave and five-day work weeks.

Some may realise that their public hospital pay is larger than they thought, after taking into account their 13th month, mid-year, year-end and performance bonuses, sign-on and retention bonuses and the corresponding CPF contributions.

And some do so well in private practice that they may start their own group, with themselves as the boss and leader.

It is a great financial loss when a junior associate leaves the practice. The

clinic's cost will take some time to drop back to solo practice levels as I would need to continue to pay for the rental and manpower for the extra clinics till the contract expires. Renovation works for the new clinics, which are usually a six-figure sum, will also go to waste. And some of my existing patients may decide to leave and go to the associate's new clinic instead.

Keeping my junior associate happy

This is an important issue. The remuneration package offered needs to be adjusted with time, to ensure that the associate is satisfied and paid what he/she deserves. Involving him/her in making administrative decisions and eventually making him/her a partner with better profit-sharing formula will help. The potential to enjoy financial gain when the whole group is acquired or doing an IPO may also entice him/her to stay.

Conclusion

Having a group brings in many advantages, both professionally and financially. However, finding a new hire and keeping him/her happy require lots of hard work. As of the time of writing, I have not found a new hire, but I will continue to search.

It is better to be happily solo than to be unhappily grouped. Just like finding a spouse, it is better to remain single than to marry the wrong person. ♦

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Dr Wai is a gastroenterologist in private practice. He enjoys writing about life as a doctor. He strongly believes that doctors must share their experience and knowledge with one another to raise the standard of the medical profession.



Threading the Needle

Text and photo by Christic Moral

Christic is a second-year medical student at King's College London and is the Editor of the 31st SMSUK executive committee.



As winter settles in, the days grow shorter, and a grey expanse of clouds dominates the sky. Though the days may be drab and a world away from sunnier, more comfortable times, their weight is lightened by the holiday season, with long evenings being brightened by Christmas lights and decorations across the country. With much to look forward to between the holidays and the new year ahead, winter serves as a time for growth in new ways, with unique challenges. Until the holidays arrive, we find new ways to break the humdrum routine that forms from escaping the cold, from finding new hobbies to spending time with loved ones.

Being in my second year of medical school, I have felt the excitement of experiencing my first winter pass. Last year was full of firsts. I saw snow fall for the first time, explored the Christmas markets around London and even stood around a brazier sipping on hot chocolate with friends. After all those firsts, I am left facing the realities of the changing weather, and venturing outside

in the cold no longer feels like the most appealing choice. I often walk back from my Friday hospital placements, which has become a sacred time for me to listen to music and ruminate about my past week. Of course, a 40-minute walk in thin trousers, which are barely saved by my thermals, is not quite so enticing when the weather is in the single digits, and the winds render umbrellas useless against the cold and piercing rain. Taking the bus feels much less ceremonious, but it certainly saves me from freezing. Going to the grocery store requires greater effort, and I am almost always lured to my cupboard instead, enticed to live a meal or two off of my quickly diminishing supplies of instant noodles. With such big changes to living, the weather of the day becomes more than just small talk. An hour of sunshine feels momentous enough for friends to make impromptu plans to enjoy it.

Resigning myself to being outside less has shown some benefits. With my usual routines now broken, my friends and I have found new ways to spend time together. Cooking together has been a great way to try new recipes, share laughs and learn about each other. My friend has convinced me to love peppercorns, which I usually avoid, and I have convinced him to start using frozen mixed berries, which I am sure is infinitely better than going for months without a single fruit. We also held a potluck at our flat with other members of the Singapore Medical Society of the United Kingdom (SMSUK) members from our batch, where we brought a variety of dishes that reminded



us of home. Besides that, I have also been playing music together with my friends at home. Though we usually book music rooms for practice, we have been opting to practise at home to escape the long travel times. This has certainly been a different experience, having to figure out quirky workarounds to get guitars and a borrowed electric drum set to play through a single portable speaker. When the speaker inevitably runs out of battery, we sit and talk while patiently waiting for it to recharge. Last year, winter was about braving the cold to spend time outside. This year, it has been about finding new ways to make the most of each moment.

SMSUK has also had its fair share of activities for members to stay connected, from watching *The Phantom of the Opera* at our annual Dinsical (dinner and musical), to having a trip together to Glasgow or even having fun at an escape room. In this edition of Letters from the UK, Ritvik shares his experience of navigating winter in his first year of school.

Text and photos by Ritvik Gupta

Ritvik is a first-year medical student studying at Imperial College London.



Winter during my first term of medical school was a unique experience. It took some time getting used to the early sunsets and chilly days. Rather than feeling dull over the days, I found it to be a very memorable and enjoyable time.

This term was full of new experiences, including meeting new people, exploring new places and slowly adapting to life in medical school in London while being away from home. Winter became a part of that backdrop. There were times when I took a step out and was met with a sense of regret, notably when the wind hit my

face at 60 km/h. Growing up in Singapore, where sunsets are consistently around 7 pm, evenings felt long and predictable. In London, it would be completely dark by 4 pm, which slowly became my new normal. While many hoped for later starts to their classes, a small part of me looked forward to days that began and ended early, simply to experience daylight on the commute home.

Like most medical students at Imperial College London, I stay in accommodation in North Acton. This means a daily commute of 30 to 40 minutes to campus at either South Kensington or Charing Cross. As bad as that might sound for university accommodations, it really was not. Sharing a packed tube with fellow Imperial students made the journey feel quicker and more familiar. The peaceful walks through Hyde Park to campus were a highlight, and something I genuinely looked forward to each day.

A huge defining factor of this term was the people around me. Time spent with new friends made the cold and darkness easier to ignore, as did long walks through London, spontaneous meals and day trips outside the city that broke the routine. Exploring new neighbourhoods, often bundled in layers of clothing, became a small adventure in itself. Food, however,

was a greater challenge. As someone who grew up eating spice with every meal, learning to settle for milder flavours took some adjustment, and it made me appreciate the comforts of home even more. Near the end of the term, I was introduced to the Scotch bonnet chilli, which thankfully helped, but it was never quite the same as back home.

There were quieter moments too. Evenings spent indoors, dealing with a faulty radiator, taught me the value of a thick duvet and the simple comfort of staying in bed just a little longer on dark winter mornings. Those slower days created space to pause, reflect and recharge amid the busyness of the first term, giving a welcome balance to the constant pace of lectures, new routines and social experiences.

Finishing my first term in university feels less defined by academics and more by adjustment and growth. The cold and gloomy days were something that subtly shaped the term and made it more memorable. Being back in Singapore for the winter break, however, has allowed me to find comfort in the warmth and light at home. While the break is coming to an unfortunate end, there is excitement in seeing what the second term has in store for me. ♦



Mini golf at Puttshack during Freshers' Fortnight



Dinner at a Thai restaurant near Hyde Park

From Prescription to Participation:

Partnerships that Empower Seniors to Age Well in the Community

by the Agency for Integrated Care (AIC)



As Singapore's population ages, general practitioners (GPs) are increasingly expected to support not only disease management but also functional independence and well-being over time. This requires care models that extend beyond clinical settings into the communities where seniors live.

Healthier SG and Age Well SG support this shift by connecting primary care with community-based resources that help address seniors' holistic wellbeing. Healthier SG anchors preventive care through personalised Health Plans and long-term GP-patient relationships, while Age Well SG supports seniors to age actively by addressing physical, social and functional needs within their communities.

Within this landscape, Active Ageing Centres (AACs) are emerging as important community-based partners to GPs, helping translate preventive health goals into practical, day-to-day actions.

What AACs offer

AACs serve as accessible points for seniors' community health, lifestyle and social needs. They provide what is known as the "ABC" suite of services: **A**ctive ageing activities, **B**efriending and buddying, and information and referral to **C**are services, supporting seniors to remain engaged and connected within close proximity to their residences.

In support of Healthier SG, AACs also act as Social Connectors to help seniors participate in programmes aimed at keeping them active, and provide Community Screening which involves assisting them with screening and measurement of vital signs, as prescribed in their Health Plans.

Why this is imperative for GPs

For GPs, this represents a practical extension of care beyond medical management.

The collaboration between Dr Lim Chien Chuan, Clinical Lead of I-CARE Primary Care Network (PCN), and MWS Active Ageing Centre – GreenTops@Sims Place (AACGT) illustrates how this partnership works in practice. Dr Lim notes that many seniors who benefit from AAC programmes do not necessarily present with overt medical diagnoses.

As he explains, "There are patients who are physically frail without a specific disease, simply because they have not been exercising. There are also those who are socially isolated. From a medical point of view, we can see the risk, but these are not issues that medication alone can address."



Dr Lim Chien Chuan (right) from I-CARE Primary Care Network

How it works in practice: Mdm Tan's story

One such patient is Mdm Tan, an 80-year-old woman living alone. While Mdm Tan is still physically independent, Dr Lim observed signs of social withdrawal during consultations and recommended that she explore programmes at the AAC near her home.

Dr Lim often encourages patients not to think of the AAC as a place where they go to receive help, but a place where they can contribute.

“Many older adults are proud,” he says. “When they see themselves as giving rather than receiving, they are more willing to take the first step.”

At MWS AACGT, Centre Lead Ms Melissa Teo observed that Dr Lim's recommendation was instrumental in encouraging Mdm Tan to re-engage with the community.

“Mdm Tan was already known to our team even though she had not been actively participating in our centre's activities,” Ms Teo shares. “With Dr Lim's timely encouragement, she found the confidence to visit the centre and begin exploring what was available.”

While Mdm Tan experienced giddiness and chose not to participate in group exercise sessions, she remained open to alternative forms of support.

Ms Teo observes that Mdm Tan now visits the centre more often for assistance with her mobile phone and government letters. Mdm Tan also uses the Community Health Post at the AAC to monitor her health, returning to Dr Lim for follow-up whenever symptoms recur.



Seniors keeping active through foosball
Photo credit: MWS AACGT

Supporting GPs through structured referrals

Within the I-CARE PCN, referrals to AACs are designed to fit into busy GP workflows. Each GP is supported by dedicated PCN staff who coordinate referrals, liaise with AACs and follow up directly with seniors.

As Dr Lim notes, “GPs are already very busy. It is not realistic to expect them to know which centre offers which activities, on which day and at what time.”

Observable functional improvements

Beyond social engagement, Dr Lim has observed tangible functional improvements among seniors who participate in structured exercise programmes facilitated through AACs.

He recalls one patient who struggled to stand up from a chair and get in and out of a car. Initially, it took her about six seconds to stand up. After supervised exercise, this was reduced to about two seconds.

The patient's daughter also later shared that after the programme, her mother is able to get in and out of the car independently.

“These are changes that affect dignity and confidence, not just physical strength,” Dr Lim adds.

An evolving partnership in community-based care

As the partnership between GPs and AACs deepens, both sides are finding more effective ways to support seniors to age well within familiar community settings.

Ms Teo shares that between 2023 and 2025, MWS AACGT received referrals for older adults to programmes such as gym sessions and befriending support, with varying levels of engagement. Other than these referrals, the AAC's collaboration with I-CARE PCN has also included health talks and bone mass checks conducted at the centre.

AACs are also beginning to experiment with interest-based activities beyond traditional exercise formats. Activities such as pickleball have shown promise in engaging certain groups, particularly when programmes are matched to participants' interests rather than age.

Dr Lim acknowledges that social prescribing within primary care remains an evolving practice, and it takes time to understand what truly engages different patients.

“We are not there yet but the direction is right,” he reflects. “With an ageing population and increasing social isolation, AACs are necessary. More work needs to be done but overall, I am optimistic about where things are heading.”



GPs are encouraged to refer their senior patients to attend AACs near their homes, as part of supporting preventive health and active ageing in the community.

Click or scan the QR code to locate the nearest AAC.

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The session will cover (1) medical clinics’ obligations under HIA; (2) NEHR contribution requirements on what needs to be contributed and how to contribute; (3) the baseline cyber- and data security requirements; and (4) support available to help medical clinics transition to the HIA era, including practicalities of using third-party vendors versus doing it yourself. Find out more about the HIA requirements to get your clinic ready – register for this webinar today.

Time	Topic	Speaker
1.30 pm	Opening Address	Dr Ng Chee Kwan <i>President, SMA</i>
1.40 pm	Overview of HIA	Adj Prof (Dr) Raymond Chua <i>Deputy Director-General of Health (Health Regulation), Ministry of Health (MOH)</i>
1.50 pm	NEHR Contribution: The Professional Practice Aspects	Dr Goh Min Liong <i>Chief Medical Informatics Officer, MOH</i>
2 pm	Cybersecurity: The Professional Practice of Standards Required by MOH	Kenny Yee <i>Senior Manager, Chief Information Security Officer's Office, MOH</i>
2.10 pm	Data Security: The Professional Practice Standards Required by MOH	Melanie Yip <i>Assistant Director, HealthTech Policy Division, MOH</i>
2.20 pm	Support Available for the Journey	Patrick Low <i>Lead Manager, Health Information Protection Office, MOH</i>
2.30 pm	Questions and Answers	Moderator: Dr Lee Pheng Soon <i>Immediate Past Executive Director, SMA Centre for Medical Ethics and Professionalism</i>

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