

# SMA



VOL. 58 NO. 10 | OCTOBER 2026 | MDDI (P) 057/04/2026

## *Our Junior Doctors*

**Doctors in  
Training**

# The Future of Singapore's Healthcare



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READ ONLINE

Investing in Our  
**Junior Doctors**

Supporting Doctors with  
**Psychiatric Conditions**



**DukeNUS**  
Medical School

*A different  
route.  
A stronger  
purpose.*

“ When you find something you truly care about, you keep finding your way towards it. My passion for neurosurgery gave me the conviction to keep learning, gaining experience and moving towards that goal, no matter how long the journey took. ”

**Dr Brian Chan**

*MD Class of 2017, Duke-NUS Medical School  
Year 2 Resident, Singapore Integrated Programme for Neurosurgery*

 **SingHealth DukeNUS**  
ACADEMIC MEDICAL CENTRE

Read more about Brian's journey into neurosurgery by scanning the QR code.



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# CONTENTS

## Editorial

### 04 The Editors' Musings

*Dr Tina Tan and Dr Calvin Tjio*

## Feature

### 05 Investing in Our Junior Doctors Through the Years

*Dr Calvin Tjio, Dr Maxz Ho and @cryingin7eleven*

## President's Forum

### 10 Beyond Hospital to Community: Reflecting on My Experience Across the Public, Private and Long-Term Care Sectors

*Dr Daniel Lee Hsien Chieh*

## Council News

### 12 Highlights from the Honorary Secretary

*Adj A/Prof Ng Chew Lip*

## Insight

### 13 Seven Essential Components of a Rounding Note: A Primer for Medical Trainees

*Dr Isaac Ng, Dr Arturo Neo, Dr Gaurav Deep Singh, Dr Peter Daniel, Dr Thanawin Pramotedham and Dr Kei Jun Poon*

## Opinion

### 16 Supporting Doctors with Psychiatric Conditions – The Making of the WISE Guideline

*Dr Caitlin O'Hara*

### 18 Dear Me: What I Wish You Knew

*Dr Lincoln Lim*

### 20 Woes of Parenthood in Residency

*Dr Christina Png*

## AIC Says

### 22 Health Plan AI: Turning Goals into Action

*Agency for Integrated Care*



## Letter

### 24 The Quest for the Perfect Lasagna

*Lye Ting Yin and Shiv Dewan*

## Event

### 27 Exploring the Wilds of Africa

*Joanne Ng*

### 28 AI in Your Practice: Cutting the Admin, Not the Care

*Joanne Ng*

## SMA Charity Fund

### 29 SMACF Board Appreciation Dinner 2026

*Sharmilah Banu*



# 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.



I visited someone in a ward the other day. The last time I was in that particular ward was as a junior doctor doing her general surgery rotation. The way that simple stroll through the ward, past the nurses' station, evoked such strong, visceral memories in my mind is testament to how formative those days were for me. And, I can imagine, for every doctor reading this.

Sometimes, I can hardly believe that over 15 years have passed since I was a house officer. The healthcare landscape has changed drastically in those years, what with the increasingly heavy reliance on technology and artificial intelligence. But some things do

not change, including the fact that we humans fall sick, get older and will someday need the expertise and care of those younger than us.

Think about it. Gen Z, the first digital natives of our time, are already practising doctors. Someday soon, Gen Alpha, the "six seven" and "skibidi" kids, will enter medical school. How will we guide them through their formative clinical years?

This is why our issue's title focuses on the people who will man the future of healthcare. Even as our juniors learn the ropes from us, it remains vital to ensure they are supported in that learning. Even as healthcare evolves, so too must medical education and training.

## DR CALVIN TJIO

Guest Editor

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



As Singapore's healthcare system continues to evolve, one truth remains unchanged: the future of healthcare depends on the people who deliver it. Today's medical students and junior doctors will become tomorrow's senior clinicians, educators and leaders. Developing our junior doctors is not just about having good medical education. It involves a multifaceted investment in our workforce to ensure the continued resilience of Singapore's healthcare system.

The journey of a junior doctor today markedly differs from that of previous generations. The COVID-19 pandemic disrupted medical training, while the evolving healthcare environment, patient expectations and increased formal documentation have affected the clinical learning environment. During this time, progress has been made to support healthcare worker wellbeing, safeguard work hours and increase the career opportunities available. As we look ahead, the challenge for us is to figure out how to continue to train competent doctors who remain compassionate, resilient and fulfilled in a perpetually changing world.

This issue explores key topics for junior doctors. In one article, we highlight the development of the Well-Being, Inclusion, Safety and Equity (WISE) Guideline by a joint workgroup consisting of representatives from the College of Psychiatrists, Academy of Medicine, Singapore (AMS), College of Public Health and Occupational Physicians, AMS, and the SMA Doctors-in-Training Committee. With this guideline, we hope to help create healthier workplace cultures to support our doctors with psychiatric conditions. We also examine the considerations of starting a family amid medical training, an issue that many face when balancing their professional and personal lives. Last but not least, we return to the fundamentals of medicine with a guide on writing an effective morning ward round note – a skill that remains central to patient safety, interdisciplinary communication and learning clinical reasoning.

We hope these articles will inform, encourage and inspire. Ultimately, developing our junior doctors well is one of the most important investments we can make in the future of Singapore's healthcare. ♦



# Investing in Our Junior Doctors Through the Years

Text by Dr Calvin Tjio and Dr Maxz Ho

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



Dr Ho is an Air Force medical officer and will commence his A&E residency training in 2027. He is currently vice chairperson of the SMA Doctors-in-Training Committee and serves as the secretary for the Medical Association of South East Asian Nations Junior Doctors Network. He believes that every junior doctor we invest in today becomes the mentor someone else needs tomorrow.



This year marks the 60th year since the establishment of *SMA News*, and it is timely that we take a look back at the history of SMA and junior doctors in Singapore. In the beginning, there was the SMA Medical Officer (MO) Committee which advocated for various concerns, notably house officer call allowances (long ago, our house officers were not paid for going on call).<sup>1</sup> Committee members at the time included current SMA Council members Adj Prof Tan Sze Wee and Dr Wong Chiang Yin, as well as past Council member Prof Wong Tien Yin.

The SMA MO Committee later became the SMA Doctors-in-Training (DIT) Committee, which has since continued to advocate for our young doctors. For example, in 2016, the DIT Committee received feedback that reservist leave was considered as being part of the leave quota in some institutions, but not in others. Dr Wong Tien Hua, then President of the 56th SMA Council, wrote on behalf of the Committee to the Ministry of Defence and Designated Institutional Officials to recommend that reservist leave should not be considered part of the leave quota for residents.<sup>2</sup> Back then, the DIT Committee members included current SMA Council members Clin Asst Prof

Benny Loo Kai Guo, Clin Asst Prof Lim Kheng Choon and Adj A/Prof Ng Chew Lip. Their early advocacy laid the foundation for the continuous investment in the development of our junior doctors.

## Changes concerning junior doctors

There has been a lot of talk about healthcare transformation and the need for change. Similarly, over the past few decades, much has changed with regard to the experiences of junior doctors (such as reduced working hours but higher administrative loads), and our current DIT Committee members Dr Caitlin O'Hara and Dr Haidah Kamal have published their findings in the *Annals of the Academy of Medicine, Singapore*.<sup>3</sup>

In medical education, our three medical schools are constantly improving their practices. Singapore's shift to the ACGME-I residency system comes with increased documentation of supervision from faculty, more formal assessments and feedback, and stipulated protected time for learning.<sup>4,5</sup> Yet, despite this, the SMA DIT Committee recognises that many junior doctors need guidance in the workplace. We

hence transformed our junior doctor guidebook into a phone application that is accessible on the go. We know that starting work is hard – our aim is to ease the steep learning curve for new house officers or medical officers, supported by initiatives such as our annual “starter pack” workshops.

In terms of numerical workload, the overall patient-to-doctor ratio has improved. We support the plan from MOH Holdings (MOHH) to increase manpower to enable the 24/80/1 work hour model (a maximum stretch of 24 consecutive hours, cap of 80 hours per week, and at least one rest day per week).<sup>6</sup> However, each patient case is now more complicated. Current junior doctors cite new difficulties in the workplace: a concerning medico-legal landscape, defensive medicine, complex patient needs and expectations, and higher administrative loads. In 2021, the Ministry of Health (MOH) established the National Wellness Committee for Junior Doctors (NWC-JD).<sup>7</sup> Our representatives in the NWC-JD advocated for issues such as improved assistance for doctors at risk of burnout in an increasingly complex healthcare landscape, improved access and competitiveness of career and training opportunities for junior doctors, and automated work-related claims/work-hour tracking through electronic medical record use, allowing doctors to spend more time focusing on patient care.<sup>8</sup>

### Helping ourselves, helping others

SMA's slogan is “For Doctors, For Patients”. Amid the evolving healthcare landscape and assistance of artificial intelligence, we must continue to strive for clinical excellence and invest in ourselves. Beyond medical expertise, there are numerous soft skills and hidden curriculums that are equally important to develop. Examples include communication skills and documentation, resource management and allocation as well as quality improvement. With improved patient-to-doctor ratios, there are concomitant reduced learning experiences for junior doctors.

Educators and learners need to be aware of any deficiencies that arise in training and actively address them.

There have also been increased efforts nationwide to support the mental health of our population. Concerns raised by junior doctors in this domain include the fear of stigma in the workplace and being treated differently from other doctors if they were to declare their symptoms or diagnoses. Together with representative psychiatrists and occupational health physicians from the College of Psychiatrists, Academy of Medicine, Singapore (AMS) and the College of Public Health and Occupational Physicians, AMS, the SMA DIT Committee established a workgroup to find a way to support our junior doctors better. The workgroup is developing the Well-Being, Inclusion, Safety and Equity (WISE) Guideline, to support the registration and practice of doctors with psychiatric conditions.

Apart from the numerous workplace improvements, we must not overlook the importance of supportive interpersonal relationships. The SMA DIT Committee encourages everyone to first take care of our colleagues, so that we can take better care of our patients. Nowadays, there are numerous avenues for junior doctors to turn to for help, be it within their department, hospital, MOHH or even outside of the workplace. We implore everyone to not go through medicine alone and to ask for help when you need it. Both senior and junior doctors should recognise that they play a pivotal role as mentors, near-peer teachers and friends.

The SMA DIT Committee will continue to advocate for junior doctors and medical students. We believe that every junior doctor deserves the same care and support that he/she gives to his/her patients. One day, our junior doctors will become the senior doctors taking care of Singapore's population. Let us continue to work together to support our junior doctors in their journey to become competent, confident and compassionate healthcare professionals. ♦



## SMA Doctors-in-Training 101

### Android

1. Open page settings > Click “Install app”
2. Click “Install”

### iPhone

1. Open in Safari settings > Click “Add to Home”

### To stay up to date with the SMA DIT Committee:

- Join our DIT Telegram channel @helpourjuniordocs
- Follow our Instagram page @jrdocs.sg

If you are keen to get involved with SMA DIT efforts, please write in to us at [dit@sma.org.sg](mailto:dit@sma.org.sg).

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# The Winds Have Changed:

## A DAY IN THE LIFE OF A JUNIOR DOCTOR IN 2026

In this illustration, we review some current issues in the junior doctor workplace (some old, some new).

Note: These are fictional characters, but the stories in this comic are based on multiple junior doctors' real-life work experiences in Singapore's public hospitals in 2026.

Illustration by @cryingin7eleven

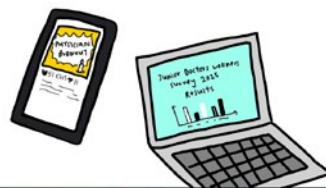
1

Healthcare rarely stands still.



Over the past decade, the experience of being a junior doctor in Singapore has changed significantly.

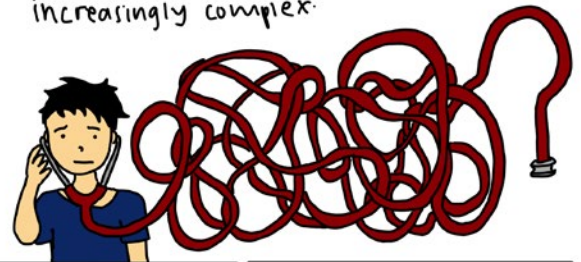
Conversations about wellbeing have become mainstream.



Greater attention is paid to fatigue, education, & safety.

2

At the same time, healthcare has become increasingly complex.



Patients are living longer with multiple medical conditions.

Our next patient is Mr Tan Ah Tee. 97 year old with a pertinent past medical history of DM, HTN, HLD, IHD, COPD, prostate ca expertly managed, previous right thalamic stroke on aspirin complicated by ICH & ...

Families are more involved in decision making.

Hi Mr Tan. Thanks for coming down to speak to us today about your dad... Can you wait 5 minutes for my brother from Sydney & my Sister-Sister from Canada to join us on a video call

While some departments now have improved staffing & more manageable workloads, others continue to be stretched & face significant pressures



With Challenges old & new.

3

Today is the first day of posting for Joel, a medical officer starting a new rotation.

READY PLAYER ONE:



STATS

Education ★★★★★  
(Studied & graduated amidst covid pandemic)  
Experience ★★★★★  
(3rd mo posting)  
Perseverance ★★★★★  
Caffeine levels ★★★★★



4



5



6



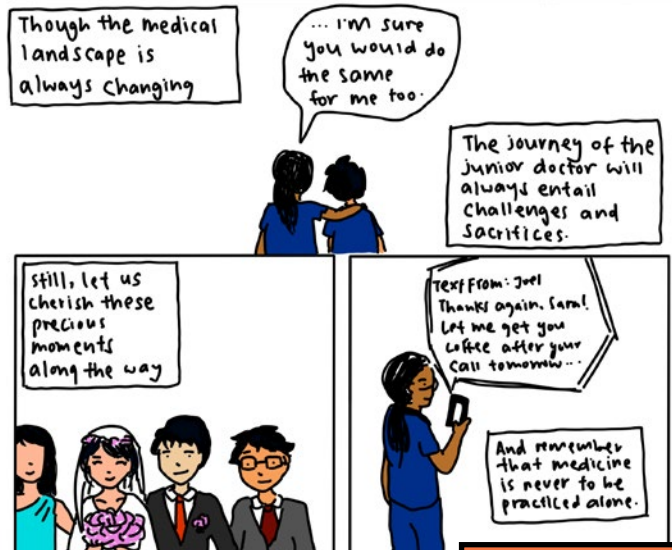
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8



9



THE END



# Beyond Hospital to Community:

## Reflecting on My Experience Across the Public, Private and Long-Term Care Sectors

Text by Dr Daniel Lee Hsien Chieh

Dr Lee, MBBS (NUS), GDFM (NUS), MPH (Harvard), is a public health specialist and Cluster CEO of St Andrew's Nursing Home, with seven homes across Singapore and four more in the pipeline. He started his medical career in internal medicine at Changi General Hospital and still sees patients regularly at St Andrew's Migrant Worker Medical Centre.



My journey in medicine began as a student at the National University of Singapore, followed by clinical training in internal medicine. Driven by an interest in how macro-level decisions shape bedside care, I went on to pursue a specialist traineeship in public health and completed my Master of Public Health at Harvard University on a Fulbright Scholarship.

That professional foundation opened doors to a diverse healthcare management journey. I served in policy

at the Ministry of Health (MOH) and in acute hospital operations as Assistant Director of Operations and Deputy Director of Clinical Services at Changi General Hospital. Subsequently, I led in the private sector as General Manager, Chief Operating Officer and eventually CEO of Thomson Medical Centre. Today, I serve in the not-for-profit (NPO) long-term care sector as Cluster CEO of Singapore's largest NPO nursing home operator, overseeing seven homes across Singapore, with four more developments in the pipeline to reach 3,500 operational beds by 2030.

Having worked across these three distinct sectors – public acute care, private for-profit care and NPO long-term care – I have gained a holistic appreciation for the spectrum of patient needs across the care continuum. I have seen how women and children's care leverage operational agility and contextualisation, how acute hospital systems move towards value-based and population health transformation, and how long-term geriatric and psychiatric care demands a deeply integrated model of clinical and psychosocial empowerment. Most importantly, it has shown me how health financing,

regulatory frameworks and policy decisions directly shape clinical delivery and patient health on the ground.

### The imperative of systems thinking

These three sectors are not isolated silos; they are interconnected components of a single ecosystem supporting a person across his/her lifetime. Patients do not experience wellbeing or ill health in administrative compartments, nor do diseases respect sector boundaries. Poorly managed chronic conditions or neglected preventive care in early life inevitably manifest as acute crises later, ultimately inflating the long-term burden on community care.

Because the relationship between payor, provider and patient is tightly linked, financing models heavily dictate patient behaviour. When health insurance structures or funding frameworks incentivise episodic or high-cost care, demand shifts unpredictably (or rather, expectedly) between the public and private sectors.

Here, we must be discerning about health economics: a cost saving achieved in one sector is not necessarily a win for

the nation or Singaporeans if the burden is simply shifted to another sector.

When financial incentives reward rent-seeking behaviour or unconstrained profit maximisation for some parties, the resultant negative externalities – such as rising overall health expenditure, fragmented care and patient dissatisfaction – are borne by the entire system. True efficiency requires us to look at the total cost and quality of care across a patient's entire disease life cycles, rather than chasing localised, short-term financial metrics.

Addressing these systemic challenges also requires strong governance and regulatory oversight. In this regard, the Government plays a critical role as regulator of services for both providers (eg, hospitals, clinics, doctors) and payors (eg, insurance companies). The Chandler Institute of Governance recently highlighted the strong pillars of leadership, foresight and strong institutions in the Singapore Government (which it ranked as top in the world). We are thankful to have wise and capable leaders in policy design, and we must never take this advantage for granted as demographic pressures accelerate.

Singapore is now a super-aged society. By 2030, nearly one in four citizens (24%) will be aged 65 and above. On top of this, our old-age support ratio,

which stood at 4.9 working-age adults per senior in 2019, is projected to halve by 2030. To meet this shift, national strategies must work in tandem. The Healthier SG initiative establishes the primary care foundation, shifting our focus upstream towards preventive health to keep residents well and out of hospitals. The Age Well SG programme complements this by addressing the social determinants of health – upgrading physical infrastructure, enhancing Active Ageing Centres and enabling safer, supported living in the community.

At the same time, MOH is expanding physical infrastructure to meet rising demand. Hospital capacity is growing through upcoming acute hospitals in Tengah (Tengah General and Community Hospital) and Bedok North (Eastern General Hospital), while nursing home capacity is scaling rapidly from 16,300 beds in 2020 to over 21,000 in 2025, heading towards 30,000 and more beyond 2030.

Crucially, the planned introduction of a new private NPO hospital in the eastern part of Singapore (joining Mount Alvernia Hospital as the second such facility) presents a valuable structural opportunity. As a flagship, it is set to be a potential game changer. Beyond adding 300 to 400 acute beds, this new non-profit private model provides a

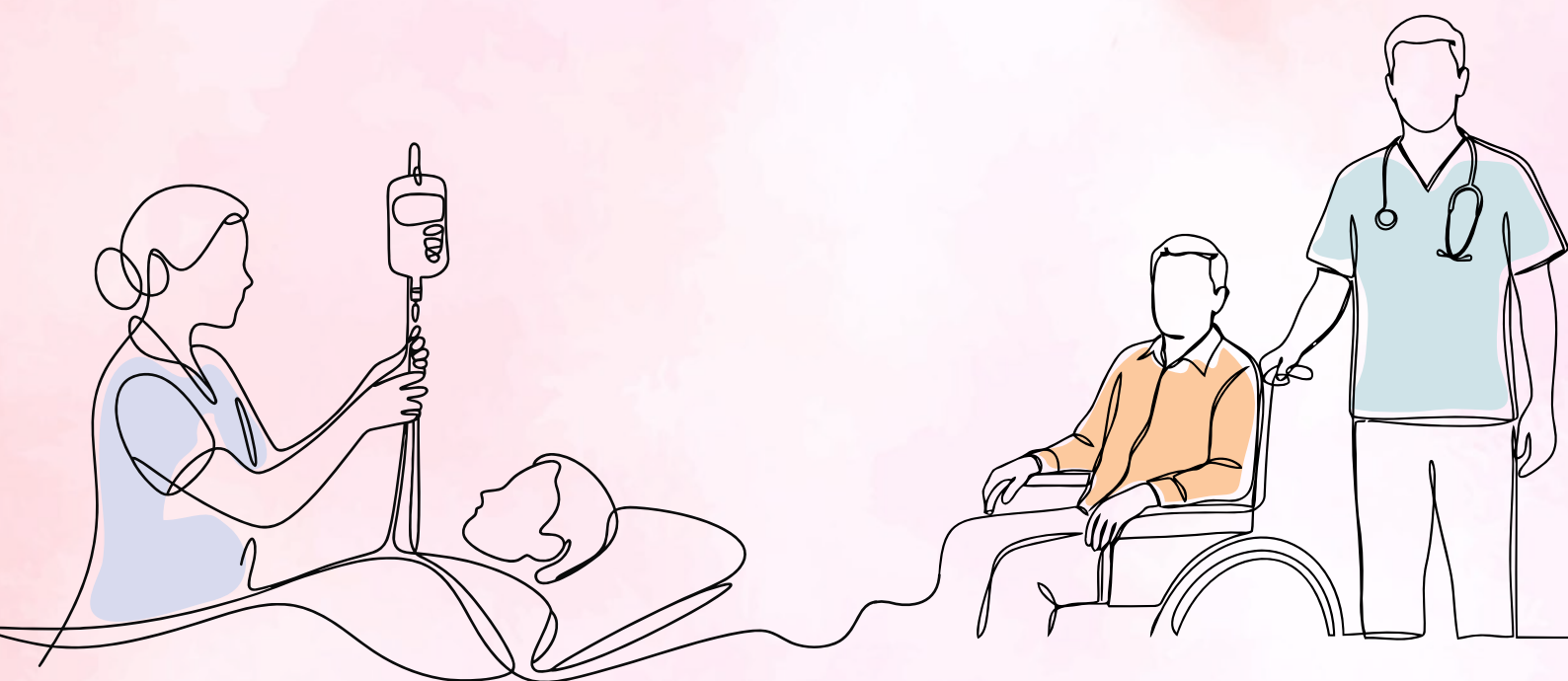
unique space to innovate care models in the current reality, implement balanced medical manpower remuneration structures and deploy alternative financing strategies that align provider incentives with long-term value for the payor. Such initiatives are essential if we are to attempt to bend the national healthcare cost curve.

## Leading beyond boundaries

Stewarding care beyond the hospital into the community requires public, private and long-term care sectors to operate as a cohesive and responsive entity.

As physician-leaders across clinical practice, management, financing and policy, we must resist the seduction of low-hanging fruits or quick fixes that only offer short-term convenience at the expense of systemic stability. We must have the resolve to look past artificial boundaries, evaluate the downstream impacts of our decisions and address root causes that matter.

With doctors serving across every tier of Singapore's healthcare landscape, our leadership role invariably extends beyond clinical delivery. We must lead adaptively, courageously and ethically, to ensure that our healthcare ecosystem remains equitable, sustainable and always grounded in the best interests of our patients. ♦



# HIGHLIGHTS

## From the Honorary Secretary

Report by Adj A/Prof Ng Chew Lip



Adj A/Prof Ng is an ENT consultant in public service. After a day of doctoring and cajoling the kids at home to finish their food, his idea of relaxation is watching a drama serial with his lovely wife and occasionally throwing some paint on a canvas.

### NEHR contribution requirements

On 27 July 2026, the Ministry of Health (MOH) published a reference guide summarising the health information components required for contribution to the National Electronic Health Record (NEHR). The guide helps healthcare providers understand the appropriate data that should be submitted to NEHR under the Health Information Act.

The guide may be viewed in full at: <https://bit.ly/4hB3He3>.

### SMA joins Healthcare iSSWG

On 14 October 2026, SMA officially became a member of the Healthcare Industry Safety and Security Watch Group (iSSWG), formed by the Singapore Police Force (SPF). The Healthcare iSSWG aims to foster collaboration between SPF and the healthcare sector to co-create a safer healthcare environment to tackle crime and security issues.

An article by the *Straits Times* on the iSSWG launch was published on 14 October 2026 and may be viewed at: <https://bit.ly/4zUuoQX>.

### Health Sciences Authority (Amendment) and Other Matters Bill

On 4 August 2026, the Health Sciences Authority (Amendment) and Other Matters Bill was tabled in Parliament. The proposed law seeks to confer functions on the Health Sciences Authority in the administration and enforcement of certain laws currently under MOH, and also to provide administrative services to healthcare profession regulatory bodies in place of the Singapore Medical Council.

The Bill may be viewed in full at: <https://bit.ly/4qplVI8>.

### MMA Annual Banquet

On 12 September 2026, SMA Council member Dr Michael Lim Khong Jin attended the Malaysian Medical Association (MMA) Annual Banquet as SMA's representative. ♦



# SEVEN ESSENTIAL COMPONENTS OF A ROUNDING NOTE: A Primer for Medical Trainees

Text by Dr Isaac Ng, Dr Arturo Neo, Dr Gaurav Deep Singh, Dr Peter Daniel, Dr Thanawin Pramotedham and Dr Kei Jun Poon

Dr Ng is currently a senior resident in rheumatology in the National University Health System (NUHS). In his free time, he likes to watch K-dramas, play board games with friends and occasionally overindulge in ice cream.



Dr Pramotedham is currently a senior resident in gastroenterology in NUHS. In his free time, he spends time with his wife and young kid, and does music on the side.



Dr Neo is currently a senior resident in respiratory and critical care medicine in NUHS. He enjoys the challenge of doing calls.



Dr Daniel is currently a senior resident in gastroenterology in NUHS. In his free time, he enjoys grilling meat on his BBQ and doing Brazilian jiu-jitsu.



Dr Singh is a senior resident in respiratory and critical care medicine in NUHS. In his free time, he likes to sing and travel.



Dr Poon is currently a senior resident in infectious diseases in NUHS. He values education for the next generation of young doctors.



In March 2025, we came together as a group of like-minded friends to put together several tips on surviving the dreaded overnight call for our incoming house officers.<sup>1</sup> Other members in our local medical community have also contributed useful articles sharing insights on pre-rounding, referral making and discharge summary writing.<sup>2,3</sup> In this piece, we aim to elucidate the seven essential components of a good ward round entry, which can be remembered with the mnemonic “POSh-SOAP” – patient demographics/pertinent social background, old records (past medical or surgical history), summary of current admission/history of presenting complaint, subjective, objective, assessment (issues and progress), and plans. We hope that junior trainees and student interns doing their clinical rotations in the hospitals will find this article useful. The importance of efficiently and comprehensively written rounding note documentation cannot be overstated – it helps to ensure that the patient’s past and current medical issues are succinctly and accurately captured, and helps readers (be it other medical professionals, nurses, allied health professionals or the on-call team) to be

**Table 1: Examples of POSH-SOAP details for rounding notes**

| Information                 | Explanation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Key demographic information | <ul style="list-style-type: none"> <li>• Name (and/or preferred name that patient wishes to be called)</li> <li>• Age</li> <li>• Gender</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                               |
| Important medical alerts    | <ul style="list-style-type: none"> <li>• Drug allergies/adverse drug reactions (including the specific reaction(s) and whether patient has tolerated other medications in similar drug classes before)</li> <li>• Diagnoses not to be disclosed to next of kin</li> <li>• Advance care planning or “code” status – note that unlike advance medical directives, these are clinical and not legal documentations. They are therefore not cast in stone and can be reversed (eg, peri-procedurally or due to change in patient’s condition/preferences)</li> </ul> |
| Premorbid function          | <ul style="list-style-type: none"> <li>• Activities of daily living</li> <li>• Mobility status (and walking aids required)</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Pertinent social history    | <ul style="list-style-type: none"> <li>• Occupation (especially if it is relevant as a risk factor or as part of management considerations in patient’s clinical context; eg, vocational driver who is newly diagnosed with epilepsy/stroke)</li> <li>• Social set-up (helpful for older patients who may have more caregiving needs, for discharge planning purposes)</li> <li>• Smoking/alcohol status (especially if relevant as disease risk factors)</li> </ul>                                                                                             |

able to decipher the salient aspects of the patient’s case to guide their actions and decision-making.

### Patient demographics/pertinent social background

At the beginning of the ward round entry, besides documenting the consultant or team in charge, you should provide pertinent patient details and social background as relevant to the current clinical diagnoses, management and/or discharge planning. Table 1 provides examples of types of details that should be recorded.

### Old records (past medical/surgical history)

It is important to succinctly and accurately summarise the patient’s past medical/surgical history, ensuring it is kept up to date, and ideally categorised appropriately for ease of reading. The past medical history is often copied over from the last discharge summary on the National Electronic Health Record, which may contain inaccuracies, outdated and/or irrelevant details. Therefore, due diligence in cross-referencing,

summarising and updating the past medical history with information from the patient or family, other documentation (eg, clinic, procedure, progress or subspecialty consult notes), and/or investigation reports/findings is necessary. For example, if a patient has diabetes mellitus, it would be helpful to specify whether it is type 1 or 2 physiology, with documentation of the latest HbA1c. On the other hand, in a patient with a history of coronary artery disease with heart failure, it would be helpful to include a summary of previous procedures (eg, diagnostic coronary angiogram or percutaneous coronary interventions) and the latest transthoracic echocardiogram for left ventricular ejection fraction. In addition, grouping of similar conditions based on systems/specialty (eg, cardiovascular, pulmonary, gastrointestinal, renal, eye, surgical, orthopaedic), and even separating out the most important medical history pertinent to the current admission (eg, renal/dialysis history for nephrology patients, or cancer diagnoses and treatment history for oncology patients) can improve the readability of this section. If there was

a recent admission, it may be helpful to summarise briefly the main events and interventions administered.

### Summary of current admission (history of presenting complaint)

A simple summary of the reason for current admission and/or pertinent inpatient events would help to jog the memory of the junior or the reader on the patient’s case and initial presenting complaints. This could be, for example, “presented on XX date for fever, productive cough, night sweats and constitutional symptoms, subsequently



diagnosed with active pulmonary tuberculosis”; “developed hospital-acquired pneumonia and went to ICU from XX to XX date for type 1 respiratory failure requiring high-flow nasal cannula, but subsequently improved and stepped down to general ward on XX date”. It also helps with ward round presentations, especially when the junior physician or trainee is taking care of numerous patients and may not readily remember all the cases.

## Subjective

This section should document any overnight events (including “called to see patients”, nursing concerns, or investigations that were newly reported), the patient’s current active complaints, and targeted history-taking/questions looking for associated symptoms/complications and/or significant negatives in the given clinical context. It is also important to write down salient aspects of clinical communications (eg, explanation of provisional diagnoses and investigation/management plans to the patient) during ward rounds/pre-rounds at the bottom of this section.

## Objective

Documentation of physical examination findings should include vital signs and other key parameters (eg, blood sugar trend, intake-output charting), as well as targeted, relevant physical examination findings that were actually performed on that day. It is crucial that the prevalent practice of “copy-pasting” is curbed, which has potentially serious implications in patient safety and medico-legal risks.<sup>4</sup> For example, for a patient who came in for a fall and had normal neurology on admission, if the neurological findings were copied in daily clinical entries when they were not actually re-performed, it would be both dishonest and dangerous – as the patient could have developed a new intracranial event (eg, stroke) inpatient.

## Assessment (issues and progress)

Crafting of a good “issues list” is an important skill that takes practice. The ability to synthesise the patient’s clinical presentation and investigation findings into well-crafted problem lists

demonstrates good clinical reasoning skills and is a mark of a mature clinician. It is important to provide provisional diagnoses/differential considerations for the patient’s clinical problem – for instance, it is not appropriate to write “chest pain or breathlessness for investigation” as the issue throughout admission, nor to state a laundry list of abnormal investigations without alluding to possible underlying causes. We suggest that issues should be sequenced from active diagnoses to passive/resolved events. Clinical problems which are part of manifestations of multi-systemic conditions or complications of disease/treatment should be listed as sub-issues to the primary diagnosis. Underneath each new diagnosis, it would be good to incorporate a short description of the patient’s relevant clinical presentations, summarised with semantic qualifiers (eg, acute inflammatory oligoarthritis of the left ankle and both metatarsophalangeal joints, on a background of known chronic tophaceous gout non-compliant to low-purine diet and urate-lowering therapy). For more complicated diagnoses, it is a good habit to incorporate differential diagnoses with reasons for and against each diagnosis in order to make clinical reasoning/thought processes explicit. Following this, incorporate pertinent investigation findings and treatment/procedures performed. Finally, document the current clinical progress and treatment response. While the above represents the authors’ suggestions in the framing of issues lists, we understand that different people have their own writing and stylistic preferences – which is perfectly fine, so long as the section conveys the clinical thought processes about the patient’s problems and summarises the investigation/treatment progress.

## Plans

Fresh out of medical school, it is common to see junior physicians structuring clinical plans as follows: nursing interventions (eg, vitals, diet, intake-output charting, blood sugar monitoring, fall and other precautions, and other forms of charting), allied health involvement, investigations, management, extent of care and

discharge/follow-up plans. This is a reasonable structure, but it is important to remove completed tasks from the plans (eg, completion of a course of antibiotics) and avoid unnecessary copy-pasting of the exact same nursing, vitals/chart monitoring or dietary plans that lead to information clutter and risk of missing out important information. It may be helpful to use colour coding or bold the important/urgent changes that need to be done on the same day. It also allows your colleagues to help with your changes on busy days.

## Conclusion

In summary, these are the seven key components of a rounding note, which can be summarised by the “POSh-SOAP” mnemonic. Proper clinical documentation and ability to write good “clinical issues/problem lists” are required skillsets of every physician, especially in the current information age. ♦

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# Supporting Doctors with

# PSYCHIATRIC CONDITIONS



## The Making of the WISE Guideline

Text by Dr Caitlin O'Hara

Dr O'Hara is a resident in the National University Health System Department of Obstetrics and Gynaecology and has been a member of the SMA Doctors-in-Training Committee since 2023. She enjoys DIY projects in her free time and otherwise spends it doing what she can to make our healthcare system more equitable for both its workers and patients.



“Most of the time, I do feel that having a mood condition has actually been very beneficial to my practice. There's a certain kind of empathy that you get from going through this yourself, where you can see a patient in distress and you genuinely understand how that feels. Sure, I did require one week off work when I was a house officer to recover because I had a minor relapse during that time, but I'd have required time off if I had a minor fracture too, right? And after returning from that time away, I've come back a better doctor for it.”

– Participant A

In 2024, members of the SMA Doctors-in-Training (DIT) Committee observed that colleagues with mental health conditions were being treated differently from other junior doctors at work, and often not in ways that left them feeling supported. Several colleagues recounted instances where they felt scrutinised or disempowered on the basis of the psychiatric conditions they were living and working with.

The prevalence of mental health conditions within the medical fraternity is well established internationally. A 2025 scoping review published in *Frontiers in Public Health* found that up to 67% and 80% of physicians had depression and anxiety respectively, with junior physicians and residents being disproportionately affected.<sup>1</sup> A local study of psychiatry residents found that almost 40% had clinical depression and over 12% struggled with suicidal

ideation.<sup>2</sup> Beyond mood disorders, we know mental health conditions encompass psychotic disorders, addiction and substance use disorders too. Though their prevalence is not

“There was a point in time, where I [thought], ‘Maybe I should just go off medication.’ Which is dangerous, right? [But] that tells you the extent to which people don't want to be stigmatised... [It is as if I have to] prove that I can function... It's more like I'm being limited [by] a very outdated structural issue... I think [it can be] very insulting [and] it also reduces the desire for people to come forward and raise these kinds of issues.”

– Participant C

as well documented, doctors are also susceptible to experiencing these conditions.

Together with nominated representative psychiatrists and occupational health physicians from the College of Psychiatrists (CPSych), Academy of Medicine, Singapore (AMS) and the College of Public Health and Occupational Physicians (CPHOP), AMS, the SMA DIT Committee formed a workgroup with a vision: psychiatric condition or not, every doctor should be able to practise to his/her full potential in the workplace.

### Making of the WISE Guideline

We started by interviewing six junior doctors with psychiatric conditions from Postgraduate Year (PGY) 2 to PGY5 about their lived experiences at work, getting and maintaining their medical registration, and navigating life as a

“Reflecting on a time spent away from work during a Medical Officer Posting Exercise posting due to an adjustment reaction) The primary person I was liaising with was very supportive and a very strong advocate for me... [Others] were less supportive and more dismissive, and they were only being held in check by this supportive member [of the team]. The first thing was that he told me it was okay to take time off work for mental health issues... Once I returned to work, he adjusted my scope [to] ease me back into work... I don't have an affinity to the OT at all, and I think that was a big part of my issue when I had to take a break from work initially, so he facilitated a transfer such that I was doing mostly clinic and ward-based work instead... He made sure I was assigned under a [senior] that was known to be flexible, responsive and supportive rather than someone who was known to be abrasive...”

– Participant B



junior doctor while being on treatment for a psychiatric condition. Following this, we ran a survey among junior doctors to get a sense of the measures or initiatives in the workplace that provided the most mental health support. We also interviewed chief wellness officers from public healthcare institutions and medical directors from private healthcare groups to understand the existing support systems and considerations from senior management. Together, we used these insights to scope out the concerns of junior doctors with psychiatric conditions and set out to develop recommendations supported by an extensive literature review. After iterative discussions within the workgroup, these components shaped the Well-Being, Inclusion, Safety and Equity (WISE) Guideline: Supporting the Registration and Practice of Doctors with Psychiatric Conditions.

The WISE Guideline has four main sections: (i) identifying individuals at risk, (ii) fitness to practise assessments, (iii) leave of absence/return to work, and (iv) supporting mental health in the workplace. Each section is accompanied by applicable case studies crafted with reference to real situations facing junior doctors which we gathered from our interviews, including both positive and negative examples. Recommendations made in the guideline stem from a review of international best practices, as well as expert opinion from our workgroup's psychiatrists and occupational medicine physicians. Beyond the recommendations and case studies themselves, our guideline illustrates the typical journey through medical practice

of a doctor with a psychiatric condition in Singapore, as well as an action-oriented summary table that pinpoints the specific recommendations that various stakeholders should act on.

### Call to action

Evident from the insights gathered, the underlying issues affecting doctors with psychiatric conditions are multi-systemic – ranging from navigating medical registration, to disclosure and privacy in the workplace, to supervision and accommodations in the workplace, and broader working conditions and climate.

Multi-systemic issues require multi-stakeholder action. Above all, this guideline serves as a call to action for all of us. For junior doctors, this guideline emphasises the role of peer support and normalising help-seeking behaviours. For treating physicians such as psychiatrists, occupational medicine physicians or family physicians, this guideline places emphasis on the affected doctor's ability to function at work as the gauge for fitness to practise. For senior doctors, this guideline details ways to support affected doctors in day-to-day work and to create a psychologically safe space that genuinely encourages help-seeking. Lastly, for senior management and human resources staff, this guideline discusses the indispensable role of systems-based changes in supporting mental health in the workplace: going beyond often-cited ideas around “wellbeing” which tend to centre individual resilience while lessening the role of the wider structures that we live and work in.

The WISE Guideline aims to set a reasonable, meaningful and actionable standard for how doctors with psychiatric conditions can be best supported in the workplace. This aligns with the 2023 National Mental Health and Well-being Strategy which focuses on “improving the mental health ecosystem” so people can “seek help without stigma” and be “readily supported for their recovery”.<sup>3</sup> In the past few years, Singapore has also issued the Tripartite Advisory on Mental Health and Well-being at Workplaces (2023), and the Workplace Safety and Health Council's Handbook on Supporting Employees' Mental Health (2026), further validating our movement for junior doctors by aligning with ongoing nationwide workplace reforms.



**I think the same support [measures] that benefit a doctor with a mental health condition would also trickle down to benefit the whole workforce of junior doctors. So things like proper ending times, proper compensation, reasonable patient loads... Ultimately, these are things that are not just for us: [they're] for everybody.**

– Participant A





## Beyond doctors with psychiatric conditions

Looking beyond junior doctors with psychiatric conditions, bringing about a systemic change in how our healthcare system treats doctors creates a kinder workplace for everyone. Our guideline touches on these points and provides actionable recommendations for physicians, colleagues and institutions. By collaborating to build spaces which assure doctors of sufficient rest, balanced loads and psychological safety, we create a healthcare system with greater capacity to care safely and effectively for its patients too.

When we focus on a doctor's ability to function at work regardless of the illnesses he/she may be navigating, we create a more inclusive workforce with deeper empathy for the patients we care for.

Would it not be wise to work towards that? ♦

**The WISE Guideline is endorsed by the SMA Council, CPsych and CPHOP, and will be published in end 2026. When published, it will be available on the SMA website at: <https://www.sma.org.sg/page/doctors-in-training-20>.**

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*The WISE Guideline Workgroup comprises: Dr Derrick Yeo Chen Kuan, Dr Lim See Ming, Dr Hwang Yi-Fu Jeff, Dr Licia Tan Mei Ling, Prof Paul Tambyah, Dr Nur Haidah Binte Ahmad Kamal, Dr Caitlin Alsandria O'Hara, Dr Jared Ng Chuan Kai, Dr Kalista Wan Yearn Yee, Dr Muhammad Taufeeq Wahab, Dr Calvin Tjio Kai En and Dr Ivan Low Jinrong.*

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# Dear Me: WHAT I WISH YOU KNEW

Text by Dr Lincoln Lim

Dr Lim is a Postgraduate Year 2 medical officer, currently a member of the SMA Doctors-in-Training Committee. He currently wishes to have a pet cat.



Dear Me,

Hello! I am you – writing from the future. This time machine I invented lets me send a letter back one year, so please enjoy this note from yourself. If I recall, this time last year I was worrying a lot about surviving housemanship and adapting to the unfamiliar physical and emotional demands of being a junior doctor.

Well, since I know you have a habit of peeking at the last pages of books,

let me do you a favour and spoil the ending: you survive. Unfortunately, not without some battle scars (trial by fire, as they say). They have taught me valuable lessons about my relationship with work, and I hope to share them with you.

## Calls are always better with friends

You might not think medicine is a particularly lonely place to be – always surrounded by patients, whether you like

it or not. But at night, do not be surprised to be the only junior on the floor.

You will be tempted to hole up in a room and focus on your duties by yourself. But it is dangerous to always go alone. When you get used to self-isolating in the hospital, you become less likely to ask for help, even when you are out of your depth. That puts patients at risk, not to mention the toll social isolation takes on your mental health.

Actively seeking out others on call, sharing supper or even just spending a few idle hours in the medical officer room together is enough to fill a difficult call with joy. Even if you do not know anyone on call, every call is a chance to make a new friend. This does not go just for doctors either; you will find that some of the best comfort and jokes come from nurses and pharmacists!

Also, do not skip post-call breakfasts; the sunrise is always better witnessed in the company of those who survived the night with you.

### **There is a difference between resting and recharging**

As a doctor, rest does not come easy. Between the early mornings, late nights, calls and floats, the physical fatigue can be overwhelming; many people post-call will sleep until the next day. You will be tempted to protect your rest to an extreme degree: staying in bed past noon, choosing not to meet friends after work, all for the sake of getting an early night.

At some point you will realise that more rest will not help you feel less tired.

You need to do things that recharge the mind – things that lift the weight off your shoulders. It does not matter what it is, and it does not always have to be the same activity. It only has to ease the tension and inspire you to keep going.

You may point out that someone who is too tired will not be able to do the things that recharge them and will therefore continue to accumulate fatigue. But in truth, when you find something that breathes life back into your work, you will find the strength to do it even when running on no sleep post-call. Find what recharges you, and the rest will follow.

### **Have great expectations, but greater self-compassion**

At the start, you will get frustrated with yourself for your incompetence. You cannot present patients on rounds as nicely as others, you can only handle half as many patients, and you take twice the time needed to clerk admissions. But worst of all, you will beat yourself up for not knowing how to bear the responsibility of being a doctor. Other people seem to know how to make the right decisions and what to say in difficult situations. Medical school can teach you how to hold difficult conversations, but you have to learn for yourself the words that actually bring comfort to patients – especially in situations where you might be the only one available.

There will be a day, before rounds, when you palpate the abdomen of a boy due for discharge. You will recognise the rigidity and rebound tenderness in the right iliac fossa, the tachycardia, and widened pulse pressures heralding the systemic inflammatory response. You will escalate a case of perforated appendicitis with impending shock, but because manpower is tight, you will be the only one available to stabilise the boy and prepare him for the appendectomy. It will take two tries to get his laboratory results; you will forget to order antibiotics, fumble through the surgery referral, and finally come to speak to the boy. You will not know what to say, but you will see the shock in his eyes and his body shivering with fear. You will find a blanket for him, tell him that he will be okay and send him off to the OT.

The boy will write to you when he is well and thank you for your reassurance. That letter will remind you that competency is built in the midst of failures. You just need to keep giving it your best effort.

There is much more I want to tell you, but this time machine has a word limit, so I will let you learn the rest as you go. Do not worry – you will be fine.

With love,  
You ♦





# Woes of Parenthood in Residency

Text by Dr Christina Png

I once told my husband on a whim, while we were hanging up our seemingly endless pile of laundry after returning from an overseas trip, that I do not think I want kids. Immune to my random rants, he calmly asked how I had come to that conclusion. Lamenting, I told him: if I could barely keep on top of laundry for two people, how would I ever manage laundry for a family? After all, we had previously talked about wanting two kids. Amused, he replied, “Laundry is not an excuse not to have kids.”

Amid Singapore’s falling total fertility rate, I too find myself wondering what it would take for me to start a family. As a resident, I find myself thinking about juggling the demands of residency and the responsibility of nurturing the healthy growth and future of a little being. We are expected to learn, perform, take on increasing responsibilities, do well for examinations and progressively become the specialists we aspire to be. Similarly, we also want to do well in our postings, successfully complete training and excel in our chosen fields.

I have enormous admiration for my peers who have embarked on parenthood during residency, particularly the women who have navigated pregnancy, miscarriage, maternity leave and the postpartum period while

continuing to meet the demands of their training. Sometimes I look at them and wonder: how did they do it? At other times, perhaps more uncomfortably, I wonder: would I be able to do the same?

Other questions have also crossed my mind. Would taking maternity leave cause me to be perceived as being less invested or capable in my training and career? Would I fall behind my peers as they continue their training while I am away? Would I be seen as someone who is less willing to make the sacrifices needed to succeed? Would I be letting my team down by being absent from work to manage the demands of childbearing or child rearing?

## Residency training shapes our parenthood choices

I am glad to know that I am not alone in having these concerns.

An unpublished survey was conducted by a group of National University Health System (NUHS) resident leaders, surveying residents across 17 NUHS residency programmes. The survey found that 70% of respondents (n=86) felt that residency training had delayed their decision to have children, while 70% cited career progression concerns in parenthood

decisions. Of residents who were parents (n=36), 80% had concerns about the impact of parenthood on their careers.

Other findings also stuck with me. Surveyed residents reported significant concerns about the demands and inflexibility of training: 84% cited lack of scheduling flexibility and long working hours, 80% cited night duties and examination commitments, and 62% reported difficulty using parental leave.

I am fortunate that being in the National Preventive Medicine Residency Programme, I am allowed considerably more flexibility in leave requests than in the clinical training environments. I know that if I need to attend a medical appointment, I can generally do so without feeling that I am leaving my team short-handed in the wards. Should I need to plan for maternity leave, I do not have to worry about returning to find that months away have affected my clinical acumen or procedural skills. We also do not do calls, which means I do not have to imagine combining pregnancy or caring for a young child with the physical exhaustion of being post-call.

Like any other residency, our training in public health is not without its stresses

and demands, but I really appreciate the greater capacity that our work allows in accommodating the realities of personal life. I am well aware that that capacity is much harder for my clinical counterparts to find.

And yet, as a senior resident, in some ways I feel more pressure than ever to make the most of these final years of training. I think back to my registrars and residency seniors who had children during residency – some even twice – and wonder how they navigated this especially demanding phase of training alongside pregnancy and parenthood. I also wonder how these stresses might have affected their pregnancies.

### Uncertainties of pregnancy

I know of residents who have experienced miscarriage, sometimes more than once. Among the surveyed female residents who had been pregnant, 18% had experienced miscarriages, 23% faced intrauterine growth restriction and 9% had preterm deliveries. I cannot imagine how difficult it must be to face such pregnancy complications while navigating residency training, as well as the impact on their mental health and marriage. I am also not confident if I would be resilient enough to put myself through it.

Even if I overcome the question of whether I can juggle parenthood with residency, there is another uncertainty: would I be physiologically able to conceive? In the resident survey, 23% reported difficulty conceiving, which was defined as taking more than six months to conceive. Of those residents who had children or were trying to conceive, 4.4% had undergone fertility treatment.

I have seen friends and family go through cycle after cycle of fertility treatments, facing disappointment after disappointment, each time having their hopes raised and then having to cope with the loss. It made me realise how much of parenthood is ultimately beyond our control. Being able to conceive, carry a pregnancy and bring a healthy child into the world is indeed a blessing in itself.

### Making space for parenthood in residency

I have been told that having children is not a logical decision. Parenthood comes with financial costs, health risks, career implications and an enormous amount of uncertainty. Wiser friends told me: have a child only if you really want one. I agree.

I do not yet know if or when I will become a mother. I do not know whether it will be straightforward nor do I know the amount of heartbreak I will have to endure. And I certainly have not figured out how I will manage the never-ending pile of laundry that comes with having children in the household. But I do know that parenthood will always involve sacrifice. I just hope that the way we structure training does not make that sacrifice harder than it needs to be.

Living as a DINK (dual income, no kids), some may question whether I have the moral authority to talk about the challenges of parenthood at all. I do not claim to know what parenthood in residency is like. But I hope I have fairly echoed the sentiments of a generation of younger doctors who are ready or of the age to start families, while also trying to reconcile that desire with the demands of a profession they have worked so hard to enter and hope to excel in.

These challenges are not unique to our generation or even our profession. Many of our seniors have had their own difficult experiences: missing their child's birth because they were called back to do an emergency surgery, or missing milestones as their children quietly grew up while they spent long hours at work treating patients. But I believe our profession has come a long way in recognising the importance of our medical workforce's wellbeing. Perhaps we could also ask ourselves how the medical fraternity can go one step further and better support our junior doctors through parenthood during training.

The answer is not to make residency easier or to lower the standards we expect of our residents. But perhaps it is

to ask how the same rigour of training can be arranged differently, in ways that allow our doctors to develop into excellent specialists while also having the space to build the families they hope for. And perhaps those who have been on this path before have the best insights and are in the best position to help make that change.

### Acknowledgements

I would like to thank Group 3 of the NUHS Residency Leadership Development Programme (Cohort 10) for being the inspiration for this commentary and for allowing me to share the findings from their survey. ♦

Dr Png is a senior resident in the National Preventive Medicine Residency Programme under the National University Health System (NUHS) and was part of the NUHS Residency Leadership Development Programme (Cohort 10). Her group (Group 2) also shares an interest in parenthood issues and has proposed improvements to organisational support for staff who are breastfeeding.



# Health Plan AI: Turning Goals into Action

by the Agency for Integrated Care (AIC)



Under Healthier SG, enrolled residents work with their doctors to develop personalised Health Plans that include health goals and actions enrollees can partake in such as engaging in regular physical activity. However, questions often arise about suitable activities and how enrollees can fit exercise into their daily lives.

The Health Plan Artificial Intelligence (AI) beta feature on HealthHub aims to help address these questions.

## Introducing Health Plan AI

Health Plan AI enables eligible Healthier SG enrollees to generate a personalised seven-day exercise plan based on information in their Health Plans, together with demographic data and personal preferences.

Developed by the Ministry of Health (MOH) and Synapse in collaboration with healthcare professionals, Exercise Is Medicine Singapore (EIMS), and the Health Promotion Board (HPB), the feature follows the Singapore Physical Activity Guidelines (SPAG).

The beta feature was launched on HealthHub on 27 July 2026 and will run for an initial six-month period to assess user behaviour and receptivity. MOH will review the outcomes of the beta before deciding the direction forward for the feature.

## Supporting Health Plan Conversations

Health Plan AI complements existing Health Plan discussions and does not change the process for creating or updating Health Plans. Its recommendations serve as a guide and do not replace personalised medical advice. The feature also incorporates safeguards and is developed in line with Responsible AI principles and the Infocomm Media Development Authority's (IMDA) Model AI Governance Framework for Agentic AI.

Doctors should continue discussing health goals and recommended actions with their enrollees. Following these discussions, enrollees can use Health Plan AI to generate personalised exercise plans, which can be further tailored to their preferences, location and availability. The exercise plans may include a mix of self-guided exercises, as well as programmes offered by HPB, People's Association and SportSG.

By supporting enrollees beyond the consultation room, the feature helps enrollees translate goals into action, while enabling doctors to focus on preventive and chronic care discussions.

## Setting Clear Exercise Goals

While safeguards help ensure appropriate use, the recommendations do take into consideration the information recorded in enrollees' Health Plans by doctors.

A clear and specific Frequency, Intensity, Time and Type (FITT) aerobic exercise goal also enables the feature to generate more relevant recommendations. Doctors are encouraged to record FITT duration in minutes per day, based on what the enrollee should aim to achieve by the next Health Plan check-in.

Clear targets can also help motivate action. According to a report by HPB, enrollees who were given more specific goals, such as 30 minutes of moderate-intensity aerobic activity three times a week, showed an almost twofold increase in median weekly physical activity levels compared with those given a basic goal.

Doctors can also reinforce the importance of strength exercises in line with SPAG, and highlight any needs for flexibility and balance exercises. Where applicable, any precautionary remarks, injuries or contraindications can also be documented in the Health Plan's free-text fields.

## A Simple Prompt beyond the Consultation

After creating or updating a Health Plan, doctors can encourage eligible enrollees to access their personalised exercise plan through the Healthier SG module on HealthHub. Feedback submitted through the platform will help shape future enhancements to the feature.

During the beta phase, the AI-generated exercise plans are visible only to enrollees and are not automatically shared with doctors. If interested, doctors may ask their enrollees to show their exercise plans during Health Plan check-ins.



# HEALTH PLAN AI (Beta)

Available until 27 January 2027

Set specific exercise goals in Health Plan. Help eligible Healthier SG enrollees act on it.

## ELIGIBILITY CRITERIA

- Healthier SG enrollee aged 40–64
- No chronic conditions
- Has a Health Plan

Eligible enrollees will automatically be able to access Health Plan AI on HealthHub.

## WHAT WILL HEALTH PLAN AI DO?

**Health Plan + Demographics + Preferences → Tailored seven-day exercise plan**

May include self-directed exercises, community exercise programmes, rest days, recommended weekly frequency and exercise guidance.

## SAFEGUARDS BUILT IN

**Before an exercise plan is generated:**

- A one-time physical activity readiness declaration by the enrollee is required
- No plan if: BMI  $<18.5 \text{ kg/m}^2$  or  $\geq 32.5 \text{ kg/m}^2$ ; declared injury or mobility limitation; Frequency, Intensity, Time, and Type (FITT) aerobic exercise goal recorded on Health Plan is  $<10$  minutes/day or  $>300$  minutes/week

**During the beta:**

No intensity progression unless the prescribed intensity in the Health Plan is updated

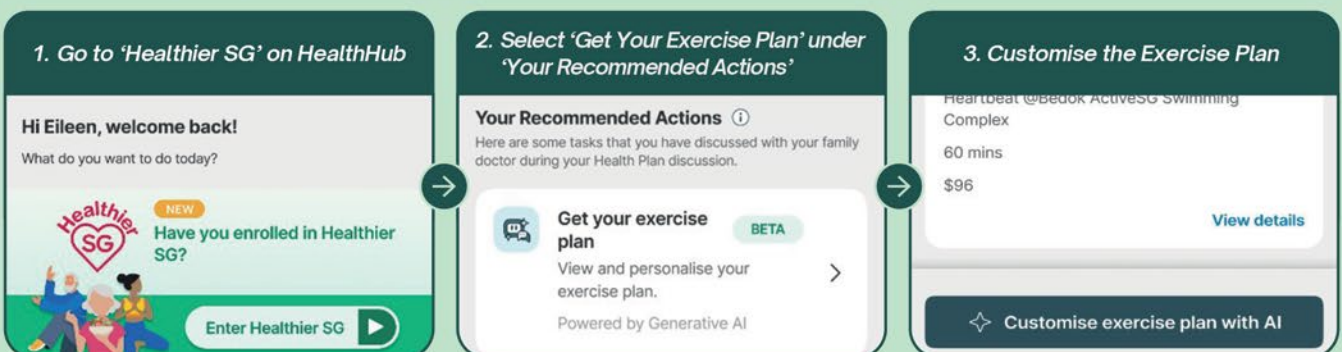
## HOW CAN HEALTHIER SG DOCTORS HELP?

### 1. Set specific exercise goals in Health Plan

- Set clear and specific FITT aerobic exercise goal for enrollee to achieve by their next Health Plan check-in
- Record FITT duration in minutes per day
- Document any precautionary remarks, injuries or contraindications in the 'Record of Discussion' free text field (if applicable)

There is no change to the existing process to create and update Health Plans.

### 2. Encourage eligible enrollees to try Health Plan AI



Enrollees can provide their feedback through HealthHub.

The Health Plan AI project team would like to express our appreciation to the following clinicians and representatives who have contributed to the development of Health Plan AI:

**Subject Matter Experts:** Dr Fadzil Hamzah (SHS, EIMS), Dr Leroy Koh (HPB)

**Healthier SG GPs:** Dr Rick Chan (Phoenix Medical Group), Dr Aziz Noordin (Tampines Family Medicine Clinic), Dr Amaris Lim (Frontier Healthcare Group)

**Polyclinic Doctors & Cluster Representatives:** Dr Chua Ying Xian (NUP), Dr Ling Zheng Jye (NUHS), Ms Tan Pei Ling (NUHS), Dr Sabrina Wong (NHGP), Dr Valerie Teo (NHGP), Dr Kung Jian Ming (NHGP), Dr Ding Si Yan (NHGP), Dr Sabrina Wee (SHP), Dr Rachel Lim (SHP), Mr Ivan Tan (SHS, EIMS), Ms Iris Low (SHS, EIMS)

**MOHT Clinicians:** Prof Gerald Koh, Dr Tham Tat Yean, Dr Alvin Neo, Dr James Cheong, Dr Lee Eng Sing, Dr Eunice Wong

# The Quest for the Perfect Lasagna



Text by Lye Ting Yin

Lye Ting is a second-year medical student at Bart's and the London School of Medicine and is editor of the 32nd SMSUK executive committee.



So much of our lives are built on the environment around us. Familiar sights and sounds. Loved ones who populate the spaces around us. The specific route from home to the MRT station, that coffee shop auntie who has known you since primary school. What happens to all of these when you move thousands of miles away?

Members of the Singapore Medical Society of the United Kingdom spend long periods away from home and often find themselves building new routines and rituals while settling into their new life. In this letter, Shiv explores how moving to Glasgow to read medicine has disrupted a long-standing birthday tradition and shares with us his journey to find something new.

Text and photos by Shiv Dewan

Shiv is a second-year medical student at the University of Glasgow.



Once, when I was eight years old, I happened to go to an Italian restaurant for a family dinner. Its name was Lafiandra Ristorante. As a cheese-loving child, I ordered the lasagna and absolutely demolished it. When my next birthday came around and my parents asked where I wanted to celebrate, I chose to revisit Lafiandra. This repeated year on year, and so a tradition was formed!

The *trattoria* is run by a couple; Cataldo runs the kitchen and Brenda manages the front of house, and the space is adorned with cozy wooden furniture, warm ambient lighting and

elegant concrete and glass. Our order became routine over time: we would start with bread, burrata and a pizza to share. Everyone's main courses varied over the years, but I never strayed from lasagna. We always tried each other's food. The lasagna would come in a round clay dish prepared-to-order, and the most striking detail was a moat of cheesy, tomatoey goodness between the square slab and the round perimeter – this molten gold was piping hot, delicious and unique to this restaurant. The ingredients were fresh – a perfect symphony of tomato, meat and cheese, exactly the right portion, and delicious



Shiv and his friends  
enjoying Christmas dinner  
in matching pyjamas

without being egregiously rich or decadent. After this, the only right way to end the meal was with tiramisu. I have visited almost exclusively annually on my birthday with my family, and I have accumulated so many fond memories over the years.

Last September, I began studying medicine at the University of Glasgow. As I would be turning 22 in a few months, one of my first thoughts was how I would continue my birthday tradition away from home. I initially tried a few Glaswegian restaurants in search of a “replacement” but none held a candle to Lafiandra. More importantly, I realised that no restaurant could replicate the years of memories attached to it. I needed a more organic solution and settled on the idea of cooking the best possible lasagna for myself.

On a different note, I have been trying to take better care of my well-being in recent years while navigating some difficult events and a new phase of life. One issue I struggle with is perfectionism, and when I set this challenge for my birthday, I knew I wanted to plan properly and give it my best effort.

### A twist on an old tradition

There were several moving parts to align and details to iron out: I wanted to perfect the ragu and bechamel, experiment with homemade and store-bought pasta and different cheeses, source the best ingredients and plan the entire operation. My “North Star” was the memory of the Lafiandra lasagna. I also decided to cook for my nine flatmates

– friendship and good company is of course invaluable, but I cannot say this made my task any easier. I had to confirm attendance, make a second ragu for a few vegetarians, find single-serve baking dishes to recreate the “moat” effect, and somehow manage ten dishes at once. The silver lining was that it gave me more opportunities to practise, experiment and figure out what worked.

I initially devised a comprehensive plan, including a fixed research period and a scheduled test cook. However, I fell into an all-too-familiar trap: I got caught up in small details, became overwhelmed, stressed and anxious, and avoided preparation almost entirely. My preparation ended up consisting mostly of watching lasagna recipes on Instagram reels until my eyeballs burned and creating a rough plan with ChatGPT. It was not a terrible effort overall, but I was still nervous and underprepared by the time cooking day arrived.

The plan sprang into action at around 8 pm the night before, starting strong by meandering through multiple supermarkets for hours. I only started cooking at midnight, slept at 3 am and got up at dawn to check that neither the bolognese nor the kitchen had burned down. I was stressed, unhappy with the progress, uncertain it was any good at all and terrified I had done something wrong: too little tomato, too much beef stock and cooking wine, vegetables not diced small or evenly enough and so on. Six hours flew past quickly as I was occupied with adjusting the bolognese, making bechamel and fresh pasta, grating cheese, cleaning up and assembling ten individual dishes. I

also had an apartment viewing at 3 pm, while simultaneously picking up a cake my sister ordered for me. Coincidentally, it was the last day of the semester, so I cooked lunch for two flatmates before their evening departures home, then invited other friends for dinner as well at the last minute.

At some point amid the afternoon chaos, I realised that how the lasagna tasted no longer mattered to me. No matter how good it was, it would not be “worth” the stress, lack of sleep and total focus it had sapped from me over the previous 24 hours. And yet, that thought was quite freeing – I let go of any expectation of the outcome and all that was left was to have fun. Frankly, my lasagna was delicious, though not as good as Lafiandra’s – who would be surprised? Of course I would enjoy food more when it is served in a fancy restaurant on a platter, perfectly hot and steaming with me barely raising a finger.



### Closing thoughts

When I was younger, I dreaded birthdays because I thought they involved calling unnecessary attention to myself. I intentionally kept celebrations to the bare minimum: a simple family meal at my favourite restaurant with my favourite lasagna. Not that I did not enjoy myself then, but it felt like too much pressure to have a good time on a specific day. It was easier to manage my expectations than risk trying to make it something more.

This year, I gave myself permission to try something, put sincere effort into it and accepted that it might not work out. It was incredibly stressful and yet it was genuinely the most memorable day of my year, not just because it was my birthday. I genuinely enjoyed learning how to make my favourite dish, figuring things out on the fly, putting in my own effort and sharing it with people I care about. For once, the possibility of imperfection did not stop me from trying and the fact that it was difficult did not make it any less worthwhile. All of this aside though, it was just good fun to give it a shot and have good people around. Next year though, I will try to start cooking before midnight. ♦





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Members gathered for  
"Into the Wild – Explore Africa"

# Exploring the Wilds of AFRICA

Text by Joanne Ng, Deputy Manager, Membership Services

On 4 September 2026, 34 SMA Members gathered at the Scotts Room, Pan Pacific Orchard for "Into the Wild – Explore Africa", an evening of adventure, wine, canapes and breathtaking insights organised by beCuriou, an international travel concierge.

Guests arrived at 6.30 pm for registration in the foyer, where canapes and refreshments were served while attendees mingled. As the night went on and the party moved into the Scotts Room for the talk, wine flowed freely along with more canapes, creating a relaxed, intimate atmosphere.

beCuriou's world-class experts then whisked attendees across the continent with stunning visuals and insider stories, starting in South Africa from the vibrant streets of Cape Town and Table Mountain to Big Five safaris in Kruger National Park and tastings in the Cape Winelands. In Botswana, they explored the tranquil waterways of the Okavango Delta and the elephant herds of Chobe National Park. The journey continued to Rwanda

for a moving encounter with mountain gorillas in Volcanoes National Park and to the thundering Victoria Falls on the Zambia-Zimbabwe border. Following the Great Migration across Kenya's Masai Mara and Tanzania's Serengeti, attendees then learnt about the best seasons and lodges for front-row views. The crowd favourite lodge was the Giraffe Manor in Nairobi, where giraffes join guests for breakfast.

A lively question and answer and networking session rounded off the evening alongside a thrilling raffle. Congratulations to our two lucky winners, who took home exceptional prizes: a complimentary two-night stay for two at The Silo Hotel in Cape Town including breakfast, minibar, parking and Wi-Fi, and an unforgettable one-night stay for two at &Beyond Bateleur Camp in the Masai Mara with luxury tent accommodation, all meals and drinks provided, and scheduled safari experiences beneath the Olololo Escarpment. ♦



Canapes served during  
the evening talk



beCuriou's expert bringing attendees  
across Africa with insider stories



# AI in Your Practice: Cutting the Admin, Not the Care

Text by Joanne Ng, Deputy Manager, Membership Services

On the evening of 19 August 2026, over 110 SMA Members gathered at the Lifelong Learning Institute for the “AI in Your Practice: Cutting the Admin, Not the Care” talk, focused on one question many of us are asking: how can we spend less time on paperwork and more time with patients?

In the wake of initiatives such as Healthier SG, patient care has become more comprehensive. Inevitably, documentation load, referrals, follow-ups and National Electronic Health Record submissions have also increased. The session offered a practical look at artificial intelligence (AI) tools that are already live in Singapore clinics and hospitals today. The two speakers gave attendees a grounded overview of current possible AI use cases, from

clinical documentation and patient communications to tools supporting chronic disease screening.

Joel Koh, head of AI at One X Group, walked attendees through real deployments across Singapore healthcare settings and shared a simple framework with which to evaluate any AI tool: patient data governance, Personal Data Protection Act compliance and regulatory approval. He also broke down the Ministry of Health’s updated AI in Healthcare Guidelines into plain and simple language for doctors and practice managers.

Dr Anthony Li, a public health resident at Tan Tock Seng Hospital, shared his firsthand experience applying AI and machine learning in public health and clinical research. He highlighted how AI

can cut administrative time by up to 50%, how to identify the right “first use case” for one’s clinic or department, and what responsible adoption looks like in practice.

Then came the lively question and answer session, with attendees asking about data security, workflow integration and how to start small without overwhelming their teams. The session closed with a networking segment, giving GPs, specialists, hospital doctors, clinic owners, practice managers and operations leads a chance to connect and swap ideas.

Thank you to all who joined us. For those who missed it, we appreciate your interest and look forward to seeing you at future SMA events. ♦

10 20 30 40 50



Mr Joel Koh sharing real-world AI use cases in Singapore clinics



Members networking and exchanging ideas over refreshments

# SMACF Board Appreciation Dinner 2026

Text by Sharmilah Banu, Executive, SMA Charity Fund



*Coming together in celebration of the SMA Charity Fund Board*

The work we do at the SMA Charity Fund (SMACF) is no less important than the people who make it possible. Behind every awarded bursary and every supported student is a community of dedicated individuals who give generously of their time, expertise and unwavering commitment to our mission. In keeping with our cherished annual tradition, the SMACF Board gathered once again on 22 July 2026 for the SMACF Board Appreciation Dinner – an evening dedicated to celebrating the people behind the mission and expressing our heartfelt gratitude for their continued support.

This year's appreciation dinner was held at Le Mansion, a Chinese restaurant operated by the Singapore Recreation Club and renowned for its authentic Cantonese delicacies. The warm and elegant setting provided the perfect backdrop for an evening of fellowship, bringing together members of the SMACF Board, SMA President Dr Daniel

Lee Hsien Chieh and the dedicated SMACF team. It was also the first Board Appreciation Dinner attended by Dr Lee in his capacity as SMA President, following the conclusion of immediate past President Dr Ng Chee Kwan's three-year tenure.

The evening began with our second Board meeting of the year, where members received updates on the Fund's financial position and noted that the bursary application exercise would open on 31 July 2026. The meeting served as an important opportunity to reflect on the Fund's progress while looking forward to the work that lies ahead.

Bringing the Board meeting to a meaningful close, SMACF Chairperson Dr Chong Yeh Woei expressed his appreciation to the SMACF team for their hard work and dedication. He also acknowledged the team's efforts in producing SMACF's first ever corporate video, which premiered at the SMA Annual Dinner earlier this year. He then

invited everyone to raise a toast to the shared commitment and collective efforts that continue to advance the Fund's mission.

Everyone settled in to enjoy the exquisite spread of authentic Cantonese delights, sharing many meaningful conversations and much laughter throughout the evening. Beyond the excellent food, the gathering provided an opportunity to strengthen friendships, exchange ideas and celebrate the partnerships that have enabled SMACF to continue supporting financially disadvantaged medical students.

Each year, the Board Appreciation Dinner provides an opportunity to recognise those who work quietly behind the scenes. Their guidance, generosity and steadfast support continue to strengthen the Fund's mission, enabling us to make a lasting difference in the lives of aspiring medical students and, ultimately, the future of healthcare in Singapore. As we look ahead, we remain deeply grateful for their unwavering commitment and look forward to continuing this meaningful journey together. ♦

To learn more or to donate to our cause, please visit <https://www.smacf.org.sg> or reach out to us at [smacf@sma.org.sg](mailto:smacf@sma.org.sg).



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**Review for Prunella Ong on 30-JUL-2026 by Baik Gi Won :**  
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