

Professional development – in a changing world*

R M Nambiar, SMA Lecturer 2004

**Edited version of the SMA Lecture*

INTRODUCTION

Dr. Lee Pheng Soon, President of the Singapore Medical Association (SMA), Professor Low Cheng Hock, Master, Academy of Medicine, Council members, friends, ladies and gentlemen, I am immensely honoured to be invited to give this prestigious lecture of the SMA. I am most grateful to the President and Council of SMA for the privilege.

The task of giving an SMA lecture is indeed a daunting one mainly because of the eminence of my predecessors, but I have taken courage in the fact that besides politicians, presidents of SMA and learned physicians there have also been a few surgeons of my species.

I must thank my esteemed colleague, Professor Low Cheng Hock, for his very kind words. He is always most generous in his remarks which in my case, simply reflects how old I have become and how long I have been around.

I have learnt that ageing is inevitable but wisdom is not. So I accepted it as a natural consequence when the flow of invitations for me to lecture in the last few years have been reduced to just a trickle. Therefore you can understand how much I relish the opportunity to speak on this occasion. I am aware that the tradition of SMA lecture is to deal with ethics-related issues. While some repetition of the subject matter is unavoidable, I have chosen a theme that is relevant and of interest to all doctors.

I shall deal with the topic in several parts. I shall start with clarification of the meaning of professionalism and professional development, then trace the historical evolution of professionalism, describe the changes that have altered medical professionalism and practice, outline the world wide efforts to promote professional development, and finally summarise the lessons learnt and steps we can take in enhancing professional development. In the preparation of the lecture, I have gained much insight from recent publications of the Royal Colleges, the General Medical Council, and the leading journals.

MEDICAL PROFESSIONALISM AND PROFESSIONAL DEVELOPMENT

Professionalism, professional development, continuing medical education and life-long learning are terms that have been very much in the news during the last decade. It is generally assumed that all doctors know what professionalism means and why professionalism in medicine is distinct from all others.

When I asked a group of young doctors recently what they understood by professionalism, the answers ranged from practising good medicine, being highly skilled, being a competent doctor, practising ethical medicine etc. Most young doctors do not think of ethics as a top priority for the medical profession. It is well known, even to the public, that medicine is a unique profession and doctors are professionals of the highest order. Someone recently remarked that professionalism is like pornography, easy to recognise but difficult to define. Professionalism is at the heart of all professions, which are characterised by specific types of occupations requiring special knowledge and skills. Having monopoly over its work requiring maintaining standards, independence in carrying out the work, but with responsibility and self-regulation as a condition in return for autonomy⁽¹⁾.

Professions are different from trades in many ways, the most important of which is the ethical code⁽²⁾. The professional code of ethics is more stringent and demands that professionals place public interest ahead of self-interest. A profession is more of a public trust, whereas trade is for self-interest and is subject to society regulations. In its organisation, trade uses a corporate structure, which is hierarchical, while professions use a community structure, which has common goals and involves voluntary networking for common good. However the distinction between profession and trade may get faded when trade services raise their standard and become involved in public service. Similarly, when professional organisations make cost reduction and profit generation their main focus, it can disrupt the community structure.

Medical professionalism is unique. It involves much more than being smart doctor. It is a reflection

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of the values and behaviours of every doctor in their daily work, which involves their interaction with patients, families, colleagues and public. It is the dedication to care and commitment to subordinate one's self interest to the interest of one's patients.

Sir Donald Irvine characterised medical professionalism as excellence in clinical care for which knowledge and skills are essential, scrupulous observance of ethical standards which implies respectfulness, integrity and reliability, acceptance of responsibility and accountability, which means self regulation of the individual and self discipline collectively⁽³⁾. Professionalism serves as guardian of social values and as Sir William Osler said long ago, medicine is a calling and not simply an occupation.

Professional development is the learning process by which health professionals keep updated to meet the needs of patients, the health service and their own professional development⁽⁴⁾. Continuing professional development (CPD) involves life-long learning and improvement of all aspects of practice that contributes to professionalism. Its main component is continuing medical education (CME), which is the acquiring of knowledge, skills, attitudes and behaviour to enable competent practices. It is a continuum of formal undergraduate and post-graduate education and training throughout one's professional life.

Recently there has been some confusion in the use of CME and CPD. As there is no sharp division between the two, the term continuing medical education has also been used to include subjects beyond traditional medical education, which are often grouped under professional development.

HISTORICAL EVOLUTION

Professionalism has been the essence of codes of conduct in medicine long before the medical profession accepted the Hippocratic Oath (circa 400BC). The first written declaration of physician ethics is more than 3500 years old. The principles in the first physician oath taken by Hindu physicians are healing of sick even at the risk to life of physician, doing the sick no harm, seeking no remuneration, always seeking to grow knowledge, paying attention to behaviour, deportment and attitude, and attending to nothing but the patient's case and keeping it confidential. A high ethical code was also a requirement for practitioners in ancient China and the Judeo-Christian tradition and Greece. Religion, social change, etiquette and behaviour of physicians and patients have altered the medical ethic through the ages.

Serving humanity justly, improving medical knowledge, assuring physician competence, maintaining

confidentiality and protecting patient vulnerability are some of the important obligations that appear in all the modifications of Hippocratic Oath.

In Britain, the Royal College of Physicians of London formulated the first ethical code for physicians in 1520. The American Medical Association created their ethical code in 1847. In 1949, the International Code of Medical Ethics was developed. This has undergone many revisions, most recently in 1998. The Singapore Medical Council has similar codes and since 1995, has introduced a physician pledge for all newly-registered doctors. Ethical codes provide an ethical structure to govern the practices of physicians and their relationship with patients, society and each other. They create the doctors' moral identity

THE CHANGING WORLD

Medical practice was fairly simple until about 50 years ago. Medical care was inexpensive and hospital care was either free or heavily subsidised. Patients trusted their doctors completely as they had confidence in the professionalism of their doctors and believed that medical decisions by their doctors were made in the best interest of the patients.

In the late 1950s a wind of change started to blow, which became stronger since the 1960s. Medical knowledge and technical skills have expanded at an unprecedented rate. New drugs, advances in imaging, minimally invasive surgery and information technology have significantly improved the outcome of treatment and the quality of life. These have altered the external environment and pose new challenges that strain professional and ethical codes. In the USA, when Medicare was introduced, it provided the opportunity for an extraordinary rise in physician's income. Many physicians misused their professional privileges, and it seemed that there was more emphasis on remuneration and less on self-regulation. The public outrage finally resulted in the formation of an antitrust legislation in USA⁽⁵⁾.

The world is changing rapidly, and so is the life and work of physicians and patient expectations. People know more about health matters now and there is easy access to clinical information from the Internet. There is intense public interest stimulated by the media, and the expectation of patients is high and sometimes unrealistic. Patients want to be well informed and want an open relationship with their doctors. They want to be involved in making decisions about their treatment.

There is also rapid change in the structure and process of healthcare and delivery. The doctor's roles, prerogatives and financial compensations are altered. Doctors have to be multi-skilled, work in

multidisciplinary teams, and are increasingly drawn to the business of medicine and to bureaucratic procedures. The professional autonomy of physicians has declined, and there is increasing call for public reporting of physician errors and quality practice. The corporate and professional cultures have different priorities and sometimes, opposing approaches to various issues such as birth control, cloning, euthanasia, genetics and confidentiality

There is also a changing attitude among doctors. Ethical integrity and professional values and behaviour are deteriorating which, in some instances, have caused serious medico-legal problems and disrepute to the profession.

In the highly-publicised Bristol cases in 1998, two cardiac surgeons and the medically-qualified chief executive officer (CEO) were found guilty of professional misconduct following nearly 50 paediatric cardiac operations, which had excessively high mortality. The surgeons had failed to recognise this as a problem and continued such operations, while the CEO had failed to investigate and take action⁽⁶⁾.

In the Shipman case the popular general practitioner was convicted of murdering some 215 patients by administering excessive doses of intravenous dimorphine which was obtained unlawfully. It is almost unbelievable that such a continuing criminal practise would go undetected for almost five years⁽⁶⁾.

There were other examples such as removing organs and tissues for research without consent, dishonesty, criminal behaviour, and system failures. Significant variation in practices and outcome of treatment, major mishaps in treatment and a lack of disciplinary action have also been highlighted, resulting in public call for greater accountability for doctors.

It is of interest to note that about 150 years ago, the American Medical association (AMA) was formed because medicine had reached new lows in public opinion. Public trust was eroding and medical status as a profession was being threatened. The AMA then set their standard, made it known to the public and threw out physicians who would not follow the standard. By rigorous self-regulation, they preserved medicine's professional status⁽²⁾.

THE RESURGENCE OF PROFESSIONALISM – BACK TO BASICS

If we have to flourish as a true profession today, we must recognise the need for change. We need to initiate and enhance professionalism and professional development. In the last five years or more, much greater attention has been focussed on redefining of professionalism, emphasising the components and promotion of professionalism.

1. The foundations of the American Board of Internal Medicine, American College of Physicians and the European Board of Internal Medicine have together produced a charter on medical professionalism, which has been accepted, modified and adopted widely in many countries⁽⁷⁾.

The charter consists of three fundamental principles, namely: primacy of patient welfare (dedication, altruism, trust), patient autonomy (honesty, respect and patient independence to make decisions), and social justice (fair distribution of health care resources, elimination of and discrimination in healthcare based on culture, religion or socio-economic status) and ten professional responsibilities, namely: commitment to professional competence, honesty, confidentiality, relationships, access to care, resource distribution, knowledge, trust, conflict management and professional responsibilities.

2. The General Medical Council has, in its guide, described the principles of good medical practice and standards of competence, care and conduct expected. It sets out areas of knowledge, skills, attitudes and behaviour under seven headings, namely: good medical practice, communication and relationship with patients and working with colleagues, teaching and training, probity (providing relevant information about services offered, avoiding conflicts of interest, declaring financial dealings etc) and ethical duties and health status that will affect clinical judgement and operations⁽⁸⁾.

3. In Australia, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, on behalf of all Royal Colleges, described three main strands that run through the frame work for medical professionalism, namely: clinical expertise which includes medical expertise, clinical judgement and clinical informatics, risk management under which is included communication personal management and insight and medical informatics, for practice and professional values and responsibilities which include relationship and accountability, advocacy and equity and education⁽⁹⁾.

Many organisations have re-defined professionalism in the new context and looked at the opportunities to redefine the goals of future training of doctors and specialists. The Royal College of Physicians and Surgeons of Canada noted seven competencies required for specialist physicians (Can MEDs Roles Framework)⁽¹⁰⁾. These are medical expert, communicator, collaborator, manager, health advocate, scholar and professional. These have been

accepted as a framework by most postgraduate institutions in USA, Canada, the UK, Australia and New Zealand.

The Accreditation Council for Graduate Medical Education in USA has identified six competencies as the desired objectives of the specialist-training programme. These are patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and improvement and interpersonal and communication skills. The basic ideas in all the various recommendations underscore two fundamental principles, namely: changing the focus of training from the interests and abilities of providers to the needs of the society, and considering the needs of the individual patients in the context of the population as a whole.

PROFESSIONAL DEVELOPMENT (CPD) – A LIFE-LONG APPROACH TO LEARNING

The challenge is to identify the most important competencies that need to be developed, propagated and maintained. I would like to characterise these as three major commitments: the commitment to CME for professional competence, commitment to ethical values and behaviour and commitment to professional responsibilities.

1. Commitment to professional competence – Continuing medical education (CME). We have heard repeatedly that new knowledge that we acquire today can only last four or five years without further learning. CME is a life-long commitment to improving our knowledge and skills to be competent in our practice. Patients today expect their doctors to be skilled and competent to provide them with high quality care. CME and certification are means by which physicians can demonstrate that they are updated. Every doctor has a personal responsibility to participate in continuing medical education programmes and make it a life-long habit. Until recently, there have been serious doubts expressed whether CME actually makes a difference in medical practice. There is now growing evidence that change and learning can improve clinical performance. CME is now a requirement for doctors in many countries, although there are wide variations in different countries and health care systems.

CME is now compulsory for all doctors in Singapore. From year 2005, all doctors will need to obtain 50 CME points (20% in core areas) within a two-year period to renew their practising certificate. According to recent report from SMC,

about 4121 (or 86%) of doctors have obtained their required CME points while the remaining 662 (or 14%) will have to achieve it before 2005. A variety of educational activities that are accredited for CME points are available from different professional organisations and hospitals.

However, there can be no argument that we need motivation to learn and keep up to date. Practice-based and self-directed learning is noted to be the most effective mode of learning for adult practitioners. The great advantage of self directed learning is that it encourages reflection of one's own experiences. The learning activities may take a variety of forms: 1) Informal or random learning activities are attending lectures, grand rounds, journal clubs, audio and video presentations and conversation with colleagues. These activities do not have specific learning objectives. 2) Semi-structured learning experiences are practice-based activities. Examples are those associated with immediate patient problems such as consultation with peers and colleagues, literature search to find solutions to specific clinical problems and small group discussions. 3) Formal, intentional or planned activities are attending specific courses, workshops and self-assessment programmes.

2. Commitment to ethical practice: values and behaviour

Of the many themes included under the broad banner of professional values, ethical integrity, honesty and self-regulation are perhaps the most important values and behaviour⁽¹⁾. The teaching of professional values is generally in two main settings.

a) In the clinical setting – by role models:

The delivery of care with integrity, honesty and compassion and exhibiting appropriate personal and interpersonal behaviour is a moral obligation of every doctor.

It is believed that the most effective way to learn ethics is from the role model of a teacher. It is common knowledge that every day behaviour of clinical teachers and consultants is the living demonstration of their expertise, ethics and commitment – their professionalism. There is little doubt that appropriate moral behaviour can be instilled or changed by teachers. This assumes that the teacher understands the responsibilities of professionalism and acts in ways that reflect the values. However it is more easily said than done. In my career, I have seen the best role models and sadly, some poor examples too. It is a sad fact that in our culture where money is

everything, values and behaviour have taken a back seat

Teaching trainees to be more compassionate and to demonstrate respect for patient autonomy are important and desirable goals. When these qualities are enhanced, physicians would be perceived not only by their medical competence but also by their behaviour as a humane person.

b) In medical school: undergraduates

Medical education has traditionally placed the highest value on scientific knowledge of biological sciences and technical aspects of medicine. The teaching of psychological, humanistic qualities, such as caring, empathy, humility, compassion, sensitivity, have been mostly ignored. The Association of American Medical Colleges in 1998 recognised the need to change this focus and instructed all medical educators to cultivate the core values of professionalism in future practitioners⁽¹²⁾. Students were to be instructed to learn the values that make the profession honoured and honourable. It is important to recognise the strengths and limits of scientific knowledge, and act on humanistic dimensions of medical practice and integrate their social responsibilities into the context of personal goals.

Chantler observed that most healthcare systems seek a balance among three ethical principles with difficulty⁽¹³⁾. These are: the need to protect life and death; the need to ensure justice or equity in the delivery of health care and primacy or autonomy; and the right for adults to make their own decision on healthcare. He recommended that professionalism must be taught as a subject, and identified several topics for the curriculum. These include practical knowledge about the health care market, different forms of health care management and their basis, restraints on professional autonomy, and doctor-patient relationship.

The revised undergraduate curriculum of the National University of Singapore has included communication, critical thinking and analysis, and skills and habits of life-long learning. While this is certainly a good start, much more emphasis on professional values will be required in the future revision of the curriculum to enhance professionalism in the future generation of doctors.

One of the most important, but neglected, skills for doctors in caring for patients is

communication. Most patients think that doctors do not communicate well. Failure in communication is an important cause of patient complaints. The best technical expertise and drugs cannot add quality to care without good communication. Communication reflects attitudes, values and behaviour. It is essential not only to get information from patients, but also to explain, to convey feelings, alleviate distress, make decisions, and maintain relations and trust between doctors and patients. It is important in the early years of medical studies to hone the skills in communication in history-taking, consultation, in dealing with peers, patients and relatives. Professional development programmes can now tap an increasing body of knowledge that is available and can be imparted in an academic environment.

Another important aspect of professionalism is self-regulation. It has been observed that the goal of maintaining technical expertise is usually well met because of the requirement for postgraduate training and certification examinations. However, in most countries, the record of self-regulation particularly with respect to incompetent practices and impairment has been poor. The stories of failed professional regulations resulting in disasters are often headlines in the newspapers. It is alleged that instances of failures in self-regulation are often under-reported and complaints rarely result in disciplinary action. The professional societies have also been blamed for not effectively disciplining its members. One of the often-quoted examples is the relationship between doctors and pharmaceutical companies.

It is essential that professional organisations should clearly establish the rules and regulations regarding relationships, particularly sponsorships and receiving of donations and travel grants from the pharmaceutical industry. There should also be strict rules regarding penalties when infringement occurs. It has been suggested that organisations must also encourage the so-called "whistle blowers" so that the profession is not dependent on outsiders for reporting. For obvious reasons, it is not something that is easy to implement⁽¹⁴⁾.

The SMA deserves much credit for having taken the lead in establishing the Centre for Medical Ethics and Professionalism for the professional development of doctors. Among the many ongoing activities, the regular medico-legal and ethics seminars have remained popular and useful to doctors and other professionals. I believe that professionalism would be further enhanced by organising more formal, structured

modular courses on professionalism on a regular basis. All new graduates and newly-registered doctors should be advised to take such courses and be certified before starting medical practice. Furthermore, if opportunities can be created for young people to work with the under-privileged, poor and unemployed, it would help them to appreciate the values and attitudes that reflect humanism and develop a concern for human beings, their values and dignity.

3. Commitment to professional responsibilities

Quality assurance, teamwork, organisational management and leadership and advocacy are skills that are becoming increasingly important in professional development. There have been major concerns about the quality assurance in healthcare, following well-publicised disasters in medical care. The idea of measuring and reporting outcome of care delivery is now becoming a requirement in many countries. Both patients and the health authorities now demand that the medical profession to be more transparent by reporting performances.

The delivery of healthcare now has become complex, and satisfactory delivery can only be achieved through team work and collaboration between doctors, nurses and other healthcare professionals. We need to learn how to work in teams to ensure efficient and effective care that is also personal. A major problem due to increased specialisation and multiple specialists is that patient care is fragmented and uncoordinated. The coordination of care by the primary physician is now very important, especially in hospital care. Many clinical decisions in patient management require discussions between multidisciplinary care team and also involve general practitioners, patient and family. Without adequate skills of collaboration, physicians will be ill-equipped to function as a professional.

All physicians need some experience in skills for management and clinical governance. Management skills are not a subject of study in medical school. The utilisation of scarce resources, understanding of the healthcare system, the utilisation of technology and ability to use patient-related databases and informatics, and working effectively with teams and managing staff are important activities in today's healthcare systems. These skills, although new to any doctor, can be learnt. There is no consensus regarding the need for physician leadership versus administrators who are trained in the corporate world. Physicians

not only know medicine but they also understand the core mission upon which all patient care activities are based. These values earn the physician leader the kind of respect from fellow physicians that can never be earned by an administrator. However, physicians need to be nurtured and trained with two key elements, namely: clinical insight and professional leadership competence. It has been suggested that the ideal is a medically-qualified doctor with 5 to 10 years experience who goes through administrative duties for 1 to 2 years. It is important that the leader should be a respected clinician who has all the virtues as a true professional.

The skills in health advocacy involve the ability to recognise, assess and respond to socio-economic and biological factors that affect the health of the population and developing health and social policy. Physicians have a major role in health promotion, health screening, cancer detection and prevention of trauma.

PROFESSIONAL DEVELOPMENT – THE WAY FORWARD

In Singapore we have a fair and robust healthcare system, and a high standard of professional practice. Access to good medical care is available to all Singapore citizens. We are not faced with large variations in standard or outcome of treatment, as in large countries. We have maintained a good standard of professionalism. Reports of serious breach of professional misconduct are fortunately rare. The public continues to trust and respect their doctors. The dedication and courage that the doctors and nurses showed during the SARS crisis was a shining example of true altruism – sacrifice in serving patients in need above self-interest.

However, the threat to professionalism will always be present in this changing world. There are already some dark clouds appearing in the sky. The much publicised neurological research case, the multilevel marketing about which the Ministry of Health has sent out a warning letter, and the subtle advertisements in the newspapers, magazines and television, and the letters from the public expressing disappointment regarding doctors' business relationships are certainly causes for concern.

During the last five years, the medical litigation cases have been on the increase and the medical insurance premium has steeply risen. These are warning signs that need our attention. Based on the experiences of other countries, there are important lessons that we can learn in our efforts to professional development.

1. First, we need to assess the needs our patients, reassess our professional values in our changing scene, and get a consensus on the qualities, values and skills that we expect in our future doctors. It may be feasible to find out from patients by surveys and consultations their needs, wishes and perception of what an ideal doctor should be.
2. Second, we need our professional bodies to agree to common standards in professionalism and methods to implement them. Professional development programmes have to be structured and co-ordinated so that the student in the medical school, the young graduate in training, and the practising doctor can all have relevant activities to suit their needs. Professional development cannot be left to grow by chance but it must be nurtured and taught as subjects in undergraduate and postgraduate courses and in CME programmes⁽¹⁵⁾. In some countries, patient/public representation is now a common practice so that all interested parties are involved.
3. Third, the competency and performance have to be monitored, which is probably the most difficult part of all. Self-regulation and personal responsibility are key elements in the mandatory CME programme. It is time that we move towards the next stage, that is revalidation, which has existed for some time in USA and Australia, and will be implemented in the UK in 2005.
4. Fourth, we need to protect our patient interest. The revised Medical Registration Act has provided the Singapore Medical Council with adequate responsibility and authority in this regard.
5. Last, no rules, regulations, penalties and incentives will ever work unless each one of us as professionals have a moral responsibility for our actions.

In conclusion, I have dealt with ethics in the context of a broad theme of professional development. I fear that some of the things I have said may have been a repetition of what others may have said before me. However, I do not wish to make excuses, for repetition in many different ways is what we all do in medical teaching and practice.

As we extend human life, create new technologies, pharmaceutical agents and stem cell research and transplantation, it is inevitable that the cost of

healthcare will continue to rise. While most doctors will practice holistic medicine, there will be some doctors who will be attracted to seize various business opportunities. There will be conflicts of interest that will erode professional values and behaviour. If we have to preserve our professional status in the society, we need to focus on the interest of our patients, and give our best care as true professionals. If we ignore our professional responsibilities and forget our professional values, we will lose our most valued public trust and our high standing in the society. In his poem entitled *Scientific Doctor*, DH Lawrence has a powerful message for doctors:

“When I went to the scientific doctor, I realised what a lust there was in him to wreak his so called science on me, and reduce me to the level of the thing. So I said “Good morning – and left him”.

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