THE
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Convocation 2014

DIRECTOR OF MEDICAL SERVICES - A/PROF BENJAMIN ONG ON TRAINING AND INTEGRATING FAMILY PHYSICIANS' ROLES IN OUR HEALTHCARE SYSTEM

A/Prof Benjamin Ong (left) presented with a token of appreciation from A/Prof Lee Kheng Hock, President of CFPS.

A/Prof Benjamin Ong, Director of Medical Services (DMS) was the Guest-of-Honour at the 2014 Family Medicine Convocation held on 22 November 2014 at The Tanglin Club, Singapore. Graduands of all the Family Medicine training programme including the Diplomat, Master and Fellowship of College of Family Physicians Singapore (CFPS) were honoured at the ceremony.

In his address, A/Prof Ong spoke on the development of Family Medicine in Singapore and the critical role that trained family physicians must play in our healthcare system in Singapore. He believes that 'indeed family medicine is one discipline in many settings' and stressed the importance of integrating family physicians with that provided by other sectors. The DMS speech is reproduced below.

Distinguished Guests,

Ladies and Gentlemen,

1. I am delighted to be at this College Convocation Ceremony to recognise and congratulate our doctors who have successfully completed their Family Medicine training programmes.

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EDITOR'S WORDS

by Dr Irwin Clement A. Chung Wai Hoong, MCFP(S), Editor

It is that time of the year again, when work slows down (well, at least for some fortunate folks) and a festive mood pervades the air, giving that "feel a lot like Christmas" aura which somehow bodes goodwill and peace. A time to make amends for some, a time to celebrate for others; a time for resolving a better year ahead or a time to reflect on the year past. Be it one or the other, be you a traditionalist or modernist, a believer or an agnostic (even an atheist), the festivity on the streets, in the malls, at the churches, and even at the workplace, the celebration of Christ's birth, with its religious sobriety and commercial trappings alike, is undoubtedly a season many enjoy.

But for some among us, all these decorations, pageantry and greetings, good food and lots of cheer, mean little or nothing... They remain trapped in their own little world far removed from this reality around them. They could be cocooned in memories of old, oblivious to the goings-on of today. They could see all the bright lights and sparkles as foreboding malevolence. Christmas carols are far from music to their ears and the smiles on faces mean nothing to them. Such is the tragedy of people suffering from one form of mental incapacitation or the other; gives a whole new meaning to the oft-sounded seasonal "ding dong".

But lest we think that only those who are clinically certified as mentally incapacitated fail to appreciate the season's cheer, we would do well to spare a thought and incline our hearts to those who suffer grievous loss of esteem, who are gripped by disproportionate fear, who experience such great stress in life that their beatific vision of humanity's goodness is all but obliterated. We continue to hear about people depressed and lonely, of those who border on suicide (and those who actually do commit them), those in financial and social situations so challenging one is hard pressed to know how to start helping them. They, too, could do with some Christmas cheer and hope for the new year to come. Who will bring it to them?

And even if one is not submerged in such dire straits, it is not hard to be dysphoric in the midst of euphoria. Just last week, while struggling to put up a very stubborn Christmas tree that refused to unfold into its desired shape after one year of hibernation in its box, I was reminded of a Christmas season many years back when I had to "abandon" my tree and most of its decorations as I moved out in a hurry due to family conflict. As much as I have made a conscious effort to move on from that episode and put the experience behind me, the memory of that time overwhelmed me and left me in anguish for a good many hours. And even as I write of the experience I felt that day, the gnawing in my heart returns.

In Christian tradition, one says that Christ was not born only on Christmas Day (which incidentally is a convenient, albeit logical to some extent, liturgical invention) but every day in the Christian's heart. Therefore, in some sense, Christmas is a year-long affair. What can we do then, in the year ahead, to increase our understanding and appreciation of those among us who suffer psychologically and emotionally for one reason or the other? Do we continue to relinquish them to the "mental places" or should we with certitude and empathy look out for them in the home, in the workplace, in the schools and institutions, and in society at large? Can that "feel a lot like Christmas" become reality to them through our actions?

As we ponder our new resolutions for the journey ahead, let us remember those for whom pondering is often a journey of grief, trepidation and even terror. As we make merry and celebrate the close of the year, let us consciously reach out to those seeking closure for their afflictions. Have a truly blessed and wonderful Christmas, peace and all good for 2015!

CM

FAMILY PRACTICE SKILLS COURSE

Wound Care

The College of Family Physicians Singapore would like to thank the Expert Panel for their contribution to the Family Practice Skills Course #59 on "Wound Care", held on 27 September 2014.

Expert Panel:
Dr Low Lian Leng
Ms Yang Leng Cher
Ms Susie Goh

Chairperson:
Dr Low Sher Guan Luke

Disability Assessments

The College of Family Physicians Singapore would like to thank **Ministry of Health** and the Expert Panel for their contribution to the Family Practice Skills Course #60 on "Disability Assessments", held on 18 - 19 October 2014.

Expert Panel:
A/Prof Goh Lee Gan
Dr Phua Cheng Pau Kelvin
Dr Young Hsueh Yi Sherry
A/Prof Ong Hian Tat
Dr Ng Zhi Min
Dr Choo Henn Tean Sylvia

Chairperson:
Dr Cheng Heng Lee
Dr Pang Sze Kang Jonathan

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(continued from Cover page: DMS - A/Prof Benjamin Ong On Training and Integrating Family Physicians' Roles in our Healthcare System)

A/Prof Benjamin Ong (centre) was the Guest of Honour at the Family Medicine Convocation 2014.

From the traditional settings of singleton general practitioners and polyclinics, family doctors today are providing care in diverse settings, such as in nursing homes, hospices, community hospitals, Family Medicine Clinics (FMC), restructured hospitals, and academic FM centres.

The Development of Family Medicine in Singapore

2. You are part of a fine and honorable institution, the College of Family Physicians Singapore. This College was formed in 1971 by a group of family physicians seeking to advance the art and science of medicine, discuss medical and scientific problems, teach family medicine to undergraduate and post graduate students, and promote and maintain standards in family medicine.

3. Consistently since then, the College continues to shape and develop the family medicine community in Singapore and to foster leadership and training for our family doctors. It also conducts advanced training through the College Fellowship Programme.

Critical to Train Doctors to Become Competent Family Physicians

4. As vocationally qualified family doctors, you are heading into a future where you will be increasingly called upon to contribute to a vastly expanded role across diverse settings in our vision for an integrated and patient centred community health care sector.

5. In Singapore, I believe that family physicians play a pivotal role – providing patients with a high level of preventive, personal, continuing and comprehensive care. This includes the potential to influence behavior and healthy lifestyle adoption.

6. This is fully aligned to the Ministry of Health's vision for every Singaporean to have a regular family doctor who is well-trained to deliver a high level of care for all family healthcare needs, but in particular for chronic disease management.

7. In other words, family doctors should be core to our integrated healthcare system. They advise patients on when to seek specialist, acute, or step-down care, and help patients navigate the healthcare system, between different healthcare settings and providers.

8. By the year 2030, 20% of our population is expected to be 65 years or older. This demographic change brings increasing disease burdens and poses greater strain on our healthcare system. As patients in Singapore get older and develop multiple disease conditions, there is a growing need to access various parts of the healthcare system beyond acute hospital settings and specialist care. Family physicians can play a central role in managing the population's health, and support our ongoing shift away from an acute-centric model of care, towards more person-centric care with a focus on continuity of care in the community.

The longitudinal relationship family doctors have with their patients allows them to be well-placed to help patients navigate the healthcare system between different healthcare settings and providers, and play an anchoring role through the changing seasons of life.

9. In 2006, the Government began allowing patients to use their Medisave for outpatient treatment of some chronic diseases under the Chronic Disease Management Programme (CDMP). The list of diseases covered under the CDMP has since expanded to the current 15. Besides enhancing chronic disease management in primary care, we have also stepped up efforts to educate and encourage patients to turn first to their family doctors for acute care for non-emergencies and less serious conditions. These initiatives have expanded the role of primary care physicians in the community.

10. However, the success of primary care ultimately rests on the ability of practitioners to maintain a holistic view of patient's needs and grasp the breadth of practice, both of which are defining features of Family Medicine practice.

> Indeed, family medicine is one discipline in many settings. Building on the versatility that is required, the family doctor, backed by effective career development and professional support systems, will become effective primary care providers.

With the rising demands on primary care, it is critical that we enhance undergraduate training, continuing professional education and vocational training in Family Medicine. To this end, the College can continue to be a key catalyst for this.

Importance of Integrating the Roles of Family Physicians

11. We have seen Family Medicine evolve as a discipline. From the traditional settings of singleton general practitioners and polyclinics, family doctors today are providing care in diverse settings, such as in nursing homes, hospices, community hospitals, Family Medicine Clinics (FMC), restructured hospitals, and academic FM centres.

12. Formal education and training of Family Medicine must thus prepare our family doctors for this greater diversity of settings, and continual medical education and professional training are important for practitioners to keep abreast of developments in clinical practice.

13. Beyond the Family Medicine residency and the Graduate Diploma in Family Medicine (GDFM) programmes, family physicians from both the public and private sectors can

progress further and continue their training through the Master of Medicine (Family Medicine) programme. This latter move would be important and should be encouraged, to raise the standing of Family Physicians.

14. In addition, the College has developed the Family Medicine Fellowship Programme to groom family physicians into leaders and mentors in Family Medicine. The Fellowship Programme provides structured, advanced, directed and self-initiated learning, supervision and mentorship for the advanced clinical practice of family/ community medicine, and education and research in the practice of family medicine. It is regarded as the pinnacle of advanced Family Medicine training in Singapore.

Family Physicians to Become Effective Primary Care providers

15. In an Annals of Family Medicine paper on "The Changing World of Family Medicine" published earlier this year, a distinguished panel of family medicine leaders in the US described the ideal family physician as "a pluripotent stem cell – (their) generalist inclination, diverse training, and range of meta-skills, such as listening, systems thinking, team-building, and advocacy allow family physicians to pursue a wide range of careers both in and out of medicine, and even change careers within family medicine".

16. Indeed, family medicine is one discipline in many settings. Building on the versatility that is required, the family doctor, backed by effective career development and professional support systems, will become effective primary care providers.

Primary care Entities and Family Physicians Need to be Integrated

17. In closing, it is a fact that family doctors are increasingly depended upon to support Singapore's integrated care needs amid a fast growing and ageing population, longer life expectancies, and changing lifestyles.

18. Our family doctors must be equipped and empowered to deliver this holistic, quality and continuing care for patients with chronic diseases. It is my hope that even as colleagues in the regional health systems and acute hospitals seek to reach out to the community, our family doctors will likewise actively reach out to integrate care with the regional health systems for the sake of all our patients!

19. I hope that each and every one of you, graduating today, will proudly rise to the challenges and respond to the many opportunities that await you to make a difference in the health of our people.

20. Thank you.

CM

Convocation 2014

SREENIVASAN ORATION 2014

DEVELOPMENT OF FAMILY MEDICINE IN THE WORLD AND IN SINGAPORE

Dr Alfred Loh, Past President,
College of Family Physicians Singapore
(Text abridged by Dr Irwin Clement A. Chung Wai Hoong, MCFP(S), Editor)

Dr Alfred Loh - Sreenivasan Orator for 2014 - at the College Convocation 2014.

The fraternity of Family Medicine has made rapid progress these past years, first in getting Family Medicine recognised as a distinct discipline and now also a Chapter in the Academy of Medicine, Singapore.

In 1963, the WHO report "The Training of the Physician for Family Practice" stressed the need for the training of family doctors in every country in the world. 10 years later, it again emphasised the importance of Primary Care and identified the general medical practitioner as a key player in the healthcare of a population. In 1978, the Declaration of Alma Ata was made, articulating a vision of 'Health For All' by the year 2000.

In tandem with these developments, training of generalist physicians was occurring around the world. These so termed family doctors were provided with post graduate training specifically designed to prepare them to diagnose and treat the majority of peoples' health problems within the context of families and communities. In 1972, 23 countries established the World Organisation of National Colleges, Academies and Academic Associations of General Practitioners / Family Physicians (WONCA), Singapore was among them.

The acceptance of Family Medicine as a distinct discipline grew quickly from that point on. By 1995, 56 countries had developed specialty training programmes in Family Medicine through partnerships with medical schools, community hospitals, and practicing physicians. Today, Family Medicine has become more widely accepted globally and family medicine colleges, academies and organizations have sprung up at a faster rate in the past two decades. WONCA, now with 128 member organisations in 105 countries covering almost every corner of the globe, is testament to that. However a number of countries in Central Asia and Africa have yet to formally accept Family Medicine concepts. Sadly, these are also places most likely to benefit from its introduction to their health care systems.

The Family Medicine evolution in Singapore very much mirrors that observed in most other countries with well established family medicine concepts, training and practice, in 3 phases - Infancy, Adolescence and Adulthood.

The Infancy Phase

The College of General Practitioners, Singapore was formed in 1971, a result of efforts by luminaries such as Drs Sreenivasan, Wong Heck Seng, Wong Kum Houng and Victor Fernandez, to name a few. Formal training to Membership of the College of General Practitioners, Singapore (MCGP) began in 1972. In those early days, the curriculum planning, training and assessment had to be done by our pioneers who were aided to some extent by visiting consultants from the Royal Colleges of the UK and Australia. MCGP was subsequently recognised as an additional qualification by the Singapore Medical Council in 1974.

In the 1980s, the College and the National University of Singapore jointly launched Family Medicine as a formal discipline in the undergraduate curriculum. The family practice curriculum gradually increased from the initial one week to the current eight weeks by 2007.

The Adolescent Phase

1991 marked the beginning of a structured Ministry of Health sponsored and hospital based training programme with clinical specialty rotations marked the beginning of the Master of Medicine (Family Medicine) programme. In 1995, the College initiated the private practice arm leading to the same examination. This firmly established the formal recognition of family medicine as a distinct discipline and specialty with its own prescribed curriculum and training requirements. As of December 2013, there are about 400 family doctors with the MMed (FM) specialist qualification.

In 2000, the College introduced the Graduate Diploma in Family Medicine (GDFM) as the entry level vocational training program for Family Medicine. Today, the GDFM forms the minimal standard for entry into the Register of Family Physicians

The Adult Phase

The College introduced the Fellowship by Assessment in 2001. This required the Masters holders to undergo an additional two years of training in clinical practice, pedagogy and research methodology, whereupon the candidates exit as Fellows of the College of Family Physicians, Singapore

Finally, and most significantly, we celebrate the acceptance of Family Medicine as a distinct discipline and specialty in the formation of the Chapter of Family Medicine in the Academy of Medicine, Singapore in June this year.

It has been a long journey of over 40 years for the College. Much is owed to the early pioneers of the College and to the many Council Members over many years who believed in the visions of our pioneers and were prepared to persevere and strive for this noble goal. I salute and thank you all who have played one role or the other in this pursuit.

CM

SEVENTY-TWO FM PHYSICIANS:
FELLOWS OF BOTH THE COLLEGE OF FAMILY PHYSICIANS & THE ACADEMY OF MEDICINE SINGAPORE

On 25 October 2014, 24 Fellows of the College of Family Physicians (FCFP) were inducted into the Academy of Medicine, Singapore (AMS) at its Induction Comitia. The Guest of Honour, Ms Tan Ching Yee, Permanent Secretary for Health, in her address noted that a Chapter of Family Medicine (FM) Physicians is formed in AMS. She reiterated that 'MOH values the holistic care provided by our Family Physicians whose practice is defined by its breadth and patient-centricity'. She welcomed the AMS initiative to develop FM physicians together with the College of Family Physicians, Singapore.

Guest of Honour Mrs Tan Ching Yee addressing the Comitia

Ms Tan said that 'The formation of the Chapter within the Academy is timely. As we look at our future needs, we need many more Family Physicians'. Addressing doctors practicing in hospitals, she stressed that 'Family Medicine residents will come to your hospital departments for training exposure. Please train them well and devote time to them'.

Master AMS, Prof Lim Shih Hui looking forward to closer collaboration for AMS and CFPS

The Master AMS, Prof Lim Shih Hui thanked Permanent Secretary for Health for 'her solid endorsement for having FM Physicians join our Academy' and announced that 'the Chapter of Family Medicine Physicians will be inaugurated in January 2015 and [we] look forward to a closer collaboration of our Academy with the College of Family Physicians, Singapore through this chapter'. Prof Lim announced that 64 eligible doctors have applied for the fellowship this year. With 8 doctors with the FCFP(S) who have already been admitted to AMS in past years, there would be 72 doctors who holding both the FCFP(S) and FAMS.

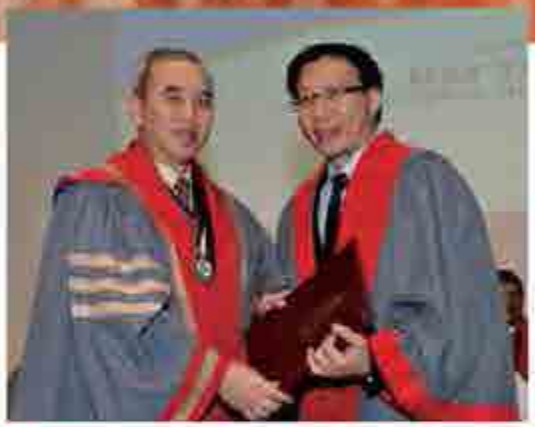
In his address, Prof Lim noted that unlike other specialists who need only 'concentrate and excel in just one, two or three of the 35 specialties and 5 subspecialties, our Family Physicians have to be competent in many specialty subjects, not only 14 Internal Medicine related specialties, but also general surgery, orthopaedic surgery, ophthalmology, ENT, O&G, psychiatry, paediatrics as well as emergency medicine'.

He informed the house that FM residents have to undergo 3 years of basic training to gain knowledge of and exposure to as many specialties as possible, 'pass an intermediate examination which is the Master of Medicine, Family Medicine'. He reiterated that 'just like the rest of specialty trainings, Family Medicine has an equivalent AST or Senior Residency phase. Those who chose to undergo advance FM training have to enrol into the College of Family Physicians, Singapore's Fellowship training programme. They also have to conduct research, complete a thesis, and pass the Family Medicine Fellowship Examination which includes assessment of clinical competencies, teaching pedagogy and research methodology. Based on training and assessment criteria, these Family Medicine Physicians have already fulfilled the entry criteria to be Fellows of our Academy'.

Dr Paul Goh, FM Physician (FMP) leading the Inductees' Pledge.

The inductees' pledge of all the 81 new fellows for this Induction Comitia was led by Dr Paul Goh, a senior family physician. At the end of the ceremony, a stage photo of the FMP inductees was taken with the Permanent Secretary Ms Tan Ching Yee, Master AMS Prof Lim Shi Hui, President (CFPS) A/Prof Lee Kheng Hock and the pro-tem chairman of the FMP chapter A/Prof Cheong Pak Yean.

(more event photos on the next page)



(ABOVE)
Stage Photo of Family Medicine Physician Inductees with Permanent Secretary, Masters Academy & President College of FP.

(FAR LEFT)
Dr Juhan Lim with Prof Lim Shi Hui

(LEFT)
A/Prof Tan Boon Yeow with Prof Lim Shi Hui

With the 8 doctors with FCFP who are already admitted to AMS in past years, there would be 72 doctors who are both FCFP and FAMS.

(LEFT)
A section of the FMP inductees in the Cantata. (from L to R) A/Prof Tan Boon Yeow, Dr Gilbert Tan, Dr Tan See Leng & Dr Lucienne Tan

CFPS President, A/Prof Lee Kheng Hock, Dr Ng Lee Beng, A/Prof Cheong Pak Yean & Dr Wong Tien Hua

Dr Ng Lee Beng with Permanent Secretary (Health), Mrs Tan Ching Yee

All image courtesy of Academy of Medicine, Singapore (AMS)

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E-mail: **lim.teng.teng1@singhealth.com.sg**
(We regret that only shortlisted applicants will be contacted for an interview.)

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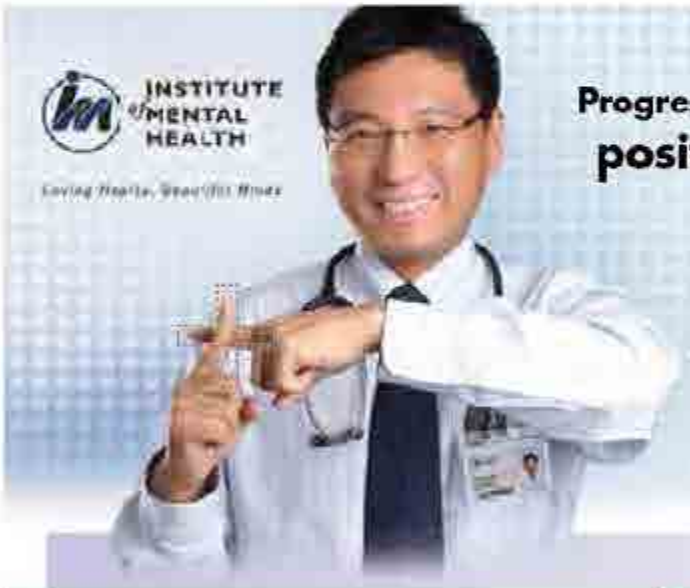

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www.imh.com.sg

A Member of the National Healthcare Group

CARING FOR PATIENTS WITH DEMENTIA

by Dr Phua Cheng Pau Kelvin, FCFP(S), Editorial Board Member

With the increasing prevalence of dementia, there is an urgent need for community hospitals and nursing homes create capacity and capabilities to be able provide care for this group of patients. With that in mind, Dr Lester Leong from Ang Mo Kio – Thye Hua Kwan Hospital (AMK-THKH) implemented an activities-based group therapy programme for patients with dementia (PWD) rehabilitating at the hospital in October 2013. The programme engaged dementia patients in meaningful activities at the Sunshine Corner, a homely cubicle for the care of PWD.

Dr Lester Leong and his team are keen on helping as many patients with dementia (PWD) as need be.

Dr Lester Leong is a family physician working at AMK-THKH. He has a special interest in dementia care and has worked hard with a team of therapists and nurses to create this cubicle where the care staff can carry out patient-centred care for PWD.

The activities that our patients are being engaged in are usually prescribed by the Occupational Therapists. They engage in activities familiar to them, such as their hobbies, which the therapists determine through sharing of life stories and by interviewing their loved ones. Participation in these meaningful activities assists in the improvement of the patient's self-esteem, confidence and general well-being. These activities also aim to slow down cognitive decline by putting patients through purposeful and stimulating activities such as drawing, painting and playing games. This will ultimately help in the management of behavioural and psychological symptoms commonly seen in PWD.

Since starting in early October 2013, 52 PWD have been admitted to the Sunshine Corner with most of these patients being discharged home. The improvement in Modified Barthel's Index for these patients was 19.2, which is 13% better than the average for all PWD.

Perspective From The Patients and Their Families

Another objective of the dementia programme and setting aside of a dedicated space for care of PWD is to galvanise family cohesiveness and support around the patient. Very often, family support keeps one strong and encouraged through difficult situations. Such support has meant much to Madam Lijah bte Kairan, aged 76 years, a PWD who has also suffered a hip fracture after falling at home. In October 2013, Madam Lijah underwent hip surgery at Khoo Teck Puat Hospital (KTPH), it was then that her diagnosis of dementia was confirmed.

Madam Lijah was one of our first few patients warded at the Sunshine Corner, a homely cubicle providing dementia care for our patients as they undergo holistic rehabilitative treatment to regain their functional independence. A typical day for Madam Lijah started with a range of functional activities. Assisted by our nurse, she tidied her own bed, a daily routine for her at home.

Her morning routine continued with light limb exercises designed to help her regain her functional independence. Guided by her therapists, Madam Lijah participated in activities involving movement of her hands and legs such as ball throwing, folding plastic bags and even personal grooming.

Madam Lijah (left) enjoys participating in the various guided activities, especially dough kneading.

What Madam Lijah enjoyed most was her favourite dough kneading, one of the brain simulation activities which took place in the afternoon. It was also a form of reminiscence for her as she used to bake frequently for her family during festivities.

"Apart from the routine therapy programme, the group activities conducted in the afternoon were also very helpful for my mother. She has become more cheerful after participating in these activities as she likes to make friends. In preparation for my mother's post-discharge care, I also went through the caregiver training conducted by the hospital. Nursing officer Mr Rohizad bin Md. Jani encouraged us to engage my mother in daily tasks such as cooking as a form of support for my mother and also to build up her sense of self-worth. We do want her to be happy and lead a normal life for as long as she can despite her illness." expressed her daughter.

Madam Lijah's daughter (standing) is glad that her mother remains cheerful despite the illness.

Images courtesy of Ang Mo Kio - Thye Hwa Kwan Hospital

The Road Ahead

Dr Lester and his team in AMK-THKH have been very encouraged by the positive feedback from staff, patients and caregivers and are keen to make this programme available to as many patients as need be. With the lessons learnt from setting up this cubicle, the team is looking forward to increase the number of such beds to cater to more patients with dementia.

CM

24th Council (2013-2015)

College of Family Physicians Singapore

Standing (from left)

Dr Subramaniam Surajkumar (Honorary Assistant Treasurer), Dr Ng Chee Lian Lawrence (Honorary Assistant Secretary), Dr Eng Soo Kiang, Dr Leong Chaon Kit, Dr Yee Jenn Jet Michael, Dr Tan Hsien Yung David, Dr Farhad Fakhrudin Vasanwala, Dr Pang Sze Kang Jonathan, Dr Ng Lee Beng, Dr Low Sher Guan Luke

Seated (left to right)

A/Prof Tan Boon Yeow (Censor-in-Chief), Ms Lek Siang Pheng, Dr Alfred Loh, A/Prof Lee Kheng Hock (President), A/Prof Benjamin Ong [Guest-of-Honour, Director of Medical Service (DMS), Ministry of Health], Dr Moti H Vaswani, Dr Tham Tat Yean (Vice President), Dr Tan Tze Lee (Honorary Secretary)

Not in photo

Dr Lim Fong Seng (Honorary Treasurer), Dr Tan Ngiap Chuan (Honorary Editor)

FAMILY MEDICINE *Convocation 2014*

22 NOVEMBER 2014
SATURDAY
THE TANGLIN CLUB

To view more photos of the event, please visit **www.cfps.org.sg**

Fellowship Programme - [FCFP(S) Recipients]

Standing (from left)

Dr Anandan Gerard Thiagarajah, Dr Leong Wen Pin Lester, Dr Lee Kwang Haw, Dr Chan Hian Hui Vincent, Dr Moey Kirm Seng Peter, Dr Ng Wei Liang David, Dr Tay Wei Yi, Dr Koong Ying Leng Agnes, Dr Phua Mei Fang,

Seated (from left)

Dr Koh Mei Lin Jocelyn, A/Prof Tan Boon Yeow (Censor-in-Chief), A/Prof Lee Kheng Hock (President), Dr Tham Tat Yean (Vice President), Dr Wong Zhen Sinead

Collegiate Membership - [MCFP(S) Recipients]

Standing (from left)

Dr Kong Jing Wen, Dr Tan Swee An Benjamin, Dr Ang Teck Wee Andrew, Dr Ong Cang Wei Alvin, Dr Cheang Cher Chee David, Dr Daniel Rufus, Dr Ramasamy Jaganmohan Raja, Dr Kharbanda Manojkumar Amarlal, Dr Wang Wei Mon, Dr Tan Zhong Wei Mark

Seated (from left)

Dr Lee Wan Sian, Dr Tea Hui Ying Valerie, Dr Jayabalan Bhavani, A/Prof Tan Boon Yeow (Censor-in-Chief), A/Prof Lee Kheng Hock (President), Dr Tham Tat Yean (Vice President), Dr Tan Hwee Mian Jane, Dr Chandran Thulasi, Dr Wee Wei Keong

MMed(FM) Graduands Year 2014

Standing (from left)

Dr Wang Mingchang, Dr Neelakshi Dilmini Kalambaarachchi, Dr Chen Shing Huei, Dr Koh Li Jia, Dr Teoh Ren Shang

Seated (from left)

A/Prof Tan Boon Yeow (Censor-in-Chief), A/Prof Lee Kheng Hock (President), Dr Tham Tat Yean (Vice President)

GDFM Graduands Year 2014

Standing (from left)

Dr Tan Li Wen Terence, Dr Chiu Pit-Tat Peter, Dr Khoo Hui Leng, Dr Yap Sui Ling, Dr Chia Min Yan, Dr Lew Kai Xin, Dr Tay Jun Sheng

Seated (from left)

Dr Pau Lai Yin, A/Prof Tan Boon Yeow (Censor-in-Chief), A/Prof Lee Kheng Hock (President), Dr Tham Tat Yean (Vice President), Dr Moosa Aminath Shiwaza

A SIGNIFICANT MOMENT IN THE HISTORY OF FAMILY MEDICINE IN SINGAPORE

by A/Prof Lee Kheng Hock, President, 24th Council, College of Family Physicians Singapore

I remember being a young Council member sitting in the old College lecture room and feeling a bit forlorn. It was the 1998 College Annual General Meeting. Dr Alfred Loh who was the President then had the unenviable task of delivering some bad news. The rental of the College premises had gone up from a nominal $1 to $8956.37 as there was a change of policy on levying nominal rent to professional bodies like the College. On top of that, we had to give up half the floor area, including the spacious lecture room (now converted to an office of MOH) to keep rental sustainable. The College was running at a deficit of $194,589 per year and our reserves were dwindling.

The next piece of bad news was like being drenched with a bucket of ice except that it was not done for a good cause. One year earlier, at the 1997 AGM, there had been a lot of excitement. The College was in talks with the Ministry of Health to start an advanced specialist training programme, which would have given Family Medicine recognition as a specialty, just like any other discipline in medicine. It was not to be. Dr Loh reported that there was a change of heart by the other stakeholders. The College did not have the authority to go it alone and the Advanced Specialist Training Programme for family medicine did not carry through. The reasons were not made explicit but most of us at the AGM knew about it through the grapevine.

The opponents of this development had many reasons; chief of which was that making Family Medicine a specialty would increase healthcare costs.

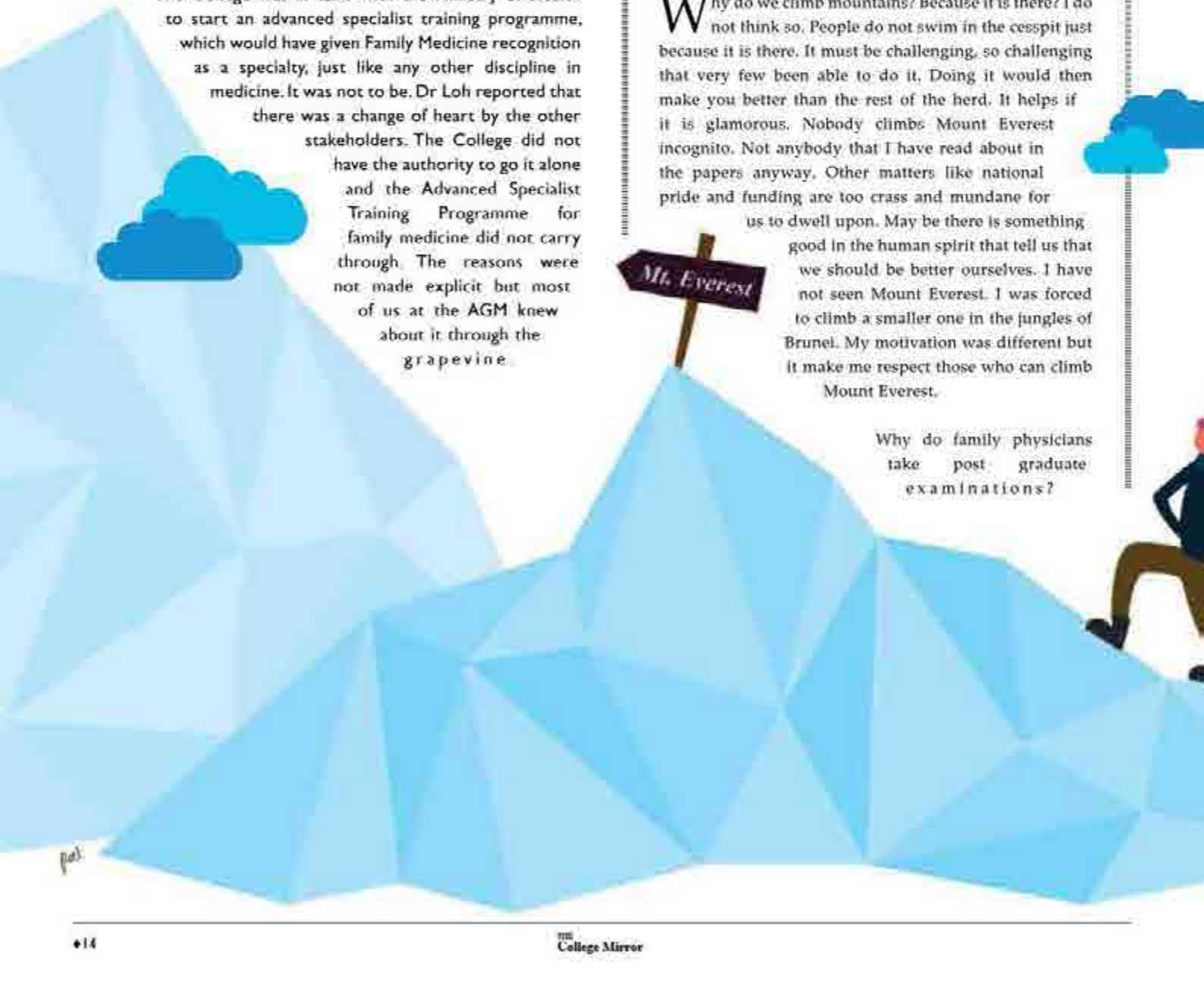
The following is a reflective article that I wrote in 1998 for the Singapore Family Physician. I think it is still relevant today and is worth sharing, especially for those who are persevering in the various Family Medicine training programmes despite the lack of recognition.

Climbing Mount Everest

Lee KH

Why do we climb mountains? Because it is there? I do not think so. People do not swim in the cesspit just because it is there. It must be challenging, so challenging that very few been able to do it. Doing it would then make you better than the rest of the herd. It helps if it is glamorous. Nobody climbs Mount Everest incognito. Not anybody that I have read about in the papers anyway. Other matters like national pride and funding are too crass and mundane for us to dwell upon. May be there is something good in the human spirit that tell us that we should be better ourselves. I have not seen Mount Everest. I was forced to climb a smaller one in the jungles of Brunei. My motivation was different but it make me respect those who can climb Mount Everest.

Why do family physicians take post graduate examinations?



Small minded people would tell you it is for the money. They jump to the conclusion that it is because they want to charge more. Their simple minds tell them that specialist who completed post-graduate examinations are paid more. So these GPs must be up to the same tricks. The reality is that doctors who do such exams lose a lot of money. Patients are not prepared to pay such doctors more and general practice is largely a free market. One doctor estimated that he lost about $70,000. If he had not spent all that money buying books and paying fees and spend his time earning as a locum and not studying, he would be a richer person. Materially richer that is.

May be it is the love of glamour and the one upmanship that drives these masochistic people. Wouldn't it be nice if some of these people are motivated to a small extent by the desire to improve themselves? Is it possible that they may actually love the call of medicine and enjoy pursuing knowledge in a science that they are interested in? If there are people who dedicate their lives to study UFOs, is it so difficult to believe that some doctors actually love the profession that they are in and take joy in pursuing knowledge?

At the 1998 AGM, Dr Alfred Loh rallied the College and urged everyone to put our heart and soul into developing the AFMP, also known as the FCFP by Assessment Program. The College decided to do the right thing and go it alone. In order to avoid opposition from naysayers, we renamed our project the Advanced Family Medicine Programme, leading to the award of the FCFP(S) by assessment. Prof Goh Lee Gan completed the development of the programme. Prof Cheong Pak Yean renovated and donated the use of his clinic premises as a training centre for the FCFP by Assessment Program. Drs Paul Goh, Kwan Yew Seng, Julian Lim, Ong Chooi Peng, Swah Teck Sing, Siaw Tung Yeng, Tan Chee Beng and I became the first cohort of trainees for this programme.

Many years have gone by. A few weeks ago, I had the pleasure of seeing some of my old comrades-in-training walking up on stage to be recognised for their clinical expertise and their professional fortitude. The Academy of Medicine Singapore, which is the professional body representing specialists in Singapore, has accepted family physicians as one of its categories of Fellows. At the induction program, Prof Lim Shih Hui, the Master of AMS said, "Based on training and assessment criteria, these Family Medicine Physicians have already fulfilled the entry criteria to be Fellows of our Academy. However, I wish to point out that Family Medicine is not only an important field of medicine in Singapore but an integral part of our healthcare system."

Ms Tan Ching Yee, Permanent Secretary MOH, was the Guest of Honour at the event and she commended this positive development. "I note that the Chapter of Family Physicians was recently formed to recognise Family Physicians with higher Family Medicine qualifications. MOH values the holistic care provided by our Family Physicians whose practice is defined by its breadth and patient-centricity. I am happy to learn that there are already about 50 Family Physicians in the Chapter. I look forward to the Chapter developing Family Physicians together with the College of Family Physicians, Singapore."

This is indeed sweet vindication for the pioneers of our College who pushed through the advanced training programme despite tough resistance from many quarters more than 15 years ago. Today there is overwhelming evidence that a primary care system with highly trained family physicians brings healthcare costs down and reduces the utilisation of expensive hospital resources. It has also become painfully obvious that continuing our present hospital-centric healthcare system would be disastrous in the face of our rapidly ageing population. This makes me wonder - what if we had the good sense to really try to enhance and develop Family Medicine all those years ago? What wonders we could have done! So what more must we do today?

CM

COMMUNITY HEALTH ASSIST SCHEME FOR PIONEER GENERATION

	CHAS Blue	CHAS Orange	CHAS for Pioneer Generation (PG)
Eligibility Criteria			
Household monthly income per person	$1,100 and below	$1,101 to $1,800	All Pioneers
Annual Value (AV) of home *(only for households with no income)*	$13,000 and below	$13,001 to $21,000	
Maximum CHAS Subsidies			
Acute conditions	$18.50 per visit	Not applicable	$28.50 per visit
Chronic conditions under CDMP[1]			
Simple[2] (Tier 1)	$80 per visit, capped at $320 per year	$50 per visit, capped at $200 per year	$90 per visit, capped at $360 per year
Complex[2] (Tier 2)	$120 per visit, capped at $480 per year	$75 per visit, capped at $300 per year	$135 per visit, capped at $540 per year
Integrated Screening Programme (ISP) under HPB			
Recommended health screening[3]	**Screening test:** Free with HPB's invitation letter		
	Doctor's Consultation Subsidy: $18.50 per visit (up to 2 times per year)		**Doctor's Consultation Subsidy:** $28.50 per visit (up to 2 times per year)

3 Common Questions Asked by Clinics

What can I do if my patient does not bring his/her Health Assist(HA) or PG Card?
Patients are encouraged to produce their NRIC and HA or PG Card for every visit. Should they only bring their NRIC, you could check their card details using the "Patient Card Enquiry" function on CHAS Online.

Do Pioneers need to sign the Patient Consent Form during their first visit?
Pioneers should sign the Patient Consent Form on their first visit. They do not need to sign again if they have done so earlier, when using their Health Assist cards.

What investigations are claimable under CHAS for PG patients with chronic conditions?
The investigations must be relevant to the 15 chronic conditions under the Chronic Disease Management Programme (CDMP). Please refer to the Handbook for Healthcare Professionals 2014 for more details.The handbook can be found in CHAS Online website under the "Download" tab.

For more info, visit **www.chas.sg** or call AIC at **6632 1199** or email to **gp@chas.sg**.

To be a CHAS Clinic, please call **6632 1222** or email to **gp@aic.sg**

[1] These are Diabetes, Hypertension, Lipid Disorders, Stroke, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Major Depression, Schizophrenia, Dementia, Bipolar Disorder, Osteoarthritis, Benign Prostatic Hyperplasia, Anxiety, Parkinson's Disease and Nephritis/Nephrosis

[2] Simple" refers to visits for a single chronic condition. "Complex" refers to visits for multiple chronic conditions, or a single chronic condition with complication(s).

[3] Subject to HPB ISP's eligibility criteria. The programme includes screening for Hypertension (blood pressure measurement), Diabetes (fasting blood glucose test), Lipid Disorders (fasting blood lipids), Colorectal Cancer (Faecal Immunochemical Test) and Cervical Cancer (Pap smear).

MINISTRY OF HEALTH

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THE JOURNEY OF A THOUSAND MILES BEGIN WITH ONE STEP: A WORD OF THANKS

by Dr Marcus Tan, Psychiatrist

Dr Marcus Tan

It was a couple of minutes to 10 am on a wet and somewhat easy Thursday morning. My 9.30 am appointment patient was late, probably due to the rain. The 9.45 am patient phoned in from the market behind the clinic to inform me – between mouthfuls of soup – that he would come in as soon as he has finished his Bak Kut Teh breakfast.

As I contemplated having the same for lunch, the copper bell on the glass door to my clinic clanked. As she walked in, I could hear the muffled sound of her slippers slapping against the soles of her feet. She greeted my counter staff in her usual effervescent tone. Some casual banter, which I could not make out, ensued. I tried to count the footsteps - 7 to be exact, when she crossed over to the refreshment area and she helped herself to a cup of hot green tea as per her usual routine.

Green tea, or tea of any other colour, was her drink of choice for the days of the week that had a "t" in them. Coffee was strictly reserved for the days without. It was something, as I understood, that she had practiced since her days at university. When she started work, she made it a point to use only the third disposable cup in the stack as she deemed that to be sufficiently clean to put to her lips.

Once she felt ready enough, she was ushered in for her session. The well-worn armchair in front of me creaked ever so slightly under her moderate frame as she settled into it. Our eyes met. She grinned at me toothily and nodded. This was our 16th time meeting. Over some 10 months, we had developed a certain rapport that allowed us to dispense with the questions I usually asked. Save some rituals of minimal impact to her daily routine, she was stable, her symptoms were under control and most importantly, she was functioning well in her life.

It had not always been this way.

I recall that when I first saw her, she was guarded and somewhat mortified to have been referred to a "psychiatrist". Prior to seeing me, she had doctor hopped from one clinic to another in the neighbourhood for multiple somatic complaints and insomnia. She was dysphoric, irritable and exceedingly anxious.

The turning point came when one of the family physicians she saw astutely picked up on the root cause of her symptoms. Over the course of several extended consultations, he painstakingly explained to her about her condition and the treatment needed. He also managed to dispel the unfortunate "myths" that confounded the public-at-large about Psychiatry, enough for her to agree to first have me see her at his clinic before considering formal treatment. The key role that family physicians play in de-stigmatising Psychiatry could not be understated.

Over the course of the next few months, her family physician and I continued to collaborate closely, informing each other of her progress as we jointly managed her health-seeking behaviour. When she became frustrated at times with the slow progress, he encouraged her not to give up.

To date, she is considerably less anxious and has refuted more than a few of the rigid and irrational rules that she conceived for herself. In doing so, she has been able to enjoy life as it should be enjoyed – in relative carefreeness. My family physician partner and I particularly enjoy the part of our sessions where she would gleefully tell us about the new records she has set and others that she has broken. For someone who had become a virtual recluse to the point that she was relegated to shuttling between home and the various clinics in her neighbourhood after a particularly distressing job venture, she had indeed grown from strength to strength.

At the time of writing, she has returned to work, braved the crowds on public transport and even gone deep-sea fishing with friends, who she dissociated from and later reconnected with.

This is but one of the successful collaborations I have had with my family physician partners in the community to help persons afflicted with psychiatric illnesses. I am grateful and honoured to have the opportunity to work alongside professionals like you.

As Lao Tzu said, the journey of a thousand miles begins with one step. Seeing a psychiatrist for the first time can be highly anxiety provoking. I thank you, my colleagues on the front line for taking this first step with these patients to listen, empathise and appreciate what they have to endure. Because of you, lives and livelihoods have been and continue to be regained.

CM

DIGNITY IN DEMENTIA

by Agency for Integrated Care (AIC)

Singapore has one of the fastest aging populations in the Asia Pacific region. By 2030, it is expected that 15-20% of the population will be made up of individuals aged 65 years and above.

Local epidemiological studies show that the prevalence of dementia ranges between 2-14%, and is expected to increase from the 28000 reported in 2012, to 80000 in 2030. The prevalence of cognitive impairment also increases with age – from 0.8% in individuals aged between 60-64 years, to 32.2% in those aged 85 years and older.

With a rapidly greying demographic and longer life expectancy, we will be caring for an increasingly frail population, many of whom may suffer from dementia.

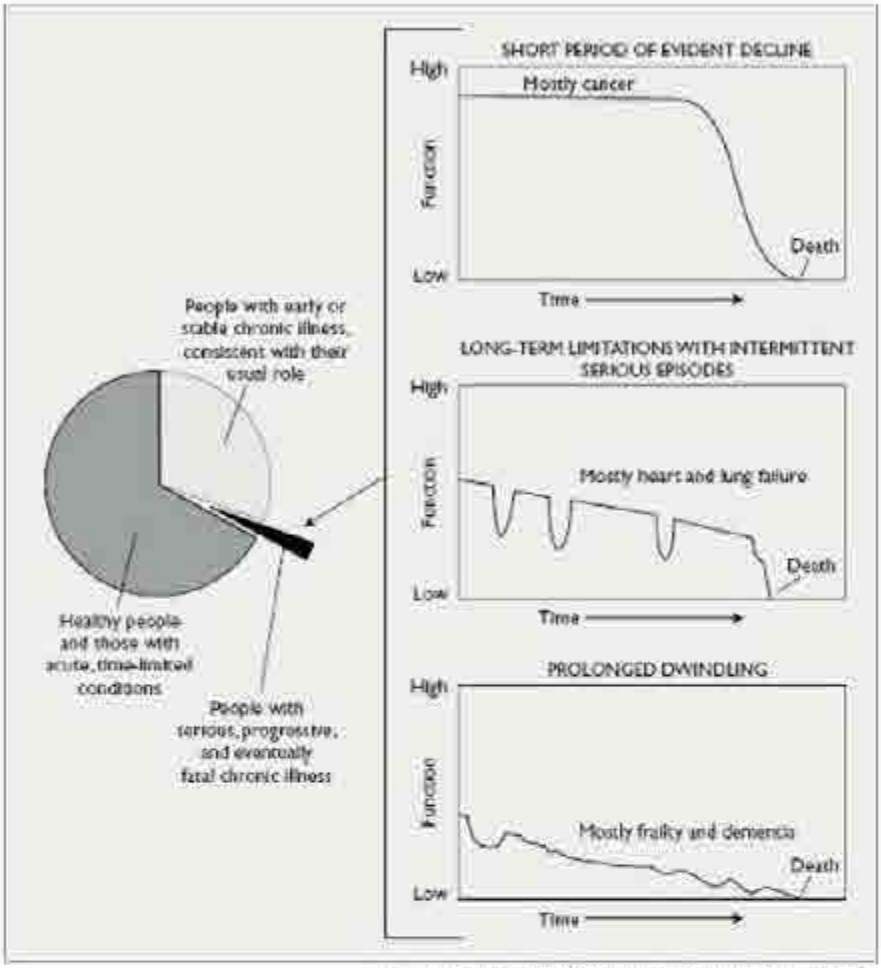

Figure 1: Trajectory of End Stage Illnesses. Lynn and Adamson, 2003

Dementia as a Terminal Illness

The disease trajectory for dementia is progressive (Figure 1). Patients inevitably move from the mild phase where one can be forgetful, through the moderate stages where one may require more help with basic care, and eventually, to the advanced stages where speech and mobility becomes severely diminished. While dementia per se is not lethal, patients do die from complications related to advanced dementia as a result of increased mental and physical disability.

Despite this knowledge, dementia is not traditionally viewed as a life threatening illness. In the United States, where dementia is the 6th leading cause of death, it remains under-recognised as a terminal illness. In Singapore, the situation is similar.

Unique Challenges Faced by Dementia Patients

The unfortunate outcome of such under-recognition is that many advanced dementia patients do not receive care that dignifies the last days of their lives. They may not receive the support that allows them to live their final days comfortably with their loved ones. Their families, many of whom have cared for them unreservedly for years, suffer significant psychological morbidity with burn-out, depression, demoralisation and anxiety.

Dementia patients face many unique challenges. They suffer losses which may be more prolonged compared with patients suffering from advanced cancer or other end organ diseases. Many dementia patients also have poor pain management as they may be less able to articulate their pain, leading to it being under-treated. Other challenges that arise as their disease progresses include diminishing mental capacity, sun downing, behavioural and nutritional issues, overuse of psychotropic medications and restraints, as well as recurrent infections and hospitalisations.

The need to support caregivers of dementia patients cannot be over emphasised. Due to the disease trajectory of dementia, there is a prolonged period of adjustment where the loss of patients' personal attributes leads to a "social death", and loss of cherished interactions which add to the sense of grief for loved ones long before death approaches. Coupled with the demanding needs of caregiving, it is no wonder that many caregivers of dementia patients face severe stress and burnout.

Palliative Support for Dementia Patients

What can the medical community do to better care for dementia patients and their caregivers? The answer lies in palliative care.

The World Health Organisation (WHO) defines palliative care as "an approach which improves quality of life of patients and their families facing the problems associated with life threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain

(continued from Page 18: Dignity in Dementia)

and other problems, physical, psychosocial and spiritual".
Not only is the palliative approach well placed to provide person-centric dementia care, the provision of specialist palliative care will alleviate suffering experienced by patients and their caregivers at the final stage of life. Such support should be integrated into the care of patients with advanced dementia, to achieve the best possible quality of life for both patients and their caregivers.

In addition, advance care planning (ACP) discussions are also important in helping families and caregivers of dementia patients cope with and prepare for the uncertainties ahead. ACP plays an important role in helping medical providers and patients' loved ones formulate decisions that support patients' preferences, goals and values. Understanding the patient's disease trajectory and prognosis helps medical providers hold such discussions at appropriate timings.

Developmental Opportunities

Currently, such support is not readily available for dementia patients and their caregivers in their homes. The Agency for Integrated Care (AIC) is working with palliative care providers in the community to develop programmes catered to this group of patients and their caregivers. More updates will be available by next year.

CM

A TIMELY CONSULT

by Dr Nicholas Foo Siang Siew, Editorial Board Member

"Doctor, my wife is not well," frowned Mr Raj, "she has been unable to take her meals over the last three days."

The GP listened as the patient's husband continued talking, noting that the patient herself did not utter a single word.

Mr Raj concluded in a whisper," Doctor, I think my wife has been 'hexed'..."

"Why do you say that she has been 'hexed'?" enquired the GP.

"To tell you the truth, my wife was warded in the hospital about two months ago. She had suddenly become confused one day. They did all sorts of tests on her including a CT scan of her head but they could not find anything wrong with her. Eventually a psychiatrist came to see her and he concluded that she was fine and discharged her! All that money wasted! "said Mr Raj, sounding most exasperated.

He continued, "So I then concluded that she must have been hexed. I had a dispute with someone over some business matters before that and I believe that person must have placed a curse on my wife. I decided to bring my wife to see a priest and she was back to her usual self after he said some prayers for her. I thought that everything was settled but it seems that she has taken ill again."

"Maybe you could prescribe her some medication to make her feel more comfortable for now," he replied, "I will probably have to bring her to the priest again but he has gone away for a while and will only be back next week. I am a little worried that she is not eating and behaves strangely."

Mr Raj had been the GP's patient for several years. He was about fifteen years older than his wife and they had been married for ten years. Both of them ran a small but profitable business together and seemed to be happily married with no domestic issues. They had an 8-year-old daughter, whom they doted on dearly. The GP had known Mrs Raj to be a level-headed person and this current problem was most puzzling to him. Something was not quite right.

The GP turned to face Mrs Raj and asked her if she had anything to say. The previously stoic lady suddenly burst into tears, as if relieved that she had been granted permission to break her silence.

"It's that boy who is causing all the trouble!" she cried out.

And then the whole truth came gushing out. For the first time, the GP found out that Mr Raj had previously been married to another woman with whom he had a son. His son was now

(continued on Page 20)

(continued from Page 19 A Timely Consult)

15 years of age and lived all this while with his mother. Mrs Raj only found out about this boy two months ago when the boy approached Mr Raj at their shop in an attempt to make contact with his father. Mr Raj had claimed that this boy was a distant relative but Mrs Raj had her suspicions and found out the truth after she did her own investigative work. She felt angry and threatened by the boy's presence but kept her feelings to herself. After an absence of two months, the boy had reappeared at the shop again three days ago.

"Well, I think we have solved the mystery of your wife's illness. I am not sure if I should prescribe her any medication but the two of you certainly should have a long chat," concluded the GP.

The GP was amazed at how patients would choose to open up to him and reveal things that they would not be comfortable telling others. He had to constantly remind himself that this was a privilege that he should never take for granted. Upon reflection, this was one of the things which kept him going whenever he felt jaded by the routine of GP practice. A reminder that being a GP was mostly about doing little things which counted.

CM

AN UNFORGETTABLE FEVER

by Dr Nicholas Foo Siang Sern, Editorial Board Member

"Hello doctor! Good to see you again. The past two months were really a torture," declared the patient, a middle-aged Chinese gentleman by the name of Ah Hock.

"Yes, Ah Hock, but I am glad that you are well and good now," replied the GP with a smile.

"Thank you for saving my life doctor. If it was not for you, I might have died two months ago. The only good thing is that my diabetes is now well-controlled after eating hospital food for so many weeks. I am really glad to be discharged!" laughed Ah Hock.

The clinical notes brought to life the GP's consultation with Ah Hock just prior to his hospitalisation. Ah Hock had initially consulted the GP a week earlier complaining of fever, headache and giddiness which had persisted for three days. Blood tests had ruled out Dengue Fever and Ah Hock had been prescribed with the necessary medication and also the instruction to return for a repeat consultation if his fever continued.

The GP was a little surprised when Ah Hock returned to the clinic one week later for a repeat consultation.

"My fever has been ongoing for ten days now!" declared Ah Hock, looking most unhappy. "All your medication did not work. Besides this fever, I am having this persistent headache. I think you better given me an injection!"

"Well, let me take a look at you first. Do you have any other symptoms?" enquired the GP.

"My left ear is very painful today. I also seem to have trouble remembering things over the past one week. I keep forgetting the names of the people I have just met or certain things that I need to do. The only thing that I remember is that I saw you last week and am not better despite your medication. You better do something about it doctor. I need to go back to work!" grumbled Ah Hock.

The GP examined Ah Hock before declaring, "I am so sorry Ah Hock, but you need to go to the hospital for a further check-up. Giving you an injection is not the appropriate thing to do...."

Ah Hock's laughter brought the GP back to the present.

"And I apologise for being so rude to you two months ago. It must have been difficult persuading me to go to the hospital but you were so insistent. I am glad that I went in the end!"

As the GP flipped through the discharge summary from the hospital, the words '4 cm rim enhancing lesion left temporal lobe', "intracranial abscess" and 'craniotomy" summed up the whole story. The GP locked the details of this particular case into his own temporal lobe. He was grateful that he had the opportunity to learn from his patients as diseases did not always present themselves in a textbook manner. He was forever a student at heart, taking pains to correlate symptoms with pathology, a habit he had picked up from a senior doctor whom he been fortunate enough to observe at work. He was also glad that patients trusted him enough to come back for a review instead of doctor hopping when they did not get better.

The GP felt a sense of satisfaction as he finished typing his case summary and filed the sheets of paper into his "Folder of unusual cases". Who said that GP life was boring?

CM

MENTAL HEALTHCARE *AT ST. ANDREW'S MISSION HOSPITAL*

by Dr Lim Khong Jin Michael, Editorial Board Member

"Persons with psychiatric illness should be treated with dignity just like any other person. We should not neglect them in society," says ***Dr Jennifer Loh*** *who works with St Andrew's Mission Hospital. She belongs to the pioneer batch of general practitioners that went through the Graduate Diploma in Mental Health in order to be better equipped to care for psychiatric patients. Dr Jennifer Loh feels that the case write-ups of the different psychiatric conditions such as depression and dementia (psycho-geriatrics) for her GDMH has helped her to gain a better understanding of caring for the patients in her current work at St. Andrew's Mission Hospital. The course has also helped her to be familiar with the common medicines used in psychiatry and the possible adverse effects to watch out for.*

Dr Jennifer Loh works as a Family Physician at St. Andrew's Mission Hospital Clinic and St. Andrew's Autism Centre. She also attends to patients at the St. Andrew's Nursing Home. St Andrew's Mission Hospital is a non-profit voluntary welfare organisation consisting of St. Andrew's Community Hospital, St. Andrew's Mission Hospital Clinic, St. Andrew's Autism Centre, St. Andrew's Nursing Home and St. Andrew's Lifestreams.

Dementia Care at St. Andrew's Community Hospital

St. Andrew's Community Hospital (SACH) provides inpatient rehabilitation, sub-acute, dementia and palliative care services. With support from the Ministry of Health and the Agency for Integrated Care, SACH converted one of its wards into a dementia ward in early 2013. It was by no measure merely a change in the designated use. There was firstly an infrastructural change as the ward was renovated to add features that promoted a greater sense of calm and security for the patients. The number of beds in the ward was also reduced from the usual 32 to 22 in order to make space for more common areas where patients could gather for meals, games and other communal activities. Other than a rehabilitation gymnasium, there is also a small open garden next to the ward for the patients to enjoy basking in natural sunlight while taking a stroll with their family members.

Secondly, there has been an upgrading of staff capabilities so that they might better understand dementia and the care required by the patients as well as support for their caregivers. For this, SACH is grateful for the partnership with Changi General Hospital, which generously provides staff training and mentoring in the dementia ward.

Finally, the staff-to-patient ratio has been adjusted to meet the increased care, support and counselling for dementia patients and their caregivers. It is important for the staff to spend more time talking with the dementia patients and their caregivers in order to gain their trust and cooperation as well as to understand their baseline well-being and behaviour. The caregivers provide the doctors with a more complete understanding of the patients' mental state and behaviour, which in turn allows the clinical staff to more effectively respond to the patients' unique behavioural challenges.

Dr Jennifer (right) and Sister Jasmine (left) examining a patient at St. Andrew's Mission Hospital Clinic

Patients discharged from the inpatient service at SACH may be followed up at its Outpatient Clinic where appropriate. It is preferable for patients with dementia to be followed up by the same doctor on a regular basis as it puts the patients at ease and they can enjoy their visits to see their doctor. The doctors are also better able to detect changes in their patients' mental state and behaviour and render appropriate management early. At the same time, doctors can also gauge the well-being of the care-givers and encourage and give appropriate advice and referral to other community resources when necessary.

Another important aspect of caring for dementia patients and their caregivers is helping them to navigate the community resources. As the patient's condition enters a different phase, the patient and the caregiver will need different services and support in the community. The staff at the outpatient clinic play an important role in linking them up with the appropriate resources. For example, caregivers of dementia patients who need a break may be linked up with the respite inpatient service of SACH. Caring for dementia patients requires a multidisciplinary and at times multi-organisational approach.

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(continued from Page 21: Mental Healthcare at St.Andrew's Mission Hospital)

St. Andrew's Autism Centre

When Dr Jennifer Loh attends to patients with autism in the clinic, she asks to have a parent or teacher whom the patient trusts present as this usually has a calming effect on the patient. She spends more time with such patients and even allows them to wander in the clinic as they take time to build that doctor-patient relationship. At times, she even has to come out to attend to patients in the corridor when they refuse to enter the unfamiliar setting of the clinic. She counts it a great privilege and joy to partner in the care of autistic patients who are themselves unique individuals with very specific medical and social needs.

St. Andrew's Nursing Home

St Andrew's Nursing Home (SANH) was set up at the end of 2013 to provide long term residential care to patients with psychiatric illnesses. According to Dr Jennifer Loh, it cares for patients with dementia, schizophrenia, bipolar disorder and other psychiatric conditions. She believes that the best way to care for long term psychiatric patients is by listening to them, understanding their needs, and being kind and supportive of them. The Home also receives help from the Institute of Mental Health which sends its staff over to SANH weekly to help guide and train the staff, and to render care to some of the patients that may require specialist attention.

Dr Jennifer Loh finds that simple things that we take for granted, such as an awareness of basic personal hygiene, is a major problem for many patients with psychiatric illnesses placed in residential care. She is careful in examining her patients' skin and treating their dermatitis and infections if present. A careful examination is necessary because many of her patients with severe dementia or schizophrenia do not verbalise their needs effectively.

Not Lesser Beings

Patients with psychological or cognitive impairment are as sensitive, if not more sensitive, to both verbal and non-verbal cues than healthy individuals. They quickly sense when the care staffs are interested in their well-being or otherwise. Dementia patients' behaviour tends to improve when they are surrounded with care staffs who take a genuine interest in them as fellow human beings, not lesser beings. As Dr Jennifer Loh puts it, "we need to value and care for every person with love and respect whatever his or her mental state." The care for a person with mental illness appears challenging to many, but is in turn fulfilling when the fruits of one's labour is seen when a patient is able to live life as fully as his or her mental capacity permits.

CM

A MOTHER'S JOURNEY

Interviewed by Dr Lim Khong Jin Michael, Editorial Board Member

I am a mother of three, the eldest of which is 31 years old; she is married and gainfully employed. The second is my 25 years old son Fauzee, on whom I will be sharing with you here. The third is my 19 years old son who is serving his National Service with the Singapore Civil Defence Force.

On 31 January 2014, when many of you would have been celebrating Chinese New Year, I received a call from Fauzee's team leader in the Police Coast Guard. He informed me that Fauzee had met with a traffic accident on his way home. He was found just about three minutes away from his workplace and was in a serious condition. No eye witness to the accident had come forward.

I spent much of the next six months with Fauzee in Changi General Hospital (CGH), forgoing my work as a babysitter in order to be beside my Fauzee. The staff at CGH kindly allowed me to sleep over in the

Fauzee (middle) surrounded by his brother and mother at Pasir Ris Park

hospital. Fauzee had blood drained from his brain, a piece of his skull taken out, a tube put into his head to drain fluid, a piece of bone put back to patch up part of his head, a hole cut in his throat to help him breathe and a tube put through his nose to give him food. Through it all, Fauzee's eyes only looked down as saliva drooled out of his mouth.

Before the accident, Fauzee was a very active boy. He was a Tae Kwon Do black belter. After receiving a Diploma in Mechatronics Engineering at Nanyang Polytechnic, he was called up for National Service. He did well during his two years with the Singapore Police Force during which he was made a sergeant. He liked it so much that he decided to join the Police Coast Guard soon after he completed his National Service.

When I first saw Fauzee at the hospital, I nearly fainted. I was very worried that I would lose him. For the next six months, my life routines revolved round him at CGH. Yes, I was very tired but I was happy to be with Fauzee. However, I had a breakdown during his third month of stay at CGH. Fauzee was having a fever and he kept vomiting. While coming to the hospital to visit Fauzee, my husband who was then having a gout attack skidded on his motorbike and injured his shoulder at the hospital car park. I started crying and I could not stop crying. My sister talked

to me and told me that I could do it. At that point of time I was not sure if I could do it. With the support of family and with Fauzee gradually improving, I managed to pull myself together again.

After six months, it was time to take Fauzee home. Yes, I felt confident of taking care of him at home because I had been learning the ropes from the nurses and therapists at CGH every day. At home, I fed Fauzee through his nasogastric tube and I applied the spigot to the tracheostomy tube to train his oral breathing. We used a hoist to transfer him from place to place. My youngest son, who had completed his studies at SHATEC resigned from his job as a part-time chef at a reputable hotel to help take care of Fauzee at home. The two brothers are very close; almost like twins even though they are six years apart. When Fauzee first came home, he could not even sit upright because his back muscles were weak. We sat him at the side of the bed for twenty minutes every day to strengthen his muscles. A therapist at CGH had taught us to do that. Then when he was able to sit better without back support we would stand him for a few seconds every day after his morning shower. We would massage him with oil regularly in the hope that he would continue to gain some strength and control of his weaker right side. Initially, Fauzee was not able to move his right hand at all. Then slowly he started to move his right hand a little. He still suffered drooling of saliva. He had diapers on all the time as he was incontinent. He also could not talk. Dr Patricia Lee with the Transitional Care Programme of CGH visited us at home to make sure that we were managing. The nurse came to help whenever Fauzee dislodged his feeding tube. And the physiotherapist came once a week to assess and follow up on his rehabilitation.

The doctors at CGH were able to wean Fauzee off his tracheostomy tube during a second admission. We were very grateful for that step towards normalcy. It was about ten days in CGH and then we were home again. At that time, although he could only move his right hand a little, he could do high five with his left hand, but he would do it only with some people. He would do high five with me because we were very close as I took care of him every day. And he would do high five with his brother and sometimes with his niece and nephew when they visited. I am very grateful to my sisters and brothers and Fauzee's friends for their help and support and for visiting Fauzee.

Not long after, my youngest son showed me that he had managed to support Fauzee and walk a few steps together. We took a video clip and showed it to Dr Patricia during her next visit. At that time, my youngest son was about to start his National Service. Dr Patricia suggested referring Fauzee to St Andrew's Community Hospital (SACH) for inpatient rehabilitation because she felt that he had potential to functionally improve further. We agreed and she kindly made the arrangements for admission to the hospital.

At first I was concerned that SACH did not allow me to stay in the hospital with Fauzee. I had been with him every day and night in CGH and at home for seven and a half months since the accident. However, it turned out to be good for me. I did not realise that I was so tired because I had not slept properly for months. Finally, I was able to rest at home. And I did not need to worry much because Sister Lim and the nurses at SACH continued to take good care of Fauzee.

When the nurses from CGH who knew Fauzee sent other patients to SACH they were so surprised to see that he had started to walk. Other than standing and walking, the physiotherapist also taught Fauzee to pass the big yellow ball. He could not throw yet but he could pass the ball standing up. I also participated in passing the ball with Fauzee. In the second week at SACH, the nurses excitedly told me that the speech therapist had succeeded in weaning Fauzee of the feeding tube and that they had managed to safely feed him a few spoonsful of food. That week Fauzee also started looking at us and responded to us by nodding his head when we talked to him. The occupational therapist tried to get Fauzee to identify colours and animals but he could not do it yet.

In the third week, Fauzee was able to shrug his shoulders and shake hands. He could even gesture to indicate which drink he preferred. At that time Dr Michael Lim, who was looking after Fauzee at SACH also suggested that we introduce music therapy to him. During the first session, Fauzee did not respond much to the keyboard music. However, Fauzee liked the guitar music during the second and third sessions and he gently played the tambourine as the therapist strummed on her guitar and sing. Fauzee used to enjoy playing the electric guitar.

Last weekend, we took Fauzee to McDonald because he used to like to go to McDonald. When his brother said goodbye to him because he had to return to camp, Fauzee tried to talk. His mouth moved but he still could not get his tongue to make any sound. This weekend we brought Fauzee to the beach. I cooked Fauzee's favourite food for him. We went to the Pasir Ris Park as a family and Fauzee was able to walk by himself at the beach.

Thank you for reading. This has been my journey with Fauzee for the last nine months since his road traffic accident. We have seen and experienced the countless efforts many people have made to help Fauzee in his recovery, and help me and my family cope with his care. We are thankful for the many people who have helped us. As a mother, I will always be praying for Fauzee. I will never give up. Thank you for believing in Fauzee's recovery even though the journey has only just begun and the road ahead is long.

CM

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