



# THE College Mirror

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## Primary Care Partnership Scheme Steps into the Limelight

by Dr Wong Tien Hua, MCFP(S), Editor

## Need for a Rethink: “Family Physician” as Reserved Words in the Family Physicians Register

by A/Prof Lee Kheng Hock, President, 23<sup>rd</sup> Council, College of Family Physicians Singapore

### Reserved words

The website of the Family Physicians Accreditation Board (FPAB) states that “... the use of the title “Family Physician” will be protected from 1 July 2012. Doctors who are not registered as FPs, will not be allowed to use the title of a “Family Physician” and the word “Family” in their clinic names e.g. “Family Physician”, “Family Medicine”, “Family Clinic” and “Family Doctor(s)” etc. Any doctor who is not registered as a FP and uses the title after 1 July 2012 will be subject to a penalty as stipulated in the MRA Section 65(1).”

With its enforcement in July 2012, the word “Family” and “Family Physician” become protected words.

This is problematic because it is a common English word

Following the Prime Minister’s National Day Rally announcement of major healthcare initiatives in primary care on 14 August 2011, the Ministry of Health (MOH) made a press release the following day, detailing a series of initiatives to make healthcare more affordable for Singaporeans. These changes will be implemented by the first quarter of 2012.

The key changes include:

- 1) Increasing the drug subsidy for selected high-cost standard drugs for eligible patients from 50-70%.
- 2) Expanding the **Medication Assistance Fund (MAF)** to cover more non-standard drugs, and increasing the level of subsidy from the current 50% to 75%.

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frequently used in normal conversation and writings. What are the possible unintended consequences of enforcing this?

This is a timely moment for us now to seriously consider the issues and work together to ameliorate the unintended consequences that may potentially result from this good intention.

To this end, the College will be conducting a town hall meeting of our members followed by an electronic survey to



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# The Real Deal

by Dr Wong Tien Hua, MCFP(S), Editor

**T**he primary healthcare system in Singapore has always been weighed down by an imbalance of resources, with government polyclinics (OPD) handling the majority of chronic disease cases whilst private General Practitioners (GPs), who form the physical majority of the doctors in primary healthcare, seeing only about 20% of such cases. All this is not surprising as the system evolved as a result of government subsidies that funded the OPD system. It is simply cheaper for patients to go to the OPD for subsidised care, especially for those with chronic diseases that require long term medication.

Through the years, and to their credit, the OPDs have also improved and upgraded themselves in their physical environment, staffing, and training of its doctors. Perhaps as a result of its own success, it faces the problem of not only long queues but sometimes patients short on temper.

On the other hand, private sector GPs has seen its share of patients gradually eroding. A survey conducted by the Singapore Medical Association (SMA) indicates that the average GP worked longer hours but saw fewer patients, and income has stagnated over the past 10 years.

Private sector GPs clearly have an important role to play in primary care. With the Continuing Medical Education (CME) system introduced some years back, many GPs have upgraded themselves through self study and attendance at CME activities. The College has been faithfully organising the Family Practice Skills Courses (FPSCs) regularly to keep GPs updated on topics of importance. The increasing numbers taking the Graduate Diploma in Family Medicine (GDFM) course run by the College has resulted in a sizeable pool of GPs with this qualification. Although it can be said that experience counts when working as a GP, at least many young doctors have challenged themselves and have met the standard of the GDFM. The recent implementation of the Family Physicians Register will further help raise the bar and compel young doctors contemplating a career

as a Family Physician in the community to seek higher qualifications. GPs are now better trained and better equipped to handle chronic diseases in the community.

However, raising the standards of GP training does not solve the chronic imbalance of patients.

**At the end of the day, cost factors still play an important role in driving patient's health seeking behaviour.**

At the end of the day, cost factors still play an important role in driving patient's health seeking behaviour. The Ministry of Health had tried with different schemes in the past to level the playing field and channel more patients away from the overcrowded OPDs. Schemes such as the Primary Care Partnership Scheme (PCPS) and Medisave



for chronic diseases have been around for a while, but have not really made a very large impact on the primary healthcare landscape.

The new expanded PCPS scheme just announced on 15 August 2011 could be the game changer that GPs have long been waiting to hear.

By raising the qualifying income for PCPS from the current \$800 to \$1,500 (per capita monthly household income), and at the same time lowering the age criteria for eligibility from the current 65 years old to 40 years old, the pool of patients covered by the new PCPS scheme will increase by a factor of more than 20 to 710,000 persons.

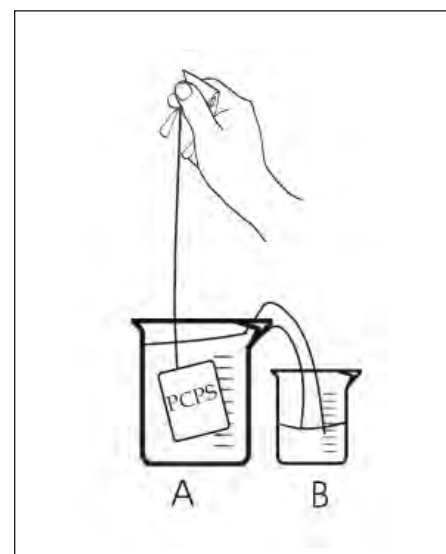
This figure of \$1,500 per capita is the median per capita monthly household income in Singapore. A sole bread winner who earns \$6,000 a month to feed his family of four will qualify. By definition, this median number theoretically covers half of the GP's pool of patients who are above 40 years old, but the impact will be felt even more so by GPs who practice in HDB estates, where the proportion of families who qualify will be larger. Of course patients not only need to fulfill income and age criteria but must also suffer from one of

## The new expanded PCPS scheme just announced on 15 August 2011 could be the game changer that GPs have long been waiting to hear.

the prescribed list of eight chronic diseases, and not everyone who qualifies will sign up for the scheme. But certainly the pool of patients is going to be significant, and the questions facing GPs now is - could they afford not to join the PCPS scheme?

One of the factors that could be a barrier to GPs signing up for PCPS is the administrative processes that are yet to be finalised. Most GPs want to spend time with their patients and are adverse to complicated and restrictive claims procedures. There is also the additional responsibilities of data entry of key indicators (such as BP and HbA1C), and the worry of clinical audits. The College Mirror understands that the Agency of

Integrated Care (AIC) has been tasked with coming up with the new on-line system and interface to run the scheme. What they need to do over the next few months is crucial - they will need to gather as much feedback from GPs as possible to fine tune the system and to ensure that the interface is easy to use and hassle free. A proactive and consultative approach will reassure GPs and encourage them to sign up for PCPS to make this scheme work. ■CM



Science quiz: In the experiment above, how much water will overflow into beaker B?

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## The law of unintended consequences revisited

Having seen first-hand the meandering course of this register from its initial proposal in 2005 to its implementation this year and the impending enforcement in 2012, it is likely that unintended consequences will arise. A call is made therefore to reflect on this law of unintended consequences with some seriousness.

Unintended consequences are common place and experienced almost on a daily basis. It was first fully conceptualised and studied by Robert K Merton, a renowned American sociologist in 1936. Bad outcome often results from a combination of hubris, expediency erroneous assumptions and sloppiness during implementation.

**The fear of the law of unintended consequences should however not paralyse us into inaction. On the contrary, it serves as a good guide to successful crafting and implementation of policies.**

Fortunately or unfortunately, not all unintended consequences are bad. By sheer dumb luck, we often get good outcome from bad decisions. Such happy problems are often attributed to good foresight and there will be rounds of champagne popping, promotions and bonuses.

The fear of the law of unintended consequences should however not paralyse us into inaction. On the contrary, it serves as a good guide to successful crafting and implementation of policies. It should make us mindful of the harmful tendency towards arrogance and defensiveness when we advocate for a course of action.

## Food for thought

Let us have a serious rethink about the words "Family" and "Family Physician" as reserved words in the implementation of the Family Physicians Register. We look forward to your contribution at the town hall meeting and the electronic survey of members' opinion and suggestions. ■CM





# “Family Physician” Title

## to be Protected from 1 July 2012

by Dr Wong Tien Hua, MCFP(S), Editor

**H**ave you applied to include your name in the Family Physicians (FP) Register? If you have not done so, here is the summary of important dates and the steps you need to go through:

Important dates:

1 July 2011	Application opens for all registered doctors to apply for Family Physicians (FP) Register.
1 Jan 2012	List of doctors approved to be on FP Register will be published.
1 Jul 2012	<p>“Family Physician” title may only be used by doctors who are on the FP Register.</p> <p>Doctors who are not registered as FPs, will not be allowed to use the title of a “Family Physician” and the word “Family” in their clinic names, e.g. “Family Physician”, “Family Medicine”, “Family Clinic” and “Family Doctor(s)”, etc.</p>
31 Dec 2013	Cut-off date for entry via practice route: Doctors applying via practice route need to complete all training requirements and practice experience by this date.

### Application Procedure

GPs applying to be included on the FP Register need to apply to 2 bodies:

#### 1) Accreditation

The Family Physicians Accreditation Board (FPAB) was appointed by the Minister for Health in 2011 and serves as the regulatory body to accredit medical practitioners with the necessary qualifications as FPs. This is the body that will go through your application and supporting documents (e.g. post grad degrees) to determine if you have satisfied the entry criteria. One must therefore apply to the FPAB at its website at [http://www.hpp.moh.gov.sg/HPP/FPAB\\_Home.html](http://www.hpp.moh.gov.sg/HPP/FPAB_Home.html).

#### 2) Register

Singapore Medical Council (SMC) maintains the register itself. They

will enter the doctor's name into the FP register once FPAB has cleared the applicant. One should however apply to SMC at the same time to minimise the waiting period. There is a one-off application fee payable. The actual application webpage is available after the individual doctor has logged into the secure pages, similar to the procedures to check one's CME credits.

- For FPs applying via the **Degree or Diploma route**, there is an additional step of including at least one registrable postgraduate qualification that is specific to Family Medicine into the Register for Medical Practitioners. If you had not already done so previously, you may choose to apply to SMC for inclusion of a postgraduate qualification, which will then appear on the FP Register in addition to your basic degree. A separate administrative fee applies.
- For doctors applying via the **Practice Route**, he must have five years or more of FM practice experience and complete between two to four Accredited Modular Courses (AMC).

### About the Accredited Modular Course

#### What is the Accredited Modular Course (AMC)?

The AMC comprises of eight modules that run cyclically over a two-year period. The AMC uses the course materials of the GDFM course. Modules are repeated every two years. It is recognised by the SMC as structured training for the purpose of entering the Register of Family Physicians.

#### Who needs to do the AMC?

The AMC is for experienced GPs who wish to enter the Register of FPs via the practice route. The minimum number of AMC that needs to be completed will be pro-rated according to years of relevant FM experience.

- A GP with five and up to ten years of FM practice will need to complete four AMC modules;
- A GP with ten and up to 20 years of FM practice will need to complete three AMC modules;
- A GP with 20 years or more of FM practice will need to complete two AMC modules.

The College of Family Physicians Singapore has been appointed as the AMC course provider. AMCs are adapted from the Family



Medicine Modular Course designed for GDFM and are tailored to suit GPs' needs and schedules.

### What must I do to complete an AMC module?

Each AMC module consists of the following:

- Study a set of distance learning notes available online. Hardcopies are also provided to each course participants
- Attend four Saturday afternoon workshops from 2.30pm to 5.00pm for which you must attend at least three out of four workshops

- Complete e-learning activity on the College website to collate learning (<http://www.onlinemedlearning.org>). These are:

- Read the therapeutic note update: one topic
- Attempt the interactive case scenarios: two cases
- Complete the on-line MCQs (passing mark is 60%, i.e. 18 out of 30 questions correct)

A Certificate of Completion will be issued to you after the completion of each module.

### How much do I have to pay?

The fee payable for each module is S\$500 (non- CFPS member) and S\$450 (CFPS member). Please note that all fees are non-refundable upon registration.

All fees paid are strictly for the modules you have chosen on the application form. You are not allowed to change your preferred modules once the application form is received. Participants who fail to attend/ complete any part of the training course and who wish to make up for it, would need to apply again to the College.

### What are the AMC modules that I can sign up for?

The following modules are available for signing up.

Month/ Year	Topics	Workshops Dates **	Closing dates for each module
Nov 2011	<b>Module 6:</b> Work Related Health, Renal, Urological and Endocrine Problems	12, 13, 19, 26 Nov	14 October 2011
Feb 2012	<b>Module 7:</b> Women's Health (Gynaecology); Emergent Problems & Acute Medicine	4, 11, 18, 25 Feb	To be Announced
Apr 2012	<b>Module 8:</b> Women's Health (Obstetrics) and Neuromusculoskeletal Problems	7, 14, 21, 28 Apr	To be Announced
Aug 2012	<b>Module 1:</b> Respiratory, ENT and Eye Problems	4, 11, 12, 25 Aug	To be Announced
Nov 2012	<b>Module 2:</b> Child and Adolescent Care, Gastro-Intestinal Problems	3, 10, 17, 24 Nov	To be Announced
Feb 2013	<b>Module 3:</b> Chronic Disease Management, Haematology, Oncology and Palliative Care	2, 3, 16, 23 Feb	To be Announced
Apr 2013	<b>Module 4:</b> Elderly Care and Mental Health Problems	6, 13, 20, 27 Apr	To be Announced

\*\* Subject to change based on venue availability.

AMCs are adapted from the Family Medicine Modular Course designed for GDFM and are tailored to suit GPs' needs and schedules.



### How do I apply for the AMC module I want?

- Decide on the module you want to attend
- Download the application form (<http://www.cfps.org.sg>) and fill it up accordingly.
- Send the completed form together with the cheque to:

**College of Family Physicians  
Singapore**

16 College Road, #01-02  
College of Medicine Building  
Singapore 169854



# A Sampling of iPhone Apps for the Clinic

by Dr See Toh Kwok Yee, MCFP(S), Editorial Board Member & Dr Wong Tien Hua, MCFP(S), Editor

**A**pp is the abbreviation for application which is a computer programme that runs on your Apple equipment (iPod, iPad or iPhone) and android phones.

The multitude of apps available today covers every imaginable aspect of modern living, spanning from entertainment, travelling, social networking and finances to healthcare.

Some of these apps have unsurprisingly found their way into the consultation room.

Some offer a quick consult or reference between patients, while others are useful tools in the consultation process.

We have discovered the following gems which are available free or for a small price.

Likewise, we welcome our readers to write to us via [collegemirror@cfps.org.sg](mailto:collegemirror@cfps.org.sg) to share any useful apps they have come across so that we can make this a regular sharing column.

## Calorie Counter & Diet Tracker by MyFitnessPal

It was recommended by a patient who was asked to lose weight!

The app requires you to key in your current weight and height and then set a weight-loss goal. It then calculates the daily allowable calories and keeps track of the score after each meal.

The database of food includes local fares like laksa, chicken rice and even char siew bao with their attending nutritional facts.



Images: BabyCenter LLC, Epocrates, Inc, BetterQOL, Inc.

## Medscape

This program gives instant access to a huge catalog of drugs, diseases and procedures.

A useful feature is the Interaction Checker. Especially helpful when the patient is on warfarin!



Image: Epocrates, Inc

## Epocrates

A good drug reference resource with regularly updated DocAlert Messages, Pill Identifier, Interactions checker and tools like coronary heart disease risk calculator.

## theheart.org

This program showcases the latest development in cardiology and cardiovascular research and trials.

## AFP By Topic

A helpful topical quick reference book from the American Academy of Family Physicians covering over 40 commonly encountered medical conditions.

## Elmo Loves ABCs Lite

Elmo is universal! Every patient regardless of nationality or race readily identifies this character.

Play this app to distract the uncooperative toddler for a sneak physical examination.

## Color Blindness Test Lite

Contains a few Ishihara colour test plates for screening colour blindness.

Image: Movisol Media S.L.



## ACLS Sim Lite

For doctors to practice their advanced cardiac life support.

Image: Anesoft Corporation



## Diagnose the Disease game

Fun app for spot diagnosis, just like the Objective Structured Clinical Examinations (OSCEs).

## Sleepmaker Rain Free

This app generates the soothing sounds of rainfall in a variety of scenes such as rainfall on porch, windows, puddles, and even heavy torrential downpour. It gives you a cozy feeling with a calming effect. An adjustable timer will turn off the app. I adjusted it for a 10min countdown, and fell asleep even before I realized, only waking the next morning with my earphones still plugged in!

This app is a good recommendation for patients who are stressed out and having problems with sleeping and anxiety.



Image: Taconic System LLC

## Blood Pressure Monitor - Family Lite

Keeps track of important health stats, including blood pressure, weight, and heart rate. Graphical charts for visual trend and warning. Able to send charts via email.

## Blood Pressure Tracker by Tapcalc

Very simple and useful BP tracker, able to chart the blood pressure, heart rate, or weight. Converts into visual graphs for trending.

## Diabetes Companion

Logs and tracks blood glucose levels for better management. Also contains diet and recipe advice. Has a video library for information on DM.

## iPeriod Free (Period / Menstrual Calendar)

Helps patients track their menstrual cycle.

Image: Winkpass Creations, Inc.



## BabyCenter® My Pregnancy Today

Simply enter the baby's due date and the app calculates the expected deliver date. Based on this it will help the user track the pregnancy on a daily basis with information on fetal development and what to expect.

This app comes in a Singapore version which has local information for prenatal appointments and immunisation schedule. This app can be recommended for patients who are expecting.



Image: BabyCenter LLC

## iHeadache - Headache & Migraine Diary

This app helps patients to keep track of their headaches, the disability, medications taken, and triggers. The app uses the International Headache Society Criteria (IHS Criteria) to classify the headache as a migraine, probable migraine, tension headache or unclassified headache.



Image: BetterQOL, Inc.

This app will help both patients and doctors maintain a detailed headache diary and access the severity and disability caused by the headaches.

## Army Physical Readiness Training

This app prepares US Army soldiers for combat fitness, it complies to the US army's new physical readiness training manual.

The good thing about it is it incorporates full body workout that can be done without using weights or gym equipment. Exercises are grouped into sections e.g. starting with preparation, moving on to core muscles, hip stability, shoulder stability, conditioning, and strength training. For each prescribed workout there are specific illustrated instructions as well as a video to demonstrate the workout.

This app is a good recommendation for males who are preparing to enlist in National Service as it sets a higher standard than the IPPT test requirement.



# CFPS 40th Annual General Meeting

## 25th June 2011, Saturday

by Dr Pang Sze Kang Jonathan, Honorary Secretary, 23rd Council, College of Family Physicians Singapore

**T**his significant milestone speaks highly of how far our College has come since the incorporation in 1971.

It was also a watershed as elections were held to elect the 23rd Council to serve the College. The outgoing President, A/Prof Goh Lee Gan, our longest serving Council member to date (since 1983, the 9<sup>th</sup> Council), decided to step down as President and also from the Council.

There was a good turnout of members beyond the minimum needed for the quorum. The members were brought through the reports of the various committees and the work done by the outgoing Council. There were a total of 12 Family Practice Skills Courses (FPSCs) and 8 modules of the modular courses conducted for the Graduate Diploma in Family Medicine (GDFM) programme. We also published 11 issues of the Singapore Family Physician, the journal of our College, which is also produced in relation to the FPSCs conducted.

The membership number has increased a little from 1,368 to 1,407. Our financial status remains healthy and we will try to maintain the courses and educational activities to benefit our members.

A/Prof Lee Kheng Hock, Head of Department of Family Medicine and Continuing Care (FMCC) in Singapore General Hospital, was elected as the next President of the College. He leads a mix of old and new Council members in the 23rd Council. He has indicated his desire to continue the traditions and motto of the college and emphasised that education, service to members and research are the 3 areas that he would like to focus on.

Some members felt that the town hall meetings were a good way to initiate contact and outreach to members. It can also be an avenue to source for feedback on issues pertaining to our practice. A/Prof Lee noted that our members work in many different settings and sectors. We will try to address the various needs and try to bring more members together and also advocate Family Medicine as a



discipline. He also wants to encourage more to help in teaching and help raise our recognition of Family Medicine as a discipline and the image of Family Physicians.



Some members also reminded us of the need to be patient advocates as we are Family Physicians and we take care of the patients. The College should help promote the 'One Patient, One Family Physician' concept. There was also a discussion on the Family Physician Register and how College should help advocate for and help our members. We will try to collect and collate feedback through the various channels and also find ways to engage everyone.

We are all encouraged by the presence of the members of the College. There was a lively exchange of ideas and we look forward to more active participation by the members as we strive to attract more to join us. Our quest to gain better recognition for all our doctors continues as well as the need to be an advocate for all our patients.

■ CM



## New Faces in the 23rd Council (2011 - 2013)



### Vice President

Dr Tan See Leng  
Group Chief Executive Officer &  
Managing Director  
Parkway Holdings Limited



### Council Member

A/Prof Koh Choon Huat Gerald  
Associate Professor  
Yong Loo Lin School of Medicine,  
National University of Singapore  
National University Health System



### Council Member

Dr Ang Choon Kiat Alvin  
Family Physician in Private Practice  
Our Family Physician Clinic & Surgery



### Council Member

Dr Siew Chee Weng  
Consultant Family Physician  
Department of Continuing &  
Community Care  
Tan Tock Seng Hospital



### Council Member

Dr Chng Shih Kiat  
Deputy Medical Director of  
Raffles Medical Group  
Raffles Executive Medical Centre,  
Raffles Hospital



### Council Member

Dr Yee Jenn Jet Michael  
Family Physician  
Rapha Medical Centre

## A Meeting with Health Promotion Board's CEO

by A/Prof Goh Lee Gan, Immediate Past President, College of Family Physicians Singapore

A College delegation led by A/Prof Goh Lee Gan, the then President of the College, Dr Pang Sze Kang Jonathan, Executive Director, Ms Jennifer Lau, Administrative Manager, and Ms Stella Teh, Corporate Communications Executive, paid a courtesy call to Mr Ang Hak Seng, the new CEO of Health Promotion Board (HPB) on 1 June 2011, Wednesday, at the Care & Concern Room in HPB.

A/Prof Goh briefed Mr Ang of the collaborative efforts between College and HPB and thanked HPB for sponsoring several Family Practice Skills Courses (FPSCs) for the family physicians. These included: Nutrition Updates, Childhood Obesity, Oral Health in Primary Care and Management of Functional Decline in Older Adults. Dr Jonathan Pang elaborated on the contents of courses.



Mr Ang thanked the College for the support of its health promotion programmes. He said prevention and reduction of obesity will be one key area that HPB will be working on. A healthy diet, moderately active exercise and weight control are the key components of obesity control.

Mr Ang also spoke of the need for doctors to come forward to help HPB give talks to the public on disease prevention and health promotion. A/Prof Goh agreed that this is an area that our family doctors could help to contribute to create a greater awareness amongst the public of the health

messages and health education materials that HPB has developed.

The meeting ended on a positive note of continuing collaboration. A/Prof Goh also presented Mr Ang with a memento from the College.

■CM

(from page 1: Primary Care Partnership Scheme Steps into the Limelight)

- 3) Expanding the **Primary Care Partnership Scheme (PCPS)** for private General Practitioners (GPs) and dental care. In essence making GP more affordable and accessible for middle to low income patients.
- 4) Raising the **Medisave** withdrawal limit allowable for outpatient treatments from \$300 to \$400 per Medisave account, per year.
- 5) Enhancing **Medifund** to include non-residential Intermediate and Long Term Care (ILTC) services, such as day rehabilitation, home medical and home nursing.

For GPs practicing in the private sector, the expanded PCPS scheme will increase the potential pool of patients from the current 31,000 to 710,000, more than a 20 fold increase. Raising the Medisave withdrawal limit will also directly enable more patients to cover the cost of managing their chronic diseases.

## There will be two benefit tiers under the expanded scheme.

### Expansion of the Primary Care Partnership Scheme for private GP and dental care

The qualifying income for the Primary Care Partnership Scheme (PCPS) will be raised from the current \$800 to \$1,500 per capita monthly household income. At the same time, the age criteria for eligibility will be lowered from the current 65 years old to 40 years old.

There will be two benefit tiers under the expanded scheme (Table 1). With this change, 710,000 Singaporeans can receive subsidised care at participating PCPS GP clinics to better manage their chronic conditions. Successful PCPS applicants will receive a healthcare benefits card to identify them as PCPS members to the participating clinics.

There are currently more than 31,000 PCPS members and 405 participating GP clinics and 170 participating dental clinics.

**Table 1**

PCPS Tiers		Subsidy Received		
		Acute	Chronic conditions under the CDMP <sup>1</sup>	Dental
A	Income $\leq$ \$900 Economically inactive households with AV $\leq$ \$13,000	\$18.50	\$80 (Previously \$60) (Increase in annual cap)	Up to \$256.50
B (new tier)	\$901 < Income $\leq$ \$1,500	-	\$50	Up to \$170.50 for selected dental procedures

Current PCPS	Revised PCPS
<b>Application criteria:</b> <ul style="list-style-type: none"> <li>Aged 65 and above or</li> <li>Disabled</li> <li>Monthly per capita household income of \$800 or less</li> </ul>	<b>Application criteria:</b> <ul style="list-style-type: none"> <li>Aged 40 and above or</li> <li>Disabled</li> <li>Tier A: Monthly per capita household income of \$900 or less</li> <li>Tier B: Monthly per capita household income between \$901 to \$1,500</li> </ul>
<b>Scope of coverage:</b> <ul style="list-style-type: none"> <li>Acute conditions (coughs, cold, etc)</li> <li>Standard dental treatments</li> <li>Chronic diseases under the Chronic Disease Management Programme (CDMP):               <ul style="list-style-type: none"> <li>Diabetes</li> <li>Hypertension</li> <li>Lipid disorders</li> <li>Stroke</li> <li>Asthma</li> <li>Chronic obstructive pulmonary disease (COPD)</li> <li>Schizophrenia</li> <li>Major depression</li> <li>Dementia (from Nov 2011)</li> <li>Bipolar disorder (from Nov 2011)</li> </ul> </li> </ul>	<b>Coverage:</b> <ul style="list-style-type: none"> <li><b>Tier A:</b> no change in scope of coverage</li> <li><b>Tier B:</b> covers chronic diseases under CDMP and selected dental procedures</li> </ul>
<b>Subsidies:</b> <ul style="list-style-type: none"> <li>\$18.50 per acute visit</li> <li>\$60 per chronic visit, subject to annual cap of \$240 or \$360, depending on severity of condition</li> <li>Range of subsidies for various dental treatments</li> </ul>	<b>Tier A:</b> <ul style="list-style-type: none"> <li>Increased subsidy for chronic visit to \$80.</li> <li>Increase in annual cap of \$320/\$480.</li> <li>No change for acute and dental visits.</li> </ul> <b>Tier B (new tier):</b> <ul style="list-style-type: none"> <li>\$50 per chronic visit (annual cap of \$200/ \$300).</li> <li>Coverage for selected dental procedures.</li> </ul>

## About 112,000 chronic disease patients will stand to benefit from the scheme.

The new changes will be implemented from early 2012. Existing PCPS members can continue to benefit from the scheme until their card expires. Those who qualify under the current PCPS criteria and wish to apply for the scheme now can do so. Application forms are available at the CDCs and Community Centres.

### Raising the Medisave withdrawal limits for outpatient expenses under the new Medisave400

To help Singaporeans better manage chronic diseases like diabetes, high blood pressure, lipid disorder and stroke in the outpatient setting, the Medisave withdrawal limit allowable for such outpatient treatments will be raised from \$300 to \$400 per Medisave account, per year. The scheme will be renamed Medisave400.

Medisave400 can also be tapped on for preventive mammogram screening and selected vaccinations. About 112,000 chronic disease patients will stand to benefit from the scheme.

### Given the new MOH announcement regarding PCPS:

As a result of lowering the age limit from 65 to 40, and raising per capita household income, the potential pool of PCPS patients has increased remarkably to 710,000.

We would foresee a lot of GPs will want to consider signing up for PCPS and this is also a necessity in order for the scheme to work to manage the surge in demand.

Dr Koh Thuan Wee (KTW), Chief Operating Officer of Frontier Healthcare Group shares his experience with The College Mirror (CM):

**CM:** What was your experience managing PCPS patients in the past?

**KTW:** Generally, there is no difference between managing a PCPS patient and any other patient.

**CM:** Was there a lot of administrative procedures? Did you have to be subject to audit/ do you need to submit any clinical data?

**KTW:** The administrative procedures are mainly related to online submission of claims and clinical indicators.

**CM:** How was the payment - was it efficient and timely?

**KTW:** The payment was generally timely.

**CM:** Do you foresee any problems in the new PCPS scheme and what could be improved?

**KTW:** There are a couple of important issues to note:

The administrative workload pertaining to online submissions will increase with the volume of patients. It is important to review the online workflow to see whether processes can be made more efficient and responsive. Even minor improvements can make a lot of difference when dealing with increased patient volume.

It should be communicated to the public and the press that GPs who serve patients under the PCPS are not substitutes for public polyclinic services and these GPs should not be expected to charge low rates for their medical services. However, the PCPS will make GP services more affordable and more patients can potentially benefit from care provided by the GPs in the community.

The following article first appeared on the blog, Health Minister Says (<http://mohsingapore.blogspot.com/2011/08/pcps-caring-for-those-step-behind.html>), on 17 August 2011.

## PCPS - Caring for those a step behind

by Dr Chan Teng Mui Tammy

I am a lady doctor running a family practice in the heartlands of Jurong for the past 12 years. I dropped by today to share some thoughts on my journey with the Primary Care Partnership Scheme (PCPS).

### How the "PCPS King" inspired me

I met the "PCPS King" (my nickname for him) during a focus group meeting organised by AIC (Agency for Integrated Care). He was

the first General Practitioner I met that championed how the PCPS scheme was helping the elderly of the lower socio-economic group. He had more than 100 regular patients using their PCPS Card. Many of these PCPS holders were initiated by his Dental neighbour who was also on the PCPS' panel of dentists. The Dental Surgeon had referred PCPS patients to him for medical care.

I had read about how some of our elderly could ill afford dentures.



## The changes are meaningful to family physicians managing the rising burden of chronic medical diseases.

My heart warmed when I realized how there were indeed many that had fallen between the gaps and how meaningful the PCPS can be in helping out the needy.

At that time, my claims for PCPS ranged from insignificant to nonexistent. So, I was peasantry in comparison.

### Spreading the word around

We simplified things for our patients by writing to MOH to obtain the colourful brochures, went over to the nearby Community Centre to obtain a sample application form. We then photocopied many copies, stapled the two together and gave it to the elderly we met on monthly chronic medical care visits. My staff gave them clear instructions to get their children to fill in the forms, informed them how sensitive information like income was required and after filling them all in, to get their children to mail the forms. I'm therefore glad to read that the Ministry is looking into fine-tuning the application process.

Meanwhile, the evident appreciation from the patients makes it all worthwhile. On one notable occasion, a lady returned with her recently arrived PCPS Card. So profuse the thanks, she teared and held my hand in hers. I choked in emotion. To me each happy face was a humbling experience. Despite rising cost through the years, they continue entrusting their healthcare in my hands. It is not easy financially to continue seeing a private GP for regular chronic medications.

### Getting Closer to Family...

When you are someone's family doctor for more than 10 years, it offers you a lot of insights into a family's dynamics. Through the years you also empathise with how they are challenged with stagnating incomes and changing market forces.

Take this family - 12 years ago, he was the sole breadwinner - a 36-year-old lorry driver supporting his homemaker wife, he has two young toddlers and a healthy 65-year-old mother. His take-home monthly pay then was \$2,000. Today, he is 48 years old, still a lorry driver, with two teenagers, a wife and his mother is now 75 years old. He still earns \$2,000 a month.

We gave him the application form twice to apply for his mother. She obtained her card a couple months ago after much guidance. The first time he read the brochures, he discarded the idea. He did not understand the concept of "per capita monthly household income" and felt at \$2,000 a month take-home pay, he was earning too much.

I hardly saw him as a patient except when he was too ill to drive. His blood pressure was always high. We do free blood pressure checks at the waiting area but he does not return to recheck. His wife said he avoided us as it meant spending more money.

Dropping the age to 40 years and increasing the per capita monthly household income criterion had my thoughts about how tweaking the PCPS scheme made sense each time I met families like these. For my patient who is the lorry driver, the enhanced PCPS changes will help not only his mother but also himself who will be eligible under the new changes.

The changes are meaningful to family physicians managing the rising burden of chronic medical diseases. Problems like Diabetes Mellitus need to be well controlled upon the first five to ten years of diagnosis. If we miss that window period, long term risks of complications go up.

Most of us do not become family physicians in private practice only to take care of those who are in good health and can afford to pay. We want to continue taking care of those who need medical care and are a step behind because we know we are strategically placed and trained to help manage their medical problems before they escalate to complications.

I have placed the brains of my clinic assistants in the washing machine regarding this scheme. Initially they ignored me when I told them to get down to helping the old folks to fill in forms. To them it was more work photocopying, stapling, explaining and even more work with internet submissions, invoices, accounting, etc.

However, believe me, if you were to see all my elderly folks' faces when they returned flashing their pretty cornflower card - you will gladly be dishing out forms and doing internet submissions too. What these patients save is very significant to them. Now my clinic girls are keen to help whenever they can. They have probably discovered the priceless satisfaction in helping others.

We are a rapidly progressing society, but should not be so jet speed that we cannot pause a little and give back when we can. I look forward to MOH simplifying the processes for everyone. I am confident the enhanced PCPS will bring us all closer to caring for those a step behind. ■CM

*Reproduced with permission from Dr Chan Teng Mui Tammy and Ministry of Health.*

# Family Medicine Residency Programme and the Future of Family Medicine in Singapore

by Dr Benjamin Lam, MCFP(S), Registrar, Department of Family and Community Medicine, Khoo Teck Puat Hospital

**T**he Ministry of Health, Singapore has adopted the U.S.-styled post graduate medical education where medical graduates undergo training in a more organised and supervised manner, known as the Residency Programme. The key differences are the emphasis on training in the 6 key competencies – patient care, medical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism, and system based practice and the different formative assessments along the way to measure learning and mastery.

The various programmes of the different specialties are offered in phases, and the Phase 1 programmes have started in July 2010. These were: Emergency Medicine, General Surgery, Internal Medicine, Paediatrics, Preventive Medicine, Pathology, Psychiatry (National Programme) and Transitional Year.

Family Medicine is under the Phase 2 programmes due to start in July 2011. The other Phase 2 programmes are: Eye, Ear Nose & Throat, Orthopaedics, Radiology and Obstetrics & Gynaecology. While the change to the Residency Programme is largely a change in training structure and methods for each of the specialties, the change to Residency Programme presents an exciting opportunity for the future of Family Medicine in Singapore. Let me elaborate.

## Family Medicine in the U.S.

The trend towards specialisation started around WWII with the advent of new technologies. Following the war, the hospital specialists had hospital privileges, rising incomes and increasing prestige. As the specialists and the sub-specialists rose in



popularity, the number of physicians in general practice declined.

At the same time, many medical advances were being made and there was concern within the General Practitioners (GPs) that four years of medical school plus a one-year internship was no longer adequate preparation for the breadth of medical knowledge required of the profession. Many of these doctors wanted to see a Residency Programme added to their training; this would not only give them additional training, knowledge, and prestige, but would allow for board

certification, which was increasingly required to gain hospital privileges. In addition, there was a growing disenchantment that the health care was becoming too fragmented and impersonal as a result of specialisation.

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**Essentially, the factors confronting the General Practitioners and the patients here were similar to the ones in the U.S., namely, fragmented care**

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While the American Academy of General Practice (now known as American Academy of Family Physicians) was formed in 1947, it was not until 1969, that Family Medicine (then known as family practice) was recognised as a distinct specialty in the U.S.

## Family Medicine in Singapore

Singapore was not exempted to the effects of specialisation and the Family Medicine movement worldwide, and the College of General Practitioners Singapore (now known as the College of Family Physicians Singapore) was set up in 1971 to develop standards of care in

general practice. Essentially, the factors confronting the General Practitioners and the patients here were similar to the ones in the U.S., namely, fragmented care, the overpowering image of the specialists together with higher recognition and privileges, and the lack of a rigorous training programme comparable to the specialists' training with GPs being able to practice in the private sector even straight after internship as long as they are able to pay up their bonds (to the Government). Considering also that the visits to Polyclinic doctors (General Practice doctors in the public sector)

are sometimes just a formality to gain entry into the subsidised (by the Government) system to see the specialists in the hospital, it is no wonder why the patients have a poor image of the GPs. More often than not, the GPs also lack an assertiveness to keep these patients in the general practice setting, especially when they lack the time and resources.

The introduction of Family Medicine into the undergraduate curriculum in the National University of Singapore (NUS) since 1987, the setting up of Master of Medicine (Family Medicine) [MMed(FM)] programme since 1990, and subsequently a 'finishing school' in the form of a Fellowship by Assessment programme since 2000 probably have improved the understanding and image of the family physicians somewhat, but in terms of parity, it is still tilted very much in favour of the specialists.

### Family Medicine Residency

In terms of policy, the fact that we have a Family Medicine Residency Programme puts us on par with the rest of the specialties. Since all programmes have to be accredited by Accreditation Council for Graduate Medical Education – International (ACGME-I), the public and the rest of the medical profession should be assured that our training programme is as rigorous as the rest of the specialties. Family Medicine in Singapore should also follow the lead to be 'Board Certified' as with the rest of the specialties and even be re-certified periodically as is practiced in the U.S. to assure the public and the rest of the medical profession that Family Physicians continue to be competent and are able to keep pace with medical advances.

The Family Medicine revolution in the U.S. started with the Residency Programme and the early Family Medicine leaders had to fight for such a programme. We need not fight for it here and hence, it would be a pity if we do not seize this alignment towards residency to continue this Family Medicine revolution as what happened in the U.S. I am not advocating a change to the U.S. healthcare system as we know that the Singapore healthcare system has worked so well for us, and in many ways, superior to the U.S. healthcare system. The key difference between the two healthcare systems is in who pays for healthcare and the U.S. system is largely an insurance (third party) system, whereas the Singapore system stresses on an individual's responsibility towards his/her own health by way of enforced savings and co-payments. Therein lies the main area of fight in terms of parity: the patients. Why should the patients be willing to pay more to see a Family Medicine specialist?

### Family Medicine Centre

The Family Medicine specialists in the U.S. take great pride that they practice in a Family Medicine Centre, where they not only espouse the values of Family Medicine but they practice them: Primary,

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of the specialties.**

Personal (Patient Centred), Comprehensive and Continuing care. The physical set-up and work flow in the Family Medicine Centre is patient centred driven. The doctors spend enough time with the patient to address all his/her health needs, including health promotion and disease prevention. The doctor is able to meet the patient's health needs 80 - 90% of the time, having the time and resources to do common procedures without having to refer to other specialists. In short, a one-stop shop for patients, where the Family Medicine specialist is truly a specialist in breadth and an expert in the common conditions. Ideally, the patients

get to see the same doctor each time, with the doctor feeling that these are truly his patients and the need for continuity even when the patients are admitted to the hospital.

When the patients see the value they are getting in seeing a Family Medicine specialist, and proudly declares that his/her doctor is the Family Medicine specialist, our counterparts in the medical profession will acknowledge our roles. As for the government and the press, when they see positive health outcomes, they will recognise our work, thus affirming our place in the Family Physicians Register. Then there will be true parity with the other specialists.

### Moving On

The road ahead will no doubt be tough. How do we set up Family Medicine Centres in the local setting and get all the stakeholders: private General Practitioners, polyclinic doctors and Family Physicians in the hospitals to move in the same direction? We may need to modify or even radically change the current healthcare delivery model and attending systems. But that's not the topic of discussion here.

The point of this article is that if we only try to adapt the U.S. Residency Programme to our graduate medical training and not look beyond, we may miss the opportunity to leverage on all these changes to effect a systemic change that could level up Family Medicine and gain true parity. My fear is that should the status quo prevail and we somehow manage to 'fit' the Residency Programme to our setting, the discordance will show up down the years, when these residents graduate and find out to their dismay and frustration that Family Medicine is not what they envisioned. ■CM

### References

1. Wikipedia: Family Medicine in USA
2. Robert B. Taylor. The Promise of Family Medicine: History, Leadership, and the Age of Aquarius. JABFM March-April 2006 Vol. 19 No. 2
3. A/Prof Goh Lee Gan. From Counterculture to Integration: The Family Medicine Story. Sreenivasan Oration 2001
4. Teck Yee Wong, Seng Kwing Cheong, Gerald CH Koh, Lee Gan Goh. Translating the Family Medicine Vision into Educational Programmes in Singapore. Ann Acad Med Singapore 2008; 37: 421-5

# Invitation to Town Hall Meetings

## 30 Sept & 28 Oct 2011

Dear Colleagues,

Ministry of Health (MOH) will be implementing several improvements and changes to our healthcare delivery system over the next few years. These changes involve the entire healthcare sector including primary care providers in the public and private sectors. They are implemented in the hope of providing a cost-effective and cost-efficient health care system for Singaporeans in the future.

The series of changes started about a year back where MOH revamped the specialist training system and adopted the ACGME. Several specialties started the residency program last year under phase I. Family Medicine residency has just started under Phase II implementation.

Next on the list would be the enactment of the changes to the Medical Registration Act, meaning the full implementation of the Family Physicians Register. There will probably be more policies coming our way in the next few months to years. All these are for the good of our fellow country men.

As such, the CFPS Practice Management Committee would like to take this opportunity to hear your views on these changes and learn from one another. We have planned the following Town Hall meetings:

- A. 30 Sept 2011 (Friday)** 5:15 pm - 6:30 pm CFPS Lecture Room  
Topic: Changes to Primary Care – The Effects on GPs
- B. 28 Oct 2011 (Friday)** 5:15 pm - 6:30 pm CFPS Lecture Room  
Topic: FP Register – What does it mean to us?

The above dates and time might not be convenient for some of us. However, we would still like to hear from you. Please send your thoughts to us via email at [drleongck@cfps.org.sg](mailto:drleongck@cfps.org.sg).

Besides the Town Hall meetings, we have started a trial Facebook group page for the College. If you are keen to experiment the social media with us, please contact me or the secretariat.

Our committee is continuing to hold informal lunches for our colleagues working in the same locality to build closer bonds and ties among fellow GPs. If you are keen to play host to your neighbouring GPs, we would like to do so with you.

We look forward to seeing you at the meetings and to hear from all of you.

Warmest regards.

Sincerely yours,  
Dr Leong Choon Kit  
Chairperson  
Practice Management Committee

# Invitation for Feedback Regarding the College Constitution



Dear Members,

The CFPS 40<sup>th</sup> Annual General Meeting held on 25 June 2011 directed that the College Constitution be looked into with a view to review it if deemed necessary.

You are invited to write in to share your views by 31 December 2011 to:

College of Family Physicians Singapore  
16 College Road #01-02,  
College of Medicine building,  
Singapore 169854

Email: [contact@cfps.org.sg](mailto:contact@cfps.org.sg)

Thank you.

Yours sincerely,  
A/Prof Cheong Pak Yean  
Chairman  
College Constitution Review Committee



# Prescribing in Pregnancy

by Dr Kiran Kashyap, MCFP(S), Editorial Board Member

**T**he risk of exposure of the foetus to drugs is greatest during the first trimester of pregnancy, as this is the period of organogenesis. However, more subtle deformities may develop with drugs taken during later stages of pregnancy also. Hence, there should be an effort to limit the use of any drugs throughout pregnancy. In this era of "googling", our patients have access to detailed product information, often in contradiction to the prescribing doctor's advice. We need to be aware of the safety profile of any prescribed drugs. This article serves to highlight the use of drugs in the management of minor and self-limiting conditions commonly encountered in general practice.

Principles of prescribing in pregnancy:

- Try non-pharmacological treatments first where possible.
- When selecting drugs,
  - o Consider the one with the best safety record over time
  - o Avoid newer drugs, unless safety has been clearly established
  - o Do not assume that over-the-counter and herbal drugs are safe
  - o Check the latest advice from the manufacturer about cautions and contraindications in pregnancy
- When considering dosage and duration of treatment
  - o Avoid first trimester
  - o Use the lowest effective dose
  - o Limit the duration to the minimal period required
  - o If possible, use intermittently rather than continuously
  - o Consider reducing or withdrawing the drug before expected date of delivery

## Pregnancy Category Classification (US FDA)

**Cat A:** Controlled studies in women fail to demonstrate a risk to the foetus in the 1st trimester (and there is no evidence of a risk in later trimesters) and the possibility of foetal harm remains remote.

**Cat B:** Either studies in animals have not demonstrated a foetal risk but there are no controlled studies in pregnant women or animal-reproduction studies have shown an adverse effect that was not confirmed in controlled studies in



women in the 1st trimester (and there is no evidence of risk in later trimesters).

**Cat C:** Either studies in animals have revealed adverse effects on the foetus and there are no controlled studies in women, or studies in women and animals are not available. Drugs should be given only if the potential benefit justifies the potential risk to the foetus.

**Cat D:** There is positive evidence of human foetal risk but the benefits from use in pregnant women may be acceptable despite the risk.

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"googling", our  
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prescribing doctor's  
advice.**

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## Common conditions encountered

### A) Conditions of the Gastrointestinal tract

**Nausea and vomiting** are common symptoms, especially in early pregnancy. Non-drug advice includes eating small meals (high in carbohydrates, low in fat), taking small volumes of fluids frequently.

Pyridoxine (a Vit B6, Cat A) is useful in reducing morning sickness. The use of metoclopramide (Cat B), domperidone (Cat C) and prochlorperazine (Cat C) have not

been associated with a teratogenic effect. While some doctors may be familiar with a common practice of prescribing domperidone (off-label) to increase breast milk production, the product

literature actually states breastfeeding is not recommended for women taking motilium.

**Gastroesophageal reflux and heartburn** are common symptoms in pregnancy. Antacids containing calcium, magnesium, aluminium (Cat A), or alginates are considered safe to use. With histamine H2-blocking drugs, a possible anti-androgen effect has been identified in rats given cimetidine (Cat B). Ranitidine (Cat B) did not show any malformations, and may be considered if lifestyle changes and antacids prove ineffective. Proton pump inhibitors (PPIs) e.g. omeprazole (Cat C) remain a third-line option as there have been animal reports of toxicity with excessively high doses.

**Constipation:** Bulking agents (such as isapaghula husk) and lactulose (Cat B) are not appreciably absorbed and can be used. Bisacodyl (Cat C) would be used third line. Senna (Cat C) may stimulate uterine contractions in the third trimester and is best avoided close to term. Docusate sodium may be considered as a fourth-line agent. Purgatives containing magnesium or sodium salts as the main ingredient may cause electrolyte disturbances and are best avoided. Glycerol suppositories are unlikely to have adverse effects on the foetus.

**Diarrhoea:** Oral rehydrating agents should be used if necessary. Antidiarrhoeal drugs are best avoided as experience is limited. If short-term use is necessary, loperamide (Cat B) may be an option (not recommended in lactation). There is little information on the safety of probiotics, although widely thought (or advertised) to be beneficial.

**Haemorrhoids:** Proctosedyl – avoid prolonged usage. Daflon – avoid during lactation.

### B) Conditions affecting the Respiratory Tract

**Cough:** There is no clear evidence for or against the use of many medications used commonly for acute cough. Expectorants e.g. Diphenhydramine (Cat B)+ ammonium chloride (no categorisation found) and mucolytics e.g. Acetylcysteine (Cat B) are generally considered ineffective. Weak opioids such as codeine (Cat C/D at term), pholcodine (special precaution in pregnancy, though no adverse effects on foetus observed; not recommended in lactation) or dextromethorphan (Cat C, precautions in 3rd trimester) are often used to suppress cough but have to be used with caution in pregnancy.

**Rhinitis:** The older sedating antihistamines e.g. chlorpheniramine (Cat B) are preferred, on the basis of more extensive safety data. The limited experience with cetirizine (Cat B) has not suggested



There is no clear evidence for or against the use of many medications used commonly for acute cough.

any increased risk. However, it is not recommended in the first trimester, and contra-indicated in lactating mothers. Exposure to loratadine (Cat B) was investigated for possible incidence of hypospadias and is not recommended in the 1st trimester and during lactation. Insufficient data exists to assess the safety of fexofenadine, levocetirizine or desloratadine in pregnancy.

Pseudoephedrine (Cat C), a commonly used decongestant, is not recommended in pregnancy or lactation.

### C) Pain Management

Paracetamol (Cat B) is widely used in all stages of pregnancy. Short term use within normal therapeutic doses has not been associated with congenital defects. The combination of paracetamol with other compounds (e.g. anarex) should be avoided in pregnancy, due to uncertain side effects.

Aspirin (Cat C/D in third trimester): Analgesic doses are best avoided due to risk of maternal or neonatal bleeding and closure of ductus arteriosus in utero. Low-dose aspirin is used in the prevention of pregnancy induced hypertension and preeclampsia, and appears not to have adverse effects.

NSAIDs (Cat B/D in third trimester) are best avoided in the periconceptual period as implantation of the blastocyst may be inhibited. Avoid in the third trimester also in view of risk of closure of ductus arteriosus and of bleeding. COX-2

The combination of paracetamol with other compounds (e.g. anarex) should be avoided in pregnancy, due to uncertain side effects.

inhibitors (Cat C/D in third trimester) are not recommended at any stage in pregnancy due to insufficient experience.

#### D) Infections and Use of Antimicrobials

Most upper respiratory tract infections do not require antibiotic treatment. For lower respiratory tract infections, amoxicillin (Cat B), co-amoxiclav, erythromycin (Cat B), cefuroxime (Cat B) or cefotaxime (Cat B) may be prescribed. Clarithromycin (Cat C) and azithromycin (Cat B) do not have the proven record of safety in pregnancy yet.

**Urinary Tract Infection:** A common problem, suitable antibiotics

include Nitrofurantion (Cat B), cephalixin (Cat B), amoxicillin, co-amoxiclav. Trimethoprim (Cat C) is potentially teratogenic in the first trimester.

**Vaginal infections:** Candida – Topical clotrimazole is suitable. Avoid oral anti-fungals, as there are reports of congenital malformations. Bacterial vaginosis: May be treated with oral or topical metronidazole (Cat B).

#### References:

1. Prescribing in Pregnancy, 4<sup>th</sup> Edition. Peter Rubin, Margaret Ramsay. 2008.
2. MIMS.com

# Prescribing in Pregnancy & Lactation

The following was an email sent to Dr Lawrence Ng, a former Council Member of the College, regarding a GP's experience with a common drug used during lactation, and the reply and advice from Dr Lawrence Ng.

The College Mirror thought that it would be timely to review this subject as a reminder for our readers to remain vigilant and to keep up-to-date, especially when prescribing for patients who are either pregnant or breastfeeding.

*Dear Sir,*

*I encountered a patient who related to me the following incident – This patient went to see a colleague and was diagnosed with a straightforward Upper Respiratory Tract Infection (URTI). As she was breastfeeding, she specifically told the GP to prescribe medications which would be safe for breastfeeding. The GP noted this and assured the patient that the medications he prescribed were safe for breastfeeding.*

*Upon arriving home to take her medications, she decided to double-check the list of her medications on the internet and found that one of the medications, Zyrtec (Cetirizine), an anti histamine, is contraindicated in breastfeeding as the drug may be secreted in breast milk. Finding the name of the medication familiar, she looked through her 4-year-old son's medications and found the same medication with a product insert together with the medication stating that the medication is contraindicated in breastfeeding. With this information, she went back to the GP to seek an understanding/ explanation from the doctor. The doctor was adamant that the medication is safe for breastfeeding, as she (the doctor) has prescribed to breastfeeding mothers before and there had been no problems. She also commented that drug companies tend to be more cautious. My patient did not take the medication in the end, despite the re-assurances.*



*I have checked up on the medication, and most references either state that the medication is not recommended or contraindicated in breastfeeding. There is, however, a medical website (Medscape) that states the medication to be used with caution in breastfeeding, as opposed to the outright contraindicated.*

*My question is: If hypothetically, my patient had taken the medication, and then were to present her baby in the Children's Emergency for inconsolable crying/ restlessness (agitation is a possible side effect of anti histamines in a baby), and the emergency doctor after reviewing the medication list that the mother was taking, mentioned that this could be a possible cause; and then my patient went to find out from the drug insert that it is supposed to be contraindicated, would the mother have a case against this doctor?*

*I feel that this is also a learning opportunity for myself (as a GP), whether a doctor's prescribing experience can justify (defensible) should anything unfortunate happen. Thanks.*

*Dr L*



*Dear Dr L,*

*Thank you for your email.*

*I would answer your question in general first. The prescribing of drugs is based on the balance of risks vs. benefits. It should be given only in the patient's best interest. If the drug is likely to harm more than benefit the patient or the baby, then it should not be given.*

*If a drug is to be given, it should be given with a warning of potential side effects to mother and child. It is up to the mother if she wants to take the drug.*

*All drugs have a classification of its safety profile in pregnancy and breastfeeding. It is graded according to the classification which can be found in the MIMS or product insert. It would be prudent if doctors follow this in order to be above criticism later on, should anything happen.*

*You are right that drug companies are very conservative when it comes to this classification as there is a legal liability should the drug be accused of causing a certain complication in the mother or child. Some doctors have chosen to ignore the classification or to "bend it" on a case by case basis. It will then be up to the doctor to defend himself if he is later accused of causing damage to the mother or child due to the drug he had prescribed.*

*As for the hypothetical case, I hope you understand that I cannot give advice on hypothetical cases.*

*I hope this helps.*

*Kind regards  
Dr Lawrence Ng*





# Primary Care Pages

by Agency for Integrated Care (AIC)

**D**eveloped by the Agency for Integrated Care (AIC), the Primary Care Pages (PCP) is an online gateway that hosts a comprehensive range of information and applications for the primary care professionals. Since the portal's launch on 20 August 2011, AIC has continuously enhanced the PCP's features to better serve the healthcare professionals:

## • Highlights and News

Find out what's new and newsy from the various health organisations including Ministry of Health (MOH), Health Promotion Board (HPB), Health Sciences Authority (HSA) and AIC.

## • Initiatives

Update yourself on the latest government healthcare schemes and read about enhancements to the Primary Care Partnership Scheme (PCPS) and Chronic Disease Management Programme (CDMP), and new initiatives of the Restructured Hospitals.

## • Surveys and Forum

Share your views about new healthcare campaigns and programmes and hear what other professionals are saying about them.

## • Educational Materials

Access, download and print past CME materials or patient educational brochures in a jiffy.



Images courtesy of Agency for Integrated Care (AIC)

**Join us at the Hilton Hotel (Panorama 4, Level 24) on 12 November 2011 from 2pm to 4pm to share your views on how the Primary Care Pages can better serve your needs. Visit [www.primarycarepages.sg](http://www.primarycarepages.sg) or call 6603 6860 for more information.**



Family Practice Skills Course #42

# Integrated Eldercare Course

**Sat-Sun, 3-4 September 2011**

**2.00pm-5.45pm**

**Shaw Foundation Alumni House, Auditorium (Level 2)  
11 Kent Ridge Drive, Singapore 119244**

## TOPICS

- Unit 1: Delivery of Integrated Care
- Unit 2: Role of the Multi-disciplinary Team in Integrated Care
- Unit 3: Hospital and Community Resources, Financial Policies and Funding Schemes
- Unit 4: Discharge Planning in Integrated Care
- Unit 5: A Family Physician's Perspective on Prescribing Ambulatory Aids to the Elderly
- Unit 6: Caregiver Support, Training and Enablement

## WORKSHOPS

- Part 1: Case Studies on Complex Medical Case; Discharge Planning Procedural Skills
- Part 2: Use of Aids and Appliances

## SPEAKERS

- |                        |                         |
|------------------------|-------------------------|
| Dr Ng Joo Ming Matthew | Dr Rukshini Puvanendran |
| Ms Faezah Shaikh Kadir | Dr Koh Wee Boon Kelvin  |
| Ms Tan Poh Noi         | A/Prof Lim Swee Hia     |

## DISTANCE LEARNING MODULE

(6 Core FM CME points upon attaining a minimum pass grade of 60% in MCQ Assessment)

- Read 6 Units of study materials in The Singapore Family Physician Journal and pass the MCQ Assessment.

Registration for the event has closed. Sign up now for Distance Learning Module! Distance Learning available via SFP Portal (<http://www.cfps2online.org/>).

Closing date for submission: **14 October 2011, 11.55pm**

This Family Practice Skills Course is jointly organised and supported by the College of Family Physicians Singapore and Agency for Integrated Care (AIC)



*\* All information is correct at time of printing and may be subject to changes.*

## REGISTRATION

INTEGRATED ELDERCARE COURSE  
Please tick (✓) the appropriate boxes

**FREE  
REGISTRATION  
for College  
Members!**

	College Member	Non Member
Seminar 1 (Sat)	<b>REGISTRATION CLOSED</b>	
Seminar 2 (Sun)		
Workshops (Sat-Sun)		
Distance Learning (Journal)	FREE	<input type="checkbox"/> \$40.00
	<b>TOTAL</b>	

- ☐ I attach a cheque for payment of the above, made payable to: **College of Family Physicians Singapore.**\*

Cheque number: \_\_\_\_\_

Signature: \_\_\_\_\_

\*Registration is confirmed only upon receipt of payment. The College will not entertain any request for refund due to cancellation after the registration is closed OR after official receipt is issued (whichever is earlier).

Name: Dr \_\_\_\_\_

MCR No: \_\_\_\_\_

(For GDFM Trainee only) Please indicate: ☐ 2010 Intake ☐ 2011 Intake

Mailing Address: (Please indicate: ☐ Residential ☐ Practice Address)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

E-mail: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

### Note:

Any changes to the course details will be announced via e-mail. Kindly check your inbox before attending the course. Thank you.

Please mail the completed form and cheque payment to:

**College of Family Physicians Singapore**

16 College Road #01-02, College of Medicine Building, Singapore 169854

Or fax your registration form to: **6222 0204**

# Dementia

Sat-Sun, 17-18 September 2011

Health Promotion Board, Auditorium (Level 7)

3 Second Hospital Avenue, Singapore 168937



## TOPICS

- Unit 1: Overview of Dementia & Diagnosis of Dementia
- Unit 2: Behavioural and Psychological Symptoms of Dementia
- Unit 3: Pharmacological Treatment of Dementia
- Unit 4: Family Caregivers and Caregiving in Dementia
- Unit 5: Chronic Disease Management Programme (CDMP)

## WORKSHOPS

- Part A: Cognitive and Functional Assessments
- Part B: Non-pharmacological Management of Behaviours

## SPEAKERS

Dr Nagaendran Kandiah  
Dr Ng Li-Ling  
Dr Mark Chan  
Dr Aaron Ang  
Dr Lim Wee Shiong  
Dr Philip Yap  
Dr Chong Mei Sian

## DISTANCE LEARNING MODULE

(6 Core FM CME points upon attaining a minimum pass grade of 60% in MCQ Assessment)

- Read 6 Units of study materials in The Singapore Family Physician Journal and pass the MCQ Assessment.

Registration for the event has closed.

Sign up now for Distance Learning Module!

Distance Learning available via SFP Portal (<http://www.cfps2online.org/>).

Closing date for submission: **28 October 2011, 11.55pm**

*\* All information is correct at time of printing and may be subject to changes.*

*This training for Family Physicians is organised as part of the CDMP MI initiatives.*

This Family Practice Skills Course is jointly organised by the College of Family Physicians Singapore, Ministry of Health, Institute of Mental Health, and Agency for Integrated Care.



## REGISTRATION

### DEMENTIA

Please tick (✓) the appropriate boxes

	College Member	Non Member
Seminar 1 (Sat)	<b>REGISTRATION CLOSED</b>	
Seminar 2 (Sun)		
Workshops (Sat-Sun)		
Distance Learning (Journal)	FREE	<input type="checkbox"/> \$40.00
	<b>TOTAL</b>	

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\_\_\_\_\_

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E-mail: \_\_\_\_\_

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**College of Family Physicians Singapore**

16 College Road #01-02, College of Medicine Building, Singapore 169854

Or fax your registration form to: **6222 0204**

**^ For Non Members: Please send in cheque payment together with registration form. First 50 doctors eligible to enjoy FREE registration will be notified and refunded accordingly. ONLY registration form and cheque payment received by post will be applicable.**

# Bipolar Disorder & Depression



**Sat-Sun, 29-30 October 2011**

**2.00pm-5.45pm**

**College of Medicine Building, Auditorium (Level 2)**

**16 College Road, Singapore 169854**

## TOPICS

- Unit 1: Role of Primary Care Doctor in Bipolar Disorder & Depression
- Unit 2: Overview of Bipolar Disorder
- Unit 3: Overview of Major Depressive Disorder
- Unit 4: Management of Major Depression
- Unit 5: Management of Bipolar Disorder
- Unit 6: Special Populations

## WORKSHOPS

- Part A: Case studies on Bipolar Disorder
- Part B: Case studies on Depression

## SPEAKERS

- A/Prof Goh Lee Gan
- Dr Chan Hern Nieng
- Dr Lim Boon Leng
- Dr Nelson Lee
- Dr Mok Yee Ming
- Dr Chua Tze-Ern

- **SEMINARS** (2 Core FM CME points per seminar)  
Seminar 1 • Unit 1-3: Sat, 29 October 2011 (2.00pm - 4.15pm)  
Seminar 2 • Unit 4-6: Sun, 30 October 2011 (2.00pm - 4.15pm)

- **WORKSHOPS** (1 Core FM CME point per workshop)  
Workshop 1: Sat, 29 October 2011 (4.30pm - 5.45pm)  
Workshop 2: Sun, 30 October 2011 (4.30pm - 5.45pm)

\*Registration is on first-come-first-served basis. Seats are limited.  
Please register by 21 October 2011 to avoid disappointment.

- **DISTANCE LEARNING MODULE**  
(6 Core FM CME points upon attaining a minimum pass grade of 60% in MCQ Assessment)  
• Read 6 Units of study materials in The Singapore Family Physician Journal and pass the MCQ Assessment.

This Family Practice Skills Course is jointly organised by the College of Family Physicians Singapore, Ministry of Health, Institute of Mental Health, and Agency for Integrated Care.



\* All information is correct at time of printing and may be subject to changes.  
This training for Family Physicians is organised as part of the CDMP MI initiatives.

## REGISTRATION

### BIPOLAR DISORDER

Please tick (✓) the appropriate boxes

	College Member	Non Member
Seminar 1 (Sat)	<input type="checkbox"/> FREE	<input type="checkbox"/> \$20.00
Seminar 2 (Sun)	<input type="checkbox"/> FREE	<input type="checkbox"/> \$20.00
Workshops (Sat-Sun)	<input type="checkbox"/> FREE	<input type="checkbox"/> \$40.00
Distance Learning (Journal)	FREE	<input type="checkbox"/> \$40.00
	TOTAL	

☐ I attach a cheque for payment of the above, made payable to: College of Family Physicians Singapore.\*

Cheque number: \_\_\_\_\_

Signature: \_\_\_\_\_

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First 50 Non Members^  
to sign-up will be  
sponsored by  
MOH

Name: Dr \_\_\_\_\_

MCR No: \_\_\_\_\_

(For GDFM Trainee only) Please indicate: ☐ 2010 Intake ☐ 2011 Intake

Mailing Address: (Please indicate: ☐ Residential ☐ Practice Address)

E-mail: \_\_\_\_\_

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