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Interview with Dr Wong Tack Keong Michael

Deputy Chairman Medical Board, Khoo Teck Puat Hospital

by Dr Michael Yee, FCFP(S), Editorial Board Member

Photo courtesy of Khoo Teck Puat Hospital.

Dr Wong Tack Keong Michael is well known in the College. In fact, his Family Medicine (FM) journey is well-documented in the archives of The College Mirror and SMA News. See SMA News February 2000 (http://www.sma.org.sg/sma_news/3202/feature.pdf), The College Mirror Vol 31(2) June 2005 (http://www.cfps.org.sg/collegemirror/31/312/312_HMDP_exp.pdf), The College Mirror Vol 32(2) June 2006 (http://www.cfps.org.sg/collegemirror/32/322/cm322_interview.pdf).

Dr Wong has been a Fellow of the College of Family Physicians Singapore [FCFP(S)] since 2003 and has served as a Council Member in the 21st and 22nd Councils. Besides teaching in the FM Residency Programme, he has been an examiner for the Graduate Diploma in Family Medicine (GDFM), Master of Medicine (Family Medicine) [MMed(FM)] programmes and as an examiner for our College Fellowship Exit Interview.

CM: Congratulations on your appointment as Deputy Chairman Medical Board (DCMB) of Khoo Teck Puat Hospital (KTPH). What does your new role entail?

Thanks. A/Prof Kenneth Mak is our current Chairman, Medical Board (CMB) for KTPH. A/Prof Pang Weng Sun, our former CMB, is currently the CMB for our upcoming Yishun Community Hospital. There are currently 4 DCMBs working under A/Prof Mak and A/Prof Pang in our CMB office.

Besides assisting CMB in the general management of medical matters pertaining to the hospital, each of us are assigned additional roles: A/Prof Koh Kwong Fah, who is also head of Anaesthesia, is in charge of Education and Professional Development, Dr Wong Moh Sim, also head of Laboratory Medicine, is in charge of Quality & Clinical Affairs, Dr Christopher Cheok, also head of Psychological Medicine, is in charge of Integration.

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If Only Doctors Stopped to Think: Making Charging Transparent to All

by Dr Wilson Eu, Editor

The title is unashamedly adapted from this website: *If Only Singaporeans Stopped to Think* (*http://ifonlysingaporeans.blogspot.sg/2012/05/polyclinic-services-are-heavily.html*) that I found whilst trawling the Net to look for an on-line record. I was looking for the letter a Straits Times reader wrote in the Forum pages about the Consultation charges at Toa Payoh Polyclinic. Mr Lim Ingyew wrote that his wife's consultation fee was $37. National Healthcare Group Polyclinics (NHGP) clarified that whilst $37 was the actual cost of the service; all Singaporeans receive a government subsidy of $26.70 and need only pay $10.30 out-of-pocket. Of course, there are further subsidies when it comes to drugs and investigations. Polyclinics represent terrific value indeed. For many patients, this out of pocket amount has defined the worth of a general practice consultation. In response, many private clinics display rack figures which are comparable to the subsidised fees at the polyclinics. Earnings are derived from investigations, procedures and drug dispensed as well as the low consultation fee. Indeed, sometimes a patient after a consult, who does not require any medication would express surprise at being presented a bill for the consultation: "No medicine also must pay ah?"

Out of pocket physician consultation fee for elderly Singaporeans and children at Singhealth Polyclinics is $5.60. For Nurse Clinician service, it is $6.00. It is good that all Singaporeans are able to access this. But there are difficulties if expectations are formed that that is what our clinical assessment and management is worth.

Previously, in various Ministry of Health's (MOH) feedback sessions, GPs have asked for Polyclinics and SOCs to list the actual cost of the service as well as the amount payable after subsidy. Thus NHGP and Singhealth Polyclinics should be commended for making their charges clear and transparent. Singhealth Polyclinic charges are available here: http://polyclinic.singhealth.com.sg/PatientCare/Fees/Pages/Home.aspx and the NHGP's charges are listed in the individual polyclinic profiles: http://www.nhgp.com.sg/ourclinics.aspx?id=2357

Drug prices at retail pharmacies are also available on-line. Recently, Pharmaceutical Society of Singapore has posted a list of drug prices of common chronic illnesses such as diabetes, hypertension and hyperlipidaemia on their website: http://pss.org.sg/pss/index.php?view=article&catid=139:issue-no-30&id=1418:drug-prices-end-2011&tmpl=component&print=1&layout=default&page=

Indeed there are GPs who charge even less, as another reader Mr Colin Loh writes: (http://www.straitstimes.com/STForum/Story/STIStory_807058.html). There is thus a wide variation in the cost structure between individual clinics. With the demise of the Singapore Medical Association (SMA) fee guideline, setting fees have been even more of an art. Whilst the "free market" has been touted as the most efficient method of setting fees, it requires free flow of information. GPs sitting in their individual consultations rooms often do not have the wherewithal to ascertain the true or fair range value for his labour and the prices of the drugs and services he provides. It would thus be useful to have a study to answer this question in contemporary private practice.

We also need to think through the whole gamut of roles a GP can and should play - from being a physician to research and being a clinical teacher, mentor to our juniors. And of course, our responsibilities to our families and loved ones.

Every GP and FP needs to look at our individual practices from time to time and review our cost structure and the way we charge for our services. With the internet and the proliferation of mobile 3G devices, more information is at our fingertips. Polyclinic charges are now transparent; the MOH subvention programmes [Chronic Disease Management Programme (CDMP) and Community Health Assist Scheme (CHAS)] are going to influence more the manner in which we charge our patients especially those with chronic illnesses. With discussion now on allowing certain patients access to Community Pharmacies, are we prepared to look after our patients under the new paradigm? As about half the local population will qualify for some form of subsidy under CHAS, many doctors must think through these issues

In this issue we will revisit CHAS and encourage our readers to keep themselves informed of this important programme. CHAS and CDMP will form the backbone of right-siting and Integrated Care especially for our Chronic Care Patients.

CHAS as two key features in respect to fees:

- Differentiation between subsidies for acute and chronic consultation
- Recognition that GPs should charge a reasonable amount *above* the subsidy levels depending on the costs of each individual clinic. (http://www.chas.sg/faqpatients.aspx)
  - o Patients are expected to co-pay for their treatment under CHAS. Participating private GPs and dentists will charge CHAS patients reasonable fees for the common medical treatments and basic dental services covered under the scheme.
  - o Patients are encouraged to check with their doctor on the likely fees that they will be charged prior to consultation, as the treatment required would vary according to each patient's condition.

We also welcome Dr Victor Teo as the newest and youngest member of the Editorial team.

CM

this issue >>

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Masterplan and Changes

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

"Insanity is doing the same thing over and over again and expecting a different result."
- Albert Einstein *(attributed but disputed)*

My first experience of a conscious attempt at planning for change was when I was child in Primary 2. It followed the painful experience of being usurped from my position as first in school by my rival classmate. This was the first wake-up call. On hindsight, it was a very valuable lesson to learn that you are not the always the smartest kid in the block. As a snotty little kid, it was hard to take. When the next school examinations loomed, the younger version of me decided that I have to study for exams and I needed a plan. The school timetable was my first encounter with "masterplans" and I decided I needed something like that after school as well. It was great fun drawing up the study plan. You get the feeling that you are doing important work and at the end of it, the sense of accomplishment was quite blissful. It was as if I had already achieved my goal. It was also the first time that I had the illusion that everything will be OK when you have a plan. The first day of the new "me" went pretty well for the first 2 hours until my favourite TV programme came up in the middle of homework. After that, it was back to flying by the seat of the pants and last minute revisions before exams, and of course, the next masterplan.

Now that I am older and hopefully wiser, I am glad to know that I am not the only one who makes plans that don't work out. In fact, I see it all around me usually at a much grander scale where the stakes of failure are so much more severe than not being number one in class. The whole world seems to be doing it on a massive scale all the time. The resources poured into strategy meetings, focus groups, workplan cycles and pilot projects are often monumental compared to what is actually provided to get the real work done. The fact is that planning for change is so much more enjoyable than actually changing. Real change is painful hard work that brings uncertainty. Who needs that when you can just sit in the boardroom and revise organisation charts and doll up pretty Power Points?

So is there really no hope for planning for change? Come to think of it, why change when we are doing alright? Wasn't there another wise person who said, "If it ain't broke don't fix it."?

Recently I was at a Family Medicine symposium in Korea. The theme was on the state of primary care in Korea. A young, idealistic local academic delivered a scathing review of the Korean primary care system. It was the usual story of a privately funded primary care system (>90% of primary care in Korea is provided by the private sector) that is neglected by the government which invest most of the healthcare resources on specialist care and basic science research. The moderator who was his senior and mindful of the presence of an international audience was not amused. He interjected and made a measured defense of the health system, citing the fact that healthcare indices of the country are quite good by world standards notwithstanding the weakness of primary care. During the Q&A session, an innocent young doctor asked the speaker an equally politically incorrect question (at least at a Family Medicine conference). She was puzzled by all the fuss about improving primary care when the health indices are all so good even when primary care was so messed up. All the academics were at a lost for words.

In my mind, I was thinking that the same could be said of the Titanic before it hit the iceberg. Every thing was hunky dory right up till the last moment before steel and ice collided. The engines were humming, the ship was lit up like a Christmas tree and the guests were safe and many sound asleep. In other words, all the KPIs were good. The argument against changing course when everything is presently good just does not hold water.

Nouveau riche countries with an under developed primary care system and a rapidly ageing population is like the Titanic bearing down on an iceberg. The most worrying thing is that people are lulled into a sense of complacency. It is always tempting to just solve problems by doing more of the same. I think there is much similarity with our attempt to improve primary care in Singapore. Now that the masterplan has been drawn up, we seemed to be faltering and going back to the old ways. It is true that no plans should be cast in stone. A masterplan should be a living document. Deviations and adjustments must be made as soon as wrong assumptions become apparent and new changes are detected in the environment. I suppose that's what life is always about - Adapting to change and changing to adapt. That will be my new masterplan… … for now anyway.

CM

"The course has been helpful, I have gained a lot of knowledge, and it has made me feel more confident in dealing with the more common mental conditions like anxiety, depression and even in the detection of early mental psychosis.

– Dr Peter Yeo."

Graduate Diploma in Mental Health (GDMH)

The Institute of Mental Health collaborates with the Division of Graduate Medical Studies (DGMS), Yong Loo Lin School of Medicine, National University of Singapore to offer a part time Graduate Diploma in Mental Health (GDMH). This structured training programme is open to general practitioners who wish to gain insights into human psychiatry and knowledge on mental illness. Through this professional certification, participants will develop an in-depth understanding of the subject and learn the different approaches towards patient treatment. Clinical attachment opportunities will also be available.

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Module 2: Psychosis
Module 3: Mood, Anxiety and Grief
Module 4: Addiction / Personality Disorder
Module 5: Child and Adolescent Mental Health including Learning Disabilities
Module 6: Psychogeriatrics

Registration starts from 2nd May 2012 to 4th July 2012. For more information, contact
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Community Health Assist Scheme (CHAS)

by Dr Kelvin Goh, Editorial Board Member &
Dr Wilson Eu, Editor

The Community Health Assist Scheme (CHAS), formerly known as the Primary Care Partnership Scheme (PCPS), is one of the Ministry of Health's (MOH) programmes to help provide accessible and affordable primary care to Singaporeans.

For patients with chronic conditions, CHAS works in conjunction with the Chronic Disease Management Programme (CDMP). CHAS and CDMP cover the same set of chronic diseases. Whilst CDMP allows a patient to draw upon his/her Medisave accounts (and those of her family members), CHAS is a direct portable means-tested subsidy from the government. This CHAS subsidy of up to $480 per year is available for chronic conditions while each acute visit is subsidised up to $18.50.

From January 2012, the qualifying age for CHAS has been lowered to 40 years old, from the previous age of 65 years old. The new qualifying income criteria are $1,500 per capita monthly household income, raised from the previous $800. For instance, a family of four with a monthly household income of $4,500 (resulting in a per capita monthly household income of $1,125) will qualify for the CHAS.

Let us review the impact:

i) CHAS is essentially a targeted portable subsidy from the government to help needy patients afford private outpatient medical treatments for acute and chronic conditions.

By providing portable subsidies which can be combined with the CDMP, this will defray health care cost for the lower income Singaporeans and help level the playing field for private General Practitioners (GPs).

With both CHAS subsidies ($480) and access to their own Medisave ($400 per year per account), patients are able utilise up to $880 to help defray the costs of chronic disease management. This is a sizeable amount, especially if one is using generic medications.

The provision of $18.50 per acute visit is an efficient and direct subsidy. An average acute consultation bill of $30 to $40 would result in an out of pocket expenditure of between $11.50 to $21.50. This reduces the cost differential between polyclinic care and private GP care. With the premium placed on more personalised care this may hopefully right site acute cases from the Emergency Department and polyclinics to private GPs.

ii) Basic dental services

The scheme covers basic dental services. This helps provide better dental health care among the middle to lower income Singaporeans.

iii) Subsidised referrals to specialist outpatient clinics

For many years private GPs have lamented the need to "generate work" for the healthcare system by loading the polyclinics with referrals simply because referrals by GPs are not recognised by government specialist outpatient clinics (SOCs). CHAS now allows private GPs to refer their patients to subsidised Specialists Outpatient Clinics.

iv) Expansion of CHAS eligible households from
- a per capita income of $800 to $1500.
- qualifying age lowered from 65 to 40 years old.

With the new changes, an estimated 710,000 Singaporeans will benefit from the extended subsidies. As of January 2012 there are over 450 participating clinics. That works out to potentially over 1500 patients on average utilising the CHAS per participating clinic. (http://www.chas.sg/newsarticle.aspx?id=364 / http://www.chas.sg/newsarticle.aspx?id=218)

CHAS is a good scheme in the right direction. As in all new schemes, it will improve and evolve with time only with constructive feedback from all stakeholders. Below are some common issues raised by patients and doctors who have started using it.

PATIENT

CHAS had a successful launch publicity campaign via various media platforms. While most patients are aware of the scheme, the details still need more work.

- **Misconception of unlimited acute visits?**

As shown in Table 1 from the CHAS website (http://www.chas.sg/page_patients.aspx?id=320#chas) it has not been shown clearly that the limit per month is 4. The patient expects unlimited acute visits and at the doctor's end they are worried if the claim will go through as the patients can walk into any accredited clinic.

Table 1: CHAS Subsidy Tiers

CHAS Subsidy Tiers		Subsidy Received		
		Acute conditions	**Chronic conditions under CDMP**	**Dental procedures**
CHAS Subsidy Blue Tier Blue Health Assist card 	Per capita household income is $900 and below or households with no income and live in a residence with Annual Value of $13,000 and below	$18.50 per visit	$80 per visit and up to $320^ or $480^ per calendar year	Up to $256.50 per procedure
CMB Elderly# 				
CMB Disabled# 				
PA# 				
CHAS Subsidy Orange Tier Orange Health Assist card 	Per capita household income is above $900 but less than or equal to $1,500	Not Applicable	$50 per visit and up to $200^ or $300^ per calendar year	Up to $170.50 per procedure, for selected procedures only

^ *Annual subsidy of up to $320 or $480 is given based on the number and severity of one's condition(s).*
\# *The existing Community Medical Benefits (CMB) and Public Assistance (PA) cards will still be accepted by the CHAS clinics until the cards expire.*

Table information taken from Community Health Assist Scheme website (http://www.chas.sg/page_patients.aspx?id=320#chas).
Card images courtesy of Agency for Integrated Care (AIC).

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[from Page 7: Community Health Assist Scheme (CHAS)]

However, the FAQ page, (http://www.chas.sg/faqpatients.aspx) questions 31 and 32 deals with this limit. According to AIC, the basis of this administrative cap of four visits per month for acute patients stems from a concern for patient safety. Those with multiple visits should be carefully reviewed for more serious underlying conditions. This is done through the eCHAS system where the fifth claim onwards is highlighted to the administrators, who are senior-level polyclinic doctors.

- **"You mean I have to pay? Or "How come the amount is more than what I normally pay at the polyclinics?"**

There are patients whose regular GP absorbs the extra charges if they exceed $18.50. This is a legacy issue from the previous more restrictive terms and conditions of the old PCPS. When patients go to another clinic they continue to expect CHAS to cover all acute costs. Some patients also come with the expectations that they will pay the same amount in the polyclinics. Typically, these are the elderly patients who were introduced to the CHAS at the polyclinics.

To help our patients understand the level of subsidies the FAQ page (http://www.chas.sg/faqpatients.aspx) is useful: refer to question 4: How much subsidy will I receive?

- **Despite the huge publicity, there are still many eligible patients who have yet to apply for the CHAS to tap on the government subsidies.**

We can all do our part by introducing CHAS to our patients and educating them on the benefits and limitations of the system.

FAMILY PHYSICIAN

- **More paper work?**

Ease of claims for CHAS is greater than with CDMP. However, solo practitioners who are new to CHAS have to master the necessary administrative skills sets for the CHAS system. Understandably, solo practitioners are upset over more paper work. Some doctors have suggested linking both claims systems together or even for a central facility to process CDMP/ CHAS related administrative requirements.

Currently MOH has simplified accreditation for CDMP and CHAS. Chronic disease data submitted for medisave claims will auto populated back end and thus need not be resubmitted for CHAS.

Ultimately the success of the CHAS scheme is dependent on all stakeholders – patients, doctors and government working together for the betterment of family practice and the health of our patients.

If you require further assistance on CHAS, the hotline for general practitioners is 6632 1199. The 1800 275 2427 contact is the CHAS public call centre.

Besides a hotline for practitioners, AIC has a GP engagement team that aims to provide a hand holding experience for interested practitioners/ newly accredited CHAS clinics. The GP team will visit the clinic to train clinic staff on the administration of the scheme as well as the CHAS Online claims system.

- **Will I actually see sufficient CHAS patients in my practice to make it worthwhile?**

There is a definite huge untapped patient base of 710,000 patients eligible for CHAS. More is being done to spread the word about CHAS. Thus if your clinic is located in a neighbourhood with middle and lower income households, it is very likely that many of your patients will qualify. Practitioners will benefit greatly by introducing the CHAS to their patients. It is a win-win situation for both private practitioners and patients. Simply put, a reduction in out of pocket payment would increase accessibility to healthcare and reduce cost barrier as a reason for non-compliance.

- **I run a busy practice and have no need for such schemes, why should I sign up?**

As future healthcare costs are likely to increase, direct or indirect government subventions are here to stay. These will likely be distributed via existing platforms such as CHAS and CDMP. It is best to be involved early. Furthermore, medicine is not about serving the patient who can pay, most of us possess a deep sense of moral responsibility to our patients and the community at large.

- **Acute conditions are not covered for patients using the Orange (Orange Tier) Health Assist Card**

The main focus of the CHAS in these patients is to extend targeted subsidies for their chronic disease management.

- **How do my patients apply?**

They can pick up a CHAS application form at any Restructured Hospital, Polyclinic, Community Centre and Club (CC) or Community Development Council (CDC). Alternatively, the application forms can be downloaded at: http://www.chas.sg/uploadedFiles/Patients/Apply_Now/CHAS%20Application%20Form.pdf

- **How can I apply CHAS for my clinic?**

If your clinic is already participating in CDMP, you can apply for CHAS using this link: https://www.mediclaim.moh.gov.sg/mmae/CDMPAccreditedClinicPCPSApplication.aspx

If you have yet to register your clinic for CHAS and CDMP accreditation, follow the link below for a joint accreditation: https://www.mediclaim.moh.gov.sg/mmae/ClinicApplication.aspx Or http://www.chas.sg/page_gpdental.aspx?id=168

Ultimately the success of the CHAS scheme is dependent on all stakeholders – patients, doctors and government working together for the betterment of family practice and the health of our patients.

CM

Primary Care Subvention: Making Primary Care More Affordable For All

by Dr Michael Yee, FCFP(S), Editorial Board Member &
Dr Wilson Eu, Editor

It would not be a stretch to claim that Singapore's 3M concept is one of the most balanced healthcare financing systems around. We must now adapt this tertiary care based 3M system for the ILTC (Intermediate and Long Term Care) and primary care sector. This systemic change has evolved into a hybrid consisting of 3M, 2E and 2Cs *. In the preceding months, through various discussions with regards to the Community Health Assist Scheme (CHAS) a new picture has emerged with respect to the relationship between doctors' consultation charges, patients' out of pocket payment and government primary care subvention. The situation is still fluid and various details have not been finalised. Nonetheless, it is useful for all of us to look at what the future medical landscape may look like.

Consultation Fees

Through historical experience, we learn vicariously that it is futile to control healthcare cost by limiting doctors' remuneration. Experience of other countries found that chronic underpaying of doctors resulted in, for example, widespread bribery and unnecessary procedures such as routinely ordering intravenous drips. The reason is simple. Much of the inherent cost of running a clinic service is not within the control of the practitioner. Components of practice cost include (escalating) rental expense, drug cost, salaries, utilities, licensing fees, maintenance of facilities etc. There is no utility in simply trying to talk the primary care market into charging less, when much of the cost structures are a given. Stakeholders need to recognise the constraints of a privately funded medical practice and cannot expect the consultation charges to be stagnant or reduced on command. In an environment of rising cost of living, private GPs' relative standard of living has receded over the past decade or so. The apparent exodus of GPs towards aesthetic medicine may be evidence that the practice of Family Medicine in many cases is not viable, given the current conditions and structures.

Thus, GPs will need to charge accurate consultation fees to reflect the true cost of practice. Current pre-subsidy charges at Polyclinics are now available on line (http://www.nhgp.com.sg/ourclinics.aspx?id=32 or http://polyclinic.singhealth.com.sg/PatientCare/Fees/Pages/Home.aspx) and should serve as a marker of the true fees for delivering a sustainable private health service. Non-subsidised fees at polyclinics for acute conditions are around $37 and for chronic conditions (those seen at the Family Physician Clinics) is around $48. Singaporeans especially the young and those above 65 pay much less (about $6 for acute conditions and about $20-26 for chronic conditions as a result of generous government subsidies).

* **Key**
3M: Medisave, Medishield, Medifund
2E: Eldersave, Eldershield
2C: CDMP, CHAS

Despite the complexities, the future of private primary care must prevail. No country can do without a strong primary health care system, nor disregard the strength of the free market private sector economy.

Managed care companies must play their part and not falsely represent to their clients unrealistically low consultation charges so as to garner a larger market share in an attempt to get more profits.

Out of Pocket

But what is the point of having a safe and accessible primary care system of high quality if the patients are unable or unwilling to pay for the medical services offered? That would be as undesirable as a nationalised primary care system with expected widespread poor access. Unfortunately, there still exist pockets of poorly communicated health financing programmes that have led to a reduced willingness of patients to pay for safe and proper primary care. Anecdotally, segments of the population have found basic unsubvented primary care unaffordable together with the general rising cost of living. Current data has already uncovered high rates of undiagnosed and incompletely treated chronic diseases in Singapore. Yet Singapore's healthcare spending as a percentage of GDP has remained about half of comparable OECD countries. Recent letters to the Straits Times Forum revealed that the public is still unable to accept realistic consultation charges and even nominal out of pocket payment for routine chronic care. Concerted efforts need to be made not just by politicians and health administrators, but also the mass media to work together to ensure the viability of the primary healthcare system. Public opinion must shift from the "cheap is good, even cheaper is even better" notion in favour of the paying for quality concept for the long term good.

The public image of GPs must therefore advance with the rapidly improving standards and capabilities of the Family Physicians.

Subvention to bridge the gap

CHAS fills the gap where patient ability or willingness to pay cannot meet necessary and realistic consultation fees charging. It has given GPs a much needed lifeline that is required to sustain their practices.

The next question is: at what level of subvention to implement? Contrary to popular perception, subvention is not free money, but rather, the funds are derived from government taxes in various forms. A higher subvention is therefore akin to a bigger tax burden and a more extensive intrusion of the government on the healthcare industry. This would theoretically affect economic competitiveness and lead to added economic inefficiencies and further skews the allocation of resources. A high or non-optimal subvention rate is hence not desirable as well.

Conversely, a healthy nation is a public good with much positive externalities. Thus society as a whole would positively respond to investing public resources into healthcare for the good of the public, especially in areas like primary care where it affects long term health outcomes significantly. The under emphasis of primary care viz a viz secondary and tertiary care is already being corrected. Current CHAS subvention allows claims eligibility of up to median household per capita income. The quantum of individual consultation subvention limits and eligibility criteria should be responsively adjusted until real decanting of case loads are established for the average private GP clinics. While the policy to invest more public funds into primary care cannot be faulted, the follow-on question of how to allocate these funds must be considered carefully. Continued majority subvention at the polyclinics would force the CHAS subvention to escalate to keep up. On the long term, polyclinic subvention would have to be means-tested. The successful implementation of the CHAS at a national level has proven that the feasibility of such a means testing scheme.

The systemic approach: Many hands working together

Politicians must make an effort to understand the intricacies of private primary care and ensure effective and quality work is paid for at the right price. The mass media needs to aid the co-ordination of these complex coalitions instead of blindly playing the adversarial role of counter balance, to bring about a smooth reformation of primary care. They must use their influence in public relations for the good of the people. Will the big Pharmas be wise enough to overlook more profits for the sake of humanitarian objectives? We can only hope that their corporate social conscience will be able to match their looming influence. We have not explored if the RHS are even ready to embrace these changes.

Despite the complexities, the future of private primary care must prevail. No country can do without a strong primary health care system, nor disregard the strength of the free market private sector economy. If our collective inertia continues to take things for granted and do not get the trimming right, the proverbial Silver Tsunami will blow us away. Having sailed thus far, it is with quiet confidence that Singapore will get things right.

CM

FAMILY MEDICINE COMMENCEMENT CEREMONY 2012

Saturday, 30 June 2012
2.00pm - 3.30pm
Auditorium (Level 2)

Tea Reception

3.30pm - 4.00pm
Function Room (Level 1)

CFPS 41ST ANNUAL GENERAL MEETING

Saturday, 30 June 2012
4.00pm - 6.00pm
Auditorium (Level 2)

College of Medicine Building (COMB)
16 College Road
Singapore 169854

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Bright Vision Hospital is a 302 bed community hospital under SingHealth which is the largest health care group in Singapore. Clinical services are supported by Singapore General Hospital. We offer comprehensive and holistic care to patients after their discharge from acute hospital with services ranging from rehabilitative care, palliative care, chronic-sick care, sub-acute care and nursing home care.

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Registrar
A recognised basic medical degree and post-graduate qualification such as MMed, MRCP or equivalent which is registrable with the Singapore Medical Council and minimum 3 years' experience as Medical Officer (post-housemanship).

Associate Consultant
In addition to the above, applicants must have the FCFP or equivalent qualifications certifying completion of advanced family medicine or specialist training.

Please write or email with a detailed resume to :

The Human Resource Department
Bright Vision Hospital
5 Lorong Napiri
Singapore 547530
Email : recruit@bvh.org.sg
Website : www.bvh.org.sg

(from Page 1: Interview with Dr Wong Tack Keong Michael, Deputy Chairman Medical Board, Khoo Teck Puat Hospital)

As for myself, I am heading the Family & Community Medicine Department, and CMB has tasked me to look after Primary Care for the northern health cluster. We'll have to look for opportunities to collabortate in projects with our fellow GPs and Polyclinics in the north. Hopefully, primary care in the northern cluster would be seamless and integrated for our patients.

CM: What value will you add to your new position?

Well, I have been an MOH MO, from the pre-cluster era, a private GP running a solo GP practice for a group for 5 years and then returned after clustering to work for SHP (Singhealth Polyclinics) for 8 years till I joined Alexandra Health System (AHS), when it was still at Alexandra Hospital (AH) in late 2008.

I had the privilege to also work on a PT basis in MOH PCC under Dr Ho Han Kwee, for about 2 years while working in SHP. Now I am back in the hospital.

AHS being the northern health cluster appointed by Ministry is hoping to find ways to engage and integrate healthcare in this region. Our primary care landscape is very unique and different with both the public and private sector playing key roles. We all need to discover a primary care program that is truly seamless for our patients and a system or processes that work for all the primary care players in the communities.

The end in mind will be to see the Regional Health System, private GPs, Polyclinics and other community providers working together for the best outcome for our patients and their families.

I am glad MOH has pushed for the primary care masterplan and is enhancing our Community Health Assist Scheme (CHAS) programme. The latter programmes are still in the early phases, we need everyone in the system to make it work, for our patients really.

It's also exciting to work with Health Promotion Board (HPB) and other partners in the area of health promotion and preventive medicine. Khoo Teck Puat Hospital is also a Health Promoting Hospital (HPH). We are part of a World Health Organisation (WHO) worldwide movement of Health Promoting Hospitals and Health Services. We have recently formed our local network comprising of other public hospitals and polyclinics in Singapore. HPB is currently our network leader. Being a HPH, we want to not only be the best in disease curing and treatment like any hospitals, we also want to be effective in disease prevention and health promotion.

I cannot say I have done it all and experienced it all. No one is completely prepared for the job at hand. Moreover, the job at hand for primary care is ever changing and the strategy evolving. My team will need the support from our management, fellow colleagues both in our cluster and also in the private sectors and public institutions to make anything work.

CM: How did your training or experience as a FM practitioner help you with this new role?

Well, I have mentioned my experience above. I have functioned in almost every role a FP could possibly have, except acute FM in Family Medicine & Continuing Care (FMCC) in Singapore General Hospital (SGH) and step-down care in the Community Hospital.

The FM Hospital is a very exciting development. Kheng Hock and his team are playing a key role in care transitions. This movement will grow and we need to watch this space! Another area which I have not worked in would be the Community Hospital. Boon Yeow and Chi Siong and other FPs doing work in these areas in our various Community Hospitals have my admiration. They are contributing tremendously to the community care needs, playing a key role in our intermediate and long term care sector.

I have no regrets going back to do the MMed(FM) via Programme B and progressing on to exit with my Fellowship in the early 2000s. Both these 2 major academic achievements and subsequent postgraduate diplomas in geriatric (NUS) and diabetes medicine (Cardiff) prepared me well for the professional aspects of my current work.

Over the years, my appointments and roles in the various institutions had opened the way for me to take on clinical leadership appointments. That's how I started to learn on-the-go and from my superiors about leadership and general management.

I recently completed and will be graduating from SMU after completing the eMBA. This was made possible by a generous sponsorship from AHS and most importantly, moral support from wife to embark on this course!

We all need to discover a primary care program that is truly seamless for our patients and a system or processes that work for all the primary care players in the communities.

Now that I have both clinical and some administrative training and exposure, hopefully, I could over time, strike a good balance and walk the straight and narrow path of being a competent clinician and effective administrator, a clinician leader.

Sir Ken Robinson, the well known educator and TED speaker, mentioned the 3 roles of education, ie. first for self or individual, to develop talents and sensibilities, second economic, to provide the skills required to earn a living and be economically productive and lastly, cultural, to deepen our understanding of the world.

If I may add my own fourth role and that is, to do what we can for the betterment of our fellow man... our patients, their families, our friends, colleagues and folks which God sends along our way.

Our FM folks who are running private clinics or working hard in the polyclinics are doing a fantastic job. The care of the individual patient is what we are well-trained for.

The challenge I face in this role is the need for a FP to look beyond the single patient, to families, and community groups and the cluster region; Population Health is what FPs, at least for myself, will need to grasp and understand. I reckon we might be crossing into the Public Health Practitioner's game... but seriously, I would encourage anyone to take up the challenge to be well-trained both as a PH and FP... you will be comfortable taking care of a population down to the single individual... panning in and out very comfortably, like Google Map, without losing perspective and focus.

CM: What are the 3 most important tasks ahead?

The 3 important tasks ahead for my role as Primary Care coordinator:

(A) The northern cluster needs a primary care plan that woks for the patients and their families... what do the man in the street, staying and working in the northern region needs in primary care? I need to find the right partners with the same goal to come together to make our good primary care work even better!

(B) Thereafter, I need to take this plan and link it up with our cluster health plan. This integration must work for our patients both vertically, ie. from community to primary to secondary care and back, but also horizontally moving among all the primary care providers within the community. Eg. the polyclinics and fellow GPs. There are also other key players like our cluster Community Nurses under our Aging and Dying in Place Program (ADIP) headed by Senior Consultant Geriatrician, Dr Wong Sweet Fun and Our Chief Transformation Officer, Mr Lau Wing Chew. The ADIP is another piece of exciting news for another article! We are working out to see how GPs could be involved in this very interesting program. More later on! These executions would mainly concern service provision and thus would carry a fair amount of process and care models. We also need to think through carefully on the funding aspects too. The latter has sometimes been a bugbear and challenge. But I am hopeful we can work things out in the long term.

(C) I hope to build strong alliances with my fellow GPs in this region and also with the polyclinics in the north through relationship building on mutual trust and respect. I am aware of the grievances, and mistrust of the system some of us may have developed over the years from bad experiences and hearsay. I do hope the projects our cluster plans to roll out will hopefully bring our primary care partners closer together. Let's work for the patient, that's our common ground. It will take the load off having to look at our differences. If we focus hard enough on the patients, their outcomes will not only be good, they may even become our advocates and supporters as we work with MOH to improve primary care!

Well, Einstein said, "Not everything that can be counted counts and not everything that counts can be counted... would trust and respect be such? But we need to start somewhere.

Apologies for belaboring the last action point... I am building a team to take care of Community/GP engagement. Skeletal staffing at the moment but I am confident we will build a great team and put in place an appropriate cluster GPs support structure as our engagement plan and strategy evolves.

CM: Are there any projects involving Community health that you are doing now?

You must do an article on ADIP which I mentioned above. It's the brain child of Sweet Fun and Wing Chew whom I mentioned above. In short, we are hoping that some of the cases managed by the community nurses could be linked up to GPs located around these patients to manage for the long term. This way, we can keep care in the community and minimise unnecessary ED visit or hospitalisation. We'll share on the details once our strategy and funding are finalised.

(continued on Page 14)

(from Page 13: Interview with Dr Wong Tack Keong Michael, Deputy Chairman Medical Board, Khoo Teck Puat Hospital)

We are also reaching out to the community through health screening at community events. We are hoping also to work with special groups from the mosque and also workplaces in the northern region to promote health. These latter groups are interesting as they are placed together due to social or economic reasons... and they spend lots of time together. It would be key to impact their health at their meeting places. Imagine the impact this would have on the communities should every workplace and mosque or religious group promote health and fittness! Population Health in action!

CM: How did you get to where you are now?

It all started when I left private practice and returned to the polyclinics. My former bosses gave me lots of opportunities to practice and develop myself in management and leadership.

I came over to AHS to work with then CMB A/Prof Pang Weng San to start a new clinical department, Family & Community Medicine. The other key task was also to look at primary care for the cluster.

There was even greater exposure in management and leadership in my current role. Not to mention excellent role models in my former CMB and CEO, A/Prof Pang and Mr Liak Teng Lit, who has since moved on to be our Alexandra Health System Group CEO, and my current CMB A/Prof Kenneth Mak and CEO Mrs Chew Kwee Tiang. I am extremely grateful for their investment in my development and the tremendous amount of opportunities they have given me.

Management and leadership is a journey, one hopes to do better today than yesterday and we look forward to tomorrow for another opportunity to grow. Just like a good doctor keeping current and doing CMEs, a clinician leader should never be a finish product!

CM: How would you respond to my provocative statement that you seem to have abandoned Family Practice for the proverbial dark side? Has anyone asked that question yet?

Light is not the absence of darkness but Darkness is the absence of light! There is no darkness where light is! So we all should work and walk together in the light!

How do we shine?

- Be involved in hospital admin, do not shy away... ask questions and ask for help!
- We love to run back to our comfort zone... our consultation room! Yes, do that, it "cleanses us" and keeps us in perspective as FPs... we are here for the patient!
- Teach FM! Build into the professional lives of the younger FPs… thus you will ensure that we "breed" right and more light!

I believe all sides are striving for the best outcome and experience for our patients! We must not stumble each other in the process!

CM: Advice to Family Physicians in the light of the progress in Family Medicine and the healthcare scene?

Speaking for myself, I recall sharing with some of my GP friends back in early 2000, they were curious why I left for polyclinic. I was excited because the clustering just happened and I had the MMed(FM) under my belt and was embarking on the Fellowship... wow, I want to change the world, man! But how has the primary care world changed and how it has changed me.

Night clinic came and went. The 2 clusters have become 5 and growing? The FPs are moving out to do work where they previously were not involved. FM residency training. New medical schools with strong emphasis on community care. MOH Primary Care Masterplan, MC, FMC, CHC, CDMP from Medisave, PCPS grew up to become CHAS! Most of us would have been impacted in some ways. Some of us may have chosen to ignore and carry on to do our work. I do understand.

I don't want to sound cliche and say Change is the Constant… change is good and hopefully change takes us to a better state for FM. Perhaps we should have our Family Medicine Master Plan some day! But I am concerned about the "unknown" or "known but no ability to influence" variable that might throw us off in our attempt to progress FM, destroying our already fragile trust and respect for the system and but hopefully not each other.

Just some general observations:

- Continue to learn and train ourselves up... bearing in mind why we educate ourselves, the 4 roles I mentioned above.
- Train the next generation of FP well, this way, the subsequent generation could only get better and better...
- Stay true to our calling as FP, we are our patient's best advocate.
- I have intentionally stayed cleared about financial issues... but I recall what my FM mentor A/Prof Goh Lee Gan said in one of his many wise sayings... "Take good care of the patient, and they will take good care of you"... I don't think A/Prof Goh was referring to care for us in the form of eggs and chickens and sacks of rice...
- Work with the Ministry, work with us from the cluster, work with EACH other! We need to work in teams, real or virtual!
- Lastly... 以病人在中心，让病人在心中!

Be Patient-Centric in our processes but let the patient be in the centre of our caring heart! Subtle difference when written in Chinese, but a huge chasm of difference in the eyes of our patient. In all our attempts to make FM work, we need to keep this to heart... whether it's for one patient or for a whole community!

All views expressed are personal and does not represent the views of the organisation.

CM

Re-visiting the Early Years of the Master of Medicine (Family Medicine) [MMed(FM)] for Private Practitioners

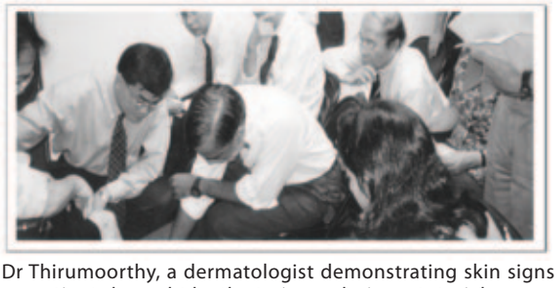
by Dr Lim Lee Kiang Julian, FCFP(S)

On 30 May 2012, the current 2011 – 2012 intake of Master of Medicine (Family Medicine) [MMed(FM)] Programme B trainees were given the rare privilege to visit the birthplace of the programme at Cheong Medical Clinic for the course debrief.

The clinic is located in a conserved shop-house at Jalan Jurong Kechil. A/Prof Cheong Pak Yean shared with them the historical significance of the building during the Japanese occupation in World War Two. Dr Lim Lee Kiang Julian then narrated the history of post-graduate Family Medicine training for the Masters for private practitioners. In 1992, the clinic hosted the two-week GP posting for Ministry of Health (MOH) Family Medicine (FM) trainees. Soon another group of doctors, those who left the public service but who were still keen to sit for the MMed(FM) examination joined the weekly tutorials organised by A/Prof Cheong. Resource persons for the sessions included the late Prof Wong Poi Kwong – the former Dean of the Faculty of Medicine and Dr Thirumoorthy, now Associate Professor in the Duke-NUS Medical School.

Group photo of 2011 – 2012 intake of MMed(FM) Programme B trainees.
(Photo courtesy of Dr Lim Lee Kiang Julian.)

The tutorials were conducted by resource persons such as the late Prof Wong Poi Kwong.



Dr Thirumoorthy, a dermatologist demonstrating skin signs on patients brought by the trainees during a tutorial.

When the Private Practitioners' Stream (PPS) was officially launched in 1995, the meeting room above the clinic became its "club-house". Dr Lim showed them a picture of the official opening of the Graduate Family Medicine Centre (GFMC) on 9 Oct 1998. This occasion was also the inaugural session of the Fellowship [FCFP(S)] programme offered by the College but held at GFMC. Prof John Murtagh, who is renowned for his Family Medicine textbook and other Family Medicine luminaries graced the occasion.

Of note in the picture were the symbolic "3 Things" in the picture frame (that Dr Lim was holding) and the three plaques above the notice board that exhorted "Cover potholes always. Consolidate plateaus often. Conquer peaks sometimes". To give a sense of the heady, can-do spirit of that time, we reprint a truncated version of the poem that was recited during the opening ceremony.

Official opening of the Graduate Family Medicine Centre (GFMC).
Standing (Left to Right): Dr Swah Teck Sin, Dr Siaw Tung Yeng, Dr Paul Goh, A/Prof Shanta Emmanuel, Dr Julian Lim, Dr Kwan Yew Seng, Dr Tan Chee Beng, Dr Lim Kim Leong, A/Prof Cheong Pak Yean.
Seated (Left to Right): Dr Lam Sian Lian, Prof Lewis Ritchie, Dr Alfred Loh, Prof John Murtagh, A/Prof Goh Lee Gan

A truncated version of the poem that was recited during the opening ceremony of the Graduate Family Medicine Centre (GFMC) on 9 Oct 1998.

Let's give Goh Lee Gan a surprise says Dr Cheong
And let him unveil this work of yours
And by the way explain the meaning
And the thinking behind The 3 Things

Oh what to say, Oh what to say as I drove down Orchard
Fill the valleys of your knowledge says Dr Cheong
Consolidate and recapture the skills of the GP says Murtagh
Help specialists by allowing them to concentrate on their peaks says McWhinney

Murtagh mentioned his masquerades and pitfalls
And the skeleton hanging from his wall
And Ritchie spoke of the 3 paintings
Which reminded him of precious things

The first was a cottage, his very first home
The second was a break in the coastline, knowledge gaps to be bridged
Bringing in the fish was the third
Like knowledge, accumulate with pleasure

The cottage was without a tap nor a toilet
In humility remember where we came from
When asked how he got the department to grow
Kindness was what he said, sounds like Prof Goh

So here we go - The spade to cover the potholes of knowledge along the paths we walk everyday
The rake to consolidate the plateaus of skills to better manage the difficult problems we often face
And like mountain climbers who plant flags, we would plant the spike like satisfied gardeners
Whenever a peak is conquered - they are there. It is up to us to find it

So here we have it - **The 3 Things**

Cover Potholes Always
Consolidate Plateaus Often
Conquer Peaks Sometimes

The stewardship of the programme was handed over to Dr Lim Lee Kiang Julian in 2004 and teaching was done in the College. Another 4 years passed before the GFMC found another home. With some creative renovations to his clinic, Dr Julian Lim was able to conduct the clinical tutorial at Newlife Family Clinic & Surgery at Teban Gardens. Trainees sit around collapsible tables in the clinic's waiting room and can view the proceedings going on in the consultation room transmitted via a slide and sound projector in real time.

A clinical tutorial conducted at Newlife Family Clinic & Surgery at Teban Gardens.

(Photo courtesy of Dr Lim Lee Kiang Julian.)

2006 saw a name change from PPS to Master of Medicine (Family Medicine) [MMed(FM)] Programme B, though still catering mainly to those from the private sector, started taking on doctors coming from the polyclinics who had missed out on the MOH scheme (Programme A). As of June 2012, since the name change in 2006, of the 104 successful candidates, 31 came through the MMed(FM) Programme B route.

Although MOH adopted the ACGME-I residency programme in 2011, Programme B continues to train and qualifies candidates to sit for the MMed(FM) examination for those who had "missed the boat" for a variety of reasons and should continue to do so. Through the years, we have seen a constant stream of family physicians who have obtained their Masters degree through this programme and many have moved on to assume leadership positions throughout the healthcare system. Try to match the names of the graduates on the two boards to the appointments below.

As of June 2012, since the name change in 2006, of the 104 successful candidates, 31 came through the MMed(FM) Programme B route.

Adjunct Assistant Professor of University
Clinician Lead for Overseas University
Consultant Family Physician in Community Hospital
Consultant Family Physician in Nursing Home
Consultant Family Physician in Public Hospital
Council Member of College of Family Physicians Singapore
Deputy Chairman of Hospital Medical Board
Director FMRAC MOH
Director of Polyclinic
Executive Director of Professional Body
Former Chief Airforce Medical Officer
Group CEO of Private Hospital Group
Head of Department
Medical Director of Hospice/ Nursing Home
Programme Director of Post-graduate Training
Programme Director of Residency Programme

Almost two decades have passed since the beginning. The spirit and ethos of these pioneers should continue to shine and shine brighter in the present and future generations of MMed(FM) Programme B.

CM

Engagement for Primary Care Reform - Town Hall Meeting on 19 May 2012

In April and May, Ministry of Health (MOH) met separately with the Councils of Singapore Medical Association (SMA) and College of Family Physicians Singapore (CFPS). Discussions centered on ways to improve affordability of care of chronic diseases to our patients. Among the many issues discussed was the idea of setting up community pharmacies that will dispense medicine at subsidised rates for eligible patients that are seen in private GP clinics.

As this initiative is likely to impact the practices of many of our members, the CFPS Council felt that it was important for MOH to receive feedback directly from our members. A town hall meeting was organised by our College's Practice Management Committee on 19 May 2012. This was attended by more than 50 doctors who came to listen and provide feedback to officers of the Primary & Community Care division, MOH. Senior officials from the Ministry as well as many physician leaders from the professional bodies were present.

There was widespread agreement that communication between the policy makers and the GPs is crucial as we work towards closer partnership between public and private sector in our common goal of delivering first world primary care to our patients.

A healthy two-way dialogue ensued, centering on the rationale of and issues related to the implementation of the Community Health Assist Scheme (CHAS). Various ways to improve CHAS were discussed. One major challenge was the difficulty of finding a way to dispense subsidised medication to CHAS patients. There was widespread preference for MOH to look into allowing these drugs used by CHAS patients to be dispensed at the private clinic dispensaries with appropriate audit measures instead of compelling patients to fill these prescriptions at another site.

The overall impression was that MOH was willing and indeed eager to seek the views of all stakeholders to optimise the way primary care is delivered. There was a palpable reciprocity from the private primary care sector to play its part to the fullest. The level of interest among GPs is high. There was widespread agreement that communication between the policy makers and the GPs is crucial as we work towards closer partnership between public and private sector in our common goal of delivering first world primary care to our patients. CM

Musings on... Being a More Productive Doctor

by Dr Victor Teo, Editorial Board Member

Just the other day, I was tasked by the Editor of The College Mirror for a light-hearted article. That was on one of the many afternoons on which I was ruminating on how best to *(what's that catchphrase nowadays, ah yes)* "increase productivity" in my Family Medicine practice. For some reason, I thought that the two things dove-tailed nicely, and this is the product of that momentary lapse of good judgement.

Since writing things down helps to crystallise thought, I considered that the first order of business was to list the various **widely discredited schemes** (some dodgy, some not), of others who have gone before me.

1. **Sell cough mixtures to all comers,** over and under the counter, perhaps with a take-away window enabling "patients" to snatch up bottles of the good stuff at a running pace if they so require. The latest twist is to be a distributor.

This one is easy. A casual scanning of the printed news would reveal a seeming steady stream of medical practitioners being brought to book for this. (The fact that the vast majority of Family Medicine practitioners do not, in fact, condone nor partake of this practice is conveniently left unmentioned in the said news. But that would be an unfunny article in of itself, for another day.)

2. **Sell sedatives aka sleeping tablets, like adult candy.** You know, like that lady blindfolded and holding a pair of scales at the Supreme Court *(what's up with that really? See no evil, hear no evil? How about plausible deniability of responsibility? Hmmmm)*.

Refer 1 above. Moreover, I hold the gift of sleeping easy at night MYSELF at high regard.

Besides which, the relevant authorities may put in place a system of monitoring prescription of sedatives whereby physicians will update a central registry whenever they prescribe certain sedatives. But hang on, if rogue practitioners are content to break the rules and prescribe sedatives excessively, might it just be a little too much to expect that they would put in that extra effort to incriminate themselves by updating the central registry conscientiously and in a timely manner?

Would this also mean that it would actually be the ethical, law-abiding practitioners (who would not, in the first instance, be prescribing sedatives indiscriminately) who are saddled with extra administrative chores?

**Takes in deep breath* Hmmmmm.*

3. **Subutex.** Ok, let's not go there. Except to say, that in any transaction where one party loses, the counter party would be the winner. It must be nice being a big pharma company, one day touting a wonder drug for treating drug addicts *(laudable objective, isn't it?)*, and yet finally, not having to take any responsibility at all when things end badly. Ka-ching!

4. **Insurance and Managed Care Schemes.** Kor! Why not?!?

I still remember that day quite well, when a nice gentleman from a Dubai-based *(!)* medical marketing company came into my consult room to inform me that I could, in fact be earning more, perhaps much more than I am currently.

By now, I am starting to realise that there are many wide and seemingly enticing detours on my journey as a Family Physician. And only one straight and narrow path that is truly meant for a Family Physician.

This is due to the fact (as he illustrated) that the Dubai-based company holds a ready pool of local patients, all ready to make a beeline for my practice, if only I would sign onto their health management scheme.

There was a short few seconds where I entertained the fantasy of finally being able to afford that luxury German limousine in place of my Japanese family saloon.

Nevertheless, good sense prevailed and I quickly realised that there are various minor detours on this route to that German marque. One, total charge for each patient is capped at a rate that would be far less than my current average. Two, the esteemed Dubai-based company takes a substantial cut of the already nano-size amount. Three, I would have to do substantially more work, since I would have to deal with the admin hassles of submitting claims, monitoring payment, answering managed care's queries on medication and treatment for managed care patients.

The nice gentleman tried one last try, suggesting that since there are lull-times during my clinic sessions, it would be good that I earn some money (rather than earn no money) from his managed care patients during those hours. Fortunately, the high regard that I still hold for the medical profession and my fellow medical practitioners precluded me from such persuasion. Not least, I did not think that it would befit distributive justice that my private paying patients should cross-subsidise the profits of managed care companies.

I quickly cut short the encounter and succeeded in squelching my inner pyrotechnics as I verbally deposited the nice gentleman's behind on the five-foot-way outside my clinic.

5. **Aesthetic medicine.** Why not indeed?

Alas, the easy money of such practices is not destined to meet at the intersection of my bank account.

My excuse is that the Palm Reader had solemnly pronounced that any little money that I have, or will have, has to be hard-earned. Not through any streak of luck at Toto, or 4D, or yes, not via aesthetic medicine either. *(Leave aside the small matter that I do not believe in fortune telling, and have thus, not in fact, consulted any Palm Readers.)*

Perhaps more importantly, I do not, in fact, possess any suitable character traits *(I have a mirror in my car)* for such practice. Being naturally bereft of said talents needed to win "clients" and influence people.

6. Randomly pick any of my **corporate accounts**, call ALL their employees down for flu vaccination without exception *(patients who have flu vaccine allergy MAY be exempted from the shots, but then I have adrenaline injections in my clinic)*. If the patients ask, just inform them that flu vaccination is mandatory for them. Final important step, of course, is to bill the vaccinations promptly to the company and let them know that flu vaccination is mandatory, citing some obscure legal provision or cite medical imprimatur.

The only little things stopping me from implementing this scheme were:

i. The fact that I have no corporate accounts.
ii. I have not had my sense of medical ethics excised yet.

7. **Advertising, promotion, discount schemes.** Only difficulty is that my singleton clinic cannot afford a marketing department.

By now, I am starting to realise that there are many wide and seemingly enticing detours on my journey as a Family Physician. And only one straight and narrow path that is truly meant for a Family Physician.

Was it not an illustrious medical forebear, a luminary who said that the first and foremost thing for a physician, is to take care of his patient and that they will then naturally take care of him? Another thought also comes to the fore, that happiness is not found in external things, but within a person and also greatly intertwined with this thing called "contentment".

Wait, I notice the Editor drives a bigger Japanese vehicle than me, yes an MPV, but technically still a bigger car than my Japanese saloon. I must buttonhole him one of these days on this issue of "increasing productivity". Hope springs eternal.

"Either this man is dead or my watch has stopped."
- Groucho Marx

CM

Really Doc?! Medical Myths, Facts and Tips

Book by Dr Bina Kurup

by Dr Wilson Eu, Editor

It has happened often enough. An adult patient consults you; he is obviously well educated, dresses smartly and carries himself with confidence. Then he leans forward and asks "Doctor, was this because of the "heaty" mango I took last night?" Oh o, time to put down the pen, back track a little to make sure our patient and you are on the same page.

There are still widely held beliefs that illness and disease are caused by imbalances in "heat" and "wind". As Dr Bina Kurup writes, "... most of these are harmless and just require simple explanation… there are some practices that can actually be harmful or detrimental to one's health".

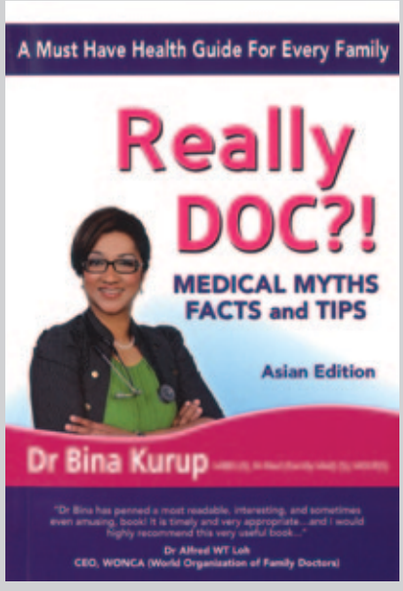
This book does not explore these myths and beliefs which would be fascinating. It acknowledges their presence and the likely points they are appear in a person's health journey. So, one would not get the answer why the "heaty" mango was not cause of this patient's illness.

Written in clear and uncomplicated language, the book sets out the basic facts behind some common illnesses and some self-care measures that all our patients can read to help themselves. There is also a "red-flags" which suggests situations where are patients really should come for a consultation.

There is a call in the final chapters of the book for patients to list down their concerns regarding their presenting problems and also some of the details that we, the health care provider, would be looking out for, and I think this is a useful and constructive way to educate our patients to get the most out of every visit to a clinic.

So this is a book for our patients. Avail yourselves to peruse the copy available at the College library.

CM



Written and self-published by Dr Bina Kurup, the book **Really Doc?! Medical Myths, Facts and Tips** is available for purchase at all major bookstores.

Family Practice Skills Course

Update on Function & Disability in Primary Care

The College of Family Physicians Singapore would like to thank **Centre for Enabled Living (CEL), Ministry of Health (MOH), Ministry of Community, Youth and Sports (MCYS)** and the Expert Panel for their contribution to the Family Practice Skills Course #49 on "Update on Function & Disability in Primary Care", held on 26 - 27 May 2012.

Expert Panel:
Dr Chong Shang Chee
A/Prof Winnie Goh
Dr Sylvia Choo
Dr Chan Kin Ming
Dr Peter Lim
Dr Ng Yee Sien
Ms Alice Chin
Mr Darren Yeong
Ms Yee Yiling

Chairpersons:
Dr Marie Stella P Cruz
Dr Rukshini Puvanendran

Asia Pacific Primary Care Research Conference 2012

1 - 2 December 2012
National University of Singapore
Block MD6, Centre for Translational Medicine
14 Medical Drive, Level 3 (LT 36)
Singapore 117599

Plenary Speakers

Plenary Lecture 1: Innovative Interventions for Anxiety and Chronic Stress in Primary Care

Prof Wong Yeung Shan Samuel
The Chinese University of Hong Kong

Prof Samuel Wong completed the Doctor of Medicine research degree at the Chinese University of Hong Kong. He is the Director of the Diploma in Family Medicine and the Master in Family Medicine of the School of Public Health and Primary Care, the Jockey Club School of Public Health and Primary Care.

Plenary Lecture 2: Setting up Family Medicine Research Network

A/Prof Ng Chirk Jenn
University of Malaya

A/Prof Ng Chirk Jenn is an Associate Professor in the Department of Primary Care Medicine, University of Malaya, Malaysia. He is the editor of the Malaysian Family Physician and chaired the Malaysian Primary Care Research Group 2010 – 2012.

Plenary Lecture 3: Health Services Research

Prof David Matchar
Duke-NUS Graduate Medical School Singapore

Prof David Matchar is the Director of Health Services Research (HSR) and a Professor in the Department of Internal Medicine (General Internal Medicine) at Duke University Medical Centre. He is also working with Academic Clinical Programs in SingHealth (SH) to establish the Health Services Research Institute.

Plenary Lecture 4: Enhancing Scholarship of Teaching-Learning in the Primary Care Setting

Prof Gwee Choon Eng Matthew
National University of Singapore

Prof Matthew Gwee is a Professorial Fellow in the Department of Pharmacology and Interim Director, Medical Education Unit, Faculty of Medicine. Prof Gwee previously served as Chairman of the faculty's Problem-based Learning Committee (1998-2004).

Workshop Speakers

Workshop 1: Medical Writing

Prof Teng Cheong Lieng
International Medical University

A/Prof Ng Chirk Jenn
University of Malaya

Workshop 2: Biostatistics

A/Prof Koh Choon Huat Gerald
National University of Singapore

Workshop 3: Enhance Scholarship of Teaching-Learning in the Primary Care Setting

Prof Gwee Choon Eng Matthew
National University of Singapore

Dr Dujeepa D Samarasekera
National University of Singapore

Research Championship Coaches

Chairperson
Dr Tan Ngiap Chuan

Coaches
Prof Khoo Ee Ming
Prof Teng Cheong Lieng
Prof Wong Yeung Shan Samuel
A/Prof Lee Ping Yein
A/Prof Ng Chirk Jenn
A/Prof Nik Sherina Hanafi
A/Prof Tong Seng Fah

Assistant Coaches
Dr Adina Abdullah
Dr Ang Seng Bin
Dr Chew Boon How
Dr Ho Chih Wei Sally
Dr Irmi Ismail
Dr Noor Laili Mohd Tauhid
Dr Stalia Wong Siew Lee
Dr Tan Chai Eng
Dr Tan Shu Yun
Dr Verna Lee Kar Mun

Conference Programme

DAY 1 1 Dec 2012 (Sat)	Event		
8.00am - 8.45am	Registration		
8.45am - 9.00am	Welcome Speech by Dr Chng Shih Kiat		
9.00am - 9.45am	**Plenary Lecture 1:** Innovative Interventions for Anxiety and Chronic Stress in Primary Care *Speaker: Prof Wong Yeung Shan Samuel*		
9.45am - 10.30am	**Plenary Lecture 2:** Setting Up Family Medicine Research Network *Speaker: A/Prof Ng Chirk Jenn*		
10.30am - 10.45am	Tea Break		
10.45am - 12.45pm	**Workshop 1:** Medical Writing	**Workshop 2:** Biostatistics	**Workshop 3:** Enhancing Scholarship of Teaching-Learning in the Primary Care Setting
12.45pm - 1.30pm	Lunch Talk		
1.30pm - 2.30pm	Lunch		
2.30pm - 3.15pm	**Plenary Lecture 3:** Health Services Research *Speaker: Prof David Matchar*		
3.15pm - 5.30pm	**Workshop 1:** Medical Writing	**Workshop 2:** Biostatistics	**Workshop 3:** Enhancing Scholarship of Teaching-Learning in the Primary Care Setting
6.00pm	Gala Dinner		
DAY 2 **2 Dec 2012 (Sun)**	**Event**		
8.00am - 8.15am	Admin Briefing		
8.15am - 9.00am	**Plenary Lecture 4:** Enhancing Scholarship of Teaching-Learning in the Primary Care Setting *Speaker: Prof Gwee Choon Eng Matthew*		
9.00am - 10.15am	**Workshop 1:** Medical Writing	**Workshop 2:** Biostatistics	**Workshop 3:** Enhancing Scholarship of Teaching-Learning in the Primary Care Setting
10.15am - 10.30am	Tea Break		
10.30am - 11.45am	Free Paper		
11.45am - 1.00pm	Research Championship Finalists' Presentations		
1.00pm - 1.30pm	Prize Presentation & Closing Ceremony		

Pre-Conference Programme: Research Championship

30 Nov 2012 (Fri)	Event
8.00am – 8.30am	Registration
8.30am – 8.45am	Introduction and housekeeping
8.45am – 9.00am	Self-introduction of team members and research topic
9.00am – 9.15am	Introduction of Primary and Assistant Coaches to teams
9.15am – 10.15am	Group work 1: Transforming research ideas into answerable research questions
10.15am – 10.45am	Break
10.45am – 12.15pm	Group work 2: Developing research methods (1)
12.15pm – 12.30pm	Short updates on progress from each team leader
12.30pm – 1.30pm	Lunch
1.30pm – 3.00pm	Group work 3: Developing research methods (2) and identifying resources
3.00pm – 3.20pm	Break
3.20pm – 4.30pm	Group work 4: Preparing for the preliminary round of presentation - Proposal and PowerPoint
4.30pm – 5.30pm	Team presentation to panel of jurors: Selection of finalists for Research Championship Finale on 2 Dec 2012
5.30pm – 5.45pm	Jurors' critique
5.45pm – 6.00pm	Closing

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Asia Pacific Primary Care Research Conference 2012

1 - 2 December 2012
National University of Singapore
Block MD6, Centre for Translational Medicine
14 Medical Drive, Level 3 (LT 36)
Singapore 117599

Registration Fee

Proceed to **www.cfps.org.sg/appcrc2012/** to register now!

Early Bird Registration*: By 31 August 2012	S$320.00	Registration for APPCRC Conference ONLY
	S$370.00	Registration for APPCRC Conference + Research Championship
Normal Registration: By 25 November 2012	S$450.00	Registration for APPCRC Conference ONLY
	S$500.00	Registration for APPCRC Conference + Research Championship
Walk-in Registration	S$600.00	Registration for APPCRC Conference ONLY
	S$650.00	Registration for APPCRC Conference + Research Championship
Registration for Allied Healthcare Professionals	S$230.00	Registration for APPCRC Conference ONLY
Registration for Medical Students ^	S$160.00	Registration for APPCRC Conference ONLY

All prices stated are inclusive of 7% GST & gala dinner (exclusive of hotel accommodation).

** Any unpaid early bird registration after 31 August 2012 will be cancelled and can only be reinstated when full payment for normal registration fee is received.*

*^ A discounted registration fee of S$160 is available to full time medical students only. A photocopy of your student identification card is required. Please fax a copy to +65 6222 0204 or email to **enquiries_appcrc@cfps.org.sg** prior to the conference.*

Registration will not be confirmed until payment in full is received.

The gala dinner will be held on 1 December 2012 (Saturday), 6.00pm at the National University of Singapore Society, Kent Ridge Guild House, 9 Kent Ridge Drive, Singapore 119241.

Key Dates & Submission Details

Abstract submissions close on 31 August 2012.
Authors notified of acceptance by 30 September 2012.
Pre-Conference: Research Championship registration close on 21 November 2012.

Free Oral Papers
Free oral paper presentations will be 12 minutes duration with 8 minutes presentation and 4 minutes of discussion.

Poster Presentations
Poster presentations will be on display at the conference. Session times will be organised for presenters to be at their posters to discuss their work and receive feedback. Poster dimensions are to be no more than portrait 90cm wide and 120cm high without backing.

- Abstracts must not exceed 250 words and should be submitted in English, the language of the Conference.
- All abstracts must be original work.
- The abstract will contain text only; no diagrams, illustrations, tables, references or graphics.
- Abstract submissions will only be accepted via this website.
- All presenting authors must register and pay for the Conference by 31 August 2012; otherwise the paper will be removed from the conference.
- 2 copies of abstracts are to be submitted in Microsoft Word format using the abstract template provided: 1 copy with full information including outline and instructions, the other copy should exclude any information in the attachment that may lead to identification of authors and/or institutions. This copy will be used for blind review.
- A committee will blind review all abstracts. The committee reserves the right to accept and reject abstracts for inclusion in the program.
- Abstracts received after the closing date will not be accepted.

Email submission to **enquiries_appcrc@cfps.org.sg**

Visit **www.cfps.org.sg/appcrc2012/** for more details.

For enquiries, please contact College Secretariat at 6223 0606 or email: enquiries_appcrc@cfps.org.sg