



THE College Mirror

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Ethical Issues Related to Managed Care

by Dr Cheng Heng Lee & Dr Lee Pheng Soon

INTRODUCTION

The authors sought to identify ethical issues related to managed care and also to clarify the conflict between duty of care to the patients and the contractual obligations of the doctor to the managed care organisations.

WHAT IS MANAGED CARE?

Managed care refers to a variety of techniques for influencing the clinical behaviour of health care providers and patients, often by integrating the payment and delivery of health care.

The overall aim of managed care is to place administrative control over cost of or access to health care services in a specific population of covered enrolees. Some managed care practices also seek to impact the quality of care through use of clinical guidelines that aim to alter the clinical management of specific health concerns (e.g. treatment of hypertension and diabetes).

The stakeholders are patients, doctors [solo general practitioners (GPs), large GP groups, private hospitals], corporations providing medical benefits to their employees, insurance companies and possibly even MOH (subsidised care, use of MediSave for chronic disease management).

Managed care is structured around a variety of incentives to encourage the practice of cost effective medicine and to minimize variations in clinical practice patterns. In its ideal state, money is saved through several mechanisms:

(continued on page 8)

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Managed care is structured around a variety of incentives to encourage the practice of cost effective medicine and to minimize variations in clinical practice patterns.

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Three is a Crowd?

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

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The following was used as an introduction to my presentation entitled "Economic Considerations in Managed Care" at the Singapore Medical Association's 37th annual medical convention in 2006 on the topic of Managed Care. It is my personal "quick and dirty" history of managed care, which highlights some of the competing interests and ethical tensions underlying this system:

The One Minute History of Managed Care:
Once upon a time, the private healthcare landscape was populated by 3 groups :

1. Patients – Wanted good quality healthcare, convenience and easy access, and wanted medical coverage to be provided by the employers
2. Doctor – Private GPs need to see more patients to cover overheads, and wanted to be paid a reasonable fee
3. Employers – Wanted to provide healthcare benefits to its staff, but wanted to control healthcare spending and monitor health-seeking behaviour by its staff

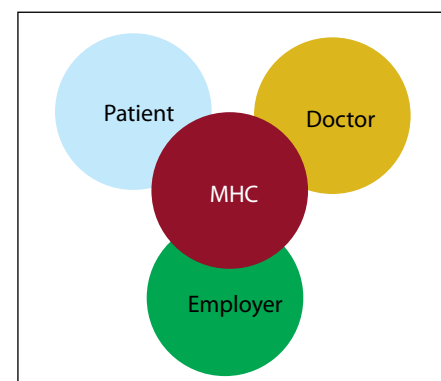
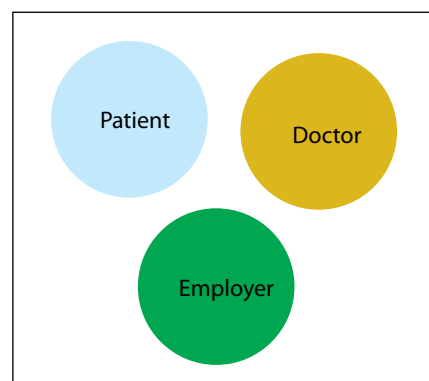
Against this background, Managed Health Care (MHC) was mooted. It could connect all 3 groups and satisfy them by providing a wide network of GPs making it convenient for the patient, providing more business for the doctors by canvassing for more corporate contracts, and satisfying employers by purporting to manage costs and by administering healthcare for them.

In theory this was to be a happy win-win situation for all.

Unfortunately the reality of the business environment meant that MHC companies started to face stiff competition from other MHCs who entered the market, and in order to survive, MHCs had to market cheaper and cheaper schemes and propose cost cutting measures, with the result of lower and lower margins. This led to a reduction in the consultation fees paid to doctors, and patients ultimately suffered from suboptimal treatment or from some form of rationing. Companies were also unhappy with the schemes after receiving complaints from their staff, and reports of poor quality care. So as time went on it, seemed that none of the stakeholders seemed to be happy or satisfied.

The question is - why do such schemes still exist today? There are many factors. For one, MHCs come in many different forms, as the lead article in this issue of College Mirror outlines. For another, patients would rather put up with some inconveniences to see an appointed 'company doctor' than to pay out of pocket for private primary healthcare. For example some patients would rather take a bus to the other side of town to see their appointed doctor than to attend the nearest GP within walking distance, unless it was something that cannot wait, like the sufferance of pain or bleeding. Doctors are also willing to hang on to such schemes because of the increase in volume, albeit at the cost of lower margins. There is also the hope that patients on MHC schemes may introduce their family members to attend as well.

In any case the economic reasons for entering



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From a patient's point of view, managed care is akin to living at home with your parents – you save money, everything is taken care of, but you need approval before you can stay out late. A patient under a MHC plan can have most of his basic primary health care needs taken care of by the appointed GP near his home or workplace, but there will be restrictions. These can come in the form of a cap on the number of visits, the choice of GP, exclusion of certain conditions and treatment especially when it is non-medical related, and referral to specialists which is often limited to a preferred panel.

From a GP's point of view, the increase in

volume may be worthwhile in the short term, but there are potential costs as well. The main problem is the low fees paid for GP consultations. This leads to under servicing and lowers quality of care. Complex claims procedures and increased administrative workload are also part and parcel of any MHC scheme. Margins for drugs and procedures are low, and delayed reimbursement exposes the solo GP to financial risk.

In addition to the financial considerations, this month's issue of College Mirror also highlights one other aspect as well – the ethical aspects. In their article, Dr Cheng and Dr Lee point out that "...contractual obligations to a third party, notwithstanding its financial limitations and troublesome administrative procedures, in no way diminish or absolve the doctors of their ethical duties to the patients".



In conclusion, the GP must therefore be very familiar with each and every MHC scheme he signs on in order to make such a scheme worthwhile for himself and his patients. The GP must know the rules and the exclusions. The GP should keep a long-term view by developing a strong doctor-patient relationship. Schemes come and go, but satisfied patients are more likely to remain with their preferred family doctors in the long run.

■CM

this issue >>

- 01 < Cover Story:**
Ethical Issues Related to Managed Care
- 02 < Editor's Words:**
Three is a Crowd
- 04 < President's Forum:** Practice Issues - Working with the Four 'P's in Mind
- 12 < Resident Article:** New Look at the Old Prescriptions - Part 1
- 14 < Resident Article:** New Look at the Old Prescriptions - Part 2
- 16 < Event:** 2nd Asia Pacific Primary Care Research Conference 2010

- 18 < Practice Management:** Management of Drugs in the GP Setting
- 20 < Hints & Tips:** A Practical Approach to the Complaint of Fatigue
- 24 < Family Practice Skills Course 41**

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Practice Issues

Working with the Four 'P's in Mind

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

In this issue of the College Mirror two evergreen practice issues are revisited – managed care and management of in-house dispensing. I would like to add another dimension to the discussion – working with the 4 Ps (patient, press, policy makers, and profession) in mind.

Working with first P – the patients in mind – Managed care is a slippery slope if the funding is inadequate. The doctor surreptitiously is forced to cut corners to stay within budget. There is a need for the medical fraternity to work together to confront the managed care organizations concerned to deal with patient safety concerns. And we should get the patient on our side too. It is not enough to think of saving costs; we need to think of cost effectiveness, and most of all patient safety. Let us work together with the 4Ps to put managed care on the correct footing.

Working with the fourth P – the profession

in mind – In-house dispensing contributes to the income of the clinic and reduces patient consultation fees. In the long run, the doctor needs to make it a point to the patient, the policy maker, and the press that the doctor should be earning the bulk of his income from consultation fees. Also, if the primary care doctor is to play an effective role in chronic disease care management, there must be adequate compensation to make it sustainable for the doctor to do this kind of work. As I have pointed out before – a point that needs repetition – chronic disease management requires more than one unit of the time needed for acute care. If acute care needs 10 minutes for an adequate consultation, a routine chronic disease follow-up consultation will need 20 minutes at least, namely, 2 units of acute disease consultation time. The patient, the policy maker including

company human resource people, and the press needs to take this idea on board.

Working with the middle 2 Ps – the press and the policy maker in mind – Managed care, paying the primary care doctor adequately for chronic disease management, and cost effectiveness versus lowest costs are topics that the primary care fraternity needs to engage the press and policy makers constructively. These are topics easier said than done but unless we make a start we will not be able to do the needful for the people that we care. Any suggestions on how can go about things?

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Graduate Diploma in Mental Health (GDMH)

The Institute of Mental Health collaborates with the Division of Graduate Medical Studies (DGMS), 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.

Module 1: Introduction To Psychiatry**

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Module 3: Mood, Anxiety And Grief

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Module 5: Child And Adolescent Mental Health Including Learning Disabilities

Module 6: Psychogeriatrics

2nd Intake September 2011!
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Registration starts April till May 2011.

For more information, call 6389 2968 or email enquiry to: helen_bc_ong@imh.com.sg

**Applicants who have completed the GP Training in Mental Health GP Partnership Programme (as of 2008) are exempted from this module.



Graduate Diploma in Family Medicine

The Graduate Diploma in Family Medicine (GDFM) is a vocational training certification for primary care doctors. The aim of this 2-year part-time trainee programme is to train primary care doctors to practise Family Medicine at an enhanced level to meet the needs of the child, the adolescent, the adult and the elderly. The courses emphasise on basic clinical diagnostic and management skills essential to general practice.

The programme is planned to accommodate the busy doctor's schedule as almost all courses which require in-person attendance are conducted outside regular office hours. The courses consist of the following:

- 8 modules of Family Medicine Modular Course (FMMC) with each comprising of 4 workshops (2½ hrs each), 1 tutorial (1 hr each), online case studies and multiple choice assessments
- 3 Practice Management Courses (9 hrs in all) and 1 elective Family Practice Skills Course (6 hrs)

Eligibility

You are eligible to enroll in the GDFM programme if you are :

- Registered with Singapore Medical Council and possess MBBS degree or an equivalent qualification.
- A registered doctor who is about to complete housemanship or becoming a Medical Officer in April/May 2011.

GDFM Components

To qualify for GDFM Examination, trainees are required to complete the following components:

8 FMMC Modules

Each FMMC module consists of 4 workshops conducted over 4 Saturday afternoons, with online case study, multiple choice assessment, and 1 small group tutorial based on the theme of the FMMC module of that particular quarter. One module would be covered per quarter. Attendance in tutorials and at least 3 of the 4 workshops, and completing online case study and multiple choice assessments are mandatory for the trainees to be certified of having completed the FMMC module.

3 Practice Management Courses

- Principles & Practice of Family Medicine (P&P)
- Consultation, Communication & Counselling (CCC)
- Professionalism, Ethics & Law Skills Course (PEL)

1 Elective Family Practice Skills Course

Trainees can choose to complete any one of the several Family Practice Skills Courses conducted by the College before the GDFM Examination

1 GDFM Clinical Revision Course

1 BCLS competency certification

Trainees are to make their own arrangement to attend a BCLS and obtain a valid competency certification.

Fees

Registration and course fees are payable to 'College of Family Physicians Singapore'.

Course fees (inclusive of Registration fees)

- College member: S\$4,284.00
- Non-College member: S\$4,716.00

Fees do not include the elective skills course (Family Practice Skills Course), BCLS, tutorials, and examination. (Examination fees are payable to 'National University of Singapore', when applying for examinations in 2013).

GDFM Examination

The examination is conducted by DGMS, NUS, in June/July 2013, and consists of:

- Written paper - Applied Knowledge Test paper (MCQ), (2 hrs); Key Features Problems paper (1 hr)
- Skills Assessment in the Objective Structured Clinical Examination (OSCE), (2 hrs)

Registration

GDFM is open for registration until 31 May 2011. For more details and application forms, please visit our website www.cfps.org.sg, or contact us at: Tel: 6223 0606, Fax: 6222 0204, E-mail: gdfm@cfps.org.sg, or Address: 16 College Road, #01-02, College of Medicine Building, Singapore 169854

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Join us on the following day to find out more about GDFM and MMed (FM) Progr. B

Date/Time: Friday, 8 Apr 2011, 6.00pm

Venue: Lecture Room, College of Family Physicians Singapore

Please RSVP via email to gdfm@cfps.org.sg by 6 April 2011.

Master of Medicine (Family Medicine) Programme B

- 1-year part-time structured training programme for mature practising family physicians
- Jointly organized by the CFPS and DGMS, NUS.

To be eligible for the programme, one must have the following:

- Work Experience – at least 5 years in primary care (part-time or locum tenens are not considered)
- Training – completed 8 modules of FMMC
- Practice Audit – fulfill audit requirements for Family Medicine training
- FM Workload - at least 28 hours a week during the programme year
- Registration with SMC – Full or Conditional

Registration for MMed Programme B is open until 16 May 2011.

Family Medicine Fellowship Programme

- A 2-year programme that is the pinnacle of training of Family Physician in Singapore.
 - Advanced training in family medicine
 - Acquire the competencies to perform at the level of an expert
 - In the areas of service, research and teaching
- It is a requirement for promotion to senior grades by many institutions as well as to hold faculty position in academic and professional development in Family Medicine.

To be eligible for the programme, one must have the following:

- MMed (Family Medicine) / MCGP (Singapore) / equivalent qualifications (approved by the Censors' Board on a case by case basis); OR
- MMed (Int Med) / MRCP (UK) / equivalent internal medicine training, and
 - o Graduate Diploma of Family Medicine (GDFM), and
 - o At least 6 months experience working in a family medicine practice setting of which at least 3 months must be in primary care.

Please visit www.cfps.org.sg for full entry criteria. Registration for Family Medicine Fellowship Programme is open till 23 May 2011.

from page 1 - Ethical Issues Related to Managed Care

- a) standardisation of fees,
- b) reduced variation of care,
- c) cheaper alternatives without undue sacrifice of quality,
- d) exclusion of non-effective treatment and
- e) reduction of unnecessary tests and treatments.

The drive in managed care should not be on cost savings alone but also quality and effectiveness. "Effectiveness" means providing a product, in this case health care, while minimizing resources used, most often dollars. Hence managed care may create pressure to do more with less time per patient, less costly medicine, and fewer costly diagnostic tests and treatments. Herein lies the tension between ethical and unethical behaviours on the part of the health care providers. The good, the bad and the ugly of managed care become manifest.

MANAGED CARE IN SINGAPORE

Managed care in Singapore is not a recent phenomenon. A few types of managed care exists, including the corporate fee for service system, the agent system, the Health Maintenance Organisation (HMO) system and the fee caps system.

(i) Corporate fee for service system

This system is the oldest managed care system and is the most widely used by companies. Typically the company negotiates for a discounted consultation fee.

(ii) Fee caps system

In such a system, the company arranges a fee cap, e.g. \$18, for simple consultation and medicine and \$26 where more expensive medicines are used and \$36 for chronic conditions.

(iii) Agent system

An agent takes care of the healthcare delivery of the employees' medical benefits of a company. The agent may be an insurance company, a medical group or a private hospital. The agent can be called the managed care organisation (MCO). The MCO collects a premium from the company, creams off a profit for itself and uses the balance to pay the doctors on their panel. The doctors are usually paid a consultation fee of around \$9-\$12 and medicines dispensed are reimbursed at cost. Invariably there is no transparency between the MCO and the doctors with regards to the premium collected and the profits taken upfront.

(iv) Health Maintenance Organisation (HMO) system

In this system capitation is a key feature. Capitation involves

paying a fixed, prospective amount to the doctor for each patient regardless of the cost of caring for the patient.

An example of HMO is the NTUC Managed Health Scheme (MHS). This system had both corporate and individual schemes. The NTUC MHS has since been withdrawn from the market.

IDENTIFICATION OF POSSIBLE ETHICAL ISSUES RELATED TO DOCTORS INVOLVED IN MANAGED CARE

(i) Doctor knowingly enters a contract that limits range of treatment options for the patient

The doctor knowingly enters into a contract that might limit the quality of care he can offer the patient, due to limits imposed by the manage care organisation (MCO) as a cost management strategy. Examples of such limits are:

- a. Total cost of drugs dispensed per consultation.
The doctor may not be able to treat to target chronic diseases like diabetes, hypertension and lipidaemia as escalating treatment will make it out of budget.
- b. Exclusion of certain kinds of drugs (for STI, gum infections, depression/anxiety/psychosis) or prosthetic devices.
- c. Limited number of specialists on referral list.

Autonomy of referral:

A primary care physician who refers a patient needing further care should do so to a specialist who, in his opinion, is likely to best meet the medical needs of the patient. However, many Managed Health contracts have a limited range of specialists to whom the primary care physician is restricted, and the patient may therefore not receive optimal specialist care. In such a situation, the primary

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Careful discussion is needed so that the patient understands his options, including the consequences if he declines treatment.

care physician should discuss the potential benefits of the patient seeking such care independently (whether as a self-paying private patient, or through the current subsidized healthcare system available in Singapore, i.e. the “OPD route”). One example is a patient requiring surgery that can be performed as a minimally-invasive procedure, and for which he is suitable, but such an option is not offered by the specialists listed by the MHC. There are ethical concerns if a primary care physician enters into an agreement with an MHC that specifically prohibits him exercising such autonomy of referral, because this in turn deprives the patient of the autonomy of personal choice of management.

(ii) Doctor accords lower priority to MCO patient, in response to limits set by contracts

Due to the lower pre-fixed consultation fees in the agreement with the MCO, doctors may accord lower priority to patients of the MCO, e.g.:

a. have a shorter consultation time

[There have been anecdotal accounts of doctors quoting \$1 for consultation fee to snare a contract. This is unrealistically low and would not be sustainable in the longer term. To ensure sustainability in an underpaid system, the company doctor tries to recover cost by charging high fees on variable cost items like medicines or by generating high volume through short contact time and low quality service.]

b. sees MCO patients only after completing his private patients; or

c. “rations” the number of days of sick leave offered.

(iii) Doctor limits treatment options only to those paid by the MCO contract

The doctor may fail to discuss with his patient possibly advantageous treatment options that are not available under his MCO scheme (e.g. the use of coated stents versus bare-metal



stents); or the contract may limit or restrict the doctor from discussing all potentially beneficial health care services with the patients especially if these are not covered by the health plan (such clauses are often referred as ‘gag clauses’).

Limitations for payment of medical services provided: some Managed Care Organizations (MCOs) require the doctor to seek prior approval for some kinds of treatments (e.g. prescriptions or procedures above a certain charge). However, there are times (after office hours, during weekends) when the approval telephone number is not manned, when the doctor might have such a patient seek medical treatment in his clinic.

In such instances if the doctor wishes the patient to personally pay (or pay a deposit) for the proposed treatment first, he should tell the patient prior to commencing treatment. He should also tell the patient the options available in case the patient cannot, or prefers not to, pay first (e.g. referral to an A&E department of a RH). Careful discussion is needed so that the patient understands his options, including the consequences if he declines treatment. In the ideal situation, MCOs should have pre-agreed arrangements with their doctors regarding such approval “after-MCO-hours”.

(iv) Doctor fails to discuss potentially treatable conditions identified incidentally

The doctor may fail to highlight incidental diagnosis not related to the main reason for consultation, or to discuss with his patient these potentially treatable conditions noticed incidentally (e.g. venereal warts seen when examining for haemorrhoids, severe acne) because these are excluded from the MCO’s cover (“not medically necessary”).

(v) Over servicing

There are anecdotal accounts of the service provider over investigating, being over-zealous with surgery, offering exotic screening packages when they are in a direct fee-for-service arrangement with a corporation.

(vi) Breach of confidentiality

Disclosure of diagnosis by way of reports for claim purposes, making available case records for disputed claims or on requests by the human resource (HR) department because patient was given medical certificate (MC).

Consent to release medical information that is directly communicated by the employer or MCO to the patient in writing, rather than the doctor, can still be seen as effective consent to the doctor.

In some situations, a doctor may regard a representation from the employer that there is such a contractual consent as being insufficient. For example if there is reason to suspect that the consent given may not be accurate or genuine, the doctor should check directly with his patient.

However, doctors have to remember is that such consent, even if properly given at the time of the contract, can always be specifically revoked by the patient directly to the doctor. So if a patient tells a doctor that he knew he had previously signed a contract agreeing to give his medical information to his employer, but have since changed his mind, or didn't want a particular sensitive diagnosis to be revealed, the doctor may not presume that the patient's consent has been given for the medical information to be notified to his employer. Indeed, the doctor will have to assume that consent has



been specifically revoked. Since the consent is obtained even before the medical information becomes available, it would in fact be prudent for doctors to re-confirm with the patient the validity of the consent if there is any reason to think that the medical diagnosis is so sensitive that the patient may revise his earlier decision

What are the diagnoses that may sufficiently sensitive for the doctor to double check with the patient before disclosing the information to the employer? One rough rule of thumb is to consider anything that could potentially jeopardize the patient's job, or anything which is deemed so sensitive that our Parliament has passed

specific laws criminalizing breach of confidentiality (disclosure of termination of pregnancies, disclosure of HIV/AIDs, etc).

What happens if the patient revokes consent? The doctor has to respect the patient's wishes but it may mean that the doctor has to inform the patient that he will have to treat him as a private patient if he does not want his employer to know of the condition for which he is being treated (and thus cannot expect his employer to pay for his treatment). If the patient nevertheless asks the employer to pay for his treatment, and his employer asks the doctor for a report, the doctor will have to reply that he is not authorized by the patient to provide the information. The patient should have been warned that this may jeopardize his medical coverage.

There have been more difficult cases where the patient asks the doctor to help him lie to the employer by selectively disclosing information. For example, giving the employer the impression that he received treatment for a medical condition that is claimable from insurance, when in fact the patient was undergoing other treatment that is not claimable, and asking the doctor to put everything under one bill. Of course doctors cannot help patients to lie and misrepresent.

At the end of the day, on matters of patient confidentiality, the duty is owed to the patient. The patient's decision has to be respected. The only reason why information can be given to the employer or MCO is because the patient had authorized the disclosure. Such authorization can always be varied and revoked.

(vii) Relationship between doctor and patients

Managed care limits patients' ability to establish a relationship with the doctor of their choice as the patient gets reimbursement of a smaller percentage of the cost of care or no reimbursement at all when patients see a doctor outside the panel.

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Termination of doctor patient relationship can also occur without the patients' choosing. For example, when employers shift health plans to another healthcare provider, employees may have no choice but to sever ties with the original doctor and see another doctor on the new panel. This might not be aligned with the patients' autonomy to adopt the ideal of one family physician for one patient espoused by the MOH.

DISCUSSION

Arguably any system, whether it is fee for service on a doctor to individual patient basis or the various variant of managed care system, can be abused. The same doctor who over treats or even over bills on the fee for service can under treat or under provide on the other systems of managed care.

The medical profession just has to be on its guard to maintain high ethical standards and professionalism and not succumb to the dictates of third parties. It is thus important that medical practitioners be well informed and educated about the many potential ethical pitfalls. Their contractual obligations to a third party, notwithstanding its financial limitations and troublesome administrative procedures, in no way diminish or absolve the doctors of their ethical duties to the patients. It is imperative that doctors exercise good judgement to walk away from managed care contracts with prejudicial terms and conditions. As for those who still want to be involved in managed care, they should be prepared to sacrifice time, effort and monetary gain to uphold their professional and ethical standards because of inherent administrative hassle and remuneration limitations in managed care.

The Singapore Medical Association has issued an advisory on Managed Care Contracts in March 2009 and expressed views which are congruent with those above.

"The primary duty is to the patients regardless of the contractual terms. Basically this means you will still be accountable even if the contract has made it difficult or not possible for you to fulfill your role/duty to the patient. This extends to situations where you are restricted to certain hospitals, laboratories or panels of specialists. It does not matter if a contract has oppressive rules and regulations that impede your practice, you are still accountable to fulfill your care to the patient.... We hope the doctor will understand his obligations better and be mindful of the pitfalls and areas of difficulty that he faces when he participates in these schemes"

Managed care is here to stay. More likely than not, it will become more pervasive. This is because of the vested interests of the different stakeholders - the MCOs want a share of the healthcare pie and will promote it, the human resource departments (HR) of the corporations love it and finally there will always be medical practitioners who need it for economic reasons of survival to supply them with a base load of patients.

Just as the medical practitioners need to be apprised of the challenges of managed care similarly the HRs or corporations,

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labour organisations such as NTUC and patients should be educated about the limitations of managed care. With better understanding perhaps their medical benefits plans could be made more flexible to give workers the autonomy to seek a primary care of physician their own choice without losing out in terms of monetary benefits or non-recognition of medical leave if they opt out of the company's managed care plan.

CONCLUSION

There is anecdotal evidence both the medical practitioners and the patients are unhappy with managed care in its present state. Hopefully this paper will engender the policy makers to facilitate the development of a more equitable and transparent form of managed care.

In addition, this document can be offered as such in ethics-related activities where a practitioner's point of view is potentially helpful. For example, in the upcoming exercise by the Singapore Medical Council where Ethical Code and Guidelines are being reviewed, this paper may be offered to the team working on the revision, as a reminder of how complex actual clinic practice may be on the ground, and therefore why any pronouncements on Ethics that affect practitioners, need to be flexible enough to embrace actual context of clinical practice.

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■ CM

New Look at the Old Prescriptions

Part 1 by Dr See Toh Kwok Yee, MCFP(S), Editorial Board Member



It is not an uncommon refrain in the last few years when you, the Family Doctor, have to tell the patient, “Hi Madam Tan, the medication you have been using the past years has now been withdrawn,” or “Mr. Lim, the drug that I gave you have to be taken with extra precautions from now on.” It is an unpleasant situation, to say the least, for both the doctor and the patient. Having to backtrack, the former may feel that he has let his patient down, though, through no fault of his. After all, was it not too long ago when he, the doctor, has expounded the virtues of the particular medication based on existing data and evidence and has confidently reassured the patient it was very safe? It would not be unreasonable then to expect some form of backlash and an earful from the so affected patient. Fortunately, for the many of us, the years of goodwill do pay dividends and the patient usually accepts our sincere explanation and graciously continues with our management.

The purpose of this article is to highlight a list of medications that are commonly encountered by the Family

Physician that have either been withdrawn or flagged with extra safety alerts in the last two years. It is obtained from the Health Authority of Singapore (HSA) website under Safety Information and Recalls. The reader is advised to be acquainted with latest information available on this website.

Against this backdrop, Dr. Soh Soon Beng, a senior Family Physician, also shares his thoughts and feelings on the topic.

First, the selected list of drugs of concern:

1. RHINATHIOL 2% CHILDREN AND INFANT SYRUP

This product is now contraindicated in children under two years of age following the French authority’s decision which was based on a comprehensive evaluation of pharmacovigilance data. There is a risk of aggravation of respiratory symptoms when used among infants. (The reader is reminded here that the use of PROMETHAZINE is not recommended for the same age group since 2005.)

2. SIBUTRAMINE (REDUCTIL)

This anti-obesity drug has been suspended following the results from the SCOUT (Sibutramine Cardiovascular Outcome) study which has involved about 10000 patients over a six-year period. The results have showed increased coronary and cerebrovascular events.

3. ROSIGLITAZONE (AVANDIA)

HSA, based on data reviewed and the recommendation of Pharmacovigilance Advisory Committee and expert panel of endocrinologists and cardiologists, has assessed that a possible increased risk of myocardial ischaemic events associated with this drug cannot be excluded. Additional restrictions and contraindications will be required for its use.

4. ROTAVIRUS VACCINE (ROTARIX, ROTATEQ)

Based on reports of finding DNA fragments of porcine circovirus in the vaccine, HSA, in consultation with MOH and its Expert Committee on Immunisation (ECI), has allowed the continued use of the vaccine as the benefits outweigh the risks. However, parents should be made aware of the findings so that they can make an informed decision.

5. BIPHOSPHONATES AND ATYPICAL FRACTURES

There are recent additional label warnings regarding a risk of atypical femur fracture associated with the bisphosphonate class of drugs (which includes Fosamax) used in treatment of osteoporosis. The label change reflects the uncertainty of the optimal duration of bisphosphonate use in osteoporosis as this information has not been elucidated. To date, there are eighty-two cases of subtrochanteric fractures associated with bisphosphonates. Doctors are advised to look out for new thigh or groin pains among the users of such drugs. (The reader is reminded of the risk of Osteonecrosis of the Jaw, ONJ, associated with bisphosphonates. The risk may increase with invasive dental procedures while taking the drug.)

6. VARENICLINE (CHAMPIX) AND NEUROPSYCHIATRIC EVENTS

Pfizer has revised safety labeling for this drug, which is used in smoking cessation treatment, to include warnings of psychosis,

hallucinations, suicidal thoughts, suicidal attempts and completed suicides among patients. Doctors are reminded to advise their patients on the potential of occurrence of such neuropsychiatric adverse reactions.

7. ORLISTAT (XENICAL) AND SEVERE LIVER INJURY

USA FDA recently received thirteen reports of severe liver injury which occurred over a period of ten years associated with the use of orlistat containing medicine. Since 2000, HAS has received a case of liver failure and another case of elevated liver enzymes associated with Xenical. Doctors are advised to consider benefits and risks when prescribing this anti-obesity medication.

8. FINESTERIDE AND MALE BREAST CANCER

Finasteride 5mg is used in the treatment of Benign Prostate Hyperplasia and the 1mg formulation for Androgenetic Alopecia (Male Pattern Baldness). UK Medicine and Healthcare products Regulatory Authority (MHRA) after reviewing data from clinical trials and post-marketing

reports has concluded that an increased risk of male breast cancer associated with finasteride use cannot be excluded. Doctors are advised to inform patients on this drug to report any breast symptoms (lumps, pain, gynaecomastia and nipple discharge) promptly.

9. SITAGLIPTIN AND ACUTE PANCREATITIS

FDA has reported eighty-eight cases of acute pancreatitis between 2006 and 2009 in patients taking the anti-diabetic drugs sitagliptin (Januvia) and sitagliptin/metformin (Janumet). HSA has advised doctors to look out for symptoms of acute pancreatitis (nausea, vomiting and abdominal pains) in patients taking these medications.

10. MEDIAXAL

This dyslipidemic agent has been withdrawn since NOV 2009 following post-marketing reports by the French Medicines Agency of very rare cases of cardiac valvular disorders associated with its use.

The purpose of this article is to highlight a list of medications that are commonly encountered by the Family Physician that have either been withdrawn or flagged with extra safety alerts in the last 2 years.

11. CLOPIDOGREL (PLAVIX) AND PROTON PUMP INHIBITORS (PPI) INTERACTION

HSA has highlighted that some reports have suggested the use of certain PPI may decrease the anti-platelet effect of clopidogrel while others did not demonstrate this effect. HSA has recommended the concurrent use of PPI and clopidogrel be avoided unless absolutely necessary.

12. WARFARIN AND GLUCOSAMINE INTERACTIONS

Australian Therapeutic Goods Administration (TGA) and UKMHRA have received reports of possible interaction between these two drugs which may increase the International Normalised Ratio (INR). Doctors are thus advised to monitor the INR of these patients and to titrate the warfarin accordingly.



13. CODEINE TOXICITY IN BREASTFED INFANTS

HSA highlights a very rare but serious risk of toxicity in breastfed babies posed by codeine use in nursing mothers who are ultra-rapid metabolisers of codeine which can result in higher than expected levels of morphine in the serum

and breast milk. Doctors are advised to use codeine at the lowest effective dose and for the shortest needed duration in nursing mothers.

It must be emphasized that the abovementioned list of medications is intended only for the purpose of this article and is by no means comprehensive. The reader is once again advised to familiarize himself with all the drugs reported on the HSA website. ■CM

New Look at the Old Prescriptions

Part 2 by Dr Soh Soon Beng, MCFP(S)

Like many Family doctors and GPs I was rather perturbed over the recent years by the numerous recalls, added safety alerts and contraindications of drugs that I have been familiar with and have used without incidents. I cannot help but wonder which of my trusted old medicines will be flagged next! At times the frustration stems from the feeling that a certain drug has seemingly been maligned as a result of unconventional and improper use in foreign countries and becoming penalized despite its long history of eventful service locally.





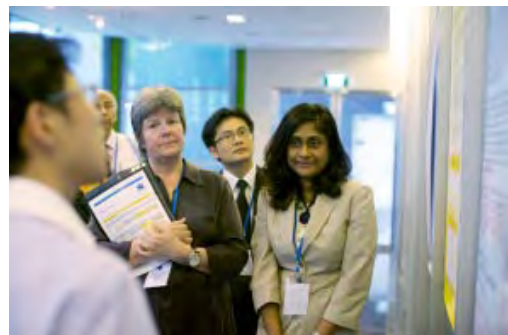
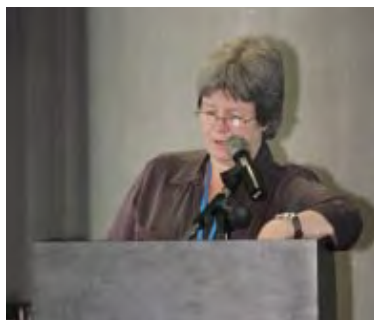
2nd Asia Pacific Primary Care Research Conference 2010

After months of preparation, the 2nd Asia Pacific Primary Care Research Conference 2010, held at the Gallery Hotel, Singapore from 4th to 5th December 2010 was at last upon us.

The conference was very well subscribed, with over 116 paid delegates from all around the region, from as far afield as Japan, Australia, Bangladesh, Thailand, India, Hong Kong, Myanmar, Malaysia, the Philippines, Taiwan and of course Singapore.

We were privileged to have three very distinguished speakers for our plenary sessions.

Prof John Rush Vice-Dean of Duke-NUS Graduate Medical School and CEO of the Singapore Clinical Research Institute, kicked off the conference to a roaring start, speaking on "Treatment Research in Family Medicine Practices". His talk opened our eyes to the practicalities and advantages of primary care research networks, and whet our appetite for more of the two day programme.



(Clockwise): 1. Prof John Rush, Plenary Speaker; 2. In search for the Best Poster; 3. A/Prof Goh Lee Gan, Prof John Rush and A/Prof Lee Kheng Hock; 4. A/Prof Goh Lee Gan and Prof Desiree Lie from the University of California, Irvine; 5. A/Prof Jan Radford, Plenary Speaker



A/Prof Jan Radford from the University of Tasmania Medical School, and previous Censor-in-Chief of the Royal Australian College of General Practitioners spoke on "Conceptual Frameworks: A research foundation for all researchers", and further built on this theme of primary care research.

Prof Desiree Lie, from the University of California, Irvine, spoke on "Qualitative or Quantitative? When Why trumps What in Research". Her exposition on the advantages of qualitative as opposed to quantitative research was very received, and hopefully this augurs well for the research appetite amongst our own researchers.

We were also very privileged to have Prof Wilfred Peh from the Khoo Teck Puat Hospital speak on the vagaries and expected standards in medical writing, with his exposition on "Medical Writing: Expected Standards and Pitfalls." We were taken on a whirlwind tour of the medical editor's mind, and his well-attended talk was certainly worth every minute.

The theme of primary care research was carried through to the four workshops, which were run in parallel. Workshop A dealt with "Qualitative Research and the Delphi Study", Workshop B dealt with "Family Medicine Research Protocol", Workshop C dealt with "Designing and Understanding Impactful Primary Care Studies", and Workshop D facilitated the inaugural "Primary Care Research Championship".

This Research championship is a new and innovative concept. Teams come together to conceive research questions and ideas and learn which appropriate research methods to use to answer these questions, guided by veteran academic family medicine research mentors. The Primary Care Research Championship serves to act

as a crucible and catalyst for ideas to develop amongst our young researchers, and we are hopeful that this will set the stage for greater things to come.

As with tradition, we had a friendly competition for all participants who presented papers and posters. The Rajakumar Award for Best Overall Paper was awarded to A/Prof Tan Boon Yeow from Singapore, and for Best Poster Award to Dr Tin Myo Han from Myanmar. The Rajakumar Award for winner of the Research Championship went to Dr Peter Moey Kirm Seng from Singapore. Our new Wong Heck Sing Award for the best paper or poster produced by trainee, resident or medical student went to Mr Wee Liang En, a fourth year medical student at the Yong Loo Lin School of Medicine, National University of Singapore.

The 2nd APCRC 2010 marks a milestone in the history of the College. As the 21st century continues to unfold, we envisage primary care research racing to the forefront of medical investigation. May what we have achieved in our conference go some way to nurture our fledgling researchers.

■ CM



(Clockwise): 1. Research Championship workshop; 2. Winners of the Rajakumar Award for Research Championship; 3. Gala Dinner at Shiraz, Clarke Quay; 4. A/Prof Tan Boon Yeow, winner of the Rajakumar Award for Best Overall Paper. (Below): 5. Qualitative Research Delphi Study workshop.

(Top left corner): A/Prof Lee Kheng Hock, Chairman, Host Organising Committee; Dr Tan Tze Lee, Vice-Chairman, Host Organising Committee; A/Prof Ng Chirk Jenn, Member of Scientific Committee

Management of Drugs in the GP Setting

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

In Singapore, most clinics store and dispense medications. There are many advantages to this practice, both to the patients (one-stop service and therefore convenience, lowered overall costs) and to the physicians (familiarity with a range of medications, cover overheads and keeps consultation rates affordable) as well as some disadvantages (chiefly the administrative work that it encompasses).

The average physician knows little about the administrative aspects about drug handling when he first enters private practice. Here are some tips:

Drug formulary

The choice of drugs that a GP clinic stocks and uses vary greatly, depending on the patient profile, the preference and special interest on the part of the resident doctor, and factors such as cost and storage space. Drugs for common conditions should obviously be well stocked both in quantity and range to provide more individualized treatment options. These include medications for common conditions such as URTI, Gastroenteritis, and pain relief. Drugs for chronic conditions will depend on patient profile and doctor preference. Older estates with an ageing population will require more drugs to treat Diabetes, hypertension, and other chronic illnesses. Newer estates tend to attract a younger population and therefore have a larger proportion of paediatric patients.

Purchasing of Drugs

The medications may be ordered by clinic staff, but must be received and signed for by a pharmacist or a doctor. There are many sources for the purchase of medications including the pharmaceutical firms that do research and development of new drug (e.g. GSK, Merck), the companies that make generic drugs, sales companies that import and market drugs from the original

or generic pharmaceuticals and pharmacies – especially for emergency kit supplies such as intravenous medications.

The costs of the drugs, especially generics, can vary tremendously amongst companies. It is worthwhile to compare pricing lists. Purchasing in bulk can reduce individual drug costs significantly, but puts a burden on the doctor to prescribe the drug before it expires. Thus this can influence

the choice of medications prescribed. However, the reduction in costs can also be passed onto patients as cost savings. Generally, for smaller practices, a guideline may be to keep a 3-month supply of stocks. Medications can be ordered in small quantities whenever required also, albeit at higher individual prices, from some companies such as Pan Malayan or MHC. For delivery, there is often a minimum order required. The packaging of the drug also makes a difference to costs – loose tablets or large

tubs of cream are less costly, but less convenient to dispense.

For small quantities of drugs or special drugs catered to only a few patients, doctors should also consider providing prescriptions to patients for them to purchase from the pharmacy instead of keeping such stock.

Managing the drug inventory well takes practice and experience, but when done properly it will improve efficiency, save costs and reduce wastage.

Storage

Vaccines have to be transported and stored with strict adherence to the cold chain. They usually have to be stored in a refrigerator (no food stuffs allowed in the same refrigerator) at 2 – 4 degrees Celcius. A log book of daily recorded temperature must be kept.

For small quantities of drugs or special drugs catered to only a few patients, doctors should also consider providing prescriptions to patients for them to purchase from the pharmacy instead of keeping such stock.



There are various ways of displaying and storing drugs. Safety and convenience are the key considerations. Liquids, tablets, creams, suppositories, must be kept separately, for safe dispensing. Medications may be stored according to category (e.g. respiratory, anti-hypertensive, gastrointestinal) or administration site e.g., topically versus orally administered drugs. A recent case where a similarly named mouth gel was dispensed in place of the prescribed eye ointment highlights this point.

Stock Management

Stock counts have to be performed periodically to check on quantities and expiry dates of existing stock. With computerisation, much of the information is readily available. However, physical stock taking is still necessary to monitor stocks and to safeguard against pilfering.

Dispensing

Clinic assistants are trained in-house by the doctors and senior staff to dispense medications. Herein lies the greatest risk in having in-house dispensing – as the clinic assistant is not a pharmacist, the doctor takes on the final responsibility for the dispensing of medications. The staff should be well versed with the medications and very diligent in performing their duties safely. Many doctors check all medications before they are dispensed as an additional safeguard, and this is especially important if the staff are new and inexperienced. Clinic assistant courses that teach these skills are very important and include those run by SMA

and ITE, and a pharmacy assistant course run by NTUC Learning Hub. The clinic can apply for an SDF grant to offset the costs of the courses.

A daily dispensing log has to be kept available for inspection.

Pricing

With patented drugs, the general guideline is to follow the recommended price given by the pharmaceutical company. As for generics, a sales price can be worked out based on a set formula, or using the usual selling price in a pharmacy. The Singapore Medical Association has also mooted the idea of an additional Practice Cost to reflect the cost of over heads and administration that may differ from clinic to clinic, this will make medication prices more transparent.

In line with the ministry's goal of increasing transparency, the patient must be given an itemised bill, and given the option of buying the medications from a pharmacy. A prescription fee may be levied if there is a request for repeat prescription of a medication without a consultation.

Controlled Drugs

Controlled drugs have to be kept locked and a separate log of dispensing kept. ■CM

Yong Loo Lin School of Medicine Division of Graduate Medical Studies



2011/2012 GRADUATE DIPLOMA IN GERIATRIC MEDICINE

The one year part time course which is organized by the Division of Graduate Medical Studies in collaboration with the Geriatric Society of Singapore is designed to provide primary care physicians with basic skills in caring for the elderly.

Applicants seeking admission to the course must be a Medical Officer (MO) or a General Practitioner (GP) who has a first medical degree with a minimum of 2 years clinical postgraduate experience. Applicants should have spent at least 6 months during the last 2 years looking after elderly patients on a regular basis. Experience gained could either be from local or overseas.

For other applicants such as overseas doctors from non-traditional sources, besides having the minimum 2 years postgraduate experience, they must also have an additional 1 year (minimum) of local experience in Geriatrics (i.e. 2 years of clinical postgraduate experience plus 1 year of geriatrics-related work experience in Singapore). A strong letter of support from the institution which they are working for is also required at the point of application.

Course Duration:	13 August 2011 to August 2012
Application Fee:	S\$ 40.00 (non-refundable)
Course Fee:	S\$ 4,860.00 (inclusive of exam fee and S\$53.50 registration fee)
Closing Date:	31 May 2011

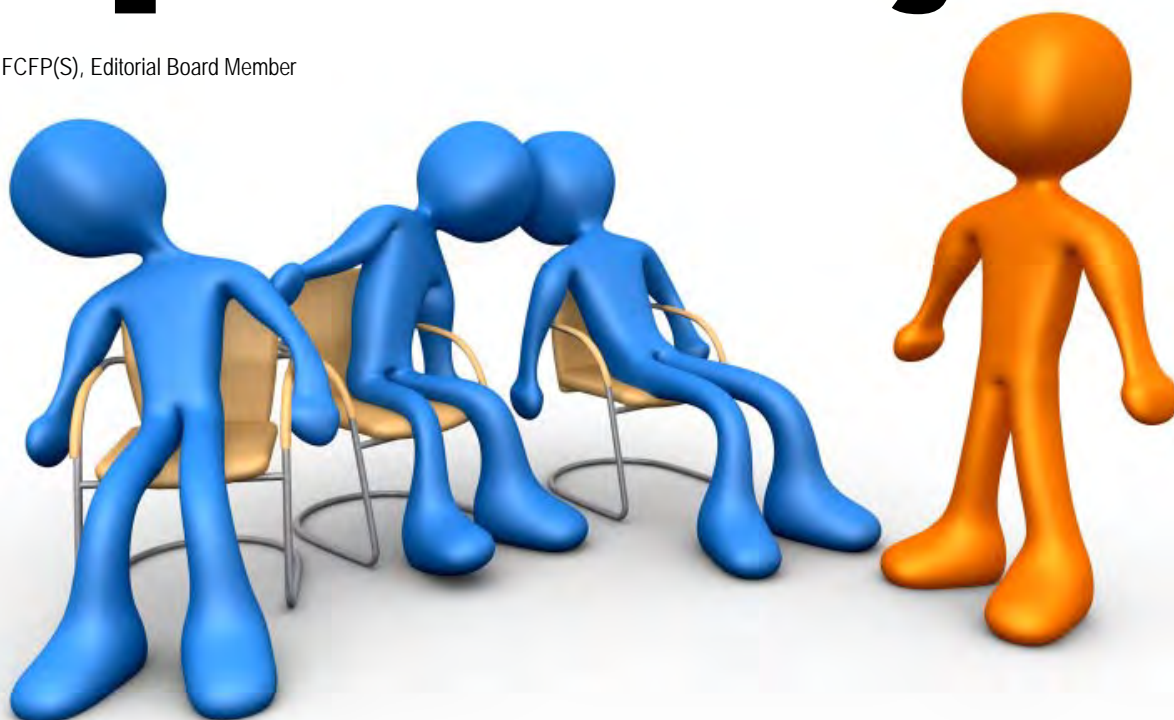
Course registration details and application form can be downloaded from www.med.nus.edu.sg/dgms For further enquiries, please contact :

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eunice_chung@nuhs.edu.sg or yu_chen_aw@nuhs.edu.sg

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A Practical Approach to the Complaint of Fatigue

by Dr Gabriel Seow, FCFP(S), Editorial Board Member



Nobody better understands fatigue than housewives and doctors (or wives of fatigued doctors; or housewives who moonlight as doctors).

Everyone experiences tiredness on occasions; but it is the persistence and the negative effect it has on our normal functioning that makes it abnormal!

As with all subjective symptoms, fatigue is difficult to characterize but a reasonable definition: the lack of energy to complete tasks, exhaustion or tiredness > 2 weeks.

The causes of fatigue are truly myriad for there is no known disease which cannot have fatigue as one of its symptoms. Our challenge is to distinguish between a serious physical disease which demands urgent treatment & a psychological entity which demands another modality of management. Fortunately, a careful history with special attention to psychosocial issues, a directed physical examination and few selected laboratory tests should reveal the cause in most.

Most patients with fatigue do not present. Those who do may be more likely to have poor social support and be more vulnerable to social or work stress.

This is one of those situations in medicine when the knowledge of pre-test probabilities helps a lot in decision making! In other words we work backwards!

>2 weeks:	Depression	¼	e.g. anxiety, dysthymia, drugs, chronic fatigue syndrome (CFS)
	Physical disease	¼	
	No cause	¼	
	Others	¼	
>6 mths:	Depression	½	(somatization and anxiety disorders)
	Psychiatric	¼	
	CFS	10%	
	Chronic physical disorders	15%	

So now we know:

- Fatigue lasting < 2 weeks to 1 month is commonly the result of physical illness
- Fatigue lasting > 3 to 6 months is more likely to be caused by psychological factors

What are the commonest physical illnesses in which fatigue features prominently?

Cardiac	CCH, IHD
Respiratory	COPD, OSA
Endocrine	Hypo/hyperthyroidism, DM
Infections	post-viral, TB, HIV
Musculoskeletal	inflammatory arthroses, connective tissue diseases
Haemato-oncological	anaemia, malignancy
Renal	CRF
Neurological	post-stroke, Parkinson's disease
Drugs & alcohol	prescribed, OTC, illicit
Life-style	poor physical conditioning

Getting started

Fatigue should be distinguished from excessive daytime sleepiness which suggests a primary sleep disorder. It should also not be confused with exertional dyspnea or true muscle weakness as the implications and the underlying causes are different.

The first step is to characterize the onset, duration, frequency, precipitating & mitigating factors.

1. Ask the patient to describe the fatigue ("what do you mean when you say you are tired?")
2. Listen for clues to psycho-social issues and the impact on the social and occupational function ("Tell me about any new or unusual circumstances in your life when you first noted the tiredness"; "Has the tiredness changed your lifestyle?")
3. Pay attention to the chronology of the fatigue and any associated symptoms. It is essential to pin-point the onset of fatigue.

e.g. worse in the morning	> depression
tired all day	> chronic anxiety
worse at end of the day	> medical illness
only with exertion	> muscle weakness/ cardio-pulmonary dx
unrelated to physical effort	> psychogenic fatigue
better on weekends	> chronic occupational stress
better after a good sleep	> sleep deprivation

History

1. Systems screen (constitutional symptoms, cardio-respiratory, GI, UG, joints, neurological). Ask about illnesses already diagnosed.
2. Depression screen: "have you been bothered by feeling down, depressed or hopeless?"; "have you often been bothered by little interest or pleasure in doing things?" in the past month
3. Anxiety screen: "do you find yourself worrying a lot or on the edge?"

4. Dissatisfaction screen: "do you usually get out of bed in the morning looking forward to the day ahead?"
5. Sleep screen (3 parts):
 - Quality
 - Excessive?
 - Daytime sleepiness vs fatigue? (see Epworth sleepiness scale in appendix)
6. Snoring
7. Alcohol use: "How often do you have an alcoholic drink?" ≥ 4 days a week is significant
8. Work & exercise habits
9. Drugs: prescribed, OTC, illicit. (Beta-blockers, anti-psychotics, hypnotics, anxiolytics, diuretics, anti-histamines, anti-convulsants, anti-depressants, opioids)
10. Prolonged fatigue syndromes screen (see SOFA screen in appendix)

Physical Examination

A routine PE is unlikely to be so helpful if the history has not already provided any clues. The specific clues to look out for will be:

1. Pallor
 - Overall, P/E can detect $\frac{1}{2}$ of anemic patients, the absence of pallor cannot rule out anemia
2. Hypotension (sBP < 110 in men; sBP < 100 in women)
 - low sBP is associated with fatigue but the association is not independent of psychological dysfunction. Hence low BP is not a cause of fatigue in its own right.
3. Thyroid signs
 - hypothyroidism (coarse skin LR+5.6, slow speech LR+5.4, bradycardia LR+4, peri-orbital puffiness LR+3, goiter LR+3) absence of any of these practically rules out hypothyroidism.
4. Lymphadenopathy & hepatosplenomegaly (chronic infectious/inflammatory disease or malignancy)
5. Weight loss (see previous issue)

Characteristics which help distinguish Psychological from Physical causes of fatigue

Characteristics	Psychological	Physical
Duration	Chronic	Acute
Onset	Stress related	Unrelated to stress
Diurnal pattern	Worse in the morning	Worse in the evening
Course	Fluctuates	Progressive
Effect of activity	Relieves	Worsens
Associated symptoms	Multiple & non-specific	Few & specific
Previous problems	Functional	organic
Family	Stressful	Supportive
Appearance	Anxious/depressed	Ill
Placebo effect	Present	Absent
Effect of sleep	Unaffected/worsened	Relieved
Decreased ability to cope	No	Yes

(Katerndahl DA. Fam Pract Res J 1993;13:82)



Identifying alarm symptoms

Patients with medical illness are more likely to explain their fatigue in relation to specific activities.

Those with fatigue of psychogenic origin tend to be “tired all the time.”

Those with a few organ-specific symptoms are more likely to have underlying medical illness compared to those with multiple somatic complaints.

Investigations

The yield from laboratory studies unlikely to be high (5-10%) if history and P/E do not already suggest the cause.

1. Full blood count + ESR
 - anemia
 - macocytosis of alcohol misuse & hypothyroidism
 - raised ESR of chronic inflammatory/ infectious disease
2. Fasting/ random glucose for diabetes mellitus
3. Thyroid stimulating hormone

Because of the high baseline rate of asymptomatic thyroid disease (up to 30%), abnormal TSH may not explain the fatigue in those patient. In the patient with fatigue but no other signs or symptoms of hypothyroidism, a rising TSH raises the probability that fatigue is due to hypothyroidism to 60% while a normal TSH reduces it to 0.02%.

In addition although the UK Royal Colleges recommend that the following be checked in any patient with a history >6 months, we would probably have already included these in the initial work up:

4. liver function tests
5. urea, electrolytes, and UFEME
6. creatine kinase

Other tests (CXR, ECG, connective tissue disease screen, pregnancy testing, drug screen, viral serologies, etc) may be ordered if suggested by history and P/E.

Caveat

Any patient may have both a physical and a psychiatric reason for fatigue and psychiatric complications are especially common in chronic physical illness.

Just because an abnormality is discovered, it does not necessarily mean that the problem is of fatigue “solved”:

- there is often more than one etiology to the complaint
- the abnormality may be discovered and resolved without changing the patient’s complaint of fatigue!

In summary

In most patients with fatigue, the etiology will be determined by a careful history. If the history does not initially suggest an organ failure, perform a systems review, paying attention to any alarm symptoms. Then focus the interview to uncover any possible psychiatric disorders.

A thorough P/E is done with special attention to those systems suggested by the history.

Significant weight loss, night sweats, fever suggests a systemic illness especially infection & malignancy.

Laboratory studies rarely contribute to the diagnosis of fatigue but may help exclude potentially serious medical illness.

Serious illnesses are often apparent at the time of consultation because of associated clinical features. Hence an extensive work-up for occult medical illness is generally not warranted.

Appendix

SOFA (Schedule of Fatigue & Anergia)

(Hadzi-Pavlovic, et al. Soc Psychiatry Psychiatr Epidemiol 2000;35:471-479)

Over the past one month:

1. I feel tired for a long time after physical activity
2. My concentration is poor
3. My muscles feels very tired after physical activity
4. I get headaches
5. I need to sleep for long periods
6. I get muscle pain after physical activity
7. I sleep poorly
8. I have problems with my speech (e.g. feeling “lost for the word”)
9. My memory is poor
10. I get muscle pain even after rest

Score 1 for each question if patient says the statement is true for “a good part of the time”. Score 0 if the statement is only true “some of the time” or less.

The screen is positive for prolonged fatigue syndrome if score is ≥ 3 (sens 81%, specif 100%)

The Epworth Sleepiness Scale

Ask "How likely are you to fall asleep in the following situations, in contrast to just feeling tired?"

- sitting & reading
- watching TV
- sitting inactive in a public place (e.g. a theatre or at in meeting)
- as a car passenger for 1 hour without a break
- lying down to rest in the afternoon when circumstances permit
- sitting & talking to someone
- sitting quietly after lunch without alcohol
- in a car, while stopped for a few minutes an traffic

Score:

0	would never doze
1	slight chance of dozing
2	moderate chance of dozing
3	high chance of dozing

Score >11 carries a high chance of sleep problem (not necessarily narcolepsy), provided that other causes e.g. lack of sleep, depression have been excluded.

Chronic fatigue syndrome

The Canadian Working Case Definition (Carruthers, et al. J Chronic Fatigue Syndr 2003;11:7-115)

Of the 6 known, this is the only definition intended for clinical, rather than research use.

The following should be present for ≥6 months and is not due to another disease:

1. Fatigue physical/mental bad enough to decrease activity by ≥50%
2. Post-exertional fatigue muscular and/or mental with delayed recovery (≥24hr)
3. ≥ 2 neurological/cognitive decreasing concentration/memory, disorientation, word-retrieval
4. at least 1 symptom from 2 of the following 3 categories
 - autonomic: orthostatic hypotension, palpitations, irritable bowel/bladder, nausea
 - neuroendocrine: heat and cold intolerance, change in appetite or weight
 - immune: tender lymph nodes, recc sore throat/flu-like illness, new sensitivities to food, drugs, chemicals

References

1. Polmear A. Evidence-based diagnosis in primary care. 2008.
2. Mengel & Schwiebert. Family medicine- ambulatory care & prevention 5th Ed 2009.
3. Tierney LM, Henderson MC. The patient history-evidence-based approach. 2005.



Family Practice Skills Course Managing Family Violence

The College of Family Physicians Singapore would like to thank Ministry of Community Development, Youth and Sports (MCYS) and the Expert Panel for their contribution to the Family Practice Skills Course on "Managing Family Violence", 29-30 January 2011.

Expert Panel:

Ms Jeanne Chua, Programme Branch, MCYS
Ms Prabhavathe S., Child Protection Service, MCYS
Dr Barathi Rajendra, KKH
Ms Pang Kee Tai, Head (Training), Centre for PAVE
Mr Bay Chin Chye, Community Involvement, SPF
Dr Wong Tien Hua, CFPS
Mr Alvin Chua, TRANS SAFE Centre

Family Practice Skills Course Oral Health

The College of Family Physicians Singapore would like to thank Health Promotion Board (HPB) and the Expert Panel for their contribution to the Family Practice Skills Course on "Oral Health in Primary Care", 19-20 February 2011.

Expert Panel:

Dr Wong Mun Loke, Health Promotion Board
Dr Eu Oy Chu, School Dental Services, HPB
Dr Rahul Nair, Preventive Dentistry Department, NUS
Dr Adeline Wong, School Dental Services, HPB

Family Practice Skills Course Online Notifications

The College of Family Physicians Singapore would like to thank MOH, MOM, HPB, HSA and the Expert Panel for their contribution to the Family Practice Skills Course on "Online Notifications & E-Services Platform, 5-6 March 2011.

Expert Panel:

A/Prof Goh Lee Gan, Division of Family Medicine, NUHS
Dr Jeffery Cutter, Communicable Disease Division, MOH
Dr Kenneth Choy, Occup. Safety and Health Div., MOM
Ms Dorothy Toh, Health Products Regulation Group, HSA
Royceton Martin, National Immunisation Registry, HPB
Prof Chng Hiok Hee, Tan Tock Seng Hospital
Dr Jonathan Pang, CFPS
Dr David Cheong
Dr Muhammad Iqbal

Management of Functional Decline in Older Adults

COURSE OUTLINE:

Overview

- Geriatric Care within a Primary Care Setting
- Role of GPs in Management of Functional Decline in Older Adults
- Community Functional Screening Programme

Physical Function - Dr Wong Sweet Fun

Continence - Dr Terence Tang

Hearing - A/Prof Lim Hsueh Yee Lynne

Mood - Dr Ong Pui Sim

Vision - Dr Au Eong Kah Guan

Oral Health - Dr Wong Mun Loke

Distance Learning Module opens until 3rd May 2011. Register now!

Registration is closed for seminars/workshops.

Date: 12-13 March 2011

Venue: Gallery Hotel, Kenzo Room (Level 2)



DAY 1 PROGRAMME

Seminar 1 • Unit 1-3: Sat, 12 March 2011 (2.00pm - 4.15pm)

Workshop 1 • Case scenarios: Sat, 12 March 2011 (4.30pm - 5.45pm)

DAY 2 PROGRAMME

Seminar 2 • Unit 4-6: Sun, 13 March 2011 (2.00pm - 4.15pm)

Workshop 2 • Case scenarios: Sun, 13 March 2011 (4.30pm - 5.45pm)

(Max. of 3 Core FM CME points per seminar cum workshop.)

*Registration is on first come first served basis. Seats are limited. Please register early to avoid disappointment.

DISTANCE LEARNING MODULE

(6 Core FM CME Points upon completing the 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 and supported by the College of Family Physicians Singapore and Health Promotion Board (HPB)



REGISTRATION

MANAGEMENT OF FUNCTIONAL DECLINE

Please tick (✓) the appropriate boxes



	College Member	Non Member
Seminar & Workshop 1	REGISTRATION CLOSED	REGISTRATION CLOSED
Seminar & Workshop 2 (Sat-Sun)		
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☐ I attached a cheque for payment of the above, made payable to: College of Family Physicians Singapore.*

Cheque number: _____

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*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: ☐ 2009 Intake ☐ 2010 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. Please kindly check your inbox prior to attending the course. Thank you.

Please mail the completed form and cheque payment to:

College of Family Physicians Singapore

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

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