The College Mirror

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Contents

The 19th Council & Editorial Board wish all Doctors & their families a Merry X'mas & a Happy New Year.

College Art Gallery

"After a day's work" by Tay Bak Koi, From College Art Collection

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National Standard for Primary Care

At the 2004 FM Convocation held on 30th October 2004, President of the College of Family Physicians Singapore, A/Prof Cheong Pak Yean made public the College's Memorandum to the Ministry of Health proposing that the Graduate Diploma in Family Medicine (GDFM) be the national standard for family doctors in Singapore.(*see pages 3 & 5*)

The news was featured on the front page of The Straits Times 2 days later, on Nov 1, Monday, 2004 under the banner "Young docs needs more training to go private".

The FM convocation and dinner was held at the College of Medicine Building with Mr Khaw Boon Wan, Minister of Health as the Guest- of-Honour. Other distinguished guests present were Prof K Satku, Director of Medical Services, Dr Lee Suan Yew, President of Singapore Medical Council, Prof Low Cheng Hock, Master of Academy of Medicine, Dr Wong Chiang Yin, Acting President Singapore Medical Association and Clinical Prof Chee Yam Cheng, the Sreenviasan Orator 2004.

This year, 50 doctors attained the GDFM, 19 MMed, 6 MCFP and 12 FCFP.

The 19th Sreenivasan Oration was on the "Family Practice of The 21st Century- Computers, Changes & Challenges" (*Pg 4*).

(L-R): Dr Lee Suan Yew, Prof K Satku, A/Prof Cheong Pak Yean, Mr Khaw Boon Wan, A/Prof Goh Lee Gan & Clinical Prof Chee Yam Cheng

Defining a Standard for Primary Care Practice *in Singapore*

By A/Prof Cheong Pak Yean President, College of Family Physicians Singapore

The need to define a standard for primary care practice in Singapore has gathered momentum over the last few years and in particular in recent months. This is in tune with the quality and patient safety movement worldwide. The initiative to consider a national standard for primary care started five years ago when in May 1999, a decision was made at the College Annual General Meeting(AGM) to develop a graduate diploma (GDFM) based on the syllabus used in the Master of Medicine(Family Medicine) programme which had been in use since 1990.

This concept of a standard of practice for primary care was tabled to the Family Medicine Committee, which is made up of representatives of the Ministry of Health, the University, the College and service providers in both the public and private sector. The Graduate Diploma in Family Medicine (GDFM) was the outcome of the deliberations.

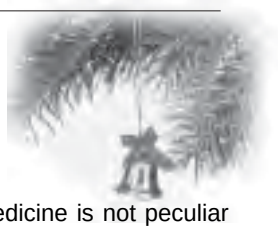
The GDFM was started as a pilot programme in the national endeavour to train doctors to be able to practise at an enhanced level of primary care in keeping with current standards of family medicine practice around the world. The University conducts the examination and awards a Graduate Diploma for successful completion and passing the examination. The College was given the responsibility of training the doctors who registered for this programme.

A memorandum that the GDFM be adopted as the general standard for primary care practice was submitted to the Ministry of Health following several dialogues with the stakeholders in primary care. This was made public in the FM Convocation held on October 30 this year and it was also reported as a front page news in *The Straits Times* two days later.

The syllabus and training programmes in the current GDFM relate to the national health care agenda. The GDFM examination itself is also aligned to meeting the healthcare needs of the Nation. Common conditions as well as rare but not to be missed conditions are the staple of the cases used for testing.

The College is now in the process of gathering feedback on the implementation details and fine-tuning the syllabus and training to meet national needs. An FAQ on the GDFM is on page 5. The College looks forward to your feedback on how we could use the GDFM to set the practice benchmark for primary care doctors in Singapore.

Setting in Order



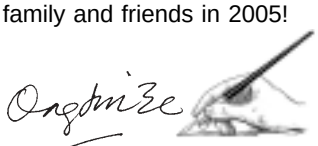
It is Christmas time again. Just as two thousand years ago there was a star that appeared in the East directing the Magi to the Christ child, so it is that Family Medicine is looking for its guiding star to take it to the future. There is uncertainty in reformation and transition but it should be for the good - to set the FM house in the right order & build capacity for the betterment of our patients.

This issue we highlight vocational training for the GP - the GDFM as a minimum standard akan dating? (Pages 1 & 5). On page 20, a solo GP shares his dilemma in "*Reflections of a Solo GP".* There are important lessons also to learn about the plight of the GP from the movie, *Titanic* (Page 16). College Mirror also interviewed *"A Few Good Men and Women"* who have just exited their Fellowship at the Convocation '04 (Page 10).

The reformation of family medicine is not peculiar to Singapore. The Practice & Quality SIG of College invited two overseas speakers to share with us the Australian and Scottish experience in developing quality care in family practice (Page 14).

In business as usual, our SIG chairmen round up the year (Page 6). Practice Corner features a new bite size series on Family Medicine research (Page 19). Get in the act for those so inclined.

We thank all our contributors and wish good health and peace to all our family and friends in 2005!



Dr Ong Jin Ee
Editor of The College Mirror

19th Sreenivasan Oration: Family Practice of the 21st Century - *Computers, Changes & Challenges*

By Dr Ong Jin Ee, MCFP, Editor

A/Prof Goh Lee Gan gave the citation on Clinical Professor Chee Yam Cheng & College Mirror extracts his personal account on Prof Chee's contribution to the discipline of Family Medicine(FM).

A/P Goh Lee Gan

Made family medicine training happen

"...Perhaps the most memorable thing that I will say of Prof Chee in my perspective of him is the contribution he has given to FM. Great historical happenings often have simple beginnings. For family medicine's recognition as a discipline for training & practice it was certainly so.

It began as an almost casual telephone call from Prof Chee one day in 1988 as the Director of Manpower in the Ministry of Health(MOH). He asked me how many postings does a GP need to be trained. I replied that it is a short question that required a very long answer & suggested that we form a vocational steering committee in FM to look into this. He did & the traineeship in FM became a reality.

We formed a tripartite vocational steering body made up of the MOH, College of Family Physicians & the Graduate School of Medical Studies. Under the tenure of Prof Chee as Director of Manpower, we were able to have 3 monthly postings for doctors wanting to take on a career in FM. Prof Chee took a personal interest in the professional development of the FM traineeships and he ran feedback sessions. With that headstart we got on.

Prof Chee also contributed professionally in teaching the FM trainees & being a member of the panel of examiners in the Master of Medicine (FM) Examinations. For his contribution to the College, the College Council elected him to be a Honorary Fellow of the College of Family Physicians, Singapore in 1999."

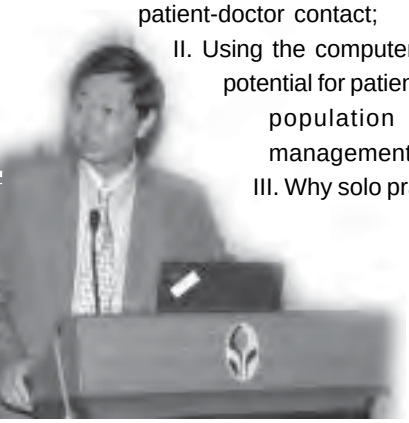
(The full text of the Oration would be published separate as an occasional paper of the College)

Prof Chee in his oration addressed the challenges ahead for the family practice of the 21st Century. He addressed three key issues:

I. The need for clinical quality care at every patient-doctor contact;

II. Using the computer to its full potential for patient care and population health management; and

III. Why solo practitioners will find it harder and harder to survive. "It is, as it were, apoptosis(or programmed cell death) for the solo family physician, if each continues to practise as of today – alone, long hours(when a 5 day week is the norm), poor family and personal life and little time for CME, audit and accountability activities."



Clinical Prof. Chee Yam Cheng

He concluded "the culture of our profession will shift towards more teamwork, continuous improvement, learning and timely implementation of lessons learnt. This will help us achieve higher clinical quality at lower cost. The specialist is not above the family physician nor vice versa. We need every member in the team to do best the part we have been trained for. Only then will our patients receive increasingly higher quality care at lower costs."

"....clinical quality care at every patient-doctor contact.....using the computer to its full potential ....apoptosis (or programmed cell death) for the solo family physician..."

Clinical Professor Chee Yam Cheng

- Born in 1949 & married with 2 children
- Prof Chee Yam Cheng currently Senior Physician & Head in the Department of General Medicine, Tan Tock Seng Hospital . He has been an enlightened administrator both in the Ministry of Health, at the level of the hospital, and now in the healthcare cluster as Assistant CEO (Clinical) of the National Health Care Group.
- Prof Chee has a long string of portfolios covering general administration and special areas like technology assessment, case-mix, biotechnology, renal dialysis, neuroscience, tuberculosis, research, nursing, ethics and professional conduct during his days of working in the Ministry of Health.

Awards and Milestones

- ACS Old Boys' Association Meritorious Silver Medal 'O' levels
- ACS OBA Gold Medal 'A' Levels
- Medical School NUS :Bailey Memorial Medal, the Albert Lim Liat Juay Medal, the Gordon Arthur Ransome Essay Prize
- Best Teacher Award in the Division of Medicine TTSH in 1999.
- Fellow of the Royal College of Physicians, Edinburgh; the Royal College of Physicians & Surgeons (Glasgow); the Royal College of Physicians (London); the Royal Australasian College of Physicians; Fellow of the American College of Chest Physicians.
- Recognized by the American Biographical Institute Chosen for distinguished standing and conferred with an honorary appointment to the Research Board of Advisors.
- Pingat Perkhidmatan Awan (PPA), Certificate of Appreciation from the Ministry of Health, and the Long Service Award in the National Day Award in 1999.

Graduate Diploma in Family Medicine (GDFM) FAQs

1. Why is there a need for further vocational training of family doctors?
Over the years, disease pattern had changed from mainly infectious diseases to mainly chronic diseases. In Singapore, as in many developed countries, the burden of disease arises from cardiovascular diseases, diabetes, asthma (and chronic obstructive lung disease), as well as cancers. Management of these diseases & their risk factors requires medical knowledge that crosses specialties & good individualised & personalised counselling skills.

Today, market driven forces has resulted in greater emphasis on specialisation and thus has little development on the role of the generalist. Medical (super)specialisation also has its side effects of fragmentation of care and deterioration of patient-doctor relationship. A well-trained family physician can take the role of the new generalist and help coordinate care for the patient and family.

2. Are we the only country requiring further vocational training of family doctors?
In many developed countries like United Kingdom, USA, Canada & Australia, vocational training for family doctors beyond basic medical degree has become the norm. These vocational training are usually 2-3 yrs long & requires passing of various examinations. In fact, in 1996 in Australia & in 1998 in UK, it has become mandatory for doctors to have additional vocational training before they can practice as general practitioners.

3. Does taking the GDFM course really make me a better family doctor?
The training programme consists of 8 modules & 5 skills courses. The modules cover whole person medicine, disease management by body system & practice management. Workshops & tutorials are also conducted to provide the interactive leading on the more important the topics in each module. There are also various skill courses covering a wide range of topics, including principles & practice of family medicine, communications & counselling courses.

Thus the GDFM course covers the spectrum and the depth, from the perspective & principles of family medicine, which emphasises holistic, continuity personalised and preventive care.

GDFM in brief

- 2-years part-time course
- Face-to-face sessions outside usual clinic hours
- Training programme by College & Exam by NUS
- 8 quarterly GDFM modules & 5 Skills Courses
- Each module consists of 8 topics and 1 small group tutorial
- 2 topics covered in Sat afternoon workshops i.e. 4 workshops every 3 months
- 5 Family Practice Skills Courses - 3 mandatory
- Exam held in one weekend, writtten & OSCE
- Objective Structured Clinical Exam on 10 common/important scenarios seen in GP clinics

4. What are the benefits of better trained family doctors?
A better trained family doctor is a strong health advocate, a good resource manager & a good personal counsellor. He will be able to advise & treat a wide range of medical problems for the whole person, with strong emphasis on preventive medicine & holistic care. He would also be in better position with work closely with hospital doctors to manage some complex patients. In the long term, we can look forward to better trained family doctors playing a greater role in the healthcare system & a healthier population.

5. I am so busy in my practice that I do not have time to do the GDFM course, what should I do?

The materials for GDFM are available online. Lectures are mainly held on Saturday afternoons and tutorials are arranged mutually between tutor and tutees.

6. If I do not have GDFM, will my practice be affected if the proposal is eventually implemented?
CFPS's main aim for this proposal is to raise the future standard of family medicine in Singapore. It remains committed to its members' interest. College in making its proposal to MOH to make GDFM the national standard, will also gather feedback from its members about current doctors who do not have the necessary qualifications & make the necessary recommendations to MOH. The basic working principles that college is working on is that no existing doctors' will have to stop practising as a result of our proposal. We will also work out a recommendation that is consistent with the years of experience of doctors who have been practising family medicine & consider an alternative route for GPs who have been practising for some time to achieve the same standard.

7. With this recommendation, does it mean that new doctors with basic medical degree can no longer practice if they do not take up vocational training?
New doctors will have to decide if they wish to pursue a specialty or family medicine. However, even if they do not wish to, there are many other career options other than family practice like nursing homes, emergency room, residency, research, teaching or administrative work.

8. Does it mean patients have to pay more to see family doctors?
Currently, vocationally trained GPs are not charging more than their fellow colleagues. CFPS will also not be recommending any changes to the current SMA fee guidelines.

Quality? Show Me the Money First

By Dr Lee Kheng Hock, FCFP, Chairman of Practice & Quality SIG

In the bad old days of the USSR, there was a shoe factory that makes shoes in one ugly design, in one standard size.

One day, a management guru & quality advocate asked the manager why don't they improve their quality by having better designs & make shoes that at least fit their customers' feet. The manager gruffly said with the contempt he reserved for such ivory tower types, "Oh yeah? Who is going to pay for all these quality mumbo jumbo? And can't you see we are already so busy making the shoes. Customers? Look at the long queues in the stores, they can't get enough of the shoes we make."

Indeed there was a long queue of people shivering in the snow, waiting for their ration of shoes. Horribly crafted & ill-fitting but the demand was insatiable. People get their shoes & traded them with people who had bread but no shoes. Others rip up the shoes & use the leather as raw materials to make wallets and belts, and sometimes better shoes. Sometimes, if they were lucky, the ugly shoe fits. This is the tragic cost of low quality & we live with it everyday. The Berlin

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wall may have crumbled and Communism presumed dead but there is a little bit of the evil empire in everything around us. Ugly and ill fitting shoes are everywhere and we hobble along each day.

Consider the health care system for one. Ask any stakeholder in the system and you will get a earful of how bad things are in various areas. Long queues of patients wait for hours for a dose of health care that sometimes does not really meet their needs. Poor outcome of chronic diseases testifies to the low quality of the system. Underemployed family doctors in private practice try to make ends meet by doing more of the same in ever-longer hours and at ever-lower prices.

The answer lies not in more bellyaching but on insisting on quality. Quality is a double-edged sword. As you demand quality from the system, so shall the system demand quality from you. For this reason many would blink and prefer the safe comfort of mediocrity. People put up with low quality, busy working in factories that make low quality shoes & bearing the pain of wearing the same shoes that system dish out to them.

At the end of the day is it worth it? Like the proverbial frog that is boiled alive by slowly increasing the temperature of the water, is it not better to make a leap for quality? Vocational training is the first of many steps in the reform of primary care. The light at the end of the tunnel is a better state of health for our nation and job satisfaction for our doctor & yes, a decent sum of money for a job well done. It is a long road ahead but at least we begin the journey with a nice pair of shoes.

An Intellectual Feast of Ideas on Quality

by Dr Lee Kheng Hock, FCFP, Chairman of Practice & Quality SIG(PQSIG)

The PQSIG was very lucky to have a steady stream of quality advocates of Family Medicine(FM), visiting our College.

Associate Professor Steve Trumble is the Director of Education at the University of Melbourne. He is also the Editor-in-Chief of the Australian Family Physician, a renowned family medicine journal published by the Royal Australian College of General Practitioners. He was the external examiner for the Fellowship by Assessment 2004. We took the opportunity to invite him to give a talk on *"Training for Quality"* on the 23 Sept '04. The very interesting session was chaired by Dr Tham Tat Yean, Vice-Chairman of the PQSIG. Many of the Fellowship trainees took the opportunity to have a practice sparring session with their external examiner.

They were not disappointed as Prof Trumble gave a very frank discourse on the limitations of the examination process & the various ways that people had tried to improve on the validity & reliability of the summative assessments. He concluded that stringent & challenging summative assessment must be balanced by an encouraging, supportive formative assessment system that promotes professional development. Trainees of our various programmes must be cheering in agreement.

Signing of Guest Book: (L-R) Dr Lee Kheng Hock, Dr Moya Kelly, A/P Cheong Pak Yean & A/P Goh Lee Gan

Dr Moya Kelly is a familiar friend of the College. Dr Kelly and her co-workers played host to our College study group when they visited Scotland between 20-27 March '04 to study the primary care system in the United Kingdom. Her first visit to Singapore was six years ago when she was invited to participate as a trainer for the family medicine course of the MMed (Family Medicine) training programme. Dr Moya Kelly is the Assistant Director of NHS Education for Scotland. This year she was invited to Singapore as the external examiner for the Masters of Medicine (Family Medicine) Examinations 2004. The PQSIG took the opportunity to find out about the latest quality improvement developments in the UK.

Signing of Guest Book: (L-R) Dr Tham Tat Yean, Dr Paul Goh, A/P Goh Lee Gan, A/P Steve Trumble, A/P Cheong Pak Yean & Dr Lee Kheng Hock

On 21 October 2004, Dr Kelly was invited to give a talk on "Rewards for Quality Clinical Practice". Dr Kelly gave an overview of the strategy to improve quality in primary care in the United Kingdom. The latest innovations in quality were implemented in April 2004 as the "New Contract" for GPs in UK. The United Kingdom is the first country in the world that has implemented a comprehensive system that pays primary healthcare providers based on how well they meet performance indicator for the management of a range of chronic diseases. Most members of the audience were very impressed and felt that it was a very well designed system that took into consideration most of the important aspects of primary care. It is still early days in this bold initiative in paying for quality. So far the results are encouraging. The lecture made many of us reflect on the causes of the low quality of primary care in Singapore. One member of the audience was so inspired after attending the talk that he later wrote an article for the College mirror (See page 18)

A Model of care for the older person in Singapore

By Dr Tan Boon Yeow, FCFP, Chairman of Eldercare SIG

The following is a special report of the development of the Eldercare SIG with the visit of Dr Forsyth & subsequent meet up with geriatricians & various stakeholders. College hosts Dr Duncan Forsyth, a UK geriatrician who was involved in the setup of SIG for older persons.

(L-R) Dr Fong Ngan Phoon, A/P Goh Lee Gan, Dr Duncan Forsyth, Dr Ong Jin Ee & Dr Tan Boon Yeow

Dr Duncan Forsyth visited the College of Family Physicians on the 11 Sept 2004 at the invite of the President and College's eldercare SIG. Here is an abstract of the discussion we had with him.

A/P Goh: *"Duncan, can you tell us a little more about yourself."*

Dr Forsyth: "I am currently Senior lecturer & consultant Geriatrician at Addenbrookes Hospital, Cambridge. My specialist interest is in Parkinson's Disease & cognitive problems in the elderly. I am actively involved in the Royal College of Physician & examine for the diploma of geriatric medicine. I also recently spent 1 mth in Malaysia visiting local hospitals & establishing links for training & service development for geriatrics in Malaysia."

A/P Goh: *"Could you give us some reasons why you see a need for GP SIG (GP with Special Interest) to be set in the UK?"*

Dr Forsyth: "There are various reasons. Some of the more important ones include:
a. Long waiting time to see specialists. Some GPs took on extra training to provide this expertise at the primary care level.
b. GPs wanting to do more than their routine practice and to develop some form of special interest.
c. The lack of appropriate structure for career development and training for areas of special interest.
d. Government policies. (eg. NHS removed long term care(LTC) facilities and rehabilitation beds from the purview of geriatricians and hence these came under the jurisdiction of the GPs) Geriatricians are therefore made to cater to acute care and do not manage much chronic disease."

A/P Goh: ***"****How do you ensure that these GPs with special interest have adequate training to look after the elderly?"*

Dr Forsyth: " We have tried to do this by implementing the following 'criteria':
i. GPs must be interested.
ii. There must be some standardization of the training process. (e.g. Diploma in Geriatric Medicine)
iii. They must have a good track record (i.e. have been doing the job satisfactorily, e.g. member of department of geriatrics/ hospital practitioners)
iv. 'Grandfather' clause of those who have worked in 2 previous postings in a geriatric setting.

Currently, this special interest group is an initiative of the British Geriatric Society. This development is led by the SIG(Special Interest Group) in primary care and home care which has representatives from the Royal College of General Practitioners (RCGP) and geriatricians.

A/P Goh: *"The UK system & issues in care for the older person as well as setup of SIG is similar in many ways to the situation in S'pore. We will work with the various stakeholders to develop a system of care that will best suit the nation."*

Following the meeting with Dr Forsyth, College representatives met up with Dr Pang Weng Sun, President of the Society of Geriatric Medicine, Singapore to discuss further the role of GPs/Family physicians with special interest in the older person/eldercare.

A/P Goh: *"..We recently had Dr Forsyth visit us and he had suggested a model of care of the elderly involving family physicians. What are your thoughts on this matter?*

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Figure 1 : CARE PROVISION FOR ELDERLY BY MEDICAL PROFESSIONALS

Type of Care	Acute Care	Subacute Care	Rehabilitation	Chronic Care	End of Life Care
Settings	RH	RH, CH, NH Home Care	RH, CH, NH Day rehab Home Care	GP/Polyclinic NH Home Care	RH, CH, NH Hospice Home care
Geriatrician (FAMS) College of Physicians	+++	+++	++	++	++
Special Interest FPs (GDFM or MMedFM + GDGM) (College of Family Physicians)	+	++	+++	++	++
FPs (GDFM) College of Family Physicians	NA	+	+	+++	++

***Key: +++ major involvement, ++ some involvement, + minor involvement,* NA not applicable**

Continue from Page 8

Dr Pang: "I think that family physicians/ GPs, as well as those with special interest in eldercare, have a major role to play in the care of the elderly. I have drawn up a chart (Figure 1) that I think may work for us caring for the elderly in S'pore."

In this model of care, the two colleges [College of Physicians (COP) - under the Academy of Medicine & the College of Family Physicians (COFP)] will oversee the different professionals in the care of the elderly. Academy (through JCST) will accredit geriatricians (MRCP, FAMS) & COFP accredit family physicians, & family physicians with additional training in geriatrics.

***A/P Goh**: Yes, this is a good way to build capacity. I see that a possible accreditation system would be attaining the status of family physicians first by obtaining either Graduate Diploma in Family Medicine (GDFM) or Masters in Medicine [MMed (FM)]. Further training through relevant attachment/posting & completing additional training in geriatrics [Graduate Diploma in Geriatric Medicine (GDGM) or equivalent] for those who want to be accredited as family physicians with special interest in the care of the elderly. [FP SIG (eldercare)}*

Community eldercare in Singapore is at the cross-roads for development to greater heights. The discussions with Dr Forsyth and with Dr Pang were illuminating in showing the way on what can be organised into our healthcare system drawing into their experiences and insights. In a nutshell, we need to talk, to train, and to build a seamless healthcare system for the Singapore elderly that will provide the appropriate levels of care that can effectively manage the elderly's problems and needs at any particular point of their illness-wellness spectrum. Dr Pang's table gives a good insight into the role that each of the stakeholders - Geriatrician, Special interest GPs, and the other GPs - can contribute in the total care of the elderly infirm. Let us make things happen in 2005.

Eldercare SIG update

By Dr Tan Boon Yeow, FCFP, Chairman of Eldercare SIG

The eldercare SIG held her final grand-round of the year on 2nd Nov '04. We were honored to have Dr Ding Yew Yong, Head & Senior consultant, Geriatric Medicine Department, Tan Tock Seng Hospital share on clinic assessment of the elderly. Dr Ding emphasized that, armed with correct tools and expectations, many physicians will find that caring for older people can be gratifying rather than frustrating.

He went on to define what geriatric assessment comprises of and also reviewed the evidence for its effectiveness. He concluded that we could consider supplementing our traditional medical assessment of our patients with a brief screening for common geriatric problems and perform a comprehensive evaluation only on those who have problems identified by screening.

Dr Ong Jin Ee, Collegiate member and home care physician, shared her experience on the care of her elderly patients in their homes. A survey of her patients showed that the majority of them had stroke or dementia. She spoke on the essentials in conducting home visits & illustrated with a few case studies.

The eldercare SIG core group also took the opportunity to review our activities for the year. We felt that we had made a good start but would like to reach out to more college members and interest all towards the care of the elderly. We hope to conduct feedback on how we can improve our activities as well as ways to make it more relevant for family physicians. Some initiatives that we will be taking include:

a. Asking members to submit questions or difficult cases which they encounter that is relevant to the topic of the grand-round. Questions and cases that are not directly relevant to the upcoming grand-round are also welcomed and will be brought up for future discussions.

b. Organizing college skills courses that will be relevant to family physicians. These skills courses will provide more in depth discussion and review of the topic concerned. We hope to do a skills course on dementia at the end of next year.

Finally, we would like to take the opportunity to wish all members a most refreshing year-end holidays as well as a very blessed Christmas and New Year. We also hope to see more of you join our activities in the coming year.

Dr Chin Khong Ling
Dr Goh Lay Hoon
Dr Goh Yann Pbor
Dr Koh Wee Boon Kelvin
Dr Lim Soon Meng Edward
Dr Lim Yin Yin Michelle
Dr Liu Elaine
Dr Meena Sundram
Dr Neoh Sue Fern
Dr Ng Wei Leong Tommy
Dr Poon Beng Hoong
Dr Siew Chee Weng
Dr Sng Wei Kwan
Dr Tan Elaine
Dr Tan Ming Ying Michelle
Dr Tan Yew Seng
Dr Wu Ming-Jark Basil
Dr Yam Pei Fang Jacqueline
Dr Yeo Wee Shung Yehudi

A *Few Good Men And Women*

By Dr Ong Jin Ee, MCFP, Editor

Riveting court room drama A Few Good Men (1992) had a few Navy lawyers bent on seeking out truth in a murder involving the entire marine corps in Guantanamo Bay, Cuba. It pitted Defense attorney Lieuftenant Kaffee (played by Tom Cruise) against high level Navy Colonel Jessup (played by Jack Nicholson). In it a group of men and woman engaged themselves in a court battle to uphold justice and bring truth to light.

After Family Medicine(FM) Convocation in Oct 2004, we meet up with a few of our own good men and women who have just completed their fellowship programme and hear from them their own experience in pursuit of excellence in family medicine.

The FM Fellowship programme is a 2 year programme whose objective is to develop the family physician in the areas of clinical practice, teaching and research so that he can take on leadership role in family medicine. Entry requirements programme include completion of MMed(FM), MCGP or equivalent, embarked on personal professional development and training related to family medicine and active involvement in postgraduate training and undergraduate education in FM.

Dr Loke Wai Chiong,
Director/Associate Consultant,
SingHealth Polyclinics-Geylang

On his experience

It is about continual professional development, among a small group of like-minded motivated senior family physicians, intellectual sparring, reflection on our practice and comparing it against best evidence and practice according to literature or experience.

Also to be able to continue along a fruitful professional development track, a few yrs after my MMed(FM) exams, & to complete it, of course! I also enjoyed the fellowship ("pun" intended) & camaraderie we had as a class, over the past 2 yrs together!

How I hope to contribute and continue to practice...

As a Fellow of the College, I hope to play a part in the transformation of Primary Health Care in our country, a topic that is of much interest to our Health Ministry at this time.

What can be improved about the programme?

I feel the FMFP programme is still in evolution and work in progress so certain assignments & assessment formats changed along the way. My suggestion is that formative assessment in the setting of coaching/mentoring can play a much bigger role, & summative assessment should be more structured, & communicated clearly.

Dr Kang Aik Kiang,
Family Physician , Raffles Medical Group,
Compass Point

On his experience

I felt it was training for clinical leadership in Family Medicine. What was satisfying was the opportunity to participate and interact with various experts and talents from FM and other specialists. Definitely intellectual stimulating.

How I hope to contribute & continue my practice...

Focus on quality time management. Be motivated and passionate about family medicine practice.

What can be improved about the programme?

Doing a research project for FM was tough. Perhaps, reseach projects for 5 trainees to work on over a 2 years may be more appropriate instead of individual effort. Also my suggestion is perhaps there is need to look into advanced skill training courses for Fellowship…Must be a continuum ..perhaps in-patient management for family medicine (seeing our patients in the hospital) or advanced surgical or procedural skills.

Dr Marie Stella P Cruz,
Family Physician, National Healthcare Group Polyclinics – Yishun

On her experience

The FMFP enabled me to do & learn things that I ordinarily wouldn't have – eg how to do research, design a clinical audit & become a good teacher to adult learners. It has given me a helicopter view of Family Medicine, making me realize that primary care & the family physician play an equally, if not more important, role as other established medical disciplines, in healthcare. Networking with colleagues from Singhealth cluster polyclinics, & from the private sector was good. My GP colleagues always gave interestingly differing views from us public sector doctors.

I immersed myself in teaching, both within the polyclinic as well as in the M Med Private Practitioners Stream programme. As the saying goes 'To teach is to learn' . The programme allowed me to become familiar with the theory of conducting research, critical appraisal, clinical audit and significant event analysis. The 'training of teachers' workshop taught on varied aspects of teaching including on the psychology of learning, different styles of teaching, designing a study curriculum and setting exam questions eg OSCE and MCQs.

I also presented on 'Healthcare Management' and wrote a review paper on 'Legal Requirements of Setting Up a

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General Medical Practice in Singapore'. Other memorable moments was when I attended the WONCA Asia Pacific Regional Workshop on Training of Teachers held from April 16 to 18, 2004 in Kuala Lumpur. The synergy from being with more than 100 doctors from neighbouring ASEAN countries was invigorating. Besides the knowledge gained from this intensive workshop, this was also the first time I had ever traveled alone, *sans* husband and kids! The FMFP literally took me out of my comfort zone!

I would say that I have come out a more confident, mature and knowledgeable doctor from the FMFP.

How I hope to contribute and continue my practice...

I see myself as staying on in the polyclinic in the next several years, as there is a need for more senior doctors here. Providing a good level of care here, where manpower is so short, is a good way to contribute to the FM community.

Besides teaching, I would like to be involved in primary care research. However, doing research in the polyclinic setting would be a challenge, as necessary resources such as the infrastructure set-up, time and experience are just not available yet.

What can be improved about the programme?

I would have liked it to be more practically oriented. Specifically, one project each of clinical audit and significant event analysis should be done by each trainee. Or, to embark on a small pilot research project.

It would be good to make it compulsory to attend one overseas FM conference/ meeting/ workshop e.g those organized by WONCA. The lessons gleaned from interacting with FM counterparts from other countries can be tremendous.

The activities at our monthly meetings should be more varied. Besides presentations, other activities like critical appraisal of papers, significant event analysis and debates could be held.

Dr Derek Tse,
FamilyPhysician–SingHealth Polyclinics– Tampines

On his experience

It's an interesting & challenging experience to organise a group of senior, extremely busy family physicians to come together every month for 2 yrs. I've learnt from the meetings to look at things, ranging from practice guidelines to ethical issues through the eyes of different practitioners working in different environments. Prof Goh Lee Gan brought us through the steps of writing a review article in a systematic manner, which was extremely helpful. The informal sharing with fellow candidates also helped me gain invaluable insights into future directions and challenges in the development of family medicine in S'pore.

What can be improved about the programme?

I hope to see expectations more clearly laid out to the trainees at the onset to ensure that the trainees are able to craft out an efficient and meaningful training programme. Hopefully we can reach a stage where there is more uniformity, with the fellowhip exit interview more a final check of the candidate.My viewpoint is at the moment doing the fellowship training programme is born of personal aspiration and intention to contribute, hence the the focus should be on the process, rather than the assessment at the end. So apart from a solid training schedule, continual monitoring and guidance (formative assessment) should be the main form of assessment in the programme.

How I hope to contribute and continue my practice...

After having gone through the fellowship programme, I am thinking more of family medicine as a fraternity. I've become aware that there're like-minded people around.

In terms of future contribution I'm passionate in doing my bit in whichever area, be it teaching, research or quality improvement, to help raise the practice of family medicine.

WELCOME

The College would like to extend a warm welcome to the following members who joined us between Jul-Oct 04.

Ordinary Members

Dr Ang Li-Shan Constance
Dr Chiam Yih Hsing John
Dr Chng Shih Kiat
Dr Gan Ow Tin
Dr Ho May San Karen
Dr Khoo Yiok Bin Christine
Dr Lee Oh Chong Leng
Dr Lim Hwee Boon
Dr Lo Yoke Hwa Penny
Dr Ng Shu Ping Linda
Dr Oon Hwee Boon Hazel
Dr Puvanendran Rukshini
Dr Seah Chin Mui Jaime
Dr Tay Wen Sien
Dr Vasanwala Farhad Fakhrudin

Associate Members

Dr Ang Pei-Ming Samuel
Dr Chan Pai Sheng Daniel
Dr Chao Tar Liang Anthony
Dr Chin Khong Wee Justin
Dr Htwe Tin Cho
Dr Lee Mun Heng
Dr Lee Wei Hsin Carol
Dr Lwin Sann
Dr Myat Htwe
Dr Ng Wei Kian
Dr Tan Eileen
Dr Tan Eng Chun
Dr Zuberi Quaratulain Tahira

Notice

For current developments in the epidemiology of infectious diseases, **Epidemiological News Bulletin (ENB)** is now free & easily available online at this website:
http://www.moh.gov.sg/corp/publications/enb

Family Medicine Convocation 30 Oct 2004

Mr Khaw Boon Wan, Minister of Health visits College Premises

VIPs at the Convocation Ceremony 2004

Music performed by the *Striiiings*, an instrumental ensemble filled the auditorium

(L-R)Prof Chee Yam Cheng, Prof Satku, Dr Lee Suan Yew & Minister for Health, Mr Khaw Boon Wan

Audience at the Convocation Ceremony

Council of CFPS with Minister for Health & Director Medical Services - Standing(L-R): Drs Yii Hee Seng(Hon Treasurer), Pang Sze Kang Jonathan, Tan Yew Seng, Wong Weng Hong, Lim Fong Seng & Cheng Heng Lee
Seated(L-R): Drs Ng Joo Ming(Hon Editor), Tan See Leng, Prof K Satku(Director of Medical Services, MOH), A/Prof Cheong Pak Yean(President, CFPS), Guest-of Honour, Mr Khaw Boon Wan(Minister of Health), A/Prof Goh Lee Gan(C-in-C), Drs Tan Chin Lock Arthur(Vice-President) & Lee Kheng Hock(Hon Secretary)

Graduands of MMed(FM) 2004 - Standing(L-R): Drs Goh Yann Pbor, Koh Wee Boon Kelvin, Siew Chee Weng, Yeo Wee Shung Yehudi & Tan Yew Seng
Seated(L-R): Drs Tan Elaine, Tan Ming Ying Michelle, A/Prof Cheong Pak Yean(President), A/Prof Goh Lee Gan(C-in-C), Drs Goh Lay Hoon & Meena Sundram

Appreciation award presented to Mr Tan Kin Lian, CEO, NTUC Income Insurance Cooperative Limited

Dr Justina, emcee for Convocation Ceremony awarded MCFP.

Appreciation award presented to Ms Tan Mui Mui, Sales & Business Director, GlaxoSmithkline Pte Ltd

Dr Tan Yew Seng, 19th Council Member & MMed graduand 2004

Standing(L-R): Drs Ling Yee Kiang, Kang Aik Kiang, Tse Wan Lung Derek, Lew Yii Jen, Tan Choon Seng Gilbert & Chua Chi Siong
Seated(L-R): Drs Marie Stella P. Cruz, Tang Wern Ee, A/Prof Cheong Pak Yean(President), A/Prof Goh Lee Gan(Censor-in-Chief), Drs Lim Mien Choo Ruth & Tan Yu Sing Lucienne

FCFP

FAMILY PHYSICIANS
Doctors *for* Life

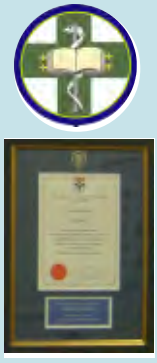
Standing(L-R): Drs Marie Stella P. Cruz, Khemani Neeta Parshotam, A/Prof Cheong Pak Yean(President), A/Prof Goh Lee Gan(Censor-in-Chief), Drs Justina Dairianathan & Low Chee Wah Mark

MCFP

FAMILY PHYSICIANS
Doctors *for* Life

Standing (L-R): Drs Wong Eu Joon Adrian, Liau Kah Han, Sim Chin Sing Evan, Ho Keng Boon Kenneth, Tan Chu Hui, Anne Regina, Sa'adah Bte Ismail, Lim Jiak Woon, Cheng Kah Ling Grace, Ang Lai Lai, Ng Poh Heng, Eapen Sunita, Beh Chong Teck Peter, Low Siew Teong, Ong Ming Jiunn & George Varghese
Seated (L-R): Drs Mah Li T'ing Adelina, Ng Soon Yin, Nam Min Fern Alvina, A/Prof Cheong Pak Yean(President), Dr Matthew Ng(Deputy Director, GDFM), A/Prof Goh Lee Gan(Censor-in-Chief), Drs Chew-Lau Clara, Davamani Diraviyam, Christine Khoo Yiok Bin & Sng Gek Khim Judy

GDFM



Quality Improvement in General Practice - *the Australian & Scottish Perspective*

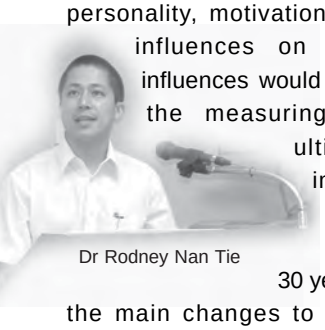
By Dr Stephen Tong, Editorial board member

Invited speakers at the FM Grand Round 18th Aug 04 were Dr Rodney Nan Tie, Senior Lecturer & Trainer, School of Medicine, James Cook University, Australia & Dr Douglas Murphy, Associate Advisor, Vocational Training for Family Practice, NHS Education for Scotland, UK. A/P Goh Lee Gan, chairing the session, noted that quality improvement is important in general practice. The Ministry of Health has also been keen to look at measuring quality of health care. However, in Singapore & current climate, even our managed care systems tend to be more concerned about cost control rather than quality control. This session also represented a second leg of a course that started in Glasgow in Mar' 04.

Quality is important in today's practice settings and patients' care. What then is quality and how can it be evaluated?

THE AUSTRALIAN PERSPECTIVE

Dr Rodney Nan Tie discussed how factors like education, renumeration, lifestyle, infrastructure & individual factors like personality, motivation & culture have influences on quality. These influences would have bearing on the measuring of quality & ultimately quality improvement.



Dr Rodney Nan Tie

In Australia, in the 30 years prior to 1984, the main changes to the health care system affecting quality of GP care were in the areas of improvement to education.

1958 – Australian College of General Practice
1963 – Undergraduate GP teaching
1968 – First GP examination
1973 – Family Medicine Program
1984 – Medicare

Medicare in Australia, implemented in 1984 is a Government Health Insurance program has its pros & cons. While it resulted in the majority of the population having free GP consultations & improving public access to GP care, it also resulted in increasing government control, shorter consultations time (renumerations of doctors being dependant on number of patients seen) & a general loss of respect for GPs as their services are not valued because it is free.

On a positive note, Medicare allowed for further development of GP training & quality assurance programs, rewarding doctors with proper accreditation in GP training programs. From 1987 to 1989, the Royal Australian College of General Practitioners (RACGP) developed Quality Assurance with their Continuous Professional Development (CPD) programs, & subsequently linked these to doctors' renumeration. In 1994, quota on GP training position was imposed and 2 years later, GPs access to Medicare was limited only to those with FRACGP.

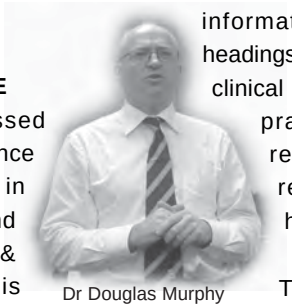
In the late 1990s Practice Accreditation and Practice Incentives Programmes were developed & implemented to ensure clinics maintain standards & quality of care. In the year 2002, the government developed General Practice Education Training (GPET) program & took over the training for the RACGP.

In Summary

These series of development resulted in increased government control over the practice of GPs, increased paperwork & costs, as well as a general decrease in income & morale to the GPs. However by using financial incentives, the government has increased ability to enforce compliance to QA & CPD programs as a result increasing standards of care & a gradual push towards recognising GP as a specialty.

THE SCOTTISH PERSPECTIVE

Dr Douglas Murphy discussed importance of quality assurance & professional development in primary care in Scotland, and the system of appraisal & revalidation process that is implemented. *The GP appraisal system* in Scotland covers aspects like success & problems at work, learning & development needs, goal setting & reviews of previous goals, reviews of complains, & carrier ambitions. It is conducted by peers, time protected, & with resources for needs identified.



Dr Douglas Murphy

Purposes of appraisal are to help identify educational & development needs, support preparation for revalidation & to reassure the public. However, this appraisal is not an assessment of performance, is not a pass/fail process, nor is it used as mechanism to deal with under performing doctors.

By the end of 2004, the GMC will give all doctors(except those who opt out) a licence to practice. From 1 January 2005, any doctor who wants to practice must hold a licence to practice. In April 2005, the GMC will start to invite doctors to be revalidated, & it is expected that it will take 5 years for all doctors to be revalidated for the first time. The GMC will revalidate doctors every 5 years thereafter.

Under revalidation, doctors are required to show to the GMC that he has followed the principles of *Good Medical Practice* that are relevant to his practice. The Scottish GP appraisal scheme has been designed to support doctors do this by focusing on 1 of 5 core categories of evidence in their appraisal each year. This makes the production for evidence & the agenda for appraisal manageable, & gives the doctor choosing the appraisal route to revalidation an effective method of showing that all seven headings of *Good Medical Practice* are covered.

The GMC will not prescribe & has no legal power to say exactly what information a doctor should collect & retain.The information should just cover all 7 headings of *Good Medical Practice* : good clinical care; maintaining good medical practice; teaching & training; relationship with patients; relationship with colleagues; health and probity.

The doctor decides how to show the GMC that he has followed these principles through 2 main ways - appraisal route or independent route. It is anticipated that the majority of GPs in Scotland will choose the appraisal route, which is why the appraisal scheme has been designed to support revalidation in addition to other functions.

The "Heart Sink" Patient

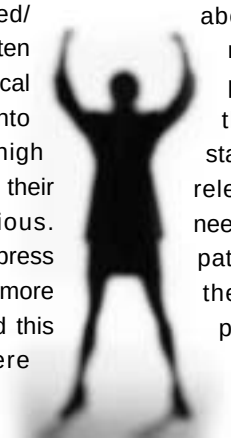
By Dr Yvette Tan, Editorial board member

I am sure most of us will have 2-3 'heart sink' patients in our practice. You know who they are. The ones who, as soon as you see their case notes, exclaim "Oh no , not again!" or "Oh great that's all I need today..." They are the 'difficult' 'FON (full of nonsense)" problematic patient that can evoke despair, anger, frustration in us. It is not even the extra time you have to put in for these patients either. Most of us will gladly spend time with our patients to help to get the patient back on track. However, it is this impending sense of doom, knowing that no matter how much time, empathy is poured out into the consultation, it may still end up like all previous 'investments' with these patients..... into the bottomless pit of their unquenchable needs.

Dr Liow Pei Hsiang, Consultant Psychiatrist at Alexandra Hospital helps us throw some light into this problem. While she has interests in eating disorders, her encounters in liaison psychiatry in Alexandra Hospital has put her at the receiving end of the other departments' eg surgical, medical, orthopedics, geriatrics heart sink patients as well.

A " Heart Sink" Case Profile

Female, over 40yrs, single/divorced/ widowed or marital problems, are often frequent attenders with minor physical symptoms; and who lack insight into their psychological problems. A high proportion of them are regarded by their doctors as depressed or anxious. Societies which lack language to express emotional distress tend to manifest more in terms of physical symptoms; and this is also common in settings where psychiatric problem is stigmatized.



The doctor who is usually at risk of such heart sink patients are those who have a greater perceived workload, lack of competence or lack of the appropriate qualification.

A GP classification of heart sink patients:

1.dependant clinger
2.entitled demander
3.manipulative help rejecter
4.self destructive denier
5.somatizers

Dr Liow commented that she preferred the term 'MUS(medically unexplained symptoms)' to describe most of the somatizers as it less stigmatizing. Such patients often present to the doctor with physical symptoms that have little or no basis of an underlying organic disease; & if an organic disease is present, the symptoms are inconsistent or out of proportion to the disease itself. The experience of such symptoms is in no way always a sign of psychiatric problem or a personality problem, as it is a legitimate way of expressing distress. This only becomes a problem if it results in abnormal health seeking behaviour or the persistence of the sick role.

Strategies to help the doctor help the heart sink

1.Know your patient well. Who they are, what they need, being attentive to the shades and colours with which the patient describes her symptoms, any recent significant life events, attitudes and beliefs about their symptoms, a good medical history, a good psychosocial history , assess the personality style, mental state, physical examination and relevant investigation. You may need to modify your style to suit the patient's needs. Formulation of the problem should consist of predisposing, precipitating and prolonging factors.

2. Build on the doctor-patient relationship. A positive regard is essential. Help the patient 'save face' by saying "I will help you cope better" rather than "It's in the mind" or "it is depression". Validating her emotion, trying to understand it, respecting and supporting it are ways of winning the patient's trust and showing your concern. Using the 'therapists' authority' by saying something like "don't worry, I think you have the resources to help yourself" can be very empowering to the patient .

3. Cognitive Behavioural Therapy is probably the best form of psychotherapy for the patient. However, it will only be effective if the patient is psychologically minded. Cognitive reorientation includes exploring the patient's explanatory model,

demystifying disastrous explanations and replacing them with benign ones and altering unhealthy thinking patterns and associated behaviour. Set mutually acceptable goals, achievable homework, and contracts on frequency of visits.

4.Good mental health advice, relaxation exercise

5. Symptom diary for those with chronic symptoms - detailing their thoughts, emotions, triggers and relievers

6. Work with significant others

7. Consider referral if patient is suicidal, aggressive, psychotic or if there is a failure for depression and anxiety to respond despite adequate treatment. Also to refer if there is worsening of the dysfunctional behaviour, failure to engage the patient or if patient requests. Reassure the patient that by referring, it is by no means a sign that you are about to abandon her.

8. Self-awareness is essential. Who is a heart sink for a doctor may not be a heart sink for the next doctor. Discovering why a certain kind of patient makes our heart sink may reveal more about ourselves, our needs than other kinds of patient encounters; & this can be an opportunity for further professional & personal development.

9. Discharging the negative feelings with a sense of humour, discussion with your mentor or ventilation to your colleague is absolutely important too!

Movie-based Teaching: *Titanic*

By Dr Yee Jenn Jet Michael, MCFP, Editorial board member

In the September issue of the College Mirror, *Engaging the Private Practitioners,* Dr Tan Yew Seng wrote a passionate piece on the pervasively neglected lot known as the private GPs (1). It ended with a reference to the ill-fated Titanic hitting an iceberg (2) and most of us will remember the movie starring Kate Winslet and Leonardo Di Caprio. In a recent series of lectures given by Dr Ryuki Kassai of the Hokkaido Centre for Family Medicine, he introduced a novel and effective way of teaching family medicine called 'movie-based-teaching'. We all know how effective 'story-based-teaching' is from listening to the more experienced teaching colleagues among us. Movie-based-teaching is particularly effective in drawing lessons from observing snippets of a specially selected movie and gleaning lessons from the behaviour, emotions and attitudes involved.

Personal Reflections from the Titanic

To begin with, the Titanic was an epic tragedy. We knew where the movie was going as soon as it started. Eventually most of the crew and passengers, in particular the third class passengers, would meet an icy death in the freezing depts. And on retrospect it was a disaster waiting to happen and could be averted (2). Is the private-GP-ship headed for disaster? Not surprisingly, some family physicians among us do feel as if we are on a sinking ship. It is clear that we shall not have enough time or resources for professional upgrading, research, audits (1), if we continue with bare-bone $10 consultations. Yet with the reality that polyclinics are offering about half that amount, we find it difficult to compete constructively (3).

The arguments for keeping consultation charges low for affordable primary healthcare is passé. Our specialist colleagues are charging five to ten times more, in both private and restructured institutions alike and hairdressers are charging between $10 and $50 for a basic hair cut and another few hundred for extra treatments. My feeling is that Singapore is underspending in primary care. Are GPs given enough room to survive? How do we practice effectively when our patients keep running to the polyclinics every time we diagnose a condition that require specialist intervention, since government subvention can only be obtained if referred from the polyclinics (4,5)?

The recent merger of SPH and Mediaworks was applauded on all sides as timely since both the print and TV media were bleeding from 'destructive competition'. Perhaps the healthcare community needs to take a leaf from the media experience and take a bold step to optimize our medical resources for an aging population that will increasingly tap on it. (6). Meanwhile, the private GPs are in danger of accepting the position of third class passengers after years of neglect and abuse (1).

Time to act

The R.M.S. Titanic, although doomed from the minute it was struck, took a long time to sink. A whole 2 hours of drama I may add. There was plenty of time and opportunity to avert disaster, but poor communication and selfish irrational behaviour made the tragedy much worse. The California although within range of the Titanic kept its distance and erroneously misread its distress signals (2). If one is perceptive, one can certainly sense distress signals firing off from the family physician community.

Take the recent spate of incidents relating to the over-prescription of Benzodiazepines. The unfortunate involvement of our GP as well as specialist colleagues in multilevel marketing that has surfaced recently is certainly not just another coincidental scandal. These are unrecognized distress signals surely. Condescending attitudes may not be helpful. We should instead be looking urgently into this silent cry for help. Are enough resources and priority given for the family medicine community to initiate programmes for professional and academic upgrading, improving quality and research? Is it a wonder why GPs were caught short time and again? Dr Tan Yew Seng has brought up the Winnicottian concept of regarding the mother and child as a single entity (1). The behaviour or misbehaviour of the GP and the policies of the health authorities are in fact 2 sides of a coin. It is time to look at how to help strengthen and reverse the neglect of the family physician community.

There is a need to urgently set up a full scale family medicine department at medical school to do not just research but adequate undergraduate teaching in family medicine as well (1). We require resources to help launch and maintain the graduate teaching programmes, quality practice initiatives and family medicine research. Unnecessary practice barriers need to be removed (4,5). Not least, we require moral support to get things right. There is time and resources to avert disaster only if we behave rationally, but we need to act and act swiftly we must.

Ahoy there!

The Titanic was ill equipped, lacking life jackets and lifeboats. The few available lifeboats were in fact not fully utilised as discussions continued as to who should and should not be saved first and how the people have to do their other important things before boarding at the last minute, only to find that it was too late (2). In this story, the private GPs are the third class passengers. We did not have priority to equip ourselves in the past. But there are

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upgrading Graduate Diplomas (Family Medicine), Masters of Medicine (Family Medicine) and even Fellowship classes, our proverbial lifeboats, courtesy of the College. For those of us already struggling in the icy waters, we may be in imminent danger of drowning. Hang on to whatever drift wood and debris you may find, but when the lifeboat comes along please blow your whistle hard and clamber onboard. As the world surges ahead with relentless progress, there is no room to rest on our laurels and wish our woes away. Upgrading ourselves is good for our profession, good for our patients and essential for our survival. The reduced current intakes of the GDFM and MMed(FM) classes can be disquieting. Family medicine is built on sound foundations and our fraternity should hang in there and take pride in the discipline despite the adversity.

Evidence based shipbuilding

When the Titanic was finally rediscovered in its icy grave after a century, the hull was found to be very brittle. Being built in temperate waters, the hull was not designed to sail in the sub freezing temperatures of the Antarctic Ocean (2). Family medicine is a distinct discipline. It is certainly not a discipline to capture all that is left over after filtering through the specialist sieve. Specialist disciplines instead needs to work closely to support primary physicians. In doing so, there must be mutual understanding of each of our unique roles. Family physicians do not practice like our institutionalized specialist colleagues. Family physicians often make presumptive diagnosis, based on the hypothetical-deductive model, not because we are negligent or do not follow specialist guidelines, but because it is the most efficient and cost effective manner to solve the problem under primary care circumstances.

Evidence-based-practices are mixed with a much higher proportion of narrative-based and preventive-based medicine as patient-centredness are much more important in our practices. That does not mean getting more patients by pandering to the wants of our patients, but more accurately, meeting the needs of our patients like exercising the autonomy of deliberately choosing symptom relieve in favour of cure. Guidelines for GPs should be treated as such and not rulebooks requiring a high level of compliance or worse, ammunition for further GP abuse. If our ship designed for temperate waters is made to sail in the icy waters of our specialist colleagues' rules, we will simply break up quickly and sink. Shipbuilding needs a good frame to begin with. Inculcating the unique principles of family medicine is applicable to all healthcare disciplines and should start from the beginning of our medical education during undergraduate training.

Avoiding the Icebergs

Should health authorities behave like icebergs? Do the authorities owe us a living (1)? They certainly do. Health authorities need to perform daunting tasks of keeping the healthcare system running smoothly. It is certainly in their interest and duty to distribute limited resources equitably, provide training and research opportunities, keep primary care standards high and provide safe effective primary care. Looking after the family physicians' welfare is certainly critical to achieving some of these difficult goals. On the other hand, do GPs owe the health authorities anything (1)? The answer is again in the affirmative. Times have changed. We no longer practice in a vacuum. The provision of healthcare is not just about the doctor-patient relationship. We need to practice with responsibilities to not just our patients but also other stakeholders, like the employers, society at large, the state etc. We need to be responsive to cost pressures, ethical considerations, national security etc.

Back to the question on icebergs, health authorities should surely behave more like lighthouses that guide ships to useful destinations and less like icebergs. Ideally health authorities would act like control towers, giving ships instructions, resources and authority to pass and yet allowing the ships to sail under their own steam and destiny to arrive at specific planned destinations.

And should we just blow our horns at the iceberg for it to get out of our way. Common sense tells us that that is foolhardy. The iceberg does not have the mechanism to get out of our way; the currents and storms in the vicinity push it along. It is up to the ship captain and its crew with the co-operation of its passengers to steer a path through the treacherous seas and avoid any catastrophic collisions. To reiterate Yew Seng's wisdom, we should not be mere "passive" victims. It is time we distinguish ourselves from the unproductive relationship issues of the past and forge a more meaningful one as responsive "parent" to the future generation of GPs.

The 'movie-based' method of teaching promises to be an exciting teaching method that can be effectively used in the teaching of family medicine.

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Pediatric pearls for the non-pediatrican!

By Dr Gabriel Seow, MCFP, Editorial board member

1 "Veterinary" Pediatrics.

Small children and animals share certain characteristics:
- they are very lovable
- they don't like being stared at
- they lie down when they are sick
- repeated food refusal is unusual
- they have limited ability to express themselves
- they adopt the position of comfort when well
- they have a strong survival instinct

Inspection and intuition are hence important introductions to the pediatrics examination. So begin yours as vets do: by listening and looking.

Gill & O'Brien: Pediatric clinical examination 1988;3-4

2 It's a crying shame…

So just how much do babies cry each day? (we probably need to pull out our ear plugs and humbly ask our wives!). Fortunately, Brazelton's oft-quoted study way back in the 60's will spare us the embarrassment :

Age/ Weeks	Average crying time/hours
2	2
6	3
12	1

Useful stuff to reassure parents and us!

BrazeltonTB: Crying in infancy. Pediatrics 29:579,1962.

3 Sleeping beauties?

And since we are at it, the average number of hours children sleep isn't 24 minus the time we have left for ourselves:

Age	Average sleep requirement/hours
Birth	16
6 mos	14.5
12 mos	13.5
2 yrs	13
4 yrs	11.5
6 yrs	9.5
12 yrs	8.5

By 3 months, 70% of infants will not cry or awaken their parents between midnight and 6am; and by months, 90%. But between 6 and 9 months, the night awakenings increases before settling down again.

Pediatric secrets 3rd ed, 2001, Polin/Ditmar, pg 61

4 The tonsil counsel

The oral cavity is hostile territory, replete with mouths that won't open, jaws that clamp on prising spatula and teeth ever ready to snap on probing fingers. Often we get little more than a fleeting glimpse of the uvula and some breakfast on our ties.

Asking the child to open wide, stick out his tongue while saying "ah" causes the pharynx to contract thereby forcing the tonsils toward the midline, making them look larger than they really are. A far better method is to ask the child to open the mouth, keeping the tongue in and to pant. Demonstrate this to the child who is usually amused. Panting lets the tongue relax out of the way, the spatula touches only the front of the tongue, minimizing retching and the tonsils can be seen in their normal position.

For older children, ask them to simulate a yawn.

Grossman: Everyday pediatrics1994;232

5 To see eye to eye

To get a newborn to open his eyes, don't try to pry them open- somehow it doesn't work. Instead ask the mother to hold him upright, or suckle him. They will usually open in this position.

For treating small children, drops are easier to use than ointment. One trick is to have the child supine with eyes closed. When the lids are opened, the drops flood in without much discomfort. Eye ointment has the advantage of persistence implying fewer daily doses. The lower lid should be pulled down and a ribbon of ointment laid from one corner to the other, between the lid and the bulb. Hold open the eye for 30 second to allow the ointment to melt and spread. If you fail to instruct the parents, the medications may be used imaginatively but not effectively!

Grossman: Everyday pediatrics1994;213

FM Research Bites Series(1): *The Research Question*

By Dr Yee Jenn Jet Michael, MCFP, Editorial board member

INTRODUCTION

Primary care research is essential for the progress of healthcare and is the missing link in the development of high quality, evidence-based health care for populations. As family medicine practitioners, we have a critical role to get ourselves involved in research either as users, researchers or motivators of primary care research. Using research evidence based on population sampled from our specialist colleagues' practices for our practices and for the development of clinical practice guidelines for primary care is not ideal. Family medicine deals with a different population with different circumstances and concerns .Primary care research at present occupies a very low priority and is partly contributed by lack of awareness, motivation and knowledge.

Hence our new Research Bites Series. Our first of a series is on Formulation of the Research Question.

(Adapted with permission from the lecture notes of the AP WONCA Research Network Conference)

THE ORIGIN OF THE RESEARCH QUESTION

Research originates with an idea about some general problem or question. This problem or question is narrowed down to a more specific research question, which then represents the central issue being addressed. Is it an answerable question?

FIRST STEPS IN FORMULATING YOUR QUESTION

The best ideas for research come from everyday clinical problems. When an idea comes up, write it down. Let it lie for a day or two and see if it is worth pursuing. Once you can describe your idea clearly and explain why it is important and how it could be done, you have the beginnings of a research proposal. Let your idea/ proposal mature for a few weeks. Talk it through with a colleague.

FOUR ELEMENTS OF WELL-BUILT CLINICAL QUESTIONS

Well-built clinical questions usually contain four elements (Centre for EBM, 2002):

- Patient or problem. Starting with your patient, ask, "How would I describe a group of patients similar to mine?"
- Intervention or exposure. Ask, "Which main intervention am I considering?"
- Comparison intervention. Ask, "What is the main alternative to compare with the intervention?"
- Outcomes. Ask "What can I hope to accomplish?" or "What could this intervention really affect?"

An example. Using CEBM's four elements for focusing clinical questions on the problem of chronic backache, the research question can be framed around the four elements of PICO (1):

- Patient or problem- "In patients with chronic back pain"
- Intervention- "would providing a flexibility class as well as the standard back care education class"
- Comparison intervention- "when compared with the standard back care education class alone"
- Outcomes- "lead to less pain and improved function?"

Once your question is defined, it is important to think about how it might be answered.

- Is the question specific enough?
- Does it suggest factors or items that can be measured?
- Are these reasonable and acceptable measures?
- The question itself may have to be modified according to the constraints of time, money and effort to undertake the project.

THE FINER CRITERIA FOR A GOOD RESEARCH QUESTION

A good research question is described by the acronym FINER (Hulley & Cummings, 1998, p14):

- Feasible (adequate subjects, technical expertise, time and money, and scope)
- Interesting to the investigator
- Novel (confirms or refutes previous findings, provides new findings)
- Ethical
- Relevant (to scientific knowledge, clinical and health policy, future research directions)

PITFALLS TO AVOID IN DEVELOPING THE RESEARCH QUESTION

The most common pitfalls to avoid in developing the research are (2):

- Don't' make a simple study difficult
- Have sufficient commitment
- Assess practicalities.

Don't make a simple study difficult. Don't add to the study design unwanted questions leading to the collection of unnecessary data. Avoid unfocused questions, which will lead you to collect large amounts of data. The solution is to clarify in detail the purposes of the study, the patient group to be studied or the measurements to be made and prune the less important questions.

Have sufficient commitment. It is only when the researcher is genuinely interested in the answer to the question posed, that the study may be completed to a high standard.

Assess practicalities. Thinking through the possible methods and likely difficulties, which might be encountered often leads to modifications to the research question. And it begins by considering what can be learned from others through reviewing the published literature.

THE REWARD

If your research question is well written, it will suggest to you the most appropriate study that you could undertake to answer the question.

FINALLY OUR CHALLENGE

We invite you to apply above principles to formulate a research question and send it to Editor of The College Mirror(CM), (*collegemirror@cfps.org.sg*). Your idea may challenge us to take up the idea to develop it into a full-scale research project. Depending on enthusiasm level, we might even be able to start a database of ideas & answers to family medicin truths. Best ideas shall be published in subsequent issues of CM & participants will receive a token from the College. Next issue we shall deal with 'Literature Search'.

College Special Interest Groups - *A Year On*

By A/Prof Goh Lee Gan, FCFP, Censor-in-Chief

THEIR PURPOSE

College Special Interest Groups(SIGs) were announced at the Family Medicine Convocation of the College of Family Physicians' Convocation in 2003. The idea was to create forums to enhance the clinical skills of family physicians. Also, the focus was in areas where there are societal & professional needs to enhance the clinical skills. The areas identified were mental health; eldercare; practice & quality; & research in FM Research.

MENTAL HEALTH

Mental health and/or the lack of it are important clinical concerns in the care of patients at the community level. What is also important is mental dysfunction can be part of a medical, social or more complex problem. The presence of mental ill-health may also be crowded out by the attention to biomedical issues. The Grand Rounds on Mental Health had cases to illustrate such aspects.

ELDERCARE

Eldercare in the community is multidisciplinary in nature & involves the geriatricians, primary care doctors with interests in care of the elderly infirm in the community. These can range from ambulatory patients to those who are housebound or are in nursing homes & day care centres. Some of the sessions of the eldercare SIG meetings were devoted to the discussion on the organization & delivery of eldercare services. The goal is to develop a seamless & integrated service where stakeholders can contribute effectively. Dr Tan Boon Yeow has reported on the discussion with Dr Forsyth from Cambridge & a discussion with Dr Pang on the care delivery models on eldercare & their application in the S'pore setting.

PRACTICE & QUALITY

Practice & Quality SIG has found its place with the increasing attention being paid to the quality of care initiative around the world. The study tour to Glasgow sponsored by the NHS Scotland to a group of family medicine leaders had much to report on the quality initiative that UK is presently embarking upon. There is a big scope for activities focused on the transformation of primary care to be organized in the coming year, particularly in the wake of Prof Chee Yam Cheng's Sreenivasan Oration on challenges, changes & computers.

FAMILY MEDICINE(FM) RESEARCH

FM research is now beginning to claim attention as a necessary part of development of the discipline. The road to develop, organize & build capacity in research capability takes time. The clusters, the university & the College are working on it. The FM research SIG hopes to be a forum for exchange, discussion, and collaboration in FM research activities on how care can be better organised, delivered more effectively, & also how patient & provider behavior could be better understood.

EARLIER PUBLICITY

One of the feedback on the SIG activities is that it is not well publicized beforehand. It was suggested that perhaps the whole set of activities could be made available to interested doctors at the beginning of a 3 or 6 months' period, more doctors could participate in the activities.

THE END IN MIND

We could also work with the end in mind for the various SIG activities. To be truly useful and meet the objectives for them to be set up in the first place, there would be a need for participants to take an active part in helping the organizers of the SIGs suggest topics & ideas on how to run the sessions to enhance the skills of practicing doctors. Drop us a line today.

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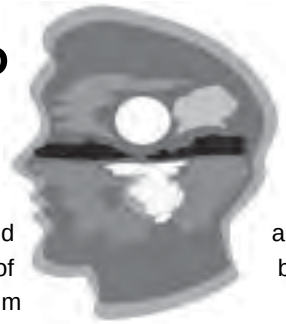
Reflections from a solo GP

By Dr Choo Kay Wee, MCFP



I turned to the College of Family Physicians because I could not find a suitable forum anywhere else to discuss the plight of solo General Practitioners in Singapore. I arrived at this conclusion after I attended a CME talk on 'Rewards for Quality Care' at the CFPS given by the external examiner for MMed FM Examination in October 2004. I was greatly encouraged that in Scotland they revamped the whole payment schemes for their National Healthcare to stress on renumeration based on Quality rather than Quantity care.

I also would like to forewarn enthusiastic GP trainees about the risk involved in setting up a solo practice.

What is the status of solo General Practice in Singapore? I would like to share my experience and let you the reader make your own judgment.

I obtained my MCGP in 1990 after going through a very comprehensive theory and practical training organized by the National University of Singapore, Ministry of Health and the College of General Practitioners. I was then very confident of my new skill and knowledge, very eager to practice what I have learned. I took over an old GP practice and began my new career as a solo general practitioner. It was immediately evident that there are many things which are not found in the medical text books which are very important in opening and managing a medical practice. The College was helpful with their publication, some years ago with a guide to the set up of a GP clinic which I followed religiously. Other than that everything else is on our own.

I had to struggle with high rentals, unavoidable relocation of practice from compulsory HDB acquisition, flooding from choked sewage pipe, and unpleasant and unreasonable landlady etc. I suffered from diminished patient load every time I relocated. I also lose contract patients to Managed Healthcare and Insurance schemes. And also from other causes of falling patient load from decreased birth rates resulting in fewer pediatric patients, attachments of office workers and their families overseas, increase of travel abroad by patients for work…and many patients going to polyclinics for subsidized primary care in this difficult economic times.

The cost of renovation, staff salary, license fees, maintenance fee for example - autoclaves, medical indemnity & public liability insurance etc are escalating through the years.

Other aspect of running a solo practice are to employ your own staff, maintain proper accreditation standards, order medicines, equipments & surgical dispensables, clinic stationeries etc, keeping of accounts & mending the clinic.

You are your own boss and this provides the reassurance that you work your best because you are working for yourself and there is no one else to answer to. This is the most important aspect in having a solo general practice. I really hope that this will never be lost!

However, as you can see there are only one pro and many cons.

We are seeing GPs who peddle sleeping pills and selling MCs who got into trouble. Others are branching out, by 'specializing' in aesthetics and cosmetics surgery or became involved with multi level marketing to supplement their income. Many of the older GPs have closed down their clinics and worked as a full time locum which pays better than what they were actually earning in their solo practice without the headaches of all the administrative work and financial burdens.

Should this trend of GPs forgoing the role which they were initially trained to do healthy? Will the private solo GPs die out?

The doctors in the private medical groups are employed and they enjoy just doing the clinical stuff. They have support from auxiliary staff. They have better patient load and cross covering. They have MCs, annual leave, 13 month pay, bonuses and promotions. But they are answerable to their bosses.

Polyclinics doctors are our unsung national heroes, they see a patient in 3 to 5 minutes. They work non-stop even past their lunch-time sometimes. At the same time, they are upgrading themselves, taking up post-graduate courses, trying very hard to practice what they have learned. Many times they are rewarded by undeserving trivial complaints from patients who are not aware that they are heavily subsidized. They complained about the slow services, short operating hours, inadequate attention & refusal of doctors to submit to their abuses of the system. Polyclinic doctors are not paid better than solo GPs, I feel they deserve more. Many are not staying for obvious reasons. And unfortunately they leave and hopefully not into solo GP practice as it is now.

"...Is there a way of allowing solo GPs to group together to lower their overheads and financial burdens and yet allow them to remain their own boss..."

From the things as it is, it looks like there isn't much of a future if nothing is done to change the primary healthcare landscape. My final question from the heart then is this: *Is there a way of allowing solo GPs to group together to lower their overheads & financial burdens & yet allow them to remain their own boss & practice the best primary care medicine that they can provide?*

Trip to Wonca World Conference 2004

- Orlando, Florida, USA, (13-17 Oct 04)

By Dr Tan See Leng, FCFP, Chairman of Wonca 2007 HOC

Introduction

The WONCA World Conference 2004 was held in Orange County Convention Centre, Orlando, Florida, USA, 13-17Oct '04. This was also held in conjunction with the American Academy of Family Physicians (AAFP) Annual Scientific Meeting. The conferences were well attended. There were 5,000 delegates from the AAFP & 1,800 delegates from all over the world who attended the WONCA World Conference 2004, making the event one of the largest medical conferences ever staged.

Singapore Delegation

A delegation comprising 12 persons was sent to the 2004 WONCA World Conference, of which 10 were members of the WONCA 2007 World Conference Host Organising Committee.

The members of the team were:

- Dr Tan See Leng (Chairman & team-leader)
- Dr Matthew Ng (Honorary Secretary)
- Dr Wong Weng Hong (Honorary Treasurer)
- Dr Chng Woei (Social & Cultural Chairwoman)
- Dr Lucienne Tan Yu Sing (Social & Cultural Chairwoman)
- Dr Lim Fong Seng (Scientific Vice-Chairman)
- Dr Tay Ee Guan (Scientific Vice-Chairman)
- Dr Tan Sze Wee (IT Resources Chairman)
- Dr Wong Chiang Yin (Member)
- Dr Chan Boon Kheng (Member)

Ms Tay Mei Lin, Senior Conference Organizer from Pacific World, the appointed 2007 WONCA World Conference Organizer, came along to be familiarized with how the conference was organized while Ms Emily Lim from the College of Family Physicians, Singapore, came to assist & understudy her.

The Exhibition booth

The College was able to send the delegation to Orlando because of the generous sponsorship from Pfizer, GSK, MSD and Novartis thus covering more than 80% of the travel and accommodation expenses for the conference. The College ended up spending less than S$10,000 from its funds & managed to gain tremendous amount of positive publicity on the upcoming 18th World Conference to be held here in S'pore

Objectives

The delegation had the following objectives:

1) To learn how to organize the WONCA World Conference 2007 in S'pore especially with regards to the scientific programmes for the WONCA World Conference

2) To market & promote awareness of the WONCA 2007 meeting in S'pore.

3) To solicit for sponsors and exhibitors for the WONCA 2007 conference

Publicity & Marketing Efforts

Our team attended different plenaries, lectures & symposiums, handing out flyers & door gifts to the delegates at the conference. In addition, the team also manned the exhibition booth & handed out numerous S'pore Tourism Board's fact book about S'pore. In general, a lot of interest has been generated for the conference in S'pore in 2007.

We also decided to offer a discount voucher to sell to potential delegates of our conference. We have met with measured success in our efforts to raise some funds to contribute toward our marketing drive & managed to sign up some more than 20 delegates from the US, UK & Europe and raise more than S$20,000 which will help to fund our future promotional drives.

Visiting Exhibitors

The delegation members took turns to visit the potential exhibitors with a view to solicit for sponsors and exhibitors for the WONCA 2007 World Conference in Singapore. 11 companies have expressed interest in the exhibition of WONCA 2007. Details of the contact persons of the potential exhibitors were elicited. Follow-up action with the relevant exhibitors will be made later.

Presentation by Dr Tan See Leng, Chairman of Wonca HOC 2007

Presentation by Chairman

Dr Tan See Leng, Chairman, gave a slide presentation followed by a short 7-mins video feature on S'pore(*courtesy of Discovery Channel's Lonely Planet*) was very well received by both the Wonca World Council(*presented on the 11 Oct*) & the Wonca World Conference delegates(*presented on the 15 Oct*). A total of some more than 600 delegates watched the presentation live in Orlando during lectures & an undisclosed greater number watched the unabridged version lasting more than 40 minutes at our exhibition booth.

The members attending the conference also formed an espirit de corp never achieved & brought the morale of the team to a new high, ready to take on the drive to make our conference the most successful ever in the history of Wonca. In the coming months ahead, the team will set down to tackle the more pressing issues of funding raising, calls for abstracts, posters and lectures, marketing the conference as well as creating new ideas to beef up the conference so that the attendance, program content and flow of the conference will be one etched in the memories of those who attended forever.