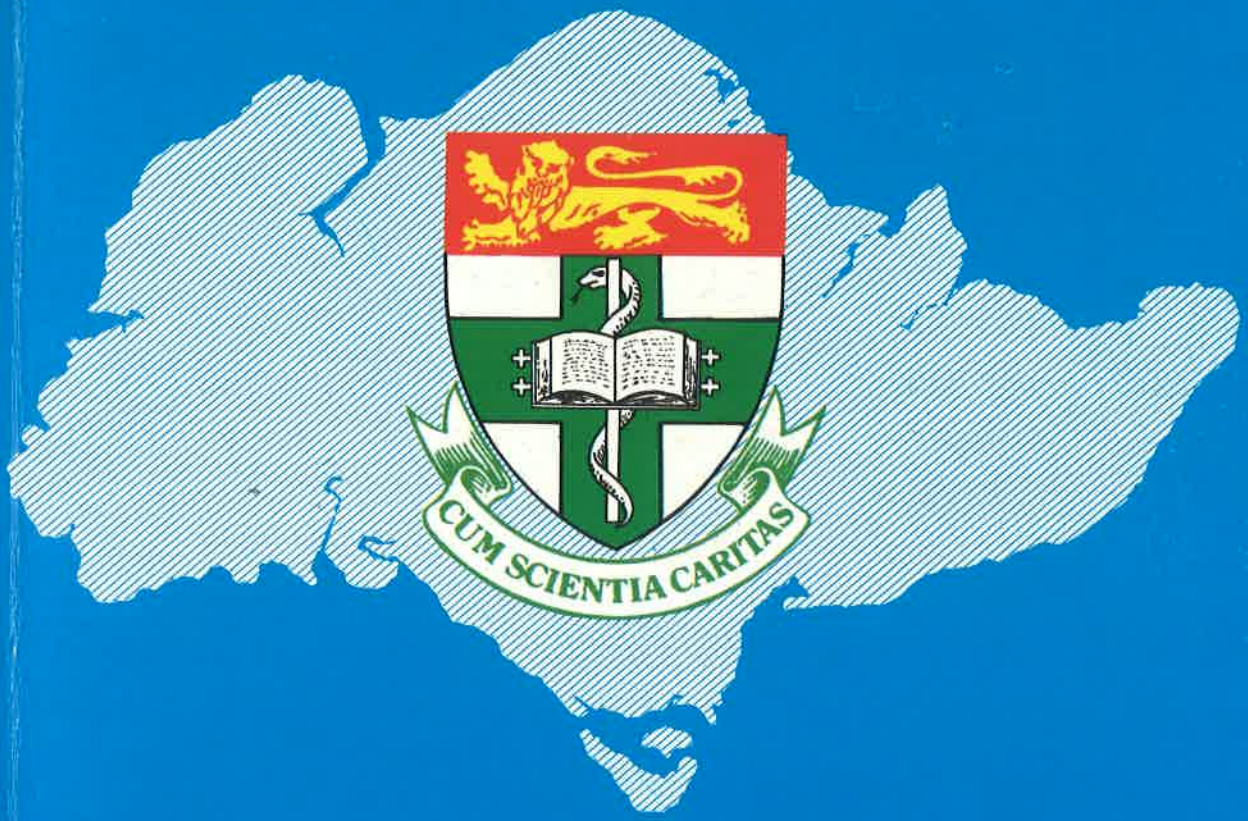
Opening of New College Premises
College of Medicine Building
Commemorative Issue

The Singapore Family Physician

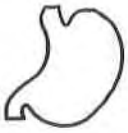


ISSN 0377-5305

The College of General Practitioners Singapore
Vol. XIII No. 2
April/June 1987

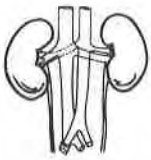
Once-daily dosing with Voltaren SR 100 (diclofenac sodium)

... formulated with the patient's safety in mind



Absence of gastro-intestinal side effects ~ 90%

Absence of CNS side effects ~ 98%



Change in dosage in patients with impaired renal function — no

Risk of drug accumulation in the plasma — no

Interaction with antidiabetics and oral anticoagulants — no

Influence of age on adsorption, metabolism, and excretion — of no clinical significance

Suitable for use in children (aged two years and above) — yes

1. Voltaren, ten years of experience (1981)
2. Sioufi, A., et al.: In Kass, E. (Editor): Voltaren-new findings (1982)
3. Fowler, P.D.: Rheum. and Rehabil., 17, Suppl. 2 (1979)
4. Stierlin, H., et al.: Scand. J. Rheum. Suppl. 22 (1978)
5. Willis, J.V., Kendall, M.J.: Scand. J. Rheum. Suppl. 22 (1978)

Detailed product information available from:

CIBA-GEIGY (M) SDN BHD.
14 & 16, Jalan SS2/61, P. Jaya, Malaysia
CIBA-GEIGY S.E. ASIA (Pte.) LTD.
4, Fourth Lok Yang Road, Singapore 2262
A. BAUR & CO. LTD.
P.O. Box 11, Colombo, Sri Lanka

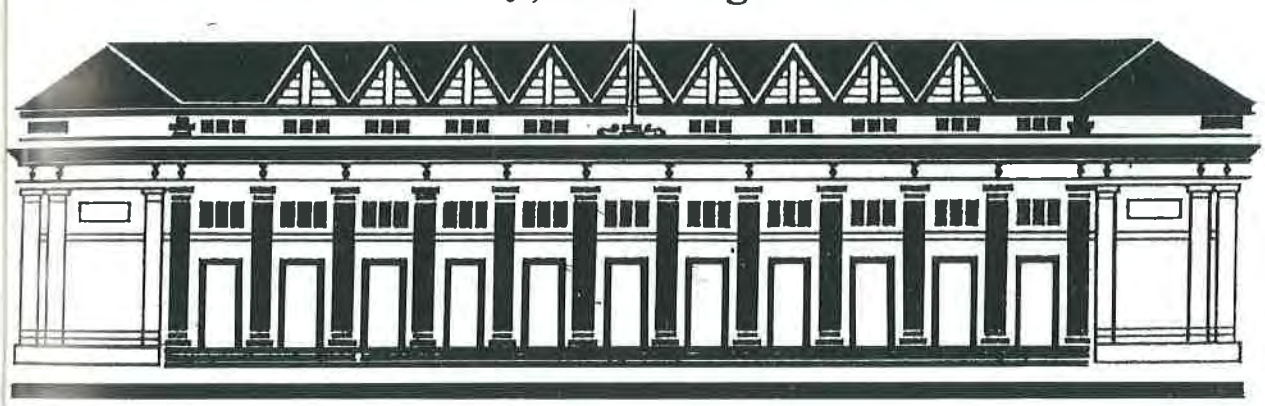
Geigy

COMMEMORATIVE ISSUE

in conjunction with the Official Opening of

THE NEW PREMISES OF THE COLLEGE OF GENERAL PRACTITIONERS, SINGAPORE

Saturday, 15th August 1987



COLLEGE OF MEDICINE BUILDING

Officially opened by

Mr Howe Yoon Chong

former Minister for Health, Singapore

COLLEGE OF GENERAL PRACTITIONERS SINGAPORE

FOREWORD

The opening of the College's new premises at the College of Medicine Building marks another milestone in the seventeen year history of the College. At the invitation of the Ministry of Health, the College and the Academy of Medicine were offered the golden opportunity to set up offices and a Joint Postgraduate Medical Library in the same building as the Ministry of Health. This move probably indicates two factors. Firstly, our years of hard work and persistent desire to upgrade General Practice/Family Medicine in Singapore has been recognised as a significant contribution towards medical excellence. Secondly, it is imperative that we continue to work closely with the Ministry of Health, the Academy of Medicine and the National University of Singapore so that the momentum of progress can be further accelerated.

To achieve greater heights the College has set aside half its area for training and up-grading General Practice/Family Medicine. The lecture theatrette, the mock-up clinic, the lending Library-cum-archives room and the Computer Education Centre are designed in such a manner that members of the College can make full use of the facilities in a compact and conducive environment. To complement this, we have a well designed administrative centre surrounded with beautiful paintings by our local artists and enhanced by a small antique collection of ceramics, just to remind us of our cultural heritage.

The College is further committed to improve our Continuing Medical Education modules which are already very well attended. With assistance from the Ministry of Health and the Department of Community, Occupational and Family Medicine we hope to implement some form of vocational training in the future.

The College will continue to provide lectures in General Practice to the undergraduates and it will continue to organise their one-week clinical attachments with the

Clinical Tutors. Part of the practicals for the Diplomate Examination (MCGPS) will be held at the mock-up clinic at the College to give a more realistic environment.

All these plans and activities could not have been achieved but for the dedication and hard work of the College Council, the Administrative Staff, the unstinting support of our members and members of our sister bodies, the National University of Singapore and the Ministry of Health. I wish to take this opportunity to thank all those who have helped the College to arrive at this crucial stage of our development.

Our thanks also go to all the local organisations and GP Colleges overseas for their congratulatory messages and words of encouragement.

Finally, I wish to express our deep appreciation to Mr Howe Yoon Chong, former Minister of Health for agreeing to officially open our new College premises.

Dr Lee Suan Yew
President

MINISTRY OF HEALTH
SINGAPORE

MESSAGE

The College of General Practitioners has made a commendable effort towards the upgrading of general practice in Singapore. It is in recognition of this important role of the College that the Ministry of Health has offered the College accommodation within the College of Medicine Building. In partnership with the College of General Practitioners and the Academy of Medicine, we can now look forward to developing the College of Medicine Building as a centre for postgraduate activities for the medical, scientific and allied professions.

I congratulate the College of General Practitioners on the official opening of its new premises in the College of Medicine Building, and look forward to a close working relationship towards upgrading the standard of medical practice in Singapore.

Dr Kwa Soon Bee
Permanent Secretary (Health)/
Director of Medical Services

SINGAPORE MEDICAL ASSOCIATION

MESSAGE

The official opening on 15th August, 1987 of the new offices of the College of General Practitioners Singapore in the College of Medicine Building marks a new and very important phase in the history of the College.

The College although only 16 years old has established itself in the medical life of Singapore as a leader in post-graduate and continuing medical education for the general and family practitioners. The College of Medicine Building has seen most of the members of C.G.P. pass through majestic portals in their undergraduate education. There can be no more fitting place for these members, and indeed for most of the medical practitioners in Singapore in which to pursue their post-graduate education.

The timing also could not be more propitious in the light of the forthcoming Continuing Medical Education requirements soon to be laid down by the Singapore Medical Council. The improved facilities now available in the College of Medicine Building, the tradition and history of the Building itself which is synonymous with Medical Education in Singapore, and the atmostphere of seriousness of purpose that the Building itself conveys should all be more conducive to serious learning.

On behalf of the Singapore Medical Association, I wish the College of General Practitioners Singapore further success in their efforts to raise and maintain a high level of medical practice.

Dr N. K Yong
President

A.P.M.P.S.

THE ASSOCIATION OF PRIVATE MEDICAL PRACTITIONERS OF SINGAPORE

MESSAGE

On behalf of the Association of Private Medical Practitioners of Singapore I wish to congratulate the College of General Practitioners Singapore on shifting to their new home namely the College of Medicine Building. Architecturally and historically the College of Medicine Building is indeed a majestic building. Many a practising doctor has gone through its doors.

Hence it is indeed a great honour that the College of General Practitioners Singapore is one of its chosen tenants. Undoubtedly the College of General Practitioners Singapore will pursue medical excellence and honour with ever-continuing zeal and enthusiasm. May I wish the members of the College of General Practitioners Singapore everlasting progress, happiness and joy in their new home.

Dr Chan Heng Thye
President
7th Council of Management

ACADEMY OF MEDICINE SINGAPORE

MESSAGE

On behalf of the Academy of Medicine, Singapore it is my pleasure to send to the Council and the College of General Practitioners, Singapore our congratulations and good wishes on the occasion of the official opening of the College's new premises in the refurbished College of Medicine Building.

The College of General Practitioners, Singapore in its 17-year history has contributed much to the promotion of high standards of medical care provided by general practitioners and family physicians. This has been achieved through a carefully planned Continuing Education Course and assessment by the MCGP (Singapore) examination. The Journal of the College besides being a vehicle of exchange of information among family physicians in Singapore also contributes to continuing education and clinical research by documenting clinical problems and their solutions.

The refurbished College of Medicine Building in addition to housing the headquarters of the Ministry of Health, has the College of General Practitioners and the Academy of Medicine on the first floor. Both bodies manage the Shaw Postgraduate Medical Library. Thus, the College of Medicine Building in the new phase of its existence is committed to the continuing education of doctors whereas it was previously meant for undergraduate training. In this, it is the ardent desire of the Academy of Medicine that together with the College of General Practitioners we will contribute to the achievement of high standards of general medical practice and specialist medical care in Singapore.

Dr Lawrence Chan
Master

ALUMNI ASSOCIATION SOUTHERN BRANCH
SINGAPORE

MESSAGE

The Alumni Association of the KE VII College of Medicine is an alumni association of the medical, dental and pharmacy graduates of the College of Medicine whose building is now beautifully restored to its splendid grandeur on the outside and ultra modern appointments on the inside. We are mighty proud of the COM Building.

We are envious that you are moving into such a stately home.

We congratulate you and wish you all the very best.

Dr Moses Yu
Chairman

SINGAPORE DENTL ASSOCIATION

MESSAGE

It is highly commendable that within such a short time after its founding, the College of General Practitioners Singapore has achieved so much and so remarkably well.

Your founder-members are to be praised for their foresight and the successive office-bearers for their meritorious efforts in building up the College to what it is today.

What we have in common is that we are health care providers. We feel we have much to share with you in organising our profession to provide a high standard of care which is second to none.

On this auspicious occasion, the Singapore Dental Association wishes to convey to you its greetings, joys and felicitations and may your College grow from strength to strength.

Dr Yii Kie Mung
President

SINGAPORE GOVERNMENT MEDICAL, DENTAL AND PHARMACEUTICAL OFFICERS' ASSOCIATION

MESSAGE

Since its inception, the College of General Practitioners has been instrumental in raising and maintaining high standards in the practice of Family Medicine in Singapore. Over the years, the College has developed a firm commitment to medical education at both the undergraduate and postgraduate levels. It is therefore fitting and appropriate that the College now be located in a building that has for so long stood as the symbol of medical education in Singapore.

The SGMDPOA congratulates the College on this auspicious occasion of the opening of its new premises at the College of Medicine Building and wishes the College every success in its future endeavours.

Dr Clarence Tan
President

PHARMACEUTICAL SOCIETY OF SINGAPORE

MESSAGE

Geneal practice is the backbone of the medical profession and in this age of specialisation its contribution to the status and public recognition of the profession may sometimes be overlooked.

The College of General Practitioners Singapore is to be congratulated for promoting a high standard of General Practice/Family Medicine and thus contributing to the excellent medical care available in Singapore and the maintenance of a healthy population.

The location of the College of General Practice within the new College of Medicine Building is evidence of the high esteem held for the College and should inspire it to higher endeavours.

My Council and the members of the Pharmaceutical Society of Singapore believe that pharmacists and medical practitioners working in their separate disciplines can together bring greater excellence to health care for the people of Singapore.

We send fraternal greetings and best wishes on the official opening of the College premises.

Assoc Prof Alfred S C Wan
President

AMERICAN ACADEMY OF FAMILY PHYSICIANS

MESSAGE

It gives me great pleasure to send greetings from the American Academy of Family Physicians to mark the official opening of your new quarters in the College of Medicine Building. Your accomplishments and contributions to family practice and to the people of Singapore can be viewed with pride. We in the Academy have great admiration for your dedicated efforts on behalf of family practice.

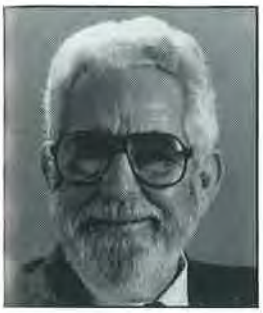
It is good to be family physicians, providing continuing, comprehensive care to our patients. In today's climate of evolutionary changes — some of them depersonalizing to the patient — the role of the family physician grows ever more vital as the need for patient advocacy becomes more compelling.

When scientism fails to address the human dimension of medicine, it is to the family physician the patient turns — for advice, for reassurance and for compassion. These roles that we fill in health care delivery are what distinguish us as physicians who blend the art and the science of medicine for the well-being of our patients.

Your commitment to excellence through your graduate and continuing medical education programs augurs well for the continued success of family practice in your country.

Robert H. Taylor, M. D.
President

THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS



MESSAGE

"Congratulations to the College of General Practitioners Singapore upon the opening of its new Headquarters in the College of Medicine Building.

To general practitioners the significance of a permanent home will not be lost. We all know that the stability and growth of the family is enhanced by the possession of a permanent family home.

I trust that the family of members of the College of General Practitioners Singapore will attain similar attributes from the acquisition of its new home. May your College grow in stability, peace, knowledge and understanding. May its members derive from its bosom the learning and emotional growth so necessary in the care of their patients in general practice."

Eric Fisher,
President

THE HONG KONG COLLEGE OF GENERAL PRACTITIONERS

MESSAGE

Heartiest congratulations on your new premises! Your achievement to move into the College of Medicine Building together with the Academy of Medicine, Singapore and a Postgraduate Medical Reference Library marks a major milestone in the annals of your College and signifies the acceptance by your professional colleagues of the equal status of the specialty of General Practice with other medical disciplines. Such acceptance will undoubtedly herald a new era in the provision of medical services to your country by putting the emphasis on primary care as a cost-effective means of bringing medicine to the community. We shall watch with interest your future development in the hope that we may learn and benefit from your experience.

Once again, our heartiest congratulations and all our best wishes and regards.

Dr Peter C. Y. Lee
President

INDIAN ACADEMY
OF GENERAL PRACTICE

MESSAGE

I am delighted to learn that the College of General Practitioners Singapore is opening its new premises at the refurbished College of Medicine Building on 15th of August, 1987 and bringing out a souvenir to commemorate the occasion. Luckily this date of opening ceremony coincides with our Country's Independence Day.

I can understand how much valuable medical services in various fields the College has rendered since its inception in June 1971. I can also realise, how necessary separate premises are, with increase of membership and expanding activities.

It is also a matter of pleasure that the inauguration is being done by distinguished Former Health Minister of Singapore, Mr Howe Yoon Chong.

I congratulate you and all concerned for the achievement and send my warmest greetings and wish the ceremony a great success.

Dr J. R. Karwal
President I.A.G.P.

IMA COLLEGE OF GENERAL PRACTITIONERS

MESSAGE

The Indian Medical College of General Practitioners is happy to learn that the College of GPs, Singapore, is going to step into its new premises in the renovated College of Medicine Building in the city on 15th August, 1987. It is indeed another creditable achievement of the founders and builders of the College after their successful hosting of the 10th WONCA World Conference on Family Medicine in 1983 and testifies to their sustained efforts for the upliftment of General Practice/Family Medicine which is a must for every developing country aiming at providing scientific medical care to the maximum number of its people. On behalf of IMACGP I look forward to closer ties between the GPs of our two countries as we both are striving to attain the goal of "Health for all by 2000 AD".

B. Ray Chaudhuri
President,
Indian Medical Association &
President, IMA CGP.

THE IRISH COLLEGE OF GENERAL PRACTITIONERS

MESSAGE

The Irish College of General Practitioners is a relatively new College like your own, our basic objectives are similar. We now have over 2,000 members, almost 90% of the practising General Practitioners in Ireland.

It is with great pleasure that we send you our congratulations and best wishes on the opening of your new premises at the College of Medicine Building on 15th August, 1987.

Our Colleges have an increased responsibility in these difficult times with financial cutbacks and in some instances unnecessary adverse publicity. It therefore behoves us to communicate regularly with one another as medical problems are now not limited by national boundaries. With increased sophistication in diagnosis and treatment we have to be constantly looking forward to anticipate problems that will arise.

Dr. C. K. O'Doherty
President

THE JAPANESE ACADEMY OF PRIMARY CARE PHYSICIANS

MESSAGE

On behalf of the members of the Japanese Academy of Primary Care Physicians, I wish to offer hearty congratulations to Dr Lee Suan Yew, the President of College of General Practitioners Singapore, and its members on the opening of the new premises of the College.

While full cooperation of the members is a requisite for the activities of the college of general practitioners, establishing its headquarters for promoting multifaceted activities is essential in achieving the goals. We are sure that your organization with the brilliant past achievements will now be able to reinforce your activities and further advance toward the 21st century, thereby contributing to the development of your nation's medical care.

We extend our hearty felicitations for further developments of your organization and the health of its members.

Masatami Yamaguchi, M. D.
President

COLLEGE OF GENERAL PRACTITIONERS OF MALAYSIA

MESSAGE

The opening of the new offices of the College of General Practitioners Singapore at the old Faculty of Medicine Building of the Medical School is a cause for celebration. A great many Malaysians share memories with Singaporeans of that venerable building.

I must congratulate you on your achievement in persuading your Government to make this very generous gesture to the College and Academy. The new College of Medicine Building will I am confident become a source of encouragement and stimulus to post-graduate medical education.

My best wishes go to the College Council in this important new venture.

Dr. Ruby binti Abdul Majeed
President

THE ROYAL NEW ZEALAND COLLEGE OF GENERAL PRACTITIONERS

MESSAGE

As the Royal New Zealand College of General Practitioners prepares to move into its own new premises in our capital city, it sends congratulations and best wishes to the College of General Practitioners Singapore on moving into premises in the College of Medicine building in Singapore.

Those who have followed the history of general family practice in modern nations know the importance of our discipline, providing a wide range of medical care and advice to people, on preventation surveillance, through diagnosis and management of confusing but simple health problems, through early diagnosis of simple diseases to help with chronic diseases, personal dynamics and problems in living constructively.

In a world where medical school teachers have tended towards specialisation and research, we in general and family practice have had to develop our knowledge base to influence the medical schools and planners of health care systems.

We trust the physical placing of the Singapore College in a building with other health sciences will promote constructive dialogue so that the people of Singapore get the best combination of health care available in the modern world.

With best wishes,

B. H. Young
President

COLLEGE OF FAMILY MEDICINE PAKISTAN

MESSAGE

On the great festive and auspicious occasion of entering the new premises, with great pleasure and most sincerely I wish to congratulate the great people of the Small City State of Singapore on behalf of self and members of the College of Family Medicine Pakistan.

We all wish you good luck and Godspeed in development and progress for professional efficiency and better services to your people. I had the good fortune to visit that building long time ago on the invitation of great Dr Sreenivasan just a year after the birth of your College.

Though young in age, the College of General Practitioners Singapore, through its achievements, has contributed admirably to the noble cause of WONCA and its health promotion activities including the memorable hosting of the Tenth World Conference of WONCA.

We all hope and pray that now blessed with the present prestigious accomodation the College will be able to fulfill its obligation more profitably to the profession and people of Singapore.

Dr S. H. Naqvi
President

GROUPEMENT BELGE DES OMNIPRATICIENS

MESSAGE

The Board Members of our group were most honoured by your kind invitation.

So I am glad to wish your College, in the name of our Board, a brilliant future dedicated to maintaining a high standard of general practitioners' scientific and professional qualities.

As we know our Singapore friends, we are confident that after the opening of the COMB, you will continue to be a prosperous and fertile womb for all the initiatives mentioned in your College's premises!

Congratulations and best wishes for your College and all its Members!

Dr K. Van De Meulebroeke
President

THE PHILIPPINE ACADEMY OF FAMILY PHYSICIANS, INC.

MESSAGE

Warmest greetings and heartfelt congratulations to the Singapore College of General Practitioners on the formal opening of its new premises at the refurbished College of Medicine Building.

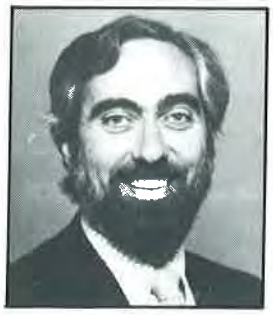
In the pursuit of the goal of "Health for All By the Year 2000", Family Physicians must possess the required skills and competence through a relevant and up-to-date continuing medical education program, to be able to deliver total personalized comprehensive medical care effectively.

It is with great interest that we in the Philippine Academy of Family Physicians look forward to the success of all your undertakings.

Best Wishes!

Benjamin Y. Chang, M.D.
President, PAFP

THE SOCIETY OF TEACHERS OF FAMILY MEDICINE



MESSAGE

Congratulations from the Society of Teachers of Family Medicine to the College of General Practitioners Singapore.

The opening of your new headquarters is most gratifying and symbolic. It signals the obvious growth and development of the College and the continuing realization of that basic objective for which the College was founded — the assurance of high quality general practice/family medicine for the people of Singapore.

Equally important, progress made by the College is representative of progress on a larger scale to bring to the needful people of this world those concepts of concerned, comprehensive health care which are the roots of family medicine.

We wish you well in the broader endeavors which your growth makes possible.

Jonathan (Jack) Rodnick, MD
Président

COLLEGE OF GENERAL PRACTITIONERS OF SRI LANKA

MESSAGE

I consider it a great honour to have to send this message to the College of General Practitioners Singapore on the occasion of your moving to your new home. On behalf of the College of General Practitioners of Sri Lanka I congratulate you on the progressive step you have taken.

The College of General Practitioners Singapore is one of the most dynamic and progressive members of WONCA. I am confident that in your new home the College will progress from strength to strength.

Dr Walter R. Gooneratne
President

THE GENERAL PRACTITIONER ASSOCIATION THAILAND

MESSAGE

On the auspicious occasion of The Opening of The College of General Practitioners Singapore New Premises, may I, on behalf of The General Practitioner Association, Thailand, offer my heartiest congratulations and invoke the power of all sacred things in this universe to shower blessings on your College, Council and staff members with all best wishes for future prosperity and progressiveness always.

Prof. Dr Snoe Indrasukhsri
President

THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

MESSAGE

I send the warmest greetings of the Royal College of General Practitioners to the College of General Practitioners Singapore upon their move into the College of Medicine Building. I know that the whole College will join me in wishing every success to you upon the pursuit of your aims, which we share, to promote the highest possible standards of general practice.

Professor Michael Drury
President

A DAY TO REMEMBER.....

Official Opening of College Premises by the late President B. H. Sheares 19th January 1975

The President unveils the Memorial Plaque....

...signs the visitors' book,. watched by Mrs. Sheares and Dr. Wong Heck Sing, President of the College...

...and speaks at the Celebration Dinner.

VIEWS OF THE NEW COLLEGE PREMISES

The imposing entrance lobby.

Director's/President's Room.

The Lounge.

The grand Conference Room.

The Secretariat.

Computer Education Centre.

SECOND ANNOUNCEMENT

8th Asian Congress on Thoracic and Cardiovascular Surgery

30 October — 3 November 1987
Singapore
The Westin Stamford Hotel
Raffles City

Organised by
Chapter of Surgeons
Academy of Medicine, Singapore

Sponsored by
Ministry of Health, Singapore
School of Postgraduate Medical Studies, National University of Singapore

Secretariat
Academy of Medicine, Singapore
College of Medicine Building
College Road
Singapore 0316
Tel. 2238968/2245166
Telex: RS40173 ACAMED

The College of General Practitioners Singapore

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The start of tooth decay can lie in the choice of formula

The start of a sweet tooth begins the day baby takes to the wrong bottle.

Because most follow-up infant formulas contain sucrose — a principal cause of dental caries.

Enfapro* is the follow-up infant formula that isn't a formula for bad teeth. It's sucrose-free.

Enfapro, being sucrose-free, minimises the cariogenic effect of milk residues left in the baby's mouth after feeding. And it does not develop a sweet tooth in baby.

What it does do, however, is provide older babies with all the protein, energy, vitamins and minerals they need for continued go growth and development.

Enfapro has more protein to keep pace with the developing infant. It has more carbohydrates, a excellent fat blend and optimum vitamin and mineral levels.

In short, everything for the older baby — exce dental caries.

To reduce the risk of dental caries, recommend Enfapro — the sucrose-free, follow-up infant formula.

Pregnant women and new mothers should be informed of the benefits and superiority of breastfeeding. Mothers should receive guidance on proper maternal nutrition and be advised that the decision to avoid or discontinue breastfeeding may be hard to reverse. The introduction of partial bottle feeding may have a negative effect on breastfeeding. Inappropriate infant feeding practices should be avoided so breastfeeding is not discouraged. Mothers should be advised of the social and financial implications of the decision to formula feed and the importance to the health of the infant to use infant formula properly.

MeadJohnson* *A World Leader in Nutrition*

P/N 20-7/86 SPECS (MOH)/243/86

THE SINGAPORE FAMILY PHYSICIAN

The College of General Practitioners Singapore
College of Medicine Building, Level 1 (Right Wing)
16 College Road, Singapore 0316.

Vol. XIII, No. 2 April/June 1987 Price to Non-Members S$5.00 M.C.I.(P) No. 20/3/87

CONTENTS

An update

VOLTAREN INJECTION

is more than just a good antirheumatic

IN RENAL COLIC

A comparison with morphine/spasmolytic combination

Voltaren injection

- significantly more effective and has fewer side effects[1]
- no risk of addiction

Efficacy

Partial or complete relief of pain within 30 minutes of injection[1]

Voltaren Injection — % of patient — 91%

Morphine/Spasmolytic — % of patient — 62%

IN TRAUMATIC PAIN

A comparison with dipyrone

Voltaren injection

- as effective as dipyrone but significantly better tolerated[2]
- has no effect on the organs of haemopoiesis[3]

Efficacy

Severity of pain before and after treatment[2]

Percentage of patient in V (Voltaren Group) and D (Dipyrone Group)	Before treatment V	Before treatment D	After 30 min. V	After 30 min. D	After 4 hrs. V	After 4 hrs. D
No pain			3	8	46	50
Slight			26	27	37	36
Moderate	17	21	40	38	14	12
Severe	52	48	25	21	2	2
Very Severe	31	31	6	6	1	—

1 Sven O A Lundstam, Lars A Wahlander, Karl-Henrik Leissner, John G Kral Prostaglandin synthetase inhibition with diclofenac sodium in treatment of renal colic comparison with use of a narcotic analgesic The Lancet May 15 1982 1096-97

2 A Folha Med 79 (5) 371-76 Nov 1979 A comparison of the analgesic activity of diclofenac sodium with that of dipyrone in pain following trauma

3 Miura T Long term tolerability study of diclofenac sodium J Int Med Res 3 145 (1975)

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Geigy

EDITORIAL

A TIME OF CHANGE

To every thing there is a season.....
a time to break down, and a time to build up.
— Ecclesiastes 3:1,3

1987 is indeed a momentous and historical year for our College. Not only are we moving into a brand new home which is both prestigious and palatial, we are also reaping the fruit of our labours over the past many years when the National University of Singapore revamped the Department of Social Medicine and Public Health to incorporate a division of family medicine under the new Department of Community, Occupational and Family Medicine.

The recognition we have secured from both the Ministry of Health and the University means that the ball is now at our feet. Now is the time for us to prove what we have been claiming all along — that primary health care is the cornerstone of a cost effective health care system and not simply a matter of treating coughs and colds.

In an editorial in 1983[1], it was pointed out that the time has come for the College to shift into second gear and that we must establish the main raison d'etre for the existence of the College. With the formation of an academic department for Family Medicine which will take over the undergraduate teaching of general practice, time is running out for us to do so.

We need to establish our own areas of expertise and to demonstrate that we have a pool of knowledge that is peculiar only to general practice which no other members of the profession can teach us. In fact there are many areas of medical practice where experience and knowledge can be said to be special to general practice.

The Art of Consultation

One such field is the art of consultation. Consultation is more than a question of eliciting the symptoms and signs of a disease in a particular patient and the formulation of a definitive diagnosis. The consultation in general practice is not only diagnostic — it must be therapeutic as well as educational. In the astute observation of Michael Balint, the most frequently used drug in general practice is the doctor himself.[2] As every general practitioner would have experienced, it was not only the bottle of medicine or the box of pills that mattered, but the way the doctor gave them to his patient.

The surgeons have their operations to dazzle their patients, the physicians can depend on their battery of laboratory tests, but the bread and butter of a general practitioner rests on a good doctor-patient relationship. General practitioners, more than any other members of the medical profession, must therefore be the experts of interpersonal communication as well as experts in consultation. The importance of the consultation has unfortunately not been sufficiently reiterated in hospital practice where technology reigns supreme. However, as Pendleton has pointed out, the most careful diagnosis and the most appropriate management will be frustrated by a patient who is unable or unwilling to follow the advice given.[3] This is often due to a failure to recognise that the patient has his or her own ideas, concerns or expectations which must be explored and addressed in the consultation. This is an area of medicine which general practitioners can contribute to medical education.

Pendleton has also dissected the process of consultation and has outlined seven tasks to be performed during the consultation in general practice.[4] More research is needed into the process of effective consultation in general practice. With a mock up clinic in our new premises and with the availability of video recording facilities, much work can be done.

Stress and Illness Behaviour

In contrast to hospital medicine where the majority of the patients are suffering from serious organic disorders, there is high percentage of patients in general practice who are suffering from psychosomatic or "functional" disorders. These problems are the result of stress and problems in living. The fact that no organic pathology can be found in such patients does not make the suffering of these patients any less real or less important.

Furthermore, the older view that psychosomatic disorders are limited to a mere handful of disorders has been replaced by the view that most, if not all, disorders have a psychosomatic element as their onset, mode of presentation and response to treatment and outcome are all affected by psychological and social factors.[5]

The general practitioner is again in the best position to deal with such disorders as well as the psychosocial effects of disease. The challenge to general practitioners is to develop the necessary skills to deal with these disorders which more often than not tend to be dismissed by the doctors in the hospitals.

Whole person medicine

Another area of medical care in which no other discipline can provide is whole person medicine or holistic care. In an increasingly technological society, patients tend to be dehumanised and treated as disease entities rather than as individuals. General practitioners with their contact with the other members of the family are better able to see the patient's illness in the context of the family and to recognise the effects of dysfunctional family relationships in the pathogenesis of illnesses as well as the disruptive effects of illnesses on family relationships. The nature of general practice provides many insights into the illnesses and problems of patients which are not easily available to the specialists. Again much research can be done in this field.

P.C. Bugel rightly pointed out that somatic-fixation has become a major social problem in the rich western world. In his view, the very person who takes a key-position in the handling of this problem is the general practitioner. With him lies the decision which way people will go: a mere medical one or a way which leaves room for non-medical aspects. Bugel aptly described the general practitioner as a frontier guard.[6]

Early detection of diseases

The general practitioner is also a frontier guard in another sense — he is generally the doctor of first contact for the patient. Consequently the general practitioner is in the best position to do the most good for the patient. Early diagnosis means a better chance of a complete cure in diseases such as cancer and less complications for problems such as acute appendicitis.

We need more documentation of the early warning signs and symptoms of these diseases which are usually seen in general practice. To do so we need more feedback from the doctors in the hospitals so that we can improve our diagnostic skills. We need to recognise that making a diagnosis in general practice requiries more skill than in hospital practice for these are often very few signs in the early stages of the disease. Early diagnosis is thus another domain of general practice.

Epidemiology:

This is another area in which general practice can make a very significant contribution to medicine. Much of the data on the management of chronic diseases such as hypertension and diabetes mellitus are based on statistics drawn from populations of hospital patients. Such data tends to give an unbalanced perspective of such disorders.

With the availability of computers, analysis of data is just a finger touch away. It is time we collect and analyse the vast amount of data that are presently locked away in our patients' records.

Epidemiological studies of patients seen in general practice will provide more logical approaches to the management of acute minor illnesses as well as the chronic disorders.

Conclusion

We are on the threshold of an exciting era in general practice. We have at long last attained official recognition of the importance of general practice in medical care. All the developed countries are now channeling their

efforts towards upgrading primary care as this is the only way to combat the rising cost of health care. General practitioners thus have a worthy challenge before them. It is not only a time of change — it is a time for change and a time to change!

REFERENCES

1. EK: Shifting into Second Gear, The Singapore Family Physician, 1983, 9: 165-166.
2. Balint, M: The Doctor, His Patient and the Illness, London, Pitman Medical, Second Edition, 1964.
3. Pendleton D: Consultation Analysis, Update 1987, 34 (7): 803-807.
4. Pendleton D, TheoSchofield, Tate P, Havelock P: The Consultation, Oxford, Oxford University Press, 1984.
5. Davies G.: Stress-related disorders. 1987, 34 (7): 755-760.
6. Bugel P.C.: The Family Physician as Frontier Guard. Conference Proceedings, Tenth WONCA World Conference on Family Medicine, 1983, 490-492.

HISTORY OF THE COLLEGE — THE EARLY DAYS

Dr E K Koh

Like most of the other higher academic bodies for general practitioners in the world today, the Singapore College of General Practitioners came into being to fulfil the need for higher academic studies and research for the primary physician, namely the family doctor and general practitioner. For too long the general practitioner has taken the back seat where the rest of the medical profession has bounded forward with the latest advancements in their respective fields. If the general practitioner is not to be considered an anachronism in this day and age he must also keep up with the times. He must know the recent advances in therapeutic medicine, he must be aware of the latest thinking on healing and caring, and he must be able to look after the needs and wants of the patients entrusted to his care.

Would not all this be possible without the need to set up a special college for the general practitioners? Aren't there enough institutions of higher learning in the country which could very ably conduct refresher courses for general practitioners who wish to up-date their knowledge? These are pertinent questions that are always asked and have to be answered. Recent thinking has shown that primary medical care is a field of its own distinct from institutionalised or hospital care. Patients who are being treated outside the hospital have problems which are generally not seen in those patients who have been admitted to hospitals for treatment. The spectrum of illness and disease seen outside the hospital is also different from the kind of illnesses treated in hospital.

Because of these and many other factors it is necessary for the primary physician to focus his attention and care on the patients who are seen outside the hospital. To understand the nature of the illness better and to be able to treat his patients more effectively, it stands to reason that the primary physician must study in depth the nature of the ailments which these patients present, and the method of management and treatment which could be used to help the sick.

This renaissance of interest in primary medical care and general practice can be said to have started both in the United Kingdom and the United States in the early fifties. In the United States increased specialisation in the medical profession forebode the exit of the generalist and family physician. There was quite an alarm at this trend because it would leave the onus of primary treatment on the individual who was ill. He had to decide whether to take a trip to the corner drug-store for a pill to relieve his symptoms, or make the arduous and usually expensive journey to seek specialist medical treatment. The real danger lay in his ignorance in the evaluation of his symptoms and his inability to seek out the correct specialist to attend to his ailment.

In the United Kingdom many doctors too were alarmed especially at the low status and morale of the general practitioner following the introduction of the national health service. These people felt that unless a stop was put to the rot, and medical and public opinion reversed, Britain too like the United States would soon see the end of the general practitioner and family physician. They felt strongly that such a matter should never be allowed to come to pass because the family physician and primary medical practitioner was the cornerstone of all good family and health care.

Two British doctors decided to do more than lament the situation. On 13th October 1951 the Lancet and the British Medical Journal carried a letter from Dr F. M. Rose and Dr John Hunt which began,

"There is a College of Physicians, a College

of Surgeons, a College of Obstetricians and Gynaecologists, a College of Nursing, a College of Midwives, and a College of Veterinary Surgeons...but there is no college or academic body to represent primarily the interests of the largest group of medical personnel in this country — the 20,000 general practitioners."

The principal architect of the English College of General Practitioners formed in 1952 was Dr John Hunt. This later became the Royal College of General Practitioners, and John Hunt who became Lord Hunt of Fawley was untiring in his efforts to set the College on a firm and sound foundation. The early days were not easy ones. Many people were openly hostile to its formation. Some questioned the need for a separate college for general practitioners arguing that whatever further training a general practitioner needed could be provided by the existing Royal Colleges of Physicians and Surgeons. In fact as long ago as 1851 an attempt was made to form a college for general practitioners in England but this fell through because of lack of support from the profession.

Stressing the importance of the work of the family doctor, Lord Hunt in his Lloyd Roberts Lecture said, "No matter how clever the consultants or how excellent the hospitals, it is the efficiency of the family doctors, and the work they do in and near the homes of their patients, which will determine the calibre of the medical services in any country." This is an observation which all of us would do well to observe in planning for the medical care of our country.

The work of the English College in its pioneering efforts to establish the study of general practice as an accepted medical discipline did not go unnoticed in Singapore, and even in those early days of the nineteen fifties, four local doctors had already applied to join the English College. They were Dr B. R. Sreenivasan, Dr A. W. S. Thevathasan, Dr Koh Eng Kheng and Dr Teng Peng Min.

There was however at that time a lack of urgency to establish a higher educational body for general practitioners in Singapore. This was perhaps due to the fact that most of the general practitioners here were doing well economically in their practices despite the absence of vocational training. Unlike the situation in the United Kingdom prevailing then, where general practitioners were paid very much less than their specialist colleagues in hospital practice, the Singapore general practitioner then was usually much better off financially than their specialist collegues in the government service.

Society of General Practice

This lassez-faire attitude however did not last long. In 1962 the Singapore Medical Association with Dr Foo Chee Guan as President gave consent to the formation of the Society of General Practice under the S.M.A. This body had come about through the work of Dr F. B. Kampfner, Dr Colin Marcus, Dr John Chong and Dr William Heng. On the 21st February 1963 the Society was formally launched and Dr William Heng, who was chairman of the protem management committee, installed Dr Gopal Haridas as the founder chairman.

The early years of the society were difficult ones and were marked by the general apathy of many of its members. The main activities at that time centred on the holding of educational talks and social events to cement ties between doctors in the private sector and those in public service. Attendances at the various meetings were often poor and at one stage its continued existence seemed to be very much in doubt. The untimely death of Dr G Haridas in 1964 was a further blow to the Society and in his memory the Society decided to endow the Haridas Memorial Lecture. This lectureship was later sponsored in conjunction with the Singapore Paediatric Society.

Despite its limitations the Society of General Practice made the first real attempt in this country to conduct refresher courses for our general practitioners. This was usually in the form of talks on the latest forms of medical management given by specialists from various disciplines in hospital practice. There was no attempt in getting general practitioners themselves to impart their experience and knowledge to fellow general practitioners. No move had then been made at any form of undergraduate medical education in general practice, no research in general practice was done, and no plans had been laid out for post-graduate vocational training. The Society of

General Practice functioned as its name implied, chiefly as a medical society serving medical practitioners with like interests. It did not profess to be an academic body and did not conduct any examinations in its field.

Some of the activities of the society in fact were of a medico-political nature and in 1966 the Society received the support of many doctors in its fight over the controversial Pharmacy dispensing issue.

The need for general practice to be promoted as a medical discipline which should be taught to medical students was first seriously considered in a series of meetings in October 1966 between the vice-dean of the medical faculty of the University of Singapore Dr Charles Toh and three general practitioners, Dr Tan Joo Liang, Dr E K Koh, and Dr Wong Kum Hoong. It was however not until 1969 that the curriculum revision committee of the University decided that there was a place for undergraduate education in general practice. There were no plans however to set up a separate department for this but students would be posted for one week sessions to general practitioners who would be selected for this by the University.

Academic Body

By this time the Singapore Medical Association too had woken up to the limitations of the Society of General Practice. In August 1969 a committee was set up with the following terms of reference.

"To look into the feasibility of forming a Higher Academic Body of General Practitioners in Singapore and to deliberate and recommend in what form or style this academic body should be."

The Committee was chaired by Dr Koh Eng Kheng with Dr Lim Boon Keng as secretary. The other members of the committee were Drs A. L. G. Chan, Foo Choong Khean, Lee Hoe Guan, Lee Suan Yew, O. C. Leow, Liok Yew Hee, Colin Marcus, Ng Kong Kai, Tan Joo Liang and Seah Cheng Siang. This committee discussed three possibilities, the formation of a Singapore College of General Practitioners, a chapter of General Practice within the Academy of Medicine, or as a faculty of the Royal College of General Practitioners or the Royal Australian College of General Practitioners.

After considering the options the Committee recommended that there were two feasible moves, firstly as a chapter for General Practitioners in the Academy of Medicine, or the formation of an independent Singapore College of General Practitioners.

It was perhaps fortuitous also that at this critical phase in the gestation of the College, Dr John Hunt who was then President of the Royal College of General Practitioners arrived in Singapore in April 1969 on his way to Australia. Dr Hunt made the special effort to meet Dr Toh Chin Chye who was then Vice-chancellor of the University of Singapore to sell the idea of general practice as a medical discipline in its own right. He also met the various heads of the medical departments including Prof Sir Gordon Ransome whom he remembered as a colleague in Barts. Without this groundwork by Dr Hunt who was much respected by all whom he met, the formation of a college for general practitioners in Singapore would have met with more formidable opposition from many quarters of the medical profession.

During his short stay in Singapore Dr Hunt was indefatigable in keeping his appointments and meeting the people whom he felt could help in the cause. He stayed up till the early hours of the morning on one occasion to write a special article for the Singapore Medical Newsletter on the subject of the need for a higher academic body for general practitioners in Singapore. His words are prophetic.

"In Singapore you already have your medico-political organisations. The time is now ripe, I believe, for you to develop an academic body to represent your 500 general practitioners. Fifteen or more countries already have such a college or academy, all of them founded during the past 20 years. You must not be left behind.

These colleges and academies have raised the status and academic standing of family doctors, the tendency for students to avoid general practice has been revered, education (undergraduate, special vocational and continuing) has been helped, research into all

aspects of general practice has been encouraged, and, most important of all, standards of clinical and social medicine outside hospitals, and the equipment of premises needed for these have been improved.

When you in Singapore have such an academic body to watch over general practice in your country you will be amazed to find how much there is for it to do. Our College's tape recordings alone, go out now to a listening audience of 50,000 doctors a year...It will mean a great deal of hard work for some of you; but I can assure you that this will be well worthwhile. Within a few years your University and the whole of your medical profession will bless you for having taken this step; and as it will lead to better patient care outside hospitals and therefore to cheaper patient care, your Government and all your patients will bless you too."

In 1968 the Society of General Practice under the chairmanship of Dr Ng Kong Kai was receptive to the idea of a higher academy body outside the Society for the further training of general practitioners. An important symposium on the "Founding of a College of General Practitioners was held in September 1969 under the chairmanship of Dr Fred Samuel. The symposium came close on the heels of the 2nd Medical Convention of the Singapore Medical Association. Dr R. W. Roberts from the Royal Australian College of General Practitioners who had attended the Convention spoke to many of those who were interested in setting up the College.

In October 1969 the first breakthrough for the recognition of general practice as an academic discipline came with the appointment of clinical tutors in general practice by the University of Singapore.

Another forum was held in November 1970 where the Master of the Academy of Medicine Mr Yahya Cohen announced that while the Academy was sympathetic to the need for the establishment of a higher academic body for general practitioners, it regretted that it was not feasible to form a separate chapter for general practitioners within the framework of the Academy.

Protem Committee

The die was now cast. If the general practitioners wanted to have a higher academic body they had to do it on their own and accordingly the Society of General Practice on 22 November 1970 initiated the formation of a pro-tem committee to form a College for General Practitioners. Dr Wong Heck Sing headed this committee. The other members of this committee were Drs L. G. Chan, Chen Chi-Nan, Chuah Chong Yong, Foo Choong Khean, E. K. Koh, Lee Soo Chew, O. C. Leow, B. K. Lim, Colin Marcus and Ng Kong Kai.

This committee did a lot of spade work for the formation of the College. Dr Wong himself travelled down to Australia and met many of the senior officials of the Royal Australian College of General Practice in order to tap from their experience. Dr Ng Kong Kai also met several officials of the Australian College when he went there.

The idea of a College for general practitioners was not unanimously welcomed by all members of the medical profession here. To some specialists it seemed strange that general practitioners would want to regard their work as a kind of specialty that required vocational training, some were unhappy because they were afraid that a College for general practitioners would compromise their standing as specialists within the medical profession. Amongst the general practitioners too there were some who disliked the idea of an academic body that could act as a watch dog over the standard of general practice in the country. A few felt that the establishment of a higher academic body meant only an opportunity for those who sought positions within the council to set themselves as superior to the ordinary rank and file general practitioner. We were lucky to have the moral support of some of the eminent specialists in the country. Dr Arthur Lim who was President of the Singapore Medical Association during that period, and Dr Seah Cheng Siang of the Academy of Medicine gave us much encouragement. It was fortunate that those who disliked the idea of a College or dissented in its formation were few and with the support of

most of the general practitioners in the country the College of General Practitioners was formed on the 30th June 1971. The protem committee had done its work well, and Dr B R Sreenivasan, one of our most senior general practitioners and a past Vice-Chancellor of the University of Singapore, was invited to be the founder President of the new College.

The other members who made up the foundation committee were Drs Wong Heck Sing, Wong Kum Hoong, Foo Choong Khean, Chen Chi-Nan, E. K. Koh, Lim Boon Keng, Colin Marcus and Ted Wong Hoption. Dr Chee Phui Hung was very helpful in the drafting of the constitution of the College with his knowledge and expertise on these matters. With the formation of the College, the Society of General Practice decided to change its name and role to the Society of Private Practice to serve the interests of all medical practitioners in private practice.

It has been a long uphill climb for many to set the College on the firm foundation it rests on today. Some of the doctors who were in with us at the beginning, sadly are no longer with us, but their hard work has not been in vain. Many were the long meetings which often stretched into the early hours of the morning through which the members of the various committees sat. Friendships were made and broken through the discussions and arguments that went on during the meetings but with the sacrifices came success. Shortly after its formation, the College was able in March 1972 to jointly sponsor the 4th Medical Convention together with the Singapore Medical Association and the Malayan Medical Association. Many doctors from the R.A.C.G.P. attended the Convention.

The recrudescence of interest in general practice in this part of the world also led to the formation of sister colleges in Malaya, Hongkong and Sri Lanka.

With an academic body of their own, our general practitioners can now look forward to a useful participation in extending the frontiers of medical knowledge and care. We in Singapore can be proud that when the challenge was laid down we have not been found wanting. With our participation in regional and world gatherings featuring topics on general practice, our members have held their own with the rest of the profession within the world community. The holding of the WONCA (World Organisation of Colleges and Academies of General Practice) World Conference in May 1983 in Singapore was an event which signalled another milestone in the short history of the College. Together with the granting of partronship by the President of the Republic in 1974 and the recognition of the M.C.G.P. as a registrable additional qualification by the Singapore Medical Council in 1977, the College has come a long way since its foundation. What has been achieved has been spectacular, what has yet to be achieved in the years ahead will no doubt prove to be even more promising.

HISTORY OF THE COLLEGE — PRESENT AND FUTURE TRENDS

Dr L. G. Goh

The inaugural issue of the College journal "The GP" in 1973 has this to say on the need for the formation of a higher academic body for general practitioners.

"The role general practitioners/family physicians play in delivering medical care is becoming increasingly important in Singapore. We are now going through the phase of improving the education of general practitioners at all levels of medical education. The future of community health and of general medical care will depend on maintaining and raising the standard of general practice. The general practitioners realised that some sort of academic and educational organisation was needed in Singapore."

OBJECTIVES

The basic objective of the College of General Practitioners is the promotion of a high standard of general practice in Singapore. The College seeks to achieve this through its various activities.

Continuing Medical Education

One such activity is Continuing medical education. This has been described as "the lifeblood for maintaining high professional standards in medical practice."

The inaugural issue of the College publication (GP Vol 1 No 1 in 1973) goes further to say:

"The role of the College is to provide education. The immediate target is to try and encourage as many general practitioners as possible to participate in our bi-weekly programmes. Areas of deficiency in our knowledge and in our conduct should be identified, discussed and remedied...Continuing education is a must if we are to provide the skilled care expected of us."

Training Programmes

Another is through training programmes for general practice. The same editorial said, "The long term goal is to institute vocational training for the intending general practitioners and to organise undergraduate teaching at the university. Family practice must become a positive factor in our health care delivery system and family practitioners must be trained by design if they are to serve Cum Scientia Caritas."

THE FIRST TEN YEARS

Continuing Medical Education

Continuing medical education featured strongly in the College's activities. The College started with a bi-weekly programme of talks and discussions. This led to the 1974 and 1975 examination orientated refresher courses and since then were replaced by in-depth lecture courses conducted at least once yearly.

Additionally, since 1976 weekly Thursday lunch-time sessions were held at Maxwell Road OPD. These included talks, discussions and tape sessions using Audio-Digest Foundation tape recordings on topics of Family Medicine/General Practice. It is interesting to note that these sessions are on-going up to this day.

Since the October of 1976, the sessions have been "regionalised" so that apart from Maxwell Road OPD, sessions became available in Still Road initially and later in Clementi and Bukit Merah Polyclinics.

The College also has the Reuben Meyer Library of books and periodicals as well as an audio-tape and video tape library. These facilities are open to members during office hours.

Research

Several College research projects were completed. They included (a) a survey of self-medication in General Practice (b) Upper Respiratory Infection and (c) Coronary risk factors in Singapore doctors. These were reported in the Singapore Family Physician. The 4th project on Surgical Scars was presented as a Free Paper in the 10th WONCA Conference and reported in the WONCA proceedings.

Examination

The first Diplomate examination was conducted in 1972. Over the first 10 years 8 examinations were conducted.

Regional/International Meetings

Organising regional meetings was another important activity. Shortly after the formation of the College it was able in March 1972 to jointly sponsor the 4th Medical Convention together with the Singapore Medical Association and the Malayan Medical Association. Since then numerous other regional meetings were organised. The College is also represented in international meetings of the World Organisation of National Colleges and Academies of General Practice (WONCA).

Undergraduate teaching

Undergraduate teaching was started in 1971. This consisted of a one week posting at the GP clinic and since 1975 a written test has been added.

THE PRESENT DECADE (1982 — to-date)

Major Events

The major events of the last five years are (1) the hosting of the 10th WONCA World Conference in 1983, (2) the preparation for the move to the College of Medicine Building in 1987.

The Tenth WONCA World Conference

This Conference has been to-date the largest medical meeting held in Singapore. A total of 1315 delegates and 534 accompanying persons attended. It was also a Conference of other "firsts". It was the first time that an audio-visual "curtain raiser" was introduced into the Opening Ceremony in a Medical Conference in Singapore. It was the first WONCA Conference that had its Conference proceedings ready before the end of the Conference and it was the first time that a WONCA Conference had a daily bulletin throughout the duration of the Conference. The Conference was opened by Mr Devan Nair, then President of the Republic of Singapore.

College of Medicine Building

With the move of the Faculty of Medicine to Kent Ridge, it was felt that the College of Medicine Building should be restored as a historical monument. The idea was floated to house the Ministry of Health Headquarters and both the Academy of Medicine and the College of General Practitioners, Singapore there under one roof.

To justify its occupancy there, a Sub-Committee of the College for Planning of New Premises prepared and submitted a paper to the Ministry of Health giving an overview of the current College activities in the 1980s.

Committee Activities

Apart from the glamour of the WONCA Conference and the excitement of moving to new premises, various Committees of the College worked unobstrusively behind the scenes to consolidate various activities — continuing medical education, research, undergraduate teaching and diplomate examinations. The growing importance of practice management resulted in the addition in 1983 of one more Committee to assist Council — the Committee on Practice Management.

Continuing Medical Education

The Continuing Medical Education Committee continues to organise update courses and contribute to the Home Study Section of the Singapore Family Physician. Between 1981 and 1983 the number of update courses were increased to 2 per year and since then has been increased to 3 per year.

Since 1983, a certificate of attendance is awarded to doctors who have attended at least 80 percent of each of 6 modules of update courses in 2 to 3 years. This has since been made a requirement for the Diplomate Examination.

Since 1985 an attempt has been made to conduct a 2 year cycle programme for the whole field of major topics in General Practice. It was found that some 10 courses over the two years are required. Apart from the 3 indepth lecture cum clinical courses, weekend seminars will be introduced as well as postal courses. So far 3 lecture courses and three seminars have been completed.

Research

Between 1981 and the present 4 other College projects have been lauched, of which 2 were completed, namely (a) Profile of the GP Practice, and (b) Housecall Survey. Two are in the data-processing stage, namely (c) Members' perception and utilisation of College facilities, and (d) Career outcome of doctors graduating each year. The latter two studies were done to obtain information for planning and design of College activities.

Undergraduate Teaching

Undergraduate teaching faces problems of time scheduling and competition of interest with the other segments of the undergraduate programme.

At a recent brainstorming session of Undergraduate GP teachers a search was made to overcome the difficulties in delivering the Undergraduate teaching package. The idea of conducting the lectures as two weekend workshops is being considered. This will cut down the number of times the students have to come for lectures. Also the workshop environment will encourage better integration of teaching content.

Examinations

Refinements have been added to the College's Diplomate Examination. The Board of Censors has produced an Examination handbook for candidates.

A practice log of cases has been introduced to assess candidates practice profile and longitudinal management of such cases. The forthcoming examination will be in October/ November this year.

Practice Management

This new Committee conducted a seminar on Dispensing in 1984 open to members and non-member GPs. The proceedings of the Seminar were published in the Singapore Family Physician.

In 1985 it conducted a workshop session amongst Council Members on medical records. The proceedings of the workshop are being published in this issue of the Singapore Family Physician. It was felt that this type of meeting amongst practitioners may provide a platform to look at various topics relevant to better management of our practices.

THE FUTURE

New Premises in College of Medicine Building

The College's new premises in the College of Medicine Building (COMB) were ready for occupation in early 1987.

The occupants of the Alumni Building, of which we were one, had been given official notice to vacate in July 1986. In the interim, through the good offices of the Dean of the Faculty of Medicine, the College was housed in the Orthopaedics Research Centre (which used to be the Pharmacology Building) behind the COMB until the premises in the latter were ready.

Common Library and Resource Centre

The College and the Academy of Medicine will be jointly maintaining the Post-Graduate Medical Library in COMB. A system of appeals to support the maintenance of the Library will be publicised shortly.

Opening of Postgraduate Medical Centre

Plans are underway by the Ministry of Health to celebrate the opening of this Post-graduate Medical Centre in the refurbished Building with a conference and exhibition. The College has been invited to participate.

Research

A small computer centre has been included in the new premises. This will enable the data processing of research projects to be carried speedily. Also it can be used for teaching research applications on the computer.

As a fringe benefit, the computer centre can also be used to stimulate the use of computers by the medical profession in their practices through the conduct of application courses and computer use meetings.

A department of general practice

One of the avowed aims of the College was to see the formation of a department of general practice within the framework of the University. It has always been felt that such a department would give greater impetus to the teaching of general practice as an academic discipline both at the undergraduate and post-graduate level.

This aim saw fruition in early 1987 with the reorganisation of the University's Department of Social Medicine into the new department of Community, Occupational and Family Medicine (COFM). Although some felt that it would have been better if the University had agreed to a separate and independent department for General Practice/Family Medicine, nonetheless the acceptance of Family Medicine into the University is a major step forward in the recognition of the importance of this and allied fields like primary care and general practice.

The new department will need a network of teaching practices, both in the Government polyclinics and private GP clinics. The participation of Government primary health doctors will also encourage quality care in both public and private sectors in primary health care.

Vocational training

As is enunciated in the editorial of the inaugural issue of the College's publication a long term goal of the College is the institution of a vocational training programme for the would be general practitioner.

Successive Councils have raised the idea with the Ministry to develop a vocational training programme. Understandably this is not without logistic problems and these have to be resolved.

Most recently, a paper on a proposed vocational training programme for doctors intending to pursue a career in General Practice/Family Medicine was prepared by the present Council. This was submitted to Dr Wong Poi Kwong, Director of Manpower Planning in December 1985.

The Search for Excellence

Medical services could be looked upon as a pyramid with primary health care services at the base and specialities in the middle and sub-specialities at the peak. In the high tech quest, the cost-effective part which is primary health care should not be forgotten.

The development of excellence in General Practice is an integral part of the development of Singapore into a centre of medical excellence in the twenty-first century. Towards this, the College and the community of General Practitioners remains committeed.

The College has been fortunate in having several dedicated and capable persons at the helm. After the loss of Dr Sreenivasan, Dr Wong Heck Sing assumed the President's mantle. He was followed by Dr Victor L Fernandez whose untimely demise saw Dr Lee Suan Yew taking over the onerous duties of President.

No record of the activities of the College would be complete without the names of those who served on the College Councils. There are also many who served on the various committees of the College, without whose enthusiasm and hardwork the College will not be what it is to-day.

COLLEGE OF GENERAL PRACTITIONERS SINGAPORE

Members of 1st to 10th Councils (1971-1987)

1ST COUNCIL 1971 — 1972

President	:	Dr B. R. Sreenivasan
Vice-President	:	Dr Wong Heck Sing
Censor-in-Chief	:	Dr Wong Kum Hoong
Honorary Secretary	:	Dr Foo Choong Khean
Honorary Treasurer	:	Dr Leow On Chu
Council Members	:	Dr Chen Chi Nan
		Dr Koh Eng Kheng
		Dr Lim Boon Keng
		Dr Colin Marcus
		Dr Ted, Wong Hoption

2ND COUNCIL 1972 — 1973

President	:	Dr B. R. Sreenivasan
Vice-President	:	Dr Wong Heck Sing
Censor-in-Chief	:	Dr Wong Kum Hoong
Honorary Secretary	:	Dr Foo Choong Khean
Honorary Treasurer	:	Dr Chen Chi Nan
Council Members	:	Dr Chin Keng Huat, Richard
		Dr Koh Eng Kheng
		Dr Lim Boon Keng
		Dr Colin Marcus
		Dr Ted, Wong Hoption

3RD COUNCIL 1973 — 1974

President	:	Dr Wong Heck Sing
Vice-President	:	Dr Chen Chi Nan
Censor-in-Chief	:	Dr Wong Kum Hoong
Honorary Secretary	:	Dr Koh Eng Kheng
Honorary Treasurer	:	Dr Liok Yew Hee
Council Members	:	Dr Chang Ming Yu James
		Dr Chin Keng Huat, Richard
		Dr Foo Choong Khean
		Dr Gordon O. Horne
		Dr Colin Marcus

4TH COUNCIL 1974 — 1975

President	:	Dr Wong Heck Sing
Vice-President	:	Dr Chen Chi Nan
Censor-in-Chief	:	Dr Evelyn Hanam
Honorary Secretary	:	Dr Koh Eng Kheng
Honorary Treasurer	:	Dr Chang Ming Yu, James
Council Members	:	Dr Gordon O. Horne
		Dr Leong Vie Chung
		Dr Liok Yew Hee, Timothy
		Dr Colin Marcus
		Dr Frederick Samuel

5TH COUNCIL 1975 — 1976

President	:	Dr Wong Heck Sing
Vice-President	:	Dr Chen Chi Nan
Censor-in-Chief	:	Dr Evelyn Hanam
Honorary Secretary	:	Dr Lim Boon Keng
Honorary Treasurer	:	Dr Victor L. Fernandez
Council Members	:	Dr Chang Ming Yu, James
		Dr Foo Choong Khean
		Dr Gordon O. Horne
		Dr Liok Yew Hee, Timothy
		Dr Tay Leng Kong, Moses

5TH COUNCIL 1976 — 1977

President	:	Dr Wong Heck Sing
Vice-President	:	Dr Liok Yew Hee, Timothy
Censor-in-Chief	:	Dr Evelyn Hanam
Honorary Secretary	:	Dr Lim Boon Keng
Honorary Treasurer	:	Dr Victor L. Fernandez
Council Members:	:	Dr Chang Ming Yu, James
		Dr S. Devi
		Dr Gordon O. Horne
		Dr Lim Lean Huat
		Dr Frederick Samuel

6TH COUNCIL 1977 — 1979

President	:	Dr Victor L. Fernandez
Vice-President	:	Dr Frederick Samuel
Censor-in-Chief	:	Dr Evelyn Hanam
Honorary Secretary	:	Dr Moti H. Vaswani
Honorary Treasurer	:	Dr Lim Lean Huat
Council Members	:	Dr S. Devi
		Dr Lim Kim Leong
		Dr Ng Ban Cheong
		Dr Wee Sip Leong, Victor (till August 1977)
		Dr Tan Cheng Bock, Adrian (from December 1977)
		Dr Wong Heck Sing
Honorary Editor of the College Journal	:	Dr Gordon O. Horne

7TH COUNCIL 1979 — 1981

President	:	Dr Victor L. Fernandez
Vice-President	:	Dr Frederick Samuel
Censor-in-Chief	:	Dr Chang Ming Yu, James
Honorary Secretary	:	Dr Lim Kim Leong
Honorary Treasurer	:	Dr Chiong Peck Koon, Gabriel
Council Members	:	Dr Chan Swee Mong, Paul
		Dr Loh Wee Tiong, Alfred
		Dr Tan Tian Cho
		Dr Moti H Vaswani
		Dr Wong Heck Sing
Honorary Editor College Journal	:	Dr Leong Vie Chung

8TH COUNCIL 1981 — 1983

President	:	Dr Victor L Fernandez
Vice-President	:	Dr Frederick Samuel
Censor-in-Chief	:	Dr Chang Ming Yu, James
Honorary Secretary	:	Dr Lim Kim Leong
Honorary Treasurer	:	Dr S. S. Chin, Philbert
Council Members	:	Dr S. M. Chan, Paul
		Dr P. K. Chiong, Gabriel
		Dr Hia Kwee Yang
		Dr W. T. Loh, Alfred
		Dr Moti H. Vaswani
Honorary Editor College Journal	:	Dr Leong Vie Chung

9TH COUNCIL 1983 — 1985

President	:	Dr Wong Heck Sing
Vice-President	:	Dr Victor L. Fernandez
Censor-in-Chief	:	Dr Chang Ming Yu, James
Honorary Secretary	:	Dr Alfred W. T. Loh
Honorary Treasurer	:	Dr Lim Kim Leong
Council Members	:	Dr S. M. Chan, Paul
		Dr Goh Lee Gan
		Dr Loh Peng Yam, Michael
		Dr Moti H Vaswani
		Dr Yeo Peng Hock, Henry
Honorary Editor College Journal	:	Dr Leong Vie Chung

10TH COUNCIL 1985 — 1987

President	:	Dr Victor L. Fernandez (till October 1985) Dr Lee Suan Yew (from December 1985)
Vice-President	:	Dr W. T. Loh, Alfred
Censor-in-Chief	:	Dr Lee Suan Yew (till November 1985) Dr Lim Kim Leong (from December 1985)
Honorary Secretary	:	Dr Goh Lee Gan
Honorary Treasurer	:	Dr S. M. Chan, Paul
Council Members	:	Dr Sivakami Devi (till February 1987) Dr Omar bin Saleh Talib Dr Soh Cheow Beng Dr Tan Kok Yong (till December 1986) Dr P. H. Yeo, Henry Dr Koh Eng Kheng (from February 1987) Dr Chong Pak Yuen (from February 1987)
Honorary Editor College Journal	:	Dr Moti H Vaswani

A MODEL OF PRIMARY HEALTH CARE FOR SINGAPORE

DEFINITION OF PRIMARY HEALTH CARE

Primary health care is more than just the treatment of cough and colds and other minor illnesses. It is most unfortunate that the misconception of primary health care has obscured the critical role general practitioners play in the health of our citizens. Attempts to upgrade the status of general practitioners inevitably fail if they are merely confined to efforts to make general practitioners into "mini-specialists" without recognising general practice as a distinct discipline.

The Primary Care Task Force Report of the New York State Health Advisory Council described primary care as a "constellation of health activities" that contains the following components:

1. *Responsive care for episodic illness;*
2. *Continuing care of chronic illness;*
3. *Health screening and monitoring;*
4. *Preventive services;*
5. *Appropriate health education; and*
6. *Integration with care in acute and long term institutions.*

A more comprehensive definition of primary health care is given by Dr. S. Proger:

> *Primary care consists of everything that the patient needs and expects as a person and member of a family and community when he decides to call a doctor, and the primary physician specialises in paying attention to the patient at the point of first contact, in considering the person as a whole as well as his illness per se, in handling the conditions that he can diagnose and treat, in delegating to his paramedical team tasks appropriate to their abilities, in referring those requiring more specialised diagnosis and treatment to the appropriate specialists, and in providing the beginning and end points to comprehensive care, including post-hospital follow up or continuing care. In other words, the primary physician shall serve both the patient and the health-care delivery system as a clinical health manager.*

THE COMPONENTS OF PRIMARY HEALTH CARE

Primary health care comprises of several components. These are discussed below.

First Contact Medicine

Primary health care involves first contact medicine as the general practitioner should be the first doctor a patient sees. This is a very important role as this is the stage in which the patient can derive the greatest benefit. For example, early diagnosis of diseases and early detection of health risk factors would save the patient the cost and pain of the treatment of complications arising from them.

It has also been estimated that some 80% of the medical problems presented to the general practitioner can be competently managed by him if he is adequately trained. This will reduce the cost of care for the patient and for the nation.

Longitudinal Responsibility

Another aspect of primary health care is the longitudinal responsibility for the patient, regardless of the presence or absence of disease. This means caring for the patient through more than one stage of life, for example, from infancy to childhood, from childhood to adolescence, from adolescence to adulthood, from middle age to old age, and from old age to death.

(A Chapter from "Primary Health Care in Singapore", A Report by the SMA Adhoc Committee on General Practice).

As the general practitioner assumes longitudinal responsibility for his patients, health education become an important tool in his management. When the patient has yet to develop an established disease, health education to change unhealthy life styles would be more beneficial to the patient.

Comprehensive and Continuing Care

Another function of the general practitioner is to provide comprehensive and continuing care. It is therefore necessary for him to know his patients and their families well. This can only be achieved if he has a relatively small population of patients under his care.

As medical science advances, specialisation and super-specialisation inevitably results in a fragmentation of care. The general practitioner will then have to assume the role of a "clinical health manager" in order to coordinate the care given to the patient by the specialists. This necessitates good communication between the specialists and the general practitioner on one hand and between the general practitioner and the patient on the other.

Such a role would imply that the general practitioner will have to assume full responsibility for the clinical decisions made and is accountable to the patient.

Caring in the family context

Another role which is within the ambit of the general practitioner is that of a family therapist. It is now recognised that psychosomatic and behavioural disorders in childhood are often a symptom of a dysfunction in family relationships. Many child psychiatrists are adopting family therapy as part of the treatment of such disorders. However, as there is a shortage of child psychiatrists, there is a place for general practitioners to be trained as family therapists to cope with the rising incidence of family disorders as evidenced by the rising figures of juvenile deliquency, child physical abuse and child sexual abuse in the United Kingdom.

There is also a high percentage of psychosomatic disorders seen in general practice. Such disorders are often the result of marital and parenting stress. To manage these psychosocial problems effectively, it is necessary to see the patient in the context of his or her family and social environment. A working knowledge of family therapy would be most useful in helping the general practitioner understand and evaluate the significance and role of the dynamics of family interaction in the pathogenesis of the patient's illness.

Health Screening and Research

With the advent of the computer, the horizons of general practice have been expanded. For example, opportunistic screening and epidemiological research are now readily available at the touch of a key of the computer keyboard.

The rationale for the treatment of chronic diseases such as hypertension and diabetes mellitus is often based on data collected from hospital patients. With more information about such disorders from patients in general practice, our concepts of treatment may well change.

Team Approach

It would be apparent from the above that such a concept of primary health care cannot be provided for by one single person but requires not only a team approach with the medical specialists but which involves interdisciplinary co-operation with the nurses, medical social workers, psychologists, occupational therapists, physiotherapists and sociologists.

THE INGREDIENTS OF PRIMARY HEALTH CARE IN SINGAPORE

At the present moment, we have an excellent infrastructure for Primary Health Care in the Primary Health Care Division of the Ministry of Health. We have all the ingredients to develop an ideal primary health care service and to attain the target of health for all by the year 2000.

Accessibility

Our patients are concentrated in the various housing estates and are currently

served by general practitioners who are practising within the estates. Hence physical accessibility is not a problem. Fees are also generally low so that cost is not a factor limiting accessibility. The major cause of unavailability of the services of general practitioner is due to the fact that it is humanly impossible for a solo general practitioner to be on call 24 hours a day, 7 days a week.

Manpower

We should soon reach an ideal doctor: patient ratio with the present number of medical students in our University. However, it would be necessary for practices to be organised so that there is a fairly even distribution of doctors throughout our small nation state. For example, doctors can be encouraged to form groups to serve particular neighbourhoods in the HDB estates.

Resources & Facilities:

We are a small and compact society with an excellent primary care infrastructure in the Ministry of Health. We also have a well developed secondary and tertiary medical care.

With better interaction between the general practitioners and the government doctors through the polyclinics and hospitals there would be better and more efficient utilisation of present health facilities.

There have also been healthy moves by a few government hospitals to increase their communication and interaction with the general practitioners working in their catchment zones. Such efforts augur well for the future development of an integrated health care system for Singapore.

Computerisation

With the advent of the computers, the data management of a population of 3000 to 4000 patients is only a finger stroke away. A major obstacle to the use of computers for patient records at the present point of time is the high patient load of the general practitioner. The use of computers will improve patient care as well as facilitate opportunistic screening. It would also enable the general practitioner to monitor chronic conditions such as diabetes mellitus and hypertension more accurately and improve the management of these conditions.

Medisave

The Medisave scheme can form the basis for a prepayment system for primary health care without causing any extra financial burden to the patients. As the Medisave belongs to the patient, the financial contract is thus between the patient and the doctor with no third party involvement.

A SINGAPORE MODEL OF PRIMARY HEALTH CARE

Taking into consideration the concepts of primary health care and the ingredients of primary health care present in Singapore, a model of primary health care for Singapore and a description of the future Singapore general practitioner is described below.

An ideal system of primary health care for Singapore would be one in which groups of general practitioners serve particular neighbourhoods in the HDB estates. These groups of general practitioners will have a defined patient population by having a register of patients who will pay a fixed fee per month per head. Such prepayment will be for services as determined by a contract between the patient and the doctor.

The general practitioners will also work closely with the paramedical teams such as nurses, counsellors, psychologists, and medical social workers who would be based in the government polyclinics. Patients requiring home nursing care can then be managed conjointly with the nurses in the Home Nursing Foundation.

The polyclinics can also provide ancillary services such as laboratory and radiological facilities as well as specialist clinics so that ambulant patients need not be referred to the hospital. Problems detected by the School Health Service could also be channelled to the polyclinics and the general practitioners informed.

Each polyclinic would also be affiliated to a regional hospital and patients admitted to the hospital would be managed conjointly

with the general practitioners.

With such a system, the patients will receive comprehensive care that has continuity and is well co-ordinated.

THE FUTURE SINGAPORE GENERAL PRACTITIONER

From the above discussion, it is clear that we can further improve our health care system. Our model of the future Singapore general practitioner is that he will no longer be simply a "cough and colds" doctor but a trained family physician in the true sense of the word.

He would be a skilled clinician, adept in making early diagnoses and aided by the computer to screen and detect premorbid conditions before they are manifested in the patient.

He would also be a clinical health manager co-ordinating whatever treatment his patient is receiving from the specialist.

He would be a skilled communicator and counsellor and able to help his patients cope with the stresses and frustrations at work and in the home. He would also be competent in educating his patients about unhealthy life styles and motivating them to adopt healthier ways of living.

He would also be a competent research worker in monitoring the epidemiology of diseases in his community and the effects of treatment prescribed.

He would truly be the family doctor, caring for the aged sick in the family home and helping the family to deal with the problems posed by illnesses and deaths.

Last but not least, he would be a professional who is proud of his work from which he derives full satisfaction and which does not deprive him of opportunities and time for his personal, family and social development.

CONTINUING MEDICAL EDUCATION FOR THE GP — PRESENT & FUTURE

Dr Goh Lee Gan

"Continuing medical education (CME) is the lifeblood for maintaining high professional standards in medical practice" so declared the College memorandum to the Ministry of Health on the subject of a postgraduate medical centre in General Practice/Family Medicine in the College of Medicine Building.[1]

The College of General Practitioners has a commitment to CME. This was stated in an editorial in the first issue of the College Journal in 1972: "The role of the College is to provide education... Continuing education is a must if we are to provide the skilled care expected of us."

How has continuing medical education of the General Practitioner (GP) come to be at the present and how could we make it more effective in the future is the subject of this paper.

THE PRESENT

A questionaire survey of College members conducted in October 1985 where a 73.8% responded (299 out of 405), the need for self-study materials was felt in 93%. Of group learning methods, the preferences were as follows: lectures (81%), clinicals (72%), seminars (57%) and conferences (37%).[2] The number who benefitted from communication with colleagues was not asked.

Self study

Self study as a most preferred method of CME was also found in a Scottish study where 1 in 5 general practitioners were surveyed by questionaire.[3] Pickup et al in another study found a similar preference.[4]

In UK, the results of the Scottish study led to the development of the CASE programme through the CLIPP project by Prof Harden and his team in Dundee.[5] Several of us in the College were quite interested in the project and were privileged to have Prof Harden talk to us about it when he passed through Singapore in 1985.

Presently, the Singapore Family Physician, the publication of the College, has a home study section with review articles and quizzes. The College has not yet embarked on Self study course although some thinking on this subject has been done.

Self study courses (synonymous with Home study courses) was a subject that was debated in several meetings of the CME Committee. It was felt that to be effective such courses had to be practice oriented, problem solving oriented, self-assessment oriented, oriented to current literature and systematic. We came to the following conclusions:[6]

* Course design — there are several possibilities:

  A. A collection of annotated and graded recent articles in the literature — supported by MCQs, Patient Management Problems (PMPs), and essay questions.

  B. Specially designed courses based on that developed by the CLIPP project by Prof Harden and again supported by MCQs and PMPs.

  There are several existing self study courses that we could collobarate with, such as the CHECK programme of Australia, or that of the College of General Practitioners, Malaysia to mention two.

* Tutorial support

  This was felt to be important. This could be through model answers to questions or self marking answers for MCQs both of which are not too labour intensive. A more labour intensive way will be to have a panel of

course tutors to mark the answers and give comments. Alternatively, the answers can be linked to standard "tutor" responses using the computer. Print-outs can be easily produced.

* Frequency and course areas

  One approach is to cover the gaps of areas not covered by lectures or seminars. Eventually, complementary courses to lectures and seminars can be developed.

* Avoiding overlap of the various parts of the CME programme

  — between lectures/seminars and home study courses

  As the latter are to fill the gaps left by lectures/seminars overlap will not occur; furthermore home study courses can contain background material and self-evaluation materials.

  — Home study course and home study section of the Singapore Family Physician

  The Singapore Family Physician can run snippets of the course MCQs and quizzes and some more important or basic articles. It will thus provide a peep-hole into the home study courses.

  — Home study section and lectures

  Some of the topics from the lectures can be run in the home study section of the Singapore Family Physician after the live presentations are over.

Additionally, the College has since 1974 set up a tape lending library and a book and journal lending library largely through the financial support of the Reuben Meyer Trust. These facilities are open to members during office hours.

Lectures

Lectures form the staple diet of CME for the GP. This is not surprising as they are the easiest to organise and can reach out to a large audience very cheaply. However, the effectiveness of these in changing practice behaviour has been questioned. Notwithstanding this, lectures are here to stay. The exercise is therefore how to make them more systematic, more relevant and hopefully more effective.

Systematic lectures as a means of CME for GPs were instituted a long time ago. The early issues of Annals of the Academy of Medicine had such articles. With the formation of the College in 1971 the organisation of CME lectures continued in earnest.

The College started with a bi-weekly programme of talks and discussions. This led to the 1974 and 1985 examination-oriented refresher courses and since then were replaced by in-depth lecture courses conducted at least once yearly. The early courses were either held in the afternoon or at night, and a few were held at 7.30 a.m. After 1976, the courses have been held exclusively at night.

Between 1981 and 1983 the number of update courses were increased to 2 per year and since then has been increased to three per year.

Since 1983, a certificate of attendance has been awarded to doctors who have attended at least 80 percent of each of 6 modules of update courses in 2 to 3 years. This has since been made a requirement for the Diplomate Examination.

Since 1985 an initial attempt was made to conduct a 2 year cycle programme for the whole field of medicine relevant to General Practice. We ran 6 modules and 3 weekend seminars in the two years. We had difficulty trying to accomodate all the areas without unduly increasing the number of modules.

The solution we came up with after several discussions was to combine two or more areas in one module. This is reflected in the second 2 year programme for 1987/89 which will consist of the following:

1987/1988

Module A

1st quarter — Family Medicine, Paediatrics and O & G

Module B

2nd quarter — Surgery, Orthopaedics & Anaesthesia

Module C
3rd quarter — Internal Medicine I; practice management

1988/89

Module D
1st quarter — Internal Medicine II; practice management

Module E
2nd quarter — Geriatrics, Psychiatry, Family Medicine

Module F
3rd quarter — Minor specialities, Occupational Medicine

It should be noted that the coverage of each discipline is not meant to be comprehensive, but rather to concentrate on the key issues and priority areas of the subject in relation to clinical practice.

Several other evolutions took place. The first was to involve GPs in managing the programme. A review of the education policy of the College in 1973 by the then Chairman, Education Committee, Dr Evelyn Hanam, had this to say: "For the first time, the current series of Friday night sessions is being led by general practitioners. This is not a reflection on the "academics" who have so loyally led these sessions on so many occasions, but the College feels that it is time their own members took over some of the responsibilities of this type that are within their scope."[7]

Next, is the use of the GP as moderator for each session since 1981. The GP moderator's task is to brief the specialist lecturer on aspects of the subject that are of importance and relevant to the GP, such as recent advances, new directions and the interface area between GP and specialist care. The GP moderator will also introduce the lecture and highlight the main issues of the subject as seen from the GP context.

Finally, the CME Committee is experimenting getting GPs themselves to speak. Thus, in a recent module on Family Medicine, Paediatrics and O & G, 3 of the 8 talks were delivered by GPs. This module had a record registration to-date of 197 out of 447 members.

Attendance at the College update courses has been going up. In 1978, where the earliest record of attendance is available, the number was 68. Today, the attendance is around 140. We would like to believe that making the programme systematic and involving the GP to give the specialist lecturer indications of what the GP population wants has led to this increase. We would like to believe that we have overcome what has been described as a shotgun effect — "scattered, weak and unpredictable",[8] rather than the fear of compulsory CME!

Additionally, since 1976 the Ministry of Health's Primary Care Division has been holding weekly Thursday lunch-time sessions initially at Maxwell Road OPD through the initial efforts of Dr S Devi in the Ministry of Health. These include talks, discussions and tape sessions on topics of Family Medicine/ General Practice. It is encouraging to note that these sessions are not only on-going to this day, but since October 1976, the sessions have been "regionalised" so that apart from Maxwell Road OPD, sessions have become available in Still Road initially and now in Clementi and Bukit Merah Polyclinics.

Clinicals

Lectures suffer from the deficiency of not being "hands-on". Recent innovations in this area are showing good promise of catching on. The credit for this goes to Dr Ng Yook Kim. In 1985, he explored the possibility of the hospital supporting GPs in CME with a group of GPs from the Association of General Practitioners, Singapore.

Out of the discussion it was decided to experiment on the idea of a jointly organised CME and a joint committee of hospital medical staff and the GPs working in the drainage area of the hospital was formed to draw up a CME programme initially at Changi Hospital and later at Alexandra Hospital. The emphasis was to be on "hands-on" and practical ward knowledge and skills rather than didactic lecturing. Additionally, the opportunities for interaction between doctors of both the sectors were just as important as the CME part; they got to know one another.

The idea has caught on. Now there are clinical rounds in medicine, O & G, surgery and paediatrics for the GPs. Apart from Alexandra Hospital and Changi Hospital, Kandang Kerbau Hospital, Toa Payoh Hospital and several private hospitals like Thomson Medical Centre, Mt Elizabeth Hospital and American Hospital are also organising CME sessions for GPs.

Conferences

These have not been very actively attended by GPs, chiefly because they cannot afford the time to be away from the clinic. Another possible reason is that conferences are generally specialist oriented and therefore not immediately relevant to the practising GP.

THE FUTURE

We can work towards more effective CME programmes for the future. If the programmes are useful, it is likely that they will attract GPs to attend. In the design of CME programmes, several factors have to be satisfied if the programmes are to be attractive. Prof Harden calls it the CRISIS model. This acronym stands for Convenience, Relevant, Individualised, Self-assessment oriented, Interesting and Systematic. We can work on several directions.

Building on the Present

Lectures

The College's update programme satisfies most of the factors of the CRISIS model. Judging from the attendance, it is about 25% to 50% successful, although we know that not all doctors would prefer lectures and not all are able to come on Friday nights at 9.00 pm.

Combining lectures into seminars can be an alternative to increase the cost/benefit ratio of coming to the lecture hall. Repeating the lectures at another time could also be explored.

The important points are the lectures must be planned by practising GPs and judging from the results of the Scottish study, recent advances in the diagnosis and treatment of disease and clinical developments in general practice will be favoured; in that study, 82 per cent and 62 per cent of the respondents respectively favoured these two areas. Similar findings were reported by Pickup and by Reedy.[9]

Clinicals

Clinicals form an important medium of effective CME. As Gray[10] point out, the majority "need practical assistance and not vague exhortations to translate good intentions into better practice." In addition to new knowledge gained form research, the physician's own work should be the basis of his education. Education should take place in the surgery or ward as well as in the seminar room or postgraduate centre.

He goes on to say, "The physician should be given help to evaluate a particular aspect of his work and compare it with that of others in similar settings. One focus should be the quality of clinical care: educational projects such as 'How could we improve our management of congestive cardiac failure?' could be undertaken. Other members of the team in which the doctor works should participate in the project. Patients' views should, where possible, be incorporated."

The clinical sessions jointly planned by GPs currently in vogue show great promise, but they must not be allowed to degenerate into didactic lectures simply because these are easier to organise than case presentations. The GPs must play an active part in planning and presenting the CME programmes.

Capitalising on the Teachable Moment

There are few systems that provide doctors with information at the time when they would be most likely to learn from it — when they are faced by a patient with the difficulty that could be satisfactorily solved.

Referral of the patient to a speicalist and the specialist's reply offer a common and important opportunity for continuing education, although in practice this is often neglected. Communication between the doctors often leaves much to be desired. A new commitment to better communication could be developed.

There are ways in which doctors can be helped to learn at such teachable moments.

The provision of telephone hotlines, easy access to information (for example, a computer database), and expert systems to help decision making are possibilities.[11]

Development of Self Study Material

Well designed material can be used for self study as for example, during the slack time in the clinic, or before a clinic starts or after it ends.

Considering that 93% of respondents in the College's survey favoured self study, there is a need to develop self study material. To be effective, such material will have to be relevant to practising doctors, provide a means for comparing his responses with those of his peers, and have problem-oriented exercises as well as MCQs to evaluate himself. For the latter, answer keys should be provided for immediate feedback. The approach of the CLIPP project could be a model for developing such material for our doctors.

Organisation, Coordination & Leadership

Like any other group activity, CME requires organisation, coordination and leadership. The College can provide the leadership and perhaps overall coordination but organisation at unit levels has to be decentralised and made cellular.

One approach is to have the drainage hospital (government and/or private), the polyclinic and the area GPs together form one unit for joint planning and implementation of the CME programme at local or unit level based on the guidelines provided by the College in order that the programme will be systematic and not suffer from the shotgun effect — "scattered, weak and unpredictable."

For co-ordination of the total CME programme, policy, and planning, a SMC coordinating committee consisting of representatives from the Ministry, academic and medical bodies will be useful. Such a body could have a service arm for dissemination of information of CME programmes, perhaps on a quarterly basis.

Quality Assurance

Doctors should be encouraged to do self-evaluation of their learning and practice; the co-ordinating bodies can stimulate the design of such protocols. If accreditation of CME hours is desired for doctors to take stock of themselves, a voluntary scheme may be enough, unless doctors prove themselves to be incapable of being responsible for themselves. Just as CME should be a culture, quality assurance too should be a culture; not a policing instrument. This is a challenge for doctors to prove themselves capable of such a responsibility.

REFERENCES

1. CGPS: Proposed Postgraduate Medical Centre in General Practice/Family Medicine, 1984.
2. Chan SMP: Feedback Survey of College Activities. Singapore Family Physician, 1987, 12: 92-95.
3. Scottish Council for Postgraduate Medical Education. Survey on continuing education in general practice. Edinburgh: SCPME, 1979.
4. Pickup AJ, Mee LG, Hedley AJ. The general practitioner and continuing education. J R Coll Gen Pract 1983; 33: 486-490.
5. Donald AG. Continuing Learning in Practice Project (CLIPP). (Ed). J R Coll Gen Pract 1984; 32: 242-244.
6. CGPS CME Committee. Internal Paper: CME — Developing a 2 year programme for 1985-87, 1985.
7. Hanam E: Education Programme. GP 1973, 1:30-31.
8. Wood J, Byrne PS. Section 63 activities. Occasional Paper 11. London: RCGP, 1980.
9. Reedy BLEC, Gregson BA, Williams M. General practitioners and postgraduate education in general practice. Edinburgh: SCPME, 1979.
10. Gray JA. Continuing Medical Education: Retooling and renaissance. Lancet 1986, 1:1261-2.
11. Gray JA. Continuing Education: What techniques are effective? Lancet 1986, 2:447-8.

THE COLLEGE AND UNDERGRADUATE TEACHING

Dr Moti H Vaswani
Chairman, Undergraduate Teaching Committee

Historical perspective

General practice was first included in the Singapore medical undergraduate curriculum as a compulsory posting in 1971, when the Dean of the Faculty of Medicine invited the College of General Practitioners to submit a list of general practitioners from which could be appointed General Practice Clinical Teachers. Medical students were to be attached for a week, in pairs, to these Teachers' Clinics:

> "to give them the opportunity of seeing medical practitioners outside hospitals, for a more balanced perspective of the pattern of medicine in Singapore;
>
> to introduce them to the problems in general practice in the private sector, and
>
> to enable them, wherever possible, to see general practitioners at work in the setting of patients' natural environment".

The College Undergraduate Teaching Committee in 1973 started a series of introductory lectures to provide a theoretical basis introducing students to the discipline of general practice. Topics for the lectures included the consultation, goals of general practice, human development and behaviour, disease patterns in general practice, difficulties and limitations in general practice, and ethico-legal considerations in general practice.

The Committee also organised an end-of-course seminar to provide the undergraduates with an opportunity to raise questions and discuss any points not covered in both the theory and practical sessions. Forms were also devised for the assessment of the students by their general practice teachers, and for the assessment of the teaching course by the undergraduates. It later introduced the Written Test in General Practice to be taken by students after their postings.

When the Faculty of Medicine set up its Curriculum Review Subcommittee in 1980, our College sent in a Memorandum on "Type of End Product and Overall Objectives of the Undergraduate Curriculum", and in July 1982 sent the Dean of the Faculty of Medicine another Memorandum advocating the setting up of a Department of Family Medicine within the Faculty.

From 1983, the number of pre-attachment lectures to students were increased from five to ten, with the inclusion of additional topics in general practice — Clinical and Affective Skills; Interviewing, Communicating and Counselling Skills; Emergency and Sports Medicine; Health Education and Preventive Medicine; Care of the Aged and Chronic Sick; Terminal Care; and Practice Management.

Recognising the fact that while most general practice Clinical Teachers were well able to demonstrate and explain their job to students, they lacked educational expertise, the Undergraduate Teaching Committee held a Seminar on Teaching Methodology by lecturers from the Institute of Education in April 1984, and in November the same year, organised a Teacher Training Course by Dr Edward J Kowalewski from the Department of Family Medicine, University of Maryland, USA. The teachers were very enthusiastic about both, and the daily attendance at the 6-day Teacher Training Course was overwhelming.

An experiment was conducted in 1984, wherein students spent each morning of their General Practice posting week at a Ministry of Health Primary Care Polyclinic. They were given tutorials by teachers from the College

on patients seen at the Polyclinic — covering areas like: the consultation, undifferentiated illness and symptoms, chronic care and continuing care. After another year of this arrangement, the sessions at the Polyclinics were discontinued because of lack of teaching material and because of logistic problems for both teachers and students.

For the past two years, the introductory lectures were increased to eleven, and at the instruction of the Dean's Office, were held from October to December, six to eight months before the students' actual General Practice postings.

The Present

The National University of Singapore finally recognised the importance of general practice in the undergraduate curriculum, and early this year formally established the discipline of Family Medicine/General Practice within the Department of Social Medicine and Public Health, which took on the new name of Department of Community, Occupational and Family Medicine. (COFM)

General Practice in Singapore has academically come of age, and will never again be the poor cousin that it may have been in the past. The teaching of undergraduates in Family Medicine/General Practice remains an important function of the College, with its firm belief that a knowledge and understanding of the medical and social problems seen in the community is invaluable to all graduates in their future career, whatever path this follows.

The Way Ahead

While it continues to work with the Department of COFM in the teaching of Family Medicine to medical undergraduates, the College must not let up in its efforts to upgrade and improve medical teaching (in general practice/family medicine particularly, but also in the undergraduate curriculum as a whole) and to increase the role of general practice (or primary medical care) in the curriculum.

There is absolutely no reason why general practice cannot legitimately undertake the role of elementary medical teaching to students in their early years. Outside the hospitals, where such teaching has traditionally taken place, the variety of disease is greatest, the distinction of health from illness is more pronounced, and human behaviour and reaction to illness can be studied in their natural environment, unmodified by the effect of removal to strange surroundings. Only if basic clinical education takes place at the primary care level, can it become more relevant to the future medical needs of the community.

The College must continue to urge the University to shift its weightage in teaching medical students away from the high technology environment of the modern teaching hospital towards the Community setting, with greater emphasis on preventive medicine and health education, on medical conduct and ethics, on primary medical care, and on preparing its graduates for vocational and continuing education. It must demonstrate to the University, and to the Governent health authorities, that the role of the medical school is not to produce a graduate ready for general practice, but to lay the necessary groundwork to enable graduates to proceed to vocational training in the discipline of their choice, including Family Medicine/General Practice.

The Clinical Teachers in General Practice and the College members who have lectured to the students, have year after year spent a lot of valuable time and energy in this activity of the College. We have now built up a core of about 40 dedicated and committed teachers. It is high time the College, especially Council, consider demonstrating its appreciation for their sacrifice and efforts by doing much more for them than merely exempting them from payment of fees for the College's regular update courses. The University must also be coaxed to organise or sponsor courses on teacher training and also to adequately compensate the teachers for their loss of remunerative time (for lectures and teaching students in their clinics), which is an inevitable consequence of good teaching, if it wants to see the teaching become more professional.

Only by addressing themselves to all these areas can the College and the University look forward to the production of future general practitioners/family physicians/primary care physicians capable of making a distinct and pivotal contribution to the delivery of health care to our nation.

MEMORANDUM ON THE ACADEMIC RECOGNITION OF THE DISCIPLINE OF FAMILY MEDICINE BY THE FACULTY OF MEDICINE, NATIONAL UNIVERSITY OF SINGAPORE

1 PREAMBLE

This memorandum formally proposes that the Department of Social Medicine & Public Health (SMPH) undertakes the responsibility for the teaching of Family Medicine to medical undergraduates of the National University of Singapore. It is the result of discussions between the College of General Practitioners, Singapore (CGPS) and SMPH on how the learning and teaching of Family Medicine could be given greater emphasis to reflect the current trend in medical education throughout the world.

Although the terms "General Practice" and "Family Medicine" are not exactly synonymous, they have much in common and the practitioners concerned are often engaged in both professional fields at the same time.

As a discipline, the preferred term "Family Medicine" (FM) will be used in this memorandum to emphasize the importance and relevance of family-based medical practice in the delivery of health care. A practitioner, on the other hand, is better known as a General Practitioner (GP), and will be referred to as such.

Jointly Submitted by
Department of Social Medicine & Public Health, National University of Singapore

and

College of General Practitioners, Singapore
December, 1986

2 CASE FOR RECOGNISING THE DISCIPLINE OF FAMILY MEDICINE

2.1 Historical perspective

The teaching of Family Medicine as a discipline in the undergraduate curriculum has to date been done by CGPS, SMPH, and in parts by the various Departments of the Faculty of Medicine.

The CGPS has advocated the setting up of a Department of General Practice over the last 15 years of its existence because it perceived a need to give the learning and practice of FM a greater emphasis since at least half of the undergraduates eventually become General Practitioners/Family Doctors/Primary Health Care Doctors.

The CGPS has since 1971 contributed voluntarily in providing undergraduates with a one-week posting in GP clinics and has, since 1975, introduced a 10-lecture course on Introduction to General Practice. Needless to say, no depth or breadth in the discipline was possible within this limited time frame.

The absence of academic recognition by the University has made it difficult for CGPS to meet the perceived need. This lack of academic status meant that a sizeable proportion of students and staff from clinical departments regard CGPS' efforts with scant attention. Similarly, it was difficult to attract practising GPs to be clinical tutors to conduct the GP postings. The negative response from students also had a dampening effect on the enthusiasm of practising GPs who have offered to take students.

The Medical Faculty's Statement of End-Product clearly states that:

"The overall aim of the undergraduate medical course is to produce a balanced scientific and humanitarian doctor: a graduate equipped to function initially as a houseman, with the ability to work in primary health care and with the potential to undergo specialised training."

To this end, the SMPH Department has some aspects of General Practice/Family Health in its teaching programme. (See ANNEX A). It nevertheless faces difficulties of clinical orientation because its medical staff are not practising GPs. As the CGPS undergraduate posting and lectures are conducted independently of it, there were no opportunities for integrating teaching content.

Clinical departments have reported in recent years that their teaching programmes have been more GP oriented but here again they face the same difficulties of GP clinical orientation as none of the clinical departmental staff are GPs. The hospital captures only a small part of the whole spectrum of illness seen in the community, the large proportion of which do not find their way to hospital specialist units.

2.2 Justification for academic unit/team in Family Medicine

In pursuance of the general objective of the undergraduate medical curriculum, an academic teaching unit/team in FM will be in a better position to fulfill the said objective through the participation of selected practising GPs who are to teach and to promote good standards of GP practice in Singapore.

Of the medical problems that present to the GP, who is usually the doctor of first contact, most of them can be competently and effectively handled by him, if he has been adequately trained. Such primary care, by virtue of its use of less sophisticated equipment and facilities will be cheaper than the secondary and tertiary levels of care.

Thus, a high standard of primary care delivery will contribute substantially to the overall health care of our people. Since at least 50% of our graduates become GPs or Primary Health Care doctors, it is vital that relevant training in the GP as well as Government Polyclinic settings should be provided. For those who move into specialised disciplines, a good exposure to GP practice will allow them to see the management of patients in a continuum from the individual to the family and to the community as well as from the ambulatory context to the hospital environment.

Apart from undergraduate teaching, a full time academic unit will serve as a base for the development of teaching programmes and research projects and thereby raise the standards of teaching and practice of this discipline. In these endeavours it should work closely with CGPS, which will continue to be responsible for post-graduate training and the certification by examination of the MCGP Diploma in Singapore.

3 ACADEMIC RESPONSIBILITY FOR TEACHING FAMILY MEDICINE

3.1 We accept the premise that the discipline of FM be given academic recognition by the Faculty. As such, decisions have to be made as to whether it should be an independent department by itself, or become part of an existing department.

The choice between being part of an existing Department or becoming an independent Department is a dilemma faced by many other universities worldwide. The general feeling is that it is better to start off in an existing Department. The chances of starting an independent Department of General Practice/ Family Medicine from scratch in any university are slim, partly because there are few academically inclined GPs in the community to head and staff such a Department and partly because of the difficulties of curriculum time, funding and administration.

The CGPS, which has hitherto championed the setting up of an independent Department of General Practice/Family Medicine, has reconsidered its stand and is prepared to accept the idea of being part of a Department on the strength of the reasons given above.

The Department of Social Medicine & Public Health is the logical choice for the following reasons:

(a) The Department of Social Medicine & Public Health already teaches several elements of direct relevance to the practising GP such as epidemiology and disease control, occupational health, environmental health, health education, family health, organisation of personal health services and health economics. The teaching of family medicine can be easily integrated into the SMPH programme.

(b) Staffing and administrative support can be provided for by the NUS through the SMPH Department.

(c) The Department is receptive to the idea of including General Practice/Family Medicine within its fold.

4 ADMINISTRATIVE SETUP FOR TEACHING OF FAMILY MEDICINE

4.1 Name of Discipline

Both the CGPS and SMPH propose the name of "Family Medicine" in preference to the older name of "General Practice". The term "Family Medicine" reflects the current trend of naming this discipline as well as the emphasis on family-based medicine. "Family Medicine" suffers less from an identity image in contrast to the more ambiguous name of "General Practice".

4.2 Name of Department

We propose that with the inclusion of Family Medicine in the Department of Social Medicine and Public Health, the opportunity be taken to change the departmental name to Department of Community, Occupational and Family Medicine, with the acronym of COFM.

Apart from reflecting the inclusion of Family Medicine in the Department, the suggested change of name reflects current trends in terminology of the disciplines named. The three terms in the new name, namely, "community", "occupational" and "family" are all pertinent as each is represented by a Faulty, College or Postgraduate Board in UK and the USA. As such they have recognised professional roles and interests which should be reflected in the teaching and research programmes as well.

4.3 Overall Objectives of the Academic Unit in Family Medicine

The Unit's objectives will be as follows:

(a) to organise and conduct undergraduate teaching programmes in Family Medicine in line with the Faculty's Statement of End-Product and objectives.

(b) to provide a clinical service to complement the teaching of Family Medicine.

(c) to undertake research either independently or jointly with relevant bodies, in areas of Family Medicine.

4.4 In fulfilling its functions, the unit will undertake:

(a) to work closely with other staff of the Department in meeting the teaching and research commitments of the SMPH Department;

(b) to work closely with the Primary Health Care Division of Ministry of Health in the teaching of Primary Health Care;

(c) to collaborate with CGPS, in its on-going CME and post-graduate teaching programmes in Family Medicine and possibly with the Ministry of Health in its Vocational Training programmes when these are set up.

4.5 Educational Objectives

The National Morbidity Survey of Singapore (1976) undertaken by the Ministry of Health showed that only 1.4% of patients seeking care from Western trained practitioners were hospitalised. Thus, the general objective is for all students (including those whose futures lie in other disciplines) to develop insight into the concepts and practice of patient management in the community, outside specialised hospital settings.

With the above general objective in mind, the specific objectives of the undergraduate course with regards to knowledge, skills and attitudes have been defined as given in ANNEX B.

5 UNDERGRADUATE TEACHING PROGRAMME

5.1 Current teaching package in General Practice undertaken by CGPS

The teaching of this subject currently consists of:

(a) A 1-week posting to a GP clinic

(b) A 10-week module on introductory lectures in General Practice — see ANNEX C.

(a) The 1-week posting

The Undergraduate Teaching Committee of CGPS has conducted workshops amongst its corps of clinical tutors to review the problems and limitations of teaching this component. Their recommendations include:

(i) Standardisation of teaching content by establishing a checklist of areas to be covered — see ANNEX D.

(ii) Adoption of criteria for selection of clinical tutors — see ANNEX E. These criteria are very similar to that of the Joint Committee on Postgraduate Education of the Royal College of GP, UK (1980). — see ANNEX F.

The CGPS Undergraduate Teaching Committee has been perturbed by the poor attitude of some of the students which has a dampening effect on the willingness of GPs to take students; this attitude of the students may have arisen from the fact that the posting has no academic status. The programme also suffers from inadequate number of clinical tutors.

(b) The Lecture Course

The timing at 8.00 a.m. — 9.00 a.m. presented problems where students had to be in the wards by 9.00 a.m. or soon after, especially if the ward was located in another part of Singapore. Students are therefore reluctant to attend. Others have felt that to come to the campus to attend just one lecture on a Saturday morning does not justify the effort and expenses. As practising GPs have long working hours, scheduling a mutually acceptable time becomes difficult.

Others have complained of repetition of subject material with other parts of the SMPH course. Such feedback has been useful for course organisers to fine-tune the lecture programme. The feedback survey for the 1986 course can be found in ANNEX G.

5.3 Proposed changes

The following are proposed changes to overcome the observed limitations described above:

(a) Making the subject examinable.

Questions on Family Medicine should be included in the SMPH Examination. Details have to be worked out. Such a change will make the students take a serious view of the subject. .Similarly, hospital and GP colleagues may be motivated to come forward to help once the subject has academic status. The appeal of the subject to students, however, must be sustained by designing as interesting and useful a programme as possible.

(b) Reorganising the 1-week GP Posting

The involvement of full-time clinical staff in designing the programme is necessary if the programme is to succeed. The following changes are suggested:

(1) Implement the criteria of selection of GP clinical tutors as set out by the Undergraduate Teaching Committee of CGPS in ANNEX E.

(ii) Conduct training workshops for GP clinical tutors as is done for trainers in the Oxford area in UK. — see ANNEX H. If possible, this could be implemented in Jan — Mar 87 in preparation for the Apr — Jun 1987 M3 posting. Otherwise, we can think in terms of 1988.

(iii) Redesign the 1-week posting to provide for more objective learning goals. Useful input is provided by the University of Nottingham student's protocol for the GP attachment.

(iv) Introduce a student's posting protocol.

(v) Get clinical tutors to produce common background reading material, which should have been agreed upon in the teachers' workshops.

(vi) Introduce seminars based on GP cases to stimulate exploratory learning. The case material for the seminars could form a suitable alternative to the material used for the paediatric and orthopaedic short

cases in the SMPH socio-medical Case Studies. It is suggested that each posting batch for a particular week should form one teaching group for the seminar presentations. Each student is obliged to attend all the seminars within his group. The resource persons will be the GP clinical tutor and the relevant departmental staff.

Suggested subjects of the seminars could be:

(i) Injuries from whatever causes seen initially either in the clinic or hospital.

(ii) Acute illness seen in the clinic or home — with or without hospitalisation e.g. acute chest pain or acute abdominal pain.

(iii) Common illness not seen in hospital e.g. measles, chicken pox or herpes zoster.

(iv) The difficult child, with or without referral to child psychiatrist.

(v) The at-risk elderly and chronic conditions of the aged requiring long-term follow-up.

(vi) Ill-defined conditions, as for example, stress-induced psychosomatic symptoms.

(c) **Minor changes in the content of the Introductory Lecture Course to General Practice**

Efforts have been made by the CGPS Teaching Undergraduate Committee in past years to avoid duplication of teaching content with that of other parts of the SMPH course.

6 A GP/FM TEACHING PRACTICE

6.1 Case for such a practice

As General Practice/Family Medicine is a clinical discipline, it has to be academically supported by a Practice Clinic.

A departmental report of the SMPH on "Teaching of Primary Health Care in Singapore" in 1982 had this to say of a teaching practice:

"The base for primary care practice is the community. Teaching of primary care should hence reflect a true representation of the eventual work in the community. the selection of patients to provide the material for clinical teaching must be representative of the community to be served. Therefore it is preferable that the setting for teaching the vocational aspects of primary care must be an existing practice within the community. Local community health practitioners can be utilised with the appropriate incentives to participate in the planning and development of innovative teaching in which they can naturally function on a part-time basis."

6.2 Objectives

Such a clinic fulfils the following objectives:

(a) Teaching

The Practice Clinic will provide its clinical teachers with patients, clinical data, case records, material related to managing the practice as well as the practice environment. From these resources, the teachers draw practical experience as well as clinical and other teaching material. Teachers of other aspects of community and occupational medicine could also run sessions to acquire a clinical angle in their total experience.

(b) Research

The Practice Clinic forms a life model for research and development into practical aspects of patient care, record keeping, staff management and practice management. New approaches to health care can be introduced and tested out in a real environment.

(c) Service

The Practice Clinic will be able to provide a service component to patients in the community. With the focus on standards, it is hoped that the service provided will be exemplary.

6.3 Set-up Considerations

The options available for such a Practice Clinic include the following:

(a) Active participation on a sessional basis in a selected Government Polyclinic (e.g. Jurong);

(b) Active participation on a sessional basis in a selected private group practice;

(c) Setting-up a clinic de-novo.

(d) Leasing from MOH at a nominal rent an existing OPD.

Option (a) may not resemble real life private practice, but it is nevertheless part of the Primary Health Care system of the country and it can be implemented without much delay.

Option (b) may be a bit complicated in terms of administrative arrangement, but it would provide the real private setting and even give the relevant full-time departmental staff opportunities for some private practice in addition to teaching and research.

Option (c) suffers from the difficulty of a long set-up time from planning to completion. There are also concerns whether the University should set up a private GP clinic which will be in competition against other clinics. Nevertheless, such concerns should be balanced by the fact that besides its exemplary role in the conduct and running of a primary health care practice, it will not be profit-oriented.

Option (d) will provide the opportunity to run the teaching practice as a model GP clinic in our local context. Negotiations may be made with Ministry of Health to provide some support including staff.

One or more of the above options could be chosen and further developed depending on needs and available resources.

6.4 Manpower

Manpower would have to be provided by the academic unit directly or through the utilisation of part-time teachers or vocational trainees. The staff complement will have to be worked out depending on the type of location of the Teaching Practice.

It is envisaged that we could start off by having two full-time academic staff members to spearhead the work of the Teaching Practice.

8 RESEARCH

An ongoing activity of the Family should be to undertake research in general practice aimed at:

— upgrading GP standards of practice;

— research and development of new trends in practice such as computer use in the clinic etc

— promoting clinical research based on GP patients.

In such activities the academic unit in SMPH can collaborate with CGPS, Ministry of Health and other departments of the Medical Faculty.

Funding for research will have to come from sources external to SMPH and applied for in the usual manner.

Editor's Note: Only 3 of the Annexes submitted with the Memorandum are reproduced here.

ANNEX B

EDUCATIONAL OBJECTIVES OF THE DISCIPLINE OF FAMILY MEDICINE

KNOWLEDGE

At the end of the Course, the student should be able to:

1 Describe the morbidity pattern and prevalence of common, acute and chronic illnesses in the community as well as indicate the differences between the community patient and the hospital patient.

2 Demonstrate an understanding of the disease processes of common, acute and chronic diseases, their recognition, how to

deal with them including appropriate intervention as well as the use of time as a diagnostic or therapeutic tool.

(a) Common illnesses not seen in hospitals — know how to differentiate from serious ones and the appropriate treatment to prevent them from becoming worse. Acquire a knowledge of early presentation of serious illnesses.

(b) Acute illnesses — know how to differentiate between the following categories: life threatening, dangerous if not managed properly and not dangerous but symptomatically requiring attention.

(c) Chronic illnesses — know how to provide continuing care including compliance monitoring and vigilance for early signs of complications.

3 Understand the effect of illness on the family, the patient's work and the working environment as well as how these considerations affect the total management of the patient.

4 Outline the opportunities and limitations for preventive medicine, health screening and health education in the setting of a general practice.

5 Outline the medico-legal considerations in general practice.

5 Understand the philosophy of team care, the relationships of the General Practitioner, the specialist, paramedical staff and the utilisation of available resources.

SKILLS

1 Demonstrate a basic grounding of effective consultation, diagnostic and problem-solving skills.

2 Develop effective communication skills for interviewing patients as well as giving information, instructions and counselling.

ATTITUDES

1 To the patient:

(a) Doing the best for the patient.

(b) Listening to what the patient has to say about his problem.

(c) Encouraging the patient to provide self-help and gaining independence.

(d) Giving enough time to the patient and trying to understand him as a person.

2 To the community & profession

(a) Contributing to the good of the community and profession.

(b) Maintaining ethical relationshps amongst colleagues and with patients.

3 To oneself

(a) Participating in continuing education and keeping abreast with new information.

(b) Exercising critical self evaluation of one's work.

ANNEX D

CHECKLIST OF TEACHING CONTENT

CHECKLIST OF TOPICS/AREAS TO BE COVERED DURING GENERAL PRACTICE POSTING OF UNDERGRADUATES

☐ Early presentation of illness in General Practice — paucity or lack of physical signs.

☐ Symptomatic treatment vs Diagnostic labels and appropriate treatment.

- ☐ Detection of serious or potentially serious illness — when and where to refer.
- ☐ Selective history-taking and investigations.
- ☐ Overcoming limitations in General Practice e.g. time.
- ☐ Interviewing and Communicative Skills.
- ☐ Episodic Care/Continuing Care/Long-term Problem.
- ☐ Preventive Care and Health Education.
- ☐ Total care of patients' illnesses, including psychological and social aspects.
- ☐ Emergency care.
- ☐ Domiciliary Care and Home-Visiting.
- ☐ Multiple Pathology in a Single Patient.
- ☐ The Human Aspects of Consultation/Management — the Patient's personality and the Doctor's attitude.
- ☐ Ethical Aspects of Practice — Confidentiality, Certificates, etc.
- ☐ Relevant Aspects of Practice Management e.g. Medical Records, Dispensing Laws, etc.

ANNEX F

SELECTION CRITERIA OF CLINICAL TEACHERS CGPS UNDERGRADUATE COMMITTEE WORKSHOP 1983

III. CRITERIA FOR SELECTION OF CLINICAL TEACHERS IN FAMILY MEDICINE

A Personal qualities

i) A desire to teach

Assessed by:

a) Past and present activities in the teaching of undergraduates or paramedical personnel.

b) Interest in teaching methods including attendance at courses for teachers on a regular basis after appointment and plans for the further improvement of personal teaching.

c) Willingness to submit to academic and operational assessment.

ii) **Time to teach or Readiness to make time**

Assessed by:

a) Personal statement.

b) Selection Committee's local and personal knowledge of the intended teacher, his/her practice and his/her premises.

iii) **Membership of the College**

Although membership of the College of General Practitioners Singapore cannot necessarily be a pre-requisite, a non-member cannot be expected to be totally committed to the ideals and goals of the College, especially its educational objectives.

iv) **Attitudes to Patients, Previous Undergraduates and to Family Medicine itself**

Assessed by

a) Personal statement.

b) Selection Committee's local and personal knowledge.

v) **Clinical Competence**

Assessed as in (iv), together with attendance at Refresher Courses organised by the College of General Practitioners Singapore and other academic bodies.

Experience in General Family Practice (Minimum three years).

vi) **Special Interests**

Assessed by

a) Critical analysis and research

b) Publication of original articles in medical journals.

vii) **Academic Qualifications**

Special emphasis must necessarily be placed on success in the Diplomate Examination of the College of General Practitioners Singapore.

B Practice Organization and Premises

i) Ability to make available the necessary time for teaching by means of good organization.

ii) Practice premises, equipment and practice library.

iii) An organized efficient record system.

C General Comments

1. To ensure a wide distribution of geographical locations and types of practice, all General Practitioners in Singapore should be invited to participate in the teaching programme.

2. As is usual in academic selection, there should be no appeal from the decision of the Selection Committee.

3. Appointment to the programme should be applicable to individuals, and not to partnership practice. It is essential that an appointee in a Group must have support from his partners, and be able to designate a deputy from within his practice.

   The quality of all members of a practice and of their organization and premises should be taken into consideration.

4. Factual data regarding practices and if possible an interview by representatives of the Selection Committee in the practice premises would be useful in differentiating between suitable and unsuitable practices.

5. In the assessment of teachers, greater weightage should be accorded to personal qualities than to practice organization and premises.

FAMILY MEDICINE IN THE DEPARTMENT OF COMMUNITY, OCCUPATIONAL & FAMILY MEDICINE

Dr Goh Lee Gan

1. INCEPTION

FAMILY MEDICINE has since February 13, 1987 been accepted by the Faculty of Medicine, National University of Singapore as an academic discipline. Its inclusion in the Department of Social Medicine & Public Health has also made it appropriate for the latter to take on a new name — the Department of Community, Occupational and Family Medicine (COFM).

These changes followed the acceptance by the NUS Council of a Memorandum submitted by the College of General Practitioners, Singapore and the Department of SMPH on 1 December 1986. The proposal had the support of the Dean of the Faculty and also Ministry of Health.

This Memorandum formally proposed that the Department of Social Medicine & Public Health (SMPH) undertakes the responsibility for the teaching of Family Medicine to medical undergraduates of the National University of Singapore. It was the result of discussions between the College of General Practitioners, Singapore (CGPS) and SMPH on how the learning and teaching of Family Medicine could be given greater emphasis to reflect the current trend in medical education throughout the world.

The choice between being part of an existing Department or becoming an independent Department is a dilemma faced by many other universities worldwide. The general feeling is that it is better to function from within an academic department with similar views on the content and purpose in family medicine teaching for medical undergraduates particularly as at present, there are few academically inclined GPs in the community to form an independent Department of Family Medicine and partly because of the difficulties of curriculum time, funding and administration.

Dr Goh Lee Gan
Sr Teaching Fellow
Department of COFM

2. WHAT IS FAMILY MEDICINE?

The terms "General Practice" and "Family Medicine" for practical purposes are nearly the same, the difference being that the latter is an evolved discipline of the former.

As a discipline, the preferred term is "Family Medicine" (FM) because it emphasizes the importance and relevance of family-based medical practice in the delivery of health care although that is not the only feature. There are many descriptions of Family Medicine. I think the one by Lynn B Carmichael (1973) describes it rather well:

"Family medicine is a new concept in medicine, designed to meet the health care needs of the public in a more responsive and responsible manner. The physician trained in family medicine assumes primary responsibility for both the acute medical care and the continuing health maintenance of the family. By treating family units as well as individuals and by practising continuous and primary health care, the family physicians personalises medical care and can be more effective and far-reaching in treating not only the demands of illness but also the patient's frequently unspoken needs. And by the practice of this kind of medicine, which includes and emphasizes preventive techniques and early

detection and treatment of disease, he is able to reduce the need for hospitalisation.

Family medicine departs from the traditional approach which is limited to diagnosis and treatment of symptoms. It is the knowledge and application of medicine for physical ailments, behavioral science for emotional problems, and community dynamics for social aspects of health and disease.

The family physician deals with his patients as members of family units, viewing the family as the basic unit of social organisation, the functional dependent group with which the individual establishes primary relationships.....The family is naturally the primary unit of health management."

Having settled the definition of the discipline, it is not difficult to define the job of the general practitioner/family physician. The job definition given by the College of General Practitioners, Singapore in its Examinations Handbook (1986) is as follows:

"A general practitioner/family physician is a doctor who provides personal, primary, comprehensive and continuing health care to his patients in relation to their families, the community and their environment. He may attend to his patients in his clinic, in their homes or sometimes in the hospital.

In treating his patients the practitioner must take into consideration the whole person, their psyche as well as their organ-systems and must not treat just the signs and symptoms.

In providing comprehensive and continuing care he will need to interact with his medical and para-medical colleagues. In promoting his patients' health he will not only treat therapeutically but also educate and counsel his patients."

3. OVERALL OBJECTIVES OF THE FAMILY MEDICINE UNIT IN COFM

The Family Medicine Unit's objectives in the Department of are as follows:

(a) to organise and conduct undergraduate teaching programmes in Family Medicine in line with the Faculty's Statement of End-Product and objectives.

(b) to provide a clinical service to complement the teaching of Family Medicine.

(c) to undertake research either independently or jointly with relevant bodies, in areas of Family Medicine.

In fulfilling its functions, the unit will undertake:

(a) to work closely with other staff of the Department in meeting the teaching and research commitments of the Department of COFM;

(b) to work closely with the Primary Health Care Division of Ministry of Health in the teaching of Primary Health Care;

(c) to collaborate with CGPS, in its on-going Continuing Medical Education and post-graduate teaching programmes in Family Medicine and possibly with the Ministry of Health in its Vocational Training programmes when these are set up.

4. EDUCATIONAL OBJECTIVES

The National Morbidity Survey of Singapore (1976) undertaken by the Ministry of Health showed that only 1.4% of patients seeking care from Western trained practitioners were hospitalised. Thus, the general objective is for all students (including those whose futures lie in other disciplines) to develop insight into the concepts and practice of patient management in the community, outside specialised hospital settings.

With the above general objective in mind, the specific objectives of the undergraduate course with regards to knowledge, skills and attitudes are:

TO KNOW:

1. The Illness Pattern and Clinical Care in General/Family Practice

(a) the disease profile and illness presentation encountered in general practice which includes psycho-somatic problems, early stages of disease and the late stages of medical problems when the hospital is unable to benefit the patient further;

(b) importance of the family structure and dynamics as the cause and effect of illness and well-being of the patient;

(c) scope of acute medical care and its delivery, including the housecall;

(d) the concept of comprehensive and continuing care, its scope and importance including terminal care;

(e) the community and other support resources available for patient management;

2. **The Consultation, Counselling and Preventive Health Care**

(a) the importance of effective consultation, which includes finding out the reason of encounter and the discovery of the patient's ideas, concerns and expectations; clear referral letters and communication with colleagues;

(b) the mechanics, objectives and importance of counselling as part of the total management of the patient;

(c) the concept of health maintenance and the place of health screening as part of health maintenance;

3. **The Principles of Practice Management**

(a) ethical aspects of practice such as confidentiality, certification and colleague relationships;

(b) relevant managerial and administrative aspects of the practice such as medical record keeping, appointment system, staff management and day to day operations.

(c) relevant legal aspects of practice such as certification of death, notification of diseases, vaccination, police cases, labelling of medicine and controlled drugs recording.

TO BE ABLE TO:

1. elicit the nature of the patient's problem through effective communication and interviewing skills;

2. understand the process of problem solving and its application in patient care;

3. manage the patient appropriately:

   be it to treat or to refer; therapeutic invention; or health education

TO RECOGNISE:

1. the importance of the doctor-patient relationship and empathy with the patient;

2. the importance of proper ethical relationship with colleagues and the patient;

3. the importance of self-study and continuing medical education.

The exhortation of Wright that "The undergraduate experience in medicine should be primarily educational. Its object is not to produce a fully qualified doctor, but an educated person who will become qualified in the course of training." applies to teaching of Family Medicine as well.

5. UNDERGRADUATE TEACHING PROGRAMME

The teaching of this subject currently consists of:

(a) FAMILY MEDICINE LECTURE MODULE (Module 8) — 10 lectures

(b) GP CLINICAL POSTING (Module 10) — 1 week

(i) Family Medicine Lecture Module (Module 8)

This module of 10 lectures introduces the student to the job content, morbidity profile and service needs of general practice. The module provides the background knowledge and prepares the student for the one week GP Clinical Posting to follow.

L1 Knowledge, Skills and Attitudes to be an effective GP

L2 Disease profile and illness presentation encountered in general practice

L3 Family structure and dynamics relevant to patient care

L4 Effective consultation, clear referral letters and communication with colleagues

L5 Counselling

L6 Acute medical care; the housecall

L7 Comprehensive and continuing care; terminal care

L8 Health maintenance and health screening

L9 Practice management —ethical, and administrative aspects

L10 Laws relating to general practice

Feedback evaluation from this year's students on the module were:

(1) Timing was too far from the GP Posting (October 1986 when their GP posting was in April — July 1987)

(2) Saturday morning was not a suitable day as the GP lecture is the only lecture the students have and many had ward work to do at locations in another part of Singapore.

(3) More visual teaching aids were requested.

In the 1988 module two improvements will be introduced to this module, namely, the 10 lecture module will be given on Fridays, January to March 1988, with the GP Posting in May to June 1988 and more visual teaching aids will be introduced.

(ii) GP Clinical Posting (Module 10)

The aim of the one week clinical posting, held during the Year Three Vacation Term, is to give the student the opportunity to use and improve the clinical knowledge and skill that he has learned in the other parts of the course in a new and radically different environment.

The specific educational objectives of the posting are (1) to apply the knowledge gained through module 8 of the COFM programme in the clinic; (2) to be acquainted with the skills and attitudes required of the practising GP as described under the specific educational objectives of the undergraduate family medicine programme.

The one week learning programme consists of four parts:

(a) "Bedside" teaching

This is for the student to appreciate the process of general practice and to compare and contrast it mentally with his hospital posting in terms or patient mix, symptom presentation, consultation and management.

(b) Topic teaching

This is to provide the basic principles and additional information on what the student observes in "bedside" teaching.

(c) Study assignments

This is for the student to gain further understanding on the more common symptoms that the student has observed in the course of "bedside" observations. A set of teaching resource on these symptoms is given to each clinical tutor.

(d) Case presentation

The student is assigned a presenting symptom by which to select his case for presentation and write up. The write up will be graded. There are 2 sessions of presentations for each batch of students, 4 cases being presented each session.

The 1984/1989 batch of Third Year Medical Students is the first batch to have the GP posting co-ordinated by the this Family Medicine Unit.

To make clinical exposure of the GP posting more uniform, a workshop of clinical tutors was held on 5 April 1987 where the objectives and principles of teaching general practice, the teaching content and organisation as well as evaluation of the posting were discussed. The proceedings from this workshop formed the clinical tutors' handbook. A students' handbook was also prepared and given to each student just before the posting.

40 GPs participated in the teaching of this year's GP Clinical Posting. More than 85% of students reported the usefulness of clinical sessions and discussions with their tutors to be "good" or "excellent". More than 75% of students reported the usefulness of case presentations at the department to be "good" or "excellent".

(iii) Medical Sociology Module

Two lectures on Doctor-Patient Communication will be introduced in the medical sociology module (module 2) to Year Two students in the 1986/91 batch.

6. POSTGRADUATE TEACHING PROGRAMME

(i) MSc Public Health & MSc Occupational Health

Two lectures on Family Health have been scheduled for this year's MSc course to give an appreciation of care of the Family as part of health service delivery.

(ii) Vocational Training & CME

The Family Medicine Unit will play a synergistic role in the postgraduate education of GPs in collaboration with the College of GP and the Primary Health Care Division of the Ministry of Health. Details are being worked out.

7. ACTIVITES RELATED TO THE TEACHING OF FAMILY MEDICINE

(i) Curriculum Content Development

A workshop has been planned for GP clinical tutors to discuss the feedback received from both students and clinical tutors on content and organisation of this year's GP posting.

(ii) GP Tutors' Bulletin

Plans are underway to start this newsletter for GP tutors as a forum for exchange and dissemination of ideas, views and methods on the teaching of Family Medicine.

(iii) Resource Material

Resource material on GP Content, Teaching methodology and related subjects are being collated at the Department of COFM. A section on Family Medicine books and journals has been created in the Department's Resource Centre. A library list has been given to the University's Medical Library for acquisition.

A collection of reprints and papers on Family Medicine has also been started. To facilitate filing and searching, it has been found necessary to draw up a classification system of Family Medicine content. The classification system is as follows:

FM01	Disease profile and illness presentation in general practice — psycho-somatic problems — early stages of disease — late stages of medical problems
FM02	Family structure and dynamics; the individual — family – individual — Family Health
FM03	Acute medical care — Organisation and delivery — the housecall
FM04	Comprehensive and continuing care — chronic diseases — terminal care — non-compliance
FM05	Community and other support resources available for patient management — The primary health care team
FM06	Consultation, reason for encounter, communication — effective consultation — reason for encounter — doctor patient communication — referral letters — communication with colleagues — doctor patient relationship
FM07	Counselling
FM08	Health maintenance; health screening — health maintenance — health screening
FM09	Practice Management
FM09A	— Administration and Staff
FM09B	— Clinic design
FM09C	— Medical Records
FM09D	— Computerisation
FM09E	— Library
FM09F	— Ethical aspects
FM09G	— Laws relating to General Practice
FM09H	— Quality assurance

FM10	Problem solving
FM10A	— Symptoms
FM11	Family Medicine as a discipline
FM11A	— Definition, Role, Content and Philosophy
FM11B	— History
FM12	Family Medicine Education
FM12A	— Teacher Training
FM12B	— Undergraduate Teaching
FM12C	— CME and Vocational Training
FM13	Family Medicine — GP Departments
FM13.JS6	— Singapore
FM13.JA3	— Asean
FM13.JA1	— Asia
FM13.K	— Australasia
FM13.FA1	— United Kingdom
FM13.DA2	— United States and Canada
FM13.DA4	— Latin America
FM13.GA1	— Europe
FM13.H	— Africa
	The classification by country follows that of the National Library of Medicine.
FM14	— Family Medicine — Family Medicine Programmes
FM15	Family Medicine — Practice by country
FM16	Family Medicine Research
FM17	Family Medicine Research Projects by country
FM18	Family Medicine Lectures
FM19	Organisation of PHC
FM19A	— The Primary Health Care Team
FM20	Miscellaneous

(iv) Practice Clinic

As General Practice/Family Medicine is a clinical discipline, it has to be academically supported by a clinical practice.

We are pleased to say that the Ministry of Health has been very helpful in making arrangements for academic staff from the Department to do clinical sessions at the Clementi Government Polyclinic. It has commenced since 1st July 1987.

Such an arrangement will provide its clinical teachers with patients, clinical data, case records, material related to managing the practice as well as the practice environment. From these resources, the teachers draw practical experience as well as clinical and other teaching material.

It will also form a life model for research and development into practical aspects of patient care, record keeping, staff management and practice management. New approaches to health care can be introduced and tested out in a real environment.

(v) Research

An ongoing activity of the Family Medicine unit should be to undertake research in general practice. In these endeavours, the Department will collaborate with the College of General Practitioners, the Primary Care Division of the Ministry of Health, clinical departments of the University and individual General Practitioners.

Such research could be aimed at one or more of the following:

- teaching of Family Medicine
- upgrading standards of practice in Family Medicine/General Practice;
- research and development of new trends in practice such as computer use in the clinic, etc
- promoting clinical research in Family Medicine/General Practice. The possibilities are many — acute medical care; continuing care of common conditions like diabetes or hypertension; clinical profile of various segments of general practice such as contract practice or housing board practice; symptoms and reason for encounter.

  As Harvard Davis, Emeritus Professor of General Practice, University of Wales College of Medicine pointed out in his 1986 Harvard Davis Lecture, "the study of symptoms opens up an entirely new approach to the management of psychosomatic illness which is currently based upon the traditional biomedical model of excluding organic disease. This practice has the effect of reinforcing the

patient's somatisation of their symptoms. If we could predict with reasonable consistency which patients had symptoms that were psychosomatic in origin then we could manage them differently and more effectly from the outset."

REFERENCES

1. Charmichael LP: Family Medicine, in Family Health Care ed Hymovich DP, Barnard MU. New York: McGraw-Hill, 1973 pg 61.
2. Davis RH, Harvard Davs Lecture 1986: General Practice and the unity of clinical medicine. J R Coll Pract 1987, 37, 196-198.
3. College of General Practitioners, Singapore: Examination Handbook 1986.

FEEDBACK SURVEY OF COLLEGE ACTIVITIES

by Dr Paul Chan S. M.

INTRODUCTION

The College of General Practitioners Singapore was founded in 1971 as an academic body to meet the educational needs of its members who are mainly practising General Practitioners/Family Physicians. Through its various committees, members can participate in continuing medical education, research and practice management activities. In addition, members receive the official journal of the College, the Singapore Family Physician; a monthly newsletter; and use of the College Library.

The College Council in 1986 requested the Research Committee to carry out a survey to ascertain members' views and comments regarding their participation in all these activities. The results of this survey would enable the College ot design activities to meet the needs of its members.

METHODOLOGY

A questionaire was prepared and circulated to 405 members in October 1985. Two more mailings were done to members not responding in December 1985 and January 1986 respectively. A total of 299 completed questionaires were received giving a 73.8% response rate. The use of a reference number for each member on the questionaire was most helpful: it enabled the Committee to keep track of all mailings and members' responses. Confidentiality was ensured since Research Committee Members were not allowed access to these records which were kept by the College's Administrative Secretary.

Report on a survey carried out by the College Research Committee

The data in all the completed questionaires were entered into a micro-computer and analysed using a DBASE II database program.

RESULTS

1. Members' Particulars

Of the 299 members participating to this survey, 216 were males and 83 were females. Their age distribution is shown in Table 1.

TABLE 1. AGE DISTRIBUTION OF MEMBERS

Age Group	No.	Percent
Less than 34+ yrs.	62	20.7%
35 yo 49+ yrs.	143	47.8%
50 to 64+ yrs.	78	26.1%
Over 65 yrs.	10	3.4%
Age Not recorded	6	2.0%
Total:	299	100.0

2. Motivation

Members were asked regarding their reasons for joining the College. 232 or 77.6% of members joined the College for the purpose of "continuing medical education" as against 46 or 15.4% of members joining as a result of "peer influence by their colleagues". The remaining 21 members gave different reasons: 11 or 3.7% joined "to support General Practitioners" while 10 or 3.3% joined "to be eligible to sit for the College's MCGP examination".

3. Practice Management

Members were asked regarding their willingness to participate in seminars and workshops to be organised by the Practice Management Committee. Their responses based on replies from 299 members are summarised below.

TABLE 2. MEMBERS' INTEREST IN PRACTICE MANAGEMENT SEMINARS

Area of Interest	No. "YES"	Percent
Computers in Practice	159	53.2%
Drug Inventory Management	131	43.8%
Medical Records	120	40.1%
Government Regulations	113	37.8%
Accounting	95	31.8%
Staff Training & Development	73	24.4%

4. Research

Research as a College activity was examined. 65 or 21.7% of the 299 members said they "would be willing to take part in College research projects". 122 or 40.8% of members indicated interest in attending a research methodology course if it was organised.

5. Publications

The College main publication is its quarterly journal called the "Singapore Family Physician (SFP)". Members were asked for their readership of the Journal. Members who read "some of it" accounted for 219 or 73.2%, while members who read "all of it" numbered 72 or 24.1%, leaving 8 or 2.7% of members who read "none of it" or failed to give an answer to this question.

Members reading the SFP were asked to comment on the usefulness of various sections in the Journal. The results showed the following preferences: "Original Articles" first with 69.2% (207). "Practice Management Articles" second with 52.5% (157), "Home Study Articles" third with 43.8% (131), "Book Reviews" fourth with 43 (14.4%) and "Research Articles" last with 40 or 13.4% of members finding this section useful.

6. College Library

The College's Ruben Meyer Library has a fairly comprehensive selections of journals, books, proceedings, video- and audio-tapes. Its use by members was surveyed. Members who used the Library "at least once or more a month" accounted for 7.0% or 21 of the 299 respondents as compared to 57.5% or 172 of members who had "never made use of the Library". Those who made use of the Library "once every few months" accounted for 34.1% or 102 members.

Of the 123 members who used the College Library, booked were preferred by 72 members; audio-tapes by 54 members; journals by 48 members; video-tapes by 7 members and proceedings by 3 members.

7. Continuing Medical Education

Members were asked regarding their views on a) self-study, b) group learning methods and c) clinical attachments to Hospitals and the type of posting desired.

a) Self-study

The majority, 93.0% or 278 members, saw a need for home-study materials as opposed to 4.7% or 14 members who felt that there were no need for such materials. Another 7 members or 2.3% did not reply to this question.

The method of self-study was next attended to. The results are shown in Table 3.

Method of Self-study	No. of Members doing Self-study			
	#> = 1x/month	1x/3-months	Never	No. Reply
Med. Journals	243	31	8	17
Med. Books	183	69	11	36
Postal Course	28	51	105	115
Audio/video-tapes	34	83	87	95
Computer-aided Prog.	2	16	155	126

Note: "#> = 1x/month" meaning "at lest once or more a month".

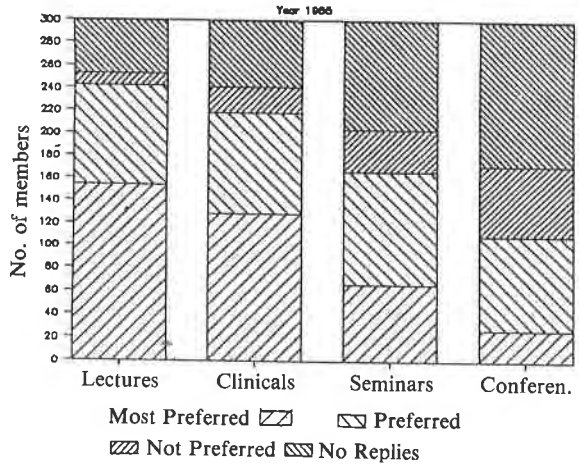
In the second part of this section, members were asked to indicate the types of Home-study Materials they preferred. (See Table 4).

Table 4: Type of Home-study Material	No. of Members & Degree of Preference Most Pref. (%)	Pref.	Pref.	"No Reply"
Case Problems	137 (45.8%)	104	12	46
Reprint Articles	166 (55.5%)	72	16	45
Exhibits: Photo/ECG/X-rays	121 (40.5%)	102	14	62
Multiple-choice Questions	42 (14.0%)	96	50	111
Reading List	38 (12.7%)	88	56	117

b) Group Learning Methods

Members were asked to indicate their preferences for various group learning methods. (See Graph 1).

GRAPH 1.
CHOICE OF GROUP LEARNING METHODS



Members were asked if they had attended any of the above group learning methods (GLMs) as GPs during the years from 1983 to 1985. The results showed that 247 or 82.6% of members had attended one or more of the above GLMs with 45 or 15.1% of members failing to do so. "No Replies" were recorded from 7 or 2.3% of the 299 respondents.

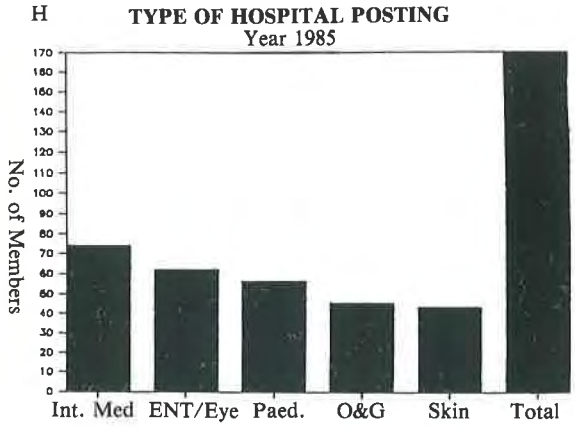
Further information were gathered regarding members' perception of the usefulness of attending these GLMs. Such GLMs usually take the form of lectures, clinicals, seminars or conferences organised by the College, Government hospitals or OPDs, fellow medical bodies and drug companies. Their views are shown in Table 6.

c) Hospital Postings

The last section of the questionaire dealt with the need for hospital postings and the type of postings desired. While 169 or 56.5% of the 299 respondents were "keen to have hospital postings", 119 or 39.8% of members felt that there were "no need for such hospital postings". There were 11 or 3.7% of members who gave "no replies".

Table 6: GLMs org. by:	No. Attended	Members' Perception very useful	useful	not useful
College	205	113 (55.1%)	90	2
Drug Companies	217	26 (12.0%)	170	21
Other Med. Bodies	197	44 (22.3%)	148	3
Govt. Hospital/OPD	137	44 (32.1%)	88	5

A survey of the five major postings wanted by these 169 members who were keen to have such postings are shown in Graph 2.



DISCUSSION

The overall results of the survey

Respondents to this feedback study provided valuable information on their needs and mode of delivery of continuing medical education. The percentage of response was 73.8 (299 out of 405).

The majority of respondents (77.6%) of this survey cited continuing medical education (CME) as their main reason for joining the College. CME has been the main thrust of our College's activities since its inception and if the wishes of members are to be respected, CME must continue to be the raison d'etre of the College's existence.

Of the resources in continuing medical education, the College journal, the Singapore Family Physician, enjoys 97.3% readership, of which a quarter read all of it. It is therefore an important medium of academic communication. The three most desired sections in order of preference were original articles (69.2%), practice management articles (52.5%) and home study articles (43.8%). The College Library was used by 42.5% members. This was perhaps due to the fact that it was open during office hours and was closed during weekends.

Of the vehicles for continuing medical education, the following were found:

(1) 93% saw a need for home study material. The three most preferred contents of such material were case problems (45.8%), reprint articles (55.5%), and exhibit quizzes (photographs, ECGs and X-rays) (40.5%).

(2) Lectures remain the most preferred group learning method (242/299) followed by clinicals (219/299), seminars (167/299) and conferences (110/299).

(3) A little more than half of the respondents (56.5%) were keen to have hospital postings. The three most preferred areas were Internal Medicine, ENT/Eye, and Paediatrics.

(4) Of the 205 (out of 299) who responded on usefulness of existing group learning methods, only 2 found the College update courses to be not useful. A little more than half (55.1%) found them very useful as compared to 12.0% for drug companies sponsored talks, 22.3% for talks from other medical bodies and 32.1% for talks organised by Government Hospitals/ OPDs.

Practice Management

Practice management is a new area of activity that the College Council is trying to stimulate an interest in amongst its members. About half of respondents indicated willingness to participate in practice management workshops and seminars. The three most preferred topics were computer use (53.2%), drug inventory management (43.5%) and medical records (40.1%). Staff training and development as a subject attracted only 24.4% positive responses.

Research

Research is creating knowledge from what is already known. It is an activity upon which the frontiers of knowledge can be advanced. However, it is generally accepted that lack of time and practical research know-how are difficulties. These were confirmed by the survey. 40.8% members were willing to attend a research methodology course if it were organised. Only 21.7% of respondents were willing to take part in research projects; the lack of time available may have prompted such a low positive response rate.

CONCLUSION

College members look to the College for continuing medical education. Designing relevant and interesting programmes must remain the pre-occupation of all College activities.

PIONEERING RESEARCH IN GENERAL PRACTICE

Dr V. C. Leong

Research is an activity that cannot be taught. It, however, can be learned. Certainly, research methodology can be taught and the circumstances can be made favourable. Encouragement and inducement can be offered. But in the final reckoning the drive, the curiosity and other personal qualities rest with the researcher.

A well quoted Chinese saying states that a horse can be led to water but making it drink is quite another matter.

The College of General Practitioners, Singapore since its inauguration in 1971 has a standing Research Committee. The experiences of this committee are worth recording. In sharing these experiences, members of the College may understand and appreciate what the College has done by way of research activities, the motivation, the difficulties encountered, the modest success achieved and the quiet determination to continue.

Why Research?

For public institutional doctors, evidence of research work is taken into consideration in promotion exercises. With the same qualifications and length of service, the doctor who shows evidence of research work has the edge in promotion.

For GPs research activities do not have the same attraction or monetary inducements as they have for public institutional doctors. Promotion prospects are non-existent in private practice. Indeed many an active public institutional doctor becomes "dormant" in research activities the moment he steps into the private sector.

Why then do GPs bother to do research work in general practice? Why does the College of GPs put so much emphasis on research activities? Two basic reasons are offered and they are "inspiration" and "recognition".

Inspiration

K. F. Wenckebach was born in the Hague. He studied medicine at Utrecht and gained his doctorate in 1888. He became a general practitioner with a special interest in cardiology in which he did considerable research. In 1900 the University of Groningen offered him the chair of internal medicine. However, it was in 1894 when he was an active general practitioner that he discovered the cardiac arrhythmia known today as the Wenckebach period. He certainly was a constant reminder what a GP could achieve in research activities.

Our founder president the late Dr B. R. Sreenivasan was also an inspiration. He had always regarded himself as a general practitioner notwithstanding the fact that he was one of the very first local graduates to acquire the Membership of the Royal College of Physicians of London. It was as a general practitioner that he was invited by the late Professor of Medicine, G.A. Ransom to lecture and teach medical students in his medical department. His outstanding clinical acumen must have been the result of numerous research activities he conducted as a general practitioner. He gave credibility to general practice and his research papers stressed the phenomena of every day clinical practice rather than a rigid reliance on laboratory results.

Recognition

General Practice has inherent defects and they should be recognised.

First, we recognise that general practice is somewhat isolated from the mainstream of intellectual activity inherent in a hospital setting. The presentation of cases to peers and the intel-

lectual stimuli from searching and probing questioning in the diagnosis and care are absent.

Second, GPs have become somewhat too dependent on formal teaching and have to be weaned from the expectation of formal education in a classroom situatioin. Self directed education means a reliance on the library and research activities geared to generating new knowledge relevant to general practice needs. Active acquisition of knowledge must take the place of passive acceptance of knowledge.

Third, we have to be reminded that medicine's basic tenet is that it recognises no authority. We need to be reconditioned to accept only the truth of authoritative opinions but NOT authoritative opinions per se.

Weaning from Educational Breastmilk

By the time the average student qualifies as a medical graduate, he would have spent 17 years in a formal educational situation consisting of teachers, classrooms, laboratories, dissection rooms and clinical assignments within a set syllabus of studies. The implication of a formal educational situation is that the responsibility of learning lies with the teachers. They assume the responsibility of ensuring that students under instruction will have completed the set syllabus and achieved an accepted standard of competence by a system of assessment. Different teachers discharge their duties in ways differing only in the relative degree of responsibility consigned to their students for their own progress. But the underlying fabric of understanding is that the teacher and the educational institution are fully responsible for the progress of students. It is instruction by the teacher and absorption of knowledge by the students. Research is one way to wean GPs from taking only an imbibing role. The need to be critical, to ask probing questions and to look for answers are part and parcel of research activity.

Re-emphasis of Medicine's Basic Tenet

Medicine is a biological science and as such recognises no authority other the authority of truth. This emphasis is important because passive acceptance of an authoritative statement implies rigidity in discipleship. When we cease to ask questions and be critical of assertions we cease to progress.

The classical example of such rigid disciples is that of the medieval scholars who "worshipped" rather than "studied" Aristotle. Aristotle was appealed to as an ultimate authority and his views were regarded as dogmas. The thinking then was if it conflicted with what Aristotle said then it was wrong. Instead of following the bold inquiring spirit of Aristotle and developing his work to new conclusions, his followers killed the whole point of his work.

Research demands that the worker be both critical of unsound views and yet adventurous in extending and developing new ideas. He is receptive towards what others have thought but unwilling to accept it as final. He sifts out the sound parts from the unsound and attempts to develop and experiment with what satisfies the critic in him as worthy of attention.

Unwelcome Bugs of the Mind

1. Error in Observation

Personal bias and projection need to be guarded against. We want to record what really occurs rather than what we want to see occur.

Bertrand Russell cautioned, "The manner in which animals learn has been much studied in recent years, with a great deal of patient observation and experimentation... One may say broadly that all animals that have been carefully observed have behaved so as to confirm the philosophy in which the observer believed before his observations began. Nay, more, they have all displayed the national characteristics of the observer. Animals studied by Americans rush about frantically, with an incredible display of hustle and pep and at last achieve the desired result by chance. Animals observed by Germans sit still and think, and at last evolve the solution out of their inner consciousness". It appeared to Bertrand Russell that the type of problem which a man naturally set to an animal depended on his own philosophy and that this probably accounted for the differences in the result.

2. Error in Interpretation

A foreign student studying in the USA

wrote home after a few months stay. He told his family that the Americans were:-

a. lazy,
b. dirty and
c. superstitious.

He based his interpretation on what he personally observed and these observations were factual.

In the American way of life, there were frequent holidays as well as weekends off. In the homes he visited, the student found numerous bathtubs. Everywhere he went he came across churches and people going in and out of them.

3. Error of the Obvious Conclusion

Statisticians rightly point out that the man who finds a correlation and starts to say "it's obvious" is more often wrong than right. They point out that three inferences are equally applicable when two variables or phenomena show a high degree of correlation. One might be the cause of the other. They might be related by one or more shared factors. The correlation might have occurred by chance.

The Scope of General Practice Research

The scope of research is very wide. In general terms it includes the following:-

1. Molecular e.g. anaemia where an amino-acid substitution can make the difference between a stable and a nonstable haemoglobin. Pref.
2. Cellular e.g. the LE cell, the drumstick phenomenon in leukocytes or the basement membrane of the glomerulus in nephritis.
3. Organ e.g. the pancreas and its function.
4. Clinical/multiple organs e.g. the study of hypertension and its effect on the target organs.
5. Man in his totality/environment where both patients and physicians are proper subjects of study.

Items 1 and 2 are not within the competence of General Practice research. General practice research therefore embraces broadly the following areas:-

a) Morbidity surveys & community studies,
b) Clinical research,
c) Medical care/health services research and
d) Research into GPs education, practice (structure, organisation & fucntion), health and family recreation.

In a separate paper the research activities by the Research Committee and individual members or groups of members of the college are annotated. They correspond very closely with what has been outlined.

Difficulties of General Practice Research

Research projects done by the Committee are undergirded by five considerations.

Firstly, the project should be one which as far as possible, will enable maximum participation by members. This is not easy because the work load of each GP differs considerably. A GP with a great work load is less inclined to spend time participating.

Secondly, the research project must utilise the minimum of expenditure in terms of funds, time and resources. A project requiring a sustained period of observation may result in defaulting as the project wears on.

Accessibility of material is the third consideration. Fortunately, there is no lack of material for research in patients who come for primary health care. However, fee-paying patients require a lot of tact and gentle persuasion before condescending to be part of a project however worthwhile and beneficial it may appear to the GP. Patients' primary concern is to get well quickly and return to work. Due regard must be given to ethical considerations when patients are used as "data material".

Sophisticated laboratory investigations requiring expenditure of time and money have no appeal to fee-paying patients. Such investigations should not be imposed on patients just for the sake of research.

The final consideration is that the research project should be mutually beneficial to both patients and their doctors. To both it should

result in better medical care and to the doctors in particular an upgrading of the art and science of medicine.

Levels of Research

Research in the College of GPs is undertaken at three levels namely:-

a. College level — calling for maximum participation by members.

b. Group level — where two or more doctors with similar interest may undertake a research project.

c. Individual level — the advantages and disadvantages of individual research require no comments.

Summary

A glimpse of research activities in the College of GPs, Singapore has been shown. In this momentary visual impact, members will note that:-

1. We have the necessary inspiration.
2. We have recognised our weaknesses and have done something in rectification.
3. We are aware of the pitfalls of research.
4. We know the scope and limitations of general practice research.
5. We recognise the difficulties in general practice research.
6. We have successes and failures and we have learnt and benefitted from both lessons.
7. Most important of all, we are undeterred. We are determined to continue because research is the intellectual stimulus in general practice. Without this general practice will have lost a major pillar of support. The 4 major pillars of support of general practice have been identified by Professor I.R. McWhinney of the University of Ontario as:-
   a) a distinguishable body of knowledge,
   b) an unique field of action,
   c) an active area of research and
   d) the training which is intellectually vigorous.

Voyage of Discovery

When Christopher Columbus set sail on his historical voyage of discovery, he did not know where he was going; when he arrived he did not know where he was; when he returned home he did not know what disease he brought back; neither did he know who had given him the infection. The most remarkable thing was he did all of these with other people's money.

Voyages of discovery set out by the College of GPs of Singapore are not done "Christopher Columbus" fashion. No member of the College needs feel any misgiving in sailing the seas with the captain and crew of the Research Committee. They are assured that the good ship will return with answers to the mysteries of what, why, where, when, who and how.

THE FUTURE OF GENERAL PRACTICE RESEARCH IN SINGAPORE

Dr Chan Swee Mong

The greatest challenge facing the College of General Practitioners today is how to motivate and get more General Practitioners/ Family Physicians in Singapore to do research either on an individual or group basis. The value of such research must centre on the common clinical and non-clinical problems facing GPs in their daily work. Such research would help to clarify the scientific basis of medicine as well as demonstrate the differences between research in hospital-based patients and general practice patients.

Advantages

The advent of office diagnostic technology eg. portable analysers able to perform various biochemical tests like blood glucose, cholesterol, triglycerides, uric acid, Hb, SGPT, SGOT, etc has given GPs new dimensions and confidence to do clinical research. The increasing usage of micro-computers by GPs in their clinics has also encouraged GPs to do more research. The setting up of a Division of Family Medicine in the Department of Community, Occupational and Family Medicine in the National University of Singapore is another step forward in the battle to get GPs to be more research-minded in their work. The often repeated complaint that GPs do not know research methodology can now be remedied.

The College Research Committee can now work towards bringing these three elements together. Its job must be to educate, to organise, and to assist interested GPs in their research endeavours. For these reasons the present Council of the College of General Practitioners Singapore (CGPS) had purposely allocated space at its new office at the College of Medicine Building for a computer training centre, a model clinic cum laboratory, teaching equipment, and a lecture theatrette. For the first time in 16 years since its founding in 1971, College can now claim to have all the ingredients it wanted to seriously promote and stimulate research activities amongst its members.

Dr Chan Swee Mong
MBBS, MCGP (S'pore)
Blk 106, Hougang Ave 1
Singapore 1953

Research

GP-research may be classified mainly into a) clinical and b) non-clinical type of research.

a) Clinical Research

The future emphasis of the College must be on clinical research. Unless this is done, GPs cannot claim to have established enough scientific information regarding their field of clinical medicine in Singapore. In the Statement on General Practice Research,[1] the European General Practice Research Committee in 1982 summarised the work of GPs as:-

(i) the emphasis in general is on the primary assessment of all previously undifferentiated clinical problems;

(ii) the GP is in the unique position to see the initial phase of all clinical problems;

(iii) many illnesses are seen and treated exclusively within general practice;

(iv) the long-term contact resulting from continuity of care over time with all the clinical problems of each individual patient offers the possibility for perceiving and co-ordinating information about lifestyles and about the natural history of disease.

The above list can form the framework for subsequent research. For example, a study of diabetic patients can demonstrate the effectiveness of various oral hypoglycemics. Its findings can establish guidelines on what con-

stitute acceptable blood glucose levels for control of diabetes mellitus in such patients in the community. It can also determine the reasons why GPs prefer certain diabetic drugs or combination of such drugs. The study can also keep track of the complications seen in the longterm management of these patients.

GPs also treat a whole range of vague and undifferentiated signs and symptoms which may in essence represent the very early manifestations of serious organic diseases. For example, a survey of GP-patients complaining of vague aches and pains might reveal that some of these complaints are gouty in origin instead of associating such complaints with overwork or stress.

The illness pattern encountered in general practice clinics is also related to the demographic, occupational and other socio-economic factors influencing the GPs' patient population. Unless more research is done, such knowledge cannot be ascertained.

b) Non-Clinical Research

This applies in a GP-setting to seeking the causes and solutions to problems arising from one's practice. For example a practice survey would define the age, sex and racial distribution of the clinic's patient population. This information would help the GP for example to plan his CME programmes to meet anticipated demands on his expertise in the future. If the survey shows that more of his patients are elderly then his future education programmes must be directed to geriatric/rehabilitative medicine than say to paediatric medicine. Other projects can touch on enhancing clinic productivity, computerisation, better medical record keeping, and feedback from patients with view to better patient management.

Priorities

The Research Committee must set its priorities for the future. Foremost is the task of identifying the number of GPs interested in research and their training in research methodology, computer know-how, and medical writing. The holding of seminars, workshops and hands-on practical sessions would help to achieve these aims.

Secondly, it must link up with Ministry of Health, University and specialists' bodies for more collaborative research projects. This approach is valuable as it allows both parties, the specialists and GPs, to pool their resources together, thereby giving greater depth and perspective to the subject of research. One good example is the joint project by the College with the Obstetrical and Gynaecodlogical Society on "Shared Antenatal Care in Singapore — a worth-while Option?"[2]

Thirdly, it must continue to support medical students and GPs who are keen to do research in general practice. Such support can be in the form of research grants or the giving of advice on the appropriate methodology or facilities to be used. With the enhanced facilities available at the College's new office, this should be no problem.

Finally in the years ahead College must employ qualified research personnel on a full-time or sessional basis. This will allow the College to plan on a continuing basis the active organisation and promotion of research activities amongst its members. Such a job might interest the more academic GPs who many be keen to retire or leave active general/family practice. Since research is a serious matter it must be given its due consideration if it is to reach new heights of achievement.

Conclusion

From 1975 to 1986, GPs had contributed most of the 56 research papers that had been published in the Singapore Family Physician, which is the official publication of the College. In a review article entitled "The Singapore Family Physician — Annotated Review of Papers", published in this issue, Dr Chong Tong Mun found that these papers have focussed on a wide variety of topics both clinical as well as non-clinical. It is therefore clear that the College has not failed its duties in the promotion of research activities in general/family practice in Singapore. The road ahead is to improve on this record.

REFERENCES

1. European General Practice Research Workshop. "Research: The role of the general practitioner". J. Royal College of General Practitioners, 469-471, August 1983.
2. Viegas et al: "Shared Antenatal Care in Singapore — A Worthwhile Option?" The Singapore Family Physician, Vol. Xl No. 4 1985.

THE COLLEGE DIPLOMATE EXAMINATION

Dr Lim Kim Leong

The College

In the 60s the continuing medical education of general practitioners in Singapore was in the doldrums. Those who wanted to update their knowledge had no organisation to see to their needs. They attended the occasional lectures and seminars organised by the specialists or hospitals, and these were usually geared for the specialists.

Some of the general practitioners in the Society of Private Practice (now the Association of Private Medical Practitioners of Singapore) and the Singapore Medical Association (SMA) met informally to discuss this matter, and it was only in 1969 that the SMA appointed a special committee to study the possibilities of forming a higher academic body for general practitioners in this country.

On 30th June, 1971 the College of General Practitioners, Singapore was officially registered. Our Founder-President was Dr B. R. Sreenivasan. A congratulatory note was received from His Royal Highness The Prince Philip, Duke of Edinburgh (President, Royal College of General Practitioners) on 7th February, 1973.

Continuing Medical Education (CME)

The role of our College is to provide education to the general practitioners so that they may provide better medical care to our people.

At the beginning the target of the College was to try and encourage as many general practitioners as possible to participate in the bi-weekly teaching programme. The lectures were given by our colleagues from the institutions and the Academy of Medicine, and were attended by a handful of about 20 doctors. The number of doctors who attended these lectures increased gradually. Over the years the lectures were regularised and systematised, so that we now have, over a period of 2 years, six modules of lectures which cover most of the disciplines in family medicine/general practice. The number of doctors attending these lectures now average over 150 per module. The response has been most encouraging.

The diplomate examination (M.C.G.P.S.)

From the onset it was felt that an examination specifically for general practitioners was necessary for those doctors who would like to asses themselves in their continuing medical education. Such examinations had by then been well established in countries like United Kingdom and Australia.

It was in March 1972 that the Council decided to prepare to hold its first examination leading to diplomate membership. The decision was made at about the time of the Fourth National Medical Convention jointly organised by the College and the Singapore Medical Association. Dr H. N. Merrington, the then President of the Royal Australian College of General Practitioners, Dr G. H. Puddicombe, the Honorary Secretary, Dr B. S. Alderson, the Deputy Chairman of Council, and Dr F. M. Farrar, the Secretary-General, were present at the Convention. The College had many fruitful discussions with them. Dr Merrington and his colleagues readily agreed to send examiners from their College to help in our examination and to assess our standard.

Censor-in-Chief
College of General Practitioners Singapore

Our first examination was held in November, 1972. The external examiners included members of the Faculty of Medicine of the University of Singapore, Ministry of Health and the Academy of Medicine. The Australian College sent Dr R. B. Geeves one of their Censors and Dr W. E. Fabb, their Chief Examiner. The external examiners were satisfied with the standard set by the College.

Right from the beginning the College adopted the policy of setting high standards for the diplomate examination, and having external examiners to validate them. We had to have a standard comparable to that of the United Kingdom and Australia for the examination to be meaningful. To this day we have not deviated from that policy.

We have held our examinations regularly since, and the 12th was held in 1986. The examination has been improved to make it more relevant to family medicine/general practice. This is reflected in the format and content of the examination, and the examiners have understood this philosophy of ours.

Recognition of the M.C.G.P.S.

In 1974 the Royal Australian College of General Practitioners recognised our Diplomate Examination as being of equivalent standard to theirs. The Council immediately reciprocated their fine gesture. It was fantastic for us to achieve this within 4 years of our foundation, and the principal credit must be given to Dr Wong Kum Hoong, our first Censor-in-Chief.

In 1977, our diploma, the M.C.G.P.S. was recognised by the Singapore Medical Council as an additional registrable qualification. This was a significant milestone for us, and it was more so to receive from the President of the Republic of Singapore, Prof. B. H. Sheares, the Patron of our College, a letter congratulating us on this significant event. Our policy of maintaining a high standard has been vindicated, and our Diploma continues to be recognised by the Singapore Medical Council.

Board of Censors

Our first Censor-in-Chief was Dr Wong Kum Hoong, whose dynamism and enthusiasm saw us holding our first examination leading to diplomate membership in November, 1972, just over a year from the formation of the College. The Board of Censors had to start from scratch, meeting late into the night discussing the format and the content of the examination, formulating the questions and evaluating them, designing the marksheets, and meeting with colleagues in the institutions and the sister colleges. The Ministry of Health was most helpful in allowing our examination to be held in the hospital, and to make use of the patients there. The Australian College was most helpful, providing not only their help and expertise, but also sharing some of their materials with us.

In February 1972, two of our Censors attended the Examination Seminar in Canberra, organised by the Royal Australian College of general Practitioners. The knowledge gained, together with the experience of the first examination enabled certain improvements to be made to the second examination.

Dr Evelyn Hanam took over as Censor-in-Chief in 1974. She was just as dedicated and enthusiastic, working the Censors Board late into the night, increasing the bank of questions, checking the hundred and one details necessary in holding an examination. She would never allow the standard of our examination to be compromised. Dr Hanam remained as Chief for a period of five years till 1979, bringing the standard to a new height.

Dr Hanam was succeeded by Dr James Chang Ming Yu, one of our first Diplomate members. He had been a Censor for many years, and continued the same tradition of dedication and diligence, and of upholding the standard. Dr James Chang was also Censor-in-Chief for the maximum of six years.

Our fourth Censor-in-Chief was Dr Lee Suan Yew who took office in 1985. In the same year, on the demise of the then President, Dr V. L. Fernandez, Dr Lee Suan Yew was elevated to the high office of the President of the College. Dr Lim Kim Leong was appointed Censor-in-Chief in his place.

Format and content

From the outset, the examination was structured specifically for general practi-

tioners, and not as a scaled-down membership examination. Help was obtained from many people, but most of all from the Australian College. After much discussion and hard work, we were able to format our own examination.

For the first examination in 1972, the candidates were required to sit for 3 papers:

(1) Essay Questions..... 2 hours
(2) 1st Multiple Choice Questions 1 hour
(3) 2nd Multiple Choice Questions (problem solving)..... 1 hour

In the clinicals, the candidates were examined in 4 sections:

(1) 1 long case (clinical)
(2) 1 short case (clinical)
(3) ECGs, X'rays, Photographs, etc
(4) Viva.

With experience, expert advice and diligence, the quality of the multiple choice questions were improved, and the databank increased over the years. The clinical cases chosen were patients with problems more commonly seen in general practice. New sections considered more relevant to family medicine/general practice, e.g. Practice Log, were introduced. Candidates were briefed more carefully, and clinical tutorial sessions organised in the hospitals for them to attend. All these modifications and improvements were to format the examination to be more relevant to our practices.

For the 1986 examination, the candidates were examined in the following:

A. Written
   (1) Essay questions 2 hours
   (2) MCQ I 2 hours
   (3) MCQ II 2 hours

B. Clinical
   (1) 2 long cases (one in Internal Medicine, one in Paediatrics)
   (2) 4 short cases (one each in Surgery/ Orthopaedics, Obs-Gyn, Medicine, Paediatrics)

C. Practice Log (a write-up of cases from the candidate's practice)

D. Visual interpretation (of ECGs, X'rays, photographs, charts, etc)

E. Viva voce

The diplomate members

To date we have 62 diplomate members out of 109 doctors who sat for the examinations. The candidates have all been practising general practitioners who had to study in their own time, while running their practices. 4 members have been elected to the Fellowship of the College. Many of the diplomate members have returned to help in the College and are doing a fine job.

Exam	Year	No of candidates	No passed
1st	1972	17	7
2nd	1973	9	5
3rd	1974	15	6
4th	1975	8	5
5th	1977	6	5
6th	1978	6	4
7th	1979	10	7
8th	1980	7	3
9th	1981	6	4
10th	1982	4	2
11th	1984	9	5
12th	1986	12	9
	Total	109	62

Acknowledgements

We have to date held 12 examinations, and our diploma is recognised by the Singapore Medical Council. We have achieved these because of the help we have received over the years: from generalists to specialists; from colleagues in Singapore and abroad. We have received help and encouragements from Ministry of Health, the University, sister organisations in Singapore, and from Colleges around the world. We must thank all our tutors, lecturers, examiners, and the candidates who sat for the examinations, and all the members and friends who have helped all these years. We look forward to your continuing support and encouragement.

The Future

(1) The family physicians/general practitioners
(2) The Primary Health Care doctors
(3) The A & E doctors
(4) The company doctors
(5) The SAF doctors

We are all generalists and primary care doctors. Not only must we be clinically competent, we must also be competent in caring for the patient's psychological and social needs. We cannot just treat his signs and symptoms; we must manage him physically and psychologically, in relation to his family, and his environment. In short, we must practice Family Medicine.

While we have achieved some success and recognition, we have to continually strive to improve our examination format and content. Although it is generally accepted that our examination and diploma are the only ones in Singapore relevant to family medicine/general practice, we must continue to uphold our policy of maintaining it at a high standard.

In the near future, candidates seeking to sit for the examination might be required to have some form of vocational training. With the establishment of the Department of Community, Occupation and Family Medicine, and with the co-operation of the Ministry of Health, it would be possible for us to have vocational training clinics. This would then firmly establish the discipline of family medicine, providing impetus to continuing medical education and a career structure for all primary care doctors.

TOWARDS BETTER PRACTICE

Dr Henry Yeo P H and Dr Goh L G

To be able to practice with optimal efficiency, attention has to be paid to practice management. It is for this reason that many colleges have committees on practice management. In our College, such a committee was formed since 1983. Some areas of relevance to practice management are discussed.

MEDICAL RECORD KEEPING

The traditional way of keeping medical records is the SOMR or source oriented medical record as opposed to the more useful POMR or problem oriented medical record.

Source oriented medial record

The source oriented medical record has the following features:

* primarily a diary of past events.
* data is entered as it comes in: observation notes, laboratory data, ECG tracings, and consultant notes are entered where there is a space. Often there are serious omissions of important findings.
* the ad hoc way of entering data means that although a lot of information is recorded, retrieval of wanted information may be a nightmare.
* may be adequate for crisis-oriented episodic care of acute illnesses but may run into difficulties in coping with chronic illnesses or complex cases involving multiple problems.

Such a state of affairs probably arose because time is at a premium in a busy general practice. This is coupled by a wrong perception about priorities. Doctors generally believe that clinical care must come before record care so that when pressure occurs, the medical record suffers. What is not perceived is that time "saved" by bad record keeping is subsequently wasted because an incomplete record cannot be relied upon with the consequent frustration to the doctor when the patient's history and progress becomes complicated.

It is often quicker to take a new history then to plough through the mass of illegible and disorganised records, provided of course, the patient is able to remember enough of his past medical history.

The problem oriented medical record

The problem oriented medical record in constrast to the source oriented medical record is structured. The essential feature is that there is a defined place in the medical record for each piece of information.

Such information organisation has at least three strengths:

* to the person entering new information, the spaces serve as a built-in prompt. Where the information is missing, the empty space becomes conspicuous and prompts its completion.
* to any one looking at the record, rapid retrieval of information is possible. One knows exactly where to look. This cuts down information search time. Furthermore, unsolved problems stand out in the problem list.
* the record is also space saving. The saving has been put as some one third of that of the source oriented medical record.

Not a panacea without pains

It must be pointed out at the outset however, that the adoption of the POMR may not be a panacea to solve poor recording and bad housekeeping habits.

Also, the implementation of the POMR system has to be organised as the exercise will require designing and printing new medical record forms, staff orientation and accep-

tance. Finally, the transfer of data from the old records to the new records can be a back-breaking job and unless every able-bodied staff is involved difficulties may arise.

Components of the POMR

The problem oriented record consists of four essential components namely, (a) DATABASE, (b) PROBLEM LIST, (c) PROGRESS NOTES and, (d) FLOW CHARTS.

The database contains profile information of the patient such as his identification, past history, risk factors, preventive procedures, biological baseline data, and social habits.

The problem list is said to be the most important component of the POMR. Even if only the problem list alone is adopted, the usefulness of the medical record is greatly enhanced. This list has been likened to an index of a book. Without it, one has to leaf through the whole record to get at what is required. With its use, one can be directed to the appropriate page of the medical record to obtain the desired informatiion.

Progress notes are entered in the SOAP format, the acronym for subjective, objective, assessment and plan.

Flow charts show graphically the progress of important parameters such as blood pressure, body weight, biochemical results over time. They are therefore particularly useful in managing chronic medical conditions. The design of practical flow charts take time and ingenuity.

The practice management committee is in the process of organising a workshop to discuss the key aspects of the problem oriented medical record.

EQUIPPING THE CLINIC

Development of innovations in office equipment and medical equipment is an ongoing process. It is thus important to keep abreast of such developments. Several examples can be quoted to make the point.

The glucose meter

This machine has made it possible to provide better diabetic control, chiefly because accurate blood glucose levels can be obtained in 2 minutes and changes made in the dosage of medicines. It is not enough to rely on urine sugar readings as these can be unreliable.

The reflotron

This machine enables several different biochemical tests to be done at the office in less than 5 minutes a test. Some of the tests available include SGPT, cholesterol, blood urea, and uric acid. The waiting time for blood results can thus be drastically reduced.

The number calling system

A number calling system will save the work of one nurse or save the precious minutes that are wasted by the doctor in having to get up, poke his head through the door and call for the next patient. Many electronic systems are available in the market, most complete with a buzzer to alert the patient whose number is being served.

ECG analysis system

An ECG is an asset to any clinic in aiding decision making on chest pain. Currently, there are models that are able to interprete the tracing based on certain parameters on the cardiac tracing. Though helpful, its interpretations have to be screened in the context of the clinical picture.

The nebuliser

The nebuliser has almost done away the need for injections of bronchodilators in the treatment of acute asthmatic attacks. It is therefore almost a must in every clinic. Great care however is necessary in putting in the correct dosage of medicines as an overdose can be disastrous.

COMPUTER USE IN THE CLINIC

The computer is fast becoming a standard equipment in the clinic. However, to maximise the use of this modern invention, four things must be sorted out. First, which office functions are time saving on the computer and second, the staff has been properly introduced to its use. Unless there is both management and staff support, the computer may be an "unwanted child" and subjected to much ridi-

cule and blame for shortcomings of management. Third, geographical space has to be thought through and fourth, the hardware and software has to be systematically considered before money changes hands. Don't accept pay first and implement later because the implementation may never take off.

The College has just equipped a computer education centre with 10 16-bit microcomputers. The purpose of this centre is to run courses for doctors and their staff so that computer literacy can be enhanced.

HEALTH CARE FINANCING

It is known that fee-for-service may not encourage anticipatory preventive care. Other ways of health care financing like health maintenance organisation scheme or pre-paid scheme may overcome the deficiencies of a fee-for-service scheme although the alternative schemes may have intrinsic problems of their own.

Workshops on such topics will enhance our awareness of the pros and cons of alternative methods of health care financing in our search for a system that will be equitable to both doctor and patient.

A SCIENTIFIC FOOTING

Notwithstanding that management is just as much an art as a science, it is perhaps necessary that the science is not neglected. It is because of this that the practice management committee exists.

THE SINGAPORE FAMILY PHYSICIAN — A BRIEF HISTORICAL SKETCH

Dr V. C. Leong

The "pioneers" of any movement are people with vision. They pursue their goal unrelentingly. They press on despite hardship and discouragement. If a price has to be paid they are prepared to make the necessary sacrifice. They are overcomers.

The second generation, "the settlers" have somewhat different perceptions. They cultivate their possessions, insist on safeguards and will make regulatory laws and order to preserve what they have achieved.

The "ruler/citizens" constitute the third generation. Their pioneering spirit has abated. They are content with their possessions, interests and customs. They are not too eager to change and are generally resentful of change — the very pioneering spirit that brought them to where they are.

Have the people responsible for publishing the Singapore Family Physician come full circle?

The Pioneer Publication

The Singapore Family Physician began life by another name. The founders named it the "GP" after a conceptual period of two years, after the College of GPs, Singapore was founded in June 1971. The Editorial Board members of Volume 1, No. 1, March 1973 of the GP were Doctors Wong Heck Sing, Lim Boon Keng, Koh Eng Kheng and Colin Marcus.

In the foreword to this first issue, the founder president, the late Dr B. R. Sreenivasan wrote,

> "This issue is our first effort at written education and will perforce be a modest one. We hope and expect, however, that in due course of time it will grow into a robust journal introducing new knowledge, that is, advancing the frontiers of knowledge and disseminating known facts and views, in other words, research and instruction".

The First Honorary Editor

Although the Editorial of GP Volume 1, No. 2 was unsigned, the style was unmistakably that of the first appointed editor of the College of GPs, Singapore, the late Dr G. O. Horne. A lot of thought must have been given to this editorial.

He wrote with uncanny prediction when he stated, "Perhaps, in the years to come, when our successors ask about the origins of the Journal, the answer may be that of Topsy, in UNCLE TOM'S CABIN, who, when asked, 'Do you know who made you?', replied (with a short laugh), 'Nobody, as I know on....I s'spect I growed'."

The Journal's policy was also recorded. "This publication", wrote Dr Horne, "will not be a magazine or a newsletter; it will eschew 'politics' (in so far as this is possible in Singapore) although it may reflect 'policy'; and might even indulge in 'propaganda'. However, at this early stage in the development of the College it would seem to us that one of the main functions of its official publication is to act as a 'chronicler' — a recorder of events — even if this means inflicting on its readers from time to time a list of names and dates, and even group photographs. It is not conceit that makes us believe that the College is very much bound up with the future medical history of Singapore.... and we feel that, at least in its formative stage, a public record of the motivations, aspirations, activities — and even mistakes — of the College should be kept for posterity".

Quoting Dennis Bloodworth, he was con-

fident that in Singapore there was "obviously an ability and a will to write" and that given the necessary incentive and encouragement and advice that talent could develop. As far as GP writers to the Singapore Family Physician are concerned, this observation has been proven right.

The problems of the journal were set out. The journal would keep an even keel — balancing the requirements of mature doctors and those of the young solo general practitioners. It was to avoid the duplication of information already available to general practitioners in the lectures and publications of the numerous medical associations and societies with which many GPs were already connected. A suitable "rhythm of publication" was to be established as the journal set out to sea.

Changes

One of the first changes that had to be made was the change of name. The GP was to yield its name to "The Singapore Family Physician" by Council decision and reflecting the more positive role it was to make in family practice. The format of the Singapore Family Physician was larger in dimension and bulkier because of the increase in articles for publication. The first issue of the Singapore Family Physician was dated Jan/Mar 1975 Volume I, Number 1. The rhythm of publication was to be 4 issues per year.

Editorship

The Singapore Family Physician is currently in its 13th year of publication and readers will be reading this in Volume XIII, No. 2. Although the journal has received the nurture and care of 4 successive Honorary Editors, the basic philosophy undergirding the publication has remained relatively unchanged. All 4 Honorary Editors came from the "pioneers" of the College and had worked very closely together in the College Council as well as in the Editorial Committee and other standing committees.

For posterity and certainly for ease of information retrieval their services are recorded below:-

SINGAPORE FAMILY PHYSICIAN		
Volume	**Number**	**Editor**
I	1,2,3 & 4	
II	1,2,3 & 4	Dr G. O. Horne
III	1,2,3 & 4	
IV	1,2,3/4	
V	1,2	Dr E. K. Koh
V	3 & 4	
VI	1,2,3 & 4	
VII	1,2,3 & 4	
VIII	1,2,3 & 4	Dr V. C. Leong
IX	1,2,3 & 4	
X	1,2,3 & 4	
XI	1	
XI	2, 3 & 4	
XII	1,2,3 & 4	Dr M. Vaswani
XIII	1,2	

Editorial Content

The editorials in the first 3 volumes of the Singapore Family Physician were commentaries on the contributors and their contributions — a very prudent decision during the early years of growth.

It was Dr E. K. Koh who initiated the "essay" style of Editorial in Vol. IV, No. 1 of the journal and the problem addressed was Primary Medical Care, a concept that was soon to pervade the medical scene in Singapore. The essay form of Editorial writing was soon to prove its worth. As the leader it was liken to a symphony orchestra conductor who would determine how a rendition should be interpreted. The performers appeared satisfied with the musical interpretation so far.

A wide ranging repertoire of subjects were discussed in the editorials of the Singapore Family Physician. Although not everyone might agree with everything that was said they were written with sincerity and outspokenness tempered with a prudent tongue.

With justifiable pride we record them for easy reference.

THE SINGAPORE FAMILY PHYSICIAN		
Volume	**Number**	**Editorial Topics**
IV	1	Primary Medical Care
	2	The Private Sector
	3/4	Selection of Medical Students
V	1	The Pharmaceutical Trade
	2	Quo Vadis?
	3	Educational Weaning
	4	1979 — The International Year of the Child
VI	1	Medical Registration
	2	Medical Certification
	3	Snobbery-A Medical Approach
	4	Medical Publications
VII	1	Measuring Medical Competence
	2	Sounds, Words & Language
	3	Authoritative Views
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VIII	1	The Doctor & Productivity
	2	Medical Audit in General Practice
	3	Kidneys in Perspective
	4	Singapore's Medical Co-partnership
IX	1	Implications of the 10th WONCA Conference on Family Medicine
	2	On Reporting & Notification
	3	Information Needs of GPs
	4	Shifting into 2nd Gear
X	1	Our National Intelligence — Will It Decline?
	2	Learning Medicine
	3	The Ethics of Terminal Care
	4	The Third Party
XI	1	The Labelling Laws
	2	Teaching General Practice
	3	The Family at Variance — Enter the Family Physician
	4	On Continuing Medical Education
XII	1	Towards Excellence in General Practice
	2	Getting Through
	3	Academic General Practice Faculty Development
	4	Technological Changes and General Practice
XIII	1	Family Medicine Aspects of the "New" Population Policy
	2	A Time of Change

Of the many problems addressed in the Editorials of the Singapore Family Physician, the only non-general practitioner contribution was that in Volume IX, No. 2 "On Reporting and Notification" by the late Dr V. S. Rajan writing as Head of the Middle Road Hospital.

Those associated with the Editorials would like to believe that they had in a very small way made a contribution to General Practice.

GP Contributions

In an annotated paper printed in this issue the contributions to The Singapore Family Physician made by GP writers either individually or in co-authorship numbered 56 articles (not counting the contributions in the present issue). No editor will ever be satisfied that the writing talents of GPs have been stretched, let alone stretched to the limits. However, the egg has been made to stand on its end and excuses and diffident apologies of inability to write, can no longer be offered and accepted.

Epilogue

At the end of this necessarily brief historical sketch of the Singapore Family Physician, the question posed at the beginning has remained unanswered. An unanswered question disturbs the tranquility of the mind. Perhaps it is better to put it to rest. A categorical answer has no finesse and appears puerile as well as unbecoming in a journal that has come of age.

The illuminating answer lies in the following old zen saying:-

To a man who knows nothing
Mountains are mountains
Water is water
Trees are trees.

When he has studied and knows a little
Mountains are no longer mountains
Water is no longer water
Trees are no longer trees.

When he has thoroughly understood
Mountains are again mountains
Water is water and
trees are trees....

THE SINGAPORE FAMILY PHYSICIAN — ANNOTATED REVIEW OF PAPERS

By
Chong Tong Mun
MBBS (Malaya), MD (Singapore)

The College of General Practitioners Singapore was founded and officially registered on June 30, 1971. Its first Journal publication appeared in March 1973, and after five publications the Journal was renamed The Singapore Family Physician with its first issue, Volume 1, Number 1, that appeared in January/March 1975.

This review covers mainly papers written by general practitioners.

The College Research Committee published its first research project (1975) on "A Survey of Self-Medication in General Practice". 28 general practitioners in Singapore volunteered to take part in the survey for 4 consecutive days in October 1973. 25% of a total of 6,571 patients seen admitted to self-medication. The vast majority of the instances of self-medication were judged trivial and probably harmless. Only 3% resulted in adverse drug reactions or were considered ill-advised.

Horne G.O. (1975) discussed "Hypertension as Seen in General Practice", and the problems encountered in its management.

The College Research Committee reported its second research project (1975) on "Upper Respiratory Infection — As Seen By Three General Practitioners in Singapore". Part I deals with the epidemiological features, and part II on the clinical features.

Foo, C.M. & Foo, S.L. (1975) discussed "Pre-Employment Examination."

Paul, D.R. & Seet, L.C. (1975) described "Medical Screening Practice In Military Service" at that time.

Chong, T.M. (1975) in a paper on "The Truth About Hypnosis" pointed out the recognition of hypnosis as a useful medical tool, its place in medical education, its uses in medical practice, its dangers and contraindications.

Leong V.C. (1975) in an interesting paper on "A Study on Infant Feeding Practices as Seen in a General Practice" found that the incidence of breast-feeding at birth was only 38%, and the incidence of successful breast-feeding was 28.6%, and the most common duration of breast-feeding was only 30 days. The factors which determined a mother's decision on the type of infant feeding were discussed and he felt that if breast-feeding were to succeed, dedicated and wholehearted "after delivery service" must be rendered to mothers.

Chang, L.L. (1976) conducted a survey among flat dwellers in a section of Toa Payoh New Town, where samples of venous blood were examined for their haemoglobin concentration, packed cell volume, serum iron concentration and serum total iron-binding capacity. The purpose of the study was to obtain haematological values from apparently healthy subjects of different ages and to find out whether these differed from figures reported from other countries. The second objective was to discover the prevalence of anaemia in the population under study. The results obtained showed that though the mean values of the haematological tests carried out compared favourably with reported figures, anaemia was by no means uncommon. 43 out of the 764 subjects studied were found to have haemoglobin levels below the standards considered to be adequate for their age and sex. The majority of those found anaemic were women in the reproductive period of life.

Foo, C.K. (1976) treated 10 cases of herpes zoster, 8 with gamma globulin and 2 with injection vitamin B12, and both groups given an analgesic for pain relief and antibiotic cream locally. The results showed that gamma globulin shortened the duration of illness.

Chao, T.C. (1976) discussed the problem of battered children with reference to experience in Singapore, and doctors were urged to be alert to the signs and symptoms of an abused child and to report such cases without the fear of possible litigation.

Liok, Y.H. (1976) discussed the problem of palpitation as met with in general practice and stressed the importance of careful history taking and physical examination.

The College Research Committee reported the third research project (1977) on "Coronary Risk Factors in Singapore Doctors". 83 doctor underwent health screening examinations. The incidence of "coronary risk factors", i.e. diabetes mellitus, cigarette smoking, hypertension and hyperlipoproteinaemia, in this group was not greater than that seen in average Western communities.

Chong, T.M. (1977) reprinted his paper on "The Management of Bronchial Asthma in General Practice" which originally appeared in the Journal of Asthma Research. Part I dealt with the Psychological Factors in Bronchial Asthma, and Part II dealt with General Management.

Cheng S.L. (1977) reported his preliminary study of "Acoustic Trauma in Industrial Workers in Singapore". Two groups of workers in Singapore had their hearing tested. The audiograms of the group of workers with no aural protection showed that there was acoustic trauma in 50% of the workers who had worked between 1-5 years and 90% in those who had worked from 6 to 10 years. No further damage or deterioration occurred in the other group of workers provided with ear plugs.

Chong, T.M. (1978) in a paper on "Psychological Intervention in Patient with Cancer", showed ways in which patient with cancer could be helped through psychological intervention. The paper also stressed the importance of emotions and stress in relation to malignancy. 4 illustrative cases were given.

Vaswani, M.H. (1978) presented his preliminary observation in the use of Beta-Blockers in General Practice. 20 patients receiving beta-blockers for a variety of different clinical conditions were studied. 4 were hypertensives, 4 had ischaemic heart disease, 4 had thyrotoxicosis, 1 had ventricular extrasystoles, 1 had migraine and the last had anxiety symptoms. Significant improvement was noted in all cases. A few side effects — cold extremities, nightmares and drowsiness were reported but they were not serious to require cessation of therapy.

Wong, H.S. (1978), in the First Sreenivasan Oration — "The Future Singapore General Practitioner", outlined the training of the future general practitioner.

Koh, E.K. (1979) in a paper delivered at the 8th World Conference on Family Medicine, described family counselling in the East.

Leong, V.C. (1979) in an interesting paper discussed Cause, Coincidence and Correlation.

Koh, E.K. (1979), in the Second Sreenivasan Oration, "Art in Medicine" reiterated that medicine is an art as well a science.

Chang, M.Y, & Chang, L.L. (1979) showed the advantages and feasibility of general practitioners conducting simple laboratory investigation in their own offices.

At the 4th Combined Colleges Conferences and SEA Regional Meeting of Wonca in Manila, September 1979:-

Fernandez, V.L. presented his paper on "New Horizons in Primary Health Care in South East Asia".

Rajakumar, M.K. presented "Primary Health Care for all the People".

Vaswani, M.H. presented "The Aged Patient in a General Practice".

Chong, P.K. presented "Impotence in General Practice".

Chia, S.F. (1980) did a survey of defaulting treatment in general practice. 176 cases were studied. Most defaulters had chronic complaints such as cardiovascular, dermatological or respiratory symptoms. The main reasons for defaulting in order of importance

were apathy, no improvement, inconvenience, too many side-effects of drugs, and inability to afford long-term treatment.

Koh, E.K. (1980) discussed behavioural problems in childhood.

Leong, V.C. (1980) delivered the Third Sreenivasan Oration — "Medical Journalism in Singapore".

Chan, S.M. & Lim, C.L. (1980) in an interesting study, "Looking At Death" consisting of 84 males and 61 females, ranging from 1 year old to 99+ years. Objectives were to know how our patients died, where and in what manner they differ from deaths in a hospital or from the national statistics of deaths.

Chang, L.L. & Chang, M.Y. (1981) reported 7 cases of Infectious Mononucleosis Syndrome in their practice, presenting clinical features, haematological and serological findings.

The College Research Committee presented its fourth research project (1981) on "a Survey of Post-Surgical Patients". 33 general practitioners participated. A total of 861 patients with past histories of 940 surgical operation were surveyed. The survey showed that 49% of patients remained ignorant of their surgical experiences; only 51% were able to give relevant and meaningful account of their surgical experiences. It was suggested that all surgical patients be given a certificate stating the nature of the operation done and the pathological basis which necessitated it.

Koh, E.K. (1982) gave an account of the history of The College of General Practitioners Singapore.

Chang, M.Y. & Chang, L.L. (1982) conducted a "Study of Vaginal Trichomoniasis in a Family Practice". 706 cases of vaginal discharge over a 3-year period revealed that 63 cases (8.9%) were due to Trichomoniasis. An analysis of the results showed that this condition occurred in sexually active women.

Koh, E.K. (1982) discussed patient management in a General practice. He pointed out that the management of a patient requires more than therapeutic management of his illness. Establishment of empathy and rapport with a patient is very important for the successful management.

Kee, C.W. (1983) discussed effective communication in general practice. It was pointed out that the skill of interpersonal communication can only be cultivated through practice and a determination to change our "life long patterns".

The Research Committee conducted a survey to study the available facilities and procedures in general practitioners' clinics in Singapore and published its findings titled "General Practice Profile", (1983).

Fernandez, V.L. (1983) presented the Sixth Sreenivasan Oration — "Twenty-five Years in Retrospect: From General to Family Practice".

Chang, M.Y. & Chang, L.L. (1983) made a study of the disease patterns in their practice.

Fernandez, V.L. (1984) delivered his paper, "Family Medicine In The Eighties" at the XV Mid-Year Academic Seminar & International Conference on Family Medicine in New Delhi, August 1984.

Kee, C.W. (1984) discussed "The Diagnostic Process In General Practice". He pointed out that diagnosis in general practice required more than a systematic way of asking questions and doing a physical examination. It involves more than logical thinking and encompasses intuition, pattern recognition and the generation of hypotheses.

The Research Committee conducted a survey on Housecalls and published its findings, (1985).

Quek, K.C. (1985) gave his personal reflections on Housecalls.

Loh, W.T. (1985) described his group practice experiences with housecalls.

Goh, L.G. (1985) gave some idea of the doctor's call bag, the contents of which, he said, vary from that of one doctor and another for 3 reasons: the type of cases seen usually, the number of cases seen and the personal preferences of the doctor.

Chang, M.Y. & Chang, L.L. (1985) described "A Family Physician's Approach to The Diagnosis of Diabetes Mellitus".

Fernandez, V.L. (1985) delivered the SMA Lecture on "Health Care: To-Day and Tomorrow" at the Silver Jubilee National Medical Convention of the SMA in April 1985.

Kee, C.W. (1985) described "The Placebo Effect" in an interesting paper, discussing the mind-body connection, the components of the placebo effect, with interesting case histories.

Chong, T.M. (1985) expressed doubt about "Risk Factors in Atherosclerotic Diseases".

Chong, T.M. (1985) pointed out the controversy and implications in medical practice in the control of adult-onset diabetes.

Chong, T.M. (1986) described "The Powerful Placebo — A Neglected Asset in Medicine", pointing out that Surgery could be a placebo and that placebo could cause toxic and side effects.

The Tenth Wonca World Conference on Family Medicine was held in Singapore on May 20th — 24th, 1983. The following papers were contributed by Singapore general practitioners.

Lee, S.Y. (1983) presented his paper on "The Challenge of Family Medicine in South East Asia". He described the medical facilities available in the region and the pertinent medical problem. He stressed the importance of preventive and primary health care and made a plea for a balanced perspective in the era of rapid medical progress and medical technology.

Wan, F.K. (1983) traced the history of Family Planning in Singapore which dated back from the formation of The Family Planning Association of Singapore in 1949 to the taking over of these activities by the Government in 1966 till the 1980s. He discussed the important role of the Family Physicians in its Family Planning Programme.

Chew, P.K. (1983) high-lighted the emerging industrial health problem and the rising trend of occupational diseases in Singapore.

Leong, V.C. (1983) presented a paper on "Surgical Scars — elucidating their significance", a study by the College Research Committee on 861 patients with histories of 940 surgical operations.

Nair, V.P. (1983) presented "Drug Abuse/Rehabilitation". He described the Singapore scene and emphasized the role of the Family Physician in Drug Abuse/Rehabilitation.

Chang, M.Y. (1983) reviewed "A 4-year Study in his Family Practice of Vaginal Moniliasis", presenting prevalence, clinical features and treatment.

REFERENCES

1. Chan, S.M. & Lim, C.L. (1980): Looking at death, S.F.P. 6:4, 106-114.
2. Chang, L.L. (1976): Some Haematological Values From a Toa Payoh Population, S.F.P. 2:1, 21-24.
3. Chang, L.L. & Chang, M.Y. (1981): Infectious Mononucleosis Syndrome in General Practice, S.F.P. 7:1, 6-10.
4. Chang, M.Y. (1983): Vaginal Moniliasis — A four year review in a Family Practice, Tenth Wonca World Conference on Family Medicine, Singapore, May 1983, Conference Proceedings, 455-459.
5. Chang, M.Y. & Chang, L.L. (1979): 'Instant' Laboratory investigations in a general practitioner's office, S.F.P. 5:4, 146-149.
6. Chang, M.Y. & Chang, L.L. (1982): A Study of Vaginal Trichomoniasis in a Family Practice, S.F.P. 8:2, 32-37.
7. Chang, M.Y. & Chang, L.L. (1983): Disease patterns in a family practice, S.F.P. 9:4, 174-177.
8. Chang, M.Y. & Chang, L.L. (1985): A Family Physician's Approach To The Diagnosis Of Diabetes Mellitus, S.F.P. 11:1, 22-25.
9. Chao, T.C. (1976): The Abused Child, S.F.P. 2:4, 107-111.
10. Cheng, S.L. (1977): Preliminary Study of Acoustic Trauma in Industrial Workers in Singapore, S.F.P. 3:1, 28-31.
11. Chew, P.K. (1983): Family Practice and its interface with a industralizing community, S.F.P. Tenth Wonca World Conference on Family Medicine, Singapore, May 1983, Conference Proceedings 302-305.
12. Chia, S.F. (1980): A Survey of defaulting in general practice, S.F.P. 6:2, 35-38.
13. College Research Committee (1975): A Survey of Self-Medication in General Practice, S.F.P. 1:1, 5-10.
14. College Research Committee (1975): Upper Respiratory Infection. As seen by three general practitioners in Singapore, Part 1 — Epidemiological Features, Part II — Clinical Features, S.F.P. 1:2, 47-52.

15. College Research Committee (1977): Coronary Risk Factors in Singapore Doctors, S.F.P. 3:1, 7-13.

16. College Research Committee (1981): A Survey of Post-Surgical Patients, S.F.P. 7:4, 97-102.

17. College Research Committee (1983): General Practice Profile, S.F.P. 9:3, 112-122.

18. College Research Committee (1985): Housecalls: A General Practice Survey, S.F.P. 11:1, 9-15.

19. Chong, P.K. (1980): Impotence in general practice, S.F.P. 6:1, 21-25.

20. Chong, T.M. (1975): The Truth About Hypnosis, S.F.P. 1:3, 77-81.

21. Chong, T.M. (1977): The Management of Bronchial Asthma in General Practice, Part I: Psychological Factors in Bronchial Asthma, S.F.P. 3:1, 32-40; Part II: General Management and References, S.F.P. 3:2, 60-64.

22. Chong, T.M. (1978): Psychological Intervention in Patient with Cancer, S.F.P. 4:1, 20-25.

23. Chong, T.M. (1985): Risk Factors in Atherosclerotic Diseases, S.F.P. 11:3, 130-135.

24. Chong, T.M. (1985): The Control of Diabetes: Its Controversy and Implications in Medical Practice, S.F.P. 11:4, 176-182.

25. Chong, T.M. (1986): The Powerful Placebo: A Neglected Asset in Medicine, S.F.P. 12:4, 144-151.

26. Fernandez, V.L. (1980): New Horizons In Primary Health Care In South East Asia, S.F.P. 6:1, 6-11.

27. Fernandez, V.L. (1983): The Sixth Sreenivasan Oration, Twenty-Five Years in Retrospect: From General to Family Practice S.F.P. 9:4, 169-173.

28. Fernandez, V.L. (1984): Family Medicine In The Eighties, S.F.P. 10:3, 85-86.

29. Fernandez, V.L. (1985): Health Care: To-Day and To-Morrow, S.F.P. 11:2, 69-74.

30. Foo, C.K. (1976): Herpes Zoster — Treatment with Gamma-Globulin, S.F.P. 2:2, 45-46.

31. Foo, C.K. & Foo, S.L. (1975): Pre-Employment Examination, S.F.P. 1:3, 69-72.

32. Goh, L.G. (1985): Housecalls: The Doctor's Call Bag, S.F.P. 11:1, 20-21.

33. Horne, G.O. (1975): Hypertension as seen in General Practice, S.F.P. 1:1, 24-30.

34. Kee, C.W. (1983): Effective Communication in General Practice, S.F.P. 9:1, 5-7.

35. Kee, C.W. (1984): The Diagnostic Process in General Practice, S.F.P. 10:3, 96-103.

36. Kee, C.W. (1985): The Placebo Effect, S.F.P. 11:3, 116-120.

37. Koh, E.K. (1979): Family Counselling in the East, S.F.P. 5:1, 15-17.

38. Koh, E.K. (1979): The Second Screeninvasan Oration, Art in Medicine, S.F.P. 5:4, 131-133.

39. Koh, E.K. (1980): Behavioural problems in childhood, S.F.P. 6:3, 65-67.

40. Koh, E.K. (1982): Early Days of the College, S.F.P. 8:1, 8-11.

41. Koh, E.K. (1982): Patient Management in General Practice, S.F.P. 8:4, 107-110.

42. Lee, S.Y. (1983): The Challenge of Family Me dicine in South East Asia, Tenth Wonca World Conference on Family Medicine, Singapore, May 1983, Conference Proceedings, 14-18.

43. Leong, V.C. (1975): A Study on Infant-Feeding Practices as Seen in a General Practice, S.F.P. 1:4, 103-109.

44. Leong, V.C. (1979): Cause, Coincidence and Correlation, S.F.P. 5:2, 39-40.

45. Leong, V.C. (1980): The Third Sreenivasan Oration — Medical Journalism in Singapore, S.F.P. 6:4, 98-104.

46. Leong, V.C. (1983): Surgical Scars — elucidating their significance, Tenth Wonca World Conference on Family Medicine, Singapore, May 1983, Conference Proceedings, 316-319.

47. Liok, Y.H. (1976): Palpitation — The Problem as met with in General Practice, S.F.P. 2:4, 112-114.

48. Loh, W.T. (1985): Housecalls: A Group Practice Experience, S.F.P. 11:1, 18-19.

49. Nair, V.P. (1983): Drug abuse/rehabitation, Tenth Wonca World Conference on Family Medicine, Singapore, May, 1983. Conference Proceedings, 362-366.

50. Paul, D.R. & Seet, L.C. (1975): Medical Screening Practice in Military Service, S.F.P. 1:3, 73-76.

51. Quek, K.C. (1985): Housecalls: Personal Reflections, S.F.P. 11:1, 16-17.

52. Rajakumar, M.K. (1980): Primary Health Care for all the people, S.F.P. 6:1, 12-14.

53. Vaswani, M.H. (1978): Preliminary Observation in the use of Beta-Blockers in General Practice, S.F.P. 4:2, 70-78.

54 Vaswani, M.H. (1980): The Aged Patient In A General Practice, S.F.P. 6:1, 15-20.

55. Wan, F.K. (1983): Population and Family Medicine in Singapore, Tenth Wonca World Conference on Family Medicine, Singapore, May 1983, Conference Proceedings, 266-268.

56. Wong, H.S. (1978): The First Sreenivasan Oration — The Future Singapore General Practitioner, S.F.P. 4:3&4, 89-93.

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FAMILY MEDICINE
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1985 — 1987

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