THE SINGAPORE FAMILY PHYSICIAN

College of Family Physicians

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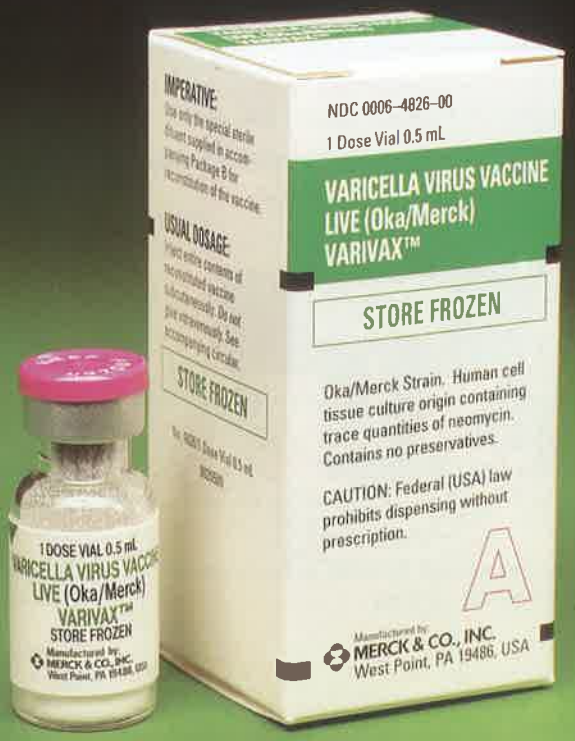

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The New Singapore Family Physician

1997 is a momentous year to remember with the regional currency crisis, the haze and in the medical scene, tragically, the first blood transfusion related HIV victims. In 1997 we also experienced resurgence of old familiar infections - measles, dengue fever, coxsackie, chickenpox and malaria. Certainly, doctors who may be cyclically busier this year need to pause for a dose of education. Hence our journal, the *Singapore Family Physician*, now dressed up with a new look, focuses on education in as current a way as possible; certainly a desire of the College is to keep up with the times.

There is no better familiar universal method of communicating than through the printed word even in these days of electronic communication. One purpose of this journal is to provide its members comprising 60% of family physicians in Singapore the means to be updated efficiently though articles and news updates. The content of the journal will be practice orientated and will be a resource to our members and Family Medicine trainees. We hope another reason why trainees want be members of the College is in order to get the *Singapore Family Physician* ! The Journal will take over the task of providing quarterly news through the College Mirror which is now incorporated into the journal.

A focus of this issue is on Dengue in Singapore by BH Heng, KT Goh and KS Neo. As practitioners, we need to be constantly updated and aware of the epidemiology of local infections. Certainly if our vicinity is a hotspot for dengue, it should alert us to look out for it. Besides immunisation for preventable infections, we can give prescriptive preventive advice to our patients. This issue also has different sections catering for the different types of articles. The sections will enable the journal to develop a continuity in content and a focus for every successive issue. New sections will be added, and sections which have exhausted its content after a period will be taken off.

As can be seen, there are significant contributions from trainees in this issue. Whenever I attend trainee tutorials, I have often thought how good it is to channel the thoughts and efforts of our trainees to reach a wider audience. Hence the research and learning of trainees is very much evident in this issue -their contributions are recognised as a valuable resource. Adding photos of our trainees is a way to personalise the journal because it is good to know our colleagues not only as a name but also as a recognisable face. Family physicians and general practitioners cloistered in their office practices may not have the opportunities to know and recognise colleagues. The editorial committee hopes this renewed journal will be a resource and reference which readers can draw on in their daily practice. My thanks goes to the editorial committee and all contributors for their efforts and to the College Council for their support.

Dr Lau Hong Choon
Honorary Editor

Update on the College

Dear Member

It has been more than half a year since the new Council has taken over and there are changes and plans for the College that you as a member should be kept informed about. Feedback from the membership on these changes and plans would very definitely be most welcome since the Council is elected to serve the interest of the College and its members.

The present Council consists of only 11 Council Members instead of the required 13 after the resignation of one Council Member due to his posting abroad plus the vacant seat left unfilled at the AGM in May 1997. The Council would be very glad to welcome any member prepared to serve on it and bring fresh and new ideas into the deliberations of the Council. The two new and younger Council Members in the persons of Drs Tan See Leng and Tan Chee Beng have contributed much since they took up office.

Without realising how quickly time has passed by, the 10 year tenancy that the College had enjoyed at it present premises with only a quick rental to pay through the very generous assistance of the MOH, has ended. The College has to now pay rental at market rates for its premises as a result of changes in policy by the Ministry of Finance and the Government Land Office. Therefore, we have had to reduce the floor-space occupied by the College by half to keep costs down to a manageable level.

As most of you know, the College has over the past 9 years been conjointly managing The Postgraduate Medical Library (PGML) with the Academy of Medicine. The Joint Committee decided to close the PGML earlier this year as the library had outlived its usefulness and the cost needed to keep the library going did not justify its use which had fallen to a very low level. The College is now in the process of upgrading its own library with the funds made available to it from half of the remaining monies in the PGML Fund. This new College library, to be known as the Postgraduate Medical Library (Family Medicine), will in time play an important role in the CME of all members and trainees in Family Medicine through the various media of IT, textbooks and journals relevant to Family Medicine. Funds to manage this library shall come from the interest accrued from deposits of the monies transfered to the College from the PGML. You are invited to give suggestions on how this library could serve you better.

Finally, as you will have noticed, there is a new format in the College Newsletter in that it has become incorporated into the College Journal which itself has now taken a new look under the current Publications Committee headed by Dr Lau Hong Choon. We hope you will find the change refreshing and be stimulated enough to contribute articles of academic, ethical or practice value for publication.

I hope to be able to keep members updated on issues of importance to the College and all FPs/GPs, and on the discussions and decisions made by your Council, quarterly through this College Journal. This, in time would hopefully make the College more meaningful and relevant to all.

Thank you and my best wishes to you and your loved ones.

Dr Alfred W T Loh
President

Dengue in Singapore - an Epidemiological Review of the Current Situation

B H Heng*, K T Goh**, K S Neo***

INTRODUCTION

There has been a resurgence of dengue fever/ dengue haemorrhagic fever (DF/DHF) in Singapore in recent years. The epidemiology of the disease is also changing.

DHF was first reported in Singapore in 1960[1], and subsequently emerged as an important public health problem, with epidemics reported almost annually from 1961 - 1964 and 1966 - 1968. In 1969, a nationwide *Aedes* control programme incorporating source reduction, public health education and law enforcement was implemented[2]. The effective measures resulted in a marked drop in the overall house index (HI) (percentage of premises positive for *Aedes* breeding) from >25 to around 5 in 1972, and a corresponding decline in dengue morbidity rate from 42.2 per 100,000 population in 1968 to 3-10 per 100,000 population during the period 1969- 1972 (**Fig 1**). However, an epidemic of 1,187 cases of dengue fever DF/DHF with 27 deaths occurred in 1973. With further intensification of *Aedes* control, the HI was reduced to 2 in 1983 and to a record low of 1 in 1985[3]. In spite of this, nationwide outbreaks occurred with even greater frequency and intensity in subsequent years.

Fig 1. Reported morbidity rate of DF/DHF and its relationship to *Aedes* house index in Singapore, 1960-1996

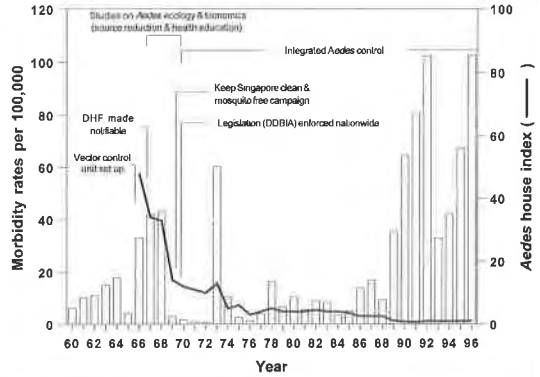
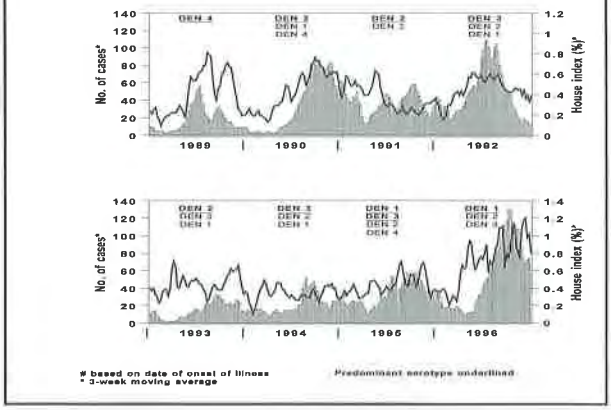


Fig 2. Relationship between reported cases# of dengue fever/dengue haemorrhagic fever, dengue serotypes and *Aedes aegypti* house index, 1989 - 1996



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THE CHANGING EPIDEMIOLOGY

Secular trend and seasonal distribution

The annual outbreaks of DF/DHF in the earlier years were replaced by a five-year cyclical pattern: 1968 (846 cases with 18 deaths), 1973 (1,187 cases with 27 deaths) and 1978 (352 cases with 2 deaths). Following a period of low dengue transmission during the years 1979-1985, the yearly outbreaks returned in 1986 with greater intensity in each successive year: 1986 (354 cases-with one death), 1987 (435 cases with two deaths), 1989 (944 cases with two deaths), 1990 1,733 cases with three deaths), 1991 (2,179 cases with six deaths), 1992 (2,878 cases with six deaths), 1993 (946 cases with no death), 1994 (1,239 cases with one death), 1995 (2,008 cases with one death) and 1996 (3,128 cases with three deaths). During the period January-August 1997, a total of 2,935 cases has been reported, compared with 1,221 cases during the same period of 1996.

Most of the cases were reported during the second half of the year with peak incidences occurring around September-November (**Fig 2**).

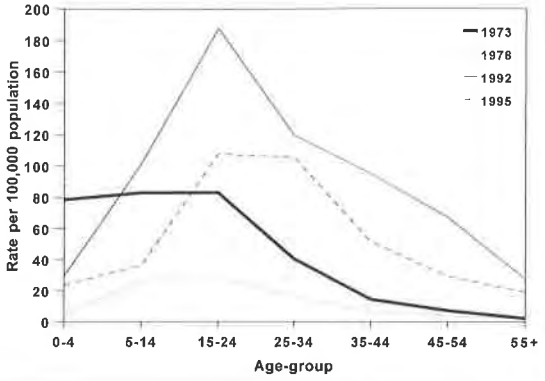
Age distribution

When DHF was first reported in Singapore in 1960, older children and young adults were affected. The clinical manifestations were relatively mild and there were very few instances of gastrointestinal bleeding[1]. As the disease became more established, younger children were involved and the disease assumed a more severe form with haemorrhages and shock[4-7].

There has been an upward shift in the age distribution of reported cases. More adults are

being infected now. In 1973, the highest age-specific morbidity rates were reported in the 0-24 year age group; in 1976, in the 5-24 year age group; in 1992, in the 15-24 year age group;

Fig 3. Age-specific morbidity rates of reported DF/DHF in Singapore, 1973, 1978, 1992 & 1995

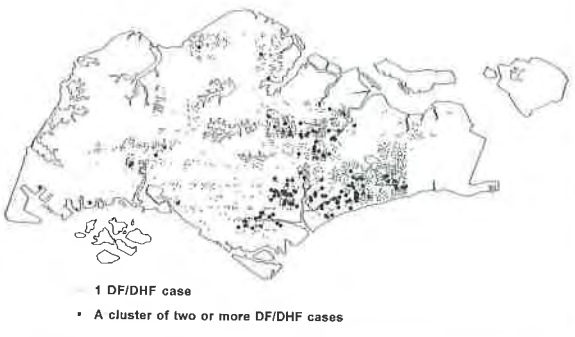


and in 1995, in the 15-34 year age group (**Fig 3**). The median age of reported cases has shifted from 14 years in 1973 to 27 years in 1996. This trend was also seen among the reported death cases. Unlike in 1973 when virtually all the fatal cases were below 10 years of age, 13 of the 16 serologically confirmed deaths reported during the period 1990-1996 were 19 years and above.

Geographical distribution

In 1996, 70% of cases were concentrated in the highly populated urban and suburban areas located in the southeastern, northeastern, eastern and southern parts of Singapore. Over a third (37.4%) of the cases occurred in the southeastern area alone. The majority of the cases occurred

Fig 4. Geographical distribution of reported DF/DHF cases, 1996



singly and sporadically (**Fig 4**).

During the period 1994-June 1997, about a third (33.8%-37.0%) of the reported cases were epidemiologically linked to one another by place (the same geographical location within 200 metres) and time (within three weeks or approximately two incubation periods) at various clusters or foci of dengue transmission, an increase from 15.6%-25.6% during the preceding period 1990-1993. During the period 1990-June 1997, the percentage of large clusters (≥ 10 cases) decreased from 27.5% to 11.5%, the median number of cases per cluster decreased from 4.5 cases to 3 cases, and the median duration of transmission in clusters decreased from 10 days to 4 days during the same period **(Table 1).**

Table 1: Dengue clusters* identified during the period 1990-1997#

Year	No. of cases	No. of clusters	No. of cases in cluster areas (% total cases)	No. of clusters with ≥ 10 cases (% total clusters)	Median No. of cases per cluster	Median duration of transmission (days)
1990	1,733	40	270 (15.6)	11 (27.5)	4.5	10.0
1991	2,179	74	414 (19.0)	9 (12.2)	3.5	6.0
1992	2,878	134	733 (25.6)	13 (9.7)	3.0	5.0
1993	946	33	183 (19.3)	4 (12.1)	3.0	8.0
1994	1,239	75	424 (34.2)	8 (10.7)	3.0	7.0
1995	2,008	118	679 (33.8)	16 (13.6)	3.0	7.0
1996	3,128	143	1,088 (34.8)	27 (18.8)	3.0	6.0
1997#	1,700	113	629 (37.0)	13 (11.5)	3.0	4.0

* cluster is defined as two or more cases epidemiologically linked by place (within 200 metres) and time (within three weeks or approximately two incubation periods)
\# as at June 1997

Housing type

In the 1995 and 1996 outbreaks, residents of landed properties had the highest morbidity rate which was almost five times that of dwellers of high-rise public housing estates (**Table 2**).

Table 2: Morbidity rates of reported indigenous DF/DHF cases by housing type, 1995-1996

Type of dwelling	1995		1996	
	Cases (%)	Rate per 100,000*	Cases (%)	Rate per 100,000
Landed properties (bungalows, semi-detached bungalows, terrace houses)	561 (32.0)	179.3	862 (30.0)	275.5
HDB/JTC dwellings	896 (51.0)	36.1	1,414 (49.1)	58.1
Condominiums and private flats	116 (6.6)	78.8	186 (6.5)	126.4
Others (shophouses, attap/zinc-roofed houses, bangsals)	183 (10.4)	203.1	415 (14.4)	460.6
Total	1,756(100)	59.6	2,877 (100)	94.5

* Based on Singapore Census of Population 1990 (Source: Department of Statistics)[20]

Construction sites and foreign workers

In the 1960s and 1970s, most outbreaks occurred in the urban slums and resettlement areas[2]. With the construction boom since the late 1980s, most large localised outbreaks had occurred in or around construction sites e.g. Suntec City (78 cases in July-October 1994, 51 cases in June-

September 1995), Astoria Park condominium (58 cases in July-September 1994), Kew Gardens (48 cases in May-August 1996) and Simsville condominium (60 cases in August-September 1996. A significant correlation was found between the number of building projects and foreign workers with DF/DHF during the period 1991 - 1996 (**Table 3**).

Table 3: Building construction activities and its association with foreign construction workers with DF/DHF, 1991-1996

Year	No. of new building projects commenced* [a]	No. of indigenous DF/DHF cases		
		Total	Foreign workers	(%)
1991	784	2062	198	(9.6)
1992	823	2,741	272	(9.9)
1993	978	784	88	(11.1)
1994	1,174	1,084	257	(23.7)
1995	1,371	1,756	490	(27.9)
1996	1,393	2,877	819	(28.5)

* Source: Yearbook of Statistics Singapore, 1996 (Department of Statistics)[21]
[b] vs [a]:r = 0.97;p = 0.0009

Aedes surveillance

The primary vector is *Aedes aegypti,* an indoor breeder, while *Aedes albopictus,* an outdoor breeder, plays a secondary role in the transmission of dengue in Singapore. The common breeding habitats of the 1960s, i.e. ant traps, earthen jars, basins and drums[2], have changed with urbanisation. Presently, the common breeding habitats for both *Aedes aegypti* and *Aedes albopictus* detected during routine vector surveillance are discarded receptacles, domestic containers, ornamental containers, puddles, ground depressions, canvas/plastic sheets, roof gutters, toilet bowls/cisterns, perimeter drains, gulley traps and ponds/ swimming pools. A noticeable shift from indoor to outdoor breeding habitats has also been noticed in more recent years. The proportion of landed properties breeding *Aedes aegypti* and *Aedes albopictus* was significantly higher than that of HDB/JTC dwellings. During the period 1989-1996, vector surveillance in construction sites has also shown that both Aedes aegypti and Aedes albopictus populations have increased significantly.

Although the Aedes population was generally low with an overall Aedes HI of between 1 and 2, in some localised areas the HI was as high as 18. The incidence of DF/DHF was also observed to be significantly associated and preceded by a rise in Aedes aegypti HI (**Fig 2**) but not with Aedes albopictus HI. On the of other hand, Aedes albopictus population was more closely correlated with rainfall than Aedes aegypt. However, there was no correlation between disease incidence and rainfall.

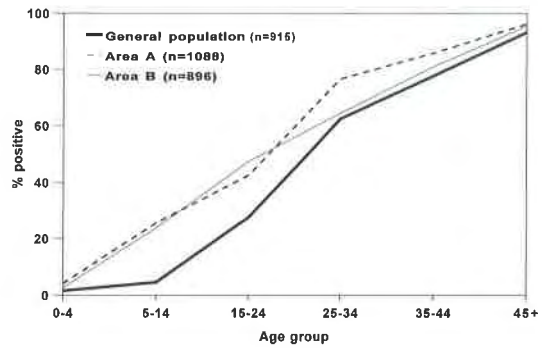
Dengue virus serotypes

Virus surveillance has shown that different serotypes have emerged as major causative agents of successive epidemics. Infection with any one dengue serotype is followed by the development of solid immunity to that type but only temporary immunity (lasting around three months) to the other serotypes[8]. DHF and dengue shock syndrome have been shown to occur more frequently with secondary or sequential infection ending with either dengue 2 or dengue 3[9-12]. All the four dengue serotypes had been detected from blood samples of infected persons, with dengue 2 predominating in 1990, 1991 and 1993, and dengue 3 in 1992 and 1994. Dengue 1 has emerged as the predominant serotype since 1995 (**Fig 2**).

Seroprevalence surveys and herd immunity

Periodic serological surveys has shown that the immunity level of the general population to dengue virus infection to be low. In 1993, the overall seroprevalence was 39%; only 6.4% of children and young adults below the age of 25 years possessed haemagglutination-inhibition antibody to dengue 2. However, in a prospective study in two highly endemic localities in the eastern part of Singapore in 1994, the overall seroprevalence of the residents was found to be between 65.6% and 68.8%, with children living there acquiring dengue infection much more rapidly than those in other parts of Singapore

Fig 5. Age-specific prevalence of HI antibody to dengue 2 virus in the general population (1993) and residents of two highly endemic areas (1994)



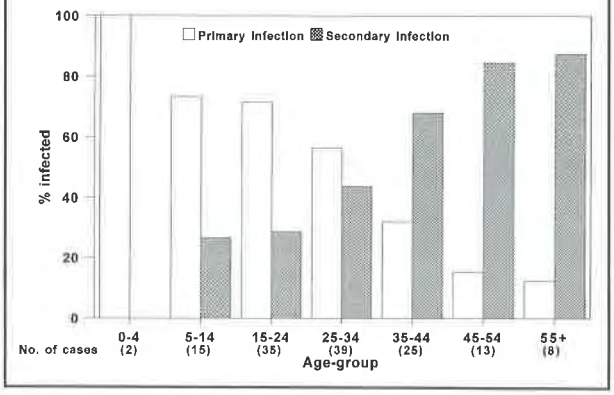
(**Fig 5**). The annual rate of acquisition of dengue virus infection among residents in these localities was 5.6%; the rate being highest in adults aged 25-34 years (11.8%) and residents of landed

properties (8.3%). The survey also confirmed that a very high proportion (97.5%) of recently infected residents did not seek medical treatment as they were either asymptomatic or had subclinical infection.

Primary and secondary infections

Surveys carried out in 1985,1987 and 1989 showed that 40%-43% of DF/DHF patients had primary infections[13]. In a more recent survey conducted on 138 cases of DF/DHF reported during the period January-May 1997, it was found that based on WHO's criteria[14], 72 cases (52.2%) had primary infection, and 66 cases (47.8%) had secondary infection. Primary infection occurred in younger individuals (mean 24.9 years, median 25 years), while secondary infection occurred in older individuals (mean 36.4 years, median 35 years), the difference in age being statistically significant ($p < 0.001$). As expected, there was generally an inverse correlation between age and primary infections, i.e. the proportion with primary infection decreased with increasing age, while there was a direct correlation between secondary infection and age, i.e. the proportion with secondary infection increased with increasing age (**Fig 6**).

Fig 6. Age distribution of 71 cases of primary and 66 cases of secondary dengue virus infection, January - May 1997



DISCUSSION

The epidemiological pattern of DF/DHF in Singapore has shifted from one with high Aedes population and high dengue transmission in the 1960s to one with low Aedes population and low disease transmission. The majority of cases in 1996 involved teenagers and young adults, who acquired predominantly secondary infections. The median age has shifted from 14 years in 1973 to 27 years in 1996. More than three quarters of serologically confirmed fatal cases reported during the period 1990-1996 were young adults above 19 years of age.

The effectiveness of the Aedes control programme since the early 1970s was confirmed by the low level of dengue transmission[15]. A 1993 national serological survey showed that virtually all children and young adults aged < 25 years did not possess HI antibody to dengue 2 virus. A mathematical model developed by the US Centers for Disease Control and Prevention showed that the Aedes mosquito becomes much more efficient when the herd immunity of the human population is low[16]. When the immune status of the human population is high, epidemic transmission would not occur even in the presence of high Aedes population. The comprehensive vector surveillance and control programme implemented during the past two decades has brought about a paradoxical situation in that dengue outbreaks tend to occur more frequently and with greater intensity in a highly susceptible population[17].

There are other factors that could have contributed to the periodic outbreaks of dengue. Firstly, Singapore is situated in a dengue endemic region where there is a resurgence of the disease, hence it is very vulnerable to the introduction of dengue viruses by the large influx of visitors to the country. Secondly, although the overall Aedes HI is very low, the annual increase in disease incidence was preceded by localised build-ups of Aedes population in construction sites and in landed properties in several dengue-receptive areas where Aedes HI of more than 18 had been recorded. Thirdly, although it is not clear to what extent the changing disease trend could be accounted for by the prevailing dengue serotypes in circulation, routine virological surveillance seemed to indicate that each outbreak could be due to the emergence of a predominant serotype, i.e. dengue 2 in 1993, dengue 3 in 1994 and dengue 1 in 1995-1996.

Until the tetravalent live-attenuated dengue virus vaccine is commercially available for mass immunisation, the key to the prevention and periodic epidemics is *Aedes* surveillance and control, with the full cooperation and participation of every resident of the community[18]. Although the mere presence of *Aedes is* not sufficient in itself to create a potential for an outbreak, it has not been determined at what critical level the *Aedes* population should be reduced so that it would not sustain virus transmission epidemically in a susceptible population. The main thrust of the *Aedes*

population. The main thrust of the *Aedes* surveillance and control programme is to prevent any high *Aedes* pockets from developing into a potential focus of dengue transmission. The goal is to maintain the *Aedes* HI in every part of the country at between 1 and 2. It is difficult to achieve a zero HI, because breeding habitats in premises are constantly available at replacement level, i.e. habitats are being created as quickly as they are being eliminated by routine source reduction control measures.

The public is constantly reminded to keep their homes mosquito-free by adopting a routine system of checks for *Aedes* breeding within and around their homes and by applying insecticide sand granules in water-containing receptacles. Residents of landed properties are advised to repair or remove defective roof gutters and to apply insecticide paint on roof gutters and flower pot plates. Health education and publicity through all possible channels, including the use of videos, are continued throughout the year and stepped up whenever there are signs of an impending outbreak. Educational talks and exhibitions are regularly conducted with the assistance of grassroots organisations, such as residents committees and town councils, schools and other agencies. Pamphlets in Tagalog and foreign languages and roving exhibitions are used to spread the dengue message to foreign maids and workers. Surveys showed that the publicity blitz on dengue in the mass media has a definite impact in raising the level of awareness of the public on the dangers of dengue and the *Aedes* mosquitoes. However, there are still misconceptions about the disease and the vectors, and there has not been a significant change in attitude and behaviour modification, as reflected by the high recurrence of *Aedes* breeding in some residential areas. Therefore, the public has to be continually motivated to play a more active role in dengue prevention and control.

Table 4: Criteria for dengue diagnosis

1	Fever - acute onset, high, continuous and lasting 2-7 days
2	Haemorrhagic manifestations including at least a positive tourniquet test, and any of the following: - petechiae, purpura, ecchymosis - epistaxis, gum bleeding - haematemesis and/or malaena
3	Enlargement of liver
4	Thrombocytopaenia (≤ 100,000/mm3)
5	Haemoconcentration (haematocrit increased by ≥ 20%)

Notes:

(a) The presence of the first two clinical criteria plus thrombocytopenia and haemoconcentration is sufficient to establish a clinical diagnosis of DHF.

(b) When shock occurs with high haematocrit levels (except in patients with severe bleeding) and marked thrombocytopaenia, the diagnosis of DHF/ dengue shock syndrome is highly likely.

(c) The presence of thromobocytopaenia with concurrent haemoconcentration will differentiate the milder forms of DHF from classical dengue (fever accompanied by non-specific constitutional symptoms and a positive tourniquet test of spontaneous bleeding).

(Based on "Dengue haemorrhagic fever: diagnosis, treatment and control "World Health Organisation, Geneva, 1986)

Early diagnosis and notification of DF/DHF are essential for prompt institution of vector control measures. For the family physician, a high index of suspicion is crucial, and every febrile case should be investigated for dengue. A summary of the clinical and laboratory criteria for the diagnosis of dengue is given in **Table 4**. Various commercial kits for the rapid detection of dengue IgM and IgG antibodies are now available. One of them could be easily carried out by the family physician in his clinic[19]. It should be remembered however, that a negative test result does not preclude an acute dengue infection as the IgM antibodies take about 5-6 days to develop in primary infections. Every suspected and confirmed case of DF/DHF should be immediately notified to the Ministry of the Environment, with the addresses of residence, workplace or school. This would enable early identification of foci of dengue transmission in order to implement epidemic control measures to prevent further spread of infection.

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Family Medicine Meeting People's Needs: Optimum Medical Practice

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ABSTRACT

The three statements on optimal medical practice in the Executive Summary of the WHO-WONCA Conference on Making Medical Practice and Education More Relevant to People's Needs held in Ontario, Canada in 1994 were used to develop a framework for implementation.

There is much we can do in "making medical practice responsive to the individual and community" namely, by attending to the doctor-patient relationship, understanding the patient, addressing the patient's problems, dealing with the exceptional potential in the primary care consultation, setting limits on the care agenda with the problem patient, as well as being an advocate for primary care and community care.

With regards to the statement that "every person should know their family doctor and be known personally by him or her", the doctor needs to make efforts to make contact with the patients and community and keep appropriate records.

On the statement that "the well-trained family doctors provide quality medical care", we need to recognise that quality care is more than being well-trained. There is a need to define quality, achieve it, develop ourselves, and reflect on our work. We also need work collaboratively with specialist colleagues to mutually achieve quality care.

Dr Charles Boelen's "five star doctor" paradigm of care provider, decision maker, communicator, community leader and team member/manager is a memorable way of remembering the attributes that are central to the optimum medical practice.

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INTRODUCTION

At the WHO-WONCA Conference on Making Medical Practice and Education More Relevant to People's Needs held in Ontario, Canada in 1994, several statements were made about optimal medical practice (ref 1). In this paper, an attempt has been made to develop a framework for implementation.

1 Three statements on optimal medical practice

In the Executive Summary to the Report on the WHO-WONCA Conference in 1994, three statements (para 8, 9, 10) defined optimal medical practice, namely,

- Medical practice is responsive to individual and communities
- Every person should know their family doctor (or primary care provider) and be known personally by him or her.
- Well-trained family doctors provide quality medical care

2 The five star doctor

In the Report (Page 43), Dr Charles Boelen's "five star doctor" paradigm (ref 2) was highlighted as the set of doctor attributes needed in the optimum medical practice.

BE RESPONSIVE TO THE INDIVIDUAL AND COMMUNITY

A. BEING RESPONSIVE TO THE INDIVIDUAL

To be responsive to the individual requires us to take five actions.

1 Attending to the doctor-patient relationship

Much has been written about the doctor-patient relationship in the consultation. Table 1 shows the points we need to remember about the doctor-patient relationship in relation to optimum medical practice.

The consultation is a meeting of two experts (ref 1). The patient is an expert of his illness. The doctor is an expert of disease. Mutual respect is needed to begin a coherent plan of action.

If the patient is not competent to make a decision, the doctor is expected to decide for

him; the relationship becomes that of parentalism. A knowledgeable patient on the other hand, would want to participate in the decision making process. The appropriate relationship becomes that of egalitarianism and autonomy. This is especially true of chronic medical conditions. The doctor takes on the role of the valued guide and mentor besides being the doctor.

Table 1. Attending To The Doctor-Patient Relationship

We need to remember that
- a consultation is a meeting of two experts (Tuckett et al)
- there is an autocracy-parentalism-egalitarianism -autonomy spectrum in the relationship (Botelho)
- explicit boundaries between the doctor and patient need to be set

Clear boundaries between doctors and patients are needed. They help prevent abusive behaviour from either party. Boundaries set by society help doctors fulfill their legal, ethical and professional tasks (ref 3). When patient and doctor are close friends; both professional and personal relationships can suffer. Jointly exploring and setting explicit boundaries help to avoid conflict and maintain these valuable relationships (ref 4).

2 *Understanding the patient*

The important strategies in understanding the patient that have been developed in the last 30 years are shown in Table 2. Contributions came from writers like Pat Byrne, BEL Long and David Pendleton (ref 5, 6). As Middleton (ref 7) points out: "What is presented in the consultation may be the tip of the iceberg. The presenting problem may be that which is easiest or least threatening to express, perhaps even a ticket of entry. What develops from this will depend on the response of the doctor."

Table 2. Understanding The Patient

The requirements on the part of the doctor are:
- Active listening: attending, reflecting, paraphrasing
- Finding out the reason for encounter (RFE)
- Seeking out his/her ideas, concerns and expectations (ICE)
- Asking specifically if there is anything else to avoid the frustration of the "by the way" syndrome.

Seeking the reason for encounter and the ideas, concerns and expectations of the patient gives the best chance of addressing the patient's agenda. Asking specifically if there is anything else before one proceeds to make a working hypothesis of the patient's problems helps to avoid the frustration of the "by the way" syndrome - which is the hidden agenda for the visit to the doctor.

3 *Addressing the patient's problems*

Every patient expects his doctor to address his/her problems. Specifically, he/she looks forward to the doctor to make a prediction of his/her problems and a plan of what to do. The details are shown in Table 3.

Table 3. Addressing The Patient's Problems

The patient expects the doctor to:
Provide a prediction
- What is wrong with me, Doc?
- or, do I have that, Doc?
- Is it serious, Doc?
- So, what would you suggest we do?

Take appropriate action (one or moreof the combination)
- Reassurance
- Cure
- Care
- Comfort

We often fail the patient by not making a prediction to his problems. Some of us is under the illusion that the patient is looking for "a pill for every ill". What the patient wants may be just reassurance. If there is indeed a problem, then the patient is eager to know what action needs to be taken. The paradigm of "to cure sometimes, to care often, and to comfort always" is applicable to every situation. By way of illustration, Table 3A gives the range of actions appropriate to the problem of chest pain that be experienced by the patients

Table 3A. An Example: Reassure, Cure, Care And Comfort

The problem: Chest pain.	The action:
• A relative just died of chest pain	Reassurance: the situation does not apply here
• Bornholm's disease	Cure: Don't worry: analgesia and time will cure it
• Angina pectoris	Care: Yes, we cannot cure but we can take care of your angina
• Rib metastasis	Comfort: Well, let us try to make you as comfortable as possible

4 Dealing with the tasks in the consultation: a map for recognising the exceptional potential of consultation

Stott and Davies in a paper in 1979 described the potential in each primary care consultation. Essentially, each consultation has four potential areas for us to manage. How much of the potential areas are eventually covered depends on time and the perceived importance to address one or more of the areas B, C and D. As time is usually a constraint, and as workload increases, the desire to deal with these areas become diminished.

Every consultation addresses Area A. The important points to remember are: doing things right the first time and making timely decisions to refer those cases that need specialist attention.

Area B requires communication skills to persuade and convince the patient. For example, what would he do for a patient who expects to have antibiotics for every upper respiratory tract infection (URTI) or a sick certificate for a mild attack of URTI.

There is a need to try to address Area C whenever the patient visits. Time spent in this area will result in better compliance and reduce or delay complications from chronic diseases.

Much can be achieved in Area D to reduce the onset of diseases related to adverse lifestyles. This is a challenging and difficult area because the adoption of healthy behaviours require the change of life-long habits.

Table 4. Recognising The Exceptional Potential Of Consultation

Four areas in the consultation are recognised in the Stott and Davies model:
Area A - Management of acute problems
Area B - Modification of help seeking behaviour
Area C - Management of continuing problems
Area D - Opportunistic health promotion

5 Dealing with the problem patient

Every doctor has his/her share of difficult patients, hateful patients and heartsink patients. Many writers (ref 10-14) have given us insights on how to manage them optimally. There is a need to set limits and boundaries to the caring agenda for these patients. The revelation is to recognise that we can call for resources to help them: we need not be alone in trying to battle our way through.

Table 5. Dealing with the problem patient

The following problem patients have been described:
• The difficult patient (Anstett)
• The hateful patient (Groves)
• The heartsink patient (O'Dowd, McDonald, Mather N, Jones and Hannay D)
Set limits and boundaries to the caring agenda
Call for resources to help them

B. BEING RESPONSIVE TO THE COMMUNITY

Being responsive to the community requires the doctor to be an advocate for primary care as a means to deliver cost effective care and also to be an advocate for community based services for the underserved e.g. the stroke patient, the disabled or the elderly.

KNOW THE PATIENT, FAMILY AND COMMUNITY

Getting to know the patient, the family and the community requires continuing effort to meet up with the patients and keep appropriate records as shown in Table 6. Such information helps us to make relevant and appropriate decisions on patient care. A trusting relationship can only develop if both the patient and doctor know one another.

Table 6. Know The Patient, Family And Community

Patient and family
• Keeping a record of the biodata of the patient
• Recording the family genogram
The community
• Keeping a dossier of the health events social and legal happenings

PROVIDE QUALITY PRIMARY CARE

Providing quality care is more than being well-trained doctors. It underscores a need for us to be quality conscious. We need to think of what is quality as shown in Table 7. Quality is delivering appropriate care at a given point of time and not the latest technology.

Table 7. What Is Quality Primary Care ?

Quality is meeting and exceeding expectations:
- Satisfaction of the patient with the doctor and practice
- Professional standards on structure, process and outcome
  - in frontline, interface and continuing care
  - in preventive care and health promotion

Quality is delivering appropriate care and not the latest technology

We also need to think of ways to achieve quality as shown in Table 8. Moore writing in Milbank Quarterly in 1992, observed that the public will support payment reform favouring generalists where the primary care that is delivered is what they want and need.

Table 8. Achieving Quality Primary Care

Develop your own practice guidelines
Do things right the first time
Work to reduce dissatisfactions
Do a gap analysis periodically
Develop the culture of continuing improvement
Develop yourself and your staff
Producing a better product
Collaborate with specialist colleagues

Family medicine doctors need to strive to do well in what they are now doing. They must demonstrate that they provide better personal medical care than subspecialists for common medical problems, especially those of moderate severity (ref 15).

Increasingly, there is also a need to collaborate with specialist colleagues, particularly those in general medicine. Family medicine has developed as a counter-culture to specialist care. After thirty years, the ground has changed. There is better recognition of family medicine and mutual understanding of the roles each could play in the core of the patient.

The evolution of managed care systems has created powerful incentives for primary care providers to care for patients with a broader range of disease severity. The patients of general internists now more closely resemble the adult patients of family physicians in terms of disease severity and acuity than at any time in the past. Although their relationship was once that of referring physician and consultant, the family physician and the general internist are becoming peers, and they increasingly have similar needs and interests (ref 16).

We also need to think of ways to develop ourselves as the central figure in quality assurance (Table 9).

Table 9. Developing Yourself

Brush up your medicine
Keep up with current practice
- evidence based medicine
- practice guidelines and consensus statements

Reflect on your work

Reflecting on one's work satisfaction is important. It should be part of training, continuing education and medical audit programmes. A study of the emotional reactions of 57 general practitioners by Grol et al (ref 17) showed that those with many positive feelings (satisfaction, feeling at ease) correlated with more openness to patients, more attention to psychosocial aspects of the complaints but also with a higher rate of referral to medical specialists. On the other hand, many negative feelings (frustration, tension, lack of time) correlated with a high prescription rate and with giving little explanation to patients.

BEING A FIVE STAR DOCTOR

Dr Charles Boelen's paradigm of the "five star doctor" is a memorable way of remembering the attributes of care provider, decision maker, communicator, community leader and team member/manager. These attributes are central to the optimum medical practice. We need to reflect on these periodically, make gap analysis and make continuing improvements. Only then are we truly five star doctors.

Table 10. The Five Star Doctor

- be a care provider who considers the patient as an integral part of the family and the community and provides high standard clinical care (excluding or diagnosing serious illness and injury, manages chronic disease and disability) and personalises preventive care within a long term trusting relationship.
- be a decision maker who chooses the technologies to apply ethically and cost-effectively while enhancing the care that he or she provides.
- be a communicator who is able to promote healthy life styles by emphatic explanation, thereby empowering individuals and groups to enhance and protect their health.
- be a community leader who having won the trust of the people among whom he or she works can reconcile individual and community health requirements and initiate action on behalf of the community.
- be a team member/manager who can work harmoniously with individuals and organisations, within and without the health care system to meet his or her patients' and communities' needs.

CONCLUSION

We need to take action to achieve optimum medical practice. We must make the three statements that define optimum medical practice happen: we are responsive to the individual and the community; we know the patient, family and community; we provide quality medical care. We can be five star doctors.

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The Educational Expectations and Experience of Family Medicine Trainees in Singapore

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ABSTRACT

Objective: To survey the expected and actual educational experience of Family Medicine trainees in Singapore

Method: A directly administered questionnaire survey with a Likert grading scale on a single day during a regular Saturday afternoon lecture session for the trainees.

Results: There were 34 respondents. Most considered altruism as the primary reason for choosing medicine as a career. Ward rounds were expected and found to be the most valuable teaching forum. It scored significantly higher than lectures and journal clubs. The length of the ward round did not correlate with its educational worth. On-call work was not rated highly for its educational worth. Senior staff and textbooks were the main sources of new medical knowledge. Only 40% of consultants were considered as good role models. Trainee's opportunity for feedback of their views was considered poor.

Conclusion: The profile of a family medicine trainee appears to be a young altruistic and predominantly Chinese Christian single or married doctor living with his or her family. Ward rounds are the main forum for expected and actual education. This should be the focus of further educational strategies for clinical teaching and role modeling.

Keywords: Family Medicine trainees, education, ward rounds.

INTRODUCTION

Family medicine trainees are rotated through a variety of hospital and outpatient postings over a 3 year training period. The aim is to provide a broad-based medical education that will equip them to become competent general practitioners. As such, these trainees are exposed to a variety of hospitals and different departments. Although the aim of such postings are educational, there has not been any systematic survey to establish the actual value of the programme. We have therefore conducted a small pilot study to survey the expected and actual educational value of the family medicine programme.

Methods

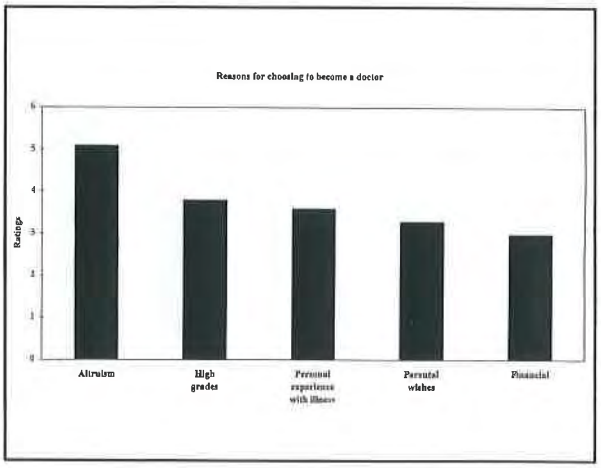
A questionnaire survey was performed on one Saturday afternoon (April 12, 1997) at a regular lecture session for the family medicine trainees. The anonymous survey was directly administered. The questionnaire consisted of various questions (Appendix I) to elicit the trainees' expectations and actual experience of medical education as part of their traineeship. A Likert scale was employed to grade the degree of responses.

Data analysis

The results of the questionnaire were tabulated and are presented as mean ± standard deviation. Statistics were performed on Excel (version 4.0), and ANOVA was used for differences amongst groups, while paired t-test was used for comparisons between 2 groups. A 'p'-value of < 0.05 was considered significant.

Results

There were 34 respondents on that day. The total number of registered family medicine trainees are 90. There were 18 females and 16 males. All respondents were Chinese and 82% were Christians. The age was 27.7 ± 1.2 years old. The majority were single (65%), with everybody living with their family. The majority (65%) had private transportation to work and nearly all (97%) lived within 40 minutes of their work. Altruism was cited as the main reason why trainees chose to be doctors (figure 1), and



76% said they would choose medicine again if given a second chance. The language spoken were primarily English (100%) and Mandarin (95%). Malay was only spoken by a minority (18%), while dialects spoken were mainly Hokkien (59%) and Cantonese (56%). Current postings (number of trainees) were: anaesthesia (6), medicine (5), obstetrics & gynaecology (4), accident & emergency (4), outpatient services (4), and others (9).

Trainees expected ward rounds to be significantly the most educational experience compared to lectures or journal clubs (table 1),

Table 1: Expected educational value of various medical activities

	Ward round	Lecture	Journal club
Mean	4.7	4.4	3.7
Standard deviation	0.98	0.92	1.08
Median	5	4	4

p=0.0007, ANOVA

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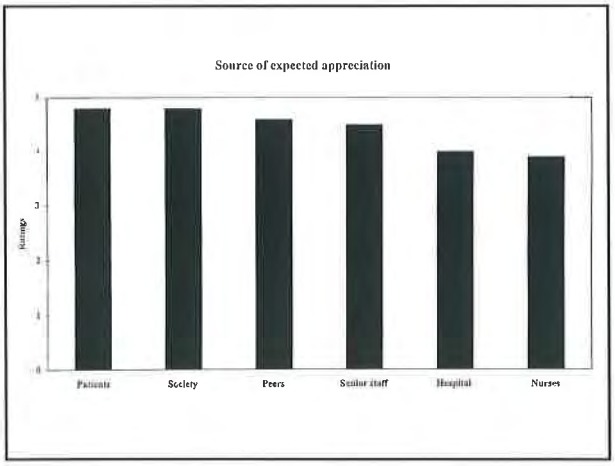
and actual ward rounds were also rated significantly higher for their educational value (table 2).

Table 2: Actual educational value of various medical activities

	Ward round	Lecture	Journal Club	Mortality round
Mean	4.4	3.9	3.3	3.4
Standard deviation	1.02	1.13	1.24	1.37
p - value (t-test)		0.04	0.0002	0.0006

Interestingly, there was no correlation between time spent on ward rounds (median 3 to 4 hours) and the rated educational value. When asked about the origins of new medical knowledge, senior staff and textbooks were scored significantly higher than journals or the internet. On-calls were rated slightly higher than average (3.9 ± 1.2) for their educational value. Median sleep was from 2 to 3 hours. The median was 40% for consultants regarded as good role models. The majority (74%) felt there was inadequate feedback of their views, and hospitals plus nurses were not expected to appreciate the trainees' contributions (figure 2).



Discussion

Our duties as doctors are two-fold. The first is to provide good and caring patient care, and the second is to teach our juniors as espoused by the Hippocratic oath to "hand on precepts, lectures, and all other learning to my sons, to those of my master and to those pupils duly apprenticed and sworn...". It is thus timely to begin evaluating the experiences of our trainees in this light, as education is the key to the future generations.

The ward round was expected to be the main focus of teaching and was borne out in practice, as opposed to the more formal sessions of lectures and journal clubs. The ward round itself appears to be the main forum for consultant and trainee interactions and as such, it was not surprising to note that new medical knowledge was acquired primarily from senior staff and medical textbooks. The style of ward rounds were not inquired into, although the length of ward rounds did not correlate with the actual teaching value. Another study from UK has suggested that the feedback and detailed enquiries at ward rounds from the consultants contributed to improved work attitude, and generally were inadequate (1). This had an impact on their roles as appropriate role models for the junior doctors. Our survey found that only 40% of consultants could be considered role models. Furthermore, patients themselves at John Hopkins were found to have slightly more positive feelings about their hospital experiences and their relationships with their physicians, when their cases were presented at the bedside (2). Ward rounds thus represent an important focus for consultant/trainee interaction as well as reassuring the patient of our interest and care for them. It provides an opportunity to observe house-staffs' behaviours and attitudes to patients, nurses, and fellow colleagues. Trainees themselves can watch a more experienced physician take a history, demonstrate physical signs and show compassion and sensitivity to the patient and their relatives (3). Ward rounds provide the demonstration of the art and science of medicine, and should thus remain a powerful medium for the continued education of both the practice of medicine and the conduct of a caring doctor.

Trainees felt that their views were not considered and as such, the lack of expected appreciation from the hospitals demonstrate the gulf between junior doctors and the administration. Trainees have left the Ministry of Health before the end of traineeships for private practice and many have cited the feeling of inflexibility, bureaucracy, and poor working conditions. Our trainees are the future and form the foundation of successive generations of doctors. It is thus extremely important to inculcate in them the right ethos of clinical medicine and the positive contributions they have to public medicine. They must be made to feel valuable members of the health service, and not exploited as warm bodies to perform onerous duties on-call or see excessive number of patients in the outpatient departments with inadequate consult times. More audits and surveys should examine our practices to ensure that our trainees are adequately trained to the highest standards and are cared for in order that they will remain as valuable members of the health care team for the benefit of the Singapore public.

In summary, the profile of a family medicine trainee appears to be a young altruistic and predominantly Chinese Christian single or married doctor living with his or her family. The trainees value ward rounds as the main teaching focus.

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A REALISATION OF PURPOSE

D Gowri

I have worked in the Family Health Service for one and a half years and during this period, I have had the opportunity to meet patients from almost every walk of life. Most of the time I have been able to put aside my patient's problems once they leave the consultation room, but there have been a few patients who have left an indelible impression on my mind.

I would like to share my experience with a young woman with a past history of unwanted pregnancies, who presented to me with an additional two unwanted pregnancies over a period of three months.

Wendy (not her real name) was a twenty year old flight stewardess and was single. She had two older siblings who were married and living apart from the family. Her father was a businessman and her mother, a housewife. Her sister was an accountant and her brother was reading Law at the National University of Singapore.

Wendy had been having an intimate relationship with a 45 year old divorcee for the past three years. Her partner had no children from his previous marriage. Wendy had had two terminations of pregnancy previously at the ages of eighteen and nineteen. The abortions were carried out by different gynaecologists at a private hospital.

THE FIRST VISIT TO THE CLINIC

I did not expect to see a young, educated, sexually active, single working woman presenting with two unwanted pregnancies consecutively over a period of three months. I may not have been too surprised if it had been a lesser educated woman from a lower socio-economic class with a limited knowledge of contraception. The crux of the problem was that my patient had a lack of knowledge about contraception an the ills of repeated abortions. The sad fact was that my patient's presenting complaint during the first visit was not to find out more about contraception but simply to check if she was pregnant. In fact, once the pregnancy test was done, my patient was prepared to leave the consultation room. It would have been very easy to let her walk out the door but my conscience dictated otherwise.

She needed advice on contraception and had to be informed about the complications of repeated abortions. I had to urge her back into the room and reassure her that my questions were not meant to offend or belittle her but rather to try and ascertain what the root of the problem was that resulted in her having repeated unwanted pregnancies. I persisted in an attempt to understand her psyche. The situation was not as simple as I had thought.

THE COMPLEX FAMILY MAKE-UP

Wendy studied in a Convent school and went on to Catholic Junior College. Her academic achievement thus far was average. She described her relationship with her parents as satisfactory until the results of her Advanced Level Cambridge examination were announced. She did not perform well enough to secure a place at the university. This proved to be a great source of disappointment to her parents as both her siblings were academically successful.

Moreover, her parents apparently felt let down when she became a flight stewardess, a profession her mother did not look upon favourably. The relationship soured further when she became intimately involved with a much older divorcee. This sequence of events isolated her from her parents. She felt that her siblings were not sympathetic either. As a result, she spent most of her time with her boyfriend away from home.

My instinctive feeling was that she was a insecure, young girl who committed herself too quickly into a relationship because she lacked emotional support at home. I was convinced that she had a certain degree of an inferiority complex especially upon noting her siblings' academic accomplishments. For the first time after a long while, she probably found some security in this relationship. It was possible that her boyfriend also provided some form of a father figure. Wendy mentioned that she left much of the decision about contraception to her boyfriend, thinking that being a formerly married man, he would make the right choice. Although I had misgivings about her relationship, it was not my prerogative to sit in judgment of her.

Wendy did express feelings of guilt over her previous abortions. She knew that an abortion should never be used as a means to an end especially when there were contraceptive methods available. She had always thought that the condom was a suitable method provided it was used on most of the occasions during which she had sexual intercourse. She did not realise that in order to be effective, the condom should be used during every sexual act.

MY ROLE AS A FAMILY PHYSICIAN

My impression of Wendy was that she not only needed advice on contraception but also needed her guilt to be assuaged. She did not feel she had any family support in this personnel matter and understandably felt alone in her dilemma. My task was to provide her with the advice and guidance she needed in a non judgmental, supportive manner.

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My first objective was to make my patient realise the complications of repeated terminations of pregnancy. I explained both the short and long term complications. Without alarming her to a great deal, I explained in detail the two complications which I felt would make the most impact on her ie uterine bleeding and subfertility. I wanted to discourage my patient from indulging in unprotected sex in future. It would have been futile to go into great detail about all the complications as they would not touch the most vulnerable part in her which was future childbearing. My patient was actually aware that repeated abortions were unfavourable but did not know the extent of damage they were capable of.

Next, I dwelled on the contraceptive methods available for her. I did not wish to overwhelm her by plunging into an in-depth review of all the various forms of contraception available for women. That would have been inappropriate. Rather, I focussed on the more suitable methods for her. I took into consideration her age, her previous abortions as well as her socio-cultural set-up. She was a young, single, healthy, sexually active woman. She needed a reliable form of contraception with a low failure rate and preferably minimal supervision.

The rhythm method as well as the natural methods such as withdrawal and periodic abstinence were not suitable because of the high failure rate of about thirty to forty per cent. The condom, if used during each sexual act had a fairly low failure rate of about ten percent However, it had failed before and I was rather hesitant to recommend it to her as I felt it may not be used as required. Depot injection of medroxy-progesterone acetate intramuscularly once every three months is more suitable for women who have had at least two children. The subdermal implant such as Norplant is a convenient, long acting, reversible method but a very common side effect is prolonged, heavy menstrual bleeding that may last up to six months. My patient's occupation rendered this method unsuitable at this point in time. The intra-uterine contraceptive device required careful patient selection. It was best suited for a woman who had at least one child and was in a monogamous relationship.

THE MOST SUITABLE CONTRACEPTIVE FOR MY PATIENT

I advised her that oral contraceptive pills were the best choice for her. She had no cardiovascular, hepatic or circulatory risk factors and the side effects were minimal and tolerable. I had to carefully broach the subject of whether her boyfriend would be keen on accompanying her as I felt that both of them might benefit from contraceptive advice. However, she was quick to point out that her boyfriend would not be comfortable discussing these details with a stranger. I could sense that she did not wish to jeopardise her relationship with her boyfriend. I respected her wishes and let the matter rest.

I felt a pang of guilt when I saw her for the second time with the fourth unwanted pregnancy. I wondered if in some way, I was responsible for this. Perhaps I had not emphasised enough about the dangers of repeated abortions or was unclear in my contraceptive advice.

After some soul searching, I realised that my obligation towards my patient was to provide her with enough information about all her treatment options. I could guide her towards making an intelligent choice but I should not consider it a failure if she did not heed my advice. She was after all, entitled to her own life choices.

My purpose at the end of the day I believe, is to maintain an open channel of communication and make myself accessible to my patient. I was glad when Wendy actually purchased the oral contraceptive pills at the clinic but this was replaced by disappointment when I realised that she had not returned to purchase any more. My wish is that she is well.

MY PERSONAL REFLECTIONS

Young single women presenting with an unplanned pregnancy are not an uncommon sight in a primary healthcare setting. Many of them harbour a tremendous amount of guilt. Not surprisingly, almost all of their family members are left in the dark. This is to be expected in our Asian society where premarital sex and unplanned pregnancies in single women is considered taboo and frowned upon. The stigma of being ostracised by the family and society is the main reason why many of these women are alone in their predicament.

Their visit to the primary health physician is very often a thinly disguised cry for help. Most of them are not aware that primary health care settings can provide comprehensive information and guidance on contraception. We have to broach the subject of contraception with sensitivity as most women would not admit that their knowledge of contraception is lacking. However, once we gain their trust, they are receptive to advice. In my patient's case, there was a need for her to re-establish her image of herself. It was important that she did not view herself as a failure. The question was whether she was ready for counselling and who was the most appropriate person to do this.

CONCLUSION

For a long time, I felt that I had failed in my capacity as a doctor. Something must have been lacking in my management which resulted in Wendy having repeated unwanted pregnancies under my care. But I have since learned to see this problem in a different and more meaningful light.

Family practice is unique in that it recognises that no family physician is an island by himself. Nor was he ever designed to be. Not every ailment can be cured with a pill or the knife. Many diseases which affect modern society like unwanted pregnancies need a concerted effort by all members in the community including the family.

They cannot be treated by good intent alone which I had mistakenly thought was enough. My patient herself was an important member of the health care team. Only time will tell if she realises this and becomes more motivated to change her lifestyle.

Cough Mixture Addiction: A Case Report

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SUMMARY

Cough mixture addiction can arise with the centrally acting cough suppressants. The case reported here highlights how the addiction problem developed in a young man and the psychosocial consequences. It serves as a reminder for careful prescribing.

Key Words: Cough mixture, codeine, addiction.

INTRODUCTION

Writing a prescription for a cough mixture when a patient complains of a non-productive cough can sometimes become a reflexive action. The issue of codeine addiction surfaces when one encounters a patient who makes recurrent visits to doctors with specific requests for cough mixture.

Patients dependent on codeine frequent casualty departments, government out-patient clinics and private clinics. The Ministry of Health has control measures for the sale of codeine compounds. There is also the problem that patients may abuse other preparations that contain codeine like paracetamol and aspirin which contain codeine with analgesics. This contributes not only to codeine addiction but the additional complication of analgesic overdose (1).

Cough mixtures have cough suppressant, expectorant or mucolytic action and are mainly used in various respiratory conditions (2). It is the cough suppressants with a central action on the cough reflex which are subject to abuse. These centrally acting agents, the morphinoid groups include dextromethorphan and other opium-alkaloid compounds or derivatives like codeine, diamorphine and methadone. Prolonged use of high doses of codeine can produce dependence of the morphine type but produces less euphoria and sedation than morphine (3). Withdrawal symptoms develop more slowly and are milder than with morphine. Other cases of cough mixture addiction have been reported and the acute and chronic sequelae of codeine use and their management have been outlined (4, 5).

This case report of a patient with cough mixture addiction is presented in the "first person" as reported by the patient as it was felt this best describes the angst of one caught in the web of addiction.

CASE REPORT

I started drinking cough mixture at the age of 15 years in Myanmar. I did it for fun and socially with my friends because it made me feel "steam" (high). It also helped me cope with an event which occurred when I was 12 years old. I was involved in a motorcycle accident in which my friend died and I suffered severe injuries. I was admitted to hospital and was seen by a psychiatrist. I experienced low mood and guilt feelings and had insomnia for about one to two years. Cough mixture was easily and cheaply available at that time as I was helping my sister who worked in a dispensary. Initially I drank about half to one bottle every two to three days but increasingly needed more. By 17, I was addicted.

When I was 20 years old, I went to Taiwan to work as an odd job worker. I left Myanmar because I felt inferior to my sisters who were successful and had all completed university education. I only completed primary school. My relationship with my parents is very poor. I sometimes tell people that my father is dead although he is still alive. In Taiwan, I stopped drinking cough mixture but drank alcohol and smoked heroin instead. I was jailed there for 2 years for heroin abuse and illegal worker status. I returned to Myanmar after this but did not work. I was drinking brandy and whiskey at that time. I subsequently spent 3 months in Thailand and a month in Malaysia. I was unemployed and used up five thousand dollars my sister gave me.
At 26 I came to Singapore to work. I had difficulty finding a job and for 2 years did odd jobs. I tried repairing cars but did not get certification. After that I worked in an electronics factory. My employer was initially happy as I was very hardworking but when I resumed drinking cough mixture, my addiction problem incapacitated me. I drank it to help me forget

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my problems and I needed increasing amounts, up to 5 to 6 bottles a day. I would borrow money and even resorted to stealing money in my desperation to get the cough mixture.

Initially I could obtain cough mixtures easily by visiting different clinics and buying over the counter in pharmacies and from traditional medicine shops. But when it became increasingly difficult I resorted to illegal means. Through friends I illegally purchased bottles for 5 to 6 dollars and at times even had to pay 10 dollars for a bottle of cough mixture. I drank all types of cough mixture but found some 'better' than others. Drinking it made me feel comfortable and happy. If I did not drink for more than a day I would start to get agitated, fidgety and hot-tempered. I also developed a "running" nose, diarrhoea and felt weak. So if I was unable to get cough mixture, I drank alcohol. The cough mixture affected my work, I forgot things, I missed meals and sometimes I just drank it till I fell asleep by the roadside. As a result I lost my wallet and identity card and have been arrested for vagrancy.

I decided to seek help because I wanted to lead a normal life. I had not sought help earlier as I was afraid of getting reported. My family refused to send me money. I have not written home for 2 years as my hands are shaky. In the last 2 years I have had 3 admissions to the psychiatric hospital. The first time I was found by the roadside by police after I had overdosed on cough mixture. The second time my friends took me to hospital because I became paranoid that they were trying to cheat me. The last time I decided to come in myself as I wanted help in overcoming my addiction.'

DISCUSSION

This patient was diagnosed as suffering from Polysubstance Dependence (Codeine Dependence) and having an underlying personality problem (6). During his first admission he was treated with an antidepressant as he had depressive symptoms. At the second admission he was prescribed a major tranquillizer chlorpromazine 100mg at night to control his paranoid symptoms. Following both these admissions he defaulted treatment. At his third admission he was prescribed a benzodiazepine which was tapered off over a short period of time. When last reviewed he was noted to be well and had not been drinking cough mixture or abusing alcohol.

The case highlights several issues in codeine abuse. Codeine addiction is often a chronic relapsing illness. History of polysubstance abuse, the premorbid personality, presence of comorbid psychiatric conditions, social and family support and importantly the patient's motivation are significant factors in the chronicity of the problems. This patient has poor prognostic factors and will need long-term counselling and supportive therapy.

Psychiatric complications of codeine addiction have been reported. These include organic brain syndrome, psychotic disorders like schizophreni from psychosis and paranoid disorders and affective episodes (7, 8).

This case serves as a reminder to practitioners of the potential for abuse of the seemingly innocuous cough mixture and reiterates the need for careful prescribing.

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General Practice in the UK

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INTRODUCTION

I had the opportunity of visiting the UK for three months to observe and study primary care provision and training in the UK. This was the first HMDP fellowship programme for Family Medicine. Attachments and visits were made to various GP practices, Postgraduate Health Education Boards, the Royal College of General Practitioners, and other relevant medical facilities in Croydon and Glasgow.

General practice in the UK is different from that in Singapore. This article is a short write up on general practice in the UK.

THE ROLE OF THE NHS

Health Care in the UK is provided through the National Health Service (NHS). This is free at the point of delivery which is different from Singapore's primary healthcare system which is essentially a fee for service system. Citizens in the UK do not pay for any medical services, as this is paid for through its system of high taxes.

The NHS implements and monitors the provision of healthcare through 100 Health Authorities. Each Health Authority has the responsibility for implementing national policy in their region. They also look into specific healthcare needs of the people in their region. The Health Authority is responsible for managing the terms of services for GPs, dentists, opticians, and pharmacists, setting and monitoring GP fund holding budgets; monitoring the quality of healthcare services; developing primary care; and overseeing patient registration with GPs.

Each Health Authority holds a budget and provides a comprehensive healthcare service to the people in the region. The Health Authorities do not provide medical services directly but 'purchase' healthcare services from the healthcare 'providers' which deliver a wide range of healthcare services to the patients. The 'providers' include general practitioners, dentists, pharmacists, opticians and NHS Trusts.

The NHS Trusts, which are self governing public corporations within the NHS, provide a full range of health services like community health services, mental health services, or ambulance services. NHS hospitals are either under the NHS Trusts or they can function as 'directly managed units' which come under the NHS directly. These hospitals provide secondary care and specialised medical services.

GENERAL PRACTITIONERS

Each GP is an independent contractor who holds a contract with the Health Authority to provide General Medical Services (GMS) to patients on their list. Each GP has a patient list and the GP is responsible for providing medical services to his patients 24 hours a day, 365 days a year. Payment is by capitation i.e. by the number of patients on their list. Additional allowances are given for achieving certain targets for health promotion, chronic disease management, vaccination, inununisation and cervical cytology. Postgraduate educational allowances (PGEA) are also given to GPs who have achieved CME targets.

Fundholding was introduced to the NHS in 1991. Fundholding practices are GP practices which hold and manage budgets independently. Using the budget, they provide primary care services and 'purchase' secondary care and other medical services for their patients. With greater control over the use of resources, GPs are more able to provide effective and cost effective care to their patients. The Health Authority is responsible for the fundholding GP contracts and monitoring expenditure against budget. Currently 35% of the GP practices in the UK are involved in fundholding.

PROFILE OF THE UK GENERAL PRACTITIONERS

In 1995 there were about 35,600 GPs in the UK. Most GP practices in the UK are multi-partner practices. Only 30% are single handed practices. Each GP has a patient list and the average patient list size per GP is about 1820 (estimated figures for 1995). Most GPs in the UK do not dispense medicine. Patients would go to the pharmacy to get their medicine. Only about 14% of GPs dispensed medicine. These are usually practices in rural areas where there are no pharmacies nearby.

In 1992-93 a GP worked at an average of 58 hours per week (including night calls) and over

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10% of the GPs worked more than 100 hours per week. The average number of consultations is about 152 consultations per week. Home visits constituted about 12.6% of these consultations.

In 1992-93 the average time spent per consultation in the clinic was about 8.4 minutes. The average time spent per GP per home visit is about 25.4 minutes (including 12 minutes travelling time). Most GP practices see patients by appointment only. Ten minutes appointment slots are given to patients. Patients would call the practice to arrange for an appointment before coming down to see the doctor. Very few GP practices have walk-in services. The appointment system allows the GP to control the workload and the consultation time more effectively. GPs also need to make house-calls for patients who are either too sick or not able to come down to the practice.

Outside-office hours, duties are either covered by the GPs themselves or by GPs on a rota basis in a cooperative or by private deputising services (locum services). The cooperative is a good concept whereby GPs within a region would pool financial and manpower resources to provide outside office hours care for their patients. GPs take turns to be 'on call' to cover each other outside office hours duties.

The main reasons for consultation are for respiratory illnesses (31%), nervous and sense organ illnesses (17%) and musculoskeletal illnesses (15%). The referral rate to secondary care is about 16%, ranging from 6.7% of 1 to 5 years old to 45% of the over 75 years old.

Almost all the GP practices are computerised. Most of the practices use the computer for registration, recall and repeat prescriptions. 29% of the practice use the computer for recording full clinical records. Larger practices make use of the computers for tasks like payroll, research and practice accounting

The average intended gross remuneration for a GP in the UK is about Ł64,000 (Pounds Sterling) per annum. This is comparable to Singapore's GP whose average remuneration is about S$120,000 per annum.

THE PRIMARY HEALTH CARE TEAM (PHCT)

GPs directly employ a number of staff to work in the practice; up to 70% of the costs for them are reimbursed by the Health Authority. These teams include practice managers, practice nurses, receptionists and other administrative or clerical staff. There are also attached staff from the Community Health Trust which provides nursing, health visiting and other para-medical support to the PHCT. These include district nurses, health visitors, community midwives and community psychiatric nurses.

Practice nurses, which are similar to our staff nurses, provide treatment and advice on asthma) blood pressure, blood tests, diabetes, dressing of wounds, diet and weight control, childhood and adult immunisations and ear syringing. Some have added special skills and knowledge and are capable of running special clinics like DM or asthma clinics.

Nurse practitioners are registered nurses with post-basic education and training. They are employed alongside GPs to manage common cough and colds and to relieve GPs of their heavy workload. Some are also involved in multi-disciplinary care e.g. diabetic clinics, asthma clinics or epilepsy clinics.

District nurses are based in clinics, GP surgeries and community hospitals. They provide a wide range of home nursing care to the elderly and mentally ill people, people at home recovering from major surgery or illnesses or those living with disabilities.

Health visitors are trained in child health, health promotion and health education. They work with families with children under the age of five and older people. They play a key role in child immunisation and developmental assessment.

Midwives specialise in uncomplicated pregnancy, childbirth and the postnatal period. Many midwives teach antenatal and parentcraft classes. They also provide counselling on antenatal screening for Down's syndrome and other conditions.

Community psychiatric nurses, physiotherapists, occupational therapists, dieticians, chiropodists, optometrists and speech therapists are also attached to the GP practices to provide additional services for the patients.

SPECIAL CLINICS

Most GPs have special clinics which provide more specialised services for the patients. These include the Well Women Clinic, Family Planning Clinic, Child Health Surveillance Clinic, Immunisation Clinic etc. Some of the practices also have a DM clinic, Asthma clinic, Hypertension clinic, and Epilepsy clinic.

VOCATIONAL TRAINING SCHEME (VTS)

All doctors who want to practice as GPs must undergo formal training. The Vocational Training Scheme (VTS) is a three year programme, which includes at least 12 months of general practice training and two years of hospital postings which include specialties like A & E, General Surgery, General Medicine, Geriatrics, Paediatrics, Obstetrics & Gynaecology, and Psychiatry.

At the end of the VTS all trainees must pass the Summative Assessment before they are allowed to practice as general practitioners. The Summative Assessment has four components which includes an MCQ paper, video assessment, trainer's report and an audit report. This is a test of minimum competence in a wide range of knowledge, skills and attitudes required for an independent practitioner in general medical practice. The main aim of the Summative Assessment is to pick out doctors who are not suitable for general practice. Counselling and career guidance are given to those doctors who fail the Summative Assessment.

MRCGP

The MRCGP is a membership examination of the Royal College of General Practitioners. It is set at a higher standard than the Summative Assessment, and almost 2000 candidates per year sit for this examination which is held twice a year in May and October. The papers are an MCQ paper, a Modified Essay paper and a Critical Reading paper. There is also a video component to assess consultation skills.

POSTGRADUATE EDUCATION ALLOWANCE (PGEA)

Previously, there was no legal requirement for doctors to continue training. In 1990, the introduction of the new GP contract, the Postgraduate Education Allowance was introduced to encourage GPs to attend CME courses through financial incentives.

A GP practitioner is paid an allowance of almost Ł2000 per annum if the doctor attends 25 days of accredited postgraduate education over 5 years They are given a reduced allowance if they fail to maintain a five year CME programme. For courses to be recognised as counting towards PGEA payments, they have to be approved by the Postgraduate Medical Boards.

THE ISSUE OF RE-CERTIFICATION

There is no re-certification of GPs in the UK yet. Re-certification is a very controversial issue. Currently both the General Medical Services Committee (GMSC) and the Royal College of General Practitioners (RCGP) are looking at models for re-certification. Work is being done to look into the controversial issues revolving around re-certification. So far there are no definite plans to go ahead with rectification, but the signals are clear enough that re-certification will certainly become a reality in the future.

ROYAL COLLEGE OF GENERAL PRACTITIONERS (RCGP)

The RCGP is the only academic organisation in the UK providing a professional network for doctors in general practice. It was established in 1952 and has worked vigorously to establish general practice as a discipline and to promote the importance of primary health care.

The RCGP works to support doctors in general practice by providing the members with up to date developments in general practice. It also develops policy and clinical guidelines for general practice and plays an important role in continuing education and training.

ENCOURAGING RESEARCH IN PRIMARY CARE

Many schemes and training progammes are organised to foster a research culture among GPs. One of the schemes is the London Academic Training Scheme (LATS). This is a one year scheme funded by the health authority to train doctors in research methodology. There is also a Research Network at the Royal College of General Practitioners which is active in the promotion of research among GPs. Currently the RCGP is looking into systemic research studies to examine causes of diseases, prevention and management of diseases in the home/family setting and to examine how illness presents and how early diagnosis and early intervention can be made.

WHAT CAN WE LEARN ?

Improving professional standards in family practice

The UK has a very well established primary care system. General Practice is recognised as a specific discipline and all doctors must undergo formal vocational training before they can practice as GPs. This has produced good quality general practitioners in the UK.

Currently the Family Medicine Training Progamme and the Private Practitioner Stream (PPS) in Singapore provide a good platform for raising the professional standards of GPs and primary care doctors. To date (1997) some 63 doctors have graduated with a Masters degree in Family Medicine. This is still a relatively small number. We must continue to upgrade the training programme and encourage more primary care doctors to take up the programme. With time, we will definitely see the numbers growing and a better quality of family practice in Singapore.

CONCEPT OF THE FAMILY PHYSICIAN

The concept of having a single family physician is well illustrated in the UK system. The patient sees his/her GP, who is responsible for providing and coordinating medical care for him/her. The GP is thus able to provide good continuity of care. The gate-keeper role of the GP also restricts excessive utilisation of secondary or tertiary care which is generally considered as high cost medical care.

We need to emphasize the concept of the family physician in Singapore. Patients need to be educated on the importance of having a regular family physician as it will improve the contnuity of care. Patients would also derive greater satisfaction of seeing his/her family doctor who is the doctor who knows them best. The GP should be seen as the coordinator of healthcare services, providing good primary care and coordinating secondary care for his/her patients. Giving the GPs the gate-keeper role would also optimise the usage of secondary and tertiary care. This would help reduce health care spending.

TEAMWORK AND COOPERATION

GP practices in the UK are similar to the government polyclinics and bigger group practices in Singapore. Doctors, nurses and other clerical staff work together as a team to provide a comprehensive range of services to the patients.

Most of the GP practices in Singapore are on a much smaller scale and are mostly single handed practices. The GP has to do most of the clinical work. He/she is also the manager and administrator. The clinic staff are usually not professional nurses but clinic assistants who are trained in registration, record searching and dispensing.

With increasing property prices and operating costs in Singapore, it is becomng more difficult for GPs to survive as single handed practices. GPs need to explore ways of working together cooperatively rather than competitively. Perhaps some form of cooperative or group practice may eventually become more prevalent in Singapore. With economies of scale, bigger practices or cooperatives are financially and operationally more flexible and effective in the delivery of medical care.

CONTINUING MEDICAL EDUCATION (CME)

Medical science and technology advances rapidly. GPs need to constantly upgrade their knowledge and skills. In the UK, financial incentives are provided to encourage GPs to be more involved in continuing medical eduation. A wide range of training programmes are provided for GPs in the UK.

In Singapore, CME participation is voluntary and there is no added advantage in fulfilling CME requirements. Hence, there is little incentive for doctors to involve themselves in CME. We need to develop a culture of continuing education among GPs. Perhaps some form of financial incentive scheme can be introduced in Singapore to encourage greater participation in CME.

There is a move towards re-certification worldwide. It is important to further develop the CME programme in Singapore with a view towards re-certification. Rectification is better professionally led than being imposed on. GPs need to take a proactive approach in this issue.

The College of Family Physicians Singapore should continue to take a leading role in providing and coordinating better CME programmes for GPs in Singapore. Courses with emphasis on clinical skills would also enhance the GPs' professionalism and expertise.

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These Information Sheets can be obtained through the Information Service Section of the RCGP, or viewed on the RCGP's Web site: http://www.rcgp.org.uk

Side Effects of Commonly Used Drugs - Part I

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SIDE EFFECTS OF NSAIDs

Although aspirin and its salicylate congeners are also technically NSAIDs, the term is usually reserved for the nonsalicylate nonsteroidal anti-inflammatory agents. NSAIDs inhibits cyclo-oxgenase, a key enzyme in prostaglandin synthesis. Most adverse effects are related to this property.

Gastric Ulceration and Bleeding

Gastric mucosa integrity depends on gastric prostaglandin activity and can be compromised by an NSAID. This can result in dyspepsia, abdominal pain, peptic ulceration, upper GI bleeding and gastric perforation. The risk of clinically important ulceration is estimated at 2-4% per patient year of NSAID use. About 15% of chronic NSAID users demonstrate gastric ulceration at endoscopy. Risk generally increases with dose and duration but up to one quarter of complications occur within the first month of therapy. The elderly are at greatest risk with a relative risk of 4. NSAIDs should be used with care and at the lowest dose in the elderly. There may be no warning symptom preceding severe bleeding or perforation.

Renal Injury

The injured underperfused kidney is dependent upon prostaglandins as an important regulator of renal blood flow. NSAIDs may lead to fluid retention, diminished sodium excretion and aggravate renal impairment.

Situations of inadequate renal perfusion include CCF, dehydration, advanced age and use of potent diuretics. Renal injury may develop after only a few days of therapy but is reversible if NSAIDs are promptly stopped.

A case in point is a patient having hyperuricaemia and gouty attacks. Initially, the S. creatinine was not done and the patient was treated with NSAID. On one visit it was found that the S. creatinine was raised to 300μmol/l. The NSAID was immediately stopped. The questions here were: Did the NSAID aggravate the renal failure or was it due to hyperuricaemia ? Or was it a renal failure at first with subsequent hyperuricamia due to azotemia ? In this case aspirin may be better as no nephrotoxicity has been reported with high dose aspirin use.

Many of our patients on NSAIDs are elderly patients with chronic OA of the knees. A checklist should include: Have you checked renal function ? Have you checked his blood pressure ? Did you ask for symptoms of GI bleeding ? Did you check for pallor and anaemia ?

Monitoring serum creatinine is advisable particularly in high risk patients. If the movements of the knees are not painful, is it necessary to treat ? Can a simple drug be used instead ? Can we spend more time counselling the patient on non-drug measures or to accept the discomfort and use the NSAID only sparingly ?

Mental Impairment

The elderly are particularly susceptible to mental impairment caused by NSAIDs. The next time you see an elderly patient on NSAIDs presenting with alterations in cognitive functions, mood or personality, think of NSAIDs as a possible cause. This is especially so with NSAIDs like indomethacin which crosses the blood brain barrier. Confusion, poor memory, irritability, depression, lassitude, insomnia and even paranoid behaviour may develop. Minor neurologic illness like headache, dizziness, light-headedness are seen in patients of all ages. The take home message is to manage medical conditions without drugs as often as possible in the elderly.

NSAIDs, Antihypertensive Agents and Loss of Blood Pressure Control

It is common for patients seen by primary care physicians to be taking both NSAIDs and antihypertensive agents. If blood pressure control diminishes in these patients, the possibility of NSAIDs causing this should be considered. Although the increase in blood pressure secondary to NSAID may be only 5-10 mm Hg, this increase may be enough to justify a change in medication.

The following have been recommended[2]: (1) Blood pressure should be monitored frequently when NSAIDs are combined with diuretics, beta-blockers or ACE inhibitors. (2) It appears that NSAIDs may be used with calcium antagonists without an effect on blood pressure control. (3) Indomethacin, the most potent prostaglandin inhibitor appears to alter blood pressure control to a greater extent than weaker agents, such as sulindac. (4) NSAID use should be evaluated before starting its use in an hypertensive patient, before increasing the dosage of an antihypertensive agent and before adding an additional antihypertensive drug. (5) If patients have lost blood pressure control while taking an NSAID / antihypertensive combination, paracetamol may be considered as alternative therapy since its does not alter prostaglandin synthesis and therefore should not attenuate antihypertensive efficacy.

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A Consultation Model:

How to maximise the exceptional potential in every doctor-patient contact using the Stott-Davis Practice Model

E Yong

Introduction

All too often in clinical practice, one comes away from a day's work with feelings of dissatisfaction, of how one could have done better or more for the patient given our rigid time constraints. Adding on to this, one's day may also be marred by unpleasant patient encounters and the extreme discomfiture they engender in us as their doctors.

To help us address these issues, we started the Family Medicine tutorial series with these topics:

1. How to maximise the exceptional potential in every doctor-patient contact using the Stott-Davis practice model: and

2. How to identify the difficult patient.

THE STOTT-DAVIS MODEL

What is the Stott-Davis Model?

The Stott-Davis Model describes the possible scope of a family medicine consultation, which includes the following:

A Management of Presenting problems
B Modification of help-seeking behaviour
C Management of continuing problems
D Opportunistic health promotion

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Area A Management of Presenting Problems	**Area B** Modification of Help-Seeking Behaviour
Area C Management of Continuing Problems	**Area D** Opportunistic Health Promotion

Fig. 1: Diagrammatic Representation of Stott-Davis Model

Objectives of Stott-Davis Model

It was intended for use as an aide-memoire, hence its simplicity. The author's objectives for the framework are:

1 To provide a theoretical base from which a practitioner can develop the full potential in any primary care consultation.
2. To highlight some unique features of good primary care.
3 To provide a basis for teaching in primary care which is simple enough for the undergraduate but equally valid for the postgraduate when more detailed knowledge and skills are acquired.
4 To allow the philosophy, principles and research achievements in comprehensive care to be discussed within a simple patient-centred framework.

The Traditional Approach: Management of Presenting Problems

Traditionally, the emphasis has been always on diagnostic and therapeutic processes at hand i.e. the presenting problem (area A, Fig. 2).

Area A Management of Presenting Problem	**Area B** Modification of Help-Seeking Behaviour
Area C Management of Continuing Problems	**Area D** Opportunistic Health Promotion

Fig. 2: Current Emphasis of Clinical Practice

The "Added Touch": Management of Continuing Problems

Good primary care should take into account the importance of combining clinical acumen with insight into human behaviour and development to better understand the patient's problems. In order to achieve this, it is important to have a complete view of the patient which includes a knowledge of any other ongoing problems (area C, Fig. 3), his family and environment. However, many doctors are loathe to consider this, as it is more time-consuming and demanding on the consultation process. Possible aids that may alleviate the problem comprise the upkeep of good medical records and the use of ancillary staff to 'free' consultation time.

Area A Management of Presentg Problems	**Area B** Modification Of Help-Seeking Behaviour
Area C Management of Continuing Problems	**Area D** Opportunistic Health Promotion

Fig. 3: A More Complete View of Patients' Problems in Clinical Practice

The Importance of Opportunistic Health Promotion

Area D (fig. 4) shows how Stott and Davis view the consultation as a unique opportunity to promote healthy lifestyles and for the early pre-symptomatic diagnosis of disease. This embraces modern understanding of disease pathogenesis in that many diseases have their origins in the lifestyle of individuals. Several studies also bear this fact:

1. Patients and their families are often very receptive to advice from the doctor or nurse at the time of consultation. (Russell 1971; Truax and Mitchell 1971; Stott 1976; Eiser 1977)
2. One-to-one discussion is widely recognised as one of the most successful strategies in producing health-related behavioural changes. (MacQueen 1975)
3. Future improvements in major causes of morbidity and mortality are more likely to come through modification of lifestyle than through legislation. (Bellac 1973)

Area A Management of Presenting Problems	**Area B** Modification of Help-Seeking Behaviour
Area C Management of continuing Problems	**Area D** Opportunistic Health Promotion

Fig. 4: The Importance of Opportunistic Health Promotion

Unfortunately, many doctors are reluctant to use their influence to "preach" and some may even become resentful if the advice proffered is not followed ! Nevertheless, the author maintained that as a caring profession, one should not withhold knowledge and influence to help patients make better-informed choices about their lifestyles.

Using the Consultation to Influence Patient's Help-Seeking Behaviour

Area B (fig. 5) embodies the assumption that each consultation may in some way influence the patient's future help-seeking behaviour and that recognition of this fact should lead to better care. The model seeks to highlight the need for every clinician to consider his management plan takes cognizance of future behaviour. Each symptomatic prescription is a ticket to reinforce the patient's belief that the doctor has a solution for every minor aliment and as such, sets his expectations for the next consult. And so, the vicious cycle is begun.

Area A Management of Presenting Problems	**Area B** Modification of Help-Seeking Behaviour
Area C Management of Continuing Problems	**Area D** Opportunistic Health Promotion

Fig. 5: Influencing Patient's Help-Seeking Behaviour

This four-point framework was first proposed in 1979, but it remains relevant and highly applicable to every clinical consult in comprehensive primary care.

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The Difficult Patient

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The difficult patient is defined as one whose goal for the consultation is at variance with that of the doctor. The key subjective manifestation is one of the chronic dissatisfaction with the medical care received, despite the adequacy of treatment.

There are 4 clinical categories:

1. Oppositional - the patient who could but does not follow instruction.
2. Manipulative - the patient who manoeuvres the unknowing doctor into gratifying some pathological need.
3. Hostile - the patient who is endlessly critical and dissatisfied.
4. Malingering - the patient who deliberately deceives the doctor by feigning illness. He usually has sociopathic personality.

The important point to remember, before classifying a patient as difficult, is that the problematic behaviour must be repetitive. The doctor should rule out other possible causes: these include problems within the physician, the real possibility of undiagnosed physical illness in the patient, contributory problems within the medical environment and non-medical problems in the patient's life.

How to deal with the difficult patient

The cultivation of a clear awareness within the doctor of the dynamics of the doctor-patient relationship is central to minimising problems. Some useful steps that one can take are:

1. Inform the patient that his behaviour is causing difficulty - this should be expressed as "We have a problem" as opposed to "He" has a problem.
2. Point out disruptive behaviour and express a desire to understand and seek solutions for it.
3. Provide a warm and caring atmosphere throughout the contact with the patient.
4. Have a close follow-up initially to allow adequate time to discuss issues.
5. To not hesitate in the referral of cases that require psychiatric care if need arises. In these cases, to cultivate highly structured relationships with clearly defined goals.

With these points in mind, hopefully, the doctor-patient relationship will be one of a therapeutic alliance (as it was meant to be) and perhaps not just for the patient himself.

A Psychosomatic Case

W Soon

Mdm Teo is a 70 year old Chinese lady. She has no significant past history of note except for an operation for uterovesical prolapse more than twenty years ago.

She was seen in 1993 for diarrhoea and abdominal cramps which occurred once in a few months. She requested an X-ray and wanted a specialist referral. A barium enema was done which was normal and the patient was duly reassured. She also presented repeatedly for a right ear problem - Jul 93 (earache), Nov 93 (ear itch), Oct 94 (ear itch), Nov 94 (ear pain). Examination performed at each visit was normal and the patient was reassured. However, the patient presented in March 95 for deafness and auroscopy revealed a polyp. In view of this, the patient was referred to an ENT specialist. She was seen for a total of 3 visits, and informed that there was no abnormality and was subsequently discharged.

In July 97, she had complaints of giddiness, right breast pain and "movement" in the perineum. She expressed worry over the possibility of a recurrence of her UV prolapse. Examination and basic investigations which included FBC, U/E and ECG were all normal. Throughout the consultation, Mdm Teo appeared rather anxious, tense and preoccupied.

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Discussion

In this case that Mdm Teo was probably bothered by something that she did not want to reveal. She instead presented with multiple and varied complaints over a period of time.After further questioning, it was finally revealed that Mdm Teo had been having sleepless nights worrying about her youngest daughter who is mentally deficient. In view of her advanced age, she was afraid that when she dies, there would be no one to care for her daughter. She had previously approached her eldest daughter who initially agreed but subsequently changed her mind. Her concern was that if she had any cancer or other serious medical problems, she would die with "unfinished business". She was subsequently referred to the social worker for counselling.

My Learning Points

1. It is important to remember that psychosocial problems can present as sonutizing medical problems. A myriad of physical symptoms are brought up to the doctor that have their root in the patient's poor mental wellbeing. As doctors, we must learn to pick up on the "hidden agenda".

2. As illustrated by this case, 'no man is an island'. Hence, if the problem does not directly involve the patient herself, the next step would be to inquire into the condition of her family, work or environment. This proved to illuminate the problem.
3. In view of the patient's age, it is prudent to be aware of possible underlying medical problems, eg cancer, which can present atypically. In other words, we must never dismiss any patient who presents to us with a variety of vague, complicated symptoms as being a "difficult - psychosomatic" patient. One of the strengths of the general practice setting is our follow-up system. Close and regular follow-up can be arranged as disease conditions may evolve with time.

The Demanding Patient - A Case Illustration

E Tan

A 45 year old lady, accompanied by her husband, came to the clinic with a complaint of a chronic sorethroat over the past one year. A preliminary search for possible associated symptoms and physical examination were unremarkable. What was thought striking at that time was the dynamics of the patient-doctor interview. The patient herself appeared timid and anxious. When a question was posed to her, it was often answered by her husband who was very assertive.

Sensing the somewhat lopsided balance of power in the husband-wife relationship, and reading as the main problem the need to tackle the wife's high anxiety state, reassurance was given about her symptoms. A trial of symptomatic medication was offered. However, this management plan was met with some resistance, and a prompting from her husband to his wife to bring up her symptoms of "dysphagia". An ENT referral was requested.

The dysphagia was also of a year's duration, with symptoms more suggestive of a functional cause than an anatomical one. Bearing in mind that this was a diagnosis of exclusion, medication was offered with a review suggested in 2 weeks to reassess her symptoms, with a view to a referral then if necessary. After some discussion, the patient agreed and left the room.

Five minutes later, the husband entered the clinic during the next patient's consultation, shouting that they be given an ENT referral immediately. Although aware that it had been a difficult interview, the sudden rise in aggression was unexpected and upsetting. He refused further discussion, and an ENT referral was made.

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My Learning Points

1. The patient we deal with may come with family members and a whole host of social pressures and not merely medical issues. The family member may be the difficult one rather than the patient himself/herself.
2. Be aware of a hidden agenda. Here, the hidden agenda was an ENT referral. By the time it was brought into the open, the fuse had blown.
3. While dealing with over-dominant partners/accompanying friends or relatives, separate interviews may be more conducive. The wife may then have opened up, and the consultation may have gone more smoothly.
4. A second doctor could have been consulted to add weight as a second opinion, and eased concerns.
5. What symptoms would cause worry would understandably differ according to each doctor's perception. A good guiding principle to go by would be to treat one's patients as one would treat one's relatives. Looking back at this case, perhaps a referral should have been made more readily in the first place, given the long period of symptoms.
6. Sometimes, despite the best of intentions, one's actions or management may be deemed unsatisfactory by the patient or his/her relatives. Although there are certainly some "no-win" situations, one hopes that these are actually fewer than one thinks. It is never necessary to fight fire with fire.
7. Perhaps, with greater sensitivity and tact, as well as the "sixth sense" that comes from experience, one could, one day, see the "demanding patient" as someone in need and dig deep into oneself for the compassion and empathy.

Minor Operation in Ophthalmology: Management of Chalazion

Dr T H Lim, Dr H B Fam, Dr W J Heng, Dr T Y Siaw

1 INTRODUCTION

Chalazion is the accumulation of myxogranulomatous degenerative material in the Meibomian gland within the tarsal plate of the eye-lid. When it is infected, it is termed as internal hordeolum.

2 MANAGEMENT

2.1 Non-surgical Management

In general, a small chalazion may be managed by warm compress (for 5 minutes) followed by scrubbing of the lid margin with baby shampoo and application of topical antibiotic drops and ointment (eg Gutt Chloramphenicol qds and Oc Tetracycline bd). Up to 50% of chalazia may be resolved with non-surgical management which is particularly apt for small chalazia with ill-defined borders.

2.2 Surgical Management

Incision and curettage of chalazion releases the accumulated myxogranulomatous material from the Meibomian gland lesion and breaks up any septae or locules within it.

Careful examination of the chalazion allows the doctor to decide between cutaneous incision and tarsal conjunctival incision. The former approach produces a scar (usually fine and inconspicious, hidden within the lid crease). Though uncommon, keloid formation may occur. Hence the tarsal conjunctival approach is generally preferred unless the lesion is pointing. The cutaneous approach is also indicated if the chalazion is so large that eversion of the lid may be difficult and painful.

Topical anaesthetic agent (Gutt Amethocaine 1% or Gutt Proparacaine 0.5%) is applied if the conjunctival approach is chosen. After preparing the surgical site with Chlorhexidine (1:2000) scrub and draping, subcutaneous lignocaine (1-2%) is injected around the chalazion. Firm massage is applied for a minute to enhance the spread of the anaesthetic agent.

2.2.1 Conjunctival Approach

The exact site of the lesion is confirmed by palpation. The Chalazion clamp is applied with the open side facing the eye. The lid is everted using the edge of the tarsal plate as a fulcrum. The chalazion may be recognised transconjunctivally as an area of greyish discolouration or erythema. Incision is made vertically, perpendicular to the lid margin. If little or no myxogranulomatous material is expelled, parallel cuts 1 to 2 mm to each side of the initial incision may be made, often with success. Curettage is then performed to remove any remnant content and fibrous septae.

2.2.2 Cutaneous Approach

The Chalazion clamp is applied with the open side facing externally. An incision is made horizontally parallel to the lid margin. Curettage is similiarly performed.

2.2.3 Post Surgical Management

The patient is instructed to apply firm but not excessive pressure on the surgical wound for 15 minutes for hemostasis. Oc Tetracycline is applied to the lower conjunctival fornix. The eye is padded lightly for about 6 hours. Topical antibiotics (Gutt Chloramphenicol qds and Oc Tetracycline bd) are prescribed for one to

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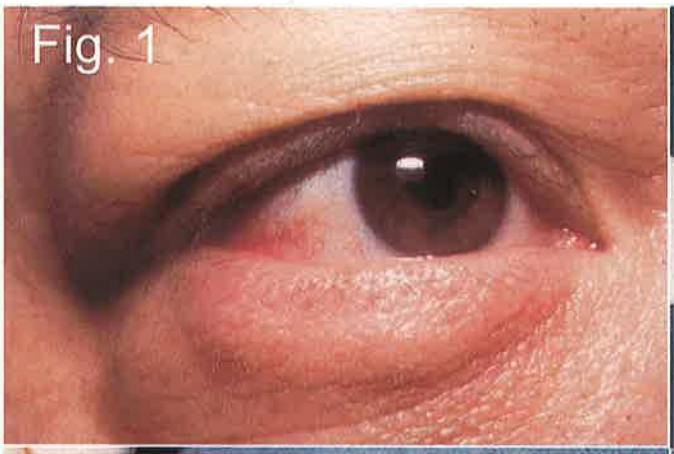

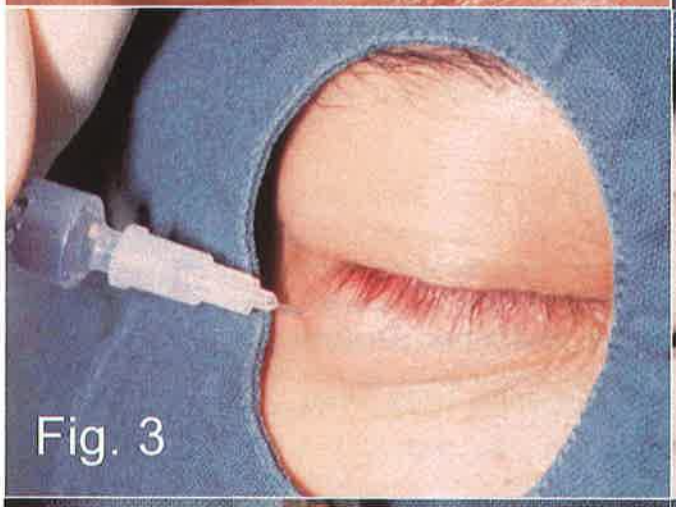

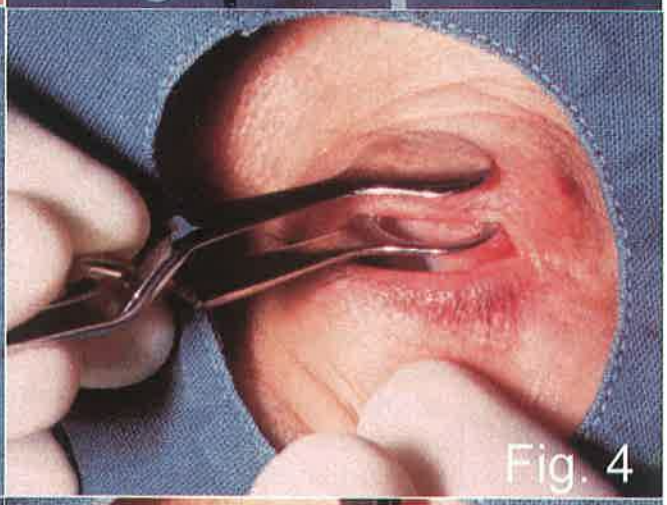

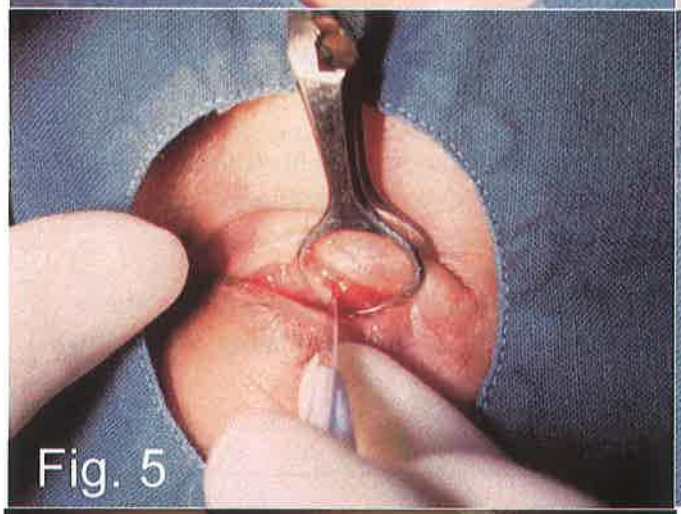

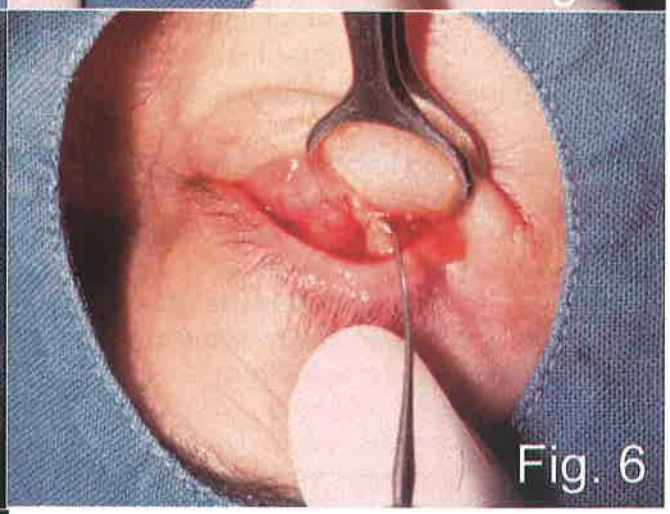

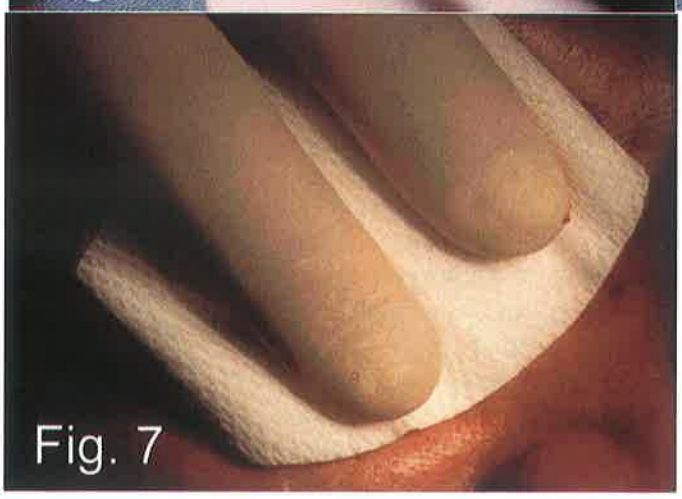

Fig. 1 Rt lower lid chalazion
Fig. 2 Instrument
Fig. 3 Inject 2% lignocaine
Fig. 4 Apply chalazion clamp
Fig. 5 Incision with BK no.11
Fig. 6 Currettage
Fig. 7 Apply firm pressure

(Fig. 4-6 Surgeon's view)

Incision & Currettage of Chalazion

two weeks. In general, oral antibiotics are not necessary.

2.3 Infected Chalazion (Internal Hordeolum)

The management is surgical, though the procedure is usually more painful due to the inflammation. Pre-treatment with oral antibiotics (Ampicillin and Cloxacillin) for 2 days may reduce inflammation and pain during surgery but is only possible if the lesion is not pointing. Continue oral antibiotics for 1 to 2 weeks after surgery.

3 INSTRUMENTS USED

1 Dental syringe with 30s.e.g.needle or the smallest gauge needle available
2 Gutt Amethocaine 1% or Gutt Proparacaine 0.5%
3 Chalazio Ring Forcep (blepharostat)
4 Chalazion curette (various sizes)
5 Scalpel blade size 11
6 Scalpel handle size 3

For old cyst:

1 One pair iris scissors (11.4 cm) curved
2 One pair fine-tooth Adson dissecting forceps (12 cm)

My experience with chalazion:Practice Tip

Comments by Dr Siaw Tung Yeng

(i) Adequate anaesthesia is essential. Wait for the LA to act and inject a little local anaesthetic agent into the cyst itself using the smallest gauze needle available.

(ii) Make a vertical incision for conjunctival approach and horizontal incision for cutaneous approach. This will not only be cosmetically acceptable but will also provide good homeostasis.

(iii) Adequate pressure with the ring forcpes will ensure a near bloodless field. Avoid too tight a clamp so as not to cause discomfort to the patient.

Management Tips (I)

HSS Leong

The practice of medicine is always fascinating. No two patients have the same set of problems. To adequately help a patient solve his problems be they organic, psychological, or social, one must strive to put oneself in the patient's shoes. The busy doctor's wish is a patient who agrees to every investigation or treatment prescribed to cut down consultation time used in a lengthy explanation ! However, patients have different perceptions and views and they do have their rights.

Non-compliance with medication or other treatment procedure is one area in which we can deal with effectively if we know the underlying reasons. Exploring these issues in a non-judgmental, non-critical manner and a tactful, caring attitude goes a long way towards making the patient less defensive and more open in disclosing his reasons for non-compliance.

Understanding a patient's social concerns and environment is important in formulating treatment plans which are suitable and appropriate. The physician needs to see the person within the patient and not give him label such as 'diabetic' or 'hypertensive'. The 'non-compliant patient' can be 'interesting' when one considers the social context and the reasons behind his non-compliance.

a) Educating the patient in stages

While making the right diagnosis is important, it is equally essential as part of the management of any patient that he understands his disease condition before he is able to appreciate the relevance of investigations and procedures involved during the process of treatment. Information must be given in a manner appropriate to the patient's level of understanding. This may have to be done in stages over several consultations. Giving too much information within one consultation may overwhelm the patient. Opportunity must be created for the patient to ask questions.

b) Denial of disease

Denial is very often a form of coping by the patient before he eventually accepts the diagnosis. It often leads to delay in seeking treatment which in turns delays appropriate diagnosis. The patient may 'doctor-hop' in an attempt to look for a different view or opinion. He may also seek help from healers using unorthodox treatment. Diagnosing an illness which has a significant impact on the patient's subsequent lifestyle is frequently devastating news for the patient and time is needed for the patient to accept the diagnosis and subsequent management. Patience and assurance that the doctor or his health care workers will be available to assist the patient will help to allay the fears and anxiety a patient encounters.

c) The doctor-patient relationship

Poor rapport between the doctor and patient hinders the management process of the patient. A patient who perceives the doctor as being uncaring, rude or impatient is unlikely to return for subsequent consultations. A doctor who is not able to instill trust in his patients will not succeed in persuading his patients to comply with treatment. Honesty, sincerity, integrity, empathy, appropriate dressing, decorum and ability to carry himself well will go a long way to help the doctor develop confidence in his patients. Needless to say, he must constantly keep himself updated with medical knowledge and skills. Finally, a patient who is involved in the decision-making process concerning his treatment is more likely to carry out what he has earlier agreed or decided to do !

Further discussion on management tips will continue in the next issue of Singapore Family Physician.

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Open Randomised Trial of Prescribing Strategies in Managing Sorethroat

Source : BMJ 1997; 314 : 722-7

Authors : P Little, I Williamson, G Warner, C Gourd, M Gortley, A L Kinmonth

Sorethroat is one of the most common presentations of upper respiratory illness presented to general practitioners. This is a randomised follow-up study to assess the outcome of three common plausible strategies in the management of patients with sorethroat. It involved 11 general practices in the south and west regions of Britain.

The trial recruited 716 patients aged 4 years and above with sorethroat and an abnormal physical sign in the throat. Patients were randomised into 3 groups: (I) Antibiotic prescription for 10 days (Penicillin V 250 mg qds or Erythromycin 250 mg qds). (II) No prescription and (III) Delayed prescription i.e. prescription for antibiotic if symptoms did not settle after three days. Diary or phone responses were obtained in 582 patients (81%).

The following results were obtained:

1 69% of patients in group III did not use their prescription.
2 The proportion of patients better by day 3 did not differ significantly (37% vs 35% vs 30%; p 0.28)
3 No significant difference in duration of illness (median 4 vs 5 vs 5 days; p 0.39)
4 No significant difference in patients' satisfaction (96% vs 90% vs 93%; p 0.09)
5 No significant difference in days off work or school (median 2 vs 2 vs 1 day; p 0.13)

More patients in group I thought the antibiotics were effective (87% vs 55% vs 60%; $p < 0.001$) and intended coming to see doctors in future attactks (79% vs 54% vs 57%; $p < 0.01$)

Legitimation of illness - to explain to employer or school (60%) or family or friends (37%) was an important reason for consultation.

The authors concluded that for most patients with sorethroat presenting to general practitioners, antibiotics only marginally affect the resolution of symptoms. Even after one consultation, prescribing antibiotics significantly enhances belief in antibiotics and intention to consult in the future. Psychosocial issues are important. Legitimation of illness is an important reason why people consult their general practitioners and satisfaction is strongly related to effective management of patients' concerns. Hence, doctors should address patients' concerns in simple sorethroat and avoid prescribing antibiotics indiscriminately.

Review by C J Ng

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Primary and Secondary Stroke Prevention

Source: Current Opinion in Neurology 1996, 9:46-52

Author: W Friedman

This article summarises the modifiable risk factors associated with an increased risk of stroke.

Hypertension was identified as the most important, prevalent and treatable risk factor with a relative risk of 4% to 5%. Smoking carried a relative risk of 1.5% to 3%, with light smokers reverting to the risk of non-smokers on cessation of smoking. Other risk factors amenable to primary prevention of stroke are diabetes mellitus, alcohol abuse and atrial fibrillation. The relative risks are 1.5 to 2%, 1 to 4% and 5 to 7% respectively.

It was noted that patients with non-valvular atrial fibrillation (AF) had a stroke risk of 5% per year. Warfarin has been shown to reduce this risk by 70%. Stroke risk is not uniform in all AF patients. Independent risk factors in patients with AF included history of stroke or TIA (transient ischemic attack), diabetes mellitus, hypertension, increasing age, congestive heart failure and coronary artery disease. Recommendations had been issued whereby Warfarin was prescribed for patients with risk factors; those of a younger age group and no risk factors received either aspirin or no treatment. Anticoagulants are effective for secondary prevention of stroke in patients with a cardiac source of embolism.

Antiplatelet therapy is effective in secondary prevention of stroke and in primary prevention in high risk patients. The relative merits of aspirin and ticlopidine continue to be debated.

Carotid endarterectomy has been shown to be effective for patients with TIA or stroke and 70% to 90% carotid stenosis, and in asymptomatic patients with high grade stenosis if the surgical risk is low, i.e. less than 3%.

There remain areas of uncertainty. These include the role of estrogen in stroke prevention, aspirin as primary prevention, the optimal dose of aspirin, the relative merits of the antiplatelet agents, aspirin for patients with AF and Warfarin in non embolic stroke.

Comments:

Patients with diabetes with atrial fibrillation in the presence of independent risk factors should be put on Warfarin to reduce stroke risk. The family practitioner should have a high awareness of the risk of stroke in their patients by taking into account the combined risk factors present and initiate appropriate therapies for prevention.

Review by K T Goh

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Tropical Fishes As A Hobby

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The motto of a hobby is to have fun, enjoy yourself and to get caught up in the moment at hand. As doctors, we need the diversion provided by a pleasing, enjoyable hobby (eg rearing tropical fishes) if we expect to maintain any shred of visible sanity. Keeping tropical fishes is a most enjoyable and relaxing hobby you can ever have. Admire and be thrilled by the variety, colour, shapes, movement and the whole aquascape that you have designed.

You can have a tank at the reception counter and in the consultation room (like what I have). If you acquire the right equipment and fishes, only very little maintenance is required. You certainly don't need to change the water once a week with hi-tech filtration nowadays.

Many people have pre-conceived ideas that it is difficult to maintain a tank of beauties. But it must also be emphasised that to succeed, one must understand the requirements of the fishes and their health hazards.

Requirements refer to specific water conditions that mimic the natural habitat of fishes. Guppies and Goldfish thrive well only in hard (mineral-rich) water, whereas Tetras and Discus love soft (mineral-poor) water. There is a need to know about general and carbonate hardness as well as the pH of water.

Before embarking on keeping fishes one must understand the conditions that can be detrimental/ fatal to them. I classify these broadly into two categories: chemical & pathogens. Usually the fatal diseases are due to chemicals in the water like the build-up of ammonia and nitrite (by-products of metabolism). The detoxifier is the biological part of the filter that employ millions of decomposition bacteria to breakdown the forementioned chemicals to less toxic substances like nitrate.

Diseases by pathogens are predominantly the result of poor water quality as a consequence of inefficient/poor filtration and poor maintenance. Never believe anyone nor any company that there is a 'self-cleansing' system.

Recently, many homes and offices have installed 'plant tanks' that are beautifully landscaped. These aquariums can be stunningly beautiful to behold, but the cost and maintenance are high. They all use sophisticated CO2 fertilising equipment (you can learn from me!).

As regards to cost, it ranges from twenty dollars to fifteen thousand dollars. For most beginners start with a tank less than 2 feet and buy a power filter. The total cost should be less than $150.00. Don't buy acrylic tanks as they scratch easily.

Finally, having aquariums at home or in the clinic also broadens and deepens your knowledge on the various geographical regions/localities of the world where these fishes come from. It will also enable you to appreciate the biodiversity of the aquatic environment.

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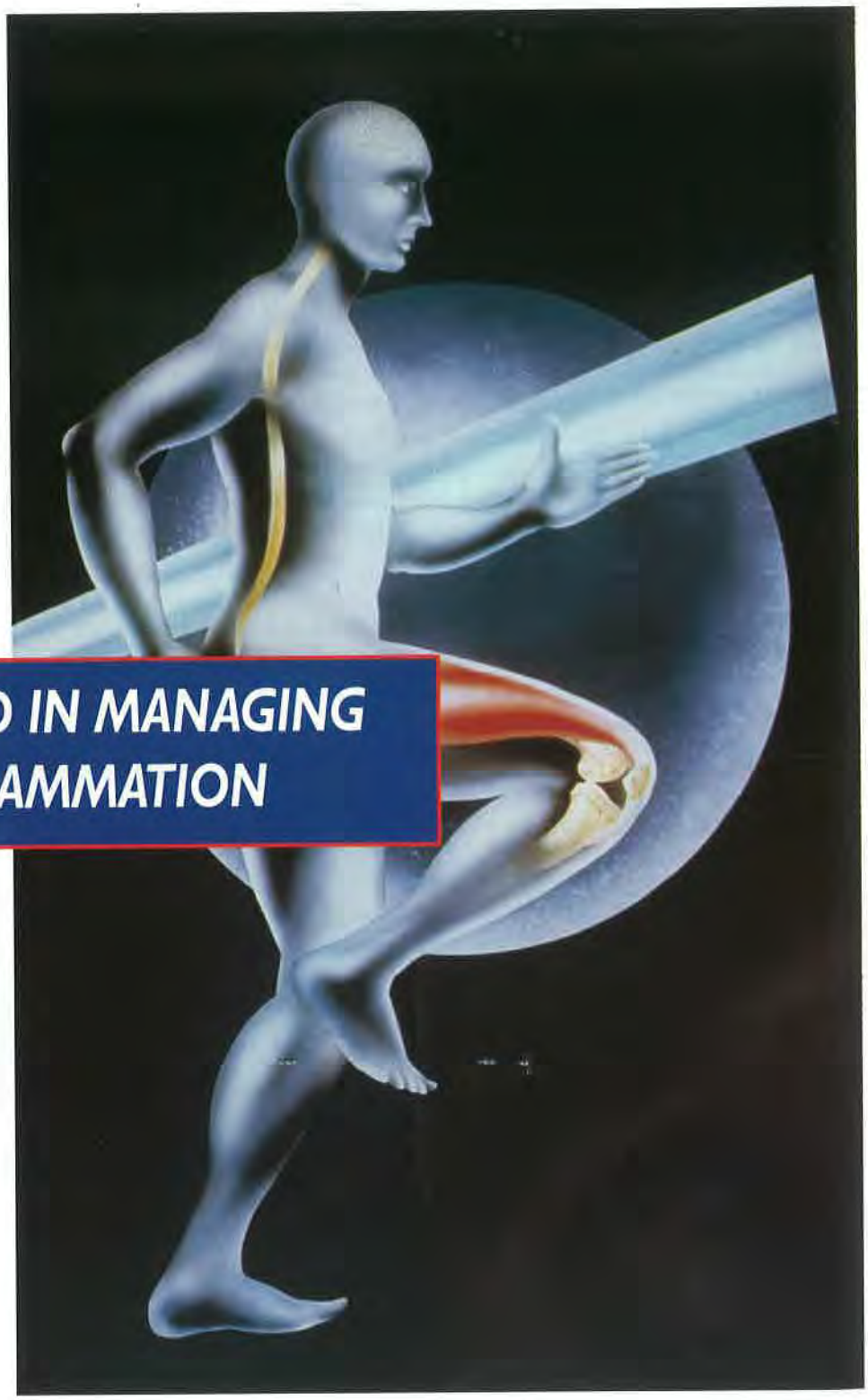
Current concept strongly supports a dual approach to the effective management of pain - peripheral & central.

The peripheral action of [Orudis/Oruvail] is well known and recent studies also confirm its central analagesic effect[1-4].

Orudis/Oruvail is available in various formulations to effectively control the various types of pain from acute to chronic.



FURTHER AHEAD IN MANAGING PAIN & INFLAMMATION

FURTHER AHEAD
KETOPROFEN

Orudis E-100 IM Inj
Oruvail Capsules Gel

PRESCRIBING INFORMATION

PROPERTIES : Ketoprofen is a non-steroid anti-inflammatory drug of the propionic group, derived from aryl-carboxylic acid. Ketoprofen possesses an anti-inflammatory, analgesic and antipyretic action; it inhibits the synthesis of prostaglandins and also has an inhibiting activity on platelet aggregation. *INDICATIONS* : Indications are as follows :- Long term symptomatic treatment of: chronic inflammatory rheumatism particularly rheumatoid polyarthritis, ankylosing spondylarthritis or related symptoms such as Fiessinger-Leroy-Reiter syndrome and psoriasic rheumatism; certain painful and disabling osteoarthritis. - Short term symptomatic treatment of acute attacks of : abarticular rheumatism (acute painful shoulder, tendinitis etc.) , microcrystaline arthritis, osteoarthritis, lumbago, severe radiculalgia. *CONTRA-INDICATIONS* : Known allergy to ketoprofen and to substances with similar activity : asthma attacks have been observed in certain patients, especially in patients allergic to aspirin. - Gastro-duodenal ulcer, severe renal and hepato-cellular insufficiency. - Pregnancy: possible teratogeneous risk during the first three months and, during the final three months, possible retardation during labour, premature closure of arterial duct and possible hemorrhage in the newborn infant. - Nursing mothers: in the absence of pharmacological data, ketoprofen is not indicated for nursing mothers. - Children under 15 years of age. *WARNING* : Gastro-intestinal side effects may be serious, particularly in patients receiving anti-coagulants. Physicians should therefore be alert to the appearance of digestive symptoms. In the event of gastro-intestinal hemorrhage, treatment must be interrupted. *PRECAUTIONS FOR USE* :- Patients with a history of gastro-duodenal ulcer. - At start of treatment, attention should be paid to the diuretic volume and to the renal function in patients with cardiac, cirrhotic and nephrotic insufficiency , in patients receiving diuretics, or in cases of chronic renal insufficiency and particularly in elderly patients. - Risk of impairment of IUD efficacity. *INTERACTION WITH OTHER DRUG* : - Ketoprofen should not be administered in association with the following : oral anticoagulants, heparin : increased risk of hemorrhage. Hypoglycemiant sulfamides : amplification of effect. Lithium : amplifications of lithemia. Methotrexate: increase in hematological toxicity. Diuretics : diminution of activity. Ticlopidine : increase in platelet antiaggregant activity. Other NSAIDs : increased risk of ulcer or hemorrhage. *SIDE EFFECTS* : Gastro-intestinal disorders, digestive hemorrhage, intestinal perforation. At 200mg per day per os : increased occult digestive blood loss. Headache, dizziness, drowsiness. - Dermatological or respiratory hypersensitivity, (possibility of asthma attack, particularly in patients who are allergic to aspirin or to other NSAIDs). - Moderate reduction in hemoglobin rate ; some rare cases of slight leucopenia have been observed. - For side effects related to renal insufficiency see PRECAUTIONS FOR USE. - Rare bullous dermatosis. *ADMINISTRATION AND DOSAGE* : 100mg to 300mg per 24 hour period depending on mode of administration. In case of minor digestive side effects (heartburn, pain), it may be useful to prescribe topical gastro-duodenal medication. No reduction in absorption has been observed when ketoprofen is associated with aluminium gels. *OVERDOSE* : The effects observed in cases of intoxication relative to doses of ketoprofen of up to 2g have always been benign. In the event of massive overdose, (accidental or deliberate), symptomatic treatment is required. **REFERENCES 1-4:** Available upon request.

S/ORU/94-5

MediAd

Further information available on request

RHÔNE-POULENC

14 Chin Bee Road, Jurong, Singapore 619824

THE COLLEGE MIRROR

A WARM AND FRIENDLY HELLO FROM . . .

Ms Yvonne Chung

. . . . the Administrative Manager

Yvonne has been with the College since November 1996. She joined us from the UK, where she worked as an Information Officer at the City and East London Family Health Services Authority (British National Health Service), and latterly, from the Nanyang Technological University, where she conducted and managed a research project on the determinant factors and future trends of health expenditure and utilisation in Singapore.

Yvonne was brought up and educated in the UK and following her graduation from the University of London, has worked mainly in the areas of research, health and public administration.

She came to Singapore in 1995 and is now happily settled, taking in the sights, sounds and tastes of Singapore, and of course, making new friends.

Please drop by the College to say hello, Yvonne would be delighted to meet you and help you in any way she can !

Yvonne is ably assisted by Ms Katy Chan at the College Secretariat.

Ms Yvonne Chung

WHAT'S BEEN HAPPENING

Study Tour & Visit to Myanmar

A 15-strong delegation comprising members of the College and the Singapore Medical Association, visited Myanmar on a study tour and attended the Myanmar Medical Association's Medical Conference on 14-19 January 1997.

Left to Right : Drs Lee Kang Hoe, Alfred Loh, Yap Chin Vie, Arthur Tan, Elaine Tan, Ms Yvonne Chung, Tan E-Ching, Elsie Yong, Tan See Leng, Cheong Pak Yean, Tan Sze Wee, Goh Lee Gan, Wong Chiang Yin, Chan Kok Yew, (not in the picture Dr Sebastian Leong)

New Yangon General Hospital

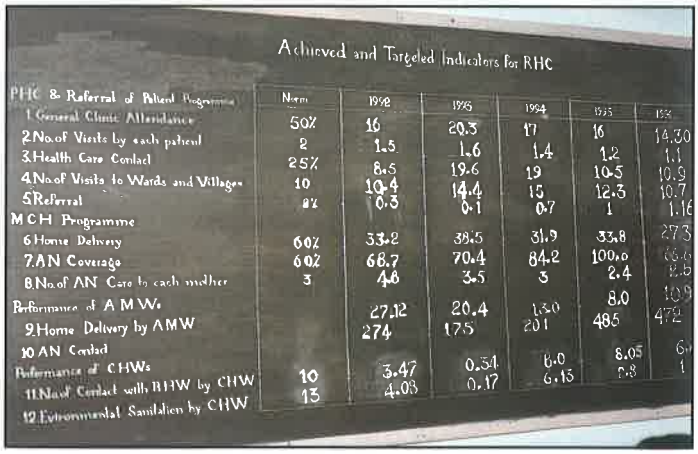
The aim of the visit was to attend the Medical Conference, to participate in joint clinical sessions, to visit an urban health centre and a rural health centre, and to discuss a collaboration on professional exchange and training with representatives of the Myanmar Medical Association.

The clinical sessions were in Paediatrics, Internal Medicine and Surgery & Orthopaedics at the Yangon General Hospital, and the New Yangon General Hospital,

A warm welcome from staff and nurses of the Inntakaw Rural Health Centre

The Singapore delegation with staff at the Inntakaw Rural Health Centre

The Singapore delegation at the MCH Mingalar Taung Nyunt Health Centre, Yangon



Statistics, Statistics

..... and more statistics

Visit by Myanmar Deputy Minister of Health

Following the visit to Myanmar in January 1997 by representatives form the College, H E Colonel (Dr) Than Zin visited the College on 28 February 1997. He met with the President, Council and staff of the College and also held joint discussions with the President and Council members of the Singapore Medical Association on the collaboration and development of a training programme on Family Medicine in Myanmar.

Left to Right - Dr Alfred Loh - President, and Col (Dr) Than Zin, Deputy Minister of Health, Myammar signing the visitors' book

Left to Right - Dr Arthur Tan, Mr Myint Soe, Dr Alfred Loh, Col. (Dr) Than Zin, Ms Yvonne Chung, Dr Wong Chiang Yin, A/Prof Goh Lee Gan, Dr Cheong Pak Yean

Training Course for Myanmar Doctors

In January 1997 a delegation of doctors comprising members for the College and the Singapore Medical Association, visited Myanmar on a study tour and attended the Myanmar Medical Association's Medical Conference. Discussions with the Myanmar Medical Association (MMA) General Practitioners' Section resulted in a request for assistance from the Singapore College to develop and enhance the Family Medicine teaching programme in Myanmar. A "Train the Trainers Programme" was subsequently devised for a group of doctors who would form the core team of trainers in Myanmar.

A delegation of five committee members of the MMA's General Practitioners' Section, arrived at Changi International Airport on 18 May 1997. They were:

Dr Kyaw Myint	President
Dr Tin Aye	Vice President
Dr Myint Zaw	Treasurer
Dr Sein Ni	Secretary, Academic Committee
Dr Ne Win	Secretary, Research Committee

For some of this delegation, it was their first time in Singapore. Before the serious training began, the doctors were given an orientation of Singapore. Site visits were arranged and the delegation met with members from the College, representatives from the Ministry of Health, and the Singapore Medical Association on their first day. From the second day onwards, their training covered topics on:

- The role of the family doctor in providing primary, personal, comprehensive and continuing care
- Consultation tasks and skills required of the family doctor
- Teaching methods in Family Medicine

The Myanmar delegation being introduced to Dr Aline Wong, Senior Minister for Health and Education (2nd Right) by Dr Alfred Loh (3rd Right)

The didactic training was held mainly at the Department of the Community, Occupational and Family Medicine, National University of Singapore.

Site visits to general practitioners' clinics were also in line for the Myanmar delegation. They were deeply impressed with the set-up at Tampines Polyclinic, a singleton practice (Family Medicine Clinic at Marine Terrace) and a large group practice (Raffles Surgicentre in Clemenceau Avenue).

As a grand finale, the Myanmar doctors joined us at the 6th Scientific Conference and 7th Meditech Exhibition held on 24 & 25 May, followed by the College's 25th Anniversary celebrations at the at Shangri-La Hotel, where the highlights of the evening included the Sreenivasan Oration delivered by the President of WONCA, Dr Goran Sjonell, the Conferment of Fellowships upon distingushed members of the College who had made substantial contributions to Family Medicine, and the Chinese banquet.

The entire training programme, accommodation and registration for the 6th Scientific Conference was sponsored by the College.

Left to Right - Drs Kyaw Myint, Myint Zaw, Sein Ni, Ne Win, Tin Aye

25th ANNIVERSARY CELEBRATIONS

6th Scientific Conference & 7th Meditech Exhibition
24 - 25 May 1997

The College's 6th Scientific Conference, 7th Meditech Exhibition and 25th Anniversary celebrations were put in the limelight after a press conference on the event was held on 12 May 1997. Wide media coverage was received from the Straits Times, Lianhe Zaobao, Radio Corporation of Singapore and the Television Corporation of Singapore. Our publicity efforts did not go unseen as registration forms kept pouring into the College even on the date of the event.

Dr Aline Wong, Senior Minister of State for Health & Education, officially graced the opening ceremony of the Conference and Exhibition. Her opening speech was well received and the College Mirror has the privilege of publishing the speech in this issue of newsletter.

The Conference Organizing Committee had the honour of inviting Dr Charles Boelen, Chief Medical Officer, Educational Development Human Resource for Health, World Health Organization, to deliver the Keynote

The College Mirror

Address on "The Five Star Doctor: An Asset to Health Care Reform".

The Scientific Conference and Meditech Exhibition marked a new milestone in the history of the College. Besides celebrating the 25th Anniversary of the College, there was a distinct move away from the usual didactic lectures and seminars to practical, hands-on workshops in ultrasonography, dermatology and office orthopaedics and minor surgical techniques. The College specially purchased life-like intelligent anatomical synthetic tissue models from the UK which have been designed to enhance the teaching of such practical procedures.

Dr Aline Wong at the opening ceremony of 7th Meditech Exhinition

The response to these practical workshops was overwhelming. Many of those who attended these sessions have already inquired whether more detailed courses will be conducted in the near future. This positive response confirms the College's belief that the way forward in CME is the provision of well structured programmes that incorporates a balance of hands-on practical teaching as well as didactic teaching.

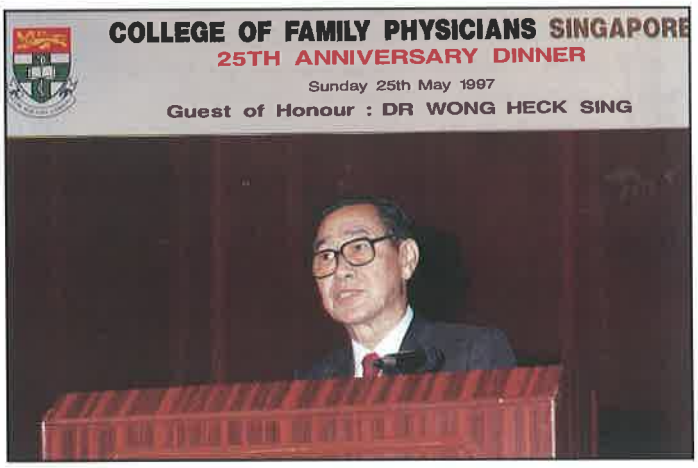
The second new feature in the Conference was the Free Paper Session which included awards and cash prizes for the best research paper. The winner of the research award which was sponsored by Merck Sharp & Dohme, was Dr Kwan Yew Seng who presented a paper on: "Assessment of Diabetes Control and Complications in Patients Seen in One Government Clinic". The runner-up award went to Dr Lim Hui Chuan whose paper was entitled: "Why do Patients Complain? A Primary Health Care Study".

We hope this will lead to more research work and publication of scientific papers by Primary Care Physicians. This will be another direction that the College is actively moving towards.

The third feature was the Public Forum on "Making your Home Safe for Retirement and Old Age" and was the College's contribution to the community. It was an appropriate time to discuss the topic in view of the demographic trends in Singapore as the design of the home can be an important aspect of preventive medicine for the elderly which is often forgotten.

To commemorate the Silver Anniversary of our College, a special Stereophonic Stethoscope (worth $285.00) as a souvenir for all participants in the Conference was commissioned. The College wanted all participants to celebrate the special occasion together, hence all pre-registered delegates were invited to the 25th Anniversary Dinner at the Shangri-La Hotel at no additional cost.

Dr Goran Sjonell, President of WONCA delivered the Sreenivasan Oration on "Organized Family Medicine - The Key Issue to Cost-Effective Health Care" at the 25th Anniversary Dinner. This was followed by the Conferment of Fellowships to the following distinguished Members of the College who had contributed much to Family Medicine: Dr Kwa Soon Bee, Dr Chen Ai Ju, Dr Ling Sing Lin, Dr Lam Sian Lian, Dr Chan Nang Fong and Dr Cheong Pak Yean.



Guest of Honour at the 25th Aniversary Dinner - Dr Wong Heck Sing, former President of the College

Behind every successful conference lies a hardworking organising committee. Special thanks are extended to the following people who put in so much time, effort and energy:

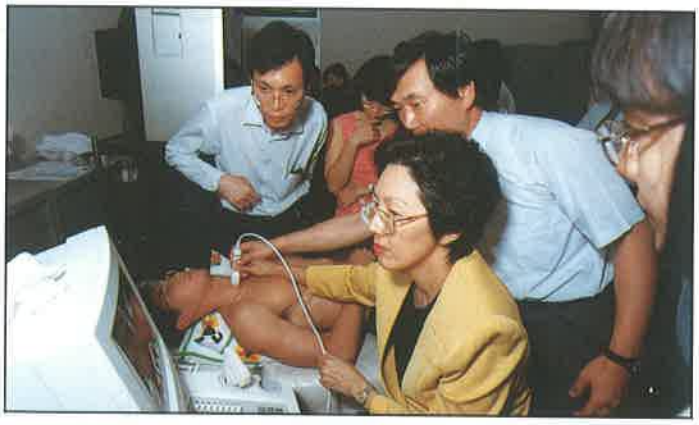
Chairman	Dr Yii Hee Seng
Secretary	Dr Arthur Tan Chin Lock
Treasurer	Dr Richard Ng
Scientific Programme Committee	A/Prof Goh Lee Gan
	Dr Bina Kurup
	Dr Lau Hong Choon
Exhibition Committee	Dr Paul Chan
	Dr David Lim
Public Forum Committee	Dr Lau Hong Choon
Publications Committee	Dr Hong Ching Ye
Ex-Officio	Dr Alfred Loh
Conference Co-ordinator	Ms Yvonne Chung
Secretariat staff	Ms Katy Chan

Look good, smells good, tastes good!
Taking a well deserved tea break at the 7th Meditech Exhibition

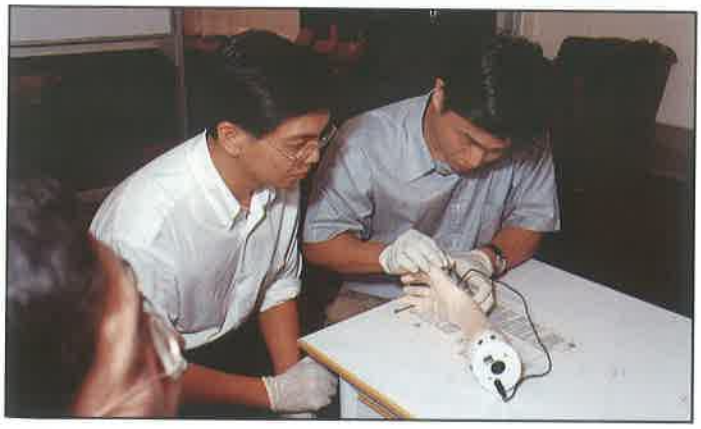
Finally, special thanks to the generous support of our main sponsor, MSD, as well as substantial contributions from Glaxo Wellcome, the exhibitors, temp staff and many others.

A/Prof Satkunathan and participants at the Office Orthopaedics workshop

Members of the 15th Council with Dr Goran Sjonell, President, WONCA (front, 2nd left) and Dr Charles Boelen, Chief Medical Officer, WHO (Front 2nd right)



Ultrasound workshop



Trying their hand at the Office Orthopaedics workshop

Speech by Dr Aline Wong

SENIOR MINISTER OF STATE FOR HEALTH & EDUCATION AT THE OPENING OF THE 6th SCIENTIFIC CONFERENCE AND 7th MEDITECH EXHIBITION 24 May 1997

"Primary health care is first line medical care. It is an essential or fundamental health care provision that should be easily accessible to all. In Singapore, primary health care is heavily subsidised in the public sector, which caters to approximately 20% of all the patients. The private sector caters to 80% of the patients and the GPs' charges are highly affordable to the population.

The College of Family Physicians is the organisation concerned with the professional health or the professional competence of its members, the family physicians. You, therefore, have an important role to play, to ensure that primary health care provided in Singapore is of a high standard.

For many years now, the College has played an important role in the training of family physicians, and in their continuing education. In recent years, the College has been conducting a 64-session modular course leading to a Masters in Family Medicine. I have been informed that this programme will be further modified and upgraded, and will include some hands-on clinical components. I commend the College for its dedicated efforts in improving the standard of practice of family physicians through this programme, as well as through the many continuing education programmes it has been conducting.

It is right and good to be internally driven, to continuously look for ways to improve your profession. For it is through increasing the numbers of well-trained family physicians, both in the public and private sectors, that primary health care in Singapore can be upgraded to compare with the best in the world. Good primary health care has been said to be capable of handling 90% of medical problems. It is one good way of controlling health care costs, as good primary health care doctors can be effective gate-keepers to the more expensive secondary and tertiary health care services.

Of course, controlling health care costs is only one reason why we should do primary health care better. All forms of medicine should have as their central goals the curing of diseases, alleviating suffering and improving the quality of life of the patients. Under these objectives, specific health programmes and medical services can be targetted at different sectors of the population.

Women constitute half of the population. Their health and well-being are an integral part of the health of the nation. When women are in good health, not only will they become more productive persons, enjoying a higher quality of life, but the next generation will also be healthier, more productive and have a better quality of life.

By international standards, Singapore women's health is good. Their expectancy of life at birth is 78.7 years and the maternal mortality rate is 4 per 100,000 live and still births. Women here have equal and ready access to the whole range of medical services.

Similarly, antenatal care, postnatal care and family planning services are widely available at GP clinics, O&G clinics in both public and private sectors, and at government polyclinics. Babies are all delivered in hospitals by trained medical personnel. Polyclinics have well-women clinics that provide general health screening as well as special screening services,

such as cervical cancer screening for women. Health education specially for women is provided not only by the Ministry, but also by the media such as radio programmes and women's magazines, as well as by civic organisations, such as community centres.

However, with a better educated female population, there is greater expectation for more health programmes focussed on women. In addition, there are certain women's health issues which are currently a cause of concern. For example, the incidence rate of breast cancer, which is the No 1 cancer among women, has increased from 19.9 per 100,000 women 30 years ago (1968-1972) to 38.7 per 100,000 women (1988-1992). Another is cervical cancer. Its rates have only declined slightly, from 18.1 per 100,000 women 30 years ago (1968-1972) to 15.2 (1988-92). By comparison, some places like British Columbia and Finland have cervical cancer rates which are about one third of ours. Moreover, there are still women coming late for treatment when the cervical cancer is already advanced.

Other problems concerning women here are: insufficient intake of iron and calcium that can lead to anaemia, particularly in pregnancy, and osteoporosis among elderly women; late antenatal care, particularly among women from the lower income groups; high abortion rate at 25% of all pregnancies; hip fractures and senile dementia among elderly women and stress and fatigue among working women who have to shoulder multiple work and family responsibilities.

Dr Aline Wong delivering the opening speech

To tackle these problems, I have initiated a Women's Health Programme within the Ministry and formed a committee on Women's Health to oversee the implementation of the programme. The Committee will identify specific issues concerning women's health in Singapore, prioritise them and set up the approach to be taken to address each issue. It will review the existing programmes and services for women, streamline and repackage them and recommend new programmes to fill in any significant gaps identified. It will also monitor the progress of the programmes, including harnessing public support and women's participation.

Apart from officers from Ministry of Health, KK Women's & Children's Hospital and Institute of Mental Health, I have invited representatives from the College of Family Physicians, the Women's Committee of People's Association, and NTUC Health Care to be members of this Committee. Together, we will formulate strategies to further improve the health of women in Singapore. These activities need not be expensive. Much will be carried out at the primary health care and health promotion and education level. It is thus essential that the community be involved, including the family physicians who are at the front of primary health care. I am confident that all of you will give this programme your heartiest support".

Presenting Dr Wong with gifts of appreciation after her opening speech
Left to Right: Ms Yvonne Chung, Dr Aline Wong, Dr Alfred Loh

POINTS TO SHARE

We invite you to share your views, thoughts and interests with other members.

A LETTER FROM HONG KONG

It has been some four months since I was transferred to Hong Kong. This is indeed an exciting time for this former British Colony and the mood is optimistic, with property and stock prices climbing steadily. The medical profession has also shared some of the limelight recently with public debate on the supply of doctors.

The government recently announced a reduction in medical students intake, in response to feedback from the medical profession that there is an oversupply in the market. However, the Universities and the public swiftly countered that there is actually a shortage of doctors, citing the long queues and waiting time at the government polyclinics and hospitals, as well as the long hours being put in by the doctors in the institutions. In fact, a houseman recently committed suicide because he could not cope with the stress of the job!

A few well-publicized incidents in the hospitals added fuel to the fire, and so the saga continues.

Dr Yii Hee Seng
Hong Kong

WONCA ASIA PACIFIC REGIONAL CONFERENCE SEOUL, KOREA

The 1997 WONCA Asia Pacific Regional Conference was held in Seoul, Korea from 30 August 1997 to 3 September 1997. This year, the theme of the Conference was "Family Medicine: Diversity and Harmony in the Evolving Era". The conference was very well attended, with about 1,200 participants from 32 countries. Philippines alone sent 110 participants and, for the first time, there were 28 delegates from the People's Republic of China.

The venue for the Conference was the Convention Centre at the Sheraton Walkerhill Hotel. The speech at the opening ceremony was made by Prof Hong Myung Ho, Chairman of the Department of Family Medicine, Korea University. During the speech, he wished that all the participants would have a smiling face everyday during the Conference. This was followed by performances of a traditional Korean dance and songs by a children's choir. The choir was accompanied by musicians using traditional Swiss cowbells. All these, plus the generous hospitality and the great food really put a smile on everybody's face everyday.

The keynote address was given by Prof Robert Taylor from the United States. In his speech, he predicted a worldwide community of family physicians with increased opportunities for family practice post-graduate training and more specification in the requirements for such training. He also sees a worldwide enhancement of the status of family practice as a specialty and family physicians taking their rightful place in medical schools. Family physicians share a common value system and together they go beyond health care to provide something extra for patients in their practices and to make worldwide health care better for all.

The scientific program covered a wide range of topics, from evergreen topics like diabetes, hypertension and hyperlipidaemia to new topics like evidence-based medicine, information technology and the Internet. Full texts of all the plenary lectures were available making it easy for the participants to follow the lectures. Plenary sessions were followed by workshops to more in-depth discussions.

Master and disciple .....
A/Prof Goh Lee Gan (right) and Dr Kwan Yew Seng (left) at the 1997 WONCA Asia-Pacific Regional Conference in Seoul

One of the highlights of the Conference was the first WONCA Research competition for the Asia Pacific Region. Dr Nandani de Silva from Sri Lanka won the first prize with her paper on "One day general practice morbidity survey in Sri Lanka". I presented a paper on diabetes control in the Polyclinic. My paper was not part of the competition because it was not presented at the 1996 Kuala Lumpur workshop. Many posters were presented. I found that there were just too many posters to be able to engage much attention.

A Conference is not complete without social programmes and this was no exception at Seoul. There was a Korean Night, where we were treated to a night of cultural performances and good food. The Conference Dinner saw 13 cultural performances from various participating countries.

True to the theme, the WONCA Conference displayed great diversity and harmony.

Workshop on Family Medicine Education

There was a post-conference workshop held from 4 to 6 September 1997. The theme was Assessment of Clinical Competence and Performance. The keynote address was given by Prof Stephen Abrahamson, an expert in medical education from the United States. We had three very distinguished speakers giving the plenary lectures: our own A/Prof Goh Lee Gan, Prof Wesley Fabb and Dr Neil Spike from Australia.

The plenary lectures were followed by small group discussions. These were particularly interesting and rewarding as there was active participation from all the delegates from the different countries. We had much to share and learn from each other, and at the same time, achieved the course objectives which were:

- to define clinical competence and clinical performance
- to discuss the role of formative and summative assessment in training and certification
- to discuss the different methods of assessment as it relates to cognitive knowledge, problem solving skills, clinical skills, practice, interpersonal skills, values, attitudes and behaviour.
- to discuss different methods of formative assessment
- to discuss different methods of summative assessment eg, essay questions, short answer questions, MEQ, structured vivas and MCQ
- to appreciate and understand the value and proper techniques of constructive feedback.

At the end of the two and a half days, all the participants felt that they had benefitted much from this workshop and were full of praise for the host country for an event that was well organized.

Dr Kwan Yew Seng

FAMILY MEDICINE TEACHING PROGRAMME

FMTP Module 7 to begin in January 1998

What a long break for doctors doing the Family Medicine Training Programme ! The FMTP Module 6 ended on 13 September 1997, and the MMed (Family Medicine) exams took place on 28 September – 5 October 1997.

Congratulations to all those who passed (see separate report).

For those still continuing, FMTP Module 7 will start on 10 January 1998.

FMTP Module 7

10 January 1998 –7 March 1998
2.30pm – 5.00pm

Lecture Theatrette, College of Medicine Building Level 1

NEUROLOGY, EYE, ENT, GYNAECOLOGICAL PROBLEMS, SEXUALLY TRANSMITTED DISEASES & AIDS

Date	*Topic*	*Speaker*	*Chairman*
Session 1 10 Jan 98	Common Neurological Problems in General Practice	Dr P N Chong	Dr Richard Ng
Session 2 17 Jan 98	The Eye in General Practice	Dr Yvonne Ling Dr Richard Fan	Dr Tan Chee Beng
Session 3 24 Jan 98	Sexually Transmitted Diseases & AIDS	Dr T Thirumoothy	Dr Kevin Koh
Session 4 7 Feb 98	ENT Problems in General Practice	Dr Pang Yoke Teen	Dr Shah Mitesh
Session 5 14 Feb 98	Family Planning	Dr Mahesh Choolani	Dr Kwan Yew Seng
Session 6 21 Feb 98	Common Gynaecological Symptoms	Dr S H Yeo	Dr Kevin Koh
Session 7 28 Feb 98	Gynaecological Cancers	Dr Ho Tew Hong	Dr Richard Ng
Session 8 7 Mar 98	Financial Management	Dr Alfred Loh Mr Karamjit Sandhu	Dr Alfred Loh

The 1997 MMed (Family Medicine) Examinations

The School of Postgraduate Medical Studies conducted the fifth MMed Examination in Family Medicine. It started on 30 September 1997 and finished on 5 October 1997. The two External Examiners were Professor Wesley Fabb from Australia and Professor Stuart Murray from Glasgow, Scotland. Professor Fabb is the CEO of WONCA (World Organization of Family Doctors) and a past Director of the Family Medicine Programme in the Australian College of General Practitioners. Professor Murray is the Regional Advisor in General Practice to the West of Scotland Region and he is a Professor in the Postgraduate School of the University of Glasgow.

This year was unique because there were for the first time, 10 candidates who were trained in the Private Practitioners' Stream of the MMed (Family Medicine) Programme. Of the 10, six were successful. They are Drs Lim Liang Boon, Low Chee Wah, Low Sze Sen, Lawrence Soh, Lucienne Tan Yu Sing, and Yu Wai Hong.

There were 16 candidates from the MOH Stream of the MMed (Family Medicine) Programme. Thirteen were successful. They are Drs Chang Tou Liang, Chong Phui-Nah, Doraisamy Gowri, Khairul Bin Abdul Rahman, Khemani Neeta Parshatom, Anand Kumar, Leong Weng Sun Vincent, Lim Jen Pei, Lim Fong Seng, Lo Kit Leong, Lawrence Tan Cheng Chwee, Eliza Ng Chyi Yoke, and Sim Soon Seng.

The candidate with the highest overall mark and distinction was Dr Doraisamy Gowri. She receives the College of Family Physicians Singapore Gold Medal.

For those who missed the mark, we would like to encourage them to try again in 1998.

A congratulatory lunch was thrown for the new graduates on 1 November 1997, where they met with the College Council members and other invited guests from the Ministry of Health.

A/Prof Goh Lee Gan
Censor-in-Chief

WHAT'S HOT ON THE SHELVES ?

Some new additions to the College's Library...

Drugs Used in Sexually Transmitted Diseases and HIV Infection
World Health Organization, Geneva

Research on The Menopause in the 1990s
World Health Organization, Geneva

Medical Hubris
David F Horrobin

Principles of Practice Management in Primary Care
Members of World Health Organization

Fitness for Work - The Medical Aspects (2nd Edition)
Faculty of Occupational Medicine of The Royal College of Physicians

Prevention in General Practice (2nd Edition)
Powler, Gray and Anderson

Promoting Health: A Practical Guide
Linda Ewles and Ina Simnett

Directory of Research: Academic Year 1996-1997
National University of Singapore

Patient-Centered Medicine Transforming the Clinical Method
Stewart, Brown, Weston, McWhinney, McWilliam, Freeman

Ethical Dimensions in the Health Professions (2nd Edition)
Ruth Purtilo

Conducting Research in the Practice Setting
Various Doctors

Clinical Reasoning: Forms of Inquiry in a Therapeutic Practice
Cheryl Mattingly, Maureen Hayes and Fleming

Principles of Biomedical Ethics (4th Edition)
by Tom L Beauchamp and James F Childress

Statistics in Clinical Practice
Kogon

New audio/visual aids in the College's Library...

Vascular Disasters in the Head
Emotional Disturbances
Common Oral Problems
Key Issues in Geriatrics
Advances in Obstetrics & Gynecology
Antibiotic Therapy
Low-Back Pain
Concerns in Cardiology
Gastrointestinal Problems
Risk Management in a Changing Environment
Respiratory Problems in Pediatric Patients
Controversies in Heart Disease Prevention
The Difficult Child: Temperament & Fits
Dermatology Update
The Love Buds - STDs
Aching and Inflamed Joints
Special Concerns in the Elderly
Advances in Infectious Disease
Prevention of Cardiovascular Disease
Eye Disorders
Too Fat and Too Thin
Diabetes Mellitus
Life Supports/Dementia and Delirium
Paediatric Challenges

COLLEGE MEMBERSHIP

Discover a new world of family medicine at the College of Family Physicians Singapore

Membership to the College has been steadily increasing over the past few years. We would like to invite you to apply for membership and to enjoy many of the benefits.

How do I apply?

You can come and collect an application form from the College, or ring us at 223 0606 for more details. Each application must be signed by a Proposer and a Seconder.

What are the benefits ?

- Automatic registration for the SMC-CME programme at no extra cost. Non-members have to pay an annual registration fee. This means you will be accredited with CME points for each CME accredited event that you attend providing you sign the attendance register.
- You will receive a monthly CME calendar of events at the beginning of each month free of charge.
- Members will enjoy discounted registration fees for seminars, conferences and other events organized by the College. For instance, members who attended the 6th Scientific Conference only paid S$150 instead of S$200 for non-members.
- You will receive a complimentary copy of "The Singapore Family Physician" journal and the newsletter which is published by the College quarterly.
- Free use of the College's library facilities for reference purposes and to loan books, visual & audio tapes.

How do I qualify for membership ?

Associate Membership is for doctors holding a registrable qualification but with less than 5 years of family practice.
Ordinary Membership is for doctors holding a registrable qualification for 7 years or more and with at least 5 years of family practice experience.

What are the Annual Subscription Fees ?. ...Very Reasonable!

S$50 one-time entrance fee
S$50 for Overseas Membership
S$75 for Associate Membership
S$150 for Ordinary Membership

Sign up and join now !

A BIG but gentle reminder . . . . .

A large number of our members have still to pay their membership fees for the current year despite reminders being sent out in March. We would be grateful if outstanding payments could be made as soon as possible by cheque, payable to **College of Family Physicians Singapore**. If you are unsure whether you have paid or not, please ring the College Secretariat at 223 0606. (The Outstanding Payees list will be published in the next issue).

YOUR CO-OPERATION WILL BE MUCH APPRECIATED

I WANT ONE TOO ! - College Gifts and Accessories

For those of you who attended the College's 6th Scientific Conference in May 1997, we hope you are making full use of the stereophonic stethoscopes (worth S$285) and those smart conference briefcases which were given to each delegate on a complimentary basis.

In fact, we have had so many enquiries from other doctors who have seen their colleagues sporting these items that they would like to purchase them for themselves or for their friends. Well, here's the good news...

College briefcases

The Conference briefcases are available at a very affordable price of only S$25 each (similar ones are retailing at S$40 but without the embossed College logo of course).

College silk ties and scarf

The stereophonic stethoscopes are available at S$285 (the College has absorbed the GST!)

You may also have noticed that some of our College members wearing the new College ties and the silk scarves. These ties and scarves were specially commissioned and designed to to be launched on the 25th Anniversary of the College. All are made of 100% pure silk; the ties come in 3 colours at S$25 each: claret red, dark green and dark blue. The silk scarves are beautifully designed with multi-coloured orchids, the national flower of Singapore at S$30 each.

You are most welcome to come to the College and have a look; they make idea gifts to yourselves or friends and colleagues.

WHAT'S COMING YOUR WAY .....

The Ultrasound Course

It has finally arrived - the long awaited course leading to a formal structured training programme for the general practitioners to be fully competent in performing ultrasound examinations in obstetrics and gynaecology.

After many years of waiting, a joint collaborative committee comprising members of the College of Family Physicians, the School of Post Graduate Medical Studies and the National University Hospital's department of O&G has finally worked out and is in the final process of formalising a one year structured programme for the training of general practitioners in basic ultrasound for obstetrics & gynaecology.

This one year programme will cover most of the theoretical and practical aspects of obstetric & gynaecology ultrasound and will lead the candidate to a Diploma in Basic Ultrasonography (Obstetrics & Gynaecology).

Intensive training by the O&G department's lecturers as well as practice sessions will be offered to the candidates enrolled on the course. The O&G department of NUH has dedicated 2 clinics every weekday morning to train the candidates and provide logistic support. On top of that, the candidates are expected to perform their own ultrasound on their patients in their respective clinics and eventually log 400 patient cases so as to achieve the standards required. All these will then culminate in a practical examination and the award of the Diploma.

The target date for implementation of this course is expected to be July 1998.

With the tremendous benefit that competence in performing ultrasound can bring to the family physician, this course is certainly going to generate a lot of interest amongst the much queried practitioners' community.

Certainly, we all know that ultrasound is an extremely useful tool in our daily clinical practice. It can cut down on a lot of unnecessary referrals of our O&G patients and certainly relieve a lot of anguish for our patients while waitng for their appointments to see their obstetricians and gynaecologists.

Who knows, perhaps one day we might even be able to be trained adequately in performing other small parts ultrasound as well as abdominal ultrasounds by our radiologists' colleagues.

We will keep you updated with details on registration, costs, course curriculum etc. in the next issue.

Dr Tan See Leng

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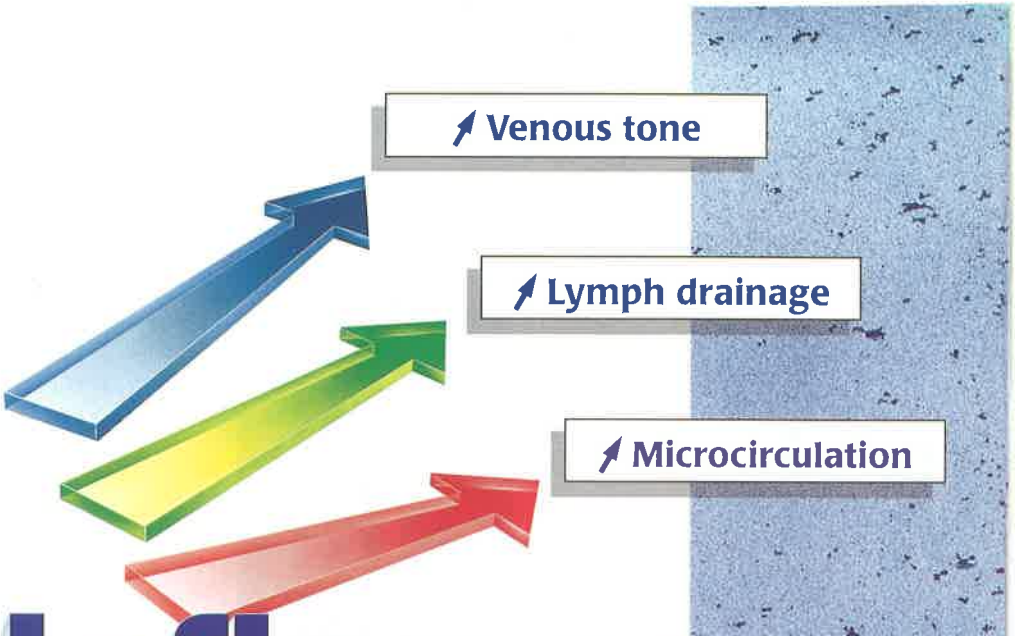

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Before prescribing, please consult physicians circular.

1. Anderson J T et al: Can Finasteride reverse the progress of BPH? A two year placebo-controlled study. Urology 46(5),1995

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