



# THE College Mirror

VOL. 44 NO. 3 SEPTEMBER 2018

A Publication of College of Family Physicians Singapore



## CFPS Commencement Ceremony 2018

*Professor Doris Young, Head of Department of Family Medicine at NUHS, was invited to be the Guest-of-Honour at CFPS Commencement Ceremony on 28 July 2018. Prof Young addressed the guests with the following speech.*

Prof Doris Young

### IN THIS ISSUE:



COLLEGE WELCOMES WONCA PRESIDENT

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**T**hank you, Dr Tan Tze Lee for your kind invitation to speak at the Commencement Ceremony today.

Good afternoon, colleagues and friends and a special welcome to all the residents, doctors who have decided to enter the College of Family Physicians Singapore (CFPS) training programme. I am Doris Young, Professor and Head of the newly established Department of Family Medicine at NUHS (which is only 5 months old). Hopefully, together with Professor Helen Smith from LKC Medicine, the College of Family Physicians Singapore and all of you sharing the journey to raise academic Family Medicine in Singapore to another level.

So to the FM trainees who commence today, you all came from different backgrounds, some straight from

internship, some from other branches of medical practice – no matter, you have all decided to enter FM training. Majority of you have enrolled in the Graduate Diploma of Family Medicine (GDFM) (247), others in Masters of Medicine (20) and the rest in the Fellowship programme (19). I gathered that the College FM training programme is a modular programme with GDFM at the basic

**Regardless of your journey to get here - whether it is by choice or by chance - you have all made the right move, saw the light and entered FM training.**

level and then building up to a more advanced Masters and finally to a senior consultant level with the Fellowship programme. I guess most of you just wanted to gain some skills in FM and then perhaps move on to do the Masters later and then the Fellowship to gain more research skills. Regardless of your journey to get here – whether it is by choice or by chance – you have all made the right move, saw the light and entered FM training.

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Published by the **College of Family Physicians Singapore**  
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16 College Road #01-02, Singapore 169854  
Tel: (65) 6223 0606 Fax: (65) 6222 0204  
GST Registration Number: M90367025C  
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MCI (P) 120/09/2017

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(continued from Cover Page: CFPS Commencement Ceremony 2018)

The medical workforce needs more and better trained GPs/FPs. I was in London just a few weeks ago and one of the plenary speakers, Professor Val Wass presented a report commissioned by Medical Schools Council and Health Education England in the UK entitled 'By Choice, Not by Chance'. The report highlighted some of the reasons for the decline in medical students in UK choosing General Practice and contained some excellent recommendations to overcome the decline. In addition to the usual workload demands, negativism about general practice, one key reason still holds true to this day everywhere amongst the medical profession and the community – the low status of general practice and general practitioners. It is indeed hard to understand why this perception holds so strongly considering worldwide as a workforce, General Practitioners and Family Doctors form the largest group of doctors. We ought to have so much 'bargaining power' and yet there remains a sense of professional low self-esteem as in some countries, Family Medicine/General Practice is still not recognised as a medical specialty in its own right with poorer remuneration and status. I think time has come for us to stand up and be proud of our roles and contributions.

### WONCA Award Excellence in Health Care- Attributes of a 5-Star Primary Health Care Doctor

- A care provider- with skills to deliver preventive, acute, continuing, whole person care, family care, build trusting relationships
- A decision maker-chooses technologies ethically and cost effectively to enhance care
- An effective communicator-to promote healthy life style and improve care to the population
- A community leader- understands the community health needs and initiate actions in consultation and on behalf of the community
- A team member- works with individuals and organisations within the health care system to meet patient and community's needs

I think if we were challenged as being JUST a General Practitioner implying that we are not specialising in any particular branch of medicine and thus 'not so good', then the organ or systems specialists ought to be known as 'partialists' as pointed out to me by some other colleagues. Well, we don't really want a debate or set up a war of words but rather raise the status of FM and our roles by delivering quality care to the community.

(continued on the next page)

(continued from Page 3: CFPS Commencement Ceremony 2018)

This slide reminded us that all doctors, in particular, family physicians ought to practise quality care, applying ethical principles, show compassion and respect to patients, develop good listening skills, updating and maintaining our breath of knowledge, and if you do this well, you are on a journey to a fulfilling career in Family Medicine. We have seen many TV shows with good GP role models and in nearly all of them they listened, showed compassion and cared for their patients and their families.

So are these qualities of a well-trained family physician aspired to by Dr Wong Heck Sing ... the second President of the CFPS who in his delivery of the first Sreenivasan Oration in 1978 some 40 years ago envisioned?

He stated:

1. "The decline (of general practice) is due to fewer and fewer graduates venturing into a territory that is uncharted, untaught and unsung in the academic world"
2. "...The future general practitioner or family physician .... Needs a broad education and should not concentrate on the physical and biological sciences to the exclusion of the humanities and the arts....and this understanding (of people) will heighten his sensitivity to the feelings of his fellow men..."
3. The answer (to prohibitive healthcare costs) ... is in preventive medicine and no one in the medical profession is as well placed as the general practitioner to do the job provided he is well trained."
4. "In no other field of practice is it more necessary for the practitioner to continue his learning process throughout his professional career."

So some 40 years later, how does what Dr Wong declared what a good Family doctor should do compare to what WONCA stated as the qualities of a 5-star Primary Care doctor? Are we nearly there?

WONCA's attributes of a 5-Star Primary Health Care Doctor comprise of:

- A care provider - with skills to deliver preventive, acute, continuing, whole person care, family care, build trusting relationships
- A decision maker - chooses technologies ethically and cost effectively to enhance care
- An effective communicator- to promote healthy life style and improve care to the population
- A community leader - understands the community health needs and initiate actions in consultation and on behalf of the community
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I think Singapore is now finally heeding Dr Wong's plea to strengthen Family Medicine workforce, to deliver the types of care he envisaged when he headed CFPS some 40 years ago. Well, at least I think it is getting close when one looks at this recent slide shown by the Ministry of Health, declaring the three Beyonds: from hospital to the community, health care to health and from quality to value. This strategy is absolutely vital as Singapore is facing a rise in its ageing population, chronic diseases resulting in unsustainable rising health care costs. The National strategy is to promote healthy living, strengthen early detection and follow up, enhance disease management and prevent complications. Family doctors can take up the challenge to screen, prevent and promote health as its core business. The Commonwealth fund study in the USA have demonstrated convincingly that a country with a strong primary health care system such as New Zealand, UK, Australia, Canada, the Netherlands etc., spent about 9% of the country's GDP on health care thus enjoyed the best health outcomes in addition to access, and equity for their communities.

However, to meet the challenges of becoming a 5-star doctor, we cannot underestimate the demands put on the GPs who face an increasing high patient load/demand. Not only do they have to run a well-managed practice, we at the Universities asked them to teach students, residents, trainees and help us with research. Of course for some GPs, they also play a vital part in advancing the profession such as College work. What about our families? Children, siblings, parents and partners also need to be cared for. Have we got any time left for ourselves in personal growth development and have a life?



Therefore in order to last the distance, so to speak, we need to strike a balance like this acrobatic lady (who reminds me of myself) and some of you who often wear multiple hats, the demand put on our lives is like spinning the plates, keep everything going – our children, parents, career – and can't afford to let one plate drop. The burden on top of our heads is often the issue that caused us the most stress and headache, e.g. the unhappy child, illness, unhappy relationships, etc.

Thus, in order to survive, we all need to learn to relax and find some outlet in life and of course, being such self-driven individuals with many of us having some OCD traits, even when we try to relax we want to pursue relaxing activities relentlessly, to be the fastest, the best! So don't forget in your life journeys, to stop and smell the roses and for these cows to eat some roses.



To conclude, a reminder to all the GPs here to say to people when they ask you what do you do for a living, you say I am a doctor, then if they ask you what sort of a doctor, you reply with confidence as in this billboard displayed in the Perth airport in Australia, "I am a GP (NOT JUST a GP) and your specialist in life'.

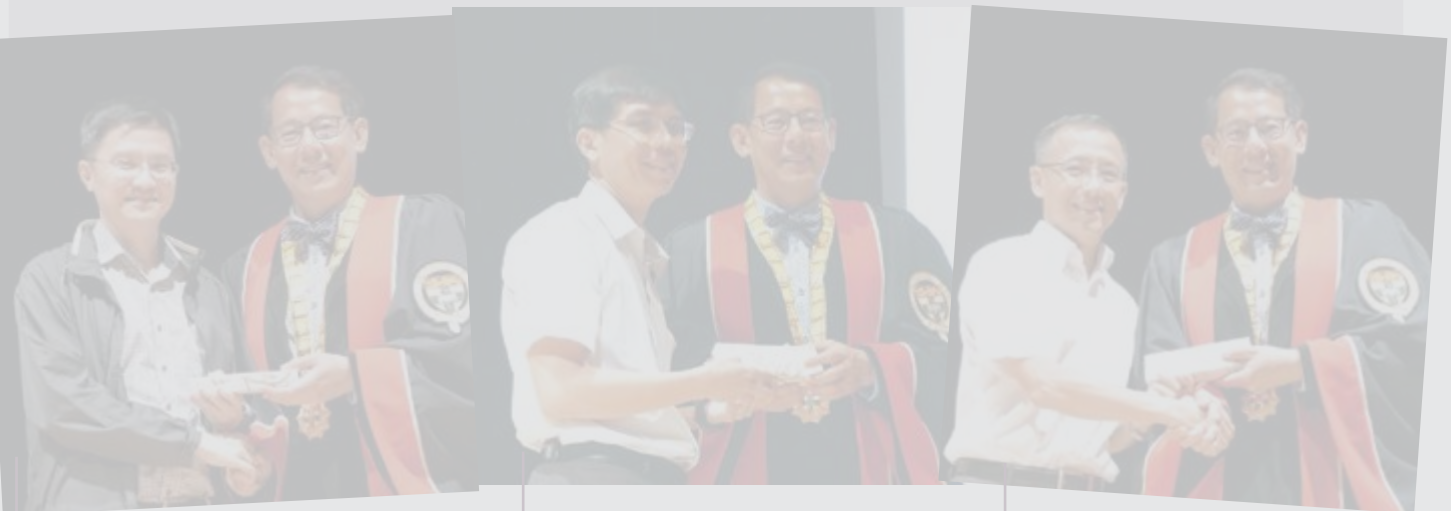
Thank you for your attention.

■ CM

## CFPS Thanks Our Immediate Past Programme Directors

by Dr Chan Hian Hui, Vincent, FCFP(S), Council Member, Team C Editor

The College of Family Physicians Singapore, thanked 3 of our immediate past Programme Directors during our Commencement Ceremony 2018 on 28 July 2018, with tokens of appreciation given out by College President, Adj Asst Prof Tan Tze Lee. They are:



### Dr Kwong Kum Hoong

Dr Kwong served as GDFM Programme Director from 2009 till 2018. While in this role, more than 500 doctors were trained.

### Dr Eng Soo Kiang

Dr Eng served as GDFM Associate Programme Director from 2016 to 2018.

### Dr Julian Lim

Dr Lim served as Master of Medicine (Family Medicine) College Programme, Programme Director from 2007 to 2018. Under his watch, some 96 doctors were trained.

As 3 Programme Directors step down, so is College pleased to welcome:

- 1) **Dr Wong Tien Hua**, as the incoming GDFM Programme Director
- 2) **Dr Lawrence Ng**, as the incoming GDFM Associate Programme Director
- 3) **Dr Suraj Kumar**, as the new Programme Director for the MMed (Family Medicine) College Programme. College also congratulates Dr Suraj on his new appointment to the Singapore Medical Council by Minister of Health, Mr Gan Kim Yong.

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# The Commencement Issue 2018

by Dr Chan Hian Hui, Vincent, FCFP(S), Council Member, Team C Editor

In this edition of College Mirror, **we welcome new trainees** to our various College programmes, namely the Fellowship Programme, the Master of Medicine College Programme, and the Graduate Diploma in Family Medicine (GDFM) Course. There is also a new Enhanced GDFM Programme, which aims to better prepare trainees for Community Hospital work. Immediate past president A/Prof Lee Kheng Hock will share with readers about the journey to create this programme. Indeed, it is hard work and dedication that created and sustained all College Programmes. Here, College wishes all trainees a good and successful learning journey. And of course, a reminder to return and serve the College after you have successfully completed your training.

During Commencement 2018, held on 28 July at the Singapore Chinese Cultural Centre, College was delighted to have Prof Doris Young as our guest of honour. I particularly liked her statement about **how the “time has come for us (Family Physicians) to stand up and be proud of our roles and contributions.”** College also took the opportunity to thank 3 of our immediate past programme directors, while welcoming another 3 colleagues who have taken up the baton.

On the current affairs front, **one hot topic has been the proposed Healthcare Services Act (HCSA)** due to be tabled in Parliament soon. In President's Forum, Adj Asst Prof Tan Tze Lee shares with readers about the results of a joint public survey conducted by the Singapore Medical Association, the Academy of Medicine and our College of Family Physicians Singapore. College has been actively engaging the Ministry of Health (MOH) on HCSA, and MOH for their part have been active listeners. College Mirror has

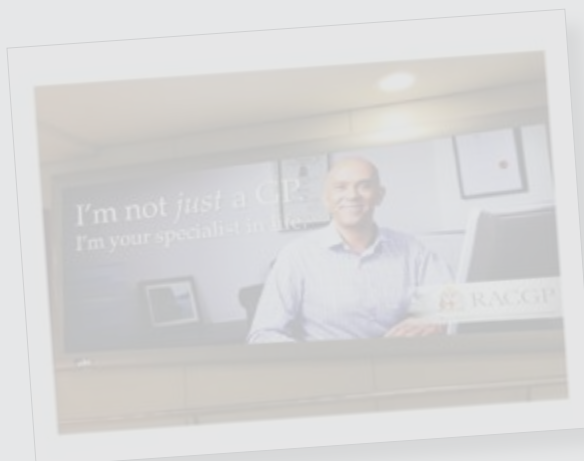
published MOH's response to the joint survey in full, alongside President's Forum. We have also interviewed A/Prof Goh Lee Gan who shares his views on HCSA with us.

**On serving the community,** we feature Dr Goh Wei Leong, a senior Family Physician who has volunteered much of his time creating a holistic care framework for the care of migrant workers. His work is an inspiration to many of us that we can make a difference, by “looking around” and identifying the needs of society then working passionately to meet them. We also have an interview with Dr Joshua Lam, a HealthServe volunteer and GDFM alumnus, as done by Dr Jonathan Yeo. Additionally, Dr David Ng shares with readers about his experience leading the project to build the new Punggol Polyclinic.

**Other news events** covered include WONCA President Prof Amanda Howe's visit to College on 04 August 2018, College President's panel interview on Chanel NewsAsia on the topic of “Patient Empowerment” and a report on ASEAN Dengue Day filed by Dr Cheong Siew Meng who represented the College as our speaker. This edition is a first for me as an editor, and my team includes Dr Lawrence Ng and Dr Wong Tien Hua. I am grateful for their support, and in particular, Dr Ng's advice. In this edition, Dr Ng writes about the ethical considerations behind Nasogastric Tube insertions, while Dr Wong shares with readers about Telemedicine, which was another recent hot topic. I also thank Chief Editor Dr Luke Low and College Secretariat's Ms Patricia Cheok for their invaluable assistance.

■ CM

Thus, in order to survive, we all need to learn to relax and find some outlet in life and of course, being such self-driven individuals with many of us having some OCD traits, even when we try to relax we want to pursue relaxing activities relentlessly, to be the fastest, the best! So don't forget in your life journeys, to stop and smell the roses and for these cows to eat some roses.



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CM

# About the Certificate in Community Hospital Practice (CCHP)

by A/Prof Lee Kheng Hock, Immediate Past President, College of Family Physicians Singapore



The Certificate in Community Hospital Practice (CCHP) is a new training programme organised by College of Family Physicians Singapore (CFPS). It is a structured programme designed to train family physicians to be competent in managing patients with complex conditions.

Responding to the needs of our community and the challenges posed by a rapidly ageing population, our College deliberated and decided to create this new training program. A GDFM graduate with this additional training (CCHP) can embark on a career as a family physician working in the community hospitals. The CCHP is recognised by all the major community hospitals in Singapore and is supported by the Ministry of Health which provides for 50% subsidy of course fees for Singaporeans and Permanent Residents.

The planning of this programme started almost 2 years ago. After extensive consultation with all the community hospitals and the Ministry of Health, a workgroup chaired by A/Prof Tan Boon Yeow, CEO of St Luke's Hospital, was formed and tasked to develop this programme. Our Past President and Medical Director of Bright Vision Hospital, A/Prof Lee Kheng Hock was the Advisor to this work group. Work group members come from all the major community hospitals. They are:

<b>Dr Jeffrey Jiang</b>	St Luke's Hospital
<b>Dr Kalaimamani Kanagasabai</b>	Ren Ci Hospital
<b>Dr Colin Ngeow</b>	Yishun Community Hospital
<b>Dr Farhad Fakhrudin Vasanwala</b>	Sengkang Hospital
<b>Dr Alvin Ong</b>	Jurong Community Hospital
<b>Dr Kelvin Phua</b>	Ang Mo Kio Thye Hwa Kuan Hospital
<b>Dr Fatima Reyaz Singaporewalla</b>	Bright Vision Hospital
<b>Dr Low Lian Leng</b>	Bright Vision Hospital

The team created a rigorous and pragmatic programme. It provides opportunities for trainees to see the spectrum of cases commonly encountered in community hospitals. They will go through 80 hours of clinical training where they are attached to community hospitals and supervised by family physician faculty working as senior doctors there. The timing of the sessions are flexible. It is quite feasible even for busy and family doctors working in GP clinics and polyclinics to take up this course. At the community hospitals, they will learn and acquire critical competencies such as running family conferences and multidisciplinary meetings (MDM). They will also be coached on developing good comprehensive care plans on admission and at discharge from the community hospital. The team have successfully recruited an impressive faculty of highly qualified and experienced family physicians who will guide the trainees throughout their 2-year learning journey.

In the pipeline is an expedited 1-year programme for candidates who have completed their GDFM. Family physicians with higher family medicine qualifications can also enrol if they wish to polish up their competencies that are relevant to community hospital practice.

It is envisaged that this programme will contribute significantly to meet the increasing demand for family physicians as more community hospitals open in the next few years. Presently family physicians with MMed (FM) and FCFP are recognised for employment as registrars and consultants at community hospitals. The GDFM plus CCHP training route will allow family physicians who prefer to work in community hospitals and follow the Resident Physician career track. The bottom line is a win-win situation for family physicians and the community hospitals. Ultimately the patients in the community hospitals will benefit from the hallmark effective and holistic care that is provided by our well-trained family physicians.

■ CM

# Channel NewsAsia Panel Interview on Patient Empowerment

Transcribed by Dr Chan Hian Hui, Vincent, FCFP(S), Council Member, Team C Editor

College President Dr Tan Tze Lee represented the College of Family Physicians Singapore at this panel discussion held on 7 May 2018, and this was subsequently broadcasted on national television in the “Perspectives” series by Channel NewsAsia (CNA). The topic of the panel interview was “Patient Empowerment”, and other participants included Geriatrician Dr Wong Sweet Fun, Cardiologist Dr Lim Toon Wei, Mr Raman Singh, CEO of MundiPharma and CNA moderator Ms Karen Lam.

## Information is power... or is it?

The rise of internet and the availability of large quantities of medical information to patients is a double-edged sword. For patients can be informed, misinformed or both. On this matter, Dr Tan commented that:

*“Sometimes there are misconceptions about what they have actually learnt, and very often we (doctors) have to sift through all these thick documents, well this one works and this one doesn’t work, and what you (the patient) believe is not quite right.. and you steer them along the way. Hence in a sense a good Family Physician in my view is a guide, he gives that map for the patient to look at, and perhaps find a way to give them some hope, so that that target is very attractive.”*

## Training Family Physicians to be good guides to patients

Yes, our College takes Family Medicine training very seriously.

*“One of the things is, when patients come, very often they have questions and when they have questions we try our best to answer those questions, and at the same time we also try and help them to navigate the meandering stream of medical information that they encounter, sometimes it is true, very often it is not. So, we need to clear those misconceptions. So that is what we try and do in College, we train our trainee doctor to do that, to be able to help them to be guides.”*

## The importance of time

When asked whether patients actually walk into the consultation room dictating their own treatment, Dr Tan replied that:

*“Of course, all the time. Because they have already made up their mind. Some of them really do come with bags and bags of blood tests or stuff that they found out about themselves. And when you go through it, actually the story that comes out is really simple. Just*

*needed some time to go through it. And that amount of time being spent to dispel the misconceptions is well worth it.”*

To that, Ms Karen Lam the moderator opined that this would require time resources, a challenge in busy General Practice clinics.

*“Well, in my practice we do run on appointments, sometimes we run over, my patients understand, and because we are part of the landscape of where I practice, it is not a problem. I have a friendly coffee shop just across the road and they will go there and have a coffee before they see me. So, you have to make a conscious choice to do that, so as a Family Physician I would recommend to all my mentees and all my colleagues, take your time with the patients, give them time, and it will be rewarded. It’s all about relationship.”*

## On Fake (Medical) News seen by patients on the Internet

Ms Lam raised an example in China, where a student requested for cancer treatment based on research done from the internet, and died as a result. To that, Dr Tan mentioned that:

*“You need to have a trusted health care professional, who can give you an unbiased advice... Goes back to the friendly family doctor that you see from the time you were small... Some one that you trust... And ultimately it is that trust that is important. Because there is so much stuff out there. It’s a jungle to navigate through.”*

*“Once you have a guide, it could even be your pharmacist, pharmacists are very knowledgeable people! It could be your community nurse.. So I have always felt that within the health care environment, the team is all important to provide that care, it doesn’t matter who.”*

(continued on the next page)

(continued from Page 7: Channel NewsAsia Panel Interview on Patient Empowerment)

## On Telemedicine and Artificial Intelligence

*“If you talk about say Telemedicine, for an example as a case, we had an afternoon symposium on this a few weeks back ... The trouble is, you must have a platform where you have to be sure that the person at the other end of the platform is number one, truly a patient and number two truly a doctor. So there are these two fundamental things. So there must be some trust that this platform actually does that. The second thing is how well can you actually manage a patient just by looking down the telephone. Some people say yes, but many of us say no. Because you can't examine, you can't take things at face value that I am this, this or that, or the other. (Example on space station.) Very often, unless you are in that sort of situation (where) you have all the equipment, very often you are not able to fully assess. So for most of us, we would say we would be able to offer Telemedicine to our patient that we have seen at least once before. Those are actually*

*in some of our guidelines. And then if our patients are known to us, we are able to offer them advice.”*

*“Artificial intelligence..Where does the buck stop? If AI is going to be able to do it. If something goes well, that is fine. What if it goes awry, what if it goes bad, who is responsible for that AI decision? So these are things we have to contend with as medical professionals, because end of the day, the buck stops with us.”*

## In Conclusion

*“If every Singaporean has their own family doctor. I think they will be very much more empowered than they are now, because they will have someone they can go to, with their problems. And if this primary care doctor, this family physician, this GP, is freely chosen by the patient, you will have much better outcomes. You will have much better cost savings, and the whole delivery of health care will be very much improved.”*

■ CM

# 8th ASEAN Dengue Day Seminar – Primary Care at the Forefront

by Dr Cheong Siew Meng, MCFP(S)

The 8th ASEAN Dengue Day Seminar was held on 23 June 2018 at Tan Tock Seng Hospital. An annual seminar organised by the National Centre for Infectious Disease (NCID), the event aimed to keep general practitioners and healthcare workers up to date on the latest developments in dengue management. This is timely as May to October is the traditional peak dengue season in Singapore.

This year's event focused on dengue prevention efforts in the community, with the spotlight on primary care. Bringing together speakers from key stakeholders, who are Ministry of Health (MOH), National Environment Agency (NEA), College of Family Physicians (CFPS), Saw Swee Hock School of Public Health (SSHSPH) NUS and NCID, the seminar provided a comprehensive update covering the latest in vaccination, vector control, epidemiological trends and roles of the primary care physician in dengue control.

The seminar kicked off with Prof Leo Yee Sin, Executive Director of NCID, updating the audience on the mission and capabilities of the new NCID building, which will be operationalised from November 2018. With a 330 bed capacity and capabilities for advanced infectious disease treatment, control and research, the NCID will strengthen Singapore's ability to respond, contain and manage infectious disease outbreaks.

Mr Yusuke Kita from MOH then shared the ministry's framework for dengue vaccine implementation, and shared key considerations for its use in Singapore. Using an evidenced-based approach, primary care and infectious disease physicians could adopt a risk stratification and shared decision model to ensure persons most at risk of severe dengue can be protected.

Vector control and bite avoidance continue to be the cornerstone of dengue eradication efforts, and the next 2 speakers sought to update the audience on the latest in these domains. Dr Christina Liew and Dr Wilson Tan, who are entomological experts from NEA, provided interesting insights in *Aedes aegypti* behaviour and how native disease-causing population interacts and responded to an introduced *Wolbachia*-carrying *Aedes* males. I can quote Sun Tzu from his book “Art of War”

*“If you know the enemy and know yourself, you need not fear the result of a hundred battles. If you know yourself but not the enemy, for every victory gained you will also suffer a defeat. If you know neither the enemy nor yourself, you will succumb in every battle.”*

*(continued from Page 7: Channel NewsAsia Panel Interview on Patient Empowerment)*

### On Telemedicine and Artificial Intelligence

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## 8th ASEAN Dengue Day Seminar – Primary Care at the Forefront

by Dr Cheong Siew Meng, MCFP(S)

The 8th ASEAN Dengue Day Seminar was held on 23 June 2018 at Tan Tock Seng Hospital. An annual seminar organised by the National Centre for Infectious Disease (NCID), the event aimed to keep general practitioners and healthcare workers up to date on the latest developments in dengue management. This is timely as May to October is the traditional peak dengue season in Singapore.

This year's event focused on dengue prevention efforts in the community, with the spotlight on primary care. Bringing together speakers from key stakeholders, who are Ministry of Health (MOH), National Environment Agency (NEA), College of Family Physicians (CFPS), Saw Swee Hock School of Public Health (SSHSPH) NUS and NCID, the seminar provided a comprehensive update covering the latest in vaccination, vector control, epidemiological trends and roles of the primary care physician in dengue control.

The seminar kicked off with Prof Leo Yee Sin, Executive Director of NCID, updating the audience on the mission and capabilities of the new NCID building, which will be operationalised from November 2018. With a 330 bed capacity and capabilities for advanced infectious disease treatment, control and research, the NCID will strengthen Singapore's ability to respond, contain and manage infectious disease outbreaks.

Mr Yuske Kita from MOH then shared the ministry's framework for dengue vaccine implementation, and shared key considerations for its use in Singapore. Using an evidenced-based approach, primary care and infectious disease physicians could adopt a risk stratification and shared decision model to ensure persons most at risk of severe dengue can be protected.

Vector control and bite avoidance continue to be the cornerstone of dengue eradication efforts, and the next 2 speakers sought to update the audience on the latest in these domains. Dr Christina Liew and Dr Wilson Tan, who are entomological experts from NEA, provided interesting insights in *Aedes aegypti* behaviour and how native disease-causing population interacts and responded to an introduced *Wolbachia*-carrying *Aedes* males. If I can quote Sun Tzu from his book "Art of War"

"If you know the enemy and know yourself, you need not fear the result of a hundred battles. If you know yourself but not the enemy, for every victory gained you will also suffer a defeat. If you know neither the enemy nor yourself, you will succumb in every battle."

For doctors, this was a good lesson not just of our enemy – the dengue virus, but also of its most important ally, the *Aedes* mosquito. It also provided a larger ecological perspective of dengue to clinicians, who usually only see and manage the human host.

I was privileged to share my views on the roles of the primary care physician in dengue prevention. I outlined the multi-faceted role of the primary care physician in dengue management, which are in clinical, public health and health promotion aspects. With the vast information available to the both doctors and patients, I highlighted key challenges for doctors, which are to assimilate the large body of evidence, apply it in a patient centred manner and helping patients navigate the healthcare network. A summary of the recommendations for mosquito breeding sites eradication and mosquito repellents was presented to help doctors provide evidence-based advice to patients.

Professor Vincent Phang from SSHSPH shared key findings of the knowledge, attitudes and practices of primary care physician during the 2013 dengue epidemic. This public health perspective was useful to give stakeholders and the practitioners greater insight on how we continue to do well and do better to respond effectively to an dengue epidemic.



◀ The other speakers for the event include (from left) Dr Lee Tau Hong, Professor Leo Yee Sin, Dr Christina Liew, Dr Wilson Tan Cheong Huat, Mr Yuske Kita, Dr Sapna Sadarangani, Dr James Cheong Siew Meng and Dr Vincent Pang

Finally, Dr Sapna Sadarangani, an infectious disease consultant from NCID, provided a succinct summary of the yellow fever, a highly fatal but vaccine preventable disease caused by the yellow fever virus, which like dengue, is also from the flaviviridae family. Besides listing key clinical characteristics of the disease and its management, key takeaway from the segment highlighted the important role of primary care physicians in travel medicine and ensuring our patients are advised on the appropriate vaccinations.

In summary, this year's event brought together regulators, environment experts, public health specialists and physicians to provide a broad and balanced perspective to a perennial enemy. Being a global hub to the world, Singapore is susceptible to communicable diseases, both indigenous and imported. Therefore as primary care physicians, we will need to be vigilant and ready at the forefront to respond to any emerging or persistent infectious disease threats.

■ CM

## Building Punggol Polyclinic — My Experience

by Dr David Ng Chee Chin, FCFP(S), Clinic Director of Punggol Polyclinic

I gave the editor quite a headache with my procrastination coming up with this article. The struggle I had was this - how to summarise the last 4 years of my life and the gamut of emotions in a matter of a few paragraphs?

Yes it took 4 years to build a polyclinic and I have learnt and gained so much from the whole experience. It wasn't often that one can have this privilege of building a new polyclinic. Having said that, you only need it once in a lifetime.



So I must thank the editor's persistence and persuasion which 'nudged' me towards self-reflection.

### 1 Polyclinic building itself

This is the most obvious and instinctive association most will have and that is certainly

true to an extent. But even before the first drill pierces the soil, the first 2 years were spent in deep discussion conceptualising the clinic itself, writing papers to secure Ministry of Health (MOH) funding and the negotiations that

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ensue. There were times when the administrative process was painfully slow, almost grinding to a standstill and those were the times where patience had to be honed. Then there were the exhilarating moments when you got the necessary approvals and saw that glimmer of hope to carry on.

Then comes the building itself. It's truly quite astounding the sheer details and effort that goes into planning. The various patient flows, staff and equipment flows. My team poured through countless floor plans looking at layouts, furniture, electrical points, LAN points etc. So many nitty gritty details yet each one critical to the success and ease of operating the clinic.

I gained a deeper respect for architects and planners as they orchestrate the various activities that needs to take place and a deeper appreciation of my hospital and GP colleagues who are involved in similar projects of varying scale.

You also gain a deeper insight about yourself which is often the case when stretched or placed in unfamiliar situations. I never knew I could be so meticulous and detailed when it came to some parts of the planning (which is just not me if you ask my wife!). And, that just leads me to the next point.

## 2 People

You can't do it alone. Oftentimes, an area you are all focussed about means there are 3 other areas which you have neglected – blind spots. You need a team. A team to work together with you and get it done. That is obvious enough and does not need belabouring. There is only so much you know and so much more you don't. The power of a team comes when each one harness his or her strength and subject matter expertise to make the whole endeavour so much richer.

I was blessed to have had a great planning team. We had lots of fun together which made the overall journey so much more pleasant. However, a great team alone will not make it without HQ support. And HQ support is one of those things that needs to be finely nuanced. It is that balance of oversight, not over nor under but just right and in the right areas that is the most effective. It requires a great deal of insight on both sides, mutual trust and communication to strike that balance. I am grateful to have received HQ support.

In the latter half, the focus shifts to recruitment and forming a new clinic team. It's crucial to get the right people on the bus although in an organisation that may be beyond your control. In my case, I had equal proportion of freshly recruited people some new to healthcare and existing staff from other clinics. Each having different backgrounds, experiences and strength. What culture do you want to set? How to gel them together towards a common purpose?

In a way, culture is embodied inside you and expressed in relationships and the way people interact with each other. And so, the culture (whether intentional or unintentional) is set right from the planning stage and with whoever you are working with. It then gets crystallised, articulated and cascaded down more intentionally especially by your clinic management team.

## 3 Processes

Whether it be a GP clinic or a polyclinic, there is so much going on every day and potential risk that lurks. We all need processes and standard operating procedures (SOPs) so that everyone knows what everyone else is doing and stay safe. This is where I am thankful being in an organisation, because most SOPs have been written down and it's just a matter of adopting and adapting to fit your

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The College is pleased to welcome Prof Amanda Howe, President of the World Organisation of Family Doctors (WONCA), during her visit to Singapore on 4 August 2018. Prof Howe visited our College premises and signed our guest book. That evening, College President Adjunct Assistant Professor Tan Tze Lee hosted Prof Howe to dinner at the Capella Hotel.

This visit affirms the strong relationship between WONCA leadership and CFPS.



Prof Amanda Howe (seated) signs on the guest book as (standing, from left) immediate past CFPS president A/Prof Lee Kheng Hock, CFPS president Adj Asst Prof Tan Tze Lee and Hon. Secretary Dr Suraj Kumar look on.

local setting. (Along the way, you uncover a few that makes you scratch your head but that's for another day.)

The key difference is oftentimes we are not building a cookie cutter polyclinic. Change is in the air (whether it be internally or externally driven) and care evolves in anticipation and in response. So in a sense, the organisation evolves with each new clinic because of changes in care delivery and processes which impact both organisational and clinic level.

And that boils down to the most important Ps.

#### 4 Product and Patients

The building is merely an empty shell, a conduit for people and processes to deliver a product. And naturally product is intimately connected to patients/people you are delivering to. Rather than the afterthought, this is foremost in everyone's mind and the dominant thought that anchors the rest of the Ps. The first 2 years were spent thinking through and articulating just that – the patients we are serving and the product we are delivering - the care delivery revolution we want to see and the subsequent processes that wrap around it.

Yet the commonest question posed to me is “So, what new services are you going to have?” Perhaps a better question could be what unmet need is out there? And who is best



placed to meet it? That requires us to firstly uncover that unmet need in the community we are serving and sometimes the answer lies with the existing service provider (medical or non-medical) down the road. Then to consider whether the polyclinic is

best placed to meet that and in what form/manner or is someone else better placed to meet that.

A more institution centric one could be “What is a better way to deliver the care we are currently delivering to meet a known need i.e. can you improve your current product or process?” Of course, this is a common improvement question that can be asked each day. It's just that the project itself gives opportunity and impetus to consider this.

The astute reader and healthcare provider will know that this whole section is the hardest to think through. And to think through this 4 years into the future makes the task even more challenging (and almost obsolete the moment you think you finished!).

Such is the challenge of providing primary care especially from a community/ population approach. The wide scope of primary care incorporating all life stages from cradle to grave and the demographic changes means that needs are constantly evolving and emerging. Medical and

*(continued on Page 23)*

*Dinner at the Capella Horel (standing, from left): Dr Kee Loo, Dr Lim Ang Tee, Dr Low Lian Leng, Dr Lim Hui Ling, Dr Wong Tien Hua, Dr Suraj Kumar*

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CM

**CM:**

Please share one or more anecdotes from your experience with our helping our migrant worker friends that has made an impact on you.

**JL:**

While volunteering full-time doing casework and social assistance, I got the chance to visit a shop-house apartment along Desker Road where ten migrant workers were cramped into. The living facilities were bare; ventilation was poor. They each paid a few hundred dollars a month to stay in that apartment. It showed me that life can get very tough if you are a migrant worker, suffer from work injury and have no income while awaiting for work injury compensation. On another note, while volunteering in the food programme, I found out that some migrant workers were great cooks!

**CM:**

After your video interview was published by The Straits Times, how did you feel? Did it motivate you to keep pressing on as a volunteer?

**JL:**

Many of my friends and colleagues texted me to tell me that it was inspiring. But I was most happy that we did get increase in volunteer numbers after the video, although we will always appreciate more doctor volunteers, because it will help reduce the workload for each doctor, and allow us to treat more of our migrant brothers each clinic shift.

**CM:**

Please share how the training you have received in Family Medicine has equipped you to serve out your role as a volunteer in HealthServe.

**JL:**

The training that I received from the GDFM course was broad and yet very practical and structured, something which I really liked. Hearing from our tutors let us learn

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from their experiences as well, so that we are more confident and competent in giving care to our patient, regardless of their upbringing and background. Specifically for volunteering at HealthServe, the lessons related to Work Injury Compensation Act (WICA) taught me how to better help migrant workers know their rights and navigate the system to seek compensation after work injury.

**CM:**

How would you encourage more doctors to come on board this meaningful partnership despite their busy schedules?

**JL:**

I like how you refer it as a meaningful partnership; while migrant workers benefit from the direct medical treatment and reduced costs of consultation, I think personally I have grown to be more sensitive to the nuances and complexities of issues regarding the unjust treatment of migrant workers, at the same time being aware of a few instances of migrant workers who may be malingering. The whole experience has helped me see this world with more discerning lenses.

Once you get used to communicating with migrant workers, the clinic sessions should be very comfortable (and enjoyable) for those who run general practitioner/ family medicine clinics or those who work at the polyclinics.

For those doctors who wish to spend quality time with their family on weekends, volunteering could be a family activity, as HealthServe needs non-doctor volunteers as well. Maybe while driving past the dormitories where migrant workers live, or seeing them play at the fields outside Chinese Gardens, one could spark a conversation on how these foreigners who have put in their blood, sweat and tears to build Singapore's skyscrapers and facilities and, notwithstanding age limitations, further explore how as a family you could volunteer.

■ CM

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technological advances open up new possibilities in the type of care and the way it can be delivered. Everyone, from GP to polyclinics, have to constantly reinvent themselves to harness, incorporate and apply these cost effectively to stay relevant and on the ground to meet the needs of their community.

## 5 Purpose

Everyone must find that enduring purpose that anchors us amidst the constant changes, challenges and cacophony of noises that pull us in all directions.

And this is what the team at Punggol Polyclinic came up with:

*The Oasis Tree of Health - a place of Healing and Hope for the young to elderly residents of Punggol.*

A tree alone can't do much but an ecosystem of different trees with roots intertwined and interdependent will make a verdant forest providing shade and rest to all.

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CM

# September 2018 President's Forum

by Adj Asst Prof Tan Tze Lee, President, 26<sup>th</sup> Council, College of Family Physicians Singapore

The 3rd quarter has been a very eventful and exciting one for the College. We had our Commencement Ceremony and Annual General Meeting on the 28th July 2018, and this year it was held at the Singapore Chinese Cultural Centre. Prof Doris Young was our Guest-of-Honour, and she gave a rousing and inspiring speech to our new trainees.

We are very encouraged by the strong interest by our young doctors in our programmes. This year there are 247 applicants for the Graduate Diploma of Family Medicine (GDFM) course, 20 for the MMed(FM) College programme, and 19 for the Fellowship programme. With these increased numbers comes much responsibility. I am happy to report that our GDFM candidates have done very well, with a pass rate of 73.6% in 2018, a great improvement when compared with 60% in 2017. Credit must go to the candidates and the GDFM team for working so hard to achieve this excellent result.

Dr Wong Tien Hua and Dr Lawrence Ng now lead the GDFM team as Programme Director and Associate Programme Director respectively. They will be making every effort to revamp and enhance the course, to better prepare our trainees for the new challenges they will face with an ageing population, which include new modules in mental

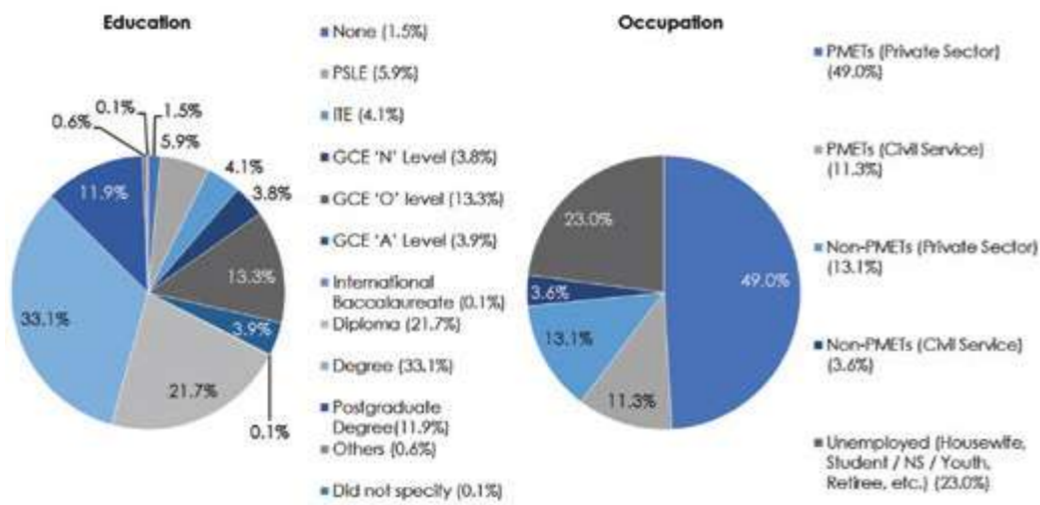
health, geriatrics, and an optional Certificate in Community Hospital Practice programme.

As a profession, we are active observers and participants in the development of our healthcare system. Early on in 2018, whilst reviewing the proposed Health Care Services Act (HCSA), and the implications for the nationwide implementation of mandatory contribution to the National Electronic Health Record (NEHR), the College of Family Physicians Singapore, the Academy of Medicine Singapore and the Singapore Medical Association agreed to conduct a joint survey on the public sentiments towards the NEHR.

The objectives of the survey were to evaluate the general public's sentiment and awareness of the NEHR, understand the perceptions and misconceptions of the public towards the NEHR, and identify any concerns they might have.

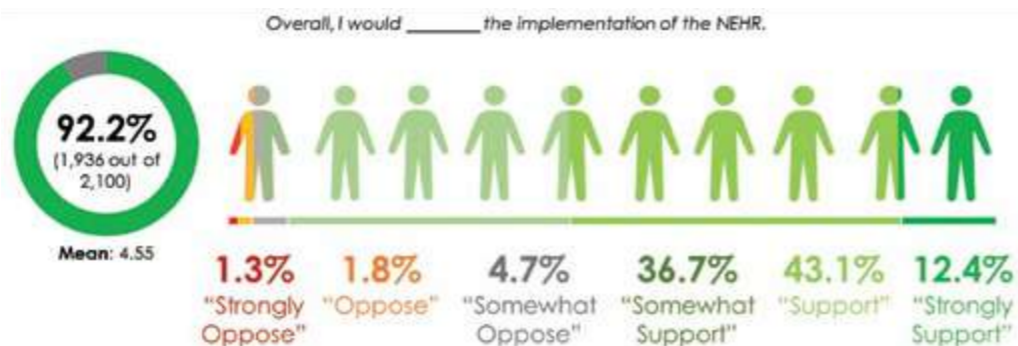
This survey was carried out over a six-week period between 9 Mar 2018 to 15 April 2018. A total of 2100 responses were collected comprising 2000 online submissions and 100 face-to-face interviews. The face-to-face interviews were done to reach out to non-IT savvy respondents aged 60 years and above with these being recruited in the town centres, key districts and heartland areas.

The subject pool comprised 90.4% (1899 of 2100) being Singapore citizens, with 79.8% (1676 of 2100) living in public housing. 58.0% (1217 of 2100) were females, with the ethnic distribution being representative of the Singapore population.



Note: This analysis was based on all respondents, n = 2,100.

We found that 1936 of 2100 (92.2%; "Somewhat Support" / "Support" / "Strongly Support") of the study cohort were supportive of the NEHR.

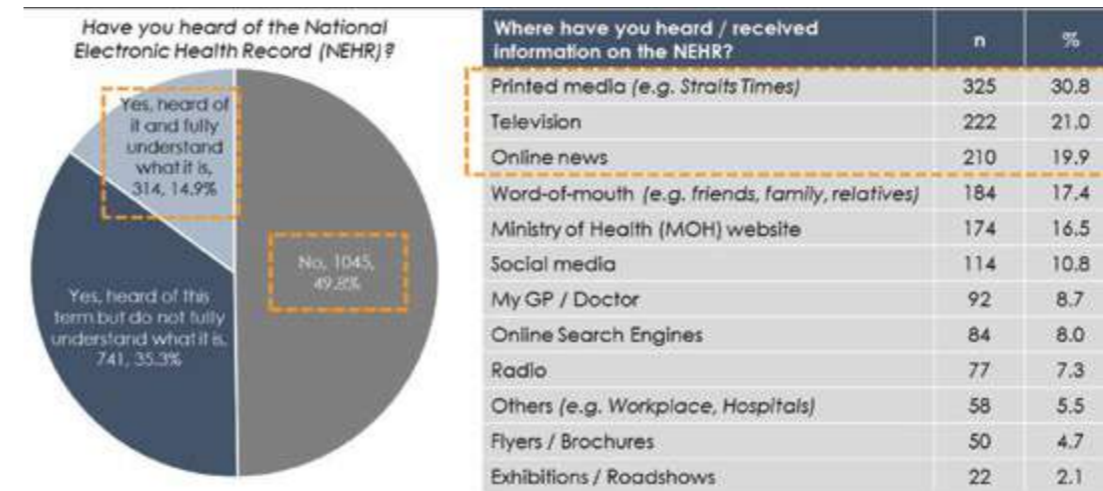


Which of the following best describes your intention towards the NEHR?	%
I would <b>definitely like</b> to have my records maintained in the NEHR.	27.7
I would <b>like</b> to have my records maintained in the NEHR <b>BUT</b> do not want any healthcare provider to access it without my explicit consent except during emergencies.	56.0
It <b>does not matter</b> to me whether my records are in or out of the NEHR.	5.0
I would like to <b>opt out</b> of the NEHR presently, <b>BUT</b> still have my records uploaded in the NEHR (with access blocked for now) so that they can be viewed in the future should I choose to opt in again.	6.0
I would like to <b>opt out</b> of the NEHR presently <b>AND</b> do not want any records stored in the NEHR. Should I change my mind and opt in in the future, I accept these permanent gaps in my record.	3.3
I would like to <b>opt out</b> of the NEHR and am unlikely to opt in in the future. I would not want to store my data in the NEHR at all.	2.0

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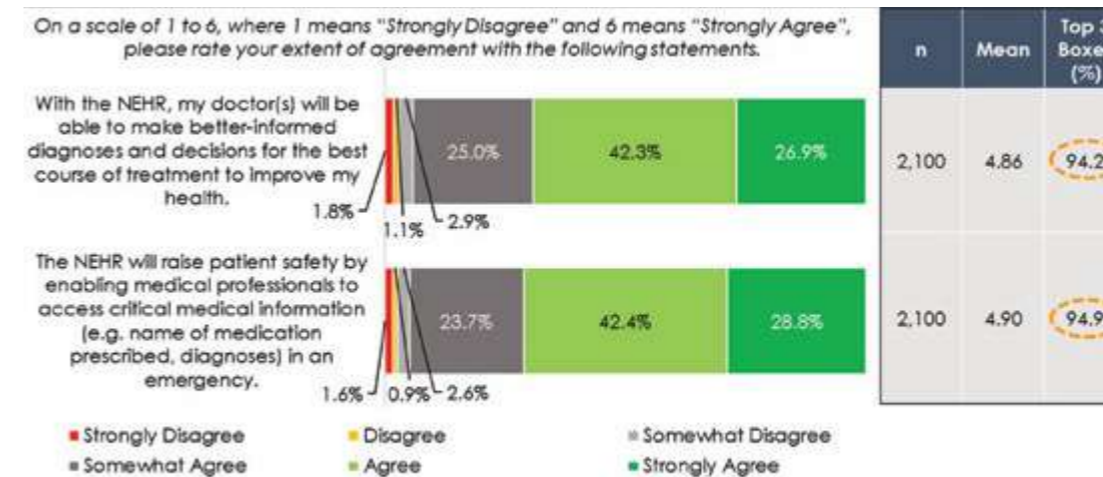
581 of 2100 (27.7%) definitely wanted to have their records maintained in the NEHR.

1175 of 2100 (56.0%) would like their records maintained in the NEHR but did not want any healthcare provider to access it without their explicit consent except in emergencies.



Note: 1. This analysis was based on all respondents, n = 2,100. 2. Analysis on "Where have you heard / received information on the NEHR?" was based on all respondents who answered "Yes" for the question "Have you heard of the National Electronic Health Record (NEHR)?", n = 1,055.

314 of 2100 (14.9%) were fully aware of the NEHR, and 1045 of 2100 (49.8%) had not heard of it at all. Awareness of the NEHR was lowest amongst the 21-29-year olds (62 of 170; 36.5%) and those above 60 years old (141 of 320; 44.1%).



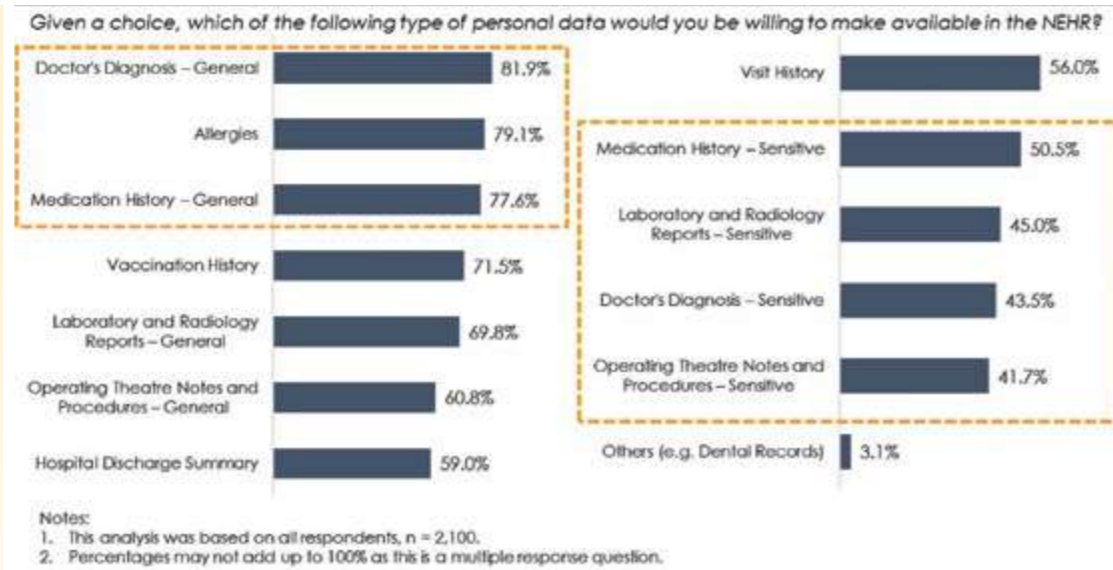
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1979 of 2100 (94.2%) of the respondents felt that their doctors would be able to make better informed diagnoses and decisions with the NEHR, and it would also have raised patient safety (1993 of 2100; 94.9%).

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Majority of the respondents were willing to disclose general information, such as doctor's general diagnoses (1719 of 2100; 81.9%), allergies (1661 of 2100; 79.1%) and general medication history (1629 of 2100; 77.6%).

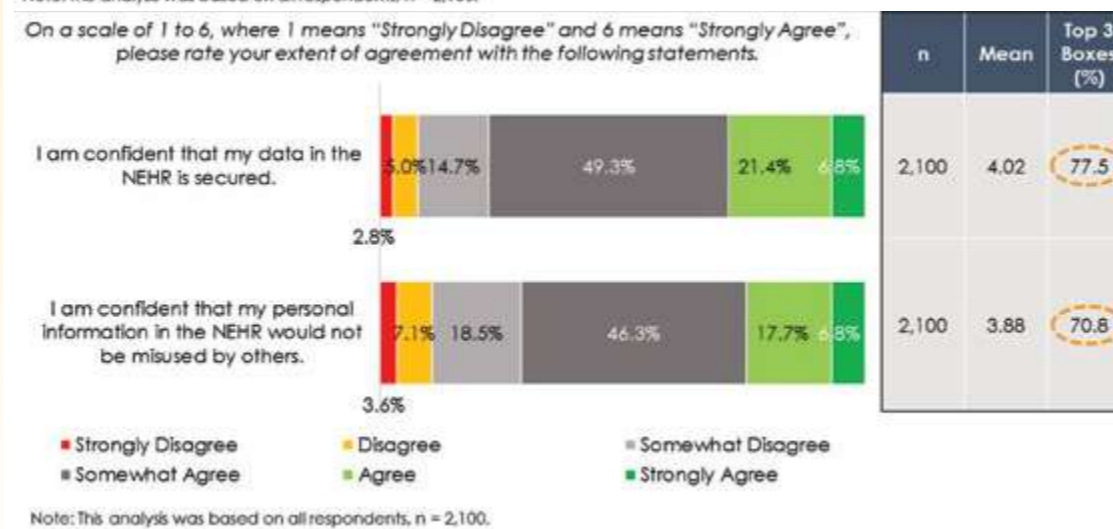
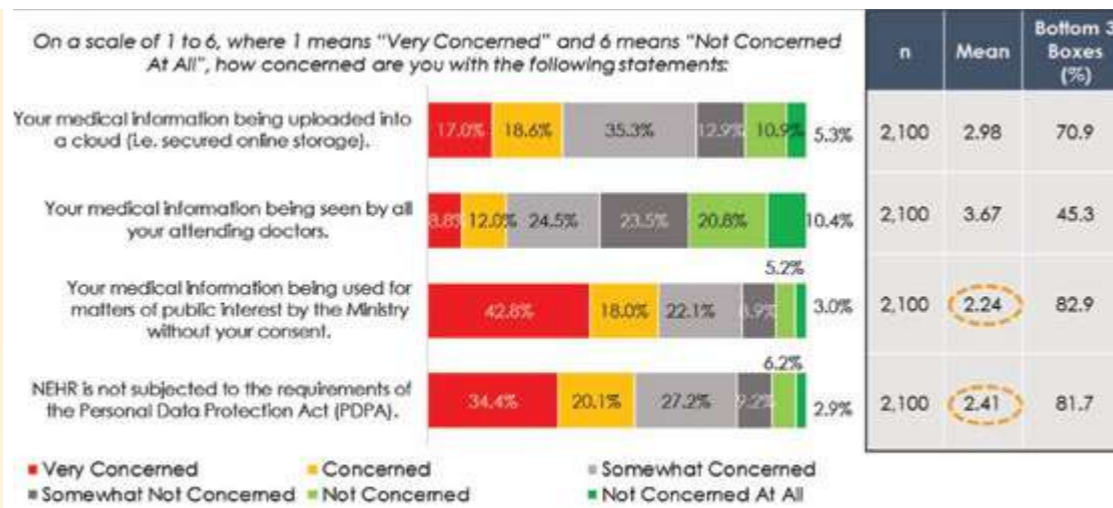


However, when it came to "sensitive" information, the support was lower [medication history (1061 of 2100; 50.5%), lab and radiology results (946 of 2100; 45.0%), doctor's more specific diagnoses (914 of 2100; 43.5%) and operation/procedure notes (876 of 2100; 41.7%).]

77.5% (1627 of 2100) of the respondents were confident that their data in the NEHR was secure, and 70.8% (1487 of 2100) were confident that their data would not be misused by others. Nevertheless, there were specific concerns:

1. 70.9% (1489 of 2100) were concerned about their medical information loaded onto a cloud (secured online storage),

2. 82.9% (1741 of 2100) were concerned that their medical information would be used for matters of public interest by the Ministry without their consent, and



3. 81.7% (1715 of 2100) were concerned that the NEHR was not subjected to the requirements of the Personal Data Protection Act (PDPA).

The conclusion was that

- About half (1055 of 2100; 50.2%) of the respondents were aware of the NEHR with 14.9% (314 of 2100) "fully understanding" what NEHR is.
- More than 90.0% of the respondents agreed that with the NEHR, "their doctor(s) would be able to make better-informed diagnoses and decisions for the best course of treatment to improve their health" (1799 of 2100; 94.2%) and that "the NEHR would raise patient safety by enabling medical professionals to access critical medical information (e.g. name of medication prescribed, diagnoses) in an emergency" (1993 of 2100; 94.9%).
- Most of the respondents were confident that their data in the NEHR was secure (1627 of 2100; 77.5%), and that their data would not be misused by others (1487 of 2100; 70.8%). Nevertheless, there were still concerns with data confidentiality with regards to their "medical information

being used for matters of public interest by the Ministry without their consent" (1741 of 2100; 82.9%) and that "NEHR is not subjected to the requirements of the PDPA" (1715 of 2100; 81.7%).

4. In a nutshell, while 92.2% of the respondents supported the implementation of the NEHR to varying extents, about a quarter of all the respondents (581 of 2100; 27.7%) mentioned that they "would definitely like to have their records maintained in the NEHR". More than half of the respondents (1175 of 2100; 56.0%) "would like to have their records maintained in the NEHR but do not want any healthcare provider to access it without their explicit consent except during emergencies".

The survey results has helped us to better understand the public perceptions of the NEHR, and the sensitivities regarding the privacy and confidentiality issues of personal medical records that concern the members of the public. With this insight, we hope that it will help to shape how the NEHR will develop especially in the light of the forthcoming Health Care Services Act (HCSA).

CM

## MINISTRY OF HEALTH'S STATEMENT ON THE JOINT PUBLIC SENTIMENT SURVEY ON NEHR BY AMS, CFPS AND SMA

The Ministry of Health (MOH) would like to thank the Academy of Medicine, Singapore (AMS), College of Family Physicians Singapore (CFPS) and Singapore Medical Association (SMA) for providing additional valuable feedback on the National Electronic Health Record (NEHR).

2. The survey validates much of the feedback that we had gathered during MOH's public consultation sessions in early 2018 from various stakeholders, including current and prospective licensees, professional bodies, and members of the public.

3. The survey indicates broad support for the NEHR as an enabler to facilitate care continuity as patients move across healthcare settings. We are also heartened that respondents agreed that the NEHR will raise patient safety by enabling medical professionals to access critical medical information during emergencies.

4. The survey findings reiterate concerns similar to those raised during the public consultation, such as

patient confidentiality and data security. MOH plans to enact legislations to protect patients' healthcare data and usage in NEHR.

5. As patient confidentiality is of utmost importance to us and in view of the recent major cyberattack on SingHealth's database, MOH has directed the Integrated Health Information Systems (IHIS) to conduct a thorough review of the robustness of the cyber safeguards of our key IT systems. These include the NEHR, which is different and separate from the affected system at SingHealth. While we conduct this review, we will take a pause on our plans on mandatory contributions of healthcare information to NEHR. This will allow us to review and strengthen our cybersecurity measures where necessary before proceeding.

6. MOH recognises that doctors and dentists, as future users of NEHR, play a critical role in ensuring that electronic medical records are used safely, effectively, and ethically for the benefit of our patients. We thank AMS, CFPS, and SMA once again for sharing their survey findings with us.

# Family Medicine

## COMMENCEMENT CEREMONY & AGM 2018

28 JULY 2018 ♦ SINGAPORE CHINESE CULTURAL CENTRE



Inauguration of the Fellowship by Assessment Programme in 1998

Graduate Diploma in Family Medicine (GDFM)

Programme Director: Dr Wong Sien Hwa  
Associate Programme Director: Dr Lawrence Ng Chee Lian

College of Family Physicians Singapore  
47th Annual General Meeting (AGM)  
28 July 2018 (Sat), 4pm  
Singapore Chinese Cultural Centre, Level 9 Auditorium

	2017	2016	2015	2014	2013	2012
Accumulated fund	8,113,693	8,113,693				
Management funds	2,898,130	2,898,130	2,817,821	2,512,836		
Revolvement income						
Total Funds and Reserves	11,011,823	11,011,823	2,817,821	2,512,836		
UNASSIGNED						
Current Liabilities						
Other creditors						
Current liabilities						
Total Liabilities						
Total Funds and Reserves						

More event photos can be viewed at [www.cfps.org.sg/galleries](http://www.cfps.org.sg/galleries)

## Interview with A/Prof Goh Lee Gan on Healthcare Services Act

Interviewed by Dr Chan Hian Hui, Vincent, FCFP(S), Council member, Team C editor and Dr Low Sher Guan, Luke, FCFP(S), Honorary Treasurer, Chief Editor

### HCSA AND NEHR

As readers are aware, the Ministry of Health is currently inviting feedback on the proposed new Healthcare Services Act (HCSA) due to be tabled in Parliament soon. The HCSA is intended to replace the current Private Hospitals and Medical Clinics ACT (PHMCA) in regulating the provision of health care services in Singapore (ref 1). One of the new requirements is for mandatory input of patient data by all healthcare institutions, including laboratories in the National Electronic Health Records (NEHR). The College Mirror team interviewed A/Prof Goh Lee Gan for his opinion on this.

### IMPLICATIONS TO PRACTITIONERS

#### College Mirror (CM):

Should we doctors be concerned about HCSA, especially the provisions on mandatory clinical records submission to the National Electronic Health Records (NEHR)?

#### A/Prof Goh Lee Gan (GLG):

Yes. Doctors who are submitting patient health information to the NEHR are described as “Contributing licensees” and doctors accessing patient health information are described as “Accessing licensees”. Section 42 of the HCS Bill (Ref 2) states that “The Minister may prescribe, by name or licensable healthcare service provided, the licensees that are required to disclose the health information of their patients to the national integrated electronic platform...”

Clearly, there are implications on patient confidentiality and privacy that must be followed. Thus, Section 46(2) of the HCSA Bill states “(2) An accessing licensee must not disclose the health information of an individual that the accessing licensee has accessed ... to another person except –

- with prior consent of the individual;
- when it is necessary to do so in connection with the administration or execution of anything under this Act;
- when ordered to do so by a court
- for the purpose of providing the identity of the individual to any person or class of persons to whom, in the Director’s opinion, it is in the public interest that the health information be disclosed;
- where it is permitted or provided for under this Act or any other law; or
- in such other circumstances and to such persons as may be prescribed.”

In the Public Consultation Paper from MOH on the New Healthcare Services Bill (Ref 3) it is also stated in item 5(iv) that “Safeguards will be put in place to ensure that patients’ NEHR records are kept confidential. The NEHR can

be accessed only for purposes of patient care, and not for other purposes, including assessment for employment and insurance.”

#### CM:

There is a section, namely section 48 (1) (a) (b) on “Accessing and using health information for other purposes”, presumably in the context of public interest (See Section 46(2)(d) in Reference 2). Some doctors are particularly concerned for the potential for misuse by authorities of such circumstances. The question is, what is defined “to be in the public interest that the health information be disclosed” and are there safeguards here?

#### GLG:

Yes. This is a sensitive area. There is a need to examine and define as to what are examples of information that are to be “in the public interest” to warrant disclosure. Also, the question of whether Minister of Health is enough to grant approval or more than one person is required as a safeguard needs further discussion. Studying the provisions in other jurisdictions such as UK or Australia may be useful here.

#### CM:

Are there any professional implications arising from NEHR? For example, will overprescription for cough syrups, or inadequate standard of care be liable for prosecution?

#### GLG:

If there is a complaint, be it from patients, or other health providers, or MOH with an affidavit submitted, SMC will investigate. The presence of an NEHR record that is properly entered with adequate factual details will clearly be the doctor’s best defence. The consultation time should be adequate to include the time for entry of adequate records.

#### CM:

Is it even possible to read every NEHR entry, especially if there are decades of data in it. What about liabilities arising from missing one line, hidden in decades of NEHR records?

#### GLG:

This is an important question. For the “first visit” patient, an adequate consultation process that seeks out the reason for encounter (RFE) and ideas, concerns, and expectations (ICE); past history of medical illnesses and hospitalisations; social history including past and present occupations; family history; past allergies; and systems review will be needed either from the patient, and or accompanying person.

This will indicate how much scrutiny of the NEHR is needed. Obviously the need for a scrutiny of the NEHR will be of greatest value in the first consultation of a patient. If there is a NEHR record and this is the patient’s first consultation it will be foolhardy not to look at it.

It is also useful to cross-check entries in the NEHR judiciously with the patient, such as the cause for hospitalisation, current illnesses, and medications. For example, I have detected entries where the side of weakness from a stroke is on the wrong side; or the patient had wrong ideas of which medications for what medical conditions.

Will all this take too much time? Well, this is legitimate consultation time. Dividing the consultation into long or short helps one to decide which type of consultation and how much the consultation fee should be. Certainly, if the patient has multiple problems, it will take some time to sort things out in the first consultation, and even subsequently.

#### CM:

Is there really a need for mandatory NEHR?

#### GLG:

There are many advantages for a NEHR to be set up. It allows the implementation of the “One Patient, One Health Record” system where information from different providers can be on one common platform and shared. Authorised clinicians are able to access their patients’ medical history from NEHR at any time to make better informed diagnoses and treatment decisions that could improve a patient’s health outcomes. The sharing of critical information such as drug allergies or travel history could potentially be lifesaving. The availability of information in the NEHR can also reduce duplicative tests (Ref 4). So the answer is a resounding “Yes”.

#### CM:

Mandatory NEHR also means that all doctors will soon practice in a more “open system”, where other colleagues and the government can see our management. Any advice on this?

#### GLG:

Yes. We expect a learning curve. Positive thinking helps us provide better quality care and be better practitioners. Let us welcome the ability to integrate our understanding of the patients’ medical problems and care received with other providers. By being an “open system” helps us to be on our toes too.

### PUBLIC SENTIMENTS TOWARDS NEHR

#### CM:

The College recently conducted a “joint survey on public sentiments towards NEHR with SMA and AM.” Should we be concerned that while 92.2% of patients supported implementation of NEHR to varying extents, only 14.9% of respondents had “full understanding” of what NEHR is?

#### GLG:

The survey results are helpful. It shows there is a need to help our patients to have a fuller understanding of what are their medical conditions and what have been documented in the NEHR records of their conditions. They can help to verify

if the entries are correct if they are able to understand what are their medical conditions all about.

#### CM:

Most of the respondents in the public survey were confident that their data in the NEHR was secure (1627 of 2100; 77.5%), and that their data would not be misused by others (1487 of 2100; 70.8%). What are your comments?

#### GLG:

It is good the public trust towards the NEHR is good. We should work hard to ensure this trust is not misplaced.

### WHERE DO WE GO FROM HERE?

#### CM:

The NEHR is going to be the centre-piece of the HCS Act. Where do we go from here?

#### GLG:

There is a need for many helping hands – doctors, nurses, allied health practitioners, administrators, patients to contribute ideas, express support and contribute community support to make the NEHR a tool that helps us together create a workable healthcare information delivery system. Attention to defining what are in the public interests for using the NEHR outside healthcare provision, as well as safeguarding the security of NEHR is of ongoing importance too.

#### CM:

Thank you A/Prof Goh.

#### GLG:

Thank you. You are welcome.

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# HealthServe – a GP-Led Holistic Care VWO

## An Interview with Dr Goh Wei Leong, Co-founder of HealthServe

Interviewed by Dr Chan Hian Hui, Vincent, FCFP(S), Council Member, Team C Editor

College has been very impressed with Dr Goh Wei Leong's work with HealthServe and how it has gained national recognition, raising the profile of Family Medicine. Dr Goh kindly agreed to an interview with me on 09 May 2018. During the interview Dr Goh shared with me that his volunteering journey began when his good friend and dentist, Dr Simon Mahendran, asked him to volunteer at the Karunya Community Clinic which serves marginalised migrant workers.



Dr Vincent Chan (left) and Dr Goh Wei Leong

And this he did, providing his first glimpse into this work. Also, "looking around... (he) observed the increasing numbers of migrant workers in Singapore," and by volunteering he gradually came to understand the complexity of issues facing these marginalised migrant workers.

Thus, about 12 years ago, Dr Goh decided to hold a party in his house and gathered some 15 to 20 friends, including a few doctors, and told them of about "this crazy idea about setting up this thing (HealthServe)." And to his surprise, his friends told him that it was a great idea. And 3 of the General Practitioners (GPs) among them helped him register and set up HealthServe as a medical clinic. These 3 GPs include Dr Soh Ling Ling, Dr Teo Boon See and Dr Lau Kit Wan. Dr Goh also invited A/Prof Wong Mee Lian, A/Prof Lim Poh Lian, Dr Shawn Vasoo and Dr Jeremy Lai to help out as well. Dr Goh mused that he is a "networker...a collaboration kind",



Migrant workers making a beeline for HealthServe - both outside and inside the clinic.



one who gathers a team to work on this project. He is also very grateful for the enormous support from his businessman co-founder, Mr Tang Shin Yong and the 2 of them are the main drivers for HealthServe.

On the unexpected growth of HealthServe as an organisation, Dr Goh said that "to be honest, (he) had no plans to grow it into what it is today. Doctors, we just bring our stethoscope, we donate some of our drugs, speak to some pharmaceuticals,

can make it lah." one of their first tasks was to secure a physical clinic space, and it was decided that this must be "where the migrants are, where the needs are, and we found Geylang." And the clinic was located inside a place called High Point Community Services, where the rent was low as it was zoned as a social enterprise. So they started very small with just a clinic. But as they received their "first few migrant workers that came in, (they) realised that my goodness, they got problems that doctors cannot solve." Dr Goh shared that if the patient has cough or back pain, this can be alleviated with medications.

### Creating a Holistic Care Framework

"But (he) personally realised that migrant workers got lots of problems including no shelter, no makan (food), no job. So, when that happens, what do I do? Do I carry on giving medicines and say good luck to you, or one has

to intervene?" And intervene HealthServe did, and that required some fund raising which was done. HealthServe thus launched a food programme, topped up MRT cards, and phone cards so that these injured workers and others in need of assistance can call home. For the injured with no place to stay, pocket money was also given out. In the early days, they did not have the luxury of referring to a Medical Social Worker (MSW), so HealthServe had to create the service with Dr Goh inviting Social Work and Counsellor friends to provide this service. He notes that many of these migrant workers also suffer from depression and a few are suicidal. And gradually, the work team expanded to include doctors, nurses, dentists, medical social workers and counsellors. Such is the confidence that Tan Tock Seng Hospital has in their services, that they refer migrant workers to HealthServe for further care and befriending support, under a signed agreement. To better assist these marginalised migrant workers, HealthServe also does "upstream work" such as research and advocacy, and they have started engaging with the Ministry of Manpower on key issues facing their patients.

When asked about his thoughts on getting the Straits Times Singaporean of the Year Award for 2017, he said that it was a "seriously humbling award... and it was given to the entire organisation and not just (himself)." For they even have migrant workers volunteer at their centre. For younger doctors, Dr Goh advises that "one has to do what (one is) passionate about. And sometimes we find that passion when we are attentive to what's going on around us... And working your passion through these issues, (bring) us sort of joy." He also salutes the generosity of many doctor colleagues, including neurosurgeons who performed a spinal surgery on a patient for free and senior ophthalmology consultants who waive their consultation fee for these needy patients. Dr Goh ends off with the remark that "I am happy to say that a platform like HealthServe brings up the best in our fraternity, and I want to thank everyone for that."



All images courtesy of Dr Natarajan Rajaraman, HealthServe medical director

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## Interview of HealthServe Volunteer Dr Joshua Lam

Interviewed by Dr Jonathan Yeo Cheng Hsun, FCFP(S)

Dr Joshua Lam is a CFPS member who graduated from NUS Yong Loo Lin School of Medicine in 2010. He obtained his Graduate Diploma in Family Medicine in 2016 and is currently a Lead Informatics Specialist at Integrated Health Information Systems (IHIS) where he is playing a part in the development of Singapore's HealthTech landscape. Joshua, who is 31 this year, has devoted his free time to helping as a regular medical doctor volunteer at HealthServe's clinics since July 2015. In Feb 2017, Joshua was interviewed by The Straits Times for his contributions to HealthServe.

College Mirror (CM) had the opportunity to interview Joshua (JL) about his involvement as a HealthServe volunteer.



Dr Joshua Lam (middle) devotes much of his free time as a regular medical medical doctor with HealthServe.

### College Mirror (CM):

Please share with us what motivated you to start volunteering at HealthServe?

### Dr Joshua Lam (JL):

While working in the restructured hospitals, I remember a migrant worker who had classical signs and symptoms of appendicitis but left against medical advice because he needed confirmation from his employer that they would cover the hospitalisation fees. It left a deep impression in me that he prioritised his financial situation above his health.

I also realised migrant workers tended to be very ill by the time they presented to the polyclinics. That led me to find out more about the plight of migrant workers in Singapore and eventually volunteer.

### CM:

Does Dr Goh Wei Leong's passion and heart for this group of workers motivate you in any way, and how?

### JL:

Dr. Goh's dedication in serving the migrant workers is truly inspiring. Dr. Goh will always set aside some time in his busy schedule to guide the younger generation of interns and volunteers to think about how to help our migrant brothers more holistically, beyond their immediate needs of medical care, daily expenses and social assistance. He also brainstorms with them to think out of the box in finding ways to serve our migrant brothers.

### CM:

Please describe what areas of volunteer work that you were/are involved in at HealthServe.

### JL:

At the start I was volunteering between twice or thrice a month for clinic sessions at the Geylang and Jalan Papan clinics during which I would see patients for about two hours. Last year, I also took the opportunity to help out as a full-time volunteer in their casework, social assistance and food programme for about six weeks. Right now, I am trying to work on a project where we look into the care of injured migrant workers immediately after receiving acute medical treatment to help them re-integrate back into the community.

### CM:

What motivates/ inspires you to keep on volunteering after so many years?

### JL:

I recently caught up with a friend, another regular volunteer doctor at HealthServe who shared that she felt quite isolated

while volunteering at HealthServe. I was quite perplexed because it was exactly the warmth and energy of the larger HealthServe community that kept me going back! I would recommend any one who is keen to volunteer to spend some time before or after the clinic shift to get to know the full-time staff and volunteers. You never know as you may hear about a project which may pique your interest! Also, the dedication of the staff to achieving HealthServe's vision and mission inspires me to keep on volunteering.

**I also realised migrant workers tended to be very ill by the time they presented to the polyclinics. That led me to find out more about the plight of migrant workers in Singapore and eventually volunteers.**

### CM:

Please share one or more anecdotes from your experience with our helping our migrant worker friends that has made an impact on you.

### JL:

While volunteering full-time doing casework and social assistance, I got the chance to visit a shop-house apartment along Desker Road where ten migrant workers were cramped into. The living facilities were bare; ventilation was poor. They each paid a few hundred dollars a month to stay in that apartment. It showed me that life can get very tough if you are a migrant worker, suffer from work injury and have no income while awaiting for work injury compensation. On another note, while volunteering in the food programme, I found out that some migrant workers were great cooks!

### CM:

After your video interview was published by The Straits Times, how did you feel? Did it motivate you to keep pressing on as a volunteer?

### JL:

Many of my friends and colleagues texted me to tell me that it was inspiring. But I was most happy that we did get increase in volunteer numbers after the video, although we will always appreciate more doctor volunteers, because it will help reduce the workload for each doctor, and allow us to treat more of our migrant brothers each clinic shift.

### CM:

Please share how the training you have received in Family Medicine has equipped you to serve out your role as a volunteer in HealthServe.

### JL:

The training that I received from the GDFM course was broad and yet very practical and structured, something which I really liked. Hearing from our tutors let us learn

**The training that I received from the GDFM course was broad and yet very practical and structured, something which I really like.**

from their experiences as well, so that we are more confident and competent in giving care to our patient, regardless of their upbringing and background. Specifically for volunteering at HealthServe, the lessons related to Work Injury Compensation Act (WICA) taught me how to better help migrant workers know their rights and navigate the system to seek compensation after work injury.

### CM:

How would you encourage more doctors to come on board this meaningful partnership despite their busy schedules?

### JL:

I like how you refer it as a meaningful partnership; while migrant workers benefit from the direct medical treatment and reduced costs of consultation, I think personally I have grown to be more sensitive to the nuances and complexities of issues regarding the unjust treatment of migrant workers, at the same time being aware of a few instances of migrant workers who may be malingering. The whole experience has helped me see this world with more discerning lenses.

Once you get used to communicating with migrant workers, the clinic sessions should be very comfortable (and enjoyable) for those who run general practitioner/ family medicine clinics or those who work at the polyclinics.

For those doctors who wish to spend quality time with their family on weekends, volunteering could be a family activity, as HealthServe needs non-doctor volunteers as well. Maybe while driving past the dormitories where migrant workers live, or seeing them play at the fields outside Chinese Gardens, one could spark a conversation on how these foreigners who have put in their blood, sweat and tears to build Singapore's skyscrapers and facilities and, notwithstanding age limitations, further explore how as a family you could volunteer.

■ CM

(continued from Page 11: "Building Punggol Polyclinic – My Experience")

technological advances open up new possibilities in the type of care and the way it can be delivered. Everyone, from GP to polyclinics, have to constantly reinvent themselves to harness, incorporate and apply these cost effectively to stay relevant and on the ground to meet the needs of their community.

## 5 Purpose

Everyone must find that enduring purpose that anchors us amidst the constant changes, challenges and cacophony of noises that pull us in all directions.

And this is what the team at Punggol Polyclinic came up with:

*The Oasis Tree of Health - a place of Healing and Hope for the young to elderly residents of Punggol.*

A tree alone can't do much but an ecosystem of different trees with roots intertwined and interdependent will make a verdant forest providing shade and rest to all.

■ CM

# Challenges facing Telemedicine

by Dr Wong Tien Hua, FCFP(S), Council member, Editorial Board Team C

According to the 2015 MOH National Telemedicine Guidelines, “Telemedicine” refers to the systematic provision of healthcare services over physically separate environments via Information and Communications Technology. Telemedicine can be categorised into 4 domains of which the concept of Tele-treatment is of the most interest to healthcare providers. **Tele-treatment** refers to interactions between healthcare professionals and patients for direct clinical care e.g. triage, history, examination, diagnosis and treatment (including robotic surgery) from a remote location.

Telemedicine has been the hot topic in recent months with news reports of medical apps that connect patients with doctors, allowing online consultations using smart phones. The media has interviewed more than a handful of technology startups that aim to develop apps that facilitate telemedicine and challenge the traditional model of a doctor’s consultation.

The traditional, or perhaps the widely practiced, model of care today is one in which the patient visits the healthcare practitioner in a bricks-and-mortar institution. A simple illustration will be the patient who goes to his nearby GP clinic to visit the doctor when he is unwell.

It may sound like stating the obvious but there are some characteristics of this process that can be gleaned, which is often taken for granted.

- The patient has to physically attend in person
- A **face to face** consultation occurs within the clinic
- The **identity** of the patient can be verified, and the doctor has reasonable certainty that the patient in front of him is the patient being treated.
- The doctor is able to personally **observe** the patient, perform a **physical examination**, communicate with the patient and come up with a shared management plan
- Any **treatment** or procedure is conducted within the clinic premises, or referred to another healthcare institution if specialist skills are required.
- It is quite clear that the doctor in attendance has agreed to see the patient and to take on the responsibility of managing that patient. A **duty of care** that is therefore established. This means that if the patient is unhappy or suffers medical negligence, he or she is able to identify who was the doctor in charge.

- The **medical records** are generated in the clinic and stored in the clinic
- The healthcare institution is easily identifiable, and is **regulated** by the relevant laws that apply to the healthcare institution, including being subject to audits and inspections by the Ministry of Health. As such, any patient who walks into a clinic or medical facility in Singapore can reasonably expect a high standard of care and safety from harm.
- And finally, there is an established system of **payment** for the services of the doctor. Whether it is paying a fee for service, or through third party insurance, the patient acknowledges the services that he or she has received.

With the advent of information and communications technology, Telemedicine is now set to revolutionize the model of care as we know it. Medical encounters will no longer be confined within a healthcare institution, as patients are freed from the need to physically visit a clinic or a hospital. They may not even be required to leave their own homes. Physical distance will therefore no longer separate a patient from his healthcare provider.

This concept is not new. It has been around since the invention of the telephone by Alexander Graham Bell in 1876. We have of course come a long way since, from voice communication to the ability to transmit digital data from one person to another.

Now with the power of information technology, a patient can have access to any number of healthcare professionals anywhere in the world. The advent of the **smartphone** took this healthcare revolution another quantum leap, when the “doctor”, having “moved” from his office to the desktop, jumped into everyone’s pockets. Medical information is now available 24/7, and telemedicine means that a doctors’ consultation can also be available 24/7.

I recently saw a funny cartoon of a sign in a doctor’s office, which read: “For those patients who has already self-diagnosed themselves on Google and are here for a second opinion, please check yahoo.com”.

If the current model of face-to-face consultation with a doctor defines the standard of care, then telemedicine should not be treated differently and be allowed to fall below such standards. I think we can all agree that the overriding principal is that of **patient safety**.

(continued from Page 24: “To tube or not to tube (feed)”)

4. The patient’s situation is such that no discomfort or pain will be experienced by discontinuing the intervention.

He went on to say “... ANH should be evaluated in light of the principle of proportionality, i.e. the assessment of the ratio of burdens to benefits for the patient. We support the view that if a patient has formulated an advanced directive which specifically mentions omission of ANH in a condition of advanced dementia, such a directive should be honoured.”

Coming back to the question of whether to nasogastric tube or not to tube Mrs F, we must weight all factors. Whether Mrs F had her advanced care plans made, and whether she had pre-specified that she wanted or objected to such a tube being placed. We next have to consider

medical indications for this, and then address family’s concerns, before coming to a decision together. This article is not meant to be prescriptive as the case scenarios will vary not just from patient to patient, but also in the various settings of Family Medicine. So in the end, the answer is, “it depends”.

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3. Jonsen A et al. Clinical ethics. 8th Ed.

■ CM

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# “To tube or not to tube (feed)”

by Dr Lawrence Ng Chee Lian, FCFP(S), Editorial Board Team C

## Case scenario:

A patient's daughter left a phone message: “My mother, Mrs F, has eaten nothing all weekend. What should we do?” A 70-year-old woman with dementia, Mrs F rarely speaks, is confined to a wheelchair, and requires diapers for incontinence. The family had been increasingly worried as she had stopped feeding herself. Even with hand feeding by relatives, her intake continues to decline significantly. The family thus ask you if she should be fed through a feeding tube? The situation evokes strong and conflicting reactions. The patient's sister says, “We can't let her starve to death to death!” The daughter, however; says, “She's telling us to stop. We're just torturing her.”

*(Adapted from: B Lo. Resolving ethical dilemmas. A guide for clinicians. 5th ed.)*

Singapore's ageing population will result in greater increase in cases of end of life (EOL) care and its ethical dilemmas.

Artificial nutrition and hydration (ANH) is a medical intervention and not just a provision of food and water. It is a medical treatment, with its benefits and harms, thus requiring careful consideration if there is greater harm than benefit (principle of proportionality versus the absolute duty to preserve life). We may inadvertently extend life but worsen the suffering.

The family should be informed of both the benefits and harm of ANH before they decide on any intervention. All medical treatment should have a goal and family should ask what the goal of inserting a feeding tube is. We may ask what the feeding tube will accomplish in a particular case. Is it to improve the quality of life or merely to prolong life for as long as possible? If so, is that a reasonable goal? Is that the family's goal or is that the patient's goal?

Will it make the patient more comfortable? Most patients seem to find feeding tubes very uncomfortable – all you have to do is watch how many try to pull them out.

The right to choose not to undergo treatment comes under the principle of informed consent and the right to self-determination. Difficulty arises when the patient is not able (has no mental or decisional capacity) to express his wishes and no documentation is available to indicate their preferences. Often, family or friends (surrogates) become decision makers with the burden falling on them and not the dying person.

Physicians may not be clear about whether there is a difference between withholding (not starting) and withdrawing (stopping) a treatment when both are nowadays considered as the same. A decision not to act is still an act, thus not providing ANH is no different from removing ANH.

Many physicians may wish to avoid conflicts with the family or are misinformed about the benefits of tube feeding in advanced dementia and may be unaware of the harms. ANH carries many false promises as it does not provide benefits of prolonged life, less aspiration, ease of symptoms, ease of medication provision or nutritional status.

Dying persons often do not experience thirst and hunger - giving ice chips and oral hygiene can alleviate dry mouth symptoms. Oral food and fluids should be encouraged as it gives comfort, pleasure as well as autonomy and dignity.

Most persons will say no when asked if they wish to be kept alive via ANH if they become demented at the end of their lives. However, in times of crisis, many will have tube placed. The weight loss, malnutrition and dysphagia are terminal signs of the end stages of dementia as a disease. More than 20% of demented patients in hospitals or nursing homes in the US have had tubes placed but nearly half died within a year. Moreover, provision of ANH often requires restraints to prevent self-extubation.

In an acute emergency situation, both family and physician can come under distress as the atmosphere is filled with emotion. Confusion sets in to cloud the thinking further.

We can play our role as the patient's advocate (respecting his choices). However, when that has not been stated and documented, we can act as a guide in helping the family and surrogates in making a decision with the patient's best interest. During a consultation, communications between the FP and family members can be aided by the table on the next page:

**Table 1:  
Questions to Ask Regarding the Ethics of Providing ANH at the End of Life  
— Processes and relevant Questions**

Framing process	<ol style="list-style-type: none"> <li>1. Is the patient able to make autonomous decisions?</li> <li>2. Are the patient’s choices in line with professional assessment of beneficence?</li> <li>3. Are there conflicts in an ethical or moral sense?</li> <li>4. What is the nature of the decision that needs to be made?</li> </ol>
Data collection process	<ol style="list-style-type: none"> <li>1. What are the facts regarding diagnosis, prognosis, and treatment outcome for this patient at this point in time?</li> <li>2. What are the religious, cultural, social, spiritual, and personal issues for this particular patient?</li> <li>3. What is the degree of physical, psychological, and spiritual suffering that the patient is experiencing?</li> <li>4. Is the patient clinically depressed, and if so, is it influencing his or her decision-making abilities? Will treatment of the underlying depression result in a different outcome?</li> <li>5. Is the patient demented? If so, does the harm of providing ANH outweigh the benefit?</li> </ol>
Decision-making process	<ol style="list-style-type: none"> <li>1. Is the patient or a surrogate making the decision?</li> <li>2. Is there adequate information on the values, preferences, and wishes of this patient?</li> <li>3. What clinical options have been outlined?</li> <li>4. Have the ethics of each course of action been weighed and their true intent delineated (e.g., fiscal consequences to the family determines removal of ANH)?</li> </ol>
Individuality process	<ol style="list-style-type: none"> <li>1. Has every patient been treated as a unique case?</li> <li>2. Has a blanket approach to provision, withholding, and withdrawing ANH been taken? Have institutional policies, procedures, and culture been adequately evaluated to prevent a blanket approach to care?</li> <li>3. Is the decision right for this particular patient at this particular time and in this particular place?</li> <li>4. Has the decision been re-evaluated on a daily or even hourly basis?</li> <li>5. Has patient autonomy been sacrificed for sparing professional and/or family distress?</li> <li>6. Have steps been taken to ensure that stopping ANH has not resulted in stopping care?</li> <li>7. Has open ongoing communication been central to the process?</li> <li>8. Has adequate support been provided to the patient, the family, and the staff to ensure successful outcome, regardless of what course of action is taken?</li> </ol>

Reference: Huerberger

In seeking meaning at the end of life, what comes to the fore are quality of life (or quality of dying), independence, dignity and comfort. Life at all costs, quantity of life and control recedes into the background.

Albert Jonsen has stated:  
“In our opinion, a decision to forgo ANH is ethically permissible when:

1. No significant medical goal other than maintenance of organic life is possible;
2. The patient is so mentally incapacitated that no preferences can be expressed now or in the future;
3. No prior preferences for continued sustenance in such a situation has been expressed;

(continued on Page 27)

(continued from Page 24: "To tube or not to tube (feed)")

4. The patient's situation is such that no discomfort or pain will be experienced by discontinuing the intervention.

He went on to say "... ANH should be evaluated in light of the principle of proportionality, i.e. the assessment of the ratio of burdens to benefits for the patient. We support the view that if a patient has formulated an advanced directive which specifically mentions omission of ANH in a condition of advanced dementia, such a directive should be honoured."

Coming back to the question of whether to nasogastric tube or not to tube Mrs F, we must weight all factors. Whether Mrs F had her advanced care plans made, and whether she had pre-specified that she wanted or objected to such a tube being placed. We next have to consider

medical indications for this, and then address family's concerns, before coming to a decision together. This article is not meant to be prescriptive as the case scenarios will vary not just from patient to patient, but also in the various settings of Family Medicine. So in the end, the answer is, "it depends".

### References

1. Heuberger R. Artificial nutrition and hydration at the end of life. J Nutrition for the elderly 2010.
2. Bernard Lo. Resolving ethical dilemmas. A guide for clinicians. 5th Ed.
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