



THE College Mirror

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Research Networks and You An Interview with Professor John Rush

By Dr Loke Wai Chiong, FCFP(S), Editorial Board Member

Ever wondered, as you see your umpteenth diabetes patient for the day, whether there was a pattern in the way their particular drug usage, lifestyle and genetic makeup interacted with their disease control? Or, whether the latest treatment you've read about would be effective for 52 year old Mr X sitting right in front of you, who is a smoker and has three other co-morbidities? And could you, not alone but perhaps in a network of physician-researchers, be contributing to this cutting edge of clinical research?

To shed some light, and give you some ideas, College Mirror had the privilege of interviewing Professor John Rush, CEO of Singapore Clinical Research Institute (SCRI) and Vice-Dean of Clinical Sciences at Duke NUS.

CM: Hi Professor John Rush, you are heading up a new and exciting initiative on the local clinical research scene. Can you tell us more about the Singapore Clinical Research Institute (SCRI)?

Prof John Rush (JR): "One of the key functions of the Singapore Clinical Research Institute (SCRI) is to play the role of an Academic Research Organisation. It seeks to develop core capabilities, infrastructure and scientific leadership for clinical research in Singapore and the region. We want to build Singapore's capacity for designing and conducting cutting edge clinical research and at the same time increase support for clinicians who are doing research.

SCRI's expertise includes protocol design and development, project and data management, site monitoring, data analysis, medical writing and training. We can provide help in site management and provide coordinating center functions for multisite studies and clinical research networks. SCRI collaborates in government and/or industry-sponsored studies that range from proof of concept to late phase and epidemiological studies.

(continued on page 6)

The Box



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

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The theme for this issue of College Mirror is about Boxes, as a metaphor for our physical work environment both within and without, and also as a metaphor for our way of thinking as a Family Physician- are we comfortable to continue to operate in the status quo of the Family Physician that is defined by our culture today or is there another dimension of Family Medicine that is as yet untapped?



Thinking out of the Box

Let's first think out of our "GP culture" box. In this edition's cover story, College Mirror turns to an issue that has traditionally been

somewhat neglected by Family Physicians - that of research.

General Practice has often been perceived as a non-academic discipline. As front line providers of Primary Care with large clinical workloads, academic aspects such as research have inevitably taken a back seat. At present very few GPs are involved in research locally, yet ironically we profess to practice evidence based medicine, i.e. we are dependent on the fruits of other people's research in our decision-making processes. This problem is compounded by the fact that most of the research is done in academic institutions in foreign countries, so there will also be problems in adapting research results for local patients and in the context of local culture.

There is no doubt that research in Family Medicine is critical for the profession, and we need to overcome the many obstacles that are preventing Family Physicians from taking interest in this area. The future for research is now brighter in that research methods are modernizing with the advancement of Information Technology and communication. Whereas the traditional researcher literally was a "one-man show" who had to tediously plan and execute the entire project single handedly, Family Physicians today

have more opportunity to be involved in research networks, collecting data from his or her practice with minimal hassle and transmitting the data electronically.

Dr Loke Wai Chiong had the opportunity to interview Professor John Rush at SCRI to understand a bit of what he does and what the prospects for Family Medicine research are. Who knows, for many of us GPs, the opportunity may one day arise to participate in meaningful research that may make a difference in the care of our patients.

Working outside the Box

The next focus we have this issue is on those times when we are called to attend to patients outside our clinics and therefore out of our comfort zone



"box"- very often in situations of urgency and stress, with limited resources and equipment. This can be in the form of an emergency near our clinic premises, or in the form of a housecall request to attend to the patient at his or her home.

The issue of housecalls gained the spotlight in the press recently when a member of the public



There is no doubt that research in Family Medicine is critical for the profession, and we need to overcome the many obstacles that are preventing Family Physicians from taking interest in this area.

wrote to the news forum describing what had happened when he asked for a nearby GP to do a housecall to see his father who was ill at home. Unfortunately his request was turned down. This was followed by some exchanges, including an impassioned appeal from a GP's wife to members of the public to be more sensitive and spare some thought for the neighbourhood GP who has to contend with very long hours at work, typically leaving him little time for family and social life.

In this issue, Dr Seetoh Kwok Yee spoke to some of our College members to ask them their views on housecall requests and how they usually handle such cases. The views of the GPs are purely their own and do not represent the College, but there is much to learn from the discussion. We also reprint an article on housecalls by our President, written almost 30 years ago (December, 1983) on page 14-15.

Working differently within the Box

We can certainly think of our physical work environment as another "box", because it is within the 4 walls of our clinics that we establish a certain way of working that over time establishes itself in terms of efficiency and comfort. However things may change as our patients themselves change over time. An ageing population means that our patients will have more chronic diseases that demand more of our time and attention, a better informed public means more challenges in patient education and communication, which in turn also demands more of our time and attention.



Queues - A perennial problem

The majority of the clinics in Singapore operate on a walk-in queue system, which means that the longer the queue, the better the business (good), but the longer the waiting time (bad). Whilst this may have been an efficient system in the past to handle large crowds in an equitable way, it is certainly not the best solution when it comes to providing the best care for our patients. Some patients simply need more time but having the pressure of a queue building up as you are trying your best to spend more time with a patient leads to added stress.

Perhaps it is time to seriously consider some form of appointment system that can cater to this group of patients. It does not mean that the two systems are mutually exclusive, as a clinic can also operate on two systems, for example having a walk-in system in the mornings and appointment system in the afternoons. One big hurdle will be that of patient expectations, as most patients want to be seen as soon as possible when they walk into their doctor's clinic. Appointments also need both parties to co-operate, patients who book a time slot need to show up during the allotted time. Managing these expectations through good communications by front line staff will be essential.

Dr Kiran Kashyap's article explores the different appointment systems and some of the considerations that need to be made when planning an appointment system - for your reading pleasure, and before the next patient arrives.

■ CM

this issue >>

- 01 < **Cover Story:** Research Networks and You
- 02 < **Editor's Words:** The Box
- 04 < **President's Forum:**
Research Network for Primary Care
- 09 < **Perspectives:**
Housecalls - Point of view
- 12 < **Announcement/Event:**
GDFM Roadshow 2010
- 14 < **Doctor in Practice:**
Housecalls - A Personal Perspective
- 16 < **Practice Management:**
Appointment System vs. Walk-ins in Family Practice Clinics in Singapore

- 18 < **Report:**
Medical Pedagogy Skills Course -
Current Pedagogy Concepts and Tools
- 20 < **Report:**
Launch of Editorial Manager for The
Singapore Family Physician Journal
- 22 < **Hints & Tips:** Functional Backache
- 24 < **Family Practice Skills Course 35**

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Research Network for Primary Care

by A/Prof Goh Lee Gan, President, 22nd Council, College of Family Physicians Singapore

In this issue of the College Mirror I am very happy to see the conversation between College Mirror and Professor John Rush, Director of Singapore Clinical Research Institute (SCRI) on his thoughts on research networks and the primary care physicians. The time for family physicians in Singapore to contribute to the search of effective interventions, documenting successes and pitfalls in practice has finally arrived.

In this discussion, I will take primary care, family practice, and general practice and the corresponding labels of its practitioners to be broadly synonymous - primary care physician (the preferred label of WHO today), family physician (for those more affiliated with the newer label of the general practitioner) and general practitioner (the original label of the group of health care providers that we all know so well - the GPs).

Working together with hospital specialists, community health care providers, researchers, and health care delivery systems, the time has come for family physicians to contribute to fill in the gaps in health care delivery. The next advance in health care delivery will be on how well we can integrate the

pieces on the healthcare chess board on service, teaching and research. So there is excitement.

Discipline

It has been said that Research is one of the four pillars that defines a discipline. The other three are the service system, the training system, and the accreditation system. Family medicine has the other three in place in Singapore. The fourth pillar will complete the definition of a discipline.

Research networks

Family medicine thrives on integration of the pieces of the healthcare delivery system. Hence, research networks resonate well with family medicine. There will be activities coming from Prof

Rush's centre that give the family physicians opportunities to participate in learning, co-creating, and sharing new information from family medicine research activities.

Breadth of primary care research

The number of topics can be broad. The European Primary Care Research group has grouped the potential topics into three which I thought is a very good idea: clinical issues, health care services issues, teaching, and training issues.

Research related activities in the College

At the moment, there are already some research related activities in action. Thus, the Fellowship by Assessment has within its training programme - clinical topic reviews, a research project, and research pedagogy courses. Perhaps we could explore whether doctors who are interested can sit in to listen to what is being presented. We could explore this with the Fellowship Training Committee.

The Singapore Family Physician is now indexed. This is a good leap forward. Hopefully, authors would consider it as another forum to publish their work.

“The time has come for family physicians to contribute to fill in the gaps in health care delivery.”

The time for participating in FM research as a defined and concerted effort has arrived.

Primary Care Research Conference 2010

The College of Family Physicians Singapore will be playing host to this year's Primary Care Research Conference on first weekend of December 2010 - 4th and 5th December. The Conference is a training conference meaning that there will be tracks on research processes from: the research question, how to create a research questionnaire that works, biostatistics, qualitative research, clinical trials, writing the results of research, and more. There will be primary care research prizes for the best 3 oral papers and best 3 posters -

this is in the newly created tradition of Formula-1 Prizes in Family Medicine Research. The inaugural Primary Care Conference with the Formula-1 Prizes was held in Melaka in November 2009.

An Institutional Review Board for FM Research

There is the need for an Institutional Review Board for FM Research has been discussed and mooted for several years. It would be time to set this up, with the support of the College Council and various stakeholders in research and primary care. As President, I look forward to its formation in the near future.

The time has come

The time for participating in FM research as a defined and concerted effort has arrived. We would encourage that for a start family physicians get in touch with Professor John Rush's Research Network in SCRI to get your research hands wet. Helping to co-create the new practice information to fill the gaps of knowledge can be great value and great fun to say the least. Think about it. Thank you Professor John Rush for inviting our doctors to join your Research Network.

■ CM

Tan Tock Seng Hospital (TTSH), established in 1844, is the second largest acute care general hospital in Singapore, with specialty centres in Rehabilitation Medicine and Communicable Diseases. Tan Tock Seng Hospital champions the development of Geriatric Medicine, Infectious Disease Management, Rehabilitation Medicine, Respiratory Medicine, Rheumatology, Allergy & Immunology in Singapore.

DEPUTY DIRECTOR Operations (Health Information Services)

The Challenges

You will provide strategic oversight, direction and management of the departments under your charge (mainly the Medical Records Office and Clinical Coding Unit) to ensure quality and timeliness of hospital's patient medical data for reporting as well as to deliver patient-centric and cost-effective healthcare for our patients. In addition, you will play a key role in driving, planning and overseeing the implementation and management of the Financial Counseling and Means Testing systems in the hospital. Other key responsibilities will include reviewing and development of policies, documentation, standards and procedures to support hospital-wide audits and accreditation

initiatives as well as quality improvement projects.

The Requirements

- Preferably MBBS with 5 years of healthcare experience
- Knowledge of Financial Management Systems, Health Information Management will be advantageous
- Strategic and creative thinker, results-oriented, focused towards service excellence in patient care, & has an aptitude for quality and process improvement
- Excellent leadership and communication skills

DEPUTY DIRECTOR Department Of Clinical Standards & Improvement, Office Of Clinical Governance

The Challenges

You will assist the HOD in driving, developing and implementing improvement programmes for clinical quality and patient safety in the hospital. You will help oversee the establishment of policies and procedures, internal quality management systems, development of new programmes, monitoring & compliance of quality standards required by external accreditation / regulatory bodies and provision of relevant training to support the hospital's strategic quality plans.

The Requirements

- MBBS, preferably with some healthcare experience including 1 year of clinical experience and/or involvement in quality improvement programmes
- Those with Masters in Public Health or equivalent qualification will be advantageous
- Knowledge in quality management principles and tools
- Strong interpersonal and communication skills coupled with excellent leadership and people management skills

Interested applicants are invited to write/fax in/email, with full particulars including educational qualifications, work experiences, current and expected salary, contact number(s) and email address before 15 April 2010 to:

Human Resource Department
Tan Tock Seng Hospital
11 Jalan Tan Tock Seng Singapore 308433
Attn : Ms Sharon Tham
Email : sharon_tham@ttsh.com.sg
Fax : 6357 8625



(from page 1 - Research Networks and You: An Interview with Professor John Rush by Dr Loke Wai Chiong)

In the longer term, we hope to further develop SCRI and Singaporean scientists as an ASEAN hub for clinical research. To achieve this vision, SCRI continues to strengthen its expertise in executing multisite research, developing harmonized ASEAN regional study management capabilities, training and education capabilities and continuing its development of clinical research networks."

CM: How did you come to Singapore to take up your role with SCRI?

JR: "I am a psychiatrist by training. My passion is clinical research. Singapore presents great potential and opportunity to develop more effective platforms such as research networks for clinical research. There is also a great need to build enhanced linkages between laboratory-based and clinically-based scientists. This synergy will reap incredible returns for the investment of resources that we put into research. In my previous role as Vice Chair in the Department of Clinical Sciences at University of Texas Southwestern Medical Center at Dallas, I developed and led the Clinical Scholars Training Program which provided both didactic and critical learning experiences. We also helped to develop clinicians from all disciplines into independent, grant-getting clinician scientists. At this point in my life, my passion is to help to develop the careers of the next generation of clinician scientists, and Singapore offers this opportunity."

CM: Do you see more doctors becoming involved in research in

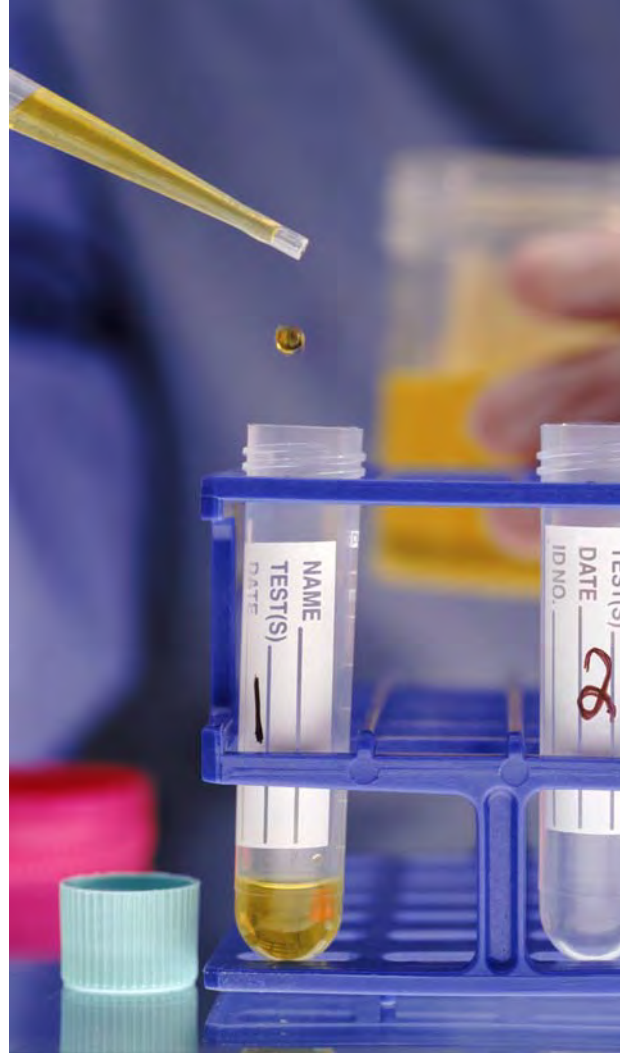
Singapore and what advice will you give to them?

JR: "Singapore has already made substantial commitments to basic and translational research. We are also starting to see increasing interest and investments in clinical research. More funding schemes have been launched to address some of the obstacles that clinician researchers face. Salary support, protected time, space, didactic education, and mentored training, career development as well as the opportunity to conduct pilot work with supervision are all essential elements for clinicians to become successful clinician scientists."

Research (whether basic, translational, clinical, or service/service system research) is not for everyone. The path is demanding. The personal commitments and sacrifices are substantial. And one must be willing to fail in order to learn and later succeed. There are no guarantees. Finally, it is essential that clinician scientists work collaboratively with diverse disciplines.

But for persons with the curiosity, perseverance, an ability to think critically and a willingness and desire to challenge conventional wisdom, the rewards are priceless. The experience of making even modest contributions that help others better understand, treat, or prevent disease is a remarkable privilege and a unique experience.

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The need for collaboration cannot be overstated. Individuals who can work collaboratively in multidisciplinary teams (often in networks) whether they link clinical sites, laboratories or both will succeed. This is a major shift from 30 years ago, when academic promotion and recognition was only to be achieved by individuals working largely in isolation who felt they could do everything by themselves. Today, we need a trained team of researchers and research staff to provide the infrastructure to conduct the research, to ensure efficient and accurate data collection, regulatory conformance, efficient operating and administrative procedures. These are all critical elements to a sustained research enterprise.

Family medicine is comprehensive and holistic and as such family physicians are naturally inclined towards the multidisciplinary and collaborative approaches to research. They are in an ideal position to collaborate in the execution of clinical research especially given advances in electronic data capture and the recognized need to study large

samples of representative patients. Family physicians are experts in chronic diseases and co-morbidities - an area that is fertile ground for innovative solutions and high impact research. Such work spans the development and registration of new treatments, better, more efficient organization to deliver care, learning how and when to combine or sequence of our current treatments, and a host of other issues. In this case, collaboration in well-organized, multisite, disease-focused networks of family physicians can address clinically relevant questions that lead to better patient care outcomes."

CM: We often hear about how busy our clinics and hospitals are, and how patients in our cultural context are not so willing to participate in research. Do you see these as big hurdles?

JR: "You have identified two potential hurdles: Those who conduct and those who participate in studies (i.e. the subjects).

From the perspective of those conducting research, it is clear that clinical research needs to be funded and managed in ways that ensure that routine care is not compromised and that budgets that are intended for health care not be used to support research. In busy care systems, lack of time is a fact as is the need for more trained clinical research staff, space and funding. These challenges are not unique to Singapore. The solutions which are not without cost are:

- (1) hire more physicians to help conduct the research and to backfill for other physicians who are already in the clinics who wish to conduct the research;
- (2) provide a research budget that actually covers all of the costs of research staff and research tasks;
- (3) ensure that HR systems provide coherent, predictable, career paths that have progressive and adequate compensation and specified stepped requirements;
- (4) either build more space, or reconfigure service delivery so as to create adequate space to conduct clinical research. For example, one might need to add space to or rent additional offices right next to polyclinics to develop adequate clinical research space. Staff and patients in research must have a workable, safe, and confidential environment that meets regulatory requirements.

Notwithstanding these substantial challenges, I still trust and hope that physicians are intrinsically interested in the welfare



*Architects of the Family Medicine Research Network of the SCRI
From left to right: Prof Sam Lim, Ms Enny Kiesworo, Prof John Rush,
Ms Angeline Koh and A/Prof Lee Kheng Hock*

of their patients and continue to persevere in these conditions to try to make a difference for patients. Conditions are very similar in other Asian countries and physicians are continuing to perform research to address the unmet needs of our patients.

Clinical research is relatively new for both scientists and patients in Singapore.

From the patient's perspective, we need to better inform patients about what clinical research entails. Family medicine practitioners are well positioned to take the time to educate patients about a clinical research study. On-going initiatives are underway to better educate the public in the different types of clinical trials; i.e. they can participate in small, controlled environment, healthy volunteer studies to multi-national, disease orientated post-marketing studies. Studies of clinical trials have shown that the quality of care given the careful monitoring of patients is very high. This knowledge will help further patients' interest and enrollment in research."

CM: What would an ideal future for local clinical research look like, if there are networks of physicians in place?

JR: "I can easily envision two types of Clinical Research Networks in Singapore: The first would be one based entirely

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Family medicine is comprehensive and holistic and as such family physicians are naturally inclined towards the multidisciplinary and collaborative approaches to research.

in Singapore for studies of conditions/ disorders for which Singapore can provide the entire sample (e.g. Phase 3 or 4 studies of common diseases like Type 2 diabetes or smaller proof of concept or first in man Phase 1 or 2 studies, conducted by Investigational Medicine Units (IMUs) or a network IMUs or by specialty clinics at the public hospitals.

The other would be a Singapore/regional network which includes both Singapore and regional sites outside Singapore. One such network is the Asia Pacific Hepatocellular Carcinoma Network (<http://www.scri/AHCC.html>) headed by A/Professor Pierce Chow. It includes 4 Singapore sites; National Cancer Centre, Singapore General Hospital, Tan Tock Seng Hospital and Changi General Hospital and 13 non-Singapore sites in 11 countries.

Both types of networks can conduct high impact, commercially sponsored or government sponsored studies (e.g. registration trials, diagnostic test assessments, cohort studies to identify biomarkers of early disease, etc.)

In fact, it is now more common and very important to combine investigator-initiated studies with commercially sponsored efforts as it saves time and money. For example, one can conduct an investigator initiated, ancillary study on top of a registration trial (pharma supported) that can ask (1) is the treatment effective and (2) which types of patients or types of disease are best treated with the treatment. Such clinical research networks (whether Singapore focused or beyond) provide streamlined administrative, fiscal and legal frameworks, and other efficiencies in study execution. The aim is to reduce

investigator hassle, enhance scientific impact and career advancement of site Principal Investigators and ensure high quality efficient execution.

Singapore is well positioned to create such networks in family medicine through collaborations among family medicine practitioners. SCRI has formed a Family Medicine Research Network (FMRN) with a team led by Dr Lee Kheng Hock who is very active in the College of Family Physicians Singapore. We see great potential in developing research in family medicine which in turn will translate into higher standards and prestige for this rising discipline in Singapore."

CM: Professor John Rush, thank you very much for sharing your thoughts and the upcoming opportunities for research with our readers.

■ CM



A. John Rush, MD
Chief Executive Officer, SCRI
Singapore Clinical Research Institute
Pte Ltd

Other Affiliations:
Vice Dean, Clinical Sciences
Duke-NUS Graduate Medical School
Singapore

Dr Rush is currently the Chief Executive Officer of SCRI. His research has focused on the development and testing of innovative treatments for mood disorders including medications, somatic treatments and psychotherapy, as well as disease management protocols (treatment algorithms) for severe and persistent mental illnesses, especially mood disorders. He has authored more than 500 papers and chapters and 10 books and has received continuous NIMH research support for 30 years.

He was Principal Investigator on the NIMH sponsored STAR*D (Sequenced Treatment Alternatives to Relieve Depression) trial. He directed the NIMH Depression Trials Network (DTN) for 10 years, which conducted efficacy-effectiveness research with depressed patients.

Dr. Rush's past awards include the Mood Disorders Research Award from the American College of Psychiatrists, the Paul Hoch Award from the American Psychopathological Association, the Edward J. Sachar Visiting Scholar Award from Columbia, the Nola Maddox Falcone Prize from NARSAD, the American Psychiatric Association Award for Research in Psychiatry, and the Gold Medal Award from the Society of Biological Psychiatry. He is past president of both the Society of Biological Psychiatry and Society for Psychotherapy Research.

Biosketch

A. John Rush, MD

Housecalls: Point of View

by Dr Seetoh Kwok Yee, MCFP(S), Editorial Board Member

A recent complaint letter to the Straits Times Forum Page has once again brought the predicament of housecalls to the fore. The letter was disparagingly entitled "Strangers helped dad, 80, but not doctor".

The author had detailed how a pair of good Samaritans had assisted the father who had a sudden back pain and only to be turned away by the neighbourhood doctor when a home visit was requested.

Expectedly, the account served its objective and provoked a flurry of comments and rebuttals in the newspaper forum pages and several online discussion boards, notably, the Straits Times and the SMA Forum.

The incident also stirred memories of an unpleasant episode I personally had with the housecall issue some years ago.

I had only come to know about the alleged incident after receiving a letter from SMA requesting my response to a complaint that I had turned down a request for a housecall.

Apparently, the complainant had come by my clinic one crowded evening asking for an urgent and immediate home visit for her aged father with a history of Hypertension and who had suddenly developed vertigo.

(In her letter, the complainant had

explained why she had come to my clinic: her father's two regular GPs were unavailable that night.)

Knowing that I was pressed for time in the clinic and that the complainant's father had never consulted at the clinic before, my experienced clinic assistant had advised the complainant to call 995 instead if she had wanted immediate medical attention.

According to the letter, the complainant had later managed to get her ill father down to my clinic and, seeing how packed it was, had decided instead to visit the clinic in the next block whereupon an injection was given and the father had become well.

In my reply I pointed to the fact that it was not a medical emergency and that I was equally duty bound to the patients before me.

(Has it been an emergency like a collapse, my standard response is to gather my resuscitation bag, rush to the patient immediately and have my clinic assistant call 995 for backup.)

Aside from this aberrant episode, I have always enjoyed making housecalls for my patients who may have become suddenly incapacitated by an ailment, commonly: vertigo, gouty arthritis, gastroenteritis and febrile illnesses.

I would usually schedule these visits between clinic sessions or see them during a lull in between consultations.

I also take pleasure in my routine scheduled visits to the housebound chronically ill patients. I believe that since they have chosen me as their family doctor, I owe them the duty of continuity of care.

These housecalls are also my escapades from the humdrum of clinic consultations and on such occasions the patients and their families are usually most appreciative.

With an aforehand knowledge of their medical history, such visits are usually productive and produce positive outcomes, especially when you could co-opt the family members present to help monitor and care for the patients.

.....

Aside from this aberrant episode, I have always enjoyed making housecalls for my patients who may have become suddenly incapacitated by an ailment...

But on the other hand, when the housecall pertains to a complete stranger, it can become a very time consuming and challenging exercise.

Invariably, by the time a house visit is warranted, the patient is too ill or distressed to give you a good medical history and the caregiver in attendance may at best supplement the needed information in dribs and drabs. The frustration is compounded when the clinic you left behind is filling up with patients.

These visits often end apologetically with a referral to the emergency department when I could not arrive at a safe management plan. That explained why, in the past, my usual response to these requests is to ask them to go to the emergency department directly where their problems can be sorted out more effectively.

But with the advent of full-time 24-hour Housecall Services, I have started collaborating with one such medical colleague to manage my housecall requests.

If, for some good reasons I cannot avail myself to my own patients (busy clinic, weekends, holidays, back to back housecall requests), this helpful colleague would deputise for me (His 24-hour mobile number will be made known to these patients).

The medical information in such instances should be forwarded beforehand to him either in the form of the patient's record or a telephone briefing by me. Upon completing the housecall, I would receive a feedback from him to plan for any follow-up action deemed necessary.

Housecall requests for individuals whom I have no prior contact and therefore would probably require a much longer consultation will be directed to him if I can't make the time.

The above outline is my personal approach in dealing with housecalls born out of professional responsibility and desire for effectiveness. It allows me to give a constructive response to the different housecall scenarios.

To turn down a housecall request flat without giving any helpful instruction or advice potentially exposes one to criticism and censure as exemplified by the recent incident in the newspaper.

I have invited views from two of my experienced colleagues and included a self-introduction by a housecall doctor.

Saving the best for last, I have also reproduced an endearing article by A/Prof Goh Lee Gan written almost thirty years ago on this subject and which we can relate to even today.

The reader is encouraged to ponder these points of view and formulate his own housecall protocol to keep his practice and professional conduct beyond reproach (and, hopefully, bad press too!). ■ **CM**

(Photos by Dr Wong Tien Hua)



Dr. Soh Soon Beng, Family Physician

"I work in a solo practice and have the following housecall rules:

1. The Clinic Assistant answering the request is taught to politely obtain details like the name of the person, the age, past medical history and the reason for the housecall (Most of the time when a request comes in, I would be in consultation and the screening by the CA ensures no disruption).

The information given will help me decide whether I would be able to help. If not, I would offer to call 995.

2.. If the case is urgent and warrants a housecall, I will attend immediately. But if I am held up in the clinic, I would give them the telephone number of the Mobile Doctors.

3. For the housecalls that I can go, the clinic assistant would advise on the charges (\$100-\$150). We would make it clear that this fee is payable even if I decide, after examining the patient, to refer him to the emergency department. Upon this advice, some of them may decide to go straight to the hospital instead.

I feel too much blame and accusations have been unfairly leveled against the poor GP who is not able to attend a housecall.

After all, he has an equal responsibility to the patients in the clinic. There could be an AMI waiting patiently and quietly in the queue versus a dramatic vertigo panicking at home and demanding immediate attention.

An important aspect of a housecall request is managing the expectations of the relatives. They often mistakenly believe the GP has every cure in his housecall bag. I would try my best to explain to them the limitations and most times they would take my advice and bring the patients to the hospital. I would also offer to give these patients first priority if they can make it down to the clinic. This often does the trick and saves me a housecall trip!"

Dr. Chiam Yih Hsing John, Family Physician

"My clinic is a solo doctor outfit and I have implemented a Housecall policy for my practice :

1. I will advise my patients that I will not be able to do housecalls during the peak office hours as I would have a lot of sick patients in the clinic needing my attention. If the housecall cannot wait, my advice is to go to the hospital.

2. I am only available for housecalls in the immediate vicinity; within walking distance from my clinic. The reason being I should be able to return quickly in case of a medical emergency in the clinic.

3. My charges are at least \$150 during office hours and \$300 outside office hours. This is made known to the patients upon requesting a housecall. I believe by doing so will help to deter any unnecessary housecalls. However, there are occasions when, after making the house visits, I realised that the patients are old, infirmed, and needy, I

would then waive the charges. I also do scheduled house visits for my home bound patients and for such instances, I will too forgo the housecall charges.

4. If the request pertains to a medical emergency, I will offer to call 995. I recall a case of a Diabetic patient who had collapsed at home. After calling 995, I had run to her flat and realising that she was on Glibenclamide, quickly did a stat hypocount. It was 1.7mmol/l and I had immediately instilled intravenously 4 vials of 50% Dextrose. She was then transferred to the hospital, stayed a week and made a complete recovery. My reward was a reply from NUH which said " it was your quick thinking that saved this patient".

Thus far, I have had good experiences with housecalls.

Of course, there might still be grumbles if I cannot make the house visit for good reasons. But with a clear explanation of the reasons and the limitations a GP can do in a housecall, the patients usually understand."

Dr. Choo Wei Chieh, The Housecall GP

The Housecall GP is a 24-hour (island-wide) medical housecall service that was started in 2006. It is a housecalls only practice where our doctors are not based in any clinic and are always on the go. Patients seen by us usually have difficulties getting to a clinic (e.g. immobile/ bed-bound, joint pains and cannot walk, too giddy to get up, etc.) and therefore request for a doctor's housecall. In the typical scenario, patients are referred to us by their GP who is unable to attend to the housecall request. The patients can contact us directly and we will arrange for a housecall visit. We can be contacted at: 6247-9247; or via email: enquiries@thehousecallgp.com (website: www.thehousecallgp.com). **ICM**

Commencement of new Academic Year 2010

The College of Family Physicians Singapore is calling for applications for the following post-graduate training programmes:

- Graduate Diploma in Family Medicine (GDFM)
- Masters in Medicine (Family Medicine) Programme B
- Family Medicine Fellowship Programme (FMFP)

At a recent Censors' Board Retreat, it was agreed that there was a need to make Family Medicine training more relevant and clinical for our family physicians. With effect from the 2010 intake, the FMFP will incorporate an additional clinical component where trainees can further hone their family medicine skills by spending time at specialists outpatient

clinics as well as Family Medicine units in the acute and community hospital settings.

In addition, as part of College's efforts to be more encompassing for doctors working in primary care setting to receive further training, doctors with basic internal medicine training i.e. MMed (IM)/ MRCP (UK) equivalent will also be eligible to sign up for the FMFP. At exit, the candidate should have the GDFM or equivalent.

Applications close in May

For more details, please visit www.cfps.org.sg or contact the College Secretariat at 6223 0606 for more details. **ICM**

Graduate Diploma in Family Medicine

Direct Route to FP Register!

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

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

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

* For the senior GPs applying to be on the FP Register by the indirect route, we understand that the FM modules can be accredited for this purpose. Please call the College Secretariat for further details.

Invitation for Application 2010-2012 Intake

Eligibility

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

- Registered with Singapore Medical Council and possess MBBS degree or an equivalent qualification.
- A registered doctor who is about to complete housemanship or becoming a Medical Officer in April/May 2010.

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

CAREER SEMINAR IN FAMILY MEDICINE

Date/Time: 6 Apr, 5.30pm

Venue: Lecture Room, College of Family Physicians Singapore, 16 College Road, #01-02, College of Medicine Building

Please RSVP via email to gdfm@cfps.org.sg by 3rd April 2010.

GDFM Components

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

8 FMMC Modules

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

3 Practice Management Courses

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

1 Elective Family Practice Skills Course

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

1 GDFM Clinical Revision Course

1 BCLS competency certification

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

Fees

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

Course fees (inclusive of Registration fees)

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

Fees do not include the elective skills course (Family Practice Skills Course), BCLS, tutorials, and examination. (Examination fees are payable to 'National University of Singapore', when applying for examinations in 2012).

GDFM Examination

The examination is conducted by DGMS, NUS, in June/July 2012, and consists of:

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



Registration

GDFM is open for registration until
21 May 2010

For more details and application forms, please visit our website
www.cfps.org.sg,

or contact us at:

Tel: **6223 0606**

Fax: **6222 0204**

E-mail: gdfm@cfps.org.sg

Address:

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

Housecalls: A Personal Perspective

by Dr Goh Lee Gan, The Private Practitioner, December 1983. SMA Private Practice Handbook.



Housecall is an emotive word. Perhaps one could sum it up by saying that housecalls exact a high opportunity cost on any doctor's time; they should not be indiscriminately requested for; and at times it is better to go straight to hospital rather than have the doctor call at the house. Having made these statements, one must accept that some housecalls remain necessary and inevitable as part of the services that the doctor is expected to provide; the best recourse is to see how we can gear ourselves to undertake them.

Some find it difficult

It must be noted at the outset that some doctors may find it difficult to attend to housecalls. I have in mind my solitary practitioner colleague who runs three sessions a day, morning, afternoon and night. By the time he or she reaches home, it is pass ten or eleven at night. He has some 9½ hours to repair his jangled nerves before the next day is on him again. And this goes on day after day, save for holidays when he runs one session. Given this type of life, it is small wonder he is finding it hard to cope with housecalls. It might be argued that if the patient is indeed ill, it would be better for him to get himself admitted; if it is not so serious, it could wait till the next day. In fact, by providing a three-session clinic, the need for housecalls - arising because the doctor is not available- is greatly reduced.

Then, there are doctors who have other commitments thrust upon them. Like most other people, they have families that make demands on their time. A lady doctor who is married has 2 jobs in fact, that of a doctor and that of a wife, mother, and housewife. It may not be entirely fair, therefore that accusations be leveled against her for being heatless as it has been done in the forum page of a local newspaper some months again, when an irate patient's relative request for a housecall could not be met.

I suppose one solution out of this difficulty is for doctors to group themselves up to cover one another so that a colleague could stand in for calls coming through at inappropriate times.

Some have bad experience

I know of a colleague who swore that he would not do another housecall because one day he was mugged in the lift while on the way to attend a housecall.

Calling the ambulance may be a better alternative

Not all emergencies can be tackled satisfactorily by the doctor

in the home. Examples that come quickly to mind are (a) the evolving stroke, (b) the acute chest pain, (c) the injured, (d) the poisoned, (e) the breathless. There is little one can do except to give moral support, to restore a little order out of chaos by suggesting that the ambulance be called. Indeed, it will be more fruitful that in such instances, the relatives summon for the ambulance rather than summon for the doctor. Nowadays, the ambulance service is so efficient that even before the patient is dressed up ready to go, the ambulance is waiting at the door step. The ambulance is equipped with air viva, vacuum sucker and portable oxygen. The public should be educated that for the groups of emergencies listed above, the rally call should be 'get the ambulance' rather than 'get the doctor'. Precious time wasted in trying to get the doctor can be avoided. The public should also be trained to render some basic first-aid and symptomatic relief rather than add panic to an already panic situation. Indeed, the Civil Defence courses will have some beneficial effect in this direction.

The 'unnecessary call'

There are instances in the practicing doctor's experience of being summoned to see a patient who was painted a picture of being in most desperate straits by the relative but in actual fact was quite well and only had minor discomfort. Imagine the let-down at the end of a frantic rush from an interrupted dinner or meeting to come to what I would classify as an 'unnecessary call'. To cool one's unhappiness one can only rationalize that the relative was genuinely worried and not trying to exaggerate the situation. Fortunately, such instances are not many.

Prophylaxis to housecalls

With some thought and arrangement, the doctor can indeed convert many of the housecalls into clinic visits on the next day, thus saving the patient money and the doctor the need to call at the patient's house at some late hour of the night or wee hours of the morning, or in the midst of a talk or a dinner engagement. Fever, diarrhoea, running nose and even constipation can cause acute discomfort but with some medicines they can symptomatically relieved, at last till the clinic opens the next day. I will in fact encourage that the patient keep such medicines on 'standby' at home, properly labelled, stored in a cool place and well instructed on the dosages to be administered.

As a precaution, the patient should be properly briefed that if no relief is obtained after a reasonable time, the doctor should

be called. Personally, I have found this arrangement to quire satisfactory in allowing me to convert the situation from having to call straightaway to not having to call at all or allowing me to call at a more convenient time, say in an hour or two.

The Necessary Call

This brings me to the necessary calls. There is a core of housecalls that by all standards are necessary; the patient may have a simple diarrhoea or abdominal colic but he has no medicine at home, or a fever that does not settle with Panadol given an hour earlier or the patient is bed-ridden, so to be able to visit the clinic is out of the question.

The decision to be made are: (1) can one call within the time the patient requested; (2) can the time be made more convenient by some interim advice over the telephone, like sponging the patient for instance; or (3) would it be better to advise the patient to go to hospital if the condition fails under those I have listed earlier. If the answer to any of these questions is 'no' and one cannot make if for one reason or another, then the options open are to get a colleague to attend or to advise them that as a last resort, he should go to the A&E unit of the nearest hospital. This will be preferable to such nonsensical advice like 'drink plenty of water, take plenty of honey...', which I have indeed heard one doctor advise.

The alternative to seeing patient at home

Sometimes, it may be preferable to see the patient in the clinic or at a private hospital's A&E Department rather than at home. This will certainly apply to a patient requiring toilet and suture.

Gearing for housecalls

It can never be too irksome than to realize that one has run out of an injection or a tablet. Whilst sometimes one can give an alternative medication, often, one has to pay the penalty for being 'out of stock' by driving back to the clinic. It is for this reason that I now have a checklist to tick off the medicines as they are used up so that I know when to re-stock.

The next most useful item is the road directory. On innumerable times, I could not find the road I want because I could not find



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Over the years, I have learnt how to locate the patient's house with a little less trouble than when I first started doing housecalls.

my road directory. To play safe, I now ask for a few landmarks that can lead me to the place but often one still needs the road directory.

Over the years, I have learnt how to locate the patient's house with a little less trouble than when I first started doing housecalls. For private houses, I found that looking at the numbers on dustbins to be quite useful. Indeed, at night, the small number plates on the gate cannot be seen; sometimes they were not to be found. For HDB flats, I look for the house numbers on post boxes. If the number is present, it tells me that I am at the correct block and the correct segment of the block. Many HDB flats are in segments separated by walls except at a few levels. To go up the wrong segment is to have to come down again.

Those HDB block numbers

One thing that never fail to evoke a few expletives is to try and locate a HDB block at night. The plates are bashfully located behind trees and from the road it is impossible to make out which is the block you should go to. Surely the plates could be placed out of reach of the trees. In fact, I felt so upset one day that I wrote to the HDB suggesting that they put the plates at the top of the lower rise blocks and at a similar level in the higher rise ones. I received no acknowledgement.

A word about fees

There are several groups of people whom I charge minimally; the old and poor, and the cancer patient because I sympathise with the patient's relatives. My main concern is to make sure the money paid is worth the service I give and I am against charging a whale of a lot as a 'deterrent' for trivial calls; I think to do so will be to have a NIGYSOB attitude. I would rather try and convince the patient as best as I could that the call is not necessary but if I am in doubt, I would rather go and see the patient. One never knows when to push a call will be a mistake in judgment.

What I have said may not be entirely acceptable to some of my colleague, but as I said, the word housecall is an emotive word. It depends on who are at both ends of the telephone line. ■CM

(Photos by Dr Wong Tien Hua)



“To meet the changing demands, an increasing number of clinics are adopting an appointment system. An ideal and effective appointment system aims to provide benefits to both the healthcare providers and to the patients.”

Appointment System vs. Walk-ins

in Family Practice Clinics in Singapore

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

The "walk-in" system is a common practice in primary health care clinics in Singapore, as it is in many South-East Asian countries. In many other countries, e.g. in Australia, United Kingdom and the USA, an appointment system is the norm. There are benefits and problems with each type of system.

Historically, primary care practices have been physician owned and managed clinics that look after the medical needs of families from cradle to grave. Many clinics in Singapore are still functioning this way. Increasingly however, clinics are growing larger or are a part of a larger network, where several doctors work together or at different time slots to cover the longer opening hours. We have also seen an influx of expatriates into Singapore in the last few years, who often have different expectations of how the clinic should function. To meet the changing demands, an increasing number of clinics are adopting an appointment system.

Appointment System

An ideal and effective appointment system aims to provide benefits to both the healthcare providers and to the patients. The patients should enjoy timely and convenient access to health services, and the ability to meet the physician of their choice when they want to, and to be attended to urgently if required.

Appointment system also smooths workflow and reduce crowding in waiting rooms. The physician is able to anticipate the patients for the day and arrange the mix of the caseload to his preference. The physician's personal schedules can be factored in, especially if working part-time or when taking leave. In a multi-physician clinic, the patients can be matched to their own regular physician for continuity of care.

Appointment system in common usage includes:

1. **Sequential scheduling:** ten to fifteen minute booking slots, with some longer slots and added urgent consultations as required. There is a nominated start and finishing time. It is simple, but delays are inevitable.
2. **Block scheduling:** a group of bookings are made per block e.g., 2 to 3 patients every half hour. This overcomes the problem of patients arriving late as the patients within a block are seen in order of arrival.

3. **Block release** scheduling: the hours of consultation are further divided into three blocks: Block one can be booked any time in advance; Block two can only be booked twenty four hours or less in advance and Block three can be allocated after the previous appointments have ended.

4. **Modified wave system:** Half the average number of patients are booked on the hour, a third at 20 minutes past the hour and one sixth at the 40 minute mark.

The physicians provide the receptionist with guidelines on how to triage the patients requests. Certain types of appointments, e.g. health screenings, require multiple slots. Other types, e.g., routine follow-up visits, require a single slot. Blocks can be set aside to cater to urgent requests or walk-ins.

In the USA, there is a growing trend to adopting an Open Access System, (also known as Advanced Access), credited to Murray and Tantau, which attempts to accommodate patients' requests for appointments on the same day they call. (This is different from a walk-in system, where patients do not call for an appointment.) The patients are given an appointment regardless of the urgency of the matter, hence a triage receptionist is no longer required. This new trend has grown out of a desire to be more patient oriented, and able to accommodate urgent requests.

Walk-In System

As practiced in many clinics in Singapore, the walk-in system is a simple system where patients register according to time of arrival, and are seen in that order, save for the very urgent or emergency case. Patients here are accustomed to this system, and find it convenient to be able to have a consultation on the day that they want it, so long as they have registered within the designated hours. They are often reluctant to have to call in advance for an appointment. A major problem of the walk-in system is the unpredictable wait that the patients face. They may be able to waltz in and out in twenty minutes or may face a three hour wait on a busy day. The providers also cannot plan the day's cases in advance. Follow up of chronic medical problems

may suffer as the patient does not know when exactly they are expected to return for a doctor's review or for blood tests and it is difficult to encourage preventive health care e.g., vaccinations and health screenings without the provision of appointments. Over the long-term, the walk-in system encourages a mindset of just 'clearing the crowd' daily, and will lead to shorter and less thorough consultations, possibly more tests and referrals, and a slow erosion of the skills and knowledge needed to manage chronic diseases.

Potential Problems

No shows and late arrivals will mess up the best appointment system. These slots are often utilized to accommodate urgent requests or walk-ins. However, they do represent a loss of revenue, efficiency and can contribute to a longer delay in appointment scheduling. Reminders via phone calls or SMS messaging on mobile phones have been shown to reduce the no show rate.

Patient and provider preferences

Patients often have specific preferences e.g., to be seen as urgently as possible, or on a particular day and time, or only to see a specific provider. The providers also differ in handling of heavier than usual workload - some may work through lunch or after hours to cope, while others will stick to daily schedules only.

In clinics where a mixed appointment system is practiced, walk-ins often upset the system as they are unwilling to wait for another patient who came with a scheduled appointment

An important factor in implementing the appointment system is the issue of costs. In a walk-in type system, consultation costs can be kept lower as often the turnover is high. Patients also know not to linger and prolong a consult if there is a crowd waiting. With the appointment system, one can accommodate only a fixed number of patients, e.g., four to six patients per hour. Hence, revenue may be affected, especially if there are frequent no shows. Consultation charges may need to be increased to make up for the shortfall. Patients expect to be given their full time slot, as they feel they would

An important factor in implementing the appointment system is the issue of costs. In a walk-in type system, consultation costs can be kept lower as often the turnover is high.

have paid for it, and would be more unhappy to have been kept waiting.

An ideal system should provide for regular appointments for the majority of patients, with provision made for availability of urgent attention when needed. I hope we can slowly move toward a more dignified system, and educate our population along the way.

Quote (Dr Tan Tze Lee, of Chua Chu Kang): "Since implementing a system where patients call in for appointments, waiting time spent in the clinic has reduced, and my patients are happier about the way in which their waiting time is utilized."

Quote (Dr Shivcharan Gill, of Holland Village): "With the appointment system, the waiting room is more calm and the workflow is much smoother" **ICM**

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3. Murray M, Tantau C: Same-day appointments: exploding the access paradigm. Family Practice Management 2000.

Medical Pedagogy Skills Course

Current Pedagogy Concepts and Tools

by Dr Juliana Bahadin, MCFP(S), Family Physician

We conducted a Medical Pedagogy Skills Course on 5th September and 12th September 2009. Despite it being held over two Saturday afternoons, we are gratified by the large turnout of enthusiastic participants. The participants were certainly not disappointed by our panel of speakers that not only offer great insights to advances in medical pedagogy, allowed our participants hands on experiences and amused them with their wit and humour.

After a rousing opening by Dr Lee Kheng Hock and a fascinating induction to the concept of 'The Teaching Sandwich' in family medicine by A/Prof Goh Lee Gan, the session went into high gear with Prof John B. Collins, an adjunct professor of the Department of Educational Studies, University of British Columbia, leading us into the topic of 'Teaching Perspectives and Engaging the Learner'. Prof Collins has extensive expertise in the areas of programme evaluation and research methods to determine best practices in educational settings for adult learners and is co-author of 'The Teaching Perspective Inventory'. Participants were given an introduction to the Teaching Perspective Inventory which looks into five key teaching perspectives: transmission, apprenticeship, developmental, nurturing and social reform. Prof Collins explained how The Teaching Perspective Inventory can help the user identify and evaluate his teaching philosophy style. Participants were given the opportunity prior to the session to take the Teaching Perspective Inventory on-



line (www.teachingperspectives.com) to determine their individual teaching perspective profile, making for an interactive experience!

Dr Julian Lim ended the first day's session by expounding on the topic of 'Technology in Family Medicine Andragogy', introducing us to the multitude of technological progressions that can be incorporated into Family Medicine Teaching.

The second day started with hands on experience with "Audience Response System". A/Prof Goh Lee Gan and Dr Julian Lim shared the advantages and disadvantages or using the Audience Response System in medical pedagogy. Prof Goh also shared recent papers written about the Audience Response

System. The question and answer session that followed allowed participants to try the Audience Response System. Most of the participants were impressed by the immediate feedback given by the system as well as the ability to compare their answers with their peers.

This is followed by a very stimulating session on 'Effective Clinical Teaching and Learning'. The speaker, A/Prof Tham Kum Ying, Associate Dean, Tan Tock Seng Hospital, passionately and enthusiastically shared her personal appreciation of medical education. According to her, the concept of learning is a relatively permanent change in behaviour that comes about as a result of a planned experience. Participants were also able to find out their own learning styles by answering the Kolby questionnaire provided. From that survey, participants discovered that learning is characterized by 4 domains: Concrete Experience, Abstract Conceptualisation, Reflective Observation and Active Experimentalisation. Most people have two predominant learning styles and as

.....

“...the concept of learning is a relatively permanent change in behaviour that comes about as a result of a planned experience.”

“Most people have two predominant learning styles and as they 'grow' in learning, the deficient areas are improved upon and their learning domains become well-balanced.

they 'grow' in learning, the deficient areas are improved upon and their learning domains become well-balanced. She went on to guide participants to conduct effective teaching sessions. Through role-play, participants not only have a humorous time but also learnt that teaching can be broken down into (1) Set (objectives), (2) Dialogue (conversation, demonstration) and (3) Closure (summary, feedback, homework) so as to make their teaching session more effective. They were also thought the "1-Minute Preceptor Micro-Skills" which most participants find it to be a handy tool that they can use.

The last speaker, Dr Zubair Amin, is well known in the field of medical pedagogy. Dr Amin has written many papers on medical education and assessment as well as is the lead author of three books: Basics in Medical Education, Profiles of Asian Medical Schools: Part I Southeast Asia, and A Practical Guide on Student Assessment. He was indeed the fitting finale for the session. He shared "The basic psychometric principles and basic education principle of clinical performance", as well as George Miller's "Pyramid for assessment of clinical competence". He also guided participants in their thought process on the design of a clinical examination, as well as the importance of linking learning with assessment. Dr Amin introduced useful Instruments for performance based assessment including: Objective Structured Clinical Examination (OSCE), PACES, Mini-clinical evaluation exercise (mini-CEX), Direct Observation of Procedural Skills(DOPS), 360 degree evaluation, Portfolio/Logbook.

We had an invaluable experience organising this event. We would like to thank A/Prof Goh Lee Gan and Dr Julian Lim for guiding us, as well as all the speakers and participants for making this event such a success.

■ CM

Integrated Care Clinical Skills Course



22-23 May, 2.00 - 5.30pm
CFPS Lecture Room
16 College Road #01-02
College of Medicine Building

*Singapore is preparing itself for the "Silver Tsunami", as our population ages it will bring about demographic changes that will affect health trends and ultimately the way health care has to be delivered. How can the individual practitioner cope with the changes that will come? The answer lies in **integration of healthcare services**, which focuses on **coordinated and integrated forms of care provision**. Integrated Care may be seen as a response to the fragmented delivery of healthcare that presently pervades the healthcare industry.*

Programme:

Saturday 22nd May 2010

- Principles of Discharge Planning
- Roles of Multidisciplinary Team in Patient Care
- Communications Issues in Care Integration:

Sunday 23rd May 2010

- Financial Resources Available
- Functional Assessment
- Caregiver issues

To register, please call 6223 0606 or email to contact@cfps.org.sg

Launch of the Editorial Manager for The Singapore Family Physician Journal

by Dr Tan Tze Lee, Honorary Editor, College of Family Physicians Singapore

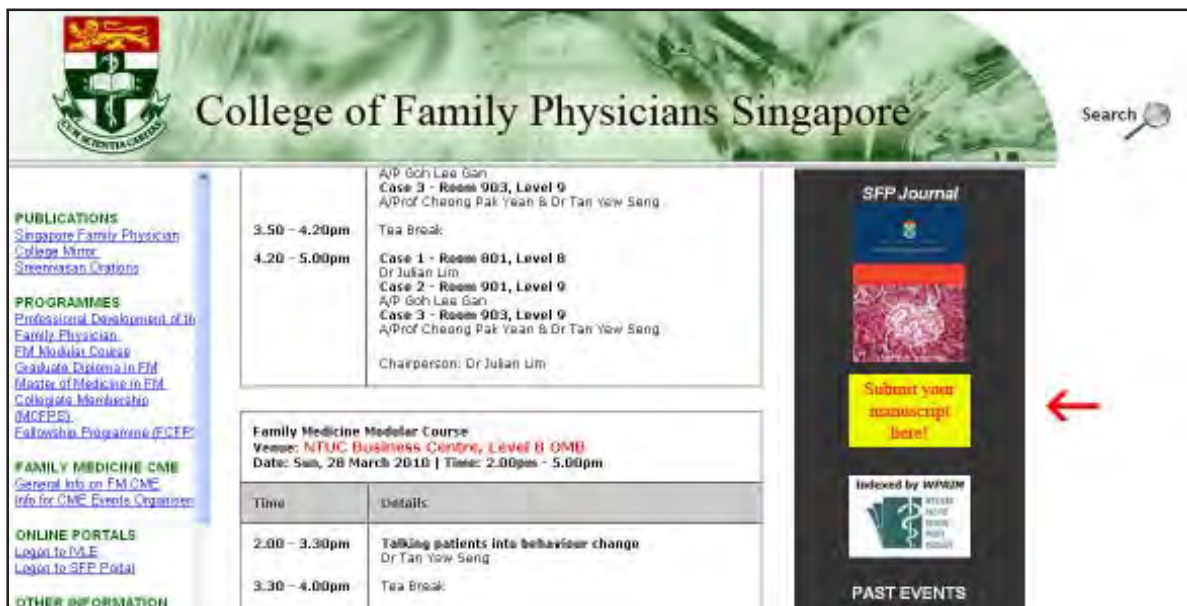
It gives me great pleasure as Honorary Editor to unveil the Editorial Manager system for our College Journal, the Singapore Family Physician. Editorial Manager will take care of all article submissions, peer reviews which will be blinded, and all editorial office functions which were previously manually performed by our secretariat staff will from now on be automated. Special mention should be given to Linda and Ariel of the College Secretariat whose hard work made it possible for us to configure and implement Editorial Manager in a little over ten weeks.

Automating these functions will greatly enhance the workflow and efficiency of our journal editing process. Together with the imminent launch of the Western Pacific Region Index Medicus database in May 2010, where the SFP will be indexed as a peer reviewed

medical journal, it is my hope that more of our family physicians and general practitioners will take up the gauntlet of primary care research, advancing the cause of primary care in Singapore.

From February 2010, all article submissions to the SFP will be only accepted via the Editorial Manager web portal. All authors, reviewers and editors will be able to follow the progress of their articles through the entire review and editing progress by logging into the system.

We welcome all original articles, and hope that this new platform, together with indexing by WPRIM, will encourage you to write and submit your paper to us for publication. Submission of articles is entirely web-based, and can be accessed from our College



webpage, <http://www.cfps.org.sg>. The bright yellow icon "submit your manuscript here" below the SFP icon on the right leads us to the editorial manager login page.



Editorial Manager: main page



Editorial Manager: login page

First time author users will have to register, thereafter they will be able to login to submit their articles. The mechanism is very straightforward, and there are clear authors' instructions and tutorials that are available on the login page.



Editorial Manager: pre-registration page



Editorial Manager: registration page

The stage is set for our Singapore Family Physician Journal to feature more prominently on the global academic stage. Now it is your chance to make this your New Year resolution; to make that observation, to take that survey and write that article or letter to the editor. We will gladly receive all contributions to the SFP. Happy writing! ■CM

Invitation to Contribute to "DOCTORS IN PRACTICE"

Dear Colleagues,

DOCTORS IN PRACTICE is a regular feature of The College Mirror. Each issue showcases the personal experiences of a Family Physician/ General Practitioner at work which are inspiring and instructive. If you do have such a story to share, please send your submission in less than 1000 words to the College at the given address. You will receive a token of appreciation from the College if your story is published. Thank you.

College of Family Physicians Singapore

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

Email: collegemirror@cfps.org.sg

(All submissions will be the property of The College Mirror.)

Functional Backache

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

Every now and then we get a patient (usually in his 20-40s) who takes five minutes to limp into the consultation room. He assumes a stooped posture with one hand over his lower back as if attempting preventing some internal organ from popping out, wearing that characteristic grimace that apparently epitomizes unspeakable torment.

He apologetically but resolutely declines the proffered chair, preferring to stand reasoning that: (1) any movement including the effort to sit, results in heightening of an agony that was already excruciating; (2) having sat down, he fears that he'd then be unable to arise.

The physical examination is remarkable for the lead-pipe rigidity in all planes of movement. Throughout the ordeal, you would think the unflinching hand was glued to the lumbar triangle until it unexpectedly grabs at your examining fingers. There follows the baring either a tortured (60%) or affronted (45%) or undefined (5%) facial expression, that's supposed to mean: "Wow! THAT really hurts! Do that again and I'll...."

You quickly extricate your fingers, temporarily dazed by the unexpected display of strength and agility. The nostalgic straight-leg raise, knee jerk, pin-prick and dreaded per-rectal maneuvers weave through your mind. Out of habit, you even reach out for the good ol' tendon tapper only to find your fantasies rudely interrupted by the terse "Doc-it's-too-painful-please-gimme-an-injection!" routine which is purportedly the seal of authenticity.

You have a problem: you have 17 suffering patients weeping over the waiting time, especially over the five

minutes it took for Mr. Backache to enter and egress (i.e. 10 mins in all); this is the first time you are seeing him. You decide grudgingly to give him the benefit of the doubt and so after some bargaining and negotiation a settlement for two days of medical leave is agreed upon.

You glaze over the next three patients with a heavy heart, an unsettled conscience and distracted mind.

Then, as the foremost champion of the triumph-of-hope-over-experience adage, you pop your head through the side-window and ask your faithful clinic assistant that which she has heard a

thousand times, "Er- how was Mr. Backache?"

And you brace yourself the thousandth time for the recoil: "Oh! He straightened himself and skipped out!"

It is quite plausible that Wadell et al (bless their souls!) were long-suffering doctors who had been assailed by the slings and arrows of outrageous backachers and had decided to retaliate. What other motivation could have spawned "Wadell's signs" for distinguishing organic from non-organic back pain? (And with what passion? It was first published in Spine in 1980 and reappraised and revised in 1998!)

It is quite plausible that Wadell et al were long-suffering doctors who had been assailed by the slings and arrows of outrageous backachers and had decided to retaliate.

Waddell reported eight signs (referred to as behavioral signs) that were consistently capable of identifying non-organic back pain.

Sign	Positive finding
Superficial tenderness	Skin discomfort on palpation
Non-anatomical tenderness	Crosses multiple somatic boundaries
Axial loading	Report of low back pain
Simulated rotation	Report of low back pain
Distracted straight-leg raise	Report of pain in low back or posterior thigh Lessening of pain with continued leg raising Severe pain at 10° flexion in patient with no apparent disability
Regional sensory change	"Stocking" or global distribution of numbness
Regional weakness	Sudden, uneven weakness (e.g. "cogwheeling") in patient with normal Strength in muscle testing
Overreaction to examination	Exaggerated, non-reproducible response to stimulus (grimacing, sighing, guarding, bracing, rubbing)



Malingersers seldom accept psychiatric referral, and the success of such consultations is minimal. Psychiatric consultation may also be suggested as an augmentation to dealing with an acknowledged symptom.

The predictive value is greatly improved when three or more positive signs are present. (Adapted from Waddell G, et al: Non-organic physical signs in low back pain. Spine 5:117-125, 1980 and Behavioral response to examination: A reappraisal of the interpretation of non-organic signs. Spine 23:2367-2371, 1198)

If the diagnosis is that of a functional backache, it is necessary to discover the agenda behind the consultation:

- Is this a sign of stress?
- Are there external incentives? (avoiding military duty, obtaining financial compensation, evading prosecution, obtaining drugs, etc)

Management: some tips

1. Do not accuse the patient directly of faking an illness. Hostility, breakdown of the doctor-patient relationship, lawsuit against the doctor and rarely, violence may result.
2. Instead, state that the objective findings do not meet the physician's objective criteria for diagnosis. This gives him the opportunity to save face.
3. Alternatively, inform such patients that he could be required to undergo invasive testing and uncomfortable treatments (provided, of course, that such warning is true).
4. Consider psychiatric consultation in cases of possible somatoform disorders which are differential diagnoses for functional pain. Malingersers seldom accept psychiatric referral, and the success of such

consultations is minimal. Psychiatric consultation may also be suggested as an augmentation to dealing with an acknowledged symptom. For example, you might propose, "Your pain has to be causing your system a great deal of stress, and we know that stress only makes the pain worse. Consultation from a psychiatrist might help us with your pain by reducing the stress."

5. Avoid unnecessary consultations to other medical specialists because such referrals only perpetuate the problem.

Depending on your experience and familiarity with the patient, you may wish to educate the patient about better ways of achieving goals. Sometimes the reasons are deeply rooted and require behavioral interventions, psychotherapy, and counseling.

Finally, do not let the subjective confidence in your ability to detect malingering be your guide. The successful malingeringer rarely confesses after fooling us. The individual we have falsely called a malingeringer is unlikely to convince us otherwise. Remember the definition: Malingering is intentional production of false or exaggerated symptoms motivated by external incentives. Malingering is an intentional deceptive behavior, not a medical or psychiatric disorder. A false diagnosis of malingering constitutes a grave injustice to the patient. When in doubt, assume that the patient is not malingering and treat and investigate accordingly. is a better course of action.

I hope this makes the assessment and management functional backache a little less onerous if not more agreeable!

REFERENCES

1. David Bienenfeld: Malingering, Medscape 2008
2. Mangione S: Physical Diagnosis Secrets 2nd Ed 2008

Family Practice Skills Course #35

Vaccinations 2010: What's Old What's New

22 & 23 May 2010 | 2.00pm - 6.45pm

Venue: (to be confirmed)*

SEMINARS

(2 Core FM CME Points for each seminar)

Seminar 1 • Unit 1-3: Sat, 22 May 2010 (2.00pm - 4.15pm)

Seminar 2 • Unit 4-6: Sun, 23 May 2010 (2.00pm - 4.15pm)

WORKSHOP (2 Core FM CME Points)

Workshop 1: Practical Skills

Sat, 22 May 2010 (4.30pm - 5.30pm)

Workshop 2: Case Studies

Sun, 23 May 2010 (4.30pm - 5.30pm)

*Registration of workshop is on first come first served basis. Seats are limited. Please register by 14 May 2010 to avoid disappointment.

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Pneumococcal, H1N1 & Seasonal Flu

Vaccines for Children

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WORKSHOPS

Practical Skills:

Baby Bonus and Medisave for Immunisation

Updated Vaccination Schedule

Case Studies:

Seasonal Flu and Travellers Vaccines

*Venue is to be confirmed and announced via email and on the College's website, www.cfps.org.sg

This Family Practice Skills Course is organised by the College of Family Physicians Singapore and supported by an educational grant from **GlaxoSmithKline**



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