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Slow Medicine and Step-down Care Integration is the Key

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

Slow Medicine

Prime Minister (PM) Lee Hsien Loong devoted a major segment of his recent National Day Rally Speech on the state of the healthcare system and the healthcare needs in Singapore in the near future. In his speech delivered on 16 August 2009, PM articulated his concerns about the ageing population in Singapore, and said that the Government is gearing up the healthcare system to prepare for this. He pointed out that older patients need to be admitted to hospital more frequently and have multiple problems. After their acute condition has stabilized under intensive hospital care which he called "fast medicine", these elderly patients still need several weeks to recuperate. Even after discharge, they require

continuing care for their long term conditions and are constantly at a higher risk of being readmitted. The PM dubbed this step-down care "slow medicine".

He said the Government is responding to these healthcare needs by putting in more resources. This includes the upcoming new hospitals in HDB towns - Khoo Teck Puat Hospital and Jurong General Hospital; and increasing the government health budget. The current 3M (Medisave, MediShield, Medifund) system is also being strengthened to keep healthcare affordable to all including the low income group. Medisave has recently been extended to cover an expanded list of chronic diseases, MediShield is providing a higher insurance payout, and Medifund is giving more help to the needy to settle outstanding bills.

PM cautioned that 'more' by itself is not enough and that Singapore needs to build up step-down care - i.e. community hospitals, nursing homes, general practitioners and home care. These key components, if suitably organized, will be able to provide the spectrum of care required to look after the ageing population. Another key step is to link up acute hospitals with community hospitals, so that once a patient has stabilised, he can move to the "sister" community hospital and receive their "slow medicine" in the form of physiotherapy, occupational therapy and rehabilitation. PM cited the co-location of RenCi hospital and Tan Tock Seng Hospital as an example of this synergy.

But ultimately, patients who are recuperating need to "step-down" from community hospitals and look forward to being discharged home, the sooner the better as the home is more comfortable and surroundings more familiar, patients being happier and the arrangement cheaper than hospitalization. Home support would be needed, with families assuming more responsibility for the care, they too need help and professional advice.

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Barriers to Communication

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

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2009 - 2011

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It is quite interesting to note how things can change so quickly within a span of a few months. Two issues back in the March editorial of the College Mirror, I was talking about how tough times were upon us, as the world faced a global economic slump. Take a look at the press reports now, at the financial markets, or the property sector, or just look around at all the new glittering shopping centres opening its doors these past few months. Things certainly seem to be looking up again, for whatever logic-defying reason. Are we seeing a V pattern of recovery, as if the economy was a rubber ball that went down and came bouncing back straight up, or is this a bearish rally heralding a "what comes up will go down again" W pattern. All I can say is, your guess is as good as mine.

The other thing that has rapidly evolved from seemingly nowhere in the past few months is the flu pandemic. This has undoubtedly affected all of us frontline physicians in a profound way, from the initial worries of having to deal with a new deadly flu strain, to rushing to get the much needed stocks and supplies, getting ourselves up to date on the latest information, and having to deal with the surge in patients coming to consult us with influenza like illnesses. It is now hard to imagine the kind of clinical practice that we seemed to have left behind for good.

Nothing is left unscathed by H1N1, including that fundamental principle or capstone of family practice that we hold so dear to us - the doctor-patient relationship. Yes, I am talking about none other than the dreadful masks that we all had to wear for the past few months. They come in all guises whether flat shaped, dome shaped or triangular like a duck's bill, with names like N95, N99 or FFP3; not only are they an effective barrier to viruses and other nasty particulates, but they are also an extremely effective barrier to communication.

Albert Mehrabian's oft-quoted rule for non-verbal communication states that 7% of communication is attributed to the spoken

word, whilst 38% is through voice tone, and a staggering 55% of communication is done through facial expression and non-verbal language. By shielding the better half of our faces most of the time, doctors are losing out on a very basic communication tool, with the casualty being nothing less than the therapeutic relationship itself. (I am of course assuming that the mouth is the "better half" compared to the eyes - drawing my conclusion from the observation that both Batman and Zorro, as well as their friends and foes, prefer to mask their eyes and not their mouths. Surely this meant something.)

To better understand what exactly is affected, we can break down the essential tasks of communication. The Bayer Institute for Healthcare Communication teaches communication skills pertaining to the physician consultation via the 4Es:

1. ENGAGE - The doctor introduces himself and listens to the patient.
2. EMPATHISE - The doctor tries to see things from the patient's perspective.
3. EDUCATE - Provide the patient with the necessary information.
4. ENLIST - Getting the patient to agree and to adopt the suggested management plan.

Nothing is left unscathed by H1N1, including that fundamental principle or capstone of family practice that we hold so dear to us - the doctor-patient relationship.

The following is an illustration on how the 4Es consult may go:



So it looks like we are stuck with the N95 mask for some time to come. No point lamenting about it but how can we overcome it?

Obviously, speaking more slowly and clearly with deliberate emphasis on important words that we want to convey is now imperative, and so too is our body language and eye contact. We have to take note of the way we sit to show interest to the patient, and the way we gesture with our hands, sometimes with deliberate exaggeration to highlight important messages. Eye contact is also

a powerful communication tool. It connects the doctor to the patient, projects sincerity and shows that the doctor is listening to the patient with undivided attention. We therefore need to bear in mind that our patients will notice something amiss from the consultation process if we do not put in extra effort to make up for the communication shortfall, whenever we don that barrier on our face.

Looking ahead over the next few months, we have to prepare for more changes as the current H1N1 influenza

enters a new phase. There have been warnings of a resurgence of H1N1 cases as well as a more virulent strain appearing during the northern hemisphere winter season. We can however look forward to the H1N1 specific vaccine being made available soon, but as is the case for any new vaccines, there will be questions on its safety and efficacy. We can only hope that the flu pandemic blows over as quickly as the financial crisis, and return to the days when our patients could see our friendly smile once more. ■CM

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Old Council, New Council, and Tasks Ahead

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



The thirty-eighth Annual General Meeting of the College of Family Physicians was held on 27 June 2009. The AGM was interesting in that for the first time in many years there was a contest for the position of President of the Council. Looking back, having a contest is good. Good to be challenged so that each of us will be on our toes to do even better. Good too to be able to say what is one's vision to be fulfilled in the next two years. I must thank Dr Arthur Tan for providing that forum.

Thanks are due to the following retiring members: Drs Cheong Pak Yean, Cheng Heng Lee, Adrian Ee, Lew Yii Jen, and Lawrence Ng. The new Council will no doubt continue to seek their help and support when the need arises.

The New Council

The names of the President and members of the new Council, the 22nd Council, are listed on page 20. There are five new faces in the 12 member Council. They are: A/Prof Tan Boon Yeow, Drs Shirley Goh, Tan Tze Lee, Leong Choon Kit, and Tham Tat Yean. Welcome to the College Council.

Our important tasks ahead

What are the important tasks ahead in the coming two years? Thinking aloud, it is good to set out with a clear vision of what needs to be achieved. Three tasks have been identified and action has begun.

1. Strengthen the recognition and equitable worth of the family physicians

The recognition of the equitable worth of the family physician by the 4 Ps - public, press, policy makers, and profession - is to my mind the top

objective of the present Council. It is an ongoing process and it is the product of all our actions, corporate and individual. We must first set for ourselves as a fraternity and as individuals the image and professional worth of the family physician i.e. need to value ourselves first before others will value us. Council will welcome views, ideas, and strategies on how we can go about achieving this. And to help in this task, the practice management committee chaired by Dr Leong Choon Kit has been set up to realize this objective and to drive the needed discussions by various parties.

2. Set up the accredited modular course programme for senior family physicians

The setting up the accredited modular course programme for senior family physicians to meet the requirements of the Family Physician Register has been done. The previous College Council had anticipated the need for this programme with the setting up of the Family Physician Register which is now in the final stages of being passed in Parliament.

The concept is for senior family physicians to complete four accredited modular courses of the eight modular courses of the Graduate Diploma in Family Medicine, in order to fulfill the requirements to be on the Family Physician Register. The College Secretariat anticipates that we can provide up to 100 places for each of these modular courses at the start.

3. Making right-siting work for GPs

Right-siting of patients is an important objective of the Ministry of Health to

unclog the specialist outpatient clinics. This would free the SOC clinics to serve the important function of seeing new patients with as short an appointment waiting time as possible. Stable patients and patients who do not have complex problems can be managed by family physicians. This right-siting initiative serves the patient because, besides unchoking the specialist outpatient clinics, this right-siting of patients will increase the convenience of patients, and increase the timeliness that such patients can be attended to for any unexpected developments to their medical conditions.

We have now accrued enough experience to make things happen based on the work we have been doing in the last year and particularly in the last few months. We discover that right-siting is the product of right-skilling of all doctors at the frontline and in the SOCs. By working with our hospital specialists, we are beginning to fine-tune the skills that frontline doctors needed for this right-siting of patients.

We also see the need to work with hospitals on the three pillars of effective right-siting:

- Good discharge summary - so that the receiving doctor is clear of the management issues and endpoints;
- Working hotline - one that the receiving frontline doctor can call to seek clarification and expert advice on the patient who has just been right-sited; and
- Good support resources - Such support resources enable the frontline doctor to do his work effectively and efficiently: skills courses, afternoon programmes to see cases with specialists to learn the finer clinical skills of looking after patients who can and cannot be right-sited, care plans, and patient education materials that can be downloaded. This list goes on. We have made experimental starts with one hospital. The results are encouraging.

Right-siting is only a concept; it has to be made real with the whole host of efforts to create the right skilling on the finer points of clinical care. We will have more to report and share on these pages as we move on with our path-finding efforts for the fraternity.

A journey of ten thousand miles begins with the first step. And we need to set the direction right. We have two years ahead to make a difference for everyone, provider and patient. Let us achieve that. ■CM

Role of the GP

This is where the General Practitioner (GP) steps in. GPs have a large and central role to play in monitoring and supervising the care that is required. But the question is how can this be implemented? For GPs to be empowered to look after the elderly sick in their home environment, what is critical would be the availability of medical information. Currently this information is not portable, with many GPs relying only on discharge summaries or first-hand information from patients. This is grossly inadequate and this is the weak link in the overall vision of providing seamless care from hospital to home.

The Silver Tsunami

The Permanent Secretary (PS) to Health, Ms Yong Ying-I, recently delivered her speech at the National Health Informatics Summit. In her speech, she too echoed PM's concerns for an ageing population. She referred to the Health Minister Khaw Boon Wan's analogy of the "Silver Tsunami", a wave of surging healthcare needs for the ageing population that could make the current H1N1 pandemic seem like a swim in the lap pool by comparison. Mr Khaw had informed parliament in February this year that "our hospitals are already facing the first wave, a relatively small wave, as our baby boomers turn 60. In 10 or 15 years time, when the baby boomers turn 70 or 75, we will feel the pressure of the second and the larger wave of the silver tsunami. We have been served notice; we must protect Singapore against it and we have started the preparation."

The Health Ministry estimated that a person over 65 years of age would consume on average four times the healthcare resources compared to a younger person. With this in mind, the model of care for the elderly needs to be changed, with less emphasis on "fast medicine", and the building up of the primary



"In 10 or 15 years time, when the baby boomers turn 70 or 75, we will feel the pressure of the second and the larger wave of the silver tsunami."

care sector with better capabilities in the community to support the elderly being cared for at home by their families.

PS hinted that to increase capability, the way forward was to train and upgrade the Family Physicians. Larger group practices will in future be better equipped to leverage on costly IT equipment, Community care would involve a multidisciplinary team including nurses, nurse educators, medical social workers, and physiotherapists. Community hospitals will increase their capabilities by playing a larger role in providing subacute care and rehabilitation, i.e. the "slow medicine". PS declared that these services will continue to be provided by private sector players, social enterprises and VWOs.

Integrating Care

This brings us back to our earlier question - how can the GP be empowered to perform his central role and how can all this be implemented? The answer lies in integration of care.

PS acknowledged that achieving integration is not going to be easy as it requires breaking down institutional boundaries and changing mindsets. Learning how to be a team player is not what a doctor, especially a solo GP, is traditionally trained to do; partnerships between restructured hospitals and community hospitals, between GPs and community providers, need to be negotiated.

Fundamental to all these healthcare developments is the establishment of a nationwide National Electronic Health Records (NEHR) system that spans all sectors from tertiary to primary care, public to private. This has to be the common language that all members of the team are able to communicate. Crucial personal information such as medical history, investigations, reports and treatment plans will no longer be site specific. To be sure, we are not starting from scratch as most health care establishments already have functioning electronic medical records. Whether this is a good thing is arguable as the systems in place currently suffer from incompatibilities, there will be much negotiating ahead to forge a common system that is able to talk to each other.

PS said that more therefore needs to be done, and the Health Ministry is really looking for a sophisticated system that can extend across the country to all healthcare institutions, including the private hospitals.

The main requirements in implementation are:

- A national architecture and national IT policy standards to ensure interoperability of systems and interpretability of shared data, or the so called "enter data once, use many times".

- A stringent policy on data privacy and security - this is crucial to gaining public trust and support for this initiative. There will be a need to balance access to information against privacy and security lapses.

PS also addressed the complexities of implementation. She summarized this into 3 main issues that often occur, alone or in combination:

- Lack of standards for medical solutions, and therefore difficulty in enabling data exchange between tailored systems.
- Medicine itself is complex and therefore not easily transcribed into workable IT solutions, this is further complicated by the fact that each patient differs in their individual healthcare needs.
- A NEHR is going to be an immense team consensus exercise that requires large numbers of people to work collaboratively together.

What are the chances of us seeing all this come together when many others have failed? PS ended her speech by saying that Singapore has a better chance than most to succeed in this venture; given our small size we are able to get everyone together to talk in one room. But ultimately the success of the NEHR, and along with it a truly integrated healthcare system, depends on us, the users and providers and how we can come together as a collective whole to collaborate towards a better future. ■CM



...how can the GP be empowered to perform his central role and how can all this be implemented? The answer lies in integration of care.

The use of Medisave was liberalized for outpatient treatment of chronic diseases since Oct 2006, starting with diabetes, under the Chronic Disease Management Programme (CDMP). Since then, more chronic diseases have been included and today Medisave could be used for outpatient treatment of six chronic diseases including diabetes, hypertension, lipid disorders, stroke, asthma and COPD. The liberalization of the use of Medisave for outpatient treatment help reduce the out-pocket expenditure for patients. Over 90,000 patients have enrolled in this programme. In 2008, \$18 million Medisave was withdrawn for outpatient treatments under the CDMP.

Extension of CDMP to Cover Mental Illness

From October 2009, MOH will be expanding the CDMP to cover outpatient treatments for schizophrenia and major depression. Similar to the existing six major chronic diseases, mental illness is a chronic condition requiring regular care and often long-term treatment which can be delivered in an outpatient setting. While the cost of each treatment episode may be manageable, the cumulative cost of treatment can be significant. The proper management of psychiatric conditions in the outpatient setting would also improve outcomes in terms of function, morbidity, complications and reducing costly hospitalizations.

However, unlike the current six chronic diseases under Medisave CDMP, treatment protocols for mental illnesses are less structured and clinical outcomes are harder to measure. To address this, MOH will put in place a quality assurance framework to ensure quality clinical care and the appropriate use of Medisave for the treatment of mental illnesses.

Chronic Disease Management Programme (CDMP) Extended to Cover Outpatient Treatments for Schizophrenia and Major Depression

Prepared by Primary and Community Care Division, Ministry of Health



The extension of CDMP for mental illness ... is an opt-in scheme for all GPs regardless of whether they are already a CDMP provider.

It will be good to start with Schizophrenia and depression as they together form the commonest major mental illnesses in Singapore, and have an established evidence-based treatment protocol with good outcomes.

Eligibility

The extension of CDMP for mental illness will be open to all psychiatrists and relevant specialists providing outpatient treatment for schizophrenia and depression. It is an opt-in scheme for all GPs regardless of whether they are already a CDMP provider. IMH will provide the first line training in the treatment of schizophrenia and depression for GPs who sign up to be accredited as an approved clinic under the CDMP scheme. For the GPs,

however, they are required to be in a partnership programme or shared care programme with a restructured hospital (including IMH).

GP Partnership Programme with RHs

Under the partnership programme, restructured hospitals will support the GPs in areas such as additional training, on-call consultations and professional back-up in crisis situations, follow-up calls, regular periodic review at the restructured hospitals and access to allied health services if needed.

All participating CDMP clinics will receive an updated handbook for medical professionals containing the new disease management guidelines

for schizophrenia and major depression, as well as FAQs on registering and making claims.

Programme and Care Indicators

Unlike the existing six chronic diseases, the treatment protocols for mental illnesses are less structured and there are relatively fewer objective patient-level clinical care components. The treatment outcomes are multi-factorial and very much dependent on clinical signs and symptoms. MOH has selected both care and programme indicators for tracking under the quality assurance framework (Table 1).

The CGI is a simple, easy to administer 2-item scale to indicate the severity and improvement of the mental condition. It can be applied to reflect severity and improvement in other mental conditions too. For patients on atypical anti-psychotic medications, the blood test for Fasting Lipids and/or Fasting Glucose would allow their doctors to monitor for complications from treatment. To address GPs' concerns, training on administering the CGI is included in the training programme to be conducted by IMH. **ICM**

Table 1: Indicators to be tracked under QA framework

	Indicator	Recommended Frequency	Measurement	Data Collection Method
1	Percentage of patients discharged to GPs who did not visit Emergency Department for psychiatric reasons in past 12 months	At least once yearly	Programme indicator	Via backend system*
2	Percentage of patients discharged to GPs who were not hospitalised for psychiatric reasons in past 12 months	At least once yearly	Programme indicator	Via backend system*
3	Blood test for Fasting Lipids and/or Fasting Glucose <i>(Only for patients on Atypical Antipsychotic medication)</i>	At least once yearly	Care Component	Provider-administered: Yes/No field
4	Clinical Global Impression (CGI) Scale: a. Severity, b. Improvement	At least once yearly	Care Component	Provider-administered: Numerical value from 1 to 7 (for Severity); Numerical value from 1 to 7 (for Improvement).
5	Patient Attendance	At least twice per year	Care Compliance	Provider-administered: Yes/No field

*not operationalised for FY09 due to significant work required to enhance the system to cater to data submission and collation.

MOH Holdings' Medical Informatics Team New Frontiers

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

CM: Tell us more about the team, and why physicians should take an interest in Medical Informatics?

The primary focus of Medical Informatics is improving the quality of care and efficiency of care delivery at various levels within the Healthcare System by leveraging on the full spectrum of IT & related technologies. In many ways, Healthcare has always been on the bleeding (no pun intended) edge of technological innovation through the huge advances in medical imaging, devices, and drug therapies.

However, in terms of the use of IT and the ability to fully leverage electronic information to support decision making, ensure quality outcomes and safety - Healthcare has been lagging behind many other sectors.

Our team of doctors at MOHH believe that in an era where medical textbooks are out of date by the time they are published, and the influx of clinical information required for the holistic management of increasingly frail and complex patients exceeds any physician's ability to keep track of - the judicious use of IT, where it makes sense, can not only make the individual physician's life a easier, but have a significant impact on how we work and collaborate with other clinicians and the patient.

The big 'IF' here, is that this is true if, and only if the significant investments being made in Health IT are put-together with clinical objectives in mind i.e. ensuring continuity of care between primary and acute care, facilitating

patient access to services based on need, improving care-coordination for chronic disease.

The goal of our team is to engage clinicians on the frontlines, and dealing with the multiple day-to-day challenges of real-world practice, and ensure that our national approach to Health IT is developed with clinicians, by clinicians and for clinicians.

CM: What are you working on now?

Our flagship program is the national Electronic Health Record (EHR) program. There's always a bit of alphabet soup in Medical Informatics, but to put it in non-techie terms:

Unlike the Electronic Medical Record (EMR) or Clinic Management Systems (CMS) which are intended to contain the

full documentation of the process of clinical care, and are largely specific to a facility i.e. institution or private office, the EHR is intended to be the repository of key clinical information from across the various settings of care - acute, step-down, primary and community. (See Inset)

In our conversations with a diverse range of practicing clinicians, it's been abundantly clear that what's important is not knowing every detail of the patient's care in a single setting (e.g. the patient's IABP at 2.30pm on the 3rd post-op day), but a limited set of common things: i) current problems, ii) active medications, iii) key investigations and iv) instructions to continue care, as the patient transits between settings.

The EHR will be implemented in phases



(From left to right) Dr Cheng Chee Leong, Dr Walter Lim, Dr Patrick Chia (Principal), Ms Janet Lim, Dr Liem Sian Yang, Dr Kevin Awyong, Mr Tong Ien Ling

We believe the EHR can be a useful tool with which to strengthen the GP-patient relationship by providing the relevant information at the point of care.

over the next few years, starting end 2010. Over time, we think it will start to provide answers to practical questions such as:

- Who is the patient currently on follow-up with, and has the patient had any significant healthcare encounters recently (ED visits, inpatient admissions)? - a seemingly straightforward question, but a non-trivial exercise for the chronically ill patient with multiple co-morbidities, and just as many attending specialists.
- The "plastic bag" problem - where the patient or caregiver comes in with a bag of half consumed, partially labeled medications and the physicians has to reverse engineer the medication list
- Questions around the significance of incidental findings - i.e. when is a diagnostic result significant? For example, was a lung nodule picked up on a chest X-ray present in previous studies, or are historical baseline results available to compare with equivocal lab results from a screening examination
- How do we identify and take advantage of opportunities for prevention? - i.e. the patient's last pap smear was more than 3 years ago

CM: How do you think it will affect GPs in Singapore?

Bearing in mind the challenges of a busy general practice, we are aware that whatever we introduce has to be simple and intuitive to use, and of course speedy in terms of performance. In addition, some of the key IT capabilities we hope the typical GP will find useful are:

- The ability to pull up a one-page summary-view of any given patient's recent diagnoses, medications and healthcare encounters
- Ready access to electronic resources such as a drug information, and clinical practice guidelines or references
- Information on downstream clinical events e.g. what happened to the patient referred by his GP for suspected cardiogenic chest pain - was the patient admitted, and what was the eventual treatment/outcome?
- Over time, consolidated electronic laboratory and radiology results from both the public and private sectors

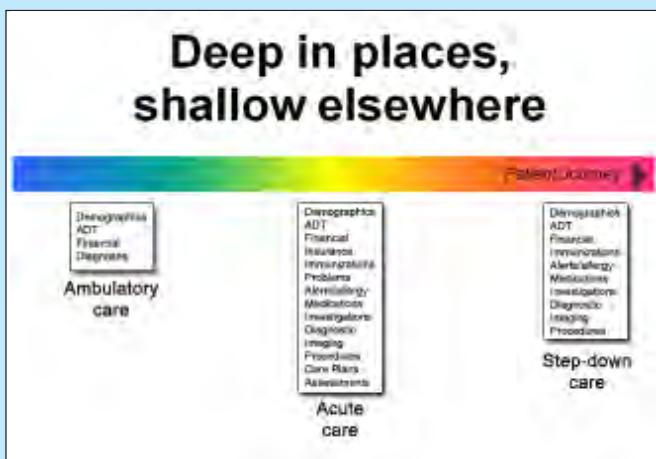
Specifically, we hope to support the primary care provider role. And we believe the EHR can be a useful tool with which to strengthen the GP-patient relationship by providing the relevant information at the point of care. Additional capabilities will be gradually introduced over the various phases of the EHR implementation in conjunction with our revamped GP IT program. (Watch this space for announcements soon!)

CM: How would you advise other doctors keen to explore Med Informatics as a career?

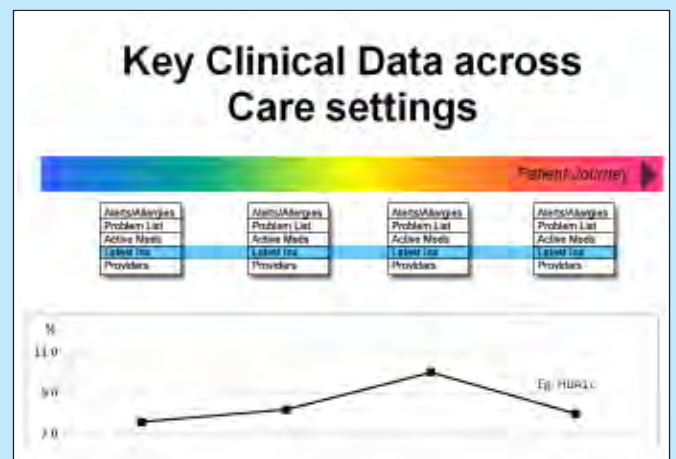
Medical Informatics and Health IT is in the early stages of development. We foresee rapid growth and expansion, and IT spending in Healthcare is projected to outpace IT investments in all other sectors, for a long time to come.

INSET

From the current state of information exchange:



To an EHR-enabled future:



Private industry has taken a strong interest in this field. Aside from traditional players such as GE, Siemens and EMR solution-providers, medical device manufacturers and to some extent big-pharma have been increasing involved in this space, whether directly or in-directly.

With patients themselves turning to IT and the internet for answers to many of their health-related questions, large consumer-focused firms such as Microsoft and Google have begun to enter this space, through personal health record offerings such as Google Health, and Microsoft Healthvault.

Most interestingly, the recent Obama stimulus package allocated an un-precedented 20 billion US dollars to further the adoption and deployment of EHRs across the US - a strong signal of the growing importance of Medical Informatics in the global health arena.

For a Medical Informatics-trained physician play these crucial roles the most important thing is to have a solid foundation in terms of clinical knowledge and experience. There are similarities with family medicine in the sense that our clinical knowledge has to be broad and holistic rather than focused on any given specific area. In addition, we try to understand provider roles (including nursing and allied health), workflows and responsibilities across various care settings. This is an ongoing learning process, as no one can pretend to know all the complexities and nuances of our modern-day healthcare delivery system.

In terms of formal education and certification, we are looking to increase the options available to fellow physicians who are keen to explore or acquire formal training in this area.

One of our early steps in this area has been to launch an introductory course in Medical Informatics, in conjunction with Gateway Consulting, the Infocomm Development Authority (IDA) and the American Medical Informatics Association (AMIA). This is the just the beginning of what will eventually be a full range of educational offerings in Medical Informatics, and creatively structured to cater to busy clinicians.

We encourage all interested physicians to go to <http://www.gatewaypl.com/g2hi/> for more details. ■ **CM**

WITH DEEPEST SYMPATHY

Dr Wong Kum Hoong



Just as this issue of the College Mirror goes to our printers, we receive the mournful news of the passing of one of the pioneers of the College of Family Physicians,
Dr Wong Kum Hoong.

Dr Wong passed away on 28 August 2009. He was 78 years old.

Dr Wong Kum Hoong was the Censor-in-Chief of the College from 1971-1974, during the tenure of the first three Councils. Raising the standards of General Practitioners was the primary aim in setting up this College and Dr Wong was instrumental in setting and maintaining high standards of the College Examinations at that time. His reputation for high standards was known even among international members of the Family Medicine fraternity.

The College expresses our deep condolences to Mrs Wong and her children during this time.



*College 1st Council (1972-1972).
Dr Wong Kum Hoong (front row, 2nd from R) served as
the Censor-in-Chief in the 1st, 2nd, and 3rd Council.*



*Dr Wong Kum Hoong (L)
“gowning” the Honorary
Fellow, Emeritus Prof Sir
Gordon Arthur Ransome at
the 2nd College Convention.
Also in the picture: the late
Dr Wong Heck Sing (R) and
late Prof Seah Cheng Siang
(2nd from R)*

Dr Leong Choon Kit and Dr Tan Tze Lee

Newly Elected Council Members

Interviewed by Dr See Toh Kwok Yee, MCFP(S), Editorial Board Member

The College Mirror has the pleasure of talking to two of our newly elected members of the 22nd council, Dr Tan Tze Lee and Dr Leong Choon Kit.

The interview sets out to better understand the motivation and passion behind these new leaders and torch-bearers and to have an inkling about the future direction they will steer the College.

CM: Give us a brief history of your career as a Family Physician thus far.

Dr Tan: I was a medical officer at the Alexandra Hospital Medicine Dept, thereafter was a medical resident at the National University Hospital and obtained my MRCP (UK) in 1992. At that point, my family encouraged me to change my career path and go into family practice instead, and in the third quarter of 1992, my wife, Kee Loo, and I established The Edinburgh Clinic in Choa Chu Kang Town, where we have been practicing ever since.

Dr Leong: I did my postings in various polyclinic and ended off as a resident at Ang Mo Kio Polyclinic. After which, I left for overseas mission till the end of 2000. I felt handicapped after not practicing for 4 years and resumed my career with the Graduate Diploma course and stated my practice with a few like-minded friends in 2003.

CM: What made you decide for the first time to run for council election?

Dr Tan: My mentor Prof Cheong Pak Yean approached me to put myself up for the council election and Dr. Tan See Leng likewise approached me to do so. They were aware of my interest and passion to develop the research aspect in family practice and so I agreed to run for council in the hope that I can make my contribution in this area.

Dr Leong: I felt that General and Family Medicine Practitioners can be more united in all ways and at all levels. Secondly, I felt that family medicine practice is the way forward for General practice in Singapore. With these



Dr Leong Choon Kit: "I must confess that my family is an excellent family where they understand why I do what I do."

convictions, I started discussion with a few classmates 2 years ago. I hope to bring our private discussion and

idealism into a higher and more formalised level with the college. That is why I accepted the invitation to run for council.

CM: Did you have to actively canvass for support in the days leading to the election? Any anxious moments?

Dr Tan: I did not canvass for support at all! There were no anxious moments, and in fact the whole process was very smooth. Amazing!

Dr Leong: None at all. I hope we can see my challenges in the council election in the future for the good of our profession. There is no anxiety as I am prepared not to be elected. However, elected or not, I am committed to pursue the discussion my friends and I have started.

CM: More specifically, what contributions, improvement and changes, if any, do you intend to bring into the new team?

Dr Tan: At the first council meeting, I was elected Honorary Editor and this responsibility weighs heavy on my shoulders. I hope to be able to develop the content of "The Singapore Family Physician", encourage original research and papers by our members for publication. I hope we will be able to grow the content of our College Journal that will gain in

reputation and recognition in the worldwide medical community.

Dr Leong: I would not say there will be any significant changes nor improvement. I would like to contribute towards the unity and enhancement of Family Medicine as a "specialty" and as a target and goal all of us GP should aim for.

CM: In your opinion, what are some of the challenges ahead for the college, say, in the next two years?

Dr Tan: I see the College representing Family Practice and all Family Physicians in Singapore as a whole, and as it is striving to do so at present. We have a tremendous task to raise the profile and perceived role of the Family Physician.

Dr Leong: I believe the main challenge is to get all the GP/FP to come together for a common goal and identity. As it is, unlike the specialties, there is very little that binds us together. This is so despite the fact that FP/GP practice is unique and is one of its kind.

CM: What is your advice to a new doctor who wants to follow your footsteps to become a Family Physician?

Dr Tan: Get skilled before stepping out, and before anything else, clothe themselves with compassion and empathy.

Dr Leong: Join us in the college for training and for CME. Contribute to the future generations by volunteering to teach undergraduates.

“Get skilled before stepping out, and before anything else, clothe themselves with compassion and empathy.”

CM: What is your advice to an older GP who want to continue to practice amidst the multitudes of new initiatives and changes?

Dr Tan: Recall your first love for your calling, Join us at the college and our skills upgrading programmes and social events! It's fun!

Dr Leong: Stay true to our calling and hearts and keep the patients at the centre of our practice. Be bold and confident and reject all unreasonable demands from drug companies, management companies and even some institutions. Don't shortchange our patients by undercutting our colleagues or by attracting higher patient load.

CM: On a lighter and more personal note, what's life like after a day in the office? Share with us your secrets to such a balanced and accomplished worklife!

Dr Tan: After work, I had in the past much parenting duties to do. Now that the children are more independent, I do play my violin now and again, and picked up my camera to shoot some film too (yes I am a luddite!). On a more serious note I am hoping to get a few likeminded family physicians to engage in some community based research in the next 1-2 years, and hopefully this will help our College to develop the research arm like there is in some of our brother colleges in the UK and Australia.



Dr Tan Tze Lee: “After work, I had in the past much parenting duties to do. Now that the children are more independent, I do play my violin now and again.”

Dr Leong: I don't have any secret formula and I don't think I am a good example for a balanced family life. I believe there will never be a balanced life so long as we want to serve as a doctor. Everyone's idea of a balanced life is different in my family. However, I must confess that my family is an excellent family where they understand why I do what I do. The only way for all of us to have a balanced family life is when all FP/GPs helped chip in for the good of the fraternity.

CM: Thank you Dr. Tan and Dr. Leong and our best wishes.

"Unless someone like you cares a whole awful lot, nothing is going to get better. It's not." - Dr. Seuss

■ CM

“I hope to bring our private discussion and idealism into a higher and more formalised level with the college. That is why I accepted the invitation to run for council.”

Update on Influenza-related Vaccinations

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

In view of the current Influenza A (H1N1) viral pandemic, it may be timely to review vaccination recommendations in relation to Influenza infection and its sequelae.

The Hospital Influenza Workgroup (Singapore) have published a position paper in the Singapore Medical Journal (2009 June edition) regarding management of novel influenza epidemics in Singapore. We use the information from this paper and from the latest Recommendations of the Advisory Committee on Immunization Practices (United States) (31 July 2009) to discuss the topic of vaccinations here.

INFLUENZA VACCINATION

The vaccine against the new H1N1 virus is as yet unavailable. Once it is available, there will be the issues of prioritizing vaccinations to high risk groups, and monitoring for potential adverse reactions.

In the meantime, the seasonal influenza vaccination is recommended to reduce mortality and morbidity from seasonal influenza, reduce the strain on hospital beds and reduce use of oseltamivir (Tamiflu).

In Singapore, MOH recommends routine annual seasonal influenza vaccination for:

- Elderly persons aged 65 years or above,
- Young children aged 6 months to 5 years,
- Those with chronic heart and lung diseases, and
- Persons with diabetes mellitus or renal diseases.

The Hospital Influenza Workgroup also recommends vaccinations for women in second and third trimesters of pregnancy, and health care workers. Priority, in case of limited supply of vaccines, should be given (in addition to the above mentioned categories) to schoolteachers and those providing essential services including the military, police and civil defence.

In the United States, the Advisory Committee on Immunization Practices of the United States now recommends that all children aged 6 months -18 years be vaccinated annually. For adults, it is recommended that annual vaccination be offered to all persons who want to reduce the risk of becoming ill with influenza or of transmitting it to others.

Specifically, the following high risk groups are identified:

- Persons aged >50years;
- Pregnant women;
- Persons with chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, cognitive, neurologic/ neuromuscular, hematological or

metabolic disorders (including diabetes mellitus)

- Persons with immunosuppressive conditions;
- Residents of nursing homes and other long term care facilities;
- Healthcare personnel;
- Household contacts and caregivers of children aged <5 years and adults aged >50 years, and of persons with high risk medical conditions.

PNEUMOCOCCAL VACCINATION

The Workgroup also recommends Pneumococcal vaccination as an additional measure of protection for all those at risk, to potentially reduce the burden of secondary bacterial infections.

The target group (US Recommended Adult Immunization Schedule 2009) includes:

- All persons >65years of age
- High risk groups of all ages: Chronic lung disease (including Asthma), chronic cardiovascular diseases, diabetes mellitus, chronic liver

The seasonal influenza vaccination is recommended to reduce mortality and morbidity from seasonal influenza, reduce the strain on hospital beds and reduce use of oseltamivir (Tamiflu).



diseases, cirrhosis, chronic alcoholism, chronic renal failure or nephrotic syndrome; functional or anatomic asplenia; immunocompromising conditions; cochlear implants; cerebrospinal fluid leaks.

- Residents of nursing homes or long-term care facilities
- Persons who smoke cigarettes.

In adults, the 23-valent pneumococcal polysaccharide vaccine (23PPSV) is used.

In children below 9 years, the heptavalent conjugate vaccine (Pevnar) is available. For children above 2 years with chronic medical problems, the 23PPSV can be used.

Revaccination with pneumococcal polysaccharide vaccine:

One-time revaccination after 5 years is recommended for persons with chronic renal failure or nephritic syndrome, asplenia, immunocompromising conditions.

Also recommended for persons aged 65 years and older, if they were vaccinated 5 or more years previously and were aged less than 65 years at the time of primary vaccination.

In summary, offer the influenza vaccination to almost everyone (unless contraindicated) and pneumococcal vaccination to high risk groups. **ICM**



With a primary healthcare network consisting of 9 Polyclinics, SingHealth Polyclinics provides affordable patient-centric, comprehensive and integrated services to patients at accessible locations across the eastern parts of Singapore.

We seek qualified candidates to fill the following positions:

- | | |
|---|--|
| <ul style="list-style-type: none"> ● Resident Physician ● Senior Resident Physician ● Principal Resident Physician | <ul style="list-style-type: none"> ● Family Physician ● Senior Family Physician ● Consultant Family Physician ● Senior Consultant Family Physician |
|---|--|

You will render primary healthcare to patients and ensure maintenance of clinical and service standards.

Applicants must have a basic Medical Degree, which is recognised and registered with the Singapore Medical Council. Applicants with a Master of Medicine (Family Medicine) will be considered for the Family Physician position.

Applicants with more years of relevant experience in general practice and additional qualifications such as Graduate Diploma Family Medicine and Fellow College of Family Physicians will be considered for the senior positions. Good communication and interpersonal skills are essential.

◦ Locum Doctors

Doctors who are able to provide locum services at our polyclinics are welcome to apply. Selected candidates will be remunerated with competitive rates.

Interested applicants are invited to apply with detailed curriculum vitae, stating full personal particulars, educational and professional qualifications, career history, present and expected salary, contact numbers and e-mail address to:

Director, Clinical and Corporate Services
c/o HR Department
SingHealth Polyclinics - Head Office
167 Jalan Bukit Merah, Tower 5, #15-10
Singapore 150167
E-mail: jasmime.teo@singhealth.com.sg

Or on-line application at
<http://polyclinic.singhealth.com.sg/JoinUs>

Building a Research based Primary Care Service

Are we ready to meet this challenge?

by Dr Matthias Toh, MBBS, MMed(Public Health), FAMS

The Unique Work of Family Physicians

The work of the family physician (FP) provides a functional and task-oriented approach to the categorization of its domains.

There is probably no one better positioned than the FP to investigate people of all ages and walks of life and the nature of what happens in daily frontline medical practice. Each of these following components is amenable to enhancements through research:

- o serving as the point of first contact (treating symptoms without disease, probabilistic problem-solving, early diagnosis, accepting uncertainty inherent in complexity)
- o committing to the person as a whole, not only to the disease
- o adopting a family oriented approach in clinical practice
- o incorporating the family and social context in which the patient lives
- o preventing disease and promoting health
- o encouraging the autonomy of patients
- o accepting any type of problem, usually undifferentiated

Importance and Challenges in Primary Care Research

During the last 2 decades, there has been an increased recognition by the

World Health Organization of the importance of primary care in improving the health of populations. However, this provision of primary health care clinical service and education has not been accompanied by an investment in research efforts.

Family medicine is a well-defined discipline in which research in the context of primary care is essential to guide FPs in appropriate clinical decision making. Primary care research is important in the development of high-quality, evidence-based health care for populations. FPs need to be more proactive in clearly defining the discipline of family medicine and assisting our colleagues, policy makers, educators and funding agencies to understand why research in the primary care context is essential for improving any nation's health.

Knowledge gained from the research can be applied locally and internationally, resulting in improved quality of health care and often reducing use of expensive therapy. Ironically, the more common the problem, the less it is researched, creating considerable deficiencies in knowledge for practicing FPs. I hope to encourage primary care professionals to see participation in research as a welcome necessity in higher professional training.

Kerr White, widely recognized for his lifetime contribution to primary care and health services research, has challenged FPs to ask and answer important questions about the origin and relief of disease. FPs are well-positioned to discover answers to questions related to what causes people to get and stay sick, circumstances present at the onset of problems, concomitant factors, predisposing factors, factors that precipitate a person to seek health care, and the nature of the therapeutic environment. The Research Domain of Family Medicine

Without doubt there are domains of family medicine research that are important and ripe for development. The poorly understood, but discoverable, areas of inquiry about the causes of disease and illness are important not only to FPs and their

.....

Without doubt there are domains of family medicine research that are important and ripe for development.

patients but also to the rest of Medicine. They must not be regarded as trivial and being peculiar to family medicine, and can be explored from different perspectives, including:

- (1) the ecology of medical care and its focus on the environments of health care and interactions among them
- (2) the realm of causation and important opportunities to discover how people lose and regain their health
- (3) understanding medicine in different ways, focusing on what things mean in the inner and outer realities of individuals and groups of individuals
- (4) the nature of the work of FPs, such as first-contact care for any type of problem, sticking with patients regardless of their diagnoses, incorporating context into decision making, development of relevant technologies, articulating useful theory, and measuring what happens in family medicine
- (5) the standard research categories of basic, clinical, health services, health policy, and educational research
- (6) thinking of family medicine research as both a linear process of translation and a wheel of knowledge with iterative loops of discovery that come from within family medicine

Health care at each of the 3 levels of primary, secondary, and tertiary care can be studied by the FP. Research can be further classified at each level as follows:

- (1) basic research about mechanisms, methods and theory
- (2) clinical research (medical and health research intended to produce knowledge valuable for understanding human disease, preventing and treating illness, and promoting health)
- (3) health care (services) research -

- studying the structure, function, and outcomes of health care
- (4) health systems (policy) research
- (5) educational research - looking into the education and training of family physicians.

A robust family medicine research enterprise adds to overall medical research and will benefit large groups of people. We need the thinking and imagination of the best investigators.

Development of Primary Care Research in Singapore

We will need the support and cooperation of our FPs, primary care organisations and Ministry of Health to promote and rally primary care research in Singapore. Many important issues need researching in primary care, particularly the epidemiology and treatment of common illnesses that are seen almost exclusively outside of hospitals. At present, only a small number of researchers and academics are contributing to the knowledge base. There is a need to expand the research capacity in primary care from its present low base. Five areas need attention:

- (1) the range of content of primary care research
- (2) the methodological quality of research
- (3) the availability of research leadership
- (4) the number of non-medical clinical staff with research expertise
- (5) the involvement of non-clinical researchers

The domain of family medicine research is large and the potential is limitless. As FPs, be ready for exploration. Research requires curiosity, courage, focus, training, collaboration, patience, resilience and dedication - not unlike the requirements of being a good physician. Just as FPs focus on one patient at a time, successful family

A robust family medicine research enterprise adds to overall medical research and will benefit large groups of people.

medicine researchers take on questions much like eating the proverbial elephant, "one bite at a time." Not all aspects of the domains of family medicine research will be equally compelling at all times. The versatility of our training guarantees our relevance to the investigative enterprise of greatest interest in their locations. Your work may be poised to benefit not a few, but billions of people!



Recommendations from WONCA

The World Organization of Family Doctors (Wonca's) meeting in 2003 was themed "Improving Health Globally: The Necessity of Family Medicine Research", and made the following 9 recommendations:

- (1) Research achievements in family medicine should be displayed to policy makers, health (insurance) authorities, and academic leaders in a systematic way.
- (2) In all countries, sentinel practice systems should be developed to provide surveillance reports on illness and diseases that have the greatest impact on the population's health and wellness in the community.
- (3) A clearinghouse should be organized to provide a central repository of knowledge about family medicine research expertise, training, and mentoring.
- (4) National research institutes and university departments of family medicine with a research mission should be developed.
- (5) Practice-based research networks should be developed around the world.
- (6) Family medicine research journals, conferences, and Web sites should be strengthened to disseminate research findings internationally, and their use coordinated. Improved representation of family medicine research journals in databases, such as Index Medicus, should be pursued.
- (7) Funding of international collaborative research in family medicine should be facilitated.
- (8) International ethical guidelines, with an international ethical review process, should be developed in particular for participatory (action) research, where researchers work in partnership with communities.
- (9) When implementing these recommendations, the specific needs and implications for developing countries should be addressed.

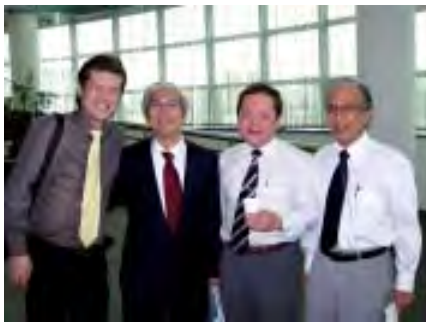
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■ CM

Family Medicine Commencement & Annual General Meeting

27 June 2009, Health Promotion Board Building



(L-R) Dr Lawrence Ng, A/Prof Goh Lee Gan, Dr Arthur Tan, and Dr Cheng Heng Lee, enjoying the tea reception.



A chance to browse medical books and to network during the tea reception.



Briefing for trainees on various Family Medicine programmes; Fellowship Programme (top), MMed (FM) (bottom left), and Graduate Diploma in Family Medicine (bottom right).



The 2009 College Annual General Meeting was attended by 144 voting members, and elected the 22nd Council to serve for the next 2 years (2009-2011) (See page 20).



(L-R): Dr Lim Fong Seng, Honorary Treasurer; Dr Jonathan Pang, Honorary Secretary; A/Prof Goh Lee Gan, President; and A/Prof Lee Kheng Hock, Vice President.

College of Family
Physicians Singapore
22nd Council
(2009-2011)



President

A/Prof Goh Lee Gan

Vice-President

A/Prof Lee Kheng Hock

Censor-in-Chief

A/Prof Tan Boon Yeow

Honorary Secretary

Dr Pang Sze Kang Jonathan

Honorary Treasurer

Dr Lim Fong Seng

Honorary Editor

Dr Tan Tze Lee

Council Members

Dr Chow Mun Hong

Dr Eu Tieng Juoh Wilson

Dr Goh Choon Kee Shirley

Dr Leong Choon Kit

Dr Rukshini Puvanendran

Dr Tham Tat Yean

Dr Wong Tack Keong Michael



Invitation to apply for post of

Executive Director

College of Family Physicians Singapore

The shortlisted candidate should ideally possess good leadership and interpersonal skills:

- be able to lead and supervise the secretariat in the daily work
- ensure effective implementation of College activities
- help ensure financial viability of projects and programmes run by the College
- be familiar with programmes and roles of the College
- be able to function in and out of College premises
- preferably MMed or Fellow with previous Council experience

Executive Director will be remunerated on a contract of service by honorarium.

Interested applicants are invited to apply with detailed curriculum vitae, contact numbers and e-mail address before 30 September 2009 to:

Honorary Secretary

College of Family Physicians Singapore

16 College Road #01-02

College of Medicine Building

Singapore 169854

E-mail: information@cfps.org.sg

Fax: 6222 0204

Only shortlisted candidates will be notified.

Useful Mnemonics & Acronyms in Family Medicine



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

■ Diagnostic Criteria for Kawasaki Disease: **FEAR ME**

Fever plus at least 4 other features:

- F**ever >38.3C lasting >5 days
- E**ye bilat conjunctival injection without discharge
- A**denopathy usually unilat, cervical > 1.5cm
- R**ash truncal exanthem
- M**outh dry, chapped & red lips; Mucosa: strawberry tongue
- E**xtrimities reddened, edematous, peeling hands and feet

■ Infantile Colic: Wessel Criteria - **The rule of 3's**

The child cries for at least:

- 3 hours/day
- 3 days/week
- 3 weeks

Starting before 3 months of age

■ Adolescent psychological screening: **SAFE TIMES**

- S**exuality issues
- A**ffect (depression) & Abuse (drugs)
- F**amily (function & history)
- E**xamination (sensitive & appropriate)
- T**iming of development (body image)
- I**mmunizations
- M**inerals (nutritional issues)
- E**ducation, employment (school & work issues)
- S**afety (vehicle)

The SAFETIMES questionnaire (STQ) is a valid, reliable self-report health behavior screening instrument useful in the identification of subjects at risk for depression and family conflict.

■ Substance abuse screen: **CRAFFT**

- C**ars (have you driven under the influence?)
- R**elax (do you use a substance to help you relax?)
- A**lone (do you use a substance alone?)
- F**orget (any spells of forgetfulness/blackouts while using?)
- F**riends (are your friends concerned about your use?)
- T**rouble (have you gotten into trouble from your use?)

The CRAFFT is a behavioral health screening tool recommended by the American Academy of Pediatrics' Committee on Substance Abuse to screen adolescents at high risk for alcohol and other drug use disorders. A "yes" answer to ≥ 2 of the 6 questions indicates that the youth is at risk. Further conversation about the context of use, frequency, and other risks and consequences of alcohol and other drug use is then warranted.

■ Major Depressive disorder: **MISS SPACE**

- M**ood down
- I**nterest down
- S**hame / guilt
- S**uicide or suicide ideation
- S**leep more or less
- P**sycomotor retardation
- A**ppetite up or down
- C**oncentration down
- E**nergy down

The DSM IV criteria is 5 of the 9 of which Mood and/or Interest down for ≥ 2 weeks must be present. (i.e. M or I plus 4 other, M and I plus 3 other). Note that 'MISS' represents higher functions more common in depression (vs anxiety) while 'SPACE' are neurovegetative functions which respond well to medications and are shared with anxiety.

■ Suicide Risk Assessment: **SAD PERSONS**

- S ex: male
- A ge: older (M>75 yr, F>60 yr)
- D epressed
- P revious attempt
- E thanol abuse
- R ational thought loss
- S ocial support lacking
- O rganized plan
- N o spouse
- S ickness

Assign 1 point to each of the 10 items and score:

- 1 - 2 points = low risk
- 3 - 5 points = moderate risk
- 7 or more points = high risk

■ Criteria for Manic episode of bipolar disorder: **DIG FAST**

These must last 4-7 days and must produce social and occupational dysfunction

- D istractibility
- I mpulsivity
- G randiosity
- F light of ideas (thought racing)
- A gitation psychomotor
- S leep requirement decrease
- T alkativeness (pressured speech)

N.B. These symptoms, in the context of treating a patient with depression, suggests bi-polar and is a trigger for referral to psychiatrists.

■ Activities of Daily Living (ADLs): **DEATH**

- D ressing
- E ating
- A mbulating
- T oilet
- H ygiene

■ Instrumental Activities of Daily Living (IADLs): **SHAFT**

- S hopping
- H ousekeeping
- A ccounting
- F ood preparation
- T ransportation

■ Screen for Domestic Violence: **SAFE**

- S tress and safety
Do you feel safe in your relationship?
- A fraid or Abused
Has partner ever threatened/abused you or your children
- F riends and Family
If you were hurt, would your friends/family know? Would they be able to help you?
- E mergency Plan
Do you have a safe place to go in an emergency? Do you need help in locating a shelter? Would you like to talk to a counselor about this?

■ Precipitants of Delirium in the Elderly: **DELIRIUM**

- D rugs especially when introduced or changed
- E lectrolyte/metabolic hyponatremia, acidosis, hypoxemia
- L ack of medication acute withdrawal
- I nfection
- R educed sensory input blindness, deafness, isolation
- I ntracranial problems stroke, meningitis
- U rinary retention & fecal impaction
- M yocardial problems MI, CCF, arrhythmia

■ **CM**

Volunteer Your Help

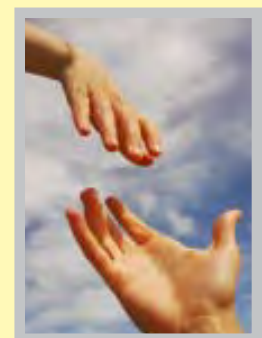
Locum Needed

Dr Eric Kwek, our Family Medicine colleague and college member, has not been well and will be undergoing chemotherapy very soon. He urgently requires the services of locum doctors to cover his clinic duty in his absence and during his treatment.

In support of our fellow colleague in need, we would like to encourage our members to either volunteer ourselves, our partner or staff to help. If you are aware of any reliable and available locum doctors, please also contact any one of the followings:

- a. Dr Leong Choon Kit, email: choonkit@singnet.com.sg
- b. Dr Alex Kuan, email: systrac@gmail.com

We look forward to your partnership in helping a fellow Family Medicine colleague.



CONGRATULATIONS!

The 22nd Council of College of Family Physicians Singapore and
The College Mirror Editorial Board congratulate our Fellows:

Dr Lee Kheng Hock

Vice President of the College of Family
Physicians Singapore

for the appointment as

**ASSOCIATE PROFESSOR,
DUKE-NUS GRADUATE MEDICAL
SCHOOL**

Dr Tan Boon Yeow

Censor-in-Chief of the College of Family
Physicians Singapore

for the appointment as

**ADJUNCT ASSOCIATE PROFESSOR,
YONG LOO LIN SCHOOL OF
MEDICINE, NUHS & DUKE-NUS
GRADUATE MEDICAL SCHOOL**

THE ANNUAL FAMILY MEDICINE CONVOCATION CEREMONY & DINNER 2009

We invite you to join us as we celebrate
another milestone year in Family Medicine.



Sat, 28 November 2009
Grand Copthorne Hotel

For more information, please contact
Tel: 6223 0606, or email: contact@cfps.org.sg.

Mental Capacity Act



26 & 27 September 2009 | 2.00pm - 6.45pm

Singapore Management University

Ngee Ann Kongsi Auditorium Lvl 2

School of Accountancy, 60 Stamford Road, Singapore 178900

- Unit 1: Overview of the Mental Capacity Act (2008)
- Unit 2: The Mental Capacity Act (2008): Legal Implications
- Unit 3: The Mental Capacity Act (2008): Code of Practice
- Unit 4: The Mental Capacity Act (2008): Banking Matters
- Unit 5: Psychiatric Assessment of Mental Capacity
- Unit 6: Ethical Issues Related to the Mental Capacity Act

SPEAKERS

Prof Kua Ee Heok, Professor and Senior Consultant Psychiatrist, Dept of Psychological Medicine, National University Health System

A/Prof Chin Jing Jih, Senior Consultant, Dept of Geriatric Medicine, Tan Tock Seng Hospital

Ms Sumytra Menon, Legal Analysis, Wrtg & Res Instructor, Faculty of Law, National University of Singapore

Mr Lek Siang Pheng, Partner, Rodyk & Davidson LLP's Litigation & Arbitration Practice Group, Honorary Legal Advisor, College of Family Physicians Singapore

Mr Ong Kian Peng, Senior Vice President, Business Change & Controls, Personal Financial Services, HSBC

Ms Cynthia Chan, Assistant Director, Office of the Public Guardian

SEMINARS

(2 Core FM CME Points for each seminar)

Seminar 1 • Unit 1-3: Sat, 26 Sept 2009 (2.00pm - 4.15pm)

Seminar 2 • Unit 4-6: Sun, 27 Sept 2009 (2.00pm - 4.15pm)

WORKSHOP (2 Core FM CME Points)

Workshops:

Sat, 26 Sept 2009 (4.30pm - 6.45pm)

Sun, 27 Sept 2009 (4.30pm - 6.45pm)

Part 1 • Case Studies & Skills 1-2

Part 2 • Assessment for Accreditation

*Registration of workshop is on first come first served basis. Seats are limited. Please register by 20 Sept 2009 to avoid disappointment.

DISTANCE LEARNING MODULE

(6 Core FM CME Points upon completing the MCQ Assessment)

- Read 6 Units of study materials in the Singapore Family Physician Journal and pass the MCQ Assessment.

This Family Practice Skills Course is conducted jointly by the College of Family Physicians Singapore and **Ministry of Community Development, Youth and Sports (MCYS)**



REGISTRATION

MENTAL CAPACITY ACT

Please tick (✓) the appropriate boxes

	College Member	Non Member
Seminars (26-27 Sep) & Workshops (26-27 Sep)	<input type="checkbox"/> FREE	<input type="checkbox"/> \$ 120.00
Assessment Fee	<input type="checkbox"/> \$ 20.00	<input type="checkbox"/> \$ 20.00
Distance Learning (Journal)	<input type="checkbox"/> FREE	<input type="checkbox"/> \$ 40.00
TOTAL		

I attached a cheque for payment of the above, made payable to: **College of Family Physicians Singapore**.*

Cheque number: _____

Signature: _____

*Registration is confirmed only upon receipt of payment. The College will not entertain any request for refund due to cancellation after the registration is closed **OR** after official receipt is issued (whichever is earlier).

Name: Dr _____

MCR No: _____

(For GDFM Trainee only) Please indicate: 2007 Intake 2008 Intake

Mailing Address: (Please indicate: Residential Practice Address)

E-mail: _____

Tel: _____ Fax: _____

Note: Any changes to the course details will be announced via e-mail. Please kindly check your inbox prior to attending the course. Thank you.

Please mail the completed form and cheque payment to:

College of Family Physicians Singapore

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

Or fax your registration form to: **6222 0204**