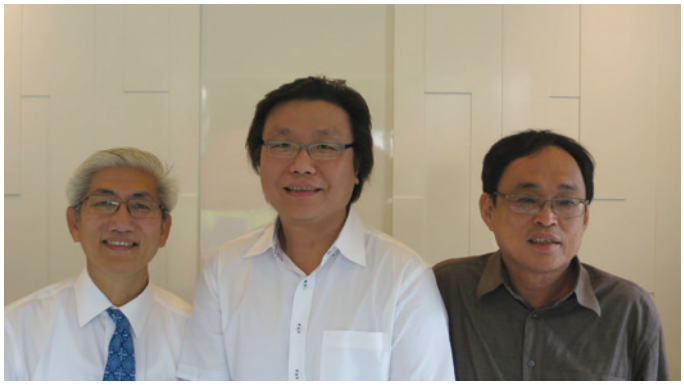
THE College Mirror

VOL. 38 NO. 1 March 2012

A Publication of College of Family Physicians Singapore

A Truly Inclusive Family Physicians Register

by A/Prof Lee Kheng Hock, President, 23rd Council, College of Family Physicians Singapore,
A/Prof Cheong Pak Yean, Past President, College of Family Physicians Singapore &
A/Prof Goh Lee Gan, Immediate Past President, College of Family Physicians Singapore



From left: A/Prof Goh Lee Gan, A/Prof Lee Kheng Hock, A/Prof Cheong Pak Yean. (Photo courtesy of A/Prof Lee Kheng Hock.)

A family physicians register was first mooted by the College of Family Physicians Singapore in 2005. The time it took from concept to implementation spanned the terms of 3 Presidents. The College had consistently urged for an inclusive approach and we were reassured by the recent turn of events following feedback from the College and from the media. The President and the Past-Presidents spanning this journey of the family physicians register are pleased to jointly write this issue's President's Forum for our College Mirror.

The recent enquiry in the Straits Times Forum Page on the restricted recognition of the family doctors' work for maintenance of competency (MOC) to be in the Family Physicians Register (FPR) has resulted in a positive response for an inclusive Register by the Family Physician Accreditation Board. The College welcomes Ministry of Health's decision to expand the definition of family medicine and to accept that family physicians do practice across the health care spectrum contributing to the continuity of care from the restructured hospitals, to intermediate and long term care sector, and to GP and polyclinics in the community. This progressive and broader perspective will contribute greatly towards achieving an integrated health care system that is needed to meet the challenges of a rapidly growing population, a rapidly ageing population and the rise of chronic diseases. This is consistent with the call to promote the enlarging role in primary care partnerships that our Minister of Health Mr Gan Kim Yong speaks about.

An expanded definition of family medicine

In a nutshell, the 30 hours per month of accredited experience for family physicians to stay in the Family Physicians Register (FPR) can include practices in care settings that are consistent with the broader definition of family medicine.

Indeed the scope of the family physician's work will be enlarging to meet the needs of the older patients with complex chronic diseases and in the implementation of the primary care partnerships envisaged by the Ministry of Health and our Government. Apart from the traditional work in the clinics in the community, the care of older patients increasingly takes the family physician into home care, and transitional care in the hospitals. And rightly work in such areas is now counted in the 30 hours per month requirement in maintenance of competency of family physicians.

Home care is important – This is not just care in patients' home but also care in nursing home - in fact, care in patients' home is often more challenging because in nursing home, more professional support is available. It is a big challenge to for all family physicians to be conversant of this area of care in the present and future.

Transitional care is also important – This is not just in ambulatory clinic but also in acute hospitals. In a way, healthcare is always transitional as the patient is constantly

(continued on Page 5)

There is presently a high level of collegiality and camaraderie among these doctors who are committed to improve the standard of family medicine through a tripartite collaboration between our College, the Universities and the Ministry of Health. This augurs well for our healthcare system as we now have a re-invigorated generalist discipline who shares a common care paradigm working together across the spectrum of the healthcare system.

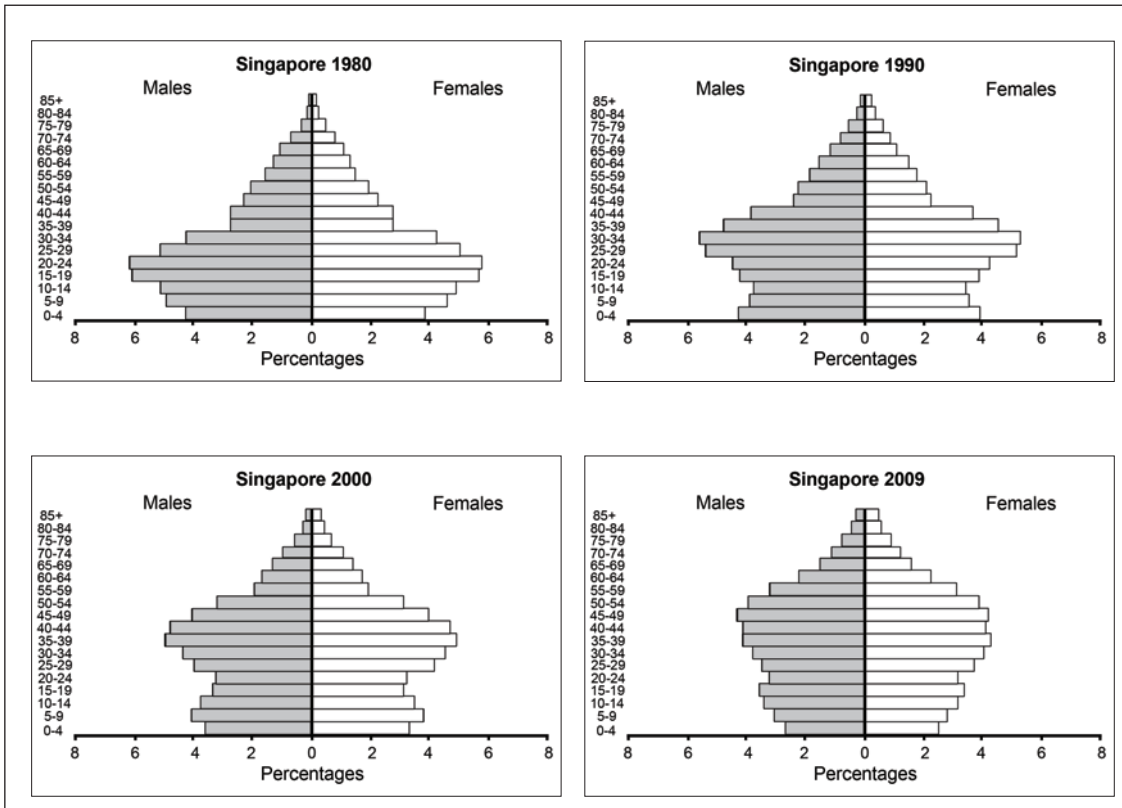
Healthcare 2020 and the Family Physician

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

Health Minister Mr Gan Kim Yong unveiled the Ministry of Health's (MOH) road map for the future in his Committee of Supply Speech *Healthcare 2020: Improving Accessibility, Quality and Affordability for Tomorrow's Challenges* in Parliament on 6 March 2012. Calling it the Healthcare 2020 Masterplan, he set out 3 strategic objectives: enhancing the accessibility, quality and affordability of healthcare.

The underlying change in the healthcare landscape that is lending some urgency to the new initiatives is fundamentally a change in population demographics - Singapore's population is ageing. Life expectancy in Singapore is already at 82 years in 2010, one of the highest in the developed world. By 2030, 1 in 5 Singaporean residents will be aged 65 and above. This will be a threefold increase to 960,000 elderly, from about 350,000 today. There is no better way to illustrate this than by looking at the population chart and projection (Figure 1): from a population pyramid that was young in the 80s, to a diamond shape in the 90s, the centre of gravity can be seen to be shifting upwards well into 2009.
(Source: MCYS, State of the Elderly in Singapore 2008/2009)

Figure 1: Population pyramid



The elderly will therefore be a strong driver of healthcare demand in the future. The share of chronic disease will continue to go up, with more emphasis on its management in the community and less emphasis on episodic care in hospitals.

As family physicians, we not only have to ask ourselves how this shift in demographics will affect our practice, but more importantly what we need to do to prepare ourselves for the changes that lie ahead.

The share of **chronic diseases** that we see will increasingly take a larger proportion of our workload. Private GPs in Singapore traditionally see the lion's share of acute cases in primary care, whereas polyclinics handle a disproportionate amount of chronic diseases. As part of Healthcare 2020, this imbalance has been addressed with increased portable subsidies under the Community Health Assist Scheme (CHAS).

As family physicians, we not only have to ask ourselves how this shift in demographics will affect our practice, but more importantly what we need to do to prepare ourselves for the changes that lie ahead.

Patients can now enjoy subsidised services at private GPs. As family physicians, we must now prepare ourselves to not only handle more complex cases with multiple chronic diseases such as diabetes, hypertension, hyperlipidemia, but also depression and dementia. In this issue, College Mirror (CM) talks to Dr Ho Han Kwee who offers some ***Insights on the Primary Care Masterplan***.

Integrated care will also be a significant part of our workload, with more elderly patients being managed in the community setting. The ***Regional Health Systems*** (RHS) concept will see acute general hospitals working closely with community hospitals, nursing homes, home care and day rehab providers, as well as polyclinics and private GPs within a geographical region. Dr Loke Wai Chong's interview article in this issue of CM examines some of the concepts and issues relating to the RHS.

No proper plan to implement care integration can go without electronic medical records. The **National Electronic Health Record** is a government initiative to move Singapore into a "one patient one record" system. In this issue of CM, we look at the impact of electronic medical records on clinical practice, and Dr See Toh Kwok Yee speaks to a GP who has been using electronic paperless medical records in his practice.

On a final note we must remember that, as family physicians facing an ageing population, we are part of the demographic too. Our life expectancy should be no less than our patients, provided we take good care of ourselves both mentally and physically. Working in the primary care frontline is indeed a demanding occupation and we must take time for a better work-life balance, protect ourselves from burnout and run a steady measured pace. CM

this issue >>

Published by the College of Family Physicians Singapore
College of Medicine Building
16 College Road #01-02, Singapore 169854
Tel: (65) 6223 0606 Fax: (65) 6222 0204
GST Registration Number: M90367025C
E-mail: collegemirror@cfps.org.sg
MICA (P) 157/12/2011

Insights on the Primary Care Master Plan:
A Conversation with Dr Ho Han Kwee

CM: The primary care master plan that was recently unveiled by the Ministry of Health had captured the attention of our nation and the medical profession. There had been quite a few feedback sessions with GPs about the master plan. So far, what is the general feeling among the GPs with regard to the masterplan? Despite the publicity, many of us still feel that it is rather vague. There seems to be more questions than answers. Can you tell us why things seems to be so?

Photo courtesy of Dr Ho Han Kwee.

Recognising this as an opportunity for change to better support their practice and further enhance patient care, the GP community has provided us with a lot of important feedback and ideas on how the primary care masterplan should be developed. One of the possible reasons why some GPs still feel that the masterplan is rather vague is because MOH have taken the approach of co-creating the solution with our GPs instead of presenting a fully developed idea. As such, we have deliberately presented a straw-map, so that GPs can complete the picture with their ideas. To achieve this, we have formed three workgroups for each of these models, namely Family Medicine Clinics (FMCs), Community Health Centre (CHCs) and Medical Centres (MCs). Each workgroup is co-chaired by a GP and members of the workgroup included other GPs. All these efforts are to ensure that the GP community is represented and their views can be heard.

An important element of the masterplan is the proposed development of new care models – CHC, FMC and MC. GPs welcome the provision of support services at CHCs and ambulatory specialist services at MCs as they believe that these would complement their practices. We have also taken in feedback from GPs for CHC to help them with administrative support for data submission and claims, as well as Allied Health Professional support, including mental health services. There were also suggestions for a community pharmacy. Some GPs hope that these community pharmacies will help decrease the drug costs for some of their patients, especially those on multiple drugs. Because of the price differentiation of drugs, many of these patients today prefer to be seen in polyclinics.

The feedback on FMC is mixed. Some GPs are concerned that there is already spare capacity in the private sector and the introduction of FMC will only add competition. There are also others who feel that this would be an opportunity for like-minded GPs to come together and provide team-based care for chronic patients even as they prefer the greater autonomy of practising in the private sector.

Besides addressing the needs of our patients, we have taken extra efforts to ensure that the masterplan will also allow the needs of all GPs to be met as much as possible. This is regardless of whether they are in solo or group practice, whether they are highly experienced or have just started their career. In essence, the different care models are meant to be all encompassing to cater to GPs with different profiles and preferences.

CM: We hear that one of the reasons why we need the Primary Care Master Plan is because of our ageing population. This seems to be the most commonly cited reason for changes in health care policy. We keep hearing this thing about the ageing population. Is the situation really so bad?

I would not say 'bad' because aging per se is not a bad thing. But the aging issue poses some problem which we as a health system need to recognise and do something about it early. By 2020, the elderly will account for 20% of the population. But the 20% elderly is projected to account for half of all hospital bed days. Chronic disease prevalence is expected to increase by about 4% each year and we can expect the absolute number of Singapore residents requiring chronic care to increase 50% from 1.2 million in 2010 to 1.8 million in 2030. This potentially means the number of chronic patients seen at primary care clinics may well increase significantly. While hospitals are ramping up to meet this need, primary care also needs to level up to match the demand.

CM: There are many who feel that our present primary care system, while not perfect, is very cost effective. There is a good equilibrium of private and public primary care clinics. In fact many feel that there is too much capacity in the private sector. Why is there a need to create new entities like the FMC, CHC and the MC?

Yes, there are indeed some capacity in private sector and engaging the GPs to tap on this capacity and achieve a healthy equilibrium of private and public primary care clinics is one objective. Today, there are sharp differences between the way primary care is funded between public and private sector. This has in part caused some patients to shift from GP clinics to polyclinics. Through the masterplan, we hope to change this and work out good public and private partnerships models such that subsidised care can be provided to patients based on their needs regardless of the site of care.

For the public sector, which is functioning at capacity, the masterplan will be a welcomed relief. For the private sectors, this may be an opportunity to shift gear slightly for a different case mix, tap on structures such as CHCs or allied health services to support care by the GP and better link up with the hospitals. For the system,

(continued on Page 5)

(from Page 1: A Truly Inclusive Family Physicians Register)

guided to the most appropriate site of care in the system. This is especially so when patients end up in the acute hospital and all work is directed towards transiting the patient safely out of the hospital and back to the community. Ultimately all care must seek to restore the patient back to the community that he lives in. This is the enlarged role of the highly trained family physicians many of whom now work in the various family medicine departments in the restructured hospitals, the community hospitals and community clinics. Supporting one another in professional development activities and working in close partnerships, family physicians will take its rightful place as the community and patient centered generalist physician who will work towards gearing up our health care system to meet the immediate and future challenges.

Therefore arguably, instead of mandating just ambulatory care experience as meeting the requirements of maintenance of competency, we should look into the future and require all new and fresh entrants into the Family Physicians Register to have home care and transitional care experience as well as the competency to work with fellow family physicians across an integrated health care system.

The Masters programme in Family Medicine, since its inception in 1991 some 20 years ago, has provided for the experience in these varied settings. The Residency programme in family medicine is continuing with such a broad based training for Family Physicians.

Indeed such a visionary definition of family medicine will make this discipline very attractive to a large group of doctors who are considering their choice of residency training. We know for a fact that many young doctors wish to maintain a broad range of clinical skills and do not find the narrow focus of sub-specialisation attractive. Family medicine with its emphasis on a broad range of clinical competency and its community focus is arguably the broadest of all generalist disciplines. Many young doctors will consider the prospect of becoming a highly competent multi-talented generalist, who can function in different care settings, across the entire health care system to be a pinnacle of professional excellence that is highly desirable.

Acceptance of the Accredited Modular Course

For senior family doctors practicing in the community, Ministry of Health has instituted the Accredited Modular Course (AMC), the number of modules required to be attended to qualify to be in the Family Physicians Register depending on the number of years of graduation. Again we are heartened that MOH had accepted feedback from our College to make the requirements more achievable, taking into consideration the years of practice experience that senior family physicians possess. Family doctors who graduated 20 years or more only need to attend 2 out of the 4 AMC. Also if they have satisfactorily completed a course that is recognised as equivalent to one AMC, as for example the DFD course, the number of AMC to be attended will be reduced by one. Feedback from senior family doctors who attended the AMC had been generally positive. They find the workshops useful as refresher sessions in their clinical work.

Working towards an inclusive family physicians register

In Singapore, doctors who are trained family physicians practice not only in polyclinics and GP clinics but also in restructured hospitals, in community hospitals, in nursing homes and, in home care and even in palliative care facilities. Many such centres are helmed by doctors who are well-trained in the family medicine paradigm of personal, preventive and continuing care. There is presently a high level of collegiality and camaraderie among these doctors who are committed to improve the standard of family medicine through a tripartite collaboration between our College, the Universities and the Ministry of Health. This augurs well for our healthcare system as we now have a re-invigorated generalist discipline who shares a common care paradigm working together across the spectrum of the healthcare system. The challenge is to forge an identity and purpose for these doctors. One such exercise must surely be to work towards an inclusive family physicians register. ▮CM

(from Page 4: Insights on the Primary Care Master Plan: A Conversation with Dr Ho Han Kwee)

this will provide better continuum of care, better access and affordability for patients. However, GPs and polyclinics will remain the 2 key models of care in near future.

CM: We often hear that Singapore's healthcare system is already among the best in the world. Why do we need massive changes like what is proposed in the plans. Isn't it a safer strategy to continue to make incremental improvements instead of risking massive changes to our primary care system?

Our healthcare system today is already in transition. It is very much hospital-centric. In comparison to our hospitals, our primary care system has received a lot less attention over the past years. Thus, while our hospitals may be some of the best in the world, there remains a lot of room for improvement in primary care. As Singaporean age, and more people develop chronic diseases, the preference is clearly to be managed in the community rather than in hospitals. It is thus an opportunity for primary care to rise to the occasion and ride the wave of change and be ready for the aging population which is already right in front of us. If we age healthily and keep chronic disease at bay, we can prevent the 'tsunami of chronic diseases'. Our vision is to transform our primary care such that our healthcare system is one that is primary-care centric rather than hospital-centric.

CM: Thank you Dr Ho. What would be your take home message for the GPs who are going to be affected by the master plan?

The time is now! Together, we are entering into a golden era for primary care. Whether our vision of "A Family Physician for every Singaporean" will be realised meaningfully or not depend on each and every family physician. Let's make it happen. ▮CM

Regional Health System: How Will It Impact Our Practice?

by Dr Loke Wai Chiong, FCFP(S), MBA, Editorial Board Member in Global Healthcare Advisory Practice

By now, many of us in the family medicine community will have heard something about the Regional Health System (RHS) development in Singapore. Simply put, within a specified geographic region, each RHS will be responsible for improving the overall health of its region's population. It is proposed that each RHS could be anchored by an acute-care hospital in close partnership with other healthcare providers in the region, which includes GPs in primary care and intermediate/ long-term care (ILTC) providers. The aim of the RHS is to provide continuity in health services within its geographic region to meet the patient's needs, with the patient in the centre, so that patients need not seek services outside the region merely because of the lack of appropriate services in their locality.

The intention behind the RHS concept can be seen as three-fold, that:

- Structured, formalised partnerships and integration between healthcare providers and clinical pathways will ensure that the right combination of services are present within the region to meet the needs of the population;
- The integration of services will result in a continuum of care which is seamless and appropriate; and
- The establishment of shared systems will result in the delivery of quality, efficient and sustainable services.

College Mirror (CM) interviewed several of the important players in the forefront of this initiative across the regions to get their perspectives and insights into the new RHS framework. We thank A/Prof Lee Kheng Hock (**LKH**), Dr Tan Kok Leong (**TKL**), Dr Michael Wong (**MW**), Dr Lim Fong Seng (**LFS**), and Ms Selina Seah (**SS**) for sharing their views and advice to our readers in the FP/ GP community.

What does a Regional Health System and integrated care mean to you, in terms of your hospital and its partner care-givers in the community?

SS: I think it's the ultimate goal of good population health management that all of us want to achieve. Providers and patients have a role to play for better health. With the right flow of information, funding and support to the various providers and patients in the region, a good visibility of the care continuum and right governance of the whole system, we can perhaps reach the world-class healthcare standards outcomes we've set for ourselves.

LFS: I see it more simply as all the care providers, from primary care to hospitals to step-down care to support services, all connected up and flowing seamlessly from one to another, focused on the patient in the centre.

MW: I think, in a way, many of us are already practising this concept. In our region, we see ourselves congregating around the common mission: to care for people in the north. It might be easier for partnerships between acute hospitals and community hospitals/ nursing homes, as the former provide support for the latter. Partnerships between public hospitals and private GPs will be more about knowing and trusting one another, which is already happening today.

LKH: The dilemma about the RHS concept is that in Singapore, unlike in some other countries, patients have a choice of where they can go to receive medical services. For example, patients from all over Singapore come to Singapore General Hospital

(SGH) and consequently it may not be easy to care for only those within a region. However RHS will provide a chance for mindsets to be reset – it promotes the notion that it is no longer about institutional silos and that it is important for boundaries to be diminished, especially for the group of patients with multiple co-morbidities and complications of chronic diseases, who do need multidisciplinary care.

TKL: Whatever structure it takes, there are four aspects that I believe are essential for the RHS concept of integrated care to work effectively: right siting, funding flow, information sharing and standardised care. An example might be how Tan Tock Seng Hospital (TTSH) has addressed this starting from post-acute care, after patients are discharged home. The Post-Acute Care at Home (PACH) program provides time-limited multidisciplinary care for patients with complex needs after discharge from TTSH, and includes services such as medical assessments, nursing monitoring, caregiver training and support, and therapy services. The PACH service collaborates with various community healthcare partners including GPs, community nurses, etc. in providing continuity of care to patients. We have also developed standardised Care Bundles around common care problems, which can then guide the treatment at different sites respectively down the line.

What can a FP/ GP working in the vicinity of your hospital expect in the near and mid-term future?

TKL: In the future, we hope to see more GPs be involved in the care of patients with sub-acute conditions in the commuinty - working closely with a multi-disciplinary team, similar to that of PACH service and the 'Virtual Hospital' model of care. There will be many opportunities for FP/GPs in the community to participate in these programmes as they are being rolled out.

SS: FP/GPs play an important role in maintaining the patient well in the community. Supporting them with the necessary information to provide better care for their patients, and allied health support for conditions that require a multi-disciplinary approach, are things that FP/GPs have been asking for. The Community Health Centre at Tampines is one such example which was set up within the integrated regional system to work together with regional FP/GPs.

LKH: For FPs and indeed other doctors who are trained and comfortable being generalists, it will not be a problem to adjust to this new way of thinking, because even currently, FPs work across the system. They should be able to collaborate and work well together because they have the shared values of family medicine. Today, even though the majority of us are traditional FPs/GPs in the community, a good number are already serving in roles that span the continuum - from restructured hospitals to community hospitals to hospices and nursing homes. FP/GP who work in the community can expect to work with peers who work in other segments of the healthcare spectrum as part of a coordinated effort that promotes care continuity as patients navigate the RHS.

(continued on Page 8)

(from Page 7: Regional Health System: How Will It Impact Our Practice?)

MW: There will be many opportunities to build up the relationship with hospital colleagues, such as Continuing Medical Education (CME) sessions, the GP engagement office and joint outreach events. It is therefore beneficial to keep apprised of the happenings in your nearest regional acute hospital and other providers in the neighbourhood.

LFS: Occuring in tandem to this is the increasing opportunity for FP/ GPs to be involved in the training of the next generation of doctors. The medical cohort size will grow to 500 undergraduates annually within the next few years in our 3 medical schools: Yong Loo Lin, Duke and Lee Kong Chian. Family Medicine training at both undergraduate and postgraduate (residency) levels will need the help of as many of our colleagues in the community as possible, to be part of the trainer and tutor pool, working hand-in-hand with the those in the academic centres and teaching hospitals.

What should a FP/ GP do now/ start to do, to prepare for the full roll-out of RHS?

LKH: I think it is important for FPs not to be rattled by the many changes and to make sure that they continue to focus on the patient and allow the environment and system to self-organise over time. The pendulum may continue to swing from over-specialisation towards greater recognition of generalists. Remember that we are the natural experts in care integration. Make your practice the Medical Home of your patient.

TKL: GPs could proactively keep a look out for programs that are being rolled out relating to the RHS initiative and be involved.

MW: Build trust and relationships, focus on providing care to our community, and await firmer details on the policy changes that will likely be coming with regard to governance and funding – the nitty-gritties which are crucial for this to achieve its full potential.

SS: I think this is a good opportunity for all of us to drop many pre-conceived ideas and outdated assumptions, such as what a GP can or cannot do, how a hospital and a GP co-manage a patient, etc. Give the concept and especially the relationships, time and space to develop. And do feedback on what is the best way for FP/ GPs to work together with the RHS for our patients.

LFS: Yes, keep an open mind, and be actively engaged. Areas of engagement could be in clinical shared-care initiatives, professional training, family medicine teaching, or whatever that is of interest to you. ■CM

The Regional Health System

Each regional system would have an acute general hospital working in close partnership with community hospitals, nursing homes, home care and day rehab providers, as well as polyclinics and private GPs within the geographical region to provide seamless and holistic care for patients.

- Alexandra Health - managing Khoo Teck Puat Hospital in the north
- Jurong Health Services (JHS) - managing the upcoming Ng Teng Fong General Hospital and Jurong Community Hospital in the west
- National Healthcare Group (NHG) - Tan Tock Seng Hospital in the central region
- Eastern Health Alliance (EHA) - Changi General Hospital in the east
- National University Health System (NUHS) - National University Hospital
- Singapore Health Services (SHS) - Singapore General Hospital

Patient Questionnaires

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

A questionnaire can be a very useful tool to obtain basic information about a patient new to your clinic or during health screening. At registration, the patient is given the questionnaire by the receptionist, thus keeping the patient productively occupied while waiting to be seen. The availability of important information shaves off precious minutes from the consultation time and also makes the clinic workflow smoother and more professional.

The following examples can be customised to suit your clinic and patient profile.

PATIENT QUESTIONNAIRE – CHILD

NAME: Surname: _____ First name: _____

BC/ NRIC/ PASSPORT NO.: _____ **NATIONALITY:** _____ **RACE:** _____

ADDRESS: _____

_____ **POSTAL CODE:** _____ **TEL NO.:** _____

AGE: _____ **DATE OF BIRTH:** (dd/mm/yy) _____ **SCHOOL:** _____

DRUG ALLERGIES: No/ Yes: (Name and reaction) _____

_____

PAST MEDICAL HISTORY: Asthma/ Eczema/ Wheezing/ UTI/ Hospital admission/ Others: _____

_____

VACCINATIONS: Up to date: Yes/ No/ Unsure. *Please provide vaccination records.*

PAST SURGICAL HISTORY: Any operations? _____

BIRTH & DEVELOPMENTAL HISTORY: Birth Weight: _____ kg

Any developmental problems/ concerns? _____

_____

FAMILY HISTORY: Asthma/ Eczema/ Allergic Rhinitis/ Others: _____

_____

CURRENT MEDICATIONS (including vitamins): _____

MEDICAL CARE: On follow up with the following doctors: _____

MAIN CAREGIVER: _____

PATIENT QUESTIONNAIRE – ADULT

NAME: Surname: _____ First name: _____

NRIC/ PASSPORT NO.: _____ **NATIONALITY:** _____ **RACE:** _____

ADDRESS: _____

_____ **POSTAL CODE:** _____

TEL NO.: (H) _____ (O) _____ (HP) _____

LANGUAGE(S) SPOKEN: _____

AGE: _____ **DATE OF BIRTH:** (dd/mm/yy) _____ **INSURANCE:** _____

MARITAL STATUS: Single/ Married/ Divorced/ Widowed

OCCUPATION: _____ **Company:** _____

DRUG ALLERGIES: No/ Yes: (Name and reaction) _____

_____

MEDICAL HISTORY: Diabetes/ High blood pressure/ Heart disease/ Asthma/ Thyroid / High Cholesterol/Cancer/Stroke/ Others: _____

_____

SURGICAL HISTORY: Any operations? _____

CURRENT MEDICATIONS (including vitamins) **AND DOSAGE:** _____

_____

MEDICAL CARE: On follow up with the following doctors: _____

FOR WOMEN: Gynaecological History: No. of children: ____ Year of delivery: _____

Latest Pap smear: _____ Latest Mammogram: _____ Contraception used: _____

FAMILY HISTORY: *Diabetes/ High blood pressure/ Heart disease/ Asthma/ Thyroid / Cancer/Stroke/ Others:* _____

SMOKER: No/ Yes : _____ cig/ day _____ years

LATEST HEALTH SCREENING: _____

CM

Notification of GST Registration

College of Family Physicians Singapore

Dear Members,

Please note that the College of Family Physicians Singapore is GST registered with effect from 1 December 2011. Hence, all course fees and renewal of membership subscription fees will be subjected to 7% Goods and Services Tax.

Our GST Registration Number: M90367025C

Asia Pacific Primary Care Research Conference 2012

Date: 1 - 2 Dec 2012 (Sat - Sun)
National University of Singapore

PLENARY SPEAKERS

Setting Up Family Medicine Research Network
Prof Teng Cheong Lieng
International Medical University (IMU)

Health Services Research
Prof David Matchar
Duke-NUS Graduate Medical School Singapore

Medical Education Research
Dr Dujeepa D Samarasekera
National University of Singapore

WORKSHOPS

Medical Writing
Prof Teng Cheong Lieng
International Medical University (IMU)

Biostatistics
A/Prof Koh Choon Huat Gerald
National University of Singapore
National University Health System

Health Services Research
Prof David Matchar
Duke-NUS Graduate Medical School Singapore

Medical Education Research
Dr Dujeepa D Samarasekera
National University of Singapore

Research Championship
Adj Asst Prof (Dr) Tan Ngiap Chuan
Duke-NUS Graduate Medical School Singapore

REGISTRATION FEES

(All prices stated are inclusive of 7% GST)

Early bird registration (till 31 Aug 2012): S$320
Normal registration (till 30 Nov 2012): S$450
Walk-in registration (1 - 2 Dec 2012): S$600

For students only: S$230

All fees stated above are exclusive of hotel accomodation, gala dinner and transportation charges.

For enquiries, please contact
College Secretariat at 6223 0606
or email: enquiries_appcrc@cfps.org.sg

Family Practice Skills Course

Obesity: Prevention & Management

The College of Family Physicians Singapore would like to thank **Health Promotion Board (HPB)** and the Expert Panel for their contribution to the Family Practice Skills Course #47 on "Obesity: Prevention & Management", held on 14 - 15 January 2012.

Expert Panel:
Dr Jonathan Pang
A/Prof Loke Kah Yin
Dr Audrey Tan
Dr Tham Kwang Wei
Mr Robert Sloan
Ms Vivian Lim Feng Yu
Ms Samantha Bennett

Chairpersons:
Dr Marie Stella P Cruz
Dr Wong Tien Hua

Management Update on Functional Decline in Older Adults

The College of Family Physicians Singapore would like to thank **Health Promotion Board (HPB)** and the Expert Panel for their contribution to the Family Practice Skills Course #48 on "Management Update on Functional Decline in Older Adults", held on 25 - 26 February 2012.

Expert Panel:
Dr Wong Sweet Fun
Prof Kua Ee Heok
Dr Lawrence Tan
A/Prof Lynne Lim
Dr Au Eong Kah Guan
Dr Hilary Thean
Dr Wong Mun Loke

Chairpersons:
Dr Siew Chee Weng
Dr Tan Kok Leong

Revisiting Cough and Cold Medication: Challenges and Pitfalls

by Dr Soh Soon Beng, MCFP(S)

Cough and cold medication are one of the most commonly used medications in the primary care setting. In 2007 the FDA released a public health advisory banning the use of over-the-counter cough and cold medication (OTC CCM) in children less than 2 years old [1]. Following that UK, Canada and Australia also released similar restriction on the use of OTC CCM in children less than 2 years old [2, 3, 4].

In Singapore, Health Sciences Authority (HSA) released a Drug Advisory on the use of cough and cold medication in children in 2007 [5]. The interim advisory is summarised as follows:

Table 1: Interim recommendations on use of cough and cold medicines in various age groups of children

Category	Under 6 months	6 months to 2 years	2 years and above
Promethazine	Contraindicated	Not recommended	To be used with caution
Antihistamines *(Brompheniramine, chlorpheniramine, diphenhydramine)**	Not recommended	To be used only when benefits has been assessed to outweigh risks.	To be used with caution
Cough suppressants *(Codeine, dextromethorphan, diphenhydramine)**	Not recommended	To be used only when benefits has been assessed to outweigh risks.	To be used with caution
Cold and flu products *(Pseudoephedrine, ephedrine, guaifenesin, phenylephrine)**	Not recommended	To be used only when benefits has been assessed to outweigh risks.	To be used with caution

As can be seen from the above table, most of the commonly used CCM were affected. The effects of these advisory coming from a local regulatory body is significant as it must necessarily impact on the use of such medications in daily practice. Furthermore it affected almost all the CCM that doctors often used, unlike the case with promethazine in 2006 and phenylpropanolamine in 2001.

So what are the challenges and pitfalls that doctors faced today in the light of these advisories?

1. Is there any safe antihistamine or CCM for use in children less than 2 years old?

The paediatric dosages are traditionally extrapolated from adult doses. There is no trial showing actual and safe dosing in children for the commonly used CCM. For the newer generation antihistamines, Cetirizine appeared safe for children 12-24 months old [6]. Desloratadine was showed to be well tolerated in children 2 - 5 years old with minimal side effects [7].

Safety of these CCM was raised in the US due to a Citizen petition to the FDA which subsequently conducted a review of these OTC CCM which led to the advisory [1, 8]. Apparently most of those who presented to the ED with medications related problem, 66% were due to unsupervised ingestion (The US National Electronic Injury Surveillance System-Cooperative Adverse Drug Event Surveillance program). Schaefer et al reported that 2-5 years old were the most common age group involved [9]. However, they found that ED visit whereby CCM had been properly administered occurred less commonly with CCM than with other medications (26% vs 51%). Most errors were due to overdosing. In another study, Rimsza found that out of the 10 unexpected infant death in Arizona in 2006, only one can be attributed to OTC CCM [10]. However 10 out of 21 death in which autopsy toxicological test were done showed recent OTC CCM usage. The extent of such problem is compounded by the fact

that many parents in US self-medicated their children, often incorrectly. In the Slone Survey 10.1% of the children in US used a cough and cold medications in a week, highest in the 2 - 5 years group followed by the less than 2 years old group [11].

The ease of access to OTC CCM coupled with the apparent lack of efficacy led FDA to restrict the sale of OTC CCM. What then can one proceed from here? Perhaps the comment by the American Academy of Family Physician in response to the FDA enquiry puts the issue of safety in perspective: serious complications are rare when the medications are used properly [1].

2. In what situation is the "benefits outweigh the risks"?

According to the HSA interim advisory, CCM can be used in the young (6 months to 2 years old) provided that benefit-risk ratio is favourable. Regrettably no clinical scenario was suggested that might fulfill that criterion as a form of illustration. Would an infant not responding to 5 days of Iliadin nasal drops qualify or must we wait till the patient develop rhinosinusitis before prescribing CCM?

In the latter instance, would we not be liable for the perceived delay in treating with CCM in the first place? It would certainly be useful to have some form of consensus statement with input from the relevant expert in this respect.

3. What would be the medico-legal consequences if patient do develop adversely to the prescribed CCM?

At the present it would be difficult to justify oneself if this were to happen as the HSA had already issued guideline on this. It would therefore be up to the doctor involved to convince the Court that what he did was acceptable. Regrettably this is not the case here as most of the trials that were reviewed by FDA did not show unequivocal efficacy. On the hand if there is a consensus practice statement outlining their proper usage, given the local experience with these medications, then the doctor involved could rely on this to defend himself. As professionals, we are expected to stand up to scrutiny but at least provide us a basis to show that the treatment was following generally accepted peer-reviewed practice.

4. Familiarity with CCM used

Since most CCM contain multiple ingredients (antitussive, antihistamines and decongestant), it is therefore good practice for the prescribing doctors to be familiar with the CCM that they are using. For example, a child maybe prescribed Fedac syrup, Cough En syrup but both contains tripolidine as well as pseudoephedrine, resulting in overdosing. Another example would be Sedilix DM and Actifed syrup, both of which contain pseudoephedrine.

5. Review prescribed dosages

In connection to the earlier point, it would be prudent to review the usual dosages that we have been prescribing in view of the fact that all CCM contain similar component. So for example if a 5-year-old child was given Fedac and PhenexpectCD syrup, he would have received two types of antihistamines (tripolodine and diphenhydramine). What is the correct dosage in such a case

is not clear, but obviously we cannot give both syrups as 5mls each. Common sense practice dictate that this must not be so as both the antihistamines serve the same function. It is like we prescribed Diclofenac and Ponstan at the same time for pain relief, which is something we do not do. So why do it for cough and cold medications?

6. Actual dosages of individual component in CCM

Doctors should also be aware that the actual dosages of the individual component in CCM are not identical across the board. For example, Dhasedyl contains 9mg of codeine whereas PhenexpectCD contain 5.7mg. The syrup Chlormine contains 4mg per 5ml of chlorpheniramine so if doctors prescribed 5ml, he would be overdosing the child.

7. Measuring tool for proper dosing

The last point is that doctors should provide proper measuring cup or syringe for proper dosing. The common practice of estimation of dosing should be discarded as paediatric patients may be more susceptible to slight changes in the doses.

In conclusion this article served to highlight the potential problems associated with the use of cough and cold medications in the paediatric patients. One must be mindful that the FDA advisory was originally intended to restrict the sale of OTC CCM in United States; there was no actual recommendation to stop the use of these medications by doctors altogether. It did raise an important point however, that is the treatment must not be worse than the disease itself. It is also heartening to note that the local experience with cough and cold medications (except promethazine) has been good as most paediatric patients obtained their medications from doctors. It would certainly be our fault if adverse drug reactions were to occur as a result of our ignorance and complacency when using these useful medications. Until then we can only hold our collective breath as the FDA reviewed the data for the 2 - 6 years old.

References

1. Food and Drug Administration: Using Over the counter medication in Children. www.fda.gov/ForConsumers/ConsumerUpdates/ucm048515.htm.
2. Health Canada website at www.hc-sc-ca/ahc-asc/media/advisories-avis/_2008_184info 1-eng.php.
3. MHRA press release: OTC cough and cold medication in children. in UK.
4. Australia Therapeutic Goods Administration: Restriction on the use of OTC cough and cold medication in children. 11/4/2008.
5. HSA Drug Safety Information No 19, 30/10/2010.
6. Prospective, long-term safety evaluation of the H1-receptor antagonist cetirizine in very young children with atopic dermatitis, Journal of Allergy Clin Immunol 1999;104;433-40.
7. The ARIA/EAACI criteria for antihistamines: an assessment of efficacy,safety and pharmacology of desloratadine, Allergy 2004:99 (Suppl 77); 4-16.
8. Use of over the counter cough and cold medications in children, Allan E Shefrin, Ron D. Goldman, Canadian family Physician, Vol 55; Nov 2009, 1081-83.
9. Adverse Events from Cough and Cold medications in Children, Melissa K. Schaefer, Nadine Shehab, Adam L. Cohen, Daniel S. Budnitz, Paediatric,2008; 121;783 http://pediatrics.aappublications.org/content/121/4/7.full.html
10. Unexpected infant deaths associated with the use of cough and cold medications, Mary E. Rimsza, Susan Newberry, Paediatric,2008; 122;e318, http://pediatrics.aappublications.org/content/122/2/e318.full.html.
11. Cough and cold medications use by US children,1999-2006: Results from the Slone Survey, Louis Vernacchio, Judith P. Kelly, David W. Kaufman, Allen A. Mitchell, Paediatrics 2008; e323, http://pediatrics.aappublications.org/content/122/2/e323.full.html

CM

The paediatric dosages are traditionally extrapolated from adult doses. There is no trial showing actual and safe dosing in children for the commonly used cough and cold medicines.

Invitation to Feedback Session on Review of College Constitution

Dear Members,

The CFPS 40th Annual General Meeting held on 25 June 2011 directed that the College Constitution be looked into with a view to review it if deemed necessary.

You are invited to share your views at the Feedback Session on:

Date: 20 April 2012 (Friday)
Time: 5.00pm
Venue: Lecture Room,
College of Family Physicians Singapore
16 College Road #01-02,
College of Medicine building,
Singapore 169854

To RSVP, please email by 16 April (Monday) to:
contact@cfps.org.sg

Thank you.

Yours sincerely,
A/Prof Cheong Pak Yean
Chairman
College Constitution Review Committee

Impact of Electronic Medical Records on the Clinical Practice of Medicine

by Dr Paul Barach, MD, MPH, President, J Bara Innovation; Professor, University of Stavanger, Norway;
Associate Professor University of South Florida. Tamp, Florida &
Dr Loke Wai Chiong, FCFP(S), MBA, Editorial Board Member

"... The value of history lies in the fact that we learn by it from the mistakes of others, as opposed to learning from our own which is a slow process"

W. Stanley Sykes (1894-1961)

Introduction

Recent attention to the question of value in health care - the ratio of outcomes to long-term costs - has focused on problems of definition and measurement: what outcomes and which costs? Less attention has been given to an equally difficult but important issue: how do health care delivery organisations reliably deliver higher value and what is the role of electronic medical records (EMR) in delivering value and patient safety? As Singapore progresses with the hard work of reforming the health care delivery system, the widespread adoption of health information technology (health IT) is a national strategy and priority.

What exactly is an EMR?

EMRs have been characterised in several ways both in peer reviewed and trade literature. These characterisations differ in terms of functionalities emphasised and the extent of systems integration across inpatient and ambulatory care providers. A *comprehensive EMR**, as defined by the US IOM Committee on Data Standards for Patient Safety includes [1] (1) longitudinal collection of electronic health information; (2) immediate electronic access to person and population-level information by authorised, and only authorised, users; (3) provision of knowledge and decision-support that enhance quality, safety and efficiency of patient care; and (4) support of efficient processes for health care delivery.

It would certainly simplify health care reform if we could show the superiority of one type of dominant EMR delivery model and roll it out nationwide, developing and proving new approaches to creating value only once. However, experience suggests that not only do new EMR delivery models and systems - for example, integrated EMR networks - not necessarily live up to their promise, but they are surprisingly difficult to transfer, even when successful; those that succeed in one region haven't always done well in another. Organisations that succeed in implementing EMR successfully often have unique personalities, structures, resources, and local environments. Given the health care sector's mixed record of disseminating clinical innovations and system improvements, how do we learn from leading organisations? [2]

The policy discussion on National Electronic Health Records to be rolled out across Singapore by 2015 is attracting the attention of health leaders around the world. The plan for every doctor to have digitisation of their records and electronic practice by then including all GPs, who are now predominantly practicing pen-paper documentation, is daunting. Already, early implementation of full EMR and Computerised Physician Order Entry (CPOE, example e-prescription) in Singapore hospitals is causing the reaction of it "taking time away from doctoring/ patient interaction", etc. Anecdotally, doctors complain of spending less time interacting with patients, while patients complain of decrease in physician eye contact, increased interruptions and decreased satisfaction, etc. It is similar in the ambulatory and GP setting. [3]

Patient Safety and Electronic Medical Records

It has long been recognised that medical care itself has the potential to cause harm. Simply being in an acute hospital in Europe carries, on average, a 200-fold greater risk of dying from the care process than being in traffic, and a 2000-fold greater risk than working in a chemical industry, or flying on a plane. [4] Recent

* Footnote:
Here, "*comprehensive EMR*" is used to describe a combination of National Electronic Health Record (NEHR) and Electronic Medical Record (EMR). Whereas NEHR is a subset of of health information about an individual shared across his various care providers, EMR is more narrowly the computerisation of everything about a given patient within a facility (eg clinic or hospital).

health policy reports in US, Europe and Australia estimate that approximately 50,000 people die in hospitals each year as a result of medical errors (Landrigan 2010). Nonfatal "adverse events" and near misses are ten- to hundredfold more numerous than deaths due to errors [5]; and total national costs for adverse events (lost income, lost household production, disability, health care costs) are between $38 and $50 billion annually. [6]

There is substantial evidence that the majority of health care errors are preventable, and are the result of systemic problems rather than poor performance by individual providers. [7] In spite of (and maybe as an unintended consequence of) all the extraordinary advances in medical science and technology, getting sick (or injured) is a safety issue. Complex systems fail for many inter-related reasons. Technology and EMR offer paths to safer hospitals but right information technology and sharing is just a tool.

EMR Implementation Lessons: Cross-Cutting Findings From Around the World

Emergent themes from several studies that have evaluated the implementation of EMR systems can be categorised as (1) Systems Selection and Design; (2) Implementation Planning and Training; (3) Executing a Smooth Implementation; and, (4) Considerations for Supporting Use. [8] We shall cover the first two in greater detail, with the sub-themes delineated within those categories.

A. Systems Selection and Design

i. "Technology is not the answer - it is the tool".
Physicians generally feel that while technology itself does not result in better quality of care, it is a useful tool that, when used correctly, allows physicians to make quicker decisions based on a greater quantity of more accurate information.

ii. Belief that CPOE has greatest impact on patient safety.
Physicians across the board express their belief that electronic provider order entry most benefits their quality of care by improving the legibility of their orders and by providing checks on accuracy.

iii. A single, web-based interface that requires the least number of "clicks" is most user-friendly.
Users save time and avoid confusion by being able to access all the necessary systems through a single interface at the point of care.

Having both a long term IT strategy and vision regarding EMR purchase and implementation that is well disseminated promotes system-wide buy-in should be the first priority.

iv. Careful system design is critical to avoid potentially harmful "workarounds".
In cases where users found the system overly burdensome, difficult to customise, or lacking necessary restrictions, often they worked around the system to speed up their process, while sacrificing accurate documentation and leaving open the potential for error. Those tasked with design and implementation must observe doctor-computer interactions to eliminate features and practices that could result in harm to the patient and inaccurate documentation.

v. Clinician involvement in system selection and design is critical.
Steering committees, which pair computer savvy clinicians with IT staff along with other parties, are often effectively employed as sounding boards where end-users can voice to the IT staff how they need the systems to change in order to work most effectively in the clinical environment. Investing in this usability in all stages of the EMR development and implementation is essential for building trust and enabling clinician buy-in.

B. Implementation Planning and Training

i. Concrete "vision" of IT implementation encourages buy-in.
Having both a long term IT strategy and vision regarding EMR purchase and implementation that is well disseminated promotes system-wide buy-in should be the first priority.

ii. Planning for system integration produces efficiencies.
Hospitals that prioritised system integration ended up with a product that was easy to use and encountered fewer barriers post-implementation.

iii. Adequate training necessary for buy-in and appropriate use.
Successful implementation leaders make it clear that institutionalised training both before, during, and after system implementation is important for many reasons: it makes the technology seem more manageable, users are exposed to all the functionalities of the system that they can take advantage of, and relationships with IT staff or knowledgeable colleagues can be fostered.

iv. Employing "super users" increases buy-in and works as an effective training tool.
Successful projects commonly trained a group of super users, or technologically savvy end-users, so that they could train their colleagues and demonstrate the capabilities of the system.

C. Executing a Smooth Implementation means *implementing in manageable phases, continuous communication between IT and clinician staff, and having centralised IT decision-making*.

D. Finally, in Considerations for Supporting Use, beyond responsive technical support, we must take into account *ergonomic considerations and recognise those that maximise system benefits*. Several studies have discussed the importance of correctly spacing the computer screen in relation to the patient. In order to maintain eye contact with the patient, it is important to have the screen situated at a point in the room where that line of sight is possible or to have the computer mobile to be able to involve the patient in the use of the system.

"MBA medicine should not drive MD medicine". With this statement, a physician in our study made clear the limitations of technology and its potential to detract from patient care if used incorrectly or for the wrong purposes. [9] Many physicians emphasised that a balance must be drawn between closely observing the patient and entering the necessary data in the computer. Respondents suggested that system designers and leadership should keep that balance in mind when drafting regulations for the use of the system. Using the computer solely to enter data for billing or legal purposes can detract from the visual monitoring of the patient that is necessary for high quality care.

What do Patients think about EMR?

For the promise of health IT to be realised, consumers must both trust and value it. In any discussion of quality, patients define quality differently than do "experts." Consumers do not always think of quality in terms of clinical aspects – e.g., whether care meets evidence-based guidelines. Many consumers perceive quality in terms of service quality (i.e., timeliness of appointment, friendliness of providers); people are more comfortable with, and can talk more easily about, ideas of service quality than clinical quality. Online access to an EHR can affect several service dimensions if used in certain ways – e.g., filling out forms ahead of time shortens wait time, and secure messaging between provider and patient enhances ease and speed of communication. While patients may not now intuitively connect the role their record system can play in their experience or clinical quality of care, showing them how certain features of an EHR can improve both could change their perception. [10]

Fulfilling the Promise of Healthcare IT in Singapore

While there are considerable barriers to technology adoption in healthcare, in several communities where information systems have flourished, their systems have become safer as a result. Engagement and trust of healthcare providers is essential if healthcare is to receive a continuous flow of information about possible hazards or unsafe conditions, and provides information to support good clinical care.

Large-scale countrywide implementation in Singapore may be challenging, but there is significant opportunity to fund pilot tests and create "centres of innovation and evaluation" and lead in the national movement to computerise healthcare delivery and improve patient safety. Encouraging and funding these small concrete "tests of change" will bring about rapid adoption of large-scale improvement system changes if they prove successful.

Singapore has the opportunity to lead the world in making it the first country-state to have full EMR for all health care encounters. Although building the information technology infrastructure is critical to both error prevention and error reporting, the elegance of implementing EMR system across Singapore is its ability to provide innovation, safety, quality and value for all Singaporeans.

References

1. Aspden, Philip. II. Institute of Medicine (U.S.). Committee on Data Standards for Patient Safety. Patient Safety: Achieving a New Standard for Care (2004), ISBN 0-309-09077-6.
2. Barach P, Berwick DM. Patient safety and the reliability of health care systems. Annals of Internal Medicine 2003;138 (12): 997-998.
3. Ilie V, Courtney J, Van Slyke C. Paper versus Electronic: Challenges Associated with Physicians' Usage of Electronic Medical Records. Proceedings of the 40th Hawaii International Conference on System Sciences – 2007.
4. Leape LL, Brennan TA, Laird N, et al. The nature of adverse events in hospitalized patients. Results of the Harvard Medical Practice Study II. NEJM. 1991;324(6):377-384.
5. Barach, P., Small DS. Reporting and preventing medical mishaps: Lessons from non-medical near miss reporting systems. British Medical Journal 2000; 320:753-763.
6. Orszag, P., and Emanuel, E. Health Care Reform and Cost Control. N Engl J Med 2010; 363;7: 601-603.
7. Reason J: Human error: models and management. BMJ 2000, 320:768-70.
8. Rodríguez, B., Moiduddin, A., Ketchel, A., Mohr, J., Williams, J., Benz, J., Gaylin, D., Fitzpatrick, M., Barach, P. EHR Final Report on Case Studies and State-Wide IT Survey Analysis. Report submitted to the Florida Agency for Health Care Administration (AHCA). June 29, 2004.
9. Barach P. The End of the Beginning. Journal of Legal Medicine 2003; 24 (1), 7-27.
10. Communicating about Quality: Communications Research Conducted by the RWJF. Robert Wood Johnson Foundation. November 2007. Page 6.

CM

Project Lokun

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

Project Lokun is an ongoing effort by our very own medical students [from the Yong Loo Lin School of Medicine (YLLSoM) at National University of Singapore] to provide medical and humanitarian aid to some less fortunate people in the region. Jerome Ong (**JO**), a 2nd year medical student who was the project leader for 2011 speaks with The College Mirror. We hope to increase awareness of this commendable initiative amongst the medical fraternity in Singapore. The group can always do with a helping hand, be it in person, via financial aid or by other means.

CM: Could you tell us about Project Lokun? How did it begin?

JO: Project Lokun was started in 2007 by a group of students (now MOs), being one of the pioneering projects from YLLSoM to help Cambodians. The other project whose history is linked to ours is Project Sabai. It was apparently a request for medical aid from this Catholic priest called Father Hernan, who has set-up a decade-old organisation called Centre for Research on Optimal Agricultural Practices (CROAP). CROAP, and hence Project Lokun, is based in Pursat, Cambodia, a relatively small town in south-western Cambodia and we have been serving the villages around CROAP ever since we started. Project Lokun was named simply for its translation as "Doctor" in Hokkien.

CM: What are the aims?

JO: I would say the primary and most well-preserved aim of Project Lokun is to maintain/improve the healthcare standards of the villages around the rural part of Pursat town, which comprises mainly of farmers. We provide free healthcare services when we are on our missions (which is actually biannually for 10 days each time) but have since started a programme of hiring a local doctor to follow up and monitor patients with chronic health problems in our few months of absence.

Photo courtesy of Jerome Ong.

The secondary, yet very important aim of our project is to educate the villagers about basic hygiene and healthcare-related lifestyle practices (anti-smoking, anti-hypertensive diet, dental health). We approach this aspect of our project in two ways: house-to-house education as well as school education.

Of course, envisioning ourselves in the future and thinking for the project in the long run, we have a team of people dedicated to helping the project find out more about the community and environment we serve, as well as to make viable connections with partners whom we can work with. These include finding more about the Cambodian healthcare system, the private healthcare system (mainly run by NGOs) as well as the non-medically related NGOs that perhaps could sponsor us in a way or another. This committee has been said to be the driving force, the engine of the project, their findings about the Pursat community often steers the direction of the project in one way or another.

CM: Who runs the programme, and co-ordinates the activities?

JO: The project has been handed down by its pioneers into the jurisdiction of mainly year 2 students who lead the project comprising mainly an equal proportion of M1s and M2s.
The key stakeholders in this project are:
- Medical students who form the organising committee
- A team of (hired) translators and drivers who provide the language and transport ability for us to conduct our screenings, clinics and education.
- A team of 6-8 doctors (usually MO/HO level) who provide the expertise for clinics
- The team at CROAP who provide food and lodging throughout our length of stay at their farm

CM: What are the achievements so far?

JO: In the period of time we are in Cambodia, we manage to see over 700 patients in a course of 3-4 days spread out over 3-4 villages. For educational purposes, we reach out to about 200 households in the 3-4 days we spend on education. As such, there has been sort of a template to our project with an equal emphasis on continual education and provision on primary healthcare.

While we are buried in our books during the semester, there is a hired local doctor who is contracted to hold weekly clinics at CROAP to provide an avenue of acute medical attention for the villages, as well as to monitor patients with a chronic disease profile (HTN, DM).

A computer crash and lack of proper backing-up two years ago, has led to us losing valuable digitalised patient information/ records. We are currently building up the database from scratch.

CM: Is it limited to Cambodia, and are there any plans to expand it further?

JO: Yes the project is limited to Cambodia, specifically CROAP and the villages it serves but we are open to expansion into other needy communites as well.

Delving into the expansion plans of the project is like opening the Pandora's box, but I shall summarise and list a few possible expansion plans and their considerations.

Expansion plans:
- Expand and digitalise the database: aim is to have a proper system to keep track of all our patients.
[Problem(s): lack the technical ability or outsourcing capacity or funds to acquire a program that suits us]
- Have a more sustainable project by involving local medical students: aim is to instil a sense of community spirit in the Cambodians and also to support us constantly throughout the year - this might sound like a lofty aim but I would say that it is something that we have been working on very passionately about because we believe that is the only way to ensure long term continuity.
[Problem(s): logistically difficult and ideologically distant]
- Specialised teams of doctors to correct pathologies with relatively significant morbidity, we are looking at corrective surgery for cataract, cleft lips and palates: aim is to bring corrective surgical teams to help people on a more practical manner in a short period of time, because we thought that primary care for a short 10 days out of a year has minimal impact.
[Problem(s): there are no venues, no OT, no proper evaluation of what form of corrective surgery or specialist care is needed]

CM: What kind of assistance would be useful - financial, pharmaceuticals, personal accompaniment or support? What can the medical community in Singapore do to help?

JO: In fact, any form of donations, preferably in cash, also in specific kind would be useful for the team. But ultimately it really depends on the logistical requirements of each team that returns (and therefore monetary donations are the most flexible and useful).

Just a brief description of our needs:
- Financial - each trip needs a minimum of $9000 to happen
- Pharmaceuticals - all basic drugs, heart drugs, GI drugs etc. (we have a list)

Photo courtesy of Jerome Ong.

- Personal accompaniment/doctors - any doctor who is willing to help will surely not be rejected, but if we were gearing future trips towards specialist treatment, we definitely would publicise to the relevant departments.
- Support - in fact what I personally think is lacking in our project, is a dedicated "leader" (who can be a doctor) who will and can spend 5 years or so spearheading the project.

CM: Is Project Lokun linked with any religious group, and does it preclude those from other faiths?

JO: Technically, we are "linked" to the Catholic church system of Cambodia, through Father Hernan, the founder of CROAP. But as groups/NGOs going to Cambodia might already know, the Catholic system is widespread and is providing a robust healthcare system alongside the public one. Hence many medical missions to Cambodia are in someway or another linked to the Catholic Church.

With that being said, it does not preclude those from other faiths. All are welcome to lend a helping hand! I would also like to express my gratitude to a few people in particular who have helped me and the project succeed:
My co-leader Manraj Singh (Year 2 medical student),
Dr Hanley Ho for his commitment to the project,
Drs John and Priscilla Lee for their invaluable guidance and immense help,
All Project Lokuners and participating doctors past and present for their contributions.

Contact details for any help/ queries:
nusprojectlokun@gmail.com

The current leader is an M3 student, Tan Yuguang who will lead the 11th project in May 2012.

CM: Thank you, Jerome, for updating us on Project Lokun. We hope that this may serve to increase the support available for your project.

CM

Electronic Medical Records

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

Any clinic which has a decade or more worth of medical records will have to, sooner or later, contend with the problem of storage space.

The recurring challenge is how to store away inactive records for the stipulated legal duration to liberate space for those still in use.

One doctor who has prevailed over this problem is Dr David Cheong Cher Chee (**DC**), a Family Physician practising in Sengkang. Dr Cheong is a pioneer among GPs to make a complete switchover to electronic record keeping.

It was thus a pleasure to interview him and to learn more about this technology.

Photo courtesy of Dr David Cheong Cher Chee.

CM: What made you decide to go electronic in the first place and how long have you been at it?

DC: First of all, allow me to explain some of the acronyms which I will use in my replies.

CMS or Clinic Management System is a computer programme that allows a clinic to register patients, store their data such as name, IC number address, telephone number, company or contract details and drug allergy. It keeps a record of patient visits and drugs dispensed and medical certificates issued. It also keeps a drug inventory and prints labels. Lastly, it can generate invoices for billing companies which the clinic has contracts with and keeps records of financial transactions such as purchase of drugs and the clinic income. The doctor using a CMS still has to write his clinical notes the traditional way, pen to paper.

EMR or Electronic Medical Record is a computer programme that not only encompasses the full range of functions of a CMS but also able to keep clinical notes, investigation results and correspondences in a true paperless format.

NEHR or National Electronic Health Record is a government initiative to move Singapore into a "one patient one record" system. It is currently being progressively deployed nationally and is live in a variety of public & private healthcare institutions. The rollout will complete by July 2012. The NEHR currently would allow a doctor who is seeing a patient to access certain medical information such as diagnoses, drug allergies, drugs dispensed, laboratory and radiology investigations and discharge summary. Currently, only data from the hospitals and polyclinics will be available and data from other private clinics will not be available as part of the initial phase. Most doctors access the NEHR via their hospital EMR. However, for those which do not have an EMR, a secure portal is available for use.

I have been using a CMS/EMR system since 2006. I felt that we would all need to use EMRs one day and technology could be used to enhance one's practice not only in improving clinical care but also to streamline clinic processes.

EMRs have been in use in other countries such as Australia for many years. However, most of them required the doctor to type in his clinical notes and use a mouse to enter data. In countries where doctors have the luxury of 15 - 30mins consultations, that is not a problem, but the crucial difference in Singapore is the speed at which consultations are done, sometimes within just 5 mins. Such type written and mouse-based systems were too slow to be practical in Singapore's context. With technology comes the tablet PC which allows a hybrid mix of handwritten clinical notes and fast data entry with the tablet pen and keyboard. I could now handwrite clinical notes, yet tap the screen and enter clinical diagnosis and prescriptions as fast as I could on pen and paper. I could then generate an MC faster than I could write it and generate an invoice and print it out. I could pull out a patient's or his relative's medical record with just a click. There were no more 'lost' patient cards and I could junk my filing cabinets to free up valuable clinic floor space. I backup my entire clinic's patient and clinic data into my thumb drive which I bring home every day. There were no more medication errors like when the clinic assistant couldn't read my handwriting (but that also meant the medication errors were my entire fault!)

Essential patient parameters and laboratory data were keyed into the system by my nurse (in the near future we should see this automatically uploaded from the laboratory). I could plot out children's growth charts or a hypertensive patient's blood pressure trend over the last 5 years. X-ray reports and correspondences could be retrieved with a click.

I could make appointments and auto-send SMS reminders to the patient to return to the clinic for a follow-up visit.

My EMR is linked to my patient queue system where I could call the patient from my room.

To me, this was the crux of why I use an EMR, that it helped me perform my day-to-day tasks.

With MOH spearheading the EMR initiative, there will be potentially even more advantages with automated laboratory ordering, electronic X-ray films and reports, automated notifications for infectious diseases and immunisations, easy CDMP, CHAS claims and submission of clinical data to streamline clinic functions. I foresee in the future that even managed care submissions may one day be automated.

Clinical care will improve with built-in care plans for chronic diseases, drug interaction checks. EMRs will be integrated with the NEHR to allow seamless access to patient information from other healthcare facilities.

There are disadvantages but I feel that the advantages and future potential far outweigh these. As with any change, there will be a learning curve of about a month. Computers are prone to fail but these can be circumvented by proper backup systems and good technical assistance. There are costs for the hardware and software but worked out over 3-year depreciation, these are minimal.

CM: How does one get started in terms of software and hardware? Must the system be approved by the licensing body?

DC: For hardware, 2 to 3 PCs running Windows with a local network would suffice. A tablet PC or monitor is advised but optional (one could still use an EMR/CMS with just keyboard and mouse). Internet connection may in some cases be necessary. The total cost for this would be around $5000 - 8000. It would be advisable to upgrade computers every 3 years or so to ensure that the hardware is not prone to fail. A good IT vendor to supply and set up the computers and to provide hardware maintenance will save a lot of headaches.

> … use a system which supports handwriting. Few or any of us can type without looking at the keyboard. All of us can write while looking at a patient.

There are many EMR solutions in the market. The more commonly used ones in Singapore are Clinic Assist, Crimson Logic, Gloco and Medi2000. There is other software which just has CMS functions but may not have EMR capability.

Most of the vendors will provide free demonstrations and also training for the doctor and nurses in the use of the software. One would have to try out the different software to find which software best suits his/her way of doing things. It may be helpful to visit a fellow doctor who has the system installed to see the software perform in a 'live' setting.

CM: A common complaint from a patient after a visit to polyclinic is "the doctor was looking only at his two monitors the whole consultation". How do you overcome this problem?

DC: This is why I use a system which supports handwriting. Few or any of us can type without looking at the keyboard. All of us can write while looking at a patient. I can also write far faster than I can type.

In fact, a lot of medical information – such as physical parameters e.g. blood pressure, temperature or laboratory data can all be entered by the nurses before the consultation. A quick glance at the screen would give you that information. I find myself spending more time looking at the patients rather than at my screen. The notion above is a myth.

CM: What about the medico-legal aspect of EMR?

DC: The medico-legal aspects of an EMR are no different from paper records. In fact, it will be easier to keep your records even indefinitely. It is incorrect to amend a previous written or electronic medical record without annotating it. It would be wise to use a system where the records are locked after 24 hours and one can only annotate an amendment to a previous record which will include information on the person, date and time when the amendment was made. That way, there can be no question on the integrity of the medical record. Any system whereby its EMR can be amended without proper audit trail should never be used at all. As in all electronic systems, a doctor must safeguard his password to prevent unauthorised entries under his name. The usual computer anti-virus and firewalls are necessary and should be updated regularly.

CM: I understand the long term objective of EMR is the interoperability towards sharing of medical records, the 'one patient one record' concept. Are you sharing your medical records with other healthcare providers and vice versa? And where does the GP feature in the scheme of things?

DC: Currently I am not sharing records with any other healthcare provider. However, I personally feel the way forward to improve clinical care for the patient is to share information. Private GPs may not be keen to share any information for fear that our practice may be scrutinised or our financial records made known. However, I don't think the purpose of sharing records is to find out which doctor hasn't been following clinical practice guidelines.

We private GPs see 80% of primary care patients. We hold the bulk of the medical information of Singapore's population in our hands. Wouldn't you like to know what the white tablet or black cough mixture prescribed by a fellow GP was? Wouldn't you save a lot of time and breath if that information was a click away? If we were just to share the patient bio data, drug allergy, clinical diagnosis, drugs prescribed, investigation results, I'm sure many of my fellow colleagues would be fine with that.

To get private GPs on board, we need an EMR that is quick to use, helps automate tasks like notifications and submissions. It would help if MOH provided more information as to the scope and aims of the NEHR to allay fears of sharing information. I hope the government will consider subsidising the cost of setting up an EMR system in clinics. This will remove one of the biggest hurdles facing the adoption of EMRs by private GPs.

On our part, private GPs must learn to accept and embrace change that is ultimately for the patient's good, which is our common goal.

CM: Thank you, Dr Cheong. CM

Career Seminar in Family Medicine

Date & Time: 4 April 2012 (Wed), 6.00pm
Venue: Lecture Room, College of Family Physicians Singapore
To RSVP, please email by 2 April 2012 (Mon) to: **gdfm@cfps.org.sg**
For more details, please visit **www.cfps.org.sg**

Graduate Diploma in Family Medicine

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, adolescent, adult and elderly. The courses emphasise on basic clinical diagnostic and management skills essential to general practice.

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:

- 8 Modules of Family Medicine Modular Course (FMMC) - each comprising of 4 workshops, 1 tutorial, online case studies and multiple choice assessments
- 3 Practice Management Courses
- 1 Elective Family Practice Skills Course
- 1 GDFM Clinical Revision Course

Eligibility

You are eligible to enrol 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 2012.

Fees

Course fees *(inclusive of Registration fees)*

- College member: S$4,583.88*
- Non-College member: S$5,046.12*

** Prices stated are inclusive of 7% GST*

Fees do not include the elective Family Practice Skills Course, BCLS and examination.

Registration

Registration is open until 18 May 2012.
For more details, please contact College Secretariat at 6223 0606 or email: **gdfm@cfps.org.sg**

Master of Medicine (Family Medicine) Programme B

A structured training programme for family physicians in Singapore, this is jointly organised by the College of Family Physicians Singapore and DGMS, NUS.

Eligibility

The intending course participant must have:

- Work experience – Has practiced at least 5 years in primary care (Practicing part-time or as locum tenens are not considered)
- Training – Satisfactory completion of 8 modules of FMMC
- Practice audit (Visit) – Fulfils audit requirements for Family Medicine training
- Ability to work at least 28 hours a week during programme year – To fulfil the 1 year work experience whilst under training
- Registration with SMC – Full or conditional

Fees

College member: S$6,206* Non-college member: S$6,634*
(Inclusive of 7% GST & S$107 non-refundable registration fee)*
Programme fee does not include fees for Advanced FM course, BCLS and examination.

Registration

Registration is open till 11 May 2012.
For more details, please contact College Secretariat at 6223 0606 or email: **programmes@cfps.org.sg**

Family Medicine Fellowship Programme

A 2-year programme that is the pinnacle of training for Family Physicians in Singapore, the objective of this programme is to provide further advanced training in family medicine.

Entry Requirements

To be eligible for the programme, one must have the following:

- MMed(FM)/ MCGP (Singapore)/ equivalent qualifications (approved by the Censors' Board on a case-by-case basis); OR
- MMed (Int Med) / MRCP (UK) / equivalent internal medicine training, and
  - Graduate Diploma of Family Medicine (GDFM), and
  - At least 6 months experience working in a family medicine practice setting of which at least 3 months must be in primary care.

Fees

Course fees: S$3,745.00
(Inclusive of 7% GST & S$160.50 non-refundable registration fee)
Programme fee does not include short skills courses, summative assessment, entrance and initiation fees.
Summative assessment fee of S$1284* per trainee applies.
On completion of the training programme and Summative assessment, the Fellowship trainee is required to pay the prevailing FCFP(S) entrance fee (S$1070*) and initiation fee (S$535*).
** Fees indicated are inclusive of 7% GST*

Registration

Registration is open till 18 May 2012.
For more details, please contact College Secretariat at 6223 0606 or email: **programmes@cfps.org.sg**

Family Practice Skills Course #49

Update on Function & Disability in Primary Care

Sat - Sun, 26 - 27 May 2012
2.00pm - 5.45pm
Shaw Foundation Alumni House, Auditorium (Level 2)
11 Kent Ridge Drive, Singapore 119244

TOPICS
Unit 1: Diseases that Result in Disability in Infants and Children
Unit 2: Rehabilitation and Coping with Disabilities in Infants and Children
Unit 3: Assessment of Activities of Daily Living in Infants and Children with Developmental Disabilities
Unit 4: Diseases that Result in Disability in Adults
Unit 5: Rehabilitation and Coping with Disabilities in Adults
Unit 6: Assessment of the Six Activities of Daily Living in Adults

WORKSHOPS
Day1: Case Studies/ Demo – Infants and Children
Practice and Review
Day 2: Case Studies/ Demo – Adults
Course Assessment for Accreditation

SPEAKERS
Dr Chong Shang Chee
Dr Sylvia Choo
Dr Chan Kin Ming
Dr Peter Lim
Dr Ng Yee Sien

All information is correct at time of printing and may be subject to changes.

☐ **SEMINARS** (2 Core FM CME points per seminar)
Seminar 1 • Unit 1 - 3: Sat, 26 May 2012 (2.00pm - 4.15pm)
Seminar 2 • Unit 4 - 6: Sun, 27 May 2012 (2.00pm - 4.15pm)

☐ **WORKSHOPS** (1 Core FM CME point per workshop)
Day 1: Sat, 26 May 2012 (4.30pm - 5.45pm)
Day 2: Sun, 27 May 2012 (4.30pm - 5.45pm)

*Registration is on first-come-first-served basis.
Seats are limited.
Please register by 21 May 2012 to avoid disappointment.

☐ **ASSESSMENT FOR ACCREDITATION**
Day 2: Sun, 27 May 2012 (after Workshop)
In order to be accredited, doctors must attend all seminars & workshops on both days, attain a minimum pass grade of 60% in Distance Learning MCQ Assessment AND attain a pass in the Course Accreditation held on Sun, 27 May 2012.

☐ **DISTANCE LEARNING MODULE**
(6 Core FM CME points upon attaining a minimum pass grade of 60% in 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 jointly organised and supported by the **College of Family Physicians Singapore** and **Centre for Enabled Living (CEL)**

Centre for Enabled Living

REGISTRATION

FREE REGISTRATION for College Members!

Update on
Function & Disability in Primary Care
Please tick (✓) the appropriate boxes

	College Member	Non Member
Seminar 1 (Sat)	☐ FREE	☐ $21.40
Seminar 2 (Sun)	☐ FREE	☐ $21.40
Workshops (Sat-Sun)	☐ FREE	☐ $42.80
Distance Learning (Journal)	FREE	☐ $42.80
Assessment Fee for Accreditation	☐ $32.10	☐ $32.10
TOTAL		

All prices stated are inclusive of 7% GST. GST Registration Number: M90367025C

☐ I attach 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: ○ 2010 Intake ○ 2011 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. Kindly check your inbox before attending the course. Thank you.

Please mail the completed form and cheque payment to:
College of Family Physicians Singapore
16 College Road #01-02, College of Medicine Building, Singapore 169854

Or fax your registration form to: 6222 0204