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The Singapore delegation with Professor Michael Kidd, President WONCA
Image courtesy of A/Prof Lee Kheng Hock

CONNECTING WITH FAMILY PHYSICIANS AROUND THE WORLD

by Dr Lim Fong Seng, Honorary Treasurer, 24th Council, College of Family Physicians Singapore

The College of Family Physicians Singapore was represented by A/Prof Lee Kheng Hock, Adj A/Prof Tan Boon Yeow and Dr Lim Fong Seng at the World Organization of Family Doctors (WONCA) World Council Meeting at Prague from 22nd-24th June 2013.

The World Organization of Family Doctors (WONCA) is a global not-for-profit professional organization representing family physicians and general practitioners from all regions of the world. WONCA has 126 member organizations in 102 countries with a membership of about 300,000 family doctors.

The college has a proud tradition of having a visible and tangible presence in the WONCA platform for many years. Dr Alfred Loh served as the CEO of WONCA for many years while A/Prof Goh Lee Gan was the Chairman of the WONCA Asia-Pacific Regional Council. Both of them contributed significantly to putting Singapore on the world map of Family Physicians. Many delegates we met spoke fondly of A/Prof Goh Lee Gan and Dr Alfred Loh.

Among the highlights of the World Council Meeting was an interesting presentation on the various ways that the World

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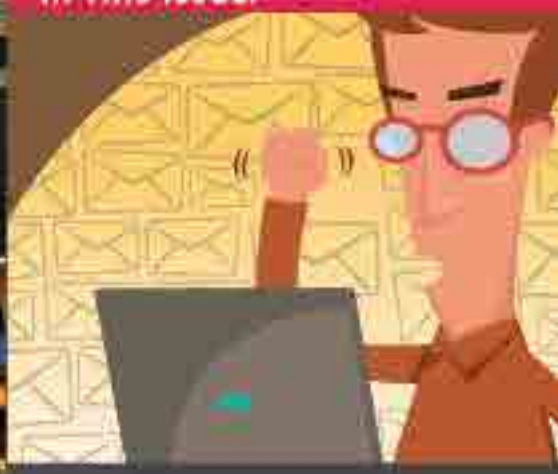
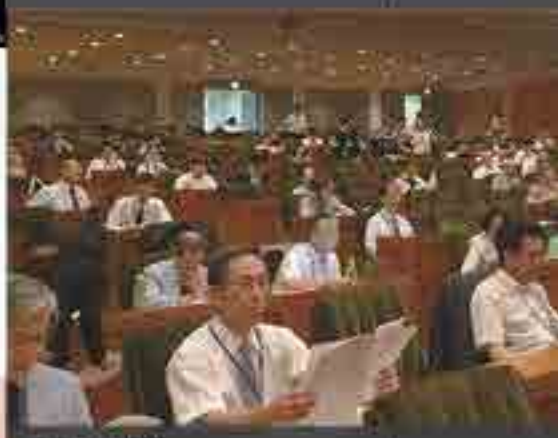
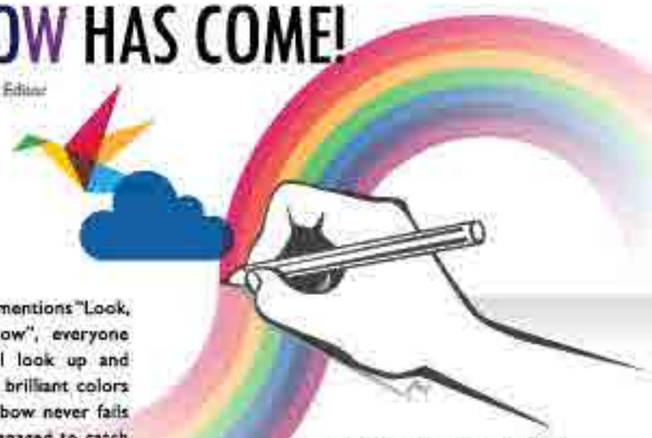




THE RAINBOW HAS COME!

by Dr Low Sher Guan Luke, MCFP(S), Editor



Whenever anyone mentions "Look, there's a rainbow", everyone without fail will look up and expect to see 7 brilliant colors streaking across the sky! A rainbow never fails to bring smiles to those who managed to catch a glimpse of it, even if it is for a brief moment.

Yet at the same time, many of us know that a rainbow is an optical phenomenon that results from contradictory elements of the weather. It requires the sun and the rain to co-exist at the same time. Most people expect the sun to brighten our mood, and the rain to have the opposite effect to dampen it. Put them together, and something unexpected happens – a beautiful rainbow.

As I was putting my thoughts together, our College President A/Prof Lee shared this story with me, which struck a deep chord in my heart. The story was about a man who was puzzled by the different attitudes of 3 different bricklayers working in the hot sun. The grumpy first bricklayer said, "I am just doing my job". The indifferent second bricklayer said, "I am bringing home food for my family". The final bricklayer who was brimming with enthusiasm said, "I am building a cathedral!"

Both the rainbow as well as the bricklayer stories shared something in common. It showed that different people see different things in the same picture, and as a result, they have different visions and passions for what they believe in (or what they do not believe in).

These past few months saw many happenings and changes. It was with great sadness when I received the news of Dr Tan Chee Beng's passing. When I worked under him in Singhealth Polyclinics, I often recalled his pep talks and visits to the clinics to speak with ground level staff like me. He was at the same time a great man at the distant helm, yet also a close and passionate man who comes down to the rank and file to connect with us all. The fraternity of family medicine suffered a loss as a result of his passing. However, as I was doing the memorial article and gathering opinions from the many I spoke to, I was deeply touched by the numerous wonderful feedbacks and encouraging remarks made by them about Dr Tan. I realized something... his legacy lives on, and the lives he touched are changed forever. The gloomy rain (his passing) and the sun (his passion for his work and people) resulted in something unexpected – transformed lives (rainbow).

Moving on, there are still happy moments to look forward to in healthcare. Ministry has just announced some enhancements to the Community Health Assist Scheme (CHAS) which will benefit more Singaporeans on the low- to middle-income tiers. More chronic medical conditions will be covered by CHAS, and the income ceiling has been revised so more Singaporeans will qualify for the scheme. This benefit will extend to all their family members as the age floor is removed, so the children of needy families will soon stand to benefit come January 2014.

Our College members met together on 6th July 2013 for the commencement ceremony of our Graduate Diploma of Family Medicine (GDFM), Masters of Medicine (Family Medicine) Programme B [MMed (FM) Programme B], Fellowship programmes and our Annual General Meeting (AGM). After the AGM, we ran the highly-anticipated council elections. That election saw intense rounds of rallying and anxious moments of voting. In the end, we saw a fair number of new council members being sworn in for the 24th Council of CFPS. Our editorial team also poked our noses in bravely to bring you more insider news about these new council members on the block.

Many landmark annual events have taken place as well, noticeably the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) world conference held in Prague and the Asia Pacific Association of Medical Journal Editors (APAME) convention held in Tokyo, Japan. Members of college council have attended these events and brought much knowledge and experience back to home ground. All these and more will be coming up in this issue.

Finally, in case you are wondering why I am writing this column as the editor, humor me with your time as I explain myself. Some months back, I got a message from my friend Tze Lee asking if I can take over as a budding editor because Dr Wilson Eu has other commitments. As I was maintaining polite radio silence, another SMS came along saying that this challenge will be too good to pass up. So I agreed with much hesitation, wondering what challenges (or stormy times) lay ahead for me. But after working with the editorial team and fellow writers who have so selflessly penned beautiful articles for this issue, I finally realized that what lay ahead was not so much the stormy rain that I wrongly expected, but the unexpected beautiful rainbow that sprung out from the wonderful experience of being the editor.

Please patiently guide me along and show me the ropes of editorship, and I sincerely apologize ahead of time for any mistakes unintentionally made along the way.

By Low Sher Guan Luke,
budding editor and enthusiastic bricklayer (hopefully)

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Family Doctor Day, an initiative started by WONCA, was celebrated in various countries around the world. Another highlight was the lively and interesting discussions on the important role of Family Physicians in the health care systems of countries, and strategies for engaging the World Health Organisation and other key stakeholders to proactively advocate for the important role that Family Physicians play in the national health care systems.

At the WONCA Asia-Pacific Regional Council Meeting, there were elections held for key office-bearers for the WONCA Asia-Pacific Regional Council. Dr J.K. Lee from the Korean Academy of Family Medicine was elected as the President, while Prof Meng-Chih Lee, from the Chinese Taipei Association of Family Medicine, was elected was the Vice-President.

The Singapore delegation from left to right: A/Prof Lee Kheng Hock, A/Prof Tan Boon Yeow and Dr Lim Fong Seng
Image courtesy of A/Prof Lee Kheng Hock

At the World Council Meeting, our President A/Prof Lee called for greater emphasis on primary care in emergency preparedness, using the haze in our region as an example.
Image courtesy of A/Prof Lee Kheng Hock

We were able to renew ties with old friends of the Singapore college; among them were Ex-Presidents of WONCA, Prof Bruce Sparks from South Africa and Prof Chris van Weel from the Netherlands, and Prof Michael Kidd, President of the new WONCA World Council.

We met up with key members of the International Committee of the Royal College of General Practitioners (RCGP) including Dr Sandy Mather, Dr John Howard and Dr Elizabeth Goodburn, to explore a closer working relationship between the RCGP and our college. We also met up with Dr Tim Malloy, President of the Royal New Zealand College of General Practitioners, to explore how we could strengthen the working relationships between the two colleges.

Prof Richard Roberts, the outgoing President of the WONCA World Council, did an excellent job in chairing and guiding the meeting through some difficult discussions. There was also an election to decide on the President-Elect and other office-bearers for the WONCA World Council. Dr Amanda Howe from the Royal College of General Practitioners was voted to be the President-Elect for the World Council for 2013-2016.

It was passed at the World Council Meeting that the 22nd WONCA World Conference in 2019 would be brought forward to 2018. This time there were two countries which bid for the right to host the 2018 WONCA World Conference- Hong Kong College of General Practitioners and the Korean Academy of Family Medicine. There was strong campaigning and lobbying for our votes from the 2 Asian countries. In the end South Korea, which has never hosted a prestigious WONCA World Conference, won the bid to host the 2018 WONCA World Conference. Singapore was one of the very few countries in the world which hosted the WONCA World Conference twice, the last time in 2007. It is an honour for Asia that the WONCA World Conference will be held in Asia again in 2018.

COMMUNITY HEALTH ASSIST SCHEME (CHAS) *Enhancements*

by the Agency for Integrated Care (AIC)

The Ministry of Health has unveiled a set of measures to give Singapore citizens greater peace of mind over healthcare costs today, as announced during the recent National Day Rally. Outpatient costs will be made more affordable through the expansion of Government subsidies and Medisave use, to reduce cash outlay for patients. CHAS will be enhanced to enable Singapore Citizens in lower- and middle-income households to receive more subsidies for medical care for chronic conditions and/or common illnesses at participating General Practitioners (GPs) near their homes.

These CHAS enhancements will take effect from 1 **January 2014.**

CHAS CRITERIA	Current CHAS		Enhanced CHAS (from 1 Jan 2014)	
	Blue Tier	Orange Tier	Blue Tier	Orange Tier
Citizenship, Age & Disability Status	Singapore Citizens, 40 years old and above or disabled[1]		All Singapore Citizens, removal of age floor and disabled category	
	AND			
Per Capita Household Monthly Income (PCI)	$1,100 and below	More than $1,100 but less than $1,800	No changes	
	OR			
Annual Value (AV) of Residential Properties (for households with no income)	$13,000 and below	-	$13,000 and below	More than $13,000 but less than $21,000

[1] *Unable to do any of the following six activities of daily living (ADLs) without assistance: washing/bathing, toileting, transferring, feeding, dressing, and/or mobility.*

CHAS SUBSIDIES & COVERAGE	Current CHAS				Enhanced CHAS (from 1 Jan 2014)			
	Blue Tier		Orange Tier		Blue Tier		Orange Tier	
Acute conditions	Up to $18.50 per visit		Not applicable		No changes			
Chronic conditions[2]	Tier 1	Tier 2	Tier 1	Tier 2	Tier 1	Tier 2	Tier 1	Tier 2
	Up to $80 per visit and up to $320 per year	Up to $80 per visit and up to $480 per year	Up to $50 per visit and up to $200 per year	Up to $50 per visit and up to $300 per year	No changes	Up to $120 per visit and up to $480 per year	No changes	Up to $75 per visit and up to $300 per year
	Covers existing 10 chronic conditions[3]				Addition of 5 new chronic conditions: Osteoarthritis (OA), Benign Prostatic Hyperplasia (BPH), Anxiety, Parkinson's Disease, Nephritis/Nephrosis			
Dental services	Up to $256.50 per procedure		Up to $170.50 per procedure		No changes			
HPB Integrated Screening Package (ISP) Health Screening	Not covered				• Health Assist cardholders will be able to enjoy subsidies for the recommended screening tests under HPB's ISP. They will receive a letter from HPB when it is time to go for screening. • Enjoy subsidies for their doctor's consultation charges (up to $18.50 per visit) for screening and related follow-ups, up to two times per calendar year.		

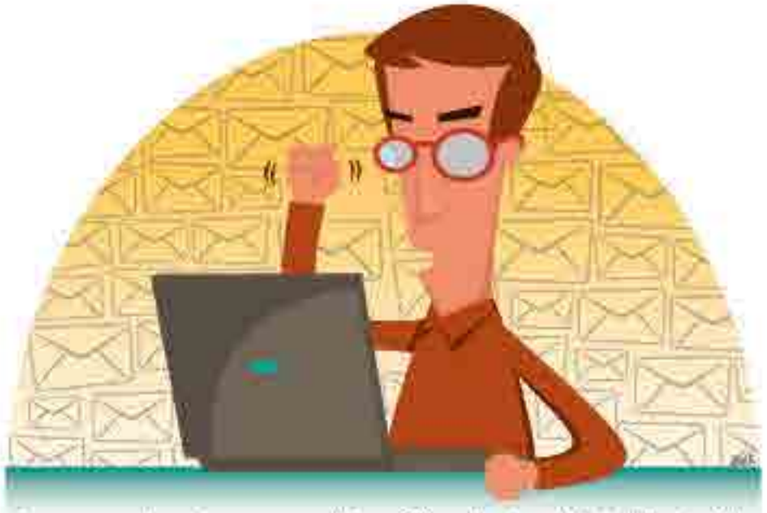
[2] *Per calendar year limit is dependent on the extent of patient's chronic condition. Tier 1 patients have a single condition, while Tier 2 patients have more than one chronic condition or condition(s) with complications. Please check with the CHAS General Practitioner (GP) during consultation.*

[3] *The conditions are: Asthma, Bipolar disorder, Chronic Obstructive Pulmonary Disease (COPD), Dementia, Diabetes, Hypertension, Lipid disorders (e.g. high cholesterol), Major depression, Schizophrenia, and Stroke. GPs must be CDMP+ accredited to claim for mental conditions.*

I HATE EMAILS

by A/Prof Lee Kheng Hock, President, 24th Council, College of Family Physicians Singapore

I hate emails. More accurately, I love and hate emails. Every morning I get woken up by my smartphone which also doubles up as my alarm clock. (I am still looking for a smartphone that can cook breakfast as well). After bashing the phone into silence, invariably the next thing I would do is to look at the emails. It is like an addiction. You know it is not good for you but you can't help yourself.



I don't really hate all emails, only some. Not those that keep asking me whether I am suffering from erectile dysfunction. They are actually quite funny. I half suspect that there may be a prankster among my urologist colleagues who is spamming everyone with this kind of junk. I stare hard into their eyes when I get the chance but so far none had blinked or confessed. Then there are those who are concerned about the size of my body parts. I sometimes wonder how they target prospects. Do they have secret cameras installed in the toilets? Then of late, I had also been very lucky. I seem to be striking lotteries all around the world. Not a week goes by without some conscientious administrator of lottery companies tracking me down and informing me of my good fortune. Regrettably I am an honest man and had never tried to take advantage of these kind-hearted people and claim the prizes that I didn't win. Otherwise, I would be very rich by now. My reputation as a helpful and honest person had also spread far and wide around the world. I get so many requests from total strangers asking me to help them with their financial difficulties. Most of them have huge sums of money but are unable to avail themselves to their fortune because there are many bad people who are trying to harm them and deprive them of their wealth (although I suspect some of them may be ill gotten gains based on the stories that they tell me). Again my honesty gets in the way and I can't get myself to accept their generous offers of rewards and commissions. I always remain politely silent, just in case temptation gets the better of me.

The emails that I really hate are those that I can neither delete nor reply. Some emails are easy. All they want is a "yes", "no" or "sorry you send to the wrong person". By far the best system to triage your emails is to look at the sender. Just scan the senders' column and read emails from the following category (not necessarily in order of importance nor mutually exclusive):

1. Boss
2. Government
3. Spouse
4. People who can hurt you

Ignore the above entities at your own peril. Generally everyone else can be ignored with impunity. As we all know, if there is anything really important, you will get more emails, phone calls or they may actually be kind enough to send someone to your home or office to hand deliver the summon.

Then there are those whom you must delete quickly and frequently. The senders of such emails are like hospital bugs. They just love to infect your inbox. Usually they are colonisers and pretty harmless, copying you on everything or sending you verbose tirades on all sorts of trivialities. One tell-tale sign that can alert you to such emails is that they tend to come with a read receipt. That is a sure sign they are trying pin you down. Never acknowledge. In fact you must quickly delete this email so that they cannot claim that you have read them. Then there are the self important ones who mark their email as "High Priority". Oh yeah? Says who? I will be the judge of what has priority or not. It is my inbox for crying out loud. However you must be careful as sometimes they go berserk and start getting inflammatory, especially when you try to engage them or try to get them to shut up. This would be a great mistake. The only defence is to adopt universal precaution. Delete every time you open or close your email application. Under no circumstances should you be tempted to read these emails. Otherwise you will find yourself in the midst of a cytokine storm. And for goodness sake don't forward their email or put even more people on copy. It is bad for your karma.

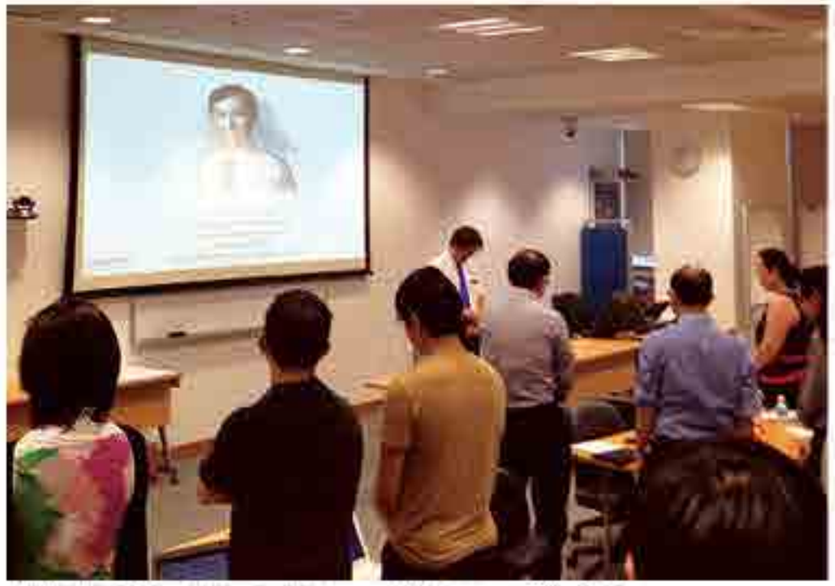
The worst emails are actually the justifiable ones. They are those that you can't ignore, can't delete and can't answer within the limits of your deficient attention span. Usually they ask for things that require you to actually think before answering. Really inconsiderate when we jolly well know that the average time allowed for each email is only about 11 seconds. When push comes to shove and things can't really get solved via emails, then it is time to raise the stakes and call for a meeting. If there is anything more hateful than emails, it must be meetings. That will be my rant for another day. Until then if you should receive yet another email blast from the College, know that I had tried to stem the tide. It could have been worse, much worse.

DEDICATED IN REMEMBRANCE OF DR TAN CHEE BENG — *a leader, mentor and friend*

by Dr Low Shar Guan Luke, MCFP(S), Editor

September the 3rd, 2013, Tuesday. A day which I thought to be like any other day, started out rather differently. Just before I started calling my first patient through the consultation doors, I received an SMS from a friend of mine which caught me off guard, informing that Dr Tan Chee Beng had passed away. I knew Dr Tan was struggling with cancer. Part of me was hoping that he will make it through despite the odds. That same part of me was also in denial of the news. I immediately rang up a mutual friend of mine who works in Singhealth Polyclinics, and she confirmed the news. There was sadness in her voice, and I knew that Singhealth Polyclinics had lost a great leader.

Dr Tan's contributions to the fraternity of family medicine were countless. As I discussed with the editorial team and some of our College members, all of us unanimously decided to dedicate a memorial article in remembrance of Dr Tan. We spoke to a few of his closest friends and comrades, and these are what they have to say about him.



Medical students and family medicine teachers observing a moment of silence in memory of Dr Tan Chee Beng
Image courtesy of A/Prof Lee Kheng Hock

■■■ Contributed by Singhealth Polyclinics

3 September 2013 will always be a sad day for SingHealth Polyclinics (SHP) - the day that Dr Tan Chee Beng, Chief Executive Officer (CEO), leader, mentor and friend, succumbed to a two-year battle with cancer.

Dr Tan was appointed CEO of SHP in 2002. During his tenure, he made invaluable contributions and built SHP to what it is today – a strong and progressive organisation which not only continually improves and provides great care for its patients, but for its staff as well.

Since his graduation from National University of Singapore in 1987, apart from serving his patients, Dr Tan devoted his time to three areas: acquiring and sharing medical knowledge, continuous self-improvement and contributing to various medical committees either by leading or participating in their activities.

In 1996, Dr Tan was awarded the Health Manpower Development Programme (HMDP) Fellowship in Family Medicine (FM) in United Kingdom (UK) where he studied the practice of general medicine and professional training of general practitioners in UK. Shortly after, he attended and completed modules one and two of the 'International Course for Teachers of General Practice' organised by the Royal College of General Practitioners and De Montford University - a first in the world for Family Medicine teachers.

Dr Tan strongly believed in the sharing of medical knowledge. He organised the first Family Medicine Trainers' Workshop in Singapore for FM trainers in the public and private sector in 1997. Subsequently

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regular trainers' workshops were organised for FM Trainers and Graduate Diploma in Family Medicine (GDFM) tutors.

He also organised and implemented the structured training programme for 3rd Year FM trainees which includes workshops, tutorials, clinical teaching and postings.

With a burning passion for learning and continuous self-improvement, Dr Tan obtained his Graduate Diploma in Geriatric Medicine in 1998. He also went on overseas study trips to learn more about FM and FM Residency programmes which he would then share with colleagues.

In his career as a doctor, Dr Tan held many appointments and sat in various committees because he believed in contributing back to the society. He served as Honorary Editor of College of Family Physicians Singapore (1999 – 2001), an Examiner for the MMed (FM) Examinations (since Oct 2000) and Chairman of Training Accreditation & Audit Committee (TAAC), a subcommittee of Interim Joint Committee of Family Medicine Training, MOH (Nov 2005) to name a few.

A learned man, Dr Tan lived by three important principles: the most important time is now; the most important person is the one before you; and the most important thing is to care. Even after passing on, his words will continue to inspire many to care for others, to serve others, to put others before self. Singhealth Polyclinic staff describe him as "a guiding light, a bright smile, an inspiring leader and a great person". No doubt the loss will weigh heavy in the hearts of many but to move forward and bring SHP to greater heights in his honour - that is the focus and goal.

Rest in peace, Dr Tan – our leader, our mentor, our friend. Thank you for everything, you will be missed.

■■■ Contributed by A/Prof Lee Kheng Hock

I always find Chee Beng to be warm and easy to talk to although some of my classmates may think that he is quiet and reserved. Perhaps it is because we came from fairly similar social background.

Even when he became the busy chief executive of a public institution, he is always warm and cheerful whenever I call him on his mobile, very often at inconvenient times. Such is the nature of Chee Beng. He is humble despite his many achievements and he is unflappable regardless of provocations.

We share a similar passion in advocating for family medicine as a critical discipline that is undervalued by our society. We also share the belief that the College of Family Physicians Singapore is the best platform to advance family medicine in Singapore. To that end, we had laboured as co-workers and comrades in many struggles.

While I tend to get excited with new ideas and innovations, Chee Beng is usually cautious and circumspect.

In our years working together in the College under our common mentor, A/Prof Goh Lee Gan, we had created some things of value for the fraternity. The best thing we can do to honor his memory would be to continue his legacy. I will miss my classmate and colleague Dr Tan Chee Beng.

■■■ Contributed by Dr Tay Ee Guan

Many know Chee Beng not only as the CEO of SingHealth Polyclinics, but also a leader who has contributed significantly to the development of Family Medicine in Singapore. He was a passionate educator who played significant roles in several FM education milestones in Singapore. As a clinician leader, he has also shared his insights at many platforms on how we can provide better primary care in Singapore. I suspect many of his contributions are known to many, so I will not belabor the points. I have known Chee Beng for many years and I would like to share my thoughts about him as a person. He was very much a people person, who valued everyone that he encountered. He could empathize with the concerns of people, and value the views of others. As such, he did not impose his opinions on others, but would often patiently explain his position. Chee Beng is also a humble person. Even though he holds the position of CEO in the organization, he did not have any airs about him. When he attended his medical appointments, he would register like any patient would, waited quietly for his turn to see the doctor and collected his medications at the pharmacy. At official functions, he did not like to be in the limelight, preferring to mingle quietly with the guests. This makes him very approachable to people at all levels, and endeared him to many staff at the polyclinics. Chee Beng was also a visionary. He was clear about what needed to be done for the organization and for Family Medicine in Singapore, and he worked with the constraints he faced. His pragmatic visionary leadership has helped the organization achieved many of the successes.

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Contributed by A/Prof Goh Lee Gan

Today I received the sad news of the passing away of Dr Tan Chee Beng, a stalwart Family Physician and CEO of the Singhealth Polyclinics. Chee Beng lost his fight to a two year battle with his cancer, and in his usual way, gallantly, and quietly.

I remember him as one of my close disciples in Family Medicine. He was a graduate of the second batch of the MMed (FM) Programme A trainees in 1994. Those were the early days of the start of Family Medicine and I remembered he came to talk to me often on how we could advance the Family Medicine undergraduate and postgraduate programmes. He was one of the ten doctors who graduated from the first Fellowship in the College of Family Physicians Singapore [FCFP(S)] class which was started in 1998.

In the year 2000 when the GDFM programme, which was proposed by the College of Family Physicians Singapore as a tripartite programme of College, Ministry of Health and National University of Singapore, was approved by the NUS Senate, Chee Beng was one of the three-member team who visited the newly built James Cook University to learn how the Australians conducted their Objective Structured Clinical Examinations (OSCEs) for the Fellowship of the Royal Australian College of General Practitioners (FRACGP). The other two of the team were myself and Dr Lau Hong Choon. Chee Beng had an elephant memory – He was able to summarise all the OSCE scenarios with quite a bit of details when we met that evening. The rest was history. We have conducted more than 10 of those OSCE examinations since 2002. Chee Beng was also very good at setting MCQs.

Chee Beng was very much involved in the Family Medicine training programme and he was the first chairman of the Family Medicine Residency Advisory Committee (FMRAC) which was set up in 2010. The College invited him to give the Keynote address in the Commencement Ceremony in 2011. He spoke about the fundamental enhancements to the Family Medicine postgraduate programme. His speech is available in full text in the CFPS website and is a lasting testimony of his contribution to Family Medicine and a reminder in his words – "to continue to push the frontiers to strive for the values and ideals of Family Medicine.... to ensure our next generation of family physicians will be better trained than us."

Contributed by Dr Chow Mun Hong

Chee Beng was a pioneer in many ways in Family Medicine. He was an early adopter in post-graduate Family Medicine training, one of the first 3 Family Medicine Consultants appointed in MOH, and the first Family Physician who had a Fellowship under the Health Manpower Development Plan (HMDP). He was a firm believer in professional development and did much to support the growth of formal postgraduate Family Medicine training.

I remember Chee Beng as a humble, unassuming person who cared about patients and about people. Beyond getting the job done, he would put in extra effort to make sure that his team was well looked after. During the SARs outbreak in 2003, our nurses were deployed to the airport to perform temperature screening at very short notice. After getting them set up, Chee Beng and a few of us bought big plastic boxes and filled them with drinks and snacks and drove these to the airport so our nurses would have some refreshment during their breaks. He was always supportive of efforts to help our colleagues learn and grow, and put in place programmes to encourage, support and even require continual learning for career progression, and many of our colleagues have benefitted from this extra nudge to gain higher qualifications and skills.

Chee Beng was quiet and unassuming. His legacy lives on not through flashy monuments, but in the lives his efforts touched. Patients who have access to affordable care because of his financial prudence, colleagues who now have better careers because they benefitted from the support built into the system, and Family Physicians who have a better training framework. Many of these people would not know about Chee Beng's efforts and how these made a difference in their lives, and I think this is how Chee Beng prefers it.

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Contributed by Dr Adrian Ee

I have had the privilege to work closely with Chee Beng as he led SingHealth Polyclinics from 2002. He was a simple man but truly dedicated to developing Family Medicine and focusing on patient care through the practice and principles of Family Medicine. Many a times, when we are at crossroads, it was clear that Family Medicine would serve to guide and shape the path ahead.

While he was busy running the institution, it would always be the education domain that sparkles in his eyes, evident from the books he placed before me, on competency and assessments, pedagogy and training etc. He believed that training future generations of Family Physicians would benefit the greater public and primary health care, looking to longer term value as we moved onwards.

I remember his sharing story of "Two Bricks in the Wall", where a monastery was built brick by brick, painstakingly over years. Upon completion, although beautiful, the long wall had 2 bad bricks, somewhat misshapen and a little out of alignment. That brought much distress and prompted the monk to fret, fume and consider tearing down the wall to rebuild, but it was not to be. The monk lived with some degree of frustration and depression, hiding the wall, avoiding it when visitors came.

One day, a visitor commented that it was a beautiful wall, only to be alerted that two bricks were bad, and the monk wondered why he did or could not see it. The reply was the remaining 998 bricks were good and the wall was actually fine.

Reflection and I shall remember him for sharing this...

Contributed by Dr Tan Ngiap Chuan

I remember vividly the presence of CEO at the strategic planning workshop. He was breathless and spoke laboriously, yet he was determined to convince the directors and senior management of the need "to stop the leaks and boost the engines" in order for the institution to strive towards the strategic goals. This was a display of perseverance, courage, sacrifice and excellent leadership. These qualities are truly admirable but would be difficult to emulate. The photo of him giving me the SHP cap engraved with my name will be most treasured. It underpins his passion for the institution and his desire for all of us to lead and continue to develop family medicine, so as to bring the discipline to another pinnacle of achievement. We must strive towards this goal and not to disappoint him.

Contributed by Dr Farhad Vasanwala

Dr Tan Chee Beng was then the Director of Geylang Polyclinic when he gave me my first introduction to life as Polyclinic doctor in November 2000. That morning on the first day at Geylang Polyclinic, I feared that I would be thrown into the lion's den with little help to treat the huge throng of humanity seeking treatment for their ailments.

Surprisingly that day proved to be a pleasant one. He knew those doctors joining were raw recruits and yet he treated us with upmost respect, courtesy, and humility and ensured that we were buddied with senior doctors; taken care of and supervised during the first few formative weeks.

Those few weeks sealed my love for family medicine. His leadership over the years further exemplified those qualities and impressed me even more. He was taken away from us far too soon, but he has left a great legacy in innumerable number of ways.

CSM

YES, WE CAN LEARN, TEACH AND PRACTICE *At the Same Time!*

by Dr Zheng Mingli Ruth, MCFP(S), Family Physician, Associate Consultant, National Healthcare Group Polyclinic

My interest in family medicine first budded in my undergraduate years when I was drawn by the holistic, personal and comprehensive care given by family physicians in primary care. Even at that early stage of training, I was inspired to be part of the family medicine fraternity, to be involved in providing good quality primary care.

Upon graduation, I decided to pursue the Masters of (Family Medicine) programme to further hone my skills to be a competent family physician. Personally, I think it is imperative for doctors entering primary care to receive some form of post-graduate training in primary care, whether it is in the form of Graduate Diploma in Family Medicine (GDFM), MMed (FM) or residency. This is because undergraduate training alone is inadequate to sufficiently prepare one to have what is required of a good and effective family physician. With adequate post-graduate training, primary care doctors can be more confident in practicing good quality primary healthcare.

To me, the most satisfying aspect of practicing as a family physician is the ability to care for the patient holistically in the bio-psycho-social aspects of their lives. The doctor- patient relationship built upon a strong foundation of trust is something powerful and not to be taken granted for. One of the patients that I had a very satisfying consultation outcome was Mr A, who has been seeing me for white coat hypertension and palpitations. He had been extensively investigated at the specialist centres but investigations did not reveal any particular pathology that could account for his symptoms. By offering a listening ear, I was able to gain a better insight of the psychosocial aspects of Mr A's life and offer him practical advice in dealing with his life stressors. It was truly satisfying seeing Mr A's symptoms resolve dramatically and him being upbeat about life again.

After completion of the MMed (FM) programme, I was thankful to be given the opportunity to be involved in medical education. It was then that my interest in teaching was given the opportunity to blossom.

I am currently involved in both undergraduate training of the Yong Yoo Lin medical students, as well as postgraduate training of family medicine residents. I find it greatly rewarding to be involved in molding the younger generation of doctors- to be a coach, mentor and motivator to them. Imparting to the younger generation of doctors has a multiplying effect, which in turn would help propel the family medicine fraternity forward.

Teaching is also a great opportunity to keep learning actively. It is a two-way process of mutual learning. In the process of imparting our knowledge and skills to the younger generation of family medicine doctors, we are constantly motivated to keep up-to-date and we get to learn new perspectives from our learners as well. Part of the learning process involves learning how to be an effective teacher. As such, I decided to equip myself by signing up for the Fellowship [FCFP(S)] programme offered by the College of Family Physicians Singapore. One of the aims of this programme is to hone one's teaching skills via the pedagogy sessions.

Primary care will continue to be the cornerstone in our nation's healthcare system. It is imperative for us as a fraternity to come together with our combined pool of rich resources to be well trained, as well as to train our future generation of family medicine doctors to be competent family physicians. One could consider this as a form of 'national service' as well!

CM

MULTI-PRONGED APPROACH TO "LIFESTYLE DISEASES"

— a perspective of a private general practitioner

by Dr Lim Yii Hong Ethan,

In my humble opinion, above and beyond understanding and interpreting medical information and how the local medical system work, the true requirement for crafting good healthcare and health financing policies requires a fairly good understanding of people and the ability to understand health-seeking behaviour and the psychology of making irrational choices. Hence I think that the current policy of increasing subsidies for treatment of common chronic medical conditions is no doubt a popular decision, but perhaps more can be done to solve the problem.

To begin, let's talk a bit about these diseases. The greatest burden in the past 20 years of disease and healthcare cost on economies, nation, society and the community is due to a special group of problems fondly termed "lifestyle diseases". There is a common denominator that links high blood pressure, diabetes, high cholesterol, obesity, osteoarthritis, gout, alcoholism, fatty degeneration of the liver and many others. These diseases seem pretty diverse but they really boil down to one common denominator - lifestyle choices. Lifestyle and choices, coincidentally 2 domains that modern men struggle with. We lead sedentary lifestyles with poor dietary choices and minimal exercise.

Patient may find it easy to attribute it to their family history. Many of us would have heard patients saying "It is not my fault! My father and mother have high blood pressure, so that is why I have it!" While that may be true, the genetic code very often does not translate into fate. The factors which are within their control are also the very things they neglect – smoking, eating too much salt, fat, red meats, not exercising enough and poor compliance to treatment plans.

Beyond genetics and lifestyle diseases, in our modern age of information, even in the realm of infectious diseases there is very often a choice, a choice of risk-taking and risk-reduction: Think HIV and condoms, travelling to high risk areas without vaccinations or parents with cryptic calculations that somehow end up deciding that 1-in-10,000 chance of dying is somehow preferable to a theoretical risk of 1-in-a-few million risk of serious neurological disorder and hence becoming conscientious objectors to childhood vaccinations.

The burden or responsibility in healthcare is primarily self-responsibility at a personal level. However what most people fail to appreciate is that these personal choices have implications and significant effects beyond the personal and associate level and often cascade into effects on the structuring, financing and capability of the healthcare system of an entire country. There needs to be a fine balance between healthcare costs, subsidies and the medical needs of the patients.

Choices, especially the ones patients make with regards to their own health or how they define their health and healthcare system may be very personal, but it has a profound effect on society – both in burden and cost. Healthcare extends beyond self. The system should ideally aim to encourage a person to take good care of his own health in order to have sustainability in its success. Some of the core ingredients may include good health literacy, a well-developed sense of self-responsibility with regards to one's health in the population, and strong governance in the gatekeeping and allocation of healthcare resources.

The main drive is to incentivise people towards better health-seeking behaviour using both positive and negative incentives and enforcements, an example would be recently launched AIA Vitality scheme where people making healthy lifestyle choices will be given benefits such as lower insurance premiums. Understanding people at both the personal level and in a generic, universal way may be the key to the successful implementation and uptake of such policies. There is a need to educate people on the principles of good health, the choices that they can make and a basic but clear understanding of good health-seeking behaviour. There is also an overwhelming urgency to play catch up to get our population regardless of age to live better, treat their bodies better and make better lifestyle choices in a whole myriad of ways but more importantly the feasible and workable strategies that each individual can employ to achieve that self-determination. All of us in the healthcare sector will need to play their part in restricting, removing and reducing temptations towards poor health choices.

CM

At the General Assembly of APAME Convention 2013.

APAME CONVENTION 2013 *in TOKYO, JAPAN*

by Dr Tan Tze Lee, Honorary Secretary 24th Council, College of Family Physicians Singapore

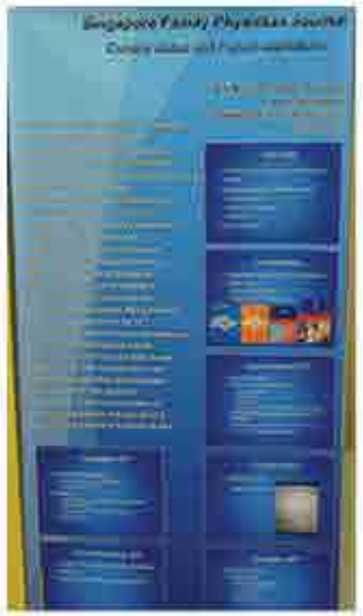
In the early days of the Global Health Library (GHL) and WPRIM (Western Pacific Region Index Medicus), a need for the medical journal editors to come together to manage needs for the WPRIM and GHL resulted in the formation of the Asia Pacific Association of Medical Journal Editors (APAME) in 2007. Since then APAME has held annual meetings, and in 2009 in their meeting in Singapore, our Singapore Family Physician journal was finally admitted into WPRIM.

Over the past years, it had been a great privilege meeting with giants in the medical editing field, such as the current APAME President Professor Kiyoshi Kitamura, past Presidents Professor Hahm Chang Kok from the Republic of Korea and Professor John Arokiasamy from Malaysia, and Prof Jose F Lapeña, Jr from the Philippines, and I looked forward to meeting with them again.

This year, the APAME Convention 2013 was held in Tokyo, Japan. There was a stillness in the air as I stepped off the Yamanote Line at Komagome station. Right smack in the middle of Tokyo's suburbia, Komagome is where the Japan Medical Association have their headquarters, and where the Asia Pacific Association of Medical Journal Editors meeting was held this year. The convention ran from 2nd to 4th August 2013, and even though it was 8pm, the weather was still warm and humid. It was the height of summer in Japan, and the instructions from the organizers were for us delegates to be wearing short sleeves, with no tie and jacket. Good advice indeed, as most of us were drenched with perspiration just from walking the 2 blocks from the station to the Japan Association Headquarters! To our surprise, our Japanese hosts appeared in their suits and ties, without breaking a sweat.

Participants came from many countries in the Asia-Pacific and South Asian regions. We had delegates from Singapore, Vietnam, Laos, Cambodia, China, Japan, Korea, Mongolia, the Philippines, Indonesia, India, Nepal and Sri Lanka. Many had come as their journals had just been admitted to the Index Medicus. It was a wonderful opportunity to renew old ties and make new contacts with the editors of the newly admitted journals. Dr Arun Neopane, Secretary General of Nepal Association of Medical Editors and Prof Peter Munk from Canada were some of many who shared from their vast experience as medical editors.

A presentation by Dr Tan Tze Lee



Banner by College of Family Physicians Singapore
Image courtesy of Dr Tan Tze Lee

Group photograph of delegates from various regions

Extreme left: Prof. Seo Jeong Wook (Republic of Korea)
Extreme right: Prof Kiyoshi Kitamura (Japan)

The Japan Medical Association building

One of the best aspects of these meetings has been how editors, reviewers, publishers and librarians have come together to share ideas and experiences, and worked together to improve on the quality of review and publication; this year was no exception.

The President of the Japan Association of Medical Sciences, Dr Fumimaro Takaku, gave the welcoming address. The convention this year took on a somber tone, as the focus was on the integrity of articles, publishing standards and responsibilities.

The opening plenary by Prof Eva Baranyiova from the Czech Republic dealt with just that. The Vice President of the European Association of Science Editors, her "Science Communication and Integrity in the Third Millenium" highlighted many of the disturbing trends of academic fraud, plagiarism and the loss in integrity in scientific publications. Studies have revealed the trend of increasing numbers of articles retracted because of fraud and fabrication as compared with scientific effort.

Several examples of such articles included those reporting the clinical trial of valsartan, which were retracted in 2013 following evidence of "critical problems of data." The scandal severely compromised research integrity in Japan.

Problems of plagiarism and fraud continue to plague the academic community and editors and reviewers have to be on the lookout for more of this increasing trend. There is an increasing need for tools to detect such articles submitted to our journals for review and publication.

The convention also held sessions on duplicate publication and authorship, and clinical trial registry and responsible conduct of research.

Although the convention had to deal with such weighty issues, the members of APAME came together to sign the Tokyo Declaration on Research Integrity and Ethical Publication in Science and Medicine in the Asia Pacific Region on 4th August 2013, in an effort to preserve academic and intellectual integrity in our research spheres.

At the end of the convention, we were all a little sad to leave. The gracious hospitality of our Japanese hosts made us feel all very welcome, and though exhausted from a hardworking weekend we were glad that we had been able to achieve so much.

LET'S HEAR FROM A **CHAS GP**...

by the Agency for Integrated Care (AIC)

The Community Health Assist Scheme (CHAS) provides middle and lower income Singaporeans with subsidies for medical care and dental services at participating clinics near their homes. Response from the public to this scheme has been encouraging, and the number of successful CHAS applicants is expected to exceed 240,000 by end 2012.

Having more GPs participating in CHAS is paramount to its success. Since the roll-out of CHAS in mid-January 2012, the Agency for Integrated Care (AIC) together with other stakeholders, have been introducing steps to simplify the administrative and operational aspects of CHAS. Improvements to the online claims portal were made in phases since June this year, and GPs can look forward to more technological enhancements in 2013. It is good for participating GPs to note that they are not limited to charging a cap level of medical fees, but can charge within a reasonable range instead. If clinics need assistance in administering CHAS or would like to receive one-to-one training, they can call AIC during office hours to make arrangements.


Dr Rodney Lim

Here's what Dr Rodney Lim of Healthlink Medical Clinic and Surgery has to say about CHAS, why he signed up to be on it and how the scheme has benefited his patients.

AIC: What made you sign up for CHAS?

Dr Rodney Lim: I registered my clinic for CHAS in November 2011, when it was still known as the Primary Care Partnership Scheme and since then, I have been seeing more CHAS patients. It's the first such scheme introduced by the Ministry of Health (MOH) to benefit the patients directly by helping those who are financially in need. Since joining CHAS, my clinic's business has grown, and more importantly, I am able to provide a higher level of primary care to my patients without them worrying about their financial means.

AIC: How have your patients benefited from the scheme?

Dr Lim: My patients have benefited in several ways.

Firstly, the $18.50 rebate allows me to prescribe better medications, which tend to be slightly more expensive, to my patients when they need them, without imposing too much financial strain on them. Secondly, my patients are more likely to seek medical consultation early when they are ill because of the subsidy. Thirdly, they are able to enjoy the convenience of visiting my clinic, which is close to their homes, experience shorter waiting times (compared with the outpatient department), obtain better medications when needed, and even have minor procedures done if necessary. When patients are unwell, it's understandable that they prefer not to travel far to see a doctor, so being able to visit a CHAS clinic in their neighbourhood really helps. Lastly, the four visits per month criterion allows my patients to come back for review, and such follow-ups are important in ensuring that I am able to treat their medical conditions until they are fully recovered.

AIC: How has administering CHAS at your clinic impacted your clinic operations?

Dr Lim: For acute illnesses, $18.50 is deducted directly from the patients' total bill and they only need to top up the difference. The scheme is straightforward and how it works is easily understood by my patients, especially the elderly ones. The claim submissions done via the CHAS website thus far have been relatively hassle-free. I find the website design simple, straightforward and easy to navigate. On average, my CHAS submissions can easily be done in between patients' consults as it takes only about two to three minutes to complete it.

AIC: What's your advice to GPs with regard to signing up for CHAS?

Dr Lim: I strongly encourage more GPs to come onboard! It's a win-win situation for your patients and the clinic. On one hand, your patients can benefit directly from the $18.50 rebate. On the other hand, your clinic can see an increase in patients as you cater to patients under CHAS. I have seen more elderly patients seeking medical consultation early whenever they are not feeling well because of the rebate, so you can greatly contribute to monitoring and managing their overall health early, at the onset of any medical conditions, rather than later. And this is important in the treatment of chronic conditions.

AIC: What improvements would you like to see for CHAS?

Dr Lim: For acute conditions, perhaps bigger subsidies to benefit patients even more. I'm also wishing for more subsidies to be given for procedures, for example, $20 for incision and drainage, intra-articular injections, hydrocortisone and lignocain injections, paring of callosities, and nebulisation, etc. Again, providing an upfront lump sum subsidy for these would be appreciated. Another would be to provide subsidies for flu vaccination, especially for the elderly and sickly, eg, those who are above 60 years old, or those with diabetes, asthma, chronic obstructive pulmonary disease, and so on. A one-time subsidy would be good.

I find the reimbursement for chronic illnesses more difficult. It would be better if this process could be simplified, similar to making claims for acute conditions, which is a lump sum subsidy given per visit per month. I am also looking forward to the day when a subsidy could be given for blood tests that are mandatory for patients claiming under the Chronic Disease Management Programme (CDMP), eg, some arrangement or agreement could be made with certain laboratories to offer discounts for patients under the COMP scheme, so that more funds are available for patients' chronic medications.

AIC: What is your experience with using CHAS Online? (https://pcps.gpcare.sg)

Dr Lim: So far, it has been good. The website is easily accessible via SingPass. The claims I need to make are straightforward and quick. Reports can easily be downloaded for my clinic to keep track of claims, and these are usually paid up within a month.

AIC: Has the support provided by AIC – on-site training, account servicing, and GP hotline – been useful?

Dr Lim: Whenever I encounter any problems, my emails to gp@chas.sg have been promptly answered and my problems attended to. I have also received follow-up calls from AIC to ensure that my problems are solved.

Dr Lim is part of more than 500 GPs participating in CHAS. AIC would like to invite more GPs to be part of CHAS so that more people who qualify for this scheme can enjoy affordable healthcare at clinics close to them. The number of CHAS beneficiaries is expected to increase next year.

I have seen more elderly patients seeking medical consultation early whenever they are not feeling well because of the rebate, so you can greatly contribute to monitoring and managing their overall health early, at the onset of any medical conditions, rather than later.

AIC, which was set up by MOH to oversee healthcare integration in Singapore, is the one-stop contact point for GPs and dentists for CHAS (http://www.chas.sg). For more details, please contact the CHAS hotline at 6632 1199 or email gp@chas.sg.

FAMILY PRACTICE SKILLS COURSE

Chronic Lung Disease

The College of Family Physicians Singapore would like to thank **Boehringer Ingelheim Singapore Pte Ltd** and the Expert Panel for their contribution to the Family Practice Skills Course #53 on "Chronic Lung Disease", held on 11 – 12 May 2013.

Expert Panel:
A/Prof Ng Tze Pin
A/Prof Lee Pyng
Adjunct Assistant Prof Tee Kim Huat Augustine
Dr Ong Kian Chung
Dr Chua Seng Wee Gerald

Chairpersons:
Dr Tan Kok Leong
Dr Tan Hsien Yung David

Dementia

The College of Family Physicians Singapore would like to thank Agency for **Integrated Care (AIC), Institute of Mental Health (IMH), Ministry of Health (MOH)** and the Expert Panel for their contribution to the Family Practice Skills Course #54 on "Dementia", held on 1 – 2 June 2013.

Expert Panel:
Dr Nagaendran Kandiah
Dr Seow Chuen Chai Dennis
Dr Seng Kok Han
Dr Lim Wee Shiong
Dr Yap Lin Kiat Philip
Ms See Yen Theng
Dr Chong Mei Sian

Chairpersons:
Dr Siew Chee Weng
Dr Koh Wee Boon Kelvin

INTERVIEW WITH THE NEW COUNCIL MEMBERS ON THE BLOCK

Interviewed by Dr Low Sher Guan Luke, MCFP(S), Editor

6th July 2013 was an exciting day as our College members gathered for our Annual General Meeting (AGM). The latest updates were given by our President, Associate Professor Lee Kheng Hock and his EXCO committee. Thereafter, the tension-filled moment of electing our council members came. While some of the original Council members stayed on and continued to serve, there were others who served their illustrious terms and chose to allow fresh blood to continue their good work. From the elections rose several new council members who were totally new to the Council. Our editorial team sought these new council members out, in a bid to find out more about them and what led them to step up valiantly to serve.


Dr Subramaniam Surajkumar


Dr Farhad Vasanwala


Dr Tan Hsien Yung David


Dr Low Sher Guan Luke

College Mirror (CM):
Can you tell us a bit about who you are and where you work?

Subramaniam Surajkumar (SK):
I am Dr Suraj Kumar, and I graduated from NUS medical school in 1984. I have been in the private practice since the 1990s. I am now with Drs Bain and Partners, which is a medium group practice with about 4 branches and 14 doctors. Ours is essentially a town practice which deals mainly with corporate clients. It has a strong industrial base with many clients in the Jurong area where we also run several in-house clinics.

Farhad Vasanwala (FV):
Hi! I am Dr Farhad Vasanwala and I have been with the Department of Family Medicine and Continuing Care since 2007. Before that, I was working at Singhealth Polyclinics for quite a number of years. I am currently a consultant, Adjunct Assistant Professor at Duke-NUS and Director of the Transitional Home Medical Care in SGH.

Tan Hsien Yung David (DT):
I'm a Family Physician Associate Consultant and currently the Deputy Head of Jurong Polyclinic. I am also an Adjunct Assistant Professor with NUS Yong Loo Lin School of Medicine (YLLSOM) for medical student teaching, and a faculty for the National Healthcare Group (NHG) Family Residency Programme. I'm married with 2 beautiful daughters who take up most of my time when I'm not at work.

Low Sher Guan Luke (LL):
Good day! I'm Low Sher Guan Luke, and I'm currently with JurongHealth Department of Health and Wellness. I'm helping to set up Lakeside Family Medicine Clinic as part of my work. I'm also involved in undergraduate teaching in NUS YLLSOM and Duke-NUS, and post-graduate teaching in the College of Family Physicians Singapore.

CM:
How did you first get involved with College work?

SK:
I had other priorities early in my career and only started my family medicine journey late. After completing my earlier commitments, I did my GDFM, MMed and Fellowship in quick succession from 2007-2013. The GDFM was my first introduction to the college even though I had been a non-active member since 2001. Witnessing family medicine teaching first hand when I was training, made me interested in teaching and tutoring. It was also a way of 'giving back'. After passing the MMed, I became involved in teaching MMed, GDFM and precepting in Duke-NUS. Through this, I got to know many colleagues in the college and family medicine fraternity – both junior and senior to myself. Thus I became part of the college family so to speak – a very big family.

FV:
I had the privilege to teach the MMed (FM) Programme B students organised by the college right after my MMed (FM) exams in 2007, and for five consecutive years have enjoyed the camaraderie and fellowship of the learning journey with the fellow tutors, specialists and trainees. I have taken a break in the Programme B teaching for this year and hope to be back soon. I have also been a GDFM tutor since 2008.

DT:
I probably became more involved with College work during the course of my Fellowship programme, during which my group organised the 2nd Asia Pacific Primary Care Research Conference (APPCRC) in 2010. During this time I had the opportunity to work with some of the Fellows and staff of the College and found them to be a passionate group of people with a heart for Family Medicine. After the APPCRC I was invited to contribute to the College Mirror in the form of articles and had the opportunity to chair some of the Family Practice Skills Courses (FPSC) conducted by College.

LL:
As I started my MMed (FM) training in 2007, I was deeply and positively influenced by many role models in the College. After passing my MMed (FM) exams, I decided to see how I could contribute more. I was given the opportunity to teach at the GDFM in 2011, and subsequently the MMed (FM) Programme B in 2012. Along the way, I have received guidance from excellent mentors such as A/Prof Goh Lee Gan, A/Prof Lee Kheng Hock, Dr Julian Lim, Dr Farhad Vasanwala, Dr Eng Soo Kiang, Dr Subramaniam Surajkumar and Dr Jean Jasmin Lee. They have impressed me with their untiring teaching efforts and inspired me to carry on their good work. Even as I teach alongside most of them now, they never fail to amaze me with their teaching excellence and perseverance.

CM:
What made you decide to run for College Council?

SK:
Therefore my involvement up to now had been teaching. But I felt that I could contribute perhaps a little more. The opportunity presented itself when the college elections came round and several incumbents stepped down after their terms. It was then that I decided to run as new blood was needed for the council.

FV:
Many patients attend the hospital for multiple specialist outpatient appointments for various organ centric problems when a substantial number of the medical conditions could be managed by well-trained and accredited family physicians living near the patient's homes. Besides

I thought that instead of being a passive member, I can contribute more by running for the council. Together with my colleagues in the council, we hope to bring family medicine to greater heights.

– Dr Subramaniam Surajkumar

reducing such fragmentation of care, provision of care by our family physicians will helps to reduce costs and free up more appointments slots for more pressing problems requiring the expertise of our specialist colleagues.

The National Electronic Health Records (NEHR), real time access to laboratory results and hospital discharge summaries, with subsidised access to specialists in our hospitals and universal extension of the CHAS benefits to the community are positive steps forward.

Much progress has been achieved over the years to raise the standards of our MMed (FM) exams and Fellowship programme, hopefully to be on par with our specialist colleagues in their BST, AST and Residency programmes. By raising the standards of our training, it is our hope Family Medicine will one day be recognised in the Academy Medicine of Singapore (AMS), as in many developed countries. Recognition of the FCFP(S) as a start as an entrance qualification to the FAMS would result in ripple effect of more attracting more medical students and doctors keen to pursue advanced training in family medicine. We can certainly look forward to improving the care of our patients through consolidation of multiple medical problems and promoting research in the field of family medicine. These changes would make the discipline of family medicine in my view, more viable and further improve the standing of family medicine among our patients and society as a whole.

I thought that instead of being a passive member, I can contribute more by running for the council. Together with my colleagues in the council, we hope to bring family medicine to greater heights.

DT:
I decided to run for College Council to give more representation from the primary care sector in shaping some of College's decisions. I also hope to help to raise College's profile among the medical community (both the Primary Care and specialist).

LL:
My teaching and training duties in College allowed me the opportunity to impress upon the trainees and impart knowledge and skills to them. But that influence rarely extended beyond the confines of the training programmes. That was when I tried to see how else I could make a difference to the bigger community of family physicians outside the training boundaries. Serving time in College also gave me a glimpse of some of the pressing issues that our fraternity had to face.

The Family Physician Register was a positive move to improve the recognition for family physicians that went through the training programs and had a minimum duration of clinical experience. This Register helped patients to find the better trained family physicians for their continuing care.

(continued on the next page)

(continued from Page 19: Interview with the New Council Members on the Block)

However, there are still ways in which the criteria to qualify for the register can be improved. Eventually, it is my hope that the Register can become all-encompassing and recognise dedicated family physicians and community care physicians who work in a variety of practice settings in primary care, community hospitals and tertiary hospitals.

Family Medicine as a discipline has evolved over the years, and our training programmes, including GDFM, MMed and fellowship programmes have groomed many established family physicians who are leaders in their fields of work. With such clinical, teaching and leadership excellence, we wish to bring ourselves up to a level whereby we stand shoulder-to-shoulder with our fellow specialists and be able to discuss patients with complex medical issues with them, receive patients from them, continue care from them or even co-manage patients with them. This will be immensely beneficial for our patients and improve the standards of care that they receive.

Family Medicine as a discipline has evolved over the years, and our training programmes, including GDFM, MMed and fellowship programmes have groomed many established family physicians who are leaders in their fields of work.

~ Dr Low Sher Guan Luke

CM:
What are your other contributions to College?

SK:
I humbly took on the role of Honorary Assistant Treasurer, and I am still learning the ropes from more senior and experienced council members.

FV:
I have represented College for this year's MOH dengue committee work group and helped to chair and be a resource person for some of the GDFM/ MMed(FM) modules over the years. Plus I have been an examiner for the GDFM exams, and FCFP(S) clinical formative assessments.

DT:
I have taken on the portfolio of being the Course director for the 2013-2015 Fellowship Programme.

LL:
I've also taken on the portfolio of Editor for Editorial Team A of The College Mirror, and am coordinating for this publication as we speak. This is my maiden attempt, and I hope to get pointers on how we can make the publication better and how I can improve myself. A/Prof Lee Kheng Hock, Dr Tan Tze Lee, Dr See Toh Kwok Yee and the rest of my editorial team members have been very supportive thus far.

CM:
What is your hope for the College moving forward?

SK:
I want to be part of this new exciting period of change and evolution of family medicine in Singapore. There are many challenges ahead such as the aging population and the need for better trained FPs. I will help in any way I can, be it teaching the younger FPs or being part of the council, in meeting these challenges.

FV:
Enormous amount of effort and good work has been already made by the previous councils to engage our family physicians on the ground and solve the issues they are facing. We need to continue in this journey and advocate the needed changes, so that we can have better health outcomes for our patients and nation and as a whole.

DT:
It is my wish for College to be a leader in academia, research and advocacy for Family Medicine and Primary Care in Singapore.

LL:
My heart is with the teaching and training portfolio of the College. College must remain as the training centre of excellence for the family medicine fraternity, whereby the experienced fellows and members of College take on the roles of inspiring, mentoring and guiding aspiring general practitioners and family physicians to upgrade their knowledge and skills through many of the courses conducted by College, predominantly the GDFM, MMed (FM) and FCFP(S) programmes. Only when family physicians upgrade themselves and acquire higher level of skills necessary to achieve better continuity of care in a variety of settings such as primary care, community hospitals and tertiary hospitals, can we truly position ourselves better to cope with the increasing healthcare needs of the population and have a greater positive impact on the healthcare scene in Singapore.

■CM

I want to be part of this new exciting period of change and evolution of family medicine in Singapore. There are many challenges ahead such as the ageing population and the need for better trained FPs.

– Dr Subramaniam Surajkumar

NAVIGATING THE MEDICO-LEGAL MINEFIELDS IN PRIMARY CARE RISK MANAGEMENT IN GENERAL PRACTICE
— covering the bases

by Dr Lim Lee Kiang Julian, FCFP(S)

This is an excerpt of the lecture given on 28 September 2013 during the Primary Care Forum 2013 organized by the Primary Care Academy held at the Max Atria @ Singapore Expo. Reproduced here with permission.

Medico-legal minefields in primary care can potentially cause the physician to lose his/her reputation, finances and practice which he/she enjoys - if the mines should blow up. Because students of the law are taught that the patient can always sue - covering the bases requires the physician to practice defensive medicine. Risk management includes the ability to pay up in the event of a home run - a successful lawsuit against the physician. The basis of the doctor-patient relationship is trust. If there is trust, there will be no complaints. ***Defensive medicine erodes that trust. The conception of a lawsuit starts with the filing of a complaint – that is the first base.*** *The key to building that trust and preventing that first base complaint is professionalism - "Minding your Ps and Qs"; "Please & Thank You-s"; "Ps and Qs"; "Pints and Quarts"; "Professionalism, Ethics & the Curiosity called the Law"; "Pee and the Queue", "Pleds & Cues"; and finally, "Peas & Co-cumber".*

What I will do is go through the abstract and elaborate on a few points.

"Medico-legal minefields in primary care can potentially cause the physician to lose his/her reputation, finances and practice which he/she enjoys - if the mines should blow up."

Depending on the doctor, some would feel that the biggest lost would be to their reputation and others, their finances when hit with a lawsuit. Others - the joy of practice - losing their trust, believe and faith in people and the patients and worst of all, in themselves.

"Because students of the law are taught that the patient can always sue - covering the bases requires the physician to practice defensive medicine."

First, we would need to know the four stages of civil litigation using the game of baseball as an illustration. The first base would be the stage of complaint and pleading when the complaint is first lodged. The second would be discovery and deposition when both parties submit their side of the story. The third would be the summary judgment when the case would either be dismissed or proceed to the trial. The home base would be the trial proper and if the lawsuit is successful, monetary payment would have to be made to the complainant, the courts and the lawyer.

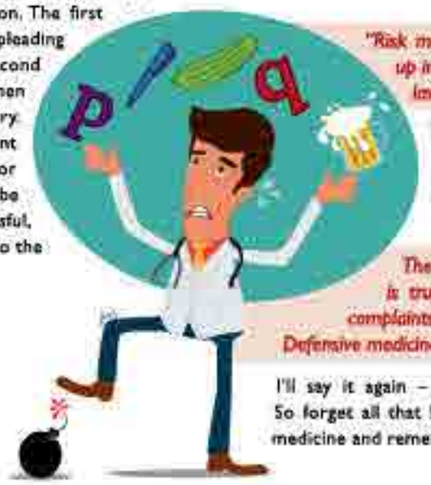
So how do we cover the bases?
We can practice defensive medicine by:

1. Taking more detailed notes
2. Giving more detailed explanations to patients
3. Doing more screening tests to exclude other conditions
4. Doing audits of our work processes
5. Doing consumer satisfaction activities like collecting patient feedback

The above five "defensive medicine" practices could be beneficial in a sense, but consider the following five.

1. Referring more patients away
2. Increasing the frequency of follow-up
3. Increasing diagnostic testing
4. Avoiding treatment of certain conditions
5. Prescribing unnecessary drugs

But does covering all the bases prevent a lawsuit? No. Take the example of a home run. This happens when the batter hits the ball beyond the boundary of the field and no amount of "covering" can prevent that home run.



"Risk management includes the ability to pay up in the event of a home run - a successful lawsuit against the physician."

That means the doctor has to set aside funds to cover this eventuality or purchase insurance to cover that. That is very droll and depressing isn't it?

The basis of the doctor-patient relationship is trust. If there is trust, there will be no complaints.
Defensive medicine erodes that trust.

I'll say it again – defensive medicine erodes that trust. So forget all that I mentioned previously about defensive medicine and remember this:

The conception of a lawsuit starts with the filing of a complaint – that is the first base.

The key to building that trust and preventing that first base complaint is professionalism.

So what do patients complain off?

1. Lack of courtesy
2. Treatment and medication errors
3. Over-charging
4. No medical certificates
5. Long waiting times
6. Poor communication

What is professionalism? The goal of the doctor-patient relationship is healing. The basis of the doctor-patient relationship is trust. Professionalism is the structure, upon which that trust is built.

Trust is key. Trust is all. It is as Prof Chris van Weel mentioned the day before of the about the importance of maintaining the relationship and working in and with time.

"Minding your Ps and Qs"

But if we "mind our 7 Ps and Qs", there is no need to cover any of the bases. Watch the video of a strikeout. This happens when the batter makes three strikes and the batter is out and leaves the field. He does not even get to first base.

So what are the "7 Ps and Qs"?

1 *"Please & Thank You-s"*

Courtesy and manners – self-explanatory.

2 *"Ps and Qs"*

This refers to the advice given to the type setters not to mistake the "p" and the "q" while type setting as they are mirror images and easily mistaken for each other. In practice, this means paying attention to details and be careful in not mistaking the left for the right; microgram and milligram; carbamazepine and carbimazole etc.

3 *"Pints and Quarts"*

This refers to the tallying done at the pub for charging purposes. Counting and charging. If a pint is served, charge for a pint. If a quart is served, charge for a quart – within ethical limits. Dr Andrew Lee Einer succinctly put it the day before: "Payment should be aligned with value" and "orientated to person, place and time."

4 *"Professionalism, Ethics & the Curiosity called the Law"*

As mentioned previously, professionalism is the structure upon which trust is built. This would encompass the way the clinic is furnished; the way the doctor and staff dresses; and the car the doctor drives.

With regards to ethics, it is a matter of balancing the four cardinal principles of autonomy against distributive justice; and beneficence against non-maleficence.

Law – just follow lor.

5 *"Pee and the Queue"*

Patients need to "pee", eat, sit and have something to occupy themselves and we should provide them. Managing a queue is a big topic but suffice to say, do make it a point to visit the Universal Studios and see how they manage their queues.

6 *"Pieds & Cues"*

This refers to dancing with a partner and minding each other's feet and taking each other's cue. The importance of non-verbal communication and an example would be how the doctor communicates with the pen in the doctor's hand like noting down the patient's concerns while maintaining eye contact; addressing their concerns by confidently scribing the prescription in a deliberate manner; dropping the pen when a sensitive issue is broached to give the patient the fullest attention; and signaling the conclusion of the consultation by signing off etc.

7 *"Peas & Cu-cumber"*

Cucumber as in the male genitalia. That's the best I can do to fit the mnemonic of the "Ps and Qs". Do not have sexual relationships with patients.

In conclusion, the secret to avoiding a lawsuit is not in defensive medicine, but is in avoiding the complaint in the first place.

■ LCM

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CHAMPIONING CHAS

by the Agency for Integrated Care (AIC)

Since its introduction in 2000, the Community Health Assist Scheme (CHAS) has enabled needy families and the disabled to treat their acute chronic ailments in an outpatient setting. From early 2012 onwards, enhancements to the scheme will include a lowered qualifying age of 40 and a raised income ceiling of $1,500 per capita household income. These enhancements will help a wider pool of patients manage their chronic conditions in the long run.

We speak to four general practitioners (GPs) who have been on CHAS since its early days. **Dr Kong Kum Leng** from Marine Parade Clinic, **Dr Pauline Neow** from Mei Ling Clinic in Queenstown, **Dr Goh Wei Leong** from Manhattan Medical Clinic in Chinatown, and **Dr Loong TW** from King Georges' Clinic in Lavender, let us in on why they support the enhancements to CHAS.

AIC: Why did you sign up for CHAS?

Dr Kong:
I wanted to do my part to relieve patient load at the polyclinics. I saw it as a chance for a private GP like myself to really focus on primary patient care.

Dr Goh:
I saw the potential of CHAS to help lower income families and the elderly in the community I serve.

AIC: How do your patients benefit from CHAS?

Dr Loong:
PCPS enables patients who qualify to seek medical treatment conveniently and at subsidised rates.

Dr Neow:
Patients with low incomes worry less about the cost of visiting a GP. Visiting a neighbourhood GP is also more accessible for the frail elderly. Another great aspect of the scheme is that I can refer patients on the scheme to Restructured Hospitals at subsidised rates.

AIC: Will the enhancements help more of your patients?

Dr Kong:
Patients in their 40s already form about 20% of my chronic patients. It is common for the diabetic ones to also suffer from high blood pressure and high cholesterol.

Dr Neow:
For those in their 40s, early detection of medical conditions enables them to continue to enjoy a reasonable lifestyle. My clinic sees quite a number of blue collared patients under 65 with chronic illnesses such as hypertension and high cholesterol. Most of them cannot afford to take time off work to wait at a polyclinic. Visiting a GP is more convenient because they can visit us after work, or on weekends, and even public holidays.

AIC: What would you like to tell other GPs about CHAS?

Dr Loong:
There might be a learning curve for the submission process for claims, but it is not too steep and definitely worthwhile for the benefit of the patients.

Dr Goh:
Your patients really do appreciate the money saved and the opportunity to carry on receiving treatment from one regular GP at a lower cost and greater convenience.

Dr Neow:
Signing up for CHAS is easy and the reimbursements are also paid promptly within the following month.

The Agency for Integrated Care will serve as the primary contact for GPs on all CHAS matters from 2012. For more information about how you can sign your clinic up for CHAS, log on to www.mediclaim.moh.gov.sg/mmae/pepsoverview.aspx.