



THE College Mirror

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A Publication of College of Family Physicians Singapore.

Convocation 2013 HIGHLIGHTS FROM THE SREENIVASAN ORATION 2013

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



Professor Richard Murray delivered the Sreenivasan Oration 2013 at the NUSS Kent Ridge Guild House on 23rd November 2013.

Our Sreenivasan orator this year was none other than Prof Richard Murray President of the Australian College of Rural and Remote Medicine. In his address he focused on Medical Generalism and his vision of the future of Family Medicine.

In Rural communities there is an urgent need for an expansive generalist role for Family physicians to provide comprehensive coordinated ambulatory care for individuals, families and communities. This extends to hospital inpatient care and emergencies, extended specialized skills and a systems and population health approach relevant to the community of practice.

Why is there a need for medical Generalism? The issues of affordability, safety and effectiveness comes to mind, unfortunately we can only choose 2 out of 3.

Affordability is always at the fore. However is there really a shortage of doctors? Doctor densities globally have been decreasing globally. The real issues confronting us are in fact the excessive



Professor Murray's address on the "Medical generalism & the future of Family Medicine".
Courtesy of Prof. Richard Murray's presentation slides

IN THIS ISSUE:

ONE YEAR there are at least... articles in medical

Who Am I?

Family physician the ambulatory care at the entry point approach... continue... and their quality to their... Generalist Intern... would... practice... system with



MRI of H Simpson

GENERALISM IN THE URBAN ENVIRONMENT | Pg 10



FAMILY MEDICINE CONVOCATION 2013 | Pg 12



FPSC: EMERGENCY MEDICINE | Pg 19

(continued on Page 3)

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EDITOR'S WORDS

by Dr See Toh Kwok Yee, MCFP(S), Editor

The Family Medicine Convocation Ceremony and Dinner is always one of the major events on our calendar.

This year's outing was no different as the College rolled out its best with distinguished VIPs and guests, exceptional award recipients and witty presenters in attendance.

The choice of venue at NUSS provided a cozy backdrop for renewing acquaintances and making new ones.

And as expected whenever Family Doctors met, the banter and camaraderie had flowed freely over a sumptuous dinner.

A/Prof. Lee Kheng Hock, the College President, had opened the evening in his usual endearing style by welcoming the graduands into the Family Medicine Fraternity.

He reminded these new members not to rest on their laurels but to continue to upgrade themselves to serve our patients better.

He also took the opportunity to encourage these younger colleagues to heed the call to serve in the college.

The Guest-of-Honour for this year's Convocation Ceremony was none other than Mrs. Tan Ching Yee, Permanent Secretary (Health), Ministry of Health.

She spoke about the family doctor as being the first-stop doctor and the regular-stop doctor in our healthcare delivery system.

Mrs. Tan, in her speech, had also familiarized the audience with some of the current schemes like CDMP and CHAS, the newly launched FMCs and CHCs and shared her thoughts about the "what's next?" for primary care.

Mrs. Tan would be looking forward to celebrate World Family Doctor Day next year with all of us!

The Sreenivasan Oration was delivered by Prof. Richard Murray, President of the Australian College of Rural and Remote Medicine who spoke about the need for Medical Generalism.

He had lamented the sad state of excessive subspecialisation and unequal geographical distribution of doctors which had resulted in the needed medical care not reaching the more rural areas.

In such circumstances, the Family Physician should be "working at the top of his license", stepping up to fill the gap.

He illustrated the point with the example of managing renal failure in rural Australia by GPs with extended skills in Nephrology supported by a distant Specialist Nephrologist.

The Recipient of The Albert and Mary Lim Award was Dr. Julian Lim Lee Kiang, a true friend of the college and a torchbearer of Family Medicine.

The evening also saw the college honouring its stalwarts with the Long Service Awards going to Dr. Jonathan Pang Sze Kang and Dr. Lim Fong Seng.

The Conferment Ceremony was presided by A/Prof. Tan Boon Yeow, Censor-in-Chief.

This year, there were a total of 72 GDFM graduands, 29 MMED (Family Medicine) graduands, 20 recipients of MCFP and 7 recipients of FCFP.

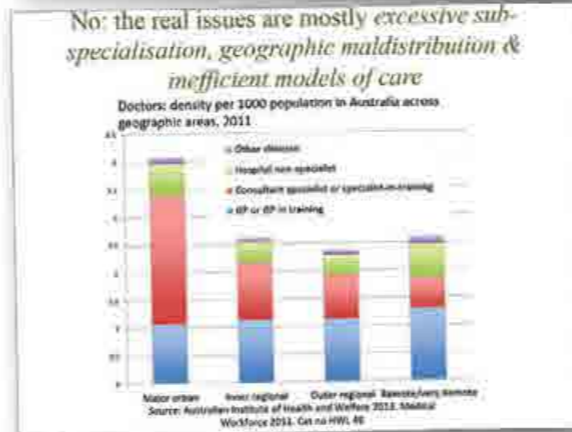
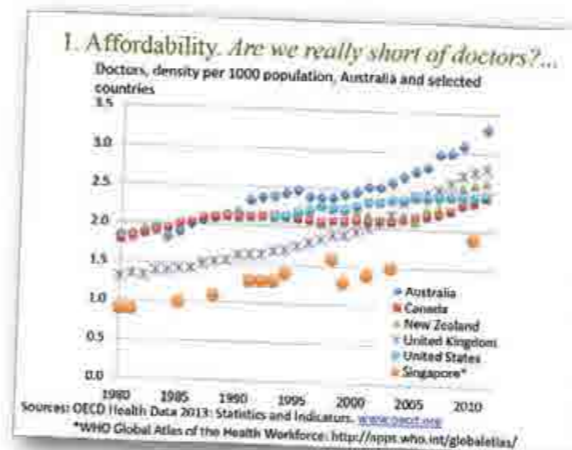
Prof. Tan, in closing, had shared with the audience the two inspiring inscriptions that adorned the Dexter Gate of Harvard Yard, which, on the outside read "Enter to grow in wisdom" and on the inside, "Depart to serve better thy country and thy kind."

It was truly an evening to remember!



COVER STORY

(continued from Cover page: Highlights from The Sreenivasan Oration 2013)



subspecialisation, geographic maldistribution, and inefficient models of care. Most specialist doctors in Australia are found in the major urban coastal cities, whereas the GPs are fairly well spread out in the nation, both rural and urban.

He also added that even though health expenditure had increased far above inflation over the past 10 years these increases were mostly accounted for by new improved and more services per individual rather than the result of population growth or the ageing population.

He touched on the need to radically change the systems to care to beyond the individuals' professional credentials and scope, and that the Family physician should be working at the top of his license. He gave the example of managing kidney failure in rural Australia. The numbers needing renal replacement is doubling in remote Australia every 5 years, and access to haemodialysis is a key issue. Metro service models based on Home HD" or major centre "satellite HD", with remote embedding "satellite" in a PHC context in remote centre, with training and support for "home HD". Home was often better in a local clinic, with a salaried health worker,

(continued on the next page)

Specialism, now a necessity, has fragmented the specialties themselves in a way that makes the outlook hazardous. The workers lose all sense of proportion in a maze of minutiae. Everywhere, men are in small coteries, intensely absorbed in subjects of deep interest, but of very limited scope... Applying themselves early to research, young men get into backwaters far from the main stream.

~ Sir William Osler

CONTENTS

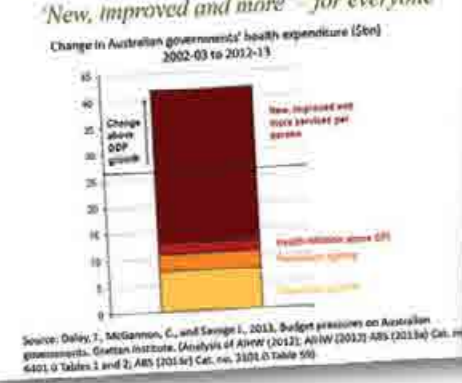
- 01 Cover Story: HIGHLIGHTS FROM THE SREENIVASAN ORATION 2013
- 02 Editor's Words
- 05 Event: CITATION FOR SREENIVASAN ORATOR 2013 - PROFESSOR RICHARD MURRAY
- 06 Event: ADDRESS BY GUEST-OF-HONOUR - MRS TAN CHING YEE
- 08 Event: CITATION FOR THE RECIPIENT OF DR ALBERT AND MARY LIM AWARD - DR JULIAN LIM LEE KIANG
- 10 President's Forum: GENERALISM IN THE URBAN ENVIRONMENT: THE OXYMORON OF THE SPECIALIST GENERALIST
- 12 Event: FAMILY MEDICINE CONVOCATION 2013
- 16 Photo Quiz: PHOTO QUIZ
- 17 Perspectives: THANK YOU
- 19 Event: FAMILY PRACTICE SKILLS COURSE (FPSC): EMERGENCY MEDICINE
- 20 Practice Tips: ANKLE SPRAINS REVISITED
- 22 Report: SINGAPORE FAMILY PHYSICIANS FACILITATE PRIMARY CARE RESEARCH WORKSHOP 2013 IN FIJI
- 23 Invited Article: CASE REPORT - PERSISTENT THROMBOCYTOSIS AND MANAGEMENT
- 24 Family Practice Skills Course #56: EMERGENCY MEDICINE (RE-RUN)

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(continued from Page 3: Highlights from The Sreenivasan Oration 2013)

And how much can we really afford to spend?
'New, improved and more' - for everyone



Source: Deloye, T., McGarmon, C., and Savage, L., 2013. Budget pressures on Australian governments. Grattan Institute. (Analysis of Aiewer (2013); ANHW (2012); ABS (2013a) Cat. no. 4401.0 Tables 1 and 2; ABS (2013a) Cat. no. 3304.0 Table 5B)

Features of a system of care



Eg: Tele-Derm



Dr Jim Muir
Tele Dermatologist
extraordinaire
ACRRM TeleDerm service
& educational resource

community nurse or lay helper. This would be complemented with medical oversight by GP nephrology with extended skills, and a delegated practice relationship with distant specialist nephrologist. Better outcomes were the order of the day and results were not inferior to those from major urban centres.

He highlighted the use of disruptive technologies to help rebalance generalism, such education at a distance, information at the bedside and breaking down the walls of medical care.

integrity and the provision of altruistic service to society.

He gave several examples of telemedicine at work, such as Dr Jim Muir Tele Dermatologist extraordinaire who provides the ACRRM TeleDerm service

"For the ideal of professionalism to survive, physicians must understand it and its role in the social contract. They must meet the obligations necessary to support professionalism and ensure that healthcare systems support, rather than subvert, behaviour that is compatible with

The features of a successful system of care are two-fold, first the Network of referral pathways, training, supervision, 'phone a friend', education, QA, advocacy for and with communities. And secondly the Culture of the system, which is patient centre, inter-reliant, cultivation of personal relationships, trust and respect.

You are in this business as a calling, not as a business; as a calling which exacts from you at every turn self-sacrifice, devotion, love and tenderness to your fellow men. Once you get down to a purely business level, your influence is gone and the true light of your life is dimmed.

~ Sir William Osler

We have to rethink questions about quality and safety. Volumes have poor correlation with outcomes and it would appear that team competence is as important as individual competence. A whole system planning is required, not just narrow facility focus. Accessibility acceptability is integral to quality and safety with generalism being preferred as opposed to organ-based care.

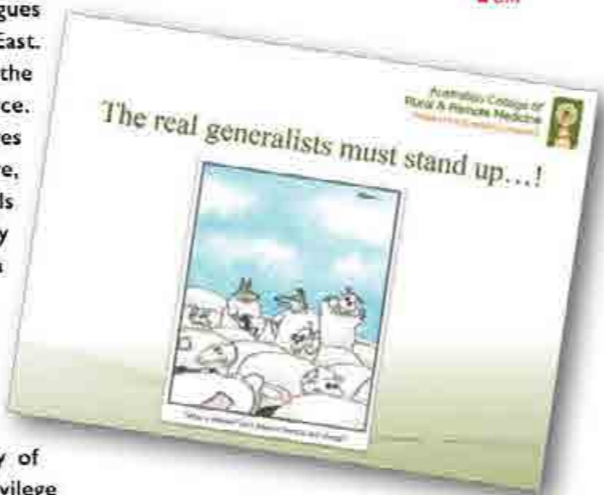
and education resource. Consultation was just an email away, even for colleagues serving in the military in the Middle East. Such telemedical consults is just the beginnings of an educational resource. In the rural setting, telemedicine gives communities access to consultant care, and allows for education and skills transfer and is wholly efficient in supporting a 'system of care'.

professionalism's values." Cruess R, Cruess R.

What that means is that family physicians should work at the 'top of licence', and be advocates of teamwork providing medical expertise in a broader team, and provide leadership in a person-centred generalist care across the patient care journey.

The generalists must standup!

CM



As medical practitioners, society grants us monopoly over the use of a body of knowledge and the privilege of self-regulation, whereas the profession in turn guarantees professional competence,

Implications of the social contract for Family Medicine

- **Value for money:** working at 'top-of-licence'
- **Teamwork:** medical expertise in a broader team
- **Leadership:** person-centred, generalist care across the patient journey

You are in this business as a calling, not as a business; as a calling which exacts from you at every turn self-sacrifice, devotion, love and tenderness to your fellow men. Once you get down to a purely business level, your influence is gone and the true light of your life is dimmed. Sir William Osler

Convocation 2013
CITATION FOR SREENIVASAN ORATOR 2013
-Professor Richard Murray

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



(top) Professor Richard Murray, the Sreenivasan Orator 2013, is presented with a token of appreciation from A/Prof Lee Kheng Hock (CFPS President).
(top left) A/Prof Lee Kheng Hock delivers the citation for Professor Richard Murray.
(right) Professor Richard Murray addressing the audience.

For those of you who know me, you will know that I am a shy and socially awkward person who don't make friends very easily. I am also by nature a very skeptical person. It takes a long time before I consider someone to be both a good friend and a respected intellectual. Generally it takes between 10 to 20 years. I have known Richard for about 4 years. I consider him an exceptional intellectual and a good friend. That should be good enough for you. You should take my word for it and we can proceed with the oration. Obviously some of you are as skeptical as me. So it seems that I have to proceed to introduce Richard in greater detail.

Richard spent 14 years working in the remote Kimberley region of Western Australia, including 12 years as the Medical Director of the Kimberley Aboriginal Medical Services Council, a position in which he had broad-ranging clinical, population health, teaching, research and medical administration and management roles.

In his role as an academic, Richard had received numerous grants and published prolifically in books and journals. His good work in medical education is widely recognized in Australia. He is the recipient of the Carrick Institute Awards for Australian University Teaching, Citation for Outstanding Contributions to Student Learning.

Richard Murray is the Dean of Medicine and Head of the School. Originally opened as the School of Medicine in February 2000, this was Australia's first new medical school in 25 years and the only medical school in northern Australia. It is a very innovative school that seeks to produce doctors who are responsive to the needs of their community. Richard's career is focused on Aboriginal health, rural medicine, public health, tropical medicine and the needs of underserved populations. In 2011, Richard was appointed as the President of the Australian College of Rural and Remote Medicine. He is the immediate past Chair of the Federation of Rural Australian Medical Educators.

For almost 2 decades, Richard has participated in shaping health policy in Australia and in particular Queensland especially in the area of advocacy for making healthcare more relevant to the needs of underserved populations especially in rural and remote areas.

Among friends and colleagues, Richard is best known as a passionate advocate for reform in medical education and training. He firmly believes that medical education should be relevant to the communities and the patients that the doctors serve. One pressing need to this aim is to restore the balance between generalism and specialization. I am confident that tonight's oration will bring some "eureka" moments to you. If you are not careful, he might even change your mind and affect how you see things. If you are a stubborn stick in the mud that likes to hold on to old ideas, this would be a good time to leave the room. You have been warned so listen carefully. Ladies and gentleman, I present to you Professor Richard Murray.

Richard's current work focus includes the establishment of the Institute for Health Care Research with Underserved Populations (IHCURP); marshalling the evidence and policy commitment for expanded regionally-based general specialist vocational training; expansion of the distributed regional academic and research network across northern Queensland and advocacy of medical workforce innovation including development of a Physician Assistant model.

CM

Convocation 2013

ADDRESS BY GUEST-OF-HONOUR -Mrs Tan Ching Yee

Delivered by Mrs Tan Ching Yee, Permanent Secretary (Health), Ministry of Health Singapore



Mrs Tan Ching Yee, Guest-of-Honour at the Family Medicine Convocation Ceremony & Dinner 2013

Prof Lee Kheng Hock, President CFPS
Members of the 24th CFPS Council,
Graduands of the Master of Medicine in Family Medicine
and Graduate Diploma of Family Medicine programmes
Colleagues, ladies and gentlemen

Introduction

1. I am pleased to be here today among the 2013 graduating class of Family Physicians. My heartiest congratulations to all graduands on reaching this important milestone. You now join the many seniors present today, as key pillars of the primary care community.

Primacy of Primary Care

2. I know I am preaching to the converted when I emphasise the primacy of primary care. There are two aspects to this.

3. First, the family doctor as our first-stop doctor. Our patients see us as their first port of call when encountering any medical or health issue. Second, the family doctor should be our regular stop doctor. A visit to the Emergency Department or an episode of inpatient admission should just be an acute intervention – a short period of intense intervention, followed by a return to our regular doctor for follow-up and monitoring. A specialist is someone who zooms in on a specific disease or organ, helps us to fix the problem, before we again return to the care of our regular family doctor.

The State of Primary Care

4. The state of primary care in Singapore is in pretty good shape. On average, Singaporeans make about four visits to our family doctors (in GP clinics or polyclinics) every year. The latest available National Health Surveillance Survey (2007) showed that close to 4 in 10 Singaporeans had a regular family doctor. The 2013 Survey is still in progress. In addition, a recent survey conducted by HPB this year showed that two thirds of those surveyed planned to see the same family doctor within the next 12 months. Singaporeans do understand the value of having a regular family doctor.

5. There has been increasing collaboration between the public and private sectors. The Chronic Disease Management Programme (CDMP) was introduced in 2006. The Community Health Assist Scheme (CHAS), previously known as the Primary Care Partnership Scheme, was started in 2000 (the change to CHAS was made in 2012), to make available subsidised care in GP and private dental clinics. These programmes have been expanded in breadth and depth: a total of 15 chronic diseases and virtually all acute conditions will be covered under CHAS from January 2014. The age floor for CHAS will also be lifted to make outpatient care more affordable for all Singaporeans from the lower and middle-income groups. Together, these changes will make it more convenient for more Singaporeans to seek care with their family doctor.

6. As part of the Primary Care Masterplan, the public sector institutions have partnered private doctors to pilot new models of care. New words have entered our vocabulary - Family Medicine Clinics (FMCs) and Community Health Centres (CHCs).

7. The three FMCs are in Lakeside, Clementi and Ang Mo Kio, and have been operational between 4-6 months. These clinics were set up through the collaborations of Jurong Health Services, National University Health System and the National Healthcare Group respectively with their primary care partners.

8. There will be three more FMCs planned for launch by early next year in Bedok, Serangoon and Chinatown. The Eastern Health Alliance, National Healthcare Group and SingHealth are working on the implementation and we look forward to them opening soon.

9. The three Community Health Centres are in Tampines, Bedok South and Jurong East, and will provide services such as diabetic eye and foot screening, nurse counselling, and other allied health and support services.

10. We are working with the Agency for Integrated Care and the Regional Health Systems to plan for a few more CHCs next year, and welcome family doctors to tap on the CHC as their clinic resource centre, which were designed to better support their management of patients with chronic conditions.



Mrs Tan Ching Yee addressing the audience at the NUSS Kent Ridge Guild House.

11. I would like to this opportunity to thank the primary care community for your active participation and support in the Haze Subsidy Scheme, which was rolled out in June this year to mitigate the impact the haze situation had on Singaporeans. More than 280 clinics indicated their support to the scheme within a day of implementation, and more than 600 clinics signed up within the week.

12. While much remains to be done, to borrow the words of a Family Physician, the Ministry of Health has 'turned the corner' in our efforts to engage our primary care partners. Trust takes time to build and can only continue to grow with goodwill, good faith and good intentions on both sides. The Ministry and our agencies will continue to work hard to win your trust and support. In turn, we hope that you will join our efforts to help Singaporeans lead healthy and disease-free lives.



A token of appreciation from Prof Lee Kheng Hock (CFPS President).

What Next?

13. While we are in pretty good shape, we should not be easily satisfied. It is not too early to ask "What next?"

14. In my eighteen months since joining MOH, I have had the good fortune to meet many of you and heard many suggestions and ideas on improving primary care. Let me play back a couple of the ideas my colleagues and I have heard. In so doing, I hope to stimulate more ideas and discussion about the many ideas thrown up.

15. First, on enrolment and capitation. Inspired by the experience in other countries, including in Australia, the National Health Service in the UK or the Accountable Care Organisations in the US, some have advocated for an enrolment or capitation model. In such a model, patients are enrolled with specific family doctors who are then paid a fixed sum for each enrollee.

16. We are mindful that the local context is different from that in Australia or the UK. Many Singaporeans want option and choice, to visit any clinic or to check out GP clinics and polyclinics in turn. Even if we do not want to take away choice, how do we better encourage as many people as possible to build a sustained relationship with their family doctor? Are there impediments to individuals seeking care at their GP?

17. Second, on capabilities. I have been told that some patients refuse to return to their GPs for follow-up because they have become too fond of their "black-tag" big doctor, aka the specialist in the hospital. Equally, some specialists are concerned if their patients will receive the appropriate care after being discharged. And for good measure, some GPs have made it clear that they prefer not to see such patients with chronic conditions, especially if the conditions are not under control.

18. We can engage in mutual finger pointing on where the problem is, or we can tease out what the underlying concerns might be. Might it be a question of capability development or stronger clinical partnership between hospital and primary care partner?

19. On this score, we have done well in helping our family doctors raise capabilities. Today, about 60% of primary care physicians are

already on the Register of Family Physicians. I applaud the good work of the College in this and also wish to recognise the leadership of my colleagues, Prof K Satku, Director of Medical Services.

20. We hope to increase training opportunities over time, so that more of our new doctors can choose Family Medicine and become Family Physicians. Our Regional Health Systems and acute institutions have in place GP partnership programmes, to jointly care for patients.

World Family Doctor Day

21. I understand that World Family Doctor Day falls on 19 May 2014. This is a good time for MOH, the Health Promotion Board and the College of Family Physicians Singapore to come together to raise the public profile of family physicians. I welcome your suggestions and ideas of meaningful projects and activities we can jointly organise.

Conclusion

22. Let me once again offer my heartiest congratulations to each and every one of the graduands. I wish you success and a fulfilling career.

23. Thank you.

COLLEGE OF FAMILY PHYSICIANS SINGAPORE
CONGRATULATES

Dr Alfred Loh

Recipient of The Fellowship of WONCA 2013, in Prague

Ms Yvonne Chung & Ms Gillian Tan

Recipients of WONCA Honorary Life Direct Membership 2013

Convocation 2013

CITATION FOR THE RECIPIENT OF DR ALBERT AND MARY LIM AWARD -Dr Julian Lim Lee Kiang

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



(top) A/Prof Lee Kheng Hock (CFPS President) presents Dr Julian Lim with the Dr Albert and Mary Lim Award.
(right) Dr Tan Tze Lee delivers the citation for Dr Julian Lim

It is my great pleasure and privilege to deliver the citation for the 2013 Dr Albert & Mary Lim award for Dr Julian Lim Lee Kiang. This highest accolade is awarded for contribution and services rendered to the College and to the discipline of Family Medicine.

For the benefit of many in our audience who may not be familiar with Dr Albert and Mary Lim, I shall tell a story of an incredible medical family whose influence on the course of medicine in Singapore over the past century to this date has been profound.

Dr Albert Lim was born in 1890, went to school at George Watson's School in Edinburgh, and went on to read medicine at the University of Edinburgh. Together with his brother Harold, they distinguished themselves during the Spanish Flu pandemic in 1919, before returning to Singapore where they started in private practice.

He was affectionately called by his patients "Tua Lim" or Big Lim as opposed to Harold, "Sueh Lim" [Little Lim] even though Harold was a good head taller than him. We have



our very own Tua Lim with us tonight, and that is none other than our beloved Julian.

Dr Julian Lim graduated with Bachelor of Medicine, Bachelor of Surgery (MBBS) from National University of Singapore (NUS) in 1988.

Julian was born premature in the old Kandang Kerbau Hospital on 29 December 1964 the first son of a teacher and a housewife.

Julian attended Paya Lebar Primary School initially and thereafter Swiss Cottage Primary School in Primary 4. Whilst at Anglo-Chinese School (ACS) and

thereafter Anglo-Chinese Junior College (ACJC), although his love for flying and aircraft culminated in him being selected to be the Singapore representative to the International Air Cadet Exchange programme in Hong Kong in 1981, his burden for the needs of the less fortunate led him to become involved and subsequently elected the secretary of the Social Service Club in ACJC.

Whilst reading Medicine at NUS, his leadership qualities led him to be Chairman of the Freshman Orientation Committee in 1985.

This leadership streak followed him into mandatory National military Service where in the 33rd Medical Officer Cadet Course, Julian was awarded the Sword-of-Honour for being the best trainee.

He joined the Family Medicine Traineeship Programme in 1991 but left the Ministry of Health in November 1993, six months before completing his training so as to support his family as his wife had to stop work suddenly to look after their intellectually-challenged son. Julian has been running a successful solo practice in Teban Gardens for many years.

Not one who lets adversity press him down, even his early years in general practice, he found the time to prepare for the Master of Medicine (Family Medicine) diploma as a private candidate. A/P Dr Cheong Pak Yean had then just started lunch time sessions in his clinic when he first took in Family Medicine trainees during their private clinic posting. Through this informal sessions, he pursued and was successful during the Master of Medicine (Family Medicine) examination in 1995. His dedication was such that whilst his devoted wife Choy Leng was in labour with their 3rd child, Julian was labouring equally hard printing out the entire copy of the practice profile and case commentaries in the labour ward.

(continued on the next page)

So we must also thank Choy Leng for all the support she's given Julian all these years!

Three years later, he was in the pioneer batch of family physicians to undergo the College of Family Physicians Singapore's fellowship programme by assessment; this he successfully completed in 2000.

After obtaining the Masters, Julian continued to help organise sessions for other doctors to prepare for the Master of Medicine examination as private candidates after leaving the Ministry of Health. These sessions subsequently became the officially recognised tutorial sessions for post-graduate doctors who matriculated with the Graduate School of Medical Studies in the private practitioners' stream of the Master of Medicine (Family Medicine) training program.

In addition to his involvement in the Master of Medicine (MMed) programme, he has been heavily involved in the development and running of the Graduate Diploma Family Medicine (GDFM) programme from its inception. Many of the GDFM trainees will remember his articulate and amusing lectures.

Despite his already heavy commitments, Julian continues to be heavily involved in medical student teaching, and mentors the NUS Yong Loo Lin School of Medicine, Duke-NUS and James Cook students.

Julian had published an original paper in the SMJ on Portfolio-based Learning which he co-authored with Dr Cheong. He has also contributed articles to the Singapore Medical Association (SMA) News and Asian Medical News. He has held several posts in the medical profession and continues to be active in them, including:

- Member, Family Physician Accreditation Board 2010 to current.
- Member, Training Coordination Committee JCFMT 2007 to 2010.
- Member, Training Coordination Committee FMAC 2010 to 2013.
- Member, Residency Advisory Committee Family Medicine 2010 to current.
- Interview Panel, FMRAC 2010 to 2013.

The College is privileged and pleased to award Dr Julian Lim Lee Kiang the 2013 Albert Lim and Mary Lim Award for his contribution to the College of Family Physicians and Family Medicine in Singapore.

CM

FAMILY PRACTICE SKILLS COURSE

Emergency Medicine

The College of Family Physicians Singapore would like to thank **Health Promotion Board, Ministry of Health** and the Expert Panel for their contribution to the Family Practice Skills Course #55 on "Emergency Medicine", held on 5 – 6 October 2013.

Expert Panel:

LTC (Dr) Ng Yih Yng
A/Prof Malcolm Mahadevan
Prof V. Anantharaman
A/Prof Mark Leong
Dr Kenneth Heng
Dr Jade Kua
Dr Kurugulasigamoney Gunasegaran
APN Patsy Chiang
SNM Lee Chin Hian
Cl Lim Choon Chai
NC Zainab Binte Amat
A/Prof Ng Kee Chong
Dr Quek Lit Sin
A/Prof Lee Kheng Hock

Chairpersons:

Dr Ng Joo Ming Matthew
A/Prof Lee Kheng Hock



Bright Vision Hospital is a 302 bed community hospital under SingHealth which is the largest health care group in Singapore. Clinical services are supported by Singapore General Hospital. We offer comprehensive and holistic care to patients after their discharge from acute hospital with services ranging from rehabilitative care, palliative care, chronic sick care, sub acute care and nursing home care.

The successful candidate can expect an attractive remuneration package, which includes annual vacation and conference leave, medical/hospitalisation benefits and comprehensive insurance scheme. Training and supervision to familiarize candidates to the community hospital practice setting will be provided. There will be opportunities for advanced training for professional development through Singapore General Hospital and SingHealth.

Resident Physician/Registrar/Associate Consultant/Consultant Responsibilities

Provide general medical care to patients of the hospital under the supervision of the Medical Director and Head of Medical Services.

Requirements Resident Physician

A recognized basic medical qualification or equivalent, registrable with the Singapore Medical Council.

Registrar

A recognised basic medical degree and post-graduate qualification such as MMed, MRCP or equivalent which is registrable with the Singapore Medical Council and minimum 3 years' experience as Medical Officer (post-housemanship).

Associate Consultant/Consultant

In addition to the above, applicants must have the FCFP or equivalent qualifications certifying completion of advanced family medicine or relevant specialist training in Internal Medicine, Geriatric Medicine, Rehabilitation Medicine or Palliative Medicine.

Please write or email with a detailed resume to:

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GENERALISM IN THE URBAN ENVIRONMENT: THE OXYMORON OF THE SPECIALIST GENERALIST

Plenary lecture delivered by A/Prof Lee Kheng Hock (President, 24th Council, College of Family Physicians Singapore) at the World Summit on Rural Generalist Medicine on the 30th of October at Cairns, Australia

INTRODUCTION

I bring greetings from my colleagues in Singapore.

I have a disclaimer and a confession to make – I am not the rural generalist. But I am remotely rural, because I really sympathized with what that had been said. That sympathy comes deep inside because I am a generalist. And I think that as 'generalist' – whether you are in the urban environment or in the rural environment – we have all been neglected by the tide of the specialization. And if anything, I think rural medicine could be the last bastion of generalism and hopefully, you guys might even help us turn the tide against this rampant specialization.

I am going to start by giving you a perspective of what family medicine was and will become in the future. To begin, let's consider if it is even possible to be a 'generalist' today?

COMPLEXITY OF MEDICINE TODAY

Is it Possible to be a Generalist Today?

- IN ONE YEAR there are at least.....
- 900,000 articles in medical journals
 - 10,000 randomised control trials
 - 4,000 clinical practice guidelines
 - 150 disease management programmes



MRI of H Simpson.

[Slide: In one year it is estimated that there are at least 900,000 new articles in medical journals, 10,000 randomized control trials, 4000 clinical practice guidelines and 150 disease management programs.]

I think the young doctors in medical school now are really frightened if you tell them, "You should be a generalist; you should go to the rural areas and practice medicine". They are truly frightened because medicine has advanced so fast and

so quickly. And most of us – at least for me – who is just slightly more intelligent than Homer Simpson, do not expect myself to be able to cope with so much information and acquire so many competencies in such a short time. Three years? Four years? Five years? Even ten years may not be enough. So are we really putting too much on to the plate of our young doctors; and expecting them to do miracles – to be this heroic doctor who would go forth and save the world?

All doctors started out as "General Practitioners" and that is how doctoring all began. Sometime along the way, and long ago people wanted a good work-life balance too. They want to practice where the grass is green and the water is clean; and where people are willing to pay a lot for your services.

In those days, they have self-proclaimed specialists who professed to have special abilities in treating things like syphilis, eruption, pimples and so on. And that trend actually started when Medicine first began; and so it is nothing new. We cannot blame this on the Gen Y phenomenon.

So what really makes it into what it is today is the rise of medico-political organizations. That is the beginning of all these 'politics' that we talked about – people trying to define and build turfs and silos. The American Medical Association was one of the earlier medical-political organizations. Then came the Flexner Report that says that medical schools should focus

on science. Then very quickly, people were thinking that if there are different areas of science, shouldn't we therefore, define a special way of training such doctors and devise special exams for them? And that is how specialization started in earnest.

Even today as we try to define "Generalists", we are still using the same method of the specialists to define ourselves; which is why we constantly run into trouble. In 1933, the Advisory Board of Medical Specialties started in America and the tide of specialization soon became a global phenomenon.

FAMILY MEDICINE AS COUNTER CULTURE TO SPECIALIZATION

Specialties after specialties kept coming up and eventually sometime around 1969, the term 'Family Practice' and the specialty of Family Medicine was started. That really epitomizes what 'Generalism' is really all about. Why in 1969? Possibly because that was the time when people were more self-reflective; some became hippies and they started thinking there was more to life than just making money.

The main reason was the push-back from the people, who asked where is my doctor whom I used to know. There was this counter-culture movement that started in the 1960s. And really, it is a grass root movement. The people said, "Specialization is great, but what happened to the good of family doctor that I used to have? Where is he now?" So it is in this context that Family Medicine started. And if you trace back to all the colleges of Family Medicine and all the academies of Family Medicine, most of them started in the late 60s and the early 70s. My College for example, in Singapore, started in 1971.

So we are part of this counter-culture to gain back what had been lost in Medicine. There are many thinkers in family medicine in the early days and many of them were in the US. One of them Dr. John Geyman made this very important point. He said that it is quite futile to try to define ourselves based on what is unique about 'Family Medicine'.

We are generalists – we can't use the specialists yardstick to measure ourselves.

Identity Crisis of Family Medicine

"In the early years of family-practice development, considerable attention was paid to the conceptual definition of its academic discipline. There was some focus primarily on its unique content as different from all other clinical disciplines blurred the debate for a time."



John Geyman, MD

It is difficult – even impossible – to define with precision the distinguishable body of knowledge in any broad clinical specialty such as family practice, internal medicine... Family practice... incorporates in a particular way portions of all other clinical disciplines...."

Geyman J.P. Family practice in evolution. Progress, problems and projections. NEJM 1978. Vol 298, No 11. 593-601.

[Slide: "In the early years of family practice development, considerable attention was paid to the conceptual definition of its academic discipline. There was some focus primarily on its unique content as different from all other clinical disciplines blurred the debate for a time. It is difficult – even impossible – to define with precision the distinguishable body of knowledge in any broad clinical specialty such as family practice, internal medicine... Family practice... incorporates in a particular way portions of all other clinical disciplines...." Geyman J.P. Family practice in evolution. Progress, problems and projections. NEJM 1978. Vol 298, No 11. 593-601.]

It is impossible to define Family Medicine using the principles that define specialties. We then began to further confuse ourselves. Dr G. Gayle Stevens – another very prominent thinker – concluded that we had squandered public credibility. The Americans invented the term 'Family Medicine' so as to distinguish ourselves as a specialty from General Practice. On hindsight, many felt that it was a mistake because it confuses rather than clarifies what we are trying to do.

In the late 70s and early 80s, commercialization of medicine happened in a big way – health management organizations emerged

Confusing Ourselves

"On balance, I judge that we have squandered some public credibility in our evolution despite our success in having created a specialty. We probably confused the public early on when we changed our name from General Practice to Family Practice, and we confused ourselves in drawing finer distinctions with the addition of Family Medicine, Community Medicine and Primary Care. We all know the reasons for these changes, but they held no interest for the public, conveyed no weight of meaning, and sometimes allowed us to mistake the cart for the horse... We took a hit to our public credibility when we were suckered into 'gatekeeping' by managed care organizations..."



G. Gayle Stevens, MD, during his tenure as chair of the Family Practice Department at the University of Alabama, Birmingham, from 1974 to 1982

Stevens GG. Family practice and social and political change. In: Keystone III: the role of family practice in a changing health care environment: a dialogue. Washington, DC: Robert Graham Center, 2001:230-3.

[Slide: "On balance, I judge that we have squandered some public credibility in our evolution despite our success in having created a specialty. We probably confused the public early on when we changed our name from General Practice to Family Practice, and we confused ourselves in drawing finer distinctions with the addition of Family Medicine, Community Medicine and Primary Care. We all know the reasons for these changes, but they held no interest for the public, conveyed no weight of meaning, and sometimes allowed us to mistake the cart for the horse... We took a hit to our public credibility when we were suckered into 'gatekeeping' by managed care organizations..." Stevens GG. Family practice and social and political change. In: Keystone III: the role of family practice in a changing health care environment: a dialogue. Washington, DC: Robert Graham Center, 2001:230-3.]

and health economists started tinkering with the system. They thought to themselves, "A-hah, let's get the family physicians to become gatekeepers; just triage doctors who can control utilization and when necessary, quickly and efficiently send the patients along the way to the specialists." However they were proven wrong because this resulted in the further acceleration of specialization and hospital centric care due to the de-skilling of primary care.

In the process, the generalist nature of family medicine was further eroded. The use of family physicians as specialized 'postman' was a terrible waste of well-trained generalists. They were denied the opportunity to use their valuable skills to deliver actual care to the patients.

There are other thinkers who felt that we compromised our competency. We should not sharply divide medicine into community-based and

hospital-based care, and develop two silos and create this great Chinese wall between these two settings. Patients need to move between the hospitals and the community. Such a mindset jeopardizes the quality of care and we further depersonalize care – and the patient becomes part of this factory process where he goes from one point of assembly to the next and then becomes a finished product. This kind of "industrialized thinking" actually harmed Medicine in a big way.

This point has troubled many other thinkers of Family Medicine as well. One such thinker was Prof. McWhinney. He said that one of the greatest objection to the idea of the family doctor is that, one physician cannot effectively master all. And he calls this the 'Lump Fallacy'. In this false theory, knowledge of medicine is actually a lump; and it gets bigger and bigger, and then after which you have to divide it into small bits and feed the little people so that they can carry on. What he is saying, is that a reductionist approach to solving complex problems does not work. In such a situation, what we need to do is to go back to 'Generalism'.

Who Am I?

"Some had proposed that the future family physician confine his... practice... exclusively to the ambulatory care setting while serving in a triage role as the entry point to the health care system. Such an approach... would in the long run compromise the continued clinical competence of these physicians and their ability to provide primary care of high quality to their patients. The sharp separation of medical careers into community-oriented... and hospital-based... would involve serious problems for both medical practice and medical education. The creation of a system with built in discontinuity between ambulatory and hospital patient care could be expected to jeopardize the quality of care... and depersonalize care further."



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If we define Medicine or Family Medicine by lumps, and we cut bits and pieces off saying 'this is not Family Medicine; someone else specialized should do this – maybe a GPwSI or maybe a sub-specialist', then at the end, what is left? And when do we cease to become effective doctors, or even doctors at all?

We pondered on this in our College. In 2011, we decided that we should not play by their rules and let others define us – we should define ourselves. And we define ourselves by thinking back to the old days; we realized and reaffirmed that Family Medicine is a generalist discipline – with all the ethos and values of the Generalist. We are the largest spool of generalists in

(continued on Page 14)

FAMILY MEDICINE CONVOCATION 2013

23 NOVEMBER 2013 (SATURDAY) • NUSS KENT RIDGE GUILD HOUSE

24th Council (2013 - 2015), College of Family Physicians Singapore

Standing (left to right):

Dr Farhad Fakhruddin Vasanwala, Dr Tan Ngiap Chuan (Honorary Editor), Dr Ng Lee Beng, Dr Low Sher Guan Luke, Dr Yee Jenn Jet Michael, Dr Leong Choon Kit, Dr Eng Soo Kiang, Dr Ng Chee Lian Lawrence (Honorary Assistant Secretary), Dr Subramaniam Surajkumar (Honorary Assistant Treasurer)

Seated (left to right):

Dr Lim Fong Seng (Honorary Treasurer), Dr Tan Tze Lee (Honorary Secretary), Dr Tham Tat Yean (Vice President), Mrs Tan Ching Yee (Guest-of-Honour, Permanent Secretary (Health), Ministry of Health), A/Prof Lee Kheng Hock (President), A/Prof Tan Boon Yeow (Censor-in-Chief), Dr Pang Sze Kang Jonathan

Not in photo:

Dr Tan Hsien Yung David



Long Service Award



Recipients of the Long Service Award 2013
Dr Lim Fong Seng (extreme left) and Dr Pang Sze Kang Jonathan (left)

Fellowship Programme [FCFP(S)] & Collegiate Membership [MCFP(S)]



FCFP(S) Recipients

Standing (left to right):

Dr Subramaniam Surajkumar, Dr Eng Soo Kiang, Dr Low Sher Guan Luke, Dr Chang Ngai Kin Christopher, Dr Yeo Cheng Hsun Jonathan

Seated (left to right):

Dr Tan Yee Leng, Dr Tham Tat Yean (Vice President), A/Prof Lee Kheng Hock (President), A/Prof Tan Boon Yeow (Censor-in-Chief)

MCFP(S) Recipients

Standing (left to right):

Dr Kaot David, Dr Koh Kim Hwee, Dr Lim Chi-Kien Derek, Dr Phua Mei Fang, Dr Koong Ying Leng Agnes, Dr Anandan Gerard Thiagarajah, Dr Tan Puay Wee Steve, Dr Low Lian Leng, Dr Lee Kwang How, Dr Ong Luan Seng Desmond, Dr Ng Wei Liang David, Dr Lim Ang Tee

Seated (left to right):

Dr Wang Zhion Sinead, Dr Koh Mei Lin Jocelyn, Dr Chua Hwee Ling Angelia, Dr Tham Tat Yean (Vice President), A/Prof Lee Kheng Hock (President), A/Prof Tan Boon Yeow (Censor-in-Chief), Dr Lee Ai Ming Audrey, Dr Chung Wei Pyng Clara, Dr Peh Tan Ying

MORE PHOTOS FROM THE EVENT



Graduands of Master of Medicine (Family Medicine) [MMed(FM)] & Graduate Diploma in Family Medicine (GDFM)



MMed(FM) Graduands Year 2013

Standing (left to right):

Dr Ramasamy Jagannathan Raja, Dr Rufus Daniel, Dr Wong Wei Mon, Dr Tan Wee Hian, Dr Tan Chee Wei, Dr Kong Jing Wen

Seated (left to right):

Dr Teo Hui Ying Valerie*, Dr Tham Tat Yean (Vice President), A/Prof Lee Kheng Hock (President), A/Prof Tan Boon Yeow (Censor-in-Chief), Dr Tan Eng Chun

* MMed(FM) Gold Medallist - Dr Teo Hui Ying Valerie

GDFM Graduands Year 2013

Standing (left to right):

Dr Wan Wei Hwang, Dr Zeng Shiyong, Dr Ang Teng Soon, Dr Lin Xiu Min, Dr Xu Bangyu, Dr Yeo Kwang Chong Christopher, Dr Zai Qiaojian Justinian, Dr Tey Inn Kuang, Dr Tan Aik Lim Calvin, Dr Tan Wee Kiat

Seated (left to right):

Dr Bagasol Jonna Charisma Agbayani, Dr Cordez Sherry Hugo, Dr Tham Tat Yean (Vice President), A/Prof Lee Kheng Hock (President), A/Prof Tan Boon Yeow (Censor-in-Chief), Dr Foong Yee Wah, Dr Cheak Wan Ying

(continued from Page 1 | Generalism in the Urban Environment: The Oxymoron of the Specialist Generalist)

Defining Family Medicine

"One of the greatest objection to the idea of the family doctor...one physician cannot effectively master the whole field of medicine. The root of this objection is a concept of medical knowledge that I hold fallacious. I call it the 'lump fallacy'."



Professor Ian R McWhinney
Source: <http://www.oum.ca/fammediation/oum.htm>

McWhinney IR. Family medicine in perspective. NEJM 293:176-181 (July 24), 1975

[Slide: "One of the greatest objection to the idea of the family doctor... one physician cannot effectively master the whole field of medicine. The root of this objection is a concept of medical knowledge that I hold fallacious. I call it the 'lump fallacy'." McWhinney IR. Family medicine in perspective. NEJM 293:176-181 (July 24), 1975]

the system, and we are the one who is able to practice medicine in the context of the person, the family and the community. In our College, we feel that Family Medicine is one discipline but our people who are very well-trained generalists, practice across many settings. In Singapore, it is largely in the cities but even within the cities, you will find different populations and communities of patients with different needs.

We will confuse ourselves if we keep asking "What am I? Who am I? How should I study? How should I train?" But it becomes very clear, if you think from the patients' point of view and the community's point of view – What kind of training do we need to make us effective doctors for this particular community of people that we are trying to serve in a particular setting. And if you think along this line and become less doctor-centric in our own definition of ourselves and our training, then you will find that things become very clear and all these political squabbles in the medical profession become unimportant.

THE EFFECTIVENESS OF THE SINGAPORE HEALTHCARE SYSTEM

Coming back to Singapore, we are a city-state, a small island of 710km². That is only slightly bigger than the whole city limits of Cairns; about 1.5 times bigger. And I just learnt from the Internet that in Cairns, the population density is 309 persons per sq km. In Singapore, we have 7540 persons for every sq km. But it is not as bad as it seems because if you have visited Singapore, you will see that we had planned our city very

well. And if that is anything good about being small it is that you have to really plan well, because there is very little margin for error.

Likewise, we are putting all our top brains together to figure out what is the best healthcare system that we should have for the future. I am going to tell you the challenges that we face as a city that is rapidly aging, if you think that the rural setting is bad or rural medicine is under threat, then really the poor people living in the cities are in the worst state.

We have very few doctors – we have only 19 doctors for every 10,000 persons. According to Australia's Bureau of Statistics, you have about 32 doctors per 10,000 population. We have less nurses – about half of what you have – we have 64 per 10,000, compared to yours (Australia) which is about 120 per 10,000. But we have a lot of mobile phones. We have more mobile phones than we have people – our mobile phone penetration rate is 151; everyone has one-and-a-half mobile phone. But how much do we spend on healthcare? For Singapore we spend 4.6% of our GDP on healthcare, which is not too bad. Australia spends about 9%, about double of what Singapore spends. And of course US leads the world in everything, spending 17.9% of their GDP on health.

But is that all there is to it? What does the Government spend? That 4.6% of GDP that is spent by Singapore is the total spending by the whole country; our Government's share is only 1.4% – quite incredible if you look at the healthcare services that we have in Singapore. You may think that Singapore is probably not such a good place to be in when you fall sick. On the contrary, it is not so. So how do we do it? We are really good at organizing ourselves effectively, as I have said earlier. If you look at efficiency, we

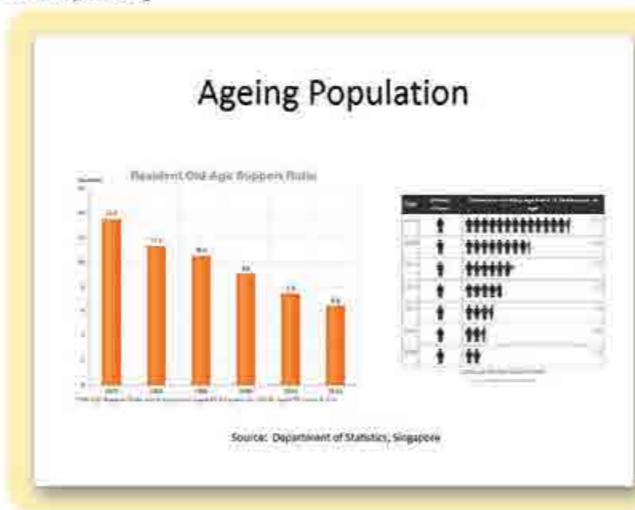
are extremely efficient – everything in Singapore is about achieving maximum efficiency.

According to the Bloomberg's ranking system – weighted to three parameters: life expectancy, GDP spending and the absolute dollars spent on the people in healthcare – Singapore is second in the world in terms of efficiency. But is efficiency everything? What if you are efficient but the people are not served justly? How fair are we as a healthcare system?

The World Health Organization ranks how good the healthcare system is based on fairness – the quality that you have; and how fairly you distribute this quality to the people that you serve. And I am quite proud to say that Singapore – for spending just 1.4% GDP worth of taxpayers' money achieved ranking of No. 6. Australia is not too bad either, at No. 9.

PROBLEMS AHEAD FOR SINGAPORE

But all is not well, as I have said. Our population is aging very rapidly and we have the fastest aging population in the world. The Old-Age Support ratio is the number of people in the productive age group (age 20 – 64) in proportion to the people who should be retired and enjoying the good life when they are older than 65. This ratio tells us that in the coming years, we will have less and less young people supporting the elderly and this a very worrying trend, because by 2030, we expect a ratio of only 2:1. Even if we are willing to spend beyond 1.4% of GDP, how are we going to be able to support such a healthcare system with so working adults?



We know that with aging, the needs increases. We anticipate that in 20 years' time, our dementia prevalence will increase by 188%! In addition, there will be so much more hip fractures. Diabetes prevalence is going to skyrocket and complications of chronic diseases are going to be a real burden on the healthcare system. We are already beginning to see the trend of this increased consumption of healthcare resources – emergency hospital attendances are climbing. Just within 2 years, we had an increase of 14.7%. Admissions to hospitals are also increasing rapidly.

Specialist Outpatient Clinics (SOC) – where patients go for Specialist Outpatient care – the percentage of patients with more than 4 Specialist Outpatient specialties that care for them is 13.3%! They go from one specialist to another because there is not enough Generalist. Looking at all these, it became very clear to our policy-planners – that the hospital-centric / specialist-centric way of managing healthcare is not sustainable. Even in the big city – with all the wealth and resources – it is not sustainable. Because patients move – from the primary care, to the acute care, to rehab care, etc. Where do we develop or find such a generalist who can take care of this kind of patient in this kind of community and in this kind of setting?

This problem was posed to Singapore General Hospital (SGH) campus which has the ambition to become the leading regional academic medical center. As a tertiary hospital the problem of fragmentation and specialization was really at its worst. SGH is the biggest and the busiest – with 84,000 inpatient discharges every year; 1.2 million outpatient visits every year with 36 different clinical specialties. We have with more than 10,000 staff. In the earlier days, our mission was that we see ourselves as the hospital that will scour the world; learn the latest and the best in Medicine and bring it to our country. We send our specialists all round the world to the best centres to learn and to come back to teach ourselves. This was perceived to be the mission of our hospital. What we then realized is that things cannot go on like this because the sheer weight of complex care would bring down the system.

DEVELOPING NEW MODELS OF CARE

Back in 2006, we started exploring for solution to this problem that is looming ahead. We visited centres around the world. The leadership of the hospitals concluded that the solution lies in Generalism – we need good Generalists. Who would be the best generalists in the country? The Internists came quite close, but really, we need a Generalist who is very in touch with the community; one who look outwards into the community rather than look inwards to the high dependency units and the intensive care units. We then thought we should look for a group of family physicians, create this new model and then experiment with it.

And in 2006, we started the first Family Medicine Unit that is based in a hospital – a commonplace event in some other countries but completely new to Singapore. We tried out the experiment – created a 34-bed unit; put Family Medicine Generalists to be in charge of this place, and treat them just like any other general physicians in a hospital. The way the family medicine people would approach and solve problems; the way we organize ourselves; the way we organize resources for our patients, we apply and practice what we had been taught. We followed our values to practice and treat our patients.

What were the outcomes? We studied ourselves over one year; we took the patients that were managed by us (the family medicine generalists) and we compare them to the usual care that is cared for by specialists. We found very interesting results. The length of stay was significantly different between the 2 groups – the Generalists tend to send the patients home faster and back to the community earlier, by the difference of 1.1 day. It is not very much but if you add up large number of patients, it means a lot. The costs of care was much cheaper – about \$502 cheaper per patient – quite a substantial amount. But are we killing our patients? Are our patients dying from the lack of specialists' care? We found no difference – both in the unscheduled re-admissions as well as in the hospital mortality. Secretly worried that we were doing things the wrong way, we were then very relieved we did no worst. In fact, in many ways, we did better.

What does that mean? If this was translated – if all the patients were managed the usual way by the multitude of specialists, we can potentially save quite a lot of money and quite a lot of bed-days, freeing up a lot of resources for more people.

Moving on, we realized that was the way to go, and moved on to more new ways to try optimize this Generalists' approach to caring for patients. We started Hospital-wide Integrated Care Conferences (HICC), led by generalists family physicians with a multi-disciplinary team. Patients that have difficulty moving out of the hospital; that keeps coming back every 3 to 4 days for re-admission, we brought them to this platform for discussion. We applied our skills and knowledge to help such patients. We also realized that we need to send our Generalists back into the community, just to ensure that they are properly integrated with the community care providers.

We have created a primary care team that is based in the hospital, and I think that is the secret sauce. Why don't we send our people into the hospitals and say 'let us be the person to link up to the folks back in the community'? Perhaps that is one way we can think about. We actually have this team of family physicians and their nurses that help to bring the patients (after they are discharged) and link them back to our colleagues in the primary care community.

We have also realized that bigger hospitals are not always better. SGH has taken over a community hospital called Bright Vision Hospital – a 318-bed hospital; no MRI; no operating theatres; no specialists except the occasional visiting specialist – run by Family Physician Generalists, with lots of help from our nurses and therapists. We take patients quickly out of the tertiary hospitals and put them in the community hospital, where they can continue recuperation under more optimal conditions.

After discharging patients from hospitals, we thought we should continue to monitor them. After they are discharged from the hospitals from our inpatient units, we admit them to what is called the virtual ward for the next 90 days, where our nurses and family doctors will call them from the hospital and ask if they are all right, are

(continued on next page)

(continued from Page 15: Generalism in the Urban Environment: The Oxymoron of the Specialist Generalist)

things all right, and are there needs which are not met or is there anyone we can link them up with to make things better, etc. The virtual ward is very exciting; we are evaluating our service with a randomized-control study – and we should be able to analyse the results in the coming months.

The whole concept is patient-centeredness – we have to organize our care around the patient rather than the patients around the doctor. We are now in the Phase 2 of our study; we should be able to complete the study by April 2014.

CONCLUSION

Therefore, I think that there is this entity called the Generalist, and it depends on where you practice. A rural generalist, if you practice in a rural and remote area; urban generalist if you practice in the city. But the important things we have in common is this belief in Generalism. We really need to get contexts rather than just content. We need to practice and apply our knowledge

based on the contexts of the person and the community, and not to define everything according to our own needs. The patient moves – from the hospital back to home, to the community hospital or the rehab

services and then back to his GP or family doctor. Who is to follow this patient as he navigate through this very fragmented and increasingly complex system - that is very dangerous for our patients?

"The future is in the beginning" said a wise thinker in Family Medicine. But we have not delivered that promise that we

Review of Outcomes

The length of stay, cost and outcomes of care of patients cared by hospitalist and usual care

| | Usual care, n=2892 | Hospitalist, n=601 | Difference (%) | P |
|----------------------------------|--------------------------|--------------------------|----------------|--------|
| Length of stay, day [†] | 5.7 (5.4, 5.9) | 4.6 (4.2, 5.0) | 1.1(-19.3) | <0.001 |
| Cost, \$ [‡] | \$746.4 (3624.0, 3873.0) | \$244.9 (3035.1, 3469.2) | \$502(-13.4) | 0.0012 |
| Unscheduled readmission, %* | 7.5 | 7.3 | 0.2(-2.9) | 0.854 |
| Hospital mortality, %* | 5.3 | 4.0 | 1.3(-24.5) | 0.187 |

* p value was calculated using Chi-Square test
[†] Geometric mean (95% confidence interval); p value was calculated using Mann-Whitney U test

made during the phase of the counter-culture. The whole basis of the invention of Family Medicine is that we realized that Specialization is the problem; it has fragmented healthcare and it is our role to bring everything back together and return it back to the patient. We are still working towards this and we have yet to deliver on this promise of Family Medicine.

CM

PHOTO QUIZ

Case contributed by Dr See Toh Kwok Yee, MCFP(S), Editor & edited by Dr Soh Soon Beng, MCFP(S), Editorial Board Member (Minor modification had been made to the details of the case to protect patient's confidentiality)



were swollen, warm and erythematous with indistinct margin. Areas of lichenification were seen on a background of xerotic skin. There was no crusting, vesicles or pustules seen.

- A. What is the diagnosis?**
The clinical diagnosis was asteatotic eczema with secondary bacterial infection.
- B. What are the principles involved in the management of this patient?**
Management of this patient involved the following principles:

1. Treatment of the superimposed bacterial infection (probably Staph.aureus)

This can be topical such as antibiotic-steroid combination cream (Fucicort, Fusidin-H) for localised infection or oral antibiotics (cloxacillin) if there is systemic involvement. Such superimposed bacterial pathogen often exacerbate the eczema. In this patient since there was no localised painful rash or systemic symptom such as fever, oral antibiotic was not started. However in such elderly patient who has diabetes, one needs to closely monitor the condition and institute oral antibiotic promptly when the need arises.

atient was a 80-year-old Chinese gentleman with a history of Ischemic Heart Disease, Type 2 Diabetes Mellitus, Hypertension and Dyslipidemia

He had presented with a pruritic rash over both forearms of two-week duration that was interfering with his sleep.

There was no fever or any recent change in medications and he did not have any history of food or drug allergy.

The rash had coincided with a recent onset of hot weather.

Clinically the flexor surfaces of both forearms, as shown above,

(continued on Page 18)

THANK YOU

by Dr See Toh Kwok Yee, MCFP(S), Editor

I was routinely sieving through the pile of letters collected over the week when this otherwise ordinary handwritten envelope arrested my attention.

It wasn't the handwriting, which actually looked to me like it belonged to a young student temping in the office.

What made me linger over it was that three little words tucked in the lower corner.

I can't help but imagine how the postman who delivered this letter must have felt; it made my day and I had no doubt it had made his or hers.

Why had I experienced this happiness when I was not even the recipient of this thoughtful act?

The answer was probably it had reaffirmed my belief that nice people still abound.

I was probably going through a temporary trough in the "being-thanked-enough" cycle of our profession when I received the said envelope; those times when you wished you could monetize your practice and buy a sailboat!

What particularly irked me were a couple of incidents when I felt my colleagues could have been more gracious.

The first happened during my clinic hours when a terse phone call from a specialist clinic by a nurse apparently calling on behalf of the doctor that went "my doctor wants you to fax over the lab results of this patient now."

(The test was done months before and the patient had apparently referred herself for a second opinion.)

I thought it was rude and my first instinctive reply would have been unprintable and downright unprofessional.

Fortunately good sense prevailed and I had agreed to call the clinic back with the results but only after I had called the patient first to verify the matter and to seek her permission to release the results.

The second incident was a call from a second year medical student made from a hospital where a patient of mine was admitted after referring himself to the emergency department.

The student had politely asked for the list of drug allergy on behalf of the ward team managing the patient.

I was uncomfortable with the request.

Firstly, a second year student might not be accustomed with the drug formulary yet and when accuracy of information conveyed over a phone call was never foolproof, the risk of misinformation was real.



Secondly, to be honest, I had felt slighted; they could have at least appointed the houseman to call me.

God forbid that I should be tempted to ask my clinic assistant to call the consultant to convey the required information, quid pro quo!

Instead I had asked the student to re-clerk my patient awhile later to give me time to call my patient to ascertain the allergy first.

I was beginning to wonder how far down the rank the next call for information would be from; could it be the ward housekeeper who is also rightfully a part of the ward team?

And what could the reasons that your fellow doctors were seemingly reluctant to accord you a courtesy call personally?

Being too busy to make that call would not be reason or excuse enough, for so was the doctor that you are seeking information from.

But personal experience tells me that these distasteful examples are just aberrations; the overwhelming majority of our fellow colleagues who take care of our mutual patients are cordial, helpful and thoughtful in words and action, examples of which are too numerous to detail.

Unfortunately, often in the mundaneness of our work and amidst the hustle and bustle of life, we may forget professional etiquettes in our communication and interaction with one another.

I, for one, am guilty of signing off referral letters to my colleagues without the two most important words in the vocabulary. This lowly envelope has served as an unusual reminder to be appreciative and thoughtful in our dealings with others.

Nowhere is this truer than in our profession where as a result of the growing complexities of medical science and technology, the interdependence of doctors is becoming ever more important. (1)

It has been suggested that the doctor-doctor relationship is only second to the doctor-patient relationship in importance because of its impact on the quality, efficiency and availability of medical care. (2)

Reference:
 (1) & (2) The Canadian Medical Association Journal, 27APR, 1968, vol.98

CM

(continued from Page 16: Photo Quiz)

2. Regular use of Emollients

This remains one of the cornerstone in the management of eczema. Most patients with eczema have dry skin, more so in the elderly as in this patient. Emollients not only greatly reduce the discomfort and itch but also can reduce the potency of topical steroid used (steroid sparing effect). This is particularly relevant in this case as elderly patient tends to have thin fragile skin which can be worsened by steroid. Remember the teaching "Red skin needs steroid, dry skin needs only an emollient".



Images courtesy of Dr See Teh Kwok Yee

3. Judicious use of steroid

A few principles are worth repeating

- Use the lowest potency steroid that can control the inflammation.
- Use for the shortest time needed to control the flare-up.
- Use body site appropriate steroid (eg hydrocortisone for face or children).
- Do not give steroid over extended period of time without review.
- Can be applied to broken or abraded skin.
- Not contraindicated in the presence of infection but infection must also be treated.
- Cream based preparation for weepy or inflamed areas; ointment for dry or lichenified areas and lotion for hair bearing areas.

Treatment for this patient was :

- a) Fucicort(fusidic acid and bethamethasone 0.1%) cream BD
- b) Atopiclair Lotion
- c) Cetaphil cleanser
- d) Zyrtec 10mg OM
- e) Atarax 12.5mg ON

The same forearm 2 weeks later (as shown above).

4. Use of sedating antihistamines

Sedating antihistamines (eg. piriton, atarax) are more effective in controlling itch as they greatly help to relieve itch and the night time scratching. For this elderly patient, care must be taken to remind him or his caregiver of the potential for fall as a result of using a sedating antihistamines. Another problem is that of drug tolerance. Hence it may be necessary to change to a different type of antihistamine after a certain period of time.

5. Judicious use of steroid

- Do not bathe more than 2 times a day. Keep each bath to 5-10 mins
- Use soap substitute such as Cetaphil, Sebamed etc.
- Use a soft cotton towel to pad dry. Do not wipe as this will abrade the skin.

6. Identify any triggers

In this case scratching due to a combination of dry skin and hot weather causes the condition. Use of air-con or fan may help, in addition to the clipping of the nails.

References:

1. Atopic Dermatitis, p54-75, Colour Atlas and Synopsis of Clinical Dermatology, 3rd edition, Thomas B. Fitzpatrick, Richard Allen Johnson, Klaus Wolff, Machiel K. Polano, Dick Suurmond.
2. Eczema and dermatitis, Chapter 3, p86-104, Clinical Dermatology, 2nd edition JAA Hunter, JA Savin, MV Dahl.
3. Dermatitis and Eczema, Chapter 5, p77-89, Clinical Dermatology, 4th edition, Rona M. Mackie.
4. Atopic dermatitis: A practice parameter update 2012. SCHNEIDER ET AL, J ALLERGY CLIN IMMUNOL FEBRUARY 2013.
5. Consensus guidelines for the management of atopic dermatitis: An Asia-Pacific perspective, Diana RUBEL, Thiru THIRUMOORTHY, Retno W. SOEBARYO, Steven C. K. WENG, Teresita M. GABRIEL, Lillian L. VILLAFUERTE, Chia-Yu CHU, Sandipan DHAR, Deepak PARIKH, Li-Chuen WONG, Kuen-Kong LO, Asia-Pacific Consensus Group for Atopic Dermatitis Journal of Dermatology 2013; 40: 1-12.

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FAMILY PRACTICE SKILLS COURSE (FPSC): *EMERGENCY MEDICINE*

by A/Prof Goh Lee Gan, Director, Institute of Family Medicine (IFM), College of Family Physicians Singapore

A Family Practice Skills Course (FPSC) on Emergency Medicine was conducted on 5 - 6 October 2013 at Gallery Hotel. Jointly organised by the College of Family Physicians Singapore, Health Promotion Board (HPB) and supported by Ministry of Health (MOH), this FPSC has several objectives: to update ourselves on the conditions that we need to make the correct judgment call to refer early, to be aware of the pitfalls that we can avoid, and finally to be confident on what we can safely treat and observe. There is also a need to educate patients on what they need to be on the look-out for as their acute problems unfold and seek appropriate emergency attention as the need arises.

We asked Dr Quek Meng Poo, one of the participants who attended the course, and this was what he said, "It is very informative and enlightening on emergency medicine in addition to refreshing general practitioners on steps to Basic Life Support. The course also highlights when and how patients should be referred to the Accident and Emergency department."

A repeat of the Emergency Medicine FPSC will be conducted on the weekend of 22-23 February 2014. If you have not had the opportunity to attend it, you may wish to avail yourself of the opportunity to do so in the coming course. The registration form is found on Page 24.

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The course speakers in action:



Workshop discussion panel



Workshop CPR and AED in progress



Seminar room full of audience



ANKLE SPRAINS REVISITED

by A/Prof Saminathan Suresh Nathan, Senior Consultant,
Limb Salvage and Revision Arthroplasty Surgery, Mount Elizabeth Medical Centre.

The ankle sprain is probably the most common sport-related injury and among the most common musculoskeletal maladies the generalist is likely to face. Traditional treatment seems simple enough – rest, immobilisation, compression, elevation (RICE); ice packs and analgesia. In the last decade or so improved imaging techniques like ultrasound and high resolution MRI has allowed a better understanding about the long term consequences of the injury and apparently the repercussions of the injury are not so straightforward. We present here a review of the available literature and an update on the management of the condition.

Anatomy

The ankle joint is made of three bones, the fibula and tibia (which together form a socket or mortise) and the talar dome (the ball). It is a fairly mobile joint in all planes – sagittal, coronal and axial. The principal restraints are the lateral ligaments – the anterior talo-fibular ligament (ATFL), calcaneo-fibular ligament (CFL) and posterior talo-fibular ligament (PTFL) respectively a, b and c in **Figure 1**. The medial joint is restrained by the deltoid ligament which for all intents and purposes functions as one tough unit.

Pathophysiology

The ATFL is most prone to injury with plantar-flexion and forced inversion forces. The CFL can rupture in a continuum of lateral ligament ruptures but this is very uncommon and the PTFL generally does not rupture. In **Figure 2** below it is clear that if the ATFL ruptures, the resultant anterior translation of the talus on the tibia can only be prevented by the peroneus brevis tendon (arrowed in a). This would

result in tears of this tendon. On the axial view this ligament is arrowed on the model (b) and MRI (c).

It is also useful to revise some of the norms of biological healing. Skin and soft tissue tends to take about 2 weeks to heal. This means that bleeding and inflammation starts to settle about then and most injuries

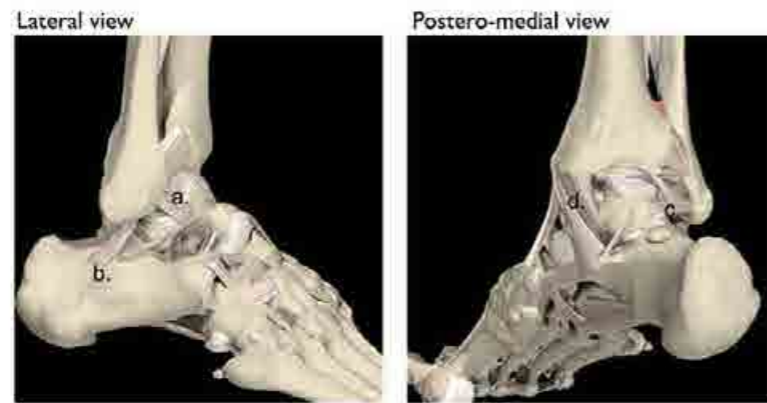


Figure 1. Medial and lateral anatomy of the ligaments of the ankle

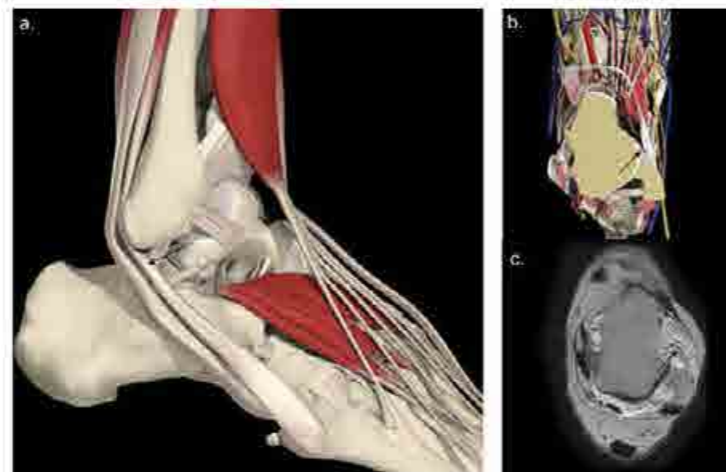


Figure 2. The ATFL in relation to the peroneal tendons around the ankle

can be manipulated about then. Ligaments take about 6 weeks to heal and maybe about 6 more weeks to establish range of motion. Therefore, it is reasonable to surmise that an injury that is re-evaluated about one week after an injury would be painless enough to assess for function and yet not be too late that whatever injury there is could still be intervened on if correction is required. Within this time frame even occult fractures that only become apparent later would also be discovered.

Assessment

The main point of concern with most generalists is when should one refer such cases – the concern being that a more serious sprain has not been missed.

Clinically, in the acute phase it can be very difficult to know when an x-ray is required. In general if there has been gross deformity

or significant hematoma formation then an x-ray is mandated. A simple AP and lateral x-ray of the ankle would suffice. Varus and valgus stress views are not necessary in the acute phase and can be painful to perform. Nevertheless, if a tibio-talar varus tilt is noted without fracture this may be indicative of a lateral ligament rupture. This lateral ligament rupture causes a progressively worse tilt as the ATFL, CFL and PTFL are in turn ruptured.

If at this point no fractures are seen about the ankle, then rest, immobilisation, compression, elevation (RICE); ice packs and analgesia are adequate treatment for the next 6 weeks. Depending on the swelling, an ankle brace may be too painful to fit in the acute phase. If the patient has significant pain and swelling, the patient should be seen 7 to 14 days later.

In the second week of injury swelling should have receded and pain considerably lessened. At this point, tenderness over the ATFL should be elicited and distinguished from pain that may be of a more generalised nature. An anterior drawer test can usually be performed by having the patient in a supine position, securing the leg with one hand, cupping the heel with the other hand and pulling forward (**Figure 3**). The foot should be internally rotated (I

use my distal ulna to do this) to reduce tension on the deltoid ligament which could cause a false negative appreciation of lateral ankle instability. A subjective sense of the talus moving forward on the tibial plafond is an indication of significant instability. This manoeuvre while alarming for the patient is not generally painful at 2 weeks after injury. Such a case can then be referred for further management. All others can be managed in the community

Treatment

If the ankle is found to be unstable at two weeks it should be immobilised in an ankle cast or functional brace for a further 6 weeks. These braces are only available via prescription and do not refer to the sorts used for sports (eg, aircast boot). The big advantage of these braces is they can be removed for hygiene. The disadvantage as can be guessed is patient non-compliance. Hence, a cast is often more desirable in these circumstances.

At the end of the 6-week period of immobilisation the ankle is re-assessed for stability. If the ankle is stable, physiotherapy is initiated to increase range of motion and a sport brace is used to assist in active sports. If there is persistent instability however certain undesirable effects can result (**Figure 4**). This patient presented with retro-malleolar pain referable to the peroneal tendons. Unlike similar medial pain which is often due to tibialis posterior tendinitis, peroneal pain is unusually primary in nature. The MRI confirmed peroneus brevis tendon thickening and tear (4a). In addition however the ATFL was noted to be chronically thickened and scarred (4b). On further probing, this patient had presented a year before to another centre with an ankle sprain. She was placed in a cast and told to return a week later but removed the cast herself one week later because there was no more pain. When this new retro-malleolar pain developed one year later she was not able to make the connection and effectively felt this was a new problem. It was not. In fact whenever significant ATFL tears are not appropriately repaired, their incompetence results in the peroneus brevis taking over this function. In the process this tendon can become torn and require a formal repair (4c and d; Arthroscopy: The Journal of Arthroscopic and Related Surgery Volume 25, Issue 11, Pages 1288-1297, November 2009 Peroneal Tendon Tears: Associated Arthroscopic Findings and Results After Repair. Aaron Bare, M.D., Richard D. Ferkel, M.D.). They are the main cause of persistent pain after repairs of ankle instabilities. In addition, osteochondral lesions in the talar dome can result from the ankle subluxing repeatedly. This eventually results in osteoarthritis of the ankle.

When appropriately managed, most ankle sprains do not require surgery. Surgery may however become necessary with persistent instability in the active patient. Many procedures have been described to stabilise the ankle (**Figure 5**). In the past non-anatomical repairs were advocated. This involved borrowing nearby tendons to fashion an artificial lateral ligament complex. These procedures underestimated the fine balance the native ligament provides and resulted in over tightening the lateral complex and causing a non-physiological flexion extension manoeuvre even if varus stability was restored. The anatomical repairs advocated nowadays all involve some variation of reconstruction the ATFL itself and is the method of choice practiced by our surgeons today.

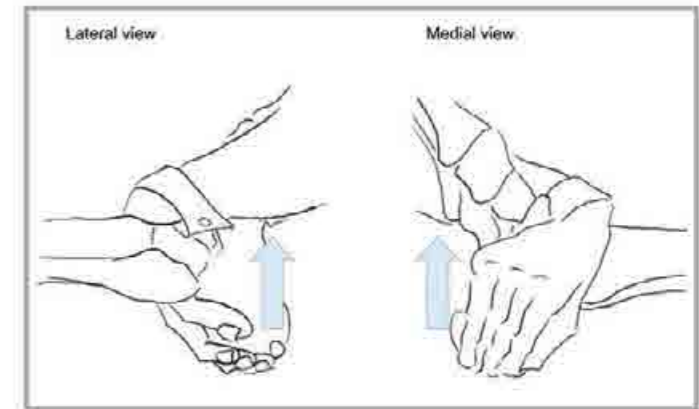


Figure 3. The anterior drawer test in assessing ankle instability 2 weeks after a sprain

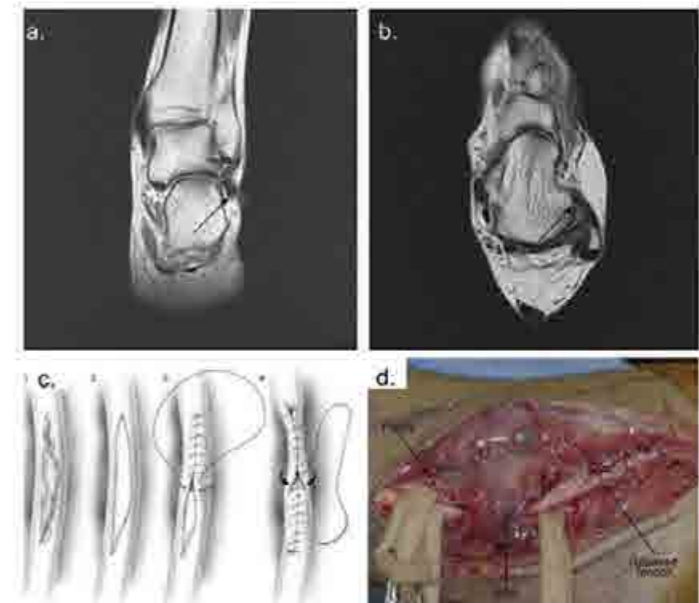


Figure 4. Occult tears of the peroneus brevis tendon after neglected ankle sprains

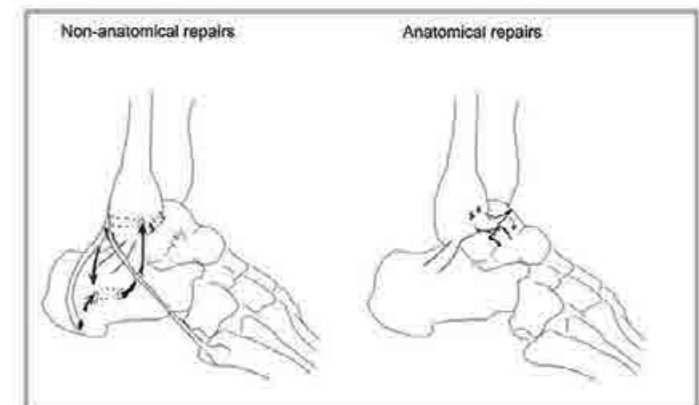


Figure 5. Surgical techniques in restoring stability to the ankle

SINGAPORE FAMILY PHYSICIANS FACILITATE PRIMARY CARE RESEARCH WORKSHOP 2013 in FIJI

by A/Prof Goh Lee Gan, Director, Institute of Family Medicine (IFM), College of Family Physicians Singapore
Dr Tan Ngiap Chuan, Honorary Editor, 24th Council, College of Family Physicians Singapore
Prof Ng Chirk Jenn



Group shot of the entire participants and facilitators at the event.

Images courtesy of Dr Tan Ngiap Chuan

Two members from the College of Family Physician members, Singapore and one member of Academy of Family Physicians, Malaysia were honoured to be invited by the Fiji College of Family Physicians to conduct a Primary Care Research workshop for its members. They were A/Prof Goh Lee Gan, Dr Tan Ngiap Chuan, and Prof Ng Chirk Jenn respectively.

This research workshop was conducted in Radisson Blue in Fiji from 18-20 October 2013. The workshop was attended by 39 participants. Among the participants were the current President of Wonca Asia Pacific Region (APR) Prof JK Lee, Dr Rosemary Mitchell, President of the Fiji College of General Practitioners (FCGP), and 6 local mentors.

PROOF OF CONCEPT

This research workshop had a special mission. It was a social experiment to prove a concept, namely, that a research workshop style of two days can be useful. This social experiment is multistaged. The next stage of development will be to showcase the research proposals and presentation at the forthcoming WONCA APR Conference in Kuching in May 2014.

GENESIS

The genesis of the workshop was at the 2012 WONCA APR Conference in Jeju, South Korea. It was clear from



From left: A/Prof Goh Lee Gan, Dr Robin Mitchell with wife, Dr Rosemary Mitchell (President, Fiji College of General Practitioners) and Dr Tan Ngiap Chuan

the discussions then that is a need for a Primary Care Research workshop that takes novices on to the beginning of the research runway for a successful take-off. Thanks to the persistence of two people, Dr Donald Li, the then President WONCA APR and Dr Wahid, its Secretary General cum Honorary Secretary of the FCGP, the idea of a Primary Care Research workshop became a reality in 2013.

PARTICIPANTS & CONDUCT OF WORKSHOP

The workshop was conducted workshop style with 3 participating groups. Each

group consisted of one overseas mentor, 2 local mentors, and a group of local participants. Recruitment of participants was the purview of the Dr Wahid –he did a marvellous job of rounding up those who were interested. Out of a population of 150 primary care doctors looking after 900,000 population in Fiji 30 of them participated.

ROADMAP, ENGINE AND FUEL OF THE WORKSHOP

The detailed proof of concept was to test the road map, engine and the fuel of the workshop. The road map was the programme and time tabling, the engine was the programme and the workshop notes, the fuel of the workshop were the research questions, leadership, collaboration and shared vision.

REFLECTIONS

Testing of concepts is part and parcel of organised curiosity, and a research on research is also needed. Certainly it looks like a 2 day research workshop for busy GPs can succeed. The importance of the roadmap, engine, and fuel of the workshop, metaphorically do underpin the success of this workshop. The lessons learnt have important implications on how to move primary care research forward in Asia

Pacific. Thanks are due to Dr Wahid who believed in us.

THE NEXT LAP

The next lap is to bring the participants in this workshop to the next lap in the research cycle in Kuching to present their research proposals and beyond. Hopefully, this report will inspire the conduct of similar primary care research workshop in other parts of Asia Pacific, even back home in Singapore and Malaysia.

■ CM

CASE REPORT - PERSISTENT THROMBOCYTOSIS AND MANAGEMENT

by Dr Li Shi'An Derek and Dr Seow Zhiqiang Jeremy

Editor's note:

The College Mirror is thankful to Dr. Lim Lay Cheng, Consultant Haematologist, Blood Specialist Clinic, Gleneagles Medical Centre for her valuable comments and input.

From time to time, we encounter the problem of thrombocytosis in patients. In managing this problem, it is helpful to ask two questions:

- Is this due to reactive process (eg infection, post surgical) or is there underlying haematological disorder?
- What are immediate risks of the elevated platelet counts to the patient and how should we manage?

We share a case report of a young patient who had Dengue and persistently elevated platelet counts.

Mdm L, a 29 year old lady, with no significant past medical history except mild longstanding anaemia (possibly Thalassemia trait) presented to our clinic with non-specific symptoms of fever, headache and nausea of one day's duration. Further enquiry revealed no localising source of infection and physical examination revealed pyrexia of 39.3 deg C but no other physical signs of note. She was treated symptomatically.

On Day 2, she had a persistent pyrexia of 38.0°C but still unremarkable physical findings. We proceeded to carry out blood investigations, and this revealed positive reactivity for Dengue NS1 antigen, mildly depressed leukocyte count and elevated monocytes. Platelet count was normal at 263k and Liver function tests were also normal.

On Day 3, she was reviewed and found to have postural hypotension (120/70 lying to 100/70 standing), persistent fever and no bleeding signs. She was referred to A&E for possible dehydration.

Patient was admitted for Dengue Fever and she was noted to have transaminitis with a peak ALT of 550 during her stay. Upon discharge, she had returned to our clinic for follow-up blood tests on Day 14 post Dengue diagnosis. By this time her fever had subsided and she was otherwise well. The following showed the investigation results chronologically:

| | Hosp. | Day 14. | Day 15. | Day 17. |
|------------------------------|-------|---------|---------|---------|
| Platelet.(¹⁰⁰⁰) | 334 | 590. | 734. | 738. |
| ALT (IU/L) | 550. | 294. | 240. | 151. |
| AST.(IU/L) | 315. | 89. | 74. | 43. |

The rapidly rising platelet count was alarming and the patient was promptly referred back to A&E for management of the thrombocytosis.

She was diagnosed with **reactive thrombocytosis** and was discharged the same day with instructions to repeat her blood tests in one month's time.

Both the Liver Function Test and the platelet count were normal one month later.

We discuss our practical approach to managing patient with newly identified thrombocytosis:

1. Is there any test that can help family doctors differentiate between primary and reactive thrombocytosis and are ESR and CRP useful?

In a patient with recent onset thrombocytosis, it is important to distinguish between reactive thrombocytosis and **primary thrombocytosis** due to underlying haematologic disorder such as myeloproliferative disorders (MPN).

Common causes of reactive thrombocytosis include infection, post surgical states or trauma.

In absence of such recent history to explain the thrombocytosis, it would be advisable to refer the patient to the specialist for further investigations.

ESR and CRP are non-specific markers to assess for infection or inflammation. Where it is not clear if such states exist and could be cause of thrombocytosis, these markers may be helpful.

2. How often should we check the platelet level in such situation? In reactive thrombocytosis, the platelet counts should normalise after resolution of underlying problem.

Should platelet counts remain persistently elevated, primary thrombocytosis has to be considered.

3. At what level of platelet count is the patient at risk of thromboembolic complications and necessitate treatment?

The level of thrombocytosis is not useful in distinguishing the cause of thrombocytosis – reactive or primary.

It is uncommon for patients with reactive thrombocytosis to experience vasomotor symptoms (such as headache, visual symptoms, erythromelalgia) or thrombotic complications. Such symptoms are more commonly seen in primary thrombocytosis although sometimes these patients may also be asymptomatic. Reactive thrombocytosis rarely causes thrombosis and thus does not require specific therapy.

Low dose aspirin is helpful in patients with vasomotor symptoms but it would be important to evaluate these patients for underlying haematologic disorder.

■ CM



Family Practice Skills Course #56

Emergency Medicine (Re-run)

Sat - Sun, 22 - 23 February 2014
2.00pm - 5.30pm

Venue: To be confirmed
(please visit www.cfps.org.sg for venue details)

TOPICS

- Unit 1: Optimal use of Emergency Services
- Unit 2: Improving primary care management of time sensitive emergencies
- Unit 3: Update on cardiopulmonary resuscitation
- Unit 4: Pitfalls & red flags in common clinical syndromes
- Unit 5: Trauma & injuries
- Unit 6: Emergencies in very young patients

WORKSHOPS

- Day 1: Quick refresher on CPR & use of AED
- Day 2: Improving emergency care: Case based discussions
 - A panel of experts will discuss cases to illustrate strategies for improving care
 - Participants are encouraged to bring their cases up to the panel for discussion

■ **SEMINARS** (2 Core FM CME points per seminar)
 Seminar 1 • Unit 1 - 3: Sat, 22 February 2014 (2.00pm - 4.00pm)
 Seminar 2 • Unit 4 - 6: Sun, 23 February 2014 (2.00pm - 4.00pm)

■ **WORKSHOPS** (1 Core FM CME point per workshop)
 Day 1: Sat, 22 February 2014 (4.30pm - 5.30pm)
 Day 2: Sun, 23 February 2014 (4.30pm - 5.30pm)

* Registration is on first-come-first-served basis.
 Seats are limited.
 Please register by 17 February 2014 to avoid disappointment.

■ **DISTANCE LEARNING MODULE**
 (6 Core FM CME points upon attaining a minimum pass grade of 60% in online MCQ Assessment)
 • Read 6 Units of study materials in *The Singapore Family Physician Journal* and pass the online MCQ Assessment.

This Family Practice Skills Course is jointly organised by the **College of Family Physicians Singapore, Health Promotion Board (HPB)** and supported by **Ministry of Health (MOH)**



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

REGISTRATION

Emergency Medicine (Re-run)
Please tick (✓) the appropriate boxes

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