# The College Mirror

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**Date: 26 June 2004**

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***College Art Gallery***

"In The Evening" by Tay Bak Koi
From College Art Collection

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# Blueprint for Bold Changes in Primary Care

Prof K Satkunanantham, DMS, MOH

*Prof K Satku, Director of Medical Services(DMS), Ministry of Health gave the opening address as Guest of Honour at the College of Family Physicians Seminar: Transforming Primary Health Care -The Scottish Experience on Saturday, 15 May 2004 at the Auditorium, College of Medicine Building.*

*In his address, he expressed confidence that the personal and collective recent Scottish experience would have endowed the Family Medicine Leadership from the private and public sector with the necessary expertise to critically evaluate the prevailing primary care situation. The following is the speech that was delivered by the DMS.*

"It is my great pleasure to be here today at this Seminar on Transforming Primary Health Care – The Scottish Experience. I understand that a number of you had a very fruitful trip to Scotland and are eager to share what you have learnt with the rest of the primary care community. Transforming primary care is one of the eight key priorities of the Ministry of Health. It is indeed timely that the college is also giving significance to this area.

**Vision for Primary Care**

Primary care is one of the critical elements of our healthcare system, providing first contact medical care to the general public. As we become increasingly aware of the implications of chronic illness and the ageing population, primary care will need to move beyond its traditional role.

It is now well established that the management of various chronic diseases like diabetes and asthma achieve better patient outcome and are more cost-effective when managed at primary care level. Our current primary care system is well equipped and handles acute diseases of a wide variety, with considerable expertise and with only occasional referrals to specialists.

However, the primary care system does not do nearly enough in the area of chronic disease prevention, early detection and management. The recent National Report Card on Quality of Health Care in America conducted by Rand Corporation and the NHS initiative in UK offering general practitioners a new contract linked to performance based on 76 quality indicators is an affirmation that similar issues are being faced by healthcare systems around the world and it is timely for Singapore to join this effort.

The Ministry of Health places great emphasis on the development and enhancement of primary care and I would like you to consider and deliberate on three initiatives that I feel that we must pursue.

**The Family Doctor Concept**

Firstly, we should continue to promote the family doctor concept. The principles of Family Medicine – Personal, Primary, Preventive, Comprehensive, Continuing and Community are hallmarks of holistic care for patients. These principles must be adhered to.

There is more to a consultation than just prescribing medications or issuing a medical certificate. A listening ear, care and concern, a few words of advice and of course the necessary expertise. We must continually enhance these skills necessary for holistic management and provide the care that patients will go to lengths to receive.

A general practitioner in the private practice who secures a sustained doctor-patient relationship will be well placed to influence patient's behaviour



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# Transforming Vocational Training

*By* A/Prof Cheong Pak Yean, President, CFPS

The primary care system in UK and Singapore have developed differently. The recent College study of the primary care system in UK provided invaluable insights as we strive to transform the Singapore system.

The College started the Graduate Diploma in Family Medicine(GDFM) four years ago in the hope that it be made the minimum standard of vocational training for family practice. During the UK visit, we learnt that it is mandatory for many years for doctors doing general practice there to undergo one year of compulsory supervised training and pass the summative assessment in general practice. This has resulted in high standard of primary care in UK.

The College believes that a standard for FM vocational training based on the GDFM should be now formalized in Singapore. The standard can be gradually made mandatory for all doctors in general practice with consideration made for those already practising. Singapore can then begin to move up from the estimated percentage of 20 to 25 % vocationally trained family physicians to the majority being trained in years to come.

About two-thirds of vocationally trained doctors in UK undergo further training to pass the membership examination of the Royal College of General Practitioners (RCGP) of the United Kingdom. The Censor Board of our College has developed a programme leading to the Collegiate membership of the College (MCFP) by assessment.

This programme incorporating what we observed as strength in the UK system (viz. training in consulting skills with video consultation plus quality assurance & professional development initiatives) has been approved by the College Council.(see pg 8). The first trainees for the new MCFP programme would be inducted in the FM Commencement Ceremony to be held on 26 June'04.

For those doctors with GDFM who wish to acquire higher clinical skills, they can undergo further training for the Master of Medicine in Family Medicine. They are thus clinically trained to practise to the level of consultants in community hospitals, 'stepped- down care' and in specialized primary care clinics. The requirements for Masters training are also being looked into and would be announced later.

The College is able to achieve consensus and move decisively on measures to augment FM vocational training standards as all the stakeholders of primary care participated in the UK study & the deliberations after. The College hopes that the "blue-print for bold changes in primary care" as set out by the Director of Medical Services can be implemented soon to transform service delivery in primary care and its integration with the hospital and specialist services.

## Editor's Words

# Is it a situation of Physician heal thyself?

Family Medicine as a discipline has the hope to continue being a healthy and thriving body. Family doctors in both the private and public sectors face the realities of practice daily. In the current climate, it may be the sense of lowered esteem, underpricing, long hours for the private GP or long queues in the polyclinics. With all the external stresses, benchmarking may bring a visceral reaction to the already taxed family doctor.

However, focusing on a minimum benchmark for family physician will better define their roles and also better patient care. It will improve esteem of family physicians in the long haul and we should band together to support it.

Change being the one constant in current times, we have to embrace ourselves to meet the coming developments with a positive mindset.

Thus in the feature of this issue on "Transforming Primary Health Care" section, we report DMS's opening address(front pg), the "Scottish Experience" (pg 5) from the study trip, presentations at the Transforming Primary Health Care Seminar(pg 6) and also UK benchmarks of vocational training.

The College Mirror also reports the regular College activities, such as the happenings in the Elderly and Mental Health Special Interest Groups(SIGs) and recent organised courses. Also check out our usual features in Down Heritage Trail, Hints & Tips and Practice Corner.

As family physicians, we have to band together to heal ourselves and also look forward to support from colleagues and policy makers for a conducive healing environment.

**Dr Ong Jin Ee**
**Editor of The College Mirror**


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and lifestyles to prevent, detect early or finally contain the disease.

**Organising Primary Care for Optimal Effectiveness**

The second issue that I would like to address is the need to organise primary care to optimise it. The public sector and large practices have adequate infrastructure to support their needs. However the nature of general practice is such that most of the doctors function as independent practices.

Prof K Satku, delivering opening address

It can be a daunting task for any single doctor practice to provide and at the same time organise optimally the many and varied services to benefit the individual patient.

To this end, the College can play a pivotal role by making available its expertise to the individual practitioner. Besides working towards a more structured and patient outcome driven service, the college may also want to facilitate the formation of individual primary care practices into functional groups for the purpose of teaching, learning and sharing of CME and other activities.

**Training of Family Doctors**

The third issue that I think we should address is the training of family physicians. Undergraduate medical teaching lays the foundation for medical practice. However, we now recognise that it is essential for doctors to undergo structured postgraduate training to equip them with the special skills required for the particular discipline they choose to practise in, including family medicine.

It is important to recognise the unique features in the training of family physicians. There is a strong emphasis on communication and counselling skills. There are also skills needed to integrate care between hospital and community, as well as in management of a wide range of chronic illnesses. These skills are unique and complex, and we should therefore look into establishing a minimum training requirement for family physicians.

As the professional body representing the family physicians, I believe that the College of Family Physicians would be in the best position to set standards for the competency requirements for family physicians. On my part I will endeavour to facilitate this transformation.

**Conclusion**

Summing up - Your personal, collective and recent Scottish experience should have endowed you with the necessary expertise to critically evaluate the prevailing situation. This seminar and others I hope will result in a blueprint for bold changes in primary care that will serve our society well.

I look forward to working with the college to define solutions for the key challenges faced by the primary care service in Singapore. Together, we can bring about a meaningful change in primary care. I would like to thank you for the kind invitation to this seminar. I am certain we will have an enjoyable and productive afternoon. Thank you."

# Responses from *Family Physicians*

We asked some doctors for their views on the DMS's speech and the subject of transforming primary healthcare.

"The College fully supports the Ministry's initiatives. We must now implement these initiatives as a nation across the private-public divide to build strong infrastructure & social capital. Adequate resources, strong resolve & national directives are critical success factors" *- A/Prof Cheong Pak Yean, President, CFPS & leader of Glasgow study group*

"The 3 initiatives that DMS has proposed are three practical levers that if actively pursued will surely transform primary care from being an appendage to be an integral part of the whole healthcare delivery system. They should be on the personal agenda of every primary care doctor's roadmap for continuing professional development" *- A/Prof Goh Lee Gan, Censor-in-Chief, CFPS & Glasgow study group member.*

"Finally, a recognition that Family Medicine is a unique and complex discipline that requires special skills. Some of the ideal of the concept of the Family Doctor are in place and need fine-tuning. Collaboration between the college and the MOH will go a long way to help achieve the ideal." *- Dr Jonathan Pang, Family Physician in private practice & Council member, CFPS*

"DMS is spot on in his assessment that primary care need to be organised for optimal effectiveness. Eagerly look forward to new initiatives in this direction that will include private practioners." *- Dr Cheng Heng Lee, Family Physician in private practice & Council member, CFPS*

"It is heartening that MOH supports the idea that basic competency requirements needs to be attained before practising as family physicians. Using GDFM as a platform, the College of Family Physicians will now need to re-define practice requirements, training structure & execution." *- Dr Gilbert Tan, family physician in Singhealth Polyclinic & Glasgow study group member.*

"NHS (National Health Service of the UK) has a systematic approach towards evaluation of quality of patient care in primary health care setting. The doctors are positive, highly motivated and receptive of the process of certification and re-validation for licensing for practice."*- Dr Helen Leong, family physician in NHGP & Glasgow study group member.*

"I think the DMS's blueprint for change is an excellent prescription that will cure the malady that is afflicting our primary care. The challenge is in getting the sick people to swallow the medicine. Everyone in primary care, regardless of cluster or sector, must co-operate in order for this to work. We should all put aside our differences and work towards the common good of our profession, our patients and our country." *- Dr Lee Kheng Hock, family physician in a private group practice & Glasgow study group member.*

# E-learning Review

By Dr Lawrence Ng, MCFP

I was looking for a way of doing my CME online when I read a flyer from the College that its e-learning portal is free from now until end Oct 2004. Curious to find out how it works and lazy to travel to far away venues for CME talks (which usually gives one point), I was keen to try out the portal at www.onlinemedlearning.org. Moreover, each completed module earns 5 CME points.

The first step was to apply via email for a password which I received on the same working day. The current module, on Communication & Counselling, is the fourth in the series.

There is a set of notes in pdf file (for reading or downloading) and a multimedia role playing exercise. The latter is particularly interesting as it is an re-enactment of actual cases in general practice in a consultation setting. This set the mind of the learner in a clinical setting and helps him put into immediate practice what he learns online. It is a more powerful way to learn that cut-and-dried classroom or hotel lectures. Surprisingly, the script is uncanningly realistic.

Two case exercises are done in a Q&A style which, although similar to the CME test, does not contribute to the passing or failing. These exercises are also multimedia and is both audio and visual to the broadband user. The dial-up user can only hear the audio conversation. I found making mistakes on the MCQs here rather educational as the wrong answers are followed by a pop-up dialogue box which tells you why the answer was wrong. For soft topics such as communications, the correct answer is actually a "best-practice" answer and it helps me to reflect on my current ways of thinking, talking to the patient and choices in management such as making a referral whilst not giving the patient a sense of abandonment.

Dr Lawrence Ng

The exercises can be done in separate sittings which means that one can log off and go to attend to a patient or have lunch, and return later to resume the exercise. This would not have been possible in a diadactic classroom or drug talk CME. Hence, it is flexible and fits into my schedule and does not impact on my lifestyle. It saves precious weekend time for the family and leisure pursuits!

At the end of doing the exercises, reading the pdf notes and viewing the mutlimedia role play, I took the plunge and submitted myself to the CME test. It was with a measure of satisfation when I found that I passed with 20 correct answers out of 25 MCQs. For me, this is the way to go for CME.

# Heraldry of the College

By Dr Lee Kheng Hock, Executive Director, CFPS

Since the dawn of history, groups of individuals, tribes and nations with a common cause would adopt a symbol around which they would rally and be distinguished from other powerful social groups. They often prove critical in the heat and confusion of battle.

This custom reached its most elaborate development in Europe during the Middle Ages. These elaborate symbols were eventually used to mark a warrior's armor and his surcoat, which was the garment he wore over his suit of mail. From this use comes the expression "coat of arms." No one knows when was the first time that coats of arms were used but there are indications that they began to take definite form in the time of the crusades. As art flourished and artisans became more skillful these insignia became decorative and were worn outside the warrior's coat of mail.

Originally, the coat of arms were not hereditary. They gradually became so and were recognized as evidence of the wearer's noble birth. Starting with ecclesiastical bodies and later with the mediaeval guilds, the use of heraldry soon spread beyond the personal use of knights to the corporate use of institutions and municipalities - one of its most frequent uses in the modern world.

Our College crest or coat of arms was instituted at the founding of our College in 1971. It was designed by Dr Koh Eng Soo who described the symbolism of the crest.

The original drawing of the College Crest by Dr Koh Eng Soo circa 1971. The drawing was donated to the College archives by Dr Koh Eng Kheng, Past President of the College.

Each day as we ride into battle in our 4 wheeled aluminium chariots, not unlike the knights of yore on their 4 hoofed sturdy steeds, we should perhaps reflect on the badge of our vocation and be encouraged to stay true to the cause.

**"The upper portion of the badge of the College consists of a golden lion in a passant stance superimposed on the chief which is red in colour.**

**The lion represents our nation of Singapore. Red is the colour of blood which is the precious liquid on which life depends and which is our mission to save.**

**The lower portion of the badge consists of a green cross superimposed on a white shield. The green cross symbolizes the humanitarian mission of our College. White is the colour of purity which is our aim.**

**On the green cross is superimposed an open book and a caduceus. The open book represents knowledge and continued learning and the caduceus is the recognized symbol for the art of healing."**

# The Scottish Experience

*By* A/Prof Goh Lee Gan, Censor-in-chief, CFPS

A team of 13 doctors from the College of Family Physicians visited the West of Scotland from 20th to 27th March 2004 to study their primary health care system. The study was facilitated by the University of Glasgow Department of Postgraduate Education.

The comprehensive programme covered various aspects of practice and service delivery, training, and research. There were also field visits to the Scottish practices.

The team was also briefed on the recent developments in professional standards and summative assessment programmes of the Royal College of General Practitioners.

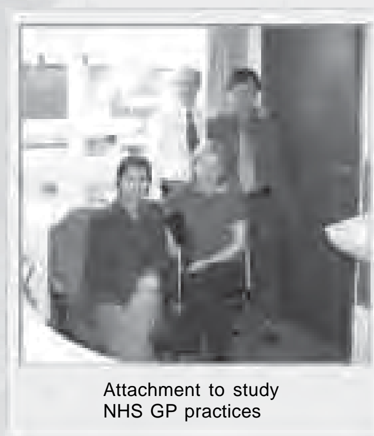
*(L-R): Dr Goh Jin Hian, Dr Helen Leong Soh Sum, Dr Ho Han Kwee, Dr Matthew Ng, Professor Stuart Murray, A/Prof Goh Lee Gan, A/Prof Cheong Pak Yean, A/Prof Shanta Emmanuel, Dr Arthur Tan Chin Lock, Dr Tan Yew Seng, Dr Tan Chee Beng, Dr Gilbert Tan & Dr Lee Kheng Hock taken at NHS Education Trust, Glasgow*

Professor Lewis Ritchie, the Professor of General Practice in Aberdeen made the special trip from Aberdeen to give an afternoon presentation on undergraduate training and departmental research programme in his University.

There were several booklets of useful resource materials given by Professor Stuart Murray and his postgraduate education team of the West of Scotland and Professor Lewis Ritchie. Special thanks are due to Professor Stuart Murray and the West of Scotland Region for a sponsorship of 8,000 sterling pounds towards this study trip.

## The Study Visit *Photos*

Momento of thanks to Prof Cochrane,Post-graduate Medical Dean of Uni. of Glasgow



Attachment to study NHS GP practices

College delegation with Prof Lewis Ritchie from University of Aberdeen

A visit to the Royal College of General Practitioners

## The Study Visit *Schedule*

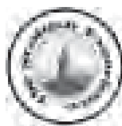
**Day 1- Monday 22nd March**
- Objectives of visit – SWOT Analysis
  Professor Stuart Murray
- Significant Event Analysis
  Dr John Mckay & Mr Paul Bowie
- Audit and Management of Change
  Dr John Mckay & Mr Paul Bowie

**Day 2 – Tuesday 23rd March**
- Practice & Professional Assessment
  Dr Murray Lough & Dr Douglas Murphy
- Primary Care Research & Development
  Dr Murray Lough & Dr Douglas Murphy

**Day 3 – Wednesday 24th March**
- Field Trip: Practice Visits to examine systems & IT

**Day 4 – Thursday 25th March**
- The use of video in teaching & training
  Dr Colin Hodgson
- The MRCGP exam incorporating the use of video
  Dr Rhona McMillan

**Day 5 – Friday 26th March**
- Undergraduate Department & Faculty Development
  Professor Lewis Ritchie
- Vocational Training & the practice visit
  Dr Moya Kelly
- Continuing Professional Development & revalidation
  Dr Diane Kelly



# The Seminar

The Transforming Primary Healthcare seminar was conducted on 15 May 2004 to share experiences after the study visit. The opening address was given by Prof K Satku. (*See front page*) The seminar was chaired by Dr Arthur Tan.

A/Prof Shanta Emmanuel

**Role and status of General Practitioners in Glasgow and in Singapore**

A/Prof Shanta Emmanuel then kicked off the seminar with a presentation of the role and status of General Practitioners in the two countries. She noted that general practice in the past 20 years has been undergoing remarkable changes as part of the increasing prominence of primary care and this was a global phenomenon.

Successive UK and Scottish governments in their discussion papers and policy documents have called for greater attention on primary care, the latest document being 1st April 2004.

Reforms to Primary Health Care has been targeted at two levels. First at the level of service contracts between NHS and the general practitioners and second, at level of professional licensing mandated by General Medical Council. The certification to practice is revalidated every 5 years. Revalidation is expected to be implemented in UK by end 2004 and all general practitioners have to be re-validated before they can continue to practice.

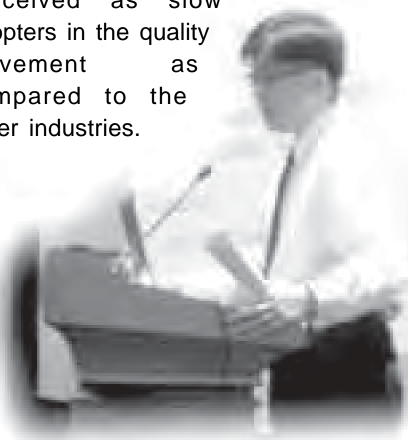
In comparison, there has been also been increasing attention directed at the primary care setting in Singapore. The Health Minister has defined his directives for primary care.(*See following figure*)

**Minister's Directives for Primary Care**

- **Family Physicians should do more than provide just outpatient care, ie, provide holistic family care**
- **Promote healthy living – focus on health promotion and disease prevention**
- **Strengthen the role of the family Physician – "Every Singaporean should have a good family doctor"**
- **Focus on Quality Of Care and not Quantity of Care**
- **Audit of Care important and to focus on good outcomes**
- **Exploit IT in primary healthcare provision**
- **Implement an Appointment System in Primary care clinics**

**Quality Assurance: Audit & Significant Event Analysis**

Dr Lee Kheng Hock presented the development of quality assurance activities in the Scottish scene. He noted that quality assurance is the clarion call for all health service providers. The medical profession has often been perceived as slow adopters in the quality movement as compared to the other industries.



Dr Lee Kheng Hock

Confusion between means and ends often result in suboptimal effort and outcome. Understanding the history and definition of quality helps us to stay focus on means and ends. Audit of clinical practice and significant event analysis had proven to be very effective tools in quality assurance programs in the medical services. Increasingly it is adopted as essential knowledge and skills in vocational training and continuing professional development.

In UK, quality assurance has been incorporated into the new General Medical Services contract of United Kingdom's National Health Service (NHS). It has introduced a novel way of rewarding quality by paying for achievement of quality indicators. Quality assurance is also incorporated into the recently introduced 5-yearly revalidation process of doctors there. The NHS is able move in this direction largely due to its consistent effort in funding and developing a nationalised primary care delivery system. The new contract for GP had been hailed as the biggest and boldest initiative at quality improvement in primary care that the world had ever seen.

Dr Tan Chee Beng

**Training and Education in Family Medicine**

Dr Tan Chee Beng presented the training and education developments in the UK. He noted that UK has a fairly well established system of educating and training general practitioners. Undergraduate training is guided by the recommendations of the General Medical Council. This is to ensure undergraduate training produces "tomorrow's doctors".

General Practice is recognised as a distinct discipline and all doctors intending to practice as general practitioners must undergo structured vocational training. The Summative Assessment is a test of minimum competency and trainees must pass

*Page 7* ►

◄ *Continue from Pg 6*

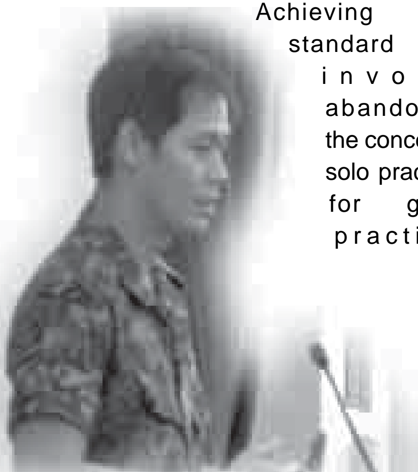
before they can become GP principals. The MRCGP is a College examination which is set at a higher level. All GP trainers must possess the MRCGP.

There is increasing emphasis on continuing professional development of general practitioners in UK. Peer appraisal ensures maintenance of competency through a formative process of reviewing consulting skills, significant events, referral and prescribing patterns. There are lessons to learn from the UK system of educating and training general practitioners. We need to review our current system of training family physicians in Singapore towards an increasing emphasis on continuing professional development.

**Service delivery**

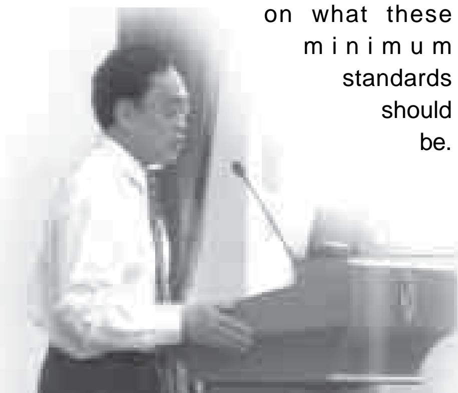
Dr Goh Jin Hian presented the service delivery aspects in the Scottish scene. He noted that service delivery broadly encompass professional aspects and the physical clinic / practice structure aspects.

The main aim of professional service delivery is to improve the way the healthcare system manages diseases within a country. Ultimately, the people will enjoy a better quality of life at an economic cost that is acceptable to all stakeholders. Achieving this standard may involve abandoning the concept of solo practices for group practices


Dr Goh Jin Hian

where lifelong learning can be encouraged by organisational programs and audits. It may also require the restriction of patient care to a specific group of doctors, so that the management of diseases can be coherent and the doctors can be made responsible for attaining the desired clinical outcome. To achieve the goals of community programs, a multi-faceted approach, involving practice managers, nurse managers, physicians, pharmacists and therapists, is required and should be coordinated from a national perspective.

Ensuring uniformity of quality standards in the physical clinic and practice structural aspects between the public and private sectors is challenging as it involves funding issues.And also whether a competitive free market is better than a controlled environment. For example where minimum standards are met but there is lethargy to go the extra mile. In this context, all stakeholders need to agree on what these minimum standards should be.


A/Prof Cheong Pak Yean

Raising service delivery standards in primary care in Singapore will require a roadmap, spelling out the processes and protocols to be followed, how these will be audited and how continuing professional development is carried out to achieve lifelong learning and improvement. A carrot and stick approach may be ultimately necessary.

**Lessons learnt**

A/Prof Cheong Pak Yean presented the lessons learnt by the study team. We learnt not just from the didactic programmes organized but also from visiting GP practices and discussions with doctors and other members of the primary healthcare team in Glasgow.

Organising primary care teams into group practices with a number of doctors and other healthcare workers under one roof has many strengths. Ensuring minimum competency for independent practice in UK has ensure a consistent and uniform standards. Video to teach and assess consulting skills is well established in the various training programmes. The well-funded NHS Education Trust has resulted in a robust and sustained vocational training programme. A range of quality

A/Prof Goh Lee Gan & Dr Tan See Leng chairing Q & A session.

assurance measures are gradually put in place to monitor and improve primary healthcare delivery.

Finally, because of the active participation of the various stakeholders of primary care in Singapore in this study trip, there is also a greater awareness of the positive measures that must be taken together to reform primary healthcare in Singapore.

**Question & Answers**

In the question & answer session, several questions were asked on improvement of primary care. It was noted that there would be a need to attend to several aspects of infrastructure support, training, and creating better confidence and positive image of the general practitioner in the minds of the patients.

Question & Answer session

# The UK Benchmarks

The College delegation to Glasgow in March 2004 learnt at firsthand the three benchmarks of GP training in the United Kingdom viz. the Vocational Registration administered by the National Health Services (NHS), the Membership examination of the Royal College of General Practitioners (RCGP) and the revalidation exercise of the General Medical Council (GMC) recently introduced on 1st April 2004. These are shown in the table below.

The Singapore delegation noted the emphasis on consulting skills as assessed by video consultation and also the active promotion of a quality assurance culture. There was however no summative assessment on clinical skills like that of the OSCE used in the Graduate Diploma in FM examination in Singapore and the 'MRCP'-style of short and long clinical cases assessment of our Master of Medicine examination.

Every doctor who wishes to practise as a general practitioner in UK must pass the summative assessment and be vocationally certified. Doctors must first apply to the NHS and be designated a 'registrar' (equivalent to what is the term 'trainee' in Singapore) and though paid by NHS are assigned to work under supervision for a year in GP training practices. Usually the GP registrars are young doctors who choose to pursue careers in general practice. Occasionally, there are specialists and hospital doctors switching careers undergoing the 1-year programme as every doctor must be vocationally certified under the 1-year programme before assuming general practice.

About two-thirds of doctors who are vocationally certified in addition pass the membership examination of the RCP after at least 3 years of independent general practice. Membership is a certification of professional excellence and a pre-requisite for appointments to trainers and supervisors.

As the system of mandatory vocational certification and majority collegiate membership has been in placed for 3 decades and the culture of quality assurance ingrained, the GMC is beginning to introduce revalidation of the license to practice once every five years.

The UK Government funds the development & implementation of all three exercises. We learnt that in the jurisdiction we visited under the "NHS Education Trust for the West of Scotland", serving a population of three million people (two-thirds living within 20 miles of Glasgow) the operational budget of the Trust just for training GPs is 3 million sterling pounds per year. A total budget of eighty million is allocated if research grants & other NHS funding for salaries for doctors in training (registrars) are included.

## Table of the three Primary Care Benchmarks in UK

| **National Health Services Vocational Training Summative Assessment** | **Royal College GP MRCGP – professional recognition & development** | **General Medical Council (GMC) Maintenance of competency** |
|---|---|---|
| Independent GP Practice | Professional excellence<br>GP Trainer | License to practise medicine |
| 1 year as registrar under supervision(paid by NHS) | 1 yr each HO & SHO<br>3 yr GP practice | Revalidation every 5 yrs |
| Audit Project | MCQ Paper | Quality Assurance |
| Written Paper | Written Paper | Peer Appraisal<br>Prescription Review<br>Significant Event Analysis<br>Audit activities |
| Video Consultation | Video Consultation | |
| Trainer's report | Oral Examination | |

# MCFP (S)

## *by Assessment*

**INTRODUCTION**

There is a need to upgrade the present criteria for the award of the Collegiate membership to bring it in line with international standards and the global trend of award by objective assessment and validation. **The College Professional Development Programme (CPDP)** seeks to fulfill this need by introducing a training programme as well as a summative assessment process.

**ENTRY REQUIREMENTS**

The minimum entry requirements are: GDFM or recognized equivalent, professional good standing and ordinary Member of the CFPS for at least 2 years.

**PROGRAMME**

The programme consists a course of three modules, each with a summative assessment. The order for the modules may be completed in any order. The normal duration is two years but completion within a year is allowed.

The 3 modules to be completed and the required standards are:

***1.*** Consulting, Communication & Counseling Skills Course. Standard: Candidates will be required to submit 6 video consultations for assessment;

***2.*** Clinical Quality Skills Course - Pass in clinical quality project assessment. Standard: Candidates will be required to submit 3 case studies of significant events analysis **OR** conduct an audit project in his or her clinic of practice; and

***3.*** Professional Development Project – which may be organization and conduct of a modular CME course or other teaching programmes; publish a paper in a medical journal such as the Singapore Family Physician or its equivalent or other professional development projects approved by the College Council. Standard:A satisfactory supervisor's report and pass in the candidate's report of the professional development project.

**AWARD**

The successful completion of the summative assessment of all the three modules will satisfy the conditions for award of the Collegiate Membership of the College of Family Physicians (MCFP) Singapore.

# Family Doctors in Singapore seeing fewer patients

A scientific paper '2001 survey on primary medical care in Singapore' by A/Profs Shanta Emmanuel, Cheong Pak Yean and Ms H.P. Phua, was published in the May 2004 issue of the Singapore Medical Journal (SMJ). This paper is based on the study of the same name conducted under the aegis of the College in late 2001.

In the same issue, A/Prof Goh Lee Gan wrote an editorial based on the study titled, 'One-day primary care morbidity surveys: a feasible means for obtaining valuable healthcare services data'. In his editorial, A/Prof Goh emphasized the usefulness of a national survey to monitor the health needs of the population, workload of healthcare providers, health planning policy, as well as the design of medical curricula.

As a survey based on the same methodology was done in 1993, comparison of the findings also revealed the trends over the past 8 years and the roles of family doctors in polyclinics versus family doctor in private practice (GP), The study revealed the answers to some questions that family doctors often ask.

**Are GPs seeing fewer patients?**

The answer is both 'yes' and 'no'. Yes, the average number of patients seen per GP per day has dropped from 40 in 1993 to 33 in 2001 but this is not because the family doctors in polyclinics are seeing more proportionally. In fact, the GP's percentage share of primary care patients increased marginally viz. private vs. public was 82.1% vs. 17.9% in 1993 and 83.4% vs. 16.6% in 2001. The number of visits to the GP per patient per year dropped from 5.0 in 1993 to 4.4 in 2001.

No, GPs saw more patients in absolute numbers. There were 15.02 million encounters in 2001 vs. 13.62 million in 1993. The number of GPs however increased from 1,103 in 1993 to 1480 in 2001, a greater percentage increase than the increased in-patient encounters resulting in a dilution of patient load per GP.

**Are fewer patients seeing family doctors?**

The answer is 'yes' if the population increase is taken into account. A/Prof Goh also noted in his editorial, "What is also interesting is, despite the population growth of 25% from 3.3 million in 1993 to 4.1 million in 2001, the increase in primary care attendance was only 8.6%. This leads one to ask: Are primary care patients increasingly being taken care of by the specialist sector?"

The 'coughs and cold', upper respiratory tract infections also declined in percentage of total attendance across the board. Are patients now more healthy, seeing the traditional Chinese medicine practitioners or pharmacists for self-medication of these minor ailments? This study was not designed to answer these questions and one can only speculate.

**Are primary care doctors seeing more patients with chronic diseases?**

That is true for family doctors in both sectors increasing from 29.2% in 1993 to 34.3% in 2001 with the increase higher in polyclinics compared to that of GP clinics.

The findings are not unexpected as there are also a greater percentage of elderly patients and the burden of chronic diseases is higher in the geriatric group. This fact and the graying of the population however did not result in primary care doctors seeing the majority of patients with chronic diseases. Some believed that other factors such as perverse funding and perverse public education play a part.

**Take-home messages**

The proportional number of patients seeking primary care is presently heading south. In the private sector, the work-load per GP is further diluted by the number of doctors 'pushed' out into primary care. The work-load of doctors in the polyclinics is less affected by this decline as there is still demand fueled by location-based state subsidy.

Yet the number of doctors in the GP sector is set to further increase with the increase in number of doctors trained in Singapore and increase in recognized medical schools overseas where Singaporean can study. How low would the workload go considering there is a lag-time for correction due to the long training period?

A/Prof Goh concluded in his editorial that 'the message to the primary care sector is this: as a corporate body, primary care needs to retool itself, to promote itself, and to negotiate with the hospital and specialist sectors on the apportioning of work in the care of chronic medical problems. There are, of course, other implications that the provider and administrator can see and should act on, based on a careful study of the 2001 Singapore one-day morbidity survey in its entirety."

**"Primary care needs to retool itself, to promote itself, and to negotiate with the hospital and specialist sectors on the apportioning of work in the care of chronic medical problems. There are, of course, other implications that the provider and administrator can see and should act on"**

- A/Prof Goh Lee Gan

The College's corporate role is clearer when seen in this perspective. What is yours?

*The paper and the editorial are published in the Singapore Med Journal 2004 Vol 45(5) available both in print and from the Internet. www.sma.org.sg/smj/smjcurrent.html*

# A decade in postgraduate FM education - *GFMC expands to take on new role*

*By* Dr Julian Lim, FCFP & A/Prof Cheong Pak Yean, FCFP

The Graduate Family Medicine Centre (GFMC), a body approved by the College, NUS and the Singapore Medical Council to conduct structured core FM CME has chalked up yet another milestone. From July 2004, the Masters of Medicine (FM) training would be conducted in Dr Lim's clinic at Teban Gardens while the Jalan Jurong Kechil (JJK) venue would be devoted to the new College Professional Development Programme (CPDP) leading to the Collegiate Membership of the College (MCFP). (See Pg 8)

Professors John Murtagh and Lewis Ritchie, our guests with primary care leaders at the official opening of the centre. *Standing (L-R)*: Dr Swah Teck Sin, Dr Siaw Tung Yeng, Dr Paul Goh, A/Prof Shanta Emmanuel, Dr Julian Lim, Dr Kwan Yew Seng, Dr Tan Chee Beng, Dr Lim Kim Leong & A/Prof Cheong Pak Yean. *Seated (L-R): Dr Lam Sian Lian, Prof Lewis Ritchie, Dr Alfred Loh, Prof John Murtagh & A/Prof Goh Lee Gan*

The GFMC had its beginnings in 1993 when Family Medicine trainees were posted for their 2-week private practice attachment to Cheong Medical Clinic. Formal teaching sessions based on the 'hospital' model of case presentations and topic reviews were conducted. Other learning tools like Portfolio-based Learning were innovated later. These weekly sessions soon attracted many doctors. The late Professor Wong Poi Kwong used to attend both to teach and to learn. Many specialist colleagues have also been to the lecture room above the clinic to share their knowledge and skills.

In 1995, the NUS FM Committee recognized the GFMC as a training centre for the private practitioners' stream (PPS) of the Masters. A/Prof Chan Nan Fong came abroad as a supervisor and due to the increased interest, a new FM postgraduate centre, the NUS Centre was started under her direction. The two centres for training family doctors in private practice have since produced 44 of the 195 MMed(FM) trained in Singapore to date, the other 151 being sponsored by the Ministry of Health and the clusters.

**The two centres for training family doctors in private practice have since produced 44 of the 195 MMed(FM) trained in Singapore to date...**

On 9th October 1998 , the GFMC attained another milestone when the first FM Fellowship Programme was launched in GFMC to train the first batch of Fellows of the College by assessment. Professor John Murtagh, the world renowned FM Professor from Monash University delivered the inaugural lecture. The inauguration in July 2004 of the new programme towards the Collegiate membership (MCFP) would be another 'first'.

The GFMC was and still is a voluntary body that does not receive any financial funding. It remains a self-help group surviving because of the love of learning. The trainees and supervisors somehow manage to get things going. When there was a dire need for a photocopier, one trainee actually paid $1500 of his own money to donate one so that the class can photocopy transparencies and notes when needed. When a borrowed overhead projector had to be returned, a second-hand OHP was purchased for $100 after a frantic but fruitful search of the Straits Times classified.

One trainee described the JJK centre as his 'scout den' of learning where he would meet fellow doctors every week to learn to be better doctors. The rag-tag and memorabilia on the notice boards surrounding the lecture room attest to this. The eclectic mix of donated and second-hand furniture and equipment completes the ambience.

A decade has past. A new challenge lies ahead. We hope that this same spirit of voluntarism and camaraderie would see both the Master's and the new Collegiate programme attain new height of learning in the years ahead. We also hope that with the new thinking, training resources in Singapore will be marshalled to level up all sectors of primary care.

*Page 11* ►

◀ *Continue from Pg 10*

One-page feature in *"The Straits Times" Sept 27,1996, Life At Large* section. The above published photo was captioned "A child psychiatrist in private practice discussing a case study with a group of part-time Masters of Family Medicine students."

The tutorials and clinical sessions attracted many doctors to the centre.

Dr Thirumoorthy, dermatologist demonstrating skin signs on patients brought by the trainees.

Fellowship class in session that trained the first batch of College Fellows by assessment.

## Case Presentations And All

Traditional hospital-style case presentations
History, clinical signs and investigations
Discussion on differentials and management
Come to the point and spare us the torment

Topic reviews to dig into the case
Give out more information just in case
Really over loaded with academic information
When do we really get to put it into action

Literature review for the brave hearted hor
Sourcing for the right articles a chore
Trying to remember studies a bore
Not to mention all the numbers and all

What to do if there are no real patients
We break up the body into different stations
Slides and trainees modeling should work we hope
And not forgetting the marvelous digital stethoscope

Clinical sessions are refreshing
Especially when we get good teaching
Of course it depends on the cases we get
See once and not easy to forget

Mock viva can be quite intimidating
And we are not very accommodating
Candidates can feel the doom and gloom
Well, better now than in the examination room

The specialist talk is informative
Helps us in our practice
But we must not forget the grand picture
That is to pass the exam for sure

The curriculum, training, assessment sandwich
We finally found an interesting way to teach
It's case based modeling to simulate an examination
Cognition, psychomotor and affect - what an innovation

*Dr Julian Lim*
*19 May 2004*

With mock vivas just over and Diploma in Family Medicine exams around the corner, Dr Julian Lim, FCFP and a supervisor of the MMed (FM) programme shares about his passion about teaching family medicine, through verse. He continues to explore innovative ways of training doctors for the real world of general practice. One of his work on portfolio-based learning has been published in the Singapore Medical Journal.

(Singapore Med J 1998; Vol 39(12): 543 - 546 www.sma.org.sg/smj/3912/articles/3912a2.html)

# Mental Health Special Interest Group

*By* Dr Sally Ho, Fellowship Trainee

Dr Tan Yew Seng, Chairman, Mental Health Special Interest Group, chaired an insightful session on psychotherapy on 6 Apr 2004.

Dr Helen Leong, FCFP, Assistant Director, Professional Standards & Audit, NHGP

Dr Helen Leong presented a case of an 18-year-old student (TG) who presented with recurrent episodes of vomiting for 2 months.

Further history taking clarified that she experienced nausea rather than actual vomiting and that there was no associated weight loss. The gastrointestinal and central nervous systems as well as the menstrual history were normal. Recognising that the history and examination were not suggestive of organic problems, Dr Leong proceeded to explore the student's circumstances and realized she was facing tremendous stress from the upcoming 'A' level examinations.

TG had problems coping with Physics and Mathematics. She believed the only way for her to have a good life was to make it to university. She was close to her older sister and her older brother. They helped her in her studies and she considered doing well in the examinations an obligation so as not to let them down. She was so fearful of failure that at one stage, she harboured thoughts of skipping the examinations. Having "sized up" the situation and developed a case formulation, Dr Leong scheduled a series of 10 consultations over a period of 5 months from the time of initial presentation to completion of the 'A' level examinations.

Dr Leong's management of TG involved:

1) Helping TG to recognize the symptoms of stress.

2)Teaching her to use behavioural techniques such as diaphragmatic breathing, progressive muscle relaxation and visualization technique to relieve stress.

3) Modifying her belief system by providing a safe environment for her to explore alternative thoughts, perceptions, interpretations and beliefs.

Specific techniques such as the use of a Dysfunctional Thought Record Chart, the challenge of automatic negative thoughts, the exploration of the worst outcome, etc were also employed during the consultations. She shared practical tips on preparing for the individual papers in the 'A' level examinations and emphased the importance of having regular meals and exercise.

Having developed good rapport with TG and gained her trust, Dr Leong obtained her permission to engage her family members and close friends in the discussions. TG learned that her family would not have minded even if she did not do well. Along the way, she changed her goal from doing well for entrance into the university to that of just doing her best for the examinations. Eventually, TG was able to control her anxious thoughts and emotions adequately for her to do fairly well in her exams.

The above case illustrated the use of Cognitive Behavioural Therapy (CBT), a form of psychotherapy, in the management of a patient with an anxiety state as a result of having to prepare for examinations.

Dr Leong proceeded to give a comprehensive outline of cognitive models, cognitive distortions and interventions, behavioural therapy, patient selection and the necessary physician attributes for successful CBT. A lively discussion with interested family physician participants wrapped up the 2nd Mental Health SIG meeting.

*NB. Case history and initials of the patient had been modified to maintain patient confidentiality.*

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Mental Health Special Interest Group

**"Understanding Family Dysfunctions: Implications for Assessment, Case Consultation & Referral"**

**Chairman:**
Dr Tan Yew Seng
Chairman, Mental Health Special Interest Group CFPS

**Speaker:**
Dr Kit Ng
Kean University, New Jersey

**27 July 2004 (Tuesday)**
**5:15pm - 6:45pm**
**College Lecture Room**

**Outline:**

Family dysfunctions threatens the well-being of the individual, and can even lead to physical illness. Conversely, ill-health can be the stressor that triggers or aggravates dysfunctional patterns in the family. And all these issues may well be covert, except perhaps for the fact that the patient's illness remains persistent or recurrent. It is therefore invaluable that the GP has a framework to understand or approach family dysfunction. But how can we, in the short span of a consultation, identify and assess potential cases of dysfunction? When do we need to refer? And to who? How can the family physician be helpful (and when is he not so)? To answer these questions and more, we shall have the pleasure of Dr Kit Ng to enlighten us.

**About the Speaker:**

Kit S. Ng, PhD, is a Graduate Faculty member and Director of the Post-Graduate Degree in Marriage and Family Therapy and Master's in Psychological Services programs in the Psychology Department at Kean University, Union, New Jersey. He has taught courses in Marital Therapy, Family Psychology, Child Psychology, Clinical Supervision, Counseling Internship, Marriage and Family Practicum/ Internship, Counseling Strategies and Techniques, Adult Psychology, Interpersonal Relationship, and Human Sexuality.

# Elder Care Special Interest Group

*By* Dr Tan Boon Yeow, FCFP & Chairman, Eldercare SIG

The eldercare SIG had the pleasure of hosting the visit of Dr Charles Samuel who is the 1st visiting expert for the Ministry of Health Manpower Development Programme for Step-down Care (HMDPSC) on the 19th March 2004.

Dr Scherer giving a talk in College Lecture room.

Dr Scherer is a geriatrician from Melbourne, Australia. He has contributed extensively to the community aged care services in Australia. He is the Chairman of the Policy and Planning Committee of the Australian Society for Geriatric Medicine, and is actively involved in the implementation and development of aged care policies and guidelines. Dr Scherer is also involved in working with the GP divisions in Australia with the training of family physicians in the area of aged care.

Dr Scherer met up with the president and council members of the college as well as members of the eldercare SIG. An active discussion ensued with comparison of the different systems of care and training of doctors. Dr Scherer was very impressed with the training available for local family physicians and feels that we have a very good foundation to work on.

Dr Scherer with president of College, council members & eldercare SIG members.

The session was followed by a talk by Dr Scherer on: "**The role of Family Physicians in Nursing Homes**". In the talk, he highlighted the training models of primary care physicians in different countries caring for the elderly in residential facilities and explored the various areas of training/competencies required to provide quality care. He also looked at the funding mechanisms of medical services for Australian nursing homes and highlighted their strengths and deficiencies.

The SIG also had its second SIG family medicine grandround on the 4th of May. We had a interesting session when Dr Ho Han Kwee, a family physician who spent 2 years in Japan, shared about his experiences. We enjoyed the many slides he showed on the Japanese elderly and how active a life they led there. The Japanese elderly are known to have the longest disability free life expectancy.

Dr Tan Boon Yeow, family physician and Fellow of the college then presented on his one and half years' working experience in a wide range of aged care services in Melbourne and Sydney, Australia. The highlight was the exploration of the processes that we could learn from the Australian aged care system as well as how as family physicians can adapt to the care of aging population in Singapore.

A/Prof Goh Lee Gan rounded up the evening with a presentation of a new Graduate Diploma in Geriatric Medicine (GDGM) syllabus and encouraged family physicians to consider enrolling for the enriching program to increase their capacity to care for the elderly.

Elder Care Special Interest Group | "Healthy Aging in the Elderly"

**Chairman:**
Dr Cheong Seng Kwing, FCFP,
Senior Family Physician, NHGP

**3 Aug 2004 (Tuesday)**
**5:15pm - 6:45pm**
**College Lecture Room**

**PRESENTERS:**

Dr Pang Weng Sun, head and senior consultant of the department of Geriatric Medicine, Alexandra hospital and the president of the Society for Geriatric Medicine Singapore, will explore the concept of healthy aging in the elderly and look at ways how family physicians can be involved.

Dr Ong Chin Fung, senior family physician, Singhealth Polyclinic will look at evidenced based health screening in the elderly. There are many screening programs available in the market. However, only some have proven value.

Dr Tan Boon Yeow, Dr Ho Han Kwee & A/Prof Goh Lee Gan sharing their unique experiences from overseas systems of healthcare for the elderly.

# WONCA Asia Pacific Research Workshop - Phuket, 10-12 July 2004

A workshop On Research Network Development for WONCA Asia Pacific Region is jointly organised by the General Practitioners/Family Physicians Association, Thailand, the College of Family Physicians of Thailand and WONCA Asia-Pacific region.

**Date:** Saturday, 10- Monday, 12 July 2004.
**Venue:** Thavron Grand Plaza Hotel, Phuket, Thailand.

Registration Fee: US $200. This fee includes 3-nights stay with twin share room, & workshop materials.

· Closing date for applications is Jun 15, 2004. Application forms can be downloaded from http://www.cfps.org.sg/wonca_research.doc

· Wonca Asia Pacific will sponsor the Registration Fee (US $200) for two delegates nominated by the National College of each Member country: *Please apply through your National College.*

· Please organise your travel arrangements early as the Aids Conference is on the same weekend.

| Date | Time | Program |
|---|---|---|
| **July 10 2004 Saturday** | 08.00 | Registration |
| | | Plenary 1 |
| | 09.00 | Research roadmap, domain & network — Goh Lee Gan |
| | 09.20 | Research question — Goh Lee Gan, Justin Beiby. |
| | 09.40 | Electronic literature search — Chusak Okascharoen |
| | 10.10 | Coffee break |
| | | Plenary 2 |
| | 10.30 | Qualitative research: Methods & case study I — Ng Cherk Jenn & Tan Ngiap Chuan |
| | 11.30 | Quantitative research: Methods & case study II. — Supasit Pannarunothai, Chusak Okascharoen, Nicholas Glasgow |
| | 12.30 | Lunch |
| | 14.00 | Workshop I — Collaborative research project proposal – Objectives and methods (Project A,B,C,D,E) – Small group work |
| | 15.30 | Coffee break |
| | 16.00 | Plenary 3 |
| | | Research Project Proposals – presentation and critique |
| | 19.30 | Welcome Dinner |
| **July 11 2004 Sunday** | | Plenary 4 |
| | 08.30 | Data management & case study — Chusak Okascharoen |
| | 09.15 | Data analysis & case study — Chris van Weel, Goh Lee Gan |
| | 10.00 | Coffee break |
| | 10.30 | Workshop 2 — Collaborative research project proposal – Gantt chart, Data collection, data management (Project A,B,C,D,E) – Small group work |
| | 12.30 | Lunch |
| | 14.00 | Plenary 5 |
| | | Research Project Proposals – presentation and critique |
| | 15.30 | Coffee break |
| | | Plenary 6 |
| | 16.00 | Research presentation & writing – Deborah Saltman |
| | 16.40 | Research network formation – Panel discussion |
| **July 12 2004 Monday** | 09.00 | Plenary 7 |
| | | Debrief – lessons learnt, future issues and plans |
| | 10.30 | Coffee break |
| | 11.00 | Follow-up meeting in mid 2005 |

## College Membership

### Benefits of membership includes:

• Complimentary quarterly issues of **Singapore Family Physician(SFP) journal** and accompanying distance learning courses. Successful completion of each course earns six Cat 3B Core FM CME points. Non-members are required to pay $40 per course & $160 for 4 courses in all.

• Quarterly issues of newsletters -**The College Mirror**

• **Preferential rates** for seminars, workshops & courses.

• **Assistance for submission** of SFP reading articles **for FM CME points** under CAT 3A Self-study. A specially-coded mark sheet will be given to members at the end of each year and articles in SFP so marked will be entered into the SMC system on members' behalf for CME points.

Every doctor registered with the Singapore Medical Council (CME) qualify for membership of the College as 'associate member'. Depending on other criteria, those qualifying as family physicians would be accorded the status of 'ordinary member'. All members pay an annual subscription of $180 & a one-time entrance fee of $50 for year commencing 1st April 2004.

(Download application forms from http://www.cfps.org.sg)

## Welcome to New Members

The college would like to extend a warm welcome to the following members who joined us between the months of December 2003 and May 2004:

**Ordinary Members**
Dr Chan Miow-Swan
Dr Ong Su-Anne
Dr Cheong Wei Ling
Dr Ding Yock Seck
Dr Lai Li Cheng
Dr Lee Meng Kam Richard
Dr Liow Chee Hsiang
Dr Lo Kit Leong
Dr Mohamed Ghazali
Dr Sng Li Wah
Dr Yeoh Gueh Kwang
Dr Anaswala Shehnaz Manan
Dr Chan Tat Hon
Dr Chiam Choon Guan Eric
Dr Chin Khong Ling
Dr Chong Chee Keong Michael
Dr Chong Yan-Gerald Mark
Dr Chua Kok Keong
Dr George Varghese
Dr Goh Tien Siong
Dr Khoo Boo Cheong
Dr Leong Peng Fai Samuel
Dr Lim Shee Lai
Dr Loh Seow Foong
Dr Murali Dharan Palanisamy
Dr Ng Guat Hua
Dr Ng Juak Cher
Dr Ong Wah Ying
Dr Quek Gim Hian James
Dr See Toh Wai Khuan
Dr Subramaniam Durai Raj
Dr Tan Chin Hor
Dr Tan Gek Yin Christine
Dr Tan Hai Chuang
Dr Tan Kok Leong
Dr Tan Teck Shi
Dr Tay Choon Mong Leslie
Dr Teo Swee Neo Angela
Dr Tong Mei Lin Philomena
Dr Wee Teong Boo
Dr Wong Tien Hua
Dr Yeo Ling Yen Peggy

**Associate Members**
Dr Fuse Yuka
Dr Ikegami Toru
Dr Miyasto Hiroyasu
Dr Say Jia Kuey
Dr Sundarrajan Chitra
Dr Tsubota Noriyuki

# Communication and Counselling Course 2004

## *A survey of outcome of training*

*By* Dr Tan Yew Seng, Chairman, Mental Health SIG & Council Member, CFPS

Communications and Counselling skills course is a compulsory module of the Graduate Diploma in Family Medicine Programme jointly conducted by the College of Family Physicians Singapore and the Graduate School of Medical Studies of the National University of Singapore. This year's course is a watershed where e-learning was used as a tool to facilitate active learning. The trainees had to successfully complete the theory component via e-learning before they proceed to the practical component of the course. The theory component was structured in the following manner:

The e-learning module included interactive case scenario exercises on management of depression and behavioural modification. There was also an instructional video and a role playing video case scenario. The practical module comprised two 15-minute didactic lectures, a 15-mins video presentation, and followed by two 45-mins role play exercises. 48 trainees attended. They were divided into 4 groups of 12 for the role play exercises.

We conducted a survey to find out the usefulness of the course for the trainees.*(see table below).*

Most trainees (>90%) agreed that all chosen topics were probably useful to them. However the determination of relevance or usefulness involves 2 concepts: firstly, a topic may be relevant or useful because it is seen frequently in the practice; secondly, it may be relevant or useful because of the topic may concern a very important practice issue, which though uncommon, would have significant consequence to the doctor had he not known about it. It may be for this reason that only 48.4% of trainees believed that breaking bad news about cancer is a frequently or very useful topic to their practice. In terms of the perceived helpfulness of the programme to learn about the topics, the responses were generally positive.

Before the start of the practical course, about one third of the trainees were not confident or only a little confident in applying the following:

- Communicating and counselling depressed patients
- Breaking bad news about cancer
- Stages of change model in behaviour modification
- Approach to Change

The trainees were already "quite confident" or "extremely confident" in topics such as "active listening skills" (41.9%), and "motivational interviewing for asthmatic patients" (35.4%), before the start of the practical course.

After the course the changes are as follows: For "communicating and counselling depressed patients" and "approach to change" the results suggested a positive shift in the level of confidence after the course, regardless of their starting confidence level.

For "Use of motivational interviewing for asthmatic patients", the results showed only a minimal increase in the number of trainees achieving mastery (quite confident or extremely confident), but contrary to the trend in all the other topics, there were one more trainee who felt a lack of confidence after the course.

For "breaking bad news about cancer" and the "BATHE technique", the decrease in those who are not confident is modest compared with the increase in those who became very confident.

The situation for "active listening skills" is somewhat reversed – the decrease in those felt less confident is much more that those who felt very confident.

Communication & Counselling course conducted at College lecture room.

In summary, the course contents were generally well accepted as relevant or useful topics. The success of any teaching programme however, has to be defined by its outcome. Ideally, the outcome of such a programme as the Communication and Counselling Course would be the ability of the trainee to communicate and counsel patients effectively.

In this case, our course appeared to have a positive impact on the confidence of the trainees to apply such communication and counselling skills, despite the limitation in terms of resources, trainers and facilities. Nonetheless, the College will work continuously to improve the quality of the courses and CME programmes to meet the needs and demands of our trainees and members.

### USEFULNESS OR RELEVANCE

**Q1. From your perspective, how useful/relevant are ideas/skills taught in the C&C course?**

| Topics | Blank | Not useful | Infrequently useful | Probably useful | Frequently useful | Very useful |
|---|---|---|---|---|---|---|
| 1. Communicating & counselling depressed patients | 0 | 0 | 0 | 11(35.5) | 16(41.6) | 4(12.9) |
| 2. Use of motivational interviewing for asthmatic patients | 0 | 0 | 3(9.7) | 9(29.0) | 18(58.1) | 1(3.2) |
| 3. Use of motivational interviewing for smoking cessation | 0 | 1(3.2) | 1(3.2) | 9(29.0) | 18(58.1) | 2(6.5) |
| 4. Breaking bad news about cancer | 0 | 0 | 2(6.5) | 14(45.1) | 13(41.9) | 2(6.5) |
| 5. Stages of change model in behaviour modification | 0 | 0 | 0 | 13(41.9) | 17(54.9) | 1(3.2) |
| 6. Active listening skills | 0 | 0 | 0 | 5(16.1) | 21(67.8) | 5(16.1) |
| 7. BATHE technique | 1(3.2) | 0 | 1(3.2) | 5(16.1) | 19(61.3) | 5(16.1) |
| 8. Approach to Change | 0 | 0 | 1(3.2) | 13(41.9) | 14(45.1) | 3(9.7) |

# Atherothrombosis Skills Course

Dr John Tan Choon Heng doing a demo at the Ankle Brachial index workshop

On 10 and 11 April 2004, the College organised the Atherothrombosis Skills course.

The development of this Family Practice Skills Course was made possible with an educational grant from Sanofi Synthelabo Pte Ltd and Bristol Myers Squibb(Singapore) Pte Ltd. The Skills course is held in the Ministry of Health Auditorium and received over-whelming responses.

There were also workshop sessions on cases studies and measurement of Brachial - ankle index.

With that, the College would like to thank all the resource persons and the sponsors who had contributed their time and efforts to making this skills course a success.

Workshop on case studies by Dr Sivathasan

Participants of workshop

# Effective Medicine in Small Doses

## 1 Consulting skills and communication issues- *improving outcome of care*

*- Dr Yvette Tan*

Father of a 5 yr-old boy comes demanding that you should refer him to the cardiologist because of some shortness of breath. You have made a thorough examination of the child and are convinced that it is most likely a psychological cause.
*What may be some of your responses?*

a. Negotiate and acknowledge the underlying concern of the parent. Make plans for future action. (patient-centred)
b. Write referral letter as father demanding and it takes too long to explain. (time-centred)
c. Refer to specialist as they are the ones who know best.(skill-centred)

### *Tips:*

In a survey of 90 NHG polyclinic doctors on their response to above scenario, 50% chose a doctor- centred response Vs 23% time-centred response Vs 27% skill-centred response.
So what are the benefits of patient-centred care?
• Patient-centredness has been shown to improve outcomes of care, including patient's and doctor's satisfaction.
• Patient-centredness has become one of the key features of quality care.

Patient-centred care consist of 6 domains:
i. Exploring illness experience and expectations
ii. Understanding the whole person
iii. finding common ground
iv. health promotion
v. enhancing the doctor-patient relationship

## 3 Elderly Medicine- *Is there a difference in depression in the elderly?*

*- Dr Ong Jin Ee*

### *Tips:*

Differences in late-onset depression include:

Depression in the elderly tends to be under-diagnosed.It is associated with more life events as well as chronic diseases and disabilities. There is lower frequency of family history of depression and higher frequency of associated cognitive impairment. There is also more somatic presentation and more psychotic features.

Treatment issues:
• Depression tends to be longer lasting in elderly
• May present as physical illnesses requiring more medical services.
• Living arrangement may become institutional as elderly have decline in function

## 2 Child & Adolescent health - *a medical approach to tight foreskin*

*- Dr Shah Mitesh*

A 3-yr-old Chinese boy is brought by concerned parents to see you. They notice ballooning of prepuce when he urinates past 2 weeks. There are otherwise no symptoms of no genital pain, dysuria or urine frequency. You note phimosis with pinhole prepuce and glans is not seen. His parents are not keen for surgical consult at the moment and ask if anything else can be tried first.

### *Tips:*

One approach to tight foreskin is daily gentle retraction with mild steroid creams or NSAIDs gel or EMLA with petroleum jelly. Choice depends usually on personal experience. My choice is

- Trial of gentle retraction
- 1% hydrocortisone cream bd x 4 wks
- changed to 0.025% betamethasone cream bd x 4 wks
- Review 4 weekly

*Revision of normal physiology:*
Almost all boys are born with a narrow non-retractile foreskin which is fused with the glans with no "right" age for retraction to occur. A narrow non-retractable prepuce in boys is within the normal range of development and usually causes no problems up to puberty. Prepuce will spontaneously widen until complete retractability is obtained. 50-60 %of boys at age 10 do not have fully retractable foreskins.

After puberty, % of boys with full retractability rapidly increases.

Symptoms of phimosis include ballooning of prepuce, dribbling of urine, urine stains in undergarments, painful erections,pain on urination.

Failed medical treatment warrants referral for circumcision.

## 4 Improving medical consultation records - *an aide memoire*

*- Dr Ong Jin Ee*

Ever had patients who walk in greeting you with great familiarity and expect you to know their family history and events?

### *Tips:*

Useful aide memoire is to draw a family genogram on front page of card and note down key history.
Details can always be added on in separate consultations.

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# Medical Mission to a Border Hill Tribe Village

*by* Dr Michael Yee Jenn Jet, MCFP

Dr Michael Yee, private GP and currently enrolled in Fellowship Programme 2003 describes his experience in organizing a medical mission to the hill tribes in Northern Thailand.

Fellow colleagues in his fellowship class debated the merits of short-term medical missions. Short term medical missions, while able to bring hope and good cheer to the villagers as well as the mission team participants, may not meet the wider healthcare needs of the villagers. General consensus was that improving the level of healthcare among the remote hill tribes required a much larger scale effort involving government intervention, large financial resources, human resource commitment, political stability and resolve.

It may be more useful on a small scale to focus on health education and training the local villagers on public health measures. However participating in such humanitarian trips certainly play a part for the current generations of family doctors to be exposed to the needs of the rural population and is an enriching experience.

**REPORT ON MEDICAL MISSION**
**INTRODUCTION**

With support from my church, I was tasked with setting up a medical clinic at the mission house in Northern Thailand and to study the longer- term medical needs of the Lahu people at Mae Gone Village north of Chiang Mai. We were there from 26-29 March 2004. The team of ten consisted of 1 team leader, 1 doctor and 7 support staff. The medical clinic was part of a previous identified need and a new phase in the long term commitment of the church to improve the living conditions of the Lahu people.

Lahu Village, North of Chiang Mai, Thailand

**SETTING UP A RURAL CLINIC**

Advanced preparation and adequate training was key to a good experience setting up the clinic.

There was manpower projection and logistics of purchasing medications, medical equipments, custom clearance and the actual setting up of physical structure. I was also involved in doing prior research to the culture and health needs of the Lahu people.

**BACKGROUND AND EPIDEMIOLOGY**

Mae Gone Village is a foothill village situated along the Mei Ping River. The Lahu people were originally hunters from Yunnan. They have since settled into a lifestyle involving shifting cultivation and animal husbandry. The prevailing religion is animism and believe in one spiritual being with 30% Christianity. The spiritual dimension forms the Lahu people's basic concept of illness.

Night Clinic during a black-out.

The age of the patients encountered at our clinic were biased towards children with equal representation of males and females. The shorter life expectancy also skew the population to the younger age groups.

The distance needed to travel to reach the clinic also potentially excluded the elderly and expecting mothers from accessing the clinic.

**DISEASE PATTERNS OBSERVATIONS**

Dental health was noted to be generally poor. This could be due to the lack of chlorination or fluorination of the water supply or the lack of dental hygiene practices. Thyroid problems form an unusually large proportion of endocrine diseases due to the inherent lack of iodine in the diet of a hill tribe villager lacking in seafood. Simple use of iodinated salt and seaweed in the diet might help eliminate the problem. Lifestyle diseases like hypertension and diabetes mellitus, although less common compared with Singapore, was encountered even in the remote countryside at Mae Gone Village.

There was a fair number of cases with vague complaints which could be explained by the lack of previous health knowledge of the villagers, the free service, and language barriers.

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## PITFALLS

TB and malaria were known health problems. In the region, opium production and trafficking is also an issue. The aggressive introduction of cultivation and animal husbandry techniques could inadvertently introduce new soil and zoonotic diseases.

## HYGIENE ISSUES AT THE CLINIC

Food, water & sanitation was satisfactory at the mission house, American missionary groups having earlier done much of the sanitation works. Tap water was clean and safe for washing and bathing. Drinking water was via portable bottled water.

Food was handled hygienically in a dedicated centralized kitchen. Sewage system was centralized and clean with modern flush system. Piped methane gas was used from recycling pig's manure. Vector control was well maintained with mosquito netting in the mission house and little sign of mosquito breeding. This was also the dry season and hence more conducive to our clinic project.

## LEARNING POINTS

The primary care rural clinic was useful as a point of direct personal contact with the population to help with rapport building and identify specific and changing healthcare needs of the villagers. The clinic was generally well received by the villagers, despite our limitations. Village leaders indicated that they wanted us to return to set up future clinics. The medical mission team truly enjoyed the warm hospitality of the villagers who showed their appreciation by food & small gifts.


### *Acknowledgements*

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### *Further reading:*


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