



The College Mirror

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Graduate Diploma in Family Medicine 5th Intake Enrolment

Sign up for GDFM roadshow now! Pg 12 & 13

College Art Gallery



"Fishing" by Tay Bak Koi
From College Art Collection

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MITA (P) 125/04/2003

Life-long learning for the Family Physician



President of College of Family Physicians Singapore (1985-1988)

Dr Lee Suan Yew, President of Singapore Medical Council and past College President (1985 to 1988) delivered the 15th Sreenivasan Oration in 1995. In the Oration entitled "Dare to Dream", he challenged family physicians community with 5 "dares", one of which is to sit for postgraduate examinations in Family Medicine. It was during Dr Lee's tenure as President of the College that Family Medicine was established in the university as a discipline and the foundation for the Masters of Medicine in Family Medicine examination was laid.

In a revisit of the Oration in page 6, Dr Lee noted with pride that "there are now 180 doctors with the MMed(FM) degrees". He also believes that "We certainly still need more such doctors including those taking the Graduate Diploma course. The more doctors signing up for the GDFM or MMed courses and examinations, the better it is for Singapore. We do not know. There may come a day when MMed(FM) may be a requirement for a principal partner in a group practice".

In the same vein, this issue of Mirror also features interviews with 3 senior family physicians who are showing leadership by example by signing up for the new Graduate Diploma in Family Medicine (GDFM) intake 2004-2006. (Pg 4)

Dr Cheng Heng Lee, family physician in solo practice and Director of Health Maintenance Office Pte Ltd said, "The structured training conducted by the College will not only update and expand my knowledge and skills but also to allow my competency to be validated through formative assessment."

Dr Wong Weng Hong, Chief Executive Officer (CEO) of Healthway Medical Group, expressed his views that certain doctors will ask if the vocational training programme will really help them deliver better care, counting in the investment in time and money. He said, "These issues are especially pertinent for the GPs in the private sector, especially those in solo practices." However he agreed that whatever will help bring better care and outcome for patients should be supported.

The role of the family physician was also seen as integral to the health care system. There was a general consensus that with more commitment to professional development and with a clear message sent to the public and medical community, better patient care as well as a greater self-worth for the family physician would follow.

Register Atherothrombosis (Pg 23)... Enrol in Graduate Diploma in FM (Pg 12 & 13)... Join the College! (Pg 15)...

Wide angle and zoom lens perspective of clinical practice

By A/Prof Cheong Pak Yean, President, College of Family Physicians Singapore

Dr Lee Suan Yew, President, Singapore Medical Council and past President of College drew a very appropriate analogy when describing the best practice of family medicine in an interview with the College Mirror.

He said "GPs/Family Physicians are best when they can use both lenses, that is, the wide angle lens and zoom lens. In other words, they are good in general medicine but can narrow down their interests in a particular field."

Applied to continuing medical education, the wide-angle perspective of medicine is best developed by participating in vocational training programmes like the Graduate Diploma and Master in Family Medicine. These wide-angled programmes cover the breath of medicine, honing knowledge and skills of other clinical disciplines in the context of

Family Practice and more importantly providing the glue that gel the aggregates together. The zoom-lens perspective can then be built on top of this infrastructure by participation in skills courses, ad-hoc CME events and specialized diplomas.

This is not just philosophical musing. No less than three senior members of the profession have come out publicly to endorse the value of broad-based FM vocational training (pg 4). They are practitioners, understanding what patients want and need.

They reiterate what Dr Lee advised in another part of the Mirror's interview and that is "For those who wish to be Family Physicians, it is certainly worth while for young doctors to take up the challenge of the various post-graduate courses conducted by the College".

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Editor's Words

School for the Family Physician

I did not plan it that way but medical school never quite ended for me.

With this issue's focus on life-long learning for the family physician, it has set me thinking of my own experience.

I reflect on what Adult learning has been for me. I started off as a fledgling MOH Master of Medicine (Family Medicine) trainee back in 1996. In the midst of rotating through various specialties in hospitals, there was a gradual appreciation of the discipline of Family Medicine(FM). One of my favourite text, McWhinney's Textbook of Family Medicine; it inspired me that Family Medicine is about patient-centric care that is primary, personal, continuing and comprehensive. The family is the basic unit and the consultation a cornerstone of family practice.

Then I moved to the domiciliary care arena, learning on-the-job to deal not only with patients but also caregivers in their homes.

I did not hear Dr Lee Suan Yew, President Singapore Medical Council and past President

College deliver the 15th Sreenivasan Oration, "Dare to Dream" in 1995. But as events often strangely turn out, I had answered his dare to sit for the MMed(FM) examination in 2000 and in an interview for this issue of the Mirror, revisited the Oration with Dr Lee himself.

It is 2004 and the journey does not end. I find myself enrolled in the FM Fellowship Programme. There will be the opportunity to grow with peers, to be guided by senior family physicians and to be stretched to learn new things.

Sir Denis Hill writing in "Psychiatry in Medicine, Retrospect and Prospect" said it well: "The family physician's role is a difficult one. If it is to be sustained and developed, the general practitioner must become the most educated - the most comprehensively educated of all the doctors in the health service".

School for the complete family physician truly never quite ends.


Dr Ong Jin Ee
Editor of The College Mirror



Thoughts, comments and contributions that is of interest to your fellow family physicians are welcome. Please address correspondence to: The Editor, Email : collegemirror@cfps.org.sg

Leadership by Example - 3 Senior practising family physicians signing up for the coming GDFM intake

By Dr Lee Kheng Hock

Leadership by example calls for leaders who are prepared to say, "Do as I do and not do as I say." Three senior members of the family physician fraternity had signed up for the new intake of the GDFM program. Despite their seniority, they had no qualms about being coursemates with newbies who had just joined the fraternity. In their eyes, structured vocational training in family medicine is a commitment to quality and the validation of family medicine as a distinct discipline. The College Mirror took the opportunity to speak to the trio.

Dr Cheng Heng Lee, is a veteran family physician in solo practice. He is a Director of Health Maintenance Office Pte Ltd, a doctors' 'co-operative' with more than 40 general practitioners as share-holders.

Dr Wong Weng Hong, is one of the founding physicians of Healthway Medical Group. He is presently the Chief Executive Officer of the group practice.

Dr Goh Jin Hian is the Executive Director of Parkway Shenton Pte Ltd.

CM: Some doctors feel that there is no need for practising doctors to sign up for structured training in family medicine. As senior family physicians with many years of experience, what are your thoughts?

only update and expand my knowledge and skills but also allow my competency to be validated through formative assessment.

Dr Wong: As physicians, our perspective



"More practising family physicians should take up structured training programs. This way, we will send a strong message to everybody that family physicians possess special skills and knowledge that can be validated."

- Dr Cheng Heng Lee, Director of Health Maintenance Office Pte Ltd

Dr. Cheng: We always believe that family medicine is a distinct discipline with its set of required core knowledge and skills. Personally, as a practising family physician, I want to satisfy myself that I meet these requirements. The structured training conducted by the College will not

must always be patient-centric. Whatever that will help bring better care and outcome for the patients should be supported.

The questions that some doctors may have is whether the current program will

really help them deliver better care, counting in the investment in time and money. These issues are especially pertinent for the GP's in the private sector, especially those in solo practices.

Dr Goh: I personally believe that structured training is necessary in all fields, and not just medicine. Such structured training and the accompanying work experience should be documented and audited, and there should be open sharing of knowledge and experience to create a learning environment.

CM: A common perception is that further qualifications is just paper chase that is useful only if one is in government service or in public practice, where it is recognised for promotion. Do you agree?

Dr Cheng: I believe there is further value beyond just the piece of paper for promotion purposes. Regardless of level, whether it is graduate diploma, masters or fellowship, all the structured programs are practice oriented. The objective has always been to have doctors who will be more effective in patient care.

Dr Wong: If "paper chase" is the common perception, then perhaps we have not done enough to communicate that the programs are designed to help us deliver our best to our patients. Again we need to be honest and look at what we have done to see if the programs really fulfill this objective.

Perhaps the best thing to dispel the misconception is to listen to what some GP's, especially those in solo or small practices, want to see in a patient-centric program.

Dr Goh: I do not think that paper qualifications in themselves are important. However, if the paper is a by-product of a structured and systematic form of continuous training and education, then I have no issues with that. A paper chase, however, can be harmful if a doctor feels that the paper signifies the completion of education in any medical field. The fact is, education never ends and must be continuous.



"Family Physicians should be well-rounded in their training and competent, so as to be able to know when a patient needs to be referred and whom to refer to."

- Dr Goh Jin Hian, Executive Director
Parkway Shenton Pte Ltd

CM: *Some people feel that family doctors do not need to be highly trained as they should refer all the complicated cases to the hospital. What are your views on this?*

Dr Cheng: Referring a complicated case to hospital initially for workup of diagnosis and management is reasonable but family physicians still have to play the role of an integrator of care or to continue the care of the patient in the community after he or she is discharged from the hospital. Patient often look to their family doctors for advice and information on health.

The care provided by specialists and subspecialists in hospitals tend to be fragmented. A high level of knowledge and skills is necessary if we expect family doctors to provide holistic continuing care to such complicated cases.

Dr Wong: Family doctors need to be safe, be aware of their gaps and weaknesses and know when to refer cases that are beyond their scope to facilities best suited for the patients. Family doctors serve a unique purpose in the community. Once we are clear and have an agreement on what our purpose is, then we will know how well we need to train ourselves.

Dr Goh: It is quite common to find specialists referring to other specialists when a patient has concomitant medical conditions. This may be a malady of sub-specialisation or simply a case of doctors being more conscious of medical

litigation. Family doctors are unlikely to behave differently. I feel that family doctors should be well-rounded in their training and competent, so as to be able to know when a patient needs to be referred and whom to refer to. This is different from



"Family doctors serve a unique purpose in the community. Once we are clear and have an agreement on what our purpose is, then we will know how well we need to train ourselves."

- Dr Wong Weng Hong, CEO of
Healthway Medical Group

being 'highly trained'. It may be detrimental to a patient if a doctor continues to manage a patient, failing to recognise that it is clearly outside his area of expertise.

CM: *What are your visions for professional development of family doctors in Singapore?*

Dr Cheng: Presently only 7.6% of the 4,086 registered, "non-specialist" doctors are vocationally trained through structured programs such as the MCGP, MMed or GDFM. More practising family physicians should take up structured training programs. This way, we will send a strong

message to everybody that family physicians possess special skills and knowledge that can be validated and we are all committed to professional development.

Dr Wong: People choose to be family doctors for a variety of reasons, but I hope we have one key overlapping and overriding reason that is common to us all, i.e. to serve the patient the best we can. If we all believe in that and together work on it, professional development and greater self-worth will follow.

Dr Goh: I believe that ultimately, all doctors should practise in groups, where they are subject to peer review and where they can freely discuss cases in a supportive atmosphere. Whilst CME and other training programs can, to some extent, ensure continuous education, there is still no way of determining how such

education is applied in practice when a family physician operates on his own without any form of audit.

Groups of family doctors can also internally decide on which area each individual doctor should take a special interest in.

This ensures an even spread of skills that can be developed in the GP community. We then won't have a situation where every GP wants to be trained in 'the flavour of the month', for eg. anti-aging, aesthetics, etc, leaving the unglamorous fields bereft of good physicians.

Dare to Dream II

Dr Lee Suan Yew, President, Singapore Medical Council (SMC) and past College President (1985-1988) delivered the 15th Sreenivasan Oration entitled "Dare to Dream" in 1995.

In it, he outlined 5 'dares' or challenges for the family medicine community:

- to actively participate in the CME programme
- to sit for the M.Med (Family Medicine)
- to understand the impact of Traditional Medicine in Singapore
- to practise a high ethical standard of medicine
- to practise medicine with compassion.

9 years on, College Mirror revisits the oration. We spoke to Dr Lee on how the landscape of family medicine and medical practice has evolved thence.

CM: In 1995, you delivered the 15th Sreenivasan Oration and titled it "Dare to Dream".

You dared doctors to actively participate in voluntary CME

"GPs/Family Physicians are best when they can use both lenses, that is, the wide angle lens and zoom lens. In other words, they are good in general medicine but can narrow down their interests in a particular field."

programme in spite of their busy schedules. Voluntary CME was first launched by SMC in 1989. 15 years on, CME is now compulsory. Has there been a positive push by doctors to keep abreast in the past year?

Dr Lee: I must admit that voluntary Continuing Medical Education (CME) was not successful across the board. The majority of doctors did not achieve the voluntary 25 points per annum.

Now that it is compulsory, many doctors will need to complete a minimum of 50 points within 2 years. In fact, in my conversations with fellow colleagues, many have already achieved more than the 25 points required in 2003 and expressed a sense of pride in that

achievement.

There are 2 groups of doctors: one group is highly motivated and keeps abreast with modern medicine, those in the institution attend ward rounds, write

papers and give lectures; the other groups of doctors feel that they know enough medicine and are practising comfortably without having to attend any CME. From experience in advanced countries, where compulsory CME exists, this group of doctors needs to be motivated. Once they attend lectures, seminars and read journals... they would soon realize that medicine is advancing so rapidly that they find the need to keep abreast.

New knowledge and jargons are surfacing very rapidly. If Singapore is to

maintain its role as a medical hub in this region, we doctors need to update ourselves.

CM: Interestingly, you mentioned and I quote "Internet and teleconferencing will be more commonly used by doctors... The whole scenario on transfer of medical information using "electronic skyways" will make it easier for younger doctors who are computer intelligent.

Those of us who are older may have to learn computer technology or gain information through conventional methods."

Dr Lee: Yes, medical information will increasingly be disseminated via the internet using the "electronic skyways". The College of Family Physicians Singapore did the right thing in launching e-learning and in using webcast to inform doctors about SARS during the outbreak in 2003.

CM: In your Oration, you quoted a US study "Evidence for the effectiveness of CME" by Davis, Thomson, Oxmen and Haynes on enabling and reinforcing factors that would improve physician performance, would you like to elaborate further?

Dr Lee: Ideally, effective CME should be conducted by "opinion doctors and eminent leaders". They lecture with authority and they share their experience



Dr Lee Suan Yew giving words of encouragement to young doctors who had successfully passed the 2000 examinations.

which textbooks cannot provide. CME with modular courses are certainly better than ad-hoc lectures. This is where College is doing an excellent job. It is up to each doctor to individualise his/her CME. Each doctor has a particular interest or has a gap in certain areas in the doctor's medical practice.

CM: Organising courses that are 'enabling and reinforcing' take considerable effort, how could we further encourage such development?

Dr Lee: Organising courses such as the College's Asthma and Homecare Skills conducted last year are steps in the right direction. The role of the College or institutions is to organise such courses, although I understand that such activities can be taxing. It is important to get good, hard working and dedicated leaders, who would in turn embrace the right people to organise and teach.

CM: Moving on...to the dare for more younger doctors to sit for the MMed (Family Medicine) Examination. In 1995 when the first examination was conducted, 19 doctors obtained their MMed(FM). Now, we have a total of 180 doctors with MMed(FM).

Younger doctor readers may not appreciate the obstacles surmounted in establishing this programme. Could you share some of your thoughts on this?

Dr Lee: I challenged the younger doctors to take up the vocational course and to sit

"For those who wish to be Family Physicians, it is certainly worth while for young doctors to take up the challenge of the various post-graduate courses conducted by the College."

for the MMed(FM) when it was introduced. It took us some time to convince the relevant authorities that family medicine was the key to effective medicine when the nation was faced with an escalating healthcare cost. Once that was accepted, the facilities and processes were provided.

The next step was to convince bright young doctors that there is an important role for good family physicians. As in advanced countries, the family physician status is equally high amidst a rising trend in specialisation. The authorities also realised that preventive medicine also saved healthcare cost. The best doctors involved are the primary healthcare doctors. However, they need to undergo vocational training and to take post-graduate examinations.

Finally, when the post-graduate school of medicine, under the aegis of the NUS, agreed to conduct the examination, the MMed (FM) finally reached its legitimate status as a formal post-graduate examination equal to the other MMeds. This was an opportunity for our doctors to take up the challenge and sit for the MMed(FM) examination. I am very glad that there are now 180 doctors with the MMed(FM) degrees.

CM: The Graduate Diploma was started in 1999. Would your 'dare' in the oration also include the GDFM route to vocational training?

Dr Lee: We certainly still need more such doctors including those taking the Graduate Diploma course. The more doctors signing-up for the GDFM or MMed courses and examinations, the better it is for Singapore.

We do not know. There may come a day

when MMed(FM) may be a requirement for a principal partner in a group practice. For example in the United Kingdom, a group GP practice must have at least one doctor who is a Fellow of the College of General Practitioners, U.K.



Dr Lee Suan Yew at the Examiners meeting of 1988 FM Post-graduate Examinations.

CM: There has been talk about the enhanced role of Family Physicians beyond that of a "cough and cold" doctor. Our Health Minister Mr Khaw Boon Wan positively said "I am a strong believer in every citizen having a good GP who is your family physician."

Dr Lee: Mr Khaw Boon Wan, Acting Minister for Health, is absolutely right in stating that everyone should have a good GP/Family Physician. He knows what he is talking and he does not mince his words. He has been in the Ministry of Health for many years, including being the CEO of NUH and Chairman of the Board of Directors of SGH.

We need to progress in the various specialties and sub-specialties but good basic primary healthcare doctors are equally important. A trusted and knowledgeable Family Physician knows how to diagnose serious diseases early, when to refer his/her patients to specialists and how to follow up post-hospital discharged patients.

Under those circumstances, such patients are experiencing comprehensive care, and not a fragmented impersonal

care. In fact, I would even say that everyone should have a 'Personal Physician'. Patients would be able to share their medical, family and personal history with a friendly and trusted doctor.

CM: *Thirdly you dared doctors to understand the impact of Traditional Medicine in Singapore. I believe there is now some regulation of TCM. What are your current views?*

Dr Lee: Singaporeans often use the services of Chinese sinsehs/physicians and the bomohs because that is their cultural inclination. All doctors should try to understand the way they practice and the message they convey to their patients. It makes it so much easier to manage such patients when their doctors understand why they consult both Physicians. Fortunately, the Ministry of Health has formed the Chinese Physicians' Medical Council and in the near future all Chinese Physicians will have to pass a formal examination.

In Singapore, it is unlikely that the two types of medical practices will merge. One is scientific evidence-based medicine and the other is generally empirical. The Singapore Medical Council is quite clear in its ethical code regarding doctors associating or even practising TCM.

CM: *Beyond that, could a paradigm be that GPs are generalists but there will surface groups within the generalist population with a special interest in certain areas of family medicine, TCM included? This year saw the start of Family Medicine Grand Ward rounds together with start of SIGs or Special Interest Groups in Elderly Health and Mental Health.*

What is your view of GPs with special niche interests coming together?

Dr Lee: I think GPs/Family Physicians are best when they can use both lenses, that is, the wide angle lens and zoom lens. In other words, they are good in general medicine but can narrow down their interests in a particular field. Certainly, a caution is for doctors not to pose as the experts, for example in plastic/cosmetic

medicine. They should respect the territory where specialists are good at. They should try to c o n f i n e themselves to their field of general medicine. A fine example happened during SARS. The role of the family physician was a b s o l u t e l y important as frontline first contact. The management of SARS, flu and dengue in the general population by family physicians during the epidemic was crucial.

CM: *Perhaps now to end on a practical note, how would you encourage younger doctors to balance work, family life, community activities and yet do vocational training?*

Dr Lee: It is possible to balance work, family life and community activities by budgeting one's time! As a young single doctor, go for the vocational post-graduate training programmes and sit for the examinations. If a doctor gets married and starts a family he/she has to prioritise his/her time. It is only when the children have grown older and are more independent that they can have more time for leisure and community activities.

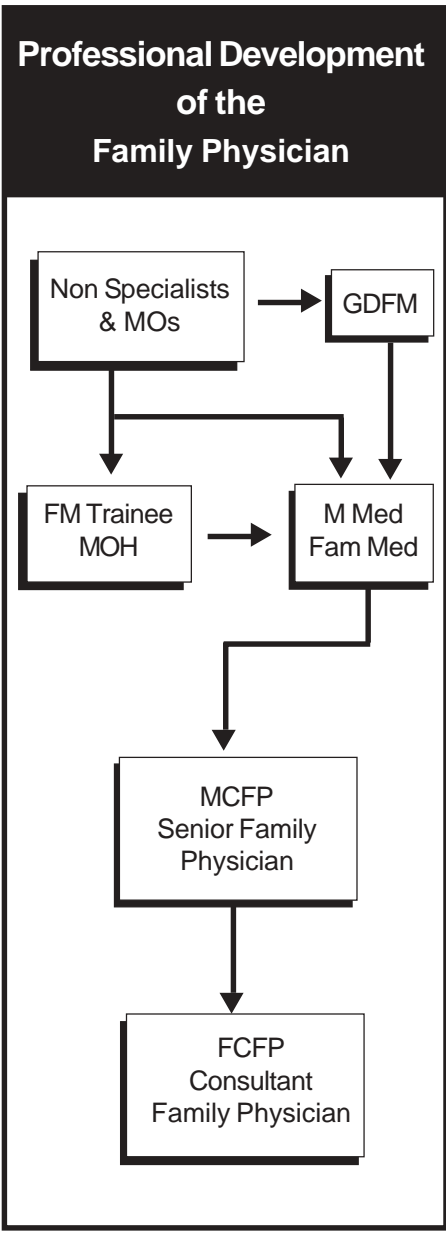
With compulsory CME and the rising importance of post-graduate diplomas, the role of the College is critical. For those who wish to be Family Physicians, it is certainly worth while for young doctors to take up the challenge of the various post-graduate courses conducted by the College.

CM: *Thank you for bringing the 5 'dares' you first enunciated in the 1995 Sreenivasan Oration up-to-date.*

(The Oration can be found at: <http://www.cfps.org.sg/sreenivasan/index.htm>)



Dr Lee Suan Yew presenting awards as the President of the College at the 1988 MCGP Convocation ceremony.



Graduate Diplomas as life-long, inter-disciplinary adult education

This article is based on the valedictory speech given by A/Prof Cheong Pak Yean at the Graduate Diploma presentation ceremony organised by the Division of Postgraduate Medical Studies (DPGMS) of the National University of Singapore on 17th December 2003. Diplomas for the Graduate Diploma in Family Medicine as well as that of Ultrasonography, Psychotherapy, Geriatrics and FP Dermatology were presented to successful graduands by Prof Lee Eng Hin, DPGMS, NUS.

1. Life-long Education

"If the license to practise meant the completion of education, how sad it would be for the young practitioner, how distressing for his patients." Sir William Osler

By law, all that is needed to practise medicine in Singapore is to be registered with the Singapore Medical Council (SMC). In addition, if a doctor puts himself to be a medical specialist, he has to be registered in the Specialist Medical Register as well. However, generalists or specialists, medical education should be a continuing process. There are gaps of knowledge and skills to be filled as well as new ones to acquire. Even basic clinical skills have to be revisited. A recent study of basic auscultation skills of heart sounds by doctors revealed that competency rapidly deteriorated after 8 years post-MBBS irrespective of the clinical postings done by these doctors. (see page 11)

The study reinforced the notion that while knowledge may be kept current with ad-hoc continuing medical education (CME), cognitive and psychomotor skills are better maintained with structured and verified training such as that afforded by the graduate diplomas programmes. A barrier to greater enrolment in diploma programmes must be the psychological trauma inflicted on some by professional medical examinations be it the MBBS examinations and even more so post-graduate examinations leading to membership and Masters degrees. However, without both formative and summative assessment of learning, there would not be the discipline to spend enough time in clinical apprenticeship and scholarship nor the confidence acquired with successful completion.

2. Inter-disciplinary Education

"There are, in truth, no specialties in medicine, since to know fully many of the

most important diseases a man must be familiar with their manifestations in many organs." Sir William Osler

Each of us practises in an area of healthcare, experts in our own field and working as a team with others in caring for our patients. Specialisation of care that benefits some patients can however disenfranchise other patients because of fragmented and poorly co-ordinated care. Graduate diplomas provide the



Prof Lee Eng Hin, Director, DPGMS, National University of Singapore presenting the Diploma in FP Dermatology to A/Prof Cheong Pak Yean

opportunity for doctors to acquire better skills so that care can be better integrated. For example, psychiatrists should be better trained to practice psychotherapy, family physicians in geriatrics.

The benefits of such interdisciplinary education are magnified when doctors so trained at the interfaces are accepted in the worlds of more than one discipline. As a concrete example, Special Interest Groups in Mental Health and Elder Care are now set up in the College of Family Physicians to further enhance such care. These groups are led by family physicians that have completed their Diplomas in psychotherapy and geriatric programmes respectively and equipped not just with better skills but closer professional ties with their specialists colleagues. (See page 16 & 17)

3. Adult education

"The successful teacher is no longer on a

height, pumping knowledge at high pressure into passive receptacles...he is a senior student anxious to help his juniors" Sir William Osler

Unlike undergraduate programmes, teachers and students in the diploma programmes travel the same learning journey together. I bear personal testimony to this being the Director of the Graduate Diploma in Family Medicine (GDFM) programme since 2000 as well as a student enrolled in the Dermatology Diploma programme in 2002. In the best tradition of the medical profession, there is this great commitment of our teachers in Singapore to teach freely just as there is the zeal of our doctors as students to learn humbly. And preparing for examinations is equally arduous for both teachers and students.

The late Professor Chan Heng Leong who left us in the middle of 2003 epitomised this tradition of teaching. Prof. Chan was instrumental in starting the dermatology diploma and chairing the committee that oversaw the programme. Few of us attending the Diploma in Dermatology in 2002 knew that he was stricken with illness as he so enthusiastically continued to give lectures, provided clinical tutorials and conduct the clinical dermatology examination despite the pain and debilitation he suffered.

I like to conclude this valedictory address on a personal note, not to those present here who have already taken the step but to other colleagues. I have publicly advocated as a teacher that structured training such as that leading to graduate medical diplomas is the preferred CME. Now that I have walked my talk as a student almost 30 years after MBBS, I hope that you would too.

Reference:

Quotations from "Sir William Osler: Aphorisms from His Bedside Teachings and Writings" Collected by Robert Bennett Bean, M.D. (1874-1944) Edited by William Bennett Bean, M.D. Charles C. Thomas, Publisher, Springfield, Illinois, 1968

For those who are interested in Graduate Diploma Family Medicine(GDFM), please contact college at 6 2230606 or email : contact@cfps.org.sg.

For other diplomas, please contact NUS at 68743353 or email : dgms@nus.edu.sg

WONCA Asia Pacific Workshop on Training of Teachers

By A/Prof Goh Lee Gan, Censor-in-Chief of CFPS

INTRODUCTION

At the Wonca Asia Pacific Regional Council Meeting, Malaysia's proposal to organize and host a Workshop on Training of Teachers was accepted. This will on 16-18 April, 2004 at the Hotel Grand Maya in Kuala Lumpur.

Date	Time & Program
16.04.2004 Friday	18.00 hrs Registration 19.00 hrs Welcome by Regional President Wonca Asia Pacific — <i>A/Prof Goh Lee Gan (Singapore)</i> Orientation Lecture — <i>Dr Ian Ong (Malaysia)</i> Keynote Address by <i>Academician Dr.M.K.Rajakumar (Malaysia)</i> 20.00 hrs Fellowship Dinner
17.04.2004 Saturday	09.00 hrs Curriculum, Teaching Method & Assessment — <i>Dr.Sheikh, Dr. Henry Hee (Malaysia)</i> Challenges of Distance Learning — <i>Dr.Ludher, Dr.Harbinder Kaur (Malaysia)</i> Psychology of Learning — <i>Dr Hirotake Onishi (Japan)</i> 10.00 hrs Coffee Break 10.30 hrs Workshop 1- Curriculum design — Small Group discussion and report back — <i>A/Prof.Dr.Goh Lee Gan (Singapore)</i> 12.30 hrs Lunch 14.00 hrs Workshop 2-Learning Models-Skills building in Role play, tutorial, counseling — Teaching/learning communication skills – sharing experiences — <i>Dr Yong Rafidah (Malaysia)</i> Mentoring trainees on the 5 domains of family medicine — <i>Dr Ian Ong (Malaysia)</i> Running a tutorial — <i>A/Prof Khoo Ee Meng (Malaysia)</i> 15.30 hrs Tea Break 16.00 hrs CINE Education — <i>Prof.Dr.Ryuki Kassai (Japan)</i> 20.00 hrs Official Dinner
18.04.2004 Sunday	08.30 hrs Trainee Assessment – Log Book, Clinic Visits, Dealing with Difficult Trainees – Lecture & a panel discussion -- <i>Dr.John Chung (Hongkong)</i> 10.00 hrs Tea Break 10.30 hrs Workshop 3- OSCE Organizing & Examining – <i>A/Prof.Dr.Goh Lee Gan (Singapore)</i> 12.00 hrs Lunch 14.00 hrs Workshop 4 MCQ – <i>Dr.SCChan (Malaysia)</i> & KFP — <i>A/Prof.Dr.Goh Lee Gan (Singapore)</i> 15.30 hrs Tea Break 16.00 hrs Sharing of Ideas – Expert Panel "How to Create Better Teachers" 17.00 hrs Close

TRAINING PACK

A training pack for the participants made up of background reading and programme instructions will be collated and a soft copy emailed to participants 2 weeks before the workshop with the suggestion that the participant go through it as much as possible as the distance learning component. A hard copy will be provided at the workshop.

ACTIVE PARTICIPATION

The participants will be divided into 4 groups of about 15 participants for small group activities. Each group will appoint its chairperson and 2 rapporteurs. Reporting back and feedback discussion.

CURRICULUM DESIGN

The small groups will design a module or short course and present it to the plenary. The topics suggested are women's health, psychiatry short course, men's health, chronic disease management, but the group can decide to choose a different area. The group will write out the educational objectives – knowledge, skills or attitude competency as objectives; training methods to achieve the objectives; Assessment – assignment (essay, project, MEQ, OSCE, OSPE, MCQ etc as appropriate); Resources needed – manpower, materials, money.

TEACHING METHODS

A refresher on the teaching/Learning communication/counselling skills through the role play; mentoring trainees on the 5 domains of family medicine; and running a tutorial – preparation, ice-breaker, ensuring participants, dealing with difficulties will be hosted by the Malaysian trainers' group.

CINE EDUCATION

A highlight of the workshop will be Cine Education to be presented by Prof Ryuki Kassai from Hokkaido University. He is a veteran in this form of education. Cine education is an excellent medium to study non-verbal language and behaviour.

TRAINEE ASSESSMENT

The session on nuts and bolts of trainee assessment – Log book, clinic visits, as well as the strategies to deal with difficult trainees will led by Dr John Chung, sharing the Hongkong experience in family medicine vocational training.

OSCE ORGANIZING & EXAMINING

OSCE as a method of assessment is now a staple in undergraduate and postgraduate examinations. The session will deal with three aspects of the OSCE

- Writing of the OSCE — instructions to candidates/learner, the script and training the "patient", marking checklist. The example of an OSCE written to examine telling bad news will be discussed

- Organising the OSCE – the tasks of organizing a 10 station OSCE — time-tabling, stations, actors and examiners, stationery will be presented
- Examining the OSCE – this will be done as a plenary activity. Participants will grade the "candidate". Discussion of the grades that they have given the candidate will follow with take home lessons.

MCQ & KFP

The essentials for writing effective testing instruments of the MCQ and Key feature problems (KFP) will be conducted as a workshop. Small groups will present one MCQ and one KFP for critique in the plenary.

INVITATION

The workshop will be a good forum to brush up your teaching skills in two days. This workshop is targeted at trainers who are involved in teaching family medicine, either at the postgraduate or undergraduate levels.

REGISTRATION

The registration fee is US \$200 per delegate which will include workshop papers, meals, refreshments, Official Dinner, and two-night twin occupancy accommodation (US \$250 for single occupancy). Soft copy of application form available from CFPS Secretariat (jace@cfps.org.sg). There will be places for 60 delegates.

Relearning cardiac auscultation skills – *Is there a need?*

By Ms Ng Wei Fern, Final Year Medical Student

The stethoscope has been a time-honored tool, and long regarded by most to be the hallmark of a physician's practice. But, do most doctors still retain the auscultation skills acquired from medical school? This must be an interesting question to most of us. Or perhaps even a question we all fear to answer. Indeed, how do our doctors here fare in cardiac auscultation? Our study "Retraining Physicians in Cardiac Auscultation - is there a need?" seeks to find the answer.

106 doctors from the Family Medicine Training Program (FMTP) participated in our study. Most of them are currently running their own clinics in general practice or working in polyclinics. Others are medical officers working in restructured hospitals. They were asked to listen to and interpret 10 sets of standard cardiac sounds stored on the Littman E4000 electronic stethoscopes.

The mean score was 4 correct diagnoses out of the 10 sounds with a range from nil to eight correct. Systolic murmurs were more often correctly identified compared to the more technically difficult diastolic and added sounds. In 1997, Mangione and Nieman¹ reported a similar study in the US and found their physicians achieved mean scores of 2.5-2.6 out of a maximum of

12. In that light, the performance of doctors in our study may not be as disheartening as it first appears to be. Are the low scores due to a greater reliance on technology in developed countries (like the echocardiography) and less clinical exposure as many patients with abnormal cardiac sounds are sequestered in cardiac departments? What are the reasons some doctors perform better than others?

In 1960, Butterworth and Reppert² found that physicians' auscultatory abilities declined with increasing time in clinical practice. We arrived at the same conclusion in our study, with a significant drop in performance at the watershed of 8 years after graduation. We also found that the place of current practice and the time spent previously in internal medicine, cardiology and pediatrics (where higher level of exposure to cardiac auscultatory signs is expected), did not improve auscultatory scores. This suggests that cardiac auscultation skills are maintained not just by working stints in relevant departments, but that specific attention must be accorded to such skills throughout the course of our medical practice, lest they erode with time.

We recognize certain limitations of our study. Firstly, it was carried out on a select group of doctors and hence may not be representative of Singapore's medical practitioners in general. Secondly, the study only assessed accuracy in identifying selected cardiac sounds and the scores do not reflect diagnostic proficiency, as we know that other clinical input are essential in working up real patients.

However, this study suggests that it is important to revisit and reinforce basic clinical skills in the continuing medical education of doctors, for CME is not just about learning new advances in medicine.

Reference:

1. Mangione S, Nieman LZ. Cardiac auscultatory skills of internal medicine and family practice trainees. *JAMA* 1997; 278(9):717-22.
2. Butterworth JS, Reppert EH. Auscultatory acumen in the general medical population. *JAMA* 1960; 174(1):114-6.



The E-stethoscope research team celebrating the completion of the projects, X'mas 2003: (L-R) Ng Wei Fern, Michael Lam, Dr Carolyn Lam, A/P Cheong Pak Yean & Ho Khek Yu, Hey Hwee Weng, Theodric Lee and Boey Pui Yi

Research projects born of SARS

234 pre-clinical medical students were denied access to real patients for their 'elementary clinics' during the SARS outbreak in 2003. 3 members of the teaching staff of National University of Singapore (NUS) came out with an innovation to use electronic stethoscopes to teach them cardiac auscultation skills. 5 final year medical students joined the research team under the NUS medical student elective programme. The outcome – 2 innovative research projects on the novel use of e-stethoscopes.

The team confirmed the validity and effectiveness of this teaching tool and presented it as a poster exhibit in the 2003 NHG Annual Scientific Congress. In

addition, a parallel study on 106 doctors doing the FM Training Programme (FMTP) revealed that proficiency in cardiac auscultation deteriorated significantly 8 years after graduation from medical school regardless of their hospital work experience:

Both studies were shared as poster exhibits in the 2003 NUS-NUH Annual Scientific Meeting. Medical students, Theodric and Michael further presented the studies in the 2nd Symposium of the Asian Medical Education Association held in Shanghai, China in Nov 2003. Wei Fern won the 1st prize for the best oral presentation at the 1st Asian Pacific Medical Education Conference held in Singapore in Dec 2003 for her

presentation of the doctors' study. The NHG-NUS Simulation Training Laboratory now uses the e-stethoscope as one of its training tools. This innovation caught media attention during the official opening of the laboratory and was reported in both broadcast & print media on 23rd Oct '03. Research papers based on these two studies have been submitted to peer-reviewed journals for publication.

Necessity inspired this innovation. The camaraderie of the whole team and the tenacity and hard work of the student researchers led to its successful completion. E-stethoscopes are now used to teach medical students and doctors cardiac auscultation skills in Singapore.

Course Overview

The Graduate Diploma in Family Medicine (GDFM) is a vocational training certification for primary care doctors. The aim of this 2-year part-time trainee programme is to train primary care doctors to practise Family Medicine at an enhanced level to meet the needs of the child, adolescent, the adult and the elderly.

This programme is planned to accommodate the busy doctor's schedule as almost all the in-person attendances are conducted outside regular office hours. In-person attendances consist of:

- **8 GDFM Modules with each comprising:**
 - 4 Workshops (2½ hrs each)
 - 1 Tutorial (1 hr each)
- **5 Courses**
 - 3 mandatory courses (9 hrs in all)
 - 2 elective courses (6 hrs each)

These in-person attendances are supplemented by distance learning - paper and web-based.

GDFM Roadshow

College is holding a GDFM roadshow for doctors who are interested in enrolling.

Highlights:

- Overview of GDFM Programme
- Continuing Postgraduate Education
- My Learning Experience by present GDFM trainees
- Q & A and panel discussion

Venue: Lecture Room, College of Family Physicians Singapore #01-02, College of Medicine Building

Date & Time: Wednesday 7th April 2004, 5.15pm

Core FM CME Points

Trainees of 2004/2006 batch can expect to earn:

GDFM Modules

For Year 2004: a maximum of 18 FM CME points under Category 1A for 2 GDFM modules.

For Year 2005: a maximum of 36 FM CME points under Category 1A for 4 GDFM modules.

For Year 2006: a maximum of 18 FM CME points under Category 1A for 2 GDFM modules.

GDFM Courses

For GDFM Courses, trainees can earn between 2 to 12 points FM CME points, depending on the type of courses attended.

Graduate Diploma In Family

8 GDFM

1 Aug 2004 Module 1 Principles of FM, CVS & Respiratory System

- Principles of FM; Consulting Skills
- Counselling; Communication Issues
- Respiratory Infections; Non-Infective Respiratory Disorders
- Ischaemic Heart Disease; Medical Records & Confidentiality

2 Nov 2004 Module 2 Child & Adolescent Care, GIT

- The Preschool Child; Normal & Abnormal Development
- On the Adolescent; Childhood Behavioral Disorders
- Upper GI Diseases; Lower GI Diseases
- Liver & Biliary Tract Disorders; Notification, Certification & Dispensing

5 Aug 2005 Module 5 Individual, Family & Community, Skin

- Human Behaviour & Beliefs; Family in Health & illness
- Disease Control & Immunisation; Preventive Medicine
- Non-Infective Dermatoses; Infective Dermatoses
- Skin, Hair & Nails; Practice Issues

6 Nov 2005 Module 6 Adult Care, Musculoskeletal/Emergency Medicine

- The Occupational Health & Disease; Workplace Hazards
- Fitness to Work; Travel Medicine
- Emergency Care & Housecall; Rheumatic, Bone & Joint Disorders
- Sports & Accidental Injuries; Setting Up Practice

GDFM Modules

Each GDFM module consists of 1 Family Medicine Modular Course (FMCM) with 1 small group tutorial based on the theme of the FMCM module of that particular quarter. 1 module would be covered per quarter. Trainees are required to attend all the 8 modules.

The FMCM consists of distance learning, 4 Saturday afternoon workshops and formative assessment. Attendance of the tutorial and at least 3 of the 4 workshops is mandatory for each FMCM module to be certified. The structure of each module consists of 8 sub-modules, 4 in whole person medicine, 3 in body systems and 1 in practice management.

Sample - Tutorial Topics for Module 1

Unit 1: Focussed Examination of The Respiratory System

Unit 2: Therapeutics Approach - Cough Mixture; What Should Cough Mixtures Contain?

Unit 3: Therapeutics Approach - Antibiotic Use in Upper Respiratory Tract Infection (URTI)

Unit 4 (Additional teaching materials)

Diagnostics Approach - Problem Based Learning: A Man With A Cough And Fever

Medicine Programme (GDFM)

Eligibility

Modules

3 Feb 2005 Module 3 Chronic Medical Care, Renal & Blood <ul style="list-style-type: none">• Continuing Care; Hypertension• Diabetes Mellitus; Care of the Terminal ill• Oncological Problems; Haematological Problems• Urinary Tract Problems; Doctor as Manager	4 April 2005 Module 4 Elderly Care & Psychiatry <ul style="list-style-type: none">• Ageing, Fitness & Assessment; Stroke & Rehabilitation• The Frail Elderly; Prescribing in the Elderly• Mood Disorders; Anxiety Disorders• Computer Use in Practice; Teaching & Research
7 Feb 2006 Module 7 Antenatal/Obstetric Care, Neurology & EENT <ul style="list-style-type: none">• Family Planning & Infertility; Common Gynaecological Disorder• Gynaecological Cancers; Sexually Transmitted Diseases• Common Neurological Disorders; Eye Disorders• ENT Disorders; Financial Mx	8 April 2006 Module 8 Gynaecology & Endocrinology <ul style="list-style-type: none">• Antenatal Care & Drug Use; Medical Disorders in Pregnancy• At Risk Pregnant; Postnatal Care• Nutritional Counselling; Metabolic Disorders• Endocrine Disorders; Quality Assurance in Practice

The candidate must possess the following to be eligible to register for the GDFM programme:

- A basic degree of the MBBS or equivalent qualification registered with the Singapore Medical Council
- Any registered medical practitioner can apply including doctors now finishing housemanship & becoming MO in April/May 2004

Fees:

GDFM Programme Fee (payable to College of Family Physicians Singapore)

- *College member* : S\$ 3570 (covers registration fee of \$50, 8 GDFM Modules & 3 GDFM mandatory courses; fees does not include the BCLS & 2 electives FP skills courses)
- *Non-College member* : S\$ 3930

Examination Fees (payable to Division of Graduate Medical Studies, NUS when apply for examination in May 2006) : S\$ 500 (does not include registration fee of \$52.50)*

GDFM Courses

The GDFM Courses emphasize on basic clinical diagnostic and management skills essential to general practice and will be conducted in the two years. To qualify for the examination, trainees must complete 3 mandatory courses, 2 elective skills courses and 1 BCLS course.

3 GDFM Mandatory Courses

- Principles & Practice of FM (P & P)
- Communication and Counselling (C&C)
- GDFM Clinical Revision Course

2 Elective FP skills courses (excluded in GDFM programme fee)

Family Practice skills courses which are organised or accredited by the College consist of distance learning, seminars and workshops.

1 BCLS competency certificate(excluded in GDFM programme fee)

A valid BCLS competency certificate is required for examination application with DGMS, NUS. (*To be completed by the trainee on his/her own*)

GDFM Examination

The examination is conducted by the DGMS, NUS in July/August 2006 and consists of:

- Written Paper: Applied Knowledge Test(MCQ) paper (2 hours) 25%
- Key Features Problems paper(1 hour) 25%
- Skills Assessment by OSCE(Objectively Structured Clinical Examination)(2 hrs) 50%

Response Form

- Please send me GDFM application form.
- Yes, I am interested in attending the GDFM roadshow on 7th April 2004.

Name :Dr _____

MCR No: _____

College Member: Yes No

Mailing address: Residential Practice

Tel: _____(H) _____(O)

Fax: _____

Email: _____

* Subject to changes

Study Team from Vietnam

A dozen-strong Family Medicine Study Team from Vietnam visited the College on 8 Jan this year. Singapore was the first part of the Study Team's two-venue tour. The second venue was the Philippines. The team was led by Prof. Le Van Khang, a member of the National Family Medicine Committee in Vietnam. Other members comprise representatives from the Vietnamese Ministry of Health, clinical teaching centres and various Universities. The team was here to study Singapore's system of undergraduate and post graduate training in family medicine.

Vietnam's development in Family Medicine Vietnam has embarked on a national programme to develop Family Medicine as a discipline in both in the undergraduate and postgraduate levels. It is recognized as a first level specialty, somewhat like the situation in the United States. General Medicine, Paediatrics and Obygn are the other first level specialties. The vision for Family Medicine is to have at least one doctor trained in Family Medicine for its Government Health Centres. There are some 80 of these Health Centres in the whole of Vietnam. Currently, the University of Vermont in Maine in the United States is actively helping Vietnam develop its Family Medicine training programme. Many of the Teaching Faculty have gone to the United States for training.

The Singapore visit programme

The Study Team spent one day in the Department of Community, Occupational & Family Medicine to exchange ideas and programme development in Family Medicine in the two countries. This was followed by a visit to the College of Family Physicians, Singapore. The focus of the visit to the College was to understand and learn from the structured training programs organized by the College. There was a great deal of interest in the Graduate Diploma in Family Medicine programme which was seen as a programme that can reach out to large numbers of family physicians.

Syllabus and content of family medicine

The Vietnamese study team was very impressed by the syllabus and content of

the College's family medicine training programme and requested that the College gives permission for the useful parts to be incorporated into the Vietnamese national programme in addition to the Essentials of Family Medicine by Sloanne that Vietnam is currently using.



Standing(L-R) : Prof Hoang Cong Dac-Vice Director, E Hospital, Dr Quang van Tri - Lecturer, Hanoi Medical University, Dr Nguyen Van Thang - Lecturer of Pediatric Dept, Hanoi Medical University, Prof Le Van Khang - Member of National Family Medicine Committee, A/Prof Goh Lee Gan, Dr Alfred Loh, Prof. Nguyen Thi Kim Chuc - Member of National Family Medicine Committee, Dr Dang Thi Kim Oanh - Lecturer of Intermedicine Dept, Hanoi Medical University, Nguyen Thi Thuy - Health Strategy and Policy Institute.
Seated(L-R) :Dr Nguyen Quoc Hung - Bavi District Hospital, Dr Trinh Xuan Trang - Lecturer, Thainguyn Medical School, Dr Tran Tien Manh - Post graduated Dept, Hanoi Medical University, Phan Thi Bich Thao - Science and Training Department, Hanoi Medical University, Dr Tran Quy Tuong - Secretary of Vice Minister, MOH, Vietnam.

Teaching methods

The model of part-time teaching programme made up of self-directed learning and face-to-face learning through workshop and tutorials in the Singapore programme was felt to be a useful model. The Vietnamese Team said it would like model its programme after the Singapore system.

Visit to Polyclinic

The team also visited Bukit Merah Polyclinic provided an opportunity for the Study Team to view the set-up of family practice in the public sector. The counterpart of the Polyclinic in Vietnam is the commune health center.

Training Of Trainers (TOT)

It was agreed that TOT is important to build capacity of trainers. The three key areas in TOT programmes are: Family Medicine programme design; teaching methods (workshop and tutorials); assessment methods (written examination, MCQ, Key feature problems (KFP), and OSCE). In the discussion, it was suggested that one collaboration model is to have the US,

Philippines, and Singapore trainers form the FM TOT teaching faculty for the Vietnamese trainers. The first activity could be a TOT course in Hanoi with the participation of these three countries. The delegation will be discussing the model with Philippines. The desired length of the TOT course was set as 5 days. Another

idea that was floated by the visitors was to send about 20 doctors abroad for training each year. An alternative to full financial support given by the host country receiving the Vietnamese trainers is a work-for-pay programme.

The visit was extremely beneficial for both the hosts and the visitors. Both parties benefited from the exchange of ideas in training and improving the standard of family medicine. This visit is just another example of the College's continuing effort in building bridges and lending a hand to the family medicine fraternity in the region.



A/Prof Cheong Pak Yean receiving a gift from Prof Nguyen, Prof Le & Dr Tran

College Special Interest Groups (SIGs)

Report - Mental Health SIG

By Dr Tan Yew Seng, Chairman of Mental Health SIG & 19th Council Member

Family physicians (FP) can intervene effectively in mental health problems in the community. This was the key message at the FM Grand Round on Mental Health that was held on 6 Jan 2004. This inaugural session of the Grand Round series was opened by A/P Goh Lee Gan, who cited the significance of the grand round as a forum for FP. The chairperson, Prof Kua Ee Heok of the Psychological Medicine department of the National University Hospital, affirmed the FP's role in mental healthcare, noting that the person in mental distress would more likely visit their FPs than any other professionals.

The theme of the Grand Round, "Symptom/Disease Attribution in Family Practice", was apt as patients in family practice frequently do not present with well-differentiated conditions, and symptoms are what FPs have to contend with at the first consultations. 3 cases were presented by Dr Dixie Tan and the author. Dr Tan chose her cases carefully to show how differently she handled the

problem before and after her family therapy training. The frankness and humility with which she shared her experience in the patient management provided valuable lessons that are hard to find in conventional textbooks. The author presented a case of somatic complaints during the recent SARS outbreak.

The grand round has been significant in 2 aspects. Firstly, judging from the ensuing questions, comments and discussion from the audience, this event fulfilled the intention of the organizers – that this should be a forum for FP, by FP. Secondly, the turnout was encouraging not only in numbers, but also in their ages. The age range of the attendees ranged from twenties to seventies. This provided a unique mix of fresh viewpoints and seasoned experience, from esteemed Professors to junior medical officers. This form of discourse evidently struck a chord with members of the audience. Said one of them, it was the "experiential" nature of the event that she found most useful.

FMGR- "Symptom & Disease Attribution in Family Practice"

By Dr Shah Mitesh, Registrar NHG polyclinic, Advanced trainee(FM Fellowship Programme)

3 cases were presented at the first FMGR focusing on mental health in family practice. We feature the 2 cases presented by Dr Dixie Tan. The 3rd case presented by Dr Tan Yew Seng has already been published in the Singapore Medical Journal in Nov 2003 as a case report "Fever Attribution in the SARS Outbreak" - Tan YS, Cheong PY Sing Med J 2003 Vol 44(11): 590-594 .

Case no. 1: A woman who was "afraid in the chest"

51 yr old Chinese principal of a reputed school, married with children, 2 years post menopause. She consulted the doctor because she felt "afraid in the chest" and wanted to exclude cardiac pathology. She also had stiff neck, mild weight loss and dizzy spells without vertigo.

On examination, she looked depressed and the check up was otherwise normal. CXR and cervical-spine xrays, ECG and general laboratory screening tests were all normal. A diagnosis of tension was made. She came back every 2 months with different symptoms each time. Each time accompanied by her husband for moral support. Later she confided that the husband was having an affair with someone in Shanghai.

The symptoms seem to improve by themselves with no intervention. Finally after a long lull the patient came to see Dr Tan on her own. She was happy and symptom-free and merely wanted to talk with her doctor who had known her through the years. She had separated from her husband and the children were grown up, freeing her of any financial responsibility. A final diagnosis of psychosomatic disorder secondary to marital disturbance was made.

Discussion points

1. Commonest symptom of outpatient psychiatry is phobia. Fear of crowded places, fear of failing exams/projects/

Family Medicine Grand Round

"A Teenager With Vomiting"

Chairman:

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

Discussant:

Dr Helen Leong Soh Sum
Assistant Director, Medical Affairs
National Healthcare Group Polyclinics

Outline:

School examinations are significant life events for many Singapore teenagers. However, it is not uncommon in family practice to find the stress of such an event being expressed somatically. In this grand round, we shall hear about a teenager whose problems in dealing with examination stress are manifested as vomiting. What can the family physician do in such situations? What psychological techniques can the family physician use to help this teenager? Dr Helen Leong, a consultant family physician who is also trained in psychotherapy will discuss the case and share her expertise in dealing with this often-encountered problem in family practice.

We look forward to your participation. For enquiries, contact the College Secretariat at 6223 0606 or email contact@cfps.org.sg. **ADMISSION IS FREE. (1 Core FM Point)**

6 April 2004 (Tuesday)

5:15pm - 6:45pm

CFPS Lecture Room
#01-02
College of Medicine Building
16 College Road
Singapore 169854

relationships, and fear of marital disharmony are some good examples.

2. Patient complained of fear in the heart, not physical heart but emotional aspect of heart.

3. Doctors can reassure patients even without prescribing medicines. The counter nurse is a counselor to the patients in many cases.

Case No. 2-A young woman presenting with nocturnal chest pain

A 35 yr old Malay divorced Factory Executive complained of a 2 day history of chest pain, waking her up in early hours of morning. The pain radiated to the nipples every 5 minutes, and was relieved by getting up. The symptoms were similar to those one month ago, after her father died. She also had poor appetite and insomnia. The patient admitted that something was "upsetting her" but did not wish to talk further. Examination was unremarkable, except for mild epigastric and LIF pain. A diagnosis of gastritis triggered by emotional disturbance was made. She was treated with Zantac, antacids, Prothiaden 25 mg om and Lexotan, for 2 weeks and asked to return for a review.

2 weeks later, she confided that since her father died, she had rented out his room to her niece and her husband. The niece's husband had made sexual advances towards her. There was anger but likely she was also loathed to bring up matter with niece having already suffered a loss of emotional support with father's death.

Discussion Points

1. Young patients usually have chest pain of non-cardiac origin.
2. Knowledge of old and recent issues in the family help to link and relate the symptoms better, hence coming to a diagnosis much earlier.
3. People who are depressed are much more prone to IHD and AMI. Most post-MI patients develop depression.
4. Antidepressant treatment should be given for 6 months, giving the patient enough time and confidence in us to confide her family / social problems. As psychotherapy kicks in, we can then taper off treatment.

Report - Eldercare SIG

By Dr Tan Boon Yeow, Chairman of Elder Care & Fellow of College

The first Family Medicine Grand Round on Elder Care featured a 2-part presentation on the topic of "Treatment Resistant Depression in the Elderly". The first was presented by Dr Tan Boon Yeow, family physician practicing in St. Luke's Community Hospital. He explored ways in which a family physician can manage the depressed elderly. This was further illustrated with difficult cases that were encountered in practice. Dr Francis Ngui, consultant psychiatrist with a special interest in geriatric psychiatry, then looked at ways a psychiatrist can tackle this problem of treatment resistant depression.

In addition, the eldercare SIG had her first two meetings on the 16th of Jan and 3rd Feb this year. At the first meeting, we were able to discuss the various ways we hope to fulfill the objectives of the SIG group (highlighted in the previous College Mirror). It was reiterated that the SIG is really meant for college members and the

only criteria for being part of the group is that one has an interest in caring for the elderly.

The group expounded on ways we can achieve our aims. The newly inaugurated family medicine grand rounds as well as other ad hoc programs and College journal publications will be the means by which the eldercare SIG hopes to generate interest in the first year of its inception. The group also recognize the importance of being relevant to the needs of the practicing family physician in his clinic as well as to others that may deal more with the elderly in different settings (community hospitals, domiciliary care groups, nursing homes etc). It is envisaged that the College SIG will look more into the first group as there are other organizations and programs that cater for the latter groups. The SIG also hope to conduct a survey later in the year to find out more about the members' needs in this area of medicine.

Family Medicine Grand Round

"Eldercare experience"

Chairman:

Dr Tan Kok Leong, Fellow of College and Senior Family Physician, Singhealth Polyclinic.

Outline:

In this special interest group meeting, we look at eldercare through the perspectives of three family physicians.

The Japan Experience - Dr Ho Han Kwee. Dr Ho spent 2 years enjoying the maple leaves and sushi in

Japan. He was fortunate enough to be around during a time when the Long Term Nursing Insurance scheme was implemented in Japan and benefited from the discussion, actual implementation and evaluation of this scheme. During his spare time, he interacts with elderly from this country with the world's longest life expectancy.

Eldercare Down Under- Dr Tan Boon Yeow. Dr Tan spent a year and half in Melbourne and Sydney gleaning from the various aged care set ups ranging from acute to community geriatric services

Eldercare training in Singapore - A/Prof Goh Lee Gan . A/Prof Goh is chairman of Diploma in Geriatric Medicine Committee. He looks at the challenge of gearing up the family physician to meet the needs of the greying population .

Come, join us to hear about these unique experiences by our fellow colleagues as well as to draw lessons from these overseas systems of healthcare for the elderly. The 3 presentations will be followed by a discussion session to explore ways we can improve the local eldercare system. **ADMISSION IS FREE. (1 Core FM Point)**

4 May 2004 (Tuesday)

5:15pm - 6:45pm

CFPS Lecture Room
#01-02
College of Medicine Building
16 College Road
Singapore 169854

Adverse Drug reactions - the Singapore Experience

Ms Chan Cheng Leng heads the Pharmacovigilance Unit (PV) as well as the Information & Research Unit at the Health Sciences Authority. As the head of the PV Unit, she is responsible for monitoring the safety of marketed drugs and related health products in Singapore. Ms Chan spearheads efforts to improve the national level of adverse drug reaction reporting.



1. What is pharmacovigilance and what does the pharmacovigilance unit of the HSA do?

Pharmacovigilance was a term coined in France in 1972 to describe a national system for maintenance of vigilance over toxic and unwanted effects of pharmaceuticals. Since then, Pharmacovigilance has evolved to encompass the postmarketing surveillance activities related to the detection, assessment, understanding and prevention of adverse drug reactions.

The Pharmacovigilance (PV) Unit at HSA is responsible for monitoring the safety of marketed drugs and related health products in Singapore and ensuring that appropriate regulatory action is taken to enhance the safer use of these products based on the signals that it obtains. It does this by conducting the following activities:

- Reviewing Adverse Drug Reactions (ADRs) reports submitted by local healthcare professionals, pharmaceutical companies, from the scientific literature and from information shared among its regulatory counterparts
- Assessing the risks & benefits of a drug and instituting appropriate regulatory action to enhance the safer use of these products
- Providing relevant safety information to advise and inform the clinical community and the public at large to ensure safer and more effective use of these products

2. How serious is the problem of adverse drug reactions in Singapore?

The magnitude of adverse drug reactions in Singapore is uncertain, because of the limited incidence data. Nonetheless from the reports and signals that we receive from our healthcare professionals, it is definite that ADRs has a direct impact on patient's morbidity and mortality.

The US Institute of Medicine reported in January 2000 that about 44,000 to 98,000 deaths occur annually from medical errors. Of this total, an estimated 7,000 deaths occur due to ADRs.

The Pharmacovigilance Unit has been receiving an increasing number of ADR reports from our healthcare professionals over the last 6 years. There has been a 5-fold increase in the reports since 1997. The proportion of serious ADR reports has also increased from 4% in 1997 to 22% in 2002. However, this does not necessarily indicate an increasing number of serious ADRs experienced by our population per se but signifies the increase in participation of our healthcare professionals in reporting ADRs to us and the improved quality of reporting.

3. Why should doctors report adverse drug reactions?

All drugs have the potential to cause adverse effects. The US General Accounting Office reported that in about 50% of drugs that are approved by the US FDA, the serious ADRs manifest only after the product is marketed and used

extensively in a large number of patients with the majority of them occurring within the first 3 years of marketing of a drug.

In addition, traditional and herbal medicines are gaining in popularity. They pose different toxicological problems, e.g. drug-herb interactions, and the potential for adulteration with western medicines for commercial reasons.

Reporting of spontaneous adverse drug reactions by healthcare professionals is recognized as one of the most powerful and cost effective tools for detecting serious adverse drug reactions associated with a product throughout its marketed life. Doctors are critical to this process, especially those who are working directly with patients as the first hint of a potential safety problem originates with the perceptive physician who then reports the case to the regulatory authority.

Your reports will allow us to detect serious ADRs or an increase in the trend of serious ADRs and enable us to take relevant regulatory action to protect public health and safety. These actions include updating the prescribing information of a product to reflect the new risks, re-evaluation of the earlier regulatory approval decision, suspension of particular batches of a product, and in rare cases, complete withdrawal of the product from the market, if the health risk is assessed to be too great.

4. What is the role of the family physician in monitoring adverse drug reactions?

Adverse Drug Reactions represent a significant public health problem. Although we do not have the incidence data for our population, the overseas data suggests that ADRs account for 2-6% of all hospital admissions. Our family physicians being the first line of care for our patients would thus be in an ideal situation to be among the 1st to be alerted to a potential drug safety problem.

The Slim 10 incident was an exemplary case of the value of ADR reporting by our doctors. Slim 10 was approved for

marketing as a Chinese Proprietary Medicine in November 2001 and was tested free of adulterants at the time of marketing approval. The product was already sold freely in China before its introduction into Singapore.

Three months after its launch in the local market, a family physician was among the first to report to us of hyperthyroidism in her patients who were taking Slim 10 for weight loss. In addition, she was able to furnish us with relevant clinical laboratory results to support her suspicions of possible adulteration of Slim 10 with an exogenous source of thyroxine. In this instance, the high quality of our doctors' reports were powerful signals of a potential safety problem with Slim 10 and provided HSA with the stimulus to mandate a withdrawal of a harmful product.

Slim 10 was subsequently found to be adulterated with thyroid gland material, nitrosfenfluramine and fenfluramine. You can imagine the epidemiological disaster that could have followed if our doctors did not alert HSA to the ADRs.

5. What should a doctor do when he sees a case of adverse drug reaction?

I appreciate that the recognition of an ADR is quite subjective and imprecise. However, causality is NOT a pre-requisite for ADR reporting; suspicion that a health product may be related to a serious adverse event is sufficient reason for a doctor to lodge an ADR report to us.

In order to facilitate the reporting process, we have opened several channels for reporting. These include the following:

- Mail/Fax the yellow ADR reporting form (please contact PV Unit if you do not have access to this form).
- Call PV Unit (Tel no: 63252432/63255498)
- Email to hsa_drugsafty@hsa.gov.sg
- Online reporting at http://www.hsa.gov.sg/ADR_Online

6. Does reporting of adverse drug reactions really make a difference?

Yes, most definitely! Local ADR reporting

allows us to develop our own signals which may or may not be the same as the other countries. We all are aware that most of the clinical trials are conducted in the American, European and Japanese patients with very little Asian exposure; active reporting of ADR allows us to detect adverse events unique to our population eg whether they be due to genetic differences, smaller body build of our patients and life-style differences eg concomitant use of complementary medicine.

Your reports will enable us to take the appropriate regulatory action to protect public health.

7. How does Singapore compare to other countries in pharmacovigilance and what would be the ideal situation that we should all work towards?

I think generally on the whole, we have come a long way since the unit was first established in 1993. We are slowly but surely building a brand name for ourselves as being efficient and responsive to the needs of our healthcare professionals in the area of pharmacovigilance.

There are of course, various areas in which we can improve, eg to leverage on IT such as electronic medication records for signal detection and communication and working more closely with GP groups and the national clusters to develop sentinel centres for ADR detection.

The ideal situation would be that when our doctors are confronted with what looks like an ADR matter at hand, their first instinct would be to alert the Pharmacovigilance Unit of their suspicions, whether it be to western or complementary medicine.

Ideally, the regulators and the healthcare professionals should work more closely together in order to bring about more quality signals and also the learned and professionals inputs from our healthcare professionals will refine our regulatory decisions.

Join as College Members

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.

(Application forms can also be downloaded from <http://www.cfps.org.sg>)

College Membership Response Form

Please send me an application form.

Name : Dr _____

MCR No : _____

Mailing Address : _____

Contact No : _____

Fax No : _____

To:
College of Family Physicians Singapore
16 College Road #01-02
College of Medicine Building
Singapore 169854
Tel : 62230606 Fax : 62220204
Email : Contact@cfps.org.sg

Effective Medicine in Small Doses

By Dr Yvette Tan, Editorial Board Member

1 Does 5% tea tree oil shampoo reduce dandruff?

Tips:

Daily shampooing with 5% tea tree oil reduces the severity and extent of dandruff. Overall improvement is similar to topical treatment with ketoconazole or terbinafine. Tea tree oil is a good alternative for patients who prefer a natural product, don't mind daily hair washing, and can tolerate the distinctive tea tree oil fragrance.

The Journal of Family Practice • April 2003 • Vol. 52, No.4, review of paper by Satchell AC, Saurajen A, Bell C, Barnetson RS. Treatment of dandruff with 5% tea tree oil shampoo. J Am Acad Dermatol 2002; 47:852–855.

3 Do probiotics decrease antibiotic-associated diarrhoea?

Tips:

Taking probiotics containing Lactobacillus or Saccharomyces species decreases the incidence of antibiotic-induced diarrhea from 23% to 13% (number needed to treat=10). The optimal dose of ingested organisms is unknown.

The Journal of Family Practice • April 2003 • Vol. 52, No. 4, paper reviewed : Cremonini F, Di Caro S, Nista EC, et al. Meta-analysis: the effect of probiotic administration on antibiotic-associated diarrhoea. Aliment Pharmacol Ther 2002; 16:1461–1467.

5 Are topical antibiotics effective in treating bacterial conjunctivitis?

Topical antibiotics can reduce the time to clinical and microbiologic remission in patients with bacterial conjunctivitis, particularly with culture-proven infection. However, the majority of patients experience clinical resolution of the condition without treatment. Further, as many cases of conjunctivitis in a primary care clinic are viral in origin, the efficacy of antibiotics is likely to be lower in practice than in this study. Antibiotics should be reserved for patients in whom bacterial infection is strongly suspected.

Tips:

Bacterial infection is more likely to present with an abrupt onset of ocular irritation, diffuse hyperemia, and purulent drainage that mats the eyelids at waking. Viral conjunctivitis is characterized by a watery or mucoid discharge and often a history of a viral upper respiratory infection. Viral infection is also suggested in the case of rapid spread in families, daycare, or school settings, as it is highly contagious even up to 2 weeks after the onset of symptoms.

The Journal of Family Practice • SEPTEMBER 2001 • Vol. 50, No. 9. paper reviewed : Sheikh A, Hurwitz B. Topical antibiotics for acute bacterial conjunctivitis: a systematic review. Br J Gen Pract 2001; 51:473-77

2 Duct tape removes warts?

Duct tape (or any durable, occlusive, tacky tape) appears to be at least as effective as traditional cryotherapy for removal of the common wart.

Tips:

A piece of duct tape the size of the wart was applied for 6 days. After 6 days, the tape was removed and the wart was soaked in water and then debrided. Tape was left off overnight and then new tape was applied for another 6 days.

The Journal of Family Practice • February 2003 • Vol. 52, No. 2, Review of paper : Focht DR III, Spicer C, Fairchok MP. Efficacy of duct tape vs cryotherapy in the treatment of verruca vulgaris (the common wart). Arch Pediatr Adolesc Med 2002; 156:971–4.

4 Hair apposition technique is better than suturing scalp lacerations

Using hair apposition with tissue adhesive appears to be an effective technique for closing simple scalp lacerations. It is faster and better tolerated than suturing, and appears to result in less scarring. The superficial apposition provided by this technique will not be adequate in those cases where deep sutures are required. Using the hair apposition technique appears to be a practical method of treating scalp lacerations.

Tips:

After cleaning the wound, and without anesthesia, about 4 to 5 strands of hair from each side of the laceration are twisted together once and a drop of tissue adhesive is placed on the twist to hold it in place. A series of twists are placed over the laceration to appose the wound. Patients are instructed not to wash their hair for 2 days.

The Journal of Family Practice • October 2002 • Vol. 51, No. 10, Paper reviewed : Hock MO, Ooi SB, Saw SM, Lim SH. A randomized controlled trial comparing the hair apposition technique with tissue glue to standard suturing in scalp lacerations (HAT study). Ann Emerg Med 2002; 40:19–26.

6 Suturing unnecessary for hand lacerations under 2 cm

Tips:

Hand lacerations less than 2 cm long without tendon, joint, fracture, or nerve complications and not involving the nail bed can be cleaned and dressed without suturing, with similar cosmetic results and time to resume normal activities. Moreover, managing these uncomplicated hand lacerations conservatively could result in better use of medical resources and improved patient satisfaction due to less pain and less time spent in the emergency department.

The Journal of Family Practice • January 2003 • Vol. 52, No. 1 Review of Paper : Quinn J, Cummings S, Callahan M, Sellers K. Suturing versus conservative management of lacerations of the hand: randomised controlled trial. BMJ 2002; 325:299–300.

References:

POEMs (Patient-Oriented Evidence that Matters) editorial team reviews more than 90 journals of interest to primary care physicians. The collected reviews are available online at www.jfponline.com.

WHI (Women's Health Initiative) Update

By Dr Shiau Ee Leng, Editorial Board Member

WHI Update

National Institutes of Health (NIH) established the Women's Health Initiative (WHI) in 1991 to address the most common causes of death, disability and impaired quality of life in postmenopausal women. WHI will address cardiovascular disease, cancer, and osteoporosis. WHI is a 15 year multi-million dollar endeavor, and one of the largest U.S. prevention studies of its kind. The 3 major components of the WHI are:

- a randomized controlled clinical trial of promising but unproven approaches to prevention for Hormone Replacement Therapy Trial (HRT), Dietary Modification Trial (DM) and Calcium/Vitamin D Supplementation Trial (CaD)
- an observational study to identify predictors of disease;
- a study of community approaches to developing healthful behaviors

In July 2002, the investigators stopped the estrogen-plus-progestin study after finding that the associated health risks outweighed the benefits. The researchers are continuing to analyze and report on data from this trial while they complete other WHI studies

Key Findings from the Women's Health Initiative

1 Fracture Risk and Bone Mineral Density (JAMA October 2003)

Summary of results :

After an average of 5.6 years, 733 (8.6%) of women in the Estrogen and Progestin E+P group and 896 (11.1%) women taking placebo (inactive) pills experienced a fracture.

- Overall, there was a 24% reduction in all fractures and a 33% reduction in hip fractures in women assigned to E+P.
- Hip bone density increased 3.7% after 3 years of taking E+P compared to 0.14% in the placebo group.

While it appears HRT will reduce fractures, WHI concludes the risks of E+P outweigh the benefits. In conclusion, treatment with E+P should not be recommended for the prevention and treatment of osteoporosis in women who do not have menopausal symptoms. Other medicines for osteoporosis should be considered. If E+P is prescribed to prevent osteoporosis, women need to be informed of the risks of taking E+P.

2 Gynecologic Cancers and Diagnostic Procedures (JAMA October 2003)

Summary of results:

The WHI investigators report that women randomized to combined estrogen plus progestin (E+P) experienced:

- A 19% decrease in endometrial cancer rates
- A 58% increase in ovarian cancer rates

Thus, women taking E+P have a risk of endometrial cancer that is similar to or slightly less than women taking placebo. Progestin appears to cancel the harmful effect of estrogen in the uterus, as previous studies showed. However, E+P does not completely prevent endometrial cancer, so the bleeding problems that women often have with this therapy must still be monitored via endometrial biopsies. In the WHI study, E+P use was associated with a 5-fold increase in the number of women needing endometrial biopsies.

These results support current recommendations to use the lowest dose of E+P for the shortest duration needed to treat menopausal symptoms.

3 Coronary Heart Disease Risk (NEJM August 2003)

Summary of results :

WHI published the final coronary heart disease (CHD) results for the Estrogen plus Progestin (E+P) study. Findings suggest E+P does not protect the heart and may even increase the risk of coronary heart disease (CHD).

In final analyses, E+P use was associated with:

- A 24% overall increase in the risk of CHD (6 more heart attacks annually per 10,000 women using E+P)
- An 81% increased risk of CHD in the first year after starting E+P

Women who had higher baseline low-density lipoprotein (LDL) cholesterol levels at the beginning of the study were at particularly high risk of CHD with E+P use. No other factors significantly changed the risk of CHD while using E+P.

In conclusion, E+P does not protect the heart and may increase the risk of CHD among generally healthy postmenopausal women, especially during the first year after beginning hormones. E+P should not be started or continued to prevent heart disease.

4 Breast Cancer Risk (JAMA June 2003)

Summary of results :

The 2002 report showed that more women taking E+P developed breast cancer than those taking placebo (inactive) pills. After an average of 5.6 years, 245 of the 8,506 E+P women and 185 of the 8,102 women on placebo developed breast cancer. Of the total cancers, 349 cases were invasive, a type of breast cancer with a greater chance of spreading to other parts of the body. The conclusions below are based on the invasive breast cancer group.

- The increased risk of breast cancer due to E+P was eight additional cases of breast cancer for every 10,000 women over one year
- Overall, there was a 24% increase in the risk for breast cancer due to E+P

Family Practice Skills Courses

During the period November 2003 & February 2004, the College conducted the following courses:

- Men's Health Skills Course
- Pain Management Skills Course

The Men's Health Skills Course was conducted on 12 & 13 November 2003 at Concorde Hotel Ballroom. Workshops on case discussion & implementing disease management strategies and relaxation therapy



The Men's Health skills course involved seminars, workshops and Q & A sessions

were conducted along with the seminar sessions.

The Pain Management Skills Course was conducted on 21 & 28 February 2004 at the auditorium of the Ministry of Health. Workshops conducted were on "Joint injections for orthopaedic disorders" (See *Picture 1*).



Picture 1

These courses were made possible with an educational grant from Pfizer Pte Ltd.

REGISTER NOW!

Atherothrombosis Skills Course

**10 Apr(Sat) &
11 Apr(Sun) 2004**

Venue: MOH Auditorium

**Seminar: 2 - 4 pm
Workshop: 4 - 6 pm**

See page 23. ▶

◀ Page 21 - WHI (Women's Health Initiative) Update

Also, after one year, quite a few more women had abnormal mammograms in the E+P group (9.4%) compared to the placebo group (5.4%); this pattern continued until the study ended. Although we have known from other studies that E+P use increases the density of breast tissue on mammograms, the increase in abnormal mammograms with E+P use seen in this study is a new finding.

Further WHI studies are being done to learn what happens to breast cancer rates and mammograms after E+P use is stopped.

5 Stroke Risk (JAMA May 2003)

This study concluded that women taking active E+P developed more strokes than did those taking placebo (inactive) pills. This updated analysis showed that after an average of 5.6 years, 151 (1.8%) of the 8506 women on estrogen plus progestin and 107 (1.3%) of the 8102 women on placebo developed strokes. There is a 31% increase in the risk for stroke due to E+P.

Most of these strokes were caused by blood clots in the brain. The increased risk of stroke due to E+P was seen in all groups of women studied, including those closest to the menopausal change and those with symptoms like hot flashes disease.

Limitations of WHI

The WHI did not address use of HRT for short-term relief of symptoms. Also, other doses, formulations, routes of administration of E+P, the effects of Progestin separate from Estrogen, the longer term risks & benefits were not taken into account. Also, the non-adherence to E+P was up to 40%. All these may have diluted observed risks & benefits. Therefore whether to start HRT or not, this question will have to be addressed by both the patient concerned and doctor. The doctor & patient should discuss:

- Why was hormone therapy initiated?
- Why should it be continued?
- What are her risks?
- What are her benefits?

All these should incorporate best evidence to arrive at the best decision for the patient herself.

WHI Publications Reference List

1. NHLBI Women's Health Initiative Site <http://www.nhlbi.nih.gov/whi/index.html>
2. Women's Health Initiative Participant Web Site <http://www.whi.org/default.asp>
3. The Clinical Impact of the Women's Health Initiative (WHI): Entering a New Era in Managing Postmenopausal Health Issues <http://www.medscape.com/viewprogram/2152>

Atherothrombosis Skills Course

Course Structure

1. Distance Learning Course Contents

Unit 1: Atherothrombosis: key concepts and pathogenesis

Dr Mak Koon Hou, Senior Consultant, Cardiologist

- Current Concept of atherothrombosis
- Inflammation and apoptosis
- Immune signals
- Clinical Prediction and Inflammation Markers

Unit 2: Epidemiology of Atherothrombosis

Dr Yeo Tiong Cheng, Consultant Cardiologist

- Disease burden
- Risk factors and risk reduction
- Preventing Atherothrombosis

Unit 3: Diagnosis & Evaluation of Atherothrombosis Patients

Dr Sivathanan, Consultant Vascular Surgeon

- New understanding, diagnosis and prognosis of atherothrombosis
- Clinical presentation
- Role of imaging
- Ankle-brachial index

Unit 4: Clinical Sequelae of Atherothrombosis: Stroke

Dr N V Ramani, Consultant Neurologist

- Atherothrombosis and cerebrovascular disease
- Clinical syndromes • Assessment of patients
- Medical management • Role of surgery
- Rehabilitation and secondary prevention

Unit 5: Clinical Sequelae of Atherothrombosis: Acute Coronary Syndrome

Dr Tan Huay Cheem, Consultant Cardiologist

- Disease process and coronary circulation
- Clinical syndromes
- Assessment of myocardial ischaemia
- Medical management
- Interventional procedures
- Rehabilitation and secondary prevention

Unit 6: Clinical Sequelae of Atherothrombosis: Peripheral Artery Disease

Dr John Tan Choon Heng, Consultant Vascular Surgeon

- Disease syndromes
- Clinical presentation
- Assessment of patients with PAD
- Medical management • Surgical management

2. Seminars (2 CORE FM CME Points each)

Seminar 1: 10 April 2004

2.00pm – 4.00pm

- 1) Atherothrombosis: key concepts and pathogenesis
- 2) Epidemiology of Atherothrombosis
- 3) Diagnosis & Evaluation of Atherothrombosis Patients

Seminar 2: 11 April 2004

2.00pm – 4.00pm

- 1) Clinical Sequelae of Atherothrombosis: Stroke
- 2) Clinical Sequelae of Atherothrombosis: Acute Coronary Syndrome
- 3) Clinical Sequelae of Atherothrombosis: Peripheral Artery Disease

** Seminars are on 1st come 1st serve basis and are limited to the first 200 participants*

3. Workshops Session(2 CORE FM CME Points)

(10 April 2004 OR 11 April 2004)

Group A: (1 hr)

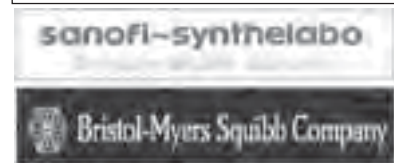
- Ankle Brachial Index
- Case Study 1: Peripheral Artery Disease

Group B: (1 hr)

- Case Study 2: Transient Ischaemic Attack
- Case Study 3: Acute Coronary Syndrome

** Workshops are on 1st come 1st serve basis and are limited to the first 100 participants*

Date: 10 & 11 April 2004
Time: 2.00pm – 6.00pm
Venue: MOH Auditorium



The development of this Family Practice Skills Course is supported by an educational grant from Sanofi Synthelabo Pte Ltd and Bristol-Myers Squibb(Singapore) Pte Ltd

Register

Atherothrombosis Skills Course Registration Form

Please tick appropriate boxes.

	College Member	Non-College Member
Seminar 1	\$10.00	\$20.00
Seminar 2	\$10.00	\$20.00
Workshop	\$20.00	\$40.00
Please tick your preferred date for workshop:	<input type="checkbox"/> 10 Apr '04	<input type="checkbox"/> 10 Apr '04
	<input type="checkbox"/> 11 Apr '04	<input type="checkbox"/> 11 Apr '04
Distance Learning Module	FREE	\$40.00
TOTAL		

Name: Dr _____ MCR No : _____

Mailing Address:

Please indicate: Residential Practice Address

Tel: _____ Fax: _____ Email: _____

Please make cheque payable to :

College of Family Physicians
Singapore

Mail to:

College of Family Physicians
Singapore
16 College Road #01-02
College of Medicine Building
Singapore 169854

IMPORTANT:

Participants with fever should not attend the seminars and workshops.