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Translating Preaching into Practice

"Competency, relevance, being up to date, credibility, and practising what we preach". Are these just words and phrases, or do they describe us and our practice? Soul searching, making adjustment, undergoing overhaul or just carrying on the status quo, are some of the possible outcomes that each one of us, trainees and teachers alike, may experience after attending this year's Commencement Ceremony. It will be wonderful if a positive response that jumpstarts the engine of our medical profession would be the result of this encounter.

Professor John Wong, Dean of the Faculty of Medicine, National University of Singapore, in his opening address on 26 June 2004, touched on these attributes, and the issue of medical knowledge based on evidence, that we must live by, as caring family physicians serving Singapore's present and future healthcare needs. The following is the full text of his speech.



Prof John Wong, Dean, Faculty of Medicine, National University of Singapore

"I am deeply honored to be with you at the commencement of the Family Medicine Academic Year. I congratulate all of you, especially those of you who are embarking on postgraduate training programs, and would like to thank those of you who are involved in teaching these programs. One of the most noble aspects of our profession is the passing of skills and knowledge from one to another.

Yet medical education is more than just reading text. It must be relevant to our needs, and something which we can apply to our daily patient care. Relevance and thus credibility of those who teach, and what they teach, is crucial for the success of education.

However I would like to touch on an aspect of

I am not here to preach to the converted. All of us understand and appreciate the importance of continual learning.

"We must not only ensure that we are educated, but relevant to Singapore's needs. We must ensure that what we preach, is practiced, not only by ourselves, but by all those involved in health care, and by our population."

- Prof John Wong

How else can we look our patients in the eyes and tell them that what we are recommending is in the best of their interests if we are not aware of what is current state-of-the-art?

medical education which is often forgotten, that is, do we actually practice what we preach?

How else can we win the respect of our colleagues, peers, and juniors, if we do not know as much as they do? How can we call ourselves teachers if we are not aware of what has been proven, repudiated, and at what level of evidence?

There are 3 excellent papers, published in the New England Journal of Medicine last year and this year, one from the RAND Corporation, entitled "The Quality of Health Care Delivered to Adults in the United States", another being the Shattuck Lecture, entitled "Clinical Research to Clinical Practice - Lost in Translation?", and the third being

College Family Medicine Convocation 2004
30 Oct 2004

(See Page 11)

College Art Gallery



"Two in a Boat" by Tay Bak Koi
From College Art Collection

Building Capacity

By A/Prof Cheong Pak Yean, President, CFPS

This edition of the Mirror focuses on the capacity building processes of the College. It is also the maiden effort of the second editorial team invited to augment our editorial resources.

GDFM 'Teachers Awards '04'(Pg 5) were presented in this year's Commencement to 18 doctors with Masters in Family Medicine(FM) for their role in mentoring the GDFM trainees for 2 years or more. Fifty new doctors passed the GDFM exam held in July(Pg 8,15) thus further increasing the pool of vocationally trained family physicians in Singapore. GDFM also took centre-stage in this year's Annual General Meeting when the house unanimously endorsed the Memorandum to the Ministry of Health recommending that the GDFM be the minimum standard for independent practice of FM in Singapore.(Pg 7)

The Special Interest Groups (SIGs) are also creating an impact. The Mental Health and Elder Care SIGs continue to organize robust activities as reported in pgs 12 & 13. The 3rd & latest SIG set up, the 'Practice & Quality' SIG convened with a renowned international expert as keynote speaker. It will focus its attention

on the four dimensions of practice quality viz. clinical standards, care experience, cost-effectiveness & equity as well as what each dimension means to the 4 stakeholders viz. the physicians, the patients, the payers and the policy-makers.

In the run-up to the World Conference of WONCA 2007 which the College would host, literally hundreds of academic papers from all over the world would have to be adjudicated for presentation & publication. Increased capacity in research methodology (Pgs 17-19) is therefore important. The inaugural tutorial of the collegiate membership by assessment programme (Pg 8) is also an on-going effort to train more leaders for the College.

In the midst of these hustle and bustle, one family physician in his personal reflections (Pg 9) alludes the present situation to be like that of a taut spring not yet sprung. Which direction would these built-up positive energies lead to? Prof John Wong's advice in his keynote at the Commencement '04 is that 'we must not only ensure that we are educated, but relevant to Singapore's need'. The College agrees wholeheartedly. However, more than the College's capacity building effort is needed (Pg 7)

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Editor's Words



"A journey of a thousand miles starts with the first step"

—ancient Chinese saying

The Commencement Ceremony 2004 takes centre stage in this issue. It heralds a new beginning for some of us who have taken the 1st step towards professional development(PD) & learning. Borrowing A/Prof Cheong Pak Yean's favourite "peak & valley" analogy, we must "fill up the valleys of ignorance with 'earth' from the mountain peaks of knowledge" in order to 'cover all bases' as we proceed along this journey of learning. Practising what we preach, hence the heading of "Translating Preaching into Practice" form the gist of Prof John Wong's message for us, trainees & teachers alike, in his opening address at this year's ceremony.

The Teachers' Awards 2004 provided an occasion where we "stop and smell the flowers" along this road of learning, an opportunity to show our appreciation to those of us who chose to contribute by sharing their experience & wisdom.

This issue of College Mirror(CM) also put on record some "firsts" in College's history. The 9 GDFM graduates, enrolling as the pioneer batch of the MCFP by Assessment programme, & the use of video as an aid to teaching & assessment are just 2 examples that illustrate the College's role in the PD of all Family Physicians in Singapore.

Do not dismiss the AGM report, pay particular attention to the appendix; I am sure it will raise a few eyebrows and heart rates especially for the younger ones amongst us.

A/Prof Goh Lee Gan's plenary lecture at the Wonca Asia Pacific research Workshop is presented in full, underlining the importance of research in Family Practice in this new millennium. The accompanying report on the workshop by Drs Mike Yee and Sally Ho show that the Phuket trip was not just a "free holiday".

A special note of thanks to Dr Tan Yew Seng for being a regular contributor to the CM. His article on personal reflection is a 'must read' in this issue. Perhaps, this article could be the spark that is needed to ignite the fire in all of us, to stop 'waiting to be invited for tea' but step forth and be counted.

Other articles included for your reading pleasure encompass the regular (Hints and tips; Practice Corner), various SIGs and GDFM exam reports. Don't forget to book your places for the coming Convocation Dinner scheduled for 30th October and celebrate with our friends who were successful in their exams. *See you there!*

Dr Wee Chee Chau
Editor of The College Mirror

Commencement of FM Academic Year 2004

By Dr Wee Chee Chau, MCFP

The more motivated amongst us, who committed themselves for further medical education by going back to 'school' were gathered at the Ministry of Health Auditorium on 26 June 2004 for their Commencement Ceremony.

Professor John Wong, Dean of the Faculty of Medicine, was the Guest-of-Honour, (refer to front pg for full-text). Prof Wong provided the extra "push " to help the trainees begin their journey of learning reminding them that acquiring knowledge for its sake is not the only purpose for their endeavors, but to be able to "practice what they preach", should also be high on their agenda.

An overview of the year's academic programme was presented by A/Prof Goh Lee Gan, the College's Censor-in-Chief, providing the road map for the year's journey. He also launched the MCFP by Assessment for some of the GDFM graduates who had decided to become Collegiate members, at the same time giving them a glimpse of what is lined up for them in the next one and a half years.

Teachers were not forgotten as eighteen of them were awarded the Teachers' Award 2004 for their role in the GDFM programme. Their acknowledgement serves to inspire all present, as well as to motivate those that may wish to contribute

to the College as teachers after their graduation.

The ceremony was closed with the appointment of the FM CME Advisors for 2004-2006.

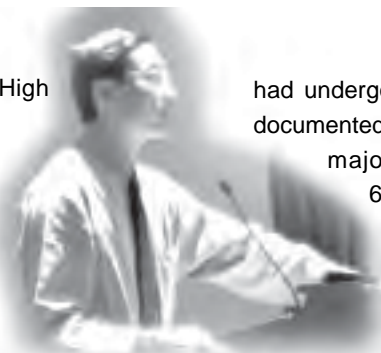


Commencement Ceremony 2004 held at MOH Auditorium.

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"Paying Physicians for High Quality Care".

These papers are part of several done to look into why after US\$250 billion of NIH funding alone, the US life expectancy is only 22nd in the world, lagging behind Japan, Israel, Canada, and Western Europe.



Prof Wong delivering opening address

What do they find? Generally only 55% of American adults received recommended care for common diseases. This is care established by national and specialty expert panels which had been published in the major medical journals.

For instance, we have known since 1981 that beta blockers prolong survival after a myocardial infarct. Yet in 1996, only 63% of patients were prescribed a beta blocker after a myocardial infarct.

On the flip side, coronary angioplasty and CABGs were both being recommended inappropriately in up to 14% of patients.

What about patient's behavior? Compliance with aspirin in patients who

had undergone coronary angioplasty for documented coronary artery disease at a major medical center was only 60% in 1995. 47% of hypertensives were compliant with their medication.

What about education? Only 42% of obese patients had been advised by their doctors to lose weight, and only 34% had been counseled about exercise after a routine doctor's appointment.

How can we fix this? Reimbursement for quality is one of them. Reimbursement for primary care doctors in the UK, the Partners Healthcare Group in Boston, and the Integrated Healthcare Association of California are now based on defined quality indicators.

What is the status of healthcare of adults in Singapore? I would not be surprised if many of our fellow citizens are not getting standard recommended treatment. Can we be proud that we prescribe expensive antibiotics for pneumonia when the

majority of our population over 65, and those with underlying diabetes, renal, liver, and hematologic disease, congestive heart failure, and chronic obstructive lung disease are not vaccinated against pneumococcus?

I would like to end by paraphrasing Thomas Chambers's Goulstonian Lecture in 1850 : Knowledge, however good and lovely, be it for its own sake, must always be considered a step. We should review our research and deduce



Prof Wong with College Council Members at Commencement 2004

rules of practice, for the refreshment of mankind.

We must not only ensure that we are educated, but relevant to Singapore's needs. We must ensure that what we preach, is practiced, not only by ourselves, but by all those involved in health care, and by our population."

GDFM Teachers' Award 2004

By Dr Wee Chee Chau, MCFP

Eighteen of the College members were awarded the GDFM Teacher's Award 2004 at this year's Commencement Ceremony.

These exemplary family physicians expend time and effort to selflessly share their knowledge with fellow doctors who took the GDFM course.

Their contribution to the Family Medicine community is recognized with the Award. It is hoped that like-minded members of the College will be inspired to do the same when duty calls.

The following are some words from two of the teachers, Dr Gerard Low & Dr Kwan Yew Seng.



Teachers' Awards 2004

- Dr Chow Mun Hong
- Dr Ee Guan Liang Adrian
- Dr Goh Choon Kee Shirley
- Dr Goh Khean Teik
- Dr Kwan Yew Seng
- Dr Leong Soh Sum
- Dr Lim Hui Ling
- Dr Loke Kam Weng
- Dr Low Mun Heng Gerard
- Dr Low Sze Sen
- Dr Shah Mitesh
- Dr Swah Teck Sin
- Dr Tan Kee Wang
- Dr Tan See Leng
- Dr Tan Yu Sing Lucienne
- Dr Tay Ee Guan
- Dr Thng Lip Mong Barry
- Dr Yung Charlotte

"It is indeed heartwarming that the College affirms and recognizes our contribution, though small, in helping our fellow colleagues in their continuing medical and professional development.

are getting better and that keeps me on my toes. Along with 2 other tutors, we managed an enlarged tutorial group. Finding the right time was always a problem but our persistence always paid off. The challenge for each tutorial is to make it directed and yet diverse, focused and yet expansive.

Now giving tutorials it is not so much teaching but sharing of knowledge, experience and wisdom. I remember A/Prof Goh Lee Gan once told us in class that all of us doing Family Medicine are travelling along the same path, some are more ahead while some have just started. What I wish to do by teaching is to smoothen this path for others to walk on. It certainly has not been on directional learning. Teaching makes me learn and has kept my mind stimulated.



Dr Low receiving award from A/Prof Cheong Pak Yean

Teaching is also a humbling experience as I have found out. One is continuously challenged to update and mend all gaps in knowledge and information. Still, there are many problems that do not have perfectly packaged answers, and this I have come to terms with.

My own knowledge and practice of medicine has changed for the better because of teaching. To those who are

I will continue to support the College in her teaching endeavours as I have always believed that when we teach others, we, too, teach ourselves. It is my hope that we continue to **learn** as we grow, and **grow** as we learn."

- Dr Gerard Low

I started off unsure of what to do and what to expect. I was even doubtful of my own teaching ability initially. I settled down quickly and served comfortably as a guide, a mentor. The interaction with the trainee doctors rejuvenated my academic fervour. Their enthusiasm was absolutely infectious, almost addictive. An important spin-off from these tutorials was the sharing with each other, our difficulties with our patients. This was not only insightful, but served as the perfect balm for our tired souls and bruised egos.

With each successive year, the trainees

"My teaching experience started out with giving tutorials to MMed trainees in the polyclinic. At that time it was more like passing on experience in the traineeship and helping them prepare for the exams. Later I became a tutor for GDFM trainees.



Dr Kwan Yew Seng

in a position to impart knowledge and are not doing so, I have this to say: Do it. It will require some time and effort, but it is worth every minute and you will be richer for the experience."

- Dr Kwan Yew Seng

At the 33rd College Annual General Meeting

By Dr Jeff Tay, MCFP



(L-R): Dr Lee Kheng Hock, A/Prof Goh Lee Gan, A/Prof Cheong Pak Yean, Dr Arthur Tan & Dr Yii Hee Seng

In his opening address, A/Prof. Cheong Pak Yean reported that the College membership has increased by 200 in the past year and now stands at 1074 members. He also highlighted that several academic programmes such as the Collegiate membership & Fellowship programmes are well established to nurture academic & professional leadership.

approved by the Singapore Medical Council (5 core FM CME points per module). Currently, 4 modules are available in the e-learning website.

The **Family Practice Skills Course** (Category 3B) comes in the form of distance learning programme coupled with MCQs. Optional workshops over a weekend complete one module. Past

for family doctors and SARS posters, which were made widely available. Singapore's first live webcast, at a time when it was difficult to organise CME activities, was made possible with help from sponsors – Merck Sharp & Dhome, StarHub, and ST Teleport.

Manning the **Hotline for Frontline** were key members Dr Cheng Heng Lee, Dr Tan See Leng, Dr Lawrence Ng, A/Prof Goh Lee Gan and Dr Jonathan Pang, who provided much needed support to doctors both professionally and emotionally. In the first 8 weeks of service, they received 239 calls.

The College also aided the **trainers' training for SARS preventive measures course**. In recognition of its national contributions, the College received a commendation award from the President of the Republic of Singapore.

"The meeting.....unanimously supported the motion to endorse the Council's Memorandum to the Ministry proposing that GDFM be the minimum standard for general practice in Singapore."

Censors' Report

Convocation 2003 was held on 16th November 2003 and graced by Dr Lily Neo, Member of Parliament, to celebrate the fruits of hard work of the many graduates who attended.

A/Prof Goh Lee Gan noted that **membership** has crossed the 1,000 mark to 1,074 members possibly aided by SMC's imposed compulsory CME.

Academic Programmes & CME

Dr Lee Kheng Hock reported that the now established **Graduate Diploma of FM programme** may evolve into a national programme for all family physicians. The 2004 (5th intake) has 50 participants, so we still have much ground to cover before the College's hope of structured training for all family doctors can be realised.

In 2003, 15 College members (with MMed family medicine) were elected and awarded the **MCFPS**. From 2004, the MCFPS will also be opened to GDFM graduates by assessment. The **FCFPS** remains as a 2 year training programme, followed by an exit interview.

There is at present no Family Medicine department in NUS. However, a unit within the COFM department which focuses on **family medicine research** has been planned.

For **CME**, new programmes, such as the e-learning programme, had been

courses include Home Health Care, Asthma, Hypertension, Musculoskeletal, Hyperlipidemia, Men's Health and Pain Management. Another 4 to 5 such courses are in the pipe line and will cover chronic illnesses like Diabetes.



Annual General Meeting 2004 held at College Lecture Room

Community Service Activities

Dr Lee thanked everyone involved in the College SARS activities. The SARS workgroup was probably the first in the world to come up with the SARS advisory

14 doctors were successful in the 2003's GDFM examination. This year, about 60 doctors are expected to sit for the GDFM examination. For MMed FM examination, 15 doctors have graduated making a total

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◀ Continue from Pg 6

of 195 doctors with MMed FM qualification to date. 15 doctors were awarded the MCFPS and 14 doctors have been awarded the FCFPS.

Undergraduate Medical Education

A/Prof Goh Lee Gan noted that 130-over **tutors** are required to teach each of the three batches of medical students in their 4-week positing viz. about 40 GP tutors, 40 polyclinic tutors, 13 teachers in palliative care and 11 private paediatricians. The number of students trained per year now is about 240 to 250. A/Prof Goh recorded a word of thanks to all GP tutors for the work done.

On **undergraduate Family Medicine education**, Dr Lau Hong Choon past Censor-in-Chief commented that only 4 weeks of clinical posting in Family Medicine seem grossly inadequate compared to other specialities. As Family Medicine is an important clinical discipline and most of the medical students' cohort would be generalists, more intensive exposure is necessary.

Minimum National FM Standards

Past President, Dr Alfred Loh proposed a motion in support of the Council's Memorandum to the Ministry to make the **Graduate Diploma in Family Medicine** to be the **national standard for family doctors in Singapore** (see side story). The meeting unanimously supported the motion and noted that the College has also recommended that a 'grandfather' clause be adopted for older doctors and that the implementation be measured.

A/Prof Cheong Pak Yean informed the meeting that a special interest group (SIG) on **Practice & Quality** has been set up. Dr Lau Hong Choon speaking as a senior College Fellow suggested that accreditation for practice and quality should come from the College which should also be the body to set the criteria. We should also communicate to the health care providers and the public and explain to them how we define quality.

The Meeting ended at 6.25pm with a vote of thanks to the Chair.

Memorandum to the Ministry of Health

Proposal for Graduate Diploma In Family Medicine (GDFM) as The National Standard For Family Doctors in Singapore

The College memorandum was presented to the Ministry of Health on 3rd June 2004 for GDFM to be made the minimum vocational standard for family doctors. This landmark paper states the benefits of having doctors vocationally trained in family medicine and the steps that must be taken to achieve these objectives. The full text is published in the 2004 Annual Report. (Available on the online version of *College Mirror* from the *College website*)

IS TRAINING IN FAMILY MEDICINE NECESSARY?

- Undergraduate education is not enough. In Singapore, a registered medical practitioner presently does not need any vocational training in family medicine/general practice to practice as a GP whilst postgraduate vocational training is mandatory in developed countries such as Australia and the United Kingdom.
- The increasing numbers of chronic medical problems and geriatric patients in developed countries require a model for patient-centred and community based continuing care.
- Medical specialization and sub-specialisation have created the need for community based, generalist doctors who are able to fill in the gaps of care and to integrate the management of the patient.

BENEFITS OF BETTER TRAINING OF FAMILY DOCTORS?

- Freeing up costly resources. Well-trained primary care doctors will be able to manage conditions without wasteful and unnecessary referrals to hospitals. The national emphasis on prevention and management of risk factors will also help to keep people healthy and minimize the use of expensive interventional care.
- Implementing national health care policies and quality assurance initiatives. A primary care that is staffed by well-trained doctors who are committed to the values of family medicine will be more effective in carrying out national health policies and quality assurance initiatives.
- Imparting principles and values of family medicine. The emphasis on communication, preventive care, continuing care and patient centeredness will promote personalized primary care.
- Nurturing functional groups and teamwork. A national training structure will provide opportunities to form functional groups and encourage co-operation and peer interaction.

ACTIONS REQUIRED OF THE MINISTRY

- Ministry of Health adopt the GDFM as the minimum required vocational standard for independent primary care practice.
- A Joint Committee of Family Medicine Training be set up to mobilise all the available training resources.
- MOH mandate non-specialist trainee doctors be trained in Family Medicine so that in effect a young doctor chooses either to be a specialist trainee or a Family Medicine trainee.

College Professional Development Programme (CPDP)

By Dr Wee Chee Chau, MCFP

The CPDP (MCFP by Assessment) was launched by our Censor-in-Chief, A/Prof Goh Lee Gan at the Commencement Ceremony in June & on 6 Aug, the inaugural tutorial was conducted at the College lecture room.

A/Prof Cheong Pak Yean gave a general overview of the entire programme which will run for 2 years and result in successful trainees being admitted as Collegiate Members. (All GDFM graduates are eligible for the programme)

Basically CPDP is made up of 3 parts:

1. Consulting, Communication & Counselling (CCC) Course
2. Clinical Quality Course (CQC) &
3. Professional Development Project (PDP)

The CCC & CQC involve 6 units of Distance learning, 2 seminars & 2 workshops. A Clinical Quality project is also included in the CQC, where the

trainee has to submit 3 case studies of significant events analysis OR conduct an audit project in his/her practice. For PDP, an assigned mentor will supervise the completion of a project that aids in the professional development of the trainee, to equip him/her for future tasks that require leadership, administrative and/or technical ability.

The goal of the CPDP is to produce Family Physicians that :

1. Are capable of researching, writing and publishing a paper in the Singapore Family Physician or its equivalent.
2. Can organize a Professional course, &
3. Participate in College activities like workgroups or clinical practice guideline committees.

Dr Wong Tien Hua provided the expertise in conducting the lecture on Video Assessment of Consultation Skills. The video camera would be used as a tool to assess the competency of the trainees in



Presentation by Dr Wong Tien Hua

the consultation room. The criteria for performance assessment as well as the intricacies of the video camera & its associated lighting & sound requirements were interestingly demonstrated with sample videos of 'real life' consultations. The lecture also covered the legal aspects of consent for filming and all the 'dos & don'ts' of video filming in the clinic.

'Practice makes perfect' is the take home message as the trainee has to submit 6 video consultations for assessment as part of the CPDP requirement.

A/Prof Goh Lee Gan ended the tutorial with a summary of the course and encouraged the trainees to embark on this journey of learning to find their area of interest and calling, and to see how they can contribute to the development of the College as future leaders of Family Physicians.

GDFM Examination 2004

**See Page 15 for names of GDFM Graduands 2004*

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

PASS RATE OF 50 OUT OF 59 (85%)

The 3rd GDFM Exam was held on 17 & 18 July '04. Fifty of the 59 candidates passed, giving a passing rate of 85%. Congratulations to the successful candidates (*Pg 15). For the rest, take heart. Consolidate your knowledge, hone your skills & come back again.

3 SEGMENTS

Examination consists of :

- Paper I: 2 hrs - Multiple Choice Question Paper (MCQ), 100 Qtns
- Paper II: 2 hrs - Key Features Problem Question (KFP), 10 problems
- Clinical Examination: 80 mins - Objective Structured Clinical Examination (OSCE), 10 stations. The OSCEs were modelled on clinical situations commonly encountered in primary care. For each OSCE, the teams of examiners calibrated the standard each candidate must have in order to pass that case.

STANDARD SET

The standard set is a pass in all 3 segments:

- Paper I – 50 marks.
- Paper II – 50 marks.
- Clinical Examination – a pass in at least 6 OSCEs.

THE OSCE

The OSCE examination was conducted in 2 cycles. In each cycle, the candidates were divided into 2 groups of 15. Each group went through the 10 OSCE stations. The scenarios tested this year were:

- Case 1: Unstable angina - Acute chest pain with symptoms highly suggestive of an acute myocardial infarction but a normal ECG at presentation. - Tested candidate's recognition that patient had to be referred to A&E for further management
- Case 2: Health screening appropriate for a 52-year-old man - Tested candidate's ability to advise appropriate screening tests.
- Case 3: Abnormal Pap smear - Tested candidate's ability to explain the abnormality, refer patient for colposcopy
- Case 4: Follow-up consultation for urinary tract infection in a 13 mth-old child - Tested candidate's recognition of the need to refer the patient as he was still febrile & unwell.
- Case 05: Hyperlipidemia - Tested candidate's ability to recognize the need for pharmacotherapy.
- Case 06: Use of medihaler - Tested candidate's ability to correct the patient's technique.
- Case 07: Early dementia - Tested candidate's ability to do a screening test for memory impairment e.g., ECAQ score and explain the condition to the son.
- Case 08: Recurrent headache - Tested candidate's ability to take a comprehensive history and diagnose migraine headache.
- Case 09: Sex and travel - Tested candidate's ability to advise against the use of prophylactic antibiotics, the advice on condom use and safe sex.
- Case 10: Sleep problem - Tested candidate's ability to counsel the patient on sleep hygiene and explain the risk of addiction if sleeping pills are used regularly.

RESULTS

In the MCQ paper, there were 3 failures. All passed the KFP paper. 7 failed the Clinical Exam. In the OSCEs, candidates on the whole did well on Cases 2, 3, 5, 6, 9 & 10. Performance was poor on Cases 1, 4, 7 & 8.

Engaging the Private Practitioners

By Dr Tan Yew Seng, Chairman, Mental health SIG

"Isn't that an iceberg on the horizon, Captain?"

"Yes, Madam"

"What if we get in a collision with it?"

"The iceberg, Madam, will move right along as though nothing had happened."

-'The People, Yes'
Carl Sandburg

Time compression has a curious way of giving new meanings and insights to past events. For example, over the last year or so, three events in the general practitioner (GP) scene in Singapore would have stood out as significant when re-examined collectively in compressed time. There is a certain cautious exhilaration or relief about this sequence of events, not unlike the feeling that one gets when he or she is at the verge of or has just released a taut coil spring.

The first was when the Severe Acute Respiratory Syndrome (SARS) hit Singapore in 2003. The private GP fraternity, which was so frequently labelled as "diverse and fragmented", became united in a formidable defence against SARS. Even more significantly, this was done through efforts and initiatives emanating from within the fraternity itself. One senior family physician had described the private practitioners as the often forgotten 'third force in primary care' (the other two being the polyclinic clusters) - it was the 'silent' majority revealing rare glimpses of its awe-some potential. This is the coil spring.

The second event was the Glasgow study trip by the primary care physicians to explore ways to improve the quality of primary care in Singapore. It was a rare occasion when the public and private sectors were able to share and exchange diverse perspectives on health care delivery. The observations and reflections from the study transpired into the seminar on Transforming Primary Health Care – The Scottish Experience on 15 May 2004. This is the tightening of the spring.

The third event was the recent Academic Year Commencement Ceremony on 26

June 2004. During that meeting, the President of the College officially announced plans on vocational training that may eventually alter the landscape of family practice in Singapore. This is the point at which the spring gets released. It is common experience that for that fraction of a moment when the taut spring is about to be released, one might stare at the spring in anticipation, and yet be apprehensively ready to close one's eyes. Where would that spring end up? Where are we heading?

Private practitioners are 'out there'

The phrase "Lost in Translation" is catching on recently, not only because of the Bill Murray comedy movie by the same name. In 2003, Claude Lenfant delivered the 113th Shattuck Lecture on "Clinical Research to Clinical Practice – Lost in Translation?" He described how despite the burgeoning amount of medical knowledge that is gained, not that much actually arrived at the patient's doorstep to corroborate the research impact. There is no denying that the same is also happening here as well. However, there is another dimension that seems to be lost in the delivery of health care at ground zero Singapore. This was somewhat demonstrated during the feedback session that followed the seminar on Transforming Primary Health Care mentioned earlier.

The major question that was raised at that seminar was essentially: How do you organize the private GPs, especially the solo practitioners to participate in quality assurance or team care? The responses from the participants varied: there was a general admission that this was a difficult task, the most often quoted reason being "lack of funding"; some of

the group practices have allocated funds for their own in-house programmes, and one has even developed its own service code or philosophy. The common sentiment though was that there was little hope in waiting for "hand-outs".

It was then that a solo practitioner asked: *"how can the solo GP, with his limited resources and time, be expected to do all these audits and analysis?"* On the surface, this sounded much like asking about the same things. However, the doctor added that he did not expect an answer for he knew how difficult the situation was. The responses were indirect. One suggestion was to think of quality as a critical part of providing health care – the sharper the tools, the better the outcome. Another involved the need for GPs not to under-price as this behaviour runs counter to good quality practices. One participant even suggested using legislation to prevent under-pricing.

On reflection, the 'question' was not really begging for an answer. It was more of an expression of the solo practitioner's predicament and his concern, which I will guess was probably not far off what many other private GPs might feel. But the fact that the responses could not address his problem pointedly perhaps was more telling. There is a cliché statement that "GPs play an important role in ... (healthcare services)" – usually used in the context that they have to fulfil some kind of standard. That they are important is not an understatement because private GPs make up 80% of the primary care doctors. But where exactly are they figured in the provisions to deliver that all-important service, when compared with their institution counter-parts?

Perhaps then, the most appropriate response to that doctor should have been: *"We ought to know more about YOU"*. Many attributions can be postulated for not having done so, such as "GPs are a diverse group and difficult to generalise", or even truthfully "the private sector cannot be our concern", or just "you were not in our sights", but essentially, it comes to the same – the processes, funding and programmes

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somehow fail to reach them, or in another manner of speaking, they are 'lost', somewhere out there.

Lost, but staying alive

This loss is not simply about overlooking a part of a simple equation or balance sheet. Somehow, I felt myself being drawn towards the analogy of a 'neglected child'. We know for a fact that family medicine as a discipline has been sidelined for a long time, till recently. Until recently, generations of medical students have trained under programmes that did not emphasise efficacy of the GPs. Vocational training even now is voluntary and involves mainly the younger generation of doctors. It is not a surprise then to see why some colleagues in the other disciplines who were cast in the same mould, do not take GPs seriously.

Fortunately, most of the private practitioners even when left "out of the loop" or "lost" do adapt themselves to the realities of private practice. However, many of such adaptations are based on so-called "short term market forces". While some of these, which include under-pricing, long working hours and shorter consultation times, might not seem consistent with "quality practices", it has to be remembered that these are but responses in the name of survival, with whatever knowledge of health economics and practice management these doctors have at hand. In fact, some has become quite affluent from their practices. Therefore, to change the very principles that promoted 'success' or survival is understandably a difficult task, if not unthinkable.

One of the difficulties mentioned in the seminar was prevention of under-pricing. This was curiously linked to the issue of self esteem. Here I contend that if there was ever poor self-esteem among GPs, it might have come from systematic neglect during the formative years – the behaviour of under-pricing is more likely to be a situational reaction rather than the cause of low self-esteem, although it is one that can perpetuate the problem.

Left to their own devices, most GPs try to make sense of their predicament by constructing their own philosophy and

meaning about general practice or the practice of medicine for that matter (much like how one participant developed his service philosophy for his group practice). Altruistic calling in life or business, lavish clinic with state of the art equipment or low-cost set-up, 'true-blue' clinical medicine or aesthetic clinic, each of these approaches represent the different ideas, expectations and expression of medical practice that have evolved in the given environment. Sometimes these styles are conveniently under the guises of personal styles of practice.

Standardisation of practices, which was mentioned in the seminar, was never quite a necessity, nor even desirability in small practices in competitive neighbourhoods. To impose them, even though it sounded like the right thing to do (or worse, just because one has been given the authority to do so), would inevitably provoke resistance, not only because the private practice has become a personal articulation of self-found efficacy, but it also leaves mixed or ambivalent feelings, much like a child who struggles to grapple with the commands from the parent who had forsaken him in the first place.

Identifying with the child abuser

It was also commented at the feedback session of the same seminar that graduates of family medicine programmes do not return to help the college. This is not surprising in the neglected child analogy because it may well represent an example of "identification with the abuser". This is an important process in the intergenerational spread of abusive behaviour, where the abused child of a generation becomes the abuser in the next generation. It should be notable that the corollary of the oft-heard dictum "*nobody owes you a living*" may easily be "*I don't owe you anything either*". But it is saddest when one who has suffered contempt would eventually show contempt to his fellow colleagues.

At this juncture, some may argue that the analogy is not appropriate because the private practitioners are not "*children*", and "*as professionals, they should know better*". I agree that some people do

conquer the unfavourable influences of their formative past. Yet, it does not take much to notice that within each and every one, there are parts of the formative past, good or bad, that obstinately manifests in our speech, decisions, behaviour and mannerism. The "child" never really leaves us. Moreover, the belief that "people should know better" is a stance that prevents further any understanding of the problem.

Engaging the private practitioners

So what if we understand the neglected child model? What is the significance of the model? Firstly, it helps understand the problem as upstream, during the formative years of the doctor. While time and exposure in the curriculum is important, it may be even more crucial to inculcate the sense of self-efficacy of the GP, not only among family medicine students but also among students of all the medical disciplines.

Secondly, it is a point in humility to remind ourselves of the Winnicottian concepts that "*there is no such thing as a baby – only a mother and a baby together*". One cannot comment on the state of affairs of the private practitioners without reflecting on the institutions that produce them or the policies that perpetuate their behaviour. There is little constructiveness in being judgmental, unless the policy makers are prepared to judge ourselves.

Thirdly, engaging the 'neglected' GP is the same as engaging a neglected child. It must be done in their own terms, at their pace, and with their concerns in mind. And the engagement must be built on TRUST. Pushing for change in the name of quality only repeats the processes of neglect and abuse.

Fourthly, the model emphasises the need to put personal faces to the problem. The statement that "*they are grown-up professionals and they ought to know better*" has long been used out of context and even abused to depersonalise the issues and absolve responsibilities. With the clamour for patient- or client-centred management, it is only consistent and congruent that we also consider the private practitioners as the 'clients' in the quest to transform primary care.

Family Physician Awarded Healthcare Humanities Award

By Dr Stephen Tong, MCFP

31st May 2004 marked the first anniversary of Singapore being declared SARS free.

That day, 34 outstanding healthcare professionals / workers were awarded the inaugural Healthcare Humanities Award.

This new annual awards is disbursed by the Courage Fund, and will honour healthcare workers for humanitarian contribution to the community. Recipients are chosen for their dedication, courage, compassion and humanity.

Three quarters of this year's winners were nurses, with doctors (6) and other healthcare workers making up the rest.

Amongst the award recipients was a family physician, Dr Ho May San, Karen. She was honoured for her courage, compassion and dedication to her patient. At the height of the SARS outbreak in April 2003, she continued to manage her bed-bound patient in his home, even though he was recently discharged from SGH, which had a SARS outbreak in one of the wards then.

Her view was that; *"Family doctors have a role to play too. If you want, you can do a lot and make a difference."*

Dr Ho is a family physician presently practising in a HDB branch clinic of a group practice. She obtained her MBBS in 1990 and Master of Medicine in Family Medicine in 2003 after completing 2 years



Dr Ho receiving award from President of the Republic of Singapore, Mr S R Nathan

of part-time training under the private practitioner scheme (programme B). We salute Dr Karen Ho and also congratulate the other Healthcare Humanities Award winners for their outstanding work and contributions.

Announcements



HUA MEI SENIORS CLINIC (HMSC) of TSAO FOUNDATION

REQUIRES FULL TIME PHYSICIAN

The Tsao Foundation is a not-for-profit organization committed to ageing issues and aged care.

HMSC provides community-based, primary health care specific to the needs of the older person. It has been designated by WHO as a pilot site for WHO Age Friendly Primary Health Care Project which aims to develop a benchmark model for accessible and effective community-based geriatric care.

Requirements

- Training/experience in primary care clinical practice essential
- Training/experience in geriatric medicine preferred
- Interested and committed to working with the older person in the community
- Ability to speak Mandarin and dialects.
- Team player with leadership and management skills

Interested applicants, please fax/write in with full resume by 30 September 2004 to:

TSAO Foundation
5 Temasek Boulevard, #12-06 Suntec Tower Five
Singapore 038985
Fax: 6337-9719

(Only shortlisted candidates will be notified)

College Family Medicine Convocation 2004

Venue : MOH Auditorium
Date : 30th October 2004 (Saturday)
Guest-of-Honour : Mr Khaw Boon Wan,
Minister for Health

PROGRAMME:

- All Guests to be Seated by 5.20pm
- Welcome Address by College President
- A/Prof Cheong Pak Yean
- Sreenivasan Oration
- Delivered by Clinical Prof. Chee Yam Cheng
- Conferment Ceremony
- Academic Procession of College Council
- Conferment of Fellows by Assessment
- Conferment of Collegiate Membership
- Recognition for GDFM Graduates & MMed(FM) Graduands
- Appreciation Award Presentation
- Dinner
- End of Dinner at 9.30pm



Helping Dysfunctional Families - the role of Family Doctors

By Dr Tan Yew Seng, Chairman, Mental Health SIG

Origins of Family Dysfunction

Dr Kit Ng, PhD, Graduate Faculty member and Director of the Post-Graduate Degree in Marriage and Family Therapy & Master's in Psychological Services programs in Psychology Department at Kean University, Union, New Jersey.

In his lecture, Dr Ng depicted family dysfunction as a system that becomes centered on a particular "leading" part. This leading part then forces an initially "whole" system to segregate into parts which conform to the confines as dictated by the leading part. In terms of relationships, this means that people assume dysfunctional roles which may become patterned and repetitive.

These dysfunctions in the family may manifest physically, emotionally, socially, inter-generationally, and or religiously

It is important to realize that these manifestations or symptoms have relevancy, such as meeting basic family needs, maintaining a functional marriage, rearing and socializing of children, or minimizing family shame.

Themes of Dysfunction

Generally, several dysfunctional themes may be identified:

- Triangulation – for example, the parents whose relationship (2-person) is conflicting and tense may triangulate with their daughter (3-person) by over-focusing on her issues and so avoid their dealing with their own issues.
- Toxic secrets – such family events as suicides or mental illness, are often taboo subjects that family members refuse to discuss amongst themselves or with others. These subjects ultimately become unresolved issues that condition the dysfunctional patterns among the members.
- Structural problems – such as single-parent family, or complex structures like multiple divorces and step relatives.
- Family myths – such as the belief that it is the duty of adult children to get married.
- Unresolved grief – particularly in instances where the death had been unexpected or catastrophic, like in murders or accidents.

Finding Answers

With the background, the family physician should seek answers to the following questions when assessing for family dysfunction:

- What is the outward appearance of the family?
- How is the cognitive functioning of the family?
- What repetitive, non-productive sequences do you notice? Defences? Resistance? What is the basic feeling state in the family and who carries it?
- What subsystems are operative in this family?
- Who carries the power in the family? What part of the life-cycle is this family experiencing and are the problem-solving methods stage appropriate?
- What are the reactions of the therapists to the family?

In summary, in the rating of family functioning, the dimensions involved include:

- Communication patterns
- Problem-solving methods
- Coalitions and roles
- Affective responsiveness
- Behavior control methods
- Recent family stresses
- Operative family beliefs

Questions (excerpts):

Q: "When does one decide if a patient should have family therapy and not individual therapy?"

A: When dealing with family issues, Dr Ng felt that it will be best for all to have family therapy. But it will certainly be a consideration if seeing the individual alone does not bring about resolution of the complaints.

Q: A question was asked regarding the issue of pharmacological management versus family therapy, and in particular whether the prescription of medication undermines the prescription of family therapy.

A: Dr Ng replied that in his practice, most family therapists are not medically trained and hence are not allowed to prescribe medication. However, there may be



Presentation by Dr Kit Ng

instances where rapid relief of symptoms with medication is important, and if so, referral to the medical doctor will be made. Medication and therapy therefore complements each other.

Q: "How can one help a family if certain members are not present?"

A: Dr Ng expressed that the situation is not uncommon, especially so in the US where families are highly mobile in a vast landscape. Fortunately, there are available techniques to focus on family issues with some members of the family present or with the individual alone.

Reflections of the author:

This session stood out for two reasons:

Firstly, it was an informative session, and the participants generally expressed relevance in the subject. This session being an excellent opener, it is hoped that family physicians will regard family issues with new perspective and depth. The next step is perhaps to explore the specific skills that will better equip family physicians to handle to some extent, some of these problems.

Secondly, this session was also significant because we had, in the midst of the audience, special guests from non-medical professions. To reiterate the aims of the SIG, apart from imparting knowledge and skills, the development of an "environment" for effective primary mental health care is crucial. It is unlikely that the family physician will be able to manage the spectrum of mental health conditions without the help from community resources. Building the care network and establishing care pathways in the primary care setting is therefore a necessity. As such, we will continue to promote interactions between family physicians and our allied professional workers.

Health Promotion & Health Screening for the Elderly

By Dr Cheong Seng Kwing, FCFP

The third SIG family medicine grand round was held on the 3rd of August 2004.

Evidence based Screening

Dr. Ong Chin Fung, Senior Family Physician from SingHealth Polyclinic (Bedok) gave a talk on "Evidence Based Health Screening for the Elderly".

The target of geriatric assessment is actually a heterogenous group. This includes the younger, well elderly, for which preventive geriatrics is geared toward, and the older, frail elderly, who needed extensive assessment. She stressed that assessment instruments were to be used only as a guide, and must be interpreted in the context of their limitation. They are rarely diagnostic, but served more to indicate a need for further evaluation.

The conditions for screening into can be divided into three groups namely:

- 1) Common geriatric problems: nutrition, hearing, vision, mental status, urinary incontinence, depression, mobility,
- 2) Common medical condition in the elderly : diabetes, hypertension, hyperlipidemia, osteoporosis
- 3) Malignancy.

For each condition, she gave the audience the evidence for screening as well as the different tools that can be used. Dr Ong also gave tips on how to use time efficiently in the busy family physician clinic eg use brief assessment instruments, when appropriate, utilise non-physician personnel to perform standard geriatric assessments, and omitting parts of the physical examination that are likely to be low yield.

It's Great to be old

Dr Pang Weng Sun, Head and Senior Consultant from the Department of Geriatric Medicine, Alexandra Hospital, spoke on the interesting subject of "Health

Promotion and Ageing".

The components of successful ageing was the combination of 3 factors of avoiding disease and disability, maintaining high cognitive and physical function, and engagement with life.

He highlighted the benefits of exercise as well as of maintaining a balanced diet in the elderly. Dr Pang also stressed the need of maintaining a correct mindset and philosophy of "I am old, and it's great to be old", that is, a mentality of self-efficacy.

He stressed the recurring messages of a healthy lifestyle of exercise, diet, smoking cessation, early detection, management of disease and prevention of disability, a positive attitude towards ageing with an active engagement in life, and lifestyle and environmental modifications to facilitate active living in old age.

He concluded by giving Ten Tips for Healthy Aging.

Please note that the powerpoint presentation slides of the above is available on the SIG section of the College Website.

Mental Health Special Interest Group

"Heart-sink" patients:
Approaches & strategies in management

Date : Tuesday, 5th October 2004
Time : 5.15 pm to 6.45 pm
Venue : College Lecture Room

Synopsis: "There are patients in every practice who give the doctor and staff a feeling of 'heartsink' every time they consult" - Thomas O'Dowd 1988. 'Heart-sink' patients, or difficult patients or problematic patients, or health care abusers or patients with medically unexplained patients, or simply FON, are labels for a group of patients that somehow evoke unpleasant feelings among doctors & staff. However, this not infrequently encountered situation may transgress moral, professional and ethical issues. In addition, some of these patients may have hitherto undiagnosed psychological disorders. So what exactly sinks the heart – is it a problem of the patient, the medical condition, the relationship, or the doctor himself? And how can we approach this problem or survive the sink?

Chairperson: Dr Yvette Tan, Deputy Director, Hougang Polyclinic

Presenter: Dr Liow Pei Hsiang is a consultant psychiatrist at Alexandra Hospital. While she has interests in eating disorders, she encounters in liaison psychiatry, many of the potentially 'difficult' scenarios such as in diabetic care, obesity management, ill-defined gastro-intestinal syndromes, or pain syndromes, some not unlike those encountered in general practice.

Elder Care Special Interest Group

"Clinic and Home Assessment of the Elderly"

Date : Tuesday, 2nd November 2004
Time : 5.15 pm to 6.45 pm
Venue : College Lecture Room

Synopsis: The clinic and home evaluation of the elderly is an art as well as a science. It is challenging as time is an essence in a busy clinic session. The session will explore ways we can maximise the consult time as well as look at the essential areas in the assessment of the elderly.

Chairman: Dr Gerald Koh, Family Physician and Fellow of the College, Ang Mo Kio Hospital.

Presenters: Clinic Dr Ding Yew Yong / Dr Ong Jin Ee

Dr YY Ding, Senior Consultant Geriatrician & Head, Geriatric Medicine Department, Tan Tock Seng Hospital, will share his experience in clinic assessment of the older person. Dr Ding is known for his systematic approach in geriatric evaluation. TTSH geriatric department is also renowned for their comprehensive geriatric assessment clinics. Dr Ong Jin Ee is Collegiate member of the college & a home care physician. She has extensive experience in the care of the elderly at home working with Touch Home care. She is actively involved in training medical students, postgraduate diploma in geriatric medicine trainees as well as family medicine trainees in the area of home care. She will present an approach to the evaluation of the older person at home.

Family Medicine in the Land of the Rising Sun & Graying Hair

By Dr Lee Kheng Hock, FCFP, Chairman, Practice and Quality Special Interest Group

Inauguration of the Practice and Quality Special Interest Group (PQSIG)

The Practice and Quality Special Interest Group (PQSIG) was formed by the College to spearhead initiatives in advocating quality assurance in family medicine. Continuing the tradition of learning from other countries started by the study trip to Scotland, the SIG invited Dr Ryuki Kassai to the College to speak on Japan's experience in advocating quality assurance in primary care.



Presentation by Dr Kassai

Dr Ryuki Kassai

Dr Kassai is the Director and Chair of the Hokkaido Centre for Family Medicine. He is the Vice President of the Japanese Academy of Family Medicine. He also sits in various state and national committees in Japan. Dr Kassai visited the College on the 13th and 14th July 2004.

He gave two lectures entitled "Family Medicine in Japan: Development and challenges in training, practice and quality assurance" and "Beyond Facts and Psychomotor Skills: New Methods in Teaching Family Medicine". Dr Kassai gave an overview of the primary care system in Japan. He also gave a very frank assessment of the slow development of family medicine in Japan as compared to other countries. The slow adoption of family medicine principles was largely due to historical reasons and the legacy health care system that provides primary care mainly through outpatient clinics in general hospitals and community hospitals. Dr Kassai also spoke passionately about the teaching of family medicine trainees. Many of our trainers who attended his second lecture were very impressed by the novel method of using contemporary cinema to teach communication and empathy to family medicine trainees.

Family medicine is a new discipline in

Japan

Japan is among the oldest countries in Asia and one of economic powerhouses of the world. However when it comes to family medicine, Japan counts itself as a new kid on the block. Dr. Kassai recalled that when he was still a medical student, he was inspired to take up family medicine after reading an article in an international family medicine journal.

When he graduated in 1984, he found that there was no family medicine training programme available in Japan. Finding no avenue to further himself in this discipline, Dr Kassai eventually trained and then worked as a pediatrician for 6 years. His passion for family medicine remained undiminished. Eventually there was an opportunity to take up a family medicine residency programme in Canada and he seized it. Upon his return, he worked in the primary care department of a hospital but found that the practice was far from the principles and the core competencies that he had trained for during his residency. In 1996, he left the department and founded the Hokkaido Centre for Family Medicine to provide postgraduate training for doctors who aspire to be trained as family physicians.

Despite years of effort by the Japanese Academy of Family Medicine (formed in 1986) and the Japanese Academy of Primary Care Physicians (formed in 1978), family medicine training in Japan remains largely unstructured. Doctors who deliver primary care are more like general internist who practice in outpatient departments of hospitals and community hospitals. Those who leave the hospital structure to practice as independent general practitioners tend to be trained in general medicine or its subspecialties. Many are older doctors. More than half of the general practitioners in Japan are more than 60 years old. However the number of young doctors who have received formal postgraduate training in family medicine is growing and the system is changing slowly.

The deficiency of the health care system both in terms of quality of primary care and the high cost of direct specialist care are apparent to all. The Japanese Ministry

of Health, Labour and Welfare has plans for a compulsory 2-year postgraduate clinical training program in primary care for all doctors following graduation from medical school. The aim of this national residency programme is to ensure that doctors have the essential skills and knowledge to work in the primary care setting.

Author's Reflection

Advocates of family medicine are often stumped when they looked at Japan. How can something so wrong be so right? Japan may not be leading the pack in the family medicine movement but her health care performance indicators are the envy of the world. Japan has the highest average life expectancy in the world. In 2000, the World Health Organisation published a set of rankings of the world's health care system using disability adjusted life expectancy as a parameter. Japan was number one.¹ However all is not as well as it looks.

Rising life expectancy combined with rapidly declining birth rate equals a rapidly aging population. Japan has the most rapidly aging population in the world. There had been widespread concern in Japanese society on the impact of such a development on their health care system. Around the world, countries with aging population (like ourselves) are watching the developments in Japan closely. On 1 April 2000, Japan introduced the biggest and most radical, public, mandatory, long term care insurance (LTCI) in the world. This had been perceived as shift in paradigm which in the past had fervently held on to the tradition that caring for the sick elderly is the responsibility of the family and not the state.²

Notwithstanding the radical measures, more difficulties are expected. In the Japanese Ministry of Health, Labour and Welfare's own words, "one of the biggest future issues for the long-term care insurance in the middle to long run, is the improvement in the quality of long-term care services."³ The Japanese LTCI is due for mandated revisions in 2005. It has already been seen as a system under strain and facing a potential overhaul due

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Signing of College Guest Book : (L-R) Dr Lee Kheng Hock, Dr Kassai, Dr Arthur Tan Chin Lock & A/Prof Goh Lee Gan

A well developed primary care system is widely accepted as an effective way to deliver good quality and low cost long term care to patients. In this aspect, Japan is lagging behind many countries despite being a global economic powerhouse and a leader in quality movement on the world stage.

to rising cost and inadequate premiums.⁴

Japan's top position on the ranking of health care systems has also been disputed.

The WHO's World Health Report that ranked world health system, attributes health attainment to health systems. Many had argued that life expectancy and health statistics are determined by many other factors besides health care systems. A country's gene pool, level of economic development, cultural attitudes towards health, traditional diet and even climate and geography have significant impact.

A recent study used age standardized mortality amenable to health care instead of disability adjusted life expectancy as a parameter.⁵ Japan's ranking fell from 1 to 3 (including mortality from ischemic heart disease) and from 1 to 13 (excluding mortality from ischemic heart disease).

Interestingly, the rankings of Southern European countries which enjoyed the known benefits of the Mediterranean diet, also fell significantly when mortality from ischemic heart disease was excluded. The ranking of Scandinavian countries such as Denmark, Sweden and Norway, known for their well organized primary care, improved remarkably when mortality amenable to health care was used as a parameter. The most remarkable was Norway whose ranking rose from 11 to 2.

Perhaps here lies the cause of their difficulties and possibly the solution to their problems. Japan had done well despite being encumbered with a hospital centered health care system. This appears to be supported by the recent study that showed a relative fall in mortality ranking when amenability to health care is taken into consideration.⁵ The health care system may not be as effective as was assumed. Her past success may be largely due to her ability to manage the sick elderly in the community, through a well-developed social support system and a culture that emphasizes personal and family responsibility. Perhaps things might be even better if the health system is transformed into one that delivers primary care through an integrated network of family practices in the community, managed by trained family physicians.

¹ World Health Organisation. *The world health report 2000. Health systems: Improving Performance.* Geneva: WHO 2000.

² Matsuda S. *Long term care insurance and integrated care for the aged in Japan.* *International Journal of Integrated Care* 2001. Vol 1 Jul-Sep.

³ *Long term care insurance in Japan.* Ministry of Health, Labour and Welfare July 2002. www.mhlw.go.jp/english/topics/elderly/care/

⁴ Saidel A M. *Japan's Long-Term Care Insurance System Faces Overhaul: Straining to Meet Demand, Lawmakers Set to Make Change.* *AARP Global Aging Program.* www.aarp.org/international/

⁵ Nolte E, McKee M. *Measuring the health of nations: analysis of mortality amenable to health care.* *BMJ* 2003; 327: 1129.

CONGRATULATIONS

National Day Awards 2004



The College congratulates
A/Prof Goh Lee Gan
for receiving the award of
"The Public Service Star"
(Bintang Bakti Masyarakat)



Drs Ang Corey Damien, Ang Lai Lai, Beh Chong Teck Peter, Chen Jenn Yuh, Cheng Kah Ling Grace, Chin Wai Meng Andrew, Chew-Lau Clara, Chng Chee Kiong Ronnie, Chong Chin Kwang, Choo Chee Hoe Ivan, Chow Yew Cheong Daniel, Chua Kim Ghee Vincent, Chua Thiam Eng, Davamani Diraviyam, Eapen Sunitha, Eu Tieng Juoh Wilson, Foo Ti-Wei, George Varghese, Goh Shu Huey, Ho Keng Boon Kenneth, Khin Naing Naing Htut, Kao Wei Hung, Khoo Chooi Yong, Khoo Yiok Bin Christine, Ko Hong Beng Gregory, Liao Kah Han, Lee Chian Chau, Lim Jiak Woon, Lim Wei Liang Daniel, Low Siew Teong, Mah Li T'ing Adelina, Nam Min Fern Alvina, Ng Poh Heng, Ng Siau Peng, Ng Soon Yin, Ng Su Lyn Lynette, Ong Min Jiunn, Sa'adah Bte Ismail, Seah Chiew Wan, Sim Chin Sing Evan, Sng Gek Khim Judy, Tan Chee Keong, Tan Ching Wah, Tan Chu Hui Anne Regina, Tay Say Kee, Wong Eu Joon Adrian, Wong Khai Hong, Woodworth Belinda, Yang Chyan Han Jasper, Yap Yang Ming Milton

Research Roadmap, Domain and Network

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

WHAT IS RESEARCH?

Research is a process of finding things out, of filling gaps in our knowledge and understanding of phenomena we encounter in the world. It provides an organized, systematized way of answering questions related to our work.

Research involves gathering, analyzing and interpreting data to answer the research question. In practice research performs four main tasks. It:

- Describes
- Searches for explanations
- Tests hypotheses
- Leads to generalizations.

MAKING RESEARCH WORK

Research is difficult, but it is more likely to succeed if the researcher:

- Critically assess the design
- Pilot the process
- Assess the costs, resources and expertise required
- Read the literature
- Plan
- Assess potential benefits

Choose topics that are:

- Specific
- Manageable
- Achievable
- Realistic
- Time delimited.

RESEARCH & THE DISCIPLINE

Research is needed to:

- advance the discipline, provide answers to phenomenology – what, who and why,
- find answers to clinical problems and provide the evidence based medicine – what works
- find answers to delivery problems – what barriers to overcome for health care to be delivered effectively and efficiently

Gaps to effective FM research are found in the structure, processes, and outcome of the system.

Structure

- to explain phenomenon needs, there is a need for a tutored mind on “organised curiosity” and we need the protected time to pursue things
- to meet our practice needs, we need to consider pilot and mainstream studies. Large studies have better statistical power; Cross country studies show diversity; Multi-country collaboration – provide mutual support and also better statistical power because of larger studies possible.

Processes

- A cascade training and learning system to build capacity. The concept of three levels of capacity building of User (101 level) – Researcher (201 level) – Programme Developer (301 level) can be applied to the tasks of learning & teaching,

doing research, and directing research.

Effective outcomes

- Collating & disseminating research findings – presently research is a situation of pearls separated by oyster shells. There is a need for a system to collate the findings and disseminate them in a user friendly way. One of the ways is to develop collaborating family medicine centres to do the collating work. There are some centres in the West. There is a place to develop such centres in the Asia Pacific countries.
- Publish work on the Internet & hard copy. The Internet is now an effective worldwide portal that allows information to be shared, stored and printed. The family medicine collaborating centres could work on using such a common channel of information
- Develop and contribute to Practitioners’ Databases where all the user needs to do is to click and find answers in the middle of a consultation. The TRIP database by UK Practitioners is a good example of how family medicine research could find its way to meet practitioners’ day-to-day information needs

CLASSIFYING RESEARCH DOMAIN IN FM

Stange et al has described a new way of classifying the knowledge base of family medicine into 4 quadrants of knowledge (See Table 1). This new way of classifying the knowledge base of family medicine provides a practical way of classifying the research domain in family medicine.

This new model of classification could be compared with that proposed by

Barbara Starfield in the early 1990s where she grouped the research areas into basic research, clinical research, and health services research. The basic research and the clinical research fit into Stange’s quadrant 4, and the health services research into quadrant 3. The two quadrants given new recognition are quadrant 1 focussing on the doctor, and quadrant 2 focussing on the patient, family and significant others.

SWOT ANALYSIS OF FM RESEARCH

Family medicine research has to recognize its strengths, weaknesses, opportunities and threats.

Globally, FM research has the following features:

- Strengths. There is recognition of the importance of research for FM development and the consequent apportioning of time and resources for development of research frameworks, tools and systems that is now beginning to happen; awareness of what needs to be done for effective family medicine research e.g., the understanding of collaborative studies to increase statistical power.
- Weaknesses. There is a lack of infrastructure, protected time, know-how in most countries
- Opportunities. There is a big potential of translating the information of FM research into clinical knowledge for the reduction of disease burden across the regions
- Threats. There is a lack of focus of what each country should be doing for FM research.

Table 1. Ways of Knowing and Seeking Medical Knowledge

	INNER REALITY	OUTER REALITY
Individual	Quadrant 1	Quadrant 4
Type of Knowledge	“I” knowledge	“It” knowledge
Why	Understanding the clinician is essential to family practice, since in part “the doctor is the drug.”	Understanding natural phenomena and interventions to affect them is the biological basis of medical practices.
What	Knowledge of the clinician	Disease-specific knowledge of clinical phenomena
How	Self-reflection, journaling	Observation, epidemiology, experimentation
Who	Reflective clinicians	Detached observers
Where	Practice	People or parts of people.
Collective	Quadrant 2	Quadrant 3
Type of Knowledge	“We” knowledge	“It” knowledge
Why	The voices of patients, families, and communities are central to the goals and effectiveness of family practice.	Family practice operates within a systems context, which must be understood to enhance its effectiveness.
What	Knowledge of the patient in context.	Systems knowledge
How	Participatory research	Health services research
Who	Participant observers	Health services researchers
Where	Community or practice	Health care system

Source: Stange et al. 2001

◀ Continue from Pg 17

In the Asia Pacific, FM research in has the following features:

- Strengths. There is a diversity of developed and developing countries in family medicine so the potential of rapid development through collaboration and capacity building is there.
- Weaknesses. There is a wide variation of growth & development that need to be narrowed before research productivity can take place
- Opportunities. There are opportunities for developing and developed countries to apply and translated research into paradigms for the reduction of disease burden across the region
- Threats. There is lack of focus of what each country can do for FM research that need to be overcome.

BUILDING CAPACITY IN THE SYSTEM & PEOPLE – 7 STRATEGIES

The 7 strategies are:

- Set up a country nodal system to span the various stakeholders
- Establish a country research forum to discuss activities, build ideas, motivate research
- Set up a country research resources archive to store research tools & outputs
- Implement a cascade training system of learning & teaching, doing, & developing research
- Set up a local research network for collaborative research
- Organise presentations for research endeavours — local, national, region, & world
- Initiate collaborations – across countries & regions

Strategy – 1

Set up a country nodal system to span the various stakeholders

- Universities can contribute the tools, research power, language and culture, and lead in the best practice of research
- College of family medicine provides the research hub where the various stakeholders can be linked together for collaborative work and national capacity building; it provides the channel to link to Wonca and small international groups for research collaboration
- GP groups provide the real world, clinical questions, and are collaborators for showing and sharing best practices.

Strategy – 2

Establish a country research forum to discuss activities, build ideas, and motivate research

- Promote discussion of research activities,

- Provide the platform to build up research ideas,
- Motivate research – awards, conferences, workshops e.g., the activities of NAPCRG

Strategy – 3

Set up a country research resources archive to store research tools & outputs

- Tools. These are questionnaires, scales, methodologies useful to family medicine research in a location that can be easily accessed
- Outputs. These are papers, proceedings, workshop programmes

We can work towards setting up an electronic library of research tools and outputs across countries more effectively by working towards a common archival system. The member countries of Wonca for example can contribute towards a Wonca network housed on the Global Family Doctor website.

Strategy – 4

Implement a cascade training system of learning & teaching, doing, and developing research

- The cascade concept of learning & teaching, doing research through working with trainers who are one/two levels up in the knowledge/skills ladder provides an effective way to build capacity for research. Thus at the user level (101 level), novices and users of research are taught by those who are able to show the way namely, practitioners and researchers at the researcher level (201 level)/research programme developer level (301 level); and those at the researcher level (201 level) hone their knowledge and skills through their interaction with fellow researchers (201 level) and research programme directors and developers (301 level).

- For user level (101 level) – *target all GPs & the course objectives will be to able to:*

- Understand research as a pathway to evidence based care;
- Ask relevant clinical questions;
- Search answers to clinical questions in databases;
- Read literature critically – *look for methodology flaws, interpretation errors*

- Researcher level (201 level) – *target 1% GPs for a start and the objectives will be to able to*

- Ask answerable research questions;
- Choose appropriate methodology

options

- Sampling, Questionnaire, Interviewing issues
- Data collection & checking
- Data analysis & interpretation
- Write up & presentation
- Participative & Collaborative projects

- Research developer level (301 level) – *self selected group with experience & research interests & the course objectives*

- Research analysis & interpretation techniques
- Research programme organisation & funding
- Promotion of research culture, ethics & standards
- Participative & Collaborative projects

Strategy – 5

Set up a local research network for collaborative research

- Organise participatory research
- Promotion of ideas
- Pay attention to structure, processes, outcomes
- Building capacity
- Funding – seed money
- Link up with other networks across the world – collaborative projects on common research ideas and projects

Strategy – 6

Organise presentations for research endeavours — local, national, region, and world

- Local, national, region, world family research units can learn from one another and build capacity this way
- Research is effective only when the results are disseminated & the new knowledge & understanding result in outcomes of care-Conferences, workshops, meetings, writings, & databases keep the meaning of research alive.

Strategy – 7

Initiate collaborations – across countries and regions

- Cross countries & regions can link themselves up for capacity building activities as well as to build the network for research collaboration and dissemination
- The areas of collaboration can be in new topics in Primary care research e.g., genomics; Meta-analysis of existing information; and contributions to physicians' database contributions from primary care research centres.

Family Medicine Research in the Asia Pacific Region: *Making History*

By Dr Michael Yee Jenn Jet, Senior Family Physician, Private Practice
& Dr Sally Ho, Deputy Director, Singhealth Polyclinics

The Inaugural *Workshop on Research Network Development for WONCA Asia Pacific Region* was held in Phuket, Thailand (10th – 12th July 2004), jointly organised by the General Practitioners / Family Physicians Association, Thailand, The College of Family Physicians Thailand and WONCA Asia-Pacific Region. The aim?

1. Develop family medicine research in the Asia Pacific region,
2. Provide delegates with hands-on approach to developing a research project, and
3. Encourage cross border collaborations.

A/Prof. Goh Lee Gan, WONCA Asia Pacific Region's Vice President, gave the keynote address, 'Research Roadmap, Domain & Network' (see pg 17). Practical research topics ranging from 'Formulating the Research Question' to 'Research Presentation and Writing' were enthusiastically delivered by:

Prof. Chris van Weel (Netherlands), Dr Justin Beilby (Australia), Dr Tan Ngiap Chuan (Singapore), Dr Ng Cherk Jenn (Malaysia), Dr Chusak Okascharoen (Thailand), Dr Supasit Pannarunothai (Thailand), and Dr Michael Kidd (Australia).

Delegates from Australia, Fiji, Indonesia, Japan, Korea, Malaysia, Thailand and Singapore attended the workshop. The Singapore delegation comprised of A/Prof Goh Lee Gan, Dr Tan Ngiap Chuan, and us.

Small groups of about 6 delegates each, worked together to develop cross border research projects. The 4 projects initiated were:

- a) Would antibiotic prescribing rate in upper respiratory tract infections be reduced through academic detailing and leaflets, compared to usual care?
- b) A 5-country review of national literature on the effectiveness of smoking cessation in general practices.
- c) The use of PADAM score, and intervention with counseling and testosterone in managing andropause in men.



Delegates who attended the Wonca Asia Pacific research workshop

- d) A review of type II diabetes mellitus clinical practice guidelines.

Already the results of these 4 project proposals have been tabled for presentation at the Kyoto WONCA 2005. We were subsequently swamped by invitations from various delegates to hold the next meeting in their respective countries!

Our hosts impressed with their renowned Thai hospitality and added to our lovely experience in scenic Phuket. Some of us were 'unfortunately stranded' due to problematic return flight schedules, so (sigh!) the last day was spent with yet more intellectual exchanges with our new-found friends in the sun, sand and sea of Phi Phi Island.

And the lessons learnt? (1) The core knowledge required for carrying out research and building a research network. (2) Identifying common problems faced in our struggles to make family medicine research feasible in our respective healthcare systems. (3) Some countries have research capabilities far beyond what we have in affluent Singapore. (4) Achieving powerful results on a shoestring budget.

We were encouraged that the established research networks in Europe and Australia began with a first meeting very much like this one.

We hope to encourage our fellow Singaporean family physicians to take advantage of this interest in research. Whether we are enthusiastic beginners, disenchanted learners, cautious performers or self-reliant achievers, we all have a role to play in keeping family



Presentation by Dr Michael Yee

medicine research alive and vibrant in Singapore. Let us all work together to put Singapore on the research map. With determination and enthusiasm, we can help develop the Asia Pacific research network in family medicine!

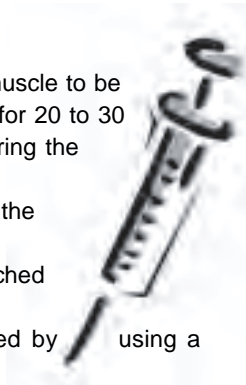
Effective Medicine in Small Doses

By Dr Wee Chee Chau, MCFP & Dr Jeff Tay, MCFP

1 Less Pain, More Gain

Almost painless injection technique:

1. Ensure relaxation of patient and the muscle to be injected by massaging the intended site for 20 to 30 seconds. (By using the alcohol swab during the cleaning process.)
2. Stretch the skin firmly before inserting the needle.
3. Insert the needle quickly into the stretched skin.
4. The discomfort can be much reduced by using a smaller gauge needle.



Painless wound suturing: (non contaminated wounds only)

1. Irrigate the wound with a small volume of local anaesthetic.
2. Insert the needle through the open wound to reach the subcutaneous tissue.
3. Infiltrate the length of the wound on both sides.

Ref: Practice Tips – John Murtagh (3rd Edn.)

2 “Dry” ear Syringing

Most of us use a kidney dish to collect the syringed fluid during ear syringing.

This usually results in a wet patient and doctor, or repeated trips to clear the kidney dish at the nearest sink.

A very useful and practical solution is to use an empty plastic container or ice cream bucket container.

The pliable side of the plastic container moulds itself to the side of the patient's face and if a small recess is cut out from the side of the container (to accommodate the ear), the fit would so good that spillage would be a thing of the past.

I personally use half a 3.6 l plastic bottle that has the added advantage of being able to keep more fluid thereby reducing the need for repeated emptying.

Ref : Practice Tips – John Murtagh

3 Eruption of Teeth (how to advise anxious parents)

Deciduous Teeth (total 20)	Number	Age at eruption*
Lower central incisors	2	5-9 mth
Upper central incisors	2	8-12 mth
Upper lateral incisors	2	10-12 mth
Lower lateral incisors	2	12-15 mth
1 st molars	4	10-16 mth
Canines	4	16-20 mth
2 nd molars	4	20-30 mth
Permanent Teeth (total 32)	Number	Age at eruption*
1 st molars	4	5-7 yr
Incisors	8	6-8 yr
Bicuspid	8	9-12 yr
Canines	4	10-13 yr
2 nd molars	4	11-13 yr
3 rd molars	4	17-25 yr

* Varies greatly.

The average child should have 6 teeth at age 1 yr, 12 teeth at 1.5 yr, 16 teeth at age 2 yr and 20 teeth at age 2.5 yr.

Molars are numbered from the front to the back of the mouth.

Ref: The Merck Manual of Diagnosis & Therapy 17th Ed. Merck & Co., Inc. 1999

4 Teething Issues

- Exclude other possible causes of irritability in a 'teething' child (e.g. urinary tract infection, meningitis, and otitis media).
- Teething does *not* cause fever per se.
- Relieve discomfort with paracetamol.
- Can chew on: Teething ring (kept cold in the refrigerator) or a clean, cold, lightly moistened cloth facewasher (a piece of apple can be placed in the facewasher).
- Parent can massage gum with forefinger wrapped in a soft cloth or gauze pad.



Ref: General Practice (International Editions 2000) 2nd Ed. John Murtagh. McGraw-Hill Book Co. 1999

Clinicians who are familiar with helping patients with behaviour change will realise that establishing relevance and importance for the patient may likely result in patient-initiated changes, in contradistinction to blanket regulation and ineffectual enforcement. The SARS episode demonstrated that GPs are not different from patients in that aspect – relevance, importance, support and feedback were the key ingredients of their success.

And finally and if not most important, it must not be misconstrued that the solo or private practitioner of the present or those of us who have gone through the ‘neglect’ should smugly become the passive ‘victim’. Perhaps it is about time that we differentiate ourselves from the unproductive relationship issues of the past and forge a more

meaningful one as a responsive ‘parent’ to the future generations of general practitioners.

Looking (Out) Ahead

Is this article a plea to understand private GPs better? Yes, but only in two conditions. First, it is true in so far as to ensure that partnerships can be built that will activate the formidable “third force”, which will undoubtedly benefit primary care in Singapore. Second, it is a plea for the private GPs to understand **themselves** more and establish themselves in the scheme of quality health care delivery in Singapore, if only for the sake of the ultimate end-users – the patients and their families.

The metaphorical iceberg therefore applies to all, and it is up to the reader to find out what it represents to him or her,

bearing in mind that even if just the tips are appreciable now, they are significant. To some, it may represent ‘engaging private GPs’; to others, it may represent ‘engaging the health authorities’; and yet to others, it is about ‘emotional baggage of the past’. Whatever it is, no matter what superior ideas we have to transform primary health care with; or what sophisticated technology we have to translate into practice; or simply as proud captains of our own destinies in medical practice, we should start to pay heed to it. Otherwise, like the ill-fated Titanic, the iceberg will yet again move right along...”as though NOTHING had happened”.

The views of expressed in this article are solely those of the author and do not necessarily represent the opinion of College of Family Physicians Singapore.

PRACTICE BASED RESEARCH NETWORKS

GP practice based research networks can shift from the role of primarily collecting data for research undertaken through the primary care setting. GPs can be more involved in the development, conduction and interpretation of research, in addition to their collection role (Gunn, 2002).

Practice based research networks around the world have contributed useful pointers on making these work. The following have been demonstrated to be important (Gunn, 2002):

- Research networks should have explicit aims about what is to be achieved – encourage evidence based practice, small scale practice-based research or large scale interventional or longitudinal studies;
- Research networks bring interested people together – opportunities for collaboration
- Networks should have academic links – in order to have easy access to suitably qualified researchers
- Networks should complement other capacity building initiatives – collaborative and complementary activities amongst networks, academic institutions, and research bodies.
- Research networks should be realistic about what they can achieve – Setting up a network that tries to achieve progress in many areas is unlikely to succeed.

- It is worthwhile considering the optimal size of a research network – The Dutch experience shows that small groups of practices with skilled GP researchers can achieve considerable outputs, such as publications and higher degrees.
- Evaluation and monitoring are essential – the network’s objectives, strategies and activities.

SUPERVISING RESEARCH STUDENTS

Deborah Saltman has worked out a model matching research student & supervisor leadership styles. The learner is found to go through four development stages (D) in the process of mastering a new task.

These are: D1 – enthusiastic beginner; D2 – disenchanting learner; D3 – capable but cautious performer; and D4 – self reliant achiever. The match supervisory style (S) should be correspondingly: S1 – directing; S2 – coaching; S3 – supporting; and S4 – delegating (Saltman, 2004).

WHERE DO WE GO FROM HERE?

Asia Pacific Mission & Objectives

For each country - the 3 initial tasks are suggested

- Get ideas across-AP research network development workshop in March 2004
- Set up the AP country nodes – through AP country representatives by end 2004
- Provide answers to clinical questions for family physicians – a physicians’ clinical Q & A database in GFD by 2007

For each family physician

- View yourselves in the FM research endeavour – user, researcher, research developer
- Users think about stating your clinical research needs & use the system to help your practice
- Researchers think about the FM Research Domain Classification for questions to answer
- Research developers think about the roadmap to build capacity in FM research

TRACKING RESEARCH STRUCTURE, PROCESSES AND OUTCOMES

Key performance indicators to track research structure, processes and outcomes are:

- Development of capacity at national level - Number of doctors participating in FM research; Publications; Implementation of results in practice
- Research centre performance - Best Practice, training, research output, Leadership role, Enabling role, Disseminating role

Reference and further reading

Stange KC, Miller WL, McWhinney I. Developing the knowledge base of Family Practice. *Family Medicine* 2001;33(4):286-97. Gunn JM. Should Australia develop primary care research networks? *MJA* 2002; 177(2):63-66. Saltman D. Supervising research students in primary care using a leadership model. *Aust Family Physician* May 2001;33(5):1-3.

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Diabetes Mellitus Skills Course

Course Structure

1. Distance Learning Course Contents

Unit 1: Epidemiology of Diabetes Mellitus & Important Evidence Based Information

Dr Tan Chee Eng, Consultant Endocrinologist, Gleneagles Medical Centre

- Pathophysiology of Diabetes • Beta Cell Dysfunction & Insulin Resistance • Classification of Diabetes • Diabetes Mellitus in Singapore • Some Important Studies that matters in Practice

Unit 2: Diagnosis and Diagnostic Issues

Dr Lee Chung Horn, Consultant Endocrinologist, Gleneagles Medical Centre

- Diagnostic Criteria • Metabolic Syndrome - Criteria and Relationship to Diabetes Mellitus • Pitfalls and Practical Issues in Diagnosis • Impaired Glucose Tolerance • Screening for Diabetes

Unit 3: Pharmacology of Oral Antihyperglycaemic Agents & Insulin

Dr Loh Keh Chuan, Consultant Endocrinologist, Mt Elizabeth Medical Centre

- Conventional Oral Antihyperglycaemic Agents and Insulin
- New Oral Antihyperglycaemic Agents & their Mode of Action
- Practical Points in Pharmacodynamics and Pharmacokinetics
- Special Population: Pregnancy, Elderly & Children
- Contraindications & Adverse Drug Reactions

Unit 4: Issues in Pharmacotherapy

Dr Kevin Tan Eng Kiat, Consultant Endocrinologist, MD Specialist Healthcare, Paragon Medical Centre

- Initiating treatment • Combination Therapy
- Early Aggressive Treatment • Treating to Target
- Assessment of Control • Compliance • Treatment Failure

Unit 5: Complications of Diabetes Mellitus

Dr Lim Su Chi, Consultant Endocrinologist, Diabetes Centre, Alexandra Hospital

- Cardiovascular Complications • Renal Complications
- Eye Complications • Neurological Complications
- Prevention of Complication

Unit 6: Issues in Long Term Care & Living with Diabetes

Dr Tan Chee Beng, CEO, SingHealth Polyclinics

- Strategies in ensuring continuity of care • Quality indicators
- Practical Issues in Follow-up • Patient Education and Self-Care

2. Seminars (2 Core FM CME Points each#)

Seminar 1: 6 November 2004

2.00pm – 4.00pm

- 1) Epidemiology of Diabetes Mellitus & Important Evidence Based Information
- 2) Diagnosis & Diagnostic Issues
- 3) Pharmacology of Oral Antihyperglycaemic Agents and Insulin

Seminar 2: 7 November 2004

2.00pm – 4.00pm

- 1) Issues in Pharmacotherapy
- 2) Complications of Diabetes Mellitus
- 3) Issues in Long term care & Living with Diabetes

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

3. Workshops Session(2 Core FM CME Points#)

(6 Nov 2004 OR 7 Nov 2004)*

Details to be confirmed at a later date.

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

* A similar workshop is held on both 6 Nov (Saturday) & 7 Nov(Sunday).



The development of this Family Practice Skills Course is supported by an educational grant from GlaxoSmithKline Pte Ltd.

Date: 6 & 7 November
Time: 2.00pm – 6.00pm
Venue: MOH Auditorium

Subject to approval from SMC

Register

Diabetes Mellitus 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"/> 6 Nov '04	<input type="checkbox"/> 6 Nov '04
	<input type="checkbox"/> 7 Nov '04	<input type="checkbox"/> 7 Nov '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