The College Mirror

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Graduate Diploma in Family Medicine
6th Intake Enrolment

See Pg 12 & 13

College Art Gallery

"Movement in silver / gold" June 1987 by Thomas Yeo, From College Art Collection

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Reforming Primary Care

The Ministry of Health Perspective

The Mirror collates published statements made by Minister for Health, Mr Khaw Boon Wan, Senior Minister of State (SMS), Dr Balaji Sadasivan and Director of Medical Services (DMS), Prof K Satkunanantham on the Ministry's perspective on reforming primary care.

When Mr Khaw took office in Aug 2003, he challenged the Family Physicians (FP) to be well trained to deliver a high level of care in preventive, personal, comprehensive and continuing care. It was reported in The Straits Times, 22 Dec 2004, that there are now plans for a Family Physicians Register by 2007.

In Jan 2005, the Ministry spelled out the FP involvement in the healthcare system in an addendum to the President Address to Parliament and DMS outlined measures that would enable FP to fulfill these roles. In Feb 2005, SMS announced that care for chronic illnesses are to be delivered in "Specialist family medicine clinics staffed by family medicine specialists".

On preventive, personal, comprehensive & continuing care

Excerpts from College Mirror Vol.29/3 3rd Qtr 2003 pg 1, Minister's address to the College Council at a tea reception at Harrower Hall on 22 Aug 2003.

"Mr Khaw outlined the eight priorities of his Ministry & emphasized the important role of Family Physicians. In his vision, Family Physicians in Singapore must practise holistic medicine and help patients both in health and in sickness. He should practise preventive medicine and coach his patients to adopt a healthy life-style.

Famly Physicians must not be just a "cough & cold doctor". Instead they must manage diseases from the time the patient falls ill, during his hospital treatment and after he is discharged from the hospital.

In his view, every Singaporean should have his own Family Physician who is well trained to deliver a high level of care"

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President's Forum

The College's Contributions

Do we want to reform primary care? The Ministry has set clear directions for the years ahead(see lead article). What is holding the Family Medicine fraternity back?

The College has in the past months conducted dialogues with doctors representing different sectors in primary care. Some doctors were right to point out that training alone would not lift primary care out of the present malaise. A healthcare system is a complex ecosystem with many stake-holders, each with different, at times conflicting needs and wants. Issues of policies, funding and perception all have to be reformed and aligned. Clearly all stakeholders including practitioners, patients and third-party payors must be co-opted for the reform movement to mature.

However, there would never be a time when every star in the sky is aligned optimally. The College as one agent of change can begin to build up capacity and competence. It offers a menu of 11 programmes viz 4 for vocational training, 4 Special Interest Groups & 3 Continuing Professional Development(CPD) programmes.

For vocational training, the College takes over the 1-year programme B leading to the Masters for doctors who have passed the GDFM(Pg 21) this year. It is prepared for an increased intake for the GDFM as that programme has matured through the years (pg 12). The other two programmes, the MCFP and FCFP training programmes continue to train leaders and teachers.

The four special interest groups set up in the past year are ready to go the next lap. One direction set by the Ministry is to 'sub-specialise' in whole person medicine such as 'geriatics, psychiatry, palliative care or even sports medicine'. The concept of 'GpwSI' as practised in UK is explored on page 11 while enhanced training in mental health is proposed on page 15. The Practice and Quality SIG after concluding a round of 'grass-root' consultations is exploring different models of funding and relationships in service delivery for discussion in this year's Annual General Meeting. The Research SIG takes research to the ground by involving heartland GPs in research projects.

CPD is taken care of by 3 programmes viz core FM CME accredidation, Family Practice Skills Courses & the E-learning platform.

The College is a voluntary professional organisation with limited resources. It can contribute to the reform movement by training and providing leadership. Clearly all GPs and other stakeholders must now come on board. Only then can real levelling up of primary healthcare happen. ■

Editor's Words

"The darkest hour is the hour before dawn"

- A/Prof Goh Lee Gan

The ground has been primed. For as long as I can remember, moans and groans are heard from all quarters of the Family Medicine fraternity, be it the private or public domain, of how work pressure has increased without a commensurate increase in income. Worse, it is all too often accompanied by loss of pay and morale.

SARS came and boosted egos and morales of Family Physicians for a few months but it was soon back to business as usual. It was strangely apparent to me that any measure to stretch the health dollar or to reduce healthcare cost, always seem to translate to a lesser take-home pay for private GPs.

It will be most interesting to see if the GP fraternity can be galvanized into action and support the College in her effort to reach an equitable solution. The fight will not be easy, hard work will be required of all. The rewards promise to be great, not only for doctors but also for the patients as well as the country's healthcare. Let us work together for a better practice environment.

This new year has indeed spell a new resolution for the Family Medicine fraternity where we will be moving towards a new branding for all interested parties to pursue our dream of "good health for all clinics" including that of the private practice. ■

Dr Wee Chee Chau, Editor of The College Mirror

Page 1 - Reforming Primary Care - The Ministry of Health Perspective

Minister for Health,
Mr Khaw Boon Wan

"Every Singaporean should have his own Family Physician who is well trained to deliver a high level of care."

Quotations from The College Mirror, Vol 29(3), Sept 2003, Pg 1
"Eight Health Priorities for Singapre"

On plans for a Family Physicians Register

Excerpts from Straits Times article of 22 Dec 2004 report of interview with Prof Satku, Director of Medical Services, Ministry of Health

Plans are afoot to introduce a Register of Family Physicians by 2007 for doctors who can do it. "The qualifications that a GP needed to be on the register was being worked out," said Prof Satku. "Getting on the register will be optional. The extra qualification could be a masters degree or a postgraduate diploma in family medicine or other specialist areas".


GPs to bring new skills to elderly care

"With these advanced skills, they can say, look after diabetic patients who are now being seen by specialists and paying much more, and costing the state much more." He said. "Besides a specialist may also not be the right person for the job, especially if the problem is not severe and the persons suffer from more than one chronic disease. A family physician with knowledge of the common diseases of the elderly would be better placed to deal with them."

Current training prepares doctors only "for the basic fundamentals of care". "The additional expertise would come with experience plus continuous skills upgrading and more training", he said. "With the registry, patients could be assured that its doctors would go beyond treating the patient at hand", said Prof Satku.

"In Singapore, the current practice would remain." Prof Satku said. "Doctors without the specified extra qualifications will not get on the register but exceptions would be made for experienced ones who have continuously upgraded their skills. He said the Ministry would seek doctor's views before finalizing the criteria for registration.

On Roles of Family Physicians

Excerpts from Straits Times article, 14 Jan 2005 of the Health Ministry's Addendum to the President's Address to Parliament

"Health-care delivery will see a number of ongoing changes to make it more patient-centred: More of those with stable chronic illnesses will be cared for in the community, rather than in the more expensive hospital setting. This will involve boosting the training of family physicians, as well as nurses and other allied health professionals; it will also see increased use of technology so that patient records can be kept intact."

"Developing a 'patient-centric' health-care system, with a focus on prevention rather than cure, is another important thrust. The holistic approach to patient management will involve all health-care partners, such as community hospitals and nursing homes, and most crucially, general physicians and polyclinic doctors.

The Ministry hopes that eventually, all Singaporeans will have a single family doctor they go to for both preventive counselling and care for chronic conditions."

"New register to be set up for family doctors with extra skills to help patients"

Quotations from "The Straits Times, 22 Dec 2004, "GPs to bring new skills to elderly care"

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On Enabling Family Physicians

Excerpts from SMA-News January 2005 reporting DMS's Conversation with the SMA Council, 13 Jan 2005

"For the current Family Physicians, the plan is to enable them in two ways: First, to enhance their clinical activity, with greater emphasis on consultation and continuing care. Second, to encourage, recognise, and reward those Family Physicians who have, or who choose to upgrade by pursuing a sub-specialty interest.

More primary care physicians alone will not reduce the load on tertiary institutions. You must go beyond this and have sub-specialised Family Physicians, be it in geriatrics, psychiatry, palliative care or even sports medicine.

You can also have functional groups of (non-identical but synergistic) Family Physicians working together in the same area. So, if you have a patient who needs greater attention to palliative care than you are comfortable managing yourself, you may refer him to your colleague with further training in that sub-specialty instead of to a Specialist in a tertiary care institution."

For new medical graduates, there will be tailored opportunities to better prepare them to enter family medicine, better qualified and with more skills. "If sometime soon after graduation, a Medical Officer decides that he wants to be a Family Physician, we can offer him the Masters of Medicine programme, as well as some time in the Polyclinics as background training."

Prof Satku stressed: "If patient care initially requires a Specialist, it does not always mean that continuing care also needs a Specialist. After his condition is worked out and stabilised at the tertiary institution, the patient can be sent back to the community, to his family doctor, for continuing care. In addition, this Family Physician is best placed to continue his management in the context of the spectrum of other conditions that this particular person may also have.

If you achieve that, then logically, patients will pay somewhere intermediate between the current GP charge, and that of a visit to the Specialist, provided the Family Physician delivers the necessary level of care. Otherwise, confidence will be lost and we are back to square one.

The Family Physician must therefore have greater depth, both in his personal clinical capability and in his relationship with the patient, and be really involved in his chronic disease management. Hypertension and diabetes will be the first two big things that we will roll out in this aspect."

"Let us work together to address this issue. My interest is not only to provide for the Polyclinic patients, but for patients across the nation. I do understand many of you are restricted in the resources open to you as Family Physicians in private practice. And if that is the problem, we will have to address it. Not to address it means not caring for some Singaporeans. And I will definitely look into it."

On Roles of AM, College & SMA

Excerpts from SMA-News January 2005 reporting DMS's Conversation with the SMA Council, 13 January 2005

"We (the MOH) cannot improve healthcare all by ourselves. We want the professional bodies to be directly involved. Very simply put: the Academy of Medicine and College of Family Physicians will be responsible for the academic aspects of Specialists and Family Physicians respectively. The Singapore Medical Association would be responsible for: (1) being the liaison body with the public; and (2) coordinating, educating and managing the aspects that affect every doctor's life – professionalism, ethics, health law, practice, and medico-legal matters."

Prof Satku concluded the evening by bringing us back to our reason for being. "In the end, my objective is that our patients must be better taken care of. It is why most of us have decided to do Medicine."

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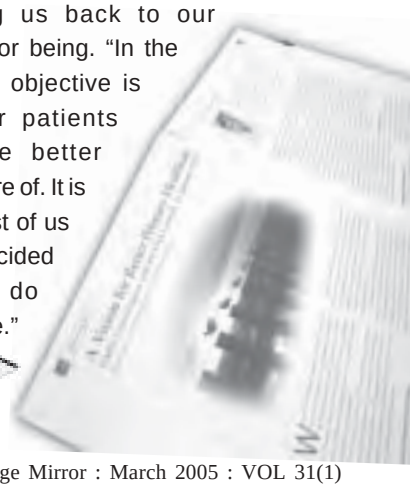
"First, to enhance their clinical activity, with greater emphasis on consultation and continuing care. Second, to encourage, recognise and reward those Family Physicians who have, or who choose to upgrade by pursuing a sub-specialty interest."

Quotations from SMA News, Vol 37(1) Jan 2005, Pg 6 & 7
"A Vision for Better Primary Healthcare"

Director of Medical Services,
Ministry of Health, Prof Satku



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On Care of Chronic Illnesses in Specialist Family Medicine Clinics

Excerpts from speech 16 Feb 2005 by Dr Balaji Sadasivan, Senior Minister Of State For Information, Communications And The Arts & Health at The Institute Of Mental Health.

"The number of specialist outpatient visits in the restructured hospitals has risen sharply. In the 3rd quarter of 2003, there were 254,000 subsidized consultations. In the 3rd quarter of 2004, there were 301,000 subsidized consultations. This is an increase of 18%. This sharp increase will stress the quality of the specialist outpatient clinics in the public hospitals. Many of the subsidized specialist clinics are not staffed by specialists. They are staffed by medical officers under the supervision of specialists. The increase in the volume of cases will certainly stress the system and may reduce the quality of the supervision. Because restructured hospital specialist clinics are narrowly focused, patients with chronic illness who often have problems affecting multiple systems may end up being referred to multiple specialist clinics for their care resulting in high cost for patients.

One solution to the problem of increased volume in the specialist clinics is to improve the clinical services at the primary health care level. Patients who attend the polyclinic often complain that they see a different doctor at each visit and that they wished the doctor would spend more time explaining things. Currently our polyclinics provide a good standard of clinical medical care in an economically efficient way. But patients may sometimes want the confidence of a personalized service from a doctor whom they know and who knows them, because he is the same doctor at every visit. The polyclinics should consider how they can provide for this demand for better service levels.

One possibility is the creation of specialist family medicine clinics at the polyclinic. If these specialist family medicine clinics are staffed by family medicine specialist, patients who are followed up in these clinics may enjoy better management of their chronic disease. These clinics will certainly cost the patient less than if he were being followed up at the specialist clinics in the public hospitals. Specialist family medicine doctors are better qualified and more experienced than the hospital medical officers who staff many of the specialist clinics. They also have a holistic view of medicine and can treat the whole patient instead of a particular body system. Hence there will be less need for referrals to multiple clinics for minor complaints. "

The Straits Times reported on Feb 17 2005 an interview with Dr Balaji on the above speech.

"Very often in the hospital clinics, Dr Sadasivan said, there is one specialist and a lot of trainees looking after patients. We don't want to keep on increasing the numbers and then, one day, find the quality is not what we expect."

On top of that, those who are treated by a doctor who specialises in one area are likely to be referred to another specialist if they have an unrelated problem. This leads to cost for patients and is not an efficient way of providing health care for patients.

In most countries, he pointed out, hypertension and diabetes, the two most common chronic diseases, are not followed up in specialist clinics but by specialist family practitioners. We want to create specialist clinics for chronic diseases, and we're going to start with hypertension and diabetes, he said. These clinics will be manned by GPs with a second degree in family medicine.

In the last two years, those who study medicine are all trained in family medicine, so there is a steady stream of such professionals, he said, adding that MOH is also looking at how the treatment of diabetes and hypertension can be improved. If the approach to these two works, then chronic psychiatric disease can also follow the same route.

He said: "We want to provide better care, maybe even an appointment system to give more time for these patients. And this will be cheaper for patients than in the current specialist outpatient clinics." ■

Senior Minister of State for Health, Dr Balaji Sadasivan

"We want to create a specialist clinic for chronic diseases, and we're going to start with hypertension and diabetes."

"These clinics will be manned by GPs with a second degree in family medicine."

Quotations from The Straits Times, Feb 17 2005, "Polyclinics to treat two chronic diseases"

Aug '03: Family Physicians (FP) to deliver high level preventive, personal, comprehensive and continuing care. **Dec '04**: Plans for a Family Physician Register by 2007. **Jan '05**: Pivortal role in the healthcare system and enabling directions in trainng and service delivery. **Feb '05:** "Specialist family medicine clinics staffed by family medicine specialists" to manage chronic diseases.

Referrals Revisited

By A/Prof Cheong Pak Yean, President of CFPS & A/Prof Goh Lee Gan, Censor-in-chief of CFPS

A medical referral is the transfer of responsibility for care of a patient to a colleague. As such it should provide the reason for referral and the facts of the case including the treatment and progress so far. It would also be good to detail any follow-up care arrangements such as, to keep you informed should further referrals to another colleague be required. Failure to communicate the necessary information may result in a sub-optimal outcome.

Four types of referrals are described by Ian R McWhinney in his book "A Textbook of Family Medicine". Prof McWhinney is the Emeritus Professor of Family Medicine (FM) of The University of Western Ontario and a doyen of FM. In the chapter on "Referral and consultation", he describes four types of referrals viz. the interval, collateral, split and cross referrals. For discussion, the four types of referrals are briefly represented in Figure 1.

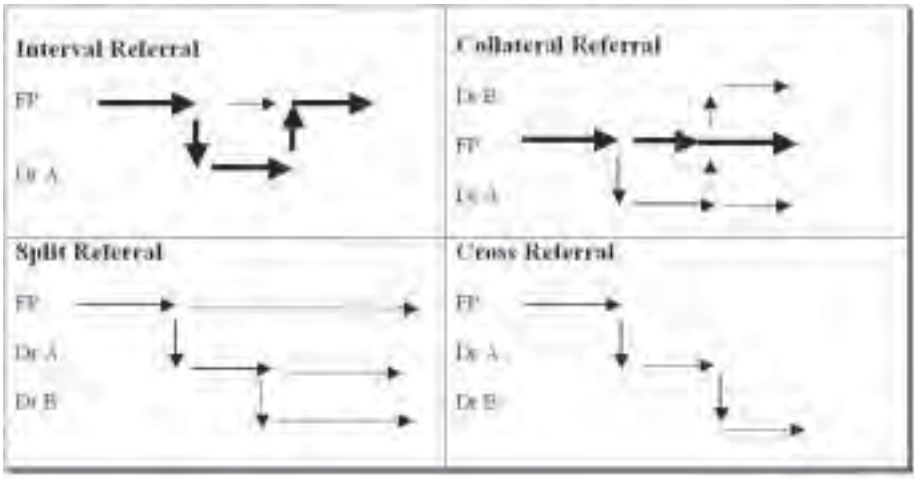

Figure 1: Graphical representation of the 4 types of referrals (primary responsibility for care in bolder arrows), FP - Family Physician

Interval referral

In interval referral, the patient is referred for complete care for a limited period during which the referring FP has no direct responsibility other than being available to the patient, the family and other doctors caring for the patient for advice and resource. The specialist takes complete charge during that interval of time usually a period of hospitalization and refers the patient back to the FP after that interval for continued care. During the period, the specialist may consult the referring FP for information and advice as the FP has a more comprehensive knowledge of the patient over time. He may also consult other specialists for acute problems during that period for example, complications of in-patient treatment. An example is the FP referring a patient to the surgeon for acute appendicitis and an appendisectomy was performed.

Collateral referral

In collateral referral, the referring FP assumes overall responsibility but the specific problem is by mutual agreement under the care of the specialist referred to. This connotes that the FP is the primary physician and would be responsible for treatment and if necessary, further referrals should problems other than specific related ones arise. An example is a referral to the eye surgeon for glaucoma and surgery. The patient is subsequently followed up and treated for the eye condition by the eye surgeon as well. Should the eye doctor detects other ailments in the course of care, he would communicate this to the FP who would as the primary physician assumes responsibility for the new problem.

Split referral

In split referral, the responsibility of care is divided(split) amongst the many physicians, each looking after a system or part of the body in parallel over time. Each physician is responsible for only the part of the body within his specialty. This is sometimes derogatively called "partialists' care".

Cross referral

In cross referral, the entire responsibility of care is with and transferred to the doctor referred to. This occurs when the patient self refers to the specialist and is the standard procedure in hospital when the emergency department physicians after triage-ing refer patients to various departments for management. This also occurs when FPs refer patients consulting them for acute episodic care with no intention to continue the relationship with the referring FPs.

The term, 'shared care' implying a number of physicians 'sharing' the care of the same patient can be examined in this light. Care may be provided in parallel by a number of physicians through either collateral referral or split referral. The difference is that in collateral referral, the FP still assumes the role of the primary physician while in split referral, even if a FP is involved, he only assumes partial responsibility for the problems he is directly presented with.

Interval referral and collateral referral are in McWhinney's opinion good for patient care as the FP is still the primary care provider. Split referral is undesirable because there is a 'collusion of anonymity', a term coined by Balint, another doyen of FM. The fourth and final type of referral is the cross referral where there is no primary physician/generalist overall responsible. Care is fragmented and uncoordinated.

The types of referrals made determine the model of patient care. This is important for better continuing care envisaged in the healthcare reform. ■

Reference: McWhinney Ian 1997. Consultation & Referral IN A Textbook of Family Medicine 383-4 Oxford University Press ISBN 0-19-511518-X

Transforming Primary Care - A Grassroots' Perspective

By Dr Wee Chee Chau, MCFP & Editor

A capacity crowd of more than 100 doctors at the three and a half hour forum on 15th Jan 2005.

Some specialists notably our College Honorary Fellow, Prof Chee Yam Cheng, were also present.

SEMINAR STRUCTURE

1 STATE OF PRIMARY CARE: PERSONAL PERSPECTIVES

Three working family doctors at the "battle front" comprising a veteran practitioner with more than twenty-five years' experience - Dr Cheng Heng Lee (who collated feedback from a group of 9 doctors from the heartlands to Orchard).

Next, a much younger Dr Wilson Yu, representing a small group of three doctors working together in Siglap presented the "Katong experience".

Dr Sally Ho, a senior Family Physician working at the Polyclinic was the third speaker.

2 THE ACADEMIC & BUSINESS SIDE OF FAMILY PRACTICE

Dr Tan See Leng, currently the admin CEO at Mount Elizabeth Hospital spoke first, followed by A/Prof Goh Lee Gan, who touched on the Medical education system.

Lastly, Dr Lee Kheng Hock, the Honorary Secretary of CFPS elaborated on "Quality in Family Practice".

3 QUESTIONS & ANSWERS

An interesting and charged Question and Answer session, where several speakers have their say, rounded off the afternoon.

STATE OF PRIMARY CARE: PERSONAL PERSPECTIVES

The first two speakers provided the gist of the grouses from those in private practice: that GPs are indeed suffering from income depreciation, dwindling patient numbers and shrinking fees due to high overheads and super efficient managed health care corporations that seem to equate reducing healthcare cost to cutting the GP's pay.

The situation is aggravated by the extremely well-equipped Polyclinics that are continually being improved - financed by tax dollars that seem to drive the GPs out of business. These "one stop" establishments have indeed proved to be a formidable foe to vanquish the already languishing GP.

Patients' perception that the GP is "useless" is demonstrated by the countless demands for self referrals to Specialists and the numerous shared-care patients that get lost to the system.

The third speaker, Dr Sally Ho painted a different picture of Polyclinic doctors being overloaded with work and endless queues of patients. The morale of doctors is low and there was hardly any opportunity to practise good medicine due to the ultra short consultation time.

The burgeoning number of patients in the polyclinics result from public subsidy that does not differentiate the haves from the have-nots. With cheap fees, Family Medicine trained doctors and even specialist support, it is no wonder that the private sector is crying foul play.

The only thing that all three speakers agreed is the need to continually upgrade. Vocational registration is also mooted as a possible way for the private sector to achieve some reputable and improved standard of practice that may help to level the playing field. A branding exercise for the Family Doctor may set the pace for changes that may actually "save" private practice in Singapore.

One important point that crept up in the presentation was that joining the College may provide the necessary mutual support and interaction. The "lonely" GPs would benefit as they will be kept on their toes on medical skills and knowledge, and share in a common goal and voice by their involvement.

THE ACADEMIC & BUSINESS SIDE OF FAMILY PRACTICE

The next three speakers spent time to illustrate the macro level view, from their experience at the management level.

Dr Tan See Leng contrasted the long waiting time and queues at Specialist outpatient clinics and the empty waiting rooms of the GP - a case of uneven distribution.

Misconception of GP abilities, lack of consistency in the practice standards and a perceived lack of quality control and audit, are all contributing factors that had resulted in the current sad state of affairs. The future healthcare situation according to Dr Tan is unlikely to improve, unless there is an extreme makeover of sorts of the Family Medicine fraternity.

Every Family Doctor must overcome the sense of competitiveness and co-operate or even form a Committee for Primary

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Care that can handle negotiations with insurance companies, perform the necessary audits and quality control etc. If these are done, then there may still be hope for all of us.

A register for Family Physicians may well be a good starting point that can lead to further developments. A consolidated and cooperative effort may then be forthcoming. We can negotiate for all family doctors (with Ministry of Health, insurance companies, corporate accounts) and even organize charitable, medical relief for disasters, epidemics etc. Outsourcing need not be a bad word. Overloaded specialist clinics and polyclinics can unload their burden to GPs. It will then be a win-win situation.

Dr Lee Kheng Hock spoke of something intangible and difficult to define, called quality. Vocational training, revalidation and branding are all measures for the sake of improving quality for consumer and policy maker alike. Benchmarks such as the proposed FP register would convince them to put their trust and money into Family Doctors who exercise self policing, peer review and revalidation.

QUESTIONS & ANSWERS

The Question and Answer session was quite interesting. The audience bombarded the panel with questions such as: What the College and Singapore Medical Association have been doing all these time to alleviate the problems? Is means testing a way to level the playing field between private and public sector? How to "beat" the hegemony of the insurance and managed healthcare companies? How to handle the endemic undercutting amongst GPs?

CONCLUSION

The Chairman concluded the meeting with a call to all Family Physicians to galvanize and gel into a formidable group, to come forward for more discussions/ feedback. Issues such as accountability and audits must also be addressed to reform primary care. ■

Feedback sessions from Oct to Dec 2004

GDFM As the Minimum Required Vocational Standard

- What does those who are already trained have to say?

As part of the process of consulting family doctors on the proposal of making the GDFM the minimum required vocational standard for family physicians, the College conducted a series of focus group discussions with doctors who had vocational training in family medicine namely the GDFM, the MMed(Family Medicine)/MCFP and the FCFP. The sessions were held on the 27 October 2004, 25 November 2004 and 2 December 2004 respectively.

Since the proposals were endorsed at the last Annual General Meeting, it was not surprising that support for the proposal was very strong. However there were concerns about implementation. Some of the points raised during the meetings were:

1)Training Structure

There is a pressing need to create a ready pool of trainers, mentors, and examiners. This would involve "unlocking" trainers from the clusters and pooling of training resources at a national level. The College could maintain the register of accredited teachers, tutors and examiners

2) FM register

"Magic year" for those who have/do not have the qualification to be in the FM register. The register should take an inclusive approach and should not threaten the existing doctors' rice bowls.

Criteria for grandfathering-Those with recognised FM qualifications equivalent or higher than GDFM could be considered for grandfathering e.g. MCGP, MRCP/ MMed(IM) with family practice experience, MRCGP, FRACGP etc

Established GPs who are accepted by NUS as clinical teachers for students could also be accepted in recognition of their skills and experience. All teachers for GDFM/MMed & FM examiners could be accepted. Practising GPs who have other qualifications that do not have significant general FM cannot be accepted.

Practising GPs who would like to go into the register can do so provided they complete a prescribed course which will include some form of assessment.

3) Practice value of GDFM

Graduates generally feel that the course made them change their practice and their relationship with patients in a positive way. Course content were structured, informative and relevant. GDFM helps the transformation of medical school graduates into good family doctors. Compared to other specialty training, GDFM does not increase a doctor's earnings at the end of the training process. The benefits is mainly enjoyed by the community in the form of better care at the same price. The GDFM training should therefore be partially subsidised. ■

"If it ain't broke, don't fix it!"

By Dr Jeff Tay, MCFP, Editorial member

When news about plans for a register of Family Physicians by 2007 appeared in the Straits Times 22 December 2004, some members in the GP fraternity were understandingly alarmed. Why the need for one since we have done without it for the last few decades? Has the standard of primary care in Singapore deteriorated so much? Can't one still practise as a GP with a MBBS?

A structured vocational training programme was instituted soon after the College was set up in 1972. The diploma awarded, MCGP was recognised as a post-graduate qualification by the Singapore Medical Council. The MCGP was replaced by MMed(FM) in 1992. [1] The GDFM was started in 2000. However, to date, only about 25% of GPs in Singapore are vocationally trained.

Perhaps, the resistance to change had obscured the vision and efforts to identify "anything broke" or the need to shake the foundation of healthcare in Singapore. But as recent events in the health scene has shown, we may have finally come of age to admit that there is indeed something terribly wrong and in fact getting worse (see pg 8), and the need to change is now. The change that is referred to is the Family Physician register and all the necessary 'evils' that comes with it.

"We may have finally come of age to admit that there is indeed something terribly wrong ... and the need to change is now."

No escape from change

Just when you may go away with the idea that these changes are isolated in our local context, this article will show that even the more 'advanced' countries like the US and UK cannot escape the pressure to change for the better when it comes to health matters.

As recent as 2002, the Department of Health and Royal College of General Practitioners (United Kingdom) introduced the General Practitioner with Special Interest [2] to provide localised services, in familiar surroundings with easier access and speedier care for patients, at the same time supporting GPs in their professional development and allowed GPs with specialist experience and expertise to apply their skills and knowledge to best effect. Despite being in existence for so long, the National Health Service is still setting out to improve access to, and convenience of primary care services.

"Don't shoot the messenger"

In the US, it was only in 1978, that the US Institute of Medicine, having described primary care as "first contact, comprehensive, and continuing" and subsequently encompassed "integration, access, and sustained partnerships with patients" found that the American people wanted a regular physician who knew their medical history and showed personal regard, and they did not feel that their physicians were fulfilling that role. This situation is not unlike what we are experiencing in Singapore, and our doctors are also suffering from low morales and unhappiness with their take-home pay.

National health agenda

In our local context, the Ministry of Health has set several objectives for primary care in Singapore. The role of the family doctor should be to promote healthy living focused on health promotion and disease prevention and to provide more than just episodic outpatient care. Concerns about General Practitioners(GPs) needing more training were highlighted in the local press and brought attention to the GDFM programme. [6]

The College proposed that a minimum vocational standard for family doctors to be the Graduate Diploma In Family Medicine (GDFM). [5] It has proven to be relevant and of a standard achievable by practising doctors. The strategy is to have training that emphasizes practical application of skills, knowledge and promote evidence based, cost-effective interventions for better care.

The "Registry of Family Physicians by 2007" was first reported in the Straits Times (see pg 4). The MOH's vision for better primary healthcare was further expounded in the Singapore Medical Association News (see pg 5). In another article in the same issue, A/Profs Goh Lee Gan & Cheong Pak Yean envisaged that the GDFM would be a suitable reference standard.[9]

Continuing Care

The press also reported on reforms in the costing of healthcare, how it was paid for and the way it was delivered. [10] Stable chronic illnesses will be cared for in the community, rather than in the more expensive hospital setting. As a result, healthcare professionals, including family physicians, would require further prepatory training. Eventually, all Singaporeans would have a single family doctor to go to for both preventive counselling and care for chronic conditions.

The Feedback Group for Health suggested that polyclinics be merged

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General Practitioners with Special Interest (GpwSI)

– *The United Kingdom experience*

By Dr Tan Boon Yeow, FCFP, Chairman of Eldercare SIG, CFPS

"The art of being a generalist is the key to any GP's work, and special interests are fundamentally there to complement, not replace, the core work of family doctors. But there is little doubt that enthusiasm for a special interest is truly beneficial to morale, recruitment and retention, and most important to patient care."

- Professor David Haslam, Chairman of Council, Royal College of General Practitioners.

What is the GP with special interest (GpwSI)?

GPs with special interests supplement their important generalist role by delivering high quality, improved access service to meet the specific areas of needs. They may deliver a clinical service beyond the normal scope of general practice, undertake advanced procedures or develop services. They will work as partners in a managed service, keeping within their competencies.

What roles can they (GPwSI) play?

We envisage three broad roles:

1. To lead in the development of locality services (e.g. a leader for cancer services) through working with generalist and specialist teams
2. To deliver a procedure based service (e.g. endoscopy) as part of a locality wide clinical team
3. To deliver an opinion or offer a clinical service on the request of clinical colleagues (e.g. a pigmented lesion clinic)

The last two of these are similar, in that they both involve delivering clinical care while the first does not, but differ in the technical skills required. Some GPs with Special Interests will undertake two or three of these roles in one job.

Will they be useful?

The identification, support and reward of GPs with clinical special interests offer considerable benefits:

a.Patient care

For patients, easier and more rapid access to high quality care and closer to their home offers considerable advantages. The increased communication between local GPs may enhance team working and continuity.

b.Developing GP careers

For some general practitioners, taking part in clinical care outside the general practice core offers interest, personal development and heightened self-esteem. There is evidence that this activity may, for some, enhance retention, delay burn out and increase job satisfaction.

c. Breaking down health service barriers

Increased team working with consultants will help to break down the barriers that often currently limit team working in the interests of patient care. This will be good preparation for intermediate care, which will lead to increased community working by specialist teams.

d. Cost effectiveness

GPs with special interests may be able to offer to some patients a higher quality clinical service at a lower cost to the NHS.

What are some potential problems?

a)The value of generalism

It is imperative that the creation of GPs with special interests does not degrade the discipline of general practice and the value of generalism. Such doctors must be good GPs first and foremost and they must deliver their special interest within their generalist care. We do not wish to see a fragmentation of general practice with the devaluing and eventual loss of generalism to the detriment of patient care as occurred to the general physician (which is a role in renaissance, at least in the context of the acute physician).

b) Quality

Before GPs with special interests are appointed, we must be sure that this is not a second class service designed to ease the pressure on hospital outpatient clinics, reducing clinical standards while denying patient access. This means that all such GPs must be trained properly, accredited, supported, and regularly re-accredited. They must be regularly revalidated for their clinical areas. Those providing a local service within a primary-secondary care team must be part of the clinical governance and service monitoring arrangements for that team. Audits must demonstrate that such care is equivalent to or of higher quality than traditional hospital based care. And patient care must be enhanced, not diminished.

c) Risk effectiveness

In addition to proving the quality of such an innovation and its cost-effectiveness, we must be sure that there is risk effectiveness as well. This means that the maximum effectiveness is achieved for the minimal risk. An increase in GP endoscopy, colposcopy or other invasive investigations undertaken in community settings must not increase patient risk. For every procedure proposed, there needs to be clear guidelines on numbers to be undertaken to maintain skills,

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RANGE OF SPECIAL INTERESTS

- Education (undergraduate teaching, vocational training and postgraduate education)
- Leadership in service provision and representative organisations
- Research & academic general practice
- Quality assurance (including examiners, mentors, appraisers and assessors)
- Management (for example, in primary care organisations or in deaneries)
- Public health
- Clinical areas (which could possibly include the following):

- Cardiology, - Care of the elderly, - Diabetes - Palliative care and Cancer - Mental health (including substance misuse) - Dermatology - Rheumatology and sports medicine - Orthopaedics - Women and child health, including sexual health - Ear, nose and throat - Procedures suitable in community settings

Graduate Diploma In Family

Course Overview

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

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

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

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

GDFM Roadshows

College is holding 2 GDFM roadshows for doctors who are interested in enrolling.

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

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

Date : Tuesday 29 March 2005(5.15pm) & Saturday 30th April 2005(2.30pm)

Core FM CME Points

Trainees of 2005/2007 batch can expect to earn:

GDFM Modules

For Year 2005: a maximum of 18 FM CME points under Category 1A for 2 GDFM modules.

For Year 2006: a maximum of 36 FM CME points under Category 1A for 4 GDFM modules.

For Year 2007: a maximum of 18 FM CME points under Category 1A for 2 GDFM modules.

GDFM Courses

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

8 GDFM

1 Module 1 Principles of FM, CVS & Respiratory System

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

2 Module 2 Child & Adolescent Care, GIT

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

5 Module 5 Individual, Family & Community, Skin

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

6 Module 6 Adult Care, Musculoskeletal/Emergency Medicine

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

GDFM Modules

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

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

Sample - Tutorial Topics for Module 1

Unit 1: Focussed Examination of The Respiratory System

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

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

Unit 4 (Additional teaching materials)
Diagnostics Approach - Problem Based Learning: A Man With A Cough And Fever

y Medicine Programme (GDFM)

M Modules

3 Module 3 Chronic Medical Care, Renal & Blood

- Continuing Care; Hypertension
- Diabetes Mellitus; Care of the Terminall ill
- Oncological Problems; Haematological Problems
- Urinary Tract Problems; Doctor as Manager

4 Module 4 Elderly Care & Psychiatry

- Ageing, Fitness & Assessment; Stroke & Rehabilitation
- The Frail Elderly; Prescribing in the Elderly
- Mood Disorders; Anxiety Disorders
- Computer Use in Practice; Teaching & Research

7 Module 7 Antenatal/Obstetric Care, Neurology & EENT

- Family Planning & Infertility; Common Gynaecological Disorder
- Gynaecological Cancers; Sexually Transmitted Diseases
- Common Neurological Disorders; Eye Disorders
- ENT Disorders; Financial Mx

8 Module 8 Gynaecology & Endocrinology

- Antenatal Care & Drug Use; Medical Disorders in Pregnancy
- At Risk Pregnant; Postnatal Care
- Nutritional Counselling; Metabolic Disorders
- Endocrine Disorders; Quality Assurance in Practice

GDFM Courses

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

3 GDFM Mandatory Courses

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

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

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

1 BCLS competency certificate(excluded in GDFM programme fee)

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

GDFM Examination

The examination is conducted by the DGMS, NUS in July/August 2007 and consists of:

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

Eligibility

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

- A basic degree of the MBBS or equivalent qualification registered with the Singapore Medical Council
- Full or conditional registered medical practitioner can apply including doctors now finishing housemanship & becoming MO in April/May 2005

Fees:

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

- *College member : S$ 3570*
- *Non-College member : S$ 3930*

(covers registration fee of $50, 8 GDFM Modules & 3 GDFM mandatory courses; fees does not include the BCLS & 2 electives FP skills courses)

Examination Fees (payable to Division of Graduate Medical Studies, NUS when apply for examination in May 2007) : S$ 500 (does not include registration fee of $52.50)*

Response Form

❑ Please send me GDFM application form.

❑ Yes, I am interested in attending the GDFM roadshow.

❑ 29 March '05 ❑ 30 April '05

Name :Dr _____

_____

MCR No:_____

College Member: ❑Yes ❑ No

Mailing address: ❑ Residential ❑ Practice

_____

_____

Tel: _____(H)_____(O)

Fax:_____

Email:_____

** Subject to changes*

Interview with GDFM Graduands 2004

By Dr Stephen Tong, Editorial member

The College Mirror spoke with 2 doctors who successfully completed the GDFM in 2004, to find out their views about the program, their concerns and difficulties, what it was like to be studying while juggling with their usual workload and family time, and how it has made a difference to their medical practice.

Dr Anne Regina Tan

Dr Anne Regina Tan (AT) graduated from NUS in 1995 and has been practising as a GP since 1998. She is working with a private GP group in a Health Assessment Centre in Orchard Road. She has 2 young children, 3 and 5 years old.

Dr Ang Lai Lai (ALL) graduated in 1984, started working as a GP since 1987. She is currently working as a Family Physician in a solo practice in West Coast Road. She is married with 4 children, the eldest in NUS High School, and the youngest attending Primary 1 classes in ACS.

Dr Ang Lai Lai

Q:Why did you take up the GDFM training program?

AT: Took it up as a sort of refresher course and also to "fill the gaps" on areas I am not so familiar with or don't see too often in practice.

ALL: Have always wanted to go through some form of structured programme for the training of family practice. GDFM seems to be the answer.

Q: Have you found the program useful & how has the program benefited you?

AT: It has been very useful. Also, I got to hear how others practise & have benefited from discussions during tutorials.

ALL: The Saturday afternoons were generally well spent. The program was mostly useful, comprehensive & covered almost all aspects of family practice.

Q: How did you manage the time to do this program amidst your other priorities - work / family?

AT: I work 6 mornings and 2 afternoons a week. We were taught to find time to read and I ended up doing so early in the morning before going to work, or late at night after kids slept. I have a lot of support from my mom and husband babysat while I attended lectures and tutorials.

ALL: I did not find the program too tedious, no problem completing it. My solo practice is not busy and I work morning, afternoon & night sessions for Mondays to Thursdays only. On Fridays and Saturdays we are open only in the mornings, and I have since closed my Sundays sessions following the SARS outbreak in 2003.

Q: Do you find that your practice or approach to patients different after going through the course?

AT: Quite different, I now look more towards holistic care.

ALL: Definitely – I am more confident with a more practiced approach; I am also more willing to listen to patients and explore with them their thoughts about various modalities of care, and will not feel insulted if they chose other options.

Q: Would you advise others to do the program?

AT: Yes. it was a very good, concise and gave us what we needed. It is also very practical and nothing too academic.

ALL: Sure. I'm sure that they will benefit from it.

Q: What practical tips & advice do you have for doctors contemplating on taking up the program?

AT: The earlier the better.

ALL: Sign up! They will be glad that they just get on with it. The only difficult part was preparation for the examinations. A fair bit of anxiety but also found much fun in studying for exams after such a long break from student days. Surfing the net was fun too. There was so much knowledge to be acquired just at the computer front.

Q: Are you contemplating or have you been doing or have you done any other postgraduate medical training programs?

AT: I am not thinking about any as yet.

ALL: Did the DFD course and the Dermatology course for GPs. Been too long ago and so cannot comment on their usefulness now.

Q: How long have you been practising family medicine? Do you find that you are lacking any medical skills/ knowledge?

AT: I have been practising as GP since 1998. I find the family medicine training during undergraduate time not adequate because we were in the hospital most of the time, with not much exposure to primary care.

ALL: I graduated in 1984 and have been a GP since 1987. Previously, I attended a lot of medical talks even before CME was made compulsory. Still my style of relating to patients and their family was more instinctive rather than acquired.

Q:Any regrets with the program? Anything you find inadequate with the program?

AT: No.

ALL: No regrets going through the program. Perhaps more could be done on counselling skills, to be given by professional counsellors?

Q: Do you still have time to maintain your recreation/social events while doing the program?

AT: Yes.

ALL: Sure. In fact, the program gives us opportunities to interact with seniors and juniors. Time for friends and family remains unaffected generally. ■

Mental health training for GPs

By Dr Tan Yew Seng, Chairman of Mental Health SIG

The Mental Health Special Interest Group (SIG) was formed about a year ago with the aim of promoting primary mental health care. Since then, there were quarterly sessions featuring various topics such as symptom attribution, using cognitive behavioural therapy in clinical practice, understanding family dysfunctions, "heart-sink" patients, and managing moods, pain and insomnia in people with chronic illnesses.

Most session attracted a small group of "regulars". But the later sessions, especially the last one had a much higher attendance as we decided to actively promote multi-professional learning. The audience then had included not only of general practitioners(GPs), but also doctors from institutional practices, counsellors, social workers, family therapists & teachers.

Why mental health?

However I believe that the learning experience of the SIG can be extended beyond just a group of loyal practitioners. To begin, it would be apt to remind ourselves the relevance of mental health in primary care. Research has established that emotional problems may comprise from 15 to 50% of the GP's workload. As with many other countries, mental health training in Singapore has, until recently been traditionally minimal in the under-graduate curriculum.

Here, it might be necessary to differentiate between disordered mental health and mental disorder/disease. The former constitutes what GPs see in the clinic most of the time; the latter tend to belong in the realm of the psychiatrists. To give an example, a patient who suffers from stress at work because he has an unrealistically high expectation of himself would not be mentally healthy, but he does not have a mental disorder (although it could eventually lead to one if he persists in mental ill-health). This patient would not have presented to the psychiatrists, but may be picked out by his GP when he presents with stress-related complaints or coincidentally in the course of the GP-patient interaction. By preserving mental health, GPs can even play an important role as the vanguard against the more serious psychiatric disorders.

Why Family Physicians?

Some may ask if the GP is really the correct person to deal with mental health or from the patient's perspective, an acceptable person to handle such matters. The answer becomes apparent indirectly when we consider the agitation and discomfort in patients when their regular doctors are not around to serve them. And it is really not about medical records because some of these patients would rather wait for their doctors to return than to see the locum doctor at the clinic.

The GP has thus a very personal function, as someone who can provide and has been accepted to provide a safe environment for the patient's expression of his suffering/illness (the "I am not used to other doctors" thing). One can say that some social bonding has occurred that now places the doctor in a special position within the social framework of the patient. The doctor in effect becomes the patient's buffer or stabilizer against insults to the body and mind; he is a person to go to particularly when the toll of life events results in illness.

But further, the GP is special because through time, he becomes aware of the patient's physical and mental developmental phases, and that of his family. With this information, which appears rather privy to the GP compared with other medical professionals because of the conduct of his practice, he can probably devised more appropriate intervention for his patient. It is worthwhile to realize here that while GPs should learn about psychiatry, Michael Balint's classic works suggested that psychiatry has little to teach GPs manage their patients at the GP setting – this too, is quite exclusive to general practice.

Looking ahead

Reflecting on the short-comings of the SIG sessions in the last one year, and based on a survey done by the author in 2004, some improvements to this year's programme may be called for:

1. The session will be held on Saturdays afternoons, whenever possible.

2. There will be more sessions in order to be comprehensive.

3. The topics will be progressive, with emphasis on enabling or empowering skills.

4. Inclusion of "skills-you-can-use" such as Motivational Interviewing, Mind-Body techniques, and Cognitive-Behavioural Therapy.

5. We should ultimately aim to acknowledge the GP's participation and even consider accreditation for GPs trained in mental health, so that they can perform a higher level of mental health care in the community. This could be structured as a Diploma in Clinical Counselling/Mental Health for those who have attained the GDFM or the Masters in Family Medicine.

The last point is a distinct possibility in view of the current political vision of the Ministry of Health. To quote from a SMA interview with the Director of Medical Services, Professor K Satkunanantham earlier this year: "….You must go beyond this and have sub-specialised Family Physicians, be it in geriatrics, psychiatry, palliative care or even sports medicine…. So if you have a patient who needs greater attention… you may refer him to your colleague with further training in that sub-speciality instead of to a Specialist in a tertiary care institution".

To sum it simply - the patients are there; there is increasing official recognition of the doctor's role; and the training is being formulated. What remains then is doing it. ■

The Role of General Practitioners in Healthcare System

6th General Practitioners' Scientific Conference in Yangon, Myanmar, 1-2 January 2005

By Dr Julian Lim, FCFP & Dr Wong Tien Hua, MRCGP

At the invitation of Professor Myo Myint, President of the Myanmar Medical Association (MMA), a four men team, (comprising Associate Professors Cheong Pak Yean, and Goh Lee Gan, Drs Wong Tien Hua and Julian Lim) chaired and lectured in the Family Medicine Seminar & Workshop segment of the Conference.

Group photo taken at the 6th GPs' Scientific Conference

The team presented:

1. Update on Family Medicine Training in Singapore (A/Prof Cheong)

- tracing the milestones in Family Medicine education in Singapore, vocational training and post graduate development.

2. Family Medicine Practice: The WONCA Guidebook (A/Prof Goh)

- a guide for the development of Family Medicine at the national level.

3. Using Video as a Learning and Teaching Tool (Dr Wong)

- a video demonstration and providing a first-hand experience in marking and critiquing a pre-recorded consultation based on the Pendleton's 7 tasks of the consultation.

4. Play-back based Learning (Dr Lim)

- a method of teaching ambulatory care that evolved from problem-based and portfolio-based learning, that requires the doctor to play the patient while another doctor plays the doctor emphasizing the importance of the consultation and bringing out the affective aspects apart from the cognitive & psychomotor aspects.

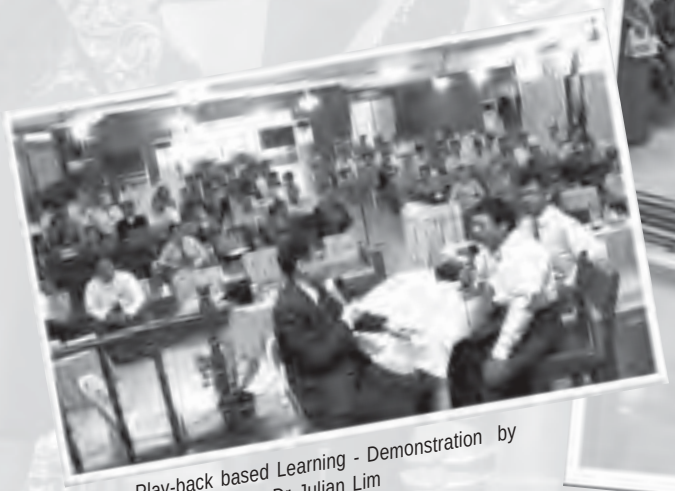
5. Using the OSCE(Objectively Structured Clinical Examination) as a Teaching Tool (A/Prof Goh)

Dr U Tin Aye, President of the General Practitioners' Society of the MMA provided an update on Family Medicine Training in Myanmar and also shared the Myanmar experience with the OSCE.

It was not all work as the gracious hosts arranged a visit to Dr Win Lwin Thein's home and clinic . His clinic has many similarities with the Singapore counterpart except the patients leave their shoes outside the clinic, and everyone seems to get an injection at the end of the consultation. Due to the unreliable power supply, both Dr Win's home and clinic are fitted with backup generators.

The team was also brought to Chinatown, Shwe Dagon Pagoda and the Scotts Market.

Opportunities for networking came in the form of formal and informal mealtime meetings with leaders of the Family Medicine community as well as GPs and specialists from other disciplines. ■



Play-back based Learning - Demonstration by Dr Julian Lim

Remove your footwear before entering GP clinics!

Enjoying "Tau Huay" in the streets of Chinatown, Yangon by night

Relief Mission to the Tsunami hit areas of Sri Lanka

By Dr Kevin U-Jyn Chan, Flinders Practice Pte Ltd & Volunteer Doctor with Mercy Relief

The extended writeup & more photos are available online - www.cfps.org.sg/collegemirror/cm_index.htm

On Boxing Day 26 December 2004, the world's strongest underwater earthquake, measuring 8.9 on the Richter scale, unleashed flash floods and huge tidal waves, causing massive destruction and great loss of life in countries ranging from Indonesia in South East Asia through Sri Lanka up to East Africa. About 300,000 lives were lost, many costal villages destroyed and a great number of people were displaced.

I am a volunteer with Mercy Relief, an independent charitable non-governmental humanitarian organization (NGO), and we undertook a relief mission to the Tsunami hit areas of Sri Lanka. Our main focus was in "recce", to provide needs assessment of the disaster area. Though I have been on similar missions with Mercy Relief in the past, each mission is different, and one has to expect the unexpected. Our Team consisted of 7 persons, and I was the medical physician and medical liaison person, providing medical feed back for the mission. A great deal of preparation work had to be done within a short time to organize the relief supplies and to brief the volunteers. We departed by commercial flight to Sri Lanka on the 3rd of January 2005, barely a week after the disaster struck, with 52 tonnes of relief supplies, which included medications, water, food, and clothes etc.

Trains derailed with carriage torn away from each other.

The degree of devastation in Colombo itself was not significant and one would not even have noticed any difference to the way of life of Sri Lankans in Colombo. But as we ventured south of Colombo the degree of destruction seemed to creep in and the full effects were seen as we entered the township of Galle, 6 hours' drive south of Colombo. There, the devastation was terrible, brick houses were shattered; cars, trucks and buses were displaced, fishing boats were parallel parked neatly on the side of the road and some were even about 200 to 300 metres in land. As we walked in to what used to be a cozy neighborhood, the heavy smell of seawater filled the air. As we ventured further into the area, the sense of panic, helplessness and death seemed to fill the atmosphere. A clock stood still at 12:30, another stopped at 1pm, and furniture was strewn out from what used to be a house. Clothing, books, kitchen utensils seemed to be laying on the ground in a haphazard fashion. A watermark about 8 meters high stained the walls, while a bus and a fishing boat laid on their sides in the middle of what used to be a play ground. While we were threading carefully in these areas we came across people who have lost their homes and loved ones. They have come back to try to find their family, regain their belongings, and put closure to the dreaded episode, so as to move on and start their lives again.

No matter how much one prepared for the destruction, the power of the waves of the Tsunami was unexpected. The destruction not only involved the collapse of solid infrastructure (as in houses) but also displacement of sea going vessels in land, and the further destruction and death of the people by way of drowning. Every mission to disaster stricken countries is different and no amount of preparation is able to make one fully take in and comprehend the degree of destruction. We had to expect the unexpected.

Providing medical aid to the victims

After seeing the various destruction areas, we proceeded further inland to higher ground to the campsites of the internally displace people, to distribute the various relief supplies that we brought with us. These campsites were located in temples, churches, mosques, and schools, with religious leaders, mainly monks, helping to provide shelter to the people. At one of the campsites located in a temple, we provided medical aid to some of the people. They were mainly suffering from muscular skeletal problem, skin diseases, gastroenteritis, fever and dehydration.

As we spoke with the people in the various campsites, their main concern is how they were going to rebuild their lives again, as all their possessions have been destroyed and washed away by the sea. They also felt betrayed by the sea, as most of them earned their living from the sea, but now they have lost everything to it. Post-traumatic stress was also an important issue in the rehabilitation of this displaced population. Those that have survived this ordeal may relive the memories of that fateful day on Dec 26.

Our mission ended on the 8th of Jan, a total of 6 days. At the end, we felt that medical support in the areas of bio-psycho-socio support for the people was of prime importance for rehabilitation of the population. Though the mission was short it did soften our hearts to see how lucky we are to live in the Lion City, where our geographic location makes us less vulnerable to natural disasters. Besides, this disaster has also shown the unity of Singaporeans to band together, extending hands and connecting hearts. ■

A display of photos of the Tsunami Events & Survivors, put together by volunteer photographers & cooperated sponsors can be viewed at Mercy Exchange at Robertson Walk.

Hints and Tips

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

1 Rectal Injection

When no veins can be found in emergency situations, sometimes the rectal route can be effective. This can be done in:

In Diabetic hypoglycemia, with an unconscious collapsed and oftentimes obese patients the nozzle of a 20 or 10 ml syringe filled with 50% glucose can be pressed firmly into the rectum and slowly injected.

In children with persistent febrile convulsion or patients with status epilepticus Diazepam or Paraldehyde solution can be used rectally with equal success eg. For a 12 kg 2 year old child with febrile fit, the dose of Diazepam is 0.4mg/kg , so 5mg of Diazepam diluted to 5 – 10 ml of solution can be introduced into the rectum

Ref: Practice Tips by John Murtagh 3rd Edition.

2 Finger Lancing with Less Pain

Those of us who had donated blood before would definitely appreciate a less painful way of getting a drop of blood from our fingers. This is more so for those patients that need to check their blood sugar daily.

Well, here are some "food for thought" and perhaps conduct a trial at the clinic:
1. The sides of the fingers are less painful than the pad or base of the nail bed.
2. The 3rd or 4th finger are supposed to be less painful than the thumb or index finger.

However, a randomized controlled trial published in the The Lancet (1999, 354 pg 921-2) showed that the least painful area to lance was the side of the thumb.

Ref: Practice Tips by John Murtagh 3rd Edition.

3 Injection of Trigger points in the back

A trigger point is one that:
. has circumscribed local tenderness
. localized twitching with stimulation of juxtaposed muscle'
. pain referred elsewhere when subjected to pressure.
NB. Use only moderate amount of LA

Method:
1. Identify and mark the trigger point- the maximum point of pain
2. Select a 21-, 22-, or 23-gauge needle
3. Insert the needle until the pain is reproduced, which may be referred distally
4. Introduce 5-8 ml of LA
5. Local massage for the affected segment.

Ref: Practice Tips by John Murtagh 3rd Edition.

4 Dietary Factors that May Worsen Diarrhoea

"Doctor, is there anything in my diet I need to avoid?"

Dietary Factor	Sources
•Lactose	Milk, ice cream, yoghurt, soft cheeses, chocolate
•Fructose	Apple & pear juice, grapes, honey, dates, nuts, figs, soft drinks (if quantity surpasses the gut's absorptive capacity)
•Hexitols, sorbitol & mannitol	Apple & pear juice, sugar-free gums, mints
•Sucrose	Table sugar
•Magnesium-containing compounds	Antacids
•Caffeine	Coffee, tea, cola, OTC headache remedies

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

5 Developmental "Limit Ages" (Upper Limit Normality & Individual Variation)

• Simple & helpful guide for busy family physicians conducting regular Child Health Surveillance

• Further assessment is indicated if the following developmental sign(s) has/have not been acquired by the respective ages (two standard deviations from the mean)

Age	Developmental Sign
8 weeks	Responsive smiling
3 months	Good eye contact
5 months	Reaches for objects
10 months	Sits unsupported
18 months	Walks unsupported
18 months	Says single words with meaning
30 months	Speaks in phrases

Ref: Illustrated Textbook of Paediatrics. Lissauer & Clayden. Mosby. 1997.

Literature Search - Useful Internet Resources

By Dr Sally Ho, Editorial member

We discussed formulation of a research question in the last issue of the College Mirror. Conducting a literature review is a necessary next step before embarking on a research project. There is no lack of current medical literature. In fact, it is increasingly difficult to synthesize and make sense of the explosion of medical information. PubMed, which includes MEDLINE and other life science journals, contains greater than 15 million citations from more than 4800 journals published in over 70 countries.

This article attempts to offer a few tips on 1. Useful Internet resources for family physicians. 2. Levels of evidence.

Why Do We Search?

1. To find evidence-based solutions to clinical problems in patient care.
2. To generate research questions and prepare research proposals.

• Identification of similar investigations would avoid duplication of efforts.

• Inconsistencies in findings between previous projects would indicate areas for further study. • Past papers often contain suggestions for future research. • To place the proposed study in its historical context. This helps to justify one's research by showing what has been done and what needs to be done. • To assess if the proposed research meets the requirements of research funding agencies. • To anticipate problems in study design and identify potential pitfalls in the conduct of the study.

Where Do We Search?

Medical literature can be found in print, on electronic storage media such as CD-ROMs and on the Internet. The Internet is gaining increasing importance as a source of health information for both health professionals and patients alike. It has the advantages of timeliness, accessibility, interactivity and low cost. This article will highlight selected useful resources for primary care physicians. Background resources are useful for general information about a condition. Foreground resources answer specific questions a clinician may have regarding a specific patient. Primary resources such as original research reports would need to be evaluated for relevance and validity. Time may be better spent searching first in high quality secondary resources (e.g. The ACP Journal Club) which appraise individual articles and present the evidence in structured abstracts. Some secondary resources (e.g. Clinical Evidence) summarise the best evidence from across the literature in answer to clinical questions.

What is the Hierarchy of Evidence?

The Evidence Pyramid presents the different levels of evidence with the highest level of evidence & most clinically relevant studies at the top of the pyramid. Evidence from systematic reviews, meta-analyses and randomised controlled trials rank highest in terms of evidence. ■

Enjoy exploring the various sites and databases. We will return in a subsequent issue to discuss how to conduct an effective electronic literature search.

BACKGROUND RESOURCES

(provide general overview of topic)

Textbooks

- The Family Practice Handbook - *http://www.vh.org/adult/provider/familymedicine/FPHandbook/FPContents.html*
- FP Notebook - *www.fpnotebook.com*
- GP Notebook - www.gpnotebook.co.uk
- Merck Manuals - www.merck.com/pub
- UpToDate - www.uptodate.com
- Virtual Hospital - www.vh.org

Guidelines

- MOH Clinical Practice Guidelines - *www.moh.gov.sg/corp/publications/list.do?id=pub_guide_clinics*
- National Guideline Clearing House - *www.guideline.gov*
- NICE-*www.nice.org.uk/page.aspx?o=guidelines.completed*
- USPSTF - *www.ahrq.gov/clinic/uspstfix.htm*

Health Portals/Organisations

- InteliHealth - *http://www.intelihealth.com*
- Martindale's Health Science Guide - *www.martindalecenter.com/HSGuide.html*
- MayoClinic.com - *www.mayoclinic.com/Index.cfm?*
- MD Consult* - *www.mdconsult.com*
- Medscape - *www.medscape.com*
- Primary Care - *http://medicine.ucsf.edu/resources/guidelines/index.html*
- HPB - *www.hpb.gov.sg*
- National Library of Medicine - *www.nlm.nih.gov*

* Subscription required.

FOREGROUND RESOURCES

(reports of original research or abstracts. summaries, syntheses of primary research)

PRIMARY RESOURCES

(Original research articles)

Databases

- PubMed (MEDLINE)-www.ncbi.nlm.nih.gov/entrez
- CINAHL* www.cinahl.com/wpages/login.htm
- Embase* - www.embase.com
- HighWire Press - highwire.stanford.edu/lists/freeart.dtl
- Ovid* - http://gateway.ovid.com

Journals

- American Family Physician - www.aafp.org/afp.xml
- Annals of Family Medicine - www.annfammed.org/
- Australian Family Physician - www.racgp.org.au/publications/afp_online.asp
- BMJ - http://bmj.bmjjournals.com/
- Canadian Family Physician - www.cfpc.ca/cfp
- Family Medicine - http://stfm.org/fmhub/fmhub.html
- JAMA* - http://jama.ama-assn.org/
- Lancet* - www.thelancet.com/journal
- NEJM* - http://content.nejm.org
- Singapore Medical Journal - *www.sma.org.sg/smj/smjcurrent.html*
- Singapore Family Physician - *www.cfps.org.sg*

SECONDARY RESOURCES

(appraisal, interpretation or analysis primary resources; e.g. systematic reviews)

- ACP Journal Club* - *www.acpjc.org*
- Cochrane Database of Systematic Reviews* - *www.cochrane.org/reviews/index.htm*
- DARE(Database of Abstracts of Reviews of Effects) - *www.york.ac.uk/inst/crd/darehp.htm*
- InfoPOEMs* - *www.infopoems.com*
- Bandolier - *www.jr2.ox.ac.uk/bandolier*
- Clinical Evidence* - *www.clinicalevidence.org/ceweb/conditions/index.jsp*
- TRIP Database(Turning Research Into Practice) - *www.tripdatabase.com*

The extended writeup(inlcuding references) is available online - http://www.cfps.org.sg/sig/sig_fm_research.htm

Background Resources (provide general overview of topic)

Textbooks

The Family Practice Handbook http://www.vh.org/adult/provider/familymedicine/FPHandbook/FPContents.html	Primary care textbook of University of Iowa.
FP Notebook http://www.fpnotebook.com	An ongoing compendium of the diagnosis and management of common medical problems seen in Family Practice. US counterpart.
GP Notebook http://www.gpnotebook.co.uk	An ongoing compendium of the diagnosis and management of common medical problems seen in Family Practice. UK counterpart.
Merck Manuals http://www.merck.com/pub	A trusted source for medical information available online for free.
UpToDate http://www.uptodate.com/	Web based electronic textbook that is updated daily.
Virtual Hospital http://www.vh.org/	Digital health sciences library. University of Iowa.

Guidelines

MOH Clinical Practice Guidelines http://www.moh.gov.sg/corp/publications/list.do?id=pub_guide_clinics	Guidelines published by Ministry of Health, Singapore.
National Guideline Clearing House http://www.guideline.gov	Online access to clinical practice guidelines and related materials developed by medical specialty societies and other organizations with standardized abstracts and comparisons.
NICE	National Institute for Clinical

http://www.nice.org.uk/page.aspx?o=guidelines.completed	Excellence, National Health Service, UK. Provides evidence-based guidance on technology appraisals, clinical guidelines and interventional procedures.
USPSTF http://www.ahrq.gov/clinic/uspstfix.htm	U.S. Preventive Services Task Force. Independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services.

Health Portals/ Organisations

InteliHealth http://www.intelihealth.com	Comprehensive general consumer health site featuring Harvard Medical School's Consumer Health Information
Martindale's Health Science Guide http://www.martindalecenter.com/HSGuide.html	Information resource containing teaching files, medical cases, courses and textbooks, tutorials, databases, and movies.
MayoClinic.com http://www.mayoclinic.com/Index.cfm?	Consumer health site. Mayo Foundation for Medical Education and Research.
MD Consult* http://www.mdconsult.com/	Comprehensive online medical information service. Full text of medical journals and reference books, practice guidelines, medical news, drug information, MEDLINE and more. Offers 30-day free trial.
Medscape http://www.medscape.com	Features medical journal articles, free interactive CME, MEDLINE, case reports, medical news, major conference coverage and comprehensive drug information.
Primary Care http://medicine.ucsf.edu/resources/guidelines/index.html	Clinical resources: guidelines, clinical reviews, cross-cultural health, teaching, online references and superlists. School of Medicine. University of California, San Francisco.
HPB http://www.hpb.gov.sg/	Health Promotion Board of Singapore. Consumer health information resource.
National Library of Medicine	Extensive collection of online information for the public and health care professionals dealing with clinical care, toxicology and environmental health, and basic research. National Institutes of Health. USA.

Foreground Resources
(reports of original research or abstracts, summaries, syntheses of primary research)

Primary Resources (original research articles)

Databases

PubMed (MEDLINE) http://www.ncbi.nlm.nih.gov/entrez	PubMed, a service of the National Library of Medicine, includes over 15 million citations for biomedical articles back to the 1950's. These citations are from MEDLINE and additional life science journals. PubMed includes links to many sites providing full text articles and other related resources.
CINAHL* http://www.cinahl.com/wpages/login.htm	Cumulated Index to Nursing and Allied Health Literature. Access from 1982 to the present.
Embase* http://www.embase.com	Excerpta Medica database, a comprehensive bibliographic database covering the worldwide literature on biomedical and pharmaceutical fields. Includes many European journals not indexed in MEDLINE.
HighWire Press http://highwire.stanford.edu/lists/freeart.dtl	Stanford University Libraries' HighWire Press is the largest archive of free full-text science. Over 15 million articles from over 4,500 PubMed journals, including 834,579 free full text articles from 810 HighWire-hosted journals.
Ovid* http://gateway.ovid.com	Allows simultaneous searching of MEDLINE and multiple EBM databases such as DARE, Cochrane and ACP.

Journals

American Family Physician http://www.aafp.org/afp.xml	A peer reviewed journal of the American Academy of Family Physicians.
Annals of Family Medicine http://www.annfammed.org/	Peer-reviewed research journal.
Australian Family Physician http://www.racgp.org.au/publications/afp_online.asp	Official journal of the Royal Australian College of General Practitioners.
BMJ http://bmj.bmjjournals.com/	British Medical Journal. Full text of all articles published in the weekly BMJ since January 1994. Additional material that is unique to the website. Currently access to the entire site is free. From 2005, some users will have to pay for some content on bmj.com.
Canadian Family Physician www.cfpc.ca/cfp	Journal of the College of Family Physicians of Canada.
Family Medicine http://stfm.org/fmhub/fmhub.html	The Official Journal of the Society of Teachers of Family

	Medicine.
JAMA* http://jama.ama-assn.org/	Journal of the American Medical Association. Search facility with free abstracts. Full text requires subscription.
Lancet* http://www.thelancet.com/journal	Search facility with free abstracts. Full text requires subscription.
NEJM* http://content.nejm.org/	New England Journal of Medicine. Search facility with free abstracts. Full text requires subscription.
Singapore Medical Journal http://www.sma.org.sg/smj/smjcurrent.html	A publication of the Singapore Medical Association.
Singapore Family Physician http://www.cfps.org.sg/	A publication of the College of Family Physicians Singapore

Secondary Resources
(appraisal, interpretation or analysis primary resources;
e.g. systematic reviews of a topic, synopses and reviews of individual studies}

ACP Journal Club* http://www.acpjc.org/	Structured abstracts of selected high quality original and review articles in internal medicine with commentary by clinical experts. Published by American College of Physicians.
Cochrane Database of Systematic Reviews* http://www.cochrane.org/reviews/index.htm	Largest collection of high quality systematic reviews on healthcare interventions. Abstracts available free. Full text requires subscription.
DARE (Database of Abstracts of Reviews of Effects) http://www.york.ac.uk/inst/crd/darehp.htm	Structured abstracts of quality-assessed reviews.
InfoPOEMs* http://www.infopoems.com/	InfoRetriever provides clinicians with the best available evidence as they practice.

	Daily InfoPOEMs alert them to the latest developments in clinical medicine research.
Bandolier http://www.jr2.ox.ac.uk/bandolier/	Summary abstracts of systematic reviews of treatments, of evidence about diagnosis, epidemiology and health economics.
Clinical Evidence* http://www.clinicalevidence.org/ceweb/conditions/index.jsp	Series of evidence-based reviews on the current state of knowledge, and gaps in knowledge, on the treatment and prevention of nearly 200 medical conditions. Published by the BMJ Group.
TRIP Database (Turning Research Into Practice) http://www.tripdatabase.com/	Medical search engine with emphasis on high quality sites. Features include EBM resources such as Evidence-Based Medicine, Bandolier and DARE. Also features clinical guidelines, peer reviewed journals, MEDLINE, e-textbooks and patient information leaflets. Non-subscribers allowed 5 free searches a month.

* Subscription required.

Enjoy exploring the various sites and databases. We will return in a subsequent issue to discuss how to conduct an effective electronic literature search.

References:

1. Goh LG. Background papers. Workshop on research network development for WONCA Asia-Pacific region. July 2004.
2. Conducting a medical literature search: Accessing and using MEDLINE on the internet/world wide web. http://www.west.asu.edu/jbuenke/medicine/web3.html
3. A ScHARR Introduction to Evidence Based Practice on the Internet. http://www.shef.ac.uk/scharr/ir/netting/
4. Healthcare and medical sciences web site links. Academic services, Milbrook House. http://www.ex.ac.uk/Affiliate/stloyes/netlinks/lnk2heal.htm#Databases%20:%20General%20Medical%20&%20Health%20Care
5. Amin Z. Internet resources for practice and teaching of evidence based medicine. Singapore Med J. 2001 Mar;42(3):136-8. http://www.sma.org.sg/smj/4203/4203me1.pdf
6. Literature searching: learning the language. The Society for Academic Continuing Medical Education. http://www.sacme.org/Research/language.htm
7. Evidence-based medicine tutorial. Medical Research Library of Brooklyn. Suny Downstate Medical Centre. http://library.downstate.edu/EBM2/contents.htm
8. Bidwell SR. Finding the evidence: resources and skills for locating information on clinical effectiveness. Singapore Med J. 2004 Dec;45(12):567-73. http://www.sma.org.sg/smj/4512/4512ebm1.pdf
9. Pwee KH. What is this thing called EBM? Singapore Med J. 2004 Sep;45(9):413-7; quiz 418. http://www.sma.org.sg/smj/4509/4509ev1.pdf
10. Dr Hunter's Medical Web Page. http://www.myhq.com/public/d/o/dochunter/
11. Dr Alper' links. http://www.myhq.com/public/a/l/alper/

12. Evidence-based medicine: Using OvidWeb to locate clinical information. Library of Rush University. http://www.univ.rush.edu/library/pdf/ebm.pdf#search='ebm%20level%20of%20evidence%20pyramid'
13. Evidence-based medicine. American University of Beirut. http://www.aub.edu.lb/libraries/medical/ues/user-tuto2-R.html
14. Evidence-based medicine resources. Family medicine. Georgetown University Medical Centre. http://gucfm.georgetown.edu/dept/ebm.html

Page 10 (If it ain't broke, don't fix it!)

and linked to private GPs, which could result in a more coordinated approach to chronic problems. [11,12] As 80% of the care of chronic diseases occur in the primary care sector, the focus should be shifted to primary healthcare. [12]

More recently, the polyclinics will soon have specialist family medicine clinics, where patients may enjoy better management of their chronic disease, without having to pay specialist clinic rates. [13,14] By June this year, patients with hypertension and diabetes will begin going to polyclinics for treatment, rather than specialist clinics in hospitals. [14] This comes as part of an effort to improve the management of these conditions at the basic level of care. These clinics will be manned by GPs with a second degree in family medicine. Specialist family medicine doctors are expected to be better qualified and more experienced than the hospital medical officers staffing the specialist clinics. [1]

If you need another reason why there is a need for change: the problem of competence or the lack of such that resulted in the recent compulsory CME. Most of us would think that doctors with more experience have accumulated knowledge and skills during years of practice, and should logically be able to deliver high-quality care, but evidence suggests otherwise. There is in fact, an inverse relationship between the number of years that a physician has been in practice and the quality of care that the physician provides, as shown in a study featured in the Annals of Internal Medicine (Feb 2005). [4] In other words, physicians who have been in practice longer may be at risk for providing lower-quality care.

Finally, something is 'definitely broken and really need fixing'. My prayer is that we have the right remedy, may the good Lord help us all. Some last words : "Don't shoot the messenger." ■

References: Available online - www.cfps.org.sg/collegemirror/cm_index.htm

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appropriate facilities and back-up support.

How do they implement such a scheme?

• A national framework for defining the eligibility of GPs to be recognised as GPs with Special Interests should be drawn up by the National Steering Group.

• For a range of common special interests areas, a set of criteria within the national framework should be defined. These definitions will be led by the RCGP in partnership with other Colleges, professional associations and other stakeholders, and submitted to the National Steering Group for ratification.

• A local health economy (usually led by a Primary Care Group or Trust in England but taken to include all relevant stakeholders) will consider national and regional priorities and its local needs, and may decide to appoint a GP with a Special Interest to meet those needs.

• Where appropriate, the GP with a special interest will work closely with existing specialist teams in the locality, as well as with clinical generalists.

• The GP will need to be satisfied that he/she has the skills to undertake the job description and job content. The GP will include evidence of fitness for the role in annual appraisal & revalidation. Appropriate training should be provided in order to ensure that skills are developed when necessary, and appropriate educational & learning opportunities should be provided during the period of contract.

• The local health economy must be satisfied that the appointment can be justified on three levels: to the local health community, to clinical governance mechanisms (including CHI), and to the Department of Health and its auditors for the use of NHS money. Provided the appointment is within national criteria, these requirements will normally be regarded as being met.

• The appointment of the GP with Special Interests should be reviewed annually through appraisal, and at least every three years through clinical and corporate governance in the local health economy.

What does the above mean for us in Singapore?

It is difficult for a generalist in this age of development and evidenced-based medicine to keep abreast in every field. Therefore, it may be good to be a little more focused in our approach. Developing an area of special interest could be the way to go. However, we must be careful to guard against potential pitfalls as alluded to above. We certainly do not want to replicate the work of our specialist colleagues or compete with them for patients. On the contrary, we want to complement them. The primary aim for developing any such special interest group should be to meet needs in the community and ultimately to benefit patients at large.

The biggest challenge right now for the fraternity is really to ensure there is a minimum standard of care that we as general practitioners/family physicians can deliver to our patients. This can be ensured by first being properly trained and accredited as family physicians.

Having achieved the above, there may be some of us that are willing to contribute in a more focused way. This could be through a special interest group by further training to ensure competency. This is surely something worth considering. ■

Refs: 1.General practitioners with special interests. A paper prepared on behalf of The Royal College of General Practitioners The Royal College of Physicians of London. Professor Mike Pringle March 2001

2.Implementing a scheme for General practitioners with special clinical interests. Professor Mike Pringle Sept. 2001 Practitioners with Special interest: bringing services closer to patients. NHS. Nov 2003.

Useful Links on GpwSI available online at - www.cfps.org.sg/sig/sig_eldercare.htm

1 –Year Programme B Master of Medicine (Family Medicine)

Eligibility to apply :
(a) Conditional or Full registration with the Singapore Medical Council & GDFM qualification (b) 2 years of 4 hospital postings of 6 months each of which, Internal medicine or its equivalent is compulsory (c) Keep a MMed logbook (d) Graduates with MBBS or equivalent in 2003 or before may either fulfil (b) & (c) OR 5 years of GP practice/primary care practice (e) Be practising in an accredited/supervised primary care posting/clinic during the 1-year programme

The 1-year Programme B(commencing July '05):
(1) 40 teaching sessions on Wednesdays between 5.15-6.45pm except those Wednesdays in the Ministry of Education school holidays

· 10 x combined seminars with MOH trainees (1st Wed of month)
· 20 x Case-based tutorial sessions
· 10 x clinical skills sessions (Last Wed of month)

There will be no make-up sessions for Wednesdays that fall on a public holiday. Each trainee would be posted to a tutorial class (3 to 4 trainees per supervisor).

(2) 5 days Clinical/Hospital Attachments or equivalent - The Clinical Attachments comprise 5 full day sessions (same day or split sessions) to be held once every two months.

(3) Two formative assessment sessions (1 to 1) would be conducted to review the trainee's cases write-up, practice log & audit project.

Fees: Programme fees (payable to College of Family Physicians Singapore)
· College member: S$ 4,800*
· Non-college member: S$ 5,000*

Please issue two cheques, one cheque for above Programme fee and the second cheque (non-refundable) for registration fee of S$100. Cheques must accompany the application. The cheque for the programme fee would be returned if the application is not successful after the interview and clinic accreditation visit by the Family Medicine Committee.

Upon satisfactory completion of above, trainees may apply in June '06 with the required examination fee payable to Division of Graduate Medical Studies, NUS.

Please direct all enquiries to contact@cfps.org.sg. Dr Julian Lim and other supervisors of the MMed Programme B would be in the College Conference Room on 29 March 2005, 5.15pm - 6.30pm to answer any query you may have.

** exclude registration fee*

Mental Health SIG

Sleep disorders – Prescribing & beyond

26 March 2005 (Saturday)
CFPS Lecture Room
2.30 to 5.00pm

Synopsis: Sleep difficulties are common complaints among patients in general practice. It is important to realize that sleep difficulty is a symptom, not a diagnosis. The causes of sleep difficulty are varied, and while symptomatic treatment frequently does little to resolve the underlying problem, it may however delay proper management of more urgent issues. Moreover, the controversies surrounding the use of benzodiazepines (BZP) resurface recently with the spate of adverse publicity about BZP over-prescriptions.

Therefore, it is apt that the primary healthcare worker be aware of a sound approach to sleep difficulties, the various pharmacologic options and the professional regulations regarding their use. Besides discussing these pertinent issues, the second half of this session will be devoted to an experiential session on effective non-pharmaceutical techniques that are practicable in the office setting.

Speakers :
Dr Ng Beng Yeong
Consultant Psychiatrist, Department of Behavioural Medicine & Sleep Disorders Unit, SGH, Vice President, Singapore Sleep Society

Dr Lim Kok Kwang
Consultant Clinical Psychologist
Clinical Adviser, Shan You Counselling Centre & President of Singapore Society of Clinical Hypnosis

This event is jointly organized by the College of Family Physicians Singapore, Shan You Counselling Centre, and the Singapore Society of Clinical Hypnosis.

For registration, please call College Secretariat at 6223 0606

Elder Care SIG

Feeding and Nutritional Problems in the Elderly

3 May 2005 (Tuesday)
CFPS Lecture Room
5.30 to 6.45pm

Synopsis: Swallowing impairment and nutritional disorders are common among ill elderly. As family physicians, we are often called to attend to older patients on enteral feeding with nasogastric and percutaneous feeding tubes. The upcoming Eldercare Special Interest Group Session will incorporate didactic teaching and case studies to facilitate learning on how we can deal with feeding and nutritional problems in elderly.

Speakers
Dr Lieu Ping Kong (MBBS, MMed(Int Med), FAMS) is a Senior Consultant in the Department of Geriatric Medicine at Tan Tock Seng Hospital. He is a lecturer for the Diploma in Geriatric Medicine and areas of special interest include swallowing disorders and falls in the elderly.

Dr Gerald Koh (MBBS, MMed(FM), FCFP, GDGM) was recently in Malta pursuing a Post-Graduate Diploma in Gerontology and Geriatrics at the United Nations International Institute of Ageing under a Merck International Scholarship. Previously from Ang Mo Kio Hospital, he is now a Consultant Family Physician at Raffles Medical Group and Adjunct Assistant Professor in Family Medicine at the National University of Singapore.

Sports Injuries Workshop for the Family Physicians

Chairperson: Dr Shah Mitesh
Speaker: Dr Benedict Tan
Venue:Changi Village Hotel, Basement 1, Cube room
Date: 22 May 2005, 2:00pm - 6.30pm
Cost: $50 (excluding dinner)

Optional twin sharing room $142, Children's program - Table etiquette (Age 4 to 12)

An Interview with A/Prof Goh Lee Gan on

Institute of Family Medicine(IFM), Training Arm of the College

By Dr Lee Kheng Hock, FCFP

A/Prof Goh Lee Gan

1. Can you tell us about the origins and the function of the IFM?

GLG: The Institute of Family Medicine (IFM) arose from the felt need for sustainable action to develop the training activities of the College in early 2000. A similar need was felt in the executive function of the College. Council took two important management steps, namely, the setting up of the position of executive director of the College for the latter and the position of Consultant to the IFM.

The terms of reference of the Institute are to oversee and guide the development and implementation of (1) the modular family medicine course which as you know is the core component of both the MMed(FM) and the GDFM; (2)Family Practice Skills Course(FPSC) and (3) E-learning programme of the College.

2. What has the IFM achieved so far?

GLG: The IFM has achieved modestly the three tasks that have been its terms of reference. The modular course has undergone revision of its context to make them more relevant and user friendly to the course participants.

The FPSC which appear in the Singapore Family Physician are beginning to have a place in the minds of readers as relevant and more than good to know; the attendance at these courses have been around a hundred or more private family physicians and public sector family physicians. The online e-learning programme of the College has still to attract a sustainable crowd of users.

3. What are the development plans for the IFM?

GLG: The development plans of the IFM in the coming two years will be (1) to build capacity for an escalation of the numbers of doctors enrolling in the GDFM which has been set towards 150 intake a year; and (2) to build capacity to take over the training of the private practitioners' stream for the MMed FM training with effect from May 2005 from the Division of Graduate Medical Studies, NUS.

4. The College had recently moved to appoint Adjunct Teaching Fellows to the IFM. What is the reason for this and what are the role and functions of the appointees?

GLG: The appointment of Adjunct Teaching Fellows to the IFM is consonant to the development plans of the IFM as described under Answer 3.

5. What are the challenges in the training of family medicine and how can we overcome them?

GLG: The challenges in the training of family medicine are many. The trainees need to take on the mindset that training will result in them becoming more effective family physicians in the years to come. The patients need to feel that the family physicians are more than cold and cough doctors.

The specialist colleagues need to help to support the development of the family physicians - the upgrading of the family physician colleagues will enable the specialists to have more time to give to the more problematic cases. These three changes form the core challenges in the training and motivation of family medicine practitioners.

Ultimately, we all need to work towards the shared vision of all stakeholders (policy makers, managers, the community, practioners, and academics) - this shared vision of "towards unity for health" (TUFH) was started in the latter half of the 20th century. To reduce the disease burden that plague mankind, we need to remind ourselves that we need to work together towards "Unity for Health". ■

Obesity Skills Course

Course Structure

1. Distance Learning Course Contents

Unit 1: Epidemiology of Obesity & Complications
- Epidemiology of obesity in Singapore
- People at risk
- Complications of obesity

Unit 2: Definition Diagnosis Evaluation & Classification
- Definition of obesity
- Diagnosis
- Approach
- Evaluation

Unit 3: Psychological Aspects of Obesity & Body Image
- Body image
- Eating disorders
- Readiness for weight loss
- Behavioural therapy
- Psychological evaluation of the obese patient

Unit 4: Therapeutic Lifestyle Changes
- Physical activity
- Lifestyle activity & weight loss
- Exercise prescription
- Starting an exercise programme

Unit 5: Dietary Therapy – Facts & Myths
- Calorie balance
- Effects of diet on weight loss
- Making food choices
- Modified diets & non-traditional diets
- Popular slimming programmes

Unit 6: Pharmacotherapy & Surgery
- How drugs work?
- Commonly used drugs & important practical considerations
- Combination of anti-obesity drugs
- Adverse effects & monitoring
- Role & type of surgery

2. Seminars *(2 CORE FM CME Points each#)*

Seminar 1: 3 April 2005

2.00pm – 4.00pm
1) Epidemiology of Obesity & Complications
2) Definition Diagnosis Evaluation & Classification
3) Psychological Aspects of Obesity & Body Image

Seminar 2: 10 April 2005

2.00pm – 4.00pm
1) Therapeutic Lifestyle Changes
2) Dietary Therapy – Facts & Myths
3) Pharmacotherapy & Surgery

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

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

Workshops
(3 April 2005 OR 10 April 2005)
4.15pm – 6.15pm

Group A
- Case Discussion – The Obese Child: Managing in the context of school & home.

Group B
- Case Discussion – The Obese Adult: A request for slimming treatment.

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

**** A similar workshop is held on both 3rd April (Sunday) and 10th April (Sunday).***

 # Subject to approval from SMC.

Date: 3 & 10 April 2005
Time: 2 pm – 6.15 pm
Venue : MOH Auditorium

The development of this Family Practice Skills Course is supported by an educational grant from **Health Promotion Board(HPB).**

Register

Obesity 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:	☐ 03 Apr '05 ☐ 10 Apr '05		☐ 03 Apr '05 ☐ 10 Apr '05	
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

Dear Editor ...

The College had received calls from our members with regard to an article in the SMA News Vol 37 Issue 02 February 2005 titled "Hobbit: 12 Wishes for the GP in the New Year". Many were concerned about the following paragraph "The CFPS has cloistered itself with the cloak of academia. So who speaks for the GP dying from lack of work, low prices and long working hours (that is, nonacademic issues)? Who is the Voice that will speak on bread and butter issues that keep us alive even before we continue to drone on about ethics, professionalism and academic development? The GPs need a real voice. One that states the issues clearly, passionately, and if necessary, bluntly as well."

It is therefore necessary for the College to refute the innuendoes contained in this article. The College has always pursued its objectives dilligently since its founding in 1971. The objectives of the College as stated in our constitution spells out our mission, which is primarily to improve the standard and professionalism of family physicians through advocacy of training and accreditation. This is a noble mission crafted by the founding fathers of the College who wanted to counter the anti-training, anti-professionalism, "shopkeeper mentality" that is expounded in the article published in the SMA News. For years, this was the prevailing mentality in the family medicine fraternity which resulted in the present state where family physicians are not highly regarded by the public, the press and the policy makers. The poor working conditions is the result of the low status of the family physician. We believe that the solution to the problem is found in the constitution of our College and we will continue to pursue it conscientiously. Readers may be interested to read the College's objective at http://www.cfps.org.sg under the section 'about us' for the Mission of the College.

As for speaking up for "nonacademic issues" and who should be "the Voice", readers may find Article II Item 4 of the Singapore Medical Association's constitution to be more relevant. It states: "To voice its opinion, and to acquaint the Government and other bodies with the policy and attitude of the profession." This Article is available at http://www.sma.org.sg/about/constitution.html.

Members have also called up the College saying that they heard rumours that the College is advocating an increase in the annual CME point requirements from 25 points to 50 points. This is untrue. The College is represented in the SMC-CME committee and we have advocated that the point requirements should remain the same at 25 points. Together with the Academy of Medicine and the Singapore Medical Association, we are working with the Singapore Medical Council on the accreditation of CME organisers. We do not know why or how this rumour started. We request our members to contact us for clarification if they hear of anymore rumours. Our email is at contact@cfps.org.sg.

Yours truly
Dr Lee Kheng Hock
Honorary Secretary
19th Council
College of Family Physicians Singapore

OBJECTIVES OF CFPS

(1) Advance the Art and Science of Medicine.
(2) Discuss Medical and Scientific problems.
(3) Organise post-graduate courses and encourage participation by Family Physicians
(4) Teach family medicine to undergraduate and post-graduate students
(5) Promote and maintain standards in family medicine
(6) Encourage and assist young people in preparing and establishing themselves in family practice
(7) Preserve the right of family physicians to engage in procedures that they are qualified to do
(8) Provide and support academic posts and programmes in family medicine
(9) Bestow accreditations in recognition of proficiency in family medicine

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OBJECTIVES OF SMA

i. To promote the medical and allied sciences in Singapore.
ii. To maintain the honour and interests of the medical profession.
iii. To foster and preserve the unity and aim of purpose of the medical profession as a whole.
iv. To voice its opinion, and to acquaint the Government and other bodies with the policy and attitude of the profession.
v. To arrange and hold periodical meetings of the members of the Association for scientific and social purposes.
vi. To support a high standard of medical ethics and conduct.
vii. To promote social, cultural and professional activities among members of the Association.
viii. To enlighten and direct public opinion on problems of health in Singapore.
ix. To publish papers, journals and other materials in furtherance of the above objects.
x. To acquire by purchase, lease or otherwise, land, buildings, tenements or hereditaments and any movable or immovable properties for any of the objects of the Association.
xi. To construct, maintain and alter any houses, buildings or works for the objects of the Association.
xii. To sell, manage, lease, mortgage, dispose of or otherwise deal with all or any part of the property of the Association.
xiii. To borrow and raise money and to invest any monies of the Association not immediately required for any of its objects in such manner as the Association may from time to time think fit.
xiv. To collect or otherwise acquire sums of money for charitable purposes and to establish and maintain a Trust Fund for the said charitable purposes.
xv. To incorporate a limited company to carry out commercial activities and to hold property. (Amended)

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