The College Mirror

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Contents

34th Annual General Meeting

Date: 25 June 2005

See back cover

College Art Gallery

"Lotus" June 1987
by Chen Wen Hsi,
From College Art Collection
College of Medicine Building

16 College Road #01-02 Singapore 169854
Tel :(65) 62230606 Fax:(65) 62220204
Email: collegemirror@cfps.org.sg

MITA (P) 024/04/2005

Dr Lam Sian Lian, Chief Executive Officer, Health Promotion Board

Important role of Family Doctors in Health Promotion

Dr Lam Sian Sian is an honorary Fellow of the College & past chairperson of the Family Medicine Committee of the National University of Singapore. She delivered the following opening address at the Family Practice Skills Course on Obesity for General Practitioners on 3rd April 2005 at the College of Medicine Building Auditorium.

"I am very happy to be here today at the opening of the Family Practice Skills Course on Obesity for General Practitioners. The rising prevalence of overweight and obesity worldwide has led to increasing public health concern. Overweight and obesity are also becoming more prevalent among children and adolescents.

When people talk about overweight or obesity, they often consider it as an aesthetic or image problem or a weight problem. Very often, they will go to the slimming centers or turn to fad diets or slimming products. Judging from the numerous newspaper and TV advertisements, there must be a huge market for weight loss services in Singapore.

But obesity is a chronic, relapsing disease which is associated with significant ill health. Obesity is also associated with increased mortality, mainly from cardiovascular complications and diabetes, and reduced lifespan of between 1 to 13 years. It is therefore not a condition that can be ignored even if patients are prepared to live with it.

As obesity is a chronic disease, we should approach the problem of obesity using the chronic disease management model. This encompasses primary prevention which focuses on controlling risk factors of the disease, secondary prevention which focuses on early detection through screening and tertiary prevention which focuses on good disease management.

The GP plays a very important role in primary prevention and health education.

Obesity is the result of an imbalance between

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President's Forum

Masters All

Three masters programmes have been announced this year for the healthcare profession in Singapore. Masters degree courses for nurses and pharmacists were announced in the Straits Times on 22 & 23 April 2005 respectively and that for psychologists two months earlier.

Amendments to the Nurses & Midwives Act have been passed in Parliament for a register of nurses with the Masters (called Advanced Practice Nurses or APN). The amended Act permits these APN to "do certain tasks traditionally performed by junior doctors" and "keep medical costs down without compromising quality". Other tasks in the skills set of APNs are to "interpret diagnostic tests such as X-rays and scans and help manage patients with chronic health problems".

The Master of Family Medicine (FM) programme on the other hand was started 12 years ago. To date, 214 doctors or about 12% of practising GPs have successfully completed the training. 163 of these doctors obtained their Masters through the Ministry's FM traineeship programme and 51 GPs through the self-sponsored private practitioner's programme. After obtaining the Masters, many doctors in the polyclinics move to the private sector in time while a few from the private sector joined the polyclinics so that presently about a-third of those with Masters are still in the polyclinics.

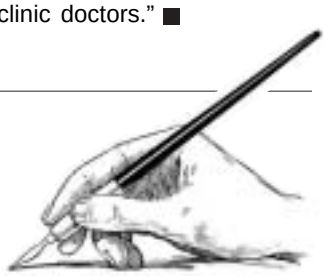
These statistics should prompt a rethink into the training system for the Mmed (FM) as there is an urgent need to achieve capacity in both the public and private sectors. This is in response to the twin challenge of managing chronic medical diseases in the setting of a graying society.

The statistics show that doctors so trained whether in the Ministry sponsored or out-of-pocket private scheme both contribute to the national agenda. This is the crux of the recommendations on training the College submitted to the Ministry on 3 June 2004, in which also "proposed that a Joint Committee of Family Medicine Training be set up to mobilise all the available training resources.

With the up-scaling of skills and roles for nurses, pharmacists and psychologists, the need to scale up the training for the Masters in Family Medicine and the joint committee by marshalling all national FM training resources become even more relevant. After all, it has been announced that 'the holistic approach to patient management will involve all health-care partners … and most crucially, general physicians and polyclinic doctors." ■

Editor's Words

Moulding the future Doctor



Recently I took a group of 2nd-year medical students on a ward round tutorial on patient communication. We were in an O&G ward and spoke to 3 young women. The first was a single teenage mother, who had just delivered her baby, the second, a young woman who had lost her first pregnancy waiting for a D&C, and the third, a newly married lady planning to start a family and found to have an endometriotic cyst.

Certainly doctors need to develop the art of sensitivity in communication skills! This lesson hit home that day to the group of 2nd year medical students as they interviewed the patients.

One of our forum page letter writers expressed that good doctoring come through learning from other experienced colleagues(Pg 12). In this issue, we look at the balance of evidence-based medicine(EBM) and intuition -are they really strange bed fellows?(Pg 14) Evidence-based practice amalgated with the experienced GP's intuition allows for good patient care and is also a basis to discuss care decisions with our specialist colleagues.

With more chronic illnesses and emphasis on preventive health, the doctor as teacher has to engage his patient in behavioural change such as counselling on weight management and obesity. In this light, Dr Michael Wong shares his HMDP experience in US on Preventive Medicine and also the family medicine training in Duke University, Durham. Read Dr Yvette Tan's article on Adult learning and Patient care.(Pg 18).

My group of 2nd year medical students will graduate in a few years. I think they will agree their undergraduate education has just allowed them to begin their lifelong learning journey. If they choose to become family physicians, they must then consider the opportunity to benefit from Family Medicine training programmes. ■

Dr Ong Jin Ee
Editor of The College Mirror

HMDP Experience in Primary Care - *Washington DC & Duke University, NC.*

By Dr Michael Wong Tack Keong, FCFP

Arriving Washington DC, March 2005, American College of Preventive Medicine (ACPM) Annual Conference

It was the tail end of winter when I arrived in the US. The weather was still cold and snow threatened each day. Fortunately, it was mostly just plain cold with rain. My trip was made more bearable now that we could fly non-stop to New York Newark Airport. But the transfer to DC was not without a story to tell! My baggage did not arrive with me in DC. Like all wise travelers, I had all my necessary vouchers and a change of clothing in my hand luggage! My luggage arrived 12 hours after I checked in to my hotel.

The ACPM was held over 5 days in the Washington DC. It was very well attended with primary care physicians from all over US converging here. Most are family physicians in practice and institution. Many were also from the military.

The Conference was a time for the delegates to get updated on the latest from United States Preventive Task Force. There were also plenary sessions every morning and concurrent sessions every day on various topics in preventive care.

Preventive Care Scene in the US

Preventive Care is very much part of the medical scene in the US and it is practised in every field from primary care to the military fighting the war in Iraq. It was interesting to know that most of the fighting units in Iraq have Preventive Med teams to help "clear areas" before the rest of the forces move in to occupy or set up camps. The other recurrent theme that has plagued the Americans is the issue of Obesity. Some of the states in the US have almost a third to half of their population in the obese to overweight range and many states are also moving in that direction. Many plans and direction were mooted and discussed. It was clear that funding and political support were crucial. Thus some of the sessions had Senators and Congressman giving Preventive Medicine a boost. Many had felt that the money was all going into curative medicine that are earth shattering and spectacular. Not enough was going to preventive medicine. Many had their funding cut or reduced and also had to cut their preventive medicine programs.

Duke Chapel in Spring

Editorial Note: *Dr Michael Wong Tack Keong , a Fellow of the CFPS and Head of Bukit Merah polyclinic under the Singhealth cluster shares his HMDP experience in Primary Care. His interest in primary care has been in the area of preventive care and screening. Through a generous grant from SingHealth Foundation, he spent 6 weeks in the United States, immersing himself in the practice of preventive medicine in the US and visited the Duke University Medical Centre (DUMC) Department of Community and Family Medicine.*

Duke University, one of the top medical schools in US, has recently signed an agreement with NUS to set up a second medical school, Graduate Medical School(GMS) at the Outram Campus.

Remembering what my old primary school health education class teacher always made us repeat after each class "Prevention is better than cure", I can't help but realize that in real life, "Prevention is good, but cure is better cos' that's where the funds are going..."

Preventive Medicine and screening is very much what the American would call the Annual Physical. This is an insurance payable visit and most of the insured would usually make time for such an activity.

Such appointments would be usually scheduled for 40 minutes and the patients would have been advised on fasting and other instructions when calling for appointment.

The physician uses ages specific charts with the relevant questionnaires and physicals and investigations for the various age categories. These charts also have reminders and guides to ensure that the attending physicians discussed and checked with the patients on various issue relevant to their age category like, HRT, andropause, etc. Most of their recommendations follow that of the USPTF closely.

I had some time to catch some sights like the Washington Monument, Lincoln Memorial, Capitol Hill and the White House. Arlington Cemetery would be the best for me. There is nothing like it in the world, the people buried there and the history and events behind makes this place second to none.

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Next stop: Durham, North Carolina, Duke University Medical Centre

So off I went from DC and caught a plane to Raleigh-Durham in North Carolina. My next destination was to Duke University.

I had the privilege to spend my next 5 weeks visiting the Department of Community and Family Medicine.

Community Medicine Division(DUMC)

Community Medicine Division was where I spent my first week and a half. The division is staffed by many non-medical staff who are trained in Public Health or Administration. They were responsible for many of the health promotion and preventive health programs in the surrounding communities. Much of their efforts are to ensure communities close to and surrounding Duke have access to the state funded health programs and access to quality health either in DUMC or in their own communities.

The Community Medicine division functions very much like our Health Promotion Board(HPB). They have numerous collaborations with interest groups and agencies in the communities to promote their health prevention programs.

The underprivileged and the uninsured are also helped in accessing quality primary care. Many of them are called the "working poor". Enough for the family to eat and live day to day but just not enough for health insurance or to see a doctor. The Community Medicine division has set up many community clinics to serve these truly needy people. Doctors, Physician Assistants and also Nurse Practitioners and administrative staff run these clinics. Medication is dispensed at a very low rate. A sliding scale payment system is in place to prevent abuse. The scale would dictate how much the patient pays based on their non-insured state and income.

Prof Lloyd Michener, Chief of Dept of Community & Family Medicine and Dr Wong.

These community clinics also make their way into schools. Many of the schools have very well equipped sick rooms where the attending nurses could treat and manage simple health problems in the students. These clinics also allow parents of these students to bring their other siblings to attend these clinics.

Family Medicine Division(DUMC). Marshall Perkins Family Medicine Centre

I spent a good part of my time in Duke in the division of Family Medicine. I will share some of the interesting observations while I was there.

Duke runs a 4-year graduate medical school program that is like no other program in US. Singapore will have a similar school in our Outram Campus come 2007 when our collaboration between NUS and Duke will see the first batch of Graduate Medical Students.

The student enters DUMS after completing college. The first year med school is for basic medical sciences. The second year is when all the clinical sciences are taught while the students are doing the clinical postings. The third year will be when the students are required to take on a scholarship spending the whole year doing a mentored research either in basic or clinical sciences. They are also allowed to use that one-year to do a degree in Public Health. The fourth and last year will be for their clinical electives. Most of the students would either be doing postings of their choice in preparation for the relevant residency program that they would be going into.

Throughout the 4 years, the students are kept in the same clinical group and 2 such groups are usually under the mentoring of 2 senior physicians. They would meet regularly and are put through a "Practice Course". The latter has 3 sections which covers topics such as Doctor/Patient relationship to ethic, professionalism and end of life issues. The mentors are also required to help the students see through some of their problems encountered in school or in the course of their work or while relating to their colleagues. On the last month of their 4 years, before they are given their MDs and their residency posting, a "Capstone Course" covering topics like health systems, advanced basic science topics, communication skills, self-care and internship-specific skills is made compulsory attendance for all of them.

Family Medicine Posting for Medical Students and Residents

The Medical Students undergo a one-month posting where they are attached to a participating and recognized Family Medicine Practice. The interesting thing for these students is not what street this practice is in but what state it is in! They have to pack their bags and go stay in that state and fend for themselves while learning from the Family Practice. Some have it good with vacation-like places but others do have some hardship postings like farms and rural areas! Besides the usual assignments and tests that are usual requirements, the students are also required to do a project while at the practice. This project would have to be of relevance and use to the practice. It is Duke's way of allowing the student not

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Stone buildings housing Duke South Clinic

just to learn and take, but also to contribute back to the practice. Some of the projects were like developing web pages for the practice, audits and education brochures.

The Family Medicine Residency is spread over 3 years with most of the training and practice of Family medicine done during the 3rd and last year. For the 1st and 2nd year, the residents are required to do the hospital rotations in DUHS. They would be required to take the calls and do rounds but a portion of their time per week would have to be spent back at the family medicine center seeing cases and keeping in touch with family medicine. On completion of the residency, they would be required to sit for the board examination and be certified as a family medicine specialist. Thereafter, they would be able to practise independently and would only need re-certification after 7 years.

On Work-life programmes

I spend the rest of my time visiting the other divisions and centers talking to program directors and physicians. In line with my interest in preventive health, I had the opportunity to look at their Staff Health Surveillance. They have been doing this surveillance for the last 15 years. This is very similar to many of our work life programs which some organization are getting into. The staff are assessed both as an individual and then given recommendations based on their health status. The corporate health picture is also taken and presented to the respective department. The Health Surveillance also has a team of physical therapist and exercise physiologist to organize programs to keep them fit and healthy. These programs are all graded to the level of fitness and would thus allow the staff to fully enjoy the program and at the same time meet up with fellow colleagues.

Staff who are found to have unsatisfactory health status would usually be advised to see their primary care doctor. Staffs who have borderline health status would be followed up for 1 year by a dedicated group of nurses and counselors who would check on and give advise on a 3-month basis to these staff to ensure they are making progress in their health status. All these are part of their staff benefit.

Coming to Journey End

My 5 weeks was very quickly coming to an end. Time flies with all the running around rooms and departments and meeting various people, some many miles away with having to drive there sometimes on your own and getting lost in the process.

Being a university town would mean very little nightlife. Most of many evenings were spent in the supermarket figuring out what to eat and cook for my next few meals, doing laundry and ironing while at the same time catching the latest American Idol and the superb medical drama “Dr House”. 5 day week (I wish we have that in Singapore!) is the norm but it can be long and dreary without your family to spend it with. Much of my weekends were spent on completing my shopping list, browsing in the numerous bookstores and catching up on my readings in the cafes. Having to drive on the left side, which is a challenge in a new country and also having to make that ‘dangerous’ left turn, has limited my mobility and I could manage only short distances in good weather. Bad weather advice: don’t drive if possible! The road is slippery! Nonetheless, on good days, I could still walk the paths and the gardens in Duke to take in the scenic sights of stone buildings, the famous Duke Chapel and the world famous now blooming Sarah P Duke Gardens! Spring had arrived now and the flowers are beautiful!

It is not an easy HMDP to undertake.

I stand corrected but it may be easier on our specialist colleagues who go to established centers all over the world for 6-12 months knowing what skills to learn and from whom to learn from. Primary care HMDP is a challenge in itself. The program is yours to plan, yours to make it as useful and enriching or yours to waste away! It is really not the fault of the host as primary care HMDP Fellows are not what some of these centers are used to receiving, unlike some other specialty centers training surgeons and internist.

Fortunately, in my loneliness and confusion at times, I had support from my conversations with God, from my wife, whom we spoke over the phone at least twice a day with numerous SMS, MMS of family pictures and emails, (my phone and internet bill was nearly $2K!), and also the support of my colleagues and supervisors back in SHP. With it, my focus was clear and I was able to carve out nuggets of valuable knowledge and insights from this whole experience in USA to take home to Singapore. ■

Lunch with colleagues. (L-R) Prof Truls Ostby, Dr Wong & Prof Paul Lee.

Asthma Skills Course

By Dr Matthew Ng, FCFP

The first asthma Family Practice Skills Course(FPSC) was held in 2003. Two years later, on 18th & 19th March 2005, the second asthma FPSC was conducted and I have had the privilege of attending both.

What has changed over the last two years?

On World Asthma day 2004, the WHO released a report on global asthma burden. Singapore was ranked as an intermediate risk country for asthma prevalence (4.9%) but a very high-risk country for asthma death (morbidity rate of 0.6 – 0.8/ 100000 ppl 5-34 years of age). This suggested that asthma in Singapore is not managed well.

The goals of successful management of asthma are:
1. Minimal or no symptoms, including night symptoms.
2. Minimal asthma episode or attack.
3. No emergency visit to hospital or physician.
4. Minimal need for relieve medication.
5. No limitation on physical ties and exercise.
6. Minimal or no side effects from medication.
7. Maintain normal pulmonary function.

In children, the goals of asthma management include not only the control of symptoms but also the ability to lead a healthy unrestricted lifestyle. It is interesting to note that in some schools, they have a badge made for children to wear that says "Exempt from PE". Caregivers also came to the Primary care Physician with numerous requests to exempt their asthmatic children from physical activity. Patients and caregivers need to be provided with knowledge and training in asthma care and management. It is important to inform patient and caregivers to "take control of asthma and not let asthma control you".

Total asthma control is achievable. To achieve that, we have to move away from acute rescue treatment to long-term control of asthma with prevention therapy using inhaled corticosteroids. Asthma is a chronic disease and should be rightly treated as such. Patient should be educated to change their perceptions and coping skills.

Physicians should acquire the skills to
1.Lower our detection threshold for persistent and poorly controlled asthma
a. Persistent asthma = need to use quick reliever > once per week daytime or > once per 2 weeks at night.
b. Poor control = nebulisation and or oral steroids for severe acute attacks > once per year.

2. Enhance our communication skills to change patient habits of over reliance on quick reliever medications and to learn new self-management skills.

3. Look out to overcome barriers for non-compliance to medications. Address uncertainties, fears, cost and side effects.

Prevention of attacks is the key to successful long-term asthma control. Patients should avoid exposure to risk factors such as allergens and irritants that make asthma worse, and to use daily preventive inhaler for those with persistent asthma. ■

The College's Expert Panel on Asthma gave a comprehensive coverage of the topic.

A/Prof Daniel Goh Yam Thiam

A/Prof Lee Bee Wah

Dr Chay Oh Moh

Dr John Abisheganaden

A/Prof Lim Tow Keang

A/Prof Sin Fai Lam

Obesity Skills Course

By Dr Lee Kheng Hock, FCFP

Obesity is a leading chronic disease in Singapore that is on the rise. This was the focus of the latest of the very popular series of skills courses organized by the College. The 2-days seminar cum workshop was held over two weekends on 3rd April and 10th April 2005 the Auditorium of the College of Medicine Building. The teaching faculty comprising members of the College's Expert Panel on Obesity gave a very comprehensive coverage of the topic, including the latest classification of obesity and evidence based management tips.

Dr Mabel Yap, Director, Research and Information Management Division, Health Promotion Board

"Obesity can be defined as a condition of excessive fat accumulation to the extent that health and well-being is adversely affected. The current WHO BMI cut-offs of 25(overweight) and 30(obese) did not properly reflect the higher risk of diabetes and cardiovascular disease in Asian populations. Whilst the classification remains unchanged, WHO recommended that Asian countries consider introducing new BMI cut-offs for "public health action". A BMI of 23 or higher represents moderate cardiovascular risk and 27.5 or higher represents high cardiovascular risk. This had been adopted by the Ministry of Health in 2004."

Dr Leonard Koh Kia Hui, Consultant Physician and Endocrinologist, Gleneagles Medical Centre

"Patients often say 'I am overweight' but weight is not the problem. Obesity is a disease that has adverse health outcome. There had been some confusion in the recent announcements as reported in the press. The criteria for classifying obesity has not changed. The difference is that now there is a call for public health action at a lower BMI of 23 and 27.5 depending on the local cardiovascular risk situation. Appropriate action, which may be as basic as improving diet and physical activity levels, should be contemplated, starting at a BMI of 23."

Dr Lee Ee Lian, Consultant Psychiatrist, Eating Disorders Programme, Department of Behavioral Medicine, Singapore General Hospital

"Adding behavioral and psychological techniques is a useful combined approach to obesity treatment. It is important to discuss target goals and plans of action with the patient. We must also teach stimulus control, how to identify risky situations that make the patient want to eat and develop strategies to overcome them. For example if a dangerous situation is identified as snacking at work, then one strategy would be to keep snacks away from the work station."

Dr Benedict Tan Chi-Loong, Head and Consultant Sports Physician. Changi Sports Medicine Centre, Changi General Hospital

"The body is able to compensate for small energy deficits and as a result body weight remains the same. That is why some of our patients tell us that they don't seem to lose any weight even after they started walking everyday. We need to prescribe a daily energy deficit of 500 to 1000 kcal during the fast weight loss phase of about 1 kg per week. There is no short cut. You need sensible dietary restriction, structured exercise and increased daily activities. Structured exercise means about 200 to 300 minutes of aerobic exercise per week at a level of 55 to 70% of predicted maximal heart rate."

Ms Gladys Wong, Chief Dietician, Alexandra Hospital

"Weight loss is a juggling of calories contained in fats, proteins and carbohydrates. Calories in versus calories out. Excess weight that one wants to loose is fats not water. When it comes to diet it is all about quality (how

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you cook), quantity and frequency. There are numerous weight reduction/slimming programmes/centres advertised in the local newspapers and media.

In general, the majority of these are endorsed by celebrities with convincing before and after digital photographs and dynamic testimonials. Nearly all have a disclaimer "Your results may vary" in fine print. They also emphasise change in bodyweight and circumferences but very seldom in reference to the body mass index. Some of the celebrities used actually have BMI in the underweight range."

Dr Tan Chee Eng, Consultant Endocrinologist, Gleneagles Medical Centre, Senior Research Fellow, Centre for Molecular Epidemiology, National University of Singapore

"Patients must earn the right to go on medication to lose weight. They must demonstrate a willingness to change their lifestyle. Otherwise the treatment is bound to fail in the long term. Never view medication as an alternative to lifestyle changes. The success of pharmacotherapy is not weight loss but to change the metabolic profile of a patient so that there is a decrease in mortality and morbidity risks. Currently there are two anti-obesity medication approved by the FDA i.e. sibutramine and orlistat.

The pharmacological agents are particularly useful in maintaining weight loss after lifestyle and dietary changes have induced weight changes. Bariatric surgery should be considered for patients with morbid obesity (BMI>40) or those with severe obesity (BMI>35) and with serious medical problems."

A/Prof Loke Kah Yin, Senior Consultant, Department of Paediatrics, National University Hospital

A/Prof Loke took the participants through a series of cases of childhood obesity during the workshop and gave many useful tips on managing such children in the context of their home and school environment.

Dr Daniel Wai Chun Hang, Registrar, Department of Endocrinology, Singapore General Hospital

Dr Wai conducted a workshop on managing obesity in an adult patient. Participants were given practical tips on how to manage a request for slimming treatment. ■

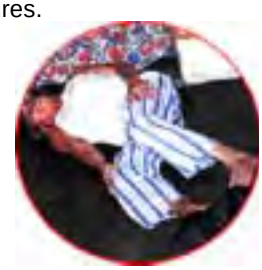
Eldercare SIG

Falls in the elderly – an approach to evaluation and management

Date: 2 Aug 2005
Time: 5.15pm
Venue: College LT

Synopsis:

Falls in the elderly is a common symptom that can easily escape our scrutiny. About 30% of the community-dwelling people aged 75 years and older fall at least once each year, and the percentage is greater in hospitalized elderly persons and nursing home residents. Those who fall will sustain considerable injury, including fractures.



Fear of falling and restricted mobility pose appreciable limitations on the freedom of movement and the quality of life for many older persons. For these reasons, gait instability and falls are important health problems in the elderly.

About the Speakers:

Dr Wong Wei Chin (MBBS, MRCP) is the Registrar in the Department of Geriatric Medicine at Tan Tock Seng Hospital. Her subspecialty is Falls & Balance.

Dr Tan Kok Leong (MBBS, MMed (FM), FCFP, GDGM) is the Director of SingHealth Polyclinics-Outram. He is appointed the member of the teaching faculty for the Graduate Diploma in Geriatric Medicine for year 2004 – 2005.

energy intake and energy expenditure. Weight gain is the result of excessive caloric intake and insufficient physical activity. Weight loss should, therefore, be achieved through a combination of increased physical activity and reduced calorie in the diet.

The GP plays a very important role in primary prevention and health education. Patients respect their doctor and will often do what their doctor tells them. Studies have shown that even brief counselling of a few minutes by the doctor is effective in motivating patients to change their health behaviour. The saying "an ounce of prevention is better than a pound of cure" is very true in relation to obesity. It is much better to prevent obesity than to treat it because we know how difficult it is for people to lose weight, especially in Singapore where the national past-time is eating.

Many people consider themselves healthy as long as they do not have any symptoms of illness. Similarly, many people who are overweight or obese often do not perceive themselves to be so. A recent study conducted in the US showed that Americans tend to see themselves as well until they are really sick. Their definition of healthy is "I feel fine". In another survey, one-third said they were overweight and two-thirds said they were physically active. The reality was the reverse. Two-thirds were overweight and one-third were physically active.

GPs need to acquire the skills to play their important role. The Health Promotion Board working closely with the College of Family Physicians will help GPs acquire the necessary skills through professional development.

As you see your patients, regardless of the condition they consult you for, check their BMI regularly and provide counselling in leading a physically active lifestyle and eating a healthy diet. This would apply to children as well. It would be good to inculcate healthy habits from young. Although parents and the school play very important roles, the GP too, can influence the development of good health habits among their young patients.

It is important ... that GPs develop skills in weight management, disease prevention and chronic disease management.

Weight management is not easy. Successful weight reduction requires the patient to be motivated and committed to spend time and effort in attaining their weight goal. A combination of dietary calorie reduction, physical activity and behavior modification will result in greater and more sustained weight loss than individual measures. It is important, therefore, that GPs develop skills in weight management, disease prevention and chronic disease management.

A/Prof Cheong Pak Yean, President of CFPS presenting a token to Dr Lam.

In view of the rising trend of obesity worldwide, the Health Promotion Board formed a Taskforce on Obesity Prevention and Control last year. The College of Family Physicians, Singapore was represented on the Taskforce. This is in recognition of the important role GPs play in the prevention and control of obesity and other chronic diseases. The Taskforce recommended that HPB work with the College to produce a training module on weight management to encourage holistic care in general practice, and for GPs to include advice on healthy lifestyle in their routine clinical consultations. HPB has taken this recommendation very seriously and this training module which you will soon be participating in is the result of the collaboration between HPB and the College. The College has put in great efforts to develop the modules as you can see from the College's publication (The Singapore Family Physician Supplement on Obesity).

I would like to conclude with these 3 messages:

(1) Overweight and obese people are at higher risk of cardiovascular diseases, diabetes, osteoarthritis and other conditions which adversely affect their quality of life. Obesity needs to be managed.

(2) GPs play a very important role in the prevention and management of obesity and other chronic diseases.

(3) GPs need to acquire the skills to play their important role. The Health Promotion Board working closely with the College of Family Physicians will help GPs acquire the necessary skills through professional development.

On this note, I wish all participants a very enjoyable experience in the training course. ”■

What has adult learning got anything to do with patient care?

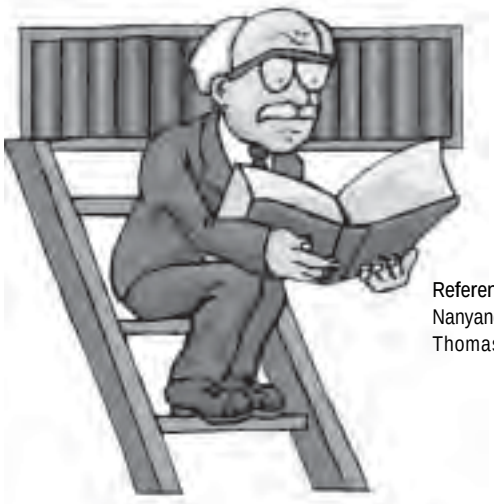
By Dr Yvette Tan, Editorial member

Andragogy, the theory of adult learning addresses the psychological and special needs of adult learners; the main assumption being that the learner brings with him a rich source of knowledge and experience. This is opposed to Pedagogy, the theory of child learning; the main assumption being that the learner has very little prior knowledge and prior experience.

It is an intrinsic nature of a doctor to want to teach. In fact 'doctor' in latin, ' docere' means 'to teach'. With the evolution of medical science and its resultant change in disease patterns, doctors are now faced with the challenge of helping our patients manage their growing lists of chronic medical conditions. A large part of this challenge is to engage our patients in some form of behavioral modification or another. Our teaching skills have never been put to greater test than in these current times.

How do we engage our patient, the learner? How do we identify the gaps in their knowledge and skills? How do we impart these to them in the most effective and efficient manner? Or more importantly, how do we address the attitudes that may be lacking or interfering with their behavioral change process?

By understanding the characteristics of the adult learner, we will be able to modify our teaching methods to suit the patient's learning needs. Certainly, the method of teaching a child, where all the relevant knowledge are simply spoon fed to him may not appeal to any adult patient's learning, nor provide any effective results.



The wise doctor will be able to discern the adult learners in their patients and modify their health education and counseling to meet their needs. Of course there will still be adult patients who insist on being treated like a child, not wanting to make their own decisions, and not allowing for any self accountability. For such patients, we may still have to use the spoon feeding and carrot and the stick approach, but gently prodding them towards being adults in their own care. Such patient empowerment can only serve to enhance and deepen the therapeutic alliance that we have with our patients! It would certainly make our practice more real and meaningful too! ■

Characteristics of the adult learner - patient	Strategies for the doctor - teacher
1) meaning of what is to be learnt is important	Effort should be made to let the patient appreciate the relationship of what he is learning with that of his health and life goals.
2)immediate application of knowledge is much appreciated	Effort should be taken to make learning as relevant as possible to the current needs of the learner. What can be applied will stick; but what cannot be applied to his immediate reality will be lost. Identify and harness the 'teachable moment' when the need is glaring you in the face or when the insight to the learning need is present.
3)prefers emphasis on learning concepts and principles vs facts	Do not overload the learner with details. Making the effort to explain the principles and concepts; and ensuring proper understanding of these will probably ensure more efficient use of your consultation time. Provide guidance to various sources of information, teach the learner how to evaluate this information and appropriately apply the information
4) has background of knowledge and experiences that can be harnessed.	Connection to such background knowledge is important for learning of new knowledge. Addressing of previous misconceptions is also important. In fact, neglect this aspect at your own peril! If the 'old knowledge/experience' is not acknowledged and addressed, there would probably be little chance of learning anything new. Old habits do die hard!
5) has enough resources and resourcefulness to obtain evaluate and apply information	Need to help the learner identify the gap in competence (the learning need), raise awareness of the gap (reflection and feedback), facilitate the filling up of the gap through using the patient's own resources, or with the help of added resources.
6) Very much involved in own learning, which is self directed . Like to set up own learning objectives.	Always involve the patient in any decisions about his care, with patience and respect for his own priorities and goals.
7) appreciate formative evaluation and feedback	Communicating feedback in a constructive way, always ending with reaffirmation of learner's self worth and his contribution to his own treatment plan. Use self disclosure, empathy reinforcement of congruency to good effect. This will certainly enhance the therapeutic relationship!

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Our readers share their thoughts & responses on "Reforming Primary Care" in the March issue.

The GP must remain a generalist...

I have read your last issue of College Mirror. Does there not seem to be some confusion over the many solutions and proposals put forward? The General Practitioner is once and for all a "generalist" and so must remain a Doctor who has that all- encompassing view of illness and its earliest signs and symptoms.

How then to improve his status and quality of life?

1. The Single-manned practice is out of date unless you are in the Highlands of Scotland or on an Isle with a population of one hundred and fifty souls. No young doctor should have been permitted to set up in his own isolated shophouse full of ignorance but high principles. General Practice is never taught or learned in Hospital or Medical Schools. It is learned from one's seniors and peers in General Practice itself over years.

So, in any one urban or suburban area there should be one or more Group Practices, with several doctors working together, and making it their life's work. Sharing and caring will allow for interchange of ideas, consultation, advice, and for time off for home-visiting, to visit hospital patients and attend the odd emergency in the district, knowing that someone is looking after the home base.

2. The "Generalist" must resist being made into a little minor Specialist. If he has special interests and ability then these will be of benefit to his partners in practice.

Now, if one or two of those doctors in the Group Practice had had special experience and particular knowledge of one or other of the Specialties, then they should put this into practice to the general advantage and reputation of the Clinic. There is mention that such "General Practitioners with Special Interest" will be "rewarded". In a Polyclinic of course their salary might receive increment. In a general Group Practice no doubt extra fees could be charged for this expertise. After so many years in training there must be many who have extra skills.

3. There seems to be a contest between the beleaguered General Practitioner and the Polyclinic. Of course there is competition and one wonders if this was intended, to squeeze out the private doctor? Just who is it that will provide this Primary care? If the Ministry dictates, then the Polyclinics will supply it and the General Private Practitioner will be squeezed out. Is that the idea? The College of Family Physicians should find out from the lay bureaucrats.

The Polyclinic is a good idea but it should have been built in cooperation with, not opposition to the local doctors. There could have been an offer to local doctors that they leased Consulting Rooms there and ran their practice from within its four walls. It would save expense and patients would have been able to see the same doctor on each visit.Why not?

4. The College must defend the independent status of the General Practitioner, and his position as a "generalist" first and foremost. Otherwise you will end up with a migration of those generalists to where he is not going to be pushed around by Ministries. Mr Khaw has discovered what a General Practitioner ought to be doing. But the Doctor has probably been doing this unheralded for a long time, being a "generalist" and "listening to what the patient is saying" (Aesculepius).

5. There is another competing factor. Seemingly our Specialists often do not confine themselves to their own Specialty but will also dabble in General Practice. These matters ought to be kindly referred back to the General Practitioner. Indeed, the Private Specialist has the habit of holding onto a patient and the referring doctor may never see his patient again. The patient should return immediately with a letter to his General Practitioner giving advice on further care and treatment.

The Specialist regularly and now traditionally accepts his patient straight off the street, without referral. Referral is the traditional and accepted way of seeking a further opinion. Should not Insurance Companies insist upon the presentation of that Referral Letter before a patient's claims are reimbursed? Many patients find they have chosen the wrong Specialist and must pay twice before obtaining satisfaction. They would have been better advised if they had first visited their own General Practitioner.

6. There is now all this fashionable business of Examinations and Revalidation. By the time a doctor is registered he/she is pretty well indoctrinated with the principles of Medicine. He/she must then go out into the world and put them into practice without further interference or further examinations. They should join that Group Practice wherever with their peers. At the outset he has his principles but no knowledge of General Practice, which he will slowly begin to learn. It comes with experience.

Revalidation is a response to pressure from the Press. Apart from being an over-reaction to criticism of a few of the medical profession, it is not a practical proposition to have these five-yearly Inquisitions. I know of one such in a Group Practice in Canada which took four hours of observation and a recommendation only that the doctor should improve his writing.

Where are these Invigilators to come from? Should they not be "Generalists" like oneself who understand General Practice?

Dr George Caldwell

Qualified Private GPs can run FM Specialist Clinics for Chronic Conditions too

I am a Family Physician in the 11th year of my private practice in a neighbourhood in Queenstown. My post-grad qualifications are M.Med (FM) and Graduate Diploma in Geriatric Medicine. Many thoughts surfaced in my mind after reading the latest edition of the College Mirror regarding the ongoing revamp of primary health care in Singapore. I agree with the professional development proposals by the relevant bodies, i.e. MOH, SMA and CFPS. I believe GPs in private practice who have the necessary qualifications also have the ability to run Family Medicine Specialist Clinics for chronic conditions, like what Dr Balaji had said for the Polyclinics in his interview with Straits Times in Feb 2005.

However, professional satisfaction aside, I think the adequately qualified private GPs may not have adequate financial incentive for running such clinics for the following reasons:

1. Specialist clinics for chronic illnesses will require longer consultations for each patient in order to have enough time for clinical review, patient and carer education, and the relevant investigations and office medical procedures.

2. These clinics will also require more staff for the same reasons, eg. dietary advice, foot care, etc

3. The private sectors do not have the necessary subventions from the MOH for subsidized patients that are currently given to the hospital groups, i.e. SingHealth and NHG. Most of the patients in the hospitals' subsidized clinics need the financial help from the government as they are in the lower income group, e.g. retirees. I refer patients to the subsidized specialist clinics when I know that they cannot afford the more expensive investigations, e.g. ultrasound scans, MRIs etc.

Why am I talking about dollars and cents when everyone else is focused on professional development and accreditation? Perhaps the following calculations can illustrate my concern.

Suppose a FP sees a URTI case every 7 minutes, and needs 15 minutes to see a case of complicated diabetic case with hypertension, hyperlipidaemia and mild renal impairment. He can see at least 8 patients with URTI in an hour and collect a consultation fee of $15 per patient, which I believe to be a competitive rate but is less than the SMA recommended fees for a short consultation.

However he can only see 4 cases of a complicated chronic case and collects a consultation fee of at most $25 per patient. The arithmetic is obvious.

I work in a community with many retirees, many of my patients will balk at the idea of paying me $25 for a single consultation, no matter how good a service I give.

I propose:

1. That the MOH can consider giving qualified GPs the necessary subventions, for consultation and laboratory investigations, so that they too can run the FM Specialist Clinics. An annual cap for these subventions for each patient can be applied - it need not be a bottomless pit for the government.

2. That the MOH and Finance Ministry can consider the use of Medisave if a GP would refer a patient to the public hospitals directly for the more expensive investigations, e.g. ultrasound scans of the kidneys, or treadmill ECG. Many patients are cash poor but have adequate Medisave.

I hope my intentions for this correspondence are not misconstrued as money-mindedness on my part. I just want to be fair to my patients, my staff, myself and my family, which bear the brunt of my long hours at work.

Dr Goh Tiong Jin

These are my current personal views and not those of my current employers.

Letters to the Editor

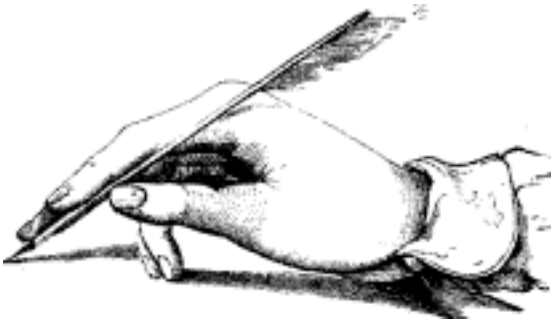
We want to hear from you! Share your thoughts & comments on the articles in "The College Mirror".

Please write to us at:

The Editor, The College Mirror
College of Medicine Building
16 College Road, #01-02
Singapore 169854

OR fax: 6 222 0204

OR email: collegemirror@cfps.org.sg



We welcome your opinions & comments.

Intuition & EBM - uneasy bedfellows?

By Dr Doraisamy Gowri & Dr Ong Jin Ee, MCFP, Editor

Recently in our fellowship class, we did an article review of Tricia Greenhalgh's critique entitled Intuition and EBM–uneasy bedfellows? (RCGP)

As we get inundated with clinical practice guidelines from Ministry of Health, it was refreshing to hear a balancing perspective on how good clinical decisions for our patients are governed both by an intuitive and evidence –based process. She gives an elegant discourse on what is intuitive medicine, what is evidence based medicine and suggests a respect between the two rather than an adversarial relationship between the two is what will make a good marriage bed for expert clinical practice.

Interestingly, she also puts forth a systematic way to develop intuitive expertise through reflective writings and group discussions as in our portfolio learning.

What is intuition?

Intuition is a decision-making method that is used unconsciously by experienced practitioners but is inaccessible to the novice. It is rapid, subtle, contextual, and does not follow simple, cause-and-effect logic.

Best exemplified in the words of Sir Arthur Conan Doyle, creator of Sherlock Holmes and himself a medical doctor, who wrote in The Memoirs of Sherlock Holmes: "It is of the highest importance in the art of detection to be able to recognise out of a number of facts which are incidental and which are vital…"In one of the first Sherlock Holmes novels, Holmes when asked to explain a particularly impressive and obscure feat of reasoning, responds as follows: "From long habit the train of thoughts ran so swiftly through my mind that I arrived at the conclusion *without being conscious of intermediate steps*." Conan Doyle thus presented intuition as a method of problem solving that marks the expert out from the novice, and they acknowledge the elusive nature of the intuitive method. Experts themselves can rarely provide an immediate, rational explanation for why they behaved in a particular way.

She shared an interesting example on the difference between the novice, competent and expert practioner. Table 1, which is based on real life observations, shows excerpts from four clinical 'clerkings' of a single patient. The different problem-solving approaches adopted by clinicians at varying stages of training illustrate stages in the classification that Dreyfus and Dreyfus derived from observations of professional engineers. According to them:

The **novice** practitioner is characterized by rigid adherence to taught rules or plans, has little situational perception and no discretionary judgment.

The **competent** practitioner is able to cope with 'crowdedness' and pressure. He sees actions partly in terms of long term goals or wider conceptual framework and follows standardised and routinised procedures.

The **expert** practitioner no longer relies explicitly on rules, guidelines and maxims. He has an intuitive grasp of situations based on deep, tacit understanding and uses analytic (deductive) approaches only in novel situations or when problems occur.

She recognized that doctors are at our most intuitive when doing our regular job and dealing with patients whom we know well. In unfamiliar situations, we resort to a more formal and rational approach based on explicit (and defensible) professional rules. The skill of the expert is to respond to the subtle cues that signal a need to shift between the two approaches. The GP who writes the single word 'conjunctivitis' in a medical record may live to regret it when the patient subsequently sues for a missed diagnosis of uveitis.

Table 1: Examples of clinical clerking styles of health professionals at different stages of training

3rd year medical student "Mr Brown is a 38 year old computer operator who attended the Accident and Emergency department with a bad feeling in his eye. The history of the presenting complaint was that it was there when he woke up at 7.15 am on Wednesday morning. When he was a little boy he had had an operation on his eyes for squint. He is up to date on his jabs….."	5th year medical student "This 38 year old male attended with a feeling of grit in his right eye. The eye also had a yellow discharge. He could still read the paper with that eye. He had not had any previous episode like this. His visual acuity was 6/6 bilaterally. His pupils were equal, concentric responding to light and accommodation…."
Casualty officer "38 year old male Gritty Rt eye 2/7; no h/o traumaPurulent dischargeVision 6/6, 6/6 No PMH of noteRx: G. chloramphenicol to Rt eye q.d.s. Review: See GP 1/52"	GP "Rt conjunctivitisChloramphenicol drops See S.O.S."

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Conversely, what is Evidence Based Medicine (EBM)?

EBM rose to prominence in late 1990s and is based on principles developed by Sackett and his colleagues. The principles of EBM states that:

1. Clinical decisions should be based on the results of high quality epidemiological studies, clinical intervention trials, and other robust research designs on human subjects.
2. The prognosis of disease, and the benefits and harms of different management options, should be expressed as mathematical estimates of probability and risk.
3. Randomised controlled trials are more valid and generalisable than "anecdotal" evidence when assessing interventions.
4. Secondary sources of research, especially systematic reviews and the guidelines derived from them, can summarise the relevant research evidence on a topic and provide the busy clinician with a useful short cut to the 'clinical bottom line'.
5. The recommended approach to clinical problems is as follows: formulate a focussed question, search the literature for relevant research evidence, appraise the evidence for its validity and usefulness, and apply the results.

The contribution of evidence-based medicine to improved patient outcomes in general practice is incontestable. For example, the old-fashioned family doctor, was frequently to be heard reassuring elderly patients that although their blood pressure was "a bit high", it was "nothing to worry about at your age and certainly not worth treating". Large, prospective randomised controlled trials have shown precisely the opposite - that even the old elderly have substantial reduction in their risk of stroke if blood pressure is treated to below the target level of <160/90.

Of course, we all know that certain elderly people would be better off not taking the standard recommended tablets for their blood pressure, perhaps because they have expressed a preference for non-drug measures or because they suffer from relevant comorbidity. 'Breaking the rules' in individual cases is entirely justified.

Achieving a healthy balance

Despite claims to the contrary by their critics, the founding fathers of evidence-based medicine never claimed that evidence from clinical research trials should be sought or applied in a vacuum. Indeed, in one of the most widely cited paragraphs ever published in the BMJ, they state that "The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence ... By individual clinical expertise, we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice".

So how do doctors develop clinical expertise?

A number of studies by educationalists have begun to throw light on the process by which clinical expertise accumulates. We start by learning detailed 'rules' about the cause, course and treatment of each condition. As we gain knowledge we convert these rules to stereotypical stories ('scripts'). We refine our knowledge by accumulating atypical and alternative stories via experience and the oral tradition (such as grand rounds, 'corridor consultations', and so on). Furthermore, there is growing evidence that clinical knowledge is stored in our memory as stories rather than as structured collections of abstracted facts.

Finally in her own words :

"I rarely escape without being asked to take a side in the perceived adversarial relationship between those who view themselves as experienced clinicians proud to be practising 'old-fashioned' medicine based more or less on intuition, and those (generally younger, computer-literate and possessed of formal postgraduate qualifications) who support the rational, explicit and systematic use of research evidence in the clinical encounter and seek to 'convert' their colleagues to this approach. The false dichotomy between evidence-based medicine and clinical intuition, with the former defined as the 'scientific' element, has no sound theoretical basis."

On Group discussions and Individual reflections

"The enduring tradition of 'Balint groups' indicates, storytelling and reflective discussion in groups is a time-honoured method for professional development Surely it is time to acknowledge, and take steps to overcome, the false dichotomy between the science and art of clinical practice as taught in undergraduate and postgraduate settings? Having quite rightly placed the principles and methods of evidence-based practice on the mainstream educational agenda, it is now time to raise the status of intuition as a component of expert decision-making, and begin to integrate both group discussion methods and individual reflective writing alongside the teaching of these skills.

Once we have recognised that none of us ever needed to choose between evidence-based medicine and old-fashioned clinical intuition, the stage is surely set for developing an educational method that draws productively on both traditions. Far from being a contradiction in terms, the evidence-based Balint group is surely the marriage we have all been waiting for.

The educational research literature suggests that we can improve our intuitive powers through systematic critical reflection about intuitive judgments - for example, through creative writing and dialogue with professional colleagues. It is time to revive and celebrate clinical storytelling as a method for professional education and development." ■

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Practice Tips on writing Medical Certificates (MC)

By Dr Cheong Pak Yean, Senior Consultant Family Physician

Introduction

MC (acronym for medical certificate) is a brief medical document, usually a printed form filled up by a registered medical practitioner (doctor) to give recommendations as to medical leave, restrictions to work, school and other organized activities.

The Singapore Medical Council (SMC) "Ethical Code & Ethical Guide" January 2002 Clause 4.1.8:10 states that "*The issuance of a medical certificate by a doctor carries with it the responsibility to ensure that the patient deserves it on proper medical grounds and that such grounds have been arrived at through good clinical assessment".* It cautions that "*untrue, misleading, improper*" information in MCs would make the doctor liable to disciplinary proceedings.

> ... "untrue, misleading, improper" information in MCs would make the doctor liable to disciplinary proceedings.

This article provides practice tips on writing of MCs in clinics based on advice (reproduced in italics) given in the SMC Guide.

1. On 'Back-dating' and 'Post-dating' MCs

"*Medical certificates may neither be post-dated nor back-dated and shall start from the day of consultation or procedure, except where it is clear that a patient's absence from work prior to consultation is consistent with the patient's clinical presentation to the doctor & there is medical justification to issue the certificate."*

Most MCs are written at the same time or soon after a consultation takes place. The date the MC is written is therefore the date of the consultation. The term 'back-dating' of MC refers to the unprofessional practice of writing on the MC a date that precedes the actual date it is written, to give the impression that the MC was written earlier and the medical consultation and recommendations were made at the earlier date.

The only exceptions are when "*it is clear that a patient's absence from work prior to consultation is consistent with the patient's clinical presentation to the doctor and there is medical justification to issue the certificate."*

If the doctor after due examination is of the professional opinion that the debilitation started prior to the consultation and there are reasonable explanations why the patient did not attend a clinic at an earlier date, the doctor should document the findings in detail in his medical records and may wish to recommend an earlier start-date. This date should usually be the day before the date of examination. Only in extenuating circumstances should an earlier start-date of more than a day prior be recommended. In such a case, a more detailed memorandum should be written instead of the simple form to indicate the manifest reasons for recommending so.

As to post-dating of MCs, it is acceptable for the start-date to be the next day after the consultation if the doctor is certain that the patient is on own leave on that day, for example on a Sunday. Another scenario is when the patient consults the doctor in the late evening.

2. Lost MCs

If a patient requests an additional copy of a previously issued MC on the grounds that it is lost or misplaced, no new MC should be issued. The doctor should instead write a statement dated the day of writing giving the facts contained in the original MC viz. the date of issue of that MC and recommendations therein. If a photocopy or duplicate computer-generated copy of the MC is given instead, the contents of the original MC should be left intact and the words, 'duplicate copy issued on (current date)' clearly written on it and signed.

3. Duration of MC

"*The certificate which is issued after the medical examination should specify the expected period of illness.*"

It is not sufficient to just indicate the number of day(s). For example, the recommendation for one day's leave should be qualified by 'on (date)" while a recommendation for more than 1 day should be qualified by the period 'from (start-date) to (end-date)'.

4. Name of doctor and signature

"*As a medical certificate carries with it a professional and legal responsibility, the doctor must sign the certificate personally and if another person has filled in the details on his behalf, he must satisfy himself that the details are correct before signing."*

The name of the doctor and signature should be that of the doctor who actually attended to the patient. It is improper to sign a MC on another doctor's behalf. His/her name should be clearly written and should be the same as that registered with the Singapore Medical Council. The doctor should sign only after all details in the MC have been duly completed. Doctors should never pre-sign MCs for further details to be filled in by nursing staff or another doctor for example a locum.

5. Amendment and "Endorsement" of MC issued by another doctor

"A doctor shall not amend the provisions of a medical certificate given by another doctor without assessing the patient personally and consulting the doctor who gave the medical certificate initially."

'Endorsement' of MC issued by another doctor occurs when some employers require that the MC issued by doctors other than from employer's appointed panel be subjected to further purview by their own designated doctors.

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Doctors who take on this task must be clear about the tasks they are performing. These could be in three categories viz.

(a) Human resource tasks;
(b) Medical documentation tasks; and/or
(c) Medical review tasks

(a) Human Resource Tasks
Employers at times may request that the doctor verify the MC to be bona-fide and to assess how it bears on the employer's human resource policy of leave entitlement and reimbursement for medical costs incurred. These tasks should best be left to human resource officers of the company. If a doctor agrees to verify the MC authenticity, he/she should perform the duty diligently viz. checking that the MC bears the name of a registered clinic and the doctor signing is a registered medical practitioner. The doctor must not take on the role as approving authority for leave entitlement and reimbursement as this may conflict with his professional duty to patients.

(b) Medical Documentation Tasks
This is the task of recording the information contained in a MC issued from another clinic/doctor in the medical records of the patient kept by the panel doctor. This may be in the context of continued care. For example if there is a pattern of repeated medical leave and the recording doctor is unaware of the medical condition, the doctor who has taken on this medical documentation tasks should ask to see the patient even though he may not have been consulted for that aspect of care.

(c) Medical Review Tasks
The doctor may wish to take on the tasks of medical review of the case when MCs issued by another clinic/doctor are presented to him.

The reviewing doctor should note the information contained in the said MC in the review. If after this initial review and his/her recommendation is the same as that stated in the MC, he should note it in his own medical record (and not on the other doctor's MC). Adding his signature on the MC indicates that he agrees with the recommendations of the other doctor even though he did not examine the patient at the date of issue and is not privy to contemporaneous medical records of the other doctor.

If his opinion differs from the issuing doctor as regards recommendations, he should request to see the patient. If he still differs in his recommendations after reviewing the patient, he should record his findings and issue a new MC under his own name stating his opinion. The date of review/ examination should be clearly stated in the new MC as the original MC was issued on an earlier date. The new MC given to the patient could recommend either more restricted or extended leave. It is up to the employer to decide which recommendation he decides to accept for the purpose of granting sick leave and reimbursement. Under no circumstance should the reviewing doctor amend another doctor's MC without the explicit consent of the latter.

If he still differs in his recommendations after reviewing the patient, he should record his findings and issue a new MC under his own name stating his opinion.

The doctor must thus be clear in his mind exactly what tasks he/she is performing when such MCs are presented. Medical documentation and review are professional services and the doctor should charge professional fees for those tasks.

6. Validity of MCs for absence from judiciary proceedings
It is the convention in Singapore for MCs to have the caveat that they are not valid for use by patients for the purpose of excuse from judiciary proceedings. If the doctor intends that the MC should be used for such purpose, he/she would write a purposeful statement in the prescribed format. Please refer to SMA advisory on " MCs issued to patients who are medically unfit to attend court/judiciary proceedings' based on extract from the Subordinate Courts Practice Direction No. 3 of 1997. (Sma/ywm/cge/12/64a/2001 dated 30 Nov 2001)

7. Writing of diagnoses on MCs
It is the doctor's discretion whether he/she wants to write the diagnoses or other clinical information in a MC. If he does so, he should give the MC directly to the patient and not to a third party without the knowledge or consent of the patient. Certainly sensitive medical information must never be written on such MCs. ■

Learning Points

1. All MCs must be dated with the current date on which they are written.
2. The start-date of the medical recommendation should generally be the day the MC is written.
3. The duration of the MC from the start- date to end- date should be clearly filled in.
4. The name and signature of doctor on the MC should be that of the doctor who attended to the patient.
5. A doctor must never amend the MC issued by another doctor. If a doctor accepts the role of 'endorsing' or reviewing the MC of another doctor, he must be clear about the tasks and the implications therein.
6. MCs are generally not accepted as excuse from judiciary proceedings. A special memo must be written.
7. MCs with diagnosis must be given directly to patient or to parties with patient's consent. Sensitive diagnoses should not be written on MCs.

Family Medicine Trainee from Japan

By Dr Lee Kheng Hock, FCFP

(L-R) Dr Lee Kheng Hock, Dr Yuko & A/Prof Goh Lee Gan

Dr Yuko Takiyoshi, who is a Family Medicine trainee under Dr Ryuki Kassai, Director and Chair, The Hokkaido Centre for Family Medicine, Nikko Memorial Hospital, visited Singapore in April 2005 to learn how FM is taught and practised in Singapore. College Mirror interviews Dr Yuko on her impression of the visit.

CM: Dr Yuko, welcome to Singapore and thank you for agreeing to this interview. Can you tell us a little bit about yourself?

Yuko: I am from Aomori Prefecture which is in the northern tip of Honshu Island, just south of Hokkaido. I graduated in 2003 and I am now doing my family medicine traineeship with the Hokkaido Centre for Family Medicine.

CM: I understand that Family Medicine is a new discipline in Japan. Why did you choose to take up the family medicine traineeship?

Yuko: In my undergraduate days, I was initially interested in psychiatry probably because I was searching for a good model for helping a patient as a whole person. What we learn in medical school is very biomedical. The psychosocial component is not well covered. Also, I found out psychiatry is not equal to see patient as whole person.

I came to know about the discipline of family medicine in my final year in the University of Hirosaki. I was very impressed. It dawned upon me that this was the missing approach to patient care that I was searching for. Since medical school days, I have always wanted to help patients as a whole person. Personally, I find that this need is even greater for female patients which is why I have an interest in women's health.

CM: I think many of our own family medicine trainees would be interested to know what is it like to be a family medicine trainee in Japan. Can you tell us how is the training process like?

Yuko: Well, actually the Singapore programme is very much more structured than what we have in Japan. Your system has a very good framework and it is organized to a greater level of detail. I am very impressed. The family medicine training programme in Japan is quite new and not so well-organised. We need to complete a 6-years undergraduate programme which is followed by a 2-years internship. In this 2-years internship period of time, every new doctor will be attached at the hospital, we are called "junior resident", and we are taught family medicine training at the same time. After that, we have a 2-years family medicine traineeship at our centre and we are called "senior resident". For the first 2 years as junior resident, we are attached to the hospital specialist departments most of the time.

Personally I think I don't get enough training during those first 2 years. We are pretty much on our own and the framework of training is not detailed. We have to take our own effort to learn from the specialists. And besides that we have a "half-day back" programme to learn family medicine which we learned from the Canadians. Once a week, we will spend half a day at the family medicine clinic. During those sessions, we will see family medicine cases for about 15 minutes. After that we will present and then discuss the case with our senior trainee who is seeing cases next door. We will then come back to our own patient to complete the consultation. The patients are quite used to this and they don't mind. At the "half-day back" programme, we will attend 4-5 patients.

CM: That is very interesting. Actually our own trainees who are doing their hospital posting experience the same kind of passive neglect. Our system of training also has many areas that we can improve upon. I think this "half-day back" programme is an excellent idea. We should learn from you. What other training do you have during your first 2 years?

Yuko: We have portfolio-based learning in our junior term of training as well, different from your style, our way is basically individual filing for what we learn that day. This time, I found out that we should learn from Singapore. We found it useful and it was introduced to our programme. I have seen your trainees doing portfolio based learning. I think yours is better because the discussion is more in depth and there is more interaction compared with our style. We also have video review in our training. We have a special consultation room with camera and one way mirror where we can record the consultation, with the patients' permission, and after that we have discussion on our interview skills.

CM: Now that you are a senior trainee can you tell us what it is like?

Yuko: I have just started my third year of training a few months ago and I am not really sure. But I find it very enjoyable as I am now attached to a real family medicine clinic. I also have more responsibilities.

CM: Thank you very much. I understand that you are considering to do an elective posting in Singapore next year. I hope that you will visit us and we can share our learning experiences again.

Yuko: I had a very enriching learning experience during my visit and I am very impressed by Singapore's system of FM training. I hope you and your colleagues can visit us in Japan as well. ■

FM Research Bites 3: Designing the Study

By Dr Michael Yee, MCFP, Editorial member

After formulating the research question, one would need to evaluate if doing the study is feasible and ethical. There are indeed several ways of answering the question at hand and some questions can only be answered through certain methods. In general studies can be broadly divided into qualitative and quantitative methods.

QUALITATIVE METHODS

Qualitative research is exploratory in character, setting out to describe, understand and explain a particular phenomenon in their natural setting and the meanings health care workers, patients, diseases and health services bring to them. It may address the what, why and how, but not how many or how frequent.

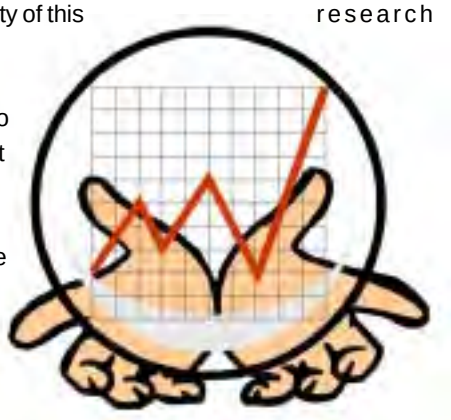
Qualitative studies seek to collect data on emotions, experience and prevailing issues of interest. Among qualitative methods we might choose from the below listed:

1. One-to-one interview
2. Group interview
3. Focus group discussion (FGD)
4. Assessment Intelligence (AI)
5. Observational

One-to-one and group interviews are self-explanatory where the researcher asks an individual or a group of people specific questions to solicit an answer. FGD is conversely more unstructured and seeks the opinion of a select group of people on a specific topic in a controlled setting. AI seeks the opinion of an uncontrolled group of people in a specific area or place, for example in the clinic waiting area, where individuals in the dynamic group is allowed to come and go while the discussion progresses.

In observational studies the researcher observes the subject of interest and records the findings, for example in a consultation room. The results of qualitative studies are useful in getting a general snap shots of the ideas, concerns and expectations, knowledge, attitude and practices of the study population, although external validity of this research method is low.

The study would also provide the focal point of further quantitative studies or provide the material for the preparation of questionnaires for further quantitative studies.



QUANTITATIVE METHODS

Quantitative methods use descriptive and inferential statistical techniques to analyse the collected data or variables as shown below.

Types of variables

Dependent variable
Outcome

Independent variable
Factors/Exposure(X)

Intervening variable
Confounding factor(Z)

Types of studies

A) Observational studies: no control over X

1.Cohort studies: start with exposure or factors (X) and wait for outcome (Y) e.g. clinical trials
2.Case control studies: start with Y and then retrospectively look at X
3.Cross sectional studies: start with both X & Y at same time (Useful for ensuring size of the problem but may not be able to infer any association)

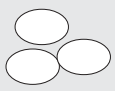
B)Interventional trials: able to control X

1.Randomised controlled trials
2.Historical controlled trials
3.Cross over trials

C)Meta-analyses

Types of data

• Nominal: unable to rank; eg: race, sex, disease



• Ordinal: subjective; eg. different grades of anemia

• Interval or ratio: objective, standard way of measurement; eg: height, weight, Hemoglobin levels

(Adapted from the CFPS Fellowship Research Short Course)

Sleep Disorders - Prescribing & Beyond

By Dr Tan Yew Seng, Chairman of Mental Health SIG

Dr Lim Kok Kwang

Dr Ng Beng Yeong

The Mental Health SIG session on 26 March was entitled "Sleep Disorders: Prescribing and Beyond". The session was presented by two distinguished and eloquent speakers – Dr Ng Beng Yeong, who is a consultant psychiatrist of the Department of Behavioural Medicine and Sleep Disorders Unit of the Singapore General Hospital, and also the Vice President of the Singapore Sleep Society; and Dr Lim Kok Kwang, a clinical psychologist in private practice, who is the Clinical advisor to Shan You Counselling Centre, the President of the Singapore Society of Clinical Hypnosis and Adjunct Assistant Professor at NTU.

Once again, this approach of getting speakers from different professions is to present different perspectives in dealing with clinical conditions in general practice and to promote networking among the different health professionals.

Dr Ng's presentation was a well-organized stepwise exposition of the various forms of disordered sleep and the appropriate management of each of them. There were numerous practice tips which the audience clearly appreciated. He then talked about prescribing for sleep disorders and the medico-legal aspects of drug prescription for insomnia. There was so much audience participation generated in this section that session had to be extended.

Dr Lim's talk focused firstly on the very important and practical aspect of enhancing doctor-patient relationship, such as using the BATHE technique, as a prerequisite for managing patients with sleep disorders. This was followed by the discussion of the cognitive techniques in approaching sleep difficulties, and finally, the audience got to practise techniques that encourage sleep. These techniques, such as the Hh techniques, were chosen because they are effective, easy for the doctors to teach their patients and easy to learn. As a testimony to their effectiveness, members of the audience were heard yawning within minutes of the experiential session.

Based on the many positive feedback from the audience, this was certainly a successful session. The timing to hold the session on a Saturday afternoon was initiated after feedback from some doctors and it appeared that this decision to change the time was appropriate. Future sessions will therefore be held on Saturdays as far as possible, subject to the availability of the College lecture room.

Feedback is therefore important to the planning of a successful session. If there is any feedback, or topics that you may want to be discussed, or an interesting case that you may want to present because of its learning value, please feel free to contact me at tan_yewseng@pacific.net.sg. ■

Feeding & Nutritional Problems in the Elderly

By Dr Gerald Koh, FCFP

Dr Lieu Ping Kong

The Eldercare SIG Session held on 3 May had a fresh approach this time round with the session centred around case vignettes based on common problems and real patients seen by FPs, instead of didactic lectures. Two patients were discussed and the geriatrician who provided clinical input and insights was Dr Lieu Ping Kong, Senior Consultant in Tan Tock Seng's Geriatric Medicine Department.

The first patient was a stroke sufferer who had developed dysphagia after his cerebral infarct. Being diabetic, hypertensive and hyperlipidaemic, the challenge was modifying his diet to meet his medical requirements without reducing palatability, caloric and nutritional value of his meals. Concurrent depression, which occurs commonly among stroke patients, also tends to reduce food intake. The patient's case was further complicated when he developed a second stroke and aspiration pneumonia, eventually requiring parenteral feeding. This led to a discussion on what a family physician needs to know about parenteral feeding, care of feeding tubes and aspiration pneumonia prevention.

The second case vignette was about an underweight frail elderly patient with multiple medical problems including depression, anxiety, old fractures, heart failure and chronic constipation. Dr Lieu shared with the audience a practical and systematic approach to evaluating the possible reasons for the patient being underweight and useful tips on improving the nutritional status of frail older persons.

Time was set aside for a fruitful question and answer session when family physicians present clarified doubts and brought up their personal cases for discussion.

All in all, the whole session was a illuminating learning experience and family physicians present appreciated Dr Lieu's comprehensive and pragmatic advice. The Eldercare SIG welcomes all FPs interested in improving the care of their elderly patients to join us for or next session in August. We hope to see you all there! ■

Indonesian FM Study Team in Singapore

By A/Prof Goh Lee Gan, Senior Consultant Family Physician

Study Team at Singapore International Foundation(SIF) Lecture room.

Study team

A study team of 26 strong made up of Family Medicine teachers, practitioners, office bearers from the Indonesian Medical Association, the Association of Family Physicians of Indonesia and staff from the Ministry of Health of Republic of Indonesia visited Singapore on a training course from 28 March to 10 April hosted by the Singapore International Foundation (SIF) under its Singapore Volunteers Overseas(SVO) Programme. The delegates came from different corners of Indonesia: Jakarta, Yogyakarta & Solo in Central Java, Palembang in South Sumatra, and also Surabaya.

Study objective, site visits and reports

The key study objectives were to see how Family Medicine(FM) could be taught and services delivered with the vision of Sehat Indonesia 2010 in mind. The component objectives were to study: (1) teaching of undergraduate FM, (2) teaching of postgraduate FM, and (3) service delivery of family physicians in the private and public clinics as well as Raffles Hospital, (4) professional development, and (5) to continue discussion amongst the delegates themselves on the best way forward in building capacity of the family doctors towards helping people achieve the Healthy Indonesia vision in 2010.

The site visits ranged from Dover Park hospice, GP clinics, FMTP workshop, and the College during teaching sessions gave the participants the real world. Training sessions on postgraduate learning like the portfolio based learning, small group case study learning, MCQ, KFP and OSCE as assessment instruments were also included. There was also a one-hour "Meet the MOH session" with doctors in charge of FM training & development in Singapore. A visit to the College and discussion on professional development of family physicians completed the study programme. The delegates also completed their draft reports, together with course material, were compiled into a CD to take home.

The Indonesian Study team met up with the doctors in charge of FM training & development from MOH at College.

Positive vision of Healthy Indonesia 2010

The idea of a Healthy Indonesia 2010 is a positive and attractive national vision. It will be the best answer to healthcare cost containment. No disease or little disease means little need for health care expenditure. It cannot be no health expenditure because health promotion, disease prevention and control of chronic disease still requires resource spending.

In a way, Indonesia has moved from the negative vision of family practice as gate keeper to a positive vision of family practice as gateway to health. Like most countries, family doctors were asked to keep the gate when a national programme of managed care was introduced in the late 1990s. With the Sehat Indonesia 2010 vision, Family Practice has taken a positive turn. The idea is now a positive one to train family doctors to help people develop acquire the knowledge and skills for preventive care, chronic disease control and early treatment of medical problems.

GP-FP Conversion

A one-year curriculum has been developed as part of the project of the Singapore International Foundation and the Ministry of Health of the Republic of Indonesia (SIF-MOH RI) for conversion of GPs to FPs. The curriculum has three semesters of self-directed distance learning, complemented by small group learning, and big group workshop studies using the GDFM idea, but with only one year for the conversion:

- The first semester covers the commonly seen problems based on organ systems.
- The second semester covers common problems in child health, women's health, men's health & chronic disease.
- The third semester covers health of the working adult, elderly health, & public health.

The next steps

The next steps of the Indonesian delegates will be to implement what they had seen and discussed in the course in Singapore. The SIF-MOH RI SIF/SVO Family Medicine Project Phase II has four prongs of (1) GP-FP conversion; (2) Undergraduate FM programme, (3) A social marketing plan for family practice amongst the stakeholders of Sehat Indonesia 2010, and (4) An IT platform to house the FM training materials and the public health education materials.

"A journey of ten thousand miles begin with the first step." The Indonesian delegates have taken more than the first step. We wish them every success in the journey towards Sehat Indonesia through the family physicians. ■

Women Talk

By Dr Shiau Ee Leng, Editorial Member

1 What to do when your female patient sees you after unprotected intercourse and ask for post-coital contraception?

Immediate Postcoital contraception should be used within 72 hours of coitus and include:

• High dose Estrogen containing Oral Contraceptive (50 mcg Estrogen and 250mcg of Progestogen -
2 tab stat and another 2 12 hours later
• Danazol 200 mg 2 stat and 12 hours later
(General Practice second edition, Murtagh, Pg 815)
Failure rate is 2.6 %
• Postinor 1 tab stat and 1 more 12 hour later if more than 1 coitus
• Insertion of IUCD

2 How to start a Family Planning Method after Emergency Contraception?

• Oral contraceptives
Regular start- Use back-up contraception method until next period, then begin oral contraceptive pills according to regular patient instructions.

Jump Start- Start a new package of oral contraceptives the day after taking the two emergency contraception doses (use back-up contraception method for first seven days).
Perform pregnancy test if patient does not have a normal period after completing first package of pills.

• Injectable contraceptives
Regular start- Use back-up contraception method until next period, then start either injectable method according to regular patient instructions.

Jump Start- Start either injectable method the day after taking the two emergency contraception doses (use back-up contraception method for first seven days).

Modified jump start- start oral contraceptives the day after taking the two emergency contraception doses (use back-up contraception method for first seven days); start injectable contraceptive after next period (use back-up contraception method for first seven days).

• Combination patch
Regular start- Use back-up contraception method until next period, then begin patch according to regular patient instructions.

Jump Start- Apply the patch the day after taking the two emergency contraception doses (use back-up contraception method for first seven days).
Perform pregnancy test if patient does not have a normal period after completing a one-month supply

• IUCD Intrauterine device
Regular start- Use back-up contraception method until next period, then proceed with IUD insertion.

(AFP Aug 2004)

3 Tips for more accurate Pap Smear

An effective tool for screening of cervical cancer Pap smear is performed daily in the GP's clinic.
Tips to improve the accuracy:
• Best instrument to obtain sufficient cervical specimen is the plastic spatula compared to the wooden one.
• Important to locate and obtain cells sample from the transformation zone as well as the endocervical area
• Bristles are good for nulliparous or atrophied os.

(KKWCH on general O&G 6 March 2005)

4 Should pregnant women travel?

Generally travelling is safe after the first trimester of pregnancy up till the 34th week of pregnancy

Those who should avoid travelling due to Obstetrical risk factors:
• History of miscarriage
• Incompetent cervix
• History of ectopic pregnancy (ectopic with current pregnancy should be ruled out before travel)
• History of premature labor or premature rupture of membranes
• History of or existing placental abnormalities
• Threatened abortion or vaginal bleeding during current pregnancy
• Multiple gestation in current pregnancy
• Fetal growth abnormalities
• History of toxemia, hypertension, or diabetes with any pregnancy
• Primigravida at 35 years of age and older, or 15 years of age and younger

Those with general General medical risk factors who should be assessed before traveling or discouraged from traveling if possible
• History of thromboembolic disease
• Pulmonary hypertension
• Severe asthma or other chronic lung disease
• Valvular heart disease (if NYHA class III or IV heart failure)
• Cardiomyopathy
• Hypertension
• Diabetes
• Renal insufficiency
• Severe anemia or hemoglobinopathy
• Chronic organ system dysfunction requiring frequent medical interventions

Region of Travel (potentially hazardous destinations) which should be discouraged
• High altitudes
• Areas endemic for or with ongoing outbreaks of life-threatening food- or insect-borne infections
• Areas where chloroquine-resistant Plasmodium falciparum malaria is endemic
• Areas where live virus vaccines are required and recommended

(CDC information for international travel 2003-2004)