THE
College Mirror
VOL. 31 NO. 3 September 2005 A Publication of College of Family Physicians Singapore

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Stoneware Jar
Tang Dynasty
B.C. 618 - A.D. 906

Published by the College of Family Physicians SIngapore
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

Three Challenges for Family Medicine

This year's Commencement Ceremony was held on 25 June 2005 at the MOH Auditorium. The occasion was graced by Dr Mohamad Maliki Osman, Parliamentary Secretary, Ministry of Health and Ministry of Community Development, Youth and Sports.

In his speech, Dr Mohamad Maliki Osman touched on the development of Family Medicine and presented the MOH's vision of a Family Doctor for every Singaporean and issued three challenges as to how the College can play her role to meet the coming changes. His speech is presented in full for the benefit of those who did not have the opportunity to attend the ceremony.

Dr Mohamad Maliki Osman

"It gives me great pleasure to join all of you here today at the Commencement of Family Medicine Academic Year 2005. The term commencement is often used in different context in different countries. For example in the States, many Universities use the term commencement to mark the end of the University education for the graduates, suggesting that the graduates would embark on a new phase in their life outside the University.

Of course, many of you here may wish that you have already completed your training programme but, commencement today refers to the start of your academic year. What is similar, however, is that many of you here have made the decision to embark on this new phase of your professional career by taking up Family Medicine Training. And I congratulate you for making this decision.

DEVELOPMENT OF FAMILY MEDICINE AND FAMILY PHYSICIANS

The term "General Practice" has been in use since early 19th century. However, Family Medicine as a specialty is relatively new, with the Americans introducing board certifications for Family Physicians only in the 1960s. Just like many other specialties, the need for Family Medicine as a specialty came about as a result of demand. Demand not only from the patients, but also from within the profession.

The 20th century saw the rapid development of medical science as well as sub-specialisation. While medical specialisation and sub-specialisation certainly brought about their benefits, they also carry the side effect of fragmentation of care. The result is that various doctors may know different systems or organ parts of the patients very

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President's Forum

Restructuring within

By Associate Professor Cheong Pak Yean, President, CFPS

The College was founded in 1971 to maintain standards of and to champion the practice of family medicine. The College Constitution also spells out its roles in vocational training and recognising doctors who have achieved these distinctions. These objects are still relevant today.

However, the instruments laid out in the Constitution to achieve these objects (which have survived largely intact through the years) should be carefully examined and amended if necessary to bring it to date. For instance, the quorum required to amend the Constitution is one-eighth of the voting membership. This requirement translates to in-person attendance of more than one hundred doctors. In the 2005 annual general meeting (AGM), an attempt was made to amend this to an absolute number of 50 voting members. Though there was a record turnout, the quorum still fell short. Another concerted effort to amend this and other clauses must therefore be made in the June 2006 AGM.

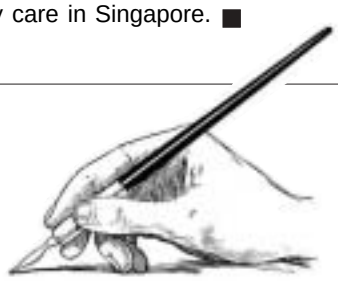
There are three broad areas in the Constitution to examine viz. membership, leadership and governance. The eligibility and rights of the various categories of membership must be discussed. The process of nominating and electing leaders too should be scrutinized.

As for governance, the relative roles of the Council, the Censor Board and the executives in charge of the College organs such as the Institute of Family Medicine (IFM) should be worked out. Necessary amendments can then be tabled at the next AGM in June 2006 for consideration.

In the next ten months, focus groups would be formed to debate these issues and to publish the views in the College Mirror so that come June, a broad consensus can be reached. We invite members to submit their views and to participate in the exercise to restructure the College from within in tandem with other moves to reform primary care in Singapore. ■

Editor's Words

A new beginning...



In this issue of the College Mirror, the limelight fell on the one hundred and twenty men and women taking the GDFM and sixteen taking the MMed programme, at this year's Commencement Ceremony.

These courageous souls have taken the next step up the professional ladder. By becoming full fletched Family Physicians in two year's time, they will add on to a growing list of our fraternity, who believe that the only way to progress is through structured and disciplined training. Then our vision of a well trained and reliable Primary Care team that is trusted and respected, can gain fruition.

I am particularly happy to see that a couple of my old reservist "buddies" who are in their forties had joined up, proving that it is certainly never too late to start learning again!

This issue of the College Mirror is "early" for a purpose. Sometime in September, we will be having the next Primary Care Survey (PCS). It is hoped that the interview with Dr Michael Yee, the College's representative of the advisory committee for MOH PCS 2005(Pg 9), will convince all of us to take part in this survey so that the conclusions drawn would be useful and representative. Each one of us can make a difference.

For those of us who would like to know more about herbs etc, Dr Gabriel Seow's article should prove helpful and informative.(Pg 14)

I will leave the rest of the College Mirror for your reading pleasure and hope that you can give valuable feedback as well as submit your pearls of wisdom so that more can benefit from this sharing of knowledge. ■

Dr Wee Chee Chau
Editor of The College Mirror

Page 1 - *Three Challenges for Family Medicine*

well, but none have a very good overall picture, or know the patient as a person well.

Very often, we hear feedback from patients that after being referred to one specialist outpatient clinic for one problem, he ends up being further referred to 3 or 4 other specialists to look at different parts of the body. There is certainly a need for a more holistic approach in managing our patients.

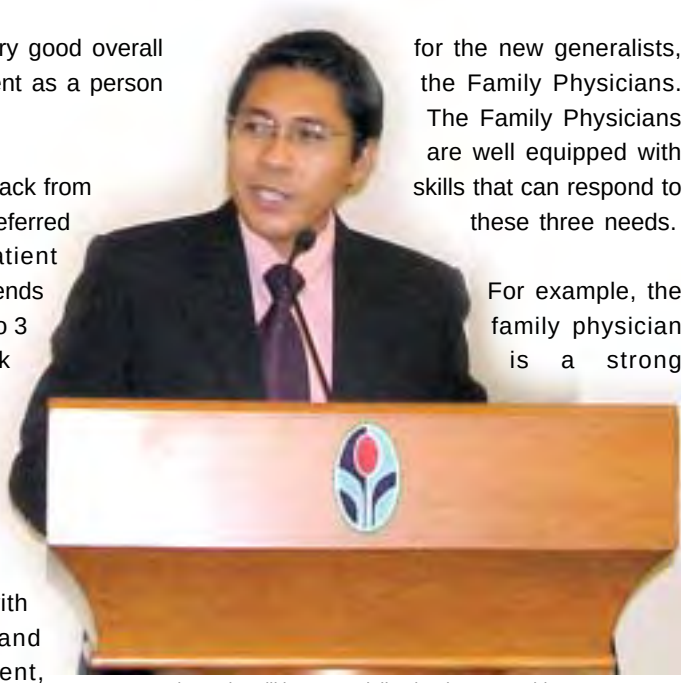
On the disease front, with industrialisation and economic development, disease patterns shift from infectious diseases to chronic lifestyle conditions. These chronic diseases often share three common needs:

First, they require the significant participation on the part of the patients, often in lifestyle modifications. For example, in the management of high cholesterol, the patient needs to play his part and watch his diet. Medicine alone will not help. Even in taking medications, doctors need the cooperation of the patient. If the doctor prescribes the medicine but the patient does not take it, he will not get well. Thus participation of the patient in management is critical.

Second, chronic diseases require long term management and follow-up. For example, high blood pressure requires long term medications, regular follow-up and periodic adjustment of dosages.

Finally, the management of chronic diseases often require help from other members of the healthcare team or resources in the community. Diabetes for example requires regular eye screening and foot checks and some may even require more detailed dietary counselling by dieticians.

It is against such a backdrop of fragmentation of care and high prevalence of chronic diseases that sets the stage for the new generalists, the Family Physicians. The Family Physicians are well equipped with skills that can respond to these three needs.



Dr Mohamad Maliki Osman delivering keynote address

For example, the family physician is a strong health advocate equipped with excellent counselling skills to understand the attitudes of his patient towards his illness and motivate the patient to modify his lifestyle. This personal relationship with the patient is also the key reason why the patient would continue to come back for follow-up.

At the same time, the Family Physicians see not just the patient but often the family members as well. He thus has a good understanding of not just the family medical history, but also the family dynamics and how the patient can be best managed in the context of his family.

In addition to these softer skills, the Family Physician is also equipped with the knowledge of best evidence based practices and will effectively utilised the community resources in the best interest of his patient.

In short, instead of being the undifferentiated bulk of professionals defined by lack of special training, the new generalists, the Family Physicians have a well-differentiated role with a well-defined set of skills.

MINISTRY'S VISION

Since 2002, our Minister of Health has set "Managing Patients Holistically" as one of the 8 priorities for our Ministry. We hope that through promoting Family Medicine and getting Family Physicians to play an even greater role in our healthcare system, we will be able to achieve better outcomes for our patients and reach our vision of "One family doctor for every Singaporean."

In the last few decades, the role that Family Physicians play in the various healthcare systems around the world has become pivotal. Aging populations, and the rapid rising cost of hospitalisations around the world will further contribute to the rapid development of Family Medicine.

In Singapore, we still have a distance more to go to reach our vision. Currently, we have some 200 doctors with the Master of Medicine in Family Medicine. The Graduate Diploma of Family Medicine (GDFM) training programme has produced more than 100 graduates since its first examination three years ago. Together, this forms only an estimated 15% of primary care physicians.

This year, I understand, we have a record intake of 120 trainees for GDFM. However, to reach our vision of a family doctor for every Singaporean, we will need as many doctors trained in Family Medicine as possible. Ideally, we should work towards having all of our primary care physicians trained to deliver care at the level of a Family Physician.

ROLE OF COLLEGE AND THE PROFESSION

Training will not happen without the profession themselves being the provider and being committed to delivering quality training programmes. On this note, I am glad that the College of Family Physicians has played a key role not just in setting and maintaining the standards of training but has been forward thinking in responding to the needs of patients and the profession.

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Council members with Guest-of-Honour.

I am also happy to note that College has made continuous effort to improve the teaching programme by integrating e-learning into the programme this year so that even the busy doctor could learn in his spare time. The College's appointment of part-time Teaching Fellows also demonstrated your commitment to continually renew the core training curriculum and to ensure that the programme stays up-to-date and relevant to the challenges faced by Family Physicians of tomorrow.

It is really heartening to see the College and profession taking such an active role in the training. It must be obvious to many by now that it is no easy task to plan, coordinate and carry out these training programmes, especially for the record number of trainees this year.

Thus I hope all of you including the trainees, would also consider how you could one day play your part in helping to support the training programme, develop it further so that more younger doctors in the same fraternity can be trained. The profession, after all, is made up of each and every one of you.

However, if I may pose three challenges to the college in the medium to longer term future, with the hope of bringing Family Medicine to even greater heights.

First is the concept and role Family Physicians, how do we encourage both the medical profession as well as the public to embrace this concept. How can we convince the medical profession, in particular the more senior GPs practising for a number of years to come forward and be trained so that they can take on an even larger role? We have the infrastructure with GPs operating in all our housing estates, making them easily accessible to the Singaporeans.

Freedom of choice in our healthcare system is so deeply ingrained that very often patients may see a few doctors for the same condition. How can we convince the public of the value and benefits of having a regular Family Physician? These are certainly big challenges but if we are able to overcome these, it will certainly bring about benefit both to the public as well as to the profession.

Second, is the challenge of life long learning as a Family Physician. With more and more doctors taking up vocational training and thus starting at a higher baseline, how can we ensure that life long learning continues? And that the training is interesting and relevant to the practising Family Physicians and is able to further bring his skills up to the next level. At the same time, how do we ensure that these training programmes are not just training for the sake of training, but are relevant to the needs of the patients and society?

The third challenge is in the area of research. While Family Medicine research has already been well established in some countries overseas, it is an area that needs to be developed in Singapore.

How can our Family Physicians of tomorrow take part in meaningful research that will help shape the future of Family Practice here in Singapore? How can we challenge the inquiring minds of every Family Physician and interest them to take on research. How can the research questions raised in Family Practice be answered with the relevant research?

With research as a strong foundation, Family Medicine can certainly scale greater heights. Family Physicians can and will stand alongside their other specialist colleagues at the forefront of medical advances. Together, they will achieve the vision of Singapore being a medical hub.

Leaving on the note of these three challenges, may I congratulate the trainees again on your choice of Family Medicine as well as on the commencement of a new phase in your professional career. You have every reason to be proud of your choice. I wish you success and a fulfilling career as a Family Physician. Thank you." ■

Family Medicine Commencement Ceremony

By Dr Wee Chee Chau, MCFP & Editor

This year's Commencement Ceremony took place on 25 June '05 at the MOH auditorium. The packed venue was made up of the 120 new GDFM trainees (a record size for the GDFM programme), 16 MMed(FM) trainees, teachers, other academic staff, and the previous batch of doctors that enrolled on the programmes last year.

The auditorium was filled with GDFM, MMed(FM) trainees & tutors.

The event's Master of ceremony, Dr Lee Kheng Hock likened the ceremony to a "sowing of seeds of learning" that will result in a "harvest" of Family Physicians in two years' time.

Welcome address:
The President of the College, A/Prof Cheong Pak Yean, emphasized the value of training to the audience. He spoke about the current paradigm that places care experience over clinical quality and spelt out the College's endeavour to change, through vocational training, regulation and public education, the focus from cost to value instead.

A/Prof Cheong contrasted the instant gratification nature of care experience to the more desired character of clinical quality which comprises preventive, continual, personal & comprehensive care.

The College's push towards clinical quality, by providing leadership, motivation and putting in place proper vocational training and care standards will hopefully produce results(ie. trained Family Physicians) that will justify themselves, and convince everyone(providers & consumers alike) of the need and ability to shift towards clinical quality. His take home message was "training adds value".

Guest-of Honour:
The occasion was graced by the Guest-of-Honour, Dr Mohamad Maliki Osman, Parliamentary Secretary, Ministry of Health and Ministry of Community of Youth and Sports. (See pg 1).

Overview of Academic Programmes:
A/Prof Goh Lee Gan, the Censor-in-Chief of CFPS gave an overview of the academic programmes next.

A history lesson on the evolution of the post graduate training programme over a thirty-four year period was given. The humble beginnings of vocational training for General Practitioners in 1971's Diplomate GP programme progressed to the Master of Medicine(Family Medicine) in 1991, and the latest GDFM was initiated in 2000.

In all, these programmes provided the continuation of post graduate training to allow any GP to upgrade himself. The choice of the climb to further education can either be the more gradual gradient through the GDFM or the steeper climb to reach the MMed.

A/Prof Goh emphasized that the tripartite, cooperative relationship involving the Ministry of Health, College of Family Physicians Singapore and the National University of Singapore, form the basis for success of the programmes. Besides vocational training, the programmes also provide the avenue to develop the profession, as well as leadership abilities and encourage Family Physicians to assume the teacher and researcher roles.

The College's MCFP and FCFP programmes cater for such professional development. The Family Medicine Skills courses provide an alternative source, whereby the skills of the practitioners can be honed, hopefully to perfection. A/Prof Goh next touched on the vision of Primary Health Care in Singapore whereby all players from user to the provider, can be on the same wavelength and agree to come to terms with clinical quality in three areas, viz:

1. Chronic illnesses
2. Prevention of diseases and
3. Care of the Elderly

He spoke of the roles that the doctor can play eg. as a trainee, the doctor need to be committed to improve himself professionally and also acquire the skills of adult, reflective and lifelong learning.

As a trainer, the doctor has to be a role model, to motivate his trainees, disseminating knowledge and passing on skills to them. He also has to be a researcher in order to be a well rounded Family Physician.

Induction of Trainees and Teacher's Award 2005:
Next in the agenda was the induction of the trainees and presentation of the Teachers' award 2005.

This year's Teachers' awards went to :

1. Dr Chin Swee Aun
2. Dr Colin Ngeow
3. Dr Koh Choon Huat Gerald
4. Dr Koh Kheng Keah Philip
5. Dr Kwong Kum Hoong
6. Dr Lim Mien Choo Ruth
7. Dr Pang Sze Kang Jonathan
8. Dr Tan Ngiap Chuan
9. Dr Theng Thiam Seng Colin
10. Dr Wong Tack Keong Michael

Lastly, the new tutors for this batch of GDFM trainees were appointed, a total of 17 of them. ■

Report on the 34th CFPS Annual General Meeting

25 June 2005, College of Medicine Building Auditorium

By Dr Jeff Tay, MCFP & Editorial Board Member

President's Address

A/Prof Cheong Pak Yean informed the house that the response to the memorandum submitted by the College in June 2004 to the Ministry of Health(MOH) is positive. The Ministry would soon embark on an exercise to consult all the stakeholders as to what the minimum standard of vocational training should be for the proposed Family Physicians(FP) Register. There was also in-principle agreement that national committees should be formed to monitor and regulate standards and training, in parallel with those formed for the Specialists Register. The College would need to review its constitution in the light of these developments.

3 important areas to be looked into were:
a) Membership categories – in line with the criteria-based FP Register,
b) Election & selection of leaders, and
c)Governance of the College – a professional association & training centre.

ANNUAL REPORT OF THE 19th COUNCIL FOR THE YEAR ENDED 31 MAR '05

The College's activities reflected the need for quality of care and transforming primary care.

Academic Programmes

Dr Lee Kheng Hock remarked that 120 doctors were admitted into the 2005 **Graduate Diploma of Family Medicine (GDFM) programme.** In the GDFM exam(4th intake) conducted on 17 & 18 Jul '04, 50 out of the 59 candidates passed. That showed that whilst the GDFM exam was a reasonable and achievable assessment, it could identify candidates who had not met the required standard.

For the year 2004, 6 members of the College were awarded the **MCFP(S)**, the **Collegiate Membership** of the CFPS. The **Fellowship Award(FCFPS)** by assessment, deemed the highest academic qualification for FPs in Singapore, was conferred to 12 successful doctors of the 4th cohort.

Newly launched at the 2004 Commencement, **College Professional Development Programme(CPDP)** that leads to **MCFP(S) by Assessment** was to upgrade existing criteria for award of the Collegiate membership and to bring it in line with international standards and the global trend of award by objective assessment.

The **Institute of Family Medicine** was formed to develop the academic and training programmes of the College. There are plans to appoint doctors as part-time (adjunct) teachers, in a bid to further improve the quality of the training materials.

Continuing Professional Development Activities

The minimum **Continuing Medical Education (CME)** point requirements for family medicine has remained unchanged. The College was represented in the Singapore Medical Council CME Co-ordinating Committee to ensure that the quality of the CME events was acceptable. To date, doctors have earned a total of 2,085 CME points through the **E-learning website**, launched in 2003. The College's highly popular **Family Practice Skills Courses (FPSC)** allow healthy interaction between FPs and leading specialists.

College Activities

The annual **convocation** and dinner were held at the College of Medicine Building on the 30 Oct '04, with the Guest of Honour, Mr Khaw Boon Wan, Minister for Health. Clinical Professor Chee Yam Cheng gave the Sreenivasan Oration, "Family Practice of the 21st Century – Computers, Changes & Challenges". The next convocation was planned for 1st Oct '05.

A delegation of 13 College doctors (various doctors from the healthcare industry in Singapore) visited the **University of Glasgow, Scotland**, at the invitation of their Department of Postgraduate Education(20-27 Mar '04). The primary care system in Scotland, managed by the National Health Service, was scrutinised in a bid to improve primary care in Singapore. The Scottish faculty had organised a course on "Quality Assurance & Professional Development in Primary Care".

On 15 May 2004, a seminar on "**Transforming Primary Care**", was well attended by stakeholders in primary care and members of the family medicine fraternity. The Guest of Honour was Prof K Satkunanantham, Director of Medical Services, who reiterated that transforming primary care was one of the eight key priorities of the MOH. He also outlined his vision of a better primary care system in Singapore. The seminar covered the following:

- Comparative role & status to GPs in Glasgow and Singapore,
- Quality assurance through audit & significant event analysis,
- Training & education in family medicine,
- Improving service delivery, and
- Drawing lessons from the study visit to Scotland.

There was consensus by the doctors present, that there was a need to focus on quality of care, and not just quantity of care.

The **Commencement of the Academic Year 2004** was held on the 26 June 2004, at the College of Medicine Building Auditorium. Prof John Wong, Dean of the Faculty of Medicine was the Guest of Honour. The MCFP(S) by Assessment Programme was launched, as part of the Commencement Program.

Dr Ryuki Kassai, the Director and Chair of the Hokkaido Centre for Family Medicine visited the College on 13 & 14 July 2004. He gave 2 lectures "Family Medicine in Japan: Development & challenges in training, practice and quality assurance" and "Beyond Facts & Psychomotor Skills: New methods in teaching family medicine".

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The College had the pleasure of inviting distinguished guests, **Dr Douglas Murphy** (Associate Advisor, Vocational Training for Family Practice, NHS Education for Scotland) and **Dr Rodney Nan Tie** (Senior Lecturer and Trainer, School of Medicine, James Cook University, Australia) in Aug '04, as external trainers of the MMed (FM) course 2004. They also gave a talk on "Quality Improvement in General Practice", enlarging our perspective on quality improvement efforts in Scotland, UK and Australia respectively.

Associate Professor Steve Trumble, Director of Education at the University of Melbourne, was also invited as the external examiner of the Fellowship by Assessment in Sept '04. The Practice and Quality Special Interest Group took the opportunity to invite A/Prof Trumble to talk on "Training for Quality".

The **WONCA World Conference 2004** was held in Orlando, Florida(13-17 Oct '04). The College delegation, comprising of 10 members from WONCA 2007 Host Organising Committee(HOC), was there to establish networks with academics and potential sponsors of the next conference in Jul '07, to be held in Singapore.

Dr Moya Kelly, Assistant Director of NHS Education for Scotland, was invited by the College as the external examiner of the MMed (FM) Examination 2004 in Oct '04. She gave a talk on "Rewards for Quality Clinical Practice".

The proposal to make the GDFM the minimum required vocational standard had previously been endorsed at the AGM 2004. In response to the concerns about problems in implementation and operation, the College conducted a series of **focus group discussions** with doctors who had experienced vocational training (GDFM, MMed(FM), MCFP & FCFP). **3 main areas of concern** were highlighted:

1. Training Structure – The need to create a pool of trainers, mentors, examiners and other resources,
2. Family Medicine Register – Such a register would probably be created, should be inclusive and should not threaten the livelihood of practising doctors, and
3. The Value of Training – Whilst further training would improve care and professionalism, the value of such training was not recognised by policy makers and payors of health services.

The College held a dialogue cum seminar titled, "**Transforming Primary Care – A Grassroots' Perspective**" with rank and file members on 15 Jan '05. A capacity crowd of more than 100 doctors attended the session, where invited speakers from the public and private sector gave their views.

The College's Censor-in-chief, A/Prof Goh Lee Gan took the opportunity to emphasise that attaining the GDFM was the first-step to getting the MMed (FM). Whilst the MMed (FM) provided academic & vocational training, membership with the College provided professional development.

Was the course fee for the GDFM programme considered very expensive? Dr Lee Kheng Hock argued that whilst the GDFM costs between $3,500 to 3,900 (depending on College membership) for the 2-year course, it paled in comparison to the oversubscribed Dip. Dermatology course's $6,000 for 6-month course! An MBA course in a reputed college could cost as much as $200,000. Moreover, the GDFM was presently not perceived to add-on value i.e. improve returns. A/Prof Cheong agreed with Dr Lee, and that in years to come, the fee of the GDFM Programme would likely go up.

ACTIVITIES OF THE STANDING COMMITTEES

Report of the WONCA 2007 Host Organising Committee

Dr Tan See Leng, Chairman, Wonca 2007 HOC, urged the assembly to *not only* attend symposiums, but to avail themselves to chair meetings & conferences, and secure sponsorships. It was to be held at Suntec City Convention Centre or Swissotel Hotel(24-27 Jul '07). Dr Alfred Loh, CEO of Wonca Asia-Pacific, requested to maintain the high standards for selection of scientific papers. He made an impassioned plea for College doctors, with vocational and professional qualifications, to help vet and score papers from the international delegates.

Report of the Finance Committee

Dr Yii Hee Seng, Chairman of the Finance Committee, commented that College's finances remained healthy. The income in 2004 had dropped, due to oversubscriptions received and lower subscription for CME programmes. Costs have been kept prudently low and surpluses could be maintained. The income/expenditure from WONCA 2007 will deferred until after the event was over. Some members who have paid their membership in advance will have it reflected in last year's income, rather than this year. The Finance Committee plan to go into accrual-based accounting to address that anomaly.

Acknowledgements

Finally, the College expressed its appreciation to all College members for their commitment to improving the standards of family medicine in Singapore. The moral support of the Ministry of Health in the College's activities was also acknowledged. Sponsorship, funding and goodwill from Friends of the College enabled the programmes to continue, despite scarce resources. The College Secretariat was applauded for their dedication and professionalism in carrying out their duties.

The AGM duly elected the 20th Council members of the CFPS.(See Pg 12&13)

The AGM nominated Dr Chan Nang Fong and Dr Lau Hong Choon for the **Albert & Mary Lim award** for their contributions to the Council.

Any Other Business

The Council would review Dr Lawrence Ng's concern on the MOH imposed restriction on prescription(s) for insomnia not exceeding 2 weeks, as some GPs may have inadvertently breached it without realising it. ■

Primary Care Survey 2005

The Primary Care Survey (PCS) was undertaken to compare updated utility data of primary healthcare practices such as workload, working hours and determine private and public sector market shares in primary medical care provision. The survey also aims to gather the biographical profile and a one-day morbidity profile of patients seeking primary medical care from both sectors in Singapore. A primary healthcare establishment characteristics survey was also planned in the coming PCS 2005. This is the fourth survey in its series, the earlier three having been carried out in 1988, 1993 and 2001 respectively. The Ministry of Health (MOH) shall conduct the PCS 2005 on the 14th September 2005.

The survey questionnaire shall be sent out to a randomly selected sample population of approximately one third of the 1500 private primary health outpatient practice, and also to all polyclinics. The latter comprise the polyclinics under the two health clusters in Singapore, namely the Singapore Health Services Polyclinics (SHP) and National Healthcare Group Polyclinics (NHGP). Subjects shall consist of all patients who sought treatment at the private primary health outpatient practice and polyclinics on the survey day.

Dr Michael Yee

The College Mirror caught up with the College representative of the Advisory Committee, Dr Michael Yee Jenn Jet, to the MOH PCS 2005 project.

CM: Why is the PCS such an important survey?

Dr Yee: PCS 2001 showed that the average daily patient-load of a family doctor in private practice was 33 patients per day, lower than the 40 patients a day recorded in 1993. Family doctors in private practice provided 83.4 percent of patient load. Singaporeans made approximately 4.4 visits to a family doctor in 2001, which was lower than the 5.0 visits ascertained in 1993. Chronic medical conditions increased from 29.2 percent in 1993 to 34.3 percent in 2001. The average workload for each family doctor in private practice had dropped from 40 to 33 patients a day between 1993 and 2001. There had been a notable growth in family doctors working in the private sector over that period.

These figures are certainly of immense value to the family physician, their primary healthcare establishments as well as the health authorities in planning health services. It is therefore in the interest of all concerned parties that the coming PCS be carried out conscientiously.

CM: How do you feel about your appointment to the advisory group of the PCS 2005?

Dr Yee: It is a great privilege to have had the opportunity to participate as a member of the advisory group to the Ministry of Health for the PCS 2005. The survey is of immeasurable value to many family physicians who have been struggling with many aspects their practices that have been impacted in one way or another by seemingly senseless policies. The results of the previous survey gave us a small window into the big picture, which till the survey results was published, no one had. I therefore cherish the chance to be able to influence the project intimately and hopefully make a positive contribution.

CM: What are the potential problems of the PCS 2005?

Dr Yee: The response rate to the 2001 survey from family doctors in private practice was 36 percent. Owing to the structured administrative organisation of the polyclinics, all returns were completed and submitted to the respective headquarters. Response from the community-based pediatricians was so poor that their findings were omitted in the survey analysis. Although the response rate did not deviate far from norms of similarly designed studies, the external validity of the data was nonetheless hampered by the low response rate. The aim is to obtain at least 70% response rate.

In preparation for the survey, the family physicians themselves have also been involved at the planning stage to gauge the feelings and obtain feedback to improve the methodology and parameters studied, in a forum organised jointly by the MOH and the newly formed Research SIG of the College of Family Physicians. These drastic measures reflect the renewed importance the current leadership has placed on primary care.

CM: What is the difference between the PCS 2005 and previous surveys?

Dr Yee: The PCS project has reached a crossroad. For one, the MOH now conducts the survey. Previous surveys were headed by the NHGP, which, by nature of its structure, was more akin to a well, executed audit with the private sector as a comparator. In addition, tender for commercial research services have also been called and research assistants shall be paying a visit to all chosen healthcare establishments that have not returned voluntarily.

For those doctors who feel it is too much trouble to fill in the survey forms, the research assistants shall fill it in on their behalf at the clinic premise. The expected increase in return rates would improve the

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reliability of the results. We are encouraged that the MOH has taken leadership in the conduct of the PCS and have obviously invested much interest in it.

CM: How is confidentiality assured?
Dr Yee: There can be no absolute confidentiality in a health service survey. I am however satisfied that careful consideration has been given to preserve medical confidentiality as far as possible. The clinics are coded to avoid direct identification with the primary healthcare establishment. The codes are known only to the statisticians. Coding is nonetheless necessary for retrieval and reminder purposes.

No patient names or identification information shall be collected; hence information cannot be linked to the patients. Patient's postal codes are to be collected as a surrogate marker for the socioeconomic level of the subject instead of the address proper. The statisticians shall replace postal codes of landed houses and other houses, where postal codes can be traced to the individual dwellings, with a predetermined code before handing the data to the primary investigators.

Eventually, we would have to place our trust in the people holding office at a reputable State ordained institution, to use the information obtained ethically. From what I have observed, I am confident that the honest people in charge have both feet firmly planted on the ground.

CM: Can GPs clarify their doubts?
Dr Yee: Yes. The MOH shall be setting up a hotline and a webpage to clarify any doubts that the GPs might face, participating in the survey.

CM: Do you have any parting words for Family Physicians?
Dr Yee: The health authorities have shown that they are concerned about primary care and have taken efforts to study it in depth. It is with bated anticipation that we look forward to the results of this coming PCS 2005. The ball is now in the court of the primary care community to actively participate to make the PCS 2005 a resounding success. ■

"Family Practice/General Practice as a Global Standard."

Wonca Asia Pacific 2005 Regional Conference, Kyoto, Japan(27 May - 31 Jun 2005)

"Kagami Biraki", the breaking open of a Taru (sake barrel) lid with a hammer signifies the start of a special occasion and also signifies a new beginning. The splashing forth of the sake brings good luck and blessings to all at the occasion. Dr Tan See Leng was honored by our Japanese hosts to part take in this ceremony at the opening of the Kyoto conference.

A steady stream of delegates visited our booth at the Kyoto conference. A great deal of interest in the WONCA 2007 world conference was generated in Kyoto.

The Wonca 2007 HOC sent a team of 7 delegates to the Kyoto Wonca Asia Pacific Conference to promote the world event here in Singapore in 2007. There was a record turnout of some 1800 delegates comprising 1300 local and some 500 international participants. The Chairman, Dr Tan See Leng presented the host organizing committee updates to the Wonca Executive Committee and also made a speech at the cultural night highlighting Singapore's convention and exhibition facilities, the scientific program as well as social and cultural events to attract Japanese and other international delegates to participate in the Wonca 2007 world conference.

The cultural night was well attended and almost all delegates turned up for the event. The entire HOC attended the night in full red Batik motifs and created a lot of fanfare and interest amongst the delegates about Singapore. The exhibition however, was not particularly fruitful as most of the exhibitors came from within Japan and although expressing interest in our event, have also stated that it would be quite unlikely for them to participate as exhibitors in Singapore as most of their products were only marketed domestically.

The HOC also learnt a lot from the Japanese hosts in terms of their efficiencies and detailed attention to all event proceedings. Everything went like clockwork and the HOC benefited tremendously from this experience.

Dr Lee Kheng Hock presenting findings of his study on chronic disease management to a group of enthusiastic Japanese delegates.

At the cultural night - (Top L-R): Dr Chng Woei, Dr Wong Weng Hong, A/Prof Goh Lee Gan, Dr Tan See Leng, Dr Alfred Loh & Dr Lee Kheng Hock (Bottom L-R): Dr Matthew Ng, Dr Wong Chiang Yin & Dr Lim Fong Seng proposing a toast (with sake) to the future success of the WONCA 2007 World Conference which will be held in Singapore.

Our President A/Prof Cheong Pak Yean was at the conference to deliver a keynote lecture on depression. He took this opportunity to visit our booth and gave encouragement to Dr Chng Woei who worked very hard getting our booth ship shape.

"There are three priorities for the College in the next 2 years viz. consolidating the training programmes in tandem with the Family Physicians Register to be introduced, gearing up to host the 2007 WONCA World Conference and restructuring the Constitution of the College to make it more relevant"

Associate Professor Cheong Pak Yean,
President

"The three key tasks ahead are to work with (1) President & Council to improve the environment family doctors practice in; (2) WONCA Host-Organising Committee towards a successful world conference for July 2007; and (3) Executive Director to keep the Institute of Family Medicine and the College Secretariat in top form."

Vice President
Associate Professor Goh Lee Gan

"I graduated in 1973 and am a solo general practioner since 1979. I am a council member since 2003 and a member of Transplant Ethics Committee since 2005. I look forward to serving the College in her efforts to enhance the cause of family medicine. The vocational potential of family medicine is well known. However much work needs to be done to bring them into fruition."

Dr Cheng Heng Lee, Honorary Secretary

"I have been in the College Council since 1992. It has been a challenging but meaningful journey. We all know that the practice environment is changing and our colleagues are all going through difficult times. There are concerns that the status and the respect for family doctors in Singapore are being eroded. If we cry, we may get pity. If we scold, we create resentment. If we want respect, we must work to regain what was lost. I hope the College can be the common platform for all family doctors from different clusters and sectors, to work together in this area. If we can prove that we are competent and caring we will regain the confidence and respect from the public, our peers, the press and the policy makers. In my opinion, the role of the College is to make this happen."

Dr Lee Kheng Hock, Censor-in-chief

"I've been a family physician in private practice for 28 years & the College Council for 18 years. I still meet every new day in my practice with great enthusiasm & interest, and I do feel the same excitement with the new College Council, to be working and interacting with new personalities in new roles. I've served as Hon. Secretary for 3 terms, with the Treasury post for 2 terms in between. Hence, after another 3 terms as Vice President, it's interesting to land myself into the Treasury again.

Council has always been very prudent with its financial policies and we do try to make every penny work its full worth. This term will be interesting in that, as we work towards WONCA SINGAPORE 2007, there will be a need for forward financial planning to cater for expenses of unprecedented scale, to meet up with the ambitious programmes on the drawing board."

Dr Arthur Tan Chin Lock
Honorary Treasurer

"I graduated from NUS in 1988. Obtained the Degree of Master of Medicine Family Medicine in 1998, Graduate Diploma Occupational Medicine in 2000, MCFPS in 2001 FCFPS by assessment in 2002. I have been in the Council of the College of Family Physicians Singapore for the past 6 years. The first two years I was holding the portfolio of Chairman of the now defunct Practice Management Committee and for the last 4 years as the Editor of the Singapore Family Physician Journal. I am also the Deputy Director of the GDFM course for the past 5 years since its inception in the year 2000. The last few years in the College has been a challenge because of the conflict it created with work. However all these sacrifices have been worthwhile as all the "brain food " that I have gained has more than make for all the loss."

Dr Matthew Ng Joo Ming, Honorary Editor

ıncil (2005-2007)

"After graduating in 1986, I spent several years working in the SAF and MOH before joining the private sector in a group practice in 1990, and completed the MCFP exams in 1992.

The College had been instrumental in establishing standards for Family Medicine in Singapore and has raised the stature of Family Physicians in the process. The Continuing Medical Education programs conducted by the college are well structured and organised, providing many avenues for the busy family physician to meet his professional obligations to upgrade himself. We should be proud of such programs, which is among the best available in Singapore today. We seek the support of the College membership to continue this process of continuous training and upgrading as family medicine is as much a rapidly advancing science, and an art. "

Dr Yii Hee Seng, Council Member

"I graduated in 1988 and have been in private practice since 1992. I started working for a group practice initially but later started my own clinic with my wife. I have been in the council since 2003 and have learnt to appreciate some of the things that the council tries to do for family physicians in Singapore.

I have and will attempt to continue to provide a link and feedback channel between those in the council and those that we represent i.e. the practicing physicians out there. I hope to raise the awareness of practicing issues and encourage more family physicians to upgrade and equip themselves with new skills and engage their patients and provide better value added services to their patients."

Dr Pang Sze Kang Jonathan, Council Member

"I've been a council member for the past 3 terms & this is my 4th term in the council. I graduated in 1988 from NUS and have been a family physician in private practice till September 2004.

Being in the college council for these many years has taught me the significance of working behind the scenes for the enhancement of the academic programs for the empowerment of the family doctor. I also won the bid for the college to host the 2007 Wonca World Conference in Singapore(24-28 July 2007) & will be looking forward to putting Singapore's family medicine program & its community on the world map. I am also the 2nd Vice President of the Singapore Medical Association."

Dr Tan See Leng, Council Member

"I graduated in 1988 and subsequently obtained training in Family Medicine. Currently, I am practising in a little corner of HDB heartland with a polyclinic, but I would count my most challenging assignment as that of bringing up two nearly-there teenagers and an adolescent dog. I credit my surprise appearance in the College council to a regrettable inability to say no to old friends."

Dr Ong Chooi Peng, Council Member

"I am currently working in Primary Care Branch in Ministry of Health. Although my work is 80% administrative and 20% clinical, I am fundamentally Family Physician at heart. I hope to work together with everyone in the next 2 years to bring Family Medicine to greater heights."

Dr Ho Han Kwee, Council Member

"I graduated in 1990 and obtained my Master of Medicine in Family Medicine in 1997. I am currently the Director of Medical Affairs of the National Healthcare Group Polyclinics. It was an eye-opener to serve in the previous council and certainly a good learning experience for me. It is encouraging to see Famly Medicine moving forward and making good progress and I hope to be able to contribute to this whole process."

Dr Lim Fong Seng, Council Member

"I graduated in 1992. I am a family physician in private practice and also the managing director of my group practice.

Prior to being elected, I was serving as Vice Chairman of the College's Practice and Quality SIG. I have also been a Council member of SMA for several years. The College has contributed significantly to the training and professional development of family physicians in Singapore. It is a privilege for me to serve in the new College Council."

Dr Tham Tat Yean, Council Member

Application for Fellowship by Assessment 2005

PROGRAMME OVERVIEW

The objective of the Family Medicine Fellowship Programme of the College of Family Physicians, Singapore is to provide advanced training in family medicine with the view to develop family physicians who at the end of the process would be equipped to take on leadership roles in the teaching, research and practice of family medicine in Singapore.

On satisfactory completion of the two-year programme, the Fellowship Trainee will be awarded the *Fellow of the College of Family Physicians, Singapore (FCFPS).*

ELIGIBILITY

The following are entry requirements:

- Collegiate Membership of the College of Family Physicians Singapore
- Possess the M.Med (Family Medicine) or the MCGP (Singapore) or equivalent qualifications; the acceptance of the equivalent qualifications has to be approved by the Censors' Board.
- Has embarked on personal professional development, and training related to family medicine.
- Is actively involved in postgraduate training and undergraduate education in family medicine.
- Is in active clinical practice.
- Is of sound professional and personal character.

The registration fee for the FM Fellowship Programme is S$2800 (excludes the short skills courses) for the two years. Eligible candidates are invited to apply for the training programme. The number of vacancy for this programme is very limited. Only applicants who are eligible will be invited to attend a selection interview.

REGISTER NOW

Course syllabus and application forms are available at the College Secretariat. They are also available at website at www.cfps.org.sg.

Closing date has been extended to 26th August 2005.

Congratulations to the following doctors who have passed the GDFM Examinations.

2005

Dr Aung Thein
Dr Aung Gyi
Dr Chang Wan Ern
Dr Cheng Geok Min, Ruby
Dr Chiam Yih Hsing
Dr Choo Chin Yeng
Dr Chua Sing Hue Eunice
Dr Chuah Chin Khang
Dr Cindy How Chwee Chwee
Dr Dang Simrit Kaur
Dr Dharshini Puvanendran
Dr Hor Oi Lin
Dr Kao Wei Hsing
Dr Kay Aih Boon Erwin
Dr Khi Yue Ling Audrey
Dr Lai Kok Wei
Dr Lau Teh Yee
Dr Lee Eng Sing
Dr Lee Wen Yan
Dr Lee Yah Leng
Dr Leong Tyng Tyng
Dr Lim Bee Ling Tina
Dr Lim Pui San
Dr Loh Seow Faan
Dr Loh Su Lin, Jennifer
Dr Low Jin Kheng
Dr Mah Tuck Cheong
Dr Ng Shu Ping, Linda
Dr Nirmala Kandasamy
Dr Nyi Nyi Tun
Dr Ong Kok Kiong
Dr Poh Chern Loong Andy
Dr Quratulain Tahira Zuberi
Dr Say Jia Huey
Dr Seah Chee Yong
Dr Tan Chin Beng Melvyn
Dr Tan Peng Wee
Dr Tan Teck Shi
Dr Tay Peng Leng
Dr Tiah Seow Hwee, Jane
Dr Tong Weng Kay Danny
Dr Wang Joon Leong

Review on Herbal Medicine

By Dr Gabriel Seow, MCFP & Editorial Board Member

Introduction

According to the World Health Organization, as many as 80% of the world's people rely for their primary healthcare on traditional medicine, most types of which use remedies made from plants. The global market for herbal medicines currently stands at over US $60 billion annually and is growing steadily.

3 Differences from Conventional Drug Use

1.Use of whole plants: unpurified plant extracts for synergistic and buffering properties
2.Herb combining: combination improves efficacy and reduces adverse effects
3.Diagnosis: different diagnostic principles

3 Problems

1. Safety: Many plants are highly toxic and also present a greater risk of adverse effects and interactions than any other complementary therapy. Herbal remedy without demonstrated efficacy may compromise, delay or replace an effective form of conventional treatment. Embryotoxic and carcinogenic effects are likely to remain unrecognized in traditional settings.

2. Quality: if an herbal therapy is effective, quality assurance is needed to ensure that the product has the expected effects and do not contain adulterants or contaminants. Standardization of herbal remedies can be difficult because herbs contain complex mixtures and the constituents responsible for the claimed effects are often unknown.

3. Efficacy: Only a small fraction of the thousands of medicinal plants used worldwide has been tested rigorously in RCT's. Positive findings from trials should not be accepted without considering the methods used and the quality of the data.

In Practice

Increasingly, more patients are taking herbal medications either as a health supplement or as treatment for their ailments. Many patients have already tried some form of "OTC" herbs before consulting a physician. The problem is that they do not consider herbs as a form

Table 1

Herb	Uses	RCT evidence	Conventional drug	Potential problem
Echinacea	Prevention & treatment of common cold	Lack of properly designed trials. Data inconclusive	Steroids, methtrexate, ketoconazole, amiodarone	Hepatotoxicity
Evening Primrose oil	Pre-menstrual syndrome	The 2 best -controlled trials fail to show benefit	Anti-convulsants	Lowered seizure thresholds
Gingko leaf	Dementia, tinnitus, intermittent claudication	Superior to placebo, with caveats	Warfarin, asprin	Altered bleeding time
Ginseng	Various indications	Efficacy is unclear for each indication. RCT's needed	Phenelzine, estrogens, corticosteroids, oral hypoglycemics; digoxin	Headache, manic episodes, tremors, additive effects with steroids; impaired glucose tolerance; alters digoxin Pd
Ginger root	Nausea & vomitting	Promising data, but more rigorous trials needed	Warfarin, asprin	Altered bleeding time
Garlic	Hypercholesterolemia	RCT's: small short term benefits on lipid & anti-platelet properties	Warfarin, asprin	Altered bleeding time
St John's wort	Depressive disorders	Superior to placebo in mild to moderate depression	MAOIs, SSRIs	Insufficient safety data with concomitant use. Do not combine
Hawthorn leaf	Heart failure	Improvement in cardiac performance & symptoms in mild CHF	Digoxin	Interference with pharmacodynamics, monitor digoxin levels
Feverfew leaf	Migraine prophylaxis	Superior to placebo, with caveats	NSAIDs; warfarin	NSAIDs inhibits feverfew; altered bleeding time
Valerian root	Insomnia	Inconclusive data	Barbiturates	Additive effects

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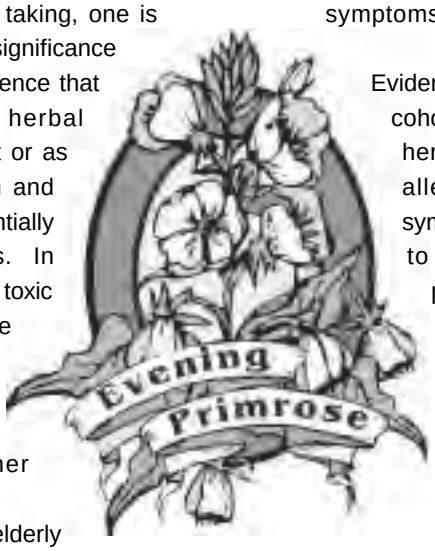
of medication, so that unless specifically sought for during history taking, one is likely to overlook it. Its significance lies in the increasing evidence that many of the common herbal remedies are not as inert or as innocuous as they seem and may actually result in potentially serious drug interactions. In fact, many plants are highly toxic and herbal medicine probably presents a greater risk of adverse effects and interactions than any other complementary therapy. This is particularly true in elderly patients with chronic cardiovascular disease as many common herbs alter bleeding time (garlic, ginger, ginseng, gingko) and interact with conventional cardiac medications (digoxin, diuretics, anti-arrythmics).



Another consideration is that practitioners of herbal medicine tend to concentrate on treating chronic conditions typically : asthma, eczema, pre-menstrual syndrome, rheumatoid arthritis, migraine, chronic fatigue, etc. It is prudent to anticipate the use of herbs when such groups of patients seek consultation.

Hence, it is to add to the GP's scope of knowledge some of the more common and more dangerous interactions. The following will be relevant in most practices:(Refer to Table 1)

For Menopausal symptoms

This deserves a special mention as herbal medicinal products are particularly popular with women aged 40 to 50 years as these are very often used to alleviate the symptoms associated with menopause, especially as more women become wary of the risk of HRT.

There is a lack of reliable evidence for herbal medicines nd phyto-oestrogens as treatment for menopausal symptoms. However, it cannot be concluded that they have been shown to be ineffective. From the reviews of recent RCT's, the most encouraging data are from soy extracts, which seem to reduce hot fluhes without affecting other oestrogen-mediated symptoms.

Evidence emerging for black cohosh suggests that this herb may have value in alleviating menopausal symptoms. Kava appears to reduce some of the psychological problems associate with menopause. None of these treatments is devoid of risks, but for soy extracts, black cohosh and kava, the benefits may outweigh the risks. Thus these treatments may b recommended to women, provided they are used under supervisionby healthcare professionals with sufficient knowledge of both conventional medicine and phytotherapy. (Refer to Table 2)

Conclusion

With increasing recognition and acceptance of traditional herbal remedies as alternatives, the burden is on the GP to keep abreast not only in his field of specialty but, for the sake of his patients, alternative medicine as well. ■

Table 2

Herb	RCT Evidence	Problems
Black Cohosh -flavinoids -phytosterols	Effective in alleviating neurovegetative & anxiety sympmtoms; increasing vaginal epithelium	- CI in E2 dependent-tumors, depression, lactation, pregnancy - Interacts with anti-hypertensives
Dong Quai - vasoactive agent	No significant effect in menopausal symptoms or vaginal epithelium	- CI in lactation & pregnancy - Bleeding, fever & photosensitivity - Interacts with anti-coagulants
Evening primrose - gammalinoleic acid	No significant effect in menopausal symptoms	- CI in lactation, pregnancy, mania & epilepsy - Interacts with anti-inflammatories, B-lockers, anti-psychotics & anti-coagulants
Ginseng -anti-inflammatory -immunomodulatory	No significant effect on menopausal symptoms or vaginal epithelium	- CI in lactation, pregnancy - Caution in hypertension, CCF,DM, depression - Interacts with anti-coagulants, MAOIs & OHAs
Kava -anxiolytic -sedative	Significant improvement in neurovegetative & psychosomatic dysfunction in menopause	- CI in lactation, pregnancy & depression - Hepatotoxicity - Interacts with CNS drugs
Red clover -flavinoids & isoflavinoids -coumarin	Conflicting results	- CI in pregnancy, lactation, bleeding diathesis - Interacts with anti-coagulant, HRT, OCPs
Phyto-oestrogens -isoflavinoids -oestrogenic	Significant improvement in vasomotor symptoms & vaginal dryness but not other menopausal symptoms	- Generally safe. - Should avoid in pregnancy, lactation, E2-dependent tumors & bleeding diathesis - Theoretical interaction with anti-coagulants & hormonal therapies

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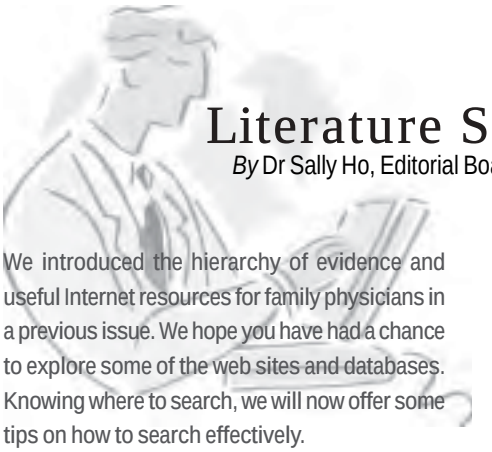

Literature Search - Clever Searching

By Dr Sally Ho, Editorial Board Member

We introduced the hierarchy of evidence and useful Internet resources for family physicians in a previous issue. We hope you have had a chance to explore some of the web sites and databases. Knowing where to search, we will now offer some tips on how to search effectively.

INTRODUCTION

With the explosion of medical information, the retrieval of the best clinical evidence from large, general purpose, bibliographic databases can be difficult. PubMed, one of the commonly searched databases, which includes MEDLINE and other life science journals, contains greater than 15 million citations from more than 4800 journals published in over 70 countries. It is a common experience to retrieve many more articles than one has time to sift through, let alone read. Simple searching with single keywords will generate some relevant articles and many irrelevant ones. This article aims to offer a few tips on:

1. Generating sensible questions.
2. Developing search strategies.
3. Evaluating a search

GENERATING SENSIBLE QUESTIONS

Before a search, one must be clear about what information one seeks. Having just prescribed amoxicillin-clavulanate for a child with acute otitis media, I wondered if it was the best evidence-based treatment. To conduct a literature search, which of the following would be a sensible question to ask?

1. What is the best treatment for acute otitis media (AOM)?
2. What is the most appropriate antibiotic for treatment of AOM?
3. What is the difference between treatment with amoxicillin/clavulanate and amoxicillin for AOM?

A sensible question should be
• Focussed • Answerable • Applicable
Question 1 may not be sufficiently focussed. I was primarily interested in antimicrobial therapy and not pain relief, non-pharmacological treatment, alternative therapies or other aspects of treatment.

Question 2 is probably the most useful question to find clinically applicable answers.

Question 3 is perhaps too narrow in focus. These 2 antibiotics may not be the best antimicrobials to treat AOM.

DEVELOPING SEARCH STRATEGIES

Having a useful initial question, how does one go about searching? This article will focus on searching PubMed, one of the most commonly searched databases. It can be accessed for free at URL:http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?DB=pubmed. Do note that individual databases may require different search strategies. It is important to be familiar with the search features of any particular database that one intends to use.

See Table 1 for the number of citations retrieved using different search strategies on PubMed. There is a need to balance sensitivity with specificity. It is advisable to start broadly and narrow down if necessary. Different search strategies may be needed to find the information needed.

To narrow down a retrieval, apply specific subheadings, limit to major mesh concepts, combine search terms with the Boolean operator <AND>. On the other hand, select all subheadings, combine synonyms and different search terms with the Boolean operator <OR>, use truncation of a root word <*> and click on related articles so as to increase the number of retrieved hits.

Keyword Search

3 keywords can be identified from the question "what is the most appropriate antibiotic for treatment of AOM?":
•Antibiotic •Treatment •Acute otitis media

Boolean Operators

AND (intersection) - Only citations that contain all terms connected by AND will be retrieved.
OR (union) - Citations that contain any of the terms connected by OR will be retrieved.
NOT (exclusion) - Citations with the selected term will be excluded.

Boolean operators must be entered in UPPERCASE and are operated in a left-to-right sequence. Enclosing terms in parentheses, e.g. (antibiotic OR antibiotics) processes it as a unit.

PubMed assumes the Boolean operator AND between terms if none are specified. Note that Ovid requires the entry of Boolean operators between multiple terms or the search may return no citations. Searching <antibiotic acute otitis media treatment> in PubMed retrieved 1681 citations but the same search terms in Ovid's MEDLINE yielded 0 citations. Searching <antibiotic AND acute otitis media AND treatment> by adding Boolean operators, 376 citations were retrieved through Ovid's MEDLINE.

MeSH Terms

Medical Subject Headings (MeSH) is a controlled vocabulary thesaurus developed by the National Library of Medicine to index articles for MEDLINE. MeSH terms are arranged hierarchically by subject categories with more specific terms arranged beneath broader terms. Searching MeSH terms in PubMed automatically includes the terms beneath it. The MeSH Database is available from either the Search pull-down menu or the sidebar. Searching by MeSH terms focuses the search and increases the relevance of articles. However, citations not indexed under the particular MeSH heading may be missed.

The MeSH terms for <antibiotic> and <acute otitis media> are <anti-bacterial agents> and <otitis media>. MeSH terms can be further searched under subheadings, e.g. complications, diagnosis, etiology, pathology, prevention, surgery, therapy, etc. The relevant subheadings here would be <therapeutic use> and <therapy> for <anti-bacterial agents> and <drug therapy> and

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<therapy> for <otitis media>.

Automatic Term Mapping and Phrase Search

PubMed automatically maps keywords typed into the search box without a search tag to relevant indexed PubMed search terms. They are matched in order against the MeSH (Medical Subject Headings) Translation Table, the Journals Translation Table, the Full Author Translation Table and an Author Index. E.g. <antibiotic> is mapped to anti-bacterial agents (MeSH term) and antibiotic (text word). <Acute otitis media> is mapped to otitis media (MeSH term) and it is combined with <acute> to generate the citations.

It is useful for broad searches but may return more articles than desired. One can also conduct an exact phrase search by enclosing the term "acute otitis media" in quotes. It would turn off automatic term mapping and search only articles with the exact phrase. However, that may miss articles e.g. those that cover both acute otitis media and otitis media with effusion and are indexed under the more general term of otitis media.

It would be useful with text words that have associations which are out of context. E.g. if one is interested in the effect of air filters on asthma symptoms, searching <asthma AND air filter> generated 54 articles, out of which 9 were relevant. There were many irrelevant ones on traffic pollution, air pollution and industrial filters. On the other hand, searching <asthma AND "air filter"> returned 10 articles, out of which 6 were relevant.

Search Fields and Search Field Tags

It is possible to search certain words within specific fields by

1. Accessing search fields through the Limits feature. The default being <all fields>.
2. Directly entering search tags within square brackets [ ] in the query box. Boolean operators need to be used in PubMed when searching with field tags.

[all] all Fields
[au] author
[ta] journal title
[la] language
[mh] MeSH term
[pt] publication type
[ti] title
[tw] text words

If I am only interested in English language articles on antibiotic treatment of otitis media published in the BMJ, I may search <antibiotic [tw] AND otitis media [mh] AND bmj [ta] AND eng [la]>.

Truncation

Place an asterisk at the end of a term to search for all terms that begin with that word when searching in PubMed. <Antibiotic*> would retrieve antibiotic, antibiotics, etc. <Smok*> would find all terms that begin with smok, e.g. smoker, smoking, smoked, etc. PubMed searches for the first 600 variations of a truncated term. If a truncated term, e.g., tox*, produces more than 600 variations, PubMed displays a warning message.

Note that truncation turns off automatic term mapping and the automatic explosion of a MeSH term. For example, heart attack* will not map to the MeSH term, myocardial infarction, or include any of the more specific terms, e.g., myocardial stunning, shock, cardiogenic, etc. The equivalent symbol for truncation in Ovid is <$>, e.g. <antibiotic$>.

Wildcard

This is a feature available in Ovid but not in PubMed. The mandated wildcard <#> substitutes for one required character, e.g. <wom#n> searches both <woman> and <women>. The optional wildcard <?> substitute for one or no character, e.g. <colo?r> searches both <color> and <colour>.

Limits

Limits can be applied to narrow a search. Searches in PubMed can be limited by age group, gender, humans or animals studies, language, publication types, dates, and other parameters. It is accessed through the Feature Tabs directly beneath the query box.

From Table 1, it can be seen that a search for <antibiotic AND acute otitis media AND treatment> yielded a total of 1681 citations. As I am interested to find out the latest guidelines on antibiotic therapy for children with acute otitis media, I successively limited the citations to English language articles, those relating to human subjects, children aged 0-18 years, articles published from year 2000 and finally practice guidelines. The number of citations retrieved reduced from 1681, 1332, 1265, 1063, 369 to 3.

To turn off the limits before running the next search, click on the check box to remove the check.

Clinical Queries

This PubMed service can be accessed from the left sidebar.

1. Clinical Queries using Research Methodology Filters

This specialized search query with built-in research methodology filters is intended for clinicians. Five study categories or filters are provided: therapy, diagnosis, etiology, prognosis and clinical prediction guides.

Two emphasis categories or filters are provided

- Broad, sensitive search
- Narrow, specific search

2. Systematic Reviews

This feature is provided to help health professionals locate systematic reviews, meta-analyses, reviews of clinical trials, evidence-based medicine, consensus development conferences, and guidelines.

Related Articles

Each citation in PubMed has a link that will retrieve a pre-calculated set of PubMed citations that are closely related to the selected article. Click on Related Articles to the right of each citation to display the related set of articles. PubMed creates this set by comparing words from the title, abstract, and MeSH terms using a powerful word-weighted algorithm. Citations are displayed in rank order from most to least relevant, with the "linked from" citation displayed first. This can be

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used to expand a search.

Single Citation Matcher

If one has heard a colleague or a speaker mention an article and want to find it, this PubMed service, accessible from the left sidebar, can help. The Single Citation Matcher is a fill-in-the-blank form that allows one to enter partial journal citation information to locate a single citation, or citations from a particular volume or issue of a journal.

Evaluating A Search

The results of a search should be evaluated for

1. Relevance and validity.

Look for the presence of key citations:

- Systematic reviews and meta-analyses.
- Recent published large-scale randomised controlled trials.
- Classic studies.

2. Currency.

- Studies should be up-to-date. Look for data within the last 5 years.

Conclusion

A search can be more effective by having a clearly defined question and by applying appropriate search strategies. To learn more about searching on PubMed, visit the highly recommended animated PubMed online tutorial by the National Library of Medicine. It is available from: URL:http://www.nlm.nih.gov/bsd/pubmed_tutorial/m1001.html. ■

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Table 1. Search performed with PubMed on 16 - 17 July 2005

Search Terms	All Citations Retrieved (Citations of Reviews in Brackets)	Citations Retrived with Setting of the Following Limits (Citations of Reviews in Brackets)					
		English	English Human	English Human All Child: 0-18y	English Human All Child: 0-18y From Year 2000	English Human All Child: 0-18y From Year 2000 Practice Guideline	English Human All Child: 0-18y From Year 2000 Meta-analysis
Antibiotic AND acute otitis media	1776(340)	1405(298)	1319(296)	1110(212)	388(106)	3(1)	6(1)
Antibiotic AND acute otitis media AND treatment	1681(335)	1332(294)	1265(292)	1063(209)	369(105)	3(1)	6(1)
Antibiotic AND "acute otitis media" AND treatment	1164(243)	987(220)	931(220)	807(158)	285(80)	3(1)	6(1)
(Antibiotic OR antibiotics) AND acute otitis media AND treatment	1785(357)	1414(316)	1336(312)	1116(223)	392(113)	3(1)	6(1)
Antibiotic* AND acute otitis media AND treatment	1078(226)	866(199)	808(196)	669(139)	273(71)	1(0)	6(3)
MeSH terms Anti-bacterial agents AND otitis media	1958(404)	1466(338)	1425(335)	1128(254)	376(109)	4(1)	6(1)
MeSH terms Anti-bacterial agents AND otitis media, suppurative	218(44)	154(34)	150(34)	112(22)	33(11)	0	1(0)
MeSH terms Antibacterial agent, subheadings therapeutic use and therapy AND otitis media, subheadings drug therapy and therapy	1662(369)	1253(309)	1226(307)	986(235)	344(102)	4(1)	6(1)
Clinical Queries, Find Systematic Reviews (antibiotic OR antibiotics) AND acute otitis media AND treatment	107(55)	91(45)	90(45)	64(26)	44(22)	3(1)	8(3)
Clinical Queries, Search by Clinical Study Category, therapy, narrow, specific search (Antibiotic OR antibiotics) AND acute otitis media AND treatment	267(6)	254(5)	253(5)	244(3)	63(0)	0	0

By Dr Wee Chee Chau, MCFP & Editor and Dr Jeff Tay, MCFP & Editorial Board Member

1 "It's a dirty job but someone's got to do it."

It is often an unpleasant job to manually disimpact a rectum full of hard stools, a not too uncommon task, for some of us taking care of old patients.

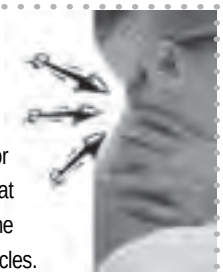
To make the job less unpleasant, the following are some tricks of the trade as taught by Prof Philip Choo, a most experienced Geriatrician.

a) A *small pail of water*, deep enough to immerse the evacuated stools in, will help a lot to minimize the smell.

b) Using *multiple latex surgical gloves*, at least 3 layers, and tying up the evacuated stool which had been invaginated into the glove, at each evacuation. Then donning a new glove for the next effort, repeatedly, may seem a little extravagant but is very effective to eliminate the smell and mess. This technique is also very easily taught to caregivers.

- Professor Philip Choo

2 Pain in the Neck



Muscle energy therapy is an effective treatment for acute torticollis. This relies on the basic principle that the contracting and stretching of muscles leads to the automatic relaxation of agonist and antagonist muscles. Lateral flexion or rotation or a combinations of movements can be used but treatment in rotation is preferred. The direction of contraction can be away from the painful side or towards the painful side whichever is most comfortable for the patient.

Method:

1. Explain the method to the patient and reassure the patient that the procedure is not painful.
2. Rotate the patient's head passively and gently towards the painful side to the limit of pain.
3. Place your hand against the head on the side opposite the painful one.
4. Ask the patient to push the head (in rotation) as firmly as possible against the resistance of your hand. The patient should therefore be producing a strong isometric contraction of the neck in rotation away from the painful side. Your counterforce (towards the painful side) should be firm and moderate but never forceful, and should not break the patient's resistance.
5. After 5 – 10 seconds, ask the patient to relax; then passively stretch the neck gently towards the painful side.
6. The patient will now be able to turn the head a little further towards the painful side.
7. The sequence is then repeated 3 to 5 times until the full range of movement returns.
8. You can ask the patient the next day for another treatment or taught to perform the same procedure at home.

Practice tips – 3rd Edition – John Murtagh

3 " Help! My child swallowed a …"

Swallowing foreign objects are quite common presentations in a Family Practice.
Accurate history is very important to ascertain the culprit material as certain things like 'button' batteries, medications etc may require urgent referral to the emergency department of the nearest hospital.

Hard objects like the following:
- small coins • buttons • sharp objects
- safety pins • glass (eg. ends of thermometers)

Often pass through the stomach naturally.

However, some special cases include:
- very large coins like 50 cent pieces
- hair clips (usually gets stuck at the duodenum if the patient is under 7 years)

Management:
- Conservatively
- Investigate unusual gagging, coughing and retching with X rays of the head, neck (nasopharynx and respiratory tract), thorax and abdomen
- Watch for passage of foreign body in stools (usually 3 days)
- If not passed out in the stools, order an X ray in 1 week
- Blunt foreign object that has been stationary for 1 month without symptoms may need to be removed at laparatomy.

Practice tips – 3rd Edition – John Murtagh

4 Causes of Chronic Cough

- Chronic cough = cough lasting 3 weeks or more
(Viral URTIs causing acute episodes of cough usually settles within 3 weeks)
- Active & passive smoking, in the adult & child respectively, is an important cause of chronic cough, and thus should be asked-for during history taking

Cause	% of Patients	
Postnasal Drip Syndrome (PND)	41	} *account for 80 to*
Asthma	24	} *90% of cases of*
Gastroesophageal Reflux Disease (GERD)	21	} *chronic cough*
Chronic Bronchitis	5	
Bronchiectasis	4	
Miscellaneous	5	

Ref:
1.Irwin RS et al. Chronic Cough. The Spectrum & Frequency of Causes, Key Components of the Diagnostic Evaluation & Outcomes of Specific Therapy. Am Rev Resp Dis 1990; 141: 640-7
2. Irwin RS & JM Madison. The Diagnosis & Treatment of Cough. NEJM Dec 2000; 343(23): 1715-1720

Vaccinations & Prevention of Infectious Diseases

By Dr Stephen Tong, Editorial Board Member

The Vaccinations and Prevention of Infectious Diseases Skills course was conducted on 16 & 17 July 2005 at the auditorium of the Ministry of Health, and it attracted approximately 150 doctors participants. The teaching faculty, comprising members of the College's Expert Panel, gave a comprehensive coverage of the topic.

It is noted that more than 20-50% of individuals report health problems while travelling, and attention to details of prevention is necessary to reduce these illnesses. To assess travellers' risks for a particular journey, primary care physicians must consider both the physical status of the travelers, as well as details of the trip. Advice to the travellers should include recommendations regarding appropriate immunisation, food and water hygiene, insect borne diseases, as well as measures to maintain good general health.

Appropriate immunisations before travel help reduce risks of infectious diseases for individuals, as well as the international spread of diseases. Travel vaccines can be grouped into those that are routine, required and recommended. Considerations for vaccines need to be evidence based, and take into consideration factors like disease epidemiology, environment and host factors, legal requirement, characteristics of the trip, as well as the efficacy and safety of the vaccine.

Early treatment of the returning travellers with illness symptoms is important. Symptoms that should alert the primary care physician to ask for history of recent travel are: fever, diarrhoea, dermatological conditions, and animal bites. Initial evaluation of fever should focus on infections that are life threatening, treatable or transmissible. Careful assessment of travel and exposure history, incubation period, associated signs and symptoms, duration of fever, immunization status, as well as the use of malaria chemoprophylaxis (if any), will help to establish diagnosis and management.

Other vaccines that are of importance besides travel are the influenza and pertussis vaccines.

Influenza in Singapore occurs throughout the year, with seasonal increases, rather than epidemic peaks, occurring from March to May, and around December. The influenza syndrome caused by influenza A & B results in annual epidemics and occasional pandemics. These viral antigens undergo continual changes, termed as antigen drift, and are the reason why the various influenza virus strains incorporated in vaccines are changed annually.

Since September 2003, the Health Promotion Board began a public health education to advise influenza vaccination to travelers visiting countries that had SARS. Subsequently, the Ministry of Health advised that health care workers, elderly patients in chronic care facilities and those with underlying medical conditions be vaccinated against influenza. These recommendations target the following groups for vaccination.

1. Elderly >65years of age. (CDC now recommends that all those above 50 years should receive vaccinations)
2. Residents of nursing and long term care facilities.
3. Adult and children with chronic pulmonary and cardiovascular diseases.
4. Adult and children with renal and metabolic diseases.
5. Children receiving long-term aspirin therapy and therefore are at risk of developing Reye's syndrome if they are infected with influenza.
6. Family members of (1) – (5) as they are at risk of transmitting influenza.
7. Health care workers and allied health personnel.

Pertussis was a common childhood disease in the pre-vaccine era, with an average of 40 cases reported annually in Singapore. With the introduction of the pertussis vaccination into the national program in 1959, the incidence of the disease has reduced to 1 case per year by the late 1990s. The current National Immunisation Schedule for pertusis is at 3, 4, 5 months (primary series) and a booster at 18 months. Vaccine-induced protection lasts about 5-10 years but because of reactogenicity of the older pertussis vaccines, boosters are not given in adults.

Many countries around the world however, have reported resurgence of pertussis, despite immunization, mainly in young infants, teenagers and adults. Infections are thought to occur in teenagers and adults, due to waning of immunity, with transmission of infection to infants who have not been immunised.

With the development of immunogenic but less reactogenic acellular vaccines, boosters may now be considered for adolescence and adults to increase herd immunity.

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College's Expert Panel on Vaccinations & Prevention of Infectious Diseases

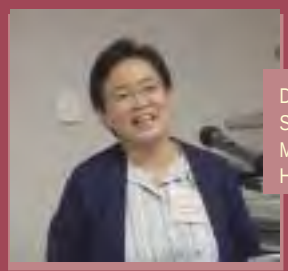
Dr Annelies Wilder-Smith, Head, Travellers' Health & Vaccinations Centre, Tan Tock Seng Hospital

A/Prof Lim Lean Huat, Dept. of Community, Occupational & Family Medicine, National University of Singapore

Dr Wong Sin Yew, Infectious Disease Physician, S Y Wong Medical & Infectious Diseases Clinic, Gleneagles Medical Centre

Dr Anne Goh Eng Kim, Head & Senior Consultant, Respiratory Medicine Services, Dept. of Paediatric Medicine, KK Women's & Children Hospital

A/Prof Lee Bee Wah, The Child & Allergy Clinic, Mount Elizabeth Medical Centre



Dr Helen Oh May-Lin, Senior Consultant, Dept. of Medicine, Changi General Hospital

The Singapore **Childhood Immunisation** Programme offers vaccination against tuberculosis (BCG), hepatits B, diphtheria, pertussis, tetanus (DPT), poliomyelitis, measles, mumps and rubella (MMR). Recent changes to the National Schedules include the omission of the 2nd BCG dose, and the introduction of the 2nd dose of MMR given to primary school leavers.

For immunisation be effective in controlling communicable diseases, at least 80% of the whole population and 80% of the newborns have to be successfully vaccinated. This is the condition for creating herd immunity. Parental concerns on the safety of vaccines need to be addressed and their individual supports of the immunisation programme are essential in the creation of herd immunity. Catch up programmes are required for children who are delayed or missed their immunisation dates.

The most important strategy for the control of **Hepatitis A** is in prevention. Education on good sanitation, personal hygiene, adequate clean water supplies, proper waste disposal, hygiene in food preparation, and vaccinations for at risk individuals (eg travelers to areas where disease is common) are important measures.

Widespread **Hepatitis B** immunisation programmes implemented in more than 100 countries have led to dramatic reduction in the occurrence of chronic HBV infections and hepatocellular carcinoma.

Vaccines are close to 95% effective in preventing HBV infection or clinical hepatitis B. Whether HAV or HBV vaccines provide lifelong protection remains to be determined but it is known that the duration of protection from vaccine-induced immunity appears to be prolonged even if levels of anti-HBs fall below seroprotective threshold over time (anti-HBs of 10mIU/ml or higher are thought to be seroprotective). This persistence of immunity is attributed to immunologic memory.

Documented genetically determined non-responsiveness is believed to be due to absence of a dominant immune response gene that mediates production of anti-HBs. Post vaccination anti-HBs antibody level should be checked in persons with risk factors for a lack of response (age >30years, obesity or immunodeficiency), or those at high risk for exposure to blood or bodily fluids. High-risk non-responders should be revaccinated with three additional doses of vaccines. Persistent non-responders after 2 vaccines series are unlikely to benefit from another vaccine series or switching to another recombinant vaccine. Whether revaccination with currently novel vaccines or the use of more potent adjuvants can circumvent non-responsiveness remains to be determined.

Breakthrough infections in immunized infants of HBV-infected mothers are not common but are of concern. They may be due to mutant HBV viruses that escape the normal anti-HBs protective response. Incorporation of antigens from mutant strains into HBV vaccines could be necessary.

Vaccinations are important in decreasing the mortality and morbidity of vaccine preventable diseases, and the success of the National Immunisation Programs is dependent on the large majority of the cohort adhering to the program. Primary care physicians have important roles in behaviour modification, education and ensuring that all children are properly vaccinated according to the immunisation schedule. ■

Workshop session conducted by Dr June Lou on case study of "Common Problems encountered in Childhood Vaccinations"

Developments in Diagnosis and Management

Course Structure

1. Distance Learning Course Contents

Unit 1: Chronic Hepatitis B Infection Management
- Spectrum of presentation
- Follow-up of chronic hepatitis B infection
- Indications for treatment
- Goals of treatment
- HBV therapies

Unit 2: Diagnostic Approach to Prostate Disease
- Symptoms and signs
- Differential diagnosis
- Differentiating BPH from cancer of the prostate
- Investigations of prostate diseases

Unit 3: Management of Benign Prostatic Hyperplasia
- Medical treatment
- Surgical treatment
- Complications of treatment
- Follow-up of patients

Unit 4: Human Papilloma Virus (HPV)
- Role of HPV in cancer of the cervix
- Strategies in prevention
- HPV vaccines: Issues to consider

Unit 5: Rota Virus Infection in Childhood Diarrhoea
- Epidemiology
- Clinical features
- Diagnosis
- Management

Unit 6: Prevention of Childhood Diarrhoea and the Rota Virus Vaccine
- Preventive measures in childhood diarrhoea
- Role of rota virus vaccine
- Developments in rota virus vaccine

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

Seminar 1: 22 October 2005
2.00pm – 4.00pm
1) Chronic Hepatitis B Infection Management
2) Diagnostic Approach to Prostate Disease
3) Management of Benign Prostatic Hyperplasia

Seminar 2: 23 October 2005
2.00pm – 4.00pm
1) Human Papilloma Virus(HPV)
2) Rota Virus Infection in Childhood Diarrhoea
3) Prevention of Childhood Diarrhoea and the Rota Virus Vaccine

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

3. Workshops Session *(2 CORE FM CME Points#)*
Workshops
(22 October 2005 **OR** 23 October 2005)
4.15pm – 6.15pm

Group A
- Case Studies on Benign Prostatic Hyperplasia

Group B
- Case Studies on Chronic Hepatitis B

**** Workshops are on 1st come, 1st served basis and are limited to the first 100 participants on each day.***
**** A similar workshop is held on both 22 Oct(Saturday) and 23 Oct(Sunday)***
 # Subject to approval from SMC.

Date: 22 & 23 October 2005
Time: 2 pm – 6.15 pm
Venue : MOH Auditorium

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

Register

Developments in Diagnosis and Management Skills Course Registration Form
Please tick √ appropriate boxes.

	College Member	√	Non-College Member	√
Seminar 1 (22 Oct)	$10.00		$20.00	
Seminar 2 (23 Oct)	$10.00		$20.00	
Workshop	$20.00		$40.00	
(Please tick your preferred date)	22 Oct (Sat)		22 Oct(Sat)	
	23 Oct (Sun)		23 Oct(Sun)	
Distance Learning Module	FREE		$40.00	
TOTAL				

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