



THE College Mirror

VOL. 31 NO. 4 December 2005

A Publication of College of Family Physicians Singapore

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FAMILY PRACTICE SKILLS COURSES

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in Jan & Mar 2006!

(See Pages 23 & 24 for more details)

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Published by the College of Family Physicians Singapore
College of Medicine Building
16 College Road #01-02 Singapore 169854
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MITA (P) 024/04/2005

"The Family Physicians Register"

Keynote Address by Professor K Satkunanantham, Director of Medical Services, at the College of Family Physicians Convocation, 1 October 2005, 5.00PM at MOH Auditorium, College of Medicine Building

It gives me great pleasure to join you this afternoon to witness the convocation of doctors who have successfully completed the Graduate Diploma in Family Medicine, and to welcome them into our midst as family physicians.

With the proposed Family Physician Register in the horizon, those of you who have just completed the course must feel an added sense of purpose and pride. With these additional skills you will be ready to meet the challenges and responsibilities of being a family physician in the coming new era of family medicine.

Today, while Singaporeans enjoy a relatively long life-expectancy of 79 years, about 9 of those years are spent in disability, dependent on care givers for

activities of daily living. Chronic diseases account for approximately two-thirds of this burden.

As our population ages, we expect to see more of the elderly having not just one or two, but several chronic diseases at the same time. They might be managed concurrently by a few specialists in the hospitals. The key to reducing the number of years spent in disability is prevention, early detection and treatment, as well as sustained lifestyle changes.

Family physicians should not only manage their patients holistically but should also efficiently coordinate the care given to their patients by various specialists. This should be the outcome in every responsible health care system.

MOH will put in place the necessary

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(Standing L-R) Prof Low Cheng Hock (Master, Academy of Medicine), Dr Cheng Heng Lee (Hon. Secretary, CFPS), Dr Arthur Tan Chin Lock (Hon. Treasurer, CFPS) & Dr Lee Kheng Hock (Censor-in-chief, CFPS)
(Seated L-R) Prof Ng Han Seong (Chairman, Division of Medicine, SGH), Prof Lee Eng Hin (Director, Division of Graduate Medical Studies, NUS), Prof K Satkunanantham (Director of Medical Services, MOH), A/Prof Cheong Pak Yeap (President, CFPS), Prof Stuart Murray (Sreenivasan Orator), A/Prof Goh Lee Gan (Vice President, CFPS) & Mrs Karen Koh (Deputy CEO, Singhealth)

The 20th Council
& the Editorial
Board wishes all
readers a Merry
Christmas & a
Happy New
Year!

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2005 - 2007

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COLLEGE'S POSITION ON MOH PUBLIC CONSULTATION PAPER 'PROPOSED ESTABLISHMENT OF THE FAMILY PHYSICIAN REGISTER'

Adopted by 20th Council on November 16, 2005

PREAMBLE

1. College of Family Physicians Singapore welcomes the Ministry's proposal to establish a Family Physician Register (FPR) in Singapore to establish Family Medicine (FM) as a distinct discipline with structured training requirements and to empower the family physicians to play a bigger role in the care of patients. This document provides the College 20th Council's position sought in paragraph 42 on the 'Criteria for registration in the Register' and secondly on 'The proposed plan to require future FM clinic licensee and clinic manager to be on the Register.'

2. The establishment of such a register is in line with the Constitution of the College promulgated in 1972 and its involvement in professional and vocational training of family physicians through the years. Responding to the Ministry's call for primary care involvement in the eight national healthcare priorities announced in August 2003, the College's 19th Council engaged representatives of major primary care stakeholders in Singapore to examine the roles primary care could play. The consultation included seminars, focus group meetings and a two-week study of the United Kingdom's National Healthcare System in March 2004.

3. This consultation exercise resulted in the College Memorandum (CM) to the Ministry in June 2004 proposing for a minimum vocational standard for family physicians in Singapore. The full paper was circulated to all College members for deliberation at the 2004 Annual General Meeting (AGM) held on 26th June 2004 and was unanimously affirmed by resolution. The memorandum has since been ratified by the 20th Council and further discussed in the AGM held on 25th June 2005.

4. As part of the continuing dialogue, the College has organized profession-wide feedback and discussion meetings on the College Memorandum and the wider issue of transformation of primary care. Notices inviting doctors to these feedback sessions and reports of these activities were published in its newsletter, the College Mirror. The Mirror published quarterly is sent to 5000 doctors in Singapore, members and non-members. (The College has 1178 members as of October 2005.) College members and some non-members including a few specialists responded to the consultation. The feedback obtained was used for further discussion with the

Ministry. Appendix 1 lists these activities and related articles published in the College Mirror.

CRITERIA FOR REGISTRATION IN THE FAMILY PHYSICIAN REGISTER

5. The College supports the principle of criteria based on acceptable vocational qualifications in family medicine as well as approved medical practice experience. The use of either the Master of Family Medicine or Graduate Diploma in Family Medicine (GDFM) or the Diplomate membership of the College of General Practitioners (MCGP) as a criterion for the direct route for those with at least 2 years of approved FM practice experience is supported. The role of a Joint Committee for FM training to recommend overseas equivalent to the Ministry is also accepted.

6. The College accepts the criteria of an alternate qualification for doctors who have more practice experience in the practice route to include other relevant qualifications registrable with the Singapore Medical Council and the Maintenance of Proficiency Certification. The provision of the 'Practice Route' acknowledges the experience that these doctors have spent in medical practice.

LICENSEE AND CLINIC MANAGER OF FAMILY MEDICINE CLINICS

7. The College Memorandum of 3rd June 2004 (CM Para 6.1) calls for 'some groups of doctors who are already in practice' to be exempted from the proposal for a minimum required vocational standard for independent primary care practice. The College notes that in the proposed amendments to the PHMC Act spelled out in MOH Consultation Paper (Para 39), 'existing clinic licensees and clinic managers who are not family physicians will NOT be affected by this new requirement... even if they have to relocate or rename their clinics.' The College welcomes this proviso, as it would not compel doctors presently in practice who are clinic managers and license holders to seek registration in the proposed FPR if they do not want to.

8. The College did not link its proposal for a Family Physician Register to licensing of clinics in the College Memorandum of 3rd June 2004. Nevertheless, the 20th College Council on studying the MOH Public Consultation Paper accepts that the linkage to licensing of new family medicine clinics (as laid out in paragraph 35 to 39) would enhance their clinical governance.

CONCLUSION

9. The College agrees with the Ministry that the proposed changes as laid out in the Public Consultation Paper would establish family medicine as a distinct discipline and enhance its practice so as to achieve better healthcare for our people in the face of the challenges of chronic diseases, ageing population and rising healthcare costs.

10. The College also agrees with the statement in paragraph 22 of the Public Consultation Paper that 'setting training standards alone without addressing other practice related issue may prevent us

from achieving the desired outcomes'. This view is reflected in many feedback sessions conducted by the College. The College believes that these measures to address other related practice issues should be taken in tandem with the implementation of the Family Physician Register. The implementation framework and timeline should be made known. The value of the additional vocational training required for the Family Physician Register would then be better appreciated and anxieties that the proposed measures for the register would not achieve the stated outcome could be allayed. (*Enclosure: Appendix 1*) ■

APPENDIX 1: College activities and the articles printed in the College Mirror

Date	College Activities/Articles	College Mirror(Issue)	College Mirror (Website Address)
23 Aug 2003	"Eight Priorities for Singapore" - Meeting with Minister Khaw Boon Wan	Vol 29 No 3, Pg 1	http://www.cfps.org.sg/collegemirror/29/293/headlines.pdf
20-27 Mar 2004	"The Scottish Experience", Study Trip to Glasgow	Vol 30 No2, Pg 5	http://www.cfps.org.sg/collegemirror/30/302/302_scottishexp.pdf
Apr - Jun 2004	"Responses from Family Physicians"	Vol 30 No 2, Pg4	http://www.cfps.org.sg/collegemirror/30/302/302_headline.pdf
Apr - Jun 2004	"The Seminar"	Vol 30 No 2, Pg 6 & 7	http://www.cfps.org.sg/collegemirror/30/302/302_seminar.pdf
15 May 2004	"Blueprint for Bold Changes in Primary Care"	Vol 30 No2, Pg 1	http://www.cfps.org.sg/collegemirror/30/302/302_headline.pdf
27 Oct 2004	Feedback Meeting session for Fellows, "Feedback sessions from Oct to Dec 2004, GDFM as the Minimum Required Vocational Standard"	Vol 31 No 1, Pg 9	http://www.cfps.org.sg/collegemirror/31/311/311_transform_pri_care.pdf
2 Dec 2004	Feedback Meeting session for GDFM Graduates and Trainees, "Feedback sessions from Oct to Dec 2004, GDFM as the Minimum Required Vocational Standard"	Vol 31 No 1, Pg 9	http://www.cfps.org.sg/collegemirror/31/311/311_transform_pri_care.pdf
15 Jan 2005	Meeting on Transforming Primary Care - A Grassroots' Perspective (A capacity crowd of more than 100 doctors attended), "Transforming Primary Care - A Grassroots' Perspective"	Vol 31 No 1, Pg 8 & 9	http://www.cfps.org.sg/collegemirror/31/311/311_transform_pri_care.pdf
Oct - Dec 2004	"National Standard for Primary Care"	Vol 30 No 4, Pg 1	http://www.cfps.org.sg/collegemirror/30/304/304_headlines.pdf
Jan - Mar 2005	"Reforming Primary Care, The Ministry of Health Perspective"	Vol 31 No 1, Pg 1, 4-6	http://www.cfps.org.sg/collegemirror/31/311/311_reform_pri_care.pdf
Jan - Mar 2005	"President's Forum - The College's Contributions"	Vol 31 No 1, Pg 3	http://www.cfps.org.sg/collegemirror/31/311/311_president_editor.pdf
Apr - Jun 2005	"President's Forum - Masters All"	Vol 31 No 2, Pg 3	http://www.cfps.org.sg/collegemirror/31/312/312_president_editor.pdf
Jul - Sept 2005	"Three Challenges for Family Medicine"	Vol 31 No 3, Pg 1	http://www.cfps.org.sg/collegemirror/31/313/cm313_3challenges.pdf

Family Medicine World in Focus



As the year draws to a close, this issue focuses on the Proposed Family Medicine Register. The College leadership issued a position paper on the MOH Public Consultation Paper summarizing the events starting from 2003 leading up to its publication for public feedback and e-consultation on 1st Oct 2005 (Pg 2 & 3). Doctors from the ground, physician leaders in the FM community as well as several specialists were invited to give their views on the need for the FP register and their concerns. We thank those who have given their viewpoints (Pg 4-7).

The FM Convocation ceremony was held on 1 Oct 2005. The Guest-of-Honor, Prof K Satkunanantham, gave the keynote address (Pg 1) and Prof Thomas Stuart Murray delivered the Sreenivasan Oration 2005 on "The Resourcing of Quality Primary Care" (Pg 9).

It is a complex FM world out there to negotiate. But on a brighter note to end this year, it made my day to hear a doctor friend share how he resuscitated a patient; thanks to a life-saving tip he read

in "The College Mirror". A mother had brought her semi-conscious toddler to his clinic. The child had gastroenteritis and was hypoglycemic. Struggling to insert an intravenous line, he recollected reading about rectal injection of 50% glucose solution for hypoglycemia. The child responded to the rectal injection which bought some time for the doctor while he organized transfer to an emergency facility.

The glow of satisfaction in providing good competent care for our patients warms our hearts. As my two-year tenure as an editor of "The College Mirror" draws to close, it has been worthwhile publishing the stories of the practices of many good doctors out there.

It leaves me to raise a toast to good health for all. I also hope for a better healthcare system in the new year ahead that allows for better job satisfaction for all Family Physicians and better care for our patients. ■

**Editor of The College Mirror
Dr Ong Jin Ee**



Dr Lee Suan Yew

I agree with the setting up of the Family Physician Register because it is well accepted by advanced

countries that Family Medicine is now recognized as a separate discipline. Therefore, doctors who have undergone vocational training in Family Medicine or have attended modular courses in Family Medicine and have passed those post-graduate examinations can identify and register themselves as Family Physicians.

However, to avoid excluding those doctors who have been practising Family Medicine/General Practice, provisions should be made to embrace them as Family Physicians *intendum* since they have been practising their discipline for a number of years.

Once the Family Physician Register is formally established, future registered medical practitioners who wished to be registered as Family Physicians will need to undergo a post-graduate course and examination.

All the specialists practising in Singapore are accredited by the Specialist Accreditation Board and are registered at the Singapore Medical Council. It is timely that the medical practitioners who fulfill their criteria as Family Physicians can be accredited and registered by a separate Family Physician Accreditation Board. The criteria as proposed by the Ministry of Health's Public Consultation Paper are acceptable. These can be refined as we progress over the next few years.

Concerns for Senior GPs

I envisage that many experienced and senior Family Physicians/General Practitioners may question the

advisability of such a register. They may ask, "Why should there be discrimination and why more examinations?"

I would like to propose that those who have been practising for over eight years be included in the register by virtue of their experience. Those who have less than eight years of experience may be required to have a "Maintenance of Proficiency Certificate" as proposed by MOH under the heading "Practice Route".

Clinic Licensee & Clinic Managers

This regulation as set out in paragraph eight and nine of the paper may need some time to be implemented. The younger doctors who are planning to set up their medical practices may be caught prematurely by this regulation.

It would be fairer to give a moratorium of two to three years so that all aspiring doctors who wish to set up their family practice would have sufficient advance warning of the new changes, which are necessary if we are serious about upgrading the practice of Family Medicine. Besides, it is cost-effective and necessary as our senior citizen population grows.

Manpower

My other concern is manpower. We need to build up a large cohort of good clinical teachers and lecturers in order to facilitate the doctors who may choose the "Practice Route" for their registration. The College, the Medical School and other medical institutions will need to co-ordinate and assist in building up such cohorts. This needs to be addressed as early as possible, failing which the implementation may be in jeopardy. ■

Dr Lee Suan Yew is a past President of College of Family Physicians Singapore and a past President of the Singapore Medical Council



Dr Alfred Loh

Before my appointment as the CEO of The World Organisation of Family Doctors (Wonca) in 2001, I was in the College Council in one

capacity or other for about 20 years. During all this time, the College had always had the hope that one day Family Medicine would be recognised as a distinct discipline in its own right.

This plan by the Ministry of Health to set up the Family Physician Register is indeed a welcome move and the realisation of the efforts of the many College Councils of past years. This move deserves all our support. With the institution of the Register, Family Medicine becomes a distinct discipline of medicine in Singapore.

This milestone will be very much welcomed by the many family doctors in Singapore and by the greater fraternity of family doctors worldwide in Wonca.

Whilst there is much to be glad about in the way the issue of recognition of Family Medicine has turned out in recent months or years, care must be taken by the College and the Ministry to ensure that policies to be instituted to certify and register practising doctors are not formulated and executed too rigidly. Due regard should be given to certain categories of practitioners who may find fulfilling the criteria rather problematic. There needs to be certain leeway for such doctors to eventually come into the fold of registered family physicians.

I do not presume to be able to provide the answers to such problems but I'm sure the deliberations of the present and future College Councils in consultation with the Ministry will eventually be able to ensure that the appropriate solutions are in place. ■

Dr Alfred Loh is a past President of College of Family Physicians Singapore and presently the CEO of the World Organisation of Family Doctors (Wonca)



"The establishment of this register is a very public statement of professionalism from the Family Medicine community.

Prof John Wong
 All registers demand a transparent process of entrance requirements as well as criteria for remaining on the register. This will boost the standing of the specialty significantly among the public as well as the professional community.

The registry must be proactive to ensure that all Family Medicine physicians have the opportunity to be enrolled. This would include opportunities to do the requisite training. If 'grandfather' clauses are enacted, it must be done with some mechanism to ensure the quality of people who enter by this route to avoid allegations of 'double standards'." ■

Prof John Wong Eu Li is the Dean of the Yong Loo Lin School of Medicine, NUS



"I am for the register. The register will help to upgrade the primary care practice and ensure a healthier population rather than one that is (merely) not sick.

Clinical Prof Chee Yam Cheng

I hope there will be a IT-based system, which allows more communication with specialists, and data retrieval (labs, x-rays etc) that will assist the Family Physician in his practice and raise efficiency (reduce the time and resources spent by doctors and patients). Also, we need to ensure clinical guidelines/pathways are implemented 100% once the national guidelines are out i.e. translational research into effective practice by the primary care doctor soonest possible. You would agree that taking 17 years as of now, is absurd." ■

Clinical Prof Chee Yam Cheng is a past Master of the Academy of Medicine Singapore and presently the Assistant CEO (Clinical) of NHG



Excerpts from the Public Consultation Paper

(Source : Available online at http://www.moh.gov.sg/cmaweb/attachments/speech/3691dfe8b49j/Public_Consultation_FP_RegisterFINALPRINT.pdf)

“ AIM OF ESTABLISHING THE REGISTER

2. The aim of the Family Physician Register is to raise the overall standard of family medicine practice in Singapore. Formal training in family medicine will be a pre-requisite for entry into the Register.

The Desired Outcomes

3. The desired outcomes of the Family Physician Register are:

- (a) Improved management of chronic diseases and, consequently, reduced national burden of disease.
- (b) Reduced avoidable hospitalisation of chronic diseases through emphasis on early treatment and prevention.
- (c) More appropriate siting of care at family clinics in the community instead of at specialist outpatient clinics in hospitals.
- (d) Increased public confidence in the skills and knowledge of family physicians.
- (e) An effective and sustained doctor-patient partnership, to realize the vision of "A family physician for every Singaporean".

4. With the above outcomes, we would be able to improve patient care at primary care level, contain overall healthcare cost and enhance professional fulfilment for both family physicians and specialists. ”

“

CONCLUSION

10. MOH envisages a larger role for family physicians in our healthcare system. While there are other practice-related issues that need to be addressed, setting training standards is a necessary step that has to be taken. With family physicians enabled through appropriate training, the stage will be set for many more positive changes that will allow the family physicians to play a pivotal role in our healthcare system and realise our vision of "One family physician for every Singaporean". This will bring about a higher level of primary care for Singaporeans.

11. MOH would like to seek the views and feedback of the public and healthcare professionals on the proposed Family Physician Register. Specifically, we are asking for feedback on:

- The criteria for registration in the Register.
- The proposed plan to require future family medicine clinic licensee and clinic managers to be on the Register. ”

Are You Ready?



Dr Lawrence Ng

Family Medicine is a new name for General Practice. It was coined in the 1970s and 1980s to shape the discipline into a new wineskin in the hope of meeting the challenges of the new century and beyond. Why the need to change? Why move the cheese?

That the future of general practice around the world and in Singapore is bleak has been well written in many articles. In the Feb 2005 issue of the SMA News, no less than 5 authors (TY Tham, KS Tan, The Hobbit, PK Tan and SW Tan) wrote about the dilemma that we have unwittingly found ourselves to be in.

GPs have been compared to Dodo birds, which is the most famous example of how extinction can come about to a species that became complacent and did not develop the necessary wings to fly from threats that arrived at its shores (KH Lee, SMA News - Jul '05 issue). In a word, innovate or perish.

Competition is a topic that GPs lament much about. Michael E Porter in his book, *On Competition*, wrote about what Strategy to adopt in the face of relentless competition. In short, he advocates that choosing low-end low-skilled work is the dodo bird approach.

Being "stuck in the middle" is also not an option since this would confuse customers as to your positioning and branding. The only way to survive in this world dominated by market forces is to move to the high-end high-skilled work. This can only come about through constant training, re-training and targeting for excellence.

So where do we start? How do we achieve a buy-in from all stakeholders (i.e. all GPs, healthcare players & government)?

The CFPS has taken the initiative and the Ministry of Health has accepted the College's

well thought out proposal for a FP Register. The training structure has been in place for many decades since the advent of the MCGPS in 1973. The trainers are available. Funding will come from us and from the Ministry.

In the past, we can only encourage GPs to upgrade. Now, time has come for the GP fraternity to heed the clarion call and upgrade en mass rather than piece meal on an individual basis.

To meet the challenge of caring for an ageing population at the primary care level is a daunting task that every government and Academies and Colleges of Family Physicians around the world struggle to respond adequately.

- Are we ready to take care of the entire population with ever rising healthcare costs and rising expectation of level of service?
- Are we ready to train ourselves or be accused of being the poor cousins of the specialists?
- Are we ready to take care of the patient when he is discharged from tertiary hospitals with complicated problems and to achieve targets of quality in healthcare?

To do this, we must be willing to attend training and to upgrade. Whether as a young GP or as an old experienced senior GP, we must be humble enough to say we shall train and re-train regularly in order to serve the patient adequately and safely.

I believe the time has come for Singapore as a developed nation to follow the lead of other developed nations such as the UK & Australia where it is no longer acceptable for a newly-graduated MBBS to set up shop in an unsupervised practice. It is not tenable in today's highly litigious society. To allow a young doctor to learn from his mistakes by trial-and-error approach, by committing them on unsuspecting patients is not acceptable to a conscientious government or medical profession.

We have the chance to revamp general practice as a whole group. Or we can let this opportunity slip away. The choice is up to you. ■

Meeting Expectations



Dr Jason Yap Soo Kor

"I decided to embark on the GDFM course four

years ago to be a greater blessing to my patients. I work in the Raffles Place area and I see a lot of expatriates. I wanted to be a better GP to these expats than their own doctors back home.

Exams were 'by the way'. Like many GPs who have been keeping themselves updated through medical seminars, workshops and conferences, I did not encounter much difficulty in the course nor was I stressed out by the exam preparations.

The 2-year course is a better way of updating oneself on the entire system of the human body than the 'haphazard piece meal' offered by the different short courses and meetings that I've attended.

For me, the Register for Family Physicians is about setting standards and a benchmark for the new generation of medical graduates who wish to do general practice work. The undergraduate medical course is grossly inadequate. Most have the mindset of knowing enough to pass the exams.

Going through a structured vocational training will ensure that primary care in the community is raised to the highest possible level which is in line with our nation's pursuit after medical excellence." ■

Defining Our Roles

By Dr Wilson Eu Tieng Juoh

"I agree that Singapore GPs need a GP register. Having a register is one step to defining GP work as having its own set of skills and knowledge. It is not a 'default' state of being a medical doctor in Singapore. A radiology trainee or an O & G trainee who decides to give up his/her traineeship for whatever reason does not have the wherewithal to be a GP simply from the fact that he/she did MBBS plus a couple of A&E/polyclinic postings. Similar argument for those at the other end of our work-life cycle.

Does being on a register make one a better doctor? By itself, no. However, until we have better instruments to gauge/ benchmark, the family medicine register is an essential tool. This is important from the patients' point of view and hopefully, useful for the powers-that-be to recognize as a means to access subvention.

One article that I came across recently on the net: eMJA 2003, 179, p27, was interesting. The article itself was on the need for primary care academic research but the point that caught my eye was the table that compared GP profiles in the UK, Netherlands and Australia. For me, this table just crystallized the problems for GPs in Singapore: Singapore's dr-pt ratios are much lower, vocational training and registration is until fairly recently, non-existent; and a lack of government investment in GP research and training.

Each passing month, the 'GP's pie' grows smaller: pharmacists want a role in dispensing medications, nurse practitioners say they can treat common and chronic complaints better and cheaper, TCM et al are saying they view problems more holistically... and so it goes on. We need to define our role as a healthcare provider par excellent (and that's evidence-based!) and continue to expand our areas of expertise. Currently, 'right siting' of healthcare is in primary care, but will it be so if we do not step up our game?

So, the proposed register is a no-brainer for me... we need it and it is the start of a long process to make primary care the focus of healthcare." ■

"It is important to have standards in Family Medicine Practice. Establishing the FP Register will help gain recognition for training, which results in better patient care." - *Dr Stephen Tong Jia Jong*

"I want to be proud to be a Family Physician and to practice at a higher level of care delivery." - *Dr Audrey Lee Ai Ming*

"It helps to set a certain standard of care that both doctors and the public can recognize and understand. Accreditation helps people to understand the 'added value' of the care delivered. Registry allows its members opportunities to develop themselves." - *Dr Teoh Mei Lin*

"It will raise the standards of care as well as encourage and develop the fraternity of Family Medicine. We need to engage the rest of GPs to understand the rationale for a FP Register and make known the incentives for GPs to go for further training." - *Dr Tan Boon Yeow*

"The register, which will set a minimal standard of family medicine training, would be in line with healthcare practices in developed countries such as Australia and UK. The register will certainly upgrade the overall standard of family medicine practice in Singapore. Older GPs, who do not have MMed/GDFM, may feel uncomfortable about the register. Reassurance needs to be given that they will not be left behind." - *Dr Kok Jaan Yang*

"To help set the direction for Family Medicine. It is time that GPs and Family Medicine start to come together as a single group. There are three areas that I feel should be addressed: (1) The apparent division and lack of co-operation between GPs, especially of different generations (2) Good and relevant updates in patient care that can be brought to the attention of all GPs and (3) Better control or design of CMEs for GPs." - *Dr Tan Kim Kiat*

"I believe a registry would lead to assurance and maintenance of standards. Hopefully as a result it would allow family medicine to be better recognized by the public as well as our specialist colleagues.

The training programme (for entry into registry) must be so structured that its primary objective is to facilitate a continuous learning journey for the general practitioners, rather than to focus on passing the examinations. Sufficient incentives must be provided for training appointments so that more with the relevant qualifications would come forward to share the training burdens."

- *Dr Derek Tse Wan Lung*

"It will encourage more to go for vocational training, which in turn will raise the standard of Family Medicine." - *Dr Siew Wei Fong*

"This will increase the public's awareness of family physicians." - *Dr Tang Wern Ee*

"The register would provide proper recognition and move Family Medicine to greater heights." - *Dr Kwong Kum Hoong*

"The Family Physician Register will help bridge the gap between public and private sector family medicine. More importantly, it will help maintain a standard of care, which our patients greatly deserve, in the interest of patient safety. Medicine is all about continuous learning, keeping abreast of changes." - *Dr Sharon Kaur Minhas*

FM Convocation Ceremony 2005

By Dr Gabriel Seow, FCFP & Editorial Board Member

1 October 2005 was not just another Children's Day; it marked another significant milestone in the family medicine fraternity.

The **Inauguration of the College Convocation Tapestry** was one such highlight. It served as a reminder of the struggles and challenges in providing quality vocational training and continuing professional development.

The **Welcome Address** by College President, Prof Cheong Pak Yean was on "Celebrating Defining Moments in Family Medicine". The MOH adoption of a tangible national standard for family doctors in Singapore was one such moment. The College was in the process of setting up a clinical Department of Family Medicine and Continuing Care (FMCC) in SGH. Such a department further entrenches Family Medicine (FM) as a distinct discipline with integrative roles in the hospital and the community.

The Director of Medical Services, Prof K Satkunanantham graced the occasion as the Guest-of-Honor. His **Keynote Address** on the setting of the Family Medicine Register underscored the ever increasing role of primary care. Family

Physicians (FP) should not only manage their patients holistically but also efficiently coordinate the care by the various specialists. He also gave his whole-hearted support to and applauded the relentless collaborative efforts of the College, NUS and the re-structured hospitals to forge ahead in development of good vocational training in FM.

Prof T Stuart Murray, Director of Postgraduate General practice Education, NHS Education for Scotland, was the **Sreenivasan Orator** for 2005. His reflective lecture on "The Resourcing of Quality Primary Care" focused on 5 themes:

1. FM as a specialty
2. Global trends and setting standards
3. Delivering quality in primary care
4. Role of primary care in a healthcare system
5. Role of Continuing Professional Development (CPD) in supporting change

The **Conferment Ceremony** saw 42 GDFM graduates, 1 MCFP and 5 FCFPs added to the College's ever-growing fraternity. Dr Lau Hong Choon and Dr Chan Nang Fong were the deserving recipients of the 2005 Albert and Mary Lim Award in recognition of their untiring contribution to medical education.

This was indeed a seminal time in the development and role of family practice within the healthcare system in Singapore. The ever-increasing public demands for holistic and humanistic medicine and the achievement of better health outcomes with fewer resources has shifted the scales towards the much under-rated primary care; family physicians form the backbone of primary care.

It is springtime for Family Medicine and its champions and practitioners have every reason to face the future with pride and hope.

On this cheerful note, temperance was given rest as the delectable culinary delights, better wines and still better company concluded the memorable night. ■



The gathering at the Convocation ceremony

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Sreenivasan Oration 2005: *The Resourcing of Quality Primary Care*

By Ms Fan Yingshi, Editorial Writer

A/Prof Goh Lee Gan gave the citation on Professor Thomas Stuart Murray and College Mirror extracts his personal account on Prof Murray's contribution to the discipline of Family Medicine (FM).

First meeting

"I first met Prof Murray in 1990 when I was on a British Commonwealth Training Fellowship to learn about the teaching of General Practice. The West of Scotland Region's General Practice Faculty, centred around the University of Glasgow, was one of my two destinations. Prof Murray, who was the Regional Advisor for the Region and the man-in-charge, was my host. We became good friends. At the end of the attachment, I decided to invite him to participate in our budding Postgraduate Family Medicine Programme.

A/Prof Goh Lee Gan

The links with Singapore

From that simple beginning, strong links were developed between Glasgow and Singapore:

- The West of Scotland Region under Prof Murray's leadership provides a Visiting Lecturer yearly to our Family Medicine Course since the Course started in 1993.
- Prof Murray has been an External Examiner to our Master of Medicine Examinations in Family Medicine twice.
- Last year, Prof Murray was instrumental in hosting a Singapore delegation to his country to study the transformation of general practice in the UK setting. Prof Cheong Pak Yean has already alluded to the events that came in the wake of that study trip.

The man himself

Let me say a few words about Prof Murray, the man himself. He is a giant in General Practice of our time. He is a scholar, researcher, thinker, and developer of talents all in one."

Prof Murray in his oration addressed the issue of the resourcing of quality primary care. It is timely with the proposed establishment of a Family Physician register.

"Resourcing is a wide topic and encompasses training and education, commitment of individual and groups of people as well as the availability of finance."

He addressed five themes: Family Medicine as a specialty; global trends and setting standards; delivering quality primary care; the role of primary care in a health care system and the role of CPD in supporting change.

"It is important that doctors keep up to date with their knowledge and skills throughout their

working life. They should take part regularly in educational activities which maintain and develop further their competence and performance."

He concluded "Life long learning is an easier aspiration when the family doctor achieves job satisfaction, has good health and contentment as these contribute to satisfactory outcomes. Doctors are actively involved in adult learning and they gear this to their own style and pace of learning. Self-directed learning underpins adult learning.

Finally this is a seminal time in the development and role of family practice within the health care system in Singapore. The College is in pivotal position to influence government and should help to operationalise policy over a significant timeframe." ■



Prof Stuart Murray

Professor Thomas Stuart Murray

- Graduated with MB ChB from the University of Glasgow in 1967, obtained his DRCOG in 1969, MRCP in 1971, the MRCP in 1975, PhD in 1977 and MD in 1995.
- Prof Murray was made a Fellow of the Royal College of General Practitioners in 1981. The Royal College of Physicians of Glasgow and Royal College of Physicians of Edinburgh have also made him a Fellow of their Colleges in 1981 and 1993 respectively.
- His area of research is in assessment. He and his department is well known for his work in summative assessment for entry into general practice, which has been adopted throughout the United Kingdom.
- Prof Murray currently has 125 articles in peer reviewed journals, 65 of which he is the first author. Sixty-four of the 125 articles are in the Lancet, BMJ, BJGP, and Medical Education.
- He has developed the West of Scotland training region into the West of Scotland Deanery with a significant critical mass of Assistant Directors and Associate Advisors, 35 in total, providing 11 full-time equivalents.
- He is very much a mover in the transformation of primary care in the UK setting, based on the philosophy of innovation, academic underpinning and people development to be quality healthcare providers.
- Professor Murray is recognized among his peers. He has the distinction of being recipient of 3 named lectures: the William Pickles Lecturer, RCGP in 1998; the Sir David Bruce Lecturer, RAMC, in 2000; and the Ian Murray Scott Lecturer, North East Faculty, RCGP, 2001.

(The full text of the Oration would be published separate as an occasional paper of the College)

In Conversation with Book-prize Winners & Gold Medalist *Dr John Chiam, Dr Lai Kok Wei & Dr Gwee Sheau Min*

By Dr Shiau Ee Leng, Editorial Board Member

42 doctors passed the GDFM examinations and 17 doctors the MMed (Family Medicine) examinations in 2005. "The College Mirror" met up with the top performing candidates for these examinations. The two book prize winners this year for GDFM are **Dr John Chiam Yih Hsing** and **Dr Lai Kok Wei**. The Gold Medalist for MMed(FM) went to **Dr Gwee Sheau Min**.

Dr Lai is a veteran GP running a MHC clinic for the past 10 years in Yew Tee. He is married with 2 young children. **Dr Chiam**, who is married to an ex-accountant, is a dermatology trainee turned family physician. **Dr Gwee** graduated from NUS in 1999 and is currently working in Yishun Polyclinic. She began her MOH Family Medicine traineeship in 2001 and en route to completing her Master, also started her family. This high achiever is friendly and unassuming, and is the proud mum of 2 young children.



Dr John Chiam and his wife, Catherine.

CM: Tell us a little about your practice and your journey to family practice

Lai : I share my practice with other colleagues who practises O&G, Ophthalmology, ENT..so it is rather like a mini polyclinic. I tend to see more paediatric patients in my practice.

Chiam: My practice is in Bukit Batok and because of my background tend to see

more dermatology patients. For me it has been a long tortuous path to family medicine practice. I was granted a Colombo Plan scholarship to study Medicine in the University of Sydney. I obtained my MRCP (UK) in 2001, MRCP (Glasgow) in 2002 and completed my Diploma in Dermatology(UK) in 2004.

I found myself much more interested in General Practice as we deal with the prevention of diseases rather than seeing patients with late complications of disease as often seen in hospital practice. I also obtained a Diploma in Occupational Medicine in 2005.

CM: What made you do the GDFM course?

Lai: Well, the GDFM

course is likely going to be the benchmark for family practice in time to come.... plus it is useful as a refresher course for us jaded GPs.

Chiam : I was strongly encouraged by a few veteran GPs, namely A/Prof Goh Lee Gan and A/Prof Cheong Pak Yean. Also I find the course relevant and useful in my work as a GP.

CM: You have both done very well in your exams and been awarded the Book Prize. Do you have any study pointers for doctors going for GDFM?

Lai: A point of encouragement...I think it is easier in postgraduate studies as we are studying what we are practising.

I did not really spend long hours on my studies... just read up regularly and correlated what I learnt with my real life work. I find the requirement for the GDFM exams fair and the content/structure based on what we need to know for daily GP practice.

I actually postponed my exams once due to the bereavement of my mother, but I am



Dr Lai Kok Wei and wife, Evelyn with their daughters, Hannah & Elizabeth.

thankful to God that He helped me through that difficult period and also my group mates for their encouragement.

Chiam: I agree with Kok Wei the examinations questions are fair and based on GP work. Key thing was the GDFM was very relevant to my daily practice. I found it easy to apply the theory and remembered what I have learnt from the course.

CM: How has the GDFM course impacted the way you practise? Do you plan to carry on with the MMed in Family Medicine?

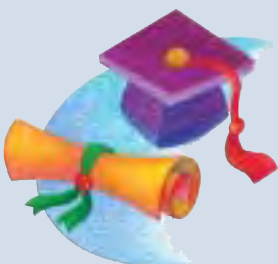
Lai: It has certainly sharpened my knowledge and improved my practice of Family Medicine. However, due to my work, family and other commitments, I probably will not move on to the MMed course for now.

Chiam: It has certainly been invaluable to me as I changed my career path to become a GP. I am quite keen to pursue further the MMed(Family Medicine) course. I have always been interested in teaching and will be willing to contribute to Family Medicine teaching in any way. Currently I am involved with teaching dermatology as a tutor for the University of Cardiff in UK via online.

CM: Share with us something of who you are, your hobbies and dreams.

Lai: I am an introverted family man who adore my kids. In my free time I enjoy still-life photography using my trusted SLR. For my long term plans, I hope one day to do mission work with my wife.

Chiam: I write in my spare time for the SMA Sensory magazine. I also sit on the SMA Complaints Committee. I am an idealist who follows his heart. Being a recipient of a scholarship, I was able to study Medicine despite my humble background. Therefore, I am grateful and hope to give back to society. ■



Dr Gwee Sheau Min and husband, Dr Ng Chin Hwee, with their kids, Tze Yang & Tze Yuan.

CM: Share with us what you felt contributed to your doing well for the MMed exams.

Sheau Min: Well (smile) I was fortunate to be on my maternity leave just before the M Med exams, so I did have one month to study really hard for my exams. I "stole" time from my children to study in the Medical Library from 9 am to 9 pm every day during that one month. My motivation to study stems from wanting to learn more. I also got a lot of help from my trainers and my husband, who helped in baby-sitting.

CM: Studying from 9am to 9pm, that takes great discipline. How has the MMed course changed the way you practise?

Sheau Min: I find studying for the MMed a worthwhile cause and hence worth the huge amount of time and efforts invested. The studying process itself forced me to discipline myself to read through the books and broaden my knowledge in the different disciplines of medicine. This breadth I feel is necessary in the practice of Family Medicine. I emerged more confident in my daily practice. Though, I cannot say for now whether I will continue with the Fellowship course ..but I strongly believe in continual learning as the medical field is ever evolving.

CM: What made you decide to become a GP and any reason in choosing to work in the public sector?

Sheau Min: Well, it is both a practical lifestyle choice as well as my interest in the practice of holistic medicine. My husband, Dr Ng Chin Hwee, is a GP in the private sector who has to work evenings. For me to work office hours in the Polyclinic is the best arrangement for us as it gives me more time with my children.

Furthermore I enjoy and find it a challenge seeing the broad spectrum of cases in the public sector, not to mention the camaraderie and CME training sessions we share with fellow colleagues in the Polyclinic.

CM: Tell us how you spend your after-work hours and any plans regarding contributions to family medicine?

Sheau Min: My free time is spent with my family. I enjoy sewing and have made quite a few quilts! Also, I am currently doing an overseas Diploma course in Dermatology. My interest is in Dermatology, Paediatrics, and O&G and I hope to see more patients in these disciplines. I am quite keen to be involved in teaching in the future. ■



GDFM

Standing (L-R): Drs Puvanendran Dharshini, Quratulain Tahira Zuberi, Lai Kok Wei, Lee Wen Yan, Lau Teh Yee, Ong Kok Kiong, Aung Thein, Nyi Nyi Tun, Aung Gyi Du Jean Min, Chang Wan Ern, Chuah Chin Khang, Lim Pui San & Poh Chern Loong Andy
 Seated (L-R): Drs Lim Bee Ling Tina, Loh Su Lin Jennifer, Leong Tyng Tyng, Choo Chin Yeng, Hor Oi Lin, A/Prof Goh Lee Gan (Vice President), A/Prof Cheong Pak Yean (President), Lee Kheng Hock (Censor-in-Chief), Ng Shu Ping Linda, Cheng Geok Min Ruby, Tay Peng Leng & Tiah Seow Hwee Jane

FAMILY MEDICINE

01 OCT



Dr Lau Hong Choon receiving the Albert & Mary Lim Award



Mr Lam Pin Woon, CEO of Health Promotion Board, receiving Appreciation Award



FCFP

Standing (L-R): Drs Doraisamy Gowri, Chia Tee Hien, Seow Hoong Wei Gabriel, Ong Chin Fung & Ho Chih Wei Sally
 Seated (L-R): A/Prof Goh Lee Gan (Vice President), Prof K Satkunanatham (Director of Medical Services, MOH), A/Prof Cheong Pak Yean (President), Prof T Stuart Murray (Sreenivasan Orator) & Dr Lee Kheng Hock (Censor-in-Chief)



Organising Committee (Drs Lily Aw & Ang Lai Lai) with Exco members



(L-R) Dr Arthur Tan with our guests: Dr Vaswani Moti, Dr Ling Sing Lin & Mr Lam Pin Woon



Keynote address by Guest of Honour, Prof K Satkunanatham



Inauguration of Convocation Tapestry - Unveiling by Guest of Honour, Prof K Satkunanatham



20th College Council



Council of CFPS with Director of Medical Services, Ministry of Health - Standing (L-R): Drs Ong Chooi Peng, Ng Joo Ming Matthew (Hon Editor), Pang Sze Kang Jonathan & Tham Tat Yean
Seated (L-R): Drs Tan Chin Lock Arthur (Hon Treasurer), A/Prof Goh Lee Gan (Vice President), Prof K Satkunanantham (Director of Medical Services, MOH), A/Prof Cheong Pak Yean (President), Prof T Stuart Murray (Sreenivasan Orator), Lee Kheng Hock (Censor-in-Chief) & Cheng Heng Lee (Hon Secretary) Not in photo: Drs Yii Hee Seng, Lim Fong Seng, Ho Han Kwee & Tan See Leng

CONVOCATION 2005



MCFP



Standing (L-R): Dr Ng Lai Peng
Seated (L-R): A/Prof Goh Lee Gan (Vice President), Prof K Satkunanantham (Director of Medical Services, MOH), A/Prof Cheong Pak Yean (President), Prof T Stuart Murray (Sreenivasan Orator) & Dr Lee Kheng Hock (Censor-in-Chief)



Prof Stuart Murray, Sreenivasan Orator, receiving a token of appreciation from the College President.



The audience at the packed auditorium



Our guests at the dinner (L-R): Prof Murray, A/Prof Goh Lee Gan, Dr Lee Suan Yew, Dr & Mrs Jerry Lim.
Backs to Camera(L-R): Dr & Mrs Chee Phui Hung & Prof Lee Eng Hin



Dr Wong Tien Hua, Emcee for the Ceremony



Family Doctors and Their Practice

A Small Group Practice for Expatriates

By Dr Yvette Tan, Editorial Board Member

"The College Mirror" starts a series on family doctors in their practices.

Dr Yvette Tan interviewed Dr Lim Hui Ling who is currently practising in a small group practice. Dr Lim, MBBS, MMed(Family Medicine), MCFPS graduated in 1993 from NUS and attained her MMed (FM) in 1999. She is married to Dr Anthony Goh, an oral surgeon at Mt Alvernia Hospital and is the proud mother of 2 boys aged 7 and 8, conceived and born during her MMed training period !

What are your aspirations as a doctor?

I had always wanted to be a surgeon in medical school. However, I realized that surgical training would not leave me much time to be a wife and mother as well. So, I turned to Family Medicine when the crucial time came to apply for traineeships.

Albeit my "second choice", I realized that Family Medicine was challenging, endlessly interesting and could be as fulfilling as Surgery. The MMed course opened my eyes to a whole new perspective on Family Medicine. It afforded me a breadth of knowledge that was not available to a non-trainee. It revealed to me the vision of how important good primary care is and what a difference we, as Family Physicians, can make to the individual patient as well as to the healthcare of our nation.

Tell us about your practice?

I am currently practising in International Medical Clinic, where I really think I have found my niche.

It is a small group practice with 2 clinics, one in Tanglin Shopping Centre and the other at Jelita Cold Storage in Holland Road where I am the anchor doctor. We focus on a very specialised "market", which I believe, most GPs try to avoid – the expatriates. More than 95% of our patients are expatriates. All our doctors have a Family Medicine mindset and most hold further qualifications like the FRACGP and FCFP.

At risk of sounding like I am gushing, it is an almost "utopian" practice, straight out of the pages of a Family Medicine textbook.

Expatriate practice

Our expat patients are used to the idea of having a true family doctor. They do not doctor hop, once they have found a doctor they like. They keep follow-up appointments. They are willing to pay for preventive healthcare. They appreciate the time I spend on counseling and advice; and also on the niceties like chatting about their families and asking about their hobbies and holidays. I spend a



Dr Lim Hui Ling in her practice.

minimum of 15 minutes per patient and in most of the cases I now see; at least half an hour or even an hour. These would include patients that are depressed or who need counseling about contraception or chronic ailments like hyperlipidemia and hypertension. I feel greatly privileged to be entrusted with the intimate details of my patient's lives.

I also get to do plenty of procedures like toilet and suture, removal of moles and "lumps and bumps" which satisfies the surgeon in me. Many times, all I dispense

is reassurance after a thorough history and examination. Yes, I actually DO get to ask all that history in the textbook!

After I refer them to specialists, my patients will still come back to discuss it with me before going ahead with whatever surgery or medical treatment offered.

Contrary to popular perception, expatriate patients are not "demanding" or "difficult". However, they do have high expectations of their doctors & are also very well informed. Cultural sensitivity & a good bedside manner are also important to them.

Good work-life balance

We are only open office hours and I myself work only a 4 ½ day week (I have Wednesdays off, which I spend with my 2 sons). We employ only state registered nurses for clinical work (another perk that makes my day so much easier). I take home a very comfortable salary (although nowhere near that of many of my friends in the busy HDB practices) and have enough time to indulge in my hobbies of ballroom dancing and golf and still be a wife and mother.

The only "con" I can think of about our practice is that our patients are always on the move, usually about every 2-3 years. You can build up a good relationship with the whole family and suddenly their company moves them to

China and you have to start all over again with a new set of patients. This keeps me on my toes and prevents complacency.

I have worked as an MO and as the head of a polyclinic before and also in a corporate town practice with a mix of expatriate and local patients. In IMC, I am practising Family Medicine the way I was trained to practise it. I am able to go to bed every night happy that I have done a good job for my patients and have not short-changed them for lack of time, or pressure from an MHC.



Visiting HMDP Expert - Prof. Stuart Murray (1 Oct to 4 Oct 2005)

“Transformation of Primary Care” Talks

By Ms Tessa Koh Mui Hoon, Editorial Writer

In his series of Transformation of Primary Care talks as MOH visiting HMDP expert, Professor Murray covered various topics ranging from training to research. He urged participants to upgrade themselves constantly in terms of knowledge and skills throughout their working life. Besides personal development, doctors might want to contribute to the education of trainees by assuming a teaching role.

In his talk, **Setting Standards in Postgraduate Training in Family**

“The talks have been very good as they allow us to get behind the scenes to see the processes and the right ways to do things” - A/Prof Goh Lee Gan

Medicine, Professor Murray illustrated how training is conducted in UK with their Scottish Prospective Trainers’ Course. He also highlighted the qualities and teaching abilities that a good general practice trainer should possess.

Apart from Family Medicine training, Professor Murray also addressed the perception of general practice and global trend of revalidation. In UK, general practice used to be a highly regarded

career with good recruitment of high quality applicants. Patients appreciated and respected the general practitioners.

Now, patients have changed from accepting that a doctor’s opinion is always the best to wanting to be more involved in their treatment. Recent evidence suggests that GPs today have low morale. He thus touched on addressing these issues and raising the quality of general practices.

In UK, doctors must demonstrate that they are currently fit to practise and are held accountable through regulation by the General Medical Council. Other countries such as USA, Australia and Canada also have their own revalidation systems though the degree of sophistication differs widely. Australia has its RACGP system while Canada’s systems are more provincial. He raised the question of whether Singapore should follow the global trend of revalidation.

The talks ended with a general sentiment that a combination of implementing quality care, training and research in the transformation of Primary Care is the way to go. ■



Prof Murray in action



Participants engaging in a lively discussion



Interactive session with Prof Murray



A sharing session with Dr Lee Kheng Hock



Prof Murray & Prof K Satkunanantham having a chat after a talk

Any interesting anecdotes that keep your passion for Family Medicine alive?

Once a patient, a big shot in an MNC, shyly invited me to a party at his house. My husband and I arrived casually dressed for a typical Singaporean house party at a huge “black and white” bungalow. The guests were many of his close friends and business associates. To my surprise, when I arrived, I realized that the purpose of the whole “do” seemed to be so that he could introduce me as his doctor, “the one who keeps this old machine running”.

This is a man who has a list of medical problems that takes me at least an hour to sort out at every visit and has seen about

every specialist and subspecialist in the medical lexicon. Consolidating and coordinating his care is the exclusive role of the Family Physician & that is something that no specialist could do for him.

Any wish list for the future of your practice/ Family Medicine in Singapore?

My wish for Family Medicine in Singapore is for the standards and professionalism of Family Medicine to be upgraded and improved. I am really happy that the Family Physician Register is finally becoming a reality.

I hope that the Register will be the first step in educating Singaporeans about the

importance of good primary care. Hopefully, Singaporeans will come to appreciate that they should have their own Family Doctor, who has only their interest at heart and will be willing to pay for it. We should have the confidence in our standard of care not to shortchange ourselves, nor our patients.

We should not be charging less and working longer hours than the hairdresser next door, just to “grab market share”. Singaporeans need to realize the economics of it all, “what you pay is what you get”, to a certain extent. “Cheap and good” should only exist in the Polyclinics because they are heavily subsidized. ■

Reflections from the Clinical Quality Skills Course

By Dr Chow Mun Hong, FCFP

I remember a sense of anticipation in the days leading up to the Clinical Quality Skills Course held at the CFPS lecture room at the end of July 2005. This was new territory for many doctors.



Dr Lee Kheng Hock

Dr Julian Lim

Dr Gilbert Tan

Dr Matthew Ng

A/Prof Goh Lee Gan

Prof Ng Han Seong

Dr Chow Mun Hong

The clinical performance of the healthcare delivery system was largely unmeasured and the Bolam principle appeared to accord protection to doctors performing at the average standard of his peers. Data from the US alluded to a Quality Chasm in healthcare.

As reported by Elizabeth McGlynn in NEJM 2003 Jun 26, patients in the US received 54.9% of recommended care. Here was an opportunity to create some constructive dissatisfaction with the status quo, and engage early adopters in the quest for better clinical quality. There was even a method to improvement.

If I could list six lessons from the course, it would be these:

1. There are different dimensions of Quality.

The Institute of Medicine from the US listed 6 domains to quality from the patient's perspective: timely, safe, effective, efficient, equitable and patient centred. We should be mindful of this balance so that we do not inadvertently sacrifice some domains in the interest of others.

2. Audit is the starting point.

If we do not check, we will not know how we are performing. Audit is part of practice, and data collection should be built into normal clinical processes. Selecting a standard is a central part of the process. Stakeholders of the process define the standard. In certain situations, the payor defines the required standard as a condition for funding.

Selecting a reasonable standard for accountability is different from setting a stretch goal for improvement. Both approaches are important in the effort to improve clinical quality. On the one hand, overspecification is wasteful. On the other hand, stretch goals drive substantive

changes that can provide quantum improvement to systems.

3. 'When you see a puddle of water on the floor, look up.'

Always look for the cause of problems. We do not want problems to recur. Just mopping up a puddle on the floor would not be enough if there were a leak in the ceiling. Safety is about building systems to prevent errors from occurring or from leading to harm. Simply blaming an individual seldom helps to prevent another similar error.

4. Significant events provide excellent opportunities to learn.

Significant event analysis is an excellent complement to clinical criterion audit. This technique is especially useful in the area of patient safety.

Significant events can be confirmation of good practice, near misses, errors and adverse events. These should be analysed by the practice team to facilitate repetition of good outcomes and avoidance of bad outcomes. Ask 'what happened', 'why did it happen', 'what has been learned', and 'what has been changed'?

5. There are many tools and models to guide our efforts.

Process tools like Ishikawa diagrams help in cause and effect analysis. Pareto charts identify areas of greatest impact. Rapid cycles of learning and improvement, like PDSA cycles, are helpful in developing, testing and implementing changes that lead to improvement.

The Chronic Care Model (now updated and known simply as the Care Model) provides a useful conceptual framework where prepared, proactive teams engage informed, activated patients to achieve

quality outcomes. This can be applied to practice teams of different sizes.

6. Not all change is improvement but all improvement is change.

We need to take a systems approach to improvement. Systems include people, things and processes. To improve substantively, we have to do things differently.

We should identify one or two problems to work on at a time. Start by analysing the problem and then develop changes that address the main causes of the problem. Changes should be tested initially on a small scale to maximise learning and minimise risk. Useful interventions can then be refined through rapid PDSA cycles and implemented.

Measurement is central to the process of change, and is central to PDSA cycles. Time based run charts are useful to track the progress of an improvement project.

The human aspects of change are also important. The practice team has fundamental knowledge of the process, and active involvement by the team is essential.

Will healthcare ever achieve six-sigma quality? Our patients certainly expect us to. The Clinical Quality Skills Course was only an appetizer. The next step in the learning process would be to actually do an improvement project, or a significant event analysis in the clinic.

Looking ahead, the road to improvement is exciting.

'It is not whether we succeed but by how much we succeed. The only way we fail is if we do not try.' ■

Family Medicine Joint Session:

Should Family Physicians continue to be generalists?

By Dr Tan Boon Yeow, MMed (Fam Med) Course Convenor 2005 & A/Prof Goh Lee Gan

Editorial Note: Dr David Cunningham and Dr Rodney Nan Tie were in Singapore as external teachers in the 2-week M.Med(Family Medicine) Course conducted in August 2005 for MMed (FM) examination candidates. They shared their views on the topic at a special session held on 24 August at the College.

Background

The development of Family Medicine started out in the 1970s as a counter culture to specialization as there was too much fragmentation of care as a result of sub-specialty medicine. The six distinctive aspects that describe family medicine are personal, primary, preventive, comprehensive, continuing and community care. However, the rapid proliferation of medical knowledge makes it difficult for the generalists to keep in touch with medicine, let alone be proficient in it. In addition, the need to cater to service needs that are not well served by our specialist colleagues led to family physicians taking on specialized areas of work.

Over time, such doctors developed increased competence in specialized areas. There are concerns that this will lead to loss of skills in other areas that would make the family physician unable to provide the comprehensive care that is distinctive of a family physician.

The UK viewpoint

Dr David Cunningham, Associate Advisor from NHS Education Scotland, shared that in UK there is a move towards the development of GP with special interest (GPwSI). NHS also started encouraging GPs to manage more chronic disease by awarding them financial contracts in 2004. This was created with an aim of shortening waiting time for patients to get appropriate care; encouraging GPs to learn new knowledge and skills and to break down the barriers between primary and secondary care.

The other advantages of GPs being involved in secondary care is that there is improved communication skills between

doctor and patients; a more holistic approach to care as well as a better appreciation of psycho-social aspects of medicine. There is also improved continuity of care between different chronic diseases e.g. diabetes and IHD and hence resulting in integration instead of fragmentation of care. However, this may come with a price. GPs may be less accessible as they see less acute problems and they may become de-skilled in areas that are not the GP's special interests.



Dr David Cunningham

The Australian experience

Dr Rodney Nan Tie, Senior Lecturer of James Cook University Australia, started his discussion by comparing Singapore and Australia. Singapore is a small country with dense population density and a rapid population growth.

Australia, on the other hand, has a vast amount of land with a dispersed population and the GP is often one of the few doctors available in a rural setting. Historically, a large number of Australian GPs has 'specialists' skills and most of them share their skills in a group practice.

He noted that Singapore is evolving towards the Australian system with accreditation of her GPs, postgraduate training, emphasis of chronic disease management and continuing care by GPs and rewarding GPs with sub-specialty qualifications. This could possibly lead to decrease in overall healthcare cost with improved/maintained clinical outcomes as the nation becomes less dependent on hospital specialists for conditions that can be managed in a primary care setting.

On the contrary, Australia seems to be moving towards a more generalist approach of care due to the emergence

of highly paid specialties in GP (e.g. dermatology and travel medicine). The attraction to these disciplines include shorter working hours, no after hour care, less stress and hence a better lifestyle for the practitioner. This has resulted in a lack of GPs wanting to do general work especially in less attractive & lower paid areas (e.g. aged care). There is also resentment towards these 'specialists' GPs 'pinching the cream'. Other potential problems include fragmentation of GP care with the loss of generalist skills as well as a loss of public confidence in generalist GPs. Finally, there are concerns



Dr Rodney Nan Tie

that these 'specialists' GPs have no proper training program & accreditation.

However, it is recognised that the development of specialists GPs can achieve the following:

- Reduce load on specialist services
- Improve retention of GPs through the development of new skills, increase in job satisfaction and reduce burnout.
- Increase income for the GPs with attraction for more to join the specialty.
- Increase patient demand for such services as there will be a perception of greater expertise provided by the GPs.

The Australian response is to be more focused in the specialized care provided by the GP and to incentivise GPs to provide care for patients with chronic conditions (like asthma, diabetes) as well as chronic conditions in those with complex needs (e.g. Older patient with stroke or other chronic degenerating diseases). There is also a greater emphasis on post graduate training in these areas with the aim of developing a competent Australian GP who would be a general specialist!

In conclusion, there will need to be a balance between generalist work and the special interests' type of work and the maintenance of competency in the respective areas. ■

infrastructure to facilitate this change. This will ensure that our patients can live healthier lives with fewer disabilities, at a lower health care cost and with care delivered largely at the primary level.

Let me give you the example of the Singapore National Asthma Programme which was extended to the polyclinics in 2004 to test out these strategies. Preliminary results from one of the polyclinics have shown a 30% decline in the number of acute asthmatic attacks amongst patients in the programme. The number of acute referrals to hospitals has also decreased from 3 cases per month to almost zero.

In 2004, MOH also initiated disease management programmes for diabetes and hypertension run by family physicians in the polyclinics.

The programme ensures that adequate consultation time is provided for family physicians to appreciate the backgrounds of their patients, to counsel and educate them according to their needs, and to facilitate the human touch that is critical in building the successful doctor-patient relationship – a relationship so essential for influencing health behaviour.

Although patients have to pay a little more for the longer consultations, the feedback I have received is that they are happy with the improved standards of care. To address the increasing demands for such clinics, 3 more^[1] FP clinics will be set up by November this year.

On another front, MOH has proposed a regulatory framework for opticians and optometrists to ensure that training infrastructure is put in place to enable optometrists to upgrade and provide better refraction services to our patients within the community.

Proposed FP Register another initiative
Likewise, the proposed Family Physician Register is yet another such initiative designed to ensure that structured and directed training programmes are available to enable our doctors provide the right level of care in the community.

A strong base of family physicians is expected to improve the coordination and continuity of care of patients with chronic diseases and ultimately improve clinical outcomes.

For example a family physician's patients who are obese or who have a strong family history of certain cancers can be proactively screened or encouraged to modify their lifestyles before the disease sets in.

Patients are also more likely to be compliant to treatment if a family physician knows his medical conditions well.

While many GPs, through their years of practice, have gathered experience to care for this type of patients, a system needs to be put in place to ensure that newer generations of family physicians will acquire the necessary skills much earlier in their professional career.

Other measures in Transformation of Primary Care

Having said that, the Family Physician Register is but one of the many measures that MOH and the profession as a whole have to take to bring about the transformation of primary care.

Use of IT in Primary Care

For example, there is tremendous potential for the use of information technology or IT in enhancing primary care delivery. New medical evidence is making chronic disease management protocols more complex and it will be increasingly difficult for any doctor to keep up with the latest treatment protocols.

Judicious use of IT in primary care can empower the family physician with appropriate decision support tools to ensure that chronic disease management is up-to-date. This will free up precious consultation time for health education, care coordination and to better understand the patient's social and occupational issues. I was told that there are already pockets of such IT developments amongst private practitioners but much more can be done to encourage widespread adoption of such IT systems.

To further realize the potential of IT in primary care, the exchange of medical information between hospitals and family physicians should ideally become seamless. With the introduction of the electronic medical records exchange system in April 2004, medical records can now be shared between public hospitals and polyclinics.

A huge potential remains, for more *and* better linkages between the medical record systems of the private and public sectors. For example, timely exchange of medical information between public hospitals and family physicians will facilitate the follow-up of patients who have completed treatment at the hospitals.

Similarly, IT systems should help to optimize the use of specialist resources by allowing family physicians to obtain specialist input on complicated cases before upstream referral. The receiving specialist should be able to review medical records online and advise the family physician to complete any required investigations or treatment before he decides to refer the patient.

The IT developments that I have highlighted can be costly and solo-practice clinics may find difficulty in embarking on them. MOH will continue to work with all stakeholders to promote these linkages, and to exploit IT fully in order to achieve the most efficient delivery of holistic primary care.

Family Physician involved to coordinate specialist care

However, the seamless availability of medical information to specialists through IT systems must not result in the movement of patients to hospitals without the involvement of a family physician to coordinate care.

This is an aberration seen today, even without the seamless IT system. There are a number of patients who prefer to seek specialist treatment without first consulting their family physicians.

A paper in the British Medical Journal^[2] suggested that patients who went directly

to specialists were less likely to be ill, increasing the chances that diagnostic and therapeutic procedures were applied inappropriately.

The study concluded that despite consumerist trends in most developed nations, patients would continue to need family physicians to guide them through an increasingly complex healthcare system.

As such, MOH will continue to explore ways to support the role of family physicians so that they may help to safeguard patient interests and ensure that specialist resources are utilized in the most efficient way.

Strengthen long term Family Physician-Patient relationship

We will also explore ways to help strengthen and sustain long-term family physician-patient relationships. For example, ageing patients with increasing medical needs may find that as a result of reduced income and increased complexity of disease, they can no longer afford to continue seeing the family physician they have been seeing for years.

We want to explore ways to help these patients remain under the care of the same family physician whom they have been with for the past many years.

The task will not be easy but it is our belief that long-term family physician-patient relationships are essential if we want to secure better health outcomes for all Singaporeans.

Horizontal integration among Family Physicians

So far, I have spoken about family physicians in relation to their hospital colleagues and with their patients. Family physicians must also actively explore ways to integrate their practice horizontally with the practices of other family physicians.

Retain Generalist Role

While it may be necessary for certain family physicians to develop additional expertise in geriatrics or psychiatry to

enhance the care they provide, family physicians must resist the temptation to sub-specialize and must continually upgrade their skills and knowledge in the broadest sense in order to retain their generalist role.

Due to the increasing complexity of primary care, maintaining the breadth and depth of family medicine practice will become increasingly difficult. No man is an island. Multi-practitioner interactive functional groups in the primary care sector will enable family-physician-groups to discuss complicated cases together, to share and learn from each other, and to coordinate and manage more complex medical conditions within the community. We are currently exploring incentivising such groups by accrediting them as CME providers for family medicine.

To facilitate and support the greater involvement of family physicians in the management of his patients in the community, he must also have access to laboratory and radiological investigations with rapid turnaround times so that critical medical decisions can be made better and faster at the primary care level.

Horizontal integration with other family physicians may result in economies of scale that can justify the establishment of laboratory and radiological facilities in every township, while immediate access to specialists in diagnostic radiology and pathology for reporting purposes may become a non-issue with the help of Telemedicine services.

MOH will explore ways to support such infrastructural developments within the community. The College must in turn ensure that family physicians are appropriately trained to take advantage of these support services to bring about a more efficient delivery of primary care within the community.

As an added benefit, horizontal integration will also permit more time for family physicians to take part in continuing medical education and generally encourage a more flexible work-life balance. All these features will ultimately

bring about better health outcomes for Singaporeans.

Primary Care Research

Despite our many efforts, a new era of primary care will not emerge if we do not concurrently step up our efforts in primary care research. Monitoring of clinical outcomes in the primary care sector is necessary if family physicians are to continually develop better and more cost effective models of care for chronic diseases within the community.

Research will also help policy makers ensure that our strategies are correctly positioned to effect the transformation of primary care. The polyclinics in our two public health care clusters are well positioned to take the lead in this but GP groups and perhaps even solo practitioners should not feel left out.

The College must find ways to encourage family physicians to embrace primary care research so that the profession as a whole will be able to develop this culture of inquiry, innovation and excellence. These are qualities that family medicine will need to foster in order to secure its position alongside established specialities like internal medicine, paediatrics and surgery.

When the Family Physician Register is established in 2007, a Family Physicians Accreditation Board will be appointed to manage the register and also to ensure that training programmes remain relevant to the emerging and changing roles of family physicians.

Duty of College & relevant appropriate training programmes

The Ministry of Health will continue to provide the necessary legislative support and infrastructure for the profession to meet the challenges of primary care. However it is the College which has the greater duty.

Perhaps it is time to stop burdening doctors with examinations. Perhaps it is time to repackage the GDFM and other qualifying examinations without a focus on examinations but as a programme of

skills acquisition, continuing learning and continual assessment. A programme that will facilitate life long learning and incidentally entry to the FP register.

You must ensure that the training stays relevant to the needs of family physicians.

The College must be an inspiration so that experienced practitioners will step forward to lead the profession into the new era of primary care.

I have tremendous faith that the College will rise to this challenge. However translating training programmes into clinical practice that can secure better clinical outcomes requires more than just thoughtful planning.

Hard work ahead

Many years of hard work and dogged perseverance by members of the College will be required. This will be an arduous task that only the most dedicated amongst you will be able to perform. Many will be looking to you and you must not fail.

To mark the start of this long but necessary journey, MOH will officially release the public consultation paper on the proposed Family Physician Register today. A copy of the consultation paper is on the way to every registered medical practitioner.

You will find that the criteria for registration are both achievable and inclusive. Existing general practitioners who do not wish to register may continue their

practice and will not be negatively affected.

However, I believe that the majority of these primary care doctors will gladly join us in this quest. The Family Physician Register is but the beginning of our efforts to reshape primary care. I urge all of you to consider the proposal for the register and suggest where it may be improved.

In closing, I would like to extend my warmest congratulations to the 5 doctors who are conferred fellowships of the College of Family Physicians and the 42 GDFM recipients. The future of family medicine is as much in your hands as it is in mine and the College's. We are proud to have you with us on this journey. ■

1[1] The three polyclinics are Bukit Batok (NHGP), Outram (SHP) and Tampines (SHP). 2[2] Christopher B Forrest. Primary care gate keeping and referrals: effective filter or failed experiment? BMJ 2003;326:692-695.

1 Making treatment decisions in End of Life Care for the Elderly

As family physicians, we often encounter treatment decisions for our dying elderly and families who want our advice and support in making treatment decisions for their loved ones.

Situations include:

1. Those with a progressive advanced illness, where life expectancy is relatively short e.g. Advanced cancers, End stage organ failures e.g. ESRF
2. Those with chronic diseases with long term disabilities, who now develop an acute illness that is life threatening e.g. Dementia, recurrent stroke disease who develop severe sepsis
3. Those who are very elderly but otherwise well, and now with an acute illness that is life threatening



Ask yourself 3 questions:

1. What is the medical intervention?
 - Consider beneficence, non-maleficence, medical futility, quality of life
2. What does the patient/ family want? (patient autonomy)
 - Consider preferences, surrogate decision making, advanced directives
3. What is the context?
 - Consider Justice and resource allocation
 - Legal issues

Type \ Intervention	Terminally Ill	Chronic disabilities with Acute life threatening illness	Very Elderly with Acute life threatening illness
Advanced Life Support	Medical Futility	Limited Benefits Justice	Judgement Call
Antibiotics	Limited benefits Non-maleficence	Some benefits	Beneficence
Feeding Tubes	Limited benefits Maleficence	Judgement Call	Judgement Call

2 What does Numbers Needed to Treat (NTT) mean in clinical trials?

Statistical ways to express outcomes of clinical trials include p values, odds ratios, relative risk and relative risk reduction or increase. All may have their place, but they are difficult outputs for the non-specialist to interpret. In order to overcome this, the number needed to treat is increasingly being used.



The NTT, as the name implies, is an estimate of the number of patients that would need to be given a treatment for one of them to achieve a desired outcome who would not have achieved it with control. The NTT should specify the characteristics of patients being treated, the intervention and its duration, and the outcome being measured.

How to calculate NTT?

For an analgesic trial, the NTT may be calculated very simply as:

$$\text{NTT} = 1 / (\text{proportion of patients with desired outcome minus the placebo effect})$$

$$\text{NTT} = 1 / (\text{proportion of patients with at least 50\% pain relief with analgesic minus the proportion of patients with at least 50\% pain relief with placebo})$$

For example, let's say :

- 50 patients were given ibuprofen, and 27 of them had more than 50% pain relief over 6 hours.
- 50 patients were given placebo, and 10 of them had more than 50% pain relief over 6 hours.

The NTT is therefore $1 / ((27/50) - (10/50))$

$$= 1 / (0.54 - 0.20)$$

$$= 1 / 0.34$$

$$= 2.9$$



The best NTT would, of course, be 1, when every patient with treatment benefited, but no patient given control benefited. Generally NTTs between 2 and 5 are indicative of effective treatments, but NTTs of 20, 50 or 100 may be useful for prophylactic treatments, like interventions to reduce death after heart attack.

My HMDP experience

Visit to the National Patient Safety Agency, London, 1 – 30 May 2005

By Dr Hwang Chi Hong, Senior Family Physician, NHGP Patient Safety Office, Head of Clementi Polyclinic

Introduction

As part of my HMDP, I was privileged to visit the National Patient Safety Agency (NPSA) in London in May 2005. My trip was generously financed through the NHG Patient Safety budget.

So at the end of April, with my family in tow, I made my way to London. I started out with a very basic understanding of patient safety and returned with ideas of integrating Patient Safety features into our daily work in NHG.

The Start of the National Patient Safety Agency (NPSA)

Around the turn of this century, the National Health Service (NHS) in England acknowledged that it was not learning from Patient Safety Incidents (PSIs). There was a lack of unified mechanisms for analyzing and reporting lessons learnt from PSIs. Solutions were seldom shared with other institutions, and when shared, were not integrated into the daily work processes.

With the realization of the importance of ensuring patient safety, the National Patient Safety Agency (NPSA) was set up in October 2001.

The People of the NPSA – an open culture of learning and sharing

Ms Joanna Parker, Head of Safer Practise Department in NPSA was the contact person for my trip. On my first day at the NPSA, I found waiting for me on the desk a huge pile of Patient Safety materials published by the NPSA. A laptop computer connected me to the NPSA Intranet and the Internet for ease of access to online Patient Safety information. My schedule in NPSA had been pre-arranged and was fully packed. On most days I would be meeting up with NPSA people back to back, sometimes as many as 3 to 4 people in a day.

The NPSA believes that openness as well as sharing and learning from one another are the best ways to increase Patient Safety knowledge. This attitude

is actively encouraged within the organization and throughout the NHS. I was impressed that the staff of the NPSA not only preached this but lived it as well. They were friendly and eager to speak to me in their areas of expertise. Materials and documents were given freely to me, even ones that were not yet officially published.

Capturing and storing Patient Safety knowledge at NPSA

The ultimate goal of the NPSA is to ensure that it captures and stores the Patient Safety knowledge of every single NHS staff, patient and organization.

The NPSA works towards this goal by:

- Creating an IT infrastructure
- Creating a Patient Safety Culture in NHS that encourages reporting

The IT infrastructure has 2 components:

- A database to store the information - the *Patient Safety Observatory*.
- A Web-based Reporting System - the *National Reporting and Learning System (NRLS)*.

Building a Culture of Patient Safety

Over the past 5 years, the NPSA works with healthcare institutions to create a non-punitive culture in the NHS. Staff will report patient safety incidents (PSI) more willingly when they are not fearful of punishment. There is active promotion of the message of looking at systems failure rather than targeting the individual when things go wrong.

The NPSA has also trained a group of Patient Safety managers to work with clinics and hospitals in the community.

The Primary Care Patient Safety Scene in the NHS

Internationally, Patient Safety work has so far focused more on hospital-based



Group Photo: Dr Hwang(3rd from Left) with NPSA Staff

practices. In the past 1 to 2 years, Primary Care physicians have increasingly recognized the need for Patient Safety and have shown great enthusiasm in participating in this movement.

Reflections back home in Singapore and work ahead

Speaking of safety culture, on a personal note, there was the irony of dealing with stolen luggage, a lost kid in the toy store, falls & cuts and jet lag, amongst other things! But we took it in stride and soaked up the sights, the history and the culture of London, explored many playgrounds and enjoyed many good meals!

Certainly on my return to Singapore and back to work, I carried back the same can-do spirit and continued brimming with ideas on patient safety.

It has struck home that, in the initial stages of building a culture of patient safety, staff need to be encouraged and motivated to embrace patient safety initiatives rather than be criticized for their lack of it. Patient safety in primary care is an exciting area as in the long run it benefits our patients, cuts down litigation and results in a better outcome for both doctors and patients!

I believe the NPSA's open culture of learning and sharing is something that we should actively pursue in our healthcare system in Singapore. In the words of a Patient Safety Officer I met, "Culture takes time to create...Even while work has begun in England and we have come a long way, the situation here is far from perfect..." ■

FM Research Bites: The Research Paper

By Dr Michael Yee, Editorial Board Member

We started the series by introducing the finer points of formulating a research question. We will end the series by finishing the product, which is the research paper for submission.

CHECKLIST – WHAT GOES INTO AN ORIGINAL RESEARCH PAPER

Original research papers have the same basic format irrespective of the journal in which they are published. Papers are composed of a summary, introduction, methods section, results section, and discussion. The task of preparing a paper is greatly simplified by writing sections in the following order:

1. Methods
2. Results
3. Discussion
4. Introduction
5. Summary

METHODS

Study design:

Introduce the methods section with a brief overview of the study design. **Outline** the sequence of steps which were followed - precise details will be provided in the sections which follow.

Subjects:

1. List the eligibility and exclusion criteria for entry into the study. This includes such information as diagnostic criteria, age, and sex.
2. Describe how eligible subjects were recruited and from where.

Instruments (questionnaires, tests & investigations):

For each instrument,

1. State its purpose in relation to the objectives.
2. Describe the method and how it was applied in this study.
3. Where necessary, give a published reference to the method.

Analysis:

1. Name the computerised statistical package used.
2. Describe how the data were used to address each of the stated objectives.
3. Name the statistical tests used. If the test is unusual or complex, give a published reference.

RESULTS

Begin by describing the subjects of the investigation:

1. Give the numbers of eligible subjects and the response rate.
2. Describe the characteristics of subjects entered in the study.
3. Describe the results of any investigation into the characteristics of non-responders. For each of the stated objectives of the paper,

1. Select the principal outcome measure(s) and describe the results.
2. Describe the results of subsidiary findings and analyses which add to or explain the principal outcome.

DISCUSSION

The purpose of the discussion is to point out the strengths and weaknesses of the research, draw conclusions, and speculate about the wider meaning of the conclusions.

Strengths and weaknesses:

The conclusions need to be considered within the overall limitations of the study. These fall into two groups - conceptual and methodological.

1. Conceptual:

With the benefit of hindsight, ask whether the study failed to examine some important outcome which now appears essential to meeting the stated objective.

2. Methodological:

Ask whether any of the methodological weaknesses could have **biased** the results leading to **false** conclusions. Non-response of subjects, missing data, and the imprecision of assessment instruments are common sources of bias.

CONCLUSIONS

For each of the stated objectives,

1. State your principal conclusion and describe how/why the results of the present study support the conclusion.
2. Do not over-interpret the findings. Consider whether other interpretations could be placed on the same results.
3. Describe and discuss the findings of other studies which either support or refute your conclusion.

4. Describe the theoretical implications of your conclusion.

5. Describe the practical implications of your conclusion.

INTRODUCTION

The purpose of the introduction is to briefly describe the:

1. Current state of knowledge and the unanswered questions
2. Previous work which has addressed the unanswered questions.
3. The specific objectives of your research and how they will advance knowledge.

SUMMARY OR ABSTRACT

The purpose of the summary is to give a short synopsis of the study. It is composed of exactly the same sections as the entire paper. That is to say:-

1. There is a statement about the purpose of the study (introduction).
2. There are a few sentences describing the study design and principal outcome measures (method).
3. The principal results are given (results).
4. The main conclusions are drawn (discussion).

PRESENTATION

Submit the paper in the format requested by the journal. Read the "instructions to authors" and follow them! Include a covering letter to the Editor, which briefly states:

1. The importance of the research.
2. Why it should be published in that journal e.g. - journal has published previous, related work
- journal readers are most appropriate target audience

OUR CHALLENGE

I hope the short series of articles has given us enough motivation and know how to at least start thinking that FM research in Singapore is doable. It's time to convert our efforts into results and visions into reality. Start by attending the Research SIG meetings. ■

(Adapted from the Asia Pacific WONCA workshop on building a research Network)