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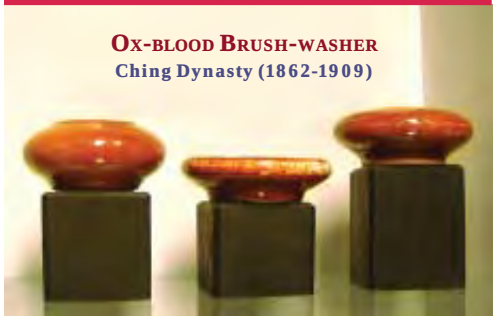

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Fulfilling the Unspoken Contract

by Dr Wee Chee Chau, MCFP & Editor

This year's Commencement Ceremony was held at the MOH auditorium on 1 July. The occasion was graced by Professor Satkunantham.

In his welcome delivery, the President of the College, A/Prof Cheong Pak Yean recounted some events that made last year significant, viz:

1. The announcement for the setting up of the Family Physician Register.

2. The formation of the independent department of Family Medicine and Continuing Care at Singapore General Hospital. With the appointment of the Senior and Associate Consultants, Dr Lee Kheng Hock and Dr Matthew Ng respectively, and an advisory role for the College, Family Medicine has finally been accorded a place among the various specialties in Singapore.

A/Prof Cheong was obviously proud to announce the admission of a record 113 doctors that registered for this year's GDFM, and the revival of programme B that leads to the MMed Family Medicine.

"good primary care... provide the solution to the problems"

Prof Satkunanantham's speech took an inspirational tone as he centered on the aspirations of many to advance their medical knowledge, and the resultant overwhelming demand for the GDFM. He expressed hope that good primary care in Singapore could provide the solution to the problems of an aging population and play a major role in the prevention of chronic diseases.

The ability to provide good quality care and influence health behaviour, from early detection of diseases to the continuity of care, based on a good patient-doctor relationship and the breadth of knowledge in providing holistic care, naturally makes the Family Physician the patients' advocate in health issues.

Meeting challenges head-on and shouldering the responsibility to society to maintain good medical standards and provide quality care are some of the features of good family practice. Prof Satkunantham also pointed out the "unspoken contract" that necessitate the Family Physician to act in the patient's interest as exemplified during the SARS incident that high lighted the professional way in which all doctors, especially the Family Physicians in the frontline of healthcare, plodded on in their work, in caring for their patients even in the face of personal peril.

Professor K Satkunanantham

Just as important, reminded Prof Satku, is the silent epidemic of chronic diseases that needed every attention that can be mustered in order to avert impending crises of immense proportions.

"College's responsibility to initiate and sustain changes, meet challenges, providing leadership..."

The College's responsibility to initiate and sustain changes to meet any challenges by providing leadership to direct the profession cannot be overemphasised. By providing the opportunity to upgrade medical education from undergraduate to post graduate levels, the College can bring the profession to the cutting edge of current medical practices, thereby meeting the needs of patients' expectations. To do all these on a voluntary basis, without the need for compulsion by regulations, will certainly be a move in the right direction, and even provide a role model for the entire medical profession.

"Formal training... not stop at the GDFM"

Prof Satkunantham expressed his hope that the desire to learn will increase in the Family Medicine fraternity and that formal training will not stop at the GDFM, but will continue to the level of MMed. He hopes that more will come forward to accept the challenge and thus, fulfill our part of the "unspoken contract".

Meanwhile, the MOH is looking at ways to improve primary healthcare, such as the impending release of Medisave for use in four chronic illnesses as was announced in April, and the collaboration of the HPB in providing community resource in terms of educational materials and opportunities.

All these will result in a slow but steady transformation of the primary healthcare scene that will put the Family Physician as a leader in patient care. Courses that will empower the Family Physician in this leadership role will provide the necessary platforms for mentoring and imparting of skills and expertise to the younger generation, from medical students to the practicing doctors.

Next, the Censor in Chief of the College, Dr Lee Kheng Hock carried out the briefing for this academic year's programme that had been lined up.

His delivery was focussed on training for the professional. An extract from his speech is published under the heading "Training for a Better Tomorrow" in page 5.

The appointment of the new GDFM tutors for 2006 to 2008 was completed before the Commencement Ceremony drew to a close. ■CM

Old and New

by Dr Wee Chee Chau, MCFP & Editor

EDITOR'S WORDS

The editorial team would like to register a congratulatory note to A/Prof Goh Lee Gan for taking over as the President of the College. We are confident that he will do the College proud as he leads us, especially through the coming WONCA Meeting in 2007.

Another year has passed, and we are celebrating yet another Commencement for this year. A new record has been set as the number of GDFM trainees has risen again. With the impending Family Physician Register coming up, I am sure that many of us are feeling the nudge to join the crowd and not be left behind.

As such, the article that reviewed the replies of fresh graduates and new trainees of the GDFM should be a welcome read, as more of us can then get a feel of the GDFM through the experiences of these GPs that had already launched their professional development programme.

Our Censor in Chief, Dr Lee Kheng Hock, currently the newly appointed head of department in SGH's FMCC, provides a good insight to current and future Family Medicine training directions for those who are contemplating their next move up the tree of knowledge in his entertaining article on professional training.

I would particularly like to draw your attention towards two articles.

The first, written by a polyclinic doctor, focuses on patients' non medical problems in the polyclinic situation. Dr Yvette Tan's thought provoking article makes one wonder if the allocation of funds to help our less fortunate patients (through the subsidy at the polyclinics) is actually reaching the right people. Can we, as Family Physicians do more to 'heal' the family and not just to treat the disease?

The second article, by Dr Sally Ho, brings to mind the numerous times when I presumed that the patients actually understood what I told them, only to get the same queries at the next visit. All of us should pay attention to the contents of her article and improve our communication skills, thereby empowering our patients to share in the management of their health. Following the steps laid out in the article should go a long way to improve our practices.

We have come to the end of our two year term as the editorial team and I take this opportunity, on behalf of the Editorial Board, to thank the College council especially A/Prof Cheong Pak Yean for his advice and help during this two years. It's time to make way for new blood and we wish the next team all the best, and hope that they will benefit as much as we did in the last two years. ■CM

Taking the Next Lap

by A/Prof Cheong Pak Yean
President, College of Family Physicians Singapore
May 2001 to June 2006

At the 33rd Annual General Meeting in June 2006, I announced that A/Prof Goh Lee Gan has agreed to complete the rest of the 20th College Council's term as President and that I shall take his place as Vice-President. I have been at the helm of the College for five years since my election in May 2001 for the first of three two-year terms.

This change in portfolio will put the College in a good position. In July 2007, Singapore will be hosting the Wonca (World Organization of Family Doctors) World Conference. This is the second time that Singapore plays host since first hosting it in 1983. A/Prof Goh is no stranger to the Wonca world. He was one of the seven members in the 1983 Wonca Host Organising Committee. He is presently the Regional President of the Asia-Pacific region and also a member of its World Executive Committee. For his contribution in promoting the training of Family Medicine, he was conferred its Fellowship in 1995.

In the past five years, the College has focused its resources on its core business to develop our doctors vocationally, and beyond that, to continuing professional development. The GDFM programme is an example of vocational development and the Family Practice Skills Courses is that of continuing professional development. There are also innovations like the e-learning platform that would take us into the future. The formation of the Department of Family Medicine in the Singapore General Hospital is yet another milestone. Figure 1 captures the significant milestones for family medicine in recent years.

The Ministry's consultation paper on the Family Physicians Register (FPR) published on 1st October 2005 is perhaps the high point of the College's and the fraternity's future. The FPR consultation attracted a great deal of discussion. I am happy that the College continues to contribute to the Nation's endeavour of consolidating primary care resources.

The membership of the College has increased in the last five years from 806 members (March 2002) to 1243 (March 2006). The College certainly has engendered majority support. A strong College is important as family practice continues to transform in Singapore from acute episodic care to holistic, integrated and continuing care. I am confident that A/Prof Goh Lee Gan would lead the College to greater heights in the next lap ahead. CM

Figure 1. Family Medicine Milestones 2001-2006

2001	• First batch of Fellows by Assessment conferred October 2001 • Wonca World Secretariat in Singapore inaugurated on 8th Nov 2001
2002	• Institute of Family Medicine established June 2002 • First batch of GDFM Graduates October 2002 • Family Medicine Skills Courses started
2003	• Special Interest Groups set up in College • College participation in Core FM Accreditation programme of SMC
2004	• College Memorandum in June 2004 to the Ministry proposing the establishment of a national register of family physicians
2005	• College Advisory Group set up to advise SGH on a FM Dept June 2005 • Ministry of Health consultation paper on Family Physicians Register 1st October 2005 • College appointed to host the interim Family Medicine Training Committee
2006	• Department of Family Medicine and Continuing Care in SGH on 2nd May 2006 • First batch of Collegiate Membership by Assessment to be conferred November 2006

Building on What We Have Achieved

by A/Prof Goh Lee Gan
President, College of Family Physicians Singapore
June 2006 - present

In the last six years we have set our sights to transform general practice (or family practice) to make it more satisfying and viable for the rank and file colleagues of the land. Admittedly it is tough work because of conflicting values, conflicting interests, fear, misunderstanding, and sometimes, also mistrust.

Nevertheless, we are persisting at it. As I was quoted in the seminar on transformation on primary care two years ago - "The darkest hour is the hour before dawn.". Hopefully, we have passed that. Whatever it is, we are not out of the woods.

SWOT Analysis

Perhaps we could begin by taking stock of our strengths, weaknesses, opportunities, and threats, the four elements of the SWOT analysis.

Strengths

Certainly, we have now - over the years - built up the infrastructure to build capacity amongst our doctors professionally. The Institute of Family Medicine was set up in 2003 to help develop the knowledge base courses for the vocational training programmes and the continuing professional development programmes. We now have a team of eight doctors in the Institute.

For vocational training, we have the Graduate Diploma in Family Medicine and the MMed(Family Medicine) both as tripartite efforts of the Ministry of Health, University, and the College. The Graduate Diploma is to build postgraduate clinical knowledge and clinical competence: The vision is to have every primary care doctor to be at this level of expertise. The MMed is aimed at training family doctors to be leaders and the standard is pegged to be on par with the hospital specialists colleagues. It is therefore by design aimed to be a more rigorous and steep programme.

For professional development we have set in place the MCFP and FCFP by assessment for several years now.

Many still think of the general practitioner as cold and cough doctors with very little other expertise.

Our MCFP Diplomates and Fellows are now in leadership and training positions in the two clusters, the private sector, and University. These people will lead family medicine to a higher plane.

For those into the third phase of professional life namely, Continuing Medical Education (CME) and Continuing Professional Development (CPD), we have set in place the Family Practice Skills Courses anchored by the distance learning material and MCQs in the College publication, the Singapore Family Physician, the seminars and the workshop to complement the distance learning components. We are grateful we have supporters in the multinational pharmaceutical companies and Health Promotion Board for these training endeavours. There is also the e-learning platform that is being developed.

These training programmes, aimed at various phases of the professional life of the family doctor, will certainly build capacity in our doctors to take on a bigger role in the health care delivery system beyond acute care.

The practice infrastructure has also developed. We now have many more group practices, and most of our practices are well organised and staffed. There are also training programmes either in house or at the ITE for clinic assistants.

Weaknesses

There are many system weaknesses that together contribute to the woes of the family doctor. Many in the public are not aware of the capacity building that is taking place. Many still think of the general practitioner as cold and cough doctors with very little other expertise. We therefore need to sell ourselves to our patients and their significant others.

We will also need to gain the support of our colleagues to say positive things about us so that the patients' trust is not eroded. And this needs understanding and rapport. Gratefully, the introduction of family medicine into the undergraduate curriculum since 1988 has something to develop a better mutual understanding of the hospital

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Training for a Better Tomorrow

The following are abstracts from the speech by Dr Lee Kheng Hock, Censor-in-Chief, College of Family Physicians Singapore, at the Academic Year Commencement 2006

"A profession is an occupation that requires extensive training and the study and mastery of specialised knowledge and usually has a professional association, ethical code and process of certification or licensing."

The College as the professional body representing family doctors will do its part to restore professionalism, largely through the advocacy of training and higher standards of practice. Training is the means to an end. Ultimately, we want to create a more satisfying vocation for our colleagues and better, more effective family doctors for our patients and our country.

Training is the first and essential ingredient for a better tomorrow. Other changes must follow. Well trained family physicians must be given the time and resources to practice what they are trained to do. The health system must be re-designed to harness the power of a revitalised profession in the quest for better health for our citizens.

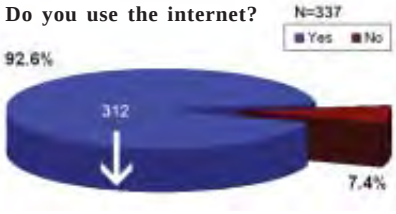
Study on Training Needs

The College of Family Physicians Singapore and the Joint Committee on Family Medicine Training (JCFMT) conducted a study to better understand the training needs of our colleagues. The survey was conducted in March 2006. 1174 questionnaires were mailed out to our members. A total 337 responses were received.

The following are some of the findings:

1. The use of internet and access to broad band services was higher than was widely assumed (Figure 1).
2. An encouraging number of respondents were willing to participate in professional development activities (Figure 2).
3. Contrary to expectations, most respondents prefer the traditional modality of delivering CME by lectures and seminars. More than half (62.9%) would like to have CME delivered via e-learning (Figure 3).
4. Analysis of the indications of preferred topics revealed that most respondents want practical topics that are related to their day to day practice.
5. "Orphan topics" that are usually poorly covered in weekend CME sessions due to a lack of interested sponsors appears to be well favoured (Figure 4).

Figure 1. Use of Internet



Among these 312 respondents who use the internet:

Purpose for internet usage: (MA)	
Email	95.2%
Personal use	93.3%
Literature search	66.0%
CME and medical training	60.9%
Professional association updates	46.8%
Access online journal	46.2%
Searching for patient scientific information	36.2%
Clinic administration	34.0%
Consultation with colleagues	17.6%
No comment	0.3%

Access to internet: (MA)	
Broadband access at home	76.6%
Broadband access at office	39.4%
Dial-up access only	19.9%

*all respondents have access to internet

The survey showed that family physicians are pragmatic and want CME that is relevant to their daily practice. In particular, they want the subjects that deal with practical issues that are encountered in their work. There is demand for topics that are not well covered under our present system of organising CME activities which is dominated by the availability of sponsorships by vested interest.

Training is the first and essential ingredient for a better tomorrow. Other changes must follow.

Acccedited Modular Course

The Accredited Modular Course leads to registration with the Family Physician Register for doctors who do not possess recognised postgraduate degrees in family medicine. The objective is to have a structured training programme that caters to the needs of doctors who work long hours. Participants can register on-line and download course materials via an e-learning system. This is followed by face to face seminars organised by the health care clusters and concludes with a simple on-line MCQ test and certification of module completion. Provisions will be made for doctors who do not have internet access.

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Why Did You Take Up the GDFM?

As more GPs are coming forward to join the GDFM, we, at the College Mirror decided to do a random, unscientific survey of sorts, via e-mail, to some new trainees and fresh GDFM graduates.

We hope to present an idea of the spectrum of GPs that signed up, took the course and sat for the exams, and see if more GPs will be encouraged to join this group of people that had taken the challenge of moving up the "tree" of medical knowledge and professional development.

At the same time, we hope that new trainees can benefit from some of the comments on how best to tackle the GDFM examinations.

New Trainee Interview

For the new trainees, the following queries were sent to them. Their replies were studied and summarised for your reading pleasure.

1. Professional data:
- number of years in general practice
- type of practice

2. Why did you take up GDFM and how do you think it will benefit you?

3. What do you expect from the GDFM and how do you think your practice will change after you attained the GDFM?

4. What do you feel about the current primary care situation in Singapore and how do you see yourself fit into the system after attaining the GDFM?

5. Will you consider furthering your professional development after the GDFM?

6. If there is one thing you can change to make the current healthcare system better, what will that be?

The Answers

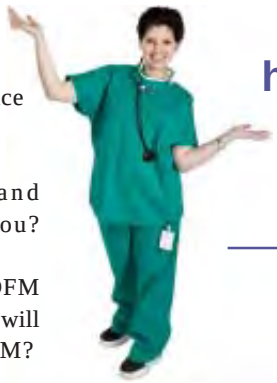
1. In the selected group of GPs, were doctors that had been doing GP work from just 6 months to a long 24 years.

Most are from the government sector (polyclinics) but there were a few from the private sector in solo as well as small group practices.

Besides the run of the mill GP type of cases that include acute and chronic care, some are involved solely in the care of the elderly.

It was pretty interesting to find a couple of doctors from non traditional sources, ie foreign graduates that are already post grad qualified in Family Medicine that were enrolled in the course.

"GDFM will prepare the doctor to take on role of holistic healthcare provider..."



2. Reasons for taking the GDFM included:
- for professional development
- acquire and hone skills and knowledge, upgrading self
- as part of CME, a learning opportunity
- being a requirement for foreign doctors from non-traditional sources
- to increase quality of care for patients

3.Expectations / effect of GDFM on practice:
- to improve management of acute and chronic cases
- develop skills that are on par with international standards
- ensure practice is within clinical guidelines
- increase exposure to, or interaction with colleagues and specialists to enhance and share knowledge
- comprehensive training will come in handy for the day to day running of the clinic
- structured learning to inculcate discipline in acquiring new knowledge

4. Current primary care situation:
- GDFM will prepare the doctor to take on role of holistic healthcare provider, health educator, counselor as compared to the current situation
- Unfair playing field, with poly-clinics having more patients than they can handle, whilst private GP clinic are empty. Some sort of means testing should be instituted to correct the state of affairs.

5. Further professional development after GDFM:
- most replied in the affirmative

6. Healthcare improvement:
- involve the patient in managing his/her own health
- increase the consultation time, and treating the person and not only the disease.
- achieve a better doctor-patient ratio in the polyclinic, by appointment system etc
- have more doctors in the government service.

Graduate Interview

Similarly, a set of questions were sent to a group of randomly selected fresh graduates from the last GDFM course.

1. Professional data:
- years in general practice.
- type of practice- solo/group/ government service

"... the MCQs were 'killers'..."

2. How were the exams that you just cleared?

3. Did it take a lot of your time and effort to do the GDFM?

4. What are some memorable moments during the last two years? (The best and the worst times/ incidences)

5. Any tips for the new trainees to make it easier for the course and exams?

6. What can be done to improve the GDFM or deleted from the syllabus?

7. How will your practice change, now that you have passed the exams?

The Answers

1. The range of GPs that passed the exams were quite similar to that of the new trainees with a work experience in family medicine ranging from 1 to 20 years.

2. GDFM Exams - Tough or Walkover?

- Most felt that the MCQs were "killers" especially when marks were deducted for wrong answers, the older candidates felt that a 2 hour MCQ was overwhelming.
- One felt that the exams was fair and widened his knowledge but another had only one word for the exams: "Phew!"
- A few thought that the exams were fair but on the whole, almost everyone were impressed by the practical OSCE exams and marveled at the organisation and effort that must have been put into it.

3. Time and Effort

- One doctor gave a ballpark figure of 3 solid weeks to prepare for the exams, but most felt that daily toil and revision is the way, not a last minute cramping.
- Most also complained of having too much notes to study but agreed that the tutorials and tutors helped them tremendously in their preparation.
- Almost everyone quoted on the sacrifice of family and friendship time to cater for the course, although one guy felt that the 2 year course was quite comfortably paced and manageable.

"consistent and regular reading and no last minute cramping..."

4. Memorable Times- Good and Bad:

- Presenting to more than a hundred GPs at a workshop was the highlight of one participant's experience.
- Getting to know new friends and refreshing old friendships, by working and 'suffering' together, were the most quoted memorable part of the GDFM experience.
- New bonds formed by study groups create networking that will be beneficial to all.

Bad memories come in the form of messy notes that needed organization just before the exams for a trainee. The panic attacks that accompanied such times will be remembered for a long time to come.

- Another doctor experienced his first 'floaters' and found that they really irritated his revision.
- For another, the mock clinical exams before the real thing was such a bad experience that 'woke him up' to do some serious mugging, especially when he had forgotten simple clinical examination techniques.

By and large, the majority could not come up with any bad memories.

5. Tips for the Exams:

The feedback for this question is most enthusiastic which emphasised everyone's concern is the exams.

- Consistent and regular reading and no last minute cramping is the rule of the day for most.
- The other tip that keeps popping up is: apply what you learnt into your practice to reinforce the knowledge.
- Form a study group but keep in mind that a big group may pose problems in coordinating time for meetings.
- Practice OSCE with friends to get used to the examination techniques and test each other.
- Prepare some approaches to common cases that are normally seen in the clinic.
- Know basic knowledge well and keep updated in clinical practice guidelines.

6. To Improve the GDFM:

- Most of the candidates were pleased with the organisation and conduct of the entire course, but they did brought up some points that may help improve the course for future batches.
- Most found the interactive style of teaching much more palatable and request for more of such.
- Tutorials were also very popular and helpful, as a source of information, motivation and direction.
- Quite a few felt that the notes were just too voluminous and hoped that more concise and updated notes will be made available.

7. Post GDFM - Changes to Practice:

- More will be practicing evidence based medicine with more confidence.
- Management will be more patient-centered and holistic.
- Some will try to institute chronic illnesses registers to enable better management and follow up of these patients.

CM

Highlights of the 35th Annual General Meeting 2006

This year's AGM was held together with the Commencement Ceremony with the view of capitalizing on the attendance of doctors for the Commencement event. Nonetheless, the attendance of 104 voting members was short of the required quorum (136) for constitutional amendments.

SIGNIFICANT EVENTS IN THE YEAR 2005

Honorary Secretary Dr Cheng Heng Lee reported that the 2005/2006 College work year was significant in three areas:

- Family Physician Register (FPR),
- Academic Programmes & Continuing Professional Development Activities; and,
- Constitutional review

Family Physician Register

The 2005/2006 work year of the College was significant for the announcement of the Ministry of Health (MOH) Public Consultation Paper on the Proposed Establishment of the Family Physician Register. This generated passionate discussion during the MOH initiated feedback sessions with DMS Prof Satku and SMS Health Dr Balaji Sadasivan.

Para. 22 of the Public Consultation Paper stated that "setting training standards alone without addressing other practice-related issue may prevent us from achieving the desired outcomes". This view was reiterated by the doctors during the MOH and College initiated feedback sessions as well as by the 20th Council in its feedback to the MOH on the Public Consultation Paper.

Academic Programmes & Continuing Professional Development Activities

Dr Cheng reported an increase in demand for the GDFM programme, with 113 trainees enrolled in 2006. There were 42 graduands in the 4th GDFM programme, out of the 50 candidates.

For year 2005, one member of the College was awarded the MCFP(S), the Collegiate Membership of the CFPS. The Fellowship Award (FCFPS) by assessment was conferred to five successful doctors. 8 out of 9 trainees passed their exit interviews for the MCFP(S) by Assessment programme.

A/Prof Cheong Pak Yean highlighted the importance of remunerating members of the Institute of Family Medicine, who are responsible for producing materials

which the MOH had tasked the College. Eight of the members were receiving a monthly $1,000, and two of the members were being paid a monthly $2,000.

The College continued to advise the Singapore Medical Council on the accreditation of Core Family Medicine Continuing Medical Education (CME) events, through its panel of FM CME advisors. The cost effectiveness of E-learning in reaching CME and professional development standards would make this an increasingly attractive learning method. This is undergoing a major revamp and will be ready to take on more users by January 2007.

The College has focused on structured courses, crafted to meet the needs of practising family physicians, resulting in the Family Practice Skills Courses (FPSC). There is currently a minimum of 4 courses per year.

Constitutional Review

The formation of the Constitution Review Committee was the implementation of the proposal of the 2005 AGM. The Committee made the following proposals to this year's AGM:

- The change of the quorum to 50 voting members, or 1/8 of the voting membership, whichever was the lower (instead of the 1/8 membership requirement), and
- The use of voting methods that would facilitate greater participation of eligible members.
- Further amendments would be considered (e.g. membership categories, election and selection of leaders, and governance of the College) when the Ministry of Health's FPR is finalised.

A/Prof Cheong elaborated on the reasons for the need to amend the constitution:

- It would be more difficult to reach the quorum in subsequent AGMs due to the growing membership.
- There was a need to amend the way in which the College worked when the FPR is in place.
- The importance of external parties viewing the College as having the mandate and support of its members.
- A quorum of 50 voting members was a reasonable proposal, as it was the same number used by the Singapore Medical Association, which has a membership of more than 5,000.

The lack of quorum prevented the proposals of the Constitutional Review Committee to be passed.

To attain the necessary quorum in subsequent AGMs, members of the house suggested:

- Encourage doctors at the GDFM Commencement Ceremony to attend the AGM.
- Conduct an Extraordinary General Meeting (EGM) for Constitutional review
  (Not feasible. Constitutional amendments could only be done at AGMs, not at EGMs)
- Sending out SMS reminders 2 weeks before the AGM.
- Do a survey to find out why members were not attending the AGM.
- Inform members about the importance of the constitutional review.
- Getting members to remind other members to attend the AGM.

OTHER COLLEGE ACTIVITIES

The Annual Convocation and Dinner was held on 1 October 2005, with the Guest of Honour, Prof K. Satkunanantham, Director of Medical Services. His keynote address was on the setting up of the Family Physician Register. Prof Thomas Stuart Murray gave the Sreenivasan Oration, "The Resourcing of Quality Primary Care". The inauguration of the College Convocation Tapestry was to commemorate the formation of the Institute of Family Medicine.

A study team, made up of 26 family medicine teachers, practitioners, and office bearers, from the Indonesian Medical Association, the Association of Family Physicians of Indonesia, and from the Ministry of Health of Republic of Indonesia, visited Singapore on a training course. The team had discussions with the College on professional development of family physicians.

Our team of 7 delegates from the Wonca 2007 Host Organising Committee attended the Kyoto Wonca Asia Pacific Conference 2005. It was attended by more than 1,800 international delegates.

The Commencement of the Academic Year 2005 was held on 25 June 2005, at the College of Medicine Building Auditorium. Dr Mohamad Maliki Osman, Parliamentary Secretary, Ministry of Health and Ministry of Community Development, Youth and Sports, was the Guest of Honour. Ten trainers of the GDFM programme were recognised for their dedication to training and were honoured with the Teachers' Award.

Dr David Cunningham, Associate Advisor, Vocational Training for Family Practice, NHS Education for Scotland, and Dr Rodney Nan Tie, Senior Lecturer and Trainer, School of Medicine, James Cook University, Australia, were the external trainers of the MMed (FM) course 2005. They also shared their views on the topic "Should Family Physicians Continue to be Generalists?"

During the dengue outbreak in October 2005, the College issued an Advisory on "Primary Care Management of Dengue/Dengue Haemorrhagic Fever During an Outbreak".

The College Workgroup for Influenza Pandemic Preparedness was formed to draft advisories and organise seminars, to heighten awareness and knowledge of family physicians.

CHANGE IN COUNCIL OFFICE-BEARERS

A/Prof Cheong announced the change of President at the AGM. A/Prof Goh Lee Gan agreed to continue the term of Council 2006-2007 as President. A/Prof Cheong would continue to serve in the Vice President capacity. Both had agreed to this change in view of the Wonca World Conference in 2007 to be hosted in Singapore. As A/Prof Goh is a member of Wonca World Executive Council and also the Regional President of Wonca Asia Pacific, the World event would be more familiar to him.

A/Prof Goh informed the house that he would continue the infrastructure building efforts of A/Prof Cheong and consolidate the following areas of work:

- Implementation of the Family Physician Register,
- College membership, and
- College council and secretariat.

STETHOSCOPES AND THANKS

The 20 exclusive Baum Stethoscopes were given away by raffle draw to members who stayed until the conclusion of the AGM. The AGM ended at 6.30 pm with a vote of thanks to the Chair. ■CM

Reported by Dr Jeff Tay Guan Yu, Editorial Board Member

Medisave for Chronic Disease Management Programme

Why do we have such a programme?

- To enhance the manage-ment of chronic diseases and improve health outcomes for patients
- Medisave is an enabler to assist patients pay for their chronic outpatient bills, thereby increasing access for patients to these disease management programmes.

When is it starting?

- It will be launched on 1 October 2006, focusing on diabetes mellitus.
- Starting January 2007, hyper-tension, lipid disorders and stroke will be included.

What effect will it have on my practice?

- Patients with the targeted chronic diseases, namely diabetes, high blood pressure, lipid disorders (e.g. high cholesterol) and stroke, will be able to use Medisave to pay for their outpatient treatments.
- Patients will benefit from the structured care programme.
- A variety of options available for claims and data submission for GP clinics.
- Low barrier to entry and start-up cost for clinics to ease participation.
- Audits focused on accurate submission of data while clinical quality improvement focus on helping clinics achieve the best possible outcomes for their patients.

What is the amount claimable and the charges incurred?

- Patients can claim up to $300 per Medisave account per calendar year for outpatient treatments of the approved chronic diseases.
- They can use their own Medisave accounts and the accounts of their immediate family members (e.g. spouse, child, and parent).
- $30 deductible and 15% co-payment for all claims.

What is MOH doing to support my practice as a GP?

- MOH, together with HPB, is developing a patient education folder which will contain a patient record booklet, education materials, details of the Diabetes Disease Management Programme as recommended by MOH and FAQs.
- Healthcare Professionals' Booklet which includes the details as well as FAQs on the scheme for healthcare professionals.
- Doctors' tool kit.
- Public education efforts in print and broadcast media to encourage compliance and regular follow-up with one physician.
- Decals for clinics on this programme.
- List of participating clinics listed on HPB website.

How do I register?

- All clinics are eligible for this programme.
- Application forms (and instructions) can be downloaded from the MOH website at http://www.moh.gov.sg/corp/publications/details.do?cid=pub_forms&id=39616515
- Please visit: http://www.moh.gov.sg for more details.

The Medisave for Chronic Disease Management Programme *had generated a lot of interest amongst family physicians. The College Mirror asked Dr Lee Suan Yew, past President of our College, for his views on this programme. Dr Lee chairs the committee that advises the Ministry of Health on this programme.*

College Mirror: Dr. Lee, can you tell us what this programme is about?

Dr Lee: The Ministry of Health (MOH) will be launching a programme whereby patients with any one or more of these chronic conditions namely: diabetes mellitus, hypertension, lipid disorders and stroke will be able to withdraw $300 per annum per Medisave account. Health Minister, Mr Khaw Boon Wan encourages as many primary health-care physicians as possible to participate in this programme.

College Mirror: What advice do you have for doctors who are considering taking up this programme?

Dr Lee: All members of the College should not miss this golden opportunity to respond to such a unique programme. I personally would advise every GP/family physician to opt in this programme which promises to have good outcomes if the patients comply with the protocols and if all the doctors maintain a high standard of care.

College Mirror: There are concerns that the processes can be quite complicated. What are your views?

Dr Lee: MOH is making every effort to make it as seamless as possible. There are bound to be initial teething problems but if we cooperate and approach it positively, it will benefit many patients and ultimately we hope to reduce severe end stage morbidity and hospitalisation. In two to three years' time we will be able to assess whether such a programme is effective. However, based on such "good medical practices" the results could be promising. In any case, our patients will benefit from using their Medisave on an outpatient basis. The rapport between doctor-patient relationship and primary healthcare doctor-specialist care doctor is bound to improve. CM

The text above, which provides basic information about colonoscopy, provides a sense of what it might be like for a person with limited literacy skills to read a handout similar to those you may give to patients in your clinic.

Individuals with limited literacy skills prefer information that has short words and short sentences and that contains only essential information. Long or unfamiliar words (written backwards in the example above) are often difficult to decipher. Difficult words slow down reading speed and, as a result, decrease understanding. Similar concerns apply to oral communication - simple, plain language is the best way to communicate.

Health Literacy:

Helping our patients understand

by Dr Sally Ho, Editorial Board Member

Do our patients always understand what we tell them? Why don't they? Language difficulties, lack of familiarity with a complex health care system, an ever-increasing array of medications and complicated self-care regimens are contributing factors.

What is Health Literacy?

Health literacy is the ability to read, understand and effectively use health information and follow medical instructions.

According to the National Adult Literacy Survey (NALS) conducted by the US Department of Education in 1992, nearly half of all American adults - 90 million people - have limited literacy skills. 21% were functionally illiterate (able to sign name, unable to locate information in news article). 27% were marginally illiterate (able to locate information in news article, have trouble completing standard forms, unable to write brief letter of complaint).

The 2000 Census of Population classified 97.1% of Singaporeans over the age of 15 years as literate. Literacy was defined as a person's ability to read with understanding, e.g. a newspaper, in the language specified. The figure appears rather high and likely included those with the lowest level of literacy who were functionally illiterate.

However, health literacy is more complex than general literacy. Everyone is susceptible regardless of age, race, education or income. A personal experience brought home the point powerfully. I had performed a high vaginal swab for a well-educated young lady. I handed her the long, narrow plastic container containing the swab-stick to bring to the laboratory. I also instructed her to go for a urine test. Moments later, she returned with the swab-stick container filled with yellow fluid. What I assumed to be obvious was not apparent to her. She failed to understand that she needed a separate container for her urine specimen though she had found it odd and almost impossible to collect urine into a container with such a narrow opening. She did not clarify the situation, as she was embarrassed to admit she had difficulty with the instructions.

(continued on page 14)

Patient Advocacy

by Dr Yvette Tan, Editorial Board Member

Recently, I encountered 3 patients who got me thinking....

1. An elderly man who came for his blood pressure medication, with his hand already at the door, asked if his medication could be collected one month at a time.

Reason: He is the sole care giver for his mentally ill wife and 2 other mentally ill adult children. Both unaffected daughters had jumped to their deaths; one after the shame of not being able to pay for her medical care after a visit to the doctor. I offered him a referral to our in-house social worker but could not help but feel that this would have little impact on his woes.

2. A 40-plus male lorry driver whom I have been seeing on and off for diabetes care, has seen his HBA1C deteriorate from below 7% to more than 11% over the past one year.

Reason: Working long hours, then spending most of his spare time teaching his 4-year-old autistic son, and supporting his wife who is at the end of her tether coping with her son's behaviour and housework. He simply does not have the time or the energy to comply with treatment, nor is he able to cut down the one pack of cigarettes per day that he is using. Flipping back to previous records, I noted with some sadness as four years ago, I had congratulated a much happier version of him as he shared with me the joys of his recent marriage and the impending arrival of his baby. Now, I see the hopelessness in his eyes as he tells me that because of his limited resources, he can only depend on himself to learn everything about autism to help his son whom he believes will have a bleak future ahead. How could I even begin to engage him to improve his poor diabetic control or smoking habits when I know where his priorities and concerns were?

3. A 40-plus lady who became significantly hypothyroid after defaulting her thyroxine replacement for 3 months.

Reason: She had suffered from a prolonged bout of conjunctivitis and spent all her money she could spare for medical needs on her three visits to her GP. She has two children now embarking on some form of tertiary education, and has to help out her husband's fledging business financially. She insisted that I gave her three months of medication all at once while she had enough cash at hand. She was afraid that it might end up elsewhere if not committed to her medication that very day.

Are these hardship cases many?

Considering that I work in the polyclinic which is strategically placed to provide a safety net for such patients in Singapore, such cases who default on or struggle with the care that we provide are seen fairly common in our setting. Our observation with our Diabetes case conference team, which is a multi-disciplinary team comprising doctors, care managers and medical social workers that looks into all very poorly controlled diabetic cases in the clinic, has also been that the social and psychological issues feature as very important factors - often, much more than the financial aspects.

What reflective questions may we ask?

Is healthcare in Singapore not affordable for some? Is the safety net for those who

may slip through tight enough? What are the other determinants of health? Are the social, psychological, financial, and the dignity with which the person has or feel that he has, as important or even more crucial to a person's health outcomes?

It has been observed that mortality has been more closely related to relative income differences within a country than to that in absolute income between them. The importance of relative standards may imply that psychosocial pathways are particularly influential. Job classification, a measure of socioeconomic status, was a better predictor of cardiovascular death

He simply does not have the time or the energy to comply with treatment, nor is he able to cut down the one pack of cigarettes per day that he is using.

than cholesterol level, blood pressure, and smoking combined in employed London civil servants with universal access to the National Health Service. Hence, it does seem that there is a need to take into account the complex ways in which the biological risk interacts with economic, social and psychological factors in the development of chronic disease, and as such, there are 'critical periods' in an individual's life, where when protected, e.g. through social policies, can help defend the individuals against an accumulation of risks. Such safety nets may make a difference to prevent the individual from being pushed down another step in the aetiological pathway towards established chronic disease.

What are the basic requirements of good care?

In a situation of unlimited healthcare needs but limited spending, this is a question all healthcare systems struggle with. It is also an issue many physicians struggle with at the point of care. Advocacy for the individual patient often conflicts with the need to be the advocate for the wider community where rationalizing of the resources through group deliberation and decision making is considered an ethical requirement. Have we clearly defined this locally? Yet, a lot of decisions as to how healthcare resource should be allocated are dependant on what is considered basic.

Why is it important to raise these questions and have them addressed?

We are at the threshold of a paradigm change in healthcare delivery - with restructuring, remodeling of health delivery models, a review of financing mechanism, including the use of Medisave for primary care, improving competitiveness both within and outside Singapore, new criteria for regulation like the Family Physician Register and increasing accountability for outcomes - it is inevitable that there will be significant changes made in the way GPs deliver care in the near future. During such uncertain times, it is crucial that we remain a strong voice of advocacy for our patients. The vulnerable individuals in our society who may otherwise have no one else to highlight their difficulties, will especially need our assistance. Even the JCI (Joint Commission Institute), a standard which many of our local health institutions have embarked on achieving, recognises the importance of this role and had made it a requirement for the institutions to identify the vulnerable patients under their care and put in place processes that will safeguard their needs.

A society will be judged not by how successful we are, but by how well we look after the vulnerable in our population.

A society will be judged not by how successful we are, but by how well we look after the vulnerable in our population. As GPs, we are in a privileged position to witness the struggles our patients go through when they decide to present themselves or disclose themselves in the consultation. We can either choose to be sucked in and be part of the hopelessness and helplessness that they experience, or we can choose to be their voice - and that of the other 99 who do not present themselves to us - and actively participate in the changes that will surely come, with honest feedback and insistence on what should never be compromised in the care of our patients.

We will need to be on the look out for those who experience financial hardship and be their advocates. ■CM

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(continued from page 11)

Why is It Important?

Low health literacy impacts safety, quality, costs and patient and provider satisfaction.

- Patients with low health literacy are at risk of poor health outcomes as they:
  - fail to seek preventive care,
  - are more likely to engage in unhealthy, risky behaviours,
  - tend to have diagnoses made at later stages,
  - are less likely to adhere to prescribed treatment and self-care regimens,
  - make more medication or treatment errors,
  - miss appointments,
  - are at higher risk (>2x) for hospitalisation and longer hospital stays.
- Increased healthcare costs (>4x)
- Physicians and institutions can be held liable for adverse outcomes suffered by patients who do not understand important health information needed for diagnosis and treatment.

Chances are high that some of our patients have low health literacy. We may not know they are in our care as they:

- use well-practiced coping mechanisms that effectively mask their problem:
  - Ask other patients.
  - Ask for help from medical staff.
  - Watch and copy others' actions.
  - Bring someone who can read.
- are often ashamed to admit they have difficulty understanding information and instructions.

What Can We Do?

Ten steps to improving patient understanding:

1. Slow down.
2. Use plain, non-medical language.
3. Show or draw pictures.
4. Limit the amount of information provided, and repeat it.
5. Provide reader-friendly written materials.
6. Review medications.
7. Assure understanding
   - Use the "teach-back" or "show-me" technique.
8. Encourage patients to ask questions
   - Ask Me 3.
9. Enlist interpreters or family members to promote understanding.
10. Create a shame-free environment: be respectful, caring and sensitive.

What is Ask Me 3?

Ask Me 3 is a quick, effective tool designed to improve health communication between patients and providers.

Ask Me 3 promotes three simple but essential questions that patients should ask their providers in every health care interaction. Providers should always encourage their patients to understand the answers to:

What is "Teach-Back" or "Show-Me"?

How do we check if our patients had understood what we said? Do not simply ask, "Do you understand?" Experience shows that patients often answer "yes" even when they understand nothing.

MYTH vs REALITY

Myth: Encouraging my patients to ask more questions will increase the length of their visit. I simply can't afford to spend more time with each patient.

Reality: Fearing lengthy appointments, most doctors allow patients to talk for an average of 22 seconds before taking the lead. Research shows, however, that if allowed to speak freely, the average patient would initially speak for less than two minutes. Encouraging questions during the initial visit may require a short-term time investment; however, the long-term payoff may include improved adherence, less follow-up visits, and shorter, more focused interactions as the patient proceeds through his/her condition.

Experience shows that patients often answer "yes" even when they understand nothing.

- Teach-Back
  - Ask patients to explain in their own words.
  - It may be insensitive to ask the patient to repeat what we had just said.
  - Less offensive questions could be: "I'm sure you have other friends who have gout. What foods would you tell them to avoid?" "When you go home and your daughter asks you about your diabetes control and your medicines, what are you going to tell her?"
- Show-Me
  - Ask patients to demonstrate a skill that was taught, e.g. inhaler technique, insulin injection.

If the patient does not explain correctly, assume that we have not provided adequate teaching. Reteach the information using alternate approaches. **CM**

POSITIVE DATA ON TEACH-BACK

"Asking that patients recall and restate what they have been told" is one of 11 top patient safety practices based on strength of scientific evidence.

- *AHRQ, 2001 Report on Making Health Care Safer*

Physicians' application of interactive communication to assess recall or comprehension was associated with better glycemic control for diabetic patients.

- *Schilinger D. Arch Intern Med. 2003; 163*

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End-of-life Care of the Older Person

Friday, 29 September 2006
5.15pm - 6.45pm
College Lecture Room
College of Medicine Building

Speaker
A/Prof Pang Weng Sun
Senior Consultant, Geriatrician, and Chairman, Medical Board, Alexandra Hospital

Chairman
Dr Cheong Seng Kwing
Senior Family Physician
AMK Polyclinic

Organised by Elder Care SIG,
College of Family Physicians Singapore

Monthly Secretariat Meeting

With effect from July 2006, the secretariat office of the College, at College of Medicine Building, will be closed during lunch time (12-2pm) every last Friday of the month for the monthly secretariat meeting.

Your Secretariat Team

The College of Family Physicians Singapore is delighted to announce the latest lineup of our dedicated team at the secretariat who will be assisting you with high standard of professionalism.

Manager
Ms Sim Siew Ching

Accounts & HR Executive
Ms Amy Chin Yuet Yun

Corporate Communications Executive
Ms Linda Marelie

IT Executive
Mr Kuah Yeow Teng

Programmes & Trainings Executive
Mr Chan Jian Hong

Senior Administrative Assistant
Ms Katy Chan Yuet Wah

Senior Family Doctor: Dr Cheng Heng Lee

In Shape and Still Positive

by Dr Stephen Tong, Editorial Board Member

*The College Mirror interviewed **Dr Cheng Heng Lee**, a senior family doctor in private practice, to gather some of the moments, thoughts and issues that he goes through in his years of family practice. Dr Cheng has been appointed the Executive Director of the College of Family Physicians Singapore, 20th Council, 2005-2007.*

Tell us a bit about yourself and a brief summary of your medical work since graduation.

I graduated in the early 1970's, did a couple of years stint with then senior GPs before embarking on a solo practice in Ang Mo Kio. I recall with fond memories those days of climbing up oil tankers in shipyards and doing house calls on patients in kampongs after clinic hours at night.

I am also a Director of HMO Pte Ltd a company owned by group of about 40 doctors. The main activity of this company is to purchase drugs at bulk with good discounts for sale to GPs.

Tell us about some of the high and low moments that you encountered in your years of medical practice.

High moments are when patients bring humour into my life. Early in my practice, a young boy brought his sick pet dog and asked me in all seriousness if I could treat it.

Also recently, Media Corp showed video clips of me examining a patient in my clinic during the news report of the proposed Family Physician Register. This elderly patient of mine told me she saw me advertising on TV and noted I did not say anything during the video clips. She asked if it was because I would have to pay more if I were to say something.

High moments are also when patients reciprocate the care we give them with their concern for us. I remembered that the week before the GDFM results were out, there was this elderly patient who kept enquiring whether I passed the exams.

Low moments are when patients suffer for the mistakes I make. I remembered missing out on diagnosing an acute myocardial infarct in an elderly patient early in my career. She succumbed and my conscience still pricks me.

You have recently completed the GDFM, why did you decide to do it and how have you found it to be useful?

I am an avid attendee of CME programmes. I felt that the broad base vocational GDFM course is a continuation of this process, and it

I recall with fond memories those days of climbing up oil tankers in shipyards and doing house calls on patients in kampongs after clinic hours at night.

helps plug gaps in my knowledge not covered by ad hoc CME.

I find the interactive workshops and tutorials beneficial, as these provided avenues for trainees to shared their experiences with their tutors and resource persons, something that I think textbooks cannot provide.

Have you found much changes in the practice of family medicine over the years that you have been in practice?

The explosion of knowledge in medicine has certainly impacted the way we practise now compared to 30 years ago when I started my clinic. An example is the management of chronic diseases like diabetes, hypertension, hypercholesterol-aemia and asthma. Now we have well defined and established clinical guidelines, and new jargons like treatment to target. While patients, hopefully, will enjoy better end results from better preventive care. The immediate impact is on their pockets, with requirements for more tests and more drugs.

Do you find it challenging keeping up with changes in medical knowledge and how have you been coping with that aspect?

Indeed it is a challenge to keep a balance between work, keeping up with medical knowledge and maintaining family/social life. The trick is to be selective with CME as after a while, the programmes are repeated.

How you feel that the College is helping in the practice of Family Medicine in Singapore?

The College thus far has done a good job of spearheading and facilitating the vocational training of family medicine to improve professional standards. The profile of family medicine has been raised. These achievements however, have not translated into increased patient load for many in the private sector and understandably there is some disappointment on the ground.

...these provided avenues for trainees to shared their experiences with their tutors and resource persons, something that I think textbooks cannot provide.

Do you have any comments about the virtues of group medical practice versus solo GP practices?

My sense is that the group practice model is more efficient with economies of scale and more efficient use of resources. With more available manpower there is flexibility to extend operating hours maximising use of expensive assets. Patients seem to like the extended hours, as there is anecdotal evidence that such clinics are doing better.

In a group practice there is also more scope for peer review and audit to enhance the practice.

Do you think the use of Medisave for outpatient management of chronic illnesses will have a major impact on the management of chronic illness in private family practice?

Management decisions of the doctor should not be influenced by availability of Medisave money. However the compliance of patients to guidelines can be facilitated through such money and hopefully there will be positive impact on clinical outcomes.

What do you think is the image of family medicine in Singapore today among fellow doctors and the general public?

It is positive. The Health Minister, Mr Khaw Boon Wan, has stated that every citizen should have a good GP as his family physician. SGH has set up the Family Medicine Continuing Care Department headed by Dr Lee Kheng Hock a senior consultant family physician. Increasingly our heart-lander patients call us "jia ting yi sheng".

Looking ahead, do you foresee any major changes in the practice of family medicine?

I view the future with guarded optimism as there is an increasing emphasis on right siting of care, and family physician will have a big part to play in that.

I also foresee continuing changes to the funding for delivery of primary care and chronic diseases manage-ment.

Do you enjoy family medicine and what aspects keep you excited about going to work each morning?

I enjoy clinical medicine and fortunately family medicine has lots of this. I look forward to meeting my patients as "old friends".

Thank you, Dr Cheng, for sharing with us your experiences and thoughts from your years of practice. We send you good wishes as you continue enjoying the practice of family medicine.

CM

(continued from page 05)

Family Medicine Training

The ambitious and massive effort to upgrade the training of all family physicians in Singapore will require a considerable increase in the amount of training capacity. The present level of training is barely sustained by a group of dedicated trainers in the College of Family Physicians Singapore. With its meager resources and limited internal funding, the College had made some progress in creating a teaching faculty of teaching fellows and tutors under the Institute of Family Medicine.

There had been repeated calls for full time teaching positions in family medicine to increase the capacity and the quality of training. In addition, a sustainable national effort can only be achieved by the pooling and sharing of training resources and trainers from all stakeholders.

Our long suffering trainers who are motivated by their passion for family medicine are finding it increasingly difficult to sustain the effort in the midst of coping with long working hours and the struggles of making a living in an increasing difficult economic environment. They need to be supported with more resources and protected time for teaching. Financial compensation should at least be sufficient to meet locum fees paid to employ locums to cover their duties. The importance of their work which is done for the greater good of the community should be given recognition by their employers, regardless of whether they are from the public or private sector.

The Interim Joint Committee on Family Medicine Training (which is the parallel body to the Joint Committee on Specialist Training) was formed on the 12 September 2005. The appointment of this committee by the Ministry of Health underscores the commitment to improving the standard of family medicine in Singapore. The JCFMT is tasked to structure and review training activities in family medicine. It also defines training standards and the equivalence of training outside the existing structure. The JCFMT conducts accreditation of training sites and audits the training activities that are carried out.

Role of MOH

At the behest of the Ministry of Health, restructured hospitals have started various initiatives to right site patients to primary care providers in the community. Such initiatives promise to bring forth a new and equal partnership between the hospitals and the primary care providers in the community.

The advent of chronic disease management programmes that are partially funded by the Medisave scheme underscores the new understanding that chronic diseases can be better managed when more resources are made available to the primary care physicians. We need to move beyond training and start to empower these same better-trained doctors with the necessary time and resources to achieve the better care and outcome. ■CM

Figure 2. Professional Development Activities

Activities that respondents are interested to participate in: (MA)

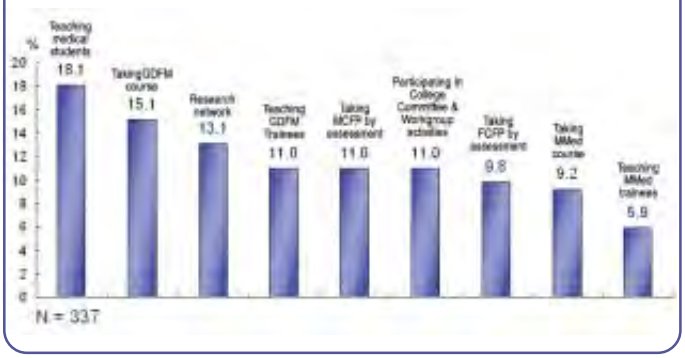


Figure 3. Modality of Learning for CME

Modality of learning for Continuing Medical Education (CME) that respondents prefer: (MA)

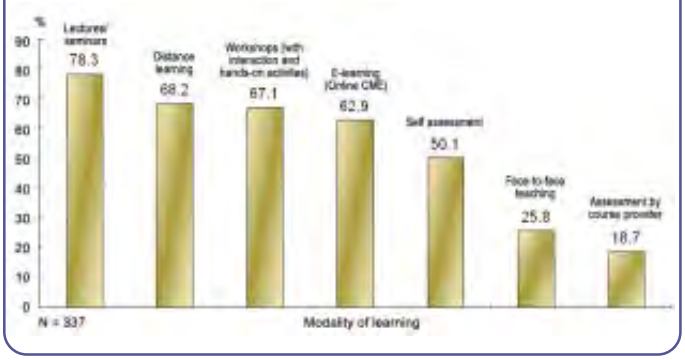


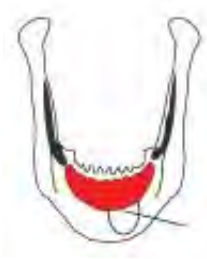
Figure 4. Orphan Topics

Topic	% of Respondents indicatinginterest
Dealing with common emergencies seen in the clinic	62.0
Anxiety disorders	57.9
Hyperactivity, conduct disorders, & juvenile delinquency	57.3
Behavioural problems in the school child & adolescent	57.0
Management of common sports injuries	57.0
Psychiatric assessment in the family practice setting	56.1
Safe use of sedatives & anxiolytics in the elderly	54.6
Behavioural problems in the infant, toddler and preschool child	54.3
Preparing for emergency care situations in the clinic	54.0
Drug therapy during pregnancy	52.5
Learning disabilities	52.2
Chronic cough	52.2

by Dr Wee Chee Chau, MCFP, Editor
and Dr Jeff Tay Guan Yu, MCFP, Editorial Board Member, Senior Family Physician Private Practice

1 Use a Spatula!

Fracture of the Mandible



It is not unusual to have someone coming into the clinic after a fall and hitting the bottom of the chin and sustaining a laceration of the chin. In particularly, for bad falls in the elderly, how can we exclude a fracture of the mandible?

A simple office test for a suspected fracture is to get the patient to bite on a wooden spatula or tongue depressor.

Ask the patient to maintain the bite as you twist the spatula. If they have a fracture, they cannot hang on to the spatula because of pain.

2 Is there a Nerve Injury in the Hand?

Occasionally, an in jury to the arm or hand may result in a nerve injury. Three simple tests will help to distinguish injury to the three main nerves:

- **'4-fingered cone'**
  If the patient can bring the four fingers together forming a cone, the ulnar nerve is intact.

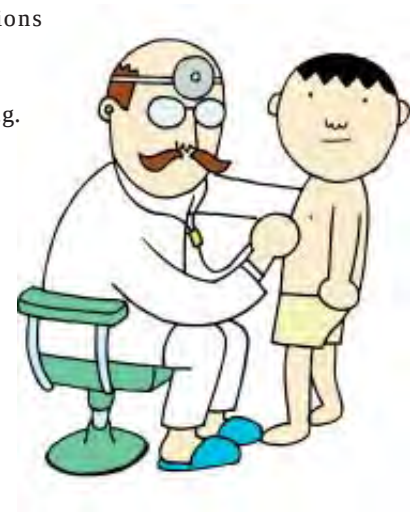
- **'5-fingered cone'**
  and the ability to approximate the thumb means the median nerve is intact.

- **'trigger test'** for the thumb
  i.e. extension, if normal, denotes an intact radial nerve.

3 "My Child Has An Itchy Backside, Doctor!"

Pruritus Ani has many causes:

1. Dermatological disorders (e.g. psoriasis, atopic dermatitis)
2. Allergic reactions (e.g. contact dermatitis) and eczema (e.g. food-related)
3. Superficial fungal (e.g. dermatophytosis, candidiasis) and bacterial infections
4. Parasite infestations (e.g. pinworms, scabies)
5. Oral antibiotics (especially tetracyclines)
6. Disease processes - systemic diseases (e.g. diabetes), proctologic disorders (e.g. skin tags, cryptitis) and tumours (e.g. Bowen's disease)
7. Hygiene - either poor, or excessive (cleaning)
8. Warmth and hyperhidrosis (e.g. warm bed clothes, obesity)
9. Psychogenic response



N.B. Haemorrhoids do not usually cause pruritus ani.

Investigations

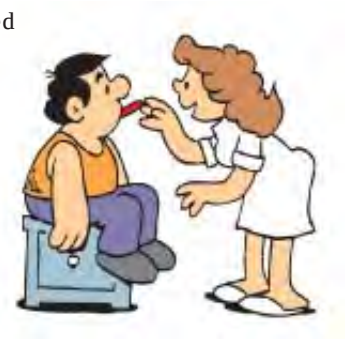
- Skin scrapings - to identify fungal infections
- Stool FEME - to exclude parasite infestations

Treatment

- Determine and eliminate certain food which may cause pruritus ani
- Wear loosely fitting clothes and light bed clothing
- Post-defaecation, the anal area should be cleansed with absorbent cotton moistened with water
- Non-medicated talcum powder can help reduce excessive moisture
- Hydrocortisone acetate 1% applied sparingly is usually very effective
- Topical fungicides may be used
- Systemic causes & parasitic infestations must be specifically managed

4 Advice for Resting a Painful Temporomandibular Joint

- When eating, avoid opening the mouth wider than the thickness of the thumb and cut all food into small pieces.
- Do not bite any food with the front teeth, use small bite-sized pieces.
- Avoid eating food that require prolonged chewing.
- Avoid chewing gum.
- Always open the mouth in an arc or hinge motion, avoid protruding the jaw.
- Avoid clenching the teeth together.
- Try to breathe through the nose at all times.
- Practise a relax lifestyle.



5 Chronic Disease Management Keeping the Perspective

GPs are expected to manage chronic diseases well. As the patients' treatment card/folder gradually thickens with a mishmash of chronic and acute entries, keeping track of vital data becomes quite a challenge! Well, don't worry. What you need is a "Summary of Results" table in the card/folder, or in your computer. An example (for Diabetes Mellitus) is shown below.

Name: _____ NRIC/DOB: _____

Date	Glucose	HbA1c	LDL-c	Ur MicroAlb	DRP
9/8/06	6.7mmol/L	7.0%	3.8mmol/L	19mg/L	Normal

Creating such a table is initially painstaking and laborious, as it involves going through the old notes/results. However, during subsequent patient reviews, management planning (and typing-out medical reports) becomes a breeze, not a chore!

6 Having Trouble Removing Splinters?

Removal of a splinter under the skin is a common and time consuming procedure. The next time, instead of using forceps or making a wide incision, use a disposable needle to 'spear' and lever the splinter out through the skin.

REFERENCES
Practice by John Murtagh (3rd Edition)
The Merck Manual of Diagnosis & Therapy 17th Ed. Merck & Co., Inc. 1999

Congratulations!

College Mirror congratulates the following doctors who have successfully passed the GDFM Examinations.

Dr Abdul Bashir Bin Adbul Kadir
Dr Ang Pei Ming, Samuel
Dr Ang Seng Bin
Dr Chan Hui Kwan, Diana
Dr Chee Fang Yee
Dr Cheng Heng Lee
Dr Chin En Loy, Conrad
Dr Chitra Sundarajan
Dr Chng Shih Kiat
Dr Chng Woei
Dr Chong Shih Tsze, Steven
Dr Choo Heng Wee
Dr Goh Tien Siong
Dr Ho Thong Chew
Dr Kao Chin Yu
Dr Khaw May May
Dr Koh Aye Aye Maw, Amanda
Dr Kuan Mae Yee
Dr Lee Siu Lin
Dr Leong Peng Fai, Samuel
Dr Lim Ka Pheck, Angela
Dr Loh Chiu Khuen
Dr Lwin Sann
Dr Ng Juak Cher
Dr Ng Kwee Choon
Dr Ng Lee Beng
Dr Ong Chon Kin, Fabian
Dr Oon Hwee Boon, Hazel
Dr Rajan Rekha
Dr Seah Chin Mui, Jaime
Dr Soong Chuon Vui, Jovian
Dr Tan Eileen
Dr Tan Eng Chun
Dr Teo Boon See
Dr Tham Tuck Seng
Dr Tjang Tjung Fa, Francis
Dr Vasanwala Farhad Fakhrudin
Dr Wee Bee Poh, Diana
Dr Wong Hoong Wai
Dr Wong Li Lian
Dr Wong Wei Mon
Dr Wong Weng Hong
Dr Yap Yew Chong, Bernard
Dr Yeo Ling Yen, Peggy
Dr Yuen Heng Wai

The Annual Convocation Dinner will be held on 4 November 2006, 5:30pm. (Venue to be announced)

(continued from page 05)

specialist and the primary care colleague. More, however, needs to be done to build this rapport. Joint teaching in both the undergraduate and postgraduate settings are therefore good opportunities not to be missed. More of that to be said under opportunities.

The Sunday Times article (Sunday Times, 6 Aug 2006, *Tough Times for Heartland Doctors* (page 4) trotted out a litany of GP woes. They pinned them down to: declining earnings, fiercer competition, rising costs, and falling patient numbers. Working hard is obviously not enough.

Look at these four causes again. The problems lie in the fraternity or at least to many in the fraternity. We need to scrutinise the root causes a bit more. More of that in the next President's column when I give my views on Managed Healthcare and consultation fees - what need to be done.

Opportunities

There are certainly opportunities in the horizon that we need to capitalise on.

First is the Family Practice Register (FPR). This provides a benchmark for individuals to work towards. Is it necessary? Are we not trained? You mean back to MBBS again? I can almost hear loud unhappy noises. Of course, continuing learning is necessary and of course, it is not MBBS again. It must be postgraduate in content and focus. I am glad to note that the GDFM course enrollment has gone up from 50 a year to 120 a year with some who have to sign up the next year.

The truth is that we had better be prepared to practice competently in the 21st century. The children could well decide to take the doctor to court for missed opportunities of controlling their acute or chronic problems. For those who have the task of defending doctors, this is certainly surfacing. So take the opportunity to get into the AMC (Accredited Modular Course) and the GDFM courses. There is more beyond the GDFM if you want to build even greater professional capacity.

The children could well decide to take the doctor to court for missed opportunities of controlling their acute or chronic problems.

Threats

There will always be threats that we need to identify and neutralise.

It is important we do not let the FPR fizzle out into nothingness. It is easy to be harassed by the few who do not want to build professional capacity. It is an opportunity to raise a flag to tell the public that the family doctor is going for training so that the care given will be quality care and then we can follow what the West has put in place - Pay for performance.

It is easy to be paralysed by cost control at the expense of quality. It is also easy to be paralysed by public outcry. We need to explain and tell our colleagues and our patients, our employers, that we need to be in it together.

The West has gotten over this. It is now patient's safety and pay for performance as the rally cry. The healthcare savings, including Managed Healthcare, must come not by gatekeeping and denying care, but through prospective care.

Every person needs to have his or her health risks quantified and graded into: (1) well and low risk; (2) at risk; and (3) requiring treatment to prevent complications. Working on each individual to ensure that he or she is kept at that level or better still move down in the risk ladder is the new vision in health care. In this will lie the savings that the world is looking for.

And for those who require medical care there is appropriate level of care and therefore right siting of care. A stable patient can be treated at the primary care level, provided of course the patient can be assured that the primary care doctor taking over has been well informed and well informed on the things that need to be done. The threat is from patient, employer, specialist, and primary care doctor not being on the same page.

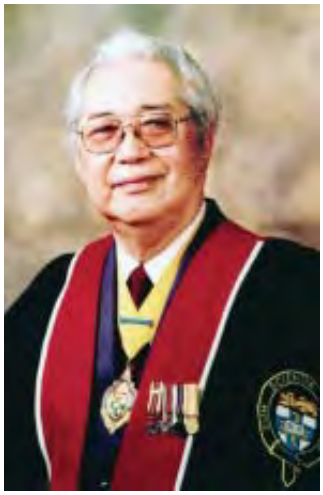
Take home message

The litany of GP woes need not be inexorable. We can work on our strengths, capitalise on our opportunities, reduce our weaknesses, and neutralise our threats by constructive engagement of the profession, people, politician, and press. GP survival can be more than flourishing if we are all on the same page, including our patients.

CM

Dr Koh Eng Kheng

1928 - 2006



Dr. Koh Eng Kheng was the President of the College of General Practitioners Singapore from 1989 to 1991.

Contributions to the Medical Profession

Dr Koh Eng Kheng was born on 10 July 1928. He was a keen medical student at the University of Malaya (Singapore) and scored a Distinction in Social Medicine & Public Health. He graduated with the degrees of M.B.,B.S. in June 1955.

He became an Associate Member of the Royal College of General Practitioners U.K. in 1957, obtained his M.R.C.G.P. in 1962, and went on to become Fellow of the Royal GP College in 1973.

In 1972, he was elected President of the Singapore Medical Association. During his term, he led the first-ever delegation of Singapore doctors into China, at the invitation of the China Medical Association.

He was a Founder Member of the then College of General Practitioners Singapore, being a Committee Member of the Protem body for the formation of the College in 1970, and Council Member when College was formed on 30 June 1971. He proudly recalled his role in the formation of our College when in 1970, he introduced the Late Lord Hunt of Fawley, who was then the President of the Royal GP College UK, to the Minister of Health, a meeting that opened the way for the founding of the College in Singapore. In recognition of his contribution to this formation, he was awarded the Fellowship of the Royal GP College UK.

After 4 years on the Council, he became Secretary of the College and Chairman for Undergraduate Education in 1974 to 1975, Editor for the Singapore Family Physician Journal in 1978 to 1979, and Publication Chairman in 1979 to 1980. In 1979, he was the Convocation Lecturer for the Medical Faculty and in the same year, delivered the Second Sreenivasan Lecture on "Art in Family Medicine". In the following year, he was the Speaker for 75th Anniversary of the Medical School, University of Singapore. In 1979 to 1980, he was appointed as a Member of the Singapore Medical Council.

During his years as President of the College of General Practitioners Singapore from 1989 to 1991, the following milestones of the College were recorded:

1990

- The proposal for a Family Medicine Programme leading to the award of MMed (Family Medicine) was adopted by the School of Postgraduate Medical Studies, National University of Singapore.
- Establishment of the Postgraduate Medical Library in partnership with the Academy of Medicine, Singapore

1991

- The Family Medicine Training programme was finalised as a 3-year-programme, made up of two years of hospital rotation postings and 1 year in Family Health Service. During this one year which was in the 3rd year, the Family Medicine trainees spent six months in Community Health Service and six months in Maternal & Child Health Service. There were also attachments to the departments of primary care - School Health Service, Food & Nutrition department, Training &

One example of Dr Koh's artistic expression of his feeling about computers in the early days of computerisation

Health Education (now called National Health Education), Health Services for the Elderly (now called Home Nursing Foundation) and a GP clinic attachment.

The training programme is very much similar in structure today except that the Family Health Service is now the Government Polyclinic Service and there is amalgamation of the Community Health Service and the Maternal & Child Health Service into one service. It is called the Programme A and is intended for younger doctors working in Ministry of Health. A parallel programme for doctors in the private sector was set up in 1995. This is called Programme B.

His Publications

The list of his publications included the following:

1968	SMA Newsletter - Medical Curriculum need for re-appraisal
1969	Editorial , SMA Newsletter An Academic Body for GPs in Singapore
1969	Journal of Royal GP College UK Emotional Disorders in General Practice in Singapore
1970	SMJ - General Practice in a Developing Society
1973	Journal of Royal GP College UK - Acupuncture
1975	Australian Family Physician Mental Health & Urbanisation in Singapore
1975	Proceedings 5th Pan Pacific, Conference International Society of Rehabilitation & Disabled, The Community & Rehabilitation of the Psychiatric Ill.
1977	AMA Gazette Singapore Doctor Looks at Acupuncture
1977	Family Practitioner (CGP Malaysia) The GP & Sex Education
1980	Royal GP College UK - Occasional Paper Family Counselling in the East

Contributions to Society

In spite of his varied contributions to the medical profession, Dr Koh Eng Kheng did not forget the need to contribute to Society. He served in the following community and welfare organizations:

1969 onwards:

- President, Singapore Association for Retarded Children (presently known as MINDS)
- First President, Singapore Association for Mental Health
- Chairman, Convalescent Home of the Singapore Children's Society
- President, Singapore Children's Society
- Chairman, Singapore Children's Charities
- Vice-President, Singapore Council of Social Services

He had also volunteered for National Service and serviced in the first Singapore Armed Forces (SAF's) Volunteer Medical Corps for several years. His contributions to the SAF included the composition a song, "The Medics of the Field" jointly with Dr Cheong San Than who penned the original lyrics.

In 1990, he was appointed a Justice of The Peace by the Minister of Home Affairs.

His Life's Work

Dr Koh Eng Kheng commenced his private general practice, the ChungKhiaw Clinic, in Upper Bukit Timah in 1957. This became a two-man practice when his brother Dr Koh Eng Soo joined him in 1965. Dr Kevin Koh, joined his practice in 2003. Dr Koh Eng Kheng practiced for more than three decades, and developed an outstanding reputation as a good family physician. He worked on until 7 May 2006, in spite of his 15 years of difficult times, coping with his illnesses.

His Final Journey

In 1991, Dr Koh Eng Kheng developed carcinoma of the descending colon. It was then that he decided to step down as College President, to embarked on an arduous task of doing battle with this disease. He underwent a year of chemotherapy, after which he was well enough to be seen at the many continuing medical education meetings and events.

In 1998, he was diagnosed with Ischaemic Heart Disease, and had two stents inserted through angioplasty.

In April 2001, he developed a hepatoma, and underwent partial hepatectomy with irradiation. However, his condition did not resolve completely. After 4 years of fighting his disease, he developed end-stage renal failure in August 2005, necessitating haemodialysis until his end came on 5 July 2006.

Dr Koh Eng Kheng was such a well-liked family physician by his patients that one died of an acute myocardial infarction on hearing of his demise, while another went into atrial fibrillation and had to be warded.

We, his friends at the College, will always remember our Past President, Dr Koh Eng Kheng for his many contributions to our organisation, his friendly demeanor and the many stories told with relish and enthusiasm. Last but not least, we will always remember him as a brave warrior, battling with his disease for 16 years, but always ready with a smile for all patients and friends, even during his most trying times. **CM**