



THE College Mirror

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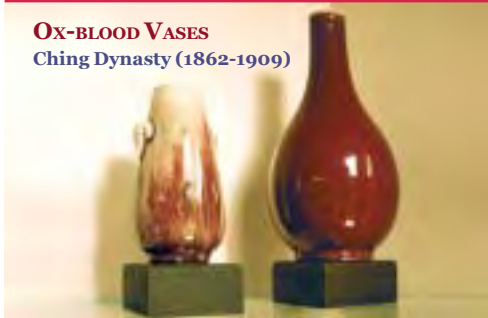
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FAMILY PRACTICE SKILLS COURSE

Diabetes Mellitus: Essentials for Best Practice Seminar & Workshop in January 2006 page 24

COLLEGE ART GALLERY

Ox-BLOOD VASES
Ching Dynasty (1862-1909)



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The Stars are Aligned for You

Keynote Address by Mr Heng Chee How, Minister of State for Health, at the Annual Family Medicine Convocation Ceremony, 4 November 2006 at Ministry of Health Auditorium, College of Medicine Building



Mr Heng Chee How, Minister of State for Health, delivering his keynote address.

"I am delighted to join you at this convocation of 104 primary care doctors who have attained post-graduate qualifications awarded by the College of Family Physicians, some jointly with the National University of Singapore. To our graduates, I offer my heartiest congratulations.

This is a significant step in your career as family physicians. By pursuing this postgraduate training in Family Medicine, you have demonstrated your commitment to continuous improvement for the sake of your patients. It is a noble undertaking.

With your enhanced knowledge and capabilities, you are set to embark on the next phase of your careers, one which promises to be both exciting and opportune. It is exciting because you will not just be more skilful versions of

yourselves, but would be key partners in the national quest for better health with peace of mind. And I say opportune because this invitation to partnership is not an empty statement. The stars are aligned for you to now make a real and big difference.

Medisave for Chronic Disease Programme

As you know, MOH has since 1st October this year introduced the Chronic Disease Management Programme. Under this programme, patients can use Medisave to pay for outpatient treatment of selected chronic diseases. We are doing this for two reasons.

First, we want to do more to right-site care. Ailments that can best be treated

(continued on page 4)



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Paying for Performance

by Dr Yee Jenn Jet Michael, FCFP(S), Editor

The pen is mightier than the sword, but money does talk louder than words. The recent changes in the health financing structure of management of chronic diseases in primary care must surely be taking up the better part of our time. Amidst all the decision making and preparation for the inevitable, one must not lose sight of the positive nature of the paying for performance concept. Granted that health policy changes has been used as a political tool in years past, these developments were in no small part due to the resolve of a few people, with a good measure of behind-the-scene planning in an attempt to get the policies right for the sake of good healthcare for our patients and our country. The College Mirror invited Dr Ho Han Kwee, a good friend and tireless crusader who gets things going for primary care, to tell us more.

Talking about few good men and women, this year's recipient of the MCFP award by assessment, Dr Jason Yap has candidly shared his research journey with us. Yes, more needs to be done, Family Medicine research is in its infancy stage, but it does exist for a start! With the perseverance of such conscientious colleagues, the support of well wishers and the continued emphasis on research, this small trickle will no doubt develop into a deluge in due time. The missing link in our national biomedical research structure is clinical translational research, and about 80% of primary care patients are seen by family physicians. An infrastructure conducive for primary care research needs to be built up quickly, so that we may get on with it.

A new batch of experienced family physicians have been awarded the professional recognition MCFP and FCFP. These accreditations would signify that these colleagues of ours would be able to practise at the level equivalent to our specialist colleagues of Senior Family Physicians and Consultant Family

Physicians respectively. Students of Family Medicine would be trained in the art of primary care research, practise quality primary care at an even higher level of confidence, and become future leaders of Family Medicine. Dr Tham Tat Yean shares with us his experience as a student in the first batch MCFP by assessment. 15 MMed(FM) and 45 GDFM candidates passed this year's exams. The College Mirror editorial team extends our heartfelt congratulations to all those who have been awarded the professional and academic qualifications in 2006.

The launch of the Medisave for primary care is a first for Singapore, and saw much passionate exchange during the feedback and briefing sessions. One wonders how much more the Family Medicine fraternity can achieve if this passion can be channeled profitably. The College Mirror being a reflection of the Family Physician community decidedly thrives on feedback and opinions. If you feel strongly enough about certain issues and would like to share your opinions, we welcome any contribution of articles. May I also take this opportunity to thank those who have contributed and those who have provided their valuable opinions when approached. **ICM**



More Equitable Less Variable

by A/Prof Goh Lee Gan, President, College of Family Physicians Singapore

In my last forum, I promised to address the consultation fee in this issue. We need to revisit and tweak it in order that general practice / family practice will be satisfying to its practitioners and will attract doctors to be in this sector of the profession into the future. In a nutshell, we need to tune it to make it more equitable and less variable from practice to practice.

How much to pay the doctor?

Based on a survey response in 1996 of 501 doctors out of 854 doctors mailed in the housing estates, it was found in a sub-sample of 216 practices, that to recover the cost for running a clinic and seeing 40 patients a day, \$9.86 is to be recovered per consultation. Add to this the \$11.38 contribution per patient for the doctor's remuneration, it worked out to be \$21.24 per patient for a consultation of 6 minutes, or so, in 1996 figures. This was the basis for the SMA's recommendation of \$18-26 in 1996 for a consultation of less than 15 minutes. (To download this study, please see reference at the end of this article).

The SMA has revised the recommended fees in 2006. The amount increased since 1996 is shown in Table 1. Over 10 years, the recommended increase for the GP consultation fee is only 11-15%.

The need for a realistic and equitable consultation has been made more relevant in recent years as we now have to pay attention to patient's safety and effective care outcomes. The 5-6 minute consultation may slowly have to be phased out into the future.

Need to explain

The man-in-the-street, and employers as well, are likely to let out a loud yell whenever fee increases are mooted. Hence, there is a need to patiently explain and get their support. The reason for the increase is to provide a safer practice, and more time for the consultation work, and therefore better outcome of care can be achieved. It is a worthwhile investment for the man-in-the-street.

Truth is, for a consultation to be done adequately, time is needed. In the West, the standard is now 10 to 15 minutes per consultation for the usual problems. Meanwhile, consultations for chronic disease management will need double that time.

Thinking aloud

In the private sector, this is now possible as the average number of patients per doctor in the last survey done in 2005 was in the region of early 30s, compared to 40s in 1996. In the polyclinic, where the fees are 50% subsidised, the resulting attraction of patient load creates a real

Table 1. SMA GUIDELINE ON FEES 2006

The percentage increases compared to 1996

General Practitioner/Family Physician

In-office Consultation Fees

	Lower range	Upper range
Short Consultation: \$20 - \$30	up 11%	up 15%
Long Consultation: \$30 - \$55	up 20%	(no change)
Extended Consultation: \$20 - \$25 (per 15 min block)	(no change)	(no change)

Out of Office Consultation Fees

	Lower range	Upper range
Non-Emergency Consultation: \$120 - \$200	up 20%	up 33%
Emergency Consultation: \$200 - \$300	up 33%	up 50%
Hospital Inpatient Consultation: \$50 - \$100 (per day)	(no change)	(no change)
Death Certification: \$150 - \$300	(new addition to guidelines)	

Specialist

In-office Consultation Fees

	Lower range	Upper range
Short Consultation: \$60 - \$100	up 33%	up 17%
Long Consultation: \$90 - \$150	up 28%	up 15%
Extended Consultation \$50 - \$80 (per 15 min block)	up 25%	up 60%

Out of Office Consultation Fees

	Lower range	Upper range
Non-Emergency Consultation: \$200 - \$250	up 33%	up 25%
Emergency Consultation: \$250 - \$400	up 25%	up 33%
Hospital Inpatient Consultation: \$100 - \$250 (per day)	(no change)	up 25%
Death Certification: \$200 - \$400	(new addition to guidelines)	

The consultation fees DO NOT INCLUDE costs of medicine, injections, operations, special procedures, laboratory tests and other investigations, e.g. X-ray.

Short consultation refers to routine consultation for relatively simple medical cases / problems, where the problems allow for quick diagnoses and treatment. Examples: for GPs, uncomplicated cases of influenza or gastroenteritis; for specialists, routine antenatal visits for maternity patients or routine post-operative office visits (added in 4th edition).

challenge to give patients more than 5-6 minutes on average.

Thinking aloud, perhaps the polyclinic will need to work on charging the same fee scheme for its patients and have a simplified subsidy scheme only for those who truly cannot afford, namely those who are elderly with no source of support, those who are mentally unwell, and those who declare that they are unable to pay.

Finally, as a profession, we also need to work on managed care institutions to provide a premium to doctors such that the figures are computed on current consultation fee of \$20 (the low end of the \$20-30 recommended by the SMA). This should be achievable considering that many of the managed care institutions have primary care doctors who are either managing them or advising the institutions. **ICM**

REFERENCE

Singh K, Goh LG, Sandhu K, Cheong PY. 1996 survey of housing estate practice costs and GP fees in Singapore. Singapore Med J. 1997 May;38(5):192-9. (<http://www.sma.org.sg/smj/3805/articles/3805a1.pdf>)

(from page 1)

and managed at primary care level should be treated and managed at primary care level. As family physicians, you know your patients best, and they trust you more than any doctor elsewhere. Seeing you is probably the most convenient for your patients than seeking treatment from a different provider. At the other end, this would also allow acute and specialist care resources to be used for their intended purposes. It benefits everybody.

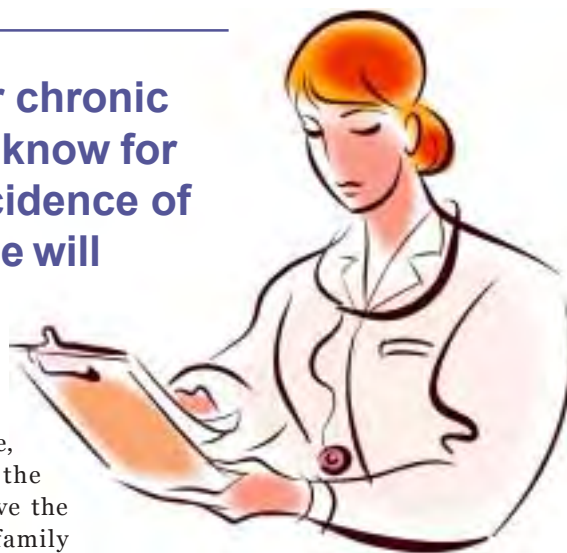
Why do it for chronic disease? In the context of an aging population, we know for sure that the incidence of chronic disease will tend to rise. A patient stricken with a chronic disease will have to live with it for life. That itself is expensive and upsetting. If not well controlled and managed, premature and unnecessary complications and deterioration will cost the patient even more in terms of money and loss of quality of life.

So it makes sense to activate and energise family physicians to tackle this emerging health need in our population. With the help of a structured treatment programme and well qualified family physicians who are committed to continuous improvement, patients will benefit from improved outcomes.

The second reason for our rolling out the initiative this way is a practical one. We want to encourage people to seek treatment for chronic diseases early and to manage their conditions systematically, so we help them work the sums. For many people, the out-of-pocket cash outlay is a big factor that affects their willingness to seek treatment, and their stamina in following up. This is why we allow Medisave to be tapped for this, subject to safeguards against early depletion of such savings. It makes life easier for many.

Here, I return to my earlier point about this invitation to partnership. As you can see, the pieces and policy are now

“Why do it for chronic disease? ...we know for sure that the incidence of chronic disease will tend to rise.”



in place. To bring the idea to life, to let the population enjoy the intended benefits, we must have the support and participation of family physicians. This is why MOH and the College of Family Physicians have worked hard to reach out to family physicians to join this programme.

I am told that the Continuing Medical Education (CME) events organised to explain and promote the use of Medisave under the Chronic Disease Management programme were very well-attended. So too the structured programmes to update doctors on the latest in chronic disease care and management.

Doctors' Response to the Challenge

How are we doing so far? Since the launch of the programme for diabetes on 1 October 06, half of all Family Clinics have already joined the scheme. More Clinics are joining these early adopters each week. This response is very encouraging to us in the Ministry. It shows that when doctors see the benefits for their patients, they will step forward to help.

We believe that when treatment for hypertension, lipid disorders and stroke are added to the list in January 07, the vast majority of Family Clinics would be active partners in the programme.

Supporting the Physician

On MOH's end, we are doing some more things to nurture conducive

conditions for the programme. A national public awareness and education effort has been launched. The key messages are: everyone should first see his family physician, follow treatment instructions closely, and be proactive about managing one's own health and illness. We hope that over time, patients' understanding of and participation in the care that they receive would grow.

Then, to simplify matters for the patient even more, a booklet to help him monitor his progress has been specially developed. This booklet allows patient to record key information about his condition. The patient tracks his own progress and brings the booklet with him each time he sees the doctor. This allows the layman to become an active partner in his own care.

Conclusion

We will learn from the experience, and see what else needs to be done or fine-tuned to get us ever closer to our goal of a nation of healthy Singaporeans. But whatever we do, one thing I know for sure is that family physicians and primary care will play a crucial role in the entire scheme. And so I hope that you will rise to the occasion again and again as we make progress together. Society will recognise and thank you for your efforts and contribution.” ■CM

Family Physicians Working in Hospitals

A new paradigm in continuing care for Singapore

The Hospitalist Paradigm for Family Physicians

In many countries, GPs or family physicians are not confined to caring for patients in the community. They admit patients and continue to manage them as the primary physician in the hospitals, in consultation with the relevant specialists. Some had gone further and become hospital based. The term “hospitalist” had been used to describe these doctors. They are essentially generalists, often trained as family physicians, who work in the hospitals and function in areas where there are gaps of care. The Canadian system uses family physicians to run its hospitalist programme. The Singapore General Hospital (SGH) wanted to test out this system of care as it will allow better transition of hospital patients into the community and also involve family physicians to help in providing the co-ordination and transition care between hospital and the community family physician. A study visit to Calgary Health Region was made in November 2005.

As a follow-up to the study visit, the College of Family Physicians Singapore (CFPS) and SGH jointly organised a think tank seminar entitled “Family Medicine Hospitalist: Possibilities and

Challenges” on the 30th August 2006. The invited speaker was Dr Peter C Jamieson, Division Chief of Acute Family Medicine of the Calgary Health Region. Dr Jamieson was instrumental in developing and running a very successful hospitalist programme in the Calgary Health Region since the late 1990s. This system had worked well for the Health Region, which has a cluster of 5 hospitals, an integrated network of community clinics and long-term care facilities serving a population of 1.2 million people. He spoke on the topic “Family Practice Hospital Model in the Calgary Health Region – A Proven Model of Care”

The lecture was followed by a spirited panel discussion chaired by Dr Lee Kheng Hock (Head Department of Family Medicine and Continuing Care, SGH and Censor in Chief, CFPS). Members of the panel were Prof Tay Boon Keng (Chairman Medical Board, SGH), Prof Ng Han Seong (Chairman Division of Medicine, SGH), Prof Ong Yong Yau (Emeritus Consultant, SGH) Prof Goh Lee Gan (President, CFPS), Prof Cheong Pak Yean (Vice President, CFPS) and Dr Peter Jamieson. The event was well attended with many distinguished guests including Ms Yong Ying-I (Permanent Secretary,



Dr Peter C Jamieson gave an overview of the Canadian hospitalist system and shares his experience in starting the service in Calgary.

Ministry of Health) and Dr Lee Suan Yew (Past President, CFPS and Singapore Medical Council).

A Brief Overview Of The Canadian Hospitalist System in the Calgary Health Region

Dr Jamieson gave an overview of the hospitalist programme in Canada. 90% of the hospitalists in Canada are family physicians as compared to the USA, where 90% of them are internists. He sees the advent of the hospitalists as a logical response to the increased complexity of health care. The hospitalists are a “group of physicians whose sole purpose is to move patients expeditiously and effectively through the system”. Studies have shown that dedicated hospital medicine programmes had resulted in reduced length of stay, decreased costs, improved outcome, and better patient satisfaction. In a tertiary hospital in the region such as the Foothills Medical Centre, which has 1,000 plus beds, 140 beds are managed by the hospitalist programme. The ratio goes up in the smaller hospitals in that region. He noted the historical



The event was well attended by key members of the family medicine fraternity and many distinguished guests, including Ms Yong Ying-I (Permanent Secretary, MOH), Dr Lee Suan Yew (Past President of the College and the SMC) and Dr Ling Sing Lin (Deputy Director, Medical Services, MOH).

difference between the healthcare systems of Canada and Singapore. In Canada, family medicine traditionally has a strong presence in hospitals. There is continuity of care as the family doctors admit patients and continue to care for them as inpatients.

How it all started in Canada

Urbanisation and increased specialisation caused many family physicians in Canada to give up hospital medicine. It was inefficient and the family physicians found it difficult to cope with running a busy town practice and managing a few inpatients in the hospital at the same time. The dearth of generalists in the hospital led to a deterioration of care continuity. Strengthening the presence of family medicine in the hospitals was an obvious solution in such a context. However, there were challenges as medicine had become more complex over time. The new model also called for a role reversal where the family physician now becomes based in the hospital and forays to link up with his peers in the community.

The first hospitalist programme was introduced in the new Peter Lougheed Hospital, built in 1998. The hospitalist programme started small with 30 beds. More programmes were introduced in other hospitals and presently about 400 beds and 10,000 admissions a year

are under the care of 100 hospitalists. Of these, there is a core of full-time hospitalists supported by others who still run practices in the community. This arrangement works well because the focus of the programme is care co-ordination and returning the patients to the community. Over the years, the physicians' skills increased and the scope of work expanded. The patients managed by the family medicine hospitalist have equally good outcome compared to those managed by specialists, provided the cases are appropriately selected and there is adequate consultative support in the hospital. "The goal of our programme is not to replace the consultant. The goal of our programme is to work collaboratively with the consultants." The objective is to leverage on the strength of one another.

The Reasons for Success

"Family physicians are trained to be good in communications, care co-ordination, being holistic and patient centred and working in a team." "This is the skill set that we bring to and deploy in the hospitals." Such skills complement the intense and disease centred specialist interventions in the hospitals.

The programme had resulted not only in better patient satisfaction. Physician satisfaction and morale is better. The family physicians enjoy the challenge and variety that hospital medicine brings.

"The major complaints I get from the specialists who ask how come you are not managing more of our patients, not how come you are taking away my patients. They also ask how come you are not providing me with more support."

Another important achievement of the programme is the better communication between the hospital and the family physicians in the community. Having their peers working in the hospital helped, but more importantly is the commitment to bridge the gap between the hospital and the community. An important service criteria spelled out in the employment contract is that the family physician caring for the patient must be notified within 24 hours of admission. Upon discharge, a written summary must be presented to the patient and a copy to reach the family physician's office within 24 hours of discharge. Failure to comply is considered a serious failure of service.

Dr Jamieson's lecture set the stage for a vigorous exchange of ideas among the panelists and members of the audience. Overall there was enthusiasm and excitement towards this new concept of care. There were some who raised caution and the need to adapt this to our local situation.

Reflections from our Physician Leaders

A/Prof Cheong Pak Yean shared his experience on managing patients in the community and inpatients in the hospital in his earlier year of practice. Many doctors with postgraduate qualifications have admission rights to private hospitals. Like their Canadian counterparts, they find it difficult to manage the time and had to give up hospital work.

A/Prof Goh Lee Gan felt that we have found the missing component in family medicine and that it is not enough for general practice to just stay in the community. "There are two worlds. The hospital world and the community world with a big chasm



The panel discussion that followed the lecture threw up many interesting ideas and different perspectives of the issue. Prof Tay Boon Keng spoke about the fragmentation of care in the hospital and sees family medicine as bridge to better care co-ordination and communication with patients.



Prof Ng Han Seong who was part of the SGH leadership that formed the first hospital family medicine department in Singapore sees a bigger role for family physicians in hospitals, especially in providing transition care between hospitals and community.

in between.” He felt that family medicine is the missing link that can interface both worlds and bridge the chasm. He is worried about the future. “If we do not train the family doctors to get into interface care, they will recede further and further into nothingness. The hospitals will just spread out.” A/Prof Cheong used the analogy of the Dead Sea where everything flows in and nothing flows out. The specialist outpatient clinics in hospitals are used as primary care clinics and the whole healthcare system is choked.

Prof Ong Yong Yau said that after years of helping with the MMed (Family Medicine) Programme, he had no doubt that these trained family physicians can do the job. However, he felt that before we jump into a new system, we should consider whether we can deliver the same kind of comprehensive and co-ordinated care within the present system.

Prof Ng Han Seong sees the family medicine department in the hospital as an important base, which will complete the training for the family physician so that they will be empowered to provide transition care and close the loop between the hospital and the community. Family medicine should take on a bigger role and move into the hospital to perform some of the roles that our Canadian counterparts do in their country.

Prof Tay Boon Keng expressed his concern about the fragmentation of care as a result of specialisation. What is referred to as multi-disciplinary team care often is in effect, patchy episodic care where the patient is managed in parts without any form of care co-ordination. The value proposition of family physicians working in hospital is that they will bring about better co-ordination and better communication with the patient.

Dr Lee Kheng Hock felt that we should be more patient-centred as we look for better solutions to improve the system. One distinct advantage that family physicians working in hospitals have is the knowledge of the community aspects of patient care. They came from the same environment and understand the struggles that their colleagues in the community go through. Unlike the other doctors in the hospital, the core business of family physicians is to consider care of the patient before they come to the hospital and after they leave the hospital.

Dr Lee Suan Yew was very heartened by the recent developments. He recalled the Sreenivasan Oration entitled “Dare to Dream”, which he delivered at the College convocation ten years ago. One of the five dreams he spoke about was that, family physicians would become the well-trained generalists of Singapore’s health care system. He congratulated the leadership of the College and the SGH for bringing

forth the beginning of a new paradigm. He also commended the timely introduction of the MOH’s chronic disease management programme, which was aimed at positioning the family physicians to take on a greater role in the healthcare system. He said that this would put to rest the false notion that family doctors are just “cough and cold doctors”.

Conclusions

Just like the Canadian system, Singapore’s hospital system will benefit from having family physicians work as hospitalists. This will ensure that there will be no gap of care for our patients into the future as they move from the community to the hospital and back again. Family physicians will be able to play a bigger role in health care delivery. ■CM



Dr Lee Suan Yew was very happy that his vision of family physicians becoming the well-trained generalist physicians in Singapore had been realised. He said that the detractors who put family physicians down as mere “cough and cold doctors” have been proven wrong.



The discussion continues after the seminar. Whatever the conclusions, family medicine is poised to take on greater challenges to meet the health care need of our nation.

Chronic Disease Forte of Family Physicians

by Dr Ho Han Kwee, Council Member, College of Family Physicians Singapore



“...about a quarter of the population in Singapore requires chronic medical care on a regular basis.”

Every year, close to one-third of the mortality in Singapore is attributable to cardiovascular and/or cerebrovascular events. These unfortunate events have been proven over and over again to be associated with uncontrolled diabetes mellitus, hypertension, lipid disorders and other known reversible risk factors. Currently, a quarter of a million of our population are suffering from diabetes mellitus. If other chronic diseases like hypertension and lipid disorders are taken into consideration, that number rises to about a million. In other words, about a quarter of the population in Singapore requires chronic medical care on a regular basis. These statistics not only mean that the government must reign in such health problems, they also imply that primary care physicians have a large role to play in the control of such diseases.

The local standard of healthcare is well regarded internationally. However, we can continue to strive for even better management for our patients with chronic diseases. We should not be resting on our laurels if we hope to keep Singapore's healthcare standards among the best in the world. The strategy towards this is perhaps not the introduction of high end, highly specialized technology, but well-established, cost-effective, system-wide programmes to progressively improve the health outcomes of our patients with chronic diseases. In this regard, MOH rolled out an ambitious programme to allow the use of Medisave for chronic disease management programmes, beginning with diabetes mellitus in October 2006. By January 2007, three more diseases, hypertension, lipid disorders, and stroke will be included.

The Programme

The programme for each disease consists of a number of essential care components that clinics registered on the programme will deliver. These care components are recommended based on current clinical practice guidelines. While doctors are well aware of these care components, they are lesser known amongst the patients. Thus, doctors often have difficulty convincing their patients to undergo some of the required tests. By defining a structured programme and working with HPB in patient education, it will go a long way toward helping our patients comply with the care components. By seeking care in one of the registered clinics under the programme, not only are patients given the option to pay for services with Medisave, they are also more assured that care components defined by the programme are delivered.

Response Rate

To date, the number of clinics who signed up for the scheme accounts for almost half of all GP clinics in Singapore. Many in the GP community are perhaps waiting for feedback from colleagues and planning to come on board once the programme expands to include more diseases. The attitude of GPs has gradually turned from sceptical to expectant as MOH has introduced and revised the scheme in accordance with feedback received. This is certainly a tribute to the good attitude of GPs in Singapore towards such a major change.

Benefits

It is too early to tell if the primary objectives of the scheme have been attained, but GPs have already provided feedback indicating that the cost of the HbA1c test has dropped since the scheme was announced. Practitioners would also have noticed the slew of new diabetes mellitus laboratory and investigations packages available to the GP. Patient adherence would definitely improve as affordability becomes less of an issue for many patients.

Many GPs have also opined that the credibility of the GP has improved merely through having the health authorities approve the participation of GPs in the scheme. It seems that this scheme has also given patients renewed confidence to go visit their neighbourhood GPs for chronic diseases.

Eventually, these changes would lead to improved morbidity and mortality for the country.

Role of Family Physicians

Clinics and GPs have joined the programme for a variety of reasons. One GP friend, who runs a solo practice, told me: "I join so that I can keep my chronic patients." Indeed. Over the years, the GP community has had its fair share of bad news and it is perhaps inevitable that pessimistic remarks like my friend's are not uncommon. The Medisave programme is certainly one major piece of positive news in recent memory. To me, it holds great significance for the

“The ball is now in our court, as family physicians, to play it right.”



“Patient adherence would definitely improve as affordability becomes less of an issue for many patients.”

community. Over the years, many GP colleagues have gone into areas of medicine other than what we are formally trained for in medical school. I see this Medisave initiative as the starting point and call for GPs to return to where our forte should be: management of patients with chronic diseases. The very nature of chronic diseases fits like a glove in hand to the principles of family medicine: continuing, comprehensive care in the community characterised by a very personal and preventive approach.

The Medisave programme will help address some of the common difficulties faced by family physicians and patients in managing chronic diseases, such as affordability to patients, the need for national level public education and patient education materials, established clinical protocols, and community resources. Admittedly, many more issues need to be looked at. Nonetheless, with the implementation of this programme, the role of family physicians as the providers of care in the community has been strengthened.

The ball is now in our court, as family physicians, to play it right. We should perhaps look beyond our

consultation rooms and review some of our current practices in the face of the changing landscape of chronic disease management. Key amongst the principles of disease management is the team approach, with the physician as the centre of the team. In order for patients to receive appropriate care, physicians may have to draw upon external resources, be it for screening, counselling, or treatment. Family physicians who establish solid, working relationships with other members of the healthcare team will enhance their ability to provide comprehensive disease management.

As physicians, we know that patients need to play their part in lifestyle changes when it comes to managing chronic diseases. Family physicians can often motivate the patient to change when other members of healthcare team cannot. This is because of the strong doctor-patient relationship, built up over the years, sometimes even with patients' family members. While the science of managing chronic diseases has seen many advances, the basic art of consultation and building up rapport with patients remains essential and should not be forgotten or overlooked. Family physicians should be a source of knowledge, support and guidance

for their patients, not just dispensers of medication. The elements of trust and fellowship between patient and physician cannot be over-emphasised. If patients can perceive a tangible bond from working with us to manage their conditions, they will be far more likely to appreciate the value of "visiting the GP", as opposed to what could easily be "visiting the pharmacy".

As with other professional communities, the gains of individual members will lead to gains for the group, to the betterment of all. When one GP does a good job of managing his patients, it is a boon not only to his own clinic but also to the reputation and professionalism of the fraternity as a whole. The positive standing of the community is essential to assuring patients' continued trust in their doctors.

Conclusion

The Medisave for Chronic Disease Management Programme is the start of what can potentially be a profound empowerment of family physicians. If we perform well, we can look back years later and recall that this was the scheme that opened the doors to a bright era for our profession. Let us answer the rallying call to go back to the basics and do what we are best at: chronic disease as our forte. ■**ICM**

Medical Indemnity Insurance for Family Physicians

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Perspective

The College Mirror met up with a family physician in private practice, Dr Lim, an early adopter of the new Medisave workflow and has already successfully claimed on behalf of some of his diabetic patients. This is what he had to say.

"I applaud the Government for such a move. I am sure it is going to be beneficial to the patients with chronic illness. It allows patients to go a step further into the management of chronic disease, in cases where patients' finances are constrained, such as better communication with the patients (many just repeat medicine), performing various disease parameters e.g. HBA1C, microscopic albuminuria, cholesterol, retinal photography, etc. Many a time, patients think it is good enough as long as they are taking their medications and these tests are painful and unnecessary (or worst, think the doctors are there to make more money out of them). Now with the Government involvement and with all the checks spelt out, and the use of Medisave, it is easier to explain the need for such tests. This also acts as a good platform to enhance public awareness and public education on various chronic diseases.

Now, with such a good program rolled out, a lot of extra administrative procedures have been passed onto Medical Institutions and doctors, especially General Practitioners in private practice where manpower are usually limited. The claiming procedure was made complex as security has to be taken into consideration. Multiple levels of IDs and passwords, including the use of Security Tokens, need to be used. It is worst than drawing out money from the bank for a meagre \$300 per annum. In addition, a fee has been imposed for each transaction, and thus encouraging "advance" payment in term of management package. At the end of the year, there are still all the patients' details and parameters recording to be uploaded onto the website (which I have yet to try at this point of time).

E-claiming has been in place for several years already. Ezyhealth and NTUC have already done it with much success and ease. Steps are simpler and easier. Their e-claim systems have been quite stable now. MOH should tap on their experience.

I also hope MOH will make all Laboratories in Singapore accredited to this scheme so that they could help doctors and institutions to upload patients' laboratory results that have been done through them onto the website. With concerted effort, I would like to see this scheme become a great success."

Dr Lim

Family Medicine Convocation Ceremony 2006

The College of Family Physicians Singapore held the Family Medicine Convocation Ceremony on Saturday, 4th November 2006 at the Ministry of Health Auditorium, College of Medicine Building. It was a celebration of the achievements of another milestone reached by 104 family physicians.

**Increasingly,
there is a need for
the family
physician to
receive training.**

In his Opening Address, College President A/Prof Goh Lee Gan said that the College has its vision of developing doctors to be medical practitioners to provide the frontline and continuing care for our fellowmen. In the past, this has been focused largely in the ambulatory care setting.

Increasingly, there is a need for the family physician to receive training so that he or she can function in settings where our elderly will be cared for their medical needs, namely, the community hospital, the daycare facility, nursing home, and also care at home or home care. There is also a need to train family physicians to provide the interface care between the hospital and the ambulatory care clinic. This is a new area of work that will be important in the right setting of care."

He said that there are now 246 Master of Medicine (Family Medicine) and 191 Graduate Diploma in Family Medicine holders. "The Master of Medicine is aimed at training a family physician to a level on par with the hospital specialist in terms of rigor and demand for excellence, whereas the Graduate Diploma focuses on training family physicians in providing enhanced care in the domain of preventive care, acute care and continuing care problems."

The College certifies two professional development programmes. They are the College Fellowship programme FCFP(S) by assessment which was initiated in 1998, and the Collegiate Membership programmes MCFP(S) which could be obtained either by (1) completing the MMed (Family Medicine) programme and fulfilling the requirements of continuing education and training of fellow doctors, or (2) by the assessment Programme.

The Minister of State for Health, Mr Heng Chee How, graced the occasion as the Guest-of-Honour. His Keynote Address concerns the Medisave for Chronic Disease Programme, doctors' response to the challenge and Ministry of Health's support for physicians (see page 1).

Two doctors were conferred FCFP(S) and 25 MCFP(S). Seventy-seven doctors were recognised: 17 MMed (Family Medicine) Year 2005, 15 MMed (Family Medicine) Year 2006, and 45 GDFM Year 2006 graduands. Dr Chong Shih Tsze Steven was awarded the GDFM Book Prize Year 2006. **ICM**



From top:

1. Dr Lee Kheng Hock, Censor in Chief, College of Family Physicians Singapore
2. Mr Heng Chee How (Minister of State for Health), Guest of Honor and Dr Alfred Loh (President, WONCA)
3. A/Prof Goh Lee Gan, President, College of Family Physicians Singapore
3. Guest of Honor, Mr Heng Chee How, with Dr Alfred Loh, Dr Ling Sing Lin, and Clinical Prof Nambiar.

20th College Council



Council Members of CFPS with Minister of State for Health
Standing (L-R): Drs Yii Hee Seng, Ng Joo Ming Matthew (Hon Editor),
 Tham Tat Yean, Lim Fong Seng,
 Pang Sze Kang Jonathan, and Ho Han Kwee.
Seated (L-R): Drs Cheng Heng Lee (Hon Secretary),
 A/Prof Cheong Pak Yean (Vice President),
 Mr Heng Chee How (Minister of State for Health),
 A/Prof Goh Lee Gan (President) and Lee Kheng Hock (Censor-in-Chief).
Not in photo: Drs Arthur Tan Chin Lock (Hon Treasurer),
 Tan See Leng, and Ong Chooi Peng.



Mr Heng Chee How receiving token of appreciation from A/Prof Goh Lee Gan after his keynote address.



Assembly of Family Physicians in the 2006 Convocation



20th Council members on stage for Award Ceremony



Dr Tham Tat Yean signing the MCFP(S) roll

FAMILY MEDICINE 04 NOVEMBER



MCFP(S)

Standing (L-R top): Drs Yap Soo Kor Jason, Chong Poh Heng, Leong Choon Kit, Soh Soon Beng, Tan Yew Seng, Wong Tien Hua, Sim Kok Ping, Hwang Siew Wai, and Tung Yew Cheong.

Standing (L-R mid): Drs Wong Ern Ling Helena, Goh Tiong Jin, Tham Tat Yean, Chew Sze Mun, Siew Chee Weng, Koh Wee Boon Kelvin, See Toh Kwok Yee, Long Mei Ling, and Lim Hwee Boon.

Seated (L-R): Drs Goh Lay Hoon, Gwee Shou-Yi Rachel, Lee Kheng Hock (Censor-in-Chief), A/Prof Goh Lee Gan (President), A/Prof Cheong Pak Yean (Vice President), Aw Lee Fhoon Lily, and Shiau Ee Leng.



MMed (FM) 2005 Graduates

Standing (L-R): Drs Koh Yong Hwee Norman, Hau Tah Wei, Chao Tar Liang Anthony, and Lim Chien Wei.
Seated (L-R): Drs Gwee Sheau Min, Puvanendran Rukshini, Lee Kheng Hock (Censor-in-Chief), A/Prof Goh Lee Gan (President), A/Prof Cheong Pak Yean (Vice President), Yong Molly, and Toh Mei Ai Lena.



FCFP(S)

Seated (L-R): Drs Yee Jenn Jet Michael, Lee Kheng Hock (Censor-in-Chief), A/Prof Goh Lee Gan (President), A/Prof Cheong Pak Yean (Vice President), and Ong Jin Ee.

THE CONVOCATION

NOVEMBER 2006



Dr Wong Tien Hua, emcee for the Ceremony, being conferred MCFP(S)



Dr Yap Lip Kee, gynaecologist, with A/Prof Goh Lee Gan



Standing (L-R top): Drs Ng Kwee Choon, Ong Chon Kin Fabian, Abdul Bashir bin Abdul Kadir, Soong Chuon Vui Jovian, Chin En Loy Conrad, Yuan Heng Wai, and Ng Juak Cher.

Standing (L-R mid): Drs Cheng Heng Lee, Tjang Tjung Fa Francis, Lwin Sann, Kao Chin Yu, Ng Lee Beng, Vasawala Farhad Fakhruddin, Ang Pei Ming Samuel, Chong Shih Tsze Steven, and Choo Heng Wee.

Seated (L-R): Drs Aye Aye Maw Amanda Koh, Lim Ka Pheok Angela, Lee Kheng Hock (Censor-in-Chief), A/Prof Goh Lee Gan (President), A/Prof Cheong Pak Yean (Vice President), Sundarraj Chitra, and Wee Bee Poh Diana.

GDFM



MMed (FM) 2006 Graduates

Standing (L-R): Drs Ng Han Lip, Chung Wai Hoong Irwin, Chong Tsung Wei, Lau Chin Hoh, Quah Hui Min Joanne, Lee Mun Tuck, Azman Osman, and Foo Fung-Yee.

Seated (L-R): Drs Ong Cheng Ean, Phua Mei Fang, Lee Kheng Hock (Censor-in-Chief), A/Prof Goh Lee Gan (President), A/Prof Cheong Pak Yean (Vice President), Wong Sabrina, and Tan Wen Hui.



Dr Jason Yap, Dr Ng Lee Beng, Prof David Koh (Head of COFM, NUS) and Dr Lily Aw



Dr Lee Kheng Hock and Dr Matthew Ng with CEO of WONCA, Dr Alfred Loh (middle)

Winner of GDFM Book Prize Award 2006 Dr Chong Shih Tsze Steven

Could you explain briefly about your positive lifestyle?

I work in a Polyclinic which leaves me with time in the evenings for my family, friends and myself. I try to exercise when I can, but working in Polyclinic can be rather draining on one's energy levels. Weekends are really for recuperating, catching up with family and friends. I regularly attend church on Sunday.

Have you always been in the tops since school days?

Definitely no! In retrospect, I have come to discover that I have done well at times when it really mattered. In fact, I was an average performer up till my Junior College.

Is there a particular skill to achieve this award?

I truly believe that I have God's blessings in achieving this award. In addition, I believe that my regular work at Polyclinic is also a great help. Many of the practical scenarios and Key Feature Questions were somewhat familiar clinical situations I encountered at work. In addition, my organisation arranged to have OSCEs tutors for us, which was a great help.

What's your motivational factor in taking up GDFM?

I was feeling a strong sense of stagnation in professional development at one stage, especially after learning so much in medical school, and I felt that I desperately needed to continue learning again.

In general, what do you think of the image of Family Medicine in Singapore?

Unfortunately, I feel that there is still a significant proportion of our population who still sees Family Doctors/Physicians as providers of acute care. This is partly also because they themselves do not see the importance of preventive healthcare. It is indeed heartening to see the strong push in recent times for patient

empowerment and education. In addition, the emphasis towards more holistic primary care and personalised physician is a great step towards the right direction. The call for primary care doctors to go through some vocational training is also a very necessary step forward. All in all, the paradigm shift is definitely happening and I am sure the image of Family Medicine will be a shining one in times to come.

What are the difficulties encountered in this course?

None really. The only difficulty I encountered was the exams. The sheer volume of material to go through was pretty daunting.

What are the beneficial knowledge gained in this course?

Personally I found two things of the greatest benefit. Firstly, the well-structured course gives me a framework to do my own learning from other resources. Secondly, the workshops were very useful because the scenarios are always so practical and it was great to learn from the specialists what their management would be in these cases.

What are the many memorable experiences during the past two years while learning GDFM?

I enjoyed the tutorial sessions where we were able to socialise with our colleagues, share our various practices and management pearls. I also enjoyed the workshop sessions, meeting regularly with friends and chatting, and learning at the same time. Another wonderful experience was when we get to translate what we have just learnt into clinical practice. As mentioned, the workshops scenarios were very realistic and it was great to know for sure that you are practising appropriately.

Is there any specific area which you think should be looked into to improve the course?



In general, I was happy with the course as a whole. A couple of areas that perhaps can be looked into are the accuracy of the module notes and the efficient use of workshop time. There were a few inadvertent errors in the notes which made studying more difficult. Some recommendations were repeated, but were quoted from different sources which caused some confusion. As the workshops scenarios were so practical, it was a waste that we did not get to go through more of such cases during the workshops.

Is there any Word-of-Advice for those who wish to take up GDFM?

Go for it! It is really not very time-demanding and in real life, it is so easy to stagnate and not learn further. This course will really make you a better doctor, and you get to socialise with your colleagues along the way. This is especially important for solo GPs, who may lose out on having peers to discuss cases with.

Do you have any study tips to share?

Do regular work. Make sure what you practice is what you have learnt. This will really make exam preparation much easier as what you do in examination is what you do naturally. Try to approach each patient in your daily consult as an exam case and you will not be rusty in your list of differential diagnoses and questions to ask.

Find one or two study partners for support and to practise OSCEs. Especially important before the examination.

While practising OSCEs, work out a list of dos and don'ts and useful phrases to have, e.g. do listen and show empathy, use of "Tell me what's your concern?", etc. ■ CM

Collegiate Membership of the College / MCFP(S) by Assessment

by Dr Tham Tat Yean, MCFP(S), Council Member, College of Family Physicians Singapore

The Collegiate Membership of the College of Family Physicians (Singapore) MCFP(S) is the professional benchmark for recognition as a Senior Family Physician. It may be attained by one of two routes. Family physicians with the Graduate Diploma in Family Medicine (GDFM) must undergo the two-year MCFP(S) by Assessment Programme, while those with the Master of Medicine (Family Medicine) may be elected via an interview.

MCFP(S) by Assessment Programme

Aims and Objectives

In line with the international trend of awarding professional memberships by objective assessments and validations, the MCFP(S) by Assessment Programme was introduced to encourage members to participate in objective and structured professional development activities. This constitutes the College Professional Development Programme (CPDP) for the award of MCFP(S) and comprises structured training, formative and summative assessments.

Eligibility

The minimum entry requirements to the MCFP(S) by Assessment Programme are: GDFM or recognised equivalent, professional good standing and ordinary membership of the College of Family Physicians Singapore for at least two years.



Standing (L-R): Dr Tham Tat Yean, Dr Leong Choon Kit, Dr Yap Soo Kor Jason, Dr Soh Soon Beng, Dr Wong Tien Hua, and Dr See Toh Kwok Yee.

Seated (L-R): Dr Aw Lee Fhoon Lily, Dr Wong Ern Ling Helena, Dr Lee Kheng Hock (Censor-in-Chief), A/Prof Goh Lee Gan (President), A/Prof Cheong Pak Yean (Vice President), and Dr Long Mei Ling

Course Overview

The programme consists of a course of three modules, each with a summative assessment. The duration of the programme is two years. The three modules to be completed and the required standards are:

1) Consulting, Communication & Counselling Module - which includes an Effective Clinical Consultation Skills Course and its components.

Standard: A pass in video consultation assessment. Candidates will be required to submit six video consultations for assessment. At least one video consultation submission is expected to be either a paediatric or psychiatric case.

2) Clinical Quality Module - which includes a Clinical Quality Skills Course and its components.

Standard: A pass in clinical quality project assessment. Candidates will be required to submit three case studies of significant events analysis or conduct an audit project in his or her clinic of practice.

3) Professional Development Project - which may be based on the organisation and conduct of a modular Continuing Medical Education course or other teaching programmes; publishing a paper in a medical journal such as the Singapore Family Physician or its equivalent or other professional

(continued on page 22)

Trials, Tribulations, and Triumphs

Antibiotic Associated Bowel Disturbances

by Dr Jason Yap Soo Kor, MCFP(S), Family Physician in Private Practice

Trials

I was very curious to find out what it takes to do research and wanted to learn to do research first hand. The opportunity came when I decided to do the MCFP course. I felt that if there was one thing that was lacking in the medical curriculum during my undergraduate training, it would be in the area of research. I opted to work on a research project to fulfill the MCFP course requirement under the optional module.

I started by consulting A/Prof Goh Lee Gan on how to do a Medline search. I visited his office one Saturday morning and he took time to show me the finer points of how to do a search. We also discussed a little on composing a possible research question. I met up with a consultant gastroenterologist at Gleneagles Medical Centre, Adj A/Prof Gwee Kok Ann in the following week to discuss and formulate a research question. I needed a mentor who could show me the ropes. A/Prof Gwee was willing to guide me. He invited A/Prof Wong Mee Lian of COFM department to help with the statistics and organise a research account with the NUS. A medical graduate, Dr Joel Hwang joined the team to assist A/Prof Wong with the statistics. Two research nurses helped with the interview of 800 subjects for the study at my clinic.

Gastrointestinal symptoms are perceived to be common complaints arising from the use of antibiotics. This prospective study examines the association between antibiotics and the gastrointestinal symptoms of pain, bloating, hard stools and loose stools in a primary care population.

Over a two-month period, 200 consecutive outpatients (cases) who were prescribed antibiotics and 600 consecutive healthy subjects (controls) who came for pre-employment check-ups and screening were enrolled in the study. A structured questionnaire was administered at face-to-face interview and repeated 2 weeks later by telephone interview.

Tribulations

Not surprisingly, the MCFP supervisor assigned to me was not experienced with Family Medicine clinical research. I did not know anyone personally in the family medicine fraternity who was able to guide me on the arduous journey, which I had embarked on. A/Prof Gwee is one of a few select specialists in private practice who has done a lot of research and published innumerable papers in reputable international journals. I was acquainted with him in one of the CME talks he gave to GPs. I decided to approach him to help me. He did. A/Prof

Gwee was a good mentor. He let me go through the learning curve and patiently corrected me along the way.

Funding was another issue to grapple with. We needed funding for the two research nurses to interview 800 subjects over a period of two months and to cover for printing costs. Some adjustments and accounting of funds was necessary to get what we needed.

While doctors doing research in various institutions have their own Institutional Review Boards (IRB), GPs in private practice will encounter difficulties in trying to get the necessary ethical clearance or approval, as GPs belong to no-man's-land. Yet potentially, GPs play a very important role in health service research as a much higher proportion of primary care patients visit private GPs rather than government doctors.

“...potentially, GPs play a very important role in health service research”

Perhaps my greatest challenge came when I have to put in writing the findings of the study. I began with the abstract and had to do it many, many times to get it right. I spent many nights and weekends to get the relevant papers and read them before writing a draft. I can still remember that I had to do it countless times before it was finally deemed acceptable for submission.

Triumphs

Patients who were given a course of antibiotics had an increased risk of developing bowel disturbances as compared to patients who were not given antibiotics. This study also revealed that some patients could develop antibiotic associated constipation



Dr Jason Yap Soo Kor is an experienced Family Physician in Private Practice and truly a keen student of Family Medicine. Despite his busy schedule as a full time practitioner in Parkway Shenton Medical Group, he found the motivation to complete a primary care research project. Photo: Dr Yap and family.

rather than diarrhoea. Furthermore, some patients developed symptoms consistent with irritable bowel syndrome (IBS). Further longitudinal study is needed to confirm the association of IBS with antibiotic use.

I was fortunate to have A/Prof Goh to help me 'kick' start and A/Prof Gwee and A/Prof Wong to guide me along. I could not have done it on my own, regardless of the amount of notes I have read on how to do research and write a research paper. They would not have shown up if I had not humbled myself to ask for help.

I was at a meeting for COFM Department clinical tutors when Dr Annelise Wilder Smith shared her experience in writing research papers. She said that when you have written it 50 times and felt totally fed up with your paper, then you are close to writing a good paper. Those remarks made my day as

I was close to giving up after having to rewrite my paper countless number of times.

My humble advice for a Family Physician who wants to start doing a research project? Find a mentor who is willing to help you. Do not be afraid to ask for help. Keep going even when you feel alone and discouraged. One great lesson that I learned was to be like a postage stamp. "Stick to one thing until you get there."

What needs to be done to help FM research flourish?

1. senior practitioners who are willing to guide and mentor research trainees,
2. ethics committee under the College who can grant approval for research by its members,
3. funding for research,
4. insurance coverage for trials. ■CM

Smart Handles in Neurology

by Dr Gabriel Seow, FCFP(S), Editorial Board Member

HINTS and TIPS

A smart handle is a symptom or a sign which either produces a shortlist of possible disease or helps localise a lesion accurately. Smart handles are used extensively by the skilled clinician, consciously or otherwise, and are particularly helpful in neurological conditions are suspected.

The following are examples:

1 Blackout with eyes tightly shut

a. In a genuine blackout, the eyes are usually open and staring, with dilated sluggishly responsive pupils; if the pupils are closed there is no difficulty in opening them. If a patient resists having his or her eyes opened, a functional disorder is likely.

b. If the patient's eyes are deviated to look to look at the ground or mattress, rolling him or her to the other side is useful. In genuine cases, the eyes continue pointing in the same direction; in a simulated episode, the eyes will turn to face the floor or mattress again.

2 The patient who stands during the consultation

A person who stands during a consultation and does not have piles (and you have provided a chair, of course!), usually has a functional back disorder. Most patients with lumbago or sciatica are more comfortable sitting or lying down. It is very rare for a patient with organic back pain to stand during a consultation.

3 The patient who cycles for miles but only walks for yards

This patient presents with a history of calf claudication on walking but also has no vascular or significant neurological findings on physical examination. If the patient finds cycling relatively easy, then lumbar spondylosis is a likely diagnosis. Reason: the flexed-trunk position increases the sagittal diameter of the lumbar canal, reducing nerve compression.

4 The headache

a. The cough headache:

A cough headache is caused by cough or other manoeuvres that raise intracranial pressure. It should be distinguished from aggravation of existing headaches by coughing, which is much more common. 50% of patients with cough headaches have no obvious problem. However, a significant of the remainder have a posterior fossa tumour. Cough headache is therefore potentially serious.

b. The morning headache:

There are relatively few causes of a morning headache which is present on awakening. Tension headaches usually starts later in the day. If morning headache is occipital, consider cervical spondylosis or raised intracranial pressure. The fundi should be examined. Frontal morning headache can also be caused by sinus disease or migraine.

5 The overly friendly patient

This is the patient who makes remarks like "what a nice day, doc!" or "how is your family?" at the beginning of his or her first consultation. The patient is unlikely to have organic illness and often turns out to be neurotic or someone is repeatedly hopping from one doctor to another. The greeting may also be followed by a request for sleeping pills.

These diagnostic shortcuts though useful when we are in a hurry are nonetheless guides and not infallible. They should always be used with commonsense and caution! ■CM

Adapted from Hawkes C.H., Update Oct 1994

Regional Conference on Professionalism in Medicine 2006

Reported by Dr Yvette Tan, Editorial Board Member

Regional Conference on Professionalism in Medicine 2006 which was jointly organised by SGH-PGMI and Stanford University was held between August 22nd to 25th in Singapore, attended by 116 participants from all over the world, including Asia Pacific, Europe, Africa, United Kingdom and America.



Why a conference dedicated to Professionalism in Medicine?

To many who attended this conference, the focus on Professionalism in Medicine is timely and much needed. Medical professionalism determines the core of what is good medicine and healthcare. Increasingly, medical educationists around the world are clamouring for the subject of Professionalism to be formally taught in medical schools. Yet many of us continue to ask: What exactly do we understand by professionalism? Why is it necessary to teach it?

At its very core, the practise of Medicine is a moral enterprise grounded in a covenant of trust. Given the vulnerability of patient in the relationship, the probabilistic nature of medical knowledge, the often times uncertain nature of outcomes which can have both inter and intraindividual variation, and the knowledge and skills asymmetry between physician and patient, trust is crucial for the relationship to be healing. The essence of professionalism is self-regulation and self-governance. It embodies the characteristics¹⁻² of exemplary behaviour in the profession which includes compassion, empathy,

altruism, professional competence, primacy of patient's welfare, and social justice. Such characteristics are what society will hold their medical practitioners accountable for.

What are the threats to professionalism?

With the commodification³ of healthcare in recent times where patients are now seen as consumers, and medicine, a product to be sold, delivered and serviced, the doctor - patient relationship is under serious threat. Lack of leadership, lack of clarity of the standards of practice, erosion of trust by the patient leading to rising litigation, increasing use of team based care, increase dependance on technology, increase emphasis on science versus the art of medicine and the changing aspirations of the doctor's own needs have all taken its toll on the Doctor - Patient relationship as we know it.

The erosion of trust⁴ in the medicine has result in a higher cost to societies since this erodes the Doctor-patient relationship from within and results in defensive medicine which is medicine practiced in a morally lazy manner. However, we do acknowledge that the most important determinant of long term success for

medicine in the age of biology is the Doctor-Patient relationship and the medical profession's obligation to the well being of society at large.

What can we do to preserve and protect this?

To rediscover the physicians' true vocation and whom we serve⁵; reaffirming and redoubling our commitment to teach future generation of physicians, teaching them how to balance the science and art of medicine through role modeling and actively counter acting cynism which tend to occur in the harsh context of actual practice and often brings into conflict the professional ideal and the ideal professional (employee) in many of us. To keep alive and build upon these altruistic motivations so that physicians can continue to be leaders and agents of change in professionalism and guide the profession's relationship with society.³ There is a crucial need to adapt to changes and evolving structure of the health care system, as well as address the implications of new technology, complementary and alternative medicine and physicians should not be sidelined in these areas of change, but take a lead in continuing to advocate for the patient.

“As a result of the seemingly lack of mutual purpose with her doctor, she vowed never to return to the doctor again.”

How to bridge the Science - Art gap of medicine ?

Using some Harry Potter stories as examples, Dr Trisha Greenhalgh⁶ in her keynote lecture invited the audience to consider narrative-based medicine to be an integral part of an evidence approach to clinical care. She proposed that the patient's story, rich in context, metaphors, plots and concerns, provide the best raw material from which we can generate meaningful and plausible hypothesis about the causes and management of diseases.

She gave an example in her own practice of a young lady patient of hers with Type 2 diabetes. Whilst the patient's perspective of her problem had been that she would like very much to have a baby; her previous doctor's concern had been on her poorly controlled diabetes and its possible teratogenic effects on her baby should she ever become pregnant.

The lady recalled that the only thing she could remember the doctor telling her was that " You are fat and your diabetes control is horrible. The last thing you should do is to get pregnant". As a result of the seemingly lack of mutual purpose with her doctor, she vowed never to return to the doctor again.

When she met Trisha for a second opinion; and was allowed to narrate her story, the research questions that

came out from the consultation was very different from those already answered in the many protocols about Diabetes care. What was the percentage of young women with Diabetes who default care? What was the prevalence of unplanned pregnancies in patients with Diabetes? What happened to patients who default on their diabetes follow up? What interventions to reduce default rate in this child bearing age group? What interventions can improve the outcome of the the baby and the diabetic mother?

Any evidence gleaned from the science of medicine must have at the "Bayesian priors" the right question to start from. Narrative medicine is able to illuminate and refine the path which evidence medicine should take.

Among the distinguished panel of

speakers who spoke were Dr Malcolm Parker, who spoke on the assessment of Professional Behaviour, Professor Goh Lee Gan and Prof Cheong Pak Yean elucidated on the use of narratives locally, Dr Koh Dow Rhoun shared about how professionalism development program is being taught in the undergraduate curriculum and Dr Thirumoorthy spoke on how to help the impaired professional.

It was indeed a very interesting and useful conference, providing plenty of insight and food for thought. One could not help thinking that preserving and developing medical professionalism is like 'do or die'. Woe to us all if we should stop becoming relevant to the needs of our patients and the privilege of self regulation and self governance be taken away from us! **ICM**

Table 1

	Evidence Based Medicine	Narrative Based Medicine
Starting point	illness	story
Patient	object	subject
Paradigm	empirical	interpretive
Context	controlled for	interwoven with
Focus	on events	on plot
Emphasis	generalisability	uniqueness

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3. Dr Tan Chor Chuan . Deputy President and provost of the National University of Singapore in his lecture on " Human Capital Development as an Instrumental Value in Professionalism.
4. Dr Chin Jing Jih. Consultant in the Department of Geriatrics Medicine, Tan Tock Seng Hospital in his lecture on Ethics and Professionalism : Are they still relevant to medical practice in Singapore?
5. Professor Ong Yong Yau. Department of Internal Medicine, Singapore General Hospital in his keynote lecture on " The Professional Ideal: In search of the Southern Cross "
6. Professor Trisha Greenhalgh. Professor of Primary Health Care at University College London.in her keynote lecture on " Harry Potter and the Number Needed to Treat : The Use of Narrative in 'Evidence-based' Decision Making"

Recipient of Healthcare Humanity Award

Dr Tan Boon Yeow

In this issue, College Mirror caught up with Dr Tan Boon Yeow, one of the few family physicians who were awarded the Healthcare Humanity Award.

The Courage Fund was established in 2003 to commemorate the courage, commitment and compassion of healthcare workers who faced life threatening dangers with fortitude and self sacrifice.

This year, besides Dr Tan, among those honoured are family physicians Dr Evelyn Lim Hui Moey, Dr Ong Jin Ee, Dr Tan Ngiap Chuan, and Dr Elaine Tan Suan Leng.

CM: First, congratulations for receiving this year's Healthcare Humanity Award. Please tell us more about yourself.

Dr Tan: Thank you. I have been working at St Luke's Hospital for the past 7 years after completing my postgraduate training in Family Medicine in 1999. The work thus far is challenging yet a highly satisfying one (being among a pioneer batch of doctors working to provide care to the elderly in the community - i.e. community geriatrics.)

CM: Why have chosen to take this path. How did it begin?

Dr Tan: My passion to do Family Medicine began as early as a 4th year medical student after hearing Prof Goh Lee Gan's lecture on the role and career opportunities of a family physician. This had led me to take on the Family Medicine traineeship after completing my National Service.

Subsequently, I was rotated to St Luke's Hospital just prior to completing my training in Family Medicine in 1999 (i.e. before the MMed (Family Medicine) examinations). Spending six months at the hospital exposed me to the service gaps in the delivery of care for the elderly, and especially the lack of doctors and professionals caring for the elderly. Having to make a choice whether to return to primary care or continue to work with the elderly, I chose the latter as I realised that there are already many good family physicians and GPs out in the community.

The doors of opportunities just started to open up one after another. Firstly, I managed to transfer my outstanding bond



Dr Tan at his office in St Luke's Hospital

with MOH to St Luke's Hospital. I was then offered a one and half year scholarship from St Luke's hospital to pursue a postgraduate course leading to a Master in Medicine (Geriatrics) with University of New South Wales. Concurrently, I was allowed to train with Professor Edmond Chiu, a world renowned expert in dementia in Melbourne, and later with A/Prof Daniel Chan, a professor in geriatrics in Sydney. As a result, I had the opportunity to work in various geriatrics settings which included acute and rehabilitation hospitals, psycho-geriatric services, nursing homes as well as home care (doing home visits with clinical teams

comprising of geriatricians, therapists and social workers).

At about the same time, the College started a fellowship program with a slant towards eldercare and the four of us (including Colin, Kala, and Gerald) embarked on it. It was similar to the fellowship program that the other fellows of the College underwent, except we were trained by both geriatricians and family physicians and did our research and write ups on geriatric and family medicine topics and patients.

CM: What are some of the challenges working in such a setting?

Dr Tan: The challenges I find working in this setting briefly include:

1. A lack of proper training path for doctors wanting to work in elderly setting. This was even more acute when we first started. Since then, we have managed to develop a career path as well as create more opportunities for training through the Diploma in geriatric medicine as well as attachments and postings in geriatric care postings.
2. Being able to convince the elderly themselves, their relatives, as well as fellow health care providers, of the importance of maintaining good physical function. Often, they tend to only look at the medical aspects of the illness without looking at how their physical functions, like walking, dressing, bathing, etc., can be affected by an episode of illness, and in turn affect recovery and

rehabilitation post illness. Hence, there is difficulty convincing some of them and their relatives of the need to spend sufficient time and effort in maintaining their physical function.

3. The presence of service gaps in the community. It is still difficult to support an elderly who lives alone and is unable to be independent due to their physical, mental or sensory impairments with the current services available in the community. There is also a lack of subsidised home rehabilitation for those who have difficulty leaving their dwellings.

There are many more challenges which I do not want to bore you with here but I will be happy to meet up with doctors interested to do work in this area to discuss more.

CM: What keeps you going?

Dr Tan:

1. My greatest satisfaction is in seeing the patients return to their own homes with their physical functions back or almost back to their pre-illness state. It is an even greater joy if we can get them into an even better shape than pre-illness. I recall a patient that came in with a bed sore and the relatives were wondering if the wound would heal. Not only did the wound heal but with rehabilitation, the patient even managed to walk again.

2. The other satisfaction is in being able to improve the quality of life in the elderly. Many of them have concomitant depression as a result of their physical illness. They find themselves useless and a bother to the family. With constant encouragement by the nurses, social workers and chaplaincy team at the hospital as well as working with the family and occasionally prescribing medications to lift their moods, many overcome their gloom.

3. In tandem with that, I also find great satisfaction in being able to work with family members to help them to care for their elderly relatives. We also manage many patients with dementia and severe disability. Often this is very draining on the caregivers. Helping these care givers

by lending them a listening ear as well as helping them to arrange for services to help relieve their stress and make it possible for them to carry on caring for their loved ones without having to place them in institutions.

CM: We understand that you are also involved in teaching at NUS as well as SIG eldercare in College. Could you tell us more about it?

Dr Tan: I was asked to start the SIG on eldercare during my fellowship interview so really I had no choice, **grin**. On a serious note, I think it is a small yet very significant start as College recognises a need to train and expose family physicians to the care for the older patient.

I joined NUS as an adjunct staff since last year. What attracted me was the opportunity to contribute to teaching and research in a structured way with time set aside to do so. I must thank my employers for allowing me to take one day off a week to spend time at NUS.

CM: What is your typical week like?

Dr Tan: Mornings are dedicated to time with patients either seeing them in the outpatient clinic or doing ward rounds. This is interspersed with weekly journal/book club that we present to each other for the purpose of CME.

Afternoons are spent in administrative work which include assessing referrals of patients made by the acute institutions or meetings with the various committees and staff in the hospital. Occasionally, there will be meetings at MOH or at NUS to attend to.

I do about 2-3 night calls a month with one being usually a weekend as the weekdays are tied up with the many commitments present. Fridays are usually spent at NUS teaching or preparing for lessons or catching up with reading and research. Most Saturday mornings and occasional Sunday mornings are spent back at the hospital and the rest of the weekends reserved for family, friends and church (that is, if I am not on call or distracted by extra-curricular activities like CME activities or rushing for last minute assignments/marketing of scripts, etc.)

CM: Is there a need for more doctors to be involved in the work that you do?

Dr Tan: Definitely! Many, many, more!!! As we all know, the population is ageing and we will all need to see and manage more elderly, either in the hospital or outpatient setting. We will also need to have more doctors contributing to teaching and research.

Well, you may not be driving a Lexus or putting golf in some country club weekly but I always believe and have experienced that it is certainly more blessed to give than to receive. ■ **CM**



Dr Tan with patient at outpatient clinic.

(from page 15)

development projects approved by the College Council.

Standard: A satisfactory supervisor's report and a pass in the candidate's report of the professional development project.

Award

The successful completion of the summative assessment of all the three modules and an exit interview will satisfy the conditions for award of the MCFP(S).

The First Batch of Trainees in the MCFP(S) by Assessment Programme

The inaugural batch of candidates for the MCFP(S) by Assessment Programme commenced their CPDP in academic year 2004. Nine out of ten candidates exited their programme successfully this year and was conferred the MCFP(S) award at the recent Family Medicine Convocation Ceremony held on 4th November 2006.

A review of the video consultation topics submitted by these candidates reflects the breath of cases seen in family practice (please see Table 1).

The nine candidates also published their papers (please see Table 2) in the Singapore Family Physician. The topics of their papers were related to their professional development projects in the CPDP.

Our country now has an emerging corps of vocationally trained family physicians.

Table 1. Examples of Video Consultation Cases Submitted

Atopic eczema	Burn management
Acne	Primary prevention of hypertension
Weight reduction	Review of diabetic care
Hyperlipidaemia	Hypothyroidism
Urticaria	Psychosomatic symptoms
Tension headache	Low back pain
Left plantar fasciitis and Anxiety	Chondromalacia patellae
Viral fever	Insomnia and Psychosocial problem
Hypertension	Paediatric bronchitis
Gastro-oesophageal reflux disorder	Food diary
Chest pain	Work-related backstrain
Viral gastroenteritis	Uterovaginal prolapse
Allergic rhinitis	Feeding problems
Secondary agenda in consultation	Growth on scalp
Paediatric viral fever and Overweight child	

Table 2. Published Papers in the Singapore Family Physician

Using Video-Recorded Consultations as an Assessment Tool
Heraldry & Regalia of the College of Family Physicians Singapore
Antibiotic Associated Bowel Disturbances in a Young Healthy Primary Care Population
Toward Quality in Family Practice
Organising a Family Practice Skills Course in Women's Health
Resolving Ethical Dilemmas in Private Family Practice in Singapore
Revisiting Red Flags in Family Practice
Abbreviations, Acronyms and Symbols in General Practice (Two authors)

The Future

The College Professional Development Programme (CPDP) for the award of MCFP(S) represents a milestone development. The College now has both the Fellowship and Collegiate Membership by Assessment programmes for family medicine vocationalists.

Our College President, A/Prof Goh Lee Gan, in his Opening Address during the Family Medicine Convocation 2006, elaborated on the College vision of lifelong professional development of the family physician for the present day and future day Singapore. The objective of the

professional development programme is "professionalisation of the family physician to be a trainer, leader, organiser, and developer of the discipline of family medicine".

Our country now has an emerging corps of vocationally trained family physicians. In line with the College vision, these family physicians can participate in the college professional development programmes to continue their learning and professional development journey. This bodes well for the family physicians, their community and the discipline of family medicine. **■CM**

Redefining Health Care: Creating Value-based Competition on Results

by Michael E. Porter & Elizabeth Olmsted Teisberg

Reviewed by Dr Lee Kheng Hock, Censor-in-Chief, College of Family Physicians Singapore

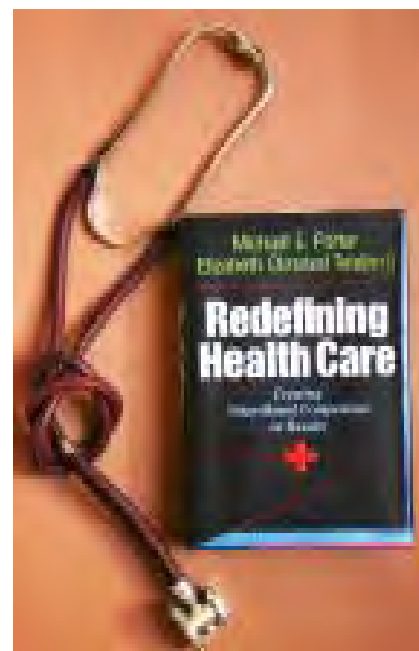
Michael E. Porter is the Bishop William Lawrence University Professor, based at Harvard Business School. He is a world renowned authority on competition and strategy. His ideas on strategy are taught at the required strategy course at the Harvard Business School as well as business schools all over the world. His name had become synonymous with international competitiveness and business strategy. In 2001, Michael Porter visited Singapore and many credited him with influencing Singapore's present strategy of developing a competitive national economy. If this is not reason enough to want to read this book, here are some more:

Michael Porter was the man who brought the word "cluster" into competition. A six year quest to understand the competitiveness of national economies culminated in an earlier book, the *Competitive Advantage of Nations* (1990). His conclusion was that the answer to national competitiveness lies in understanding the microeconomics of how firms compete. He developed the "cluster" concept which he defined as a 'geographically concentrated group of interconnected firms and associated institutions in a similar field'. He believes that clusters affect competition by increasing productivity of grouped firms, giving direction to innovation and stimulating the formation of new businesses within the cluster.

His latest book, published only this year, is a masterpiece of well researched scholarship. The first three chapters of the book analyses the failure of the health system. More importantly, the authors seek to understand why competition had failed to produce the anticipated improvements in cost and quality. Although the analysis is largely based on the United State's health system, most of the problems studied are universal. Reading the first few chapters of the book is like attending a professorial round in the good old days of medicine. Suddenly, all the symptoms and signs make sense.

The remainder of the book expounds the cure. In chapter four, the concept of value-based competition is explained and advocated. In chapter five to eight, the authors explain the implications of such a strategy on the various stakeholders in healthcare, namely: the health care providers; the health plan providers; the suppliers; the consumers; the employers and the government.

This is not one of those management books that promises a winning strategy that one can bring back, apply and run a better business. It is a call for structural changes in the health care system. In the authors' own words, "this book sets forth a new and different vision of the health care system, in which everything in the system is realigned around its fundamental purpose - patient health".



Sometimes things come full circle. Since the 1970s many clinicians, seeing the deterioration of the health care system, had raised the alarm and advocated patient centred care as the strategy to counter the ill effects of disease centredness and provider centredness. The new type of "competition" that is advocated now, sounds more and more like calls for co-operation for a common purpose.

Perhaps the health care system itself is suffering from multiple comorbidities. As in most chronic diseases, diagnosis is easy but management is difficult. There is no one solution or one strategy that will cure all. Ultimately, we have to work on getting incremental improvements on many fronts that will lead us to a better, more effective and functional health care system.

Nevertheless, Prof Porter has written, consider health care redefined. Even the most obstinate detractor will waiver after reading this book. The concepts are well argued and backed by facts, figures and case studies. This book is a good read for people who like to ponder about problems of the health care industry. It is a must read for those who are working to heal the health care system. **ICM**