THE College Mirror

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CONTENTS

FAMILY PRACTICE SKILLS COURSE

COLLEGE ART GALLERY

CENSER
Ming Dynasty (1368-1644)

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Towards IT Integration

The College Mirror understands that MOH is actively looking at how to enhance the adoption of Information Technology (IT) and to extend electronic linkages particularly amongst the primary and step down care providers. It has formed an Advisory Committee for IT Integration for Continuity of Care, which will be chaired by Dr Lee Kheng Hock, the Censor in Chief of College of Family Physicians Singapore.

The committee will seek to advise MOH on IT integration for the purpose of continuity of care across hospitals and primary care facilities in order to bring about right siting of care in the community. Focus groups and feedback sessions to gather representative views and to bring about seamless IT integration will be held. The committee will then come up with strategies to encourage IT adoption.

The benefits of sharing of health information among physicians are nearly universally understood and desired. However, the level of adoption of electronic health record systems in primary care settings remains low. Further, there is very little sharing or exchange of health information concerning patients between the many different types of electronic health record systems employed by tertiary institutions. The full potential of the current technology in computer science and health informatics is not being realised. The consequences of this include a drain on resources both financial and administrative, propagation of avoidable medical errors, poor communication between primary care and tertiary institutions, and poor communication between public and private sectors.

CM takes some excerpts from a speech given by Ms Yong Ying-I, Permanent Secretary (PS) for Health in her address at the Healthcare IT Innovation Week conference on 2 February 2007.

Healthcare and IT

PS (Health) started her address by declaring that integrating Healthcare via the use of IT is going to be a huge undertaking, and one that requires an in depth knowledge of healthcare. She gave a candid assessment of the current situation when she said that: "Health care is a complex field - it is one of very personal doctor-patient relationships juxtaposed against a large system with many moving pieces. And IT in health care is a particularly challenged area. It is widely recognised that while healthcare is a high-technology high-skill sector, it is not one that makes extensive use of IT. We use a lot of expensive high-tech medical equipment like 64 slice CT scanners. But we have been slow to build and use systems that allow patients' clinical data to flow within and across medical institutions."

"For health care IT to work, it must make sense in meeting the needs of patients and their doctors. That's no different ultimately from saying that a product or service must meet customers' needs. It is just that these customers' needs are complex."

Strategic Imperative - One Singaporean, One Family Physician, One Electronic Medical Record

PS (Health) outlined the way forward for the delivery of health care in

(to page 4)

Are You a Paper or PDA Person?

by Dr Wong Tien Hua, MCFP(S), Editor

I recently started using the paper planner/ organiser at the beginning of this year. I have previously tried using handheld electronic planners, but they usually did not last long as the technology became obsolete very quickly. I even tried using my mobile phone as electronic planner, but trying to key in the text proved too daunting. So in this day of palm-sized razor-thin electronic organisers with phones and cameras, it looks like I am actually regressing in my use of technology. In terms of writing notes and reminders, I have found that bits of paper win at the end of the day. I guess it all depends on personal preference and there is really no right or wrong method, and no one method is better than the other. You can choose to use either paper or electronic, but usually not both.

This kind of dilemma permeates clinical practice. I have seen so many attempts in taking case notes electronic. But it seems that till now, no software is quite able to replace the humble paper case records that we are so familiar with. Nothing can be as convenient and fast as scribbling our clinical notes on a case card and moving on to the next patient - the "File and Forget" method. I do believe that many GP clinics make use of PCs and software for registry and billing, however the majority have probably not gone fully electronic with clinical records. GPs with broadband internet access may even be a minority. The day of electronic data exchange between primary care and hospitals has yet to be realised.

The time to make use of IT may finally be here, as we are beginning to see a major push to adopt IT in primary care. Our cover article reports on some of the IT initiatives that the Permanent Secretary for Health has alluded to. I hope that you will now seriously consider to start adopting IT in your work processes, and to take part in the feedback sessions that will be organised. There needs to be a smooth transition and a common platform for medical record exchange; it would be wise for stakeholders like us to get involved.

In this issue of College Mirror, we have a special focus on Community Resources. Dr Shirley Goh and Dr Tan Boon Yeow's article describes four of their patients in the community hospital, giving us interesting insights into the work that they do. The second article examines the role of specialist/day surgery centres in the community. They are now being sited in HDB estates with the aim of serving the local GPs and bringing specialist care and procedures closer to patients' home. Even our regular feature on Doctors in Practice is about two GPs providing community resources, one as a 24 hour housecall doctor and the other working in Hospice Care. Career options for GPs have never been better, and there will always be room for energetic young doctors with the right ideals.

Speaking of energetic doctors, as the new Editor for College Mirror Team B, I am really glad to have Dr See Toh Kwok Yee and Dr Loke Wai Cheong on my side. We hope to be able to keep you readers up to date with the latest developments in Family Medicine. We want to make *The College Mirror* true to its name- to provide a platform for discussion and reflection. We therefore welcome your contributions and ideas, so please feel free to contact us via the College.

And finally, the 18th Wonca World Conference on "Genomics and Family Medicine" will at last be coming to Singapore in July, after many months of planning. We should be proud that such an international event is being organised by our very own family physicians from public and private sectors, so please show your support by signing up for the conference early. The event will be held from 24-27 July. I shall mark those dates in my trusty new organiser, having the assurance that my paper records won't fade or run out of batteries. Now if only I can find a pen... ■CM

Right Siting is a Journey

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

Right siting is a journey. And it has been said that a journey of 10,000 miles begins with the first step. Every important journey has a vision.

What is a vision? The best example that comes to mind is the statement by one of the American presidents who said, "We will put a man on the moon by the end of the century." In other words, we are talking of the end in mind. And it will be spectacular.

The same parallel can be drawn on right siting. Right siting means the patient is cared for at the right place and right time at any point of his illness or wellness. This is visionary because it is simple in idea, but is a quantum leap in action and in thinking - just like putting a man on the moon. And it can be spectacular. If one takes the trouble to sit down and calculate the savings from morbidities prevented, re-admissions saved, and timely interventions done, that sum may be economically staggering. Of course, health care costs can be reduced to patient and nation.

A vision will remain a vision until we turn it into a journey. Every journey has an itinerary, a start, a progression, and achievement. Let me think aloud with regards to right siting.

ITINERARY

The aim of right siting is the patient being cared for in the right place at the right time at any point. The user and the provider need to work out the needs and wants, and develop the system for meeting these. Presently, the healthcare system has been crafted based on what providers think patients need and want. There is also a need for sharing between provider and patient on what is the best bang for the buck. What must be screened, what must be treated, and what must be monitored are answers that must fill the right siting itinerary. Then, health care will be cost effective.

Prevention

We need to work out what are the gaps that need to be filled. The most glaring one is prevention of disease by working on the risk factors, and we do not need to do much screening.

As we look around Singapore, a substantial majority of our people are afflicted with the metabolic syndrome. Eye ball them and you would have screened them. Too fat, they are time bombs ticking away. Heart attacks, strokes, kidney failure, diabetes will be part of the pathological journey.

Is enough being done to counter this with three simple words (but of course a life time of discipline), diet, exercise and weight control? And to think bravely, can we get patients convinced that upon diagnosis of the metabolic syndrome or its complications, they would be offered a life saving training package on practical skills and knowledge on diet, exercise, and weight control?

We need to move from cognitive concepts to psychomotor action. How many patients know what to do when they leave the doctors' office? We should include the things and the people who can make the difference - not mere talks. They could be cooking lessons, chefs, and teachers who will have no problems doing that, exercise programmes and exercise providers from tai' chi (which by the way, has been proven to bring down blood pressure by several millimeters of mercury) to aerobics, and resistance programmes.

What about weight control? If you do the first two right and aim for 5-7% of weight loss, you will get patients to prevent 58% of diabetes happening. Read about this in the Diabetes Preventive Programme published in the New England of Medicine Journal in 2002.

A vision will remain a vision until we turn it into a journey.

Transition care

Patients who are not well primed and handed over to doctors ready to receive them will end up with re-admissions, morbidity and even mortality. Money can be saved. Quality of life can be improved.

There is a need to work with the family physicians, the hospital specialists, and patient leaders on how this idea of transition care can be implemented. And we can start with "low lying fruits": better transition of surgical patients to family physicians to provide the follow-up care and catch the wound infections early. It is being done, but not

(continued on page 9)

(from page 1) - Towards IT Integration

future. She noted that healthcare has historically been institution based and care had been largely episodic. The Chronic Disease Management (CDM) Programme was a first step in changing this approach. The extensive use of IT in support of the CDM Programme was also a big leap for many providers.

"We now recognise that we cannot afford to take an episodic view of healthcare. My Ministry's top priority for the year will be to push on strengthening the framework for integrated delivery of long term care for a patient. The nationwide Chronic Disease Management approach we launched last year encouraged family physicians and specialists to partner each other in providing appropriate long term care of the patient. The fundamental logic is about right siting of care that for chronic diseases, it is more cost effective and it is better medicine for the family physician to provide long term care to the patient. But long term care and coordination between GP and specialist requires IT support - it requires IT to facilitate claims for Medisave payments. It requires IT to track clinical outcomes for long term care. GPs and specialists need to share the patient's electronic medical records.

"It will become increasingly critical with an ageing population, that we have a stronger infrastructure to support health care in the community setting. When patients are discharged from tertiary hospitals to step down care or care by the GPs at home or in the community, we need the medical care to be seamless.

My Minister has stated more than once his vision that every Singaporean should have his or her own family physician who provides him general care over the long term. The second thing that is required is IT. The GP needs access to health screening results, medical treatments, drugs prescribed in the hospital or step down care institution. My Minister has thus also stated that our databases must be networked. We must build a national electronic health records, and get primary care GPs, community hospitals, care centres in the community linked into this.

I was pleased to note in the Chronic Disease Programme that a huge percentage of participating GPs were keen to leverage IT. In the Medisave claim process, we provided options for paper submission. But no one used this. 100% of submissions have been electronic. Many clinics took the opportunity to upgrade their computers and clinic management systems, as well as install broadband access. This enthusiasm has given us confidence to support you further."

A Central Backbone - Common Standards

The key word in IT is interoperability. Public hospitals are now linked electronically. A common standard must now be developed to link public and private institutions as well.

"Realising our vision of One Singaporean, One Family Physician, One Medical Record would rely critically on an integrated IT backbone. This is particularly applicable to Singapore where the pattern of patient care and flows is asymmetric. 80% of primary care is provided by private sector GPs, while 80% of acute care by the public sector. The majority, about two-thirds, of admissions into our hospitals are through A&E departments. This underscores the importance of easily accessible centralised medical records.

The Electronic Medical Records Exchange (EMRX) that we started working on in the public sectors since 2003 now links most of the medical records for the public hospitals. The EMRX has been gradually populated with useful information - inpatient discharge summaries, allergy alerts, etc. It is quite comprehensive now. We are now ready to take the next step. The Government will identify and set nation wide standards for our health care IT infrastructure. This common backbone should include standardised data definitions and formats for medical records to be shared. It will be cheaper and more effective for everyone if Government designs the common backbone that everyone can use - both our public sector clusters, primary care GPs, private hospitals step down care institutions and the charity sector."

"It is also important that we are practical in our approach. I think we have built a sensible system where we are not trying to standardise all hospital systems nor try to share everything with everyone. Strong championship from clinical leaders has helped us think through what subset of data needs to be shared or standardised nationally. Beyond that, we can give institutions the flexibility to build tailored systems for their needs that will ride on the common backbone. There are "soft" components as well as the "hard" components - Government will also put in place "soft" components such as a comprehensive framework that safeguards patient confidentiality. We will need processes for audits, workflows, and so on.

We welcome and need partners. In particular, we will need to work closely with the College of Family Physicians, the Singapore Medical Association and the other professional healthcare bodies amongst others. "

Implementation is everything

"Healthcare IT implementation is extremely challenging because it requires the people building the system to really understand how doctors work and what they need. If the builders build systems where the workflow design does not support doctors to work efficiently and effectively, they will naturally not wish to use the system. The healthcare IT only works if it makes sense.

It is difficult for pure IT folk to understand the intricacies of clinical systems. Hence, clinicians must champion and participate intensively in any implementation that involves clinical applications. It is easier for clinicians to understand IT. Second, we have to build broad based consensus amongst users. That takes skills to do and those are not technical skills. Third, it may not be possible to define very clearly on Day 1 what we will do in a massive project. Of course, we must have some specs to start, but it is necessary to continually review and evolve the plan as we learn on the way. Pilots are a good way to learn what the teething problems are and resolve them. That gets us faster down the road of clinician buy in. Hence, a big bang approach to projects may not work well in health care." CM

Feedback and Participation

If Health Care IT is an area that you have great interest in, be sure to sign up early and participate in the feedback sessions that will be organised by CFPS. Please send your email to contact@cfps.org.sg.

The Community Hospital & the Family Physician

by Dr Shirley Goh and Dr Tan Boon Yeow

The three men sat looking at each other. Near them laid a fourth man who was not able to communicate much with them, he seemed to be in a world of his own.

Each had his own story to tell as how he came to this place. Each had a goal for coming to this place.

The first was an elderly man called Mr Lim. Mr Lim was an active grandfather who enjoyed bringing his grandchildren out for walks. He was also involved in coaching the local chess team at the community club. All this took a change when he was diagnosed to have colonic cancer. He underwent an operation and ended up with a stoma. His mood fell, and it got worse when the abdominal wound became infected. His family was not sure how to cope with this new change. They could not cope with the care of the stoma, neither were they prepared for the reversal in roles. Mr Lim had changed from being a caregiver to his family, to one who needed care himself. On the recommendation of the surgeon, Mr Lim and his family agreed to come to this place. They had hoped that while Mr Lim's wound healed, they would learn how to cope with his condition and the stoma. They also hoped that Mr Lim would regain some strength.

The second man in the room was a middle aged gentleman. He was about fifty years old. He was a fishmonger at a neighbourhood market. He was fit. He was seldom sick. His favourite past-time was to enjoy a cigarette after a morning's work. He had been smoking since his teens, and kicking the habit was not a consideration at all. He woke up last week with a strange sensation. He could not lift up his right leg and his right arm. He had suffered a stroke! At the hospital, he was told that he had high blood pressure and high cholesterol levels. He was told to quit his smoking too. He was determined to go back to his work. He was the sole bread winner. He wanted to get well as much as he could. Hence, he agreed to come to this place too.

The goal was common... so that they could be integrated back into the community.

The third man was Albert. Albert was an odd job labourer. Tragedy struck him while he was on his way to work one day. He was crossing a road when he was hit by a car. He survived the impact, but ended up with a tibia fracture. The fracture was plated, but it was soon populated with a much dreaded bug. The physician and the surgeon had recommended for several weeks of intravenous antibiotics to manage the infection. He had to stay in the hospital during this period to receive the medication. He also needed to learn how to cope with moving along without putting weight on his injured leg. He too came to this place.

The fourth man lay on his bed. He barely spoke. When he did, it was more crying than words. He had contractures in his limbs. He had been bed bound for five years. He needed a feeding tube to provide for his nourishment. He came as he had bad sores on the back from prolonged lying. These developed when the family maid was changed and the new maid was not sure how to care for him. The sores almost killed him, but he managed to recover with treatment and was referred to this place for further care before returning home.

The place where these four men were at was a community hospital. They had been referred into the place for various reasons. The goal was common - to get better so that they could be integrated back into the community.

Events had caused them to be tossed out of their usual orbits. The community hospital was a place where they had come to receive treatment.

For Mr Lim, it was for the care of his infected abdominal wound and for his family to learn how to care for his stoma. He also wanted to have rehabilitation to regain his stability when he walked. The period of bed-rest following his operation had somehow made him less confident in walking. He felt unsteady when he stood up. During his stay, the nurses attended to his wound, the family learned how to manage the stoma. The therapists helped Mr Lim regain his confidence in walking. Upon discharge, Mr Lim was referred for follow-up rehabilitation at the Day Rehabilitation Centre of the hospital. He was also seen by the doctor at the Outpatient Clinic for the follow-up of his chronic medical conditions, and saw the surgeon for his surgical problem.

For the middle-aged fishmonger, he wanted to get back to his job. Deep down he knew that he would not be the same as before the stroke, but he was determined to try to regain as much as he could. He had heard that intensive rehabilitation was important for this. Hence he was there.

Family Practice Skills Course 16 (Repeat)

Women's Health

COURSE STRUCTURE

Unit 1 : Menopausal Health in Women
Dr Carol Tan

Unit 2 : HIV Infection and Other Sexually Transmitted Infections (STIs) in Women
Dr Fong Kah Leng

Unit 3 : Breast Biopsies - When, Why, and How
A/Prof Hong Ga Sze

Unit 4 : Reducing the Risk of Gynaecological Cancers
A/Prof Tay Eng Hseon

Unit 5 : Cervical Cancer Prevention
A/Prof Arunachalam Ilancheran

Unit 6 : Pap Smears - Techniques, Interpretation of Results and Management of Abnormal Results
Dr Fong Kah Leng

SEMINARS
(2 Core FM CME Points for each seminar *)

Seminar 1 : 24 March 2007 (2.00pm - 4.00pm)
- Unit 1: Menopausal Health in Women
- Unit 2: HIV Infection and Other Sexually Transmitted Infections (STIs) in Women
- Unit 3: Breast Biopsies - When, Why, and How

Seminar 2 : 25 March 2007 (2.00pm - 4.00pm)
- Unit 4: Reducing the Risk of Gynaecological Cancers
- Unit 5: Cervical Cancer Prevention
- Unit 6: Pap Smears - Techniques, Interpretation of Results and Management of Abnormal Results

WORKSHOP SESSIONS
(2 Core FM CME Points **)
- Case Studies
- Pap Smear Technique: Dr Quek Swee Chong

Day 1: 24 March 2007 (4.15pm - 6.30pm)
Day 2: 25 March 2007 (4.15pm - 6.30pm)

* Subject to approval from SMC
** Workshops held on Day 1 and Day 2 are similar workshops. Workshops are on first come first served basis with limited seats available.

Date: 24 & 25 March 2007

Time: 2.00pm - 6.30pm

Venue: Auditorium Level 7 & Lecture Hall Level 1
HPB Building, 3 Second Hospital Avenue

Due to limited seats available, please register early to avoid disappointment.
For enquiries, please contact us at Tel: 6223 0606 or E-mail: contact@cfps.org.sg

REGISTRATION

WOMEN'S HEALTH
Course Registration Form

Please tick (√) the appropriate boxes

	College Member	Non-College Member
Seminar 1 (24 March 2007)	☐ $ 10.00	☐ $ 20.00
Seminar 2 (25 March 2007)	☐ $ 10.00	☐ $ 20.00
Workshop	☐ $ 20.00	☐ $ 40.00
Please choose your preferred workshop date	○ 24 March 2007 (Sat)	○ 25 March 2007 (Sun)
TOTAL		

Name: Dr _____ MCR No: _____

Mailing Address: (*Please indicate:* ○ Residential ○ Practice Address)

_____

_____

_____

Tel: _____ Fax: _____ E-mail: _____

Registration is confirmed only upon receipt of payment. The College will not entertain any request for refund of registration fee after official receipt is issued.

The development of this Family Practice Skills Course is supported by an educational grant from Health Promotion Board.

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The aim for the therapists at the hospital was to try to help him to become community ambulant again. It was not to be an easy task, but they would support him. It was a difficult road, but each little step was a step forward.

Albert being thirty plus in years was initially disturbed to be in a place where the patients appeared a lot older and sicker than him. He soon settled in when he realised that he was in a caring environment where the team of nurses and therapists were concerned about his wellbeing. They had encouraged him to regain his independence. He entered the place in a wheelchair, and gradually progressed to a walking frame. By the end of his antibiotic therapy, he was able to walk using crutches. That was a great relief to him as his home was rather cramped and maneuvering a wheelchair would be almost impossible. He was also glad that the occupational therapist had recommended some changes for his home after an assessment before he returned home. These enabled Albert to be independent and safe in his home environment.

The last person was elderly Mr Wong. He had suffered a stroke many years ago, and had gradually declined in his function. He also had dementia. He became bed-bound in recent years. The new maid was briefly "trained" by the previous maid. However, being new to the job, she was uncertain about some of the tasks. Unfortunately, Mr Wong developed bed-sores, and they became infected. He was referred to the community hospital for care of his sores. The maid also received care-giver training. After several weeks the wounds were manageable, and the maid was more confident in caring for Mr Wong. The family also took the opportunity to learn about the care for Mr Wong as they regretted that they did not have the knowledge previously, being dependent much on the previous maid. Mr Wong was discharged home and was referred to the Home Nursing and Home Medical Team for follow-up.

In the initial years, inpatient rehabilitation of the older patient was the main emphasis.

A community hospital located at the west of Singapore.

The above are sampling of the types of patients that are seen at the community hospital. The patients are usually admitted for rehabilitation, like the fishmonger who had a stroke. Other types of cases in this group would include post- hip fractures and post lower limb amputations.

A small proportion of the patients are admitted for continuation of medical therapy that has been started at the acute hospital, like in the case of Albert and Mr Wong. Other examples will be patients who have multiple co-morbidities and have become deconditioned following a major surgery, like in the case of Mr Lim, or illnesses. The degree of rehabilitation in these cases varies from case to case. For Albert, this will be an important component. For Mr Wong, the training is more directed towards the care-giver.

The community hospital, as the name suggests, is a hospital that is sited in the community. It is, in essence, an intermediate care facility that serves to rehabilitate and facilitate re-integration of patients back into the community (which is usually home).

Community hospital care was first introduced in Singapore slightly more than a decade ago, with one community hospital each sited in the west, central and eastern parts of the island. In the initial years, inpatient rehabilitation of the older patient was the main emphasis. Over the years, it has slowly evolved to a facility which provides a range of in and out-patients services in addition to rehabilitation. These include sub-acute care, cardio-pulmonary rehabilitation, palliative care as well as outpatient clinics specialising in the care of the elderly and those with chronic illnesses as well as providing outpatient rehabilitation, home medical, home therapy and home nursing services.

Thus, the community hospital can be viewed as an extended arm of care for the patient. The family physician can play a pivotal role by referring suitable cases to the community hospital for rehabilitation or medical care. This can be done by contacting the admission team of the respective community hospital, or establishing contact with the respective outpatient services.

In the near future, it may even be that family physicians can directly admit their patients for inpatient management into community hospitals, thus reducing the demand of acute hospital beds. More family physicians could also choose to work full time in community hospitals, spend part of their time running clinics, or doing inpatient hospital work in these settings. ■CM

REFERENCE

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2. Definition of a community hospital : www.norfolk.gov.uk/consumption/groups/public/documents/committee_report/norfhealth191006item7.pdf
3. Ang Mo Kio - Thye Hua Kwan Hospital Ltd: www.amkh.com.sg
4. Bright Vision Hospital: www.sbws.org.sg
5. St. Andrew's Community Hospital: www.sach.org.sg
6. St. Luke's Hospital Ltd: www.slh.org.sg

The writers are colleagues who work in one of the community hospital located in Singapore. They are among a group of physicians trained in family medicine who have chosen to work in the community hospitals.

Getting to Know the Editorial Board (part 1)

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

Since its revival, The College Mirror has developed into an important communication tool where both the family medicine community look to for objective reporting of changes and developments in family medicine, as well as for relevant interested parties to keep a pulse of the wants and needs of family physicians so that appropriate policy changes and services can be adjusted to cater to our requirements.

Good people with the appropriate outlook and relevant primary care experience is thus crucial to provide the leadership and energy to keep things running. It is hence my utmost pleasure to see the appointment of the Team B Editorial Board of Dr Loke Wai Cheong (WC), Dr See Toh Kwok Yee (KY), and Dr Wong Tien Hua (TH) as Editor. The College Mirror asked them a few probing questions to get acquainted and know where they stand.

Gentlemen, welcome to the College Mirror Editorial Board. I am glad that the College has found good people to fill the editorial positions.

CM: Tell us something about yourselves?

TH: I remember that Medical school showed me that life was essentially a miracle (and so was passing exams). Thereafter, as I gained more experience from clinical practice, I began to realise that there is still a large part of our work that had nothing to do with science. Our consultations were based on human understanding and how we respond to verbal and non-verbal cues. This was medicine as an art. It made all the difference between one consultation and the other, even if the clinical problem was the same. No two patients were alike. I guess I am still learning every day.

"... there is still a large part of our work that had nothing to do with science. Our consultations were based on human understanding and how we respond to verbal and non-verbal cues. " **- Dr Wong Tien Hua**

KY: I obtained my basic medical degree in 1987 and served nearly the full duration of my government bond before leaving for private practice.

My first job thereafter was with a medical centre that offered medical evacuation by land and air. I had the privilege then to travel in private Lear and Falcon jets to as faraway places as inner Mongolia to evacuate ill patients. I left a year later despite a generous salary as I did not feel it was my calling and I was living by the pager.

My next job as a family physician has kept me on it until today, some thirteen years later. I thoroughly enjoy the mature charming neighbourhood where my clinic is sited and where my elderly patients still display old fashion good manners, affection, and respect for their doctor.

WC: Early in my career, I chose to train in family medicine because I loved the holistic approach, caring for all age groups and a wide variety of conditions, and especially the challenge of problem solving at the first vague presentations of an illness.

After more than seven years of practicing in (and running) polyclinics, I made a mid-career switch to administration seven months ago - to oversee quality, and hopefully improve processes and safety in our larger healthcare system. Having been a generalist and a family physician gave me a broad perspective across the spectrum of care. My passions straddle working with and impacting people, teaching and counseling, which I will have greater opportunity to pursue in my new role. I look forward to the

"I look forward to the chance to influence professional training, career development, and welfare of junior doctors."

- Dr Loke Wai Chiong

"... my elderly patients still display old fashion good manners, affection, and respect for their doctor."

- Dr See Toh Kwok Yee

chance to influence professional training, career development, and welfare of junior doctors.

CM: Are there any significant role models that have impacted your life as a doctor?

TH: A friend passed me a copy of 'The Inner Consultation' by Dr Roger Neighbour near the start of my career. It changed my whole perception of being a GP. It showed that the consultation process could be a powerful tool for therapeutic change for the patient.

KY: Growing up, I was enthralled by the exploits of Charles Darwin and David Livingstone in my reading and had daydreamed of following their footsteps. I was also captivated in my formative years by the work of my family doctor in his laidback shophouse clinic along rustic old Cantonment Road.

WC: One role model whom I know only from afar is Dr Don Berwick, President and CEO of the Institute of Healthcare Improvement in the US. His insight into the problems in our current healthcare (non) system, his ability to rally countless others to the cause over the decades, and his untiring passion to drive quality improvement across the States and the world have been nothing short of inspiring!

CM: If there is one thing you want to change in family medicine, what would it be?

TH: If I had a genie in a bottle, I would wish for our patients to start paying us GPs the consultation rates that we deserve. Let them recognise the true value of the time that we spent with them, and pay us accordingly! The genie would, of course, rather I asked for a simpler task like world peace instead.

KY: More trust and cooperation among family physicians to further our cause and common good.

WC: That family physicians will be fully recognised for their crucial role and be integrated into the local healthcare system to provide the necessary coordination and continuity, especially for our many chronic patients. ▮CM

(to be continued)

(from page 3) Right Siting is a Journey

systematically. Mr Liak, one of our hospital CEOs recounted to me what he did in his hospital and that certainly saved patients some money and prevented suffering too.

From this, we can move on to more complex patients, patients requiring chemotherapy shots, antibiotic shots, and the list goes on. For the journey to begin, the family physicians will need to have a desire to provide this type of care and be empowered through briefings and "handshaking" with their hospital counterparts, as well as handshaking with patients and family. Confidence needs to be ensured on the part of the hospital specialists and their patients. I believe the results and savings will be spectacular. We need to embark on this.

A START, A PROGRESSION AND ACHIEVEMENT

My challenge to the new community health organisations, like Northern Hope and Jurong Medical Centre, is for them to explore the joint venture with the people who can help patients in preventive medicine empowerment. Offer to every metabolic syndrome patient a practical preventive programme. It will be a win-win. Our metabolic syndrome patients will be saved. The community health organisations will be buzzing and the cooking lesson teachers; the exercise programme people will have plenty of things to do and I will leave you to imagine the rest.

A start has been made on transition care and right siting of care between hospital and community with the setting up of the Department of Family Medicine and Continuing Care at Singapore General Hospital. As is expected of any new idea, there are many who say, "Cannot be done, lah". However, there are the early adopters who say, "Why not try it?"

The idea seems to be catching on, judging from the interest taken by other hospitals on this new development. And it will be a right start. So, I would encourage family physicians to take part in the venture to be the receivers of patients being transitioned out to your care. Keep a look out for invitations to participate. Attend the briefing. Learn what is needed to provide the handed over care from the hospital. There will be lots of meaningful things to do.

We need the hospital specialists to work on the patients too to give them the confidence that effective care will be provided by the doctors receiving such patients. Then there will be a progression of the journey. And as I said, the achievement can be spectacular. Right siting is a vision and a journey. Let us make it work. ▮CM

A Tale of Two Centres

There is a trend towards stand-alone specialist and day surgery centers in recent years. These centers offer patients the opportunity to see specialists in their community, and to have selected surgical procedures done outside the hospital setting. The growth of ambulatory day surgery has been fueled by the development of newer, short-acting anaesthetics, better pain management, technological advances in minimally invasive surgery and development of endoscopic techniques.

Put simply, patients can now look forward to being seen early by a specialist and having procedures, previously only performed in hospitals, done at locations closer to their homes.

The idea behind such centres is that it should support and augment the medical services offered by the GP in the area. By pooling resources and providing specialists and diagnostic services, it is a happy symbiosis between primary and secondary health care.

However, setting up such centres is a complicated endeavor with no guarantee of success. Having a good location is certainly one of the most important considerations, but the centre must also provide a wide range of services as well. Challenges like high rentals and high start-up costs, finding a good management, attracting a team of dedicated doctors and providing adequate support staff make such a task extremely daunting.

The College Mirror takes a closer look at the newly opened Jurong Medical Centre in the West and Northern Hope Specialist Centre in Punggol to give readers a better idea of the services available and challenges they face.

Jurong Medical Centre

Opened in October 2006, Jurong Medical Centre (JMC) partners Alexandra Hospital, National University Hospital, NHG Diagnostics and NHG Pharmacy. JMC aims to bring specialist care into the community, provide ambulatory outpatient treatment and day surgery, and function as a resource for general practitioners in the vicinity. It is located in western Jurong next to Jurong Point, an area that is densely populated but not currently well served by hospitals. JMC covers some 86,000 square feet spread over three floors.

The idea behind such centres is that it should support and augment the medical services offered by the GP in the area.

Jurong Medical Centre is situated in a three-storey stand-alone facility.

JMC comes across as having a strong emphasis in promoting self help for patients. It has programmes that empower patients to care for themselves, by offering knowledge and support. JMC also supports the Chronic Disease Management Programme by offering a range of allied health services for the GP.

The Homecare Solution Centre

Entering from the ground floor of JMC, one is greeted by a large open area on the side specially set up to foster greater empowerment amongst the residents to care for themselves. The Homecare Solution Centre (HSC) offers tips and suggestions for home safety, especially for those caring for the elderly at home. Through the life-size mock ups of a typical flat, one can learn more about improving home safety to prevent falls and injuries. Various aids and equipment such as walking frames and wheelchairs are displayed for trial and comparison.

The pharmacy, and diagnostic services are also located on the ground floor. The JMC diagnostic centre provides X-ray services and a laboratory for simple lab analysis. Patients can have their blood tested and analysed on the spot. This may be useful for urgent cases where the GP would want to know the results, e.g. in suspected dengue cases.

The second floor of JMC houses a Chronic Disease Management Centre, focusing on supporting GPs in the management of chronic diseases such as diabetes mellitus, hypertension, hyperlipidaemia, asthma, and obesity.

GPs can refer their patients to care managers to co-ordinate

Chronic Disease Management Centre at JMC

care, or make direct referrals to counsellors and allied health services. There are dedicated rooms for podiatry, eye screening, and dietary counselling. There is also a Rehabilitation Centre operated by physiotherapists. Specialist Clinics for Pediatrics and Obstetrics & Gynaecology is also situated at level two, alongside the Dental Centre.

The third floor comprises the main Specialist Centre and Day Surgery/ Endoscopy Theatres. A range of specialist clinics including ophthalmology, ENT, orthopaedics and general surgery line the sprawling waiting area.

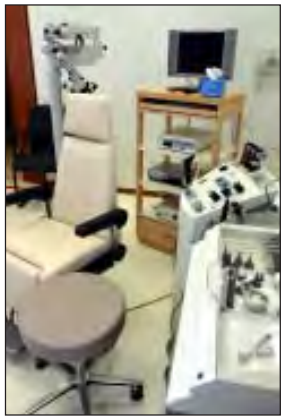
The Day Surgery Centre has two operating rooms, with specific rooms dedicated to and equipped especially for eye care, general surgery, orthopedics, gynecology and ENT procedures.

The Endoscopy Centre has a full range of endoscopy services offering cancer screening, evaluation of bowel disorders, and gastric and colorectal assessment. JMC offers direct access services, enabling the GP to arrange for endoscopy directly, without the need for a separate specialist visit.

The visit to JMC certainly left a very good impression as it was spanking new and was housed in its own stand-alone facility. Its location next to busy Jurong Point with MRT station and bus interchange must have been carefully chosen for maximum exposure and convenience. There is no doubt that popular specialties like paediatrics, eye, and ENT will be well received, as well as the endoscopic and dental services. However, it remains to be seen whether the Chronic Disease Management Center will serve its purpose in assisting GPs to manage their patients. Although diet counseling and foot care are specified clearly by MOH as part of the CDM programme, there is no requirement for GPs to send patients to a podiatrist or dietician unless they feel that the patient cannot be managed adequately.

Northern Hope

Northern Hope (NH) was established in July 2005. It aims to service the North and North-East areas, and in particular Punggol, Sengkang, Hougang, Serangoon, Ang Mo Kio, and Pasir Ris. Northern Hope provides a one-stop multi-specialty medical centre with X-ray and day-surgery.



A well-equipped specialist room at Northern Hope

Located on the fourth floor of Punggol Plaza, NH occupies some 6,000 sq feet of space; combining specialist consultations with three operating theatres, including an Endoscopy Suite for gastroscopy and colonoscopy, patient recovery day rooms, X-ray, ultrasounds and ECG treadmill. Patients are able to claim Medisave for Medisave-approved procedures at NH.

Visiting specialists cover virtually the whole spectrum of care, including paediatrics, ENT, eye, gastroenterology, general, colon & rectal surgery, cardiology, internal medicine, obstetrics & gynaecology, orthopaedic surgery, plastic surgery, respiratory medicine, dermatology and urology.

Asked about how NH specifically provides support to the GPs in the vicinity, Dr Khor Chin Kee, Medical Director of Northern Hope explained, "We allow direct referrals for procedures that have clear indications. Such referrals are reviewed and concurred by specialists before the procedures are carried out. Regular mailers to update new services are sent to the GPs, and post procedure medical report is faxed to the referring physician within the same day. We also ensure that patients are referred back to their family physicians for further management and follow up."

NH left the impression that the centre was doing as best as they could in providing specialist services for the residents in nearby HDB estates. The challenge is that Punggol new town is still undergoing development and construction, and it has yet to realise its target of being a home for some 80,000 households. The uptake of new flats has been slow over the past years and this will likely affect the patient load at NH. Partnership and close cooperation with the GPs will be necessary for NH to remain viable. ■CM

Acknowlegement: CM wishes to thank Mr Ng Kian Swan, Director for Operations at Alexandra Hospital for the JMC visit, and Dr Khor Chin Kee, Medical Director of Northern Hope.

Northern Hope is located on the 4th floor of Punggol Plaza.

Closer to Home

by Dr See Toh Kwok Yee, MCFP(S), Editorial Board Member

It has often been lamented that the scope of family medicine is rather limited, and given the robust competition among today's family physicians for the same cut of the pie, it is small wonder that a lot of us are losing heart.

But like all worthwhile endeavors, if we are prepared to work hard, keep the faith and explore new frontiers, there is no reason why we cannot bring family medicine to the next level.

With this in mind, The College Mirror sought out two younger colleagues who have ventured into different aspects of Family Medicine to find their own niche and meaning in life.

One is a pioneer in 24-hour housecall service and the other works with the Hospice Care Association (HCA).

Dr Choo Wei Chieh

CM: Tell us about yourself and your work experience.

Dr Choo: I graduated in 1996 and have rotated through polyclinic, A/E and geriatric medicine postings. I have also worked in private GP practice as a locum. Currently, I am running a 24-hour housecall service, and I also work part-time with Ren Ci-Code4 Home Care.

CM: How did the idea of a 24-hour mobile GP come about? Does your job complement that of a regular family physician?

Dr Choo: While working at GP clinics, I had the opportunity to do a few housecalls. I liked practicing medicine this way as it was a refreshing change from seeing patients in the clinic. It enabled me to interact with the patient's family and allowed me to see the patient in his home environment. I also realised that for some patients, housecalls were necessary because they were immobile or too sick to go to the clinic.

GPs are usually very busy during clinic hours and may not have the time to attend to patients at home. However, many GPs are committed to their patients and will usually attend to them after they finish their clinic sessions. Being a full-time house-call doctor enables me to provide a quicker response to patients' request for housecalls and this complements regular GP practices. The other way that I complement GP practices is to help GPs see patients after hours, as I operate round the clock.

CM: Is it an entirely new concept in Singapore? What about in other countries?

Dr Choo: Home care is definitely not a new concept and has been the traditional way medicine was practiced in the past. In fact, many voluntary welfare organisations (VWO's) provide home medical services in Singapore, although these organisations focus on chronic, continuing care (geriatric, palliative) rather than acute care. There are informal networks of GPs who help cover each others' request for housecalls and also several housecall service providers locally.

(I am not too sure about the situation overseas, but there are definitely many housecall doctors and service providers in the US - see http://aahcp.org/physician referral.shtml).

CM: Tell us about your work. I heard your office is your car. What are the cases you see?

Dr Choo: As I travel most of the time and keep equipment and supplies in my vehicle, it practically becomes my 'office'. Most of the patients I see present with acute problems and they are largely in the geriatric age group. There are also younger or middle aged patients who are unable to visit a clinic, such as patients with severe vertigo or incessant diarrhea/vomiting. I have a handful of patients who I visit regularly to follow-up on their chronic medical problems.

CM: How are you equipped? Mobile phone/palmtop/PDA no doubt. What's in your doctor's bag?

Dr Choo: My doctor's bag contains the usual diagnostic equipment like stethoscope, BP set, torch, blood glucose meter, urine test strips, etc. I carry a stock of emergency and common medications that patients need. I also take along i.v. cannulae and fluids as these have come in useful on occasion. In my vehicle, I keep surgical supplies like urinary catheterisation sets and T/S sets.

CM: Tell us a day in your life.

Dr Choo: As most cases I see are acute and not scheduled, it's hard to predict when I will need to see patients. A busy day could mean traveling more than 100km on the road to

Dr Choo Wei Chieh and his 'office'

Dr Choo: "My doctor's bag."

Dr Chua Tien Wei and colleagues

see patients, while a light day could be spent entirely at home with family.

Today (Sunday, 14/01/2007), I saw two patients in the morning. Fortunately they were located relatively close by, so not too much time was spent on traveling. The next patient I saw was during the night. In between, I managed to do some reading and also went out for dinner with my family.

CM: How do you balance work and family? What happens when you go on leave?

Dr Choo: I am lucky that my wife is supportive of what I do, given the erratic nature of my practice. When not seeing patients, I spend most my time at home. On family outings, I drive my 'office' vehicle so that equipment and drugs are always carried along, in case I need to go see a patient. Sometimes, the distinction between work and family time is blurred, but this is a compromise that my family accepts.

So far, I have not gone on leave, but I have a few colleagues who help me when I need to take time off.

CM: In the future, how are you going to upgrade yourself? Do you see the need for more doctors like yourself?

"Sometimes, the distinction between work and family time is blurred but this is a compromise that my family accepts."

"Dying patients helps me mature as a person..."

Dr Choo: As this is a relatively new service (started in May 2006), I am adopting a wait-and-see approach to the future. I think that there is a need for round-the-clock home medical services that supplement regular GP practices and maybe even in other practice contexts. So, yes there will probably be a need for more doctors to practice this brand of medicine. Doing a course like GDFM in the near future is definitely on the cards.

Dr Chua Tien Wei

CM: Dr Chua, tell us about yourself and your work experience thus far.

Dr Chua: I am a third year Medical Officer with Singhealth, and I have done postings in geriatric medicine, anesthesia, palliative medicine, psychiatry and children's emergency.

CM: Why did you choose a posting in hospice care? Any event/incident that may have contributed to your decision? Any role model that may have inspired you?

Dr Chua: I decided to try hospice home care mainly because I thought that it would be interesting to see the patient in his home. Palliative care interests me because I have always liked the concept of caring for patients holistically. I find it particularly rewarding when I have made a connection with patients and patients' families and build a good doctor- patient relationship. I think that working with dying patients helps me mature as a person, and that in turn helps my work as a doctor.

There wasn't any particular event, incident or role models that contributed to my decision. Instead, it was a few incidents, and a few people in my life that inspired me in different ways.

CM: Tell us more about your department and the services available to GPs and family physicians. How can we refer our patients to you?

Dr Chua: HCA offers day care and home care services to patients with life limiting illness, usually with a prognosis of less than 12 months. HCA aims to provide pain, symptom relief and psychosocial support to patients and families. HCA has five multidisciplinary health care teams and each team comprises of a doctor, four to five nurses, one medical social worker, one social work assistant and trained volunteers. A primary nurse is assigned to each patient, and makes home visits once a week or once a fortnight. Depending on patient's condition, visits may be more frequent. Visits by doctors will be monthly and when necessary. There is an after office hours helpline manned by doctors and nurses. GPs and family physicians can download the community hospice care palliative services common referral form at http://www.hca.org.sg/images/referral form.pdf and fax or mail the completed form to the Head Office.

CM: Walk us through a day in the office.

Dr Chua: Our working hours are from 8.30am to 5.30pm. Usually in the morning we would start planning which patients to see. I usually do home visits with the primary nurse and we start off from the office at about 10am. Depending on the complexity of each case, we can take between 30 minutes to 1 hour 30 minutes to assess the patient, treat, and speak to the caregiver. We see about five to six patients each day. If I am rostered to be on call that day, I will be back in the office before 5.30pm. We do calls from home, and

(continued on page 20)

Research Reflections

by Dr Yvette Tan, Family Physician

I started my journey in research in the year 2001. I was fortunate to have started off with a team of equally enthusiastic but research naïve individuals, and was mentored by Dr Hong Ching Ye and A/Prof Goh Lee Gan from COFM. Now, four studies and some papers (mainly conference papers) later, it is probably a good time to look back and reflect on the experience and the lessons learnt.

Aim

My initial big draw to research had been that it appealed to my own quest for searching for the truth about everything - about life and life after, about human nature, about practice, etc. However, like all research questions which start off lofty or ambitious, this initial aim has been whittled down to the bare essentials of simply documenting the good work that we are doing in the hope of influencing the practice of family medicine positively. My research focus has also narrowed to concentrate in the areas of the doctor-patient relationship and the impact of psychosocial factors on patient's health in both acute and chronic conditions.

Methods

All my studies so far have been cross sectional surveys. One of them had a prospective component where we followed up a group of patients with URTI until the resolution of their symptoms. I was also involved as a co-investigator in a few pharmaceutical-sponsored clinical trials. Although the research community does not hold cross sectional studies with high regard, I think they have a lot of value in primary care where problems and solutions are not clearly defined. This

"My initial big draw to research had been that it appealed to my own quest for searching for the truth about everything..."

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is especially so in modern day medicine where many of our interventions require the patients' compliance to lifestyle changes, and in future medicine where patient empowerment is the key. The need to understand and address the patients' concerns in order to engage them in their care will be increasingly important, and this will require a lot of exploratory research to see how best we can approach these challenges. However, I have come to appreciate that developing a questionnaire is not easy and the process to validate it both internally and externally is even more tedious, but nonetheless necessary, so that it can stand to scrutiny among those in the research community. I have learnt to look for shortcuts by using previously validated questionnaires, but these too run into problems when adapting for local use. In fact, in order for more meaningful and fruitful quantitative studies, I feel that in depth understanding of the clinical problem through qualitative research would actually be a good first step. This will be an area of development and exploration for myself in the next few years.

"There were many times when the temptation to make everything look neat and proper challenged my integrity..."

I have also learnt that the handling of the data, including making sure that the data is collected and recorded properly, coding, and 'cleaning' it can be a very tedious affair - something that makes it even more agonising for enthusiastic first timers eager to get on with the business of using the data. There were many times when the temptation to make everything look neat and proper - including the minimising of missing values or looking for that ultimate ($p < 0.01$) for a suspected association - challenged my integrity and resolve to find out the truth about things. The truth often led us to concede that we were barking up the wrong tree.

Results

Once the results were ready for sharing, it was either accompanied by a feeling of great excitement and euphoria at having unraveled something possibly novel or of significant clinical value; or a feeling of grave disappointment and a big stone around the neck at having discovered nothing new. Even with the best results, finding the discipline to sit down and write up a paper required tremendous effort, and there were many times when I felt like giving up altogether. Receiving rejection upon rejection from editors of journals was demoralising. And even when it was considered for publication, having to comply with reviewers' comments and suggestions also required a lot of tenacity. I will always remember what was told to me by Dr Hong Ching Ye, "We owe it to our research subjects and to those who provided our funding to share the results through publication." This often keeps me going, even if it means going through the manuscript ad nauseam!

Presenting posters at conferences seem to be a quick win for a 'publication', but I really wonder who bothers to read all that has been put up. Oral presentation is more satisfying since this allows some interaction from the audience and provides direct feedback as to the significance of the study.

Conclusion

Research is not for the faint hearted. There were many times during the course of the projects when I wanted to give up. Fortunately the reason for deciding to do the study often was compelling enough for me to soldier on. Research has been a deeply satisfying experience for me, and has developed in me an appreciation for scientific purity. Nothing is more satisfying than the pleasure of using your own results to influence practice, and to know that you have contributed to the body of knowledge in family medicine. CM

Oral presentation

Regional Conference on Professionalism in Medicine 2006. Singapore. What are the attributes of a Good Doctor? : A Qualitative Study of a group of primary Care Doctors in the National Healthcare Group Polyclinics, Singapore.

WONCA Europe 2003, Slovenia. Patient-centredness: What determines the doctor's clinical behaviour? 18-21 Jun 2003

2nd NHG ASC . Revisiting the characteristics of URTI in the light of SARS in Singapore. 4-5 Oct 2003 . Best oral presentation GP category

Poster presentation

4th NHG Annual Scientific Congress 2006. The doctors' perspective of the influences to their practice and the measures they take to preserve themselves as Good Doctors: A Qualitative Study of a group of primary Care Doctors in the National Healthcare Group Polyclinics, Singapore

Combined Scientific Meeting 2005. The determinants of the Doctors' Professional satisfaction : A cross-sectional study involving primary care doctors in National Healthcare Group Polyclinics

3rd NHG Annual Scientific Congress, 2004. Smokers with Acute Upper Respiratory Tract Infection (URTI): A Study of their Symptoms and Outcomes. (Best poster award - General Practice Category)

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Family Physicians Learning from the

Quality Gurus in Orlando

by Dr Loke Wai Chiong, FCFP(S),
Director Quality NHG, Editorial Board Member

High on the list of events for any healthcare leader or provider involved in quality or safety work, especially in the United States, must surely be the Annual National Forum on Quality Improvement in Health Care.

For its 18th year, the Forum held in December 2006 saw some 5000-odd delegates from the States and many countries around the world gather in Orlando, Florida, for "a chance to recharge your batteries, and to reconnect with like-minded health care leaders for whom improvement is now the strategy for success." The theme for 2006 was "Building A Health Care System That Works. Here. There. Everywhere." - emphasising both the goal and the potential to spread widely the growing number of successes from where care is best practiced, and to make the best care the new standard of care - for everyone.

As part of my current role in quality improvement for National Healthcare Group, I was privileged to be part of that amazing buzz, the wonderful learning, and most significantly, the inspiration and energy of those at the forefront of healthcare innovation and improvement. Fresh from their success in the Saving 100K Lives Campaign, the next ambitious campaign aims at Protecting 5 Million Lives From Harm over the next two years.

In the crowd with me were also a handful of family physicians from Singapore, there to learn how some of these proven tools and evolving ideas can be applied to their work and setting back home. We ask two of them: Dr Michael Wong (MW) and Dr Hwang Siew Wai (SW), both from SingHealth Polyclinics, what they gained from the experience.

CM: What was the conference all about and what did you expect?

SW: Before I left for the forum, I was hoping that I could pick up the latest ideas on clinical quality and also to learn on how healthcare staff from around the world overcome the many barriers to healthcare improvement. I had heard so much from colleagues who have been there from previous years and in the end, I certainly wasn't disappointed. It was just amazing experiencing first hand the gathering and intermingling of the very best clinicians, all of whom focused on exchanging ideas and establishing contacts with one another.

MW: The conference to me is all about safety and quality. Safety to the patient and also to ourselves and staff as we practice quality medicine. It is so different from say, a conference on research or some research topics. Translational research may be dramatic when it is applied. Quality and safety is impactful almost immediately.

CM: Which sessions were the most impactful to you personally, or to your current practice?

MW: I was vey thrilled to listen to the mini session on healthcare reform by Michael Porter who wrote the book Redefining Healthcare. Healthcare globally is in need of some radical change. The other was the use of proven, time tested, manufacturing industries' improvement methodology in healthcare. It was interesting to have a first hand account of how Virginia Mason in the US applied the Toyota Production System to turn the hospital around. I also had a great time learning about Lean 6 Sigma. It was interesting to know that the NHS is the middle of their ten year transformation plan for their health systems and Lean 6 Sigma is one of the methods they have used in their improvement efforts. Ever tried to fold a T shirt nicely? You will take many many folds and steps. I've learnt how to do it in three short continuous seamless steps like a pro! Now that is lean!

SW: The plenary presentation by Donald Berwick, the president and CEO of the Institute for Healthcare Improvement, left a deep lasting impression in me! He is an excellent public speaker and his ability to motivate and inspire was nothing short of extraordinary. Listening to his presentation and learning about what he has accomplished made me realise that I can also play a role in improving clinical quality in my own setting in the polyclinics (albeit on a much smaller scale!).

CM: What were the main learning points that could be applied straight away?

MW: I thought something from Lean which we all could apply to our workplace or workstation would be the 5 S : Sort (remove things you don't need or use, do house keeping); Straighten/Simplify (set in order, arrange your stuff); Shine (keep your area clean and neat); Standardise (have list and make sure everyone sticks to it); and Sustain (when you see the good the difference makes, keep it up!). It will certainly make your work faster and safer too.

CM: What was your overall experience and feeling, after having attended this conference?

MW: It's a sampler really. But I must say this conference has given me two views, safety and quality is a global issue, though it may differ culturally to a certain extent; and we have to make safety and quality a personal mission and involve the patient and their family in our quest. Nothing we do will matter if the patient, family, or community is not there with us in body, soul or spirit!

SW: Attending the conference has provided me with added confidence to involve myself in projects on clinical quality. After listening to the experiences of others, I realised that if all these other people at the forum could do something to help patients or improve upon patient care, then why not myself? ■CM

Principles of Family Medicine & Practice Management

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

To pass the GDFM Course, candidates would be required to attend one elective and three compulsory GDFM skills courses: the "Principles of Family Medicine and Practice Management Skills Course", "Consultation, Communication and Counseling Skills Course", and the "Professionalism, Ethics and Law Skills Course".

On 20th Jan 2007, the first GDFM compulsory skills course of 2007, the Principles of Family Medicine and Practice Management Skills Course, was conducted at the College of Medicine Building Auditorium and Lecture Rooms respectively. The resource person was Mr Christopher Chong, a lawyer with Rodyk and Davidson who is on the panel of the Medical Protection Society, and A/Prof Goh Lee Gan, who needs no introduction.

The skills course was well attended and had to be run in two locations to accommodate the class. The well-attended course was characterised by active participation of GDFM candidates, MMed (Family Medicine) candidates and GPs who were interested to learn more. Questions on practice, legal and ethical aspects of a case of error in diagnosis were discussed thoroughly with new insights gained. Mr Chong was both objective and informative in his comments and answers to participants' questions. The rules and procedures of setting up a clinic and operating theater was also discussed. After the break, the class considered a case of a vague presentation of epigastric discomfort, gleaning principles on comprehensive care. Finally, hands-on practice quality was also attempted, when students were told to come up with a topic for clinical quality audit and present how they would carry out the actual audit in terms of indicators, criteria, standards, etc.

Practice management is a very wide topic that cannot be completely covered in one afternoon workshop. Clinically important and interesting aspects were chosen to aid in the students' acquisition of the relevant knowledge, skills, and attitude. Essential principles of family medicine were also shared among the students. ■CM

(from page 14-15) *Closer to Home*

either render advice over the phone or make a home visit. The primary nurse in charge of the patient would be updated about the details of the call the next day.

CM: Sounds like a demanding job. What drives you?

Dr Chua: I am driven by the knowledge that even when cure is no longer possible, I can still try to relieve symptoms, and comfort always, and that itself can make a difference.

CM: How do you balance work, leisure and family?

Dr Chua: I make it a point to stop thinking about patients once I leave the workplace, and to leave the workplace on time as much as possible. I juggle the rest of my time between courses, family, friends and salsa. I balance all these by prioritising, and being aware of my own limits.

CM: I understand you are a GDFM trainee. Is the course helpful in your job?

Dr Chua: I think this course is helpful in my job; it helps me to have a good overview of family medicine, and keep updated about current treatment.

CM: Any future plans?

Dr Chua: I see myself working in the primary healthcare setting in the long term. ■CM

Tips in Dermatology

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

Below is a potpourri of tid-bits in practical dermatology, meant for daily consumption. Bon appetit!
(Adapted from N.H. Cox, UPDATE)

1 Unilateral eruptions with eczematous morphology should always raise the suspicion of a dermatophyte fungal infection. If the eruption is on the hand, always examine the feet as well, as tinea pedis is almost inevitable.

2 Any form of eczema where there is weeping or crusting, or which is located in a hairy area of the body, should be assumed to have a secondary bacterial infection - usually staphylococcal. Failure to treat the infection may lead to the increase in the duration and potency of topical steroid treatment required.

3 Oral terbinafine should not be given in the absence of a microscopically proven dermatophyte infection. It will not treat pityriasis vesicolor (although it works topically!) or chronic paronychia due to Candida albicans.

4 Rapidly ascending cellulitis of the lower leg, often with systemic symptoms, is likely to have a streptococcal rather than a staphylococcal cause. Unless there is a significant contraindication, penicillin should always be included in the therapy, as streptococci are more sensitive to penicillin than to flu/cloxacillin. Tinea pedis may be a portal of entry.

5 A butterfly rash in a patient without any systemic symptoms is highly unlikely to be due to systemic lupus erythematosus. Rosacea, seborrhoeic dermatitis, and if the eruption is clearly photosensitive, polymorphic light eruption or possibly subacute cutaneous lupus erythematosus may be possible diagnoses.

6 Angular cheilitis (stomatitis) is most commonly due to age-related loss of facial hair or worn dentures, and there is usually secondary candida infection. Treatment should therefore include a topical anti-yeast agent. Intra-oral candidiasis should also be treated, and patients should remove and disinfect their dentures at night.

7 Consider typical sites for rashes. For example, if psoriasis is considered, examine the elbows, knees, scalp, ears, and nails. For lichen planus, always examine the mouth for striae. And for scabies, examine the penis in men, areola in women, and feet in infants.

8 A solitary patch of "eczema" or "psoriasis" in an elderly patient is likely to be Bowen's disease (mainly on the lower leg in females) or superficial basal cell carcinoma (mainly on the trunk in males).

9 Most scabicides give best results if applied twice at an interval of five days - this reduces the chance of missing some mites and kills them at different stage of development. Also apply treatment under fingernails to the scalp in infants, and treat family contact even if asymptomatic.

10 And finally the ABCDE's of the dreaded malignant melanoma:

- A Asymmetry
- B Border irregularity
- C Color variation
- D Diameter > 6 mm
- E Elevation above skin

Aesthetic Medicine

Aesthetic Medicine, in the broadest sense, is currently practiced by many in Singapore. They include doctors, beauticians, slimming centers, spas, home practitioners and some visiting beauticians from China and other countries who do carry out the procedures in some HDB homes.

It is getting popular and the demand for such services in Singapore and the rest of the world is going up. In order to help our patients have a more informed choice and to protect them, the Ministry of Health has convened committees to help to define the scope of practice and the standard of care that practitioners have to maintain.

The College of Family Physicians Singapore, as a matter of policy neither promotes nor discourages its members in the practice of Aesthetic Medicine. Its view is that whoever wants to practice Aesthetic Medicine must acquire the necessary knowledge and be trained in the skills set for this area of practice. It is also the College's view that the public needs to be educated on the aesthetic treatments performed by doctors who are trained in the field. Patients who seek out treatments by non-doctors do so at their own risks.

The College will work with the MOH and other relevant organisations or societies to help define the standards of care expected in this area of practice. To this end, MOH has set up a committee to study and formulate policies and guidelines on Aesthetic Medicine and the training needed.

A survey will be sent out to a sample population of doctors to help ascertain the types of procedures being done, patient profile, and the standard of procedures being carried out. CM

Family Practice Skills Course 21

STI and HIV/AIDS

COURSE STRUCTURE

Unit 1: Principles of Management and Screening for STI
Dr Tan Hiok Hee

Unit 2: Principles and Counseling Adults and Youth on HIV/AIDS
Ho Lai Peng

Unit 3: Syndromic Approach to STI (Discharges)
A/Prof Roy Chan

Unit 4: Syndromic Approach to STI (Ulcers)
Dr Priya Sen

Unit 5: HIV/AIDS Prevention
Dr Jeffrey Cutter & Dr Koh Yang Huang

Unit 6: HIV/AIDS Diagnosis, Screening, and Management
Dr Lee Cheng Chuan

SEMINARS
(2 Core FM CME Points for each seminar *)

Seminar 1 : 26 May 2007 (2.00pm - 4.00pm)
- Unit 1: Principles of Management and Screening for STI
- Unit 2: Principles and Counseling of Adults and Youth on HIV/AIDS
- Unit 3: Syndromic Approach to STI (Discharges)

Seminar 2 : 27 May 2007 (2.00pm - 4.00pm)
- Unit 4: Syndromic Approach to STI (Ulcers)
- Unit 5: HIV/AIDS Prevention
- Unit 6: HIV/AIDS Diagnosis, Screening, and Management

WORKSHOP SESSIONS
(2 Core FM CME Points **)
- Sexual History Taking and Contact Tracing Interview
- Case Studies

Day 1: 26 May 2007 (4.15pm - 6.30pm)
Day 2: 27 May 2007 (4.15pm - 6.30pm)

* Subject to approval from SMC
** Workshops held on Day 1 and Day 2 are similar workshops. Workshops are on first come first served basis with limited seats available.

Date: 26 & 27 May 2007

Time: 2.00pm - 6.30pm

Venue: College of Medicine Building, MOH Auditorium

Due to limited seats available, please register before 12 May 2007 to avoid disappointment.

REGISTRATION

STI and HIV / AIDS
Course Registration Form

Please tick (√) the appropriate boxes

	College Member	Non-College Member
Seminar 1 (26 May 2007)	☐ $ 10.00	☐ $ 20.00
Seminar 2 (27 May 2007)	☐ $ 10.00	☐ $ 20.00
Workshop	☐ $ 20.00	☐ $ 40.00
Please choose your preferred workshop date	○ 26 May 2007 (Sat)	○ 27 May 2007 (Sun)
Distance Learning Module (Journal)	FREE	☐ $ 40.00
TOTAL		

Name: Dr _____ MCR No: _____

Mailing Address: (*Please indicate:* ○ Residential ○ Practice Address)

_____

_____

_____

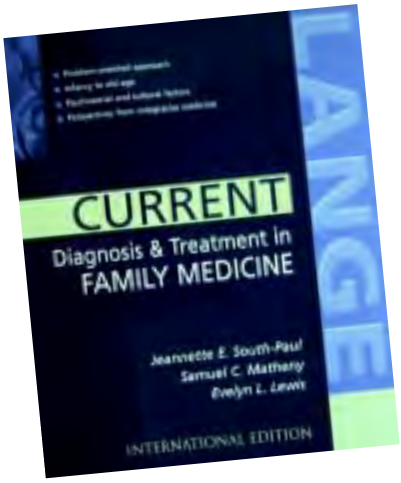
Tel: _____ Fax: _____ E-mail: _____

Registration is confirmed only upon receipt of payment. The College will not entertain any request for refund of registration fee after official receipt is issued.

The development of this Family Practice Skills Course is supported by an educational grant from Health Promotion Board.

Please make cheque payable to:
College of Family Physicians Singapore

and mail it with the completed form to:
College of Family Physicians Singapore
16 College Road #01-02
College of Medicine Building
Singapore 169854



CURRENT Diagnosis & Treatment in FAMILY MEDICINE

Jeannette E. South-Paul, Samuel C. Matheny, Evelyn L. Lewis

Published by McGraw-Hill.
Reviewed by Dr See Toh Kwok Yee, MCFP(S), Editorial Board Member

Busy family physicians are always in the hunt for a concise and yet complete single-source reference book on the many bread and butter conditions that we see on a daily basis. Such a book should ideally be a light and thin paperback edition that can easily be tucked inside the consultation room for a quick consult between patients. This is one such book.

The intended audience are the training and practising Primary Care Physicians and the authors have indeed dedicated this book “to all family physicians who deliver care in austere environments, especially our colleagues in uniform.”

The reference book is organised according to the development lifespan, starting with infancy and childhood, through adolescence and adulthood, to geriatrics. The common attendant medical conditions seen at each stage of development are discussed accordingly.

A useful feature of this book is that many of the discussions open with the "ESSENTIALS OF DIAGNOSIS". An example, in the commentary on Roseola, these essentials are listed as:

- Sudden onset of fever
- No diagnostic signs
- Development of rash as fever breaks after 3-4 days.

These essentials can readily be committed to memory or quickly referred to for checking one's diagnosis at a glance.

An outstanding feature of this book is the evidence-based approach, that is, references are made to medical evidence, clinical trials, and national recommendations available in some conditions or disorders. For instance, in the chapter of Dyslipidemias, a detailed account of the landmark clinical trials viz. WOSCOPS-1995, AFCAPS/TEXCAPS-1998, 4s-1994 is given.

Another outstanding feature is the recommendation of useful internet websites and resources at the conclusion of coverage of a selected medical condition. For example, in the discussion of Arthritis, the reader is introduced to websites with information helpful and friendly to both doctor and patient.

Another highlight of this book is in its last section which deals with Doctor-Patient Issues. An important read here is in the chapter on Communication which deals with patient satisfaction, communication skills, and special challenges - like the angry patient and giving bad news to the terminally ill. The management of Cultural Health Disparities, albeit written based on the American experience, is useful in its expounded fundamentals. The exhortation to learn about patients as cultural beings and to learn culturally appropriate communication skills is universal.

One highlight which reflects the currency of this book is the coverage on the Health Care Needs of Gay, Lesbian, Bisexual and Transgender patients. These issues are generally not adequately covered in our local curriculum despite their existence.

Another is the discussion on Complementary and Alternative Medicine, and their relationship to the conventional physician.

In conclusion, this is one readable family medicine resource and textbook to have in one's consultation room. For those intending to get a copy, please wait for the second edition which is already in print, but may not have arrived at our local bookstores. The first edition is also available for downloading from the internet at http://www.accessmedicine.com/home.aspx by subscription. ICM

Desktop Guide for Managing Type 2 Diabetes

Have you collected your “Desktop Guide for Managing Type 2 Diabetes?”
The College of Family Physicians Singapore is pleased to announce the completion of the “Desktop Guide for Managing Type 2 Diabetes”. If you are a member of the College, you can collect your copy of the Desktop Guide at the following address during office hours (9.00am - 6.00pm):

College of Family Physicians Singapore
College of Medicine Building, 16 College Road #01-02, Singapore 169854