THE College Mirror

VOL. 33 NO. 2 June 2007

A Publication of College of Family Physicians Singapore

CONTENTS

FAMILY PRACTICE SKILLS COURSE

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MICA (P) 057/03/2007

PRESIDENT'S FORUM

Welcome to Wonca World Conference 2007

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

On behalf of the College of Family Physicians Singapore, I am pleased to welcome all our family physicians and their significant others, both in Singapore and worldwide to the Wonca World Conference 2007. The theme "Genomics and Family Medicine" is chosen to reflect the family physician's place in a changing world.

Family Medicine has been on the scene for at least 30 years now. It started as a counter-culture to the biomedical focus and specialisation of care, with the vision of person-centred care and holistic approach of bio-psycho-social dimensions of care. This vision has stood the test of time. Our relationship over time with our specialist colleagues has also moved from counter-culture, to parity, and in the present day and age to integration of care. With the growing numbers of people living into their 80s and 90s, there is a need for convergence of hospital specialist care with community based family physician care. We have shifted from the paradigm of learning and practising simple things to relevant and even complex things.

The keynote and plenary sessions, the various seminars, and workshops reflect this changing focus as we grapple with the changing landscape to provide what is expected of the health care delivery system: unity for health.

The Wonca World Conference 2007 is also a time for reflection of Family Medicine in Singapore and worldwide. This is the second time that Singapore hosts a World Conference in Family

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A Very Warm Welcome

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

A very warm welcome, all delegates to Wonca World Conference 2007. For visitors coming to Singapore for the first time, may I also wish you an enjoyable stay and hope to see you back at our shores again soon. The College Mirror has prepared a bumper edition to celebrate this momentous occasion for the College of Family Physicians Singapore with this 32-page publication. The topics chosen are not only cutting edge, but also relevant to family physicians of our times who shall be facing ethical dilemmas in time to come in this era of healthcare in the Genomic Age. This edition of the College Mirror shall also highlight the Singapore healthcare system as well as the milestones of the College since the last Wonca World Conference held in Singapore. With the breakneck pace of progress of Family Medicine in Singapore, even local practitioners need to find out the latest comings and goings.

Those with intact long-term memory might recall that Singapore hosted the Wonca World Conference back in 1983. It is with much pride that this generation of family physicians shall be witnessing and participating in Wonca World Conference 2007 on this 'little red dot' of ours, better known as the Lion City. Family Physicians can expect to rub shoulders with the best the world has to offer, an opportunity not to be missed. This sharing of experience has the potential to enrich us in more ways then one. Wonca World Conference 2007, for the organising committee, was ten years in the making. Find out all about it in our interview with Dr Tan See Leng, Chairman Host Organising Committee Wonca World Conference 2007.

The College shall be holding its Annual General Meeting (AGM) on the 18th August 2007. The membership to the College has recently grown in leaps and bounds, a fine tribute to the effectiveness of its endeavors. Such success brings with it problems of an enlarged membership. The College Council has been trying hard to rectify the problems through the proposed constitutional change to meet the growing and new demands. An important amendment would be the reduction of the quorum to at least 50 persons for its AGM. Failing which, the College would potentially be paralysed by its own constitution. Seriously, no family physician would want to see that happening, but despite the best of efforts, we have failed to meet the existing constitutional quorum of 1/8 of the membership. Last year's AGM was attended by a record 104 members, still short of the 136 required. In order for the College to continue to serve its members effectively, it is imperative that earnest efforts need to be made to reach the quorum so that the constitution can be changed to accommodate the changing needs of the organisation. May I encourage all to do our parts by giving due support.

Finally, this year saw the passing of a stalwart of the College who in 1971 made a proposal to start an organisation to represent general practitioners in the form of a college. He subsequently chaired the pro-tem committee that led to the formation of the College of Family Physicians Singapore. Dr Wong Heck Sing, a true role model of our time, passed away peacefully on Sunday 4th March 2007 after a 12-year battle with cancer. The College Mirror invites you to share with us your fond memories of an era gone past. ▮CM

With the breakneck pace of progress of Family Medicine in Singapore, even local practitioners need to find out the latest comings and goings.

(from page 1 - Welcome to Wonca World Conference 2007)

Medicine. The last time was in 1983, which was the 10th Wonca World Conference. Today we are hosting the 18th Wonca World Conference. Certainly, Family Medicine in Singapore and around the world has progressed much since 1983. Today, most countries have structured vocational training programmes in Family Medicine; there are active Family Medicine research programmes, and the practice of Family Medicine has become more varied and special interest areas have crept into the landscape. The desire to remain holistic and patient-centred needs to be an enduring vision, not withstanding moving into special interest areas like geriatric care, palliative care, sports medicine, emergency care, and chronic disease management. This is the challenge going into the 21st century.

As we look back to the 1980s too, we realise that time has removed many of our stalwarts. Many of the pioneers in Family Medicine have moved on: Dr Wong Heck Sing and Dr Koh Eng Keng, the brothers-in-law who were instrumental in setting up the College of Family Physicians Singapore as we know it today. There are others, Dr Victor Fernandez who was the host President in the Wonca Conference of 1983, and Dr Fred Samuel who was the Chairman of the Scientific Committee of the 1983 Conference. They may have departed, but their work and memory live on as footprints on the sands of time.

"The desire to remain holistic and patient-centred needs to be an enduring vision..."

What would Family Medicine be like the next time Wonca World Conference comes to Singapore? It all depends on what we do today. So, let us revisit our goals, and set new sights in Wonca 2007. Once again, to one and all, welcome to the Wonca World Conference 2007. There is much for you to contribute, to share, and to learn.

Theme & Topics - "Genomics & Family Medicine"

Family Medicine covers the entire breadth of illnesses in human kind. What are the critical areas that we should focus on?

Wonca 2007 has identified these 20 priority areas that will be given special attention during the conference. Come and participate in the challenging task of finding solutions for these priority areas.

Highlights of the Programme

Human Genomics: Where to after the breakthrough?

The Human Genome Project is the international 13-year effort formally begun in October 1990 to discover all the estimated 30,000 to 35,000 human genes and make them accessible for further biological study. Completed in April 2003, where are we heading from here?

2007 Top 20 Priorities in Primary Care

1. Integrating Care and Services
2. Patient Enablement
3. Reducing Untreated Asthma
4. Effective Cancer Screening
5. Behavioural And Learning Disorders in Children
6. Childhood Nutrition
7. Preventing Complications in Diabetes Mellitus
8. Treating to Target: Hypertension, Hyperlipidemia, Diabetes Mellitus
9. Managing the Elderly Sick in the Community
10. Customising Vaccinations for Your Patient
11. Managing Cardiovascular Risk Factors
12. Finding and Treating Depression in the Community
13. Medical Errors
14. Emerging Infectious Diseases
15. End of Life Care
16. Helping Patients
17. Early Intervention and Rehabilitation of Strokes
18. Controlling Obesity
19. HIV & AIDS Control
20. Caring for the Physician

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18th Wonca World Conference

A Journey of Ten Years

by Dr Shiau Ee Leng, MCFP(S), Editorial Board Member

Dr Tan See Leng, the Chairman of the Host Organising Committee of the 18th Wonca World Conference, the second to be held in Singapore, is the Group Executive Director of Pantai Holdings, Pantai Hospitals. He shuttles between Malaysia and Singapore weekly. Despite his hectic schedule he has agreed to be interviewed by the College Mirror to help all of us know about Wonca.

CM: It is indeed a tough call to be the Chairman of the Organising Committee of this 18th Wonca World Conference. How did you form your team?

The core team was formed more about ten years ago at the end of 1997. Only two of us are left from the original committee. We went to bid for the conference in Ireland in a picturesque countryside town of Killarney to the South West of Ireland around the Ring of Kerry. We lost the bid to the Americans who hosted the conference in 2004.

We went back again with another bid three years later in 2001 in Durban South Africa and managed to win the bid from the Australians by just one vote. The second bidding process was better as we were able to form a team comprising our current scientific chairman, Dr Lee Kheng Hock, and Vice Chairman, Dr Tan Chee Beng.

CM: Wow, that certainly took more than 10 years. Could you tell us more about the preparation process of the conference?

The preparation was a very long drawn process requiring much patience, understanding and perseverance. Motivation of a group of volunteers like the whole bunch of us was also a key success factor in the overall preparation process. Commitment to the whole process over a period of some six years requires a lot of dedication to the cause.

Our main driving force was to put Singapore on the world map for family medicine and also to beef up the standing of our College of Family Physicians.

CM: What is the biggest challenge you faced as Chairman of the Host Organising Committee so far ?

Persuading our local family doctors to support the conference by signing up for the conference. We have done a lot to secure sponsorships and a host of excellent and renowned plenary speakers. It is a once in a lifetime opportunity to listen to them over the span of three days and learn about their cutting edge research. We have almost one thousand international delegates who have signed up so far. It will be a great pity if Singapore family physicians are not adequately represented in this conference. Beside the scientific program, the conference also offers fantastic networking opportunities and a good way of obtaining CME points.

CM: What impact do you foresee organising the 18th Wonca World Conference will have on the medical scene in Singapore?

Singapore is at the crossroads between the Eastern and Western cultures. By organising the world conference, we hope to promote the medical scene in Singapore to not only the region but also internationally and showcase our strengths, expertise and experiences whilst leveraging on the vast networks of Wonca members and other international participating colleges and institutions.

Dr Tan See Leng, the Chairman of Host Organising Committee of the 18th Wonca World Conference

CM: What have you learned which you would like to share with the next organiser?

To work with Wonca Executive and the World Council to ensure that the World conference does not clash with another regional Wonca conference especially within a six month window. We feel that our attendance would have been better if not for another regional Wonca conference being held so close to our World conference. ▮CM

"Our main driving force was to put Singapore on the world map for family medicine..."

Wonca 2007 Highlights

by Dr Tay Ee Guan, Scientific Co-chairman,
18th Wonca World Conference Host Organising Committee

The year 2007 shall be remembered as a significant milestone in the history of Family Medicine in Singapore. The College of Family Physicians Singapore (CFPS) is honoured to assume the responsibility of hosting the 18th Wonca World Conference, from the 24th to 27th July 2007. It will be the second time Singapore is organising this notable international event.

Singapore hosted the Wonca World Conference in 1983. Wonca stands for World Organisation of National Colleges, Academies, Academic Associations of General Practitioners/ Family Physicians. Held every three years, it is the paramount international scientific meeting for family physicians.

Preparations for the event started in 2001, after Singapore won the bid to host the event at Durban, South Africa. The theme for the meeting is entitled "Genomics and Family Medicine", and will highlight the frontiers in medicine as expressed in genomics, and also address current issues related to the discipline of Family Medicine. The conference promises to be an intellectual buffet feast for family physicians from all parts of the world, with programmes catering to both clinicians and academics. There will be something for everyone.

At the Conference, participants will hear, from world-renowned experts, on topics close to the hearts of family physicians including the exciting developments in genomics. In fact, there will be two keynote addresses, one on Family Medicine, and the other on Genomics.

Dr Shigeru Omi

Dr Shigeru Omi, the WHO Regional Director for the Western Pacific region will kick off the opening night with the first keynote address for Family Medicine with a lecture on the role family physicians will play in addressing the future of health care, especially in harmonising science and humanity for the world.

Dr Francis Collins

The other keynote speaker will focus on genomics, and we are very honored to have Dr Francis Collins to deliver this keynote lecture. Dr Collins helms the well-known Human Genomic Project, which maps out the 30,000 to 35,000 genes in humans, and is currently the Director of National Human Genome Research Institute in USA. Dr Collins is a physician geneticist, and he will discuss the impact of the human genome project on society and medicine.

In other plenary lectures on genomics, we shall hear from experts such as Dr Spencer Wells, a population geneticists and an eminent documentary film maker with the National Geographic, Singapore's very own Professor Edison Liu from Genomic Institute of Singapore, and experts on ethics and research in the era of genomics.

Dr Spencer Wells

Prof Edison Liu

Important clinical topics relevant to Family Medicine will also be addressed in the plenary sessions such as novel ways to approach the diabetes mellitus

...participants will hear, from world-renowned experts, on topics close to the hearts of family physicians including the exciting developments in genomics.

Keynote speaker Professor David B. Goldstein

epidemic and the use of vaccination in cancer prevention. There are recent breakthroughs in these areas, which hold the potential to revolutionalise our management of these important medical conditions.

Keynote speaker Professor Yvonne Carter

There are altogether nine plenary sessions, anchored by speakers from various parts of the world to update the Family Medicine fraternity on pertinent issues that will affect how we practice, teach and conduct research in Family Medicine.

Symposia, seminars, and workshops

To cater to the varied interests of family physicians, three simultaneous breakout sessions have been allocated.

Keynote speaker Professor Michael Kidd

The breakout sessions will comprise 30 symposia and 21 workshops altogether. There is variety for participants with different interest, be it practice, teaching, faculty development, leadership, or research. Since there are many choices to be made, the breakout sessions would be very challenging.

These symposia and workshops are conducted by invited speakers, participants, and Wonca Special Interest Groups (SIG), as well as Wonca working parties. Topics covered span the Top 20 Priorities in Primary Care. Sessions not to be missed include the ones on Traditional Chinese Medicine (TCM) and Aesthetics Medicine.

Besides clinical topics, the Wonca World Conference 2007 will also be a platform to share the developments and challenges of Family Medicine in other parts of the world through the Family Medicine Showcase. The organising committee has invited Family Medicine colleges from various parts of the world to update the global community of family physicians on significant changes in the practice of Family Medicine and the training of family physicians in their respective countries. Many have responded positively, and we can look forward to learning from one another.

The topics to be discussed are not only relevant but also exciting. Those who participate shall certainly not go back empty-handed.

To date, the Wonca 2007 Scientific Committee has received more than 820 abstracts. There will be 320 oral free paper presentations and 500 poster presentations. A peer review process is in place to ensure the submissions are of submission standard before they are accepted. The rest of the abstracts are of the symposia and workshops.

To encourage and recognise excellence in Family Medicine research, the Scientific Committee will be giving out two types of Merit Awards: the Wonca Conference 2007 Merit Award for poster presentations and Wonca Conference 2007 Merit Award for oral presentations.

In between sessions or during breaks, participants may view the poster presentations displayed within the conference venue.

Since our island nation - no bigger then a little red dot on the world map - received the mandate for a second time to host Wonca World Conference 2007, the organising committee has worked very hard to make the event a resounding success to find ourselves among the very best the world has to offer. The topics to be discussed are not only relevant but also exciting. Those who participate shall certainly not go back empty-handed.

More information about Wonca World Conference 2007 can be found at the Wonca 2007 website (http://www.wonca2007.com). CM

Besides clinical topics, the Wonca World Conference 2007 will also be a platform to share the developments and challenges of Family Medicine in other parts of the world through the Family Medicine Showcase.

18th Wonca World Conference
24–27 July 2007
Suntec Singapore

For Official Use:
Date received _____
Receipt Number _____
Processed By _____
Reference Number _____

Registration Deadline: 24th June 2007

Register online at www.wonca2007.com or complete this form and fax it to (65) 6336 2263. A confirmation letter will be sent to you upon successful receiving of your registration fee.

DELEGATE'S DETAILS

Salutation : ☐ Prof ☐ A/Prof ☐ Dr ☐ Mr ☐ Mrs ☐ Mdm ☐ Ms

Surname/Family Name _____

First/Given Name _____

Name on Badge _____

Organisation/Institution _____

Department (if any) _____

Mailing Address _____

City/State _____

Postal Code _____ Country _____

Telephone ( ) _____ Fax ( ) _____

Email Address _____ Wonca Direct Membership No. (If any) _____

CONFERENCE REGISTRATION FEE IN SGD

Please √ as applicable

Category	Pre Registration Normal Fee	Onsite Registration Fee After 10 July 2007
Wonca Direct Member	o SGD 825	o SGD 900
Regular Participant	o SGD 825	o SGD 900
Students and Trainees*	o SGD 450	o SGD 500
Accompanying Person	o SGD 150	o SGD 150
Amount Payable	SGD	

* Documents verifying this status is required. Such verification must include the participant's supervisor's signature.

MODE OF PAYMENT

Payment must be made in SGD by local cheque, bank transfer or credit card (American Express, Visa or Master Card).

o **Cheque**

Bank Name : _____ Cheque No: _____

o **Bank Transfer**

Please note that all bank charges should be borne by the registrant. Kindly fax or email a copy of your bank advice slip to the Wonca 2007 Registration Manager at Fax: (65) 6336 2236 or Email: registration@wonca2007.com

The remittance should be made to the following bank:

Bank: **Citibank Singapore Limited**
Bank Account: **0-117944-018**
Bank Address: **23 Church Street #02-01 Capital Square, Singapore 049481**
Account Name: **College of Family Physicians Singapore (MaxiSave)**
Swift Code: **CITISGSGGCB**
Bank Code: **7214** **Branch Code:** **011**

o **Credit Card**

Type of Card: o AMEX o Visa o Mastercard

Cardholder's Name: _____

Credit Card Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiry Date: ☐☐ / ☐☐ (M M / Y Y)

By providing the above, I am authorising the Wonca 2007 Registration Manager to charge SGD _____ to my credit card.

Cardholder's Signature: _____ Date: _____

Cancellation: The registration and other fees will be refunded only for cancellations received in writing to the Wonca 2007 Registration Manager. Phone cancellation will not be entertained. An administrative fee of SGD 200 will apply for any cancellation on or before 1 June 2007. Cancellation after 1 June 2007 will result to a full cancellation fee, no refund will be given. Please allow up to eight weeks to process your registration refund.

18th Wonca World Conference: Genomics

Programme at a Glance

Tuesday, 24 July 2007

Level 1 — 1400hrs - 1830hrs

REGISTRATION

Guests to be seated by 1645hrs

Ballroom, Level 2 — 1700hrs - 1800hrs

OPENING CEREMONY
Guest of Honour:
Mr Khaw Boon Wan, Minister for Health Singapore

Ballroom, Level 2 — 1805hrs - 1905hrs

Keynote Lecture on Primary Care:
Future of Healthcare: Harmonising Science and Humanity
Dr Shigeru Omi, Western Pacific Regional Office,
World Health Organisation

Ballroom, Level 2 — 1915hrs - 2130hrs

Welcome Reception & Dinner

Wednesday, 25 July 2007

Ballroom, Level 2 — 0830hrs - 0930hrs

Plenary Lecture 1:
Impact of Human Genomics on the Practice of Medicine
Prof Edison Liu, Genome Institute of Singapore, Singapore

Ballroom, Level 2 — 0930hrs - 1030hrs

Plenary Lecture 2:
Preventive Strategies in Anogenital Cancers
Prof Franco Guidozzi, Johannesburg Hospital and Medical School, University of Witswatersrand, South Africa

Concourse, Level 3 — 1030hrs - 1100hrs

Morning Tea Break & Poster Presentation

1105hrs - 1235hrs

13 Breakout Sessions
(7 Symposia & 6 Workshops)

Lunch Symposium — 1245hrs - 1415hrs

Lunch Symposium:
How the Family Practice Physician can Prevent Cervical Cancer
Sponsored by MSD

Ballroom, Level 2 — 1430hrs - 1530hrs

Plenary Lecture 3:
Confronting the Epidemic of Type 2 Diabetes: Can Novel Therapies Addressing Islet Dysfunction Help Patients Get to Goal?
Prof Michael Nauck, Diabeteszentrum Bad Lauterberg, Germany

Ballroom, Level 2 — 1530hrs - 1630hrs

Plenary Lecture 4:
The Journey of the Genome - How Could It Impact Modern Medicine
Dr Spencer Wells, National Geographic, USA

Concourse, Level 3 — 1630hrs - 1700hrs

Afternoon Tea Break & Poster Presentation

Ballroom, Level 2 — 1700hrs - 1800hrs

Keynote Lecture on Genomics:
Genomics, Medicine and Society
Dr Francis Collins, National Human Genome Research Institute, USA

Free Time

Dinner Symposium — 1830hrs - 2000hrs

Dinner Symposium
Sponsored by GSK

Programme may be subject to change. Updated as of 24 May 2007.

and Family Medicine (24 - 27 July 2007)

Thursday, 26 July 2007

Ballroom, Level 2 — 0830hrs - 0930hrs

Plenary Lecture 5:
HPV, from Immunology to Vaccination against Cervical Cancer
Prof Margaret Stanley, University of Cambridge, UK

Ballroom, Level 2 — 0930hrs - 1030hrs

Plenary Lecture 6:
Herpes Zoster - A Debilitating Disease
Prof Myron Levin, University of Colorado Health Sciences Centre, USA

Concourse, Level 3 — 1030hrs - 1100hrs

Morning Tea Break & Poster Presentation

1105hrs - 1235hrs

20 Breakout Sessions
(12 Symposia & 8 Workshops)

Lunch Symposium — 1245hrs - 1415hrs

Lunch Symposium:
Importance of Adult Vaccination
Sponsored by MSD

Lunch Symposium:
Targeting Broad and Sustained Protection Against Cervical Cancer
Sponsored by GSK

Ballroom, Level 2 — 1430hrs - 1530hrs

Plenary Lecture 7:
Pharmaco-genomics - Curent Status and Future Potential in Clinical Practice
Prof David B. Goldstein, Duke University, USA

Concourse, Level 3 — 1530hrs - 1600hrs

Afternoon Tea Break & Poster Presentation

Ballroom, Level 2 — 1600hrs - 1700hrs

WONCA INSTALLATION OF NEW OFFICERS & AWARDS CEREMONY

1700hrs - 1830hrs

18 Breakout Sessions
(11 Symposia & 7 Workshops)

Friday, 27 July 2007

Ballroom, Level 2 — 0830hrs - 0900hrs

Presentation by Host Organisation of Wonca Conferences

Ballroom, Level 2 — 0900hrs - 1000hrs

Plenary Lecture 8:
Translational Research in Family Medicine
Prof Yvonne Carter, Warwick Medical School, UK

Concourse, Level 3 — 1000hrs - 1040hrs

Morning Tea Break & Poster Presentation

Ballroom, Level 2 — 1045hrs - 1145hrs

Plenary Lecture 9:
Ethical and Medico-Legal Issues in the Age of Genomics
Prof Michael Kidd, University of Sydney, Australia

Ballroom, Level 2 — 1145hrs - 1230hrs

CLOSING CEREMONY

CONTACT INFORMATION

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Exhibition and Sponsorship:
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Programme may be subject to change. Updated as of 24 May 2007.

Singapore's Healthcare System

Welcoming Wonca 2007 International Delegates

Holistic Healthcare System that Delivers

Rated Asia's best healthcare system by the World Health Organisation (WHO) in 2000, Singapore is widely recognised as Asia's premier healthcare hub. Singapore combines excellent healthcare infrastructure, world-renowned medical professionals and the latest medical technology to deliver excellent healthcare to all patients.

Healthcare in Singapore is delivered by an integrated delivery system comprising public and private healthcare institutions. The public and private healthcare providers complement each other to provide a complete spectrum of clinical services from basic health screening to complex quaternary care.

Within the public sector, the hospitals, specialty centres and polyclinics are organised into two vertically integrated delivery networks - Singapore Health Services (SHS) and National Healthcare Group (NHG) - and tasked with the mission of providing good and affordable healthcare to the local population. As for the private sector, the hospitals, such as Parkway Group Healthcare and Raffles Medical Group, continuously innovate to deliver the best total healthcare experience to their local and international patients. In 2005, Singapore attracted over 370,000 international patients, further reinforcing our reputation as one of the top destinations for international medical travel.

In 2005, Singapore attracted over 370,000 international patients, further reinforcing our reputation as one of the top destinations for international medical travel.

Strong Medical Research for Sustainable Medical Excellence

To remain on the cutting-edge of medical knowledge and clinical care, Singapore's healthcare institutions have established strong links with world-class medical institutions such as Johns Hopkins University Hospital and Kaiser Permanente to seek further breakthroughs in medical research and development. Last year, the National University Hospital (NUH) and the National University of Singapore partnered St. Jude Children's Research Hospital and Viva Foundation to improve the survival rate and treatment of children with cancer in Singapore and Asia. Under this new partnership, the existing NUH paediatric oncology facility will be developed into a focal point for research in childhood cancer and training of doctors and nurses from the region.

Our doctors continue to put Singapore on the world map for breakthroughs in medical excellence. For instance, last year, Singapore was the first to alert the world to a link between Bausch and Lomb's ReNu contact lens

solution and a global spike in fungal corneal infections. Clinicians at the Singapore National Cancer Centre (NCC) also led an international team to come up with a molecular map of stomach cancer, which was a vital starting point towards finding better treatments for the disease among Asians. On the biotechnology front, a Singapore company, ES Cell International, scored a world first by creating stem cells which can be used safely in patients. These stem cells had the potential to be a vital source of treatments for diseases such as Alzheimer's, diabetes or cancer. Singapore will continue to focus on the Biomedical Sciences initiative and will be investing S$1.5 billion over the next five years to develop its clinical and translational research capabilities.

Singapore also partners the vibrant community of pharmaceutical, biotechnology and medical technology companies based in Singapore to develop better clinical protocols and drug therapies for patient care. Singapore also welcomes investment from international players that provide new services. Last year, Joint Commission International located its regional headquarters in Singapore.

The Duke-NUS Graduate Medical School Singapore, of which the pioneer batch of students will matriculate in Fall 2007, is also part of Singapore's efforts to produce highly trained physician-scientists to realise further medical advancements. In recognition of Singapore's standing, the Duke University Board of Trustees has approved the award of a joint NUS and Duke degree for GMS graduates - the first outside the USA.

Singapore also partners the vibrant community of pharmaceutical, biotechnology and medical technology companies...

Safe environment

Singapore recognises that while it is important to allow for innovation for medical technologies, it is also critical to set and enforce standards to safeguard public health and ensure efficiency. Instrumental to this is the Health Sciences Authority. It has established regulatory standards pertaining to drug evaluation, pharmaceutical administration, medical devices, analytical science, forensic science and medicine, radiation protection and transfusion medicine. In particular, its Centre for Transfusion Medicine, which is recognised as a WHO Collaborating Centre, is internationally reputed for its high standards of blood safety practices and management of blood transfusion services.

Primary Healthcare - Enhanced Chronic Disease Management

While Singapore builds up its capabilities in clinical research and medical expertise, we will also be progressively transforming the model of care for chronic disease management. Chronic diseases are a significant cause of illness and death in Singapore. Medical problems such as diabetes, hypertension, high blood cholesterol and stroke are lifelong conditions. The Ministry of Health (MOH) aims to raise the care of these four chronic diseases to a high level, in accordance with established disease management programmes which has strong scientific evidence of significantly better health outcomes.

Singapore recognises that while it is important to allow for innovation for medical technologies, it is also critical to set and enforce standards to safeguard public health and ensure efficiency.

MOH will be working closely with General Practitioners (GP), Family Physicians and polyclinics to set up good chronic disease management programmes to help patients take charge of their health and manage these conditions in order to lead a fulfilling life. This is part of the "One Family Physician for every Singaporean" initiative, where every Singaporean should have his or her own Family Physician who provides him with general care over the long-term. To support this initiative, the government is working towards a better integrated electronic health records where primary care GPs, community hospitals and care centres can be linked. With this, GPs can have access to health screening results, medical treatments and drugs prescribed in the hospital or step-down care institution and will be better equipped to advise his patients. ▮CM

The College Mirror wishes to thank the Ministry of Health for this Invited Article.

College of Family Physicians Singapore

A Brief History of Recent Times

by Dr Ong Chooi Peng, FCFP(S), Council Member, College of Family Physicians Singapore

I always think back on my traineeship days with great fondness and some wonder. Back in the early nineties, we were a bunch of rebels who had spurned the more traditional specialties and bought into this new discipline that promised the trainees exposure in otherwise nearly-impossible-to-get-into postings. The carrot we were dangled was the Master of Medicine (Family Medicine) degree, which was to replace the College Diplomate examination which had been in place since the 1970's[1]. How well I remember that couch at the back of the lecture room on which I spent many a sleepy Saturday afternoon! (I remember Rose[2], too, who introduced the concept of attendance marking to my youthful exuberance.)

Looking back, the College spent the larger part of the 1990's toiling to build up the Master of Medicine programme. Faithful stalwarts from the public and private sectors patiently worked with Programme A (hospital- and polyclinic-based) and Programme B (private practitioner) trainees. This was a period when the lure of freedom and better compensation in private practice competed with the predictable run of polyclinic work, and the Programme A traineeship sometimes had a discouragingly high attrition rate. The first M.Med(FM) examination was conducted in1993. For those of us who passed and in later years returned to help as invigilators and examiners, the annual examination has become an October reunion of sorts with old friends from the Family Medicine as well as the specialist fraternities.

"How well I remember that couch at the back of the lecture room on which I spent many a sleepy Saturday afternoon!"

Starting around year 2000, the College introduced a succession of offerings that formed the Family Medicine training programme as we know it today.

In 2000, the two-year Graduate Diploma in Family Medicine (GDFM) programme was instituted. The GDFM is a vocational course that aims to ground the family physician in the core competencies of his trade. The first GDFM examinations were conducted in 2002. To date, the GDFM has enjoyed a greater enrollment than the Master of Medicine programme[3]. The focus has deliberately been on core knowledge, and the examination reviews the acquisition of this knowledge as well as of basic skills such as history taking, laboratory result interpretation and synthesis of common findings.

In 2006, the GDFM was recognised as an entry qualification to the Master of Medicine degree. This meant that GDFM holders would now be eligible to sit the Master of Medicine examination following a further year of training under the auspices of Programme B. The Master of Medicine examination, in addition to theory papers, is characterised by a write-up of the candidate's practice, together with an oral defense component, as well as a clinical examination involving all the major specialties. With this recognition, the GDFM is positioned as the basic vocational qualification and the Master of Medicine as the further qualification that puts the family physician on par with his hospital specialist colleagues.

Regalia of the College of Family Physicians Singapore.

Another certification awarded by the College is the Collegiate Membership/ MCFP(S). The MCFP(S) has an interesting history. It started as the MCGP(S), benchmark of the College vocational training through self-study that was awarded from 1972 up to 1992. With the M.Med (FM) and the GDFM in place, the MCFP(S) is now awarded to M.Med(FM) and diplomate

members who fulfill requirements of teaching and continuing education.

In 2001, the College convocated its pioneer batch of Fellows by Assessment/FCFP(S). This was a group of trained family physicians who had spent a further two years going beyond the basics in areas of teaching, research and community involvement. The degree is awarded based on assessment of the physician's portfolio of activities in the two years as well as his performance at an exit interview. The FCFP(S) was envisioned as the equivalent of the specialist exit qualification of membership in the Academy of Medicine (AM)[4].

The Institute of Family Medicine (IFM) was launched under the auspices of the College in 2002 to provide leadership and structure to the multiple threads in Family Medicine training. This represented the

Prof K. Satkunanantham, Director of Medical Services (DMS) Singapore with A/Prof Cheong Pak Yean, College President, when Tapestry of the College was unveiled by the DMS at the Convocation Ceremony on 1 October 2005.

fulfillment of a 30-year old vision to have an academic body dedicated to teaching and research in family medicine. Associate Professor Goh Lee Gan was appointed the founding director of the IFM. At the same time, the College appointed its first executive director, Dr Lee Kheng Hock, to oversee the implementation of the professional development programmes[5]. From 2004, teaching fellows of the IFM have been appointed, and over the past three years this group has worked to update material as well as to develop new courses. In 2006, a deputy director of training administration[6] was appointed.

In 2005, the Ministry of Health, in consultation with the College, adopted the concept of the Family Practice Register. This acknowledged that Family Medicine is a separate discipline with its peculiar core competencies rather than a default career choice, and proposed that family physicians who had completed vocational training be listed on a national register. The targeted date for publication of this register is 2012. The additional role of accreditation administration is overseen by a new committee within the College[7].

With rising costs, it has become vital to ensure that optimum patient care is rendered by the most appropriate practitioner at the best site, be it in the clinic, the patient's home, or within an institution. In the later part of 2005, representatives from the College and Singhealth participated in a fact-finding trip to Canada. This group studied the practicalities of running a hospital-based family medicine programme as part of an overall programme that allows access to comprehensive family physician care. In May 2006, the Department of Family Medicine and Continuing Care (FMCC) was inaugurated within the Singapore General Hospital. The FMCC, run by family physicians and committed to patient care, teaching and research, represents a link that closes the loop involving the various family medicine programmes on the island.

We have come some way since the early years in the 1970's. The young GPs who spearheaded the first Singapore Wonca conference back in 1983 have become the wise men of the family medicine fraternity today[8]. As we prepare for the 18th Wonca World Conference, face a different world of patients and grapple with novel compensation structures, and find fellowship and inspiration from our ties, I hope the new chapter that we write will be grand. It has been a privilege to have been part of history as it unfolded, and it's amazing to realise that almost two decades have passed since I blinked my eye. ■CM

The young GPs who spearheaded the first Singapore Wonca conference back in 1983 have become the wise men of the family medicine fraternity today.

1. The final, and 15th, MCGP examination was conducted in 1992.
2. Rose was the admin girl in charge of trainees' attendance. In those days we had cakes for tea in between lectures.
3. From 2002 to 2006, 194 doctors have obtained the GDFM. In contrast, 241 doctors have been awarded the Master of Medicine (FM) degree from 1993 to 2006.
4. To date, 30 doctors hold this certification.
5. The current executive director is Dr Cheng Heng Lee, who was appointed in June 2006.
6. Dr Wong Tien Hua, appointed in October 2006.
7. Joint Committee on Family Medicine Training (JCFMT)
8. 10th Wonca host organising committee members: Drs Alfred Loh, Victor L Fernandez (deceased), Lim Kim Leong, Fred Samuel (deceased), Goh Lee Gan, Moti Vaswani, Paul Chan Swee Mong

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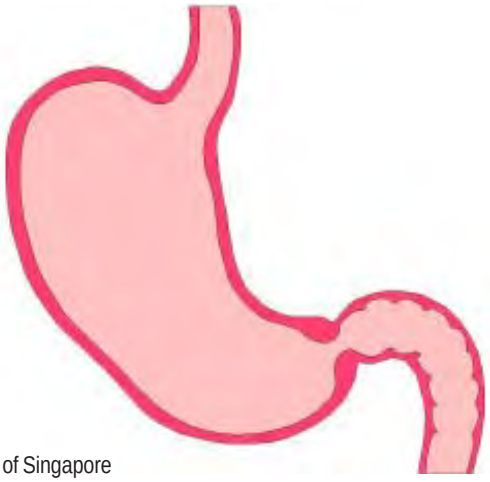
The Institute of Family Medicine - 30 Years in the making. Cheong Pak Yean, President's Forum, The College Mirror, Apr-Jun 2002.

Personal communications: Drs Goh Lee Gan, Cheong Pak Yean, Lee Kheng Hock.

This is the tale of an independent investigator initiated study that set out to fill a gap in our management of gastric complaints at the primary care level.



Filling a GAP

(Gastric At Primary care)

by A/Prof Gwee Kok Ann, Adjunct Associate Professor of Medicine, National University of Singapore

In medical school, we were taught that peptic ulcer disease and gastric cancer are important diagnoses in patients presenting with dyspepsia. We were taught how to make a diagnosis with barium meal and endoscopy. Recently the headlines announced the introduction of new techniques to detect and cure early gastric cancer. Suddenly, we get patients asking to be sent for this super test. How does the general practitioner (GP) make a working diagnosis without these tests? How should we treat patients without a firm diagnosis? Should we start with traditional treatments like antacids and the mandatory dietary advice? On the one hand, multicentre (read US and European) randomised controlled trials, reinforced by expert panel recommendations, pressure us to prescribe the strongest acid suppressing drug in the market. On the other hand, our patients worry about costs, and are suspicious of strong drugs. How does the front line GP manage these expectations for the benefit of his patients? The irony is that the majority of our dyspeptic patients have neither ulcer nor cancer, and will neither need nor benefit from endoscopic mucosal resection nor from proton pump inhibitors (PPI).

Trials

Background:
Dyspepsia is of Greek origin meaning bad cooking or digestion. Presently it is defined as pain or discomfort centered in the upper abdomen. This includes epigastric pain, belching, bloating, fullness, and early satiety. There is also an implication that these symptoms originate from the upper gastrointestinal tract, and possible causes include peptic ulcer disease, oesophageal or gastric cancer, functional dyspepsia, gastro-oesophageal reflux disease (GORD) and irritable bowel syndrome (IBS). While the spectre of cancer hangs over us, in reality, less than 1% of our dyspeptic patients will have gastric cancer.

The risks of Barrett's oesophagus is grossly overrated as the oesophageal cancer risk is ten times less than the colon cancer risk of the average individual. So, is it safe not to send all our dyspeptic patients for testing? Who will benefit from expensive PPI therapy? Who will fail therapy, and why?

Methods:
To address these practical questions, we conducted a study between November 2003 and June 2004. 55 general practitioners from various parts of Singapore contributed a total of 204 consecutive patients who had presented with dyspeptic symptoms. All patients were screened for the following alarm symptoms and signs - weight loss, haemetemesis, melaena, dysphagia, abdominal mass - and excluded if any of these were present. All patients underwent gastroscopy - no cancer was diagnosed, peptic ulcer disease was diagnosed in 13 patients and erosive oesophagitis in 24 patients.

Upon completion of endoscopy, all patients except for those with clinically significant findings were returned to their respective primary care physicians. The physicians explained the endoscopic findings to their own patients and then dispensed a two-week course of esomeprazole 20 mg twice daily. Dyspeptic symptoms were scored at baseline and at the end of

"... our patients worry about costs, and are suspicious of strong drugs. How does the front line GP manage these expectations for the benefit of his patients?"

treatment. Excellent response and poor response were defined as end of treatment score of $\leq$1 and failure to achieve $\geq$50% reduction in symptom scores.

Results:
The most common complaint was bloating (48%), while 28% had irritable bowel syndrome (IBS). Overall, only 24% achieved an excellent response, while 49% had a poor response to treatment. The most favourable response was observed in patients

complaining predominantly of heartburn (35% excellent, 35% poor), while the poorest response was in patients with bloating (11% excellent, 61% poor). Helicobacter pylori infection was found in 13.5% and was not a determinant of response. Another strong predictor of a poor response was the presence of IBS symptoms with poor response recorded in 64% and an excellent response achieved in only 9% of those with IBS.

Conclusions:
The primary care physician can draw confidence that if patients are carefully screened for alarm symptoms, the risk of missing a cancer will be less than 1 in 200. We learnt from our study to take data from mega-trials and guidelines from tertiary hospital based specialists with a pinch of salt. These are based on studies where patients are rigorously screened and only patients with pure peptic ulcer or GORD are recruited.

In the real world of primary care, patients are more complex. Our patients present with a constellation of symptoms and issues. They come with unrecognised symptoms of IBS and anxiety. They have costs constraints, but also want instant relief. To achieve the best outcome, the GP has to pay attention to these details.

Tribulations

The appeal of being an independent investigator is that you are not obligated. You can be courageous and challenge the data of pharmaceutical companies and guidelines from so-called expert panels. However, you face two major hurdles - funding and administrative support. Research grant bodies do not view clinical practice studies as priority, particularly if the area of study did not involve the two C's - cancer and coronary. The contrarian researcher has no access to professionals from multinational companies who know all the politically correct words and legalese jargon to produce a submission that will appease an institution review board (IRB). You do not get administrative support to produce the required ten copies of a 20-page document. You have to sell your story to an inexpert ethics committee who may see its role as simply gatekeepers. One former chairman of an IRB had openly advised me to borrow from the submissions of pharmaceutical companies. Mind you, this was even before the scandal involving a big name investigator in a major public hospital. Since then the screws have been tightened further. The irony is that the innumerable regulatory steps for a clinical trial serve to weed out all but the big boys.

"The primary care physician can draw confidence that if patients are carefully screened for alarm symptoms, the risk of missing a cancer will be less than 1 in 200."

Triumphs

Despite its lack of glamour, this general practice study was able to generate two international publications (reference below). More than this, the study provides ammunition for the front line foot soldiers who are often compared disparagingly against the hospitalist who is in a position to run sophisticated tests and then dispense a few months' supply of the latest most powerful drug. Personally, the triumphs go beyond the tangibles. When you present your data, you speak with authority. Your GP colleagues in the audience will appreciate your intimate knowledge and familiarity with the rough and tumble of front line medicine, as opposed to the buffered hospital corridors or hallowed halls of academia. When you speak you need not turn to complex and big studies for support, or to shield yourself with expert guidelines. Encouraged with the knowledge that these findings are of practical help to a large majority of doctors and patients, you are encouraged to ask further questions. How do our GP colleagues treat patients with GORD symptoms? Will a short course of one week PPI work as well as two or four weeks? How soon can patients expect an improvement? How long do patients remain symptom free after completion of treatment? We have in fact completed the preliminary study and results will be presented in early February 2007. TCM

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A/Prof Gwee is Adjunct Associate Professor of Medicine at the National University of Singapore and Consultant Gastro-enterologist and Physician at Gleneagles Hospital and the National University Hospital, Singapore.

He graduated from the National University of Singapore in 1985, and obtained his PhD from the University of Sheffield for his thesis on "Bowel disturbances following acute gastroenteritis: a psychobiophysiological model for the irritable bowel syndrome".

Dr Gwee has also trained at the Intestinal Diseases Research Unit at McMaster University studying the role of mast cells and inflammatory mediators on IBS. His studies on post-infectious irritable syndrome have been published in the Lancet and Gut.

MOH Budget Speech 2007 Highlights

Gearing Up for 2020, Transforming Healthcare and Care in the Community

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

The Ministry of Health Budget Speech was delivered in Parliament on 6 March 2007 by Minister for Health, Mr Khaw Boon Wan, and Mr Heng Chee How, Minister of State for Health. It was divided into three parts respectively entitled "Gearing Up for 2020", "Transforming Healthcare" and "Care in the Community". The Finance Minister had already announced that the health budget will rise from about $2 billion to $3 billion within five years.

CM looks at some of the highlights of this year's Health Budget relevant to the family physicians.

Financial Resources

Mr Khaw reminded the public that the realities of healthcare are such that everyone will require it, particularly towards the latter part of ones life when earnings will not be at its peak.

"Social welfare and comprehensive insurance are seductive ideas - no need for co-payment and nobody needs to worry about healthcare cost. But they both lead to the "buffet syndrome" of abuses and over-servicing and financial disaster. When the healthcare system is overwhelmed, the poor suffer as unlike the rich they cannot afford other alternatives. The truth is that healthcare demand is unlimited but supply is, because not many people will willingly pay more tax or insurance premiums which are needed to expand supply."

The rational approach is therefore to require some form of co-payment. The compulsory Medisave scheme ensures that everyone starts saving early, risks are then pooled through the basic insurance plan Medishield, and Medifund provides a safety net for needy cases.

Health Minister made it clear that the public should be prepared to use cash to pay for minor treatment and to see GPs and polyclinics.

"Our GP services are very competitive, inexpensive and affordable for most people. For larger medical expenses that require hospitalisation, our Medisave scheme is working as designed, especially after we have fine tuned it in recent years. I have now extended Medisave to cover outpatient treatment of four common chronic diseases. Its full impact will be felt over the years when the scheme matures. I am optimistic that, if participating chronic patients co-operate with their family physicians and actively change their lifestyle and comply with medication, their health will improve."

"Our GP services are very competitive, inexpensive and affordable for most people."

"In order to maintain the standard of care over the next ten years and beyond, Singapore will need more hospital beds, more clinics, and more doctors.

Health Minister also said that the current subsidy policy of Class C patients paying 20% of cost, and polyclinics 50% of cost will be maintained. But when unit cost goes up in line with a higher standard of care, the dollar co-payment by patients will have to go up accordingly.

Physical Resources

In order to maintain the standard of care over the next ten years and beyond, Singapore will need more hospital beds, more clinics, and more doctors. The new general hospital at Yishun will have 550 beds. When it fully opens in 2010, acute hospital beds in the public sector will hit 6,500. Day surgeries such as Jurong Medical Centre will be expanded to move towards the trend of shorter hospitalisations. MOH will be recognising more foreign medical degrees, and foreign-trained doctors will be recruited. The numbers of

foreign-trained doctors increased form an intake of 85 in 2003 to 180 in 2006.

Health Minister then talked about his vision of how healthcare can be transformed in Singapore.

"To transform healthcare to better meet the different needs of our patients, we must innovate. To innovate to meet diverse needs, we must have diversity in organisations, structures, models of care and pricing. This requires a change in mindset on the part of the healthcare providers. For example, hospital specialists will need to work more closely with family physicians and step-down care facilities as a team, with patients at the centre. Ideally, they will all share a common medical record for each patient, consult regularly and function as a team whose sole purpose is to advance the health of the patient."

Electronic Medical Record

This is an important infrastructure to invest in, in order to enable tertiary centres to work with one another and to also involve the family physician. Health Minister coined the slogan, "One Singaporean, One EMR". The current system is that each patient had multiple medical records in the different clinics and hospitals, which leads to repeated tests and unnecessary cost.

"This is a complex national project - very few if any countries have successfully implemented a system that links up public, private and the charity sector. This is because there are many issues such as data protection, regulation and audit to be addressed. We need to take a measured approach, to pilot and put together a comprehensive framework that takes care of these issues. This will begin with common data standards. We will do this within the public sector, and extend this to the step-down institutions. We have started to build the linkages to the private sector GP clinics by helping them to set up their IT systems under the chronic disease management effort. I am confident that we will get there."

Care Integration

Collaboration between acute hospitals and community hospitals need to be strengthened in order to achieve seamless care for patients when they move between these two types of institutions. For patients who no longer need medical treatment in acute hospitals and who should move into community-based care, continuity of patient care is a priority. The handover must be smooth with minimal barriers and bureaucracy.

"For a start, we need to enhance medical collaboration between the doctors in our acute hospitals and either their counterparts in the community hospitals or the family physicians who look after the patients over the long term. Patients must feel confident that they are getting seamless care"

Right-Siting

Mr Khaw explained that right siting of healthcare services means that patients should be treated in the most appropriate locations by medically-competent teams at the lowest possible cost.

"Today, many patients who choose to be treated at SGH and NUH need not be there and should not be there. They can be and should have been treated by their family physicians, at less hassle and at lower cost. Meanwhile, we will continue our push, through the Medisave for chronic disease scheme, to shift chronic disease management to the primary care level, by family physicians and in the community. If patients can be right-sited to family physicians and feel confident that they will be well looked after, we can reduce the over-crowding at the hospital specialist outpatient clinics."

HMOs

Health Minister responded to a query about HMOs: "Health Maintenance Organisations (HMOs) is an idea imported from the US. I do not how wide their coverage is but while we do not regulate HMOs, we do regulate the doctors working for them. I am sure any attempt by HMOs to cut corners will be resisted by our GPs as they have high ethical standards. Companies should also chip in to ensure that their employees do not get short-changed."

Empowering Patients

Health Minister stated that there is a need to empower our patients by engaging them in their care and giving them choices. An example is the Medisave scheme for chronic diseases launched last year. With the financial burden somewhat eased, it is now up to the patient to help themselves and work with their family physician to manage their chronic disease. Doctor hopping is discouraged as the scheme promotes each Singaporean to have one family physician.

"Medical science is now clearer on how to manage these chronic diseases to minimise future complications. The correct approach comprises 3 elements: (a) early detection; (b) regular ongoing low-tech low-intensity treatment by family physicians; and (c) good compliance by patients in changing their lifestyle and habits."

"Every patient should be given a personal health information folder by his doctor on his chronic disease and what he should do to improve his health. His health status should be regularly tracked and charted, and explained to him by his doctor."

CM

2006 Courage Fund Humanity Award Winner: Dr Ong Jin Ee

Treading the Less Trodden Path

by Dr Shiau Ee Leng, MCFP(S), Editorial Board Member

Dr Ong Jin Ee from the Touch Community Services is the winner of the 2006 Courage Fund Humanity Award. Graduated in 1993, she obtained her MMed (Family Medicine) in 2001 and Diploma of Geriatric Medicine in 2002. Since then she had also obtained her Fellowship to the College of Family Physicians Singapore and served as the Editor to the College Mirror. She is one of the pioneering batches of home care physician in Singapore and is involved in the training of medical and paramedical personnel in this field.

CM: Tell us about yourself and your previous medical trainings.

I completed my MMed (Family Medicine) in 2001 and did my Diploma in Geriatric Medicine the following year. Other than the pressures of meeting programme deadlines and requirements, I enjoyed the Family Medicine Fellowship programme of continuing professional development and exited in 2006.

I work in a voluntary welfare organisation (VWO); TOUCH Community Services (TCS).TCS runs a home care service for the frail homebound elderly. Essentially it has a home medical arm and a home help arm. The payment for our services is based on means testing and VWO internal subsidy. We provide continuing care for chronic illnesses and the main emphasis is on community geriatrics. We are multi disciplinary team based and our home care practice runs with nurses and therapists. We serve about 120 patients and take about 12 home care doctor appointments per week. Because a significant number of our patients may be the single poor elderly staying alone or families struggling financially, there is an element of social medicine as well.

CM: What made you decide to tread this less trodden path and to specialise in this field? Do you have a mentor who motivated you?

I treaded as you have said onto a less medically trodden path of community geriatrics and home visits in 1999. I had enjoyed my geriatric hospital posting in spite of some fellow colleagues telling me that they felt depressed seeing the old. Maybe it helped that I had a great relationship with my grandmother and also had positive experiences with older people hearing their stories and rich life experiences. Having volunteered through church, I got to know about the work at TOUCH and one thing lead to another.

I probably did not quite know what to expect when I left the government outpatient sector to enter into the charity people sector. There was a lot of multi tasking, getting to know my team of nurses and colleagues and grappling with caring for patients in a less established and generally more resource challenged way.

By God's grace to have resilience and a curious mind, I have been blessed to see good works in those years, and to make some difference to our patients through great teams of nurses, therapists and administration management colleagues and bosses. So now, one of my great satisfactions is to see that we have established a working home care model for chronic care that includes scheduled home visit appointments, home venesections via a dispatch and prescription collections and a fee schedule.

The inspiration for me continues to be seeing colleagues grow in

"For some of the homebound ones, it is a real challenge to go for specialist follow up so we try to manage as best at home."

their professional capacities and seeing our patients and their family members improve and supported.

CM: What does winning this award mean to you? Do you think it would motivate other health care workers?

Winning the health care humanity award occurred in part because my colleagues put up the nomination.

I think most good doctors, nurses and health care professionals enter the profession because they want to help people. Perhaps in home care, because we get a chance to enter out patient's home, get to establish relationships, empathise and know their situations better, we are moved and have the opportunity to go that extra mile.

I hope that we will continue to remain ethical, sincere and help and heal when we can, and break bad news with kindness and hope.

CM: Can you share some particularly fulfilling aspects of your job? How about some interesting cases?

Well, I was once called by a relative to attend to his father-in-law. When I reached the home, it was quite a sad sight. The elderly man was clearly in a neglected state and demented with severe exfoliative dermatitis. It turned out the relative felt sorry that the children were all pushing responsibility around. So after examining him and getting a history from the relative, I recommended an admission to do a medical work up and sort out potential elder neglect/abuse. It was a judgment call and the relative supported my call to contact a less-than-friendly son. So I was glad to have made the decision to go out on a limb and push for an admission.

A medically satisfying case was also a bedbound patient with chronic lung disease that improved much after being placed on a nebuliser machine.

CM: Any heart warming incidents?

Very often the heart warming aspects of home care is seeing the single elderly appreciate the care of my nurses and the team. I have had one previously taciturn and grouchy elderly man who warmed the cockles of my heart when he spontaneously showed his appreciation and commented we had established more bonding with him than related kin. I have always appreciated my nurses who will dress chronic wounds, joke with the elderly and we generally have an easy rapport with the poorer elderly.

Other instances are some fall risk patients who actually got their homes modified under the consultation of our therapist to make them more elderly friendly, and this makes us feel we have really done our best in providing holistic care.

Also heartwarming and satisfying is when we are able to provide enough caregiver support. We had one patient bedbound from a stroke who had complications of leg gangrene and an amputation. Finally after few months, she was so stabilised and the maid so competent that her family actually felt enough peace of mind to take off on a long needed holiday!

Dr Ong Jin Ee, with sister and nephew, celebrating a patient's birthday.

The challenge in home care is keeping up with continuing education and missing the intellectual sparring and discussion with fellow medical doctors.

So I do a lot of self directed adult learning on line and just picking the brains of fellow specialists, kind classmates and try to translate all that into practical care in the home. For some of the homebound ones, it is a real challenge to go for specialist follow up so we try to manage as best at home.

In recent years, I have also been involved with other home health care providers as it is helpful to have other physicians facing similar situations share experiences. You may be interested to have a look at our new home health care association website at www.hhca.org.sg.

CM: What keeps you going?

What keeps me going is enough rest for myself! But seriously I try to practise what I preach - prevent care giver fatigue by having enough time outs.

In home care practice, I try to make life easier for myself - my husband got me a TIBO which is a GPS for the car, which has rescued me a couple of time in visiting unfamiliar places. And check HDB addresses via mailboxes and rubbish chutes so you end up on the right lift landing to the home you are visiting! Other things which push me on include enjoying the camaraderie and teamwork with the team.

The work spills over into real life and I find it refreshing visiting friends and family in their homes and sharing life over a cup of tea. When time permits and inspiration strikes, I try to do a Martha Stewart in my home. You could say I am a home body (pun unintended). ▮CM

Need for a Quorum

AGM 18 August 2007

by Dr Cheng Heng Lee, Honorary Secretary, College of Family Physicians Singapore

Based on the existing constitution, the College can only alter, amend or make addition to its constitution at an AGM with a quorum of 1/8 of its voting membership.

For the past two Annual General Meetings in 2005 and 2006, the College proposed constitutional amendments to reduce the quorum, but the proposals could not be tabled as the required quorum was not attained in spite of enticements like free thumb drives and Baum stethoscopes.

The minutes of our AGM for the past nine years from 1998-2006 showed that a quorum was attained only in 2002. Refer to Table 1. Coincidentally, constitutional amendments were proposed and successfully tabled that year.

In the initial years of the College when the Constitution was first drawn up it is not impracticable to require a quorum of 1/8 of voting membership as it would not be too onerous to attain such a quorum with a small membership. With a fixed proportionate requirement for a quorum, the difficulty

of attaining a quorum becomes real as membership grew. The unsuccessful outcomes in 2005 and 2006 compared to 2002 seem to support this view. For this reason, the 20th Council would like to propose once again at the coming AGM in August that the quorum be amended to not less than 50 voting members or not less than 1/8 of the voting membership, whichever is the lower. In addition, Council will also propose to amend Article IX Section 4. Refer to Table 2.

TABLE 1

Year	Members Attending AGM	Quorum Required	Total Voting Members
2006	104	136	1088
2005	99	130	1040
2004	39	102	812
2003	34	82	649
2002	83	79	637
2001	45	70	554
2000	27	58	464
1999	25	59	470
1998	18	66	526

This figure of 50 voting members is not without precedence. SMA with a much larger membership of almost 5,000, has also amended their quorum to 50 voting members.

The 20th Council looks forward to the support of members to amend this anachronism in the College constitution.

Mark your calendar to attend the coming AGM on 18th August to empower the College to be more responsive with regards to making constitutional amendments that will further its objectives in the context of the new environment of family practice. CM

ANNUAL GENERAL MEETING
College of Family Physicians Singapore
College of Medicine Building
Saturday, 18th August 2007, 2.30PM

TABLE 2
PROPOSED AMENDMENTS TO THE COLLEGE CONSTITUTION TO BE TABLED BY THE 20TH COUNCIL (2005-2007) FOR THE ANNUAL GENERAL MEETING TO BE HELD ON 18th AUGUST 2007

No	Present Constitution	Amended Constitution	Remarks
1	**Article VIII, MEETINGS** **Section 6** The quorum for a General Meeting shall not be less than 1/8 of the voting membership. If within one hour from the time appointed for the meeting a quorum is not present, the meeting shall be adjourned for fifteen minutes. The number of members then present at the adjourned meeting shall constitute the quorum, but they shall have no power to alter, amend or make addition to any part of the existing Constitution.	The quorum for a General Meeting shall not be less than 50 voting members or less than 1/8 of the voting membership whichever is the lower. If within one hour from the time appointed for the meeting a quorum is not present, the meeting shall be adjourned for fifteen minutes. The number of members then present at the adjourned meeting shall constitute the quorum, but they shall have no power to alter, amend or make addition to any part of the existing Constitution.	This will allow for sufficient numbers to form a quorum in a face-to-face meeting. The quorum for SMA AGM is 50.
2	**Article IX COUNCIL OF THE COLLEGE - Section 4** "Nominations of candidates to the Council shall be signed by two voting members and contain a consent signed by the person nominated and shall be left with or forwarded to the Honorary Secretary so as to reach him at least 7 days before the Annual General Meeting."	"Nominations of candidates to the Council shall be signed by two voting members and contain a consent signed by the person nominated and shall be left with or forwarded to the Honorary Secretary so as to reach him at least 30 days before the Annual General Meeting." To append to above section two new sentences: "An Election Committee shall be appointed to oversee the nomination and election processes. Details of these processes will be specified in the College by-laws." "Voting shall be by methods that will make it easy for all eligible voters to participate: (a) postal voting (b) automated telephone voting or (c) other methods of voting that are available at the time." (The following shall be included in the by-laws of the College Constitution: "The Election Committee shall consist of past office-bearers and the Fellows of the College who are not within the present Council. The number of members is between 3 to 5. A College of temporary staff shall assist the Committee if necessary.")	The Election Committee is necessary to oversee the processes when methods of voting used are not in a face-to-face meeting. Voting by postal voting or automated telephone voting will result in greater participation of all eligible voters.

How to Produce a Poster

by Dr Julian Lim, FCFP(S), Private Practitioner

A poster can serve as a source of information, a conversation starter or even an 'advertisement' of your work. The purpose of a poster is to get your main point across visually. As such, it has to be focused on a single point as far as possible, has to be graphic to let the images get the point across instead of using only text, and has to be ordered so that sequence is logical and obvious. Hence, an ineffective poster is one where the main point is hard to find, text is too small, and graphics and organisation are poor.

Abstract

Even before a poster can be produced, an effective abstract is needed to get your work accepted for presentation at a conference. An abstract is a succinct description of your work and should explain why your work is important; describe the objective of your work; briefly explain the methods and succinctly state the results, conclusions, and recommendations. Subsequently, the abstract serves as an outline for your poster, which can be thought of as an illustrated abstract. There is no need to include the abstract on the poster.

Planning

Consider the contents, space (size of the poster), format (single sheet or multi-panel; landscape or portrait), deadlines, budget, physical safekeeping and transportation of the poster.

Layout

Use visual syntax through varying the font size and organisational cues like numbers and arrows to move readers through your poster. Top to bottom and left to right is a good rule of thumb. Headings should be exploited to highlight main points and key information. Consider the placement of text and graphics, and blank spaces creatively to help define the flow of information. Create visual balance to make the poster pleasant to look at. If a crowd is expected, a column format is easier to read. Stay focused on your message and dispense with unnecessary details.

Graphics

Clear graphics should dominate your poster. Graphs should be simple and clean and convey relationships clearly. Write explanations directly on figures, instead of referencing from elsewhere. Appropriate two-dimensional line graphs, bar charts, and pie charts are preferable. Use photographs and spot art to attract attention and help deliver your message

Text

Text should be minimised in favor of graphics, and large enough when used. The title should be at least 5cm tall. Fonts should be at least 24 point for text and 36 point for headings. Left-justify text instead of centering or right-justifying. Use a serif font, e.g. Times

Put handouts, business cards, and reprints nearby on a table or in an envelope hung with the poster.

Roman as it is easier to read. Sans-serif font, e.g. Helvetica is acceptable for titles and headings. Keep text elements to 50 words or fewer, and use phrases rather than full sentences. Use an active voice and avoid jargon. Edit ruthlessly to reduce the amount of text and focus on a results-oriented message. Print a small version and circulate it for comment.

Colors

Colors can make a poster attractive and readable, but be cautious. Use a light-colored background and dark-colored lettering for contrast. Avoid dark backgrounds with light lettering, which can be very tiring to read. Stick to a theme of two or three colors or else, it might appear cluttered and confusing to the reader. Excessively bright colors can attract attention, but cause visual fatigue. Consider people who may have problems with red-green colour blindness.

Use of colors and light-colored background.

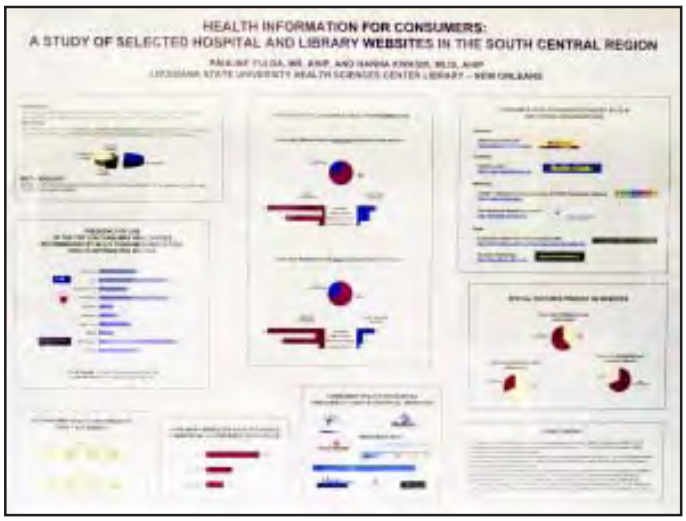
Preparation Day

On the day of the poster presentation, arrive early and bring all the necessary stationery with you. Hang your poster squarely and neatly. Ensure that you are at your poster during your assigned presentation time. People want to remember you and your work, so bring copies of a handout for your readers. It should include a miniature version of your poster and more detailed information about your work, in an illustrated narrative form. Consider doing this on an 11x17-inch sheet, folded in half. This allows three pages of information, in addition to the miniature of your poster. Put handouts, business cards, and reprints nearby on a table or in an envelope hung with the poster. Restock periodically if poster is up for a long time, and consider leaving a pen and pad inviting feedback from viewers. Prepare 30-second, 2-minute, and 5-minute tours of your poster.

Presentation Day

When people ask you for a tour of your poster, use the graphic elements to explain your work. Do not read your poster but draw attention to the relevant graphics. Talk in a clear and measured pace. Be mindful of any local accent and colloquial speech. Glancing at the figure as you point to it will redirect your viewers' eyes to the figure.

Tell viewers the context of your topic and why it is important (Introduction), your objective and what you did (Objective & Methods), what you have discovered (Results), and what the new discovery means (Discussion).



Use of two-dimensional bar and pie charts.

The categories of readers can range from well-informed people with similar research experience; to those whose interests are closely related and hence require a context to capture them (they will be able to give you novel insights and perspectives to your work); to people in unrelated fields that require patient explanation without resorting to jargon. To satisfy them all, you should adjust your presentation accordingly. Use plain language, avoid jargon and acronyms, unless the audience has similar interests. Interpret your findings so that readers in all categories can understand how your work addresses the issues you have described.

Engage your audience and do not let them escape until you have finished your presentation! Enjoy the conference.

CM

REFERENCE

George Hess, Katheryn Tosney, Leon Legel, Creating Effective Poster Presentations. http://www.ncsu.edu/project/posters/NewSite/ (last accessed 23/1/2007)

Getting to Know the Editorial Board (part 2)

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

In the last issue of the College Mirror, readers got a first hand introduction to the new College Mirror Team B Editorial Board. We continue to hear from Dr Loke Wai Chiong, the man steeped in the traditions of Family Medicine, having grown up in practicing in and running the polyclinics and settling into Health Administration, Dr See Toh, the jet setting flying doctor who has made it to faraway places like Inner Mongolia on a Lear Jet before finally being captivated by the rustic charm of his family practice in his corner of unique Singapore, and Dr Wong Tien Hua who has seen the light in practicing the art and science of family medicine with a keen understanding of human nature.

The College Mirror continues to put them on the hot seat by getting them to chew on some difficult questions.

CM: Much has been reported on Family Medicine as a sunset industry, what do you think?

TH: Family Medicine is a vocation. As long as there are patients, there will always be a need for primary care providers. The practice of Family Medicine is certainly changing; the solo GP is facing difficulties in particular, he has to contend with rising rentals, stiff competition, and increased cost of doing business. We also see the trend towards formation of large GP group practices. However, we must not forget that the core values of the Family Physician, whether practicing in a large group, in the polyclinic, or on his own, remains the same.

Personally, I do believe that there will always be a role for the solo GP providing quality personalised care for his patients. This is the nature of Family Medicine, the doctor-patient relationship being the central process.

"There is a resurgence in interest in Family Medicine, more doctors are taking postgraduate courses and examinations leading to higher qualifications..."

- Dr Wong Tien Hua

ST: We may have been wandering in the wilderness for a while but, in recent times, with the new initiatives by the College (e.g. GDFM, proposed FM register), the recognition of Family Medicine in a hospital setting (SGH FMCC) and the introduction of Chronic Disease Management Program by MOH, I think this may be the dawn of a new era for Family Medicine.

WC: Most definitely untrue. In this age of increasingly sub-specialised and fragmented healthcare, de-personalisation and spiraling costs, the role of a family physician to care for the whole person and his/her family can only grow in relevance.

CM: What in your opinion is the next ten years of Family Medicine going to be like?

TH: There is a resurgence in interest in Family Medicine, more doctors are taking postgraduate courses and examinations leading to higher qualifications, many are participating in research in Family Medicine. This is happening all over the world. I think governments are beginning to realise that a well-trained primary care sector will keep healthcare costs down, thus the willingness to invest in primary care. I hope to see more of our GP colleagues take up the excellent courses offered by the College, moving on from GDFM to Collegiate Membership, and contribute actively to College activities. Over the next ten years, I hope to see more cooperation and coordination

"I think there will be exciting times, as FM practitioners step up to the challenge of skill and knowledge development."

- Dr Loke Wai Chiong

between private and public healthcare sectors. Presently, many of our patients hop around from doctor to doctor, switching between public and private. This consumes much resource. Electronic medical records exchange is a right move that will help to share information and greatly reduce wastage. I also hope to see all GPs embrace the power of the internet in their offices; GPs can form online discussion groups, exchange knowledge and be united as one community.

ST: Optimistic. Especially if you look at our younger colleagues among the GDFM graduates and trainees. They are committed and are no run-of-the-mill.

WC: I think there will be exciting times, as FM practitioners step up to the challenge of skill and knowledge development, collaborate with each other and specialist colleagues across interfaces of care, and advances in medicine lead to greater preventive and anticipatory care possibilities at the primary level.

"... I think this may be the dawn of a new era for Family Medicine."

- Dr See Toh Kwok Yee

CM: What needs to be done to keep the College Mirror relevant to its readers?

TH: College Mirror should be the voice of the Family Medicine community by keeping up to date with the latest policies and developments in Family Medicine. College Mirror also provides a channel to promote College activities and keep members informed of upcoming events. We also need to support our course participants in GDFM and MMed (Family Medicine), and provide articles that will encourage them. I look forward to contributing to College Mirror in the upcoming issues.

ST: We must continue to inform and update our colleagues about new trends and developments, and to continually strive to connect with them through inspiring anecdotes, articles and interviews.

WC: The College Mirror must continue to be the finger on the pulse of the local primary healthcare scene, discuss what is on the minds and lips of our family physicians, and be a rallying tool to bring the whole community and other stakeholders together.

CM: Thank you gentlemen for giving us a piece of your mind. Appreciate your sacrifice and hope to hear more from you in the coming College Mirror issues. ▮CM

Family Practice Skills Course 21

Diabetes Mellitus:

Essentials for Best Practice

Left: A/Prof Sum Chee Fang, Dr Melvin Leow Khee Shing and A/Prof Goh Lee Gan in Seminar 1. Right: Insulin injection put into practice.

Left: Sr Noorani Binte Othman delivered a practical and insightful workshop. Right: Demonstrating the use of syringes and vials.

The College of Family Physicians Singapore would like to thank the Expert Panel of the Family Practice Skills Course on **Diabetes Mellitus: Essentials for Best Practice** for their invaluable contributions.

Dr Melvin Leow Khee Shing
Consultant Endocrinologist and Physician, Department of Endocrinology, Tan Tock Seng Hospital

Dr Jean Tan Su Ming
Private Medical Practitioner, Changi Clinic

A/Prof Sum Chee Fang
Senior Consultant, Endocrinologist, Alexandra Hospital

Dr Loh Keh Chuan
Consultant Endocrinologist,
Loh Keh Chuan Diabetes, Thyroid & Hormone Clinic

Dr Michelle Jong
Consultant, Department of Endocrinology,
Tan Tock Seng Hospital

A/Prof Goh Lee Gan
Associate Professor, Department of Community, Occupational and Family Medicine, Yong Loo Lin School of Medicine, National University of Singapore

Sr Noorani Binte Othman
Certified Diabetes Educator, Nurse Clinician (Diabetes), Tan Tock Seng Hospital

Dr Wong Heck Sing
1923-2007

Dr Wong Heck Sing, founding member and past President of the College of Family Physicians Singapore, passed away peacefully on Sunday 4th March 2007 after a 12-year battle with cancer. He was survived by his wife, three children and five grandchildren.

The Family Physician
- Entered medical school in 1946
- General practice at Wong Dispensary in 1953

Lectures and writings
- Singapore Medical Association's 7th National Medical Convention address in 1976, entitled "Family Medicine in Singapore: Past, Present and Future".
- First Sreenivasan Oration in 1978, entitled "The Future Singapore General Practitioner"
- 1997 SMA Lecture entitled "In Search of Future Role Models in Medicine"
- Batam Years from 1942 to 1945

Volunteer Work
- Honorary Doctor at Nanyang University from 1956 to 1960
- Honorary Physician to the Salvation Army Nursery Home from 1956 to 1963
- Honorary Physician to Boys' Town from 1956 to 1970.
- Corps surgeon to the St John's Ambulance Brigade from 1956 to 1970.
- Honorary Doctor to the Lee Kuo Chuan Home for the Aged from 1964 to 1970
- Vice-Chairman, Jalan Teck Whye Secondary School Advisory Committee from 1968 to 1971.

Public Service
- Singapore Telephone Board from 1969 to 1971
- Public Service Commission (PSC) from 1970 to 1973
- Deputy Chairman PSC from 1973 to 1994
- Legal Service Commission from 1973 to 1994
- Chaired the Ministry of Health's Committee for selection of part-time Honorary Consultants for government hospitals from 1974 to 1978.

For his contributions and services to the nation, the Singapore Government awarded Dr Wong:
- Public Service Star (BBM) in 1983
- Meritorious Service Medal (PJG) in 1989

WONCA
In the 1970s, Dr Wong was also actively involved with the world body of family doctors, WONCA (World Organisation of National Colleges and Academies). Singapore hosted Wonca World Conference in 1983.

College and Academia
- Chaired the pro-tem committee that formed the College in 1971
- President of the College of Family Physicians for three terms (1973-1974, 1975-77 and again from 1983-1985).
- Chaired the pro-tem committee that formed the Institute of Family Medicine in 2001

For his dedication and contributions he was recognised by:
- Academy of Medicine in Singapore in 1975
- Honorary FRACGP to the Royal Australian College of General Practitioners in 1975
- FCGP to the College of Family Physicians in Singapore in 1980
- Honorary member of the Singapore Medical Association in 1998

His Visionary Legacy to Family Medicine
- Formation of the College of Family Physicians Singapore in 1971
- Regular CME attended by family physicians
- Undergraduate teaching in family medicine was started in 1987
- Formal vocational training in family medicine was started in 1988
- MMed (Family Medicine) awarded by the National University of Singapore was started in 1993
- Graduate Diploma in Family Medicine was started in 2000
- Fellowship by Assessment leading to the FCFPS was started in 2001
- Collegiate Membership by Assessment leading to the MCFPS in 2006
- The proposed Family Physician Register recognising Family Medicine as a discipline
- The Department of Family Medicine and Continuing Care

In recognition of Dr Wong's commitment, the College Convocation Tapestry was commissioned in 2005.

Dearly missed by family physicians,
a true role model.
Farewell.

Family Practice Skills Course 16 (Repeat)

Women's Health

The College of Family Physicians Singapore would like to thank the Expert Panel of the Family Practice Skills Course on **Women's Health (2007)** for their invaluable contributions.

A/Prof Arunachalam Ilancheran (left) and A/Prof Tay Eng Hseon (right) delivering a lecture on Cervical Cancer Prevention and Reducing the Risk of Gynaecological Cancers respectively.

Dr Quek Swee Chong directing participants during the workshop on Pap Smear Techniques

Dr Carol Tan-Goh
Senior Consultant, Ambulatory Geriatric Service,
KK Women's and Children's Hospital

Dr Fong Kah Leng
Associate Consultant, Obstetrics & Gynaecology,
Singapore General Hospital

A/Prof Hong Ga Sze
Senior Consultant Surgeon, Mount Elizabeth Medical Centre
Adjunct Associate Professor, Department of Surgery,
National University Hospital

A/Prof Tay Eng Hseon
Consultant Endocrinologist,
Loh Keh Chuan Diabetes, Thyroid & Hormone Clinic

A/Prof Arunachalam Ilancheran
Head, Gynaecologic Oncology, National University Hospital

Dr Quek Swee Chong
Consultant, Gynaecological Oncology Unit,
KK Women's and Children's Hospital

Dr Ang Seng Bin
Resident Physician, Ambulatory Geriatric Service,
KK Women's and Children's Hospital

Dr Teoh Seng Hin
Visiting Consultant, Menopause Unit,
KK Women's and Children's Hospital

(from page 3 - Welcome to Wonca World Conference 2007)

Practice of Family Medicine in the New Era of Genomics: Practising in the day after tomorrow

The promise and the uncertainty of a new era is both exciting and worrying. How will this affect the practice of Family Medicine now and in the future?

Gene Therapy: Debugging the source code of life

In most gene therapy studies, a "normal" gene is inserted into the genome to replace an abnormal, "disease-causing" gene. A carrier molecule called a vector must be used to deliver the therapeutic gene to the patient's target cells. After the recent setbacks, will there be a breakthrough soon?

Pharmacogenomics: Tailor made drug therapy

Pharmacogenomics holds the promise that drugs might one day be tailor-made for individuals and adapted to each person's own genetic makeup. Environment, diet, age, lifestyle, and state of health all can influence a person's response to medicines, but understanding an individual's genetic makeup is thought to be the key to creating personalised drugs with greater efficacy and safety. Can we look forward to better and safer drugs soon?

Ethical Dilemmas and Legal Issues in the New Age of Human Genomics

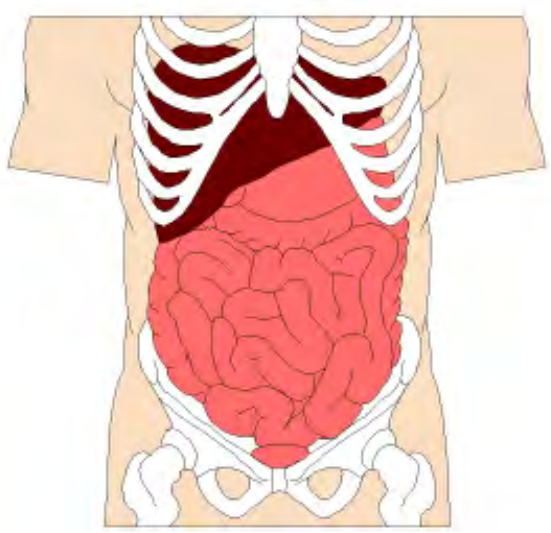
- Who should have access to personal genetic information, and how will it be used?
- Do healthcare personnel properly counsel parents about the risks and limitations of genetic technology?
- How reliable and useful is fetal genetic testing?
- What are the larger societal issues raised by new reproductive technologies?
- How will genetic tests be evaluated and regulated for accuracy, reliability, and utility?
- How do we prepare healthcare professionals for the "new genetics"?
- How do we prepare the public to make informed choices?
- How do we as a society balance current scientific limitations and social risk with long-term benefits?
- Should testing be performed when no treatment is available?
- Should parents have the rights to have their children tested for adult-onset diseases?
- Are genetic tests reliable and interpretable by the medical community?

So many questions with no clear answers. At Wonca 2007, we will try to answer some of these questions. Come and join us in consensus building in these momentous time. ▮CM

Special Consideration in Approaching an Acute Abdomen

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

The term "acute abdomen" is a well recognised but ill-defined clinical entity. It describes a rapid onset of symptoms strongly, suggestion for an intra-abdominal pathology usually, but not always featuring severe abdominal pain. The GP is not ready until he has handled at least a case of abdominal pain. The management of the patient presenting with the acute abdomen is fraught with uncertainty and danger. I have never known of any GP who is fully comfortable in discharging such a patient. Neither am I. There will always exist an element of uncertainty. This review hopes to provide practical tips.



History and examination

This is one area in which a thorough history provides the best chance of reaching a diagnosis.

There are five historical considerations:

- Demographic detail
- Pain
- Associated symptoms
- Previous history and medication
- Obstetric and gynaecological history

Special cases

When assessing children, the elderly or those in advanced pregnancy, recognise that the differential diagnosis lists are unique.

An absence of pain is more likely in this group of patients warranting more caution.

A. Considerations in Children

a. Newborn:
Any congenital anomalies of the GI tract viz. atresia, stenosis, malrotation, meconium ileus, Hirschsprung disease, diaphragmatic hernia, necrotizing enterocolitis.

b. Infants and young children:
Strangulated hernia, hypertrophic pyloric stenosis, swallowed foreign body, intussusception.

c. Pre-adolescent:
Acute appendicitis, constipation, mesenteric adenitis, lower urinary tract infection, Merkel's diverticulum, right lower-lobe pneumonia.

Young children may not be able to give a full history. It is thus vital to take as full an account as possible from parents and carers.

Ancillary tests are often inconsistent and abdominal radiographs can be normal with intussusception, appendicitis and malrotation with volvulus.

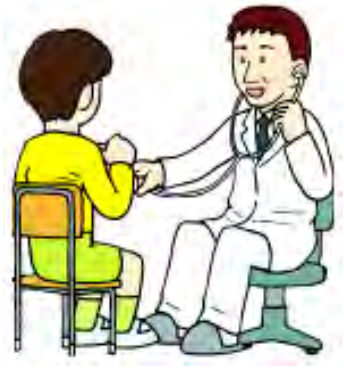
Children can display only lethargy or poor feeding as symptoms and may be happy and playful between bouts of illness, even with serious pathology.

Patience and repeated examinations when the child is quiet are the best way to the correct diagnosis.

Rectal examination has been shown not to have significant effect on the diagnostic accuracy of acute appendicitis. It is distressing and its use should be considered carefully in children.

B. Considerations in Elderly Patients

Four broad pathological categories:
a. Peritonitis
b. Bowel obstruction



Patience and repeated examination when the child is quiet are the best way to the correct diagnosis.

c. Abdominal vascular catastrophe
d. Non-specific/medical causes

Five cardinal medical causes:
a. Inferior myocardial infarction
b. Pleurisy due to pneumonia or infarction
c. Pyelonephritis
d. Inflammatory bowel disease
e. Diabetic ketoacidosis

Elderly patients are more likely to show milder and less specific symptoms and signs, requiring a high index of suspicion and a lower threshold for surgical assessment.

Appropriate attention must be paid to extra-abdominal disease, which must be detected and optimised to improve the higher surgical risk found in the elderly.

The incidence of aortic aneurysm and ischemia is higher, and atrial fibrillation is a significant risk factor for the latter. Angiodysplasia of the colon is much commoner and can be accompanied by massive GI bleeding.

Appendicitis is relatively rarer, but has a significantly higher perforation and complication rate when it does occur.

C. Considerations in Pregnant Patients

a. Non-obstetric causes:
Appendicitis, cholecystitis, intestinal obstruction, urolithiasis, trauma.

b. Obstetric causes :
Pre-term labor, abruption placentae, uterine rupture, adnexal torsion, myomatous red degeneration of uterus, round ligament pain.

As pregnancy advances, intra-abdominal contents shift, and symptoms and signs may differ significantly compared to the non-pregnant abdomen.

Early referral for surgical/obstetric advice is recommended if the diagnosis is uncertain.

Conclusions

1. Careful history and (repeated) examination remain the cornerstones of diagnosis.

2. Diagnostic errors are more likely in older patients (up to 70% compared to 20% of young adults). Have a lower threshold for referring elderly patients.

3. Beware of subtle symptoms and signs in the immunocompromised as well as those with acute or chronic mental impairment.

4. Before deciding to discharge or manage conservatively, exclude potential life threatening causes, e.g. ectopic pregnancy, leaking abdominal aneurysm, or peritonism due to sepsis

5. Document the features that indicate a benign diagnosis.

We may not be able to pin point a diagnosis, and it is often very difficult to distinguish between benign and an evolving acute abdomen. However, many a sleepless night can be avoided when the physician takes the one to two minutes to arrange clear follow-up and give patients specific advice for seeking further help, and recording this advice in the notes. If one is unavailable for consultation after office hours, giving a memo for the emergency department should the pain fail to improve within four to six hours is prudent. If the unexpected happens, the patient himself would at least realise that the problem had been anticipated and should, in all fairness, exonerate the physician from blame. ▮CM

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1. D'Agostino J. Common Abdominal Emergencies in Children. Emerg Med Clin North Am 2002;20(1):139-53
2. Dunning PG and Goldman MD. The Incidence and Value of Rectal Examination in Children with Suspected appendicitis. Ann R Coll Surg 1991;74(3):399-400
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4. Sharp HT. The Acute Abdomen During Pregnancy. Clin Obstet Gynecol 2002;45(2):553-61
5. Kavanagh S. The acute Abdomen- Assessment, Diagnosis and Pitfalls. MPS Casebook 2004;12(1):11-17

Family Practice Skills Course 22

Function & Disability in Primary Care

COURSE STRUCTURE

Unit 1 : Diseases that Result in Disability in Adults
Dr Chan Kin Ming

Unit 2 : Diseases that Result in Disability in Children and Infants
Dr Ong Hian Tat

Unit 3 : Rehabilitation and Coping with Disabilities in Adults
Dr Peter Lim

Unit 4 : Rehabilitation and Coping with Disabilities in Children and Infants
Dr Janice Wong

Unit 5 : Assessment of the 6 ADLs in Adults
Dr Ng Yee Sien & Dr Jung Heeyoune

Unit 6 : Assessment of the 6 ADLs in Children and Infants
Dr Sylvia Choo

Date: 25 & 26 August 2007
Time: 2.00pm - 6.30pm
Venue: to be announced

SEMINARS
(2 Core FM CME Points for each seminar)

Seminar 1 : 25 August 2007 (2.00pm - 4.00pm)
- Unit 1: Diseases that Result in Disability in Adults
- Unit 2: Diseases that Result in Disability in Children and Infants
- Unit 3: Rehabilitation and Coping with Disabilities in Adults

Seminar 2 : 26 August 2007 (2.00pm - 4.00pm)
- Unit 4: Rehabilitation and Coping with Disabilities in Children and Infants
- Unit 5: Assessment of the 6 ADLs in Adults
- Unit 6: Assessment of the 6 ADLs in Children and Infants

WORKSHOPS
(2 Core FM CME Points)

Workshop 1 : 25 August 2007 (4.30pm - 6.30pm)
- Overview of the 3 Disability-related Schemes
- Insurance perspective
- World view & experience in administering disability-related schemes

Workshop 2 : 26 August 2007 (4.30pm - 6.30pm)
- Video demonstration
- Assessment

Further information on this Family Practice Skills Course will be appearing on our website, http://www.cfps.org.sg.

Alternatively, please write to contact@cfps.org.sg for enquiries.

CONTACT US

FUNCTION AND DISABILITY IN PRIMARY CARE SKILLS COURSE
Response Form

☐ "I am interested in the "Function and Disability in Primary Care" Skills Course. Please send me more information."

☐ "I am interested in the development of the disability-related national schemes. Please include me in your mailing list."

Name: Dr _____

MCR No: _____

Mailing Address:

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

_____

_____

_____

Tel: _____ Fax: _____

E-mail: _____

The development of this Family Practice Skills Course is supported by an educational grant from MCYS (Ministry of Community Development, Youth and Sports).

Please mail this completed form to:
College of Family Physicians Singapore
16 College Road #01-02
College of Medicine Building
Singapore 169854

Or fax to 6222 0204.

Fight the Fat

What you must know and do to lose weight

Dr Ben Tan

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

With the recent emphasis on chronic diseases, obesity, diet and exercise has become an important topic for the general physician. In October 2006, the Head and Consultant sports physician at the Changi Sports Medicine Centre and Medical Director of the Singapore Sports Medicine Centre published a book 'Fight the Fat'.

Dr Ben Tan graduated in 1991 from NUS and went on to obtain his Masters in Sports Medicine in 1997 from the world-renown Australian Institute of Sports. His work at Changi Sports Medicine Centre and the Singapore Sports Medicine Centre has been a runaway success. He was also team physician for the Singapore contingents to the 1998 and 2002 Asian Games, and the 1999 and 2001 SEA Games. He was ranked among the world's top 50 sailors before he retired in 1996 from sailing, not before he was awarded Sportsman of the year in 1991, 1994 and 1995. For his contributions, he was awarded the Public Service Medal in 1993, the Public Service Star and Singapore Youth Award in 1995 and the Medal of Commendation in 2004. His personal experience as an outstanding sportsman and illustrious professional makes him an eminently qualified person to write this book.

Scientific jargon is totally left out, but yet the facts would withstand scientific scrutiny.

The book covers the latest definitions of obesity, scientific measurements body weight, the causes and complications of obesity. The chapter on separating facts from myths is a particularly important and convincing chapter to help physicians advise and convince our patients on the various commercial claims and fallacies that abounds today.

The book touches succinctly on the prescription of diet for weight loss, discretionary exercise, incidental daily activities and behavioural strategies. Pharmacological treatment and bariatric surgery is also covered objectively. Written by a sports physician, the book covers exercise in some details.

The book threads on a fine balance between being user friendly and being scientifically accurate. Scientific jargon is totally left out, but yet the facts would withstand scientific scrutiny. As a practicing family physician I was particularly interested in the chapter on behavioural strategies on healthy weight loss and maintenance. Needless to say, the chapter did not disappoint. The anecdotal comments on how the top executives seem to be the ones who reject the no time to exercise excuse was insightful. I shall not give away too much detail here.

Title:
Fight the Fat - What you must know and do to lose weight

Author:
Dr Ben Tan

Imprint:
Marshall Cavendish Edition

ISBN: **981 261 348 X 978 981 261 348 6**

Retail Price:
S$24.00 (before GST)

The 143-page instructional publication by Marshall Cavendish Editions, retailing at S$24.00 excluding GST, is an excellent leisurely read for the busy physician and their patients alike who wants to master the art of weight loss without the need to plough through chunks of statistics and technical details. CM

Family Practice Skills Course 23

Value of Vaccination

COURSE STRUCTURE

Unit 1: **Preventive healthcare – The role of vaccinations in adults**
Dr Wong Sin Yew

Unit 2: **Update on Adult & Paediatric Vaccines Guide 2007**
Dr Lam Mun San, Dr Chong Chia Yin

Unit 3: **Avian Influenza – Are we prepared?**
Dr Helen Oh May Lin

Unit 4: **Cervical Cancer in Singapore – A status check!**
A/Prof Tay Eng Hseon

Unit 5: **HPV Vaccine – A paradigm shift in the prevention of cervical cancer**
A/Prof Tay Sun Kuie

Unit 6: **Travel Vaccination – When, why, how? What is the role of family physicians?**
A/Prof Annelies Wilder-Smith

SEMINARS
(2 Core FM CME Points for each seminar)

Seminar 1 : 15 September 2007 (2.00pm - 4.00pm)
- Unit 1: Preventive healthcare – The role of vaccinations in adults
- Unit 2: Update on Adult & Paediatric Vaccines Guide 2007
- Unit 3: Avian Influenza – Are we prepared?

Seminar 2 : 16 September 2007 (2.00pm - 4.00pm)
- Unit 4: Cervical Cancer in Singapore – A status check!
- Unit 5: HPV Vaccine – A paradigm shift in the prevention of cervical cancer
- Unit 6: Travel Vaccination – When, why, how? What is the role of family physicians?

WORKSHOPS*
(2 Core FM CME Points)
- Practical Skills: cold chain management, injection technique, adverse reactions
- Case Studies: Travel vaccination in various countries

Day 1: 15 September 2007 (4.30pm - 6.30pm)
Day 2: 16 September 2007 (4.30pm - 6.30pm)

*Workshop held on Day 1 is repeated on Day 2. Registration of workshops is on first come first served basis. Limited seats available.

Date: 15 & 16 September 2007

Time: 2.00pm - 6.30pm

Venue: College of Medicine Building, MOH Auditorium

Due to limited seats available, please register by 31 August 2007 to avoid disappointment.

REGISTRATION

VALUE OF VACCINATION SKILLS COURSE
Course Registration Form

Please tick (✓) the appropriate boxes

	College Member	Non-College Member
Seminar 1 (15 Sep 2007)	☐ $10.00	☐ $20.00
Seminar 2 (16 Sep 2007)	☐ $10.00	☐ $20.00
Workshop	☐ $20.00	☐ $40.00
Please choose your preferred workshop date	○ 15 Sep 2007 (Sat)	○ 16 Sep 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 Glaxo Smith Kline.

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