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FAMILY PRACTICE SKILLS COURSE

COLLEGE ART GALLERY

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College of Medicine Building, 16 College Road #01-02
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Tel: (65) 6223 0606 Fax: (65) 6222 0204
E-mail: collegemirror@cfps.org.sg
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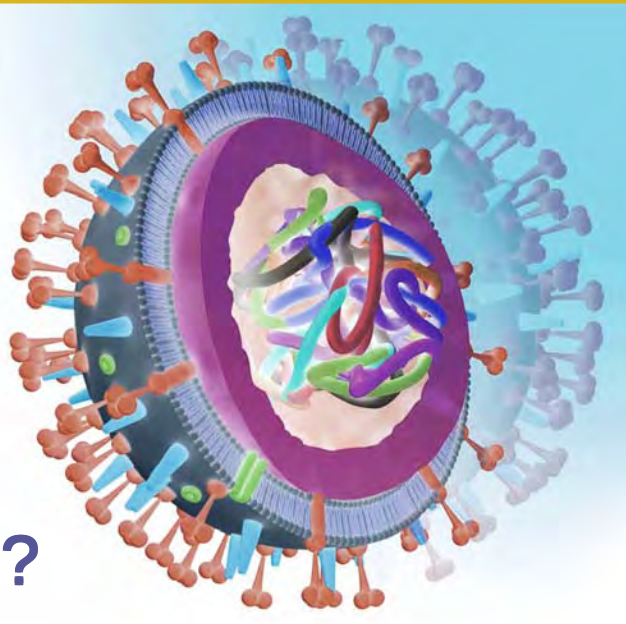
Are You Prepared for an Influenza Pandemic?



The Highly Pathogenic Avian Influenza (HPAI) virus, H5N1, rages on in countries all around us. Human cases of H5N1 are growing with high mortality rates especially in Indonesia, which recorded its 100th death from the disease in January 2008. World health authorities say that it is a matter of "when" and not "if" the virus mutates into a form that is easily transmissible among humans.

So, are you prepared? Not just for the pandemic, but for your first case of suspect Bird Flu? Does your clinic staff know how to don PPE? Does your clinic have sufficient stocks of masks and gloves? Do you have protocols to manage the suspect case safely? Do you have measures to isolate the suspect case to limit the exposure of your staff and patients? Do you have plans to organise your clinic in a pandemic to continue providing primary care to your patients?

Outpatient clinics, both public and private, are an integral part of the primary healthcare system. In a pandemic, it is essential that clinics remain open to continue to provide outpatient care to the community.

World health authorities say that it is a matter of "when" and not "if" the virus mutates into a form that is easily transmissible among humans.

To help clinics serve the community in a pandemic (DORSCON RED), Ministry of Health (MOH) will provide participating clinic staff (1 medical officer + 4 clinic staff) with similar protection as all public healthcare workers. This will include six weeks of N95 masks, gloves, gowns[1] and anti-viral drugs[2] for prophylaxis. Anti-viral drugs will also be provided to treat patients with flu-like

(to page 3)

Hoping for the *Best*, Preparing for the *Worst*

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

Avian Influenza continues to loom in the neighbouring countries. If one were to take a close look at the newspapers, one can find reports of Avian flu almost every day. The worry is not only that the threat seems to be increasing relentlessly as more and more cases are reported in countries closer and closer to home. The other real worry is also that there is a tendency for us to become complacent and adopt a fatalistic attitude. All the over-exposure in the news does not seem to help, after all what can an individual doctor possibly do? We become numb to the media reports, with apathy or indifference creeping in.

We are certainly all hopeful that the flu pandemic will not occur even though it is long overdue, judging from the historical flu pandemic cycles. However, we still must actively take steps to prepare for the worst whilst hoping for the best.

Photo (L to R): Mr Joe Leng (MOH), Dr Irene Lee, Dr Derek Tse, Dr Chong Yeh Woei (SMA),Dr Adrian Ee (Singhealth), Dr David Cheong, Dr Wong Tien Hua.

The National Flu Pandemic Framework for GPs has been in place since last year. MOH, together with College and SMA have been sending letters and emails to invite GPs to participate. In this issue of College Mirror, we highlight the benefits of signing on to the framework.

As part of the GP Framework, the Sengkang cluster of clinics met on 28 February 2008. Representatives from Singhealth and the head of Sengkang Outpatient Department (OPD) sat down with a few GPs in the Sengkang area for an informal lunch. This was a small but significant event that could herald a new beginning in public and private co-operation amongst primary care providers.

The common threat from the flu pandemic may be the catalyst we GPs need to get our act together and to start to work with each other. From the first meeting to establish links with the OPD, more informal meetings can be planned for GPs in the same cluster to meet. Follow-on visits to the OPD, participation in CME activities, and more plans to improve public - private sector shared care are all part of the endless possibilities. After all, the patient pool is finite and ultimately patients move around visiting the doctors within the vicinity. It would serve the community well with more open communication and shared understanding amongst the doctors in the same area.

The common threat from the flu pandemic may be the catalyst we GPs need to get our act together and to start to work with each other.

An interesting "test" situation occurred in January this year when we suddenly had an outbreak of local cases of Chikungunya fever. The first victim was detected by a GP, and when the test results came out positive, she informed MOH. Because of this strong relationship established between a private GP and the government ministries, a potentially serious infectious disease outbreak was averted. We quickly sent our editorial team member, Dr See Toh Kwok Yee, down to talk to her. Read all about her interesting story in this issue. This is a strong case for greater co-operation in the Primary Healthcare sector. Yes we can prepare for the worst, but there is certainly much hope as well. CM

(from page 1 - Are You Prepared...)

symptoms. A generic guide for clinics has been prepared. It provides guidelines on organising a clinic for an influenza pandemic and infection control measures and protocols to protect staff and patients.

A clustering framework has also been established around the polyclinics to assist private clinics, especially the solo practices, to seek information and advice on flu pandemic preparations and response. The framework is for normalcy and when a pandemic hits us, but it needs your collaboration and support now. Commencing in FY 2008, the 18 polyclinics will hold regular meetings with private clinics in their geographical clusters to build rapport and better understand your needs and challenges in preparing for a pandemic. Two sessions were held at Sengkang (28 February) and Choa Chu Kang (13 March).

We hope that you will take advantage of the resources and forums to prepare yourselves and your clinics for the pandemic. MOH recognises that a pandemic is a crisis and we need everyone to pull to continue to provide healthcare to our community. CM

[1] Based on 1 MO + 4 staff per clinic, each clinic will have 15 X N95 masks, 20 X Gowns, 50 pairs of gloves and 50 surgical masks per day. For the duration of the pandemic (6 weeks), clinics can expect a total of about 630 N95 masks, 840 gowns, 2100 pairs of gloves, 2100 surgical masks.

[2] Each clinic staff will receive 4 boxes (40 capsules) of antiviral drugs for prophylaxis. 1 capsule to be taken daily.

A Closer Look at Bill Itemisation

by A/Prof Goh Lee Gan, President, 21st Council, College of Family Physicians Singapore

What is current?

The requirement to make information on fees available to patients is not new. Regulation 4(1) of the PHMC Regulations says that - "The medical practitioner shall make available to the patient prior to the consultation, information on charges which are likely to be incurred for consultation, investigation and treatment. This was also highlighted in the PHMC Guidelines Paragraph 7.9 (1st edition, Jan 1993).

What is new?

Ministry of Health has revised Paragraph 7.9 of the Guidelines. It will be implemented as of 1st April 2008. This revised version was communicated to Licensees of medical and dental clinics in a letter issued by MOH dated 1 October 2007. The document is available at the URL given in Reference 1. See also article on Useful information on Bill Itemisation in this issue of the College Mirror.

The revised version provides information on:

- $ Display of common charges (para 7.9)
- $ Provide information on additional charges (para 7.10)
- $ Bill itemisation (para 7.11)
- $ Option for filling out prescriptions (para 7.12 and para 7.13)

SMA Advisory on bill itemisation (First issued on 21 Feb 2008)

SMA, as a service to members and the medical profession, has published an advisory which was emailed to its members. It will be available soon at the SMA Website.

The SMA Advisory covers the following:

- $ Definitions of professional fees, practice costs, and medications, consumables and other fees.
- $ Two options to itemise bills, namely, (1) itemise into consultation fee (which is the sum of professional fee component and a practice cost component), medications, consumables and other fees; or (2) itemise bills into professional fees, practice costs, and medications, consumables and other fees.
- $ Pricing policy of "charging a fee that reasonable and acceptable to the professional community"; "...charging a fee that enables a sustainable practice that ensures patient safety."
- $ Appendix A - template for a sample bill - consultation fees, medications/investigations/procedures, practice costs, prescription fees, 7% GST where applicable, and total cost.

What should go into the consultation fee?

The consultation fee should be adequate to cover both the practice costs and professional fee of the doctor. Some idea of the costs of providing health care is available in a paper published in the Nov 2007 issue of the SMA News. The paper is available in full text in Pubmed and in the SMA Website. (Reference 3) ■CM

REFERENCES

1. MOH. Revision of private hospitals and medical clinics guidelines - provision of information on charges, bill itemisation and option for filling out prescriptions in medical/dental clinics - a Letter to licensees of medical/dental clinics (1 October 2007). (contains the revised guidelines to the PHMC Regulations and the FAQs). http://www.moh.gov.sg/mohcorp/uploadedFiles/Publications/Guidelines/Private_Healthcare_ Institutions/Provision%20of%20Information%20on%20Charges1-10-2007.pdf.
2. SMA. SMA Advisory on Bill Itemisation first issued on 21 Feb 2008. http://www.sma.org.sg
3. Wong CY et al. 2006 Survey of GP Clinic Practice Costs in Singapore. SMA News Nov 2007; 39(11):10-19.

Useful Information on Bill Itemisation

The following pieces of useful information on bill itemisation are extracted from the following source documents:

- MOH Letter to Licensees of medical/dental clinics (1 Oct 2007)
- SMA Advisory on bill itemisation (first issued on 21 Feb 2008)
- FAQs from MOH Letter and SMA Advisory
- Paper by Wong et al on 2006 Survey of GP Clinic Practice Costs in Singapore published in SMA News Nov 2007: 39(11):10-19.

From MOH Letter 1 Oct 2007

New PHMC Guidelines (paragraphs 7.9 - 7.13)

The revisions to the PHMC Guidelines 7.9 to 7.13 will come into immediate effect from 1 Oct 2007 except sections 7.9 and 7.11 which will come into effect on 1 April 2008.

Provision of Information on Charges

7.9 Display of common charges: Information on the common charges should be prominently displayed within the medical clinic or dental clinic, for example on boards, tent-cards, etc. Supplementary brochures or pamphlets with details of the clinic's charges may also be provided. The charges may be displayed in the form of a fee range and shall include the following types of charges, where applicable:

(a) Consultation fees, e.g. long consultation, short consultation, weekend and public holidays

consultations, after office hours consultations
(b) Vaccination/Immunisation
(c) Health screening and Medical reports

7.10 Providing information on additional charges. Patients should be informed of when additional charges will be incurred, for investigation, treatment, procedures etc.

Bill Itemisation

7.11 Patients should be informed of every item charged for the clinic visit, e.g. consultation fee, medication (itemised) charges, investigation charge, etc. through itemised billing.

Option for filling out Prescriptions

7.12 Patients may either fill out their prescriptions at the clinic or to purchase the medicines from any pharmacy of their choice. They must be given prescriptions to purchase the medicines from any pharmacy of their choice, if they request for it.

7.13 Patients should be informed of this option, either verbally, or by means of notices clearly displayed in the clinic.

FROM SMA ADVISORY ON BILL ITEMISATION (First issued on 21 February 2008)

Definitions of categories of costs that could be itemised (Item 1):

Professional fees. These are earned by providing consultation in a clinical setting. In addition to taking history, performing clinical examination, diagnosis, investigations and procedures, judgment skills are also necessary.

Practice costs. These are derived from the various costs of setting up and running the practice. These various costs include rental deposits, renovation costs, equipping costs, costs incurred in meeting statutory requirements, recurrent monthly costs of rental, manpower costs, utilities, accounting costs, IT costs, etc.

Medications, consumables and other fees. These cover medications and consumables dispensed in the clinic including the costs incurred from purchasing, storage and inventory holding. "Other fees" will include items like blood investigations and imaging either done in-house or outsourced.

Pricing policy (Item 3)

Fees charged should be reasonable and acceptable to the professional community. It is expected that the fees charged for each category and for the items will vary from one practice to another, and from one doctor to another. So long as there is a rational basis for the pricing policy, there need not be undue worry. It is important to charge a fee that enables a sustainable practice that ensures patient safety.

A SELECTION OF FREQUENTLY ASKED QUESTIONS

FROM MOH LETTER (Questions 5, 6, 8, 9, 10, 12, 13)

5. Must I display the actual charges for consultation, vaccination / immunisation, health screening and medical reports?
Yes, if the charges are standard/fixed. Display of charges in the form of a fee range is acceptable, e.g.

Long consultation	$X - $Y
Short consultation	$X - $Y
Vaccination/immunisation	$X - $Y
Health screening	$X - $Y
Medical reports	$X - $Y

6. What do you mean by additional charges?
These are for services that the patient may not expect to need initially, but deemed necessary during or after consultation, e.g. lab/xray investigation, injection, surgical procedures like toilet and suture.

8. What do you mean by bill itemisation?
Every patient has to be presented with a bill. The bill must list every service and the amount that the patient is being charged for.

Example of a bill for treatment of fever, cough and cold:

Consultation fee	$ a
Full blood count	$ b
Panadol	$ c
Clarytyn	$ d
Phensedyl	$ e
Total	$ T

9. Must the itemised billing be computerised?
Not necessary. It can be handwritten or a computer printout.

10. Can I bundle the medication charges as one lump sum?
No. You are required to show each and every medication dispensed and the amount charged.

12. How do I inform patients that they can request for a prescription to buy the medicines from any pharmacy of their choice?
You can either inform your patients verbally during consultation or by displaying the information on notices, tent-cards, boards, etc.

13. Is it my responsibility to source a pharmacy for my patients if they request for a prescription to buy medicines from elsewhere?
It is good doctor-patient relationship if you can advise your patients who prefer to fill out the prescriptions where the nearest pharmacy is, or advise where they can obtain the list of registered pharmacies, i.e. at the Health Sciences Authority's website: http://www.hsa.gov.sg/prism/common/enquirepublic/SearchPharmacy.do?action=load.

FROM SMA Advisory (Questions 1, 2, 3, 6, 7)

1. Will there be a prescribed MOH format for the clinics with regard to how they should display the information on fees and charges?

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Asthma & COPD Management Program

by Prof Lim Tow Keang, Head of Respiratory & Critical Care Medicine
National University Hospital, Yong Loo Lin School of Medicine

Update on the Chronic Disease Management Program (CDMP)

The Ministry of Health has announced recently that asthma and chronic obstructive pulmonary disease (COPD) will be the new conditions included in the CDMP in 2008. New local clinical practice guidelines (CPG) have also been published for COPD in 2007 and Asthma in 2008. These are important milestones for the care of these common respiratory conditions in Singapore. The CDMP enables patients to use Medisave for long term treatment by their family doctors and conversely, it is also an opportunity for the family doctors to review, revise and perhaps upgrade their management of these conditions in line with recent advances.

Phase 0 of the CDMP was launched in 2006 with diabetes as the first condition eligible. This was followed, in phase 1, by hypertension, hyperlipidemia and stroke in 2007. And now, in phase 2 we have asthma and COPD. This scheme now covers the top 5 chronic diseases in Singapore for which treatment is deemed most cost effective.

Since the implementation of the CDMP, >91,000 individual patients have benefitted from withdrawal of over $17m of their Medisave accounts. And over 754 or half of all GP clinics now participate in this scheme, with the effect that, at least one participating clinic is within easy reach of every Singaporean. Even more important than head or dollar counts is the fact that over 90% of claims are linked to key clinical information about the control of disease in each patient. This is a major advance and a critical step in the ongoing process of improving the quality of care for chronic diseases in Singapore.

Diagnostic criteria

For most patients a diagnosis of bronchial asthma can be made with confidence by the GP in the clinic after a history and physical examination. In acutely symptomatic patients, this can be further confirmed by demonstrating a prompt response (preferably documented with serial peak expiratory flow rate measurements) to an inhaled short acting bronchodilator.

For COPD we require a pulmonary function test documenting persistent airways obstruction, a low Forced Expiratory Volume in 1 second (FEV1) expressed as percent of predicted normal, during periods of clinical stability, i.e. NOT during an acute symptomatic exacerbation. Facilities for the measurement of FEV1 are widely available in hospitals and polyclinics and are also made available to GPs. The CDMP only requires a single FEV1 record for enrollment and this may be from a referring source such as from a hospital or another clinic.

The primary goals of treatment

For both asthma and COPD, the primary goals of long term care are to achieve good to excellent symptom control, preserve quality of life and prevent exacerbations. For asthma, achieving control of symptoms will also reduce the risk of death from severe exacerbations.

For COPD only two interventions are proven to prolong survival, cessation of smoking (for all categories of disease severity) and long term home oxygen therapy (LTOT) for persistently hypoxic patients. Medisave withdrawals have already been approved for lease (not out right purchase) of LTOT for many years.

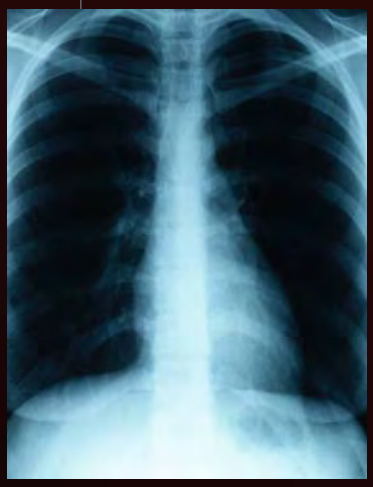
The role of inhalational drugs

These are the mainstay of long term treatment for both asthma and COPD and are likely to constitute the bulk of Medisave withdrawals in the CDMP. The most effective (and expensive) are the combinations of inhaled steroid and long acting bronchodilator in a single inhaler. They are employed to achieve the primary goals described above. Because of the high costs and stakes attached to these drugs, we recommend that doctors directly assess (and where appropriate, to rectify) inhalational techniques whenever these drugs are prescribed for every patient at every visit.

The role of antibiotics

Antibiotic are not indicated for asthma. The majority of asthma exacerbations are not triggered by bacterial (or atypical) infections and do not require anti-microbials. GPs may safely prescribe a short course of oral steroids (say 0.5 mg per kg prednisolone x 5-7 days and STOP with no tail) to treat asthma exacerbations without antibiotics.

Antibiotics are indicated for severe acute exacerbations of COPD which present with increased cough and sputum production and sputum purulence (i.e. all three positives). In the clinic setting, a five-day course of an oral antibiotic may be indicated. We recommend either a beta-lactam agent



or a macrolide. We DO NOT recommend the empirical use of oral quinolones for respiratory tract infections in the clinic setting unless pulmonary tuberculosis have been ruled out with confidence at least with a chest radiograph. By contrast, most patients with exacerbations of COPD will benefit from a short course of oral steroids.

Smoking cessation is grossly under reported in the CDMP

This is a key intervention for both asthma and COPD, in fact it is a universal life preserving intervention and indicated in all individuals. Continued cigarette smoking will negate the effectiveness of expensive inhalational drug treatment in both asthma and COPD. However, results of the CDMP showed that doctors only reported smoking habits in about 6% of patients compared with 78% of HbA1Cs in diabetics, 75% of lipid levels in hyperlipidemias and 66% of repeat Bp measurements in hypertensives. This under reporting of smoking habits is a grave concern and implies that smoking cessation efforts and quit rates (neither of which are required outcome indicators under current CDMP rules) are very low indeed in the primary care setting in Singapore.

Thus, we urge that all GPs implement screening procedures and attempt to institute smoking cessation for ALL patients who enroll in their clinics irregardless of age, sex, ethnic group, disease category and CDMP status.

Influenza vaccination

Annual flu vaccinations are indicated for all above the age of 65 yrs where they are estimated to reduce mortality from all causes by close to 50%. It is also indicated inferentially, for all patients with COPD. Flu vaccines are key performance indicators for American Veterans Administrations (VA) Hospitals where the achievement rate is around 95%. The publicity on the impact of viral respiratory tract infections after the SARS and avian flu outbreaks have made flu vaccines a lot more acceptable to Singaporeans but there is a lot of room for improvement before we even come close to the VA standards.

"...we urge that all GPs implement screening procedures and attempt to institute smoking cessation for all patients..."

Conclusions

The Phase 2 implementation of the CDMP and the launch of a new Asthma and COPD CPGs is an opportunity for us to make a positive long term impact on the burden of these two major chronic respiratory diseases in Singapore. Most of the interest and funding activities will be focused on inhalational drug treatment. However, a lot more effort is needed in promoting the two critical primary preventive measures of smoking cessation and influenza vaccination. ICM

T. K. LIM, MBBS(D), MMed(Int Med), FRCP. Professor.
Senior Consultant, Head, Respiratory & Critical Care Medicine
National University Hospital, Yong Loo Lin School of Medicine. Singapore.
Email: mdclimtk@nus.edu.sg. Office: 6772 4367.

Oil and Wheat Prices are Going Up

But Family Doctors' Prices are Bucking the Trend?

by Dr Ang Choon Kiat, MCFP(S), Family Physician in Private Practice

Less than a year ago, it cost me less than $60 to fill up my car (a modest 1600cc Japanese sedan) with a full-tank of petrol, now it costs more than $90. It is set to increase even more, with oil recently crossing the US$100/barrel level. Wheat prices have likewise gone up. A loaf of Gardenia bread has gone up from $1.90 to $2.20, and for chicken it has increased from $5.60 to $6.40 per whole-bird, a price-hike of 15% in both instances. Egg prices have also increased from $1.30 to $1.60 (for box of 10 eggs), an increase of almost 25%. Now what do chicken and eggs have to do with wheat prices? Well, there is a link - chicken feed on wheat, and eggs come from chicken.

Further back (if my memory serves me right), when I was a primary school boy, to see a GP for URTI cost $10 to $15 with medicines included. Now, it is $25 for URTI at a GP clinic ($20 or less, if it is a company contract with one of those "managed-care organisations" after subtracting their administration fee). That is to say, over the last three decades, the prices have gone up six to ten times for most things which the ordinary man-in-the-street would have to spend on, whilst what the family doctor charges has gone up by only two to three times. It is plain enough to see that we simply have not kept up. Three questions come to mind. Why is it so? Is that good or bad? What can or should we do about it?

First, the "Why?"

The simple answer is "competition". It appears that there is an oversupply of family doctors despite the shortage in the public sector. In any HDB neighborhood centre, besides the already many incumbent older clinics, we will surely see many newer clinics as well. Most of the clinics are empty at least half the time. This oversupply of family doctors results in under-utilisation. (No wonder there are increasing numbers of younger family doctors going into Aesthetics!) With half of each year's cohort of medical graduates ultimately becoming family doctors, the oversupply will worsen, leading to intense competition, and lower prices for all. Come April 2008, the law on itemised billing will take competition to dizzying new heights.

> **"Whilst low prices appear good for the people in the short-term, this may not necessarily be good for patients in the long-term."**

The MOH Polyclinics which provide subsidised primary healthcare also inadvertently "compete" with GP clinics. Originally meant to provide affordable primary medical care for the lower 20th percentile of the population, they are government funded using tax-payers' money. They charge extremely low prices for services and medications, and can still outlast any other sector family doctor. Thus, MOH will increasingly become a victim of its own success - subsiding a greater and greater proportion of the population's primary healthcare at its polyclinics, even for those that do not really need the subsidy. This is unless there is some form of means-testing even at the Polyclinics, which our Health Minister has recently alluded to at his Health Minister's Dialogue at Changi General Hospital in January 2008. However, even with means-testing, it is likely that there will still be some degree of subsidy even for those not classified as "low-income earners".

Other than providing affordable healthcare for the lower 20th percentile, the MOH Polyclinics also offer expensive payable childhood vaccinations in addition to the fully-subsidised free ones. Their economies of scale allow

them to offer the vaccinations at prices below what the private family doctors can offer. The impact on the private family doctors is obvious. As a result, not many GPs stock childhood vaccinations, and those who do, no longer stock up much in their clinics. Likewise, when it comes to drug prices, MOH's tendered drug prices will always be lower than what GPs are able to get. Well, it appears to me that the Polyclinics have forgotten their original mission, which is to provide affordable healthcare for the lower 20th percentile of the population. In so doing, the polyclinics skew market prices downward artificially. It is no longer a truly "free market" where demand versus supply will lead to a reasonable equilibrium in prices.

With the anti-Competition Act now operating in the our primary healthcare market to prevent cartel-style price fixing, the situation seems to me to be grossly unfair to the private primary care physicians. And whilst low prices appear good for the people in the short-term this may not necessarily be good for the patients in the long-term.

Secondly, is lower GP medical fees necessarily good in the long term?

Keen competition has kept private primary healthcare prices low thus far. GP/FPs' consultation fees often appear to be low, sometimes as low as -or even lower- than $10 (equivalent to what my barber charges me). So how do GP/FPs earn a decent income with such low consultation fees? Well, most actually by subsidising the consultation fees they charge with the profit from the medications they dispense in-house. And without itemised billing, since it was harder for customers to compare prices, the GP/FPs were at greater liberty to adjust their consultation fees (both upwards and downwards) they charged individual patients depending on their ability to pay. It is sort of an informal "means-testing". Most patients are having their consultation fees cross-subsidised by their medication fees, even when the patients do not really require it. In other words, most were being undercharged by their GPs by default. Of course, there are those who feel that this lack of transparency is not right and downright unfair. Worst, some may even accuse the GP/FPs of being "dishonest". Another problem is that it cheapens the professional services rendered by the GP/FPs. If the consultation fees charged are a mere $10, wouldn't GPs' professional services be considered worth no more than the neighborhood barbers? No wonder some patients feel that being billed $25 for a 15-minute consultation without medication is an overcharge. (Bear in mind the market locum rate currently is - I believe - $60 to $65/hour.) Therein lies the potential for complaints of overcharging.

"Keen competition has kept private primary healthcare prices low thus far."

Incidentally, a lawyer friend who is in private practice recently revealed to me that their professional fee was between $150 to $400 per hour (not considering high-end lawyers we read about in high-profile cases who are known to charge $1,000/hour), and this includes time spent searching for background information or pondering over the case in the absence of the client. This valid comparison gives perspective to my claims that we GP/FPs in Singapore are undercharging. Perhaps the College might consider finding out what our colleagues in Europe, America and Australia charge.

With itemised billing come April 2008, charges will become more transparent. Patients will then be able to compare prices from different clinics - both the consultation fees charged and the prices of individual medications. I believe that sooner of later, competition will cause medication fees to become more or less the same, following perhaps the formula set out under the "Practice Points 1: Some Acceptible Ways of Pricing Medicines During In-Clinic Dispensing", dated Nov 1998, and published in two SMA publications: SMA Private Practice Handbook, and The Medical Profession and Pharmaceuticals. Note that this document was released almost a decade ago. Whether this formula should be revised is another question altogether, but it appears that the Competition Act precludes it.

I seriously doubt that there is any other business that marks up the selling price of their products by a mere 25%. Look at the neighborhood Kopi Tiams (coffee shops), their cans of soft-drinks like Coke cost them no more than 40 cents (one can buy a carton of 24 cans of Coke at $10.40 from any supermarket), yet they sell them for $1.20 or more. That's a mark-up of at least 300%! We do however need to bear in mind that our in-house dispensing is a service to patients. But if so, meaning it should be kept low, why then do we use it to cross-subsidise our already low consultation fees? Looks to me like we are putting fire to both ends of the rope that we are all holding on to.

So based on administrative, storage, packaging, and dispensing costs, what should a suitable mark-up for the price of our drugs be? That is something each of us has to ponder over. But let's not forget that drugs have a limited shelf-life. The selling prices of our drugs must thus take into consideration losses incurred from expired drugs, as well as the sizeable amount of money that needs to be pre-spent to maintain adequate stocks of drugs in the clinic. If this sizable amount of money is invested elsewhere, surely its returns will not be insignificant. Administrative costs are also not negligible, considering it is often the GP/FP himself who needs to spend time deciding on what, when and how much drugs he needs to order. If only we could study how other SMEs price their products. *(to page 18)*

Dr Ang Choon Kiat Alvin, MCFP(S) *is a family physician practising at "Our Family Physician Clinic & Surgery"*
Blk 829 Tampines Street 81 #01-292, Singapore 520829.

The Chikungunya Story

Interview with Dr SL Sarma

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

When news about the first local Chikungunya case broke on the local media in January this year, family doctors and GPs were all taken aback. First, by the fact that this hitherto little known viral infection would transmit locally and, more astonishingly, that the diagnosis was attributed to a GP!

I am certain that the breaking news had all of us scrambling to refresh our memory about this disease from our text books and the internet, and at the same time, wondering aloud who this doctor was who had made the brilliant diagnosis.

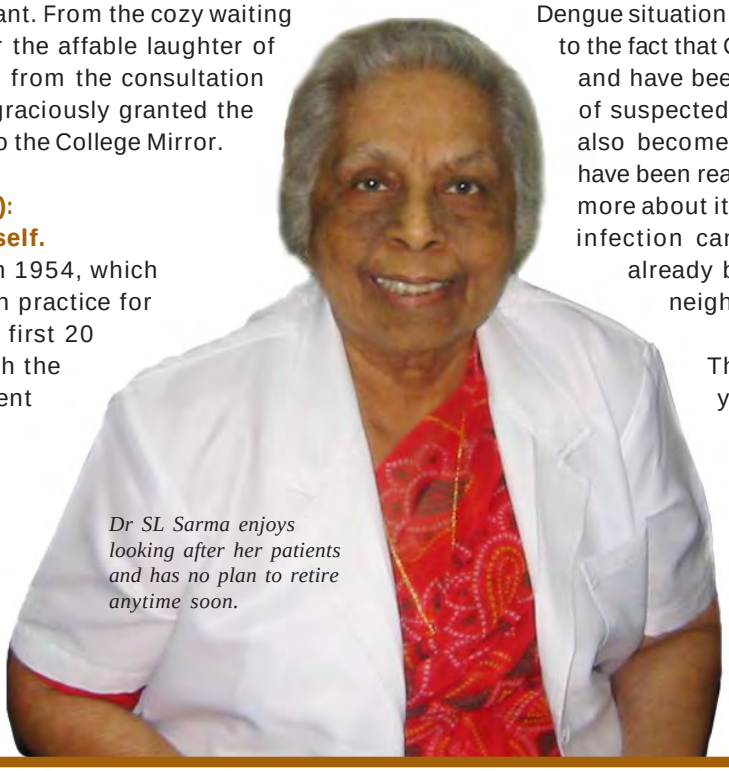
The College Mirror's Editorial Board was likewise curious about the identity of this GP who had done us proud. A search was launched through the grapevine. The trail led to a quaint conservation shophouse clinic in the designated Historic District of Little India owned and run by Dr S.L. Sarma, the protagonist in this medical drama.

Stepping inside, this interviewer was greeted by a pleasant clinic assistant. From the cozy waiting area, one could hear the affable laughter of Dr Sarma emanating from the consultation regularly. She then graciously granted the following interview to the College Mirror.

College Mirror (CM): Tell us about yourself.

I graduated locally in 1954, which means I have been in practice for about 45 years. The first 20 years were spent with the Government Outpatient Service.

I enjoy Family Medicine and General Practice and started my first clinic at the Newton area after I left the government service. I have been in my present practice for the last 12 years and I see a good mix of patients, including workers from the neighbourhood.



Dr SL Sarma enjoys looking after her patients and has no plan to retire anytime soon.

CM: How do you feel being the doctor credited to have diagnosed the first local case of Chikungunya in Singapore?

To have a moment of recognition like this is, of course, both humbling and joyous. I remember the hustle and bustle in the weeks that follow the outbreak with officers from Ministry of Health (MOH) and National Environment Agency (NEA) visiting the vicinity daily. The highlight must be the visit from the Minister of Health himself. I even had a picture taken with Mr Khaw Boon Wan in the clinic! My children and grandchildren were so proud of me.

CM: So how did it all start?

The Environment Health Institute (EHI) of NEA has a network with a number of GPs including myself to monitor the Dengue situation in Singapore. We have been alerted to the fact that Chikungunya share the same vector and have been advised to send blood samples of suspected cases for both infections. I have also become interested in this infection and have been reading up in my private time to learn more about it. I did not doubt that Chikungunya infection can happen here since there had already been pockets of outbreaks in the neighbouring countries previously.

The case that got it started was a young Bengladeshi worker from the nearby Clive Street. He had come to see me for a fever associated with chills, headaches, joint aches, and nausea. What strucks me most was his extreme fatigue; he could hardly walk!

Despite the absence of a travel history, I felt that his presentation could in all possibility be Chikungunya and had sent his serum for definitive testing. Even so, I was still surprised when the results came back as positive!

CM: Your pursuit for knowledge must have contributed to making the diagnosis. Tell us how you keep up.

I attend CMEs regularly. In fact, I always have the CME schedule next to me and will mark off those that I would attend after afternoon clinics. I enjoy updating myself even before CME became compulsory. I have a certificate of attendance for College CME from 1981-1984 by the then College of GP. I also have a certificate in Clinical Hypnotherapy obtained in 1976.

CM: What is your view on Family Medicine today?

Things are tougher now. I recall in the old days, the GP had a wider scope of practice. For example, there were a lot more of antenatal follow-ups, immunisations for babies, children, and travellers. However, nowadays, quite a bit of a GP's work has fallen into the domains of specialists.

CM: How do you relax when you are away from the clinic?

I now work about half the week and relax by spending time with my grandchildren and doing light reading.

CM: Retirement?

Yes, now the children are all grown and independent, I look forward to doing absolutely nothing! However, my heart is still very much with my clinic and my patients whom I enjoy looking after. I have no plans to retire anytime soon.

CM: Thank you, Dr Sarma. ▮CM

Dr Sundari Lily Sarma *is a family physician practising at "Winstedt Clinic", 51 Upper Weld Road, Singapore 207408.*

(from page 4-5: Useful Information on Bill Itemisation)

Clinics are free to design their own format on how the information on fees and charges will be displayed.

2. There are no longer SMA Guidelines on Fees for clinics to follow. How do I know whether I am undercharging or overcharging?

The fees charged should be reasonable and acceptable to the professional community. The Singapore Medical Association has already conducted a survey on GP costs and published it. (CY Wong, K Tan, G Foo, A Chua, YV Lee, TH Wong, YW Chong. 2006 Survey of GP Clinic Practice Costs in Singapore. SMA News 2007: Vol 39(11): 10-19). SMA is also in the process of conducting another survey on specialist charges in the private sector.

3. How should I display and provide the information?

The clinic charges should be displayed prominently on boards, tent cards or notice printouts, and, if necessary, supplemented with printed pamphlets or brochures. The charging information should be prominently and strategically displayed for the convenience of the patients. Verbal advice should also be given if required.

6. How do I fill out prescriptions and pricing of medication?

Four scenarios may arise:

- Scenario A: When a patient obtains medication from a clinic after consultation. The doctor could charge consultation and practice costs together with an appropriate price for the medications dispensed.
- Scenario B: When an existing patient requests for a repeat medication without consultation. The doctor could charge an appropriate price for the medications dispensed together with practice costs.
- Scenario C: When a patient chooses to fill out a prescription at a pharmacy after consultation. The doctor could charge consultation and practice costs only.
- Scenario D: When an existing patient wants a repeat prescription to fill at a pharmacy without consultation. The doctor could charge practice costs and an appropriate prescription charge.

7. How should I price my medication?

Bearing in mind that your medication as itemised would invite scrutiny and comparison with the pharmacies, it would be prudent to price your medication competitively with regard to recommended retail prices. Previously, mark-ups on medication might have been used to cross-subsidise practice costs. With the statutory requirement for bill itemisation, practice costs should be charged to reflect the real cost of dispensing medication in a clinic setting.

PRACTICE COST

Cost of practice and remuneration from 2006 survey and 1996 survey:

Description	2006 Survey (HDB Clnics)			1996 Survey (HDB Clinics)		
Per clinic	Mean	Median	Range	Mean	Median	Range
Number of patients per month	1,162	1000	25 - 5,000	1,283	1,250	225-3,750
Average clinic takings per month	$37,000	$30,000	$3,000-$160,000	$28,570	-	-
Total practice cost per month	$26,412	$20,781	-	$20,971	$16,263	-
Per patient						
Total practice cost per patient	$22.73	$20.78	-	$16.35	$13.01	-
Average doctor's remuneration per patient	$10.33	$12.97	-	$11.38	$ 8.00	-
Total calculated fee per patient	$31.84	$30.00	-	$27.69	$21.01	-
Average fee charged per patient quoted by GP	$29.49	$27.50	$16 - $120	$25.67	-	-

Source: 2006 Survey: Wong et al. SMA News Nov 2007; 1996 Survey: Singh K et al. SMJ May 1997

▮CM

Diabetes Mellitus: Revisited

Family Practice Skills Course 26

FREE REGISTRATION for College Members!

COURSE STRUCTURE

Unit 1 Initial Steps in Effective Management
Dr Melvin Leow

Unit 2 Counselling & Psychosocial Aspects (DAWN Study)
Mr Soren Eik Skovlund

Unit 3 Target for Control in Diabetes
Dr Loh Keh Chuan

Unit 4 Insulin Injection
A/Prof Sum Chee Fang

Unit 5 Foot Care
Dr Lim Hwee Boon

Unit 6 Updates on Diabetes Care
Dr Kevin Tan

Date: **3 & 4 May 2008**
Time: **2.00pm - 6.45pm**
Venue: **Health Promotion Board Building**
3 Second Hospital Avenue

Due to limited seats available, please register by 25 April 2008 to avoid disappointment.

PROGRAMME

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

Seminar 1: 3 May 2008 (2.00pm - 4.15pm)
• Unit 1, Unit 2, Unit 3

Seminar 2: 4 May 2008 (2.00pm - 4.15pm)
• Unit 4, Unit 5, Unit 6

☐ WORKSHOPS* (2 Core FM CME Points - attend 1 day only)

Workshop 1: 3 May 2008 (4.30pm - 6.45pm)
• Case Studies: Preventive and dressings of diabetic foot at risk
• Practical Skills: Insulin pens, injection techniques

Workshop 2: 4 May 2008 (4.30pm - 6.45pm)
• Case Studies: Preventive and dressings of diabetic foot at risk
• Practical Skills: Insulin pens, injection techniques

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

☐ DISTANCE LEARNING MODULE
(6 Core FM CME Points upon completing the MCQ Assessment)
• Read 6 Units of study materials in the Singapore Family Physician Journal and pass the MCQ Assessment.

The development of this Family Practice Skills Course is supported by an educational grant from Novo Nordisk.

REGISTRATION

DIABETES MELLITUS: REVISITED
Course Registration Form

Please tick (✓) the appropriate boxes

	College Member	Non Member
Seminar 1	☐ FREE	☐ $ 20.00
Seminar 2	☐ FREE	☐ $ 20.00
Workshop	☐ FREE	☐ $ 40.00
Your preferred workshop day	○ Saturday ○ Sunday	
Distance Learning (Journal)	FREE	☐ $ 40.00
	TOTAL	

Name: Dr _____

_____

MCR No: _____

Mailing Address:

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

_____

_____

_____

_____

Tel: _____

Fax: _____

E-mail: _____

☐ I attached a cheque for payment of the above, made payable to: College of Family Physicians Singapore.*

Cheque number: _____

Signature:

*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.

Please mail the completed form and cheque payment to:
College of Family Physicians Singapore
16 College Road #01-02, College of Medicine Building,
Singapore 169854.

Or fax your registration form to: 6222 0204

Communicable Diseases of Community Importance

Family Practice Skills Course 27

FREE REGISTRATION for College Members!

COURSE STRUCTURE

Unit 1 Communicable Diseases of Community Importance: An epidemiological overview
Dr Angela Chow

Unit 2 Communicable Disease Surveillance: What do we need to know?
Dr Steven Ooi

Unit 3 Pandemic Influenza Preparedness: Where are we now?
Dr Jeffery Cutter

Unit 4 Dengue Haemorrhagic Fever Prevention and Control: Current update
Dr Ooi Eng Eong

Unit 5 Travel Diseases of Public Health Importance
A/Prof Paul Tambyah

Unit 6 Hepatitis-B: Infection and Complication
Dr Richard Guan

Date: **24 & 25 May 2008**
Time: **2.00pm - 6.45pm**
Venue: **College of Medicine Building, MOH Auditorium**

Due to limited seats available, please register by 16 May 2008 to avoid disappointment.

PROGRAMME

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

Seminar 1: 24 May 2008 (2.00pm - 4.15pm)
• Unit 1, Unit 2, Unit 3

Seminar 2: 25 May 2008 (2.00pm - 4.15pm)
• Unit 4, Unit 5, Unit 6

☐ WORKSHOPS* (2 Core FM CME Points - attend 1 day only)

Workshop 1: 24 May 2008 (4.30pm - 6.45pm)
• Case Studies: Flu preparedness: Primary Care Framework
• Practical Skills: Hepatitis-B infection and complication

Workshop 2: 25 May 2008 (4.30pm - 6.45pm)
• Case Studies: Flu preparedness: Primary Care Framework
• Practical Skills: Hepatitis-B infection and complication

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

☐ DISTANCE LEARNING MODULE
(6 Core FM CME Points upon completing the MCQ Assessment)
• Read 6 Units of study materials in the Singapore Family Physician Journal and pass the MCQ Assessment.

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

REGISTRATION

COMMUNICABLE DISEASES OF COMMUNITY IMPORTANCE
Course Registration Form

Please tick (✓) the appropriate boxes

	College Member	Non Member
Seminar 1	☐ FREE	☐ $ 20.00
Seminar 2	☐ FREE	☐ $ 20.00
Workshop	☐ FREE	☐ $ 40.00
Your preferred workshop day	○ Saturday ○ Sunday	
Distance Learning (Journal)	FREE	☐ $ 40.00
	TOTAL	

Name: Dr _____

_____

MCR No: _____

Mailing Address:

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

_____

_____

_____

_____

Tel: _____

Fax: _____

E-mail: _____

☐ I attached a cheque for payment of the above, made payable to: College of Family Physicians Singapore.*

Cheque number: _____

Signature:

*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.

Please mail the completed form and cheque payment to:
College of Family Physicians Singapore
16 College Road #01-02, College of Medicine Building, Singapore 169854.

Or fax your registration form to: 6222 0204

Allegories *and Myths*

Lessons from the Past

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

In the past issue of the College Mirror, we looked at the philosophical movement called Existentialism and how it may be applied to the family practitioner to help him make some sense of his work as a GP. This month, we will look at two classical writings. The first is Plato's Allegory of the Cave, from his well known work, The Republic, written in 360 B.C.; the second is a more recent work by Albert Camus who wrote an essay about the The Myth of Sisyphus in 1942.

Allegory of the Cave

Plato (427-347 B.C.) was a classical Greek philosopher, the student of Socrates and the teacher of Aristotle. He started a school near Athens called the Academy which was probably the first university in Western history.

In the Allegory of the Cave, Plato asks the reader to imagine a scenario whereby a group of prisoners are chained and trapped in a cave. They have been in this cave since young. The cave is illuminated by a fire that casts a light against a wall, and the prisoners are only able to see the wall on which shadows move. The fire is maintained by the captives, who remain hidden and use puppets resembling plants and animals to cast shadows on the walls. When they speak, their voices echo off the wall and the prisoners would believe that the shadows were talking.

Essentially, the whole setup is a thought experiment in which an artificial world is constructed for these prisoners. The only reality that they experience is the shadows of the images.

Plato then asks the reader to suppose that one of these prisoners is released. This freed prisoner would run away towards the opening of the cave, but he will be immediately blinded by the intense sunlight from the outside world. His vision will be blurred as he is not accustomed to the light. The objects that he is able to see would appear less real than the shadows back in the cave. Once out of the cave, as he slowly adjusts to the new levels of light, he starts to see more and more of the vast world that exists outside his cave. The last object he would be able to see is the sun. He will eventually learn that the sun is the source of the seasons of the year, and provides the light required in the visible world.

The freed prisoner, having seen the 'light', remembers his friends still trapped in the cave and is compelled to return to free them. He returns to the dark cave and once again finds himself having to re-adjust his eyes to the darkness within. He finds his friends where he had left them, and tries to describe the outside world by explaining the objects behind each of the shadows. However his eyes are unable to see the darkened images as well as before. His fellow prisoners are therefore not convinced, but paradoxically conclude that exposure to the outside world has damaged his eyes.

Reflections

The short summary of Plato's Allegory is that it describes the state of the unenlightened, who cannot even believe that enlightenment exists. One interesting fact which you may have noticed is that The Matrix series of films have been found to contain elements of this story.

In the GP context, one is reminded of the not-too-distant past, in the pre-CME era, when a GP could set up his own practice almost in isolation and then continue on to see patients happily ever after. Continued Medical Education (CME) was introduced as it was felt that GPs, like their fellow colleagues working in the institutions, needed to keep pace with the rapidly changing and advancing medical landscape. Although many GPs were already updating themselves via self reading and attending lectures and seminars, the whole process was not regulated and was haphazard.

The truth of the matter was that a GP could go on practicing without having to update his knowledge after finishing his basic degree. When CME was first mooted, not everyone embraced the idea with open arms. The situation today is happily quite different as CME is now here to stay, and is part of every doctor's accepted duty to comply. In fact, many GPs have far exceeded the minimum 50 points required over two years. One piece of good news is that there will no longer be any limit to the CME self study returns for the Family Practice Skills Courses, previously limited to four. In 2007, a total of six FPSC courses were organised by the College, meaning that GPs had a potential of fulfilling 36 CME self study points within that year.

The Allegory of the Cave also talks about different levels of

enlightenment. This could apply to the numerous post graduate courses now available in Family Medicine. Starting with the GDFM, advancing to MMed Programmes A and B for Family Physician trainees and Private Practitioners respectively, and leading on to the MCFP, and finally, the FCFP. Critics of these programmes would argue whether or not it is necessary to train GPs to such a degree. However, successful graduates of these programmes have gone on to take leading positions in various institutions. Even solo GPs have been spurred on, as each level of achievement breathes a new understanding and fresh perspective to the vocation called Family Medicine.

"...we are all prisoners of our own perceptions and that the tangible world is our cave."

Plato in his allegory was trying to say that one has to approach the world of learning with open-mindedness. In a sense, we are all prisoners of our own perceptions and that the tangible world is our cave. Should we be happy and content to exist within our own comfort zones, or should we be like the escaped prisoner who ascends into the 'light' of knowledge? This is something we must think about.

The Myth of Sisyphus

The Myth of Sisyphus is a philosophical essay by Albert Camus. It was first published in French in 1942. In the last chapter of this book, Camus explores the legendary Greek mythology of Sisyphus. Sisyphus was a king who tried to save humanity by putting Death in chains. He tried to deceive the gods but did not succeed. As his punishment, the gods condemned Sisyphus to an eternity of rolling a rock to the top of a mountain, only to watch it roll down again. This process would be repeated in an unending cycle. The gods thought that this punishment of futile and hopeless labour was worse than death.

The situation Sisyphus was faced with is analogous to the human condition of perpetual struggle, sometimes with little meaning. Camus therefore finds this story to be a metaphor for modern lives, saying "The workman of today works every day in his life at the same tasks, and this fate is no less absurd. But it is tragic only at the rare moments when it becomes conscious".

In his analysis, Camus saw Sisyphus as an absurd hero; Sisyphus is different in his attitude towards his seemingly hopeless situation. Each time he pushes the rock to the top of the mountain, there is a brief moment when Sisyphus becomes conscious of himself, realises the absurdity of his actions, and thus accepts it as it is (there is a similarity here to the Five Stages of Grief described by Kübler-Ross, moving from denial, anger, bargaining, depression, and finally, acceptance). Sisyphus does not give up. He strives for the sake of human dignity by continuing on in his repetitive task. This conscious realisation by Sisyphus ultimately defeats the gods who sentenced him because he has found consolation in his struggle. Camus concludes by writing that "One must imagine Sisyphus happy".

So for Camus, the difference between happiness and despair lies in the ability of that person for conscious reflection. In other words, we all need to take a good hard look to recognise our life situations and learn to live within the limits set by them.

Application

Repetitive work is a fact of life for most people in the workforce. Be it the street cleaner toiling away daily up and down the same street, or the commercial pilot rushing from one flight to the next. Repetition may not necessarily be a bad thing for it is through this that experience is gradually built. Repetition is also necessary to give order and predictability to work life because a constantly changing work environment is stressful.

A doctor's work is no different. This is especially true for GPs, who spend long hours in their clinics tending to a ceaseless queue of needy patients. Even for the young doctor who starts out enthusiastically, the constant long hours and high patient loads can take a personal toll. The worry is when this task becomes such a burden that the doctor feels that his work has lost its meaning. Burn-out is a reality if left unchecked.

So what can we learn from the example of Sisyphus? We need to take time for conscious reflection - think through and reflect on one's personal values and priorities. It is surprising that many people go through life from day to day without figuring out what one wants from it. Remember our calling when we first decided to embark on Medicine as a career. We need to keep the passion alive by reminding ourselves on the important role GPs play as primary care givers in the community. Finally, just like our absurd hero, Sisyphus, we need to always be an optimist in the course of dealing with our patients' problems. The repetitious cycle of pushing the rock uphill only to have it roll down again would be futile if meaning is not derived from the struggle and toil. **CM**

(Photos by Dr Wong Tien Hua)

Beyond the Albert & Mary Lim Award

Interview with Dr Ling Sing Lin and Dr Yii Hee Seng

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

In November 2007, the College of Family Physicians Singapore presented the prestigious Albert and Mary Lim Award 2007 to Drs Ling Sing Lin, Yii Hee Seng, and Tan See Leng for their outstanding contributions to the College and to family medicine over the years.

Dr Ling Sing Lin was awarded the Fellow of the College in 1997 in recognition of her contribution to the development of family medicine in Singapore, and her support to the College's development. She played a key role in the development of family medicine as a postgraduate discipline since the very beginning, and was the Chairman of the Family Medicine Committee until her retirement last year, making up a total of 19 years of commitment to postgraduate family medicine in Singapore.

Dr Yii Hee Seng served in various capacities in the College from 2003-2007. He was Council Treasurer, Council Member, and in the Administration Committee, Finance Committee and Membership Committee. He was Chairman of the College's 25th Anniversary Committee which included the Scientific Conference that year. He is also Clinical Teacher in the Undergraduate Family Medicine Programme, and internal examiner in the Graduate Diploma Examination.

Dr Tan See Leng served as a Member of the College Council for ten years (1997-2007), and contributed greatly to the development of the College and its financial stability. He served as Treasurer, was in the Administration Committee, the Membership Committee, and was Chairman of the Wonca Host Organising Committee which successfully hosted the 18th Wonca World Conference in July 2007.

College Mirror had the honour of interviewing Dr Ling (LSL) and Dr Yii (YHS), tapping on their thoughts and insights gleaned from years of service and contribution.

CM: In your years of service and contribution to the College, what significant changes have you seen in the College and family medicine?

YHS: Quite a few changes, but I would firstly say that the College had been in existence for a long time before I got involved with the Council. Our predecessors obviously put in a lot of their time, sweat, and toil to start the College and gain the respect of the Ministry of Health as well as our specialist colleagues. Some significant changes that come to mind include:

a) Creating and starting the MMed (FM) programme and exams, the GDFM training programme and exams. Along the way, other Diploma programmes were started as well.

b) Structured training programmes for all family physicians, whether or not they take the exams. When CME became compulsory, the College took the opportunity to come up with modules, each covering one area or topic of interest to the family physician. These programmes enables our family physicians, myself included, to update our knowledge and yet secure CME points necessary to renew our registration with SMC. Our programmes are now recognised, and MOH even sponsors FM trainees to attend them.

c) College Finances - we used to be in the red, but when Dr Tan See Leng (our other awardee) become Treasurer, he put in a great deal of effort to generate revenue for programmes designed and delivered by the College, with much of it coming from sponsors. With surpluses, the College had to come up with proper governance to ensure our money is safeguarded and spent wisely.

LSL: I believe FM has progressed tremendously in the last 20 years. The College leadership worked extremely hard, literally burning the midnight oil in the early years, drawing up the training programmes for the first groups of trainees. We now have a

sizable group of GPs who are trained specifically in FM, who can deal confidently and competently with a whole range of medical problems. GPs can hold their heads up high, on par with their specialist colleagues. Moreover, some of those fortunate enough to be trained are coming back to train future batches of GPs, rapidly growing this group of FM trained doctors.

"I was determined to play a part to improve FM in Singapore before I retired from my job."

CM: What do you think is the College's strength(s), and how can it influence the landscape of healthcare in the next few years?

LSL: The College comprises a respected professional group of altruistic and well intentioned GPs with the advancement of FM in mind. Its leadership has been unstinting in giving of their precious and limited time and expertise to further develop FM in Singapore, and even beyond Singapore. With the political will to improve the care of chronic diseases like diabetes, hypertension, hyperlipidaemia and stroke, hand in hand with the College and GPs in Singapore, I foresee Singapore taking the lead in quality care for such diseases. This will lead to fewer complications from these diseases and reduced morbidity in the health landscape.

YHS: The College has always managed to attract a core group of highly motivated and energetic family physicians who contribute without expecting any material rewards, and enabled us to overcome many daunting challenges and obstacles along the way. The team harnesses the talents, strengths and energy of each and every one, and this helps propel the College forwards.

CM: What motivated you to serve tirelessly in the College Council and Committees?

YHS: To be really honest, I got into the Council by chance. I happened to be around COMB when the AGM was being held one afternoon, and I was asked to attend and sign in to help achieve the quorum. Little did I expect to be elected into the Council. After that, I realised that the College does a great deal of work that is so important to bring family medicine to a higher plane. I could see that the leaders of the College were visionary and worked really hard to achieve their vision. Often the only reward they have is the satisfaction of seeing the trees growing from the seeds they plant and nurture. It was a privilege to work with these leaders and I simply contributed in whatever small way I could.

CM: And Dr Ling? What got you started contributing to FM, on top of your Ministry responsibilities?

LSL: Because I was in charge of the government polyclinics at the time, by default I was tasked to sit on the Committee for Family Medicine (tripartite committee from NUS, College, and MOH), even though I was not trained in FM. Nevertheless, I was convinced that GPs in Singapore could do a lot more than just refer to specialists whenever they came across anything more complex. The medical undergraduate programme did not provide enough training to be a good GP, hence post graduate training was absolutely necessary. Together with representatives from the College, we made several trips to UK to study the National Health Service's GP system and FM training system, and I was determined to play a part to improve FM in Singapore before I retired from my job.

CM: Do you have any advice for our younger GPs/ family physicians in Singapore?

LSL: I would like to encourage the younger GPs to avail themselves to training opportunities, to improve their knowledge, ability, and skills. I realise it is a great sacrifice for some, at the expense of family and social life, to study and attend tutorials and ward rounds to cover the breadth and depth of FM. However, the more you put in, the more you get out of it, as in any venture. At least, the option of training is open to them. The older GPs never had this opportunity, and some of the more experienced GPs without FM training even taught the early batches of FM trainees. We should show them our gratitude.

YHS: I wouldn't call it "advice" but perhaps will simply encourage all to pursue their passion. If family medicine is our passion, we must go all the way to ensure we receive appropriate and adequate training, and continue upgrading ourselves and keeping up with progress and development. We must all upgrade our services. It is a pity to see the polyclinics upgrading and improving continuously while many GP clinics remain in the same state or deteriorate over the years. We must also harness technology in our work to help improve efficiency and productivity. Till today, a large number of GP clinics do not have any computers and things are still done manually. Family physicians should learn to work together rather than see each other as competitors. If you have an interest to train the next generation of family physicians, or have some skills to contribute, support the College and contribute your time and energy! The College is the lifeline of the family medicine fraternity. ▮CM

"Family physicians should learn to work together rather than see each other as competitors."

(from page 8-9: Oil Prices...)

At the "Conversations with MOH" dialogue in Oct 2007, nine out of the 10 GPs seated at my table felt that itemised billing was a bad idea. I was not the exception. A very senior and respected GP felt that it would encourage doctor-hopping, contrary to the Health Minister's vision of "a family physician for every Singaporean". The reason? Well, Singaporeans will surely choose what appears to be "cheap and good". Thus, more doctor-hopping can be expected.

Whilst what is "cheap" is easy to decide, what is "good" is not so straightforward or apparent to patients. "Penny-wise pound-foolish" can often be used to describe many of our local patients, who often "play being doctor" in an attempt to save themselves "pennies", only to pay "pounds" later when they develop complications or even risk their lives. I am sure each of us can easily recall many such patients from our practice.

So, if most flock go to the "less expensive" GP/FPs, what will happen to GP/FPs who believe in being thorough, comprehensive, and in spending good time understanding the patients' concerns, counselling and educating these patients? If these GP/FPs are not able to retain sufficient patients to make their business viable, they will then be confronted by two choices. They can charge much less and hope to see more patients, but then have less time to do what they believe in doing. Alternatively, these GPs can call it quit - close their practice, and retire if they are old; or if they are still young, to emigrate or change profession - perhaps become a lawyer specialising in medical litigation. A man's practice style is rooted in his conviction and to be forced to change would be tantamount to betraying himself. Thus, it is obvious which he would more likely choose. Either way, it would be a loss to Singapore - a loss of many competent GPs with passion in their profession and art. Would this benefit Singaporeans in the long term? The answer I believe is an obvious "no". Furthermore, medical litigation cases would result in worsening public's opinion of family doctors.

"In the light of the current and inevitable inflation, would we be willing to accept a stagnating or even a decreasing income without shorter hours due to more acute competition?"

We do need to be mindful that as Singaporeans become better educated and life expectancy rises, patients' expectations of their family doctors rise as well. They increasingly expect us to be thorough, to explain the basis of our decisions or advice, and want to participate in decision-making with regards to their treatment options and medications.

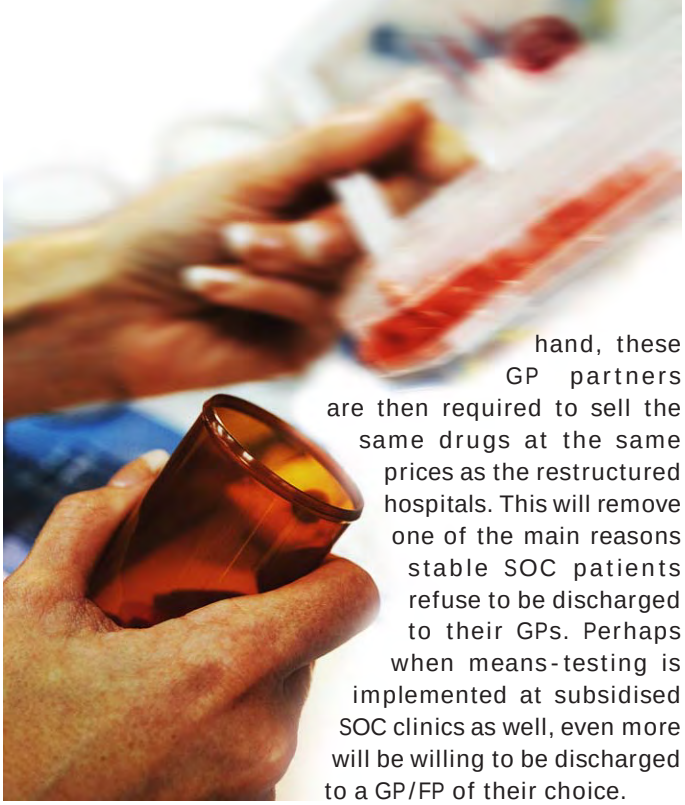
Whilst it is always a good thing when patients want to take ownership of their medical and health problems, it does behoove us that we are competent and deliver on the public's rising expectations of our profession. In this regard, the College should be commended on its untiring efforts to train family physicians through the years. However, will not delivering on such increasing expectations require longer consultation times? And if we do spend more time on the patients, should we not charge more? What if by not mentioning certain uncommon complications of medications we intend to use (because of "time-constraints"), our patient inadvertently develop it, and then turn around and blame us for not having fore-warned him, and proceeds to sue us for it? In such a case, explaining that we omitted doing so in order to shorten our consulting time so as to charge less in a highly competitive market, is not really going to be acceptable in court.

What about the next generation of family doctors? If competition results in continued erosion in the GP/FPs' incomes and yet continued long working hours, not many would aspire to become the FPs of tomorrow. In the light of the current and inevitable inflation, would we be willing to accept a stagnating or even a decreasing income without shorter hours due to more acute competition? Why bother with post-graduate training in family medicine when it does not appear to be commensurate in income? What is there to keep those who have advanced training from emigrating to developed first world countries for want of better pay commensurate with their expertise. The health of our people will suffer. It would be a national loss. Who should take action? Is it MOH or should it be us? I say it should be both.

Third, what can or should we do about it?

MOH has a perennial problem. The restructured hospitals' Specialist Outpatient Clinics are overstretched as many stable patients are being followed up unnecessarily at the tertiary institution. It is a waste of the more expensive hospital resources for it to continue to be so. The GP-Specialist partnership programmes were introduced to allow such patients to be discharged to the under-utilised GPs. Yet few of these stable patients have done so. The reasons? For one, the prices of the restructured hospitals' medications are much lower than the private sector, being heavily subsidised. For another, there is the perception that specialist-care is superior.

I would like to suggest that when MOH regularly calls for tenders, they could oblige pharmaceutical companies to sell the same drugs at the same prices to SingHealth and NHG's GP partners. These pharmaceutical companies should be pleased with the prospect of having more business. On the other



hand, these GP partners are then required to sell the same drugs at the same prices as the restructured hospitals. This will remove one of the main reasons stable SOC patients refuse to be discharged to their GPs. Perhaps when means-testing is implemented at subsidised SOC clinics as well, even more will be willing to be discharged to a GP/FP of their choice.

Section 34(1) of the Competition Act prohibits "...decisions by associations of ... concerted practices which have ... as their effect the prevention, restriction or distortion of competition within Singapore ... unless they are exempt". Ironically, MOH - in providing greatly subsidised primary care at the Polyclinics - has already distorted competition within Singapore. So, now neither SMA nor the College can recommend fees, unless our Health Minister is able to get Parliament to approve an amendment to this act, specifically exempting College, SMA or even SMC from the Act. The reason? That unbridled competition in medical fees is ultimately bad for the public, in a market already skewed by the Polyclinics. Possible? I doubt it, at least for now. Perhaps when the "bad" has begun to happen. But seriously, do we really want to wait until then? Until the exemption comes about, if ever at all, what can we do?

Should we be passive and allow the status quo to continue and watch the situation degenerate before our very eyes? I say "no". There is something each of us can do.

On my part, my drug prices will loosely follow the decade-old "Some Acceptible Ways of Pricing Medicines During In-Clinic Dispensing", as my prices should not be higher than what the pharmacies will charge, as patients will have the right to request that I write them a prescription for it to be filled at any pharmacy with an in-house pharmacist. However, for medicines not available at pharmacies, not listed in MIMS, and where the Distributor's list price are not available, I believe a mark-up of 33% to 50% would be more appropriate. For my consultation fee, my guideline would be a minimum charge of $25 for short consultations, and to charge $2 to $3 per minute of consultation time for longer consultations, depending on the complexity and number of conditions seen, and the expertise required. That is not to say that I cannot or will not charge less for the genuine needy cases. I arrived at this figure based on the current locum rates of $60 to $65 per hour. If I am already paying locums

$1/minute, shouldn't my minute-rate be higher, in order to make up for lull periods when the locum is still being paid but not generating any income for me. Whatever it is, patients should pay based on time, and it should not be so low that it "cheapens" our profession. Consultation fees would be higher if we spend more time with the selected patients whose conditions warrant it, and lower if straight-forward and simple. The merit of having a minute-rate is that patients will then come to a more accurate perception of the value our professional service.

Each GP/FP can decide for themselves how they wish to charge, but remember that by having very low profit margins, we might be exposed to an increased likelihood of medical errors that the public is increasingly less tolerant of. The way I see it, with more GP/FPs in the years to come, the only way is for each of us to upgrade ourselves, and then for each of us to offer quality medical care, which will require more time with each patient, and which will then justify charging higher consultation fees. With more time needed to see each patient, each GP/FP may not be able to see as many patients, but collectively, we can provide better medical care for the entire population. Perhaps then, it will truly become "a family physician for every Singaporean". As Barack Obama, who may well become the next and first black US president, said in his campaign speech at the start of this new year, "Our time for change has come." ▮CM

Summary

1. Our medical fees have not kept up with inflation.
2. Competition from the MOH Polyclinics and amongst private family clinics are the reason. Ours is not a truly free market, yet the Competition Act applies to us. It is a double blow that threatens to knock us out.
3. I believe itemised billing will make competition even more acute.
4. If we continue to compete by merely lowering our fees, there is a very real danger that we be tempted to "cut corners", with its attendant negative implications for the patients that we serve, for ourselves, and for our noble profession. Some good family doctors may throw in the towel and leave, but that would be a great loss to the nation.
5. There are things MOH and perhaps the government may be able to do to help the situation (e.g. exempting our GP/FPs from the Competition Act), but we should do something about it ourselves as well.
6. Its time we raise the bar by upgrading ourselves, spend more time with each patient, e.g. by doing the ABCDs of Stott Davis' framework of consultation, and charge more instead of less for the better medical service we render.
7. In so doing, we shall collectively raise the standard of primary care for the entire nation, yet have enough work for all of us, and earn a decent income for our years of hard work and sacrifices made in pursuit of excellence in our chosen profession and calling.
8. Will you contribute to the extinction of the family physician in Singapore? Or will you help make this the turning point in the history of family medicine in Singapore, and help bring about what could be the Golden Age of family medicine in our nation? Your decision counts. What will you choose to do today? Change the situation, or let the situation change you? ▮CM

Family Practice Skills Course 24

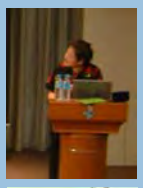
Risk Factors in Macrovascular Disease

The College of Family Physicians Singapore would like to thank **Pfizer** and the Expert Panel for their contribution to the Family Practice Skills Course on **"Risk Factors in Macrovascular Disease"**, 27-28 October 2007.

Thank you!

Dr TAY JAM CHIN - Senior Consultant, Acting Head General Medicine Department II, TTSH

Dr LIM TAI TIAN - Consultant Cardiologist and Physician, Visiting Consultant, National Heart Centre



Ms GLADYS WONG - Chief Dietitian/Manager, Alexandra Hospital

Dr BEN TAN - Head & Senior Consultant Sports Physician, Changi Sports Medicine Centre, CGH

Dr ONG KIAN CHUNG - Consultant Respiratory Physician, Mount Elizabeth Medical Centre

Dr RAYMOND LEE - Consultant Cardiologist, Department of Cardiology, TTSH

Ms DAISY KWOK - Strength and Conditioning Coach, Changi Sports Medicine Centre, CGH

Chairmen:
Dr LEW YII JEN
and
Dr JASON YAP

From the Ministry of Health

As of 1 Aug 2007, the Ministry of Health (MOH) has allowed the use of rapid HIV Test kits for HIV screening in medical clinics. An MOH circular dated 1 Aug 2007 was sent to all licensees of medical clinics, informing clinics that they would have to participate in MOH training workshops on the use of the rapid HIV test kits if they wished to offer rapid HIV testing services.

Only clinics which have participated in these MOH training workshops will be allowed to offer rapid HIV testing.

Clinics which have missed the training workshops in 2007 but still wish to offer rapid HIV testing services should fill up and fax in the form found on the MOH website (http://www.moh.gov.sg/mohcorp/currentissues.aspx?id=17036).

Clinics which have already participated in MOH training workshops on rapid HIV testing in 2007 are not required to re-attend training workshops in 2008.

Rules, Scores, and Criteria

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

Just when you thought you have had enough of CPG's to last a couple of life-times, here are still more rules, scores and criteria which I hope will help you improve your game!

1. To X-Ray or not to X-ray, that is the question

The Ottawa Rules: predict the need radiography if any criterion is present in any of the following situation:

a. Knee
i. >55years
ii. Pain isolated to the patella
iii. Tenderness at head of the fibular
iv. Inability to flex knee to 90
v. Inability to bear weight for 4 steps

b. Ankle
i. Bony tenderness at posterior edge or tip of the lateral malleolus
ii. Bony tenderness at posterior edge or tip of the medial malleolus
iii. Inability to bear weight both immediately and at the clinic

c. Foot
i. Bone tenderness at base of the 5th metatarsus
ii. Bone tenderness at the navicular
iii. Inability to bear weight both immediately and at the clinic

2. To send home or to refer?

What if it turns out to be just constipation colic? Here's some help with the **Alvarado Appendicitis** score.

Score: 0 Appendicitis less likely

Assessment	
<5	Appendicitis less likely
5-6	Possible appendicitis
7-8	Probably appendicitis
>8	Very probably appendicitis

Migration of pain to right lower quadrant?	○ Yes (1 point)	○ No (0 point)
Anorexia, or acetone in urine?	○ Yes (1 point)	○ No (0 point)
Nausea-vomiting?	○ Yes (1 point)	○ No (0 point)
Right lower quadrant tenderness?	○ Yes (1 point)	○ No (0 point)
Rebound pain?	○ Yes (1 point)	○ No (0 point)
Fever?	○ Yes (1 point)	○ No (0 point)
White blood cell count over 10K?	○ Yes (1 point)	○ No (0 point)
Left shift (over 75% neutrophils)?	○ Yes (1 point)	○ No (0 point)

3. "But Homan's sign was negative..."

Because of the unreliability of clinical features several diagnostic scoring system have been validated whereby patients are classified as having a high, intermediate, or low probability of developing deep vein thrombosis, based on history and clinical examination. **Wells Diagnostic Algorithm** for DVT is a good one to know.

Wells Diagnostic Algorithm

Active cancer with ongoing treatment or treatment within the previous 6 months or palliative care	1 pt
Paralysis, paresis, or recent immobilisation of the legs in plaster	1 pt
Recently confined to bed for more than 3 days or major surgery within 4 weeks	1 pt
Localised tenderness along the distribution of the deep venous system	1 pt
Whole leg swollen	1 pt
Calf swelling by more than 3 cm compared with the asymptomatic leg (measured 10 cm below the tibial tuberosity)	1 pt
Pitting oedema more marked in the symptomatic leg	1 pt
Collateral superficial veins, not varicose veins	1 pt
Alternative diagnosis as likely or more likely than DVT	-2 pts

Score = 0, low probability. Score = 1 or 2, moderate probability. Score = 3 or more, high probability.

4. "Hey Doc, I've got this migraine in my head..." or other similar expressions.

Because migraine without aura does not have a single distinguishing feature, the **IHS Criteria for Migraine without Aura** require the presence of a constellation of symptoms.

IHS Criteria for Migraine without Aura*

Headache Descriptions (Any 2)	Associated Symptoms (Any 1)
- Unilateral - Pulsatile quality - Moderate to severe pain intensity - Aggravation by or causing avoidance of routine physical activity	- Nausea and/or vomiting - Photophobia and phonophobia

*Must have 5 attacks fulfilling the above criteria and no signs of a secondary headache disorder. The headaches last 4-72 hours

Migraine comfort signs:
(i.e. most probably migraine and not tumor,etc)
a. Positive family history of migraine
b. Headache related to menstrual cycle
c. Headaches preceded by typical aura
d. Headaches remaining periodic and stable over time
e. Normal physical and neurologic findings ■CM