



THE College Mirror

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COLLEGE ART GALLERY



BLUE AND WHITE VASE DECORATED WITH FLOWERS DESIGN
Chin Dynasty (1875-1912)

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The Value of Medicine Today

Opening address by Mr Khaw Boon Wan, Minister for Health, at the Singapore Disease Management Conference 2008 & 1st International Conference on Healthcare Transformation

"What Value, Medicine?"

“L ast month, there was an active debate on aesthetic treatment in Singapore. It is a thriving business and there is a strong demand to look good and this demand will continue to grow. As treatments become more invasive and surgeries to shape the body become more common, plastic surgeons are voicing concerns about patient safety. From the initial concern about safety, the public debate quickly moved into the ethical issues of whether doctors should even provide procedures without strong scientific evidence of benefits like mesotherapy.



“From the initial concern about safety, the public debate quickly moved into the ethical issues of whether doctors should even provide procedures... like mesotherapy.”

What's Happening to Medicine?

The debate prompted a former MP and a respected family physician, Dr Tan Cheng Bock to write a thoughtful piece in the newspaper. It was titled: "What's happening to medicine?" As he sees it: "Aesthetics is... not medical practice. It does not heal but only enhances appearances. The practitioner of aesthetics is not treating sick patients but healthy individuals".

Dr Tan lamented that with the growth of the industry, doctors would be tempted to "shift their emphasis from healing the sick to undertaking the more lucrative practice". He therefore worried about the future of our national healthcare programmes, "such as the current chronic disease management of diabetes and high blood pressure".

(to page 5)

Family Practice *and Quality*



by Dr Shiao Ee Leng, MCFP(S), Editor

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2007 - 2009

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This issue of The College Mirror will feature and report many events highly relevant to all Family Physicians. First on our headline news is the complete and unabridged speech of our Minister of Health, Mr Khaw Boon Wan at the opening of the Singapore Disease Management Conference 2008 & 1st International Conference on Healthcare Transformation. He explained the plan of the Ministry of Health to empower the private sector of Family Physicians by involving us all in nationwide screening programme, extending the Chronic Disease Management programmes to include more chronic diseases, and extending the PCPS scheme even for chronic diseases. This is a hard fought victory for all Family Physicians, and we hope that with greater participation we can elevate the standard of healthcare in our society.

A/Prof Goh Lee Gan, then shares about the need make to invoke the support of the 4Ps in realising the mainstreaming of family medicine : viz the people (the managed care and employers), the press, the policy makers, and the profession (the Family Physicians and their training).

Next comes the inspirational interview with Dr Julian Lim, one of the pioneer graduands of MMed (Family Medicine) and teacher to many of us who were or are in the postgraduate courses of our College. We will also hear how Dr Jason Yap lives to learn as he completes his Fellowship programme after many years as a GP.

The College Mirror seeks to be a voice for all Family Physicians out there by discussing various issues close to our hearts. We have collated quite a few doctors'

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feedbacks on how itemised billing affect their practice. Dr Michael Yee's take on the history of Snake Oil and its relationship to the practice of medicine will certainly reflect many GPs indignation at being associated with one.

We hope through open discussion and feedback, we can become a voice that will influence the practice and quality of Medicine in our nation. ■**ICM**



Mainstreaming of Family Medicine

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



A highlight of this quarter is the speech given by the Minister for Health, Mr Khaw Boon Wan on 9 May 2008. This is reproduced in this issue of the College Mirror. His main messages are: All Singaporeans have their own Family Physicians, with a long term relationship; returning patients to General Practitioners (GP); and greater cooperation between Ministry and GPs.

Minister Khaw said in his speech: "I am sure there is more scope for greater cooperation with GPs and we are open to suggestions. Whatever that is practical to help you be a better GP to your patients, we will be happy to consider it." It is clear that the roll out time for the mainstreaming of Family Medicine has come.

The turf claiming between the plastic surgeons and the GPs over aesthetic procedures has prompted Dr Tan Cheng Bock to express his concerns. How do we help doctors to stay in the mainstream of medical practice - and for the GPs - Family Medicine?

The short answer is we need to invoke the support of the 4Ps in making mainstreaming of Family Medicine happen. The 4Ps are the people, the press, the policy makers, and the profession. And we are nearly there. Let me elaborate.

THE PEOPLE

People need to be convinced that the GPs and the Family Physicians can do the mainstream of medical care - chronic disease, right siting, and integrated care. I believe a substantial proportion of our GPs and Family Physicians are ready. We need to work on the awareness of the capabilities of our Family Physicians. And we need the continued support of the hospital specialists, the press,

and the policy makers in this upward recognition.

We need more of the people, the employers, the managed care organisations to be willing to pay the GPs and Family Physicians their due worth for mainstream Family Medicine work in chronic disease management, right sited care, and integration of care.

People need to be convinced that the GPs and the Family Physicians can do the mainstream of medical care - chronic disease, right siting, and integrated care.

THE PRESS

The press can play a big role in helping to keep the public posted on GPs and Family Physicians who are doing chronic disease care, right siting work, and integrated care in mainstream Family Medicine work. Together with the press, the medical profession can provide patient education on the self-management skills to reduce disease complications, and more importantly, to prevent disease. More on this in the next President's forum.

THE POLICY MAKERS

It is heartening and encouraging to hear the Health Minister's speech of 9 May 2008. We need more policy makers to share his vision and attitude in order that mainstream Family Medicine can take off and sustain itself. One group of policy makers who can play a key role here are the managed health care institutions. They can do a lot to champion the mainstreaming of Family Medicine by paying the due worth of the providers' work. This, of course, cannot happen over night, but a step in the right direction can go a long way.

THE MEDICAL PROFESSION

Today, we have more than 20 years of vocational training experience of our GPs and Family Physicians, dating from the introduction of Family Medicine as a formal discipline in the medical undergraduate and medical postgraduate curriculum in the National University of Singapore in 1988. We also have regular professional development courses for our GPs and Family Physicians.

The tripartite efforts of the Ministry of Health, the University, and the College have resulted today in having 278 doctors trained to the level of Graduate Diploma in Family Medicine, and 264 doctors trained to the level of the Master of Medicine in Family Medicine /MMed(FM).

The vision of the MMed(FM) as was laid out in the initial document to the Senate of the National University of Singapore in 1990 was that it be

pegged to be on par with the hospital based specialties. The aim is to train up to 25% of the Family Physicians to this level to be the future leaders, trainers, developers, and administrators of Family Medicine



training. There is a need to maintain this rigour of training into the future. And holders of the Graduate Diploma in Family Medicine (GDFM) can aspire to be a holder of the MMed(FM) if he or she is prepared to put one year aside to intensive part-time training. This is the Programme B. Many have done that.

All these will make meaning, however, only if mainstream Family Medicine work is given its due worth by the people, the policy makers, and the medical profession. And it boils down to making a choice by the 4Ps - to grant it or to deny it. Whatever happens, the GPs and Family Physicians need to work at it.

As the saying goes: "He who builds the best mouse trap gets to keep the cheese". Mainstreaming of Family Medicine is arduous but worth the struggle for the benefit of society of whom we form an integral part. And the GPs and Family Physicians need to work together to make "the best mouse trap" in the world. **ICM**

All these will make meaning however only if mainstream family medicine work is given its due worth by the people, the policy makers, and the medical profession.



(from page 1: *The Value of Medicine Today*)

Dr Tan felt sorry for the rapid commercialisation of healthcare but accepted that we could not turn the tide. He sympathised with the need for some GPs to go into aesthetic procedures to satisfy some of their patients' needs and demands, and to cover the operating cost of their practice. He therefore asked the regulators to clarify the aesthetic procedures that GPs could do. We will. More importantly, he hoped that MOH could do more to encourage and enable the GPs to stay involved in national health programmes, such as chronic disease management programmes.

Good GPs Support Good Health

I share many of Dr Tan's sentiments and will do my best to ensure that competent doctors, trained at great cost to our society, do not end up neglecting real patients with genuine medical needs. Like Dr Tan, I worry about the rapid ageing of our population and the consequential rise in demand for medical services. In particular, this audience knows the disastrous impact on our healthcare resources if we do not have a good handle over the prevention and management of chronic diseases, like diabetes, hypertension, mental illness, just to name a few.

In the fight against these diseases, GPs play an important role. Good GPs are our unsung heroes. They do not appear on TV or in newspapers, promoting beauty treatments to the rich and famous. They work long hours, persuading Singaporeans to eat a balanced diet, exercise regularly, control their blood pressure and quit smoking. They also comfort the terminally-ill, supervise home-nursing of the severely-disabled, do home visits so that elderly patients can avoid unnecessary trips to hospitals.

Our healthcare system today is strong. Our doctors are largely

The answer must come from the society at large. What value, Medicine? How much are you paying your GP for a consultation session on managing your diabetes which may save your toe?

dedicated and ethical. They retain their strong noble calling to serve the weak and the infirmed. But will the future be the same? I alone cannot provide the answer. The answer must come from the society at large. What value, Medicine? How much are you paying your GP for a consultation session on managing your diabetes which may save your toe? How much are you paying another for a session to whiten your skin?

If we, as a society, misalign our priorities, we cannot blame doctors for shifting their focus. In the US, fewer doctors are going into primary healthcare. More are going into glamorous, well-paying surgical specialties. While we need both, some balance has to be struck. Today, we have 7300 doctors in Singapore, with 2500 in primary healthcare. Singaporeans are well served by the current distribution of doctors. We must ensure that GPs continue to find it meaningful to be good GPs, serving the community at large.

Partners In Health

We encourage all Singaporeans to have their own family physicians, with a long-term relationship. A long-term doctor-patient relationship is particularly important for the lifelong management of chronic diseases. Doctor-hopping and serial episodic care will not produce good results. Your disease will simply worsen with time, until a complication forces you to end up in a hospital emergency room. Remedial care will then be

much more costly, with little chance of a full recovery.

To manage chronic diseases well, we need to rally our GPs and polyclinics to work together as one team, complementing each other's strengths. We are not competitors, fighting for the same market share. We are partners in health, on the same side of the battlefield.

Some GPs complain that their clientele has shrunk as their patients are lost to polyclinics with better facilities and subsidised medications. To keep up with public expectations, we will continue to upgrade our polyclinics; and we will have to help the poor cope with long term medications. But it is neither our intent nor our interest to enlarge our market share.

Correcting Imbalance

But polyclinics' market share for chronic diseases is disproportionate. More than 40% of primary care visits for chronic diseases occur in polyclinics. This is way above our market share of the primary healthcare sector. We are addressing this imbalance.

(a) Returning patients to GPs

First, our hospital specialists actively refer the patients back to their family GPs, after their conditions have been stabilised. The hospital specialists are there to give a specialist opinion, not to take over the lifelong

treatment of the patients. That is why NHG has many programmes to partner GPs to care for the patients referred back from the specialists, for heart disease, asthma, and mental illness.

(b) Medisave for chronic diseases

Second, we have allowed Medisave to be used for outpatient treatment of the 6 key chronic diseases. More than half of all GP clinics participate in this programme. We are encouraged by the early results. About 70% of diabetic patients enrolled in this programme had acceptable or better control of their diabetes. Nearly half of the diabetic patients with lipid disorders had good control of LDL-Cholesterol.

(c) Better disease management programmes

Third, hospitals and polyclinics actively pilot disease management



The hospital specialists are there to give a specialist opinion, not to take over the lifelong treatment of the patients.

programmes and share them with GPs. We will continue to support GPs in this manner, so that they will be able to consistently provide quality care to their patients. For instance, NHG's pilot Heart Failure Programme aims to improve the quality of care of heart failure patients through a multidisciplinary team approach, with strong patient education and close monitoring by case managers. Within two years, the programme has reduced repeat hospitalisations by 6%. Hospitalisation stays were also cut by 30% from 11 to 8 days.

For diabetes, the SGH has successfully piloted the DOT (Delivering on Target) Programme

with a group of GPs. We have therefore decided to roll it out nation-wide. All our public hospitals have decided to come together to fight diabetes in a comprehensive way, in partnership with the GPs. There will be more such collaborations as we bring hospital specialists together to establish national programmes to accredit, train and work with GPs to care for patients discharged from hospitals.

Greater Support for GPs

We will do more to support GPs in managing their patients' chronic diseases. Let me highlight two new initiatives.

(a) Systematic health screening

First, we will get Singaporeans to be systematically screened by their GPs for the common chronic diseases. From next month, Singaporeans aged 40 and above will receive a letter from the Health Promotion Board informing them of the importance of appropriate screening and the GP clinics near them at which they can get screened. For the poorer 30% of the population, HPB will render some subsidy to help cover the cost of the screening.

The screening programme will cover diabetes, hypertension, lipid disorders and cervical cancer, at the appropriate, recommended intervals. More importantly, we will put in place measures to ensure that there is follow-up to the screening, if the result is abnormal.

Extend PCPS

Second, we will extend the Primary Care Partnership Scheme (PCPS) to cover the main chronic diseases. At present, means-tested patients can enjoy subsidised care at participating GPs for their acute medical conditions, like coughs and colds. From next year, PCPS will also cover the three main chronic diseases of diabetes, hypertension and lipid disorder. PCPS card-holders with these chronic conditions will then be able to enjoy subsidised care by participating GPs, for consultation, medicine and lab tests.

In turn, MOH will through the polyclinics pay the GPs a subvention, on a per-attendance basis. This will enable such patients to see their regular GPs for both acute and chronic conditions. We will leverage on the IT platform which currently supports the Medisave for chronic diseases to help the participating GPs to report and monitor the health outcome of their patients. This will allow GPs to compare how they are faring, and in the end, patients will benefit.

Greater Cooperation

I am sure there is more scope for greater cooperation with GPs and we are open to suggestions. Whatever that is practical to help you be a better GP to your patients, we will be happy to consider it.

Conclusion

Singaporeans enjoy a high level of health, comparable to the best in the world. We have much to thank our doctors for. But the reality is that Singaporeans themselves hold the key to their own health. We, the healthcare providers, are just there to support the patients and to catch them when they fall.

A wise doctor said that health is a combination of two factors: genes and lifestyle. We cannot choose our parents but we can choose the way we live our lives. Good health requires great discipline. Eat less, exercise more and get slimmer. And you will live healthier and longer. There is no short cut to such a good outcome.

■ CM



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The Singapore General Hospital (SGH) is Singapore's largest acute care tertiary hospital and national referral centre with 1,515 beds. With 28 clinical specialties, SGH has the most comprehensive range of clinical specialties available in any hospital in Singapore. Our commitment to patient care is matched by a high standard of medical excellence.

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We regret that only shortlisted candidates will be notified.



Itemised Billing The Aftermath

by Dr Shiau Ee Leng, MCFP(S), Editor

Background to Itemised Billing

The SMA guidelines to charges by medical clinics were scrapped in 2007 following complaints by the Consumer Association of Singapore. Since then, the Ministry of Health had revised 4(1) of the PHMC regulations, which was fully implemented on 1 April 2008. The revised version provides information on display of common charges, provision of information on additional charges, bill itemisation and option for filling out prescriptions.

Whilst the title suggests that the compulsory presentation of itemised bills by clinics to all patients is not unlike an atomic bomb to the medical fraternity, it has nonetheless happened, and College Mirror has gone round to many GP Clinics to collate feedback. The responses were not too unpredictable.

Most reported that their practice continues as usual, with no significant changes to the patient load despite the transparent pricing of their charges. Majority of patients, especially the heartlanders, were apathetic about the implementation of itemised bills, with some even declined receiving the bills and calling it a waste of paper. Those few who accepted the bills had requested instead for the previous version, which is

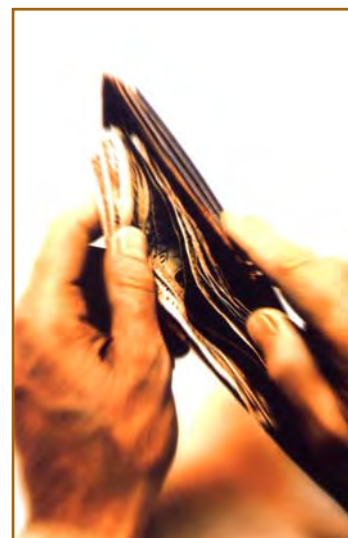
without itemisation, (with a total lump sum under one single heading of consultation and medications). This was due to various reasons:

- 1) privacy issues on their medical conditions,
- 2) problems with insurance or company claims, e.g. certain terminologies used in the itemised bills such as facilities or administrative charges were not claimable, and some items were apparently disallowed from claims.

The rationale for the compulsory implementation of itemised billing in all clinics is to be applauded as it serves to protect consumers (patients) from being over-charged by medical institutions. However, it is interesting to note that it was not welcome with much fanfare by the consumers it was meant to protect. The reason being that many have been consulting at their GPs' clinics for many years and have developed implicit trust in their doctors and their manner of charging. They felt that the charges had always been transparent and reasonable. To the College Mirror, it is indeed heartening to know that the majority of GPs had done a good job in cultivating trust from their patients.

Rather, the compulsory implementation of itemised

“In time to come the consultation rate should rise to match what the rest of the world charges, as self medication and filling out prescription become a way of life with growing literacy and affluence of Singapore.”



billing in all clinics has revolutionised the manner of charging by GP clinics, which traditionally used to underprice the medical consultation, and then compensated for the shortfall through the sales of medications. No longer able to expect extra remuneration from the sales of medications now as patients are openly encouraged to request prescription chit for purchase of medications from pharmacies, clinics have got to charge a more decent consultation rate to reflect more accurately their practice costs, at between \$15 to 25. Of course this is still a far cry from what other GPs in developed countries charge. In the UK, it is £50-100, in the US US\$100 to 200, in the EU 100-150 euros. Some Singaporean GPs training and working overseas were deterred from returning by the comparatively poor remuneration and low level of job satisfaction they saw in their colleagues here. Yet GPs in Singapore work much harder and longer hours than their counterparts.

In time to come the consultation rate should rise to match what the rest of the world charges, as self medication and filling out prescription become a way of life with growing literacy and affluence of Singapore. GPs clinics will move from being drug dispensaries to pure medical consultative practices, giving high quality medical care as we are trained to. GPs may start performing more minor surgeries in the clinic, and more may subspecialise, such as in Palliative Medicine, Counselling, Dermatology or Geriatrics.

Whilst it is hard to imagine GP Practice in the future, let us not keep looking back at the swinging good old days. We should look forward to our greater empowerment as the Ministry of Health plans to implement greater private sector involvement in our nation's primary healthcare system in the near future.

Doctors' Comments

Dr Wong Tien Hua of Seng Kang

"It is heartening to know that overall my charges are quite similar to other GPs, despite slight differences in the prices of various items."

Dr Kevin Loy, of Toa Payoh

"I think this itemisation bill intrudes into patients 'privacy and the confidentiality between doctors and patients'. Some request for the previous lump-sum bills instead as they don't want their company to know all about their medical problems."

Dr Jonathan Pang of Hougang

"Whilst it is a good idea, we are killing a lot of trees and wasting paper. Many don't want the bills and just throw them away without looking."

Dr Lam Bee Lan of Woodlands

"I have standardised my consultation fees so that it reflects more accurately what a true consultation charge should be."

Dr Sin Wen Yee of Choa Chu Kang

"Majority of my patients (99%) are not interested in the itemised billing. Most heartlanders are not even aware of its implementation. I feel that this need not be scrapped altogether, nor made compulsory. It should be made optional."

Dr Kelly Loke of Bukit Batok

"Life goes on as usual." **ICM**

Turn to page 22 for details of forthcoming seminar on 'Professional Fees & Practice'.

Dr Julian Lim is no stranger to family physicians. He is an experienced family physician in private practice and a respected Family Medicine teacher. He has been a mentor and inspiration to many who were taught by him. The College Mirror had a swipe at teasing his brain to check out what he is made of.

CM: Thanks, Julian, for accepting the interview. How long have you been practising?

Julian: Like most ordinary Singaporean citizen-soldier who happened to be a doctor: two exciting years in full-time NS and 13 fulfilling years as an operationally-ready NS Medical Officer with a Guards Battalion. Subsequently, the routine three years as a Family Medicine trainee with the MOH, but took the exam as a private candidate. So, I was the first few to benefit from the private practitioners scheme. I am 14 years into my current solo practice.

CM: So what inspired you to take the plunge into private practice?

Julian: It was both chance and choice. Taking Gordon's definition of health (see below) - I had to "function effectively" as a father, son and husband "fairly free of discomfort and pain" - both physically and financially. Haha! It was truly a "new life", including relocating the family to stay above the clinic in the shophouse.

The nearest approach to health is a physical and mental state fairly free of discomfort and pain which permits the person concerned to function effectively and as long as possible in the environment where chance or choice has placed him. (Gordon, 1958)

CM: Would you go back to practice in a hospital setting?

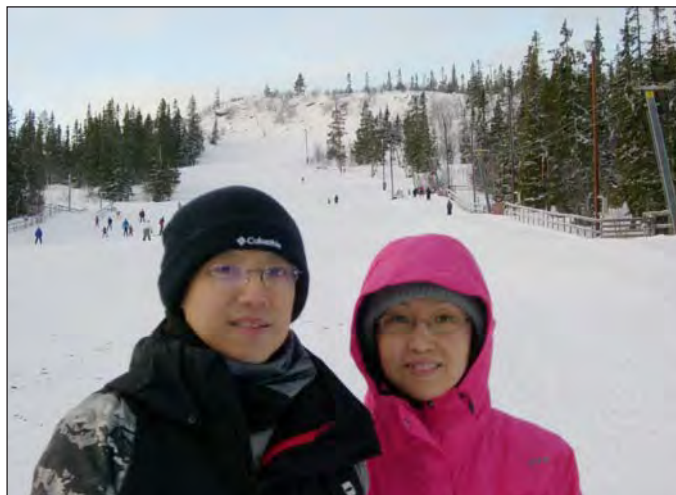
Julian: Definitely, not! It's too hot!

CM: You mean the heat of the hospital politics?

Julian: No, no. I mean I don't like to work in stuffy ward conditions and to be on my feet all the time. It is energy sapping and I need the energy to last through the night clinic and beyond. In addition, I don't like to be worrying

A Conversation with Dr Julian Lim

by Dr Michael Yee, FCFP(S), Editorial Board Member



Outside the ordinary - Dr Julian Lim and wife, Choy Leng, at Vendalem, Sweden (2007)

about the "hot" patients still lying in the wards after work.

CM: So concerns for your patients cause you to worry the whole day?

Julian: Yes it does, but it only applies if there are patients under my care still lying in the hospital bed. I don't have such patients in a primary care setting because I put them out of my mind the second they walk out of the consultation room. I choose to do it as I don't want the problems and issues of the previous patient to interfere or distract me from the patient who is in front of me or my loved ones.

CM: So you do not call up patients to check up on them?

Julian: How do I if I have already put them out of my mind? But seriously, I try not to as I'll lose the most useful clinical sign to gauge the seriousness and progress of their illness - the most sensitive and specific gauge in fact. I expect them only to come and see me when symptoms deteriorate. This, of course, would have been emphasised to the patient already. It helps me and the patient decide what to do next as the next course of action would have been settled in the

previous consultation and there would be no need to figure out their RICE (Reason for the encounter, Ideas, Concerns and Expectations) again. Otherwise, it would be a situation where I ask: "Why are you here?" and the patient answers: "You asked me to come for review." And we'll have to start from scratch again. Therein also lies the strength of primary care - accessibility.

CM: So do you give out your handphone number to your patients?

Julian: Yes, but only the dead ones call me! I do give them to relatives of the dying. It helps to ease their anxiety over many issues surrounding death.

"I had to function effectively as a father, son and husband fairly free of discomfort and pain."

“The one who values the health is the one who is willing to pay for it and that same one will decide how much.”

CM: Are there difficult patients?

Julian: Mmm...that's a difficult one. There are no difficult patients, only difficult systems.

My attitude has always been: "Their body, their money, they decide." We lay the cards on the table and advocate for them. That has always proved to be very cost-effective and efficient.

The difficulty comes when it is not their money for a variety of reasons including the administrative and political will to meet the quality indicators of health. I accept that managed care benefit the employers, insurance companies and the public because it is effective and efficient for them. We are fortunate that we have private paying patients. In state sponsored healthcare systems, doctors have to play the gatekeeper's role for the taxpayers instead of the

patient. That is why it is hard for the polyclinic doctors to find satisfaction in their role as well as doctors who see managed care patients.

CM: So how do you overcome that?

Julian: See health the way McWhinney (see below) did:

Health is a value, and to some it may not be the highest value. It is sometimes sacrificed in the service of others. It is sometimes squandered in the pursuit of pleasure, fame or fortune.
(Ian McWhinney, 1997)

The one who values the health is the one who is willing to pay for it and that same one will decide how much.

CM: What do you most enjoy about your practice?

Julian: The generous opportunity to offer grace and to receive gratitude in return. To see philosophy transcribed to principles and translated to practice. The "G"s and "P"s! I enjoy the ordinary and the routine. If today were the last day of my life - the morning would still be: wake up at 5.50am, fetch the children to school, exercise, have breakfast with my wife and watch the world go by, read my papers while my wife drives, run the morning clinic with medical students attached and then bring them somewhere special for lunch to consolidate the learning points, and a short excursion somewhere to relax.

CM: You make it sound like heaven. What is retirement going to be like?

Julian: That the last morning of my life would be as I have described and the afternoon with my wife...

Ai, but say what I like, I am still a pilgrim and half way through. What I say now in the future may not be what I do.

CM: Sounds poetic.

Julian: Haha! I do have a few sonnets on the "tender heart" of Family Medicine that was published in the February'06 issue of the SMA News.

CM: What legacy would you like to leave your students?

Julian: I would like to help them find their own calling in medicine and sustaining them in practice, though I am also on the same journey. To help them realise that the training and development of a doctor goes through the three overlapping stages of acquiring knowledge and technical skills; developing a professional identity; and learning to be a healer.

The best way to acquire technical skills is to see as many "normal" patients as possible, so that you can pick up the one that is slightly off. Unfortunately, we see mainly "abnormal" patients in medical school and don't know where "normality" begins. Be grateful for the polyclinic posting and a busy practice, the busier the better.

Developing professional identity is a matter of catching it by fellowshipping. It is said that the only true healer is a suffering one. It took me 10 years after entering medical school to be still learning to be a healer. I would like to get the philosophy and principles of Family Medicine into their blood, if Family Medicine is the calling they so choose, and help them translate it into their practice and consultation. And three vital concepts: The concept of risk to truly apply evidence-based medicine. The concept underlying Baye's Theorem to truly make sense of signs, symptoms and investigation results. The concept of health as described above by Gordon and McWhinney to have a truly satisfying practice.

CM: Where is God in your practice?

Julian: Serendipity is God's way of remaining anonymous.

CM: Thanks, Julian, for giving us a candid interview. Your simple honesty speaks volumes and your insight is a valuable guide to young family physicians. Genuine pragmatic love for your patients and students certainly shines through. I am beginning to see how you managed to inspire so many you have treated and taught. Thank you again. ■CM



Lim Juniors - Jaryl, Jasmyn and Jamie, Dr Lim's three children, snowboarding at Vendalem, Sweden (2007)

Safeguarding The Public

by Dr Michael Yee, FCFP(S), Consultant Family Physician in Private Practice, Editorial Board Member

"Tragedy! When you lose control and you got no soul, it's a tragedy." - Bee Gees

A snake oil patent was granted to Richard Stoughton in 1712, before the 1906 United States Food and Drugs Act came into effect. This is not to be confused with the original Chinese snake oil, which is a traditional Chinese medicine (TCM) used to treat joint pain, that pre-dates the 'patented version'. Alas, the American snake fats do not have the same high EPA content as those of the Chinese water snake. The snake oil in question, which was certified by the patent office of that time, was in fact nothing more than a hoax. The common understanding of the phrase, 'snake oil' is a derogatory term for unsubstantiated elixirs passing off as scientific medicines. It implies fraudulent promises of cures and medicinal effects of substances that are useless. The expression also applies to a commercial product with unrealistic marketing claims but unverifiable quality.

In the ole western Hollywood movies, the snake oil peddler was often portrayed as a travelling "doctor" with dubious credentials, selling home brewed medicines with glib marketing methods, supported by pseudoscience. To improve sales, a "shill", would attest to the value of the product in an effort to provoke a buying frenzy. The quack would quietly leave town before his customers realised that they had been scammed, in a practice called "grifting". To reinforce the timelessness of the routine, we also recognise the same pattern in the ancient ways of Chinese medicineman cum pugulist selling "gao yau", something I still witness occasionally outside the Chinese Medical Hall beside my clinic. Within

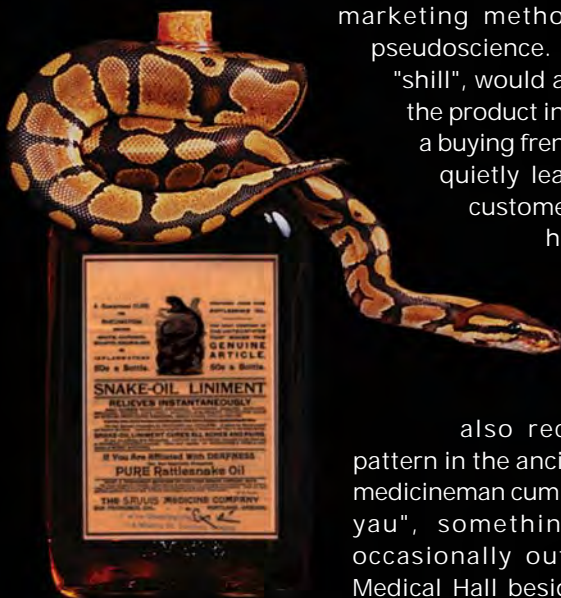
the above narration lies some of the issues modern medicine faces today with regards to the interaction between capitalism, consumerism and care based medicine. The rapidly changing balance has left regulators flatfooted in dealing with such complex issues as evident from the untidy recent turn of events, stemming from the infamous 'snake oil' comment.

It was thus with understandable indignation that respectable family physicians reacted to a newspaper report, of a spokesperson from the Ministry of Health, suggesting that our fraternity was associated with snake oil medicine. Kudos to the crisis management of the various professional bodies and the Ministry, the dust have since settled and we can hopefully come back and dissect the issues and see if we can come off with a better understanding of the matter.

What unproven treatments?

At the heart of the matter was unproven treatment masquerading as scientific medicine. The prevalence of such irresponsible dishonesty is indeed alarming.

The billion-dollar health supplement industry has taken the world by storm with the ubiquity of internet marketing and internet shopping. The bedazzled public has taken to unsubstantiated products with a vengeance despite the ready availability of ethical medicines and treatments backed by decades of rigorous studies and validation. The initial shock of the Slim 10 disaster only lasted a couple of months before clever marketers buried the incident. Even good media reporting of the Super 1 Walnut menace did not put an immediate stop to its danger. A check with our primary care practitioners will find that many have come across patients who have been advised by



“The reliance on competitive market forces to allocate healthcare and consumer centric culture have eroded our authority to protect the public.”

friends, relatives and even retail pharmacies to supplement or even abandon their regular medications in favour of the latest XYZ elixir.

Equally distressing is the plethora of beautician, skincare, hair loss, weight loss, foot reflexology, aromatherapy, wellness centres and others with claims of scientific basis via aggressive computer-modified before and after pictures and other anecdotal evidence. Using sophisticated advertising and marketing methods; they have begun to undermine the authority of mainstream healthcare workers. The Ministry's initiative to limit the spill over to more invasive treatments a couple of years ago slowed down their rapid growth significantly; but the recent turf war between aesthetic physicians and plastic surgeons threatens to destroy the reputation of both parties alike, at the same time validate the former's role as auxiliary medical practitioners by default, with promises of exclusive methods and secret concoctions.

Traditional complementary medical practices of various forms have been sprouting like wild mushrooms before a storm. Recently, we have had anecdotal encounters of these complementary clinics starting to treat diseases using mainstream modern principles like taking blood pressure, measuring serum cholesterol and glucose, x-rays, etc. The recent initiative of self-regulation only strengthens the perception of their standing as scientifically verifiable and accepted methods of treating complex diseases without addressing the problem of unproven treatment. A large segment of society has already perceived these traditional complementary practices as

a viable alternative to mainstream GPs with the erroneous assumption that they are of equal scientific standing. Surreptitiously, traditional complementary practitioners are now effectively empowered to practise modern medicine via the proverbial backdoor.

On the other hand, does it mean that health beliefs without rigorous scientific evidence is unethical? It certainly does not. But pretending to be scientific or claiming to be well versed in modern medical diagnosis, investigations and treatment is definitely fraudulent. Potential harm of unproven treatment is beyond doubt, but does the benefit outweigh the risk? The consumer-centric environment necessitates the public to discern, which is increasingly difficult to the average consumer exposed to the chaotic healthcare marketplace in an internet era of half-truths coupled with meandering commercial and political agenda.

Advising our patients objectively is becoming increasingly difficult. The reliance on competitive market forces to allocate healthcare and consumer centric culture have eroded our authority to protect the public. Even evidence based medicine is not as reliable as we like it to be. That complex task of guiding patients falls firmly on the shoulders of the GPs and there must be continuing and concerted effort to shore up the credibility of the GPs to do the job properly.

Who is the best safeguard?

Like it or not, the scientifically trained mainstream doctor is still the best

safeguard for the public's health, despite our imperfections. The training of a medical student into a good respectable practicing doctor is an intricate and enigmatic process. It starts with the imparting of knowledge, skills and right attitudes. Apprenticeship under reputable role models not only imparts essential skills but more importantly value systems that will take the young doctor into the next stage. Bonds are forged in medical school, hospitals and clinics so that the future practitioners can refer with confidence and communicate in the same proficiency and hopefully develop cooperative instead of adversarial stance when it matters. The training does not end with graduation; continuing professional education, upgrading and practical experience is necessary to build confidence, leadership, wisdom and character.

Where are we headed?

The Associated Press reported in November 2007 that 69% of 3,400 natural sex enhancement supplements purchased in China contained Sildenafil citrate, the main ingredient in Viagra. By any standards, these products are extremely dangerous and unpredictable. The prevalent use of unsubstantiated alternative health products to treat chronic diseases will most certainly lead to disastrous results in our rapidly ageing population in the near future. Last year, the Health Sciences Authority (HSA) was authorised to pull off the shelves medical products that have been tampered with illegally, with or without the support of the medical companies involved, under the Health Products

“Can complementary practitioners and other auxiliary practitioners be integrated into the healthcare system effectively without sticking out like a sore thumb? I believe they can.”

Act. The Super 1 Walnut incidents suggest that we did not go far enough to control the situation. The health authorities need to consider measures such as strict advertising guidelines for health supplements to rule out superlative and unfounded claims. Legislators can also give prominent warnings on health supplements to differentiate from ethical medicines.

The health authorities had already recognised the slippery slope of beauticians offering more and more lucrative but increasingly risky procedures while blissfully ignorant of the potential dangers. The recent spat between the aesthetic physicians, plastic surgeons and health regulators threaten to reverse the progress made. Already, wealthy beauty salon operators have ramped up their marketing efforts to take advantage of the chaos. The confused public has much to lose. To effectively protect the public, health regulators must refrain from the cowardly tack of simply restricting mainstream doctors, but widen their scope of control instead. On the contrary, doctors must be given credibility to counter the threat of fraudulent practices.

I remember coming across a case many years ago in my practice. A middle-aged lady of modest socioeconomic status consulted me for the first time with a problem of epigastric discomfort. A careful physical examination revealed an irregularly enlarged liver. It took some coaxing and probing to finally uncover an enlarging malignant looking left breast lump. She was embarrassed

to admit that she has been paying good money to be treated by a traditional complementary practitioner for 'wind' through fortnightly breast massages for the previous few months. The delayed diagnosis of advanced breast cancer with metastasis to the liver was eventually confirmed with proper investigations and the unfortunate lady passed away soon after. This is a regrettable case of very unfortunate outcome due to inappropriate healthcare management by inadequately trained practitioner.

'Wind' and 'wetness' together with a whole host of traditional medical principles are an integral part of the health belief model of TCM and has wide popular support in some sectors of society. Without the benefit of the perspective of what modern medicine can offer, the isolated practice of the ancient art of traditional medicine belongs in the past. Can complementary practitioners and other auxiliary practitioners be integrated into the healthcare system effectively without sticking out like a sore thumb? I believe they can. But like their foreign counterparts, they must first complete the relevant recognised training in mainstream medical or paramedical school and the necessary apprenticeships in mainstream medicine as described above. In the same manner, mainstream doctors who wish to practice traditional medicine, to complement their practice, must first acquire the right skills set and attitude through structured and proper training just like family physicians going through advance training in

geriatrics and sports medicine, etc. There is no room to take a laissez-faire attitude when dealing with human life. Shortcuts and backdoors spell trouble.

The amount of opportunity cost and health dollars spent on dubious treatments and unbridled unsubstantiated promises of improvement of health, beauty, sexual prowess, etc cannot be discounted lightly. Complacency with this situation is simply foolish. The healthcare marketplace must not accept greed for money at the expense of public safety, fraud and wonton wastefulness of resources. Sadly, some of these issues cannot be easily regulated and enforced. Besides safeguarding patients, healthcare regulation must also ensure easy accessibility of healthcare, protect the reputation of healthcare providers and provide equitable and efficient allocation of healthcare resources. Over zealous regulation or further restriction of the doctor's authority may not be the best answer. Neither is high profile admonishment helping to protect the severely battered reputation of modern mainstream medical doctors. Let us not be distracted by the sideshow between our plastic surgeons and aesthetic physicians and turn our attention to the more compelling inadequacies of our healthcare system instead. Failing to address these problems will not only compromise public safety, but also damage the authority of the doctors who are able to avert the makings of more tragedy. ■CM

Family Practice Skills Course

Diabetes Mellitus: Revisited

The College of Family Physicians Singapore would like to thank **Novo Nordisk** and the Expert Panel for their contribution to the Family Practice Skills Course on “**Diabetes Mellitus: Revisited**”, 3-4 May 2008.



Dr MELVIN LEOW KHEE SHING - Consultant, Endocrinologist and Physician, Department of Endocrinology, Tan Tock Seng Hospital; Clinical Senior Lecturer, Yong Loo Lin School of Medicine, National University of Singapore

Mr SOREN E SKOVLUND - Global Director, DAWN (Diabetes Attitudes, Wishes

and Needs) Programme Corporate Relations, Novo Nordisk A/S

Dr LOH KEH CHUAN - Consultant Endocrinologist, Loh Keh Chuan Diabetes, Thyroid & Hormone Clinic

A/Prof SUM CHEE FANG - Senior Consultant Endocrinologist, Alexandra Hospital

Dr LIM HWEE BOON - Director, Singhealth Polyclinics, Marine Parade

Dr KEVIN TAN ENG KIAT - Consultant Endocrinologist, Mt Elizabeth Medical Centre, Mt Alvernia Medical Centre, Singapore General Hospital; Vice President, Diabetic Society of Singapore

Dr TAN KHAI TONG - Consultant Endocrinologist, Thomson Medical Centre

Sr NOORANI BTE OTHMAN - Certified Diabetes Educator, Nurse Clinician (Diabetes), Tan Tock Seng Hospital

Sr ASLENA BTE HUSSAIN - Diabetes Nurse Educator, Diabetic Society of Singapore

Chairmen:

Dr KWAN YEW SENG and **A/Prof GOH LEE GAN**



Workshop Resource Panel:

Mr LIM KOK PENG & Dr WONG TIEN HUA

Chairmen:

Dr JONATHAN PANG and **Dr LEE MUN TUCK**



Family Practice Skills Course

Communicable Diseases of Community Importance

The College of Family Physicians Singapore would like to thank **Health Promotion Board** and the Expert Panel for their contribution to the Family Practice Skills Course on “**Communicable Diseases of Community Importance**”, 24-25 May 2008.

Dr ANGELA CHOW - Consultant, Clinical Epidemiology, Tan Tock Seng Hospital - Communicable Disease Centre

A/Prof OOI PENG LIM - Adjunct Associate Professor and Deputy Director, Communicable Disease Division, Ministry of Health

Dr JEFFERY CUTTER - Deputy Director (Policy) & Deputy Director (HIV Prevention), Communicable Diseases Division, Ministry of Health

A/Prof OOI ENG EONG - Associate Professor, Emerging Infectious Diseases Program, Duke-NUS Graduate Medical School

A/Prof PAUL TAMBYAH - Associate Professor, Medicine, and Consultant Infectious Disease Physician, Department of Medicine, National University of Singapore

Dr RICHARD GUAN - Gastroenterologist and Hepatologist, Mt Elizabeth Medical Centre

Dr Jason Yap: "How I Manage My Postgraduate Studies"

CM: Thank you for accepting our invitation to share with our readers on your postgraduate learning journey in Family Medicine. Could you begin by sharing with us what motivated you to do postgraduate training in Family Medicine?

Jason Yap (JYSK): At the exit interview of the Collegiate Membership (MCFP) exam in 2006, I shared my values and remarked that I would be a teacher today if I am not a doctor. A/Prof Goh Lee Gan, President of the College of Family Physicians Singapore encouraged me to enrol for the Master of Medicine (Family Medicine) course.

It has always been my desire to share what I have learned with medical students. I have been given the privilege to bring different clinical groups to the wards to teach on the subject of communication. I look forward to the day that I can spend more time imparting all that I've learned to medical students when my four boys are able to take care of themselves.

CM: What do you see to be the critical success factors that the postgraduate student need to get through the MMed FM Examination?

JYSK: There are a number of factors.

1. Having an enduring vision and a strong purpose - it gave me strength to overcome my fears and difficulties along the way.

2. Be willing to learn - ask and you shall be taught. I knew the many valleys that I had to cross. I sought help from 11 specialists to clear my doubts, including three paediatricians, a neurologist, two gynaecologists, a haematologist, an internist, two orthopaedic surgeons and a geriatrician.

3. Be a persistent learner - I have never stopped learning since I graduated 28 years ago. I kept myself updated regularly at CME events and even completed the first MCGP course some 20 years ago.

4. Volunteer to participate in classroom learning - I was open to feedback. I made it a point to finish my write-ups early so that I could present it in class. I had to redo my domiciliary case as it was not up to mark. I also had to spend another month to collect a fresh set of data for my audit project. I was glad that I did that. I benefited from the critique and comments from my tutors and fellow trainees.

5. Teaching others - as you gladly teach, so will you gladly learn. I realised that I learn best when I have to teach.



Dr Jason Yap and family. (clockwise from left) Joshua, Amy, Jason, Joel, Joseph and Jonathan.

Like what Stephen Covey says, 'Teach it first after you have learned it.' It stays much longer in you and becomes 'part of you'.

CM: How do you balance work and family as a postgraduate student?

JYSK: I am very fortunate to have a supportive wife. She looks after the needs of the four boys and the home affairs. When I embarked on the course, the youngest was in Primary 4 and the

third was in Secondary 2. I work office hours in a clinic at Raffles Place. I continued to spend my weekends with my family and on church activities, in addition to leading a group of men in intentional discipleship training every Friday evening.

CM: Moving from learning to contributing, how would the things you will be doing apply the Family Medicine that you have learnt?

JYSK: I have been appointed GDFM tutor for the new batch in July. I am excited that my learning journey will take on a new perspective from that of a mentor. I am also helping my medical group to draw up a curriculum that incorporates regular case reviews, significant event analysis and problem based learning approach with journal reading which I found helpful and practical.

I would recommend the following two books that have shaped my perspective of things: **Breathless** - Transform your time-starved days into a life well lived by Gary R Collins and **A Life Well Spent** by Russ Crosson.

I am glad that I have stayed fit all these years and built some emotional margin. I did not burn myself out and was never in a rush. I have extended my time horizon and hope that someday I may make a difference in the lives of some medical students. **ICM**

Dr Jason Yap Soo Kor graduated with MBBS(S) in 1980 and passed his GDFM in 2003. He then enrolled in the two-year MCFP(S) by assessment programme and was awarded Collegiate Membership of the College in 2006. He successfully completed the Master in Medicine (FM) in 2007 under the one-year programme B scheme conducted by Department of Family Medicine & Continuing Care of Singapore General Hospital. He is presently working towards FCFP(S), the Fellowship of the College, in the two-year FM Fellowship programme.

FAMILY MEDICINE COMMENCEMENT 2008

28 June 2008 | 2.00pm - 4.00pm

Guest of Honor:
Prof Fock Kwong Ming
Master, Academy of Medicine - Singapore

Level 7 Auditorium
Health Promotion Board Building
3 Second Hospital Drive

(Guests to be seated by 2pm)

ANNUAL GENERAL MEETING 2008

28 June 2008 | 4.30pm - 6.00pm

Level 2 Auditorium
College of Medicine Building

Members may sign in starting 1.30pm
at any of the Convention venues.

Convention/AGM Tea Reception | 4.00pm - 4.30pm | Function Room, College of Medicine Building

College Members who sign-up to attend the AGM 2008 will receive College polo shirts and/or College ties (worth \$25 each). Members may sign in from 1.30pm on 28 June 2008 at any of the Convention venues.

Associate Members are each entitled to 1 polo shirt (ladies) or College tie (gents). Ordinary Members, Collegiate Members, and Fellows are each entitled to 2 polo shirts (ladies) or 1 polo shirt and 1 College tie (gents). Redemption of the free items would be at College of Medicine Building until 5pm on the same day.



REGISTRATION FORM

Please tick (✓) the appropriate boxes

	College Member	Non Member
Seminar 1 Seminar 2	<input type="checkbox"/> FREE (RSVP required)	<input type="checkbox"/> FREE (RSVP required)
Course	<input type="checkbox"/> S\$ 10.00	<input type="checkbox"/> S\$ 60.00
TOTAL		

Name: Dr _____

MCR No: _____

Mailing Address: (Please indicate: Residential Practice Address)

Tel: _____ Fax: _____

E-mail: _____

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

Cheque number: _____

Signature:

*Registration of the course is confirmed only upon receipt of payment. The College will not entertain any request for refund due to cancellation after the course is conducted OR official receipt issued (whichever is earlier).

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**



Suicide and You

by Ow Yong Lai Meng, MSocSc (Counselling), Certified Hypnotherapist, RSW, Senior Medical Social Worker, Singapore General Hospital

Self-inflicted injury, attempted suicide and death are part of the human condition. They are expressions of human pain and suffering, often at its extreme. Suicide is well-documented in history, literature and across cultures from ancient times. Even then, it is only in the recent 20th century, that it sees a burgeoning interest in the study of suicide as a specific psychosocial condition.

Origin of Suicide and Applied Suicide Intervention Skills Training (ASIST)

Durkheim and later Freud's interest in suicide etched in academic history the study of suicide. Statistics were and still are being collated, often indicating upward trends in the rates of suicide and reflecting specific vulnerable groups. Suicide and impact on societal stability has overt implication on the general mental health of the public, and the same could be said of the converse relationship between the two.

The greatest challenge for health and mental health professionals is to contain these numbers and intervene as early as possible. This is in the hope to reach out and provide early intervention for this at risk group, where often a grossly under-estimated number of non-fatal, self-inflicted injury members is often missed out or ignored.

With greater awareness of the implicit cost to the society and to those who are left as bereaved survivors of suicide, interest in suicide surged rapidly in the 1980s. The Canadian Mental Health Association (CMHA) in 1981, with support from the government of Alberta and its new Suicide Prevention Provincial Advisory Committee, initiated plans for a province-wide Suicide Information and Education

Centre (SIEC) and Suicide Prevention Training Programs (SPTP) as part of the Alberta Model for suicide prevention.

Richard Ramsay, Bryuan Tanney, Roger Tierney and William Lang (from social work, psychiatry and psychology) formed long-term partnership dedicated to suicide-prevention education and consultation. The partnership brought about the current Applied Suicide Intervention Skills Training (ASIST) and the Training for Trainers (T4T) course that prepares registered trainers to conduct ASIST.

LivingWorks Education, Inc., formed in 1991 by the four, was assisted by the University of Technologies International, Inc., the knowledge transfer company of the University of Calgary. Tarie Kinzel, with both a nursing and psychology background joined the LivingWorks group subsequently to further augment the group in designing, developing, implementing and presenting continuing education programmes using Rothman's developmental research model.

Other adjunct training packages prepared include: a suicide awareness presentation (SuicideTalk) of 1-3 hours' duration for all audiences, a Suicide Intervention Handbook for distribution as a supplement or complement to ASIST; "refresher" opportunities after ASIST (ASIST TuneUp); community cooperation workshop (Working Together) and advanced clinical-management presentations in several formats.

LivingWorks extends a strong support network for all its trainers in several countries and across three continents through newsletters, conference gatherings, consultations

and regular update sessions as learning materials are revised and upgraded. This is a public service package that is available for distribution through license and arrangements to agencies, institutions and individuals.

ASIST training and you

The ASIST training package is often compared with the CPR (cardiopulmonary resuscitation) programme. Like a first aid kit, the workshop is designed to provide caregivers with emergency first-aid skills for helping persons at risk of suicide behaviour. It stretches over a span of two days and is designed for members of all caregiving groups. This includes health and mental health professions, persons in direct contact with at risk persons at work or at home.

This is with the belief that all types of caregivers would benefit from the training. Caregivers designated by society as qualified to deal with suicide behaviour are often not positioned to quickly recognise and respond to a person at risk of suicide. Caregivers in the health and mental health settings need the training to minimise or eliminate the immediate danger of suicide before and during the treatment process.

Other caregivers, less perceived by members of the society to be equipped to work with a person at risk of suicide, may often be first to encounter such a situation. With training, these "natural" caregivers would be able to intervene to prevent the immediate risk in an effective and timely fashion.

Skillful intervention from any caregiver is likely to bring about long term prevention benefits - the risk of future suicidal behaviour may be greatly reduced just by the intervention experience alone.

ASIST is a standardised learning experience using a common language to help augment collaboration among caregiving groups. It is now the most widely used suicide prevention training programme in the world, with over 400,000 caregivers having attended the workshops. Several programme evaluations studies undertaken in Canada, Australia, Norway and the United States testify to both the short-term and longer term effectiveness of training caregivers in suicide first-aid.

This presents as beginning evidence to the effectiveness in reducing suicide rates by ASIST trained caregivers in combination with other suicide prevention strategies.

ASIST Workshop

The SGH-Postgraduate Allied Health Institute (PGAHI) offers regular ASIST workshops for medical and other healthcare professions. The workshop is a 16-hour (two full-days or four half-days) small group training which equips participants with the necessary knowledge and effective skills in suicide intervention.

Caregivers in the health and mental health settings need the training to minimise or eliminate the immediate danger of suicide before and during the treatment process.

The training helps health caregivers to be more keenly aware of how individuals may be adversely but subtly affected by personal and societal attitudes about suicide. And in so doing, it empties the cup and allows the participant to listen intently without prior judgement to the reasons of dying of persons at risk. It encourages discussion on suicide with a person at risk in a direct manner upon identifying risk alerts and developing safeplans related to them.

The workshop also further enables participants harness community resources to aid persons at risk. Suicide prevention is broader than suicide first-aid and it includes life promotion and self-care for caregivers. ■CM

REFERENCES

- Durkheim, E. (1951). *Suicide*. Glencoe, IL: The Free Press.
- Lang, W.A., Ramsay, R.F., Tanney, B.L., & Tierney, R.J. (1989). Caregiver attitudes in suicide prevention: Help for the helpers. In R.F.W. Diekstra, R. Maris, S. Platt, A. Schemidtko (Eds.), *Suicide and its prevention: The role of imitation and attitude*. Leiden: E.J. Brill and World Health Organization.
- Maris, R., Berman, L. & Silverman, M. (2000). *Comprehensive textbook of suicidology*. New York: Guilford Press.
- Rosen, G. (1971). History in the study of suicide. *Psychological Medicine*, 267-285.
- Rothman, J. (1980). *Social R&D: Research and development in the human services*. Englewood Cliffs, NJ: Prentice-Hall.
- United Nations. (1996). *Prevention of suicide: Guidelines for the formulation and implementation of national strategies*. New York: U.N. Department of Policy Coordination and Sustainable Development, ST/ESA/245.
- van Hoood, A. (2000). A historical perspective on suicide. In R. Maris, L. Berman & M. Silverman, *Comprehensive textbook of suicidology* (96-123). New York: Guilford Press.
- WHO. (2002). *The World Report on Violence and health*. Geneva: World Health Organization.

Fertility Awareness

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

In these days of declining birth rates and declining fertility (due in part to later age of marriage and first conception!), discussions on family planning is becoming a common topic for family physicians.

Have you noticed that we are faced with two groups of patients? On one hand we have couples who truly desire a child (at any cost!), and those who do not want a child (also at any cost!).

At one moment, a poor GP may be struggling to decide which drug to give or contraception to insert or device to fit in order to prevent new life from coming about; and the next moment he has to do an about turn to advice a sub-fertile couple on techniques and timing in order to procreate!

These requests demand mindsets of opposing philosophies. How can a busy GP reconcile the two without becoming possibly "schizophrenic"? The good news is that education in fertility awareness has much to offer in this area of family planning.

Understanding fertility

Fertility and reproductive health are largely neglected areas in health education. This ignorance and the lack of easily available accurate information about the natural methods of family planning, means that women may not have the option of the full range of family planning choices.

True family planning is not only concerned with avoiding pregnancy. It should aim to provide the means for couples to choose whether and when to have a baby, give information about birth-spacing and infertility advice, where appropriate.

The ideal method of family planning should not be damaging to health or fertility, and should not affect the enjoyment of the sexual relationship.

Most women rely on medical advice when looking for a method of family planning. It is usually the woman who makes the decisions; although the Wise Report showed that the majority of women would prefer to share the decision-making with their partner.



What is Natural Family Planning (NFP)?

Natural methods of family planning use fertility awareness to identify the fertile and infertile phases of a woman's menstrual cycle. This involves observing the natural signs and symptoms or clinical indicators of fertility.

At this point, I must assert that this is not the "rhythm or calendar method" so often quoted in medical text books, which being based on mathematics and guesswork and not on physiology, is highly unreliable!

NFP, on the other hand has a firm scientific and biological foundation based on our clear understanding of human reproductive physiology. The hormones oestrogen and progesterone

cause physiological changes in a woman's body which can be easily observed and monitored, principally:

- Changes in cervical mucus secretion
- Changes in the basal body or waking temperature

I shall describe very briefly the most modern and well-researched NFP method to achieve or postpone pregnancy:

The Billings Ovulation Method (BOM). It was first called the Ovulation Method because ovulation is the important event in the cycle, but in 1978, the World Health Organisation added the name of the two doctors, Drs. John and Evelyn Billings, husband and wife team who developed the Ovulation Method, to distinguish it from other methods.

It teaches women to recognise their own individual pattern of fertility and infertility. Fertility is signalled by the development of a particular type of mucus from the crypts of the cervix. Sperm live in the best type of mucus but without it they die within an hour or so.

Women are not asked to do anything except to keep a simple daily chart of the changes in sensation at the vulva and the appearance of any discharge seen and apply the guidelines.

BOM can be used by a woman in all stages of her reproductive life: regular, irregular cycling, breastfeeding, approaching menopause, recovering from emotional and physical stress or coming off contraceptive medication.

Trials of the Billings Ovulation Method carried out in both developed and developing countries reveal high reliability, effectiveness and satisfaction with the method.

Location/Investigator	Years	Couples	Cycles or years	Method related pregnancies
China (Nanjing, Anhui, Kunmin and Shanghai)/Qian et al.	1996-97	992	1 year	0.0%
Africa, Burkina Faso/Minister of Health and Social Action of Burkina Faso	reported in 1990	166	2,272	0.6%
India, 5 States/Indian Council of Medical Research	1986-88	2,059	21 months	0.85%
Indonesia/Family Health International USA	1986-88	>425		0%
5 Nations-India, The Philippines, El Salvador, New Zealand, Ireland/World Health Organisation	1976-78	869	10,215	2.8%
Australia (Victoria)/Ball	1976	122	1,626	2.9%
USA/Klaus	1975-77	1,090	12,282	1%
Australia (Melbourne)/Billings	1972	98	3-4 years	0%
Tonga/Weissman	1970-72	282	2,503	0.5%

Some difficulties:

- It takes time to learn to recognise and chart fertility symptoms
- Requires initial teaching from an experienced NFP teacher
- Both partners require a high degree of motivation, and commitment. Modifications to sexual behaviour are needed to ensure abstinence during the fertile phase.

Advantages of NFP:

- No interference with the woman's normal physiology
- No worries about side effects of drugs or devices
- Can be used at all stages of reproductive life, including those with irregular cycles
- Enables a couple to be aware of their fertility
- Both partners share the responsibility for family planning.
- Fosters communication between couples
- It is true family planning: helps both to achieve as well as to postpone pregnancy
- Can help sub-fertile couples to conceive naturally
- Women can monitor their health and possibly observe changes in sexual health, e.g. changes due to infection or abnormal bleeding.
- Morally and culturally acceptable for women of all religious persuasions
- Is up to 98% effective in postponing pregnancy, when used by motivated couples, taught by experienced teachers.

It is important that the authentic Billings Ovulation Method is properly learnt. Internet instruction is available at www.woomb.org. This is the WOOMB (World Organisation of the Ovulation Method Billings) website, the reference site for the Billings Ovulation Method of natural family planning. Further information can be obtained by sending an e-mail to nfpsin@hotmail.com

I hope that this provides the busy GP with yet another option while advising couple on family planning and an avenue to refer them. **ICM**

REFERENCES

China (Nanjing, Anhui, Kunmin and Shanghai)

Shao-Zhen QIAN, De-Wei ZHANG, Huai-Zhi ZUO, Ren-Kang LU, Lin PENG, Chang-Hai HE and the Chinese Billings Ovulation Method Collaboration Programme. Evaluation of the Effectiveness of a Natural Fertility Regulation Programme in China.

Africa - Burkina Faso

Minister of Health and Social Action of Burkina Faso, Bulletin d'Epidemiol. Et d'Inform. Socio.-Sanitaire, No. 17, 1990.

India - 5 States

Indian Council of Medical Research, "Optimism With Natural Family Planning for Fertility Regulation in India", Preliminary Report of a Five-State Study of the B.O.M. in India 1986 to 1988, presented at the Conference on "The Welfare of Women", St John's College Hospital, Bangalore, India, January 1990.

Indonesia

Family Health International USA. S. Thapa, M.V. Wonga, P.G. Lampe, H. Pitojo, A. Soejoenoes, "Efficacy of Three Variations of Periodic Abstinence for Family Planning in Indonesia", Studies in Family Planning, 21:327-34, 1990.

5 Nations - India, The Philippines, El Salvador, New Zealand, Ireland

World Health Organisation, Task Force on Methods for the Determination of the Fertile Period, Special Programme of Research, Development and Research Training in Human Reproduction, "A Prospective Multicentre Trial of the Ovulation Method of Natural Family Planning, I, The Teaching Phase", Fertility and Sterility, 36:152, 1981.WHO, op. cit. Phase II.WHO, op. cit., Phase III.WHO, op cit., Phase IV.

Australia (Victoria)

M. Ball, "A prospective field trial of the Ovulation Method", European Journal of Obstetrical and Gynaecological Reproductive Biology, 6/2, 63-6, 1976.

USA

H. Klaus et al., "Use effectiveness and client satisfaction in six centres teaching the Billings Ovulation Method", Contraception, 19:6, 613, 1979.



Annual FAMILY

Chronic Diseases Management & Practice SEMINAR 1

Time 2pm to 3pm
Venue COMB Auditorium
Admission Free (RSVP required)

Synopsis

The use of Medisave for chronic diseases management in ambulatory care was successfully launched last year. Besides the technical aspects of claims and quality assurance, family physicians are also looking into professional and practical measures which can enhance clinical care to their patients such as flow charting, computerization and cost of medications. This seminar examines chronic diseases management from the perspective of the Ministry, the group practices and small practices and welcomes inputs from family physicians in the panel discussion.

Programme & Speakers

Overview

Dr Lee Kheng Hock, Senior Consultant & Head, Dept. of Family Medicine and Continuing Care, Singapore General Hospital.

Ministry of Health's Perspective

Dr Ong Chin Fung, Assistant Director (Chronic Disease Management), Primary and Community Care Division, Ministry of Health.

Group Practice Perspective

Dr Jason Yap Soo Kor, Head, Training and Development Unit of Parkway Health - Primary Care Network.

Small Practice Perspective

Dr Wilson Eu Tieng Juoh, Family Physician in private practice, Siglap Family Clinic.

PANEL DISCUSSION

Professional Fees & Practice SEMINAR 2

Time 3pm to 4pm
Venue COMB Auditorium
Admission Free (RSVP required)

Synopsis

Doctors' Fees traditionally determined by what is customary and acceptable to patients are in a state of flux. The SMA abolished its guideline of fees which has served as a benchmark reference for fees in the private sector last year. Recently, the Ministry of Health imposed the requirement of itemization of medical bills. Market Inflationary pressures on practice costs also create problems especially for those clinics with company contracts and management care patients due to the low negotiated fees. The speakers in this seminar would discuss recent experience and the challenges which impact on professionalism, ethical practice and patient care from the family physicians' perspective.

Programme & Speakers

Overview

Dr Wong Tien Hua, Family Physician in private practice, Editor of The College Mirror and Deputy Director of the College.

Itemisation & SMA Guideline of Practice Cost

Dr Chong Yeh Woei, 1st Vice President of SMA and Chairman of Private Practice Committee.

Fee Pricing Strategy

Dr Tham Tat Yean, Managing Director of Frontier Healthcare Group

Problems, Challenges, and Action

Dr Alvin Ang Choon Kiat, solo Family Physician in private practice

PANEL DISCUSSION

MEDICINE Convention 2008

Talking Cure: Narrative Lessons from Psychotherapy

COURSE

Time 2pm to 4pm
Venue MOH/College Lecture Room
College of Medicine Building

Course Fee
\$10.00 for College Members
\$60.00 for Non-members

Synopsis

This two-hour teaching course is specially designed to expose doctors to specific psychotherapeutic skills which they can adapt to patient consultations. A 30-minute plenary provides an overview of psychotherapy, Socratic questioning techniques and a framework of Narrative Therapy. By means of exercises and role plays in two 45-minute workshops, techniques of externalization, unique outcomes identification, re-authoring, retelling, re-membering & reframing would be demonstrated based on a case scenario.

Programme & Teaching Faculty

PLENARY

Talking Cure: Narrative Lessons from Psychotherapy

A/Prof Cheong Pak Yean

WORKSHOP 1

Continuing Care: A patient with poorly controlled diabetes

The diabetic management of a patient hitherto satisfactory has recently gone out of control. Using role-play between counsellor and patient, narrative techniques of how to help patient regain control and authority of 'Sugar' are demonstrated viz. 'Naming' & 'Externalising' the personified Sugar, exploring relationships and meaning, eliciting Unique Outcomes and Re-Authoring the place of 'Sugar' in the life of the patient.

Counselor:

Mrs Vivian Navaratnam, Counselor, Family and Systemic Psychotherapy, Narrative Therapy

Patient:

Dr Julian Lim, Clinical Supervisor, Mmed (FM) Prog B.

Commentator:

A/Prof Cheong Pak Yean, past President of the College and SMA.

WORKSHOP 2

Problems of living: A patient with depression

A patient presented with clinical features suggestive of depression amidst an array of psycho-social problems. Using role-play between counselor and patient, the importance of paying attention to the patient's narrative and using narrative techniques as clinical interventions are demonstrated viz. establishing therapeutic rapport, influence of the problem on the person and vice versa, re-Membering the patient's 'Club of Life' and Re-Framing the issues the patient faces.

Counselor:

Mr Tan Boon Huat, Executive Director of Counselling and Care Centre

Patient:

Dr Tan Yew Seng, Family Physician with interests in counselling and psychotherapy, geriatric medicine and palliative care.

Commentator:

Dr Peter Yeo, Nanyang Technological University Medical Centre, trained in Professional Counselling.

Participants will receive the lecture notes, resource materials and the two clinical case scenarios in the week of the workshops. It is important for all participants to read these before they attend the workshops. After the plenary lecture, to provide an overview, participants would attend the two 45-minute workshops in turn. The role-play demonstrations would take 30 minutes each after which there would be time for questions and discussion.

Asthma Update 2008

Family Practice Skills Course 28

- Unit 1 Updates in Asthma Management
Dr Kong Po Marn
- Unit 2 Management of Paediatric Asthma
Dr Anne Goh
- Unit 3 Wheezing in the Elderly: Asthma or COPD?
Dr Ong Kian Chung
- Unit 4 Asthma Control (ACT and ACE)
A/Prof Goh Lee Gan
- Unit 5 Occupational Asthma
Dr Lee Lay Tin
- Unit 6 Preventive Treatment - Allergens & Asthma
A/Prof Lee Bee Wah



Date: 19 & 20 July 2008

Time: 2.00pm - 6.45pm

Venue: MOH Auditorium, College of Medicine Building

Due to limited seats available, please register by 14 July 2008 to avoid disappointment.

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

Seminar 1: Sat, 19 July 2008 (2.00pm - 4.15pm)

- Unit 1, Unit 2, Unit 3

Seminar 2: Sun, 20 July 2008 (2.00pm - 4.15pm)

- Unit 4, Unit 5, Unit 6

□ WORKSHOP (2 Core FM CME Points)

Workshop: Sat, 19 July 2008 (4.30pm - 6.45pm)

- Case Studies on Asthma Control: PEF, Spirometry, ACT
- Practical Skills: Inhaler Techniques, Smoking Cessation

*Workshop is held only on Day 1 (Saturday). Registration of workshop 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
GlaxoSmithKline.



REGISTRATION

ASTHMA UPDATE 2008 Course Registration Form

Please tick (✓) the appropriate boxes

	College Member	Non Member
Seminar 1 (Sat)	<input type="checkbox"/> FREE	<input type="checkbox"/> \$ 20.00
Seminar 2 (Sun)	<input type="checkbox"/> FREE	<input type="checkbox"/> \$ 20.00
Workshop (Sat)	<input type="checkbox"/> FREE	<input type="checkbox"/> \$ 40.00
Distance Learning (Journal)	FREE	<input type="checkbox"/> \$ 40.00
	TOTAL	

Name: Dr _____

MCR No: _____

(For GDFM Trainee) 2007 Intake 2008 Intake

Mailing Address:

(Please indicate: Residential Practice Address)

Tel: _____

Fax: _____

E-mail: _____

Note: The College reserves the right to change details of the programme with or without prior notice. For any possible update or important announcement from the College, please kindly check your email before attending the course. Thank you.

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 due to cancellation after the course is conducted OR official receipt issued (whichever is earlier).

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**