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Primary Care Partnership Scheme

Extended to Patients with Chronic Diseases

by Prof Chee Yam Cheng
Assistant CEO (Clinical),
National Healthcare Group

For too long Singapore has focused its health manpower training resources on hospital practice and specialists. This has included overseas attachments and experiential learning in world-renowned centres through arrangements at the highest administrative levels, with favourable terms to public sector staff (doctors, nurses, allied health professionals) and the overseas receiving institutions. As a result the number of well trained health professionals in the hospital sector and in specialist centres, both private and public, has allowed Singapore to claim healthcare as one important engine of economic growth.

What about the primary care sector? One view is that it has been neglected over the last 30 years to run its own course. This has resulted in the present situation where the practice of aesthetic medicine is more lucrative than the practice of Family Medicine. Occasionally, we hear anecdotal accounts of patients who are rich enough to pay for wrinkle treatment and continue to go for wrinkle treatment on an ongoing basis (as though it were a chronic disease) but who are not willing to fork out a far smaller sum for a good and worthwhile medical consultation on preventive medicine within the family practice. This is indeed an undesirable state that we want to avoid.

While government's share of the hospital specialist practice is serving 80% of the nation's needs, primary care provided by the government polyclinics constitutes only 20% of family practice. The private family doctors provide the bulk of primary care, yet receive no government resources to do their job better. Has the market failed? Has polyclinic subsidy without means testing resulted in the less than optimal use of the expensive Family Practice set ups where solo practitioners work long hours trying to make ends meet? I think so. Subsidy has skewed and spoilt the market such that the private practitioner is unable on pure economic business sense to make a decent living doing the traditional thing, which is, see patients (not customers) with medical conditions, and not customers with no illness but who are willing to pay big bucks for a transient beauty uplift.

Come January 2009... Government subsidy will flow to the private family doctor who elects to manage and treat patients with chronic medical diseases.

January 2009

Come January 2009, things will change. Government subsidy will flow to the private family doctor who elects to manage and treat patients (not customers) with chronic medical diseases. The Primary Care Partnership Scheme (PCPS) will be extended to patients with chronic diseases who consult their family doctor. Patients from the lower income group can qualify to be on the PCPS. With this scheme, hopefully a pool of patients who currently see polyclinics for chronic diseases will revert to their family doctors for more personalised care. In other words, a cohort of patients that qualify for subsidy can now choose to have this subsidy paid to their family doctor. For this cohort with portable subsidy, seeing a specific family doctor regularly will enhance your Family Practice. Certain terms and conditions will apply.

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Changing Landscapes

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

Natural landscapes project an aura of calm and serenity. Deep valleys with meandering rivers, soaring mountains, monumental cliffs that drop off into the wide expanse of sea beyond. Such structures seem unchanging from day to day and from year to year, oblivious to the climate and weather. The picture (above) of the famous 12 apostles near Melbourne was taken two years ago whilst I was there on holiday. It would be the same scene to welcome you if you visit them in the future (but one word of advice if you intend to stay to watch

this issue >>

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College of Medicine Building
16 College Road #01-02, Singapore 169854
Tel: (65) 6223 0606 Fax: (65) 6222 0204
E-mail: collegemirror@cfps.org.sg
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the sunset, expect to drive back the winding mountain roads in total darkness). However, we know that these remarkable landscapes are not oblivious to change, but in fact they were themselves a product of change - change in the earth's geology, climate and weather. When I visited the 12 apostles in 2006, I had already missed one of the 'apostles', which collapsed a year earlier in 2005. There are only eight 'apostles' remaining today, so perhaps it may be better to plan your next visit there soon.

The General Practice landscape is similar. The numerous GP clinics and polyclinics located throughout Singapore, providing primary healthcare close to the community and tirelessly working every day of the year, is familiar to us. It seems that Family Medicine 30 years ago had remained unchanged till today. But the GP landscape is far from being a static one. Dealing with change is now a part and parcel of GP practice. Many issues confront the GP today - new advances in medicine together with new or emerging diseases, the rapid adoption of Information Technology, changing patient expectations and demands, new legislations and the ever changing market environment make practicing Family Medicine ever more challenging. The past few years have seen significant initiatives that affect the GP landscape, as MOH tries to engage and involve private sector GPs in achieving national health targets.

This month, Prof Chee Yam Cheng announces changes to the PCPS scheme that will take effect from January 2009. Patients with chronic diseases can now see private GPs using government subsidies. This is different from the current chronic disease management programme, where it is the patient's medisave that is being used. In the case of PCPS, the government is paying the subsidy for patients to see private GPs. No one knows for sure whether this scheme will truly shift patients away from overcrowded polyclinics, but the data submission that is required will help MOH keep track of the outcomes. This is the kind of undercurrent tectonic shifts that is changing the landscape of GPs today. We can either be active participants, or choose to sit back, and enjoy the scenery.

Family Medicine Convention

The first annual Family Medicine Convention was held at COMB on 28 June 2008. This was the first time that College organised an event like this to coincide with the Annual General Meeting.

The first segment involved not just one or two, but three separate events - one was the FM Commencement Ceremony held at HPB Auditorium. Prof Fock Kwong Ming was the Guest of Honour and his opening speech is reproduced in this issue. At the same time, two consecutive seminars were held back-to-back at COMB Auditorium. Seminar 1 was a forum on Chronic Disease Management chaired by Dr Lee Kheng Hock. It brought together speakers reflecting the perspectives from MOH, a large group practice and a GP who runs his own clinic. The latter was none other than Dr Wilson Eu, who is a Council Member of the College. His critiques and suggestions regarding the CDM programme is featured in this issue of College Mirror. Seminar 2 was a forum to discuss Professional Fees and Practice. We had views from Dr Chong Yeh Woei, giving the SMA advisory on bill itemisation, Dr Tham Tat Yean giving a very interesting and informative talk on how to price one's consultation and fees, and finally Dr Alvin Ang who spoke about the challenges he faced as a solo GP. Dr Ang had previously written about this in the March issue of College Mirror. ("Oil and Wheat Prices are Going Up but Family Doctors' Prices are Bucking the Trend?" - I strongly urge you to read his article if you had not already done so).

Whilst these two events were going on, a group of GPs gathered in the College lecture room to participate in A/Prof Cheong Pak Yean's short course on psychotherapy. His framework of Narrative Based Therapy will be a very useful tool for GPs with interest in psychotherapy and counselling.

Finally, after all these three events, the Family Medicine fraternity gathered together at COMB Auditorium for the Annual General Meeting. The Family Medicine Convention had indeed ensured that this year's AGM broke the record for attendance and the sweet prize for the College was being able to reach a quorum to drive through constitutional amendments. Dr Cheng Heng Lee, the Executive Director of the College, gives a summary of the AGM proceedings in this issue. CM

Talking Cure: Narrative Lessons from Psychotherapy Course, with speakers: Mr Tan Boon Huat, Mrs Vivian Navaratnam, A/Prof Cheong Pak Yean, Dr Julian Lim, Dr Tan Yew Seng, and Dr Peter Yeo, was specially designed to expose doctors to psychotherapeutic skills.

Deploying INFORMATION TECHNOLOGY for Primary Care

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

Although information technology (IT) in primary care first made its appearance in Singapore some forty-years ago in the form of bulletin boards, and later attempts at developing medical record systems for patient care, it has not yet achieved its real potential. Nevertheless, the day of using IT for primary healthcare in a big way is probably not too far away if we can harness our energies together.

Today, we have the components of IT available to develop a connected system to link primary care with institutional care. It would therefore be useful to take a step back and look at what is now available and where do we go from here.

We can examine what we can do with the internet, the medical record system, and the thumb (also called the memory stick).

The Internet

The Internet is now the online knowledge storehouse of the world. There is the Google search engine, the Wikipedia, the Pubmed online medical journals, and many websites that could provide an answer to any medical question within a few minutes. The next step will be to put together useful information in folders in some easily retrievable way to have a ready archive of information for patient education and professional education. Indeed, many doctors have put such information together and are using them to provide the just-in-time information needs.

With right-siting of patient care being seriously considered, the internet can be a useful information archival place for the sharing of information between patient, specialist, and the family physician. Into such places could be stored the care paths, the FAQs, and other useful information.

The use of the intranet and password mechanism to restrict entry to particular areas on the webpage could be utilized to safeguard medical records that can be shared.

Finally, the internet system can be linked to the handphone, PDAs for rapid communication of messages for healthcare alerts and reminders. The possibilities of exploiting the world's electronic highways to serve ourselves and patients are limitless, almost.

The medical record system

The shared medical record system is becoming a reality. Singapore has been set back for many years because the idea of a common system was not realized early enough. In medical information sharing, being unique means that information sharing is uniquely impossible. Thankfully, this is being resolved. The day that family physicians, hospital specialists, intermediate care physicians, nurses, and support staff being linked together is coming. There is a need for family physicians to champion the development of such connectability. The more connectability there is, the more uses can be deployed. Imagine the time saved and the speed of decision making in patient care made possible. We need to connect up.

The memory stick

The memory stick is a wonderful storage device that is relatively hassle free. There are now memory sticks with 16 gigabyte of storage. It can certainly store lots of patient information system. The American Academy of Family Physicians has worked on the portable continuing care record (CCR) that can be shared by doctors and patients. What started as a simple concept of being able to store patient information in an exchangeable way, to graph important information to show trends like BP readings, blood sugar readings, cholesterol readings, and other continuing care parameters has become complex with the involvement of computer scientists. The fact remains that this is a useful way of enabling the patient and his doctors, and other healthcare providers to see and use the same information to achieve better processes and outcomes. With the use of passwords, selected access to information is not a problem.

The end in mind

How much can we connect the primary care providers, the hospital specialists, and the patients together are questions that we should attempt to answer as a nation. The wow of what IT can do for the family physician is here. What is missing is for champions to help us stretch out our hands to grasp the potential. CM

Definition of FAMILY MEDICINE

A Keynote Address by Prof Fock Kwong Ming,
Master, Academy of Medicine, Singapore;
delivered at Family Medicine Commencement 2008 ceremony, 28 June 2008

Although general practitioners have worked in Singapore since the introduction of Western Medicine, the College of General Practitioners was inaugurated in 1971. By 1993, the College was renamed College of Family Physicians to more accurately emphasize the role of the medical doctors practising in the discipline. What is Family Medicine that sets it apart from other specialties of medicine. WHO, WONCA have attempted to define family medicine and I quote from the WONCA Europe 2005 that Family Medicine is an academic and scientific discipline and a clinical specialty attributed to primary care.

According to WONCA, there are 11 characteristics of Family Medicine which can be categorised into 6 core competencies (Refer to Figure 1).

Core Competence	Characteristics
Primary Care	1. Normally serves as the first medical contact within the health care system. 2. It facilitates the efficient use of health care resources through care co-ordination, partnership with other professionals and playing an advocacy role for the patients when required.
Person-centred care	3. Develops a person-centred approach focusing on the individual, family and community. 4. Establishes a relationship over time through effective communication between doctor and patient. 5. Provision of longitudinal continuity of care as determined by the patient's needs.
Problem solving skills	6. Specific decision making process determined by the prevalence and incidence of illness in the community. 7. Manages both acute and chronic health problems of individual patients.
Comprehensive approach	8. Manages illness which presents in an undifferentiated way early which may require urgent intervention. 9. Promotes health and well being.
Community orientation	10. Has responsibility for the health of the community.
Holistic approach	11. Deals with health problems in their physical, psychological, social, cultural and existential dimensions.

Figure 1. http://www.who.int/Wonca Europe 2005 Edition

Challenges

That is the challenge that family physicians face. The specialty requires a general, comprehensive, continuous approach to patient care that takes into account the family and community interests. In practical terms, this means treating both acute and chronic illnesses, caring for patients' physical, psycho-social needs, life-long, educating him on self-care and co-ordinates his care in collaboration with specialists and the rest of the health care system. This definition is broad, holistic, complex and demanding that lacks an obvious unifying concept. WONCA in its report suggested the need for a clearer definition.

Opportunities for Family Physicians

In the last 5 years, a better understanding of epidemiology, has helped to define the role of Family Physician in the healthcare system more clearly. WHO estimates that chronic diseases such as heart disease, stroke, cancer, chronic respiratory diseases are the leading cause of mortality and disability in the world accounting for 60% of all deaths. Of the 35 million people who died from chronic disease in 2005, half were less than 70 years old. The burden of chronic disease is higher in under developed or developing countries. Refer to Figure 2.

The increase in chronic diseases is believed to be due to urbanisation resulting in sedentary lifestyle, increased use of tobacco, alcohol, unhealthy diet with increased sugar and fat.

Obesity is a major problem of the Western Pacific Region and is becoming a concern in Singapore. Prevalence of overweight people in Singapore is expected to increase in both men and women over the next 10 years. At least 80% of premature heart disease, stroke and type 2 diabetes and 40% of cancer could be prevented through lifestyle changes such as healthy diet, regular physical activity and avoidance of tobacco.

Recognising the importance of providing care for patients with chronic

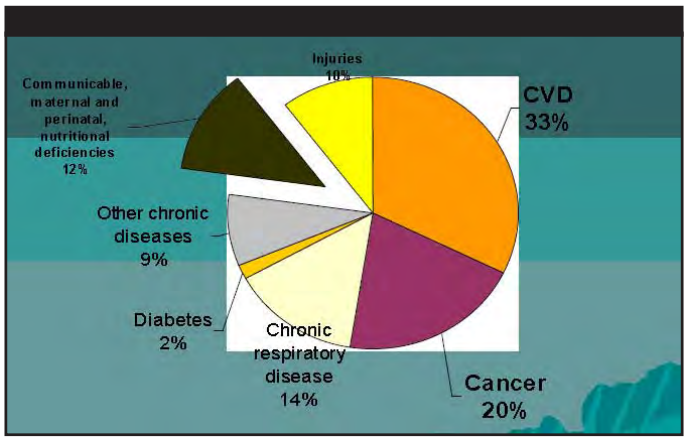


Figure 2. Cause of death in the Asia Pacific, all ages, 2005. Total deaths: 12,397,000

disease has resulted in a review of the healthcare system in many countries. In Singapore, MOH has identified chronic disease management as a top priority. A plan on integrated care across the care continuum has been developed and implemented.

In this plan, the Family Physician is involved in all the phases of patient care: preventive care, primary care, tertiary care and step-down care, making him pivotal in chronic disease management.

Preventive Care

In the (NHS 2004) report in Singapore, 50% diabetics, 39% hypertensives were undiagnosed and unaware that they were suffering from the disease. This is despite the efforts in hospitals, community centers and work places to screen asymptomatic people for these conditions. There were deficiencies due to 'same' people who were going for the screening and after detection, defaulted follow up.

PCPS

With effect from 1st January 2009, Primary Care Partnership Scheme (PCPS) will be extended to 3 major chronic diseases: diabetes, hypertension and hyperlipidemia. This is an extension of the present PCPS which was introduced in 2000 to allow means-tested Singaporeans >65 years and above or disabled to receive care treatment from participating private general practitioners at subsidised rates. Currently, there are 19,000 PCPS card holders receiving treatment from 450 GP clinics. When implemented, the extended PCPS will have a significant impact on chronic disease management.

CDMP

To strengthen chronic disease management at the primary care setting, Medisave for CDMP (Chronic Disease Management Programme) was introduced in 2006 to cover diabetes, hypertension, hyperlipidemia, stroke, asthma and COPD (Chronic Obstructive Pulmonary Disease). The treatment for patients included in CDMP are evidence-based disease guidelines to improve care for patients with diseases. To date, there are 720 GP clinics (53% of all GP population) participating in CDMP. The amount of medisave claimed has increased from $650,000 monthly in 4Q, 2006 to about $2 million monthly in 1Q, 2008. This shows that this programme is popular with the community. MOH has audited the clinical outcome to ensure that treatment is in accordance to the guidelines.

Establishing a new GP-SOC link

In Singapore, the term "Right-Siting" was coined to introduce the concept that patient receives the care at the appropriate setting, i.e. if he requires a specialist to take care of his medical needs, he will be treated at a hospital. When he no longer requires the care of a specialist, he can then be treated by a Family Physician in a clinic near his home. From April 2008, the SOCs in all the public hospitals have embarked on a programme that encourage specialists to refer patients back to their primary care physicians. KKH will start later, for asthma.

Enhancing the RH to CH links

As we speak, the detailed plans for this last piece in the integrated health care system are being developed and fine-tuned. Suffice it to say that there will be opportunities for Family Physicians in CHs, Nursing Home, hospitals.

Conclusion

In the space of 20 minutes, I have attempted to define the challenges of the family physician encounter and also describe the opportunities that are coming your way. I urge you to seize the opportunity to make yourself a key player in our integrated health care system. Focus on providing for your patients, evidence based clinical practice, optimal clinical outcome and you can stand tall in the professional community. CM

(from page 1)

Terms and Conditions

The first is that the patient has a diagnosis of diabetes, hypertension and/or hyperlipidemia to qualify for PCPS. It could be one, two, or all three diagnoses in a single patient.

The second is that the patient qualifies for subsidy and is willing to port this over from the public sector polyclinic to the private sector by choosing and staying with a specific family doctor for the care of these ailments. Should you need to refer the patient back to the hospital Specialist Outpatient Clinic, the patient remains a subsidised patient even though you, the family doctor made the referral.

The third is that the amount of PCPS subsidy for these three conditions will be equivalent to that provided to polyclinics.

The fourth is that there is an annual subsidy cap per patient. There would be two tiers of caps, one for patients with less severe (and therefore lower dollar cap) and the other for patients with more severe chronic diseases.

In return, the PCPS doctor on this scheme will be required to submit data on the bill incurred by each patient per visit. This serves two purposes. The first is to determine the adequacy of the subsidy, and the second is to allow outliers to be identified. In addition, the PCPS doctor will also be required to submit clinical data as per the current Chronic Disease Management (CDMP) framework.

The public will have access to information detailing the prevailing range of polyclinic charges for similar conditions and consultations. This would set a bench mark for what would be acceptable charges and charging.

Conclusion

PCPS is not new. It exists today. It exists for acute medical conditions for the needy elderly and disabled adults. This will remain. What is new is the extension of PCPS to include coverage of chronic medical conditions. In January 2009, these conditions are three in number; they are diabetes, hypertension and hyperlipidemia.

I would encourage family doctors true to their vocation and calling to help manage the ever-increasing pool of such elderly patients. This is why you went to medical school. This is what medical practice is all about; treating patients (not customers) with evidence based medicine to make a difference to their outcome, prevent complications and help them lead a healthy life. These patients are truly in need of your expertise. Now, government funding will help them pay you, their good doctor, for the excellent care you provide. CM

Primary Care in Singapore: Heading for Market Failure?

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

Applying economic theory to the primary health care scene, I am concerned that the "market" for family medicine in Singapore may be heading for market failure.

Why do I think so?

For years, any medical graduate after the requisite year of housemanship (or internship), can leave the hospital setting and set up shop as a solo and independent General Practitioner (GP) in a neighborhood shophouse. This is without going through any minimum level of exposure or training in internal medicine, general surgery, paediatrics, emergency medicine or other hospital postings that would have equipped him to practice independently in the community.

In the good old days this might have been acceptable, when patients were less informed and their expectations were easier to satisfy, when there were less medical lawsuits, when the doctor's word was considered unarguable truth, when medical knowledge was not growing exponentially year-on-year. But today, most people expect that GPs should be well trained and all-rounded before being unleashed into the unsuspecting public.

In the early 1990s, the Masters in Family Medicine program was started, and in the early 2000s, the Graduate Diploma was added. However uptake of these courses was very limited. Basically, young doctors (GPs-to-be) considered the opportunity costs of studying/training for an additional 2-3 years, vis-à-vis establishing a practice and clientele in a new HDB town - and the latter made much more economic sense. There was little advantage in gaining an extra degree when the public was not aware of the difference, and there was no segmentation at all in a highly competitive market (all "doctors" and GPs were the same to them).

Relatively junior doctors leave hospitals earlier to become GPs in a crowded market, and feel compelled to sign contracts with managed care groups to stay afloat. These groups have been known to milk GPs for low-margin high-volume work eg factory workers, and GPs are seen as "cough-and-cold doctors". Many GPs (up to 60%) also sought to supplement their income with aesthetic medicine work, which has received bad rap of late . With rising public expectations, improving standards in hospitals (specialist care) and polyclinics, it was perhaps inevitable that public perception of the GP's skill and value would decline.

Relatively junior doctors leave hospitals earlier to become GPs in a crowded market, and feel compelled to sign contracts with managed care groups to stay afloat.

Lower price (consult fees) drives out better quality. Less doctors are willing to supply service at this price.

Signs of this worrying trend were revealed in a recent study by Wong CY et al , which quantified the perception that GPs are operating under more trying conditions now than compared to a decade ago (the previous GP practice survey was conducted in 1996). They work at least as long hours, bear higher costs while seeing fewer patients than 10 years ago. Costs have increased: rentals by 31.4%, drugs by 41.7%, utilities/ laboratory by 58.8%. However consultation fees have only increased by 25.4%, and the GP's income has largely stagnated over the past 10 years (mean monthly income 2006: $10,524, 2007: $10,271). The report ended with a sober comment that, while "competition is necessary to bring about greater efficiency and lower prices, market forces are such that if left alone, they will reward commodity production..., while punishing sustaining relationships, listening to people, and sorting out and responding to troubles... - the traditional and valuable work of the GP."

Basic economics states that market equilibrium is a condition where a market price is established through competition, such that the amount of goods or services sought by buyers is equal to the amount of goods or services produced by sellers. It is the point where the supply curve intersects the demand curve.

Figure 1: Supply and Demand

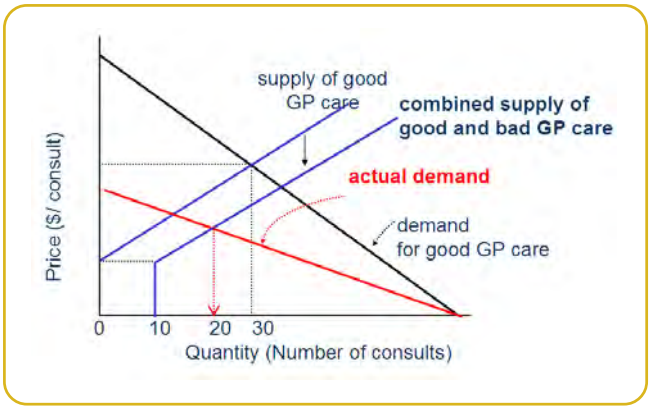


Figure 1 below shows how the market may have been sullied by low quality standards and especially low pricing, leading to a lower combined supply curve (ie less willingness to provide the service at a lower price.) In a related manner, the actual demand for good GP care by patients has also declined.

An uninformed patient faces a combined supply of good (well trained) and less well trained GPs, and knows he has a chance of drawing an "adverse selection", because he may have little knowledge on how to differentiate between the two - there is asymmetry of information. He thus lowers his demand curve, and is not willing to pay a premium, even if he sees a doctor with "GDFM" or "MMed" tagged to his name.

Lower price (consult fees) drives out better quality. Less doctors are willing to supply service at this price. Junior doctors are not keen to take up further FM training, and trained ones are not keen to join the market.

This leaves the patient facing the GP market with even worse adverse selection. One can imagine that as the demand curve adjusts lower and lower (the red line in Figure 1 above), and the combined supply curve shifts further from that of good GP care, there will come a point in time when supply of bad quality exceeds demand, and only the bad ones are left in market! This will be the ultimate market failure of primary care.

Perhaps to counter this trend, the Family Physician Register was mooted, and essentially introduces an Appraisal Mechanism to objectively resolve the asymmetry of information and differentiate the well trained GPs from the rest. Doctors who chose to take up the 2-3 year of FM training (spending money, time and effort), would be able to signal to the patients that they were serious about upgrading of skills in order to offer better treatment.

As family physicians, we now also recognize the need to invoke the support of the so-called 4Ps - people, press, policy makers and profession. The public and our patients need to be convinced that we are well trained and capable to take on mainstream Family Medicine, chronic disease management, right-siting, integrated care. Perhaps when more are aware of the value and willing to pay the due worth of good care, then we will meet at a different point on the demand-supply curves. CM

Dr Loke Wai Chiong, MMed (FM), FCFP(S) is a member of The College Mirror Editorial Board. Currently, he is also pursuing his Executive MBA at UCLA-NUS.

A Conversation with Dr Farhad Vasanwala

Spearheading Family Medicine in Hospital

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

In our unceasing quest to explore new frontiers in Family Medicine to better serve our patients and community, GPs and family doctors have in recent times made ventures into areas outside the traditional neighbourhood clinic. Some have become mobile housecall doctors while others have chosen to serve in hospices or home care services. A few have gone further by becoming hospitalists who are essentially hospital based generalists with advanced training in Family Medicine. College Mirror had the priviledge to speak to one such pioneers in this relatively new field of Family Medicine.

College Mirror(CM): Please introduce yourself. Tell us about your career and qualifications thus far.

Dr Farhad: I am father of two children, a girl and a boy aged 6 and 4 years respectively. Married to my lovely wife, Rashida who is a paediatric medicine registrar at KK Women's and Children's Hospital. Since May 2007, I have been privileged to work as a registrar in the Department of Family Medicine and Continuing Care (FMCC) of SGH. Prior to that, I was working at SingHealth Polyclinics Bedok as a Senior Resident Physician.

I was initially trained as a Microbiologist, graduated from National University of Singapore with a BSc (Hons) in 1992. Despite being trained as a scientist, I felt that I am much more suited to be a doctor. My mother who is still working as a General Practitioner played an important role in this outlook. Fortunately for me, with the support of my parents, I was able to start my medical studies at the age of 24. I did my medical studies at the University of Sheffield (UK) and graduated in 1997. I came back to Singapore, did my housemanship here, and then did varied rotations in medical, surgical disciplines and polyclinics postings. I obtained my MRCP(UK) in 2004, GDFM in 2006 and MMed(FM) in 2007. Currently I am pursuing my Fellowship (FCFP) programme.

CM: Give us an update on FMCC staff strength, ward capacity, and any new development since inception.

Dr Farhad: FMCC is a pioneering department making inroads where no one else in Singapore has ever been. Family Medicine is facing exciting times and our Department is spearheading lots of initiatives.

Our Department is headed by our Senior Consultant and Head, Dr Lee Kheng Hock. Our staff strength consists in total of 1 Consultant, 2 Associate Consultants, 3 Registrars, a Resident Physician, and Medical Officers and trainees attached to the Department. We also have colleagues who are Visiting Consultants of our Department and they include A/Prof Goh Lee Gan, A/Prof Cheong Pak Yean, and Dr Tan Boon Yeow. At the moment, we are actively recruiting staff as SGH is entrusting our Department with more responsibilities in continuing care. We also need more good people to help us in the many challenging innovations in service and teaching.

We help the College of Family Physicians Singapore run the weekly MMed (Family Medicine) training in Programme B. Our department is in charge of the Family Medicine clerkship of the new Duke NUS Graduate Medical School. We also teach medical students from the Yong Loo Lin School of Medicine at NUS when they are posted to the Division of Medicine in SGH.

Our department contribute to inpatient care under the Division of Medicine and we have 36 inpatient beds under us, managing providing general medical care to patients with an emphasis on promoting care continuity. Here, we apply our family medicine training and paradigm to help solve many complex and challenging issues. We also operate a Home Based Intermediate Care Programmes in which we provide short term home medical care to patients to facilitate an earlier discharge and transition to care providers in the community. Apart from the above, we run Hospital Integrated Care Conferences where, as part of a multi-disciplinary team, we assist in the planning of care for patients with care integration issues. Our department also supports our colleagues in the Anesthesiology Department in SGH in the pre-operative evaluation of patients who are going for major elective surgery.

There is a lot of academic activities going on in the Department. We bounce ideas on clinical research and all our staff are working on research projects and collaborating with one another and with our specialist colleagues in other departments in SGH. There is also a lot ot teaching going on. We are involved in teaching of undergraduates and postgraduates students. Everyday, there are teaching activities we conduct. The inpatient teams will have a ward based teaching at the end of everyday. Every Tuesday, we have a department book club. Every Wednesday, we have a lunch time journal club and a grand ward round in the afternoon. We end Wednesdays usually with a teaching session for MMed(FM) trainees. Every Monday and Friday, we have an integrated care conference where we confer on cases in our wards and learn from one another.

CM: What made you decide to work in a hospital setting as opposed to the conventional outpatient setting?

Dr Farhad: A/Prof Goh Lee Gan and Dr Lee Kheng Hock approached me last February 2007 and enquired whether I would be part of this pioneering team that may play an important role in further establishment and diversification of Family Medicine. They explained that there would be enormous challenges ahead, and I felt this was definitely something worth pursuing. Also professionally, I felt that I would be more able to improve my skills, medical knowledge and have more time for my patients compared to the Polyclinic setting. Plus, my fellow colleagues are a group of inspiring and innovative doctors.

CM: What would be your response to critics who feel that family doctors should be 'out there' as primary care doctors?

Dr Farhad: Family Medicine practitioners are generalists who have a very unique and inspiring care paradigm. Our unique set of skills and knowledge, and our holistic approach to patient care make us very effective in various care settings in the entire spectrum of care. The large majority will always be needed to do the important work of providing holistic care to patients in the community. The majority of family physcians will be practicing in the primary care setting. A significant number of us will be in different settings, mainly in community hospitals and academic medical centres. As Professor Ng Han Seong said, Family Medicine must have a base in the hospitals where we can learn consolidate and train the present and future generations of family physicians in the community. This is possibly the only way to put Family Medicine as a specialty on par with other disciplines. Here, we are able to honed our skills, be exposed to various other disciplines, share and interact with them and incorporate it into the family medicine ethos. We work as intermediaries between the specialists and the family physicians in the community and vice versa.

CM: How is your relationship with the other specialists in the hospital? Are you treated as equals?

Dr Farhad: I have seen over the past two

Our unique set of skills and knowledge, and our holistic approach to patient care make us very effective in various care settings in the entire spectrum of care.

Dr Farhad was initially trained as a Microbiologist, but pursued his interest in Family Medicine. After his basic medical degree, he obtained his MRCP(UK) in 2004, GDFM, MMed (Family Medicine) and is now undergoing advanced Family Medicine training under the College's 'FCFP by Assessment' progamme.

years our relationship with our specialist colleagues is going on from strength to strength. Yes, there were times when we faced obstacles, but there were many who went out of their way to integrate us. They taught us and quickly brought us back to speed in working in a hospital setting. Consequently, in the care for our patients, we are treated as equal members of a medical team in many fronts. Some specialist colleagues who were initially skeptical are gradually seeing the advantage of having Family Medicine as an important integral part of hospital care especially when dealing with patients with multiple co-morbidities and care integration issues.

CM: What's a typical working day for you?

Dr Farhad: FMCC is based on team concept. Our duties are based on a monthly "tours of duty" which cycles through the various areas of service. This allows us to focus on our area of work and gives diversity at the same time. We hope that eventually, when the department is mature, we will have monthly tours that are dedicated to teaching and research.

Typically, those rotated to the wards include two Registrars or Consultants who look after the ward patients. The rounds start at 8am and usually finish by 11am. Following which, we are involved in administrative work, teaching of students and either meeting our patients' families or our specialist colleagues for care co-ordination and management. The senior doctor is also tasked to answer "Blue Letters" for care integration.

We also prepare topics relating to difficult or interesting issues in the ward for discussion with our Medical Officers and Houseman after the exit round at 5pm.

One senior doctor would be tasked to do home visits for patients who are nearly always ADL dependent with multiple medical/social problems. Here, we follow up patients referred to us by our specialist colleagues to tie up various medical problems and then eventually hand them over to their own family physicians, polyclinics, or mobile home services (e.g. CODE 4, Hua Mei, Ren Ci, etc). We are able to do specialised procedures like changing PEG tubes, Tracheostomy, debridements of the wound, etc. Thus, these patients can be discharged back to the community earlier and it even lessens the readmission rates back to the hospitals.

Another senior doctor would be involved in the specialist out patient clinics. Here, we see referrals from our primary care colleagues and our own SGH A&E for complex undifferentiated problems. We also follow up our patients discharged from the wards. Thus, all of our senior doctors are crossed trained to handle various responsibilities in the department.

All of us are active in doing research, projects and preparing talks for post-graduate and undergraduate teaching.

CM: Please cite an interesting case to illustrate the relevance of FMCC.

Dr Farhad: We have many cases! An example was very recently, an elderly lady who was premorbid ADL independent had multiple bowel surgeries that was done a year earlier at a private hospital. She thus effectively had a short gut syndrome. Over the past half a year, this lady had repeated admissions altered mental state due to electrolyte abnormalities and vitamin deficiencies. She required the care of multiple specialties, and care co-ordination was a major issue.

On each admission, the patient recovered rapidly with I/V replacements for the fluid, electrolytes and vitamin deficiencies, and then promptly discharged. The follow-up care was fragmented. The family also did not have a clear understanding of her complex health issues. When we took over the inpatient care of this patient, we made sure that after I/V replacement we titrated various medical treatments from the input of various medical specialties to formulate a plan that was agreeable to both the family of the patient and her patient herself. We had discussions among ourselves at the department's tri-weekly meeting on care co-ordination and management of our patients on how to tackle this complex problem. We later educated the family and the patient on what to look out for, how to control their diet, intake and output of liquids and food and plus oral supplements. We also made sure we have close follow up appointments to maintain and hopefully reverse problems before they arise at our SOC clinics.

The family members and the patient herself thus have regained faith in the system from co-ordination and continuity of care. Later, when the patient is stabilised, we will link her up with a family physician who will help us support her in the community. She will then need much less visits to the hospital.

We managed to break the dangerous cycle of recurrent re-admissions, with the patient in a very dangerous state of decompensation at each repeat admission.

CM: Do you regard FMCC at SGH a flagship for Family Medicine and in your opinion, can we expect similar departments in other hospitals in the future?

Dr Farhad: Family Medicine itself is a flagship that signifies the importance of care continuity and the care integration. What FMCC does is merely to demonstrate the capabilities of family physicians and link the discipline back to the academic medical centres. FMCC helps to change our mindset and break through any mental limitations on what a Family Physician could do or should do We believe the return of the generalist to the hospital is a global trend and family medicine with our special focus on care continuity and patient centredness can make a significant contribution to the care of patients in a hospital setting.

Diabetes Prevention Program (DPP)

The Diabetes Prevention Program (DPP) was a major clinical trial.

Research question

DPP was aimed at discovering whether diet, exercise, and weight control (therapeutic lifestyle change) or oral diabetes drug metformin which reduces weight could prevent or delay the onset of type 2 diabetes in people with impaired glucose tolerance (IGT). It took the researchers working with 3234 patients with impaired glucose tolerance and three years to find the answers.

Methodology

In the DPP, participants come from 27 clinical centres around the US. They were divided randomly into three groups:

- First group was put on therapeutic lifestyle change of intensive training in diet, exercise and behaviour modification. By eating less fat and fewer calories and exercising a total of 150 minutes week, they aimed to lose 7% of their body weight and maintain that loss.
- Second group was put on 850 mg metformin twice a day
- Third group was given placebo pills.

Results

The results of the study are:

- Diet, exercise, and weight control avoided developing into diabetes in 58% of participants in the group
- Metformin is effective in delaying the onset of diabetes in 31%.
- Unmanaged, patients with IGT becomes diabetic at about a third in 3 years.

Conclusions

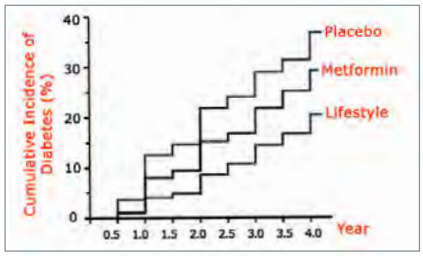
Lifestyle change which consists of diet, exercise, and weight control results in the delay of diabetes in 58% compared to IGT patients who did mot make any lifestyle change. We need to teach people with high risk for diabetes that lifestyle change can make a difference in delaying the onset of diabetes in at least half of them over 3 years.

Reference for further reading

Diabetes Prevention Program Research Group. Reduction in the incidence of Type 2 diabetes with lifestyle intervention or Metformin. New Engl J Medicine Feb 7 2002; 346:6:393-403.

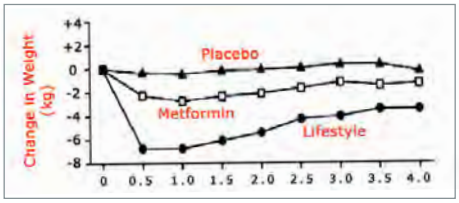
CM

Table 1. The impact of lifestyle, metformin, and placebo on the cumulative incidence of diabetes in 3234 patients with impaired glucose tolerance. Lifestyle change (diet, exercise, and weight control results in the reduction of 56% of diabetes in patients with impaired glucose tolerance.



Source: Diabetes Prevention Program. New England J Medicine 2002

Table 2. The impact of lifestyle, metformin and placebo in the change in weight (kg). Lifestyle change (diet, exercise, weight control) results in a weight loss of up to 4kg



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CM: What is your advice to anyone who wants to follow your footsteps?

Dr Farhad: Be prepared for an adventure! FMCC is constantly evolving for the better to find how we can better serve our patients/hospital/society and our family physician colleagues in the community. There is never a boring day! The spirit de corps of our department is strong and we have great camaraderie. In time to come, I am sure our department will play a vital role in the field of Family Medicine. Thus, I would highly recommend our colleagues in the community to join us.

CM: Is there life after work? How do you balance your time with your family, hobbies and other interests?

Dr Farhad: Honestly I try. I am a father of two young children. Thus, family life after office hours is crucial. I try to be home by 7.30 pm. I play and teach them during the night, and send them for classes on weekends. Social outings with my family including my parents and brother are important too. I also swim regularly to keep fit. CM

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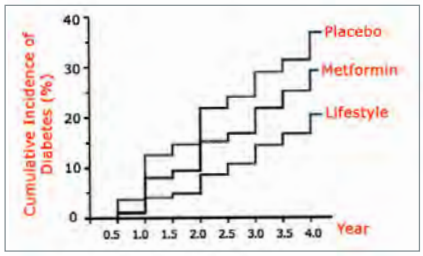

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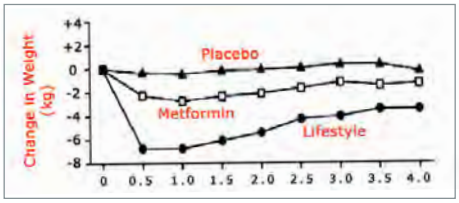

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Annual Family Medicine Convention 2008

(Top) FM Convention / AGM Tea Reception, College of Medicine Building Function Room, 28 June, 4.00-4.30pm.

(Below) Talking Cure: Narrative Lessons from Psychotherapy Course, College Lecture Room.

Family Medicine Commencement, Health Promotion Board Auditorium, 28 June, 2.00-4.00pm
(Left) Dr Tan Boon Yeow representing the Censors Board. (Right) Prof Fock Kwong Ming, Master, Academy of Medicine Singapore, delivering the keynote address (as printed on page 5).

College Annual General Meeting

The College AGM held on 28th June 2008 was notable because we finally got a quorum after failed attempts in the past few years. To cap it all the quorum of two hundred voting members was a record in the history of the College.

With the quorum the resolutions on the proposed amendments to the Constitution of the College could be tabled and it was unanimously approved.

Moving forward there need only be fifty voting members or 1/8 of the total voting members, whichever is less, to form a quorum for a AGM. Members can also look forward to being awarded life membership if they have paid 30 years of membership subscription.

During the AGM members also endorsed the 21st Council's nomination of Dr Lee Suan Yew for the Albert and Mary Lim Award. This award is in recognition of his contribution to family medicine.

Dr Lee Suan Yew will be conferred the award during the College Convocation on 23rd November 2008. CM

Family Practice Skills Course

Asthma Update 2008

The College of Family Physicians Singapore would like to thank **GlaxoSmithKline** and the Expert Panel for their contribution to the Family Practice Skills Course on **"Asthma Update 2008"**, 19-20 July 2008.

Dr KONG PO MARN - Consultant Respiratory Physician, Kong Clinic for Chest & Internal Medicine, Mount Elizabeth Medical Centre

Dr ANNE GOH - Senior Consultant, Respiratory Medicine Service; Head, Paediatric Allergy, Immunology, and Rheumatology Service, Dept of Paediatrics, KK Women's and Children's Hospital

Dr ONG KIAN CHUNG - Consultant Respiratory Physician, KC Ong Chest & Medical Clinic, Mount Elizabeth Medical Centre

A/Prof GOH LEE GAN - Senior Consultant, Institute of Family Medicine; Associate Professor, Dept of Community, Occupational and Family Medicine, Yong Loo Lin School of Medicine, National University of Singapore

Dr LEE LAY TIN - Senior Specialist, OSH Specialist Department, Occupational Safety and Division, Ministry of Manpower

A/Prof LEE BEE WAH - Adjunct Associate Professor, Department of Paediatrics, National University of Singapore

Chairman: **Dr CHOW MUN HONG**

Congratulations!

Graduate Diploma in Family Medicine (2006-2008)

Dr Chen Jer Shih
Dr Chew Ee Hern Kevin
Dr Chia Wei Meng Vincent
Dr Chin Siew Pang
Dr Chong Chun Choy Vincent
Dr Chong Yu Eric
Dr Chua Shu May Celeste Ann
Dr Chua Swee Huat George
Dr Chua Yong Kwang Kevin
Dr Dana Elliott Srither
Dr Espeno Richard
Dr Florencio III Santos Pineda
Dr Gan Ow Tin
Dr Goh Wee Teck Jerry
Dr Han Su Yin Jane
Dr Han Wui Syen
Dr Henry Ramaya
Dr Ho Jee Meng
Dr Hoo Hui Kim
Dr Koh Jean Shen
Dr Koh Kian Hiong Derek
Dr Koo Wee Khiat Alvin
Dr Kwan Pek Yee
Dr Kwee Wee Hock David
Dr Lau Eng Kien
Dr Lau Yen Ning
Dr Lee Chu Ching
Dr Lee Eng Seng
Dr Lee Hon Yee
Dr Lee Kai Xin
Dr Lee Mei Kam Irene
Dr Lee Van Hien
Dr Lee Wan Sian
Dr Leong Huey Yee Christine
Dr Leow Boon Teck
Dr Leow Cheng Gek
Dr Liang Clarence
Dr Liew Nan Piew Herman
Dr Lim Chui Yin
Dr Lim Liang
Dr Lim Mei Yuan Loretta
Dr Lim Shee Lai
Dr Lim Wee Peng
Dr Lin Kai Wei
Dr Ling Ning Margaret
Dr Lye Tin Fong
Dr Ma Sabai @ Lee Cheong Mei
Dr Ma Rachelle De Gracia
Dr Manimaran Sivasamy
Dr Manojkumar Amarlal Kharbanda
Dr Mary John
Dr Mohd Saifuz Sulaimi
Dr Ng Cheow Hua David
Dr Pang Wui Chi Jason
Dr Phua Sin Ru
Dr Pwee May Li Emily
Dr Quah Hock Aik Derek
Dr Quek Peng Lim Timothy
Dr Rebecca Martha Jacob
Dr Santiago Baby Liza
Dr Seniati Rizalina Bahari
Dr Seo Peng Sin
Dr Sng Kong Chee
Dr Sonia Haridas
Dr Tan Gek Ngor
Dr Tan Han Young Felix
Dr Tan Hsin-Hui Louisa
Dr Tan Sein Yong Esther
Dr Tan Swee Meng Robin
Dr Tang Ching Ching
Dr Tay Siew Hua
Dr Tay Wen Sien
Dr Teo Eng Swee Cuthbert
Dr Victor Risma II
Dr Wee Wei Keong
Dr Wong Pei Lin Suzanne
Dr Wong Pey Gein Franco
Dr Woo Lan Choei
Dr Woon Sin Yong
Dr Yap Tiong Toh

Rising to the Challenge

Dr Manojkumar Kharbanda on GDFM

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

With our open economy, it is not uncommon nowadays to meet colleagues from other countries in the workplace. Our hospitals, outpatient clinics and research laboratories are no exceptions. College Mirror catches up with Dr Manojkumar who had trained and practised in India and who passed the recent GDFM examinations.

CM: Dr Manoj, please introduce yourself. Where are you and your family from?

I am from Mumbai, India and currently practising Family Medicine in Singapore since January 2004. I am working as NTS Medical Officer in Ang Mo Kio Polyclinic, NHGP. My wife is also working in a polyclinic and it is such a struggle to manage work and home at the same time. I have to two cute children, my son Aditya, who is 3 years and 5 months old, and my daughter Rakhi, who is 1 year and 5 months old, both were born in Singapore.

CM: Tell us about your formative years, medical training and what you did before coming to Singapore.

I completed my basic qualification, MBBS, at Mumbai University, India in 1999. I wanted to do post-graduate studies for which I had to wait for one year. During the wait, I practised as a Resident Medical officer in one of the hospitals. I was looking after Medical, Surgical, Gynaecology wards and A & E department at the same time. So I had a varied exposure in almost all the major disciplines of Medicine. Then, I got selected for MD.PSM (Masters Degree in Preventive and Social Medicine) in June 2000. It is very similar to Family Medicine, such that it deals with patients in a more holistic manner. The main emphasis is on the preventive aspect of disease and conditions, and to see patients in context of their family and work. In addition, it also includes epidemiology and statistics, health education, promotion and screening, occupational health and public health. I completed my training in July 2003 and then applied for practicing in Singapore.

CM: What made you decide to do the GDFM course?

As a doctor practising in busy Polyclinics, which has a mix of all cases - acute and chronic, and patients with undifferentiated problems from a whole spectrum of ages, I needed to have the knowledge and skills to deal with my patients more efficiently. I have always believed in upgrading myself and keeping abreast with the latest development in the medical field.

CM: How did you find the two-year GDFM course? What was the journey like going through the course?

The GDFM course was conducted in a very structured manner and certainly catered for busy doctors to complete at a comfortable pace over the two years. We had to attend the Saturday afternoon workshops, which was worth attending as the case scenarios presented were real cases that we encountered in our daily practice. We were divided into groups and made to present the cases in a systematic manner. The modules in the GDFM course were very comprehensive, well designed, and highly applicable to our daily practice.

There were also quarterly tutorials with our tutors. It was an excellent opportunity to exchange ideas, clarify uncertainties, and share experiences to improve patient care. I would especially like to thank my GDFM Tutor, Dr Cheong Seng Kwing for his excellent guidance and support which helped me breeze through the GDFM examination with ease. He used to tell us that we should first have a basic skeleton or framework, and then we can add on our ideas and knowledge on to it. He illustrated this idea with a Christmas tree as an example, to which we can attach various gifts and decorations. It is important to apply what you have learnt during the course to your actual practice. This is a big challenge if you are working in polyclinics due to the time constraints.

The most difficult and stressful part of the whole course was the preparation for the

exams itself because the topics covered in Family Medicine have very wide range! We had tutorials in our polyclinics by our family physicians to help us practice the OSCE's. They spent extra time coaching us and encouraging us. The OSCE type examinations were new to me as we have real patients with real symptoms for the exams in my country. The training provided by my seniors and the Mock OSCE Examinations held by NHGP really opened my eyes on how to prepare for the real OSCE.

CM: Was the course helpful?

Principles of Family Medicine - like patient centered care, holistic approach to the patient and his problems, and emphasis on preventive medicine - taught to me in the GDFM course have made me more confident in providing quality care and evidence based medicine for my patients.

Communication and Counselling skills course, which was a part of GDFM course, was really helpful in teaching us how to effectively engage the patients. As primary care physicians, we are not good at communication and counselling our patients. This course really equipped me in identifying patient's problems more accurately and handling difficult patients.

Professionalism, Ethics and Law skills course has also greatly increased my knowledge on ethical and legal requirement of medical practice in Singapore. It is balancing the needs of the patients and available resources to achieve the most optimal outcome for our patients.

High moments are when the patients acknowledge the care given to them with feedbacks and appreciation. I had my share of complaints and compliments, and after the GDFM, I am a more compassionate doctor and have a greater job satisfaction. Probably this will translate to less work stress! Recently, I was selected to receive the Silver EXSA Award as service quality provider. This has inspired me to aim for service excellence in treating my patients.

CM: Now that you have passed the GDFM exams, what's next? Are there any plans to continue with the MMed(FM)?

The GDFM course has opened my eyes to a whole new perspective on Family Medicine. It had accorded me the depth and breadth of knowledge of Family Medicine that was not available to me before. I am inspired by my GDFM success and intend to continue my professional development by going through the hospital postings of the FMCP and may undergo the MMed (Family Medicine) training subsequently.

CM: Who would you recommend to do the GDFM course?

I would recommend all my fellow colleagues in Singapore to go through the training in GDFM, as this will equip them with the requisite knowledge and skills to practice Family Medicine in Singapore. With the introduction of Family Physician Register in Singapore, GDFM will be become a necessity in order to practise as a family doctor. CM

MOH Chronic Disease Management Programme (CDMP) Medisave Claims

A Personal Experience & Views

by Dr Wilson Eu Tieng Juoh

MOH Aims in CDMP

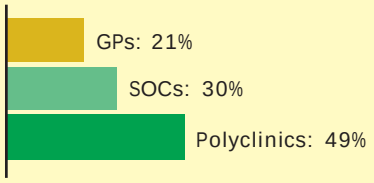
In April 2006, MOH announced the use of Medisave for chronic disease outpatient treatments. The aims were to: (1) improve care for patients with chronic disease resulting in better health outcomes, and (2) lower long term healthcare costs.

These aims are to be achieved via lower barriers to treatment (use of patients' Medisave savings) and incorporating care components that are quantifiable and subject to professional audits. These are all laudable aims.

The problems for the single practitioner lie in the many back room processes that are required to be accredited and the ongoing Medisave claims processes. There is also a lack of focus in paying for these added performance indicators.

Where were the Medisave Claims Made?

In 2007, about half of the Medisave monies was claimed in polyclinics, with about 30% claimed in SOCs and 21% in GPs. Medisave claims from GPs account for only 1 in 5 claims.



(Source: First year results of Medisave for CDMP. Dr Lee Heow Yong & Ms Wong Wai Yee,http://www.moh.gov.sg/mohcorp/uploadedFiles/Publications/Information_Papers/2008/CDMP%20OP.pdf)

The MOH CDMP Medisave Claims System

One requirement under this programme is for all participating GPs to execute a deed of indemnity with the CPF board whereby we undertake all risks and pay all fees, costs and expenses to the relevant parties in making the necessary deductions from the CPF member's Medisave account, for settlement of the clinic's bills and for any work related to it.

- ✔ Clinics shall provide their own access to use the MOH e-Services.
- ✔ Clinics are required to pay the service charges in addition to the transaction charges.
- ✔ Clinics shall be subject to periodic audits by the CPF financial audit team and MOH medical audit team.

Registration and Accreditation Process

1. Clinics submit application forms to MOH, CPF and NCS
2. Training session (processing, IT and Medisave guidelines)
3. MOH approval
4. NCS configures system set-up and issues token card
5. CPF Deed of Indemnity
6. Doctors submit accreditation forms
7. Effective date of participation

In short, to be on this programme requires taking on additional responsibilities and practice risks - to indemnify CPF, and observe guidelines and requirements imposed by CPF/MOH/NCS. For the solo GP practice, they fall on his/her shoulders alone.

Process of making a Medisave claim:

1. CONSULTATION
2. FINANCIAL COUNSELLING: explain to patient and family members whose Medisave is/are being used
3. The treatment components
4. Cost of treatment
5. Estimated amount that can be claimed
6. Out-of-pocket cash payment
7. Charging of transaction fees
8. Check if patient already has employer's benefits/ insurance
9. Signing the Medisave Authorisation Form (after verification of relationship is done, and witnessed)
10. Clinic checks Medisave balance of patient
11. Clinic makes claim via Mediclaim eService (home-work)
12. Money is GIRO-ed into clinic's account
13. Payment reconciliation

Barriers to Solo Practitioner Participation

Administrative processes require time and manpower. The administrative processes requiring the healthcare provider to file the claim for the patient from Medisave accounts (which may or may not be the patients') requires additional resources.

In a hospital setting, the nature of an in-patient episode is clearly definable. Each inpatient visit occurs over many days and there is time and manpower for all the counselling and administrative tasks to be undertaken. This is usually taken on by the 'billings department staff' with no direct involvement by the medical practitioner other than certifying the medical diagnosis.

In SOC/Polyclinic setting, as well as the larger group practices, more staff members are usually available to be trained to become familiar with the claims process and clinical data requirements. This reduces the risk of mistakes.

In the GP clinic, patients see the healthcare provider for acute/chronic/preventive care; often at the same sitting. As Mediclaims are only for specific chronic diseases, there is much work involved in separating which part of a single consult is claimable and which items are not.

Quantum of claims and the need for batching of claims

The quantums of claims involved are much smaller and the vast majority of GPs who have joined the programme are submitting claims under 'packages' or batches. So, in addition to having to work out which items in a consultation is claimable, we have to do so for multiple visits, and also visits that occur over many months. This may increase the risk of errors in submissions.

Inequitable payment

Most schemes in the market leverage on quantity discounts, be it the CDMP packages, third party contracts, or Managed Healthcare Organisations. This is at the expense of the primary care doctor. There should be a societal move to recognise the work provided by the primary care doctor and pay him equitably for the time that he spends and the expertise that is required for an effective consultation. At the moment, he is being penalised the heaviest, notwithstanding that he has the least profit margin compared to other providers in the health care system.

Practice costs

A. Set-up
   (1) IT (electronic clinic management systems, hardware, internet access subscription);
   (2) Security token: $203.30, non-refundable (valid for 3 years)
B. Cost of making Medisave claims
C. Administrative cost of un-authorised/wrongful deduction to Medisave accounts.
D. Time

In summary, from a solo GP's perspective, being in the CDMP framework means more work, more risk and increased practice costs with virtually no increase in remuneration. Given that only 1 in 5 CDMP claims are made by GPs, it is questionable whether the scheme has provided more volume for the GPs since patients do not seem to be shifting from the public to the private sector.

Some suggestions that may reduce barriers to participation

(1) Build better IT systems

There is a need for MOH financial support for the development of clinic management systems that can be fully integrated with MOH's Claims and data submission system with ease. This can be either through grants to IT providers, practices, and medical bodies.

(2) The patient submits the claims - pass the whole process of Medisave claims out of the responsibility of the practitioner to the patient as is practiced in insurance claims. The responsibility of the doctor is to fill in the form of services provided and ensure the various care components are satisfied. Let us do the job that we have been trained to do rather than being burdened to submit claims for the patient. With the implementation of itemised billing, patients can be issued with a detailed invoice together with a certification of a patient's illness and apply directly to CPF to access their own Medisave monies.

(3) A fee be levied for claims submission done by the healthcare provider

If the Medisave claims are to be made by

the practitioner, impute a cost to the Medisave claims and data submission. If the whole process of Medisave claims cannot be done by the patient, or if the patient wishes the doctor to do this for him or her, there should be a charge levied. This should be led by the public sector, patients in polyclinics under the scheme should have a charge levied to reflect the increased cost of being in the programme. To fulfil its role as a provider for the needy, polyclinics may choose to waive this charge, but the important step, signaling that a charge is due, is a fundamental one. For the private sector, quantum can be determined by the market forces in the GP market.

(4) Pay primary care doctors equitably

How should we monetise the work we do in talking to our patients about taking ownership of their health? Writing down an Asthma Action Plan, encouraging them to have a go at taking up a sport/ exercise programme? Should a GP who conscientiousy checks a patient's inhaler technique annually expect a better pay-check? This should be looked into if primary care providers are to be given the motivation to participate in mainstream patient care such as chronic disease management, preventive care education, and counselling activities.

(5) Public education

Each chronic disease management scheme should involve publicity via the media, not only on the need for screening and the importance of continuous care by the same family doctor, but also educating the public on the time and cost of delivering such care. Chronic disease care is not low cost care. It is time and manpower intensive and thus expensive, but ultimately will lower long term healthcare costs and more importantly improve outcomes to the individual patient. CM

Dr Wilson Eu is a Family Physician in private practice. He graduated with MBBS (Melbourne) in 1991 and obtained his Graduate Diploma in Family Medicine in 2004. He currently practises at Siglap Family Clinic.

Concerns About Herbal Products & Dietary Supplements

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

Introduction

Almost every other patient we see will be one some kind of health supplement be they organic (herbal) or non-organic (mega-vitamins) in nature. Unlike prescription and over-the-counter drugs, herbal products are not regulated to determine purity or potency. Manufacturers of herbal supplements are not required to demonstrate safety or efficacy prior to marketing.

As the labels on herbal products are designed to promote product use and not necessarily to inform the consumer, it may be helpful for us to be familiar with some of the more popular herbal products used. Because of their widespread use, history taking would be incomplete without specifically eliciting their use.

The following is an overview of some of the most commonly used herbal products, including important clinical considerations in the use of these products.

1. Echinacea: for fighting cold symptoms and boost immunity

Echinacea has been studied as an adjunct therapy to enhance the immune system, mostly in upper respiratory tract infections.

Common side effects of echinacea supplements include unpleasant taste and allergic reactions. The optimal dose of echinacea is unknown with recommended dosages vary widely from 100 to 500mg.

Take home message: The results are inconsistent, making it difficult to recommend specific products or dosage. However, a recent meta-analysis concluded that standardised extracts of echinacea were modestly effective in the prevention of common cold in those at risk (e.g. sick contacts). Evidence that the herb may reduce the duration of cold symptoms has been mixed.

Patients allergic to ragweed, those with progressive autoimmune disorders (HIV, MS, SLE, TB), diabetes and on hepatotoxic drugs should avoid echinacea.

2. Garlic: warding off cardiovascular disease?

Garlic may have modest antihypertensive effects. A meta-analysis of eight trials revealed three studies that concluded garlic significantly reduced systolic blood pressure in patients with mild hypertension.

Numerous studies, however, have produced conflicting results regarding garlic's ability to lower lipids.

A lack of standardisation of garlic products and formulations makes it difficult to recommend a dose or specific product. The dosage range from 600 to 1200mg of garlic powder daily in divided doses, or up to 4g of raw garlic daily.

Take-home message: Garlic should be used cautiously in individuals receiving anti hypertensive medications, and blood pressure should be monitored carefully for orthostatic hypotension. As garlic inhibits platelet aggregation, it should be

used with great caution in individuals with bleeding disorders or in those who are receiving antiplatelet therapy. As garlic may also decrease warfarin concentrations, close monitoring of the (INR) for patients taking both garlic and warfarin is prudent.

3. Ginkgo Biloba: for enhancing memory, combating Alzheimer's Disease

Ginkgo biloba leaf extract contains flavonoids, terpenoids which have been shown to stabilize and in some cases improve, cognitive function and socialization in patients with Alzheimer's disease, although the clinical significance of the improvement was not known. A dose of ginkgo extract EGb 761 at 160 mg daily has shown equivalent efficacy compared with donepezil 5 mg daily for the treatment of Alzheimer's disease.

In contrast, a recent clinical trial failed to demonstrate any improvement in cognitive function or in the quality of life in cognitively intact, older individuals.

Ginkgo is considered relatively safe, although the leaves have been associated with mild gastrointestinal side effects and headache

Take-home message: Ginkgo is a reasonable therapeutic option in patients with Alzheimer's disease who are also receiving medical care, but providers should remember that the herb has antiplatelet activity and thus may not be appropriate for patients with bleeding disorder or on antiplatelet or anticoagulation agents. Based on case reports, ginkgo is not recommended in patients with seizure disorders.

4. St. John's Wort: for depression

The herbal product has 10 constituents, of which hypericin is believed to be the most active ingredient in treating depression. St. John's wort has a high affinity for gamma-aminobutyric acid, and has been shown to block reuptake of serotonin and norepinephrine

A meta-analysis of 23 controlled trials concluded that it was more effective than placebo in treating mild-to-moderate depression the herbal extract (900 mg per day) was found to be more effective than fluoxetine (20 mg per day).

Take-home message: Patients who are depressed should not take this herb without medical supervision. St. John's wort should be reserved for the mildly depressed patient with an aversion to prescription medication. Clinicians should be mindful of the numerous potential drug interactions arising from enzyme cytochrome P450 (CYP450)-3A4 isoenzyme induction. The most commonly studied dose for depression is 300 mg taken 3 times a day, standardized to 0.3% to 0.5% hypericin per dose. Because of its pharmacology, St. John's wort should not be taken with prescription serotonin uptake inhibitors St. John's wort should be avoided during pregnancy. It has been associated with photosensitivity.

5a. Valerian

Valerian root (Valeriana officinalis) has been used for centuries for its calming effects. Randomized clinical trials have demonstrated efficacy of valerian root extract for treating insomnia.

Mild side effects have included paradoxical stimulation and may have an additive effect with other central nervous system depressants. Valerian should not be used in pregnancy. Patients should be cautioned regarding the operation of machinery when initiating therapy until they are accustomed to the effects. Other potential side effects include headaches, excitability, and uneasiness. Typical dosages for insomnia are 200-400 mg (standardized to 0.8%-1% valeric acids per dose) at bedtime.

5b. Chamomile

chamomile (Matricaria recutita) has been cultivated worldwide for its sedating and calming properties. The active component apigenin has been shown to bind the same receptors as benzodiazepines, to exert an anxiolytic and mild sedative effect.

Chamomile is considered safe by the FDA, but because of its sedative effects, chamomile should be used with caution when taken in conjunction with medications that have also sedative side effects, or with alcohol. Oral doses vary from 400 to 1600mg per day (standardized to 1.2% apigenin per dose).

5c. Ginger

In human studies, the ginger (Zingiber officinale) root (1g/day) has shown to significantly reduce symptoms in patients with peri-operative nausea and hyperemesis gravidarum and has been shown to be superior to 100 mg dimenhydrinate in motion sickness.

As ginger inhibits thromboxane synthetase it is prudent for those taking anticoagulants to have their (INR) monitored closely. Ginger can also cause mild gastrointestinal (GI) upset including heartburn, diarrhea, and mouth irritation.

Take-home message: Valerian, chamomile, and ginger can be safely recommended in the majority of patients. These agents have shown modest efficacy for their primary uses. However, patients with chronic anxiety and insomnia should be under the care of a healthcare professional and thus should not attempt self-medication with botanicals.

6. Ginseng: a natural energy booster

The term ginseng (Panax ginseng, Panax quinquefolius) means "man-root," is

mostly used today as an energy booster. Animal studies suggest that ginsenosides work by stimulating the secretion of adrenocorticotropic hormone, resulting in increased production of cortisol.

Overuse of ginseng may be associated with diarrhea, hypertension, nervousness, dermatologic eruptions, and insomnia. Ginseng has also been rarely associated with reversible mastalgia and postmenopausal bleeding. It alters haemostasis and is therefore contraindicated in patients with active bleeding; patients receiving anticoagulant and/or antiplatelet medications should be cautioned against using ginseng.

As with many other herbs, ginseng formulations have not been standardized, nor have optimal doses been determined, but common regimens involve 100-600 mg per day in divided doses.

Take-home message: Although many claims have been made, robust clinical trials are lacking. Patients who use ginseng should be cautioned not to exceed the labeled dosage since adverse effects may occur. Because it can have a mild stimulant effect, it should be avoided by patients with cardiovascular disease who are taking other stimulants. Clinicians should discourage use in patients who are anticoagulated, and those with cardiovascular or metabolic disease such as hypertension and diabetes (cortisol like action).

7. Saw Palmetto: effective for benign prostatic hyperplasia?

The extract for saw palmetto (Serenoa repens) which is often used to treat benign prostatic hyperplasia (BPH) is thought to inhibit 5-alpha reductase.

While early clinical studies suggested a modest benefit of saw palmetto in BPH, more recent studies are less consistent, and the precise clinical value of saw palmetto for treating urinary symptoms remains undefined.

Side effects are uncommon with saw palmetto, but they may include headache and GI upset. There are no known important drug interactions with this herb. The most commonly used dose for treating BPH is 160 mg twice daily.

Take-home message: Men with obstructive urinary symptoms should not self-medicate with saw palmetto because the symptoms of BPH can mimic prostate cancer and prostatitis. This herb should be reserved for men with mild symptoms due to confirmed BPH who have an aversion to prescription drugs and are also under medical care.

8. Black Cohosh: used to ease hot flashes

Black cohosh (Cimicifuga racemosa) contains phytoestrogens. Some recent clinical trials indicate that it is efficacious in relieving menopause symptoms.

Black cohosh is generally considered safe without any major life-threatening adverse events. Some patients may experience mild side effects including rash or GI upset.

The most widely studied dose is 20-40 mg twice daily standardized to 1 mg triterpene glycosides for up to 6 months.

Take-home message: Clinical trials using black cohosh to relieve menopausal symptoms have yielded conflicting results. It appears to be safe, but use should be limited to no more than 6 months and should not be used in lactating or pregnant women and those with a history of estrogen-dependent tumors.

Conclusion

Self-diagnosis and treatment in serious or chronic health complaints is never ideal, because many of these patients need supervised medical care.If the patients insist, they should be advised to take the same dosages that have been studied in clinical trials, and not to exceed labeled amounts. (i.e. avoid products with labels that fail to specify the exact amount of the herb contained per dosage unit). Generally, herbs should be consumed only for a limited time.

Take extreme caution with the following groups of patients:

a. Those with chronic medical conditions: use only under supervision
b. Those with hepatic or renal insufficiency

c. Those who exhibit CNS hyperactivity (e.g. seizure disorder)
d. During pregnancy or lactation: contraindicated because the effects on fetal development and breast milk excretion are unknown.
e. Use in infants and younger children should be discouraged.
f. Those with GI bleeding or altered haemostasis (platelet inhibitors, warfarin, heparin)
g. Undiagnosed medical problems
h. Patients anticipating surgical procedures: discontinue use of herbs at least 2 weeks prior to surgery, and should notify the anesthesiologist of any routine herb usage (bleeding diasthesis with the 4 G's: garlic, gingko, ginseng, ginger). CM

(Adapted from an article: Top Herbal Products: Safety & Concern- A Clinical Review, Medscape Pharmacist, Jan 2008)

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Unit 4	Sports Nutrition
Unit 5	Medical Nutrition Therapy for Specific Conditions
Unit 6	Nutrition and Malnutrition in Elderly Care

SPEAKERS

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Gladys Wong, Chief Dietitian, Alexandra Hospital
Mary-ann Chiam, Chief Dietitian, Bright Vision Hospital
Fahma Sunarja, Senior Dietitian, Singapore Sports Council
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