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TRUST in the time of SARS

by A/Prof Cheong Pak Yean, Past President, College of Family Physicians Singapore

It is now ten years since SARS, the novel corona virus, invaded Singapore quietly in the early days of March 2003. When I was asked to reflect on the experience of SARS 2003, the word 'trust' immediately comes to mind. The deadly virus slipped incognito to Singapore into the ICU of a major hospital. It was an unexpected invasion that hit the centre of the healthcare establishment namely the hospitals. Its vengeance was soon recognised as doctors and nurses became casualties. The hospitals scrambled to contain this deadly bug – masks, gowns, goggles, and hand hygiene were quickly recognised to be protective. From the hospitals, the virus spread into the community and continued its vengeance. Unprepared, primary care providers now became the 'second ring of defence' after the border. The College quickly responded with three initiatives to reinforce the trenches viz. providing SARS advisories, real-time hotline for frontline and interactive web-cast of medical leaders. These initiatives needed trust in ourselves, in our peers and in our medical leaders to succeed.

Antidote against ignorance and fear: SARS Advisories

I remember receiving a cold phone call from a Straits Times reporter in the middle of March 2003 asking me to comment as College President on the deadly chest infection raging in Hongkong. "I am clueless", I admitted. I scanned the news anxiously each day. By late March, 4 weeks into the epidemic, I knew that it was upon us in the community. The College was then not involved.

On our own initiative, we formed a workgroup comprising all sectors of primary care, both the private and public sectors to develop best practice consensus in dealing with the novel contagion as well as to form a channel for direct feedback to the authorities. A/Prof Goh Lee Gan took the lead connecting with ID and public health physicians in the Ministry and the workgroup to come out with advisories in the face of uncertainty and fear.

With the endorsement of the Ministry of Health, the College issued its first advisory on 3rd

April providing interim contextual information and advice to community doctors. Accurate information of SARS and the appropriate measures that GPs and their staff should take was speedily communicated subsequently in a series of advisories sent to all doctors practising in the community, both GPs and specialists. In all, five editions were published.

Unknowingly, the College work-group became the de facto feedback vehicle from the doctors on the ground to one another and to the Government. There were many complex issues settled that went beyond health such as patient evacuation route in buildings, transport and manpower issues. We did not need an authority to provide us 'terms of reference' and no one questioned our purview. In a war against a vicious contagion that does not respect boundary, human trust was our weapon. SARS paralysed the centre first but like the internet, the peripheral rings quickly organised themselves to contain and established the lines of defence.

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(continued from Page 1: Trust in Times of SARS)

Fighting shoulder to shoulder: Hot-line for Frontline

I was literally taking a 'breather' at home from the suffocating N95 mask after my afternoon clinic when my phone rang. It was Prof Tan Chorh Chuan Director of Medical Services (DMS). He told me that there were many distressed doctors who were calling the Ministry after the Pasir Panjang outbreak. As the College was already doing the SARS advisories for doctors, he asked if we could organise a telephone hot-line for doctors manned by colleagues as well. I said 'Yes' immediately. He designated one MOH administrator as his personal link and I told him that I would work it out by the next day. By Wednesday 7th May 2003, the hot-line was up for all doctors.

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“Director of Medical Services (DMS) knew that peer involvement and collegiate trust was crucial.”

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Dr Lawrence Ng who took charge reported in the College Mirror July 2003 that '239 doctors accessed the hotline over the first 8-week period. In descending order, the concerns were: diagnostic difficulties, personal protective equipment (PPE) & infection control measures (ICM), quarantine issues, ambulance and evacuation problems, triage and criterion of "fever". Such a system of information flow complemented the dissemination of interim advisories for the doctors on the ground'.

Prof Tan was trusted by College leaders even before he became Director of Medical Services (DMS). When he was Dean of the Medical School, the College leadership including past presidents had met him about undergraduate family medicine education and we felt respected and understood. As DMS, he maintained close collegiate relationships. Thus when Prof Tan proposed the hot-line, we did not asked him 'why us?' or the nitty gritty of 'how much?' or if the Ministry would provide 'medical-legal indemnity' if advice goes

wrong. Reflecting 10 years thence, the DMS could have easily organised such a hot-line with his command structure but in his wisdom, he knew that peer involvement and collegiate trust was crucial. He was right as many of the calls were distress cries for peer counselling. With the hot-line, doctors in the trenches caring for patient knew they were not alone and help was but a phone call away. We helped to calm the ground.

Solidarity in support of the trenches: SARS Webcast

A/Prof Lee Kheng Hock, now President College saw the need to connect with doctors as the epidemic dragged on and to rally the ground. In an article in the College Mirror July 2003, he wrote that 'the SARS outbreak prevented the gathering of large numbers of health care workers. The concern was, should a cluster of infection occur during such a gathering, the large number of critical personnel being quarantined would cripple the already overstretched health care service. Still, there was an urgent need to reach

out to the doctors to rally them to stand firm in the fight against SARS. The College therefore organized a live webcast on the 24th May 2003.

A panel of physician leaders were invited to discuss lessons learned and to answer questions from viewers viz. Prof Tan Chorh Chuan DMS, Dr Lily Neo & Dr Tan Cheng Bock, MPs, Dr Leo Yee Sin, ID specialist, A/ Profs Cheong Pak Yean, Goh Lee Gan & Lee Kheng Hock from the College. This was probably the first interactive webcast for CME in Singapore. Small groups of doctors gathered in different parts of Singapore for this live webcast with participants able to interact in real-time with the panellists.

Beyond the dissemination of information by a distinguished panel, the visible solidarity of the medical profession was important. It was stressful for all healthcare providers trying to combat the hitherto unknown disease and to stay uninfected. The emotional sharing of Dr. Tan Cheng Bock after seeing a patient later confirmed to be



“These initiatives needed trust in ourselves, in our peers and in our medical leaders to succeed.”

infected with the SARS virus was cathartic. No one needed to fear alone. Like Dr Tan, many General Practitioners (GPs) during the outbreak took the added precaution of physically distancing themselves from their families and friends while not at work for fear of passing on the virus through being themselves infected but still undetected or through their clothing. They minimized contact with their spouses and children and slept in separate rooms. In the SARS war, we were all one.

Collegiality, Professionalism, and Trust – the defining factors in crisis and in peace

Reflecting ten years thence, we conquered SARS because there was good collegiality and trust within the medical fraternity.

The leadership of the College and SMA was united. Together both organisations quickly decided that the SMA would be in charge of all material support such as personal protection equipment and training while the College would take charge of the advisories. Both organisations also produced joint letters to doctors and published posters and publicity materials for patients and community. The two organisations worked closely with the Ministry of Health and with the ground.

Our professional values dictate that we must not abandon our patients. Thankfully most if not all stood by their posts despite the personal fears, each at his or her station in the community. In the beginning of the outbreak, the paucity of accurate information of the SARS in the early stage and the appropriate personal protective measures that healthcare workers must take generated fears that we need to grapple and help our patients to grapple too. Because fever and respiratory symptoms are common ailments seen in GP clinics, the possibility of any patient turning out to be suspect SARS was hence threatening and anxiety provoking.

Wearing the N95 masks was suffocating and taking the strict infection control measures was onerous. That there was no disruption of community medical services despite the risks and attending anxieties of the GPs and their clinic staff of themselves

being infected by the SARS virus speaks volume for the professionalism and commitment to duty and nation. No legislation or audit can bring forth such sacrifice.

After the epidemic was contained, the College was acknowledged as one of the many public organisations that helped to contain the SARS epidemic. The College recorded its experience in the July 2003 issue of the College Mirror for posterity. Like weary soldiers fighting in the trenches, we were just too glad to go on with life. There was no victory parade, no medal minted to give to one another. Ten years on, the lesson was that trust won the day – trust in each other, trust in colleagues and trust in leaders of the medical fraternity. GP clinics remained open to their patients throughout the epidemic and no GP or staff lost his or her life.

The sacrifice of primary care doctors did not go unnoticed from the most important party in the community, the patients. A patient responding to the avalanche of praises heaped upon hospital doctors by the media wrote to the Straits Times (17th April 2003) that while ‘Hospital doctors and nurses rightfully deserve the cheesecakes, roses and accolades piled on them, let us not forget the unsung heroes, the humble general practitioner (GP) and his clinic assistants. No less at the front line, they face increasing isolation as they grapple with a falling patient load and increase in overheads (masks, bleaches and antiseptic washes don’t come any cheaper to them) amid fears that they themselves may become infected by SARS’. In the SARS war, we also won the trust of patients.

■ CM

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Illustrated by Patricia Cheok

Dr Ewen Chee - A Medical Volunteer who Shared their Joys and Sorrows

Interviewed by Dr Lim Khong Jin Michael, Editorial Board Member

During the Medical Faculty interview, the interviewees will naturally allude to their sense of concern for the common people, some subtly and others less so. Do doctors have time to exercise their concern for the less fortunate and needy in society? We are glad to hear from Dr Ewen Chee, the Medical Director of The Chelsea Clinic, who volunteers on a regular basis to provide medical care for foreign workers in Singapore through a mobile clinic.

CM: Do you have any interesting experience to share with us from your volunteer work?

There was this young Bangladeshi worker in his early 20s who came to see me for one simple request, "I need to be able to find a wife." I joked with him that I did not know that doctors have to be matchmakers. He then elaborated that back in Bangladesh, women did not like skinny men. Although he was a pleasant looking young man, he was indeed on the skinny side. After a quick history taking and examination to make sure that there was no pathological cause for his being skinny, I assured him that he was fine and I gave him some dietary and exercise advice on how to gain weight. He seemed quite pleased with the advice as he told me that he would certainly remember me when he finally finds a wife!

I realized from this encounter that medicine goes beyond just treating diseases. We as doctors are there to offer comfort, hope, and to share the joys and sorrows of our fellow beings.

CM: Can you tell us something about yourself and how you find time to be involved in volunteer work?

I am married and I have 2 young kids who are 5 years old and 18 months old. It is a constant challenge to keep up with their

boundless energy. I love the outdoors, cycling with my older kid, playing tennis and sailing.

I am a general practitioner with an interest in medical aesthetics and I work in a group practice. I do not find medical aesthetics frivolous or "not real medicine" as some may put it. I find that my interest in medical aesthetics allows me to treat a person holistically, taking care of their well being both externally and internally, in totality.



Dr Ewen Chee attending to a patient with the assistance of another volunteer at the makeshift clinic.
Image courtesy of Dr Ewen Chee

For me, volunteering in a medical team is a natural expression of my ethos of being a doctor and my faith. With 2 young kids at home, it is quite challenging to commit a Saturday evening each month to volunteer work. Therefore I have to practise good time management in juggling family life, work, personal rest and volunteer work. More importantly, I have a wife who is supportive of my involvement in volunteer work.

CM: How did you come to be involved in volunteer work?

I have been involved in the St Andrews Community Hospital Foreign Workers

Medical Work since its inception in 2011. The idea for this mission was first mooted by Prof Joseph Thambiah, an orthopaedic surgeon in NUH. At that time, he had already started the Batam Medical Mission - during the weekends, a group of volunteer healthcare workers from Singapore will go to remote villages in Batam to provide free medical care. He later felt a calling to reach out to the foreign workers in Singapore through providing free medical care at their dormitories. We achieved this through converting a bus into a mobile clinic. The mobile clinic has an onboard pharmacy and equipment that are taken down to set up a temporary clinic at the dormitories. I have volunteered at the Batam Medical Mission and now I volunteer regularly at the local foreign workers medical mission.

Once a month, on a Saturday, we go to the foreign workers' dormitory from 5 to 9pm.

On a typical night we see 400 patients. It is hard work! However, it is definitely a joy for all who participate. The first visit to the foreign workers' dormitory was an eye opener for us and the phrase "packed like sardines" came to my mind. I was surprised that so many people could be housed in each dormitory. It reminded us to count our blessings at how fortunate we are as Singaporeans. These foreign workers have to sacrifice so much as they have to leave their families to work here in order to eke out a better living for their loved ones back home.

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CM: What is the mindset and expectations that one should have when contemplating doing volunteer work?

Volunteer work is definitely rewarding, especially when you see a grateful smile from the patient's face. My advice for people wanting to do volunteer medical work is to balance idealism and pragmatism. You have to remember that you are always working with very limited resources.

CM: Thank you Ewen for sharing with us your experience as a volunteer and keep up the good work. We hope that there will be many other doctors and medical students who will also move out of their comfort zone to serve the community. As medical professionals, we are definitely blessed. May we also be a blessing to others, especially the less fortunate and the needy in our society.

■ CM



Dr Ewen Chee providing a consultation for a patient with the help of a volunteer translator. The mobile clinic with the onboard pharmacy is in the background.
Image courtesy of Dr Ewen Chee

Do You Smell a Rat?

by Dr Nicholas Foo Siang Sern, Editorial Board Member

The General Practitioner (GP) is pondering his next step. He is faced with five very angry and desperate foreign construction workers from China. They live and work at the construction site located across the road from where his clinic is.

"Doctor, so many of us are falling sick...you must do something to help us!" exclaimed one of them.

"Yes... Eight of us live in one bunk and now 3 of us are down with fever! Two of us are here to see you but the other one refuses to come. He has been having fever for ten days!" said another.

Both of the men are at the clinic to consult the GP, accompanied by their three very supportive friends, and have similar histories - fever, chills and myalgia for three days. The GP takes a more detailed history and the only other symptom both men report is the painless passage of dark red urine. Dark red urine... suddenly the GP recalls a similar case he had seen about one month back. It was also that of a construction worker from the same worksite but not known to any of these five men now present.

The GP takes out the case notes of the initial case and flips through them.

14 November

Fever/chills/left ear pain x 3/7 - treated with Augmentin

15 November

Patient reports that left ear pain is much better but still having fever, chills and myalgia. Temperature recorded 38.4 degrees Celsius. Full blood count (FBC) done:

WBC 3.6 (4.0-11.), differential counts NAD

Platelets 124 (150-400)

16 November

Repeat FBC with Dengue NS1 in view of leucopaenia and thrombocytopenia. Patient is still febrile.

WBC 2.9

Platelets 120

Dengue NS1 negative

18 November

Patient still febrile, having chills and nausea.

WBC 3.4

Platelets 139

Malaria parasite negative

22 November

Patient is still having fever and nausea. Now reports having dark red urine and abdominal discomfort - referred to Accident & Emergency (A&E)

23 November

Patient reports back. Went to A&E 22 Nov. FBC "unremarkable", dengue screen negative. UFEME: WBC 8, RBC 3, no nitrites. Diagnosed with Urinary Tract Infection (UTI) by A&E and discharged with 5 day course of Bactrim. Patient feeling better, fever has subsided.

The GP closes the case notes. The patient had not come for any further follow up after the last visit. He looks at the two sick men in front of him and then picks up his telephone.

"Hello, is this TTSH? Can you put me to the Infectious Diseases (ID) Registrar on call? I am a GP and need to seek his advice."

The GP explains the situation to the ID Registrar on call, who turns out to be friendly and receptive. The ID registrar

instructs the GP to write a memo for both men and direct them to XX clinic at Communicable Diseases Centre (CDC) the following morning.

"By the way, can you ask the patients whether they have noticed rats around their worksite or living areas? Yes? Oh, okay, they say that the rats are as big as cats? Well, if you do come across any cases, just run a FBC, malaria parasite and start them on Doxycycline 100 mg twice daily. It could be Murine Typhus." The call ends and the GP explains to the foreign workers the plan of action. He also asks for the phone number to the site office.

After the clinic has closed for the day, the GP flips through "A Guide on Infectious Diseases of Public Health Importance in Singapore".

TYPHUS

Causative agents - Rickettsia typhi (murine typhus) and Orientia Tsutsugamushi (scrub typhus)

Incubation Period - 1 to 3 weeks

Infectious Period - Zoonoses with no human to human transmission

Transmission - Scrub typhus: Bite of grass mites, Murine typhus: Bite of rat fleas. Rodents are the preferred and normal hosts.

Epidemiology - Distributed throughout the Asia Pacific rim and is a common cause of pyrexia of unknown origin throughout SE Asia. Occupational contact with rats (e.g. construction workers in make shift container facilities, shop owners, granary workers and garbage collectors) or exposure to mite habitats in long grass (e.g. hikers and soldiers) are risk factors.

Clinical features - Fever, headache, myalgia, conjunctival suffusion, maculopapular rash.

The GP closes the book and leaves a note on own his desk to call the site office the following morning. The rats must be exterminated.

A few days later the GP encounters yet another case. He runs the blood tests and starts the patient on Doxycycline. The patient returns 2 days later to tell the GP that his fever has subsided and that he feels much better. Over the following month, the GP sees a few more workers from the same construction site, all asking for the "magic medicine" (Doxycycline).

They have been recommended by their friends to come to his clinic for treatment of the "mysterious fever".

One week after that fateful night, the GP receives a call. The ID Registrar has called to update the GP as promised.

"Well, only one of the patients turned up at the clinic the following morning. We worked him up and he responded well to a trial of Doxycycline. It is probably a Rickettsial disease although the initial serology was negative. We need a paired

sample. This condition is fairly common amongst construction workers. You can treat with a trial of doxycycline and you will obtain a good response in 24-72 hours. If not treated, it will usually run its course and spontaneously resolve in three weeks. It is not a notifiable disease."

The GP puts down the phone and smiles to himself. Who says that GP life is boring? Only one question remains.....Why did they pass dark red urine?

■CM

The Guru Doctor

by Dr Nicholas Foo Siang Sern, Editorial Board Member

"Doctor, two of my toes are infected!"

Exclaimed Mr K as he took a seat in my consultation room. I had been seeing Mr K for one and a half years for his diabetes and hypertension. He was a pleasant Indian man in his late 50s, always cheerful and always smiling. He "worked in Malaysia" and came back to Singapore every two to three months to visit his family and also for his chronic disease follow-up.

He was accompanied today by Mr Y, who was also one of my patients. I soon found out that they were neighbours.

"How did this happen?" I enquired.

"He was praying at the temple and must have been kneeling too long and soon developed wounds on two of his toes. I brought him to see a doctor in Malaysia but the medicine is not working and now his toes are infected," replied Mr Y on his behalf.

"Saw a doctor in Malaysia?" I wondered out loud.

"Oh yes, the temple is in XXX (small town in Malaysia) and I was there praying with Mr K," replied Mr Y.

"You went all the way there to pray?"

Mr K just smiled and nodded his head.

"Er... Actually Mr K is the Spiritual Guru there, and I am one of his followers as well," said Mr Y sheepishly.

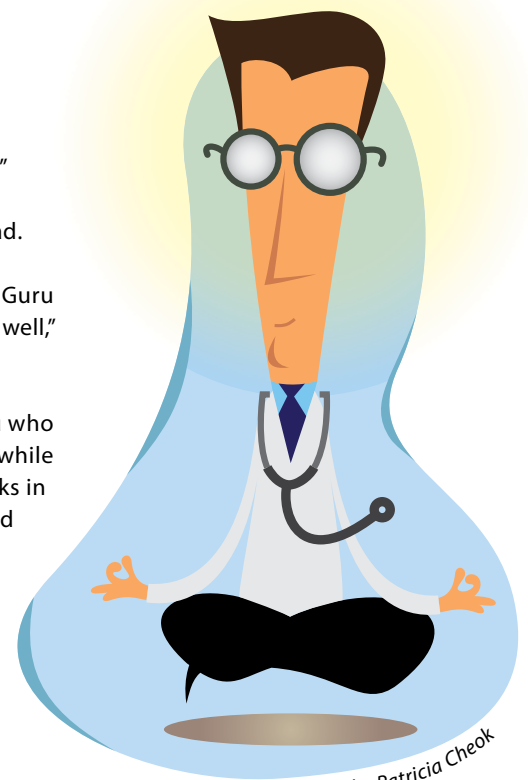
So Mr K was actually a Spiritual Guru who resided in a temple in XXX! All this while he had been telling me that he "works in Malaysia" and whenever I attempted to find out more he had just smiled politely in reply.

"Spiritual Guru? I thought most spiritual gurus don't believe in seeing doctors, let alone 'Western' doctors?" I postulated.

"Well, we are embodied beings with both a spirit and a body. We cannot just take care of our spirit but must also take care of our bodies. I have cured many people, but I cannot cure myself! So I need a doctor to take care of me." Mr K said with a smile. "Also, I cannot cure everyone and sometimes I tell them that they are better off seeing a doctor."

"Doctor, you are also a guru," said Mr Y softly.

"Me? A guru?" I laughed. I pictured myself



sitting on mat, clad in loin cloth with holy ash on my forehead. "I don't think I am anointed to do what Mr K is doing!"

"Yes, you are also a guru. All healing comes from God. I heal people using my prayers and water but I am only a channel for the healing. God also gave men the intelligence to make medicines and you doctors have studied hard to attain the

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knowledge to use the medicines for healing. God uses us in different ways. You, too, are a guru!" said Mr K.

This encounter with Mr K set me thinking. Firstly, regardless of spiritual beliefs and health attitudes, the most sensible thing one can do when he falls ill is a healthcare opinion. I found Mr K to be really enlightened in this. Hippocrates once said that while "prayer indeed is good, but while calling on the gods a man should himself lend a hand". We doctors, on the other extreme, do sometimes tend to self-medicate and are slow to consult with a colleague because we feel confident in diagnosing and treating our own ailments. Worse still, some of us are even notoriously non-compliant! There was a period of time where I suffered from gastric reflux. I self-medicated for a month with a Proton Pump Inhibitor (PPI) but the symptoms did not improve. I woke up one night with severe epigastric pain radiating to the back and alarm bells went off in my head, so I finally scheduled a consult with a Gastroenterologist. He had me "scoped"

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and it turned out that I did NOT have a duodenal ulcer. I was given alternative treatment which saw marked reduction of my symptoms within 24 hours and I was eventually cured.

Secondly, on curing and healing, is there a difference? I think curing means to be rid of a disease but healing is something broader — to be "made whole". I may not be "cured" of my disease but if I accept my incurable condition bravely and live life joyfully despite my physical limitations, then I am certainly "healed". If I get cured of a disease but continue to lead a life of bitterness and anger then I am certainly

not "healed" and made whole as a person. Of course, healing and curing are not mutually exclusive – for people living with alcohol dependence and mental illness, curing often comes hand in hand with healing. Sometimes curing is followed by healing and vice versa, but surely where cure is not possible, healing can still take place, as the Hippocratic Oath so aptly puts it – "Cure sometimes, treat often, comfort always".

And thirdly, as the same sage has said – "It is more important to know what sort of person has a disease than to know what sort of disease a person has" – this encounter with Mr K and Mr Y epitomised the fulfilment a GP gets in really getting to know his patients well in the context of family and community. Diabetic control and complications aside, deciding what treatment to give Mr K for his infected toes was mundane in contrast to the lessons derived from sharing in his life story.

■ CM

Introducing Editorial Team C

Meet the team of doctors who has made this issue of the College Mirror possible.



Dr Chung Wai Hoong Irwin (Editor)

Dr Irwin Chung currently serves as Director for Palliative Care Programmes at the Agency for Integrated Care. He is also Consultant to the agency's Regional Health System & Primary Care Development Division with particular involvement in service development for home care, as well as quality management and improvement work. He concurrently holds the positions of adjunct lecturer at the James Cook University School of Medicine & Dentistry and also runs a family physician clinic at NHGP – Jurong Polyclinic. Areas of professional interest include pedagogy, eldercare, health and social wellbeing & integration, and clinical quality.



Dr Phua Cheng Pau Kelvin (Editorial Board Member)

Hi, I am Dr Kelvin Phua. I am currently the medical director of Ang Mo Kio – Thye Hua Kwan Hospital. I am interested in the improvement of care integration in the Intermediate and Long-Term Care (ILTC) sector.

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A General 'Kaypoh'

by Dr Chung Wai Hoong Irwin, MCFP(S), Editor

"Oh, you are a doctor!"

I still get that from time to time, and oftentimes cringe in anticipation of the next question – "What specialty?" What do I say – a family doctor, a family physician, a general practitioner, or a generalist? Or, God forbid, cough-and-cold doctor? In recent times, the fraternity has pondered long and hard on what defines a family medicine practitioner and come to recognise that the skills and values we carry allows us to practice wholesome medicine in a variety of settings outside of the conventional domain of primary care. And we have many luminaries to demonstrate that our contributions are anything but circumscribed and limited to office encounters with a largely ambulatory population.

Recently, I had to explain to someone that I am no longer in full-time clinical practice. "Oh, then you are no longer a GP?" Tongue-in-cheek came the reply, "Not much of a Practitioner, alright, but still a General." (*Guffaw*)

I reflected thereafter on what I had said in jest. In its most common use, a general is the military grade given to persons holding the highest office in the armed forces. He commands and directs the entire armed operations in times of conflict and has oversight of the entire theatre of war. On him is beholden the responsibility of victory and deliverance, and the fate of many lives inexorably depend on him and his decisions. Of course, more often than not, he acts with the advice of intelligence gathered from the ground and strategizes with the advice of his trusted compatriots, each with their distinct field of control and knowledge. A good general never acts alone and surely realises the weight his judgements and directives carry. He would hear all alternatives, weigh all consequences delicately, and put in place a carefully crafted plan of operation. In a dire situation that may call for a snap decision, his experience and grasp of realities on the ground allows him to rise to

the occasion and shoulder the responsibility for orders given.

I find myself envisioning patient-centred primary care, rooted in some of the core principles that so define family medicine, with the theatre that comprises the patient, his family and community. Here, the family doctor plays the role of chief navigator and expert, who keeps the survival and victory over encumbering death and disease at the forefront of all deliberations. And here, the family doctor sees not only death and disease before him, but people, faces, loved ones, neighbourhoods and communities. There is a common purpose, and a sense of belonging. The family doctor is one that you can call your own; "A family physician for every Singaporean."

What makes patient-centred primary care? In the words of Professor Karen Davis et al. of the Commonwealth Fund, in their health policy article "A 2020 Vision of Patient-Centred Primary Care", its attributes are such:

1. Superb access to care – care delivered where rightly needed and reasonably wanted
2. Patient engagement in care – including patient education and care planning
3. Clinical information systems that support high-quality care, practice-based learning and quality improvement
4. Care co-ordination – primary care–specialist care collaboration, tracking of labs, treatment outcomes, etc.
5. Integrated, comprehensive care and smooth information transfer across providers – multi-disciplinary teams
6. On-going, routine patient feedback – patient perceptions, expectations, compliance
7. Publicly available information on practices – an extension of access to care with element of patient choice

I reckon that we who are trained in and practice family medicine in one setting or the other can

readily identify with such a vision for a patient-centred primary care. It is not hard to see how the qualities and guiding philosophies for being a good general is very much mirrored in the endeavour for patient-centred primary care – being open, engaged and engaging, capitalising on expertise and experience-derived navigation skills, maintaining a helicopter view of the health and social care system, consciously avoiding potential pitfall, being prepared for contingencies and regularly receiving and providing updates on plans and their execution. Now, if only more of us see the value this would bring to all the patient and families we serve in our various capacities and settings of practice!

I would like to end off with another anecdote. A medical student once asked me, after sitting through a particularly gruelling 5-hour clinic session with no 'kopi' or 'tandas' break whatsoever, "Dr Chung, why did you choose family

medicine and not any other speciality?" I was at least gratified that he implied family medicine was an equal to specialist training, but all I could muster from within my misty head then was, "I very 'kaypoh' one." Awaken by his look of incredulity and an overwhelming embarrassment within, I qualified, "I like to treat people as they are, as who they are, real persons with real problems – people who are sons and mothers, daughters and fathers, husbands, wives, neighbours, friends, colleagues; people with families, jobs, communities. That's why some consultations are so tedious in the GP setting because you may need to dig hard for information, like trying to know someone

you are interested in. Tiring it may be, it is at the same time extremely fulfilling. Patients will thank you for helping them solve their problems (or maybe just pay you), but they will truly love you if you are truly interested in seeing them as persons and helping them simply to understand their problems, even before the diagnosing and treating starts."



If I am just interested in managing diseases, I can be a biochemist, a radiation oncology technician or even a pathologist; they are truly and rightfully respectable experts in their field. But if I want to be a doctor, I choose to be a family doctor.

■CM

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Integrated Network of Singapore Primary Care Physicians In Research Endeavours (INSPIRE)

by Dr Phua Cheng Pau Kelvin, FCFP(S), Editorial Board Member

When family physicians hear about research, the first things that come to most of our minds are randomized controlled trials and expensive drug trials. We consume copious amount of journals daily and the breadth of what we read surprises most of our colleagues in other specialties. Evidence based medicine (EBM) is part of our lives which leads to the question: Since family physicians are the experts in their respective settings, are they contributing to new material in this world of EBM?

Gone are the days when research is restricted to those who have full time jobs in universities and laboratories. Clinicians, in particular family physicians, must answer this call to contribute research for the benefit of our future generations of doctors and patients.

Most family physicians are keen on research. The main reason why they do not do it is that it is tedious and time consuming. I will be lying if I said that it is easy to do research. Research requires long hours of thinking, analyzing and thinking yet again, and is fraught with obstacles. Someone may publish an article on what you are working on for the past few years just a few months ahead of you. The dropout rate of your trial may exceed your initial estimates or the recruitment rate of patient subjects may be dismal. Your trial may also be stuck at the ethics approval stage. If it is so very difficult, why subject yourself to all these "pain"?

The reward of doing research is definitely not monetary gain. Neither can it give you fame quickly. You can probably get

Be inspired, do research and give something back to the medical community.

more fame by blogging about the nice food you eat. So there is no fame and definitely no monetary gain.

The first reason is a simple one: This desire to do "experiments" and the curiosity to find out about new things is deep within each of us. This precedes our medical school days to the time when we were primary school kids running around with weird contraptions powered by solar panels. Research is deeply satisfying especially once your article has been published and someone from across the world contacts you to ask for your opinion. The good news is research gets very much easier after doing the first one.

The second reason is also simple: our desire to improve patient care. If you can do your usual clinic consultation and help 60 patients a day, imagine how many you can help if you can find a better way of treating a certain disease? You will be helping thousands or even millions of people every day.

The third reason is legacy. You can help thousands of patients in your lifetime as a doctor. What happens after that? Research gives you the chance to pass on your knowledge to future generations of doctors.

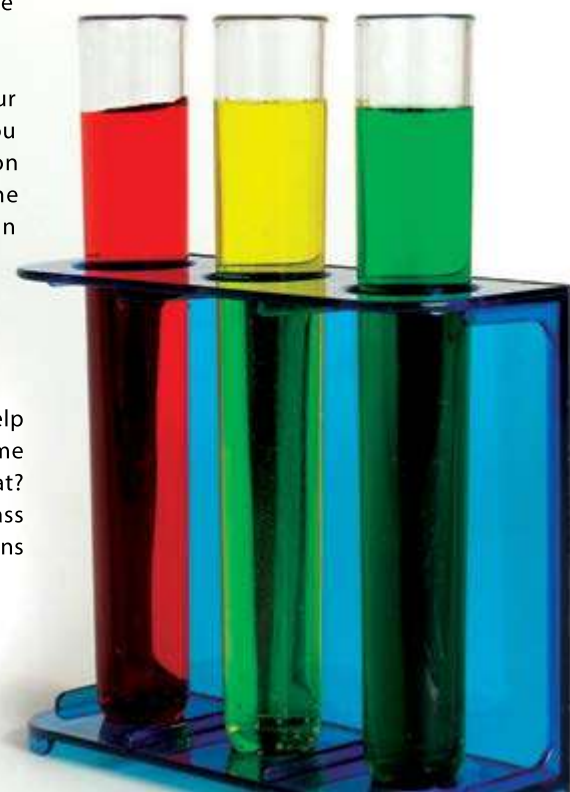
The Integrated Network of Singapore Primary Care Physicians In Research Endeavours (INSPIRE in short) was kicked off on 1 Dec 2012 by A/Prof Tan Ngiap Chuan. Together with his team, they hope to form a network of family physicians who are able to support each other.

"I have little spare time, how do I get a research assistant?" No problem. Just approach this team and they will find you one. "I am not sure how to get ethics approval." Again not a problem, the team will guide you.

"I do not have funds to do this research!" Which brings us to the next big thing, the INSPIRE Research Grant. For more information, please go to this website at <http://www.cfps.org.sg>

Be inspired, do research and give something back to the medical community.

■ CM





Family Practice Skills Course #55

Emergency Medicine

Sat - Sun, 5 - 6 October 2013
2.00pm - 5.30pm

Venue: To be confirmed

(please visit www.cfps.org.sg for venue details)

TOPICS

- Unit 1: Optimal Use of Emergency Services
- Unit 2: Improving primary care management of time sensitive emergencies
- Unit 3: Update on cardiopulmonary resuscitation
- Unit 4: Pitfalls & red flags in common clinical syndromes
- Unit 5: Trauma & injuries
- Unit 6: Emergencies in very young patients

WORKSHOPS

- Day 1: Quick refresher on CPR & use of AED
- Day 2: Improving emergency care: Case based discussions
 - A panel of experts will discuss cases to illustrate strategies for improving care
 - Participants are encouraged to bring their cases up to the panel for discussion

■ **SEMINARS** (2 Core FM CME points per seminar)
 Seminar 1 • Unit 1 - 3: Sat, 5 October 2013 (2.00pm - 4.00pm)
 Seminar 2 • Unit 4 - 6: Sun, 6 October 2013 (2.00pm - 4.00pm)

■ **WORKSHOPS** (1 Core FM CME point per workshop)
 Day 1: Sat, 5 October 2013 (4.30pm - 5.30pm)
 Day 2: Sun, 6 October 2013 (4.30pm - 5.30pm)

* Registration is on first-come-first-served basis.
 Seats are limited.
 Please register by 30 September 2013 to avoid disappointment.

■ **DISTANCE LEARNING MODULE**
 (6 Core FM CME points upon attaining a minimum pass grade of 60% in online MCQ Assessment)
 • Read 6 Units of study materials in *The Singapore Family Physician Journal* and pass the online MCQ Assessment.

This Family Practice Skills Course is jointly organised by the **College of Family Physicians Singapore, Health Promotion Board (HPB)** and supported by **Ministry of Health (MOH)**



All information is correct at time of printing and may be subject to changes.

REGISTRATION

Emergency Medicine
Please tick (✓) the appropriate boxes

**FREE
REGISTRATION
for College
Members!**

	College Member	Non Member
Seminar 1 (Sat)	<input type="checkbox"/> \$21.40 FREE	<input type="checkbox"/> \$21.40
Seminar 2 (Sun)	<input type="checkbox"/> \$21.40 FREE	<input type="checkbox"/> \$21.40
Workshops (Sat-Sun)	<input type="checkbox"/> \$42.80 FREE	<input type="checkbox"/> \$42.80
Distance Learning (Journal)	<input type="checkbox"/> \$42.80 FREE	<input type="checkbox"/> \$42.80
TOTAL		

All prices stated are inclusive of 7% GST. GST Registration Number: M90367025C

I attach 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 registration is closed OR after official receipt is issued (whichever is earlier).

Name: Dr _____

MCR No: _____ NRIC No: _____

(For GDFM Trainee only) Please indicate: 2012 Intake 2013 Intake

Mailing Address: (Please indicate: Residential Practice Address)

_____ E-mail: _____

Tel: _____ Fax: _____

Note: Any changes to the course details will be announced via e-mail. Kindly check your inbox before attending the course. Thank you.

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



Interview with Dr Leong Goh Han Gregory

Interviewed by Dr Chew Sung Boon, Editorial Board Member

Like many of our colleagues, Dr Leong Goh Han Gregory is a General Practitioner (GP) who works long hours at his clinic attending to his patients. He shares with us his thoughts on why he makes an effort to volunteer his time and skills outside of his busy practice.

CM: Gregory, tell us a bit of yourself and your practice.

I am a GP with Shenton Family Medical Clinics. It's a humble HDB practice in Serangoon Ave 2. I serve the surrounding community, mostly heartlanders. I practice purely family medicine.

CM: Your clinic can be really busy, and you still work weekends. When did you start doing volunteer medical work and more importantly, why?

I have been volunteering at Villa Francis Nursing Home for the past 13 years. It's not difficult as we have a group of doctors on roster. I usually serve 1 morning a month for about 2 hours. The home is very flexible about the time that I come to see the patients.

I have always believed that being a doctor is a vocation, not just a career. Being in a position to help people in your daily work is a great privilege. Volunteering is a natural extension of this.

I also make monthly visits to the Carecorner Senior Day Activity Centre in Toa Payoh. I will spend some time there with the elderly residents, looking into their medical problems and concerns, and if need be prescribing some medications. I have two volunteer nurses who help me there.

CM: What type of cases and issues do you have to attend to as part of your medical duties when you are at the nursing homes?

I see a variety of cases. I tend to acute illnesses among the residents that can range from simple URTIs to more serious conditions like pneumonias and CVAs that need transfer to a hospital.

I also do regular 3-monthly reviews of the

residents, looking into their state of health, and also reviewing their chronic illnesses and long term medications.

Also help with some medical administrative work like helping residents apply for Medisave withdrawals, living wills etc.

A lot of times I just listen, explain and reassure the residents about their health issues. I guess they just need a listening ear.



Dr Leong Goh Han Gregory with nurses and a resident at the Villa Francis Nursing Home.
Image courtesy of Dr Leong Goh Han Gregory



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I have always believed that being a doctor is a vocation, not just a career. Being in a position to help people in your daily work is a great privilege. Volunteering is a natural extension of this.

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CM: I understand you took up the Graduate Diploma in Geriatric Medicine (GDGM) years back. Tell us more on that decision.

I chose it at the time as I have always felt a certain interest in looking after our elderly patients in our community. I had a lot of difficulty in managing them at the time due to their long list of chronic illnesses and greatly varying functional status. So I decided to learn more about the subject by doing the diploma. It has certainly helped me tremendously in my practice.

CM: What keeps you serving as a volunteer after all these years?

The people. I enjoy helping people.

It's not just me but the entire nursing team. The nurses and other healthcare staff are the true heroes who look after the residents every day. They are the ones who make a real difference in the residents' lives. They help give the residents dignity and comfort at the last leg of their life's journey. I cannot express how important this is. I am extremely grateful to be able to contribute and play a small, meaningful part in this.

In the end, helping to bring a smile to the residents says it all.

CM: For the readers who are considering whether or not to commit time and effort to volunteering in an area of need, do you have any thoughts to share?

The most difficult part of a journey is taking the first step.

Do not be afraid to try. Each and every one of us can contribute in our own way. Do not worry about having the time or the commitment.

Most organizations are very accommodating.

Just take that first step and do what your heart tells you to.

■CM

(continued from Page 15: An Interview with Dr Tan Kok Heng Adrian)

CM: What are your future challenges?

Providing optimal care. Most of our patients are very complex and we have to deal with specialists from various disciplines like paediatricians, surgeons, adult physicians, they can be from different hospitals. It is difficult to keep everyone in the medical team abreast of the issues arising and patient care rendered. We relied on email group to handle this. We also hold monthly patient care conferences to talk through the difficult issues. But I feel that ultimately it is the patient and dedicated family member(s) that holds the greatest potential in this.

Keep updated and competent. Dr Tan is trained in many fields. He had many opportunities to learn from fellow doctors, nurses and allied health colleague in family medicine, geriatrics, palliative, rehabilitation and respiratory insufficiency. Dr Tan felt that he is always learning from his patients as health has many facets and presentations. Learning is a continuous and endless progress as he strived to be relevant and up to date for his patients. There are so many things to learn and so many improvements waiting for us to be made.

CM: Any words of advice for other family physicians?

So far we are a small team and we are the only adult home ventilation service in Singapore (HVRSS). Dr Tan is the only family physician in this service. We have answered to a call for help from these patients to address this gap in the healthcare service locally. We hope to impact the joys and skills to all doctors whether they are hospitalists or fellow family physicians. We are conducting a community ventilation course on 5th and 6th July 2013 in AMKCH. We encourage you to register with Felicia by email : Felicia_liaw@amkh.org.sg

■CM

Family Physician and Home Ventilation

by Dr Tan Kok Heng Adrian, FCFP(S)
Family Physician, Associate Consultant, Department of Continuing & Community Care, Tan Tock Seng Hospital

My interesting experience with home ventilation was with this lady who was staying in an Intensive-Care Unit (ICU) for several months. Due to her medical conditions, she required long term ventilation. Stuck within the 4 walls of the lonely ICU room, one would have paused and pondered upon the quality of life for this lady, not to mention the exorbitant hospital fees incurred on the family.

Yet, cost was not the main driver for our motivation -- the healthcare team could not help but wonder what else can be done to help her.

Together with my team, we engaged and did the first family conference in the ICU. Needless to say, everyone wanted answers. Most importantly, we all wanted to know if the patient will have to remain in the ICU for life or will she be able to go home. If so, will it be safe for the patient to rely on the medical ventilator at home?

The benefits of sending the patient home with ventilation were clear:

1. Reduced risk of nosocomial infection from hospital stay
2. Better quality of life with time spend with loved ones at home
3. Free up ICU bed for another patient

At the same time, the healthcare team went through all the possible issues that might occur to the patient at home -- including ventilator failure, chest infection and desaturation. All these details were thoroughly looked into and with intensive caregiver training on ventilator, nursing care and preparing the home setting we removed the obstacles one by one.

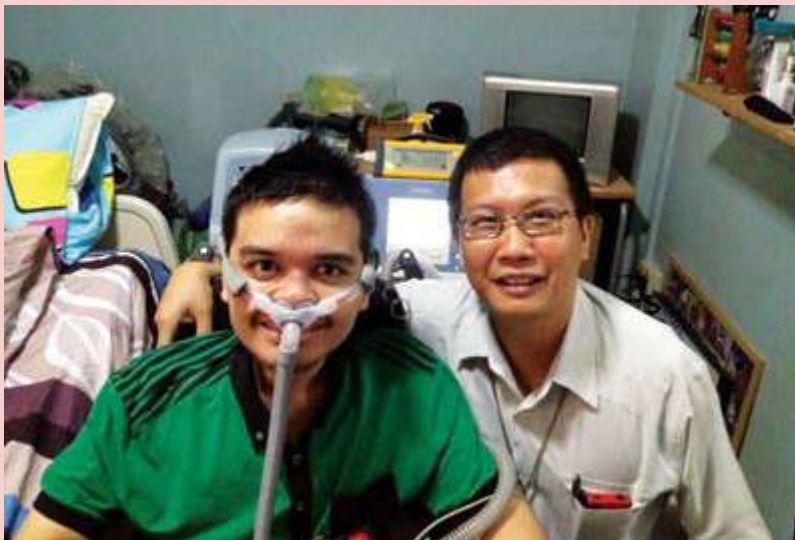


Image courtesy of Dr Tan Kok Heng Adrian

Finally, she was discharged home. The diligence of the caregiver was commendable. Through his effort and assistance from the home ventilation team, the patient managed to spend her Chinese New Year at home uneventfully. Her edema improved tremendously far beyond what we had seen in the hospital.

This patient got me thinking--"Home care with competent caregiver(s) may be superior to hospital care."

Another one of my patient is an obese patient with schizophrenia who unfortunately collapse due to respiratory failure. He was admitted to ICU and subsequently tracheostomised after several failed extubation. We needed to put him in a step-down unit as the patient was not ready to be managed at home at

that point of time. We made arrangement to transfer the patient to Ang Mo Kio -- Thye Hua Kuan Hospital (AMK-THKH), a community hospital. The Healthcare staff at AMK-THKH underwent special training and worked with the Home Ventilation and Respiratory Support Service (HVRSS) team. We managed to wean the patient off ventilator completely. I was impressed with the care and dedication of the staff of AMK-THKH. They managed to shower this man despite his size and weight. The patient said that this is the best and first shower he had in 2 months.

He was subsequently discharged home is now currently living happily at home with his wife. I personally felt that family physicians can make a huge difference for such patients with the help and motivation nurses and allied health colleagues.

A Brief Summary of HVRSS

HVRSS – refers to Home Ventilation and Respiratory Support Service.

Patients using the above service include those with neuromuscular disease requiring ventilator support e.g. Amyotrophic Lateral Sclerosis, high cervical spine injury and also some selected causes of hypoventilation.

This service helps to improve patient care, increase patient's quality of life, reduce mortality and morbidity.

I personally felt that family physicians can make a huge difference for such patients with the help and motivation nurses and allied health colleagues.

An Interview with Dr Tan Kok Heng Adrian

Interviewed by Dr Phua Cheng Pau Kelvin, FCFP(S), Editorial Board Member

CM: How long have you been doing this? What are your motivations?

Dr Adrian is the only family Physician in this service and he has been with this service for 1 year.

HVRSS provided him with new learning opportunities to view and care for patient form a different perspective. This is where he felt that truly comprehensive and continuing care is delivered to his patients.

CM: What are the difficulties you face?

Main difficulty is that patients are dependent on ventilators and the cough assist machine. Caregivers need to be trained in using such equipment safely and effectively.

Referring patients to step down unit is also difficult: not all community hospital can manage such patients. Few doctors and nurses in the community are trained to handle such patients. There is a high amount of hesitancy in handling patients needing ventilator assistance.

Institution like nursing homes are also unwilling to take in such patient as they perceive them as a high risk group.

Lastly, financial burden is a problem for most families as the cost of equipment and related consumables are relatively costly.

CM: How do we understand our patients better?

To make talking to patient regarding health care choices more meaningful, he used this tool called ACP. In Advance Care Planning, you can understand the patients' perspective and their understanding on their own view on life, joys, illness, suffering and death. From their angle, it helps them to make health care choices and we will walk the road with them till they pass on. This helps their family know what and why the patient wants. Thus when the patients are incapacitated, the family can follow the patients' wishes. It also gives doctors managing them some clarity on the patient perspective in emergency situations.

Doing this may be difficult, especially for those that can only communicate with their eyes and emotionally trying for the patients and their families in talking about death. But this allows us as a family physician to catch a glimpse of the patients' perspective of health and life.

CM: What do you think is important to these patients?

Communication to their love ones and healthcare provides is important to these patients. It gives them a sense of control and interaction with their loves one in their dying days. Sometimes patient

communications is challenging. They have lost their verbal and limb function. We try to give them dignity by exploring communication with their eyes. They may gaze at letters on a communication chart, or indicate their answer by a pre-agreed system of blinking.

One patient had a simple chart of alphabets and he uses it to construct sentences. I modified this and gave to another patient who is tetraplegic and losing his voice. His wife was so happy that she was still able to communicate with the patient despite him losing his voice. This joy was shared with the first patient and he felt so blessed that he still can make a difference in another person life despite his current tetraplegia and voiceless state. Dignity of the disabled.

CM: Is the HVRSS team valuable in the community?

We can manage most issues that arise at home without needing to see numerous specialists in the hospital. Our service is also trying to equip the outpatient services to handle ventilated patients better. We are there for them. We are there with the patient and family through their most difficult times. We are just a phone call away and we meet their medical needs in a setting that is most comfortable for them – their home.

(continued on Page 17)



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■CM

Chat with A/Prof Pang Weng Sun: Lee Kong Chian School of Medicine

Interviewed by Dr Lim Khong Jin Michael, Editorial Board Member



Image courtesy of A/Prof Pang Weng Sun

The Lee Kong Chian School of Medicine will receive its first batch of about 50 Medical Students in August 2013. What can we expect from the newest medical school in Singapore? Lets hear from A/Prof Pang Weng Sun, the Vice Dean (Clinical Affairs) of the school.

CM: Can you share with us how you come to be involved in this school?

Lee Kong Chian School of Medicine is a joint medical school by the Imperial College London and Nanyang Technological University (NTU). National Healthcare Group (NHG) is the main healthcare partner. In 2010, I was approached by the Ministry of Health (MOH) and NHG to assist with the setting up of the school, particularly with a view towards engaging other healthcare partners as the school increases its intake. I was formerly from Tan

Tock Seng Hospital (TTSH) before moving to Alexandra Hospital (AH)/ Khoo Teck Puat Hospital (KTPH) and I am therefore familiar with their teaching faculty.

CM: How have you contributed to the shaping of the direction of this school?

I won't say that I have contributed that much as it was a team effort by all the partners involved. The clinicians from TTSH, Institute of Mental Health (IMH), National Skin Centre (NSC), National Healthcare Group Polyclinics (NHGP) and KK Women's and Children's Hospital (KKH) have been most enthusiastic and passionate as they worked closely with the Imperial College/NTU colleagues over the past 2 years. The energy and passion of the team has been a great encouragement – not only the clinicians but also the administrative and support staff who have been working hard over the past 2 years to put in place policies, processes, facilities and buildings. I am quite amazed at how much we have achieved since the start of this journey, though there is no doubt still much to do.

CM: What do you see as the unique features of the Lee Kong Chian School of Medicine as compared to the existing medical schools?

Starting off with a small class of about 50 allows us to innovate and change the way we traditionally train medical students. We move away from traditional lectures to more e-learning and team based learning, where there is more active participation by students. There will be greater use of simulation, integration of basic and clinical sciences and more emphasis on practicals. Besides acute hospital postings, there will be greater exposure to primary care clinics

and community services, so that our future doctors will be well versed with managing chronic diseases and the challenges of an ageing population. All these will be on a background of strong scientific foundations, as doctors of the future will certainly need to be capable of advancing science and transforming healthcare.

CM: Does the new school plan to engage the General Practitioners?

Yes, right from the start of the first term, the students will have an opportunity to experience what a polyclinic is and does – they will interact with doctors, nurses, other staff and patients. We are renovating a polyclinic and putting in dedicated teaching clinics where family physicians can teach our students. Family physicians are already on our teaching faculty, led by our Assistant Dean, Adj A/Prof Wong Teck Yee.

CM: What are your hopes, dreams and vision for the new school?

As a team, we debated long and hard over our mission statement – “Equipping doctors who advance the science and practice of medicine for the good of humanity. The doctors you and I would like to have caring for us.” We strongly believe that our graduates must have the right ethos, in addition to knowledge and skills. On a personal note, I look forward to the first class graduating in 2018. This pioneer class will leave their mark in the history of Singapore medicine.

CM: Thank you Weng Sun and we certainly look forward to welcoming Lee Kong Chian School of Medicine's first batch of medical students into the healthcare family.

■CM

Introducing Editorial Team C

Meet the team of doctors who has made this issue of the College Mirror possible.



Dr Chung Wai Hoong Irwin (Editor)

Dr Irwin Chung currently serves as Director for Palliative Care Programmes at the Agency for Integrated Care. He is also Consultant to the agency's Regional Health System & Primary Care Development Division with particular involvement in service development for home care, as well as quality management and improvement work. He concurrently holds the positions of adjunct lecturer at the James Cook University School of Medicine & Dentistry and also runs a family physician clinic at NHGP – Jurong Polyclinic. Areas of professional interest include pedagogy, eldercare, health and social wellbeing & integration, and clinical quality.



Dr Phua Cheng Pau Kelvin (Editorial Board Member)

Hi, I am Dr Kelvin Phua. I am currently the medical director of Ang Mo Kio – Thye Hua Kwan Hospital. I am interested in the improvement of care integration in the Intermediate and Long-Term Care (ILTC) sector.



Dr Foo Siang Sern Nicholas (Editorial Board Member)

I am a GP who runs a small clinic in the HDB heartlands with another partner. My free time is spent with my wife and 3 kids, jogging and reading. I just love reading and writing short stories!



Dr Lim Khong Jin Michael (Editorial Board Member)

He loves spending time with family and friends. He enjoys being a resident physician at a community hospital, taking care of the old and sick and encouraging their caregivers.



Dr Chew Sung Boon (Editorial Board Member)

A solo "ronin" GP wandering the heartlands of our Little Red Dot providing home medical services to home-bound and bed-bound patients, hoping to make a difference.

■ CM

Community Health Assist Scheme (CHAS)

by Agency for Integrated Care (AIC)

CHAS..so far

The Community Health Assist Scheme (CHAS) launched in January 2012, was an enhancement of the scheme previously known as the Primary Care Partnership Scheme (PCPS). The enhancements include lowering the qualifying age and raising the income criteria to allow more Singaporeans to receive subsidies for medical services at the private GP and dental clinics near


their homes. To date, CHAS now has more than 280,000 beneficiaries, a seven-fold increase from the year before.

Through a concerted marketing campaign across mass media channels such as TV, radio, print and outreach events, CHAS has gained greater public awareness. The scheme has been well received by the public and GPs, and the number of CHAS beneficiaries is expected to increase even further by end 2013.

Currently, around 550 GPs and 300 dental clinics are supporting CHAS, which has raised Singapore's primary care sector towards greater levels of professional and patient care excellence.


To support the increasing number of CHAS beneficiaries, we hope more GPs and dental clinics will come on board the programme.



(continued on Page 21)



Community Health Assist Scheme (CHAS)

Table: CHAS Subsidy Tiers



Eligibility Criteria	Blue Subsidy Tier	Orange Subsidy Tier	
<p>a) Singapore Citizen b) 40 years & above or disabled c) Per capita household monthly income of \$1,500 & below or households with no income and live in a Residence with Annual Value of \$13,000 and below</p> <p>Members who are on Public Assistance Scheme will automatically qualify for CHAS.</p> <p>*Chronic Disease Management Programme (CDMP) covers:</p> <ul style="list-style-type: none"> • Diabetes • Hypertension • Lipid Disorder • Stroke • Asthma • COPD • Schizophrenia • Major Depression • Dementia • Bipolar Disorder <p><small>¹Tier 1: Single Disease (either on / not on medication). ²Tier 2: More than one chronic disease or (disease) with complications. Annual cap is calculated on a calendar year basis.</small></p>	<p style="text-align: center; font-weight: bold;">Blue Subsidy Tier</p> <div style="text-align: center;">  </div> <p style="font-size: 0.8em; color: white;">Per capita household monthly income is \$900 and below OR Households with no income and live in a residence with Annual Value of \$13,000 and below</p>	<p style="text-align: center; font-weight: bold;">Orange Subsidy Tier</p> <div style="text-align: center;">  </div> <p style="font-size: 0.8em; color: white;">Per capita household monthly income is between \$901 and \$1,500 (both amounts inclusive)</p>	
Acute Conditions			
GPs can claim up to \$18.50 per visit		None	
Chronic Diseases under CDMP ¹			
Tier 1	Tier 2	Tier 1	Tier 2
GPs can claim up to \$80 per visit		GPs can claim up to \$50 per visit	
Capped at \$320 ² a year	Capped at \$480 ² a year	Capped at \$200 ² a year	Capped at \$300 ² a year

Important:

- Existing CMB & PA patients are entitled to CHAS Blue subsidy tier. Their cards are valid until expiry.
- Acute - Cap of 1 visit per day and 4 visits per month (per patient, per clinic)
- Chronic - Cap of 1 visit per day and 4 visits per month for the subsidy claimable applies. This is in addition to the annual subsidy cap².
- ¹A patient can still obtain the CHAS subsidy should a doctor feel that he or she requires more of such GP visits within the same month. GP can put in an appeal through the eCHAS system.
- Should a patient seek treatment for both acute and chronic condition, only one claim can be made, whichever of greater value.

For more info, visit www.chas.sg (GP/Dentist section) or call AIC at **6632 1199** or email gp@chas.sg

Image courtesy of AIC

Mobile Eldercare Locator (MEL)

by Agency for Integrated Care (AIC)



Image courtesy of AIC

Healthcare professionals, volunteers, caregivers and family members with elderly folks can now have access to the list of health and social eldercare services delivered in Singapore through their smart phones or tablet computers. Developed by the Agency for Integrated Care (AIC), the Mobile Eldercare Locator (MEL) mobile app enables the user to search for different types of eldercare services in Singapore, such as nursing homes, day care centres, hospices and even CHAS clinics. Since its launch in October 2012, close to 2,000 users have downloaded the application.

The app currently has more than 1,000 service providers listed in its database. It provides the user with basic information of the service providers, including website address, contact details and operating hours. It also enables the user to locate the service provider easily with directional maps and instructions, including how much it will cost to take a bus or a taxi from a specific location.

Users can search for service providers by;

a. **Services:** A non-location specified search which allows users to look for health and/or social care service providers.

b. **Region:** A location specified search which allows users to look for service providers based on an identified region or zone(s).

c. **My Current Location:** A search which allows users to look for service providers located around their current location, or by providing a postal code or address.

d. **Service Provider:** A basic search which allows users to search for the service provider by name or browse through a list of service providers, arranged in alphabetical order.

MEL also provide users with directions on location of nearby amenities such as food and beverage outlets, supermarkets and parking places within proximity of the selected service provider, which can be useful to some. For example, a caregiver or family member can run errands or have a cup of coffee nearby while waiting for their loved one to undergo rehabilitation at a day care centre.

As part of our ongoing efforts to enhance user experience, MEL users will be able to search for GP clinics listed in AIC's Primary Care Portal. Starting 3rd quarter of this year, they will be able to find information such as medical services provided by the GP, contact details, operating hours and website address.

Why wait? Update your profile Primary Care Pages now and have your clinic listed in MEL!

CM

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Resident Physician, Palliative Care

As a Palliative Care Resident Physician, you will assist in the set-up of the Palliative Service under the Department of Geriatric Medicine in CGH. You will work with 1 Consultant and 2 full-time palliative care trained nurses to review newly referred patients and provide ongoing support to primary clinical teams for patients with ongoing issues.

Requirements

- ❖ A registrable basic medical degree with the Singapore Medical Council (www.smc.gov.sg)
- ❖ Postgraduate qualification in Palliative Medicine, Geriatric Medicine or MRCP (UK) would be an advantage
- ❖ Minimum 3 years of post-housemanship/internship experience and in active clinical practice
- ❖ Prior work experience in hospital environment
- ❖ An interest in end-of-life care and/or a willingness to be trained
- ❖ Mature and able to work independently

Interested applicants, please write in with detailed curriculum vitae and contact numbers to:

Medical Manpower, Human Resource
Changi General Hospital
2 Simei Street 3
Singapore 529889

Fax: (65) 67870876

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Emergency Preparedness: Self-Help, Mutual-Help or Government-Help?

by A/Prof Lee Kheng Hock, President, 23rd Council, College of Family Physicians Singapore

Earthquake in Sendai!

I experienced an earthquake for the first time in my life last week. It was at Sendai, the capital city of Miyagi prefecture, an area that was worst hit by the Great East Japan Earthquake and Tsunami of 2011. It was in the middle of a presentation during the annual conference of the Japanese Primary Care Association. Invited to participate as a commentator in the English session of the scientific meeting, I was intently listening to the presentation and trying to piece together some intelligent comments for the end-of-session address that I had to deliver. My concentration was jolted by a loud bang that seems to emanate from the depths of the earth. Then the entire room started to tremble as if an unseen hand had grabbed the room like a matchbox and started to shake its content. It took a few seconds for me to remember that I was in Japan, in her most earthquake prone region for that matter. The first thought that came to my mind was the comforting knowledge that I had bought travel insurance and the regret that I had bought the cheapest option. Will it be enough to evacuate myself back to Singapore should I be seriously injured? What if there was another tsunami and my body was never found? How can I tell those that care for me to move on with their life? My train of thoughts was getting a little silly when the room stopped shaking and normal cerebral function resumed.

I looked to my left to Ms Akiko Iwahashi, a fourth year medical student who was at my department as an elective student earlier this year. When she learned that I was coming to Japan for the conference, she felt duty-bound to meet the Singapore professor and to act as my translator for the Japanese sessions of the conference.

"Is this an earthquake?" I asked, trying to sound nonchalant like a consultant during a ward round when the patient is collapsing.

"Yes."

"Is it a big one?"

"It is not so big." She smiled reassuringly but I can sense a tinge of nervousness.

The speaker had stopped mid-sentence. The room was so quiet that you can hear the whirr of the projector fan. Everyone in the room was seated, calm and waiting. The speaker remained standing at the podium and stared quietly into the distance. It was as if somebody had pressed the pause button on the remote that controlled everyone in the room.

"What should we do?" I asked. In my mind, I was debating whether I should bolt like

a jack rabbit and head for the hills just behind the convention centre. I was glad I did not embarrass myself or my country.

"We wait. They will check and tell us what to do next."

It was then that I realized that they were all well drilled in the procedure. No instructions were necessary. Everyone stayed put to wait for further instructions. I noticed that only one person hurriedly left the room. She was the staff from the convention centre. The building had a well rehearsed plan for earthquakes. She was out checking with the building supervisors and engineers.

Minutes dragged on. Eventually the chairman tried to relieve the tension by making some jokes. It was a little flat but the audience appreciated the gesture and managed to respond with a faint ripple of laughter. More silence and minutes



To my left is Dr Takahashi Kuniharu, a member of the Japan Disaster Medical Assistance Team (DMAT). He gave a moving account of the harrowing days of Ishinomaki Red Cross Hospital immediately after the tsunami hit the town. *Image courtesy of A/Prof Lee Kheng Hock*



What is left of the town of Ishinomaki now is mostly empty streets and driveways. The debris and the rubble had been cleared, leaving behind grassy fields and concrete pavements. The top of this memorial pole marked the height of the water level during the tsunami. "Koinobori" or "carp streamers" that were attached to the pole fluttered in the wind. Traditionally these were raised in celebration of the presence of children in a household. Sadly in this case, it was raised in memory of the many children who perished in a school nearby. In the distance, a banner shouts defiantly into the sea. "Ganbatte! Ishinomaki" (Do your best! Ishinomaki)

Image courtesy of A/Prof Lee Kheng Hock

dragged on. Finally the lady returned to the room to give the all clear. Then somebody pressed the play button and the room came to life again. Without missing a beat, the speaker continued his presentation where he left off. The calm and discipline of the Japanese people in the face of calamity was astounding. Made me wonder what would have happened if this was a room filled with my fellow Singaporeans.

Ishinomaki, an inspiring little town

One of the highlights of the conference was a trip to Ishinomaki, a town with a population 164,294. A picturesque town by the sea, it used to be the home port of several ships of Japan's whaling fleet. It is famous for its deep sea fishing industry and sea food processing plants. The Onagawa fishing port was a favorite of the local tourists looking for a bargain in sea food products. All that had changed. The low lying Ishinomaki was one of the worst hit towns during the tsunami. Successive walls of seawater as high as 30 feet crashed into the town and obliterated the homes of 29,000 of its inhabitants. The receding waters left 3097 people dead and took away another 2770 people who were never seen again. It took more than 2 years to clear the mud and the massive amount of rubble that was left in the wake of the tsunami. Even today, wrecked cars and the skeletal remains of abandoned buildings

still dot some parts of the landscape of Ishinomaki.

Whilst the tsunami had broken hearts and homes, it had failed to break the spirit of the people of the town. Many of them led by the shop owners chose to stay on and rebuild the town. It is not an easy undertaking. The local economy was pretty much destroyed. There were no jobs. The devastated landscape brings back excruciatingly painful memories. Toshihiko Fujita was one of the residents who chose to stay back. He was upstairs at home when the earthquake struck and the water from the tsunami started funneling through the streets, submerging his home. His elderly aunt was just outside the house and could not get in because the door was jammed shut. His mother was downstairs, desperately trying to help her sister get into the house.

"I screamed to my mother, but she ran into the living room and opened the window and grabbed her sister to help her get inside the house. I saw the tsunami, look to my mother and then back to the tsunami. 1.... 2.... 3 and then it hit. My family's story ended in that moment. Everyone was dead...."

Toshihiko spent the next four days trapped on the roof of his house in the bitter cold of winter. Completely helpless, he could only look in sorrow at the lifeless body

of his mother lying amidst the water and debris below. It was only when the water subsided that he was able to recover the body of his mother with the help of emergency workers. His aunt's body was eventually found some distance away from his house. Toshihiko chose to stay but he was frustrated by the slow pace of help from the government. The condition in Ishinomaki was unbearable. Traumatized, grieving for the loss of loved ones, saddled by guilt and without means of livelihood, suicides were common in the immediate aftermath. It was estimated that there was one suicide in every three days at one point in time. Eventually, many of the survivors of the town decided that enough was enough and they embarked to help themselves, and to help one another. Notwithstanding his own woeful personal circumstances, Toshihiko decided to run a soup kitchen with the help of other volunteers. Supported by volunteers from all over Japan and other parts of the world, the locals had set up "Ishinomaki 2.0" an open grassroot organization dedicated to rebuilding a new and better Ishinomaki. Painfully but steadfastly, the people of Ishinomaki are reclaiming their town back from the sea.

Lessons on emergency preparedness from Ishinomaki

For healthcare workers, a more poignant story that came out of this disaster was the Ishinomaki Red Cross Hospital. It holds important lessons for doctors and health policy makers around the world. After the tsunami hit town, it was the only major hospital left standing. The water of the tsunami literally stopped at its doorsteps. The three other major hospitals in the area were completely trashed by the tsunami. The biggest hospital, the Ishinomaki City Hospital, was by the seaside and bore the full force of the tsunami. Many healthcare workers and patients could not evacuate in time and were killed as the sea poured into the first 2 levels of the hospital. Those that survived were stranded in the upper floors and the roof top for days, awaiting rescue by helicopters.

The fact that the Ishinomaki Red Cross Hospital emerged unscathed and fully operational did not occur by chance. In

[\(continued on Page 13\)](#)

(continued from Page 13: Emergency Preparedness: Self-Help, Mutual Help or Government Help?)

Dr Yayoi Imamura was one of the many volunteer doctors. In this picture she is seen performing a musical piece to soothe her tired and traumatized co-workers. The living conditions were harsh and the work was emotionally draining. A survey showed that many health care workers working in these areas suffered psychological trauma. An accomplished musician, she brought her flute to perform for the earthquake victim. She remembered that she was approached by a local nurse who was herself a victim of the earthquake. The nurse told her "I want to ask you to play your music for the medical staff who came from other prefectures. Many volunteers are gathering. But we feel sorry for them as no one had done anything to support them."

Image courtesy of A/Prof Lee Kheng Hock



minutes and we saw the staff holding on to computer terminals and equipment to prevent them from crashing onto the ground. There was the familiar expression of quiet anxiety on the faces of everyone as they endured the violent tremors. It must have been a terrifying experience as they stood the ground, wondering if it will ever end and whether the roof will come crashing down on them. The moment the tremors stopped, the training kicked in. The room was a hive of purposeful activity. Almost instantly, the backup generators were activated and power was restored. Television sets were switched on immediately to monitor the news. Within 4 minutes the hospital Disaster Management Task Force members had gathered. Everyone seems to know exactly what to do and where to go. There was a calm scramble to put up white boards, charts and computer terminals as the operations room was set up. Different departments started reporting in to the command post to report on the damages suffered at their respective stations. It was like an episode from Star Trek where the starship was hit by a meteor. Everybody gives a status report to Captain Kirk in the bridge of the Starship Enterprise.

Miraculously there was hardly any damage even after the record breaking 9.0 Richter scale earthquake assailed the hospital. The design passed the test with flying colors. The room started buzzing with activity. In one corner the Head Nurse was giving instructions to reschedule

elective surgeries. People were putting on pre-prepared vests that identified appointment and roles of the person. Without being called, off duty hospital staff began to stream in voluntarily to the hospital to help. Thirty minutes into the disaster, the lobby was buzzing with activity as it was quickly turned into a triage area. Administrators, nurses, doctors were all busy moving furniture out of the way to clear the triage area. Everybody knows the drill. Portable beds were set up in neat rows. Color coding for prioritization were laid out on the floor. Workers in different areas put on different colored vests. In under 45 minutes, the lobby was transformed into a giant triage area and ready to receive casualties. Doctors and nurses were gowned up and ready for action but no patients came. Information began to trickle in.

There were reports of waves of tsunami heading towards the coast of Ishinomaki. Buildings had collapsed and hundreds if not thousands had died. Everyone must be worried sick about their own home, families and friends. Land lines, mobile network and internet were all down. Yet everyone stood their ground, as if they were at battle stations. Duty came first. After about 2 hours the first wave of casualties started coming in. Most of them walked or were carried in from the surrounding areas. The most severely injured, in the worst hit areas were stranded. Roads were flooded and vehicles washed away. It was very difficult

to make it to the hospital. By nightfall the Japanese Self Defense Force arrived with their equipment. The hospital was the only place where they could set up camp. Medical Assistance Teams followed the military and rescue vehicles out into the field to pick up casualties. Slowly the trickle of patients built up into a flood. By day break, the full scale of the disaster dawned upon everyone. Television news showed the horrific scene of devastation of Ishinomaki town. Vehicles and helicopters brought in an endless stream of patients suffering from injuries, dehydration and hypothermia. The treated patients had no homes to return to. The hospital ground was converted into a temporary shelter.

The high level of preparedness of this 400-bed hospitals undoubtedly saved many lives. In addition to being prepared, Dr Kuniharu shared many more lessons that were gained from this tragic episode. One of the critical success factors was the "manual" and everyone's familiarity with it. A rapid initial response is vital. However he cautioned that a manual was of limited usefulness beyond the initial response because it is impossible to foresee how disasters will evolve. There is no point having manuals that tries to cover all eventualities.

Co-ordination between the different agencies was critical. Likewise the support of the private sector proved vital to many of the rescue effort. Like in most disasters, the planners learned that there was too

much emphasis given to trauma care and specialist care.

Counter intuitively, the greatest demand in a disaster situation was actually primary care and chronic care. The breakdown of sanitation and the lack of basic necessities increased the risk of disease outbreaks. Many of the victims developed minor illnesses that became complicated due to a lack of primary care facilities. People suffering from chronic diseases, especially those with complications suddenly find themselves without long term care. Patients that needed dialysis had nowhere to go. Many elderly residents with chronic diseases developed complications due to the harsh conditions and the lack of continuing care.

Ironically it was the family physicians and the well trained generalists that made the most difference in such a situation. Specialized trauma teams were largely not needed beyond the initial wave of casualties. The very next day of the disaster, the Japanese Primary Care Association sprang into action and created the PCAT (Primary Care for All Team) teams. These were multidisciplinary medical assistance teams led by primary

care physicians. Large numbers of primary care doctors and allied health workers responded. Within a week teams were dispatched to various parts of earthquake hit areas.

During the talk, the lesson that made the most sense to me was the concept of the triad of self-help, mutual-help and government-help. According to Dr Kuniharu, these are the 3 pillars that sustain any disaster relief operations. Again counter intuitively, he said that the more severe the disaster, the less effective is government-help and the more critical mutual-help becomes. Reflecting on this and based on our own experience in the SARS crisis, I think there is a lot of truth in what he said. It is in the nature of government organized relief efforts to be highly centralized and tightly regulated. These slow down reaction time. It hinders adaptation to rapidly changing local conditions, especially when communications are down.

Secondly it is always the unforeseen calamities that wreak the most havoc. Governments around the world are famously inadequate in predicting disasters. SARS for example was completely

unforeseen and perhaps unforeseeable at that point in time. In Singapore we are geographically blessed in that natural disasters are unlikely to happen. We get seriously upset even when a stretch of Orchard road gets flooded for a few hours. But low risk does not mean no risk as SARS had taught us.

More importantly, man-made calamities can happen either out of negligence or through acts of terrorism. Our health care system must be prepared for national emergencies. Primary care and professional bodies are important but often neglected in policy planning. When the chips are down, the most important thing we can do to help ourselves is to help one another. If the bonds of our professional community are weak, we will be ineffective.

The best defense against a nationwide calamity is probably a simple well-rehearsed plan for an initial response, a high level of professionalism of the health care workers and a commitment to help one another as members of the same community.

■ CM

Family Practice Skills Course

Schizophrenia

The College of Family Physicians Singapore would like to thank **Agency for Integrated Care (AIC), Institute of Mental Health (IMH), Ministry of Health (MOH)** and the Expert Panel for their contribution to the Family Practice Skills Course #51 on "Schizophrenia", held on 23 – 24 February 2013.

Expert Panel:

A/Prof Chong Siow Ann
A/Prof Swapna Verma
Dr Sutapa Basu
Dr Ashwin Chee
Ms Helen Lee
Mr Christopher Loh
Dr Alvin Lum
Dr Sujatha Rao
Dr Roger Ho
Ms K Pushpa
Mr Jagan s/o Rama Sendren

Chairpersons:

A/Prof Swapna Verma
A/Prof Goh Lee Gan

Sexual Health

The College of Family Physicians Singapore would like to thank **Health Promotion Board (HPB)** and the Expert Panel for their contribution to the Family Practice Skills Course #52 on "Sexual Health", held on 16 – 17 March 2013.

Expert Panel:

Ms Ho Lai Peng
Dr Lee Cheng Chuan
Ms Felicia Everard
Prof Roy Chan
Dr Ellen Chan
Dr Priya Sen
Dr Martin Chio
Ms Samantha Bennett

Chairpersons:

Dr Low Sher Guan
A/Prof Goh Lee Gan