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Family Medicine - One Discipline, Many Settings

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

Family Medicine is now de facto practised in diverse healthcare settings in Singapore such as clinics, hospitals, nursing home and home care. This situation is recognised with the amendments of the College Constitution in the Annual General Meeting 2012 and approved by Registry of Societies on 8 February 2013.

The amendments define family medicine (FM) 'as a discipline with expertise in the following six elements of care in the context of the patient, family and society:

- Personal care,
- Primary care,
- Preventive care
- Comprehensive care,
- Continuing care, and
- Co-ordinated care

and practiced in the settings of:

- Ambulatory care in the community,
- Intermediate care in the community hospitals and rehabilitation centres,
- Long term care in the nursing homes, residential care, and home based care,
- Hospice and home based end-stage diseases care,
- Interface care which is care within acute hospitals in the interface with the other settings'

These definitions de facto describe the settings where family medicine is practiced and what family physicians do.

The seamless co-ordination in the various care settings amongst family physicians is possible because of shared values and the camaraderie.

(continued on Page 2)

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(continued from Page 1: Family Medicine - One Discipline, Many Settings)

Ambulatory Care

The ambulatory care setting continues to where most family physicians work to provide the primary, preventive, personal, continuing, comprehensive and co-ordinated care (3P3C) to our people. The many polyclinics, group practices and singleton practices provide a network in the island. Some of these clinics are devoted to niche clinical interests such as statutory and well person check-up.

Community Hospitals and Rehabilitation Centres

Trained family physicians provide intermediate care in community hospitals in Singapore. Seven of the doctors in St Luke's Hospital have the Master of Medicine (Family Medicine) [MMed(FM)] and are Fellows of the College of Family Physicians Singapore [FCFP(S)], providing both clinical leadership and service to the in-patients. The College Censor-in-Chief, A/Prof Tan Boon Yeow heads the team.

Long Term Care in Nursing Homes

Long term care is provided in nursing homes. For example, in the 300 beds Bethany Methodist Home, which is home to more severely incapacitated patients, A/Prof Goh Lee Gan and Dr Marie Stella Cruz, FCFP(S), provide a high standard of clinical leadership to the healthcare team of other doctors, nurses and care givers.

Palliative Care

Home end-stage disease care and hospice care are areas in which many family physicians are practising. Dr Tan Yew Seng, FCFP(S), director of Assisi Hospice is accredited as a palliative sub-specialist by the Singapore Medical Council and is currently supervising other palliative registrars who are trained family physicians in their residency programme.

In-patient and Transitional Care

In-patient and transitional care is provided by trained family physicians in many major hospitals in Singapore. The first such department, the Family Medicine and Continuing Care (FMCC) Department was set up in the Singapore General Hospital (SGH) to provide hospitalist as well as transitional, integrated and collaborative care. A/Prof Lee Kheng Hock, FCFP(S), President of the College (23rd Council, 2011 - 2013), heads the operations.

Family physicians that wish to work in another care setting can acquire additional skill-sets needed for the tasks.

The seamless co-ordination in the various care settings amongst family physicians is possible because of shared values and the camaraderie. Family physicians that wish to work in another care setting can acquire additional skill-sets needed for the tasks.

CM

Please turn to Page 6 for the series "Family Medicine - One Discipline, Many Settings' to learn about family medicine as practised in the polyclinic, general practice, community hospital, nursing home, palliative care and a tertiary hospital.

FAMILY MEDICINE COMMENCEMENT CEREMONY 2013
Saturday, 6 July 2013
2.00pm - 3.30pm
Auditorium (Level 2)

Tea Reception
3.30pm - 4.00pm
Function Room (Level 1)

CFPS 42ND ANNUAL GENERAL MEETING
Saturday, 6 July 2013
4.00pm - 6.00pm
Auditorium (Level 2)

College of Medicine Building (COMB)
16 College Road Singapore 169854

Year of the Snake

by Dr See Toh Kwok Yee, Editor

The snake is a curious creature. How from being a vilified adversary in Eden, it has, through the ages, slithered back into our consciousness as a noteworthy symbol. Flip back this cover and you will see the College Emblem with a picture of a snake seemingly "mugging" over a thick book! Of course, in reality, the snake entwining the staff is known as the Rod of Asclepius, the Greek god of healing and medicine. It is now a universal symbol adopted by many professional healthcare associations and organisations. Many theories abound about the choice of the snake as an imagery of healing. The most plausible explanation can be found in the natural attributes of the reptile; it moults periodically throughout its lifetime. The entire old scaly skin including the covering of the eyes is shed to allow for **growth and renewal**. The analogy is that of a patient ravaged by illness and the passage of time but through the masterful healing of the physician is rejuvenated and given a new lease of life.

In a similar vein, with the recent amendment of the College Constitution, the definition of Family Medicine is reinvigorated to emphasise its growth in relevance and importance in the changing healthcare landscape. In this issue, we are privileged to have representatives and stakeholders from the five fields of Family Medicine as included in the definition, namely Ambulatory Care, Community Hospitals/ Rehabilitation Centers, Long Term Care in Nursing Homes, Palliative Care and In-Patient/ Transitional Care to acquaint us with their work.

A known fact about older snakes is that they shed less frequently but nonetheless still continue to moult when necessary. Similarly, the veteran colleagues among us must continue to renew ourselves both in spirit and in health in order to anticipate and embrace future challenges like those envisaged in the Primary Care Masterplan. On this note, we are privileged to be granted an interview with Prof Tay Boon Keng, Director of Health Services Group, Ministry of Health (MOH) who shares his views on the Masterplan.

Whilst the focus of the day must be the preparation for a greying world, we would be remiss if our younger colleagues are not brought on board to share the vision. As a follow-up to the Sreenivasan Oration delivered by Prof Ranga Krishnan we have invited two Duke-NUS medical students to share their thoughts and aspirations.

The editorial board is also rejuvenated by the addition of a new member in Dr Soh Soon Beng, a senior Family Physician and Graduate Diploma in Family Medicine (GDFM) tutor. Dr Soh has introduced a new segment in the form of a clinical photo quiz.

Lastly, the editorial board wishes its readers the best of health in the Year of the Snake.

CM

this issue >>

01 < **Cover Story:** Family Medicine - One Discipline, Many Settings
03 < **Editor's Words:** Year of the Snake
04 < **President's Forum:** Tribalism and Organised Medicine
06 < **Invited Article:** Family Medicine - One Discipline, Many Settings
14 < **Interview:** Interview with Professor Tay Boon Keng on Primary Care Masterplan Update
16 < **Interview:** Interview with Duke-NUS Medical School Singapore Students
18 < **Practice Management**: Exercise: How We Can Help Our Patients Exercise Safely and Effectively
20 < **Event**: Asia Pacific Primary Care Research Conference (APPCRC) 2012
22 < **Photo Quiz**
24 < **Family Practice Skills Course #53:** Chronic Lung Disease

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Asia Pacific Primary Care Research Conference 2012

by Dr Chng Shih Kiat, Chairperson, Organising Committee, APPCRC 2012

Group photo of APPCRC 2012 participants.

The 4th Asia Pacific Primary Care Research Conference (APPCRC) was held in the new Centre for Translational Medicine (Block MD6) in Yong Loo Lin School of Medicine, National University of Singapore (NUS) on 1 – 2 December 2012. The pre-conference Research Championship workshop was held on 30 November 2012.

This year's conference received overwhelming support from international medical communities with participants coming from 16 countries, representing 42 organisations. Participation from the medical students as well as our residents from the 3 Family Medicine Residency Programmes was encouraging, with 60% of the conference posters coming from these aspiring Family Medicine doctors.

The pre-conference Research Championship workshop allowed young, budding Family Medicine researchers to develop their research ideas under the guidance of experienced primary care researchers. This year's Research Championship attracted 8 participating teams. The workshop facilitators from the Family Medicine communities of Malaysia, Singapore and Hong Kong attended a briefing conducted by the Conference Research Chairman, Dr Tan Ngiap Chuan. This was followed by dinner at The Rice Table where the facilitators had a wonderful opportunity to catch up with one another and foster closer ties. The Research Championship started with each team giving a presentation of their proposed research projects. The facilitators then met their respective teams and had a full day of teaching and refining of the proposals. The refined proposals were presented at the end of the day and 4 teams were selected by a panel of judges to present their ideas on the second day of the conference to compete for the overall Research Championship trophy.

The Conference was officially opened with a welcome speech given by the organising chairman, Dr Chng Shih Kiat. This year's conference included 4 plenary lectures delivered by both local and overseas experts in primary care research. Professor Wong Yeung Shan Samuel from The Chinese University of Hong Kong gave an interesting lecture on Innovative Interventions for Anxiety and Chronic Stress in Primary Care, carried out in Hong Kong. Associate Professor Ng Chirk Jenn from University of Malaya spoke on the challenges that the Malaysian primary care researchers experienced prior to the setting up of the Family Medicine Research Network. He urged those present to take up the challenge and pass on the passion to advance the scope of primary care research. Professor David Matchar from Duke-NUS Graduate Medical School Singapore highlighted

Conference participants attending the workshops.

Prof Samuel Wong, A/Prof Goh Lee Gan, Dr Tan Ngiap Chuan and A/Prof Ng Chirk Jenn joining the Zumba dancers on stage during the Gala Dinner.

Teams in discussion during the pre-conference, Research Championship and group photo of Research Championship coaches and participants.

the importance of health services research in the primary care setting. Professor Gwee Choon Eng Matthew from Yong Loo Lin School of Medicine, NUS introduced the idea of how a mundane teaching activity can be translated into a peer-reviewed scholarly pursuit.

3 workshops were organised for the conference. The Biostatistics workshop was helmed by Associate Professor Koh Choon Huat Gerald with the assistance from Biostatisticians from Yong Loo Lin School of Medicine, NUS. The workshop allowed the participants to have hands-on experience using the SPSS programmes in the Computer Laboratory at Saw Swee Hock School of Public Health. The participants had the opportunity to work through scenarios on statistical analyses. The workshop on Medical Writing was facilitated by Professor Teng Cheong Lieng from International Medical University and Associate Professor Ng Chirk Jenn. The principles of medical writing were shared and the workshop finished with a questions and answers session where interesting topics such as ethics in medical writing were discussed. The workshop conducted by Professor Gwee Choon Eng Matthew and Dr Dujeepa D Samarasekera from the Medical Education Unit, NUS was on Enhancing Scholarship of Teaching-Learning in the Primary Care Setting. The workshops equipped participants with ample practical tools for future use in research.

As in all conferences, the participants had sumptuous tea breaks. They were also treated to a Lunch Symposium sponsored by AstraZeneca where Dr Daniel Wai, endocrinologist practising at Mount Elizabeth Hospital, gave an interesting talk on the safety of the use of statins for cholesterol management. The Gala Dinner held in Kent Ridge Guild House was a highlight of the conference. During the dinner, we had excellent performances from Zumba dancers and belly dancers. Professor Wong Yeung Shan Samuel, Associate Professor Goh Lee Gan, Associate Professor Ng Chirk Jenn and Dr Tan Ngiap Chuan were invited on stage to dance with the Zumba dancers. Their performances entertained and thrilled everyone present! Dr Peter Moey from SingHealth Polyclinics added to the highlight of the night by getting everyone present to participate, playing the guitar and drums using their smartphones while he played the tune of Pachelbel's Canon in D minor on his violin. The Gala Dinner brought conference participants together having fun interacting with one another.

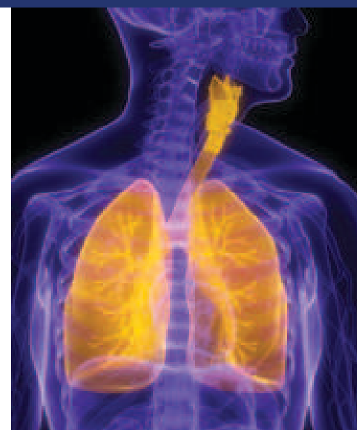
The conference drew to a close after the award presentations for Best Poster, Best Oral Presentation and the Research Championship. The conference was a resounding success, thanks to the relentless support from the secretariat staff of the College of Family Physicians Singapore and the selfless contributions of all the members of the organising committee. It has been a wonderful learning experience for everyone and it is our sincere hope that we see the Asia Pacific Primary Care Research Conference scale to greater heights in furthering primary care research in the days to come.

CM

Family Practice Skills Course #53

Chronic Lung Disease

Sat - Sun, 11 - 12 May 2013
2.00pm - 5.30pm
National University of Singapore (NUS), LT 29



TOPICS

Unit 1: Epidemiology of Chronic Obstructive Pulmonary Disease (COPD)
Unit 2: Guidelines for COPD & Non pharmacological Interventions
Unit 3: Pharmacological Interventions of COPD – Latest on GOLD Guidelines
Unit 4: The Overlap Syndrome of Asthma & COPD
Unit 5: Pulmonary Rehabilitation
Unit 6: Community Care: A Team Based Approach to Managing Chronic Lung Disease

WORKSHOPS

Day 1: Case Studies: Mild, Moderately Severe and Severe COPD Patient
Day 2: Inhaler Techniques; Spirometry Use and Interpretation

SPEAKERS

A/Prof Ng Tze Pin
A/Prof Lee Pyng
Adj Asst Prof Augustine Tee
Dr Ong Kian Chung
Dr Gerald Chua

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

SEMINARS (2 Core FM CME points per seminar)
Seminar 1 • Unit 1 - 3: Sat, 11 May 2013 (2.00pm - 4.00pm)
Seminar 2 • Unit 4 - 6: Sun, 12 May 2013 (2.00pm - 4.00pm)

WORKSHOPS (1 Core FM CME point per workshop)
Day 1: Sat, 11 May 2013 (4.30pm - 5.30pm)
Day 2: Sun, 12 May 2013 (4.30pm - 5.30pm)

* Registration is on first-come-first-served basis.
Seats are limited.
Please register by 6 May 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 organised by the **College of Family Physicians Singapore** and supported by an educational grant from **Boehringer Ingelheim**

REGISTRATION

FREE REGISTRATION for College Members!

Chronic Lung Disease
Please tick (✓) the appropriate boxes

	College Member	Non Member
Seminar 1 (Sat)	☐ ~~$21.40~~ FREE	☐ $21.40
Seminar 2 (Sun)	☐ ~~$21.40~~ FREE	☐ $21.40
Workshops (Sat-Sun)	☐ ~~$42.80~~ FREE	☐ $42.80
Distance Learning (Journal)	~~$42.80~~ FREE	☐ $42.80
TOTAL		

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

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**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).*

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MCR No: ____________ NRIC No: ____________

(For GDFM Trainee only) Please indicate: ○ 2011 Intake ○ 2012 Intake

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

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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 Duke-NUS Graduate Medical School Singapore Students

Interviewed by Dr See Toh Kwok Yee, Editor

As a follow-up to the Sreenivasan Oration delivered by Professor Ranga Krishnan, Dean of Duke-NUS Graduate Medical School Singapore on "The Greying World", The College Mirror has decided to interview two of its medical students who are currently in the midst of their Family Medicine posting.

To recapitulate, Prof Ranga has, in his insightful speech, mentioned that integrated solutions to the heathcare problems of an aging population are critical and that Family Medicine and Family Medicine practitioners can be the building blocks. It follows then, according to Prof Ranga, family care physicians are now at the top of the wish list from most healthcare systems.

It was with this timely speech in mind that the views of these two graduate students were sought.

It has started as a structured interview but the interviewer soon realised that such a format would not do justice to these young enthusiastic minds who were raring to share their thoughts and experiences beyond the usual questionnaire.

Consequently, the decision to let the two 'speak their minds' has produced the following refreshing articles.

Ms Melissa Tan, a Singaporean, pursued her undergraduate education at the University of Michigan, majoring in Neuroscience. According to Melissa, along her "clinical journey", she has been inspired by mentors who treated their patients together with their families holistically thereby adding life to the patients' years and not simply years to their lives. She is the current Honorary Treasurer of the 5th Student Council and is looking forward to contributing in the field of palliative medicine.

The "greying problem" - we often term this societal phenomenon of an aging population a problem. The fact that communities reject nursing homes built in their backyards, elderly lack caregivers, and an increasing number of elderly are suffering from depression are problems, but the elderly themselves are not. In a recent New York Times article "older people become what they think", it highlighted studies that showed when the elderly are exposed to negative stereotypes, and become convinced that ageing is burdensome, they have shorter lifespans and worse cognitive functions. That, I believe, is a problem.

In my journey through the family medicine curriculum, I have had the privilege of adopting Uncle T as my family medicine patient. He is a patient that hospitals dread to see and term as a "frequent flyer", with a whopping record of 10 admissions over the past year. Uncle T has a complicated medical history of diabetes, hypertension, hyperlipidemia, ischemic heart disease, recurrent falls, and the list goes on. His medical history made him an excellent choice as a family medicine patient, but I had no idea that his social issues went longer than that. The first time I stepped into his one-room flat, I was overwhelmed by the smell of urine and faeces. Uncle T lives alone since he was widowed 8 years ago has limited mobility and spends most of his time in his bed, wheeling himself to the hawker centre downstairs for meals once to twice a day. Uncle T's warm welcome always makes me smile, yet listening to him share his family issues (he has 5 children, with only one daughter who is officially involved in his care but difficult to contact) and the sense of resignation I get from him breaks my heart (the phrase I have heard him repeat most in Chinese is "I am old, it is troublesome"). During one of my visits, I ask him about his health, and he says "same old", insisting that he takes his medications. A sun image on the pillbox means to take in the morning, the moon means to take at night, he tells me. However, the pillboxes with the sun on it looked untouched (he said that they were refilled just), and the pillboxes with the moon on it are empty (he said he had finished taking them just). Yet the many medications in the SGH pharmacy plastic bag were left unopened. I sighed, not knowing which to believe. And he had insisted once again that he was coping. He had refused the multiple applications the social workers have put in to request for home help, and without his agreement, the medical teams are always in a pickle with regards to his home care. I have watched Uncle T bounced back and forth from hospital admissions, usually due to complications from his non-compliance to medication or due to falls. My biggest challenge in this case was how I could help him regain his dignity and independence. As I ponder this, I realised that it wasn't about what I could do or buy for him, but it came down to changing my perspective of the elderly, as much as changing his perspective of himself and his illness. He needed to know that he should not feel devalued and see himself as a burden.

My experience with Uncle T has shown me the neglected side of our society. He is one of the many who are forgotten and have fallen through the cracks. I am excited for the initiatives that are coming up by the time I graduate. Schemes and approaches like the Grand Aide System and the Ageing-In-Place programme are necessary and important. More than that, I appreciate that these new initiatives aim to care better for our elderly by building deeper relationships with them, through health care teams, their communities and fellow more able elderly and always keeping the totality of the human person in mind.

Uncle T is still caught in the web of paperwork, nursing home applications, and assessments to determine his decision making capacity before he is able to live in a safe environment. However, to accord him a quality of life and to empower him to better manage his comorbidities, I believe that helping him feel valued again is the first and all-important step. I have learnt that healthcare workers need to reinforce the positive aspects of aging. To this end, I like to quote Dr Becca Levy, a psychologist working on aging and stereotypes, *"If all of us became a little more aware of the implications of our communications — the tone of voice we use with seniors, the attitude we adopt, the use of loaded phrases or expressions, the extent to which we give older adults our full, undivided attention — that would help quite a lot."*

*Ms Zhu Guili hails from Jiangsu, an eastern coastal province of the People's Republic of China. Upon graduating from the National University of Singapore with a major in the Life Sciences, she has spent a two-year stint at A*STAR before joining Duke-NUS GMS. She is married and is looking forward to becoming a mommy in the coming months.*

I come from China, a country with a very different medical care system. Nevertheless, it is an era where almost the entire world is seeing an ageing population, be it Singapore or China. To be honest, I'm very envious of the established integrated care provided by Family Physicians in Singapore. In China, the elderly patients, who commonly have multiple co-morbidities, see different specialists for diseases arising from different systems. The consequence is increased health cost, inconvenience and a fragmented healthcare where each specialist only takes care of his area of interest and no one actually looks at the patient as a whole. I see the success of family practice providing integrated care in Singapore, and I foresee Family Medicine leading the way similarly for the rest of the world.

From left: Ms Melissa Tan and Ms Zhu Guili.
Image courtesy of Dr See Toh Kwok Yee.

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Requirements

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- ❖ 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) 67877961
Email: medical_manpower@cgh.com.sg

Changi General Hospital

As third year medical students at Duke-NUS, we go through a 10-month clerkship in Family Medicine. The curriculum is designed such that we get to experience diverse aspects of Family Medicine. Each of us is attached to both a polyclinic and a private GP clinic. A substantial proportion of the cases are elderly patients with chronic illness, and I was taught the ABCDEF model of chronic care, which aims to detect and care for all healthcare gaps of the patient, be it acute or chronic, physical or psychiatric, current or predicted illness. I especially loved the sessions in the private GP setting. My GP mentor runs a family practice in the mature community for many years. Apparently he knows his patients and their families very well. It is common to see two patients from the same family, who take turns to sit in the patient's seat for consultation. The trust that patients have in him has definitely pushed for a better therapeutic relationship.

I remember this particular case I saw which involved an elderly lady who had recently completed her treatment for lung cancer and was flying off to Thailand in a couple of hours. She had a cough that was bothering her but during the consultation it was established through clinical findings that she had chest infection. Despite her eagerness to travel as planned, she had decided to follow her family doctor's advice and gave the trip a miss. If she had not trusted him so much, I am sure she would have gone ahead. Besides the good doctor-patient relationship that I really enjoyed, I also had ample opportunities to clerk patients and practise clinical skills. While we have other commitments as third year medical students, such as a research project and the compulsory United States Medical Licensing (USMLE) step 1 exam, the posting in the family medicine clinics allows me to keep in touch with my clinical competence.

Besides the clinic attachment, our family medicine curriculum also included a module called patient-centred care. Each of us follows up two patients, beginning from their hospitalisation for a period of 10 months. The home visits allowed me to see the patient in a more realistic setting; where the patient spends most of the time. I could see the home environment and modifications that have been done to suit the needs of a particular patient. Experiencing the family dynamics first hand allows me to witness and assess the adequacy of the the patient's relationship with his family members in helping his medical conditions. I find it very fulfilling to establish a close relationship with the patient and his family over time and when they open up and share about their lives which usually do not happen in the hospital setting. Healthcare does not stop the moment a patient steps out of the hospital or clinic. It continues at home. We, the healthcare providers, should definitely take these home visits as an opportunity to improve chronic patient care further.

The pivotal role of family medicine in caring for a "greying population" that Dean Ranga mentioned cannot be overstressed. With our family medicine curriculum, I hope to be better prepared for the future medical landscape in Singapore.

CM

Interview with Professor Tay Boon Keng on Primary Care Masterplan Update

Interviewed by Dr Loke Wai Chiong, FCFP(S), Editorial Board Member, Global Healthcare Consultant

In January and February 2013, MOH co-organised three Townhall sessions in partnership with the various healthcare clusters inviting all GPs to an update of the Primary Care Masterplan. The purpose was also to engage GPs on the different models of primary care, and to understand their concerns with respect to these models, and how they can be evolved and further improved.

We interview Professor Tay Boon Keng, Group Director of the Health Services Group, Ministry of Health (MOH), on his thoughts and perspectives both as a senior policymaker and as a senior clinician leader with years of experience in our healthcare system.

CM: Since the first large-scale discussion of the Primary Care Masterplan in October 2011, what has progressed in terms of engagement and refinements made to the Plan?

MOH introduced the Primary Care Masterplan in 2011 to introduce the concept of team-based care among the GP communities. We envisioned that with the support of nurses and allied health professionals, GPs would be more equipped to manage chronic diseases within the community.

Since the first Primary Care Workplan Seminar in October 2011, we have had engagement sessions with various stakeholders, and now have a better idea of the services that we want to develop under the Primary Care Masterplan. We have been able to delve deeper into the issues concerning the different aspects of the Primary Care Masterplan, as well as to iron out issues related to their implementation.

Image courtesy of Prof Tay Boon Keng.

After the Workplan Seminar in Oct 2011, the Regional Health Systems (RHSes) hosted individual engagement sessions with the GPs in late 2011 to obtain feedback from the GPs on the Primary Care Masterplan. The rest of year 2012 saw MOH revising the Masterplan as well as the care model for the Family Medicine Centres (FMCs) and Community Health Centres (CHCs). MOH also worked with various entities to develop the pilot FMCs and CHCs to ensure a smooth implementation.

As the models of primary care piloted are constantly evolving, we wish to continue engaging GPs, so that we can refine and adjust accordingly, including through future Townhall sessions and similar platforms. Going forward, we will provide timely reviews and articles with Singapore Medical Association and the College as we roll out the models of care under the Primary Care Masterplan. While we implement and pilot new services and evaluate them, we will continue to take in their feedback from stakeholders, and refine these models accordingly to meet the primary care needs of the country.

CM: What are some of the common questions on the minds of GPs during the recent Townhall sessions? And what are some key suggestions raised?

During the three Townhall sessions that were co-organised by MOH, AIC and the respective RHS, issues that were discussed included the Community Health Assist Scheme's (CHAS) administrative processes, publicity and CHAS's expansion to cover a wider population, the rolling out of CHCs and the operating model of FMCs.

While GPs appreciated that CHAS subsidies helped alleviate the out-of-pocket payments for their patients, they felt that the administrative and audit processes were too tedious. AIC, as the programme manager for CHAS, will be streamlining the workflow for CHAS claims. In addition, we will also be looking at how the paperwork for audit purposes can be further reduced, such that only the crucial data fields are included. GPs have also requested for the age cap to be removed and allow more conditions to be claimed under CHAS. MOH has recently enhanced CHAS in 2012 to lower the age criteria from 65 to 40 and raised the income cap from a per-capita household income of $800 to $1500. MOH would continue to review CHAS and consider the need to expand its eligibility.

GPs play an important role in the delivery of primary care, and are crucial components of the care equation. With the Masterplan, we hope to offer GPs more options to participate in this constantly evolving landscape.

On the CHCs, an overwhelming majority of GPs were supportive of the model of care, and would like to see more CHCs rolled out at a faster rate. There is already one CHC in Tampines and there will be three more CHCs coming up this year. We acknowledge the strong support that GPs had expressed for CHCs. From our past experience, we note that the cost of running CHCs is rather high. Whilst we hope to build more CHCs, we would also need to do so in a sustainable manner. Over the past two years, the GP community has gradually understood and accepted the FMC care model. Key to FMC is a team-based model to manage the growing demands for chronic care. During the Townhall sessions, we noted more GPs expressing interest to develop FMCs with us.

CM: As a very senior clinician with years of experience watching the healthcare system in Singapore evolve, what are some the major innovations or improvements you see, with the implementation of the Masterplan?

For the past decade or so, we have been using a hospital-centric model, in which healthcare is focused around hospitals. The hospitals used to look after a relatively younger population, who are more likely to present with acute conditions. However, Singapore is now experiencing a rapidly ageing population. We would need to take care of this increasingly older population, who are more likely to have multiple chronic conditions, and who require long term care.

One of the key issues is the right-siting of patients from the Specialist Outpatient Clinics (SOCs) to the community. Currently, the volume of patients that our hospitals and SOCs manage are relatively large, and this would likely increase over the next few years, especially with increasing and aging population. We have noticed a significant percentage of stable patients who utilise the SOCs currently, and whose conditions may be suitable for management in the community.

With the various initiatives under the Primary Care Masterplan that MOH is rolling out, we see the healthcare system evolve to focus on encouraging and supporting more patients to seek care within the community, instead of turning to the hospitals in the first instance. Patients will benefit from good quality care nearer their homes, and are spared from long travelling and waiting times at the hospitals. In addition, they are able to enjoy personalised care that they currently do in the familiar setting of their GP's clinic.

GPs play an important role in the delivery of primary care, and are crucial components of the care equation. With the Masterplan, we hope to offer GPs more options to participate in this constantly evolving landscape. Solo GPs will be better supported in their care for patients with chronic conditions thorough CHCs, while CHAS would help patients reduce the out-of-pocket (OOP) payments for patients with lower incomes. For GPs who wish to explore practicing in an environment with on-site support of nursing and allied health services, they can consider being part of the FMCs.

CM: What are some of the benefits – both immediate and longer term – that GPs can expect as they involve themselves in the Masterplan?

The main thrust of the Primary Care Masterplan is to provide additional support to the GP communities to manage chronic diseases. We have recently expanded CHAS to enable lower and middle income Singaporeans to seek care at participating GP and dental clinics within their neighbourhood. Patients eligible for CHAS are also entitled to subsidised rates, should their GPs deem it necessary to refer them to SOCs. This will save the patients one trip to the polyclinic just to obtain a subsidised referral and at the same time incentivise them to stay with the family doctor for primary healthcare needs.

MOH has also developed the CHC with the intent to provide support services like nursing and allied health services to the GPs. The GP community is empowered to provide adequate and holistic care for patients with chronic diseases, and GPs will become responsible for the long term care of these patients, thus possibly expanding the pool of patients under their care. Ideally, patients would benefit from the convenience and choose to seek medical care from their GPs, be it for acute or chronic conditions, which also helps to fulfil the vision of "One FP for each Singaporean".

In the immediate term, GPs have a say in how they hope the primary care sector can and should evolve, as we seek your valuable opinion on the operating models that you envision for the FMCs, how GPs can work with like-minded colleagues to realise FMCs. In the longer term, GPs may benefit from better work-life balance, possibly through cross coverage with colleagues at the FMCs. GPs may also further hone their skills and benefit from the professional interaction and peer reviews.

■CM

Family Medicine - One Discipline, Many Settings

Experience in the Polyclinic: A Strong Primary Care Foundation - The Backbone of Any Healthcare System

by Dr Tan Hsien Yung David, MMed(FM), MCFP(S), FCFP(S)
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"Why Family Medicine and Why the Polyclinic?"

I am frequently asked this question by medical students and extended family alike. While I must say I had the childhood dreams of becoming an O&G doctor or a famous surgeon, it became clear to me as I progressed through medical school that I wanted to be a doctor who is trained to manage a wide array of conditions instead of being confined to just one segment of the population or a certain disease spectrum. Somewhere in my 4th year of medical school, I decided that Emergency Medicine or Family Medicine (FM) would be the way to go. While I enjoyed my exposure in the children & adult emergency departments, I wanted a career that would afford me the luxury of balancing work and family. FM therefore seemed the more attractive option.

FM in the Public Sector

In the final year of my three-year post-graduate FM training working in the polyclinic, I learnt more about the importance of primary care in managing the health of the community. I also learnt how good primary care could lower costs in the long run, not just for the patient, but for the community at large.

There is sufficient evidence in literature to show that countries with a robust primary care system do better in terms of healthcare outcomes and spending. I must give credit to Drs Meena Sundram and Irwin Chung, my mentors in Family Medicine in Jurong Polyclinic, for encouraging me to attend the Disease Management and Healthcare Transformation Conference in 2008 where the late Professor Barbara Starfield was plenary speaker. During this conference, I was inspired by her sharing and this further strengthened my resolve to remain in primary care.

Image courtesy of Dr Tan Hsien Yung David.

I also remember telling myself, when I was a fresh doe-eyed medical student setting foot in the wards for the first time, that the public sector is where I want to practice. This is where the poorest of the poor, the vulnerable and the needy could be seen in their time of need. This is the raison d'être for my wanting to be a doctor in the first place. Therefore when I made the decision to pursue a career in FM, staying on in the public primary care sector seemed to be the natural choice.

Challenges of Working in Polyclinics

It has been a challenge for FM and primary care these past few years, but I am heartened to see that the Ministry of Health is now recognising the importance of community medicine, and is taking steps to build up our capability to better manage the challenges facing our population in the future.

I must admit that it was not all plain sailing in the initial months of working in the polyclinic. The seemingly endless waves of patients day after day would sometimes overwhelm. The threat of burnout always looms on the sidelines. Temptation would come in the form of job offers from the private sector. With a wife and young child in tow, the lure of better financial security would beckon. But as I grew in maturity and confidence, I began to cope better by using tools such as Prof John Murtagh's safe diagnostic strategy to guide myself along on busy days.

Rewards of Working in Polyclinics

It does not take much to gain appreciation from grateful patients, for example by giving them extra seconds of a listening ear or by explaining to them in detail their blood results and what they can do about a certain condition. Satisfaction is also derived from finally convincing a patient to quit smoking or from initiating a medication such as insulin to better control Diabetes Mellitus. More challenging work is possible because doctors in the polyclinic work as a team - one may reap the harvest of seeds sowed by other team members. This joy is often shared over lunch with clinic colleagues where camaraderie is often built up, an opportunity not always available if one is in a solo practice.

Practicing in an institution also allows one to participate in other activities, such as teaching of medical students, supervising residents and leading projects in various capacities. I have had the opportunities to be principal investigator for a research project which won a Gold Award at a local conference and to lead a team in a Clinical Practice Improvement Project which reaped benefits for my patients. These I would not experience were I in the private sector as my own boss.

The Ministry of Health recently announced that they will be building more polyclinics over the next few years. This will greatly help to spread out the workload amongst the already overstretched polyclinics. With the regular pay review for family physicians working in the polyclinic, a career in the public primary care sector does not look too bad. The regional health systems are in their formative stages as well, and it is exciting to see how primary care will be incorporated into these systems for the betterment of our patients.

"Are you still bonded and when are you opening up your own clinic?" The answer to that question I am often asked at Chinese New Year gatherings is *"I'm not bonded, but I'm happy to stay in the polyclinic."*

■CM

Experience in Private Practice

By Dr Wong Pei Lin Suzanne, GDFM
General Practitioner, The Chelsea Clinic @ China Square Central

Image courtesy of Dr Wong Pei Lin Suzanne.

I went through a 6-year undergraduate medical course in Australia. Upon graduation, I found that I did not have a burning inclination towards any one particular specialty. Added to that, I was not convinced that I would be happy limiting myself to a narrow field of medicine. So despite many comments from consultants and family that I would be wasting my honours degree if I did not specialise, I began equipping myself for general practice.

A Generalist Education

I picked MO rotations that I thought would be helpful to a generalist such as general medicine, general surgery, geriatric medicine, paediatric medicine, O&G, psychiatry and rural medicine. When I returned to Singapore, I went on to obtain two graduate diplomas from NUS, one in dermatology and one in family medicine. The former was helpful in broadening my experience in dermatology especially with regards to the Asian skin. The latter was a good refresher course which incorporated current management trends that have come into place after I graduated.

For me, the main plus point about being a GP, is that you have variety in your practice. If along the way something interests you, you are free to delve into it, explore at your pace and adjust your practice to your inclination be it towards paediatrics, geriatrics, skin conditions, pain management or whatever.

Work-life Balance

Another major reason for my going into GP work was the flexibility in hours it afforded. I had control over my time while my trainee friends were handcuffed to their schedules. I could dictate how much or how little I wanted work which came in very handy when my firstborn was diagnosed with autism. I reduced my workload drastically at that time to help my child at home. That would have been almost impossible to do if I had been in the midst of specialty training. I have always wondered why specialty training requires one to pay in sweat and hours as if the more nights you spent away from your family or the longer the shifts are without sleep will somehow make you a better doctor.

Continuing Education

Like the majority of doctors, I do support some form of Continual Medical Education. It is necessary if one endeavours to deliver up-to-date care. Making CME mandatory, as it is here in Singapore and many other developed countries, will only raise the standard of healthcare for everyone. This is a good thing.

Coordinating Care

A typical day at work will see me attending to both acute and chronic ailments. A proportion of my patients will come for a listening ear and counselling. As a norm, I try to find opportunities to engender positive changes in behaviour and attitudes (that will impact my patient's health be it smoking cessation, overeating, exercise) in each visit. Of course, there will be the occasional emergency which gets the adrenalin pumping.

An emerging role here in Singapore is for GPs to be the "project manager" – the patient's health being the project. As the proportion of people living with multiple diseases increase (the result of an aging population and medical advances improving survival rates), there will be a need for someone to keep track, amalgamate and co-ordinate the various inputs from specialists, community services providers, etc. This would help avoid polypharmacy and its inherent risks. Unnecessary repeated testing can also be minimised. But more importantly, the GP as a trusted resource can tie things up wholistically for the patient's betterment.

(continued on Page 8)

(continued from Page 7: Family Medicine - One Discipline, Many Settings)

I know I would appreciate a GP who would do all that for me when my time comes.

As our migrant population increases, GPs need to be more mindful of cultural sensitivities and be willing to vary their clinical "style" to better serve and care for a mix of people. Depending on patient demographics, one may find it useful to learn key medical words in their patients' mother tongue. I have found that patients do appreciate the effort.

Personal Care

Having worked in busy heartland clinics, polyclinics, 24-hour clinics in private hospitals and now a city clinic, I have derived greatest satisfaction in my work when there is opportunity for follow-up and following through. I believe most patients would prefer to stick to one doctor if they had a choice as well.

I believe most patients would prefer to stick to one doctor if they had a choice as well.

In an ideal world, everyone will have a family GP who will walk with them through the years. Each visit is not a rushed affair so that effective therapeutics can be delivered.

GP work is bread and butter medicine. Mundane as it sometimes may be, it has a vital role to play in the community offering first line one-stop shop for healthcare at an affordable rate. Imagine the costs involved if one had to see an ENT every time he or she has a sore throat or to see a gastroenterologist for diarrhoea. We will always need GPs, in good economic times and bad. I suppose that is another plus point.

CM

Working in a Community Hospital

by Dr Leong Wen-Pin Lester, MMed(FM)
Registrar, Ang Mo Kio – Thye Hua Kwan Hospital

Image courtesy of Dr Leong Wen-Pin Lester.

Imagine a 70 year old lady with diabetes, hypertension and ischemic heart disease who recently had a fall after some postural giddiness resulting in a hip fracture which was surgically fixed. She lives with her elderly husband and was the one who did the cooking and other household chores. Now she cannot even ambulate independently. How are we to return her to her community and to her premorbid social roles?

Life in Community Hospital

My role as a family physician working in the community hospital is to help patients do just that – rehabilitating them to get them back on their feet and back to living life – to be that vital link between the acute hospital from where the patient came from, and the community to which he or she would be discharged to. And being part of the process of getting the patient to be in a better position medically, psychologically and socially brings much satisfaction to myself, and I'm sure, to all the doctors working in community hospitals.

And it's not just hip fracture or elderly patients we manage. We also have middle-aged patients and also those in their 20s and the medical problems of our patient population span the spectrum of medicine - stroke, post-myocardial infarction, congestive cardiac failure, COPD, pneumonia, and post-surgical convalescent care, just to name a few common diagnoses. We also treat subacute patients – those who are not that well yet (e.g. congestive cardiac failure, COPD exacerbations) but who can be managed at our setting, and palliative patients who may spend their last days with us. And while patients undergo slow stream rehabilitation, an excellent opportunity arises for us to manage chronic diseases by titrating medications, and catching up with routine investigations and recommended immunisations.

Comprehensive Skills Advantage

One can imagine how broad the knowledge base required to manage these gamut of patients must be! It is very fortunate, therefore, that my training in family medicine which spanned general surgery to geriatric medicine was as comprehensive as the patients I currently manage! Regular CMEs by the various specialists and teaching by Visiting Consultants also help to bolster my medical knowledge.

Working closely with nurses, therapists and social workers in a multidisciplinary team also helps me view each patient more holistically and also gives me a greater appreciation of the contributions each healthcare professional makes. Sometimes the social problems which we help patients and their families grapple with are far more serious than their medical problems. Co-ordination of care and careful matching of social services to respective needs often becomes the "treatment" a patient needs. Working in a community hospital has not only enriched my professional development but has made me more aware of the importance of treating the family as a whole.

Honing Special Interest

Working in my current setting also allows me to manage patient groups within my special interests, namely dementia and palliative care, where I am a member of the two dedicated multidisciplinary teams which help manage these two groups of patients. In fact, I have been given the privilege of leading the development of dementia care, an area which I have particular passion for, and I am glad that I was given the opportunity to do so.

Apart from clinical work which includes ward rounds, clerking of new patients and running outpatient clinics, the various administrative duties, teaching engagements and involvement in community outreach projects ensure that there is never a dull moment at work. And if I ever do feel bored, the interesting life stories and pearls of wisdom which patients relate to me add much spice to my ward rounds. Indeed, working in a community hospital is fulfilling – professionally in terms of the opportunities for learning, teaching and being a leader in healthcare, and personally in terms of the relationships one develops with patients who are often grateful that you were there to hold their hand as they walked back home.

CM

The Road Less Travelled - My Work Experience in a Nursing Home

By Dr Marie Stella Cruz, MMed(FM), MCFP(S), FCFP(S)
Consultant Family Physician, Bethany Methodist Nursing Home

Image courtesy of Dr Marie Stella Cruz.

Tucked away in the quiet heartland of Choa Chu Kang, nestled between a secondary school and blocks of flats is a simple red and cream-coloured building called Bethany Methodist Nursing Home. This airy non-airconditioned four-storey place is home to 270 frail and elderly residents, all of whom are significantly disabled and destitute. This is my second home too, where as the solo resident physician, I spend 10 hours a day, four days a week.

Medical and Social Background of Residents

The average ages of the residents (my patients) are 70 to 90 years. There are a handful of centenarians, the oldest being a lovable 109-year old gentleman. All have significant mental or physical disabilities or both, rendering them wheelchair or bedbound and requiring moderate to maximal assistance in their ADLs.

The bulk of cases are CVA victims with dense hemiplegia and aphasia, dementias (Alzheimer, vascular) with BPSD, have psychiatric conditions (eg. schizophrenia), or mental deficiency (congenital, cerebral palsy, Down's syndrome). Many have unsightly craniectomy defects having had clot evacuation done due to traumatic brain injury (from falls, RTA victims) and haemorrhagic CVAs. A few have hypoxic encephalopathy (eg. from VF collapse). There are several with Parkinson's disease and a handful of haematological cases eg. chronic myeloid leukaemia and polycythaemia rubra vera. Rare syndromes include a man with Huntington's chorea and a lady with Cadasil syndrome. A few have brain tumours and are on palliative care.

Very few of the residents are cognitively intact and they usually have spinal pathologies (eg. polio, multilevel prolapsed disc, traumatic cervical spine injuries, spinal abscess). Occasionally, I get an elderly respite patient, admitted for a few weeks while the maid goes home for a break.

As is usually associated with the geriatric age-group, all residents invariably have multiple chronic conditions. Besides run-of-the-mill DM, hypertension, hyperlipidaemia, ischaemic heart disease and renal impairment, a number also have osteoporosis, scar epilepsy, atrial fibrillation and the like. Equally long as the list of diagnoses is the list of their medications, with polypharmacy being the norm.

All residents are dirt-poor and most have a sad social history. Their family members fall into two types: the supportive family with unemployed or low-income earners and the dysfunctional family with strained or non-existent relationships between members. Sometimes there is a combination of both (low-income and non-supportive members). Quite a few are orphans or have no known next-of-kin.

Why I Chose the Field of Nursing Home Care

I stumbled into nursing home care by pure serendipity. Towards the end of my 5-year stint in the polyclinic I found myself veering towards elderly care. This was in part because I was treating several ailing elderly relatives and also I had the foreboding feeling that I was getting on in age and so I had to know how to care for myself in future. Hence I enrolled in the graduate diploma of geriatrics course while I worked in a community hospital, for just over a year. Then I responded to an advertisement for an opening in a Nursing Home even

though I had never set foot in one and had no inkling what work in this field of long-term care was about and entailed.

A Day in the Life of a Nursing Home Physician - The Nature of Work

That was five years ago. I have had no regrets taking the road less travelled. The work is clinically rich and mentally stimulating, spanning the fields of internal medicine, geriatrics, psychiatry, rehabilitation medicine and palliative care. A typical day will see me attending to acute emergencies, reviewing subacute cases, doing routine medical reviews, clerking new admissions, talking to relatives and signing death certificates.

Common acute conditions that I manage are pneumonias, exacerbations of COPD and asthmas, congestive cardiac failure and infections (eg. UTI). I try not to refer to the emergency department, so long as the patient remains clinically stable. This has meant, on many occasions, my patiently (and anxiously) waiting over a period of many days, for their conditions to improve. Breakthrough seizures, falls, syncope, acute retention of urine, haemoptysis, haematemesis and psychiatric symptoms eg. agitation and noisiness are also common occurences. Making the judgement call of whether to keep or send patients out can be difficult but it helps that I am familiar with the patient's medical background.

Every resident is given a thorough medical review every four months or so. I assess not only the status of their chronic conditions, but also their nutrition, hydration, contractures and bowel movement patterns. Some physical signs can be subtle eg. gradual weight loss. The indication for each and every medication is scrutinised and justified. Adverse reactions to drugs are not uncommon eg. anaemia from antiplatelets, thrombocytopaenia from valproic acid, hyponatraemia from SSRIs. A number are on insulin and warfarin requiring regular titration of insulin doses and balancing INRs. Still many have anaemia from chronic kidney disease, and I have started some on s/c erythropoietin, with good response.

The work is clinically rich and mentally stimulating, spanning the fields of internal medicine, geriatrics, psychiatry, rehabilitation medicine and palliative care.

Some patients are on maximal conservative management with families requesting for them to be managed as far as possible, in the nursing home. These include patients with terminal malignancies, octogenarians with gangrene of the lower limbs, end-stage-renal-failures. I once had an 85-year-old lady with sepsis and hypotension (SBP in 70s mmHg) but whose family adamantly refused hospital referral. I thus set up an intravenous drip and gave her 3 successive pints of normal saline. She survived and recovered!

Inspecting bodies and signing death certificates of residents who pass on are a regular part of my job. I do so with a bittersweet feeling. On the one hand, for many, death provides a merciful escape from their miserable existence. On the other, I grieve for those whom I've grown fond of, lamenting why they left so suddenly with nary a goodbye.

Seared in my memory is the time when I had to certify a death in the dead of night. I had just returned from an overseas vacation a few hours earlier when I was jolted out of my sleep at 1 am by a phone call from my staff. I had to summon every ounce of courage to get out of the house at that unearthly hour to inspect a dead body. As I was driving back home around 3 am, on a long dimly-lit stretch of the PIE, I sighted a black cat, eerily and unmoving.

Treat each resident with dignity and love. That is my maxim. I have learnt that touching has a very profound effect, hence when I examine my residents, I make sure to hold their hands or give them a pinch or pat on their cheeks. I hug my cognitively-intact residents regularly and this gives them instant, profound joy.

Ward Rounds by Visiting Specialists; Co-management with Hospital Specialists; Teaching and Training of Staff

A consultant specialist drops by one afternoon a week and does a brisk ward round with me, giving invaluable advice on patients with challenging medical issues. For almost a decade, Bethany was fortunate to have A/Prof Pang Weng Sun come regularly. Now for the past one year, A/Prof Goh Lee Gan has been providing much needed (and appreciated) medical input and support.

A visiting consultant psychogeriatrician, Dr Low Bee Lee, also comes weekly to see patients with psychiatric issues. She has been providing excellent and dedicated service for many years.

I liaise closely with hospital specialists as many of my patients (eg. with haematological malignancies, renal failure, eye problems etc) are co-managed with them.

I am involved in in-house teaching ie in our monthly 'Continuing Bethany Education' sessions and 'Mortality and Morbidity Rounds'. I help train staff eg. in insertion of urinary catheters in male patients. In the near future, my nursing home will become a training site for the nursing home posting of an FM Residency Programme.

Training and Requirements to be a Nursing Home Physician

A diploma in geriatrics, in addition to a Graduate Diploma in Family Medicine (GDFM), is highly recommended, so that one is equipped with a broad and firm grounding in geriatric principles. One must be able to work independently and be prepared to work hard – it is challenging, to say the least, to look after 270 frail elderly patients.

And needless to say, one must have a passion for geriatrics and to serve the underprivileged.

Importance of Family Physicians in the Nursing Home Sector

Many nursing homes do not have an in-house or resident doctor. Instead, when their residents turn ill, they are sent to a polyclinic, to be seen and treated by harried doctors who have no inkling of the residents' medical background. Still other nursing homes rely on locum GPs who drop in once to twice a week, 2 to 3 hours each session. Obviously these situations are grossly inadequate. My hope is that in future, every nursing home will be staffed by its own in-house doctors. Nursing

… … "*Lokun, jing ho, kamsiah.*" partly makes up for the challenging working conditions.

home physicians not only maximise the health of its residents but also play the important role of gatekeepers to hospitals, minimising admissions to hospitals most of which are operating at maximum capacity.

Remuneration of Nursing Home Physicians

As nursing homes are run by voluntary welfare organisations, the pay of Nursing Home doctors is solely funded by the VWO. The government does not contribute anything to the pay. This has resulted in a remuneration that is well below that paid in institutions. The pay does not come with any benefits that a doctor is reasonably entitled to, such as CPF contributions, 13th month bonus or annual/medical leave. The result is that there is a dearth of doctors in the nursing home sector.

By the end of year 2013, there will be more than 10 000 nursing home beds in Singapore. In the light of the impending onslaught of the silver tsunami, it is of urgent importance to ramp up the number of Nursing Home physicians. The government should address the problem of pay inequity if it seriously wants to solve the issue of shortage of doctors in nursing homes.

To Sum Up

My five years in the nursing home has been highly enriching and satisfying. I would like to encourage more GP / FP colleagues to consider working in one. The gratitude of the patients, aptly conveyed by my 96-year-old hainanese patient, "*Lokun, jing ho, kamsiah*." partly makes up for the challenging working conditions.

CM

Experience in Palliative Care

By Dr Ong Wah Ying, MMed(FM)
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A 'Crazy' Decision

'Isn't it very depressing?'

"Palliative Medicine?" some asked incredulously. Many have probably not heard about it.

"It must be mid-life crisis," one explained.

My decision to join Dover Park Hospice in 2006 sparked concern amongst my friends.

Image courtesy of Dr Ong Wah Ying.

In 2005, I was a registrar in polyclinic seeing many patients with chronic diseases. It was satisfying in its own way but there were always nagging emptiness, sadness and unanswered questions as I "lose" many of my regular patients to the hospitals, the moment they were diagnosed with cancer or other life-threatening illnesses.

One of my regular patients with pancreatic cancer returned one day to say goodbye. I knew it would be the last time I would see her as she was, by then, half her size, jaundiced and could barely walk. I wish I could do more for her at that time. It felt ironic that I was not able to care for them when they needed it most. I decided to learn more about palliative care and took up the postgraduate course organised by Singapore Hospice Council.

I was subsequently seconded to run a newly set up screening clinic at the National Cancer Centre. I shared desire to know more about palliative care with Dr Koo Wen Hsin, who was Head of Medical Oncology department at that time. He sat me down in his clinic and involved me in the care of one of his patients. She was a young girl, not even 20 years of age. She shared with me her suffering, sadness, dreams, hopes and happiness. I was greatly inspired by what Dr Koo was doing, he was helping her 'live her remaining life to the fullest'. I was hooked. This was it. I knew from then what I wanted to do for the rest of my life.

An 'Arduous' Journey

I decided to join Dover Park Hospice as Resident Physician. The young discipline of Palliative Medicine was just starting up then. Basic requirements were either exit certification in Medical Oncology, Geriatric Medicine or Internal Medicine, leading to a 2-year programme; or MMed (Family Medicine) or basic internal medicine training with MMed (Internal Medicine), leading to a 3-year programme. In addition, one needed some exposure to Palliative Medicine, just to be sure that this was no "flight of fancy". After being threatened with "If you don't take up traineeship, we cannot employ you." I took on the role of being a trainee again.

Going back to the restructured hospitals again after 4 years out proved to be rather stressful. Paper records had given way to electronic systems, being under the microscope while presenting at journal clubs was a rather alien feeling after running your own show and answering blue letters meant that you were now considered an authority on the topic. I certainly did not feel that way.

(continued on Page 12)

(continued from Page 11: Family Medicine - One Discipline, Many Settings)

... ... there were moments that I felt on top of the pack with my Family Medicine training.

But there were moments that I felt on top of the pack with my Family Medicine training. I remember giving advice to patients with IUCDs and talking to them about their children's health screening in schools. The highlight must surely be when I spent 6 months (HMDP) in Adelaide with Southern Adelaide Palliative Care services. I worked with a group of dedicated homecare and hospice nurses and did my first research project there. More importantly, it scored very highly in my husband's eyes, for it was then that I learnt to cook. During my training years, I attended conferences in Philippines, Montreal and Perth and got to meet many exciting and like-minded people around the world.

Finally, Back to What I Love

It has been 3 years since the end of my traineeship. The patients here may have only short days to months and there is often a sense of urgency as we race to control their symptoms and help them and their families as they face the closing chapter of their lives. When a pain that had seemed impossible to control, releases its hold on the patient, the sense of satisfaction makes this job, which can be at moments draining and stressful, seem like the best in the world.

When the social worker organised a funeral for a patient who has no kin except for a brother who is challenged intellectually and a "kampong" of volunteers sat throughout the 3 days of the wake and even trailed the cortege as part of "family"… I can only be awed with the magnanimity of the human heart. I also smile at moments of madness. How else can one describe it when an MO decides to start an aquarium of goldfish and guppies just because a patient had said he misses his fishes at home.

Through the years, I have seen the hospice handling more and more 'complex' patients. It is with pride that we find ourselves rising up to the challenge of what is traditionally thought to be only available in the "big" hospitals.

I am also glad that I can contribute towards the training of the next generation through the hospice's involvement with the medical students from Yong Loo Lin School of Medicine as well as all the residents, medical officers and registrars who come through us as part of their attachments. The responsibility of curriculum planning, teaching and mentoring brings with it special joy.

Looking ahead

As the population increases and ages, it is inevitable that more patients will require palliative care. What I hope to do here is not only to ensure that the needs of those who come to us are met, but also to inspire many more that some may either join us or partner with us as we travel the final leg of the patient's journey.

I also hope that what we have in the hospice, when the patient and the family are cared for holistically by a multidisciplinary team, will also be an encouragement to all, that it is possible to look after even the most "complex" of patients, but it is not just the job of one doctor.

In Reflection

There are many days that end with me being physically and emotionally drained. But even as the two of us consultants here lament about how tough our work may be, we realise that we are rejuvenated by our patients and students. We just cannot wait to see our next patient.

Palliative Medicine – Isn't it depressing? No, it has been my privilege.

CM

Image courtesy of Dr Tan Shu Yun.

The nature of the work

Our Department provides the full range of family medicine service from the tertiary hospital to the community hospital and to the patient's home. At the tertiary hospital, general medical care for inpatients in their post acute phase, focusing on discharge planning and transiting them safely back into the community. Our team also provide general medical care for inpatients in Bright Vision Hospital which is a 318 bed community hospital. We provide follow-up care for patients with complex chronic diseases after they are discharged from the hospital. We run outpatient clinics to provide continuing care for patients with complex care needs that are at risk of repeated re-admissions to hospitals. For patients who are too sick to come to the hospital we provide transitional home medical care until they are stabilised and can be managed by community based home care services. Ultimately, we work towards restoring our patients back to their home environment to be cared for by our family physician and GP colleagues who work in the community. The complex care needs of the type of patients who serve, require us to work in multidisciplinary teams. Our multidisciplinary team consists of a senior family medicine doctor [usually someone with the MMed(FM) and the FCFP(S)], a junior doctor (usually a MOPEX MO or a resident physician), an integrated care nurse (nurses trained in case management and patient education), medical social worker and a pharmacist.

Using a team-based approach, we aim to optimise their various comorbidities which may have been overlooked previously, achieve greater compliance in treatment and disease prevention by empowering

Experience in Department of FMCC

by Dr Tan Shu Yun, MMed(FM), MCFP(S), FCFP(S)
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the patients in their disease management, engaging their care-givers, reducing polypharmacy and reducing specialist SOC visits. We also identify and apply for those who need financial assistance or social support, and link all the patients up with various community resources and their primary care providers. To prevent multiple re-admissions, the management must go beyond just addressing their medical problems, but also ensuring that their social support eco-systems are healthy too.

We assess the needs of patients not just within the in-patient hospital setting, but also incorporate the assessments at discharge, at follow ups in our outpatient clinics, in further management at our community hospital.

Being part of a teaching hospital, all our senior doctors hold academic and teaching appointments in our medical schools. The majority are also faculty in the residency programs and college training programs. Many are involved in research and quality improvement projects.

Our senior doctors are required to rotate through all the services so that we maintain our broad range of skills and competency. Those who are interested in a particular area of care can opt to spend more months at one of the service areas. The upside of this arrangement is that life is interesting and you never get into a rut as far as professional life is concerned.

Why did you choose this line of work?

It is heart-breaking to hear of patients who seemed to be needing medical support all the time, when their outcomes could actually be greatly improved by changing the way we manage them. It may sound incredible, but know that sometimes it is in the small things that make the real differences to the patient's wellbeing. Small things like having the time to listen to the concerns the patients may have and addressing them, consolidating and coordinating their specialist outpatient clinic visits so that they don't have to visit the hospital so many times, and having someone looking through their medications so as to reduce their number of pills to be taken or potential drug-drug complications.

I enjoy working with my highly driven multidisciplinary team that shares the same vision as me. I learn new things from the other members all the time. There is great joy in growing with a close-knit team that supports each other.

Healthcare can no longer just be done by doctors alone. Patients grow increasingly complex in terms of their needs and these often require the expertise beyond the medical realm.

What special training is needed?

A good team player who is imbued with the values of family medicine is probably the essential foundation stone before we even talk about training. The GDFM is a good start for broad understanding and the ability to support the team at entry level. To provide the general medical care needed for complex case would require the doctor to attain the standards of the Master of Medicine (Family Medicine) [MMed(FM)]. To lead a multidisciplinary team and manage such complex cases would need someone who is trained to the level of the Fellowship [FCFP(S)] by Assessment that is organised by the College of Family Physicians Singapore. To reach the level of the masterly expert would probably require an additional 5 years constant practice, professional development and interaction with peers and experts in other disciplines of medicine. Medicine traditionally is learned through apprenticeship, and soft skills such as negotiation, counselling, complex clinical reasoning are best learned through mentorship by seniors.

A typical day in the office

There is never a typical day. As mentioned earlier, we have different services and we rotate through on a monthly or bi-monthly basis. I will usually start work at 8am. As explained above, my duties may revolve around various places such as SGH medical wards, Bright Vision Hospital, the outpatient clinics or even home visits as part of the follow up process. This depends on where I am posted internally for the month.

In the wards, rounds usually end around 11am. Thereafter, potential patients that are to be incorporated under our management are screened. Otherwise, administrative work such as planning of educational activities for junior doctors would have to be done. We will review our patients again at 3pm to look into the progress of the changes made in the morning, and also ensure continuity of care overnight. Sometimes, due to the schedule of the caregivers, family conferences are held in the evenings.

Other colleagues will be following up discharged patients at our "virtual ward rounds" where nurses report to doctors about the patients that they have been monitoring over the phone. The team may also make home visits in the afternoon when necessary. Outpatient clinics run in the morning and afternoon to follow up on patients that have been discharged from the hospital and require further assessments and optimisations.

Between various teams, there is constant sharing of knowledge and input on management at department meetings held over lunchtimes on various days in the week. This allows for auditing of management, as well as to provide a learning environment for the multidisciplinary team to improve on knowledge and communication.

Importance and relevance in the future, with the projected increase in both immigrant and aging population

We are developing new models of care for the not too distant future. We will need a lot of good generalists who can confidently handle the bread and butter cases that are presently clogging up our hospital clinics and wards. If we succeed, we can decongest the system, improve cost effectiveness and free our specialist colleagues from non-specialist work so that they can focus on bringing their specialist skills to benefit those who need it most. We will also free up time for clinician scientists so that they can pursue cutting edge research and translate their discoveries to improve the care of our patients.

The aging population will result in more patients with health problems that cross multiple medical disciplines. Well trained generalists should step forward to integrate the care of these patients and steer them in the right direction of holistic care, instead of abandoning them to the whims of a fragmented health care system.

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Photo Quiz

by Dr Soh Soon Beng, MCFP(S), Editorial Board Member

A 30–year-old Chinese man has presented to the clinic with an eruption of rash over the body for the past one week. He had some runny nose and cough in the week before the eruption and had consulted a doctor. He has complained of mild itch and was concerned that the rash was getting worse.

Clinically, there was a generalised erythematous maculopapular rash over the body and the upper arms. A close-up of the rash is as shown below. The long axis of the rash appeared to be along the body line of cleavage. There was no involvement of the palms, soles, nails and the mucosa.

1. What is your diagnosis?
Pityriasis Rosea

Key points:

- Pityriasis Rosea is considered a viral exanthem and has been linked to upper respiratory infections. However no single virus has been proven as the cause although studies have suggested Human Herpes Virus to be the likely culprit.
- A pre-eruption Herald patch, which is salmon coloured and enlarges over few days. Formed collarettes of scales (present in some plaques).Crops of papulosquamous rash appearing several days after the herald patch with the long axis of the rash along the body line of cleavage. Predominantly on the trunk and proximal parts of limbs.
- Itch is present in up to 75% of patients.
- Usually resolves within 6-12 weeks.
- Recurrences are uncommon (<3%).
- Atypical presentation (in distribution or morphology) in 20%

2. What are the possible differential diagnosis?

a. Dermatophyte infection
- Well demarcated ringed erythematous scaly rash with central area of clearing. Tends to be asymmetrical in distribution.
- Tends to affect warmer and more humid skin eg. groin

b. Guttate psoriasis
- Small drop like salmon pink papular eruption with fine scales. No collarette of scales.
- Usually patient has a history of chronic plaque psoriasis.

c. Nummular eczema
- Closely grouped small vesicles or papules that coalesce into plaques, predominantly on arms and legs.
- Often about 4-5cm in size.
- Clear border with excoriations and crustings.
- Intense pruritus.
- Duration: weeks to months.

d. Secondary syphilis
- Systemic symptoms (fever, arthralgia. malaise)
- Discrete macular rash evolving to papular lesion, involving palms, soles and mucosa. Non-pruritic and symmetrical. Generalised lymphadenopathy.

e. Drug eruption
- Recent history of drugs ingestion should alert one to the possibility of drug rash. Usually occurring within 2 weeks of ingestion, presenting with symmetrical maculopapular rash which spared the palms and soles.

f. Pityriasis Lichenoid Chronica
- Mica scales.
- Rash tends to be persistent for months

3. What laboratory test can you order?

Pityriasis Rosea is a clinical diagnosis.
The following laboratory tests may be helpful for the important differentials:

- VDRL or RPR and TPHA tests to exclude syphilis.
- Skin fungal scrape to exclude tinea infection.

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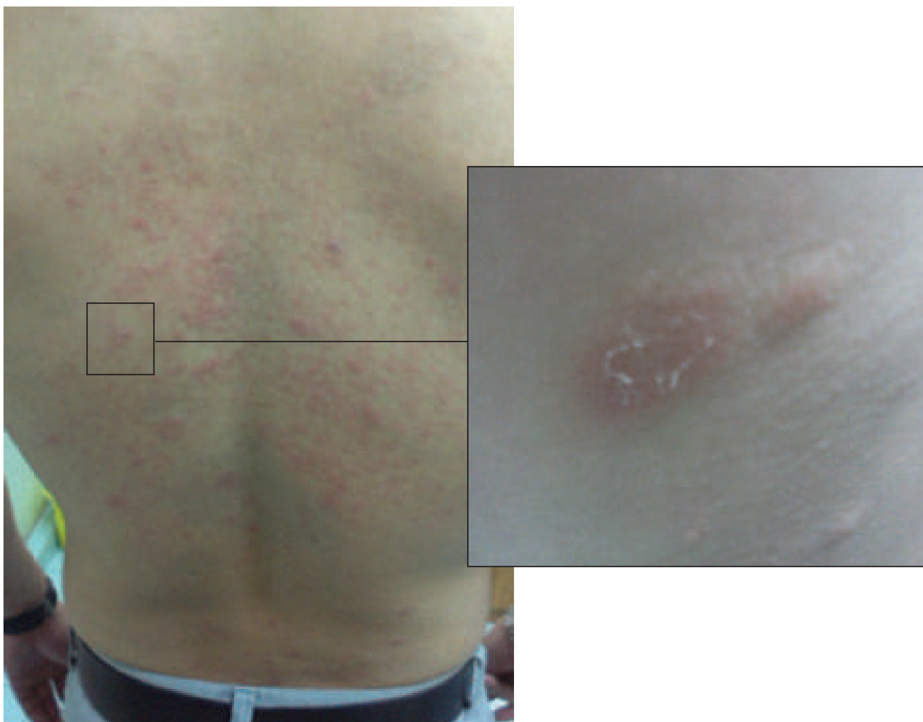

Photos courtesy of Dr Soh Soon Beng.

(continued from Page 5: Tribalism and Organised Medicine)

aggravates care fragmentation and hinders the collaboration of inter-professional groups. A recent study found that "professional tribalism" is a strong influencing factor in professional decision-making processes that results in unplanned re-admissions.[3]

Preventive Medicine

While we accept that organising health care along tribal lines is unavoidable, there are things that we can do to limit its excesses. Awareness of the negative consequences is important and conscious effort must be made to instill this awareness in the formative years of the education of health care workers. In addition, work environment and processes should also be designed promote inter-professional collaboration.[4]

Leaders of medical tribes should be constantly reminded of their responsibilities towards promoting inter-professional collaboration and limit the negative tendencies of their tribesmen's hostility towards members of other tribes in the healthcare landscape. They should consciously resist the urge to appeal to jingoism as a quick and dirty way of strengthening their leadership position. Instead they should recognise the benefits of diversity and seek common platform for collaboration with other groups.[5]

When we register healthcare workers ostensibly for the protection and well being of our patients, we must ensure that we are true to our ideals and not let our personal prejudice and self-interest get in the way. Pragmatism towards patient centered care must trump social constructs of purity of ideology. We should be reminded of the wisdom of Deng Xiao Ping who saved China from the excesses of the ideological pursuits of the Great Leap Forward and the Cultural Revolution.

“不管黑猫白猫能捉着老鼠的就是好猫”

As he famously said, "regardless of whether a cat is white or black. It's a good cat if it catches rats."

Registers should be based on training and competencies. It should not be an extension of turf wars or ideological conflicts within or between tribes. Within our College we must work to accept doctors who are committed to the values of family medicine and the advocacy of higher standards in family medicine, regardless of whether they are in or out of the register. We must remember that the Family Physicians Register is a means to an end and not an end in itself. Until the day comes when we have sufficient resources to ensure that all graduating doctors have access to formal family medicine training, if they so wish, we must accept that the register is still work-in-progress. Registers whether family physician or specialist should not be used as tools of medical tribalism. We must constantly resist any tendency to impose our narrow and legalistic definitions of tribal specialisation on our colleagues who may work in different settings or descend from different training pathways. We should instead focus on developing competencies that enable us to fulfill our common calling, which is to use our family medicine training to provide patient centered care to our patients, in accordance to the higher values of our discipline.

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(continued from Page 22: Photo Quiz)

4. What is your management plans?

- Relief of itch with oral antihistamines and mild TOPICAL steroids if necessary.
- Reassurance that it is not a contagious rash and is self-limiting.
- No need to keep patient from work or school (for children).

5. When would you refer to a dermatologist?

Referral to dermatologist in the following instances:

- Atypical presentation/distribution of the rashes.
- Duration of rashes beyond 3 months or recurrences of rashes.
- Involvement of palms, soles and mucosa.
- Systemic symptoms.
- Patient very concerned over the prolonged rash.

Special thanks to Dr Colin Kwok, Senior Consultant Dermatologist, Changi General Hospital for his input and comments.

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Exercise: How We Can Help Our Patients Exercise Safely and Effectively

by Dr Kiran Kashyap, MCFP(S), Editorial Board Member

Family physicians play a vital role in helping our patients to lead physically active lives. In my practice as a family physician, I come across patients in various stages with regard to exercise. For simplicity, I have grouped them into 3 main groups, as each group is managed differently. The '**Sedentary Patient**', who lacks awareness or interest in changing his lifestyle. The challenge here is in motivating the patient. The patient who is '**Becoming Active'** is willing to consider, or has attempted exercise, but may be facing barriers. The barriers here may include ambivalence, uncertainty about how to exercise, medical problems, and even overly restrictive advice from healthcare professionals. The focus is on pre-participation screening, risk stratification and exercise prescription. The '**Active Exerciser**' may be highly motivated and the focus is on safety, avoidance of injuries and maintenance of exercise.

The focus of this article is to work out a plan for each patient according to the stages defined above, thus facilitating risk stratification and exercise prescription. With some fine tuning of our skills, family physicians can be more confident and effective in achieving this. There are many resources available, including the Health Promotion Board (HPB) website, courses run by the Sports Medicine Departments of Changi General Hospital (e.g. "Exercise is Medicine") and of Tan Tock Seng Hospital, and many online resources.

THE SEDENTARY PATIENT

Physical inactivity is listed by the WHO as the 4th leading risk factor for global mortality. In Singapore, almost 40% of Singaporeans (18-69 years old) are physically inactive. The benefits of regular physical activity, well known to us all, include the improvements in cardiorespiratory fitness, musculoskeletal fitness, mood and cognitive function. Regular exercise is an important part of prevention and treatment of coronary artery disease, hypertension, diabetes mellitus, stroke, obesity and depression.

So why don't more people exercise? Knowledge of the benefits doesn't always equate to behavioural change – how many of us doctors actually fulfil the Singapore National Physical Activity Guidelines (150 minutes of moderate intensity aerobic exercise per week) ourselves?

Motivating your patient

The hardest part of exercise prescription is motivating the patient to start the process towards regular physical activity. There are many methods available to improve the efficacy of our efforts, including Motivational Interviewing (MI) (HPB holds courses for doctors and allied health professionals) and The Wellness Motivational Pathway (WMP) Approach [recommended by American College of Sports Medicine (ACSM)]. Different approaches may work for different patients. It is worthwhile reading up on or attending these courses to brush up on skills in motivating patients to achieve behavioural changes. The key is to activate the motivation by drawing on the patient's own long term goals. E.g., an elderly grandmother may be more inclined to go for walks regularly if the activity enables her to spend time with her grandchildren. Work in tandem with the patient to develop a plan that is SMART (Specific, Measurable, Achievable, Realistic and Timely)

BECOMING ACTIVE

Pre-Participation Screening & Risk Stratification

Once the patient is willing to consider some physical activity, it is necessary to do risk stratification to assess the patient's medical status to reduce the chance of injury or illness brought on by exercising. The use of a self-guided questionnaire such as the Physical Activity Readiness Questionnaire (PAR-Q) (www.ssc.gov.sg) is the recommended entry level for screening. This 7-question tool identifies conditions or risk factors that require further assessment before commencing exercise. Doctors may receive the PAR-Q from patients that require exercise clearance.

If all 7 questions are answered with "NO", then the patient is at **LOW RISK** and can do exercise without further screening or supervision. Patients with a positive answer or chronic diseases can be risk stratified

further using the ACSM guidelines for exercise testing and prescription. Patients classified as **MODERATE RISK** (2 or more Coronary Artery Disease Risk Factors) can begin light- or moderate- intensity exercise, but should undergo further medical assessment before partaking in vigorous intensity exercise. Patients classified as **HIGH RISK** (Known history or signs or symptoms of Cardiovascular, Pulmonary or Metabolic disease) should undergo further medical testing before starting an exercise program, and require clinical supervision.

Exercise Prescription

The exercise training session should incorporate warm-up of 5-10 minutes, conditioning exercise (20 – 60 minutes of aerobic, resistance, neuromuscular and/or sports activities), cool-down of 5-10 minutes, and stretching (10 minutes).

The components of an exercise prescription may follow the **FITT** format: Frequency, Intensity, Time and Type. This should be customised individually, with regular reviews of goals and objectives of the exercise program. For deconditioned patients, shorter duration with lower intensity but higher frequency is recommended.

FREQUENCY: 3 – 5 days per week of exercise is recommended. The importance of regularity of exercise is emphasised.

INTENSITY: Commonly used measures of intensity include the "**Talk Test**" (Light = can talk and sing; Moderate = can talk but can't sing; Vigorous = has difficulty talking) and "**Percentage of HRmax**", where predicted maximal heart rate (HRmax) = 220 minus patient's age (Light = <64% of HRmax ; Moderate = 64 – 76% of HRmax; Vigorous = >76% of HRmax)

TIME: Generally, bouts of exercise that last for at least 10 minutes can be added together to give a total duration for a given day. A total of 150 minutes of moderate intensity aerobic or 75 minutes of vigorous intensity aerobic exercise per week is recommended for most adults. For weight loss, the time required is doubled!

Resistance training is recommended for 2 or more days a week.

TYPE: The main types of exercise are

- **Cardiovascular/ Aerobic exercise:** e.g. walking, jogging, cycling, swimming, dancing, racket sports
- **Resistance exercise:** Improves all components of muscular fitness including strength, endurance and power. Includes use of hand-held weights, resistance bands, bodyweight exercises, strength training equipment. Includes mind-body exercises such as Qigong, Tai Chi, Yoga and Pilates. Functional training is a term used for exercise aimed at improving functional capacity - training the body to perform daily physical tasks, occupational or sports specific tasks with ease, efficiency, strength and control.
- **Flexibility exercises** (stretching): Recommended at least 2-3 times per week, for at least 10 minutes duration. Improves joint range of movement and physical function. Most effective when muscles are warm, performed before or after the conditioning phase. Myofascial release with massage or foam rollers is an increasingly used therapy technique that can be self-administered to improve flexibility.
- **Neuromuscular exercise:** Improves balance, especially in the elderly. E.g. core conditioning, balance and gait exercises, Tai Chi.

An example of an FITT prescription: For a 50 year old male with moderate risk profile, the prescription could include:

Aerobic Exercise (e.g. brisk walking) five days per week, at moderate intensity (target HR 110 – 130) for 30 minutes. Resistance exercise (e.g. squats, weight training) two days per week, 2-4 sets with 8-12 repetitions per set. Stretching exercise three days per week.

THE ACTIVE EXERCISERS

We are seeing more and more people in Singapore joining gyms and taking to sports, especially to run, swim, cycle and lift weights, sometimes without

regard for safety. In this group of often highly motivated patients, the focus is on screening for potential hidden or ignored medical problems, and on proper risk stratification and education on proper techniques. Such patients may be required to obtain exercise clearance from a doctor prior to organised events such as marathons. Building up a network of allied health professionals including sports physicians, orthopaedic surgeons, cardiologists, physiotherapists, rehabilitation therapists, fitness instructors and sports nutritionists can be very useful to direct to when appropriate. E.g. the 'Exercise is Medicine' program, run by CGH, aims to create a list of suitably trained doctors and fitness professionals who can work together.

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6. Singapore Sports Council (www.ssc.gov.sg)
7. Functional Training Institute (www.fti.lwz.com)
8. www.performbetter.com

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Tribalism and Organised Medicine

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

A Cautionary Tale

At about 8.20pm on 6 April 1994, a Dassault Falcon passenger jet descends to make the final approach to Kigali International Airport in Rwanda. Unknown to the VIPs on board who are looking forward to a routine landing and a swift ride into town escorted by the Presidential Guard, two surface-to-air missiles were locking on to the plane. They were launched almost simultaneously. The missiles streaked through the night sky. The first struck one of the wings splintering it. Just as it began to spin out of control, a second missile struck the tail and transformed the plane into a massive fireball in the sky. All twelve passengers in the plane were killed instantly. Among them was Juvenal Habyarimana, President of Rwanda who was working to end the simmering civil war between the Hutus and the Tutsis. The flaming smithereens plummeted down from the night sky and ignited a conflagration of hatred on the ground that had been sown and simmering for the last 78 years. What followed was known now as the Rwanda Genocide. An estimated 1 million people or 20% of the population were slaughtered within a period of just over 3 months. The killings were exceptionally chilling because of its direct and personal nature. People were killed in the most painful and brutal way imaginable. The preferred method of murder was by hacking with a machete, often perpetrated by neighbors and friends. They were killed in or near their homes and often in churches where they sought refuge. They were killed by people who shared the same religion and spoke the same language. The murders were often preceded by unspeakable acts of torture and abuse.

What hatred can drive members of the same community to turn on each other with such violence and cruelty? It took many years to fester and it started with the registration of people into categories in 1916 by the Belgian colonial masters of Rwanda.

Roots of Intolerance

Before the Europeans came in search of empire, Rwanda was a stable and prosperous kingdom. There were three informal classes of people in the society who lived in relative harmony. There were cattle herders, farmers and the hunter-gatherers. In a society that measures wealth by cattle ownership, the cattle owners were called Tutsis and formed the aristocracy. The farmers were Hutus. The original people of the land, the Twas, were hunter-gatherers. The Twas were the poorest and despised by both the Tutsis and the Hutus. The division of the people into different castes was not mandated by law. Intermarriage between the groups was not restricted and there was social mobility. An upwardly mobile Hutu who become rich can buy himself a herd of cattle and become a Tutsi. A down and out Tutsi who lost all his possession, falls from grace and becomes a Hutu.

When the Europeans arrived, one common strategy used to control the natives was to "divide and rule". It is hard to believe today but in the early 20th century racism was the politically correct ideology in many parts of Europe besides Nazi Germany. There was a belief that some races are superior and the imagined genetic closeness of the inferior races to the master race created a hierarchy of superiority. They imagined the Tutsis to be taller and fairer and a tad more European looking than the Hutus. They are therefore considered to be more highly evolved and intelligent. A lethal combination of racism and imperial pragmatism lead the colonialist to start classifying the people as Tutsis and Hutus. The Tutsis were placed in positions of power and leadership to help the colonialists control the country. In practice it was difficult to define who is a Tutsi and who is a Hutu as they were really one people with different stations in life. They therefore created a register of race through the issuance of identity cards. Henceforth the old social mobility was gone, one's registered identity determined the things you are allowed to do and your position in society. A person's fate is cast in stone based on registered race. In an effort to bring legitimacy to this arbitrary classification, they brought in "scientists" from Europe, experts in the pseudoscience of phrenology. They made elaborate but nonsensical measurements of the heads of people and then relegated them to either an inferior or a superior race.

After the registration of the races was completed, the systematic oppression and disempowerment of the Hutus began. The fortunate minority who were registered as Tutsis were understandably flattered. They were quite willing to be persuaded to collaborate as they were rewarded with things that were taken from the

Hutus. Hutu chiefs and tribal leaders were deposed. Only Tutsis were allowed to take on civil service jobs and leadership positions. They were given preferential treatment in education, business and had better access to public services. The tragic thing was that over time, the Tutsis came to believe in their superiority and the Hutus developed a deep hatred of their former brethren.

The Rwanda Genocide teaches us that categorising people into rigid groups for expedient purpose can have far reaching and sometimes, catastrophic unintended consequences. Autocratic and insecure leaders often like to exacerbate distinctions between tribes as a way of staying in power, often to the point that it boils over.

Tribalism and the Medical Profession

So we know tribalism is nasty. What relevance is there to medicine? Surely an idealistic and noble profession such as ours is above such social aberrations. However if we reflect on our day-to-day activities as doctors, the way we are registered into caste systems and the incessant conflicts between the various guises of tribal councils, we will realise that all is not well. The constant turf war sometimes makes me see some resemblance between organised medicine and organised crime. You may think I am too harsh on the medical profession but I am not alone. Sir Irvine Donald, former President of the General Medical Council, thinks that tribalism is deeply rooted in our profession. He wrote the following: "In our professional institutions, inappropriate autonomy, manifest as divisive tribalism aggravated by the fragmentation caused by specialisation, has resulted in a profession less and less able to act creatively as a coherent entity."[1] "Tribalism has a profound impact on the profession — we are a dysfunctional profession at that level right through the system, and it is hurting us."[2]

The tendency to tribalism is similar to ethnocentricity. It is hardwired into all of us. It is believed that such instincts evolved because it is a pro-survival adaptation. The benefits of loyalty to a socially constructed group is evident if we imagine early man coming together for mutual protection and greater efficiency in hunting larger animals. Group conformity keeps people together and allowed co-operation towards the common interest of the tribe, even when personal antagonism between individual members would have otherwise prevented co-operation. Therefore tribalism is not always bad if it brings order and allows division of labor towards a good cause. However if the leadership of tribes loses sight of common goals, negative tribalism often ensues.

Specialisation is necessary for us to cope with the increasing complexity of healthcare. However it is a double-edged sword as it can veer towards tribalism when intra-group cohesiveness is achieved through intolerant group identity and turf wars.

Dysfunctional Tribalism in Medicine

The strong intra-group loyalty of tribes can be maladaptive. The dynamics of what is apparently a primitive instinct to form social groups is actually a complex adaptive system. If the rules of the tribal membership evolve towards rigidity, the negative pressure on non-conforming members increases to the point that it limits the diversity of the group. Non-conformist are bullied into submission or exiled from the group. Consequently the group increases its effectiveness in a static niche and the expense of loosing its ability to adapt to changes in the external environment. An even more sinister tendency is when rules for intra-group cohesiveness are defined in terms of antagonism towards other tribes. This causes non-cooperation, confrontation and eventually, open warfare with opposing tribes. In extremis, it leads to genocide, when one tribe re-defines its existence towards the annihilation of another.

Specialisation is necessary for us to cope with the increasing complexity of healthcare. However it is a double-edged sword as it can veer towards tribalism when intra-group cohesiveness is achieved through intolerant group identity and turf wars. If tribalism exists in organised medicine, then we must take heed to limit its negative tendencies. We should remember our common goals and the raison d'etre of our existence as a profession. Medical tribalism

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aggravates care fragmentation and hinders the collaboration of inter-professional groups. A recent study found that "professional tribalism" is a strong influencing factor in professional decision-making processes that results in unplanned re-admissions.[3]

Preventive Medicine

While we accept that organising health care along tribal lines is unavoidable, there are things that we can do to limit its excesses. Awareness of the negative consequences is important and conscious effort must be made to instill this awareness in the formative years of the education of health care workers. In addition, work environment and processes should also be designed promote inter-professional collaboration.[4]

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Registers should be based on training and competencies. It should not be an extension of turf wars or ideological conflicts within or between tribes. Within our College we must work to accept doctors who are committed to the values of family medicine and the advocacy of higher standards in family medicine, regardless of whether they are in or out of the register. We must remember that the Family Physicians Register is a means to an end and not an end in itself. Until the day comes when we have sufficient resources to ensure that all graduating doctors have access to formal family medicine training, if they so wish, we must accept that the register is still work-in-progress. Registers whether family physician or specialist should not be used as tools of medical tribalism. We must constantly resist any tendency to impose our narrow and legalistic definitions of tribal specialisation on our colleagues who may work in different settings or descend from different training pathways. We should instead focus on developing competencies that enable us to fulfill our common calling, which is to use our family medicine training to provide patient centered care to our patients, in accordance to the higher values of our discipline.

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(continued from Page 22: Photo Quiz)

4. What is your management plans?

- Relief of itch with oral antihistamines and mild TOPICAL steroids if necessary.
- Reassurance that it is not a contagious rash and is self-limiting.
- No need to keep patient from work or school (for children).

5. When would you refer to a dermatologist?

Referral to dermatologist in the following instances:
- Atypical presentation/distribution of the rashes.
- Duration of rashes beyond 3 months or recurrences of rashes.
- Involvement of palms, soles and mucosa.
- Systemic symptoms.
- Patient very concerned over the prolonged rash.

Special thanks to Dr Colin Kwok, Senior Consultant Dermatologist, Changi General Hospital for his input and comments.

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