THE
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THE JOURNEY...

interview with newly minted family physician, Dr Kong Jing Wen, national healthcare group polyclinics - bukit batok

Interviewed by Dr Irwin Clement A. Chung Wai Hoong, MCFP(S), Editor

College Mirror (CM):
Thank you, Jing Wen, for agreeing to share your journey in Family Medicine with us. To begin with, could you tell us a bit more about yourself?

Dr Kong Jing Wen (JW):
I am Dr Kong Jing Wen, currently working at Bukit Batok Polyclinic. My clinical interests are in dermatology and rheumatology, as well as esoteric medical conditions. I also have a special interest in Traditional Chinese Medicine (TCM) and obtained a Graduate Diploma in Acupuncture a few years ago. My leisure pursuits include karaoke, Chinese chess and reading.


Dr Kong Jing Wen

CM:
What motivated you to pursue the Master of Medicine (Family Medicine)?

JW:
I took up MMed because of my love for teaching. I realised that before that came the need to be knowledgeable and kept up-to-date with the latest developments in the healthcare field. The MMed programme helped me to build that strong academic foundation. In addition, it provided me with the opportunity to learn from many proficient specialists and experienced family physicians. It also allowed me to interact with peers and course mates who were equally passionate in pursuing family medicine; they became very essential professional and personal inspiration to me.

CM:
Could you share with us your learning experience in the programme?

JW:
I was in the MMed Programme B from 2012 to 2013. Our class met up for weekly tutorials for about a year. The initial learning curve was steep. Not only did we have to revise and be proficient in all the steps of clinical examination which we learnt during MBBS days, we were also expected to be aware of the latest clinical practices adopted by specialists in hospital practice. As the days to our exams crept closer, our weekday evenings were often spent, not with our family members, but at the hospitals with our tutorial group mates. The study groups we formed became a much needed source of support and encouragement.

Personally, I started out on this journey as a doctor who only managed diseases, but ended as one who sought to provide holistic care for patients and their families, and not just treating their medical ailments. I began this journey, seeing a patient only as a patient, but was gradually able to visualise a patient in the context of his personhood, his life and relationships – a father to his son, a son to his mother and a colleague to his co-workers.

Along this journey, I have also befriended many course mates who now are my close confidantes. I have been enlightened by

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experienced tutors who not only guided me but also inspired me; I hope in turn to be that same inspiration to trainees who come after me. I find that this journey has fortified my resolve to be better not only professionally, but also spiritually.

CM:
Are there any changes to the training curriculum or programme you wish for future candidates?

JW:
As family physicians, we need to manage patients with multiple complex issues within time constraints. Future candidates should feel comfortable caring for our patients under the constraint of a 10-15 minute consult. My suggestion would be to have more timed clinical consultation practices that mimic real-life situations, including OSCEs. This will train candidates to think and react fast under the pressure of time. Candidates should also have regular forums for updates on the latest developments in various specialties, to ensure that they keep abreast the latest progress in health sciences and innovation.

CM:
What do you remember most of your journey to becoming a family physician?

JW:
I recall a story that Prof Goh Lee Gan shared with us during the Preparatory Course: The story was about an eagle's egg that landed in a chicken coop. The egg hatched and the baby eagle grew up thinking that he was a chicken. Every day, the eaglet will admire the birds in the sky, thinking that he could never fly, when in fact it was physically built to do so. The moral was "If you think that you are a chicken, even if you are born an eagle, you will never be able to fly." This reminded me that I ought to continue aspiring for greater heights and not let my perceived limitations hold me back from achieving greater things in life.

CM:
How would you encourage your peers to embrace Family Medicine as a professional choice?

JW:
Family medicine is an exciting discipline! From neonatology, paediatric, internal medicine, geriatrics to palliative care, family medicine allows us to manage a wide spectrum of conditions and grow together with the patient. It teaches us to treat the patient holistically, with due attention to the bio-psycho-social needs of the person. It allows us to form strong bonds with the patient and his family and potentially create the "domino effect". You will be pleasantly surprised how, at times, just by managing the patient, you have unintentionally made the lives of his loved ones better!

CM:
What do you realistically hope for Family Medicine in Singapore over the next 5-10 years?

JW:
In the next 5-10 years, I hope that Family Medicine will scale new heights. The primary care scene will be led by talented family physicians with "an internist's brain, a surgeon's hands and a social worker's networking skills". Patients can be competently cared for in the primary care setting with the family physician working hand-in-hand with the specialist to manage the patient in the community. More graduate diploma courses will be available for family physicians with a particular interest in specialty care. The arm of "preventive medicine" will be well-established with more Singaporeans being taught effective health prevention and wellness. Management of patients with stable chronic diseases will be done by Advanced Practice Nurses (APN), with the family physician intervening only for complex cases. Advance care planning will be well received, with more Singaporeans expressing their wishes way before end of life. Hopefully, one day, Family Medicine will again form the foundation of the entire health and social care continuum and receive the rightful accolade as a womb-to-tomb service to the people.

CM:
Thank you, Jing Wen, for your time and candid thoughts.

JW:
Thank you. I would also like to thank my wife, my family, my tutors, my friends, my colleagues and my course mates for journeying through the MMed with me.

CM

EDITOR'S WORDS

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

Of late, I have found myself being very conscious of my age. I would like to convince myself that for a person just approaching the 5th decade of life, I really should have nothing much to worry or wail about. It's just that having worked in the eldercare sector in various capacities for more than 4 years now, I find myself thinking about the "problem" of being old more often.

I am fortunate enough to have my parents and a grandparent alive to appreciate the implications of being old (and sick). What I have always taken for granted in terms of their bodily health, mental wellbeing and independence need a rethink with increasing frequency. It does not help that being the only medical doctor in the family, all health related queries in the family are directed to me. What is increasingly challenging is that the answers are no longer about "**what to do**", but also "**how to do**", "**who to do**", "**when to do**" and even "**which to do first**". Therein validates the fact that caring for older persons really is a rather complex, and often tedious, process.

Age is not necessarily a dirty word, but we certainly have made it seem so. Age is often still used as a criterion for opportunities at work (or lack thereof). Age is often equated with decreased productivity, increased liability, reduced adaptability and higher cost. You can put a law in place to ensure that opportunities remain open to aged persons, on paper, but it will take a lot more than legislation to change the mind set of people.

I am sometimes guilty of ageism myself. Recently, I found myself at a local supermarket checkout queue that was not moving as quickly as others. I craned my neck to see past the line of equally irate customers and noticed that the cashier was a senior citizen. "*O God… I had to choose this queue.*" For some reason, although I was actually in a hurry, I decided to stick with the same queue; while some other customers in front of me and behind me eventually made a beeline for other queues. As the queue moved along, I finally realised why it was being held up – the "old" cashier was actually supervising a trainee cashier and, judging from the latter's countenance, it was not difficult to see that she had a congenital learning disability. Not only was the older worker patiently supervising her and correcting her mistakes, she was also very adept with the merchandise on the counter, handling each item carefully and placing them neatly in shopping bags (a standard that I expected to see only in Japanese-run supermarkets). All this was performed with a genuine smile on her face. I am comforted in knowing that her charge will likely pick up some of that thoughtfulness and skill too.

Surely, the cashier's supervisor must have known that putting the two together could spell disaster in meeting customer expectations on speedy service, but surely too, he or she must have discerned the potential for this older worker to pass on some of the greatest values in the service to younger staff. After what seemed like eternity scanning and bagging my purchases and getting my credit card swiped and cleared, I left the counter in full admiration for that cashier's pride in her work.

Let age not be a taboo. It's a reality that we need to face up to both as individuals and as a society. It's strange that we can utter the terms "golden years" (something of great value to be cherished and enjoyed) and "silver tsunami" (with not exactly the most auspicious of connotations) in the same breath. Ageism is a stereotype we need to rid ourselves of, and in its place reclaim the Confucian perspective of 家有一老如有一宝 (having an elder in the home is like having a treasure).

In this edition of the College Mirror, we explore the work of our colleagues who have chosen to dedicate their professional service to the care of the elderly infirm. Theirs is a journey fraught with challenges and great reward alike, indeed inspiring to all of us. I wish you pleasant reading.

CM

BY THE WAY, DOCTOR

by Dr Nicholas Foo Siang Sern, Editorial Board Member

There was some amiss about this case. The 16-year-old girl had been brought by her mother to consult the GP just 10 minutes before closing time. Although he was tired after a long day at work, the GP tried his best to listen patiently.

"Doctor, Doctor! My daughter has been having fever, throat pain and cough for two days," ventured the mother. "Also *hor*… the phlegm is yellow and her temperature doesn't go down with Panadol *leh*... And *hor*…"

The GP nodded silently whilst maintaining eye contact, indicating that he was paying attention. He allowed the mother to ramble on for another minute or so as she described the clinical picture before he turned to face the girl herself to enquire whether she had any other symptoms. He then proceeded to examine the patient.

The GP scribbled "URTI" onto the patient's card as he explained the diagnosis and the required treatment.

"If there is nothing else, then please take a seat outside while my staff prepares the medication," said the GP with a smile.

The patient's mother seemed reluctant to move from her seat.

"Doctor, can my daughter take part in her Netball Competition next week?" she asked.

The GP gave his reply and tried yet again unsuccessfully to end the consult. The mother had another question for him. After three or four more questions from the mother the GP started to sense that something was not quite right. One may call it intuition, but after seeing many patients over the years, the GP had developed in his brain some form of pattern recognition which alerted him that something was amiss. The GP decided to probe further and asked the patient and her mother whether they had any other concerns.

"Actually I am quite worried about her nose. Every morning when she wakes up she will start sneezing and her nose will drip like a tap. This goes on for at least one or two hours. Is there something seriously wrong with her nose?"

He had read somewhere that most errors were made when the medical practitioner was *H*ungry, *A*ngry, *L*ate or *T*ired. He was not angry but he certainly was hungry, tired and it certainly was late.

The GP re-examined the patient and reassured the girl's mother that in all likelihood it was a case of allergic rhinitis and that he would give her a trial of an intranasal steroids she recovered from her URTI. He also shared with them some tips on environmental modulation to mitigate the symptoms.

The mother seemed satisfied with the answer and she finally stood up to take her leave. As she opened the consult room door, she gave the GP a sheepish look and asked, "By the way doctor, my daughter has also been having a bit of constipation for some time. Could you prescribe some medication for her constipation as well?"

The GP was about to write "Lactulose" when alarm bells went off in his head. The "By the way" question should never be taken lightly. He also remembered "**HALT**". He had read somewhere that most errors were made when the medical practitioner was **H**ungry, **A**ngry, **L**ate or **T**ired. He was not angry but he definitely was hungry, tired and it certainly was late.

It took him all of his will to ask the patient and her mother to sit down again while he questioned them on the problem of constipation.

The GP then asked the girl to lie down on the examination couch and proceeded to palpate her abdomen. He then ordered an ultrasound scan of the pelvis.

5 days later, the GP received the report and films of the Ultrasound Pelvis: "A very large complex septated cystic mass is seen arising from the pelvis and extending to above the umbilicus. The mass measures 210 x 170 x 94mm. It is most likely a large ovarian cyst and surgical evaluation is advised."

The GP picked up the phone to inform the girl's mother.

By the way, GP life can be full of unexpected excitement…

CM

LIFE OF A GP

by Dr Nicholas Foo Siang Sern, Editorial Board Member

"This is going to be boring," muttered the Medical Student under his breath as he glanced up to look at the clinic sign board, just to confirm that he was at the right place. The GP clinic was located in a HDB estate and the Medical Student dreaded the thought of seeing only "coughs, colds and GE's". He very much preferred to be seeing the "real cases" in the Hospital wards but a GP posting was compulsory and the Medical Student duly reported to the GP clinic early on a Monday morning, being the good student that he was.

The Medical student took a deep breath and strode into the clinic. The GP was already in the clinic waiting for him. The GP welcomed the Medical Student and introduced himself. "Things are pretty mundane here most of the time – coughs and colds, GE's," said the GP with a twinkle in his eye, "but sometimes things can get pretty exciting. Keep your eyes and ears open and maybe you might learn something."

The Medical Student kept his eyes and ears opened as advised. The next couple of days were busy and the clinic was packed. He observed the GP keenly and noticed that the GP never seemed to be in a rush, no matter how crowded the clinic was. The GP would spend anything ranging from 3 minutes to 30 minutes on a patient, depending on the nature of the case. The GP also took a short pause of about 15 seconds between each patient; it seemed that he was clearing his mind before proceeding to see the patient next in queue.

The Medical Student learned that a cough and cold could turn out to be pneumonia and a lady with GE could actually be pregnant. Back pain could be "renal colic" and epigastric pain could be an acute myocardial infarction. He saw various skin conditions that he had only previously seen in the textbooks and reminded himself that he should always check the ears of a febrile child. He was certain that the young lady was suffering from hyperthyroidism but she turned out to be hyper-anxious as she was not coping well with a recent life stressor.

The Medical Student learned to interpret the blood tests that the GP ran for his patients with chronic diseases and watched the GP trying to convince a patient with diabetes on the need to increase his dosage of medication. The patient had no time for exercise, was adamant that watching his diet would render his life meaningless and too much medication would make him feel sick so a compromise was struck for a higher HbA1c threshold. "Better not to win the battle but lose the war," said the GP, "at least I know he will return to me for follow up and I can work on him again."

He saw an old man with sexually transmitted diseases (STD) who came in asking for the "injection" – apparently this was not his first episode and despite the GP's pleadings, he refused to give up his weekly boat rides across the sea. He noticed the middle aged man in sunglasses who came in one morning accompanying his young girlfriend and saw the same man, sans sunglasses, bringing in his sick, cancer-stricken middle-aged wife two nights later. People are no simple beings.

He observed how the GP counselled the anxious and the depressed, and how he gently lectured the young boy in national service over asking for one medical certificate too many.

The Medical Student also assisted the GP in dressing wounds and learned how to administer vaccines and IM injections. He noticed that the GP struggled a bit when he had to suture a laceration but somehow managed to get the job done fairly decently. He also noticed that the GP had a certain awkwardness in the way he moved but could not discern what the actual problem was.

"Do you run?" asked the GP one morning. "As there is no night clinic tomorrow, I will be going for a run after the afternoon session tomorrow. You can join me if you are keen." The Medical Student agreed. The following evening, the Medical Student had a shock when he saw the GP decked out in his running gear. He saw the scars that previously had been hidden from view. The GP was wearing a faded tank top and as the Medical Student ran behind him he noticed the words printed on the back of it. The Medical Student thought for a moment and decided that he would ask about the scars after the run.

"You know, I once heard a Senior Consultant telling us to be brave and pursue our dreams. He mentioned that many years ago he had a fellow Medical Officer who could have been a specialist. Unfortunately, that person got involved in a terrible accident and never fully recovered from his injuries. He could not take the rigors of specialist training and eventually went on to practice as a GP. The Senior Consultant never mentioned any name but he did use a nickname, and that nickname is printed on the back of your shirt. He was speaking of you?"

The GP smiled indulgently as he nodded his head.

"Are you disappointed that you never got to specialise? You could be a Senior Consultant by now, rather than an anonymous GP," continued the Medical Student.

"Are you kidding me?" replied the GP. "I've always wanted to be a GP. Physical scars may remain permanent but the spirit can always heal. And after all I've been through I consider it a blessing that I am still able to practice Medicine at all." The Medical Student was floored.

"Besides that," the GP chuckled, "I am still fit enough as I have a more balanced lifestyle and great job satisfaction. That good friend of mine, your Senior Consultant, works such hard and long hours, does not watch his diet and probably has never run since national service, probably needs to activate emergency services for standby should he need to dash for a cab!"

CM

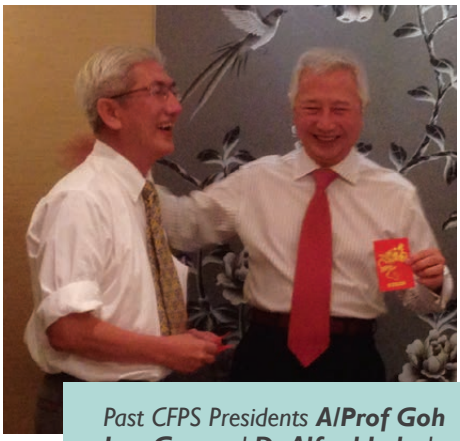
IN CELEBRATION OF WONCA AWARDS...

Together with **Professor Michael Kidd** [President of World Organisation of Family Doctors (WONCA)], College of Family Physicians had the privilege to host a dinner celebration at Wah Lok Cantonese Restaurant (Carlton Hotel) on December 6th, 2013.

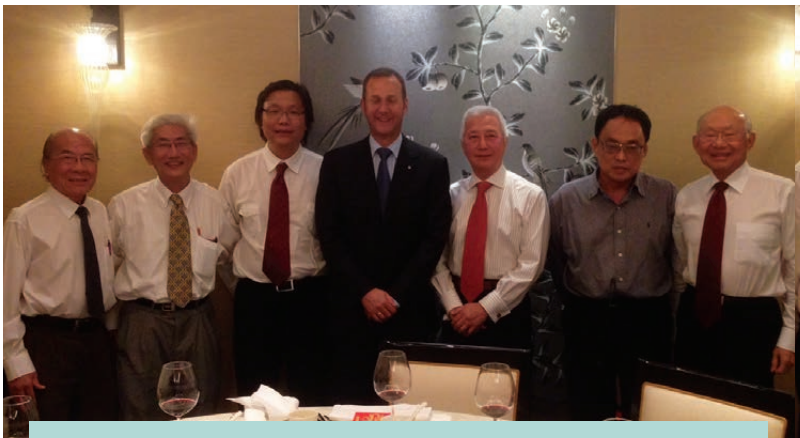
Held in celebration of the WONCA award of Honorary Fellowship to **Dr Alfred Loh**, and Honorary Life Membership to **Ms Yvonne Chung** and **Ms Gillian Tan Francis**, it was indeed a wonderful evening for everyone.

Professor Michael Kidd *presenting the WONCA award of Honorary Fellowship to* ***Dr Alfred Loh*** *[Past president of CFPS (1993 - 1999)]*

Professor Michael Kidd *with the members of the 24th Council, College of Family Physicians Singapore*



Past CFPS Presidents ***A/Prof Goh Lee Gan*** *and* ***Dr Alfred Loh*** *sharing a candid moment*



Professor Michael Kidd *with past and current presidents of CFPS*

From left:
A/Prof Lee Kheng Hock, Prof. Michael Kidd, A/Prof Goh Lee Gan, Dr Alfred Loh, Ms Yvonne Chung, Ms. Gillian Tan Francis

INTERVIEW WITH **DR TAN JIT SENG**
— the challenges of home care

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

Dr Tan Jit Seng (Director, Lotus Eldercare Pte Ltd) runs a private establishment which provides home care for patients. His team consists of nurses, therapists as well as case managers.

Kelvin: Tell me more about your team and model of care.

I am adopting a new model of home care service using resources from a mix of public, private and charitable organisations. I am supported by a team with members from various different organisations.

I practice a very "primitive" form of medicine whereby the doctor visits the home of the sick and dying and render all kinds of support (perhaps not even medical at times) so that the patient can be treated in the comfort of their homes.

Kelvin: What type of patients do you see?

I see a wide variety of patients. They can be very young or very old. These patients are mostly homebound. My patients can be categorised as follows:

1. Young

Usually severe birth trauma or cerebral palsy patients on nasogastric feeding; traumatic brain injury from road traffic accidents.

2. Vegetative

Patients with hypoxic brain injuries.

3. Palliative Care

Cancer palliative care as well as medical palliative cases with end stage organ failures

4. Neurodegenerative / Psychotic disorders

Advance Parkinson's; dementia with BPSD, burnt out psychosis, elderly psychosis

5. Insurance / Mental Capacity Assessment

For IDAPE/ELDERSHIELD/FDWG/Mental Capacity assessment for LPA or Power of Attorney applications

6. Procedural Requirements

Changing of urinary catheters/ Nasogastric tubes/ PEG tubes/Tracheostomy tubes and weaning off of these tubes

Dr Tan with his patients.

Kelvin: What are the challenges you face as a private organisation?

The main challenges for a private entity providing any home care service are:

1. Creating and leading a multi-disciplinary team in order to provide holistic health care for patients at home.
2. The affordability of these services for patients.

The well off patients can easily afford most of such services. However, I mainly serve patients staying in HDB flats who are mostly unable to afford such personalised service without funding from the government or charities.

Kelvin: Managing patients at home is quite challenging. How do you motivate your team?

To get team members to be motivated, they should be a very strong leader who understands the needs of the home bound patients. He will need to be familiar with and proficient in doing the tasks that his team members routinely carry out.

Images courtesy of Dr Tan Jit Seng

By doing so, the team will be able to fall back on the leader for any difficulties, for example, problems related to nasogastric tube insertion. The team leader will empower the care staff, whether they are nurses, therapists or care givers with the required knowledge to manage the patient at home. They are taught how to manage possible complications at home as well as how to utilise the resources available in Singapore.

I will always guide the patients and their caregivers on how to navigate the healthcare system so that they can tap on relevant funding or services.

For more info, you can go to my website at **http://www.lotuseldercare.com.sg**.

CM

THERE'S NO PLACE LIKE HOME — WHAT YOU NEED TO KNOW ABOUT WORKING IN A NURSING HOME

by Agency for Integrated Care (AIC)

As the Government makes progress on enhancing the quality of care at the community level, Nursing Homes (NHs) face a unique set of difficulties. The Agency of Integrated Care (AIC) catches up with three doctors who shared their work experience and gave us insights into the sector.

Dr Tan Ching Wah
A resident doctor for several nursing homes such as the Society for the Aged Sick, he has been working with nursing homes for 10 years with a few partners that provide contractual medical services.

Dr Lim Shee Lai
GP at private clinic Hwang & Liang Family Clinic and Surgery and doctor caring for several nursing homes, including SWAMI Home, he has been working with nursing homes for 20 years with an informal group of doctors that provides contractual medical services.

Dr Ow Chee Chung *(second from left)*
CEO of Kwang Wai Shiu Hospital. Seen here with the management and staff on Nurses' Day 2013, he has been working in the nursing home sector for more than a year.

AIC: Tell us more about working in an NH.

Dr Tan Ching Wah:
The work is mainly providing clinical consult to residents but how much you participate in other areas for example, conferences and training, depends on the needs and policies of NH.

Dr Lim Shee Lai:
At an NH, the patients are there, waiting for you and their problems are not so urgent. You can schedule your time and work out an arrangement with the NH that coincides with your downtime, since GP hours are fixed. It is up to you to prioritise.

Dr Ow Chee Chung:
My role is to be a leader, motivator and facilitator for the team. As CEO, I took up the task to direct key quality assurance programmes. This is important so that I get first-hand information on patient care, quality and safety issues and, I can make the right macro decisions.

AIC: What are some of the challenges you encounter?

Dr Tan:
A fair number of the residents are unable to communicate due to cognitive impairment. Assessment of this group of patients will largely depend on objective findings and observation reports by the nurses. Also, one needs to be able to work fairly independently as opportunities to consult a colleague or specialist are not as readily available.

Dr Lim:
Sometimes, family members will request that you sign death certificates at odd hours. The 24-hour availability for phone consult is not everyone's cup of tea but this can be mitigated to a certain extent with staff education and training.

Dr Ow:
To recruit and retain sufficient committed staff. Not just at managerial level but at all levels, including a good housekeeper. We go to great pains to reward and recognise the front-line staff.

AIC: What makes it fulfilling for you?

Dr Tan:
Working as part of the team in providing the necessary care and improving the quality of life for the residents. There is also a sense of satisfaction when the resident and family members show their appreciation.

Dr Lim:
It is the multi-disciplinary aspect and holistic approach to patient care — from physiotherapy to psychiatry — that you do not see at a GP clinic. You broaden your horizons and come to see the elderly person as a whole. In a NH, because of the nature of an elderly person, I have never stopped learning; there is always something new. I always say, the patient is your teacher.

Dr Ow:
When a patient can be supported for home discharge. It is uncommon and ambitious for an NH to set such an outcome, but you never know until you try. There are many who cannot be discharged but we feel fulfilled too when we see them smile.

WHAT DO DOCTORS DO IN A NURSING HOME?

Basic:

1. Attending to acute conditions
2. Managing the chronic conditions
3. Initial assessment of new admissions
4. Issuing death certificates
5. Procedures such as male urinary catheterisation and venipuncture

Additional:

1. Conducting training for nurses
2. Participating in ACP and Preferred Plan of Care (PPC) discussions
3. Participating in clinical conferences
4. Performing disability assessment for Eldershield, IDAPE, DPS or other insurance policies
5. Mental capacity assessment and medical reports for the appointment of deputies

BUSTING THE MYTHS!

MYTH 1

I need additional qualification to work in a nursing home.

Dr Lim:
I did what I thought was relevant and useful for my work so I did both the GDGM and GDFM. Although doctors can learn on the job, it would be better to have some more training.

Dr Ow:
Established GPs should have enough experience. They then need to understand the workflow in a nursing home. GPs should also learn about advanced care planning (ACP) and familiarise themselves with the clinical requirements of nursing home patients.

MYTH 2

There is an additional legal burden on doctors.

Dr Tan:
I think the risk is lesser as compared to a GP clinic. After patients walk out of a GP clinic, there is no trained professional to monitor them. At a NH, nurses monitor the treatment and can alert the doctor if their condition deteriorates. There's no one better to do it than nurses who know the residents well!

Dr Lim:
No, not if you have good documentation. Document both what you see and what you do not see. You would not want to be accused of having missed something, particularly for cases where symptoms appear later.

MYTH 3

Doctors do more in nursing homes.

Dr Tan:
It is not true that because there are 400 beds, you need a full-time doctor. The medical care needed in a NH is less intensive than in hospitals. Furthermore, the nurses can be trained and empowered to take up more roles and responsibilities to lessen the reliance on the doctor.

Dr Lim:
That is a popular misconception. However, NHs are driven by nurses and doctors are supporters, they are not the ones who administer the treatment. Hence, nurses are as important as doctors in a NH and they should be empowered to do more.

For more information, email gp@aic.sg

CM

(continued from Page 6: Doctors On Wheels And The Aging Population)

circumstances though, the clinician would be expected to manage the patient in 15 minutes when what they really required was at least 45 minutes.

The Bigger Landscape

Mobile clinics in Singapore such as the SATA "Doctors on Wheels" service help to address the issue of accessibility of healthcare for the elderly frail person living with suboptimal support. Although the return on investment for the healthcare system as a whole is significant for the mobile clinic, the service provider requires funding from the government and other donors to subsidise this mode of healthcare which in itself is relatively costly. The costing of mobile clinics, home care services and GP clinics in taking care of the elderly with multiple morbidities in the Singapore context should be further assessed.

Encouraging General Practitioners in Singapore to extend their care for elderly patients with multiple morbidities can begin with focus group discussions and addressing the challenges surfaced as well as those listed above and in other international research. Other than the polyclinic practice, the CHAS program and the Community Health Centres in Singapore, which are themselves examples of excellent initiatives in the right direction, more needs to be done in crossing the divide between hospital and GP practice and to provide the extra funding when General Practitioners spend that 45 minutes to care for the elderly patient with multiple morbidities presenting with very complex needs. The healthcare and social support system has to facilitate the primary care physician's training, attachment, networking and keeping up to date with the medical knowledge and skills, as well as community resources required to enhance their care of the growing number of aged persons in Singapore.

The SATA CommHealth Doctors on Wheels team and their van - "Always so happy to see them rolling in."
Images courtesy of SATA

CM

PICTURE QUIZ #1

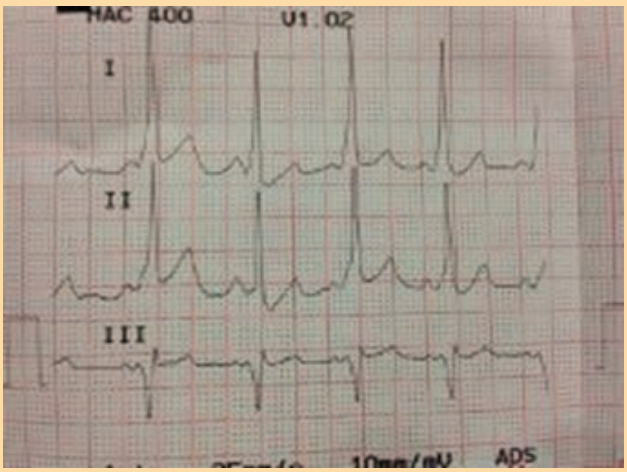
Case contributed by Dr Nicholas Foo Siang Sern, Editorial Board Member

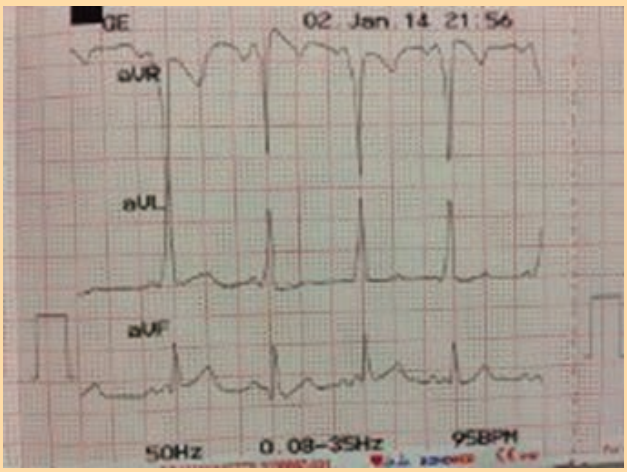
A 13-year-old boy comes with the complaint of chest pain and breathlessness. He has been having episodes which last for 2 to 3 hours that resolve spontaneously before recurring again.

An ECG is performed.

QUESTION

What does the ECG show?





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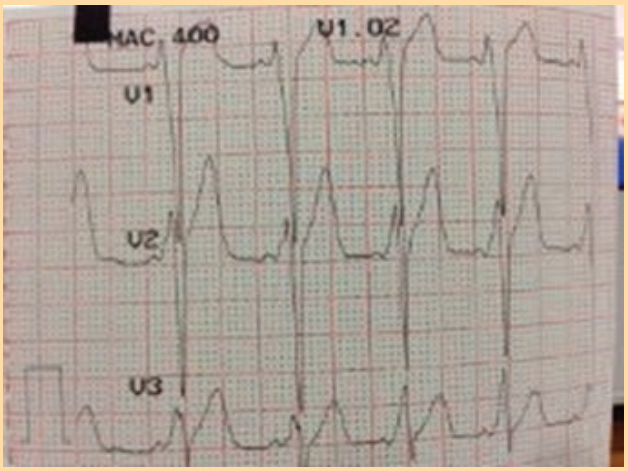

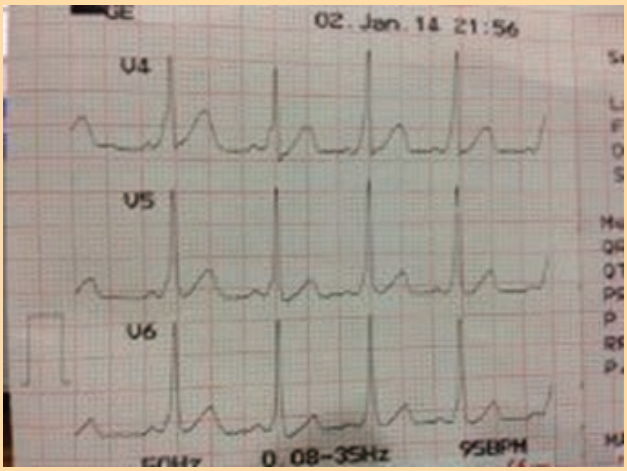

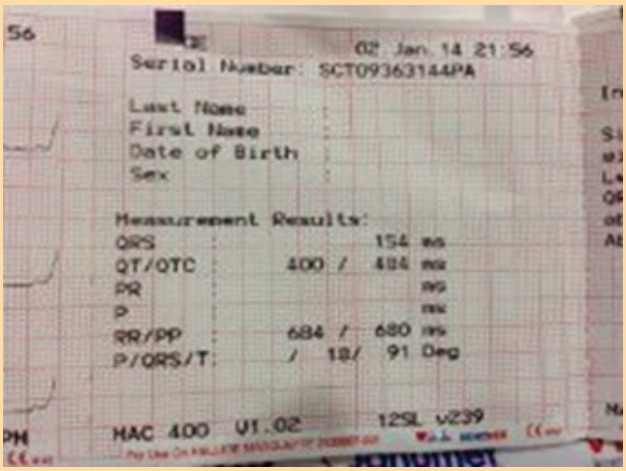

ANSWER

The ECG has the following features:

- Delta wave-slurring and slow rise of the initial upstroke of the QRS complex
- Shortened PR interval
- Widened QRS complex (total duration greater than 0.12s)
- Secondary repolarization changes reflected as ST segment-T wave changes

WHAT IS THE DIAGNOSIS?

The patient has Wolff-Parkinson-White (WPW) syndrome.

LEARNING POINTS

- WPW syndrome is defined as a congenital condition involving abnormal conductive tissue between the atria and ventricles that provides a pathway for a re-entrant tachycardia circuit.
- Clinical manifestations of WPW syndrome may have their onset at any time from childhood to middle age. Presentation varies with patient age; the verbal child with WPW usually reports chest pain, palpitations and breathing difficulty.
- The most common occurring tachyarrhythmia forms associated with WPW are supraventricular tachycardia (SVT), atrial fibrillation (AF) and atrial flutter.
- Physical examination findings are generally normal but clinical features of associated cardiac defects such as Congenital Heart Defects or Cardiomyopathy may be present.
- The patient needs a Cardiologist referral for further evaluation and management.

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(continued from Page 11:What Can Management Gurus Learn from Medicine in the Present Healthcare Crisis)

had been partially leached away to sustain life during the time of starvation. The sudden shift of electrolytes throws the heart into arrhythmia and failure. Similarly a return to normal metabolism requires a lot of oxygen and produces a lot of carbon dioxide. The skinny respiratory muscle remnants that power the lungs just cannot cope and respiratory failure rapidly ensues.

Don't Make A Bad Situation Worse

The rapid introduction of a large number hospital beds into the system is likely to be similar to the infusion of hypertonic glucose to a starving patient. Just as a starving patient needs more than glucose, the situation at hand probably requires more than just hospital beds. Especially so when our healthcare manpower is in a suboptimal state as it adapts to a new training and accreditation system. The best treatment for a starving patient is gradual refeeding to the point that we sometimes have to restrict food to the recovering patient. We have to remain resolute in rationing the re-introduction of calories even if we risk being misunderstood as cruel by anxious relatives and armchair critics. Fluids and electrolytes have to be watched like a hawk and corrected through constant monitoring and feedback. Finally as good family physicians will tell us, we need to take a biopsychosocial approach to illness. We have to treat the patient as a unique person in the context of his psychosocial environment. We need to understand why he was starved in the first place. A more robust and nourishing primary care would probably have prevented this insatiable addiction to hospital beds. Finally prevention is always better. The worst case scenario would be to go into a binge and starve cycle.

Like a bad horror movie, the ending may reveal that the bad guy is not really dead. Supplier induced demand is not completely bunk. In fact there is probably some truth in it. Last weekend, one slick salesman nearly succeeded in selling to me, an overpriced complicated camera with many features that I do not understand and will probably never use. Fortunately my rational mind overcame my emotions and I decided to just upgrade my good old compact primary camera. Say cheese or family medicine.

CM

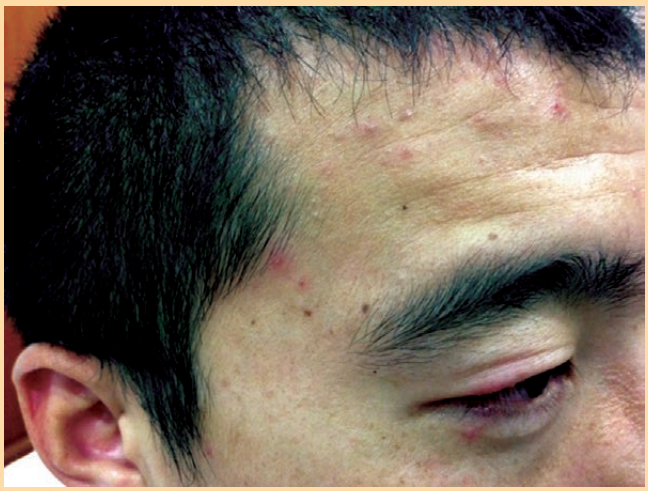
PICTURE QUIZ #2

Case contributed by Dr Nicholas Foo Siang Sern, Editorial Board Member

A 34-year-old gentleman comes to you with the complaint of right eye pain and redness of 2 days' duration. He does not have any other symptoms. You examine his eye and note that the conjunctiva of his eye is injected. There is also some inflammation on the upper lid. You notice some rashes on the same side of the face and forehead.

QUESTION

Describe the rash on his face.



ANSWER

The rash on his face has the following features:

- Erythematous papules and vesicles
- Ipsilateral distribution
- Involves Cranial Nerve V1 dermatome and upper eyelid

(continued on Page 14)

(continued from Page 12: Picture Quiz #2)

WHAT IS THE DIAGNOSIS?

Herpes Zoster Ophthalmicus (HZO)

LEARNING POINTS

- HZO represents 10-15% of all cases of Herpes Zoster.
- The risk of ophthalmic complications in patients with Herpes Zoster does not seem to correlate with age, sex or severity of rash.
- HZO develops when cranial nerve CN (V) i.e. the trigeminal nerve is involved in viral reactivation.
- For unknown reasons, involvement of the ophthalmic branch of this nerve (V1) is 5 times as common as involvement of the maxillary branch (V2) or the mandibular branch (V3).
- Ipsilateral pre-auricular nodal involvement is a common prodromal event in HZO and often is valued equivalently with pain, vesiculation and erythema in establishing a diagnosis.
- Signs of meningeal irritation may be present; therefore meningitis may need to be excluded.
- Traditionally, nasociliary branch involvement, characterised by vesicles at the tip of the nose, has indicated that eye involvement is present or imminent (the Hutchinson rule).
- HZO may be associated with conjunctivitis, keratitis, corneal ulceration, iridocyclitis, glaucoma and decreased visual acuity or blindness.
- Post-herpetic complications are more common in HZO than in other manifestations of Zoster. In particular, Post Herpetic Neuralgia (PHN) is observed in well over 50% of patients with HZO and can be severe and long lasting.
- Scarring also is more common, probably as a result of severe destructive inflammation.
- This patient needs to receive antiviral therapy and should be promptly referred to an ophthalmologist.

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FAMILY PRACTICE SKILLS COURSE

Emergency Medicine (Re-run)

The College of Family Physicians Singapore would like to thank **Health Promotion Board, Ministry of Health** and the Expert Panel for their contribution to the Family Practice Skills Course #56 on "Emergency Medicine (Re-run)", held on on 22 – 23 February 2014.

Expert Panel:

LTC (Dr) Ng Yih Yng
A/Prof Malcolm Mahadevan
Prof V. Anantharaman
Dr Juliana Poh
Dr Heng Wei Jian Kenneth
Dr Kua Phek Hui Jade
APN Patsy Chiang
SNM Lee Chin Hian
NC Zainab Binte Amat
SSN Lim Choon Chai
Dr Fam Jiang Ming
Dr Quek Lit Sin

Chairpersons:

Dr Pang Sze Kang Jonathan
Dr Tan Hsien Yung David

WHAT CAN MANAGEMENT GURUS LEARN FROM MEDICINE IN THE PRESENT HEALTHCARE CRISIS

by A/Prof Lee Kheng Hock, President, 24th Council, College of Family Physicians Singapore

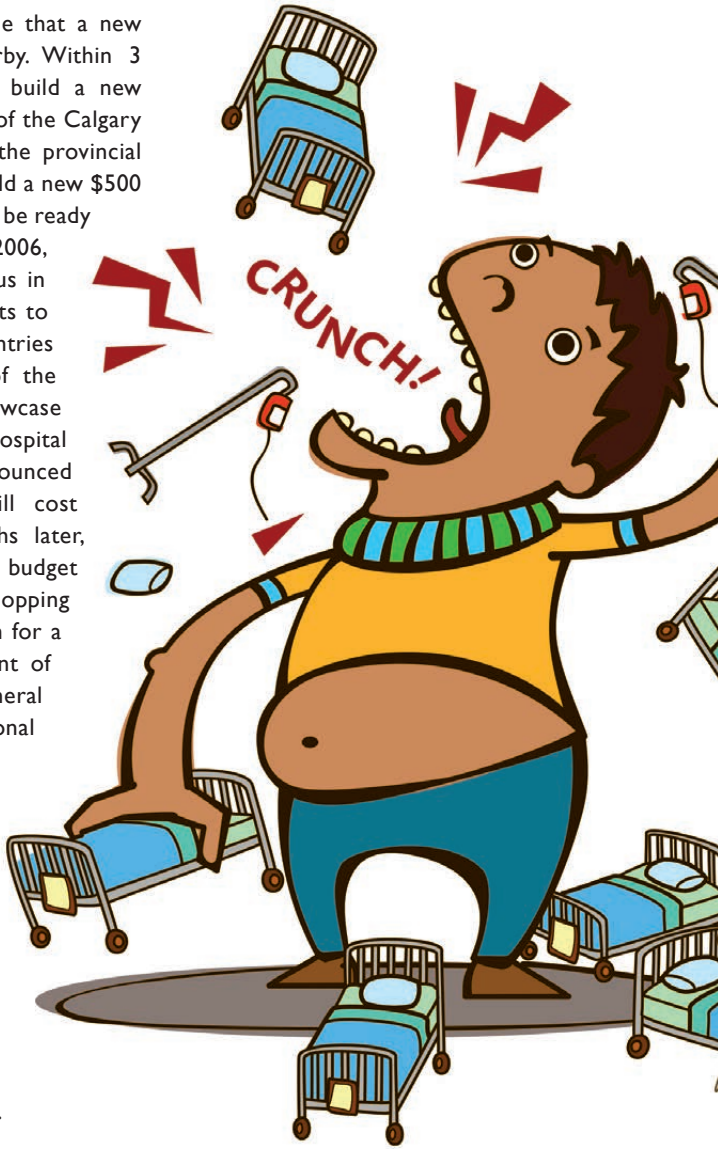
Don't Blow Up Hospitals

On October 4, 1998, a state of the art 960 bed hospital exploded and disappeared into a cloud concrete smithereens. It was a professional job. High explosives were placed strategically throughout the building to ensure that it was utterly destroyed. Fortunately there were no immediate casualties. Many untimely deaths were to follow in its aftermath. One resident of the city described this as the 9/11 of healthcare. But this was not the work of terrorists. The perpetrators were sanctioned by the government. Neither is this some outlandish conspiracy theory. In a way, this catastrophic event had some similarity to acts of terrorism. It was motivated by people who took one aspect of the truth and distort it to an illogical and extreme conclusion. If you really trace it down to the root cause, the culprits were management gurus who used the distorted truth of one economic theory.

The Calgary General Hospital in Canada was the only hospital providing emergency services to down town Calgary in the 90's. It was a huge hospital by North American standards. It provided comprehensive general hospital services including a trauma centre equipped with a helipad. The hospital even had a psychiatric unit. In a bid to contain healthcare cost, Ralph Klein, the flamboyant premier of the Canadian state of Alberta at that time, decided close down 1500 hospital beds in the region. Health economists predicted savings of more than $200 million. There was to be additional savings of $50 million per year in operating costs. Overall health care cost was supposed to go down and everybody wins. The demolition of the Calgary General Hospital was a televised public spectacle. Incredible as it seems, the huge crowd of Calgarians that gathered to watch the destruction of the hospital cheered when the explosives went off. This just goes to show how misguided both the government and the people can be when they are under the influence of prevailing management fad. What followed was more than a decade of healthcare famine that is still ravaging the city of Calgary today. Many of those who gathered to watch and cheer were probably among those who now complained bitterly about the long waits at emergency rooms and for hospital beds. Many of them had to shuttle from hospital to hospital hoping to find a shorter queue. A few high profile cases of medical mishaps resulting in deaths had been attributed to this shortage of hospital beds.

Money Isn't Everything

The promised savings never materialised. Even before the dust of the old Calgary General settled, shortages were becoming apparent. The health officials quickly reassured the people that a new hospital will be built nearby. Within 3 years plans were made to build a new hospital to replace the loss of the Calgary General Hospital. In 2004, the provincial government promised to build a new $500 million hospital which would be ready by 2009. Between 2005 and 2006, the health management gurus in the planning team made visits to 23 hospital projects in 7 countries to conceptualize a state of the art hospital that will showcase the latest and the best in hospital design. In 2007 it was announced that the new hospital will cost $900 million. A few months later, it was announced that the budget had been increased by a whopping $697 million to $1.25 billion for a 260 bed facility. At the point of destruction, the Calgary General Hospital had 960 operational beds. By the time construction started in September 2007, the budget was $1.3 billion. Concerned with the escalating cost of the project, the government formed a special oversight committee and engaged the services of more management consultants. 6 months later, it was announced that the project had been scaled down from 260 beds to 216 beds. The price tag now was $1.4 billion. More cost cutting was attempted in 2009. In 2013, almost 15 years later the new hospital was officially opened with a final price tag of $1.3 billion. With hindsight, it was quite obvious that all these were a lot of unnecessary pain. In the late 1990s when the culling of hospital beds was in full swing, the population of Calgary was growing explosively. The booming economy fuelled by a resurgent oil industry was a population magnet. In 1996 the population of Calgary was



768,082. In 2001, it was 878,866. By 2014, the projected population will be 1,419,800, almost double that of 1996. In the period from 1994 to 2010, the population grew by 327,000. In the same time period, hospital beds increased by a mere 133 beds.

Don't Be Taken By Management Fads

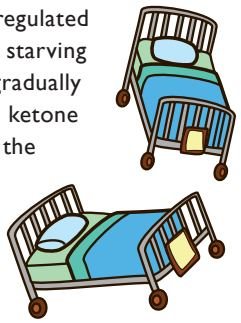
The ideology that drove this dissociation of common sense from reality was an economic theory called supplier induced demand that was hijacked by management gurus and inflicted upon the health care system. The theory of supplier induced demand says that when there is asymmetry of information between the supplier and the consumer, the supplier can use superior information to encourage the consumer to purchase more goods and services than they really need. Anybody who had bought a lemon from a used car salesman or a camera from a dodgy Ah Beng in Sim Lim Square would attest to the face validity of this theory. Capitalizing on the fear of rising health care cost around the world, management gurus began selling this theory to politicians and healthcare consumers. In most good fiction, you need a bad guy and the greedy doctor who fleeces the patient fits the bill. It was also convenient to have someone to blame for all the troubles of the world. Ideally it should be a safe target who is perceived to be privileged but unable to hit back. Again doctors fit the specifications like a well powdered surgical glove. What followed was a bestseller in health economics. It became the dominant management fad that led the healthcare system by the nose from the early nineties. Zealots proposed cuts and rationing of supplies to dampen demand. Training positions for doctors and healthcare workers were curtailed. Hospital beds and even nursing home beds were culled or frozen. Primary care was strapped down with cost control programs such as managed care. It was only in the last few years that the world started to wake up to the pain of massive shortages in hospital beds and mismanaged primary care. There was also a gradual realization that the now badly demoralized and overworked doctors were not the masterminds behind the escalation of healthcare cost.

What we need is perhaps more practical wisdom. We have to be very weary of simple feel-good solutions to complex problems such as more rules and better incentives. Perhaps management gurus should learn from medicine instead of ecnomic theories alone.

Learn From Doctors And The Nature Of Complex Systems

Where do we go from here? The present danger now comes from the swing of the pendulum to the other extreme and the arrival of a new bandwagon of management gurus and media pundits. What we need is perhaps more practical wisdom. We have to be very weary of simple feel-good solutions to complex problems such as more rules and better incentives. Perhaps management gurus should learn from medicine instead of economic theories alone. After all medicine, at least the non-specialized kind, is the science of finding practical solutions to the problems caused by malfunctioning complex systems. The next generation management guru wannabes who will have to fix this chronic shortage of hospital beds should study a medical condition called the refeeding syndrome. It was the same situation of good intentions making things worse.

When World War 2 ended, allied troops liberated concentration camps and freed thousands of prisoners who were on the brink of dying from starvation. Taking pity on these poor creatures, the soldiers gave them whatever food they had with them. Chocolates, biscuits and combat rations were all received with gratitude and consumed with great joy. It must have been a moving scene to see the most abject of human cruelty reversed by such tender acts of kindness. Unfortunately the joy turned to sadness very quickly. Within days of being saved from the jaws of the death, the prisoners started dying like flies for no apparent reason. Most to them developed heart failure or respiratory failure very rapidly and perished. Their rescuers watched helplessly as they die off one after another. It was only much later that they learned that they had all died from a newly discovered condition called refeeding syndrome. They were literarily killed off by good intentions. Those who were most starved and received the most food in the aftermath were the most likely to die. What happen was that under prolonged starvation our body tries to conserve protein and use fat instead to produce energy. Gluconeogenesis which produces glucose from protein is down regulated massively by the starving body. The body gradually moves on to use ketone bodies from fat as the main source of energy. The new steady state while not ideal, can sustain life for a much longer period of time when the body is starved of calories. When food becomes available and large amounts of calories are consumed, the body kicks back into the old ways of splurging on glucose. The problem is that going back to the old metabolism requires other things such as phosphate, potassium and magnesium. All these had become severely depleted during the prolonged starvation. Blood levels of these critical electrolytes were maintained at life sustaining levels by depleting intracellular stores. The sudden jolt of returning to a time of plenty shifts these electrolytes back into the cell where it is needed for a glucose-based metabolic process. The blood levels of these crucial electrolytes start to fall below critical levels. In the meantime, despite valiant attempts at conserving protein during the period of starvation, the protein in the muscle mass of the heart and the respiratory muscles



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(continued from Page 11:What Can Management Gurus Learn from Medicine in the Present Healthcare Crisis)

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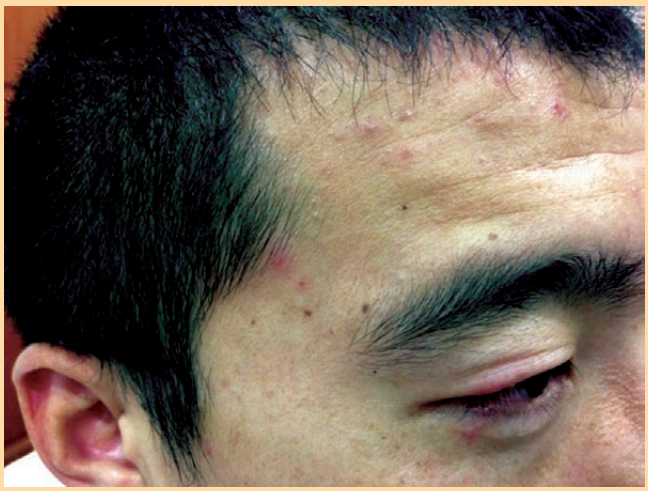

ANSWER

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- Ipsilateral distribution
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DOCTORS ON WHEELS AND THE AGING POPULATION

by Dr Lim Khong Jin Michael, Editorial Board Member

Responding to the Aging Population

The SATA "Doctors on Wheels" service brings the full complement of a medical clinic to the community in the form of a van fitted with a dispensary. The field team comprises one doctor, two nurses, one clinic assistant, one administrative executive and a driver. The mobile clinic is usually set up at a Senior Activity Centre within the community. The elderly residents from the surrounding blocks of flats are always glad to see the familiar van coming to provide them with a medical consultation and medicine, blood and urine tests, and an ECG or visual acuity test when appropriate. According to Dr Toh Khai San, the Acting Medical Director of SATA CommHealth, many of these residents no longer go to their regular GP or polyclinic for their chronic disease follow-up due to inconvenience or they simply cannot travel the distance anymore. Dr Toh says that occasionally they also go up to the flats to see patients that are unable to come down to the ground floor due to illness or disability. "Doctors on Wheels" was started by SATA CommHealth in 2007 as a response to the demographic changes and needs of the elderly in Singapore, especially those with less personal and family resources. Dr Toh notes that the Senior Activity Centre, through the efforts of the then Ministry of Community, Youth and Sports (now Ministry of Social and Family Development), has become an important node in the community for the elderly. "They seem to know one another quite well at the activity centre. They go there for lunch, language enrichment classes, some physiotherapy, exercises and recreation. Adding a regular mobile medical clinic there enhances the suite of services."

Return on Investment

The mobile clinic serves as an entry point to mainstream healthcare and social resources through its networking and referral system. According to Dr Toh, patients who need either an X-ray or ultrasound imaging will be transported to the SATA CommHealth Clinic for the test(s). Physiotherapy and diabetic retinal photography referrals are made to the nearest SATA physiotherapy department and the SATA Community Health Centre or Medical Centre respectively when required. Patients may also be referred to specialist outpatient clinics in the restructured hospitals when necessary.

One of the questions that frequently come to mind when we study the mobile clinic is the cost-effectiveness of providing such a service. According to a research done by Oriol and her colleagues, published in BMC Medicine in 2009, the systemic return on investment from The Family Van in America was calculated to be 36:1. In other words, for every dollar invested in the mobile clinic program, the return was $36 in terms of Emergency Department costs avoided and value of potential life years saved.

The patients seen by SATA "Doctors on Wheels" are heavily subsidised by the SATA Community Service Division, aided also by the recent introduction of the Community Health Assist Scheme (CHAS) programme, an initiative c-ordinated by the Agency for Integrated Care. They may also be receiving public assistance or community medical benefits.

The Challenges of an Older Person with Multiple Morbidities

Dr Toh shares that SATA CommHealth has initiated programs such as the SATA "Doctors on Wheels" and the Home Care Service with the elderly infirm in mind. Patients utilising the Home Care Service are usually bedbound from conditions such as stroke, whereas patients accessing "Doctors on Wheels" are at least mobile enough to come to the Senior Activity Centre but may not be able to cope with taking public transport to the polyclinic or GP. The service attends to about 15 to 18 patients in half a day. Apart from the usual suite of lifestyle diseases such as diabetes, osteoarthritis and mental well-being are particular concerns.

Dr. K Thomas Abraham (CEO), Dr. Toh Khai San and the elderly patients of SATA CommHealth Doctors on Wheels. Dr Abraham is inviting you to "come join us. We need more doctors to care for the elderly in the community!"

In research done using focus group interviews with primary care physicians in the United States of America and published in the Archives of Internal Medicine in 2011, Fried and his colleagues noted five challenges faced by primary care clinicians taking care of elderly patients with multiple morbidities. The first was the concern about patient's ability to adhere to complex medical regimes stemming from a consideration of the patient's cognition and availability of social support. The second was the unrealistic expectations of patients, or more commonly, the patient's family members; although the patients and their family members have information, they may not be able to assimilate it and grasp the risks and benefits of interventions in patient care. Thirdly, the clinicians found it a challenge to navigate the uncharted waters of managing elderly patients with multiple morbidities relying on guidelines that were created to help decision making in treating specific diseases in isolation. Fourthly, the clinicians found that there was a fragmentation of care for patients who received care from several specialists for their multiple conditions. Finally, one of the clinicians pointed out that it was not uncommon for an elderly person who is depressed with multiple chronic illnesses, in pain, and wants to quit smoking to turn up at the clinic. Under pressing

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circumstances though, the clinician would be expected to manage the patient in 15 minutes when what they really required was at least 45 minutes.

The Bigger Landscape

Mobile clinics in Singapore such as the SATA "Doctors on Wheels" service help to address the issue of accessibility of healthcare for the elderly frail person living with suboptimal support. Although the return on investment for the healthcare system as a whole is significant for the mobile clinic, the service provider requires funding from the government and other donors to subsidise this mode of healthcare which in itself is relatively costly. The costing of mobile clinics, home care services and GP clinics in taking care of the elderly with multiple morbidities in the Singapore context should be further assessed.

Encouraging General Practitioners in Singapore to extend their care for elderly patients with multiple morbidities can begin with focus group discussions and addressing the challenges surfaced as well as those listed above and in other international research. Other than the polyclinic practice, the CHAS program and the Community Health Centres in Singapore, which are themselves examples of excellent initiatives in the right direction, more needs to be done in crossing the divide between hospital and GP practice and to provide the extra funding when General Practitioners spend that 45 minutes to care for the elderly patient with multiple morbidities presenting with very complex needs. The healthcare and social support system has to facilitate the primary care physician's training, attachment, networking and keeping up to date with the medical knowledge and skills, as well as community resources required to enhance their care of the growing number of aged persons in Singapore.

The SATA CommHealth Doctors on Wheels team and their van - "Always so happy to see them rolling in."
Images courtesy of SATA

CM

PICTURE QUIZ #1

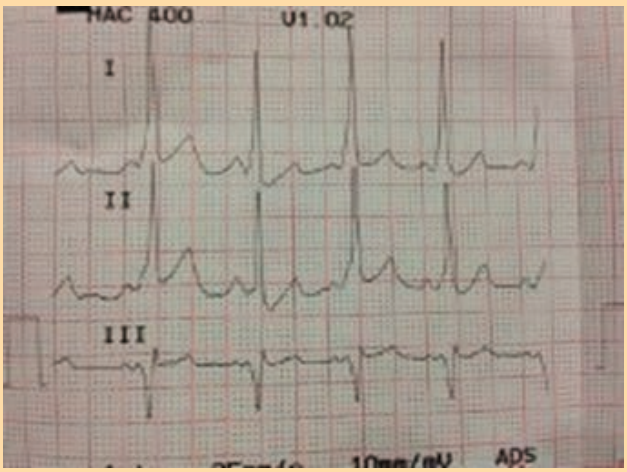
Case contributed by Dr Nicholas Foo Siang Sern, Editorial Board Member

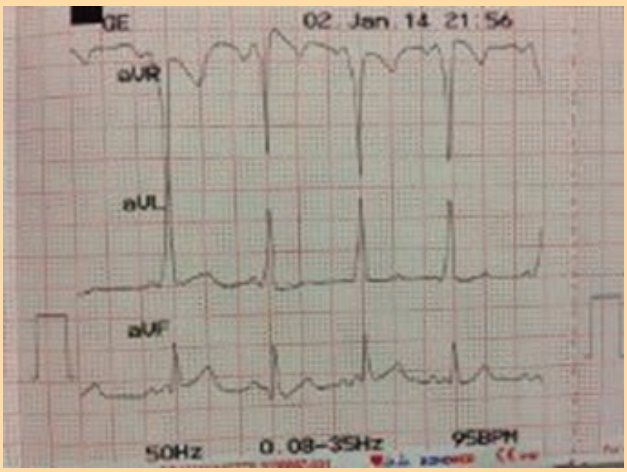
A 13-year-old boy comes with the complaint of chest pain and breathlessness. He has been having episodes which last for 2 to 3 hours that resolve spontaneously before recurring again.

An ECG is performed.

QUESTION

What does the ECG show?





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ADVANCE CARE PLANNING – AHEAD OF OUR TIME OR NEVER TOO LATE

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

Throughout known history, mankind has constantly sought to navigate the courses of nature and secure some certainty amidst its unpredictability. Where circumvention is unattainable, mitigation is desired. Intense devising and planning to lessen the influence of uncertainties in human existence permeate everything from financial markets and property prices to bus schedules and weather forecast. Strangely enough, however, where the one aspect of life – mortality – is most certain and oftentimes predictable, many do not plan ahead at all.

Dying is not necessarily a quick process of succumbing to contagion or trauma, and many endure the travail of a protracted loss of mental and physical integrity before death. It is not too dogmatic to proposition planning ahead for one's eventual demise.

Understanding Advance Care Planning

Indeed, advance care planning (ACP) has an indisputable role in health and social care today. ACP is based on the premise that one ought to have the ability and space to make conscious and informed decisions regarding care and treatment options at the end of one's life, even if one should lapse into a state wherein active decision making is rendered impossible. But the idea of starting a conversation on planning for the end of life, although logically resonant with many, might not be accepted readily. There appears to be a pervasive myth that such conversations distress the person in question and reticence can often be encountered among care providers who also hold concerns over legal and accountability issues.

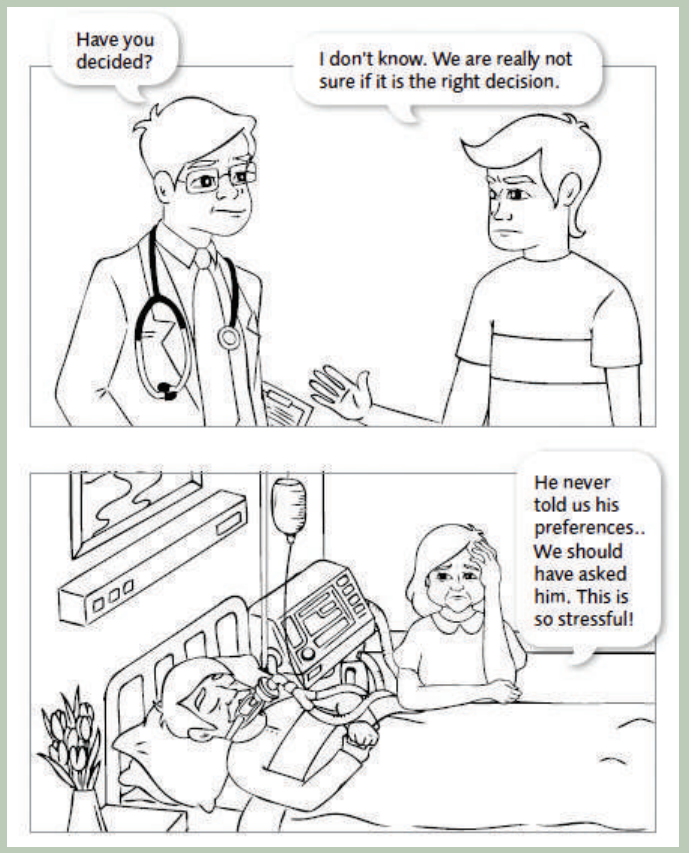
However, it is not unseemly to opine that ACP is more an art than a science, and we really cannot whitewash the challenges faced in applying ACP as a standard of care in our healthcare systems. Experiences from across the developed world, notably the United Kingdom, Canada, Australia and the United States suggest that institution, practitioner and community acceptance, both emotional and rational, are essential in ensuring that ACP resonates with good care. Interestingly, the public in general has been found to recognise and accept the benefits of ACP, especially the incorporeal such as having choices honoured, pre-empting conflicts in decision-making, reducing stress on proxy decision makers and opening the channels of communication among various stakeholders. Nonetheless, they all do need a fair bit of persuasion to talk about death and dying per se.

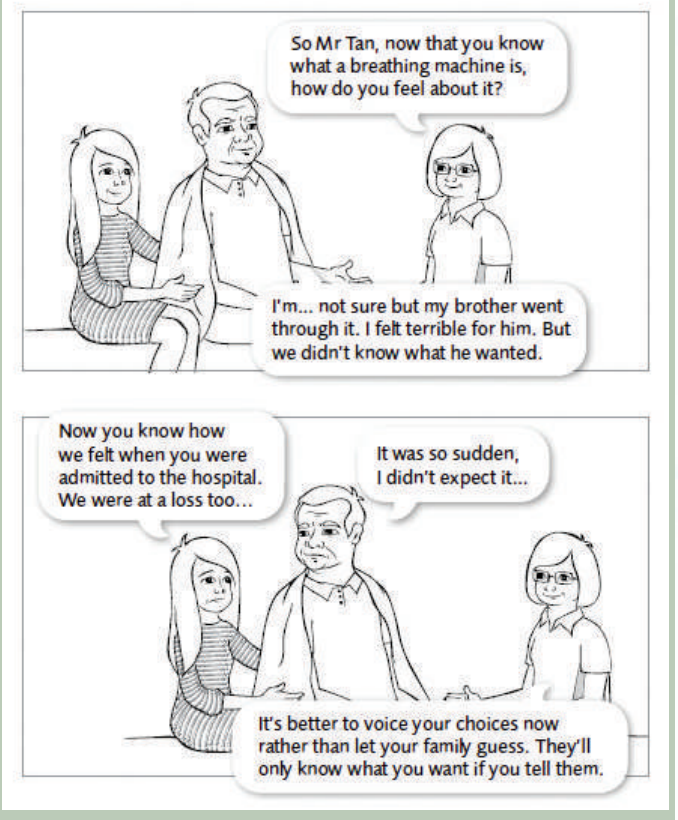
Changing Societal Mind-sets

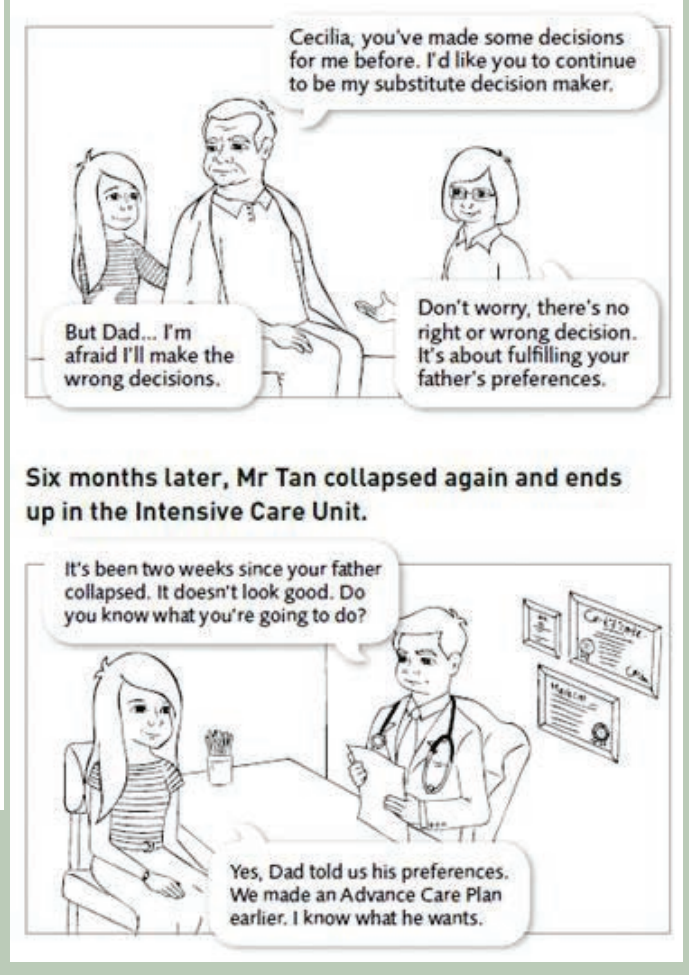
And translating ideals into practice is not without particular challenges. Besides dealing with the discomfort of talking about death and dying, concern over a covert agenda for euthanasia among faith-based advocates and apprehension towards a possibly unspoken intent to keep healthcare costs in check cannot be undermined. Here in Singapore (and likely in other Asian settings), Confucian thought and ethics exhort an almost heroic extreme of filial piety that tends towards doing whatever is physically possible to preserve longevity. This risks misjudgement of that which is truly needful and desired, and individuals' needs and wants are more often than not buried in the overzealous intentions of their loved ones. These prevailing sentiments potentially create a minefield of difficulties in propositioning ACP.

Entrenching ACP and end of life care into care services for those suffering long term debilitation and potentially life-threatening disease, therefore, necessitates a multi-dimensional approach. On the one hand, public education needs to focus on encouraging and normalising conversations over end of life issues and the need to make informed choices for care; on the other hand, care provider engagement needs to be pitched from a quality care standpoint, which tends to stir the interest and passion of committed professionals. To top it off, the use of information technology will bring about accessibility, universality and portability for ACP.

In spite of these challenges, the evidence for ACP is gaining ground. In the study of ACP programmes around the world, there is overwhelming consensus that ACP makes a palpable difference to the way people receive care at the end of life. In the United Kingdom, the Gold Standards Framework empowers and supports GPs in identifying, engaging and planning ahead for their patients who are likely to be in their final year of life; this puts in place multifaceted endeavours to ensure that the patients receive timely access to various forms of care and remain well supported throughout their disease trajectory. The efforts of the Tzu Chi Foundation in Taiwan are also a notable example. Leveraging on its Buddhist (and oftentimes universal) principles delivered through cross-cultural and multi-sector service contact points, it has managed to de-stigmatise end-of-life conversations through the use of community advocacy,







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(continued from Page 21: Advance Care Planning — Ahead of Our Time or Never too Late)

comprehensive and targeted media outreach and the support of religious and civic leadership. This translates into better family appreciation and acceptance of treatment limits and builds a healthy respect for death and dying as a phase of life that need not be approached with trepidation, thereby reducing the stress of confronting death for the individual, the family and the care provider alike.

Making ACP Part of Standard Care

Particularly in care for the elderly, who are so vulnerable to the trauma of poor coordination, over-processing and inadequate handoffs in health and social services, having detailed and systematic care objectives in place that are readily available across the care spectrum can do much in avoiding the transitional pitfalls inherently present in many of our care systems. This is the reason why Singapore has taken its first steps in designing a national advance care planning system that can cut across institutional lines and be extended into the community care sector. Branded as Living Matters©, this system of ACP conversation and documentation has been adapted from the Respecting Choices© programme from Wisconsin, USA. The Agency for Integrated Care has been tasked with its phased implementation across the health and social care continuum beginning in 2011.

Living Matters© is comprehensively structured to approach the topic of ACP according to the needs of the person in question, and so its various components of deliberation are suitably pitched according to one's state of health. Its language is as far as possible non-technical and concise, yet specific enough to help the layman understand health and healthcare concepts. The formal process is facilitated by suitably trained and certified persons who are not necessarily clinical professionals. To date, more than a thousand facilitators have been trained. There are also plans to employ the use of community advocates in public outreach and education over the next few years.

Designing a universal information technology system to support the documentation of ACP has been established since the very beginning of its strategic deliberations. This will undoubtedly go a long way in enabling standardisation, supporting decisions and ensuring information portability and accessibility to care providers across the health and social continuum. With the added advantage of future interface with our ambitious National Electronic Health Record system, ACP will literally be at the fingertip of providers across care settings. In the years ahead, when health literacy and personal health management are better inculcated in the public, ACP will no doubt lend invaluable support to patient autonomy and critical healthcare decision making.

Conclusion

Yet, ACP implementation in Singapore remains fraught with potential hurdles. It is certainly not a straightforward "sell" to both consumers and providers. It takes as much effort in the realm of the heart as it does of the head. But we dare push ahead in this endeavour, because we believe it is intrinsically a good thing. To quote the late Mr Steve Jobs – [We're gambling on our vision, and we would rather do that than make "me, too" products. Let some other companies do that. For us, it's always the next dream]. First – the vision.

For more information on Living Matters©, one may refer to the website **www.livingmatters.sg**

Images and illustrations courtesy of Agency for Integrated Care (AIC)

CM

Family Practice Skills Course #57

Infectious Disease

Sat - Sun, 29 - 30 March 2014
2.00pm - 5.45pm

College of Medicine Building, Auditorium (Level 2)
16 College Road, Singapore 169854

TOPICS
Unit 1: Emerging Infections and Role of Family Physician
Unit 2: Update on Antimicrobial Resistance
Unit 3: Childhood Vaccination and Childhood Exanthem
Unit 4: Adult Vaccination
Unit 5: Travel Medicine in Primary Care
Unit 6: Infection Control in Office-based Practices

WORKSHOPS
Day 1: Motivational Interviewing
- Key Ideas in Facilitating Behaviour Change
- Skills Application

Day 2: Case Studies

SPEAKERS
A/Prof Goh Lee Gan
Dr Hsu Li Yang
Dr Lee Bee Wah
Dr Victor Loh
Dr Wong Sin Yew
A/Prof Helen Oh
Dr Wong Chen Seong

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, 29 March 2014 (2.00pm - 4.00pm)
Seminar 2 • Unit 4 - 6: Sun, 30 March 2014 (2.00pm - 4.00pm)

■ **WORKSHOPS** (1 Core FM CME point per workshop)
Day 1: Sat, 29 March 2014 (4.30pm - 5.45pm)
Day 2: Sun, 30 March 2014 (4.30pm - 5.30pm)

* Registration is on first-come-first-served basis.
Seats are limited.
Please register by 24 March 2014 to avoid disappointment.

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

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

Health Promotion Board

REGISTRATION

FREE REGISTRATION for College Members!

Infectious Disease
Please tick (✓) the appropriate boxes

	College Member	Non Member
Seminar 1 (Sat)	Registration is closed	
Seminar 2 (Sun)		
Workshops (Sat-Sun)		
Distance Learning (MCQ Assessment)	~~$42.80~~ FREE	☐ $42.80
	TOTAL	

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

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

Cheque number: _____

Signature: _____

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

Name: Dr _____

MCR No: _____ NRIC No: _____

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

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

_____

_____

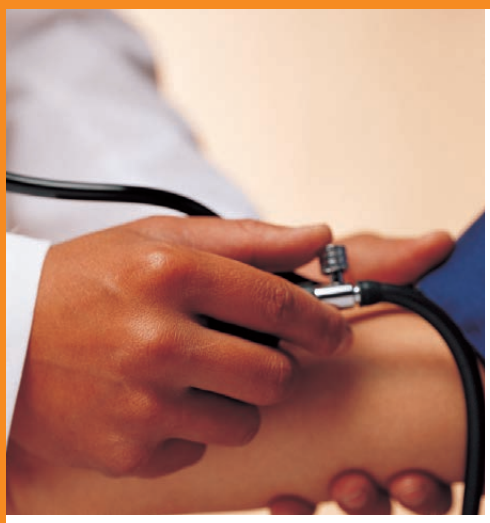
_____ E-mail: _____

Tel: _____ Fax: _____

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

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

Or fax your registration form to: 6222 0204



Family Practice Skills Course #58

Improving Healthcare for Persons with Disabilities

Sat - Sun, 26 - 27 April 2014
2.00pm - 5.30pm

Health Promotion Board, Auditorium (Level 7)
3 Second Hospital Avenue, Singapore 168937

TOPICS

Unit 1: Epidemiology and Overview of Disability
Unit 2: Healthcare Touchpoints
Unit 3: The Caregiver
Unit 4: Children with Developmental Delays
Unit 5: Persons with Intellectual Disability and Autism Spectrum Disorder
Unit 6: Persons with Physical, Sensory and Multiple Disabilities

WORKSHOPS

Day 1: Case Study Discussion
Day 2: Assessment and Communication Skills

SPEAKERS

A/Prof Goh Lee Gan
Ms Anita Ho
Dr Sylvia Choo
Dr Wei Ker-Chiah
Dr Ng Yee Sien
Dr Balbir Singh
Mr Manmohan Singh

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, 26 April 2014 (2.00pm - 4.00pm)
Seminar 2 • Unit 4 - 6: Sun, 27 April 2014 (2.00pm - 4.00pm)

■ **WORKSHOPS** (1 Core FM CME point per workshop)
Day 1: Sat, 26 April 2014 (4.30pm - 5.30pm)
Day 2: Sun, 27 April 2014 (4.30pm - 5.30pm)

* Registration is on first-come-first-served basis.
Seats are limited.
Please register by 21 April 2014 to avoid disappointment.

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

This Family Practice Skills Course is jointly organised by the **College of Family Physicians Singapore** and **Ministry of Social and Family Development (MSF)**

MSF
MINISTRY OF SOCIAL AND FAMILY DEVELOPMENT

REGISTRATION

Improving Healthcare for Persons with Disabilities
Please tick (✓) the appropriate boxes

FREE REGISTRATION for College Members!

	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 (MCQ Assessment)	~~$42.80~~ FREE	☐ $42.80
	TOTAL	

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

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

Cheque number: _____

Signature: _____

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

Name: Dr _____

MCR No: _____ NRIC No: _____

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

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

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_____ E-mail: _____

Tel: _____ Fax: _____

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

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

Or fax your registration form to: 6222 0204