THE
College Mirror
VOL. 40 NO. 3 SEPTEMBER 2014
A Publication of College of Family Physicians Singapore

CFPS COMMENCEMENT CEREMONY AND AGM 2014

by Dr Low Sher Guan Luke, FCFP(S), Editor (Team A)

12th July 2014 was a date that Dr Aw Jun Jie looked forward to. It was a date that I looked forward to as well. Jun Jie and I entered medical school together in year 2000. After graduation, our different practice sites did not grant us opportunities to meet until 2011 when he signed up for Graduate Diploma of Family Medicine (GDFM). After working hard for 2 years, he passed his GDFM and treated me to a thank-you dinner. I vaguely recalled urging him on to further his training and take on the Masters of Medicine (Family Medicine) [MMed (FM)] training. Then in June 2014, I received a pleasant surprise when I saw that he signed up for the MMed (FM). It's times like these when we trainers feel that our efforts have paid off, seeing our trainees go further after our encouragement. As a fan of Nelson Mandela, I will like to share this quote "After climbing a great hill, one only finds that there are many more hills to climb". This is the same with learning… it never stops, regardless of age. When I did my MMed (FM) at the age of 30, my friends Soo Kiang and Suraj did theirs in their 40s and 50s respectively. All of us went further to complete the fellowship program [FCFP(S)] as a group. This is a story which I share liberally, even at my workplace, to encourage many family doctors to take that first step in their professional development, even when they are in their 50s. As our population ages and becomes afflicted with multi-morbidities, we need to level up our knowledge and skills to better cope with this silver tsunami, regardless of the setting we practice.

Master of Ceremonies Dr Low Sher Guan Luke

Commencement Ceremony

When I stepped up to the podium, I was greeted with the fresh, keen and earnest faces of trainees, all ready to embark on a new phase of their training and professional development; the proud faces of trainers and supervisors all ready to impart their knowledge and share their experiences – positively influencing the aspiring trainees. And there were trainees of all ages. This stems from the uniqueness of family medicine practitioners and our training system. While most specialists are expected to complete their professional training while still in the restructured hospital system – before they can be accredited as specialists – family doctors can choose to complete their training while still in the restructured system (such as young turks like me). Alternatively, they can enrol in College of Family Physicians Singapore's various training programmes even after they had left the system – regardless of age (such as Suraj). Learning and training with these motivated individuals, I was convinced not to have any doubts about myself.

This year, we have 114 trainees who signed up for GDFM, 11 for MMed (FM) and 20 for FCFP(S). That is a total of 145 doctors who are keen to up their professional development!

(continued on Page 4)

IN THIS ISSUE:

(continued from Page 1: CFPS Commencement Ceremony and AGM 2014)

Next, College President Associate Professor Lee Kheng Hock was invited to address the audience. I knew A/Prof Lee when I was a Medical Officer (MO) during a short tour of duty in SGH FMCC. When I first entered his department, I had my doubts on starting family medicine in a hospital. After working under his team (comprising of Matthew and Farhad), I finally saw what he was trying to achieve. As he had mentioned many times, proper discharge planning into the community starts from the hospital. That was why he was there – at ground zero. I saw the broad scope of family medicine through the hospital work A/Prof Lee had done; work that most would feel uncomfortable or even shun. He has been an inspirational figure and I have grown to respect him over the years (though I have never openly admitted). At the commencement, he gave an inspiring talk and even shared about the map and the compass that are necessary for navigating the tough training course – laid ahead for every keen family doctor and physician!

College President A/Prof Lee Kheng Hock (left) and Guest of Honour Prof Lim Shih Hui

The guest of honour, Professor Lim Shih Hui gave his address as we eagerly awaited the good news – family medicine has become a chapter in the Academy of Medicine Singapore (AMS)! AMS had scrutinised and recognised the rigor of our training programmes and recognised family medicine as a specialty. This is a testament to the standards of training that College is trying to uphold over the years.

Censor-in-chief Associate Professor Tan Boon Yeow went on to describe the various training programmes that cater to family doctors and physicians at every stage of their professional development, from the novice to the experts and masters. The training programmes provided are unique because there is no age limit to programme entry. College will not leave any family doctor untrained, as long as he is willing to be trained. Through the years, we have stayed through to this promise.

Censor-in-chief A/Prof Tan Boon Yeow

The ceremony concluded with the introduction of the course trainers to the trainees, before proceeding to the respective venues for a detailed briefing; embarking on a whole new learning journey.

The EXCO (from left) A/Prof Tan Boon Yeow, Dr Tham Tat Yean, A/Prof Lee Kheng Hock and Dr Tan Tze Lee addressing AGM attendees.

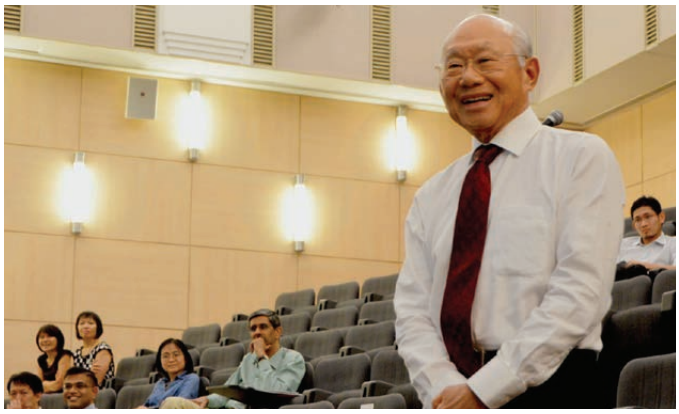
AGM

The AGM had 107 attendees, and started with a run through of the annual report. The EXCO announced the healthy state of the College, be it in its financials or training efforts. For the most part, this was a blur for me as it was uneventful. No objections from the members was indeed good news.

Prof Cheong Pak Yean then talked about family medicine becoming a chapter in AMS, and went into details on the requirements to be a fellow of AMS. Much to our amusement, there were various hearty discussions on the details, including the term to describe these fellows. There was a strong support from the college fellows (over 70 of them) to form this chapter, which was very encouraging indeed. The AGM concluded with a strong sense of achievement.

Who would have thought that this was possible, until now? Again, allow me to share another favorite quote from Nelson Mandela - "It always seems impossible until it is done". Prior to this chapter formation, there were many in our fraternity who told me that it is impossible for family medicine to be a specialty in AMS. Back then, I was disappointed at how these family doctors can think so little of our discipline. But now, we can proudly tell them, "It is done."

CM



Dr Lee Suan Yew at the AGM

Images courtesy of Dr Ng Chee Lian Lawrence

EDITOR'S WORDS

by Dr See Toh Kwok Yee, MCFP(S), Editor

This is another bumper issue!

We have a collection of good assorted articles penned by my indefatigable editorial board colleagues and many valuable contributions from our College friends.

In fact, we have more articles than the pages allowed for. Consequently, some of the submitted write-ups have to be held back for release in future issues. We apologise to these kind contributors and wish to state categorically that this is purely due to space constraints and expediency of the issue at hand.

Even this editor himself was cautioned not to exceed one page in this introduction!

The issue kicks off with the report on our CFPS Commencement ceremony and AGM 2014 by Dr. Luke Low.

As MC for the event Dr. Low discounted age as a hindrance to further training in Family Medicine. He especially noted that there are in place training programmes in the College for family doctors of any level, age and experience to participate in.

Perhaps, the crowning point of the ceremony was when guest of honour Professor Lim Shih Hui announced the formation of the Family Medicine Chapter in the Academy of Medicine Singapore. And naturally, this milestone development was the highlight of the AGM that followed which witnessed an overwhelming support from the College Fellows present for it.

And over to Japan, guest contributor, Dr. Kenichi Sato, reported on the 5th Japan Primary Care Association (JPCA) Conference in Okayama, which was attended by a Singapore delegation led by Prof. Lee Kheng Hock.

In the interesting article you will read about a clinic that has been in the family for three generations, routine home care visits which are covered by insurance, high tech medical record systems and highlights from the conference.

A brochure for the next conference in 2015 is attached for our interested readers.

We take the opportunity to congratulate our very own Dr. Wong Tien Hua who was elected to the chair of MASEAN. Dr. Wong spoke about his role as Chairman of this prestigious organization and the hard work and sacrifices it entailed in the interview.

Dr. Wong Sin Yew, an Infectious Disease Physician that needs little introduction, contributed another must-read to this issue. Dr. Wong's practice is the first private specialist clinic in Singapore to receive accreditation for ambulatory care by Joint Commission International.

The article shares with the reader the clinic's experience and the processes required to achieve accreditation. Hopefully, one of us may take up the challenge to be the first JCI accredited Family Medicine clinic!

In the education section, we have a very instructional Q&A with Prof. Toh Han Chong, Deputy Director of National Cancer Centre. Prof. Toh talks about the values and limitations of cancer screenings, the role of Family Doctors in cancer prevention and collaboration between oncologists and FPs, among other lessons.

Another learning piece is from Prof. Saminathan Suresh Nathan, a regular contributor, who has provided an article on osteoarthritis, an affliction every FP and GP must surely encounter everyday.

We have included a book review by Dr. Soh Soon Beng. The book entitled "Feeling Good" is about the use of Cognitive Behaviour Therapy to treat mood disorders.

A photo quiz that juxtapositions two skin lesions commonly encountered in our practice is also showcased.

I hope you will enjoy reading this issue as much as we have producing it!

CM

September 2014
VOL 40(3)

TRUE NORTH AND LEADERSHIP

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

In the ancient days, there was a king who ruled over a weak kingdom in troubled times. There was constant infighting among the tribes that make up the kingdom and there were frequent incursions on its territories by powerful neighbors who felt that this kingdom had no right to exist. The king and his wise man vexed day and night thinking of ways to protect the kingdom.

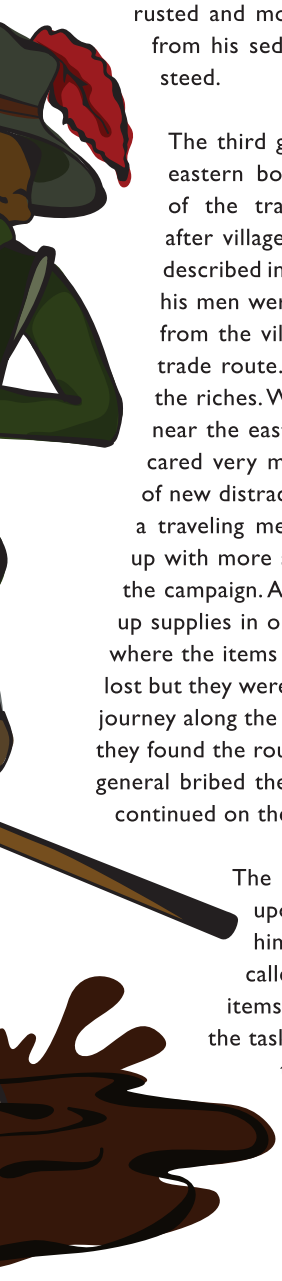
One day, a caravan of merchants from the East passed through the kingdom and offered to sell three items to the king, ensuring victory in warfare. The first was a compass that will always point to the true north. In those days, navigation through the vast unchartered territories was a hit and miss affair. In the day time the marching army was guided by the sun and at night they depended on the stars. On a cloudy night, movement was not possible at all. The next item was a map which was the best and most accurate in the ancient world. In those days, maps look like sketches made by pre-school children. Details were skimpy and missing bits were just conveniently embellished or dismissed as places inhabited by trolls and dragons. This map, however, was state of the art at that time. It had depictions of rivers, roads and mountains. The third item was a book of travels, a detailed journal recorded by all the traveling caravans that traversed the land. Every village and town was described in great detail including information about their local customs and the important members of the various communities. Every well that provided drinking water and every trail no matter how small were carefully described.

The king was delighted and summoned the three best generals in the kingdom. The first was the bravest, the second was the smartest and third was the most innovative. He gave one of the precious items to each general and charged them to secure the far borders of the kingdom. Anxious that they may not be diligent in their task, he attached a royal commissar to each of the three armies who will make monthly reports back to the capital.

The first general with the compass that point to the true north, set forth immediately marching his man day and night northwards. He was charged with pacifying the northern borders and there was nothing simpler than heading north with this compass. That was until he marched his man right into a swamp. He extricated his mud-drenched soldiers and ordered them to deviate and walk around the swamp before heading north again. He marched his man in double quick time to make up for the delay. That was until the army found itself at the foot of a mountain range which could not be by-passed. He ordered his man to abandon their supplies and heavy equipment and proceeded to climb over the mountain range. They succeeded after many grueling days. On the other side of the mountain , the path was easy but the exhausted men had no more supplies. They approached the nearby villages for help but the poor farmers who had little to feed themselves refused. Angered by their lack of appreciation of the hardship that he had endured, he ordered his man to plunder the villages and took whatever food and livestock that they needed. Replenished, they continued on their march. Next, they came upon on a prosperous town which had luxuries that that they had never seen before. Emboldened by their previous plundering of the villages, his men looted the town and delivered to the general the lion's share of the gold and treasures. Embarrassed by his lack of progress and tempted by the riches that were readily available, the general decided to abandon his mission. He executed the commissar and rebelled. He declared himself king of the provinces in the north and pillaged the land as he pleases.

The second general with the map marched his man with incredible speed along the roads that were accurately depicted in the map. They soon reached a stream shown on the map. The unusually heavy rains had transformed the small stream into a raging torrent. He ordered a bridge to be built, but his engineers did not have enough timber. He dispatched a detachment to a nearby forest shown on

the map. His men found no suitable trees as the forest had been cleared by the locals to create more farm land. Frustrated, he sent his scouts far and wide to find the nearest forest. The delay stretched into the months. After the bridge was built, he marched on until he found his path blocked by a land-slide, obliterating the road ahead. The locals led his men to a new road which started out as forest trail to bypass the landslide, but which had since transformed into a paved road with towns and villages sprouting up along its path. Frustrated by the lack of correlation between the map and the ground, he decided to improve on the map. As time goes on, he became enchanted with the task of updating his map. He sent his soldiers far and wide to chart the changes and report back to him. His interest became an obsession. He assembled the best map makers from the area and settled in one of the towns to work on his map. The royal commissar could not stop pestering him; the general decided to lock him in jail. He found a good forger of the commissar and continued to send fake reports of his progress to the king. Months go by, the weapons rusted and most of the men deserted. The general grew fat from his sedentary lifestyle and could not even mount his steed.



The third general with the book of travels set off to the eastern borders, following the description of the route of the traveling merchants. His armies passed village after village and town after town that were all accurately described in the journals. It was a fascinating journey. He and his men were well served with supplies and entertainment from the villages and towns that had prospered along the trade route. It was a long meandering route that followed the riches. Weeks and months passed, he was still nowhere near the eastern borders. Neither the general nor his men cared very much because each day was interesting and full of new distractions. He began to appreciate the joys of being a traveling merchant. The general found that he had ended up with more supplies and gold than when he first started in the campaign. Along the way, he had learned to trade – buying up supplies in one area and selling them for a profit in an area where the items were a scarcity. The general and his army were lost but they were rich and happy and continued blissfully in their journey along the trade routes. In fact they were happy each time they found the route taking them further away from the east. The general bribed the royal commissar to collude with him as they continued on their never ending journey.

The seasons came and went and soon it dawned upon the king that all the three generals had failed him. He bought a new set of the three items and called for his fourth general. He gave all three items to the fourth general and charged him with the task of securing the borders and bringing back the three renegade generals.

The fourth general headed north and easily avoided the swamp that was shown on the map. The book of travels revealed to him a wood cutters' trail and he crossed the mountain range with little effort. Soon he found the renegade first general and defeated him after a fierce battle. The population of the north was overjoyed and readily gave him fresh supplies and filled his ranks with fresh volunteers. He headed north to meet the enemies of the kingdom. With his three items, he easily outmaneuvered the enemy and completely wiped out the opposing army. The northern border was secured for decades after the decisive battle.

The second general was easily found as he had developed a reputation as a map maker. The small rebel force led by the flabby second general was no match for the crack troops of the fourth general. He soon found himself in chains and traveling in the same prisoners' cart as the first general.

The third general did not prepare for battle. He had grown immensely wealthy. He was confident that he can bribe the fourth general with a share of his incredible riches. He was surprised when the fourth general spurned his offer and bound him up in chains. Without difficulty, the fourth general defeated the armies in the east and soon returned in victory to the capital with his three prisoners.

Everyone expected a public execution as the wise king had a reputation of being harsh and strict with those who failed him. The three hapless generals were speechless when the king unbound them and gave them the royal pardon. The king said that the fault was his as he had set them up for failure. The compass was useless on its own as it does not warn the user of the barriers ahead. The map was nothing more than an abstract representation of the real ground which changes with time and events. The book of travels enchants with the description of the ground, but takes you away from your objective if you do not have a compass to show you the bearing. The fourth general succeeded because he used all three items together to navigate. Most important of all, he had a fourth item which the other three generals did not have. The king gave him a **MAP** of the heart. The king had sent him for training as a warrior since he was very young. The fourth general was in constant pursuit of **Mastery** in the art of war. The king gave him **Autonomy** and did not burden him with a royal commissar that interfered with his mission. Most important of all, the king was confident of his **Purpose**. The king had rescued him as an orphan in one of the villages devastated by the invading armies. His parents and siblings were all killed by the invading armies. His overwhelming purpose in life was to be a good soldier who will protect the people against the invaders.

Like most allegorical tales you can read more into the story. The most important thing I learned from this story is that, leaders must know more than what is true north. Deviations from the intended path are inevitable, but it must be done for the right purpose which is to reach the final destination eventually. Most sailors will tell you that the fastest route between two points is not a straight line. It depends on how the wind blows and how you trim your sails. Have a pleasant trip ☺

CM

September 2014
VOL 40(3)

A REVIEW OF NON-SURGICAL OPTIONS IN OSTEOARTHRITIS - *Part 1*

by Saminathan Suresh Nathan, MBBS, MMed, FRCS,FSMB, FAMS (Orthopaedics)
Associate Professor in Orthopaedics, National University of Singapore
Director and Senior Orthopaedic Consultant
Limb Salvage and Revision Arthroplasty Surgery
Mount Elizabeth Medical Centre
www.limbsalvagesurgery.com

The therapeutic options in osteoarthritis can be divided into medical and surgical. Medical options refer to therapies requiring non-surgical modalities like drugs and the injectibles. Arthritis is a group of joint diseases that is either caused by **active inflammation** (the rheumatic conditions) or by **mechanical overload**. In this series of reviews the knee joint is chosen for discussion but the therapeutic recommendations entailed can be equally applied in principle to the other joints.

Mechanical overload

These patients usually have a history of injury to the joint and the ensuing progressive degeneration eventually results in arthritis. Commonest among these is the primary group where (presumably) owing to the shape of the body, weight is unevenly distributed through the joint resulting in its wear and tear. Similarly, following trauma, there may be uneven weight distribution in the knee due to fractures or loss of cartilage. The same effect can be seen in post severe infections, tumors and congenital abnormal joints but these are much rarer as a group. Similarly, this can also be a complication and sequelae of previously active rheumatic conditions.

The pharmacological agents for this disease are the painkillers and over the counter supplements. Weight loss can be a very useful adjunct therapy and the patient should aim to lose about 5 kg over 6 months. Surgical procedures known as barometric procedures may be considered in the morbidly obese.

Painkillers

In the order of increasing effectiveness and side effects, the painkillers are

1. Acetaminophen

Commonly known as tylenol, panadol or paracetamol, this is a great starter drug. It is weak but can be given in divided doses up to 4 grams a day. It is often available in combined preparations where side effects are attributable to the added drug. The major side effect is hepatotoxicity which can happen in acute overdose.

2. Opiates

They are drugs that work like morphine and include codeine (combined with acetaminophen in panadeine), tramadol, fentanyl and pethidine. Common side effects are nausea, dizziness and constipation.

3. NSAIDS

They are highly effective painkillers and include aspirin, brufen, ponstan, indocid, voltaren, synflex. Unfortunately they also have the worst of the side effects namely gastric ulceration, renal toxicity and cardiovascular events. To reduce gastric ulceration, acid-reducing drugs are sometimes prescibed. This can reduce gastric ulceration but not duodenal ulceration and can have their own side effects and can be expensive in the long run. The evidence supports the use of PPIs best in preventing gastroduodenal ulceration.

The Cox-2 inhibitors have less gastrointestinal side effects but more serious vascular and renal side-effects. In general, if a patient has been taking these drugs for up to a year, the side effects of drugs would be worse than surgery.

Over-the-counter agents

1. Glucosamine

Glucosamine is a simple compound merging glucose and amine. It is absorbed whole and therefore effective as is. It is a building block of cartilage. The original studies quoting Viartril-S showed impressive results in regenerating cartilage as seen on MRI. This resulted in an explosion of generic preparations in this lucrative market. Unfortunately, many have since been discovered to be suboptimal due to either ineffective preparations or reduced concentration of effective drug per tablet. Moreover, most recent studies do not bear it out to be an effective agent. The cost of treatment with this OTC agent can be high. It is estimated that the cost of three years of continuous use of glucosamine is equivalent to that of a knee replacement prosthesis. While present guidelines do not support its use, it would seem reasonable to try it for 6 months given the good safety profile. After which, the drug probably behaves like a placebo. The literature is conflicting on its recommendations but a Cochrane review has found that Rotta preparations and Crystalline forms of glucosamine have better effect. Transdermal preparations are not supported in the literature.

2. Chondroitin

Chondroitin sulphate is often sold in combined preparations with glucosamine. It is however a large molecule and is broken down in the gastrointestinal tract to small sugars. It therefore does not work as a 'building block of cartilage' and not recommended in the literature.

3. Collagen

Collagen marketed under various preparations has also recently been advocated in osteoarthritis treatment as a building block of cartilage. The same reservations exist; it is a protein and therefore is subjected to normal physiological breakdown to amines. Nevertheless, there is certainly no harm in its use and may even be beneficial to the skin and soft tissue.

4. Others

This group of analgesics derive from the herbal preparations of ginger and chilli (capsacin). They are reasonably safe and effective but their use is not evidence based.

The **Injectible agents** will be discussed in the next issue.

CM

FROM "SHOULD HAVE" TO "MUST HAVE": CREATING A HIGHLY RELIABLE MEDICAL PRACTICE

by Dr Wong Sin Yew, Dr Lam Mun San and Ms Angela Wong

Dr Wong Sin Yew *is an infectious disease physician who has been in private practice for the past 15years. Together with Dr Lam Mun San and Angela Wong, they are building their group practice into an organization which focuses on patient safety and quality care. Dr Wong's clinic at Gleneagles Medical Centre recently received accreditation for ambulatory care by Joint Commission International. It is the first private specialist clinic in Singapore to receive this accreditation.*

In a separate article for SMA News, we had tried to answer the question of why we had considered Joint Commissions International (JCI) accreditation for our clinics. We recognize that our patients often have complicated problems and that provision of health care to them is complex. In this related article, we discuss the lessons that we had learnt as we sought to improve the delivery of healthcare and to better implement our care processes for our patients. An important aspect of what we were trying to achieve was the sustainable practice that goes on a day to day basis rather than a "last minute" focus once every 3 years to achieve re-accreditation.

In essence, accreditation usually requires you to do the following

a. Have written processes
b. Document in writing (or electronically) all activities – clinical consultations, all communications (verbal, electronic), procedures and dispensing
c. Measure these activities and their outcomes
d. Meet the standards set forth by the accreditation body

When do you really need to start writing down your processes and the standards that you want to achieve?

Perhaps, you can start by considering the following and asking yourself some "uncomfortable" questions

a. We often think that our verbal instructions are clear and specific enough. Are your internal unwritten processes going to continue if any of your staff cease employment at your clinic?
b. You remain responsible for all the (often complex) activities that go in the clinic but do you control the situation completely and how much do you depend on your staff to manage these activities? In all instances, you must appreciate that you continue to retain overall responsibility and may be susceptible to "collateral damage" if any unsafe practice is done by your staff.
c. Will the operations at your clinic be significantly disrupted if one of your staff goes on prolonged leave?
d. Are you highly dependant on one of your staff to ensure the smooth running of your clinic operations? If so, do you think that you may be "held ransom" by this staff member?

If you have answered yes to any of the questions, please think about writing down your processes and read on.

All the above appears troublesome and it may have been a nagging thought on your mind all along but you may not really want to confront it! Needless to say, documentation imposes a significant responsibility and burden to the clinic staff which includes everyone from clinic assistants, nurses to the doctors themselves. To ensure that the documentation required in the processes is complied with, it also requires regular reviews and audits of such activities in the clinic. It involves a huge mindset change in which seemingly simple tasks that "should be and expected to be done" are now escalated to "must be done". Developing a "culture of safety" in the organization was not as easy as one would have thought. You may have high personal standards and work hard to perfect and maintain these standards. You will need to transmit these standards to your staff. Insidious problems may occur and "variation in implementation" often creeps in. It requires repeated efforts to align the staff to this common purpose and the proof of the pudding is what the staff are doing when they are not being watched!!

Which Standards Do I Choose to Follow and Designate as "Must Have"?

You should start by setting up standards that are tailored to your practice. For the clinical care processes, start by utilizing the international standards used for a chronic disease management programme such as for patients with diabetes or hypertension. Even if a set of policies and processes is given or "copied from another source" it is clear that to achieve the required documentation and to conduct the measures and audits, you need to make sure that the policies and processes are tailored and relevant to your practice.

Most of the doctors in Singapore inherently want to improve and aiming to meet the international practice standards should not be difficult for most of the doctors provided they put their minds to it.

As such, we can meet and exceed patient's expectations in a reasonable fashion even without subjecting your practice to accreditation by an external body. Some of the lessons that we have learnt in our journey are as follows:

(continued on the next page)

(continued from Page 6: From "Should Have" to "Must Have": Creating a Highly Reliable Medical Practice)

You have to decide what are the "must haves" in your clinic are. Writing down the processes and ensuring that these processes are complied with removes any **assumptions** that you may have.

Obviously, the minimum standard is to meet the legal standards for MOH Licensing Unit to give your clinic a license to practice! In addition, an MOM requirement is for you to a formal written workplace safety risk assessment of your clinic once every three years. Recently, you will also need to comply with the relevant sections of the Personal Data Protection Act (PDPA). After you achieved this, you have to decide if your patients expect more than the licensing requirements, workplace safety assessment and complying with PDPA.

Why Do You Need to Do Measurements and Audit Your Own Processes?

Medical accidents/mishaps occur and it is critical that we pursue measurements and monitoring to ensure quality and safety in our practice. Many of the decisions that we make in healthcare have direct impact on patient's health and disease outcome. Whatever decisions are made, the outcomes must be measured to ensure that the care was delivered in a highly reliable and consistent manner. The way forward is to always consider the 5 S: **sort**, **standardize**, **simplify**, **sweep** and **self-discipline**. To elaborate this further,

1. Standardized care processes are necessary for execution. It reduces complexity that we so often use as an excuse in health care!
2. With standardization, we can do measurements of outcomes, our prevention practices and patient satisfaction.
3. We must take responsibility and have accountability for the outcomes of our patients.
4. These standard processes and measurements must be integrated and blended into day to day work practices which will ultimately lead to a work culture that is focused on quality.
5. As part of continuous quality improvement, we must have the discipline to review and document measurements. This level of scrutiny will ensure that the processes in your practice become more robust and resilient and ultimately relevant! It is important to remember that part of the review also includes getting rid of outdated and irrelevant processes!!

Staff Issues

Given the manpower constraints in Singapore, embarking on accreditation will incur ongoing costs in manpower beyond the costs of the accreditation process. Almost everyone will agree that external accreditation is not required for every clinic.

To reiterate, the main objective of this article is for you to consider the standards that you want to have and to write these as processes that your staff must follow. That is your first hurdle. Thereafter, the next hurdle is implementation which requires training your staff on the processes and to ensure that they comply with the processes. You are expected to face the following issues:

Staff acceptance: If your processes are comprehensive, all clinic activities will now be explicit e.g. assessment, monitoring, dispensing etc. Some of the minutiae will include how often do you weigh your patients with diabetes during their follow up, ensuring that there are double identification checks during registration and dispensing etc.

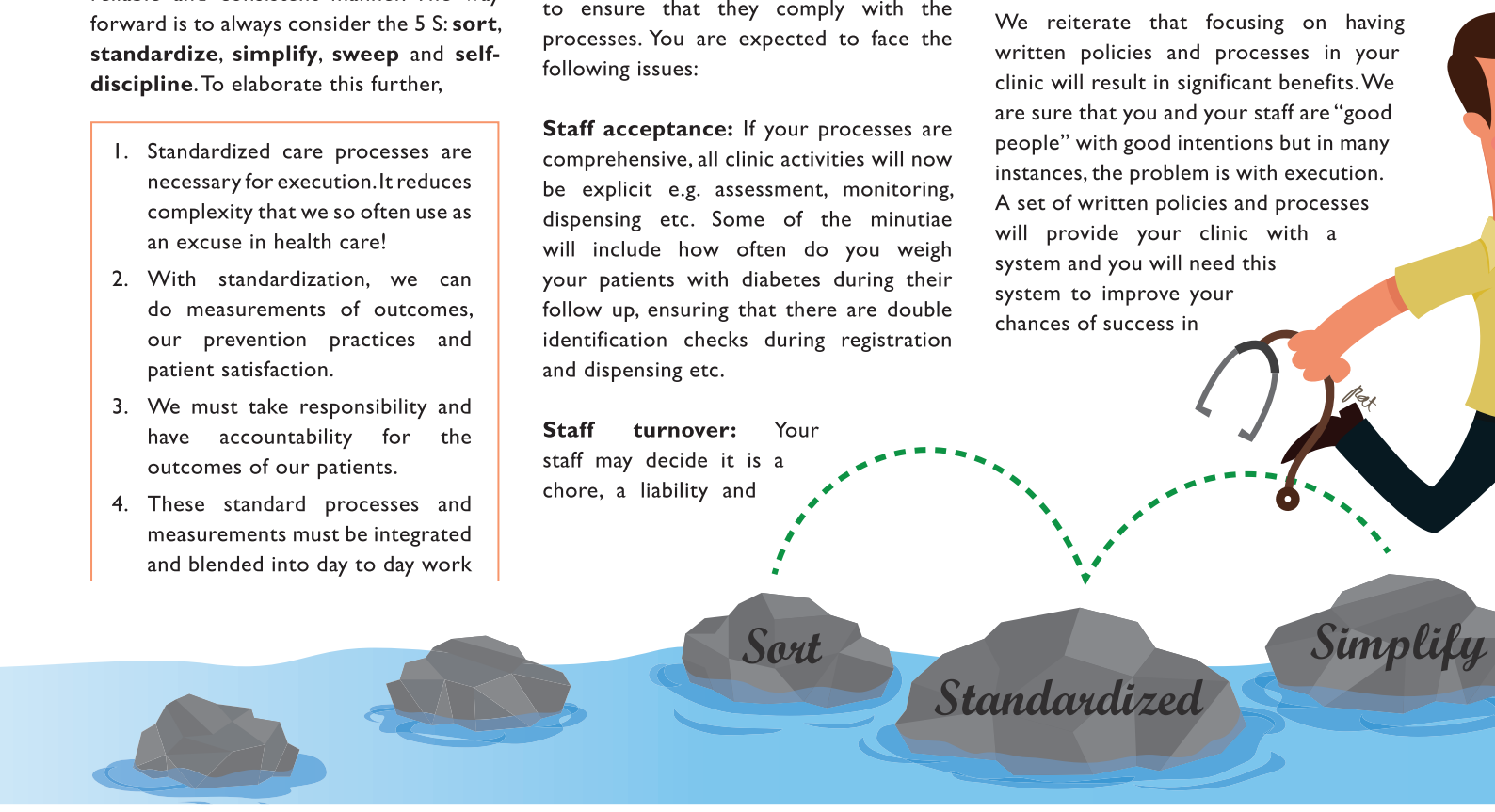
Staff turnover: Your staff may decide it is a chore, a liability and not their cup of tea! There are several reasons for this and our experience can be summarized as;

1. Reluctance to change: this typically occurs with existing staff who were working in the institution before written processes are put into place.
2. Staff do not wish to be subjected to audit and measures: No one wants to be monitored and watched over!
3. Staff do not wish to take on more responsibilities: We monitor wages and ensure that our remuneration package is better than the market rate. We expect our staff to undertake more responsibilities than what most clinics require. In return, we provide the staff with a package of benefits which include training opportunities, monetary compensation and career advancement.

At all times, you need to keep the staff energized to comply and complete their tasks. This is especially important when changes are being implemented.

Benefits for Your Practice

We reiterate that focusing on having written policies and processes in your clinic will result in significant benefits. We are sure that you and your staff are "good people" with good intentions but in many instances, the problem is with execution. A set of written policies and processes will provide your clinic with a system and you will need this system to improve your chances of success in



implementation. Having an external body such as JCI validate the processes provides a measure of confidence that your clinic has attained the relevant international standards. Even if you do not aim for accreditation, you should have a system of written policies and processes!

Checklists and Compliance

One of the common measures to ensure compliance to policies and procedures has been to use checklists. This is not as straight forward as it seems and let me illustrate this with an example. Recent data suggested that the use of a 19 point checklist prior to surgery was associated with improved outcomes. This surgical checklist was widely adopted but in a recent article, Urbach et al reported that the use of surgical checklists in 101 hospitals in Ontario was not associated with reduction in operative mortality or complications. Clearly, the act of ticking off a checklist without being involved and without appropriate communication does not improve clinical outcomes. Performance of the required actions on the checklist, communication with team members etc is critical for patient safety and in the provision of quality care.

As long as you have to delegate some of the activities at your clinic to someone else (whether it be a clinic assistant, enrolled nurse, staff nurse or any other clinic administrator), you must accept that you must monitor these delegated activities. If the processes at your clinic are documented in clear and comprehensive manner, your ability to control or monitor every aspect of your clinic operations should be greatly enhanced. The next problem lies in staff compliance!

If you are starting from scratch, go back to the basics and determine the minimal "must haves" that are relevant at your clinic. Ensure that these basic processes are carried out diligently by your staff and build upon this. A word of advice on writing processes; form a team with doctor(s) and staff involved in clinic operations. This team approach utilizing the advice and knowledge of those in the "frontline" will help to create an "integrated" solution to the outcome you wish to achieve. It seems daunting but you should start today!

Improving Patient Safety and Delivering Quality Healthcare Does Not Seem to be Innovation!

Ensuring that 2 patient identifiers are done, having 100% compliance with 5 moments of hand hygiene is not sexy and cannot be considered as innovation in health care! There is nothing creative with what we have described in the above paragraphs but it does involve transforming the way we must approach delivery of health care to ensure consistent safe and quality care.

How Is This Aligned with Patient Centred Care?

We all provide care to one patient at a time and are expected to focus exclusively on their health care problems (and sometimes, more). Every patient is different and some customization of clinical management is required. But to ensure a high reliability organization, there must be a conscious effort to carry out the minimum recommended practices in a standardized manner.

What's Next?

For those who already have written processes and have seen improvement in their delivery of care, you must persist and hold on to these gains that you have been rewarded with. It requires time, follow up and a certain level of energy to maintain the improvements. Otherwise, they often fade away and old habits will return. On the other hand, if you persist, the change in behaviour will hopefully become embedded as intrinsic values and evolve into the culture of your medical practice.

If you are confident of your processes and your staff's compliance to them, think about validating them via an accreditation body such as JCI.

Conclusion

We pride ourselves in doing the best for our patients. We can do so by ensuring that the activities at our clinics do are done with clockwork consistency rather than depending on the memory of our staff and ourselves. The standard of health care delivery in Singapore is already very good but we believe that it can be nudged a bit higher. Many of the items to be done for our patients should move from the "should do" category to the "must do" category. Then, you will be on the road to building a system to reduce lapses in standards and to create a highly reliable medical practice.

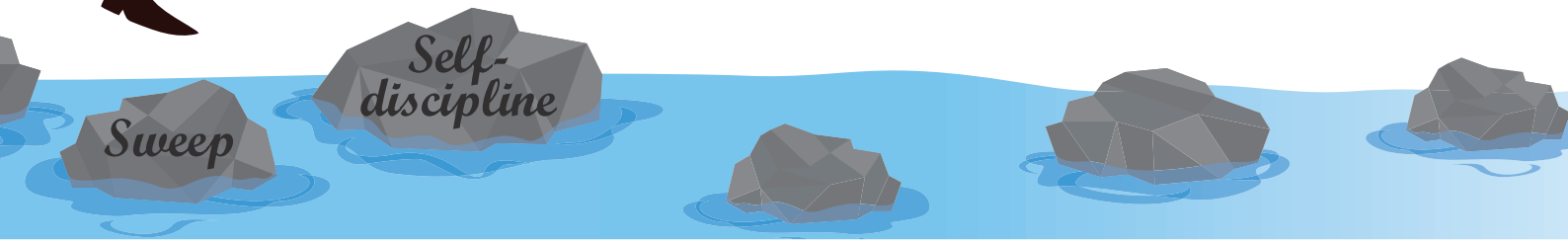
Please act now and you should sleep easier!

References

Introduction of surgical safety checklists in Ontario, Canada. Urbach DR, Govindarajan A, Saskin R, Wilton AS, Baxter NN. N Engl J Med. 2014 Mar 13;370(11):1029-38

Transforming Health Care: Virginia Mason Medical Centre's Pursuit of the perfect patient experience. Charles Kenney.

CM



THE 5TH JPCA (JAPANESE PRIMARY CARE ASSOCIATION) CONFERENCE *IN OKAYAMA JAPAN*

by Dr Kenichi Sato, Delegate Japanese Primary Care Association (JPCA)

From 10th to 11th May, the Annual Conference of the Japan Primary Care Association (JPCA) was held in Okayama, western part of Japan[1]. This was 5th conference since JPCA was established. A/Prof Lee Kheng Hock, the President of College of Family Physicians Singapore, and I had a chance to participate the conference and carried out one workshop about medical education system in Singapore. Besides the conference, we had an opportunity to visit one private clinic run by a Japanese doctor and accompanied him on a home visit. It was a short but very meaningful conference as we had the opportunity to share knowledge and experience with many Japanese doctors as well as family doctors from other countries.

What is JPCA?

Some may think JPCA is still young because this association is established on April 2010 and this was only the 5th time to conduct the annual conference. In the past, there was three professional bodies representing family medicine, the Japanese Academy of Primary Care Physicians, the Japanese Academy of Family Medicine and the Japanese Society of General Medicine were established on 1978, 1986 and 1993, respectively[2]. However, to promote family medicine to Japanese society and citizens, it is important for family physicians to work together towards to the same objective. This is why our new association, Japan Primary Care Association, was established on 2010. The parent body, the Japanese Academy of Primary Care Physicians, was established on 1978, so JPCA is 6 years younger than CFPS. Current membership is over 11,000 that include not only physicians, but also dentists and pharmacists and so on. It is the largest academic association of generalists in Japan. Every year, JPCA has a annual conference and it is held in different parts of Japan every year. Last year, the annual conference was held in Sendai[3].

Home Care with a Japanese Colleague

A day before the conference, we had the chance to visit one private clinic run by Dr. Hideki Yasuda[4]. The history of his clinic is very long. In 1924, his grandfather opened the clinic. In 1968, his father took over the practice. In 1991, Dr. Yasuda succeeded his father.

He had been practicing in the community for about 23 years and had always provided home care for his patients. He schedules home visits during his lunch time break everyday from 13:00 to 15:00. He travels by car and when the patients' home is near, he walks. He usually visit alone. In Japan, home visit is managed by two insurance system. These are the Medical Insurance and Long-Term Care Insurance. Home visit by doctor is covered by Medical Insurance. Nurse visits are covered by Medical Insurance and Long-Term Care Insurance depending on necessity of medical treatment. But as a rule, it is not permitted for healthcare providers to use both insurance schemes in the same visit. Doctors and nurses are able to visit together and actually many do, but the cost of nurse is cannot be claimed.

On that day, we visited three patients. An 80 year old lady who has osteoporosis and lives alone, a man in his 50's who is on a ventilator due to syringomyelia and other complications and a gentleman in his 90s who has chronic obstrusive pulmonary disease (COPD). Supported by family, relatives, neighbors and Medical and Long-Term Care Insurance, the majority of these sick elderly patients continue to live in their community.

The picture is the gentleman lives in a fee-based home for the elderly (Pic.1).

He has COPD. His condition is not well managed at home because he lives alone and had has mild cognitive impairment. He stays in a fee-based home for the elderly. The staff provide basic nursing care including reminders for his inhaler therapy. Dr. Yasuda as his family doctor checks in on him at the nursing home regularly. It would have been better for the patient to stay at home but if patient condition is not well controlled at home and requires repeated

(continued on Page 22)

Pic 1.
CFPS President A/Prof Lee Kheng Hock with the resident of the sheltered home(Aifamily Amase <http://www.ilief.jp/aifamily/index.html>). He can stay safely in this home and continue to enjoy his hobby of painting. His medical condition is supported by the nursing staff.

His family doctor visits him twice per month and check his condition by seeing him and discussing his care with the staff. If some trouble happens, the staff call to the doctor and get the advice.

His single room is spacious for someone living alone. It is brightly lit with natural light. Once the door is opened, he can communicate with other residents. The whole place is wheelchair and elder friendly (Image courtesy of Kenichi Sato)

The 6th Annual Conference of Japan Primary Care Association

Training and nurturing of healthcare professionals in the support of people's daily life

Date June 13 SAT - 14 SUN, 2015

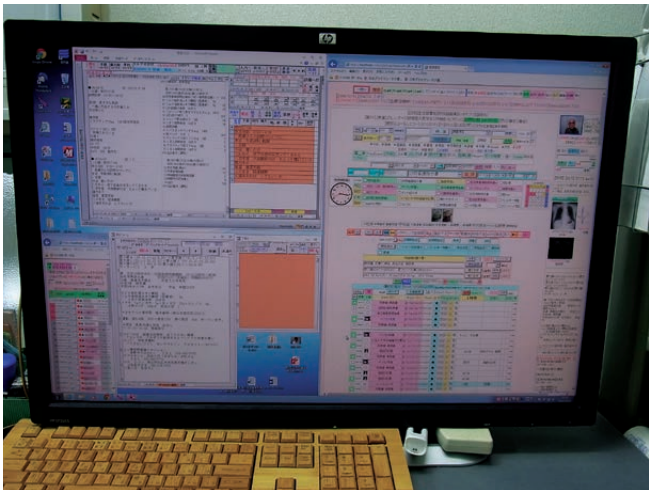
Venue Tsukuba International Congress Center
2-20-3,Takezono,Tsukuba,Ibaraki,305-0032,Japan

President Tetsuhiro Maeno
Professor, Department of Primary Care and Medical Education,
Faculty of Medicine, University of Tsukuba

http://www.c-linkage.co.jp/jpca2015/

Secretariat
c/o Convention Linkage, Inc.
Sanbancho KS Bldg., 2 Sanbancho, Chiyoda-ku,
Tokyo 102-0075, JAPAN
TEL: +81-3-3263-8688 / FAX: +81-3-3263-8693
E-mail: jpca2015@c-linkage.co.jp

(continued from Page 20:The 5th JPCA Conference in Okayama Japan)



Pic 2.
This system is designed to fetch and show the data from other system. For example, radiograph or Computed Tomography which are taken from other contracted hospital can check by this system soon after patients take and use as explanation of patients condition. (Image courtesy of Kenichi Sato)

Pic 3.
To participate each workshop, registration is needed. Even though early morning session, many doctors participate the session. Everything that they hear is new for them, they all listened intently throughout. (Image courtesy of Kenichi Sato)

hospital admissions, it creates hardship for the family, relatives and neighbors and result in expensive healthcare bills. More than anything, stress from frequent admission and environment change may cause even greater distress for such frail elderly patients with cognitive impairment. The monthly cost of this facility is about 1800 SGD (includes housing and meal but if person wants to use nursing-care service from Long-Term Care Insurance, they must pay additionally). Considering cost effectiveness, safety and the dementia-friendly environment, to live in such a nursing home is a reasonable alternative.

Dr. Yasuda's clinic has long history and the building is charmingly dated, but he uses state of the art electronic medical record system (Pic.2). By using this system, doctor can obtain patient's information including past history, family history, relationship with families and result of investigation that done at tertiary hospital near his clinic. Furthermore, this system can access from internet, doctor can see same information using smartphone even if he is not in his clinic.

Theme of This Year's Conference: The Power of Families and Local Communities - Searching for the Future of Primary Care

The congress chair is Dr. Akira Matsushita, director of Family Practice of Okayama, Nagi Family Clinic. In his chairman's speech, he talked about his past career and his aspiration for the future of family medicine and medical education in Japan. After graduating from a medical university in Japan, he enrolled in the residency program of Genesys Regional Medical Center in the United States for three years before returning to Japan. From 2001, he worked and trained young doctors at Nagi Family clinic. His clinic is far from the urban area, but many young doctors come as resident and his program grew to become a famous family medicine training centre. Tom Campbell who wrote the book Family-oriented Primary Care in 2004 also spoke at the conference. During the speech Dr.Campbell, Dr. Matsushita and a standardized patient did role play to demonstrate patient centeredness. The scenario was about breaking bad news to patients. It was a very difficult case for experts, but their true-to-life performances were well received by the audience and was very effective in bringing home the message. John Frey, Professor Emeritus, Department of Family Medicine University of Wisconsin, School of Medicine and Public Health was another invited speaker at the conference. In this lecture, he explained the story of family medicine in the US. How it all started in the early days and what he thinks need to be done for the future.

One of the attractive points of the JPCA conference is that many well-known international speakers were invited from countries such as the United States and United Kingdom. Over time, more Japanese doctors are inspired by these lectures and they become interested in studying abroad.

Improving Family Medicine Residency Training

Our workshop was held the first session of the first day. Despite being an early morning session, over 30 registered participants joined (Pic.3). The objective of this workshop is that by knowing, comparing and exchanging the experience of the residency training program in Singapore and Japan, doctors learn to improve residency programs of each hospital.

However, the main interest of participants is in the healthcare system, history of family medicine and medical education in Singapore, so we focused on these topics.

Doctors in Japan seldom have the opportunity to learn about the healthcare system and training system of family medicine in Singapore. This was a rare opportunity so many of them enthusiastically join the workshop. I hope some of them will come and see the training program of family medicine in Singapore. By seeing other countries actual situation, people can reflect on their own training program and make improvements. In Japan, there are very few trained family physicians but we have large numbers of specialists. Unfortunately, some of them run clinics in the community without formal

training of family medicine. Personally I find the GDFM course managed by CFPS very interesting and innovative. It is a very useful program for specialists who want to become family physician.

International Sessions At The JPCA Conference

In JPCA annual conference, they have international sessions arranged by the committee for International Affairs. These sessions are conducted in English so to present this session is slightly harder for Japanese doctors, but it is a good chance to have an experience of oral presentation in English. This year there was a total of 5 presentations. The topic from other countries is unique and interesting because they covered not only academic themes but they also talked about their facilities, programs and activities.

From Singapore, Dr. Min Yan Chia presented the topic "Family Medicine training in Singapore from a trainee's perspective". This presentation is impressive because she talked about medical education in Singapore from her own experience in FM training and furthermore, in Q&A session after her presentation, not only Japanese doctors but also American doctors who came to the conference as a speaker of lectures or workshop join the discussion. Usually in Q&A sessions, we mainly ask the speaker about the contents of their presentation but in this session we not only asked questions but also discuss on how we can combine our experiences to create a better system. In this way, we are able to know other countries education system and learn how to solve or improve our own training program.

Join Us At The Next JPCA Conference

You may think that the conference held in Japan is difficult to participate because of the language barrier. This is no longer true. Many Japanese doctors especially young doctors speak English fluently and without hesitation, and young doctors have a branch in JPCA, The Young Primary Care Doctors' Organization of the Japan Primary Care Association[(5)].

The aim of this branch is to promote family medicine to medical students, communicate with same generation doctors and propose their plan to JPCA. This is a very active branch and they have a very positive impact on the JPCA.

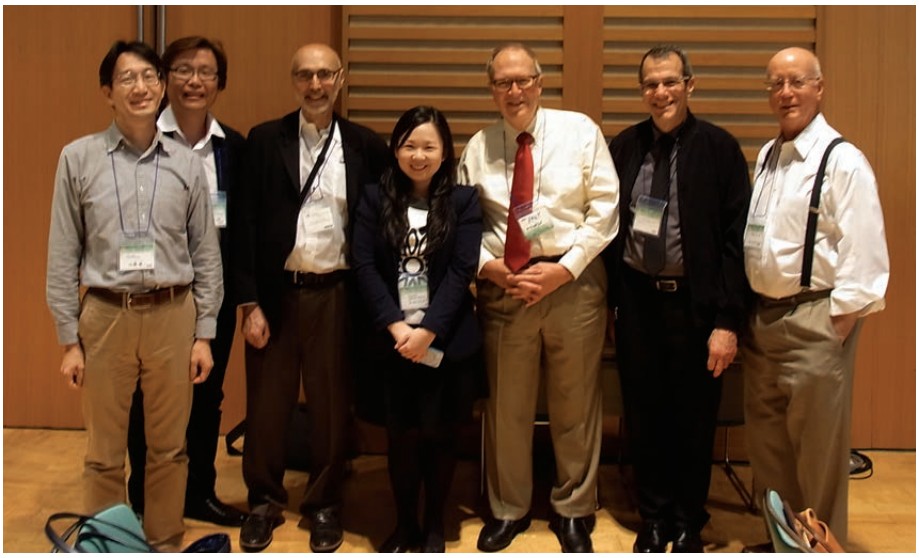
In fact, the current representative of the Rajarkumar movement is a Japanese doctor, Dr. Shin Yoshida, and also he is the representative of The Young Primary Care Doctors' Organization of the Japan Primary Care Association. The Rajakumar movement was launched at the 2009 WONCA Asia Pacific regional conference held in Hong Kong aims to be the working party for young and future family doctors in the Asia Pacific region[(6)]. He and his colleagues are trying to organize more young doctors in Asia Pacific region to come together and work on this vision.

Furthermore, many doctors are well connected with with doctors of other countries, through the many international conferences that they had attended. To communicate with such doctors is one more wonderful and precious point of the conference (Pic.4).

Next year, the conference will held on 13th and 14th June at Tsukuba, about 45 minutes from Tokyo by train[(7)]. They prepared the international session and some Singaporean doctors are expected to join the conference.

Thanks to the interest of many foreigners in this conference, the English version of the conference details is available from the website (Page 21).

In 2019, JPCA will host WONCA Asia Pacific regional conference, so JPCA eager to communicate and make more connection with many overseas doctors. So, let's join the annual conference of JPCA next year and communicate with each other for the future of both countries' family medicine.



Pic 4.
After John Frey's special lecture, our Singapore team took a picture and chatted with American dream team. Such a chance is one of the real pleasures of JPCA conference. (Image courtesy of Kenichi Sato)

References

(1) The 5th Annual Conference of the Japan Primary Care Association website <http://www.c-linkage.co.jp/jpca2014/en/index.html>

(2) Japan Primary Care Association website <http://www.primary-care.or.jp/about/eng.html>

(3) The 4th Annual Conference of the Japan Primary Care Association website <http://www.c-linkage.co.jp/jpca2013/index.html>

(4) Yasuda Clinic website(only Japanese) <http://www16.ocn.ne.jp/~oka-hok/doc/okayama/yasuda.html>

(5) The Young Primary Care Doctors' Organization of the Japan Primary Care Association(only Japanese) <http://www.primary-care.or.jp/resident/wakate01.html>

(6) The Rajakumar Movement <https://www.facebook.com/groups/rajakumarmovement/?fref=ts>

(7) The 6th Annual Conference of the Japan Primary Care Association website <http://www.c-linkage.co.jp/jpca2015/en/index.html>

CM

INTERVIEW WITH A/PROF TOH HAN CHONG

Deputy Director of National Cancer Centre Singapore

Interviewed by Dr Fok Wai Yee Rose, Editorial Board Member (Team A)

A/Prof Toh Han Chong

THE WAR ON CANCER NEEDS ALL DOCTORS ON DECK

College Mirror (CM):
CHRONIC ILLNESS: As it has been projected that one in three will have cancer in the future, do you think cancer will become a chronic illness? What is the impact on medical fraternity if so?

A/Prof Toh Han Chong (HC):
Cancer is the commonest disease in Singapore and will potentially escalate further with our rapidly ageing population. With our modern lifestyle and diet trends, certain cancers will become more frequent, particularly colorectal and breast cancer. Colorectal cancer is already the number one cancer in Singapore.

In the coming years, the impact of cancer, will be quite massive and very real, in terms of incidence, cost and burden of care. The question is whether we will be ready for it. The good news is that the Government is aware and has made a big push to create more capacity for hospice beds and services, facilities for tertiary cancer care and injected further subsidies for many cancer treatments for Singaporeans. The critical issue is to find, train and grow enough manpower, both in the medical as well as allied health profession to support this increasing growth in cancer burden.

Today, 50% of all cancers globally are curable which is testament to the achievements and progress in cancer prevention, detection and treatment in the last many decades. At the GP symposium, I mentioned that the overall incidence of cancer-free survival globally has improved to 70% from <50%, 30-40 years ago, so more and more people will be living as healthy cancer survivors than ever before.

CM:
MORE SCREENING? We understand that mammogram and Pap smear screening has detected many early cancers, does that translate to higher chance of cure?

HC:
Screening mammography has made international news discussing its true usefulness in impacting survival of women as a breast cancer detection tool. Certainly, cancer professionals do believe that it is overall still important to support and encourage breast screening. The local clinical practice guidelines advocate screening mammography from 40-49 years, where women are strongly encouraged to undergo mammography yearly and from 50-69 years, every two-yearly. Unfortunately the take up rate for regular mammogram screening of all Singapore women is less than 20%, so there should be a strong encouragement to go for breast screening.

As for Pap smear, it is important and undoubtedly reduces the incidence of cervical cancer. I feel it is important that our GPs should actively seek out and encourage screening for age-appropriate sexually active women to go for Pap smears.

CM:
WHAT IS CURE? What is the definition of OS (overall survival) and PFS (progression free survival)? What is the efficacy of most chemotherapy drugs?

HC:
OS and PFS are technical terms used by cancer professionals to objectively measure real benefit to treatment. OS means how long a cancer patient lives. For example , if we take a patient with stage 4 colorectal cancer and assess their median OS if they do not receive any systemic treatment. This is normally a median OS of less than one year. If the median OS is quoted as one year, it just means that half the stage 4 colorectal cancer patients will be alive at one year, but that doesn't mean that his own overall survival is one year. So that's why we have to be very careful how we break bad news to our patients and to do it appropriately and with empathy and care.

If we use optimal chemotherapy and biological therapies available to treat this same patient, his survival may be increased to beyond two years, so median overall survival will be more than doubled in this case.

PFS of cancer defines the period of time that the cancer is under control, the disease is stable or a remission is achieved. It doesn't mean that the patient is alive or dead. We use this benchmark to assess the duration of activity and efficacy of the drug.

The list of chemotherapy today is like going through an extensive restaurant menu where every food on the menu is different. Let's take some of the most chemosensitive cancers like testicular cancers which is very easily curable in the early stages. Even in the late stages, a significant number of patients are also curable. In another chemosensitive cancer like lymphoma there is still a window of cure even in the later stages. However for cancer that are not chemosensitive like liver cancer, we do not use chemotherapy in the first line, but instead targeted therapy.

CM:
Is there a role of SCREENING SCANS?

HC:
We do not advocate preventive radiologic scans, meaning to say that if a young 40 years old executive wants imaging for cancer screening, we do not recommend such CT scans. Moreover, CT scans and CT-PET scans are associated with a low dose of radiation exposure that might add unnecessary risk exposure to normal individuals. One large, widely publicised study conducted in USA revealed that low dose CT scans used in screening for lung cancer has shown some benefit in survival. Many factors however limit the adoption of such a strategy in Singapore. For one thing, the rate of false positive lung nodules in a tuberculosis endemic region is likely to be much higher in Singapore, potentially leading to much anxiety and unnecessary procedures. Also, the fact that the population that benefited comprised current or ex-smokers, raising the question of whether resources could be better channeled into smoking cessation programs rather than cancer screening. So although large, well conducted randomised studies can show survival benefit to screening, many factors underlie the applicability of such data to particular populations.

CM:
CANCER SURVEILLANCE: Conventional thinking of medicine is that early detection of cancer recurrence (eg by doing more scans) impacts the patient's recovery and treatment, does this differ in oncology?

HC:
In cancer surveillance following definitive treatment of cancer, CT scans may be recommended for some cancers. For example, a patient with stage 3 colorectal cancer has undergone definitive surgery followed by six months of adjuvant chemotherapy (i.e. the administration of chemotherapy with no visible disease present and is meant to prevent relapse). There are very clear guidelines for surveillance tests following the completion of adjuvant therapy: including routine CEA monitoring, normally for five years and annual CT scan surveillance, crucially for the first three years.

However for a 60-year-old woman with stage 2 breast cancer who has undergone definitive surgery followed by six months of chemotherapy and then on adjuvant tamoxifen, international guidelines does not support annual surveillance CT scans as it has not been proven to save lives. Of course we will always organise appropriate investigations in the presence of symptoms.

CM:
ADJUVANT Vs PALLIATIVE CHEMOTHERAPY – what is the difference?

HC:
Adjuvant chemotherapy means giving chemotherapy to a patient with no more visible and detectable cancer, like a stage 3 colorectal cancer or a stage 2 breast cancer patient, the role is to prevent a relapse. The rationale is that there are potentially "seeds" of cancer that are circulating in the body that may potentially come back in the form of a relapse. This may explain why the chance of cancer recurrence of a stage 3 colorectal cancer patient can be as high as 50% or more in the first three years following surgery. Adjuvant chemotherapy has been proven in some cancers to improve survival and therefore save lives.

The role of palliative chemotherapy is not to cure, but to aim to prolong life and relieve symptoms.

CM:
MORE IS NOT BETTER? Does using more and stronger chemotherapy at the first detection of cancer improve the chance of cure?

HC:
It is not that more and stronger chemotherapy is better, but the right chemotherapy and the most appropriate chemotherapy at the right dosing, so you need to trust your doctor to prescribe that. It is like the "Goldilocks and the Three Bears" story, where Goldilocks is looking for the porridge that is not too hot, nor too cold, but "just right". So by just increasing to very high dose of chemotherapy does not yield extra benefit nor longer survival, but is more likely to result in more side effects. There are occasions where high dose chemotherapy has a role, and there are also examples where low dose maintenance chemotherapy (metronomic therapy) has its usefulness.

CM:
Do oncologists ever WITHHOLD CHEMOTHERAPY?

HC:
Whenever cure is possible, we should never, ever withhold chemotherapy unless the risk benefit to chemotherapy is too high. If there are financial constraints, there is always an avenue that we can explore whether from government subsidies, Medifund, drug companies or private charitable organisations so that needy patients can receive crucial anti-cancer treatments.

CM:
Is there a role of MAINTENANCE CHEMOTHERAPY?

HC:
Taking the scenario of adjuvant chemotherapy for stage 3 colorectal cancer, the standard duration of chemotherapy is six months of single or combination chemotherapy. Maintenance chemotherapy has been proven to be of benefit in particular settings, for example advanced colon or lung cancer, or indolent lymphomas, generally when the patients have responded well to initial chemotherapy.

CM:
COST OF CHEMOTHERAPY: Can you enlighten us on how we come up with guidelines on the subsidy of chemotherapy drugs?

HC:
The government has made great efforts to subsidise the cost of many chemotherapy drugs, targeted therapy and biologics against cancer. The principle of providing subsidies towards chemotherapy is to prioritise the commonest cancers first and foremost, to subsidise the most efficacious chemotherapy that can give the best results (for example, in adjuvant therapy) and, to evaluate for the drug that goes the longest way to cure or palliate the patient. The list of drugs that has been subsidised has grown in the last few years, although there are still a considerable number of drugs that we hope will make this list. Some pharmaceutical companies have also introduced their own programmes to reduce drugs costs to the needy.

CM:
EMPATHY: As oncologists often have to deal with cancer progression and death, do oncologists have to come to terms with their own emotions?

HC:
There is a major study conducted in England, which shows that doctors that have the highest burnout rate are oncologists. When the cancer gets the better of the patient, we may sometimes feel defeated, but the important thing to remind ourselves and one another is that we have done our best for the patient throughout their cancer journey as best as possible.

CM:
UK EXPERIENCE: Can you share your experience about UK National Health Service (NHS) system as we understand you have lived in England for a number of years? How do you compare the standard of cancer care in Singapore compared to UK?

HC:
I studied in UK for six years and qualified there. The most striking thing about their healthcare system in the community is that the Family Physician (FP) is the gatekeeper and they have a register of patients in his/her neighbourhood. Every town and region has a designated GP, who is an important turn-to professional , not only in the assessment of patients for specialist referral but also in taking on part of the burden of cancer care, like that of cancer surveillance. .

Both UK and Singapore have their strengths and weaknesses. Singapore overall has a greater access and choice to cancer drugs whereas access to drugs in UK is more limited as they are regulated by an agency called National Institute for Health and Care Excellence (NICE) as part of the NHS policy on disease management. Singapore has a very good healthcare system. And we do have a very good team of cancer professionals looking after our patients. Hopefully we can further engage the primary care community to co-manage cancer patients especially in the areas of cancer education, screening and

(continued from Page 11: Interview with A/Prof Toh Han Chong)

surveillance. In the care of side effects and complications of terminal stage cancer, we need family physicians with a deep interest and passion in hospice and palliative care to step forward and we can potentially provide training for them as well.

CM:
Do share with us on FUTURE DIRECTIONS of Primary Care and Oncology?

HC:
Cancer is a very big area to cover. Fundamentally, we want to make sure that doctors in the community have a rudimentary knowledge of the principles of cancer treatment and cancer care, like pain control and other symptom management. We hope that we can provide more education in the future like how to look for red flags and danger signals of potential cancer in patient with symptoms. That is really critical for front line doctors like GPs and FPs. Screening also helps to pick up early cancers where we can do a lot more for them, so the priority here is to nip it in the bud. When cancers are diagnosed late where distant spread has already occurred, the prognosis is usually not good.

Equally important is for family physicians to educate and encourage lifestyle changes that can help prevent cancer. Primary care can make a huge impact in this area in the community setting. For example, smoking has been associated with many different cancers including cancers of lung, esophagus, throat, head and neck, breast, colon and cervix. Smoking cessation has a massive impact on the reduction of incidence for such cancers. Increasing consumption of red meat and the rise of obesity have been associated with higher risk of colorectal cancer and even breast cancer.

CM:
In your opinion, how has ONCOLOGY PROGRESSED?

HC:
There is absolutely no doubt that in the last twenty years, cancer advancements have been transformational, both in the detection of cancers using newer imaging techniques like CT PET scan, preventive medicines like hepatitis B vaccination of our young, cervical cancer vaccines, as well as the discovery of new drugs and treatment pathways. Having said that, we have to very humbly accept that there is still a lot that we do not know about cancer. There are still a lot of pitfalls in drug development, and also many failed clinical trials. It is as if we take two steps forward, and then there will be one step back, but it is very important that we must still take that two steps forward.

CM

(continued from Page 9: Photo Quiz)

Answers

1. The proximal lesion is **TINEA CORPORIS**.

   It has the characteristic annular "ringworm" morphology.
   The rim is papular and scaly and expands centrifugally leaving a cleared or resolved centre.
   Pruritus is a common presentation, which is the case here.

   Tinea Corporis is caused by a dermatophyte.
   The most common causative fungus is Trichophyton rubrum which spreads from human to human by direct contact.
   Infection acquired from animals and soil is usually caused by Microsporon canis.

   Predisposing factors include warm, humid climate and personal hygiene.
   Other known risk factors include Diabetes Mellitus and conditions with impaired immune system.

   The diagnosis is based on clinical findings and investigations are usually not needed.
   Skin scrapings for microscopy with potassium hydroxide will reveal mycelium.
   Fungal culture is reserved for recalcitrant cases.

   Treatment for a small solitary lesion like in this case is mainly topical.
   The commonly used topical antifungal agents are the imidazoles which include miconazole and clotrimazole.
   Another group of antifungal are the allylamines, an example of which is terbinafine.

   A combination cream composed of miconazole nitrate 2% and hydrocortisone 1% was used for this patient to address the fungal infection and the associated inflammatory and pruritic reaction.
   The response was good.

   Oral antifungals are only indicated in failed topical treatment or very extensive lesions.

   (Readers should be mindful of the recent HSA advisory on the Hepatoxicity risk of oral Ketoconazole)

2. The distal skin lesion is a **CAFÉ AU LAIT MACULE (CALM)**.

   The macule in the image is about 4 cm in diameter, brown in colour, solitary and present since birth.

   Solitary CALM is usually of no medical significance.
   But multiple CALMs-more than six- is a major predictive feature for Neurofibromatosis Type 1 (NF 1).
   As the neurofibromata do not appear until late adolescence or adulthood, the presence of multiple CALMs allows for an earlier diagnosis of NF 1. *(a)*

   Other conditions associated with CALMs are Tuberous Sclerosis, Fanconi Anemia and McCune-Albright Syndrome.

   Since the lesion is benign, there is no need for treatment.
   Cosmetic treatment with various lasers has variable results. *(b)*

References
(a) The Asian Skin, National Skin Centre.
(b) Medscape Reference

CM

COLLEGE MIRROR INTERVIEW
with Dr Wong Tien Hua - MASEAN Chairman

Interviewed by Dr Low Sher Guan Luke, FCFP(S), Editor (Team A)

The Medical Association of the South-East Asian Nations (MASEAN) was formed on March 1, 1980. It seeks to build closer ties among the national medical associations in ASEAN.

The National Medical Associations (NMA) include those from: Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Thailand, Vietnam, and of course Singapore.

The objectives of MASEAN are:

- To promote close ties among the national medical associations and physicians in ASEAN;
- To foster the study and dissemination of all aspects of medical knowledge;
- To study and report on the problems which confront the profession in the region; and
- To establish common policies in attaining the highest possible level of healthcare for the people.

Member NMAs take turns to host the meetings in their various countries and it was Singapore's turn this year. College Mirror learned that Dr Wong Tien Hua was the chairperson of MASEAN, and sought to find out more about it.

College Mirror (CM):
Dear Tien Hua, thanks for accepting our interview. Please accept our heartfelt congratulations to you on becoming the chairman of MASEAN. Can you share with us on how you came to be in this position, and what you hope to achieve?

Dr Wong Tien Hua (TH):
As 1st Vice President of the Singapore Medical Association, I was chosen by SMA Council to be chairman of MASEAN and to organize the regional meeting here. The meeting was held from 9 to 11 May 2014 at the Regent Hotel with Dr Amy Khor gracing the occasion as Guest of Honour.

The theme for the 16th MASEAN meeting, "Pandemic Preparedness & Response in South East Asian Nations", was timely and relevant.

Ten years have passed since the Severe Acute Respiratory Syndrome (SARS) epidemic affected more than 30 countries globally including Singapore. In the age of international air travel, the world has also been affected by the 2009 Influenza A(H1N1) pandemic and most recently the Middle East Respiratory Syndrome Coronavirus (MERS-CoV).

From left:
Prof Ronnachai Kongsakon (Secretary General, Medical Association of Thailand), A/Prof Prasert Sarnivad (President, Medical Association of Thailand), Dr Sakda Arj-ong Vallipakorn (Chairman, Public Relations, Medical Association of Thailand), Dr Wong Tien Hua, Prof Saranatra Waikakul (President Elect and MASEAN Vice Chairperson)

The role of the MASEAN community is to be constantly alert to the threat of any emerging disease outbreaks and to be ready to respond with a unified strategy.

As Chairman I had to co-ordinate the inputs from the various NMAs and distil the fundamental strategies to come up with a coherent and inclusive position statement. This was successfully adopted at the recent meeting.

CM:
What sacrifices did you have to make along the way?

TH:
As a family doctor, time is our most precious resource so one needs to manage one's resource well. I think the important thing is to not see such work as an extra burden to our already packed schedules, but to treat it as a necessary duty to contribute to the profession. The SMA secretariat was very efficient and helpful in connecting with the various overseas counterparts and arranging for the meeting and venue.

CM:
How was it like to work with delegates from other medical associations?

TH:
As members of the medical profession, the NMAs all share the common purpose and goals of upholding the profession through the promotion of ethics and professionalism.

It was most interesting to see the diverse differences in healthcare systems and practices when you get together in a regional meeting to talk about common problems such as pandemic preparedness.

One thing that struck me was how the geography and culture of the country affects public health and medical practice. For example, in Indonesia, the country consists of a chain of islands linked together by air and sea routes. They face problems with immigration checks to screen infectious disease cases, with 8

million travellers moving in and out of the many border points every year. Contrast this to Myanmar, which has a large land border with its neighbours. They face problems of movement of people, livestock and poultry over its porous land links. Philippines face many natural calamities such as destructive typhoons that contribute to disease outbreaks. We are sheltered from such harsh climates in Singapore, yet make a fuss after a tree topples from heavy rain, causing traffic jams.

CM:
What are some of the challenges you have faced in this position?

TH:
Similar to good neighbours living together in the region, MASEAN members do want to come together to forge a common identity. We want to seek effective solutions to our healthcare challenges by learning from each other.

The big challenge we have is that the health systems in the region are not only very diverse, but they are all at various stages of evolution. Even in Singapore our healthcare system is constantly adjusting to the healthcare needs of our changing demographics and ageing population. We need to keep communication channels open and provide a forum where such issues can be addressed.

CM:
We also heard of your previous contributions to CFPS. Can you share more of this with us?

TH:
I was Deputy Director of Training Administration at College from 2006 to 2011, under the Institute of Family Medicine. We used to meet every Wednesdays over lunch with Prof Goh Lee Gan and Dr Cheng Heng Lee (later Dr Jonathan Pang) and the College secretariat. We sourced for new topics for the Family Practice Skills Courses and had to find topic specialists for the themes. We also set the MCQs for the course.

From left:
Dr Ihsan Oetama (Indonesia Medical Association), Dr Wong Tien Hua - incoming chairperson of MASEAN, Dr Tran Huu Thang (Vietnam Medical Association) - outgoing vice chairperson, Dr Jose Asa Sabili (Philippine Medical Association) - outgoing Chairperson, Dr Amy Khor (GOH), Dr Lee Yik Voon - MASEAN Secretary General, Prof Saranatra Waikakul (Medical Association of Thailand) - incoming Vice Chairperson, Dr Lee Hsien Chieh - incoming Assistant Secretary General

Images courtesy of Singapore Medical Alumni

I was also editor of the College Mirror from 2006 to 2012. The College Mirror has come a long way. I am always very pleased to receive the full colour glossy magazine, and it keeps me up to date with College activities. The Family Medicine community has visibly evolved through the years and I am glad to see young residents take up FM as a long-term career, one that will afford them with lifelong learning and opportunities to develop professionally in a wide range of settings.

CM:
Family Medicine has recently formed a chapter under the Academy of Medicine Singapore (AMS). What are your thoughts on this?

TH:
I would like to congratulate the College on achieving this very important milestone in the development of Family Medicine in Singapore. I can say that even 10 years ago all this would have been wishful thinking.

I can see the visionary leadership at the College striving tirelessly to make this happen; this is like a giant jigsaw puzzle that require all the pieces to fit - at the right place and at the right time. The establishment of the GDFM as a standard for aspiring family doctors, the family physician register, Residency training for FM, and the robustness of the steps leading to the Fellowship had to be in place before we could be recognized by our specialist colleagues.

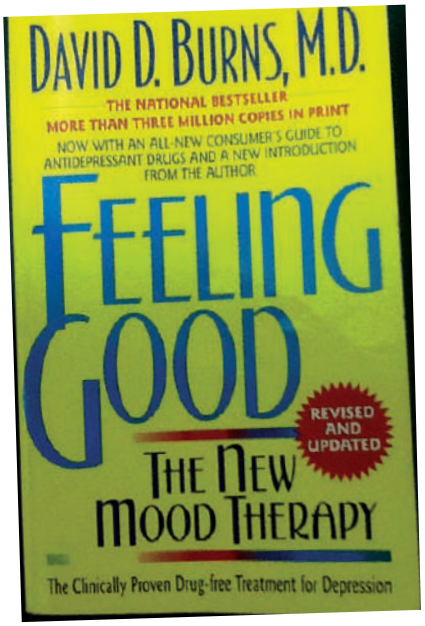
Family Medicine would ultimately be more complete with the chapter in AMS. However I also recognize that this is only a small part of the Family Medicine picture; we also need to see how we can serve all the other family doctors in Singapore and help with their professional development so that the fraternity benefits as a whole. This requires training programs from the College, as well as the willingness of many family doctors to bravely step forward and undergo the training.

CM

FEELING GOOD *by Dr David D. Burns*

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

As a Family Physician, we often come across patients that have some form of mild depression or anxiety due to the demands of modern day living. The standard practice is to prescribe some psychotropic drugs and hopefully that will do the trick. Some time ago I was recommended this book "Feeling Good" written by Dr. David D. Burns. This 700-page paperback book is an easily readable DIY book on Cognitive Behavioural Therapy (CBT). Even though it was targeted for the lay people, doctors who aspire to help such patients will find this book useful as well.



"Feeling Good" written by Dr David D. Burns
Image courtesy of Dr Soh Soon Beng

Dr. Burns, who is a practicing psychiatrist, was able to present complex human emotion in simple and easily understandable ways. Through multiple examples of real cases presented through role playing dialogue, he was able to convey his idea clearly. There is also a list of 10 cognitive distortions that were commonly encountered. He also broached the concept of "what makes you angry", how to talk back to yourself, how to deal with procrastination, perfectionism etc. With each problem that he presented, he gave a real case scenario as well as his proposed solution. The basic approach is the triple column method comprising of automatic thought, cognitive distortion and rational response. Another method that I find useful is the vertical arrow method that may help one to pin-point the root cause of the problem.

There is a chapter that he devoted to how he practiced what he preached, again demonstrating the concept of walking the talk and reinforcing the true practical value of the methods. The last few chapters of the book discussed what you need to know about the commonly prescribed antidepressants including the side effects and practical tips on usage.

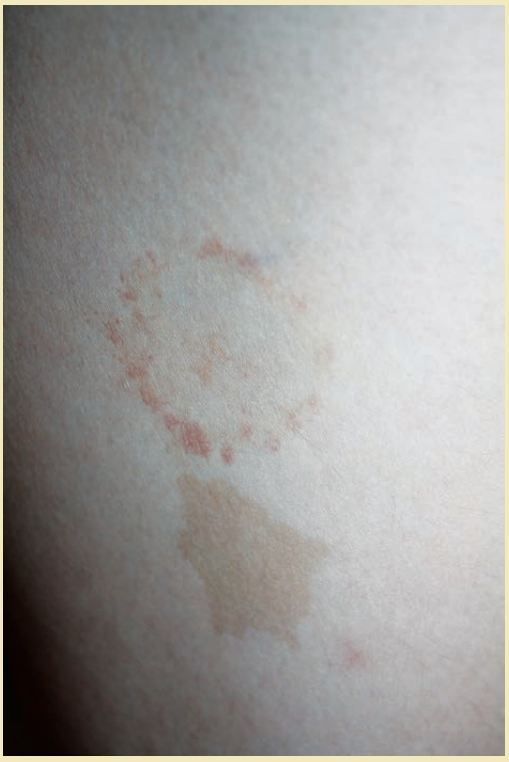
This book is not meant to replace proper psychiatric evaluation and management but serves as a useful primer for doctors interested in offering more than just medications in selective patients. For those who are interested in understanding and practising the various methods he had advocated, there is a fuller version of the book titled "The Feeling Good Handbook". Both books are available in local bookstores.

CM

PHOTO QUIZ

Contributed by Dr See Toh Kwok Yee, MCFP(S), Editor

Image of 17-year-old standing up and showing two adjacent skin lesions over her left lateral thigh.



Questions:

1. ***What is the proximal lesion?***
2. ***What is the distal lesion?***

(continued on Page 12)

(continued from Page 11: Interview with A/Prof Toh Han Chong)

surveillance. In the care of side effects and complications of terminal stage cancer, we need family physicians with a deep interest and passion in hospice and palliative care to step forward and we can potentially provide training for them as well.

CM:
Do share with us on FUTURE DIRECTIONS of Primary Care and Oncology?

HC:
Cancer is a very big area to cover. Fundamentally, we want to make sure that doctors in the community have a rudimentary knowledge of the principles of cancer treatment and cancer care, like pain control and other symptom management. We hope that we can provide more education in the future like how to look for red flags and danger signals of potential cancer in patient with symptoms. That is really critical for front line doctors like GPs and FPs. Screening also helps to pick up early cancers where we can do a lot more for them, so the priority here is to nip it in the bud. When cancers are diagnosed late where distant spread has already occurred, the prognosis is usually not good.

Equally important is for family physicians to educate and encourage lifestyle changes that can help prevent cancer. Primary care can make a huge impact in this area in the community setting. For example, smoking has been associated with many different cancers including cancers of lung, esophagus, throat, head and neck, breast, colon and cervix. Smoking cessation has a massive impact on the reduction of incidence for such cancers. Increasing consumption of red meat and the rise of obesity have been associated with higher risk of colorectal cancer and even breast cancer.

CM:
In your opinion, how has ONCOLOGY PROGRESSED?

HC:
There is absolutely no doubt that in the last twenty years, cancer advancements have been transformational, both in the detection of cancers using newer imaging techniques like CT PET scan, preventive medicines like hepatitis B vaccination of our young, cervical cancer vaccines, as well as the discovery of new drugs and treatment pathways. Having said that, we have to very humbly accept that there is still a lot that we do not know about cancer. There are still a lot of pitfalls in drug development, and also many failed clinical trials. It is as if we take two steps forward, and then there will be one step back, but it is very important that we must still take that two steps forward.

CM

(continued from Page 9: Photo Quiz)

Answers

1. The proximal lesion is **TINEA CORPORIS**.

   It has the characteristic annular "ringworm" morphology.
   The rim is papular and scaly and expands centrifugally leaving a cleared or resolved centre.
   Pruritus is a common presentation, which is the case here.

   Tinea Corporis is caused by a dermatophyte.
   The most common causative fungus is Trichophyton rubrum which spreads from human to human by direct contact.
   Infection acquired from animals and soil is usually caused by Microsporon canis.

   Predisposing factors include warm, humid climate and personal hygiene.
   Other known risk factors include Diabetes Mellitus and conditions with impaired immune system.

   The diagnosis is based on clinical findings and investigations are usually not needed.
   Skin scrapings for microscopy with potassium hydroxide will reveal mycelium.
   Fungal culture is reserved for recalcitrant cases.

   Treatment for a small solitary lesion like in this case is mainly topical.
   The commonly used topical antifungal agents are the imidazoles which include miconazole and clotrimazole.
   Another group of antifungal are the allylamines, an example of which is terbinafine.

   A combination cream composed of miconazole nitrate 2% and hydrocortisone 1% was used for this patient to address the fungal infection and the associated inflammatory and pruritic reaction.
   The response was good.

   Oral antifungals are only indicated in failed topical treatment or very extensive lesions.

   (Readers should be mindful of the recent HSA advisory on the Hepatoxicity risk of oral Ketoconazole)

2. The distal skin lesion is a **CAFÉ AU LAIT MACULE (CALM)**.

   The macule in the image is about 4 cm in diameter, brown in colour, solitary and present since birth.

   Solitary CALM is usually of no medical significance.
   But multiple CALMs-more than six- is a major predictive feature for Neurofibromatosis Type 1 (NF 1).
   As the neurofibromata do not appear until late adolescence or adulthood, the presence of multiple CALMs allows for an earlier diagnosis of NF 1. *(a)*

   Other conditions associated with CALMs are Tuberous Sclerosis, Fanconi Anemia and McCune-Albright Syndrome.

   Since the lesion is benign, there is no need for treatment.
   Cosmetic treatment with various lasers has variable results. *(b)*

References
(a) The Asian Skin, National Skin Centre.
(b) Medscape Reference

CM

Family Practice Skills Course #60

Disability Assessments

Sat - Sun, 18 - 19 October 2014
2.00pm - 5.30pm

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

TOPICS
Unit 1: Diseases that Result in Disability in Adults
Unit 2: Rehabilitation and Coping with Disabilities in Adults
Unit 3: Assessment of the Six Activities of Daily Living in Adults
Unit 4: Diseases that Result in Disability in Infants and Children
Unit 5: Rehabilitation and Coping with Disabilities in Infants and Children
Unit 6: Assessment of Activities of Daily Living in Infants and Children with Developmental Disabilities

WORKSHOPS
Day 1: Case Studies – Adults
Day 2: Case Studies – Infants and Children

Course Assessment for Accreditation

SPEAKERS
A/Prof Goh Lee Gan
Dr Kelvin Phua
Dr Sherry Young
A/Prof Ong Hian Tat
Dr Ng Zhi Min
Dr Sylvia Choo

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, 18 October 2014 (2.00pm - 4.00pm)
Seminar 2 • Unit 4 - 6: Sun, 19 October 2014 (2.00pm - 4.00pm)

WORKSHOPS (1 Core FM CME point per workshop)
Day 1: Sat, 18 October 2014 (4.30pm - 5.30pm)
Day 2: Sun, 19 October 2014 (4.30pm - 5.30pm)

*Registration is on first-come-first-served basis.
Seats are limited.
Please register by 13 October 2014 to avoid disappointment.

ASSESSMENT FOR ACCREDITATION
Day 2: Sun, 19 October 2014 (after Workshop, 5.45pm - 6.45pm)
In order to be accredited, doctors must attend all seminars & workshops on both days, attain a minimum pass grade of 60% in Distance Learning MCQ Assessment AND attain a pass in the Course Accreditation held on Sun, 19 October 2014.

DISTANCE LEARNING MODULE
(6 Core FM CME points upon attaining a minimum pass grade of 60% in 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 Health (MOH)**

MINISTRY OF HEALTH
SINGAPORE

REGISTRATION

This course is sponsored by MOH

Disability Assessments
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~~ Sponsored by MOH
Distance Learning (MCQ Assessment)	~~$42.80~~ FREE	☐ ~~$42.80~~
Assessment Fee for Accreditation	☐ ~~$32.10~~ Sponsored by MOH	☐ ~~$32.10~~

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

** To be ElderShield/ IDAPE assessors, participants must attend all seminars & workshops on both days, pass the Distance Learning MCQ Assessment AND pass the Course Accreditation held on Sun, 19 October 2014.*

Name: Dr _____

MCR No: _____ NRIC No: _____

(For GDFM Trainee only) Please indicate: ○ 2013 Intake ○ 2014 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 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