



# THE College Mirror

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WORLD *family doctors'* DAY  
singapore 2014

## FAMILY MEDICINE Teachers' Conference 2015

reported by the organising Class of FMFP 2014-2016

**23** May 2015 marked the dawn of a new chapter in the illustrious history of the College of Family Physician.

The Saturday morning had begun early for the members of the organising committee with everyone arriving at NUS-Shaw Foundation Alumni House at least an hour before the start of the event.

Nothing was left to chance with every detail scrutinised and rehearsed the umpteenth time to make sure the inaugural Family Medicine Teachers' Conference (FMTC) go off without a hitch.

Invited speakers' presentations were duplicated onto two laptops beforehand, lecture notes were printed weeks ahead, four professional grade cameras were at hand to document the day and everyone was decked out smartly in the team colours of black and white.

Working with the College, this medical pedagogy workshop was held in conjunction with the World Family Doctors' Day (WFDD), a day specially

designated to recognise and celebrate the Family Doctor the world over.

The conference was befittingly launched by A/Prof Goh Lee Gan, whose name was synonymous with medical pedagogy.

A/Prof Goh spoke about Practice-Based Assessment (PBM) which was the assessing of a trainee doctor or medical student along clinical competence. He introduced the R.I.M.E. evaluation framework which stood for Reporter, Interpreter, Manager and Educator, the performance goals of the trainee.

The Learning Cycle in which a learner will pass from Unconscious Incompetence through Conscious Incompetence, Conscious Competence and finally to Unconscious Competence was also dealt with. Next, A/Prof Goh taught the participants the One-Minute Preceptor, a 5-step skill for teaching: Get a commitment, Probe for supporting evidence, Teach general rules, Re-inforce what was done right and Correct mistakes.



A/Prof Goh Lee Gan — whose name is synonymous with medical pedagogy

### IN THIS ISSUE:



GETTING FAMILY DOCTORS  
READY FOR THE RAPIDLY  
AGEING POPULATION

Pg 9



DR LAM PIN MIN -  
COURTESY VISIT TO  
THE COLLEGE

Pg 15



AIC COMMUNITY  
CARE FORUM -  
PRIMARY CARE TRACK

Pg 28

(continued on Page 3)

# CONTENTS

- 01 Cover Story #1:**  
FAMILY MEDICINE TEACHERS' CONFERENCE 2015
- 02 Editor's Words:**  
FIRST DO NO HARM
- 06 Invited Article:**  
A BRIEF VACCINE UPDATE FOR THE BUSY GP
- 09 Event:**  
GETTING FAMILY DOCTORS READY FOR THE RAPIDLY AGEING POPULATION
- 10 Photo Quiz**
- 12 Practice Tips:**  
A REVIEW OF NON-SURGICAL OPTIONS IN OSTEOARTHRITIS
- 14 President's Forum:**  
AFFORDABLE HAIR CARE: WHAT I LEARN ABOUT MEDICINE FROM MY HAIRSTYLIST
- 15 Event:**  
DR LAM PIN MIN, MINISTER OF STATE FOR HEALTH COURTESY VISIT TO THE COLLEGE
- 17 FPSC #62:**  
HOME CARE
- 21 Practice Tips:**  
REVISITING BLOOD PRESSURE READINGS IN PRIMARY CARE SETTING
- 24 Book Review:**  
PAINLESS EVIDENCE-BASED MEDICINE
- 24 Report:**  
PROJECT SA'BAI: A LOVE FOR CHILDREN, A HEART FOR COMMUNITY
- 28 Cover Story #2:**  
AIC COMMUNITY CARE FORUM - PRIMARY CARE TRACK

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(continued from cover page)

A/Prof Goh next discussed the tools of PBM and how to manage the resident in difficulty. With the help of two video clips, he then demonstrated the American Board of Internal Medicine (ABIM) Mini-Clinical Evaluation Exercise (Mini-CEX) used in assessment of core clinical skills.

Participants were invited to grade the two contrasting clinical performances seen on the clips using CEX and to give reasons for their scores.

The first part of the plenary workshop ended with an engaging Q&A segment with more questions than the time allowed.

What followed was a tea break which saw participants eagerly posing for group photos, catching up on friendships and browsing through some good medical reference books put up by the vendor.

The workshop resumed with Dr. Matthew Ng, the new Head of SGH FMCC and Chief Examiner of Graduate Diploma in Family Medicine (GDFM), teaching the participants the principles of writing Objectively Structured Clinical Examination (OSCE). OSCE can be used to test most areas of clinical practice from history to management. A good script was needed especially if a Simulated Patient was required.



Dr Matthew Ng giving tips on writing OSCE



Dr Winnie Soon and the Essentials of Setting Good MCQs

The floor was next handed over to Dr. Winnie Soon who spoke about the Essentials of Setting Good Multiple Choice Questions (MCQs). She had likened a well-crafted MCQ to a carefully mined, cut and polished diamond that can be used to measure recall, knowledge and comprehension among other things.

The components of an MCQ are the Stem, Lead-in, Options, Rationale and References.

After a generous and sumptuous lunch, the participants were treated to a photo montage put together by the FMFP trainees to commemorate and reminisce the many fond years of teaching of Family Medicine by the college.

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Following the plenary sessions, the participants broke into two groups in accordance to their registered preference.

Track A was opened by A/Prof Goh Lee Gan who spoke on The Pedagogy of Extended FM which encompassed the extended Stott Davis' ABCD domains of Family Medicine consultation.

He further elaborated on the 4 Domains of Kolb Experimental Learning. A recommended read for the participants was the book, "Counseling within the Consultation", co-authored by A/Prof Cheong, A/Prof Goh and Dr. Ong Chooi Peng.

The highlight of the afternoon was undoubtedly the plenary session: Down the Medical Pedagogical Memory Lane presented by A/Prof Goh Lee Gan and Dr. Julian Lim.

A/Prof Goh, with the aid of charts and slides, showed the participants how far Family Medicine had come after one generation.

A commentary written by A/Prof Cheong Pak Yean entitled The Long March To FM Recognition was given a special mention by the presenters. It described the eventual triumph by the College in establishing the Advanced Family Medicine Programme (AFMP) which had its roots in the Graduate Family Medicine Centre (GFMC) inaugurated 17 years ago.

The interactive format of the session included some respected senior doctors in the audience recollecting their fond moments during their formative training. The common refrain among those who shared was that Family Medicine in its many settings will continue to increase in importance in the years ahead and Family Physicians must stay united and continue to train to meet the health challenges facing Singapore.

medical schools. Dr. Lim Fong Seng, A/Prof Lee Kheng Hock and A/Prof Wong Teck Yee acquainted the audience with the undergraduate teaching curriculum of their respective schools.

Over to Track B, the afternoon sessions kicked off with the feisty Dr. Julian Lim who brought the house down with his segment entitled Sex and Zen in 3D!

Much to the relief of the red-faced organisers, they were, but, acronyms for the strategic components of the Master of Medicine in Family Medicine [MMed(FM)] Course.

Dr. Farhad Vasanwala took centre stage next to expound the virtues of Bedside Small Group Teaching. He believed that "the average teacher tells, the good teacher explains, the better teacher demonstrates and the great teacher inspires" and that the true measure of a doctor must be empathy.

The Track A programme concluded with A/Prof Tan Boon Yeow (NUHS Residency), Dr. Sally Ho (SHS Residency) and Dr. Darren Seah (NHG Residency) showcasing their respective

rigorous and comprehensive programmes and the challenges each of them faced. The participants learned how the curriculum had departed from the British High-Stakes exams system to arrive at the current American Formative Pedagogy style.

With that, the College first-ever FMTC came to a close with a unanimous acknowledgement that the event had been a resounding success!



College Mirror (Team B) editor, Dr See Toh Kwok Yee (in blue and red tie) with the Class of FMFP 2014 - 2016.

Dr. Kwong Kum Hoong was up next to give some Insights into GDFM teaching. He was pleased to announce that the course was gaining traction among doctors including medical colleagues from the other specialties. This year alone, the intake had exceeded 140!

The Track A breakout sessions were rounded off by the three divisional Heads of Family Medicine from the Yong Loo Lin, Duke-NUS and Lee Kong Chian

# FMTC & WFDD Dinner 2015

23 May 2015  
NUS-Shaw Foundation Alumni House & NUSS Kent Ridge Guild House



College of Family Physicians Singapore

## FAMILY MEDICINE COMMENCEMENT CEREMONY 2015

CFPS  
44<sup>th</sup> AGM

25 July 2015 (Saturday), 2.00pm

Family Medicine  
Commencement Ceremony 2015  
2.00 - 3.30pm ♦ Auditorium (Level 2)

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

CFPS 44<sup>th</sup> AGM & Election of President  
4.00 - 6.00pm ♦ Auditorium (Level 2)

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

# First Do No Harm

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

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Ms Patricia Cheok

Recently, at the first edition of the Family Machine Teachers' Conference, a speaker had touched on the subject of Burnout among doctors. Strikingly, according to the speaker, Family Physicians were among the highest rates. A quick poll of the conference participants, "raise your hand, if you have experienced burnout", seem to bear this out!

Some senior colleagues I have spoken to advocate attending town hall meetings, where we can meet regularly to share and tackle our common predicaments, and spending time with our younger and bright-eyed colleagues, whether in teaching them or aiding them in medical missions, probably help build our resilience to stress.



*FMTc 2015 Organising Committee integrating fun with work!*

A 2015 Medscape survey has revealed that half of all U.S. Family Physicians sampled have reported burnout, which is commonly taken to mean loss of enthusiasm for work, feelings of cynicisms and a low sense of personal accomplishment.

The speaker had recommended work-life integration (apparently, work-life balance is passé) and seeking a higher meaning in the work we do to combat this malady.

The matter may be truer now with the sheer number of patients arriving at the private GP/FP clinics under the CHAS and PGP program and the attending electronic submission and documentation workload.

As it goes without saying, a burnout doctor serves no good purpose. I believe the oft-quoted adage, First Do No Harm, is equally applicable to the doctor himself as a memento to always take care of himself foremost in order that he can give his level best!

■ CM

# A Brief Vaccine Update for the Busy GP

by Dr Asok Kurup, Consultant Infectious Diseases Physician, Mt Elizabeth Medical Centre

There have been a number of new developments in the field of vaccine preventable conditions. These have ranged from the evolution of protein conjugate vaccines like Prevnar-13 to novel vaccines of which the zoster vaccine or Zostavax is an example.

## PNEUMOCOCCAL VACCINES (PREVNAR 13, PPSV23)

**1.** Infections due to streptococcus pneumoniae continue to adversely impact morbidity and mortality especially among older adults. In Singapore, an attributable mortality of 21.4% was noted amongst 192 adult cases of invasive pneumococcal disease from 2000 to 2007<sup>1</sup>.

Incorporating capsular polysaccharide which is virulence determinant of streptococcus pneumoniae is the basis for pneumovax or PPSV23. This consists of capsular material from 23 pneumococcal types which account for 75.4% of invasive pneumococcal disease in Singapore in 2012<sup>2</sup>.

Conjugate vaccines offer a possible advantage of eliciting immunological memory, hence priming the immune system for either natural exposure or subsequent booster vaccination. Major reductions in the incidence of pneumococcal disease have been impacted by the use of these vaccines in childhood with resultant herd effect causing significant decrease in pneumococcal disease due to vaccine serotypes in unimmunised older children and adults. A pneumococcal conjugate vaccine, PCV13 is now available formed by linking capsular polysaccharides from 13 most common serotypes that cause disease to a nontoxic protein.

Preliminary results are available from a randomized, placebo-controlled, double-blind, single-centre trial in which subjects aged 65 years and older were randomly assigned to receive a single dose of either PCV13 or placebo<sup>3</sup>. Amongst almost 85,000 subjects, there were 45%

fewer first episodes of vaccine-type community acquired-pneumonia and 75 % fewer first episodes of vaccine-type invasive pneumococcal disease among PCV13 recipients compared to placebo. While the results are encouraging, the study does not compare PCV13 with PPSV23. Available data however show that conjugate vaccines are more effective than polysaccharide vaccines in HIV-infected patients in Africa serving as a surrogate for immunocompromised populations<sup>4</sup>.

## PPSV23 or PCV13?

PCV-13 has been shown to be as safe as PPSV23. Unlike PPSV23, PCV-13 is antigenic in children under the age of two and can be used in this age group. A single dose of PCV-13 is recommended in at risk groups and revaccination is not required unlike PPSV23 which needs to be re-dosed in adults  $\geq 65$  years of age if they were vaccinated more than five years previously at a time when they were less than 65 years of age. Unlike PCV-13, PPSV23 cannot interrupt carriage or impact on herd effect. Their efficacy against invasive pneumococcal disease is unclear especially in older and high-risk individuals. Nevertheless, PPSV23 remains cost-effective for the low-risk elderly. The main drawbacks of PCV13 are its cost, lesser serotype coverage and the possible appearance of replacement strains. The United States Advisory Committee on Immunization Practices (ACIP)<sup>5</sup> endorses PCV13 over PPSV23 for adults with certain underlying medical conditions based on theoretical considerations and on results that some immunocompromised populations may show better responses.

For instance while patients who smoke, are alcoholic, or who have diabetes mellitus, and are more than 65 years should receive PPSV23, but persons with functional or anatomic asplenia, and who have immunocompromised conditions like HIV infection or malignancies like lymphoma should receive both PCV13 and PPV23 given sequentially.

## CONJUGATE MENINGOCOCCAL VACCINES

**2.** Apart from travelers to endemic areas, prevention of meningococcal meningitis is relevant to those with functional or surgical asplenia, complement component deficiencies, and overseas educational requirements.

Protein conjugate vaccines have also evolved for the prevention of meningococcal disease. The older quadrivalent meningococcal polysaccharide vaccine (Mencevax) has a good track record and is well tolerated. However repeated vaccinations may result in hyporesponsiveness. This is important as meningococcal vaccine boosters are recommended at 3 to 5 years intervals. As with other polysaccharide vaccines, they are not immunogenic in children under 2 years of age, and have little impact on clearing nasopharyngeal carriage and herd immunity.

By conjugating neisserial polysaccharides to carrier proteins a T-cell-dependent immune response can be elicited and is the basis for the new quadrivalent meningococcal conjugate vaccines (Menactra, Menveo, and Nimenrix) currently available.

The pendulum appears to be swinging more in favor of these relatively new protein conjugates vaccine over the older polysaccharide type. Expert opinion and major health bodies in the European Union, Canada, and Australia recommend the use of quadrivalent conjugate vaccines for travelers.

A recent study<sup>6</sup> showed that Menveo and Menactra show good antibody responses against all 4 serogroups. Three years after primary immunization the proportions of vaccine recipients with protective titres were higher in persons vaccinated with Menveo than with Menactra for serogroups W135 and Y, but were no different against serogroups A and C.

A single dose of Menveo booster led to excellent response to all serogroups.

These vaccines are generally well tolerated. Those with past cutaneous reactions involving skin necrosis (Arthus-type reaction) may need deferment of vaccines for a minimum of 10 years after the last dose. Although no clear link was established in previous rare reports of Guillain-Barre Syndrome (GBS) post vaccination, GBS continues to be listed as a precaution in the drug inserts. However since 2010 ACIP had removed a history of GBS as a precaution for Menactra.

### VARICELLA ZOSTER (ZOSTAVAX)

**3.** Up until recently herpes zoster was an unpreventable malady. However data from a landmark study<sup>7</sup> showed that a onetime subcutaneous injection of a novel vaccine, Zostavax reduced the incidence of herpes zoster by 51% compared with placebo in adults 60 years of age or older. It paved the way for the approval of this live attenuated vaccine in persons  $\geq 60$  years of age including those with previous episodes of zoster. In some countries like the United States, it is approved for adults  $\geq 50$  years. It is well tolerated with injection site pain being the most common side effect.

Being a live vaccine, Zostavax is contraindicated in immunocompromised conditions including leukemia, recipients of cancer chemotherapy and immunomodulatory therapy, post-transplant recipients, HIV infected individuals with a CD4 cell count of  $< 200$  cells/ul, and those who receive a dose  $\geq 20$  mg/day of prednisolone for  $\geq 14$  days.

### HUMAN PAPILLOMA VIRUS VACCINE (HPV) (Gardasil / Cervarix)

**4.** Safe and effective vaccines<sup>8</sup> are now available for the prevention of infection due to HPV 16 and 18 which are implicated in cervical cancers and HPV 6 and HPV 11 causing genital warts. The quadrivalent vaccine (Gardasil) includes HPV types 6, 11, 16, and 18, while the bivalent vaccine (Cervarix) includes HPV types 16 and 18. Gardasil is given as 3 doses at time 0, 2 and 6 months of follow-up. Cervarix is administered in 3 doses at time 0, 1 and 6 months of follow-up.

Immunization is most effective prior to acquisition of HPV hence before sexual debut. Those who are already sexually active may still benefit from immunization because they may not yet be exposed to HPV subtypes covered by the vaccine. Immunization of females should be offered to girls 9 years through to 26 years.

The quadrivalent but not the bivalent HPV vaccine is effective in preventing both genital warts in young males and anal intraepithelial neoplasia among men who have sex with men. In many countries, immunization is also offered to boys aged 9 to 26 years.

### TETANUS/ DIPHTHERIA/ PERTUSSIS (Tdap - BOOSTRIX)

**5.** Booster immunization with tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccine is rarely followed up in adults. Being part of routine childhood vaccination in children, DTaP is followed by a booster dose of Tdap at 10 to 11 years of age. It is not often practiced but subsequent tetanus doses, in the form of Td, should be given at 10-year intervals throughout adulthood. It is imperative to note that tetanus immunization should be reviewed in the context of acute traumatic wounds especially if heavily contaminated regardless of prior tetanus and diphtheria immunization.

Many practitioners also do not associate pertussis as a cause of protracted cough in adults. It is also not commonly appreciated that without boosting protection after childhood vaccination is insignificant after 10 years. A recent study in Singapore<sup>9</sup> highlighted the dichotomy between the seroprevalence of 97% amongst adults as compared with a historical seroprevalence of 50% amongst adolescents suggesting acquisition of natural infection. This argues for booster vaccine for adolescents and young adults in Singapore. The ACIP recommends a single booster administration with Tdap for adults aged 19 and above, those with obesity and pre-existing asthma and persons having close contacts with young children.

### OTHER VACCINES

**6.** Sporadic cases of measles, and mumps continue to appear in Singapore. Recently there was also an outbreak of measles in the Philippines. It is important to know that **2 doses of MMR** (measles, mumps, and rubella vaccine) are required for adequate protection.

There is a relatively new purified, inactivated vaccine for **Japanese encephalitis** (Ixiaro) for travelers at risk to rural agricultural endemic areas in Asia and the Western Pacific.

There are still several areas in the world which continue to report cases of **polio**. A booster dose of OPV or IPV between 4 weeks and 12 months is recommended prior to travel for long term travelers to countries like Nigeria, and but should be given for long term travelers to Pakistan, Cameroon, or Syria.

Last but certainly not least, as we strive to protect our patients, we must remember to keep our own vaccine record updated. The annual seasonal **influenza** vaccine should not be forgotten.

**In summary**, the newer vaccines to consider for adults include:

- 1. Pneumococcus** – All people age 65 years or older should receive a one-time dose of PCV13 (if previously unvaccinated) followed 6 to 12 months later by 1 dose of PPSV23. In adults younger than 65 years who smoke cigarettes, or have chronic cardiac or pulmonary disease (including asthma), chronic liver disease, alcoholism or diabetes, administer at least PPSV23. Those with more immunocompromising conditions like HIV infection should receive the PCV-13 first followed at least 2 months later by PPSV23
- 2. Meningococcus** – Recommended for travellers to endemic regions (e.g. for the Haj - the polysaccharide vaccine e.g. Mencevax may be given), and for college students living in student housing and for those requiring future

(continued on the next page)

repeat doses of the meningococcal vaccine (the new quadrivalent meningococcal conjugate vaccines e.g. Menactra/ Menveo / Nimenrix preferred)

**3. Human Papilloma Virus (HPV)** – HPV vaccine should be offered to girls and boys aged 9 – 26 years. In girls, the bivalent or quadrivalent vaccines may be administered, and in boys only the quadrivalent vaccine.

**4. Herpes Zoster** – Zostavax recommended for all adults above 60 years. May be given after 50 years age.

**5. Tetanus, Diphtheria, Pertussis** – All adults who have not already received Tdap or whose Tdap history is not known should receive a single dose of Tdap, followed by Td booster every 10 years. (A dose of Tdap should be given regardless of interval since previous Td). In each pregnancy, the Tdap should be administered during the 3rd trimester.

College Mirror asked Dr Asok Kurup for advice on the following scenarios:

**Scenario 1:**

**In advising a 50 year old healthy adult about routine vaccinations, unrelated to travel, which vaccinations are recommended?**

Dr AK: The following routine vaccinations are to be considered: Influenza, Pneumococcal (specific indications), Hepatitis A & B, Zostavax, Tdap, Hemophilus Influenza.

**Scenario 2:**

**What is the recommended timing of Zostavax vaccination following herpes zoster (shingles) infection?**

Dr AK: There is no specific guideline on this, but as a rule, it may be prudent to wait 6 to 12 months after resolution because zoster itself can induce some immunity. By deferring the vaccine we can potentially boost immunity better.

**Scenario 3:**

**Use of Tdap instead of tetanus toxoid (TT) to a patient with a contaminated wound.**

Dr AK: What is relevant here is TT; if the Tdap has already been given once to an adult then subsequent regular boosters every 10 years is with Td; however in the case of a contaminated wound proceed with TT.

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■ CM

# Getting Family Doctors Ready for the Rapidly Ageing Population

*a report on FPSC Transitional Care for Family Physicians by Dr Ng Lee Beng, FCFP(S)*

by Dr Ng Lee Beng, FCFP(S), Council Member, College of Family Physicians Singapore

The College organised the first ever Transitional Care skills course for family doctors in Singapore on the weekend of 9 and 10 May 2015. It was warmly attended by more than the expected number of participants despite being a busy weekend for CMEs all over the island.

**A/Prof Lee Kheng Hock** gave the introduction on Transitional Care and explained why family physicians, with their generalist training and community orientation, are the best fit for the tasks at hand. He gave statistics to show the challenging situation of the healthcare system in the years ahead as our population ages rapidly. He outlined the essential competencies of Transitional Care which include, comprehensive assessment of needs, care planning, communications, inter-setting care management and empowerment/support for self-care. He demonstrated how these competencies, in fact, matched perfectly with the competencies of family medicine. He urged all family physicians to take on this critical role in Transitional Care and help our nation meet the new challenges facing the healthcare system.

Next **Dr Low Lian Leng** elaborated on the steps of comprehensive discharge planning from the primary care perspective and gave a step-by-step strategy to get our primary care clinics ready for the transitional care.

**Dr Jesmine Lee** followed with a description of the multidisciplinary team, comprising the doctor, the nurse, the speech therapist, the physiotherapist, the occupational therapist, the pharmacist

and the social worker. She outlined the strategy of maximising the benefits of team-based care.



Principal Physiotherapist Yong Limin giving a lively demonstration on the use of mobility aids.

The first day session ended with **Advanced Practice Nurse Rachel Towles** providing a hands-on workshop best practices for home care services. She provided the participants with the steps needed to set up a state of the art home care service.

The next day, Mother's Day notwithstanding, the room was equally packed as was the first day. **Dr Ng Lee Beng** kicked off the afternoon with a talk on Advanced Care Planning (ACP). Dr Ng built a compelling

case for GPs to initiate conversations with their patients early in the management regarding the patients' choices on future care, long before a catastrophic illness occurs. She encouraged doctors to similarly start reflecting on their own personal goals and beliefs on life and their possible choices in the event of a catastrophic illness or injury, so that they may gauge their own comfort level in conducting such dialogues with the patients under their care.

**Dr Tay Wei Yi** spoke on the intricacies of holding a family conference. The participants were given practical tips on the finer points of conducting a family conference and how to use it to improve communication on care issues. Linking up social care services to help support patients in the community is a critical success factor. **Dr Matthew Ng** wrapped up the series of lectures with a comprehensive outline of the community support services and financial schemes available to help patients and families care for their loved ones in the community. He gave practical tips on how to search for such services on behalf of the patients.

The afternoon ended with a lively workshop on the use of mobility aids by **Principal Physiotherapist Yong Limin**. Participants were given opportunity to try out the different mobility aids that may be prescribed to help their patients.

The feedback from the participants was very positive with many expressing an increase in confidence to meet the needs of our ageing population.

■ CM

# Photo Quiz

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

A 50-year-old Chinese woman had presented with rashes over the face, lips and right upper arm. She had been seen previously by another doctor for persistent low backache and was prescribed Arcoxia (etoricoxib). This had provided some relief from pain but then she had started to notice the rashes. The rashes started as well defined itchy red patches which gradually became plaque like. The one on the upper arm had also developed a blister. She had also noticed that the rashes tend to occur on the same sites and nowhere else and had left behind ugly discolouration.



1. What is the diagnosis?
2. What are the possible differentials?
3. What is the management plan?

(continued on the next page)

## FAMILY MEDICINE CLINIC AT THE UPCOMING TAMPINES TOWN HUB

Eastern Health Alliance will be launching its 2<sup>nd</sup> Family Medicine Clinic (FMC), to be located at Tampines Town Hub, operational in the second half of 2016. It aims to provide quality collaborative primary care services to residents in the East.

We invite proposals from GPs to partner with us to provide:

- Continuing care of chronic diseases
- Relevant supporting services and tests to improve patient's care experience
- Coordination of patient's care with CGH, other healthcare institutions and community care providers
- Management of acute illnesses
- Training for Family Physicians

### Key Requirement

At least one doctor in the FMC should be registered as a Family Physician at the point of application.

MMed and FCFP(S) certification would be advantageous.

All interested parties must attend the following briefing:

**Date** : 25 July 2015 (Saturday)  
**Time** : 3.30pm  
**Venue** : Lecture Room, Training Centre  
 Level 1, Changi General Hospital  
 2 Simei Street 3, Singapore 529889

To register please e-mail your name and MCR number to [Rozanna.Mustaffa@easternhealth.sg](mailto:Rozanna.Mustaffa@easternhealth.sg). Upon registration you will receive an information package and application form. Closing date for applications is 14 August 2015.

### 1. What is the diagnosis?

#### Fixed Drug Eruption (FDE)

The close temporal relationship between the ingestion of the drug and the rashes suggested a possible link. Typically the rash starts as a well-defined erythematous macule which becomes oedematous, forming a plaque. Bulla can develop which may then erode (as in this patient). The erythema became dusky with time and after healing leaves behind a dark brown discolouration. The lesion can be solitary or multiple and may even be generalised. The genitalia and oral mucosal can be involved independently or together with the skin lesions. Rashes appeared from 30 minutes to 8 hours after ingestion of the offending agents. Re-exposure to the same offending drugs result in the occurrence of the rash in the same previously affected sites (and hence appears 'fixed'). The rash would resolve in days to weeks after discontinuation of the drug. However the post inflammatory hyperpigmentation may persist for months or years and does not generally respond to bleaching creams like hydroquinone.

### 2. What are the differentials?

These depends whether it is a solitary lesion, multiple or generalised. Possible differentials include but not limited to the following:

1. Herpes simplex (oral and genital region)
2. Bite reaction especially for solitary lesion.
3. Paronychia when rash is over the nail bed region.
4. Erythema multiforme (look out for the characteristics target lesion).
5. Urticaria which is an extremely itchy blanchable wheals of acute onset which resolve without residual discolouration.
6. Pemphigus vulgaris which is a mucocutaneous disorder characterised by the presence of painful flaccid blister or erosion on surrounding normal skin with or without an erythematous base. Nikolsky's sign is positive (dislodging of the epidermis by lateral finger pressure in the

vicinity of lesion leads to erosion or pressure on the bulla leads to lateral extension of the blister).

7. Bulbous pemphigoid  
Typically occurring in older patient (>60 years), presenting with erythematous urticarial type lesion that precede bulla formation by months. Bullae tend to be large and tense, arising from surrounding normal or erythematous skin.
8. Steven-Johnson syndrome/  
Toxic Epidermal Necrolysis Syndrome  
This is by far the most important differential to consider especially when there is generalised involvement as it is potentially fatal. Lesions starts as morbilliform or diffuse erythema. Discrete lesions coalesced and enlarge as blisters begin to form. Sheets of the epidermis are subsequently shed.

### 3. What is the management plan?

The key to management is to identify and remove any offending agents causing the eruptions. Patch testing is of limited use. The diagnosis is clinical and confirmed by the appearance of the rashes at the previously affected sites as reported in this patient. Management of the rash is symptomatic with topical steroid and antihistamines being commonly used.

#### References

1. Fixed drug eruption, Colour atlas and synopsis of clinical dermatology, Thomas B Fitzpatrick, Richard Allen Johnson, Klaus Wolff, Machiel K. Polano, Dick Suurmond, 3rd edition, P586-589.
2. Fixed Drug Eruptions: A Case Report and Review of the Literature Sarah B. Gendernalik, DO; Kenneth J. Galeckas, MD, Cutis 2009;84,215-219.

■ CM

### NOTICE

We would like to request for the following past publications to be contributed to our archives:

#### The Singapore Family Physician (SFP)

SFP Vol 23(2)  
April - June 1997

SFP Vol 24(4)  
October - December 1998

SFP Vol 26(3)  
July - September 2000

SFP Vol 26(4)  
October - December 2000

SFP Vol 34(4)  
October - December 2008

SFP Vol 35(1) Supplement  
January - March 2009

#### College Mirror

Early issues of the newsletter since January 1994

To contribute, please contact the College Secretariat at **6223 0606** or email to [information@cfps.org.sg](mailto:information@cfps.org.sg). We will proceed to make further arrangements on the collection details.

All kind contributions are greatly appreciated.

## A Review of Non-Surgical Options in Osteoarthritis (PART 2)

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

(Part One of the article, which appears in CM issue Vol.40 No.3 September 2014, deals with the non-injectables like the Analgesics, namely Acetaminophen, the NSAIDs and the Opiates and the OTCs like Glucosamine, Chondroitin)

### Injectables

These injectable agents that may be relevant to arthritis include steroids, viscosupplementation, platelet rich plasma therapy and stem cells. With the present available literature, strong support for use is only available with steroids and viscosupplementation. The remaining 2 are largely experimental and cannot be recommended for routine use. With any injection there is the risk of infection and this can compromise further surgery on the knee.

In **platelet rich plasma (PRP)** therapy, a sample of blood is extracted from the patient and processed to provide a platelet rich injectable. The draw is that it comes from the patient and is relatively safe representing a reinfusion of the patient's own fluids back into the patient. Over the last few years the technology has been advocated for a wide variety of orthopaedic conditions. Its use in tendinopathies about the shoulder and especially in lateral epicondylitis (tennis elbow) has been impressive if preliminary. The presumed mechanism of action is an accelerated healing or reactivation of healing of tendon tears and generally is plausible in the context of current understanding of the growth factors within the extract. Basic science data has been lacking and it can be difficult to draw any strong conclusions.

For PRP in osteoarthritis, there have been a number of papers in recent literature. These tend to be cohort based studies prospectively followed. The data is interesting but strong conclusions on advocacy cannot be drawn. Specifically many insurance companies do not support reimbursement for its use.

The conclusions of the better designed studies are that as it does no further harm, its use is justifiable in osteoarthritis. Specifically it has some benefit in reducing pain for patients with early cartilage lesions. In established arthritis, however, it has not been found to be useful. This perhaps makes sense in the context of the growth factor mechanism of action inferred above. Ministry of Health (MOH) does not advocate its use in osteoarthritis and recommends that such applications be subsumed under the governance concerning trials.

Its place in the management of osteoarthritis should therefore be positioned in the same set of indications as the injectables described elsewhere in this paper (ie. a relatively safe procedure which gives symptomatic relief). It cannot – based on present knowledge – be advocated as a routine therapeutic option in the treatment of osteoarthritis of the knee.

The idea behind **viscosupplementation** is the injection of a lubricant in the joint. It does not help cartilage growth and it does not reverse the disease.

This lubricant is a derivative of hyaluronic acid, a natural lubricant in joints. There can be organic or synthetic (Orthovisc, Monovisc) variants of this. The organic variants are derived from chicken combs whereas the synthetic ones derive from a bacterial-based manufacture process. The synthetic ones may therefore have theoretical advantage in reducing the risk of allergic reactions.

Most administrations involve single injections of about 6 ml of fluid into the knee. The procedure is a sterile process. Usually fluid is aspirated from the knee before injection. This abnormal fluid contains pain causing prostaglandins (NSAIDs target these, by the way) within them and may itself reduce pain.

In the carefully selected patient, it may give benefit to about 60 to 70% of patients

and the results may last between 6 to 9 months. Repeated injections after that, result in progressively shorter periods of relief. Unfortunately, the exposure of a patient to the agent can sensitize the patient such that the next injection can result in severe inflammation in the knee. This pseudo-infection can be distressing and lead to avoidable further treatment and even surgery. Chicken protein allergy in particular may be present in the patient and unrecognised and result in a severe allergic reaction. Many patients do develop warmth and swelling in the knee after the injection even without known allergies.

In my practice, viscosupplementation is generally provided selectively to older patients who are not candidates for surgery and with significant arthritis. Cost should be borne in mind though – three injections can cost the price of a knee replacement prosthesis.

When **steroids** are used in the joint (especially the knee) they can be very effective in reducing acute pain. Typically the steroid effect works over about 3 weeks and then the pain returns. Unfortunately, steroids themselves can cause damage to cartilage and therefore make the arthritis worse. Their use in osteoarthritis needs to be carefully considered.

Steroids work by reducing inflammation. Again this likely works on suppressing the intra-articular prostaglandins in the knee. It is therefore most relevant to osteoarthritis with an inflammatory component. Hence, one needs an understanding of the pathology of osteoarthritis to make steroid use logical. In osteoarthritis there are changes to the cartilage which are worn away (loss of joint space) and then these die and become osteophytes. The bone is exposed and becomes hardened (subchondral sclerosis) and the joint loses its shock absorbance and become prone to cracks. The underlying bone to this sclerotic layer loses its integrity and becomes weak (cysts). The anatomy becomes distorted and the ligaments

become stretched (varus or valgus). These five changes are considered the hallmarks of osteoarthritis. So when one understands this and the action of steroids, it can be difficult to recommend its use especially when the side effects of making it worse are understood.

In osteoarthritis of the knee, there can be bouts of inflammation secondary to cracks and tears in the joint. This can result in synovial inflammation. These episodes occur periodically throughout the process of osteoarthritis. There may be some benefit in this context to steroid injection accepting that cartilage may be damaged further.

Typically therefore, steroids may be used in elderly patients with advanced arthritis who are unfit for surgery and in whom systemic therapy (ie. painkillers) has not provided relief or may indeed be dangerous. In the other extreme of a young patient in whom

there is mild arthritis and is a candidate for surgery however, the steroids could make the condition worse. Furthermore by risking infection, performing a joint replacement is prevented. Steroids should therefore be viewed cautiously as a blunt instrument that can cause more damage than good.

There is no good evidence that **stem cell** injections work in established osteoarthritis. The author has himself been a pioneer in stem cell research since the nineties and it is very clear that by present methods, stem cells do not become cartilage. Rather, they become fibrocartilage and then progressively become more bone-like and the ulcer returns. With osteoarthritis as discussed above, the changes are far more extensive than just ulcers. Until gene therapy is accepted as a means of maintaining the phenotype of cartilage in such treatments,

stem cell therapy is not likely to be a long-term solution for osteoarthritis or ulcers in the knee.

### Conclusion

While we have a better understanding of what osteoarthritis is, it should be evident from the above discussion that the approach amongst healthcare providers towards this condition has been largely symptomatic. Fortunately, this is a valid approach in the vast majority of cases. Nevertheless in about 30% of patients, there needs to be a second look of sorts to see if some of these other modalities may be beneficial in the given patient. Even in the specialist clinic these thought processes are demanded – not every arthritic patient is a fair candidate for surgery.

■ CM



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**SingHealth Polyclinics – Head Office**  
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E-mail: [lim.teng.teng1@singhealth.com.sg](mailto:lim.teng.teng1@singhealth.com.sg)  
(We regret that only shortlisted applicants will be contacted for an interview.)



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Partners in Academic Medicine



# Affordable Hair Care

## What I Learn About Medicine From My Hairstylist

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

Yes, I am exaggerating. I don't have a hairstylist. This is probably quite obvious if you have seen my hairstyle. When I kept it long, some thought I was a Rip Van Winkle who woke up from the 1970s and forgot to update my hairstyle. One day, I decided to finally do something about my hair to make me look more contemporary and more like a corporate yes man. That's when I upgraded myself from affordable basic hair care to specialist hair care.

Contrary to popular belief, having long hair is much cheaper and more convenient. The real reason why I kept my hair long was to save time and money. I cut my hair once in three months. That translates to a 66% savings compared to the average person who have a haircut once a month. On top of that, I go to my favorite primary hair care provider who gives me a decent haircut for just 12 bucks. The instructions are simple and left little margin for error. "Keep long, just trim". Just four words is enough to get the shears moving. I am in and out of the barbershop in 10 minutes and there is no long queue to see your appointed hair stylist. My favorite part is when my head gets a free vacuum cleaning at the end. Every bit of cut hair and I suspect every flake of dandruff is removed from my scalp. I don't even have to get my hair wet! No down time for hair drying.

My woes started when I went for specialist hair care. The price tripled even when I chose the cheapest specialists in town. The hair go out of shape so fast that I have to visit every month. So my head is practically useless for hours on end as they fuss over my hair. What really gets me is the professionalism of the hairstylist. They all look spiffy and professional-like. The ambience is nice. I even get the latest magazines to read and nice cup of tea. What made me most uncomfortable is that they don't seem to be interested in giving me a haircut.

At my latest visit, the hairstylist referred me to a sub-specialist in scalp treatment.

He was really pushy and I relented. I got a free diagnostic test with apparently no obligations. The test involved a dermatoscope examination of my scalp. Even with my training in dermatology the results were really scary. The hairs looked like black steel columns erupting from the earth. Flakes of dandruff looked like huge concrete slabs strewn haphazardly in an earthquake zone. Dormant hair follicles were gleefully brought to my attention. Keratin bits at the root of my hair were pointed out to me. The diagnosis was scary. I have a terminal case of balding. What followed was a discourse on the latest pseudoscience of balding. My hair follicles are plugging up with skin debris. Hair follicles are forced into early retirement. And of course all is not lost despite the very grim situation that I am in. There is a cure. Surprise, surprise. I am in dire need of treatment. Not just one but a series of scalp treatment that comes in an attractive promotional package. My haircut will be on the house if I sign up for this special package today. Notwithstanding my high level of medical training, they managed to raise my anxiety level almost to the point of signing the consent form. Fortunately my natural skeptical nature got the better of my anxiety.

It was like trying to shake off a scotch tape stuck to the sole of your shoes but eventually I did manage to communicate my acceptance of terminal baldness and I was allowed to proceed for my haircut. By which time I was a bit worried that the hairstylist might hold it against me and decide to sabotage my hair. Fortunately he was not so unprofessional. They must have introduced a module on trichological ethics in the school of hairstyling. However, that did not stop the subspecialist from placing a bottle of special treatment lotion in front of me for my consideration. It apparently can do deep cleansing of my hair follicles and resuscitate them to life. I was half convinced to purchase it on the off chance that their diagnosis might be correct and to salvage my relationship with my hairstylist who was holding sharp instruments over my head. That was until I

took a quick look at the ingredients of the lotion. It was written in scientific jargon but with my quasi scientific training, I was able to decipher them. Garden variety stuff that you can get from the shampoo and lotions section of any supermarket. I just couldn't stand being taken for a ride. I refused to budge.

Throughout the hair cut, I can see that the hairstylist was quite distracted. He was constantly trying to steer the conversation back to scalp care. Half way through he found the chink in my armor which gave him the excuse to offer me a free sample of the scalp treatment. Out came the sophisticated contraption with what looked like a plastic spoon at the business end.

"You will be impressed by how effective this machine is. Just wait till you see how much debris it removes from your follicles at the end." He confidently pointed to the spotless black barber sheet that he had wrapped around me. Clearly he wanted me to make a note of the baseline state of the impending before-after experiment. Thereupon he started applying the plastic spoon all over the scalp. It seems to deliver a series of short piezo electric vibrations to my scalp. Fifteen minutes later, we looked at the black cloth that was supposed to have collected a snow storm of skin debris. There was only one strand of good hair that he managed to dislodge from my fast disappearing hair follicles. There was one or two flakes of dandruff. I was justifiably unimpressed and he finally gave up on pushing for a sale. He finished the haircut in silence. Unbeknownst to him, I had gone swimming in the morning and had a good shampoo after that. Otherwise I would probably end up like any other chum and gladly paid up. Unfortunately, I did not get off scot-free. The hair cut was badly done. I am sure he had the skill but his heart was not in. One week later, I return to my favorite cut-and-vacuum shop to trim off the uneven bits of my badly mown hair.

I think there is a lot of similarity between hair care and health care. The other day when I was at a wedding dinner, a

relative came up to me and asked for the recommendation for a specialist. She was uncomfortable with her current specialist in private practice.

"He is very good and very nice. Every time I go it was expensive. It is OK because he is a specialist but he is always asking me to buy all sort of health supplement which is more expensive than his medicine. I really don't want it but it is very hard to say no and he is so nice. Recently he asked me to buy skin care and hair care products. I don't even have a skin problem. Are doctors supposed to do that?"

I did not know what to say.

I have since returned to my primary hair care practitioner. I was pleasantly surprised that they are very good with short hair as well. I don't think they had very fanciful specialist training. However they are all very excellently trained in giving the customer a good hair cut in the context of the shape of his head as well as his idea, concern and expectation of what is good hairstyle. They focus on giving me a high quality hair cut at an affordable price. They just want to earn an honest \$12 from me

and not try to squeeze the last dollar out of my wallet every time I show up. Most important of all they treat me as a person and appreciate my little contribution to their business. Every time I leave, all the hairstylist will smile and bade me farewell. That is just so nice and professional.

■ CM

## Dr Lam Pin Min, Minister of State for Health Courtesy Visit to the College

by Dr Vasanwala Farhad Fakhruddin, Council Member, College of Family Physicians Singapore



(Above left) His increasing involvement in the Primary Health Care Scene prompted Minister of State for Health, Dr Lam Pin Min (second from right) to pay a courtesy visit to the College of Family Physicians Singapore. (Right) Dr Lam pens his message in the guestbook.

Dr Lam Pin Min, an accomplished ophthalmologist and Minister of State for Health paid a courtesy visit to the College of Family Physicians (CFPS) on the 20<sup>th</sup> of May 2015 as part of the Minister's familiarisation of the role that the College plays in enhancing Family Medicine. Dr Lam was previously the Chairman of the Government Parliamentary Committee for Health prior to his appointment as the Minister of State for Health last year. Dr Lam has been increasingly involved over

the past one year in the Primary Health Care Scene since his appointment, looking after the Primary Health Care needs of the country.

The Minister was briefed on the diverse fields the College Council members were involved in the role of the health care from the family physicians practicing in the heartlands, to the doctors working in the Polyclinics, Nursing Homes, Community Hospitals and Restructured Hospitals. He acknowledged that the diverse

representation of the council members provides a rich repository of collective knowledge. This could be leveraged upon by the Ministry of Health to tackle the challenges faced with regards to the healthcare scene in Singapore.

He was then given a brief introduction of the College by CFPS President, A/Prof Lee Kheng Hock. A/Prof Lee also gave a brief presentation on overcoming the numerous

(continued on the next page)

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■ CM

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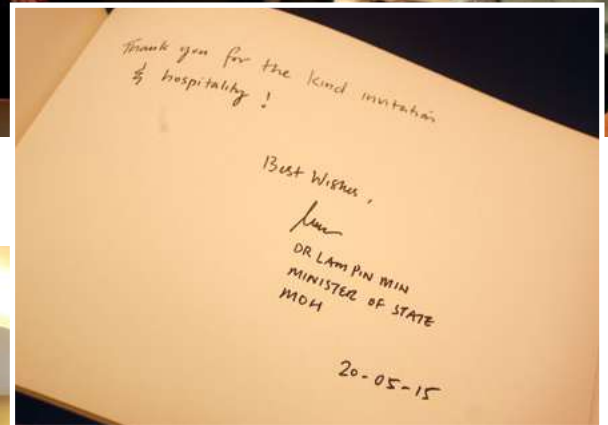
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(continued on the next page)



(Above) The members of the 24th Council, College of Family Physicians Singapore welcomes Dr Lam (seated)  
(Below) Acknowledging the importance of having the members of the Council be involved in diverse fields of health care



challenges in promoting Family Medicine as the key pillar of Primary Care in our country, and how it undertook the mantle to train Family Physicians over the decades through the sacrifices and dedications made by previous College Council Members and the Family Medicine Leaders.

The Council updated the Minister on the encouraging number of trainee doctors and family physicians who took up the bursary provided by the Ministry, to take up the Graduate Diploma in Family Medicine (GDFM) and Master of Family Medicine [MMed(FM)] programmes. Due to the Government's increasing emphasis and recognition on the role of training doctors to be trained Family Physicians, a record

number of doctors had enrolled into these programmes. This better enables Family Physicians to serve the increasing complex health care needs of our country. The Council took the opportunity to express gratitude to the Ministry of Health (MOH) in implementing this important policy to support Family Medicine education and express the hope that it would be continued on the long term.

Dr Lam was impressed with the recognition given by Australia to the Fellowship (FCFP) graduates and the reciprocity agreements between the Royal Australian College of General Practitioners and College of Family Physicians Singapore.

A candid discussion was held with the aim to find solutions on issues facing the health care scene in the community. Dr Lam was pleased that the Council shared the same vision and mission goals as MOH, and expressed his support for greater collaboration between the Ministry and College. The Council reiterated its fullest support of the Ministry's far reaching policies to improve the health care needs of our population. We bade farewell to the Minister with increased optimism as both the College and MOH shared the same ideas and ideals in formulating policies to guide the healthcare needs in Singapore.

■ CM

# Revisiting Blood Pressure Readings in Primary Care Setting

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

Hypertension is a chronic disease that can potentially imposed an undue burden on the health as well as wealth of the patients. Various international guidelines are available to assist doctors in making the diagnosis and aid in management. The table below showed the major guidelines that are in use:

| Blood Pressure  | WHO-ISH 2003  | ESH-ESC 2007                   | JNC-7 2003         |
|-----------------|---|--------------------------------|--------------------|
| <120/80         | Optimal   | Optimal                        | Normal             |
| 120-129/80-84   | Normal  | Normal                         | Pre-Hypertension   |
| 130-139/85-89   | High Normal   | High Normal                    | Pre-Hypertension   |
| 140-159/90-99   | Grade 1 Hypertension Borderline (SBP 140-149 DBP 90-94) | Grade 1 Hypertension           | Stage 1            |
| 160-179/100-109 | Grade 2 Hypertension                                    | Grade 2 Hypertension           | Stage 2 (≥160/100) |
| ≥180/110        | Grade 3 Hypertension                                    | Grade 3 Hypertension           |                    |
| ≥140 and <90    |   | Isolated systolic hypertension |                    |

(The report by panel members of the JNC 8 in 2013 dealt mainly with the management of hypertension in certain target groups and the target BP to achieve. There was no mention of the various grading for hypertension as in the previous report. Article can be assessed at JAMA.2014; 311(5):507520. doi: 10.1001/jama.2013.284427)

From the above it can be seen that the cut off for diagnosing hypertension and hence the trigger for consideration of starting treatment is ≥140/90mmHg. However in practice we know that it is not so straightforward as the blood pressure readings can be affected by a number of environmental factors and exhibit diurnal variability. It is well accepted that the BP readings taken in the office by the doctor (OBP) is the most 'inaccurate' compared to the ones taken by the nurses at the counter, home blood pressure readings (HBP) and ambulatory blood pressure (ABP). So how can we make sense out of all these different types of readings?

**ABP** has been the standard of measurement for determination of blood pressure. It is fully automated, measures BP throughout the day and even at night and hence captured a snapshot of the BP readings of the patient in his/her natural environment over 24-hour period. It had been shown that the lack of nocturnal dip and the early morning surge of BP have prognostic value in predicting cardiovascular and even cerebrovascular accidents.

But with the widespread availability of semi-automated BP devices, patients can now assist the doctor in recording BP readings at home (**HBP**).

**OBP** suffers from several confounding problems including the presence of the alert reaction of the patients when they see a doctor (the white coat effect), the technique used in taking the readings and the doctor's preference of rounding off readings

among others. Furthermore studies had shown that OBP has lesser predictive value for future cardiovascular events compared to HBP and ABP.

How then should one incorporate home BP monitoring into our daily practice? And how should one interpret a home BP reading and apply this in our decision-making?

To answer these 2 questions we need to know:

1. How to instruct patient to take and record a useful home blood pressure reading
2. What are the accepted cut-off values for office, home and ambulatory blood pressure.

## How to take Home BP

- Purchase a validated blood pressure monitors. One website that can be accessed is [www.bhsoc.org/index.php?CID=246](http://www.bhsoc.org/index.php?CID=246)

One can also access the following websites:

1. [http://www.hsa.gov.sg/content/hsa/en/Health\\_Products\\_Regulation/MEDICS\\_e-Services/Singapore\\_Medical\\_Device\\_Register\\_smdr\\_MEDICS.html](http://www.hsa.gov.sg/content/hsa/en/Health_Products_Regulation/MEDICS_e-Services/Singapore_Medical_Device_Register_smdr_MEDICS.html)

Click on the SMDR icon and perform advanced search for blood pressure monitor.

2. Dahl Educational Trust website which provide a list of validated BP monitor. ([http://www.dableducational.org/sphygmomanometers/devices\\_2\\_sbpm.html#ArmTable](http://www.dableducational.org/sphygmomanometers/devices_2_sbpm.html#ArmTable))

3. NHG Pharmacy (<https://www.pharmacy.nhg.com.sg/productCatalogue/SSCategoryProductList.aspx?iCat=4&iSCat=15&iSSCat=8&sFlag=1>)

- Always use the same arm for measurement.
- Take 2 measurements per day for 1 week. For each measurement 2 readings should be taken.
- One measurement in the morning, preferably before 8am (and before medications) and one measurement at night after 8pm.
- For each measurement, the 2 readings are to be taken 1-3 minutes apart without removing the cuff, preferably recorded into the memory of the device.
- Patient must be rested at least 5-10 mins before taking readings, with the measuring arm supported at the same level of the heart.
- There must be at least ½ hour interval before/after meals, bathing, smoking, and coffee or tea consumption.
- Calculate the average reading for each of the pair of readings.
- Readings should not be taken at other times of the day.
- Repeat the process for the rest of the week.

- There would be 14 readings.
- Discard the first day readings.
- Then calculate the average of the remaining 12 readings.
- This will be the home BP reading that the patient should present to the clinic on the next visit.

## What are the cut-off values?

- Office BP
    - >140/90 without target end organ damage
    - > 130/80 with diabetes mellitus or target end organ damage
- This is in accordance with most international guidelines as well as the local MOH CPG – Hypertension 2005 guideline. Even though there is no further update to this CPG, these values are still in current practice (Singhealth Group and Health Promotion Board). Myers et al suggested that routine office BP cut-off should be 10/5 mmHg higher than the guideline BP of 140/90 (i.e 150/95). This is due to the fact that guideline BP was based on research quality office BP readings and may not reflect the usual BP obtained by doctors in routine office practice.

- Home BP >135/85
  - < 130/80 Normal

- Ambulatory BP >130/80 (24 hour)
- Features unique to ABP are the ability to detect early morning rise in BP, day-night BP changes and diurnal or nocturnal variability. ABP also showed high degree of prognosis in predicting future cardio- or cerebrovascular events.

In general ABP reading is 20% lower than HBP reading which in turn is 20% lower than Office BP reading.

Hence it can be seen from the above that Office BP, Home BP and Ambulatory BP readings offer different types of BP readings which are complementary in nature.

Ambulatory BP is not readily available compared to Home BP but can be useful in cases of suspected white coat hypertension, masked hypertension, in diabetic and other high risk patients that require tighter control of the BP, in gauging effects of treatment and in detecting patient compliance to treatment.

HBP offers a more cost effective alternative to ABP and allows for more readings to be taken in the patient's natural environment.

Family physician would do well to incorporate Home Blood Pressure Monitoring in the management of hypertension.

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# Painless Evidence-Based Medicine

edited by Antonio L. Dans, Leonita F. Dans and Maria Asuncion A. Silvestre

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

Long gone are the days when all a doctor needs is a good memory of the textbooks and lecture notes he read during his formative years to carve out a reasonably successful medical career ahead.

No longer can the Chinese saying 一招半式闯江湖 be applicable to the current state of medical practice.

The medical lessons and axioms of yesteryear may not be valid anymore.

The practising doctor is now inundated by a deluge of new information descending upon him with increasing frequency and volume by virtue of today's technology and the internet.

Often enough, the busy practitioner is presented with a scientific paper about a certain product by the helpful pharmaceutical sales rep who has highlighted only the relevant parts as proof of its usefulness and therefore worthy of a purchase.

Beyond this, the doctor usually has little inkling what to make of the rest of the paper!

The doctor's past knowledge is constantly being challenged by the mass media, which are often quick on the draw in declaring the latest findings in the headlines. These reports can virtually plunge previously articulated medical maxims into a tailspin.

Consider the recent examples: "Cholesterol no longer a concern: US experts" and "Gout patients can eat soy products, local study finds".

The befuddled and brow-beaten doctor is left wondering what to tell his patients when the clinic opens later!

Even if he manages to get hold of the papers on which the new results are based, he may not have the knowledge to analyse and validate the findings.

How then can a doctor navigate through this daunting maze of information and hype?

Painless Evidence-Based Medicine is probably a good place to start.

As promised, the authors introduce Evidence-Based Medicine (EBM) in a simple, concise and pain-free format with humorous quotes and cartoon illustrations thrown in to keep the reader relaxed and engaged.

Thoughtful use of so-called "Tackle boxes", which are actually summaries and elaborations of the concepts discussed in the chapter, helps the reader to understand and remember the lessons better.

The first part of the book focuses on the three fundamental skills of EBM which are:

1. Acquiring the Evidence
2. Appraising the Evidence and
3. Applying the Evidence

Thereafter, the reader is taught how to evaluate articles on the essential aspects of medical practice, which are, Therapy, Diagnosis, Harm and Prognosis.

Similarly, evaluation of Systematic Reviews, which are summaries of results from several studies, is explained.

The last chapter teaches the neophyte how to conduct Literature Searches when he needs an evidence-based answer to a management question concerning his patient.

The reader will be familiarised with the electronic databases like MEDLINK and the Boolean language used in the searches.

On the whole, the book makes for a good introduction to EBM and equips the reader with some basic skills to make heads or tails of a scientific paper.

## Footnotes

1. Painless EBM is available from Auntie Cynthia at Hp 96681004. She's "Q" to many of us since medical schooldays when, from time to time, we need to be "equipped" with a certain medical textbook for the mission.
2. For those bitten by the EBM bug after reading the book and wish to further their education, there is the annually held, usually in January, Asia-Pacific Evidence-Based Medicine (APEBM) conference and workshop at NUH.

■ CM

## Project Sa'Bai: a love for children, a heart for community

by Dr Ng Chee Lian Lawrence, Honorary Assistant Secretary, College of Family Physicians Singapore

Project Sa'Bai had its humble beginnings in December 2006 when a group of 7 medical students from Yong Loo Lin School of Medicine went up to a Don Bosco School in Phum Chreh, Phnom Penh, Cambodia, as an overseas community involvement project (OCIP). At that time, without much support and resources, they carried out

simple tasks such as removing Cambodian school children's hair lice and conducting simple health education lessons for the children.

This year, Project Sa'Bai celebrates its 10<sup>th</sup> anniversary. It comprises medical students from the first and second year.

The aim is two-fold. Firstly, Project Sa'Bai provides immediate healthcare to the poor in rural Cambodia. It treats acute ailments and identifies serious cases for further management.

Secondly, in order to ensure continuity and self-reliance, it seeks to empower the

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(continued from Page 24: Project Sa'Bai: a love for children, a heart for community)

Cambodians, especially the children, to care for their own health.

To this end, it carried out Health Education in the rural village clinics in under-served rural areas such as Phum Chreh and Kamping Speu as well as in the Don Bosco Schools. The syllabus currently covers a wide range of topics, from hand washing techniques, to tips on how to choose a good doctor.

The aim is to empower the Cambodians to care for their own health, for both adult and children Cambodians alike. This is achieved by putting emphasis on taking ownership of their own health.

The medical students have expanded the range of services and increased the patient base to 3 schools (the Don Bosco Schools in Phum Chreh, Teuk Thla and Toul Kork,) and 2 villages (Phum Chreh and Kampong Speu). The total number of patients seen per trip in all these locations each year is about 2500 patients.

Besides providing health screenings and general consultations to the students and the villagers, Project Sabai involves specialist clinics, such as Vision, ENT, Dental and Women's Clinics.

This is made possible with the help of many collaborators and partners which include Sa'Bai's own alumni doctors, doctors and nurses from A Call To Share (ACTS), ophthalmologists and optometrists from Singapore National Eye Centre (SNEC), dental students and Dental Officers from NUS Dentistry, optometrists from AMIGOS Eye Care (USA), local Cambodian medical and pharmacy students from the University of Puthisastra, Cambodia, as well as the Salesian sisters of the Don Bosco Schools.

In December 2015, we hope to be able to continue to build on the foundation our seniors have laid and increase the sustainability of the project. To this goal, Project Sa'Bai is planning to partner more hospitals and non-governmental organisations (NGOs) in Cambodia

This is to ensure the continuity of care of patients who have been identified as in need of urgent follow-up action which we could not provide at the short-term mission clinics we run.

There are already established partnerships with local clinics such as the CMMC Jeremiah's Hope Clinic and the Rose Eye Clinic.

The local hospitals involved include the Sihanouk Hospital for Hope and Kong Pisey Referral Hospital.

By introducing the Cambodians back into their local healthcare system, we hope to empower them to care for their own health. The Cambodians are encouraged to be self-reliant for their own people in need.

To further increase our sustainability, Project Sa'Bai has been working closely with the students of the University of Puthisastra, and have recently agreed on a 5-year plan to provide translators for our project.

This will not only provide a steady stream of translators for the project, but also facilitate working with a small dedicated group of Cambodian students in Project Sa'Bai in establishing their own Sa'Bai Cambodian Wing. This gives back to the Cambodians a sense of ownership of the project, in the hope of reducing their sense of dependency.

By involving Cambodians in the planning and execution of our clinics, it is our hope that they will one day be able to take over the healthcare needs of these underprivileged Cambodians in the village clinics. Project Sa'Bai can then move to establish new clinics in new locations to in other areas of unmet needs in Cambodia.

While looking to increase the sustainability of our project, we are also looking forward to see how we can develop and expand our services to better meet the needs of the local community in Cambodia.

From our population studies conducted in last year, we have also observed that the villagers have the head knowledge of good hygiene habits but are unable to translate knowledge into actions. Hence, there are plans revamp the village health education program, through Participatory Learning and Action (PLA). PLA is one of the many takeaways gleaned from attending OCIP workshops. Hopefully, this will encourage the villagers to take greater ownership of their own healthcare needs.

Previous year's population studies have also highlighted a prevalence of gastrointestinal infections. Besides tackling health issues through hygiene education, there is a need to improve the quality of drinking water. To this end, negotiations are on-going with water filter companies to obtain appropriate water filters. Hopefully, these filters will be installed in December 2015, if not the next.

May we sincerely appeal to medical doctors for your participation and donations. We are a self-funded mission that continuously appeals to foundations and companies. We have been conducting school-based fundraising efforts. The funds raised are used to cover the project's expenditure in patient referral visits to the hospitals, pharmaceutical and miscellaneous logistic supplies, amongst others.

Thus, any amount, small or big, is deeply appreciated. In addition, we would also appreciate drug donation for our annual free village and school clinics.

We are constantly in need of more doctors to better serve the needs of the needy Cambodian population. If you wish to contribute your time and expertise in serving the Cambodian population, we gladly welcome you to be part of our medical team, which goes up to Cambodia every December.

Do feel free to drop us an email at [projectsabai@gmail.com](mailto:projectsabai@gmail.com) if you require more information or would like to participate or donate.

■ CM



## AIC Community Care Forum – Primary Care Track

by Dr Subramaniam Surajkumar, Honorary Assistant Treasurer, College of Family Physicians Singapore

### Keynote Lecture - Professor Michael Kidd

**P**rofessor Michael Kidd, the President of the World Organisation of Family Doctors (WONCA), was the keynote speaker of the primary care track of the recent Community Care Forum organised by the Agency of Integrated Care (AIC). The primary care track, which was jointly organised by the College of Family Physicians Singapore (CFPS) and AIC, was held on the afternoon of 16th May. The title of Prof Kidd's speech was "Dare to Dream – Visioning Primary Care of the Future" which was also the general theme of the event.

Prof Kidd, who is also an Australian general practitioner and the Executive Dean of the Faculty of Medicine, Nursing and Health Sciences at Flinders University, is no stranger to Singapore. He has been a frequent visitor here over the past 25 years and is a good friend of the College having worked closely with many of its members in the intervening years.

As WONCA president, Prof Kidd is a strong and vocal advocate for family medicine and the role family doctors play in strengthening primary health care around the world.

In what was a truly inspiring speech, Prof Kidd sent out a strong message that the answer to the challenge of universal health coverage in every country around the world is strong primary care. He stressed that our generalist tradition of primary care is the only way that nations will be able to effectively tackle the diverse health challenges worldwide.

***"Doesn't matter what the question in healthcare is, the answer is always primary care."***



Professor Michael Kidd, President of the World Organisation of Family Doctors (WONCA)

He elaborated that primary care is the answer to the control of both communicable and non-communicable diseases alike, while it is also the only way that we will be able to effectively address the rapidly rising burden of mental health problems as well as the health care needs of an increasing proportion of elderly people. Moreover, primary care is the only way that we will effectively contain the rising health care costs in our nations.

***"We cannot afford to continue building more and more hospitals. We need strong primary care to keep people OUT of hospital!"***

Finally, he pointed out that primary care is also the only way we will tackle the problems of unnecessary health care, where it would play the gate keeper role to limit overutilization, overdiagnosis and overtreatment.

However, he also stressed that strong primary care requires strong family medicine with supervised postgraduate training and programmes of continued development for our primary care workforce.

Thus he was surprised to learn that Singapore, with its excellent healthcare and health outcomes, was behind most other developed countries where family medicine is now recognised as a medical specialty. Although he was delighted to note that the Academy of Medicine Singapore had set up a chapter of family physicians, he now saw the need to get family medicine recognised as a speciality here.

***"We need the specialty of family medicine to be recognised in each country as a specialty. This specialty recognition matters. We need the brightest and the best of the nation's medical students to join us in a career in family medicine, to see community-based primary care as a viable, exciting and worthwhile career choice. We want our medical graduates to become family doctors by choice, not by accident."***

Quoting the late Professor Barbara Starfield, whose work has provided us with much of the evidence of the benefits of primary care, Prof Kidd said that she had recognised three main challenges for WONCA in the future:

- The need to develop primary care research to address the challenges of care for people with comorbidities and multimorbidities.
- The need for reformation of our health care systems to focus on patient centered care and to embrace our greatest allies in family medicine – our patients.
- The need to build our own primary care evidence base, the source being

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(continued from Page 28: AIC Community Care Forum: Primary Care Track)

none other than encounters with our own patients.

Prof Kidd then took the audience on a 'world tour' of the various countries he had visited and the remarkable family doctors he met in his capacity as WONCA president. He gave a fascinating insight on how many countries, less prosperous than us, were giving lessons to the rest of the world on how to tackle the problems of universal health care delivery. Some of the examples he gave:

- Cuba, a small island nation, offers a model of personalised, cost efficient, effective and equitable primary care that is the envy of more wealthy nations. In this country 36,000 family doctors provide health care to 11 million people with every person having their own personal family doctor and primary care nurse team. And this included teams based at 3000 clinics in rural areas.

- China has a primary care revolution taking place and has embarked on a massive drive to train and recruit 400,000 general practitioners (GPs) in the next seven years to meet the current and future needs of the population. If the rural challenges can be met with success, then this should provide lessons for other countries facing similar challenges.

- The Island of Timor in Indonesia, is not that far from Singapore but feels like a different world. Prof Kidd showed how an amazing young woman family doctor delivered primary care to the members in her community despite serious challenges due to its isolation and lack of resources which other nations in the region faced as well. He stressed that we all have a responsibility to reach out to colleagues across the world and support each other.

- Brazil is the global leader in addressing universal health coverage through family health teams. He met one such young doctor who headed a team that included a family medicine resident,

two nurses and six community health workers providing comprehensive clinic and home based care to a defined population of 4,400 people. There were 33,000 such teams in operation across the entirety of Brazil.

- Denmark has an enviable health care system based on strong family medicine and universal health coverage. It has a population of 5.5 million, which is similar to Singapore, and is served by 3,600 GPs, each providing care to an average of about 1,600 people. Each GP has a list of patients and serves as a gatekeeper to specialist and allied health services. Their general practice is also a world leader in the use of health care technology and has embraced electronic medical records, using WONCA's classification system, the ICPC (International Classification of Primary Care). This allows the Danish GPs to analyse their own data to better understand the health needs of their patient population.

In concluding his speech, he looked towards the 17 Sustainable Development Goals of the United Nations. Although, there is only one health specific goal among these, number 3 - 'Ensure healthy lives and promote well-being for all ages', he pointed out that each of the 17 new goals has an impact on global health and the health of individuals.

***"These are bold ambitions, and as global citizens, family doctors must play our part. People-centered care is a core competent of universal health***



*AI/Prof Lee Kheng Hock (left) and Dr Tim Malloy (right) each spoke about the future of family medicine in their respective countries.*

***coverage, and there will be an increasing role for family medicine over the coming years in many countries to ensure this happens. We need to support the focus on the social determinants of health and work to ensure that marginalised populations, those groups of people in our communities most at risk of poor health, are not excluded from health care."***

### Breakout Session

The breakout session was the second part of the primary care track for the afternoon. Associate Professor Lee Kheng Hock, the President of the CFPS, and Dr Tim Malloy, the President of the Royal College of New Zealand General Practitioners (RCNZGP), each spoke about the future of family medicine in their respective countries. This was followed by a panel discussion comprising Prof Kidd, Prof Lee and Dr Malloy.

**Prof Lee** envisioned Singapore's future of family medicine and first took the audience through an illuminating history lesson on the evolution of family medicine. He explained how the principles of family medicine were forged in the late 1960s in the United States, as a solution and counterculture to the fragmentation of care and the excessive reliance on specialization as a way to solve complex health care needs. Family medicine in Singapore has evolved to the point that it is now one discipline being practiced in many different settings.

Three major thrusts were identified by the Ministry of Health in the Singapore Primary Care Master Plan of 2011 which will revitalize and drive the transformation of primary care to meet the challenges of an aging population. These were finance, infrastructure and model of care. Some strides have been made in the first two tenets but now a new model of care is emerging – transitional care.

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Rounding off the programme for the primary care track with the panel discussion. The moderators were Dr Tham Tat Yean and Dr Alvin Koh.

Transitional care ensures the coordination and continuity of health care between locations and between different levels of care within the same location. It is part of community care and will play a key role in the transformation of health care in Singapore to be less reliant on hospitals.

The resources that are deployed to drive change through financing, infrastructure support and model development should perhaps be re-aligned to the precepts of family medicine which seeks to make health care primary, personal, preventive, comprehensive, continuing and community oriented. These core competencies of family medicine have a close relationship to the applications of transitional care.

Prof Lee stressed that more highly trained generalists steeped in the principles and practice of family medicine are needed and it is time to muster training resources to meet this need. At the same time, we need to facilitate willing members of the family medicine community to organize themselves into networks that will support this renewed mission of restoring a fragmented care system and returning it to the community.

**Dr Malloy** then gave us an insight into New Zealand's health care system, the challenges they faced and their vision for the future. Although they also have a multi-cultural diverse society, with a prosperous and high quality lifestyle similar to Singapore, geographically they are very different. New Zealand has a population that is only slightly smaller than Singapore but has a land mass that is 400 times bigger.

Half the population live in four main cities, while the rural 14% occupy 97% of the land area.

The main challenges facing New Zealand are also similar – and aging population, increased financial burden from chronic illnesses and growing demands on acute health services, disability services and long term care.

However government support and stability is the key to the comprehensive review of their health strategy. In fact their new Minister of Health is a family physician. The Ministry has identified three issues - a bigger aging population, new technology and an integrated model of care, the core of which is general practice and care for the whole person. This new model of integrated health delivery involves an interdisciplinary workforce of GPs, specialists, nurses and allied staff working together on patient care. This form of team based care would make it faster, easier and simpler for patients to see GPs and specialists – seeing the same GP is no longer the norm.

The other challenge is the potential shortage and aging of GPs and the need for medical staff to keep up to date with developments in health care especially aged care. The RCNZGP regularly reviews its training curriculum for the continued professional development of GPs equipping them to deal with change. This would be coupled with the training of more doctors which would thus require more educators. Therefore there is a need to keep GPs staying longer in the workforce to become teachers and mentors.

While the vision of health care in New Zealand is to make its health service as good as they can and be recognised as the best in the world, there is always room for improvement. There are still issues but these are being addressed.

Finally, the **panel discussion** rounded off the afternoon's programme for the primary care track. The audience took advantage of the opportunity to pick the brains of such a distinguished panel comprising two college presidents and a world president. Many interesting questions were asked and the speakers each gave their views to every question from the perspectives of their own country's experience. It was all the more absorbing for the audience in that their views often differed, yet there was common ground that family medicine and primary care were the main driving forces for the future of health care.

### Dr Malloy's Visit to Toa Payoh Polyclinic

**d**r Tim Malloy took time out from the conference to pay a visit to Toa Payoh Polyclinic. He was accompanied by his wife Nancy, who is a registered nurse.

They were received by the management team, led by Dr Tung Yew Cheong, the head of the polyclinic. For about 2 hours, Dr and Mrs Malloy, were given a guided tour which provided insights into a typical patient's journey through the polyclinic. This started in the self-registration area, where the

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contingent was introduced to the online appointment system (OAS) and mobile appointment booking application. The journey continued through the various areas of the polyclinic including the nursing service stations such as the treatment room, as well as the physician consultation rooms. The guests also had the chance to have a 'behind the scenes' peek at the diagnostic laboratories, radiology facilities and the pharmacy.

The visit concluded with a short presentation by Dr Tung on the overview and organization of primary healthcare in the public sector in Singapore. There was also a good exchange of information and ideas between Dr and Mrs Malloy and the Dr Tung's team. Dr Malloy and Mrs Malloy were highly impressed with the facilities, organisation and efficiency of the polyclinic and wish to thank the National Healthcare Group Polyclinics (NHGP), Dr Tung and his team for the hospitality shown to them.

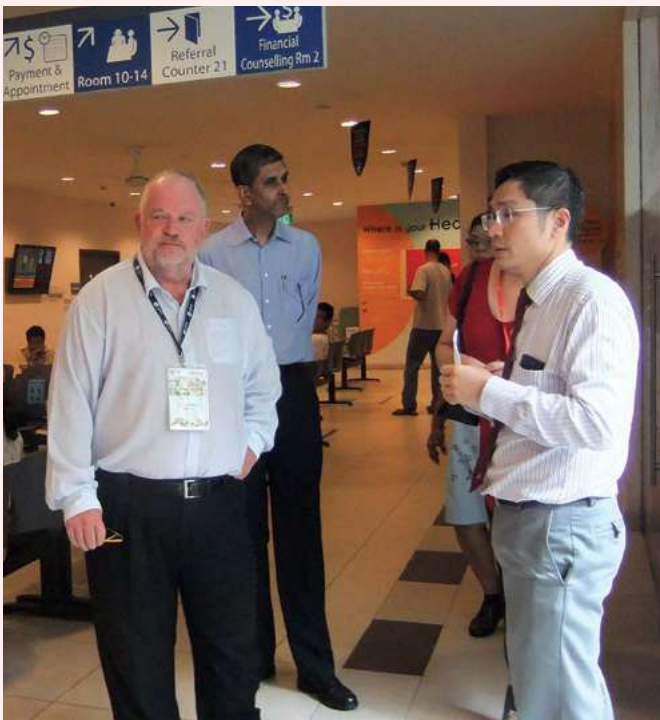
■ CM



Dr. Tim Malloy and Dr. Tung posing next to the wall poster illustrating the various NHGP initiatives in Advancing Family Medicine.



Senior Pharmacist, Ms. Wanyu explaining the functions of OPAS (Outpatient Automation System) to the visitors



Dr. Tung explaining the workflows of how patients are generally managed within the clinic, as a one-stop primary care centre.



An insightful exchange session with Dr. Tim Malloy, Ms. Nancy, Dr Surajkumar and the Toa Payoh team on both countries' primary healthcare systems.

Images (on this page) courtesy of National Healthcare Group Polyclinics (NHGP) and the rest of the images (for the article) courtesy of Agency for Integrated Care (AIC).