THE College Mirror

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40 Years of Post Graduate Family Medicine Education

A/Prof Cheong Pak Yean was the speaker at this year's Commencement Ceremony held at the College of Medicine Building on 30 June 2012.

From his speech and slides peppered with many photographs and illustrations, A/Prof Cheong walked the audience through the history of Family Medicine (FM) education and how it developed over the last 40 years.

The College Mirror gives a summary of the key events.

1971

The College of Family Physicians Singapore was founded with its key objective "to assist in providing post-graduate study courses for family physicians, and to encourage and assist practising family physicians in participating in such training".

MCGP and the First Two Decades

The Membership of the College of General Practitioners Singapore (MCGP) Diplomate was awarded by examination from 1972, one year after the founding of the College.

This annual Collegiate Examination was held for the next 20 years. Practicing GPs had to undergo College training courses to be eligible to sit for the examinations. The standards of the MCGP examination were high – only 7 of the 17 candidates who sat for the first examination passed.

The Third Decade

The 1990s saw major revamps and developments in FM training.

In 1990, a tri-partitite committee of the College, the National University of Singapore and the Ministry of Health (MOH) was formed to develop the Master of Medicine (Family Medicine) [MMed(FM)] along the lines of the Masters qualifications developed for the other specialties. MOH trainees for the

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(from Page 1: 40 Years of Post Graduate Family Medicine Education)

MMed(FM) had to go through 2 years hospital postings relevant to Family Medicine before a third year spent in the polyclinics.

In 1995, the Private Practitioners' Stream (PPS) was introduced for doctors with at least 6 years' experience in family practice. This 2-year part-time course required attendance of weekly tutorials, short hospital exposures and case studies. This allowed GPs to further their professional development in the relatively new field of Family Medicine.

Fellow of the College of Family Physicians Singapore [FCFP(S)]

The College had to train its future leaders and teachers in FM as well. The fellowship for the College was previously only awarded by honour. In 1998, a 2-year Fellowship by Assessment programme was introduced for FM practitioners who wished to achieve the highest level of expertise.

Graduate Diploma in Family Medicine (GDFM)

The leadership of the College realised that though the standards of the Masters and Fellowship programmes were high, there was a need to produce enough trained Family Physicians to serve the nation. With enough clinical teachers now available, a 2-year part-time Graduate Diploma was developed. For the clinical examination, the College studied and adapted the Objective Structured Clinical Examination (OSCE) format of the Royal Australian College of General Practitioners (RACGP) Fellowship examination.

The first batch of GDFM students started their course in 2000 and received their qualification 2 years later at a grand ceremony at the Shangri-La hotel in 2002.

1st batch of Fellows by Assessment, conferred in 2001

1st batch of doctors with GDFM qualification, 2002

Collegiate Membership of the College of Family Physicians Singapore [MCFP(S)]

The Collegiate Membership, last awarded in 1992, was revived in 2001. The MCFP(S) was awarded by interview to College members with MMed(FM) and who were actively involved in teaching.

This was the final link to fall in place. The College now had the training infrastructure and a clear path for professional developmental from Graduate Diploma to Fellowship.

The Fourth Decade

To provide more opportunities for further training, an alternative path to Collegiate Membership was created for those without the Masters but have acceptable qualifications such as the GDFM. In 2006, 9 doctors were conferred the MCFP(S) by Assessment after a 2-year structured training programme with formative and summative assessments.

In 2006, the Private Practitioners' Stream (PPS) to the MMed(FM) was renamed as MMed(FM) Programme B and its duration reduced to 1-year as the GDFM was made an entry requirement. The reduction to 1-year training for those with GDFM was successful. The practice path to the Masters, comprising the PPS and MMed(FM) Programme B produced about 30% of the 350 doctors with MMed(FM). Many of the alumni of this programme are today in clinical and administrative leadership positions in the healthcare system in Singapore.

FM Residency

In 2011, the MOH FM traineeship scheme was replaced by the FM Residency Programme conducted in 3 centres – Singhealth, National Healthcare Group (NHG) and National University Health System (NUHS). Based on the U.S. system, the residency is a 3-year structured programme with formative assessment elements and a final written examination.

Family Physicians Register

In 2012, the National Family Physician Register was introduced, recognising the GDFM as the basic training requirement for entry.

Conclusion

In 40 years, the College has strategically developed a robust training infrastructure for Family Physicians in Singapore. With more than a thousand Family Physicians so trained, half of which possesses the Masters and above, Family Physicians are now providing clinical services not only in the traditional ambulatory settings of primary care, but also in intermediate and long term care.

CM

1st batch of doctors with MCFP(S) by Interview, 2001

Doctors with MCFP(S) via Assessment and Interview routes, 2006

Ethics of Charging

by Dr Wong Tien Hua, Editor, FCFP(S)

The recent position by Singapore Medical Council (SMC) that there is an 'ethical limit' to doctor's fees has generated much debate amongst the medical profession (The Straits Times Opinion, 6 September 2012). Although the spotlight is on private sector specialists, General Practitioners (GPs) are also worried how this decision may affect their practice as well. Every once in a while, we come across patients who complain of expensive charges and some have even posted these complaints on social media and "citizen journalism" websites. The concern is that unhappy patients may accuse the doctor of "unethical overcharging" in future.

Ever since the Singapore Medical Association (SMA) scrapped their fee guidelines in 2007, most doctors in private practice assumed that the charging of fees could be left to market forces to decide. As long as the patient was informed of the fees and agreed to pay, there should be no problem of charging no matter how high.

Proponents of this argument give the analogy that there are handbags ranging from $200 to $20,000 and it was up to patients to decide what they wanted to purchase in a free market. This analogy however is flawed, as we cannot compare medical services to commodities. As one Straits Times Forum writer put it, "In commodity trading, prices and trend movements are transparent, and buyers have choices. There is also no distinction between buyers' ability to pay, that is, the rich and the poor pay the same price for the same commodity" (Follow spirit of ethical code rather than substance - The Straits Times Forum, 6 September 2012). In other words, the price for a $20,000 handbag remains the same whether or not the buyer is rich or poor. The same cannot be said for medical services. Even though every patient and every condition may be different, a doctor who marks up his fees just because the patient is rich is acting unethically.

The SMC issued this take-home message that "it is perfectly alright for a doctor to charge a poor patient less, but it is wrong to charge a rich patient more." (The Straits Times, 1 September 2012)

This suggests that doctors should always charge consistently for the same general services provided, with some margin to allow for the time spent, the complexity of the case and the expertise and experience required. One cannot vary the price of the listed service based on the patient's background, social standing, or ability to pay.

A colleague recently highlighted to me that published polyclinic charges divide their rates according to Citizens, PR and Non-residents. The non-resident rate is more than 3 times that of charges for citizens. Instituting different charges like this may seem to go against the ethical principal of fair charging. Of course, the fact is that Citizens and PRs enjoy generous subsidies at polyclinics. To avoid the accusation of price differentiation, polyclinics should publish their prevailing market rates for consultations, and then apply the subsidies for Citizens and PRs.

For patients who are unable to pay because of financial difficulty, the doctor should rightly give a discount, or even waive his professional fee altogether. This has indeed been the practice of most GPs today. GPs operate with a long-term view of service to the communities that they practice in; it is more important to build up trust and mutual understanding with their patients.

I would argue that under prevailing market conditions with stiff competition and chronic complaints of undercutting and undercharging, it is very difficult for a GP to overcharge. The nature of general practice is that patients have more experience using and paying for GP services and are better able to compare prices, as opposed to

Description	Singapore Citizen	Child/ Elderly (Citizen)	Permanent Resident	Non-Resident
Consultation	$10.20	$5.60	$15.50	$37.50
Family Physician Clinic	$20.00	$20.00	$30.00	$49.30
Nurse Clinician Service	$6.00	$6.00	$9.00	$12.00

Info taken from: http://polyclinic.singhealth.com.sg/PatientCare/Fees/Pages/Home.aspx

The charging of fees remains a difficult and fine art, but as long as GPs clearly display their charges based on what is reasonable and acceptable, they run little risk of being accused of unethical overcharging.

a one-off major surgical procedure. Patients are therefore very sensitive to GP price variations, and it would make poor business sense to charge double or triple what other GPs charge unless he or she practices in particular niche areas of interest. Company contracts and managed care also exert to a downward pressure on consultation rates.

The problem with this market practice is not only that GPs are afraid to charge more but it tends to narrow the scope of the GP practice as well. Family Physicians with higher qualifications are afraid to charge more for expertise, and low consultation fees also undermine the core values of spending time with patients to delve into holistic care. GPs with special interest and training in areas like minor surgery may find themselves charging beyond the bands of what patients expect to pay and thereafter subject to a complaint.

In the last SMA survey on private practice, it was found that even though operating costs and rentals had gone up by 30 to 40%, the mean doctor's remuneration has remained the same. And that survey was done in 2006. The majority of GPs have not raised charges very much due to market forces. Given the inexorable rise in operating costs as a result of inflation over the past few years, especially with soaring rentals, the situation today for GPs would be even more strenuous. This rise in operating cost will have a pressure on GPs to charge more. Another survey is urgently needed to shed more light on the current situation.

Going back to the polyclinic example above, it is notable that doctors are not the ones setting the fee; these are determined by management. This is also true for the private sector, where GP group practices are getting more common. This means that each doctor no longer determines his individual fee structure. Rates and fees will likely be set by the management team, taking into consideration business costs and market conditions. As a result, large fee variations tend to be more limited in the GP sector.

The charging of fees remains a difficult and fine art, but as long as GPs clearly display their charges based on what is reasonable and acceptable, they run little risk of being accused of unethical overcharging.

CM

On a final note, this is my last editorial piece as I step down as Editor. I have been Editor at The College Mirror since 2007. That year we had 2 special issues to cover WONCA, which was hosted in Singapore. It has been an exciting learning journey and I sincerely thank the guidance of A/Prof Goh Lee Gan, A/Prof Cheong Pak Yean, Dr Michael Yee, the previous Editor, and the support of Editorial Team B as well as the College Secretariat.

this issue >>

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Why are Doctors Chronically Unhappy?

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

I have got an idea that will save thousands of man-hour for doctors. At the same time, this suggestion will reduce the stress level of medical students and junior doctors. Perhaps even make most of them happy. Here is how:

Scrap Residency Selection and Have a Lottery

Scrap the very painful and complicated residency selection system that we had just inflicted upon ourselves. Guarantee all the graduates, from all our local medical schools a training position. Organise a lottery for the students where everyone will get a number ranging from 1 to 356, if we have 356 graduating students for the year. Lucky student who draws the number 1 gets to choose any training position that is on offer. Unlucky student who drew number 356 will have to take up whatever position that is left on the shelf. In between, everybody stands an equal chance of getting something interesting.

Sounds ridiculous? May be not so. This is not an original idea. This was actually the system that was used by Norway, a country with an excellent healthcare system. They had used it for the last 60 years. This system ensured that the best students are evenly distributed across specialties and across the country. It is fair, cost-effective and most important of all, it increases the general level of happiness of everyone.

Happy doctors

The doctors are happy with the system. There is no need to waste time sitting in layers and layers of selection committees. There is no need to devise non-evidence based charades that supposedly are able to tell us whether a particular student will be ethical or suitable for a particular kind of specialist training. They don't get harassed by over-enthusiastic students who want to improve their chances through personal contacts. They don't have to feel guilty because they suspect that they might have been unfair to any particular student whom they had rejected. They don't have play the role of used car salesman once a year to try to get "good" students to sign up for their programme. They don't see fellow doctors in other programmes as rivals whom they have to beat. Most important of all, doctors have peace of mind and can focus their energies towards gainful activities like spending more time seeing patients and actually teaching the doctors who had signed up for their programmes. Perhaps their work-life balance may even improve and they may choose to continue to work in the public sector.

Happy students

The graduating students are generally happy with the lottery system, even the hapless student who drew the last short straw. They can just focus all their energies on studying medicine and being the best possible all-rounded good doctor that they can possibly be. They don't have to fret from the moment they enter medical school on how to devise all sorts of nefarious schemes to put themselves one up against their fellow students. There is no suspicion that the hospitals and teachers are playing favorites. They don't have to be grilled like criminals by multiple panels of stressed-out doctors, and forced to tell the occasional white lie. Basically they have peace of mind and can focus their energies towards gainful activities, like studying hard and enjoying the experience of being a medical student.

What the experts say

Daniel Gilbert, professor of psychology at Harvard University and author of the international best seller "Stumbling on Happiness" tell us that people (especially intelligent ones) are wired to make poor choices on matters that relate to their future happiness. Providing people with a wide variety of choices, together with an infinite array of "what-if" scenarios,

just drive people nuts and set them up to make bad choices. Counter-intuitively, people are happier with limited choices. In fact given time and left unprovoked, they grow to like whatever choices that they end up with. Daniel Gilbert discovered that people are able to recover from disappointments as if there is a psychological immune system that neutralises setbacks and synthesise happiness over time.

Allocating placement in highly sought after educational institutions by lottery had been advocated by many prominent thinkers as well. Malcolm Gladwell, author of the international bestseller "Outliers", a book that studied why some people become exceptionally successful, is one of the advocates of selection by lottery. When it comes to education, he concluded that people are confused by the difference between entrance criteria and excellence criteria. For example it is obvious that people who want to play professional basketball should be tall. Beyond a certain height, tallness is no longer a predictor of future success in basketball. The same goes for IQ and doing well in intellectual pursuits. Someone who wants to win a Nobel Prize should have an IQ of at least 120. Between the IQ 120 to 200, the chances of winning the Nobel Prize is about the same. His conclusion was that the way highly sought after institutions select students based on their elaborate admission programs is largely "nonsensical". The only "intellectually justifiable" way is to conduct a lottery after ensuring that all the applicants meet certain basic criteria such as good scores in entrance exams and other objectively measurable traits. The elaborate schemes of selection are wasteful activities that distract from the more important task of developing the talents after getting them into the school. In the long run, nothing beats the good old methods like putting the nose to the grindstone and clocking up 10,000 hours of engaged learning.

Another famous psychologist and best selling author, Barry Schwartz, also supports the idea of the lottery. He independently came to the same conclusion as Daniel Gilbert that more freedom of choice is not always good. Beyond a certain manageable amount of choices (usually less than a handful), more choices brings more misery. More importantly, the main reason that made him support the idea of a lottery is that he had concluded that other methods that are supposedly based on merit are in fact intrinsically unjust, to the point of being unethical. It encourages desperate and highly intelligent people to game the system, to put themselves in a more advantageous position over their peers. For example tips on how to beat the medical school interview (including past year questions) are widely available. At its best, they coach you on how not to tell the truth. Some teach you how to lie like a crooked politician during impeachment. If you are well connected or willing to pay, you can even avail yourself to special coaching sessions by doctors. This is hardly the kind of values we want to inculcate in the young idealistic students before they even enter medical schools or residency training programs. It is frightening to consider that such interview programs may actually select for individuals who are very effective at being economical with the truth. Furthermore, there exist structural injustice in our society which allows the rich and the privileged to be more effective at gaming the system. There is evidence to show that the wealth distribution of students in prestigious universities is distorted in favor of the affluent, in proportion to the income inequality of the society at large. It goes beyond affordability. Students from middle class families can afford university education but their numbers are disproportionately low in highly sought after universities and faculties. Schwartz advocated that a lottery system will have the additional benefit of making people appreciate their own good luck and develop more empathy towards those who are less fortunate than themselves. In short, we will not breed a class of elites who have an undeserved sense of superiority over their less lucky counterparts in society.

Finally

Some months back, I received a very sad e-mail from a junior college student whom I have never met. It was a plea to allow him to have an attachment to the hospital that I work in, so that he can improve his chances of gaining admission to medical school. In the e-mail, he apologised for writing to me out of the blue. The gist of the e-mail is that he is an outsider. His parents are not doctors and do not have friends who are doctors. He does not know anyone influential who can help him secure such an attachment. In desperation, he sent me the unsolicited e-mail.

That e-mail troubled me a lot. My wish is that we can abolish all such inequalities in our system of selection of medical students and residents. If attachment to hospitals improves one's chances of admission to medical school, than it should be made universally available to all aspiring junior college students. Otherwise we should abolish it. It should not be allowed to affect admission chances. Better still, let's scrap every thing and have a lottery instead for medical student admissions and resident selection. Of course we know that it is not going to happen. Just food for thought and who knows, one day we may all get lucky.

In the meantime, we continue to programme doctors to be unhappy, from the moment they decide to vie for a place in medical school.

CM

Locum Doctors

by Dr See Toh Kwok Yee, MCFP(S), Editorial Board Member

As many doctors in solo practice can attest to, you just cannot go on leave, be it for vacation or other purposes, with any peace of mind without his blessing. In fact, ofttimes annual leaves are planned in accordance to his availability! If he so decides not to show up or lay a hand to examine the patients in your absence, one phone call from your clinic assistant by way of information is enough to wreck your holiday completely. Very few indeed can wield such power over the Family Physician like the locum doctor!

The situation is even more dire now for the solo practitioner ever since the major hospitals joined the fray to hire locum doctors to meet the growing aging and immigrant population as reported in the newspapers recently (Growing demand for locums, The Strait Times, 7 May 2012). With demand outstripping supply, the predicament is felt most when the doctor has to fulfil obligations like reservist training and maternity leave, which usually translate to weeks to months away from the clinic.

It is with this regard and other related concerns that The College Mirror decided to poll representatives from both parties to shed more light on the locum industry and the relationship between the hirer doctor and the locum doctor.

Dr Tham Tat Yean, **Dr Irene Lee**, **Dr Wong Tien Hua** and **Dr Leong Choon Kit** offered their opinions and valuable advice from the hirer's perspective while **Dr RT**, **Dr CY**, and **Dr S** shared their experience as locum doctors.

CM: When are locum doctors usually needed in your practice and where do you find them?

Dr Wong: Some of my weekday evening and weekend clinic sessions are run by my locum doctors. The same goes for my reservist training and my holidays.

I turn to the SMA website where both the hirer and the locum can advertise their need and availability respectively. I always keep an updated list of the locum doctors this way.

However, from my experience, getting a locum for urgent and unplanned coverage like when one falls sick, is very difficult and very expensive! Usually in times like this, the other partners will help out.

Dr Tham: My group practice has regular doctors to fill in the slots and we are becoming less reliant on locum doctors. When we do need locums we will stick to the same ones who are familiar with the practice.

Dr Leong: References given by fellow GPs are useful.

Dr RT: Perhaps in the future, we can have a locum register where clinics can find locums easier.

Dr CY: In some countries there are locum agencies acting as middleman. But using them may mean higher cost for the clinics and lesser income for the locum as the agencies may take a cut as commission.

The process of finding a suitably qualified locum for your practice is by trial and error. Therefore, try to develop a good and long-term relationship with your choice locums.

CM: How do you know if the locum doctor is qualified to run your clinic?

Dr Wong: I have always stressed to my locums that they must know the limits of their experience as doctors. The experience and competence of locums vary widely, ranging from freshly minted medical officers to experienced senior doctors who have previously run their own pracice.

Locums should call myself or my partners to check or refer the patients to the hospital if they are not sure. Having a good attitude and acting professionally, like not dressing too casually, are just as important factors.

The process of finding a suitably qualified locum for your practice is by trial and error. Therefore, try to develop a good and long-term relationship with your choice locums.

Dr Leong: I will check their qualifications on the SMC website and ask fellow GPs for their feedback on the locums.

Dr RT: As a locum, I always make sure I practice good medicine and there should not be any difference from my regular job as a doctor.

CM: How do you ensure continuity of care of the patients when using locums?

Dr Wong: The handing over process includes giving the locums an orientation folder. There are checklists to tell them the where the emergency bag is kept, the injectables they need to know and a formulary of drugs used in the clinic. I make it a point to meet my locums at an earlier date before I leave to help familiarise them with the practice.

I often stress to my locums to use previous entries in the case notes to guide them in their management. They should also not change the patient's prescription unless absolutely necessary.

Dr Tham: The locum doctor taking over should take the initiative to understand the casemix, the drug formulary and type of practice of the clinic.

Locums should, as far as possible, stick to the same clinics as being familiar with the patients means better rapport and trust, leading to better outcomes and continuing care.

Dr Leong: I routinely review all the case notes of the patients seen by my locum and would call the patients back for a review if the need arises.

Dr RT: I appreciate clinics that have a reference file or folder for me to refer to especially when it comes to the medications available.

If the clinic uses a computer system, let the locum get familiar with it before starting work. I also try to be nice to the clinic staff as they can often advise me on some aspects of the practice like what drugs available.

Dr CY: Some clinics have their own guide books their locums to ensure smooth transition of care.

CM: What is the current remuneration for locum doctors like?

Dr Wong: The rates range from $70 to $90 per hour depending on the patient load.

Emergency engagement may soar to $100 per hour which is about the breakeven point for the clinic and may not be worth the while if the practice is not busy.

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(from Page 9: Locum Doctors)

Dr Leong: At least $60 per hour.

Dr CY: In the past two years or so, the demand for locum doctors is more than supply and that is why our rates are on the upward trend. However, the downside is locums generally do not receive CPF, medical benefits and annual leave.

Dr S: Ask around, especially when starting at a new clinic. If you hear problems regarding delay of payments etc, better clarify before starting work.

CM: What are some of the problems you have encountered in such a working arrangement?

Dr Wong: Cancelling slots at the last minute! And of course, feedback about lack of bedside manners and rushing through a consultaion.

Dr Tham: The problems with our locums are only occasional and not very serious. They include being late for work and receiving feedback about lack of care for the patients.

Dr Leong: I have encountered locums who did not know how to give intramuscular injections, missed wheezing and were rude to patients.

Dr RT: Some clinics cancel the locum slots at the last minute resulting in loss of income! Some patients do not take to us as we are not their regular doctors.

Dr CY: Able to find enough work can be a problem. But with the demand for locums increasing, it is no longer difficult to fill the slots.

A locum has to adapt to the perculiarity of the practice; some clinics mainly attend to contract patients and the locum is expected to see a big volume of patients, whereas in the strictly private ones, you are expected to show more tender loving care.

Dr Lee: Unprofessional attitude such as badmouthing other doctors or questioning decisions made by other doctors in front of patients.

CM: Any good advice to doctors who are thinking of becoming locum doctors?

Dr Wong: Locum work can be rewarding as you gain much from being exposed to different work environment and practice style. You can learn how to operate a clinic and how patients are managed by the regular doctor.

Try to develop good habits early and remember to treat the patients like you would in your own practice.

I believe locums are an essential service which allows the clinics to continue to operate in the absence of the regular doctor so as to serve the local communities without disruptive breaks.

Dr Tham: Being a locum can be a satisfying experience with the professional exposure and training. Always do your homework; if the practice has a lot of paediatric cases, be familiar with paediatric conditions and dosings and don't forget about the parents' concerns.

Dr RT: Locum work provides good clinical experience. Be discerning and make sure you are not taken advantage of. Some clinics pay locums miserably but expect them to work very hard!

Dr CY: I would recommend a polyclinic posting before trying out as a locum. Even then, there are still a lot of differences between OPS and private GP clinics.

Do some reading about being a locum doctor. There are some handbooks written by some more experienced locums.

Dr S: One tip I learnt when I started, was to always refer to the previous case note entries for medications and their dosages. Do not be afraid to venture out to try as many clinics as possible when starting out so as to experience a variety of clinical practices.

Dr Lee: Do what is expected of our profession and not behave in a way that will make the public lose trust in doctors. Establishing a good long-term relationship with employers may serve you well in the future. Be punctual.

CM: Moving forward, what needs to be changed or improved?

Dr Wong: There is currently no standard of care or training for the locum doctors. Most locums learn on the job and as a result errors do occur like misdiagnosis and prescription errors.

In my opinion, there should be an orientation course for those who want to become locum doctors or insist on a minimum requirement in terms of number of years of experience and relevent postings which should include a stint in the polyclinic.

Meanwhile, the best option for the hiring doctor to safeguard his practice is to insist on one to two orientation sessions with the locum before going on leave.

The other important consideration is to make sure the locum doctors have proper medical protection coverage.

Dr Leong: A register for locums of good standing would be helpful. A minimum qualification for locum doctors like the Graduate Diploma in Family Medicine (GDFM).

Dr S: I guess the system is self-sustaining. If the locum does a good job, the clinic will call him/ her back, if not the clinic won't.

Dr Lee: For locums starting out, we should have a set of basic advice and pitfalls to look out for.

Locums should sign an agreement once they have agreed to locum so as to reduce any last minute cancellations unless there are truly unforeseen emergencies.

The College Mirror Editorial Team thanks Dr Tham Tat Yean, Dr Irene Lee, Dr Wong Tien Hua, Dr Leong Choon Kit, Dr RT, Dr CY, and Dr S for sharing their thoughts on this topic.

CM

Asia Pacific Primary Care Research Conference 2012

1 - 2 December 2012
National University of Singapore
Block MD6, Centre for Translational Medicine
14 Medical Drive, Level 3 (LT 36)
Singapore 117599

APPCRC2012

Plenary Speakers

Plenary Lecture 1:
Innovative Interventions for Anxiety and Chronic Stress in Primary Care

<< **Prof Wong Yeung Shan Samuel**
The Chinese University of Hong Kong

Plenary Lecture 2:
Setting up Family Medicine Research Network

A/Prof Ng Chirk Jenn >>
University of Malaya

Plenary Lecture 3:
Health Services Research

<< **Prof David Matchar**
Duke-NUS Graduate Medical School Singapore

Plenary Lecture 4:
Enhancing Scholarship of Teaching-Learning in the Primary Care Setting

Prof Gwee Choon Eng Matthew >>
National University of Singapore

Workshop Speakers

Workshop 1:
Medical Writing

Prof Teng Cheong Lieng
International Medical University

A/Prof Ng Chirk Jenn
University of Malaya

Workshop 2:
Biostatistics

A/Prof Koh Choon Huat Gerald
National University of Singapore

Workshop 3:
Enhancing Scholarship of Teaching-Learning in the Primary Care Setting

Prof Gwee Choon Eng Matthew
National University of Singapore

Dr Dujeepa D Samarasekera
National University of Singapore

Research Championship Coaches

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Conference Programme

DAY 1 1 Dec 2012 (Sat)	Event		
8.00am - 8.45am	Registration		
8.45am - 9.00am	Welcome Speech by Dr Chng Shih Kiat		
9.00am - 9.45am	**Plenary Lecture 1:** Innovative Interventions for Anxiety and Chronic Stress in Primary Care *Speaker: Prof Wong Yeung Shan Samuel*		
9.45am - 10.30am	**Plenary Lecture 2:** Setting Up Family Medicine Research Network *Speaker: A/Prof Ng Chirk Jenn*		
10.30am - 10.45am	Tea Break		
10.45am - 12.45pm	**Workshop 1:** Medical Writing	**Workshop 2:** Biostatistics	**Workshop 3:** Enhancing Scholarship of Teaching-Learning in the Primary Care Setting
12.45pm - 1.30pm	Lunch Talk		
1.30pm - 2.30pm	Lunch		
2.30pm - 3.15pm	**Plenary Lecture 3:** Health Services Research *Speaker: Prof David Matchar*		
3.15pm-3.30pm	Tea Break		
3.30pm - 5.30pm	**Workshop 1:** Medical Writing	**Workshop 2:** Biostatistics	**Workshop 3:** Enhancing Scholarship of Teaching-Learning in the Primary Care Setting
6.00pm	Gala Dinner		
DAY 2 **2 Dec 2012 (Sun)**	**Event**		
8.00am - 8.15am	Admin Briefing		
8.15am - 9.00am	**Plenary Lecture 4:** Enhancing Scholarship of Teaching-Learning in the Primary Care Setting *Speaker: Prof Gwee Choon Eng Matthew*		
9.00am - 10.15am	**Workshop 1:** Medical Writing	**Workshop 2:** Biostatistics	**Workshop 3:** Enhancing Scholarship of Teaching-Learning in the Primary Care Setting
10.15am - 10.30am	Tea Break		
10.30am - 11.45am	Free Paper		
11.45am - 1.00pm	Research Championship Finalists' Presentations		
1.00pm - 1.30pm	Prize Presentation & Closing Ceremony		

Pre-Conference Programme: Research Championship

30 Nov 2012 (Fri)	Event
8.00am – 8.30am	Registration
8.30am – 8.45am	Introduction and housekeeping
8.45am – 9.00am	Self-introduction of team members and research topic
9.00am – 9.15am	Introduction of Primary and Assistant Coaches to teams
9.15am – 10.15am	Group work 1: Transforming research ideas into answerable research questions
10.15am – 10.45am	Break
10.45am – 12.15pm	Group work 2: Developing research methods (1)
12.15pm – 12.30pm	Short updates on progress from each team leader
12.30pm – 1.30pm	Lunch
1.30pm – 3.00pm	Group work 3: Developing research methods (2) and identifying resources
3.00pm – 3.20pm	Break
3.20pm – 4.30pm	Group work 4: Preparing for the preliminary round of presentation - Proposal and PowerPoint
4.30pm – 5.30pm	Team presentation to panel of jurors: Selection of finalists for Research Championship Finale on 2 Dec 2012
5.30pm – 5.45pm	Jurors' critique
5.45pm – 6.00pm	Closing

Hiring a Locum

by Dr Wong Tien Hua, Editor, FCFP(S)

General Considerations

Decide on your leave well in advance. Allow at least 3 months advance to hire and book your locums. For high demand periods allow at least 6 months. Public holidays and school holidays, especially mid year and year end breaks are notoriously difficult to get cover.

For reservist training, SAF provides notice (SAF 100) 6 months before the in-camp. Do not procrastinate; book your locums as soon as you receive notice of in-camp training.

Once a locum has responded, be sure to obtain the full name and MCR. This is for payment purposes, and also allows you to check on the SMC website to ensure that the locum is a registered doctor.

If the locum is new and unfamiliar with the practice, arrange for your key staff (eg. senior clinic assistant) to be present. They know your patients best and can offer continuity and even protection for the practice.

Medical indemnity

Locums are strongly recommended to buy Medical Protection Society (MPS) insurance in case of any adverse events. Please ask them to contact MPS through SMA office (Tel: 6223 1264).

MPS 2012 locum rates (non procedural):
6 months - $425
12 months - $850

Handing over

The locum should have a proper orientation to the clinic, and should ideally be briefed before you go on leave. The clinic workflow, operational procedures, and the follow-up of patients should be explained. Typical referral processes should be reviewed and a list of preferred specialists for referral be made available.

Computer system: This is important especially if the clinic has paperless electronic medical records. Clinics should provide a guest account on Windows for locums to work with. Locums should have access to basic level functions like viewing patient queue and past medications. Additional technology like notepads or drawing pads should be demonstrated.

You can make a list of patients that requires special attention, just before you go on leave. This may include patients who are sicker, those chronic patients with acute unresolved or evolving problems, and those recently discharged from hospital.

Anticipate any upcoming events and try to resolve them prior to going on leave. For example, you can give chronic patients more medication to cover the period that you are away so they can return to see you once you are back. Vaccinations can also be similarly scheduled.

Before leaving the office, provide contact numbers to the office staff and to the locum, especially if the locum is unfamiliar.

Checklist

Locums should always check the following items as soon as they start their session, and to take note of where they are placed:

- Emergency bag and airway: Check expiry date of drugs and items
- ECG machine
- Nebuliser
- Refrigerator – check the types of vaccines available
- Blood taking equipment: vacuette holder, syringe and needles, torniquet, alcohol swabs, plasters
- Glucometer: insert test strip and check Code, disposable lancets
- Injections - check the range available and expiry dates
- Dressing sets and surgical equipment

Locums should familiarise themselves with the following:

- Drug formulary – Ask for a local clinic formulary if available. Take a look at the pharmacy and see what medications are available, ask the dispenser which are the common drugs used in that practice
- Laboratory – check which lab is being used and ask for the lab tests reference codes
- X-rays and radiology

Upon return

The resident doctor should review the cases seen, particularly for sicker patients. Any concerns of the office staff should be addressed.

If the locum was well liked and was particularly skilled, give him some feedback. A thank-you note will encourage him and will lead to opportunities for re-appointment. A good locum is a valuable resource for the family physician.

Reference:
American Academy of Family Physicians, "Choosing and Using a Locum Tenens", http://www.aafp.org/online/en/home/practicemgt/mgmt/locumtenens/choosinglocumtenens.html

CM

GP CME SYMPOSIUM

NCIS Oncology Updates for GPs & Family Practitioners

(2 core CME points will be accredited)

Saturday, 10 November 2012
2.00PM - 4.00PM

NUHS Tower Block Auditorium

NUHS Tower Block, Level 1,
1E Kent Ridge Road, S(119228)
(Lunch will be served at 1pm)

LEARNING POINTS

- **Evidence based standards of care for cancer screening, anticoagulation and colon cancer treatment**
- **Ensuring patient centered care through communications and supportive oncology**
- **Outlining your role in cancer management**

To register online, please visit NUH GPLC website at www.nuh.com.sg/nuh_gplc

PROGRAM HIGHLIGHTS

The conference aims to educate primary care physicians on issues related to cancer epidemiology, prevention and screening; and to review advances related to colon cancer, anticoagulation and supportive care in oncology. Don't miss this opportunity to network with your colleagues and cancer specialists from the National University Cancer Institute, Singapore (NCIS)

The target audience for this conference are family practioners, general practioners, and internal medicine physicians.

Cancer Screening in the Primary Care Setting

Dr Lim Siew Eng

Snr Consultant, Dept of Haem-Onco, NCIS
Assoc Director (Training & Education), NCIS

Updates in Colon Cancer for Primary Care

Dr Yong Wei Peng

Snr Consultant, Dept of Haem-Onco, NCIS
Adj Research Fellow, CSI Singapore

In the Clinic: New Oral Anticoagulation

Dr Chee Yen-Lin

Consultant, Dept of Haem-Onco, NCIS

Supporting the Patient Through the Cancer Journey: Part 2

Dr Noreen Chan

Snr Consultant, Dept of Haem-Onco, NCIS
Director (Education), Lien Centre for Palliative Care, Duke-NUS

Please note that you can park your vehicles at NUHS Tower Block or Kent Ridge Wing car parks.
Complimentary car park tickets are only provided for registered GP attendees

Organised By:

National University Cancer Institute, Singapore

NUH National University Hospital

NUHS National University Health System

Supported By:

AstraZeneca

The 'Software' Factor in Vietnam's Healthcare Sector

by Dr Loke Wai Chiong, FCFP(S), MBA, Editorial Board Member

Image courtesy of Dr Loke Wai Chiong.

From a height, peering down from my descending plane, the countryside of Vietnam was one of rolling farmland and greenery, rice field patchwork broken up by traditional low-lying houses and clusters of buildings making up towns and villages. Twenty percent of Vietnam's gross domestic product (GDP) is still agriculture, though like all other developing countries, this is shrinking, even as the big cities like Ho Chi Minh City and Hanoi continue to grow as urban centres.

An hour later, seated at the rear of one of their newer taxis – a spacious seven-seater multi-passenger vehicle, I saw, flitting past me, images of a rapidly evolving city-scape that is Ho Chi Minh City (or HCMC in short).

New office and hotel buildings, not really skyscrapers yet, stand knee-to-shoulder with old-fashioned shophouses and heritage buildings, reminding me of the city's French colonial past. The scenery brought back to mind a Singapore from my childhood (don't ask me how long ago that was!) – changing just as fast as my country did during those years of economic boom, if not faster.

Vietnamese authorities have reaffirmed their commitment to economic reform, but rigidities of a centrally-planned economy and an often corrupt bureaucracy are very real, and the economy remains dominated by state-owned enterprises (SOEs), which produce about 40 percent of GDP.

I was in HCMC to facilitate an interesting series of meetings. A family of 'returning Vietnamese' from the US was exploring the possibilities of investing into or starting a healthcare business in Vietnam. I had met the elder son, a public health post-graduate student, while giving a lecture in Harvard University. He shared with me his ideas for an innovative hospital business concept he wanted to start in Vietnam.

Image courtesy of Dr Loke Wai Chiong.

His father, a businessman, had arrived in the US at the age of 17 on an overloaded boat after a harrowing voyage across the Pacific Ocean. "Half the people who fled in that direction died," he recounted to me wistfully over a mug of Saigon beer. At age 25, the father started his first factory in Los Angeles, manufacturing denim jeans, and the rest is the inspiring story of an immigrant entrepreneur made good – multiple factories in US and Vietnam, wise investments (and exits) in real estate across multiple countries, a small fortune made.

No longer needing to work, he and a few friends and family in the US Vietnamese community were pooling some 'spare cash' together to invest and, in their own way, help to build up their old childhood homeland. And in the process, perhaps he hopes to provide his enterprising son who grew up in the West a real-life lesson and an exposure to how business is conducted in Asia – arguably the most exciting growth region in the world.

The health-care system in communist-socialist Vietnam is fascinating. Outwardly socialist with all of public healthcare provided "almost free" to the patient (supported by a rudimentary health insurance market and a recently-introduced partial co-payment scheme which allegedly only served to push costs beyond the reach of the lowest-income group), the system is in reality more private than public. What you see (or pay) is not as it seems.

The bulk of real healthcare expenditure, even for public sector provision, is out-of-pocket: directly to the doctor, the nurse, the counter clerk, the cleaner. Miss one, and you could be waiting in vain for care, attention, medication, or even clean bed sheets.

Specialist doctors supplement their meager public salaries with 'after hours' work out of their own homes, and 'facilitation income'. I heard of a doctor in Hanoi refusing to leave his US$50 per month university hospital job even when offered US$5,000 per month by a private hospital, because he didn't want to give up the access he had to a large pool of public patients, a proportion of which

Image courtesy of Dr Loke Wai Chiong.

were able to afford a 'referral' to the doctor's own side private practice. The existing system was earning him much more.

Access to essential and latest drugs and medical devices remains inconsistent. Procurement is seldom cost-efficient as the regulatory authorities tend to have their 'favoured' vendors, and manufacturers and brands, who stick religiously to the rules, may find themselves in mind-numbingly long delays for approval and entry.

A good friend of mine working in government relations for a big pharmaceutical company in the country tells me he's so frustrated that he's ready to call it quits. Knowing and working through the right people are still more important than following the stated procedures.

Public hospitals are enormously under-capacity, over-burdened and under-funded. A visit to the local hospital revealed scenes of four or more patients stacked on the same bed (and sometimes under it), sick elderly and children lying along corridors, harried staff struggling to cope.

The city population, on the other hand, has grown increasingly affluent, and a large and growing middle-class segment now expects and is willing to pay for better service and care. The elites and the rich upper-class already seek treatment overseas in Thailand, Singapore and Hong Kong.

Yet, despite all these pitfalls, healthcare is exciting and booming, a truly recession-proof industry. There are today too many private hospitals in the central districts of HCMC, and no more are allowed to be built.

The issue is not infrastructure – it's the people, the software. It always is. Clinics and perhaps 'shared medical centers' (catering to specialist doing after-hours work) may be the next wave of development. In an almost cowboy-town environment of break-neck growth, the discerning customer may turn out to be king, and providers who offer the best patient experience may be able to position themselves to win in the market.

As my plane wings out of HCMC, a glittering city still in her growing pains, I can only wish her all the best, and hope that she finds her way safely into the ranks of developed nations and health systems of the world. Achievable perhaps with some luck and lots of the hard-working ethic that has seen her through her first wave of success.

CM

Lead the Future of Healthcare

1 Patient experience | **2** New hospitals | **3** Integrated blocks | Discover exciting new opportunities in integrated healthcare

JurongHealth is Singapore's public healthcare cluster for the West. JurongHealth is building the new integrated healthcare hub comprising the 700-bed Ng Teng Fong General Hospital and 400-bed Jurong Community Hospital to provide holistic care for patients from 2014. JurongHealth is currently managing Alexandra Hospital and Jurong Medical Centre with a comprehensive range of clinical services for the community.

"At JurongHealth, we are building the Ng Teng Fong General Hospital and Jurong Community Hospital side by side. This gives us the opportunity to provide joint care between the teams, overseeing patient care from acute to transitional settings and finally integrating the patients back into the community."

Dr Chua Chi Siong
Medical Director
Jurong Community Hospital

Jurong Community Hospital is building a pioneer multi-disciplinary team of physicians to pilot care integration processes and workflows to manage patients requiring rehabilitation and sub-acute care. The team will provide holistic care to patients, ensuring continuity of care and optimal patient outcome in a transitional care setting. The team will also work closely with GPs, polyclinics, nursing homes and home care providers to facilitate and enable smooth transition of patients back to their home and community.

Join us to pioneer the future of integrated care!

SENIOR CONSULTANTS
CONSULTANTS
ASSOCIATE CONSULTANTS

REQUIREMENTS

- Possess basic medical degree
- Possess registrable postgraduate qualification in Family Medicine, Internal Medicine, Geriatrics Medicine, or Rehabilitation Medicine
- Possess leadership qualities, high interpersonal relationship and communication skills
- Experience working in the intermediate and long-term care sector will be an advantage

HOW YOU CAN APPLY

We offer a competitive salary and comprehensive benefits package that will commensurate with your qualifications and experience.

Please write in with your full resume including personal particulars, names of 2 referees, professional qualifications, career history, contact details and expected salary together with medical testimonials and certificate of registration to:

Medical Director
Jurong Community Hospital (Alexandra Hospital)
378 Alexandra Road
Singapore 159964
Email: **medicalcareer@juronghealth.com.sg**

For more information on Jurong Health Services, visit us at **www.juronghealth.com.sg**
Join us on Facebook at **www.facebook.com/JurongHealthServices**

We regret that only shortlisted candidates will be notified.

Winner of:
- *Leading CEO Award*
- *Leading HR Leader Award*
- *Leading HR Practices in Employee Relations & People Management (Special Mention) Award*
- *Leading HR Practices in Quality Work-Life, Physical & Mental Well-Being (Special Mention) Award*

JurongHealth

INVITED ARTICLE

Getting Your Own Website in 2 Evenings

by Dr Saminathan Suresh Nathan
Orthopaedic Surgeon
Associate Professor, National University of Singapore
Director and Senior Consultant, Limb Salvage and Revision Arthroplasty Surgery, Pte Ltd

Associate Professor Saminathan Suresh Nathan specialises in bone and soft tissue tumours of the musculoskeletal system and complex problems in joint replacement or adult reconstruction surgery (e.g. bone transplants and custom implants in revision joint surgery). He has had an accomplished academic medical career inaugurating and heading the Division of Musculoskeletal Oncology and being the Clinical Director of the Department of Orthopaedics in NUHS. He left NUH in 2012 after 20 years in Government Practice to set up a service dedicated to the practice of Limb Salvage and Revision Arthroplasty Surgery in the Mount Elizabeth Medical Center. At present he maintains his academic collaboration with the National University of Singapore as an Associate Professor in Orthopaedic Surgery contributing to research and undergraduate education there.

Websites can be a useful adjunct to many aspects of one's work. It provides information on services, opening hours, location and education and of course, advertising. In my case as a Professor of Orthopedics and Senior Consultant Orthopaedic surgeon, I host trainees on 2 monthly cycles and I am often asked the same thing repeatedly by patients undergoing knee replacement, hip replacement or tumor surgery. I had often thought therefore that if I could set up a handbook on a thumbdrive I could just hand this to my trainee. The web seemed too foreboding to venture into. Nevertheless after a conversation one evening with my wife, a GP, I learned that web page designer's charge up to $2,000 to design a web page, $1,000 a year to maintain it and $500 to register a domain. This was enough incentive for me to get into it and today, I have a fully functional website that both my patients and trainees can access for education and in deciding for surgery. As I will be making continued reference to it (www.limbsalvagesurgery.com), it would be worth exploring the website to see how the techniques I describe below may be applied to your needs.

Setting up a website literally takes minutes given the kind of templates that are available nowadays. Having this know-how allows you to update changes in real-time and not be dependent on a designer to do it in his time. In my case, whenever I see a trend in my clinic regarding a specific line of questioning (eg. stem cells in arthritis) I would then do my own research, write a summary and voila – no more spending hours in discussion of a controversial topic, I can now just refer the patient to the site.

You have to think of web design in 2 stages: Domain Registration and Webhosting. Most people think of these as the same thing but they are quite distinct.

Domain Registration

A domain name is the name your site is to take. So as above, my entry page is "limbsalvagesurgery.com". You would have to actually register this name for a fee (about $15 a year which you could specify the duration for 3 years, 5 years etc.) Do be aware that at the end of the duration, if someone else wants this domain he could have back ordered it and you would lose it then. It's therefore usually wise to regularly update your account. The registration can be done in a number of sites. I use godaddy.com which is one of the oldest and most reliable services on the net and whose main business is web domain registration although they also do webhosting and email services. While I was there I also picked up arthroplastysurgery.com and (shamelessly) nathanorthopaedics.com. It can be useful to register these in the beginning but you may allow them to lapse if you find you are not using them.

What you decide for your 'top level domain' (TLD, wait don't go!) is a matter of personal choice. This simply means the deciding on whether you want yours to end with .com, .org or .net. Also, deciding on a country code TLD (ccTLD) tells others where you're based as for example .com.sg for a website based in Singapore. Personally, I preferred to go with .com as I had concerns about the specialised nature of niche sites that offer these lower traffic alternatives and may be at risk of closing down. If for example, you are a family medicine specialist who has a clinic in Woodlands that looks after Malaysians you may choose .com.my or .com.sg. It really is up to you. Do note, though, that most people tend to default to .com when searching.

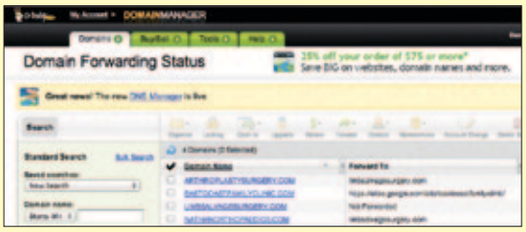
So once you've registered you now have your own domain. In the case of my website, if you type in limbsalvagesurgery.com, arthroplastysurgery.com or nathanorthopaedics.com it all goes to limbsalvagesurgery.com. This you will be able to do through the setup page in godaddy.com. They have a simple web-authoring tool known as InstantPage, which gives you a single page. If your needs are simple, this may be all you need and you can add maps, services, opening hours and simple updates. As your needs evolve however and you find that you need more services you may then have to host your new ambitious site in another format.

Webhosting

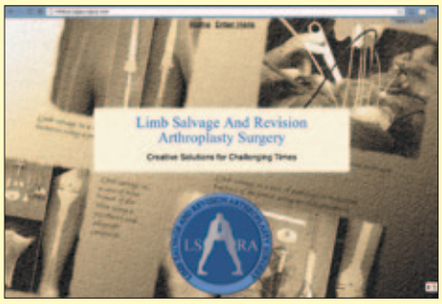
In the example given above if you type arthroplastysurgery.com or nathanorthopaedics.com it still goes to limbsalvagesurgery.com. However if you click the link for 'Enter', you enter a disclaimer and if you click the link there, which reads 'By clicking this link I verify that access to this site is for personal information', you are transported to another site with the address 'https://sites.google.com/site/limbsalvagesurgery/'. As you may have guessed this is a site offered by Google. You could of course in the first place have set up a Google site and not registered a domain but your domain would have been, well let's just say, cumbersome (that is https://sites.google.com/site/limbsalvagesurgery/ instead of just limbsalvagesurgery.com).

Domain Registration (30 minutes)

Go to a domain registrar and buy the domain name you want.

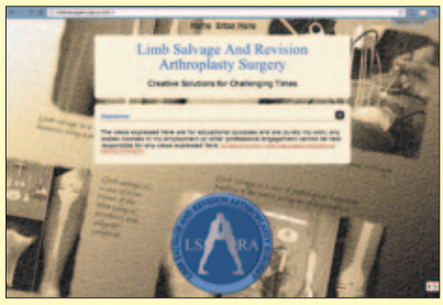


Decide on the domain manager page if you want the domain name to stay or forward it to another site (if you decide to host your site elsewhere).

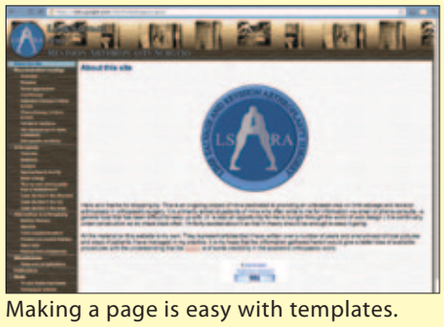


Design your simple included webpage.

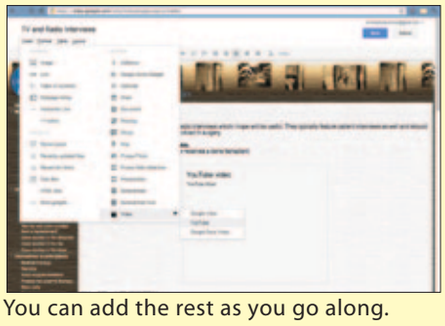
Web Hosting (As long as you need)



You can either point your domain to another site or create a link in the front page to the site.



Making a page is easy with templates.



You can add the rest as you go along.

All images courtesy of Dr Saminathan Suresh Nathan.

Webhosting, therefore refers to the process where your actual website resides. You could have upgraded your subscription in godaddy.com to expand your InstantPage service with consultancy services thrown in but hosting it independently as I have done in Google Sites has the advantage of the knowledge that one of the biggest internet companies (Google in my case) is looking after your website. In addition Google also owns YouTube and Google Docs (now called Drive) and this allows you to take advantage of all of these in your website. Inserting them onto a page is as easy as choosing 'insert picture' on a drop-down menu. Getting an account is the same as registering for a Google Mail account. You then navigate to Google Sites and you can then set up a new site from there.

Some people may want to run their own server to house their own website. While this sounds exciting, there are practical issues, which is why this approach is only possible with really big companies who then have their own ubercool domain names like apple.com. If you have a Mac this is quite easy. There is a program called iWeb in its suite of free programs. It is simple to use and has wonderful templates. It was however, only designed to be used with MobileMe a webhosting service formerly provided by Apple and abandoned. They now have iCloud, which is not compatible with MobileMe. Moral of the story? Stick to the robust webhosts even if they are simplistic. The other option is to perform webhosting on a Mac server through its Apache architecture. This again, is easy to do. The problem here is as a single broadband user you do not possess enough bandwidth to service the World Wide Web. This is the whole reason why webhosting services exist in the first place. Yes, I tried running a server but it rapidly became unusable.

One area of frustration for over-creative people is confining your vision to the templates provided by a webhosting service. This can be a humbling process. Webpage coding isn't like writing a word document; it involves some serious programming behind the scenes. Using templates helps you avoid all this. If you really want to do this, however, you've come to the wrong place - I don't do it. For the rest of us, templates are designed very similarly to Word and PowerPoint documents and if you can navigate those you can easily design your own website. When you are done you can use a tool to backup your entire site for security.

So, there you have it, the simplest approach to designing your own website. I have included the figures of my own website so you can get a feel of how I did it. There is nothing like having your own project at hand and learning the steps as you go along. Good luck. Oh and by the way, this whole exercise took one hour and less than $100!

CM

Health Promotion Board's New Health Choices Resource Kit & Family Practice Skills Course

Interviewed by A/Prof Goh Lee Gan, Director, Institute of Family Medicine, College of Family Physicians Singapore

The College Mirror is privileged to interview Ms Samantha Bennett (**SB**), Manager, Healthy Ageing Programmes & Healthcare Partnerships, Healthy Ageing Division in Health Promotion Board (HPB). She has been active in working with the College of Family Physicians Singapore on health promotion activities. HPB has sponsored several Family Practice Skills Courses (FPSC) in recent years. HPB is sponsoring the upcoming FPSC on Lifestyle Advice for Better Patient Outcomes. A/Prof Goh Lee Gan spoke to her to find out more.

CM: Ms Bennett, thank you for accepting this interview with The College Mirror. There is now a collection of resource material that Family Physicians can use to help themselves in their tasks of lifestyle advice for their patients. Congratulations to the Health Promotion Board (HPB) for the recent launch of the 'Health Choices' lifestyle advice resource for healthcare professionals. There is even a food calorie counter that is free on Apps store called iDAT for patients to find out for themselves where their calories are coming from and how to burn them. And all these will be touched upon in the forthcoming Family Practice Skills Course titled "Lifestyle Advice for Better Patient Outcomes" scheduled for next month, 20 - 21 October. To give our readers a headstart - "akan datang" as we call it, can you briefly walk us through firstly what is available for the Family Physicians and their patients, and secondly how can they obtain the Health Choices tools?

SB: It is a pleasure to be sharing with you about the HPB's new Health Choices resource kit. With chronic diseases and unhealthy lifestyle behaviours on the rise, the point-of-care resource aims to equip Family Physicians as well as other healthcare professionals with the tools to boost patients' health literacy, help them set health goals and modify their lifestyles. The resource has been designed with the busy practitioner in mind to proactively support them in providing lifestyle advice and management to 'at risk' patients (18 and above) to prevent or better manage their chronic conditions. Health Choices targets the main lifestyle risk factors for chronic diseases including smoking, overweight/obesity, as well as other priority areas such as stress and unsafe sexual practices. Health Choices consist of:

- Practice manual for healthcare professionals
- Tabletop flip chart for use during patient consultation, which includes a patient page for ease of reference to the patient and assessment cards for the four risk factors
- Poster and information brochures in multiple languages to prompt patients to start or continue conversations with their healthcare professionals about their lifestyle habits
- Dedicated webpage for viewing case videos and downloading resources
- Online evidence-based Physical Activity Advice Tool (PAAT) available for family physicians to use as an instrument to assess patients quickly (under 4 minutes); reserve time for counselling; and develop individually tailored, structured counselling messages
- Free smartphone application - interactive Diet and Activity Tracker (iDAT) to help Singapore residents better manage their personal health. iDAT is a fully integrated health application designed to track both food intake and physical activity, and calculate a user's calorie balance

On 1 September 2012, the resource kits were sent to all registered Family Physicians in private clinics and in polyclinics via their clinic addresses recorded on the Ministry of Health database. For other healthcare professionals, resources were sent to registered Dentist clinics, restructured hospitals, Traditional Chinese Medicine Practitioners (TCM) through their main schools, Pharmacists, Physiotherapists, Occupational Therapists and Optometrists registered with their professional bodies. For other healthcare professionals, the tools including links to PAAT and iDAT are available for download at http://www.hpb.gov.sg/health-choices.

CM: Good. Looks like a really useful and good resource to support not only Family Physicians but other healthcare professionals in helping their patients have a better health literacy on what their Family Physicians will be telling them so they can make healthier choices. To get back to the FPSC, could you share with us on what you hope the FPSC aims to achieve for the participants who attend?

SB: After attending the two day training, I hope that Family Physicians will have a better awareness of how to use the Health Choices resources as a point-of-care tool to prompt them to opportunistically start conversations with their patients about their lifestyle behaviours and tips to make changes. The Course will allow doctors to role-play using the Health Choices assessment chart which are clear steps to give brief and intensive advice across the lifestyle risk factors using 3As brief approach (1-5 minutes),

adapted from the ABC (Ask, Brief, Cessation model) consisting of 'Ask, Advise, Action', and 5As intensive approach (5-15 minutes) comprising 'Ask, Advise, Assess, Assist, Arrange'. Family Physicians can then practice with their patients using the Health Choices flip chart which includes a patient page for smoking, overweight/ obesity, stress and unsafe sexual practices to visually reinforce the messages said by the doctor.

Given that doctors are busy and have limited capacity and time, I hope they recognise that the tools are designed to enable them to assess patients quickly and give brief but effective advice. Also, they see the value softskills such as health literacy and motivational interviewing play in helping them deliver quality interactions which are 'patient focused', non-judgemental and facilitate understanding by both the physician and patient.

CM: Motivational interviewing and health literacy are useful skills in helping patients in their behaviour change journey. Can you tell me more about how they can help family physicians?

SB: Often, counselling patients who are 'at risk' of developing or mismanaging chronic conditions can be challenging given the patient's values and attitudes which surround unhealthy behaviours. Increasingly patients are seeking more personalised 'customer-oriented' experiences to healthcare where Health Choices aims to provide the 'hardware' for Family Physicians and health literacy and motivational interviewing skills the 'software'. As well, advice by healthcare professionals particularly doctors, is perceived as being more credible, resulting in individuals being more likely to follow their advice often when used in a patient-centric manner.

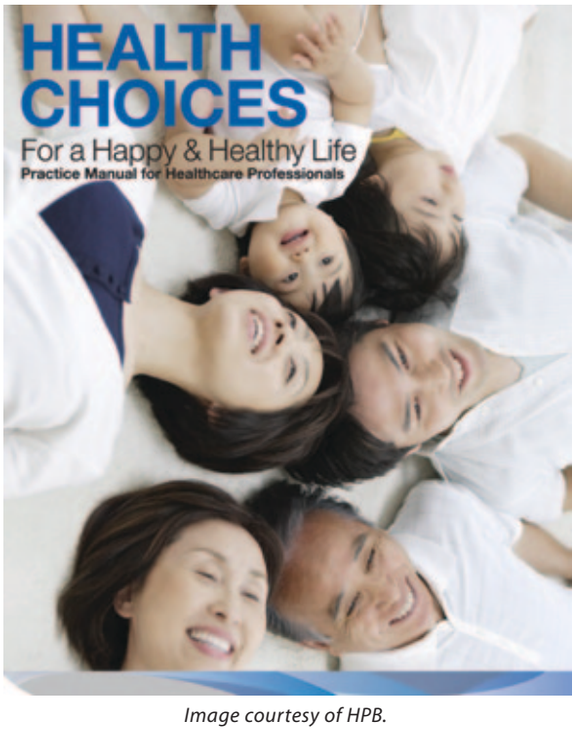


Image courtesy of HPB.

Health literacy is 'the degree to which people have the ability to obtain, understand, access and communicate the health information and services needed to guide them in making healthier decisions'. Motivational interviewing is 'a directive, patient-centred counselling style used to elicit behaviour change, during more intensive sessions, by helping patients to explore and resolve ambivalence'. Both are important skills which Family Physicians can use to help their patients understand the health advice given so they can make informed choices that are 'owned' by the patient; and secondly, explore the barriers to unhealthy behaviours and devise lifestyle modification solutions.

CM: Thank you for sharing. In adopting health behaviour change, there will be the early adopters, the early majority and the late adoptors. What strategies do you have for our Family Physicians to get the latter to cross the line?

SB: Based on National Health Survey (2010) figures, two in five Singaporeans aged 20 years and above are already suffering from at least one chronic ailment. As the population ages, increasingly all healthcare professionals in particular Family Physicians will see more of their patients become afflicted by chronic disease and the downstream impact on their longer term health, family burdens and financial constraints. Family Physicians and the broader healthcare family are well positioned to provide opportunistic advice when their patients present with other problems. Many patients have well established relationships with their doctors which is a starting point for those 'late adopters' to provide 'bite sized' pieces of advice in a trusted setting. Simple health literacy techniques can also help patients, such as asking them, "We have discussed a lot. What do you need to remember when you get home?" As well as keeping key information to three points or less, which the doctor can summarise and write down for the patient. As one of my healthcare partners said, "We doctors are good at being the 'nagger'."

For those 'early adopters', Health Choices aims to help Family Physicians opportunistically counsel patients across three touch points: 1. When patients present with other problems, 2. Anticipating preventive needs of their patients, and 3. Proactively targeting 'high risk' individuals least likely to seek out such care.

Singaporeans are very savvy in seeking out healthcare across the various multi-disciplinary touch points to get the information they need. Hopefully, as more healthcare professionals including Family Physicians provide lifestyle counselling using consistent messages from Health Choices and softskills such as health literacy and motivational interviewing in their practice, a 'tipping point' will be reached whereby patients will 'own' the advice and proactively take steps towards better health.

CM: Thank you, Ms Bennett for talking to us about HPB's new Health Choices resource kit. Good to know that primary care physicians can download materials from the HPB website. iDAT now gives us a tool that patients can share with their doctors, and most of all, themselves on the calorie counts of the food that they consume. The forthcoming FPSC on "Lifestyle Advice for Better Patient Outcomes" would be a worthwhile course to attend. Please thank HPB for us for sponsoring this Family Practice Skills Course.

SB: Welcome. It is a pleasure to work with the College of Family Physicians Singapore and through the College, our primary care physicians.

CM

Family Practice Skills Course #50

Lifestyle Advice
for Better Patient Outcomes

Sat - Sun, 20 - 21 October 2012
2.00pm - 6.00pm
College of Medicine Building, Auditorium (Level 2)
16 College Road, Singapore 169854

TOPICS
Unit 1: Overview: Epidemiology on Chronic Diseases and the Need for Lifestyle Advice
Unit 2: Lifestyle Advice and Management
Unit 3: Motivational Interviewing (MI) in Behavioural Change
Unit 4: Health Literacy – Asking the Right Questions & Broad Concepts
Unit 5: Health Literacy – Meeting Patient Needs
Unit 6: Health Literacy – Enhancing Physician Skills

WORKSHOPS
Day 1: Practical Tips – Motivational Interviewing (MI) & Case Scenarios/ Role Play
Smoking and Overweight Cases
Day 2: Practical Tips – Health Literacy & Case Scenarios/ Role Play
Sexual Health/ Stress cases

SPEAKERS
Dr Jonathan Pang
Dr Ong Kian Chung
Dr Tan Yew Seng
Ms Shirin Wadia
Ms Vasuki Utravathy
A/Prof Goh Lee Gan
Ms Samantha Bennett

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, 20 October 2012 (2.00pm - 4.00pm)
Seminar 2 • Unit 4 - 6: Sun, 21 October 2012 (2.00pm - 4.00pm)

■ **WORKSHOPS** (1 Core FM CME point per workshop)
Day 1: Sat, 20 October 2012 (4.30pm - 6.00pm)
Day 2: Sun, 21 October 2012 (4.30pm - 6.00pm)

* Registration is on first-come-first-served basis.
Seats are limited.
Please register by 15 October 2012 to avoid disappointment.

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

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

Health Promotion Board

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Lifestyle Advice for Better Patient Outcomes
Please tick (✓) the appropriate boxes

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

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

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College of Family Physicians Singapore
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