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The Greying World: What does it mean for Family Medicine, Society and Health?

Highlights from the Sreenivasan Oration 2012

Professor Ranga Krishnan delivering the Sreenivasan Oration 2012 at The Tanglin Club on 18 November 2012.

This year's Sreenivasan Oration was delivered by Professor Ranga Krishnan, Dean of Duke-NUS Graduate Medical School Singapore on 18 November 2012, during the College of Family Physicians Singapore Family Medicine Convocation Ceremony held at The Tanglin Club.

"Mortality rates have decreased in conditions such as diabetes, heart disease accidents and hypertension.

The net effect is that we are living longer. Two thousand years ago, the average Roman would expect to live to the age of 22. In the 1900s, life expectancy grew to nearly 60 years. By 1960, life expectancy was nearly 70 years. Today, new-borns can expect to live close to 80 years.

In Asia, Japan has the highest life expectancy and Singapore is not far behind. This increase in life expectancy has happened at a very rapid pace in a relatively short time frame. One should

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look at the change taking place in China. In 1960 the average life expectancy was 36 but today, a mere 50 years later, life expectancy in China is 74 years. In one lifetime, life expectancy has actually doubled.

The more important effect is that this increase in life expectancy has led to an ageing society. The number of 80 year olds has reached 150,000,000 – a veritable tsunami of elderly. With women living longer than men, it will slowly turn into a woman's world. The ratio of women to men will be 2 to 1 amongst 80 year olds.

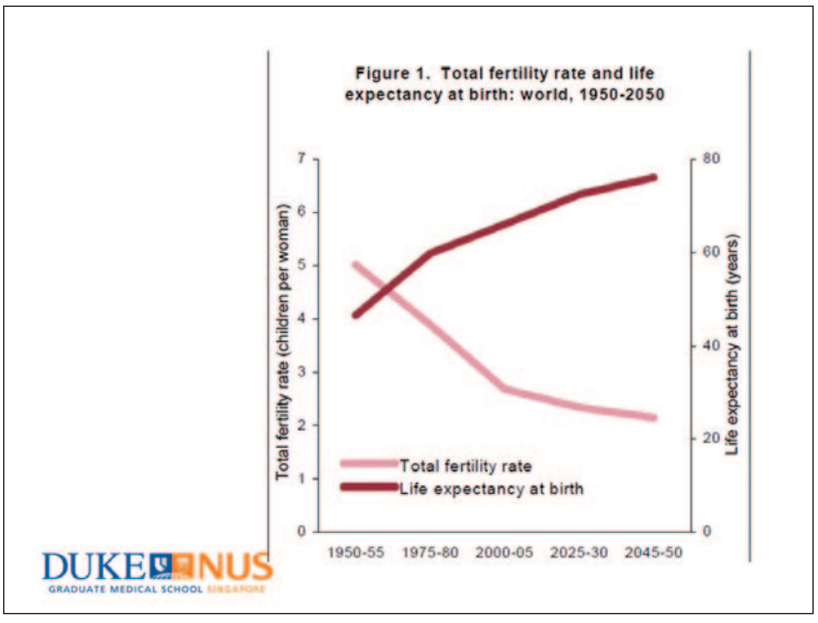
Why are people living longer?

The reasons include low infant mortality due to better vaccination, clean water, improved sewage, better education, reduced smoking and better medical treatment. Although we think of healthcare as a major factor, it is a much lower contributing factor in relation to mortality.

What is of particular concern is that fertility rates have also decreased. This has led to a changing balance in the number of working individuals compared to the number of individuals that they support, i.e. the population aged below 18 and above 65 are the so-called support ratio crucial for the health of the economy. In Singapore for example, the support ratio was above 17 in 1970 and now it is less than half at 7.9. In addition, surveys suggest that people above 65 want to work less than they used to in the past.

Another factor to keep in mind is that as the population is ageing, healthcare costs are rising. The costs are increasing mostly because of the increased expenditure in the last year of life. When one looks at Medicare costs, 27 per cent of its budget was spent in the last year of life and 12 per cent was just for the last month of life. One of the reasons why costs are going up so fast is the lack of education for patients at the end of life who are not educated about death, dying and the dignity of life. Palliative care is an important and critical piece as we work with the elderly and end of life issues are integral to the delivery of optimal care.

In addition, many incentives which led to increased healthcare costs in the last year of life need to be evaluated and addressed. The nature of disease is also changing. The prevalence of diseases like diarrhoea, respiratory diseases, which were globally very important in the early part of last century, are likely to rapidly decrease in the next 20 years while diseases such as depression, cardiovascular diseases and cancer are likely to increase. The needs of populations and types of disease will therefore be very different in the next 20 to 30 years. In particular, as a population ages, the incidence and prevalence of cognitive impairment and dementia will increase.



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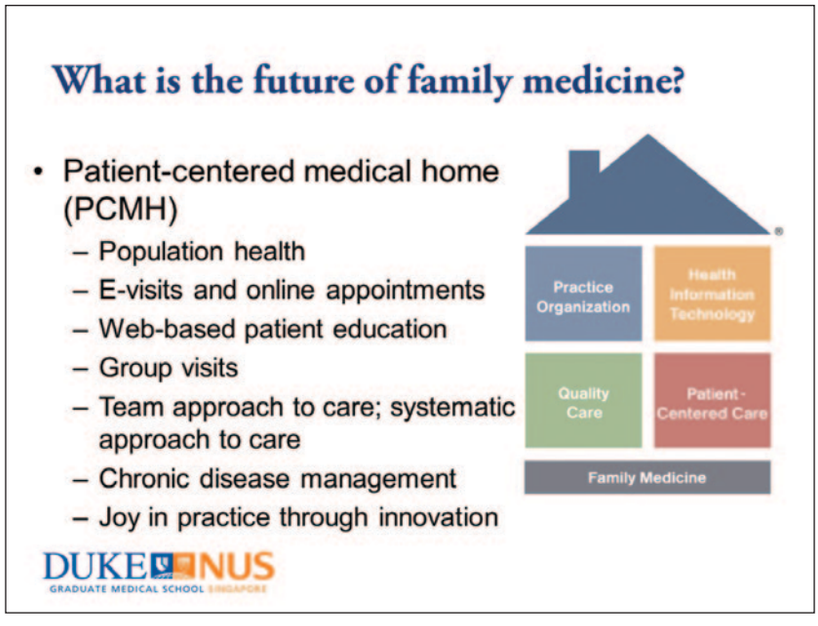
What do we need to do?

While we would like a reduction in disease morbidity and mortality, this wish may not happen. Consequently, public health and population health with a properly incentivised system of healthcare becomes essential. The key component of such a system would be the education of the population with regard to prevention as well as the end of life care.

Moreover, integrated solutions become critical. It is in this context that family medicine and family medicine practitioners can be the building blocks of the healthcare system. Family practitioner care leads to better health, more patient satisfaction and lower healthcare cost. In many cases, the care tends to be activated earlier and can lead to better detection of diseases like cancer. Family practitioners are able to provide preventive healthcare and continuity of care. They are more importantly taking care of the whole patient and not just the different organs. In this context, the attributes of the excellent family physician include the understanding of the patient as a whole person, the ability to act as a partner to the patient through many years, the command of medical complexity and most importantly, humanising of care. Family care physicians are now at the top of the wish list from most healthcare systems, the most important and desired specialty in 2012 and on the list for the last seven consecutive years. The future of family medicine includes the patient care centre, medical homes, and integrated care.



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However, even with increased numbers of family physicians and healthcare workers, there will still be insufficient family care physicians to support the needs of the community. Thus, it will be very critical for the elderly population to actually become involved in the healthcare system as direct care providers. One such approach is the *Grand Aide* system. Grand Aides are elderly but healthy persons trained in specific aspects of medical care who serve as extenders to a physician. These aides often best understand the problems of the elderly and while they themselves are healthy, can play a major role in supporting other elderly who are not as fortunate as they are.

In the next 20 years, family medicine will become the key and integral pillar of an integrated healthcare delivery system that provides evidence-based patient care to individuals in the community.

CM

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2012

by Dr Eu Tieng Juoh Wilson, Editor

The end-of-year issue of The College Mirror is traditionally one that looks back on the year that has just passed. The New Year email by A/Prof Lee Kheng Hock perfectly summarised the work of this Council and the tasks ahead. I think it is worth re-printing this for our wider audience:

"

Dear Fellow Members of the College,
The past year (2012) has been a time of exciting changes. There is increasing recognition of the importance of family medicine and the good work that family doctors do.

The Family Physician Register

Behind the scene, the College has worked very hard to moderate the Family Physician Register that was implemented this year. Through a process of consultation with members and feedback to the policy makers, we have managed to make the register more inclusive. Unfortunately some of our members are still unable to fulfill the admission criteria. We will continue to engage and shape the register so that it will avoid the pitfall of becoming a register that restricts the practice of family medicine. We are confident that it will continue to develop into a register that will enhance the development of family medicine and empower family doctors to do our important work.

The Role of College in Training

The introduction of the ACGME style residency training to Singapore was a disruptive innovation to our training system. While the jury is still out, we are confident that the many talented doctors that we have who are working under the new system and the vast amount of funding that has been poured in will make it as good if not better than our previous system of training.

Back in the 1970s when the conventional wisdom of the time denied the need for specialised training of family doctors, College fought an uphill battle and instituted a rigorous and structured vocational training called the MCGP. In 1993, this became the MMed (Family Medicine), a collaborative effort between the College and the National University of Singapore. Many of our College members have expressed concern that the College has been excluded from this new system of training of future generations of family physicians. We have made representations to the Ministry of Health and are reassured that the important educational role of our College is valued and the College will continue to be engaged in the training of residents of family medicine. We are glad that the Ministry has appointed the College as the organiser of the In-Service Training Examinations (ITE) for family medicine trainees. Some senior members of our College have been appointed into various training committees. The President of our College by appointment is also made the Co-Chair of the Joint Committee on Family Medicine Training.

As a result of our representation to the Ministry of Health, the College has been invited by the Minister to write a proposal on the how the College can be involved in a post-residency training program for family doctors. Our FCFP(S) by assessment program has gained de facto recognition as being equivalent to the advanced specialist training by local health care provider organisations and international academic bodies. We are confident that we can achieve formal recognition for our FCFP program as the post residency training program for family medicine residents. Future generations of our College members who are now entering residency training will have the same opportunities for advanced training as their peers who enter the residency programs of other disciplines.

A Better Practice Environment and a Level Playing Field

In the past year the College has engaged policy makers on many practice issues including the Primary Care Masterplan, the Community Health Assist Scheme, the proposed electronic health record, maintenance of competency, managed care, community pharmacy and various other policy and proposals. We believe that our diligent feedback has made many positive contributions and facilitated changes that make these policies more favorable to our members who are providing good quality care to their patients. The College will continue to work hard to ensure that such policies will be fair and effective. For primary care to really improve, we must ensure that ordinary, decent family doctors are empowered and fairly remunerated for the practice of patient centered medical care.

Unity for a Better Future

The strength of family medicine and our College comes from diversity and our ability to thrive in complexity. Our members practice in diverse settings ranging from solo private practices, group private practices, polyclinic, nursing homes, community hospitals and restructured hospitals. We are united by our common training and by our common belief in the paradigm of family medicine. In the next few years, we will face many challenges. It is important that we stay united and support one another through the College.

In the New Year, the College will work on various initiatives to re-vitalise our membership. In the first quarter of 2013, we will be conducting a massive updating of our membership. As we engage external parties to advocate for our members, we are often asked, "Who does the College represent?" To better answer this question and be a more effective advocate, the College will also be conducting a survey of our members. We hope that you will all support this survey when you receive our on-line survey form.

On behalf of the Council and staff of the College, I would like to take this opportunity to thank everyone for their support of the College in the past year and wish everyone good health and happiness in the coming new year.

Yours sincerely,
A/Prof Lee Kheng Hock
President
College of Family Physicians Singapore

In this issue, we highlight some of the achievements by our members. Many have won awards in Clinical Research and Scientific Competitions. Dr Lam Chih Chiang Benjamin, our Year 2 Fellowship trainee, was awarded the Gold Medal for Best Poster - Clinical Research category at the recently concluded Singapore Health and Biomedical Congress 2012. Dr Tan Hsien Yung David and Dr Lee Eng Sing won Gold and Silver Medals respectively, in the Singapore Primary Care Research category. Dr Darren Seah was awarded a Gold Medal in the Primary Care Research Best Poster Award.

Two Prizes in Family Medicine have been started for undergraduates from both National University of Singapore, Yong Loo Lin School of Medicine and Duke-NUS Graduate Medical School Singapore.

Congratulations to all who were conferred their various awards during the Family Medicine Convocation Ceremony on 18 November 2012 at The Tanglin Club.

We would like to share the learning journey of some of our recent trainees and also the diverse interests and talents that exist within our fraternity in *The Guitar Man*.

Finally, let me wish all our readers, a wonderful, fulfilling 2013.

CM

this issue >>

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College of Medicine Building
16 College Road #01-02, Singapore 169854
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E-mail: collegemirror@cfps.org.sg
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Excuse Me, Are You a Bad Doctor?

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

人之初　**Men at birth,**
性本善　**are naturally good.**
性相近　**Their nature are similar,**
习相遠　**nurturing sets them apart.**

The opening verses of the Confucian classic, The San Zi Jing (Three Character Classic), written in the 13th century and attributed to Wang Yinglin (1223-1296)

A bad example

We have all heard stories of surgeries that were unethical or go horribly wrong. Examples would include the amputation of legs on the wrong side or the removal of wombs for dubious indications. This one really takes the cake: A perfectly healthy appendix was removed from a young man who had no symptoms or signs that suggested appendicitis. The negligent surgeons were also incompetent. They had to make three incisions before they located the appendix. The surgeons then proceeded to amputate the man's arm. At least the amputation was well done although this was the first time the surgeon was performing the procedure. If there is any comfort, he was at least properly supervised by a specialist consultant. They made the effort to ensure adequate soft tissue cover and to minimise the risk of post surgical nerve pain. They then resected a perfectly healthy length of the small intestine and successfully re-anastamosed both ends. The surgeons then proceeded to do a tracheostomy, again without any justifiable indication. The young man was murdered at the end of the horrific surgery and the body was buried in the ground near the hospital. The medical director in charge of the hospital was fully aware of the case but did not punish the doctors. The blotched surgery was covered up by the government, even after the facts were revealed by the media.

This is a true story. One of the surgeons was Dr Ken Yuasa, a Japanese surgeon who knowingly participated in this horrendous crime. His acts were sanctioned by the Japanese government of the day. More than that, he was compelled by the medical authorities to perform the surgery. If he had refused, they would have removed his license to practice and maybe even kill him. Yes it happened sometime ago, one day in the month of March 1942. Does that make it less evil?

A promising young doctor

Ken Yuasa started his career as an idealistic medical student like everyone else. He came from a well to do family. His father was a doctor. Today we would probably consider him a family doctor. He did housecalls and was available day and night to the patients in the local neighborhood. When the neighborhood and his own home was razed in the great Tokyo earthquake of 1923, he chose to stay behind amidst the rubble to tend to his patients while his family and the young Ken Yuasa was evacuated to

live with relatives in Chiba. Inspired by his exemplary father, Ken Yuasa always wanted to be good doctor, just like Dad. His ambition was to be a country doctor and to travel to rural villages to help underprivileged patients. This was not to be. In fact he would be sent to wreak the most unspeakable horror on poor peasants in rural villages of another country. When he graduated in March 1941, Japan had invaded China and the brutal war was in full swing. He was compelled to enlist as an Army surgeon. He was assigned to the Luan Military Hospital in Shanxi, China. Within 40 days of reaching the hospital, he was to participate in his first human vivisection.

While he was a medical student, he had heard stories of army surgeons performing human vivisections in China. He knew that he would eventually be doing this. Nevertheless when he received information that there will be a practice surgery session in the autopsy room after lunch at 1 pm on that day, he was filled with dread and deep sense of foreboding. Once in the operating theatre, which was filled with more than 20 senior colleagues and nurses, he was more concerned about not showing signs of fear or weakness. He did not want to look bad before his bosses and colleagues.

Medical murder

He remembered the surreal atmosphere. Senior surgeons from different army institutions were there, making small talk and taking the opportunity to network. Theatre nurses were chatting and laughing as they prepared the instruments. It was probably no different from the "live" surgery demonstrations that we conduct in present times. The difference was of course the lack of consent, not even of the uninformed kind. There were only 2 persons in the room who were more terrified than Ken Yuasa. They were the patients, picked up by the Kempetai (Military Police) for the occasion. Both were farmers from nearby villages. One was a brawny young man who was stoic and showed no fear. The other was a scrawny old man who was whimpering in terror. Prodded by soldiers with rifles and fixed bayonets, the younger man went on to the table. Ken Yuasa remembered pushing the older patient towards the table with the help of the soldiers.

The prisoners were lucky. They were given anesthesia. This was not done in the patients' best interest. They just needed the patients to keep still as they practice surgery on them. In many subsequent vivisections that he participated, no anesthetic drugs were given so as to simulate frontline conditions where surgery had to be performed in the field without anesthesia. Sometimes, anesthesia was omitted because they were unsure of their effect on the live tissue specimens that had to be collected for pharmaceutical companies and germ warfare laboratories.

At the end of 3 hours of horrific torture, the practice surgery ended. The 2 mutilated patients were still breathing. As usual, the seniors left the operating theatre while the more junior doctors like Ken Yuasa were left to finish up the surgery. They decided to kill off the patients by injecting air into their heart. Death by air embolism did not work fast enough. The patients were still breathing. Ken Yuasa then tried in vain to strangle one of them with his bare hands. His colleague tried to help by improvising with the patient's belt. It didn't work either. Finally a more experienced non-commissioned officer came into the room and told them that injecting chloroether into the veins would "do the trick". It worked and the surgeons left the room for the attendants to clean up the mess that they had made. Ken Yuasa remembered feeling a little uneasy for the rest of the day. In the evening, he went for drinks with his colleagues and felt better after that. "I was afraid during my first vivisection, but the second time around, it was much easier. By the third time, I was willing to do it," Ken Yuasa remembered.

Such was the cruelty that it had become routine, best practice if you will, to be immoral. People were routinely inhuman. How could something so horribly wrong be widely accepted and enforced by the authorities? Can we trust august bodies of senior doctors to safeguard medical professionalism? How can a doctor be conditioned to do such horribly bad things?

In the next 3 years, Ken Yuasa was to participate in the butchering of 14 more prisoners. Near the war's end, Ken Yuasa was promoted and became the program director of the practice surgery sessions. At the Army headquarters, there was a committee responsible for patient care quality and training standards. It was sort of the equivalent of ACGME (H), "H" as in "from Hell". This training regulatory body decided that the army surgeons' skills were deteriorating and ordered to double the practice surgery sessions to 6 per year. In a situation that is eerily reminiscent of present times, the surgeons were too busy in the field treating real patients and had difficulty gathering for such practice sessions. Ken Yuasa remembered that the attendance was so bad that at one session, they only had enough participants to work on one victim. Not wanting to "waste" the additional patient picked up for the event, the Director of the Hospital decided to use the patient for samurai sword practice and beheaded him.

In this twisted medical health care system, doctors were encouraged to be innovative as well. Ken Yuasa was assigned to teach physiology and anatomy to army medics. The lessons were boring. In the name of innovation in medical education, he decided to use live vivisection to make the lessons more interactive and interesting. He remembered the trainees were impressed. Everyone enjoyed the session except for the poor farmer who was compelled to donate his life for the occasion.

Such was the cruelty that it had become routine, best practice if you will, to be immoral. People were routinely inhuman. How

could something so horribly wrong be widely accepted and enforced by the authorities? Can we trust august bodies of senior doctors to safeguard medical professionalism? How can a doctor be conditioned to do such horribly bad things?

The root of medical evil

Most of us will probably consider that there must be some human defect in medical colleagues who sink to such depths. A common reaction of the more self righteous would probably be to call for severe punishment of errant doctors and to organise ethics courses for medical students or junior doctors.

Simon Baron-Cohen, professor of developmental psychopathology at Cambridge University, argued against the conventional thinking about good and evil when we encounter human cruelty. Like Confucius, he believes that the intrinsic nature of man is good. Inhumanity results from the erosion of empathy. Evil and the cruelty that it generates is the absence of empathy. Many social scientists concur with Confucius' view of the intrinsic nature of man. With the exception of a small number of outliers who are certifiable psychopaths, narcissists, borderline personalities and severe autistics, the vast majority of mankind are born with a sufficient stock of the goodness of empathy. Babies show empathic distress and will cry when they hear other babies cry. This continues to blossom in early childhood and by the age of 8, we begin to understand our own mortality and the fragility of life. We are moved by the suffering and the death of others. We have all cried and laughed with real and fictional characters in the stories that we encounter in real life and in the movies. We can be prompted to "imagine" what it might be like if we see another person suffers.

Short-term cruelty is possible only if we learn to actively block the natural empathic response. Long-term cruelty will need a sustained erosion of empathy through prolonged training. The Austrian philosopher Martin Bruber proposed that empathic response can be blocked and eroded when we move from the "I-you" relationship to the "I-It" response. When the subject of potential empathy is depersonalised to the point it becomes an object (it), empathy disappears.

The fall of a good doctor

This was borne out in the case of Ken Yuasa who remembered that Japanese soldiers were conditioned to think of victims as "maruta" or "blocks of wood", to be used as objects in experiments and thrown into the fire. Performing vivisection on a Chinese victim would be no different from dissecting a frog in science class.

Ken Yuasa also remembered that throughout his education from

primary school to the university, there was a constant process of dehumanising the enemies of Japan in the curriculums of the schools. He felt that his ability to perform such inhuman acts was the result of a systematic "education of despising other races, and the deceitful propaganda" that was incorporated into the school curriculum.

If empathy can be systematically eroded through education, can we then restore or prevent the erosion of empathy through education? If it is possible, then we must seriously re-think our approach towards managing errant doctors and improving professional ethics.

The road to redemption

After the war, many of the doctors who were guilty of such horrendous breaches of medical ethics, returned to normal life. The United States military, the victorious leader of the allies in the Pacific War, was complicit in preventing the prosecution of many of these war criminals. The Cold War commenced on the heels of the Second World War. Scientific data obtained through many of such unethical experiments were deemed to be critical to the arms race between the US and the Soviet Union. National self-interest trumped human rights and the pursuit of justice. In order to secure the collaboration of Japanese military doctors, their war crimes were conveniently overlooked. The majority who survived the war returned to their civilian roles as doctors and nurses. They remain silent on their war time activities and when exposed would vehemently deny their past actions. Some such as Prof Yoshimura Hisato of the infamous Unit 731 even published his data from frostbite experiments that were performed on prisoners, women and infants. He eventually became the president of the Kyoto Prefectural University of Medicine.

Through all these, he persisted, moved by a deep-seated contrition for his past sins and the need to restore his own humanity through confession. Like many fallen doctors who came to terms with past misdeeds, he felt compelled to prevent others from making the same mistakes in the future.

Ken Yuasa was different. He returned to practicing medicine the way he had intended to, in a clinic in Tokyo up till the age of 84. Unlike the majority of his peers, he openly confessed his crimes and denounced his past actions. He dedicated his later life towards exposing the inhumanity of the past and his role in it. With the help of writer Natsuko Yoshikai, he wrote "a book of confession" which he named "The Unerasable Memory". He detailed the dark secrets of the past in public lectures around the country. They were poorly received. He was often jeered and heckled. On one occasion, firecrackers were thrown into the room in the midst of his lecture. Embarrassed contemporaries exerted peer pressure to try to make him stop. He even received death threats from right wing extremists in Japan. Through all these, he persisted, moved by a deep-seated contrition for his past sins and the need to restore his own humanity through confession. Like many fallen doctors who came to terms with past misdeeds, he felt compelled to prevent others from making the same mistakes in the future.

The redemption of Ken Yuasa was through education. When Japan surrendered in World War 2, Ken Yuasa like many other Japanese soldiers found themselves stranded in China in the midst of a civil war between the Nationalists and the Communists. Recognising the value of their military training and experience, the Nationalist conscripted many of the surrendered Japanese soldiers to serve in the Nationalist Army. Ken Yuasa became a military surgeon again, this time serving his former enemy. He even got married and had 2 children during his new career stint. When the Nationalists were defeated, Ken Yuasa fell into the hands of the People's Liberation Army in 1949 but was left alone to serve as a doctor for the Japanese families that stayed behind in China. By 1951, his past caught up with him. He was re-arrested and imprisoned as a war criminal by the Communist government. In the days immediately after the Communist victory in China, the country was in a state of euphoric idealism. The new leaders vacillated between repression and re-education as a way to transform China into a modern socialist state. Fortunately for Ken Yuasa, Japanese war criminals fell into the re-education group. The policy towards them was generosity and rehabilitation. The prisoners were well treated. In a time of food shortages, the prisoners were given better food than the guards that watched over them. The regime was one of work, education, reflection and collective confession, bearing some similarity to the group therapy techniques of modern day. Ken Yuasa was made to recollect his misdeeds and given pencil and paper to record the details and his reflections. As the defenses break down, Ken Yuasa was able to cognitively understand the wrongness of his past action. But in his recall, there was little remorse or regret for the wrong things that he had done. For the most part of it, he just did what the captors wanted, hoping that eventually he will be allowed to return home. The turning point came when he received a letter.

The process of re-humanisation

By serendipity, Ken Yuasa was transferred to a prison in Taiyuan, Shanxi. This was the same region where he had conducted a vivisection to teach anatomy and physiology to army medics. The mother of the victim managed to track him down and demanded that his captors punish him severely for his crime. She also wrote to Ken Yuasa. It was an emotionally charged letter written by a grieving mother whose son was taken away and killed in the most gruesome manner. The words were seared into the memory of Ken Yuasa. The letter began with the words, "Yuasa, I am the mother whose son you killed." The letter detailed the anguish and pain the mother went through subsequent to Ken Yuasa's casual decision to use human vivisection to make his lesson for the army medics more interesting. One day before the lesson, the women's son was picked up by the Security Police and locked up. The desperate mother waited overnight outside the gates for news of her son. In the morning, the gates opened and she saw her son taken away in a truck. The old women chased after the truck until she could not go any further. The next day, she learned that her son was taken to the army hospital and dissected alive. Her grief was deep and inconsolable. It was then that Ken Yuasa truly saw his victim as a human being. He remembered he broke down in tears as he read the mother's letter in his dimly lit cell. All the horrible details that he had blotted out flooded back to his memory. The smell of death, the cry of the victims and casualness of the brutal acts all came back with a new meaning.

Even in 2007, when he was interviewed by a reporter of the Japan Times, the tears returned when he remembered the letter. "I couldn't hold back from crying when I read the letter, because I

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felt so sorry for the horrible things I did. I was ready and willing to receive the harshest punishment after that," said Ken Yuasa. In that defining moment, the empathy that he had lost was restored.

The relative kindness that he received from his captors moved him as well, to the point that it removed the conditioned hatred that was instilled in him through years of indoctrination. As a war criminal he received better treatment than what he had meted out to the innocent victims when he was in the shoes of the captor. When he fell ill with pneumonia during his captivity, he was treated with precious antibiotics that the Chinese imported from the Soviet Union. In 1956, having been convinced that he had genuinely repented for his sins, the Chinese captors decided not to prosecute him for war crimes and allowed him to be repatriated to Japan with his wife and children.

Lessons from the story of Ken Yuasa

The unusual life story of Ken Yuasa holds many lessons for us in the understanding of empathy in medicine. It shows us how empathy can be eroded and how it can be restored. Erosion of empathy requires de-personalisation of the doctor-patient relationship. Interaction becomes a process that focuses on the task to be achieved. Tasks are defined by objectives. Patients are rendered into objects. Prolonged and systematic erosion can deplete empathy down to zero and render doctors into brutal beings. Redemption requires us to be compassionate to the fallen doctors. Hate the crime but not the person. Restoration of empathy requires deep reflection and the re-humanisation of the victims and the perpetrator. It is well known that empathy diminishes as medical students and doctors progress in their training. Many raise concerns and seek to improve curriculum or introduce knee-jerk responses such as mandatory training in ethics. Perhaps the erosion of empathy is not caused by the training or the lack of it. Ken Yuasa's medical training per se did not erode his empathy. It was the organisation that he serves and the setting that he was forced to practice in that transformed him from an idealistic doctor into a war criminal. The erosion of empathy in our present day is probably related to the fragmented and depersonalised way in which medicine is practised in our overcrowded and occasionally understaffed hospitals and clinics. The reward and value system of the larger society sustains this erosion.

Redemption requires us to be compassionate to the fallen doctors. Hate the crime but not the person.

By now many of you would have come across the moving testimony of the late Dr Richard Teo, a 40 year old multi-millionaire practitioner of aesthetic medicine. As he struggled with terminal cancer, he reflected on his professional life, repented and found redemption. These were some of the haunting words he left as a caution to the future generation of doctors.

"The truth is, nobody makes heroes out of the average GP in the neighbourhood. They don't. They make heroes out of rich celebrities, politicians, rich and famous people. So I wanted to be one of these. I dived straight into aesthetic medicine. People were not willing to pay when I was doing locum back in those days. Anything more than $30, they would complain that "Wah, this lo kun (doctor) jing qwee (very expensive)". They made noise and they were not happy. But the same people were willing to pay $10 000 for a liposuction. So I said, 'Well, let's stop healing the sick, I'm gonna become a beautician; a medically-trained beautician."

The professional shortcoming of Dr Richard Teo is a minor misdemeanor when compared to the war crimes of Ken Yuasa. However there are similarities in their fall from grace and their subsequent redemption. Like Ken Yuasa, Dr Richard Teo, was similarly conditioned to think of patients as objects, money making objects. The erosion of empathy was similarly a product of their practice setting and the prevailing cultural norms of the society at large. Both were forced to reflect on their past professional misdeeds and were restored through repentance and acts of redemption. They were contrite and publicly exposed their past misdeeds as a way of warning others not to follow their footsteps.

As we condemn and prosecute errant doctors, we should not be carried away by our own self-righteous zeal. We should spare a thought for them as fallen colleagues, even as victims of a flawed system. Our professional leaders and policy makers should also reflect on their past misdeeds and their responsibility for the present system, before they implement knee-jerk responses to curtail the deterioration of ethics and professionalism. The shortcomings of the practice settings that we impose on our doctors must be changed, if we are serious about promoting professionalism. We should all see ourselves as easily fallible but intrinsically good doctors. We have to defend our humanity against the erosion by the system. In the words of Dylan Thomas, *"Do not go gentle into that good night. Rage, rage against the dying of the light."*

CM

Interview with Dr Lam Chih Chiang Benjamin

by Dr Teo Yee Sheng Victor, Editorial Board Member

Dr Lam Chih Chiang Benjamin, a Collegiate Member of the College, won the Gold Medal for Best Poster - Clinical Research category, in the recent Singapore Health and Biomedical Congress held on 28 September 2012.

The College Mirror is pleased to interview Dr Lam to learn more about his research journey.

CM: Please tell us more about yourself, your family and Family Medicine training.

I am 34 years old this year, currently working as a Registrar in the Department of Family and Community Medicine in Khoo Teck Puat Hospital. I am happily married with 2 kids who are my pride (5 year old son) and sweetheart (2 year old girl) respectively.

I started out my BST in Family Medicine in 2006. This was after a 6 months stint at Yishun Polyclinic, which helped crystallise my preference to see patients in the outpatient as opposed to the inpatient setting, and thus my resolve to pursue Family Medicine.

I was also inspired by the deep and rewarding doctor-patient relationships a GP could develop with his patients which I witnessed during my GP attachment as a medical student.

I completed my BST in 2009, and obtained my Master of Medicine (Family Medicine) [MMed(FM)]. I proceeded to attain the Collegiate Membership of the College of Family Physicians Singapore [MCFP(S)] in 2010, as a requisite to the Fellowship of the College of Family Physicians Singapore, and am currently into my 2nd year of the Fellowship programme.

CM: Why did you choose this subject for research?

Part of my work in Khoo Teck Puat Hospital involves running the Weight Management clinic. During one of our routine journal clubs, my colleague presented a paper on a novel parameter of obesity, the Body Adiposity Index (BAI), which is a direct estimation of one's body fat just by using one's height and hip circumference. It was developed from a population study of Mexican Americans, and is validated in a separate study of African Americans. Immediately, the research question asked was whether this BAI could be applied in our local setting, and we tried to do just that.

CM: Please give us a summary, or the highlights of your research.

This is a Method-Comparison study. 105 Chinese (we decided to focus on one ethnic group first) were recruited, and percentage adiposity estimated by BAI was then compared with that derived from DEXA using the Bland Altman plot. The results of the study showed that the BAI tended to underestimate the DEXA-derived % adiposity by a mean of 5.77% (95% Confidence Interval (CI): 4.94%, 6.6%). As a follow up to this result, we tried to recalibrate

Photo courtesy of Dr Lam Chih Chiang Benjamin.

the BAI formula so that it would perform better for our local Chinese. However, we also noticed that the performance of the BAI varies with gender and level of fatness. These findings were consistent with all other papers trying to evaluate this BAI as well (in different ethnic groups).

Hence, my conclusion is that although the BAI was originally designed in view of the limitations of the BMI, namely being unable to differentiate between lean and fat masses, the results of this study in a Chinese population (in Singapore), supports the observation from other studies that the BAI has its own set of limitations as well. Nonetheless, the attractiveness of the BAI remains in that it is a direct estimation of body adiposity, which makes more intuitive sense when describing obesity and that body adiposity could be easily calculated with just a tape measure. Whether the BAI could indeed be a better index of adiposity as proposed by its original authors, will have to depend on adjustments made for its limitations and pending proof that it is a better predictor of health outcomes than the currently established BMI and Waist Circumference.

CM: Would you tell us some of the important lessons, pitfalls learnt or avoided while writing this paper?

I would extend this question to what I have learnt doing this study and subsequently writing it up. Firstly, it is to ask the right research question, because everything you do subsequently is based on the research question. You would do a literature search to see if this question has already been answered, and also to determine if the question is worth answering – what is the clinical significance in answering this question? Then you proceed to design the study to try to answer this question, and subsequently the results and discussion portions of the paper are to attempt to answer this question.

Secondly, applying for ethics approval is a necessary step, and it seems like an insurmountable amount of paper work and fraught with pitfalls to the uninitiated. But it can be done. Get some experienced help, a large dose of patience, and don't take the comments or questions by the board too personally.

Finally, the writing up of the paper. There can be an inertia to doing this, but see this as a logical conclusion to doing the research, as you would want to share the answer to this research question, especially if you had asked the right question, a never answered question, and one that will have an impact or contribution to the existing scientific knowledge base.

CM: Why do you think that Family Medicine practitioners should engage in Primary Care research?

For us to be seen as a credible discipline, we need to engage in some form of research.

For us to be seen as a credible discipline, we need to engage in some form of research. It may not be a 'double blind, placebo controlled, randomised controlled trial' but other kinds of pertinent research that answers questions in our daily clinical practice as Family Medicine practitioners. We need to have a library of scientific knowledge specific to our local practice and context, and ongoing research by members of our fraternity will add to that library.

CM: Any other thoughts about Family Medicine and Primary Care Research?

I think we are moving in the right direction in terms of Family Medicine and Primary Care Research. And all of us can play a part, even those who do not want to play a direct part in this. We can support others in their research by just answering questionnaires, and would thus be contributing to the bigger picture of things, and make primary care a more conducive environment for research.

CM

Family Medicine Convocation 2012

18 November 2012 (Sunday) • The Tanglin Club

23rd Council (2011 - 2013), College of Family Physicians Singapore

Standing (left to right):
A/Prof Koh Choon Huat Gerald, Dr Eu Tieng Juoh Wilson, Dr Leong Choon Kit (Assistant Honorary Secretary), Dr Chng Shih Kiat, Dr Tham Tat Yean, Dr Tan Ngiap Chuan (Honorary Editor)

Seated (left to right):
Dr Tan Tze Lee (Honorary Treasurer), Dr Rukshini Puvanendran (Assistant Honorary Treasurer), Dr Pang Sze Kang Jonathan (Honorary Secretary), A/Prof Goh Lee Gan (Recipient of the Dr Albert and Mary Lim Award 2012), Mr Gan Kim Yong (Guest-of-Honour, Minister for Health), A/Prof Lee Kheng Hock (President), Dr Lim Fong Seng, Dr Yee Jenn Jet Michael

Not in photo: Dr Tan See Leng (Vice President), A/Prof Tan Boon Yeow (Censor-in-Chief), Dr Ang Choon Kiat Alvin, Dr Siew Chee Weng

Council members welcoming the Guest-of-Honour, Mr Gan Kim Yong, Minister for Health, to the event.

Dr Lim Fong Seng, Censor, CFPS Board of Censors, leading the academic procession to mark the start of the Family Medicine Convocation 2012.

Guests inside the Theatrette at The Tanglin Club during the Family Medicine Convocation 2012 ceremony.

Guests mingling and enjoying the dinner in the Churchill Room after the Family Medicine Convocation 2012 ceremony.

MCFP(S) Recipients >>

Seated (left to right):
Dr Ang Su Lin Vivien,
Dr Tan Yee Leng,
Dr Zheng Mingli Ruth,
Dr Pang Sze Kang Jonathan (Honorary Secretary),
A/Prof Lee Kheng Hock (President),
Dr Lim Fong Seng (Censor, CFPS Board of Censors),
Dr Chan Hui Kwan Diana,
Dr Chan Hian Hui Vincent,
Dr Chang Ngai Kin Christopher

<< MMed(FM) Graduands Year 2012

Standing (left to right):
Dr Ong Eng Koon, Dr Ong Cong Wei Alvin, Dr Boey Weng Heng, Dr Koh Kim Hwee, Dr Low Lian Leng, Dr Tan Swee An Benjamin

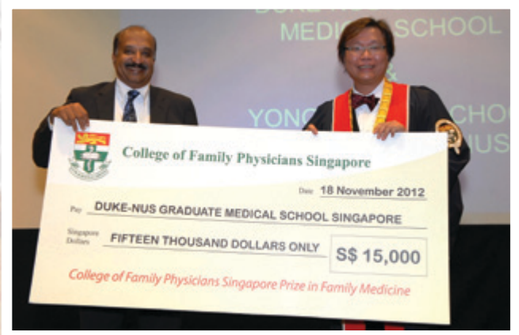
Seated (left to right):
Dr Lee Wan Sian,
Dr Lee Cia Sin,
Dr Pang Sze Kang Jonathan (Honorary Secretary),
A/Prof Lee Kheng Hock (President),
Dr Lim Fong Seng (Censor, CFPS Board of Censors),
Dr Chan Qiuhua Catherine,
Dr Hui Jor Yeong Richard

GDFM Graduands Year 2012 >>

Standing (left to right):
Dr Loke Jian Feng*, Dr Teo Yee Sheng Victor, Dr Yoshikuni Susumu, Dr Lai Junxu, Dr Lwin Moe Kyaw, Dr Kheterpal Hemant, Dr Bansal Rohit, Dr Chew Kwong Yik Jimmy, Dr Yong Zhi Yong, Dr Chew Wei Da, Dr Muhammad Adib Bin Malek

Seated (left to right):
Dr Selvaganapathi Yogeswari, Dr Waheeda Banu D/O Majid, Dr Meenakshi Jain, Dr Tan See Leng (Vice President), A/Prof Lee Kheng Hock (President), Dr Lim Fong Seng (Censor, CFPS Board of Censors), Dr Myint Myint Thein, Dr Chidambaram Shanmugasundaram, Dr Ho Lik Man

** GDFM Book Prize Award*



A/Prof Lee Kheng Hock (President) presenting a cheque for the *College of Family Physicians Singapore Prize in Family Medicine* to Prof Ranga Krishnan from Duke-NUS Graduate Medical School Singapore.

A/Prof Lee Kheng Hock (President) presenting a cheque for the *College of Family Physicians Singapore Family Medicine Prize* to A/Prof Lau Tang Ching from National University of Singapore, Yong Loo Lin School of Medicine.

Citation for Sreenivasan Orator 2012 Professor Ranga Krishnan

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

We all know Prof Ranga Krishnan as the unassuming and affable Dean of the Duke-NUS Graduate Medical School Singapore. It is my pleasure this evening to tell you more about nice gentleman who is a firm believer of the importance of teaching the values and paradigm of Family Medicine to medical students.

Prof K. Ranga Rama Krishnan was appointed Professor and, was the Chairman of the Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, North Carolina for eleven years, until 30 June 2009. Under his leadership the department flourished. It had more than 490 faculty members, conducted more than 270 human-subject studies a year and a similar number of in-vitro and in-vivo animal studies, and received US$40 million worth of research funding annually.

Prof Krishnan earned his medical degree and completed a rotating internship at Madras Medical College. He then completed his residency and held a fellowship in neurobiology at the Duke University Medical Center. He also started a translational research center for depression in the elderly, the only such center in the United States funded by the National Institutes of Health.

Prof Krishnan is an elected member of the Institute of Medicine – a prestigious institution that is highly regarded around the world for its independent, scientifically informed analysis and recommendations of health care issues. As a further recognition of his contributions to biomedical science, Prof Krishnan received the 2007 Distinguished Scientist Award from the American Association for Geriatric Psychiatry.

Prof Krishnan has authored over 400 peer reviewed publications and numerous books and book chapters. Prof Krishnan serves or has served on many editorial boards of scientific journals and on multiple research review panels for the National Institutes of Health.

Throughout his distinguished career as a clinician scientist and as a psychiatrist, Prof Krishnan had received many prestigious awards. These include the C. Charles Burlingame Award, which recognises his outstanding leadership and lifetime achievement in psychiatric research and education, the Award for Research in Geriatric Psychiatry by The American College of Psychiatrists, the Rafaelsen Award from the Collegium Internationale Neuro-Psychopharmacologicum, the Laughlin Award from the American College of Psychiatry, the Distinguished Investigator Award from the National Alliance for Research on Schizophrenia and Depression and the Klerman Award from Depression and Bipolar Support Alliance.

A/Prof Lee Kheng Hock (President) presenting a token of appreciation to Prof Ranga Krishnan, the Sreenivasan Orator 2012.

Finally, what endears him most to us is his contribution to medical education in Singapore. As the Dean of the second medical school in Singapore, Prof Krishnan and his team had introduced many innovative ideas that had transformed research and education in our county. It is my honour and privilege this evening to present to you Prof Ranga Krishnan, the 2012 Sreenivasan Orator of the College of Family Physicians Singapore.

CM

GP12 Conference

by A/Prof Tan Boon Yeow, Censor-in-Chief, 23rd Council, College of Family Physicians Singapore

The College of Family Physicians Singapore was invited by the Royal Australian College of General Practitioners (RACGP) to attend their College Convocation as well as annual scientific conference held from 24 - 27 October 2012.

Our College was represented at the event by the Censor-in-Chief, A/Prof Tan Boon Yeow. It was a good opportunity to renew ties with our Australian counterparts as well as other College's representatives including family physicians leaders from Hong Kong, Malaysia and New Zealand.

This year's Stuart Patterson Lecture: *Leading Primary Care: Health Reforms, the UK Perspective* was delivered by Professor Clare Gerada who is the current president of the Royal College of General Practitioners (UK). Prof Gerada highlighted the need for patient centeredness in the delivery of healthcare where general practitioners have a pivotal role to play, both as advocates for our patients as well as in delivering specific care to our patients.

She emphasised the need for GPs to help our patients negotiate the complex healthcare system and not leave them to make all the choices as the healthcare system is getting more complex by the day.

She also spoke against over testing of well people and the overzealous attempts to find the hidden sick as health is more than the absence of disease. The over medicalisation of everyday life leads to anxiety, fear and over consumption of healthcare.

From left: Dr Ruby Lee (President of The Hong Kong College of Family Physicians), Dr Jennie Kendrick (Censor-in-Chief of RACGP), Dr Liz Marles (newly elected RACGP President), Dr Jun Liang (Hong Kong), A/Prof Tan Boon Yeow (Censor-in-Chief of College of Family Physicians Singapore).
Image courtesy of A/Prof Tan Boon Yeow.

She concluded by reminding all of us that the doctor-patient bond forms the greatest satisfaction of general practice and we need to maintain and build upon this sacrosanct aspect of general practice care.

A/Prof Tan also managed to explore with the various GP leaders on possible collaborations moving ahead. There was also a couple of take-home points that College could consider implementing for our own college's convocation and academic activities.

CM

Family Practice Skills Course

Lifestyle Advice for Better Patient Outcomes

The College of Family Physicians Singapore would like to thank **Health Promotion Board (HPB)** and the Expert Panel for their contribution to the Family Practice Skills Course #50 on "Lifestyle Advice for Better Patient Outcomes", held on 20 - 21 October 2012.

Expert Panel:
Dr Jonathan Pang
Dr Ong Kian Chung
Dr Tan Yew Seng
Ms Shirin Wadia
Ms Vasuki D/O Utravathy
A/Prof Goh Lee Gan
Ms Samantha Bennett
Ms Angela Leow

Chairpersons:
Dr Wong Tack Keong Michael
Dr Yee Jenn Jet Michael

The Guitar Man

by Dr Goh Tze Chien Kelvin, Editorial Board Member

Dr Tan Teck Jack is a General Practitioner in private practice who has kindly agreed to share with us his passion for music and especially the guitar. Dr Tan is a graduate from the University of Melbourne. He is married to a beautiful wife and they have two lovely kids.

Image courtesy of Dr Tan Teck Jack.

CM: How many bands have you formed over the years?

I've had 3 bands in the last 20 years since 1990. My first band was named "Red Hot Curry Powder". It happened when I was in medical school in Australia with a bunch of interesting friends including a school teacher, two high school students, a catholic priest, an accountant and a fellow medical undergraduate. We played Jazz music with a twist at various functions. Sometimes we were paid, but mostly it was pro bono work. We didn't go far, never got famous but it was mega fun while it lasted. That was the most memorable.

The 2nd was a duo called Jack and Ray. My 3rd band was called "Boys in the Attic" with fellow doctors (including a hand surgeon) and a 64year old male nurse as our vocals.

CM: I understand that you have a collection of Guitars? When and how did you get started?

My first guitar was one I bought from a friend when I was 17 years old. It was a well maintained second hand guitar. I secretly smuggled it into my house because my parents were pretty strict and expected me to play the piano, not the guitar. The perception then was that a guitar is a rogue instrument played by rock musicians with long hair! My parents could not understand the allure of guitars and the concept of forming a band. My parents never found out I had a guitar till much later. I learned to play from friends but am mostly self-taught.

After I started working as a doctor, I bought more and more guitars, and the rest (as they say) is a guitar storage nightmare!

CM: What sparked your interest in music?

I've always loved all sorts of music ever since I could remember. I love jazz, blues, classical, contemporary pop, heavy rock, metal, everything! My current attic was built with acoustics being a primary consideration.

I did my classical piano exams like everyone else, got bored and rebellious, so I picked up guitar and bass. I also picked up drums when my daughter did drum lessons for a few years.

A family that plays together stays together. My daughter too shares my interest in music.

Image courtesy of Dr Tan Teck Jack.

My dad sings and plays multiple musical instruments so I guess he was my primary influence and motivation. I have always been impressed by dad. And of course, the sportsmen and musicians get all the girls. Since I was never much of a sportsman I chose the latter. It was an excellent way to woo my then-girlfriend-and-now-wife.

CM: Tell us what is so attractive about collecting guitars?

You don't hear much about people collecting pianos and drum sets. Guitars are a lot more collectible I guess because of its size, portability and infinitely varied colors and types of wood grains. Personally, I love the shape and organic feel of a wooden guitar.

When I play the guitar and sense the notes resonating through my body, it really is a wonderful feeling. My guitars are actually a playable working collection that I own and play. Whenever I feel stressed at work, I'll just pick up one of my guitar and play a tune or two for my family.

CM: How many guitars do you own?

I currently have nine acoustic guitars, twenty electric guitars, less than ten bass guitars and a few other interesting sorts of unique guitars. Whenever I visit a new country, I also make it a point to visit their music shops, sometimes buying a souvenir guitar to mark the trip.

The actual numbers are a bit fuzzy because a few are always on loan to friends, nephews and I usually don't see them for a few years after loaning them out. No, I don't expect them to return the guitar. If they do it is a bonus. If that guitar could ignite or help support their interest in music, that's more than enough for me.

CM: What is your most memorable guitar?

My first electric guitar, it was a cheap custom made guitar which was beautiful but the sound wasn't all that good but my wife loved it. Unfortunately I sold it many years ago when I was a poor medical student.

CM: What makes a good guitar?

It must talk to me in a manner that makes me smile and feel all good inside. Much like my wife still does!

CM

Go For It – Sharing My Learning Journey

by Dr Chan Hui Kwan Diana
Registrar, Medical Services, Ang Mo Kio – Thye Hua Kwan Hospital

Introduction

I started out as a doctor 30 years ago. How times have changed. As a medical student they had not even discovered what the HIV virus looked like! I practised in the public sector for 10 years before I took the plunge and opened my own clinic.

GP with Special Interest in Paediatrics

I had done Paediatrics but unfortunately I did not pass the MMed (Paeds) exam. If only they had a course similar to Programme B that I attended for the MMed (Fam Med) then things would have taken a different turn.

Anyway, I became a GP with special interest in Paediatrics and enjoyed treating my paediatric patients and along the way their mothers , fathers and the rest of the family as well. It was fulfilling because as a solo practitioner I got to practise how I wanted to (of course within the CPGs and ethics) and literally saw my patients grow up on each encounter.

GDFM

After 10 years of being a GP, I decided to upgrade myself and do the exams. I joined the polyclinics and decided to take the GDFM as the private practice route was cancelled that year. Going back to do exams after 20 years was not easy; least of all because so many things had changed. Medicine had progressed tremendously by way of Clinical Practical Guidelines for almost every major condition and it was quite exciting to be updated and be "validated" in a way. Of course all through the years I attended various symposiums and the CMEs but doing the GDFM made it all very systematic and complete. I enjoyed interacting with younger colleagues as well.

Image courtesy of Dr Chan Hui Kwan Diana.

SATA Community Health

I was next headhunted to join SATA community health which gave me experience in running one of their centres as an Operations manager and Head of Department. It honed my executive skills as we also had to do things like budgeting and watching our bottom lines.

Back to Clinical Work

However I was drawn back to more exciting clinical work when I joined Ang Mo Kio-Thye Hua Kwan Hospital where I am currently. I decided to sit for the MMed (Fam Med) last year not least because there's a 5 year limit after the GDFM.

It was initially a culture shock in Ang Mo Kio- Thye Hua Kwan Hospital as I had never encountered so many elderly patients in one place but with our rapidly ageing population it is going to be an inevitable scenario.

I quickly learnt on the job and decided the MMed was the way to go to bring me up to speed. The piece of paper is also still needed to proceed to the next level unfortunately.

Fellowship

I have also decided to embark on the College Fellowship Programme which I am doing now, to go the whole hog as it were, as I have developed an interest in research and teaching.

My children are now independent and it is nice to pursue my own interests. I enjoy interacting with the medical students and teaching them when they get posted here and giving tutorials to GDFM and MMed trainees.

You are never too old to learn and to even take exams. It helps that the examiners may be your medical school classmates or your ex housemen or MOs so you don't feel intimidated! So I would like to encourage those of you out there to look for the second wind in your career as I (and a few of my older colleagues) have done.

Family Medicine as the Way to Go

Family medicine is the way to go and experience counts a lot both in medical and non-medical knowledge so older GPs would already be in the running … We need more people to take up Family medicine to raise the standard of our family practice. Be a trained Family Physician.

In countries such as Australia and New Zealand, Family Medicine is a specialty just like other hospital based specialties. I like that -- anyone who walks into my clinic will get treated. So such a thing as "that is not my department" can be put to rest.

No one should be a GP by default. We owe it to ourselves if not our patients to get proper skills and training to be able to practice with confidence. So to all the seasoned (by experience) GPs out there, GO FOR IT!!

CM

Essential Ophthalmology: A Guide for General Practitioners and Family Physicians

by Dr Yee Jenn Jet Michael, FCFP(S), Editorial Board Member, Family Physician in Private Practice

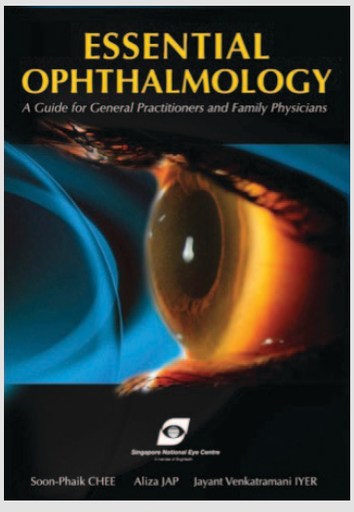


Image courtesy of Dr Jayant Venkatramani Iyer

Like many GPs, I was pleasantly surprised to have received a parcel in the mail, containing a complimentary copy of the book 'Essential Ophthalmology: A Guide for General Practitioners and Family Physicians' published by the Singapore National Eye Centre, Red Cell Series. I was delighted to find that one of the authors of this impressive guide was a former Graduate Diploma in Family Medicine (GDFM) student of mine, Dr Jayant Venkatramani Iyer, who had graduated with flying colours a few years earlier. Assuming that the book was written largely with GPs and FPs in mind, I would imagine that the Family Medicine training have contributed to a more identifiable primary eye care perspective. The other co-authors are A/Prof Chee Soon Phaik and Dr Aliza Jap.

This 300-page paperback have found a place in my office bookshelf, and as the title implied, a stripped-down, succinct reference to supplement our practices. When GPs come across less commonly encountered eye conditions, the authors have included, at the end of each chapter, an additional reading segment. The chapters are categorised pathophysiologically and anatomically. Each segment is geared towards quick reference in point form. There are lots of high-quality coloured photos in familiar local context. Illustrations and algorithms are crisp, clear and concise. The book is thus very practically oriented in a typical busy GP practice. The first 3 chapters provide useful revision to bare essentials of eye anatomy, ophthalmological history taking, physical examination and approaches to common eye signs and symptoms.

On behalf of the primary care community I would like to extend a note of thanks for the generosity and thoughtful effort in publishing this book. I am sure fellow GPs, and their patients, would find this book to be helpful in their practices. In his foreword, Minister Dr Vivian Balakrishnan re-iterated that the centre of gravity in Medicine is not at the specialist's clinic or cyberspace, but the best trained broad-based general practitioner. It is certainly significant to recognise this bilateral mutual exchange. I am proud to make out the Family Medicine culture being entrenched among our specialist colleagues, some of whom have taken the trouble to advance their understanding of primary care and making a contribution in return. We can be encouraged to affirmatively continue to train aspiring students in the enchanting values, science and art of Family Medicine whether they intend to become Family Physicians or pursue other professional areas of interest.

CM

Responding to the Call of Social Responsibility: Being an LPA Certificate Issuer

Contributed by Office of the Public Guardian (OPG), a Division within the Ministry of Social and Family Development

The Mental Capacity Act, which came into effect in March 2010, allows individuals who are at least 21 years of age to plan ahead with a planning instrument - the Lasting Power of Attorney (LPA). This empowers them to make choices for their future in the event they should lose their mental capacity and become vulnerable.

By making an LPA, an individual ('donor') voluntarily appoints one or more persons ('donee[s]') he trusts to make decisions and act on his behalf should he lose mental capacity one day. The donor can specify powers to be granted to the donee(s) in two broad areas: personal welfare as well as property and affairs matters.

All LPAs have to be registered with the Office of the Public Guardian (OPG), a Division within the Ministry of Social and Family Development.

The Role of an Accredited Medical Practitioner

To be validated, the LPA Form has to be witnessed and certified by a 'certificate issuer' who can be either a medical practitioner accredited by the OPG, any practising lawyer or psychiatrist. By signing as a witness for the donor in the LPA Form, the certificate issuer basically affirms that the donor understands the implications of making an LPA and is not making one under duress or undue influence.

Medical practitioners have often played an important role in the lives of most Singaporeans as trusted family doctors – a relationship that is established over time. They can thus play a very key role in facilitating the making of an LPA through their accessibility. Their roles as trusted family physicians will also lend critical weight to this important call to Singaporeans to plan ahead to protect their interests if they should become vulnerable because they are no longer able to manage their own affairs.

Responding for the benefit of Singaporeans

The Mental Capacity Act is a significant piece of legislation designed to meet the needs of a fast ageing population. At its core, it upholds the dignity of all individuals and their right to autonomy and choice at all times – even if the individual should lose his mental capacity.

There is now a pool of medical practitioners who are supporting this significant piece of social legislation by contributing through their roles as certificate issuers.

Four of these certificate issuers share why they feel compelled to respond personally to this call of social responsibility - for the good of Singaporeans.

Name: Dr Kevin Koh
Clinic: The Chung Kiaw Family Practice

Why did you decide to become an accredited medical practitioner? Would you encourage more medical practitioners to take on the role of a certificate issuer and why?

It was the high profile case of Mdm Huang which I read in the papers. I have witnessed similar of such cases myself. Hence, I recognise that the LPA is timely and important for everyone. I will most certainly encourage more medical practitioners to come onboard. The trust established between doctors and their patients is beneficial in motivating patients to make an LPA. It is good that family doctors are able to play this role as a certificate issuer so patients have easy access to make their LPAs.

Please share with us your experiences in issuing an LPA certificate.

My nurses and clinic assistants would brief the patients about the LPA before I meet with them for certificate issuing. I then conduct a mental capacity assessment of the donor before I sign as their witness.

Name: Dr Ng Wai Chong
Clinic: Hua Mei Mobile Clinic of TSAO Foundation

Why did you decide to be an accredited certificate issuer?

Through the course of my work in home-based medical care, I have come across cases of the elderly becoming helpless and demoralised as they became disabled and frail. As a primary care doctor, I find Advance Care Planning very helpful in supporting self-determination, dignity, and ultimately a sense of peace when the end of life draws near for such frail elders. Electing an LPA is a crucial aspect of Advance Care Planning. As for the adults in good health, I frequently take the opportunity during the LPA certification process to discuss with them their health and personal care preferences if they should become severely cognitively disabled. I encourage these adults to talk to their donees about their wishes and values, to make the donees' job easier and more meaningful.

Would you encourage other Medical Practitioners to come onboard to become certificate issuers?

I strongly encourage fellow family doctors to take up the accreditation course to become LPA certificate issuers.

I believe a family doctor does not just take care of people when they are acutely ill, or to help them manage their chronic diseases. We should be their health partners for life, providing guidance on health promotion, disease prevention, and journeying with them when they need long term care as well as meeting their end of life needs. This will make our work even more meaningful.

Assessing decision-making capacity is quite simple. This Mental Capacity Act is an excellent legislation that contributes towards our "Gross National Happiness".

Name: Dr Tan Chong Wai Vincent
Clinic: Viva Medical Clinic

What made you decide you to be a certificate issuer?

I have witnessed caregivers of elderly patients with dementia being usually stressed and financially stretched in providing daily care for them. These caregivers commonly lament about tedious legal hassles and even big family conferences in the care giving process. If the patient had made an LPA, unpleasant family disputes would have been avoided.

Why would you encourage fellow medical practitioners to come onboard as certificate issuers?

I would encourage more medical practitioners to undergo the accreditation course and become a certificate issuer. This adds to our role as a family doctor to care for our patients from cradle to grave, and to help our patients plan ahead for their care. This lends them a voice now with regard their choices and preferences should a time come when they are not able to speak or communicate.

Name: Dr Tan Ru Yuh
Clinic: Victoria Medical House

What motivated you to be an accredited certificate issuer?

It is a social responsibility to act as a certificate issuer. My initial reservation was the fear of being involved in litigations. But the accreditation course was helpful. As long as we practise within the guidelines and refer when in doubt, these concerns can be addressed.

Please share with us your experience as a certificate issuer.

I usually begin by checking the donor's medical history and going through the form with the donor in a language he is comfortable with. If the donees are present, I will also highlight to them their responsibility to always act in the best interests of donors.

Keen to find out more?

The OPG, a Division within the Ministry of Social and Family Development, is responsible for administering the Mental Capacity Act. Please visit OPG's website at ***www.publicguardian.gov.sg****, call the OPG hotline at* ***1800-226-6222*** *or email:* ***enquiry@publicguardian.gov.sg*** *if you have any queries.*

OFFICE OF THE PUBLIC GUARDIAN

MSF MINISTRY OF SOCIAL AND FAMILY DEVELOPMENT

Family Practice Skills Course #51

Schizophrenia

Sat - Sun, 23 - 24 February 2013
2.00pm - 6.00pm
Clinical Research Centre (CRC) Auditorium (Level 1)
National University of Singapore (NUS)
Yong Loo Lin School of Medicine
Block MD11, 10 Medical Drive, Singapore 117597

TOPICS
Unit 1: Schizophrenia
Unit 2: Early Detection of Psychosis & the Early Psychosis Intervention Programme (EPIP)
Unit 3: Differential Diagnosis of Schizophrenia & Co-morbid Psychiatric Conditions in Schizophrenia
Unit 4: Managing Stable Schizophrenia Patients
Unit 5: Management of Relapse in Schizophrenia and Risk Assessment
Unit 6: Update on Medications in Schizophrenia

WORKSHOPS
Day 1: Interviewing Skills
Early Detection of Schizophrenia
Management
Day 2: Managing Stable Patients & Employment
Relapse & Emergencies

SPEAKERS
A/Prof Chong Siow Ann
A/Prof Swapna Verma
Dr Sutapa Basu
Dr Alvin Lum
Dr Sujatha Rao
Dr Roger Ho
Dr Ashwin Chee
Helen Lee
K Pushpa

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, 23 February 2013 (2.00pm - 4.00pm)
Seminar 2 • Unit 4 - 6: Sun, 24 February 2013 (2.00pm - 4.00pm)

WORKSHOPS (1 Core FM CME point per workshop)
Day 1: Sat, 23 February 2013 (4.30pm - 6.00pm)
Day 2: Sun, 24 February 2013 (4.30pm - 6.00pm)

* Registration is on first-come-first-served basis.
Seats are limited.
Please register by 18 February 2013 to avoid disappointment.

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

This Family Practice Skills Course is jointly organised and supported by the **College of Family Physicians Singapore, Agency for Integrated Care (AIC), Institute of Mental Health (IMH)** and **Ministry of Health (MOH)**

aic agency for integrated care
INSTITUTE of MENTAL HEALTH
MINISTRY OF HEALTH SINGAPORE

REGISTRATION

FREE REGISTRATION for College Members!

Schizophrenia
Please tick (✓) the appropriate boxes

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

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

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

Cheque number: _____

Signature: _____

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

Name: Dr _____

MCR No: _____ NRIC No: _____

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

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

_____

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_____ E-mail: _____

Tel: _____ Fax: _____

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

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

Or fax your registration form to: 6222 0204