



# THE College Mirror

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## Defining

# Family Medicine

by Dr Michael Yee, FCFP(S), Editorial Board Member & Dr Wilson Eu, Editor

**I**n 2005, an MOH-initiated public consultation on the establishment of a Family Physician Register (FPR) found that an overwhelming majority of both healthcare professionals and the public agreed that family physicians should undergo structured postgraduate training in family medicine and a slightly larger percentage of the same sample agreed with the need to establish a FPR. The *raison d'être* for the FPR is to establish Family Medicine (FM) as a distinct discipline with structured training requirements and to empower the family physicians to play a bigger role in the care of patients.

The College in its long-standing position to work towards a recognised standard for Family Medicine has been conducting the Graduate Diploma in Family Medicine (GDFM) and Masters of Medicine in Family Medicine (MMed (Family Medicine)) programme. The GDFM aims to provide a comprehensive training programme for doctors working in primary care so that they can practice family medicine at an enhanced level, catering to the healthcare needs of the child, adolescent, adult and the elderly. It is jointly organised by the College of Family Physicians Singapore

(CFPS) and the Division of Graduate Medical Studies (DGMS), National University of Singapore. The MMed (Family Medicine) was started in 1992 with the objective of providing doctors with broad-based multidisciplinary core knowledge and practical skills. The aim of the MMed(FM) is to train family physicians who will be on par with the hospital specialists and be able to take on the role of leaders, trainers, and administrators in family medicine development.

### **The Family Physician Register (FPR)**

Broadly, there are two routes to enter the Family Physician Register:

1. The Direct Route applies to doctors with approved medical practice experience in Family Medicine in Singapore and attaining an accepted vocational qualification. This group would include those who have the GDFM or MMed (Family Medicine). The exact requirements will be determined by the Family Physicians Accreditation Board under the purview of Ministry of Health.

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2. The Practice Route applies to doctors with at least eight years of approved medical practice experience, (of which at least five years should be in Family Medicine), and the completion of Accredited Modular Course (AMC). The exact details shall only be available when MOH releases its recommendations.

The College has received confirmation that its Family Medicine Modular Course (FMMC), will be recognised as an AMC for entry into the FPR. Each FMMC module consists of four Saturday afternoon workshops and is run on a quarterly basis each year.

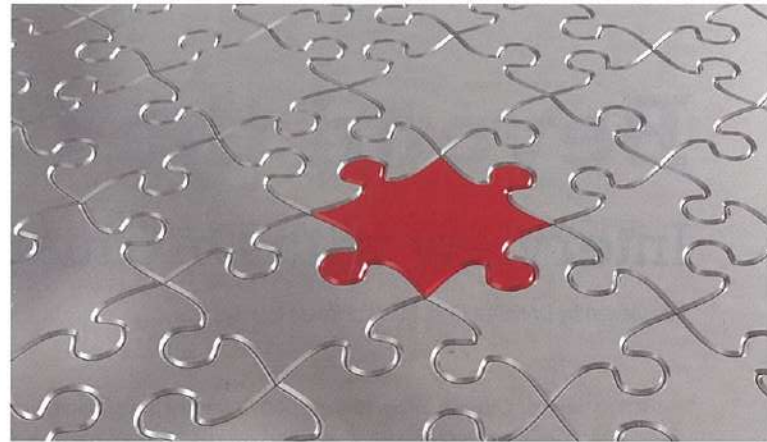
The new cycle of FMCC starts in August 2010. In each module, there will be eight units of distance learning material and four afternoon face-to-face workshops. Distance learning materials are expected to be read well before the workshops and are available on-line. At each workshop, two 'domain experts' will discuss the material covering two units of the distance learning material. This is done via four case studies involving scenarios that a family physician would likely encounter in his daily practice.

With the opening of the FMMC to all doctors, interested doctors may choose to cherry-pick modules that are relevant based on the individual doctors' circumstances, subject to availability of training places. Thus, senior doctors who are

**To the family physician, the attainment of the FPR status is a signal of his or her effort to attain the mark so that he or she can make a more productive contribution to society.**

considering entry to the FPR via the practice route can start attending the FMMC modules to accumulate credits, whilst those who wish to complement their usual CME will find the FMMC an excellent source of unbiased information that is pertinent to a primary care practice.

The College is opening FMMC as a continuing development programme for interested doctors. A CME certificate of attendance will be given if a participant attends three out of four workshop sessions. Cost is \$500 per module. A discount of \$50 per module is given for College members, amounting



to savings of \$200 if one plans to do all four modules, which is more than the College membership fees.

The accreditation of the FMMC as an AMC is certainly a significant milestone on the road to the professional recognition of the Family Medicine standards. It goes a long way in assuring the senior doctors that the years of work experience as a practicing GP has been acknowledged by MOH. Most of all, the previous reassurances are not mere lip service, but backed up by kept promises.

While the FPR is a worthy goal to the practicing GP, the means to attain it must be realistic. For GPs 'drowning' in work to make ends meet, a commitment to sign up for the GDFM, MMed (Family Medicine) or even the AMC is a daunting prospect. A reimbursement of the financial cost of further academic rigours would be welcome. An analogous scheme, applicable to only non-trainee MOs working within the clusters and who are less than six years post-graduation from medical school is already in place. To the family physician, the attainment of the FPR status is a signal of his or her effort to attain the mark so that he or she can make a more productive contribution to society. This recognition must be accompanied by tangible benefits.

In Singapore, good primary care is a public good and the public must recognise that healthcare costs would continue to rise inherently as a result of the ageing population, expensive technology, patient expectations and cost of inflation. Improving Family Medicine standards would be the most cost effective way to move ahead, provided society is willing to pay for trained family physicians.

It is heartening to witness the single-mindedness of the various stakeholders of the healthcare ecosystem towards this common goal. Ultimately, all parties must do what is correct rather than what is popular. Moving forward, Family Medicine would be developed into an inclusive distinct discipline with well-defined standards.

For signing up details please contact the College Secretariat at [contact@cfps.org.sg](mailto:contact@cfps.org.sg) or call the Secretariat at 62230606.

■ CM

# And the Work Goes On...

by Dr Wilson Eu, Editor

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**T**welve months ago, Family Physicians everywhere were confronted with the specter of the flu pandemic. Practicing medicine in the community became like a military exercise involving strategies ('revised flu pandemic framework'), equipment (secure supply of PPE), ammo (national antiviral stockpile) and communication (middle of the night MOH MedAlerts via SMS). Thankfully all that is behind us as influenza A (H1N1-2009) takes its place as another member of the many viruses that we are confronted with everyday. Now that all the action and excitement has abated, work of the College seems more prosaic and run-of-the mill.

Nothing could be further from the truth.

**FMMC (Family Medicine Modular Course) is coming of age**

For 10 years, the FMMC has formed the backbone of the teaching and academic learning for those who undertake the Graduate Diploma in Family Medicine (GDFM) and the MMed (FM). From August 2010, doctors will be able to participate in individual modules of the FMMC. They will have access to the soft copy of the course notes before the workshops. After pre-reading, participants can check their learning through an online MCQ assessment and earn CME points too. Workshops centre on case scenarios commonly encountered in everyday practice. Discussions will be lead by a resource person who is a specialist in the topic and enable participants to crystallize the application of that topic's learning points to their individual practices. CME points are earned here too.

Of import is news that participating and completing individual modules of the FMMC will enable suitable doctors to enter the Family Physician Register (FPR).

FMMC is sometimes confused with Family Practice Skills Courses (FPSC). FPSC is a separate course run as a continuing professional development programme of the College with the reading materials in the Singapore Family Physician. FPSC will continue to be provided by the College.

**For 10 years, the FMMC has formed the backbone of the teaching and academic learning for those who undertake the Graduate Diploma in Family Medicine (GDFM) and the MMed (FM).**



## Attending courses like the FMMC is all about keeping ourselves current and skilled to be a better Family Physician.

Attending courses like the FMMC is all about keeping ourselves current and skilled to be a better Family Physician. Does it make a difference? In this issue, a few doctors who are doing the GDFM and some who have done the courses/are involve in teaching it will share their individual stories.

### College e-Digest

A new initiative which the Practice Management committee will roll out is the setting up of an online newsletter. E-Digest will compliment the College Mirror as a timely communication platform. Information will be pushed to the e-mails of College members on a quarterly basis. Establishing an e-newsletter will also enable the College to rapidly download and disseminate advisories and circulars. This would be particularly useful in situations such as the H1N1 outbreak.

It would also enable us to obtain feedback from members and conduct e-feedback polls.

### Where is the value of training? How can we make it real?

Minister Khaw Boon Wan in one of his many speeches exhorting Singaporeans to have a personal FP said, "Good GPs are our unsung heroes. They do not appear on TV or in newspapers, promoting beauty treatments to the rich and famous. They work long hours, persuading Singaporeans to eat a balanced diet, exercise regularly, control their blood pressure and quit smoking. They also comfort the terminally-ill, supervise home-nursing of the severely-disabled, do home visits so that elderly patients can avoid unnecessary trips to hospitals.

Our healthcare system today is strong. Our doctors are largely dedicated and ethical. They retain their strong noble calling to serve the weak and the infirmed. But will the future be the same? I alone cannot provide the answer. The answer must come from the society at large. What value, Medicine? How much are you paying your GP for a consultation session on managing your diabetes which may save your toe? How much are you paying another for a session to whiten your skin?

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(from page 3 - And the Work Goes On...)

If we, as a society, misalign our priorities, we cannot blame doctors for shifting their focus.... We must ensure that GPs continue to find it meaningful to be good GPs, serving the community at large."

*(Opening of the Singapore Disease Management Conference 2008 & 1st International Conference on Healthcare Transformation 09 May 2008)*

Thus there are a few steps after the training and the FPR, that must be in place so that the potential of a trained family physician to be realised.

Singaporeans have a deep trust in the ability of the Government to deliver on healthcare. The recent Accenture Citizen Experience Study (ACES):2010 shows that:

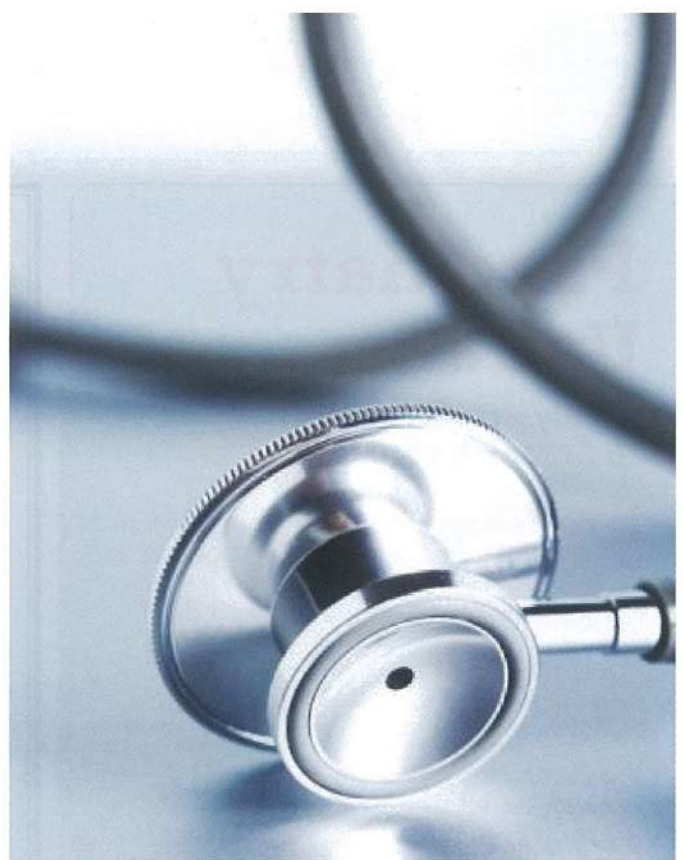
- Singaporeans trust government to make improvements in healthcare. Almost nine in ten (86%) have some or a great deal of trust in government's ability to deliver improvements. These are overwhelming levels of confidence.
- Government is seen as a primary player in healthcare in Singapore. More than seven in ten respondents wanted them to play a greater role in four key areas of healthcare: responding to health epidemics (79%), setting and maintaining quality standards (76%), promoting healthy living (70%) and providing services directly to citizens (71%).

Thus the College (Profession) needs to work with MOH (policy makers) to ensure that the public, press and third party payers are aligned in this worthwhile vision.

### Do Singaporeans recognise "The real McCoy"?

Recently, on Facebook, MOH posted the following Question of the Week (April 27), "The 'One Family Physician for every Singaporean' is a vision that we hope will gain ground with more and more Singaporeans. A good GP who is well trained to provide all-round healthcare service can be that family physician who looks after you and your family on a continuing and trusted basis. Do you have Family Physician? Share with us your personal experience with your FP." (<http://www.facebook.com/sghealthminister>)

The posts in response were illuminating. Contrary to the



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maligned view of FPs as cough and cold doctors or pencil pushers writing out referrals to hospitals, many Singaporeans wrote of a close relationship with their personal Family Physician.

#### JC

"Rather clinic hopping, we stick to one FP (essentially paying the same cost for me) as we have the peace of mind, knowing that our FP knows of each members past illnesses, allergy and recent medical record well. Instead of 'I'll give you medicine for sore throat, fever, and mc', it'll be 'he reacted to this medication well last time, we can try and going by experience, he should get better in 3 days time.."

That being said, few GPs are willing to provide that type of service without additional charge. My FP is always happy to spend a quick 5 mins doing a 2nd review of my condition or to discuss related conditions that might affect my other family members, and not charge me if no follow-up is required. That element of 'family-centric service' is rare in Singapore."

**“The FP knows our every “intimate” medical detail and is in a position to actually advise or even chastise you about your own lifestyle that impacts your body.”**

- TSH

Others shared about a rapport stretching many decades:

**TSH**

“My family has had the same family physician for the last 30 years. He was actually a doctor who had worked with my mum when she was a Nursing Officer in the 60’s ; He left the government hospital to set up his own private practice and my family still goes to him today. He’s on the brink of retirement so some of us have “switched” to seeing his Dr Nephew. The close rapport you have with a family physician is something you will never find walking into any clinic. The FP knows our every “intimate” medical detail and is in a position to actually advise or even chastise you about your own lifestyle that impacts your body.”

Many expressed comments indicating the great value placed on having an ‘all-rounder’:

**LT**

“I think that’s definitely something we should explore. I have a family physician who has been looking after my family for more than 30 years. It is not just basic medical treatment he provides; rather, an all-rounded physician care that includes counseling on various lifestyle issues and liaison with other specialist doctors (where needed). That has allowed for proper follow-up care and appropriate treatment. I have learnt that having a family physician actually saves me costs and time. Since my FP knows my medical history well, he understands what works for me and what doesn’t, thus eliminating unnecessary costs spent on drugs I don’t need. He also knows when I need to be referred to a specialist or when to order blood tests, etc. So again, I am not put through unnecessary tests and consultations. This will in turn, reduce the patient load of other specialist doctors and in the long run, reduce patient-waiting time and costs. I understand the polyclinics now run a FP program so it is affordable for the general public.”

And for some, even after retirement when costs are (presumably) no longer borne by a third party,

**PSL**

“... Having developed an excellent TRUST relationship with my ex-company Dr, I decided to continue using them as my Family Physician even after my retirement from service 1 1/2 yrs ago.

... At least for my family (parent, siblings & niece & nephew) there is synergy and holistic medical care for all members. “

Thus, there is an existing level of appreciation and confidence in the work of Family Physicians in the community. We should continue to educate, cultivate, and market our seminal roles in giving personal, primary, comprehensive and continuing care of individual patients in the context of their family and their community. At the same time, policy issues such as appropriate access to government subsidies by patients and for doctors: access to necessary subventions in order to maintain high practice standards and teaching must be in place.

In this issue we welcome Dr Kelvin Goh to our Editorial Team A. He is a FP leader in his practice and will bring a fresh perspective and drive to the team.

### 39th Annual General Meeting

As the 22nd Council approaches our annual AGM, the call goes out to all members to come and participate in our Annual General Meeting. It will be held on Saturday, 26th June at 4pm, Level 2 Auditorium, College of Medicine Building.

And so, the work goes on. So, come join the College and have a hand and a say in how we can make Family Physicians the preferred primary care providers in our community. ■CM

# The Training of the Family Physicians



by A/Prof Goh Lee Gan, President, 22<sup>nd</sup> Council, College of Family Physicians Singapore

In this issue, the editors have decided to revisit the topic of training of the family physician, asking several family physicians to share their experiences in the training journey. Interesting to read what they have experienced.

In this President's Forum, I have added pointers in the numbers trained and the various programmes available in the training of the family physician.

(1) In Singapore, attention to the training of the family physician has come a long way. From the foundation of the College in 1971 to the establishment of the MMed(Family Medicine) postgraduate qualification in 1991, and the establishment of the Graduate Diploma in Family Medicine in 2000, we have today in 2010, 283 doctors with the MMed (Family Medicine) Postgraduate degree, and 434 doctors with the Graduate Diploma in Family Medicine (GDFM). These holders are eligible to be in the Family Physician Register (FPR).

(2) Beyond the vocational training in Family Medicine which is provided by the MMed, the College has two professional development programmes as finishing school for

family physicians. Here, the training emphasis is on reflective clinical practice, teaching skills, research skills, and leadership. These are the Membership by Assessment (MCFP) and Fellowship by Assessment (FCFP). To-date we have nine family physicians who have the MCFP by assessment and 64 family physicians who have the FCFP by assessment.

(3) For senior family doctors, Ministry of Health now has the accredited modular course (AMC) programme for them to complete four modules of the FMMC (as we understand) to be eligible to be in the Family Physician Register. The first of the accredited modular course will commence in August 2010.

With these training opportunities, the care of our patients will be enhanced. We will be in a better position to make diagnosis early, treat appropriately,

delay or prevent complications, and embark on primary prevention as well.

With the changing population landscape, we need to continue to hone our knowledge, application, and problem solving skills in the four areas of care highlighted by the Prime Minister in his National Day Rally speech in 2009: geriatric care; step-down care; integrated care; and preventive care. The latter will be the best way in the long run to help patients and nation reduce healthcare costs.

The College has ongoing efforts to make learning more user-friendly, more relevant, and more interesting. For these, we need to thank the many family physician trainers, as well as our specialist colleagues who have unstintingly provided the education and training to our family doctors, young and old. ■CM

**We will be in a better position to make diagnosis early, treat appropriately, delay or prevent complications, and embark on primary prevention as well.**

# Psychiatry Updates

## Family Practice Skills Course #34 20-21 March 2010

The College of Family Physicians Singapore would like to thank Sanofi, Lundbeck and the Expert Panel for their contributions to the College on the Family Practice Skills Course held on 20-21 March 2010.

### EXPERT PANEL:

**Dr NG BENG YEONG**, Head, Department of Psychiatry, Singapore General Hospital

**Dr NELSON LEE**, Medical Director, The Psychological Wellness Centre

**Prof KUA EE HEOK**, Senior Consultant Psychiatrist, NUHS

**Dr CHIA BOON HOCK**, Private Consultant Psychiatrist

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**Yong Loo Lin School of Medicine**  
Division of Graduate Medical Studies



## 2010/11 GRADUATE DIPLOMA IN GERIATRIC MEDICINE (GDGM)

The one year part time course which is organized by the Division of Graduate Medical Studies in collaboration with the Geriatric Society of Singapore is designed to provide primary care physicians with basic skills in caring for the elderly.

Applicants seeking admission to the course must be a Medical Officer (MO) or a General Practitioner (GP) who has a first medical degree with a minimum of 2 years clinical postgraduate experience. Applicants should have spent at least 6 months during the last 2 years looking after elderly patients on a regular basis. Experience gained could either be from local or overseas.

For other applicants such as overseas doctors from non-traditional sources, besides having the minimum 2 years postgraduate experience, they must also have an additional 1 year (minimum) of local experience in Geriatrics (i.e. 2 years of clinical postgraduate experience plus 1 year of geriatrics-related work experience in Singapore). A strong letter of support from the institution which they are working for is also required at the point of application.

|                         |  |
|-------------------------|--|
| <b>Course Duration:</b> | <b>14 August 2010 to August 2011</b>                                     |
| <b>Application Fee:</b> | <b>S\$40.00 (non-refundable)</b>   |
| <b>Course Fee:</b>      | <b>S\$4,660.00 (inclusive of exam fee and S\$53.50 registration fee)</b> |
| <b>Closing Date:</b>    | <b>30 June 2010</b>  |

Course registration details and application form can be downloaded from [www.med.nus.edu.sg/dgms](http://www.med.nus.edu.sg/dgms). For further enquiries, please contact: Ms Eunice Chung or Ms Aw Yu Chen [eunice\\_chung@nuhs.edu.sg](mailto:eunice_chung@nuhs.edu.sg) or [yu\\_chen\\_aw@nuhs.edu.sg](mailto:yu_chen_aw@nuhs.edu.sg)

**BLK MD5, LEVEL 3, NUS, 12 MEDICAL DRIVE, SINGAPORE 117598**  
(65) 6516 3311/ 7957/ 3300

# Vaccinations 2010: What's Old What's New

## Family Practice Skills Course #35 22-23 May 2010

The College of Family Physicians Singapore would like to thank GlaxoSmithKline (GSK) and the Expert Panel for their contributions to the College on the Family Practice Skills Course held on 22-23 May 2010.

### EXPERT PANEL:

**A/Prof GOH LEE GAN**, Head, Division of Family Medicine, University Medicine Cluster, National University Health System

**A/Prof ANNE GOH**, Senior Consultant, Department of Paediatrics, KK Women's and Children's Hospital

**Prof LEE BEE WAH**, Adjunct Professor, Dept of Paediatrics, National University of Singapore



**Dr WONG SIN YEW**, Infectious diseases physician, Mount Elizabeth Hospital, Gleneagles Medical Centre

**A/Prof HELEN OH**, Senior Consultant, Department of Medicine, Changi General Hospital

### CHAIRPERSONS:

**Dr JONATHAN PANG, A/Prof GOH LEE GAN**



# How I Benefited from Family Medicine Training

by Dr Michael Yee, FCFP(S), Editorial Board Member

I remember back in the 1990s when I first attended the FMMC. The course was conducted as part of the academic requirement for the Family Medicine trainee in preparation for the MMed (Family Medicine) examinations. Non-trainees were also able to attend the modular course at a fee, but did not have the opportunity to take the examinations.

A characteristic of the course that was most endearing was how the students would always receive an email apology from A/Prof Goh Lee Gan on a Friday afternoon before the class as the notes were, as usual, still not ready! Invariably the students would find the notes and case studies in their mailbox on the morning of the class which started promptly at 2.30pm. On many occasions, the email was time-stamped in the wee hours of Saturday morning. I never ceased to wonder what kept him going, burning the midnight oil to deliver the lessons for the FMMC. The power of role-modelling.

## Notes

The notes back then were accompanied by a stack of references which the students had to read through before the class. The discussion was always spirited and I learnt a great deal from peers as well as the more experienced GPs who attended the class as student and facilitators. Fast forward five years, when I repeated the FMMC course so

as to fulfil the requirements to qualify to take the MMed (Family Medicine) examinations under programme B or the private practitioner's stream as it was known as then.

Despite some misgivings in having to redo the course, I found that the course materials were diligently updated to reflect the breakneck progress of Family Medicine. The notes had also been well-compiled and, this time, distributed in advance.

**The discussion was always spirited and I learnt a great deal from peers as well as the more experienced GPs who attended the class as student and facilitators.**

The structure of the lesson plan had remained relatively unscathed with a facilitator helping to guide the students as they discussed the case study, which was realistic and deliberately vague in character. These case studies were

therefore a particular frustration for the unsuspecting specialist facilitator and the doctor who was new to primary care, who are more used to cases with typical signs and more definitive diagnoses.

Although the core contents of the course remained unchanged, the skills and knowledge I picked up was as enchanting as the first time round. The experience of sharing from the perspective of an experienced GP was also refreshing and helped me consolidate my learning.

Several years ago, I had the privilege to have been appointed a teaching fellow at the Institute of Family Medicine (IFM), which was tasked to update the FMMC modules. Together with a group of enthusiastic veterans, the IFM undertook to completely revamp the FMMC curriculum and materials with inputs from people skilled in the everyday practice of Family Medicine in the community. The continuous improvements ensured that the course remained relevant to the vocation. The FMMC has thus remained relevant and effective over the years.

Unlike specialist and sub-specialty training, Family Medicine training emphasises width as opposed to depth. One would however have totally missed the mark if one were to perceive family physicians as the lesser cousins of our specialist counterparts, as

family physicians also processed a distinctive set of competences. Without a clear understanding of these core competencies, which the FMMC tries to impart, it is easy to misunderstand that the lower paid GPs are of an inferior class.

Identifying, organising and transmitting this core knowledge, skills and attitudes required of a family physician is a delicate challenge. Some of these values are not easily grasped through lectures or self-studying.

**Identifying, organising and transmitting this core knowledge, skills and attitudes required of a family physician is a delicate challenge.**

While the technical aspect of various disciplines of medicine and surgery are still extremely important to the family physician, the emphasis of the applications are different, with some overlap, from what our specialist or General Medicine colleagues are concerned with. For example, there is a greater prominence on recognising vague and early presentations of both ordinary and uncommon conditions.

The amount of narrative-based medicine takes on a much bigger role compared with the specialists' fixation with research-evidence-based medicine; much of a family physician's work is spent, among other tasks, exploring the health seeking behaviour, therapeutic

lifestyle changes, educating and comforting of the needy patients.

A good family physician needs to have excellent cultural and situational understanding of the healthcare system to be able to co-ordinate care for our patients in a holistic manner yet know precisely when the patients need the care of our specialist colleagues or the immediate attention at the Accident and Emergency Department. The family physician, besides being a healer, is also a community leader, an eloquent communicator and friend in need by default.

Putting all these skills, and much more into a package, and crafting a process to transmit it to the GP to make him into a FP is not straightforward!

### Case Study Workshops

The FMMC was designed to capitalise on the experience and acquired skills of the specialist and practising GPs through discussions and interactions over a realistic primary care case study. A resource person from the particular specialty as well as a trained family physician to provide a balance perspective is present to facilitate the discussion, correct mistakes and update students to the latest evidence-based practical ideas. Some learning is taught and others are caught; role-modelling is certainly an important part of this programme, as experienced GPs interact with young impressionable doctors. But the senior ones in contributing to the

class have the most to gain through the confirmation and consolidation of his or her learning. The student therefore learns in a complex and rich experiential learning environment.

How much one learns during the FMMC classes is dependent on the students' attitude and willingness to participate.

There are known deficiencies as well as hidden deficiencies in our formal and informal training as family physicians; since the FMMC curriculum is quite comprehensive, areas that the family physician is wanting can be built up either deliberately or through discovery. The FMMC allows ample opportunity for vicarious learning in a sheltered environment. In this way, the course would also help us practice in a safer manner.

Much of the hidden benefits are gained through the renewal of old ties and making contact with course mates, which might come in useful in the future. Discussions on referrals, computerisation, administrative and other issues would also shape the way our healthcare system evolves.

The growing alumnus allows family physicians to build camaraderie and solidarity. With this critical mass of trained family physicians I hoped that we can regain some of the due respect and correct some of the misconceptions which are so pervasive currently. ■ CM

**The FMMC was designed to capitalise on the experience and acquired skills of the specialist and practising GPs through discussions and interactions over a realistic primary care case study.**

# What Training in Family Medicine has meant to me

by Dr Anthony Chao, Family Physician

**D**uring my Collegiate Membership interview on the 28th of October 2009, Professor Goh asked me to write an article on my thoughts and reflections on family medicine development. He also asked me to share some of my personal views and the journey I had taken on my career path as a family physician.

I had no idea where to start... so I guess the beginning would be best!

## My story

I have always wanted to do medicine, ever since I was a child. I have always been fascinated with the art of healing. Even as a kid, playing dungeons & dragons role-playing games, besides the adventure itself, I would often choose to be either a cleric, or a Paladin, both characters having been imbued with the powers of healing!

However, I also thought that once I became a doctor, I would automatically know how to treat patients right away! How wrong I was.... Just like my make belief characters, who grew stronger with each adventure and with each skill they master, I realized that I only had the "passport" to start practicing the art of medicine AFTER I became a doctor. i.e. it was the START of my learning rather than the END, even after 18 years of studying!

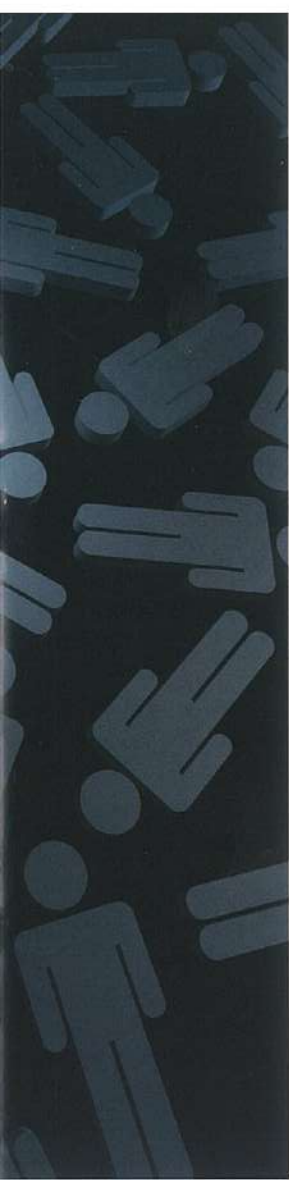
**The various postings turned out to be a very worthwhile "investment" in terms of my medical education to be a competent and confident "healer".**

After spending six years in medical school at the Royal College of Surgeons in Ireland, I decided to come back home to Singapore to do my housemanship and to begin my medical career. Needless to say, my initial postings were a bit of a culture shock to me, even though I had prepared myself mentally for the onslaught! During my first on call at KKWCH OBGYN, my pager beeped so much that it ran out of space! It was also the first time I experienced what gastric pains felt like! It was also the first time I worked 40 hours at a stretch post call, preparing for a Cancer Grand Ward Round the following morning! It seems an irony when I think of how some people now work less than a 40 hour work week that I covered in one long continuous shift without sleep!

I didn't have a five year bond like my esteemed colleagues from the local university as I am a foreign graduate. However, because of my interest in Family Medicine and me wanting to develop an all round exposure to various specialist postings, I spent more than 5 years in the hospitals, as well as other institutions, from KKWCH (OBGYN and Children's Emergency) to TTSH (General Med & ENT & Orthopedics) to NUH (General Surgery, A&E & Ophthalmology) to CDC (Infection Control), NSC (Dermatology), AH (Internal Medicine), St Luke's (Rehabilitation, Geriatrics and community hospital), and finally to the polyclinics (Woodlands & Toa Payoh mainly). I even voluntarily extended my Masters of Medicine (Fam. Med.) exams to four years (from three) because I miraculously got a Skin posting in the last year!

The various postings turned out to be a very worthwhile





"investment" in terms of my medical education to be a competent and confident "healer".

After my MMED exams, I decided to follow another dream of mine... to do volunteer work as a "mission" doctor. I started out with a few Christian organizations and did short trips, even day trips to Batam, Indonesia and ran mobile clinics. This moved on to eight day mission trips to Yogyakarta also in Indonesia after the earthquake and for another one to Kashmir, Pakistan with Crisis Relief Singapore (CRS). Then I decided I wanted a bigger exposure, so I took a whole year off and joined an international humanitarian organization called Medecins Sans Frontieres (MSF), also

popularly called the Doctors without Borders. It was one of the best things I have ever done in my life! What an adventure indeed!

MSF brought me from Singapore to Malaysia (where I was interviewed), to Hong Kong (where I was officially recruited), to Belgium (where I was employed!), to Denmark and Brussels (where I had to undergo a three-week training), and finally to Pakistan again! As God would have it, to the exact same place I previously went to with CRS in Bagh, Kashmir, although this time, I was to stay for six months, and run a 66 bedded hospital where I was the inpatient department (IPD) doctor in charge.

Unknown to me, God also had other plans for me... it was definitely the last place on earth to find romance, let alone my future wife! But lo and behold, I found my perfect lifelong companion and friend in the same place where I had to manage a cholera outbreak, a landslide and heavy storm which swept away our tent which housed my patient! The same place where the famous Marriot hotel was bombed right before and right after we were there and the same place where someone decided to throw a home made bomb into the expatriate compound we were in near the Afghanistan border in Agra, NorthWest Frontiere Province (NWFP) right after we left! (We were both sent there to provide advice in helping to setup a medical centre by MSF). Love in the time of cholera indeed!

### But I digress...

My medical training as an undergraduate, as well as my various hospital training as a MMED student definitely stood me in good stead to take on my different roles as an IPD doctor, to also run the outpatient clinics, the Accident and Emergency department, the ICU unit, the neonatal unit or NNU (we had three working incubators), and even as an acting hospital manager when my boss left. The broad based yet intensive training as a family physician also helps to sharpen the mind to focus on the important things first, yet not ignore the holistic and comprehensive approach to all problems or challenges.

I guess what I find interesting in family Medicine was not just the diversity, but also the fact that as a family physician (FP) or General Practitioner (GP), you can virtually go deeper or "specialize" in any area you are interested in. We are restricted only by our interests, our lack of knowledge or skill, or by our imaginations.

I agree with Dr Lee Suan Yew, the guest of honor for our Family Medicine Convocation Ceremony, who said that Family Practice has moved from the "Renaissance Period" to the "Golden Period" we are now experiencing.

Family Medicine or the art of General Practice is indeed charting a new course into the next era!

I remembered my stint as a medical student attached to an Irish GP in the suburb. Even then, in the 1990s, they were already computerized in their patient records. The amiable GP, who seemed to have gotten work life balance down to a pat told me that he refers less than 5% of his patients to tertiary care, handling most and a varied numbers of cases on his own confidently, and competently. I also remembered that Family Medicine was and still is an exciting and well sort after trainingship and career option there.

I believe we are also heading in the same direction here in Singapore. As a family physician, I am excited to be part of that process and to be of service! ■ CM

*Dr Anthony Chao, MBBCh BAO LRCP & SI (NUI) Hons,  
MMED (Family Medicine), MCFP, Graduate Dip. Occ. Med. (DFD)  
Family Physician*

## G.D.F.M.

Yes, GDFM stands for Graduate Diploma Family Medicine, but to me it stands for Gap ,Deficiency, Fill & Multiply. I realized this soon after attending the course.

I confess that even after 35 years in family practice and having attended numerous CME s, there are still Gaps and Deficiencies in my so called saturated knowledge. I can cope with this G & D by shunting them or even more simply by referring such patient away. As a result of this avoidance, my area of G&D continue to grow and worsen. An undesirable vicious cycle developed.

GDFM Modular course change all that. The various Modules cover many areas of Clinical Practice commonly seen in Family Practice, including those areas of my G&D, thus effectively filling them up. The combined result is that I achieved a reward which is not measure in term of sum but in multiple. The feeling is similar to transforming a previously less than perfect cut diamond into an excellently cut stone that give good contrast and brilliant scintillation. My previous skepticism about the Course and self complacency has delayed me from joining the course earlier. I hope that my confession will change your mind and influence you favorably.

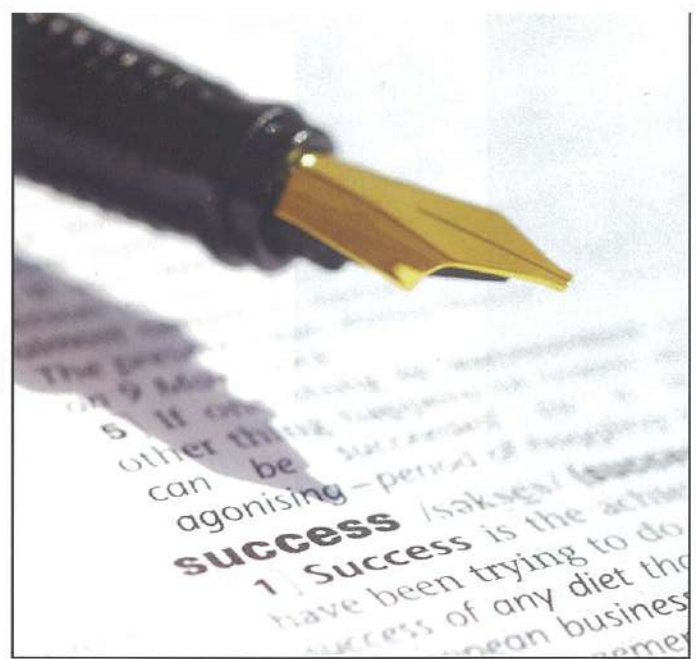
To have Gap & deficiencies is understandable and natural but let GDFM fill your G&D and reward you with a result that has multiplying effect. ■CM

### Dr Chong Tat Chong

*Dr Chong Tat Chong graduated in 1975. He practices at New Town Clinic and is currently doing his 2<sup>nd</sup> year GDFM.*

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**“...even after 35 years in family practice and having attended numerous CMEs, there are still Gaps and Deficiencies in my so called saturated knowledge.”**



## Well Organised

I have been to many CME talks prior to this course, but the problem is that I'll only go for those of interest to me only. So a large part of medicine became "forgotten", as the advance of medicine is so rapid.

The course allows me to touch on the important issues that a GP can face during our practice. The workshop method of conducting the course is useful, as it makes us think more in depth on each topics, and to focus on the important points of the most current practice. Even though the workshop is only on the few important topic, the MCQs will stimulate us to read around the topics as well.

The tutorials are helpful too, to learn from the experiences of various GPs, whether they are good or bad practice habits.

I still believe taking the course is better than just attending CME talks, with the tutorials and MCQs etc, and the exam stress motivate us to study harder and remember more. ■CM

### Dr Yea Kok Chin

*Dr Yea Kok Chin graduated in 1992. He practices at YSL Bedok Clinic and is currently doing his 2<sup>nd</sup> year GDFM.*

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**“The course allows me to touch on the important issues that a GP can face during our practice.”**

# Beyond the Call of Duty:

## Interview with Dr Chiang Wing Chiong

Interviewed by Dr Kelvin Goh, Editorial Board Member

**D**octor Chiang Wing Chiong, 40, a family physician from Dayspring Medical, appeared on the TODAY paper on 21st April 2010 in an article titled "The doctor who went above and beyond the call of duty"

The College Mirror is delighted to invite Dr Chiang, a positive role model, to share with us his experience in assisting an out of hospital cardiac arrest.

**CM: In view of the recent negative media exposure about doctors in the local papers it is inspiring to see a fellow family physician rising to the occasion. Tell us what actually happened on the morning of 20th April 2010?**

**Dr Chiang:** On the morning of 20th April 2010, I came to work as usual at about 9am. My clinic is at Basement 1 of Century Square shopping centre, so I park my car in the basement car park. As I entered the car park, I saw a middle aged gentleman lying on the floor of the car park, right in the middle of the driveway. There was nobody standing around him at that point in time. As I drove closer, he looked as if he was not breathing. I got out and attended to him. He was gasping and there was no pulse. By this time, a lady who had just parked her car arrived and I told her to call for the ambulance. I ran up to my clinic which was about 100m away, got the bag and mask resuscitator kit, one vial of adrenaline, syringe with needle and came back down. I started CPR.

I did CPR for about 10 to 15 minutes before the ambulance crew arrived. The ambulance could not come into the car park due to height constraints. The ambulance crew helped with the CPR when they arrived. They had an automated external defibrillator. He was diagnosed with ventricular fibrillation. We shocked him a few times with the defibrillator, but it was unsuccessful. We then evacuated him to the ground floor taxi stand and into the waiting ambulance. We continued CPR en route to Changi General Hospital.

After we transferred him to the waiting doctors and nurses at the Changi General Hospital, I came back to the clinic.

**CM: When was the last time you performed CPR? What were your thoughts at that point in time? What are your fears and concerns?**

**Dr Chiang:** This is the third CPR I have performed in the past 10 years since leaving hospital practice. The last time I had to do CPR was about 5 years ago. It was during a housecall. The patient complained of abdominal pain. He was talking to me one moment, started gasping and then stopped breathing the next. I did not have the bag and mask with me and had to perform mouth to mouth CPR. He had a ruptured undiagnosed hepatoma and passed away a few hours later in hospital.

I did have fears of contracting infections from the patient but I guess my moral obligation as a doctor outweighed that fear at that point. After that incident, I started carrying a CPR barrier mask with me whenever I do housecalls.

For the incident in the car park, it was fortunate that the bag and mask was readily accessible in my clinic.

**CM: Thanks to your immediate CPR, the paramedics were able to perform early defibrillation. It was reported that you assisted the paramedics all the way to Changi General Hospital, going beyond the call of duty. What prompted you to do that? Do you feel that doctors should accompany the patient in emergency cases to the hospital with the ambulance?**

**Dr Chiang:** The paramedics in Singapore are very well trained, however, when a person has no pulse and is not breathing, I think every little help that he gets could make a big difference to the outcome. Therefore I have made it a point to accompany all my CPR cases to hospital. The two paramedics

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**The paramedics in Singapore are very well trained, however, when a person has no pulse and is not breathing, I think every little help that he gets could make a big difference to the outcome.**



would be busy with the CPR, so the extra person could help with the setting of intravenous lines or the administration of emergency drugs (although very difficult in a speeding ambulance). For the above reason, I feel that doctors should accompany the patient in the ambulance should the patient require CPR. However, for other emergency cases (eg stable AMI patient) where resuscitation is not required, I do not think that it is essential for the doctor to accompany the patient to hospital in the ambulance.

**CM: How did you prepare yourself and your clinic for such emergencies?**

**Dr Chiang:** I do periodic checks on the resuscitation equipment in the clinic to make sure that they are in working order and the emergency drugs are not expired.

**CM: Do you feel that BCLS certification is a necessity for all practicing doctors?**

**Dr Chiang:** I do not think that BCLS certification is a necessity for all practicing doctors as most doctors would have performed some form of CPR in their career. BCLS was also part of the medical school curriculum during my time. I think CME programs that incorporate a CPR refresher course would be more appropriate.

**CM: Tell us more about yourself?**

**Dr Chiang:** I am 40 years old. I am married with 3 children. I graduated from NUS in 1996. I am currently working as a family physician in Century Square Shopping Centre. When I am not working or spending time with my family, I can be found on the golf course. I don't consider myself a golf addict, though.

**CM: What was your journey into family medicine like?**

**“I would like to see more emphasis on preventive medicine and the management of chronic diseases in the family physician setting.”**

**Dr Chiang:** After graduation and housemanship, I did 3 years of hospital postings before working as a family physician in Bedok. I did my Graduate Diploma in Family Medicine in 2003. I was working in the Haig Road branch of Dayspring Medical Clinic before we set up the Tampines branch in Century Square in August 2009.

**CM: What is one change you would like to see happening within our profession?**

**Dr Chiang:** I would like to see more emphasis on preventive medicine and the management of chronic diseases in the family physician setting. The private sector family physician should be engaged to care for some of the subsidized cases that are currently seen in the polyclinics. Appropriate and fair remuneration should be paid for the management of such cases. This would help to prevent the current “brain drain” of doctors into the more lucrative aesthetic trade as well as reduce the workload of the overworked polyclinic staff.

**CM: Any parting advice to our valued readers and colleagues?**

**Dr Chiang:** Life is short. We should stop and smell the roses as often as we can.

**CM: Thank you, Dr Chiang, for this opportunity. ■CM**





# The Cough Mixture Addict

by Dr Victor Teo, Family Physician

**Typically male, middle-aged, smoker. Can be blue-collar, and a lot of times, a salesman. Don't ask me why.**

**Y**ou-know-who/That-which-many-cannot-name-but-insist-they-must-have-for-their-cough. This character is actually a figure of mirth for me.

Sometimes, I can 'diagnose' them even when they are in my waiting room or standing at the nurse's counter.

It's like this, the typical cough mixture addict:

1. Typically male, middle-aged, smoker. Can be blue-collar, and a lot of times, salesman at your large chain electronic store. Don't ask me why.

2. May start asking about 'Dh\*\*\*\*\*' at the front counter. These are the straightforward ones. Other slightly subtler ones ask about the clinic consultation charges first. This is when my index of suspicion goes up to about 80+%. Whatever. Now, those who actually make it into my consult room are the not-so-observant ones - they failed to see my laminated, large-font notice at my front counter that says "NO DH\*\*\*\*\*L available in this clinic" (I

put the sign up after I got fed up with such 'patients').

3. Typically, they will have incessant, exaggerated loud volume coughing while waiting in the consult room which almost no real case of cough would. They are over-compensating: "LOOK, I really really reaaaallllllyyyy have a bad case of the coughs!!"

4. On eye-balling them in the consult room when they enter, they might be tanned and have some tattoos (but not the salesman from *Hardly Normal*, mind you). You can smell the cigarette smell wafting 3 feet towards you (smoking to steel their nerves before seeing a doctor for a bogus consultation, or whatever else is stressing them out such that they need codeine to calm their nerves).

5. During the history, they will tell you that they only have cough. Phlegm? No. Fever? No. Sore throat? No. Runny nose? No. The easier to just get what they want you see... no money to spare for other bogus symptoms. By now, my index of suspicion is up to 99.8%.

**By now, you are probably thinking that these patients are wasting your time, that you didn't go through medical school to attend to these sorts of patients....**



6. If you are getting the drift of this consultation and want to cut to the chase and ask, "What cough mixture do you usually take?" The coy ones will make a show of not knowing the name or how to pronounce Dh\*\*\*\*\*, e.g. "starts with D", "err... something Dh\* something", "errrr... start with D, ends with L". The bull craps a whopper. More often than not, these Dh\*\*\*\*\* patient play coy, like blushing brides.

7. "Why don't you try phenexpect CD, Tussidex DM, Prospan, etc etc?" "Nothing else works!!", "I will vomit with every other cough mixture", "and I am allergic to all other medications!!" (This one is THE winner).

8. If you relent/give them the benefit of the doubt at least once (remember this is the very first consultation with this 'new' 'patient'), well this just invites more steaming crap your way. "O Doctor, can I have two bottles please?" The various excuses: "Keep one bottle at home, one at the office", "Keep one bottle at home, one at Batam" (this guy says he goes to Batam to work often), "I am travelling to USA/Vietnam/Switzerland/Malaysia for two weeks", "My cough usually lasts very long", "So I can save some money/don't have to pay consultation-fee when I finish the first bottle" (!!)

By now, you are probably thinking that these patients are wasting your time, that you didn't go through medical school to attend to these sorts of patients, that the patient probably thinks that you are either naive or has low IQ, or maybe both.

BUT, matters are not concluded yet... they will....

9. Come back one to two days later, saying that they need another one or two bottles of the cough mixture.

"I spilt one bottle (accidentally)", "My children were playing, and they spilt the cough mixture", "My grandmother/maid, etc threw it away", "Ants got in" (You can just about see me rolling my eyes right now).

It's nice to reminisce, now that I do not stock any Dh\*\*\*\*\*. But, those were the days. It's kind of fun, AND funny on looking back. Glad I am looking back. ■CM

*Dr Victor Teo (MBBS 1999) practices at Y S Teo Family Clinic. He is starting his GDFM with the new intake.*



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# Interview with Our New Editorial Board Member

## Dr Kelvin Goh Tze Chien

Interviewed by Dr Wilson Eu, Editor

**CM: Tell us something about yourself. What was your journey as a doctor? What influenced you to become a Family Physician?**

**Dr Goh:** As a student my favourite postings were the medical postings as I enjoyed the intellectual challenge of internal medicine, back then I was my clinical group's resident "mugger". After my first MO posting in emergency medicine, I was inspired and had wanted to pursue Emergency medicine as a career. So I took the MRCS part 1 exams during my first posting, followed by the Part 2 six months later. After that out of sheer fun I took the MRCP part 1 as I was not eligible to take the FRCS(AnE) then. During my surgical postings I became interested in surgery, this culminated in myself taking the MRCS(edin) membership exams 3 years back. After I passed the exams I was confused. There was a period of soul searching after that. This included the thought to complete both the MRCP and FRCS(A&E) That was when I realised that I thoroughly enjoyed everything that medicine had to offer from surgery to psychiatry, that my true calling was probably family medicine.

**CM: Are there any significant role models that have made an impact on your life as a doctor?**

**Dr Goh:** Prof Ng Han Seong was our tutor and his superb clinical acumen and encyclopedic knowledge still sets the gold standard of what a great clinician is. A/Prof Low Cheng Hock's

advice is that the best way to spend your free time is to contribute and help others in whatever little way we can.

**CM: Which aspect of your current FM practice do you cherish most?**

**Dr Goh:** The unique bond that we share with our patient. To walk the path of life together with them. Last Christmas it really warms my heart when a patient came down to the clinic to give us a log cake. One of the more memorable was a patient whom I met when I had just started practice, he has since relocated overseas. He sent me a personal email with pictures of his newborn child. The birth of this child meant a lot to him for personal reasons which I shall not elaborate. Moments like these make me feel alive as a doctor.



*Dr Kelvin Goh and son*

**CM: If there is one thing you want to change in family medicine, what would it be?**

**Dr Goh:** Our image. Some members of the public still view us as cough and cold physicians or as administrators to write memos to see specialists so as to qualify for insurance benefits or government subsidies. There are patients that still ask us questions such as, "Do you vaccinate children? Do you see children below 2 years? You mean you can do T & S in the clinic? My son got flexural eczema please refer him to the specialist? Some patients would pay thousands

to salons for treatment of androgenic alopecia but cringe at a \$15 consult to the family physician for androgenic alopecia.

**CM: What are your views towards continuing professional development in FM?**

**Dr Goh:** I am very junior so I don't feel qualified to answer this. While I feel that it is crucial for us to have continuing professional development to lift the profession to the next level and improve patient outcomes. There are some very good doctors that I know who do not have many post graduate qualifications to their name. A doctor who continues to develop himself professionally without having a paper trail (i.e non-cme certified articles or books) is disadvantaged if we place too much emphasis on approved online assessments, courses and exams. Unfortunately there is currently no consensus on a better way to perform or assess CMEs.

There are also many very successful and popular senior GPs with a wealth of experience. I am sure that there are a lot we can learn from them. However many of them are too busy to come forward to share their experiences with us. It would be interesting to have CMEs chaired by them.

**CM: What is your view of the current General Practice landscape?**

**Dr Goh:** I can only give my view as a private practitioner. One word - challenging. HDB has stopped selling shop houses. Currently most shop units are for rent. In the new estates many shop units in

satellite malls are easily 5 figures per month rental. Cost of drugs and labour are ever increasing. The changes in regulatory landscape, increasing patient expectations, electronic medical records and the increasing number of forms to fill serve to compound the problem.

However we are at an inflexion point. A shift in focus to SLOW medicine and primary care by the government may herald a golden age for family physicians. Whereby patient satisfactions are high and doctor's are appropriately rewarded for their skills and knowledge.

Depending on how we as a profession respond and engage the government, the golden age may very well be descending upon us. Well as they always say the devil is in the details.

**CM: What needs to be done to keep the College Mirror relevant to its readers?**

**Dr Goh:** The College Mirror needs to mirror the views of both the private and public family physicians on the ground to remain relevant. This includes many family practitioners who are not college members. Only by engaging its members effectively can the Mirror be better able to serve their needs.

**CM: Thank you, Dr Goh.**

*Dr Kelvin Goh Tze Chien, MBBS (Singapore), MRCS (Edinburgh), is a practicing Family Physician and Director of NorthEast Medical Group at 30 Simei Street.*

■CM

## Invitation to Contribute to "DOCTORS IN PRACTICE"

Dear Colleagues,

DOCTORS IN PRACTICE is a regular feature of The College Mirror. Each issue showcases the personal experiences of a Family Physician/ General Practitioner at work which are inspiring and instructive. If you do have such a story to share, please send your submission in less than 1000 words to the College at the given address. You will receive a token of appreciation from the College if your story is published. Thank you. ■CM

**College of Family Physicians Singapore**

16 College Road #01-02, College of Medicine Building, Singapore 169854

Email: collegemirror@cfps.org.sg

*( All submissions will be the property of The College Mirror.)*

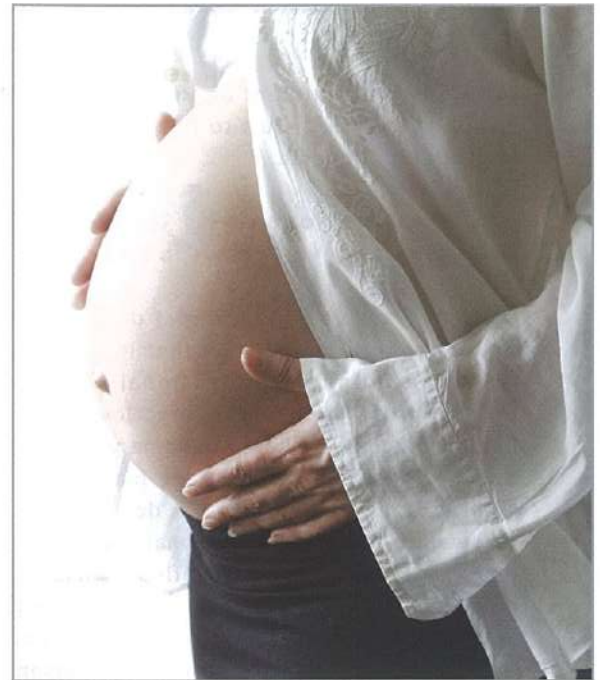
# Subfertility: What the GP can do?

by Dr Gabriel Seow, FCFP(S), Editorial Board Member

**W**hat with the new governmental incentives: increased maternal leave, tax rebates & baby bonus schemes, the overall fertility rate amongst Singaporeans remains dismal!

The increasing age of marriage and conception, pressures of work and prevalence of PID all contribute to the problem.

The problem of subfertility (SF) is a most distressing one due in part that children being considered (and indeed they are!) the blessings and natural fruit of spousal love, are often highly and even desperately anticipated. And so, the failure



to conceive may result not only in a certain void but also the perception of personal failure and lack of masculinity or femininity of the couple thus assailed.

While Assisted Reproductive Techniques (ART) such as IVF have been well documented and discussed, it would be useful for

| Etiology                | Freq | ▲▲  | H/o & P/E                                  | Simple Inx   |
|-------------------------|------|---|--|--|
| Male                    | 25%  | <u>Reversible</u><br>- varicoceles<br>- infections<br>- obstructive | Varicoceles?<br>Mumps/prostatitis?<br>STI? | UFEME/c/s  |
|                         |      | <u>Irreversible</u><br>- hypogonadism<br>- tumors<br>- obstruction  | Testicular atrophy?<br>Gynecomastia?       | FSH/LH/testosterone<br>seminal analysis                  |
| Anovulation             | 25%  | <u>Ovarian</u><br>- PCOS<br>- tumors                                | Irregular menses<br>BMI, hirsutism, acne   | BBT<br>Mid-luteal progesterone<br>LH/FSH>2<br>USS pelvis |
|                         |      | <u>Endocrine</u>  |  | PRL<br>TSH   |
|                         |      | <u>Hypogonadism</u>   |  | FSH  |
| Tubal Blockage & others | 25%  | <u>Tubal</u><br>- PID<br>- endometriosis                            | Dysmenorrhea?<br>STI/PID?                  | Chlamydia serology<br>Hysterosalpingogram                |
|                         |      | <u>Uterine</u><br>- fibroids, adenomyosis<br>- malformation         | Menorrhagia &<br>dysmenorrhea?             | USS pelvis   |
|                         |      | <u>Cervical</u><br>- hostile mucus<br>- cervicitis                  | STI?<br>Birth trauma?<br>Conization?       | Post-coital test   |
| Unexplained             | 25%  | ? coital factors<br>? psychosocial factors                          |  |  |

GPs to be acquainted with helping patients who may prefer to achieve pregnancy using natural methods.

This article will discuss one such method, using as reference in part an article published in the Journal of the American Board of Family Medicine in 2008.

The following is a practical approach for the GP with an interest in this area.

### First, some useful facts

#### Definition

SF is the involuntary inability to conceive despite 12 months unprotected sexual intercourse (SI). This could be 1<sup>o</sup>: no previous pregnancy or 2<sup>o</sup>: previously pregnant.

The likelihood of pregnancy per:

SI encounter = 8%,

Per cycle = 20% (NOT 100 %!)

Average time to conception = 6-8 cycles

#### Pertinent History

1. 1<sup>o</sup> or 2<sup>o</sup> subfertility?
2. Menstrual - regular, painful, heavy
3. Medical/surgical - erectile dysfunction, chronic illness, instrumentation
4. Medication - smoking alcohol, illicit drugs, cytotoxics, nitrofurantoin
5. STI - PID (Chlamydia), ectopic pregnancy

#### Physical examination

1. Females
  - features of PCOS, goiter
  - Pelvic examination: discharge? Uterine/ovarian enlargement? Features of endometriosis?
2. Males
  - Varicoceles? Urethral discharge? Meatal strictures?
  - Features of hypogonadism: testicular atrophy, gynecomastia

#### Commonest identifiable causes

1. Timing of coitus
2. PCOS
3. Endometriosis
4. PID and its sequelae

#### Three simple ways to confirm ovulation

1. Basal body temperature (BBT) charting: Explain that oral temperature must be taken before rising each morning. The 0.3°C ↑ which occurs just after ovulation confirms ovulation in retrospect.
2. Cervical mucus observation: this is abundant, thin and clear resembling raw albumen (due to estrogen) at the

**If a woman has amenorrhea, a progesterone induced bleed indicates an intact hypothalamo-pituitary-ovarian axis and a well estrogenised endometrium: the amenorrhea is likely to be anovular and should respond to clomiphene.**

time of ovulation and becomes thick and scant immediately after (due to progesterone).

3. A day 21 Progesterone level > 30mmol/l confirms ovulation.

If a woman has amenorrhea, a progesterone induced bleed indicates an intact hypothalamo-pituitary-ovarian axis and a well estrogenised endometrium: the amenorrhea is likely to be anovular and should respond to clomiphene.

In PCOS probably (the commonest clinical entity): weight loss, metformin and clomiphene will often induce ovulation

#### Seminal analysis (SA)

It is good to understand that the act of masturbation which divorces the conjugal union from the procreative potential of SI is morally objectionable to many formed consciences. Happily there is a way to circumvent this! The use of a **perforated condom** allows both natural SI without frustrating the passage of sperms and thus the possibility of conception and facilitates the collection of residual semen for analysis! The perforated condom is quickly removed and the contents placed in a sterile urine container and sent for study.

SA is done after three days of abstinence and should be delivered as soon as possible (within the hour!) avoiding extremes of temperature. Putting the container in one's trouser pocket is a simple way of keeping the container near to body temperature. Repeating the test three months later ↓ false negatives from 10% to 2%. ■CM

#### REFERENCES

1. Anthony, Kaye. Notes for the DRCOG 4th Ed 2001.
2. Stanford, Parnell, Boyle et al. The Journal of the American Board of Family Medicine 21 (5): 375-384 (2008)

# Baby Bonus: What We May Have Missed

by Dr Kelvin Goh, Editorial Board Member



**T**he Baby Bonus Scheme which is under the purview of Ministry of Communication Youth and Sports (MCYS) supports parents' decision to have more children by helping to lighten the financial costs of raising children. It was introduced on 1 April 2001 and enhanced on 1 August 2004. The latest enhancements on 17 August 2008 extended increased benefits to the first and second child and benefits to Singapore citizen children beyond the fourth child.

All children born on or after 17 August 2008 will enjoy Government contributions in the form of a dollar-for-dollar matching for the amount deposited into the Children Development Account (CDA). Prior to this only the second to the fourth child qualifies.

The CDA is a special savings account that your patient can open at any OCBC Bank or Standard Chartered Bank branch for their child who is eligible for CDA. They can save in the CDA any time until 31 December in the year their child turns 6 years of age. The savings will be matched up to the cap of \$6,000 each for the first and second child, \$12,000 each for the third and fourth child and \$18,000 each for the fifth and subsequent child. The Government will match your savings in the following month.

## What is the relevance of baby bonus to Family practice?

Many doctors are not aware that the baby bonus can be used to by the patients to pay for the following .

1. Vaccinations
2. Medical Consultations
3. Costs of all medications and prescriptions
4. Medical fees for siblings

This is an excellent scheme that helps lower the costs barrier for parents seeking vaccinations and medical treatments in both private and public institutions.

Gone are the days of troublesome and complex forms for patients and doctors fumbling through the various red tape. Application is now straight forward. The patient uses a special NETS card that functions like any other nets card. Payment is also made promptly back end via the CDA bank account to the vendor's account.

**Gone are the days of troublesome and complex forms for patients and doctors fumbling through the various red tape.**

.....

The clinic has to check that the person making withdrawals from the CDA is the Trustee, who is the person nominated to manage the CDA, or someone authorised by the Trustee. If usage is for the child's sibling(s), you need to verify their relationship. Written records of the following information are required to be kept by the clinic.

- (a) The CDA number;
- (b) Names of eligible child and Trustee who is managing the child's CDA;
- (c) Child's name for which CDA's funds are used;
- (d) Amount collected from the CDA;
- (e) Collection date, i.e., the date the amount was transferred from the CDA to your bank account; and
- (f) What collection (payment) was used for, fees, uniform, etc

Fellow college members who are interested can obtain the relevant forms at Via:

1. **The internet**  
<http://www.babybonus.gov.sg/bbss/html/forms.html>
2. **Phone**  
Baby Bonus hotline 1800 253 7707
3. **Snail Mail**  
Ministry of Community Development, Youth and Sports  
Family Services Division  
Baby Bonus & Adoption Branch  
510 Thomson Road  
#13-00 SLF Building  
Singapore 298135

So make use of the baby bonus scheme today to further lower health care costs, decrease treatment barriers and increase your accessibility for your patients. ■CM

# FAMILY MEDICINE COMMENCEMENT 2010

**26 June 2010  
2.00pm - 3.30pm**

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



**Convention/AGM Tea Reception**  
3.30pm - 4.00pm  
Function Room, College of Medicine Building

**College Members who sign-up to attend the AGM 2010 will receive a College Thumbdrive (8GB) while stocks last.**

# CFPS 39<sup>th</sup> ANNUAL GENERAL MEETING 2010

**26 June 2010  
4.00pm - 6.00pm**

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



# Cardiovascular Disease, Risk Factors, and Consequences

**31 Jul & 1 Aug 2010 | 2.00-5.45pm**

**Shaw Foundation Alumni House  
National University of Singapore  
11 Kent Ridge Drive, S119244**



**□ SEMINARS**

(2 Core FM CME Points for each seminar)

**Seminar 1** • Unit 1-3: Sat, 31 July 2010 (2.00pm - 4.15pm)

**Seminar 2** • Unit 4-6: Sun, 1 August 2010 (2.00pm - 4.15pm)

**□ WORKSHOP (2 Core FM CME Points)**

**Workshop 1: Practical Skills**

Sat, 31 July 2010 (4.30pm - 5.45pm)

**Workshop 2: Case Studies**

Sun, 1 August 2010 (4.30pm - 5.45pm)

\*Registration of workshop is on first come first served basis. Seats are limited. Please register by 24 July 2010 to avoid disappointment.

**□ DISTANCE LEARNING MODULE**

(6 Core FM CME Points upon completing the MCQ Assessment)

• Read 6 Units of study materials in the Singapore Family Physician Journal and pass the MCQ Assessment.

This Family Practice Skills Course is organised by the College of Family Physicians Singapore and supported by an educational grant from Boehringer Ingelheim



**Boehringer  
Ingelheim**

**LUNCH SYMPOSIUM**

**Systemic Consequences  
of COPD: A Call for  
Earlier Treatment**

**Saturday, 31 July 2010  
1.00pm-2.00pm\***

**Shaw Foundation Alumni House  
National University of Singapore  
11 Kent Ridge Drive, S119244**

\*Lunch is provided

## REGISTRATION

### CARDIOVASCULAR DISEASE

Please tick (✓) the appropriate boxes

**FREE  
REGISTRATION  
for College  
Members!**

|                             | College Member                | Non Member                        |
|-----------------------------|-------------------------------|-----------------------------------|
| Seminar 1 (Sat)             | <input type="checkbox"/> FREE | <input type="checkbox"/> \$ 20.00 |
| Seminar 2 (Sun)             | <input type="checkbox"/> FREE | <input type="checkbox"/> \$ 20.00 |
| Workshops (Sat-Sun)         | <input type="checkbox"/> FREE | <input type="checkbox"/> \$ 40.00 |
| Distance Learning (Journal) | FREE                          | <input type="checkbox"/> \$ 40.00 |
| Lunch Symposium             | <input type="checkbox"/> FREE | <input type="checkbox"/> FREE     |
|                             | <b>TOTAL</b>                  |                                   |

I attached 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: \_\_\_\_\_

(For GDFM Trainee only) Please indicate:  2008 Intake  2009 Intake

Mailing Address: (Please indicate:  Residential  Practice Address)

\_\_\_\_\_

\_\_\_\_\_

E-mail: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

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

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

Or fax your registration form to: **6222 0204**