from seeing multiple single-organ specialist to a single family medicine specialist. This also allows us to conserve hospital resources to patients who truly deserve it. Our hospital specialist outpatient clinics referral lead-time has improved. In the long run, healthcare costs are not rising due to this initiative.

CA: But won't your family medicine specialists charge more for their consultations?

CB: It is a competitive market out there. Whatever the family medicine specialists charge, they still have to remain competitive, otherwise they will not survive in the market. Anyway, even if our family medicine specialists charge more, the cost is still lower than the combined costs of seeing multiple single-organ specialists. Plus the care is less fragmented and patients are saved the hassle of multiple appointments and it is easier to coordinate with a family medicine specialist than multiple single-organ specialists. Because family medicine is a specialty in our country, many of our family medicine practitioners strive to go through the training and achieve the accreditation and qualifications that go along with it, thus raising the standards of family medicine in general. This has resulted in better standards of care in the family medicine community.

Yes, we all look forward to a brighter and more ideal state of family medicine. Where family medicine brings more balance to the healthcare equation and family medicine physicians deliver more holistic and comprehensive care as a result of more advanced training, and aspiring young doctors who wish to do more good in this discipline gets more recognition that is not considered sub-standard to the specialists. For this to happen, it will require all the stars to be aligned even beyond the walls of family medicine, into the realm of healthcare financing and policy making. Anything short of that, and family medicine remains as a discipline where physicians deemed not as good for specialty training gets enlisted into the family medicine discipline, as might already be the case in Country A. It becomes a vicious cycle where the family medicine discipline in Country A will never be able to have proficient physicians choosing them as a first choice, and it becomes a downward spiral where standards drop and the centre of care gravitates towards the hospitals. Conversely, the family medicine specialty in Country B, being the popular first choice specialty that it has garnered recognition for, will have top-notch physicians choosing to have fulfilling careers in the specialty. This has the effect of boosting standards of care in primary care and the intermediate and long term care (ILTC) sector, thus shifting the centre of care gravity more towards the community where it should rightfully be, and the acute hospitals serve only to manage acute care, crises and when organ-specialty care is truly needed. Of course with the ageing population everywhere in the world, it is certainly inevitable that new hospitals will need to be built to deal with the silver tsunami. However, where family medicine standards are higher and primary care and ILTC can better cope with the patients in the community, we will not need as many acute hospitals to be built.

CM

Family Medicine: Going Beyond the Bedroom

by Lee Mi Li Jean Jasmin, MCFP(S), Family Physician, KKH Family Medicine Service

It all began one evening a few years ago when I attended a MMed Prog B tutorial at CFPS as a trainee. At the end of the tutorial, the supervisor Dr. Julian Lim started discussing philosophy and reflecting on our local culture, norms and sexual attitudes of patients. A lively conversation ensued amongst some doctors in my group regarding sexual issues of patients they have treated in their practice. This proved an eye-opener for me as I discovered that many of my experienced polyclinic and GP colleagues do counsel their patients on sexual health issues. Upon reflection, I realized that sexual health is a significant part of a patient's overall general well-being.

Studies have shown that almost half of patients seen in primary care are waiting for the opportunity to discuss with their family physicians (FPs) about their sexual concerns but they want us to be the ones to raise the subject first. At the menopause clinic where I work, we routinely enquire about sexual health when we assess patients. Many of them seem relieved that we brought up the topic. Some patients come with their partners, a bit anxious and even a bit embarrassed and I always marvel how within that half an hour consult, manywalk out feeling much better. I would like to share a handful of the family medicine principles that I found useful in addressing patients' sexual issues in primary care.

Ask before assuming.

We've all been caught out making assumptions as we tend to interpret what we think of a patient based on our past experience of dealing with this regular patient or a type of person. Taking time to take a detailed and inclusive sexual history helps create a therapeutic physician-patient relationship and also gives the patient an opportunity to bring up sexual health issues. One of my regular patients, a sweet lady in her mid-60's who is widowed for many years, confided she had started a new relationship with a taxi driver she met at a Community Centre event. Her dear departed husband had been a childhood sweetheart and her one and only partner. So we had a good chat about safe sex practices and she left my room happily armed with her new knowledge. Studies have shown that one third of women aged 75-85 are sexually active and that physical health is significantly correlated with sexual activity and many aspects of sexual function independent of age. By routinely taking a sexual history I also discovered that a few of my regular patients I assumed were heterosexual are actually in a same sex relationship.

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Leave your Judgment outside the consult room.

As FPs our role is to ensure our patient's health concerns are attended to and not solely about our own prejudices or what we think is right. Our patients often come not only with sexual health problems but are also often saddled with guilt and anxiety about their sexuality, sexual practices and possible exposure to infections. Many patients in the LGBTI (Lesbian, Gay, Bisexual, Transgender, Intersex) community face a barrier in disclosing their sexuality to their physicians. When we are open, empathic, mindful of our own biases and use a non-judgmental approach, this strengthens the therapeutic relationship with our patients. I recently attended to a 40-year-old patient who was in a same sex relationship. She had hidden her sexual orientation from her conservative family for many years but disclosed to me during consultation. My patient had some health misconceptions which included the notion that she did not need to do a Pap smear despite having experimented with a male sexual partner previously in her teens. Through trust, we built up a therapeutic relationship and I was able to provide her with the appropriate advice, treatment and support. She even felt confident enough to bring her long-term partner to subsequent consultations.

Adoption of patient-centered instead of disease centered care. (Bio-Psycho-Social)

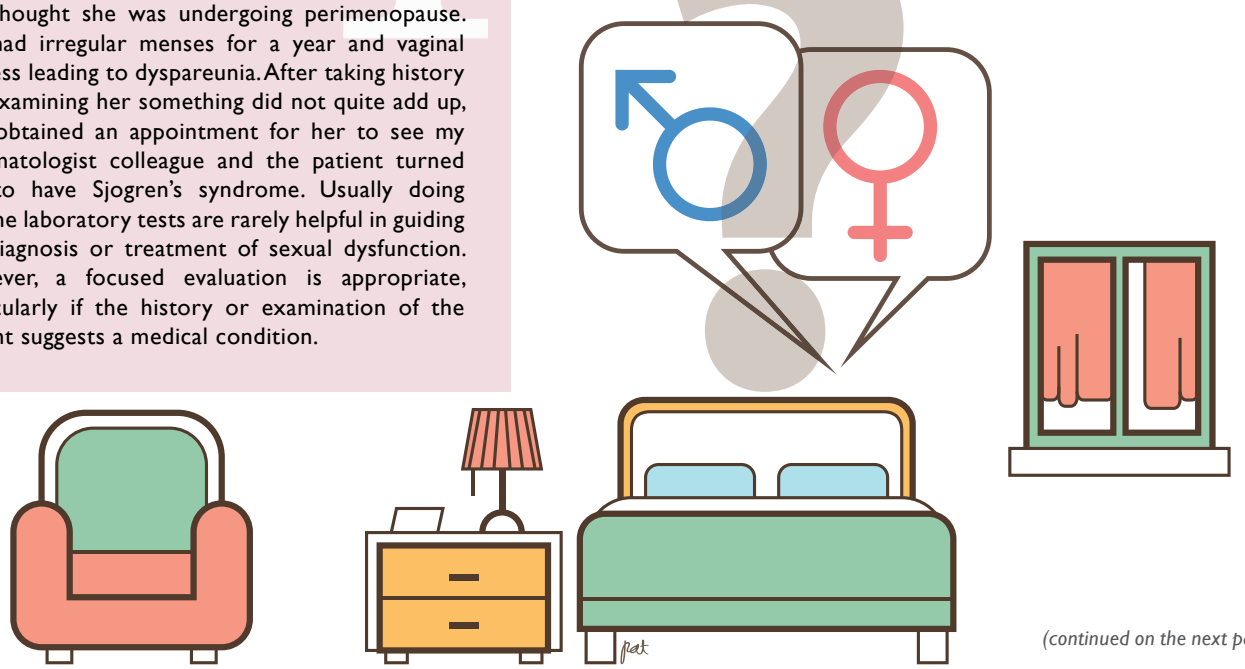
It is important to exclude medical issues that may stem from seemingly innocuous symptoms with a comprehensive history and physical examination. To highlight this I would like to share about the young woman in her early 40's who came to my clinic and thought she was undergoing perimenopause. She had irregular menses for a year and vaginal dryness leading to dyspareunia. After taking history and examining her something did not quite add up, so I obtained an appointment for her to see my rheumatologist colleague and the patient turned out to have Sjogren's syndrome. Usually doing routine laboratory tests are rarely helpful in guiding the diagnosis or treatment of sexual dysfunction. However, a focused evaluation is appropriate, particularly if the history or examination of the patient suggests a medical condition.

Assessment of the partner as well as the patient.

Intimacy issues, sexual health and relationships are interrelated. Sexual problems can significantly disrupt normal functioning for an individual, partner, and the family. As FPs, we are in a good position to help patients as we often have both partners as patients. A good approach is assessing how the problem affects the patient, the partner, both together and apart. In primary care, we often come across both men and women who complain of decreased libido and want a quick fix with medication. When we do dig deeper and examine their relationship with their partners, family and social context we often uncover the hidden stressors and often there is a foundering relationship. FPs can help link patients and their partners to the nearest family service center, family therapist or marital counselor. Counseling can be effective for helping couples to explore their physical communication and their understanding of what sex means to them. Ideally the relationship should be emotionally healthy in order for the sexual issues to be resolved.

Building on communication skills and a level of comfort talking about sex.

Many physicians feel embarrassed talking about sex and some worry about exploring this domain with patients lest they bring up topics that are perceived as off-limits and taboo. Some are also concerned about offending patients. Sexual health counseling requires practice in order to feel comfortable in carrying it out. I used to cringe inwardly if I had to discuss about "orgasms" and "masturbation" for example but I soon realized my patients were even more anxious than me. I then decided to focus instead on putting them at ease and guiding them into talking about sex. I found that it helps to be prepared as well. Some patients may not understand terms like "orgasm" so having a list of basic layman definitions of these common sexual terms is useful to help clarify and avoid medical jargon.



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Many FPs may face barriers in managing their patients' sexual problems in their practice. Some studies have shown that healthcare providers underestimate the prevalence of sexual dysfunction in their patient population or the impact sexual issues have on patients' quality of life. Too often lack of time can be a barrier as some FPs feel that sexuality is too complex of an issue to tackle in the limited time allotted during consultation. One effective framework is based on the PLISSIT (Permission, Limited information, Specific Suggestions, and Intensive Therapy) model to approach sexual problems. This framework utilizes a stepwise approach which helps the busy FP to streamline addressing sexual problems in a time efficient manner.

If we do come across a patient with a sexual issue that is too complex; exceeds our comfort level or expertise we should not hesitate to refer to our specialist colleagues be it a gynecologist or urologist for co-management. Certain conditions like primary vaginismus for example require physiotherapy and sometimes a psychologist as part of the treatment in a multidisciplinary approach.

Majority of the patients we see in primary care have sexual problems that can be addressed simply by giving patients the correct, evidence based information and helping them to deal with their concerns and anxieties.Our patients can be provided with brief and practical interventions and reassurance about the normal physiology of the human sexual response. In order to do this we need to have some basic understanding of the sexual response cycles of men and women as well as the sexual functions and practices in contemporary society today. As FPs we may not have the same values or attitudes as our patients. However simply by being mindful of sexuality and its problems we can help our patients attain sexual well-being and relationship satisfaction.

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CM

An ode to change

by Dr Teo Yee Sheng Victor, Editorial Team Member

It is said that the only constant in life is change.
Change can be scary. Change can be exhilarating.

And yet picked up the gauntlet have we.
Obeyers of the second law of thermodynamics we are not.

The path of our illustrious Seniors is fraught.
And yet we are not dismayed. We are buoyed by
the encouragement & light shone on the path ahead
by our Seniors, who have given of themselves freely.

When we are struck down low, the love of our
Family, friends, peers & Seniors will lift us up.
Remember, the darkest hour is nigh before dawn.
Hence - gird our loins, we will take this one, hand-in-hand.

Change is what we make of it.

CM

Editor's note:
Dr Victor Teo has decided to embark on a great change - to take on the MMed(FM) with gusto!