THE
College Mirror

VOL. 41 NO. 3 SEPTEMBER 2015

A Publication of College of Family Physicians Singapore

Left to Right: A/Prof Lee Kheng Hock (President College of Family Physicians Singapore), Dr Donald Li (President, Hong Kong Academy of Medicine), A/Prof Cheong Pak Yean (Chairman, Chapter of Family Medicine Physicians, Academy of Medicine Singapore)

FM Physicians in 2015 SM Congress of Medicine

The 49th Singapore-Malaysia Congress of Medicine 2015 was held on the 31st July 2015 at the Academia @SingHealth, Singapore. At the Congress, many papers and oral presentations were delivered by Family Medicine Physicians (FMP) on topics covering the different settings of FM. Dr Low Lian Leng from SGH Department of FM was awarded first prize in the FM section for a study on 'A Family Physician Led Integrated Practice Unit And Post-Discharge Virtual Ward For Patients At Highest Risk Of Readmission' while Dr Liu Changwei of Singhealth Geylang Polyclinic won the first prize for his poster on 'Increasing percentage of Chronic Lung Disease with Valid Influenza Vaccine.' Seven Fellows of the College were inducted as Fellows of the Academy at the concurrent Induction Comitia. (See page 4). The number of College Fellows (FCFP) who are also Fellows of the Academy (FAMS) now stands at 78.

The Congress organized by the Academy of Medicine of Singapore and Malaysia together with the Hong Kong Academy (FM) posits FM amongst the specialties represented. Professor Donald Li, President of the HK Academy of Medicine and a FM specialist highlighted in his welcome address the sentinel roles played by FM. The HK College of Family Physicians was one of the founding Colleges when its Academy was formed 20 years ago. More than 400 FM Fellows have gone through structured training and are now accredited by the HK Government as medical specialists. He intimated that he was delighted to learn last year, that the Academy of Medicine Singapore has formed the Chapter of Family Medicine Physicians integrating FMP into its membership of specialists. Prof Li welcome address is reproduced in page 3.

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IN THIS ISSUE:

Editor's Words

by Dr Irwin Clement A. Chung Wai Hoong, MCFP(S), Editor

When the team met a month back to cobble together articles for this publication, SG50 euphoria was in the air, and so in the same spirit of gratitude and recognition we decided to dedicate this issue to writings revolving round the word "pioneer" - pioneering spirit, care for the elderly, continuing their legacy, etc. By the time this issue is released, we would have gotten through the National Day Parade and Jubilee Weekend, heard the Prime Minister's take on how he plans to steer the country in the years ahead at the National Day Rally and even gone through a General Election. I could be forgiven if I ever stopped to wonder at how fast-paced we are in Singapore. Mind you, that is a bewilderment many of our seniors grapple with daily; the world has moved on, and on this little red dot we call home, the struggles of the pioneering years are far from most peoples' minds, except perhaps at those opportune moments for reminiscence, like at this year's parade or some rave retro party.

My granny had a health scare recently. Mind you, she is 90 years old this year, and it should surprise no one that she is not exactly in the pink of health and picture of youth. But she is a sprightly old lady who is still offering her services as a cleaner at a GP clinic a few blocks from where she lives, fully independent in activities of daily living, takes care of her own financial affairs, lives on her own and cooks for herself. Only recently has she accepted the offer of her children to have a live-in domestic helper to watch after her (she had a few falls of late) and help her with heavier chores. So when her routine hepatic ultrasound revealed a new nodule on the background of cryptogenic cirrhosis, alarm bells went off. It took a fair bit of persuasion on the part of me, her grandson who happens to be a doctor, to convince her to have it investigated further (with the help of her family physician at the polyclinic and also the GP she works for). When she was finally persuaded (on the condition that I accompanied her on all the appointments arising thereof), I was much relieved.

So off the polyclinic referral went, and not long after we found ourselves with an appointment at Gastroenterology. I knew the specialist who attended to her at the first visit. Wanting to set her mind at ease, I told introduced him as a friend to her, "我嗰朋友，係大醫生黎嘅" (in Cantonese, "He is my friend, a specialist"). She glanced at him, then turned aside and asked "點解搵個大醫生睇我？唔係好貴?" ("Why get a specialist to see me? Won't it be expensive?") I was not about to enter into a discussion about how she got a subsidised referral from a polyclinic and so fees wouldn't be too unmanageable, etc. etc. so I just reassured her that the charges would not be prohibitive. When she was told that she needed a CT scan, she asked what it was, then again made a remark about how expensive it would be. Even on the day of the scan, she was still lamenting about how we need not spend money on an old woman.

As she was a PG card holder, she got a significant subsidy for the CT scan, and she could also use her Medisave to cover the copayment portion. The bill after subsidy was a double-digit figure and could be completely covered by Medisave, so she did not part with a single cent out of her purse. On the way home, as I was reminding her the umpteenth time she had to hydrate herself well to clear the contrast quickly from her system and how it was important for her to attend the follow up sessions for the sake of her own health, she suddenly smiled and remarked, "李光耀好好呵？ 咁照顧我哋老人家. . . " (Lee Kuan Yew is very good to look after the elderly."). That was her way of saying she was grateful that she was well cared and provided for, never mind the fact that Mr Lee had already passed on some 5 months back, and never mind that her grandson had to take many hours off work to send her to the appointments.

Pioneers - they don't really ask for much, only that the folks whom they have toiled to build the good life for not forget who they are, and give them adequate recognition, dignity and just enough to get by in their latter days. And so often in our own busyness, pursuit of progress and chasing of life's pleasures, we do forget and leave them behind. As inscribed in the Cenotaph commemorating those who fell protecting the Empire against its enemies, "Lest We Forget", here's a salute to our parents, grandparents, the '*ah pek*' and '*ah mm*', '*pakcik, makcik* and nenek' , who epitomise the adage "前人栽樹，後人承涼" (the ancestors plant trees and the descendants enjoy the shade) – Thank you.

CM

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(continued from cover page)

"The Induction Comitia is a celebration of the formal admission of new Fellows. Let me, therefore, proffer my heartfelt congratulations and best wishes to your success and achievements. Today you have reached an important landmark in your career. It is the celebration of all your stories of success; a time for reflections of your sacrifices made, accomplishments as well as disappointments. You now have the obligation to show without flinching, the skills you have honed, and make full use of the knowledge you have acquired to best serve the community with the highest professional standard.

As future leaders in the profession, you need to learn to accept change. Human society is stepping into unknown territory and is developing continuously. The changes will not stop, and may even accelerate. As technology advances at such great speed today, the years of education and training you have received will not be sufficient for you to pursue a lifelong career facing the many challenges that lies ahead.

You should progress from seeking professional credentials to achieving core competencies in order to deliver quality services in our health system. The strength of the profession relies on the collective and concerted efforts of accomplished individuals like you. You should continue to work hard for improvement and strive for excellence in your area of expertise.

The ageing population, and increased prevalence of chronic diseases require a strong orientation towards prevention, self-care, and there is demand for quality primary care delivered by family physicians that is well co-ordinated and integrated. The overall healthcare strategy needs to include bringing in new disciplines, perspectives, and methodologies and taking into account anthropology, sociology, epidemiology, economics and health policies.

The Hong Kong Academy of Medicine was established by statute in 1993, empowered to set and maintain standards of specialist training in Hong Kong. Today, we have over 7,000 Fellows under 15 specialty Colleges.

(continued on the next page)

(continued from Page 3: FM Physicians in 2015 SM Congress of Medicine)

Newly inducted Fellows of the Academy (FAMS) with A/Prof Cheong and Lee. From left: Dr Juliana Bte Bahadin, Dr Soon Shok Wen Winnie, Dr Cruz Marie Stella P, Dr Tan Woei Jen Michelle, A/Prof Cheong Pak Yean, A/Prof Lee Kheng Hock, Dr Tse Wan Lung Derek, Dr Michael Yee and Dr Wong Kay Wye Sabrina

As some of you may know, I am a family physician. The Hong Kong College of Family Physicians was one of the founding Colleges when the Hong Kong Academy was formed 20 years ago. We have now over 400 Fellows under the College who have gone through structured training to become specialists in Family Medicine. I am delighted to learn that last year, the Singapore Academy has formed the Chapter of Family Medicine Physicians, integrating Family Physicians into its membership of specialists. This is an important and well-deserved recognition of the discipline. Family doctors provides holistic care and take responsibility in evaluating the patient's total health needs over an extended period of time and is thus a specialty in breadth rather than depth.

"We have now over 400 Fellows under the College who have gone through structured training to become specialists in Family Medicine"

The theme of this year's congress "Greater Integration for Better Patient Care" is most timely and appropriate. The theme highlights the need for family physicians, specialists and allied healthcare professionals to work in collaboration, involving the patient and family to evaluate treatment options and planning.

May I take this opportunity to congratulate the Organizing Committee for putting together such an excellent and well-structured program. The Congress offers an excellent opportunity for medical experts from many specialties to exchange knowledge and share expertise with the ultimate aim to improve people's health and quality of life. May I wish you all a fruitful experience during the Congress.

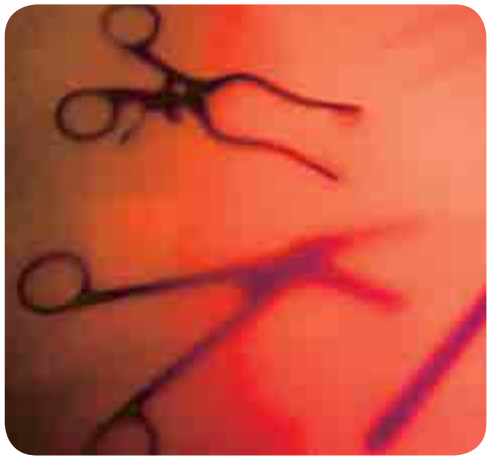
Once again, I congratulate all the new Fellows wholeheartedly on your achievements today. If you have not already done so, I urge you to take a few minutes to thank the people who supported you all these years - emotionally and financially. I wish you every success and great happiness in the years to come."

Prof Donald Li
President
Hong Kong Academy of Medicine

Welcome Address at the
49th SM Congress of Medicine

Dr Donald Li attended a welcome dinner hosted by our President A/Prof Lee Kheng Hock. At the dinner, Dr Li met with Dr Alfred Loh and A/Prof Goh Lee Gan whom he had worked very closely with to promote family medicine on the world stage.

CM



Family Practice Skills Course #64

Emergency Medicine -
What the Family Physician Can Treat

Sat - Sun, 16 January - 17 January 2016
2.00 - 6.00pm

Health Promotion Board, Level 7 Auditorium
3 Second Hospital Avenue Singapore 168937

TOPICS

Unit 1: Minor fracture, sprain and strain
Unit 2: Acute wounds
Unit 3A: Foreign body in eye
Unit 3B: Foreign body in ear, nose and throat
Unit 4: Breathlessness
Unit 5: Chest infection
Unit 6: Abdominal pain

WORKSHOPS

Day 1: (A) Fracture, sprain and strain
(B) Foreign body in eye
(C) Foreign body in ear, nose and throat

Day 2: (A) Intubation
(B) Case studies- Chest infection
(C) Case studies- Acute abdominal pain

SPEAKERS

Dr Kanwar Sudhir Lather
Dr Chua Mui Teng
Dr Dawn Lim
Dr Tay Sok Yan
Dr Sohil Pothiawala
Dr Nausheen E.
Dr Lim Jia Hao

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, 16 Jan 2016 (2.00pm - 4.00pm)
Seminar 2 • Unit 4 - 6: Sun, 17 Jan 2016 (2.00pm - 4.00pm)

WORKSHOPS (1 Core FM CME point per workshop)
Day 1: Sat, 16 Jan 2016 (4.30pm - 6.00pm)
Day 2: Sun, 17 Jan 2016 (4.30pm - 6.00pm)

* Registration is on first-come-first-served basis.
Seats are limited.
Please register by 11 Jan 2016 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 by the **College of Family Physicians Singapore** and **Health Promotion Board (HPB).**

Health Promotion Board

REGISTRATION

Emergency Medicine -
What the Family Physician Can Treat

LIMITED SEATS AVAILABLE!

Please tick (✓) the appropriate boxes

	College Member	Non Member
Seminar 1 (Sat)	☐ FREE	☐ FREE
Seminar 2 (Sun)	☐ FREE	☐ FREE
Workshops (Sat-Sun)	☐ FREE	☐ FREE
Distance Learning (MCQ Assessment)	☐ FREE	☐ FREE

Name: Dr_____

MCR No: _____ NRIC No: _____

(For GDFM Trainee only) Please indicate: ○ 2014 Intake ○ 2015 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. Kindly check your inbox before attending the course. Thank you.

Please mail the completed form 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

Signature: _____

Family Medicine
COMMENCEMENT CEREMONY & AGM 2015

25 JULY 2015 | COLLEGE OF MEDICINE BUILDING

Addressing the audience at the Family Medicine Commencement Ceremony 2015 were (from left) A/Prof Lee Kheng Hock - President of CFPS, Dr Elaine Tan - Director, Primary and Community Care Division, MOH and A/Prof Tan Boon Yeow - Censor-in-Chief of CFPS (24th Council).

An Introduction by the Programme Directors

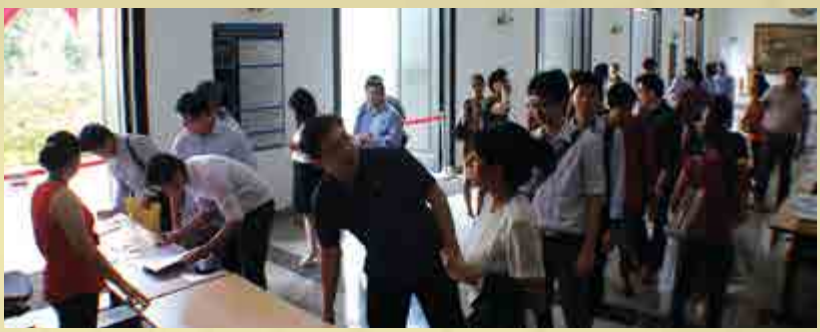
Providing a brief introduction for their respective programmes were (from left) Dr Ng Lee Beng - Programme Director for Fellowship [FCFP(S)], Dr Julian Lim - Programme Director for Master of Medicine (Family Medicine) and Dr Kwong Kum Hoong - Programme Director for Graduate Diploma in Family Medicine (GDFM)

The new trainees then headed for their Induction Sessions ...

▲ *at the College Conference Room ...*

▲ *the College Lecture Room and ...*
◄ *College of Medicine Building Auditorium*





Family Medicine 2015 COMMENCEMENT CEREMONY & AGM











FAMILY PRACTICE SKILLS COURSE

Transitional Care for Family Physicians

The College of Family Physicians Singapore would like to thank the Expert Panel for their contribution to the Family Practice Skills Course #61 on "Transitional Care for Family Physicians", held on 9 – 10 May 2015.

Expert Panel:
A/Prof Lee Kheng Hock
Dr Low Lian Leng
Dr Ali Syed Kamran
Dr Tay Wei Yi
Dr Jesmine Lee Mei Gene
Dr Ng Lee Beng
Dr Tan Yew Seng
Ms Christine Hindarto Lim
Dr Ng Joo Ming Matthew
Ms Rachel Marie Towle
Ms Yong Limin

Chairperson:
Dr Leong Choon Kit

Home Care

The College of Family Physicians Singapore would like to thank the Expert Panel for their contribution to the Family Practice Skills Course #62 on "Home Care", held on 11 – 12 July 2015.

Expert Panel:
Dr Matthew Ng Joo Ming
Ms Grace Yu Tik Yin
Dr Ng Lee Beng
Dr Tay Wei Yi
Dr Catherine Chan Qui Hua
Dr Low Lian Leng
Dr Jesmine Lee Mei Gene
Dr Kristine Joy Caratao
Dr Michelle Tan Woei Jen
Sister Magheswari Sabapathy
Sister Liew Lee Foong

Chairperson:
Dr Kwek Thiam Soo
Dr Chan Hian Hui Vincent

In Memoriam and 'Makanan'

by Dr Nicholas Foo Siang Sern, Editorial Board Member

The old man knew that the end was near, but contented he was, and therefore ready to go. His mind drifted back to times past; the memories of yesteryear were still there - safely tucked in a corner of his mind even as his body was rapidly failing him.

He slowly worked his memory back through the years, recalling each joy and grief that he had experienced in life. He was 18 once again; the year was 1994 and it was the year he entered Medical School. The man was puzzled for a moment. The 5-year chunk named 'Medical School' seemed to be a total blur. He had prided himself on his excellent memory and could not fathom why this particular bit was so vague. He certainly knew that it had been a mind numbing time where he had to study very hard but he could not recall a single lecture he had attended, the tutors that had taught him, the wards that he had been in or the patients that he had come across.

After a long while, he broke into a smile; the memories were still there – Friends and Food - those were the two things that he remembered best when it came to that 5 year chunk named 'Medical School'. Once his memory had been unlocked, the lectures, tutors, wards and patients came alive.

He had not been the most sociable of persons when he entered Medical School, retreated often to spend time in his daydreams. He remembered the brain-numbing hours of studying a first year medical student when faced with 3 formidable tasks known as Anatomy, Physiology and Biochemistry. He scrapped through the first year, passing his Physiology Exams after being put through a viva and putting a smile on the face of the Scottish examiner by the name of J. B. West. "We don't have mountains in Singapore, but we do have Bukit Timah Hill - it's 163m high!" Now what was so physiological about that?

His life changed in the second year of Medical School when the students had to form Clinical Groups. He did not jostle to be in any particular group and left it to fate. And fate decreed that he would become a member of Clinical Group P or CG P for short.

CG P would become his surrogate family over the next few years. The time he spent with this family was the happiest days of his life as a medical student. The group mates never knew they were collectively responsible for drawing him out of his shell, allowing him to display the warped humour that was hidden inside. They definitely got on each other's nerves from time to time but all these were minor infractions that were readily forgiven. Each of the group members had their own quirks but the old man could no longer remember the unlikable bits of his friends. It was mostly because he grew to accept all of them for what they were and liked them for what they were, warts and all. After all, no one was perfect, he included.

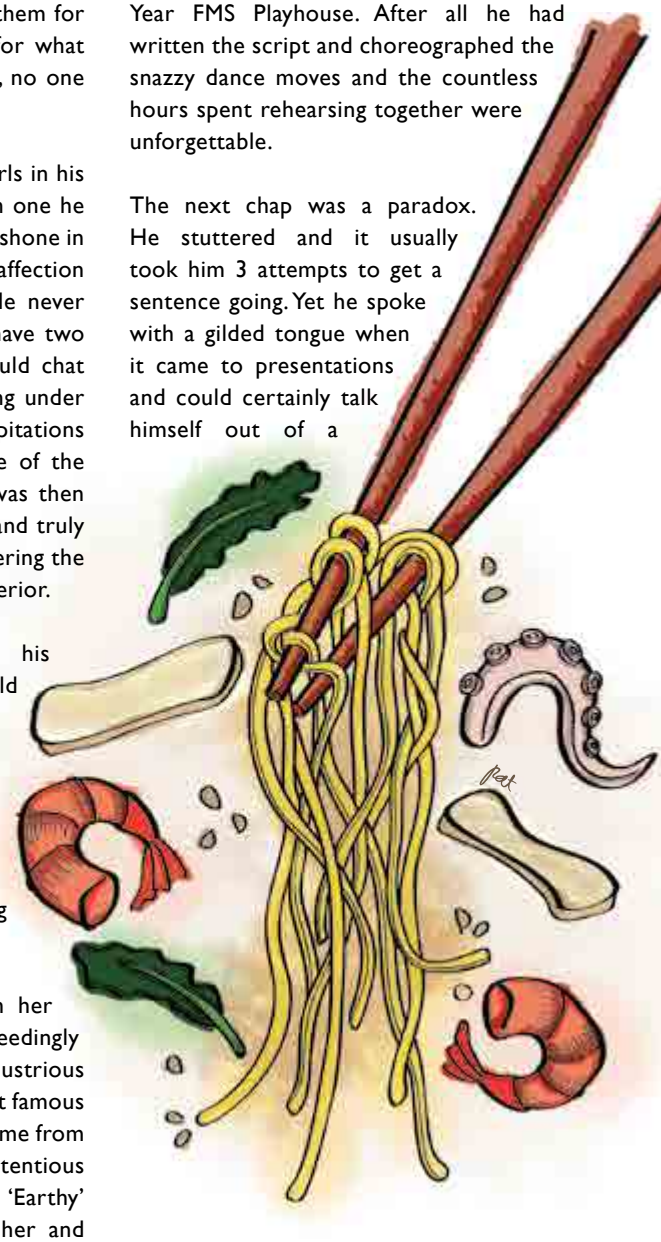
He was equally fond of the two girls in his CG. It was hard to choose which one he liked better because both of them shone in their own ways. It was a brotherly affection that he had for both of them. He never knew how fortunate he was to have two female friends with whom he could chat freely with and talk about anything under the sun. He suffered from mild palpitations when he had to practise the use of the ophthalmoscope on the girls; it was then that he discovered that the eyes and truly the windows to one's soul, discovering the beauty hidden inside the plain exterior.

One of the girls lived in his neighbourhood and they would often head to classes together. On occasion she would even invite him to have a meal with her family. She was short in height but big in heart, ever vivacious and bubbly on the surface but with a will of steel when the going got tough.

The other girl was refreshing in her simplicity, although she was exceedingly bright, having studied at that illustrious girls' school in Ang Mo Kio and that famous junior college in Ghim Moh. She came from a humble background, was unpretentious and never had any mood swings. 'Earthy' was the best word to describe her and only one of his classmates was quick enough to see this special quality in her, and eventually married her after they graduated.

Three more guys made up the rest of the group. The first one had the nickname of an insect. He was mostly grumpy in the mornings but always cheered up as the day went by. He was the only one in the CG who could wield a pair of chopsticks the proper way and had an exceedingly offbeat sense of humour. And this chap had many hidden talents, hairy legs notwithstanding. He had been the conductor of the residential hall a cappella group and had somehow cajoled the whole CG to act in the Final Year FMS Playhouse. After all he had written the script and choreographed the snazzy dance moves and the countless hours spent rehearsing together were unforgettable.

The next chap was a paradox. He stuttered and it usually took him 3 attempts to get a sentence going. Yet he spoke with a gilded tongue when it came to presentations and could certainly talk himself out of a



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precarious situation. This chap would make cynical remarks but at the same time was the most self-sacrificing person the old man had ever known, always putting the interest of others above his own.

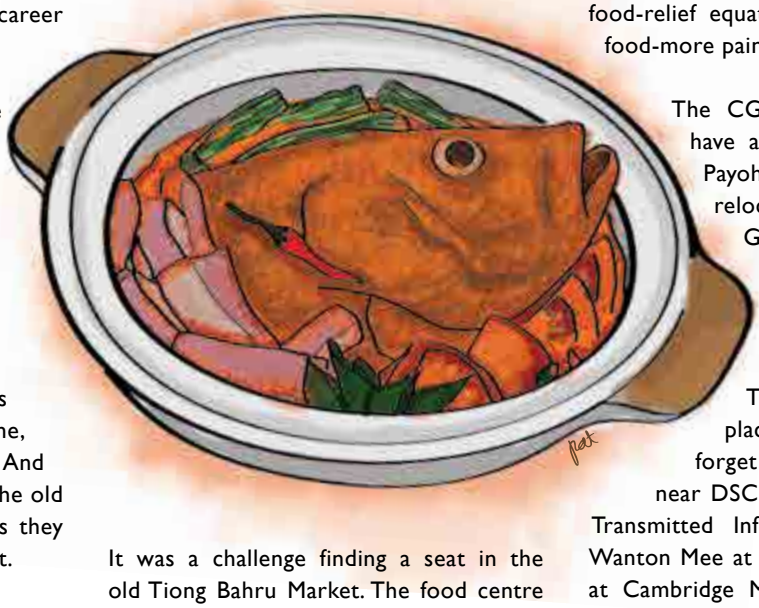
When the old man had first entered the wards as a medical student, he discovered that the first thing he should learn was not Medicine but Language. So the stutterer taught him Malay whilst the girls taught him Hokkien. It made him much more endearing to the patients, who knew that medical students were the only people who wore white coats. Knowing little bits of Cantonese and Hainanese made him even more formidable in the wards. The smattering of what he picked up would serve him well for the rest of his career as a doctor.

Each group was certain to have a mugger and the last male member fitted the bill perfectly. His textbooks were highlighted with so many colours that it was difficult to see the remaining white of the page. He had an impeccable collection of beautifully handwritten notes. But this mugger was generous and readily shared his notes and knowledge with everyone, especially members of the fairer sex. And the mugger was also a chatterbox; the old man recalled fondly the many times they spent just chatting late into the night.

The memories of places where they went for meals were just as vivid. They really bonded over these 'makan' sessions... Food for the body and food for the soul were all located in the vicinity of hospitals where they did their clinical postings.

He loved the bitter coffee sold at the National University Hospital (NUH) staff canteen - coffee was always a much needed booster for any medical student. Occasionally they would walk across the overhead bridge to Dover Estate for their fix of Fried Hokkien Mee. When time permitted, the group would make a trip down to the end of South Buona Vista road for Braised Duck Rice. The Stutterer insisted that they order individual plates instead of a portion for six people to share. He had done his calculations and found that one got a better deal if he ordered an individual plate. He had pointed out that the duck presented on a shared portion looked plentiful but this was an illusion because it was mostly sliced cucumber underneath. And so they stuck to individual portions.

Singapore General Hospital (SGH) led them to Tiong Bahru Estate. The old man especially loved the porridge sold at the little coffee shop at the corner of Eng Watt Street. The porridge stall shared the coffee shop with a Roti Prata stall and Yong Tau Foo stall. In later years the porridge stall had taken over the whole coffee shop and their business continued to thrive as they cooked up their delicious bowls of silky smooth porridge on a charcoal fire with an amazing consistency.



It was a challenge finding a seat in the old Tiong Bahru Market. The food centre was open air, seating was limited and one would sweat buckets whilst eating the Pig Offal Soup under the sweltering midday sun. The market also had certain smell to it and this certainly elevated the whole dining experience.

Tan Tock Seng Hospital (TTSH) and Kandang Kerbau Hospital (KKH) were indeed gems when it came to food. Who could forget The Longhouse at the Old Jalan Besar Stadium? The group loved having Teochew Porridge at Owen Road. They were saddened when they found that the coffee shop had to be pulled down and they were happy to rediscover their favourite stall at another coffee shop in Dunlop Street, just a stone's throw away.

The old man remembered the times when he woke up at 5 am to go for a run after delivering babies at KKH. He ran to the old Farrer Park Stadium which was not far from the hospital and was surprised to find it bustling at such an early hour, mostly with old folks doing their morning exercises. After his run, he walked across to an anonymous coffee shop and discovered the most delicious peanut porridge ever. The old man was glad that he still remembered all these because both the coffee shop and stadium were eventually demolished.

AH was always a pleasant place with a laid back 'Kampung' feel. It was also where the CG encountered the unforgettable bedside tutorials of two established and highly respected surgeons. To differentiate between epigastric pain caused by duodenal versus gastric ulcers, this statement was drilled into the students: "Hunger-pain, food-relief equates duodenal ulcer. Pain-food-more pain means gastric ulcer".

The CG was also fortunate to have a glimpse of the old Toa Payoh Hospital (TPH) before it relocated to Simei as Changi General Hospital (CGH). Unfortunately, the food scene around CGH was bland, to say the least.

There were of course many places that he would never forget - Laksa at the coffee shop near DSC (Department of Sexually Transmitted Infections Control) Clinic, Wanton Mee at Lavender, Prawn Noodles at Cambridge Market, the Chinese Fish Head Curry Shop nestled amongst the Indian Fish Head Curry Shops at Race Course Road, Rochor Beancurd at Short Street, the delicious Pork Rib Noodles just down the road from the Beancurd shop, the 'best' Chicken Rice in Singapore found in Alexandra Village, the girls' favourite Seafood Soup stall nearby, BBQ chicken Wings at ABC Market, late night suppers at Fong Seng and Hakim Restaurant and many more...

The old man closed his eyes. What did his CG mates think of him? He suddenly remembered that he had been the Group Leader. Yes... He had been the glue, the glue that tried his best to make his surrogate family stick despite the differences in taste and in character. Truly, a family that eats together stays together.

CM

Photo Quiz

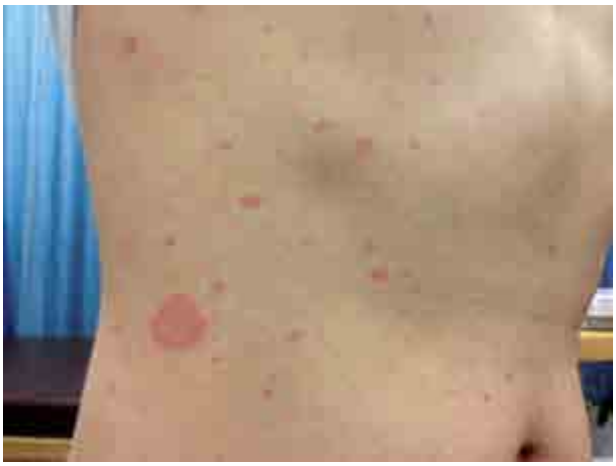
Contributed by Dr Nicholas Foo Siang Sern, Editorial Board Member

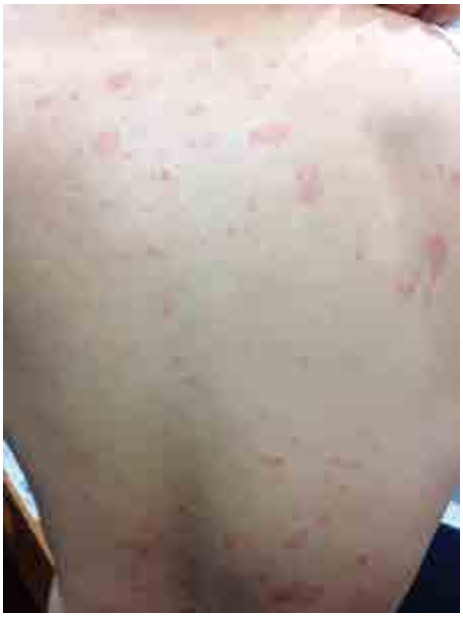
QUIZ #1

A 30-year-old gentleman presents with a mildly pruritic rash of 3 days' duration involving his thorax, abdomen and back. He had a preceding viral Upper Respiratory Tract Infection (URTI) which resolved without any medication. He did not have any close contact with persons having a similar eruption.

QUESTION

Describe the rash.





ANSWER

The rash has the following features:

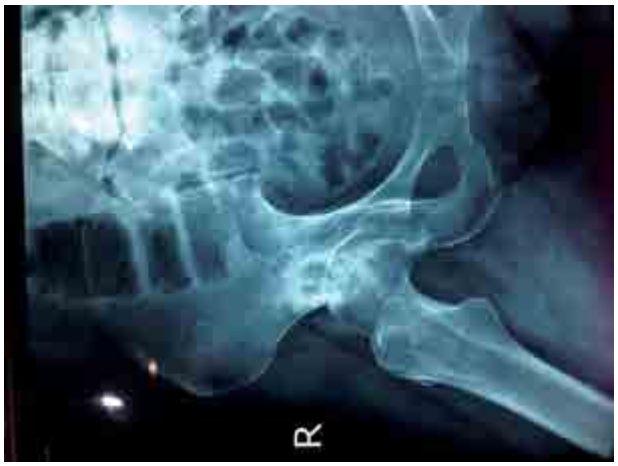
- salmon coloured macules and papules
- elliptical or ovular in shape
- bilateral and diffuse distribution, with the long axes running parallel to skin tension lines-classic "Christmas Tree" pattern

QUIZ #2

A 66-year-old lady presents with right hip pain of 1 year duration. She has temporary pain relief with painkillers prescribed by another doctor but reports that the pain has been increasing in intensity over the past 3 months. She has no medical history of note. An XR of the pelvis and right hip is performed.

QUESTION

Describe the XR findings.



ANSWER

The X-Rays of the pelvis/right hip show the following:

- Right hip joint space is obliterated and the femoral head is flattened
- Subchondral sclerosis and subchondral cysts on both the femoral head and acetabulum
- Subcondral sclerosis, marginal osteophytosis and facet joint hypertrophy are seen at L4/L5 and L5/S1

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KPI: Keeping People Ignorant

... or should we kindle positive innovations?

by A/Prof Lee Kheng Hock, President, 25th Council, College of Family Physicians Singapore

This is one of strangest KPI story that I have heard so far.

It started like a zombie story. Bodies of the recently departed started disappearing from their graves in large numbers. It occurred across many cemeteries in many towns. Distraught relatives found the graves opened and the coffins empty. The detectives investigating the case were puzzled. Grave robbery was ruled out because valuables that were buried with the dead were often left undisturbed. There was another puzzling pattern. All the cases involved persons who had died recently from natural causes.

The break in the case came one day, when the traffic police stopped a suspicious van on the road near a cemetery. When they inspected the cargo, they were horrified to find ten freshly dug up corpses stacked neatly inside. Eventually the driver confessed that he had dug up 173 corpses in the past one year. He sold them at about $350 per piece to a middle man and in the process made more than $60,000. The middle man turned out to be a mortuary assistant who collected bodies from the grave robbers and stored them in the hospital morgue. The mortuary assistant will in turn sell the bodies to funeral parlors for $3000. The operators of the funeral parlors will then sell them on at hefty mark-ups. You might be relieved to learn that the end user of this complicated supply chain is not the medical student in the dissection hall. It turned out that the bodies were bought by crematoriums which then incinerated the bodies. Even more bizarre, the web of suspects eventually brought the detectives to the steps of city hall. How did government officials ended up becoming the masterminds behind a sophisticated grave robbing scam? It all started with well intentioned government policies and key performance indicators.

Over the years, the traditional preference of burial over cremation had led to increasing pressure on the availability of land for economic production. A series of policies were introduced to discourage burials. Unfortunately, this failed to reverse the trends. It was then felt that local government officials were not diligent in implementing the policies. Key performance indicators were introduced swiftly. Quotas on cremations were introduced and officials were expected to perform to target. City officials who failed to achieve targets were reprimanded by provincial officials and so on. Under pressure, the

leaders introduced punitive measures for lower ranking officials who failed to deliver on annual cremation targets. The measures were named the "four denials". These were denial of promotion, denial of good appraisal report, denial of salary increment and denial of bonus. In an effort to enforce continuous quality assurance, a system of "yellow card" warnings were introduced and sent out whenever seasonal targets were not met.

This proved to be a roaring success. Within a short period of time, KPIs were met and everyone was pleased. That was until the grave robbing scam was exposed. Desperate officials had started a scheme where bereaved families were allowed to purchase a dead body to be handed over for cremation. Some even worked with grave robbers to establish a supply chain where stolen bodies were kept in storage to ensure timely delivery for cremation. The family members got to bury their loved ones, officials met their KPIs, leaders got promoted, some people made money and everyone should be happy. Well everyone except for the hapless families who became the victims of the body snatchers. Then there was the unintended propagation of the culture of delivering on KPI at all cost, even if it calls for unethical and illegal practices.

However KPIs are not all bad. We should not throw the baby out with the bathwater. KPIs can be effective and a force for good if used by wise leaders. I had the good fortune of being subjected to the rightful application of KPI recently. I was at a meeting which reviewed performance of projects. The senior official in charge candidly admitted that senior management was unsure what should be the most fair and accurate KPI to use. They therefore put up KPIs based on best available evidence. They called for transparent collaboration to fine tune KPIs so that the projects will be on the right track and aligned to the policy intention. Some brought up ground difficulties faced by frontline staff when trying to work towards achieving the KPI's. A rational discussion followed and a joint decision was made to adjust the deliverables. There was intense pressure for the project leaders to compete and deliver outcomes. Results of different project teams were compared with one another openly. However it was done in an open and transparent environment. Lessons learned by different teams were shared in a collegiate manner. There was trust and there were no draconian penalties for failure. Most of us left the meeting feeling enthused and motivated to do better.

Like most tools in life, KPI's are neutral. In the hands of the sincere and wise, it can do wonders. When applied in authoritarian organizations with rigid top down decision-making, it can become sheer poison that brings out the worst of humanity. Just like the dashboard instruments in a car, KPI provide useful data that enhance the performance of competent teams. However it is useless if the elaborate collection of data becomes an end in itself. I think most people can easily recall painful experiences of filling up endless forms that churned data that nobody ever referred to. Worse still, it becomes dangerous when we are forced to drive by the numbers that are churned out by these mindless processes. If you don't know where you should be going, having perfect instrument readings will only bring you further away from your objective at the fastest possible speed. Even if you know where you should be going, it is good to do a reality check once a while. Look out of the windscreen. You might be driving off the cliff at perfect speed and achieving optimum fuel economy.

CM

Running A Good Race

by Dr Nicholas Foo Siang Sern, Editorial Board Member

Earlier this year, I bumped into two old friends at a small track meet. Both of them are now coaching athletics, supervising both school kids and national athletes. We talked about how the running boom has taken off in Singapore, with one of them remarking that there seem to be more road races than the number of weekends in a year! One of them expressed concern at how some people were jumping into these events without adequate preparation and understanding, risking injury in the process.

So here is a succinct write up on running to share some useful principles and cautionary tales:

Let me first declare that I have ZERO coaching qualifications / credentials. However, I'm a runner myself and have had a lifelong interest in running. I've also asked one of my friends mentioned above to vet this piece to ensure what I put out here is sound (credit goes to Mr C Veeramani, especially for the section on Interval Training).

Increasing Mileage Gently

Jack is a 40-year-old chap who took up running 6 months ago. He now runs 3 times a week for 30 minutes each time. He has no outstanding medical or musculoskeletal issues. He wishes to increase his mileage and frequency of running such that he will be able to take part in a 10 km race. How should he go about it?

Jack must first know two things:

1. Musculoskeletal adaptations lag behind cardiovascular adaptations in running. The joints need more time than the cardiovascular system to adapt to an increase in mileage, hence the increments must be gentle.

2. To increase fitness, one Long Run a week is required. The length of the Long Run should be for a minimum of 60 minutes and should be longer if one wishes to prepare for races beyond 10 km.

His 3 sessions per week should be as follows:

Session 1	Session 2	Session 3
30 min	30 min	Start from 30 min. Increase by 2 min per week till 60 min achieved (in about 4 months)

Jack now runs 3 times a week - for 30, 30 and 60 minutes each. He continues this schedule for another month before deciding that he wants to run 5 days a week. He can structure his 5 sessions as follows:

Session 1	Session 2	Session 3	Session 4	Session 5
30 min	15 min	30 min	15 min	60 min

If I take his regular run of 30 min as a unit of 1.0, it can be seen that the ratio of his weekly mileage distribution will be as such:

Session 1	Session 2	Session 3	Session 4	Session 5
1	0.5	1	0.5	2

To put that in words: 2 regular runs, 1 long run twice the duration of a regular run and 2 recovery runs half the duration of a regular run. Jack can then maintain this ratio while gradually increasing the duration of all his runs. When Jack can complete 12 km at an easy pace (can talk while running) on his weekly long run, he can then consider signing up for a 10 km race.

Energy Systems

The 3 Energy Systems we need to develop in running are:
1. ATP- phosphocreatine
2. Anaerobic/lactate
3. Aerobic

These 3 metabolic systems do not work independently. All energy systems are active during exercise, to a greater or lesser extent, with one energy system dominating, depending on the duration and intensity of exercise. For simplicity, think of training for the respective systems as follows:

1. Short sprints of up to 10 seconds
2. Hard running
3. Easy running

Let us come back to Jack. He now runs 4 to 5 times a week, covering 30 km in total, with his Long Run being 12 km in length. He signs up for his first 10 km race and completes it comfortably and decides to sign up for yet another one.

The key to improving distance running is consistency. Jack therefore has to train in a way which is sustainable. Most of his running should be 'Easy' (aerobic). It is also safe to do short sprints year round which improve speed and neuromuscular coordination.

At this point in his running journey, Jack has completed two 10 km races at a comfortable pace. He also does sprints of 3 x 30 m twice a week after his regular runs. He signs up for his third race and now wants to achieve a good timing. He needs to add on

Anaerobic/Lactate Training. Before undertaking Anaerobic/Lactate Training, one needs to have an adequate Aerobic base, something which Jack now has. Aerobic training serves as a buffer and gives you the strength to undertake Anaerobic/Lactate Training.

For a mid-lifer like Jack, the percentage of Hard Running (Anaerobic) to Easy Running (Aerobic) should be 10/90 and certainly not more than 20/80. Anaerobic/Lactate Training should be used judiciously; there is no need to do such training year round.

New Interval Training

The most commonly used form of Anaerobic/Lactate Training is Interval Training.

Jack can now add on some Interval Training for 4-6 weeks, with an additional 10 days for a taper, before race day.

His mileage is 30 km/week, so he can split his mileage to include 27 km of Easy (aerobic) running and 3 km of Hard running (anaerobic) - a 90/10 split.

As mentioned earlier, the Anaerobic/Lactate energy system actually works synergistically with the Aerobic energy system. I've deliberately simplified things here as the whole issue of lactate metabolism can be pretty complicated, but those who are interested can check out *www.newintervaltraining.com*

Once a week, Jack can do what is known as New Interval Training/ Lactate Dynamics Training to cover a distance of 3 km. He can structure it several ways, for example:

1. 3 x 1000 m (400 r/o)
2. 10 x 300 m (100 r/o)

He should transit from the periods of harder running during the repetitions to a period of easy running, for a fixed distance of 100-400m (active roll on recovery or r/o), before transiting back to faster running again. He should pace himself such that the periods of easy running (active roll on recovery) between the periods of harder running (repetitions) are considered part of the workout. The faster repetition sections create more lactate and the easier recovery periods train the body to use and clear lactate efficiently.

For the first workout described above, Jack would run hard for 1000 m (repetition), and then transit to a period of easy running for 400 m (r/o) before transiting to running hard for 1000 m again. 3 x 1000 m would mean that the whole session would consist of 3 repetitions of running hard for 1000 m with easy running of 400 m (r/o) in between and also ending with 400m of easy running.

If he is doing the second workout (10 x 300 m), he can use a shorter distance of 100 m for r/o periods of easy running between the harder repetitions of 300m.

Collapse Point

After Jack has been running for 3 year, with several 10 km races under his belt, He now wishes to do a Half Marathon (21.1 km). How should he proceed? He should now take note of the 'Collapse Point', which was a rule of thumb developed by runners in the 1970s.

The Collapse Point is the maximum theoretical distance a runner can run before he has to slow down dramatically or stop running altogether. His training will not take him further. It is about 3 times the average daily distance he runs.

For example, if you want to run a Marathon (42.195 km), then your average daily mileage should be 14 km. This means your average weekly mileage should be 98 km.

84 km is the number figured in another rule of thumb - the minimum weekly mileage you need to cover in order to complete a Marathon is twice the distance of a Marathon (42.195 km).

To put it simply, runners need to clock between 80 km to 100 km a week in training for a Marathon. The Collapse Point was also used to explain why the longest training run for a Marathon needed to only be up to 32km-cumulative and consistent mileage gave runners enough strength to run the additional 10km to complete a full Marathon on race day.

Let us get back to Jack. When he signed up for his first 10km race, he was running 30 km a week, distributed over 4 to 5 days. His average daily mileage was 4.29 km. His Collapse Point would be 12.87 km. Therefore 10 km would have been a maximal distance for him to race.

We now understand that one can probably run much further than what the Collapse Point predicts. Neither does the Collapse Point factor in how a runner distributes his weekly mileage. However, the concept of the Collapse Point underscores the fact that consistent and cumulative mileage gives you strength. It also shows that a certain amount of mileage is required if one wishes to take part in distance races.

Following the previous principles, Jack should gradually increase his mileage till he is strong enough to handle a Half Marathon and then work onwards to a full Marathon if he so desired.

Conclusion

I have covered some of the basics in this piece on running and training; in truth, I am only scratching the surface. However, the core idea is that consistent and cumulative mileage is required if one wishes to participate in long distance events. It is also prudent to build up a base of easy running before attempting Interval Training. Jumping into these events without adequate preparation is risking injury.

CM

An Interview with Hobbit SMA on Primary Care in Singapore

Interviewed by Dr Lim Khong Jin Michael, Editorial Board Member

Although we at College Mirror did not manage to catch a glimpse of Hobbit SMA (HS), we were able to conduct an email interview with him to garner some of his thoughts on Primary Care in Singapore as we celebrate SG50. For a start, Hobbit SMA pointed out that "*this interview is made in my personal capacity and it does not represent the position of SMA. My association with SMA is merely historical in that I started by contributing to SMA News years ago.*"

College Mirror (CM):
How does Primary Care in Singapore compare with those in other developed countries?

Hobbit SMA (HS):
Singapore is a city. Primary care in a city is different from a country with urban and rural areas. While primary care in Singapore is pretty advanced in many ways, it is also under-developed because of the proximity and availability of hospitals and specialist centres, in a way making life less exciting for General Practitioners (GPs). A significant amount of primary care in Singapore is provided by specialists such as paediatricians and obstetricians.

CM:
How has the landscape of Primary Care changed in Singapore over the last fifty years?

HS:
Much of primary care in Singapore was provided by nurses decades ago. The emphasis then was on public health and preventive health. In the public sector, there were many Maternal and Child Health (MCH) Clinics and OPD (Outpatient department) Clinics. The OPD Clinics catered to the rest of the problems in primary care other than those handled by the MCH Clinics. GP services then were not easily affordable to the general population. Many people self-medicated. Visiting a private GP was a big deal in the sixties and even into the seventies.

CM:
What would you say are positive and negative policies influencing the development of primary care in Singapore and why?

HS:
I feel that the biggest positive policy was the effort to develop Family Medicine (FM) as a discipline. We forget that Singapore, when compared to developed countries, was pretty late in making FM a formal discipline. Our M.Med (FM) was only made available maybe 20 to 25 years ago and the Family Physician Register only a few years ago.

Family Medicine and Family Physicians in the private sector for many years could not develop their skills and services due to the depressant effect of polyclinics' low prices. The Polyclinics for many years was a double-edged sword: it made primary care affordable to many people, but it also hampered the development of the private GP sector. As the private sector GPs could not compete with the polyclinic on price, they often had to resort to being "cough and cold" doctors. This is bad for the patient as well as the polyclinics which only have a 20% market share. The minority provider (polyclinics) depressed the quality and scope of services offered by the majority (private GPs).

This situation still exists today in a limited way. However, policies and programmes such as Community Health Assist Scheme (CHAS) and the Pioneer Generation (PG) Package have addressed this problem significantly in that the subsidies are no longer location-based (only polyclinics) but person and needs-based. The private GP sector now has access to some of the subsidies that MOH gives and can now offer better and more complex services. In other words, there is incentive for the GP to move beyond coughs and colds, so to speak.

CM:
Is the emergence of Managed Care beneficial to Primary Care providers, companies and patients in Singapore?

HS:
Managed Care, in my opinion, is one of the bigger threats facing Primary Care today. Managed Care constrains and constricts Primary Care.

Managed Care as it stands today is a bad thing. Why do I say that? Let's return to the Golden Triangle of Affordability, Quality and Accessibility. First of all, Managed Care exists today in Singapore to simply cut costs for the payer. It does nothing to improve quality, like certain Managed Care organisations in the USA. It also does nothing to improve accessibility.

Improving affordability is in itself not a bad thing except that in Singapore, GPs today are not exactly making big bucks. How many more pounds of flesh can you extract from the GP? But Managed Care here seems to think they can always cut out some more mythical 'fat' every year, year in, year out. In the end, quality of care must suffer.

The other big problem about Managed Care in Singapore is that it is totally unregulated. A managed care entity for all purposes behaves like a healthcare institution (HCI). It can directly affect the price, volume and quality, and even ethics of healthcare services. Yet there is no need to license it under the Private Hospitals and Medical Clinics (PHMC) Act. This is incongruous. No one is held accountable under any piece of health law in Singapore for what a Managed Care company provides in Singapore. It is a big and growing lacuna in health regulation in Singapore.

CM:
How do you think Primary Care will develop in Singapore over the coming years and what are some of the challenges?

HS:
We cannot avoid the demographic change that is coming. The Silver Tsunami will ensure that Primary Care will gain prominence, because specialist and hospital care is expensive.

The funding mechanisms are largely in place, such as the PG Package and the CHAS. They can be refined and improved.

Moving ahead, I think we need a GP centric and patient centric approach to Information Technology (IT) in primary care, instead of one which is Ministry of Health (MOH) centric or IT centric. We need simple stuff that works instead of cumbersome solutions that are expensive to develop and maintain. Without IT as an enabler, a lot of programs that needs to be rolled out cannot happen nationwide. Maybe we can learn from Hong Kong (HK). I understand that the Department of Health in HK worked with the HK Medical Association and gave out a free software to all GPs in HK in the form of a CD ROM disc. Simple, elegant and neat.

Family Medicine is a highly contextual and cultural practice. Family Physicians in Singapore will continue to have special areas of interest and this is a good thing. But we must remember that FM is a "general" discipline in heart and soul. We can develop more peaks but we should not narrow the base of FM training or the skills of the Family Physician and forget to fill up the troughs that we may have. This is the main challenge.

CM

Family Physicians Gearing Up for Home Care

a report on the FPSC Home Care Course

by Dr Tay Wei Yi, Associate Consultant, Department of Family Medicine and Continuing Care, Singapore General Hospital

The College organized a Family Practice Skills Course on Home Care for Family Doctors on the 11th and 12th of July 2015 at the Auditorium of the College of Medicine Building. The timeliness of such a course was evident from the very encouraging turnout by our family doctor colleagues who are very eager to improve their skills in this unique area of family medicine. Home care epitomizes the care of patients in their own environment. It is important as it caters to the medical needs of a group of home bound patients who otherwise would find it difficult or even impossible to seek care in the ambulatory setting.

Dr Matthew Ng kicked off the sessions to a packed auditorium of enthusiastic College members.

Dr Matthew Ng from FMCC SGH kick started the two day course and covered a well digested (pardon the pun) review on enteral feeding tubes and supplements. With so many different supplements available in the market, the audience was given a very practical guide on prescribing supplements for patients on enteral feeds.

Next, Ms Grace Yu, Principal Speech Therapist from Bright Vision Hospital (BVH) gave an overview on the assessment and management of dysphagia. The use of video recordings of videofluoroscopy and fiberoptic endoscopic evaluation of swallowing (FEES) during the teaching enhanced the learning of a topic that was hardly covered in medical school. It was very much appreciated by the audience.

Dr Catherine Chan speaking on long term oxygen therapy for home care patients.

Dr Catherine Chan and Dr Tay Wei Yi from FMCC SGH helmed the topic on respiratory support for home care patients. Dr Chan gave an overview on the indications of long term oxygen therapy, the different oxygen delivery systems and the care of such patients as well as equipment management. Dr Tay Wei Yi spoke on tracheostomy, the indications, complications and care of such patients in the home care setting.

The first day ended with a workshop on enteral feeding tubes and feeds helmed by Madam Magheshwari Sabapathy, Assistant Director of Nursing of BVH. With no willing volunteers from the audience, I agreed to be the "patient" for Madam Maghesh to demonstrate the insertion of a nasogastric tube. I thought, "It probably wouldn't be too bad. If my elderly patients can do it, so can I." Boy, was I wrong! The insertion of the tube was painful and traumatic. After it was in place, the seemingly innocent white silicon tube was a constant noxious irritant to the nose and throat. Each time I breathed or swallowed, it would rub against the throat and tug at my nasal mucosa, triggering a bad bout of rhinitis (even after it was removed). The 10 minute ordeal seemed like 10 hours and I was so relieved when it was removed.

(left) Dr Tay Wei Yi gallantly volunteered to be a human subject for NG tube insertion by Sister Maghesh. (right) After a few traumatic and unsuccessful attempts the tube was finally in place..

(continued on the next page)

(continued from Page 18: Family Physicians Gearing Up for Home Care)

The second day of the workshop started with Dr Low Lian Leng giving an overview of the care of chronic wounds in the home care setting, wound assessment and selection of an appropriate wound dressing.

Dr Jesmine Lee from FMCC SGH followed, with a detailed presentation on common infections in the home bound elderly as well as the trial of treatment that can be reasonably given in the home care setting.

A lively Q & A session on Day 2 with the speakers. From left to right; Dr Michelle Tan, Dr Low Lian Leng, Dr Jesmine Lee and Dr Vincent Chan (Chairman)

All images courtesy of Dr Tay Wei Yi

Next, Dr Michelle Tan FMCC SGH engaged the audience with a topic that is both practical and important: certifying the cause of death. The subsequent Q&A was lively with the audience asking many practical questions on avoiding the pitfalls when certifying death in the home setting.

The second day ended with a hands-on workshop on wound assessment, staging of pressure ulcers and the types of dressings by Senior Staff Nurse Liew Lee Fong of BVH. The participants were presented with various dressings, their indications and dressing technique.

Feedback from the workshop was very positive and many of the participants expressed increased confidence in providing home care to for their home bound patients.

CM

(continued from Page 11: Photo Quiz)

- A larger lesion is seen at the right side of the abdomen. This lesion has a central salmon coloured area and a dark red peripheral zone

WHAT IS THE DIAGNOSIS?

Pityriasis Rosea (PR)

LEARNING POINTS

- Pityriasis Rosea (PR) is a benign rash; the name means "fine pink scale".
- It manifests as an acute, self-limiting papulosquamous eruption with a duration of 6-8 weeks.
- PR has often been considered a viral exanthem and has been linked to URTI.
- The disease typically begins with a solitary patch, usually salmon-coloured, that heralds the eruption and is commonly referred to as the herald patch.
- This initial lesion enlarges over a few days to become a patch with a collarette of fine scales just inside the well demarcated border.
- A generalised exanthem usually follows, with features as described above. In addition, fine scaling and central wrinkling is usually present.
- Pruritus is present in 25-75 % of patients, usually of mild to moderate severity.
- With resolution of the eruption, post-inflammatory pigment changes may be seen.
- PR can be confused with secondary syphilis, therefore a RPR or VDRL test should be performed to rule out this condition, especially if there is suggestion of risks.
- PR is otherwise a self-limiting condition and treatment is merely supportive.

References

1. *Medscape*

WHAT IS THE DIAGNOSIS?

Avascular Necrosis (AVN) of the right hip

LEARNING POINTS

- Avascular Necrosis (AVN) is defined as cellular death of bone components due to interruption of blood supply
- The bone structures collapse, causing bone destruction, pain and loss of joint function
- AVN is most commonly encountered in the hip
- Other locations include the carpals, talus, femur, metatarsal, mandible and humerus
- AVN maybe primary or idiopathic
- AVN that is secondary or associated with numerous conditions including trauma, systemic corticosteroid use and alcohol abuse
- Plain radiographic findings are unremarkable in early stages if AVN. MRI is the most sensitive study and imaging procedure of choice
- Several different staging systems have been developed for AVN
- Several surgical procedures have been used to treat AVN with variable success
- This patient will require a Total Hip Arthroplasty as she has advanced disease

References

1. *Medscape*

CM

EDUCATION FOR BETTER ELDERCARE

BY AGENCY FOR INTEGRATED CARE

To meet the needs of Singapore's ageing population, a substantial increase in capacity is being planned and implemented for the Community Care sector, especially since there is an increasing number of patients being discharged from public hospitals to nursing homes who have higher levels of medical and nursing needs. Managing these patients requires a greater level of care from doctors, and the Graduate Diploma in Palliative Medicine (GDPM), Graduate Diploma in Geriatric Medicine (GDGM) and Graduate Diploma in Family Medicine (GDFM) can equip doctors with the necessary skills and knowledge to care for such elderly patients.

The Agency for Integrated Care (AIC) and Ministry of Health (MOH) are pleased to announce that the Community Care–GP Partnership Training Award is now open for application. This award will fund the course fees for general practitioners (GPs) taking the GDPM, GDGM and GDFM — programmes that are relevant to the needs of the Community Care sector. MOH will co-fund 70% of the course fees under this award, while Community Care institutions that qualify for the Community Silver Trust may tap on this grant to sponsor the remaining 30%.

The Community Care–GP Partnership Training Award is designed to support GPs who would like to step forward to serve the Community Care sector. Armed with new knowledge and skills, GPs will be in a better position to manage complex cases and practise at a higher level of medicine, thus complementing hospital medicine, and benefiting more patients.

As part of the award, GPs get to collaborate with and support their sponsoring Community Care institutions, using what they have learnt. GPs and Community Care institutions are then able to forge closer links, thus seeding and strengthening a longer-term relationship. GPs can also apply their newfound knowledge and skills to meaningful causes outside their practice and connect with other groups of patients who need help.

The Community Care–GP Partnership Training Award is administered by AIC, who is working with the sector and linking up interested GPs and Community Care institutions. If you are interested to find out more, email us today at **GP@aic.sg**.

THE COMMUNITY CARE–GP PARTNERSHIP TRAINING AWARD AT A GLANCE

The study award funds **70%** of course fees for GPs who are enrolled in one of these courses and are sponsored by an eligible Community Care institution:

- Graduate Diploma in Palliative Medicine (GDPM)
- Graduate Diploma in Geriatric Medicine (GDGM)
- Graduate Diploma in Family Medicine (GDFM)

GPs who have gained admission or are currently enrolled in the above programmes are still eligible to apply for the training award through their sponsoring Community Care institution before **31 December 2015**.

Community Care GP-Partnership Training Award is now open for application. Register now!

Email AIC at **GP@aic.sg** for more details and assistance to enrol in the scheme.

The Pivotal Role of the GP in Eldercare

A Sharing by Dr Ajith Damodaran

by Dr Irwin Clement A. Chung Wai Hoong, MCFP(S), Editor

SUPPORTING THE ELDERLY

With Singapore facing a silver wave, general practitioners (GPs) could enhance their capabilities in eldercare through the Graduate Diploma in Palliative Medicine (GDPM), Graduate Diploma in Geriatric Medicine (GDGM) and Graduate Diploma in Family Medicine (GDFM) programmes. GPs enrolled in these programmes stand to benefit from the Community Care–GP Partnership Training Award, which co-funds the course fees and lets GPs gain valuable experience with sponsoring Community Care institutions. This started as an award for GDPM candidates in 2014, and has now been extended to suitable candidates undertaking any of the 3 graduate diploma courses. This was officially launched at the recent ILTC Manpower Awards Ceremony on August 27, 2015.

The intent of this training award is to encourage more GPs to explore working with the community care sector to support services that care for the elderly, disadvantaged and chronic sick, through sponsoring an opportunity for achieving post-graduate qualification. Palliative care award recipient, Dr Ajith Damodaran of Serangoon Garden Clinic & Dispensary, shares with us in AIC his thoughts on palliative care and geriatric care, and the working experience he has with his sponsoring Community Care institution, Orange Valley Nursing Home.

What made you decide to be involved in palliative and geriatric care?

Very early in my career, I did repeated house calls for an elderly patient with terminal prostate cancer who was always in pain, and I didn't know how to help. A Hospice Care volunteer later introduced me to the concept of palliative medicine, and I decided I wanted to learn more, so I took up the GDPM and GDGM.

How has studying palliative and geriatric medicine helped you in your practice?

It opened my eyes to a whole new world — when I see an old patient, I immediately notice the way he walks or sits, little details that reveal things about his health. You also know the kind of questions to ask and understand the concerns elderly patients have. There was a lady, who seemed quite fit in her sixties, and her family worried about why she ventured out of the house less and less often. It occurred to me to ask if she had difficulty controlling her urine, and she said yes. She was afraid to go out because of that, and she didn't tell anyone. Another patient of mine living with lung cancer was having breathing problems. With my knowledge from the GDPM, I was confident in prescribing him medicines to ease his discomfort effectively.

Could you name some challenges you face in helping elderly patients?

Old people think that growing older means that they will become frail and their health will decline all the way, which isn't true. It's because they stop doing things, or rather, everyone around them is too helpful in ensuring that they don't do things for themselves. This deconditioning causes them to become weak, and preventing frailty is really about keeping them active and retaining function.

Another thing is end-of-life issues. For elderly patients with chronic or terminal illnesses, we need to discuss with the patients and their families on the role of care. Sometimes, it's no longer about the patient fighting the disease, but living with the disease.

Tell us about your experience of working with Orange Valley Nursing Home.

I go to Orange Valley twice a week, about two hours each time. I look at day-to-day concerns of the residents, and manage their chronic illnesses, such as high blood pressure and diabetes. Working here has taught me much about initiating or adjusting medications for the elderly. I've learnt things from the nurses, like wound care. I also get more exposure to geriatric ailments such as dementia, and all the concurrent problems such as infection, bedsores, and falls. In palliative care, we plan with the patient's family in advance so that when anything happens to their loved one, they know what to do.

Would you encourage your peers to take the graduate diploma courses and the Community Care–GP Partnership Training Award?

Yes, gaining the knowledge in palliative and geriatric care is satisfying, as it makes a big difference to families, because you know how to manage the last days of their loved ones well. That should be why a doctor would want to take the courses, to make life better for families.

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Two Generations of General Practitioners *in Singapore over the last 50 years*

Interviewed by Dr Lim Khong Jin Michael, Editorial Board Member

I am glad to have had the opportunity to catch up with my primary school classmate, Dr. David Tay (DT). I interviewed him regarding his medical practice, which is a continuation of his father's family clinic that was started fifty years ago. We hope this article will give readers a glimpse of some changes in general practice over the last 50 years and how some doctors feel and cope with them. Dr. David Tay's father (DTF) has also kindly shared some thoughts with us here.

Dr. David Tay and his father in The Medical Clinic consultation room.

College Mirror (CM):
When was this clinic started and when did you take over the clinic from your father?

Dr David Tay (DT):
My dad started Tay Clinic in 1967 with the help of my mom, a registered nurse and midwife, who was trained and qualified in Surrey, UK. Both of them worked in the clinic at Changi Road, situated in the old UMNO House. The clinic had air-conditioning only in the consultation and procedure rooms. As the Tay Clinic was very far from their home, my parents would stay over in the clinic in the afternoons, running three shifts with a heavy workload.

He later briefly joined a medical group that looked after the people around Chinatown and the Singapore River, including the workers and coolies laboring on the riverside tongkangs, but eventually returned to a solo practice in 1987, when he started a clinic up on the 40th floor of the iconic I. M. Pei designed OCBC Centre. Upon completion of my medical studies and training in 1999, I joined my father's clinic. My father handed the management of the clinic to me in 2005, and in 2007, I moved the clinic to the ground floor of OCBC Centre East.

Dr David Tay's Father (DTF):
After David joined my practice for a number of years, I was very happy to find that although some of the older patients still liked to see the older doctor, most of the patients, both young and old, liked David a lot. My old patients gave me feedback that David was a very good doctor, both in medical knowledge and bedside manners. I therefore felt at ease letting David take over the practice.

CM:
What were the challenges of running a medical practice now as compared to many years ago during your father's time?

DT:
My dad had more freedom to run his own practice. Modern medical practice present challenges in different ways. Administrative work such as those involved with managed healthcare, insurance and more complex health regulations add to this. As the clinic grew, there was also the challenge of hiring and managing a bigger headcount. I still work with two staffs from my dad's tenure, but the total staff strength has increased. My staffs continue to be like a family to me. I feel blessed as they are reliable, careful and honest, having been with us for a number of years.

CM:
How would you describe your medical practice?

DT:
It is important to practice evidence-based medicine and there's never been a better time to do so. Back in my father's time, there were fewer clinical practice guidelines to steer general practitioners in good practice and educate our patients on disease progression, prevention and reduction of complications.

Patients are also much more savvy nowadays and they bring reams of research printouts to discuss their concerns and conditions with their doctors. Regardless of who they are, it is my principal to practice 'ICE'. This means paying attention to the patients' ideas, concerns and expectations.

In all my interactions with patients, I aim to be compassionate, and am guided in faith and morals by Micah 6:8,

"He has shown you, O mortal, what is good.
And what does the LORD require of you?
To act justly and to love mercy and to walk humbly with your God."

Despite being in the Central Business District, there are still many opportunities for pro bono work due to the wide disparity of income among my patients. Many part time workers still do not receive sufficient medical insurance cover and can barely spare the time or money for necessary care. Being in private practice does allow me to exercise some degree of flexibility in caring adequately for these individuals despite their limited financial resources, as

well as for those who have given up their lives in the commercial world to serve in the mission field.

I share the same core value as my father in providing medical care to our patients -with humility and gratitude to God for the opportunity to serve and show God's love to His people.

I am also extremely grateful I am able to practice medicine unencumbered to a certain degree as I have my wife to help me with administrative matters in the clinic. This allows me to focus on what I love about general practice, that is, the patients I meet and the friendship, trust and respect that we develop along the way for each other. Their encouragement always spurs me on to be a better doctor and indeed a better person.

DTF:
My patients belong to the older generation. They like to talk a lot about their families and home surroundings. They also tend to have more time to chat compared to the younger patients nowadays who always seem to be in such a hurry and have less time to talk about anything else other than their medical problems.

I still have fond memories of my first practice in the old "Tay Clinic" at Changi Road. It was a medical practice in a village setting. The patients were friendlier, more courteous, humble and respectful. They would greet my staff and I with "good morning" or "good afternoon" and say "thank you" after each clinic visit. They always remembered us during festive seasons such as Christmas, Hari Raya and Chinese New Year, sending us greeting cards and presents, such as cakes and eggs.

At the old "Tay Clinic" I saw patients from the very poor to the very rich and I subsidised those who could afford little. We made house calls to patients in their humble homes where their kitchen larders were empty, and would quietly waive their medical bills. Practicing medicine in a village setting was very fulfilling as we had the privilege to care for families and we in turn grew in the warmth of their trust and friendship.

Dr. David Tay and his wife, his parents and the staff of the Medical Clinic. *All images courtesy of Dr David Tay*

CM:
What do you see in the landscape of private GP clinic today? Is it possible to survive as a solo GP clinic surrounded by group practices? Any advice?

DT:
I think it is possible to survive as a solo general practice if you are earnest, sincere and practice with integrity. People will still come to you. The general practitioner is earning less money than before, given the pressures from managed health care and our current competitive environment, including leases and manpower costs.

Starting your own general practice is not easy. Do it only because you believe in looking after people in a caring and holistic manner, and find meaning and fulfillment in that practice.

Listen to all your patients and prescribe in a thoughtful manner. They all have a story to tell and a reason for being who and what they are. The patients whom I have met have helped to shape the way I practice.

Be involved in volunteer work such as with Healthserve or other medical missions in order to maintain our perspective and responsibility of caring also for the less privileged.

Have a mentor. For me, other than my father, I have found a mentor in Dr Goh Wei Leong, who runs Manhattan Clinic at Chin Swee Road. He chairs the Christian Medical & Dental Fellowship and has been actively involved in medical missions through Operation Mobilisation and Linking Hands, which we started together. Wei Leong has been helping me throughout my career, praying with me and encouraging me to keep to my original values of desiring to care for people humbly before God.

DTF:
In my opinion, there is still a place for solo general practice today. In medical practice the important things to remember are that the doctor must be compassionate, possess sound and current medical knowledge, and keep to the Hippocratic Oath in upholding ethical standards in practice.

CM

Family Practice Skills Course #65

Self Care Techniques

Sat, 30 January 2016: 2.00pm - 5.30pm
Sun, 31 January 2016: 2.00pm - 5.30pm

College of Medicine Building, Auditiorium Level 2, 16 College Road, Singapore 169854

TOPICS

Unit 1: Work Stress Management
Unit 2: Mindfulness techniques
Unit 3: Positive psychology strategies
Unit 4: Emotional regulation
Unit 5: Achieving better sleep
Unit 6: Achieving social connectedness

WORKSHOPS

Day 1: Mindfulness based stress reduction techniques

Day 2: Emotional regulation

SPEAKERS

Dr Lawrence Ng
Dr Tan Wee Chong
Dr Janet Chang
Dr Jean Cheng
Dr Tan Wee Hong
Dr Lim Hui Khim

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, 30 Jan 2016 (2.00pm - 4.00pm)
Seminar 2 • Unit 4 - 6: Sun, 31 Jan 2016 (2.00pm - 4.00pm)

■ WORKSHOPS (1 Core FM CME point per workshop)
Day 1: Sat, 30 Jan 2016 (4.30pm - 5.30pm)
Day 2: Sun, 31 Jan 2016 (4.30pm - 5.30pm)

* Registration is on first-come-first-served basis.
Seats are limited.
Please register by 25 Jan 2016 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 organised by College of Family Physicians Singapore.

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Self Care Techniques

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

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