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COLLEGE ART GALLERY

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Critical Role of Family Physicians

Keynote Address by Ms Yong Ying-I, Permanent Secretary (Health), at the Family Medicine Convocation Ceremony, 4 November 2007

"Thank you for inviting me to join you at your Family Medicine Convocation Dinner. I congratulate you for making the effort to upgrade yourself and your clinical practice. Completing a post-graduate program on a part time basis is not easy at all. I am sure that many of you must have made huge sacrifices, be it your practice, family time or just sacrificing on sleep, so as to succeed and graduate in your respective courses. On behalf of my Ministry, I offer all of you my heartiest congratulations on this happy occasion of your convocation.

GP Profession Key to Successful Healthcare System

I thought that tonight might be a good opportunity for me to speak about the Ministry of Health's thoughts and strategies about Family Medicine. We feel strongly that primary care is critical to a successful healthcare system. My Minister has repeated many times that every Singaporean should have a GP. Today, at some 2000-strong, GPs look after 78% of the primary care patient load.

However, our primary care system today is not well connected with our tertiary care system. Many GPs have told me that you find it difficult to coordinate with the specialists providing tertiary care, or with other healthcare providers in the community. Historically, our system was not designed to integrate primary and tertiary care and it is not structured to support this. We inherited the British healthcare system but while the British have evolved to make GPs the gate-keeper into the NHS system, we have not.

It is partly due to that disconnect that the market environment is a challenging one for GPs. I have heard many stories of GPs struggling to provide the best care to patients amidst long work hours, high costs, potential litigation, and competition from polyclinics. And while some find it difficult to keep your clinics viable, our public sector polyclinics and specialist outpatient clinics in our hospitals are overcrowded.

> **"Singaporeans would be better served if our healthcare system looks not just at treating sickness episodes but supports people staying well."**

My Ministry now believes that Singaporeans would be better served

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Reflections 2007 2008

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

The end of the year is always a good time to take stock of what has been achieved, when the cycle of activities at the College slows down (for an all too brief period).

2007 has been a busy and significant year for the College. The Graduate Diploma in Family Medicine (GDFM) Modular Course teachings continue every quarter. After each teaching module, the e-learning components and MCQs have to be compiled, tutorial notes and tutor's guidelines have to be prepared, and tutorial attendances collated. College also organised the additional GDFM Modules on Consultation, Communication and Counselling (CCC), Professionalism Ethics and Law (PEL), and Principles and Practice of Family Medicine (P&P). Running parallel to this is the Family Practice Skills Course (FPSC), targeted mainly for GPs who are not enrolled in the GDFM or MMed training. 2007 saw a record number of six FPSC courses held.

Family Practice Skills Course 2007

- Diabetes Mellitus (Jan 07)
- Women's Health (Mar 07)
- STI & HIV/AIDS (May 07)
- Function & Disability in Primary Care (Aug 07)
- Value of Vaccination (Sep 07)
- Adolescent Health (Oct 07)

In addition, there was also the GDFM Mock Examinations, the GDFM Examinations being held on 7th July, the Commencement and Convocation Ceremonies, Annual General Meeting, and WONCA. I think the College secretariat staff could easily have spent half their weekends this year involved in College activities. Their tireless energy was crucial to the success of the courses and we have much to thank them for.

WONCA was hosted by the College from 24-27 July and was a great success. Details of WONCA have already been reported in the last issue of College Mirror.

I hope you had not expected some light hearted reading in line with the year-end festive mood, for you will find this issue a bit like reading The Economist from cover to cover. For this I sincerely apologise. I am really grateful for all the great contributions we had for this issue. In particular we had to cover two important events. The first is, of course, the College Convocation held at the Tanglin Club on 4th November 2007. Ms Yong Ying-I's speech provided encouragement from MOH for our GP fraternity, and also had a number of key announcements. We felt that it was important to reproduce her whole speech for you.

The second important event was Conversations with MOH on 20th October. The first results of the Chronic Disease Management Programme, rolled out less than a year ago, was announced. The data showed that mean HbA1C readings submitted by private sector GPs are comparable to that of SOC's and polyclinics. For that, we have much to be proud of.

In this issue, the College Mirror lives up to its name with our theme of Reflections. Our President will give us an update of what activities the College has been involved in, and also his reflections on the significance of each. My article on Existentialism is meant to set us thinking about our work as GPs and reflect on how we have been practicing medicine. Needless to say this article only scratches the surface of this philosophical movement, interested readers should find out more and derive your own conclusions. Dr See Toh Kwok Yee's article on how to write a proper referral letter is a reminder for us to always maintain a high professional standard, especially when it comes to communication with our colleagues. A well written referral letter is more likely to generate a more informative reply.

Dr Gabriel Seow deviates from his usual hints and tips on clinical symptoms and signs; he ends off this issue with a very timely article on Moral and Ethical Principles in Medicine. So Medicine is not only about "doing no harm", but also about doing what is morally and ethically right. To quote a catchphrase from Russell Peters, a Canadian comedian of Indian descent speaking in his Cantonese American accent; "Be a Man! Do the Right Thing!" I take this opportunity to wish fellow colleagues and readers a blessed Christmas and happy New Year. ■CM

Merry Christmas CFPS

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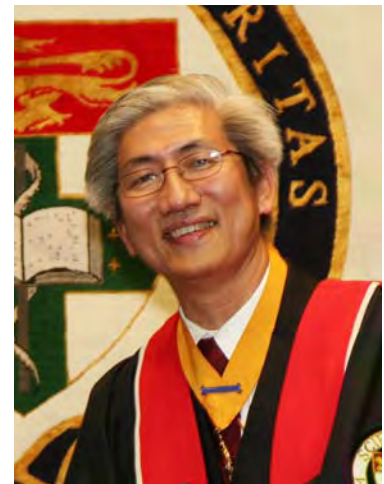
Moving *Forward*

by A/Prof Goh Lee Gan, President, 21st Council, College of Family Physicians Singapore



Ministry's Thoughts & Strategies

At the College Convocation on 4 November, Permanent Secretary (Health) Ms Yong Ying-I, our Guest of Honour, spoke of the Ministry of Health's view that family physicians can and must play a major role in our healthcare delivery system. She said that her Ministry has repeated many times that every Singaporean should have a GP. She shared with the audience the Ministry's thoughts and concrete plans to bring the community forward in primary care.

A better connection between tertiary and primary care will be established to enable the healthcare providers on either side to optimise their care. On top of that, preventive care will be given a bigger focus. The Ministry believes that Singaporeans will be better served if our healthcare system looks not just at treating sickness episodes but at supporting people staying well. It is about wellness, prevention of disease, patient education about how to stay healthy, and helping people manage their chronic disease conditions over the long term (read the details in her speech in this issue of the College Mirror). College Council agree with Ms Yong and her Ministry's efforts. We will certainly play our part in helping our colleagues move forward.

The Influenza Pandemic Primary Care Framework

The Ministry of Health's Influenza Pandemic workgroup has, in collaboration with SMA and CFPS, finalised a pandemic influenza response plan. This was presented in the briefing and discussion with primary care doctors in April this year. The central concept is that in the event of an influenza pandemic, government polyclinics and primary care clinics in the private sector will work together to provide treatment for flu cases. All participating clinics will be equipped with PPE and supplied with anti-viral drugs for treatment and prophylaxis, so that they can continue to manage the sick in the community (see Page 1 of "A Guide to Organising a Primary Care Clinic During an Influenza Pandemic, Version 1 - Jul 2007").

To ensure tight co-ordination, primary care clinics will be organised into geographical clusters linked to the 18 polyclinics for the clustering framework and responsibilities. This configuration will provide the clinics with an established framework for support in manpower resources and information sharing. MOH, together with SMA and CFPS, will appoint an in-charge for each cluster and group. The solo practice clinics will be grouped into these clusters, while the larger GP practices will form their own groupings and manage their clinic outlets as usual. The details are in the Guide.

The Primary Care Framework needs to be formed before it can be tested for readiness. Activities are already being planned for those who have signed up to be in the framework. For example, two pilot sites to kickstart the Polyclinic-GPs Cluster framework are being mooted to test out practical issues on the ground. Sparrowhawk II exercise in November last year was an example of such activities. Such and similar activities will no doubt add to the robustness of our Pandemic Response Plan readiness. We need the participation of everybody in the Primary Care Framework.

> **It is about wellness, prevention of disease, patient education..., and helping people manage their chronic disease conditions over the long term.**

So far 57.6% of the total registered clinics have agreed to participate in the Primary Care Framework. Yet, a total of 37.4% have not replied to the invitation to participate and five percent have declined. If you are in the non-responder group, we will need your answer. Please send in your response to MOH today.

In Consultation with the College Council

The College Council has been asked to give its views on several matters of relevance to our family physicians in recent months. They are: transparency of charges; guidelines for prevention and control of infectious diseases in the child care setting; and the Mental Capacity Bill.

The College Council has in turn sought views from within the Council as well as - where necessary and time permitting - sought views from relevant committees and workgroups within the family physician fraternity.

I would like to take this opportunity to invite you to join the College feedback group. If you would like to be in the feedback group of the College, please drop our Executive Director an email (contact@cfps.org.sg). We would be happy to have your valued input.

Transparency of charges

With regards to the transparency of charges, the Ministry of Health sought views from GPs, the SMA, the two polyclinic clusters, and also the College. The purpose of the feedback is that in order to enable patients to make informed choices, and to provide for greater transparency, the Ministry of Health will be requiring all licensed medical and dental clinics to display clinic charges, and provide patients with information such as bill details, under Regulation 4 of the Private Hospitals and Medical Clinics Regulations.

The Executive Director and I represented the College. Our views were that it would be good practice to define the consultation fees, the itemised drug costs, and other procedure costs. If details were required by the patient, there should be a schedule that the staff can show it to the patient immediately. I also suggested that MOH look into helping GPs have a common bill printing software if there is such a need.

Guidelines for prevention and control of infectious diseases in child care setting

The purpose of this Guideline is to reduce the spread of infection in the child care setting. Views on the exclusion of the child from the pre-school centre were sought from within Council, as well as from the College infectious disease workgroup that was formed since the SARS days.

Essentially, it was felt that a letter from a medical practitioner - to certify that the child is fit to return to the centre - is not required if the child returns to the centre upon expiry of medical certification, is well, and is not on medication. On the other hand, if the child were to return before expiry of medical certification, even if the child looks well, the child will need a letter from the medical practitioner. The letter is also required if the child is still not fully well when returning to the centre upon expiry of medical certification.

Mental Capacity Bill

The College was one of the professional bodies asked to give its comments by MCYS. The following is the feedback from the Healthcare and Medical Sector collated by MCYS. "The medical fraternity agreed that general practitioners (GPs) could perform the assessment of mental capacity. They also recommended that GPs be provided training. However, there is a role for certification by specialists in more complex cases. The medical and healthcare sector saw the need for the Code of Practice to provide more detailed guidance and clarification as to principles of "best interest" and life-threatening situations. MCYS will work together with the Ministry of Health and with the medical and healthcare fraternity to develop the Code of Practice. MCYS will also work with the College of Family Physicians in developing a training programme for General Practitioners in mental capacity assessment."

Committees Formed by the Council to Move the Fraternity Forward

Still on the theme of moving the fraternity forward, this Council has formed a Community Relations Committee, and a Physician Self Care Committee.

Community Relations Committee

The thrust of this Committee is to implement a public awareness campaign regarding the MOH vision of a family physician for every Singaporean. The terms of reference of this Committee will be announced when these are finalised.

Physician Self Care Committee

The vision of this committee is to build a system for the promotion of total physician health, and the management of ill-health including the consequences of set-backs, mishaps, and emotional consequences. The short vision statement will be a system for positive physician health. The terms of reference of this Committee will be announced when these are finalised.

Restructuring the College Secretariat

To serve College members better, the College Secretariat has also been restructured operationally into a matrix organisation with oversight by an Administrative team comprising the Administrative Executive, the Executive Director, Deputy Executive Director, and the President, with participation from the relevant College Secretariat staff.

Into the New Year

Dr Wong Tien Hua gives his reflections on the year. These reflections together with what has been described in this President's Forum will provide food for thought for the agenda for personal development of each of us into the new year.

Let me wish every reader, every supporter, and well wisher of the College a Merry Christmas, and a Happy New Year. May 2008 be a good year for you and your dear ones. ■CM

PRESIDENT
A/Prof Goh Lee Gan

(from page 1 - Critical Roles...)

if our healthcare system looks not just at treating sickness episodes but supports people staying well. In other words, it's about wellness: prevention of disease, patient education about how to stay healthy, helping people manage their chronic disease conditions over the long-term. On the supply-side, this would require integrating care across the spectrum of providers in the healthcare sector so that patients get holistic care. In this framework of holistic care, GPs play a major role.

MOH hosted a GP Forum a few weeks ago, where we discussed our strategies with several hundred GPs. The forum was called "Conversations with MOH - Making Primary Care Work". I think it was well-received, not least because GPs were pleased that they were able to discuss ideas with MOH staff and our public sector clinical leaders as to how we can build a stronger healthcare system together. Not surprisingly, there were GPs who were skeptical about Government's declarations that we want to collaborate with private sector GPs in a holistic care framework. The transformation is a major one; does the Government really mean it and how far are we prepared to follow through? Many GPs see the public sector as providing unfair subsidised competition, and they find it difficult to believe that government wants to right-site care, to drive patients from the public sector to you. I suspect some of you sitting here listening to me have thoughts running through the back of your minds, "where's the catch"?

Yes, I am talking about a major paradigm shift. As I noted at the GP Forum, Government is sincere but building trust takes time. It will also take a lot of hard work and many changes in policies and practices to build an integrated system of care. What is obvious is that we have to do it together, and this requires us to talk together, to listen, to work together and get to know each other and understand each other over time. And through engaging with you, trust will be built up. For sure, we may not be able to solve every problem, because some problems may be really tough. But we can solve some subset of the problems if we put our collective minds into tackling them. This will improve care to patients, which is our collective goal.

Integrating Care and Right-siting Patients

The best thing that I can do to show you that Government's determination to do our part to strengthen the primary care sector is to describe some of the key initiatives that Government is working on. The first is the integration and right-siting of care from specialists to primary care, especially GPs. Where it is clinically appropriate for GPs to provide the care, we hope to get patients to come to you, instead of coming to our SOCs. My Ministry believes that there is significant scope to do this.

"Where it is clinically appropriate for GPs to provide the care, we hope to get patients to come to you..."

For instance, we are designing national clinical protocols and the pathways for patients' discharge from our specialist outpatient clinics. We are beginning with diseases such as asthma, COPD, and cardiovascular diseases, where care is chronic and can be well-managed by family physicians. Using these protocols and pathways, we are working with the SOCs to 'right-site' patients to the GPs. We note your feedback that different RH/Is have different requirements for the GPs working with them on these efforts, even though the diseases are the same. Building on a national set of clinical protocols and pathways for each disease, we are rationalising the requirements amongst the RH/Is and asking them to cross-recognise the GPs working with them.

My Ministry is also working on financial levers to decant patients from SOCs to GPs. This is a difficult topic with many facets. One aspect that we have made progress on is patient financing. Last year, Government allowed Medisave use for chronic diseases. This was a significant shift for Government as it is the first time Medisave use has been allowed for outpatient treatments on a large scale. For the middle class, who have sizeable Medisave savings, this helps to make chronic disease treatments more affordable and accessible. About $15 million from Medisave was used this year. As for other financing initiatives, we are studying how best to help the lower income group with their bills for GP treatment. We may possibly expand the PCPS scheme, which is means-tested, to also cover chronic diseases.

There are challenges that we have yet to solve, but we know it is important to find solutions to. Chief amongst these challenges is drug pricing. Today, many patients come to our SOCs or polyclinics because our drugs are cheaper. Even where we don't subsidise the drugs, the public sector's bulk purchasing power enables us to get the drugs at lower cost than you can. There is a great diversity of views from GPs we have consulted about how to solve this. Views range from Government being the national purchaser and price-setter for all drugs, to allowing GPs to send patients to go to polyclinics to purchase drugs. The issue is complex and will need careful study. In the meantime, I welcome suggestions that you might have.

In the meantime, one GP in our chronic disease management programme inspired me by describing how much she has been able to achieve using only generic drugs. She is forced to prescribe only generics because her patients have lower income. She titrates the mix of generic drugs used, and tracks the outcomes achieved by her patients over time. She is developing a good sense of what is achievable using generics. This is the thinking and learning approach to care that my Ministry is encouraging, and one directly related to your ability to provide quality care at low cost to the patient. Those of you in our chronic disease programme know

"... I hope that you will lead the way in breakthrough practices, ... so that primary care can be raised to greater heights. "

that a core component is the reporting of clinical outcome results. This is not for us to check on you, but to give you a tool to help you assess how your patients are performing. This is crucial to our vision of GPs providing long-term care to their patients, as opposed to episodic care.

My Ministry is also initiating pilot programmes to integrate care between specialists in the tertiary hospitals and GPs. One such programme is the pilot led by Changi General Hospital on how to build closer working relationships with GPs in the eastern region of Singapore. It's sort of like a public-private partnership so that the hospital and its partners are functioning as an integrated healthcare provider. The key idea is to form official corporate partnerships between CGH and the primary care plus the step-down care facilities in the area, supported by IT links and support infrastructure. Government/CGH does not own or control the step-down or primary care operations. CGH is not competing with you for business or patients; instead, its goal is to send its patients to you and to provide better seamless care for its population catchment over the longer-term. This is a totally different corporate goal from the traditional episodic-care model of the tertiary hospitals. But it is an exciting and meaningful goal.

Another big new capability that we are trying to build is to strengthen community-level support for GPs. One program we are rolling out is the nurse-led patient educator program. HPB will hire a floating pool of nurses who will teach patients how to better manage their conditions, and encourage them to make lifestyle changes that are critical to their chronic disease management. Another programme is MOH's partnership with MCYS to hire "Wellness Coordinators" in the community. Today, we have many entities providing care today at the grassroots and community level, especially to the elderly population. Some entities are charities; some are social enterprises. However, they are not networked or coordinated, and there are gaps. People who need support services or treatment may not know where to go. MOH and MCYS hope that our "Wellness Coordinators" on the ground who plug the gap by guiding people to the right services. They are like neutral patient counselors or guides who help patients figure out where to go. We are piloting this in six different constituencies, starting from Jurong West in January next year. These Wellness Coordinators will partner GPs by providing services such as reminders to encourage patients to go for regular follow-ups with their family doctor. If the pilot is successful, we will roll it out nation-wide.

Yet another programme that has been announced is our major push to build community capabilities to support mental health. Hitherto, mental health has been treated as a silo-ed disease, handled by Institute of Mental Health independently of the rest of the healthcare system. Going forward, we hope to build capabilities in the community so that people in front-line institutions - our schools and universities, the workplace and community organizations - are better placed to detect problems early, and hopefully arrange for them to be treated early and the problem resolved before the condition worsens. So we are building awareness and providing training to front-line staff such as counselors in schools. We see GPs as one of the key parties in this community-level infrastructure for mental health.

Assisting GPs

I have shared quite a number of programmes that MOH is either driving or partnering with other agencies to roll-out. Many of you at this point may say "Wow! How do we do all this"? My Ministry is committed to helping you and partnering GPs so that you can succeed. Let me share just briefly plans that we have: First, we will help GPs upgrade their practice though IT and other necessary equipment. In this day and age, IT is necessary infrastructure, at home, at work, at play, and also in the clinic. IT is essential for integration of care - SOCs can only pass electronic records to the GPs and vice versa, if both sides have the necessary IT systems. Work processes can be strengthened by IT. Many GPs using clinic management systems confirm that seeing trending of patients' clinical indicators is much easier and clearer using IT as opposed to paper notes. Beyond the initial learning curve, many also say that administrative processes such as billing and making claims have become fuss-free.

To help GPs adopt IT more quickly, IDA and MOH have partnered together to get some IT vendors to develop clinic management systems centrally and offer it to GPs at competitive prices. Let me make a sales pitch here - if you have not already done so, give it a try and see if it suits your clinic's needs. For other work process improvements, SPRING has a technology adoption fund, along with a suite of other business assistance plans for small businesses, that you can apply for if you are interested. MOH can even give you the forms.

Beyond IT, MOH has decided to facilitate the GPs in their management of diabetic patients by subsidising the cost of Hba1c analysers for GPs who treat many chronic disease patients. The HbA1C analyser will allow you to get the HbA1C result immediately so he can counsel and treat the patient straight away. MOH will announce the details of this assistance soon.

We also need to educate patients about chronic disease management, mental health and other challenges, and how

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they can get help from their GPs. Health Promotion Board is taking the lead on national education, to raise the awareness of Singaporeans on the importance of family physicians; and the importance of chronic disease management. The doctors' toolkits and patient booklets have already been sent to you. We hope that these efforts make patients more receptive to the clinical care you propose to them.

Let me acknowledge here the leadership role that the College of Family Physicians is playing in partnering MOH in strengthening training for GPs, particularly in areas of new need. Prof Satku, my Director of Medical Services, often tells me, that it is easier to be an orthopaedic surgeon than to be a family physician because you have to keep up with advances across the spectrum of medicine. Nationally, we are strengthening the professional development infrastructure. For example, a GP partnership program is being developed in mental health. Interested GPs who join the programme will get further training. We hope to formalise this down the road into a Graduate Diploma in psychiatry program.

Conclusions

I'd like to end by reiterating the Government's view that we believe GPs can and must play a major role in our healthcare system. I hope that the many initiatives and support efforts I've described in my speech show you that I'm not saying this simply because you've invited me here and I have to say something nice, but that MOH is serious about this goal and has concrete plans to back our intentions. The programmes that I have described in my speech tonight have approved government funding to back each and every one of them - Wellness Coordinators, Hba1c analyser subsidy, nurse educators, mental health training, IT assistance, driving right-siting from SOCs to GPs, including the Changi GH pilot, Medisave changes - and we are ready to roll.

As some of the best trained GPs in Singapore, I believe many of you in this room tonight can play important leadership roles in bringing your community forward. With your additional training, I am confident you will be able to serve patients well. But beyond that, I hope that you will lead the way in breakthrough practices, in leveraging IT and other innovations so that primary care can be raised to greater heights. I also hope that all of you will agree to collaborate with MOH because I think that we can be more effective together in delivering on our common objective - better primary healthcare for Singaporeans." ▮CM

Conversations with MOH

Making *Primary Care* Work

"Conversations with MOH - Making Primary Care Work" was an event organised by the Ministry of Health for GPs. Held at The Legends Fort Canning Park on 20 October 2007, it was an opportunity, not only for GPs to hear about what's new from the Ministry, but also a chance for them to tell MOH about issues that affect them.

Excerpts of opening speech by Ms Yong Ying-I, Permanent Secretary, Ministry of Health

On strengthening primary care

"We have focused on funding healthcare nationally and on running our public sector services well. We are now looking at healthcare from a more holistic, national perspective. And we believe that GPs can and should play a major role in the national healthcare landscape. My Ministry therefore thinks it is time that we brought together the GP community for discussions about national level healthcare strategies.

Presently, healthcare overall is still largely episodic and institution-based. My Ministry sees a need to evolve our healthcare system towards one that is more integrated and patient-centric. With a growing elderly population, and a growing chronic disease burden, the need is to manage wellness and prevent or delay problems, and to manage chronic conditions on a continuing basis. Patients therefore need continuing care, not episodic care.

Another driving force for change is the huge numbers of people who see our specialists in our SOCs. Our SOCs are crowded and volume will continue to grow. But not everyone needs to see a specialist for their condition. Right-siting of care to move patients to more suitable providers in the community is a major ongoing initiative for the public sector SOCs.

We hope that GPs will share this view of ours, that family physicians can play a major role in this integrated healthcare system. You have all heard my Minister's vision of "A family physician for every Singaporean". As specialists in the provision of comprehensive, continuing and co-ordinated care, family physicians are equipped with core broad-based medical skills that allow you to deliver holistic and continuing care where tertiary specialists cannot.

Moving on from Chronic Disease Management to networked healthcare

CDMP was a significant policy shift, intended as a major step towards right-siting of treatment. The chronic disease effort also involved widespread adoption of clinical protocols at the primary care level. And it contributed to a major roll-out of standardised IT systems to GPs, hooked into a national platform. This IT supports long-term outcomes tracking, for both primary care physicians and their patients.

The deeper change is in MOH's engagement with GPs. CDMP has drawn GPs, specialists, and MOH into a closer partnership. It has shown that a successful partnership can be achieved. In this regard, let me say that the data we collect from you does not go into a black hole. We will share with you results on Medisave utilization, and also our preliminary analysis of care outcomes of CDMP GPs as a group, as compared to polyclinics, SOCs, and overseas providers. It is a learning and improvement tool.

Another aspect of the deeper change is that we are moving towards a networked system where there are links between parties, whether they are in the public or private sectors, GPs or specialists. This is necessary to enable integration of care. The network is hardware and software. The "hardware" includes the exchange of information through an integrated IT backbone. The software or "mentalware" is about people to people knowledge networks, such as building stronger partnerships and working relationships with SOCs, hospitals, step-down are institutions.

CDMP is symbolic of how I see the future partnership between MOH and GPs developing. For system-level initiatives, like CDMP, Government will spearhead the initiatives. We are inclusive in our approach and hope to have as many of you participate as possible. Of course, we can only involve you to the extent that you choose to participate.

Right-siting from SOCs to GPs - Enlarging community-based care

The second area that I want to mention today is right-siting of clinically suitable patients from SOCs to GPs. My ministry firmly believes there is significant scope for this. At the national level, we are designing integrated clinical protocols and financial levers to decant patients from SOCs to GPs. We are also initiating pilots at multiple levels.

Changi General Hospital is doing a pilot on how it can build closer working relationships with GPs in the eastern region of Singapore so that CGH can conceptually function as an integrated healthcare provider. It will also link up with the network of ILTC providers. The idea is to have official corporate partnerships, supported by IT links and support infrastructure, but Government/CGH does not own or control the step-down or primary care operations. CGH is not competing with you for business or patients; indeed, its goal is to drive patients to you and to provide better seamless care for its population catchment over the longer term. This is a totally different corporate goal, from the traditional episodic care model of the tertiary hospitals. But it is an exciting and meaningful goal. MOH has already

obtained funding from MOF to pay for manpower and IT systems.

The capabilities in the community level need to be strengthened to receive the patients. HPB and our hospitals are partnering to deliver stronger support services for GPs. One initiative they are seriously studying is a floating pool of nurse educators to support GPs. These nurse educators can help you teach patients how to better manage their own health, including better management of their chronic disease conditions.

Another example of strengthening the community capability is MOH's partnership with MCYS on a "Wellness Programme". The theory is that we have many entities providing care today at the grassroots and community level. However, they are not coordinated, and there are gaps. People who need help or need support services may not know where to go to get the right services. MOH and MCYS hope to plug the gap by having "Wellness coordinators" on the ground who can help guide people to the right services. This is a service provided by the government through agents, on a public-service basis; this is not a business. The Wellness Programme is being piloted in six different constituencies, starting from Jurong West in January next year. Elderly residents can get information on health and social services from wellness coordinators, who will link them to GPs like yourselves. They will also partner you to provide services, such as reminders to encourage patients to go for regular follow-ups with their family doctor. Naturally, your information has to be on their database. If these pilots are successful, we will roll them out nation-wide.

Making Primary Care Work: what's new from the Ministry of Health

The outcome of the Chronic Disease Management Programme was highlighted by Dr Jennifer Lee, Director of Health Services Integration Division, MOH. An estimated $15 million will be deducted from Medisave in 2007. GPs account for 23% of the deductions made, with 5% of GP clinics making more than a hundred claims.

Dr Lee further elaborated on how MOH is working towards supporting GPs in the management of chronic diseases such as the development of patient education toolkit and making HbA1C analyzers available to GPs at bulk purchase prices. MOH will further encourage clinics managing more diabetic patients to acquire the analyzer by subsidising cinics which are participating actively in CDMP in a three tier pricing. This new initiative is aimed at improving clinical care by making HbA1C analysers available to point of care. To ensure that more clinics will acquire the analyzer, MOH will keep the cost low. Clinics will have up to Dec 07 to qualify. Clinics will be notified regarding their tier of subsidy in January 2008 . (Please see Figure 1 for more details)

MOH will also be embarking on an Integrated Screening framework where GPs will be called upon to play a key role in the management of patients, both in screening and follow-up.

Figure 1: Tier of subsidy for HbA1c analyser

	CMDP patients	Data submission	Estimated cost of analyzer to clinic
Tier 1	>20 patients	Completed requirement	50% of Tendered price
Tier 2	≥1 but ≤20 patients	Completed requirement	75% of Tendered price
Tier 3	0 patients	-	Tendered price

Clinical Quality Tools for Chronic Disease Management

The afternoon event ended with a presentation by Dr Voo Yau Onn, Clinical Quality Improvement Division of MOH. Participants were shown the preliminary data that has been submitted for the CDMP.

85% of clinics have submitted their data and preliminary review of data have indicated that the mean HbA1C readings submitted by GPs are comparable to that of SOCs and polyclinics.

Figure 2: Screen shot of Clinical Quality Improvement tool

Participants were also given a glimpse of how the data submitted will be fed back to participating CDMP clinics to help clinics use the information as a Clinical Quality Improvement tool to improve patient care. See Figure 2.

Table Discussions

During the table discussions, participants were asked to provide their views on one of the following two topics:

1. How can more of the stable SOC patients be right-sited to GPs?

2. How can Primary Care Partnership Scheme (PCPS) be extended to cover chronic conditions?

A summary of the key points that were discussed is being compiled and this will be shared with doctors when completed.

The forum ended at about 6 pm. MOH would like to thank all those who have participated in the forum.

(GPs who wish to provide their feedback on issues related to their practice may do so by sending your responses to MOH_conversations@moh.gov.sg, we look forward to hearing from you)

CM

Installation of College Mace

at the Family Medicine Convocation 2007

In Memory of Dr Wong Heck Sing

by A/Prof Cheong Pak Yean, Vice President, 21st Council, College of Family Physicians Singapore

The ceremony to install the College Mace began with the screening of a ten-minute video recorded on 2 January 1999, in which the late Dr Wong Heck Sing recounted how the College was formed (see transcript in this article, page 11). A/Prof Cheong Pak Yean then spoke of Dr Wong's contributions to Family Medicine as 'Leader, Practitioner, and Role Model', after which the College Mace was presented by Dr Tan See Leng, Chairman of 2007 Wonca World Conference Host Organising Committee, to A/Prof Goh Lee Gan, President of the College. The ceremony was witnessed by Mrs Patricia Wong and family, Guest of honour Ms Yong Ying-I, Permanent Secretary (Health) and the Family Medicine fraternity.

Dr Wong, the leader

"Dr Wong Heck Sing is remembered as a leader of family medicine. He was a founding father, served as Vice President of the 1st Council, President (1973-1977 and 1983-1985), and steered the College through its early challenges. He was also well respected in the medical profession. He was conferred fellow of the Academy of Medicine in 1975 and honorary member of the Singapore Medical Association in 1998. He served the Nation in the Public Service Commission for 21 years. Minister Mentor Lee Kuan Yew said in an eulogy published in the Straits Times - 7 Mar 2007, "I have known Dr Wong for many decades. The Singapore Government and I would like to place his public services on record."

Dr Wong, the practitioner

We also remember Dr Wong as a family practitioner. Wong Dispensary, which he started in 1953, grew to a multi-doctor, multi-clinic group practice serving patients in rural Bukit Timah and Bukit Panjang for four decades. I was privileged to practice alongside Dr Wong for four years till he retired in 1996.

His parting gift to me on the day he retired was this gadget from his housecall bag. When opened and reassembled (like Russian nested dolls), this instrument becomes sharp trocars and cannulas of various gauges. Dr Wong told me he had used it especially in his early years to diagnose TB pleural effusion, to treat emergencies like pneumothorax, and to relieve suffering of abdominal cancer by draining cancerous fluids in patients' homes. This parting gift is indeed a meaningful reminder of the art and science of medicine that he practiced.

Effectively practising the Art and Science of Family Medicine

The 1st Council of the College (1971-1972)

Dr Wong, the Role Model

Dr Wong believed in role models. This was the theme of his SMA Lecture in 1997 titled 'In Search of Future Role Models in Medicine'[1]. He is indeed a sterling role model for all practitioners.

Dr Wong was always enthusiastic about the College. In 2001, he agreed to be the pro-tem chairman of the Institution of Family Medicine in the College. This was the beginning of an institution that continues to produce the family practice skills courses and the training programmes for our family physicians.

Wong Dispensary, set up in 1953 by Dr Wong, served patients in rural Bukit Timah and Bukit Panjang for four decades.

In 2005, Prof Satku unveiled the Convocation Tapestry commissioned from the initial $10,000 donation Dr Wong made to the IFM in 2001[2]. This year, we are installing the College Mace in memory of Dr Wong Heck Sing as regalia of the College.

Celebration of Past and Present

In July this year, we hosted the Wonca World Conference

a second time round. And it was a successful conference attracting more than two thousand delegates. Wonca is another link to Dr Wong Heck Sing, as he was the President of College when we successfully bid for the first World Wonca congress held in Singapore in 1983.

It is therefore fitting that the Mace is presented by Dr Tan See Leng , the Host Organising Committee Chairman of the 2007 Wonca World Conference."

The College Mace

The idea to install a College Mace was mooted in the article, "Heraldry and Regalia of the College of Family Physicians Singapore". With the successful staging of Wonca World Conference 2007, the 20th Council decided to commission a College Mace in celebration and to remember the contributions of Dr Wong Heck Sing who left us on 4th March 2007.

The mace incorporates the Academic Insignia as its masthead. The College Crest is embossed on its body. It is crafted in Perak, Malaysia, by the skilled craftmen who also crafted the mace of the Malaysian Academy of Family Physicians and the Royal Houses of several states in Malaysia. ∎CM

REFERENCES

1. Wong HS. In Search of Future Role Models in Medicine. SMA Lecture. 1997
2. Ong CP. A Brief History of Recent Times. College Mirror. Vol 33(2). Jun 2007.
3. Aw, Lily. Cheong PY. Heraldry and Regalia of the College of Family Physicians Singapore. Singapore Family Physician. Vol 32(2). Apr-Jun 2006

Transcript of an Interview with Dr Wong Heck Sing

Dr Wong Heck Sing in an interview recorded on 2nd January 1999 narrated how the College was formed and the challenges faced in the early years.

"In 1969, I went to Australia to look for schools for my children. I stayed with my brother who migrated to Australia in the 1950s. He had a neighbour, a GP called Dr Geeves – Richard Geeves who later became the Chief Censor of Australian College and the first external examiner for our College.

Dr Geeves had just taken his FRACGP examination and was very excited about it. The Royal Australian College of General Practitioners (RACGP) was founded several years before that. It was still a young college. Dr Geeves was very keen that all GPs should be upgraded. We chatted over the fence and he invited me over to his house to see all the question papers of the examination.

Prof Wesley Fabb and Mrs Fabb, A/Prof Goh Lee Gan, A/Prof Cheong Pak Yean, and Dr Richard Geeves in the Annual Convention of Royal Australian College of General Practitioners, Tasmania, 2003

I saw all the question papers. They were very thorough. Dr. Geeves asked if I would like to go down to the College and meet the council members. I said "yes". Just before I went, I had a word with Dr. Colin Marcus who at that time was very prominent in the Society of Private Practice in Singapore. Dr. Colin Marcus said that we couldn't form any college until we got a charter from the Government. So this was the same question I posted to the Council of the Australian College. I asked, "How do you form your college?" They said, "We had a meeting with many people and we all decided we should form a college" "Do you have a charter?" "No, you can't wait for a charter. The charter comes to you later on."

So I went back and called Dr. Colin Marcus and he was very excited about it. Dr. Colin Marcus at that time was holding a senior position in the Society of Private Practice, and at the same time he was also a council member of the Singapore Medical Association (SMA). So he said, "Look, you went down to Australia for a fact finding mission. Why don't you give the SMA a talk about what you found?" So, somewhere in 1969, they arranged for a forum to be held on the desirability of founding of the College of General Practitioners in Singapore along the line of the Australian college and British college. I was the first speaker. I spoke of what I found, that no charter was required. In November 1970, the Society of Private Practice took the initiative to form a pro-tem committee to found the College of GPs. That's where I came in (as the pro-tem chairman and then Vice-President of the first Council).

The year when we founded our College (in 1971), I wrote to the British College asking for their help in examinations. They were not interested. Dr. Koh Eng Kheng had ties with the UK College, but they were more or less too busy. So I went to Australia and the Australia College did a lot of things for us. First of all, it agreed to send their examiners to us and secondly offered to train our examiners. So we sent two persons for training, one was Dr. Wong Kum Hoong, and the other was Dr. James Chang. They both went to Australia for training to become examiners. Then Australia, at their own expenses, sent the first two external examiners, Drs. Richard Geeves and Wes Fabb. Later on, they sent other people.

Not only that, Australia said, since we sent some examiners, if your doctors pass your membership examination we would recognize your diploma as equal to ours viz. the MCGP the same as MRACGP. So on that account, I went to see Dr. Ho Guan Lim, the Permanent Secretary of the Ministry of Health and asked "Why don't you recognize the Singapore College diploma on the ground that we got external examiners, and the Australian College had recognized our diploma." So Dr. Ho viewed all that. Of course, he asked for proof and then very generously agreed that the Ministry would recognise our diploma, the MCGP. So MCGP was the first private diploma recognised by the Singapore Medical Council. "

21st Council
College of Family Physicians Singapore

Council Members of CFPS with Permanent Secretary (Health)
Standing (L-R): Dr Lawrence Ng Chee Lian (Honorary Editor), Dr Adrian Ee Guan Liang, Dr Lew Yii Jen, Dr Rukshini Puvanendran, Dr Chow Mun Hong.
Seated (L-R): Dr Lim Fong Seng (Honorary Treasurer), Dr Lee Kheng Hock (Censor-in-Chief), A/Prof Goh Lee Gan (President), Ms Yong Ying-I (Permanent Secretary [Health]), A/Prof Cheong Pak Yean (Vice President), Dr Cheng Heng Lee (Honorary Secretary),
Not in photo: Dr Jonathan Pang Sze Kang, Dr Michael Wong Tack Keong.

GDFM Book Prize Recipient (2007), Dr Goh Chee Hwei

Albert & Mary Lim Award Recipient (2007), Dr Ling Sing Lin

GDFM Book Prize Recipient (2007), Dr Ho Yew Mun

Albert & Mary Lim Award Recipient (2007), Dr Yii Hee Seng

A/Prof Cheong Pak Yean, Vice President of the College, presenting a tribute to Dr Wong Heck Sing

Albert & Mary Lim Award Recipient (2007), Dr Tan See Leng

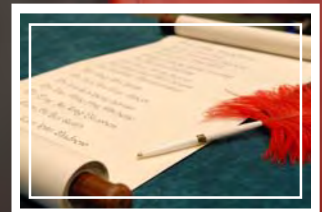
Seated at the front row: Dr Lawrence Ng, Dr Cheng Heng Lee, Ms Yong Ying-I, Dr Lim Fong Seng, and Dr Ho Han Kwee

A/Prof Goh Lee Gan, President of the College, receiving the Mace from Dr Tan See Leng, Chairman of Wonca 2007 HOC

The new batch of Fellows / FCFP(S) signing the College scroll (in the picture: Dr Loke Kam Weng)

Gracing the night was Ms Yong Ying-I, Permanent Secretary (Health), as our Guest of Honour.

Dr Rukshini Puvanendran, emcee for the Ceremony



CONVOCATION 2007
- THE TANGLIN CLUB

FCFP(S)

Standing:
Dr Siew Chee Weng, Dr Loke Kam Weng, Dr Sim Kok Ping, Dr Tan Yew Seng, Dr Ng Lai Peng
Seated: Dr Lee Kheng Hock (Censor-in-Chief), A/Prof Goh Lee Gan (President), A/Prof Cheong Pak Yean (Vice President)

MCFP(S)

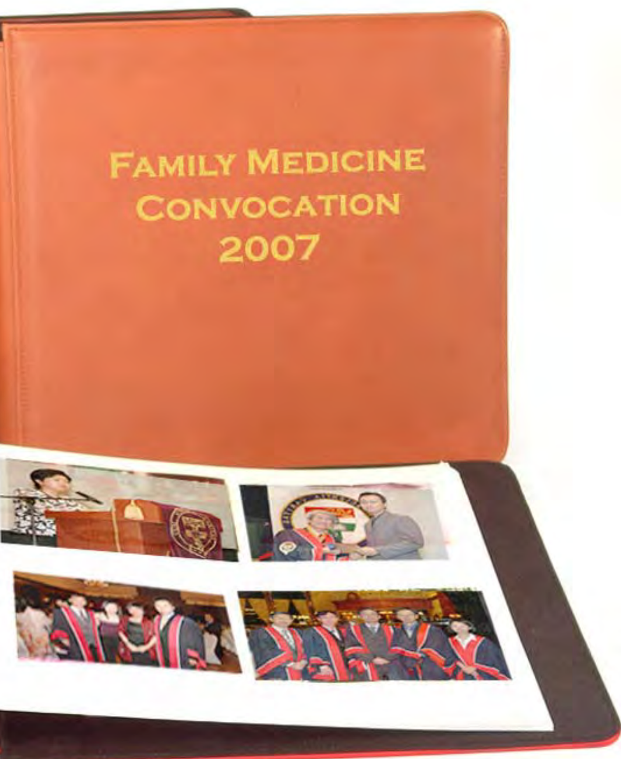
Standing: Drs Sabrina Wong Kay Wye, Andrew Wee Kien Han, Keith Tsou Yu Kei, Lee Mun Tuck, Stephen Tong Jia Jong, Albert Soh Yew Chye, Chong Chun Hon, Sng Wei Kwan, Adrian Tan Kok Heng, Dale Lim Lee Min, Michelle Tan Ming Ying.
Seated: Drs Karen Ho May San, Rukshini Puvanendran, Joanne Quah Hui Min, Lee Kheng Hock (Censor-in-Chief), A/Prof Goh Lee Gan (President), A/Prof Cheong Pak Yean (Vice President), Molly Yong, Patricia Lee Sueh Ying, Charity Low Cheng Hong.

MMed(FM)

Standing: Drs David Ng Chee Chin, Farhad Fakhrudin Vasanwala, Ian Phoon Kwong Yun, Chan Wan Ern, Andy Lo, Lim Jui Hon, Nor Azhar bin Mohd Zam, Loh Zhi Ming, Michael Wong Wen Yao.
Seated: Drs John Chiam Yih Hsing, Yang Sze Yee, A/Prof Cheong Pak Yean (Vice President), A/Prof Goh Lee Gan (President), Lee Kheng Hock (Censor-in-Chief), Alice Lee, Jason Yap Soo Kor.

GDFM

Standing (Top): Drs Soh Wah Ngee, Kwek Thiam Soo, Mervin Lim Lok Houw, Roy Teow Kay Leong, Boey Kok Hoe, Lee Oh Chong Leng, Yap Eng Chew, Gilbert Sim Buan Lee, Elias Tam Tak Chuen, Yeo Wai Pan, Richard Lee Meng Kam, Nicholas Foo Siang Sern, Swee Yong Peng, Lim Chin Wei, Heng Kuan Yong, Adam Patrick
Standing (Mid): Drs Gary Ong Pang Yeow, Yoong It Siang, Koh Hau-Tek, Lim U-Lin Queenie, Tan Ru Yuh, Radha Krishnasamy, Ong Woon Ching, Lim Wee Ni, Chan Miow-Swan, Tin Cho Htwe, Agnes Koong Ying Leng, Chow Wai Leng, Lester Leong Wen-Pin, Lee Kong How, Chen Sze Sin, Raymond Tham Meng Choong.
Seated: Drs Ho Yew Mun, Jean-Jasmin Lee Mi-Li, Shirley Lee Ching Yit, Phoon Chiu Yong, A/Prof Cheong Pak Yean (Vice President), A/Prof Goh Lee Gan (President), Lee Kheng Hock (Censor-in-Chief), Janet Gouw, Iroshini Chua, Sarina Omar, Goh Chee Hwei.



(L-R): Dr Tan Yew Seng, Dr Siew Chee Weng, Dr Loke Kam Weng, Dr Sim Kok Ping, and Dr Ng Lay Peng

Dr Lee Kheng Hock, Censor-in-Chief, leading the Academic Procession

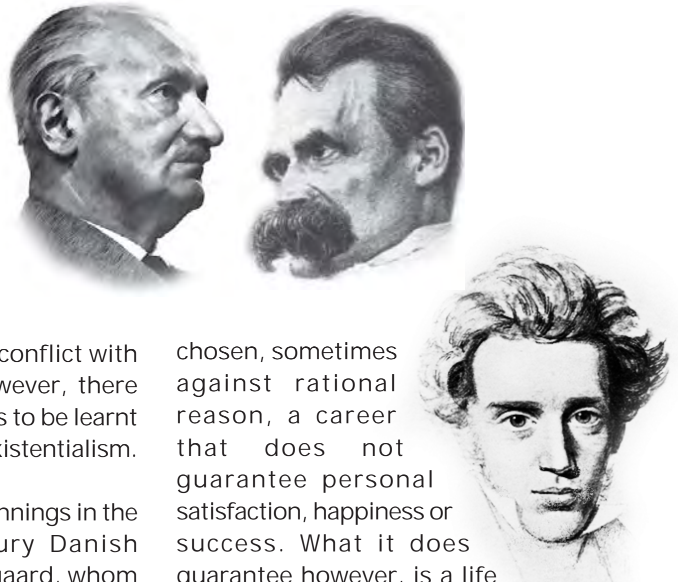
Convocation Dinner at the Churchil Room, The Tanglin Club

Family Medicine fraternity celebrated another fruitful year with the new batch of FM Graduates.

Existentialism

A reflection for Family Practitioners

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



The Greek philosopher Socrates once said - The unexamined life is not worth living. We all need to figure out what we want from life. Similarly, in our work as General Practitioners (GPs), we should, from time to time, examine and evaluate how we are doing as healthcare professionals. What better time than at the end of the year, when we can sit back to take stock of the events that have passed, and perhaps reflect on what has been achieved.

It is very easy for us GPs to be caught up in the daily grind of life, attending to patients day in and day out. With whatever little time we have left, we need to catch up with our family responsibilities, and set aside some time for personal hobbies and interests.

Time passes very quickly.

I wonder if we have ever asked ourselves the difficult question - what does it mean to exist as a GP? Is there more to GP life than the daily grind of attending to the nth number of URTI and GE cases?

This article serves as a brief introduction to Existentialism. To those not familiar with this philosophical movement, it will hopefully stimulate further questions and reading on the subject.

What is Existentialism?

Existentialism is a twentieth century philosophical movement which focuses on the individual human being, claiming that each person has the responsibility to create meaning in their own lives. Because each person has free will and choice, they have ultimate responsibility over their own destiny. Existentialism may not be everyone's cup of tea; its detractors accuse this movement of being too humanistic and self-centered; it may also conflict with ones' religious belief. However, there are many applicable lessons to be learnt from the philosophers of Existentialism.

The movement had its beginnings in the writings of 19th Century Danish philosopher Soren Kierkegaard, whom many regard as its founder. Other important figures are listed in box:

Names associated with Existentialism:

Soren Kierkegaard (1813-1855) Danish philosopher and theologian. Father of Existentialism.

Friedrich Nietzsche (1844-1900) German philosopher who coined the famous aphorism: "That which does not destroy us makes us stronger".

Jean-Paul Sartre (1905 - 1980) a leading 20th century French existentialist.

Albert Camus (1913-1960) French author and philosopher. He won the Nobel prize for Literature in 1957. Novels include - The Plague, The Stranger, and The Fall.

Martin Heidegger (1889-1976) one of the most original and important philosophers of the 20th century, contributed in such diverse fields as phenomenology, existentialism, hermeneutics, political theory, psychology, and theology. His main concern was ontology or the study of being.

What does it mean to exist?

Soren Kierkegaard (1813-1855) was a prolific Danish philosopher and theologian, who coined the famous term "The Leap of Faith". Faith is a belief in something for which there is no proof or evidence. Many of us GPs have chosen, sometimes against rational reason, a career that does not guarantee personal satisfaction, happiness or success. What it does guarantee however, is a life of long work hours, personal sacrifice, and professional isolation. Perhaps this can be considered a leap of faith.

Kierkegaard was concerned with the existence of human beings. Since we all only exist for a short period in time, the idea of our 'existence' is one of urgency. To be sure, there are many people who live their lives perfectly well without having to worry about such things, but to Kierkegaard, these people would have been merely copycats, they would not have existed as individuals. Existence is being able to be distinguished from "the crowd" and is something that has to be strived for instead of being born with.

Another central existential doctrine is the freedom of the individual. We all constantly make choices about what we do with our lives, which ultimately determine the sort of person that we become. The individual must therefore take ownership of these choices and be solely responsible for its outcomes. The sense of responsibility that comes with making irreversible choices through life is an unpleasant truth that often manifests in a sense of anxiety and dread.

Kierkegaard recognised this deep anxiety of human existence - the feeling that there is no purpose at its core. (Not everything that Kierkegaard wrote was about despair; he was also a great theologian and was able to offer religious advice in leading a purposeful life).

Quoting from Wikipedia: "Finding a way

to counter this nothingness, by embracing existence, is the fundamental theme of existentialism.... Someone who believes fundamentally in existence, and seeks to find meaning in his or her life solely by embracing existence, is an existentialist."

What does it meant to exist-as a GP?

We can draw some lessons and insights from Kierkegaard's thoughts.

Firstly, we have to accept that we have made a "leap of faith" in our career choices. These choices are mostly irreversible and we have to take responsibility for them.

Secondly, as in all careers, most of us go through our daily work without much thought or reflection. Some carry a sense of anxiety and dread and struggle for meaning in our "dull and repetitive" work. For Kierkegaard, this form of existence is not a true existence.

We therefore need to constantly reflect and to remind ourselves of our first calling when we went into Medicine, of the ideals and the ethics that we professed, and to keep our work as primary care givers in the community in its perspective. We need to develop a long term view when seeing patients and to take time to nurture the doctor-patient relationship, which is the key in transcending individual episodic care to one of holistic long term care.

Finally, we need to continue to be passionate about our work as GPs. Kierkegaard wrote that the truths that determine our existence are subjective; it is the passion and intensity of our beliefs that determines these truths.

Existentialism in Practice-Reductionist vs. holistic medicine

The French philosopher and mathematician René Descartes (1596-1650) regarded the human body as a machine, whose functions can be broken down into many smaller and independent processes. Because the processes are "reduced" into more basic units, this approach has been termed "reductionism" and has been the predominant paradigm in medicine. Today, specialists define themselves with reference to body parts (Eye, ENT, O&G), systems (endocrinology, haematology), and technology (radiology, anaesthesia)

Descartes' view did not only apply to the physical being, but also in terms of psychology and the mind. He was of the opinion that we human beings have minds and bodies which are quite divorced from each other. Each of us has minds which can only grasp with any certainty only that which is our own. Much like a mind trapped in isolation, encased in a rigid skeletal shell. Today, scientific advancements such as MRI have made tremendous inroads into the study of the physical brain. Despite this, there is still much debate on what is the Mind and what is the Brain. 'Dualism' is the idea that the mind (the consciousness of self) though inhabiting the brain has an existence of its own and thus should not be equated with the brain.Unfortunately, this tendency for human beings to take apart what they wish to understand often leads to disappointing results, Descartes' approach often does not take into account the context in which the problem exists.

Existentialism attempts to discover and explain the nature of the human as an individual being.

Martin Heidegger (1889-1976) was an influential and controversial German philosopher, whose work has often been associated with existentialism. Heidegger perceived the essence of human existence as "Being-in-the world". For Heidegger, we human beings have been inseparably "thrown" into a world in which we do not exist in isolation. Existence is always Being-in-the world, and the world is our context.

What this implies for the practice of medicine is that the relationship between doctor and patient cannot be a simple relationship of 'observer' and 'observed'. The patient cannot be understood in isolation, and the space for the therapeutic relationship is not one that is trapped within the patients mind. The doctor needs to see each patient in the context of the world in which the patient inhabits, and needless to say, this is unique for each patient.

Existentialism therefore differentiates itself from this rationalist tradition of philosophers such as Descartes, by rejecting the mechanistic view of the human organism. Existentialism attempts to discover and explain the nature of the human as an individual being. In medicine, this means that the doctor-patient relationship should play a central role in order for doctors to address problems of social, psychological and spiritual character.

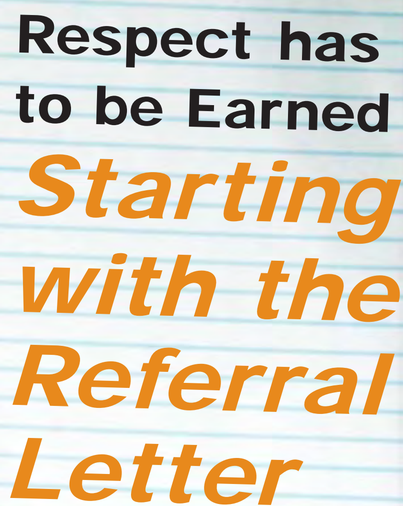
Socrates criticised Greek physicians in his day for foolishly neglecting the whole when attempting to heal a part. He argued that "just as one must not attempt to cure the eyes without the head or the head without the body, so neither the body without the soul". ■CM

REFERENCES

1. Robinson D, Zarate O. Introducing Kierkegaard. Cambridge. Icon Books Ltd, 2006.
2. Cohn HW, Heidegger and the Roots of Existential Therapy. London. Continuum Books, 2002
3. Solomon RC. No Excuses: Existentialism and the Meaning of Life. The Teaching Company. http://www.teach12.com
4. Existentialism. http://en.wikipedia. org/wiki/ Existentialism. (accessed 8 Nov 2007).

The Author wishes to thank Prof Cheong Pak Yean for his guidance and ideas in the writing of this article.

Part 2 on the theme of Reflections will continue in the next issue of the College Mirror. We will look at 2 illustrative stories - The Myth of Sisyphus by Albert Camus, and The Allegory of the Cave, by Plato. The former addresses the issue of repetitive work that GPs face, the latter addresses the issue of professional development of the GP.



Respect has to be Earned
Starting with the Referral Letter

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

Over the years as a GP, I have on many occasions received reports from my devoted patients about less than flattering remarks made about my work by my hospital colleagues upon the former's return to my clinic following a referral.

Comments like, "I can dress your wound better than your GP", "This medicine can make you bloated!" (when I had prescribed prednisolone 20mg PO for five days for acute bronchial asthma), "Didn't he listen to your heart, it could be a heart attack" (as though a diagnosis can be made this way) and the magnum opus "He gave you the wrong medicine!" (when taken to mean an adverse reaction previously unknown).

Flabbergasted, angry and thoughts of changing vocation immediately inundate my mind. But I have always managed to banish these negative thoughts partly from maturity but more so for the fact that my informant patients have continued to trust me and I owe them a duty of care.

From my interaction with other like-minded GPs, I take comfort that my affliction is not unique.

In fact, from my reading, the phenomenon of making derogatory remarks about fellow colleagues is regretfully quite common.

The referral letter is the initial and sometimes only point of communication between GPs and hospital doctors.

Insomuch as the term Medical Badmouthing was invented and defined as "unwarranted, negative and denigratory comments made by doctors about other doctors in different branches of medicine".

Why then, a GP like myself, is receiving scarce respect from my hospital colleagues?

Instead of fruitless bemoaning one's fate and putting the blame on others, perhaps, we can embark on a little self-searching to improve ourselves and hopefully, in doing so, will earn the respect of our peers and others.

We should start with the man in the mirror and change his ways.

One area where we can improve upon is our referral letter.

The referral letter is the initial and sometime only point of communication between GPs and hospital doctors.

First impression counts and a good referral letter is seen to be of value in terms of more accurate diagnosis, quicker patient processing , less investigations and better responses from the receiving doctors.

It is said that Emergency physicians dislike letters which simply state 'please see and treat".

A busy clinic and lack of time to write a proper referral should not be excuse for the paucity of information.

After all, our hospital specialists are

equally harried and yet we always expect them to oblige us with prompt, informative and educational replies.

Another important consideration must be that our patients should be rewarded with a useful referral letter for seeking our assessment first; they could have bypassed us and gone straight to a specialist or the Emergency Department.

In a survey of Australian Emergency Physicians' expectations of General Practitioners' referrals, the following items were deemed to be valuable inclusions and ingredients of a good referral:

1. Referring doctor's name, address, telephone number and qualifications.
2. Chronological sequence of symptoms or events.
3. Provisional diagnosis or clear problem definition.
4. Full relevant past history.
5. Results of investigations performed.
6. Vital signs and relevant clinical findings.
7. Allergies.
8. List of current medications.
9. Details of emergency treatment administered by the GP.

In another survey to gauge Australian Gastroenterologists and Rhematologists's expectations of GPs' referral letters, both groups of specialists held similar views on the importance of various aspects of the referral letter. These items in descending order of perceived importance are:

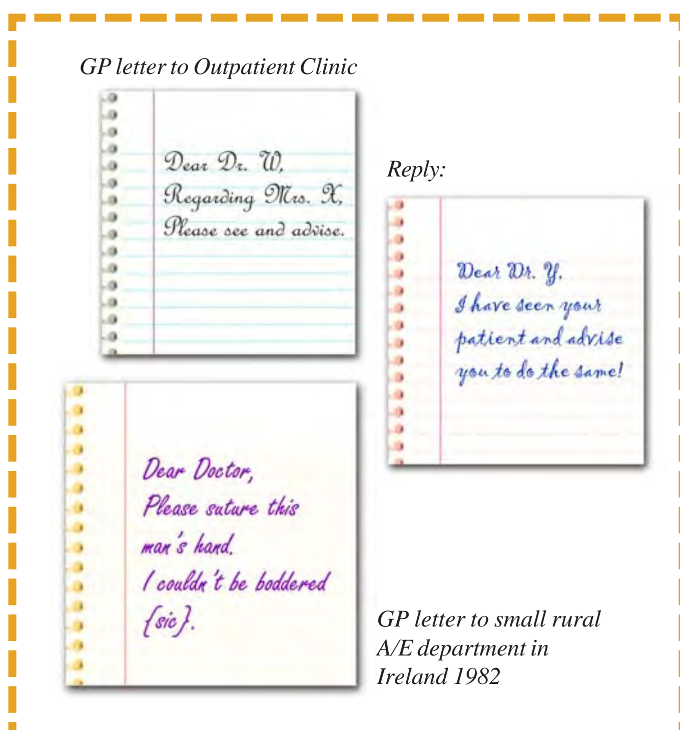
1. Reason for referral.
2. Investigations and results.
3. Current medications.
4. Legibility.
5. Past medical history.
6. Drug Allergy.
7. Family history.
8. Examination findings.
9. Social history.

It has been suggested that structured form letters, which are generally shorter (and therefore, quicker to fill in) and contains more information, are better than non-form letters.

We should take the time and effort to compose a good referral letter so that we can communicate effectively with our hospital colleagues to improve patient care and this, in turn, will augur well in our quest for respect.

Wrapping up on a lighter note, the following referral letters, I am certain, will not garner any friends nor respect whatsoever. ■CM

GP letter to Outpatient Clinic



Reply:

GP letter to small rural A/E department in Ireland 1982

The following list of information a good GP referral letter should contain has been proposed (9):

1. Presenting problem.
2. History of presenting problem.
3. Clinical findings.
4. Current medications.
5. Allergies.
6. Previous treatment of presenting problems and outcomes.
7. Past medical history.
8. Social History.
9. Results of investigations.
10. Reasons for referral.
11. Expectation of follow-up
12. Urgency of referral.

(It will often not be relevant to include all these items and the information required will vary between specialties.)

REFERENCES

1. Primary and Specialist Care: Competition or Co-operation? LH Lim, The Singapore Physician.
2. Badmouthing GPs, The Medical Journal of Australia, MJA 2003.
3. A Study of Communication between General Practitioners and Specialists, RF Westerman et al, British Journal of General Practice, NOV 1990.
4. The Singapore Medical Council Ethical Code and Ethical Guidelines, JAN 2002.
5. Medical Humour. World's Worse Referral Letters. http://www.jwolfe.clara.net/Humour/Anecdotes.htm#Referrals
6. Survey of Australian Emergency Physicians' Expectations of General Practitioner referrals. Michael Montalto et al, British Journal of General Practice, JUL 1993.
7. General Practitioners' referral letters. Do they meet the expectations of gastroenterologists and hematologists? Sia Peng Ong et al, Australian Family Physician Vol. 35, No. 11, NOV 2006.
8. A Textbook of Family Medicine. Ian R. McWhinney.
9. http://www.gpnotebook.co.uk/simplepage.cfm?ID=1443233860
10. Michael Jackson, Man In The Mirror.

Dr Kok Jaan Yang

Challenging Ground of Palliative Medicine

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

You were trained in family medicine, and are now practising palliative care/hospice care. Why have you chosen this path?

KJY: In 1988, I was a Second Year Medical Student and my mother was dying from advanced cancer. At that time, hospice movement in Singapore was just starting. I was moved when Dr Anne Merrimen visited my mother at our 3-room HDB flat during the Lunar New Year period. After my mother passed on, I developed a passion for hospice/ palliative care. I became a volunteer doctor with Hospice Care Association in 1992 after I completed my housemanship; I helped to do the calls and visited patients at home during the weekends. However, after one year, due to frequent sailing during my National Service and subsequently when I enrolled into the MMed Family Medicine Programme, I lost touch with the hospice community for quite a while. In early 2000 after I had completed my MMed (Family Medicine), I was introduced to Dr Koo Wen Hsin He was then the Medical Director of Dover Park Hospice. I joined them as a Registrar in their pioneer programme to craft a career path for those interested in pursuing a career in palliative medicine. Now, I'm doing things I am interested in and getting paid for it - why not?

What kind(s) of training or preparation is required for someone keen to follow in your footsteps? What kind of doctor will do well?

KJY: When I first started as a Registrar in 2000, there was no formal training programme in Palliative Medicine in Singapore. We had to self-learn and to learn from those were already in the field. I took the Postgraduate Diploma in Palliative Medicine Course - Cardiff (distant-learning) in 2002 and I was attached to the Department of Palliative Care Medicine, St Vincent's Hospital Melbourne, for a year under the MOH HMDP programme from Jun 2004 to May 2005.

Now things are much easier as the training path is very clear. Palliative Medicine has now been recognised as a "Subspecialty", together with Sports Medicine and Intensive Care Medicine.

Dr Kok Jaan Yang and family

The Palliative Medicine Subspecialty Training commenced in May 2007. MMed (Family Medicine) is one of the entry criteria to enroll into this three-year training programme. Successful candidates who complete this training will be accredited as a Palliative Medicine Subspecialist. We already have our first 4 trainees in this programme.

Palliative Medicine and Family Medicine are similar in many ways. It focuses on holistic assessment and management, supporting the patients and their families, and co-ordinating their care between acute hospital settings and community-based services. A career in Palliative Medicine can be very rewarding if you have the passion to assist the patients with end-of-life care issues. If you have MMed (Family Medicine) and are keen to pursue a career in Palliative Medicine, you can send an email to me at this address: kokjy@doverpark.org.sg.

What is your typical day/ week like?

KJY: A typical day is a mixture of clinical duties, training activities, administrative work and planning. I do morning rounds with my Medical Officer and Registrar in Dover Park Hospice and sometimes afternoon rounds to review new admissions. I have many concurrent portfolios which take up the majority of my working time. I spend two sessions a week in NUH Department of Haematology-Oncology as a Visiting Palliative Care Consultant, to help to manage patients with palliative care issues in the ward. At the moment, I am helping a home hospice care service to restructure its services. I lecture to doctors and nurses at both postgraduate and undergraduate levels. I am currently a Clinical Tutor and the chief co-ordinator of the Medical Student Programme in Palliative Care. I am also one of the 5 members of the newly formed Palliative Medicine Subspecialty Training Committee, appointed by Specialists Accreditation Board. In addition, I am the Chairman of the Organising Committee of the Singapore Palliative Care Conference 2008 and the Chairman of the Training & Research Committee of the Singapore Hospice Council. So I'm rather busy, and definitely keen to see more colleagues taking up this challenge.

What is most satisfying to you about your work? What keeps you going?

KJY: What is most satisfying to me and my work? To be part of the overall palliative care healthcare community to provide support to our patients who require end-of-life care. I have also a good mix of clinical work, training responsibility, administrative duties and other portfolios to make my days challenging.

What keeps me going? A supportive boss and organisation, a strong team of like-minded colleagues, and the many ***thank you*** notes from the families of our ex-patients. ▮CM

Dr Kok Jaan Yang is practising as a Consultant at Dover Park Hospice, 10 Jalan Tan Tock Seng, Singapore 308436.

Medical Mediation Workshop

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

"Wow! Learn to be a Mediator!" It was with a sense of excitement and anticipation that I approached this very interesting learning opportunity offered by the Ministry of Health (MOH), held at the ultra-modern, spanking new (ok, not so new, but I haven't been around that much) Supreme Court building (also known as the Flying Saucer behind the former High Court).

Over the next 2 days, nearly 30 doctors (with a smattering of lawyers, administrators thrown in) sat, listened, debated, role-played, and sharpened one another in a set of new skills we were learning together.

Mediation is a process of negotiation and problem-solving that involves a neutral third-party known as the mediator, and seeks to engage the disputing parties and help get them to agree on certain terms of settlement. It occupies a unique place in the dispute resolution spectrum - one step below formal arbitration, and a step above negotiation. Unlike a court proceeding, which all of us in the medical profession most definitely want to avoid, there is no judgment passed during mediation as to who is right or wrong, no judge to adjudicate the dispute based on merits and presenting evidence, nor an official to determine the nature and quantum of penalty to be borne by the party at fault. Rather, the mediator explores the interests of both parties, asks them how they would like to settle the dispute, and seeks a true win-win situation for both parties in a non-adversarial manner.

So, for example, instead of a drawn-out medico-legal lawsuit that incurs astronomical costs in legal, court and hearing fees, a patient may wish to settle a dispute if he obtains an apology, an explanation, and a fair compensation from the healthcare institution. Most importantly, the carer-patient relationship is (ideally) maintained, which is crucial if the patient still needs to obtain treatment from that healthcare institution, especially if there has been an adverse event or complication leading to harm.

Through games, lectures, videos, case studies, demonstrations and actual role-playing practice, the participants learnt the finer aspects of handling the stormy emotions that could be expected, the steps in the mediation process, unearthing the interests behind the superficial posturing, using communication and negotiation tools, brainstorming for options and how to influence two disputing parties towards a practical settlement. The energetic and occasionally heated discussions often carried on into the scrumptious teas and lunches provided, and new friendships and networks were forged in the process.

When asked how he felt about teaching mediation to this group of doctors, lead trainer Associate Professor Joel Lee said, "I believe that both the medical profession as well as their patients can benefit from having many of their disputes mediated. While at face value, much of it seems to be about attributing blame and wanting money, what tends to motivate this is that patients don't know any other way to feel heard or to deal with how they feel about the situations. Mediation provides an avenue to fill this need. From the doctor's perspective, mediation affords a confidential way to deal with complaints and has flexible methods for solving problems extra-legally."

Amidst the learning and the fun, we realized the higher purpose of these skills. We will, in time, possibly play an important role in the Medical Mediation Scheme jointly set up by MOH and the Singapore Mediation Centre, an important link in the overall healthcare complaints management framework. Mediation provides constructive opportunities, simpler and less costly, for the resolution of healthcare disputes between patients and healthcare providers.

More importantly for us doctors, it is about restoring the trust and the doctor-patient relationship after things have gone wrong, and putting the patient back in the centre again (especially if there has been unintended and unexpected harm). However one looks at it, both parties in most medical-related disputes need a vent, a listening and understanding ear, and a chance for healing and restitution. It is only right. ■ CM

Professionalism, Ethics, and Law (PEL)

Answering the Ethical Dilemmas

Reported by Dr Leow Cheng Gek and
Dr Tay Siew Hua

As required for candidates of the Graduate Diploma of Family Medicine (GDFM) course, we attended the PEL course in Sept 2007. The course consisted of reading up on lecture notes, attending the workshops & e-learning.

The first workshop on Medical Records and Confidentiality was conducted on 22 September by A/Prof Goh Lee Gan and A/Prof Cheong Pak Yean. The focus of the first part of the workshop was on the importance of keeping good medical records and preserving patients' confidentiality. Confidentiality of information was a cornerstone of the patient-doctor relationship which is built on trust. A breach of patient confidentiality could lead to erosion of the patient-doctor relationship. Doctors can be sued for breach of confidentiality. However, in clinical practice, there might be situations during which the information could be disclosed to a third party such as in the course of care of the patient, with the patient's consent, under statutory compulsion, and in cases with strongly countervailing public interest.

> **"...managed healthcare contracts would continue to be popular for some time in Singapore."**

In this workshop, discussion was lively as the microphone was passed around and everyone shared their views. Led by A/Prof Cheong Pak Yean, two scenarios based on real life cases were discussed. The fact that these cases were gleaned from Prof's actual encounters made it all the more interesting and practical. Maids presenting with positive urine pregnancy test results would present an ethnical dilemma to the general practitioner. We were cautioned to obtain informed consent before we carry out these checks. The second case was centred on patient - confidentiality versus legal requirement. If we were legally obliged to notify or make a report, this would take precedence over the patient confidentiality issue. In retrospect, I felt that the first workshop on medical confidentiality was particularly timely, especially with the legislation on need of HIV infected patients to inform their sexual partners of their disease carrier state. Certainly, confidentiality would be overridden in the interest of public in this case.

The National Healthcare Group (NHG) Polyclinics comprise 9 large one-stop primary healthcare centres situated in the residential heartlands. We offer a comprehensive range of primary healthcare services together with an array of nursing and allied health support services, all under one roof. As a network of primary care centres, we are well placed to deliver cost-effective, efficient and affordable healthcare to Singaporeans. We strive to get the best people to work in an environment of continual improvement and innovation as we evolve our care delivery model for our patients. We are committed in creating an environment where staff can reach their fullest potential and share our vision of *"Adding years of healthy life to the people of Singapore"*.

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The Human Resource Department
National Healthcare Group Polyclinics
6 Commonwealth Lane, #07-01/02
GMTI Building, Singapore 149547
Email: recruit@nhgp.com.sg

(We regret that only shortlisted candidates will be notified.)

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I have attended ethical courses on the right to confidentiality for children and adolescents in UK. The views in the UK were rather liberal. For instance, a 14 year old single pregnant girl was not obligated to inform her parents if she became pregnant after consensual sex and the doctor would have breached confidentiality if he/she informed the parents. Also, doctors should not inform parents if 14 year old girl asked for oral contraceptive pills.

It would be interesting to find out the extent to which doctors should safeguard the confidentiality of children and adolescents from their parents in the Singapore context.

The second part of the workshop on 22 September focused on Notification, Certification and Dispensing. I felt that in reality, it would often be difficult to deny a patient the medical certificate. Often, these patients might only have minor ailments such as URTI, mild GE. It would be difficult to disprove their claims as many of these illnesses would not have accompanying physical signs. Doctors often had to rely on the patient's history alone. Even if the history was reliable, I felt that many of these people with minor ailments were still fit to work. However, I felt that if a general practitioner adhered strictly to his scruples and only issued MCs to truly sick patients who were unfit for work, e.g. with moderately severe GE and tonsillitis, the patients would certainly doctor-hop and realistically, the clinic practice might not last. Nonetheless, a post dated or back dated MC was forbidden.

Certification of death was an important topic . Certainly, no doctor would relish being hauled up by the coroner for incorrect certification. The workshop provided basic guidelines on death certification.

Workshop 2 focused on Professionalism and Ethics. In particular, the cases on ethics struck a chord with me and many doctors in the audience. The scenario of patients refusing treatment after prolonged period of battling disease was particularly common. Also, in the Asian context, the scenario of well meaning family members requesting the doctor to hide bad news of grave illnesses from elderly family members was particularly relevant.

The final workshop on Professional Issues and Setting Up Practice was conducted by A/Prof Lim Lean Huat and Dr Wong Chiang Yin on 29 September. I felt that workshop 3 was particularly beneficial for general practitioners who intended to set up their own practice - either by taking over an established clinic or joining a group practice.

The workshop offered practical advice on legal and financial aspects of managing a clinic.

Managed care was also highlighted during the workshop. One of the participants at the course expressed extreme unhappiness with the managed care scheme and felt that doctors and patients were both losers in the scheme. However, as the chairperson Dr Tham Tat Yean pointed out, managed healthcare contracts would continue to be popular for some time in Singapore. Our experienced chairperson explained to us the key pointers to distinguish a non-profitable managed healthcare scheme from a scheme whereby both doctors and patients would emerge as winners.

In conclusion, I felt that the PEL course offered practical advice for dealing with the ethical dilemmas in the course of our professional practice. ∎CM

(from page 7 - Critical Roles...)

they can get help from their GPs. Health Promotion Board is taking the lead on national education, to raise the awareness of Singaporeans on the importance of family physicians; and the importance of chronic disease management. The doctors' toolkits and patient booklets have already been sent to you. We hope that these efforts make patients more receptive to the clinical care you propose to them.

Let me acknowledge here the leadership role that the College of Family Physicians is playing in partnering MOH in strengthening training for GPs, particularly in areas of new need. Prof Satku, my Director of Medical Services, often tells me, that it is easier to be an orthopaedic surgeon than to be a family physician because you have to keep up with advances across the spectrum of medicine. Nationally, we are strengthening the professional development infrastructure. For example, a GP partnership program is being developed in mental health. Interested GPs who join the programme will get further training. We hope to formalise this down the road into a Graduate Diploma in psychiatry program.

Conclusions

I'd like to end by reiterating the Government's view that we believe GPs can and must play a major role in our healthcare system. I hope that the many initiatives and support efforts I've described in my speech show you that I'm not saying this simply because you've invited me here and I have to say something nice, but that MOH is serious about this goal and has concrete plans to back our intentions. The programmes that I have described in my speech tonight have approved government funding to back each and every one of them - Wellness Coordinators, Hba1c analyser subsidy, nurse educators, mental health training, IT assistance, driving right-siting from SOCs to GPs, including the Changi GH pilot, Medisave changes - and we are ready to roll.

As some of the best trained GPs in Singapore, I believe many of you in this room tonight can play important leadership roles in bringing your community forward. With your additional training, I am confident you will be able to serve patients well. But beyond that, I hope that you will lead the way in breakthrough practices, in leveraging IT and other innovations so that primary care can be raised to greater heights. I also hope that all of you will agree to collaborate with MOH because I think that we can be more effective together in delivering on our common objective - better primary healthcare for Singaporeans." ∎CM

Moral & Ethical Principles in Medicine

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

In recent decades, medicine has made great strides in the prevention and treatment of disease. At the same time, new technologies have created serious moral and ethical problems that the previous generations of doctors did not face. Today, more than ever, the medical profession demands a highly specific professional competence and a profound ethical dimension.

Unlike Sociology, ethics does not limit itself to the description of human behaviour. It evaluates and judges it as either good or bad, appropriate or inappropriate. It acts through human reason which is capable of determining the degree of goodness or malice of human acts. Human reasoning, then, is capable of making value judgments.

Morality constitutes a peculiar dimension of human acts. Anyone can easily understand what is meant by, "He is a good professional." Or, "He is a bad person". But how do we determine if an act is good or bad? Morality is usually defined as the conformity or disagreement of the human act with the moral norms. The norms pertain to reason.

To be able to cover every ethical aspects of medicine is an impractical if not impossible task; medical science is after all, an evolving art. However, it is good to have some sound and immutable "basic principles" which we can fall back on when faced with existing or emerging issues which at best have equivocal moral standing. I find the following principles especially relevant to bioethical issues.

There are three elements to consider whenever judging the goodness or malice of a human act:
1. The object: is that which is pursued by the act
2. The end: is the objective proposed by whoever acts
3. The circumstances

For an act to be good, its object, end, and circumstances must be good.

Some principles

1. The object is the primary and essential element of the morality of the act.
This is independent of the intention of the subject.
(i) e.g. to help an accident victim is good in itself, regardless of the intention of the helper
(ii) to shorten the life of the patient is bad in itself, although motivated by pity

2. When the object is morally indifferent, the morality of the act is determined primarily by the intention and/or by the circumstances.
(i) What is in itself morally indifferent (taking a walk, reading) will receive it morality from the intention of the circumstances that accompany it

3. The principal end or intention of the subject can convert an act whose object is indifferent into a good or bad act, i.e. "The end does not justify the means" (i) Therefore killing one man in order to save 200 is illicit.

4. The circumstances cannot convert a good act into something bad or vice-versa.
(i) They can however increase or decrease the goodness or malice of an act. E.g. to steal is always evil. The gravity, though is proportional the amount stolen or if the thief was starving.

From the principles on the left, we can draw the following conclusions:

1. The obligation to correctly inform our conscience. Conscience is the judgment of our reason about the good or evil of a particular act. However, we have the prior obligation to correctly form our consciences. Otherwise, simply to "follow one's (misinformed) conscience" makes little sense. Conscience must never be set in opposition to the moral law.

2. We cannot do anything intrinsically evil to bring about good. In other words, the end never justifies the means, no matter how great the potential good. This principle is often violated in bioethical issues. E.g. one cannot kill a terminally ill patient (an evil) in order to relieve his or her suffering (a good).

3. The principle of the double effect
This important principle has multiple applications in relation to the imputability of the effects of human acts. When a human act has only one effect, it is often not difficult to pass a moral judgment. Human life is often beset with conflicts of values because there are actions which aside from producing a good effect, cause an unwanted evil effect which accompanies the former inseparably. These acts are described to have a double effect.

An act that is good, but that has an evil side effect, may be done only if:
- The good must be willed. The evil must not be willed, merely tolerated.
- The good must not be the result of the tolerated evil.
- The good desired must equal or outweigh the evil effect (e.g. administering chemotherapy to a pregnant woman with a cancer which might indirectly lead to the demise of her child).

There must be a clear distinction between procedures that are covered by the principle of the double effect from those where good is brought about by an evil act. Evil done in order to achieve good can never justified the principle of the double effect.

4. Choosing the lesser of two evils
When faced with two or more unavoidable evils, we must choose the lesser one. For this principle to apply, we cannot intend either outcome, one is simply choosing between two unavoidable evils. Obviously, if it is a choice between a lesser evil and no evil, we must choose the non-evil.

5. Counselling the lesser evil
When faced with an unavoidable evil, we may counsel a lesser evil to minimize harm. It is not the intention to support the evil action but merely lessening an evil that cannot be stopped.

6. Something can be legal and still morally wrong.
It is good to reflect upon this point. In conclusion, not everything that can be done ought to be done! I hope that the above principles will serve as a guide when you find yourself facing a moral and ethical decision in your practice of medicine.

Medicine, by virtue of its unique position as a vocation that deals directly with human life, cannot be practiced without moral and ethical considerations. Indeed ethics and moral professionalism elevate doctors from merely a collection of skilled medical technicians to society's guardians of health and social values.
■ CM

Adolescent Health

Family Practice Skills Course

The College of Family Physicians Singapore would like to thank **Health Promotion Board** and the Expert Panel for their contribution to the Family Practice Skills Course on **Adolescent Health**, 27-28 October 2007.

Thank you!

Dr VICTOR LOH – Health Physician, University Health, Wellness, and Counselling Centre, NUS

Dr DANIEL FUNG – Consultant Child Psychiatrist, IMH

Dr ONG SAY HOW – Consultant, Dept of Child & Adolescent Psychiatry and Child Guidance Clinic, IMH

Dr ARTHUR LEE – Senior Consultant Psychiatrist, Dept of Addiction Medicine, IMH

Dr GOH SHU CHEN GERALDINE – Associate Consultant, Psychological Medicine, NUH

Prof KUA EE HEOK – Senior Consultant, Psychological Medicine, NUH

Dr LEE HUEI YEN – Consultant Psychiatrist, Dept of Behavioural Medicine, SGH

Dr SADHANA NADARAJAH – Consultant, Reproductive Medicine Unit, KKH

A/Prof LOKE KAH YIN – Head, Division of Paediatric Endocrinology & Diabetes, Children's Medical Institute, NUH

Dr CHAN POH CHONG – Consultant Paediatrician, Division of Ambulatory Paediatrics, Children's Medical Institute, NUH

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COURSE STRUCTURE

Family Practice Skills Course 25

Risk Factors in Macrovascular Disease

Unit 1: Epidemiology of Atherothrombosis and Evidence for the Risk Factors
Dr Tay Jam Chin

Unit 2: Assessment of Risk Factors
Dr Lim Tai Tian

Unit 3: Therapeutic Lifestyle Changes: Nutrition & Healthy Diet
Ms Gladys Wong

Unit 4: Therapeutic Lifestyle Changes: Exercise & Weight Control
Dr Benedict Tan

Unit 5: Smoking Cessation
Dr Ong Kian Chung

Unit 6: Pharmacological Strategy - Updates
Dr Raymond Lee

*Workshop held on Day 1 is repeated on Day 2. Registration of workshops is on first come first served basis. Limited seats available.

> SEMINARS (2 Core FM CME Points for each seminar)

Seminar 1: 26 January 2008 (2.00pm - 4.15pm)
- Unit 1: Epidemiology of Atherothrombosis and Evidence for the Risk Factors
- Unit 2: Assessment of Risk Factors
- Unit 3: Therapeutic Lifestyle Changes: Nutrition & Healthy Diet

Seminar 2: 27 January 2008 (2.00pm - 4.15pm)
- Unit 4: Therapeutic Lifestyle Changes: Exercise & Weight Control
- Unit 5: Smoking Cessation
- Unit 6: Pharmacological Strategy - Updates

> WORKSHOPS* (2 Core FM CME Points - attend 1 day only)

Day 1: 26 January 2008 (4.30pm - 6.45pm)
- Case Studies: Food choices - The Facts on Fats
- Practical Skills: Exercise options for busy people

Day 2: 27 January 2008 (4.30pm - 6.45pm)
- Case Studies: Food choices - The Facts on Fats
- Practical Skills: Exercise options for busy people

> 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.

Date: 26 & 27 January 2008

Time: 2.00pm - 6.45pm

Venue: College of Medicine Building, MOH Auditorium

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Course Registration Form

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Workshop	☐ $ 20.00	☐ $ 40.00
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Distance Learning Module (Journal)	FREE	☐ $ 40.00
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