THE
College Mirror
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APPLICATIONS OPEN

COLLEGE ART GALLERY

YINGQING DISH WITH LOTUS DESIGN
Sung Dynasty (960-1279)

Published by the College of Family Physicians Singapore, College of Medicine Building, 16 College Road #01-02 Singapore 169854
Tel :(65) 62230606 Fax:(65) 62220204
Email: collegemirror@cfps.org.sg
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By Dr Wee Chee Chau, MCFP & Editor

The consultation exercise in October 2005 for the proposed National Family Medicine (FM) Register focused attention on structured FM training. With the place of family medicine so set in the national healthcare agenda, one would expect the winds of change to be sweeping through our practice, transforming family physicians' roles in ambulatory, community and in-patient care and opening even more space for family physicians.

The questions on most of our minds, especially when our rice-bowls are concerned are: "Has it really?", "Is primary care now any different?" and "How would my pie be enlarged?"

Recent job advertisements in the SMA-News bear testimony to some of these changes. The advertisements specifically invite applicants with the GDFM and Masters to apply. The vista of practice has opened up. Besides the usual group practices serving company contracts, there are now openings in niche practices that provide more personalised care. Advertisements by various Australian agencies are also prominent. A few of our trained family physicians who responded were given red carpet recognition of our local credentials, given training exemptions for their accreditation process and are now practising in Australia.

"We have to return to the core values of family medicine of care that is not just comprehensive, personal and preventive but also co-ordinated as a fraternity in the community and in in-patient institutions as well."

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Page 1 (The Return of Family Medicine)

WHO HAS MOVED MY CHEESE?

Such anecdotes are indeed good to lift the spirit of those of us who have the qualifications and are looking forward to be employees and not be "their own boss". These doctors are likely to be the younger ones amongst us, who have more years ahead to find their place.

What of the "old birds" and those of us who have decided not to join the paper chase but are satisfied to be "educated" at our own pace by just satisfying the compulsory CME requirements? Few will disagree that patient load had dipped, up to 50% in many cases. We really have plenty of time now to study and read during clinic hours. However all this knowledge with no patients to serve seems to be so futile. To borrow from a self-help book that used the 'rat and cheese' analogy - "Who has moved my cheese?"

Family practice in Singapore has been and still is besieged with a complex web of circumstances that stifles the delivery of care. Low consultation fees supports but the briefest encounter. Costs of necessary medicine and tests are perceived to be high by patients and third-party payors alike. Many blame this sad state of affairs on patients and payors who benchmarked their out-of-pocket payment to GPs against the fees in the highly subsidised public primary care sector.

A look into the forum page of the local daily will testify to the barrage of complaints that question the integrity and ethical behaviour of medical practitioners (if one reads between the lines). Calls for the removal of dispensing in GP clinics and even the recognition of medical certificates from alternative medicine practitioners have again been raised in recent letters to the press.

NEW CHEESE?

There are suggestions that Medisave would soon be allowed for chronic care in the private sector and several 'right-siting' initiatives have been announced. The situation on the ground however remains dismally unchanged. In the search for 'new cheese', some GPs have already shifted their focus to (more lucrative?) aesthetic medicine.

An article by Dr Gabriel Seow in this issue should give an insight as to how one of us has approached this topic Others are still looking for 'cheese' in any areas they can find within legal and ethical limits. Even an advertisement for a course leading to a 'Graduate Diploma in Acupuncture' by a TCM college and costing more than $8000 has generated much interest.

POSITIVE SIGNS

However, not all news is bad news. There are 'positive' signs of widening roles for the family physicians as generalists in institutions and hospitals. The Accident and Emergency Department of one acute hospital has appointed family physicians to senior resident physician positions. Another hospital is setting up a Department of Family Medicine and Continuing Care with family physicians as clinical consultants. Family physicians are heads of the medical teams of the larger community hospitals and palliative care institutions. But how many family physicians can these establishments employ?

Family Medicine in Singapore is facing necessary and at times painful reforms as it restructures. To some of us, it seems more painful than others. However, the 'Death of Family Medicine' as pronounced by one medical columnist is highly exaggerated. Some irrelevant practice models may have to be discarded.

The high-volume low-value, long opening hours and myriads of convenient small clinics approach may be well past its shelve life. In its place however, we need to return to the core values of family medicine of care that is not only comprehensive, personal and preventive but also coordinated and networked as a fraternity in the community and with in-patient institutions.

In the coordinated network of care lies the enlarged scope of work for family medicine and the new cheese. ■

FAMILY MEDICINE FELLOWSHIP PROGRAMME

CALL FOR APPLICATIONS

Interested doctors are invited to apply for the Family Medicine Fellowship Programme, which will begin in **July 2006** and end in **June 2008**. Programme details and application forms can be found at the college website (www.cfps.org.sg).

ENTRY REQUIREMENTS

The applicant must:

- Have Collegiate Membership of the College of Family Physicians Singapore
- Possess the MMed (Family Medicine) or the MCGP (Singapore) or equivalent qualifications; the acceptance of the equivalent qualifications has to be approved by the Censors' Board.
- Have embarked on personal professional development and training related to family medicine
- Be actively involved in postgraduate training and undergraduate education in family medicine
- Be in active clinical practice
- Be of sound professional and personal character.

Eligible candidates will be short-listed for consideration by the Censors' Board.

MEMBER OF THE COLLEGE OF FAMILY PHYSICIANS SINGAPORE (COLLEGIATE MEMBERSHIP)

The MCFP is the professional benchmark for recognition as Senior Family Physicians. It may be attained via one of 2 routes. Family physicians with GDFM must undergo the 2-year MCFP by assessment programme, while those with MMed(FM) may be elected by interview.
1) MCFP by Assessment Programme 2) MCFP by Election

1) MCFP BY ASSESSMENT PROGRAMME

INTRODUCTION

In line with international standards of awarding professional membership by objective assessments and validation, the MCFP by Assessment Programme was introduced to encourage members to participate in objective and structured professional development activities. It comprises structured training, formative and summative assessments.

ENTRY REQUIREMENTS

The minimum entry requirements are: GDFM or recognised equivalent, professional good standing and ordinary membership of the CFPS for at least 2 years.

PROGRAMME

The programme consists a course of three modules, each with a summative assessment. The duration of the programme is 2 years.
The 3 modules to be completed and the required standards are:

1. Consulting, Communication & Counselling Skills Course
Standard: Candidates will be required to submit 6 video consultations for assessment

2. Clinical Quality Skills Course - Pass in clinical quality project assessment
Standard: Candidates will be required to submit 3 case studies of significant events analysis OR conduct an audit project in his or her clinic of practice

3. Professional Development Project – which may be organization and conduct of a modular CME course or other teaching programmes; publish a paper in a medical journal such as the Singapore Family Physician or its equivalent or other professional development projects approved by the College Council
Standard:A satisfactory supervisor's report and pass in the candidate's report of the professional development project.

AWARD

The successful completion of the summative assessment of all the three modules will satisfy the conditions for award of the Collegiate Membership of the College of Family Physicians (MCFP) Singapore.

2) MCFP BY ELECTION

ENTRY REQUIREMENTS

The applicant must:
- Be a Member of College of Family Physicians, Singapore for at least 2 years
- Possess the Masters of Medicine (Family Medicine) degree awarded by the National University of Singapore
- Be Active in attending CME and has been certified by SMC for the past 2 years
- Be actively involved in teaching Family Medicine and College activities (e.g. postgraduate training, undergraduate teaching in Family Medicine and tutorship in the Graduate Dip. In FM Programme) for at least a year.

AWARD

Candidates who successfully pass the exit interview will satisfy the conditions for award of the Collegiate Membership of the College of Family Physicians (MCFP) Singapore.

How Do I Apply?

Interested doctors are invited to apply for the Collegiate Membership. Programme details and application forms can be found at the college website (www.cfps.org.sg).

The closing date for applications is 31 May 2006.

Beyond the Register - College of Family Physicians or a Family Physicians' College?

By A/Prof Cheong Pak Yean, President of CFPS

The College constitution has existed virtually intact since its founding in 1972 though the membership of the College has increased to close to 1200 doctors to represent the majority of family physicians in Singapore. The range of programmes it is responsible for has also expanded. There is thus an urgent need to review the constitution to strengthen the College and make it more responsive to the challenges of primary care delivery. We hope that members would take the time to give their views to the Constitutional Review Committee and attend the Annual General Meeting in June to vote on it (see this pg).

The College is certainly not just about vocational training. It is the vehicle to be used to disengage from the present quagmire weighing down family practice in Singapore and to chart the path ahead.

The call is also to all doctors in primary care and family practice to join the College as members. Some doctors have thought that attaining postgraduate qualifications are pre-requisites for membership. This is definitely not true. Any registered medical practitioner in Singapore may join the College as associate or ordinary member. Ordinary member may stand for election to Council and to vote in general meetings. They also enjoy the same privileges of membership. If you are not already a member, please join us (see pg 2).

More importantly membership of the College is different from membership of discount schemes and country clubs. It is beyond free gifts, facilities and discounts for services. As enshrined in the constitution, the College is an organisation that advocates high standards of practice and professionalism in family medicine.

Membership represents supporting the validation of family medicine as an important discipline in medicine and an essential component of an effective health care system. With the support of a broad base of members who share this aspiration, the College will become more effective in engaging our peers, the public and the policy makers in advocating the important role of family physicians.

The Graduate Diploma of Family Medicine (GDFM) for 2006/8 is now open for enrolment (see pg 12) and would certainly attract more interest as it is one of the requirement for direct entry into the proposed Family Medicine Register. The call is also out to those who have completed the GDFM/Masters to apply for the College programmes leading to the Collegiate Membership and Fellowship of the College (see pg 4). The Institute of Family Medicine is looking for teaching fellows to augment the present teaching faculty and for tutors for the GDFM programme (pg 11 & 12). The cascade of teaching and learning set up provides the training infrastructure for the fraternity gearing itself to meet the challenges posed by the proposed Register.

The spirited response as to what should be the criteria for inclusion in the proposed Register augurs well for primary care in Singapore. Doctors are now more aware of the roles they play and the skills, both traditional and emerging that society and patients expect of family physicians. The reference to the parody 'Who moved my cheese' in this issue's editorial puts it in perspective.

Change is discomforting. Few would dispute that in recent years, the cheese has been moved from the comfort zone of family physicians... insidiously but steadily for the past two decades. Beyond vocational standards, other constructs like financing and right siting must be reformed in tandem. The College is certainly not just about vocational training. It is the vehicle to be used to disengage from the present quagmire weighing down family practice in Singapore and to chart the path ahead. ■

Celebrating Family Medicine Heritage

By Dr Wee Chee Chau, MCFP & Editor and
A/Prof Cheong Pak Yean, President of CFPS

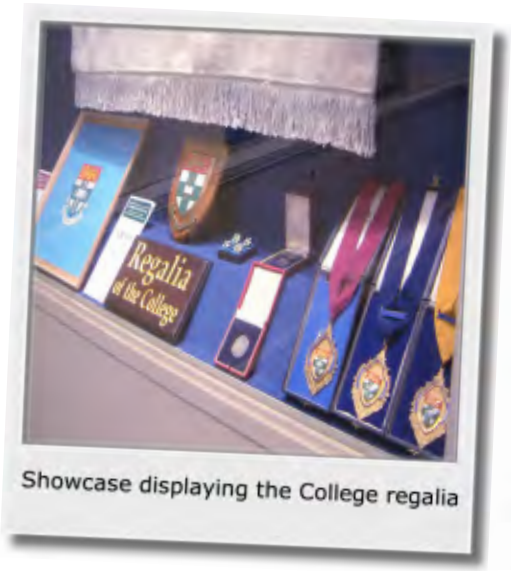
The anteroom of the College has been recently renovated to celebrate the rich heritage of the College. Taking centre-stage is the display housing the 'Regalia of the College'. Historical documents like the publications heralding the founding of the College are now in public view. A photo gallery of past Councils occupies one of the walls.

The Convocation Tapestry was unveiled by the Director of Medical Services, Prof K. Satkunanantham, during the 2005 Convocation Ceremony on 1st Oct 2005. It now takes pride of place amongst the other regalia, which include the medallion of office and original paintings of the College Crest circa 1972. The Tapestry was donated by Dr Wong Heck Sing to commemorate the formation of the Institute of Family Medicine. The events leading to its commissioning are recorded in an article by Dr Lily Aw on the 'Heraldry and Regalia of the College' published in the Singapore Family Physician Vol 32 No. 2.

Prof K. Satkunanantham, Director of Medical Services, MOH, unveiled the Tapestry at the Convocation Ceremony on 1 Oct 2005.

The design of the tapestry followed closely the original painting of the Academic Crest with the addition of the words 'The College Convocation Tapestry' and 'College of Family Physicians Singapore'. The hand-woven piled tapestry was woven in Tabriz, north-west Iran, the centre of the Persian rug trade. It was woven using wool and silk threads on a base of silk and measures 1.45m by 1m. It is now on permanent display at the anteroom except when taken out for formal use in convocation ceremonies.

We invite all family physicians to view these exhibits when attending CME events held at the College. In meeting the challenges faced by family medicine today, we take pride in the rich heritage of the College forged from the toils and sacrifices of generations of family physicians gone by. ■



Showcase displaying the College regalia

Photo Gallery of Past Councils

The College Anteroom

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Women's Health

By Dr Helena Wong Ern Ling, Family Physician

The Women's Health Skills course was conducted on 14 & 15 January 2006 and it attracted approximately 200 participants. The teaching faculty, comprising members of the College's Expert Panel, gave a comprehensive coverage of the topic.

There are unique health issues faced by women in today's society. With life expectancy for females at birth at 81.3 years, and tools for disease detection and intervention, there has been a changing pattern of disease incidence, morbidity and mortality.

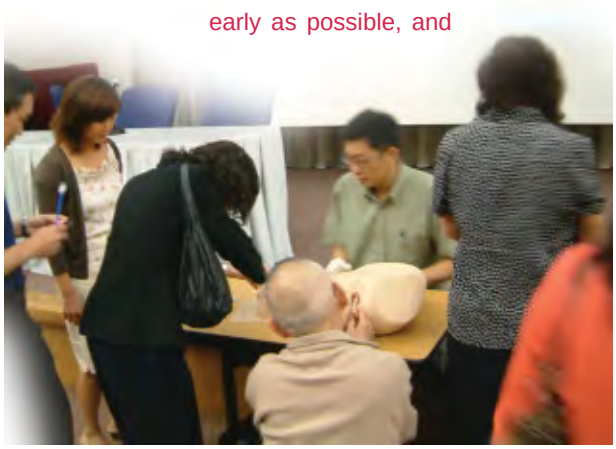
In Singapore, menopause occurs at an average age of 51 years. Whilst hormone replacement therapy was common in the past, the Women's Health Initiative in 2002 revealed that women on combined HRT had increased risk of breast cancer, cardiovascular disease, thrombo-embolic events, strokes and dementia. Currently, HRT is reserved for selected patients with intolerable climacteric symptoms. Safer alternatives include the usage of phytoestrogens, and patient support groups.

Prevention of pregnancy in the perimenopausal woman is important. Suitable forms of contraception include the combined oral contraceptive pill, the progesterone-only pill, transdermal patches, implants, intra-uterine devices, barrier method, or tubal occlusion.

Osteoporosis is a silent disease, and screening should be done in high-risk patients determined by risk factors and Osteoporosis Self-Test for Asians. Prevention of osteoporosis is by adequate intake of calcium and vitamin D, and bone-building exercises. Treatment includes the usage of bisphosphonates.

Those in the age range of 50-59 years old have the highest proportion of obesity. Treatment and prevention is through a diet low in carbohydrates, oils and fats, and high in fibre and regular exercise.

Sexually transmitted infections in women have the long-term complications of infertility, ectopic pregnancy, lower genital tract neoplasia, adverse pregnancy outcomes, chronic pain and death. Thus, for a patient with one STI, screening for other STIs, including HIV, is essential. Treatment should be initiated as early as possible, and



Doctors participating at the workshop.

effective treatment must include contact tracing and treatment of sexual partners. HIV testing should be done in early pregnancy so that appropriate antenatal interventions can reduce maternal-to-child transmission of HIV infection

Breast cancer is currently the most common cancer in Singapore women. Mammography is the only proven modality in breast screening. Microcalcifications that indicate the presence of a cancer are clustered, very fine, branching and varying in shape. The role of ultrasound is to assess a palpable lesion to distinguish between a solid and a cystic lesion. It is also used to assess non-palpable mammographic abnormality. Minimally invasive breast biopsy by stereotactic or ultrasound guidance is advocated to diagnose a malignancy before definitive surgery.

Prevention of gynaecological cancers involves patients reducing risk factors, and going for Pap smear screening to prevent cervical cancer. Modifiable risk factors include avoiding smoking and the development of the Metabolic Syndrome, avoiding multiple sexual partners, usage of combined contraceptive pills in between pregnancy, having two or more children, and breastfeeding. Vaccination against the oncogenic strains of Human Papilloma Virus has a potential role in prevention of cervical cancer. Tumour markers are of limited use as screening tests for gynaecological cancers. CA-125 is most useful as a screening test in post-menopausal women with an adnexal mass. Otherwise, routine and simple ovarian cancer screening can be performed by risk assessment and pelvic examination. Abnormal vaginal bleeding in a woman more than 40 years of age necessitates screening for endometrial carcinoma.

Cervical cancer is the fifth commonest cancer in women in Singapore. There has been a steady decline in the age-standardised rate of cervical cancer. Cervical intraepithelial neoplasia is the pre-invasive phase of squamous cell carcinoma. Preventive measures against cervical cancer include avoidance of HPV infection by abstinence from sexual activity or barrier protection with or without spermicidal during sexual intercourse. Cessation of smoking, avoiding high parity and avoiding oral contraceptive usage during HPV infection

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College's Expert Panel on Women's Health Skills Course

Dr Khong Chit Chong
Head & Senior Consultant
Menopause Unit
General Obstetrics & Gynaecology
KK Women's & Children's Hospital

Dr Fong Kah Leng
Associate Consultant
Department of O& G
Singapore General Hospital

Dr Hong Ga Sze
Head and Senior Consultant
Breast Unit
KK Women's & Children's Hospital

Clin A/Prof Tay Eng Hseon
Chairman, Medical Board &
Senior Consultant
Gynaecological Oncologist
KK Women's & Children's Hospital

Dr Jeffrey Low Jen Hui
Head & Senior Consultant
Gynaecological Oncology Unit
K K Women's & Children's Hospital

Dr Quek Swee Chong
Consultant
Gynaecological Oncology Unit
KK Women's & Children's Hospital

also serve as preventive measures. Regular Pap smears to detect precancerous lesions, and appropriate treatment reduces the cervical cancer incidence and mortality.

In view of the importance of Pap smears in the early detection of CIN lesions, correct technique of cervical cell sampling with appropriate equipment is essential. Cell material should be sampled from the transformation zone. The cervical broom is an ideal sampling device that readily picks up the endocervical and exocervical cells, and also releases these cells readily onto the glass slide. An endocervical brush should be used for cervices where the transformation zone is in the endocervical canal. Immediate fixation of the slide is essential to prevent drying artifacts. The Bethesda system of reporting Pap smears should be employed. Negative smears are normal or those which have inflammatory changes.

Patient anxiety that arises as a result of an abnormal Pap smear should never be underestimated. Patients will appreciate reassurances that the abnormal Pap smear does not represent cancer. Reasons for abnormal Pap smears include infections, menopause and infection with HPV. The vast majority of abnormal Pap smears are due to simple problems which are easily treated.

Referral for colposcopy is indicated in those with dyskaryosis (CIN I, II and III); 2 consecutive ASC-US, any ASC-H; 3 consecutive inflammatory Pap smears in spite of treatment; any glandular abnormality; carcinoma of the cervix; clinically suspicious cervix; endometrial cells in those more than 40 years old, or in younger women with intermenstrual or post-coital bleeding; and women with suspicious symptoms such as post-coital bleeding irregardless of Pap smear report.

A Pap smear is normal when the report shows that the specimen is adequate, there is an absence of dyskaryosis on microscopy, and the summary report is negative.

The clinical attachment was a special component of the Women's Health FPSC. The trainers were Dr Quek Swee Chong, and Dr Yam KL. During the attachment, participants were guided through correct Pap smear techniques in real patients. The management and counselling of patients by the specialists also served to equip the family physician with skills to provide "value-added" services to his female patients.

Many women consult family physicians when they have concerns regarding menopause, symptomatic STIs, palpable breast lumps or an abnormal vaginal discharge or bleeding. However, there are many more women who do not have these symptoms, but are still at risk of breast and gynaecological diseases. Family physicians should take the onus to identify and screen those at increased risk of these diseases, and also to provide opportunistic screening for women in the general population. ■

Constitutional Review Committee(CRC)

By Dr Cheng Heng Lee, Honorary Secretary

The President, CFPS, had stated in the President's Forum (The College Mirror, Sept 2005, Vol31 No.3) that the time has come for a review and amendment (if necessary) of the College constitution to keep it in tandem with other moves to reform primary care in Singapore. A Constitutional Review Committee (CRC) has been formed.

Terms of Reference

The CRC will review the constitution of the CFPS and recommend to the Council, consitutional ammendments that will further the objectives of the College in the context of the new environment. The review will include the following areas:

- The quorum required for constitutional amendments of the College. Presently the quorum required is one-eighth of the voting membership.
- The eligibility and rights of the various categories of membership.
- The process of nominating and electing leaders of of the College.
- The roles of the Council, the Censor Board and the executives in charge of College organisations such as the Institute of Family Medicine (IFM).
- Organisational changes that are necessary to support the proposed Family Medicine Register.

The College takes this opportunity to invite members to participate in this exercise and to submit their views.

Please send in your submission to Honorary Secretary, College of Family Physicians Singapore. Members may access the College constitution on the College website or write in for a hard copy. Do mark your calender to attend the next AGM in June 2006. ■

Members of the CRC

A/Prof Lim Lean Huat (Chairman),
Dr Alfred Loh, Dr Moti Vaswani

Ex-Officio Members:

A/Prof Cheong Pak Yean, A/Prof Goh Lee Gan, Dr Lee Kheng Hock, Dr Cheng Heng Lee, Dr Arthur Tan Chin Lock

Advisor:

Dr Lee Suan Yew

Developments in Diagnosis and Management

By Dr Jeff Tay, MCFP & Editorial board member

Editorial Note: This Family Practice Skills course, conducted on 22 & 23 October 2005 at the Ministry of Health auditorium received over-whelming responses.

Overview

Managing patients with chronic medical conditions capably is the Ministry of Health's vision for the family doctor. Diverse chronic conditions, which have been traditionally reviewed at specialists' clinics, will soon appear at our clinics with a "thank you for co-managing the above-mentioned" letter. The following distilled excerpts from the skills course will hopefully be of practical importance to the family doctors currently facing such challenging cases.

Chronic Hepatitis B Infection Management

Chronic hepatitis B (CHB) management requires life-long follow-up – assessing indications for anti-viral therapy and evaluating disease process / progress, including hepatocellular cancer (HCC) development.

CHB has three recognised phases:

- **Immune-tolerant CHB** – Persistent Hep B Virus (HBV) infection without immune reaction.
- **Immune-active CHB** – Chronic necro-inflammatory liver disease, caused by the immune response to persistent HBV infection. Subdivided into i) **HBe Ag (+)** and ii) **HBe Ag (-)**.
- **Inactive CHB carrier** – Persistent HBV infection without virological or biochemical evidence of active infection.

Long-term monitoring is for a) need for anti-viral treatment and b) evaluation of disease progression. HCC surveillance is targeted for high-risk carriers, like patients above 40 years old, patients with cirrhosis and a family history of HCC.

Complete eradication of the virus is the ideal goal. Currently, as this is not possible, the primary aim of treatment is to suppress the HBV DNA to low or undetectable levels for as long as possible. The secondary aim(s) would be to normalise the abnormal ALT, achieve HBe seroconversion and prevent histological progression.

Current approved treatments for CHB infection are a) the nucleoside / nucleotide analogues and b) the immune modulators.

Diagnostic Approach to Prostate Disease

The main afflictions of the prostate are prostatitis, benign prostatic hyperplasia (BPH) and prostate cancer. Thus, diagnostic approach to prostate disease (and lower urinary tract symptoms) requires a careful history, physical examination, and focussed basic investigations.

BPH and prostate cancer rarely occur before the age of 50 years. Lower urinary tract symptoms (LUTS) constitute bladder outlet obstructive symptoms (i.e. hesitancy, poor stream and intermittency) and irritative symptoms (i.e. frequency, nocturia and urgency).

It is important to exclude prostate cancer in men over the age of 50 years, who present with persistent bone pain, typically unremitting with rest and worse at night. Prostatitis affects young and old adults, presenting with fever, dysuria and pain of prostatic origin. In the digital rectal examination, a smooth, globular and firm prostate indicates BPH, a tender and boggy prostate suggests prostatitis, and an irregular, hard prostate is invariably prostate cancer.

Differential diagnosis include:

- Other diseases of the genitourinary tract – lower urinary tract infection, neuropathic bladder, detrusor instability, detrusor failure and urethral stricture.
- Systemic diseases with symptoms related to the lower urinary tract – diabetes mellitus (glycosuric polyuria), diuretic usage in congestive cardiac failure, obstructive sleep apnoea, insomnia due to depression, herpes zoster, cauda equina syndrome, and even genitourinary tuberculosis.

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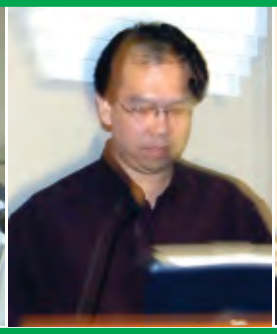
College's Expert Panel on Developments in Diagnosis and Management Skills Course

Dr Dede S Sutedja, Senior Consultant, Dept. of Gastroenterology & Hepatology, NUH

Dr Tan Yeh Hong, Consultant, Dept. of Urology, SGH

Dr Ng Foo Cheong, Chief & Senior Consultant, Dept of Urology, CGH



Clin A/Prof Tay Eng Hseon, Medical Board & Senior Consultant, Gynaecological Oncologist, KKH

A/Prof Quak Seng Hock, Chief, Dept of Paediatrics, NUH

Prof Phua Kong Boo, Senior Consultant, Dept of Gastroenterology, KKH

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Management of Benign Prostatic Hyperplasia

The therapeutic choice is influenced by the severity of bladder outlet obstruction, symptoms and complications. The options available are:

- Watchful waiting – Those who do not have significant bladder outlet obstruction or high residual urine volume. No medication is given.
- Medications – Indicated for patients with significant bladder outlet obstruction or moderate to severe symptoms. Alpha-blockers include terazosin and alfuzosin. 5-alpha reductase inhibitors (5-ARIs) include finasteride and dutasteride.
- Minimally invasive therapy – Tansurethral needle ablation of prostate (TUNA) and transurethral microwave thermotherapy (TUMT). Performed as a day surgery case under local anaesthesia, these procedures are for symptomatic BPH patients who are not fit or prefer not to have surgery.
- Surgery – Transurethral resection of prostate (TURP) is indicated for chronic urinary retention, repeated acute urinary retention, severe bladder outlet obstruction, bladder stone, frequent urinary tract infection, recurrent prostatic haematuria, and failure of medical therapy.

TURP has been the gold standard for BPH surgery over the past few decades, providing long-term relief of bladder outlet obstruction due to BPH. Under assessment for durable efficacy are the Holmium laser enucleation of the prostate and plasmakinetic resection techniques.

Human Papilloma Virus (HPV) & Cervical Cancer

The confirmation of the central aetiological role of genital HPV in cervical carcinogenesis led clinicians to use HPV testing as an adjunctive test to the Pap test and investigators to explore its role as a primary screening method. Studies on HPV vaccines, using viral-like particles (VLPs), are also underway, with the anticipated perceived potential of eradicating a large proportion of the cervical cancer incidence in the latter part of this century.

It will immunise subjects against HPVs 16 & 18, which together cause about 70% of cervical cancer, and HPVs 6 & 11, which cause about 90% of genital warts.

A therapeutic vaccine is still experimental, largely targeting at the treatment of cervical intra-epithelial neoplasia (CIN).

Vaccination for HPV in combination with screening can be a cost-effective health intervention, but it depends on maintaining effectiveness during the ages of peak oncogenic HPV incidence. Identifying the optimal age for vaccination should be a top research priority.

Successful prophylactic cervical cancer vaccines may not eliminate the requirement for a screening program, and the feasibility of HPV testing has not been demonstrated in the setting of a low-resource, developing country. Pap testing will continue to be a relevant screening tool for the near future. Vaccination against HPV infection could reduce the risk of infection and, most importantly, may decrease the incidence of cervical cancer.

Rotavirus Gastroenteritis

Rotavirus is one of the commonest childhood causes of acute gastroenteritis, with complications of dehydration and electrolyte imbalance.

Rotavirus gastroenteritis presents with acute watery diarrhoea and / or vomiting, often with fever in the initial phase of the disease.

Take care to:

- Exclude an acute abdomen – characterised by abdominal distension, abdominal tenderness and a degree of toxicity out of proportion to the hydration state.
- Assess dehydration – capillary refill time, abnormal skin turgor and abnormal respiratory patterns

Possible complications

- Dehydration and shock
- Electrolyte imbalance
- Acid base disturbance
- Acute renal failure
- Secondary disaccharide intolerance
- Protein intolerance
- Malnutrition
- Intracranial haemorrhage
- Death

Degree of dehydration estimated as:

- Mild – water loss of 4-5% of body weight.
- Moderate – water loss of 6-9% of body weight.
- Severe – water loss of more than 10% of body weight.

Type of dehydration refers to the serum sodium level:

- Isonatremic (isotonic) dehydration – serum sodium of 135-145mEq/L.
- Hyponatremic (hypotonic) dehydration – serum sodium of <130mEq/L.
- Hypernatremic (hypertonic) dehydration – serum sodium of >150mEq/L.

Hypernatremic dehydration is associated with a higher mortality and morbidity.

Oral rehydration is widely accepted in the treatment of childhood gastroenteritis with dehydration. It is effective and relatively cheap, compared to intravenous therapy.

There is no role for antibiotics. Antidiarrhoeal agents are also not recommended for young children. The side effects of antimotility agents may be harmful to patients. Absorbents can improve the nature of the stools but do not affect the amount of water and electrolyte loss in the stools.

Once dehydration is corrected, oral refeeding should be restarted as soon as possible. Early re-establishment of full feeding is associated with faster recovery and better weight gain.

Preventive measures

- Breastfeeding reduces the risk of an infant developing gastroenteritis.
- Personal hygiene, particularly when preparing milk feeds or other foods for the infants and children.

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An Interview with Dr Kwong Kum Hoong on the Institute of Family Medicine (IFM)

By Ms Fan Yingshi, Editorial Writer

Editorial : We recently interviewed Dr Kwong Kum Hoong(KKH), a new Fellow of the Institute of Family Medicine. The following is the result of the attempt to understand the man, his work and the role he envisage to play in the Family Medicine(FM) scene in Singapore.

What are your responsibilities as a new fellow of IFM?

KKH: I assist the IFM and CFPS in developing training programmes for family practice. I also develop, update and edit content and training materials for courses organised by IFM & CFPS.

What motivates you to contribute to the development of FM in Singapore?

KKH: We've come a long way in bringing FM in Singapore to the present stage, thanks to the many far-sighted predecessors and many capable contemporaries. But there are more challenges ahead of us. These include: the continual changing of the medical scene since the advent of the information age, rising healthcare cost, ageing population, shifting family practice from a narrow medical perspective to a broader perspective where it involves matters that influence the health of the people. The preparedness of the whole FM fraternity - private, public sector or group, solo practice to face all the challenges. Just hope that in a small way I can help the fraternity and colleagues face the problems and issues squarely. As the saying goes, "No man can have permanent success without bringing his fellow man with him".

Can you tell us about the challenges that exist for you as a Family Physician?

KKH: To have a delicate balance between professional development and social life, to look after my patients well and be an effective mentor to my trainees. And to be able to help IFM roll out useful training programmes.

What are the ways to overcome these challenges?

KKH: Good time management with a supportive family. A devoted team to work with to promote, and establish a desired environment conducive for family practice in Singapore and the global arena. Also, to develop a career path in family medicine for the younger doctors.

Can you tell us about the benefits of being part of IFM?

KKH: Every phase is a learning process for me. I hope that my small capability can be part of the catalyst process in bringing Singapore Family Medicine to greater heights locally and internationally.

How might we develop and strengthen these benefits?

KKH: As we promote and establish FM as a more legitimate area of professional practice, we need to inspire and invite more doctors on board. To give protected time for course development. Have a vision, have a direction, enhance esprit de corps, think out of the box at times and move forward as a team.

How do you balance your work and family life? What do you do to relax?

KKH: I try to sleep adequately, exercise regularly, think and reflect constantly. I also allocate time to involve activities that use the right side of the cerebral hemisphere and protected time(weekend) for the family. Catch up with old friends, music appreciation, have a nice meal, go for a jog or play a game. Financial education and explore areas of ignorance. ■

IFM committee(L-R): Drs Ong Chooi Peng, Kwong Kum Hoong, Lee Kheng Kock, Tan Yew Seng & Julian Lim

Facts about IFM

• The Institute of Family Medicine (IFM) arose from the felt need for sustainable action to develop the training activities of the College in early 2000.

• Council took two important management steps, namely, the setting up of the position of executive director of the College for the latter and the position of Consultant to the IFM.

• The terms of reference of the Institute are to oversee and guide the development and implementation of :

(1) the modular family medicine course which is the core component of both the MMed(FM) and the GDFM;

(2) Family Practice Skills Course(FPSC) and

(3) E-learning programme of the College.

• The modular course has undergone revision of its context to make them more relevant and user friendly to the course participants.

• The development plans of the IFM in the coming two years will be:

(1) to build capacity for an escalation in the numbers of doctors enrolling in the GDFM which has been set towards 150 intake a year;

(2) to build capacity to take over the training of the private practitioners' stream for the MMed FM training with effect from May 2005 from the Division of Graduate Medical Studies, NUS.

Interested to apply to be a Teaching Fellow? Please see Page 12 for more information.

Institute of Family Medicine, College of Family Physicians Singapore

TEACHING FELLOW

APPOINTMENT DESCRIPTION:

- Assist the Director of the Institute of Family Medicine (IFM) and the Executive Director of the College of Family Physicians Singapore (CFPS) in developing training programmes of the College.
- Develop, update and edit content and training material of the all the courses organised by the CFPS & the IFM.
- Coordinate with the vendors, editors and course co-ordinators to ensure timely delivery of the content according to the timelines determined by the CFPS and the IFM.
- You will be allowed to work at the time & place of your choice as long as the project timelines are met. As and when necessary, you would need to attend meetings & briefings at the Secretariat of the College of Family Physicians Singapore during office hours. As a guide, the minimum time spent should be equivalent to half day of work per week. There is no entitlement to overtime pay.

REQUIREMENT:

- Possess the MMed (Family Medicine) or equivalent
- Active in the teaching of family medicine
- Full registration with Singapore Medical Council

OTHER INFORMATION:

- Annual renewable appointment
- Honorarium of S$1000 per month

CLOSING DATE:

- 28 May 2006

APPLICATION:

Interested applicants please write in stating full personal particulars, educational and professional qualifications, posting/career history, contact number and mailing address and email, or send it to:

Director, Institute of Family Medicine
College of Family Physicians Singapore
College of Medicine Building
16 College Road, #01-02
Singpaore 169854
Email: contact@cfps.org.sg

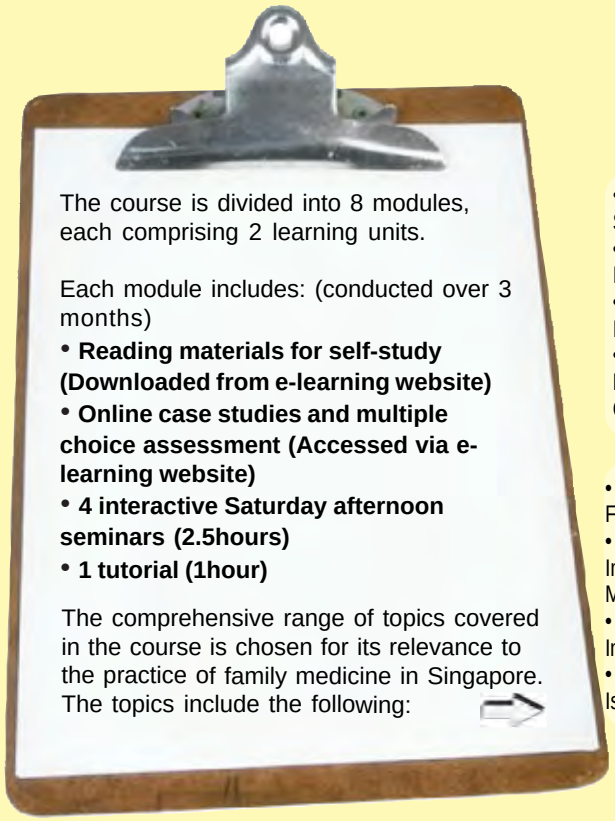
GRADUATE

Course Overview

The Graduate Diploma in Family Medic
jointly organised by the College of Fami
of Singapore.

The aim of this 2 year part-time course is to provide a comprehensive and structur
medicine at an enhanced level, catering to the healthcare needs of the child, the

The programme is designed for practising doctors who may have a busy work s
skills. Interaction with peers, trainers and expert resource persons are conduct



The course is divided into 8 modules, each comprising 2 learning units.

Each module includes: (conducted over 3 months)

- **Reading materials for self-study (Downloaded from e-learning website)**
- **Online case studies and multiple choice assessment (Accessed via e-learning website)**
- **4 interactive Saturday afternoon seminars (2.5hours)**
- **1 tutorial (1hour)**

The comprehensive range of topics covered in the course is chosen for its relevance to the practice of family medicine in Singapore. The topics include the following:

- Principles of FM; Consulting Skills
- Counselling; Communication Issues
- Respiratory Infections; Non-Infective Respiratory Disorders
- Ischaemic Heart Disease; Medical Records & Confidentiality

- Human Behaviour & Beliefs; Family in Health & illness
- Disease Control & Immunisation; Preventive Medicine
- Non-Infective Dermatoses; Infective Dermatoses
- Skin, Hair & Nails; Practice Issues

Additional Short Courses

GDFM Courses

In addition to the 8 modules, candidates must complete 3 GDFM Courses and 2 elective Family Practice Skills Courses. These are short courses conducted over 2 weekends that cover specific areas in family medicine.

BCLS

BCLS competency certificate is mandatory for examination applications with DGMS, NUS. Candidates must satisfy this requirement on their own.

E DIPLOMA IN FAMILY MEDICINE (GDFM)

cine (GDFM) is a structured training programme for family physicians in Singapore. It is ly Physicians Singapore and the Division of Graduate Medical Studies, National University

red training programme for doctors working in primary care so that they can practise family e adolescent, the adult and the elderly.

chedule. The distance-learning components enable the learning of core knowledge and ed via e-learning, and face-to-face sessions are conducted outside regular office hours.

Modular Course

- The Preschool Child; Normal & Abnormal Development
- On the Adolescent; Childhood Behavioral Disorders
- Upper GI Diseases; Lower GI Diseases
- Liver & Biliary Tract Disorders; Notification, Certification & Dispensing
- Continuing Care; Hypertension
- Diabetes Mellitus; Care of the Terminall ill
- Oncological Problems; Haematological Problems
- Urinary Tract Problems; Doctor as Manager
- Ageing, Fitness & Assessment; Stroke & Rehabilitation
- The Frail Elderly; Prescribing in the Elderly
- Mood Disorders; Anxiety Disorders
- Computer Use in Practice; Teaching & Research
- The Occupational Health & Disease; Workplace Hazards
- Fitness to Work; Travel Medicine
- Emergency Care & Housecall; Rheumatic, Bone & Joint Disorders
- Sports & Accidential Injuries; Setting Up Practice
- Family Planning & Infertility; Common Gynaecological Disorder
- Gynaecological Cancers; Sexually Transmitted Diseases
- Common Neurological Disorders; Eye Disorders
- ENT Disorders; Financial Mx
- Antenatal Care & Drug Use; Medical Disorders in Pregnancy
- At Risk Pregnant; Postnatal Care
- Nutritional Counselling; Metabolic Disorders
- Endocrine Disorders; Quality Assurance in Practice

GDFM Examination

The examination is conducted by the DGMS, NUS in July/August 2007 and consists of:

- Written Paper: Applied Knowledge Test(MCQ) paper (2 hours)	25%
Key Features Problems paper(1 hour)	25%
- Skills Assessment by OSCE(Objectively Structured Clinical Examination(2 hrs)	50%

Fees

Course Fees:(payable to College of Family Physicians Singapore)

- *College member : S$ 4284*
- *Non-College member : S$ 4716*

Important notes: 1) Fees do not include Exam fees, GDFM Courses, Elective Skills Courses & BCLS. 2) Examination Fees are payable to Division of Graduate Medical Studies, NUS when applying for examinations in May 2008.

Eligibility

The candidate must possess the following to be eligible to register for the GDFM programme:

✓ A basic degree of the MBBS or equivalent qualification registered with the Singapore Medical Council

✓ Full and conditional registered medical practitioner

✓ Temporary Registered doctors can apply with the following conditions:

- To be ranked within the top 50%(of all doctors, not just among temp-reg) in their institution/department
- Must have 1-year working experience in Singapore
- Application must be supported by HOD and CMB
- Must fulfil CME Requirements

Response Form

❑ Please send me GDFM application form.

Name :Dr _____

_____

MCR No:_____

College Member: ❑ Yes ❑ No

Mailing address: ❑ Residential ❑ Practice

_____

_____

Tel: _____(H)_____(O)

Fax:_____

Email:_____

Application forms can also be downloaded from www.cfps.org.sg.

Important Note: Eligibility for admission to the course and the GDFM examinations are subject to change upon the advice of the Division of Graduate Medical Studies and the interim Joint Committee on Family Medicine Training.

"See your name on the board"

Private Practioners' Stream (PPS), MMed(FM)

By Dr Julian Lim, FCFP

These two boards list the names of all the successful candidates from the Private Practioners' Stream (PPS) of the MMed(Family Medicine) training programme. Although the official PPS was launched in July 1995, tutorials had been held since 1993 under the supervision of A/Professor Cheong Pak Yean. The first candidate sat for the examinations and passed in 1995.

The board was first put up in 1998 to don the walls of the newly renovated Graduate Family Medicine Centre which was located above Cheong Medical Clinic. This centre was officially opened by Dr Alfred Loh, Past President of the College of Family Physicians Singapore, on 9 October 1998. Professor John Murtagh, Professor of General Practice, Head, Department of Community Medicine, Monash University, Melbourne delivered the Inaugural Lecture of Family Medicine Fellowship Programme on the same day.

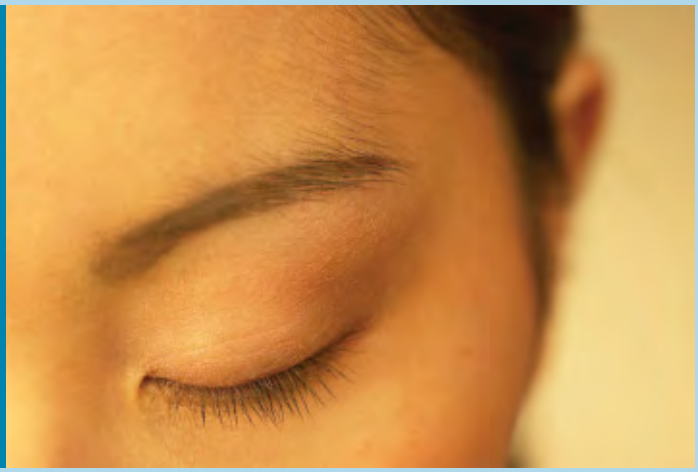
To serve as an inspiration for future batches of PPS trainees, the boards have since made its appearance on every joint session immediately following the examination to celebrate the success of the previous batch and to inspire the current batch. "See your name on the board" is the constant reminder to the trainees to inspire them on their journey.

The PPS was borne and sustained out of a spirit of altruism. All have contributed time, energy and money, without which there would not have been a PPS. As all have graciously received, all have gladly given in return. To date, the PPS has produced about a quarter of all successful Med(Family Medicine) graduates. This narration, framed by photographs of the two boards, hopes to capture the pioneering spirit of the doctors who achieved their Masters through the PPS programme. ■

(The actual wooden boards are now stored in the College closet together with the ceremonial gowns.)

Aesthetic Medicine: A Question of Beauty

By Dr Gabriel Seow, FCFP & Editorial board member



COMMON DAILY CASE SCENARIOS

1. A 47-year-old housewife asks to lighten her facial melasma. Various de-pigmentation creams and hydroxyl-acid peels have failed to produce results.

2. A 42-year-old secretary wants her forehead wrinkles "ironed-out". Her condition has not been helped by various prescribed anti-ageing or vitamin C or E serums. She has heard about Botox™ and would like a referral.

3. A 58-year-old housewife is concerned about her increasingly prominent naso-labial folds and sagging cheeks. She has tried oral collagen supplements for 1 year without noticeable improvement. She asks about Matridex™ fillers which she she read about in a beauty periodical.

POINTS TO PONDER

1. There are many people who are concerned about their appearance and are willing to pay a premium to improve their looks.

2. The GP could "help" such people by either referring them to aesthetic physicians or plastic surgeons, or by investing in formal training and equipment in order to incorporate some form of aesthetic medicine into his regular practice.

3. There are certain problems to anticipate when one has decided to go into aesthetics:

a. Further training is required. Currently, training is mainly informal and limited to a short attachment to a practitioner when one has purchased the necessary equipment. The few short sessions do not get one very far.

b. Change in practice profile
It is difficult to go into aesthetics part-time. Regular practice is required to perfect the art. One has eventually to decide whether it is feasible to attend to genuine medical problems while juggling with a demanding cosmetic problem. This requires a complete switch in the physician's frame of mind.

c. Change in patient profile
It is an entirely different matter handling the conventional patient who is ill and is seeking to get well, and the fastidious well patient who wants to look better.

d. The selection of the type and the cost of acquiring the necessary equipment must be taken into consideration. Intense pulse light or laser treatment, diamond derm-abrasion and ultrasonic serum drivers are some options opened to the GP. They vary in cost and function.

e. The stress
Once one has invested significant capital in the machine (usually $40,000-100,000), there will be a subconscious push to attempt to recoup the cost. This may tempt one to do or to offer more procedures than is necessary, raising the problem of **ethics**.

f. The lure to concentrate on aesthetic aspect of the practice is great because the financial gain of one cosmetic procedure may equate to 20-30 conventional consultations.

> There is definitely a place for aesthetic medicine for there are many patients who would truly benefit from some form of treatment for their disfigurement.

g. One must also be prepared for **potential litigation** risk knowing the temperament of the type of patients who dabble in cosmetic procedures. The aesthetic physician must ensure that his medical insurance covers this aspect of his practice.

h. Is one comfortable to be labelled as a kind of beautician?
i. Finally, is one satisfied with what he is

doing? If one is in it for the money alone, it is sobering to know that as an increasing number of GPs and beauticians are dabbling in this business, the share of the pie will shrink and the competition may prove stifling.

There is definitely a place for aesthetic medicine for there are many patients , who would truly benefit from some form of treatment for their disfigurement. However, those involved should receive proper training and be motivated by those values which made them choose medicine as a vocation in the first place.

Having thought this through, I have decided to leave the practice of aesthetics to my esteemed colleagues. I find in family practice my calling and would not give it up for anything else. It is useful however, to keep au courant with the latest developments in the treatment of various skin conditions so as to be able to advise my patients which conditions are realistically amenable to treatment and which are not. ■

Reference:
1. Goh CL. Lasers in dermatology. Medical Progress 2005;32(1):18-30. 2. Rakel RE.Textbook of Family Medicine- Office Surgery 5th ed, 1995:675-694.

A Case Study

By Dr Gabriel Seow, FCFP & Editorial board member

A single 28-year-old female secretary came for yet another attack of upper respiratory tract infection. This was her 5th consultation since she first registered with my clinic 18 months ago.

The following is her physical description:
Wt=119kg ht=1.67m
BMI=36kg/m2 BP=120/82

She had moderately severe acne with obvious facial hirsutism, a prominent hairy nevus over left cheek topped off with a left congenital divergent squint.

She was reticent, soft spoken, unkempt with shoulders hunched and head bowed. What little eye contact she managed revealed an unspeakable sadness, which was evident in her mirthless visage. She had no cushingnoid features.

I was moved by the immense emotional humiliation she must have suffered due to her physical appearance. I had no doubt that her deflated demeanor was due to her resignation to her appearance.

I decided to ask her directly what I had been itching for the past year-and-a-half: how she felt about her appearance and if she was keen to improve it, I could help her. She agreed without hesitation.

Thus started the following chain of referrals (refer to the table below):

Date	Problem	Action
2001-2002	Consulted for 3 episodes of URTI	Symptomatic treatment; MC given Tried to learn more about patient
-2003	Obesity secondary to ?PCOD	Screened for diabetes and hyperlipidemia. Referred for endocrine opinion
-2003	PCOD confirmed, Obesity	Referred for counseling and treatment of obesity
-2004	Congenital left divergent squint	Referred for occulo-plastic correction
-2004	0.7 cm hairy nevus over right cheek	Referred for excision biopsy by plastic surgeon
-2003-2005	Hirsutism and acne	Treatment with anti-androgenic Diane-35

Final visit 2005

I saw a smiling, sprightly 78kg woman exuding an air of confidence, sporting neat shoulder length hair. Her glowing complexion enhanced by light but tastefully applied make-up belied any evidence of acne or facial hair. Both her surgeons had obviously perfected their art to make their art so unobvious.

SOME LEARNING POINTS

1. Benefiting the patient

A family physician must overcome his reservation of approaching even a sensitive subject (such as appearance in this case) if he believes that it will benefit his patient.

2. Why do GPs refer?

a. Diagnosis is not known
b. Confirmation or exclusion of a serious diagnosis
c. Necessary tests or treatment available only in the hospital
d. Second opinion requested by the patient
e. Sharing the load of a difficult case

3. Referrals do matter

Directing a proper referral is a very important and often understated job of a GP. A timely and appropriate referral does great credit to the GP and specialist alike. In this particular case, my service for this patient was limited to channelling her to those competent to take care of her unique problem and what a good job they did! There was no lost of self-esteem nor was my stature diminished in my patient's eyes. ■

Reference
1. Warren E. More Postgraduate Tutorials in general practice. Heinemann 1996; Chapt 14:166-172.
2. Coulter A, Noone A and Goldacre M. Why general practitioners refer patients to specialist outpatient clinics.
Br Med J 1989; 299: 304-8

Family Doctors and Their Practice

'The Family Practice' in the HDB Heartlands

By Ms Tessa Koh, Editorial Writer

Dr See Toh Kwok Yee in his office

You wouldn't have known that it is a clinic if not for the wording, "The Family Practice Clinic & Surgery" displayed at the top of the entrance. Located in the heartlands of Commonwealth Drive, next to the recently renovated Commonwealth hawker centre, is the cosy solo practice established by Dr See Toh Kwok Yee.

An advocate for life-long learning, Dr See Toh, who graduated with MBBS in 1987, was among the first batch of doctors to obtain his Graduate Diploma in Family Medicine (GDFM) in 2002, and he went on to pursue a Graduate Diploma in Family Practice (GDFP), Dermatology. At the moment, he is working towards receiving his MCFP award when he completes the Collegiate Professional Development Programme (CPDP) which he has started in 2004.

Tessa Koh finds out more about Dr See Toh and his practice in an interview at his clinic.

Can you tell us more about yourself?

I have two children, a boy who's 13 this year and an 8-year-old girl. My wife, Dr Long Mei Ling, is currently a researcher for a company that runs trials on drugs for pharmaceutical firms. After getting my MBBS and serving out a five-year bond with the government, I worked for a group practice for one year. Thereafter, I set up my own practice in Commonwealth in 1993.

Can you tell us about your practice?

I have been practising in this clinic for 13 years. It has been a joy treating the residents here. The uniqueness of practising in a mature estate such as Commonwealth is I see quite a number of elderly patients on a daily basis. The elderly make up a third of my patients while adults and children each constitute one-third of the total. While the elderly, who have been staying here for 30 to 40 years, form the bulk of the residents in this estate, I do get to treat a fair share of people of various ages as the residents who grew up here but have moved out of the estate, leave their children with the grandparents on the weekdays.

They see me for chronic illnesses like diabetes, high blood pressure, high cholesterol, heart disease and stroke. I usually spend about 10 minutes with adults/children for common ailments and 15 to 30 minutes with elderly patients. More time is needed with elderly patients, and you have to be very patient with them as they tend to be forgetful and slow in speech.

Front entrance of the clinic

Apart from treating patients in the clinic, I also make house-visits. There are three types of house-calls: pre-arranged follow-up visits, house-calls for those who are too weak to come down to my clinic (e.g. bedridden) and urgent house-calls. Making house-calls also create an opportunity for me to talk to the children of the elderly folks, get them to monitor their parents' conditions and keep a lookout for complications.

What do you like about your profession as a doctor?

I enjoy talking to my patients, seeing them getting better and leaving the clinic happier than when they first came in. You also get unexpected visits from the elderly patients when they surprise you with their newborn grandchildren or give you bags of New Year goodies/mandarin oranges. I even get invited to their children's weddings. Elderly folks are very traditional, and they really appreciate you as a doctor. It's not the tangible things they give me that make me enjoy my work but the intangible stuff like getting to know my patients better and helping them to get well. My patients also

end up becoming my friends.

Can you recall any memorable case that you encountered in your work?
Recently, the Straits Times interviewed one of my patients who suffers from high blood pressure and heart disease. The newspaper was trying to find out how the Singapore population take to their GPs. It was very heartening to read that my patient gave very positive feedback on the subject.

I understand that you took GDFM, GDFP and CPDP. Why do you feel the need for all these courses and how do you see them as being helpful to your practice?
I am always on the lookout for courses that are relevant to my practice. As a doctor practising in a mature estate, I have to constantly upgrade myself in terms of knowledge and the latest development in treatment methods as it is very common for the elderly to have multiple problems, and I want to be able to offer them the best treatment to keep their conditions in check.

GDFM has been most useful: it has this communication and counselling course which teaches us how to relate to patients. Knowing how to talk to the elderly is essential in my contact with them. Sometimes, you need to break the ice: ask them about their family, and when they open up, ask them what is ailing them.
The GDFP (Dermatology) is a relevant course for GPs as it deals with skin conditions commonly found in family medicine.

What do you think of the future of Family Medicine?
Family medicine will become even more important as the population ages. With an ageing population, we will need more resources to look after the elderly. One possible solution is for GPs /family doctors to work in teams or groups so as to pool their expertise and resources. As a group, they would be in a more powerful position to negotiate for medicine of lower cost and could pool their finances to buy better equipment. This would also translate into lower costs for the patients.

I have also noted that over the years, the image of GPs/family doctors has changed. In the early days, family doctors were much respected and considered very important in the community. Later, the status of family doctors went on a decline.

Dr See Toh Kwok Yee with his framed certificates

Only very recently, the image of GPs/family doctors has improved as highlighted by the Straits Time article on its survey of the public's opinion on GPs. Possibly, this turnabout is because of the emphasis on Continuing Medical Education (CME) and the media's favourable publicity on our profession.

Recently, the Family Physician Register has been much talked about. What is your take on the register?
The Family Physician Register should not be viewed as a divisive tool. It is not meant to divide the doctors into two groups: family physicians and non-family physicians. I see it as a chance for the family medicine fraternity to come together as a specialty.

Does your work take time away from your family? How do you maintain a balance between work and family life?
Yes, being a doctor is not easy: the hours are long. That's why I try to finish seeing my patients by Saturday afternoon and spend the rest of the weekend with my family. In addition, my practice operates in such a way that it closes at 3pm and opens again at 7pm on weekdays, leaving me four hours to spend with my children when they come home from school. That way I get to at least have dinner with them before I leave for the clinic. Furthermore, I have a bit more time with them when I close early on Fridays.

Aside from work, what do you usually do for relaxation?
I like to play golf, swim or scuba-dive when I have the time. ■


Dr See Toh and his family

Tips on Anticoagulation for the Busy Family Physician

By Dr Sally Ho, FCFP & Editorial board member

1 What is the Target INR?

- 2-3 for most indications, including bioprosthetic valves.
- 2.5-3.5 for mechanical prosthetic valves.

Ref: Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy. Chest 2004 Sep;126(3 Suppl)

2 How often do I need to check INR?

- Consider monitoring 4-weekly.
- More frequently if
  - INR is out-of-range.
  - Warfarin dose has been adjusted.
  - Change in patient's clinical condition, particularly associated with liver disease, intercurrent illness, or drug administration.

3 What strengths do the pills come in?

- 1mg – brown
- 3mg – blue
- 5mg – pink

4 How do I adjust doses if INR is out of range?

- Always consider the trend in INRs when making warfarin management decisions.
- Consider repeating INR the same day or the next day if the observed value is markedly different from the expected value.
- Unexpected fluctuations of INR in an otherwise stable patient should be investigated.

Possible causes include:
- Change in diet - Poor compliance - Undisclosed drug use
- Alcohol consumption - Self-medication - Laboratory error

Patient's INR	< TR	Within TR (Therapeutic Range)	> TR – < 5.0 No Significant Bleeding	5.0 – < 9.0 No Significant Bleeding	≥ 9.0 OR Significant Bleeding
Dose Change	Increase cumulative weekly dose by 5 – 20% (may not be necessary if INR minimally depressed)	No change	Omit 1 dose optional Lower cumulative weekly dose by 5 – 20% (may not be necessary if INR minimally raised)	Omit 1 – 2 doses Oral vit K 1 – 2.5mg if increased risk of bleeding Lower cumulative weekly dose by 5 – 20% Resume warfarin when INR within TR	Refer A&E
Next INR	4 – 14 days	4 weekly	4 – 14 days	1 – 4 days	

Suggested Follow-up Algorithm	
# Consecutive In-range INRs	Repeat INR in
1	4 – 10 days
2	2 weeks
3	3 weeks
4	4 weeks

5 What are the common drug, herb, food and disease interactions?

- Many substances can potentiate or inhibit warfarin's anticoagulant effect. Caution patients not to self-medicate, including supplements and herbs.
- Advise a diet stable in vitamin K, avoiding large fluctuations.

	Increase INR or Bleeding Risk	Decrease INR or Bleeding Risk
Drug	Azoles, Macrolides, Penicillins, Quinolones, NSAIDs, Cox-2 inhibitors, Amiodarone, SSRIs, Fibrates, Statins, Cimetidine, Omeprazole	Cloxacillin, Griseofulvin ARBs, Barbiturates
Herb	Danshen, Dong guai, Fish oil, Quilinggao, Gingko biloba, Vitamin E, Feverfew, Garlic, Ginger	Ginseng, Vitamin K, Coenzyme Q10, St John's Wort
Food	Grapefruit juice, Cranberry juice, Mango	Green tea, Soymilk, Tofu, Dark leafy greens, Asparagus, Beans, Broccoli, Cauliflower, Avocado, Berries, Papaya, Kiwifruit, Cashew nuts, Canola oil, Olive oil
Disease	Congestive cardiac failure, Febrile illnesses, Hepatic dysfunction, Hyperthyroidism	Hypothyroidism

6 Do patients need to stop warfarin or aspirin or surgical procedures?

- Maintaining anticoagulation or antiplatelet therapy places them at risk for serious bleeding complications, whereas discontinuing treatment puts them at risk of thromboembolic complications.
- Factors such as the patient's risk of thromboembolic event, the location and extent of surgery and the accessibility of the bleeding site to compression or other physical means of controlling bleeding strongly influence management.
- For simple dental and dermatological procedures, most patients do not need alteration of anticoagulation or aspirin therapy.
- Perform INR within 24 hours before the procedure (preferably on the same day). If the INR is above therapeutic range, consider delaying the procedure in consultation with the surgeon.
- For patients with high risk of thromboembolism or those undergoing more invasive procedures, refer to a cardiologist for individualised periprocedural prophylaxis recommendations.

Main References: 1. Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy. Chest 2004 Sep;126(3 Suppl) 2. Hirsh J, Fuster V, Ansell J, Halperin JL. American Heart Association/American College of Cardiology Foundation. American Heart Association/American College of Cardiology Foundation guide to warfarin therapy. J Am Coll Cardiol 2003 May 7;41(9):1633-52. 3. Holbrook AM, Pereira JA, Labiris R, McDonald H, Douketis JD, Crowther M et al. Systematic overview of warfarin and its drug and food interactions. Arch Intern Med 2005 May 23;165(10):1095-106. 4. Wells PS, Holbrook AM, Crowther NR, Hirsh J. Interactions of warfarin with drugs and food. Ann Intern Med 1994 Nov 1;121(9):676-83. 5. Demirkan K, Stephens MA, Newman KP, Self TH. Response to warfarin and other oral anticoagulants: effects of disease states. South Med J 2000 May;93(5):448-54. 6. Jafri SM. Periprocedural thromboprophylaxis in patients receiving chronic anticoagulation therapy. Am Heart J 2004 Jan;147(1):3-15.

Wonca Executive Meeting
- in preparation for Wonca 2007

By Dr Tan See Leng, Chairman, Wonca 2007 HOC

The College of Family Physicians Singapore and the Host Organising Committee (HOC) of the Wonca World Conference in 2007 hosted Dr Dan Ostergaard, the immediate past chairman of the Wonca World Conference in 2004 in Orlando, to a visit of the proposed conference venue at Suntec City Exhibition and Convention Center on the 13th February 2006.

Dr Dan Ostergaard

The visit also coincided with the Wonca Executive meeting here in our country and the committee enjoyed a fair amount of exchange of ideas, views and suggestions from both Dr Alfred Loh, CEO of Wonca, and Dr Ostergaard.

The committee brought Dr Ostergaard on a guided tour of the Suntec City Exhibition and Convention Center and also hosted both Dan and his wife to a Peranakan dinner at an old conserved shop house along Tanjong Pagar for them to sample a little of Singapore's cultural heritage and history.

Dr Ostergaard was visibly impressed with the facilities at the Convention Center and concurred with the Host Organising Committee's views to have the world conference held there as the area has a lot of scalability in terms of conference and exhibition space, besides being located in the center of major five star hotels with some 5200 rooms.

The HOC also presented to Dr Ostergaard its scientific program, social & cultural program as well as the marketing initiatives launch thus far.

Dr Ostergaard was very supportive of the HOC's initiatives and also offered valuable insights into various aspects of the conference planning, from registration to the pre and post conference tours as well as the social programmes right down to the scholarship funds for global participants.

Dr Ostergaard has offered to continue to open up channels for the Singapore's HOC to gain marketing inroutes into the US, Eastern and Western Europe as well as the former Soviet Bloc states and has advised the committee to gain accreditation for CME points from the American Academy of Family Physicians to obtain more participants from the US.

The visit also coincided with requirements from the Wonca World Secretariat that each HOC has to have a total of 3 Conference Planning Committee (CPC) meetings, the first two being held in Orlando in October 2004 and Kyoto in May 2005 respectively, and this represents the final meeting for the CPC. The CPC comprises three members namely; the CEO of Wonca, the immediate past Chairman of the Wonca World Conference and the current Chairman of the impending Wonca World Conference. ■

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- Improve the nutritional status of the children.
- Vaccination.

Prevention of Childhood Diarrhoea and the Rotavirus Vaccine

Diarrhoeal disease remains a leading cause of morbidity and mortality in children worldwide. In Singapore, approximately 10% of all paediatric hospitalisations are the result of diarrhoea.

The main enteric pathogens associated with childhood diarrhoea are viruses, with rotavirus being the most common. Salmonella, Campylobacter, Escherichia coli and Shigella are the causes of bacterial diarrhoea.

As faecal-oral route is the most important method of transmission, good hygiene is essential for preventing the infection, and for limiting the spread of the illness. Good hygiene practices include meticulous hand washing; thorough cooking of eggs, poultry and meat of animal origin; and separating raw meat from cooked food or fruits.

Virtually all children are infected by the age of 5 years, regardless of nationality, level of hygiene, sanitation, access to clean water, and residency in developed or developing countries. In Singapore, since 1970s, rotavirus continues to account for approximately 30% of all children hospitalised for gastroenteritis. Vaccination against the rotavirus is the only effective method of reducing severe rotavirus diarrhoea.

In naturally acquired rotavirus gastroenteritis, the younger the child, the higher the risk of severe disease and hospitalisation. The first episode is the most severe and subsequent infections become progressively milder. ■

Consultation, Communication & Counselling (CCC) Skills Course Workshop

By Ms Fan Yingshi, Editorial Writer

The trainees engaging in lively discussion.

Enjoying the workshop and movie sessions.

'Fearless' in Family Medicine: Dr Julian Lim demonstrating a spot of eye-popping kung fu to illustrate his point.

Innovative Use of New Medical Education Method: Cinemeducation

Family medicine teachers in Singapore had always been at the cutting edge of medical education in Singapore. The College of Family Physicians Singapore was the first to introduce OSCE (Objective Structured Clinical Examinations) to the medical profession when it was developed for use in the clinical examinations of the first Graduate Diploma in Family Medicine (GDFM) examinations in July 2002.

The family medicine trainers broke new ground again on 4th March 2006, when for the first time in Singapore, cinemeducation was formally used as a teaching method in the training of doctors.

Cinemeducation, which is the use of popular movies in medical education, had been around for the past ten to twenty years. It has been found to be exceptionally effective in teaching psychosocial aspects of medicine. The trainers at the Institute of Family Medicine, College of Family Physicians Singapore, decided to revamp the course in consultation, communications and counselling skills using this innovative pedagogical method.

In addition to the course materials used in previous courses, participants attended a workshop where they were shown video clips of movies at 3 different stations. Each clip was chosen to illustrate aspects of consultation, communication and counselling. After viewing the clips, they were engaged in reflection and discussion by the facilitator. The course was closed with a panel discussion of a clinical case. This was done to reinforce lessons learnt and to translate them into applicable clinical techniques.

Interviews with the GDFM Trainees >>

"I found the course to be useful, informative and well-organised. The videos were interesting and thought-provoking. Effective communication is a two-way process, and it is important for us to understand the patients' needs and wants."

- Dr Samuel Leong, 2004-2006 batch

"Very informative and useful. I think we are looking at things we face during our practice."

- Dr Yang Aylwin, 2005-2007 batch

"I think that it is quite well-organised; the teaching pointers were quite effective. On the whole, the workshop was highly informative; there were good points taken up. I think the video techniques used were very useful because it showed us a real-life consultation rather than something theoretical. It was more practical based, and we were opened to critique of the video.

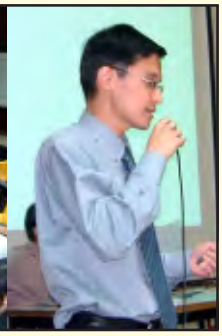
I hope in future they will actually film us doing a consultation and let us critique ourselves. I learnt how to communicate better; learnt proper consultation skills; how to pick up verbal as well as non-verbal cues from the patient, and how to open and close a consultation properly."

- Dr Samuel Ang, 2004-2006 batch

Dr Tan Yew Seng showing the movie, "Instinct".

Interactive session with the tutor, Dr Julian Lim.

Dr Lee Kheng Hock chairing the panel discussion.



Dr Kwong Kum Hoong sharing his thoughts.

INSTRUCTIONS TO PATIENTS WITH INFLUENZA

Influenza is an acute viral disease of the respiratory tract characterized by fever, chills, non-productive cough, running nose, exhaustion, headache, muscle ache and sore throat. Among children, ear infection, nausea, and vomiting are also commonly reported with influenza illness. Although influenza can worsen any underlying medical conditions (e.g., lung or heart disease) or lead to lung infection and other complications in certain groups of patients, it is usually a self-limiting disease in healthy individuals. The illness typically resolves after a limited number of days in most persons, although cough and exhaustion can persist for more than 2 weeks. Mild cases of influenza can be managed in the outpatient setting with close monitoring.

GUIDELINES FOR THE PATIENT

The following is a set of advice to help you and your family to manage influenza at home. Please note that the list is not exhaustive.

1. Ensure that you stay at home and have adequate rest if you are suspected or diagnosed to have influenza. Maintain good indoor ventilation.

2. Wear a surgical mask at all times if you have fever, cough or sneezing until the symptoms resolve.

3. Check your body temperature regularly. Antipyretics (e.g. panadol/ paracetamol) may be used for fever according to your doctor's advice or instructions on the package of the medication. Salicylates (e.g. aspirin) should not be used in children as its use has been associated with the development of Reye's syndrome.

4. Follow the advice of your doctor with regards to the use of any other medications such as antivirals, antibiotics, cough and running nose medication etc.

5. Drink enough water to prevent dehydration and consume nutritious and easily digestible food. Do not smoke.

6. Observe good personal hygiene:

- Cover your mouth with a tissue when coughing or sneezing.
- Throw used mask and tissue into the rubbish bin.
- Do not spit on the floor.
- Wash your hands with soap every time you touch your nose, mouth or eyes and after toileting.
- Surfaces soiled with sputum, phlegm, nose discharge or vomit should be washed/wiped with 1:50 diluted household bleach (i.e. adding 1 part of bleach to 50 parts of water) immediately. Metallic surfaces can be cleaned with alcohol (e.g. isopropyl 70% or ethyl alcohol 60%).
- Avoid touching your eyes, nose or mouth as far as possible.

7. Educate your family members especially children and elderly on the importance of good hygiene in order to prevent them from being infected.

8. If your symptoms persist or worsen, please go to a clinic or hospital immediately for further evaluation and management. Children, elderly, the immunocompromised or those with chronic illness should seek medical consultation earlier.

GUIDELINES FOR THE FAMILY AND CAREGIVERS

In addition to the precautions above, the family should:

1. Ensure you have the following items at home:

- Surgical masks. Several weeks' supply of masks is recommended.
- Antipyretics (e.g. panadol). About one week's supply of antipyretics for use should be kept on standby for use when necessary
- Thermometer
- Liquid soap
- Tissue paper
- Over the counter antihistamine, lozenges and cough mixture (if available)

Note: Do store all medications safely. They should be properly stored out of children's reach and sight. Any expired medications should be discarded.

2. Wear a surgical mask if you are the caregiver of patient(s) with respiratory infection.

3. Be resourceful. Know the contacts of your family doctor and medical organization hotlines and websites.

4. Have a plan for what you and your family would do if you had to stay at home during a pandemic.

5. Try to keep well and sick persons apart.

6. Sharing bedding, clothing and utensils may spread infection, but you do not need to wash a sick person's bedding, clothing and utensils separately from the rest of the family's.

Clinic Name/Doctor

This patient information leaflet is designed by the College infuenza workgroup from text provided by the Ministry of Health.

College of Family Physicians Singapore
MEMBERSHIP

We invite you to join THE ACADEMIC BODY OF FAMILY MEDICINE. The College is active in the continuing medical education (CME) and continuing professional development (CPD) of Family Medicine. Pursue your personal interests in Family Medicine and contribute to its corporate development through membership of the College. Your membership counts. There is strength in numbers. Support Family Medicine. Join the College.

PRIVILEGES OF MEMBERSHIP

- **Substantial savings** in course fees/ registration fees for seminars/conferences/CME events organised by the College compared to non-members.
- **Priority in registration** for College members.
- **Complimentary** copy of the quarterly "**Singapore Family Physician**" journal and "**The College Mirror**" newsletter.
- **Four copies** of the **Answersheet form for distance learning module** of the Family Practice Skills Course.
- **GDFM Programme –** special rates!
- **Access to e-learning modules**.

WHAT TYPE OF MEMBERSHIP?

- **Associate Member**

a) is a registered medical practitioner or has an acceptable qualification, or
b) is a provisionally or conditionally registered medical practitioner. Provisionally registered doctors must become conditionally or fully registered within the number of years stipulated by the Singapore Medical Council; and
c)is a registered medical practitioner who does not qualify for Ordinary or Collegiate membership.

- **Ordinary Member** a) is a registered medical practitioner or has an acceptable qualification,

b) has GDFM, MMed (FM) or equivalent, or is fully registered with the Singapore Medical Council and has held a registrable or acceptable medical qualification for not less than five years;
c) is engaged in family practice or equivalent.

The membership classification of the applicant is subject to the Board of Censors' recommendation and College Council's approval.

WHAT ARE THE ANNUAL SUBSCRIPTION FEES?

- S$ 50 = One-time Entrance Fee
- S$ 180 = Associate Membership
- S$ 180 = Ordinary Membership
- S$ 90 = Overseas Membership

HOW DO I APPLY?

- College membership forms can be downloaded from http://www.cfps.org.sg/formsdownload.htm.
- Please complete the application form and send it to:

The Honorary Secretary,
College of Family Physicians Singapore, College of Medicine Building
16 College Road, #01-02, Singapore 169854

- Please make cheques payable to "**College of Family Physicians Singapore**".