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Seminar & Workshops
in September 2006
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Celadon Ewer

Ming Dynasty

1368 - 1644

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Launch of Family Medicine Department

An aging population, increased prevalence of chronic diseases, discontinuity of care between hospitals and the community, the need for integrated care between hospitals and primary care clinics are challenges that we face as we work towards providing good and affordable of health care in Singapore.

Dr Lee Kheng Hock
Head & Senior Consultant, FMCC SGH

As part of its overall effort to tackle these problems, SGH had established a family medicine department. This will be the first family medicine department in a hospital in Singapore. The Department of Family Medicine and Continuing Care (FMCC) was officially launched on the 2nd May 2006.

One of the first projects of this department is to facilitate right siting of chronic disease management. Work is under way to establish a clinical care network to ensure that patients who are discharged to their family doctors will be well informed and prepared.

Primary care clinics receiving such patients will be supported by the hospital to ensure that the patient will continue to receive the right level of care when they are discharged to the community.

The family doctors will have access to the necessary medical information and the support of specialist colleagues in the hospitals to ensure that the patients remain well in the community. The family doctors will also be able to quickly refer the patients back to the hospital whenever there is a need to do so. This way, patients can enjoy a high level of care in the comfort of the familiar community environment without the inconvenience and higher cost of specialist outpatient clinics in hospitals.

The FMCC will also be involved in other core activities of SGH which are service, research and medical education. The department will work to improve the care of patients in the hospital, especially patients with multiple medical conditions which need better care co-ordination, rationalizing polypharmacy, discharge planning and more effective use of community resources. The department will be involved in research work, mainly in the area of translational and health services research. This formation of this new department is seen as another milestone in the development of family medicine in Singapore.

The Department of Family Medicine SGH

By A/Prof Cheong Pak Yean, President

The second of May 2006 was a significant milestone for the College. On this day the first Department of Family Medicine and Continuing Care (FMCC) in a tertiary institution was inaugurated in Singapore. The FM fraternity in Singapore believes that an independent department is important to take FM to greater heights. This aspiration received support in many General Meetings of the College. The College shares with the leaders of the Singapore General Hospital (SGH) the vision to embark on such an initiative.

Family Physicians have been appointed to clinical consultant positions in SGH. They would be involved in the delivery of clinical care in the tertiary hospital.

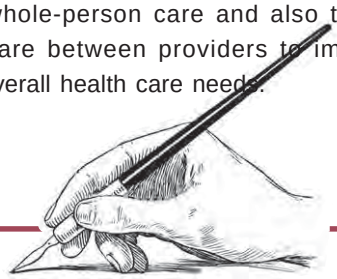
The new department would augment the care delivered by the polyclinics and GP clinics in the community. It would also play a role in the integration of care with other specialists' services in the hospital. Writing in the Annals of Internal Medicine, S J Weiner et al stressed the importance of facilitating whole-person care and also that of integrated care between providers to improve "patients' " overall health care needs.

The College believes that the new Department in SGH can contribute to "the processes for effective communication" towards the right siting of care in Singapore.

The world's family physicians are converging in Singapore in July 2007 for the WONCA World Assembly.

Independent departments of family medicine in hospitals and universities have the long tradition in many developed countries of playing sentinel roles in the right siting of care of patients in these countries. In recent years, such departments have also been set up in neighbouring countries such as Malaysia and Thailand. The establishment of FMCC will take Family Medicine Singapore to greater heights. The College believes that FMCC can contribute to the national endeavour to level up primary care and better integrate community care with the care delivered by specialists in hospitals in the long run. This will lead to more cost effective care. ■

Saul J. Weiner et al . Processes for Effective Communication in Primary Care. Ann Intern Med. 2005; 142:709-714



Turning Point

"…tell me turn here, turn there, and we are still here!" declares Phua Chu Kang.

By Dr Yee Jenn Jet, Michael, MCFP, Editor

We cannot help but notice that Family Medicine has reached a turning point and set on a firm path of future progress. Family Physicians, especially those in private practice, have hit a rough patch over the past few years. The statistics from the Primary Care Survey 2005 proved it (find out more in the Primary Care Survey 2005 Findings on page 18). The same survey also demonstrated the mettle of the humble GP who stood together where it mattered. Despite the adversity, many GPs have found positive new cheese. Some quickly validated their skills through postgraduate training and went back to the polyclinic as leaders with valuable experience (Polyclinic Experience on page 4). Many new opportunities await the certified Family Physician (read about Asst Professor Gerald Koh on page 14).

The launch of the FMCC is a landmark triumph for Family Medicine. (Frontpage Article) The College Mirror wishes Dr Lee Kheng Hock, the first Head and Senior Consultant of the FMCC Department, SGH all the very best in his new appointment. The government has stayed true to its direction of tackling the problems at primary care before diseases progress to the need for tertiary care. The Health Minister has put the money where it matters and boldly announced the change in use of Medisave funds to allow for carefully selected primary care use for the first time (Medisave for Chronic Illness on page 10).

How will our future look like? Read about how health tourism would affect us (Health Tourism and GPs on page 8). Looking at the horizon, the Flu Pandemic looms large. Getting prepared is the key to avoiding an impending disaster (GP Flu Pandemic Symposium on page 12). ■

The new department is headed by Dr Lee Kheng Hock who was formerly the Executive Director of the College of Family Physicians Singapore. He holds the appointments of Censor-in-Chief of the College, Adjunct Assistant Professor in the National University of Singapore and Co-Chairman of the Interim Joint Committee on Family Medicine Training. He is well known as an advocate of better care systems for chronic diseases. As Chairman of the Feedback Group on Health of the Feedback Unit, he had presented papers on developing better systems to ensure affordable health care for Singaporeans with chronic illnesses. ■

At the official launch of the Department on the 2nd May 2006. From left to right: Dr Matthew Ng (Associate Consultant, FMCC) Dr Lee Kheng Hock (Head and Senior Consultant, FMCC) Prof Tay Boon Keng (Chairman Medical Board, SGH) Prof Tan Kok Chai (Chairman Division of Surgery, SGH) A/Prof Cheong Pak Yean (President, CFPS) Dr Michael Wood (Emeritus CEO, Mayo Clinic) Prof Tan Ser Kiat (GCEO, SingHealth) Prof Ng Han Seong (Chairman Division of Medicine) Ms Karen Koh (DCEO, SingHealth) A/Prof Goh Lee Gan (Vice President, CFPS)

The Family Medicine Hospitalist

Possibilities and Challenges

Dr Peter C Jamieson is one of the pioneers of a new breed of family physician hospitalists who established one of the most effective hospitalist programme in North America.

He is the Division Chief of Acute Care Family Medicine of the Calgary Health Region which has a cluster of 5 hospitals and an integrated network of community and long term care facilities. It serves a population of 1.14 million people.

Dr Jamieson is a Clinical Associate Professor at the University of Calgary.

Date: Wednesday 30th August 2006
Time: 5:15 pm - 6:30 pm
Title: "Family Practice Hospital Model in the Calgary Health Region - A Proven model of care"
Venue: College Lecture Room (COMB)

5.30pm – 6.15pm Lecture by Dr Peter C Jamieson: The Family Medicine Hospitalist – the Experience of the Calgary Health Region and Lessons for the Future

5.30pm – 7.00pm Panel Discussion: The Hospitalist Care Model in Singapore: The Possibilities and Challenges (With Dr Peter Jamieson, Prof Tay Boon Keng, Prof Ng Han Seong, Prof Ong Yong Yau, A/Prof Goh Lee Gan, A/Prof Cheong Pak Yean, Dr Tan Chee Beng and Dr Lee Kheng Hock)

Please RSVP Katy at 62230606 or Melissa at 63265872 by 31st July 2006

Jointly organised by the Singapore General Hospital & The College of Family Physicians.

Singapore General Hospital
SingHealth

Family Doctors and Their Practice
The Polyclinic Experience

By Tessa Koh Mui Hoon, Editorial Writer

The Director and Associate Consultant of Bukit Merah Polyclinic, Dr Michael Wong Tack Keong, has worked in both private and public sectors. He tells Tessa Koh why he loves his work in the polyclinic and describes his various roles at work.

Dr Michael Wong at work.

Why did you decide to become a doctor and what led you to study medicine?

It was not a sudden decision to go into medicine. I have always loved science and biology, and the visit to the Anatomy Museum in Secondary four did the trick: our biology teacher challenged us to become doctors! My Christian background and the desire to improve the life of the community-at-large also played a part in the decision.

Have you ever wanted to pursue a career other than one in medicine? What was it?

I remember wanting to be a pilot as soon as I could talk. I actually witnessed the Concorde in its debut flight to Singapore. The only obstacles to my flying career were my short-sightedness and the whopping course fees for pilot school. So my flying career ended even before it could take off.

Another dream of mine was to be a vet, but there was one problem – I only wanted to treat dogs!

After graduating, did you immediately go to work in the polyclinic?

No. After serving out my bond with the government and completing National Service, I spent five years running a solo HDB practice for a group.It was a valuable experience as I gained the expertise of managing a "business".

Though I am a doctor by profession, the intricacies of keeping the practice afloat were very real.

In the initial years, I had to devote the bulk of my time to keep the practice sustainable. This was where I learnt the operational and financial aspects of running a clinic. This knowledge came in handy when I was the Deputy Director of Pasir Ris Polyclinic and in my current post with Bt Merah Polyclinic.

After I completed the MMed (Family Medicine) programme under the Private Practitioners' Stream, more options opened up, and I decided to return to public service to see if I could make a difference.

How long have you been in the polyclinic setting?

I have been with Singhealth Polyclinics for five years. In the polyclinic setting, we see somewhat the same profile of patients as that of a GP practice, albeit in greater numbers! Proportion wise, it's about 70% chronic cases (such as diabetes and hypertension) and 30% acute.

As Bukit Merah is an older estate, it also has a higher percentage of elderly patients.

What do you like about your work?

In my current role as the director, my tasks are more varied. As the medical head, I take care of the doctors under me professionally and practice-wise.

We have an excellent group of doctors in Bukit Merah Polyclinic, and they really make my job both easy and enjoyable.

As an administrator, I oversee the overall operations of the clinic with the aid of my capable nursing, pharmacy and clinic managers.

In spite of my management duties, I still find time to do clinical work. There are also many opportunities to teach both the postgraduate MMed trainees and the medical undergraduates passing through the polyclinics.

The other unique part of this job is that, being in management, I have the opportunities to improve the health of the masses through policy-making or implementation of clinical improvement projects and initiatives.

Where can you get this type of exposure and experience?

Family time for Dr Wong.

Any memorable case?

I have a patient who followed me from private practice to polyclinic, east to west! Don't be mistaken, she's not a secret admirer. I talked her out of getting an abortion at her first pregnancy, and now her daughter is 7 years old. What a bundle of joy the daughter is! Just imagine what the mother would be missing if she went ahead with the abortion. At the moment, I am co-managing her second pregnancy with her gynaecologist.

Dog-walking time!

What are the pros and cons of working in a polyclinic as compared to working in a general practice?

The polyclinic, a one-stop centre with adequate support staff and facilities, is well-equipped to handle chronic cases.

We have a very comprehensive list of cost-effective chronic medications, a well-equipped laboratory and radiology services, diabetes foot screening (DFS) and digital diabetic retinal photography (DDRP) services.

All the doctors are rigorously trained to handle these cases. The cases that require more care but are poorly controlled despite all efforts are referred to our 2nd tier clinic called the "Family Physician Clinic" where MMed Family Medicine trained physicians and a team of healthcare professionals would attend to them.

Polyclinics are usually very crowded. Time is one major constraint I face. Some of us even get verbally abused by irate patients for the long waiting time. It is very disheartening. We are already doing our best for the patients with the limited time and resources we have.

As a GP, one could spend more time with the patient and deliver a more personalized service. There is really no specialty like Family Medicine, which caters to the care of the entire family, from the new-born baby to the elderly grandparent.

GP care spans one, two and even over three generations! I had the honour of caring for the elderly patients and their families as the patients passed away, and performing the important deed of signing the death certificate.

Another unique aspect of the job is the flexibility to make house-calls and treat the patient in his home.

The only downside of running a private practice, I feel, is the constant need to watch the bottom-line and ensure that the practice is economically viable. At the end of the day, the practice is still a business.

I understand that you are involved in various teaching activities. What are the experiences like and what attracted you to take on training roles?

A/Prof Goh Lee Gan got me into teaching when I was doing my MMed & Fellowship programme. He's my role model! Teaching FM would be great fun if we could all do it like how Prof. Goh does it!

Formerly, I was a GDFM tutor. Now I am one of the supervisors for the FMFP 2004-2006 intake. I enjoy interacting with the trainees who come from various working background. It's a learning experience for me each time we meet.

What would you say to those who are interested in assuming training roles but do not know where to begin? Any word of advice?

Don't wait. Many feel that they need to be one up better than the trainees

"Teaching is learning, but from a different angle."

before they could start teaching. Nobody would be ready to be a trainer if this were the case. Think of yourself as a facilitator who gets others to share their knowledge or experience rather than one who adopts a top-down, I-tell-you-so approach.

The trainees may actually know more than the tutor! It's like photography: the student knows all about the camera and the best way to take a good photo while the tutor is the director who helps the student to focus, zoom in and get the big picture.

Do you have any plan professionally in the future?

I would like to further myself in the area of administration and management. An MBA in healthcare is my next goal if time and finances permit. I am also looking seriously at a Diploma in Geriatric Medicine to better prepare myself when dealing with aged patients.

What do you think of the future of Family Medicine?

Bright, bright, bright! There are many exciting things happening: NUS Medical School's intention to focus on Family Medicine, SGH's establishment of the Family Medicine and Continuing Care Department, and all the changes that MOH has in store for primary care. I am really looking forward to Family Medicine taking a quantum leap in Singapore!

What do you think can be improved in the local healthcare industry? How?

Presently, we are still very much in the curative stage, secondary and tertiary prevention stage. We are paying for procedures rather than focusing on prevention.

I wish we could channel more funds into preventive care and primary prevention at the GPs and polyclinic level.

As Arkansas' governor, Mike Huckabee, said, "Our healthcare system should build a fence at the top of the cliff so we can stop sending ambulances to the bottom."

The Australian government has realized the importance of preventive care and recently announced new budget funding for prevention and mental health in primary care.

Prevention will be of increasing importance as healthcare expenses are going to consume more and more of our income in the years to come. We could and should do something now!

"Working in the polyclinic gives me the opportunity to learn from as well as interact and work with other doctors and staff from different departments, including the admin, nursing and pharmacy."

As a busy doctor, how do you manage your time? Do you have quality time with your family?

I make time for my wife by utilizing the waiting time in between tasks: I chauffeur my wife to and from work, and chat with her on the phone on the way to a meeting or home when she's not in the car.

Unless there's something really urgent or important, my home hours are "protected". We try to dine together as much as possible, preferably at home. She works and is still able to churn out great dinners! Make family time and it will be happening!!

Aside from work, what do you usually do for relaxation?

I like to read, travel, walk my dogs and play my Xbox or PlayStation. And there is one thing that I really must get down to doing soon – putting on the pair of jogging shoes that has been in my closet for quite some time! ■

Trials, Tribulations & Triumphs

By Dr Yee Jenn Jet, Michael, MCFP, Editor, Senior Family PhysicianPrivate Practice

The placid family medicine research scene in Singapore meant that our specialist colleagues have taken over much of that role for us, using proxy secondary and tertiary care samples, from an alien point of view. Research is not an option, but a necessary part of our practice that most family physicians have relegated to 'someone else'. The truth is family physicians have a role to play in research: as a supporter, participant or investigator etc.

We feature a series of family medicine research projects to illustrate the trials, tribulations and triumphs of undertaking primary care research in Singapore. For those who are engaged in or thinking of family medicine research, this could be a forum to share your excitement and even appeal for resources that might be lacking.

Prescribing Pattern Trial

Inspiration

The two papers, "The Prescribing Pattern of Hospital Doctors" and "The Prescribing Pattern of Outpatient Polyclinic Doctors," published in the Singapore Medical Journal in 1998 and 1999 respectively formed the backdrop for my proposed project. Hospital outpatient and polyclinic prescription patterns have been explored.

The project to study the same in private outpatient practice was screaming to be done, to complete the trilogy.

Research Question

This study aims to analyse the prescribing pattern of Singapore private family physicians and factors affecting prescribing patterns.

Study Design

Retrospective post hoc study of 1 year of computerised prescription records in 2002. Number of prescription items per consultation, patients' age, gender, race, day of the week, month of the year and healthcare management utilised were measured.

Tribulations

The first difficulty I encountered was finding like-minded family physicians to lend me their data so that I might analyse it. Poor emphasis on primary care research as placed family physicians in a complacent attitude. The number of clinics I only managed to do a pilot study. The second problem was inadequate necessary resources. Subscription to full-text journal articles cost thousands of dollars. Formal statistical packages cost several hundred dollars and expire annually.

A non-academic practitioner not linked to an institution would not have the necessary resources to carry out the project. Many journals would also require ethical clearance through review boards before the paper could be published. Those with access to these resources should count themselves privileged.

The idea of using computers to mine data was not new. The difficulty was that there was no standard way in which data was recorded. I found out late into my adventure that it would take an 'IT genius' to combine the data before any meaningful analysis could be carried out.

Although my professor assured me that the statistical package was taught during the COFM lectures in my medical student days, I remain unconvinced. If that was true, there should be at least some vestige of memory of the methods covered. Unfamiliarity with statistics could be a daunting hurdle.

"Through perseverance, a nidus of a primary care research network was formed. With attitudes towards family medicine research changing, there is potential to develop the network and accomplish useful research work."

Triumphs

By simply bringing up the barriers to family medicine research to interested parties in the College, changes were made quickly to support my work. For a start, the College Institutional Review Board was formed to review research projects by private GPs who are interested in research work.

We all know that there are lies, lies and statistics. In other words, while the numerical data cannot be changed, the figures can be presented from the viewpoint of the author. If these figures were presented from another point of view, GPs might be 'clobbered' again for the way we 'abuse' antibiotics etc. The more accurate picture: the norms in primary care are different from the situation in secondary and tertiary care.

Here lies the essence of engaging in Family Medicine research. Our points of views can finally be put across.

KHJ Lim, KB Yap, The prescribing pattern of outpatient polyclinic doctors. Singapore Med J 1999 40(6).

KB Yap, KM Chan, The prescribing pattern of hospital doctors. Singapore Med J 1998 39(11): 496-500. ■

Health Tourism and GPs

By Dr Tan See Leng, FCFP ,Council Member, COO Eu Yan Sang

Introduction

The advent of globalization in all industries has led to the high-end specialists working in premier tertiary health care institutions extracting the most economic value from top end procedures performed on patients locally, regionally and internationally. However, the pool of patients who used to be treated by family physicians continues to dwindle.

While the government is expending resources to boost up health care tourism and making Singapore into the medical hub of Asia with a 7-hour flight radius, tertiary institutions and specialists reap the most benefits. 'Singapore Medicine' was formed with this main objective of promoting the country's tertiary institutions and specialists to regional countries as well as far away countries in the Middle East.

Considering the amount of resources and the time frame of implementation by the Singapore Medicine initiative, the outreach program to bring health care tourists into our country has been a huge success by any standards taking into account the healthy increases in the number of foreigners consulting at our private and restructured hospitals.

Unfortunately, very little of this segment of the market filters down to the family physicians who despite laboriously putting in long hours in their clinics in the heart lands, find it a gradually losing proposition to stay in business.

While many may have succeeded in newer and more novel ventures, others have just contributed to the bottom lines of medical equipment and nutritional supplement companies.

Trends in Health Care

As incomes continue to grow in a jet set age, more and more patients will demand better clinical services and better outcomes.

Some of the inevitable trends that will evolve are;

1. increase in cross border movement of health care workers to countries with the best economic, career prospects and living standards
2. tendency for highly affluent and educated patients with a greater willingness to pay for top quality health care services to move to countries with high standards of health care
3. movement of funds across boundaries and countries to invest in health care opportunities
4. outsourcing of transcription and other ancillary support services such as tele-radiology to cheaper alternatives whilst maintaining standards
5. sophisticated health care funding and financing models to tackle the increased demands especially of a rapidly ageing population

Two Tier Health Care System

How do we as a country of over 4 million population, and supported by close to 6000 doctors, collaborate to attract the top end foreign patients to our shores whilst keeping health care inflation at an acceptable level?

Perhaps, the answer lies in both specialists and family physicians collaborating in a more closely knit fashion.

Whilst the foreign patients coming to our shores to seek treatment would do best to adopt a specialists' centric model of treatment; our local patients especially the older patients with a multitude of chronic illnesses would do best with a GP centric model.

The specialists can and will also have more time to tend to the varied needs of both their local and foreign patients whilst in the hospital and at the same time co-managing the stable local patients discharged back to their family physicians for long term follow up care.

Collaboration

With more initiatives for further training and the proposed establishment of the family physician register, the level of competence and expertise in family medicine within the country will continue to rise from the already high standards practised.

However, the leveling up of the family physician must be matched by the accompaniment of clinical material for these doctors to manage and hone their skills.

Otherwise, such training and upgrading programs would lead nowhere and may also result in family physicians opting to move out of family medicine as a discipline; a move that would prove disastrous in managing health care inflationary pressures especially in the wake of a rapidly ageing population.

Our health care system has always been one of allowing free market forces to prevail.

Unfortunately, in the health care industry where information is not perfectly free-flowing and where there exists a chasm between patients' expectations and third party payers, some definitive reforms may be necessary to realign the interests of all parties.

The primary care physician has to understand that one can no longer afford

to charge low fees in expectation of bigger volumes. Whether patients are from the self-paying type to the third party paying type or insurance companies, they are getting more conscious of their rights as consumers and will continually have higher expectations at all levels.

Clinical practice guidelines and evidence based medicines will inevitably raise standards of practice; but costs to service patients will also go up contemporaneously.

How do we as family physicians survive these times?

In order to continue to fulfill our passion and commitment to heal and comfort the infirmed, we need to collaborate closer as a community; consistently improving our service standards, expertise and facilitating free flow of medical information for better and more transparent management of conditions.

As a cohort of 3000 general practitioners with about 2000+ clinics island wide, we should work closely toward collaborating in procurement, manpower cross coverage and continuing professional development.

As patient volumes remain stagnant or even decline, we must move out of our comfort zones and manage the needs of our patients in their homes, community and tertiary hospitals.

We must support restructured hospitals in their attempts to set up family medicine departments and return to the hospitals to co-manage our patients so that a more holistic shared care program can evolve.

For those in small group and solo practices, perhaps it is timely for them to engage in talks with other small groups and solo practices to share resources and commit to more collaborative ventures.

Conclusion

In the not too distant future, our family physicians, undisputedly better trained and equipped, can explore working in regional countries in collaborative tie ups with foreign primary care clinics to be conduits for referrals into our tertiary institutions.

Our local market in terms of population numbers will continue to be restricted, but the regional countries around us have a market of some half a billion people and as a leading medical hub in Asia, our family physicians can truly forge strong ties with doctors from other regional countries to becoming a Pan Asian patients' advocate team resulting in a truly comprehensive and rewarding integrated health care value chain.

As our government continues to spearhead and drive health care tourism, our family physicians would do well to leverage on their networks and expertise and venture into markets of Indonesia, Indochina, Bangladesh and the Middle East. These are immediate markets, which already have exposure to our local tertiary hospitals and specialists but perhaps have little or no knowledge about our primary care segment. A recuperative and rehabilitative program of these health tourists would definitely be welcomed by such patients.

We have to move out of the inertia of being in our consult rooms day in and day out lamenting the market forces passing us by and move on to find new areas of outreach. ■

Doctor Humour Family Practice Fables

By Dr Jeff Tay Guan Yu, MCFP, Editorial Board Member, Senior Family Physician Private Practice

The GP Flu Pandemic Symposium

Medisave for Chronic Illnesses

By A/Prof Goh Lee Gan , Vice President

By year's end, Medisave could be used for outpatient care of 4 carefully selected common chronic diseases:

- ***Diabetes mellitus***
- ***High blood pressure***
- ***Lipid disorders***
- ***Stroke***

By year's end, Medisave could be used for outpatient care of 4 carefully selected common chronic diseases - diabetes mellitus, high blood pressure, lipid disorders and stroke. In announcing the new development in May this year, the Health Minister said his Ministry will proceed with this scheme with prudence.

"This is a big step for Medisave, which was designed primarily to pay for inpatient care; it was not intended for outpatient care. Outpatient care can be easily abused or overused. If Medisave is prematurely depleted through unnecessary or ill-advised outpatient treatment or marginally effective medical screening, it will cause financial hardship for patients when they require hospitalisation in old age."

The scheme in a nutshell

There are three points to take note about this scheme:

First, MOH has limited this scheme to these four chronic diseases - diabetes mellitus, hypertension, lipid disorders and stroke for a start.

Second, the use of Medisave under this scheme will be subject to three safeguards:

Deductible: A deductible of $30 will be set on each outpatient bill. Bills below $30 will continue to be paid in cash;
Co-payment: A co-payment (in cash) of 15% on each outpatient bill in excess of the deductible will be set; and
Annual withdrawal limit: Withdrawals will be subject to an annual outpatient withdrawal limit of $300 per Medisave account.

For example, for a $100 bill, the patient will pay $30 plus $10.50 (15 percent of $70) and use the Medisave to settle the balance of $59.50.

A FAQ on how much money could be deducted for the chronic illness bill is available at the MOH Website. (http://www.moh.gov.sg/cmaweb/attachments/press/36d0550627UM/Medisave_Chronic_FAQs.pdf)

Third, continuation of withdrawals from Medisave need to be backed up by regular certification by the doctors that the patients are complying with the disease management programmes.

MOH projects annual withdrawals of up to $250 million from Medisave under this scheme. As this is a major move, careful thought is needed to ensure successful implementation.

Over the next few months, MOH and CPF Board will consult doctors, patients and other relevant parties on the implementation details. MOH aims to implement the scheme before year's end.

The Ministry hopes to involve as many GPs, and through them as many such chronically ill patients as possible in the programme. Patients who participate in such a disease management programme will be able to use Medisave to help pay their medical bills even when treatment is done at the outpatient level.

The Medisave use as a part of a larger scheme

MOH aims to raise the care of these four chronic diseases to a high level, in accordance with established disease management programmes, which has strong scientific evidence of significantly better health outcomes. The strategic intent is to bring about better health outcomes for these patients and save them cost. Success will require: (a) good compliance by patients; and (b) adherence to prescribed practices by their doctors.

MOH will monitor and publish regularly the performance, cost and effectiveness of these disease management programmes so that patients can make informed choices when selecting providers.

Specifically, MOH will do the following:

First, doctors who have such interest will be encouraged to participate in these disease management programmes. MOH will publish a list of such doctors, monitor their effectiveness and include such information on their website.

Second, patients with any of these chronic diseases will be advised to register with these doctors, who will presumably be their Family Physicians. MOH will monitor the cost and health outcomes of these patients and publish meaningful data for both patients and doctors to see and learn from one another.

Third, MOH will allow Medisave to be used to help pay for these disease management programmes, even when treatment is carried out as outpatient care.

Committees to assist in the scheme

The Ministry has formed a Steering Committee, headed by the Permanent Secretary of Health, Ms Yong Ying-I, to oversee the implementation of the scheme. The Steering Committee will be supported by three work-groups, which are tasked to look into (a) the clinical aspect, (b) the processes and (c) the necessary IT support. The Ministry has also appointed an Advisory Committee of experts to help ensure the success of the scheme. It is chaired by Dr Lee Suan Yew and comprises both specialists and family physicians, who are experts in disease management and the care of these chronic diseases.

The Advisory Committee will tap on the professional knowledge and expertise from both public and private sectors, and will help the Ministry ensure that the scheme is effective and based on best international practices. ■

Have a memorable experience or an interesting article to share?

Do you have a memorable experience in the course of your practice, viewpoints and feedback to share with fellow colleagues? Do send us a write-up of about 300 to 1200 words. We cover articles that are of relevance to the practice of Family Medicine. Readers who are interested in contributing to our regular sections such as “Hints and Tips” and “GP Research Project” are also welcome.

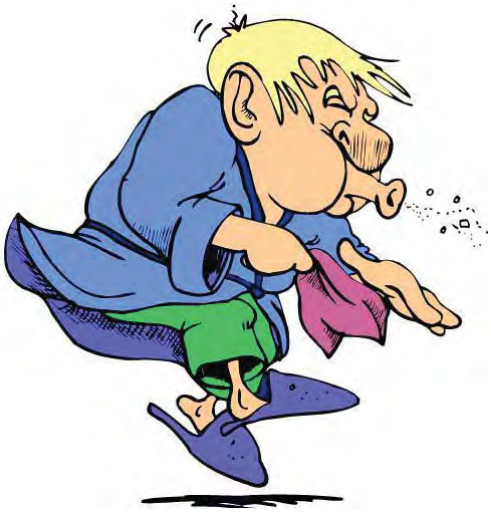
Articles might be edited for length and clarity. Please kindly include your full name, email and contact number.

Write to us!

Email to: articles@cfps.org.sg

GP Flu Pandemic Symposium

By Dr Shiau Ee Leng, Editorial Board Member



The influenza pandemic has a greater potential to cause death and illness than any other recorded natural health threat. The appearances of HFMD, SARS and DHF have caused a stir in the local health scene recently. These outbreaks pale in comparison to the potential destructive nature of an uncontrolled flu pandemic, but served us well to test and prepare our disease outbreak readiness. It was with this in mind that CFPS, SMA, MOH, SHSP and NHGP come together to hold the GP Flu Pandemic Symposium over one weekend on 13 & 14 May 2006 at the MOH auditorium. About 260 GPs attended the symposium.

Audience at the Flu Pandemic Symposium

Director of Medical Services Prof K Satku and Deputy Director of The Ministry of Health were present to welcome the attendees.

They also highlighted that the Ministry of Health has launched the National Preparedness Response Plan and this plan will involve all the family physicians as the frontline soldiers in this Flu pandemic battle. The reason for this symposium is to enable us as a nation to use this window of opportunity to prepare primary care: the family physicians, our clinics and our nurses for it. Current measures which MOH have instituted in preparing for the flu pandemic include stock-piling of anti-virals and personal protective equipments (PPE), regular national exercises in hospitals and polyclinics and the coming together of SMA, CFPS and cluster.

Scientific Update on the Avian Influenza

Dr Tan Kok Leong, Director of Outram Polyclinic and Dr Meena Sundram, Head of Jurong Polyclinic shared with us the update on Avian Influenza. Whilst knowledge of the epidemiology, natural history and management of H5N1 is incomplete, we need to still be aware of the latest update in this battle against a potential pandemic.

Clinical features of Avian Influenza include fever, usually above 38°C, influenza like illness, GI symptoms, pleuritic chest pain, epistaxis and rarely encephalopathy, diarrhea. and respiratory distress with tachypnoea and inspiratory crackles.

Laboratory changes are leucopenia, lymphocytopenia, raised amino-alanin transferases, and CXR could reveal diffuse, multifocal or patchy infiltrates, or segmental or lobar consolidation.

Confirmation of Influenza can be obtained using the viral isolation / culture and various viral assays. Commercially available rapid diagnostic test kits could be performed at GPs' clinics and Polyclinics easily with up to 70 percent sensitivity as a screen for Influenza A and B. However it must be correlated clinically for accurate diagnosis.

It was found that innate immune response to influenza H5N1 may contribute to disease pathogenesis leading to ARDS and multi-organ failure.

The management of proven or suspected patients with H5N1 should be hospitalised in isolation, given supportive care with oxygen and ventilatory support and given suitable antivirals viz Oseltamivir (Tamiflu) and Zanavir (Relenza).

To date no human version of the Avian Influenza vaccine has been launched, but prevention of the Avian Flu include:

- Tracing household and close contacts of suspected cases, treatment withchemo-prophylaxis post exposure
- Management of travellers

Advice for those going to infected areas are:

1. Vaccination against human Influenza
2. Avoid all direct contact with poultry
3. Personal hand hygiene
4. Avoid eating undercooked poultry and eggs

- Isolation precaution
- Health Care workers should have sufficient effective PPE when dealing with suspected cases, to check temperature twice daily, to take post-exposure chemo- prophylaxis and when performing high-risk procedures such as intubation / bronchoscopy.
- Food Safety measures such as proper cooking of poultry and eggs

Further details at www.who.int and www.cdc.gov

Preparing Primary Care Facilities for the Flu Pandemic

The GP sector is an important part of the overall influenza pandemic planning. As such 11 key areas have been identified for action by the College Pandemic Preparedness Workgroup during April 2006. A/Prof Goh Lee Gan singled them out as:

1. Safety Issues
2. Confidence Building
3. Including GPs as essential service providers in the pandemic
4. Educating preparedness- of the clinic and staff
5. Communication channels-to be set up. Of which the internet is identified as the most efficient

6. PPE and Antivirals
7. Organising of work
8. Decanting work re-siting of patients for better reserve capacity
9. Building local defence such as sharing of resources and mutual support amongst GPs in the same zones
10. Building infection control reserves
11. Resolving ethical and legal issues.The main outcome goal is to minimize risk of infection of staff members, and the community and the various processes to achieve these goals were outlined. were highlighted.

A/Prof Goh also explained the generic colour coded Disease Outbreak Response System. DORSCON-FLU levels shall be coded in increasing severity by:

GREEN level 0,
GREEN level 1,
YELLOW,
ORANGE,
RED and
BLACK.

These alert levels shall dictate the increasing stringent method of case management, infection control and public health measure. The proposed measures, which were modified from the lessons learnt during the SARS outbreak, are familiar to family physicians who already had a practise run with the recent SARS outbreak.

Dr Wong Chiang Yin

The take home message is for all GPs to prepare their offices, their staff and themselves for the eventuality of a severe flu pandemic, with emphasis on sustainable infection controls.

The GP Flu Pandemic Response Plan

Dr Wong Chiang Yin, the President of SMA next outlined the GP Flu Pandemic Respons Plan. He explained that in a pandemic situation, GPs being the main primary care providers will need to play the frontline role as the 18 polyclinics will be overloaded.

GP Clinic Clusters will be organized around the various polyclinics to enable efficient patient load distribution in the response plan.

He also discussed the logistic issues involved in a pandemic such as the stockade and distribution of sufficient PPE and antivirals both for treatment for the sick as well as protection of the healthy, especially the at-risk frontline workers. He then advised on stocking up on flu diagnostic kits, emergency medications and the management of medical manpower. He strongly encouraged all clinics to institute web-based IT systems for efficient information dissemination, tracking of antiviral treatment and case reporting in case of a pandemic.

The Hong Kong Flu Pandemic response

Dr Ronald Lam & Dr Chong YW

Having gone through several episodes of the Avian Flu outbreaks and SARS, the Department of Health of Hong Kong have started a series of on-going strategic preventive and contingency planning measures involving and integrating both the public and private health care sectors.

Dr Ronald Lam of the Centre for Health Protection, Department of Health, Hong Kong shared with us invaluable insight of an overview and role of primary care physicians, their primary care experience with SARS and Avian Flu and their three-tier alert serious and emergency flu pandemic, response plan.

"In the event of an uncontrolled human flu pandemic, we can only 'be prepared for the worse, but hope for the best'."

Hong Kong has instituted the volunteer doctor scheme and also conducted various drills and exercises for review of effectiveness of contingency plans.

He concluded that primary care doctors are the first line of defence in epidemics, which should be part of the overall influenza pandemic planning.

During the question and answers session, various GPs voiced their concerns over the potential shortage of PPE, antivirals and other supportive measures which they hope the Ministry of Health would address.

The entire primary care fraternity needs to recognise the gravity of the situation, but avoid panic.

After all, we have an estimated 75% chance of emerging from a human flu pandemic unaffected by the deadly virus.

The various advisories and powerpoints on the symposium can be accessed at *www.sma.org.sg/whatsnews/flu*. ■

Dr Gerald Koh - A Family Physician turned Academic

By Dr Shiau Ee Leng, Editorial Board Member

Assistant Professor Gerald Koh is a soft-spoken and unassuming family physician turned academic. An academic high flyer, he chose Family Medicine and has never looked back. He has published and presented many papers to date. He was involved in theatre works and even won the Best Cover Design Award for Commemorative Issue of Singapore Family Physician 1998

Dr Gerald Koh

Gerald, do tell us about yourself.

I completed National Service before embarking on medical school at age 21 years, and graduated with MBBS from NUS in 1995.

I fell in love with family medicine in my third undergraduate year because I was a generalist at heart and could not bear to be pigeon-holed into any one body system or age group.

I was also inspired by A/Prof Goh Lee Gan. after obtaining my MMed (Family Medicine) I was conferred the MCFP(S) in 2000.

What have you worked as before you went into academia?

Before going into academia, I worked as a Registrar at the then Ang Mo Kio Hospital, where I saw the urge to build community geriatrics in Singapore. Thus I decided to enroll in the local Graduate Diploma in Geriatric Medicine, and the Fellowship in Aged Care Programme in the following year. Because the Fellowship in Aged Care Programme was terminated, I obtained my FCFP(S) in 2003 instead.

In the same year, I was awarded an International Fellowship to read a postgraduate Diploma in Gerontology and Geriatrics in the EIG (European Institute of Gerontology) in Malta by the Merck Foundation, which married my interests in medical and social aspects of ageing from a global perspective. I was granted this sponsorship through the recommendation of my mentor Prof Joseph Troisi, Deputy Director of the United Nations International Institute of Ageing and Director of EIG, whom I met during the 3rd ASEAN Gerontology Course in Singapore a year before.

Upon my return in 2004, I joined the Raffles Medical Group as a Consultant Family Physician and ran a GP practice.

I was accepted at the COFM (Community, Occupational and Family Medicine) Department of the Yong Loo Lin School of Medicine the following year.

Since then, I have been busy setting up my research portfolio, teaching, helping to develop a new undergraduate curriculum and other administrative tasks. My current research interests

include salivary biomarkers of disease, asthma in children and adults, disability in the elderly and the health of healthcare workers in the face of emerging infectious diseases.

Tell us more about your family.

I am currently married to my beautiful and forbearing wife of seven years, Susanna, who was a choral conductor before she became a fulltime mother to our baby girl Maryanne in 2005.

My mother was diagnosed with dementia in 2000, one of the saddest periods in my life. Although she was a vibrant lady, she is now aphasic, bed-bound and in need of constant care.

Dr Gerald Koh, A/Prof. Goh Lee Gan and students at COFM

Dr Gerald Koh, Maryanne and Susanna

Upon reflection, my mother's illness and my father's example were key factors that motivated me to develop an interest in the elderly and ageing issues.

What do you do away from work?

Most of my free time is currently spent giving Susanna a break over the weekends, because we don't have a maid! I need to get 30 minutes of exercise everyday, be it swimming at night after Maryanne sleeps, running during the weekends, dancing in the privacy of my home or gym, much to the chagrin of my wife.

As for food cravings, my wife has given up on discouraging me from snacking at night; my weaknesses are chocolates, ice cream and cookies. It will be a woeful day for me when I get diagnosed with diabetes mellitus!

How do you balance work and family?

I struggle everyday like everyone else. It is the natural tendency of us doctors to throw ourselves into our work.

My wife won't understand why I work after I come home but she does appreciate the fact that I am around at nights and weekends.

I have coped by putting family as first priority as far as I can.

I have not been very successful so far since I find my work is so enjoyable.

Why did you decide to teach in the first place?

I have always been interested in teaching.

If I had not become a doctor, I would have become a teacher. When asked by Prof David Koh, the current Head of COFM, it was natural for me to join COFM as an Adjunct Teaching Fellow in 2003. Teaching is a joy to me.

I find myself teaching family and community medicine to undergraduates and post-graduates, setting questions and being an examiner (a task with very heavy responsibilities), reviewing and moulding curricular, guiding and counseling students and attending pedagogical courses to improve my teaching.

Other factors that led me to join NUS were the need to build up academic family medicine in Singapore.

Better working hours was an additional perk.

Share some encouraging incidents to motivate us all!

Heartwarming and life-affirming events are common as a teacher. Medical undergraduates are always bright, quick and passionate about learning, so teaching them is always a joy.

This is in contrast to my other NUS colleagues from other faculties who share with me their frustrations in teaching disinterested or academically-struggling students.

It always warms my heart when I receive thank-you notes and positive feedback from my students.

A particularly affirming event was when Dr Meena, a GDFM student of mine , finally passed after a year of teaching and encouragement. Other joys also include when my other GDFM student Dr Sharon Kaur, who was awarded the book prize in her GDFM exams and went on to do very well in her MMed (FM) exams.

Any last words on going through this less trodden path?

Personally, the fundamental requirement a family physician needs to have to join academic medicine is a **passion for learning**, in all its forms. A lack of good grounding in research is no impediment to becoming an academic as it can be learned. I would also recommend that you spend some years in clinical practice first because you cannot teach well without actual clinical experience.

Challenging yourselves by studying for postgraduate degrees will also give you a sound foundation to build an academic future.

The rewards in return may not be tremendous in monetary nature, but quite remarkable in many other aspects.■

"...the fundamental requirement a family physician needs to have to join academic medicine is a **passion for learning**, in all its forms."

Primary Care Survey 2005 Findings: Market Share Issues

By Dr Yee Jenn Jet, Michael, MCFP, Editor

Some would remember that in September last year the Ministry of Health appealed for participation in the Primary Care Survey (PCS 2005), the fourth in a series since 1988. The field survey was completed on schedule in October 2005 with an impressive overall participation rate of 93.9%. Opportunely, we now have the published report of the results of PCS 2005. The objectives of the PCS 2005 are:

1. To gather the morbidity and biographic profile of patients seeking primary care in the private and the public healthcare institutions;
2. To determine the private sector and public sector market share in primary care provision;
3. To obtain information on GPs' work practices such as workload, working hours, etc; and
4. To identify issues in primary care in order to aid planning and directions to bring about more holistic management of patients.

The most striking achievement of the PCS 2005 is that the report now comes in a spiffy looking 29-page report. Previous studies were reported as an SMJ article. The methodology has also been improved to increase the power of the study, hence its usefulness. The report appeared in April, less than six months after the completion of the field survey; no simple feat, for a study of such scale. As promised, a free copy of the report was given to those GPs who participated.

As anticipated, the survey was a treasure trove of essential information with deep impact on the way we practise.

Findings

The average working hours per week for private resident doctors decreased from 43 hours in 2001 to 36 hours in 2005. The number of patients seen per day per private full-time-equivalent (FTE) doctor was 30 in 2005, down from 33 in 2001. There was a corresponding decrease in number of patients seen per day per public sector FTE doctor, 58 in 2005 and 63 in 2001.

An estimated 50,596 patients, compared with 57,221 patients in 2001, attended primary care clinics on the survey day. Out of which, 78% went to private clinics and the remaining 22% to public clinics, changed from 85% and .5% respectively in 2001.

Of those patients who visited polyclinics, 25% reside in 1- to 3-room flats, down from 31% in 2001. A orresponding percentage of patients who visited private GPs and stay in 1- to 3-room flats is 21% in 2005 and 25% in 2001 respectively.

Response Rate

The private sector garnered a commendable 93.7% response rate while the polyclinics achieved a 100% response rate as expected. The high response rate means the data produced by the survey is technically even more significant. This impressive response rate might not be surprising judging from the effort the MOH had put in to improve the outcome of the survey. It also indicates that GPs can be cooperative, as long as the rationale of the study is clearly explained. Bearing in mind that the study disrupted the practices that were involved, we should be thankful for those clinics that had willingly put in their best to accommodate the exercise. GPs showed that they are able to forget past unhappiness and march on regardless of the sector they come from. This is certainly not the picture of untrained, disgruntled or disorganised physicians that GPs are often portrayed to be. The family medicine community can certainly reach new heights corporately if such solidarity continues.

Market Share Trends

The estimated total number of patients visiting primary care doctors has fallen by 11.6% despite the total population growing by 5.5% over the same period. One can only speculate as to the cause of the discrepancy. Direct self-referrals to specialist, pharmacist, and traditional or non-traditional alternative healthcare settings are possible reasons, a sign of poor public perception of the GP and asymmetrical healthcare subvention. These trends are not desirable for GPs or their patients. The College had long foreseen the problem and made preparations for it by improving the credibility of GPs through training, and at the same time pushing for the family physician register. The positive effects of the better training opportunities and the family physician register would likely bear fruits in the near future. Right-siting policies by cluster hospitals to persuade suitable patients back to GPs would also help alleviate the problem.

Recent initiatives by the College, clusters and MOH are without doubt very heartening. GPs can expect their situation to improve if these same attitudes carry through.

The polyclinics have continued to increase its market share significantly at the expense of private GPs. The percentages are still within the guidelines set by the MOH but might not be if we extrapolate the trend to the next 4 years. A quick calculation from the raw data provided showed that the estimated total number of patients seen at the polyclinics rose by about 27.5% while the total number of patients seen at the private clinics fell by about 18.7% from 2001 to 2005. The number of licensed private GP clinics has remained relatively stable, rising by about 0.9% from 2001 to 2005.

Affordable Healthcare Subsidies

The polyclinics should be congratulated for remaking themselves to attract patients. Nonetheless, one is not surprised by the pessimism among GPs in private practice, facing a dwindling patient load. However, it is not difficult to understand that such an unequal patient distribution is also not ideal for the government or to patients. For a start, increased patient loads at the already overloaded polyclinic would mean longer waiting times and harassed doctors. At the same time, more subsidized patients and a larger pool of polyclinic doctors would mean increasing the government's health expenditure at the expense of taxpayers without a corresponding improvement in quality.

Means testing, although contentious, might be an accurate and effective method to optimise the patient loads, and at the same time help maintain an affordable healthcare cost for those who need healthcare subsidies. As a gauge, only 26% of patients patronizing polyclinics stay in 1- to 3-room flats and presumably require health subsidies. This proportion is just slightly higher then the 21% who visited private GPs. These figures represent, to an extent, a low success rate of the polyclinics to provide affordable healthcare to the bottom socioeconomic groups and in fact behaves more like a market competitor to private primary care clinics with the advantage of government subsidy. To reverse this undesirable trend, the Health Minister had achieved an impressive mandate during the general elections on a platform of means testing with public consultation. Now might be a good time to start explaining the rationale and implement means testing at primary care.

Work-life Balance

On a brighter note, the work-life balances of GPs have improved as evidenced by the shorter average workweek in both private and public sectors. The lower numbers of patients seen per day by both public and private sectors also mean that the pace of practice has become more manageable, and by inference, of even higher quality and safety standard.

In short, GPs in both private and public sectors have provided more for less, something that family physicians have always strived to achieve. In having met this requirement, it is not surprising that GPs expect better recompense.

Conclusion

Although the PCS 2005 findings do not reveal anything that the practising family physician is not already familiar with, it is nonetheless an important objective

document for those who need to understand the trends, situation and problems facing family physicians so that new policies can be accurately implemented, and right-siting initiatives made to correct the legacy of old issues facing family physicians. Despite the confirmation of deteriorating conditions that GPs encounter, individual GP can somehow take comfort in the results as all stakeholders can now face the problems squarely together with one mind. Recent initiatives by the College, clusters and MOH are without doubt very heartening. GPs can expect their situation to improve if these same attitudes carry through. ■

SC Emmanuel, HP Phua, PY Cheong, 2001 survey on primary medical care in Singapore. Singapore Med J 2004 45(5): 199-214.

Ministry of Health, Integrated Health Services Division, Primary Health Branch Report: Primary Care Survey 2005. 2006.

Details of the report can be found at: http://www.moh.gov.sg/corp/publications/details.do?cid=pub_reports&id=36798507

Dementia

By Dr Tan Boon Yeow, FCFP, Chairman, Eldercare SIG

The dementia skills course held on the 18th and 25th of March 2006 attracted a larger than expected attendance of more than 150 participants. This was a pleasant and encouraging surprise to the organizers as we were not certain if the topic on dementia would appeal to a busy family physician.

The participants were treated to a series of lectures on the important aspects of dementia care which included recognition, diagnosis, pharmacological treatment, as well the management of the behavioural and psychological symptoms of dementia. This was complemented by a series of workshops which included case scenarios, discussions and role plays. The following is a brief summary of the various sessions.

Dr Chris Chen started the ball rolling by defining what dementia is about. Dementia is definitely not part of normal ageing although the elderly are more susceptible.

It is not a disease in itself but rather a syndrome. It is global (*not focal deficits eg amnesia, dysphasia)* deterioration (*not mental retardation)* of cognitive function in a clear state of consciousness (*not delirium, stupor).*

A commonly used definition of dementia is: evidence of a decline in memory and thinking which is of degree sufficient to impair functioning in daily living, present for 6 months or more.

The prevalence of dementia has risen from 2-4% in the past to 6% currently and will continue to rise as the population ages. It is very likely that we shall require a great deal more resources to effectively manage the rising burden of dementia in our community.

The assessment scales were covered in detail in the workshop sessions that followed. Case scenarios were also used to illustrate the diagnostic dilemmas which included MCI (mild cognitive impairment) vs early dementia and Vascular dementia vs Alzheimer's disease as well as delirium vs dementia and depression vs dementia.

Dr Joshua Kua gave an overview of the treatment options available for patients with dementia. The various treatment strategies targeted the 'ABC' domains of the disease where A stands for ADL (Activities of Daily Living) or the functioning areas, B for the Behavioral Complications or BPSD (Behavioural and Psychological Symptoms of Dementia) and C for Cognitive function.

The holistic treatment of dementia encompasses pharmacological and psychological interventions for the patients as well as supportive services for the caregivers.

Specific pharmacological agents that can be used include cholinesterase inhibitors and NMDA-antagonist (N-methyl-D-aspartate antagonist).
Anti-psychotics, anti-depressants and benzodiazepines are occasionally used.

Psychological management include environmental interventions, behavioural interventions, as well as recreational and adjunctive therapies such as reality orientation, validation therapy, reminiscence therapy and music therapy.

Dr Lim Wee Siong went into the specifics of pharmacotherapy and outlined the principles of drug therapy as well as the choice of drugs.

In essence, all dementia patients should be evaluated for suitability of pharmacological strategies to address the underlying disease, enhance cognitive symptomatology and treat attendant behaviorial complications.

The decision to initiate costly treatment

should be individualized and always made in conjunction with the patient and caregiver.

One of the highlights of the course was when the audience were taken on a pictorial tour of some of the behavioural problems exhibited by demented patients and the types of treatment strategies available by Dr Ng Li Ling.

Non-pharmacological interventions are usually the first line management for mild to moderate BPSD and it has been shown that environmental and behavioural interventions in conjunction with caregiver education, training and support are effective.

Medications may be needed when non-pharmacological interventions have failed or when the symptoms are moderate or severe and has an adverse impact on the person with dementia or his caregiver.

A referral to the psychogeriatrician may be necessary if the behaviors cannot be controlled. Dr Philip Yap rounded up the lectures with a passionate presentation on the emotional and social needs of the

demented patient as well as on caring for the care giver.

He emphasized that the primary goal of dementia care is to maintain the personhood of the demented patient. It is about providing dignity, happiness, comfort and quality of life to a person suffering from an incurable disease as well affirming the person's dignity and integrity to the very last moment. He also highlighted the need to assess caregiver burden and discussed the various interventions available.

A 4 step evidence-based step approach to the diagnosis of dementia was subsequently delineated by Dr Chong Mei Sian.

Steps	
1	**Is it forgetfulness or confusion acute in onset?** Is it is acute, then there is need to exclude delirium using CAM (Confusion Assessment Method) criteria. Is it is acute, then there is need to exclude delirium using CAM criteria.
2	**If forgetfulness or confusion is chronic, is it dementia?** Here, differentials like depression and late onset mental disorders need to be excluded. The DSM-IV criteria for the diagnosis of dementia is a commonly used standard. Objective evidence via using assessment scales like ECAQ (Elderly cognitive assessment questionnaire), AMT (Abbreviated Mental test), CMMSE (Chinese Mental state examination) or neuropsychological tests can be done to make the diagnosis.
3	**If it is dementia, what are the complications?** Here, there is a need to assess behavioural, functional and social complications. Mild cognitive impairment
4	**If it is dementia, what is the aetiology?** Determine aetiology via focused history taking, targeted physical examination, and selected investigation to exclude potentially reversible metabolic causes.

The most poignant moment of the course was when a short video clip was played after the end of the last lecture. The video depicted a spouse having to care for her demented husband while missing the times they shared when he was well. It certainly left a deep impression in many of the participant's hearts and most could not hold back tears of empathy after watching the clip.

We also had a very positive feedback from the course evaluation and almost a third of the participants expressed interest in being part of a regional dementia network in providing shared care with specialists in caring for the demented elderly.

The organisers are hoping to run the course on a regular basis so that more family physicians can be trained to participate in the care of the ever growing number of demented patients in Singapore. ■

College's Expert Panel on Dementia

Dr Christopher Chen Li-Hsian
Senior Consultant
Department of Neurolgy
Singapore General Hospital

Dr Chong Mei Sian
Associate Consultant
Department of Geriatrics Medicine
Tan Tock Seng Hospital

Dr Joshua Kua Hai Kiat
Associate Consultant
Department of Adult Psychiatry 3
Woodbridge Hospital & IMH

Dr Lim Wee Shiong
Associate Consultant
Department of Geriatrics Medicine
Tan Tock Seng Hospital

Dr Ng Li Ling
Senior Consultant
Department of Psychological Medicine
Changi General Hospital

Dr Philip Yap Lin Kiat
Consultant
Department of Geriatric Medicine
Alexandra Hospital

Wisdom of a Family Medicine Guru: " Do Research that will change policy"

By A/Prof Goh Lee Gan, Vice President

The pandemic influenza conference held in May this year in Singapore brought along a Family Medicine guru to our shores. Prof James Arthur Dickinson, Professor of General Practice in the University of Calgary was here to attend the conference. We invited him to spend an afternoon with us to share with us his experience and insights as a family medicine academic.

Professor James Arthur Dickinson

Prof Dickinson has certainly a rich experience of the world of family medicine. He has worked in the University of Newcastle and the University of Western Australia since the 1980s and more recently before he left for Canada, he worked in the University of Queensland in Australia.

In between the Australian Universities he was the Professor of General Practice in the Chinese University of Hong Kong in latter part of 1990s after Professor Wesley Fabb who worked there before him. He has, since last year, joined the University of Calgary in Canada.

He said that Canada is where his wife comes from and that obviously has been a pull factor to move there. His daughters are also working and studying there.

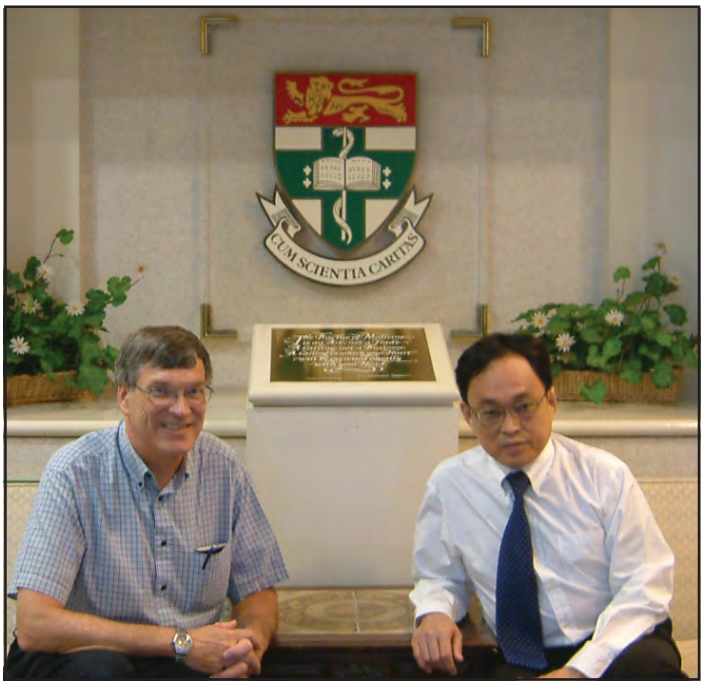
His work in family medicine research

We asked him to talk to us about his experience in Family Medicine. He chose to talk on family medicine research.

He said that he focused his research on what would change policy. And his research topics and content bear testimony to that vision.

Smoking not detected

His first topic was smoking. He said that doctors are more comfortable talking about smoking to patients who already have smoking related disease rather than talking about the smoking habit itself to those who are still disease free. This is a handicap in the prevention of smoking-related disease.



Prof James Arthur Dickinson and A/Prof Cheong in the College

Also, fewer female smokers were picked up. Maybe it is the feeling that it is not nice to bring up this question of smoking to a female patient that explained the failure to pick up female smokers, I was thinking to myself as he was talking. His smoking tale reminds me of the observation that many doctors are comfortable with biomedicine and uncomfortable with "soft" family medicine topics in their perceptions which nevertheless have a hard impact on patients' lives.

"...doctors are more comfortable talking about smoking to patients who already have smoking related disease rather than talking about smoking habit itself to those who are disease free..."

A small study done by Prof Dickinson and colleagues showed that although the

prevalence rates of smoking in the Australian setting was higher in the younger than in the older age groups from other epidemiological sources, this higher prevalence in the younger age groups was not picked up in the study.

Thus, in the older age groups, 65% of those who were smokers were picked up by the study.

In the younger age groups only 41% of those who were smokers, were picked up.

The explanation given by the authors was doctors werer more prepared to talk about smoking to a person with smoking related disease, namely, the older groups, compared to the younger age groups who generally have only the smoking habit but no smoking related disease.

For all age-groups, the prevalence of smoking in men was about 15% higher than it was in women, but there was no significant difference between the detection rates in the sexes.

In spite of their higher risks from smoking, the detection rates for pregnant women, or women who were taking oral contraceptive agents were no higher than those for other women of less than 35 years of age."

Dickinson JA, Wiggers J, Leeder SR, Sanson-Fisher RW. General practitioners' detection of patients' smoking status. Med J Aust. 1989 Apr 17;150(8):420-2, 425-6.

Abdominal Aortic Aneurysm not worth screening for

His next topic was abdominal aortic aneurysm. Is screening of old people for this condition useful, since relatively, many of them have this condition?

Together with his colleagues, Prof Dickinson embarked on a community based screening programme in Australia and the intervention was invitation to ultrasound screening. A total of 41,000 men aged 65-83 years were randomised to intervention and control groups.

What answers did they find? At a whole population level, screening for abdominal aortic aneurysms was not effective in men aged 65-83 years and did not reduce overall death rates. The success of screening depends on the choice of target age groups and the exclusion of ineligible men.

Any benefit was almost entirely in men aged between 65 and 75 years where the mortality ratio was reduced to 0.19 (CI 0.33 to 1.11). This was reported in the British Medical Journal.

Prof James Arthur Dickinson explaining a point

Norman PE, Jamrozil K, Lawrence-Brown MM, Le MT, Spencer CA, Tuohy RJ, Parsons RW, Dickinson JA. Population based randomized control trial on impact of screening on mortality from abdominal aortic aneurysm. BMJ 2004 Nov 27;329 (7477):1259. Epub 2004 Nov.

Cervical cancer screening once every three years is enough and older women should be the focus.

Cervical screening had a different professional challenge. Doctors want to screen patients every year instead of once every three years. Is this a good idea?

Looking at the Australian experience, Professor Dickinson said that despite the evidence that three yearly screening for Pap smear negative patients is enough to detect cervical cancer at a curable stage, there has been more frequent screening than that.

In Australia in 1991, the "organised approach to preventing cancer of the cervix" recommended Pap smears every two years for women aged 18-70 years who have ever been sexually active.

The two-year interval was a compromise step towards the scientifically supported three-year interval, as many influential groups were strongly attached to annual screening.

In a paper for debate in the Medical Journal of Australia in 2002, Prof Dickinson said that since the safeguards in the "organised approach" have been proven effective, it is appropriate to change the policy to recommend a three-year interval. Increasing the interval would allow more resources to be allocated to enrolling women currently underscreened and to evaluating and improving the program.

The age of commencing smears could also be reconsidered to reflect the balance of potential benefits and harm in young women, for whom cancer is very rare, but follow-up investigation common. He ended his debate with this note: "If consensus is not reached within the profession, an evidence-based decision may need to be made at the political level."

Dickinson JA. Cervical screening: time to change the policy. Med J Aust. 2002 Jun 3;176(11):547-50.

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This overscreening of women and the underscreening of some age groups of women is certainly more than an Australian problem.

For example, in Hong Kong, he found that over 80% of private doctors recommended annual smears despite local recommendations for 3-yearly tests, while graduates from western countries were more likely to recommend longer intervals.

Since the proportion of women in Hong Kong having Papanicolaou tests is still low, effort should focus on providing smears for more women, rather than repeated annual testing of those who already participate.

Dickinson JA, Chan CS. Opinion survey of Hong Kong private primary care doctors about cervical screening. Hong Kong Med J. 2001 Sep;7(3):284-90.

Hepatitis B carrier screening — should we do that?

Prof Dickinson was asked to share his views on chronic hepatitis carrier screening since he was one of the authors who did a Cochrane review on the subject. Should we screen hepatitis B carriers?

Hepatitis B is a common problem, especially in Asian countries. This disease causes complications of cirrhosis and liver cancer. Therefore doctors and patients are concerned whether to screen and treat for these complications. He said that his group searched the literature for evidence to determine the risk for people with chronic hepatitis B, the evidence that treating patients changes their outcome, and the effect of screening on death rates. They found little evidence from high quality cohort studies to demonstrate the outcome of chronic hepatitis B infection.

Consequently, he and his group constructed a mathematical model to demonstrate outcomes for them. The model showed that as the result of having chronic hepatitis B, men lose a mean of 7 years of life, whereas women lose only 2 years. While antiviral treatments change the serological status and reduce liver inflammation, there is insufficient information about their effect in cancer reduction.

Their Cochrane review of screening of liver cancer in chronic infection also showed no high quality randomized controlled trials and poor non-trial evidence. Their conclusion was that it appears unlikely that screening programmes are effective in reducing mortality for chronic hepatitis B carriers, a conclusion shared by other groups.

Hence, at the present, doctors are limited in what they can do to change the outcome for this group of patients.

Conclusions

For budding family medicine researchers and seasoned ones alike, the wisdom that Prof James Arthur Dickinson shared in his forays into healthcare research from the primary care perspective – to screen or not, how often, to refer for intervention or not – certainly was illuminating and worth reflecting on when we are thinking of what family medicine research we should do when the next call to submit research proposals comes around. ■

Congratulations!!!!

A/Prof Goh Lee Gan

The Council and members of the College of Family Physicians Singapore congratulate A/Prof. Goh Lee Gan on his conferment of Honorary Fellowship to the Academy of Family Physicians Malaysia during its Annual General Meeting in Kuala Lumpur May 2006.

Paediatric Practice Tips *(below the belt)*

By Dr Gabriel Seow, FCFPs member

1. It's all about stool

The knowledge of the normal range of stool frequency in healthy infants & children can help the GP's and parents deal with concerns regarding both constipation and diarrhea. Listed in the following table are some norms based on age:

	No. of stools / day	
Age	**(3rd - 97th%)**	**Median (50th%)**
5 days - 1 mth	0.9 - 6.0	2.7
1 - 5 mths	0.6 - 4.4	1.8
5 - 12 mths	0.8 - 3.8	1.8
1 - 3 yrs	0.6 - 2.9	1.4
3 - 6 yrs	0.4 - 2.1	1.1
>6 yrs	0.4 - 1.9	1.0

So do breastfed infants have more stools than bottle-fed babies? On the average, the answer is yes, but great individual variation exists according to different feedings:

	No. of stools / day	
Type of Feeding	**(3rd - 97th%)**	**Median (50th%)**
Breast Milk	0.8 - 6.1	2.9
Formula	0.8 - 3.9	2.0
Breast mlk + formula	0.8 - 5.7	2.3

Fontana M, et al: Bowel frequency in healthy children. Acta Paediatr Scand 78:682-684, 1989.

2. Er…but what about the floating stool?

There is a persistent myth that it is the fat content that buoys the floating stool. It is actually the air in the stool and not the fat that is responsible for this rather disturbing phenomenon:

> "While safe's the stool that comes a sinker,
> The floater's apt to be a stinker.
> So it's not fat but, rather, flatus
> That imparts the elevated status!" *Joseph D Teller*

Teller JD: Floaters and sinkers. N Engl J Med 287:52, 1972. Levitt MD, Duane WC: Floating stools_flatus versus fat. N Engl J Med 386:973, 1972.

3. The cute child with acute scrotum

In a child who presents with an enlarged, tender and discolored scrotum, the most valuable clinical aid in differentiating testicular torsion from other less threatening problems remains the absence or presence of the cremasteric reflex - the reflex is almost always absent in patient with torsion.

The presence of the CR was the most reliable clinical finding in ruling out testicular torsion. Absence of the CR should therefore strongly increase the suspicion of torsion.

4. True shoe blues

Properly fitting shoes can go a long way towards preventing certain foot problems.

1. Shoes do not aid in the development of normal feet. The longer babies can go barefoot, the better.

2. The best shoe is one that simulates the barefoot:
   a) Shoe should flex easily, soft sandals and moccasins are best for babies and toddlers.
   b) The bottom of the shoes should be flat. Heels tend to force the foot forward and cramp the toes.
   c) The shoe should be foot-shaped and generously fitted to accommodate the toddler's pudgy feet with at least ½ inch of space distal to the great toe with the ball of the feet at the widest part of the shoe.
   d) Ideally, the sole should have the same friction as skin on the bottom of the child's feet- that's a feat to achieve!

3. Shoes are expensive; hand-me-downs are perfectly acceptable if they fit and are not grossly distorted by the previous wearer.

4. Shoes should no longer be worn when the available toe and forefoot room has been outgrown. This may mean new shoes of a larger size every other month during the adolescent growth spurt. Start saving!

Grossman ER. Everyday Pediatrics. WB Saunders 1993. Chapter 16: Developmental orthopedics 164-165.

5. How do you like my collection?

The analysis of urine remains an important, simple and readily-available diagnostic tool of the GP particularly in children with recurrent abdominal pain and fever without localizing signs. While inspection of urine is a pleasanter task than examination of excreta, its collection in infants is often trickier.

Age	**Method of Collection**	**Comment**
Infancy	Clean catch	Best; requires patience
Infancy, toddler	Bag	Convenient but remove quickly to avoid contamination
Toddler	Standing in bath	Useful way of getting MSU
Toilet trained child	Classical MSU	Best
Any infant	Catheter	Rarely necessary; avoid
	Bladder stab	Acutely ill; failed MSU; rarely necessary

In infancy, when the bladder is full (usually 15-30 min after a feed), its gentle massage/percussion will often produce a contraction following which a midstream specimen (MSU) can be obtained without contamination. ■

Gill, O'Brien. Paediatric Clinical Examination. Churchill Livingstone 1988: 42,167-168.