



MITA (P) 125/04/2003

Vol 29 No. 3

# The College Mirror

A Publication of College of Family Physicians Singapore

3rd Quarter 2003

## Contents

President's Forum	2
Editor's Words	3
Dean of Faculty of Medicine NUS visits the College	4
CFPS SARS Diary and Quotes	5
The Making of SARS Webcast	6
SARS and the Emotional Toll on GPs	7
SARS Hotline for Frontline	9
College E-learning is Now Online	10
Vocational Training for Family Physicians	11
Commencement of FM Academic Yr 2003	14
Annual General Meeting 2003	15
Musculoskeletal Disorders Skills Course	16
Down Heritage Trail	18
Practice Corner	22
Hints and Tips	23
<b>CME Update Centerfold</b>	
Hyperlipidemia Skills Course	12
Men's Health Skills Course	13

## College Art Gallery



"Singapore River"

by Goh Chye Khee June 1987

College of Medicine Building  
16 College Road #01-02  
Singapore 169854  
Tel : (65) 62230606  
Fax: (65) 62220204  
Email: collegemirror@cfps.org.sg

## Eight Health Priorities for Singapore

**M**r Khaw Boon Wan assumed the stewardship of the Ministry of Health Singapore as the Acting Minister of Health on 1st August 2003. In his first month in office, he met and addressed various stake-holders in the healthcare community in Singapore. The Council of the College and some general practitioners were invited to meet him at a tea reception at Harrower Hall on 22nd August 2003. The Minister of State, Dr Balaji Sadasivan, the Director of Medical Services, Professor Tan Chorh Chuan, the Permanent Secretary, Mr Moses Lee were also present at the meeting



Acting Minister for Health  
Mr Khaw Boon Wan

Addressing the gathering, Mr Khaw outlined the 8 priorities of his Ministry (listed in the side-box). He emphasized the important role of family physicians. In his vision, family physicians in Singapore must practise holistic medicine and help patients both in health and in sickness. He should practice preventive medicine and coach his patients to adopt a healthy life-style. Family physicians must not be just a "cough and cold doctor". Instead they must manage diseases from the time the patient fall ill, during his hospital treatment and after he is discharged from the hospital.

In his view, every Singaporean should have his own family physician who is well trained to deliver a high level of care. Information technology should be leveraged to make healthcare more efficient and effective. He feels that information technology is a major enabler that will help to achieve the other priorities. For example, better use of information technology can correct information asymmetry and patients can become better informed. Greater transparency and readily available information would lead to a more efficient market.

Page 4 ►

### Eight Health Priorities

- |   |  |
|---|--|
| 1. Build Healthy Population<br>- promote healthy lifestyle                          | 5. Manage Healthcare Inflation<br>- spend within our means<br>- manage patients' expectation<br>- ration limited resources                         |
| 2. Manage Diseases<br>- maximise overall cost-effectiveness                         | 6. Ensure Long-term Healthcare Financing<br>- enhance 3Ms framework  |
| 3. Exploit IT<br>- increase productivity<br>- enhance care                          | 7. Safeguard medical standard<br>- ensure quality, reliability & cost-effectiveness<br>- develop manpower & facilities<br>- regulate appropriately |
| 4. Counter disease outbreak<br>- enhance surveillance<br>- mount effective response | 8. Exploit economic value as Regional Medical Hub<br>- ensure cost competitiveness   |

All articles represent the opinion of the authors. They are not the views of CFPS unless clearly specified. Contents are not to be reproduced without the permission of the Editor.

# The GPs in the SARS Outbreak

By A/Prof Cheong Pak Yean President, College of Family Physicians Singapore

**T**he SARS outbreak in Singapore in March 2003 caught everyone by surprise. Minister of State of Health Dr Balaji, in the Geneva World Health Assembly (WHO) meeting in May 2003 described the 4 rings of defence in the war against SARS. The GPs (General Practitioners) together with the other health care providers outside the hospital form the second ring of defence in the 4 rings of defence against SARS. The first ring is the hospital, the people and our border checks form the third and fourth ring respectively.

## Influenza-like symptoms

The early symptoms of SARS are like that of influenza and other viral fevers commonly seen in GPs' clinics. In the early phase of the outbreak, contact history with known SARS patients in our hospitals and travel history were pivotal in the diagnosis of suspect SARS patients for prompt referral to Tan Tock Seng Hospital. However when the cluster in the Pasir Panjang wholesale market broke out, there was trepidation that the virus had broken into the community at large and therefore diagnosing suspect SARS patients became even more difficult as suspect and travel history could no longer be relied on.

Keeping our clinics open was critical in inspiring public confidence in this outbreak especially with the dearth of knowledge in the early stages of how the virus spreads and the symptoms that it may present with. Early referral of suspect SARS patients and hence minimizing community spread, reassurance and appropriate treatment of patients suffering from other ailments and continuing the care of chronic conditions like hypertension thus became constant challenges. Because of irrational fear of hospitals, we also had to deal with more ill patients usually seen there seeking interim medical attention.

## College SARS workgroup

As early as the fourth week into the epidemic i.e. in late March 2003, the College of Family Physicians formed a workgroup comprising all sectors of primary care of both private and public sector to develop best practice consensus in dealing with the new disease as well as to form a channel for direct feedback to the authorities. The College issued its first advisory on 3rd April providing interim contextual information and advice to community doctors. Accurate information of SARS and the appropriate measures that GPs and their staff should take was speedily communicated subsequently in a series of advisories sent to all doctors practising in the community, both GPs and specialists.

When the Pasir Panjang market outbreak occurred, we braced ourselves for the worst that may be coming. We decided that a hotline for frontline will usefully complement the advisory we issued to GPs. We found that the telephone hotline manned by doctors was especially

pivotal in allaying anxieties and inspiring confidence that experienced colleagues were always at hand to provide advice and support. 239 doctors accessed the hotline over the first 8-week period. In descending order, the concerns were: diagnostic difficulties, personal protective equipment (PPE) & infection control measures (ICM), quarantine issues, ambulance and evacuation problems, triage and criteria of "fever". Such a system of information flow complemented the dissemination of interim advisories for the doctors on the ground.

## Stress & Fatigue

It was stressful for all healthcare providers trying to combat the hitherto unknown disease and to stay uninfected. We began to know that this disease can infect healthcare providers and death can result. The emotional response of a veteran GP like our Member of Parliament, Dr Tan Cheng Bock after seeing a patient later confirmed to be infected with the SARS virus epitomizes the kind of stress that GPs faced every day. Our professional values dictate that we must not abandon our patients. Thankfully most if not all stood by their posts despite the personal fears. The public has acknowledged the healthcare community as heroes. The GPs, like the rest of the healthcare workforce feel proud that we have served our responsibilities in the war against SARS -- each at his or her station in the community.

The paucity of accurate information of the SARS in the early stage and the appropriate personal protective measures that healthcare workers must take generated fears that we need to grapple and help our patients to grapple too. Because fever and respiratory symptoms are common ailments seen in GP clinics, the possibility of any patient turning out to be suspect SARS was hence threatening and anxiety provoking. Wearing the N95 masks was suffocating and taking the strict infection control measures was onerous.

Many GPs during the outbreak took the added precaution of physically distancing themselves from their families and friends while not at work for fear of passing on the virus through being themselves infected but still undetected or through their clothing. They minimized contact with their spouses and children and slept in separate rooms. That there was no disruption of community medical services despite the risks and attending anxieties of the GPs and their clinic staff of themselves being infected by the SARS virus speaks volume for the professionalism and commitment to duty and nation.

The GP community takes pride that we have served our stint in the war efforts. We may be the unsung heroes. Within us, we have run the race and kept the faith of serving our fellowmen. We acknowledge the confidence that our patients have in us at their hour of need.

---

### 19th Council 2003 - 2005

#### President

A/P Cheong Pak Yean

#### Vice-President

Dr Tan Chin Lock  
Arthur

#### Censor-in-Chief

A/P Goh Lee Gan

#### Honorary Secretary

Dr Lee Kheng Hock

#### Honorary Treasurer

Dr Yii Hee Seng

#### Council Members

Dr Cheng Heng Lee  
Dr Goh Jin Hian  
Dr Lim Fong Seng  
Dr Pang Sze Kang  
Jonathan  
Dr Tan See Leng  
Dr Wong Weng Hong

#### Honorary Editor

Dr Ng Joo Ming  
Matthew

---

### Editorial Board The College Mirror

#### Editor

Dr Ong Jin Ee

#### Members

Dr Seah Chiew Wan  
Dr Shiau Ee Leng  
Dr Yvette Tan

#### Advisors

A/P Cheong Pak Yean  
A/P Goh Lee Gan  
Dr Lee Kheng Hock

#### Editorial Executive

Ms Jace Phang

---

# From the Editor's Desk

It is a new lap ahead for the College Mirror.

With the Singapore Family Physician Journal taking on the added role of being a resource material for the Family Practice Skills Course, its sister publication the College Mirror undergoes a smooth and timely separation that will allow both to carry on distinct lives yet with a common parentage that will bring about synergy. College Mirror continues to be the newsletter for the GP community and will be published quarterly. It has a 3-fold intent:

1. To promote collegial spirit and sense of family medicine ownership by coverage of important college events and happenings, as well as articles that showcase the history and roots of family medicine

2. To encourage vocational training ( various layers of diplomate, masters and fellowship programme) and CME for GPs by highlighting available CME opportunities and article updates.

3. To promote a sense of professionalism among GPs by focusing on articles and contributions by the family physician community.

It is a new lap ahead as well for the GP community.

We catch a breath in this issue as we reflect on the tumultuous events that have hit the GP community before preparing for yet the next

lap. SARS was foremost in GPs' minds, having shown our human vulnerabilities the best. So this September **SARS Focus** reflects images of the GP front during the SARS outbreak not least the emotional toll it exacted on frontliners. It also reflects areas we can affirm ourselves such as dedication and courage in line of duty in clinics. Behind the scenes, quietly, many GPs have been standing forth to make a difference, from volunteering to do

*It is a new lap ahead for the College Mirror.*

*It is a new lap ahead as well for the GP community.*

infection control audits to running training sessions with professionalism and resolve. There was support for one another through informal networkings as well as through the Hotline for Frontline and other College initiated meetings.

In troubled times we can celebrate human resilience and courage and **Down Heritage Trail** features excerpts from Dr Wong Heck Sing's memoirs *The Batam Years*. These were war years in which he describes the trepidation in facing horrific war wounds as a pre-medical student and yet when faced with the horror proceeds to do his best. He also describes his experience with the infectious scourge Malaria that was rampant at that

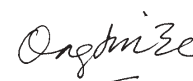
time. It makes me take heart that those who have run ahead of us faced equally challenging and unknown times and yet have risen to the occasion. Much has been said about courage. Perhaps in wars and crises, courage is about taking resolute action while others just stare in horror.

You also may have wondered about the recent exchange of forum letters regarding pre-hypertension where Straits Times writer Dr Andy Ho comments on JNC VII Hypertension update- "Prediseased-has medicine gone mad?" (ST, Aug 9). Read the latest JNC VII Hypertension update yourself in **Practice Corner** to familiarize with this latest hot topic. **Hint and Tips** is a new feature column that brings you effective medicine in digestible doses. We definitely welcome homespun sound wisdom from our fraternity out there.

We also continue to highlight CME for our doctors - July saw the commencement of academic year 2003. The commencement ceremony for the different layers of family physician professional development saw the coming together of those doing their Diploma, Masters and Fellowship in Family Medicine programmes. That day saw the launch as well of the E-learning website that is interactive and an excellent mode of learning for the busy GP.

So in the new lap ahead, let's continue to practice with competence, compassion and certainly a clear-headed relevance to the times we live in....

Thoughts, comments and contributions that is of interest to your fellow family physicians are welcome. Please address correspondence to: The Editor, Email : [collegemirror@cfps.org.sg](mailto:collegemirror@cfps.org.sg)



Dr Ong Jin Ee  
Editor of The College Mirror

## Mr Khaw Boon Wan, Acting Minister of Health on the qualities of a good General Practitioner(GP)...

" I am a strong believer in every citizen having a good GP who is your family practitioner..He is really your adviser, who will call you up for your PAP smear regularly;who will measure your cholesterol if you forget to measure;who will remind you to exercise at least three times a week;who will remind you to please go a little bit easy on your char kway teow.And if, sometimes,you need secondary or tertiary care, he will be the one to recommend that, for this medical condition.

And when the patient is admitted, I think he continues to be concerned about your care in the hospital, may even drop in at your ward, and just take a look at you.and if you are an orthopaedic patient who needs longer- term care but not in an expensive general hospital, he will look after you in the community hospital." (Page 5 , Straits Times, Aug 26 2003)

# Dean of the Faculty of Medicine NUS visits College

The new Dean of the Faculty of Medicine NUS, Prof John Wong, visited the College on the 22nd August 2003. He was received by members of the College Council and briefed on the various training programs of the College. The visit to the College was part of Prof Wong's series of meetings with the various professional bodies. He believes that the medical faculty must work closely with the professional bodies.

"Medical school is the beginning of a 50 year journey in the study of medicine. We need to make sure that the continuum is in line," said Prof John Wong.

He believes that professional bodies that

play a major role in continuing professional development of doctors should be linked

more closely with the medical school. Medical students should be made to understand that they are embarking on a life long learning process and the importance of the roles that the professional bodies play.

He feels that at the end of 5 years of medical school, all students should have a broad understanding of family medicine and develop a whole new set of skills that they would be able to use in their practice, especially if they should eventually enter the ranks of family physicians practicing in the community.

Prof Wong said that his faculty is committed to work with the College to improve the standard of family medicine in Singapore. He shares the vision that having highly trained primary care physicians will result in better health for Singaporeans and more cost-effective use of health care resources.

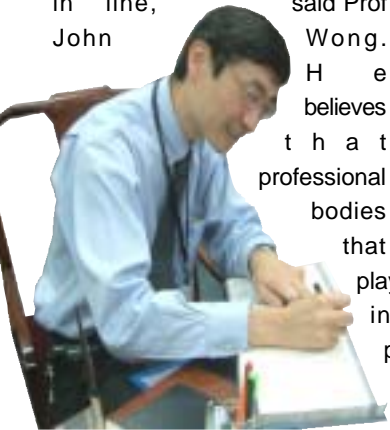
Presently the College is already working very closely with the Faculty of Medicine both in undergraduate and graduate family medicine training. As the

result of the meeting, many new initiatives are now on the drawing board.

In the coming months some of these should bear fruit. Students and doctors training to be better family physicians can look forward to better things to come.



From Left: Dr Matthew Ng Joo Ming, Dr Arthur Tan Chin Lock, A/Prof Cheong Pak Yean, A/Prof Goh Lee Gan, Prof John Wong, Dr Cheng Heng Lee, Dr Lee Kheng Hock, Dr Tan See Leng



Signing of College Guest Book

◀ Page 1 - Health Priorities for Singapore

He believes that cost can be controlled without compromising on the quality of clinical care if we can optimize the use of our resources. His vision for primary care in Singapore is to transform it into a modern and cost-effective component of the nation's health care delivery system.

The College Mirror interviewed some of the people who attended the meeting for their views.

*"The College shares the Minister's vision, especially the part on an enhanced role for the family physician. We look forward to playing our part in the effort to bring this vision to reality"* A/Prof Cheong Pak Yean, President CFPS.

*"I think the Minister's vision of a primary care initiative is very timely and important. We should all work together to achieve the goal of enabling family doctors to play a bigger role in the health care system."* A/Prof Goh Lee Gan, Head Division of Family Medicine NUS and Censor-in-Chief, CFPS.

*"We all feel very inspired. We know that the status quo in primary care is not tenable in the long run. Now that the Minister had set the vision and the direction, we should all work together to overcome some of the barriers."* Dr Lee Kheng Hock, Executive Director, College of Family Physicians Singapore.

*"I am very impressed by the clarity of the vision."* Dr Tan See Leng, COO BUPA Healthcare and Council Member CFPS.

# College's SARS Diary and Quotes

Year 2003	Activities
28 Mar	College's SARS Workgroup Formed
29 Mar	<p><b>Interim Advisory On SARS</b> For Doctors Practising In A Primary Care/Family Practice Setting In Singapore (1st Advisory) 2nd Advisory issued 3 April 3rd Advisory issued 12 April 4th Advisory issued 5 June (See Fig. 1)</p> <p>SARS Resource set-up within CFPS Website SARS Posters On Self Declaration of Symptoms (in four languages) (See Fig. 2)</p>
1 April	SARS - Self Declaration of Symptoms Form (English Version) Revised 12th May
25 April	SARS - Self Declaration of Symptoms (Chinese Version) (See Fig. 3)
29 April	<b>College Meeting</b> With Senior Minister of State, Dr Balaji and Director of Medical Services, Prof Tan Chornh Chuan "On Curbing The Spread of SARS In The Community"
7 May	<b>Hotline for Frontline</b> launched A GP helpline manned by doctors for doctors
12 May	Letter To Certify No Evidence of SARS
14 May	Press Release: Affordable SARS Insurance Package For Healthcare workers  <b>Train The Trainers Session:</b> SARS Preventive Measure Courses
17-25 May	<b>SARS Preventive Measure Courses For Doctors</b> <i>In conjunction with the Singapore Medical Association and the Academy of Medicine Singapore</i>
24 May	<b>Live Webcast</b> – "Learning From The SARS Outbreak: Strengthening The Defence Line" <i>First interactive CME webcast (See Fig. 4) in Singapore watched by more than 1000 doctors</i>
14 Jun	<b>CME Distance Learning Module Launch:</b> Severe Acute Respiratory Syndrome/ Counselling Skills

## "GPs deserve praise and government help too."

"While the Tan Tock Seng Hospital doctors and nurses rightfully deserve the cheesecakes, roses and accolades piled on them, let us not forget the unsung heroes, the humble general practitioner (GP) and his clinic assistants. No less at the front line, they face increasing isolation as they grapple with a falling patient load and increase in overheads (masks, bleaches and antiseptic washes don't come any cheaper to them) amid fears that they themselves may become infected by SARS".

*Letter by reader to Straits Times forum page on 17th April 2003(11)*

## "...many of the frontlines of battle were also out there in the primary care clinics."

"... following a symposium organised by the College of Family Practitioners and the Ministry of Health, the "Interim Advisory on SARS for doctors practising in primary care and family practice settings in Singapore" was issued. The College SARS Workgroup was spearheading this effort to equip our frontline doctors with knowledge, skills and protective gear. "

*by Prof Chee Yam Cheng, Chairman Medical Board, TTSH in SMJ Editorial "Heros and Heroines of the War on SARS" Vol 44 Issue 5 2003*

## SARS Paraphernalia



Figure 1. SARS Advisory



Figure 2. SARS poster



Figure 3. Self Declaration of SARS symptoms



Figure 4. SARS webcast in CD-ROM

# The Making of the SARS Webcast

The SARS outbreak prevented the gathering of large numbers of health care workers. The concern was, should a cluster of infection occur during such a gathering, the large number of critical personnel being quarantined would cripple the already over-stretched health care service. Still, there was an urgent need to reach out to the doctors to rally them to stand firm in the fight against SARS. The College therefore organized a live webcast on the 24th May 2003. A panel of physician leaders were invited to discuss lessons learned and to answer questions from viewers. The panelists were:

- Prof Tan Chorh Chuan, Director of Medical Services, Ministry of Health
- Dr Lily Neo, Member of Parliament and Chairperson, Government Parliamentary Committee on Health
- Dr Tan Cheng Bock, Member of Parliament and Veteran Family Physician
- Dr Leo Yee Sin, Clinical Director, Communicable Disease Centre, Tan Tock Seng Hospital
- A/Prof Cheong Pak Yean, President College of Family Physicians Singapore
- A/Prof Goh Lee Gan, Associate Professor, Family Medicine Division, National University of Singapore
- Dr. Lee Kheng Hock, Executive Director, College of Family Physicians Singapore

The event was sponsored by Merck Sharp & Dohme (I.A.)Corp. Singapore Branch, StarHub and ST Teleport. It was estimated that more than 1000 doctors watched this historic first live webcast for doctors.

## Behind the Scenes

The College Mirror interviewed Dr Lee Kheng Hock, Honorary Secretary of College to find out what went into the making of the event.

**CM: During the webcast, your co-moderator, Prof Goh Lee Gan referred to you as the "brains" behind the webcast. Can you tell us how this webcast came about?**

**Dr. Lee:** Yes, the SARS outbreak is not too long ago and we are already beginning to forget what it was like when it was raging all around us. I think it was towards the end of April when I met up with Mr Felix Soh from MSD who wanted to know how they can help doctors during this difficult period. They have heard that the College was working on an e-

learning project and quite wisely concluded that e-learning was an ideal solution for CME during the outbreak. The trouble really was



From Left : A/Prof Goh L G, Dr Lee K H, A/Prof Cheong P Y, Dr Leo Y S, Dr Tan C B, Dr Lily Neo, Dr Tan C C

that, the e-learning project was still on the drawing board. We came to the conclusion that a webcast would be an ideal way to rally doctors who were all stressed to their limit of endurance - physically, emotionally and financially. The challenge was how to get everything going at the drop of a hat and on a shoe-string budget.

**CM: So, how much did it cost to bring about the making of webcast?**

**Dr Lee:** MSD was very generous and agreed to allocate \$15,000 for the webcast and another \$15,000 for an e-learning module on SARS. It was a very altruistic gesture on the part of MSD. I later found out that just engaging the vendor to record the live webcast would use up this amount.

I approached Mr Philip Tan from Star Hub and asked him for technical advice on how to get a webcast going from scratch. Not only did he give me a free tutorial on webcast technology, he referred me to his colleagues and after a few last minute meetings, Star Hub agreed to underwrite the cost of the connection and bandwidth, which I understand amounted to between \$20,000 to \$30,000. They introduced me to Mr Wee Way Kiat of ST Teleport who immediately agreed to lend the use of their state-of-the-art studio, free of charge.

*It was really heart-warming to see this outpouring of support for the healthcare workers during the outbreak. This is something we can be proud of as Singaporeans. In time of crisis, the community spirit was very strong.*

After securing funding and the technical resources, the three weeks to the broadcast date was a blur of frenzied activity. I never

*knew there was so much work involved in a live webcast. We had many sleepless nights wondering whether we can pull it off without a*

*major disaster.*

**CM: Now that you have caught up with some sleep...what are your feelings about being involved in this historic first webcast?**

**Dr Lee:** ...A sense of loss. For our fallen comrades, some of whom I know personally, the void will always be there. But also a nagging sense of loss of opportunity.

**CM: Why that sense of loss?**

**Dr Lee:** Well, it was a time of unprecedented comradeship and co-operation amongst healthcare workers. Before SARS, we all keep hearing about the need for competition and how competition makes everything better. While that is true, the price we paid was diminishing co-operation and the depletion of social capital within the medical profession. The SARS outbreak demonstrated the importance of co-operation in health care, both internationally and within the country.

At that time, I remember being approached by a senior doctor in a group practice. He was very concerned that the solo GPs out there did not have the necessary logistic backup and the peer support to sustain them. He asked me whether there are ways he can help them. Another group of solo GPs were discussing how to set up neighbourhood networks where doctors can cover for one another if one should fall ill or need to be quarantined. There were no longer concerns of market share and competitive advantage. We were all doctors on the same side trying our best to do our work. Now that the intensity of outbreak is over, I notice everything seems to be going back to "business as usual". And that (emphasis) ... will be a loss of opportunity to make changes for better in our medical profession.

# SARS and the Emotional Toll on GPs

*SARS exacted an emotional toll on GPs across Singapore as they fought real fears while remaining at their positions of work and duty. Here, Mirror reproduces some real life sharing from fellow colleagues.*

*Dr Tan Cheng Bock, GP and Member of Parliament, relates his personal experience of first contact with SARS patient at time of the Pasir Panjang Wholesale Market Cluster Outbreak. (As Shared in Live SARS Webcast-edited)*

*"...what I went through, I am sure many practitioners would wish they don't want to go through. It is actually a very scary experience. And to say I am not afraid, I am not telling the truth."*

## First impressions, First Contact

I saw the patient on the 15th of April. And he is just like an ordinary patient coming to see you with a fever, 39°C, no other indication that he has come into contact with SARS patients or visited hospital or travelled abroad, nothing of that sort. Just an ordinary Singaporean citizen delivering goods from markets, from the Pasir Panjang Wholesale Market to the other markets. Now at that time the Pasir Panjang Wholesale Market was not on the radar screen of the SARS picture.

## What I did

So I saw him and I did not think he was SARS. I said he can't be SARS but what I did was.... and it was a standard procedure in my clinic ...was to keep on monitoring him. So I gave him some treatment and told him what to do and he must keep in close contact with us and be honest with what he has been telling us. So the next day my nurse called him and asked him what was his temperature. He said 32°C. My nurse was shocked and said "No..no..no, it can't be 32." Then after some hesitation he said 37. So I told my nurse he is not telling the truth and better call again in an hour's time. So in an hour's time we called again. He said "I (my temp) am down already, tell Dr Tan I am not a SARS patient. I'm OK." But I said no. I told my nurse call again.

## Losing Contact

We lost contact. No more contact. Next day we call again, no contact.

## Breaking of news and my immediate response

Then on 20th morning, I received a phone call from Ministry of Health, telling me the patient had SARS and apparently he died. I just could not believe it. I said no..he is not SARS. I wanted to argue with him,.. but then how can I argue with him...I mean...this is what is told

to me. My immediate reaction was what to do...immediately what shall I do. So I take my own temperature 36.4°C. I remembered very clearly and I said OK, and took temperature for my nurses quickly and decided I must go into quarantine. Quarantine because I am a public figure and if anything happens to me, I may be spreading the illness to a big group of people. So I went to hide for 10 days and made the nurse who came into contact with the particular patient to



"... And if anyone of them should be struck down, I tell you, I can't forgive myself too so the least I could do was I just had to go and hide."

-Tan Cheng Bock on going into voluntary home quarantine for fear of infecting parliament

go and also self-quarantine.

## Self- quarantine and follow-up

It is not easy to self-quarantine, I can tell you. You have got to be extremely strict and I really had no contact with anybody. The only contact was a telephone and even then a dedicated telephone to make sure all calls that I receive must go through this line. In the meantime, to make sure there is no trauma for the other patients who were in close contact with this particular patient, my partner called up and my other nurses called up the other patients that was due for this home quarantine order. I think that was an important thing because then the patient won't feel so frightened when they receive a phone call at home from MOH. But in spite of that, quite a few of them were very traumatised after the home quarantine. Because I must say the home quarantine process then was not so well

carried out and in fact every time we call the patient to check on them, they get so..so so frightened that we had to give one or two of them some tranquilisers to make them more steady.

## Lessons learnt

We have to be very vigilant. You have to assume everyone is a potential SARS. So now (at time of sharing) every patient that comes to the clinic, I'd advised all of them : give them

a mask whether they have a fever or no fever. I give them a mask, temperature taken. Everyone has their temperature taken, the time of arrival, the time of departure, and if they have a higher fever, we make them wear two masks ( surgical masks). It is a bit overdoing it but I guess it is also much better and I gown now. When I saw that patient, I was not gowned but I had gloves on and I had my mask on and that was all the protection I had. But I think it is an experience that I don't want to go through again.

It is really traumatising especially when you feel that your loved ones are also involved, your friends and I know I had so many meetings, with so many of my grass-roots. I attended even a parliamentary lunch with all my parliamentarian. And they were all there... what would happen if they were all infected. The whole parliament will be gone. You know, they will all have to be on home quarantine. And if anyone of them should be struck down, I tell you, I can't forgive myself too so the least I could do was I just had to go and hide.

# SARS and the Emotional Toll on GPs

*SARS exacted an emotional toll on GPs across Singapore as they fought real fears while remaining at their positions of work and duty. Here, Mirror reproduces some real life sharing from fellow colleagues.*

*Dr Lee, a GP who works in a group practice encountered a SARS patient on 10th of April 2003. He requested anonymity in this report.*

*"..the first thing that I did was actually to send my family away. I actually send my family to my in-laws even before I reached home and my mother went to another person's place and I actually stayed alone until day 10 in my own home..."*

College Mirror asked him to try to describe his fears at that time.

Dr Lee said that, "Fear occurred at several levels. First, is that despite being fully so called protected, there is always this fear that I am not actually. I've never work in an infectious disease ward before and therefore, whether I was doing it correctly, that was the first point. In other words, whether there was a break in infection control, whether I had unconsciously rubbed my nose or even with the mask on, that was one concern. That was a major concern.

Of course, the other level of concern is that if I get hit by the SARS, then my family, my kids, my little toddler and my kid and my wife will

be also at risk. Of course, also the other fear is that the patient is a very highly infectious chap that knocked out the chaps in my practice and that will create another cluster. So, I think the fear is at the personal level and family level as well as the concern at the patient level. Definitely, my morale in terms of that first few days was quite low, even for my nurses."

In reply to the remark that everybody was scared, he said: "Yes, I think the word is scared. I think that is the correct term to use."

As how he coped with his emotions during that time, he elaborated: "For me is that my first concern was basically the family. So, after getting that particular piece of news, the first

thing that I did was actually to send my family away. I actually send my family to my in-laws even before I reached home and my mother went to another person's place and I actually stayed alone until day 10 in my own home, because that period actually stretched over the holidays, so there were only two days that week. The employers were actually quite understanding, I actually asked for urgent leave to sort out some of this things and I went on leave until day 10, so I spent the next few days at home reflecting on this potential concern about the SARS and of course, I took the troubles to check the temperature 4 times a day, same for my children and my wife. I actually advised them."

## Announcements

### 1st HSA Drug Safety Seminar for Healthcare Professionals

Venue : Clinical Research Centre (CRC) Auditorium  
National University of Singapore  
Faculty of medicine, MD 11  
10 Medical Drive  
Singapore 117597  
Date : 25 October 2003 (Saturday)



Time	Topics
2.00 pm	Opening address- <i>Clinical Prof. Goh Chee Leok, Chairman, Pharmacovigilance Advisory Committee, Health Sciences Authority</i>
2.10 pm – 2.35 pm	Diagnosis and treatment of adverse drug reactions (ADRs) - <i>Clinical A/Prof. Chng Hiok Hee, Tan Tock Seng Hospital</i>
2.35 pm – 3.00 pm	Overview of the ADR reporting program in Singapore with case illustrations - <i>Ms Chan Cheng Leng, Health Sciences Authority</i>
3.00 pm – 3.25 pm	Polypharmacy and ADRs in the elderly - <i>Dr Ding Yew Yoong, Tan Tock Seng Hospital</i>
3.25 pm – 3.50 pm	An update on the safety of hormone replacement therapy - <i>Dr Loh Foo Hoe, President of Menopausal Society</i>
3.50 pm – 4.10 pm	Q&A Panel of speakers
4.10 pm	Refreshments

Admission is free. CME points will be accredited.

Please register with the Pharmacovigilance Unit, Health Sciences Authority, at Tel: 6325 5604 or e-mail: HSA\_drugsafety@hsa.gov.sg by **4th October 2003**.

Supported by :



### Congratulations

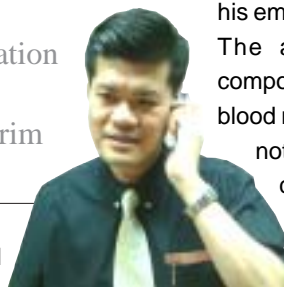
The college would like to congratulate the following doctors who have passed the GDFM Examinations 2003.

Dr Chiang Wing Chiong  
Dr Lee Biing Ming Simon  
Dr Leong Choon Kit  
Dr Murali Dharan Palanisamy  
Dr Ow Chien Koon  
Dr Pushparanee Somasundram  
Dr Puvanendran Rukshini  
Dr Sharon Kaur Minhas  
Dr Teoh Tsu Ping Kieron  
Dr Wong Ern Ling Helena  
Dr Wong Kin Chan  
Dr Yap Soo Kor Jason  
Dr Mohamed Ghazali  
Dr N Meenambikai

# SARS Hotline - Help is only a phonecall away

By Dr Lawrence Ng Chee Lian, Doctor in-charge-of College SARS Hotline for Frontline

239 doctors accessed the hotline over the first 8-week period. In descending order, the concerns were: diagnostic difficulties, personal protective equipment (PPE) & infection control measures (ICM), quarantine issues, ambulance and evacuation problems, triage and criteria of "fever". Such a system of information flow complemented the dissemination of interim advisories for the doctors on the ground.



Dr Lawrence Ng

## INTRODUCTION

In the outbreak of SARS in Singapore beginning in March 2003, the rapidly evolving situation took place within a short space of a few weeks. Information and recommendations were changing almost on a daily basis. Furthermore, many recommendations were developed with hospitals in mind and it was very difficult to translate into practical responses by family physicians at the frontline. The College therefore decided to set up a hotline to fill in the information gap.

More important than information was the moral support and the validation of one's effort. Doctors often have to face the deadly virus in their clinics all alone. The stress can become quite tremendous. As humans, we develop real worries for our personal health and the health of our loved ones. Hence, peer support was very important for psychological and professional reasons. This can come in the form of the physical company of other doctors or support via telephone.

Below are examples of some of the questions that were asked and the responses that were given. With hindsight things may have a different perspective. The cases illustrate the difficulties faced by family physicians on the ground. It also shed some light on the difficulties of applying general recommendations on very unique and specific encounters that real life throws up.

### CASE 1. Diagnostic issue

**Question:** Dr J L saw a young working girl with persistent PUO; started on 28 Apr 03, low grade of about 37.4 to 37.7 for past 2 weeks, TWDC showed leucocytosis while CXR was normal. Given Ciprobay which did not resolve the fever. Question now is should he continue her with voluntary home medical leave?

**Hotline:** Our prior medical training in handling viral fevers still applies. So, the management you have described sounds valid. The only

question is how high a level of suspicion to pitch at and what action to take when your level is reached. This is where each individual Dr reacts differently, judging from the callers we have had thus far. The duration of MC rests in each Dr's discretion. Probably useful to see how the Emergency Departments manages the cases referred by GPs and what is the outcome after these are sent home with prolonged MC. But, without a quick diagnostic kit, we are left with the FBC which will give a picture similar to other viral infections such as influenza, EBV, RSV and rhinovirus. Probably good to have FBC if NO contact or travel history. (Not always possible in HDB practice where patients either refuse or cannot afford to pay). CXR only shows late SARS (refer Lancet papers).

Dr JL's fear is that without any confirmatory test, in an off chance, it later turn out to be SARS, and he had dismissed the presence of the low grade fever as poignant and had allowed her to go to the office, it will be difficult to explain one's action. I am not saying we should overreact; just that it is a difficult time to justify having under-reacted.

### CASE 2. Diagnostic issue

**Question:** Dr Y called about a case of high fever in a male Malay farmer from Sabah seen on 20/05/03. Has backache but no cough no cold. Treatment consisted of Klacid and Paracetamol. Advised to return early for review but only came today. Yesterday, employer also developed fever and diarrhoea – now well after treatment. Farmer's **Viraemia Screen** showed abnormalities: Thrombocytopenia of Platelets 10,000 (low) TW 6.2 Lymph Normal. Mono 25% CPK 764 LDH 1079

Dr Y has advised him to go ED TTSH. Dr is worried for himself and his staff. Dr asked if he needed to quarantine himself. Has real fear of patient and employer turning around to sue him for wrongful diagnosis and

consequent loss of income. He wanted medicolegal advice.

**Hotline:** Two cases of fever in a farmer and his employer implies certain level of risk here. The abnormal blood viraemia screen compounded this case. Notwithstanding the blood results, strictly speaking, this case does not qualify for Sars. (Later, I discussed the case with Dr CHL and we concluded that probably the diagnosis is Dengue

Fever.) But, since blood tests are so abnormal, he was advised to treat with suspicion and call for Sars ambulance to fetch patient and employer to TTSH for screening. Apparently, employer was very unhappy and resistant to going to TTSH. Instead, he wanted to go a normal ED. I left it to Dr Y to make a judgement call on both the diagnosis and the type of ED to send to. As for possible missed diagnosis, he was told to call his own medical defense organization for medicolegal advice. Told him that, as for MPS, we cover for practice decisions related to Sars.

### CASE 3. Temperature issue

**Question:** Nanyang Polytechnic students are having exams and are screened by temperature check. One student had a temp of 37.5 C (so far this is the only reading of his temp) and claimed that this is his normal basal temp. He was allowed to take his exam in an isolation room. Doctor asked what is he to do for the future. Next exam is in one week's time.

**Hotline:** The best solution is for the student to record his/her temperature daily for a week to establish whether his basal temp is really 37.5 degree C. It is true that some people have a higher or lower body temp compared to others. Variation from one's norm is more important than variation from the so-called norm.

### CASE 4. Housecall for suspect SARS case

**Question:** Can Dr decline to do house call on febrile pt suspicious of having contact history. Is there any medico legal implications? What if patient later refuses to go to TTSH?

**Hotline:** Yes, he can decline as patient is a suspect SARS. Suspect SARS is best handled by dedicated SARS ambulance and it would be defensible in not going as one is not equipped to deal with a suspect SARS housecall. Advised to call for dedicated SARS ambulance. If decide to do housecall, he will need full PPE. To inform MOH by calling help-line number.

# College E-learning is now online

## Do CME and lose weight at the same time

**P**ower up your computer. Open up your internet browser. Go to the college website [www.cfps.org.sg](http://www.cfps.org.sg). Go to the right hand corner and look for a line that says "Log on to: [onlinemedlearning.org](http://onlinemedlearning.org)". (See Fig. 1) Click on it and the brave new world of e-learning Singapore style is at your finger tips. One is tempted to say "Let your fingers do the studying" but then you may not get your CME points because you need to take a simple test at the end to verify that the synapses in your brain had been beneficially re-arranged by this new learning experience.

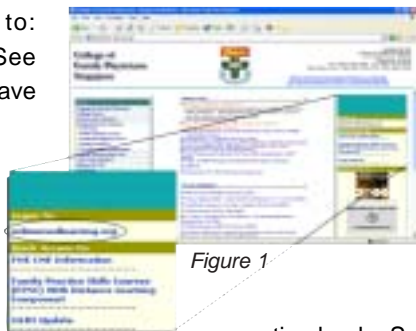


Figure 1

*"Don't worry about the test. It is not designed to make people fail. All the answers are in the content. It is like an open book test. Actually it is more like a comprehension test really,"* says Dr Lee Kheng Hock the Project Director.

*"It is a one stop learning station for us to find current knowledge, to test what we retain and to earn the points that we deserve,"* says Prof Goh Lee Gan, the head honcho of the content development team.

What about doctors who have better things

to do than just mug all day? Well, if you are thinking of beating the system and going straight for the test, you can forget it. The

system would not let you access the test module until you have gone through the materials. The questions are easy but not that easy. In any case, the questions are randomly selected from a multiple choice question bank. So it probably takes you less time to go through the materials than to try to copy the answers from your more studious colleagues.

The first module, which was open for trial during the SARS webcast on the 24th May 2003, was very well received. Many were impressed by the professional quality of the streaming videos. The dramatization of a difficult consultation starring our own Prof Goh Lee Gan (See Fig 2.) was very moving. Many users said that it was very realistic and some were almost moved to tears. On the other hand, users without broadband access were disappointed because they could not access the streaming videos. Nevertheless the videos are an optional enrichment segment that is not compulsory. Those with dial-up access can still do the text-based main

program and be eligible to take the test for CME points.

What most users were pleased about was that they could now do some serious CME without having to burn their weekends. The spouses and children of doctors can look forward to more quality family time. It also saves them the hassle of driving, parking and waiting. Nothing worse than having to sacrifice a good golf game, drive half way round the island to a hotel for CME only to be bored into taking an involuntary post prandial siesta. What most people would miss is probably the sumptuous meals that has become pathognomonic of sponsored CME. For those with a weight problem, this may be counted as another blessing. Perhaps they should state the number of calories you can gain right next to the number of CME points. Anyway, CME is supposed to feed the mind and not the body, or is it?



Figure 2

◀ Page 9 - Sars Frontline Hotline

### CASE 5. House-call for febrile elderly

**Question:** 80y/female last discharged from TTSH Dec 02. Now p/w fever and SOB at home. No contact and no travel. Shall I do house-call? Shall I call SARS ambulance?

**Hotline:** Phone triage showed no indicators of SARS. Caller was advised make a house-call with the caution to wear full PPE and observe infection control measures. Advised to call any ambulance to fetch to any ED, if patient is critically ill.

### CASE 6. Patient Declaration

**Question:** Subject refuses to make self-declaration or have temperature taken. Caller asked if patient can refuse to make self-declaration or have temperature taken? Is there any law to compel them? Would it be medicolegally acceptable if they are not seen?

**Hotline:** In the early phase of the outbreak,

there was no law to compel them. But I would be suspicious of such patients and would not see them since their refusal in the first place nullifies any contract of consultation. If it were an emergency, you'd have to attend to him regardless of him being truthful or evasive. Tough being there when this happens.

A person who refuses proper history and examination actually voids the contract; hence there is no doctor-patient relationship. If they refuse to be truthful, they are not cooperating with the consultation process. As far as I understand, most of these cases have no grounds for complaint. I would certainly check SARSweb and see if their names are there. I would certainly check SARSweb and see if their names are there.

### CASE 7. TRIAGE

**Question:** What is the point or purpose of triaging by clinic assistant?

**Hotline:** Screening by a clinic assistant does not replace consultation and diagnosis of suspect SARS by the doctor (as only the doctor can diagnose probable SARS). It serves to decide the level of risk category, i.e. whether the patient is normal risk, caution or high risk.

### Hotline for Frontline Advisors

Dr Cheng Heng Lee, Director, HMO Pte Ltd  
A/Prof Goh Lee Gan, Consultant, Institute of Family Medicine

Dr Jonathan Pang, Senior Family Physician, Everhealth Family Clinic

Dr Lawrence Ng, Doctor in-charge-of College SARS Hotline for Frontline and Medical-Legal Advisor, Medical Protection Society

Dr Tan See Leng, COO, BUPA Healthcare Singapore

# Vocational Training for Family Physicians

The Family Medicine Training Programme (FMTP) to train doctors for the College Diplomate Membership (MCGP) began a year after the College was founded in 1971. This was taken over by the Masters examination in 1993. The Fellowship training programme was started in 1999 to train FM leaders to augment those who had distinguished themselves after many years of practice and elected to fellowship. The Graduate Diploma was started also in 1999 to be the benchmark

certification of family physicians. Figure 1 gives an overview of the status of FM vocational training and Fig 2 gives details of the various training programmes.

It will be useful to position all these programmes in relation to the work that family physicians could now do and be recognized for. The GDFM, Masters and College Fellowship awards are professional prerequisites in career development upon which

other eligibility criteria for example administrative and leadership attributes are added. The term, "Family Physician" is now a term that defines those doctors vocationally trained in FM. These doctors are now put to work to provide extended and enhanced clinical services to patients. Some family physicians are taking the extra step to develop expertise in these areas by completing graduate diplomas (such as that in Geriatric Medicine and Psychotherapy from NUS), by clinical attachments and/or mentorship by experts in those fields.

The College has pledged to build the capacity of primary care by leveraging on the current FM training programmes (FMTP) in place and by working with the Ministry on other initiatives. Ensuring that primary care contributes to the health of the Nation is after all the *raison d'être* of the College.

Figure 1: Current Status of College FM Vocational Training

Current membership	Presently in training	Exited/Awarded
Fellowship by election	-	19
Fellowship by assessment	35	18
MCGP (till 1992)	-	61
MMed (FM)/MCFP	55	180
GDFM	119	56
<b>Total</b>	<b>209</b>	<b>348</b>

Figure 2: Overview of the Family Medicine Training Programmes (FMTP) in Singapore

	Family Medicine Training Programmes ( FMTP )			
	GDFM	Masters		Fellowship
Entry requirements	1 year as medical officer (MO) or GP	Programme A At least 2-year MO & selected for Ministry of Health Traineeship programme	Programme B GDFM and 2 year primary care postings OR 4 years primary care postings	MMed-MCFP & actively involved in FM clinical practice, teaching & professional development
Duration	2 years off-the-job training	3 years on-the-job - 2 year hospital postings & 1 year primary care	2 years off-the-job training	2 years off-the-job training
Supervising Body	Institute of FM CFPS	NHG & Singhealth polyclinics in 3 <sup>rd</sup> year	Division of Graduate Medical Studies, NUS	Institute of FM CFPS
FMTP Modular Courses	8 quarterly modules each comprising of distance learning & 4 workshops covering whole-person medicine, systems and practice management.			
Tutorials & small group meetings	8 tutorials based on quarterly themes	10 Combined Rounds & 10 monthly tutorial	20 Combined Round, 40 weekly tutorials, 20 clinical rounds	20 FMFP meetings held monthly
Courses	3 mandatory courses Principles & Practice (P&P); Communication & Counseling (C & C); & Exam Revision;	Short skills courses conducted by polyclinics;	1-week full-time Hospital Attachment	3 mandatory courses viz. Method of Instruction, Audit & Research Methodology;
	BCLS & 2 electives	BCLS & 2-week fulltime Mmed Revision Course in hospitals		Clinical Elective
Course Work	Distance learning & tutorial assignments	6 case commentaries 1-week practice audit		Log book documenting learning, clinical work, research & teaching involvement
Summative Assessment by	Division of Postgraduate Medical Studies, FM Committee National University of Singapore.			Censor Board CFPS
Format Of Assessment	MCO & KFP	MCQ, MEQ & spot/slide examination		Exit Interview
	Objective Structured Clinical Examination (OSCE)	2 long cases in Paed & IM 4 short cases in Paed, IM, OG & either Surgery or Orthopaedics		
College Membership Eligibility	Ordinary Membership	Collegiate Membership		Fellowship
Professional Recognition	Certified Family Physician	Senior Family Physician		Consultant Family Physician

# Hyperlipidemia Skills Course

Course Structure

## 1. Distance Learning Course Contents

### Unit 1: Epidemiology of Hyperlipidemia

Dr Tan Chee Eng, Head of Department of Endocrinology

- Disease Burden
- Pathophysiology of Hyperlipidemia
- Framingham Study
- Multiple Risk Factor Intervention Trial
- Risk Factors

### Unit 2: Review of Evidence on the Efficacy of Treatment

Dr Peter Yan Chee Hong, Cardiologist

- Oslo Diet-Heart Study
- Lipid Research Clinics Coronary Primary Prevention Trial
- Helsinki Heart Study
- West of Scotland Coronary Prevention Study
- Scandinavia Simvastatin Survival Study
- Atorvastatin Versus Revascularization Treatments
- Treating to New Targets
- Myocardial Ischaemia Reduction and Aggressive Cholesterol Lowering study
- Other Studies and Trials

### Unit 3: Screening and Classification of Hyperlipidemia

Dr Loh Keh Chuan, Senior Consultant, Endocrinology

- Principles and Pitfall in Hyperlipidemia Screening
- Interpreting Blood Test Results
- Cutpoints for Dyslipidemia
- Fredrickson Phenotyping
- Primary and Secondary Hyperlipidemia

### Unit 4: Coronary heart disease risk assessment

Dr Kurugulasigamoney Gunasegaran, Consultant, Department of Cardiology

- Concept of risk factor assessment
- Major coronary heart disease risk factors
- Assessment of a patient's overall risk for coronary heart disease

### Unit 5: Pharmacological Treatment of Hyperlipidemia

Dr Sum Chee Fang, Senior Consultant, Endocrinology

- Identifying and treating underlying causes
- Initiation of Therapy
- Choice of pharmacological agents
- Monitoring patients during follow-up
- Treatment Goal

### Unit 6: Non-pharmacological treatment

Dr Mabel Yap, Department of Nutrition

- Determining the need for non-pharmacological treatment
- Risk factor management
- Diet • Weight • Exercise

## 2. Seminars

(2 CORE FM CME Points each)

**Seminar 1: 11<sup>th</sup> October 2003**

2.00pm – 4.00pm

- 1) Epidemiology of Hyperlipidemia
- 2) Review of Evidence on the Efficacy of Treatment
- 3) Screening and Classification of Hyperlipidemia

**Seminar 2: 12<sup>th</sup> October 2003**

2.00pm – 4.00pm

- 1) Coronary heart disease risk assessment
- 2) Pharmacological Treatment of Hyperlipidemia
- 3) Non-pharmacological Treatment of Hyperlipidemia

**\* Seminars are on 1st come 1st serve basis and are limited to the first 200 participants**

## 3. Workshops Session (2 CORE FM CME Points)

### Workshops

(11th October 2003 OR 12th October 2003)

4.00pm – 6.00pm

#### 11th October 2003

Group A: Case discussion and Implementing Disease Management Strategies (A/P Goh Lee Gan, Dr Lee Kheng Hock)

Group B: Dietary Counselling Skills (Dr Tan Chee Eng, Dr Loh Keh Chuan)

#### 12th October 2003

Group A: Case discussion and Implementing Disease Management Strategies (A/P Goh Lee Gan, Dr Lee Kheng Hock)

Group B: Dietary Counselling Skills (Dr Sum Chee Fang, Dr Tavintharan Subramanian, Ms Gladys Wong)

**\* Workshops are on 1st come 1st serve basis and are limited to the first 200 participants**

**Date: 11<sup>th</sup> & 12<sup>th</sup> October 2003  
Time: 2.00pm – 6.00pm  
Venue: MOH Auditorium**

*The development of this Family Practice Skills Course is supported by an educational grant from Pfizer Pte Ltd*

Register

## Hyperlipidemia Skills Course Registration Form

Please tick  appropriate boxes.

	College Member	Non-College Member
Seminar 1	\$10.00	\$20.00
Seminar 2	\$10.00	\$20.00
Workshop	\$20.00	\$40.00
Please tick your preferred date for workshop:	<input type="checkbox"/> 11 <sup>th</sup> Oct '03	<input type="checkbox"/> 11 <sup>th</sup> Oct '03
	<input type="checkbox"/> 12 <sup>th</sup> Oct '03	<input type="checkbox"/> 12 <sup>th</sup> Oct '03
Distance Learning Module	FREE	\$40.00
<b>TOTAL</b>		

Name: Dr \_\_\_\_\_ MCR No : \_\_\_\_\_

### Mailing Address:

Please indicate:  Residential  Practice Address

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Please make cheque payable to :

College of Family Physicians  
Singapore

### Mail to:

College of Family Physicians  
Singapore  
16 College Road #01-02  
College of Medicine Building  
Singapore 169854

### IMPORTANT:

**Participants with fever should not attend the seminars and workshops.**

# Men's Health Skills Course

Course Structure

## 1. Distance Learning Course Contents

### Unit 1: Male Aging

Dr Mukherjee Jagat Jyoti, Consultant

- Pathophysiology of Aging
- Endocrinology of the Aging Male
- Rational Approach to Males Hormones Replacement

### Unit 2: Diagnosis and Understanding of Erectile Dysfunction

Dr Chia Sing Joo, Head and Senior Consultant

- Male Sexuality
- Pathophysiology of Erectile Dysfunction
- Clinical Assessment
- Psychosocial Assessment
- Investigations
- Pitfalls in Diagnosis

### Unit 3: Managing Erectile Dysfunction

Dr Enoch Gan, Consultant

- Drug Therapy
- Vacuum Devices
- Surgery

### Unit 4: Approach to Urinary Symptoms in Men

Dr Micheal Wong, Senior Consultant

- Urinary symptoms in Men
- Pathophysiology of urinary symptoms
- Diagnostic approach
- Common Pitfalls in history taking and interpreting urinary symptoms

### Unit 5: Diseases of the Prostate

Dr Christopher Cheng, Head and Senior Consultant

- Benign Prostate Hypertrophy
- Prostatitis
- Prostate Cancer

### Unit 6: Stress and Coping

Prof Kua Ee Heok, Senior Consultant

- Counseling and Psychotherapy in Erectile Dysfunction
- Mood Disorders in Men
- Coping with Aging

## 2. Seminars

(2 CORE FM CME Points each)

**Seminar 1: 29th November 2003**

2.00pm – 4.00pm

- 1) Male Aging
- 2) Diagnosis and Understanding of Erectile Dysfunction
- 3) Managing Erectile Dysfunction

**Seminar 2: 30th November 2003**

2.00pm – 4.00pm

- 1) Approach to Urinary Symptoms in Men
- 2) Diseases of the Prostate
- 3) Stress and Coping

**\* Seminars are on 1st come 1st serve basis and are limited to the first 200 participants**

## 3. Workshops Session

(2 CORE FM CME Points)

### Workshops

(29th November 2003 OR 30th November 2003)  
4.00pm – 6.00pm

Group A: Case discussion and Implementing Disease Management Strategies

Group B: Relaxation Therapy

**\* Workshops are on 1st come 1st serve basis and are limited to the first 200 participants**

**Date: 29<sup>th</sup> & 30<sup>th</sup> November 2003**

**Time: 2.00pm – 6.00pm**

**Venue : To be Confirmed**

*The development of this Family Practice Skills Course is supported by an educational grant from Pfizer Pte Ltd*

Register

### Men's Health Skills Course Registration Form

**Please tick  appropriate boxes.**

	College Member	Non-College Member
Seminar 1	\$10.00	\$20.00
Seminar 2	\$10.00	\$20.00
Workshop	\$20.00	\$40.00
Please tick your preferred date for workshop:	<input type="checkbox"/> 29 <sup>th</sup> Nov '03	<input type="checkbox"/> 29 <sup>th</sup> Nov '03
	<input type="checkbox"/> 30 <sup>th</sup> Nov '03	<input type="checkbox"/> 30 <sup>th</sup> Nov '03
Distance Learning Module	FREE	\$40.00
<b>TOTAL</b>		

Name: Dr \_\_\_\_\_ MCR No : \_\_\_\_\_

#### Mailing Address:

Please indicate:  Residential  Practice Address

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**Please make cheque payable to :**

College of Family Physicians  
Singapore

#### Mail to:

College of Family Physicians  
Singapore  
16 College Road #01-02  
College of Medicine Building  
Singapore 169854

#### IMPORTANT:

**Participants with fever should not attend the seminars and workshops.**

# Commencement of FM Academic Year 2003

28th June marked the commencement of FM academic year 2003. A total of 59 trainees have been admitted this year of which 51 are in the GDFM programme, 8 in the Family Medicine Fellowship programme.

In order to mark this joyous occasion, the College is honoured to have Dr Lee Suan Yew, President of Singapore Medical Council, as our Guest of Honour.

Dr Lee gave the following address.

“May I congratulate the College for perpetuating the tradition of organizing good training and teaching programme for her members and non-members.

At the 15th Screenivasan Oration in May 1995, I entitled my topic “Dare to Dream”. I dared the young doctors to sit for the Master of Medicine (Family Medicine) Examination. There were only 19 post-graduates then.

After eight years, there are now 180 post-graduates. The College, the Department of Community, Occupational and Family Medicine and the Graduate School of medicine should be congratulated for organizing the vocational training programme leading to the M.Med(F M). I am glad to see so many young doctors taking up this challenge. There is no doubt that the quality of care of their patients has improved as a result of the varied and structured training. The College further embarked on more programmes apart from undergraduate training; Graduate Diploma of Family Medicine (GDFM), the Home Health Care Course, the Family Practice Skills Course and E-learning.

All these programmes are indicators of the progressive and energetic mission of the College. The leaders are not satisfied to rest on their laurels. Instead, they have launched more post-graduate programmes to further improve the knowledge and skills of Family Physicians. The Graduate Diploma of Family Medicine is recognized by the Singapore Medical Council.

At the same Oration, I also dared the doctors to actively participate in continuing Medical Education. It was voluntary since 1989 when CME was initially recommended by the SMC. The College had, since its inception, conducted many series of lectures, workshops and Annual Scientific Conferences. In January this year, the SMC made it compulsory for all fully and conditionally registered medical practitioners.

Each doctor has to fulfil 25 points a year or 50 points in 2



From Left: Dr Lee Kheng Hock, Dr Arthur Tan, Dr Lee Suan Yew, A/Prof Cheong Pak Yean, A/Prof Goh Lee Gan

lectures given by “opinion leaders” or “Eminent doctors” because the information given by such persons is well-respected. Therefore, it would be prudent on the part of CME providers to assess their lectures and subjects judiciously.

I feel very confident that those of you who are committed to attend these courses will benefit from them and will eventually apply

“There is no doubt that the quality of care of their patients has improved as a result of the varied and structured training.”

years. The College is a member of the Joint CME Committee within the Academy of Medicine and the Singapore Medical Association. The College is responsible in accessing 20% of the core subjects relevant to Family Medicine. The College is helping those doctors who are busy in their practice by launching E-learning. This is certainly a step in the right direction. Most of us are aware that our younger patients are better educated and are IT literate. They often surf the internet to learn more about their illnesses and medication. It would reflect badly on the doctors who do not update the medical knowledge and are found wanting by their patients.

However, the good effect of CME interaction on physician performance and healthcare outcome is not assured. In many instances doctors improve their outcomes if they attend

your knowledge and skills for the enhancement of your professional work. I wish to congratulate the College, led by the President, A/Prof Cheong Pak Yean, a very able, dynamic and perceptive physician and your Council in spearheading the College's Academic programmes.”



Commencement held at Ministry Of Health auditorium

# 32<sup>nd</sup> College Annual General Meeting

In his opening address, A/Prof Cheong Pak Yean who chaired the proceedings reported that the College had a very eventful year. One of the major events was the restructuring of the College Secretariat. He commented that he was very glad that now the College have Dr Lee Kheng Hock and A/Prof Goh Lee Gan working part-time in the College, giving direction to the College staff and organising programmes.

The house unanimously elected Dr Tan Cheng Bock and Dr Arthur Tan to Fellowship of the College. The composition of the new Council is given in page 2.

Other matters discussed are as follows.

## CME

The College had remained focused on its twin roles of developing our own structured training programmes and evaluating CME programmes organized by other bodies. College has concentrated on developing the Family Practice Skills courses, including the distance learning and face-to-face sessions and the Singapore Family Physicians journal is now used as the resource materials.

The College managed to build up a very strong team not only in the production of CME training materials and e-learning but also in documenting and building up the membership database. The College was also fortunate to be able to obtain grants from various bodies, such as Infocomm Development Authority (IDA).

## Vocational Training Programmes

The intake of Graduate Diploma in Family Medicine (GDFM) Programme trainees for 2003 is 51. This was partly due to the recent SARS outbreak that caused many doctors to think twice before embarking on postgraduate programme.

As for MCFP, there are six more members conferred with MCFP(S) last year. More than 20 members applied this year. Under the fellowship programme, there is a new batch of 10 fellow trainees, from both the private and public sectors. The future leaders of the College will come from these members.

## Institute of Family Medicine

IFM was formed as an academic organisation

of the College to oversee the academic programmes. The IFM logo was also designed. With the change in philosophy, College would continue to encourage and advise pharmaceutical companies and societies in organising better CME activities for doctors while College would focus on developing programmes for our structured courses such as the GDFM and the FMFP. These would be made available as CME for all doctors as well.

## E-learning

The current e-learning engine being deployed is being used by NUS and is stable, robust and well tested. The program used is known as IVLE. College is convinced that more and more structured programmes will take on this distance-learning platform. Programmes like GDFM have gained an international reputation and had received applications from overseas doctors. However, the current criteria for GDFM restricts to medical practitioner registered with the Singapore Medical Council. With the adoption of e learning, it is hope that the programmes evolved into a real distance-learning programme that can be offered to doctors overseas.

## Singapore Family Physicians Journal

The new revamped Singapore Family Physicians (SFP) journal has a Family Practice Skills Course component (FPSC). There is a MCQ section which doctors can get CME points from attempting the MCQs.

## Regional and International activities

The College is taking a higher profile in the international arena. College would be sending a team of delegates to attend the WONCA regional conference to be held in Beijing in November and to establish links with our Chinese counterparts. Among the many Wonca activities was the world conference on developing family medicine research held in Canada. Dr Matthew Ng, our honorary editor of the SFP and Dr Ruth Lim, one of the FMFP trainees, represented the College in this conference.

## SARS outbreak

The Chairman also brought up the issue on the SARS outbreak, which caught everyone by surprise. College took the initiative to quickly mobilised resources to help doctors

cope with the SARS outbreak. As the routine activities of the College were suspended, the College took the opportunity to upgrade the lecture room's AV equipment and to bring forward the e-learning programme. Members can expect a full report next year.



From Left: A/Prof Lim Lean Huat, Dr Lee Suan Yew, Dr Tan Cheng Bock



Annual General Meeting 2003 held at college

**Look out for the following Family Practice Skills Courses**

**Hyperlipidemia**  
11th & 12th October 2003

**Men's Health**  
29th & 30th November 2003

*See pages 12 and 13.*

# Musculoskeletal Disorders Skills Course

On the 12th and 13th July 2003, the College organized the Musculoskeletal Disorders CME.

- Low back pain
- Systemic disease that present as joint pain

The development of this Family Practice Skills Course was made possible with an educational grant from Merck, Sharp & Dohme (I.A.) Corp. The skills course was held in the Ministry of Health Auditorium and it received over-whelming response.

There was also a workshop session which covered Case Discussion on Osteoporosis – Putting knowledge into practice and Panel discussion and consensus – Best practice in the prescription of analgesics. The College received many positive feedbacks from doctors who had attended both the seminars and the workshops.

Within 3 weeks, 130 doctors had already signed up for the course. The topics rolled out during the seminars include :

- Osteoporosis
- Osteoarthritis of the knee and hip
- Therapeutic agents in joint pain
- Orthopaedic problems of the upper limb

With that, the College would like to thank all the resource persons and the sponsor who had contributed their time and efforts to making this skills course a success. The College looks forward to continual and greater support from all its members.



*The skills course involves seminars, workshops and Question and Answer sessions*

## College Membership

### Join as College Members

Many doctors have called the College to enquire about the membership criteria for Ordinary/Associate memberships as they are interested in the 4 free distance learning modules and other privileges accorded to College members each year. Due to amendments introduced in the AGM held on 29th June 2002, the College has drawn up a new membership form which will be available upon application to the College.

#### Associate Membership

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 Membership

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.

**Annual Subscription Fee : S\$180**

**One-time Entrance Fee : S\$50**

**Application Forms can also be downloaded from <http://www.cfps.org.sg>**

#### College Membership Response Form

*Please send me an application form.*

Name : Dr \_\_\_\_\_

MCR No : \_\_\_\_\_

Mailing Address : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Contact No : \_\_\_\_\_

Fax No : \_\_\_\_\_

To: College of Family Physicians Singapore  
16 College Road #01-02  
College of Medicine Building  
Singapore 169854  
Tel : 62230606 Fax : 62220204  
Email : [Contact@cfps.org.sg](mailto:Contact@cfps.org.sg)

## Welcome to New Members

The college would like to extend a warm welcome to the following members who joined us between the months of March and July 2003:



### Ordinary Membership:

Dr Abdul Kadir Abdul Bashir	Dr Lee Boon Kok Thomas	Dr Ong Kok Kiong
Dr Ang Geok Lian	Dr Lee Chan Long	Dr Ong Wan Cheng
Dr Aw Tuan Kiat	Dr Lee Chien Shih	Dr Ooi Siew Hong
Dr Aw Tuan Soo	Dr Lee Eng Hua	Dr Pang Siung King Jonathan
Dr Beng Kiaw Lam Arthur	Dr Lee Eng Sing	Dr Quah Siok Chuan
Dr Boey Kok Hoe	Dr Lee Hew Mun John	Dr Quah Tee Hwa
Dr Chan Teng Mui Tammy	Dr Lee Lai Kit Sylvia	Dr Quek Lee Seh
Dr Chee Hsing Gary	Dr Lee Peng Khow	Dr Rajaratnam Komathy
Dr Chee Yuet Ming Lillian	Dr Lee Wen Yan	Dr See Shean Yaw
Dr Chen Lisa	Dr Ler Gee Bueh	Dr Seet Lin Tze
Dr Cheok Soo Gek Felicia	Dr Liang Hsueh Ying Joyce	Dr Si Hoe Sing Yin
Dr Cheong Chin Lee Angela	Dr Lim Bee Ling Tina	Dr Siew Boon Liong Glenn
Dr Chia Woodworth Clarice	Dr Lim Cheng Buay	Dr Siew Man Gah
Dr Chin Yee Choong	Dr Lim Choo	Dr Sim Kok Ping
Dr Chong Tsung Wei	Dr Lim Hwee Leng	Dr Soh Wah Ngee
Dr Choo Huey-Ni Janice	Dr Lim Jin Foo	Dr Tan Chieu Har June
Dr Chua Bee Yee Christina	Dr Lim Keng Chye David	Dr Tan Chin Beng Melvyn
Dr Chua Lay Hoon	Dr Lim Khoon Boon Peter	Dr Tan Kok Ying
Dr Fang James	Dr Lim Meng Choo	Dr Tan Kwang
Dr Fok Wai Yee Rose	Dr Lim Yueh Ling	Dr Tan Lian Ching
Dr Goh Miah Kiang Oswald	Dr Lo Sook Ling	Dr Tan Yew Seng
Dr Goh Pi Hian Jennifer	Dr Loh Su Lin Jennifer	Dr Toh Wai Keong
Dr Goh Yean Hoon	Dr Loh Yin Leng Carolyn	Dr Unnikrishnan Saira
Dr Gong Swee Choo	Dr Looi Chong Sin Robert	Dr Vengadasalam Sarojini
Dr Hafidza Binte Mohd Said	Dr Loong Tze Wei	Dr Virabhak Chayansak
Dr Heng Kim Boon	Dr Low Cheng Hong Charity	Dr Wee Kien Han Andrew
Dr Ho Chok Chan Alan	Dr Loy Heng Juen Kevin	Dr Wong Hon Wai Wicky
Dr Ho Lai Kwun Patrick	Dr Lum Khai Wah	Dr Wong Kai Peng
Dr Huan Yu Min Pearl	Dr Masayu Zainab	Dr Wong Mei Ling Gladys
Dr Jam Sou Lai	Dr Mok Wai Kit	Dr Wong Yu Mei Joyce
Dr Kan Dee Ching Elena	Dr Nair Sarala Devi Sankaran	Dr Yang Chyan Yeow Aylwin
Dr Kee Chin Bong Freddie	Dr Ng Chee Keong Edmond	Dr Yap Boh Wei
Dr Keong Kean Seng Gary	Dr Ng Chyi Yoke Elisa	Dr Yap Eng Chew
Dr Khaw Seng Ghee	Dr Ng Hsueh Mei	Dr Yap Soon Boon Raymond
Dr Khoo Bee Sim	Dr Ng Hwee Hin	Dr Yap Thiam Koon
Dr Koh Tann Long	Dr Ng Lai Peng	Dr Yap Tiong Toh
Dr Koo Wee Khiat Alvin	Dr Ng Siew Min Amy	Dr Yeo Chye Neo Angelina
Dr Kuan Dah Wei Alex	Dr Ng Tsornng Chinn	Dr Yeo Thoont Kiat
Dr Kwan Wai Chee Grace	Dr Ng Wei Leong Tommy	Dr Yeow Mong Oon
Dr Kwee Lee Fung	Dr Ng Wei Seng	Dr Yim Fu Chuen Benjamin
Dr Lan Jiann Jong	Dr Ong Bee Sim	Dr Yim Jean
Dr Lau Boon Kwang	Dr Ong Cheng Choon	Dr Yip Mang Meng

### Associate Membership:

Dr Abdullah Amir Adhha	Dr Heng Soo Hng	Dr Norkhalim Bin Dalil
Dr Akahoshi Midori	Dr Hor Oi Lin	Dr Poh Chern Loong Andy
Dr Ang Lay Teng	Dr K. Palaniappan	Dr Sum Lai Yan
Dr Chan Kong Hon	Dr Keith Kee Kiak Hong	Dr Tan Gek Ngor
Dr Chang Wan Ern	Dr Kesavaraj Jayarajasingam	Dr Tan Kok Ling
Dr Cheng Geok Min Ruby	Dr Koh Amanda	Dr Tan Mei Ling Penelope
Dr Cheong Yin Phoon Karen	Dr Lam Wee Min	Dr Tan Peng Wee
Dr Chew Him Lim Madeleine	Dr Lau Teh Yee	Dr Tan Siang Hon
Dr Chiang Wing Chiong	Dr Leong Tyng Tyng	Dr Tang Wen Yu Gavin
Dr Chong Shih Tsze	Dr Leong Wai Hoe Justin	Dr Teo Kah Yeen Dana
Dr Choo Chin Yeng	Dr Lie Lily	Dr Tiah Seow Hwee Jane
Dr Chook Kum Kay	Dr Lim Teik Hock	Dr Tjang Tjung Fa
Dr Dang Simrit Kaur	Dr Ling Wen Jiat Grace	Dr Von Senden Sheryn - Kaye
Dr Erwin Kay Aih Boon	Dr Loh Chiu Khuen	Dr Wang Shi Tah
Dr Goh Jin Hian	Dr Loh Kwok Thye	Dr Wong Li Lian
Dr Gouw Janet	Dr Loh Seow Faan	Dr Wong Ruei Chian
Dr Gwee Shou-Yi Rachel	Dr Low Wye Mun	Dr Wong Wei Mon
Dr Han Mei Lan	Dr Nakada Takeo	Dr Yap Yew Chong Bernard

## FM Convocation & College Dinner 2003

Venue: Orchard Hotel Ballroom

Date : 16th November 2003  
Sunday

Guest-of-Honour :  
Dr Lily Neo

Chairperson

Government Parliamentary Committee for  
Health and member of Parliament  
Republic of Singapore



Please look forward to the next issue of Singapore Family Physicians journal for further updates.

## WONCA 2004

Plan now to be a part of this historic event by attending the 17th World Conference of Family Doctors (WONCA 2004) in Orlando, Florida; USA October 13-17, 2004. Hosted by the American Academy of Family Physicians (AAFP), Wonca 2004 will be held in conjunction with the AAFP Scientific Assembly.

The 17th World Conference will continue the WONCA tradition of cutting-edge technology, global calls to Action such as the prevention and cessation of tobacco use, practical application of the latest medical advancements, as well as today's issues that affect family physicians/General Practitioners and their families.

It will be the opportunity to network with your colleagues from around the world while providing an unforgettable experience!

Go to <http://www.wonca2004.org> for more information.

# Dr Wong Heck Sing - The Batam Years




Dr Wong Heck Sing  
(Photo Archive 1971)

Dr Wong Heck Sing is role model exemplar for younger doctors and budding doctors-to-be. Born in 1923, he is the sixth child and second son of a family of 9 children. He served his patient community in his General Practice in western Singapore, was the President of CFPS from 1973 to 1977 and 1983 to 1985 and thus one of the early pioneers in the family medicine movement in Singapore. He believed in voluntary work and was a leader of leaders being involved in selecting leaders for civil service in the Public Service Commission.

His words of wisdom echo in a SMA lecture 1997 –“In search of Future Role Models in Medicine” where he said “..there may come a time where a whole new generation is brought up in an environment where doctoring is no longer a calling but a service industry, leaving behind a legacy that commands little respect.”

One way to forget not is to hear the stories of lives of men and women who have forged the road of medicine and be inspired to walk on bearing such legacies. Thus in this September edition of Down Heritage Trail, we are proud to publish excerpts from privately published “The Batam Years” which chronicles Dr. Wong’s pre-medical school days and his family to survive during the war years of 1942 to 1945. It was a time when young Singaporean males were executed by the thousands. His family with 5 sons had a lot to lose and his parents then decided to evacuate the family to Batam where the story is set.

## War Days



The war was going badly for the British. As more and more Singaporeans evacuated to Batam, all the news they brought was bad. This cast a deep despondency over us, with no hope of an early Allied victory. Our return to Singapore would be considerably delayed; in fact we sometimes wondered whether we could ever return. The lunar New Year, usually celebrated with much festivity, brought little cheer to us in Batam. We heard loud explosions coming from Singapore lasting for some hours, followed by an ominous silence. Had Singapore fallen? Everybody had the same question. We refused to believe that this could possibly have happened. No less a

story of despair and defeat. They asked how they could get away from Batam. They hoped to sail to Java, and in order to get there they wanted a boat. As they were walking, they were dislodging the firing pins from their guns. They threw the pins in one direction and the guns in the other. My brothers and I led them to the village headman, who told them to go to Big Company’s godown. The soldiers numbering about twenty then parked themselves on the verandah of the godown. They were thoroughly worn out. When I inquired whether they had brought any food with them they shook their heads. I then went home, and asked Mother to prepare a large kettleful of hot coffee. I brought them the coffee and a tinful of Marie biscuits.

Japanese came we were caught off guard. In fact, the whole village was caught unawares. The Japanese were at our doorstep before we realised who they were. There were two of them, accompanied by Indonesian guides. They appeared to be looking for something. We immediately guessed they were looking for the British guns. They came to one of the bedrooms where we kept the books we had brought from Singapore. The books were mainly English books.

At once the Japanese faces changed. They looked grim and the leading man drew out his sword. I did not realize he was an officer until I saw that he had pips on his shoulder. He ordered all of us out of the house. He then counted and found one of us was missing. He shouted to me to get the missing person out. I used sign language to indicate to him that the wanted person was ill. Not believing me, the officer strode into the house to see for himself. Third Brother was in bed with a burning fever. At once the officer’s demeanor changed. His face, which a moment ago, was grim now appeared kind and gentle. He bade me to fetch him a basin of cold water and proceeded to sponge Third Brother’s forehead. After a while he asked me to continue the sponging. The officer left soon after, followed by the others. They were then seen sitting under a tree in the village, fanning themselves. The Indonesian guides pointed to Mr Ong’s house and indicated that there were young women staying there. The

***Had Singapore fallen? Everybody had the same question. We refused to believe that this could possibly have happened.***

person than Winston Churchill, had said that Singapore would never be allowed to fall.

That evening, the first British troops arrived in Batam, confirming our worst fears that Singapore had indeed fallen. We met the soldiers, walking through Father’s rubber estate towards Sungei Panas village. They were a dispirited lot and their faces told us a

## The Japanese advance and an officer

We never expected the Japanese would come to Sungei Panas so soon, not to the village anyway. They must have had a well organized and an efficient intelligence service. News of British soldiers throwing their guns away must have been relayed immediately to them. The Japanese dispatched troops to investigate. When the

Japanese ignored the guides. They continued to sit under the tree. After a while they all left in their boat.

The Wongs and the Ongs had two lucky breaks that day. The Wongs were lucky to have got off so lightly for the English books. When the Japanese officer drew his sword, we thought we would all be killed. The Ongs were also lucky. Despite the urgings of their Indonesian guides, they refused to go to the cottage to molest the women. The Japanese were known for their barbarism towards women in wartime. Fortunately, the officer had a restraining influence on the other soldier and the Indonesian guides. As to why the officer was so kind to Third Brother one would never know. Perhaps he had a son in Japan. We were just lucky. The news of our luck soon spread, especially the news about the womenfolk in the Ong family, and people talked about the subject for a long time.

Following the visit by the Japanese, Father decided to shift as soon as possible to the second rubber estate, even though the repairs to the hut were not completed. Father said, "The Japanese are unpredictable. They may come back to punish us for the English books. We can't take any chances". We shifted that same day. So did the Ongs. They too thought the Japanese might return. They moved while there was time. We completed the move in one day, locking up house at Sungei Panas village. The neighbours were curious, asking us the reason for our move. After our explanation, they agreed that it was the right thing to do. They never questioned the Ongs. They knew there were many women in the Ong family.

**After the shift, the Wongs continued to face challenging times hiding from the Japanese and braving a tip-off on an attempted robbery in their new hide-out...**

After sending the womenfolk off, we immediately set to work to get ready for the night. Father's fail-safe plan, was to spend the night in the repaired hut's newly constructed latrine. "Nobody would ever look in the latrine for us!" Father said, "Especially if we put out all the lights and

remained very quiet". We had an early and quick dinner, eating only the leftovers from lunch, and then hurriedly prepared to bed down for the night. We did not expect much sleep that night. We listened to what Father said and prepared to be in bed with the lights out before the robbers came. They would be armed, he warned. The latrine had been in use during our brief stay. There was already a strong stench coming from it, despite having covered its opening with our bedding. There was no time to bathe. Anyway it made little difference, as we were by that time sweaty and smelly.

Sleep was out of the question for the rest of the night. We talked for a while in whispers and wondered whether the robbers would return. We soon began to notice the stink of the latrine, the odour of which escaped us earlier. The presence of the robbers made us forget the smell, as well as the hordes of mosquitoes attacking us. Now that the excitement was over the odour of faeces and the mosquitoes stinging, proved well nigh intolerable. Father warned us to keep quiet. "We could never be sure whether there were

### *On the third day I had an attack of rigors, which made the diagnosis obvious. My fever was due to malaria, and not due to "motan"*

neighbouring farmers walking at night, and they might spread the word that we were hiding in the latrine. We have to think of future robberies. The latrine might once again come in handy", he said. The next day we started early, ferrying the rest of our belongings to Sungei Panas. Father warned us against discussing the attempted robbery. He told us to say that the womenfolk found the new place too uncomfortable and too isolated. They wanted to return to the house at Sungei Panas.

After a while the robbery incident became a blurred memory. Once again life became a dull boring repetition of each day. There was nothing to look forward to, not even an early return to Singapore. That had all along served as a morale booster.

#### **Of Motan and Malaria**

Then one day I came down with a high fever.

At first I thought it was a common cold. The fever persisted and continued for several days. "Motan", somebody said, "and the best cure is needling your finger to let out the bad blood out, followed by swallowing an opium pellet".

Thus I had my first experience of blood letting. It was not a pleasant experience. I was asked to go to the village opium den to get the treatment. The same person, who suggested the cure, took charge of the proceedings. He took hold of my middle finger, and turned my palm downwards and proceeded to squeeze my terminal phalanx of that finger. He then pricked the phalanx next to the nail bed, letting out some blood. I let out a gasp of pain. He pricked several a few fingers, each two times, and each time below the nail bed. "Aha", he cried triumphantly, "dark blood! ." "I was right. The dark blood means that you definitely have "motan". I was made to swallow one black vile looking pellet. "In no time you will be up and about", he said reassuringly. Father offered to pay him for the treatment. "No", he said. "You don't have to pay me.

You know I don't do this for a living. I am a farmer like most people here. I learned this treatment from a friend and he made me promise never to make money out of it", he continued. He had promised his friend that he would only do this to help people.

By this time the opium was beginning to take effect. I was feeling very drowsy, and was



Map of Singapore and Batam  
From "The Batam Years"

unable to stand up, and maintain my balance. How I managed to reach home I am unable

to say. I seemed to be sleepwalking. I then fell into a deep and drugged sleep. On waking, my fever continued. I was feeling as miserable as ever. The farmer who pricked my fingers and gave me the treatment was incorrect when he said that I would be better after the sleep. His diagnosis that I had “motan” was wrong. The burning fever continued for two days. It caused an unquenchable thirst. I had to drink glasses and glasses of water and still felt thirsty. On the third day I had an attack of rigors, which made the diagnosis obvious. My fever was due to malaria, and not due to “motan”. Motan was a term used to describe typhoid fever. The term “motan” was a descriptive term. It was used to describe a phenomenon, found only in typhoid fever. In cases of typhoid, a rash over the abdomen usually appeared within 10 days. If one were to rub a damp dough over the abdomen of a typhoid patient, strands of “hair-like fibres” would appear. That was how typhoid was diagnosed by the traditional Chinese physician. “Mo” meant hair in the Chinese language; and “tan” meant “illness”.

I was having malaria, and not “motan”. Quinine, the cure for malaria was unobtainable anywhere in Batam. The island never had malarial cases as far as the present inhabitants could remember. Now there was an epidemic of such cases. It was after I had graduated as a doctor that I discovered the reason behind the malaria outbreak. The environment of Batam was disturbed. Large and increasing number of farmlands were used to plant food, causing large areas of trees in the forests to be felled to make way for new farmlands. After each rainfall, puddles of water collected, breeding mosquitoes including those that carry the malarial parasite. Soon the inhabitants infected with malaria reached epidemic proportions. I was told that in the 1920s when land was cleared for rubber planting, there was also malaria in Batam. By the 1930s conditions had stabilized and malaria was no longer a problem. Now malaria had returned and there was no quinine available anywhere in Batam. After my attack of malaria, Father and Third Brother also developed high fever.

They too had malaria. Their rigor, like mine, occurred at various intervals. The typical pattern of the illness was altered. The fever, usually followed by a rigor on the third day, varied.

The rigor, in Batam cases, could occur at any time, up to 5 days interval. A few weeks later, we heard some boatmen were trading in cinchona bark around the islands nearby. We knew quinine came from cinchona bark. We immediately contacted the boatmen and bought some cinchona bark from them. The bark was a godsend. Cinchona bark soon became a tradable commodity, better than money. It was traded for practically anything, including rice, which in wartime was the most sought after commodity. The demand for cinchona bark was greater than the supply, as malaria was so widespread in Batam. In Sungei Panas village alone, about 10% of the population died from malaria. The ones who died, had the most feared form of malaria, cerebral malaria.

We had no idea how much quinine the bark contained, but by trial and error we found that a teaspoon of bark could abort an attack or prevent it from occurring. We measured a teaspoon of the bark, ground it into powder, wrapped in a small piece of newspaper and swallowed paper, print and all!

We had learnt how to anticipate an attack. There would be prodromal symptoms like aches and pains in the limbs. If we took a teaspoon of the bark as soon as the aches and pains appeared, we could ward off an attack. The duration of the effect of quinine medication varied. Sometimes the cinchona bark worked for one or two days. Other times the intervals was shorter. If however, one delayed in taking the cinchona bark when the symptoms appeared, or if the bark was not readily available, a full-blown attack would ensue. We continued having malaria till the end of the war. By we, I meant Third Brother, Fourth Brother and Father, although Father had far fewer attacks than us. Big Sister and Mother were spared during most of the war years. Mother especially had fewer attacks. There was no explanation to account for it.

On one occasion, when Mother had malaria, I tried giving her a quinine injection from the ampoules I bought in Singapore. Mother recovered from the malaria, but in its place she developed a large abscess at the site of injection. She was not at all pleased. Fortunately the abscess burst discharging much pus, without further complications. Big Sister did not have malaria till the last year of the war. That was in early 1945. I did not know whether Big Brother had malaria because he was never at home. He apparently escaped or he would not have been able to travel so much. The reason Big Sister was spared for so long was that she always kept herself fully covered from the sun. Mosquitoes never had a chance to bite her. When the war was over and we were back in Singapore, none of us had any relapse of malaria, which was surprising. We also did not have enlarged spleens despite the many attacks we had in Batam. I lost a lot of weight from the many attacks of malaria, so much so I was reduced to skin and bones. I saw what Big Brother wrote in his diary. I must have been very ill for him to write “Sing’s last days”! He did not expect me to live and he must have forgotten to put away his diary.

### **My Unexpected First Patient**

A few days after Singapore fell, we had visitors from another village, asking for our help. It seemed that one of their relatives who had just arrived from Singapore, was shot in the head by a Japanese soldier, and was seriously wounded. They thought he would soon die. They waited for two days and the wounded man was still alive. They had heard they could get help at Sungei Panas, from people like Big Sister who was a trained nurse in Singapore, and had some experience in treating wounds. Big Sister asked how far was their village. “About three hours’ walk.” they replied. Big Sister was not keen to go, as she had a sore foot. She turned to me and said, “Why don’t you go, since you were in the MAS. You had some training in first aid and had some experience in treating bomb casualties.”

Let me explain. In 1941, I was offered a place to study in Raffles College in Physics, Chemistry and Mathematics. When the war broke out, on the morning of December 1941, I was busy preparing for the first terminal examinations. However the examinations were cancelled. The College announced that

all studies would be halted and all male students were asked to join the Medical Auxiliary Service or M.A.S. Before we were sent out, we were told we would be given training, both in theory as well as in practice. But the war broke out so suddenly and unexpectedly, and with the Japanese troops advancing, all the training we had was an hour's lecture, all about treating the seriously wounded with morphine injections. It was given by a British doctor, a recent evacuee from Penang. That lecture was a complete waste of our time, as only doctors were

## *Gingerly, I pushed his eyeballs back into their sockets and covered them with a light bandage*

- Dr Wong Heck Sing on giving first aid to man with gun-shot wound

allowed to give morphine injections. As a consequence, we made some horrible mistakes in carrying out our duties to the war victims. Father agreed with Big Sister that I should go. The long journey on foot, coupled with the fact that the people were complete strangers, made it necessary that I should go. The long journey on foot, coupled with the fact that the people were complete strangers, made it necessary that I should go. I had earlier brought with me some medicines when I came to Batam with Father and Little Sister. I should explain that after finishing school in 1939, I enrolled to do the Pharmacy course at the College of Medicine, Singapore. In 1940, unlike presently, the course consisted of three years work in practical dispensing, followed by a year of academic studies. During the first year of practical dispensing, I acquired some knowledge on the use of the common drugs. A newly introduced drug at that time, was the "MB 693". It had worked wonders on infected wounds, even on topical applications. That box of medicines I had brought with me to Batam, consisted of a bottle of tincture iodine, a bottle of Eusol lotion, a packet of potassium permanganate crystals and some fifty MB 693 tablets. I set off with the visitors, with the box of medicines. After three hours walking, we came upon a cluster of attap huts raised on stilts. I was ushered up the steps to the verandah of a large hut. Drinks were served. I looked around. There was no patient to be found.

"He is not here," volunteered one of the

guides. "We left him under that tree thinking he would die," pointing to a large tree to one side of the hut. "That was two days ago. He is still alive this morning. That was why we sent for you." I hastened to him. I could hardly suppress a gasp when I reached him. The group of people who came to our house did not mention that his eyeballs were protruding out of the eye sockets. What startled me most were his two bloodshot eyeballs staring vacantly at the sky. He was lying on the ground on a mat in a pool of dried blood, his face also caked with dried

blood. There was dried blood on his clothing. He was still alive as he was breathing. His half-opened mouth, revealed dried blood on his teeth and lips. His tongue was parched dry. My tongue was equally parched, not with thirst but with anxiety and fear. Tremblingly, I knelt beside him. With unsteady hands I opened up my medicine box. I called for a basin of hot boiled water, and after it had cooled I proceeded to clean the man's face. I found a wound in his left temple and a similar one on the opposite side, presumably the entry and exit points of the bullet. I cleaned the two wounds with Eusol solution. After drying them I sprinkled some MB 693 powder on the wounds. Gingerly, I pushed his eyeballs back into their sockets and covered them with a light bandage. I bandaged his wounds in his temple. I cleaned the rest of his face and head. Thankfully no questions were asked. I would not have known how serious his injuries were, and whether he would live. I did tell the people around to give him fluids, as he was parched dry and obviously dehydrated. The wounded man was carried into the house. He was put to bed in one of the rooms. When offered a cup of warm water he opened his mouth and drank greedily. He also drank half a bowl of watery congee. Soon he fell into a deep sleep. I then realized how thirsty and hungry I was, and gratefully accepted a large cup of hot coffee. A basin of warm water was provided for me to wash up, and clean myself.

Over the next few mornings the same group

of men came to fetch me. The patient continued to make good progress. His wounds were not infected, and the swelling around his eyes had visibly subsided. Big Sister accompanied me one morning. She said the man was doing well. He had no fever, and his eyeballs were settling into the eye sockets. His eyelids could partially close and his temple wounds were healing well. He was eating, and drinking, and was able to sit up. He could also respond to questions, but he remained blind. Big Sister thought the bullet had severed his optic nerves. When we asked him what had happened during the boat journey, he was thankfully unable to remember. Big Sister and I continued seeing him until his wounds were completely healed. He was totally blind, but in good spirits. He said he was very fortunate to be alive and he thanked us profusely. The morning after our last visit we were greeted by a group of the patient's relatives. They brought with them several baskets of presents. Each basket contained eggs, chickens, ducks, fresh fish, prawns and a red packet stuffed with money. They were very grateful for the help we gave to the patient.

There is a postscript to this story. About twenty years later, after I had graduated as a doctor and was in private practice, a blind man came to my consulting room accompanied by his teenaged sons. He had to be helped to a chair by his sons. I proceeded to question the man about his symptoms. He became silent as he listened intently. All of a sudden he spoke, "Dr. Wong, Dr. Wong, don't you remember me? You saved my life. You treated me in Batam. I was the man shot by the Japanese. You saved my life. I can recognize your voice". "Yes, I remember," I said to him. "But I couldn't have possibly. I have saved your life, I was not a doctor then", I explained. He refused to accept my explanation, and kept insisting that I had saved his life. He told his children that I was the man who had treated him in Batam, and saved his life. I was quite amazed that after all these years, I should meet the man who was my very first patient, although I was not even a qualified doctor then.

*Excerpts from chapters 4-6 of "The Batam Years" by Dr Wong Heck Sing. "The Batam Years" memoirs is privately published and a copy of the book is available for reading and reference in the College Library.*

# Latest Update on Hypertension - JNC 7

By Dr Shiau Ee Leng, Editorial Board Member

The last Joint National Committee (JNC) 6 report was released in 1997. Since then the National High Blood Pressure Education Programme (NHBPEP) Coordinating Committee (a coalition of organisations and agencies in USA) appointed a committee to publish the latest JNC 7 report released on May 2003. The JNC 7 has strict criteria but has simplified the classification of blood pressure and hopes to provide new and concise guidelines useful for clinicians. (See **Table 1**)

## Summary points:

1. There was a recognition of a pre-hypertensive phase defined as systolic BP between 120-139 mmHg or a diastolic BP between 80-89. For this group of patients, JNC 7 recommends lifestyle changes to prevent the development of hypertension and prevention of cardiovascular disease. This includes weight reductions, exercise, adoption of the Dietary Approaches to Stop Hypertension (DASH) eating plan, salt reduction, limiting alcohol intake and cessation of smoking, the latter being recommended for overall cardiovascular health.

**TABLE 1. Blood Pressure Classification**

BP Classification	Systolic BP mmHg	And	Diastolic BP mmHg
Normal	<120		<80
Pre-hypertension	120-139	Or	80-89
Stage 1 hypertension	140-159	Or	90-99
Stage 2 hypertension	≥160	Or	>100

2. For hypertensive patients, systolic BP of >140 mmHg is a much more important cardiovascular disease (CVD) risk factor than elevated diastolic BP in individuals >50 years. The risk of CVD also doubles with each increment of 20/10 beginning at 115/75.

3. The target BP for most individuals would be < 140/90 mmHg but lower (< 130/80) for patients with diabetes mellitus or chronic renal disease.

4. For most patients with uncomplicated hypertension, thiazide-type diuretics (either alone or in combination with drugs from other classes) should be the therapeutic agent of choice.

5. In order to achieve BP goals, two or more anti-hypertensive drugs would often be needed. If the BP is > 20/10 above goal BP, consideration should be given to initiate therapy with two agents (one of which should preferably be a thiazide-type diuretic).

6. Certain high-risk conditions are indications for initial use of other anti-hypertensive drug classes. (See **Table 2**)

7. Follow-up visits should be monthly for stage 1 and more frequently for those with stage 2, until BP goals are achieved. Subsequent review interval could then be increased to 3- and 6-month intervals respectively.

8. Finally the committee recognises that the responsible physician's clinical judgement remains paramount in deciding on the most appropriate intervention strategies.

The family physician knows full well that achieving BP goals and compliance depends on a combination of patient, cost and doctor factors. It is worth while remembering that motivation improves when patients have positive experiences with and trust the doctor.

*Summarised from the Seventh Report of the Joint National Committee (JNC) on Prevention, detection, Evaluation and Treatment of High Blood Pressure JAMA 2003;289:2560-72*

## HAND WASH REFRESHER

- a rhyme to remember all steps  
Front/Back/Front/Back/Tips/Thumbs/Wrist

Step 1. FRONT of hand (palmar surface)



Step 2. BACK of hand and finger webspaces



Step 3. FRONT of finger webspaces



Step 4. BACK of middle and distal finger phalanges



Step 5. TIPS of fingers



Step 6. THUMBS web spaces



Step 7. WRIST



Picture Source : Johnson & Johnson Medical Singapore

**TABLE 2. Therapeutic classes recommended in presence of other high-risk comorbidities**

High Risk Conditions	Diuretic	Beta-blocker	ACE-inhibitor	Angiotensin receptor blocker	Calcium channel blocker	Aldosterone antagonist
Heart Failure	+	+	+	+		+
Post Myocardial Infarction	+	+	+			+
High Coronary disease risk	+	+	+		+	
Diabetes	+	+	+	+	+	
Chronic kidney disease			+	+		
Recurrent stroke prevention	+		+			

# Effective Medicine in Small Doses

By Dr Seah Chiew Wan, Editorial Board Member

## 1 Consulting skills - The patient who refuses the right treatment

John Murtagh believes it is more appropriate to say difficult problems rather than difficult patients –afterall it is the patients who have the problems while doctors have the difficulties. One of the common problems we face as a family doctor is when a patient refuses to be referred for right treatment when indicated. This was further aggravated with the recent SARS scare in hospitals. You are asked to do a house call. It is a diabetic patient insisting on antibiotics and regular dressing for his foot gangrene. One look and you know short of a miracle, no amount of antibiotics and dressing is going to bring about healing. He needs to be referred to the orthopaedic surgeon for a likely below knee amputation. Sounds familiar? What would you do? Would you prescribe a course of antibiotics and make regular home visits to dress his wounds? Or maybe refer him to Home Care Services for home nursing care? Or simply stick to your gun, refuse his request for treatment and leave?



**TIP.** A few tested options are:

- Provide a short trial of treatment. Time itself is a management tool and allows the patient to see poor progress as well as keeping him on your side. A joint decision can be made for referral later.
- Decide not to provide any definitive treatment but write a memo detailing your assessment and advice on management. This gives family the option to seek appropriate medical attention when they change their mind and as a family doctor you eased the process by providing a letter for continuity of care.

## 2 Rules of prescription - Ever wondered just how much cream is enough?



**TIP.** Here are some simple rules to go by:

- 30 gm of cream will cover the surface area of an adult. Ointments, despite being of thicker consistency, do not penetrate into the deeper skin layers so readily and the requirements are slightly less.
- For small lesions:

1 gm of cream will cover an area approximately 10 cm x 10 cm

- For large lesions:

the 'rule of nines' (See Fig. 1), used routinely to determine the percentage of body surface area affected by burns, may also be used to calculate the amount of a topical preparation that needs to be prescribed. 3 gm of cream will cover 9% of the body surface area.

## 3 Elderly health- Handling dry eyes in the elderly with style



Elderly patient complaints to you of excessive watery eyes .

**TIP.** Before you blithely diagnose dry eyes and prescribe eye drops, explain to patient the reason as the he may wonder why he is being prescribed more eyedrops when he is already producing so much tears.

Simply, there are 2 types of tear production:

- Basic tear secretion, which is unconscious, lubricates the eye and allows the eyelids to glide smoothly across the cornea.
- Reflex tear secretion is tearing in response to stimuli for example irritants in the eyes and during emotional states.

In the elderly, loss of basic tear production occurs and the resulting eye irritation triggers the reflex secretion. Hence the paradoxical complaint of excessive watery eyes. Then explain that treatment is simple - instillation of topical ocular lubricants four times daily or more, depending on severity. Many commercial tear substitutes (like methycellulose eye drops) are available in the market and the individual patient may find a particular type most suitable for him. Some patients prefer gels. Surgery e.g. punctal occlusion is reserved for refractory cases.

## 4 Curry Leaves- a safe and economical way to treat Halitosis

Halitosis affects 50-65% of population. In the majority, bad breath originates from local factors with 10% due to systemic diseases. The bad breath is due to volatile sulphur compounds produced by bacteria in mouth.

Increase in saliva production through use of breath mints, lozenges and adequate water intake at regular intervals decreases the concentration of bacteria and helps in cleaning of oral cavity. Regular teeth brushing in morning and after dinner improves oral hygiene and controls bacteria in oral cavity.

**TIP.** Curry leaves are easily found in gardens and used in local Asian cooking. Holding two fresh curry leaves in mouth for 7 minutes has been found to decrease bad breath. The curry leaves increases the flow of saliva and contain sesquiterpenes which are essential oils with antibacterial and antifungal properties.

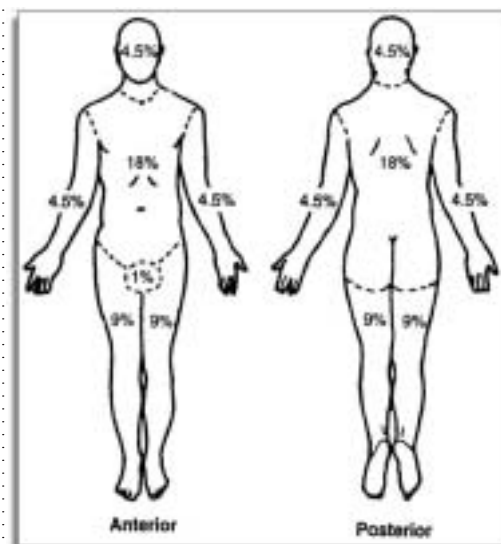
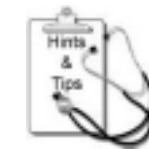


Figure 1. 'Rule of nines' for body surface area

### References:

1. *General Practice 2nd edition John Murtagh Chapter 99 Problems of the skin*
2. *Geriatric medicine for Singapore, Law NM, Chapter 21 Visual impairment*
3. *Mahantayya et al Curry leaves and Halitosis BMJ South Asia Edition May 2003; Vol. 19 No.3 ; 211*