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Family Medicine physicians, and there was some talk about having two discrete programmes for these two "different" tracks. What they had failed to realise was the common training ground and programmes that enabled Family Medicine to function in unison across both settings. A Primary Care Family Medicine physician who has knowledge of hospital medicine can better appreciate what his patient had gone through during the recent hospitalisation and who has now returned to his care. In such an instance, he would be the best physician to care for his patient.

What I found really heartening was the formation of the SingHealth Family Medicine Academic Clinical Program (ACP). This is a strong show of unity as our Family Medicine leaders in SingHealth put their differences aside and come together to complement each other's areas of strengths and weaknesses, for the greater work to be done in clinical services, education and research in the realm of family medicine. I have seen for myself how long this has taken, and how much resolve is needed to overcome the barriers. It did not come easy and overnight, but I'm glad it came eventually. It is the start of a new chapter, hopefully where Family Medicine physicians in Primary Care and hospitals are bridged and patients enjoy the seamless transfer of care between settings, which to date still remains one of the biggest reasons why patients are unnecessarily stuck in hospital care. The "team Family Medicine" spirit in SingHealth has been found again, and this certainly bodes well for the fraternity and patients alike.

The camaraderie even extends beyond the walls of SingHealth. On the education front, we are seeing more collaboration between SingHealth FM residency program and M.Med (FM) College Programme, coming together to share resources such as recommended reading materials for the residents and trainees as well as the possibility of a combined grand teaching round. Some of the core and physician faculties in SingHealth FM Residency programme also contribute towards the M.Med (FM) College Programme and vice versa. Such exchanges and collaboration between Singhealth and our college can help both sides and bring education and research to a higher level than if each sponsoring institution were to operate in siloes.

What have these few months shown me? Lost and found… not just dogs, but our "team Family Medicine" spirit.

What was once lost – As Family Medicine diversified in services and settings to cater to our increasingly geriatric population and enabling transitional care, we previously witnessed a split in our fraternity, with people and institutions drawing boundary lines, defining to what belonged to Family Medicine and what did not. That was mostly in the past and things are much different now. But even then, not everybody subscribes to the "team Family Medicine" spirit beyond their own walls, and neither can we expect everyone to share the same dream.

Has now been found – Many of us in "team Family Medicine" have re-found what it means to help each other as a team, to share resources and work alongside each other without the limits of territorial walls, be it in the realms of clinical services, education or research. With such a positive team spirit, we shall forge forward in courage and allow the next generation of Family Medicine Physicians in our team to continue this good work and make Family Medicine stronger and more united in purpose and people. Together as one, we can do greater things!

CM

My country's family medicine is better than yours?

by Dr Low Sher Guan Luke, FCFP(S), Council Member, Editor, College of Family Physicians Singapore

A friend of mine sent me a homemade comic strip on healthcare costs and family medicine specialization, titled "My country's family medicine is better than yours". It was obviously just a comic strip, and the dialogue was quite hilarious. 2 healthcare administrators from 2 countries i.e. Country A (CA) and Country B (CB) were arguing on whose family medicine is better than the other. This was what was said between the 2 of them.

CA: You know, healthcare costs are climbing and we have tried everything we can to keep costs down, but these cost saving measures just don't work.

CB: What measures did you take?

CA: We ensure that family medicine in our country is not recognized as a specialty.

CB: Did how will that help to keep healthcare costs down?

CA: We are worried that if family medicine is recognized as a specialty, then these family medicine specialists will start charging exorbitant consultation rates! That will drive up costs!

CB: Hmm, that's only one myopic way of looking at things. In our country, we recognise family medicine as a specialty, and as a result, many of those who choose not to specialize in single-organ specialty, but prefer a broad based discipline such as family medicine will want to specialize in family medicine so as to gain the training and recognition in the process. Through this rigorous process, they are trained to a level where they can manage more complex cases right sited from the hospital specialists to their clinics and there are cost savings through this consolidation process, from seeing multiple single-organ specialist to a single family medicine specialist. This also allows us to conserve hospital resources to patients who truly deserve it. Our hospital specialist outpatient clinics referral lead-time has improved. In the long run, healthcare costs are not rising due to this initiative.

CA: But won't your family medicine specialists charge more for their consultations?

CB: It is a competitive market out there. Whatever the family medicine specialists charge, they still have to remain competitive, otherwise they will not survive in the market. Anyway, even if our family medicine specialists charge more, the cost is still lower than the combined costs of seeing multiple single-organ specialists. Plus the care is less fragmented and patients are saved the hassle of multiple appointments and it is easier to coordinate with a family medicine specialist than multiple single-organ specialists. Because family medicine is a specialty in our country, many of our family medicine practitioners strive to go through the training and achieve the accreditation and qualifications that go along with it, thus raising the standards of family medicine in general. This has resulted in better standards of care in the family medicine community.

Yes, we all look forward to a brighter and more ideal state of family medicine. Where family medicine brings more balance to the healthcare equation and family medicine physicians deliver more holistic and comprehensive care as a result of more advanced training, and aspiring young doctors who wish to do more good in this discipline gets more recognition that is not considered sub-standard to the specialists. For this to happen, it will require all the stars to be aligned even beyond the walls of family medicine, into the realm of healthcare financing and policy making. Anything short of that, and family medicine remains as a discipline where physicians deemed not as good for specialty training gets enlisted into the family medicine discipline, as might already be the case in Country A. It becomes a vicious cycle where the family medicine discipline in Country A will never be able to have proficient physicians choosing them as a first choice, and it becomes a downward spiral where standards drop and the centre of care gravitates towards the hospitals. Conversely, the family medicine specialty in Country B, being the popular first choice specialty that it has garnered recognition for, will have top-notch physicians choosing to have fulfilling careers in the specialty. This has the effect of boosting standards of care in primary care and the intermediate and long term care (ILTC) sector, thus shifting the centre of care gravity more towards the community where it should rightfully be, and the acute hospitals serve only to manage acute care, crises and when organ-specialty care is truly needed. Of course with the ageing population everywhere in the world, it is certainly inevitable that new hospitals will need to be built to deal with the silver tsunami. However, where family medicine standards are higher and primary care and ILTC can better cope with the patients in the community, we will not need as many acute hospitals to be built.

CM

Family Medicine: Going Beyond the Bedroom

by Lee Mi Li Jean Jasmin, MCFP(S), Family Physician, KKH Family Medicine Service

It all began one evening a few years ago when I attended a MMed Prog B tutorial at CFPS as a trainee. At the end of the tutorial, the supervisor Dr. Julian Lim started discussing philosophy and reflecting on our local culture, norms and sexual attitudes of patients. A lively conversation ensued amongst some doctors in my group regarding sexual issues of patients they have treated in their practice. This proved an eye-opener for me as I discovered that many of my experienced polyclinic and GP colleagues do counsel their patients on sexual health issues. Upon reflection, I realized that sexual health is a significant part of a patient's overall general well-being.

Studies have shown that almost half of patients seen in primary care are waiting for the opportunity to discuss with their family physicians (FPs) about their sexual concerns but they want us to be the ones to raise the subject first. At the menopause clinic where I work, we routinely enquire about sexual health when we assess patients. Many of them seem relieved that we brought up the topic. Some patients come with their partners, a bit anxious and even a bit embarrassed and I always marvel how within that half an hour consult, many walk out feeling much better. I would like to share a handful of the family medicine principles that I found useful in addressing patients' sexual issues in primary care.

Ask before assuming.

We've all been caught out making assumptions as we tend to interpret what we think of a patient based on our past experience of dealing with this regular patient or a type of person. Taking time to take a detailed and inclusive sexual history helps create a therapeutic physician-patient relationship and also gives the patient an opportunity to bring up sexual health issues. One of my regular patients, a sweet lady in her mid-60's who is widowed for many years, confided she had started a new relationship with a taxi driver she met at a Community Centre event. Her dear departed husband had been a childhood sweetheart and her one and only partner. So we had a good chat about safe sex practices and she left my room happily armed with her new knowledge. Studies have shown that one third of women aged 75-85 are sexually active and that physical health is significantly correlated with sexual activity and many aspects of sexual function independent of age. By routinely taking a sexual history I also discovered that a few of my regular patients I assumed were heterosexual are actually in a same sex relationship.

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