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CFPS Commencement Ceremony 2016

The director of Division of Graduate Medical Studies (DGMS), A/Prof Chen Fun-Gee, was the Guest-of-Honour at the CFPS Commencement Ceremony on 30 July 2016.

Guest-of-Honour, A/Prof Chen Fun Gee

Good Afternoon
Professor Lee Kheng Hock
President
College of Family Physicians Singapore
Members of the College Council

Friends and Colleagues

I am very honoured to be invited to be at this year's Commencement for the College training programmes in Family Medicine. The College has been very active and committed to improve the standards of Family Medicine practice in Singapore since 1971. The College took the lead in establishing a diplomate examination as a requirement of College membership and this was the first postgraduate qualification in Singapore. This was around the same time that the School of Postgraduate Medicine, the predecessor of the DGMS was set up. Synergies between the College and the NUS enabled the setup in 1993 of the first Masters of Medicine in Family Medicine degree and with that Family Medicine became a formal academic discipline, on par with the likes of Internal Medicine and Surgery. In 2000 the College recognised the need for many doctors who had been in private practice to undergo formal training and set up the Graduate Diploma of Family Medicine (GDFM). This enabled many General Practitioners to be Family Physicians and enter the FM registry in 2013.

In 2006, the GDFM was recognised as an entry requirement for Programme B of MMed Family Medicine and candidates undergo modular training in the programme before undergoing the same MMed Family Examination that our current residents go through. This certainly was not an easier route, as the practice requirement of 6 years of GP practice remains an examination entry requirement.

In 1998, the College started a 2-year Fellowship by Assessment programme. Participants had to be MMed FM graduates, and had to complete a portfolio of case studies, topic reviews, teaching activities, pedagogy skills course, medical writing and research. There were formative and summative assessments and successful participants were admitted as Fellows of the College of Family Physicians Singapore. In recognition of the high standards that the College set for Fellowship, the Academy of Medicine, the premier body of Specialists in Singapore started admitting such family physicians as Fellows of the Academy. Many of the fellows are here today in the audience.

Singapore has had a good reputation for health services. We have one of the lowest infant mortality rates. We have good accessibility to good healthcare even for those who are not well off. We have good infrastructure thanks to the foresight of our leaders in government.

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IN THIS ISSUE:

Butterflies in my stomach

by Dr Low Sher Guan Luke, FCFP(S), Council Member, Editor

"*You have 99+ new messages*". I could hear my phone going off all day, and I have had to continually charge my phone so that the battery is put on continuous life support, failing which it will drain and die off and I won't be contactable by staff. You might ask "Who are sending those messages?" Essentially, it comes from a very busy chat group populated by our fellowship trainees who are abuzz with chatters on their preparations on the upcoming exams. There was so much anxiety, excitement, fear all accumulated and rolled together, that the chat group was filled with sharing of experiences and raising of questions and answers. Yes, indeed our fellowship trainees are all very motivated and many of them wish to go through the exams without a hitch. Considering this is an exit exam, it really is a high-stakes summative exam for many of them.

Having had many chances to interact with these trainees, I understood some of the reasons why they chose to go through such a traumatic training and exam. Most of them have good intentions to learn and train. Even for the occasional ones who are looking for career advancement, they too will benefit from the training, and that is all that truly matters.

The day of exam result release was even more dramatic. Many of them were so anxious that they could not focus at work. Those who had the luxury of taking leave on the day of result release told me they could not enjoy the leave fully. For me, it was like déjà vu as I recalled how this process caused me similar anguish and anxiety 3 years ago. Seeing how tortured our trainees and friends were, it was as though I was reliving that moment myself. I could fully empathize as well as sympathize with our trainees on this.

The results were finally released at the end of the day. For some, it was a dream come true, and definitely a sigh of relief. For some others, disappointment and perhaps anger at times. It was a potpourri of emotions and feelings poured out over the chat group. The trainees started to take stock of who made it and who nearly made it. It was never easy for those who fell slightly short of the finishing line. Believe me, many of them had tried to run the good race… at least they had the courage to try.

For those who really believe in training and ultimately passing the fellowship exams, I sincerely believe that they will clear the exams with determination and hard work eventually… it becomes a matter of when. Not to say that retaking exams are easy tasks, as I do not wish to belittle the gigantic effort needed. To spur us on, we are very privileged to have Dr Alvin Ong share his fellowship learning journey with us in this issue. Our editorial team member Dr Vincent Chan will also be revisiting our various college training programmes and how they can fulfill a family physician's life-long desire to train.

Even after clearing the fellowship exams, what then? In our neighbouring countries in Asia, those who exit the family medicine fellowship exam are recognized as a specialist in family medicine. Does being termed a "specialist in family medicine" mean we are narrow in discipline and look through the microscope? Or does it mean we are specialists in a generalist sense? Does according the discipline with the well-deserved recognition that she deserves help her to attract more aspiring young doctors to choose family medicine as a discipline to train in? What does it mean for the healthcare landscape? More of this in the article "My country's family medicine is better than yours?" that is hilarious yet serious and debatable in topic.

Recently, I was at a National Healthcare Group (NHG) senior residency open house where various institutions were there to offer themselves as a possibility for our exiting senior residents to consider working in. There were other hospital booths being set up, and the respective chairmen of medical board (CMB) or divisional heads were there to promote the strengths of their own. I witnessed the usual "Why join me?, and the occasional "Why you should not join the others" kind of talk, but what was particularly different was when Associate Professor Pang Weng Sun spoke of Alexandra Health System with its upcoming Woodlands Integrated Healthcare Campus. For those of us who have not had the pleasure of knowing Prof Pang, he is CMB of Yishun Community Hospital and one of the giants in geriatrics in Alexandra Health, and perhaps Singapore as well. He was giving us information on Woodlands Campus, but at the very end of his talk, he said humbly "Medicine is a calling, and we often have to consider the nation's healthcare needs and where this calling is the strongest. Sengkang Health needs good people to join as they are next in line to open in 2018, so do consider joining Sengkang Health where they need you the

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most…" or something really close along that line. I was pleasantly stunned! What I had just witnessed was the spirit of honor and magnanimity coming from a gentle-giant! Something which I thought had been largely lost in our current competitive society, found again in the heart of a humble man who will continue to influence the hearts of many aspiring young clinicians and staff alike who works closely with him. As the saying goes, "近朱者赤，近墨者黑"。It is little wonder why my friend Dr Lawrence Tan always speaks so fondly of his head, Prof Pang. Along these lines of "lost-and-found", I also recently witnessed the lost-and-found of "team family medicine" spirit. More of this is found in my article in this issue.

And as usual, our team always strives to give you a different flavor of family medicine with all our issues. This time is no different. We have invited Dr Richard Tan to tell us more about how he uses acupuncture to complement his daily practice as a physician in a community hospital. We have also invited Dr Jean-Jasmin Lee (with guidance from Dr Ang Seng Bin) from KKH family medicine service to tell us more about how family medicine has gone beyond the bedroom to tackle some of the patients' sexual health issues. A statement from her article reads "Studies have shown that one third of women aged 75-85 are sexually active…" Interested enough? Read on!

CM

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Major challenges lies ahead. We have a very rapid aging population. Today 1 in 8 Singaporeans are above the age of 65 years old. By 2030, this ratio is expected to double to 1 in 4. Chronic diseases are prevalent. About 25% of Singaporeans above the age of 40 have at least 1 chronic disease. Not only will there be more chronic diseases with an aging population, the complexity of diseases will worsen.

Demand for healthcare will increase. The model of healthcare that we grew up with, centred around hospitals will have difficulty to meet these demands, and the Ministry of Health (MOH) has started the initiative to move to that of community based, integrated with the rest of the healthcare sectors.

Primary care is the critical element for this to succeed. The MOH has a vision of "One Singaporean, one Family Doctor". The family doctor is the trusted healthcare partner of every Singaporean. A strong family doctor-patient relationship enables the family doctor to have a holistic understanding of the patient and his family's medical and social care needs. He is the patient's health advocate monitoring the patient's risk factors in chronic

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diseases and offering timely advice from screening to prophylactic vaccinations. He is also the patient's navigator across our complex healthcare system, providing appropriate referrals as well as coordinating care within the community. The family physician thus is instrumental in the provision of good an affordable care to every Singaporean, to help them age and live well in the community.

Medicine has become more complex since I graduated from medical school. Many years ago, the medical training of 5 years and a year of housemanship provided sufficient knowledge and skills to function as a general practitioner. Many of my classmates became successful GPs and became pillars of our community. The 5-year medical curriculum today provides the basis for further medical training, and it is now challenging for a fresh medical graduate to have the necessary skills and knowledge to be a good family physician without further training.

I would like to acknowledge the immense contributions of the College of Family Physicians Singapore, in promoting the values and ideals of family medicine for the last 45 years. The College has been in the forefront of providing training to up skill our medical graduates to cater to the evolving needs or our community. The College has been a valuable partner of the NUS in the setup of the Graduate Diploma of Family Medicine as well as the MMed Family Medicine programmes. Many of the graduates are leaders today in our healthcare system, and many have contributed by teaching and mentorship of our future leaders in Family Medicine.

Let me end by commending those who have taken this journey to up skill your competencies in Family Medicine. It is a challenging journey, as you have to juggle work with learning. Sacrifices will have to be made. The endpoint will certainly be worthwhile, as you become a very valuable member of the family medicine and healthcare community. I would like to also commend the teachers, who also despite having to juggle work and teaching have contributed so selflessly to the training programmes. It is individuals like you, in the tradition of the College of Family Medicine Singapore, who have made Family Medicine a very respected speciality of Medicine.

Thank you.

CM

Our CFPS Academic Programmes

- Advancing Family Medicine through academia

by Dr Chan Hian Hui Vincent, FCFP(S), Council Member, College of Family Physicians Singapore

Family Medicine in Singapore has come a long way, since the founding of our College in 1971. The charter of our College has always been to bring greater recognition and prestige to our fraternity. The academic programmes available today, did not exist back then. Rather they were designed and created by our visionary and energetic College Pioneers. Through these programmes, we are gradually creating a strong cadre of highly trained Family Medicine specialists, physicians with the knowledge and standing, who can hold our own against that of other medical specialists.

Our programmes today are well established, and widely recognised both locally and internationally. Long forgotten in distant memory, was the saga where a few externals tried to remove our MCGP(S) designation from the Singapore Medical Council's list of displayable qualifications, citing disdain for our programme then. This is why we must all realise that the prestige of our displayable Family Medicine titles is intrinsically linked to the strength of our College and her academic programmes. Thus, for those of us who have passed, do return to help improve and advance our programmes, so that the public, government and other colleagues have no doubt about the quality of our programmes.

With this, let me introduce our 3 main College Academic programmes:

1. Graduate Diploma in Family Medicine (GDFM) course
2. Master of Medicine (Family Medicine) College Programme
3. Family Medicine Fellowship Programme

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Graduate Diploma in Family Medicine (GDFM) course

This programme was first mooted by A/Prof Cheong Pak Yean, and was started in the year 2000. The GDFM course is designed to equip trainees with the minimum vocational skills for independent family practice. It is a rigorous 2-year course, comprising 8 quarterly modules, including distance learning and workshops, with 5 skills courses and 8 small group tutorials. Successful graduates from the course, can register with the Singapore Medical Council (SMC) and display their GDFM title. The Ministry of Health and SMC also recognize this designation for entry into the Register of Family Physicians. The GDFM is therefore the minimum requirement to qualify as a Family Physician in Singapore.

Master of Medicine (Family Medicine), College Programme

The M.Med (Family Medicine) College Programme, was started in 1993, though the foundation for this was laid much earlier by Dr Lee Suan Yew and A/Prof Goh Lee Gan. Prior to 2011 when the Family Medicine Residency took over Programme A, this course was known as "Programme B." This course continues today as the "College Programme" giving post-government bond doctors the option to further their training. This programme seeks to equip trainees with skills and knowledge beyond the needs of a competent Family Physician, and is pegged at specialist level. Trainees are also taught on how to be clinical leaders to other junior doctors. Presently, the M.Med (Family Medicine) qualification is being accepted as a de facto specialist degree in our local healthcare institutions, and there is increasing recognition by other overseas institutions.

Family Medicine Fellowship Programme (FMFP)

The FMTP was first started in 1998, and represents the pinnacle of training for Family Physicians in Singapore. It is the equivalent exit qualification for our specialty. The programme is a rigorous 2-year programme covering various aspects of Family Medicine such as clinical course work, bio-medial ethics, teaching and research. The objective being to provide advanced training in Family Medicine to Family Physicians who at the end of the process should become an expert clinician, leader, teacher and scholar. Currently, the FCFP(S) designation is a requirement for promotion to senior grades by many institutions. FCFP(S) is also recognised by the Academy of Medicine Singapore, and holders of this qualification can be admitted as Fellows of the Academy, just like all other specialists. Even if you were in private general practice in the heartlands, attaining the FCFP(S) is still a good measure of personal professional satisfaction.

Conclusion

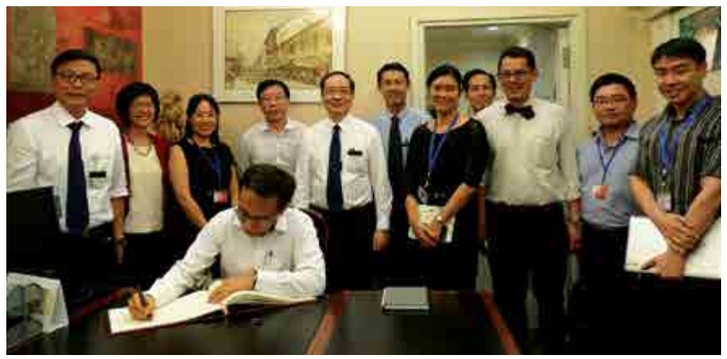
In a nutshell, every General Practitioner – Family Physician matters. As more and more of us become higher and highly qualified, we would gain greater and greater public trust and regard from other specialist colleagues. This trust would also extend to the government and our key partners in the Ministry of Health. Indeed, I can tell all that MOH wonders if the entire body of GPs are sufficiently well trained to take on chronic care, as I understand from the sub-committee College has sent me to. One answer to this is for us all, including us in the heartland GP clinics, to be highly trained. In that way, our policy makers can have better ease of mind, when they deploy tax payers' monies to help us care for our patients better. And of course, that personal satisfaction that I (we) have completed all the required Family Medicine training. Do discern your call, and consider signing up to one of these programmes next year.

CM

Perm Secretary visits CFPS

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

Signalling his keen interest to understand the Family Medicine scene in Singapore, Mr Chan Heng Kee (the new Permanent Secretary to the Ministry of Health) visited our College of Family Physicians Singapore on 18 August 2016. He was warmly received by our council, led by A/Prof Lee Kheng Hock and Vice-President Dr Tan Tze Lee. Members of council representing our Family Medicine fraternity across the various healthcare settings were also present.



Mr Chan Heng Kee, new MOH Permanent Secretary, signing our guest book. He was accompanied by Dr Elaine Tan (fifth from right), Head of the MOH Primary and Community Care division.

The visit began as Mr Chan signed our guest book after a short tour of our premises. A/Prof Lee then gave an introduction into the history of our College, from its founding in 1971, to the development of her various academic programmes and the hosting of 2 WONCA World Conferences in 1983 and 2007, among other achievements.

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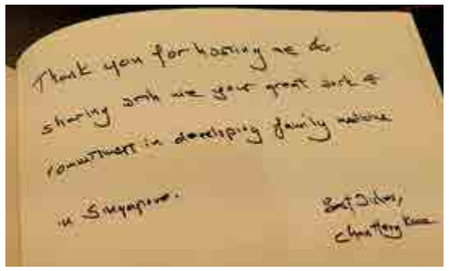

Dr Paul Goh, our Censor-in-chief then briefed Mr Chan on the various academic programmes organised by College. These include the Graduate Diploma in Family Medicine (GDFM) course, the M.Med (Family Medicine) College Programme and the Fellowship Training Programme. He highlighted that our programmes are recognised internationally. One example being the Royal Australian College of General Practitioners recognising our FCFP(S) designation as being on par with their FRACGP.

Council then had a chit chat with Permanent Secretary about Family Medicine matters in Singapore. We expressed happiness that MOH is increasingly engaging and consulting with General Practitioners in the community. Topics such as CHAS, daily clinic practice in the various health care settings and better recognition for Family Physicians with higher qualifications were also brought up. College also briefed about Family Medicine teaching, and how we plan, conduct and organise our programmes. In particular, we are proud of our system of "reservist" Family Medicine teachers. Though we also need a strong "regular core", to quote A/Prof Lee. Here, we asked if MOH can consider providing us some resources for our teaching programmes.

Being "one fraternity in many settings", we expressed confidence in our programmes in preparing our trainees for work across all our Family Medicine health care settings. However, progress is a continuous process, and we are still continually striving to improve on our courses. Hence more resources would aid in this regard.

Hearing that Mr Chan had spent his National Day public holiday advocating for Family Medicine, we are assured that our new MOH Permanent Secretary knows and feels the importance of Family Medicine along with the complexity of daily clinical practice, in fulfilling Singapore's healthcare needs. We are thus confident that the partnership between MOH and CFPS will continue to grow in strength, as we strive to serve our patients and Singapore better.

CM

The Fellowship Journey

by Dr Ong Cong Wei Alvin, MCFP(S), Council Member, College of Family Physicians Singapore

Life is a journey of experiences. On a similar note, so is the experience of the fellowship training, which forms part of the formative training journey of each family physician that embarks on it.

The Fellowship Programme [FCFP(S)], is an advanced 24-month Family Medicine training programme, to prepare and empower the trainee to become a competent consultant family physician.

Prior to signing up for this course, I had my reservations and fear if I would be able to cope with the commitments of the programme, taking in consideration of the need for simultaneous juggling of commitments from work and family.

However, I deliberated on my primary reasons for wanting to pursue this course. I have wanted to advance my knowledge and competency in my practice as a family physician. Moreover, I have also wanted to gain more experience and training in the area of research skills, medical writing as well as evidence based reviews.

The 2 years of training were intensive and covered a wide range of objectives. Quite a number of trainees including myself had little prior training as well as exposure to components such as research skills and evidence-based reviews. Thus the learning curve can be rather steep for those who are new to this field. However, one of the advantages of learning together in a big group was the ability to tap on the strengths of one another and mutual coaching to ensure that no one is left behind in this learning journey.

Our fellowship cohort had one of the largest numbers of trainees. We also had a good mix of trainees from varied practice settings, work experiences as well as seniority. Our learning sessions were very interactive and enjoyable. Each of us also brought along and shared different experiences and strengths. Our group shared many moments of laughter, joy, delicious food as well as times of challenges and difficult moments during our learning journey. One of the highlights of our cohort's teamwork was demonstrated through the organisation of the Family Medicine Teacher's Conference in 2015. During the preparation as well as conduct of the event proper, each trainee contributed significantly to the success of this pedagogy workshop.

I have learnt a lot during these two years of fellowship training. I would like to share and highlight a few of the learning points that left me with the deepest impressions:

1) Relationship

As much as the academic learning of clinical practice, scholarly activities and medical pedagogy remain the main focus of the fellowship training journey; I have learnt that the building of relationships and friendships among one another assumed an important role in the learning process. From strangers and mere acquaintances at the start of the course, many of us forged close friendships and camaraderie through learning together, as well as navigating through the many challenges and uncertainties that we faced throughout the course. I personally feel that this was an intangible yet very important experience that we gleaned from these two years of hard work together. Just as how an alternative definition of the word 'fellowship" might be defined as "the relationship among people who share common interests or feelings", I would propose viewing this fellowship course not only from an academic excellence perspective, but also from the intangible perspective of the opportunity to forge quality friendships and camaraderie, which would last even beyond the end of the course. In life, academic achievements are important, however, we ought not to forgo the importance of human relationships.

2) Collaboration

Just as how professionals collaborate and tap on one another's expertise in the course of their work, it will be important for fellows-in-training to learn and participate in collaboration efforts as well. This helps to prepare for all of us to be effective team workers as well as facilitate inter-professional collaboration in the future. The organisation of the Family Medicine Teacher's Conference in 2015 promoted synergistic collaboration amongst the trainees and allowed individuals to utilise their strengths for the common cause of the pedagogy workshop.

Within the small revision groups, which many of us have formed for the purpose of examination preparation; there was immense collaboration, mutual assistance and encouragement among all members of the group. I am very grateful to have the support and help from my friends in the revision group as I personally have benefited from their collective strengths and built upon the deficiencies of my learning journey.

3) Discipline

A high level of discipline is required to remain consistent in meeting the timelines for the submission of assignments as well as to keep up with the preparation for the examinations. It certainly helped to have buddies as well as individual small groups to keep one another in check and accountable. It also made it much easier to press on when we know that everyone shared similar struggles and stressors in this common journey. This helped in shifting the focus away from personal struggles, to a more constructive attitude of how we could all improve through mutual support and collective hard work.

4) Mentorship

The programme supervisors, tutors as well as seniors from the family medicine fraternity played an important role in teaching and molding our experiences in the various aspects of our training. The practice of Medicine itself can be viewed as a journey of apprenticeship, which involves learning the ropes from our mentors and building our knowledge upon their invaluable wealth of experience. Certain knowledge might be attainable from books, however, practical life skills, such as interpersonal skills, communication skills, professionalism, etc. are often most effectively learnt from seniors and mentors. This course also emphasised the qualities of a true leader and thinker, as depicted by the need for good grounding in ethical principles, professionalism, and leadership thinking. I am thankful to all my seniors and mentors who have helped me tremendously throughout the course in these aspects.

Overall, I felt that this course has comprehensively covered various aspects in training each doctor to be a competent consultant family physician. It will be important for all of us to continue to build upon the skills and knowledge gained from this course even after its completion. Another important aspect will be continual contribution to the training of family medicine. Just as how others have sowed and invested their effort and time in helping us, we ought to carry on this tradition in the right motivation, to help our peers and juniors alike. In my opinion, this is the intangible beauty of medical training that embodies the art of apprenticeship in Medicine.

I am thankful to God Who has seen and sustained me through this fellowship journey. I am also thankful to my wife who has been the pillar of support and encouragement for me during these 2 years, as well as all my seniors and fellow trainees who have offered me enormous help throughout the course.

I hope that all of us will continue to practice family medicine at the highest level; while at the same time, contribute to the high standard training of the fraternity, as well as continually seeking to improve the practice and delivery of quality family medicine.

CM

Much similarities between exams and giving birth

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

"Dear tutors, on behalf of the fellowship class, we will like to thank all our fellowship tutors for the help and guidance given for the past 2 years. We will like to invite you to an appreciation dinner at Tze Lee's residence."

Each and every tutor who believes in training the next generation of family medicine physicians, holds his deepest wish that his trainee will do well during exams and pass. It is like labor and childbirth which is a long and laborious process. For the candidate, it's akin to being the mother going through a tumultuous 40-weeks of labour which culminates in childbirth. For the tutor, it's akin to being an obstetrician who conscientiously monitors and screens the pregnancy over the 40 weeks and facilitating the final delivery. The candidate bears the pain, learns and grows through the process. The tutor provides guidance and pretty much goes through a similar roller coaster suspense before the release of results. Some end up in successful deliveries, and some requires a longer process as a result of complications. In the end, if the mother is determined to give birth no matter how long it takes, the obstetrician will facilitate the process and see both mother and child till the very end.

So it was with much relief to hear of the successful candidates who wanted to show their appreciation with an appreciation dinner. Dr Tan Tze Lee and his wife graciously hosted all of us at his residence, and the wonderful food provided there complemented the joy and good company for the evening. And as the common saying goes, "a picture speaks a thousand words", I thought it best to show you what I mean, rather than waste thousands of words trying to illustrate the happy moments.

Congratulations to our successful candidates of the recent fellowship exams! And let us also continue to encourage those who have made the brave attempt, to help them to persevere on and finish the good race!

CM

Our long-supporting President and College Fellowship Programme Director

The happy faces of our newly minted fellows!

Kudos to Tze Lee and his wife, our kind hosts for the evening

What fleshy durians we have!

When the wife passes and is happy, her husband is also happy!

Through thick and thin together

Happiness written all over, from the durians of course!

Images courtesy of Dr Hu Peilin

The 7th Japanese Primary Care Association Conference

by Dr Tay Wei Yi, FCFP(S), Associate Consultant, Department of Family Medicine and Continuing Care, Singapore General Hospital
Dr Low Lian Leng, FCFP(S), Associate Consultant, Department of Family Medicine and Continuing Care, Singapore General Hospital.
Council Member, College of Family Physicians Singapore

The Japanese Primary Care Association (JPCA) is an academy where dedicated and passionate family physicians and primary care physicians from all over japan come together to promote the training of generalists to support the health of the community through accessible, comprehensive and high quality care. Its academic role is not unlike that of the College of Family Physicians Singapore (CFPS) and other similar Colleges and Academy around the region.

Photo 1. Conference delegates from Singapore (left to right): Dr Tan Tze Lee, A/Prof Tan Boon Yeow, Dr Kenichi Satoh, A/Prof Lee Kheng Hock, Dr Ng Chung Wai, Dr Alicia Boo, Dr Tay Wei Yi, Dr Kee Loo and Dr Low Lian Leng.

Photo 2. Best Investigator Award: Dr Tay Wei Yi with other Singapore delegates

Images courtesy of Dr Tay Wei Yi

This year marks the 7th JPCA Conference held in Asakusa, a charming district in Taito, Tokyo on the 11th and 12th of June 2016. The annual event was attended by Family Physicians from around the Asia Pacific region: Malaysia, Korea, Taiwan, Thailand and Singapore (Photo 1). Although the majority of the conference sessions were in Japanese, there were international sessions in English that catered to non-Japanese participants and this year's theme was "Community Medicine – built by all of us, General Physicians – raised by all of us". There was also a dedicated focus on the future of Family Medicine (FM) and Generalist training.

On the first day of the conference, a special sharing session was organized for young doctors and medical students with the facilitation of Dr Kenichi Satoh, a family doctor working in Singapore. Dr Low Lian Leng, CFPS council member and Dr Shin Yoshida, chairman of the WONCA Asia Pacific Rajakumar movement for young family doctors and faculty member of the Lizuka-Kaita FM Program, shared their experiences on how they integrate teaching of junior doctors and residents during their day-to-day clinic consultation, ward rounds and home visits. Both speakers also introduced the different post graduate FM training structure in their country. Thereafter, the participants were divided into small groups for a more in-depth sharing and discussion. Later that day, Singaporean representatives Dr Alicia Boo and Dr Tay Wei Yi took part in an English oral presentation session on FM research. Dr Alicia Boo shared with the audience her eye opening experiences while doing missionary work in Nepal. Dr Tay Wei Yi presented on the use of Entrustable Professional Activities to achieve proficiency in home care among junior doctors in Singapore, which was awarded the Best Investigator Award (Photo 2).

On the second day, A/Prof Lee Kheng Hock, CFPS president along with a distinguished panel of FM leaders from the Asia Pacific region gave an international symposium on the increasing importance of well-trained generalists in modern medicine practice, resurrection of FM as a specialty, FM research and educational strategies for FM training. The day ended with a conference dinner at Asakusa View Hotel, starting with the traditional sake barrel ceremony and followed by a delightful spread of traditional Japanese and international cuisine. There was also a colourful display of Japanese culture, costumes, festival procession, music and drums. It was an excellent opportunity to get to know other like-minded Family Physicians and generalists who are equally passionate about the work that they do in the realm of FM.

The 8th JPCA conference will be held on the 13th and 14th of May 2017 at Takamatsu. We certainly look forward to this conference for continuing networking and connectivity opportunities for Family Physicians around the Asia Pacific region to enhance collaboration to promote FM practice, education and research to world standards.

CM

How do you know
when you have become a really good teacher?

by A/Prof Lee Kheng Hock, President, 25th Council, College of Family Physicians Singapore

It is not about teaching awards. You might rightly suspect that this is a case of sour grapes. In my more than 2 decades of teaching, I have only managed to snag a handful of low level awards. It might also sound hypocritical as I had been responsible for dishing out quite a number of teaching awards to others in my various roles as administrator of teaching programs. That is not to say that teaching awards are not good. On the contrary, the vast majority of recipients are good and decent teachers who truly deserve the appreciation for the sacrifice and good deeds that they had done as teachers. I just like to put up a case for the teachers who did not receive awards. They are not necessarily bad. In fact, many are really very good teachers.

A Bad Experience

I came to this conclusion some time back when I was a rookie medical educator. It was about fifteen years ago. At that time, I was a young GP running my own solo practice. Like many GP members of our College, I saw teaching as a professional duty and a very satisfying way of contributing back to our community. I was looking forward to giving a tutorial to a group of medical students who were attached to a new community hospital as part of their family medicine posting. I remembered that it was a busy morning clinic. Not wanting to be a bad role model for punctuality, I skipped lunch and rushed down to the hospital. Even then I was late by about 10 minutes. After frantically searching various levels of the unfamiliar hospital, I eventually I found the tutorial room with only 2 out of the 2 dozen or so students who were supposed to be there. I was told rather nonchalantly that the rest of the students were still having lunch and should be arriving soon. About half an hour past the appointed time, the rest of the students appeared minus 2 who were missing in action. Focusing my mind on my teacher role model, I put on a friendly smile and launched into my prepared lesson with gusto. About 10 minutes into the tutorial, one of the student stood up suddenly and walked past me and exited the classroom. I searched the blank faces of the rest of the students, looking for a clue as to what had caused that to happen. I sniffed the air to determine if someone had accidentally released bad air. I was sure I did not say anything inappropriate. Clueless as to what had happened, I shrugged my shoulders and continued with the lesson. Another 10 minute or so passed. The same student strolled past me again, took his seat and stared blankly ahead. I detected a hint of amusement in the expression of some of the students.

A concoction of dehydration, low blood sugar plus a dash of personal humiliation boiled over. I sternly asked the student what had happened. The excuse he gave was that he needed to visit the bathroom. I told him that the decent and courteous way would be to just acknowledge me and asked to be excused for a while before he left. I felt it was a teachable moment on professionalism. I told the whole class that medical school is not just about learning about diseases and treatment. It is mainly about how to become a doctor. I told them that this student's behavior was appalling because if he showed such disrespect to a senior colleague, I have little confidence that he will respect a patient who is weak and vulnerable. The rest of the tutorial was without incident.

A few months later, I received the report of my performance as a tutor. It was the lowest that I have ever received in my career as a medical educator. A few more low scores like this and it would have been curtains for me as a teacher in the school. The smart thing to do I supposed, was to go against my instinct as a teacher and bite my tongue. Most of all, never offend any student and try your best to be the most popular teacher in school. Well, I do not think this is the right thing to do. I think we should avail ourselves to practical wisdom and teach where our moral compass guides us. Anyway, all was not lost. When I looked at my feedback form in detail, about half the students gave me very low scores. I was pleasantly surprised that the other half gave me really high scores. Like true artists, we should concentrate on those who appreciate our passion. For the ignorant, we should best leave them alone and let them find their good sense eventually. So I hang my bad feedback score alongside my teaching awards. If you receive low scores which are essentially no more than popularity ratings from students, don't be disheartened. As long as it was received because you were teaching according to your conscience and in the best interest of the learner and the greater community, you should wear it as a badge of honor.

Death of A Great Teacher

If you are not convinced, then let me tell you the story of the first martyr of education. Socrates of ancient Greece was widely accepted as the first and best teacher in history. His life history holds important lessons for anyone who aspire to be a really good teacher. Actually it might be more of a cautionary tale than an inspiring story for some. Many of you probably knew that it did not end well for Socrates. For being a really good teacher, Socrates was arrested by the authorities of the day and put on trial for corrupting the youth and impiety. Corrupting the youth meant that he taught them not to accept conventional wisdom and encouraged the students to think for themselves. The so called impiety was that he failed to acknowledge the "the gods that the city acknowledges" and "introducing new deities". In modern terms, it probably meant that he was not politically correct. So he was put on trial and promptly found guilty and sentenced to death. In those days, they were half-serious about death sentences for philosophers. Most were allowed to flee the city before the sentence was carried out and henceforth be exiled upon the threat of death. The problem was Socrates was a man of principle and held on that one should obey the rule of law. It all ended in a mess with Socrates being executed with a drink of hemlock and his accusers going down into the gutters of history in eternal odium.

Still not convinced? Then heed the example of the greatest teacher that ever lived on this planet. He was betrayed by his student, flogged in public and finally nailed to a cross until he died. So I hope you don't feel too bad if you got passed over for a teaching award. Don't be despondent if you receive a low score from students if it was done in their best interest. On the other hand, I have no desire for martyrdom and would much prefer to continue the fight by flying under the radar. So how do you know if you are a good enough teacher, i.e. teach well but don't get served the proverbial hemlock during faculty happy hour?

I think teaching awards are a good guide to your level of diligence and a warranty of your personal safety. Be very heartened when you receive awards that are not given for popularity or for political correctness. So far I think those given out by our College are OK ☺

The Death of Socrates by Jacques-Louis David (1748-1825)
Catharine Lorillard Wolfe Collection, Wolfe Fund, 1931
Source: http://www.metmuseum.org/collection/the-collection-online/search/436105

What I treasure most are the little unsolicited tokens and gestures of appreciation from those whom I have taught. The greatest mark of achievement is when you see your positive action as a teacher live on through your students as they pass the goodness forward into the many lives that they touch, as doctors and as teachers themselves. Look around and be happy. By the way, thanks for the awards and please spare me the hemlock.

CM

9000 needles
An interview with a family physician who practices acupuncture

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

Whenever acupuncture is mentioned, the images of a person being punctured by multiple needles will jump into my mind. Not always the most pleasant image, or so I used to think. It was not until recently when I had more exposure to the practice of acupuncture by one of my colleagues that my worldview of acupuncture changed. College Mirror brings you an exclusive interview with Dr Richard Tan, a family physician who is also an acupuncturist, on how he uses acupuncture to complement conventional medicine to bring about better outcomes for his patients!

College Mirror (CM):
Hi Dr Richard Tan. I understand you are a family physician by training. Can you give us a short introduction of yourself and your previous work experience?

Dr Richard Tan (RT):
Hi, I graduated from NUS Med School in 1986 and thereafter obtained Grad Dip in Occupational Medicine, Grad Dip Acupuncture and Grad Dip Geriatric Medicine over the years.

I am also a Family Physician by track route as I had been practicing as a general practitioner since 1992. I had the privilege of working in various modes of GP such as running my own solo-practice, being partner in a group practice, was Clinical Director in a major group practice as well as a stint as full-time locum.

I am a Designated Factory Doctor and had worked in various industrial in-house clinics.

I was also a former head of Medico-Legal and as well as Medical Affairs and Head of Department in a private hospital and was the Senior Resident Physician in Urology in a restructured hospital and was a Principal Resident Physician in a community hospital too.

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COMMENCEMENT CEREMONY & AGM 2016

31 July 2016 ◆ College of Medicine Building

Addressing the audience at the Family Medicine Commencement Ceremony 2016

(from left) A/Prof Lee Kheng Hock - President of CFPS (25th Council), A/Prof Chen Fun Gee - Guest-of-Honour, Director of Division of Graduate Medical Studies, Dr Paul Goh - Censor-in-Chief of CFPS (25th Council)

Introducing the teaching faculty

(clockwise from top left) Dr Ng Lee Beng - Programme Director for Fellowship [FCFP(S)], Dr Julian Lim - Programme Director for Master of Medicine (FM) College Programme and Dr Kwong Kum Hoong - Programme Director for Graduate Diploma in Family Medicine (GDFM), introduced the teaching faculty to the audience.

Induction sessions conducted for trainees of the various programmes

CM:
How did your interest in acupuncture come about?

RT:
I was always fascinated with acupuncture since young. But it was when I witnessed almost instant relief for a patient with frozen shoulder (with no relief despite being treated by conventional medicine and physiotherapy) in a acupuncture clinic after a session, I was won over. Even for myself, after I had sustained a thumb injury (subluxation) and was managed by a private orthopedic consultant (with no relief), after 2 sessions of acupuncture, my thumb was pain-free and mobility was back to normal.

CM:
What does it take to go through the acupuncture course?

RT:
Fortunately for me, as a fully SMC registered medical practitioner of more than 2 years, I was allowed to attend the College of TMC approved by MOH and the TCM Board. Knowing a bit of basic Mandarin helps as most of the lecturers and tutors are more conversant in Mandarin.

CM:
It's easy to confuse acupuncture with traditional Chinese medicine (TCM). What is the difference?

RT:
TCM include diagnosing using TCM methodology, prescribing and dispensing of herbs and besides acupuncture treatment, tuina.

CM:
What specialized equipment do you need for the acupuncture service?

RT:
Besides the single use sterile disposable needles, I use heat therapy as well as electric-stimulation machine. I personally do not use moxibustion or cupping in my acupuncture service.

CM:
How does acupuncture complement your existing work?

RT:
Acupuncture is used to complement conventional treatment when the latter seems not to be able to maximize pain relief and optimizing rehabilitation.

CM:
Which types of patients will you normally consider for acupuncture service?

RT:
Normally I would select patients who have severe pain despite conventional treatment and are unable to optimize their rehabilitation because of their pain. Preferably no cognitive impairment (except stroke patients), not needle-phobic, not having any form of involuntary movements including seizures, not pregnant, no blood coagulopathy issues (such as hemophilia).

CM:
Can you describe some of the cases who have benefited from your acupuncture treatment?

RT:
I have been treating cases with severe pain score of above 8 for cases such as chronic pelvic pain as well as frozen shoulder, OA knees and back pain and after a few sessions , they feedback that the pain score was down to less than 4.

CM:
What were some of the memorable events that happened during such sessions?

RT:
I was able to witness with the patients themselves, when they came in with severe restricted range of movement of their shoulder due to severe pain and whilst doing the procedure, the dramatic improvement of their shoulder movement and pain relief, there and then! Likewise, patients with severe back stiffness secondary to pain, able to move their back smoothly without pain after acupuncture.

CM:
What is the perception of most physicians towards acupuncture now?

RT:
Most physicians that I am working with currently are open to acupuncture treatment though a few are skeptical in view of bad media reports about adulterated medications.

CM:
What is your vision for your acupuncture service?

RT:
I would like to increase awareness amongst the physicians as well as increase availability of acupuncture service to more patients who may benefit from acupuncture treatment.

CM

"Involving the community pharmacist for better patient care"

Ms Julie Ong, Mr Aaron Chong, Dr Irwin C A Chung
Agency for Integrated Care

Importance of medication safety

In 1999, the Institute of Medicine (IOM) released a ground-breaking report called "To Err is Human: Building a Safer Health System" and raised awareness of the importance of a safety culture in health care. Medication safety was highlighted as a key concern, partly because medication errors are so frequent and partly because a number of evidence-based practices were already known and needed wider adoption. In 2006, IOM published another report called "Preventing Medication Errors", which concluded that at least 1.5 million preventable medication errors cause harm in the United States each year. The report estimated that medication errors in hospitals alone cost $3.5 billion a year. Unfortunately, in Singapore, there are currently no published data or statistics on medication errors or near misses.

The term "medication error" has been defined in many ways. The US National Co-ordinating Council for Medication Error Reporting and Prevention defines it as: "any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of health professional, patient or consumer." Serious errors harm patients and expose health professionals to civil liability and possible criminal prosecution. Minimising medication errors in the total medication use process is therefore of strategic importance to improving patient safety in the healthcare system.

The risk of medication errors increases with the number of medications and/or number of comorbidities. A report of 9 studies in Australia documented that 2-4% of all hospital admissions in Australia are due to drug-related problems and 75% could have been preventable. Complex medication regimes in the older patient could also lead to readmission for an adverse drug event. Polypharmacy usually creeps in over a number of years as more and more medicines are added to a patient's repeat prescription list. Patients can end up on the same medicine for 10 or 20 years, or even longer, even if the indication has changed or ceased. Changes to patients' circumstances, such as becoming frailer or developing additional long-term conditions, may have altered its appropriateness.

Medication reconciliation is recommended at transitions of care to avoid medication-related discrepancies which may lead to medication errors and adverse outcomes. In fact, medication reconciliation has been identified by the Ministry of Health's National Medication Safety Committee (MOH NMSC) as one of the medication safety priorities.

Current landscape of eldercare

In Singapore, the number of senior citizens (more than 65 years old) is expected to surpass 900,000 by 2030, equivalent to one-fifth of the resident population. Both the specialists in the acute hospitals and the family physicians in the long-term care setting share the responsibility of providing geriatric care for the elderly patients. However, in terms of care facilities, we are no longer limited by the more traditional choices of acute hospital care, and nursing home care. Instead, a spectrum of aged care services and facilities is progressively being developed to enable the seniors who are frail and less independent to "age-in-place" successfully. The first purpose-built Senior Care Centre (SCC) was opened by NTUC Health at Silver Circle (Serangoon Central) and serves more than 100 clients. In addition to social and exercise programs, the centre offers active rehabilitation, community nursing and dementia care for clients with higher care needs, to cater to a broad spectrum of seniors with varying needs.

Besides the specialists and family physicians playing an important role in caring for the seniors, a multidisciplinary healthcare team is increasingly crucial in caring for the seniors, as seniors are heterogeneous and often have multiple needs and comorbidities. The traditional members of the multidisciplinary team include the doctor, nurse, therapist (physiotherapist and occupational therapist) and medical social worker. In the long-term care setting, SPICE (Singapore Programme for Integrated Care of the Elderly) centres have used multidisciplinary teams to cater to frail seniors with greater nursing and medical care needs and would otherwise have to enter nursing homes. The SPICE programme was first piloted at the Salvation Army's Bedok Multiservice Centre in 2010 and has since grown to 10 centres across Singapore.

Pharmacists' Role in medication management in the community

Pharmacists are well-positioned to identify drug-related problems, by conducting medication reconciliation, medication optimisation, de-prescribing for chronic diseases and patient counselling and education to improve medication compliance. Through the years, pharmacists have extended their outreach beyond the hospital and community pharmacies to provide more person-centric services in the nursing homes and patients' homes. One of the initiatives is the partnership between PSS and AIC for pharmacists to support the medication management process in nursing homes and hospices since 2011.

In Singapore, Agency for Integrated Care (AIC) coordinates an existing programme known as Aged Care Transition (ACTION) team made up of care coordinators, who are sited at various acute hospitals. The ACTION team provides transitional care to high-risk patients to reduce unnecessary readmission to acute hospitals. A hospital pharmacist would provide medication reconciliation and review services to these patients to reduce the drug-related problems and medication errors. This is supported by evidence obtained from the Pharmacist-Outreach Programme (POP) which was a collaboration project between aged care transition (ACTION) team and hospital pharmacist on medication management at home.

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Through this project, 75% of patients whom were referred to POP had their drug-related problems (DRPs) resolved and at least 90% of them felt that they could better manage their medications after the programme. Similar pharmacist services are still not commonly offered to other community-dwelling geriatric clients, who also have polypharmacy issues, after being discharged from hospitals.

Modelling and future plans for spread

AIC works closely with community care providers (such as nursing homes, centre-based services and home-based services) to support them in improving the quality of care for the geriatric clients. As medication use in older adults often presents challenges, AIC in partnership with pharmacists as part of the National Pharmacy Strategy initiative to promote Pharmaceutical Care Excellence, plans to pilot the provision of geriatric pharmaceutical care service for elderly patients with polypharmacy issues in selected SPICE centres. The aim is to empower the patient and/or the caregiver to manage medication in the community setting.

Geriatric pharmaceutical care service is a structured service by pharmacy staff to identify and address medication related issues with the client and/or caregiver and healthcare professionals. A pharmaceutical care plan [including a Patient's Medication List ("PML")] will be developed for the geriatric client who has multiple comorbidities and polypharmacy issues. The care plan will accompany the client as he/she moves across the various transitions in care settings and will be a single accurate plan for all care team members, such as the doctor, centre, pharmacist and outpatient specialists.

One of the key success factors for the pilot is to establish and refine a framework and workflow for seamless and timely communication of the client's pharmaceutical care plan between the care team involved in the client's care. Healthcare professionals involved in the care of the patient are now able share and access the pharmaceutical care plan as a part of the National Electronic Health Record (NEHR). The NEHR integrates and shares patients' medical records nationwide to support the seamless delivery of patient care and is progressively being rolled out to both public and private healthcare institutions across Singapore.

On a longer term, the plan is for larger scale implementation of the geriatric pharmaceutical care service to all clients in the community setting who require the service beyond the SPICE centres.

CM

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"Lost and found"

– the "team family medicine" spirit and camaraderie beyond our territorial walls

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

For many years, I have never been a fan of dogs. I'm not exactly sure why, but there might have been a number of reasons which led to this silly world view of mine. For one, I was chased and nearly bitten by a couple of wild dogs in my younger days. Even as I walk or jog past dogs who are leashed, some of them will stray too close to me for comfort. Lastly, I often get barked by dogs for no good reason. Needless to say, all these resulted in my phobia for dogs.

Then during one of the days in July when I was doing my usual after-work jog, I noticed a dog with a harness on – but not leashed to any visible owner – wandering at a park near where I would usually jog past. It was a large-sized dog, likely to be a German pinscher. After making a cursory judgment that the owner was really irresponsible to off-leash his large dog and leaving it to wander, I jogged off.

A few days later, as I was passing through the same spot in the park at a different timing, I spotted the same wandering dog. At that time, I thought it was quite a coincidence to bump into the same dog at a different timing.

A week later, I saw the same dog but this time, it looked more lethargic and dehydrated. No owner again. Many thoughts raced through my mind. Should I approach the dog and see if any owner comes up to me? What if this dog was aggressive, or worse, was rabid and bit me? These were severely played on by my fear of dogs. However, my gut feeling was telling me that the dog may succumb if it is still not given food and water. I made the reluctant choice to approach the dog and see if its owner might come up to me. Thank God the dog did not bite me or display any signs of aggression. Still, no one came up to me after I circled the dog for 5 minutes. It dawned on me then that the dog was lost and had been wandering around for about a week. That explained why it looked dehydrated and hungry. I tugged on the harness, and after much reluctance, the dog gave up struggling and followed me home.

Over the next few days, we gave the dog a roof over its head; fed, nurtured and showered it, and even brought it out for walks and jogs. At every opportunity, the dog greeted me faithfully and was always ecstatic to see me. It was obvious that both the lost dog and I were extremely happy with each other. We brought it to the vet for a health check and it was then that we found out its microchip number. We could call up AVA to report a lost dog found, have the owner traced to reclaim the dog. Still assuming that the owner had abandoned the dog by deliberately taking him off-leash, I wondered what good would come out from calling up the ex-owner. Keeping the dog as mine would certainly work for me. Besides, our household was happy with our newfound member.

After much deliberation, we did what was right and called up AVA to trace the owner. We soon found out that the dog belonged to a temple nearby. It had ran out and lost its way. The earnest owners were overjoyed that we found their dog and reclaimed him on that very same day. As it was a working day, I never had the chance to bid farewell to the dog when my wife returned him back to his rightful owners.

As much as I hate to admit, a huge part of me was depressed over the lost opportunity to adopt a well-behaved dog. By calling up its rightful owners, I had given up the chance to keep the dog selfishly. It was a good thing I was working when the owners came to claim the dog, or I would have been struggling to fight back tears of sadness onsite. Yet, a small part of me was happy that I abandoned my selfish thoughts which resulted in a happy reunion for the dog and its owners. Any loss? Depends on how you see it. The dog was never mine, and was someone else's. So I never really lost the dog, and I had ensured that someone else found his dog rightfully. Any gain? Of course, I had gained the invaluable experience and joys of this human-canine relationship, no matter how short-lived it was. Through this, I had overcome my ridiculous phobia for canines; understood how a close human-dog relationship can be fulfilling, and began to appreciate the joys of keeping a faithful dog in the family. But importantly, not at the selfish expense of another man. I suppose this is what it means to have the greater good in mind (for the dog and his owner), *and not to be too possessive or territorial, which can result in pain for someone else (owner).*

Recently, I got wind of a discussion on whether Family Medicine should only be in Primary Care, or only in hospital, or all encompassing. The values of Family Medicine remain the same in wherever it serves its function. A Family Medicine physician based in Primary Care seeks to deliver holistic, preventive, broad-based care to his patients. Does not a Family Medicine physician based in a hospital seek likewise? A Family Medicine physician based in a hospital seeks to upgrade himself through trainings and courses. Does not a Family Medicine physician based in Primary Care seek likewise? It is my personal hope that Family Medicine physicians unite together to serve the greater good of patients. We have to! Was that not why we took up Family Medicine in the first place? Was that not why we bravely took up "the calling of medicine" in the first place? It is only when Primary Care and hospital Family Medicine put their differences aside and come together for a united purpose, can Family Medicine be bridged and become strong enough for our patients. We talk about bridging care between Primary Care and hospital. Is it really that possible then – when Family Medicine physicians in both settings are not even "bridged" together as one united discipline?

Speaking of bridging care across settings, the strength of Family Medicine physicians lies in their intricate knowledge of both the community and the hospital. This knowledge of both settings allows us to help patients transit from hospital care to community care, thus shifting the focus of care back to the community where they can be better cared for. It is the winning formula in transitional care. Recently, some started believing that the training of Primary Care Family Medicine physicians should be different from hospital

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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, manywalk 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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Leave your Judgment outside the consult room.

As FPs our role is to ensure our patient's health concerns are attended to and not solely about our own prejudices or what we think is right. Our patients often come not only with sexual health problems but are also often saddled with guilt and anxiety about their sexuality, sexual practices and possible exposure to infections. Many patients in the LGBTI (Lesbian, Gay, Bisexual, Transgender, Intersex) community face a barrier in disclosing their sexuality to their physicians. When we are open, empathic, mindful of our own biases and use a non-judgmental approach, this strengthens the therapeutic relationship with our patients. I recently attended to a 40-year-old patient who was in a same sex relationship. She had hidden her sexual orientation from her conservative family for many years but disclosed to me during consultation. My patient had some health misconceptions which included the notion that she did not need to do a Pap smear despite having experimented with a male sexual partner previously in her teens. Through trust, we built up a therapeutic relationship and I was able to provide her with the appropriate advice, treatment and support. She even felt confident enough to bring her long-term partner to subsequent consultations.

Adoption of patient-centered instead of disease centered care. (Bio-Psycho-Social)

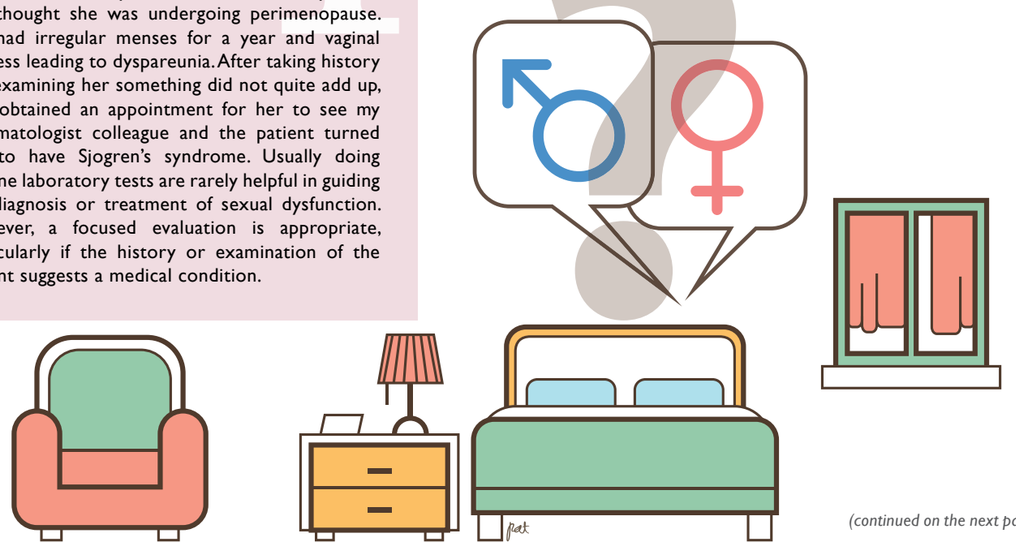
It is important to exclude medical issues that may stem from seemingly innocuous symptoms with a comprehensive history and physical examination. To highlight this I would like to share about the young woman in her early 40's who came to my clinic and thought she was undergoing perimenopause. She had irregular menses for a year and vaginal dryness leading to dyspareunia. After taking history and examining her something did not quite add up, so I obtained an appointment for her to see my rheumatologist colleague and the patient turned out to have Sjogren's syndrome. Usually doing routine laboratory tests are rarely helpful in guiding the diagnosis or treatment of sexual dysfunction. However, a focused evaluation is appropriate, particularly if the history or examination of the patient suggests a medical condition.

Assessment of the partner as well as the patient.

Intimacy issues, sexual health and relationships are interrelated. Sexual problems can significantly disrupt normal functioning for an individual, partner, and the family. As FPs, we are in a good position to help patients as we often have both partners as patients. A good approach is assessing how the problem affects the patient, the partner, both together and apart. In primary care, we often come across both men and women who complain of decreased libido and want a quick fix with medication. When we do dig deeper and examine their relationship with their partners, family and social context we often uncover the hidden stressors and often there is a foundering relationship. FPs can help link patients and their partners to the nearest family service center, family therapist or marital counselor. Counseling can be effective for helping couples to explore their physical communication and their understanding of what sex means to them. Ideally the relationship should be emotionally healthy in order for the sexual issues to be resolved.

Building on communication skills and a level of comfort talking about sex.

Many physicians feel embarrassed talking about sex and some worry about exploring this domain with patients lest they bring up topics that are perceived as off-limits and taboo. Some are also concerned about offending patients. Sexual health counseling requires practice in order to feel comfortable in carrying it out. I used to cringe inwardly if I had to discuss about "orgasms" and "masturbation" for example but I soon realized my patients were even more anxious than me. I then decided to focus instead on putting them at ease and guiding them into talking about sex. I found that it helps to be prepared as well. Some patients may not understand terms like "orgasm" so having a list of basic layman definitions of these common sexual terms is useful to help clarify and avoid medical jargon.



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Many FPs may face barriers in managing their patients' sexual problems in their practice. Some studies have shown that healthcare providers underestimate the prevalence of sexual dysfunction in their patient population or the impact sexual issues have on patients' quality of life. Too often lack of time can be a barrier as some FPs feel that sexuality is too complex of an issue to tackle in the limited time allotted during consultation. One effective framework is based on the PLISSIT (Permission, Limited information, Specific Suggestions, and Intensive Therapy) model to approach sexual problems. This framework utilizes a stepwise approach which helps the busy FP to streamline addressing sexual problems in a time efficient manner.

If we do come across a patient with a sexual issue that is too complex; exceeds our comfort level or expertise we should not hesitate to refer to our specialist colleagues be it a gynecologist or urologist for co-management. Certain conditions like primary vaginismus for example require physiotherapy and sometimes a psychologist as part of the treatment in a multidisciplinary approach.

Majority of the patients we see in primary care have sexual problems that can be addressed simply by giving patients the correct, evidence based information and helping them to deal with their concerns and anxieties. Our patients can be provided with brief and practical interventions and reassurance about the normal physiology of the human sexual response. In order to do this we need to have some basic understanding of the sexual response cycles of men and women as well as the sexual functions and practices in contemporary society today. As FPs we may not have the same values or attitudes as our patients. However simply by being mindful of sexuality and its problems we can help our patients attain sexual well-being and relationship satisfaction.

Acknowledgments:
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An ode to change

by Dr Teo Yee Sheng Victor, Editorial Team Member

It is said that the only constant in life is change.
Change can be scary. Change can be exhilarating.

And yet picked up the gauntlet have we.
Obeyers of the second law of thermodynamics we are not.

The path of our illustrious Seniors is fraught.
And yet we are not dismayed. We are buoyed by
the encouragement & light shone on the path ahead
by our Seniors, who have given of themselves freely.

When we are struck down low, the love of our
Family, friends, peers & Seniors will lift us up.
Remember, the darkest hour is nigh before dawn.
Hence - gird our loins, we will take this one, hand-in-hand.

Change is what we make of it.

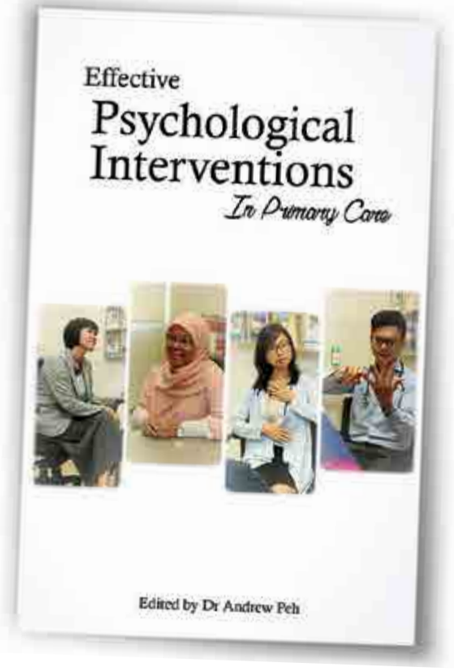
CM

Editor's note:
Dr Victor Teo has decided to embark on a great change - to take on the MMed(FM) with gusto!

Effective Psychological Interventions in Primary Care

by Ng Chee Lian Lawrence, MCFP(S)

Primary care healthcare professionals or providers - which include doctors, nurses and allied - play a pivotal role in both the management of psychological illnesses and the promotion of happiness and mental well-being in the community. Unlike in the past where the tendency was to refer such patients to secondary care, the paradigm-shift today is towards "right-siting" of treatment in the community by primary healthcare providers.



This book is written by experienced authors of diverse background such as a psychiatry, clinical psychology and nursing. It is a small handbook which summarizes the current knowledge, concepts and practices of the larger field of non-pharmacological psychological medicine in primary care. They have done a good job in condensing the topics of supportive therapy, psycho-education, motivational interviewing, cognitive-behavioral therapy, mindfulness &self-compassion, relaxation techniques and behavioral strategies to treat insomnia into a handy compendium of pocket size.

These topics were part of the Physician Burnout and Self-care Interventions skills course conducted in Jan 2016 by the authors, myself and the College of Family Physicians Singapore as part of the training of family doctors in building resilience in their professional practice and personal lives. Scholarly articles by the authors, which documented the evidence base of this book, were published by the authors in the January - March 2016 issue of The Singapore Family Physician.

During the last century in the United Kingdom, Michael Balint (1896 – 1970), who was a psychoanalyst, saw great value in the doctor-patient relationship in general practice (family medicine). He worked with general practitioners (the British phrase for "family physicians") in developing a process of brief psychotherapy he termed "focal psychotherapy". Balint introduced the concept of "the doctor as a drug" and emphasized the importance of the use of emotion and personal understanding in the doctor's work and the therapeutic potential of the doctor-patient relationship.

Hence, given the long tradition of GP's or family doctors in mental healthcare, it is unsurprising that the target audience of the book is largely family doctors. However, as the interventions described are non-pharmacological, it can be used equally effectively by non-medical healthcare professionals.

It is useful for both the beginner and the experienced since the concepts and interventions are introduced in an easy-to-understand fashion without the use of jargon. It uses abbreviated clinical vignettes to open the discussion at the start of each chapter. Concepts and exercises are based on these clinical cases. Senior readers will be relieved to know that the font size is large and the book is easy to read, even at bedtime.

The authors are part of the referral-based Health Wellness Program (HWP) under the Eastern Health Alliance. Many GPs have referred their patients to the HWP for psychological therapies and this is clearly reflected in the immediately use-able lessons and practical approach taken by the authors in this book.

However, since some patients are not keen to be referred to such services, this handbook offers sufficient current state-of-the-art knowledge to assist the GP. Reading this book, one can see almost immediate benefit in one's personal life, patients and medical practice.

To receive a complimentary copy of the book, please email your request to hwp@easternhealth.sg

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Sat, 22 Oct 2016: 2.00pm - 5.30pm
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Unit 6: Linking medical and social care

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Pendleton consultation tasks
Day 2: Practice interdisciplinary team meeting to work out transitional care, home care and social care plans for complex patients

All information is correct at time of printing and may be subject to changes.

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