of the field of geriatric oncology. The half day workshop was developed in a way to give the participant a comprehensive overview of all the key specialities involved in the care of elderly cancer patients. Hence the workshop involved medical oncologists, geriatrician, palliative medicine specialist, pharmacist, medical social worker and family physician.

▲ *Multidisciplinary team to deliver a new model of care in Geriatric Oncology*
◀ *Family physicians from diverse backgrounds coming together to train to provide more holistic care.*

Images courtesy of Dr Ravindran Kanesvaran

The course was opened by medical oncologist, Dr Ravindran Kanesvaran with an overview and a brief introduction to the unique **characteristics of the elderly person** including disease presentations, changes in physiology, principles of prescribing and the importance of a multidisciplinary approach. This was followed by geriatrician, Dr Anupama Roy Chowdhury, who shared on **geriatric syndromes** that might be commonly encountered in an older person with cancer including delirium and dementia, falls, functional decline and poor feeding. Next, Dr Ravindran Kanesvaran covered a brief description of the **common cancers seen in the older person** - breast, lung, prostate, haematological malignancies, stomach, colorectal, metastatic cancer of unknown primary including their presentation and an update on latest tools for diagnosis and workup. Dr Tira Tan, medical oncologist, covered the **basic principles of treatment in the elderly**, assessment of fitness to undergo treatment, as well as specific management of the cancers mentioned above.

In the second part of the workshop, pharmacist, Ms Yeoh Ting Ting, shared on **common toxicities** and **drug interactions** of cancer drugs as well as tools used to **predict** its risk. Palliative oncologist, Dr Lalit Krishna, gave an interactive session on the **management of common symptoms** encountered by the elderly cancer patient including pain, shortness of breath, nausea and vomiting, constipation, hiccups, itch and their management, both pharmacological and non-pharmacological. This was followed by Ms Niki Goh Ying Rou, Medical Social Worker who gave a brief update on the community resources available for the older person with cancer, how to choose the right service and how to refer to these services. Lastly, Dr Rose Fok, a Family Physician, shared her experiences dealing with patients in the **breast cancer survivorship** clinics at NCCS. She highlighted that there is an increasing role of the family physician in care coordination and survivorship plans as they have the appropriate skillset focusing on patient education, health promotion and disease prevention.

In total, there were 83 participants who turned up for the workshop. There were pre workshop and post workshops surveys completed by all the participants of the workshop. Analysis of the information from the surveys conducted indicates that the participants now have a higher level of confidence and knowledge in dealing with cancer patients they may encounter in their clinics. This coupled with the overall excellent feedback from all the participants have encouraged the organisers to plan a few more of these workshops in the future. The next workshop is planned for March 2015 and will focus on training nurses involved in the care of elderly oncology patients.

CM

Talk at SG50 Appreciation Dinner for Pioneer GPs on 30th Oct 2015

Sharing of Experiences in the Private Healthcare Setting

by Dr James Chang Ming Yu,
Life Fellow of CFPS and Life Member of Singapore Medical Association
Founder Member, CFPS
Censor-in-Chief CFPS 1979-1985
Member, Singapore Medical Council 1983-1995

Minister for Health, Mr Gan Kim Yong,
Minister of State for Health, Dr Lam Pin Min,
President of the College of Family Physicians, Dr Lee Kheng Hock,
Deputy CEO Agency for Integrated Care, Dr Wong Khek Chuan,
Dear Colleagues and Friends,

I am deeply honoured to be invited to speak on this occasion on my experiences as a family doctor of 50yrs standing. Since the other speakers have spoken on the academic and formal issues of primary healthcare, I wish to speak only of my own experiences as a family doctor in the 1960s and 70s.

I am 80 years old and my MCR No: is 00531B. I am therefore considered a dinosaur in medical circles. At a recent CME meeting, I was asked my MCR No and the young lady at the registration counter said my number couldn't be right. Why so? I asked. Everybody has 4 numbers but yours has only 3, she replied!

I started my clinic in 1965, exactly 50 years ago. It was in Beauty World Town along 7th Mile Bukit Timah Road. This is now the location of the Beauty World MRT Station that is to be opened at the end of this year. In the 1960s, there were only about 500 registered doctors and roughly half of them were in private practice. Most were general practitioners, because specialist practice was then in its infancy. The standard of practice varied with each doctor. There was no formal training for general practitioners and doctors started their clinics when they wished to. Some started immediately after serving housemanship, some after retiring from public institutions. A few of these retirees had spent years doing surgery, general medicine or administrative work and then decided to open their own clinics. There were GPs who could do complicated surgical procedures like fixing fractures, arthrodesis of joints, cleft palate and harelip repairs. Some ran maternity homes and delivered babies with the help of midwives. A

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retired public health administrator who went into private practice discovered that he had no clue of Pediatric medicine, Obstetrics and Gynaecology or other branches of medicine because he had no experience or received training in them. I had the luxury of having gone through the paces, having received postings in Surgery, Medicine, O & G, Accident & Emergency and Polyclinic Outpatient and felt fairly confident. However, I was at sea when it came to managing a "business": how to employ and maintain staff, how to buy drugs and check on the stocks.

My clinic occupied a space of 400sq ft in a single storey shop that was part of a collection of small shops carrying out different types of business. I paid $270 a month for a 15-year lease. At that time 7th mile Bukit Timah was considered "ulu" and my patients were mostly farmers, fishermen, granite quarry workers, petty traders and people living in Bukit Timah , Bukit Panjang, Jurong, Tuas, Choa Chu Kang, Lim Chu Kang, even in Woodlands and Mandai. At that time Jurong Industrial Estate had not started.

My patients were generally poor. They couldn't afford laboratory tests at the single private laboratory in town and so I improvised a small bedside laboratory. I remember having a microscope, a centrifuge machine, test tubes and reagents in my consultation room. This saved them the extra cost and inconvenience of travelling into town and I could make a diagnosis with greater confidence. My standard medical bill when I started practice was $4-5. This was an all-inclusive bill. Whenever I grossed $200 for the day, working 3 sessions, I was very happy.

When I think back on healthcare in those early days, many features of it come to my mind and I would like to illustrate them with cases that I still remember vividly.

a) Housecalls

I did many housecalls then. Most times they were for patients who were too ill to come to the clinic or had difficulties with transport. One Sunday afternoon, a young man asked me to see his grandfather who was in pain for two days because he could not pass urine. To reach his house in Choa Chu Kang, I drove my car for 30mins and thought I had arrived. But no, the young man handed me a bicycle and asked me to follow him on muddy tracks till we reached the farmhouse. There I found the grandfather writhing in agony. He had acute retention of urine from an enlarged prostate. I inserted a urinary catheter and drained two litres of urine from his distended abdomen and was rewarded with smiles from the old man. It was a satisfying moment for me as well.

b) Consultation fees

In those days, there was no such thing as a consultation fee. If no medicine was given during a consultation, the patient did not think he needed to pay anything. I recall being called to visit an elderly lady who was very ill. She had pneumonia and I advised immediate hospitalization. I wrote a referral letter for the family but did not give the patient any injection or medicines. The family thanked me but made not attempt to pay me a fee. I was too shy to ask but was happy when they gave me an *angpow*. Back in my clinic I opened the *angpow*. In it was $2!

c) Gifts in lieu of fees

I was often paid my fees in kind. I remember a young man who fell down and was rushed to my clinic, having sustained lacerations and abrasions all over. I dressed his wounds and stitched his lacerations. He didn't have money on him that day but came back a few days later with two life chickens to thank me. At other times when patients could not pay in cash, I would receive ducks, fresh eggs and home–grown vegetables. Once I even received fish and crabs from a patient who had a *kelong*. He invited me to stay overnight on his *kelong* as well.

d) Litigation

This was unheard of in the early days. Patients were inevitably grateful for what ever you had done for them and would never take a doctor to court. I once treated a woman who was cut by broken glass splinters when a windowpane shattered in her house. I stitched the laceration in her foot. Ten years later, the same lady saw me again to say that the scar on her foot was hurting. When I examined her foot, I felt something firm under the scar. I told her I needed to do a little surgery in that area. She agreed and I extracted a small piece of glass that was left behind from her previous injury. This lady thanked me profusely for what I did for her. I shudder to think what legal action I would have to face now, for leaving a foreign body behind in a wound.

e) Reliance on clinical acumen

One of our early Professors of Medicine, Professor Ransome, used to teach us that a comprehensive history would allow us to reach 75% of the diagnosis and a good clinical examination would add another 10%. Even in present day general practice, we have to rely on our clinical acumen. I was called one morning to see an Indian patient who suddenly fell unconscious after returning from his morning exercise. His wife thought he had a stroke. He was cold and clammy. I knew he was a diabetic and after examining him, gave him a bolus IV injection of glucose. Within seconds, he sat up and asked me what happened. He had suffered a hypoglycemic attack. That morning he took his diabetic medicine but thought he would eat breakfast after his morning jog. It was an opportunity at that time for me to teach him how to manage his diabetic condition, and avoid hypoglycemic attacks in the future. I was reminded of this incident recently when a friend of mine landed in A & E after fainting in the dental clinic. He was also a diabetic. He ended up with ECG, CT scan and had a full blood and urine workout, spending the whole day in the hospital, only to be discharged and told that he had hypoglycemia.

Modern Day General Practice

General practice in Singapore has evolved from third world status to first world. Solo practices are now slowly being replaced by group practices. Private patients are now scarcer, being replaced by patients belonging to companies who buy medical insurance for them and their families. Patients are more knowledgeable of their illnesses and demand longer consultation times for explanation of their medical conditions. Fortunately doctors nowadays are better trained and better prepared to treat them. There are laboratory and radiological facilities for investigations in private practice. There are now an abundance of medical and surgical specialties in both the private and public healthcare sectors for patients to be referred to, for further management. There are many CME programmes, medical journals and medical practice guidelines

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Photograph 2 shows the first batch of College Fellows having a session at the Graduate Family Medicine Centre above Cheong Medical Clinic. The FCFP(S) by assessment is now recognized as a criterion for fellowship of the Academy of Medicine Singapore in 2014. That is another short story of the "long march" of the FCFP(S) – and the march is still on.

Photograph 2. Fellowship class in session that trained the first batch of College Fellows by Assessment

Image courtesy of Dr Julian Lim

Now for the MMed and Collegiate story leading to the newly inaugurated the College MMed FM Programme at the 2015 Convocation. It started out as a cat rescue centre in 1993 by none other than Prof Cheong Pak Yean and Prof Goh Lee Gan for dropped out trainees, like me, who have left service to be the sole bread winner for the family which was also fortuitously facilitated by the early release scheme offered during that time. It gave us a fighting chance to have bite at the MMed. It became the 2-year PPS – Private Practitioners' Stream for senior GPs hoping to have the same bite in 1995 – It was quite a big bite and one of the reasons for the smaller GDFM bite. Nevertheless, we managed to graduate 61 doctors from 1995 to 2006. Many of these Graduates from the PPS stream are now CEOs, CMBs, Directors of Polyclinics, Head of Departments, Residency Programme Director and Faculty, University faculty and so on.

PPS was renamed "Programme B" in 2006 as we were taking in more and more trainees from the polyclinic who were too senior to benefit from the MOH traineeship Programme A. It was effectively a 3-year course – taking into account the compulsory completion of the 2-year FMTP – Family Medicine Training Programme. During this time, Programme B was hosted by the then COFM Department when Prof Chan Nang Fong was there and in Dr Julian Lim's clinic. With the set-up of the Department of Family Medicine and Continuing Care, SGH, the Programme B tutorials were run by this Department and some at the College premises. We had trainers from the private sector, the polyclinics and even the university. In all, PPS and Programme B together graduated a quarter of all MMed(FM) holders.

With the new residency programme (no more Programme A); the new examination format and endorsement given to our trainees to take the MMed exam offered by the NUS (the successful ones are here tonight) and more poignantly, the support of MOH in the form of financial sponsorship for the trainees this year, it is a good time to hand over the programme officially to the College and to a name change – the College programme leading to the Master of Medicine in Family Medicine and Collegiate membership.

In closing, Prof Cheong wanted to remind us why it had to be cover potholes always. CME in the past had always been one of specialists covering the rarities – what we needed was knowledge to cover the whole breadth, leaving no holes uncovered, covering all the knowledge gaps that we encounter in our practice. Consolidating plateaus is why we do what we do in continually upgrading ourselves. We weren't quite sure what conquering peaks meant at that time. But now it is getting clearer – one discipline, many settings. It is in meeting the needs of the society in areas that require us to conquer the peaks of knowledge and skills to be able to fulfill those challenging roles – be it in ambulatory care, community hospitals, rehabilitation centres, long term care in nursing homes, palliative care, home care, transitional care and even inpatient care.

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◂ *The inauguration of College Programme for MMed(FM) and Collegiate Membership - (from left) A/Prof Goh Lee Gan, Dr Julian Lim and A/Prof Lee Kheng Hock.*

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available to doctors. All these have contributed to the evolving landscape of General Practice in Singapore.

Disease patterns have also changed. We used to see patients with rheumatic fever causing defective heart valves, mitral stenosis, mitral and aortic incompetence, 3rd stage syphilis causing GPI, tabes dorsalis, charcot joints and molar pregnancies and choriocarcinoma. I also encountered many cases of silicosis among the granite quarry workers. We hardly hear of these conditions nowadays. Instead we have new infections like HIV, SARS, MERS and Ebola virus. We are also encountering diseases of an aged-population, degenerative conditions like dementia, aged related macular degeneration and diseases related to atherosclerosis.

I am now semi-retired, having handed over my practice to my son but I still maintain a few morning sessions a week to see patients. I am grateful for the opportunity to have experienced general and family medical practice for the past 50 years, coinciding with SG50.

CM