The Rise, the Fall, and the Reincarnation of Family Medicine
Sreenivasan Oration 2025, College of Family Physicians Singapore
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It is a particular honour to speak at this Sreenivasan Oration, a lecture series named for Dr Baratham Ramaswamy Sreenivasan. He was the first in a long line of College leaders who have worked tirelessly to restore the values of Family Medicine to our healthcare system and our people. This oration was established to keep his legacy alive, and in doing so, it asks us each year to adopt a Janus-like gaze: one face looking to the past, the other to the possibilities of the future. It is this dual perspective that I wish to explore with you tonight.

My address is titled “The Rise, the Fall, and the Reincarnation of Family Medicine”. This story is evolutionary, yet it is anything but linear. It is a tale woven from many threads: dedication to service, the triumph of science, the failure of wisdom, institutional inertia, the passion of our professional grassroots, and ultimately, the vindication of a collective vision. It is a global narrative spanning more than half a century, one in which Singapore has been carried on a tide of international progress while simultaneously steering its own distinct path, guided by the discipline and pragmatism for which our nation is known.

Global Origins, Local Beginnings: The Rise of Generalism
At the start of the 20th century, the physician was a generalist by design. Medicine’s great early advances were made by people who think holistically in terms of families, households, communities, and population. Patients were seen in the context of their family and communities.

At the turn of the 20th century, medicine entered a period of astonishing scientific and technological progress. Discoveries in bacteriology, radiology, pharmacology, and surgical technique reshaped the very foundations of medical knowledge. New tools such as X-rays, laboratory testing, and emerging therapeutic innovations created entire domains of information that no single physician could fully master. Universities and hospitals responded by organising themselves around increasingly narrow fields of expertise, each with its own methods, instruments, and intellectual culture. Specialisation soon became both inevitable and celebrated. In this new landscape, the traditional generalist who once cared for the whole person across the journey of life gradually lost prominence as the expanding universe of medical knowledge displaced the centre of gravity away from broad-based practice and toward focused disciplines. Specialisation was a moral and intellectual good. But, like every powerful advantage, it had costs. Fragmentation of care followed. The patient became, in effect, a set of problems and malfunctioning organs.

In the United States during the 1960s, the tension between an increasingly specialised medical system and the need for whole-person continuity of care became both visible and urgent. Two landmark national reviews gave voice to this concern. The Millis Report of 1966, commissioned to examine graduate medical education, concluded that modern healthcare required physicians who could integrate care across settings and disciplines. It introduced the idea of the primary physician, a doctor who would assume ongoing responsibility for coordinating comprehensive care for individuals and

families. The Folsom Report of 1967, produced by a distinguished committee under the American Medical Association, went further by articulating the vision of a personal physician for every American community. It emphasised that health could not be understood apart from family and social context and that the country needed doctors rooted in the everyday realities of people's lives. Together, these reports warned that their nation had slipped into a downward spiral where no one was responsible for the whole patient. Their recommendations created the momentum for change. In 1969, the American Board of Family Practice was established, formally recognising Family Medicine as a specialty and signalling the rebirth of the generalist tradition that had nearly disappeared. It marked the return of a physician who cared first for the person, not only the disease.

While the United States was wrestling with the consequences of fragmentation in the 1960s, the United Kingdom was experiencing its own reckoning with the role of the general practitioner. The National Health Service, created in 1948, had originally placed the general practitioner at the front door of care. Yet by the mid-20th century, British general practice faced declining morale, outdated facilities, uneven standards, and widening gaps between hospital specialties and community medicine. These concerns prompted a series of influential inquiries and reforms. The 1950 Collings Report revealed the poor working conditions and variable quality of general practice, which galvanised efforts to modernise training and improve professional standards. This momentum eventually led to the formation of the Royal College of General Practitioners in 1952, an institution that became the intellectual and professional champion for a revitalised general practice. By the early 1970s, the RCGP had established vocational training, strengthened examinations, and redefined the general practitioner as a specialist clinician responsible for comprehensive, continuous, and family-centred care. These reforms elevated general practice from a default career choice to a respected discipline with a clear academic foundation. In many ways, the British revival of general practice paralleled the American rebirth of Family Medicine.

As movements in the United States and the United Kingdom gained momentum, a parallel current was rising across continents. Countries as diverse as Canada, Australia, the Netherlands, and the Scandinavian nations were reflecting on the limits of fragmented care and the growing need for physicians who could hold continuity, context, and community at the centre of practice. By the late 1960s, it was clear that this was not a local adjustment but a worldwide reorientation in thinking about what modern healthcare required. This convergence found its culmination in 1972, when national colleges and academic bodies from around the world came together to establish the World Organisation of National Colleges, Academies, and Academic Associations of General Practitioners and Family Physicians, better known as WONCA. WONCA also affirmed that Family Medicine was not a fallback career or an interim stage before specialisation. It was a specialty in its own right, grounded in mastery of the whole person and committed to the health of communities. Singapore was among the early members of this new international family, aligning itself with a global movement that understood the value of relational, continuous, and context-rich care.

Singapore's Parallel: Organising, Legitimation, and Persistence

While the world was debating identity in the 1960s and early 1970s, a different kind of conversation was starting here. Singapore in the 1970s was remaking itself through

nation-building, system-building, and institution-building. Health policy and hospital development were central to that national project. Into that climate a small group of committed clinicians planted something audacious: the College of General Practitioners Singapore, founded on 30 June 1971. From the outset they asked not for ceremony but for standards: examinations, journals, a professional home. Within a year the College ran its first Membership (MCGP) examination, and within a few years the MCGP diploma was recognised by the Singapore Medical Council as a registrable postgraduate qualification.

Through the 1980s and 1990s, Singapore's Family Medicine community deepened its academic roots. NUS recognised Family Medicine as an academic discipline; structured postgraduate training matured with the MMed(FM); the College itself evolved into the College of Family Physicians Singapore. The slow architecture of training and assessment was deliberate, focused on an unshakable insistence that community-based care demanded its own rigour.

The formation of the Department of Family Medicine and Continuing Care (FMCC) at Singapore General Hospital (SGH) in 2006 was a seminal moment in the development of Singapore's health system, representing the first clinical department of its kind within a restructured public hospital and marking a deliberate strategic shift in care delivery. Its significance lay in actively moving the generalist perspective of Family Medicine "upstream" from the traditional community setting into the tertiary hospital environment, a necessary response to the immense pressures of an ageing population presenting with complex, multi-morbid chronic conditions that challenged the acute, specialised care model. The department was fundamentally a mechanism for care integration, established to bridge the historical divide between hospital and community, with its primary function being to ensure continuity of care — from coordinating services for complex patients within the hospital (inpatient consultative services) to managing the critical transitional phase upon discharge. By pioneering services like transitional care and home medical care for sub-acute patients, the FMCC laid the groundwork for a more holistic, person-centred, and continuous care model, setting a national precedent for how tertiary institutions could actively engage in population health and seamlessly link acute episodes with long-term recovery and maintenance in the community.

Meanwhile, FPs in polyclinics are advancing new care models for of chronic diseases, leading multi-disciplinary teams (including nurses, dieticians, and health educators) that run structured programmes for complex conditions like diabetes and hypertension. Simultaneously, the private sector has been galvanised through the Primary Care Network (PCN) scheme, a core component of the Regional Health System (RHS) strategy. Under the PCN model, private General Practitioners (GPs), often led by an FP, band together into virtual networks to receive government funding and administrative support. This structure allows solo GPs to provide team-based chronic care. This strategic partnership ensures that the majority of Singaporeans, who rely on private GPs for primary care, receive holistic and coordinated management for their chronic conditions closer to home. Finally, FPs are crucial in the intermediate care sector, often serving as the primary doctors in community hospitals. In this role, FPs manage patients' sub-acute medical needs, focusing on rehabilitation, care planning, and the final transition back to the community, ensuring that the generalist and

community centredness guides long-term recovery and prevents fragmentation of care.

Reincarnation: Recognition, Gravity, and Responsibility
What a decade of determined work can yield is not merely respect — it is structural gravity.

On 31 October 2025, the Specialists Accreditation Board announced that Family Medicine would be recognised as Singapore's 36th specialty, effective 1 November 2025. This moment is more than an institutional milestone; it is the vindication of a vision held and tirelessly advanced by our College leaders for over half a century. The announcement from the Specialists Accreditation Board is the structural culmination of that vision. It is the proof that decades of determined work of forging formal pathways, establishing rigorous credentialing, championing fellowship standards, and building indispensable hospital partnerships, can yield not merely respect, but what we might call structural gravity. This is the force that now pulls training pipelines, resources, and the very conversation about healthcare towards the central, indispensable role of the family physician.

Our founders and the leaders who followed did not labour for a medal or a title. They built for this very outcome: a future where the discipline they championed would be unequivocally recognised for its critical function. This specialist status is the ultimate affirmation of their conviction that community-based care demands its own unique rigour and expertise.

But let us be clear. This recognition is not an endpoint. It is a threshold that they have brought us to. With this new status comes the profound responsibility they modelled for us. That is to steward a discipline that must remain nimble, humane, and outward-looking. The fact that our fellowship-holders will form the first cohort of accredited specialists is the final, undeniable evidence that our leaders were right all along. They envisioned a physician who integrates care, coordinates complexity, and takes responsibility for whole lives. Today, that physician is not just an ideal; they are a certified specialist, their practice now the validated standard.

This is their legacy, made manifest. Our task is to honour it not with complacency, but with the same unwavering commitment to the work ahead.

***Memento Mori*: The Quiet Warning in an Age of VUCA and AI**
If our task tonight were only to celebrate, we would be repeating the complacency that once led to our decline. For triumph invites not rest, but vigilance.

In Rome, the triumphant general was accompanied by a slave who whispered, *memento mori* — remember you are mortal. That whisper is not fatalism; it is prudence. It is the attitude that keeps leadership honest.

We enter an era of VUCA: volatile, uncertain, complex, ambiguous. It is shaped by demographic ageing, multimorbidity, constrained resources, and new forms of inequality. Against this backdrop, the most disruptive force is not merely demographic: it is technological. Artificial intelligence will reconfigure knowledge flows, triage, diagnostics, and patient access to information. AI will reduce some work and magnify

others. It will make some doctors more efficient — and make other roles obsolete if we allow it. The choice is not to accept or reject AI. The choice is whether we design AI to serve the ethic of primary care — continuity, context, shared goals — or whether we let opaque systems optimise for throughput and narrow metrics.

We need only look to our own history to understand this moment. The rise of specialisation, for all its brilliance, carried a hidden cost: it fragmented care, reducing the person to a collection of malfunctioning organs. The generalist, the steward of the whole person, was nearly lost. Today, we stand at a similar crossroads, not with a new discipline, but with a new force: Artificial Intelligence.

AI presents a risk of fragmentation as profound as any we have faced. Left unguided, it promises to optimise for efficiency and narrow metrics, potentially creating a new, digital-driven fall. A system where algorithms, not relationships, dictate care, and where the patient's story is lost in a sea of data. This is not a future we can accept.

But the lesson of our past is not to reject progress, but to master it. The choice is not whether to accept AI, but whether we will imbue it with our values. We must embrace AI not as a replacement for the family physician, but as the most powerful tool we have ever had to *actualise* the full vision of our practice.

We must ensure AI serves the core ethic of Family Medicine: continuity, context, and shared goals. We must be in the rooms where algorithms are built, insisting they reflect the messy realities of multimorbidity, social determinants, and human uncertainty. Let us build tools that augment relational care and free our attention for listening and deepen our understanding.

Just as we reclaimed the generalist tradition and reincarnated it as a respected specialty, we must now seize AI. By combining this formidable technology with our timeless values, we can not only avoid a new fall but advance towards a future where the promise of whole-person, continuous, and deeply human care is finally, fully realised.

Closing: Stewardship and the Work Ahead

So where do we go from here? This hard-won recognition is not our final destination, but the starting point for the next phase of our journey. Our path is clear.

First, we must treat our specialist status as a mandate, not a medal. This new standing confers a duty to lead in medical education, to define quality standards, and to provide policy advice. Our teaching must emphasise not only knowledge, but also the ability to make sense of uncertainty, to negotiate patient priorities, and to excel in interprofessional collaboration.

Second, we must claim artificial intelligence as a profound design opportunity. We will build, co-develop, and govern tools that augment relational care. This means creating triage systems that preserve continuity, predictive models that suggest rather than instruct, and summarisation tools that free our attention for the essential art of listening.

Third, we must steward the entire health system towards greater integration. We will advocate for payment and organisational models that reward continuity of care and outcomes that truly matter to patients. We must champion team-based care that extends the reach of family physicians without breaking apart the integrity of responsibility.

Our founders, Dr Sreenivasan, Dr Wong Heck Sing, and Dr Koh Eng Kheng did not build for applause. They built standards, examinations, journals, and mentorship programmes. They understood that a professional home is constructed through practice, pedagogy, and professionalism.

Now we inherit that house. We have the honour of living within the walls they raised. Let us use this shelter not for complacency, but for the work that remains: education, research, policy, and partnership with technology, all in service of enhancing the moral project of medicine.

Let us be the discipline that insists on the person behind every record, the family behind every history, and the community that sustains health.

And as we celebrate this reincarnation, let the slave's whisper guide us: *memento mori*. Remember the fragility of achievement, the responsibility of status, and the moral seriousness of the work we do.

Thank you.