College of Family Physicians Singapore

# THE College Mirror

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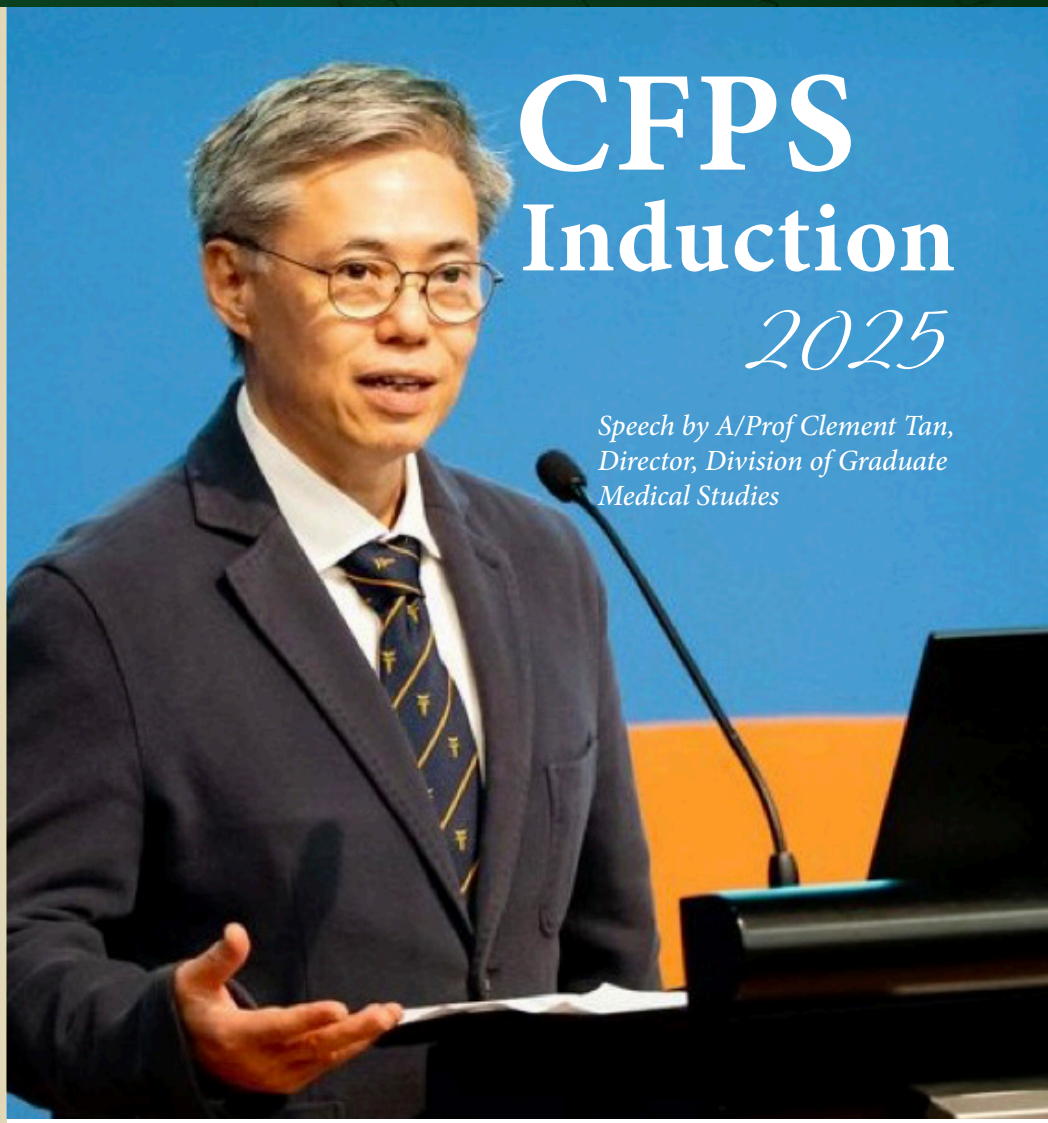
## IN THIS ISSUE





# CFPS Induction 2025

*Speech by A/Prof Clement Tan, Director, Division of Graduate Medical Studies*

Dr Wong Tien Hua, President of the College of Family Physicians, Council Members,
faculty, mentors, friends, and most importantly,
our new Family Medicine trainees.

Thank you for this tremendous privilege of joining you today to mark the beginning of your journey into the MMed(FM) and GDFM programmes.

It is a little over 30 years ago that I did a posting as a first-year Medical Officer at the Woodlands Polyclinic. This was just before returning for National Service. At that time, SAF had determined that fresh graduates just didn't have the ability to function as medical officers in the army. We were familiar with hospital processes but had no real idea how to manage patients with minor illnesses like upper respiratory tract infections, diarrhoea, eczema, fungal rashes, etc. Hence, after housemanship, all the men due to return to the army were made to do a 6-month polyclinic rotation.

I must say I enjoyed that polyclinic posting. Woodlands at the time was still quite rustic and there was quite the kampung spirit in the area. The clinic

*(continued on Page 2)*

*(continued from Cover Page: CFPS Induction Speech 2025)*

> *Thirty years ago, Family Medicine was often seen as a default—not a destination. The system was largely reactive, and the care episodic.*

attendant at the polyclinic used to pitch up periodically with Milo for the doctors at teatime.

Thirty years ago, Family Medicine was often seen as a default—not a destination. The system was largely reactive, and the care episodic. GPs worked in silos. Woodlands Polyclinic might have been new and less busy, but polyclinics in general were overburdened. Patients with chronic illnesses went from doctor to doctor without continuity. This despite the fact that there were many good GPs around who had great clinical skills and were managing their patients very well.

But 30 years ago was also the time when things were beginning to change. Formal training in Family Medicine had recently been introduced and the first Master of Medicine in Family Medicine examination was held in 1993. That same year, the College of General Practitioners was renamed the College of Family Physicians. Family Medicine was becoming a profession with rigour, scholarship, and system impact. More importantly, at a personal level, I was noticing classmates and seniors who were well regarded for their clinical acumen, industry, and grades in medical school, making a deliberate move to enter Family Medicine—taking up the Family Medicine traineeship, setting up group practices, starting their solo practices.

Over the years, I have watched with admiration the growth of Family Medicine as a discipline. Besides the polyclinics, there now are thriving group practices and Primary Care Networks that provide that continuity of care for chronic diseases. The system is now integrated and care is longitudinal instead of episodic. As an ophthalmology resident, I watched with fascination as the retina surgeons battled severe, blinding diabetic retinopathy. But gradually, the number of such complex surgeries started to decline. The real change that had happened was that Family Physicians were making a big impact on the control of diabetes and other related risk factors; they were consistently screening patients and working with the eye community to detect and treat early diabetic eye disease.

And that's just the example that's closest to me. There are many more examples of the impact that the professionalisation of Family Medicine has made.

When I came on board the Division of Graduate Medical Studies, I also started to notice that the training and exams for Family Medicine are very rigorous. The standards were as high as any of the other specialties. Family Medicine covers such a broad range of subjects, it really looks to me like the MBBS on steroids. But it does give me great confidence that those who pass through the GDFM and MMed(FM) programmes have been thoroughly trained and assessed and are going to be very competent in handling the increasingly complex healthcare needs of our ageing population. I have also watched many Family Physicians undertake further training in dermatology, geriatrics, palliative medicine, occupational medicine, mental health and so on.

So, when it was mooted that Family Medicine should be recognised as a specialty of Medicine, I had no difficulty supporting that proposal. And I feel honoured to be part of the journey of Family Medicine. To see it succeed in this would (to borrow the words of a local politician) warm the cockles of my heart.

> *Over the years, I have watched with admiration the growth of Family Medicine as a discipline. Besides the polyclinics, there now are thriving group practices and Primary Care Networks that provide that continuity of care for chronic diseases.*





> *The system is now integrated and care is longitudinal instead of episodic.*

In closing, I have a few more words for the inductees into the GDFM and MMed Programmes:

You have chosen a good path. We will be relying on you to be the glue that holds an increasingly complex healthcare system together.

I have no doubt you will be well trained. Having worked with your programme directors and faculty, I can tell you that they are excellent individuals. They have signed up to do this to ensure that the training will be nothing short of excellent. They have selflessly invested time and effort into the programme. So, train hard. Build your knowledge and skills. But do not lose that for which Family Physicians had always been well regarded—that GP's touch. That gradual and consistent building of good relationships with patients, being part of their lives, quietly influencing the community around you. Being the ones always present to provide care. Being the ones that the patients trust.

Congratulations on your induction. May your journey be rich with learning, marked by service, and grounded in the values that have always defined the very best of medicine.

Thank you.

> *... gradual and consistent building of good relationships with patients, being part of their lives, quietly influencing the community ...*

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# Editor's Words

by Dr Gabriel Yee, FCFP (S), Editor, (Team C)

It's my favourite time of the year again: Teacher's Day! As I'm writing this on a lazy Saturday morning after having three straight days of Teacher's Day celebrations (and some boxing with uncle Jason of precisionstriking.com to burn off the lovely food my students fed me), I reflect together with the rest on us on how our teachers taught us and continue to inspire us on the road ahead.

Professor Clement Tan and Dr Wong Tien Hua seamlessly kept an eye (pun intended) on each other's **speeches at this year's CFPS induction** when they spoke of how Family Physicians have always been, and continue to be, the anchors of healthcare in the community. It was high praise when I noted from Prof Tan (I was seated in the audience) that he witnessed firsthand the impact that FPs were having on lowering incidence of severe diabetic retinopathy.

It was timely to be reminded by Dr Wong of two key facts from our College's Vision and Mission—to INSPIRE health and nurture generations of FPs through EDUCATION. This is indeed, the focus of this edition of the *College Mirror*.

Starting off with the first article, we truly believe that we should all aim for "a healthy mind in a healthy body" to borrow the phrase from the Roman poet Juvenal. Drs Kong Jingwen, Julian Lim (both of whom were my teachers from my FCFP days), and myself share how we become **"Healthier Family Physicians"** through Chinese Chess, Marathoning, and—yes, you guessed it—Muay Thai and boxing! (All whilst preventing ourselves from getting Diabetic retinopathy.) It is when we are healthy in our bodies and minds that we can pay attention to and absorb matters from the world around us, for reflective practice!

In **"Behind the GDFM Scenes"**, my FCFP trainees Dr Eugene Chua (fun fact—he was my direct supervisee) and Dr Kenneth Tan (fun fact—he's my classmate and good pal and we love all things Japanese) and their fellow educator Dr Aysha share how to slay the mythical FM AKT dragon, as they equip our GDFM trainees with the relevant knowledge and skills to do so. As in any education (or operational journey), they were not alone, joined by numerous like-minded folk.

Jingwen had several of us co-teach Professionalism, Ethics, and the Law (the famed/previously-dreaded "social studies" segment) of the FCFP programme. It was thus a natural progression that we co-spoke on an MME webinar: **"Caring when Capacity Wanes"** in two different scenarios—one of a mildly depressed adolescent who came asking for an MC, and another of an elderly man with mild cognitive impairment and a foot abscess refusing surgical intervention. It was super cathartic to write an article with many of my teachers and professors like Dr Eng Soo Kiang, Dr Suraj, Dr Farhad, and Prof Thiru (of SMA CMEP fame) on this matter, gleaning their insights and having them refine our teaching styles.

If the above MME webinar gave candidates the knowledge to tackle PEL questions, then they certainly showed it as they were **"Mocking Our PEL Fears"** through mock exams with the FCFP trainers. I am deeply grateful to the FCFP trainers who came down on a dark, stormy day (literally) on 16 June and the qualitative comments from the trainees (literally) warmed the cockles of our educators' hearts!

Since I like to roll with the punches (at least in boxing; please don't do this in Muay Thai or you'll eat a knee to the face), what better way to start the education conferences for 2025 than to attend the APPCRC with our FM friends from Malaysia! We shared with Prof Lee Yew Kong from the University of Malaya about how we **"RLO-ed Over the Post-COVID EBM Fog"** and ASPIRED to help trainees do so through the use of Reusable Learning Objects (RLOs)—which by the way can be used for a wide variety of stackable curriculae! (Pssttt if you wanna know, hit me up on MS teams or email!).

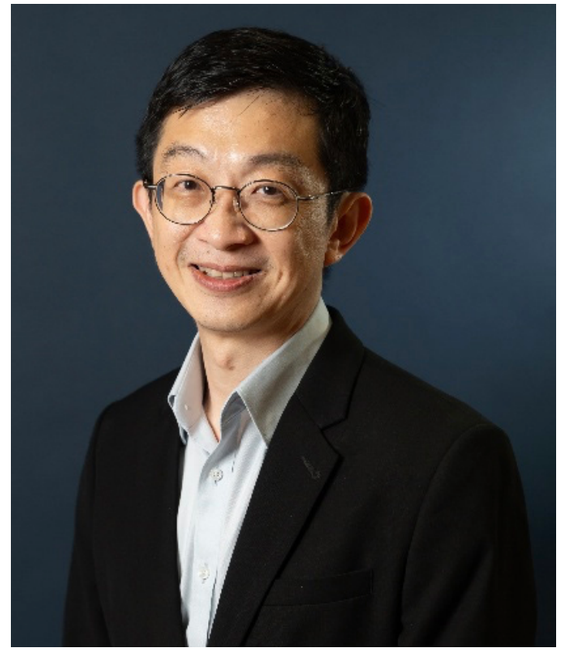
I guess all that's remaining is for me to introduce our newest editors:

- Prof Ng Chirk Jenn, who is Senior Consultant Deputy Director (talent Development) at the Centre for Population Health Research and Implementation, SingHealth Regional Health System (and my teacher)
- Dr Kenneth Tan, FP Consultant in Private Practice (and my classmate)
- Dr Yang Kaymond, Registrar in CGH Dept of Family Medicine (and my student 🙂)

I'd like to give them this space to share a little about themselves, but we definitely will be interviewing them more in a subsequent edition 🙂

And it's a wrap, folks! Let's all continue on our teaching and learning journeys, as it is when we teach that we learn. As my old geriatric senior consultant Dr Mohanaruban taught me: "You think you benefit more when I teach? I benefit MORE 🙂" with a wry smile. I must say, I truly benefited from the sparring I had with my trainees Eugene, Oka, and Pam, and diamond sharpens diamond, so… 100% FCFP pass!

CM



*Prof CJ hopes the stories we share will help you to ponder how and why we practise Family Medicine.*

*With our victorious 100% passing FCFP group (missing Pam who passed as well!) L-R: Eugene, yours truly, Kelvin, Ginny, Oka*

*Dr Kenneth Tan hopes to contribute to the voice of the fraternity, and share the stories of a GP in the heartlands.*

*Dr Yang Kaymond hopes to write the story of Family Medicine while living it daily.*

# *Induction Ceremony 2025*
# President's Speech

by Dr Wong Tien Hua, President, CFPS

A/Prof Clement Tan, Director, Division of Graduate Medical Studies, NUH,
Council Members and Fellows,
Ladies and Gentlemen,

Good afternoon and a warm welcome to the College of Family Physicians Induction Ceremony. I would like to thank our Guest-of-Honour A/Prof Clement Tan, who is also Chairman of the Joint Committee of Family Medicine Singapore, for joining us today. If you are wondering what an eminent ophthalmologist is doing at a FM event—he is keeping an eye on our training!

Our College Vision and Mission statements were crafted in November 2023, during our College Council and Secretariat staff retreat. At the retreat, we were able to collectively distil and align our aims and goals and also set a clear direction for the future.

**Our College Vision:**
Leading FAMILY MEDICINE, Inspiring HEALTH.

**Our College Mission:**
To nurture generations of Family Physicians through advocacy, education, and innovation,
so as to uphold the standards of Family Medicine.

We are committed to being leaders in the discipline of Family Medicine. Leadership here means stepping forward with integrity, with evidence-based practice, and with compassion for our patients. It means advocating for the role of Family Physicians in shaping health systems, policies, and outcomes, and the importance of further training to make sure every Family Physician is able to perform at the peak of his or her profession. This is also why most of us are here this afternoon: we have heard the calling in our hearts to do better, to further our commitment to Family Medicine, and to push ourselves to excel in our careers.

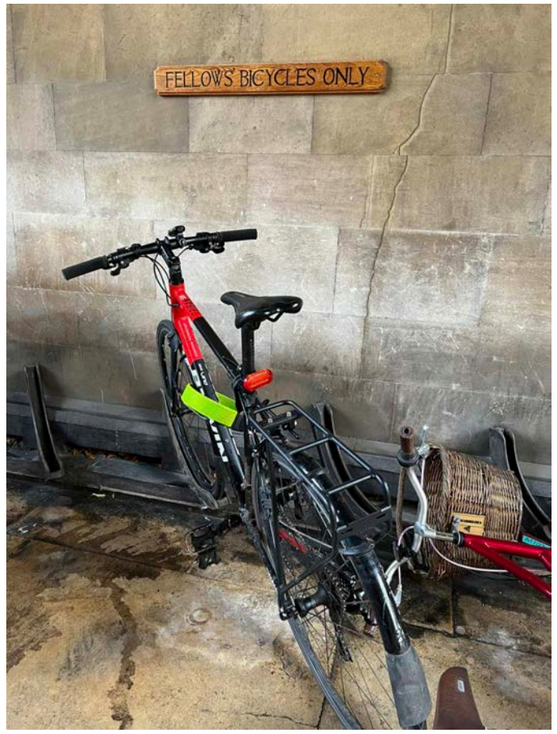
"Inspiring Health" reminds us that our impact goes far beyond the clinic walls. We are not only treating illness, but we are inspiring our patients and their families, and even one another, to live healthier lives.

Our College is here to nurture our future generation—it is not only about training, but to grow a fraternity of competent and compassionate Family Physicians. You are now part of that legacy, and also part of our future.

I am very encouraged to see that so many of you have enrolled in our programmes. This year we have 156 enrolments for the GDFM, 19 for the MMed(FM) College Programme, and 49 for the Fellowship programme.

I'm very pleased to share that our GDFM programme has done well, with the most recent cohort achieving a pass rate of around 90%. This is a strong affirmation of the programme's quality, the commitment of our GDFM team, and our Programme Directors who spent a lot of time over the past two years revamping the course materials and committing resources into the course. To those of you who are just starting on this journey, take heart—you are joining a well-supported and well-structured programme that will equip you with the skills, knowledge, and confidence to practise Family Medicine at a high standard.

Lastly, I would like to highlight the Fellowship enrolment, This year, we are heartened to see a remarkable increase in Fellowship enrolment—more than double the intake of 24 in each of the previous two years.




This photo was taken a few years ago when I was visiting Cambridge University in the UK. I noticed that one of the few tangible perks of being a Fellow at one of their colleges was having an assigned rack for bicycle parking—hardly glamorous, but still something!





Remember that it was not too long ago in Singapore that becoming a Fellow of our College, the FCFP carried no perks whatsoever—not even bicycle parking. Doctors enrolled in the Fellowship programme out of pure passion. In recent times, the Fellowship has started to matter more, especially in the public sector and polyclinics, where it is the de facto FM specialist degree for promotion and leadership positions.

Today, we are finally seeing the recognition of our Fellowship programme as a mark of specialist standing in Family Medicine.

This surge in enrolment is therefore both a response to and a reinforcement of that recognition. To me, it signals that Family Medicine is finally a discipline that is coming of age, an identity that is strengthening, and we are seeing a rising generation of Family Medicine leaders ready to shape the future of primary care in Singapore.

Once again, a very warm welcome to all our new students as you begin the academic year. I wish you all the best.

CM

# Healthier Family Physicians
## *Introduction by Dr Gabriel Yee*

With the HealthierSG movement in full force, what do Family Physicians across settings do to keep themselves biologically, psychologically, and socially resilient and agile in order to role model for our patients and population? Drs Kong Jingwen, Julian Lim, and myself share in this omnibus edition how we do so in our various busy schedules.

## RLOing with Punches

By Dr Gabriel Yee, FCFP(S), Consultant, CGH Department of Family Medicine

In a foretaste of one of the other articles where we RLO-ed with the punches that COVID dealt us for EBM teaching across the causeway, I'll be sharing my own experience getting back into fighting form ever since my waist size sadly expanded to 34 inches at the height of delta (it's now 31) and I lost the ability to do chin-ups (now at 10 straight ones).

### Why I Did (Thai/Kick/Conventional) Boxing

I was never a really athletic boy, despite my love for all things physical including the World Wrestling Federation (now Entertainment). Despite hours spent judo and karate training in my "A" level days, the max I managed to achieve was a green belt and a reasonable silver for IPPT/NAPFA. Fast forward to delta-wave COVID: a sprained ankle, and a 34-inch waist despite thrice-weekly morning runs made me realise I was getting sarcopenically obese, and quick. The fact that during COVID one of the key entertainments we had was LAN gaming from our computers (see prior *College Mirror* editions for what such zombie games taught us) contributed further to the problem! My doting wife had also caught a pneumonia from me (I had scarlet fever) and we decided to get healthy together (as I had signed her up for the Mrs Singapore Pageant—which she later triumphed in).

Thus we both wondered: what activity? We trawled through Instagram, TikTok, and yes, boomer-Facebook. A common

*Figure 1: Kinda conditioning my shins*

theme was these young, fit individuals kicking at bags, punching at mitts, and making guttural "oowee" noises! They all looked un-sarcopenic, like they had 31-inch waists and normal glucose metabolisms. "Why not you do it, since you say you are so good in martial arts," quipped my wife. It was initially insanity for me, having been put out of action from Judo 18 years ago by a torn acromioclavicular joint. But something stirred the martial artist/challenged the manhood in me, thus I dragged myself to my first Muay Thai class.

### How the Experience Went

Of course, I was "gently" instructed against "slappy/weak" Karate kicks and to punch with more force. Numerous push-ups, planks, pull-ups, squats, and hyrox-like exercises later, with several episodes of bruised shins and elbows—see Figure 1—I actually managed to out-spar some classmates, one of whom was a head taller than me.

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*(continued from Page 7: Healthier Family Physicians)*

What is the cost then? An hour of your time (and feeling like you are going to have an acute coronary syndrome for the first few sessions) for each group class, and one needs to do about two group classes each week to stay in reasonable shape. It costs about $25 for a group class. I've recently taken up shadowboxing—see Figure 2—to save some money for about 40 minutes each session so it can replace a group class (there are even virtual padwork sessions where I can experiment with various boxing styles, such as Tyson's peek-a-boo high guard, Ali's low guard with backpedalling, and Floyd Mayweather's Philly Shell doing combos like cross-hook-cross-uppercut aka 2363 with Mr Jason of Precision Striking https://www.youtube.com/@PrecisionBoxing). The best thing about it? You can do it from the comfort of your living room!

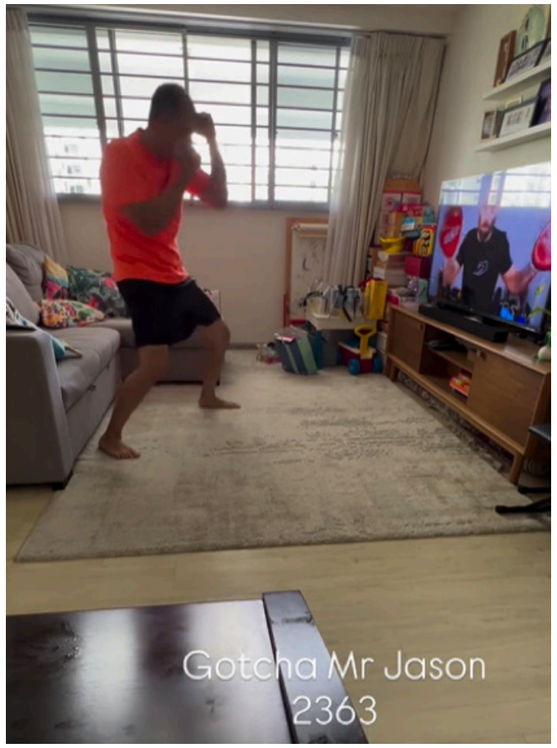


*Figure 2:Virtual Padwork with Mr Jason: saves $25 (group class cost)*

It is fun bonding with the whole family because now my wife and daughters follow me for a private family class every weekend—see Figures 3a and 3b.

## What's Next?

As the children are reaching the next threshold concept (forgive the educational references on Teacher's Day), Kru Jet and I aligned that by October 2025 they will be ready for group classes, as they now have the firm foundations (yes puns again regarding their stances) to springboard into the jumping teeps, knees, and bicycle kicks ahead.

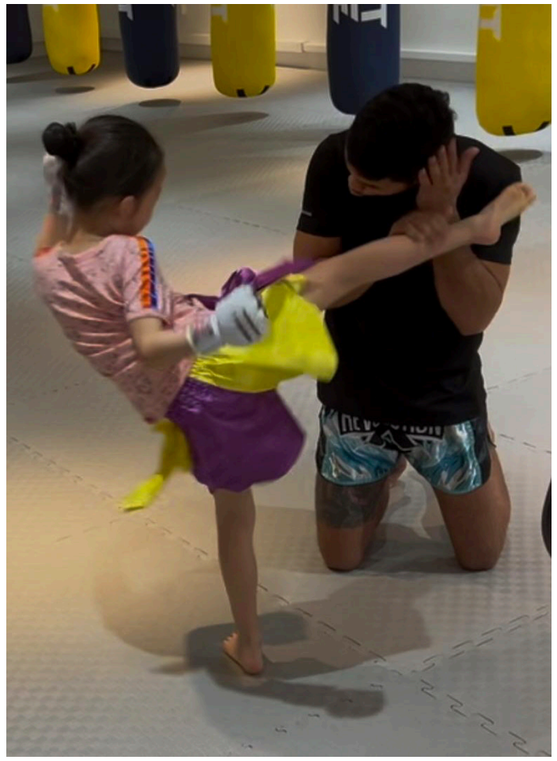

*Figure 3a: S1 lands a round kick!*

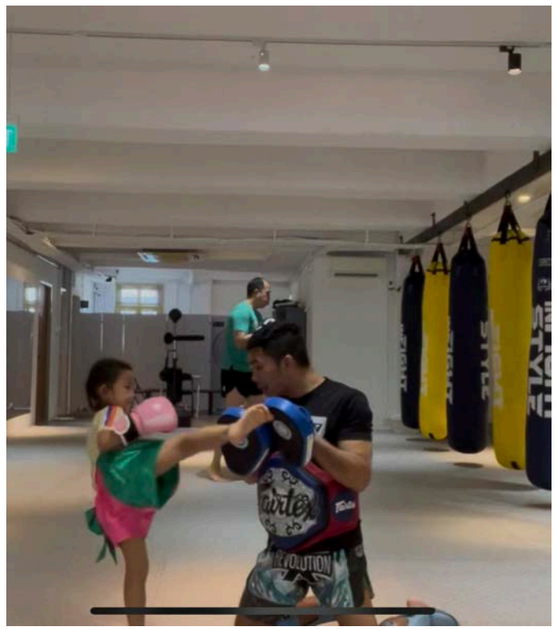

*Figure 3b: S2 lands a round kick!*

For those who are considering between Muay Thai and Boxing (why not do both?), a helpful deepseek-generated table is provided—see Table 1.





| Factor | Boxing | Muay Thai | Winner |
|---|---|---|---|
| Muscle Engagement | Focuses on upper body (arms, shoulders, core) and footwork. | Engages full body (arms, legs, knees, elbows, core). | Muay Thai (more muscle groups) |
| Resistance Training | Punching bags/mitts provide some resistance. | Heavy bag work, clinching, and kicks add more resistance. | Muay Thai (higher resistance) |
| Time Efficiency | High-intensity workouts in short bursts. | Similar intensity but more techniques to learn. | Boxing (simpler, faster adaptation) |
| Bone Density Impact | Weight shifting and footwork help bone health. | Kicks/knees provide higher impact, better for bones. | Muay Thai (greater osteogenic stimulus) |
| Skill Complexity | Easier to learn basics (jab, cross, hooks). | More techniques (kicks, knees, elbows, clinch). | Boxing (quicker to apply effectively) |
| Injury Risk | Lower risk (hands/wrists mostly). | Higher risk (kicks/knees can strain joints). | Boxing (safer for a busy professional) |
| Metabolic Boost | Great cardio, burns calories fast. | Even higher calorie burn due to full-body engagement. | Muay Thai (better for fat loss + muscle retention) |
| Stress Relief | High (punching is cathartic). | Very high (more aggressive techniques). | Muay Thai (greater mental release) |
| Practicality | Can shadowbox anywhere; minimal equipment. | Requires more space/equipment (pads, heavy bag). | Boxing (easier to fit into a tight schedule) |

*Table 1: Boxing versus Muay Thai for the prevention of Sarcopenia*

Until next time—Oowee!

# Cultivating My Mitochondria

By Dr Julian Lim, FCFP(S)

It has been said the marathon begins at 30 km. Personally, I know I need 2,800 calories to complete the full 42 km. And no matter how much I carbo-load, my liver and muscles can only store 2,000 calories in the form of glycogen. I will run out of carbohydrates to burn at 30 km. This also means that the 5 km, 10 km, 21 km, 30 km distances are the same kind of run—no real need for fuelling. The marathon is a different run altogether.

The obvious solution is fuelling. In that case, though, we will have to train our gut to absorb nutrients while running. You will also notice that people start walking from 30 km onwards—on fat burn. Whatever glucose remains is commandeered by the brain to protect itself. Hence might I suggest a better way—why not train your mitochondria to preferentially burn fat instead of carbohydrates as fuel instead?

The secret is to train easy. When you start panting, it means that the body is burning carbohydrates with its attendant carbon dioxide that needs to be ventilated out. So, cultivate your mitochondria to burn fat instead of carbohydrates. Train in the fat burn zone. Subjectively, it means that we train at conversational pace. People often say: I'm too tired to argue with you. To emphasise the point, we should train at argument pace! I will still have enough energy to carry on an argument with you. The biggest mistake is training too hard. When you train hard, you are risking injury to your body.

For those who want something more objective, simply observe the heart rate, with the help of a running watch. The fat burn zone is 70-80% of maximum heart rate. My 80% is 128 and 70% is 112. I try not to go beyond 128. When my heart rate hits 128, I slow things down. Initially, it could just be walking all the time. But as time goes by, I find that I can do more and more with 128 such as running faster with fat burn at argument pace. This is easy running, which cultivates the mitochondria to produce ATP by preferentially burning fat instead of carbohydrates. ATP is the packet of energy that drives all our metabolism—anabolism and catabolism. Just imagine those little "minions" happily producing ATP to meet my nefarious need for energy and immunity. What more can a minion ask for?

But the most important thing to me is actually recovery. You need three meals a day and a good night's sleep to get through a typical working day. If you throw in training, you are really asking for an injury unless you can squeeze in an extra meal, especially soon after training and a good night's sleep after that. So, do not train unless you can plan for that. If you are older and still working, try not train every day. A good programme will give you three days of training, one day for a recovery run, and two days of rest for the most intense week of training. Professionals are paid to eat and sleep and can train more than we can. We are paid for the work we do. After a rushed breakfast, we work while they have a hearty meal and then rest.

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*(continued from Page 9: Cultivating My Mitochondria)*

As family physicians, most of us work nights, weekends, and even public holidays. Life will always get in the way. Family, work, illness, fatigue. When in doubt: rest. The discipline and priority is to recover. Not train. It is the recovery that makes us stronger. But we need to train first before we can recover. If the recovery takes more than a few days, it is an injury. Injury usually occurs when not all the cells are pulling their weight. Those that are pulling end up being strained.

This is where activation comes in. We call it warming up. I find dynamic stretching very useful. Cramping usually occurs when the cells are not coordinated, for example contracting instead of relaxing. The aim is to get the muscles used to listening to the nerves and the nerves to the brain especially when fatigued, i.e., there is not enough ATP. I find doing coordination drills very useful.

Cultivation of the body and mind is the theme for this segment for the *College Mirror*. I have already written about the cultivation of the mitochondria. Let me now say a few words about the cultivation of the mind while running.

Do you know that the brain consumes 20% of your glucose? The less you think, the less you consume those precious glucose. My youngest daughter taught me that in freediving, the less you think, the less oxygen you consume. So, try not to think. Meditate. If I can describe Vipassana meditation in one sentence, it would be: To objectively observe your breath with equanimity, neither loving it nor hating it. Progressing beyond this is the body scan that can be practised while running. Although this will enable you to maintain good running form, the greater benefit would be the practice of equanimity in life. I first took an interest in Vipassana meditation when I heard my older daughter saying that it can "make" the hair grow. Actually, it was "feel" the hair grow! Anyway, if I can meditate for six hours straight during a marathon, I'm sure I'm close to reaching nirvana. But there's this nutritional strategy and pacing to execute so I won't be reaching nirvana any time soon.

Yes. Pacing. One month before the marathon, there will a few opportunities to do time trials. A 10 km or 21 km time trial will be more accurate but a 5 km one is sufficient. Warning—a 21 km organised race popping up at the right time during the training programme should not be treated as a race. It can be used as a time trial for those who are fit. But it is best utilised as a long slow run. I repeat, a long slow run to cultivate those mitochondria. It is particularly useful for gut training and trying out those gels. The same goes for all your runs. They are for training, not for time trialling. You don't have to aim to run faster and faster each time you run. Just keep it at fat burn. Trust the training programme, especially the last few weeks of tapering—the effect is magical.

The result of the time trial will be used to extrapolate my race pace. My aim is not do my personal best during the race. My aim is to finish strong (see Figure 1)—strong enough to believe that I can go on for another 5 km if I want to (with fuelling), after crossing the finish line. In other words: without injury. To do that, I need to hold back in the beginning. The pace had already been decided by that time trial, which is a product of my training for that season. The discipline is holding back—even if a pretty girl or a fat, old, and balding man should run faster than me. Let them go. Hold back. Maintain the pace that has already been decided. The fun is running past them after 30 km. At the finish line, I would give myself a pat on the back and remember everyone who has contributed to my marathon journey. I couldn't have done it without you! You know who you are.

Legend has it that Pheidippides ran 40 km from Marathon to Athens to deliver the message "Nike" before he collapsed and died. Whether I was first challenged, cajoled, or conned into it, one thing is certain—it is a distance to be respected. Take the time and effort to cultivate those mitochondria, not burn them.

But as the saying goes: Those who can, do; and those who can't, teach.

Still, the acronym is REST.

**R**ecovery is the priority. Plan to get enough to eat, rest, and sleep.
**E**asy does it. Train at argument pace.
**S**trength training. So that when you run, you are not pushing at 100% and risking injury.
**T**rust the easy training programme. Especially the rest sessions.

REST


*Figure 1: Dr Julian Lim finishing strong in the marathon—notice the runners behind* 🙂





# Moves That Matter: Building Resilient Minds and Meaningful Connections Through Xiangqi

By Dr Kong Jingwen, FCFP(S), Senior Consultant Family Physician

As family physicians, we are often the first to advocate for healthy living—encouraging our patients to exercise regularly, eat well, and care for their mental health. Yet in the demanding reality of primary care, we ourselves are not immune to fatigue. The long hours, the emotional complexity of care, and the constant navigation of uncertainty can take a toll, not just on our bodies, but on our minds.

Over time, I've come to appreciate that maintaining mental well-being is not a personal indulgence but a professional responsibility. One of the most effective practices I've found for cultivating clarity, balance, and resilience has been through Xiangqi, or Chinese Chess.

What began as a childhood pastime gradually evolved into a practice of mental conditioning. Xiangqi is more than a game of pieces and positions. It is a quiet exercise in focus, foresight, and emotional regulation. Each move requires strategic analysis: weighing risks, anticipating responses, and adapting under pressure. It mirrors the cognitive discipline we use in clinical care, where we manage complexity, balance competing demands, and think several steps ahead.

Just as a single impulsive move in Xiangqi can unravel an entire strategy, a hasty decision in clinical practice can lead to enduring consequences. Over time, the game has taught me to approach challenges with greater deliberation, composure, and patience. It has sharpened not only my thinking, but also the way I lead.

Serving on the Executive Committee of the Singapore Xiangqi General Association (SIXGA) has deepened this journey. In that role, I have had the opportunity to promote Xiangqi not only as a sport, but as a powerful tool for social connection, cognitive engagement, and intergenerational learning. Organising community events and working with diverse stakeholders have strengthened my leadership and reminded me that wellness is not just individual; it is communal.

One story that left a lasting impression came from an elderly Xiangqi enthusiast. A case manager at a community hospital emailed SIXGA, sharing that this gentleman, who, after suffering a stroke, could no longer travel independently. Once a regular at Chinatown's chess gatherings, he was now homebound. His mental acuity remained undiminished. The case manager had a simple yet heartfelt request: could we find a volunteer to play Xiangqi with him once a week at his HDB void deck, so he could continue doing what he loved?

This was not an isolated case. Many seniors who had once played Xiangqi in their youth now live in quiet isolation, their cognitive and emotional vitality slowly diminishing. The idea that a simple game could bring connection, dignity, and purpose resonated deeply with us. In response, SIXGA began coordinating volunteer visits. Our members brought not just chessboards but also companionship, shared stories, and respect. These encounters reminded me of what truly matters in family medicine: presence, listening, and human connection.

This kind of outreach aligns powerfully with the spirit of HealthierSG—enabling individuals to stay well in their communities, supported by networks that extend beyond traditional healthcare. It also affirms that mental well-being can be cultivated in many ways, including through heritage, play, and meaningful relationships.

As we encourage our patients to live healthier, more purposeful lives under HealthierSG, let us not forget the example we set. When we care for our own minds with the same dedication we offer to our patients, we fortify the very foundation of the care we provide.

In doing so, we not only heal others—we inspire them, by showing that wellness begins with their own family physician!

*Every move counts—on the Xiangqi board, and in life.*

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*(continued from Page 11: Moves That Matter)*

*Eyes on the board, mind in the moment.*

*Year 2024 Singapore-Malaysia Harmony Cup Xiangqi Team Tournament. It was an honour to compete alongside teammates who were crowned World Men's Team Champions. Together, we clinched the gold medal.*


*Year 2023 marked the finale of the Civil Service Club Xiangqi Competition. Over the past 14 years, the Ministry of Health Xiangqi Team has achieved an impressive track record—securing 11 golds, two silvers, and two bronzes (Team B).*





## *Behind the GDFM Scenes*

# Slaying the MCQ Dragon

## *– An Interview with Dr Kenneth Tan and Dr Muhusin Aysha Reema*

Interviewed by Dr Eugene Chua, Family Physician

Welcome back to the third instalment of our "Behind the GDFM Scenes" series!

Before we begin, we would like to extend our heartiest congratulations to all our GDFM trainees—regardless of the results, you have fought a good fight. And to our dedicated tutors, a big thank you for your unwavering commitment in guiding our future Family Physicians.

This issue, we shine the spotlight on our MCQ faculty—the formidable knights behind the shields, led by our Assistant Programme Director, Dr Kenneth Tan (KT), and fellow educator-in-arms, Dr Muhusin Aysha Reema (AR). Your humble correspondent (CM) recently sat down with both of them to find out how they've been equipping our trainees to conquer one of the most daunting trials in their GDFM journey: the FM AKT.

**CM** So what exactly is this FM AKT? And why is it giving our trainees sleepless nights?

**AR** The FM AKT, or Family Medicine Applied Knowledge Test, is the Part 1 theory examination for both the GDFM and the MMed(FM). Since 2022, it has replaced the written paper format and become a shared rite of passage for all candidates seeking to progress to Part II.

**KT** It's a beast of an exam—180 single-best-answer MCQs delivered over two gruelling sections, each with 90 questions to be completed within two hours. No extra time for breaks. No second chances mid-battle. The standard is high—as it should be—but when it was first introduced, many of our trainees found themselves overwhelmed.

**CM** What was the scene like when the new exam format first arrived?

**AR** Picture a battlefield after a storm. Our trainees suffered heavy casualties and morale was at an all-time low. The FM AKT felt like a dragon perched in the clouds—fearsome, unscalable. Tutors, too, felt unarmed—unsure how to prepare trainees, given the lack of clarity on expectations.

**KT** We took stock of the ground, gathered feedback, sharpened our swords (and minds), and set forth to forge a better path.

**CM** Sounds like a major war in the making. What was the battle strategy?

**AR** The first step was to build a proper training ground. Our trainees needed structured, consistent opportunities to practise MCQs, so that they wouldn't resort to last-minute cramming. And because GDFM trainees juggle clinical work, family, and other commitments, these practice tools had to be flexible, accessible, and embedded within the programme itself.

**KT** Hence we scouted across the land (and internet) to explore available question banks. We assessed each for usability, relevance, feedback quality, and most importantly, how closely they aligned with the FM AKT standards.

**CM** Did you find a worthy ally in your quest?

**KT** Eventually, yes. We subscribed to a commercial question bank for all our trainees, providing a much-needed practice platform. But… it wasn't perfect.

**AR** Many of the questions weren't localised to the Singapore context. Our team worked tirelessly to remove irrelevant questions, but we soon realised this wasn't enough.

**KT** That was the turning point. If we wanted a question bank that truly met our needs, we would have to build one ourselves.

**CM** That sounds like a monumental task. How did you even begin?

**AR** We sounded the battle horn—and were overwhelmed by the response. Passionate tutors came forward like knights riding into battle. Together, we formed a round table: a committed MCQ faculty ready to write, review, and refine high-quality questions tailored to our local Family Medicine landscape. These were eventually consolidated into

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*(continued from Page 13: Behind the GDFM Scenes: Slaying the MCQ Dragon – An Interview with Dr Kenneth Tan and Dr Muhusin Aysha Reema)*

our formative MCQ sets—four carefully curated challenges for our trainees to attempt.

We would like to take this opportunity to honour our amazing MCQ faculty:
- Dr Benjamin Lee
- Dr Felicia Tan
- Dr Leong Choon Kit
- Dr Pushparanee
- Dr Eunice Lim
- Dr Liew Siew Lee
- Dr Choo Kay Wee
- Dr Wu Lin Chieh

KT And here's where it gets even more exciting: we began experimenting with Generative AI to support our efforts. Using carefully crafted prompts and clinical inputs, we generated draft MCQs. But the real magic happened when our faculty meticulously reviewed each question to ensure it met the gold standard—accurate, locally relevant, and true to the spirit of Family Medicine.

It is hard work, but also an invigorating learning journey. We are deeply thankful and blessed to have such a committed team walking this path with us.

CM This has been such an inspiring tale of courage and collaboration. Before we go—any words of wisdom for our knights in training as they prepare for their next quest?

AR Never enter battle alone. Learn with your peers, seek feedback and take heart—you are part of a community that believes in you.

KT And remember, preparation is your best armour. Don't wait until the final hour to wield your sword. Practise regularly, think critically, and enjoy the journey.

And so our journey continues. Stay tuned for the next instalment of "Behind the GDFM Scenes" as we continue to uncover the legends and lore shaping the future of Family Medicine training. Until then—train hard, stay curious, and press on, brave knights!

CM

# Across the Hudson, Towards Healthier SG

## *Leadership Lessons from Mount Sinai*

by Dr Sze Kai Ping, FCFP(S), Dr Hou Minsheng, FCFP(S), Dr Leonard Leng, MMed(FM), Dr Shariffa Syahidah Chishty, GDFM, Dr Habeeb Shakila Banu, GDFM

In March 2025, five Family Physicians from Singapore embarked on a two-week leadership observership at the Mount Sinai Health System (MSHS) in New York City, supported by the College of Family Physicians Singapore and the Starry Night Foundation. Set against the vibrant backdrop of Manhattan, this programme was more than an immersion into a world-class academic health system—it was a reflective journey that challenged our perspectives on leadership, innovation, and the evolving role of primary care. From executive briefings to clinic shadowing, we witnessed how intentional design, data-driven practice, and a culture of excellence can transform care delivery. The following vignettes distil what each of us brought home.

### Reimagining Digital Health, Community Care, and Clinical Development

Dr Sze Kai Ping

I found the Mount Sinai experience both affirming and horizon-expanding. Dr Fernando Carnavali opened the programme with a powerful reminder that redesigning internal medicine begins with tackling inequity, access, and quality—themes that resonated deeply with Singapore's own Healthier SG movement.

One session that stayed with me was by Dr Eric Barna, who challenged us to think about how Artificial Intelligence (AI) can reshape clinical education. His insights spurred critical reflection on how we assess competence and train future-ready family physicians in Singapore. This aligned closely with





Mount Sinai's ongoing work in integrating technology at the point of care, such as their pilot project to deploy Abridge, an AI-enabled transcription tool embedded within Epic that generates structured clinical notes from natural patient-doctor conversations. Seeing Abridge in action during consults was eye-opening: it reduced clinicians' documentation burden, enabled more face-to-face interaction, and even produced visit summaries that patients could review afterward. Such innovations offer a glimpse into what digitally enabled, humanistic care might look like in Singapore's future primary care clinics. If thoughtfully integrated, tools like Abridge could not only enhance documentation efficiency but also restore what matters most: presence, empathy, and trust in the consultation room.

As someone invested in community geriatric care, I found Dr Helen Fernandez's sharing inspiring. Her forward-looking insights into leadership development and system redesign for ageing populations challenged us to think beyond reactive care. She emphasised the importance of sustainable, team-based models that are grounded in equity, interprofessional collaboration, and compassionate design. These are principles that resonate with my hopes for eldercare in Singapore. Her work served as a powerful reminder that effective community geriatric care is about how we deliver care to preserve the dignity, autonomy, and lived experience of older adults.

We also followed the Hospital-at-Home team to witness first-hand how Mount Sinai meets seniors from the point they were in the Emergency department to when they were "warded" at home, connecting them not only geographically but also emotionally and relationally. This reaffirmed my belief that as Singapore's population greys, primary care must lead the way in bridging medical and social needs, and in cultivating systems that age with grace alongside our patients.

Mount Sinai's approach to clinician development was another highlight. The idea that roles are project-based, not just title-bound, offered a refreshing take on how institutions can empower talent. At every level, from medical assistants to hospital leadership, we saw a shared language of purpose to deliver patient experience-focused, data-informed, and team-based care. It reminded me that even in resource-intensive systems, values like equity, compassion, and professional growth can and should remain central.

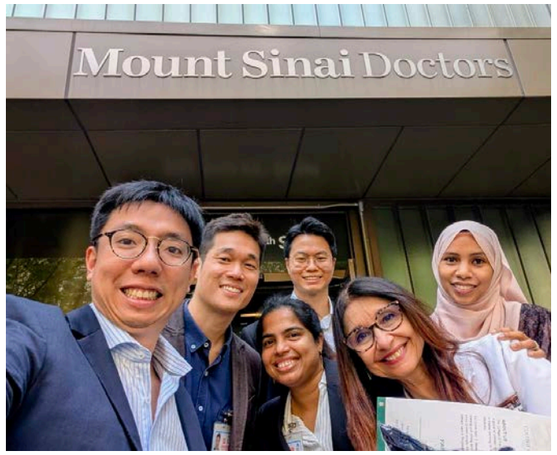
### Data-Driven Care, Compassionate Systems

Dr Hou Minsheng

Our visit to Mount Sinai Health System (MSHS) was a deeply enriching experience, equivalent to a leadership HMDP. I am grateful for the partnership between the Starry Night Foundation (SNF) and our College that made this possible.

MSHS is a leading health system in the US. It comprises seven hospital campuses and over 400 ambulatory practices. The


*Group photo taken with Dr Fernando Carnavali*




*Group photo taken along 85th Street with Dr Aida Vega*

*Thanksgiving dinner at the Harvard Club*

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system employs around 40,000 staff. We were exposed to a broad range of services, toured facilities, and interviewed staff from medical assistants to top leaders. Leaders across all levels spoke the same language. They were passionate about patient-centred, data-driven care. They also aimed to grow reputation and financial sustainability by attracting top talent.

Epic is used across all sites. It integrates billing, documentation, orders, and team communication. MyChart supports patient engagement, while apps like Abridge helps with AI-enabled documentation.

The doctor-patient relationship stood out. Clinics use a concierge-style model. Patients stay in one room, while care teams come to them. Doctors spend 20, sometimes up to 40, minutes per patient. They explain diagnoses clearly, use visuals, and follow up personally via MyChart. Continuity of care is personal and strong. The same doctor often reviews results, communicates next steps, and handles follow-up communication with patients via MyChart. However, this comes with challenges. Doctors face documentation fatigue. Many respond to patient queries outside clinic hours. Notes must be thorough due to medico-legal concerns. That said, doctors have protected admin time and fewer patients per session than we do.

Their culture values staff growth. Roles are project-based, not just job-based. Staff are given timebound opportunities to lead and shine. They also run regular staff surveys and act on the feedback. Mentorship and wellbeing programmes are well in place.

However, there were clear differences. As a specialist-driven health system, primary care forms only 10 percent of the physician workforce. Social prescribing is uncommon. Hospital-centric care is the norm. Financing is insurance-based, complex, and affects care decisions. Patients can access any specialist directly. Market competition is intense and underpins the system's ethos.

I believe this visit affirmed our own strengths. Not every forte in another country will work for us. Our system is more equitable and coordinated. Our focus on population health and capitation gives us a clear advantage. I believe there is great potential in future similar collaborations. Programmes can support national healthcare priorities such as Healthier SG and focus on strengths of the destination such as medical education, quality improvement, and research. Specific service needs, new initiatives, or areas with clear gaps can be pre-identified and aligned between participants and the selected destinations. Programmes can also be modular or locally adapted to reduce disruption and maximise relevance.

My heartfelt appreciation goes to the College and SNF for organising such a well-curated and meaningful programme.


*Dr Arshad Rahim on "Building a Population Health Infrastructure"*

*Dr Andrew Dunn on "Leadership through the Lens of Hospital Medicine"*


*Group photo with Dr David Lam, the friendliest endocrinologist*






*Dr Beth Raucher on Quality Improvement*


*Dr Helen Fernandez sharing her pearls of wisdom on how to develop a geriatric training programme for non-geriatricians*

*Hospital at Home programme with Dr Ania Wajnberg and Dr Trini Truong*

Their commitment to developing healthcare leadership and fostering global learning opportunities for primary care doctors has truly inspired me.

## QI Culture and Leadership Development in Action

Dr Leonard Leng

I am deeply grateful for the opportunity to participate in the recent observership at Mount Sinai Hospital, organised by the College of Family Physicians Singapore. As a Family Physician, the experience was both enriching and inspiring.

What stood out most was the spirit of innovation within the institution. Physicians were encouraged to pursue meaningful quality improvement (QI) projects, which not only enhanced clinical care but also fostered a strong sense of purpose and belonging among staff beyond their day-to-day clinical duties.

The doctor–patient relationship was equally impressive. Doctors consistently took time to listen attentively, communicate effectively, and connect with their patients, exemplifying the power of empathetic, person-centred care. Their communication skills were instrumental in building rapport, educating patients, and encouraging active participation in their own health journey.

It was a privilege to shadow accomplished physicians, including current and former presidents of various specialty societies. Their dedication to clinical excellence and mentorship left a lasting impression. We also had the rare opportunity to observe clinical care in areas that we do not usually get much exposure to in our routine practice, such as obesity medicine and sleep medicine, hence broadening our understanding of how comprehensive care can be delivered in these growing fields.

Beyond clinical insights, I'm thankful for the friendships forged with fellow Family Physicians across different sectors. This experience brought together like-minded individuals passionate about reimagining the future of healthcare in Singapore—something I might not have encountered outside of this unique setting.

## Continuity, Culture, and Human Connection

Dr Shariffa Syahidah Chishty

Experiencing a healthcare system dominated by specialists and tertiary care has reinforced to me the critical importance of Family Physicians as care integrators, orchestrating disparate services for patients navigating complex medical systems. This integrative function represents the heart of Family Medicine's appeal, reminding me why I chose this path. The ability to develop longitudinal relationships with

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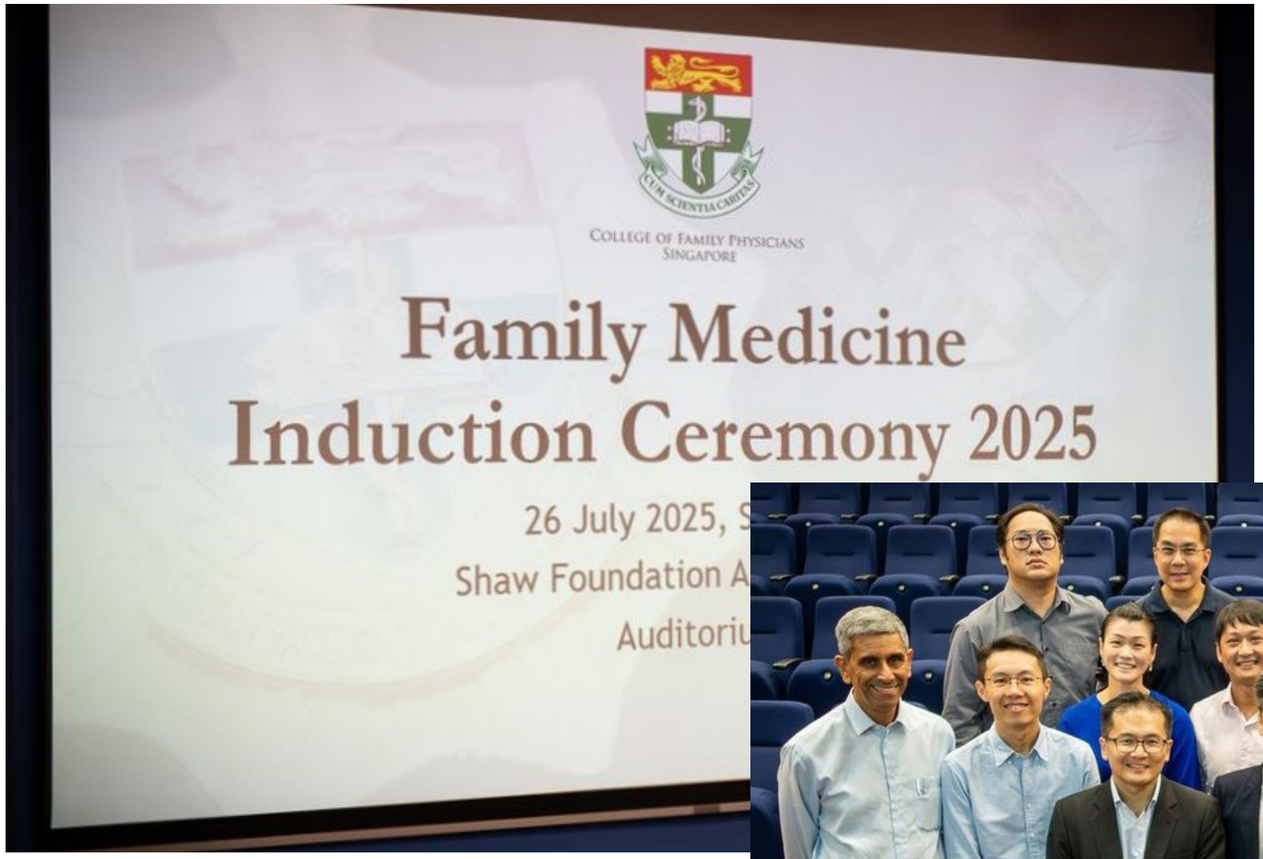
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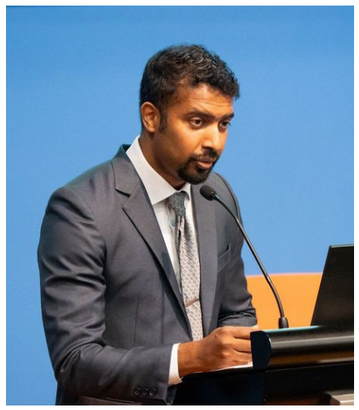
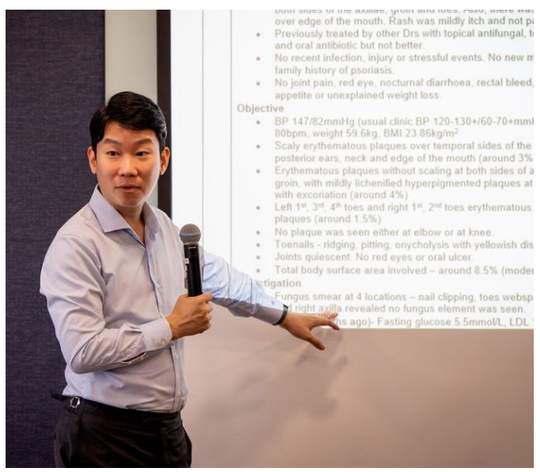



over edge of the mouth. Rash was mildly itch and not pa
Previously treated by other Drs with topical antifungal, t
and oral antibiotic but not better.
No recent infection, injury or stressful events. No new m
family history of psoriasis.
No joint pain, red eye, nocturnal diarrhoea, rectal bleed,
appetite or unexplained weight loss.
Objective
BP 147/82mmHg (usual clinic BP 120-130+/60-70+mml
80bpm, weight 59.6kg, BMI 23.86kg/m2
Scaly erythematous plaques over temporal sides of the
posterior ears, neck and edge of the mouth (around 3%
Erythematous plaques without scaling at both sides of a
groin, with mildly lichenified hyperpigmented plaques at
with excoriation (around 4%)
Left 1st, 3rd, 4th toes and right 1st, 2nd toes erythematous
plaques (around 1.5%)
No plaque was seen either at elbow or at knee.
Toenails - ridging, pitting, onycholysis with yellowish dis
Joints quiescent. No red eyes or oral ulcer.
Total body surface area involved – around 8.5% (moder
tigation
Fungus smear at 4 locations – nail clipping, toes websp
right axilla revealed no fungus element was seen.
s ago)- Fasting glucose 5.5mmol/L, LDL


University of Singapore Society
FOUNDING BENEFACTORS

*(continued from Page 18, 19: Family Medicine Induction Ceremony 2025)*


# ANNOUNCEMENTS

## Upcoming Changes to College MMED (FM) Programme Admission Criteria in 2027

CFPS would like to formally announce the upcoming changes to the admission criteria for the College MMED (FM) Programme as well as the concurrent launch of a new Pre-MMED (FM) 1-year Condensed GDFM Programme in 2027.

From 2027 onwards, admission to CFPS MMED (FM) Programme will be via a valid GDFM Certificate. To encourage other prospective applicants to enter the CFPS MMED (FM) Programme in lieu of the current route of repeating the 2-year GDFM, CFPS will be launching a new Pre-MMED (FM) 1-year Condensed GDFM Programme in 2027. The following applicants will be eligible for this new expedited programme:

(a) GDFM Applicants whose GDFM Certificate have exceeded the 5-years validity period

(b) Applicants with SMC FPAB Category C [i.e. MRCGP (UK), DABFM (USE), FRACGP (Aus), FRNZCGP, FHKCGP]

(c) Former FM Residents who have completed residency and obtained a "pass" grade in AKT or ABFM but did not successfully obtain the MMED (FM) despite maximum attempts at the clinical examinations [i.e. lapse of candidature]

Note:

- Applicant in (a) will be eligible for admission to College MMED (FM) Programme if they successfully pass the AKT during the candidature period of the new programme.
- Applicants in (b) and (c) will also be eligible for conferment of GDFM if they successfully passed the AKT and GDFM clinical examinations during the candidature period of the new programme.

Please watch the recording of the CFPS Academic Roadshow for MMED (FM) College Programme 2026-2027 for more details.

MOH-CFPS WEBINAR

# UNDERSTANDING **MOH CLINIC INSPECTION and** LAUNCH OF CLINIC **RESUSCITATION DRUGS & EQUIPMENT** TRAINING MODULE

All healthcare establishments with a HCSA licence are subject to MOH inspections. Inspections are done to ensure a clinic meets the required licensing standards, covering aspects like protocols and processes governing service provision, physical facilities, drugs, equipment and infection control, waste management, and proper record-keeping. **- This webinar helps doctors understand and better prepare for MOH clinic inspections so as to provide safe care to patients"**

**27 SEPTEMBER 2025**
**SATURDAY** [Via ZOOM]
**2PM to 4PM**

**Program Outline:**

| | |
|---|---|
| 2.00pm to 2.15pm | **Introduction** by Dr Nelson Wee, CFPS Honorary Secretary & **Opening Address** by Dr Wong Tien Hua, CFPS President |
| 2.15pm to 2.45pm: | **Understanding MOH Clinic Inspection Process - How to prepare for Clinic Inspection** [Speaker: MOH Health Regulation Group] |
| 2.45pm to 3.00pm: | **Launch of Clinic Resuscitation Drugs & Equipment Training Module** [Speaker: Dr Suraj Kumar, CFPS Vice-President] |
| 3.00pm to 3.45pm: | **Q&A with Panellist** |
| 3.45pm to 4.00pm: | **Closing Remarks** by A/Prof Raymond Chua, Deputy Director - General of Health (Health Regulation), MOH |

**View the recording here**

**Moderator:** Dr Nelson Wee
**Panellists:** Ms Jahara Ibrahim, Director, [Hospitals, Ambulatory Care & Research Regulations, MOH]
Dr Wong Tien Hua
Dr Suraj Kumar

Organised by: MINISTRY OF HEALTH SINGAPORE

*(continued from Page 17: Across the Hudson, Towards Healthier SG: Leadership Lessons from Mount Sinai*

patients and families, understand health within the context of social determinants, and provide comprehensive care across the lifespan remains a powerful draw to the specialty. As healthcare grows more complex, Family Physicians must transition from being clinicians to leaders, developing strategic thinking capabilities that connect individual patient encounters to broader population health initiatives.

Another key takeaway was the professional culture within the Mount Sinai healthcare system, which offered insights into institutional sustainability. Physicians addressing each other by first names demonstrates the comfortable rapport and camaraderie that facilitates collaboration. More significantly, the pattern of residents staying for decades, often advancing to leadership positions, reveals supportive networks that actively foster career progression and professional development.

This remarkable institutional loyalty generates multiple benefits that extend far beyond individual career advancement. It creates natural mentorship opportunities while preserving crucial organisational knowledge that might otherwise be lost with staff turnover. When successive leadership emerges from within the institution, these leaders possess intimate understanding of both frontline challenges and institutional capabilities, enabling them to deliver community-centred care that addresses patients within their full social context. This institutional memory becomes particularly valuable in preventing the loss of effective practices and hard-won lessons from past initiatives, ensuring that successful innovations are sustained and built upon rather than repeatedly rediscovered.

## A Poetic Reflection: "Across The Ocean, A Lesson Found"

Dr Habeeb Shakila Banu

Across the ocean, in distant light,
We stepped into halls shining white,
Where healing met precision's grace,
And every role had found its place.

From whispered charts to AI's aid,
Each line of code a care cascade,
Epic hummed in silent song,
Where tech and touch both danced along.

Doctors spoke with patient pace,
In every word, a soft embrace,
One room, one soul, no rush, no race –
Just time and care, a healing space.

Yet even stars have weight to bear,
Long notes, late nights, quiet despair.
Still, within this system's spine,
Were hearts that strove, that dared to shine.

Their leaders led with vision clear,
With goals that reached both far and near.
Growth, well-being, feedback heard –
In every voice, a shared, strong word.

But as we learnt and stood in awe,
We saw our strengths, our deeper law:
A system fair, with care aligned,
With health for all, not just designed.

So take this torch across the sea,
Let what we've seen reshape the "we".
Not all we saw will fit our frame,
But still, we grow, and still, we aim.

To SNF and our College dear,
Thank you for this path made clear.
In global steps, we found our part –
Leadership born from an open heart.

Closing Reflections—Carrying the Torch Home

*Grand moments at Grand Central*





*Epic weekend getaway to the Bear Mountain*

*Taking a moment at Central Park to appreciate the beauty around Mount Sinai*

Standing in Mount Sinai's glass corridors, we were reminded that even the most sophisticated systems succeed only when relationships remain at their core. From AI-enabled note-taking that hands time back to the bedside to concierge-style clinics that let care teams revolve around the patient, our two-week observership showed how design, data, and compassion can be woven into a single fabric of service.

Yet the trip also sharpened our appreciation of Singapore's own strengths: an equitable, population-health orientation and the bold mandate of Healthier SG. The lesson is clear that progress is not a matter of transplanting foreign blueprints but of translating them into our context, guided by the values of Family Medicine.

As we return to the clinic, classroom, and community, we carry three commitments:

- "Lead with purpose" by cultivating project-based roles that let every team member shine.
- "Leverage technology humanely" by letting tools lift burdens so that presence, empathy, and trust can flourish.
- "Learn without borders" by keeping global partnerships alive, because sharing stories across oceans expands possibilities at home.

We hope that our Mt Sinai experience will ignite fresh conversations about how Family Physicians can re-imagine primary care for the decade ahead. The journey continues and the next chapter is ours to write.

CM

*Strengthening international ties: Dr Wong Tien Hua (CFPS President) with Dr Tao Xu, Medical Director of Mt Sinai International*

# Honouring Our Teachers in Ethics and Primary Care

## *Reflections from the Chairperson*

by Dr Kong Jingwen, Senior Consultant Family Physician

This year's ethics webinar on 12 July 2025,"Caring When Capacity Wanes: Ethical and Practical Challenges in Primary Care", holds a special place in my heart—not just for its content, but for the people who brought it to life. As we celebrate Teacher's Day, I am reminded that the very fabric of medical professionalism is woven by the mentors who have guided us, the peers who walk beside us, and the juniors we now have the privilege to teach.

The panel of speakers this year was particularly meaningful to me, spanning three generations of educators and learners. A/Prof Thiru, who currently tutors me in my Master's programme in Medical Law and Ethics, exemplifies the enduring role of mentorship. Drs Suraj, Eng Soo Kiang, and Farhad were my tutors during my MMed days, shaping the clinician I am today. Gabriel, my peer in the Graduate Diploma in Palliative Medicine, brought fresh perspectives rooted in compassion. And it was deeply rewarding to witness Andrew and Junjie—once my fellowship trainees—now speaking with clarity and conviction as future leaders of our profession.

In a first for our MME teaching, we incorporated an original video scenario into the session. This clip depicts a challenging yet familiar situation in primary care, illustrating how professionalism and communication remain at the heart of strong doctor-patient relationships. The use of multimedia allowed us to connect with participants in a vivid, relatable way—especially crucial in navigating ethical complexities involving mental capacity in the elderly.

This session was not assembled overnight. It was the result of months of collaboration, critical reflection, and multiple iterations of slide decks—each refined with care and insight by our speakers and panellists. Our shared goal was clear: to deliver a high-quality, context-relevant ethics session, thoughtfully crafted for our primary care colleagues.

As we continue to nurture the next generation of Family Physicians, may we never forget the teachers who taught us not only medicine but also the values that underpin our practice.

## *A Fireside Chat About the Webinar*

by Dr Yee Wenjun Gabriel Gerard, Consultant, Department of Care and Health Integration, CGH [GY]; Dr Andrew Wong Peng Yong [AW] and Dr Joshua Aw Junjie [JJ], Consultants, Department of Family Medicine and Continuing Care, SGH; Dr Kong Jingwen [JW], Senior Consultant, NHG Health Polyclinics; Dr Gabriel Gonzales [GG], Resident Physician, NHG Health Polyclinics; Dr Farhad Vasanwala [FV], Senior Consultant Family Physician, IMH.

**GY** I'm sure our readers are keen to hear about our experiences preparing our video, which we will share first, after which we will share our respective experiences prepping for our case scenario presentations!

**JW** On a bright and sunny afternoon on 12 July 2025, more than 750 GPs and FPs gathered under the auspices of the College of Family Physicians. What we didn't know was that this was planned three months in the making!

**GY** Yes! And four bright sunny afternoons prior, shooting for a video that demonstrated mental capacity assessment and negotiation together with immediate video editing had been done!

**FV** Yes, I came dressed as a doctor who had to review the elderly gentleman who wanted to die whole from a small foot abscess because he had a poor understanding of his condition which he mistakenly compared to his cousin brother. The art of counselling and negotiating was demonstrated with the gentleman based on ethical principles, enabling a good outcome 🙂

**GY** You don't need to dress for that, Dr Farhad! 🙂

**FV** As Family Physicians, we must dress and behave professionally! 🙂

**JJ** To fit in the character of a son who works as a blue-collar worker, I came dressed in a singlet to act as a very concerned son! (Plus, it was a very hot afternoon haha)

**GY** And everyone asked me on my Instagram story what happened with my foot! (see Figure 1)

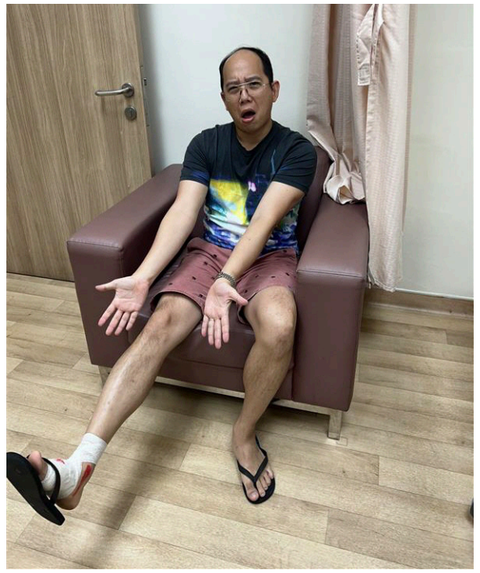


*Figure 1: Dr Gabriel acting as a bald old man with a convincing (we think) foot abscess with some cellulitis, with the red marker ink drawn on the dorsum of the foot representing blood oozing through the wound.*

**JW** I guess all that remains is to show the viewers the happy pictures of our acting! (see Figure 2)

*Figure 2: The cast and crew of "Help me die whole, doctor"—featuring (from left) old man Dr Gabriel Yee, young son Dr Joshua Aw, director Dr Gabriel Gonzales, sound manager Dr Kong Jingwen, and Dr Farhad Vasanwala playing himself.*

**GY** And Jingwen's sound bites and microphone carrying! But on behalf of our cast, I want to say that none of this would have been possible without the amazing directing skills of Dr Gabriel Gonzales! Dr Gabriel, could you please share with our readers about the directing experience? How was it like preparing to direct our (ever changing) script?

**GG** The initial draft of the script was very touching. I wanted to make sure the final version of the film adequately captured those emotions. I highlighted key scenes to emphasise moments of connection and vulnerability. A lot of credit goes to Dr Farhad and Dr Gabriel Yee for an amazing script.

**GY** I remembered we all aligned to change some portions of the script on the fly to best capture the emotions. How was it for you as both director and camera man?

**GG** As a team working together, we allowed room for spontaneity. At the same time, I made sure we didn't lose focus or coherence, as the heart of the piece was more important than sticking rigidly to the script. Kudos to our wonderful actors Dr Farhad, Dr Gabriel Yee, and Dr Joshua for their heart-rending performances. I also have to thank our sound director Dr Jingwen for his invaluable help.

**GY** And as the camera man, how did you capture the facial emotions whilst keeping your directing lens (pun intended) on?

**GG** Capturing human emotions, especially in the context of patient empathy, was both humbling and deeply moving. It reminded me of the power of storytelling: how just a glance, a pause, or a line delivered with quiet intensity can say more than pages of dialogue. I needed to treat those emotions with respect, knowing how our colleagues from the College could see themselves in this story. It was one of the most rewarding parts of the process.

**GY** I'm sure our readers are wondering: how did you learn your amazing video editing and film production skills?

**GG** I learnt production and editing skills through self-teaching and a lot of hands-on experience. I didn't have formal training, but I was driven by curiosity and a strong desire to tell meaningful stories. I started by filming short stories for our Polyclinic. This progressed to videos for Patient Safety and Infection Control for Dinner and Dance performances. Over time I started to understand not just the technical aspects but also how to capture the essence of a story and bring it to life.

**GY** Thank you, Gabriel! Dr Farhad, turning to you as an actor! How was having to adapt to an evolving script on the fly, when we noted some areas for improvement in our original script?

*(continued next page)*

(continued from Page 25: Honouring Our Teachers in Ethics and Primary Care: Reflections from the Chairperson

FV GY was apprehensive in going to the hospital; we explored whether it was money, pain, or risk of amputation as part of Jonsen's 4-box approach to GY's preferences and Quality of Life domains. GY wanted to die whole and was adamant in not having any major surgical procedures. We noted gaps in the original scenario as we were rehearsing for the scene on exploring why GY did not want to go to the hospital, hence we brainstormed and eventually achieved a convincing script 🙂 With that iteration, we addressed his ideas, concerns, expectations, and biopsychosocial issues, establishing a win-win situation for him to agree to go to the hospital.

GY We now move to our other case scenario presented by Dr Andrew Wong. Andrew, what were some of your takeaways from the experience?

AW Although I was unable to participate in the enjoyment of the video production as I was away on overseas training, I was able to witness the impact of a well-made video on teaching ethics and communications and our excellent teamwork in tackling an onslaught of questions from the floor. Great job, fellow MME comrades!

Furthermore, I had the privilege of presenting an ethical case of a young person who requested her doctor not to inform her parents of her acute stress reaction, predisposed by academic stressors. Through preparing this case, I learnt much from esteemed seniors such as FV, SK, and Prof Thiru. This includes improving medical pedagogy (e.g., fine-tuning a case around learning objectives), revising the importance of fitting facts into analytical boxes (i.e. Jonsen's 4-box approach) to arrive at a reasonable action plan, and having a clear understanding of the local statutes on consent-taking in minors.

In all, it was an afternoon well spent, harvesting lots beyond just the two MME points! It's more than what I wished for.

GY Drs Farhad and Junjie, what were your takeaways from working on Andrew's case?

FV Mental issues among the young are increasingly common and well published in Singapore by the medical profession, people, policymakers, and press. The 4Ps as espoused by Prof Goh Lee Gan of making important policy issues in the forefront, which is increasingly being done for mental health by Family Physicians. As doctors, we must have the armamentarium of knowledge as discussed above by Dr Andrew of what to do if a child arrives in mental distress, when we can treat and respect confidentiality, what are the red flags and ethical issues to look out for and consider, when to involve our community partners, psychologists, psychiatrist colleagues, etc for urgent advice and management. Dr Andrew's scenario and subsequent discussion during the MME elaborated on these important issues.

JJ Honouring an adolescent's privacy can strengthen therapeutic rapport and alliance, which is the foundation of Family Physicians' relationships with our patients. The tricky part in balancing this with the adolescent's safety and well-being is well explored by Dr Andrew. I am glad for the stage set up by the College to explore these ethical issues in-depth as we see an engaged audience extrapolating these principles to other pertinent issues involving adolescents' health such as vaping, sexual health, and protecting minors from sexual exploitation.

## *An Afterword by our Teachers*

by Dr Yee Wenjun Gabriel Gerard, Consultant, Department of Care and Health Integration, CGH [GY]; Prof T Thirumoorthy [TT], founding director of Centre for Medical Ethics and Professionalism; Dr Suraj Kumar [SK], Vice President, College of Family Physicians Singapore; Dr Eng Soo Kiang [ES], Consultant Family Physician.

GY Dear esteemed tutors, could we get your wise afterwords for our audience?

ES While mindful of the law, FM practitioners' focus is on providing optimal therapeutic support to families with ethical challenges. That will usually align with the Singapore Court's approach of therapeutic justice.

TT In developing our expertise in the domain of clinical ethics, several activities are essential, namely: Reading/Writing; Learning/Teaching; Practice/Doing; Reflecting/Introspecting. All these essential activities were appropriately covered in developing this MME Webinar. Kudos to the team.

SK The College has tried its best to deliver high quality MME events these past 1.5 years that are both thought-provoking and relevant to the primary care context. I must commend the faculty for their excellent work as they continue to find innovative ways in enhancing medical education. Well done!






*Figure 3: It's a wrap! All smiles from presenters and panelists*

CM

# FAMILY PRACTICE SKILLS COURSES

## Ageing with Vitality

The College of Family Physicians Singapore would like to thank the Expert Panel for their contribution to the Family Practice Skills Course #128 on "Ageing with Vitality", held on 28 June 2025.

**Expert Panel:**
Dr Asok Kurup
Adj Assoc Prof See Kay Choong
Dr Goh Tze Chien, Kelvin

**Chairperson:**
Dr Asok Kurup

# CME WEBINAR

## Vaccination Across the Lifespan: Strategies for Protecting Children and Adults from Infectious Diseases

The College of Family Physicians Singapore would like to thank the Expert Panel for their contribution to the CME webinar on "Vaccination Across the Lifespan: Strategies for Protecting Children and Adults from Infectious Diseases", held on 30 August 2025.

**Expert Panel:**
Dr Lee Le Ye
Dr Chong Wei Liang

**Chairperson:**
Dr Roger Teo

# MOCking Our Fellowship Philosophy Ethics and Leadership Fears Through Mock Examinations

by Drs Gabriel Yee [GY], Kong Jing Wen [JW], Rose Fok [RF], Dr Siau Kairong [KR], Chua Yingxian [YX], Wong Weimon [WM], Xu Bangyu [BY], Consultant Family Physicians; Dr Nelson Wee [NW], Fellowship Class Rep of 2023—25; and Mr Joel Woo [CM], Assistant Manager, College of Family Physicians Singapore

## Introduction by Dr Gabriel Yee

It was a dark and stormy day on 16 June 2025, unlike the bright and sunny days of our Medical Ethics webinars. This, however, did not dampen the spirits of our Fellowship trainees and tutors who gathered at Ang Mo Kio Polyclinic from all corners of the island for the final Philosophy, Ethics, and Leadership (PEL) tutorial for the academic year. Despite the busy schedules of all, a mock examination was organised comprising six stations, with each trainee experiencing each station at least once, as the hot seat candidate. The candidate got to experience a timed station of 20 minutes where they had to read and answer a professionalism/ethics question and leadership question exactly as they would in their summative examinations. Immediate and personalised feedback was also provided by the tutors, and post-session a debrief was conducted by the tutors on common areas for improvement that we had noticed.

It was a positive experience that both the teachers and learners benefited from, though don't just take my word —look at the smiles on the faces in Figure 1, and see the following interview with them after this!

None of these would have been possible without significant coordination efforts by the tutors, Fellowship class (and their class rep), and most importantly our College administrators who were the silent heroes—booking the venue, emailing the instructions to the candidates, and arranging for a pre-brief to them. See Figure 2 for some of the coordination poll efforts!


*Figure 1: Happy teachers and learners MOCking their PEL fears*





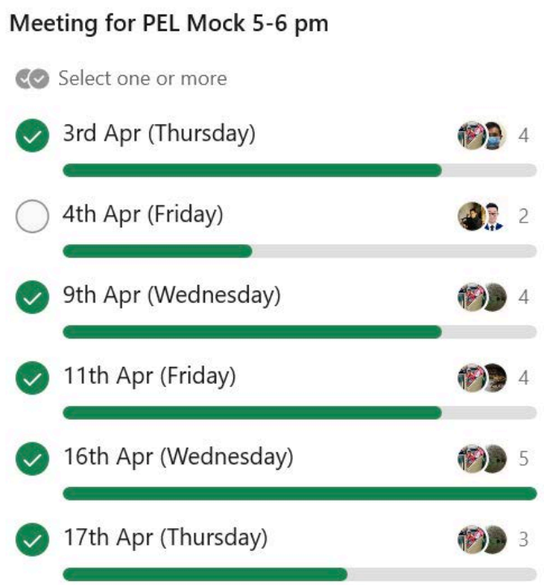



*Figure 2: WhatsApp polls to align Fellowship tutors' time to plan the examination—Thanks to our administrators Joel, Chester, and Bizhen for their coordination!*

## *An interview with our teachers and learners*

**GY** Jingwen, it's finally over! We finished the mock again. It feels like yesterday when we co-conceptualised the mock sessions back in 2022!

**JW** Yes, Gabriel, and as Family Medicine continues to evolve as a specialty in Singapore, the importance of ethical grounding, reflective leadership, and clarity in philosophical reasoning has never been more critical. With this in mind, we are proud to present this year's Philosophy, Ethics, and Leadership (PEL) Mock Exam—a collaborative effort designed to support and stretch the minds of our exiting FCFP(S) trainees as they prepare for their exit viva. This session was thoughtfully curated by our dedicated PEL faculty—Dr Gabriel Yee, Dr Rose Fok, Dr Siau Kai Rong, and myself—and further enriched by the perspectives of esteemed invited faculty members. We were privileged to be joined by A/Prof Xu Bangyu (FCFP(S) Gold Medalist), Dr Wong Wei Mon (Chairman, Chapter of Family Medicine Physicians, Academy of Medicine, Singapore), and Dr Chua Ying Xian (currently pursuing a Masters in Healthcare Ethics and Law), each bringing a unique lens to the discussions. Their presence underscored our belief in intergenerational and interprofessional learning, and the importance of discourse grounded in both practice and principle.

Our candidates engaged deeply in challenging yet meaningful conversations across a range of contemporary and complex themes: from the professional identity of the Family Medicine Specialist, to the ethical dimensions of telehealth, genetic testing, and end-of-life care. These discussions were not simply academic exercises—they were reflections of the real-world tensions, responsibilities, and values that shape our daily work as Family Physicians.

We hope that this mock exam not only sharpens the candidates' readiness for the upcoming viva, but also inspires them to lead with wisdom, courage, and compassion as they step into the next chapter of their professional journey. Wishing all candidates the very best in their exams—and beyond!

**GY** Yes, a lot of planning was, is, and will be increasingly needed! Here I would like to mention Joel, our CFPS staff who oversees Fellowship matters. I'm very appreciative of his and his team's efforts, coordinating the polls, planning the stations with Dr Jingwen, etc. A gargantuan effort indeed, and starting early and proactively always works! Over to our tutors. Rose, what made you join up with the PEL faculty?

**RF** I feel that ethics is very important for the Family Physician, especially in the outpatient setting. When we make an inappropriate decision and the patient leaves the clinic, we often do not have the opportunity to provide counsel again. This differs from the inpatient setting where we can still return to the patient's bed to recheck and revise our management. Thus the impetus to train the next generation to be competent in ethical decision-making.

**GY** And Kairong, it is nice to see you back as a tutor! What made you come back?

**KR** It's nice to be back in a different capacity this time. I returned as a tutor because I believe in paying it forward. Having recently gone through the Fellowship exams myself, I understand how valuable realistic practice and targeted feedback can be. These mock sessions are a great platform to help current trainees experience the pressure and pacing of the real exam. It's also an opportunity for me to share practical tips, whether it's on approaching tricky questions, time management, or handling challenging topics.

*(continued next page)*

*(continued from Page 29: MOCking Our Fellowship Philosophy Ethics and Leadership Fears Through Mock Examinations*

GY A virtuous circle indeed 🙂 I'm back too, on the PEL faculty, as Dr Wong Wei Mon was my fellowship tutor. Wei Mon, what do you think Fellowship candidates, as future leaders of FM, need to develop (not just for their exams) in the PEL domain?

WM Ah Gabriel, the circle turns 🙂 and how lovely to be journeying together again.

In the apprenticeship of Family Medicine, we do not merely pass down knowledge—we pass down presence. Not just what to do, but how to be.

What do Fellowship candidates need to grow in the PEL domain? I'd say: the inner architecture of leadership. Not just the skills to pass, but the character to persevere, the clarity to navigate complexity, and the humility to collaborate in uncertainty.

Beyond the mock and beyond the exams, the true ascent begins—towards the next pinnacle of FM as a systems thinker, healer, and guide.

They are called not just to manage disease, but to shape care ecosystems, to bridge hospitals and homes, to tend to both the system and the soul.
In this Healthier SG landscape, they are architects of value, weavers of the invisible threads between policy and personhood, between suffering and the hope of wholeness.

"Ars longa, vita brevis."
The art is long, life is short.
But what we shape in our apprentices ripples far beyond our time.

Perhaps that is our real task: Not just to produce better doctors, but to awaken wiser, more whole human beings—who will carry the torch of Family Medicine forward, steady hands and kind hearts in an ever-evolving world.

And we walk with them—still learning, always becoming.

GY Thanks, Wei Mon, for the wisdom that I continue to be a beneficiary of! On to Dr Xu Bangyu, our FCFP Programme Director. Bangyu, do you have any wise words for our Fellowship trainees for their PEL in their upcoming exams?

BY This FCFP journey is the reflection of your growth, insight, and maturity as a Consultant Family Physician. It captures the essence of what we do: practising medicine with thoughtfulness, humility, and a deep sense of responsibility to our patients and communities. I look forward to seeing all of you at the finish line, and more so, your subsequent contributions to Family Medicine in Singapore!

GY Last, but definitely not least, as learners are our most important stakeholder as teachers, is Dr Nelson Wee, the class representative of this Fellowship batch. Hi, Nelson, now that it's all over, how was the mock PEL experience?

NW Why don't we include some example quotes of their experience? The learner's verbatim feedback, after all, is what we value as educators!

GY Haha yes, we did share some of these principles in the medical pedagogy modules!

NW Yes, kindly see Table 1 for example quotations from our learners.

**Table 1: Learner feedback for the PEL mock session**

"Initially it was rather nerve-wrecking, especially when I opened the door and saw that my mock examiner was the much feared Dr Xu Bangyu! But I really value face-to-face training, especially in the era of Zoom training. Honestly, I learnt a lot from my peers and the tutors, and I am so grateful for the efforts put in by the faculty in setting up this tutorial. Double thumbs up from me!"
– Dr Nelson Wee, Healthway Medical

"Practical. Personal. Powerful.
This wasn't just a mock—it was a mindset shift. One session in, and I walked away sharper, clearer, and more confident for the real deal."
– Dr Benjamin Lee, Ang Mo Kio Polyclinic

GY And it's a wrap! A teachers'-learners' interview where actually the teachers learnt as much (if not more than) as the learners, as we had to prep the questions and push the entire class up towards content mastery. We look forward to the next exciting instalment of MOCKing our PEL fears in the coming year 🙂 See you all (tutors and hopefully some of our learners who become tutors) there!

CM





# RLOing Over the Post-COVID EBM Fog

## *A Cross-Causeway ASPIRation*

by Dr Gabriel Yee, FCFP(S), Consultant, Changi General Hospital, Department of Family Medicine; and Associate Professor Lee Yew Kong, PhD, Department of Primary Care Medicine, University of Malaya

GY GY: Hi Yew Kong! It's really nice meeting you again here on the sidelines of APPCRC running a workshop on how we innovated Evidence-Based Medicine (EBM) training in Primary Care through regional collaboration on Reusable Learning Objects (RLOs)! (See Figure 1) It's been such a (cross-causeway) journey to get here, literally and figuratively!

*Figure 1: The happy Singaporean and Malaysian teams and participants*

YK YK: Yes, it's been more than a year since we last caught up! But how about we go back to the beginning for the readers?

GY GY: Oh yes. It was a hot summer day on 21 Sep 2022 and Prof Adina graciously hosted us at UM! There our senior leaders recognised key areas for educational collaboration in the years ahead, especially in the area of Evidence-Based Medicine, which had become an emerging gap area ruthlessly diagnosed (with all the diagnostic studies needing interpretation!) by incessant COVID waves.

*Figure 2: Our first cross-border meetup after COVID on 21 Sep 2022. SingHealth FM ACP leaders were graciously hosted by UM's Primary Care Department*

YK I remember that meeting well. You guys did a whirlwind tour of four universities in three days (see Figure 2). After that trip in 2022, Prof Ng Chirk Jenn (SHP) and Prof Lee Ping Yein (UM) mooted the idea of developing EBM training materials that could be shared and used across both countries.

Once they had gotten the funding, we held the KL brainstorming meeting (see Figure 3) on 11 Mar 2024 at UM to decide on the topics and how to run the storyboarding workshop in Singapore taking place just two weeks later. It was a flurry of EBMs (Extra Busy Messaging) to get everything ready on time!

*Figure 3: KL Brainstorming on key gaps in EBM teaching, 11 Mar 2024*

GY So I guess the next step was to build the stories around the gaps that we had analysed and aligned with our extra busy messages?

YK Yes indeed! It was important that the storyboards were feasible for production. The faculty worked hard (see Figure 4) alongside the learners to make sure each storyboard was populated with content that could be transformed into usable RLOs. I think the Zombie Plants idea for trial bias almost didn't make it in! It is probably one of my favourites though and I'm glad we stuck with that one.

Developing storyboards into RLOs in Malaysia was quite straightforward after that as we had experienced staff from previous RLO development projects.

*(continued next page)*

*(continued from Page 31: RLOing Over the Post-COVID EBM fog – A Cross-Causeway ASPIRation*

GY Haha yes, I liked my zombie plants and herbs! And I know the learners did too! Which makes a key point—we are continuing to evaluate the success of our project by gathering ongoing learner feedback from our residents, GPs, and even faculty on both sides of the causeway.

YK Yes, and not to forget, how we sustained and spread the experience—with our first cross-causeway workshop (look back to Figure 1).

GY & YK For those with aspirations to create tailored, scalable, reusable learning objects, feel free to adopt the ASPIRE framework on the right. We look forward to more cross-border aspirations coming true in various educational and operational realms!

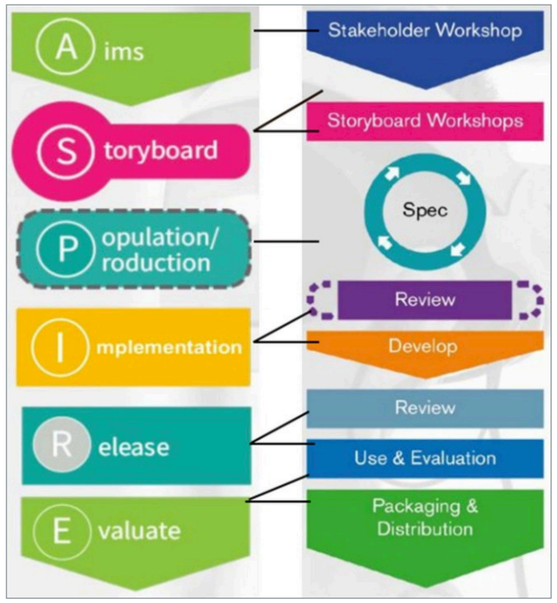



*Figure 5: The ASPIRE framework. Reference: Lim HM, Ng CJ, Wharrad H, et al. (2022) Knowledge transfer of eLearning objects: Lessons learned from an intercontinental capacity building project. PLoS ONE 17(9): e0274771. https://doi.org/10.1371/journal.pone.0274771*


*Figure 4: Storyboarding as we ASPIRE-d to plug gaps in EBM, 24–27 Mar 2024*

CM

# HealthierSG Equals Healthier Dr

by Dr Fei Loh, General Practitioner

Unfortunately, not all doctors are fitness enthusiasts. Indeed, some are rather broad, just like the broad section of the community. In a way, I prefer to consider us as pleasantly plump persons who are strong supporters of our local eateries and other food establishments. But this can be a bit of a problem, since I am a General Practitioner in the heartlands and living rather near to my clinic. This effectively means that my food choices are clearly visible to the few patients who roam the area.

Sometimes, going out for a yummy bowl of Laksa, or healthy food like fried chicken or burgers in the neighbourhood, can seem like a naughty endeavour. A sudden "Hi Dr Fei!" can lead to some interesting silence. On turning my head, my gaze would meet that patient's, which usually conveys how impressed they are by the glorious amount of food on my tray. Things left unsaid are less awkward than words actually uttered, stating facts about the amount of food I'm about to process. Despite the embarrassment, I sometimes wonder if food enthusiasts have better mental health than strict health enthusiasts. If so, then perhaps eating much might fit nicely under HappierSG.

Then came HealthierSG (HSG). Not to say I have not been counselling patients about eating right and exercising more. It's just that HSG encourages us to do this more routinely and in a more structured and detailed way. When chronic care or HSG patients arrive, we would need to check their BMI and talk about diet and exercise, among other items. We are fortunate to have the still manageable digital checklists, as provided by the electronic medical records (EMR) vendor as a platform to conduct detailed conversations.

During the typical workday, when a chronic care HSG patient comes in, I would launch into his or her reason for encounter, which could be any combination of Diabetes, Hypertension, Hyperlipidaemia, etc. Then, as demanded by HSG, we would proceed to take the patient's height and weight and calculate their BMI.

At times, the BMI numbers might lead us to utter words along the lines of "Wow! You are overweight!" With the elephant in the room out of the way, the door is open for two obese elephants in the (consultation) room to discuss the benefits and methodology of weight loss. If these patients were kind, they might react with silence, and the all-knowing glance of "Actually doctor, you are also overweight!" If they were not so kind, then I would have to react and respond that I have also started to exercise and watch my diet. Words that would make my guardian angel suddenly scratch his head like an itchy monkey.

> *"I sometimes tell my patients that I feel as though I am talking to myself when I advise and counsel them, especially on the topic of healthy eating and exercise."*

But repetition and patients' silences do have inherent magic. I sometimes tell my patients that I feel as though I am talking to myself when I advise and counsel them, especially on the topic of healthy eating and exercise. That is why the template within the electronic medical records is so useful, as we just rattle off the checklist on less sugar, less oil, less salt, and the targets for exercise. Repeating these advice multiple times? Well, I am sure one day it will sink into my consciousness and shape a new behaviour. After all, everyone goes through the various stages of change, and the doctor, being human, is no different.

Through HSG-style repetition, I believe that we can self-hypnotise ourselves on the essentials of being healthy, and one day, drive real and sustained change. I hope these words of praise will not morph into a thousand clicks on our EMR. And, when the enticing call comes to strongly support our local eateries and food establishments, we always have that few HealthierSG patients lurking round the corner, ready to call out "Hi Dr Fei!"

CM



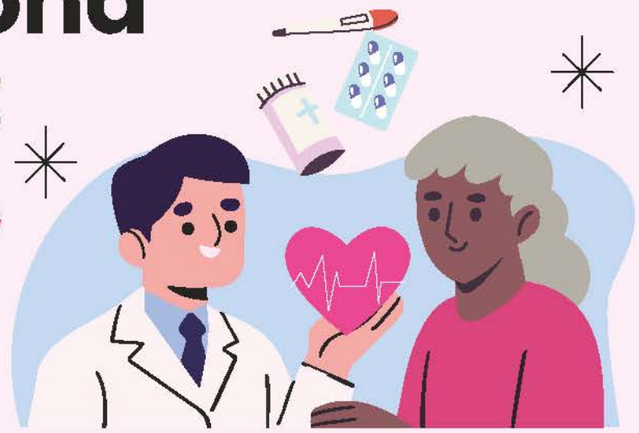


# Stay tuned for the revamped CFPS website, launching at the end of 2025!

# Caring Beyond Medication:

## How GPs can Prescribe Connection for a Healthier SG

**by the Agency for Integrated Care (AIC)**



When a woman in her 40s came into Dr Leong Choon Kit's clinic with persistent headaches, he found more than just high blood pressure. She was the family's sole breadwinner, supporting her two children and husband who just lost his job.

Over the years, Dr Leong connected the family to care, employment and education. Today, they are thriving and still visit his clinic.

This story illustrates how general practitioners (GPs) are transforming care through social prescribing: connecting patients with community resources to support their overall well-being. For many patients, especially seniors, these connections are as essential as medication.

### Social Prescribing: A Return to the Roots of Family Medicine

For Dr Leong, Clinical Lead of Class Primary Care Network (PCN), social prescribing is not new. It is a return to fundamentals.

"The World Health Organisation has long defined health as more than the absence of disease. It includes mental, social, even spiritual well-being," he explains.

"Short of public health, family medicine is best placed for social prescribing. We know people not just as patients, but as people."

This ethos aligns with the Ministry of Health's six principles of family medicine: continuity, comprehensiveness, coordination, holistic care, ambulatory care and community orientation. These principles come to life through social prescribing.

### Listening Deeply, Acting Intentionally

Some signs which suggest that a patient needs support are not medical, but social. Sub Lead of United PCN, Dr Clare Tay shares that she watches for reluctance to discuss home life or vague answers about support systems.

"I try to ask a bit more during consultations. Over time, trust builds," Dr Tay says.

She recalls referring an elderly woman who was living alone, to an Active Ageing Centre (AAC). Initially, the woman turned away help.

"The team persisted and eventually, she joined. Later, she said, 'Now I know I'm not alone.' That change was powerful."

### Tools that Make it Work

Healthier SG GPs are not expected to do this without support. AIC has developed tools and platforms to support social prescribing such as the recently launched BRIGHT (Bridging Referral Information to Guide Healthcare Transitions), which builds upon this foundation and consolidates referrals into a single form, streamlining the process for GPs and PCNs.

Dr Leong shares, "At PCN HQ, the PCN care team help pre-fill and manage submissions to reduce admin burden." The team also helps to close the loop with GPs and inform them on whether patients have received the prescribed services.

Dr Tay also points to the utility of tools like SupportGoWhere, which allow GPs and patients to locate nearby services.

"I show patients how to use it. Many prefer to walk in themselves rather than be formally referred. It empowers them."

> "It starts with asking more, listening better and being a bit of a busybody. Controlled blood pressure does not necessarily mean "healthy" if the person is isolated or struggling silently. If we only focus on sickness, we are missing 90% of the picture."

**Dr Leong Choon Kit**
**Clinical Lead of Class PCN**

### Getting Started: One Patient at a Time

Dr Tay and Dr Leong acknowledge that social prescribing can feel daunting, especially in busy clinics.

"Don't try to do it for every patient," says Dr Tay. "I usually pick one or two a shift to go a bit deeper with."

She recommends starting with the annual Healthier SG Health Plan. "It is a natural time to ask about lifestyle, support systems, or coping. That is when things surface."

Dr Leong recognises the realities holding some GPs back: time, finances and uncertainty.

"But the Healthier SG framework changes that. It legitimises what used to feel like personal missions. Now we have tools, support, even Key Performance Indicators. That gives doctors permission to act."

Still, he cautions against losing heart. "Structure alone is not enough. If we approach this only with calculation, social prescribing becomes a tick-box exercise. But if we act where our heart leads, the system will support us."

### The Heart of Care

For both GPs, the most meaningful rewards lie in watching patients rediscover dignity, build relationships and regain a sense of purpose.

"You don't need praise," says Dr Leong. "You just know you've changed someone's life and sometimes, the life of their whole family. That's enough."

"The system is finally giving us the room to care differently," he adds. "Let's use that room and step forward. Because we can, and because it matters."

> "Sometimes, with a full waiting room and many patients to see, it's easy to fall into a pattern of just solving the immediate medical issue and moving on. But that's not always enough. We need to ask: is there something in this patient's life that's contributing to their condition? Is there a reason they're struggling with their medications? These questions are central to social prescribing."

**Dr Clare Tay**
**Sub Lead of United PCN**

## Social Prescribing in Action: A Patient's Journey with i-CARE PCN

**Profile of patient, Mr Lee:**

- 69-year-old retiree
- Has Type 2 Diabetes, Hypertension and Dyslipidaemia
- Enrolled in Healthier SG through his i-CARE PCN clinic
- Referred for nurse counselling due to a BMI above 27
- Joined a structured 6-month lifestyle intervention

**Coordinated Support by PCN team:**

- i-CARE Primary Care Coordinator (PCC) handled referrals, scheduling, app setup and facilitated a WhatsApp group for meal tracking
- Nurse counsellor provided tailored advice, monitored progress and followed up as needed

**Patient's Perspective:**

- More confident in managing his diet and daily habits
- Began tracking steps using the Healthy 365 app and logs meals daily via WhatsApp
- Improved energy levels
- Lost nearly 5kg and improved his HbA1c reading

**Clinician's View:**

"Mr Lee is a motivated patient who has benefited significantly from nurse counselling. The weight loss contributed to better control of his diabetes," said his attending GP.

**Ms Karrilee Goh**
**PCC of i-CARE PCN**

## How to Start Social Prescribing in Your Clinic

Feeling unsure? Start small. Here's how:

- **Choose 1–2 patients** per shift to engage on a deeper level.
- **Use the Healthier SG Health Plan** review as a prompt.
- **Ask about home life**, support networks, daily routines.
- **Consult your PCN HQ** for workflow and admin support.
- **Refer through BRIGHT** or suggest services via SupportGoWhere.

SupportGowhere

Family Practice Skills Course (FPSC#129) (2-Day)

# Basic Obesity Management Accreditation 5

Sat, 11 October 2025: 2.00pm - 5.30pm
Sun, 12 October 2025: 2.00pm - 5.00pm

This FPSC will be conducted on the online platform "ZOOM".
A Zoom registration link will be sent to participants who have registered.

DAY 1 TOPICS
- Understanding Obesity: How and Why?
- Approach to the Patient with Obesity
- The Psychology in Obesity
- Dietary Interventions for Weight Loss
- Intensifying Treatment: Bariatric Surgical Interventions
- Approach to Childhood and Adolescent Obesity

DAY 2 TOPICS
- Obesity & Cancer: What is the Relevance?
- The Cardiovascular System in Obesity
- Pharmacotherapy in Obesity Management: The conventional, the novel and the pipelines

WORKSHOPS

Case studies

SPEAKERS

| | | |
|---|---|---|
| Dr Tham Kwang Wei | Dr Kim Guowei | Ms Pauline Xie |
| Dr Benjamin Lam | Dr Elaine Chew | Dr Lee Phong Ching |
| Dr Lee Yingshan | Dr Natalie Koh | Dr Suraj Kumar |
| Mr Adrian Toh | Ms Jessica Ong | Dr Leong Choon Kit |
| Dr Donna Tan | Dr Dawn Chong | |

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

■ SEMINARS (2 Core FM CME points)
DAY 1 • Sat, 11 Oct (2.00pm - 4.00pm)
DAY 2 • Sun, 12 Oct (2.00pm - 4.00pm)

■ WORKSHOPS (1 Core FM CME point)
DAY 1 • Sat, 11 Oct (4.00pm - 5.30pm)
DAY 2 • Sun, 12 Oct (4.00pm - 5.00pm)

*Registration is on first-come-first-served basis.
Please register by 8 October 2025 to avoid disappointment.

■ DISTANCE LEARNING MODULE
(6 Core FM CME points upon attaining a minimum pass grade of 60% in online MCQ Assessment)
• Read 8 Units of study materials in The Singapore Family Physician journal and pass the online MCQ Assessment.

This Family Practice Skills Course is sponsored by **Novo Nordisk Pharma Singapore Pte Ltd** and organised by **College of Family Physicians Singapore and Singapore Association for the Study of Obesity.** (For avoidance of doubt, Novo Nordisk shall have no direct influence over the contents of the topics discussed / presentation materials.)

novo nordisk® ASO Singapore Association for the Study of Obesity

COLLEGE OF FAMILY PHYSICIANS SINGAPORE

## REGISTRATION

Basic Obesity Management Accreditation 5

FREE registration for College Members,
Limited FREE registration for non-College member (first come, first serve basis)

Please tick ( ✓ ) the appropriate boxes

| | College Member | Non-Member |
|---|---|---|
| Seminar 1 (Sat) | FREE | ☐ $32.70 |
| Workshop 1 (Sat) | FREE | ☐ $32.70 |
| Seminar 2 (Sun) | FREE | ☐ $32.70 |
| Workshop 2 (Sun) | FREE | ☐ $32.70 |
| Distance Learning (MCQs Assessment) | FREE | ☐ $87.20 |

*All prices stated are inclusive of 9% GST. GST Registration Number: M90367025C*

☐ I attach a cheque for payment of the above, made payable to: **College of Family Physicians Singapore** *

Cheque number: _____

**We also accept payment via PayNow**
PayNow UEN: **S71SS0039J**, key in your MCR No. and Name under the UEN/Bill Reference No.

*Registration is confirmed only upon receipt of payment.
The College will not entertain any request for refund due to cancellation after the registration is closed OR after official receipt is issued (whichever is earlier).

### Online Registration Available

Scan the QR code or access the link below to register online

http://www.cognitoforms.com/CFPS/FPSC129

Name: Dr _____

MCR No: _____ Clinic HCI Code: _____

Mailing Address: (Please indicate: ○ Residential ○ Practice Address)

_____

E-mail: _____ Tel: _____

Note: Any changes to the course details will be announced via e-mail. Kindly check your inbox before attending the course. Thank you.

Please mail the completed form and cheque payment to:
**College of Family Physicians Singapore**
16 College Road #01-02, College of Medicine Building, Singapore 169854

You may send your completed form to: **sfp@cfps.org.sg**
**Successful applicants will be confirmed by email.**

College of Family Physicians Singapore
Registration Number : S71SS0039J
Registration Period : 7 Aug 2023 to 6 Aug 2029

# Family Practice Skills Course #130 (1 Day)

## COVID-19 and Respiratory Virus Vaccination Strategies for Family Physicians, 2025 Update

Sat, 18 October 2025: 2.00pm - 5.30pm

Please note that this FPSC will be conducted on the online platform "ZOOM". A Zoom registration link will be sent to participants who have registered.

**TOPICS**

**Unit 1: Vaccine-Preventable Respiratory Diseases: A Case for Ongoing Vigilance in Primary Care**
**Unit 2: Fundamentals of mRNA**
**Unit 3: Confidence Through Connection: Supporting Confident Vaccine Choices in Primary Care**

**WORKSHOP**

**Case Studies Disscusion**

**SPEAKERS**

Dr Ian Wee
*Consultant, Infectious Disease,*
*Singapore General Hospital*

Dr Leong Hoe Nam
*Infectious Disease Specialist,*
*Mount Elizabeth Novena Hospital, Singapore*

Dr Kenneth Tan
Family Physician, Kenneth Tan Medicial Clinic

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

- SEMINAR (2 Core FM CME points)
  DAY 1 • Unit 1 - 3: Sat, 18 Oct (2.00pm - 4.00pm)
- WORKSHOP (1 Core FM CME point)
  DAY 1 • Sat, 18 Oct (4.30pm - 5.30pm)

*Registration is on first-come-first-served basis.
Please register by 15 Oct 2025 to avoid disappointment.

- DISTANCE LEARNING MODULE
  (3 Core FM CME points upon attaining a minimum pass grade of 60% in online MCQ Assessment)
  • Read 3 Units of study materials in The Singapore Family Physician journal and pass the online MCQ Assessment.

This Family Practice Skills Course is sponsored by **Moderna Singapore,** organised by **College of Family Physicians Singapore.**

moderna

COLLEGE OF FAMILY PHYSICIANS SINGAPORE

# REGISTRATION

**FREE REGISTRATION for College Members!**

Please tick ( ✓ ) the appropriate boxes

| | College Member | Non-Member |
|---|---|---|
| Seminar 1 (Sat) | FREE | ☐ $32.70 |
| Workshop 1 (Sat) | FREE | ☐ $32.70 |
| Distance Learning (MCQs Assessment) | FREE | ☐ $87.20 |
| | TOTAL | |

*All prices stated are inclusive of 9% GST with effect from 1 January 2024.*
*GST Registration Number: M90367025C*

☐ I attach a cheque for payment of the above, made payable to: **College of Family Physicians Singapore** *

Cheque number: _____

**We also accept payment via PayNow**
PayNow UEN: **S71SS0039J**, key in your MCR No. and Name under the UEN/Bill Reference No.

*Registration is confirmed only upon receipt of payment.
The College will not entertain any request for refund due to cancellation after the registration is closed OR after official receipt is issued (whichever is earlier).

## Online Registration Available

Scan the QR code or access the link below to register online.

https://www.cognitoforms.com/CFPS/FPSC130

Name: Dr _____

MCR No: _____ Clinic HCI Code: _____

Mailing Address: (Please indicate: ○ Residential ○ Practice Address)

_____

E-mail: _____ Tel: _____

Note: Please ensure that this is the email account you would check regularly. All course information will be sent to the email address provided.

Please mail the completed form and cheque payment to:
**College of Family Physicians Singapore**
16 College Road #01-02, College of Medicine Building, Singapore 169854

You may send your completed form to: **sfp@cfps.org.sg**
**Successful applicants will be confirmed by email.**

College of Family Physicians Singapore
Registration Number : S71SS0039J
Registration Period : 7 Aug 2023 to 6 Aug 2029