College of Family Physicians Singapore

The Singapore Family Physician

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Contents

CELEBRATING THIRTY YEARS

A/Prof Cheong Pak Yean

In this commemorative issue to celebrate thirty years of the Singapore College we chronicle activities and developments in the areas of training, research and practice. Each of these areas may be regarded as the College's ongoing academic challenges.

In training, the challenge of the College is to work towards leveling up the family physician. Primary care doctors need to work towards the capability of providing care that is more than care of episodic, acute, self-limiting conditions. This high volume, low value work must be transformed into high value and lower volume work of continuing care, integrated disease management with the hospitals, and care of the elderly. In this way, the specialist outpatient clinic workload can be reduced and a better distribution of work to the whole health care system can be achieved.

We have now in place programmes for each of the three phases of the training of the doctor, namely, clinical attachment for the medical undergraduate, vocational training and continuing medical education for the graduate doctor. The vocational training programmes lead to the diploma, masters and fellowship by assessment. The College is a member of the SMC CME Committee and has the responsibility for delivering a CME programme for family physicians. A cyclical modular CME programme based on the 8 modules of the family medicine training programme has been drawn up. The Annual Scientific Conference is another of the College's CME Initiatives. We look forward to each family physician taking an active part in participating in these programmes.

From the standpoint of research, the College has in the past embarked on sporadic research activities. The time has come for the College to consolidate these sporadic efforts into a systematic primary care research programme. Plans are underway to embark on collaborative research efforts with primary care doctors in private and public sectors as research partners.

In practice, there are many innovations that can make primary care more effective. The Ministry of Health is working on integrated disease management programmes both within the polyclinics and also vertically between hospitals and the primary care sector. Such policy changes provide the family physicians opportunities for greater participation in health care delivery. Family Physicians must also re-tool themselves and their practices to better cater for continuing care especially that of the elderly. A more effective and workable heatlhcare financing system must evolve to support this. Neither the fee-for-service contract system nor managed care as it is practiced in the private sector in Singapore is adequate.

Primary Care is affordable now because of public subsidy for the 20% of patients seen in the polyclinics and the predominantly acute episodic care provided by General Practitioners for the other 80%. Means must therefore be introduced

to ensure that the 80% of care provided by GPs is not just affordable but responsive to the national challenge of implementing disease management and providing high quality care to the elderly.

College members in this year's Annual General Meeting in June unanimously adopted resolutions to look into setting up an independent Department of Family Medicine in a University in Singapore and a Family Medicine Foundation in the near future. An independent Department will provide the due emphasis on Family Medicine education. After all, half of all doctors will be family physicians. A Family Medicine Foundation that is founded partly by private and partly by public funding will serve to develop Family Medicine at a surer pace than hitherto to also benefit the majority of doctors in the private primary care sector.

The raison d'être that spurred the founding fathers to set up the College 30 years ago has not changed. To improve the health of our people, family physicians must play their part. Training is still the foundation. Funding and seamless delivery structure can then kick in to actuate it.

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THE TRAINING OF THE FAMILY PHYSICIAN

A/Prof Cheong Pak Yean

There are several questions that need to be revisited in the training and development of the Family Physician. The answers to these questions are important in our perception of Family Medicine (FM) training.

IS MBBS TRAINING ENOUGH?

The training received by medical students towards the MBBS is not enough for a doctor to practise FM at a level of expertise expected of primary care doctors in Singapore today. The mistaken perception that MBBS training is enough may be syllogistic – that since MBBS training is basic medical training for doctors and primary medical care deals with basic medical problems, therefore MBBS training must be adequate training for primary medical care.

With the introduction of Family Medicine into the undergraduate curriculum, some of the core concepts of FM are now taught in our medical schools such as the Principles & Practice of family medicine (P&P) and Consultation & Counseling skills (C&C) in family practice. However, as medical students lack clinical and contextual experience, undergraduate FM teaching can only provide a framework on which postgraduate vocational training can build on.

The Director of Medical Services (DMS), Professor Tan Chorh Chuan reiterated in the opening of the FM Year on 23 June 2001 that "The GP of today therefore has to realise that his professional education does not and cannot come to an end with graduation. Further training in Family Medicine is necessary as part of an overall strategy to continually improve the quality and standard of primary care physicians in Singapore"

IS FAMILY MEDICINE TRAINING SO UNIQUE?

FM is a distinct medical discipline with its own construct, world-view, doctrines and content. The presenting problems encountered by family physicians (FPs) are often an amalgam of physical, social and psychological problems, unlike the predominantly physical problems encountered by their specialists colleagues.

On top of this, primary care practice is an applied discipline that utilises the core clinical skills across a multitude of medical specialties. Some specialists therefore may mistakenly believe that FM is but an aggregate of the simpler parts of various specialist disciplines – and all that is required in FM training is for a slew of such specialists to each teach the primary care doctors the simple things in their disparate disciplines. This will not be enough because the context of practice has not been considered.

It is therefore important that FPs continue to work with specialists who understand the FPs' paradigm to develop training activities that empower the FP to deliver better care and to actively look for red-flags that mandate timely specialist referrals. More senior and experienced FPs have the responsibility of co-developing such CME that give enough emphasis on relevance and context. The FPs are the

experts of their terrain and must therefore take the active role in content development. Such organic collaboration has resulted in effective training programmes being produced.

IS AD-HOC CME EFFECTIVE?

The College has now structured post-graduate training from diploma, masters to fellowship level. Professor Tan Chorh Chuan's in his address on the 23 June 2001 said, "The Ministry fully recognises the value of FM training and in this respect, we would like more of our medical officers to obtain some form of FM training before they leave the public sector to become GPs. We realise that it is not possible for every MO who is not a specialist trainee to be given a Family Medicine traineeship to sit for the Master of Medicine in Family Medicine. However, MOH would like to encourage more public sector MOs to take up the Graduate Diploma course in Family Medicine (GDFM) while they are serving out their bonds".

The College has also launched the modular CME initiative around the themes of the quarterly FMTP modular courses. The educational sandwich of learning experience provided by updates (knowledge), patient-based workshops (cognitive skills) and skills courses (psycho-motor skills) would benefit those enrolled in the diploma and masters programmes as well as other practising FP. The College believes that such organised events should form the core CME for FPs.

OF VALLEYS, PLATEAU AND PEAKS

Specialists need to hone their knowledge and skills only in the confines of their chosen discipline. They need to worry about valleys formed by erosion through time only across a small terrain. They have the opportunities of constantly practising across the vertical extent of their discipline. FPs being generalists, have a daunting task of ensuring competency across many disciplines. They need to continually fill the proverbial valleys that form over time. Scaling peaks cannot therefore be their preoccupation. They should ensure that they know the wide practice terrain that they must constantly traverse, fill the valleys always instead of being side-tracked into peaks which should be the pre-occupation of specialists. They must achieve a high standard of primary care by consolidating high plateaus of skills and relevant knowledge.

The Graduate Family Medicine Centre that was set up in 1994 to train private FPs for the Master of Medicine examination therefore has as its motto, " Cover valleys always, consolidate plateau often, scale peaks sometimes". These dicta must be remembered in the training of the Family Physician.

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THIRTY YEARS ON

Dr Matthew Ng

The College was founded thirty years ago. In these three decades, the College has done much. Much however remains to be done in the development of excellence in Family Medicine as it progresses into its fourth decade.

In the First decade (1971-1980), the focus was on continuing medical education and the Diplomate Examination of the College. The lunch time CME talks became a staple. Dr Lim Kim Leong has more to tell about the CME activities. In 1972, the College Diplomate Examination was started. This examination leads to the Diploma of the College of General Practitioners, Singapore. This is an additional registrable qualification with the Singapore Medical Council.

As Dr Wong Heck Sing has alluded in his narration of the early years of the Singapore College, the experiences learnt by the Singapore College from the Joint Colleges Conferences spearheaded by the Australian College during this decade was to prove invaluable in the next decade.

The second decade (1981-1990) was marked several important milestones. The first milestone in that decade was the College hosted the 10th Wonca world conference in Singapore in 1983. It was then the largest conference ever held in Singapore.

The second milestone in the second decade was Family Medicine was introduced into the National University of Singapore Undergraduate Medical Curriculum in 1987. The Department of Social Medicine and Public Health (SMPH) was given the responsibility to teach the subject as an academic discipline. To reflect this change, the Department changed its name to the Department of Community, Occupation and Family Medicine (COFM).

The third milestone in the second decade was the commencement of the vocational training programme in Family Medicine. The training of family doctors has been a top priority of the Singapore College since its inception. From the initial years of CME programme and the diplomate examinations of the first decade, the College moved into a formalized structured Family Medicine vocational traineeship programme and the Master of Medicine in Family Medicine (MMed(FM)) Examination. The vocational training programme was initiated as a tripartite effort of the Ministry of Health, the National University of Singapore and the Singapore College. The pilot vocational training programme begun in 1988. This became the definitive MOH stream of the MMed(FM) traineeship programme in 1991.

The third decade of the College which takes us to the present, saw consolidation of the vocational training programme in Family Medicine, the inception of the MMed(FM) examination as an university degree, and the commencement of Fellowship by Assessment training.

The first MMed(FM) Examination was held in 1993. Since then, seven more examinations have been held. There are now 140 doctors with the MMed(FM) qualification. In 1999, the Fellowship by Assessment commenced. In the next year, the Graduate Diploma in Family Medicine was introduced. The College now has in place training programmes leading to the award of the following Postgraduate Degrees: Graduate Diploma in Family Medicine, Graduate Diploma in Basic Ultrasonography, Master Medicine (Family Medicine), Fellowship by Assessment (FCFPS)

This year the College celebrates its 30th Birthday. As it moves into the commencement of the fourth decade, the visible developmental tasks are in training, practice and research.

There is an ongoing need for the development of the Family Doctor to meet the needs of Singaporeans in the coming years. Training and practice emphasis will be on: continuity care and shared care; step down care for the elderly; and disease Management of common chronic illness. Over the years, learning and teaching of family medicine has become more innovative. Straight lectures have been replaced by self directed distance learning. Face-to-face workshops have taken the place of lectures. Skill courses are in demand. These cover not only psychomotor skills but also cognitive skills and communication skills. The College's training mission is to work with institutions to organise clinical workshops and skill courses to meet the needs of the future Family Physicians in the provision of higher value health care services.

Research in Family Medicine will also be a major academic activity in the coming decade. In this the College will work conjointly with the Ministry of Health and the National University of Singapore as it has done so in the past.

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FROM COUNTERCULTURE TO INTEGRATION: THE FAMILY MEDICINE STORY

A/Prof Goh Lee Gan

I am indeed honoured to be invited to deliver the 17th Sreenivasan Oration perpetuating the memory of Dr Baratham Ramaswamy Sreenivasan. He was the founder President of the College of General Practitioners, Singapore in 1971.

A TRIBUTE TO DR BR SREENIVASAN

I do not have the privilege to know Dr BR Sreenivasan but I do know his son Dr Gopal Baratham who is a neuro-surgeon. Dr Wong Heck Sing who was closely associated with him had this to say of him when he gave the First Sreenivasan Oration: "When Baratham Ramaswamy Sreenivasan was invited to be the first President of the College he said the founding of the College was a great step forward in the medical development of our country. He spoke with the wisdom of one who had devoted over forty years of his life to medicine, fifteen years of which was in hospital practice and the rest in private general practice. He shared the concern that the concentration of medical development in hospital medicine and its specialties with little being done in the field of general practice would not lead to a higher standard of health care for the nation as a whole. He recognised the initiative taken by the founders of the College as the first step that would lead to the establishment and recognition of general practice as a separate discipline." Indeed he was a man of great foresight and gave unstinted support to the College.

GOH LEE GAN, MBBS(Sing), MMed(IM), FCFPS, FRCGP
Past Censor-in-Chief, College of Family Physicians, Singapore (1991-1999)

CHOICE OF A TOPIC

In a paper in the Journal called *Family Medicine*, Dr JE Scherger[1], a University don in Family Medicine in California wrote in 1997 of the three phases that family medicine has gone through in time namely, counterculture in the 1970s, parity (or seeking acceptance as equals with the hospital specialist world) in the 1980s, and integration in the 1990s and beyond. I thought this is a good way to remember the march of events in the development and growth of family medicine worldwide.

I chose to tell this march of events as a story for this Oration because the Singapore College has a thirty-year history of being part of the worldwide Family Medicine movement and also because I had some part to play in the Singapore movement. Hence my title of "From Counterculture to Integration: The Family Medicine Story".

I have divided this Oration into three parts and a conclusion. The three parts are Family medicine as a worldwide movement; the Singapore movement; and where do we go from here.

FAMILY MEDICINE AS A WORLDWIDE MOVEMENT

The phase of counterculture

As a worldwide movement, family medicine had its prelude in the growing disenchantment of general practitioners and their patients with the fragmentation of care and impersonal care brought about by subspecialisation and growth of high technology.

There was clearly a need for a group of doctors to sound the warning of too much of fragmentation as well as to address the consequences of this phenomenon. The GPs on both sides of the Atlantic spearheaded the movement.

In 1947, the American Academy of General Practice was formed and in 1952, the British College of General Practitioners was formed. Another English speaking country that was to play an influential role in Asia-Pacific including Singapore had its College established in 1958. This was Australia.

The 1970s was also a period of social economic difficulty in many of the developing countries and WHO led the movement of Health for All By Year 2000 through primary health care.

In 1972, the world body of family medicine, Wonca was formed with 18 country members. Singapore was one of the early members. The Wonca Secretariat was in Australia and remained so until January this year when it moved to Singapore. Dr Alfred Loh is now the CEO, succeeding the immediate past CEO, Prof Wesley Earl Fabb who has all these years been a strong supporter of the Singapore College.

The family medicine counterculture[2] was particularly strong in America and the general practitioner community worked towards a new general practice and even changed the name of the discipline from "general practice" to "family medicine" to reflect a renaissance in its culture.

The central values of this counterculture to hospital specialist medicine are:

- Patient centred care and attention to the doctor-patient relationship,
- Holistic approach to the patient and his problems that recognizes contributions to ill-health and well-being come from not only physical disease but also from social and psychological dimensions in the patient as well as from the family and his community
- Greater emphasis need to be given to preventive medicine because this has greater impact than curative medicine
- The family doctor looks after health problems that may be initially unclear in terms of seriousness
- The family doctor looks after people across the whole spectrum of age groups
- The family doctor is willing to look after the patient not only in the consulting room but also in the home and other settings as well.

Parity

From the phase of counterculture which was quite successful because of people support and socio-economic circumstances, the champions of family medicine or general practice were able to establish family medicine as an academic subject in their medical schools.

Integration

From the phases of counterculture and parity, family medicine moved into the 1990s. Here, the prevailing mood was for integration of clinical activities. The judgment call was whether family departments would want to integrate with hospital based disciplines like paediatrics, general internal medicine and even geriatrics. The danger was for departments of family medicine to be left behind if they choose to stand alone.

THE SINGAPORE MOVEMENT

Counterculture

Singapore, like the developing countries in the Asia-Pacific region, and the developed countries around the world, too received the family medicine message. The desire to set up a College of General Practitioners to develop standards of care in general practice was strong. This was set up in 1971.

Singapore is not exempt to the side effects of subspecialisation and this subject was expressed in more than one Sreenivasan Oration, namely in the Oration given by Dr Wong Heck Sing (1978), Dr Victor Fernandez (1983), and Dr Lee Suan Yew (1995).

Parity

The specialist image in Singapore remains overpowering to GPs and patients. The introduction of family medicine into the undergraduate curriculum in the National University since 1987 and the setting up of Master of Medicine (Family Medicine) programme since 1990 probably has improved the understanding and image of family physicians.

Integration

Integration of health care activities and providers is now the focus of health care reform in Singapore. The formation of a 2-cluster system health care, the concepts of seamless care, disease management, stepped down care, and shifting the center of gravity to the GPs are steps in this direction. We would need to look into sustaining health care needs of not only the present but in the future as well.

WHERE DO WE GO FROM HERE

Let us look at integration, parity, and counterculture in that order.

Integration

The importance of integration has been alluded to. Family medicine has the role of integrating in the mind of every doctor, a balance between specialization and generalist approach in the care of patients. The organ subspecialist need to see how his expertise fits into the total well-being of the patient.

Specifically, we need to work on the following in our integrating efforts:

- Good preventive care – Preventive care must take the forefront of our care – the old adage of "prevention is better than cure" will always remain true.
- Good acute care – Acute care is where we really need to integrate knowledge, skill and experience and to share it with one another on how to do things right the first time. It is not always easy and takes a lifetime to perfect
- Good chronic disease care management – attention to these will surely reduce the burden of disease on the sufferers
- Good stepped down care – this is increasingly important with the rising cost of acute hospital care and the increasing numbers of the elderly who take a longer time to recover from their medical illnesses
- Good elderly care – the care of the elderly is the best example of the need for integrated care both vertically and horizontally. Care of these people cannot be good without adopting the paradigm of integrating the efforts of carers for a common purpose. And we have some 27% of such patients come 2030
- Good domiciliary care — this is a very much underserved area of care. It will grow in importance as an area of need as more and more people live to a ripe old age
- Good palliative care – This will include not only terminal care but also the care that can extend and enrich those with cancer who cannot be cured. Hope still springs eternal when one day we may be able to slow down the destructive effects of cancers and give the sufferers more life and longer life. The idea of controlling cancer just like the control diabetes mellitus may not be such a far-

fetched idea. And good palliative care goes beyond cancers. It is also needed to slow down the progression of end organ disease states.

Parity

Parity is the family physician being accepted as equal to the organ specialist in the eyes of the four Ps – profession, people, policy makers and the press. The journey to parity is the process of levelling up. To enable our GPs to do so, the College has in collaboration with the University and Ministry of Health develop family medicine programmes that span undergraduate to postgraduate levels. The GP community have enjoyed the support of our many specialist colleagues in training our GPs in the past and we are appreciative of their national service role.

Counterculture

Is there a place for family medicine as counterculture into the future? The answer is yes. Family medicine as an academic discipline has the role to remind every doctor that there is a need for a balance between the subspecialist and the generalist perspective. Family medicine cannot abdicate this role.

TAKE HOME MESSAGES

There are three take home message from this Oration:

- Integration between generalist and specialist care is a must to develop a cost effective and meaningful health care delivery system. The desire to do so must pervade the minds and values of every medical practitioner, whether subspecialist or not.
- Family physicians need to level up to meet the healthcare needs of today and tomorrow, in particular in the seven areas of care: preventive care, acute care, chronic disease management, stepped down care, elderly care, domiciliary care, and palliative care
- Family medicine as an academic discipline has the role of teaching and reinforcing the paradigm that the patient is an individual, has a family and background, and is a member of the community and that he is more than a bag of organs and structures but has feelings too. A holistic approach to his needs is therefore needed.

ACKNOWLEDGEMENT

I would like to take this opportunity to thank my many colleagues, both in Singapore and overseas; and my students too who have help me clarify the importance of a holistic approach to medicine and participate in the teaching programmes. I would in particular like to record my thanks to my mentor, Dr Lim Kim Leong. I come from a specialist background and it was Kim Leong who showed me the importance of a bigger world view to people with medical problems. To one and all, my thanks.

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THE COLLEGE MILESTONES – FROM 1971 TO 2001

1971, March 18
The First Council of the College was formed and presided by the late Dr B. R. Sreenivasan. The College was housed at the old Alumni Medical Centre at 4-A College Road.

1971, June 30
The College of General Practitioners Singapore was officially inaugurated.

1972, November 5
The first examination for diplomate membership, the M.C.G.P., was held. This was the first post-graduate examination for family medicine to be conducted in Singapore.

1973, March 1
The first issue of 'The G.P.' was published. This was the journal of the College. The name of the publication was changed to 'The Singapore Family Physician' in 1975.

1974, July 1
Dr Benjamin A. Sheares, the late President of Singapore became the Patron of the College. The M.C.G.P. was recognised by the Singapore Medical Council as a registrable post-graduate medical qualification.

1978
The Sreenivasan Oration was established to perpetuate the memory of the founder President and his contribution to the College.

1983, May 20
The College hosted the Tenth Wonca World Conference on family medicine in Singapore.

1985, December 9
A memorandum was submitted by the College to the Ministry of Health proposing a vocational training programme for doctors intending to pursue a career in family medicine.

1987, February 13
Family medicine was recognised as a distinct academic discipline in medicine after much persistence and hard work by College members. The Department of Community, Occupational and Family Medicine was formed in the National University of Singapore. The Undergraduate Teaching Committee of the College would work closely with the Department in the teaching of family medicine in the University.

1987, August 15
The College premise was moved to the College of Medicine Building. It was officially opened by the former Minister of Health, Mr Howe Yoon Chong.

1987, October 19
The Post-graduate Medical Library which was jointly set up with the Academy of Medicine was officially opened.

1988, November 12
The First Annual Scientific Conference and Meditech Exhibition was organised by the College.

1988
The Steering Committee on Family Medicine Training was formed. This was a tripartite body comprising the College, the Ministry of Health and the Department of Community, Occupational and Family Medicine.

1991, February
A Memorandum proposing the institution of a masters degree in family medicine was submitted to the School of Postgraduate Medical Studies by the Steering Committee on Family Medicine Training.

1992, November 26
A memorandum proposing an advanced training programme for family medicine was submitted to the Singapore Medical Council and the School of Postgraduate Medical Studies.

1992
The 15th and final M.C.G.P. examination and conferment was held.

1993
The College was appointed by the Singapore Medical Council to administer the Singapore Medical Council-Continuing Medical Education Programme.

1993, July 12
The first Master of Medicine (Family Medicine) examination was held.

1993, November 17
The name of the College of General Practitioners Singapore was officially changed to 'College of Family Physicians Singapore'.

1995
A 2-year Private Practitioner Stream (PPS) leading to the Masters of Medicine (Family Medicine) was inaugurated.

1998
The First batch of College Fellowship by Assessment was started. There were eight participants. All completed the programme in 2000.

1998
A postgraduate FM training centre was officially open – The Graduate Family Medicine Centre which was used for the PPS training since 1995.

1999
The College Internet Project was launched.

2000
The first intake of 48 doctors in the Graduate Diploma in Family Medicine commenced in July 2000.

2001
The world and Asian-pacific office of Wonca is sited in the College. The College also won the bid to host the World Congress in 2007.

2001, June 23
The First Launch of the Family Medicine Year for the Diploma, Masters and Fellowship programmes were held. The ceremony also included the inception of two new programmes – the FM Fellowship Programme in Aged Care and the Structured Modular CME.

FOUNDING OF THE COLLEGE

Dr Wong Heck Sing

The early founders of the College headed by Dr Wong Heck Sing, Chairman of the Pro-tem Committee for the formation of the Singapore College of General Practitioners, wrote a letter to Lord Hunt, then President of the Royal College of General Practitioners, to help Singapore to form its College of General Practitioners. Dr Wong was told to seek help from the Australian College. Accordingly, Dr Wong went to Sydney Australia, where the Australian College's headquarters was situated, to seek help. There he met a Dr Richard Geeves, a general practitioner who had just sat for the MRACGP examinations. Dr Geeves introduced Dr Wong to the members of the Council of the Royal Australian College of General Practitioners where he met the President, Dr Harvard Merrington and his Council. Dr Wong subsequently met the Founder President of the Australian College, Dr William O Connally.

The assistance given by the Australian College proved invaluable. They told us what pitfalls to avoid. For instance, they advised Dr Wong not to grant automatic diplomate memberships to founding members unless they had passed the diplomate examinations to prevent complications and favouritism. They learnt this from other countries which practised this form of membership. Besides the advice, the Australian College also helped in the setting up of questions for our diplomate membership examinations. Not only that, they sent two of their Australian College examiners to help the Singapore College in its College diplomate examinations. They also offered to recognize our diplomate examination as equivalent to their College membership examination, and to grant automatic MRACGP to all our successful candidates. As a result of these academic links, the Singapore Medical Council with the help of Dr Ho Guan Lim accepted the MCGP as an additional qualification.

All in all, the Singapore College owed a great debt to their Australian counterpart. The Singapore College would not have made such progress without the help so generously given by the Australian College.

The College had its roots in the Society of General Practice in the 1960s. Later the Society changed its name to the Society of Private Practice to include specialists in private practice. Among the pioneers of the Society of General Practice were Dr O C Leow, the late Dr William Heng, the late Dr C G Foo, the late Colin Marcus and later, the late Dr G Haridas.

In a talk to the Singapore Medical Association about the meetings Dr Wong had with the Australian College, the Association nominated Dr Wong Heck Sing to study the formation of the Singapore College of General Practitioners along the lines of the UK College or the Australian College. At a subsequent meeting of the Council of the Society of Private Practice, the Society's Council nominated Dr Wong Heck Sing as Chairman of the Pro-tem Committee for the formation of the College of General Practitioners, Singapore. The committee members were Drs C K Foo as Hon. Secretary, Chen Chi Nan, O C Leow, E K Koh, Colin Marcus and Chee Phui Hung as members. The committee studied various constitutions of existing Colleges and adopted a constitution to suit our needs.

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Past President, College of Family Physicians, Singapore
(1973-1977; 1983-5)

INVITATION TO DR B.R. SREENIVASAN

As the Singapore College was a newly formed body, nobody had heard of it, let alone know about it. Council decided to invite a well-known doctor to be the College first President. The name on everybody's mind was Dr B R Sreenivasan, the first Vice-Chancellor of the University of Malaya in Singapore. The Council through its Pro-tem Chairman, immediately wrote to Dr Sreenivasan, and he accepted the Presidency without hesitation. Dr Sreenivasan served the College well. Unfortunately ill health prevented Dr Sreenivasan serving longer than two terms.

JOINT COLLEGES CONFERENCE

Following the formation of the Singapore College it was proposed that a Joint Colleges Conference be held in Singapore. Malaysia had not formed its College of General Practitioners yet, but it too wanted to be involved in the Conference. Finally the Conference was called "the First Joint Colleges Conference of the Australian College of General Practitioners, the Malaysian College and the Singapore College". The Conference was to be organized by the Singapore College and held in Singapore in 1975. The Conference was meant to be opened by Dr Sreenivasan but he was too unwell to do it. The Conference was a success due in no small measure to the fact that the Australian College sent a large contingent of over 200 members to the meeting.

The Second Joint Colleges Conference, organized by the Australian College was held in Sydney. Only the Singapore College participated in the Conference. They sent a delegation of about 40 delegates to the meeting. Malaysia did not send any. They had internal problems about their College formation and foreign currency restrictions. These Joint Conferences exposed the Singapore College to overseas conferences and enabled it to play a significant role in subsequent Wonca meetings.

COLLEGE CME

Dr Lim Kim Leong and A/Prof Goh Lee Gan

The College of Family Physicians, Singapore (formerly known as The College of General Practitioners, Singapore) was officially registered on 30th June 1971. This came about two years after a committee was formed by the Singapore Medical Association "to look into the feasibility of forming a Higher Academic Body of General Practitioners in Singapore". The main objective of the College was to promote a high standard of family medicine/general practice in Singapore, and one of the most important activities was the provision of continuing medical education.

Even before the College was formed, the Society of General Practice, the forerunner of the College, was already holding talks and lectures. But these were sporadic and ad-hoc, and usually not well attended.

IN THE 70S

For a start the College held two-hourly weekly lecture sessions for the members, and about 20 members turned out week after week to revise and upgrade their knowledge. We did not have lecturers in family medicine or general practice, but we were fortunate to have friends and colleagues who were specialists who willingly gave their time and effort to hold these lectures, without any honorarium paid. Most of these sessions were held in the Alumni Association for which no fees or charge were collected.

By 1973, regular lectures and clinical sessions were held on Sunday afternoons from 2.00 pm to 4.00 pm at different hospitals, and group discussions were held regularly at the Alumni Medical Centre on Fridays from 8.30 pm to 10.30 pm. The lecturers were the Who's Who of Singapore medical fraternity, colleagues like Prof Wong Hock Boon, Prof Khoo Oon Teck, Prof Phoon Wai Onn, Prof Seah Cheng Siang, Dr Wong Yip Chong, Dr Feng Pai Hsii, Dr Tan Bok Yam, Dr Chew Chin Hin, Dr Leong Si Chin, Dr John Thambyah, Dr Chan Sing Kit and many, many others.

Many of our members were from Malaysia, and they were most active in promoting continuing education. The Kluang Study Group was formed by a small but dedicated band of family physicians. Out of a total of twelve practitioners, eleven were members of the College. They met regularly with each other and with their hospital colleagues with a common objective of improving medical and health care in their town.

In October 1973 they held a "Teach-in" on the Current Problems in Cardiology in Kluang, Malaysia to which other members of the College were invited. Their enthusiasm influenced doctors in the other towns, and a "Teach-in" was held later that year by the Johore Postgraduate Centre, founded by Datuk Dr Lim Kee Jin, the State Physician of Johore.

The College felt that an examination specifically for family physicians/general practitioners was necessary for these doctors to assess themselves in their continuing education. Such examinations were by then well established in countries like United Kingdom, Australia and New Zealand. Our first Diplomate Examination was held in November 1972. By 1977 the MCGPS was recognised by the Singapore Medical Council as an additional registrable qualification.

In-depth courses, seminars and talks with audio-visual aids were introduced and examination-oriented refresher courses were held

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to help those intending to take the Diplomate Examination.

The Ministry of Health's Primary Care Division held weekly Thursday lunch-time sessions initially at Maxwell Road OPD through the initial efforts of Dr S Devi in the Ministry of Health. These include talks, discussion and tape sessions on topics of Family Medicine/General Practice. Later, the sessions were "regionalised" so that teaching sessions were also held in Still Road, Clementi and Bukit Merah Polyclinics.

During this period, the College premises were refurbished, and well documented books, tapes and audio-visual cassettes library was established for the members and all general practitioners. This was done through donations from the Reuben Meyer Trust and other well-wishers.

In September 1973, the College was bold enough to hold the Joint Colleges Conference in Singapore. The participating Colleges were the Royal College of General Practitioners, Australia, The College of General Practitioners Malaysia, and The College of General Practitioners Singapore. It was a great success in terms of scientific programme and attendance, and doctors in Singapore were given the opportunity to attend the plenary sessions and workshops, and to listen to world leaders in Family Medicine/General Practice.

Negotiations about educational facilities have also been taking place for some time between representatives of the College and officials of the Ministry of health, and signs of fruition were beginning to appear. The following quotation from the Straits Times (22nd September 1973) described the situation very clearly:

"The new scheme, which is the result of talks between the College and the Health Ministry, will offer to the established doctor opportunities to keep pace with advances in medical knowledge and techniques in the disciplines of his choice, and prepare the new intending GP the better to serve his patients. Thus the houseman who plans to enter private practice at the end of his year's service in the hospitals may, while still a medical officer in Government service, be given postings in the particular disciplines relevant to general practice. The practising GP may express his preference for the branch of medicine in which he wishes to improve his knowledge. To enable them to continue their post-graduate education, facilities will be available to them at the following hospitals: Outram Road, Thomson Road, Tan Tock Seng, Alexandra, Middleton and Middle Road. A system of posting could be worked out between the doctors and the Ministry, which would be suitable for both sides. The scheme will be purely voluntary. On the basis of its progress a more organised and systematic programme may be planned later."

IN THE 80S

Between 1981 and 1983, the number of update courses were increased to 2 per year, and then to 3 per year as more disciplines were introduced. From 1983, a certificate of attendance was introduced and awarded to doctors who have attended at least 80 percent of each of the 6 modules of update coursed in 2 to 3 years. This was then made a requirement for the Diplomate Examination.

In 1985, an initial attempt was made to conduct a 2-year cycle programme for the whole field of medicine relevant to Family Medicine/General Practice. We ran 6 modules and 3 weekend seminars in the two years. We had difficulty trying to accommodate all the areas without unduly increasing the number of modules. The solution was to combine two or more areas in one module. Figure 1 taken from pages 70-71 in the Singapore

Family Physician 1987 Vol XIII No 2 shows a sample of the programme during this period. These were called "The Update Courses".

In 1987 recognition of Family Medicine as a distinct academic discipline was firmly established with the formation of the Department of Community, Occupational and Family Medicine (COFM) in the National University of Singapore. The Division of Family Medicine was headed by A/Prof Goh Lee Gan who was then a practising general practitioner. The close collaboration between the University and the College was beneficial to both organisations in hybridizing and balancing what was relevant in the contribution of from academic family medicine to family medicine practice and vice versa.

In 1988 a Steering Committee on Family Medicine was formed with tripartite representation from the Ministry of Health, the Department of COFM and the College. A pilot traineeship programme was organised for Government Medical Officers who had intention of pursuing a career in primary care or family practice. The family medicine trainees attended a modular course of 64 sessions over 2 years on Saturday afternoons. Other doctors were encouraged to attend these Saturday modular sessions as CME.

1987/1988

Module A:
1st quarter – Family Medicine, Paediatrics and O & G
Module B:
2nd quarter – Surgery, Orthopaedics & Anaesthesia
Module C:
3rd quarter – Internal Medicine I; practice management

1988/89

Module D:
1st quarter – Internal Medicine II; practice management
Module E:
2nd quarter – Geriatrics, Psychiatry, Family Medicine
Module F:
3rd quarter – Minor specialties, Occupational Medicine

Fig 1. College CME Programme, 1987-89 – The Update Courses

IN THE 90S

The Update Courses were conducted from 1987 to 1996. Three such courses conducted on Friday evenings from 1987 to 1995. In 1996 two courses were conducted. The attendance was around 50 participants for each course.

In the 1990s, the restructuring process in the government hospitals resulted in greater autonomy and a greater need to show productivity. One of the avenues to productivity is to link with GPs to be the preferred referral destinations. There was thus greater interest in hospital departments to provide CME for GPs.

The College was invited to be a nominal sponsor and to contribute suggestions for topics and the focus that will benefit GPs. The type of CME also moved from straight single topic lectures to seminar, workshops and hands-on courses. The result is a new symbiotic relationship between the College and the various hospital departments from College-personal links with specialists and College-hospital department links of the 1970s and 1980s to hospital departmental-College and institutional-College or specialist body-College links for the provision of CME for the GPs.

This new link does not replace the College-specialist links of either individual specialist contacts or hospital departments, but certainly the new links augment the quantity of relationships between GPs and specialists in CME and CPD programmes for the practicing GPs. The number of activities where the College is a nominal sponsor as a measure of this new link, rose from three in 1991 to twenty-three in 2000.

With the development of CME activities driven from the institutions with the College participating as nominal sponsors and advisors on CME topics, the need for College to be the key driver for the Update Courses diminished. Hence, there were no more College's Friday evening Update Courses conducted after 1996.

It is clear that CME providers for the GPs are much more plural than compared to the 1970s. Also, the content is not just drug talks but activities that will enhance the knowledge and skills of the practicing doctors. Examples are the surgical updates and O&G ultrasound courses. In the 2000s, both the College and the institutions will seek each other to provide not only CME but meaningful CPD activities to level up the GPs.

The College took charge of administering the national Singapore Medical Council - CME (SMC-CME) programme from 1993 to the end of 1999. Since Jan 2000, SMC has taken back the administration of the national CME programme with the launch of the online SMC-CME progamme. The College continues as a member of the SMC's Education Committee to oversee the new national CME programme for GPs/Family Physicians and plays an important role in the accreditation of national CME programme for GPs/Family Physicians.

CONFERENCES

Conferences may be regarded as CME carnivals. The College has held yearly conference on with focus on different subjects. The most important achievement must be the holding of the 10th WONCA World Conference for Family Physicians in Singapore. It was then the largest medical conference ever to be held in Singapore. More than 2,500 people from all over the world attended the conference. The College has set itself to provide a repeat performance come 2007, when it will host the 2007 Wonca World Conference for Family Physicians.

In 1988 the College organised its first Annual Scientific Conference, officiated by the Deputy Director Medical Services (Hospital), Dr Chew Chin Hin. This year, the theme of the 2001 Annual Scientific Conference is "Training The Family Physician", a fitting theme for the College's 30th Anniversary.

CME RESOURCES

An account of the College CME would not be complete with a mention of the Singapore Family Physician and its Home Study Section. The publication is the College's official publication. Through the years, its quarterly publications have been a chronicle and self-directed learning resource for family doctors in their CME efforts. Its home study section focuses on review articles and quizzes to teach the brains of the reader. With the impending advent of on-line CME programmes, the Singapore Family Physician will need to integrate its role with such on-line programmes.

CONCLUSIONS

In the space of thirty years, the College CME has blossomed from the lunch time lectures driven by the College to a plethora of activities ranging from to symposias and skills training workshops driven by the College, specialist bodies and institutions. Self-directed learning from hard copy journals will soon be supplemented by e-learning. All these are necessary in providing the resources for the family doctor in the twenty-first century. The College needs to be a key driver in these efforts.

COLLEGE SINCE 1987

A/Prof Goh Lee Gan, Dr Matthew Ng Joo Ming and Dr Kwan Yew Seng

INTRODUCTION

In 1987, the story of the College was told in two papers. The first was by Dr Koh Eng Kheng on its early days [1]. The second was by one of us (Goh LG) on "the present and future trends" up to 1987" [2].

The story of the Singapore College in the early years is revisited once again in this commemorative issue of the 30th Anniversary of the College from the perspective of Dr Wong Heck Sing, the Chairman of the Protem Committee. His paper is titled "Founding of the College" [3].

In 1993, the Singapore College changed its name to "College of Family Physicians, Singapore" from the old name of "College of General Practitionres, Singapore. The new name is to reflect a consistency with the label of "family medicine" as a medical discipline.

Fifteen years have since passed. What have been the progress in the things and aspirations described in the paper on "the present and future trends up to 1987"[2]? This paper follows these up and identifies challenges for the College for the future.

NEW PREMISES IN THE COLLEGE OF MEDICINE BUILDING

The new premises in the College of Medicine Building became the home of the College over the last fifteen years. Over that time, the rental has gone from the nominal rental of $1 a year to market rates in the last 5 years. Consequently, the College decided to return the portion of the premises occupied by the College which was used as a lecture room.

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COMMON LIBRARY & RESOURCE CENTRE

The Common Library and Resource Centre was set up and called the Postgraduate Medical Library. This provided a good place for readers to have a quiet place to study and to refer to current medical literature. The Medline was just being available on CD in the years after 1987 and it was a boon to use the CD version instead of manual search in the hard copies of the Index Medicus.

Today, the Medline is now in the Internet. Many articles are available in full-text that could be downloaded, and printed for use without going to the library at all. With the development of resource facilities in the restructured hospitals, the need for the Postgraduate Medical Library also diminished. Thus, in 1996, the decision was made to close down the Postgraduate Medical Library, since it has served its purpose.

POSTGRADUATE MEDICAL CENTRE

The College of Medicine Building (COMB) has indeed served as a postgraduate medical center. The auditorium and lecture rooms continue to serve the medical profession well as a postgraduate medical centre.

A DEPARTMENT OF GENERAL PRACTICE

In 1987, Family Medicine was recognized as an academic discipline by the National University of Singapore (NUS). The Department of Social Medicine and Public Health was given the responsibility of teaching the subject in the undergraduate curriculum. To reflect the new teaching task, the name of the Department was changed to the Department of Community, Occupational and Family Medicine (COFM) on 13 February 1987. Family Medicine is still yet to have a full department. A paper has been submitted to the Faculty of Medicine.

COLLEGE RESEARCH

Since 1987 the College has embarked on several research projects covering one-day morbidity studies, family values, meal practices, dietary habits of Singapore children up to 24 months, and foot problems.

Two one-day morbidity studies, one in 1988 and the other in 1993, each based on a national sample of primary care doctors were conducted in collaboration of the Ministry of Health's Research & Epidemiological Department. The 2001 one-day morbidity study is being planned.

The study on the dietary habits of Singapore children up to the age of 24 months was carried out with the assistance of consultant dieticians in 1997.

In 1998, the Achilles Project was started with a grant from Janssen-Cilag. This was a study on the prevalence of foot diseases seen by Family Physicians in Singapore. A total of 54 clinics participated in this study. The study found that foot pathologies were less common in Singapore compared to other Asia-Pacific countries. The prevalence of foot conditions was 36%. The major problems were callosities, eczema and fungal infections. In 2000 the College and Janssen-Cilag embarked on a project entitled "Achilles Project 2". This was an epidemiological study on foot problems in general practice. It involved about 50 general practitioners who screened 30 cases each. The project is currently in the data analysis stage.

Several short research methods courses had been organized by the Ministry of Health, Academy and the College. In the space of time, two one-day morbidity studies have been conducted as joint endeavours of the Ministry of Health and the Singapore College.

In 1997 the College held a Research Contest in conjunction with the 6th Scientific Conference. This was aimed at increasing awareness and interest in research among family physicians and giving incentives to those who excel in it. One of the participants subsequently represented the College and presented a paper in the Asia-Pacific Wonca Conference held in Seoul in that same year.

VOCATIONAL TRAINING

The last fifteen years have seen tremendous strides in postgraduate family medicine education. In 1988, Family Medicine Vocational Traineeship programme was started as a tripartite effort by the Ministry of Health (MOH), the National University of Singapore (NUS) and the Singpaore College. In 1991, the School of Postgraduate Medical Studies of NUS adopted the Family Medicine Training Programme leading to the Masters of Medicine in Family Medicine (MMed (FM)). In 1993, the first MMed(FM) Examination was held. Nine out of the 17 candidates were successful. Since then 140 doctors are holders of the MMed(FM) degree. In 1995, the Private Practitioners Stream (PPS) of Family Medicine training leading to the MMed(FM) was started. Today, some twenty doctors have been trained through this route.

Beyond the MMed(FM) is the training programme to train leaders in Family Medicine in teaching, practice and research. This is the goal of the FMFP.

For the majority, greater emphasis and efforts should now be placed on upgrading the nature and quality of work of the Family Physician/ General Practitioner to higher value work. The Graduate Diploma in Family Medicine (GDFM) has been created with this goal in mind.

PRACTICE MANAGEMENT

Practice management is concerned with the strategic and operational issues related to the practice. Committee members represented the College in various MOH workgroups and Statutory Boards in activities to improve the practice of the family physician.

College representatives also participated in the workgroups of the Medical Technology and Standard Committee under the Productivity and Standards Board. These meetings provided an opportunity for the College Council members to have an insight into the ISO standards and how they are being set, applied and review. An area which we were actively involved in were the adoption of the ISO certification procedures of medical devices and equipment. One of our Council Members, Dr Tan See Leng, was appointed to chair a Technical Committee to adopt a set of ISO certified standards for portable home glucose monitoring.

Members of the College participated with senior Medical Officers from HQ Medical Corps SAF in the conduct of practice audits of SAF Medical Centres. Feedback and suggestion for improvement on design and operation were made after each inspection.

THE FUTURE

The ongoing challenges of the College are to develop its training, research and practice programmes to enable each family physician to level up to be able to do high value professional work beyond the acute episodic medical problems. The College needs to attract capable and dedicated young Family Physicians/General Practitioners who are prepared to sacrifice time and give that little extra effort to serve in the College Councils and Committees.

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UNDERGRADUATE EDUCATION IN FAMILY MEDICINE

A/Prof Goh Lee Gan

INTRODUCTION

Family Medicine was first introduced into the medical undergraduate curriculum in the National University of Singapore (NUS) as an academic subject in 1987. The Department of Community, Occupational & Family Medicine (COFM) was given the responsibility to teach the subject. Since its introduction in 1987 it has been taught in Years 2-3 of the MBBS curriculum as part of the COFM course. An assessment of the students' knowledge in Family Medicine is incorporated into the 2nd Professional Part II MBBS Examinations, held at the end of the third year, as part of the Examination in COFM.

Beginning of the academic year 2001/2002, students will be exposed to a new MBBS curriculum where there will be a greater emphasis on family medicine teaching and learning. Also, the subject will be taught in Year 4 of the MBBS curriculum instead.

EXISTING CURRICULUM IN NUS

The existing Family Medicine undergraduate curriculum content consists of:

- A lecture module on Family Medicine (6 lectures)
- Tutorial sessions in Family Medicine (3 tutorials)
- A one-week posting to the General Practices
- A one-week posting to the Polyclinics.

In addition, topics related to Family Medicine are also taught in the following modules, namely:

- Health, Illness and Behaviour
- Communication with Patients
- Primary Health Care
- Community Medicine Case Studies
- Applied Nutrition
- Health Education.

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MEDICAL CURRICULUM REVISION

The MBBS curriculum in NUS has been revised in line with the recommendations of the General Medical Council's document Tomorrow's Doctors. The revised curriculum was introduced in 1998.

Essentially, the new curriculum will have a core curriculum that all doctors should know well; reduction of information overload; and encouragement for problem based learning and discovery learning and teaching.

Two of the GMC's 14 principal recommendations are of particular relevance to Family Medicine. They are:

- Recommendation 10 which states "Clinical teaching should adapt to changing patterns in health care and should provide experience of primary care and community medical services as well as hospital based services" and;
- Recommendation 9 which states that "The theme of public health medicine should figure prominently in the curriculum, encompassing health promotion and illness prevention, assessment and targeting of population needs, and awareness of environmental and social factors in disease".

NEW CURRICULUM

The road map of the new curriculum shown in Fig 1 summarises the learning programme in Family Medicine.

What is new?

The following are the main improvements that will be introduced into the undergraduate family medicine curriculum for 2001/2002 compared to the existing curriculum:

- Extension of clinical experiential learning – 2-week GP posting, 2-week Polyclinic posting, day

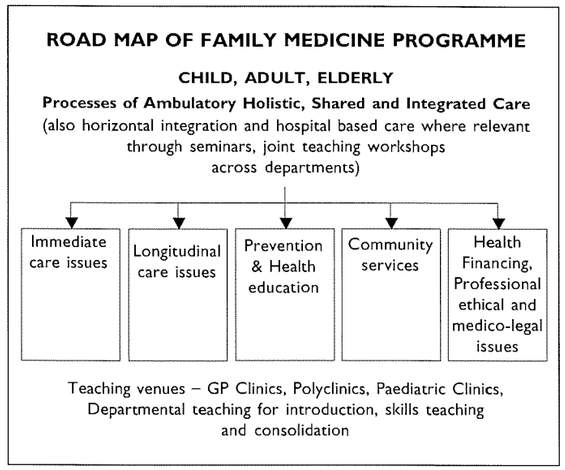

Fig 1. The Family Medicine Curriculum

with the Paediatrician, day in the corporate practice

- Focus on skills acquisition – (a) general consultation skills, (b) counseling on modification of adverse health habits done in departmental setting, (c) practice of family medicine in the context of the child, adult, and the elderly
- Cross disciplinary integration and consolidation of learning – through workshops, study assignments, case studies and presentations
- Practice based research options through the Undergraduate Research Opportunities Programme (UROP).

The organization of the four week posting

The class of 240 students will be taught in three batches of approximately 80 students per batch. In the GP setting, the students will be posted in pairs to a GP and in the Polyclinic posting a clinical group (7-9 students) will be posted to one polyclinic. There will also be a day's attachment to

- a corporate practice
- a paediatrician.

Teaching at the GP clinic and Polyclinic

The curriculum will emphasize the following aspects of family medicine principles and practice:

- The provision of primary, personal, continuing and comprehensive care of individuals, family & community care
- The wide disease patterns and stages of disease. seen in primary care – disease, early disease, chronic disease, and terminal disease
- Consultation and counselling tasks and skills that need to be mastered
- The scope of care – acute care, emergency care and housecalls, continuing and comprehensive care and terminal care – in the context of the child, adult, and elderly
- Health promotion, disease prevention and chronic disease care
- The recognition that comfort may be all that we can give to the suffering patient – we need to recognize our ability is "to cure sometimes, to relieve often, but to comfort always"
- The family doctor's special roles of co-ordination of care, shared care and step-down care where he or she needs to work with other health care providers
- The teaching and learning of practice management, health laws, medical ethics and professionalism
- General integrative learning and people handling skills required of each doctor irrespective of eventful career paths.

Department teaching

The departmental teaching sessions are aimed at giving the students a headstart on what skills are needed and also consolidate the learning of the previous week.

Week 1 – focus on symptoms and acute care

- General briefing
- Skills teaching – general consultation skills (role play)
- Skills teaching – making a difference in chronic disease care – patient educational strategies in the clinic; behavioural modification strategies; affective and social support (role play).

Week 2 – focus on population specific care and chronic conditions

- Feedback on week 1
- Presentation of case studies and assignments – women's health
- Presentation of case studies and assignments – corporate health care, domiciliary care.

Week 3 – focus on MCH, chronic problems and elderly

- Feedback on week 2
- Presentation of lessons learnt – consultation issues (difficult patient, problems of living, sick leave)
- Skills teaching – consultation skills in paediatrics (role play).

Week 4 – focus on paediatric care

- Feedback on week 3
- Presentation of case studies and assignments – paediatric problems
- Workshop of case studies on pediatric problems – continuing care issues.

Day in the corporate practice

Learning areas

- Communication skills in dealing with demands of various categories of staff
- In-house staff clinic and factory clinics – how are these run
- Common health problems of office staff
- Office calls, ship calls
- Corporate and workplace wellness programmes.

Day with the paediatrician

This is seen to be necessary because many paediatric patients see the paediatrician as a primary care doctor.

Learning areas

- Screening of well babies
- Immunisation
- Examination skills – the fretful child
- Communication skills – giving instructions to monitor and observe progress
- Common childhood illnesses – URTI, asthma, skin
- Assessment of the sick child – empirical treatment, investigation, and referral
- Pediatric drugs and dosages
- Administration of suppositories, taking temperature.

CONCLUDING REMARKS

The undergraduate teaching goal in Family Medicine is educational. Vocational training is deferred to the postgraduate period. Family Medicine has the unique tasks of teaching all medical students the importance of recognizing that the patient has physical, social and psychological dimensions of health and illness; that each is an individual, has a family and lives in a community; the importance of discovering the patient's reason for encounter; and the importance of knowing the patients' ideas, concerns and expectations towards his medical complaints. Attention to these aspects are essential if one is to address the patients' real and perceived problems satisfactorily. These learning areas will be the unique contribution of Family Medicine to the learning agenda of the medical undergraduate student.

DEVELOPMENT OF INTERNATIONAL RELATIONS

Dr Alfred WT Loh Wee Tiong

"No man is an island, entire of itself; every man is a piece of the continent, a part of the main."

– John Donne

This quotation epitomizes the connectedness that the College of Family Physicians, Singapore has enjoyed all the thirty years since its formation in 1971. In those early days when a band of doctors led by Dr Wong Heck Sing, Chairman of the Pro-tem Committee of the Singapore College, felt the need for an academic body for the general practitioners/family physicians in Singapore, they sought help from countries far away that had by then gone in the same direction of forming their academic bodies for family medicine – the United Kingdom and Australia. The requests for help were very willingly answered by these colleagues initially from the UK and later from Australia.

Lord Hunt of Fawley, representing the Royal College of General Practitioners, visited Singapore with some of his College officials and helped put together the initial Constitution of the infant college in Singapore, drawing from the early experiences of the Royal College itself. There were also discussions on the need for some form of examinations for doctors wanting to upgrade themselves and achieve some academic recognition.

For this, the fledging college looked also to the Australian College for help. Australia readily answered Singapore's call for advice and the format of the early MCGPS (Member, College of General Practitioners, Singapore) Examination, the result of the many visits and meetings between representatives of the two bodies.

Throughout the next 15 – 18 years, the local college continued to maintain close relationships with these two colleges particularly in the area of the MCGPS Examinations by way of inviting the overseas external examiners as invigilators.

It was only in 1980, when the Singapore College had a team at the 9th Wonca World Conference in New Orleans to bid for the 10th Wonca World Conference that the scope of international relations for the College suddenly expanded as the then currently young college council members met and interacted with GPs/FPs from the many countries at the conference. The 3 years between winning the bid and hosting the 10th Wonca World Conference in 1983 in Singapore, gave the College then a tremendous amount of exposure to international relations. The many contacts that needed to be made for invitations to official representatives, plenary speakers, chairpersons, free-paper presenters and delegates, all gave the organizers in the local host college a good and refreshing feel of the international flavour of GP/FM. The 10th Wonca World Conference turned out to be a success beyond the expectations of the host College in more ways than one and paved the way for more and more international involvement by the College from then on. The credibility gained by the College from holding that conference, led to its involvement in Wonca (The World Organisation of Family Doctors) in the Asia-Pacific Region initially and later at the highest level of the Executive Committee of the world body.

In 1986, at the 11th Wonca World Conference in London, a representative from the Singapore College was appointed the Regional Vice-President (RVP) for the Asia-Pacific to help the world body look into the development of GP/FM and expand its involvement in the region. That led the way for the College to build strong and close relationships with the academic bodies of GPs/FPs in the region particularly in South east Asia, namely with our colleagues in Indonesia, Malaysia, Philippines, Myamma and further afield with Australia, Hong Kong, Japan, Korea and later China. It is perhaps with the neighbouring countries in the Asia-Pacific that the Singapore College has been most closely connected in the last 10 years beginning with the formation of the Wonca Working Party on Family Medicine Education at the Bali Asia-Pacific Regional Conference in 1991. That forum provided opportunities for countries in the Asia-Pacific to get together and learn from each other the factors influencing the development of general practice/family medicine in each country. Much credit is due to doctors and teachers like Prof Wesley Fabb, Dr Clarke Munroe, A/Prof Zorayda Leopando and A/Prof Goh Lee Gan for keeping the connections going. Through the forum of medical education, Dr Nurul Islam from Bangladesh also became connected with the Singapore College and together Bangladesh and Singapore participated in the spreading of the 'family medicine message' to the South-Asia countries of Pakistan, India and Nepal.

The 6 years that the Singapore College representative held the RVP post paved the way for involvement at an even higher level – the World Executive Committee of Wonca. As the Member of Executive-at-large for 3 years, then as Honorary Treasurer for the next 3 years, the Singapore College through its representative was able to contribute to the mission and objectives of the world body. For the small size that it is, the contribution by the Singapore College to the world body can be said to be fairly significant and underlies the fact that organizational size is not what determines international involvement but rather the commitment to be involved and to go for the long haul in international relations.

In the period of over a decade (mid 1980s to end 1990s) of international involvement, the College in Singapore has gained for itself a reputation for dependability, helpfulness, respectability and a willingness to share its experience and expertise in the development of GP/FM as a distinct discipline in medicine. This fact is further exemplified by the current involvement of some members of the College in the activities of the Singapore International Foundation in its healthcare development programmes in Indonesia and Myanmar.

The high regard that the international community of GPs/FPs have for the Singapore College, has of late resulted in two very significant developments and accolades it has been showered with. Firstly, the College was again successful in its bid to host the 18th Wonca World Conference in 2007. This is a historical first for any college to host a world conference for the second time. It reinforces the confidence, faith and trust the other colleges/academies of GP/FM around the world have for the Singapore College. With the larger and newer facilities now available in Singapore for large conferences and with the aid of IT in communications, the 2007 conference will very likely surpass the 1983 conference in academic quality, number of participants and degree of success.

The second accolade given to the College, in the area of international involvement, is the honour and privilege of hosting the Secretariat of the World Organisation of Family Doctors in its

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premises and to have a past president of the College as the new Chief Executive Officer for the organization on the retirement of Prof Wesley Fabb. With this double honour of being host to the conference and the secretariat also comes the onerous responsibility of continuing commitment to greater international involvement and sharing. The commitment to the conference in 2007 is for six years of preparations and planning as well as financial outlay. The commitment as host to the secretariat is for at least nine years which fortunately involves only floor-space in the College office and no other form of financial support.

In conclusion, the College of Family Physicians, Singapore can justifiably be proud of its record on international relations and involvement. With a history of only 30 years behind it and the fact that the College is among the smallest in the 'Wonca Family' in terms of subcription-paying members, it serves to demonstrate that small organizations can play significant roles in the world affairs of international organizations. What is important is the will to be involved, the sense of global responsibility, the support of the members in the organization and the goodwill to be friends to all in the fraternity at the international level In this respect the College must record its thanks and gratitude to all past presidents and council members who have had the wisdom to place importance in international relations as part of the College's ongoing objectives. In a similar vein, the College should also express its thanks and gratitude to all sister colleges/academies of GP/FM in the international 'Wonca Family' for the trust, friendship, guidance and support given to it and for allowing it to play its part in the international millieu.

FAMILY MEDICINE DEVELOPMENT IN THE ASIA-PACIFIC REGION

A/Prof Goh Lee Gan and Prof Wesley Earl Fabb

BACKGROUND

Worldwide interest in reviving the Family Physician/General Practitioner occurred in the early 1960's as a response to the fragmentation, depersonalisation, and high cost of care brought about by superspecialisation and increasing emphasis on modern technology. With the formation of the World Organisation of Family Doctors (Wonca) in 1972, the increasing interest in General Practice/Family Medicine as a discipline also spread to the Asia-Pacific countries.

The Royal Australian College of General Practitioners played a key role in sustaining interest in the principles and practice of Family Medicine in the Asia-Pacific Region.

It was in this role that in April, 1987, Dr Clarke Munro from the Royal Australian College of General Practitioners (RACGP) was assigned by his College to make a feasibility study on Common Training and a Conjoint Examination in General Practice/Family Medicine in South-east Asia. Seven member organisations were surveyed and it showed that there was a diversity of training and assessment programmes. His recommendation was for:

- a structured two stage programme made up of a basic training programme of 2 years would consist of the essential knowledge and skills of general practice common to all countries in the region, and an advanced training programme of 1-2 years with a common content, appropriately modified by each country for its individual needs
- an examination common to all participating countries was proposed. This was to be in 2 parts: Examination Part 1, to be taken at the end of basic training, which would be in written form, assessing essential cognitive skills; Examination Part 2, to be taken at the conclusion of advanced training, consisting of clinical and oral segments designed to determine whether training objectives had been reached
- the establishment of a Regional Center for Training, Education and Assessment by Wonca in South East Asia to advise on and assist with training and examination, and ensure uniform standards.

In May 1989, when representatives from Asia-Pacific met in Israel during the Wonca World Conference and discussed the Conjoint Examination, it was agreed that instead of a formal arrangement, it may be better to have an informal arrangement to facilitate exchange of information on examination content, methods of conducting them, and perhaps exchange of examiners.

At the Wonca Bali Regional Conference in May 1990, the Asia Pacific Working Party on Medical Education was formed with Dr Lindsey Knight as the convenor. It was agreed that a core curriculum would be prepared and the core content for examination identified. Dr Munro of Australia and Hong Kong, Dr Goh Lee Gan of Singapore and Dr Zorayda Leopando of the Philippines were assigned to draft the preliminary paper. In the same Regional Conference in Bali, the representatives from different member organisations met and approved the recommendation of the Working Party to organize post-conference workshops on Family Medicine Education. The target audiences were opinion leaders, practitioners and faculty members in General Practice/Family Medicine.

The first of these was held on February 4-5, 1993 at the Holiday Inn, Manila after the Wonca Manila

GOH LEE GAN, MBBS(Sing), MMed(IM), FCFPS, FRCGP
Past Censor-in-Chief, College of Family Physicians, Singapore (1991-1999)

WESLEY EARL FABB, AM, FRACGP, FCFPS, FFGP(SA), MCFPC, FRCGP, FHKCGP
Immediate Past CEO, Wonca

Regional Conference. It was hosted by the Philippine Society of Teachers of Family Medicine with Dr Zorayda E Leopando as Project Director. The workshop aimed to define the Core Curriculum in Family Medicine Residency/Vocational Training and the Core Content and Methods for Specialty Examination. Fifty family medicine educators from 12 Wonca member organizations participated. This workshop proved to be quite seminal as a forum for exchange of ideas and sharing of experiences on Family Medicine Residency/Vocational Training and Qualifying Examinations. Conference proceedings were produced.

Since then, post-conference workshops have been held in 1995 in Macau on clinical teaching, in 1997 in Seoul on assessment of clinical competence and performance, in 1999 in Taipei on quality improvement and, in 2000 in Christchurch on designing continuing professional development programmes for doctors in practice. In 1996 a workshop on primary care research was conducted in Genting Highlands, Kuala Lumpur, Malaysia.

A survey of the 14 member countries of Wonca in the Asia-Pacific conducted in 1992 showed that 10 countries had structured training programmes. Five of the programmes were called residency while the other five were called vocational training programmes. The average length of training was 2.8 years, with Japan having the longest at 6 years. The shortest was 1 year. A great portion of training was spent in the hospital in most of the programmes.

ASIA PACIFIC TODAY

Australia

In Australia, the health care system is based on a strong cadre of general practitioners, the majority of whom have been vocationally trained in the government funded training programme of the Royal Australian College of General Practitioners established in 1973. A system of registration of general practitioners is in place. Higher insurance rebates are paid to patients of registered general practitioners, and compulsory quality assurance mechanisms ensure continuing high standards. Newly qualified doctors become registered by successfully completing the three or four-year RACGP vocational training programme (four years for those training for rural practice) and passing its fellowship examination. It is no longer possible for untrained doctors to become registered as general practitioners. Recently the Federal Government has opened the way for educational groups outside of the RACGP, such as university departments of general practice, to tender to train groups of trainees, now termed "Registrars".

Referral by a general practitioner is mandatory for any specialist consultation in order to attract a rebate from the Medicare system of health insurance, which ensures universal access to comprehensive health services of high quality. A system of accreditation of general practices has been developed, and financial incentives offered to accredited practices.

There are active undergraduate departments of community medicine/general practice in all ten medical schools. In recent years "division of general practice", comprising general practitioners in a region, have been funded by the federal government to provide local education, research and health services planning.

The importance of Government support to family medicine development is vividly illustrated in Australia, which had made very slow progress until support was forthcoming in 1973.

New Zealand

In New Zealand, general practice is well established. A vocational training programme has been operating for over 25 years. In recent years, government cutbacks on funding for vocational training have caused concern. The Royal New Zealand College of General Practitioners and the university departments of general practice there have fought strongly for more vocational training opportunities and a more congenial general practice environment, with some success. Vocational training and re-accreditation for general practitioners is enshrined in legislation.

SOUTH EAST ASIA

In South East Asia, family medicine is established in Singapore, Hong Kong, Taiwan and the Philippines. Family Medicine is beginning to be introduced into countries like China, Thailand, Vietnam and Japan. Wonca representatives from the Philippines and Singapore participated in the setting up of training programmes and the training of teachers in Thailand, China, Myanmar, Indonesia and Vietnam.

Singapore

Singapore was one of the early developers in the region, with a postgraduate examination in General Practice in 1972. Family Medicine was introduced as an academic discipline in 1987. A structured vocational programme in Family Medicine was started in 1990 leading to a Masters in Medicine (Family Medicine) degree. The government has now recognized general practice as the basis of its health care system, and is very supportive of its further development. The importance of government support, and what can be achieved when it is forthcoming, is well exemplified in Singapore.

Hong Kong

Seventy percent of the primary care in Hong Kong is delivered by the private sector, 15% by government outpatient clinics, and the rest by alternative practitioners. Although general practice has been well established for many years, and the Hong Kong College of Family Physicians has a long-standing Fellowship examination, the number of formally trained family physicians is low. To date there are less than 200 trained family physicians. There are now full-time professors of family medicine at both universities in Hong Kong providing undergraduate education in family medicine, and postgraduate training programmes for those who are academically inclined.

There is a private and a government vocational training programme, but the numbers that can be accommodated are still quite small, and inadequate for the community's needs. As the Government is now supportive, the outlook is promising.

Macau

In Macau, family medicine has been recognized as an official specialty since 1992 and the primary care physician has the same status as the hospital specialist. Although the local college is small, it is active in promoting family medicine education.

Taiwan

In Taiwan, the government made a decision some years ago to provide the community with family health care through health centres strategically placed in cities and rural areas across the island. The programme of health centre development was completed in 1984.

Undergraduate and postgraduate training programmes in family medicine were established in its medical schools, and doctors trained in its health centres. The outcome is a well-developed effective system of community health care based on the family medicine model.

Taiwan is a brilliant example of what can be achieved when Government committed to the development of family medicine.

China

With its population of 1.2 billion, China has an enormous task to provide the 1 million trained family physicians it would need to provide primary care by vocationally trained doctors. Although the growth of cities there is proceeding rapidly, the greatest need for family doctors is in the rural areas where most of the people live. At present, although there are extensive community health facilities in cities, towns and villages, because they are staffed by lowly trained health care workers, the population does not regard them highly, and therefore people prefer to pay a little more to go to specialist clinics. Many community doctors are under-worked and bored, whilst specialist clinics are overcrowded and the care they provide is often inappropriate and expensive.

There are almost no departments of general practice in China, but the recent development of undergraduate education and vocational training at the Capital University of Medical Sciences has given great impetus by establishing a model for other places. There is intense interest in family medicine in China from the Ministry of Health, provincial directors of health and a number of influential universities.

In 1998 the Central Government took an official decision to develop a community based health care delivery system; a health insurance system, and general practice/family medicine oriented education and training programmes. A rapid expansion of family medicine is predicted, as health authorities realize that this is the best way of providing health care at a cost the community can afford.

The Chinese Society of General Practice is active in promoting family medicine and has held several workshops and conferences. The WHO/Wonca document Making Medical Education and Medical Practice More Relevant to People's Needs; the Contribution of the Family Doctor has been translated into the Chinese and is having a major impact.

Mongolia

In 1991 a new structure for the family doctor was started in Mongolia, initiated by the Mongolian government. The outcome is that now seventy percent of the population has access to primary health care through the family doctor system. A Faculty of Family Doctors has been established at the Medical University and short-term training of family doctors has commenced. Special specialist recognition has been given to trained family doctors.

The Mongolian Association of Family Doctors is actively promoting family medicine and providing education and training.

Thailand

In Thailand family medicine is growing, but slowly in a country dominated by specialists. Two of the thirteen medical schools in Thailand now have a department of family medicine. Vocational training has been established since 1971 and general practice has been recognized as a specialty. A 1998 Wonca workshop on family medicine education there attracted the interest of about 60 doctors, many internists and paediatricians.

Japan

In Japan, family medicine/general practice was almost unknown until a few years ago, all medical care being based on the specialist model. Only recently have family medicine clinics been established in a few places, and in 1998 the first centre for training family physicians opened in Hokkaido. Its first graduate emerged this year. Departments of primary care medicine have been established in 26 of the 80 medical schools, but undergraduate and postgraduate curricula are still under development.

Korea

Family medicine is well developed in South Korea. It gained impetus in 1984 after its Government enshrined it in legislation as a specialty discipline. Development has been along the American model. Departments of family medicine and residency training programmes have been established in medical schools.

Indonesia

In Indonesia family medicine is developing slowly, but faces a particular problem: most specialists (the majority of whom are in public service) carry out private general practice-in-the-afternoons and evenings. As they are in direct competition with general practitioners, programmes to train general practitioners have not been well supported by specialist groups. With the setting up of a national programme of managed care, attention is being paid to the training of general practitioners/family physicians in the country.

Philippines

In the Philippines family medicine is based on the North American model, due to the long-standing American influence in that country. General practice is well established, and increasing numbers of doctors are taking the three-year vocational training programme and the certifying examination.

Vocational training has been established since 1974 and a specialty board of examiners for family medicine has been in place since 1979. In 1994 the role of the family physician was formalized in legislation.

Vietnam

In Vietnam primary health care is to be the framework for health care delivery, through community health centres. Since the Ministry of Health declared that family medicine should become a first level specialist programme in 2001 at the Hanoi Medical University, the University of Medicine and Pharmacy in Ho Chi Minh City, and at Thai Nguyen Medical College near Hanoi, preparatory workshops have been held to develop a suitable curriculum, the most recent, in Hanoi and Ho Chi Minh City in November 2000, being sponsored by the Wonca Asia Pacific region and the Philippine Academy of Family Medicine. These were attended by specialist academic who are committed to the establishment of the family medicine programme. This is another example of what can be achieved with Government support.

Myanmar

In the last few years, both the Ministry of Health and the Myanmar Medical Association have worked together to develop postgraduate family medicine training. A one-year family medicine diploma course is now being conducted annually.

Pacific Islands

Although general practice is the main form of health care in these islands, academic development is in its infancy. The College of General Practitioners of Fiji is promoting family medicine but development has been curtailed by recent political events.

SOUTH ASIA TODAY

In South Asia, general practice is established in India, Pakistan, Bangladesh and Nepal. However, most general practitioners in these countries are not vocationally trained, often are not highly regarded by their patience, and practise in difficult conditions, and often are not highly regarded by their patients. However, recently introduced programmes are now producing small numbers of well-trained family doctors in these countries.

India

In India the IMA College of General Practitioners has promoted general practice and has provided CME for practising doctors. Vocational training is established in some centres but is by no means universal. The College conducts a certifying

examination in family medicine and now has several hundred graduates. Some medical schools are supportive of family medicine while others give it scant regard. Rural health care is in need of focused attention, as so many people in India live in rural areas.

Much needs to be done to develop family medicine in this country.

Bangladesh

In Bangladesh there is government support for family medicine training. A workshop for family medicine educators was held in the Dhaka in 1966, and a workshop on the introduction of family medicine into the undergraduate curriculum in 2000. External examiners from abroad are used to standardize teaching and the examination at the end of the one-year course on family medicine established by the Bangladesh College of General Practitioners. The College also provides CME for practising doctors.

Pakistan

In Pakistan, against a background of government apathy, the Pakistan Society of Family Physicians conducts CME programmes and supports the fellowship examination conducted by the College of Physicians and Surgeons of Pakistan. The Society is working hard to initiate rural health programmes, and is promoting the establishment of departments of family medicine in the medical colleges of Pakistan. The College of Family Medicine Pakistan is also active in promoting family medicine.

A 1998 Wonca workshop in Lahore gave impetus to family medicine in Pakistan.

Nepal

In Nepal a three-year postgraduate programme in general practice was established in 1982 with the help of the University of Calgary. A 1998 Wonca workshop in Kathmandu was attended by 60 general practitioners from Bangladesh, India, Pakistan, Nepal, Sri Lanka, Oman and United Arab Emirates, enthusiastic to promote family medicine training in their countries.

Sri Lanka

In Sri Lanka, interest in family medicine is high. Departments of family medicine or community medicine are established in most medical schools, and for many years the Postgraduate Institute of Medicine of the University of Colombo has conducted a comprehensive postgraduate training programme in family medicine and a Diploma in Family Medicine Examination, which is being undertaken by an increasing number of doctors in government outpatient clinics as well as practising general practitioners. There are now 2 professorships in family medicine in Sri Lanka, and as a result family medicine is developing steadily.

CONCLUSIONS

Family medicine has made steady, and at times spectacular progress in th Asia Pacific Region over the last 30 years. Throughout the Region, academic in the discipline are well equipped to institute family medicine education at undergraduate and post graduate levels, to provide continuing education and professional development, and to undertake community based research. However, experience in several countries has demonstrated clearly that what is needed for spectacular success is the support of Government both ideologically and financially. Once a government takes the decision that family medicine will be the base of which its health system will be built, and properly fund its development, progress will be both rapid and far-reaching.

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Fabb WE. Family Practice in the Globe. In: Proceedings of a Workshop on Follow Up on Making Medical Practice & Education More Relevant to People's Needs. Chennai, India: Sri Rama Chandra College & Research Centre, Oct 6-8, 1999:57-65.

PICTORIAL STORY OF THE COLLEGE

From the College Archive Project

Dr Lee Kheng Hock & Dr Lawrence CL Ng

Mooting the idea of the College of General Practitioners

The College Archives Project was initiated in 2000 to collect memorabilia, personal accounts and chronicles of the College's heritage. A selection of the collected material is presented in this pictorial essay.

Acknowledgements. We thank Dr Wong Heck Sing, Dr Koh Eng Kheng, Dr Lee Suan Yew, Dr Alfred Loh, Dr Evelyn Hanam, Dr Lim Kim Leong, Dr Moti Vaswani, Dr Paul Chan, Dr Lawrence Ng Chee Lian and Dr Wong Song Ung for their contributions to the College Archives Project.

A SMA News Report on a speech by Lord Hunt of Fawley from the British College on the setting up of a GP College for Singapore.

NGAPORE MEDICAL ASSOCIATION

MEDICAL Newsletter

A BI-MONTHLY PUBLICATION OF THE SINGAPORE MEDICAL ASSOCIATION.

EDITORIAL BOARD:
E. K. KOH
LIM SIEW MING
TAN KHENG KHOO

VOL. 2 No. 1 APRIL - MAY 1969 MCP No. 0784 KDN No. 4260

AN ACADEMIC BODY FOR G.P.s IN SINGAPORE

In Singapore you already have your medico-political organisations. The time is now ripe, I believe, for you to develop an academic body to represent your 500 general practitioners. Fifteen or more countries already have such a college or academy, all of them founded during the past 20 years. You must not be left behind.

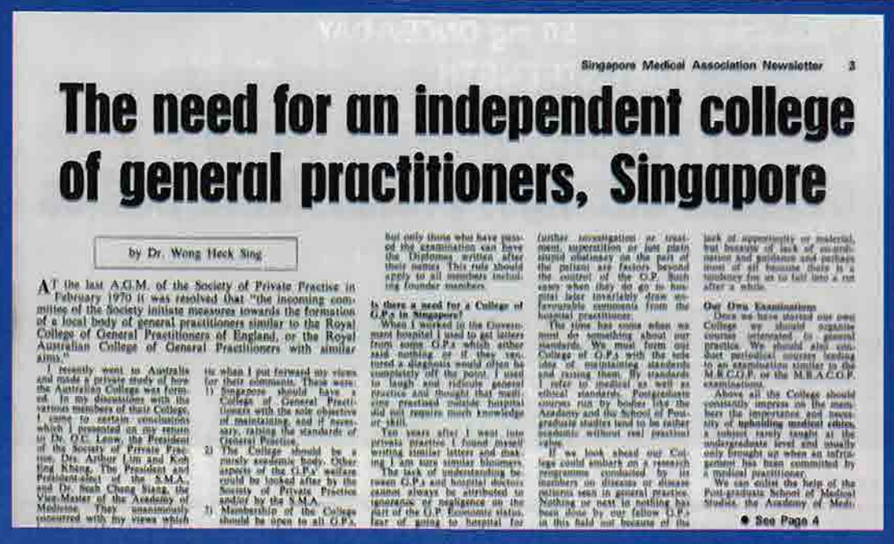
by

John H. Hunt, D.M., F.R.C.P., F.R.C.S.,
President, Royal College of General Practitioners

Dr & Mrs John Hunt being entertained to dinner by Singapore members of the R.C.G.P. and the Society of Private Practice.

Editorial: **The Speech**

This article was written by Dr Wong Heck Sing of the encouragement and support given by the Australian College of GPs on the idea of a College for GPs in Singapore. It was published in the SMA Newsletter and it served as the manifesto for the formation of the College of General Practitioners, Singapore.



Singapore Medical Association Newsletter 3

The need for an independent college of general practitioners, Singapore

by Dr. Wong Heck Sing

AT the last A.G.M. of the Society of Private Practise in February 1970 it was resolved that "the incoming committee of the Society initiate measures towards the formation of a local body of general practitioners similar to the Royal College of General Practitioners of England, or the Royal Australian College of General Practitioners with similar aims."

I recently went to Australia and made a private study of how the Australian College was formed. In my discussions with the various members of their College, I came to certain conclusions which I presented on my return to Dr. O.C. Leow, the President of the Society of Private Practise, Drs. Arthur Lim and Koh Eng Khang, The President and President-elect of the S.M.A., and Dr. Soah Chong Siang, the Vice-Master of the Academy of Medicine. They unanimously concurred with my views which is when I put forward my views for their comments. These were:

1) Singapore should have a College of General Practitioners with the sole objective of maintaining and if necessary, raising the standards of General Practice.
2) The College should be a purely academic body. Other aspects of the G.P.s welfare would be looked after by the Society of Private Practice and/or by the S.M.A.
3) Membership of the College should be open to all G.P.s, but only those who have passed the examination can have the Diplomas written after their names. This rule should apply to all members including founder members.

Is there a need for a College of G.P.s in Singapore?

When I worked in the Government hospital I used to get letters from some G.P.s which either said nothing or if they ventured a diagnosis would often be completely off the point. I used to laugh and ridicule general practice and thought that medicine practised outside hospital did not require much knowledge or skill.

Ten years after I went into private practice I found myself writing similar letters and making I am sure similar blunders.

The lack of understanding between G.P.s and hospital doctors cannot always be attributed to ignorance or negligence on the part of the G.P. Economic status, fear of going to hospital for further investigation or treatment, superstition or just plain stupid obstinacy on the part of the patient are factors beyond the control of the G.P. Such cases when they do go to hospital later invariably draw unfavourable comments from the hospital practitioner.

The time has come when we must do something about our standards. We must form our College of G.P.s with the sole aim of maintaining standards and raising them. By standards I refer to medical as well as ethical standards. Postgraduate courses run by bodies like the Academy and the School of Postgraduate studies tend to be rather academic without real practical value.

If we look ahead our College could embark on a research programme conducted by its members on diseases or disease patterns seen in general practice. Nothing or next to nothing has been done by our fellow G.P.s in this field not because of the lack of opportunity or material, but because of lack of co-ordination and guidance and perhaps most of all because there is a tendency for us to fall into a rut after a while.

Our Own Examinations

Once we have started our own College we should organise courses interested in general practice. We should also conduct periodical courses leading to an examination similar to the M.R.C.G.P. or the M.R.A.C.G.P. examinations.

Above all the College should constantly impress on the members the importance and necessity of upholding medical ethics, a subject rarely taught at the undergraduate level and usually only brought up when an infringement has been committed by a medical practitioner.

We can enlist the help of the Post-graduate School of Medical Studies, the Academy of Medi-

● See Page 4

IN THE 1970s. . .

The First Council of the Singapore College. The College was officially registered with the Registrar of Societies on 30th June 1971.

From left to right: Dr Ted Wong Hoption, Dr Colin Marcus, Dr Koh Eng Kheng, Dr Lim Boon Keng, Dr Foo Choong Khean, Dr Wong Heck Sing, Dr BR Sreenivasan, Dr Wong Kum Hoong, Dr Leow On Chu. Absent: Dr Chen Chi Nan

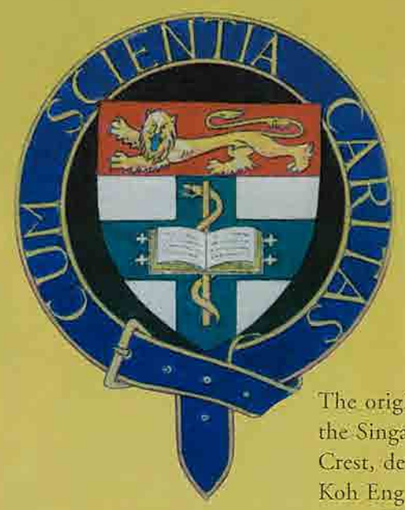
Conferment of the Honorary Fellowship of the College on Sir Gordon Arthur Ransome, Emeritus Professor of Medicine on 13th April 1973. Conferred together with him were Datuk (Dr) Lim Kee Jin, Dr Wesley Fabb and Dr Richard Banks Geeves. They have been great supporters of the College.

COLLEGE MEMORABILIA

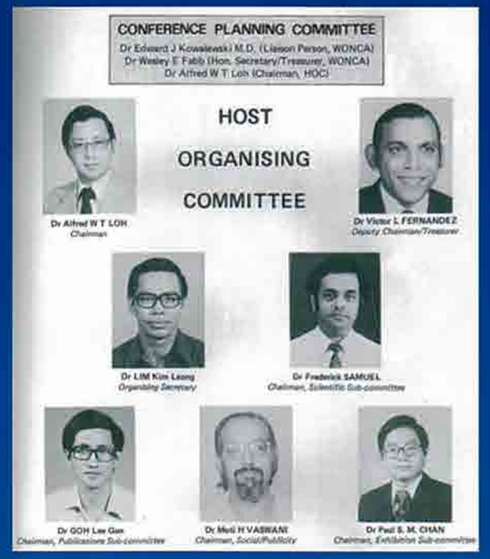
Gift of the Presidential Chair from the Royal Australian College of General Practitioners – March 1972.

The Albert Lim Award.

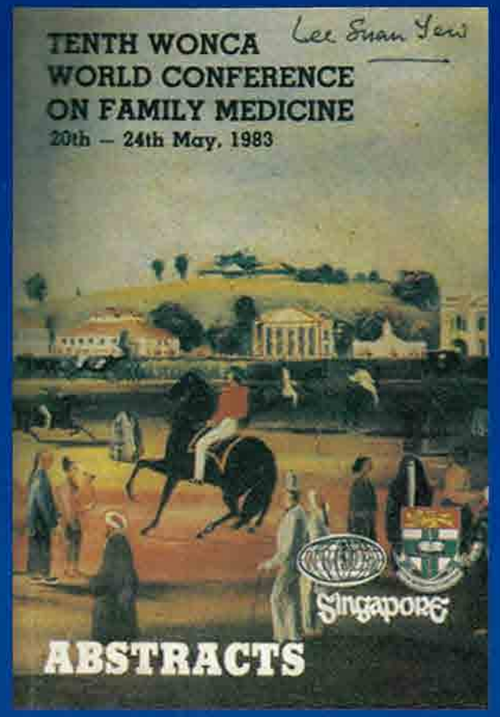
Gift of the Presidential Gavel from the Royal Australian College of General Practitioners – March 1971.



The original drawing of the Singapore College Crest, designed by Dr Koh Eng Soo – March 1971. The open book represents knowledge and continued learning and the caduceus is the recognized symbol for the art of learning.



The Host Organizing Committee of the 10th Wonca World Conference. Their hard work has since become part of our College legend. In those pre-information technology days, the team managed to produce conference proceedings ready for collection by the delegates on the very day that the Conference ended. Till this day, no organizing committee of the Wonca World Conference have managed to repeat this achievement. The historic event also bonded a team of dedicated members who were later to become key leaders in our College and the role models for many of our volunteer members. Amongst them was a bespectacled young man with thick black hair who was in charge of publication. He eventually became the first professor of Family Medicine in Singapore.



The book of abstracts of the Conference.

WONCA WORLD CONFERENCE SINGAPORE 1983

The international delegates at the Wonca 1983 Conference.

IN THE 1980s. . .

NATIONAL UNIVERSITY OF SINGAPORE
DEPARTMENT OF SOCIAL MEDICINE AND PUBLIC HEALTH
FACULTY OF MEDICINE

NATIONAL UNIVERSITY HOSPITAL
LOWER KENT RIDGE ROAD
SINGAPORE 0511
REPUBLIC OF SINGAPORE

11 December 1986

Dean
Faculty of Medicine
National University of Singapore
Lower Kent Ridge Road
Singapore 0511

Dear Dean

We submit herewith a "Joint Memorandum on the academic recognition of the discipline of Family Medicine in the Faculty of Medicine, National University of Singapore". This document is a result of several months of joint consultations between the College and the Department. It comes with the unanimous agreement of both bodies. We both sincerely feel that the implementation of the proposals within would go a long way towards the improvement of the standards of general practice in Singapore. Both the College and the Department are very keen to proceed with their implementation as soon as the University would give its approval.

May we take the opportunity to thank you and the University for your moral support throughout the recent months for the idea of improvements in general practice teaching.

With warmest regards and compliments of the season.

Yours sincerely

PROFESSOR W O PHOON
HEAD OF DEPARTMENT

DR LEE SUAN YEW
PRESIDENT
COLLEGE OF GENERAL PRACTITIONERS
SINGAPORE

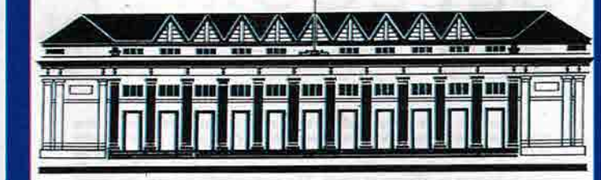
Enc

The Joint Memorandum on the academic recognition of the discipline of Family Medicine in the Faculty of Medicine, NUS submitted on 11 December 1986. On 13 Feb 1987, the Department of COFM was formed.

Opening of the new College Premises. Our present premises at the College of Medicine Building was officially opened by Mr Howe Yoon Chong on the 15th August 1987.

THE NEW PREMISES OF THE COLLEGE OF GENERAL PRACTITIONERS, SINGAPORE

Saturday, 15th August 1987



COLLEGE OF MEDICINE BUILDING

Officially opened by
Mr Howe Yoon Chong
former Minister for Health, Singapore

College Examiners. From left to right, Drs Lee Suan Yew, Lim Kim Leong, Prof Wes Fabb, and Dr Tan Yean Tin. Prof Wesley Fabb from the Royal Australian College of General Practitioners and an Honorary Fellow of our College was the first of the external examiners of our MCGP examination. Together with Dr Richard Banks Geeves, he was sent to Singapore by the RACGP to help us set up our first examinations. Prof Fabb was also the first HMDP expert in Family Medicine in 1988.

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CULTIVATING HABITS FOR LIFE-LONG LEARNING

A/Prof Goh Lee Gan, Dr Julian Lim and Dr Moira Clare Goh Chin Ai

INTRODUCTION

The practice of medicine requires us to continue learning. Family medicine covers a wide terrain and the ability to cultivate habits for life-long learning is necessary. This involves the cultivation of IQ (Intelligence Quotient) and EQ (Emotions Quotient) of life-long learning.

THE IQ OF LIFE-LONG LEARNING

The IQ of learning consists of five general principles and two specific strategies.

General Principles

Be organized

- Have your books at hand to refer to when you are at work or studying. Since there is a lot to learn about diagnosis and therapeutics, the following will be useful – the British National Formulary or equivalent, Current Medical Diagnosis and Treatment, and MOH Clinical Guidelines.
- Organise your notes into folders. Since family medicine has a huge terrain, it is better to lump topics rather than split them too finely; this will make it easier to file and find the articles that you want to refer to. You can use the FMTP topics as a framework. Since there are 8 modules, 24 submodules and 64 sessions, you can make your choice to have 8, 24 or 64 folders. You may also wish to build up the numbers as you go along. You should also have one folder for research articles and one for teaching materials.

Be ready to learn

Learning is not achieved unless you are ready. In clinical medicine the things you need to learn are three in categories: new things, mistakes and near misses, and how to do things better.

- New things are found all the time in therapeutics, disease entities and complications, and recent advances.
- Mistakes and near misses particularly the latter have a lot to learn from. Learn how to prevent slip-ups.
- Do things better. There is always a place for this. As Hippocrates observed: Life is short, art is long, experiences fleeting and judgment difficult; the physician must make the right decision at the right time. This presupposes the mindset to continually strive to do things better.

Seize the teachable moment

The teachable moment is when ignorance is encountered or the unexpected grips you. Do you let go or go through the reflective cycle (Fig 1) to learn new things?

- Don't let it go. Use every teachable moment.
- Check it up – do it now if you can; reflect on it in your quiet time.
- Write it down, collect this case or experience as one more item for your personal portfolio.

Work out a routine

Unlike during the undergraduate days, in the postgraduate period, there are many more things to occupy one's time.

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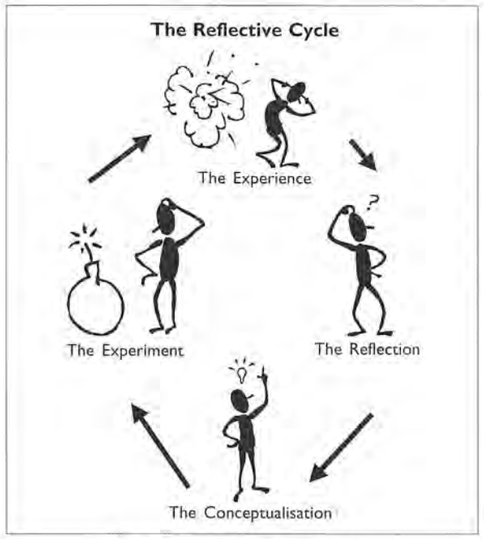

Fig 1. Learning from experience

- Find a slot around your daily routine for self-study. It may well be when the children are in bed.
- Make plans that are real. The best way towards that is to try and honour what you planned and do not chop and change at will.
- Divide the big learning task into manageable ones. In this way, apparently impossible tasks get done. This has been dubbed the technique of "swallowing the elephant in parts".

Attend to the fundamentals

There are three fundamentals to attend to:

- Remember the Pareto Principle – 20:80 rule. The number of important things are finite. Look out for the 20% of all the things that we really need to master.
- Have a system of study – Fill your pot holes always; Top your plateaus often, Scale your peaks sometimes. In Figure 2, that particular doctor has to fill up the valleys in O&G. He has also to consolidate his plateaus of medicine and immunsation to the MMed(FM) level. His peaks are in surgery and geriatrics and these will need less attention for the moment. He needs to scale these only sometimes.
- Practice evidence based medicine – practising medicine without scientific basis as short cuts has its dangers. The right approach will be to find out more about the natural history of various diseases and the reasons for delayed recovery. The clinical problem becomes a teachable moment and a moment for reflective learning.

Practise and consolidate

- Develop useful study skills – One of these is the SQRRR method. The letters stand for skim, question, read, recall and revise. It is a useful method for dealing with large volumes of notes. The skimming process will identify the appropriate parts if any, to pay attention to. The next step will be to question the extent it will fill existing gaps of knowledge or is it materials that you already know. Consequently, you may need only to study a small part. For this, the three Rs then are assiduously applied.
- Do MCQs and work out SAQs – These exercises help to assess learning and

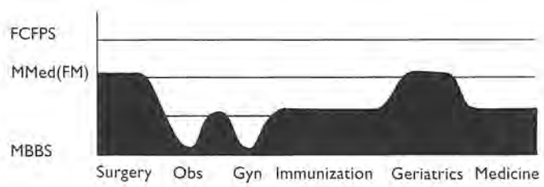

Fig 2. Fill up your valleys

respectively, whether the correct understanding and the ability to express what is learnt succinctly has taken place.

- Practise psychomotor skills – Test out your clinical examination skills and examination style time and again.
- Brush up your medicine – Consolidate your knowledge base periodically by reading systematically the whole subject.

Specific Strategies

Learning from patient to book

The patient is the "living text". As clinical presentations are not always textbook style we need to see enough patients with a particular problem to have a good ability to make a diagnosis. Also, the patient presents scenarios where management may have to be individualised. How do we learn from the patient as "living texts"?

Portfolio based learning is one way. Starting with some patients that capture our attention as interesting, record the patient's particulars for later retrieval; record the key features to remind yourself of the case and the special features to note in a portfolio based record (PBR) (Fig 3). File the record according to topic eg cardiology, respiratory etc. Dig up these records in your self-study time. Fill in learning points. Redo with more details only for those required for presentation purposes. We could keep records of patient's complaints, complications of treatment and incidental findings. We could also keep results of laboratory tests, ECGs, imaging studies and even photographs. Now that the digital camera is affordable, the pictures can be easily captured and saved to make an electronic album. Together, these materials form a portfolio of learning materials that could be reviewed, shared with other colleagues, be used as talking points as well as be the substrate for tutorials.

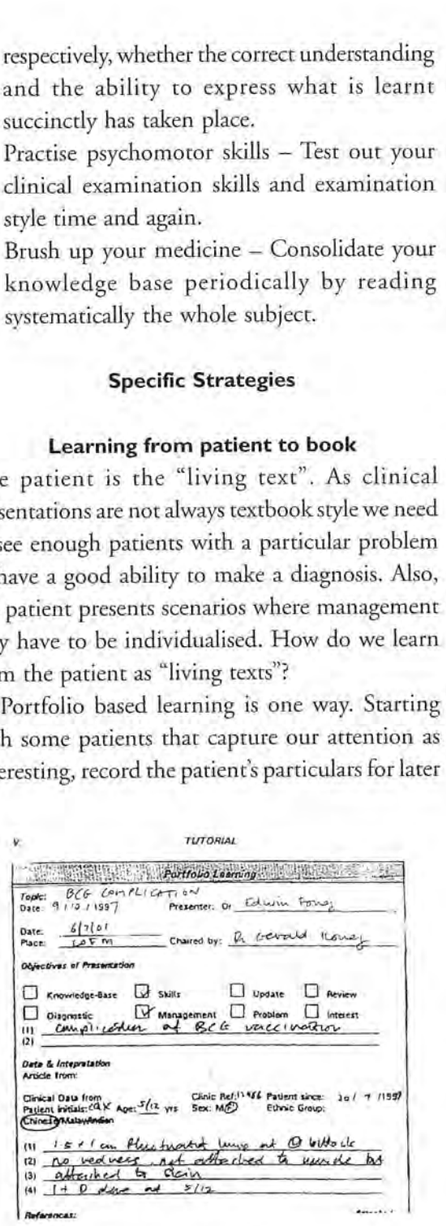

Fig 3. Portfolio Based Record (PBR)

From book to patient

The textbook that we are referring to in this context is one containing descriptions and information on one or more of the following aspects of clinical medicine – clinical features, diagnosis, investigations and treatment.

The textbook provides us with facts and frameworks for diagnosing medical problems and detecting complications. We need to be able to reframe these facts for use at the bedside. It is good exercise to work these out before we encounter the patient. This is the book to patient approach.

To help us to accomplish this we can use

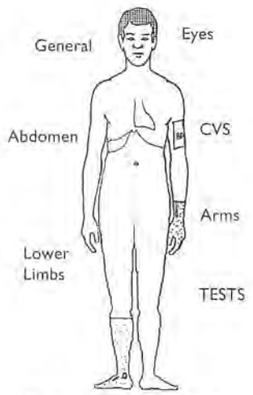

Fig 4. Approach to Adult Clinical Case: Patient with Diabetes Mellitus

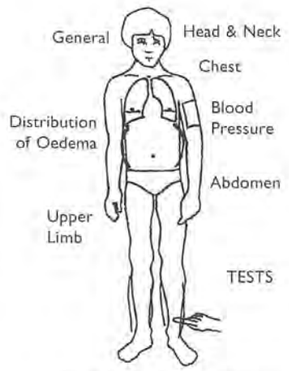

Fig 5. Approach to Child with Odema

figures from which we can write in them the information to look for in the patient. Figure 4 and 5 shows the headings for facts we need to look for in a child with oedema and an adult with diabetes mellitus.

The EQ of learning

Learning also has an EQ angle. There is a need to be able to deal with the following:

- Fight that sinking feeling – I am just hopeless, I just studied it last night. Solution: Normalise – "life is just like that; you learn and you forget; the next time will be easier"
- Inspire yourself – "Looks real tough – 40 pages to read before bedtime". Solution: Practise self-talk – "I have done this before; I am sure it is not half as hard once I get started; and there is that SQRRR method that I can use."
- Take care of yourself – "I am so tired, and..." Solution: Take a nap, call it a day. Rest is important. You will feel recharged after a break.
- Think positive and enjoy your work – "Oh dear, more patients to see, some more things to attend to..." Solution: Practise self-talk – "They need my help and I am in the position to make a difference."
- Share the slices of life in the school of life – Listen to and read inspiring thoughts and stories. Teach others to do that too: "As he will gladly learn, so will he gladly teach".

CONCLUSIONS

Cultivating habits of life-long learning is a process of modeling on what others have found effective, developing oneself and coaching oneself and others to be good at it.

GUIDELINES: PRODUCE, USE, DISUSE AND MISUSE

Dr Lee Kheng Hock

INTRODUCTION

Evidence based medicine is the distinctive of doctors who practice modern medicine as compared to the practitioners of complementary medicine. Whilst we are aware that many of the things we practice are still not based on scientific evidence, there is agreement that we should change when evidence becomes available. At the minimum, it should make us uncomfortable and circumspect.

Clinical practice guideline is evidence based medicine in action. Guidelines can be a double-edged sword. Valid guidelines lead to improvement in patient care and increase in cost-effectiveness. Invalid guidelines lead to ineffective intervention and wasteful use of resources[1]. The validity of guidelines is maximized by sound methodology in planning and thoroughness in execution.

Whilst there are many guidelines that are enthusiastically churned out, very few bear fruit. Many do not even go beyond the dissemination phase. It is important for those who contemplate writing guidelines to plan and execute the full cycle of the process down to evaluation and revision. The "fire and forget" approach to guideline writing had generated much skepticism amongst practitioners towards practice guidelines. Table 1 shows a schematic diagram of an ideal practice guideline cycle.

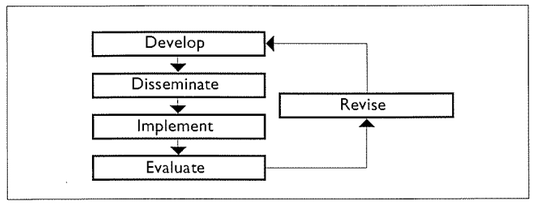

Table 1. Schematic diagram of an ideal practice guideline cycle

HOW ARE GUIDELINES PRODUCED?

Development phase

The common method is to start by gathering a panel of experts, stakeholders and opinion leaders. Issues like compensation for time spent and reimbursement of expenses have to be considered. Good guidelines take a long time to develop. The dedication of the group members is critical to the success of the project.

This is followed by a process of information collection usually in the form of published literature on a subject. Electronic databases have greatly helped the process of searching and collection of relevant information. It is usually good to lay down criteria for accepting or rejecting information. A trained health services researcher is extremely useful in this phase of development. A system of sifting through the evidence should be laid out. The panel then goes through the literature and information collected. It is useful to grade the quality of the information collected. A good way of categorizing the quality of information (Table 2) and the strength of recommendation (Table 3) was devised by the Canadian Task Force on the Periodic Health Examination. This has gained widespread acceptance amongst guideline developers[2]. An adaptation of this, which is used by the North of England evidence based guidelines development project, is an elegant way of implementing the idea to guideline development[1].

The views of the experts are usually merged through consensus development. This often would involve an element of compromise and can be affected greatly by group dynamics. The quality of guidelines and perhaps even the outcome of the recommendations adopted are influenced to a great extent by the selection and composition of the panel as well as by the rigor with which the information is gathered and scrutinized.

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Categories of Evidence

I. Based on well designed randomized controlled trials, meta-analyses, or systematic reviews.
II. Based on well designed cohort or case-control studies.
III. Based on uncontrolled studies or consensus.

Table 2. Categories of evidence

Strength of Recommendations

I. Directly based on Category I evidence.
II. Directly based on Category II evidence or extrapolated from Category I evidence.
III. Based on uncontrolled studies or consensus

Table 3. Strength of recommendations

There are basically two components in the recommendation making process. The first is the creation of consensus among the panel of experts. The second is the formal, systematic review and analysis of gathered information and data. The quality of information is also graded based on the quality of the studies that produced the information. The tendency is to favor high quality information derived from well designed studies. When evidence from the literature is lacking, recommendations are often based on consensus statements of bodies of experts or influential medical peer groups.

The format in which the practice guidelines are presented in is an important determinant of the quality of the practice guidelines. Developers of guidelines often neglect this aspect. Guidelines are meant to be used. It is a waste of time and resources to produce a perfect guideline that is too cumbersome to be used in real life practices.

Algorithms, charts and tables are very useful aids that allow quick reference and increase the likelihood of the guidelines being used by physicians. The recommendations must be logical and unambiguous. Recommendations are more likely to be accepted if the rationale is explained. This is especially true if they are backed by strong evidence from papers that are listed for verification.

Dissemination

Although the need to disseminate guidelines to the intended users is painfully obvious, many guideline developers give little thought and make no effort to this important area of guideline development. The method by which guidelines are delivered to the users needs careful consideration. Studies have shown that publication of guidelines in journals is the least preferred by users and is unlikely to change medical practice[3]. A more effective way is to deliver the guidelines to the users individually. Publicizing the availability of the guidelines is also important. There is an increasing trend to have guidelines in electronic formats that can be transmitted or downloaded via the Internet.

Implementation

Implementation strategy is the final step towards usage of the guidelines. It is not enough to convince the recipient of guideline of the quality and the validity of the written guidelines. The acid test of the success guidelines lies in whether it is able to convince users to implement the recommendations and change their practice.

Educational events centered on the guidelines had been found to be the most effective way to encourage the adoption of guidelines[4]. The adoption of guidelines is increased when peers and professional bodies endorse them. Endorsement by local opinion leaders is also helpful.

Even when the users had been won over

intellectually, guidelines are often not used because it fails to trigger action at the point of decision making. Old habits are hard to change and a new way of managing problems takes time to become routine. It is therefore very important to have physical reminders and checklists during the early adoption phase. Ideally these reminders should present themselves before the physician at the point of decision making. Such reminders may take the form of a desktop computer programme, charts or tables attached to medical records or special markings that are visually prominent.

Audit projects that are based on the adoption and implementation of specific guidelines are exceptionally effective ways to increase compliance to guideline recommendations.

An effective but potentially problematic tool to increase guideline adoption is to leverage the support of purchaser of health care services. Third party payers, which may include the controller of public funding, can exert a strong influence on the behavior of health care providers. However, this may conflict with the need for clinical autonomy and increase the risk of guidelines being abused and used for purposes other than helping clinical decision making.

Evaluation

The desired end result of practice guidelines is better clinical decision making and improved patient care. Ideally measuring treatment outcome should be a good assessment of the effectiveness of guidelines. Unfortunately, improve outcomes may be difficult to detect because of technical reasons like small sample size, lack of funding, difficulty of recruiting patients and so on. Furthermore even when evaluations show little improvement, it would be difficult to know if the guidelines were giving wrong recommendations or whether there were inadequacies in the dissemination or implementation process. Audit projects are useful ways of assessing whether guidelines have been followed. Clinical decision making before and after guideline implementation can be compared and studied. It could also take the form of goal setting and measuring how progress has been made towards attaining a standard of practice as recommended by the guidelines.

Revision

Since good guidelines are the product of evidence based medicine, they must be constantly revised as more evidence surface in the literature and new knowledge come to light. Similarly, since guidelines are meant to help clinical decision making, they must be revised or improved if evaluation shows that they are not helpful. This final link in the chain of the guideline development process is the most telling feature of whether a particular guideline is truly successful and whether the producers of the guideline were serious minded people.

WHY GUIDELINES ARE DISUSED?

In a random postal survey of 627 general pediatrician members of the American Academy of Pediatrics, it was found that 21% of respondents do not use guidelines at all[5].

In their enthusiasm to be comprehensive, many authors produced guidelines that are too complicated and difficult to use. Authors of guidelines must accept that thoroughness is a virtue in preparation but a vice in crafting. In the management of diseases, there are multiple decision points. It is important to identify major and critical decision points and limit recommendations to these points[6].

A study of 12880 clinical decisions made by 61 general practitioners in Netherlands showed that certain attributes in guidelines are more likely to encourage compliance than others. Non-controversial recommendations are favoured over those that are controversial. Specific recommendations are preferred over those that are vague and non-specific. Evidence based recommendations are more readily accepted. Recommendations that demand extra resources, acquisition of new skills and knowledge are less likely to be followed. Likewise recommendations that may provoke negative reactions in patients are not well accepted[7].

HOW GUIDELINES CAN BE MISUSED?

A common complaint heard among practitioner is that guidelines are too many and too complicated. Enthusiasm in embracing evidence based medicine has led to a proliferation of guidelines. It was estimated that in the United Kingdom alone, regional audit programmes produced about 2000 guidelines within a short span of time[8]. This proliferation, which was initially welcome, have now reach a level that it generates negative feelings towards guidelines. Increasingly, there is a feeling among practitioners that some guidelines were written for the sake of writing.

Many physicians feel that guidelines are abused when they are used for purposes other than to guide clinical decision making. A survey showed that 82% of doctors felt that guidelines should not be used in litigation. Seventy seven percent felt that they should not be used in disciplinary actions and 73% felt that usage of guidelines should not be based on the desire to reduce cost[5].

There were also concerns that clinical guidelines may be used like a "cook book". Using clinical practice guidelines in such a fashion would be extremely disastrous in the primary care setting. As we know guidelines are based on population studies. Even the best studies are never perfect in their effort to remove bias and confounding factors. Assumptions are often made in the design of studies as well. Validity of even well designed studies had often been found to be lacking in population sub-groups. Generalizing findings of population studies to an individual with his unique biopsychosocial milieu is even more problematic. Unthinking adherence to guidelines developed by non-clinicians is a recipe for disaster. This have made primary care organizations like the Royal Australian College of General Practitioners to state in its position paper that clinical guidelines should be developed by "practicing clinicians in such a way as to provide useful assistance in practical settings rather than merely as a "recipe" for intervention." [9]

PUTTING THE GUIDE BACK IN GUIDELINES?

Notwithstanding the merits of evidence-based medicine and the attempts at systematic application of methodology, guideline writing remains an inexact science which carries the value judgment of the authors. This is a clearly demonstrated in a study on hypertension guidelines of different countries[10]. Despite drawing data from the same bodies of evidence, different countries came up with different recommendations. Using the guidelines of one country as a standard, up to 50% of patients in another country would have been considered as being treated unnecessarily. This is despite the fact that all the countries studied were fairly similar in terms of culture and economic development.

There is therefore a subjective element and an experiential component in guidelines that cannot be denied. The experience, the value judgment and the special interest of the panel members responsible for crafting of guidelines would have a non-negligible effect on the recommendations of the guidelines. Treatment decisions often depend on weighing the risks and benefits. Different authors or groups of authors would make different value judgment in risk-benefits assessment. What constitute acceptable risk to one may be unacceptable to another.

There is consensus that guidelines must be concise and limit recommendations to major decision points. A conscious attempt must be made to avoid creating guidelines that are so comprehensive that becomes too unwieldy to be used.

CONCLUSIONS

Practice guidelines are the product of evidence based medicine. It is ironic that there seems to be little change in behaviour on the part of guideline developers in the light of mounting evidence that guidelines are ineffective in changing practice behaviour. There are many reasons for the failure of guidelines. It begins with many wrong assumptions that make the whole process invalid before work is even started. Some common incorrect assumptions are:

- Health care resources are unlimited.
- Patients will comply with the recommendations if the physicians say so.
- Physicians will comply if guidelines are delivered.
- Recommendations derived from population studies can be applied to individual patients regardless of their biopsychosocial uniqueness.

Even when guidelines are well written many failed because of a lack of follow-through. It would appear that many guideline developers are more interested in the publication of a guideline than the desired effect that guidelines should have in improving clinical decisions. Guidelines are means to an end and we should question the need of guidelines that do not give serious consideration to practicality issues during implementation.

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ROLE OF THE FAMILY PHYSICIAN IN DISEASE MANAGEMENT FOR ELDERLY PATIENTS

A/Prof Goh Lee Gan

ABSTRACT

Disease management as a new paradigm in health care delivery offers new challenges to the GP fraternity to stay relevant. There are two models of disease management. The primary care based disease management model is to be preferred over the carve-out model. The disease management paradigm for the elderly offers opportunities to provide better care for this group of people. The GP has much to offer in at least five areas of care for the elderly: reduction of risk factors to strokes and ischaemic heart disease; care of acute problems; management of the five giants of geriatrics; management of frailty and dependency; and detection of early cancer and management of the late stages. The GP's role is preventive, curative, palliative and supportive. He also has a role in caring for the carers. The response from the GP fraternity to the disease management paradigm needs to be both educational to enable and empower themselves; and political to win the support of the public, the profession, the policy makers and also the press.

INTRODUCTION

This paper examines the role of the GP fraternity in disease management and the responses needed from the stand point of a family physician.

THE CHALLENGE OF DISEASE MANAGEMENT

The care of patients by the GP has generally been episodic acute care and fragmented chronic care. This has been slowly changing as the values of a family doctor take root in the community in the wake of a family medicine vocational training programme which was introduced in 1988.

It is not unusual even in the present, for a patient to have several doctors: the GP for minor ailments and the specialist for hypertension, diabetes mellitus, and heart disease, and the polyclinic doctor to provide continuing care of the chronic medical problems. The GP commands a low fee and he or she has to resort to high volume of patients to earn the desired income. The specialist's fees are higher and less open to haggling.

The advent of more sophisticated patients, a larger number of GPs and the arrival of disease management as the next innovation in health delivery together with a growing elderly population presents a challenge that demands a rethink of the GP's role in order to stay relevant.

The GP needs to consider the change from an episodic and fragmented service provider to a disease management care provider. As the elderly will account for 27% of those 60 years and older in 2030, the GP will have increasing numbers of elderly patients seeking his care, provided of course, he stays relevant.

Models of disease management

Bodenheimer (Bodenheimer, 1999) commented on the possible models of disease management namely, a carve-out model or a primary care-based disease management model. Diabetes mellitus is a prototype condition for disease management.

Carve-out model. The proponents of carve-out disease management model would abandon a medical care system based on comprehensive health care organizations in favour of a fragmented collection of specialized facilities centred on diseases rather than people. The focus is on patients who are at high risk. The worry is that disease

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management this way could result in patients being shifted from programme to programme, with providers taking responsibility only for their particular "slice" (Nash, 1997).

Primary care-based disease management model. In such a model, the primary providers are in charge and they take care of not only the high risk patients but those with low risk as well. The focus is to teach patients to manage their own illness. Primary care teams are formed and supported by specialist staff to coach them how to make the best use of a 10-to-15 minute visit (Spalding, 1996; Von Korff et al, 1997).

Obviously we need to work towards the latter model. To achieve success, we need to set our vision to work towards:

- defining the GP's role in the paradigm of integrated care
- taking steps to adopt and adapt to this role

GENETIC ROLE OF THE GPS

The generic role of the GPs can be summed up by two pictures:

The prism of healthcare – to enhance and maintain health status, health promotion and disease prevention must form the base of our healthcare services, followed by primary care, secondary care and with the apex being contributed by tertiary care. The GP is therefore well placed for making a difference to the health of the elderly (Fig 1).

The spectrum of healthcare – for those who fall ill, the GP has a spectrum of care that he can provide: essential treatment and lifesaving care, palliative care, supporting carers and health education and prevention for future episodes (Fig 2).

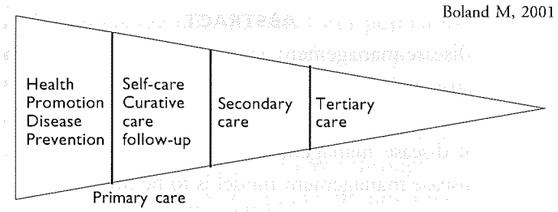

Fig 1. The prism of health care

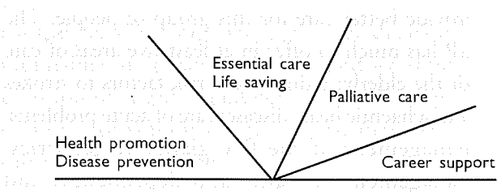

Fig 2. The spectrum of health care

PRIORITY CARE AREAS IN THE ELDERLY

The priority care areas of the elderly from the GP perspective are the following five:

(1) Reduction of risk factors for strokes, ischaemic heart disease and chronic obstructive airway disease – Contrary to common beliefs, there is much to be gained in reduction of risk factors, even in the elderly. Control of hypertension is important in preventing strokes; lipid levels and exercise in ischaemic heart disease; smoking in chronic obstructive airway disease; and diabetes mellitus in the reduction of multi-system complications.

(2) Treatment of acute infections and organ failures – these may present atypically, have only a small window of opportunity for intervention and restoration of the fragile health status.

(3) Management of the five giants of geriatrics – These are: instability, immobility, incontinence, iatrogenic effects of polypharmacy and intellectual failure.

Attention to these are important in preserving the fragile health status or quality of life. For example, attention to instability and immobility to reduce the risk of falls and fractures; drug use and side effects and risk of falls; intellectual failure and need for carer support in the face of deteriorating ability to provide self care.

(4) Management of frailty and dependency – the old-old (75 years and older) will be increasingly frail physically to need carer support to remain in the community. They would require particular care in helping them deal with infections and other acute insults.

(5) Management of cancer – these become more common in the elderly and early detection can reduce morbidity and mortality; for those who are beyond cure, attention to palliative care is important to ensure quality of life.

ROLE OF THE GP IN INTEGRATED CARE FOR THE ELDERLY

It can be seen that opportunities for the GP to work with the rest of the healthcare delivery system to ensure optimal care for a given level of resources are many.

SOME EXAMPLES

The acute unwell. We need to pay attention to the acute unwell to ensure that intervention is timely. The classical example is the patient with pneumonia. Appropriate and early use of antibiotics can reduce a downward spiral of poor health if not mortality.

The post-hospitalized patient. For the post-hospitalized patient, a system of step-down care with the GP playing a greater role once the acute hospital episode has been managed can be envisaged. An example of this is the stroke patient. The GP can certainly co-ordinate the rehabilitation of the stroke and work with the patient and carers to prevent a further stroke.

The low risk well elderly. We need also to pay attention to the low risk well elderly. Attention to these individuals may not be immediately cost effective yet the savings down the road will be hefty. An example of this is the control of hypertension.

More than one trial in the control of hypertension in the elderly demonstrated positive health outcomes in the reduction of stroke (SHEP, Eur-Sys, STONE).

The Systolic Hypertension in the Elderly Program (SHEP) illustrates the point. It was the first large-scale trial to document a benefit from treatment of Isolated Systolic Hypertension in the elderly. The 4,736 patients enrolled in this double-blind, randomized, placebo-controlled study were 60 years of age or older showed that the reduction of systolic pressure to less than 160 mm Hg in those with initial readings of more than 180 mm Hg and the reduction of the systolic pressure by 20 mm Hg in those with initial readings between 160 and 180 mm Hg resulted in an average systolic blood pressure of 155 mm Hg in patients taking placebo and 143 mm Hg in patients receiving medication (SHEP, 1991).

The overall results were very impressive. The number of strokes was reduced by 36% in the group receiving medication compared with the group receiving placebo. Analysis of secondary end points showed nonfatal myocardial infarctions plus death from cardiac causes to have been reduced by 27% and major cardiovascular events by 32%. The incidence of congestive heart failure was cut in half by treatment with medication (Pentz, 1999).

RESPONSE TO THE DISEASE MANAGEMENT CHALLENGE

Two responses are required of the GP fraternity in this context in delivery of care to the elderly:

- Enable and empower themselves in the knowledge, skills and attitude of disease management in the context of the elderly; this is the educational response;
- Win friends and influence people on what the GPs can do in the disease management era; this is the political response.

The political response is as important as the educational one. There is a need or the GP fraternity to convince the 4 Ps – public, the profession, the policy makers and the press.

The public needs to be convinced that their neighbourhood GP can now look after them for a large part of the care that they or their loved ones need. The dissemination of such information is much needed. The press can do this. Hence, it is also important to keep the press informed and convinced.

Within the profession, there is a need to convince each GP of the new focus as well as to enlist the support of the specialists to assist and include the GPs in the disease management programmes. In this way, the prism of GP care will be maintained.

The policy makers in the two clusters of health care would need to work with the GPs to develop a more integrated programme of care across the whole range of health care and population groups. There has been encouraging initiatives from the two clusters.

The GP fraternity need to work on these initiatives. GPs can be involved at the level of being in touch with the cluster initiatives, or at a higher level of shared care and stepped down care, or at yet a higher level of administration and liaison with the policy makers to implement the disease management concept that includes the GP fraternity.

CONCLUSIONS

The disease management paradigm is a challenge for the GP fraternity to continue to be relevant. There are opportunities for developing the primary care based disease management model in the care of the elderly. The response from the GP fraternity needs to be both educational and political. The fraternity needs to educate themselves and also to win friends and influence the public, the profession, the policy makers and the press of the new role that it can play.

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RESEARCH DIRECTIONS

Dr Tan Ngiap Chuan

INTRODUCTION

The potential in clinical research in family medicine is enormous as not enough is known about the common day-to-day problems, which occur outside the hospital. Chronic diseases such as diabetes mellitus, hypertension, hyperlipidaemia and asthma are fertile ground for research for the local family physicians. In fact, the scope for primary care research is wide, ranging from basic and clinical studies to health service and health system evaluation.

A paradigm shift through the initiation of regular research meetings, training, infrastructural support and a collaborative research network development to optimize time and resources, is the way ahead. The establishment of a sound primary care research culture not only confers benefits to the medical profession at all levels but enhance the quality of healthcare for all citizens in Singapore.

Primary care research has benefits. For the family physicians, research enhances the capacity to think logically and precisely so as to determine the roots of the problem and seek the pathways to all the possible solutions. This allows the family physicians to reflect on the problems in their practice and be critical on the deception and fallacies that occasionally exist in medical literature and publicity blitz by pharmaceutical companies. For health organizations, research is the foundation for continuous improvement in the content and delivery of quality health care service to their respective community.

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THE STATE OF PRIMARY CARE RESEARCH IN SINGAPORE

More needs to be done

Family physician-initiated studies in Singapore have mainly been small scale, ad-hoc in nature, self-funded and published in local medical journals. The College of Family Physicians, Singapore has been the body instrumental in stimulating family medicine research. An annotated review by Chong [1] showed that from 1971 up to 1987, general practitioners produced a total of 56 papers. Some of these were personal reflections. Some of the bigger studies done and reported in the Singapore Family Physician were that on causes of death, housecalls, diabetic care and the clinic consultation pattern in the practice, and two one-day morbidity studies (Emanuel et al [2, 3]).

Studies related to family medicine and reported in indexed journals so far have all been from University academics. They cover the subjects of bronchial asthma, diabetes and complications, consultation fees, diet and obesity. Together they totalled less than 50.

The quantity of family medicine research to-date indeed shows a paucity. The scope for family medicine research is therefore wide open for researchers interested in this field.

Mindset and training

The advent of biomedical techniques and progressive sophistication of the basic sciences led to a shift of such observation to the hospitals and laboratory settings. This is translated into a belief that research is the exclusive domain of the research scientists in tertiary institutions. This impression is still prevalent amongst family physicians and needs to be rectified.

The quest for the truth requires an inquisitive mind and personal attributes of persistence,

curiosity and systematic thinking. Exposure and training are also important. Fortunately, the didactic education system in Singapore is fast undergoing change to a more problem based and discovery learning approach. The SSM (special study modules), UROP (Undergraduate research opportunities programme) provide opportunities for students to exercise organized curiosity, the synonym for research.

THE PRIMARY CARE RESEARCH AGENDA

Scope of primary care research

Primary care research has been categorized and well summarized by Starfield[4] as to be of four types: basic, clinical, health service and health system. Basic research addresses the development of methods to study subjects relevant to primary care services, regardless of whether they deal with a clinical problem or a characteristic of service delivery. Clinical research involves issues relevant to the processes of delivering services, including recognition of people's problems, diagnostic approaches, and types of therapy and their outcomes. Health services research concerns the relationships associated with the organization, financing and their impact on the processes and outcome of care. Health system research focuses on understanding how the economic, political, and social milieu influence the structures and processes of the health service system, with specific relevance to its primary care infrastructure.

Common day-to-day problems

The fertile ground to start primary care research is in clinical research in the practice. Not enough is known about the common day-to-day problems which occur outside the hospital. Studies conducted in such settings worldwide tend to be small, diffuse and inconclusive.

Take diabetes care for instance. Out of 1200 studies, only 5 could be grouped together in a meta-analysis by Simon Griffiths[5]. The UKPDS has of course given the world, some concrete answers like 1% reduction in HbA1c will result in a drop of 25% of cardiovascular sequelae. It is only as recent as 1997 that conclusive answers on upper respiratory tract infections were provided by Little[6] and his associates in UK.

Croughan-Minihane[7] in their survey of 120 GPs from the UCSF (University of California in San Francisco) Collaborative Research Network and another 85 at Stanford Ambulatory Research Network, the most common topics of interests were disease prevention, communication and compliance, and managed care. Among specific conditions, heart disease, hypertension and respiratory infection were of interests to the majority of the respondents. Chronic diseases such as diabetes mellitus, hypertension, ischaemic heart disease, hyperlipidaemia and asthma should stimulate research interests amongst family physicians in Singapore as these conditions are prevalent in the local population.

Whilst small studies are a start, the pooling of cases together is the way ahead. Only then will there be large enough numbers to give conclusive answers. This speaks for research networks. There is scope for large studies into other common conditions to find conclusive answers in the local setting. The search for the answers to these problems, in the context of their practice, will not only develop new knowledge but also bring benefits for the patients, the other family physicians, the community and the medical profession.

Health system perspectives

The organization of Singapore into two clusters, the experimentation of managed care and the rising costs of care spawn many primary care research questions from a health system perspective, as for example "what works" in terms of clinical effectiveness within the various components of health care.

THE WAY AHEAD

The way ahead lies in the simultaneous deployment of the strategies of mindset change through regular research meetings, training, infrastructure support, and a collaborative research network development.

Training

It is a sad fact that even with liberal doses of curiosity, an interesting issue and enough time and money, many good research ideas fail to each the stage of a completed project. We can learn from the Royal Australian College of General Practitioners, which provides the new GP researcher with guidelines on asking the right question, choosing the best method and getting results published. Research in primary care should be made more accessible by "demystifying the jargon, clarifying the statistics and explaining the rules of publication" [8].

The change of the medical curriculum at the faculty of medicine at the local university towards patient centered, evidence-based approach in problem solving is a step forward towards building a research-friendly environment. Original creative and collateral thinking, together with inductive reasoning should be encouraged in the medical schools. Emphasis should be geared towards clinical observation and investigation, hypothesis testing and critical thinking.

For the medical students with a predilection for family medicine, early involvement in medical school will enrich their experience. They need to be identified and opportunities should be made available for immersion in research projects during their long vacation. At this stage, effectual tutorship to steer them on the right course of research needs to be strengthened. Hueston[9] reported that for community-based family physicians, success at conducting and publishing research is enhanced by the availability of mentorship and previous research experience during the undergraduate period.

The momentum should carry forward to postgraduate training. Medical officers especially Family Medicine (FM) trainees, in their posting to the polyclinics or school health service, should be robed in to participate in community studies. Hands-on experience will be the most cost-effective modality to acquire research skills. Refresher courses on epidemiological and statistical methods and updates on statistical computing can be incorporated in their traineeship module or in the continuous medical education (CME) program for non-trainees. FM trainers who have completed their advance training or achieved higher degrees will serve as research mentors for the novice trainees and act as team leaders in research projects.

The Department of COFM in the university and Clinical Trials & Epidemiological Research Unit (CTERU) of the Ministry of Health can be targeted to be research-training ground for family physicians. Lecturers and trained epidemiologists and statisticians can work hand-in-hand to organize and co-ordinate user-friendly training program for the busy family physicians. On-line and distant learning are pragmatic considerations in the near future. Merit points should be rewarded and included in the current on-line CME program.

Mindset change through regular meetings

It is important that, family physicians who have indulged in research, should often and aptly

rewarded with opportunities to present their findings at local, regional or international meetings and conferences. They should lead the way by infecting their colleagues on the value of being involved in primary care research.

Infrastructure

Many studies show that research is not every family physician's cup of tea. There are personal traits, which enable the family physicians to take up research and are succinctly summarized by Dr Curtis[10] (Table 1). It is rare to find an amalgamation of all these attributes in a single family physician. The solution lies in developing a collaborative research network.

Collaborations with other family physicians and nurses and working in teams can overcome this shortcoming. Littlewood[11] in a survey of all GPs in an inner city area in UK showed that 61% of GPs carried out research in collaboration with nurses. Nonetheless, it is vital to recognize the above attributes of the co-investigators so that each member play a complementary role to ensure efficiency and competency in the execution of research projects.

The establishment of practice-based research network is a logical development of collaborative research projects by family physicians. This has been done in many of the developed countries e.g. UK. (Thomas P et al[12] 2001) and in the US (Nutting [13] 1996). Collaborative research by family physicians is "practical, feasible, personally and professionally rewarding, and likely to contribute important primary care knowledge" [14].

Table 1. Desired Personal Traits of Researchers

Research activity	Individual Main Attributes
Data collection	Compulsive – cooperative
Data coordination	Compulsive – organized
Data Analysis/interpretation	Compulsive, mathematical, clarity of thought
Study design	Compulsive, curious, conceptualize
Distribution of ideas and concepts	Persistence, enthusiasm, writing and speaking skills
Generation of ideas	Curious, creative, lateral thinking
Development of original concepts	Clarity of thought, creativity, genius?

Source: Curtis P, 2000 (Reference 16)

Identification of network physicians' interest can help in focused research, minimize duplication of efforts, optimize resource utilization and facilitate funding application. This allows the pooling of resources and works on a larger patient population base; a critical mass of researchers can be assembled to take on larger, more intensive research projects. In Singapore, a practice-based research network can be created through collaborations between the two clusters of polyclinics and the larger GP groups. Individual family physicians can overcome the constraints of size by working hand-in-hand with the research committee of the College of Family Physicians (CFPS). The GP groups must recognize the importance of research to primary care and elevate its priority status in the organization. As a service to the community, the groups need to motivate their doctors to undertake research as part of their continuous professional development, thus philosophically and physically commit themselves to research.

The research "laboratory" for family practice will be located in three areas:

1. University medical school setting where resources, teaching and inter-disciplinary activities are conducted.
2. Clinical trials epidemiological resource center (CTERU) and the research committees of the polyclinics and GP groups where there is a congregation of trained personals, specialists and experienced staff to facilitate research.
3. Ambulatory "practices" involving healthy and unwell people in their homes, communities and workplaces.

Training courses and manuals are also part of the infrastructure. Course manuals and notes should be written and updated with good and not so good examples of primary care research.

Ethics

A joint ethics committee between the Department of COFM and CFPS should be set up to safeguard the interests and safety of human subjects in family physician-initiated studies. Being a small island, it makes sense to establish a single centralized ethics committee to cater to these needs.

Thus, collaborations between the Department of COFM and CFPS will optimize human resource development in primary care research. A research association to integrate resource management may be set up once primary care research matures in Singapore. Community-based and university-based family practice researchers must come together and merge into a synergistic partnership. Family physicians often need the expertise of university statisticians, epidemiologists and the enthusiasm of fellow family physicians. University researchers look to the community for subjects and the key factor of generalizability.

CONCLUSION

Primary care research has a good research agenda. Researchers can start with clinical research into day-to-day problems. Health systems research is another fertile area. Infecting colleagues on the value of such research and the part they can play as part of a research network is important. The infrastructure needs to be developed urgently to provide for training, network collaboration and research process support.

Serendipity alone is insufficient to bring community and university-based researchers together. Family physicians must acknowledge their needs and actively seek out assistance. The university-based departments can respond by deliberately starting outreach programs, setting buddy systems, engaging pro-research family physicians, and tracking and urging their medical officers to continue to do research[15]. This trans-disciplinary depth of involvement will lead to a creative interrelationship that will be rewarding and contributory to a sound primary care research culture in Singapore.

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ACADEMIC PROGRAMMES OF THE COLLEGE OF FAMILY PHYSICIANS, SINGAPORE

Dr Lau Hong Choon

COLLEGE ACADEMIC PROGRAMMES

The College has 3 Academic programmes. The Academic year starts every July. The three programmes are:

- The GDFM Programme
- MMed(Family Medicine) Programme
- Fellowship Programme

The GDFM and MMed(FM) programmes are partly Internet based. Reading materials are periodically uploaded to the College Website for retrieval by participants. The self-directed learning sessions are complemented by workshops where case studies are discussed.

THE OBJECTIVES IN THE COLLEGE'S EDUCATIONAL THRUST

The primary objective of the programmes is structured learning to develop the general practitioner or aspiring family physician with relevant lessons in as complete a manner as possible with the time given.

A further objective is accessibility. The purpose of the basic programme – the GDFM is not to filter out but to include every general practitioner into the learning community so that he or she will be better equipped for family practice. The premise is that the MBBS is not specific enough for general practice.

THE ACADEMIC CORE

The academic core of the Diploma and Masters programme is the Family Medicine Training Programme or FMTP. This is essentially a two-year, 8-module course that encompasses the breadth of Family Medicine and General practice. Each module lasts for 3 months.

Summary of the FMTP

- The eight modules cover all major topics in general practice from birth to death, practice skills and standards of care
- In each module there are 3 broad categories of topics which make each module heterogeneous and broad based.

Submodules (categories) in each module

The 3 broad categories in each module are:

- Whole person Medicine (4 sessions)
- Disease Management by Body systems (3 sessions)
- Practice Management (1 session).

How each module is conducted

- The modules are patterned to enable adult self learning by having the eight weekly lessons in each module primed by 4 face-to-face workshops and 1 tutorial.

Attendance credits for exams

- The programme also motivates participants by only allowing 75% attendance of the workshops and tutorials as qualifying for credits for the GDFM or MMed Examinations.

GRADUATE DIPLOMA IN FAMILY MEDICINE (GDFM OR MMED EXAMINATIONS)

The Graduate Diploma in Family Medicine:

- Was introduced in July 2000
- Is a two year programme, and
- Aims to provide vocational training for the majority of doctors practising as family physicians in Singapore.

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Stretching the time to do the GDFM programme

Some practitioners may want to do the GDFM more leisurely. They can stretch the GDFM programme to be done in five years since each module of the FMTP is valid for up to five years before sitting for the exam. However they will have to take the FMTP again if they intend to continue to do the Masters since the FMTP is valid for only 5 years.

Self service – use the web!

The GDFM is in part an online programme using the College website to disseminate on-line materials through the web. GDFM tutorial notes are made available for document downloads.

FMTP core

By having a common FMTP core programme it is possible for the GDFM candidate to progress stepwise to the Masters after attaining the Diploma since the credits in FMTP is valid for five years.

Four skills course

- There are three compulsory skills courses to emphasize basic clinical and diagnostic skills essential to general practice
- Candidates are also expected to attend one elective short clinical course of his or her choice eg. BCLS, surgical skills update, etc.

Compulsory skills course

The three compulsory courses are:

- The Principles and Practice (P&P) course
- The Communication and Counselling (C&C) course
- The Basic Clinical Skills course.

Tutorials

- There is also one tutorial per quarter or 4 tutorials in the year. Each diploma trainee will be attached to a tutorial group of up to six trainees under an appointed tutor.

The Examination

The GDFM culminates in an examination consisting of:

- an MCQ paper
- a short answer/modified essay question paper
- an Objectively Structured Clinical Examination (OSCE).

THE MMED (FM) PROGRAMME

The MMed(FM) programme had its roots in 1988 as the Family Medicine Vocational Traineeship programme. The Examination evolved from the College Diplomate Examination (MCGP) which was established in 1972. The first MMed(FM) Examination was held in 1993.

Two streams

There are two streams in the MMed(FM) Programme. The public sector traineeship stream was started in 1988. Trainees were selected through an interview with the FM committee. In 1995 the PPS or Private practitioners stream was initiated to cater for private practitioners

MOH Programme

This programme is the training programme for doctors working in restructured hospitals. It consists of:

- a three-years' training made up of two years of hospital rotating postings and one year of outpatient postings
- an academic core programme which is the FMTP described above
- working experience of at least one year as a medical officer.

PPS Programme

- working experience of at least 4 years in primary care OR
- fulfilled requirements in institutional practice equivalent to the FM trainees and/or approved by the FM Committee.

THE FELLOWSHIP PROGRAMME

The apex of the College's academic training is the fellowship programme. This is an advanced programme which at this point of time is a two-year programme.

There are presently two tracks in the Fellowship programme

- FMFP (general practice)
- FMFP (Aged Care).

Separate tracks to address the medical needs of the community will be implemented where relevant and necessary. The two tracks are summarised and compared in Table 1.

LINKING THE TRAINING PROGRAMMES TOGETHER

Progression through the PPS route

Participants in the GDFM programme can, during the 5 years of starting the programme, progress to the MMed(FM) by taking the PPS route.

To begin, they will apply to the College for the PPS programme before the deadline for applications of the academic year. Once accepted into the PPS programme, they will follow the tutorials in the PPS programme and join short courses. They should also organise their own clinical tutorials with their colleagues and buddies in the PPS stream (group directed, group motivated learning). The end-point of this phase of training is the Graduate Diploma in Family Medicine (GDFM).

As a progression, the GDFM graduands can take the MMed(FM) exams once they have the postings or general practice experience. In this way the road to the Masters is more gradual in contrast to the more intensive FM traineeship track. The end-point of this phase of training is the Master of Medicine in Family Medicine (MMed(FM))

As a progression, the MMed(FM) graduands can apply to be in the fellowship programme either in the Ambulatory Care Fellowship programme or the Aged Care Fellowship programme.

The requirement for the Aged Care Fellowship programme is that he must work in Aged care institutions or organisations and fulfill the requirements of a 6-month posting in a geriatric medicine department and complete the Graduate Diploma in Geriatric Medicine (GDGM) conducted by the Graduate School of Medical Studies or an equivalent Diploma from another training institution.

THE COLLEGE'S VISION

The College's vision is that through its programmes there will be opportunities for every general practitioner and non-specialist doctor to go through a formal structured training programmes. The College is confident that the programmes will add to the knowledge and skills of the general practitioner and family physician to enable them to be professionally competent if mastery of his discipline. The College also believes that the structured training of the Family physician will result in better health status of the Singaporeans. By increasing the skills of general practitioners to be better generalists and yet be able to focus on particular areas of specialty to augment their practice, they will be able to provide higher value care.

Table 1. Comparison between regular FMFP programme and Aged Care FMFP programme

COMPONENT	FMFP (AMBULATORY FAMILY MEDICINE)	FMFP (AGED CARE)
Clinical Medicine	- 5 Case Studies every 6 months - 5 Topic Reviews every 6 months - Presentation of 1 Case Study every 6 months - Presentation of 1 Topic Review every 6 months	- 2 Case Studies every 6 months & 2 Topic Reviews every 6 months during DGM year (rhe DGM course already has a total of 31 topic reviews within its 5 modules and at least 11 case studies) - Presentation of 1 Case Study every 6 months - Presentation of 1 Topic Review every 6 months Non-DGM year to revert to the same requirements as the Ambulatory Family Medicine candidates For candidates who already have the DGM, to do 7 case studies and 7 topic reviews per year to be on par with those without the DGM
Short Skills Courses	One short course every 6 months comprising - Research Methodology - Clinical Audit - Methods of Instruction - Elective clinical course	One year-long Diploma in Geriatric Medicine Course 2 compulsory short courses – Research Methodology and Clinical Audit
Teaching	- 5 MMed/GDFM Supervisor/Asst Supervisor sessions every 6 months - 1 Chairman/Seminar/Conference/Organiser/ Undergraduate Teaching every 6 months	- Teaching sessions (eg. Presentations, talks) to nurses/junior doctors - MMed (FM)/GDFM Supervisor/Asst Supervisor sessions/ Undergraduate Teaching Total of 10 teaching sessions in two years
Other Activities	Participate in 1 research project and/or acquire added clinical competence in a specific area of FM	Participate in 1 research/management/audit project related to parent organization involved in community geriatrics A 6-month supervised posting in an accredited approved acute geriatrics unit
Assessment	- 1 Formative Interview with mentor every 6 mths - 1 Exit Interview with Censor Board	- 1 Formative Interview with mentor every 6 months - 1 Exit Interview with Censors Board
Meetings	Monthly (23 meetings)	- 20 meetings – 10 per year 11 weekend workshops during DGM year
Attendance record, reports, postings, Log Book & Exit Interview	- Portfolio recording of 5 Case Studies and 2 Topic Review every 6 months & attendance record of monthly meetings - Detailed write-up of the 4 Clinical Cases and the 4 Topic Reviews which were presented. - Attendance record for 4 skills courses - Attendance record of teaching responsibilities - Report of research/acquired clinical competence in a specific area of FM - Report of the three 6-monthly formative assessment interview by mentor and summative exit interview with Censors Board	- Portfolio recording of Studies and Topic Reviews every 6 months & attendance record of monthly meetings according to the numbers stipulated for the clinical medicine categories above - Detailed write-up of the 4 Clinical Cases and the 4 Topic Reviews which were presented. - Attendance record of 2 compulsory skills courses - A pass in the DGM Course - Attendance record of teaching responsibilities - Report of research/management/audit project - 6 months posting record in acute geriatrics unit & 18 mths in aged care setting - Report of the three 6-monthly formative assessment interview by mentor and summative exit interview with Censor Board

CME PROGRAMME FOR FAMILY PHYSICIANS

Dr Lee Kheng Hock

INTRODUCTION

The family physician is a generalist who provides personal, continuing primary care to his patients. He or she is an expert in managing undifferentiated medical problems and treat patients in a holistic manner. CME requirements are therefore different from our specialist colleagues. Breadth of knowledge and skills is required. There must be core competence in areas that are critical in the management of patients in the primary care setting. Family physicians are therefore encouraged to constantly hone a broad range of skills and knowledge that are important in their daily practice. The CFPS will identify these areas of need and organize or co-organize programmes that will enable family physicians to fulfill their core CME requirements. The following is an overview of CME programmes that would be considered to fulfill the core requirements of CME for family physicians.

OVERVIEW OF CME PROGRAMME FOR FAMILY PHYSICIANS CLASSIFIED UNDER THE SMC CME PROGRAMME

- Category 1A – Teaching sessions, workshops and tutorial sessions held in conjunction with the various academic programmes (GDFM, MMed, FMFP) run by the College are relevant to the needs of practitioners of family medicine. Doctors are encouraged to include these in their CME efforts. In addition the CFPS will organize skills courses in the first month of each quarter and update sessions in the third month of each quarter.
- Category 1B - Formal courses organized by the Graduate School of Medical Studies and the CFPS. Enrolling in such courses in subjects that are relevant to the practice of family medicine is a useful and structured way to achieve CME requirements.
- Category 1C – Overseas scientific meeting, conferences and seminars. All round the year, conferences are organized by the World Organisation of Family Doctor and the Colleges and Academies of Family Medicine of different countries. Besides providing an international outlook to the practice of family medicine, such events will be considered as relevant to the core needs of the CME requirement of family physicians in Singapore.
- Category II – Publication of original paper in journals, CFPS CME on-line programme and textbooks. Writing of papers of journals and textbooks requires dedicated self-study and research. Family physicians are encouraged to contribute to journals and textbooks that the relevant to the discipline of family medicine.
- Category III A – Self study (Journal reading). Reading of journals relevant to family medicine should be included as a staple in a family physician's CME.
- Category III B – Interactive CME on-line programme. The CFPS had produced an on-line CME progamme tailored for the needs of the busy family physician. The e-learning programme has many advantages over the conventional programmes. Family physicians should take the opportunity to develop IT skills and take advantage of this enhancement of their CME.

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Honorary Secretary, College of Family Physicians, Singapore

REGULAR COURSES, TRAINING & CME ORGANISED BY THE COLLEGE (Table 1)

Table 1. Regular courses, training and CME organised by the College of Family Physicians, Singapore

Title	Nature	Organiser	Timing	Frequency	Target audience
1. Family Medicine Teaching programme Modular Course (FMMC)	Lectures/Workshops	CFPS	4 Sat afternoons per module, 2.30-5.00pm	1 module per quarter 8 modules over 2 yrs	FM Trainees for the MMed PPS Trainees Diploma in FM trainees All doctors doing CME
2. Family Medicine Workshop Mega group teaching	Workshop	CFPS	1st Fri of each mth, 5.15-6.45pm	Once a mth 10 per yr	FM Trainees for the MMed PPS Trainees
3. Family Medicine Tutorials Small group teaching	Case Presentations Meet the Expert Clinical Rounds	CFPS	Rest of Fridays 5.15-6.45pm	30 per yr	FM Trainees for the MMed PPS Trainees
4. Graduate Diploma in Family Medicine	Lectures, Seminars, Workshops, Clinical Skills Courses	College, MOH Graduate School of Medical Studies		2-yr distance learning cum workshop course leading to the Diploma in Family Medicine by examination	All GPs/FPs
5. Annual Surgical Update	Lectures & Hands-on	CFPS	1st quarter of each yr	1.5 days over a weekend	All GPs/FPs Other doctors interested in the subject
6. Bi-Annual Scientific Conference	Lectures Seminars Hands-on Workshops	CFPS	Mid yr	2 days, once every 2 yrs	All GPs/FPs Other doctors interested in the subject
7. Graduate Diploma in Ultrasonography (O&G)	Lectures, Hands-on Log Work Exam	CFPS and Graduate School of Medical Studies		Part time course to be completed in a minimum of 18 mths & a maximum of 24 mths. Intake once every 2 yrs	All GPs/FPs
8. Minor Surgical Procedures Course for Family Physicians	Lectures, Hands-on Workshops Live Surgery Viewing	CFPS, SGH & TTSH	1st quarter or each yr	1.5 days over a weekend	All GPs/FPs
9. Modular Skills Course	Lectures, Hands-on Workshops	College in collaboration with institutions	1st mth of each quarter according to FMMC theme	Saturday afternoons	All GPs/FPs
10. Modular Medical Update	Lectures, Seminars	CFPS	3rd mth of each quarter according to FFMC theme	2 days over a weekend	All GPs/FPs
11. Family Medicine Clinical Course in Ophthalmology	Lectures, Attachments to Eye Depts, Discussion & Trainee Presentations	College, SNEC & Eye Depts at various hospitals	Approx once a yr	3 days or equivalent	FM Trainees for the MMed, PPS Trainees
12. Family Medicine Clinical Course in Obstetrics & Gynaecology	Lectures, Practical Clinical Training	College & Dept of O&G at various hospitals	Approx once a yr	3 days or equivalent	FM Trainees for the MMed, PPS Trainees
13. Diabetes Training Course	Lectures, Seminars	College, MOH, Diabetic Society of Singapore	Approx once a yr	3 Saturday afternoons	All GPs/FPs

Others

Throughout the course of the year, the College receives requests from various hospital departments and societies to co-organise CME events. These are organised on a case by case basis after consideration of the relevance of the programme for Family Physicians/GPs and CME content by the College Council.

E-LEARNING – THE FUTURE OF MEDICAL EDUCATION

Dr Lee Kheng Hock

INTRODUCTION

The medical profession has a reputation of being slow adopters of technology and new ideas. Medical training has imbued in each of us a culture of waiting for evidence of effectiveness before making a decision. In practice, doing what your peers do is safe. Being a trail-blazer is hazardous for your medical insurance and increases your chance of an unexpected invitation to meet with the disciplinary committee.

Not surprising that as a profession, we lag behind when it comes to embracing information technology. Whether we jump in or get dragged in kicking, there is no escape from the tangled web of the information age.

The initial hype and unbridled enthusiasm have now given way to cynicism and disbelief. Nevertheless, information technology does present many real opportunities to improve medicine. Information technology has revolutionized the way medical data and knowledge is stored and exchanged.

Electronic learning (e-learning) is one area that can greatly enhance the teaching and learning of medicine. It is the offspring of the marriage between distance learning and information technology. Its capabilities fit the feasibility requirements of CME like a rubber glove on a powdered hand.

FEATURES OF E-LEARNING THAT COMPLEMENTS THE NEEDS OF CME

Economy of time and space

After the initial investment in time and resources to set up a platform for connectibility, what follows is a bonanza of savings for the CME provider and participants. For the participant, there is no need for the many man-hours of travelling, and the parking of vehicles. For the provider, there is no need for booking expensive seminar rooms, refreshments and a thousand and one other logistic concerns.

E-learning can be done anytime and anywhere. It is ideal for busy doctors who work long hours and trainee doctors who work shifts and irregular hours. Distance is no longer a barrier to teacher-learner interaction. They can literally be a world apart and the lessons can still go on.

No more synchronicity problems

One of the greatest challenges in organizing events for doctors is to find a time and place where everybody can get together. As health care is an essential service, long hours and shift duties are the norm. At any point in time, a substantial portion of the doctors will be on duty. Weekends are often the only time where the greatest number of doctors are available for academic activities.

The consequence of this is that every course organizer and CME provider will converge and scramble for the 52 weekends a year and try to cram everything in. Once an event is over, the speech and visuals vaporizes like ether and what is left is often a note pad of illegible scrawlings. With e-learning, the teaching material is prepared and stored. Users can download and use the material at their own pace and pleasure. Checking something you have forgotten or did not understand the first time round is just a matter of a mouse click and a back button on a browser software.

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Productivity savings (reducing employee away time)

Although it is generally given that training increases worker productivity, time away from work decreases productivity. Whether the improvement in productivity, as a result of better training, can off-set the loss in working time is often in dispute. The benefits of CME are often intangible as far as dollars and cents are concerned. Convincing policy makers and employers of doctors to allocate time away from work to participate in academic work and CME is a difficult task.

Contrary to expectation, the situation may be worse for self-employed doctors. Whilst the benefits of improvement in skills and knowledge may not be immediately apparent, the loss of income from time away from work and the fees paid to the locum are felt acutely.

As e-learning can be done anyplace and anytime, training can be done during periods of low productivity. Usage of health care facilities often peak and ebb in a fairly unexpected manner. With e-learning, a doctor can switch on his computer and catch up on his CME during lull periods. He can also use such time to search for the latest updates on difficult cases that he might have encountered earlier in the day.

Just-in-time training

We live in a world of information overload. What we carry in our resident memory is limited to what we need on a regular basis. There are always areas where we need to know less as such knowledge or skills that are not routinely used. Just as the JIT (just-in time) concept increases productivity by doing away with the need of overstocking of inventory.

JIT can also greatly enhance the effectiveness of doctors. For example a rural doctor who have not done a Caesarean section for the past 3 years may suddenly be faced with the need to perform an emergency Caesarean section within an hour. A multi-media revision lesson with video clips will be a great help. He may even be able to get in touch with an experienced surgeon via video conferencing. At a less dramatic level, a family physician who needs to do a seldom-performed office procedure may be greatly helped if he could quickly gain access to an on-line lesson.

Active learning and interactivity

Didactic lectures with a large learner-to-teacher ratio have been shown to be one of the least effective ways of teaching and learning. Nevertheless, it remains the most widely used method of teaching because logistically it is the easiest to organize. On-line lessons allow a greater level of interactivity. The course organizers can deliver the content through a very complex interactive platform. This can range from the basic multiple choice question type of interaction to complex IT technology using the latest in virtual reality. The tools and technology used in complex interactive computer games can be easily adapted for use in e-learning. The course developer is often not limited by technology but by the lack of funding and resources.

Assessment of learning process

One major area of deficiency in conventional teaching methods is the difficulty in assessing the effectiveness of programmes. E-learning can automate the process of assessment. Likewise the assessment mode can be varied. Progress of individual learner can be easily tracked and analysed. Timely remedial and corrective training can be efficiently delivered to areas and to persons who most require it.

THE CFPS E-LEARNING STRATEGY

The College recognizes the potential of e-learning in advancing our objective of improving the standard of family medicine in Singapore. We can identify two major areas where e-learning would greatly increase the effectiveness of our academic programmes.

First, we plan to enhance the existing vocational training courses, namely the GDFM and the MMed (FM) courses. In the near future the electronic component of these courses will go beyond the simple downloading of reading materials. With the greater use of e-learning technology, the GDFM will probably evolve into a far-reaching distance-learning programme that will become the cornerstone of vocational training for family physicians.

Second, the College is pioneering efforts in bring electronic CME to family physicians in Singapore. We have developed an electronic CME programme with on-line testing capabilities. We foresee that this programme will eventually developed into a highly interactive programme that will help to meet the needs of professional development of the busy family physicians.

We hope to be able to incorporate more complex and effective technology to our e-learning enhancements over time. The technology was already here yesterday. What we need is adaptability, commitment and resources to meet the challenges of tomorrow.

MITA (P) 105/03/99

THE COLLEGE MIRROR

JUL-SEP 2001

FROM THE EDITOR'S DESK

One of the major highlights of the year is winning the bid to host the 18th Wonca World Conference in Singapore in 2007. We beat the Australians narrowly by one vote.

This World Conference will undoubtedly thrust the College of Family Physicians Singapore into the international medical scene once again. We were hosts of the 10th Wonca World Conference in 1983.

We congratulate two of our Council members and our former Administrative Manager. A/Prof Goh Lee Gan has been elected Wonca Vice-President for the Asia-Pacific Region. His term of office is for 3 years. One of our former Presidents, Dr Alfred Loh, has been appointed CEO of Wonca.

Ms Yvonne Chung, the former Administrative Manager of the College Secretariat, is now the Administrative Manager of the Wonca Secretariat.

The College's 8th Scientific Conference and 7th Meditech Exhibition will be held in Orchard Parade Hotel from 25-26 August 2001. The theme for the Conference is "Training the Family Physician". Professor Lee Eng Hin, Dean, Faculty of Medicine and Director, Graduate School of Medical Studies, NUS, has kindly consented to be the Guest-of-Honour for the opening of the Conference on 25 August 2001.

We are honoured that Mr Lim Hng Kiang, Minister for Health and 2nd Minister for Finance, has kindly accepted our invitation to be the Guest-of-Honour at our 30th Anniversary Dinner on 26th August 2001, also to be held at the Orchard Parade Hotel.

A post-conference Minor Surgical Course will be held on 16th/23rd September 2001. This clinical course is a collaboration between Tan Tock Seng Hospital and the College of Family Physicians Singapore.

Ms Christina Cheong
Administrative Executive

Introducing the New College Council

At the 30th Annual General meeting of the College of Family Physicians, Singapore, held in Lecture Room 1, College of Medicine Building on Sunday 24 May 2001, A/Prof Cheong Pak Yean was elected President of the 18th Council (2001-2003). A/Prof Cheong was President of the Singapore Medical Association from 1996-1999.

The following doctors continue to hold office in the same capacity for this term: Dr Arthur Tan Chin Lock as Vice-President, Dr Lee Kheng Hock as Honorary Secretary and Dr Lau Hong Choon as Censor-in-Chief.

Dr Tan See Leng now serves as Honorary Treasurer. We also welcome both Dr Tay Ee Guan and Dr Yii Hee Seng as new Council Members of the 18th Council.

A/Prof Goh Lee Gan, Dr Kwan Yew Seng, Dr Matthew Ng Joo Ming and Dr Tan Chee Beng continue to serve as Council Members, together with A/Prof Lim Lean Huat (Immediate former President) and Dr Richard Ng Mong Hoo (Immediate former Honorary Treasurer).

We would like to congratulate the office-bearers of the 18th Council (2001-2003). We look forward to the College of Family Physicians Singapore scaling even greater heights under the wings of this newly elected Council.

Introducing our New Administrative Executive

Ms Christina Cheong joined the College of Family Physicians Singapore as Administrative Executive, with effect from 28th May 2001. She takes over the management of the College Secretariat from Ms Yvonne Chung, who is now serving as Administrative Manager of the Wonca Secretariat.

Christina's work experience spans from a Database Manager in an international conference house, to a short stint as Operations Executive in the then promising Internet industry.

After leaving her dot.com dream behind, Christina took on a challenging position as Event Executive with an events management consultancy. She ultimately realised that this fast-paced lifestyle of working 24-7 wasn't what she was looking for.

Having a love for administrative work and a keen interest in the medical field since young, Christina looks forward to contributing her utmost in serving the College.

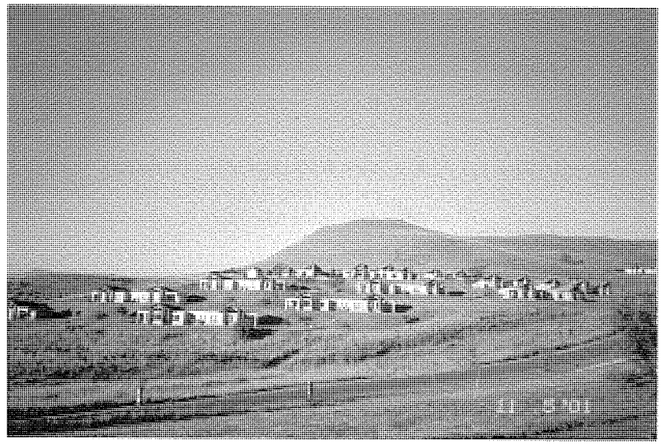
Outside work, Christina finds happiness in spending time with family and friends. She enjoys travelling, listening to music and surfing the Internet for information.

The College Secretariat now has a strength of three staff. The other two staff are Ms Rosalind Ong, who joined as Administrative Officer on 8th May 2001, and Ms Katy Chan who has been an Administrative Assistant of the College for the past 5 years.

Singapore's Wonca 2007 Bid in Pictures

Preparations for the bidding of Wonca 2007 started as early as June 2000. Since this is the second time the Singapore College is bidding to host the conference, the bidding committee was determined to succeed this time.

We were able to secure generous sponsorship for the bidding process. Strong support came from the Singapore Tourism Board, Peridot Health, Pfizer, GlaxoSmithKline, Diamond Industries and many letters of well wishes from the various professional organisations, ministries, statutory boards and NTUC Income.



WHERE THE BID TOOK PLACE. THE ALPINE HEALTH RESORT IN THE DRAKENSBURG MOUNTAINS.

THE BID TEAM. FROM LEFT DRS TAN SZE WEE, WONG CHIANG YIN, ARTHUR TAN, RICHARD NG, LIM LEAN HUAT, TAN SEE LENG AND LEE KHENG HOCK.

The bid process took place in a mountainous resort deep in the heart of South Africa, about 4 hours' drive from Durban. The Committee carried more than 250kg of bid documents, souvenirs and publicity material to prepare for battle against the Australian College.

Set against the back-drop of the Drakensburg mountains, the team of 4 doctors from our College took on the Australian team. They Australians had a much larger team, numbering more than 20 strong, made up of professional event organisers, doctors and university dons.

It was a tussle between the Australian and the Singapore College, both lobbying for support right from the time of arrival. Both were determined to woo as many votes of Wonca world Council as possible. We had very crucial support at our bidding speech from Professor Goh Lee Gan and Professor Lim Lean Huat, our President.

We managed to beat the Australians by just one vote. With the winning bid in the Singapore College's hands, we look forward to welcoming the world of family physicians to our Island nation in July 2007.

PRESENTING THE SINGAPORE PACKAGE. DR TAN SEE LENG, CHAIRMAN OF THE WONCA 2007 COMMITTEE IN ACTION.

Dr Tan See Leng

THE SINGAPORE FAMILY PHYSICIAN

Authors are invited to submit articles for publication in *The Singapore Family Physician* on the understanding that the work is original and that it has not been submitted or published elsewhere.

The following types of articles may be suitable for publication: case reports, original research, audits of patient care, protocols for patient or practice management and review articles.

PRESENTATION ON THE MANUSCRIPT

The Whole Paper

- Normally the text should not exceed 2000 words and the number of illustrations should not exceed eight.
- Type throughout in upper and lower case using double spacing, with three centimetre margins all round. Number every page on the upper and right hand corner, beginning with the title page as 1.
- Make all necessary corrections before submitting the final typescript. Headings and subheadings may be used in the text. Indicate the former by capitals, the latter in upper and lower case underlined.
- Arrange the manuscript in this order: (1) title page (2) summary (3) text (4) references (5) tables and (6) illustrations.
- Send 3 copies of all elements of the article: summary text, references, tables and illustrations. The author should retain a personal copy.
- Their accuracy must be checked before submission.
- All articles are subject to editing.

The Title Page

- The title should be short and clear.
- Include on the title page first name, qualifications, present appointments, type and place of practice of each contributor.
- Include name, address and telephone number of the author to whom correspondence should be sent.
- Insert at the bottom: name and address of institution from which the work originated.

The Summary

- The summary should state the purpose of and give the main argument or findings.
- Limit words as follows: 100 words for major articles; 50 words for case reports.
- Add at the end of summary an alphabet listing of up to 8 keywords which are useful for article indexing and retrieval.

The Text

The text should have the following sequence:

- **Introduction:** State clearly the purpose of the article.
- **Materials and methods:** Describe the selection of the subjects clearly. Give references to established methods, including statistical methods; provide references and brief descriptions of methods that have been published but are not well known. Describe new or substantially modified methods, giving reasons for using them and evaluate their limitations. Include numbers of observations and the statistical significance of the findings where appropriate.

  Drugs must be referred to generically; all the usual trade names may be included in parentheses.

  Dosages should be quoted in metric units.

  Laboratory values should be in SI units with traditional unit in parentheses.

  Do not use patients' names, initials or hospital numbers.
- **Results:** Present results in logical sequence in the text, table and illustrations.
- **Disk & Electronic Production:** If your article is accepted for publication, we may invite you to supply a copy on a 3.5 inch disk, using Microsoft Word software.

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