COLLEGE OF FAMILY PHYSICIANS SINGAPORE

Special Commemorative Issue

01 CONTENTS

FOREWORD
Forty Years On 3
A/Prof Lee Kheng Hock

EDITORIAL
Present, Past and Future 5
Dr Tan Tze Lee

KEYNOTE ADDRESS
The Future of Family Medicine is in the Beginning 7
A/Prof Lee Kheng Hock

REFLECTIONS
Contributions from Past Presidents 13
Dr Lee Suan Yew, Dr Loh Wee Tiong Alfred, A/Prof Lim Lean Huat, A/Prof Cheong Pak Yean, A/Prof Goh Lee Gan

Contributions from Past Censors-in-Chief 19
Dr Chang Ming Yu James, Dr Lim Kim Leong, A/Prof Goh Lee Gan, Dr Lau Hong Choon

HISTORICAL MILESTONES
College Mission 25
Our History – The College Milestones (1971 – 2012)
College Councils – Present and Past (1971 - 2013)

WORK OF THE COLLEGE
Primary Care Research: Facilitation and Translation 31
Dr Tan Ngiap Chuan, A/Prof Goh Lee Gan

PICTORIAL STORY OF THE COLLEGE
Pictures from the past by decades 35
Pages from WONCA World Conferences held in Singapore 40
College Regalia 49
College Paintings & Pottery – A selection 50
Reciprocal recognition between the RACGP and CFPS 52

FAMILY MEDICINE PERSPECTIVES – SINGAPORE AND WORLDWIDE
Position Statement on the Principles and Practice of Family Medicine in Singapore 2011 53
College of Family Physicians Singapore

The Expertise of Family Physicians 55
A/Prof Goh Lee Gan

Forty Years on

A/Prof Lee Kheng Hock

In human terms, age 40 is often a time when mid-life crisis sets in. The term mid-life crisis was coined in 1965 by Elliot Jaques. Interestingly he started life as a medical doctor having studied medicine from Johns Hopkins University before going on to become a renowned psychoanalyst of organisations.

The mid-life crisis is a time of intense self-doubt often triggered by external events, leading to a period of soul searching and the redefinition of the concept of self.

There are two major events in this 40th year of our College that are just causes for triggering a mid-life crisis for any organisation. The first is the implementation of the Family Physicians (FP) Register which is far more elaborate and tries to do much more than what the College initially proposed in 2005. This is also the year when the Ministry of Health unveils the "Primary Care Master Plan" which is set to completely transform the organisation of primary care in Singapore.

Contrary to popular belief, the mid-life crisis is not always a time of psychological upheaval. More often, it is a time of reflection and re-assessment. A cogent and united organisation in mid-life crisis often finds clarity and a renewed sense of mission. This new clarity can be seen in the position statement of our College on the principles and practice of family medicine in the Singapore context which was published this year. We are confident that the "Primary Care Master Plan" will spur our fraternity and our College to work closely with the Ministry of Health to bring to fruition this vision of a brave new future. A bright future where family physicians can look forward to a meaningful professional life and receive the long overdue recognition for the good work that we do across the continuum of the health care system.

Looking back at our past 40 years, we are grateful to the many long-serving and often long-suffering College members who sacrificed their time and energy to build our College to what it is today, often against much prejudice and without due recognition.

Looking forward, we are excited and confident that the College will rise above the challenges and scale greater heights as we continue to work tirelessly towards improving the standard of family medicine.

On behalf of the Council I would like to thank all our members for their unstinting support and self-sacrifice, without which the College would not have achieved so much with so little.

A/Prof Lee Kheng Hock
President, 23rd Council (2011 – 2013)
College of Family Physicians Singapore

Present, Past, and Future

Dr Tan Tze Lee

Forty years have passed since the College of Family Physicians Singapore was founded in 1971. The College started life as the College of General Practitioners Singapore, and this was the culmination of the desire of a small number of like-minded general practitioners who had the vision of uplifting the level of general practice in Singapore.

With their foresight, and with the generous academic and moral support from our GP colleagues from the Royal Australian College of General Practitioners, the College was inaugurated with little fanfare on 30 June 1971. This small step was a big leap for our local GP community, as it established for the first time a platform for primary care education, improving healthcare delivery and establishing standards in what was then known as general practice.

The founding fathers of the College of Family Physicians Singapore had many hopes and ambitions for the advance of primary care in Singapore. Three stand out.

The first was on the practice aspects of general practice. Practice management remains the daily grind many of us in primary care face. With the many new challenges we face, like the ageing population, and portable government subsidies like CHAS, the College is fortunate to have its Practice Management Committee, at present led by Dr Leong Choon Kit, to lead us through its many issues. Through networking and regular Town Hall meetings, the Practice Management Committee has its ears to the ground and hands on the pulse of our members, and the feedback from the ground has been vital for the College. As representatives of our members and the GP community, we are mindful of the need to represent their aspirations and concerns, and the Practice Management Committee does just that.

The second was on teaching, improving skills and establishing standards. From the very beginning of our forty-year history, the College has always been about GP education and establishing standards of care. The College conducted the first Diplomate examination for general practice in 1972. By 1992, the last MCGP(S) was held, and was superseded by the Master of Medicine (Family Medicine), which is now awarded by the National University of Singapore. Despite these advances, the relatively few MMed(FM) meant a vacuum for many GPs who still had a desire for further training and certification. The end result was the Graduate Diploma in Family Medicine, which was especially suited for GPs who had little time to spare outside of weekends. To date we have 665 GDFM graduands, and the course remains de rigeur for newly qualified doctors who aspire to primary care. The GDFM programme was adapted for use in the Accredited Modular Course, which became an entry requirement for experienced GPs who wished to be on the newly formed Family Physician Register. Last but not least, the Fellowship of the College of Family Physicians Singapore remains the jewel in the crown of the College's academic programmes. Rigorous and exacting, the FCFP(S) is recognised by our local institutions for promotion, and also by the Royal Australian College of General Practitioners for reciprocal recognition [Fellowship Ad Eundem Gradum].

"GPs should be engaged in research in primary care." That was one of the pursuits of many of the founding fathers of the College. The early days of GP research recorded in the first few issues of The Singapore Family Physician and its short-lived predecessor, GP, show how innovative and enthusiastic our predecessors were to pursue academic research despite a busy practice. This has continued, and just two years ago, the College organised the 2nd Asia Pacific Primary Care Research Conference 2010. This year we have again the honour of hosting the 4th APPCRC 2012, which will run in December 2012 in the National University of Singapore Kent Ridge Campus. The APPCRC has demonstrated the research potential of primary care physicians, and the yearly event promises to generate even more collaboration and output from our regional primary care community.

Our primary care community today faces many challenges, much of which stems from the changing demographics of Singapore. The need to provide good standards of care for the ageing population remains the priority for all of us in primary care. The realisation by our health authorities of the importance of engaging the primary care community is timely, as our numbers and ability to provide good standards of chronic care mean we as a primary community are well placed to provide such care to our seniors.

At these important crossroads of our healthcare evolution, we need, and intend to provide leadership to our members and the wider primary care community. By focusing on our core strengths, that is to train and equip the primary care doctor with the training and skill sets to engage these challenges, we will continue to be a strong voice for the advancement of primary care, and promote family medicine to its rightful place in the provision of healthcare in Singapore.

Dr Tan Tze Lee
MBChB(Edin), MRCP(UK), FRCP(Edin)
Honorary Treasurer, College of Family Physicians, Singapore

04 KEYNOTE ADDRESS

The Future of Family Medicine is in the Beginning

A/Prof Lee Kheng Hock

Keynote Lectures delivered at the 40th Anniversary Dinner of the College of Family Physicians Singapore on 27 November 2011

Remembering the hardships of the past

This year we celebrate the 40th Anniversary of the founding of our College. Milestone anniversaries such as the 40th, are usually a time of reminiscence and a little bit of basking in past glory. For our College, it is difficult to do so. The journey for the past 40 years has not been easy and, while the future is bright, the coming years are unlikely to be smooth sailing. To be honest, the past 40 years have been very difficult. That our College has made such good progress in the past 40 years is largely due to the hard work and self-sacrifice of some of our very dedicated members who had exceptional faith in the mission of our College and an unwavering commitment to the values and ethos of our neglected and often misunderstood fraternity.

Indeed, in the past 40 years, we have had giants amongst us who have overcome incredible odds to bring our College to its present status. We had a string of exceptional past presidents, council members, and hardworking members who preferred to work quietly away from the glare of the limelight. Together, they struggled to bring resources and recognition to our College. They have done a great service for our fraternity. It is on the shoulders of these giants that we are now able to see the bright future that is just over the horizon.

Family medicine in mid-life crisis?

In human terms, the 40th year is often the time when mid-life crisis sets in. This is a time of self-doubt and intense reflection on one's mission in life. It is often triggered by major external events. It is a time when one takes stock of achievements and tries to compensate for lost opportunities. Some of the upheavals that our fraternity is currently experiencing in relation to the introduction of the family physician register and the impending implementation of the Ministry of Health's "Primary Care Master Plan" seem to fit the triggers that bring forth the symptoms of mid-life crisis. The term "mid-life crisis" was coined by Elliott Jaques. Interestingly, he was originally trained as a medical doctor, but subsequently chose to become an organisational psychologist. Eventually he became well known as a psychoanalyst of dysfunctional organisations. So you see, it is not so far-fetched to think of organisations as having mid-life crises as well. One of the most intense activities in a mid-life crisis involves reflecting on the past with a sense of missed opportunities.

Reflection and learning from history

The ancient Romans believed that the past, the present and the future are all intertwined. This is represented in their construct of a god of beginnings and transitions called Janus. The Roman god who gave us the name January for the first month of the calendar year is two-faced, one looking to the past and one looking to the future. The present is a manifestation of the duality of the past and the future. As we look forward we should always look back at the same time. If the ancient Romans had discovered mid-life crisis, Janus would certainly had been assigned to take care of it. The point to note is that if we wish-gaze into the future, we must understand our past.

If we look way, way back, we will realise that the first physicians in the history of mankind must have been generalists. Family medicine can rightly claim to be the oldest discipline of medicine. Ancient physicians were true "generalists," providing care for men and women, children and adults through the entire spectrum of life.

Learning from the American history of family medicine

Although the development of the family medicine movement is a worldwide phenomenon, the term "family practice" and the subsequent effort to define it as a specialty arose in the United States. It was also in America that the systematic differentiation of medicine into specialist fields occurred on a massive scale. The post-war emergence of the United States as a superpower ensured the continued influence and eventual dominance of American ideas in modern medicine. The Americanisation of our own healthcare system in the area of training and accreditation had gained new momentum recently. It is therefore helpful for us to understand the origins of family medicine from an American perspective.

At the turn of the 20th century, when modern medicine (often mislabelled as "Western medicine") started to take form, the first modern doctors were definitely family physicians. According to John Stanard who wrote the book Caring for America: The Story of Family Practice, most graduates of America's medical schools went into general practice at the turn of the 20th century. They were generalists who provided the full range of care, including surgery, maternity care, care of children and all other fields, to people from all walks of life. He wrote, "Through dedication to their patients' continuing care every day, these general practitioners (GPs) established a public image that remains symbolic of what people expect from their physicians. And people could reasonably expect to get this kind of care: In 1930, about 80% of American physicians were GPs; only 20% were specialists."[1] Therefore, general practitioners were the archetypical construct of a doctor and this was etched into the psyche of people.

The origins of the specialisation of medicine

Then came the first specialists. As you can see from old advertisements of doctors professing "special skills", they were not very specialised in the beginning. They usually provided a narrower range of services, on the basis that they had exceptional competence in these areas and therefore were able to produce better outcomes and therefore deserve higher fees. The chosen special services were usually those

that were more lucrative and had good public demand. Indeed it is often said that doctors choose to practice where the grass is green and the water is clean. In our present time, the politically correct term is work-life balance. Of course this is an injustice to the majority of doctors who still believe that medicine is a calling. Fortunately for our patients and our country, there are still many such doctors among us. Many pursue specialisation out of a genuine interest in the science of a particular discipline and the passion to advance its boundaries.

Even in those early lawless days of cowboys and gunslingers, there were a majority of doctors who believed in the ethics and professionalism of our vocation. In 1847, they came together and, under the leadership of Nathan Davis, founded the American Medical Association. It was heartening to see the manifestation of altruism that is associated with professional bodies even in the early days of the AMA. Among the first order of business were the advocacy of ethics and the improvement of medical education standards.[2] In quick succession, the Committee of Ethics was formed in 1858 and the Council of Medical Education was established in 1904.

The efforts of the early reformers were focused on establishing the scientific basis of modern medicine. One of the most influential reform movements was embodied in the now very famous Flexner report. Most will agree that this was one of the pivotal moments in history that transformed modern medical education. It is often difficult to appreciate pivotal moments in history without understanding the context of their time. During the time of the Flexner report, many medical schools were "proprietary". One or more doctors with established reputations can come together and start a business to train doctors. It is unthinkable now but in those days there was no need for medical schools to be affiliated with any university or to be accredited by any professional body. Their mission was to make a profit from teaching people a trade. Some kind of "degree" was usually awarded after about two or more years of study. Many did not have any facilities such as laboratories or dissection halls. Faculty development was non-existent. Teachers were themselves without proper training or accreditation. There was hardly any regulation of the medical profession and the training process by the government. The scientific basis of the training of doctors was often incidental and unplanned.

In such an environment, the Flexner Report advocated stringent criteria for admission and graduation of students in medical school. The curriculum must be rooted in mainstream science. From 1910 onwards, state licensing boards and the AMA began to enforce the key recommendations of the Flexner Report, resulting in the closure of the proprietary schools and the dominance of medical schools that are linked to universities and based in large hospitals.[3] Flexner's recommendation laid the foundation for the modern medical school and consequently the practice of modern medicine. Many of the ideas spread outside America and took root in the leading nations of the world at that time.

The creation of the American Medical Association and the acceptance of the Flexner Report set the stage for the next major development in modern medicine. The phenomenon of specialisation took on the characteristics of these two preceding developments. The origins of the formalisation of specialist medicine started in 1908 when Dr. Derrick T. Vail in his presidential address to the American Academy of Ophthalmology and Otolaryngology proposed the formation of examining boards for specialised medicine.[4] The proposal was to define specific areas of medicine for development specialty qualifications through the enactment of specialised training and examinations. Ensuring the competence of doctors who claimed to have special skills was seen as a matter of public trust. Only doctors who successfully completed the pre-requisite training and passed prescribed examinations would be credited as having special skills. The proposal was well received and triggered a series of events that started the specialisation movement in earnest.

In 1933, the Advisory Board for Medical Specialties was created to provide oversight for the examination and accreditation of specialties. (In 1970, the Advisory Board was re-organised and became the American Board of Medical Specialties (ABMS) as it is known today.)

The trend toward specialisation accelerated tremendously around the time of the Second World War. It was a time of rapid advancement of science and technology and this spurred the specialisation process. It was around this time that the schism between specialised medicine and general medicine became increasingly obvious and to a certain extent became antagonistic. Lynn Carmichael, the Founding President of the Society of Teachers of Family Medicine remembered what it was like in those days. "In the post-war period, the specialist had hospital privileges, rising incomes, and increasing prestige. The remaining physicians were "just GPs" and were expected to die off (and "good riddance"). But sense of pride and birthright began to emerge."[5]

The painful birth of family medicine

This tension between specialism and generalism continue to simmer until the mid-1960s when things boiled over. There was a groundswell of feeling that the specialisation of medicine had gone too far. People were concerned that the comforting doctor who can take care of the patient as a person will no longer be available. The trend of the medical education system to produce ever-increasing numbers of specialists at the expense of generalist training was worrying to the point that the American Medical Association felt it was necessary to commission another study in the same vein as the Flexner Report. The general feeling was that the while the Flexner Report had made revolutionary improvements to medical education through medical school forms, it did not address the issues of the formal graduate education of doctors. There was a feeling that it might have inadvertently contributed to the phenomenon of uncompensated specialisation and the resulting fragmentation of healthcare. The Citizen's Commission on Graduate Medical Education was established under the chairmanship of John S Millis in 1966 to address the issue of the graduate education of doctors. One of its key objectives was to restore equilibrium by bringing back comprehensive healthcare and the promotion of graduate training programmes for primary care. The report now frequently referred to as the Millis Commission, set forth to address the issues of "complexity, fragmentation and the inflexibility of standards of graduate medical education." In recognising the deep public concern of runaway technology and specialisation, one of the recommendations it made resonated strongly among many. The report called for a new kind of specialist. The report stated this need unequivocally.

What is wanted is comprehensive and continuing healthcare, including not only the diagnosis and treatment of illness but also its prevention and the supportive and rehabilitative care that helps a person to maintain, or to return to, as high a level of physical and mental health and well-being as he can attain. Few hospitals and few existing specialists consider comprehensive and continuing medical care to be their responsibility and within their range of competence; and not many of the present general practitioners are qualified to fill this role. A different kind of physician is called for.

A physician who focuses not upon individual organs and systems but upon the whole man, who lives in a complex setting… knows that diagnosis or treatment of a part often overlooks major causative factors and therapeutic opportunities.[6]

Other think-tank reports emerged during this period. Another well-respected body produced the Folsom report. This called for a personal physician way back in 1966.

Eventually in 1969, family medicine gained recognition as a specialty and the American Board of Family Practice became the 20th specialty in the American Board of Medical Specialties. The achievement of this milestone was not easy. Nicholas J. Pisacano, the first Executive Director of the ABFM recalled the difficulties of the early years.

The history of the Board is a fascinating saga of travails, with frustrations and impediments punctuating its formative days. Despite the fact that by the early 1960s the number of physicians in a general type of practice was dwindling rapidly, the medical establishment opposed the creating of a specialty that would fill this void.[7]

Family medicine today

Having reviewed the past, where do we stand today? Back in 1966, the Folsom Report was another influential paper that hastened the creation of residency programmes in family medicine. A passage in this report of the past carries a sad reminder.

Every individual should have a personal physician who is the central point for integration and continuity of all medical services to his patient. Such physician will emphasise the practice of preventive medicine.... He will be aware of the many and varied social, emotional and environmental factors that influence the health of his patient and his family.... His concern will be for the patient as a whole, and his relationship with the patient must be a continuity one.[8]

The universality of this truism is reflected in our own Ministry of Health's call for a "personal physician for every Singaporean". That such a call is still made today, decades after it was recognised, goes to show the lack of progress and the unfulfilled potential of family medicine.

Gayle G. Stephens, a pivotal figure in the early days when family medicine was born in America gave this reflection of the state of family medicine in 2001.

On balance, I judge that we have squandered some public credibility in our evolution despite our success in having created a specialty. We probably confused the public early on when we changed our name from General Practice to Family Practice, and we confused ourselves in drawing finer distinctions with the addition of Family Medicine, Community Medicine and Primary Care. We all know the reasons for these changes, but they held no interest for the public, conveyed no weight of meaning, and sometimes allowed us to mistake the cart for the horse... We took a hit to our public credibility when we were suckered into 'gatekeeping' by managed care organisations...[9]

Surely this is something we must ponder over seriously as we have been told that the launch of our Family Physician register will come with the enforced distinction between the family physician and the general practitioner. More worrying is the narrow definition of family medicine that was proposed by the Family Physician register which triggered unease amongst many members of our College who practice in a diversity of care settings. Our College has had to issue a public statement on the principles and practice of family medicine, re-affirming our generalist ethos, our broad-based competency, the diversity of our practice setting and our expertise in translating care to the context of the person, the family and the community.

I was flabbergasted when a very senior specialist colleague confronted me one day and told me that he could not understand our position paper. From his specialist perspective, there is nothing unique in all of our competencies. "Isn't all these also found in all the other specialties? How are you different from internal medicine?" In his mind family medicine is defined by exclusion of what is found in other disciplines, even generalist disciplines like internal medicine.

Ian McWhinney, one of the foremost thinkers in family medicine recognised this defective thought process way back and described it very well, calling it the "lump fallacy".

One of the greatest objection to the idea of the family doctor …one physician cannot effectively master the whole field of medicine. The root of this objection is a concept of medical knowledge that I hold fallacious. I call it the 'lump fallacy'. According to this theory, knowledge is a lump of material that grows by accretion. Having reached a certain size, it becomes too large to be assimilated and must be broken up into smaller lumps. The smaller lumps continue to grow…and in their turn have to be fragmented…This view of knowledge is surely a distortion of truth.[10]

Indeed the root cause of the problem is that we are asked to identify ourselves by the lumps that we call our own or more accurately, lumps that no one else lays claim to.

Ian McWhinney rightly pointed out that doctors use three kinds of knowledge. The first is "information" which are the actual lumps that are commonly understood as knowledge — facts and figures that one has to read, listen and observe to assimilate. The use of this "information" requires translation through clinical craftsmanship. The second kind of knowledge is acquired through practice and role-modelling. The third kind of knowledge and the hardest to master is "insight" or "context". This kind of knowledge can only be attained through human interaction and reflection on interaction between the first kind of knowledge and the human experience. As the broadest of all disciplines, family medicine shares the first kind of knowledge with all disciplines. It shares a significant proportion of the second kind of knowledge. It is most distinct in the third kind of knowledge which is generally scarce or non-existent in disease-centred or technology-centred disciplines. Yet there are those who insist on defining family medicine by our parts rather than by our sum. In their reductionist world view, they can only see the trees and do not believe in the existence of the forest.

Unfortunately, this faulty approach to defining family medicine has not been entirely foisted on us by others. Among our own fraternity, there are those who seek to define family medicine in a similar way.

John P. Geyman, M.D., is one of the most published family physicians in the United States, having published more than 160 journal articles and 10 books. He was among the first residency directors when family medicine became a specialty in 1969. In 1974 John became the first editor of the first academic journal in family medicine when The Journal of Family Practice was started.

Geyman observed the following phenomenon:
In the early years of family-practice development, considerable attention was paid to the conceptual definition of its academic discipline. There was some focus primarily on its unique content as different from all other clinical disciplines blurred the debate for a time. It is difficult – even impossible – to define with precision the distinguishable body of knowledge in any broad clinical specialty such as family practice, internal medicine…Family practice ….incorporates in a particular way portions of all other clinical disciplines….

Some had proposed that the future family physician confine his…practice…exclusively to the ambulatory care setting while serving in a triage role as the entry point to the health-care system. Such an approach…would in the long run compromise the continued clinical competence of these physicians and their ability to provide primary care of high quality to their patients. The sharp separation of medical careers into community-oriented…and hospital-based… would involve serious problems for both medical practice and medical education. The creation of a system with built in discontinuity between ambulatory and hospital patient care could be expected to jeopardise the quality of care…and depersonalise care further.

In my opinion, the greatest danger to family medicine is what I would call "death by creeping amputation". Family medicine is subjected to a defining process by our medical establishment which is dominated by the specialisation mindset. The same mindset that is responsible for the fragmentation of healthcare and the resulting disintegration of care continuity. Family medicine is defined by the remains of serial lumpectomies. The worrying thing is that bigger and bigger chunks are being amputated off to be moulded into new specialties and sub-specialties. We are now at a stage where large generalist chunks such as geriatrics and internal medicine are also being sawed off the body of family medicine. If this process continues, we must ask ourselves when does this discipline that is now defined by the remains of creeping amputation, become non-viable. At which point, after progressive dismembering of parts does an entity cease to exist?

Learning from the mid-life crisis of others

In the beginning of the 21st century, perhaps at the time of the mid-life crisis of the American family medicine movement, there was a re-awakening triggered by falling residency numbers and a pervasive sense of missed opportunity among the family medicine fraternity of the United States.

The leadership of seven national family medicine organisations in the United States (The American Academy of Family Medicine, The American Board of Family Medicine, the American Academy of Family Physician Foundation, the Society of Family Medicine Teachers, the North American Primary Care Research Group, the Association of Family Medicine Residency Directors and the Association of Departments of Family Medicine) came together and initiated the Future of Family Medicine (FFM) project in 2002. The goal of the project was to develop a strategy to transform and renew the discipline of family medicine to meet the needs of patients in a changing healthcare environment. Again the trigger was over-specialisation and the fragmented US healthcare systems, and the recognised need for an integrative, generalist approach to restore the equilibrium.[11]

Recognising the innate diversity of family medicine and the need for unity, the consortium of family medicine institutions made the following observation.

A major strength of family medicine is its local adaptability, which has resulted in considerable heterogeneity within the discipline. Because of the diversity among family physicians in terms of scope of services, practice location, practice arrangements, demographic characteristics of the patient population, and financial attributes of the practice, the development of communication strategies will be challenging. Few messages will resonate well with all family physicians, so there must be a variety of messages that take into account the widely varying circumstances in which family physicians practice medicine.

At the end of a long and probably the most cogent reflection of the discipline of family medicine, the project leaders concluded in the following recommendations for the future, something that we should learn and constantly bear in mind:

Challenges and opportunities in the future:
- Promoting a broader, more accurate understanding of the specialty among the public;
- Identifying areas of commonality in a specialty whose strength is its wide scope and locally adapted practice type;
- Winning respect for the specialty in academic circles;
- Making family medicine a more attractive career; and
- Addressing the public's perception that family medicine is not solidly grounded in science and technology

Conclusion

Robert Taylor was another giant in the early days of family medicine. He was Chairman of the Department of Family Medicine at Oregon Health and Science University from 1984 to 1998. In 2003 he was named the recipient of the John G. Walsh Award by the American Academy of Family Physicians (AAFP). This is one of the highest honours given by the AAFP. The sense of missed opportunity to put things right was probably best summed up by him. This is the thought that I would like to leave with you. Taylor wrote:

The initial promise of family medicine was that it would rescue a fragmented health care system and put it together again, and return it to the people.[12]

The future of family medicine is in the beginning, the initial promise as described by Taylor. This is the true destiny of family medicine and a promise that has yet to be delivered. At this the 40th anniversary we are given a second chance in the midst of our mid-life crisis. Our mission is to stay true to our generalist ethos. The fragmentation of healthcare today is at an unprecedented level and is likely to accelerate exponentially. Our community recognises this and we are now in the midst of implementing the Family Physician register and the primary care master plan. These are two game-changing reforms that can potentially transform our primary care and fulfil the promise that was made at the creation of family medicine. If we fail again, we will still be lamenting the missed opportunity 40 years later. I urge all of us to unite and work together regardless of our differences. Everyone is important and a good generalist who is trained in the way of the family physician is needed at every level of our healthcare system. We need to work together to increase the pipeline of such doctors for the sake of our patients and our country. I am confident that if our fraternity stays united and stays true to the values of family medicine, we can be the first country in the world to deliver this promise of family medicine.

Thank you very much and I wish all members of the College a happy and momentous 40th Anniversary.

A/Prof Lee Kheng Hock
President, 23rd Council (2011 - 2013),
College of Family Physicians Singapore

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Contributions from Past Presidents

We invited past presidents to share their stories of the times when they were presidents of the College of Family Physicians. We received submissions from five Past Presidents: Drs Lee Suan Yew, Alfred Loh Wee Tiong, Lim Lean Huat, Cheong Pak Yean, and Goh Lee Gan.

(1) REFLECTIONS ON COLLEGE'S MILESTONES IN THE EIGHTIES

DR LEE SUAN YEW
Past President, College of Family Physicians Singapore (1985 – 1989)

Let me first congratulate A/Prof Lee Kheng Hock and his 23rd Council (2011 – 2013) for publishing this 40th Anniversary Commemorative Issue.

My mentors, Dr Evelyn Hanam, the late Dr Wong Heck Sing and the late Dr Victor Fernandez, persuaded me in the early 1980s to help the College of General Practitioners Singapore, as it was then called. I assisted them by delivering several evening lectures at the old Alumni Building at the King Edward VII College Halls of Residence which is the current site of the present Khoo Teck Puat Duke-NUS Medical School.

They also invited me to assist the College in the annual examination called the Member of the College of General Practitioners Singapore [MCGP(S)]. We prepared the examinations, MCQs and essays, and selected patients for the clinical examinations which were held at the Singapore General Hospital (SGH) and the Alexandra Hospital (AH).

Tenth WONCA World Conference

In the early eighties we were kept very busy preparing for the Tenth WONCA World Conference on Family Medicine (20 – 24 May 1983). After a successful bid overseas, our College won the honour of hosting the WONCA World Conference in Singapore. At that time it was the largest international medical conference ever held in Singapore. Credit went to the President of our College, Dr Victor Fernandez; Host Organising Chairman, Dr Alfred Loh; Scientific Sub-Committee Chairman, the late Dr Frederick Samuel; Organising Secretary, Dr Lim Kim Leong; Publications Sub-Committee Chairman, Dr Goh Lee Gan; Exhibitions Sub-Committee Chairman, Dr Paul Chan.

I was invited to sit in the Scientific Sub-Committee. We sat through many long hours into the night deciding on the numerous papers submitted for the conference. I was also asked to speak at one of the Plenary sessions. My topic was: "The Challenges of Family Medicine in South-East Asia."

The Conference was a resounding success. The College made Singapore proud. As a bonus, the College became richer by over a million dollars, which was no mean sum in the eighties!

At that time, we were aware that the trend in major medical centres in the West was for the setting up of departments or chairs of FAMILY MEDICINE in universities. This was so that the teaching and research could improve the training of medical students so as to produce better-trained Family Physicians. About 60% of the medical graduates ended up as Family Physicians in Singapore during that period, but they were trained in highly specialised wards and curricula, and it was "on the job" that they acquired Family Practice skills.

Family medicine as a discipline formally taught in the undergraduate curriculum

When I was President of the College (1985 – 1989), our College Council met up with Prof Edward Tock who was then the Dean of the NUS Medical School and also Prof Phoon Wai On, who was Head of the Department of Social Medicine & Public Health (SMPH). They were also aware of the then current university trend of teaching Family Medicine as a specific discipline.

Being like-minded personalities with common directions, we agreed to form the Division of Family Medicine in the Department of Social Medicine and Public Health. The NUS approved the proposal and the College appointed Dr, now, A/Prof Goh Lee Gan to head the Division. To reflect the inclusion of Family Medicine, the Department of SMPH was renamed the Department of Community, Occupational & Family Medicine (COFM) on 13 February 1987.

Family Medicine in NUHS

Some changes have occurred since late 2008. Family Medicine joined the Department of Medicine in NUHS in 2009 as it was felt that the clinical environment in NUHS would allow the discipline to develop more optimally. With the departure of Family Medicine. the Department of COFM became the Saw Swee Hock School of Public Health.

I am glad to learn that when Family Medicine left to be part of the University Medicine Cluster in NUH in 2009, A/Prof Goh was the Head of the division till mid-2011. Dr Lim Fong Seng took over as the new Head of the Division in NUH from July 2011.

Postgraduate Family Medicine

Another milestone the College achieved in the eighties was the invitation by the then "Post-graduate Medical School" to form a steering committee to develop a postgraduate Family Medicine programme for doctors who wished to specialise in Family Medicine.

The successful post-graduates would be conferred the degree "Master of Medicine (Family Medicine)" [MMed(FM)] which is equivalent to the other MMed post-graduate degrees. I am glad to learn that there are now 321 MMed(FM) post-graduates (as of 31 March 2011).

We have come a long way since the early eighties. The College can be proud of its achievements, thanks to the many dedicated doctors who have served the College; the Ministers for Health and Ministry of Health officials; and the NUS Vice-Chancellors (now Presidents) and Deans who gave strong support to the progress of Family Medicine in Singapore.

It has been a real privilege to have served the College in the eighties and on various other occasions after that.

(2) COLLEGE IN THE 1990s

DR LOH WEE TIONG ALFRED

Past President, College of Family Physicians Singapore (1993 – 1999)

My association with the College of Family Physicians Singapore dates back to 1978 when I was voted in as a fresh Council Member. The College office then was located on the second level of the previous Medical Alumni Building which is now history.

In 1980, a small number of young and eager Council Members of the College, including Drs Lim Kim Leong, Goh Lee Gan, Paul Chan, Moti Vaswani and I, took on the challenge of organising the Tenth WONCA World Conference in Singapore. This was held in 1983. That Conference turned out better than we had expected and from that challenge, the College witnessed the emergence of a group that gelled well together and provided the College with leadership in its various office appointments for many years to come.

I was unexpectedly entrusted with the Presidency of the College some time in mid-1992 when the late Dr Koh Eng Kheng, then President of the 13th Council of the College, was taken ill and was not able to carry on with his duties. As the elected Vice-President, I had to step in and be the Acting President to ensure that the plans that Dr Koh had put in place were carried out for the rest of his term. I then had the honour and privilege of being elected President of the 14th (1993 – 1995), the 15th (1995 – 1997) and the 16th (1997 – 1999) Councils.

Those were memorable years as I witnessed the growing commitment and solidarity of the Council Members towards the objectives and mission of the College.

First term of office — 14th College Council (1993 – 1995)

- At the 1993 Annual General Meeting of the College, the house voted overwhelmingly in favour of changing the name of the College to "The College of Family Physicians, Singapore".
- The vocational training programme of the College was rcognised by the School of Postgraduate Medical Studies (NUS), the Ministry of Health and the Singapore Medical Council.
- The College, together with the Academy of Medicine, Singapore, was invited by the Singapore Medical Council to take charge of the administration and secretariat function for the SMC- CME Programme.
- The first batch of 17 GP trainees offered themselves as candidates for the first Master of Medicine (Family Medicine) [MMed(FM)] Examination conducted by the School of Postgraduate Medical Studies (NUS) in 1983. Of these, 9 were successful.
- The College was informed by the Ministry of Health that the MMed(FM) was to be recognised at par with the other MMed qualifications for salary increments and promotion.
- At the international level, Dr Goh Lee Gan was one of four experts chosen by WONCA (The World Organisation of Family Doctors) to do a study visit on Family Medicine Training in The People's Republic of China in 1991. Their report was accepted by the Ministry of Health of the PRC and it was requested that the report be circulated to all medical schools in the PRC in 1993.
- The College President sat as a Member of the Executive Committee of WONCA.

Second term of office — 15th College Council (1995 – 1997)

- The Postgraduate School of Medical Studies (NUS) wrote to the College to grant permission to the College to formulate and execute the Advanced Specialty Training as its exit training.
- The Board of Censors of the College started the discussion on the Fellowship by Assessment Programme in July 1995. This was eventually launched in 2000.
- The Singapore Medical Council gave approval for the College's Fellows and Diplomates to use the new title "MCFP(S)" and "FCFP(S)".
- The College, in conjunction with the Dept. of Community, Occupational and Family Medicine (NUS), started the MMed(FM) Private Practitioners' Stream (PPS) in July 1995 specifically for doctors who had started their Family Medicine traineeship but for some reason had not completed the examination.
- The College participated in a one-week study trip to the United Kingdom in 1996 (7–15 Sep) organised by the Ministry of Health, The Postgraduate School of Medical Studies, the NUS and the Academy to study various aspects of Primary Care health delivery, including practice audit, quality assurance, and the role of trainers and trainees in vocational training and provision of CME. The College was represented by Drs Lim Lean Huat and Goh Lee Gan.

Third term of office — 16th College Council (1997 – 1999)

- The College celebrated its 25th Silver Anniversary with the keynote address given by the WHO Chief Medical Officer, Dr Charles Boelen, and the WONCA World President, Dr Goran Sjonell, delivering the Sreenivasan Oration. The accompanying conference had delegates from over 7 countries.
- The College made an official visit and study tour to Myanmar at the invitation of the Myanmar Medical Association (MMA) and the GP Section of the MMA in 1998. The College was invited to assist in the development of a Family Medicine Training Programme for Myanmar.
- As part of the College's contribution and continuing effort to support the development of academic departments of Family Medicine, the College undertook a project with the PRC Chinese Society of General Practice in Beijing, by contributing $10,000 to the translation, publication and distribution of the WHO-WONCA Report entitled "Making Medical Practice and Education more relevant to the People's Needs – The Contribution of the Family Doctor". Over 3000 copies of the translated report were distributed to the medical faculties and teaching departments of universities throughout China.
- The College launched its Advanced Family Medicine Programme (AFMP) in October 1998. On satisfactory completion, participants are awarded the Fellowship of the College of Family Physicians Singapore [FCFP(S)]. There were eight doctors in the inaugural batch.

These are just some of the milestone developments of the College during the years 1993 – 1999. All these would not have been possible if not for the dedication and focused efforts of Members of the three College Councils spanning that period. Special mention must be made of some who played especially key roles in the many activities and programmes of the College. They include Drs Lee Suan Yew, Goh Lee Gan, Lim Kim Leong, Richard Ng, Arthur Tan, Soh Cheow Beng, Lau Hong Choon, Yii Hee Seng, Lim Lean Huat, Wong Song Ung and Lee Kheng Hock among others.

It was my privilege and honour to have worked with these persons and others in the service of the College and it leaves me to wish the College brighter days and bigger achievements in the years ahead as it celebrates its 40th Anniversary.

(3) COLLEGE IN THE LATE 1990s AND EARLY 2000s

A/PROF LIM LEAN HUAT

Past President, College of Family Physicians Singapore (1999 – 2001)

I was first involved in the College as a member of the Council from 1976 to 1978, Honorary Treasurer in 1989 to 1991, and Vice President from August 1992 to 1997. I was President from 1997 to 2001. A brief account is given of the key events during my term as President.

Department of Family Medicine was mooted in 1999, discussed and put on hold

One of the key areas of discussion at the time I was President was the discussion on the setting up of a Department of Family Medicine. An Extraordinary General Meeting was held on 24 September 1999 to discuss this matter. Three resolutions were passed. The key resolution was that the College would initiate the move to set up a Department of Family Medicine at the National University of Singapore. In the ensuing discussion, it turned out that the University wanted to emphasise Research and Teaching rather than Family Medicine per se.

Launch of the College website on 18 July 1999

The late nineties was a period of website development. The College launched its website on 18 July 1999. The website is now a repository of the College's publications, activities, and information resource.

Sreenivasan Oration and the 7th Scientific Conference, 25-26 Sep 1999

During my term of office, the Seventh Scientific Conference was held in September 1999. The highlights of that meeting was the 17th Sreenivasan Oration delivered by Dr Adrian Tan Cheng Bock on the topic of "Medicine and Politics — Do They Mix?"

Launch of the Graduate Diploma in Family Medicine (GDFM) in 2000

The launch of the Graduate Diploma in Family Medicine was in July 2000. This marked an important development in the training of the Family Physician. Graduates in the Diploma in Family Medicine can proceed to do the Master of Medicine in Family Medicine when they fulfil requirements of clinical practice. Today, as of March 2011, we have 492 graduands from the Graduate Diploma in Family Medicine programme.

Graduate Diploma in Ultrasonography

The Graduate Diploma in Ultrasonography was initiated in 1998 and was conducted for several years after that.

Bidding for WONCA World Conference 2007

In South Africa in 2000, the Singapore College team led by Dr Tan See Leng successfully won the bid to host the WONCA World Conference 2007.

Hosting of the WONCA World Secretariat in the College in 2000

The College hosted the WONCA Secretariat in 2000 when the Office Headquarters moved to Singapore. This remained till 2009, when the WONCA Secretariat relocated to larger premises in Beach Road. Dr Alfred Loh Wee Tiong was appointed CEO in 2000 and stepped down in 2012.

(4) COLLEGE IN THE 2000s

A/PROF CHEONG PAK YEAN

Past President, College of Family Physicians Singapore (2001 – 2006)

I was elected President in 2001 and was President of the College for three terms. My contribution to the College was to streamline the various training programmes of the day towards a continuum of professional development.

Continuing Medical Education & Family Practice Skills Courses

In the 1990s, the College was doing very much what it had been doing in the years before — a lot of CMEs and collegiate activities. And the CMEs were done on an ad hoc basis, depending on what people interested in. The CMEs did not carry any points, and did not lead to anything.

Undergraduate Family Medicine

Although we were not directly involved in structured family medicine training as there was then no Department of Family Medicine in NUS, we were providing support for it. We supported the NUS with their undergraduate medical postings, and the NUS Postgraduate Medical School (PGMS) in their Masters programme.

In 1969, medical postings had already started informally. In fact, I remember being posted to Dr Lee Suan Yew's clinic for three weeks in 1972. (I graduated in 1974.) GP medical postings were directly organised by the College in those early days.

Membership of the College of General Practitioners (MCGP)

The Membership of the College of General Practitioners (MCGP) had been awarded since the inception of the College. This was recognised by the Singapore Medical Council as an additional qualification. The first batch graduated in 1973 and James Chang was in that cohort. In 1992, the last MCGP Examination was conducted. It continued in the Graduate School as the MMed (Family Medicine).

Training of Family Physicians in the Private Sector

In 1995, the proposal to the Ministry of Health for an alternative route to the MMed (Family Medicine) was accepted. This was the Private Practitioners Stream. This programme was initiated because it was felt that the numbers going through Programme A were low, and most stayed in the polyclinic system.

The College was concerned about where the future professional leaders were going to be found. In fact, that initial cohort that went through the Private Practitioners' Stream nurtured most of the current leadership of Family Medicine in Singapore today, including Drs Julian Lim, Dr Tan See Leng who is the current Vice President, Dr Kala who worked in the Community Hospitals, and Dr Tan Yew Seng who now heads the Assisi Hospice. This group of doctors left early from the public sector for various reasons, but were eager for education. So, when the Private Practitioners' Stream came about, they all came on board.

Clinical Focus

Singapore has had some 25 years of formal undergraduate exposure to Family Medicine now in the Yong Loo Lin School of Medicine since 1987. Since 2009, Family Medicine has moved from the Department of Community, Occupational & Family Medicine to the Department of Medicine in NUH. This allowed Family Medicine to have a more clinical focus. Since, 2011, a Family Medicine Residency Programme has been started.

The inclusion of Family Medicine as a subject to be formally taught in the undergraduate MBBS programme in NUS in 1987, and the institution of the MMed (Family Medicine) provided the foundation upon which we were able to convince MOH and NUS to bless the Graduate Diploma of Family Medicine (GDFM) which was launched in 2000. This was an initiative driven directly by the College. In fact, in the first few years of the GDFM, we tried to keep it low key. We did not have any external funding at all and generated funds internally to run it.

Fellowship Programme

In the late '90s, we felt that the College did not have a leadership plan. So we developed a Fellowship of the College of Family Medicine (FCFM) by assessment to create leaders and teachers to support the training programmes.

Integrating GDFM with MMed(FM)

Our next crucial development was the harmonising of the GDFM with the MMed training. We took the Family Medicine Modular Course (FMMC), examined the commonalities to both the GDFM and the MMed (FM) training and ensured that they had a common theoretical basis. This allowed for folks who had done the GDFM before to complete the MMed (FM) in one year.

MCFP by Assessment

In 2002, we introduced the MCFP by assessment for holders of the GDFM. This meant that we had created two routes for GDFM graduates: MCFP by assessment, and MMed Programme B. Prior to this, during the 1990s, the MCFP was dormant and not awarded at all. After 2000, the MCFP was awarded via two routes: by an interview process following the MMed; and by assessment (a two-year programme) after the GDFM and other practice qualifications.

Fellowship by Assessment

Internally, some tensions surfaced as a result of these changes, but we stuck by our decision to award the fellowship by assessment, as opposed to the honour and election route. There were those who wanted the latter route to continue as it was provided for in the Constitution. We, however, wanted to maintain strict standards. Some also felt that the Fellowship should recognise specific domain competencies, e.g. community hospitals and long-term chronic care. The original intention was for the FCFP to recognise specific clinical competencies, e.g. palliative care, under its three-year programme.

The FCFP programme was developed in 1999. It was originally a three-year programme to parallel the Advanced Specialist Training, but as a result of objections from certain quarters, we had to reduce it to two years in order for the programme not to be completely vetoed. So, instead of the Advanced Specialist Family Medicine Training, we had to be content with the Advanced Family Medicine Training (AFMT), because otherwise we would have been setting the standards too high. Our original three-year programme would have involved competency training in domains of Family Medicine, e.g. community hospitals. However, because it was vetoed and the programme became a two-year one, the goal then became the recognition of leadership and training as a teacher.

Training more Family Physicians

Although we were training those undergoing the MMed Programme B and producing good clinicians and teachers, we were still short of Family Physicians for practice. We realised that there was no way for us to increase the numbers without MOH support to train more MMed(FM). You need to understand that the MMed(FM) is very rigorous and is patterned after the other MMed programmes, e.g. Internal Medicine, and there is a great emphasis on the clinical component. As the standard is very high, there was a limit to the numbers we could produce, because many could not fulfil the clinical component requirement. That is what led to the development of the GDFM in 2000.

In place of the clinical training and assessment, we studied the Australian model which used the Objective Structured Clinical Examination (OSCE) for our GDFM. Together with Dr Goh Lee Gan, Dr Tan Chee Beng and Dr Lau Hong Choon (Censor-in-Chief at the time), we developed the GDFM. This marked a big step forward because it was directly owned and taught by the College.

Administration of the College Secretariat

During my first term as President, we decided to introduce the Executive Director (ED) model in the College Secretariat. Dr Lee Kheng Hock was the first holder of this appointment. This administrative innovation has worked well and should continue to be the administrative practice in the College.

WONCA World Conference 2007

In 2006, in the non-election year, I asked A/Prof Goh Lee Gan to accept the post of President for the remainder of the term while I became Vice President. This, I thought, was a better way to prepare for the hosting of the WONCA World Conference by Singapore in 2007 as A/Prof Goh was much more familiar with Family Medicine Colleges around the world. This arrangement was good and we successfully hosted the WONCA World Conference.

(5) COLLEGE FROM MID 2000s TO 2011

A/PROF GOH LEE GAN

Past President, College of Family Physicians Singapore (2006 – 2011)

WONCA World Conference 2007

My first task when I took over as President in 2006 was to prepare for the finishing touches to the 2007 WONCA World Conference. This was the second time Singapore was hosting the Conference. Resting on the able shoulders of Dr Tan See Leng, the Conference was a success.

Administration of the College Secretariat

The second half of the 2000s was important in terms of the fine-tuning of administrative processes and also the preparation of transition of the old guards to the new guards in the College leadership.

Institute of Family Medicine

The Institute of Family Medicine (IFM) was set up in January 2002 as a result of a resolution passed at the AGM in 2001. It functioned as a unit within the College to co-ordinate the various vocational training programmes as well as the Family Medicine Family Practice Skills Courses. I was appointed its Director in 2002 and have continued in that role to this day.

Into the future

Looking ahead, the main tasks of the College in continuing the development of Family Medicine are the sustaining of vocational training programmes, the Fellowship programme, the Family Practice Skills Courses, the development of trainer programmes to build the pipeline of family physician faculty for the undergraduate and postgraduate programme, and the development of family medicine research activities.

Preparing family physicians to meet the urgent needs of the health landscape, namely, the gearing up of eldercare training for the ageing population, step-down care, slow stream rehabilitation care, and maintainence of healthy lifestyles are the priority training activities.

To be successful in the delivery of healthcare programmes, there is a need to be able to engage the support of the public in healthcare literacy. This involves the education of the public in the understanding of healthcare objectives, processes and outcomes.

CONCLUSIONS

Three observations may be made from the reflections of the five past Presidents:

- Over the last forty years, the landscape of family medicine has evolved considerably. The Family Physician now provides care not only in the community setting, but also increasingly in acute hospital interface care, as well as in the intermediate and long-term care settings.
- Past and present Presidents of the College have been key catalysts in raising Family Medicine to its present status as a discipline with well-defined vocational programmes and training end-points.
- Subsequent decades will no doubt see greater growth of the discipline and a greater role for the Family Physician in the healthcare delivery system.

Contributions from Past Censors-in-Chief

We invited four past Censors-in-Chief to share their stories of the times that they were holding that office in the College of Family Physicians, Singapore. They are Drs Chang Ming Yu James, Lim Kim Leong, Goh Lee Gan, and Lau Hong Choon.

FAMILY MEDICINE IN THE SIXTIES AND SEVENTIES

Dr Chang Ming Yu James
Founder Member of the College of Family Physicians Singapore and Past Censor-in-Chief (1979 – 1985)

Formation of the College

In the 1960s, there were about 500 registered medical practitioners in Singapore, half of whom were in private practice. Most were General Practitioners (GPs). The GPs were from a wide spectrum of doctors. Some were "raw", straight out after housemanship, others were retired physicians, surgeons, medical administrators and even pathologists. The standards of general practice varied a great deal obviously. Some had left off clinical practice for years and forgotten much. Others who had only done adult medicine had no clue about treating children. Simple surgeries like toilet and suture, and emergency medical problems were difficult for many.

Realising that improving the standard of GPs would benefit the healthcare of all Singaporeans, a group of like-minded GPs decided to form an academic body to conduct courses for themselves and their colleagues. This was the beginning of the College of General Practitioners Singapore.

Many countries had already started similar Colleges at that time. We sought the help of Colleges in Great Britain and Australia. A few of us visited The Royal Australian College of General Practitioners (RACGP) to learn from them about the setting up of their College and their system of examination.

In 1971, with the help of the Singapore Medical Association and the Society of Private Practice, the College of General Practitioners Singapore was formed. There were 122 members, of whom I am proud to be one.

The Early Leaders and Teachers

The first President of the College was Dr B. R. Sreenivasan who was once the Vice-Chancellor of the University of Malaya. The annual Sreenivasan Oration is named after him. The Vice-President was Dr Wong Heck Sing, the man who was the main force behind the setting up of the College. The College was his brainchild and he worked extremely hard to bring it to fruition. The first Censor-in-Chief was Dr Wong Kum Hoong. He took his role with fanatical zeal and like a John the Baptist shouting in the wilderness, he would shout "We want standard, standard, standard in general practice!"

With the help of our institutional colleagues, various Continuing Medical Education (CME) Programmes were started. I remember that our early teachers were Prof Wong Hock Boon, Prof Seah Cheng Siang, Dr Evelyn Hanam, Dr Feng Pao Hsii, Dr Loong Si Chin, Prof Chia Boon Lock, Dr Paul Ngui, Dr Chia Boon Hock, to name a few, and they all taught us with great enthusiasm. They involved us in clinical rounds, lectures, round-table discussions and journal readings. I remember taking time off in the evenings and weekends to participate in these sessions. There were no CME points to be collected, yet I looked forward to the teaching sessions with eagerness, despite the long hours of work in the clinic.

The Diplomate Membership Examination

With the help of The Royal Australian College of General Practitioners (RACGP), the first membership examination was held in 1972 with 17 candidates. It consisted of 3 theory papers, (2 MCQs and 1 essay) and a clinical examination comprising long and short cases, interpretation of X-rays, laboratory reports, ECG, etc., and a viva voce. Seven out of 17 candidates passed and the Censor-in-Chief proudly declared that no doctor deserved to have MCGP(S) after his name without attaining the "required standard".

Immediately after passing the examination, I was conscripted into the Censor's Board and the Council. We continued to run the CME Courses and the MCGP(S) examinations and, in 1973, the College hosted the regional World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) conference, and I was the organising secretary. In 1993, when NUS embarked on the Master of Medicine (Family Medicine) [MMed(FM)] examination, it adopted the format of the MCGP(S) with minimal change. Nowadays, however, the candidates have more thorough preparation and training from their equally dedicated teachers before their examination.

General Practice in the Early Years

I set up my solo general practice in 1965 in a one storey shop house in Beauty World Town in Bukit Timah, the space that is now a car park and a future MRT station. The rental was rather modest. I paid a rental of $270 for a 15-year lease. This was considered a "rural" practice. There were only 3 GPs in Bukit Timah, 3 in Bukit Panjang, 1 in Jurong and 1 in Lim Chu Kang. My patients were mainly poor farmers, fishermen, small traders and their families living in "ulu" Singapore.

Unlike current practice, clinical acumen was the order of the day as investigations were only available in hospitals. Private laboratories and radiological centres were difficult to access. I improvised my own "mini laboratory" in my own consultation room and, using biochemical methods and a microscope, I would examine urine, blood and other human secretions. With that, I was able to make more accurate diagnoses without having the patients to pay more.

I made many housecalls then. I remember one housecall on a Sunday afternoon after my morning practice. A young man asked me to see his father who could not pass urine for 2 days. I drove for 30 minutes, wondering how far more I had to go. When the road ended, I was surprised to see a bicycle waiting for me. I had to cycle over mud paths for another 10 minutes to reach a farmhouse in Choa Chu Kang. The poor old man was in agony. He had acute retention of urine from benign prostrate hypertrophy and I happily whipped out the catheter I had brought with me and drained 2 litres of urine from him. What great relief there was on the old man's face and what satisfaction there was for me!

Most housecalls then were from necessity and never frivolous. There was a housecall I made to see an old lady who was very ill. She had pneumonia and I advised admission to hospital. I told the family that she had no chance of survival unless hospitalised. Because I did not prescribe any medicine but merely gave advice, the family did not expect me to charge them. They gave me an "angpow" and I discovered to my chagrin later that it contained only $2.

Often, the fees I was paid would not be money but produce from the farm — vegetables, eggs and chickens. There was one time when I did a toilet and suture for a young man and he could not pay. When he came back for review, he presented me with 2 live chickens. I had no place to keep the chickens and so left them in the toilet. Imagine the shrieks and squawks that came from the toilet when I later sent a woman to the toilet for a urine test. She was certainly not amused!

Many GPs of that era have equally riveting stories to tell. On hindsight, these added to the satisfaction of being GPs and family physicians. Patients were grateful for the little we did for them and litigation was unheard of.

Moving forward

The College has taken a quantum leap forward since those days and general practice has changed tremendously. There is now a Division of Family Medicine in NUHS to teach undergraduate Family Medicine and Postgraduate Family Medicine.

All major hospitals have Divisions or Departments of Family Medicine. The Polyclinics have Consultant Family Physicians who have higher degrees in the specialty. The Ministry of Health is in the midst of setting up a Family Physicians Register. Family Medicine has been elevated to a level equivalent to other specialties.

There are now 1,407 members in the College (as of 31 March 2011), from the meagre 122 members in 1971 when the College started. I wish the younger doctors well as they carry the torch that the pioneers of the College lit.

May I wish the College my hearty congratulations for a blessed 40th Anniversary!

FAMILY MEDICINE IN THE SEVENTIES AND EIGHTIES

Dr Lim Kim Leong

Past Censor-in-Chief, College of Family Physicians Singapore (1985 – 1991)

After I passed my Member of the College of General Practitioners Singapore [MCGP(S)] examination in 1977, Dr Evelyn Hanam, the then Censor-in-Chief of the College, persuaded me to get elected to the College Council. She inducted me into the Examiners' Board, and thus started my more than 2 decades of association with the College.

I was inspired by people like Drs Wong Heck Sing, Evelyn Hanam, Victor Fernandez, Koh Eng Kheng, Lee Suan Yew and James Chang who gave their service to the College wholeheartedly and altruistically. They had a vision and aspiration for Family Medicine to be established and accepted so that the patients will get the best care possible. I shared the same dream.

I was appointed Censor-in-Chief in 1985 and remained for 3 terms. It was a period of great change and development for the College and for Family Medicine in Singapore.

1986 – 1987: We were actively engaged in a dialogue with the University regarding the introduction of Family Medicine in the University. The idea was accepted and Family Medicine became a subject formally taught in the undergraduate MBBS programme.

To reflect the inclusion of Family Medicine in NUS, the name of the Department of Social Medicine and Public Health (SMPH) was changed to the Department of Community, Occupational and Family Medicine (COFM). Dr Goh Lee Gan, was recruited to be a Senior Teaching Fellow in Family Medicine.

At this time, the College was also engaged in a discussion with the Ministry of Health (MOH) and NUS Graduate School of Medical Studies regarding the training and teaching of MOH primary care doctors and the establishment of an examination for these officers. Our memorandum was accepted and a Tripartite Committee consisting of members from the College, MOH and NUS Graduate School of Medical Studies was formed to oversee the implementation of this teaching, training and examination. At the same time the College implemented a scheme for Family Physicians/ General Practitioners in the private sector to also get teaching, training and examination.

The College Censors Board recommended and the Council accepted that the Master of Medicine (Family Medicine) [MMed(FM)] would be the examination for private medical practitioners and MOH primary care doctors. The MCGP(S) examination would cease to be held but would continue to be recognised by Singapore Medical Council (SMC).

The 1st MMed(FM) Examination was held in 1993. The teaching and training leading to the examination have been instrumental in the raising of the standard of Family Medicine and Primary Care in Singapore. I am glad to note that the decision turned out to be correct for the FM/GP community.

It was also during this period that I got to know Dr Goh Lee Gan very well. He had joined the University as Senior Teaching Fellow and then was promoted to Senior Lecturer the same year in 1987. He was a tireless worker and seemed to have boundless energy. I remember having many discussions and arguments with him over the concept and scope of Family Medicine, primary care, community medicine, social medicine. I remember working with him deep into the nights, either in his home or mine, preparing the teaching and training programmes, and organising the MCGP(S) (together with Dr James Chang in the Censors Board) and MMed(FM) examinations.

Lee Gan was involved from undergraduate teaching to postgraduate and vocational training to preparing and running the examinations. He was working with the College, the University and MOH as a member of the Tripartite Committee. We used to joke in the Tripartite Committee that we should clone him to increase and improve productivity.

He was not discouraged by the amount of work nor distracted by the diversity of interests. In my opinion, he was the one who had a grasp of the complexity of Family Medicine, the one who made sure that there was co-ordination in the teaching and training of Family Medicine from undergraduate to postgraduate. He was the one who was balancing the interests of the College, MOH and the University, and the needs of private medical practitioners and MOH medical officers. It was my privilege and pleasure to have worked with Lee Gan.

I am very happy and satisfied that the College has progressed so far and so well with new and young leaders. We have done well. Family Medicine is now accepted as a discipline and is formally taught in the undergraduate and postgraduate levels.

FAMILY MEDICINE IN THE EIGHTIES AND NINETIES

A/Prof Goh Lee Gan

Past Censor-in-Chief, College of Family Physicians Singapore (1991 – 1999, 2001 – 2005)

I first joined the College in the mid-seventies. Little did I think at that time I would to be involved in its activities for the next 40 years. My first involvement was as a member of the Host Organising Committee of the Tenth WONCA World Conference. As a member of the Scientific Committee chaired by Dr Frederick Samuel, our main task was to go through the abstracts of plenary sessions, symposia, workshops, and free papers.

There were many hundreds of abstracts to read and select. My classmate Dr Patrick Kee Chin Wah was really first class: He was amazing in vetting and sorting out the papers — which to accept, and which to reject. We decided to create a WONCA First – to have the Conference Proceedings ready to be distributed on the last day of the Conference. We succeeded. The WONCA Conference put us in contact with the leaders in Family Medicine of the day. That was a help.

The next development was the invitation for me to join the University to help set up the undergraduate Family Medicine programme. One late morning, three SMPH academics visited my clinic in Hougang — Prof Phoon Wai On, Dr Lee Hin Peng, and Dr Phua Kai Hong. I thought I would give it a try and that was in 1987.

Dr Chee Yam Cheng, then Director of Manpower, rang up one day and asked if I could help him set up a Family Medicine postgraduate programme. We mooted the setting up of the Tripartite Committee and that arrangement was very successful in the introduction of the vocational Family Medicine Programme into Singapore. We received advice and help from several people, including Professor Wes Fabb, then the Honorary Secretary and Treasurer of WONCA. He was our First HMDP Expert in Family Medicine in 1988. He contributed a great deal of advice to the setting up of a Vocational Family Medicine Programme in Singapore. Professor Paul Freeling from the Department of Family Medicine in St Georges School of Medicine was also an HMDP Expert who visited us in the early 1990s.

All these paved the way to the setting up of an MMed(FM) programme in 1991 and the first batch of candidates sat for the Master's Examination in 1993. Of the 17, nine were successful. From that starting point, we now have 321 graduands in 2011.

In 1995, thanks to the tireless energy of Prof Cheong, a Private Practitioners Stream (PPS) was created as an alternative route to the training for the MMed(FM). The initial candidates were medical officers who did not complete their Family Medicine Traineeship for one reason or another. Over time, the PPS grew in strength and today is known as the Program B.

So the years as Censor-in-chief of the College were eventful. I owed a lot to the two Censors-in-chief before me: Drs James Chang and Lim Kim Leong. They continued to be in the Censors' Board during my stint as Censor-in-Chief. In 1999, I passed the baton to Dr Lau Hong Choon.

FAMILY MEDICINE 1999 TO 2003

Dr Lau Hong Choon

Past Censor-in-Chief, College of Family Physicians Singapore (1999 – 2001; 2001-2003)

I congratulate the College of Family Physicians Singapore for its 40th anniversary and thank the College for the privilege of being a Fellow and a past Censor-in-Chief. The College has been an important part of my professional life and I owe many of its leaders a debt for being their mentee. I also owed it to my bosses in the Community Health Service, Dr Lam Sian Lian and Dr Ling Sing Lin, who were among the first to foster and develop Family Medicine in the polyclinics. It was Dr Lam Sian Lian who encouraged me to do the Family Medicine course and take the MCGP(S) exam and gave me the many opportunities to learn and develop leadership. Dr (later A/Prof) Goh Lee Gan was a great mentor and friend. While 40 years may be one generation for man, it seems like many generations for Family Physicians. I think we have gone through at least 3 major generations of leaders in the College of Family Physicians, Singapore.

I joined the first batch of Family Medicine trainees in 1988 — it was called the Family Medicine Vocational Training Programme. My teachers were friendly, and great mentors. They were the second generation of Family Medicine leaders. It was a wonderfully collegial discipline where all respected each other and were willing to teach. I learnt much from the first modular course, from the older General Practitioners (GPs) who had joined in the discussions, and from our specialist colleagues. We learnt cognitive and affective skills, interacted, gained confidence and esteem, and took pride in Family Medicine. Family Physicians were the primary point of contact and the doctors for the lifelong follow-up of the patient and family. It was and is one of the most important disciplines to develop for healthcare to be properly delivered in any country.

The first generation Family Medicine leaders were our past pioneers and visionaries who have passed on or retired, but their spirits remain — Dr Wong Heck Sing, Dr B. R. Sreenivasan, Dr Koh Eng Kheng, Dr Evelyn Hanam, Dr Leong Vie Chung, amongst many other illustrious doctors.

The second generation included Dr Lee Suan Yew, Dr Lim Kim Leong, A/Prof Cheong Pak Yean, A/Prof Goh Lee Gan, and Dr Alfred Loh. These are the people whom I interfaced with. Many of these pioneers had built on their links in the UK and Australia to bring in important expertise to help develop Family Medicine. We remember them for their love of Family Medicine and their determination to make Family Medicine a great discipline for posterity. These eminent Family Physicians of their time believed in academic Family Medicine and were instrumental in the development of the first Family Medicine programme and the College Diplomate Exam. The foundation they laid and their aspirations, views and a common destination have made Family Medicine what it is today.

The College Diplomate Membership Examination or Member of the College of General Practitioners Singapore [MCGP(S)] was established by the College in 1972. This was changed to the Collegiate Membership of the College of Family Physicians Singapore [MCFP(S)] when the College changed its name to the College of Family Physicians Singapore.

The MCGP(S) examination was replaced by the Master of Medicine (Family Medicine) [MMed(FM)] examination in 1993 after the School of Post Graduate Medical Studies, NUS [today called Division of Graduate Medical Studies (DGMS)] used the MCGP(S) format to revise it to become the Masters in Medicine (Family Medicine) or in short, the MMed(FM) examination.

The chief architect of the MMed(FM) at that time was A/Prof Goh Lee Gan who was also instrumental in setting up the eight modules in the course. Those who had passed the MCGP(S) and the MMed (FM) were de facto Family Physicians. The MMed (FM) was linked to the College through the award of the MCFP (S).

The College then went on to implement the Graduate Diploma in Family Medicine (GDFM) examination. The GDFM was started after a spirited discussion in a College Annual General Meeting (AGM) to provide a pathway for those who may not want to do the MMed (FM) or who wish to progress through a less challenging route. It was decided that this was good for our doctors and the College started the course in July 2000 with 26 tutors and 48 trainees.

The College sent A/Prof Goh Lee Gan, Dr Tan Chee Beng and I to Townsville in Queensland in November 2001 to observe the examination conducted by The Royal Australian College of General Practitioners (RACGP). Townsville had a newly opened medical school, the James Cook University, whose Dean was a Family Physician, and it had purpose-built new infrastructure to conduct such an examination. There were rooms adjacent to the examination room in the newly built buildings with one-way mirrors and audio equipment to observe how the Australians ran the Objective Structured Clinical Examinations (OSCEs). We also learnt how the Australians designed, planned and wrote examination questions — i.e. the MCQs, Key Features Problems (KFPs) and OSCEs. Using the Australian experience and with the same learning modules for MMed (FM), the GDFM examination was born and modelled after the RACGP format. The Australian academics and examiners in Townsville were very warm towards us — they treated us very well and we owed it to their kindness that we have the very successful GDFM in place today.

When the amended Medical Registration Act was passed in Parliament last year, we had in place for the first time the Family Physicians Register. This was the culmination of a dream for many of our Family Physicians.

The year 2001 also saw the resumption of the award of the MCFPS. Nine doctors received the award. This award was initially awarded as the Diplomate qualification by the College in 1972 as the MCGPS till 1992. From then till 2001 it was not awarded. In 2001, the College decided to award the MCFPS to family doctors who have obtained the MMed(FM). They are invited to apply for admission to Diplomate membership and criteria for admission for this distinguished category of membership were:

- Membership of the College for at least 2 years;
- Demonstrated commitment to professional development by satisfying SMCs requirements for CME;
- Active participation in academic and College activities.

The Award of the Fellow of the College by Assessment was initiated in 1998. This was also the trend in the Royal College of General Practitioners in the United Kingdom. The Singapore programme was for two years; had prescribed courses in medical pedagogy, research, and leadership; and also had case presentations and topic reviews. There is an exit examination. The first batch of 8 candidates successfully completed the programme in 2008. They were conferred the Fellowship award in August 2001.

Into the present, Family Medicine has further developed. Family Physicians are now the main group of doctors in community hospitals managing mostly geriatric and rehabilitation patients. Singapore General Hospital (SGH) started the first Family Physician Hospitalists. Family Physicians can take on advanced training to become specialists in Palliative Medicine, Sports Medicine and Geriatrics.

Today's generation of Family Medicine leaders A/Prof Lee Kheng Hock, Dr Tan Chee Beng, Dr Ho Han Kwee, Dr Lim Fong Seng and many more will have the challenge of carrying Family Medicine forward and making their mark in history. Many of our early pioneers will be pleased to see the development of Family Medicine in such directions. Family Medicine, the giant of all disciplines in terms of numbers of practitioners, will grow and in future many more doctors will be trained in Family Medicine to realise the dream of every Singaporean being served by a trained Family Physician. I am confident that the College will scale greater heights in the years ahead.

FAMILY MEDICINE 2003 TO THE PRESENT AND FUTURE

A/Prof Goh Lee Gan
Past Censor-in-Chief, College of Family Physicians Singapore (1991 – 1999, 2003 – 2005)

The professional development of the Family Physician is a core business of the College of Family Physicians. We do this through a combination of learning from countries who are more advanced than Singapore, and learning side by side with fellow countries in Asia Pacific. There is also adaptation of Family Medicine to meet the enlarging role of the family physician in the provision of care in the community as well as in growing care areas of the Emergency Department, Acute hospital care, Intermediate care, and Long-term care. The core-expertise of the Family Physician lies in the continued expertise in the 3 Ps (namely, personal, primary, and preventive care) and 3 Cs (comprehensive, continuing, and co-ordinated care).

The advancing healthcare technology, ageing population, and patients with organ failures who are successfully treated to varying degrees call for a new generation of Family Physicians who are adept at integration of care.

The new compact of expertise of Family Physicians to meet the evolving Singapore Healthcare system has been succinctly summarised in the 2009 National Rally Speech by Prime Minister Lee Hsien Loong to consist of 4 elements: gearing up of our healthcare system for an ageing population; building up step-down care in the areas of intermediate and long-term care; linking the acute hospital with the community hospital for rehabilitation of patients who have recovered from acute episodes (the so-called slow medicine); and maintaining healthy lifestyles, the best way to keep healthcare costs down.

CONCLUSION

The Censors-in-Chief of the College have played the role of preparing future generations of Family Physicians during their terms of service to the College. The stories told through their lived experiences give glimpses of the College's journey in this endeavour through time. This important corporate role of the Censors-in-Chief and the Censors' Boards continues into the future.

College Mission

1. To advance the Art and Science of Medicine.
2. To discuss Medical and Scientific problems.
3. To assist in providing post-graduate study courses for family physicians, and to encourage and assist practicing family physicians in participating in such training.
4. To arrange for and/or provide instruction by members of the College or other persons for undergraduate or postgraduate students in family practice.
5. To promote and maintain high standards of family practice of Medicine.
6. To encourage and assist young men and women in preparing, qualifying and establishing themselves in family practice.
7. To preserve the right of the family physician to engage in medical and surgical procedures for which he is qualified by training and experience.
8. To provide, endow or support scholarships, lectureships, readerships, and professorships in subjects appertaining to or associated with family practice.
9. To give, grant, issue or bestow diplomas, certificates and other tokens and distinctions in recognition of proficiency or attainment in family practice or in any subject cognate to family practice; any such tokens or distinctions may be awarded upon examination or thesis or honoris causa.
10. The College may acquire by purchase, hire, lease, or grant, or sell any movable or immovable properties in furtherance of the objects of the College.
11. To receive, borrow or invest money for any of the objects of the College.
12. To do all such things as are incidental or conducive to the attainment of the foregoing objects or any of them.

Our History – The College Milestones (1971 – 2012)

1971
- 18 March: The First Council of the College was formed and presided over by the late Dr B. R. Sreenivasan. The College was housed at the old Alumni Medical Centre at 4-A College Road.
- 30 June: The College of General Practitioners Singapore was officially inaugurated.

1972
- 5 November: The first examination for diplomate membership, the MCGP(S), was held. This was the first postgraduate examination for family medicine to be conducted in Singapore.

1973
- 1 March: The first issue of The GP was published. This was the journal of the College. The name of the publication was changed to The Singapore Family Physician in 1975.

1974
- 1 July: Dr Benjamin A. Sheares, the then President of Singapore became the Patron of the College. The MCGP was recognised by the Singapore Medical Council (SMC) as a registrable postgraduate medical qualification.

1978
- The Sreenivasan Oration was established to honour the memory of the founding President and his contributions to the College.

1983
- 20 May: The College hosted the Tenth WONCA World Conference on Family Medicine in Singapore.

1985
- 9 December: 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
- 13 February: 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 (COFM) 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.
- 15 August: 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.
- 19 October: The Postgraduate Medical Library, which was jointly set up with the Academy of Medicine, was officially opened.

1988
- 12 November: The First Annual Scientific Conference and Meditech Exhibition was organised by the College.
- 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 (COFM).

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
- 26 November: A memorandum proposing an advanced training programme for Family Medicine was submitted to the Singapore Medical Council and the School of Postgraduate Medical Studies.
- The 15th and final MCGP examination and conferment was held.

1993
- The College was appointed by SMC to administer the Singapore Medical Council-Continuing Medical Education (SMC-CME) Programme.
- 12 July: The first Master of Medicine (Family Medicine) [MMed(FM)] examination was held.
- 17 November: 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 Master of Medicine (Family Medicine) [MMed(FM)] was inaugurated.

1998
- The First Batch of College Fellowship by Assessment was started. There were eight participants. All completed the programme in 2000.
- A postgraduate FM training centre was officially opened — The Graduate Family Medicine Centre which has been 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 Asia-Pacific office of WONCA was sited in the College. The College also won the bid to host the World Congress in 2007.
- 23 June: 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.

2002
- August: The Institute of Family Medicine (IFM) was formed to develop the academic programmes of the College.

2003
- The compulsory Continuing Medical Education (CME) Programme was introduced. The College was represented in the SMC-CME Coordinating Committee and worked closely with SMC to ensure the quality of CME events was acceptable.
- July: The first module for the E-Learning programme was launched.

2005
- Announcement of the Ministry of Health (MOH) Public Consultation Paper on the Proposed Establishment of the Family Physicians (FP) Register.

2006
- May: The Family Medicine Continuing Care (FMCC) department in Singapore General Hospital (SGH), the first family medicine department in a hospital, was formed. The College was involved in this initiative through its representation in the Steering Committee of Family Medicine Continuing Care, Singapore General Hospital.

2007
- 24 – 27 July: The College hosted the 18th WONCA World Conference on Genomics and Family Medicine at Suntec Singapore. The Guest-of-Honour was Mr Khaw Boon Wan, the Minister for Health.
- 4 November: College Convocation and Dinner. Ms Yong Ying-I., Permanent Secretary, Ministry of Health, was Guest-of-Honour.

2008
- 23 November: College Convocation & Dinner. Guest of Honour was Mr Khaw Boon Wan, Minister for Health.
- 23 November: Dr Lee Suan Yew received the Albert & Mary Lim Award at the College Convocation & Dinner.

2009
- 28 November: College Convocation & Dinner.
- 5 – 6 December: Inaugural Asia Pacific Primary Care Research Conference (APPCRC) was held in Melaka.

2010
- 19 May – 23 May: 19th World Conference held in Cancun, Mexico.
- July: The College Digest, a quarterly electronic newsletter, was launched.
- 28 November: College Convocation & Dinner. Guest-of-Honour was Prof Satku, Director of Medical Services, Ministry of Health.
- 6 October: A memorandum on the reciprocal recognition of the FRACGP and the FCFP(S) was signed at Cairns Convention Centre between The Royal Australian College of General Practitioners (RACGP) and the College. This signing ceremony celebrated the decision of reciprocal recognition of the fellowships of the two Colleges and led to the award of the FRACGP by Fellowship ad eundum gradum to those with FCFP(S) who wish to apply and are working in Australia.
- 28 November: Special invited guests to the Convocation & Dinner were Prof Claire Jackson (President, RACGP), Dr Jennifer Kendrick (Censor-in-Chief, RACGP), Prof Jan Radford (Immediate Past Censor-in-Chief RACGP). They witnessed the adoption of the Memorandum on reciprocal recognition of the FRACGP and the FCFP(S) between the RACGP and CFPS
- 28 November: A/Prof Cheong Pak Yean and Dr Cheng Heng Lee received the Albert & Mary Lim Awards at the College Convocation & Dinner.
- 4 - 5 December: The College hosted the 2nd Asia Pacific Primary Care Research Conference (APPCRC) at Gallery Hotel, Singapore. It was well attended with 116 paid delegates from Australia, Bangladesh, Hong Kong, India, Japan, Malaysia, Myanmar, Singapore and Thailand.

2011
- 3 – 4 December: The 3rd Asia Pacific Primary Care Research Conference (APPCRC) was held in Kuala Lumpur.
- 27 November: Fortieth Anniversary Dinner of the College. Guest-of-Honour was the Minister for Health, Mr Gan Kim Yong.
- 27 November: Dr James Chang Ming Yu received the Albert & Mary Lim Award.

2012
- 18 November: The Guest-of-Honour for the College Convocation & Dinner was the Minister for Health, Mr Gan Kim Yong.
- 18 November: A/Prof Goh Lee Gan received the Albert & Mary Lim Award.
- 1 – 2 December: The College hosted the 4th Asia Pacific Primary Care Research Conference (APPCRC) at the Centre for Translational Medicine (Block MD6) in Yong Loo Lin School of Medicine, National University of Singapore (NUS), with participants coming from 16 countries, representing 42 organisations. The pre-conference, Research Championship workshop, was held on 30 November.

College Councils – Present and Past (1971 – 2013)

23rd Council (2011 – 2013)

President	A/Prof Lee Kheng Hock
Vice President	Dr Tan See Leng
Censor-in-Chief	A/Prof Tan Boon Yeow
Honorary Secretary	Dr Pang Sze Kang Jonathan
Honorary Treasurer	Dr Tan Tze Lee
Assistant Honorary Secretary	Dr Leong Choon Kit
Assistant Honorary Treasurer	Dr Rukshini Puvanendran
Honorary Editor	Dr Tan Ngiap Chuan
Council Member	Dr Ang Choon Kiat Alvin
Council Member	Dr Chng Shih Kiat
Council Member	Dr Eu Tieng Juoh Wilson
Council Member	A/Prof Koh Choon Huat Gerald
Council Member	Dr Lim Fong Seng
Council Member	Dr Siew Chee Weng
Council Member	Dr Tham Tat Yean
Council Member	Dr Yee Jenn Jet Michael

22nd Council (2009 – 2011)

President	A/Prof Goh Lee Gan
Vice President	A/Prof Lee Kheng Hock
Censor-in-Chief	A/Prof Tan Boon Yeow
Honorary Secretary	Dr Pang Sze Kang Jonathan
Honorary Treasurer	Dr Lim Fong Seng
Honorary Editor	Dr Tan Tze Lee
Council Member	Dr Chow Mun Hong
Council Member	Dr Eu Tieng Juoh Wilson
Council Member	Dr Goh Choon Kee Shirley
Council Member	Dr Leong Choon Kit
Council Member	Dr Rukshini Puvanendran
Council Member	Dr Tham Tat Yean
Council Member	Dr Wong Tack Keong Michael

21st Council (2007 – 2009)

President	A/Prof Goh Lee Gan
Vice President	A/Prof Cheong Pak Yean
Censor-in-Chief	Dr Lee Kheng Hock
Honorary Secretary	Dr Cheng Heng Lee
Honorary Treasurer	Dr Lim Fong Seng
Honorary Editor	Dr Ng Chee Lian Lawrence
Council Member	Dr Chow Mun Hong
Council Member	Dr Ee Guan Liang Adrian
Council Member	Dr Eu Tieng Juoh Wilson
Council Member	Dr Lew Yii Jen
Council Member	Dr Pang Sze Kang Jonathan
Council Member	Dr Rukshini Puvanendran
Council Member	Dr Wong Tack Keong Michael

20th Council (2005 – 2007)

President	A/Prof Goh Lee Gan
Vice President	A/Prof Cheong Pak Yean
Censor-in-Chief	Dr Lee Kheng Hock
Honorary Secretary	Dr Cheng Heng Lee
Honorary Treasurer	Dr Tan Chin Lock Arthur
Honorary Editor	Dr Ng Joo Ming Matthew
Council Member	Dr Ong Chooi Peng
Council Member	Dr Tham Tat Yean
Council Member	Dr Lim Fong Seng
Council Member	Dr Ho Han Kwee
Council Member	Dr Pang Sze Kang Jonathan
Council Member	Dr Tan See Leng
Council Member	Dr Yii Hee Seng

19th Council (2003 – 2005)

President	A/Prof Cheong Pak Yean
Vice President	Dr Tan Chin Lock Arthur
Censor-in-Chief	A/Prof Goh Lee Gan
Honorary Secretary	Dr Lee Kheng Hock
Honorary Treasurer	Dr Yii Hee Seng
Honorary Editor	Dr Ng Joo Ming Matthew
Council Member	Dr Cheng Heng Lee
Council Member	Dr Goh Jin Hian
Council Member	Dr Lim Fong Seng
Council Member	Dr Wong Weng Hong
Council Member	Dr Pang Sze Kang Jonathan
Council Member	Dr Tan See Leng
Council Member	Dr Tan Yew Seng

18th Council (2001 – 2003)

President	A/Prof Cheong Pak Yean
Vice President	Dr Tan Chin Lock Arthur
Censor-in-Chief	Dr Lau Hong Choon
Honorary Secretary	Dr Lee Kheng Hock
Honorary Treasurer	Dr Tan See Leng
Honorary Editor	Dr Ng Joo Ming Matthew
Council Member	A/Prof Goh Lee Gan
Council Member	A/Prof Lim Lean Huat
Council Member	Dr Kwan Yew Seng
Council Member	Dr Ng Mong Hoo Richard
Council Member	Dr Tan Chee Beng
Council Member	Dr Tay Ee Guan
Council Member	Dr Yii Hee Seng

17th Council (1999 – 2001)

President	A/Prof Lim Lean Huat
Vice President	Dr Tan Chin Lock Arthur
Censor-in-Chief	Dr Lau Hong Choon
Honorary Secretary	Dr Lee Kheng Hock
Honorary Treasurer	Dr Ng Mong Hoo Richard
Honorary Editor	Dr Tan Chee Beng
Council Member	Dr Loh Wee Tiong Alfred
Council Member	A/Prof Goh Lee Gan
Council Member	Dr Lim Hock Kuang David
Council Member	Dr Tan See Leng
Council Member	Dr Kwan Yew Seng
Council Member	Dr Ng Chee Lian Lawrence
Council Member	Dr Ng Joo Ming Matthew

16th Council (1997 – 1999)

President	Dr Loh Wee Tiong Alfred
Vice President	Dr Lim Lean Huat
Censor-in-Chief	A/Prof Goh Lee Gan
Honorary Secretary	Dr Yii Hee Seng (till May 1997)
Honorary Secretary	Dr Ng Mong Hoo Richard (from Jul 1997)
Honorary Treasurer	Dr Tan Chin Lock Arthur
Honorary Editor	Dr Lau Hong Choon
Council Member	Dr Soh Cheow Beng
Council Member	Dr Lim Hock Kuang David
Council Member	Dr Lee Kheng Hock
Council Member	Dr Tan Chee Beng
Council Member	Dr Tan See Leng
Council Member	Dr Kwan Yew Seng (co-opted Feb 1998)

15th Council (1995 – 1997)

President	Dr Loh Wee Tiong Alfred
Vice President	Dr Lim Lean Huat
Censor-in-Chief	A/Prof Goh Lee Gan
Honorary Secretary	Dr Tan Chin Lock Arthur
Honorary Treasurer	Dr Ng Mong Hoo Richard
Honorary Editor	Dr Hong Ching Ye
Council Member	Dr Bina Kurup
Council Member	Dr Lau Hong Choon
Council Member	Dr Lee Kheng Hock
Council Member	Dr Lim Hock Kuang David
Council Member	Dr Soh Cheow Beng
Council Member	Dr Wong Song Ung
Council Member	Dr Yii Hee Seng

14th Council (1993 – 1995)

President	Dr Loh Wee Tiong Alfred
Vice President	Dr Lim Lean Huat
Censor-in-Chief	A/Prof Goh Lee Gan
Honorary Secretary	Dr Soh Cheow Beng
Honorary Treasurer	Dr Tan Chin Lock Arthur
Honorary Editor	Dr Moti H. Vaswani
Council Member	Dr Bina Kurup
Council Member	Dr Lee Kheng Hock
Council Member	Dr Lim Hock Kuang David
Council Member	Dr Deirdre Murugasu
Council Member	Dr Ng Mong Hoo Richard
Council Member	Dr Wong Song Ung
Council Member	Dr Yeo Khee Hong

13th Council (1991 – 1993)

President	Dr Koh Eng Kheng (resigned Oct 1991)
President	Dr Loh Wee Tiong Alfred (from Jul 1992)
Vice President	Dr Loh Wee Tiong Alfred
Vice President	Dr Lim Lean Huat (from Aug 1992)
Censor-in-Chief	Dr Goh Lee Gan
Honorary Secretary	Dr Tan Chin Lock Arthur
Honorary Treasurer	Dr Soh Cheow Beng
Honorary Editor	Dr Moti H. Vaswani
Council Member	Dr Choo Kay Wee
Council Member	Dr Huan Meng Wah
Council Member	Dr Lim Lean Huat
Council Member	Dr Ng Mong Hoo Richard
Council Member	Dr Wong Song Ung

12th Council (1989 – 1991)

President	Dr Koh Eng Kheng
Vice President	Dr Loh Wee Tiong Alfred
Censor-in-Chief	Dr Lim Kim Leong
Honorary Secretary	Dr Soh Cheow Beng
Honorary Treasurer	Dr Lim Lean Huat
Honorary Editor	Dr Goh Lee Gan
Council Member	Dr Chan Cheow Ju
Council Member	Dr Huan Meng Wah
Council Member	Dr Lim Khai Liang John
Council Member	Dr Ng Mong Hoo Richard
Council Member	Dr Tan Chin Lock Arthur

11th Council (1987 – 1989)

President	Dr Lee Suan Yew
Vice President	Dr Koh Eng Kheng
Censor-in-Chief	Dr Lim Kim Leong
Honorary Secretary	Dr Soh Cheow Beng
Honorary Treasurer	Dr Loh Wee Tiong Alfred
Honorary Editor	Dr Goh Lee Gan
Council Member	Dr Chan Cheow Ju
Council Member	Dr Chan Swee Mong Paul
Council Member	Dr Cheong Pak Yean
Council Member	Dr Yeo Peng Hock Henry
Council Member	Dr Yeo Siam Yam (resigned Jun 1988)
Council Member	Dr Leong Vie Chung (co-opted Jul 1988)

10th Council (1985 – 1987)

President	Dr Victor L. Fernandez (till Oct 1985)
President	Dr Lee Suan Yew (from Dec 1985)
Vice President	Dr Loh Wee Tiong Alfred
Censor-in-Chief	Dr Lee Suan Yew (till Nov 1985)
Censor-in-Chief	Dr Lim Kim Leong (from Dec 1985)
Honorary Secretary	Dr Goh Lee Gan
Honorary Treasurer	Dr Chan Swee Mong Paul
Honorary Editor	Dr Moti H. Vaswani
Council Member	Dr Sivakami Devi (till Feb 1987)
Council Member	Dr Omar bin Saleh Talib
Council Member	Dr Soh Cheow Beng
Council Member	Dr Tan Kok Yong (till Dec 1986)
Council Member	Dr Yeo Peng Hock Henry
Council Member	Dr Koh Eng Kheng (from Feb 1987)
Council Member	Dr Cheong Pak Yean (from Feb 1987)

9th Council (1983 – 1985)

President	Dr Wong Heck Sing
Vice President	Dr Victor L. Fernandez
Censor-in-Chief	Dr Chang Ming Yu James
Honorary Secretary	Dr Loh Wee Tiong Alfred
Honorary Treasurer	Dr Lim Kim Leong
Honorary Editor	Dr Leong Vie Chung

Council Member	Dr Chan Swee Mong Paul
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Primary Care Research: Facilitation & Translation

Dr Tan Ngiap Chuan, A/Prof Goh Lee Gan

ABSTRACT

Primary care research in Singapore has expanded since its mention in a blueprint a decade ago. More conducive infrastructure and ample research training programmes are now available to facilitate primary care research. The resultant numbers of publications have increased consequent to the seeds sowed in the last decade. We need to continue to facilitate the growth of the research firepower and infrastructure. Defining the primary care research agenda, building capacity, publishing research findings are necessary facilitation activities. Into the future, forming a research committee, running research workshops, organising and running a basic biostatical course, organising research conferences, building infrastructure support, and creating further training opportunities will continue to facilitate primary care research.

Translating the research findings into clinical practices have benefitted patients and enrich Family Medicine as an evolving but critically important medical discipline. Such translation of research ensures evidence-based primary healthcare is delivered to all in the Singapore community. This involves building the research spirit, promoting research in the local setting, translating research on practice and knowledge to action, embarking on research big or small, and publishing research findings.

Keywords: research, primary care physician, primary care

PRIMARY CARE RESEARCH DIRECTIONS AND BLUEPRINT

Exactly a decade ago, an original article entitled 'Research Directions" was published in the special edition of the Singapore Family Physician[1] to commemorate the 30th Anniversary of the College of Family Physicians Singapore (CFPS). The message in that article focused on finding answers to day-to-day problems. It was also observed that health systems research is another fertile area of research.

Next, "Primary care research - a blueprint for action for Singapore" reached out to a wider audience after its subsequent publication in the Asia Pacific Journal of Public Health[2]. The blueprint reviewed the barriers towards executing primary care research in local setting and reiterated the recommended initiatives and measures to overcome the hurdles.

Essentially the blueprint to overcome the hurdles of primary care research was a three pronged effort of training, regular meetings, and research infrastructure development.

Training. Training in familiarity with research vocabulary, concepts and the methodologies to answer a research question is an essential first step,

Regular meetings. Regular meetings aim to create familiarity to research information and gradually a mindset change of willingness to participate in research projects.

Collaboration. Collaborations among doctors, nurses, and specialist colleagues are important to bridge the gaps of research know-how, time availability, and resource availability. The establishment of primary care practice-based research networks (PBRNs) in Europe, and the United States further spearheaded development in primary care research in the last decade.

DEVELOPMENTS IN PRIMARY CARE RESEARCH IN THE LAST DECADE

There has been a steady increase of primary care research publications from Singapore in indexed medical journals in the last decade to some 70 papers in the Pubmed database, compared to a sprinkling of less than 10 in the decade earlier. Many of the papers are joint efforts of family physicians with doctors in other clinical disciplines and public health.

Apart from the interest in collaborative publications on care in the primary care setting, several activities in the Asia Pacific Region have also helped to develop the interest in primary care research in the last decade. These are discussed below.

RENAP. The RENAP (Research Network in Asia Pacific) Workshop held in Phuket in 2004 from July 10-12 set the tone for primary care research starting in the last decade. The objectives of that workshop in 2004 were: (1) to develop family medicine research capacity in the Asia Pacific region, (2) to provide delegates with hands-on approach to develop a research project, and (3) to encourage cross border collaboration. Since then various research meetings have been held to further drive the objectives of the Phuket workshop.

Primary care research buzz of prizes and research learning tracks. A second development occurred in the research meeting hosted by our Malaysian Colleges in 2008. They had been a strong force in moving the research enterprise forward. It was felt that the future of family medicine research lay in the ability to create a buzz for primary care research that will be self-sustaining. The conclusion in that brainstorm meeting was to try out the "Formula 1 Races" idea of good research prizes, and good hands-on research training opportunities -- just like in the Formula 1 Races. This culminated in the 1st Asia Pacific Primary Care Research Conference (APPCRC), hosted by our Malaysian primary care physicians, which was held successfully from 5-6 December 2009 in Melaka, Malaysia.

There were 136 participants from 5 countries: Taiwan, Singapore, Myanmar, Hong Kong, and Malaysia. WONCA Asia Pacific region sponsored 6 participants with a total cost of RM3000. In the Melaka Conference, there were research

presentations for the top 3 prizes in the oral presentations of USD1000 for the top award called the Rajakumar Award, and other two awards of USD500 each. There were also three best poster awards of USD500 each. The research training tracks included research methodology, biostatistics, qualitative research, and medical writing.

The 2010 Asia Pacific Primary Care Research Conference[3] held in Singapore maintained the headstart created by the Melaka Conference of 2009. In this conference there were the Rajakumar Award, two oral presentation awards, as well as three poster awards. There were again the teaching research tracks: qualitative research using the Delphi Study; family medicine research protocol from idea to execution; and designing and understanding impactful primary care studies.

Research championship through coaching. A third development was the research championship in a training track co-ordinated by Dr Tan Ngiap Chuan. Essentially teams of novice researchers submit their research ideas and proposals and are appraised by a panel of reviewers prior to the conference. Four teams are eventually selected for final presentations at the Research Championship[4], during which each is assigned a dedicated coach to mentor the team. The end in mind is a product comprising of a good study design incorporating appropriate methodology. Such an end-product is the ideal outcome of any aspiring primary care physicians planning to embark on research and a pre-requisite for any robust research project.

Apart from a panel of distinguished jurors who pose questions to the team members, what is unique is the audience's participation in the selection of the champion via real-time voting using a clicker system. The scores are computed almost instantaneously, putting the presenters on edge and creating unprecedented excitement in the finale of a medical conference.

Defining the primary care research agenda. There is a need for a working primary care research agenda. There are many ways we can define the primary care research agenda. One useful way is to group the primary care research agenda as what the European General Practice Research Network (EGPRN) has done into four core areas:

a. Clinical research (with outcomes at the patient level, and measuring patients' health issues including function or quality of life);
b. Health services research (focusing on doctor or system related questions and outcomes);
c. Research on education and teaching in general practice; and
d. Research on what is adequate research methodology.

Building capacity. Building research capacity is an important primary care research development strategy. Attention to this will ensure the research manpower pipeline is kept flowing. In this context various activities have been proposed as objectives for the WONCA triennium, 2010 to 2013. These were:

1. Create self-sustaining webpage – AP Region webpage as information and archival site for activities, proceedings, papers, storehouse of research tools, blogs of collaborative research developments, information, notices and announcements of research activities;
2. Develop information points for FM research activities in the Region – research training meetings, and national meetings;
3. Create forum for ReNAP projects to happen – identify champions, project leaders, project details – look for external funds e.g. Asian Development Bank, WHO, or National funding;
4. Develop a training and development forum for researchers – Workshops, Seminars -- Working Party initiated, member country initiated. These activities should synergise activities and avoid duplication;
5. (Manage and grow AP Research manpower development funds – Use of AP Region subsidy funds in assisting research delegates to meetings, and workshops; and
6. Utilise research meetings to attract participation of non-member country organisations – with the hope of encouraging them to join WONCA

Secondary multiplier effects. There is also the enthusiasm that the research conferences would generate secondary multiplier effects through the participants going home to their respective countries and generating interest and outcomes for better care through relevant primary care research.

The Asia Pacific Family Medicine Journal. The Asia Pacific Family Medicine Journal has been offered as a platform for Asia Pacific Primary Care Research. The objective is to create more avenues for primary care physicians to publish their research findings and to share them beyond their country.

The research awards for the 2011 Asia Pacific Primary Care Research Conference. The idea of good research awards is important. Thus in the forthcoming research conference there will be several awards to be given out:

- Best Poster Awards – Three awards
- Rajakumar Award – The Best Oral Presentation
- Wong Heck Sing Award – The Best Oral Presentation from Students and Trainees
- Research Championship 2011 – The Awards on Research Question and Study Design

There were thus several factors that promoted development of primary care research in this part of the world. Most of all, the application of the Formula 1 Races idea to develop Family Medicine Research appears to be working as a social experiment to promote Primary Care Research. We are succeeding where hitherto we have not.

TAKING PRIMARY RESEARCH FURTHER INTO THE NEXT DECADE

Two key strategies in taking primary care research firmly into the next decade are facilitation and translation.

(1) FACILITATION

Several initiatives described above have materialised over the last decade and primary care research is poised to reach another milestone in 2011, namely, research collaboration.

Research@CFPS, A research committee, Research@CFPS, has been established this year to spearhead research initiatives and cement research collaborations between CFPS, primary care physicians in private, public and academic institutions.

Comprising of primary care physicians with research experience, the committee is also tasked to guide Fellowship trainees at CFPS in their research endeavours, which is now a mandatory component of their curriculum.

Research workshops. Other avenues are opened to equip family physicians to take on research. Qualitative research workshops are organised by Singhealth Polyclinics, a cluster of local public primary care centres, to train participants in qualitative research methodology. Qualitative research facilitates the discovery of subjects' subjective feelings, perceptions, emotions, values and behaviour. It thus has wide applications in Family Medicine which emphasises on patient-centred care and advocates the delivery of holistic care to all subjects. The workshop participants will have direct hands-on experience as the curriculum requires them to carry out a qualitative research project, which will be supervised closely by the trainers. The workshop is open to other primary care professionals beyond the organisation. With rising demand, its frequency is increased from once to twice annually.

Basic biostatiscal course. Research@CFPS has also drawn up a plan to organise basic biostatistical course in collaboration with the Saw Swee Hock School of Public Health in the National University of Singapore (NUS) in 2012. A calendar listing of research training programmes in various public and academic institutions is in the pipeline. The calendar alerts the primary care physicians to the various training events, so as to familiarise themselves with various aspects of the research. As such an electronic calendar will be accessible at the CFPS website.

Research conference series. The Asia Pacific Primary Care Research Conference (APPCRC)[3] aims to be a key event in the Asia-Pacific primary care research calendar. Research training modules catering to primary care professionals are the core activities in this conference series with invited established primary care researchers to deliver the plenary lectures. The APPCRC Research Championship[4] aims to be an evergreen highlight of this series of research conferences. Indeed it is aimed to make this the signature of this series of research conferences, just like the Formula-1 races. Pioneered at the 2nd APPCRC in Singapore in December 2010, this novel way to coach novice researchers is based on the "Preparation-Intensive Coaching-Competition" (PICC) model. The details are described earlier in this paper under "Research championship through coaching".

Infrastructure support. At the individual level, primary care physicians who have ventured into the research arena are supported at every stage of the research cycle, from definition and refinement of research question, ethical review, study execution, data analysis and publication. Their queries and doubts can be sorted out and clarified at the monthly Research Consultation Clinics (RCC) at SingHealth Polyclinics (SHP), which cater to staff, other primary care professionals and even medical students from the two medical schools in Singapore. RCC is also available monthly at the SingHealth Academy and Singapore Clinical Research Institute (SCRI).

Master's degree. Further up the scale, primary care physicians with strong interests and a penchant for research can enrol into a specially tailored Master degree in clinical research that was inaugurated in NUS in 2008. Two family physicians were amongst the seven pioneer doctors in the Master in Clinical Investigation (MCI) programme. Now four family physicians have MCI added to their accolades, to empower them to lead more physicians, nurses and allied healthcare professionals to carry out primary care research.

(2) TRANSLATION

Research spirit. With the infrastructure and training facilities now more or less in place, primary care research will escalate if the primary care physicians are willing to imbibe the research spirit, which can be distilled at different strengths. The minimum effort is to appreciate the relevance of research to their clinical practice as medical science evolves rapidly every day, with new knowledge added on to the medical wagon, from microscopic discoveries to health system change, from drugs to medical devices to new approaches in disease management. This new knowledge are inevitably the outcomes of research and ideally the primary care physicians should be an integral part of this information vehicle, being the front-line people in healthcare to find solutions to health care challenges.

Research in the local setting. Similarly the patients' and the public's expectations of their health and medical care by their physicians are also evolving with the phenomenal impact of information technology in this rapidly changing world. Information on any aspect of healthcare, including even costs of treatment, is readily available at the flicker of the fingers at any locality and any time of the day. The gap of knowledge between the patient or public and the primary care physician has significantly narrowed. What is going to allow the primary care physicians to stay ahead of the patient or public is research grounded in the local setting. Foreign import of information in this era of information-driven society can, however, be complementary. Primary care research in local community enables the physicians to bond socially and culturally to their patients and to improve the efficiency of their clinical practice based on the latest local medical evidences.

Translating research to practice. To reap the benefits of research, primary care physicians must translate the research findings into their clinical practice. For example, written asthma action plan (WAAP) is evidence-based self-management tool[5] to empower adult patients to recognise their deteriorating asthma status, self-adjust their inhaled medications so as to abort early impending asthma exacerbation. Such measure is recommended in major international asthma clinical practice guidelines (CPG) and was introduced in Singapore via the Ministry of Health asthma CPG[6] in 2008 with a locally designed WAAP template. However implementation remains an issue. A local study[7] supported by the Singapore Asthma Association was carried out to understand the complex issues involved in the implementation of WAAP. Being a cluster of public primary care centres, measures are introduced in the clinical information system of SHP, to facilitate the provision of WAAP, based on the research findings. Currently, eight out of ten asthma patients in SHP are equipped with WAAP and the

rates of asthma exacerbation and referral to emergency units in hospitals remain stable despite rising asthma attendances in the past three years.

Embarking on research big or small. Not all research must commence at a large scale. Even a case study or case series may be helpful to primary care physicians. A case study published in Singapore Family Physician[3] highlighted the difficulty faced by primary care physicians in their interaction with their patients with presbycusis, which is expected to increase in an aging population in Singapore. Physician-patient communication is crucial in Family Medicine in order to identify patient's needs and to institute appropriate treatment as part of patient-centred care. As a result, pocket hearing aids were introduced in a public primary care centre to facilitate communication between the primary care physicians and adult-onset hearing impaired patients (without personal hearing aid) during their consultation. In this case, a simple case study allows the primary care investigators to re-look into the medical literature and identify solutions to problems encountered in their clinical practice. After all, as the word reflects, "research" means to carry out a systematic search and investigation.

This illustrates the clinical importance and relevance of research to primary care physicians, even by simple observation of their patients' needs. It does not take much more effort to collect data of more patients with similarly defined characteristics to form a case series. This will lead them to the next level in the ladder of clinical evidences. Astonishing discoveries often start from careful and systematic observations and ample examples include discovery of smallpox to HIV as well as the more recently identified SARS in 2003.

Publishing research findings. In the past ten years, publications from local primary care physicians have grown in both numbers and in the genre of medical journals. Recent publications include medical journals of higher impact factor, which reflect on the quality of primary care research that were carried out.

To enhance the value proposition of research to primary care physicians and to disseminate research findings pertinent to the local primary care community, the college journal, The Singapore Family Physician, will take steps to enhance its original article review process. From 2012, the editorial team will finally index the journal in the Western Pacific Region Index Medicus (WPRIM)[8] which is supported by the World Health Organisation (WHO). This will allow the articles' abstracts to reach out to a wider audience and to direct them to its full-text articles, which are available free at the journal website. Ultimately the editorial team aims to reach out to the global communities through its publications.

CONCLUSIONS

Primary care research in Singapore has expanded since its inception in a blueprint a decade ago. More conducive infrastructure and ample research training programmes are now available to facilitate primary care research. The resultant numbers of publications have increased consequent to the seeds sowed during the last decade. We need to continue to facilitate the growth of the research firepower and infrastructure.

Translating the research findings into clinical practices have benefitted the patients and enrich Family Medicine as an evolving but critically important medical discipline. Translation of research ensures evidence-based primary healthcare is delivered to all in the Singapore community.

DR TAN NGIAP CHUAN
Honorary Editor, Singapore Family Physician

A/PROF GOH LEE GAN
Professorial Fellow, Division of Family Medicine,
University Medicine Cluster,
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Director, Institute of Family Medicine (IFM),
College of Family Physicians Singapore

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Pictures from the Past by Decades

The pictures in these pages are taken from the College collection of photographs, newsletters, and clippings which was initiated a decade ago by Dr Lee Kheng Hock and Dr Lawrence Ng. Some of these pictures were published in the 30th Anniversary Commemorative Issue in 2001. In this 40th Anniversary, pictures from the the 1990s and 2000s are added.

In the beginning...

IGAPORE 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. 3 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

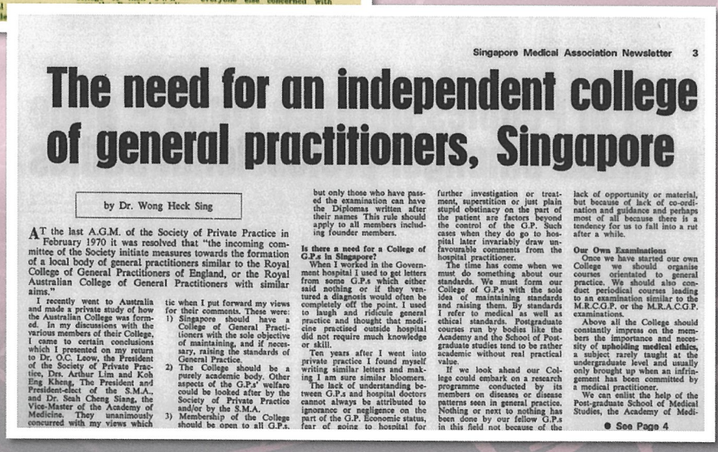
These colleges and academies of general practice have raised the status and academic standing of family doctors, the tendency for students to avoid general practice has been reversed, education (undergraduate, special-vocational and continuing) has been helped, research into all aspects of general practice has been encouraged, and, most important of all, standards of clinical and social medicine outside hospitals, and the equipment of premises needed for these have been improved.

There are several which such an acade

headquarters in London we already have 27 faculties in the United Kingdom and Ireland, four in New Zealand, one in Kenya, one in Uganda, and one (our latest) in Malta. In our early days we had four faculties also in Australia; after a while they formed a daughter college of their own —

or privately, to join as an associate. Membership and Fellowship should be achieved by those who prove themselves eligible for these more senior grades. Such an organisation should help your University, your Academy of Medicine, your teaching hospitals and everyone else concerned with

An 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.



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 Practice 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 Practioners 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 Practice, Drs. Arthur Lim and Koh Eng Kheng, The President and President-elect of the S.M.A., and Dr. Seah Cheng Siang, the Vice-Master of the Academy of Medicine. They unanimously concurred with my views which

tic 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 could 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 bloomers.

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 idea 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 orientated to 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

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 manisfesto for the formation of the College of General Practitioners, Singapore.

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 Collin 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 supporters of the College.

IN THE 1980s...

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

Telephone : 7724299/7724290/7795555
Telegrams : UNIVSPORE
Telex : UNISPO RS33943

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

Our Ref:

Your Ref:

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.

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 hlep us set up our first examinations. Prof Fabb was also the first HMDP expert in Family Medicine in 1988.

IN THE 1990s...

One important milestone in the 1990s was the development of formal vocational training Programme in Family Medicine. The Diplomate Programme of the College (MCGPS) provided the foundation for a MMed Family Medicine Programme. The last batch of the MCGPS graduated in 1992.

Graduands of 15th MCGPS in 1992.

The MMed Family Medicine Programme was approved by the Senate of the National University of Singapore in 1991 and the first Examination was conducted in 1993. In 1995 a Private Practitioner Stream was started with a programme of 40 tutorials a year for two years, and a clinical refresher course of one week duration.

A Graduate Medical Centre was set up on the floor above Dr Cheong Pak Yean's Clinic. The Centre was the training centre for several years for the Private Practitioner Stream, The course participants sat for the same MMed FM Examination. The Graduate Medical Centre also became the training ground for the first College Fellowship Programme in 1998.

The Graduate Centre was "officially" opened in 1998 and Prof John Murtagh and Prof Lewis Ritchie were the Guests of Honour. They were Visiting Lecturers in MMed FM Advance Course being conducted at that time.

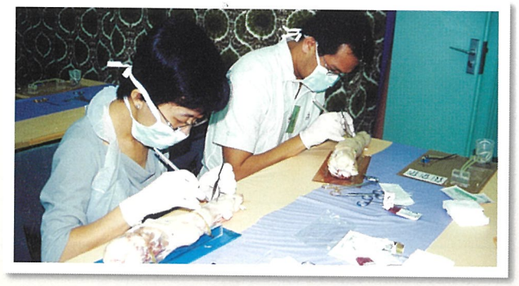
Opening of the Graduate Medical Centre with Dr Cheong Pak Yean giving his address.

Group photograph at the official opening of the Graduate Medical Centre. The First Batch of Fellows in training were in the backrow.

IN THE 2000s...

The 2000s marked a period of consolidation of Family Medicine training and development. The first batch of the Fellowship of the College of Family Physicians (FCFPS) by Assessment which started in 1998 had their Exit Examination in 2000. There were 8 graduands. Another educational activity was the minor surgical procedures course conducted by our surgical colleagues. Pig trotters had another use as material for learning stitching skills.

Inaugural FCFP Exit Interview 2000.



Minor Surgical Procedures Course 2001, 17-18 Feb – Stitching pig trotters.

In the second of 2000s family medicine research began to be a focal point of interest as the spinoff of a WONCA research Conference in Canada in 2003. This led to the Asia Pacific Research Workshop in Phuket in 2005, and eventually to the Inaugural Asia Pacific Primary Care Research Conference (APPCRC) in Malacca in 2009 and the Second Asia Pacific Primary Care Research Conference (APPCRC) in Singapore in 2010. Prof John Rush from the Primary Care Research Network (PCRN) Singapore and Prof Jan Radford, Censor-in-Chief from the Royal College of General Practitioners of Australia were speakers at the Conference in Singapore. The Research Conferences aimed at teaching and coaching participants in research skills. There were also good prizes for best research efforts.

Group photograph of 2nd APPCRC Participants on 5 Dec 2010.

Speakers of the 2nd APPCRC Participants on 2010 5 Dec. Prof John Rush and Prof Jan Radford.

Research Awards given at the Research Conference.

Pages from WONCA World Conference Held in Singapore

TENTH
WONCA WORLD CONFERENCE
ON FAMILY MEDICINE
SINGAPORE
20th — 24th May, 1983

Daily Bulletin

NO. 1 FRIDAY, 20 MAY 1983 M C (P) NO. 112/5/83

Selamat Datang

THE COLLEGE OF GENERAL PRACTITIONERS, SINGAPORE & THE HOST ORGANISING COMMITTEE EXTEND THEIR WARMEST WELCOME TO ALL DELEGATES & ACCOMPANYING PERSONS AND WISH YOU ALL AN ENJOYABLE STAY IN SINGAPORE.

Vanda Miss Joaquim Photographed by Dr. Teoh Eng Soon

Pictures below by courtesy of STPB

TENTH
WONCA WORLD CONFERENCE
ON FAMILY MEDICINE
SINGAPORE
20th — 24th May, 1983

Daily Bulletin

NO. 2 SATURDAY, 21 MAY 1983 M C (P) NO. 112/5/83

PRESIDENT NAIR DECLARES TENTH WONCA WORLD CONFERENCE OPEN

We were greatly honoured to have the President of the Republic of Singapore, Mr C V Devan Nair and the First Lady to grace the occasion of the Opening of the Tenth WONCA World Conference. It was a grand opening at the World Trade Centre attended by 1250 delegates from 35 countries.

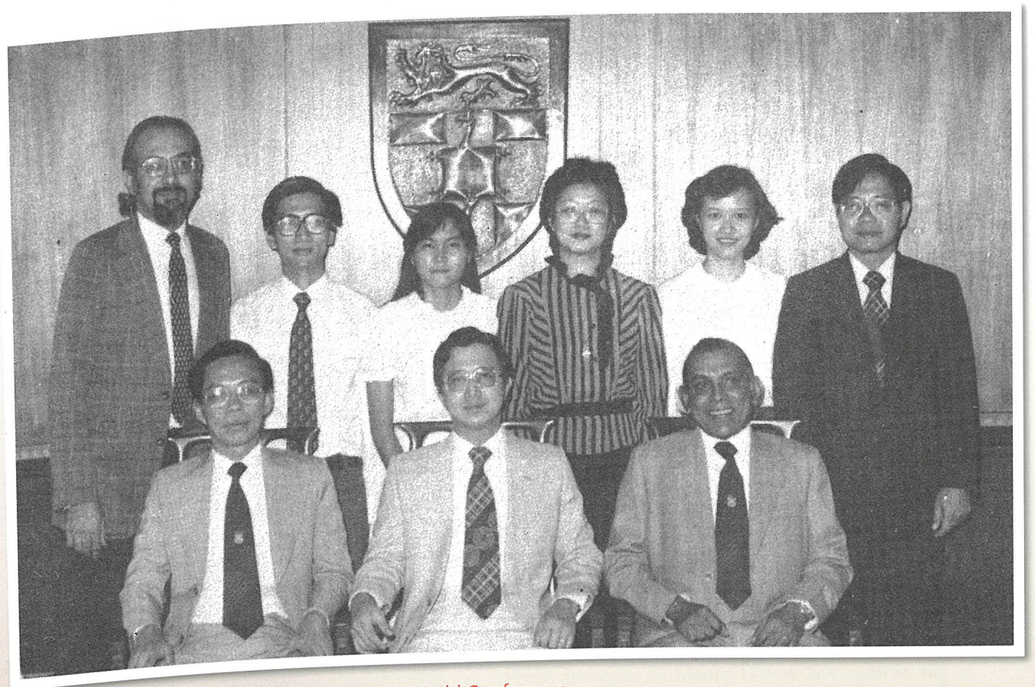
President Nair, in his address outlined the crucial role played by the Family Physician/General Practitioner. The primary task of doctors is to keep people healthy and away from hospital. Whilst the ravages of disease, accidents and ageing cannot be abolished nonetheless the syringe and scalpel should be rendered needless as far as possible. To achieve this, a holistic approach and continuous upgrading of medical knowledge is needed.

The audience were treated to a curtain-raiser, an audio-visual presentation on the family practitioner in a changing world. This was followed by a buffet reception.

Opening of Tenth WONCA World Conference, Friday, 20 May 1983

WORLD WONCA CONFERENCES

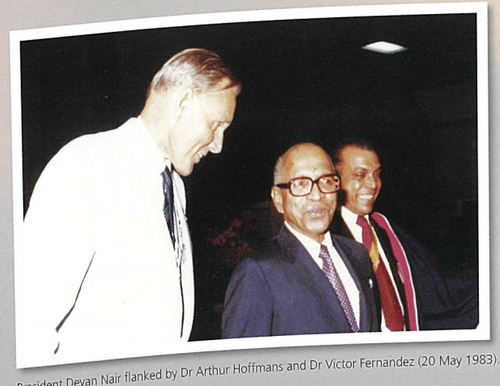
1983 – TENTH WONCA WORLD CONFERENCE ON FAMILY MEDICINE – 20 to 24 May
Singapore hosted the Tenth Wonca World Conference in 1983. It was anchored by a Host Organising Committee of 7 and 3 Secretariat staff.



Host Organising Committee of Tenth WONCA World Conference

Seated from left to right: Dr Lim Kim Leong (Organising Secretary), Dr Alfred Loh (Chairman), Dr Victor Fernandez (Deputy Chairman & Treasurer). Standing from left to right: Dr MotiVaswani (Chairman, Publicity Sub-Committee), Dr Goh Lee Gan (Chairman, Publications Sub-Committee), Miss TeoSiewGek (Administrative Assistant), Miss Janet Ho (Administrative Secretary), Miss Theresa Loh (Administrative Assistant), Dr Paul Chan (Chairman, Exhibitions Sub-Committee. Not in picture: Dr Fredrick Samuel (Chairman, Scientific Sub-Committee).

The Opening Ceremony was held in World Trade Centre. Wonca then had 31 Member countries compared to 119 member orgnaisations from 93 countries. The attendance of 1000 in 1983 including some 250 accompanying persons. The 2007 conference had more than 2000 delegates. The Conference was opened by the then President Devan Nair. Picture left shows President Nair with the then Wonca President Dr Arthur Hoffmans, and the President of the College Dr Victor Fernandez.



President Devan Nair flanked by Dr Arthur Hoffmans and Dr Victor Fernandez (20 May 1983).

Audience at the Opening Ceremony.

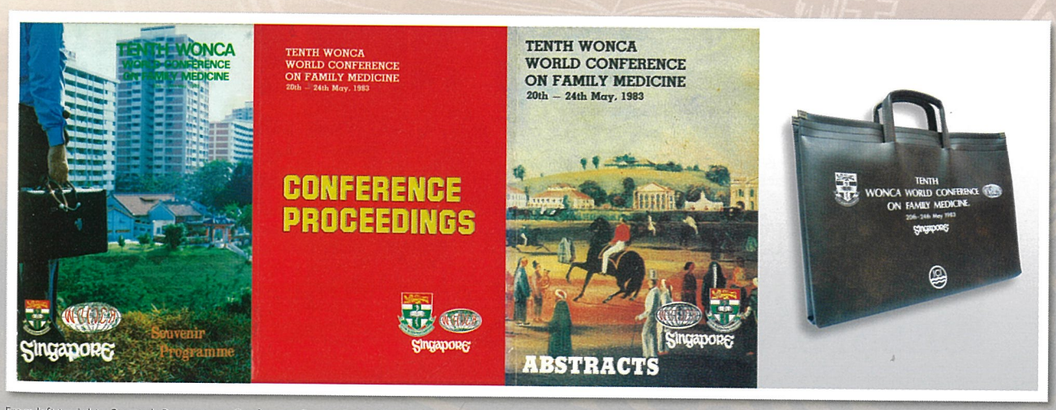
1983 WONCA WORLD CONFERENCE

The Conference had five segments: Keynote address, Plenary sessions, WONCA Open Forums, Free Papers Sessions, and Workshop Seminars. Dr Lee Suan Yew was a Plenary Speaker. His topic was "Challenges of Family Medicine in South East Asia".

Wonca Conference Plenary Speaker: Dr Lee Suan Yew.

A Conference Proceedings was available at the Conference. In it were the full text of the Key Note Address, 13 Plenary Papers, 25 Open Forum Papers from the Wonca Standing Committees, and a selection of 96 Free Standing Papers.One of the features of the Tenth Wonca Conference was a Daily Bulletin. The full sized cover page of the 5 daily bulletins are reproduced in the next and subsequent pages.

International delegates at the Tenth Wonca World Conference on Family Medicine in 1983.



From left to right - Souvenir Programme, Conference Proceedings, Abstracts Book, Conference Satchel.

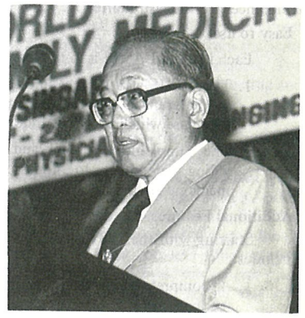
TENTH
WONCA WORLD CONFERENCE
ON FAMILY MEDICINE
SINGAPORE
20th — 24th May, 1983

Daily Bulletin

NO. 3 SUNDAY, 22 MAY 1983 M C (P) NO. 112/5/83

THE SCIENTIFIC SESSIONS BEGIN

The Scientific Programme of the Tenth WONCA World Conference was opened by Professor Wong Hock Boon, Director of the School of Postgraduate Medical Studies, National University of Singapore.



In his address Professor Wong traced the social evolution of the doctor since Ancient Days. "In those bygone days, the GP's dealt with adult medicine, paediatrics, surgery as well as obstetrics. It was therefore, inevitable that he was regarded by his patients almost with utmost awe and respect, because there were no others. Those with the days when the doctor practising in a particular area became not only a healer of physical ills but also an advisor of psychological and emotional problems, and a father confessor to the family. He often interceded on behalf of the families under his care when there were problems which were not specifically physical ones."

"Gradually, specialisation grew and nearly all aspects of what had been dealt with by the so-called GP were taken over by some specialist or other."

"Therefore, the GP of today finds himself in a situation created by forces of social evolution beyond his control. One of the ways of getting out of this dilemma is to raise General Practice to a level which can then be regarded on par with the other specialities. This is not easy to achieve unless General Practice can evolve towards a path whereby the work done can indeed be unable to be carried out by most specialists."

"The GP will have to keep abreast of the latest medical advances. Nowadays, the half-life of so-called 'new' medical knowledge may, in some instances, average only 6 months!"

"GPs working alone are at a disadvantage, and although reading, attending courses and lectures, working on postgraduate educational 'kits' — each has its uses, it is the cut and thrust of the ward round, the actual problems presented by patients and their families in the teaching units with medical undergraduates of various levels, nurses, social workers, etc. such peer review is imperative in medical learning. The GP should avail himself more of such opportunities, and research should be carried out to see how the GP could be part of such an on going apprenticeship scheme."

FROM THE PLENARY SESSION .....

Family Medicine has come of age with the Tenth WONCA World Conference on Family Medicine. From being the Cinderella of Medicine it is now the time for Family Medicine to turn into the Princess. This era, observed Dr. Donald Rice in his Keynote address, is rapidly being referred to as "the period of renaissance in general practice/family medicine".

Continued on Page 3

TENTH
WONCA WORLD CONFERENCE
ON FAMILY MEDICINE
SINGAPORE
20th — 24th May, 1983

Daily Bulletin

NO. 4 MONDAY, 23 MAY 1983 M C (P) NO. 112/5/83

1983 WONCA ASSEMBLY

The WONCA Assembly on Saturday, 21 May 1983 culminated a series of business meetings of the World Gathering.

The series of meetings began with the WONCA Council Meetings on May 18 and 19. The Council was attended by representatives of twenty-three Member Organisations and one Associate Member Organisation.

The following were admitted to Full membership:

* The Society of Teachers of Family Medicine, United States of America
* The Indian Academy of General Practice
* The Indonesian Family Physicians Foundation
* The Korean Academy of Family Medicine

Left to right: Dr David A Game, President Elect, Dr Arthur Hofmans, President, WONCA, Dr John Lawson, Chairman of Council and Assembly

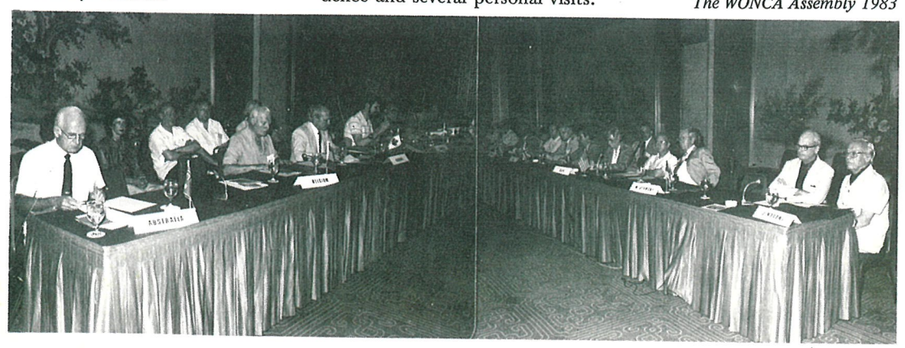
The Japanese Medical Society of Primary Care was admitted to Associate Membership.

South East Asia Region has been renamed Asia Pacific Region.

In his Valedictory Address, Dr Arthur Hofmans gave a report of activities during his term of Presidency from October 8, 1980. During his term of office, he had maintained good communication with Member Organisations through correspondence and several personal visits.

He thanked members of the Host Organising Committee of the College of General Practitioners, Singapore, the Conference Planning Committee for the time they devoted to make the Tenth WONCA World Conference a success. He also thanked members of WONCA Assembly, Council and Executive as well as Mrs Marian Threadwell, secretary of the Hon Secretary of WONCA for the support and assistance given to him during his term of office.

The WONCA Assembly 1983



TENTH
WONCA WORLD CONFERENCE
ON FAMILY MEDICINE
SINGAPORE
20th — 24th May, 1983

Daily Bulletin

NO. 5 TUESDAY, 24 MAY 1983 M C (P) NO. 112/5/83

Twin Pillars

Education and research are the twin pillars towards excellence in Family Medicine. In the plenary session devoted to Education, Prof. Marian Bishop, Dr Wes Fabb and Dr Perkin spoke. Research was the subject of yesterday's plenary session in which Dr Maurice Wood, Dr Henk Lamberts and Dr Paul Pedersen spoke.

Dr Reg Perkin, Dr Neville Andersen and Dr Maurice Wood at yesterday's workshop

The important message of Prof. Marian Bishop is that regardless of whether it is called General Practice on Family Medicine if the discipline is to succeed where it once failed, it must be involved in educational activities perceived to be relevant and which, if eliminated from the medical curriculum, will be missed and hopefully irreplaceable.

Dr Wes Fabb spoke of postgraduate education of doctors. Like all adult learners, family physicians want to assess themselves against a relevant standard; wish to be self directing in their learning experience; prefer a problem oriented, patient centred approach to learning; respond best to a non-threatening learning environment where there is a good teacher-learner relationship; want to know how they are progressing; want to apply their new knowledge and skills immediately; want to help others to learn. To be optimally effective and efficient, those responsible for postgraduate education need to adopt and apply these principles.

Dr Perkins spoke of CME in the Americas. Opportunities for continuing medical education are readily avail-

Continued on Page 5

CLOSING CEREMONY

To be held in two venues.

All too soon the Tenth WONCA World Conference draws to a close. In these four days of exchange of ideas, views and news we hope that this Conference has been fruitful. We also hope that the accompanying persons have enjoyed themselves sampling the multi-national milieu of Singapore. We hope you have had a delightful time in Singapore and look forward to have you visit us again.

Due to the large number of delegates attending this Conference, the Closing Ceremony will be held in two venues, namely, the Tropicana Restaurant and the Neptune Restaurant. Please make sure you are conversant of the transport arrangements.

Highlight of the Evening in both venues will be the Installation of the 1983–86 WONCA Executive.

TRANSPORT ARRANGEMENTS

ADMISSION TO THE BANQUET WILL BE BY TICKETS ONLY.

Please note the Coach Transport for delegates attending the Closing Banquet at Neptune Theatre Restaurant remains unchanged — please refer to Conference Souvenir Programme for details.

For delegates attending the Ceremony at Tropicana Theatre Restaurant, coaches will leave **only two** Stations — Mandarin Hotel and Orchard Hotel, between 6.30 pm and 7.00 pm. Those of you staying at the Hyatt, Holiday Inn, Goodwood, York and Dynasty are requested to go directly to the Tropicana Restaurant, which is situated next to the Holiday Inn Hotel.

Delegates are reminded that all drinks (except Chinese tea) at the Banquet will have to be paid for by delegates themselves.

EVENT

The 18th Wonca World Conference 2007

Wonca World Council Meeting

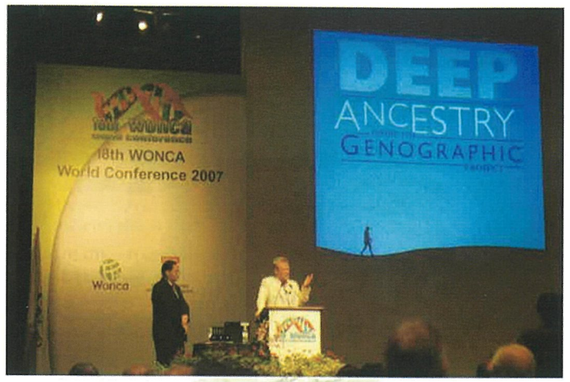
Conducted on the 21-23 July 2007, the Wonca World Council Meeting saw the movers and shakers of the primary healthcare realm.

Opening Ceremony - 24 July 2007

Mr Khaw Boon Wan, Minister for Health Singapore, with Dr Tan See Leng, Prof Bruce Sparks, and A/Prof Goh Lee Gan in the opening ceremony of the 18th Wonca World Conference 2007

EVENT

Keynote Lectures and Plenary Lectures



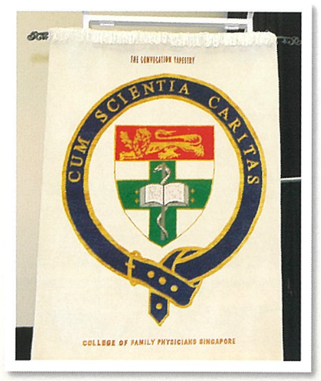
World renowned speakers - Dr Shigeru Omi, Prof Edison Liu, Dr Francis Collins, Dr Spencer Wells, Prof David B. Goldstein, Prof Yvonne Carter, and many others - delivered practical lectures and updates that brought family medicine in Singapore to a higher level.

Host Organising Committee Dinner - 25 July 2007

A relaxing and warm hospitality dinner organised by the HOC of 18th Wonca World Conference to welcome our international peers and colleagues.

College Regalia

The College of Family Physicians Singapore has an unique set of regalia for use in ceremonial occasions. The College crest has the motto of "Cum Scientia Caritas" which means scientific knowledge applied with compassion.



College Convocation Tapestry

The College Convocation Tapestry was unveiled on 1 October 2005 by Prof K Satkunantham. It consists of the Academic Crest of the College with the words "The College Convocation Tapestry" and College of Family Physicians Singapore. It was woven using wool and silk threads on as base of silk and measures 1.45m by 1m.

Academic and College Crest

The original drawing of the College Academic Crest was designed by Dr Koh Eng Soo in 1971. This was first used in 1973 as a badge of office on the left sleeve of the President's academic gown. This drawing later evolved into the current College Crest design, which has the motto "Cum Scientia Caritas" inscribed on a banner at the bottom of the emblem of "a heraldic lion in gold on a red chief above a silver shield and green cross, on which the caduceus and an open book is mounted".

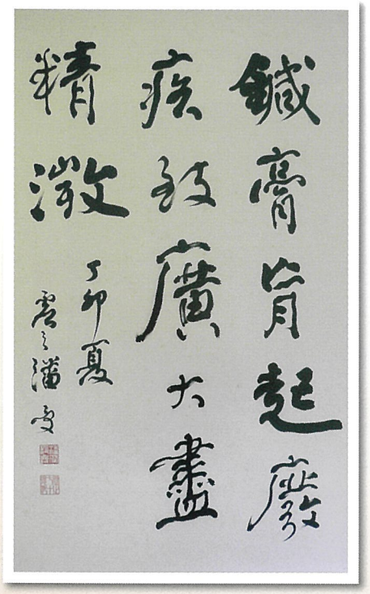
College Mace

The College Mace was installed on 4 November 2007 in memory of Dr Wong Heck Sing. It was presented to the College by the Host Organising Committee of Wonca 2007 World Conference.

College Medallions of Office

The College has three jewelled medallions for the Office of President (gold ribbon), Vice-President (blue ribbon) and Censor in Chief of the College (maroon ribbon). The medallions were commissioned by the 5th Council (1975 - 1977).

College Paintings & Pottery – A Selection



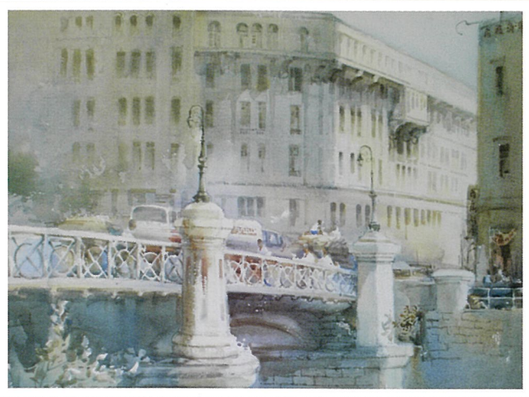
Calligraphy by Pan Shou. (Jun 1987)

"To cure the incurable, To make the lame walk, To use your skills widely, To strive for excellence."

Morning Glory. Chinese Ink & Brush. by Chen Wen Hsi

Fishing. Watercolour. Tay Bak Koi. (June 1987)

Singapore River. Watercolour. Goh Chye Khee. (June 1987)



Coleman Bridge. Watercolour. Peh Eng Seng. Presented by Academy of Medicine Singapore

Han Dynasty (BC 206 – AD 220).
Tripod Censer & Cover.

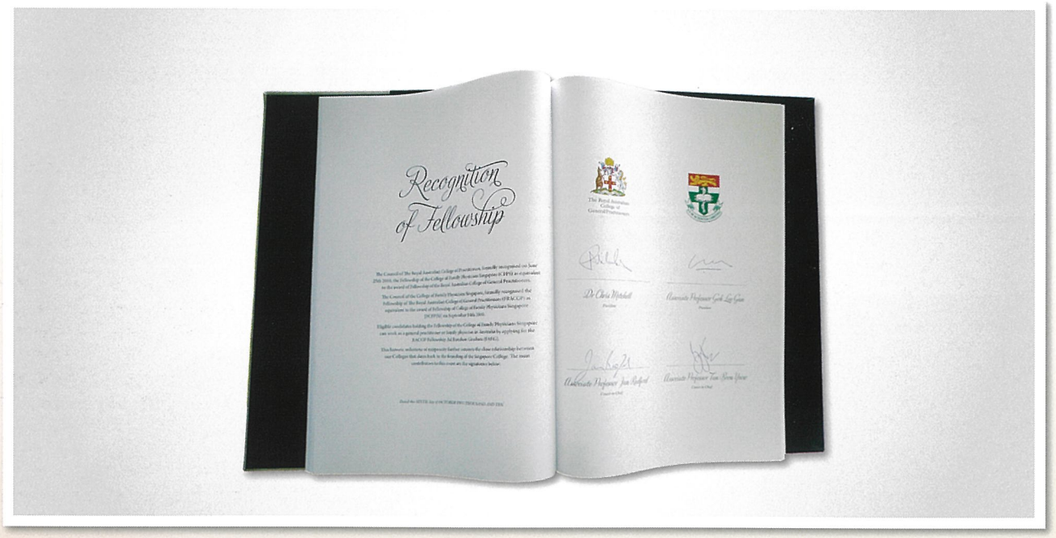
Qing Dynasty (1644 – 1912).
Ox-Blood Vases & Brush Washer.

Balinese Carving Satin Wood.
Presented by Dr & Mrs Lee Suan Yew (June 1987).

Tang Dynasty (618 – 907).
Phosphatic Splash Stoneware Jar.

Reciprocal Recognition between the Royal Australian College of General Practitioners and the College of Family Physicians Singapore

On 6 October 2010, a memorandum on the reciprocal recognition of the FRACGP and the FCFP(S) was signed at Cairns Convention Centre between RACGP and the College in Cairns, Australia. This signing ceremony celebrates the decision of reciprocal recognition of the fellowships of the two Colleges and leads to the award of the FRACGP by Fellowship ad eundum gradum to those with FCFP(S) who wish to apply and are working in Australia.



Memorandum on the reciprocal recognition.

A/Prof Goh Lee Gan, immediate Past College President, signing the memorandum with RACGP immediate Past President, Dr Chris Mitchell.

Gift of wine decanter from RACGP to commemorate the reciprocal recognition of the FRACGP and the FCFP(S).

09 FAMILY MEDICINE PERSPECTIVES — SINGAPORE AND WORLDWIDE

Position Statement on the Principles and Practice of Family Medicine in Singapore 2011

23rd Council (2011 – 2013),
College of Family Physicians Singapore, November 2011

Background

Singapore's population is ageing rapidly and patients are increasingly likely to suffer from multiple chronic diseases with complex medical and social needs. The rapid advancement of medical knowledge and technology also requires increasing levels of specialisation of care in our health care system. An unintended consequence of such a complex healthcare system is that patients are often cared for by multiple specialists potentially resulting infragmentation of care.

Family Medicine as a discipline has her roots in a generalist ethos and was birthed as a counter culture movement to the increasing sub-specialisation of medicine. The aim was to train and develop more generalist physicians so as to promote holistic care.[1,2]

Family physicians are the largest pool of generalists who are trained to provide general medical care to patients in the context of the person, the family and the community that they live in.

There is a need to define family medicine in Singapore in this current context.

Over the years, there had been various attempts to define Family Medicine (Leeuwenhorst 1974, WONCA 1991, Olsen 2000, WONCA Europe 2002).[5] The definitions evolved over time from one that concentrated on the physician's role or site of practice to one that focuses more on core competencies in order to meet the needs of patients in the changing healthcare environment.[2-4]

Defining Family Medicine in the Singapore context

All over the world, the definition of family medicine is contextual, depending on the stage of socio-economic development and the varying needs of the health care system in different countries. With the advent of the Family Physician register and the need to gear up training of our family physicians to meet the challenges of caring for our community with changing demographics and disease patterns, there is a need to define the principles and practice of family medicine in Singapore.

The College of Family Physicians Singapore defines a Family Physician as a registered medical practitioner who has acquired core competencies in the following areas after successfully completing a structured and comprehensive training program that is accredited by a recognised professional body or institution that provide for such training.

The core competencies of a Family Physician include:[5-9]

1) Clinical care

Family Physicians are skilled clinicians who are able to apply established and evolving knowledge in the biomedical, clinical, and epidemiological sciences related to family medicine as well as related knowledge in the social-behavioural sciences to their care of their patients. Their expertise includes knowledge of their patients and families in the context of their communities, and their ability to apply their clinical skills effectively.

2) Person-centred care

Family Physicians are committed to the person first rather than to a particular body of knowledge, group of diseases or interventions. As such, they provide competent person-centred care by developing a relationship with patients and their families in which health care needs are identified and addressed collaboratively in the context of the patient as a whole person.

3) Comprehensive and continuing care

Family Physicians are able to provide care for a wide range of health issues, across age groups, and may do so in a variety of healthcare settings. The clinical capabilities of family physicians span the spectrum of medical care: including health promotion and disease prevention; diagnosis; acute treatment, including the management of life-threatening illness; chronic disease management; rehabilitation; supportive care; and palliation.

4) Collaborative and integrated care

Family Physicians function effectively with the system of health care beyond the clinical encounter to call effectively on additional resources to provide optimal health care for their patients. They communicate and collaborate effectively with patients, families, communities and other health care professionals in the multidisciplinary team to bring about optimal care to the patients. They serve as integrators of care and demonstrate a long term commitment to their patients.

5) Community orientated care

Family Physicians are able to reconcile the health needs of individual patients as well as the health needs of the community in which they live in. He or she is also able to facilitate the use of available community resources to optimise patient care.

6) Professionalism

Family Physicians conduct their professional life in accordance with the expectations of the profession of medicine and society, manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds.

A family physician is required to maintain such competencies through dedicated and rigorous participation in continuing professional development activities that include continuing medical education, quality improvement, research and teaching in the discipline of family medicine.

He should also be in constant interaction with peers through membership and active participation in a professional body of family medicine.

The Practice of Family Medicine in Singapore

In the context of Singapore, family physicians provide general medical care of patients in the following practice settings:

1. Private sector primary care clinics (GP clinics)
2. Public sector primary care clinics (polyclinics)
3. Community hospitals
4. Restructured and private hospitals
5. Other intermediate and long term care facilities (home medical care, hospice and nursing homes)

The generalist ethos of family medicine emphasises the importance of managing illnesses in the context of the person, the family, the community and the health care system. With the rise of complex chronic diseases and the increasing fragmentation of care as a result of specialisation in medicine, more family physicians will be needed to meet the rising demand for good holistic care for our patients as they journey across our health care system.

References:
1. History Of Family Medicine - Virtual Family Medicine Interest Group, American Academy of Family Physicians
2. The future of Family Medicine: A collaborative project of the Family medicine community. Annals of Family Medicine Vol2, Supp 1, Mar/Apr 2004.
3. What is Family Medicine in the Asia Pacific Region, Editorial Asia Pacific Family Medicine 2003;2;1
4. Family Medicine, Scope and Philosophical Statement (http://www.aafp.org/online/en/home/policy/policies/f/scopephil.html)
5. The European definition of General Practice/ Family Medicine EURACT 2005
6. CanMEDS-Family Medicine. Working Group on Curriculum October 2009
7. Key Principles and values for family physicians in Primary Care Model development
8. The Philosophy and foundation of General Practice. The RACGP Curriculum for Australian General Practice 2011
9. Educating physicians for the 21st Century. ACGME outcome project 2006.

The Expertise of Family Physicians

A/Prof Goh Lee Gan

INTRODUCTION

The core expertise of family doctors/family physicians lies in the ability to practice the generalist approach to patient care problems. (Hennan, 2007).[1]

This generalist approach has three characteristics:[2]
Multiple dimensions taken into account simultaneously: selectivity and uncertainty; probabilities and treatability; best evidence, experience and the patient's perspective;
Constant adaptation of the scope of evaluation and of management decisions to the context (of the patient, his presenting problems, and his environment); and
Simultaneous management of multiple problems.

An attempt is made in this paper to link this generalist approach to patient care with the expertise required of the family physicians, the enlarging clinical settings that he is invited to provide care, the type of patient problems he/she is likely to encounter, and the type of care called upon to provide, in the context of the PPP-CCC definition of Family Medicine.

CLINICAL SETTINGS AND CAREER PROSPECTS

In the Singapore setting, the family doctor/family physician increasingly has opportunities to take on the role of looking after patients not only in the doctor's clinic, but also in other settings such as the emergency department, the acute care hospital, intermediate care facilities (the community hospital) and long-term care facilities (nursing home).

The broadening career prospects are the result of several professional, demographic and socio-economic forces: the continuing sub-specialisation of medicine; the short hospital stays necessitated by per-day costs of hospital care; the enlarging ageing population which demands a general approach to their problems; and the ability of modern medicine to provide intermediate and long-term care to sustain the care of disabled individuals from injury, ageing, or developmental causes.

The career prospects of future family physicians are therefore likely to be broad compared to the present clinical landscape where family physicians are largely localised to ambulatory care in the community.

TYPE OF PATIENT PROBLEMS PRESENTED TO FAMILY PHYSICIANS

Family physicians are doctors of first contact. The expertise demanded of them will be the ability to deal with the undifferentiated problems of any type, both acute and chronic, occurring in all ages and to both sexes, and varying in complexity.

This is in contradistinction to type of patient problems presenting to his organ specialist colleagues, or colleagues who deliver care to age-specific populations, e.g., paediatricians or geriatricians, or colleagues who provide gender-specific care, e.g., OBGYN, where the problems encountered are highly defined ones, with greater certainty of diagnosis and treatment plans, restricted to one age, sex, or illness at a time.[2]

TYPE OF CARE FAMILY PHYSICIANS WILL PROVIDE

Trained family physicians will be able to provide care that has the following characteristics:

- Longitudinal care, with continuity as opposed to mostly episodic care;
- Spectrum of care, from health promotion and disease prevention, diagnosis, acute treatment to chronic disease management, to rehabilitation, and supportive care;
- Focus on the physician-patient relationship and the patient-centred clinical method (Pendleton's seven consultation tasks, Stott-Davis aide-memoire on the consultation); and
- Collaboration and co-ordination of care where needed.

PPP-CCC DIMENSIONS OF CARE

The PPP-CCC definition of family medicine may be described as: "Family Medicine is a discipline concerned with the provision of personal, primary, preventive, comprehensive, continuing, and co-ordinated healthcare of the individual in relation to his family, community and his environment."

Personal Care

This is patient-centred care that is delivered with a close rapport between the patient and the doctor. The patient may consult his family doctor not only when he is unwell but may seek his counsel as a friend and mentor.

Primary Care

This is first-contact care. In primary care, the patient may present with one or more of the following reasons (for encounter):

- pain or other symptoms;
- accident and emergency;
- preventive healthcare;
- administrative requirements — physical check-up and certification;
- seeking assurance (worry about the meaning of symptoms); or
- problems of living; legitimatisation of sick role.

Of these different reasons for encounter, acute care and preventive care are the predominant areas of care. At the time of encounter at the outpatient setting, many acute problems have yet to unfold. They are said to be undifferentiated: some may be self-limiting problems and others may be early presentations of serious problems.

Strategies to cope with such problems include the use of: red flags; time as a tool (also called watchful waiting); and frequent reviews of the patient's condition.

Take, for example, a patient presenting with abdominal pain of a few hours' duration. This is often due to gastroenteritis but, in some instances, the pain could be a symptom of appendicitis, and in the woman, it could be due to an ectopic pregnancy. For such a stage of disease, time is a useful tool to help the family physician come to a definitive answer, provided the patient is well enough. This is where continuity of care (that is, care of an episode of illness by the same doctor) becomes important. If the patient is ill, time as a tool cannot be used; the problem cannot wait and the patient must be admitted.

Two points need to be made: (a) The meaning of primary care here is clinically oriented and is narrower than the WHO's wider-scope elements of primary care; (b) what is seen by the family physician is dependent on the decision of the patient — the patient may choose to see the specialist or the GP or self-medicate or do nothing about it.

Preventive care

"Prevention is better than cure" is an important value in family medicine. This can range from reduction of risk factors, detection and treatment of asymptomatic disease, to prevention of a second disease episode.

Comprehensive Care

Comprehensive care has three meanings: (a) that it cares for a whole spectrum of age groups; (b) that it spans promotive, preventive, curative, rehabilitative and palliative care; and (c) that it deals not only with the physical but also social and psychological problems (whole-person medicine).

Care of the whole spectrum of age groups. The scope of family medicine encompasses all ages, sexes, each organ system, and every disease entity. The family physician is able to respond beyond isolated disease or dysfunction and treats the patient as an individual, providing a comprehensive scope of care that is broad enough to treat all members of the family, and care for them in a continuing relationship (Jimbo, 2004).[3]

Continuing Care

Continuing care is care of a chronic medical problem which requires regular monitoring and also care of complications that may arise. This care may be provided by the same doctor entirely, or the doctor functions as a member of the team. The basic requirement is the presence of a care plan for the problem. Examples of medical conditions requiring continuing care are: hypertension, diabetes mellitus and hyperlipidaemia.

In chronic medical conditions, continuity of care is important. For this to be achieved there is a need for good medical record keeping, communication and discussion of the care plan with the patient and his significant others.

Team care is often needed. The members of this team consist of: the family physician as the coordinator of care; and the specialist who sees the patient time and again to deal with complications or to conduct a periodic review of the health status of the patient. Then there is the nurse practitioner who counsels and assists the doctor in looking after the patient; the dietitian; the physiotherapist and others.

For those who are bedridden, the domiciliary care staff will need to be activated. There may also come a time when it is no longer suitable for the patient to be looked after at home for various reasons, e.g., the absence of a carer or nursing has to be done frequently — this is where the community hospital and nursing home comes into the picture. Chronic medical conditions can be expensive and many may need financial assistance. This is where the medical social worker may also need to be drawn into the team.

How Can Continuing Care Be Encouraged?

Doctor-Patient Relationship

In the care of patients with chronic problems, establishing a good doctor-patient relationship is essential. This will ensure that patients comply with management strategies and instruction on life-style changes, medication, etc. The provision of good personal care by the doctor is important in maintaining a long-term relationship with the patient.

Consultation Tasks

Pendleton's list of 'consultation tasks' provides a good framework for the holistic care of patients with chronic problems. Some of these are: Achieving a shared understanding of the problem with the patient; Choose, with the patient's agreement, an appropriate action for each problem; involve the patient in the management and encourage him to accept appropriate responsibility for his care.

Consultation Time

In patients presenting with acute problems or requesting for non-illness related consultations, the physician should take the opportunity to review any continuing problems present, and the current state of management of these problems. The lack of time is the main constraint, and to make time for the patient requires interest and professional discipline on the part of the physician.

Health Education

Patients with chronic problems should be educated regarding the benefits of life-style changes, compliance with management strategies, regular follow-up care. Patients should also be taught what to do in the event of an acute illness which may or may not be related to the chronic illness. In addition, they should be alerted as to the symptoms which may signal the beginning of any complication, and when to seek medical help.

FAMILY MEDICINE PERSPECTIVES — SINGAPORE AND WORLDWIDE

Methods Which Facilitate Continuing Care

Medical Records

Proper documentation is necessary for efficient continuing care, as well as for medico-legal purposes. Medical information should be systematically and legibly recorded, and should reflect the patient's main problems, findings, treatment and any future plans. They should also include any special features of note, such as drug allergies, G6PD deficiency, etc. The information in medical records should be organised in the problem-oriented or Subjective-Objective-Assessment-Plan (SOAP) format of subjective information (history), objective information (clinical and laboratory findings), assessment of the problems (working diagnoses) and plan of action. Computer recording systems are recommended for efficiency of filing and retrieval.

Appointment and Recall System

This is essential in the tracking of patients who come for regular follow-up visits. Any patient who misses an appointment should be sent a reminder or contacted by 'phone. The use of computer systems will make this simple and routine. In group practices, the use of appointment systems will also ensure that patients get to see their regular doctor as much as possible, as appointments can be rescheduled when the doctor goes on leave.

Clinic Hours and Staff Orientation

The extension of clinic-opening hours to evenings and weekends, to accommodate patients with regular working hours and their family members, would greatly facilitate regular follow-up. Advance notice of any change in clinic hours should be given. Clinic staff should be orientated towards facilitating continuing care, in that patients with appointments should be given priority over walk-in patients, when they are punctual for their appointments. Trained staff can also reinforce any health advice given by the doctor.

Attention to Adherence in Continuing Care

There is a need to pay attention to factors that could reduce adherence. Several factors need to be considered:

Patient Factors: Attitude towards illness, healthcare provider, medical treatment; knowledge about illness and its treatment;

Disease Factors: Chronicity of disease condition lowers compliance;

- Treatment Factors: Treatment regimens that require behavioural changes are usually associated with poor compliance, e.g., change in eating habits, exercising, stopping smoking, and complicated medication dosing.
- Physician Factors: Physician attitude towards patient and his illness, i.e., type of care, doctor-patient relationship.

Prevention and Treatment of Poor Adherence

Prevention: Remove barriers to compliance e.g. Reduce waiting time, convenient appointment schedule, simplify drug regimen; Involve patients in their care.
Treatment: Trace defaulters; increase attention and supervision; use positive reinforcement, give encouragement.

Co-ordinated Care

Co-ordination of care is often necessary in the patient with multiple co-morbidities, and the patient with chronic disease. This will reduce duplication of care and also gaps of care.

THE FAMILY AS THE UNIT OF CARE

The family physician looks after the patient as a member of the family and also regards the family as a unit of care. Furthermore, the family physician often looks after more than one member of the family. He or she gets to know the health of the family as a unit. Also, as the family goes through its family life cycle, there are new tasks that the family has to complete. The family doctor is often called to provide his advice and care when problems are encountered in the developmental tasks of the family. One such example is advice to new parents on parenting issues. This topic will be dealt with in a later chapter.

PATIENT CENTRED CLINICAL METHODS

Two patient-centred clinical methods have stood the test of time. Together they help to define the problems of the patient for the family physician.

Pendleton's Seven Tasks in the Consultation

This is shown in Figure 1. There is a need to establish the reason for encounter as the starting point and obtain the patient's ideas, concerns and expectations so that the patient's consultation needs are meet.

Figure 1. Pendleton's Seven Tasks in the Consultation (1987)

1	Find out why the patient has come, also called the reason for encounter (RFE) and from there go on to take a history which covers the following: the nature and history of the problem, the patient's ideas, concerns and expectations (ICE), the effects of the problem on the patient and significant others.
2	Consider the other problems that the patient may have: continuing problems, risk factors.
3	Choose with the patient an appropriate action for each problem. In general practice, there is a need to prioritise the action to take if the patient has more than one problem.
4	Achieve a shared understanding of the problems with the patient.
5	Involve the patient in the management and encourage him to accept appropriate responsibility.
6	Use time and resources to good advantage.
7	Establish or maintain a relationship with the patient that helps to achieve other tasks.

Stott-Davis Consultation Framework

Doctors need a good aide-memoire to remind them of the potential of the consultation to provide comprehensive care. Out of the understanding of the patient and his or her clinical problem, comes a series of potential operational tasks for the doctor to perform. Which will be performed depends to a large measure on time available, then knowledge and skills, then awareness. These operational tasks have been described and organised into a framework by Stott and Davies which they published in a paper in the J RCGP in 1979 titled The potential in each primary care consultation — an aide-memoire.[4] The four operational tasks are shown in Figure 2.

Figure 2. Stott-Davis Consultation Framework

A	Management of presenting problems	B	Modification of help-seeking behaviour
C	Management of continuing problems	D	Opportunistic health promotion

Task A: Management of presenting problems – Every consultation needs to address this area. Besides dealing with the presenting problems, it is good practice to embark on the other tasks as far as time permits.

Task B: Modification of help-seeking behaviour – It may be necessary on occasion to change the help-seeking behaviour. For example, the patient may insist on antibiotics which are not appropriate. The modification of such behaviour needs due attention to ideas, concerns and expectations behind the help-seeking behaviour.

Task C: Management of chronic problems – There is a need to address the care of chronic problems whenever the patient visits. Time spent in this task will result in better compliance and reduce complications from chronic diseases.

Task D: Opportunistic health promotion – Much can be done to reduce the onset of disease related to an adverse life-style. However, this is a challenging task because the adoption of healthy behaviours requires the change of life-long habits.

Extending the Stott-Davis Consultation Framework to Home Care

The Stott-Davis Consultation Framework can be extended to home care for the frail elderly by including two more areas, namely (E) environmental assessment and (F) function assessment or establishment. This is described below and shown in Figure 3.

Figure 3. Extending the Stott Davis Consultation Framework in home care

A	Management of presenting problems	B	Modification of help-seeking behaviour
C	Management of continuing problems	D	Opportunistic health promotion
E	Environment assessment	F	Function establishment

Task E: Environment assessment – The frail elderly is an organism in homeostasis with his environment. The environment can be seen in 2 parts:

1. Physical environment – home setting
2. Social environment – presence of a caregiver as well as financial condition

For example, failure to thrive may be due to the elderly being unable to access nutritious food either because of physical constraints or lack of finance.

Task F: Function establishment – Establishing function is important in the frail elderly. It allows for:

- Establishing a baseline status;
- Detecting of disease. E.g., any intellectual or functional decline may herald dementia, depression or other illnesses requiring further investigations. Functional decline may be the first indication of disease in the elderly; and
- Monitoring of response to intervention. E.g., Functional improvement after treatment of depression.

Function establishment looks at:

1. Cognition and mood – Locally, a commonly used simple score for cognition screening is the modified Abbreviated Mental Test (Table 1).
2. Activities of daily living (ADL) – This refers to self-care tasks that a person performs in the course of living to maintain cleanliness, hygiene, appearance, nutrition and mobility. ADL measures the ability to feed, toilet, transfer (getting in and out of bed), bathe, dress, remain continent and walk.
3. Instrumental activities of daily living (IADL) – This refers to the more complex tasks necessary to function in society and requires a combination of physical and cognitive activities easily remembered as SHAFT (Shopping; Household chores; Ability to take medications on own; Finances, namely, banking and handling money; Transport and telephone).

Assessing of function may be through simple reporting from patient or caregiver. A simple office test includes seeing patient "get up and go" to see his mobility status. In a busy outpatient consultation, the tasks will need to be spread out over several sessions. This will make it less onerous and more manageable.

FAMILY MEDICINE PERSPECTIVES — SINGAPORE AND WORLDWIDE

Table 1: Abbreviated Mental Test (AMT)

1	What is your age?	
2	What is your home address? (excluding postal code)	
3	Time (within 1 hour)	
4	Place (Where are we now?)	
5	Person (recognition of 2 persons) or show picture of nurse/doctor	
6	Current year	
7	Name of PM (Who is Singapore's Prime Minister?)	
8	Subtracting 3 from 20 or count backwards from 20 to 1	
9	Recall of 3 objects or recall of phrase (e.g. 47 Bukit Timah Road)	
10	Date of birth (Western year +/- month and day)	
	TOTAL SCORE	

One point is given for each correct answer. A score of less than 7 indicates possible cognitive impairment.

CONCLUSIONS

As skilled clinicians, family physicians provide comprehensive, continuing care by the application of a core body of knowledge in the biomedical, clinical and epidemiological sciences related to Family Medicine. This is done within a relationship of trust with their patients and their families, in the context of their communities.

Through expert judgement and clinical reasoning, and using the patient-centred clinical method, family physicians function effectively as generalists to interpret the often undifferentiated problems that present, and to arrive at decisions, in partnership with their patients, regarding investigation and management.

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