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GPs with Focused Interests — Are We Ready?

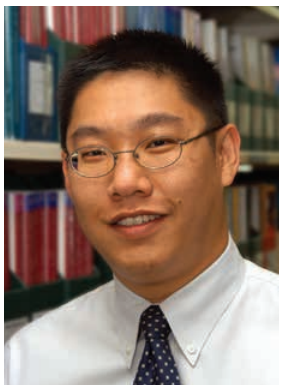
Interview with A/Prof Simon Ong, Director of Division of Cancer Education, National Cancer Centre Singapore (NCCS)

Interviewed by Dr Fok Wai Yee Rose, Editorial Board Member

Following two years of GP engagement and feedback, NCCS is now embarking on an Oncology Training program in Primary Care.

College Mirror (CM):
What is your vision of NCCS on Oncology Training in Family Medicine?

A/Prof Simon Ong (SO):
NCCS is the major provider of cancer care and training locally. We are experienced and established in providing advanced training for cancer doctors and nurses both locally and regionally. While we have done very well in these areas I feel that we can do more for the wider community beyond the Outram campus, especially the homecare nurses, primary care physicians (PCPs) and even medical social workers. My interest in PCPs arose as a result of seeing them as a critical component in the broader concept of a total cancer care system. As generalists, family physicians (FP) are able to complement the narrow focus of care provided by specialist with a more broad-based one resulting in a more holistic and comprehensive care. To this end we look forward to collaborating with our PCP partners to develop a meaningful and sustainable shared care model.


A/Prof Simon Ong

"An important trend in the Canadian physician work force is the growing number of FPs narrowing their scope on clinical areas of particular interest … According to the 2010 National Physician Survey 30.5% of FPs indicated they have a specific area of focus in their practices … In 2011, the CFPC created a new section for FPs with Special Interests of Focused Practices to "offer increased support for FPs who incorporate special interests and skills as part of their traditional broad-scope family practices, as well as for those who have focused their practices in specific areas of care." … Family physicians have been working in formal outpatient and inpatient cancer settings for several decades in Canada … The Canadian Association of GPs in Oncology (CAGPO) was formed in 2003 to foster a common identity and meet the continuing education needs of these physicians, now commonly called GPs in Oncology (GPO) or FPs in Oncology … This survey of Canadian GPOs paints the picture of a professional group active in communities of all sizes, working in a variety of roles and practice settings within the cancer care system and with a range of cancer patients. These physicians usually combine part-time work as GPOs with other medical activities such as hospital medicine, palliative care, and family practice … They also report higher job satisfaction than other FPs: 93% of GPOs were satisfied or extremely satisfied,

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IN THIS ISSUE:

You Practice Family Medicine? *Part 2*

"Why do you need FCFP(S)/ FAMS?"

by Dr Low Sher Guan Luke, FCFP(S), Editor

This becomes the new frontier we need to push for in order to benefit more patients who are now qualifying as "pioneers".

Recently, I was posed this question by a fellow doctor who questioned the need for higher post graduate training in family medicine, "Why do you need FCFP(S)/ FAMS to see URTI cases? Will it make you manage URTI better?" I had mixed feelings upon hearing this question. Part of me knows that it won't make a world of a difference if the URTI case was truly uncomplicated (save for the fact that I will be less trigger happy when it comes to inappropriate antibiotics usage for viral URTI), but another part of me knows that if it were truly pneumonia, chest infection, or something else much more complicated, the training will come in handy. In fact, most of us did not undergo post graduate training only to better manage URTI, but to manage a whole spectrum of complex cases that may come our way, and many of those who went through post graduate training came from all walks of practices, ranging from GP practices, medical groups, community hospitals to inpatient FM hospitalists who do a fair bit of internal medicine work.

Some question the reason behind all these training, and if it is truly necessary for us to function in our work. I think it depends on what type of work we choose to do. Even as community GPs, we can aspire to manage complex patients coming in from the hospitals, and post graduate training is definitely necessary in order to be in touch with evidence based medicine and for us to better appreciate the management that the hospital specialists have done and how we can continue long term care as such. We need not confine ourselves to seeing URTI for the rest of our lives if possible!

Some of us would have borne witness to the rise of hospital family medicine and know that family physicians have a complementary role in hospital outpatient clinics and inpatient wards. A decade has passed and time has proven hospital family medicine to be an integral part of transitional care, community hospital care, and consolidated care outpatient clinics, working alongside hospital specialists and playing to each other's' strengths with a common aim to help transit these patients to consolidated community care as much as possible, and minimizing chances of them becoming overly reliant on institutional care. All these can be seen by some to be unnecessary trouble, responsibility and stress which can be "easily avoided" if we do not take on that work. But for some of us who wish to build up an ideal state of healthcare system where family medicine is practiced at a higher level in harmony with hospital medicine, this becomes the new frontier we need to push for in order to benefit more patients who are now qualifying as "pioneers".

There's also another world view that feels that such hospital family medicine practices are fragmenting the family medicine discipline. There was much mention before that family medicine is one discipline, but in many settings. So I do not quite understand why hospital family medicine will fragment our discipline since we are supposed to operate across settings and over quite a fair bit of the care spectrum, ranging from inpatient medical wards, to home care and community care. Perhaps what was meant was that some "old outpatient family medicine turf" will be fragmented… alas, turf issues are always tricky to deal with and many can be misguided into thinking that the fraternity's turf is split. If anything, the various settings have always been united in our common goals of improved patient care and the practice of holistic family medicine. That is the real glue that unites us. Turf issues will get us nowhere.

Unfortunately, history poses an important lesson. People do not know what they have lost, till they have lost it. Let's hope the cost is not too great to bear. As Benjamin Mays puts it, "The tragedy of life doesn't lie in not reaching your goal. The tragedy lies in having no goal to reach."

CM

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compared with 75.6% of FPs in the NPS." (Canadian Family Physician 2013; 59:e290-7)

Singapore is a compact island with readily accessible health care services so not everything from the Canadian experience is relevant or practical to us. However the Canadian experience does tell us that it is feasible for PCPs to play a wide variety of roles in the cancer care system, both within and without the hospital.

Canada, particularly in British Columbia and Ontario, is far ahead and has a well-established training program for PCPs which involves a core module integrated into the General Practitioners (GP) in training and enhanced skills for GP in practice, as part of an integrated healthcare model. It is logical to have two sets of program, one for basic core knowledge and another to develop more specific skills.

CM:
What do you hope to see in the immediate future and in the next five years?

SO:
I hope that we can eventually develop a training model similar to the Canadian one. I hope that we can start by defining the role of a GPO in Singapore, conducting workshops to provide specific skill sets, integrating these workshops into a coherent curriculum and training program and finally developing national practice guidelines and accreditation.

a. Defining Roles of GPOs
We need to have a dialogue between oncologists and PCPs to define possible roles of GPOs in Singapore. Without knowing these roles we would not be able to develop a meaningful curriculum. NCCS will provide the space to discuss and explore different views and ideas. NCCS will provide opportunities for teaching, training and attachments to engage our GP partners. Hopefully we can identify meaningful roles for GPOs through these conversations and interaction. I am glad to say that this conversation has already begun with the setting up of a taskforce with GP partners from a diverse practice setting.

b. Workshops
A series of different workshops can be designed to equip GPs with a variety of specific skill sets. The initial choice of workshops is derived from our conversation and discussion with our GP partners. We will conduct these workshops and subject them to a rigorous critique and evaluation process by the attendees. Hopefully we will be able to identify the most useful workshops through a process of selection and elimination. This process can also help to discover and validate where the areas of needs lie.

c. Curriculum
The next task will be to organize and integrate these individual workshops into a single meaningful

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curriculum. The greatest challenge in developing such a curriculum is to avoid making it too specialized or compartmentalized. I envisage that such a curriculum should embody a more "multi-disciplinary and inter-professional" approach. In order to achieve this it becomes imperative that we collaborate with PCPs who have received training and exposure in oncology.

d. National Practice Guidelines and Accreditation

Eventually I hope to see "Practice Guidelines" written for GPOs especially in areas of screening, surveillance and survivorship. Currently many of our guidelines like the NCCN guidelines are developed for specialists for the treatment of advanced cancers. After that, I hope we can include a formal appraisal process followed by governance to ensure a minimum standard of care.

CM:
What do you think is the greatest need in GPO training?

SO:
The increasing incidence of cancer (1 in 3) together with our aging population translates to a burgeoning cancer burden and oncologists alone cannot provide the full care to our cancer survivors.

a. The greatest need is in cancer prevention, screening and early diagnosis. The greatest barrier of effective screening is the failure of take up. Some studies have shown that when GPs are actively involved in screening the take up rate improves significantly. Patients are most likely to present to their GPs first with their symptoms. Facing such a world of diagnostic uncertainty, GPs have to be trained and experienced in recognizing potentially serious conditions which may present in an undifferentiated way. Inevitably GPs play a critical role in the early diagnosis of cancer more so than cancer specialists.

b. Next is the area of cancer survivorship so as to allow the oncologists to focus on more specialized area of treatments. This comprises four large areas including:
i. Detecting relapse
ii. Screening for new cancers
iii. General preventive health
iv. Management of comorbidities

A survey of the different views among cancer survivors, PCPs and oncologists was carried out by the Harvard School of Public Heath recently (Cheung et al., JCO 2009; 27: 2489-2495). Both patients and oncologists concur strongly (91% concordance) that oncologists have the main role of detecting cancer relapse. Both patients and PCPs agree strongly that PCPs have a substantial role in screening for other cancers (81% concordance), general preventive health (91% concordance) and management of co-morbidities (92% concordance).

Eventually I hope to see "Practice Guidelines" written for GPOs especially in areas of screening, surveillance and survivorship...

CM:
What do you think are the main barriers of oncology training in FM?

SO:
The main barriers are:
a. Inadequate exposure to cancer patients.
b. Knowledge on oncology is not only limited in FM/GP training but also in the medical school curriculum. Fortunately this may change as there is a move towards including oncology as a mandatory core module in undergraduate training.
c. Apart from cancer screening guidelines, there are actually no practice guidelines for the management of cancer patients by PCPs. Available practice guidelines such as the NCCN guidelines are usually meant for management of advanced and complex cancer in the hospital setting.
d. Limited access to medical notes (e.g. electronic notes). Oncology care is complex and involves multiple specialists, multiple treatment modalities, multiple interventions, multiple conversations and multiple hospitalizations. As such it becomes pertinent that all partners of care have access to information.
e. Lack of communication. This is particularly important at the transition of care, e.g. foregoing further chemotherapy, shifting to symptomatic care, transiting to end-of-life care. There must be proper, clear and sensitive communication of the new goals of treatment and care plan as the patient moves into a different stage of the cancer journey.
f. Public confidence in GP/ Primary Care System. We need to create public awareness about GPs with focused interest in oncology and build public trust and confidence in these GP partners.
g. Payment of care / reimbursement. Acute reversible care generates more revenue. The current payment scheme for complex care, especially EOL is unfavorable particularly if the consultation is time consuming and emotionally demanding.
h. System. This is in my opinion the greatest challenge. This is not a single factor but it encompasses a complex range of administrative, financial, cultural, organizational and political challenges.

CM:
Being a veteran in cancer care, do you have any advice for patients?

SO:
Cancer survivors often continue to live under the "shadow of cancer" with a constant fear of relapse. While it is natural to fear we should not let fear take away the joy of living. On the contrary we should use that fear to live life even more vigorously and meaningfully. Although a diagnosis of cancer is often shattering and devastating, it can also be affirming and motivating. It compels us to scrutinize our lives under a microscope, to reprioritize our goals. It amplifies the singing of the birds and the blueness of the sky. It motivates one to make each day count. It makes one value life like never before.

CM:
Has your approach to cancer care change over the years?

SO:
In my early days of oncologic training, chemotherapy (chemo) was the most important thing to me as I believe that it is the main tool and weapon of cancer care. It is the most powerful medicine to eradicate cancer and save lives. I viewed myself like an alchemist, fully immersed in studying the "art" of creating potions to become the best in giving chemo. Even after a patient has failed multiple lines of chemo, I would still be able to concoct a treatment that might just work.

However over the years my views have changed to a more sobering reality. While we have become adept at giving chemo and have yielded better results incrementally, chemo comes at a COST. By having patients live longer, we have also compelled patients to live longer with the BURDEN of cancer, which may not be the best for every patient. For some, this longer life span may even be a form of suffering for both patient and family. All these made me look at cancer in a more holistic manner and I am now more sobered and less charmed by the hopes that chemo can provide. Certainly there are also many stories that have turned out positive. Some patients grow in courage and spiritual strength during their cancer journey, living life with no regrets. But coming back to the burden of cancer, I have witnessed families "crumbling" under the stress and impact of cancer. They became financially strapped, living life with lots of regret and becoming so singularly focused on treatment that they forget to address other needs and "unfinished business". This part of cancer care is not as "romantic" but just as real. As oncologists, we need to help patients see that there is a "price to pay", not just money but other costs as well.

Thus chemo to prolong life at all cost may not be the right approach. Now I take a broader view that chemo is a means to an end and not an end in itself. For example, one of my patients diagnosed with advanced cancer hoped to see her only daughter get married, which was going to happen in one year's time. Her first question to me was which chemo regimen could help to prolong her life by a year. If chemo was only a means to an end, then could there be another and perhaps easier means to the same end. I suggested to her daughter to bring forward the wedding and my patient achieved her goal. So now I first try to find out what are the patient's goals in life when facing a life-limiting illness, then explore what are the means to achieve these goals. There may be other means beyond chemo. I view death as inescapable and we cannot change the natural laws. Chemo often does not solve the problem or address one's needs, it can only buy time for us to act. What we can do for our patients, we will try to do but at the same time we do need to help patients count the cost of treatment. Where we can cure, we will certainly like to cure but where we cannot we hope we can help patients to live better and meaningfully.

For some, this longer life span may even be a form of suffering for both patient and family. All these made me look at cancer in a more holistic manner and I am now more sobered and less charmed by the hopes that chemo can provide.

CM:
Any thoughts to share?

SO:
Cancer care is a life journey and cancer education can provides people the necessary knowledge and skill to care for patients along this journey. Our outreach must be broad based, and multidisciplinary, involving everyone, including physicians, non-physicians, family, medical social workers, etc. Our ultimate goal in cancer education is to strengthen oncology skills of healthcare providers and enhance cancer care in the community.

Cancer is a life changing experience for both patients and cancer care providers. Cancer treatment should be all encompassing and not just chemo, surgery or radiotherapy.

I am driven to make this journey happen and I believe it can happen but we need all on board to make this happen.

CM

Image courtesy of A/Prof Simon Ong

Frontier Family Medicine Clinic

a new model of care

by Dr Koh Thuan Wee, Director, Frontier Family Medicine Clinic
Dr Tham Tat Yean, CEO, Frontier Healthcare Group

In a bid to plug the current care gaps of our local healthcare system, Frontier Healthcare Group together with various stakeholders in NUHS, NUH and NUS took the opportunity to pilot a new model of care in Frontier Family Medicine Clinic (Frontier FMC). This model is called the Patient Centred Medical Home (PCMH).

The PCMH is a framework whereby the McColl Chronic Care Model is implemented. In 2007, four American medical professional bodies issued the joint principles of PCMH which are as follows:

1. Personal Physician
2. Physician Directed Medical Practice
3. Whole Person Orientation
4. Care is Coordinated and/or Integrated
5. Quality and Safety Focused
6. Enhanced Access
7. Payment Reforms

Frontier FMC adopted the first 6 principles and incorporated them into our daily operations and provision of clinical care. One of the key changes is empanelment or assigning a personal Family Physician (FP) to each patient that comes through our door, whether from the community or referrals from NUH. This ensures that there is continuity of care and ownership of patients' health status by the FP. Currently, we have 84% physician specificity when a patient steps into the FMC for medical consultation.

Another key change is enhanced access compared to the Specialist Outpatient Clinic (SOC) in a bid to attend to patients' medical issues before they are escalated into a hospital admission. Currently we provide same day access for any patients who feel unwell and need an earlier review. Anecdotally, this has prevented the conditions of several patients from worsening and averted hospital admissions. We are continually working on how this access can be further increased by traditional means (increasing hours of access eg. phone calls) and technological means (emails, telemedicine, patient portals etc).

With a rapidly ageing population and an increasing number of comorbidities each patient bears, continuity of care is critical not only for each disease condition but as a whole person. The access to important background medical information especially in an unplanned visit becomes crucial in providing accurate diagnosis and timely intervention. This is greatly enhanced by the deployment of the same EMR as NUH where specialist notes, care plans, diagnostic procedures, laboratory and radiological investigations, prescriptions are readily available at the FPs' disposal. Conversely, by virtue of the same EMR system, documentation of any FMC encounter is readily accessible to the EMD physicians and hospital specialists as well. Despite the patient being referred for one disease condition from some specialists, the FPs in our FMC take ownership of the whole patient and monitor the other disease conditions as well. At the same time, our FPs will work with the other specialists to consolidate the care of the patient's other conditions in the community where appropriate and coordinate their care from the community.

Frontier FMC currently functions as a truly integrated extension of NUH. This is not only in the provision of care as the patient moves seamlessly between the FMC and NUH but also in the inter-professional interactions between FPs and Specialists, Nurses, Pharmacists, and Allied Health providers from both the FMC and NUH. There are regular CME sessions for the FMC team, attachments of the FPs to SOCs and ward round participations. The FPs are regularly in contact with the hospital clinicians (especially via emails and telephone) to discuss and sort out various clinical issues of the patients. A common EMR template facilitates this effectively. In a sense, the patients are cared "jointly" by the FPs and hospital specialists, and escalation to hospital care is only done when truly needed.

As the FMC facility is integrated into the NUHS Regional Health System (RHS), the spectrum of disease conditions that can be managed in the community can be broadened. Our FMC is refining its algorithm to stratify high risk patients that require more intensive care in a bid to keep them healthy in the community. Conditions not typically managed in primary care are now being co-managed with the specialists at the FMC - these include rheumatological conditions, liver cirrhosis with fluid overload, post stroke management of blood pressure, patients on anti-coagulation, direct inpatient referrals to FMC for intensive post hospitalisation care etc.

Frontier FMC currently functions as a truly integrated extension of NUH. This is not only in the provision of care as the patient moves seamlessly between the FMC and NUH but also in the inter-professional interactions between FPs and Specialists, Nurses, Pharmacists, and Allied Health providers from both the FMC and NUH.

The dearth of data to drive care often lull healthcare providers into a deluded sense of achievement. Frontier FMC benefited from the LEAN methodology in engineering its work processes. The doctors and staff participated in the Rapid Improvement Event conducted by the NUHS Way team and reviewed its KPIs (these KPIs were developed after buy-in by the team) in work processes weekly in a bid to cut waste. On the clinical front, clinical indicators at the team level and individual physician level help the FMC team constantly work on reengineering their workflow to improve on patient clinical outcomes. The intent is to constantly adopt quality improvement strategies to enhance its operations to achieve quality and safety in its care delivery. Our research colleagues from Yong Loo Lin School of Medicine and Saw Swee Hock School of Public Health are tracking the various process and outcome indicators, not just at disease level, but potentially useful data at systems level are analysed as well. These will contribute to future population health strategies at the RHS level in future.

It is acknowledged that funding drives behaviours of both patients and providers. Current business model in the private sector is largely dependent on face to face consultations and prescriptions. With about 39% part of our time devoted to unfunded proactive care between patients' appointments for our high-risk patients, healthcare funding must kick in to help sustain this model of care if it is proven to be effective from a healthcare system perspective. This funding model have to be different from traditional private business models and may lead to transformational models of primary care that focuses on quality outcomes in patient care.

CM

An Interview with Dr Joanna Tan

dr joanna tan, mother of 6!

Interviewed by Dr Low Sher Guan Luke, FCFP(S), Editor

College Mirror (CM):
I recently heard from Gamaliel that both of you have 6 children, and you also work part time as a family physician at Tan Teoh clinic & Surgery. I personally think that is quite a feat that you are juggling with. How do you balance work and family so well?

Dr Joanna Tan (JT):
I work three weekday mornings. I am happy to say that I truly love my job and enjoy seeing my patients. I am very grateful to have a wonderful and supportive boss like Dr Tan Chai Lee.

Dr Joanna Tan and family - six children and a dog

I spend one weekday morning going for spiritual formation such as doctrine class and confession while the other weekday morning is spent on housekeeping, ad-hoc volunteering work or meet up with old friends or teachers. My afternoons and evenings are generally reserved for the family; ferrying or coaching my kids.

My husband and I make it a point to go for drinks occasionally after dinner for some couple-time. I do not have any parental help and have only one domestic helper who has been with me for many years. My faith is the main pillar of strength for me. I try to attend mass daily. It gives me the peace of mind, fortitude, cheerfulness and a charitable heart as I deal with life's daily struggles.

CM:
I can really see your passion in parenting. Not many will consider having 6 children! What made Gamaliel and you reach that decision?

JT:
Gam and I are both Catholics. We have been taught to be open to life. We initially wanted only 4 children but gladly accepted whatever the Lord gave. We believe that children are blessings from God. It has been said that the best gift you can give your child is

a sibling and we second that. Our kids are constantly learning to share and help one another. The dynamics in a big family is different from that of a small family. Of course, they are constantly squabbling too!

CM:
You also upgraded professionally with the GDFM. Why did you choose to do the GDFM despite all odds?

JT:
I actually wanted to do MMed (Family Medicine) but was not successful at the interview (haha! because I said I wanted to have regular hours for my family). Anyway, I did the next best thing which was the GDFM. I felt the need to improve myself professionally if I wanted to be a good GP. I was in the pioneer batch. In fact I did two concurrent postgraduate diplomas at that time. I applied for the graduate diploma in dermatology and was successful so I decided to do it too. At that time, my son was less that 2 years old and I was expecting my second child. Juggling between a full time job, night calls, family and studying for 2 postgraduate diplomas definitely wasn't easy but I was blessed - I even managed to get a distinction for my graduate diploma in dermatology!

CM:
Gamaliel is the Head of Department (HOD) for Jurong Health Orthopaedics, as well as the Chief Medical Information Officer (CMIO). They say that, behind every successful man is a supportive wife. I suppose that holds true for you?

JT:
Gam is definitely the other pillar of strength in my life. He has been very supportive of my decision to go part-time as we both felt that family was important. Although he is very busy, he tries to help out in whatever way he can with the children. He is also an excellent husband who has always been generous with me. Because we share the same faith, our outlook in many issues are similar and we bring our worries to God as a family.

CM:
A lot of us hope that our children can aspire to doctors as well. Do you hold out that hope too?

JT:
We can see that each of our children has a different talent. For example, our eldest son is good in sports while another is more artistic. Of course, we hope that at least one of our children will follow our footsteps but at the end of the day, they have to do something they enjoy. I think that is important as we want them to be happy.

CM:
Are your children proud to tell their friends that both their parents are doctors and surgeons?

JT:
All my kids know their father is a doctor. However when they were younger, not many of them realized that their mother is a doctor too. I recall my kids coming back from school and asking me whether I was a doctor because their teacher told them so! I found that quite amusing. My kids generally do not tell their friends that we are doctors. I think they don't find that fact a big deal as we don't make a big deal out of it at all.

CM:
Lastly, do you have any tips for many aspiring lady doctors who wish to juggle work and family?

JT:
I think female doctors are fortunate in a sense that our profession allows us to work part-time in a fulfilling way and at the same time spend time with our kids. I feel that as mothers, we have the patience, compassion and empathy that helps us to communicate better with our patients. It would be a waste to give that up. We can contribute back to society by being both a good mother and doctor.

CM

Image courtesy of Dr Joanna Tan

Book Launch – *Counselling Within the Consultation*

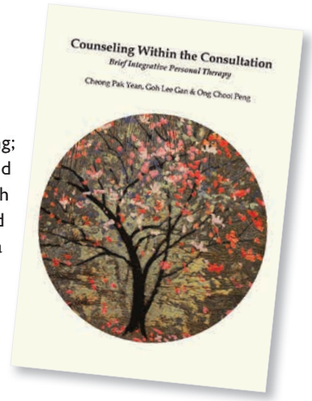
by Dr Lim Lee Kiang Julian, FCFP(S)

The much anticipated launch of the book "Counselling Within the Consultation" was held at the Medical Alumni on 31st Jan 2015. It attended by and audience of about 30 during which they were given glimpse into the inspiration and perspiration behind the book.

Authors of "Counselling within the Consultation" - (from left) Dr. Ong Chooi Peng, A/Prof Cheong Pak Yean and A/Prof Goh Lee Gan.

A/Prof Goh Lee Gan kick started the event by sharing three personal clinical situations that highlighted the need for including counselling within the consultation: the executive insomniac after the collapse of Lehman Brothers; the obese housewife who had accepted that she had to live with her obesity; and the herpetophobic who crashed her car after seeing a lizard on the dashboard.

A/Prof Cheong Pak Yean then shared with us the development of the Brief Integrative Personal Therapy based on his personal experience as a Family Physician and his professional development while doing his Masters degree in professional counselling. Using the Ec = (4P)2 approach: the "Extended consultation" that included the 4P issue formulation (Predisposing; Precipitating; Perpetuating; and Protective) and the 4P psychological approach (Pattern; Problem; Process; and Positive), A/Prof Cheong gave a demonstration of the technique with Mrs Karen Sng on stage to drive home the message. A/Prof Cheong concluded the session by reminding us that: "You can be a good doctor" – an affirmative "you can" and a command "be a good doctor".



Dr Ong Chooi Peng then shared with us the tale of the two songs to illustrate the process of appreciating art through knowledge - that "sometimes what a doctor offers his patient is not a pill but his presence" – an art that is usually painstakingly honed with the trial and error of practice but can be quickly cultivated with knowledge and training as Dr Lee Suan Yew so eloquently put it in the review: "Experienced doctors may have been practising such consultations but it is now systematized beautifully". Get a copy of the book and sign up for the course to deepen the learning!

The book at S$20 each can be purchased from book agent, Cynthia Yeow
Tel: 96681004 Email: auntiecynthiay@gmail.com

The teaching of communication and counselling skills based on this book would be the subject of a presentation by A/Prof Cheong at the FM Teachers' Conference highlighted in page 22.

CM

Images courtesy of the authors

NOTICE

We would like to request for the following past publications to be contributed to our archives:

The Singapore Family Physician (SFP)
1. SFP Vol 23(2) April - June 1997
2. SFP Vol 24(4) October - December 1998
3. SFP Vol 26(3) July - September 2000
4. SFP Vol 26(4) October - December 2000
5. SFP Vol 31(2) Supplement April - June 2005
6. SFP Vol 34(4) October - December 2008
7. SFP Vol 35(1) Supplement January - March 2009

College Mirror
Early issues of the newsletter since January 1994

To contribute, please contact the College Secretariat at **6223 0606** or email to **information@cfps.org.sg**. We will proceed to make further arrangements on the collection details.

All kind contributions are greatly appreciated.

What does the *Samurai* and the *Doctor* have in common?

by A/Prof Lee Kheng Hock, President, 24th Council, College of Family Physicians Singapore

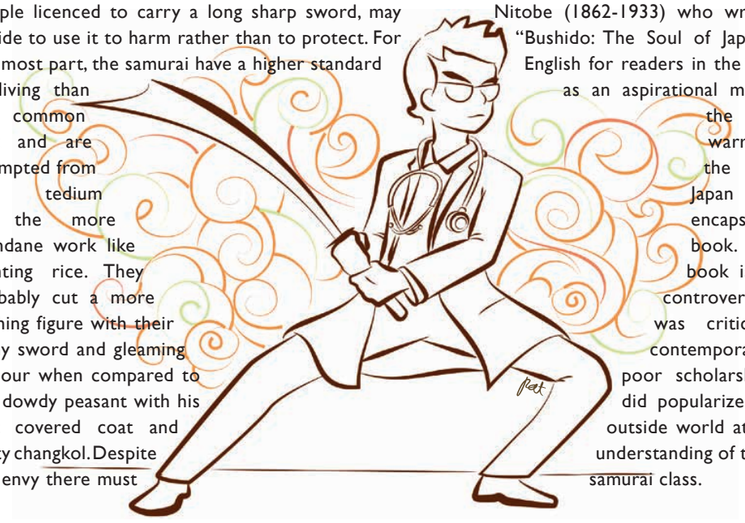
I met a very interesting friend last month who helped me re-discover the roots of professionalism. Professor Hiroshi Nishigori is an academic GP who is presently working at the Centre of Medical Education in the University of Kyoto. Hiroshi Nishigori gave a very interesting lunch time talk entitled "Bushido and Medical Professionalism in Japan". From the title you can already guess that it may not go down well with the politically correct educationist. Bushido often conjures up images of wartime atrocities and militarism. This is unfortunate because Bushido is actually a moral code for the samurai.

Most of us have a romanticised understanding of the samurai shaped by the many movies that we have watched, often featuring dashing Caucasian man in the lead role of screenplays that are on supra-physiological doses of artistic licence. It is very hard to imagine what it is like to be a real samurai. In some way it is a privileged class of elites in society. They have to undergo arduous special training before they are officially qualified for the role. They are expected to do things that ordinary non-samurais are unable to do. They provide security to the lay persons and are entrusted with authority so that they can carry out their duty. On further reflection there are indeed some similarities between being a samurai and a modern day doctor.

An ordinary person at that time probably looked at a samurai with a mixture of fear, envy and respect. They are fearful that the samurai, who were the only people licenced to carry a long sharp sword, may decide to use it to harm rather than to protect. For the most part, the samurai have a higher standard of living than the common folk and are exempted from the tedium of the more mundane work like planting rice. They probably cut a more dashing figure with their shiny sword and gleaming armour when compared to the dowdy peasant with his dirt covered coat and rusty changkol. Despite the envy there must have been a glimmer of respect for they understand that not everyone have the physical endowment to become a samurai. The training is tough and the skills level that must be attained is exacting. Most important of all, samurai are respected because beyond the glamour, they are expected to endure stress, danger and hardship in the course of their duty that is beyond what is expected of an ordinary person in a more mundane occupation.

To keep such highly trained and potentially dangerous public servants on their best behaviour would require more than simple reward and punishment. Perhaps that is why professionalism came into being. The dictionary defines professionalism as the conduct, aims, or qualities that characterize or mark a profession or a professional person. At a deeper level, we appreciate that professionalism goes beyond such a definition. Throughout history and in different cultures, there are unwritten aspirations that we have for people with special skill who are entrusted with authority and respect so that they can carry out their duty for the greater good of the community. Such an understanding passes on from generation to generation. The well-being or demise of civilisations often depends on how well such a value system is transmitted.

Attempts at making this explicit are often clumsy and sometimes counter-productive. The end product is often a caricature of the aspiration or a code book that prescribe behaviour without context. One successful attempt was by the Japanese author Inazo Nitobe (1862-1933) who wrote the book "Bushido: The Soul of Japan" (1900) in English for readers in the West. Bushido as an aspirational moral code for the professional warrior through the history of Japan was well encapsulated in the book. Although the book is not without controversy and Nitobe was criticised by his contemporaries for poor scholarship, the book did popularize and help the outside world attain a level of understanding of the ways of the samurai class.



More importantly it describes common and almost universal attributes that we wish people in the professional class should attain. Consider the 7 virtues that are enshrined in the code:

Righteousness (義 gi)
Courage (勇 yū)
Benevolence (仁 jin)
Respect (礼 rei)
Sincerity (誠 makoto)
Honour (名誉 meiyo)
Loyalty (忠義 chūgi)

A warrior who follows the true spirit of such a code would not be capable of committing any atrocity and will carry out his duty well. Referring to the true spirit of Bushido, Professor Nishigori sees a close parallel to the medical profession's aspiration to be better doctors. He argues that there is no need for educators and professional leaders to constantly re-invent the wheel or to look towards contemporary gurus of medical education. Many of such gurus may come from a different culture and they often advocate for ideas that are out of context with Asian cultures.

I think Hiroshi is wise. I had come across a few colleagues who constantly parrot faddish pseudoscience and expert opinions that they had heard in medical education conferences without thinking through and putting things in context. To a certain extent, we had been trained to doubt our personal experiences and reject anything old as being incompatible with our present evidence-based reality. The wisdom of tradition and our heritage are regarded as obsolete and unreliable. Hiroshi's message resonated with me. For a better understanding of professionalism and the hope that it will continue to flourish, we need to look to the past and remember our tradition.

Learning that Bushido originated from neo-Confucianism, I searched and re-discovered the 8 tenets (八端 ba duan) of proper conduct distilled by Confucian scholars. They were congruent, almost identical to the virtues of Bushido for after all, these are universal values and they all originate from the Sage. The eight correctitude described in ba duan are: 孝、悌、忠、信、礼、义、廉、耻

孝（xiao）*Filial piety*
Respect for parents, elders and teachers

悌（ti）*Fraternal piety*
Respect and duty to siblings and peers

忠（zhong）*Loyalty*
Duty to country, community and organizations

信（xin）*Trustworthy*
Deserving of trust in interaction with others

礼（li）*Propriety*
Proper and appropriate conduct

义（Yi）*Righteousness*
Morally right and justifiable

廉（Lian）*Incorruptible*
Not swayed by consideration of personal gains

耻（Chi）*Sense of shame:*
Sensitized to the conscience and motivated to do right

Recently I met another wise and interesting person. A successful, savvy Chinese businessman who had made his millions and who is now semi-retired in Silicon Valley. He told me that he find doctors, soldiers and teachers to be "simple" and very endearing. He meant it as a compliment. In a self-deprecating manner, he said that if they were all like cut-throat businessman there will be chaos in the world.

That gave me an epiphany.

Imagine a world without professional virtues. There is no piety. Seniors and teachers are regarded not as benefactors but as people who are in the way of your own advancement. Likewise there is no collegiality or respect for your peers. There is no loyalty to institutions that you serve or represent. Not even to the community that you work in or the country that you live in. There is no honour. Promises and contracts are inconveniences that you put up with until you can break it without being caught. There is no such thing as appropriate conduct. You do what brings you pleasure and profit. You freely exploit your juniors and your patients. Everything is relative. Nothing is really right or wrong. It is just a matter of perspective. Maximising personal benefits is the ultimate purpose of a job and all means of achieving this is justifiable. Sense of guilt or shame is to be resisted as it is nothing more than manipulation by others to weaken you and hinder your pursuit of personal success.

Reflecting on this alternate universe of chaos, I can almost see Confucius in his travels across the land during the Warring States period of China. He must have seen terrible things. There was incessant war and hardship for the common people brought on by greedy warlords and corrupt officials. It was a time that was trapped in perpetual chaos and misery. He must have seen an alternate and better world. A world that is only possible if people entrusted with authority aspires to the virtues of professionalism. We live now in this better world. Not perfect, but much better than the alternate world. We must advocate for and hold dearly to professionalism.

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For a better understanding of professionalism and the hope that it will continue to flourish, we need to look to the past and remember our tradition.

Let's Change the Game

for a Better Community Health Screening Accountability

by Dr Yee Jen Jet Michael, Council Member, College of Family Physicians Singapore

Prisoners' Dilemma

Two co-conspirators of a petty crime were arrested and interrogated separately by the police. There were no objective evidence to implicate them; hence the only way to get a conviction was if both of them confessed to the crime. The prisoners were well aware of the quandary of the police and both resolutely refused to confess by keeping silent, hoping their mutual fidelity would pay off with the ultimate prize of freedom from incarceration for both partners in crime. The police were clever enough to identify the hitch and plotted to change the rules of the game by offering immunity from conviction, provided that any co-operation helped them with the other's conviction.

The goal of the game has not changed and the best course of action to achieve the best case scenario of freedom for both prisoners has remained to refrain from participating. However, the dynamics of the game has changed. Each prisoner began to doubt if the other's loyalty would hold out, until he gave in and decided to ensure his own benefit instead. The most likely scenario is that both prisoners would confess on their own volition, earning the police a full confession without having to adhere to the prior promises of immunity. The same dynamic would apply if the story consisted of more than 2 prisoners or for multiple sets of prisoners. The strategy would lead to a full participation in most cases resulting in demise for all.

The story entitled, 'Prisoners' Dilemma' is a well known illustration of the Game Theory that was expounded by a brilliant American Math Professor, John Nash, who was featured in the movie 'A Beautiful Mind'. The story should not be read with moral overtones, but is a pure mathematical example of how any situation has an in-built expected outcome, the Nash Equilibrium, given the dynamics of the circumstance and the powerful implied application of utilizing strategic change in various disciplines ranging from business to economics, to even healthcare to achieve the desired outcomes.

A New Screening Norm

There is a prevailing trend towards mass screening of residents at designated community venues without pre-test counseling at the GP clinics. The results would then be posted to the GP clinic of patients' choice for interpretation of results. Appears harmless enough on the surface, but GPs who are trained in the practice of ethical medicine and familiar with private sector primary care industry would have several concerns:

1. Inappropriate Test

The new screening programme utilizes mass communication instruments and enticements to attract the target groups to a cookie cutter designed screening regimen that may or may not be appropriate for the patients that are participating. Some might be unduly influenced by the herd mentality effect and price discounts offered. Others are under the mistaken impression that the tests were appropriate for them because they were endorsed by highly regarded organisations. Those with pre-existing chronic diseases would have important test(s), such as electrolytes and HBA1C, omitted which are detrimental to the optimal management and safety of these patients. This inefficient 'mass-production' methodology, while expected to generate high public visibility and admirable uptake statistics, would however come with hidden issues of wasted public funds for inappropriate test, complacency and might adversely impact the health of these individual patients.

2. Unclear Professional Responsibilities

Where do professional responsibilities lie for potentially sensitive investigation results that were sent to a GP without a prior duty of care? The investigations were ordered by one physician, but interpreted by another physician who was likely unclear of the reasoning behind the diverse purpose for which such test was ordered. Abnormal results requiring urgent follow up might be left unattended to. The lines of professional responsibilities have hence become unclear. This situation is not only potentially dangerous for our patients but also put innocent GPs at risk of negligence. The local health authorities have already previously issued statements to warn against such practices. GPs should best avoid schemes that compromised their professional autonomy and patient safety. Some of my ethical GP colleagues, have already officially excluded themselves from such schemes.

3. Fragmented Care

Patients would not be able to go back to their regular GPs if the clinics were not participating in the programme. This would increase the chances of non-adherence to chronic care treatment and disrupt the continuity of care that is so important in the management of chronic diseases. Alternative care arrangements to GPs or other doctors or allied health workers who are not familiar with some of the intricacies of that particular case would not be able to optimally manage these 'dislocated' patients. The doctor-patient relationship is fractured. Professionally competent physicians who are familiar with the health screening concept would be in an ideal position to administer and co-ordinate a national preventive care programme of this nature.

4. Resource misallocation

While charity remained a central ethos of many private GPs, further pressure to provide discounted services or free services without provision of necessary resources would damage the industry, made up largely of small operators with ever expanding overheads. More significantly, there is potential compromise to patient safety in an environment already straining under the biased government subvention system in community healthcare. Miscommunication or misunderstanding of the health financing structure would lead to many unhappy encounters at the GP clinics. The allocation of funding to preventive care at the community is an excellent far reaching scheme, as it not only provided affordable and accessible preventive care to residents, but also potentially reduced healthcare cost and suffering from lessening the burden of complications from chronic diseases in the near future through timely detection and long term intervention. However, funding structures that weaken the professional doctor-patient relationship or disrupt the continuity of care are undesirable.

How is that Relevant to the Game Theory?

Many private GP clinics who have participated in these community screening programmes schemes would have had shared experience of having expended much time mending strained professional doctor-patient relationships. It would be tempting to just overlook the ethical, safety and quality discrepancies and agree to participate based on less than ideal terms. You see, that was the new Nash Equilibrium given the latest health administration and health screening matrix. The liberalized standard of community screening programme had changed the dynamics to lure GPs into practicing in a situation that we might not be totally comfortable in.

Fortunately, that was not the end of the story. The Prisoners' Dilemma template only worked if there was no communication between the 'prisoners' involved and 'prisoners' began acting in their own selfish interest. If all the prisoners remained faithful, they would escape demise. GPs can still have hope in indulging in ethical and safe practices if we continue to stay true to our calling and collectively refrain from unsafe and unsustainable practices. Unlike prisoners, GPs also have the option to communicate with each other. Organisations who try to exploit GPs' isolated nature and principled behavior would fail if we had communicated more. This screening scheme was not the first time the Game Theory was applied on GPs to exploit us. Other organisations also used the same tactics to corner GPs into accepting meagre consultation fees and restrict the use of effective treatment modalities.

Controlled experiments with respect to the 'Prisoners' Dilemma' showed consistently that repeating the same 'game' would recalibrate the results to cause the odds to favour the 'prisoners' as players became 'wiser' and collegiate was built up. The repeated application of this trick and our ability to learn collectively has given us a fresh awareness of these schemes and strengthen our resolve to do what is right. It might be unrealistic to expect others to behave in the same level of ethical standards, but that does not mean that GPs should compromise our standards. The ostensible liberalization of standards must not cause us to flinch, but instead embolden GPs to take up responsibility as staunch advocates for our patients. At stake is the interest and safety of the public and our patients and the cost effective quality of Family Medicine in Singapore. A similar strategy would enable GPs to snub out unethical screening and practices.

What is the Desired Outcome?

The 2010 National Health Survey showed that about half of subjects with diabetes and dyslipidemia and one quarter with hypertension are undiagnosed. It is understandable that innovative mass screening programmes were implemented to increase the screening take up rate. The intention to uncover the hidden problems of undiagnosed chronic diseases in the population is clearly an important one. However, that on its own will not help with the more important task to reduce the disease burden of secondary complications, which was projected to be overwhelming in the near future, unless effective integrated care and continuity of follow up was also taken into consideration. A 2010 survey of over 60 year old cohort in Singapore reported that among the elderly, 30.8% were unaware of their high blood pressure; but of significance, 75.9% had suboptimal control 2. Increasing once off screening coverage at the expense of patient safety and professional ethics is not only foolish, but also unlikely to impact real outcomes. In addition, GPs are also concerned about patients' safety, confidentiality, cost effective follow up, medical ethics and good doctor patient relationships. The health prevention visit is a good opportunity to strengthen the doctor-patient relationship to encourage adherence to any necessary treatment and continuity of care. Those patients without a regular GP should be advised to seek one out as soon as possible. Health authorities must allocate resources appropriately and continue to send the right message to this end. The time tested ISP had a better screening protocol where the patients were subsidized to go to their regular GPs for pre-test counseling before any recommended vaccinations, screening test, health education, health promotion was dispensed.

What Do Other Experts and the Evidence Say about Community Health Screening?

The medical literature dating back to the 80s has been largely skeptical of community health screening fairs as the outcome benefit and harm are uncertain. Studies done on community health screening fairs measured mainly outputs such as how many people were screened but not impactful outcomes such as survival benefit or morbidity reduction nor cost effectiveness of these programmes. The screening protocol, population selection, types of lab test, accuracy of results, follow up rates and qualifications of organizers and volunteers are highly variable.

The American Heart Association had similarly expressed concerns about the potential dangers of poorly conducted community cholesterol screening programs. The Americans recommended focusing on smaller-scale screenings with potential for higher return and getting blood cholesterol and blood pressure measurements as part of an overall plan of medical care. The physicians or para-professionals working at the direction of the physician should order the cholesterol tests and interpret the result for the patient, then direct any follow-up care if needed, such as prescribing a diet, exercise program and drug therapy. They further recommend integrating community health risk assessment programs into the medical care system. These systems should ensure that test results are interpreted by the physician responsible for the patient's care. As recognized earlier, when considerately implemented, public screenings do have the potential to detect large numbers of people with high blood cholesterol levels.

A meta-analysis of general health checkups in the general adult population, published in the BMJ 2012, found no improvement in real outcomes including total mortality (risk ratio 0.99), cardiovascular mortality (risk ratio 1.03) or cancer mortality (risk ratio 1.01) despite the increased pick up

(continued on Page 14)

rate of chronic diseases, even for screening programmes involving traditional doctor patient contact. The lackluster results were reportedly not a result of chance nor of low statistical power. The same study also suggested that there could be misplaced complacency of well being and suggested that it could be due to the lack of continuing care among other explanations.

According to a systematic review, involving 41 studies and 28,700 participants, published on the 28th February 2013 in the Cochrane Database of Systematic Reviews, patients were able to make better informed decisions and choices when given the risk information based on their own personal risk profile instead of an average public risk profile. These results were extrapolated from breast and colorectal cancer screening programmes. Researchers from the Cochrane Institute of Primary Care and Public Health, Cardiff University concluded that adequate involvement of healthcare consumers and informed decision making are now as important as goals for screening programmes.

Organisations dealing with community care and health prevention must adopt these international standards and recommendations to provide a cost effective screening programme that we can support and develop together. These adopted standards should be able to stand up to scientific and professional scrutiny implemented urgently and audited regularly.

Integrated Tsunami Prevention

Without further intervention, the new Nash Equilibrium could possibly compromise the effectiveness of health screening as a central disease burden prevention tool, in the context of the urgency and impact of the Silver Tsunami. It is no wonder that Institutes of training for health professionals have always emphasized the importance of professional ethics, personal and collective responsibility. It could be the motivation that kept us from falling in the rough and tumble world of medical practice.

Unfortunately, some community health schemes with good intentions do not meet prevailing standards and some schemes are not even intended to improve health outcomes. The immediate consequences could see GPs being blamed again for all manner of inadequacies. The ultimate victims are in fact our patients and society itself. The entire healthcare ecosystem, and not just the GPs alone need to understand and work together as responsible and accountable stakeholders.

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Clinic Computerisation *Just done it!*

by Dr Chan Hian Hui Vincent, FCFP(S), Editorial Board Member

An Impending Crisis?

"What are we going to do with all those cards!" exclaimed our chief clinic assistant one morning. That was about 6 months ago. It was an impending problem, as dad and mum had been operating our clinics since 1976 and had been using a written clinical card records system. The fact that we just renovated 2 years ago, meant that the physical space available was getting less and less. In a way, this problem was compounded by worry of medical litigation, hence the need to keep as many cards, and for as long as possible.

Shall We Computerise?

Thus began the process of deliberation, as we considered the options of keeping to the status quo versus computerisation. While the choice was clear to me, the former polyclinic doctor of 5 years, it must seem like a great leap forward for mum, dad and our clinic nurses. This was due to fears that the workload generated by this process of change might overwhelm us, and disrupt daily clinic operations. But the problem of physical space for our clinical record cards needed to be addressed.

Another factor weighed in, and that was our instinct that CHAS and the Pioneer package are good government programs, there to help us manage patients better.

Yet mum and dad had been worried about its implementation. While it is true, that we can still administer these programs manually with pen and paper, this would be less efficient and possibly prone to errors. Having to liaise with MOH, and weary of audits, we would prefer a more accurate system. The reassurance that computerisation would aid us in this regard tipped the balance, and the decision was finally made to go ahead.

Choosing a Vendor

To be fair, we were "half computerised". By this, I mean that our billing, dispensing and inventory were electronic with our trusty DOS based system of 20 years. What was "manual" were the written card based records. The decision was for a fully computerised system that included electronic clinical records. With a few vendors available in the market, I proceeded to ask my good friends and colleagues, especially those with locum experience about the best program. Naturally each program had their pros and cons.

We finally settled on the vendor who promised a degree of after sales support and affirmed the ease of CHAS submissions. The bill was of course significant, but we were fortunate that our two clinics qualified for iSPRINT and the PIC (Productivity and Innovation Credits) grants, which promised to significantly cushion our expenses. This covered computer software and hardware respectively. Admittedly, the accompanying paperwork was initially quite daunting. However these became more manageable once the vendor stepped in to guide us along. Even after submission to the relevant agencies, we had to answer several queries here and there. These are mainly clarifications though.

The Computer Guys are Here!

Then came D-day, literally, when the vendor came to the clinic and set up all the hardware and software in one afternoon. This infrastructure was set up within 2 hours, and data migration from the old program done. Once completed, we began training session 1. All our clinic assistants and us doctors paid full attention to the trainer, since there were only 2 training sessions in all. There were many features of the program we bought and we absorbed as best as we could. It was a lightning fast session of 2 hours, after which we were left on our own to explore the program in real live action.

Balancing the Pros and Cons

In the course of our computerisation exercise, here are some of my thoughts on the pros and cons from a second generation perspective:

Pros of full clinic computerisation

- The appearance of keeping up with the times. A few patients actually said we are now "modern".
- Clinically, our clinical records are now legible to all staff including our clinic assistants, locums, regular doctors and even ourselves.
- The system helps us stay neat by allowing us to scan loose notes, results and referral letters. The best part is that scanned notes stay in excellent condition for a long time.
- The use of "customised templates" during case clerking, helps us speed up, while maintaining a certain quality for each electronic record entry.
- I suspect that research potential exists, as data could possibly be mined from these electronic records.
- Improved financial governance, as the system allows the prescribing doctor greater awareness of the actual costs of medicines and treatment. This helps us optimise resources for patient care.
- We are now better placed to launch CHAS and Pioneer Package in our clinics.
- Reduced use of manual patient record cards. We still used the written cards, just in case of computer breakdown, though we have reduced the entries to diagnosis and medications for now. We will review this once our confidence in the system grows.

Cons of full clinic computerisation

- We do find ourselves a little slower in seeing cases, but this might improve with time and familiarity.
- Subconscious fear of a computer crash and data wipeout. Though i must emphasise that there is no precedent for this as yet.

Reflections... A New Epoch

It has been about 2 months since the implementation of a fully electronic system at our 2 clinics. Overall, we have come to get used to the new system. Though the initial data migration had a few mismatches, this was gradually (and is still being) rectified. Our grasp of the electronic medical records has also improved with familiarity. We are also happy that the system allows us a better view of the entire clinic operations.

It was sheer hard work though, moving to this new fully computerised system, and we are fortunate to have the full support of all our clinic assistants who rallied to the cause. Though we had not yet done away with the clinical record cards fully, we have managed to streamline the number of words written down, since most of the data is in the electronic form. This meant that less cards are needed overall. And of course we are now more confident in starting CHAS and Pioneer package in our clinics. Looking back, we were glad to have taken this great leap forward, and as my dad just said to me, "why didn't we do this earlier?"

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THE PUBLIC HEALTH PREPAREDNESS CLINICS SCHEME

Public health threats such as haze and influenza pandemic are on the rise. To better manage these threats in the primary care setting, the Pandemic Preparedness Clinics (PPC) and the Haze Subsidy schemes will be consolidated into the new Public Health Preparedness Clinics (PHPC) scheme, launching in April 2015.

In a public health emergency, PHPCs will be promptly informed of their roles via SMS and circulars.

SUPPORT PROVIDED TO PHPCs DURING PUBLIC HEALTH EMERGENCIES

- Priority for medication and vaccine supplies from the national stockpile
- Tamiflu supply for PHPC staff for prophylaxis at no cost
- Up to 12 weeks of PPE may be provided to PHPCs at no cost
- Standard Operating Procedures to guide management of each public health emergency

ROLE(S) OF PHPCs DURING PUBLIC HEALTH EMERGENCIES

- Dispense medications* (e.g., Tamiflu, antibiotics)
- Administer vaccinations* (e.g., flu vaccines)
- Provide subsidised treatment

*in accordance with MOH guidelines

BEING PREPARED IS HALF THE BATTLE WON.

Current PHPCs, thank you for supporting the scheme!
Do keep an eye out for the e-learning module that will be launched soon.

HOW TO SIGN UP AS PHPC

FOR EXISTING CHAS CLINICS ON EITHER PPC AND/OR HAZE SUBSIDY SCHEMES:

Your clinic has been automatically enrolled into the PHPC Scheme*

FOR CLINICS ON CHAS ONLY:

If your clinic is on CHAS only, sign up for PHPC via Primary Care Pages website (https://www.primarycarepages.sg/microsite/PHPC_signup)

FOR CLINICS YET TO BE ON CHAS:

Sign up for both CHAS and PHPC by contacting AIC. Email us at gp@aic.sg or call our hotline at 6632 1222

* unless you have opted out before 31 Jan 2015.

UNSURE OF WHICH SCHEMES YOUR CLINIC IS ON?

Contact AIC and we will be more than happy to help. Email us at **gp@aic.sg** or call our hotline at **6632 1222**.

VISIT WWW.PRIMARYCAREPAGES.SG/PHPC FOR MORE INFORMATION

Sexual Medicine and the Family Physician

by Dr Lee Mi-Li Jean Jasmin, MCFP(S)

"Would you like to go on a 10-day course in Hungary on Sexual Medicine?" asked my boss Dr Ang Seng Bin. My mouth gaped open in surprise not knowing if he was joking. Doubts flitted through my mind, foremost was the panicky thought, " What will my husband say?"

After working for the past 2 years in the Family Medicine Service at KK Women and Children's Hospital (KKH), I knew that this course would be very useful in my daily practice. In our clinics, we treat women with menopause, chronic illnesses and osteoporosis. Many of them have sexual concerns and issues, which I also manage with the support of the physiotherapist and psychologist. Dr Ang was keen to set up a multidisciplinary sexual dysfunction clinic in KKH. During this period, I found that there are few clinical sexologists in Singapore, and they are mostly gynecologists and urologists.

In our local context, discussing sexuality and sexual issues is still very much a taboo for the older generation and for those who had a conservative upbringing.

It is important for us to realize that sex is an integral part of being human. Love, affection, and sexual intimacy contribute to healthy relationships and individual well-being. However there are also illnesses, mixed emotions and unintended consequences that can affect patients' sexual health. When I started my medical career in the polyclinics a decade ago, the hurried, time scarce consultations were not conducive to broach this subject with patients. I was also quite clueless and lacked confidence in advising my patients about sexual issues.

When I was doing my Masters in Family Medicine (MMed Fam Med) a few years ago, I met a few senior General Practitioners like Dr Julian Lim, who shared their experiences in discussing sexual health issues with their patients. It impressed upon me that family physicians do play a key role in promoting sexual health and responsibility.

The WHO definition of sexual health is "…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." (WHO, 2006a)

Seng Bin and I with some of the participants from Netherlands and Finland on our afternoon off exploring Budapest.

So I was very curious to find out what this Sexual Medicine course entailed. I found out that The European School of Sexual Medicine has been running this course since 2007. It is a joint venture established by the European Society for Sexual Medicine and the European Federation of Sexology. This 10-day course covered a wide range of topics including sexual development, psychology and physiology of sexual desire, arousal and response, impact of gender on sexuality, ageing and sexuality, sexual dysfunctions in men and women, problematic sexual behavior, gender identity disorders, impact of medical treatments and other health problems on sexuality, clinical skills in Sexual Medicine, clinical management of sexual disorders, genital dermatology, ethical and legal aspects of Sexual Medicine and standards of care in Sexual Medicine.

My husband, who is a family physician, was very supportive and encouraged me to go for this course and reassured me not to worry about our three young children during this period. And so Dr Ang and I packed our bags and landed in Budapest in October last year. There were 35 course participants from all over world. Most were from Europe - Italy, Belgium, Netherlands, Finland, Poland, Czech Republic, United Kingdom & Ireland, Yugoslavia and Greece. There were also participants from Saudi Arabia, Israel, India, Brazil, Mongolia and of course the two of us from Singapore. We met psychologists, psychiatrists, gynecologists, urologists and a handful of family physicians like ourselves. Many of them had already been treating patients with sexual dysfunctions in their practice and were keen to improve their knowledge and skills.

The course was intensive with lectures starting at 8.30am and ending at 7pm daily. We had half a day's break during the week to rest and explore the city. During mealtimes we had the opportunity to get to know our course mates better and it was an eye opener to learn more about different cultures and how they approach sexual health in patients in different countries. One evening we all went together on a short night city tour after dinner. This was followed by a memorable boat trip down the River Danube.

The speakers flew in from all around Europe and not only were they well versed in the topics they were speaking on, they also had many years of experience in clinical practice. During this course, the speakers kept emphasizing on the use of the Biological, Psychological & Social approach in dealing with clinical sexual problems. As we often use this same Bio-Psycho-social approach to teach and practice family medicine locally, it dawned upon me then, that we as family physicians are probably in the best position to deal with our patients' sexual concerns. Family physicians are able to evaluate and integrate these three domains in an effective and comprehensive manner. Our strength also lies in the fact that we often have longitudinal relationships with patients over time and look at the maintenance of health issues, preventive health and can handle multiple problems at one time. Also, we often have both partners as patients.

Majority of sexual problems in general practice can be helped simply by giving patients information and reassurance about the normal physiology of the human sexual response. As family physicians, we should proactively address the sexual health of our patients. I used to be hesitant about discussing sexual issues with my patients. I would hesitate or cringe inwardly when I had to mention words like 'orgasm' or 'masturbation' during consultation with my patients. However I soon realized that many of my patients were happy, some even relieved when I raised the topic. They had been hoping for the opportunity to discuss their sexual health problem, however they were too embarrassed to bring it up during consultation. We can also help couples cope with the effects of chronic illness and cancers with anticipatory counseling. Through continuity of care and rapport, the trust gained will allow our patients to confide in us, their family physicians, with greater ease.

In general practice we should consider wellness in addition to infections, contraception, and sexual dysfunction. When we allocate the time to discuss sexual health during consultation, high-risk sexual behaviours that can cause sexually transmitted diseases, unplanned pregnancies, and unhealthy sexual decisions may be reduced. A useful tool for every family physician keen to embark in sexual medicine would be to develop a routine way to elicit a patient's sexual history in a sensitive and comprehensive manner that is appropriate to our local culture. Normalizing the subject of sex during consultation may take some practice but perseverance will pay off. During this course, I learnt two key points in taking a sexual history. Firstly, to always ask the patient for permission to discuss sexual function and secondly to always avoid being judgmental.

When we allocate the time to dicuss sexual health during consultation, high-risk sexual behaviours that can cause sexually transmitted diseases, unplanned pregnancies, and unhealthy sexual decisions may be reduced.

Lunchtime visit to a sex shop with course participants and lecturers to learn about sex aids.

In some complex cases, our patients may need input from our gynecology or urology colleagues for co-management. We should also not hesitate to offer to arrange for couples counseling for patients' with relationship issues. There is a sense of satisfaction and happiness like no other when I see my patients improve and when they are better equipped to cope with their sexual problems after treatment.

As Family Physicians, when we are successful in integrating sexual medicine into our general practice, we not only decrease the morbidity and mortality of our patients, we also improve the overall well-being and quality of life of our patients and their loved ones.

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All images courtesy of Dr Lee Mi-Li Jean Jasmin

Why We Doctors Should Go Back for Reservist

by Dr Low Sher Guan Luke, FCFP(S), Editor

It is that time of reservist again, having to go back to the jungle wearing green and doing a series of exercises which aims to preserve our sovereignty when needed. I vividly recall the massive blood donations every time in the mosquito infested jungles, where these blood suckers thirst for our visitations simply because they are so… starved and deprived! Nonetheless, I still look forward to that once-a-year event which allows me to clear my head amidst the tranquility of the jungle (though sometimes broken by the buzzing of mosquitoes near my ears). The fact that I'm stuck in the wilderness with no internet, email connections and all sorts of other distractions, allow me to think clearer and reflect deeper on many other matters which happens on those other 351 days of the year.

Earlier on just before I entered reservist, I met up with a good old friend of mine who has been telling me that I have tried long and hard enough to change people's opinions and that enough was said already. Much as I knew what he told me was the honest truth, I felt compelled not to let the other party down and give up hope. That naive part of me felt like it was my duty to persevere on to debunk certain delusions, but the logical part of me knew how hopeless and bleak the situation was turning out.

Fast forward to the current time when I'm in the jungle, and engaging our guys in "jungle talk" who have been out with me together for the past 3 days and 3 nights. In case you think it's because my talk is mesmerizing, you are so wrong. This is the only time when I receive undivided attention because there are no smartphone distractions. It's not easy to connect beyond the jungle to the outside world. Whenever I whip out my trusty 10-year-old Nokia dumb, camera-less phone, it logs onto "MY CELCOM" for at least 50% of the time instead of the anticipated "Starhub". That's when I know I'm quite far from the nearest Singapore cell station. So these guys have no choice but to jungle talk with me, being cut off from the rest of Singapore. But it was good because I tapped on their wisdom from wherever they came. They are a potpourri of guys including doctors, nursing officers, property agents, bankers, lawyers (yes, they do earnestly come back for reservist despite many people assuming that they do not), teachers etc. And one of them shared this story below, which many of us knew since our childhood as "The Emperor's New Clothes".

Long ago, there lived an emperor, who thought so much of new clothes that he spent all his money in order to obtain them. His only ambition was to be always well dressed. He did not care for his soldiers, and going to the theatre did not interest him. The only thing, in fact, he thought anything of was to go out and show himself off with new clothes as often as possible. He had a coat for every hour of the day. As often as you would say of a normal king "He is busy ruling the kingdom," you could say of him, "The emperor is in his dressing-room trying on new gear."

One day, two swindlers came to this city and pretended to everyone that they were weavers. They said that they could make the finest cloth anyone could imagine. Their colours and patterns, they said, were not only very beautiful, but were made of a special material invisible to any person who was stupid.

"That must be wonderful cloth," thought the emperor. "If I were to be dressed in a suit made of this cloth I would be able to find out which people in my kingdom are stupid and therefore should not be in their jobs. I must have this cloth made for me without delay."

And he gave a large sum of money to those rascals, in advance, so that they should get to work immediately. They set up two looms and pretended to be very hard at work. They asked for the finest silk and the most precious gold-cloth. All they expensive material they got they hid away for themselves and worked at the empty looms till late at night.

"I'd love to know how they are getting on with the cloth," thought the emperor. But he felt worried when he remembered that anyone who couldn't see it was stupid. He thought that of course he would be able to see it, but decided to send someone else first to check it out, just in case. Everybody in the town knew how remarkable the clothes were and were dying to see how bad or stupid their neighbours were.

"I shall send my honest old minister to the weavers," thought the emperor. "He can see how it looks, for he is very clever."

The good old minister went into the room where the swindlers sat before the empty looms. "Goodness gracious!" he thought and opened his eyes wide, "I cannot see anything at all," but he did not say so. Both swindlers told him to come near and asked him if he did not admire the lovely pattern and the beautiful colours, pointing to the empty looms. The poor old minister tried his very best, but he could see nothing, for there was nothing to be seen. "Oh dear," he thought, "Can I be so stupid? I would never have thought so, and nobody must find out! Is it possible that I am too stupid to do my job? No, I cannot admit that I wasn't able to see the cloth."

"Have you got nothing to say?" said one of the swindlers, while he pretended to be busy weaving.

"Oh, it is very pretty, really beautiful," replied the old minister looking through his glasses. "What a beautiful pattern, what brilliant colours! I will tell the emperor that I like the cloth very much."

"We are pleased to hear that," said the two weavers and described to him the colours and explained the curious pattern. The old minister listened carefully, so he would be able to tell the emperor what they said.

Now the swindlers asked for more money, silk and gold-cloth, which they said they required for weaving. They kept everything for themselves and not a thread came near the loom, but they continued, as before, to pretend to work at the empty looms.

Soon afterwards the emperor sent another good man to the weavers to see how they were getting on, and if the cloth was nearly finished. Like the old minister, he looked and looked but could see nothing, as there was nothing to be seen.

"Is it not a beautiful piece of cloth?" asked the two rascals, showing and explaining the fantastic pattern, which, however, did not exist.

"Maybe I am not clever enough for my job. I must not let anyone know that" and the man praised the cloth, which he did not see. "It is very excellent," he said to the emperor.

Everybody in the whole town talked about the precious cloth. At last the emperor wished to see it himself, while it was still on the loom. With a number of assistants, including the two who had already been there, he went to the two clever swindlers, who now worked as hard as they could, but without using any thread.

"Is it not magnificent?" said the two old men who had been there before. "Your Majesty must admire the colours and the pattern." And then they pointed to the empty looms, for they expected that the others could see the cloth.

"What is this?" thought the emperor, "I do not see anything at all. That is terrible! Am I stupid? Too stupid to be an emperor? That would indeed be the most terrible thing that could happen to me."

"Really," he said, turning to the weavers, "your cloth is wonderful, really wonderful." He nodded contentedly as he looked at the empty loom, because he didn't want to say that he couldn't see anything. All his attendants, who were with him, looked and looked, and although they could not see anything more than the others, they said, like the emperor, "It is very beautiful." And all of them advised him to wear the new magnificent clothes at a great procession which was soon to take place. "It is magnificent, beautiful, excellent," they said. Everybody seemed to be delighted, and the emperor appointed the two swindlers "Imperial Court weavers."

The whole night before the day on which the procession was to take place, these two rascals pretended to work, and burned more than sixteen candles. They wanted people to see that they were busy finishing the emperor's new clothes. They pretended to take the cloth from the loom, and worked about in the air with big scissors, and sewed with needles without thread. At last they said: "The emperor's new clothes are ready now."

The emperor and all his barons then came to the hall. The swindlers held their arms up as if they held something in their hands and said: "These are the trousers!" "This is the coat!" and "Here is the cloak!" and so on. "They are all as light as a cobweb, so light in fact, that it feels as if you have nothing on at all, but that is just the beauty of the clothes."

"Indeed!" said all the assistants, but they could not see anything, for there was nothing to be seen.

"Does it please your Majesty now to undress," said the swindlers, "that we may help your Majesty in putting on the new suit in front of the mirror?"

The emperor undressed and the swindlers pretended to put the new suit on him, one piece after another.

(continued on Page 23)

2015 FAMILY MEDICINE TEACHERS' CONFERENCE

Dear Friends and Colleagues,

Trainees from the Family Medicine Fellowship Programme 2014 – 2016 are working together with College of Family Physicians Singapore to organise a Medical Pedagogy Workshop this year in conjunction with the celebration of World Family Doctors' Day (WFDD). This is a special day to commemorate the important role and contribution of Family Doctors from all around the world.

Family medicine in Singapore has grown and evolved rapidly, especially in the recent years. Teaching will continue to be a core area so as to upkeep standards and vigour. Through this workshop, medical pedagogical skills will be imparted to Fellowship Programme trainees and medical educators within the Family Medicine community.

As Singapore celebrates SG50, we will also walk down the medical pedagogical memory lane together with our Family Medicine teachers and pay tribute for their hard work and commitment to medical education over the past decades.

We would like to invite you to join us at this enriching and meaningful workshop, which will be held on **Saturday, 23 May 2015** at the **NUS-Shaw Foundation Alumni House**.

We are happy to inform that registration is **exclusive and at no cost** to College members or FM residents. CME points will be awarded for attendance. The workshop will also culminate with a WFDD Dinner held at the adjacent **NUSS Kent Ridge Guild House** for a delightful evening with fellow members of our Family Medicine fraternity.

We very much look forward to your participation. Please email us at **fmtc2015@cfps.org.sg** for registration details. The closing date is **15 April 2015**.

THEME	TRACK	MAIN		
	Venue	Auditorium		
	Time	Programme		
Assessment	0830 - 0900	Registration		
	0900 - 0905	Welcome		
	0905 - 0935	Practice Based Assessment and One-Minute Preceptor *by A/Prof Goh Lee Gan*		
	0935 - 1000	Video Clips on Mini-CEX: Positive & Negative Demonstrations *by A/Prof Goh Lee Gan*		
	1000 - 1015	Discussion and Q&A *by A/Prof Goh Lee Gan*		
	1015 - 1045	Tea Break		
	1045 - 1130	OSCE Setting *by Dr Matthew Ng*		
	1130 - 1215	Essentials of Setting Good MCQs *by Dr Winnie Soon*		
	1215 - 1330	Lunch		
Teaching	1330 - 1340	Photo Montage: Fond Memories of FM Teaching *by FMFP Trainees*		
	1340 - 1410	Plenary: Down the Medical Pedagogical Memory Lane *by A/Prof Goh Lee Gan & Dr Julian Lim*		
	TRACK	A	TRACK	B
	Venue	Auditorium	Venue	Seminar Room 1
	Time	Programme	Time	Programme
	1410 - 1455	Counseling within the Consultation *by A/Prof Goh Lee Gan*	1410 - 1455	M.Med(FM) Programme B Course Strategies *by Dr Julian Lim*
	1455 - 1525	Insights into GDFM Teaching *by Dr Kwong Kum Hoong*	1455 - 1525	Bedside Small Group Teaching *by Dr Farhad Vasanwala*
	1525 - 1555	Tea Break	1525 - 1555	Tea Break
	1555 - 1625	Undergraduate Teaching: YLLSOM *by Dr Lim Fong Seng*	1555 - 1625	Postgraduate Teaching: NUHS Residency *by A/Prof Tan Boon Yeow*
	1625 - 1655	Undergraduate Teaching: Duke Medical School *by A/Prof Lee Kheng Hock*	1625 - 1655	Postgraduate Teaching: SHS Residency *by Dr Sally Ho*
	1655 - 1725	Undergraduate Teaching: LKCSOM *by A/Prof Wong Teck Yee*	1655 - 1725	Postgraduate Teaching: NHG Residency *by Dr Darren Seah*

(continued from Page 21: Why We Doctors Should Go Back for Reservist)

The emperor looked at himself in the glass from all sides.

"How well they look! How well they fit!" said all. "What a beautiful pattern! What fine colours! That is a magnificent suit of clothes!"

It was announced that it was time to start the procession.

"I am ready," said the emperor. "Does not my suit fit me wonderfully?" Then he turned once more to the looking-glass, so that people would think he was admiring his clothes again.

Two boys were there to walk behind the emperor, to hold up the train of the emperor's clothes, that is the material from his clothes that would otherwise trail behind on the ground. They stretched their hands to the ground as if they lifted up the train and pretended to hold something in their hands. They did not like people to know that they could not see or feel anything.

The emperor marched in the procession under a beautiful canopy and all who saw him in the street and out of the windows exclaimed: "Indeed, the emperor's new suit is amazing! What a long train he has! How well it fits him!" Nobody wanted to admit they saw nothing, for then it would mean they were too stupid. Never were the emperor's clothes more admired.

At last a little boy piped up. "But he has nothing on at all! He's completely nude!"

"Good heavens! I'm sorry about that," said the embarrassed father. "He's just a simple boy who doesn't know any better." But soon, the whole crowd was whispering what the child had said.

"He does have nothing on at all," cried all the people, realising the truth. The emperor suddenly realised they were right, but he thought to himself, "Now I must keep pretending until the end or I'll look even more stupid."

So the emperor tried to walk with even greater dignity, while the crowd laughed and teased him all the way to the end. Afterwards he sent his soldiers to arrest the two swindlers, but they had fled the city with all the money and precious material.

For the rest of his days, people joked about the time the emperor went for a parade with no clothes on and he never lived it down.

From this story, we could see that the young boy being fearless and innocent, was frank in pointing out something that was obviously wrong. The ministers having deeply-rooted fears of negative judgement from the emperor and humiliation from their peers, stayed silent and failed to provide proper advice and counsel, ultimately resulting in the emperor's own public humiliation and display of foolishness. Of course, the swindlers got away, and we can guess they will probably live many more days of deceit in another kingdom and plant more delusions in other emperors. My friend practicing psychiatry defines a delusion as an idiosyncratic belief or impression maintained despite being contradicted by reality or rational argument. It is often not easy to be the one to debunk a delusion. It takes a discerning person with all his neutrality and honesty, and putting aside all pride, to know that it smells of a rat.

Oh wait, I think I smell maggi mee, but in the jungle? Someone must be cooking that! Strange, why is it that maggi mee, when cooked at home, smelt so ordinary, but when cooked in the jungle, smells so extraordinary? I think that is because we take certain things for granted. That's why we should go back for reservist, because it allows us to reflect on those little daily conveniences we take for granted and make us treasure them more. We do not know what we have lost, till we have lost it.

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2015 FAMILY MEDICINE TEACHERS' CONFERENCE

IT'S EXCLUSIVE! *For College Members & FM Residents*

Please tick the appropriate boxes:

I am a ☐ College Member
☐ FM Resident (NUHS / SHS / NHG)**please circle one*

I'd like to attend the following session(s):
☐ AM ☐ PM Track A
☐ PM Track B

Would you be staying for dinner? ☐ Yes ☐ No
(Dinner commences at 6.30pm at NUSS Kent Ridge Guild House)

Name: Dr_____

MCR No.:_____ Email:_____

Contact: (HP)_____ (Office)_____

Please submit the completed form by **15 April 2015**. Submission can be made via **Email**: fmtc2015@cfps.org.sg or **Fax**: 6222 0204
For enquiries, please call 6223 0606.

CAREER SEMINAR *in* FAMILY MEDICINE

DATE
14 MARCH 2015 (SATURDAY)

TIME
12.30 - 2PM -- REGISTRATION AND LUNCH
2 - 5PM -- SHARING AND BRIEFING

VENUE
MOH AUDITORIUM,
COLLEGE OF MEDICINE BUILDING

ADDRESS
16 COLLEGE ROAD, #01-02
COLLEGE OF MEDICINE BUILDING, SINGAPORE 169854

Visit **www.cfps.org.sg** for more details

Registration Closing Date: 24 April 2015

Graduate Diploma in Family Medicine

GDFM

The GDFM is a structured training certification programme jointly organized by College of Family Physicians Singapore (CFPS) and The Division of Graduate Medical Studies (DGMS).

GDFM is a 2 years comprehensive and structured training programme for primary care doctors. It consists of Family Medicine Modular Courses (FMMC), Practice Management Course, Family Practice Skill Course (FPSC) and Clinical Revision Course. The aim is to train primary care doctors to practise Family Medicine at an enhanced level to meet the needs of the child, adolescent, adult and elderly.

Eligibility

The GDFM candidate must possess the following to be eligible to register for the GDFM programme:

- A basic degree of the MBBS or equivalent qualification registered with the Singapore Medical Council (SMC)
- Full or conditional registration with the SMC; temporary registered practitioners must support their applications with a letter of recommendation from their HOD
- Must fulfill CME requirements
- Must have 1 year working experience in Singapore
- Must hold a current and valid practicing certificate

For enquiries or details, please contact College Secretariat at 6223 0606 or email **gdfm@cfps.org.sg**

Master of Medicine in Family Medicine

MMed(FM) College Programme

The MMed(FM) College Programme is a one-year structured training programme tailored for GDFM graduates who wish to proceed to Masters level training. The course consists of weekly evening tutorials, FM rounds, workshops and seminars, preceptorship sessions and a practice audit. Trainees will find the practice audit useful in helping them formulate quality improvement processes to enhance patient care outcomes.

Clinical attachments for various specialties are designed to provide the breadth of exposure for trainees to acquire the requisite competencies to practise as FPs in the local context. Each trainee is attached to a supervisor assigned by CFPS.

Aims & Objectives

The aim of this one-year course is to provide a comprehensive and structured training programme for doctors with at least 6 years' experience after graduation and have completed the 8 modules of the Family Medicine Modular Course (FMMC) to prepare them to sit for the MMed(FM) Examinations

Eligibility

Registration with SMC	To have full or conditional registration with the Singapore Medical Council (SMC)
Training	The satisfactory completion of all 8 modules of the Family Medicine Modular Course not more than 5 years prior to completion **OR** Have attained MRCGP(UK)
Work Experience	At least six years of experience after graduation of which at least one year must be in a Family Medicine setting. Make up attachments may be required to make up for the shortfall in this experience
Clinical Work during Training	The trainee will be required to sign an undertaking that he/she is able to continue working at least 6 sessions a week of which 2 sessions must be in an approved Family Medicine setting
Clinical Inspection & Interview	This may be conducted when required to assess the suitability of the practice and candidate for MMed(FM) training

For enquiries or details, please contact College Secretariat at 6223 0606 or email **information@cfps.org.sg**

Family Medicine Fellowship Programme

FCFP(S)

The Fellowship [FCFP(S)] programme by assessment is a 24-month family medicine structured programme with the following aims:

- Provide structured advanced directed and self-initiated learning
- Provide supervision and mentorship for the advanced clinical practice of family/community medicine
- Provide a framework for the education and research in the practice of family medicine

Eligibility

Academic

- Possess the MMed (Family Medicine), the MCGP (Singapore) or equivalent qualification **OR**
- Possess MMed (Internal Medicine) or MRCP (UK) or equivalent internal medicine training, and GDFM* with at least 6 months experience working in a family medicine practice setting of which at least 3 months must be in primary care# **OR**
- Possess MRCGP(UK) or equivalent overseas family medicine training and GDFM*

All candidates must be conferred the MCFP(S) before being able to sit the FCFP(S) exit examinations.
** GDFM trainees with relevant qualifications may enrol into the Fellowship Programme during their Final year.*
 # Applicants via these two routes must pass a MCFP(S) by Assessment exit examination before being conferred the MCFP(S).

Clinical Practice

- Currently in active clinical practice in a family medicine setting (at least 28 hours/week)

The eligibility criteria for the Summative Assessment are:

- Satisfactory completion of all training requirements, and
- Collegiate Membership of the College of Family Physicians Singapore. Members without the Collegiate Membership may enter the training programme but will not be allowed to sit for the exit assessment without fulfilling this criterion.

Please note that the trainee must apply and sit for the exit assessment within 2 years from the end of his/her training period. Following which, the trainee is expected to re-apply and restart the FCFP(S) programme.

For enquiries or details, please contact College Secretariat at 6223 0606 or email **programmes@cfps.org.sg**