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Health Minister Mr Gan Kim Yong (in red) and Minister of State for Health Dr Lam Pin Min (second from left) joined Pioneer GPs and medical students at the SG50 Appreciation Dinner. *Image courtesy of AIC*

Singapore Thanks Our Pioneer GPs

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

The Ministry of Health (MOH), Agency for Integrated Care and our College of Family Physicians Singapore (CFPS), co-organized the SG50 Appreciation Dinner for our Pioneer Generation General Practitioners (GPs) on 30th October 2015. This was held at the Copthorne by the Waterfront Hotel ballroom, and it was graced by Health Minister Mr Gan Kim Yong, Minister of State Dr Lam Pin Min, AIC Deputy CEO, Dr Wong Kirk Chuan and College President A/Prof Lee Kheng Hock.

Minister Gan aptly summed up the event, when he mentioned that "as we celebrate Singapore's Golden Jubilee this year, we gather to honour our Pioneer GPs in recognition of your efforts and support of the development of the national healthcare system for more than 50 years." For example, the challenges of the early years were that of accessibility to basic health care services and how this has changed over the years. Today, Singapore is served by a wide network of private medical clinics spread throughout the island, providing easy access to health care as well as a "variety of services" given the diverse skill sets among today's GPs. Minister took this chance to thank all GPs for supporting the government's Chronic Disease Management Program (CDMP), Community Health Assistance Scheme (CHAS), Pioneer Generation Package (PGP) and Haze Subsidy Schemes. These were excellent programs by which the government channelled resources to participating GPs in order to enhance primary care.

On overcoming the national crises of the SARS and H1N1 outbreaks in 2003 and 2009 respectively, Minister Gan saluted GPs and all frontline staff who despite potential risk of exposure to the viruses, did remain steadfast in duty, until the outbreak was finally contained. In particular, he hailed "our pioneer doctors, (who) in the roles they have played during these crises, have also set a firm foundation for future doctors to build upon." He

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expressed hope that younger generation of doctors and medical students "(would) be inspired by the dedicated and selfless attributes of these pioneering doctors."

During the dinner, A/Prof Goh Lee Gan and A/Prof Lee Kheng Hock spoke about how the College of General Practitioners Singapore was formed on 30 June 1971 by a determined and visionary group of GPs, who saw the need to champion academic Family Medicine and raise standards for our fraternity. And how our College has continued to push the boundaries, gaining recognition both internationally and locally. To signify the academic charter of the College, the very first issue of "The GP" was published on 1st March 1973. This was to be our own medical journal, and it was renamed the "Singapore Family Physician" in 1975. Teaching was organized as well, and by 1974, the MCGP(S) designation was recognized by the Singapore Medical Council. College also organized its first major international conference in May 1983, the 10th WONCA World Conference on family medicine. Many other milestones and achievements followed.

Then Dr James Chang took the stage and shared some anecdotes with all about GP practice in those early years. He spoke about how his was a solo practice in a rural setting, where patients were poor and did at times pay in kind. For example, a patient once gave him 2 live chickens which he had no choice but to keep in the toilet, since his clinic session was ongoing. However, another patient had a fright when he was about to use that toilet. In another anecdote, he related about how he had to make an urgent house call at an even more remote location, where after a long car ride, he still had to walk a distance. Herein lies the key importance of history taking, as the patient had complained of urinary retention. He was well prepared, and once he got to the site he performed urinary catheterization with the Foley catheter and the patient was immensely grateful. There were many anecdotes, and judging from the laughter, these must be stories that many of our Pioneer GPs can relate to.

It was a wonderful experience joining in this appreciation dinner for our Pioneer GPs. I found it enlightening to hear about the history of Family Medicine in Singapore, both from a policy and ground level perspective, and to appreciate how our discipline has progressed tremendously together with our nation. It was also a night of fun, and from across my table at one of the "100% Pioneer GP tables" I could see that they were having a great time chatting about old and new times. Pioneers like Dr Moti Vaswani, Dr Neo Eak Chan and Dr Tan Cheng Bock were among those I could name. To commemorate the event, AIC and MOH presented a custom made SG50 Parker pen for all Pioneer GPs, as a gesture of Singapore's thanks for their work and contributions.

To our pioneer GPs... We salute you!

CM

Convocation 2015

ADDRESS BY GUEST-OF-HONOUR

~ *Dr Lam Pin Min*

Delivered by Dr Lam Pin Min, Minister of State for Health

Welcome

Associate Professor Lee Kheng Hock,
President, College of Family Physicians Singapore
Distinguished Guests
Ladies and Gentlemen
Good evening

Introduction

1. It is my pleasure to join you at the annual Family Medicine Convocation Ceremony. Let me extend my heartiest congratulations to the graduating class of 2015 on the successful completion of their training.

2. Family Physicians are a key group of medical professionals playing an important role in delivering care to our population today. Our graduands now join the ranks of their seniors in meeting the care needs of patients, amidst a growing national chronic disease burden and healthcare affordability concerns.

Challenges Facing an Ageing Singapore

3. As we celebrate Singapore's Jubilee Year, it is timely for us to reflect on the journey that our primary care sector has taken against the backdrop of changing demographics. Over the last 50 years, Singapore's population has grown from 1.87 million to 5.5 million. The number of citizens aged 65 and above has doubled in the last 15 years, and is expected to double again in the next 15 years.

4. Given the ageing population, chronic disease management and home care will become increasingly important in primary care.

Accessible and Affordable Primary Care

5. The Ministry of Health appreciates the partnerships of our Family Physicians and General Practitioners to ensure that primary care remains accessible and affordable to Singaporeans. The Community Health Assist Scheme (CHAS) has been significantly enhanced in recent years, such as the relaxation of the patient qualifying criteria. In addition, the Pioneer Generation Package was introduced in last year in recognition of our Pioneers' contributions to nation-building, giving all Pioneers access to CHAS. The Chronic Disease Management Programme (CDMP) was also expanded in June this year and now covers a total of 19 chronic conditions. These enhancements have allowed

Thank You For Flying with CFPS!

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

12 July 2014 – Ladies and gentlemen, good morning. Welcome on board flight CFPS. This is your Captain speaking and I have some information about our flight. Our flight time will be 1 year 4 months, and our estimated date of arrival in MMed(FM)-land is 28 November 2015. The weather in our route is unpredictable, but the forecast says it will be sunny in MMed(FM)-land when we arrive, so let's look forward to that. We remind you that if you need any special attention, all our tutors will be ready to assist you. In-flight alcoholic beverages are not encouraged as you need a clear mind and strong heart during this flight. Enjoy!

7 November 2015 – Ladies and gentlemen, keep your seat-belts fastened! We are flying through a turbulent area. Thank you!

28 November 2015 – Ladies and gentlemen, we have already started our descent procedure into MMed(FM)-land airport. We expect to land at 6pm. We wish you a pleasant stay in MMed(FM)-land and we hope to see you again very soon, flying into fellowship-land. On behalf of all our crew, thank you for choosing CFPS as your airline. Thank you and have a pleasant holiday!

At the mention of holidays, the picturesque images of the destinations will spring into mind. What gets us busy subsequently will be the planning of itineraries that stretches from arrival to departure. However, few will ponder over the flight plan, or even the things that can go wrong mid-flight. We often feel that is the job of the pilot, and we just need to enjoy ourselves upon arriving at the holiday destination. Unfortunately, exams are not quite like taking holidays. The trainees are not passengers who will be brought to the destination. In fact, the trainees are the pilots of their planes. To enjoy a holiday at the destination, we must fly there safely to begin with. Over the previous batches of trainees, I have come to realize that some are really not mentally prepared. They think about how good it will be after passing exams, to have qualifications under the belt, to be the registrar or consultant of the ward or clinic. They did not bother to think of the process of getting there, the pain that will be inflicted, the sacrifices that need to be made, the sweat, blood and toil that will be required.

Being one of the tutors, we have had our fair share of trainees relating their struggles of time management to us, and how little time they have each day to do their write-ups, studies and exam preparation. Many of them wear multiple hats ranging from being doctors in their workplace, employers to many staff and subordinates, filial children to their parents, loving partners to their spouses, nurturing parents to their children, and sometimes committee members or leaders in some organizations. There is certainly no argument on how thinly stretched we are and how much multi-tasking is expected of us. To add on the burden of exams and training, seems to be unthinkable. Yet many trainees still choose to take the hard path, to go beyond human limits. It will take the most committed of trainees to follow through the training all the way to the end and to pass the exams. Of course, we can argue that starting the training but not passing is certainly better than not starting out on any training at all! Nonetheless, once we have started on a race, there is a certain obligation to finish it, and finish it well. A lot of time, effort and grooming may be invested in the trainees by their sponsoring institutions, much as the trainees sometimes fail to recognize what is at stake and the consequences of a disappointing fail.

As I have told some trainees, I am not sure if I am allowed to add more hours to the 24 per day that we already have. But we can certainly "steal" time. It is really a productivity issue. When we took the Hippocrates oath, we swore to be good doctors to our patients. This should hold true during the hours that we spend in the clinic or hospital. At work, we need to be focused on work, and not much on family matters or even… where to go for dinner, or what to do after work. Productivity at work matters, failing which we end up with having to bring work home. Many also look at me in disbelief when I tell them how I wake up at 5am daily, leave house at 5.30am and reach workplace at 6am to "start" the day, even earlier than the house officer. Most people still do not believe that I do that, though my immediate neighbours near my table will bear witness in my favor. Of course the work with patients never start that early, but the quiet and undivided time I have between 6-8am allows me to focus on studies and exam preparations, and amazingly a lot can be done during those early hours! On occasional days after I am done with the clinic or hospital work, staying back for an hour after work will allow me to steal more time to get my studies done. All in all, stealing 3 hours a day equates to 15-21 hours per week. That's almost one whole day extra per week. I know of a few other guys who do that as well, including some heads of departments. We know this is the easiest way to steal time amidst heavy responsibilities and multiple hat wearing.

I shall now leave you with a quote from Sun Tzu - "Whoever wishes to fight must first count the cost". Be convinced in yourself that the cause is worth fighting for and the cost is worth bearing, before fighting in the first place, so that you will not give up.

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ERRATUM

2016 CFPS Calendar

Members should receive a 2016 CFPS calendar together with this issue of the College Mirror.

Under the page titled "Community Health Assist Scheme (CHAS)", the chronic conditions - *Epilepsy, Osteoporosis, Psoriasis, Rheumatoid Arthritis* - should fall under a separate header as "Addition of 4 new chronic conditions from 1 June 2015".

FAMILY PRACTICE SKILLS COURSE

Emergency Medicine – What the Family Physician Can Treat

The College of Family Physicians Singapore would like to thank the Expert Panel for their contribution to the Family Practice Skills Course #63 on "Emergency Medicine", held on 26 – 27 September 2015.

Expert Panel:
Dr Kanwar Sudhir Lather
Dr Chua Mui Teng
Dr Vivien Lim
Dr Aw Chong Yin
Dr Sohil Pothiawala
Dr Nausheen Edwin
Dr Lim Jia Hao

Chairperson:
Dr Yap Soo Kor Jason
Dr Fok Wai Yee Rose

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more Singaporeans to be eligible for the scheme.

6. I am glad that many primary care colleagues have come onboard MOH's schemes, including CDMP, CHAS, and the Public Health Preparedness Clinics (PHPC) to ensure the accessibility of affordable primary care. Since the inception of the schemes, the number of participating clinics has grown steadily. There are currently about 1,050 CDMP clinics and 900 CHAS GP clinics.

7. I would like to take this opportunity to thank you all, our primary care colleagues, for your active participation and support. I also wish to acknowledge the contributions of our Pioneer family doctors, many of whom have spent decades providing care for many Singaporeans, and mentored the younger generations of primary care physicians.

Care Transformation

8. As our healthcare needs grow, we need to transform our healthcare model and right-site care. We envision patients needing fewer visits to the hospitals because of the effectiveness of Family Medicine in our general practices. Our well trained Family Physicians are therefore critical to this transformation of care.

9. In the past several months, we have engaged various primary care doctors to seek their feedback and suggestions. We will continue to do this, as we progress on the transformational journey in our vision for primary care to be the first and continuous line of care. Our long-term goal is to achieve "One Singaporean, One Family Doctor". As chronic diseases become more prevalent and continuity of care becomes increasingly relevant, we want to encourage patients to understand, value and "stick" to one family doctor. A long-term doctor-patient relationship will allow doctors to have a more holistic understanding of patients' healthcare needs, and an active partnership will help prevent diseases and ensure appropriate care.

Role of Family Physicians

10. Compared to 50 years ago, family doctors today do much more than provide clinical care, including promoting better health through disease prevention and early detection. The role of family doctors has evolved, managing a greater breadth and complexity of chronic patients, and being vital links between acute and community-based care. Patients will also look to their family doctors to help them navigate the increasingly sophisticated healthcare system. This is especially relevant for our ageing population.

11. To support the ongoing shift towards more person-centric care and a greater focus on care continuity and integration, we need more like-minded Family Physicians, trained and equipped to manage challenging patients with multiple health issues within the community. We will also need to broaden our understanding of what Family Physicians are trained to do. Today, MOH is looking to support and encourage the training of many more Family Physicians, who will embrace the challenge of post graduate training to equip themselves with broad-based clinical knowledge and skills. This generation of Family Physicians will work not only in the primary care sector, but also in the community hospitals, to help patients transit from acute inpatient care, through the rehabilitative phase, before returning safely back into their homes and the community.

Commendation for College of Family Physicians Singapore

12. On this front, I wish to commend the College of Family Physicians Singapore for their success in promoting Family Medicine. The College has shown foresight in building a robust training framework to advance the training of Family Physicians through its postgraduate training programmes, such as the Graduate Diploma in Family Medicine, Master of Medicine in Family Medicine Programme B, and the Fellowship Programme.

13. Through these programmes, the College has groomed many doctors into well-trained Family Physicians who are well-equipped to meet the changing healthcare needs of Singapore, and who work effectively alongside other healthcare professionals in various care settings.

14. There are currently 869 doctors with the Graduate Diploma in Family Medicine, 458 doctors with the Master of Medicine in Family Medicine and 134 doctors in the Fellowship Programme. Over 70% of our polyclinic doctors and 60% of the doctors in private GP practice are Family Physicians. These are promising numbers but are

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not enough, and we look forward to the training of many more doctors in Family Medicine, in the years to come.

International Endorsement

15. I commend your Fellowship Programme, which confers the highest qualification to Family Physicians in Singapore. Those seeking to qualify as Fellows undergo rigorous advanced study and training, supervision and mentorship, as well as education and research in the practice of Family Medicine. I note that the high standards of the Fellowship Programme have earned the endorsement from The Royal Australian College of General Practitioners in 2010 and from The Royal New Zealand College of General Practitioners this year. Such international recognition is a testament to the academic excellence of the training programme.

16. Your Fellows are important leaders whom we will depend on also to bring Family Medicine forward to achieve our goal to transform care.

Conclusion

17. Singapore has made great strides over the last 50 years in building a world-class healthcare system. Looking ahead, the Ministry will continue to support and work closely with the College and primary care doctors to transform primary care. Together, we can keep our nation healthy and productive over the years to come.

18. I am also confident that our graduands will ably rise to the challenges ahead. I wish you every success and a fulfilling career. Thank you.

CM

SREENIVASAN ORATION 2015

Reflections and Recollections over the Decades

Prof Chew Chin Hin, Sreenivasan Orator 2015 and Recipient of CFPS Honorary Membership

Minister of State for Health, the President of the College of Family Physicians, Members of Council, and Friends.

Allow me first to thank the President and Council for asking me to deliver the Sreenivasan Oration and to be an honorary brethren of the College. This is an incredible double honour; but I accepted not without hesitation and with much trepidation as President Lee knows of my ageing and failing voice box!

Prologue

Dr BR Sreenivasan was a remarkable physician, scholar, clinical teacher and administrator; more so a thorough and compassionate gentleman. I knew him from my childhood days, growing up in the grounds of the then Sepoy Lines General Hospital. The Sreenivasan family were once our neighbours at the doctors' quarters along Outram Road and have been long-standing family friends. Dr Sreenivasan and my father, Dr Benjamin Chew were fellow colleagues with Dr Gordon Ransome, serving under Dr V Landor and Sir Brunel Hawes, the Professor of Medicine at General Hospital (SGH); sometimes at Tan Tock Seng Hospital (TTSH), the main teaching centre for Clinical Medicine and Surgery before the Japanese invasion.

Disease pattern then was very different. There was the predominance of infectious diseases and malnutrition eg, tuberculosis

Prof Chew Chin Hin delivered the Sreenivasan Oration despite his failing voice box.

(TB), typhoid, dysentery, poliomyelitis, malaria, Beri-beri and other dreadful diseases. Many have now been eradicated, though some still remain. Besides being fellow colleagues, Sreeni and Ben Chew shared many common interests. Both were well read in the classics and literature. They were fellow students at the King Edward VII College of Medicine, graduating LMS in 1931 and 1929 respectively with a special interest in General Medicine.

With the internment of their colonial chiefs following the surrender of Percival to Yamashita in Feb 1942, they served as Heads of Medicine, Ben Chew at TTSH and Sreenivasan at Kandang Kerbau Maternity Hospital (KKH) which also served as a general hospital, SGH having been taken over by the Japs for their own military. With their dedicated local staff, doctors, nurses and others, they ministered to the thousands of patients with compassion; battling the horrendous diseases during the three and a half years of the Occupation.

Battle Against Tuberculosis

TB was a main concern with the huge numbers of well over two thousand and five hundred in a population then of just over a million. With hardly any effective drugs and post War problems, the government could hardly cope. Also with discriminating colonial policies, many local doctors left the service, despite the promise of better conditions and scholarships for specialist training in United Kingdom (UK), including Sreeni and Ben Chew. But both continued the battle against Tuberculosis in private practice, Sreeni in little India and Ben Chew in North Bridge Road. They were supported by likeminded prominent philanthropists and former grateful prisoners of war (POWs). They had helped them during internment. First, the Rotary Club funded and built the Rotary Tuberculosis Clinic at TTSH in 1948 at their behest. Soon after, they with 13 others foundered SATA, the anti TB association.

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in hospitals, nutritious diet, fresh air and sunshine. The paltry rich went to the Swiss Alps! Collapse therapy was another important measure. Thus TTSH became the TB and Chest center for over 15 years after WWII. An important and blessed outcome of the generosity of Rotarians was not only thousands of TB patients were seen and treated, but Rotary Clinic became the centre of TB Research trials and studies. The results paved the way for the present form of treatment of 6 months short course chemotherapy the world over, from the original regime of 2 years and sometimes more!

Dr Sreenivasan's contributions to the control and his battle against TB, as an early pioneer, have not been appreciated enough. I am sure he would be happy looking 'from above' at these achievements!

Advances in Medicine and Medical Education

With developments and technological advances in Medicine that we have seen over the decades, so too there has been a tremendous evolution in medical education and training, including general practice and family medicine.

The diploma of LMS that Dr Sreenivasan had, his license to practice medicine in 1931, was a much respected qualification. LMS was well recognized by the General Medical Council (GMC) of United Kingdom (UK) as equal to any throughout the Empire! Here in Singapore and for British Malaya, the professors were all 'generalists'. They taught their students to be holistic and ethical doctors with an emphasis on good clinical skills by the bedside, listening, taking and recording meticulous history of patients. They were all well rounded doctors at graduation. There was no mandatory housemanship. A number commenced forthwith their own mostly "solo" private practice with much success.

Those who wished to further their training were selected to remain in the hospitals, SGH, TTSH or KKH with Middleton for infectious disease or Yio Chu Kang for psychiatry. Some went to Public Health Service. Thus the teaching of Medicine with an emphasis on good bedside skills and sound ethical values was well suited for general practice. This was the situation until 1952 when a year of compulsory internship was introduced by the GMC for UK and the Colonies!

It was a personal privilege to watch Dr Sreenivasan in the same way teaching students by the bedside when he was an honorary teacher in Prof Ransome's Medical Unit I in the '50s. Here we also see amongst his friends the late Drs Danaraj, Evelyn Hanam and Seah Cheng Siang amongst the teachers!

Postgraduate Education and Training

Formal postgraduate education and training in Singapore became organized only in the 1950s. Following the British pattern and institutions, this began with the founding of the Academy of Medicine in 1957, largely through the foresight of Sir Gordon Ransome, the first Master. In 1961, the Committee of Postgraduate Medical Studies was formed, the predecessor of the Postgraduate School, now the Division of Graduate Medical Studies (DGMS) in the National University of Singapore (NUS). This was also the period when Singapore became more politically independent.

More formal traineeship began in the hospitals for potential specialists, but most still had to go abroad until we had our own professional qualifications. This was when our Master of Medicine degree was introduced in 1970, not without difficulties! Yes, this was a breakthrough as our trainees do not have to spend time and money going to faraway places to take the various examinations.

Another significant milestone was the founding of the College of General Practitioners in 1971 here, following the visit in the late 60s of the President of the British Royal College of General Practitioners, Lord Hunt. This was also the foresight of some well-respected 'private practitioners' including Drs Sreenivasan, Wong Heck Sing, Gordon Horne, Liok Yew Hee, Koh Eng Kheng, Wong Kum Hoong, Victor Fernandez and Evelyn Hanam, some names I dimly but happily recall. They were the giants of Family Medicine (FM). I also remember whether the proposed body should be formed as a chapter within the Academy of Medicine or follow the British pattern of a separate College. As many thought General Practice then was not a specialist discipline, the latter prevailed; thus the CGPS in 1971! More important however, must be the promotion of highest standards of Family Medicine.

A few of the founding members like Drs Gordon Horne and Evelyn Hanam, having been consultant Physicians, were early fellows of the AMS. Dr Horne's family practice here was a forerunner of group practices as were those of the Ministry of Health Outpatient Service, now termed Polyclinics as opposed to the many "solo" Clinics. This is an advantage as more discussion and consultation is readily at hand for the more difficult cases. I believe the practice named Horne, Chin and Partners still remains well! I also had the immense pleasure of admitting Dr Wong Heck Sing a fellow of AMS under a special provision.

I was very glad when asked to officiate and open the 1st Annual Scientific Conference in 1988 at the College of Medicine Building, home of the College. In my address I said 'General Practice must be seen as a rewarding discipline and the myth of GPs treating only minor ailments... should be quickly put to rest.', and concluded '..while we as doctors strive to find new approaches to diseases, the hallmark of a well-rounded physician is his ability to provide preventive medical education and care to his patients to keep them healthy. The family physician is best placed to ensure this...'

Progress in Family Medicine

There was a "changing of the guards" at Postgraduate School of Medical Studies (also) in 1988 when I succeeded Professor Seah Cheng Siang as Deputy Director. It was personally gratifying to proffer full support of the School to the proposals to establish formalized training, and bringing FM into

(continued on the next page)

(continued from Page 7: Sreenivasan Oration 2015 - Reflections and Recollections over the Decades)

our Medical School at the Department of Community and Occupational Medicine, and the award of the Degree of Master of Medicine (FM).

The first examination was in 1993, coming alongside the Membership of the College of General Practitioners (MCGP). MCGP was already of high standard since the 70s; comparable to those of the UK Colleges and Australasia, and also recognized by our Singapore Medical Council (SMC) as a registrable qualification. The MMed enhanced even further the high standing of FM. I had the pleasure of observing the first 2 Clinical Examinations at SGH and was happy to view the commendable reports of the 2 external examiners from UK and Australasia.

Towards the end of the 1990s, the Postgraduate School introduced several graduate Diplomas for family doctors with the support of the College. The first awards of the Graduate Diplomas in FM were in the auspicious year 2000. This was an incentive for many younger doctors to further advance their training in Family Medicine.

Finally only last year, I had the pleasure of personally endorsing the establishment of the Chapter of Family Medicine Physicians within the Academy of Medicine through discussions with President Lee of the College and Master Lim of the Academy and Senior Fellows. However, the fraternal relationship that exists between the College and Academy must remain strong, strengthening even further with time. This indeed has been a full circle when I admitted Dr Wong Heck Sing to the fellowship of the Academy in 1973 under a special provision. Here is a photo that included us when our dear President Sheares visited our premises at the old Alumni Medical Centre.

"Some Things Must Not Change"

With immense scientific and technological advances in Medicine and the accompanying excitement, let us pause, reflect and not forget our primary duty must always be to our patients and fellowmen. I remember seeing a title of a paper in the Annals of Internal Medicine of the American College of Physicians: 'Some Things Have Not Changed'. I would like to add 'somethings must not change'. These include the pillars of our Medical Ethics: beneficence, non-maleficence, justice and autonomy, holding fast to our values of Caring and Compassion, never abandoning our patient-centric fundamentals. We need courage for this as the Art and Calling of Medicine stand constantly in danger of contamination!

Epilogue

I would like to conclude by drawing your attention to a masterly paper by Dr BR Sreenivasan in the Proceedings of the Alumni Association in 1953. I had earlier mentioned that Dr Sreenivasan together with his contemporaries and peers like Dr Benjamin Chew was widely read. He was a man of letters and literature. When the Japanese occupied Singapore, doctors with nurses et al at Sepoy Lines GH with all their patients, were directed to leave almost immediately en masse. It was not possible to take much away. Let me quote Dr Sreenivasan, 'I took away with me only three books — the Bible, Shakespeare and Osler — because I felt that Osler could help me earn a living and the other two would give life a meaning'.

In the paper, he dealt at some length with St Luke 'the beloved physician', the author of the longest of the four Gospels, well known for his attribute of Compassion. Allow me to show you a 1887 painting entitled 'the Doctor' by the famous painter, Sir Luke Fildes (coincidentally also named Luke!). It shows the doctor on a house visit simply looking at the sick child and the distraught parents and sharing their anxiety with Compassion. Here is another painting, an Italian classic, vividly portraying the power of Compassion – the compassion of the 'Good Samaritan', treating tenderly and soothing the wounds of a Jew in the rescue process; despite Samaritans being despised by all Jewry. By Dr Luke's account of this parable, the man had been robbed, badly beaten and stripped naked, and shamelessly ignored by two pious fellow Jews who had passed him by. I show these two paintings as compassion must be a fundamental attribute of us all.

Let me end with Dr Sreenivasan's words: "Men must endure their going hence, even as their coming hither", and when I go hence I can think of nothing I would like better for an epitaph than 'Here lies a beloved physician'."

President, fellows and friends allow me to wish you all well, and may the College long flourish!

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Accompanying powerpoint slides of the Sreenivisan Oration can be viewed on www.cfps.org.sg/about-us/sreenivasan-orations

PROF CHEW CHIN HIN

Recipient of
CFPS Honorary Membership 2015

Train For What?

... might as well just make a living

by A/Prof Lee Kheng Hock, President, 25th Council, College of Family Physicians Singapore

You can lead a horse to water but you can't make it drink. So goes an old saying. I think many teachers like me feel the same way when we are faced with students who are not interested to learn. This saying is not entirely true. You can make the horse drink if you try. You can try putting the horse on a boat. Bring it to the deepest part of the river and push it overboard. As it desperately swims to shore and presumably gets through the ordeal alive, it would most likely have drank a few mouthfuls of water. Many of us had been victims of this style of teaching. There is a more humane and equally effective way. That is to feed the horse with lots of salted vegetables before bringing it to the water. Creating a reason to drink and a thirst for knowledge is important.

Many years ago when I was still working as a solo GP in my own practice, I signed up to join the first batch of FCFP(S) by assessment after completing my MMed (FM), I was thirsting for more knowledge. I knew there was more to family medicine than what I had learned. There were many detractors who planted doubts. I remember a kind senior colleague who was one of the pioneers of the College leadership. When he heard about this program he quipped,

"You know, we are all over-trained for what we are allowed to do… You sure you want to do this?" There was no cynicism or malice in his voice, just disappointment at the sorry state of family medicine as it was practiced then.

One of my seniors in medical school was even more direct. He had built up a thriving private practice and I did locum sessions for him back then. When he learned that I was signing up to study family medicine, he had this to say,

"Train so hard for what? You don't know how to practice family medicine meh? I tell you it is all very easy." He proceeded to give me tips on how to be a successful GP. He did it with all earnestness to help me to be successful. One of the so-called tips he gave me was to add chlorpheniramine syrup to cough mixtures.

A/Prof Lee Kheng Hock addresses the guests and graduands of Convocation 2015

"Some of these young locums are very bad. They don't even know how to treat simple cough and cold. I am teaching you these things that I had learned because you are my friend. When a patient comes to see you for cough, he won't get well if you just give him cough mixture. If he don't get well quickly, he won't return to you again. The cough is caused by flu, right? So you must include flu medicine in the treatment even though he might not have a runny nose."

The really sad thing was that he was not joking. He honestly believed that he had superior clinical knowledge of family medicine and this was the reason why he had been so successful as a GP. More than anything else, his advice strengthened my resolve to further my training and perhaps one day change things for the better.

Many years had passed and now I find myself on this side of the table. I realized that much of medical education is about thinking of ways to make the proverbial horse imbibe from the fountain of knowledge. One nasty way to do this is to create high stakes examinations. A whole mountain of pseudoscience had emerged out of this. In the United States, an education-industrial complex had emerged that is similar to the military-industrial complex.[1]

I remember helping Prof Goh Lee Gan set questions for the MMed (FM) exams in the days when he was the Chief Examiner. He used to jokingly refer to what we did as inventing instruments of torture. It was a funny way to look at it but there were indeed some similarities. We were basically trying to extract information under duress from the hapless victims, to determine the truth of their claim that they had trained diligently and had attained the levels of competency that we expect. Of course we know Prof Goh to be a compassionate man and many of us had survived the torture of exams thanks to his mercy and kindness. In the really bad old days in the 60s and 70s when dinosaurs ruled the medical assessment world, things were really bad. Back then, setting exams is like concocting a potion that is designed to be lethal to about 49% of the subjects. If it was not toxic enough and there were too many survivors at the end of the ordeal, people from the other specialties will snigger and make snide remarks about the lack of rigor of the exams and that the discipline was not intellectually demanding.

Thankfully now, things have changed and become more scientific. There are lots of theories about learning and assessment. It is all about precision and psychometrics. People wax lyrical over validity and reliability. Apart from the fancy mathematics and rigorous committee meetings, the outcome of the massively complex and expensive exercise had largely remained the same. Examinations are still very painful for the subjects. There are still those who pass and some others who fail. Those of us at the receiving end, and who have to work with the product of the process will also report that little had changed. We still get to work with roughly the same proportion of competent and incompetent junior doctors who made it through the process. There may be recall bias but professionalism seems to be on the decline despite the organization of mandatory ethics courses. To be fair, it might be a sign of the times but many

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(continued from Page 9: Train For What? ... might as well just make a living)

suspected that this might be contributed by the depersonalization of medical education. Teachers are contracted to teach with their contribution expressed in fractions of their worth as lifeless time equivalents. Their teaching output is reduced to digits generated by feedback forms. There is no relationship, no mentors and no role models. We are all digitized equivalents of one another. One silver lining about depersonalization is that examiners no longer need to feel responsible or guilty when candidates fail. The claim is that everything is objective and the examiners did not have a chance to exercise their judgment beyond ticking the boxes. Another interesting difference is that, the casualties of the exams are dead for good with no possibility of being resuscitated by the wisdom of compassionate exam boards. A good change from the perspective of the candidate is that the mantra of examinations had changed for the better. The new mantra is that if too many candidates die during the process of torture, it means that your training program is no good. It is not the student's fault, it is now usually the teacher's fault. Therefore one should dial down the toxicity of the stuff. This puts a damper on the killer instincts of the examiners. The downside is that some of the undead may come back as zombies.

Another casualty of the mechanization of medical education is the dilution and eventual demise of clinical examinations. In recent times, education reformists have been raising alarm about the negative impact of standardized tests on learning.[2] Ironically, medical educationists have "re-discovered" standardized testing and pursuing it as if it is the proverbial invention of sliced bread. There are many avid advocators of the use of standardized patients, a logical extension of the standardized tests. Real patients with real clinical problems are too complex to be standardized. The logistics of organizing clinical examinations with real patients can be very daunting. This is why many so-called advanced countries have given up on using real patients in clinical exams. It is often claimed that this is because real patients cannot be standardized so therefore the exams are not objective and results are not reliable. (To the credit of our MMed (FM) Exam Committee, they did hold their ground and kept the clinical examinations with a mixture of real and standardized patients.)

I remember in one of many committee meetings, we had an argument over how important it is to ensure that FM candidates are able to pick up real clinical signs such as an enlarged liver in the exams. One of the members who advocated for completely doing away with the use of real patients argued vehemently. "How often in real life does a family doctor examine and discover an enlarged liver?" Another chipped in that exams must simulate real life and the day-to-day consultations that happened in our consult rooms. This carried the implication that those who insist on higher standards using clinical exams with real patients are somehow impractical and unreal. Real life in family medicine can be over rated.

We know how bad the practice environment in real life can be for family doctors. Conscientious and well trained family doctors are often forced to practice 6-min consults and manage patients within protocols that are more administrative than evidence based. They have to wriggle their care plans within the narrow confines of the approved menu of tests and medicine. Beyond that, he or she is forced to refer ASAP to either the specialists or the emergency department.

The problem with this line of argument is that it perpetuates the status quo and concedes that what we are doing now is the best possible practice in family medicine. With this line of thinking, whatever standards that we have now will not change and will probably degenerate with time. We will then truly become cough and cold doctors or the mail man who delivers for the real doctors in the hospitals. The leaders of our fraternity must ask ourselves tough questions. "Is this the best that I can do as a family physician? Is this the best kind of primary care for my patient? More importantly, are your patients receiving the best primary care that Singapore can afford to give them?"

I think the answer is clearly "no" to all. Mahatma Gandhi once said, "Life is an aspiration. Its mission is to strive after perfection, which is self-realization. The ideal must not be lowered because of our weaknesses or imperfections."

We must not train to remain in our present imperfections. From the first MCGP exams that our College conducted in 1972 to the latest FCFP(S) exams conducted in July this year we had stayed true to our vision of improving standards through training and preparing young doctors for a better future in family medicine. We must not let our training and assessment systems falter under the influence of faddish ideas in medical education which is presently obsessed with standardized testing. We must train for a better future. A future where family doctors are given the necessary resources to do our work. Where practice conditions are compatible with our vision of good primary care. Where we are recognized for our special competencies and given the recognition that is due to us, nothing more and nothing less.

This is what we should be training for.

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[1] *Picciano AG. Spring J. The Great American Education-Industrial Complex: Ideology, Technology, and Profit (Sociocultural, Political, and Historical Studies in Education). Published by Routledge 2013. New York, NY.*

[2] *Robinson K. Aronica L. How schools kill creativity: Forget standardized tests, here's how we really engage our kids. Test makers rake in bucks, students and teachers chafe under the strain. Here's a better way forward for everyone. http://www.salon.com/2015/04/26/how_schools_kill_creativity_forget_standardized_tests_heres_how_we_really_engage_our_kids/*

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The Light at the End of the Tunnel!

College Convocation Ceremony

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

28th November 2015 – a day which many proud graduands will remember for years to come. Finally all their hard work has paid off, and it is time to rejoice and celebrate! As I walked around the foyer outside Fort and Mountbatten room, I was overwhelmed by the many happy faces, warm handshakes and loud laughter that reflected the joyous atmosphere. Many of them gathered with their friends… or shall I say comrade-in-arms, posing for group photos with their triumphant thumbs-up. Cameras snapping, flashes firing off, clanking of glasses against each other in hearty toasts. Scenes like these do not happen often in college, but just once a year. Perhaps that is enough. Such an annual tradition constantly reminds us to applaud the brave ones who have taken the right step towards higher training and education. It is also a significant milestone occasion for my family and I, who have turned up to support my brother Dr Low Lian Leng, one of the graduands from his fellowship course.

Pain or Pleasure? Apply or Abort? Serpent-hood or Servant-hood?

All of us streamed into the ballroom and eagerly waited for the event to commence. I was back stage, preparing my work as master of ceremony. Several years ago, I was grimly reminded by a friend who related the story of a parade commander who miscalculated the number of shots fired during the parade and was demoted shortly after. "Yes, please do not screw up", I told myself backstage.

The event commenced on a high note with the academic procession marching in, accompanying our Guest of Honour Dr Lam Pin Min, Minister of State for Health. In my feeble attempt to inspire the graduands and tying back to the familiar exams they just survived, I spoke about making the simple but important dichotomy choices in life, the similarities with the patient's neurological examination and the major assessments of the sensory system, motor system and the higher executive functions. "Pain or Pleasure" for the sensory system, "Apply or Abort" for the motor system, and "Serpent-hood or Servant-hood" for the higher executive system. I have little doubt in my mind that our wise graduands will incline their choices in life towards **painful learning instead of pleasurable conceit, application of knowledge and skills instead of abortion of ideas**, and **living a life of servant-hood leadership instead of selfish serpent-hood**.

College President Associate Professor Lee Kheng Hock also spoke about the need for higher training, especially given the shifting needs of an aging population towards chronic disease management and care for our patients who may be homebound. To achieve this, family physicians must not be content to deal with simple medical conditions, but be trained to manage patients with complex conditions in their own homes and community.

Our Guest of Honour Dr Lam Pin Min commended the efforts of family physicians in playing an important role in delivering care to our population. This is also made more affordable with the introduction of the Community Health Assist Scheme, Pioneer Generation package and expanded Chronic Disease Management Program so that patients may stick to their same family doctor for many of their encounters and fulfilling the long term goal of "One Singaporean, One Family Doctor". The training of family doctors into competent Family Physicians will position us well in the upcoming care transformation that our aging population requires, to deliver person-centric care with a greater focus on care continuity and integration. Such a generation of Family Physicians will work not only in the primary care sector, but also in the community hospitals, to help patients transit from acute inpatient care, through the rehabilitative phase, before returning safely back into their homes and the community.

Professor Chew Chin Hin delivered the Sreenivasan Oration and spoke of the evolution of medicine in Singapore, from its early dawn years to where we are now. The contents of the oration is published separately in another section of this issue. In recognition of his enormous contributions towards our college, he was also conferred the College Honorary Membership by Professor Lee.

Dr Julian Lim then hosted the section on the inauguration of College Programme for MMed(FM) and Collegiate membership. This handing over of the framed 3 articles also signifies the end of its wandering days to find the promised land, finally and naturally with the College. This is further articulated in Julian's speech.

Our Censor-in-Chief Dr Paul Goh subsequently presided over the conferment ceremony for our graduands, accompanied by thunderous claps and cheers, signifying the celebration that comes with the light at the end of the tunnel! The recipients consisted of 8 fellows, 14 collegiate members, 30 MMed(FM) and 67 GDFM graduands. The night ended with dinner where congratulations and war stories were exchanged over hearty meals and drinks.

Is it over? For the event, yes. But for many of the graduands, it is time to embark on a new journey… their own unique adventure to be filled with mixed tales of hardship, challenges, glory, comradeship, and hopefully culminating in triumphant victory as they push the frontiers of family medicine wherever they are! No one ever said it is going to be easy, but if we do not do it, then who will? Think not of what others can do for you, but what you can do for others… lead a life of servant-hood leadership!

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Inauguration of College Programme for MMed(FM) & Collegiate Membership

by Dr Lim Lee Kiang Julian, FCFP(S)

Editor's note. *Speech given at the College Convocation on 28 November 2015 on the inauguration of College Programme for MMed(FM) and Collegiate membership. This programme had its beginning in 1995 to provide the training for doctors completing the MMed(FM) programme. It was named the PPS programme – the Private Practitioners' Stream and ran as a joint effort of the School of Postgraduate Medical Studies (the old name of the present Division of Graduate Medical Studies) and the Graduate Family Medicine Centre hosted by Prof Cheong and the Department of COFM. The programme was subsequently renamed Programme B in 2006 to differentiate it from the MOH MMed FM Programme which was called Programme A. As of 2011, Programme A became the Family Medicine Residency Programme. As of 2016, Programme B will be renamed the College MMed Family Medicine Programme. The PPS and its successor, Programme B had the heritage of three articles – the spade, the rake, and the spike – to symbolize the motto of the MMed training. A symbolic handover of these three tools to the College took place at the Convocation. Dr Julian delivered the speech to mark the occasion.*

PPS & MMed(FM) Programme B Motto

In case you are wondering what this is all about – it is about the handing over of the 3 articles that was first presented on the official opening of the Graduate Family Medicine Centre located above the Cheong Medical Centre on 9 Oct 1998 by Dr Alfred Loh, then President of the College of Family Physicians Singapore. Photograph 1 shows that occasion, with Dr Julian Lim holding the three articles (circled) and the 3 rectangles above the notice board in the picture are 3 posters bearing the "motto" – **Cover Potholes Always, Consolidate Plateaus Often, Conquer Peaks Sometimes**.

"The spade to cover the potholes of knowledge along the paths we walk everyday; the rake to consolidate the plateaus of skills to better manage the difficult problems we often face; and like mountain climbers who plant flags, we would plant the spike like satisfied gardeners whenever a peak is conquered. They are there. It is up to us to find them."

Genesis of These Three Tools

Now for a bit of the genesis of these three tools. Prof Cheong likes to recount the journey as the "The Long March towards FM Recognition". The College of GP Singapore was established in 1972 to spearhead the education and training of GPs which was not supported and which went against the prevailing thought at that time that only specialists require further training. But eventually, our founding fathers were right. Through their pioneering efforts the GP College was established and the vocational training was formalized, and subsequently recognized by the NUS when the GDFM diploma was conferred in 2002. That is the short story of the "long march" towards the GDFM.

The Graduate Family Medicine Centre was also the venue to spearhead the inauguration of the Fellowship Programme by Assessment in 1998. At that time, it was not universally supported that a finishing school programme be organised for Family Medicine just like the Exit Programme in the other specialties. Prof John Murtagh was invited to be the Guest of Honour for the opening of the Graduate Family Centre to train the FM Fellows first batch. Subsequent batches were largely trained in the College.

Photograph 1. Taken at the Inaugural Lecture in 1998 *Image courtesy of Dr Julian Lim*

A closeup of the 3 articles and motto.

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(continued from Page 13: Inauguration of College Programme for MMed(FM) & Collegiate Membership)

Photograph 2 shows the first batch of College Fellows having a session at the Graduate Family Medicine Centre above Cheong Medical Clinic. The FCFP(S) by assessment is now recognized as a criterion for fellowship of the Academy of Medicine Singapore in 2014. That is another short story of the "long march" of the FCFP(S) – and the march is still on.

Photograph 2. Fellowship class in session that trained the first batch of College Fellows by Assessment

Image courtesy of Dr Julian Lim

Now for the MMed and Collegiate story leading to the newly inaugurated the College MMed FM Programme at the 2015 Convocation. It started out as a cat rescue centre in 1993 by none other than Prof Cheong Pak Yean and Prof Goh Lee Gan for dropped out trainees, like me, who have left service to be the sole bread winner for the family which was also fortuitously facilitated by the early release scheme offered during that time. It gave us a fighting chance to have bite at the MMed. It became the 2-year PPS – Private Practitioners' Stream for senior GPs hoping to have the same bite in 1995 – It was quite a big bite and one of the reasons for the smaller GDFM bite. Nevertheless, we managed to graduate 61 doctors from 1995 to 2006. Many of these Graduates from the PPS stream are now CEOs, CMBs, Directors of Polyclinics, Head of Departments, Residency Programme Director and Faculty, University faculty and so on.

PPS was renamed "Programme B" in 2006 as we were taking in more and more trainees from the polyclinic who were too senior to benefit from the MOH traineeship Programme A. It was effectively a 3-year course – taking into account the compulsory completion of the 2-year FMTP – Family Medicine Training Programme. During this time, Programme B was hosted by the then COFM Department when Prof Chan Nang Fong was there and in Dr Julian Lim's clinic. With the set-up of the Department of Family Medicine and Continuing Care, SGH, the Programme B tutorials were run by this Department and some at the College premises. We had trainers from the private sector, the polyclinics and even the university. In all, PPS and Programme B together graduated a quarter of all MMed(FM) holders.

With the new residency programme (no more Programme A); the new examination format and endorsement given to our trainees to take the MMed exam offered by the NUS (the successful ones are here tonight) and more poignantly, the support of MOH in the form of financial sponsorship for the trainees this year, it is a good time to hand over the programme officially to the College and to a name change – the College programme leading to the Master of Medicine in Family Medicine and Collegiate membership.

In closing, Prof Cheong wanted to remind us why it had to be cover potholes always. CME in the past had always been one of specialists covering the rarities – what we needed was knowledge to cover the whole breadth, leaving no holes uncovered, covering all the knowledge gaps that we encounter in our practice. Consolidating plateaus is why we do what we do in continually upgrading ourselves. We weren't quite sure what conquering peaks meant at that time. But now it is getting clearer – one discipline, many settings. It is in meeting the needs of the society in areas that require us to conquer the peaks of knowledge and skills to be able to fulfill those challenging roles – be it in ambulatory care, community hospitals, rehabilitation centres, long term care in nursing homes, palliative care, home care, transitional care and even inpatient care.

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◄ *The inauguration of College Programme for MMed(FM) and Collegiate Membership - (from left) A/Prof Goh Lee Gan, Dr Julian Lim and A/Prof Lee Kheng Hock.*

(continued from Page 31: Sharing of Experiences in the Private Healthcare Setting)

available to doctors. All these have contributed to the evolving landscape of General Practice in Singapore.

Disease patterns have also changed. We used to see patients with rheumatic fever causing defective heart valves, mitral stenosis, mitral and aortic incompetence, 3rd stage syphilis causing GPI, tabes dorsalis, charcot joints and molar pregnancies and choriocarcinoma. I also encountered many cases of silicosis among the granite quarry workers. We hardly hear of these conditions nowadays. Instead we have new infections like HIV, SARS, MERS and Ebola virus. We are also encountering diseases of an aged-population, degenerative conditions like dementia, aged related macular degeneration and diseases related to atherosclerosis.

I am now semi-retired, having handed over my practice to my son but I still maintain a few morning sessions a week to see patients. I am grateful for the opportunity to have experienced general and family medical practice for the past 50 years, coinciding with SG50.

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Can Family Medicine use Sun Tzu's Art of War 孙子兵法?

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

Many know me as a fan of Star Wars and Star Trek, but only very few know me to be a fan of Sun Tzu's Art of War. It had not crossed my mind to write some of my experiences until a friend pointed out how interested I seemed to be in Sun Tzu's ways.

For some who may not already know, Sun Tzu 孙子 was a Chinese military general, strategist, and philosopher who lived in the Spring and Autumn period 春秋时代 of ancient China, roughly during 544 – 496 BC. His exploits were so successful that it led him to write a book in military tactics named The Art of War 孙子兵法. Despite the years that have gone by, many still turn to his books and teachings for wisdom and strength. Military strategists and officers refer to the tactics found within the ancient book for modern warfare. Some CEOs and directors even try to apply the timeless advice in the corporate world. Now you may ask me, "How can Luke possibly apply any of this in his everyday life?" I may not have applied much of it in my short and simple life, but I profess to have seen my fair share of leaders in family medicine applying such principles in furthering the cause of family medicine, as well as some others largely ignoring it, much to their peril. This is especially important when pushing boundaries and exploring new frontiers in family medicine. Not applying Sun Tzu's advice can come at great cost at times. If you are not aware of the wise advice of Sun Tzu, then you are in luck as I have picked the top 13 pearls to share. Do read on with an open mind.

Similarities between an Army and a Family Medicine Department

The army is built to conquer or defend land. A family medicine department is built to serve patients. Both involve banding people together for a purposeful goal, with generals or heads of departments leading the team. The army conquers land while family medicine conquers the realm of primary care, transitional home care, subacute care, intermediate and long term care etc. so as to serve patients better, whichever setting they are in.

On the weak and the strong, Sun Tzu advises that,

1. *When the general is weak and without authority; when his orders are not clear and distinct; when there are no fixes duties assigned to officers and men, and the ranks are formed in a slovenly haphazard manner, the result is utter disorganization.*
2. *When the common soldiers are too strong and their officers too weak, the result is insubordination. When the officers are too strong and the common soldiers too weak, the result is collapse.*

A good general and officer leads by example. There was a particular hospital which only had a handful of medical officers, and unfortunately there were not enough of them to be rostered for night calls. During the discussion that ensued, the question posed was what would happen when the medical officers needed to go on leave or took sick leave and their numbers were slashed further. The Division of Medicine head led by example by volunteering to go on calls himself. He did not insist that the consultants to follow suit, but all other consultants agreed they will step up to the cause should the need arise. If the general volunteers to lead his soldiers personally into battle, how much lesser can the officers and soldiers themselves do, except to step up and fight along the general? Such is leadership by example.

Reporting lines should also be clear rather than complicated and crisscrossing, as this ensures that leaders in the middle rungs are given full control of their own teams to be nimble and versatile as and when the situation changes. The head of department can truly maximise the potential of the ranks below him only when he does not feel threatened himself and allow those with the required skill set to rise up to the occasion. Conversely, obsession with personal control and selfish power amongst the heads and senior leaders will only curb creativity and result in the exodus of capable staff who are always searching for more supportive institutions and departments where they can grow and be nurtured. An institution who fails to recognise and discourage a disruptive head will never be able to retain good staff and build a strong department.

On the Use of Spies, Sun Tzu advises that,

3. *We are not fit to lead an army unless we are familiar with the face of the country - its mountains and forests, its pitfalls and precipices, its marshes and swamps. (Intelligence)*
4. *Thus, what enables the wise sovereign and the good general to strike and conquer, and achieve things beyond the reach of ordinary men, is foreknowledge.*
5. *Hence it is only the enlightened ruler and the wise general who will use the highest intelligence of the army for purposes of spying and thereby they achieve great results. Spies are a most important element in water, because on them depends an army's ability to move.*

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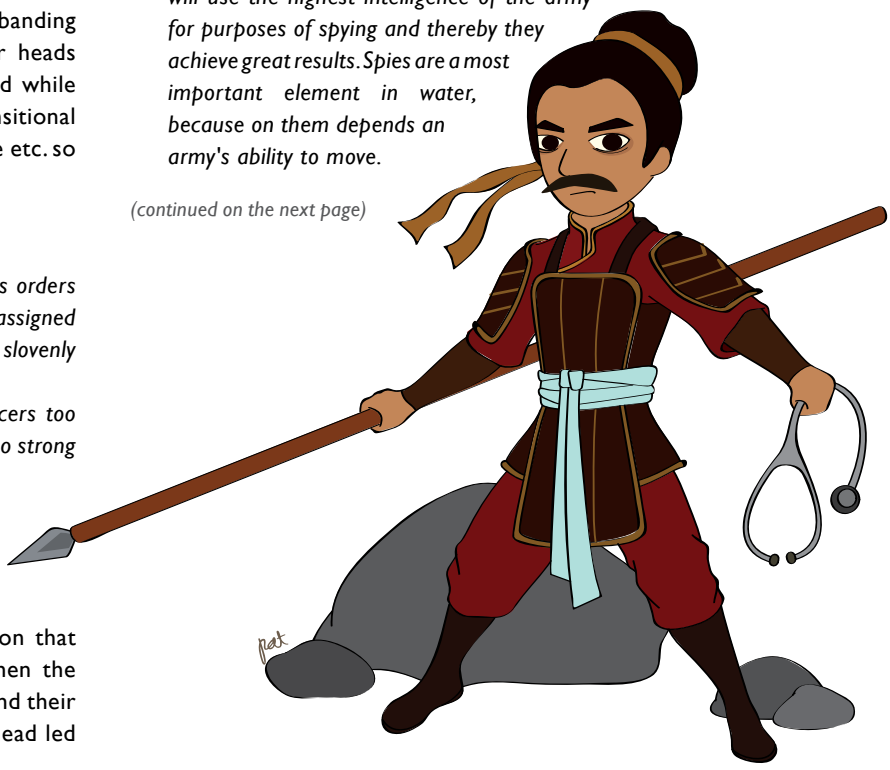

6. If you know the enemy and know yourself, you need not fear the result of a hundred battles. If you know yourself but not the enemy, for every victory gained you will also suffer a defeat. If you know neither the enemy nor yourself, you will succumb in every battle.

Spying and espionage are negative terms that are often spoken hush hushed, yet it is practiced no less abundantly in warfare. In the realm of family medicine, it may take the form of study trips, observing and learning from institutions with better practices. The heads and leaders have to be humble and recognize that there is room for improvement. Learning from his adversaries ensures that he is always one step ahead of the competition, to take the practice of family medicine to the next level and keep up with patients' ever increasing complexity.

On variation in tactics, Sun Tzu advises that,

7. Therefore, just as water retains no constant shape, so in warfare there are no constant conditions.
8. He who can modify his tactics in relation to his opponent and thereby succeed in winning, may be called a heaven-born captain

Staying predictably the same is the surest way to failure. Employing the same strategy all the time will guarantee a single and inevitable outcome – being overtaken by others who are constantly innovating. A team who is set up with the aim to remain status quo and stay comfortable will never want to move out of their comfort zone, and perhaps this team is staying employed for the wrong reasons. When such a team is pushed to innovate and squeezed out of their comfort zone, they will leave. Building such a team will be setting up for failure. The team may feel they are not ready to innovate, but that feeling will always be there. We are always our own greatest enemy. To conquer oneself is to win half the battle already. It is important to build a team with the aim of always improving tactics and doing things better.

Assess the battle situation and adapt accordingly. There is no such thing as a strategy that works forever, because the condition of the battlefield is ever changing. Our healthcare needs have evolved over the years, from episodic care arising from infectious diseases in the 1960s, to long term and continuing care arising from chronic lifestyle diseases in the 21st century. Primary care is certainly evolving. Polyclinics are changing from walk-in systems to partial/ full appointment systems in view of the long term continuing care that is required. GPs are now going onboard Community Health Assist Scheme (CHAS) and seeing more chronic care patients.

The increasingly complex needs of our patients demand that we continue to innovate our services and raise standards of care to cater to them. Planting primary care services in a hospital is simply not enough. Hospital family medicine is a different creature compared to primary care. Other countries including the Canadians and Americans have had decades of experience in various models of hospital family medicine that we can learn from. Restructured hospitals are now working closer with the polyclinics and GPs in their region, developing systematic patient workflows that right sites such patients to the community. We now proactively identify primary care providers in all our patients as far as possible, and involve these GPs in the post discharge care of these patients so that the care chain is not broken. We also try to raise up the standards of our GP partners through a structured system of CMEs, workshops and clinic/ ward attachments to cater to them as many have varying standards and needs, so that they are able to push the care boundaries for their own patients if they so wish.

On army courage and training/ operational standards, Sun Tzu advises that,

9. If in training soldiers commands are habitually enforced, the army will be well-disciplined; if not, its discipline will be bad.
10. The principle on which to manage an army is to set up one standard of courage which all must reach.
11. Place your army in deadly peril, and it will survive; plunge it into desperate straits, and it will come off in safety. For it is precisely when a force has fallen into harm's way that is capable of striking a blow for victory.

How did Sun Tzu came to the realisation that putting his team in death ground breeds deadly warriors?

This saying came about when Sun Tzu was forced to make one of the biggest and most difficult decision in his life. His ally was being attacked by a strong foe, and he was finding ways to help his ally. However, instead of combining his army with that of his ally to form a fighting force, he chose to use his own army to divert the enemy's attention away from his allied forces (thus saving his ally in the process) and to lead them to a place where there was no way of retreat for his own forces. While we believed that this was a suicidal move, Sun Tzu believed that by not allowing his soldiers an alternative route of escape, they will be forced to fight for their survival. And true enough, his forces became very much mightier than usual and fought back hard against the enemies who far outnumbered them. The enemies were taken aback by the ferocity of the counter attack and suffered a crushing defeat!

An army needs a hierarchy of generals, strategists, commanders, lieutenants and infantry which are constantly training and upgrading in order to out-battle their enemies. Family medicine departments which do not put their own doctors through rigorous postgraduate training and develop a robust hierarchy of family medicine physicians comprising of the head, senior consultants, consultants, associate consultants, registrars, residents, resident physicians and medical officers, but instead recruit many resident physicians and junior doctors will face many challenges in doing the higher level of work that other family medicine departments are otherwise able to do. Just as it is important to learn, it is just as important to teach. Thus the saying that the best way to learn is to teach. Family medicine departments which participate in under- and post-graduate training programs will always see good trainees and residents pass through their doors, increasing the chances of attracting them to stay on in the department to do the good work.

The best way to sharpen the team is to put them in situations where they either perform or they perish. Such a team will always try to outperform themselves in order to survive, and whatever does not kill them will only make them stronger. In our modern day family medicine, the same can be said as well. Evolving primary care which comprises of our polyclinics, GP clinics and family medicine clinics is only half of the equation. The other half which is just as important may be to peg our hospital family medicine practice at a higher level so as to seamlessly bridge the gap between specialist-centric hospital care and primary care to facilitate the

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(continued from Page 15: Can Family Medicine use Sun Tzu's Art of War 孙子兵法?)

paradigm shift of care focus from hospitals to communities. Putting resources into training such hospital family medicine physicians and equipping them to consolidate complex medical care, manage subacute patients coming from other specialties, mobilise multiple disciplines such as nursing and various allied health practitioners to come together for the holistic care of complex patients, and transit these patients' care from hospitals to either primary care or even their own homes for long term care can help to achieve the needed paradigm shift. To train such a hospital family medicine physician would involve subjecting them to the most extreme of training and practice conditions in the hospital, to force them to train along other specialists and understand their thinking and management, pushing them to the top of the family medicine licence, leaving no easier alternatives. Such investment into both primary care and hospital family medicine will be needed to enable patients to be cared for in their homes and communities.

On tactical disposition and choice of generals, Sun Tzu advises,

12. The general who advances without coveting fame and retreats without fearing disgrace, whose only thought is to protect his country and do good service for his sovereign, is the jewel of the kingdom.

A man who sees greater things beyond himself and strives to achieve it for the greater good, is the sort of man that every institution should strive to work with. A humble man who is ready to admit his mistakes and who does not fear disgrace is always learning from his current mistakes which sets him up for future greater success. Institutions who inculcate such humble kaizen ways will find themselves improving their services all the time.

On army morale and relationships, Sun Tzu advises that,

13. Regard your soldiers as your children, and they will follow you into the deepest valleys; look on them as your own beloved sons, and they will stand by you even unto death.

Certain institutions somehow seem to have the ability to retain good men to stay on for the cause. While outsiders may not always know the winning formula in those places, the feedback given often covers the fact that the staff are treated with respect, and there is constant engagement between various levels of management, from senior management to staff on the ground, thus minimising dissent, dissatisfaction and the feeling that "the higher ups do not understand, or do not care". If the higher management strives to listen to the staff on the ground just like how parents always listen to their children and love them, then the staff will always find coming to work a positive experience. When the challenge comes, the staff will give their best shot knowing that their superiors will always look after their best interests. That form of mutual trust between the different levels goes a long way.

13 phrases from Sun Tzu's Art of War, hopefully to help advance family medicine along in her cause wherever it may be!

CM

Family Medicine Convocation 2015

28 November 2015 (Saturday)
Singapore Swimming Club

25th Council (2015 - 2017)
College of Family Physicians Singapore

Standing (from left)
Dr Goh Soo Chye Paul (Censor-in-Chief), Dr Tan Ngiap Chuan (Honorary Editor), Dr Low Lian Leng, Dr Ng Lee Beng (Honorary Assistant Treasurer), Dr Goh Lay Hoon, Dr Lim Hui Ling, Dr Lim Fong Seng (Honorary Treasurer), Dr Low Sher Guan Luke, A/Prof Tan Boon Yeow (Honorary Secretary), Dr Tan Tze Lee (Vice-President)

Seated (from left)
A/Prof Goh Lee Gan, Dr Alfred Loh, Prof Chew Chin Hin, Dr Lam Pin Min (Guest-of-Honour, Minister of State for Health), A/Prof Lee Kheng Hock (President), Dr Lee Suan Yew, A/Prof Lim Lean Huat

Not in photo
Dr Subramaniam Surajkumar (Honorary Assistant Secretary), Dr Chan Hian Hui Vincent, Dr Doraisamy Gowri, Dr Ong Cong Wei Alvin, Dr Pang Sze Kang Jonathan

~ Graduands 2015 ~

Fellowship Programme
FCFP(S) Recipients

Standing (from left)
Dr Low Lian Leng, Dr Koh Kim Hwee, Dr Lim Chi-Kien Derek, Dr Koot David

Seated (from left)
Dr Bhavani Jayabalan, Dr Ang Teck Wee Andrew, Dr Goh Soo Chye Paul (Censor-in-Chief), A/Prof Lee Kheng Hock (President), Dr Tan Tze Lee (Vice-President), Dr Chua Hwee Ling Angelia, Dr Zheng Mingli Ruth

Collegiate Membership
MCFP(S) Recipients

Standing (from left)
Dr Loh Weng Keong Victor, Dr Tan Eng Chun, Dr Loo Yu Xian, Dr Ng Lok Pui, Dr Tan Wee Hian, Dr Kee Kok Wai, Dr Wong Pey Gein Franco

Seated (from left)
Dr Lee Cia Sin, Dr Chan Qiu Hua Catherine, Dr Goh Soo Chye Paul (Censor-in-Chief), A/Prof Lee Kheng Hock (President), Dr Tan Tze Lee (Vice-President), Dr Hu Pei Lin, Dr Ng Wei Ling

MMed(FM) Graduands 2015

Standing (from left)
Dr Chua Kee Loon Linus (Cai Qilun Linus), Dr Wan Jinhui (Wen Jinhui), Dr Chong Wern Siew Christopher, Dr Xu Bangyu, Dr Nor Izuan Bun Rashid, Dr Zhang Zhi Peng

Seated (from left)
Dr Tan Pei Fen, Dr Goh Soo Chye Paul (Censor-in-Chief), A/Prof Lee Kheng Hock (President), Dr Tan Tze Lee (Vice-President), Dr Chang Zi Ying

GDFM Graduands 2015

Standing (from left)
Dr Shankeer Sanjeev, Dr Ramaswami Rajagopal, Dr Loh Goh Chor, Dr Lee Dehao Victor, Dr Loh Shi Theng, Dr Chew Yi Chuen Adrian, Dr Nor Izuan Bun Rashid, Dr Wong Hwei May Victoria, Dr Khong Haojun, Dr Krishna Prasad Giri, Dr Lim Kheng Teong

Seated (from left)
Dr Aljunied Shariffah Nadia, Dr Loh Wenying Amanda, Dr Wong Siew Hui, Dr Goh Soo Chye Paul (Censor-in-Chief), A/Prof Lee Kheng Hock (President), Dr Tan Tze Lee (Vice-President), Dr Fok Wai Yee Rose, Dr Dey Ankita, Dr Shiau Onn Ling Kellyn*

** Book Prize Winner — Dr Aljunied Shariffah Nadia*

Family Practice Skills Course #65

Self Care Techniques

Sat, 30 January 2016: 2.00pm - 5.30pm
Sun, 31 January 2016: 2.00pm - 5.30pm

College of Medicine Building, Auditiorium Level 2, 16 College Road, Singapore 169854

TOPICS

Unit 1: Work Stress Management
Unit 2: Mindfulness techniques
Unit 3: Positive psychology strategies
Unit 4: Emotional regulation
Unit 5: Achieving better sleep
Unit 6: Achieving social connectedness

WORKSHOPS

Day 1: Mindfulness based stress reduction techniques

Day 2: Emotional regulation

SPEAKERS

Dr Lawrence Ng
Dr Tan Wee Chong
Dr Janet Chang
Dr Jean Cheng
Dr Tan Wee Hong
Dr Lim Hui Khim

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

■ SEMINARS (2 Core FM CME points per seminar)
Seminar 1 • Unit 1 - 3: Sat, 30 Jan 2016 (2.00pm - 4.00pm)
Seminar 2 • Unit 4 - 6: Sun, 31 Jan 2016 (2.00pm - 4.00pm)

■ WORKSHOPS (1 Core FM CME point per workshop)
Day 1: Sat, 30 Jan 2016 (4.30pm - 5.30pm)
Day 2: Sun, 31 Jan 2016 (4.30pm - 5.30pm)

* Registration is on first-come-first-served basis.
Seats are limited.
Please register by 25 Jan 2016 to avoid disappointment.

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

This Family Practice Skills Course is organised by College of Family Physicians Singapore.

REGISTRATION

Self Care Techniques

FREE REGISTRATION for College Members!

Please tick (✓) the appropriate boxes

	College Member	Non Member
Seminar 1 (Sat)	☐ FREE	☐ $21.40
Seminar 2 (Sun)	☐ FREE	☐ $21.40
Workshops (Sat-Sun)	☐ FREE	☐ $42.80
Distance Learning (MCQ Assessment)	☐ FREE	☐ $42.80
	TOTAL	

All prices stated are inclusive of 7% GST. GST Registration Number: M90367025C

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

Cheque number: _____

Signature: _____

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

Name: Dr_____

MCR No: _____ NRIC No: _____

(For GDFM Trainee only) Please indicate: _____ intake

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

_____

_____

E-mail: _____

Tel: _____ Fax: _____

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

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

Or fax your registration form to: 6222 0204

Interview with our newly appointed Heads of Department

Dr Matthew Ng, Singapore General Hospital, Department of Family Medicine and Continuing Care & Dr Farhad Fakhrudin Vasanwala, Sengkang Health, Department of Family Medicine

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

Dr Matthew Ng Joo Ming and Dr Farhad Fakhrudin Vasanwala are no strangers to some of us. I have known Dr Matthew since 2009 when I rotated through Singapore General Hospital Family Medicine and Continuing Care department (SGH FMCC) as a family medicine medical officer trainee.

It was even earlier that I knew Dr Farhad back in the early part of 2007 (by reputation, not by person) when I went to Bedok polyclinic to help whenever their doctor manpower was low. I vividly recalled how the polyclinic executive would walk into my room and tell me that I had to help one of their doctors see extra patients as he was "overbooked" and they had stopped his morning queue numbers since 10.30am. The same will go for the afternoon when his numbers would be stopped by 3.30pm. True enough, whenever I would walk out for lunch at 1pm, the entire clinic would be largely deserted except for the waiting area outside Dr Farhad's… his patients never seem to stop coming to see him. Of course, I only knew him in person in 2009 though my rotation in SGH FMCC. Both Dr Matthew and Dr Farhad took care of juniors like me, ensuring that we learned family medicine, enjoyed our work and kept our spirits and morale up.

I was happy this year to hear that both have been appointed as heads in SGH FMCC and Sengkang Health Family Medicine (SKH FM) departments, and College Mirror takes this opportunity to interview them on stepping up to their new roles.

College Mirror (CM):
Dr Matthew and Dr Farhad, please accept our heartiest congratulations on your newly appointed roles as heads in SGH FMCC and SKH FM department respectively! May I get you to briefly introduce yourself, for the benefit of those who have not had the pleasure of knowing you beforehand?

Dr Matthew Ng (MN):
I am Dr Matthew Ng, I have been with SGH FMCC since its inception on 2nd May 2006. The department will be celebrating its 10-year anniversary soon. I was appointed Head of Department (HOD) on 1st May 2015.

Dr Farhad Vasanwala (FV):
Dear Dr Luke Low, thank you very much for enabling me to share the goals, aspirations and currents workings of the newest Family Medicine Department in Singapore.

My exposure to Family Medicine in a hospital setting started off in 2007 when I joined SGH as a Registrar in FMCC after obtaining my postgraduate qualifications in both Internal and Family Medicine and serving various postings in the hospitals and SingHealth polyclinics for the previous past 10 years. FMCC is the pioneer of hospital Family Medicine which profoundly changed how Family Medicine is practiced in Singapore, and which I had the opportunity to be part of. In 2012, I was appointed as a member in the MOH working group responsible for setting up the planning of Sengkang General and Community Hospitals.

In June 2014 I joined Sengkang Health (SKH) as a staff and was nested in the department of Internal Medicine, working there as a Consultant till our move to Alexandra Hospital (AH) in August 2015, when the Family Medicine Department at Sengkang Health at Alexandra Hospital commenced and started looking after her first patients. I have since been given the privilege to Head the Department of Family Medicine.

CM:
What will your new role heavy responsibility entail?

MN:
SGH FMCC is a clinical department with inpatient services and outpatient services such as transitional home care and outpatient specialist services. We also participate in preventive health through our health assessment unit at Camden Medical Centre. I am in charge of the clinical services provided by the department. I also held a concurrent appointment of Head, Medical Services at Bright Vision Hospital (BVH). BVH is a 318-bed community Hospital that provides rehabilitation, sub-acute care, day rehabilitation, inpatient hospices, chronic sick units and general outpatient services.

FV:
The senior management headed by Prof Christopher Cheng and A/Prof Ong Biauw Chi believes that Family Medicine is one of the key pillars in managing our healthcare needs, especially in our rapidly ageing society. We will be managing patients with acute complex medical problems from the Sengkang General and Community Hospitals. Our goal is to seamlessly right site them to our home care services, intermediate and long term care (ILTC) partners, volunteer services and Family Physicians (FPs) in the North East (NE) region of Singapore. There are lots of work to be done, and a great number of right minded partners to be engaged with. My team and I are very focused on engaging community partners and Agency of Integrated Care so that we can take charge of the healthcare needs of the North East (NE) part of Singapore. We will incorporate pioneering paradigms of healthcare in order to minimize upstream health problems of our patients through good preventive health and addressing the complex social issues that are usually intertwined with it.

CM:
Other than clinical work, what else do you intend to value-add, now that you are the HOD?

MN:
FMCC is an established department of 10 years in SGH. Initially, we were looking at areas where we can value add in SGH. The department has, over the years, participated in various services in SGH such as being part of the Internal Medicine Hospitalist Care teams, pre-op evaluation clinics etc. In the recent years, we have been focusing on step-down care at BVH and Transitional Home Care services in SGH, looking into ways to minimize frequent admissions and bringing care to home bound patients in their own homes. The next area we intend to look into will be community services. The important things to do in the coming years will be to improve on and scale up the services that we are providing.

FV:
Our culture in Sengkang Health is one that encourages mutual respect, collaboration, collegiality and understanding with each other through both work and shared activities e.g. mindfulness, yoga, games, exercise etc. Mutual respect for each other irrespective of rank or title is crucial as all of us can pool and share our ideas without fear or reproach on how we can promote the betterment of family medicine. I always believe that the most junior member has things we can always learn from, if we make the effort to listen and understand each other's viewpoints and come to a mutual win-win consensus. We must ensure that the Family Physicians we train eventually must be better than us or else we have failed in our duty to the nation. Finally we must always put our patients first and work toward their best interests, treat them with empathy and compassion as how we would want our loved ones to be treated likewise regardless of social strata or ward status.

To do this we must work as a multidisciplinary team. I am glad to say that this has already taken effect in our daily multidisciplinary rounds with our nurses, physiotherapists, occupational therapists (PT, OT), medical social workers (MSWs) and pharmacists and our weekly multidisciplinary meetings. Our level of care has gone up many notches as a result of this mutual shared collaboration and mutual respect.

CM:
What are some of the important tasks that lie ahead?

MN:
There are three areas which SGH FMCC will be concentrating on:

- **Clinical services**
  - o scaling up transitional home care services
  - o enhancing our virtual ward services and minimizing readmissions of patients
  - o ensuring that BVH operations are sustainable and viable in the long run
  - o nurturing and encouraging doctors to join the community hospitals especially Family Medicine residents

- **Education**
  - o training medical officers and other doctors posted to the department to be competent in providing care to the complex patients in our transitional home care programme
  - o improving the Duke-NUS family medicine clerkship programmes
  - o providing training and education to the residents in the SingHealth Family Medicine Residency programmes

- **Research**
  - o concentrating on Health Services Research (HSR) in SingHealth. Currently we have two doctors with Master in Clinical Investigations (MCI)
  - o nurturing and encouraging medical officers and Family Medicine residents to participate in such research

FV:
: At SKH FM we have established a great team of doctors, nurses, administrative and allied health staff who have the common goal of making Family Medicine an integral part of(Hospital and Community medicine – what is this?) to ensure seamless transition of care for our patients from the hospital to the community and vice versa. We are continuing the tradition of training highly competent family physicians to able to handle complex chronic diseases that our increasingly elderly population grapple with. The most important thing is that our senior management supports us in our endeavours and go all out to make this a reality. We are truly blessed in this regard.


Dr Farhad Fakhrudin Vasanwala, Head, Department of Family Medicine

Family Medicine must have a base in the hospitals where we can learn, consolidate and train the present and future generations of family physicians in the community. This is possibly the only way to put Family Medicine as a specialty on par with other disciplines. Here, we are able to hone our skills, be exposed to various other disciplines, share and interact with them and incorporate it into the family medicine ethos. We work as intermediaries between the specialists and the family physicians in the community and vice versa. Hence, we too are part of the General Medicine team so that we can keep our academic and clinical skills razor sharp in the various specialties and share the knowledge from a FM perspective to the community hospital, home care, Family Physicians and ILTC partners in the community.

CM:
How do you plan to engage and work with the existing primary care landscape, including our general practitioners (GPs), polyclinics, family medicine clinics and home care partners?

MN:
The population in Singapore is aging and life expectancies are increasing. By the year 2030, Singapore will have a million people above the age of 65. Disease trends are also moving towards chronic, non-communicable diseases. Patients are also becoming more complex with many co-existing illnesses. Many such patients now have many health providers managing them in the Restructured Hospitals. They have a cardiologist taking care of their heart problems, an endocrinologist taking care of their diabetes and a respiratory physician taking care of their COPD etc. It is important for all of us as Family Physicians to equip ourselves with the necessary knowledge and skills to care for all these patients with complex diseases, keeping them well managed in the community. FMCC is a small department, and since it is impossible for us to take care of all these patients with complex needs, we will need all the help we can get from our family physician colleagues in the community.

FV:
We will work with Family Physicians (FP) and ILTC partners in the NE region of Singapore and engage them closely so that they will be able to take over most of our patients discharged from the hospital. We hope to consolidate the specialist appointments through our General Medical /Family Medicine Clinics, cutting down the multiplicity of medical appointments and right siting them to our private practice FP colleagues, rather than discharging all of them to the Polyclinics as they are already facing a very heavy work load. We hope to empower our FPs by making them associates of our hospital and allowing them to practice at the top of their licence through shared care with our specialists. We hope to achieve this enhanced level of care and seamless right-siting of patients through the use of common information technology (IT) platforms and even tele-health. Similarly, our FP associates can refer these patients back to us via fast track referrals should they require specialists' opinions. These 2-way right siting between our hospital and the community ensures that our SOCs will not be

(continued on the next page)

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chock-a-block with patients, as those who do not require single specialty care will be seen by our experienced FPs in the community, and patients who truly require our specialists' attention will be seen in our SOCs. To build such a synergistic equilibrium between FPs and specialists will require constant contact between them, and a culture of mutual respect and coaching. By focusing our care in the NE part of Singapore, we stand a good chance of succeeding.

CM:
What are your plans for education and research in the realm of family medicine?

MN:
SGH FMCC encourages continuing education. All our resident physicians, staff registrars and even consultants are encouraged to continuously upgrade their skills. Resident physicians are encouraged to take up the Graduate Diploma in Family Medicine (GDFM) and other post-graduate courses such as the Masters of Medicine in Family Medicine [MMed (FM)] etc. All doctors in the department have clear career paths mapped out for them.


Dr Matthew Ng, Head, Family Medicine and Continuing Care

SGH FMCC has been doing Health Service type of research since its inception in 2006. Many of its programmes have been proven to work and in the coming year you will see many of its projects being published in international and local journals.

FV:
Within the first month of our operations at Alexandra Hospital, we were already giving bedside teaching to our Family Medicine Residents and FCFP(S) colleagues who were preparing to sit for their clinical exams. All the doctors in our team are involved in the teaching of post graduate students in Family Medicine in one form or another and actively going for postgraduate courses/ conferences, or in house CMEs to upgrade themselves. Such teachings and discussions with the students and colleagues in training helps us to gain a deeper knowledge and understanding of the subject matter, and also enables the invisible yet vital transmission of values of care and compassion alongside medical knowledge and skills. Upgrading themselves is also our duty so that we are able to transfer the best practices and knowledge to the care of our patients. We hope to have fruitful collaboration between our family physicians and our specialists in SKH, exploring new ways of treating and managing our patient, and possibly generating potential areas of research in the near future.

CM:
Is there any possibility of SGH FMCC and SKH FM collaborating and working together in future projects in view of the fact that both are sister hospitals under SingHealth?

MN:
Both SGH FMCC and SKH FM belongs to the same organization. We at SGH FMCC are open to any areas where we can work together. SKH FM nurses have already been attached to SGH FMCC for orientation and training. However, my view is that SKH FM is still in its infancy stage, and there is no need to rush to set up FM services at the moment. More important at this stage is to get all FM staff trained to handle patients with complex needs in the acute hospital.

FV:
Of course. Dr Luke Low Sher Guan and I have close ties with our fellow colleagues in FMCC. We have the advantage of being able to try out new paradigms of health care in the NE part of Singapore. The number of Family Physicians trained in the hospitals are few still, but we hope that the Ministry can see the good work that we are currently doing alongside our community FPs and ILTC partners, so that Ministry may support hospital FM and make it an attractive and fulfilling career for future aspiring FPs. There are also opportunities for both departments to pool our expertise together and do collaborative research. We are in the midst of doing a research project with one of our colleagues in FMCC. Hopefully, we will be able to get the grant soon and kick start the research. Collaboration for research can also take place with our colleagues in KKH Family Medicine and Singhealth Polyclinics. With the impending establishment of the Academic Clinical Program (ACP) in Family Medicine, this will definitely take place more readily.

CM:
Do you have any aspiring hopes and dreams for your departments?

MN:
SGH FMCC has well-established programmes and niche areas of services mapped out for us. In the foreseeable years ahead, the department would be more involved in the ILTC sector in both BVH and Outram Community Hospital, transitional care services and less of acute inpatient services in SGH.

FV:
I hope SKH FM department will be a centre of medical excellence and compassion for our patients in both within hospital and in the community. We also hope to work very closely with our colleagues in the ILTC sector, polyclinics and private practice FPs through strong collaboration with each other, so that our coordinated efforts will help our patients in the NE part of Singapore. My dream is that our community FPs can eventually round with us or at least take part in the grand ward rounds in the hospitals, and even take over the management of the patients upon their discharge. Imagine the confidence the patients will have of our community FPs if they are seen discussing with the hospital colleagues in the management of the patients in the wards. This will help tremendously with the right siting of the patients. The use of tele-health to collaborate with our community FPs and ILTC partners will promote enhanced care for our patients in the community. I also hope that our community FPs can gain direct access to specialised investigations at the restructured hospitals at a subsidized rate so that they need not be referred to the SOC clinics just for our specialists to order the pertinent investigations, thus saving unnecessary referrals and boosting the confidence levels of not just the community FPs but their patients as well. With postgraduate training and exposure to our specialist colleagues, we will be able to do this wisely and judiciously. The day will come when our patients and the public will start to have a higher regard for Family Physicians, trusting them not only with acute, episodic medical conditions, but also with their ongoing, chronic medical ailments as well, realizing our nation's dream of "One family physician for every Singaporean".

CM:
Lastly, any wise words for us on the ground?

MN:
I would like to encourage more young doctors especially Family Medicine Residents to take up work in the ILTC sector, especially in the Community hospitals and the FM departments of restructured Hospital. It is more meaningful and less daunting than what people think. In terms of work life balance, I don't think you are any less well off than working in a primary care clinic.

FV:
We must always be humble, to know our limitations and be ready to acknowledge our shortcomings, and to learn from others' good points. I personally still have so much to learn from our fellow colleagues. We should never stop learning from everyone, be it from medical students, housemen, medical officers, registrars, fellow consultants, nurses and other allied health practitioners. No man is an island, and no man can possibly know everything there is to know. Always be ready to share what you know and help our colleagues professionally. All of us can contribute in various ways. We may not have the same personality or viewpoints but our common goal to push the boundaries of healthcare and family medicine must be the same in order to further improve our population's health. Continuing education is the key. Finally, be happy with yourself by adopting a balanced work life and seek fulfilment in the work you do. By adopting the above principles, I sincerely believe this is possible.

CM

A Day in the Life of a Home Care Medical Doctor

Interview with Dr Chew Sung Boon

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

As a result of an ageing population, low birth rates and longer life expectancies in developed countries, there is an increasing worldwide prevalence of patients with functional decline, dependence and impairment of activities of daily living (ADL). The medical follow-up of these functionally dependent patients pose a challenge, especially in the traditional outpatient settings where transport of these patients to a clinic is required. Delivering care for these dependent patients in their own homes still remains to be one of better ways of providing optimal care for them. But not many doctors have the confidence and competence to deliver care in such a manner. In this article, we attempt to shed some light on home medical by getting an insider interview with Dr Chew Sung Boon.

College Mirror (CM):
Good day Dr Chew! We have heard of your collaboration with Home Nursing Foundation (HNF) to provide home medical and nursing care. Why HNF?

Dr Chew Sung Boon (SB):
Actually, I work with several charity organizations that are involved in providing home care services. HNF is one of these organizations that I have the privilege to work with. With the HNF, I like it that they are well-established (founded in 1976), well-organized, and have their processes well-thought out. They have a sizable group of dedicated nurses who visit patients at home, and the HNF have been focussed on home care for years. It only made sense that they were one of the first few organizations I approached, and I'm grateful for the opportunity to work with the HNF team.

CM:
Do you have any private patients of your own?

SB:
Nope, I don't. My medical practice is focused on doing the home medical visits for the patients under the care of charity organizations. I'm just going home visits full-time, so I don't have any walk-in patients. The need for home medical support for patients under the care of the charity organizations is growing, and for me it's less distracting to just concentrate my attention and energy on this area.

Don't be mistaken, the charities receive subvention by MOH for the home visits, and I do get paid by the charities, so my medical practice is still sustainable.

CM:
Before coming to community home care, where were you practicing previously? Can you tell us how you came to be in community home care?


Dr Chew Sung Boon

SB:
I had MOPEXed my way through a bunch of clinical postings before finally deciding that I was better suited for primary care. Was then in GP Land for quite a while, but had nagging doubts that it was not quite the best fit for me. An unexpected opportunity then came along for me to work with a great bunch of people doing Phase I clinical trials; that was an interesting experience and I learnt a lot from working in a MNC, but at the end of the day, I still missed the patient-care part of the profession. I didn't want to go back to the "typical" GP clinic work- I'd done that for several years and knew it's wasn't really for me - and yet I remembered that what I had enjoyed most about the practice was attending to the patients with chronic illnesses, spending time discussing care issues and building the doctor-patient relationship and rapport with them. I knew I didn't enjoy sitting in my rather small consultation room for 8 to 12hrs a day. So, what's a GP going to do if he wants to attend more to the chronic ill, have an excuse to be out of the clinic more often than to be in, and have sufficient time to do consultations instead of rushing through dozens of consultations a day? Anchors aweigh, and I set sail for the uncharted waters (for me anyways) of community home care. It wasn't plain sailing, but I had help from friends and colleagues, including the folks from Ang Mo Kio-Thye Hua Kwan Community Hospital and the TTSH HVRSS team. I worked part-time with them, learning from them, and spent the remainder of the time

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(continued from Page 23: A Day in the Life of a Home Care Medical Doctor)

trying to build a sustainable medical practice. The initial years were not easy, but I'm still around and afloat, so I must be doing some things right, or at least doing more things right than wrong.

Reading what I just wrote, it sounds like I had a mid-life crisis... possibly, but then without the dough to buy an expensive Italian car with an animal logo, the lack of culinary skills to open a patisserie or ice-cream palour, and I cannot appreciate a $5 cup of coffee, I suppose this "internal" career-switch will have to suffice.

CM:
What are some of the happier and more gratifying moments in community home care?

SB:
For me, it's the small things - the smiles on the faces of my patients, their families and caregivers, their expressions of thanks for what I would I have thought was expected of me in the course of my duties, their request to have me specifically come back attend to them... doesn't sound like much and it's clichéd, I know, but it's an aspect of the home visits that makes a difference and keeps me going.

CM:
What are some of the challenges that you face?

SB:
I would say it is more inconveniences rather than challenges. A fair amount of time is spent on the roads driving from one home to another, and then walking a bit in the wonderful Singapore weather - blazing sunshine or pouring rain, and depending on the time of year, inhaling the invigorating hazy air, all the while lugging along my equipment and documents along in a travel case. Finding fairly clean toilets to use is also an interesting distraction from clinical work.

CM:
Is it easy for family doctors and family physicians to make a career switch from a clinic setting to a home care setting?

SB:
I hesitate to say it's easy but neither is it very difficult. I can only share my "fun" experiences. Doing home care is not what I'd been exposed to going through the usual training and postings in the hospitals and clinics. So a fair amount of planning and mental preparation was needed to anticipate the change in working environment. The "clinic" is now the patient's home and it's often that the usual conveniences we take for granted aren't available. No pleasant air-conditioning (prepare to perspire!), no table to neatly place all equipment/ stationery, no additional colleague to call upon for assistance, and I can only work with whatever "tools of the trade" that I've bothered to cram into that bag of mine. In short, if you are adaptable and don't mind forgoing some of the creature comforts of a clinic, the transition should be OK.

Also, those who are used to running a clinic with a good revenue should count the cost of making the switch. In the home care setting, there are only so many patients that can be seen in a day (do factor in significant travelling time, and more time to enter clinical notes). For some, it might not work out to be a financially palatable choice.

CM

Launch of SG50 Healthcare Commemorative Book and MOH Long Service Awards

by Dr Goh Lay Hoon, Council Member, College of Family Physicians Singapore

About 250 health care workers and volunteers from healthcare institutions in Singapore gathered at the Suntec Convection Centre on the afternoon of 8 Oct 2015, to commemorate the launch of the SG50 book "Caring for our People Celebrating 50 Years of Healthcare in Singapore". The event was organized by the Ministry of Health (MOH) and graced by Mr Gan Kim Yong as the guest of honour.

The Guest of Honour for the event, Mr Gan Kim Yong, Minister for Health

The 241-page hard copy coffee table book was filled with a rich tapestry of pictures, photographs, short stories of healthcare workers and patients, interesting facts and figures and collectibles. It tells inspiring stories of dedicated healthcare workers working in the various healthcare sectors in Singapore, in a 50-year health care journey. The 7 Chapters start at "The long dawn - From Colony to Independence", and end at "Looking ahead - Transforming for the future". These are stories about the first General Hospital in 1821 near the junction of Bras Basah Road and Stamford Road, the "Stop at two" family planning program in 1978 and the Severe Acute Respiratory Syndrome (SARS) epidemic in 2003. There are over 50 insightful interviews with Singaporeans from all walks of life, 14 interactive inserts ranging from a 1946 midwife birth report to the Great Singapore Workout pamphlet in 1992, as part of the National Healthy Lifestyle Programme. 297 black-and-white and coloured photographs were obtained from the National Archives of Singapore and Singapore Press Holdings.

Alongside are also heart-felt stories illustrating the sterling and steadfast work the healthcare workers from our hospitals and clinics do every day like the nurse at the Institute of Mental Health's Sunshine Wing, the Health Promotion Board ambassador and the Medical Technologist from the Department of Pathology, Singapore General Hospital. There were also pages devoted to Mr Wong Ngiap Leng, from Ah Leng's canteen at Singapore General Hospital enticingly entitled "Counsellor, banker, provider of food and drink…"

Work on the book was started in June 2014 by an editorial team from MOH. The fruits of labor are 11,000 limited copies, while an e-book is available on the MOH website:
https://www.moh.gov.sg/content/moh_web/home/pressRoom/pressRoomItemRelease/2015/launch-of-sg50-healthcare-commemorative-book-and-the-ministry-of.html

The Prime Minister, Mr Lee Hsien Loong, gave a message in the book. Mr Gan, the Health Minister, penned a foreword and did a calligraphy which is shown in the book, expressing his wishes for Singapore, quoting a Chinese saying 养生之道, which means nurturing the habits of maintaining good health and leading good lives.

This event also celebrates an MOH Long Service Awards to 187 individuals who have served in various capabilities in more than 90 MOH-appointed boards, councils and committees over the years, e.g. committees advising on professional standards, ethics and Medifund. The years of service for the award recipients are 5, 10 and 20 years, the last of which there were 2 recipients

Amongst the recipients are Family Physicians, Dr Arthur Tan Chin Lock, Dr Lew Yii Jen, Dr Tang Wern Ee, Dr Tham Tat Yean, Dr Leong Choon Kit and Dr Uma Rajan, all of whom received 5-year Long Service Awards. Other recipients are a porter assistant, an ambulance driver, nurses, doctors, the volunteer "Caring Clowns" at Kendang Kerbau Hospital and frequent blood donors who organized the annual blood donation drives. We congratulate all of them!

The event ended with photo taking and a hearty tea session to catch up with friends and colleagues. Truly, a memorable and meaningful afternoon to remember and celebrate the lives of healthcare workers past and present, for their unerring commitment and accomplished work, in caring for patients and society, for promoting healthy living, keeping pace keeping pace with medical progress and transforming the healthcare landscape, for the past 5 decades.

Family Physicians who received the MOH Long Service Awards, (from left) Dr Leong Choon Kit, Dr Tang Wern Ee and Dr Lew Yii Jen.

All images courtesy of Dr Goh Lay Hoon

CM

Live Radio Interview with Capital 958 FM on Family Medicine training in Singapore

by Dr Low Lian Leng, Council Member, College of Family Physicians Singapore

On 27th November, College President Associate Professor Lee Kheng Hock and Dr Low Lian Leng attended a live radio interview with Capital 95.8 FM, a popular Chinese infotainment station on its morning talk show. The interview was hosted by Mr Phua Kia Peow and covered on the need for more family physicians with family medicine training to support Singapore's aging population and changing healthcare needs in the primary, intermediate and long term care (ILTC) sectors. The following are some key take-away from their interview.

Capital 95.8FM morning talk show host Mr Phua Kia Peow finds out more about Family Medicine from Dr Low Lian Leng (middle) and A/ Prof Lee Kheng Hock (right).

Image courtesy of Dr Low Lian Leng

Professor Lee started by sharing that since its inauguration in 1971, the College has been advocating for post-graduate training for family physicians, culminating in formation of the Masters of Medicine (Family Medicine) program in 1993, followed by the Graduate Diploma in Family medicine and the Fellowship of the College of Family Physicians. The programs have nurtured many batches of well-trained family physicians. Professor Lee also highlighted the importance of ongoing training for family physicians to upgrade their competencies to manage the increasingly complex patient care needs in our aging population. Older family physicians can also enroll in College programs if they had missed out on formal training programs before its formation.

Dr Low added that today's family physicians will play a major role in the healthcare system as they are versatile to work in many settings including acute interface, ILTC and home care. The family medicine training programs are rigorous to prepare the family physician to function as "One discipline, many settings" and fulfill the full potential of family medicine in these diverse settings. The holistic training is what motivated him to do the Masters followed by the College fellowship program.

To meet the needs of the aging population with increasingly complex care needs, Professor Lee emphasized that today's family physicians are required to be well-trained to prioritize their patients' multiple problems. Patients can be taken care of by family physicians starting from the post-acute phase and continuing the care in the step-down setting before transition to the community family physician. The rigorous training family physicians receive will allow them to appreciate the impact of the illness at different transition points of the healthcare continuum and understand the interaction between multiple disease complications and individualize management plans appropriately. The longitudinal relationship built by caring for patients from cradle to grave is beneficial for the family physician to apply the context and provide patient-centered care.

Finally, Dr Low gave an example of how the additional training has benefitted him in his work. He pointed out that many family physicians now play an important role in caring for the chronically sick and home-bound patients in home care as they are unable to return for hospital follow up. The additional fellowship training benefitted him to lead his multi-disciplinary home care team competently and prevent unnecessary readmissions and emergency department visits for his patients.

CM

1st SSO-NCCS Geriatric Oncology Workshop - *10th Oct 2015*

by Dr Ravindran Kanesvaran, Consultant, Division of Medical Oncology, National Cancer Centre Singapore

The Singapore Society of Oncology (SSO) together with the support of the Department of Cancer Education of the National Cancer Centre Singapore (NCCS) had organised a workshop on Basic principles of Geriatric Oncology for family medicine specialists recently. Geriatric oncology is a fairly new field that has come to prominence of late with the realisation that elderly cancer patients should be treated differently from younger cancer patients in view of the various factors from biology to psychology that changes with aging. Elderly cancer patients (defined as those aged more that 65 years old) consist of 60% of all cancer patients, hence forming a large of cancer patients with unique needs.

Geriatric Oncology is a field that is fairly well developed in USA and some European countries but still in its infancy in Asia. NCCS has the only geriatric oncology program in the region and it was initiated in 2007. Currently it is a clinical service provided to selected cancer patients who are older than 70 years old presenting at NCCS.

The Singapore Society of Oncology, through its President, Dr Ravindran Kanesvaran, had applied for the "International Neighbour of Choice (INOC)" grant from MSD Philantrophy for 2015 and was successful in its application for funding to conduct 3 geriatric oncology workshops. The first of the workshops was the one conducted on October 10th 2015. It was held at the NCCS Auditorium from 12pm to 5pm.

The objective of this workshop was expose family medicine specialists and general practitioners to the fundamental concepts

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Dr Low added that today's family physicians will play a major role in the healthcare system as they are versatile to work in many settings including acute interface, ILTC and home care. The family medicine training programs are rigorous to prepare the family physician to function as "One discipline, many settings" and fulfill the full potential of family medicine in these diverse settings. The holistic training is what motivated him to do the Masters followed by the College fellowship program.

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of the field of geriatric oncology. The half day workshop was developed in a way to give the participant a comprehensive overview of all the key specialities involved in the care of elderly cancer patients. Hence the workshop involved medical oncologists, geriatrician, palliative medicine specialist, pharmacist, medical social worker and family physician.

▲ *Multidisciplinary team to deliver a new model of care in Geriatric Oncology*
◄ *Family physicians from diverse backgrounds coming together to train to provide more holistic care.*

Images courtesy of Dr Ravindran Kanesvaran

The course was opened by medical oncologist, Dr Ravindran Kanesvaran with an overview and a brief introduction to the unique **characteristics of the elderly person** including disease presentations, changes in physiology, principles of prescribing and the importance of a multidisciplinary approach. This was followed by geriatrician, Dr Anupama Roy Chowdhury, who shared on **geriatric syndromes** that might be commonly encountered in an older person with cancer including delirium and dementia, falls, functional decline and poor feeding. Next, Dr Ravindran Kanesvaran covered a brief description of the **common cancers seen in the older person** - breast, lung, prostate, haematological malignancies, stomach, colorectal, metastatic cancer of unknown primary including their presentation and an update on latest tools for diagnosis and workup. Dr Tira Tan, medical oncologist, covered the **basic principles of treatment in the elderly**, assessment of fitness to undergo treatment, as well as specific management of the cancers mentioned above.

In the second part of the workshop, pharmacist, Ms Yeoh Ting Ting, shared on **common toxicities** and **drug interactions** of cancer drugs as well as tools used to **predict** its risk. Palliative oncologist, Dr Lalit Krishna, gave an interactive session on the **management of common symptoms** encountered by the elderly cancer patient including pain, shortness of breath, nausea and vomiting, constipation, hiccups, itch and their management, both pharmacological and non-pharmacological. This was followed by Ms Niki Goh Ying Rou, Medical Social Worker who gave a brief update on the community resources available for the older person with cancer, how to choose the right service and how to refer to these services. Lastly, Dr Rose Fok, a Family Physician, shared her experiences dealing with patients in the **breast cancer survivorship** clinics at NCCS. She highlighted that there is an increasing role of the family physician in care coordination and survivorship plans as they have the appropriate skillset focusing on patient education, health promotion and disease prevention.

In total, there were 83 participants who turned up for the workshop. There were pre workshop and post workshops surveys completed by all the participants of the workshop. Analysis of the information from the surveys conducted indicates that the participants now have a higher level of confidence and knowledge in dealing with cancer patients they may encounter in their clinics. This coupled with the overall excellent feedback from all the participants have encouraged the organisers to plan a few more of these workshops in the future. The next workshop is planned for March 2015 and will focus on training nurses involved in the care of elderly oncology patients.

CM

Talk at SG50 Appreciation Dinner for Pioneer GPs on 30th Oct 2015

Sharing of Experiences in the Private Healthcare Setting

by Dr James Chang Ming Yu,
Life Fellow of CFPS and Life Member of Singapore Medical Association
Founder Member, CFPS
Censor-in-Chief CFPS 1979-1985
Member, Singapore Medical Council 1983-1995

Minister for Health, Mr Gan Kim Yong,
Minister of State for Health, Dr Lam Pin Min,
President of the College of Family Physicians, Dr Lee Kheng Hock,
Deputy CEO Agency for Integrated Care, Dr Wong Khek Chuan,
Dear Colleagues and Friends,

I am deeply honoured to be invited to speak on this occasion on my experiences as a family doctor of 50yrs standing. Since the other speakers have spoken on the academic and formal issues of primary healthcare, I wish to speak only of my own experiences as a family doctor in the 1960s and 70s.

I am 80 years old and my MCR No: is 00531B. I am therefore considered a dinosaur in medical circles. At a recent CME meeting, I was asked my MCR No and the young lady at the registration counter said my number couldn't be right. Why so? I asked. Everybody has 4 numbers but yours has only 3, she replied!

I started my clinic in 1965, exactly 50 years ago. It was in Beauty World Town along 7th Mile Bukit Timah Road. This is now the location of the Beauty World MRT Station that is to be opened at the end of this year. In the 1960s, there were only about 500 registered doctors and roughly half of them were in private practice. Most were general practitioners, because specialist practice was then in its infancy. The standard of practice varied with each doctor. There was no formal training for general practitioners and doctors started their clinics when they wished to. Some started immediately after serving housemanship, some after retiring from public institutions. A few of these retirees had spent years doing surgery, general medicine or administrative work and then decided to open their own clinics. There were GPs who could do complicated surgical procedures like fixing fractures, arthrodesis of joints, cleft palate and harelip repairs. Some ran maternity homes and delivered babies with the help of midwives. A

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Images courtesy of Dr Ravindran Kanesvaran

The course was opened by medical oncologist, Dr Ravindran Kanesvaran with an overview and a brief introduction to the unique **characteristics of the elderly person** including disease presentations, changes in physiology, principles of prescribing and the importance of a multidisciplinary approach. This was followed by geriatrician, Dr Anupama Roy Chowdhury, who shared on **geriatric syndromes** that might be commonly encountered in an older person with cancer including delirium and dementia, falls, functional decline and poor feeding. Next, Dr Ravindran Kanesvaran covered a brief description of the **common cancers seen in the older person** - breast, lung, prostate, haematological malignancies, stomach, colorectal, metastatic cancer of unknown primary including their presentation and an update on latest tools for diagnosis and workup. Dr Tira Tan, medical oncologist, covered the **basic principles of treatment in the elderly**, assessment of fitness to undergo treatment, as well as specific management of the cancers mentioned above.

In the second part of the workshop, pharmacist, Ms Yeoh Ting Ting, shared on **common toxicities** and **drug interactions** of cancer drugs as well as tools used to **predict** its risk. Palliative oncologist, Dr Lalit Krishna, gave an interactive session on the **management of common symptoms** encountered by the elderly cancer patient including pain, shortness of breath, nausea and vomiting, constipation, hiccups, itch and their management, both pharmacological and non-pharmacological. This was followed by Ms Niki Goh Ying Rou, Medical Social Worker who gave a brief update on the community resources available for the older person with cancer, how to choose the right service and how to refer to these services. Lastly, Dr Rose Fok, a Family Physician, shared her experiences dealing with patients in the **breast cancer survivorship** clinics at NCCS. She highlighted that there is an increasing role of the family physician in care coordination and survivorship plans as they have the appropriate skillset focusing on patient education, health promotion and disease prevention.

In total, there were 83 participants who turned up for the workshop. There were pre workshop and post workshops surveys completed by all the participants of the workshop. Analysis of the information from the surveys conducted indicates that the participants now have a higher level of confidence and knowledge in dealing with cancer patients they may encounter in their clinics. This coupled with the overall excellent feedback from all the participants have encouraged the organisers to plan a few more of these workshops in the future. The next workshop is planned for March 2015 and will focus on training nurses involved in the care of elderly oncology patients.

CM

Talk at SG50 Appreciation Dinner for Pioneer GPs on 30th Oct 2015

Sharing of Experiences in the Private Healthcare Setting

by Dr James Chang Ming Yu,
Life Fellow of CFPS and Life Member of Singapore Medical Association
Founder Member, CFPS
Censor-in-Chief CFPS 1979-1985
Member, Singapore Medical Council 1983-1995

Minister for Health, Mr Gan Kim Yong,
Minister of State for Health, Dr Lam Pin Min,
President of the College of Family Physicians, Dr Lee Kheng Hock,
Deputy CEO Agency for Integrated Care, Dr Wong Khek Chuan,
Dear Colleagues and Friends,

I am deeply honoured to be invited to speak on this occasion on my experiences as a family doctor of 50yrs standing. Since the other speakers have spoken on the academic and formal issues of primary healthcare, I wish to speak only of my own experiences as a family doctor in the 1960s and 70s.

I am 80 years old and my MCR No: is 00531B. I am therefore considered a dinosaur in medical circles. At a recent CME meeting, I was asked my MCR No and the young lady at the registration counter said my number couldn't be right. Why so? I asked. Everybody has 4 numbers but yours has only 3, she replied!

I started my clinic in 1965, exactly 50 years ago. It was in Beauty World Town along 7th Mile Bukit Timah Road. This is now the location of the Beauty World MRT Station that is to be opened at the end of this year. In the 1960s, there were only about 500 registered doctors and roughly half of them were in private practice. Most were general practitioners, because specialist practice was then in its infancy. The standard of practice varied with each doctor. There was no formal training for general practitioners and doctors started their clinics when they wished to. Some started immediately after serving housemanship, some after retiring from public institutions. A few of these retirees had spent years doing surgery, general medicine or administrative work and then decided to open their own clinics. There were GPs who could do complicated surgical procedures like fixing fractures, arthrodesis of joints, cleft palate and harelip repairs. Some ran maternity homes and delivered babies with the help of midwives. A

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retired public health administrator who went into private practice discovered that he had no clue of Pediatric medicine, Obstetrics and Gynaecology or other branches of medicine because he had no experience or received training in them. I had the luxury of having gone through the paces, having received postings in Surgery, Medicine, O & G, Accident & Emergency and Polyclinic Outpatient and felt fairly confident. However, I was at sea when it came to managing a "business": how to employ and maintain staff, how to buy drugs and check on the stocks.

My clinic occupied a space of 400sq ft in a single storey shop that was part of a collection of small shops carrying out different types of business. I paid $270 a month for a 15-year lease. At that time 7th mile Bukit Timah was considered "ulu" and my patients were mostly farmers, fishermen, granite quarry workers, petty traders and people living in Bukit Timah , Bukit Panjang, Jurong, Tuas, Choa Chu Kang, Lim Chu Kang, even in Woodlands and Mandai. At that time Jurong Industrial Estate had not started.

My patients were generally poor. They couldn't afford laboratory tests at the single private laboratory in town and so I improvised a small bedside laboratory. I remember having a microscope, a centrifuge machine, test tubes and reagents in my consultation room. This saved them the extra cost and inconvenience of travelling into town and I could make a diagnosis with greater confidence. My standard medical bill when I started practice was $4-5. This was an all-inclusive bill. Whenever I grossed $200 for the day, working 3 sessions, I was very happy.

When I think back on healthcare in those early days, many features of it come to my mind and I would like to illustrate them with cases that I still remember vividly.

a) Housecalls

I did many housecalls then. Most times they were for patients who were too ill to come to the clinic or had difficulties with transport. One Sunday afternoon, a young man asked me to see his grandfather who was in pain for two days because he could not pass urine. To reach his house in Choa Chu Kang, I drove my car for 30mins and thought I had arrived. But no, the young man handed me a bicycle and asked me to follow him on muddy tracks till we reached the farmhouse. There I found the grandfather writhing in agony. He had acute retention of urine from an enlarged prostate. I inserted a urinary catheter and drained two litres of urine from his distended abdomen and was rewarded with smiles from the old man. It was a satisfying moment for me as well.

b) Consultation fees

In those days, there was no such thing as a consultation fee. If no medicine was given during a consultation, the patient did not think he needed to pay anything. I recall being called to visit an elderly lady who was very ill. She had pneumonia and I advised immediate hospitalization. I wrote a referral letter for the family but did not give the patient any injection or medicines. The family thanked me but made not attempt to pay me a fee. I was too shy to ask but was happy when they gave me an *angpow*. Back in my clinic I opened the *angpow*. In it was $2!

c) Gifts in lieu of fees

I was often paid my fees in kind. I remember a young man who fell down and was rushed to my clinic, having sustained lacerations and abrasions all over. I dressed his wounds and stitched his lacerations. He didn't have money on him that day but came back a few days later with two life chickens to thank me. At other times when patients could not pay in cash, I would receive ducks, fresh eggs and home–grown vegetables. Once I even received fish and crabs from a patient who had a *kelong*. He invited me to stay overnight on his *kelong* as well.

d) Litigation

This was unheard of in the early days. Patients were inevitably grateful for what ever you had done for them and would never take a doctor to court. I once treated a woman who was cut by broken glass splinters when a windowpane shattered in her house. I stitched the laceration in her foot. Ten years later, the same lady saw me again to say that the scar on her foot was hurting. When I examined her foot, I felt something firm under the scar. I told her I needed to do a little surgery in that area. She agreed and I extracted a small piece of glass that was left behind from her previous injury. This lady thanked me profusely for what I did for her. I shudder to think what legal action I would have to face now, for leaving a foreign body behind in a wound.

e) Reliance on clinical acumen

One of our early Professors of Medicine, Professor Ransome, used to teach us that a comprehensive history would allow us to reach 75% of the diagnosis and a good clinical examination would add another 10%. Even in present day general practice, we have to rely on our clinical acumen. I was called one morning to see an Indian patient who suddenly fell unconscious after returning from his morning exercise. His wife thought he had a stroke. He was cold and clammy. I knew he was a diabetic and after examining him, gave him a bolus IV injection of glucose. Within seconds, he sat up and asked me what happened. He had suffered a hypoglycemic attack. That morning he took his diabetic medicine but thought he would eat breakfast after his morning jog. It was an opportunity at that time for me to teach him how to manage his diabetic condition, and avoid hypoglycemic attacks in the future. I was reminded of this incident recently when a friend of mine landed in A & E after fainting in the dental clinic. He was also a diabetic. He ended up with ECG, CT scan and had a full blood and urine workout, spending the whole day in the hospital, only to be discharged and told that he had hypoglycemia.

Modern Day General Practice

General practice in Singapore has evolved from third world status to first world. Solo practices are now slowly being replaced by group practices. Private patients are now scarcer, being replaced by patients belonging to companies who buy medical insurance for them and their families. Patients are more knowledgeable of their illnesses and demand longer consultation times for explanation of their medical conditions. Fortunately doctors nowadays are better trained and better prepared to treat them. There are laboratory and radiological facilities for investigations in private practice. There are now an abundance of medical and surgical specialties in both the private and public healthcare sectors for patients to be referred to, for further management. There are many CME programmes, medical journals and medical practice guidelines

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Photograph 2 shows the first batch of College Fellows having a session at the Graduate Family Medicine Centre above Cheong Medical Clinic. The FCFP(S) by assessment is now recognized as a criterion for fellowship of the Academy of Medicine Singapore in 2014. That is another short story of the "long march" of the FCFP(S) – and the march is still on.

Photograph 2. Fellowship class in session that trained the first batch of College Fellows by Assessment

Image courtesy of Dr Julian Lim

Now for the MMed and Collegiate story leading to the newly inaugurated the College MMed FM Programme at the 2015 Convocation. It started out as a cat rescue centre in 1993 by none other than Prof Cheong Pak Yean and Prof Goh Lee Gan for dropped out trainees, like me, who have left service to be the sole bread winner for the family which was also fortuitously facilitated by the early release scheme offered during that time. It gave us a fighting chance to have bite at the MMed. It became the 2-year PPS – Private Practitioners' Stream for senior GPs hoping to have the same bite in 1995 – It was quite a big bite and one of the reasons for the smaller GDFM bite. Nevertheless, we managed to graduate 61 doctors from 1995 to 2006. Many of these Graduates from the PPS stream are now CEOs, CMBs, Directors of Polyclinics, Head of Departments, Residency Programme Director and Faculty, University faculty and so on.

PPS was renamed "Programme B" in 2006 as we were taking in more and more trainees from the polyclinic who were too senior to benefit from the MOH traineeship Programme A. It was effectively a 3-year course – taking into account the compulsory completion of the 2-year FMTP – Family Medicine Training Programme. During this time, Programme B was hosted by the then COFM Department when Prof Chan Nang Fong was there and in Dr Julian Lim's clinic. With the set-up of the Department of Family Medicine and Continuing Care, SGH, the Programme B tutorials were run by this Department and some at the College premises. We had trainers from the private sector, the polyclinics and even the university. In all, PPS and Programme B together graduated a quarter of all MMed(FM) holders.

With the new residency programme (no more Programme A); the new examination format and endorsement given to our trainees to take the MMed exam offered by the NUS (the successful ones are here tonight) and more poignantly, the support of MOH in the form of financial sponsorship for the trainees this year, it is a good time to hand over the programme officially to the College and to a name change – the College programme leading to the Master of Medicine in Family Medicine and Collegiate membership.

In closing, Prof Cheong wanted to remind us why it had to be cover potholes always. CME in the past had always been one of specialists covering the rarities – what we needed was knowledge to cover the whole breadth, leaving no holes uncovered, covering all the knowledge gaps that we encounter in our practice. Consolidating plateaus is why we do what we do in continually upgrading ourselves. We weren't quite sure what conquering peaks meant at that time. But now it is getting clearer – one discipline, many settings. It is in meeting the needs of the society in areas that require us to conquer the peaks of knowledge and skills to be able to fulfill those challenging roles – be it in ambulatory care, community hospitals, rehabilitation centres, long term care in nursing homes, palliative care, home care, transitional care and even inpatient care.

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◂ *The inauguration of College Programme for MMed(FM) and Collegiate Membership - (from left) A/Prof Goh Lee Gan, Dr Julian Lim and A/Prof Lee Kheng Hock.*

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available to doctors. All these have contributed to the evolving landscape of General Practice in Singapore.

Disease patterns have also changed. We used to see patients with rheumatic fever causing defective heart valves, mitral stenosis, mitral and aortic incompetence, 3rd stage syphilis causing GPI, tabes dorsalis, charcot joints and molar pregnancies and choriocarcinoma. I also encountered many cases of silicosis among the granite quarry workers. We hardly hear of these conditions nowadays. Instead we have new infections like HIV, SARS, MERS and Ebola virus. We are also encountering diseases of an aged-population, degenerative conditions like dementia, aged related macular degeneration and diseases related to atherosclerosis.

I am now semi-retired, having handed over my practice to my son but I still maintain a few morning sessions a week to see patients. I am grateful for the opportunity to have experienced general and family medical practice for the past 50 years, coinciding with SG50.

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