



# THE College Mirror

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## On Numbers, Settings and Teamwork in Family Medicine

*The Permanent Secretary, Ministry of Health, Mr Chan Heng Kee spoke at the dinner on 25 February 2017 to celebrate the 30<sup>th</sup> Anniversary of Family Medicine (FM) in NUS YLL School of Medicine. He traced the evolution of FM education in Singapore, paid tribute to FM leaders who developed the infrastructure before delving into the three elements going forward viz. Numbers, Settings and Teamwork.*



Mr Chan Heng Kee

### Evolution of Family Medicine Education in Singapore

When undergraduate Family Medicine training was first started in 1971, it entailed a one-week posting to a GP clinic. This was supplemented by ten lectures on General Practice, organised by the then College of General Practitioners. In 1987, Family Medicine was formally recognised by the NUS Faculty of Medicine as an academic discipline. A dedicated Academic Family Medicine unit was set up.

Fast forward to today - Family Medicine is part of the core curriculum in all three medical schools in Singapore. The curriculum has also been enhanced. Since 2007, Yong Loo Lin has had in place an

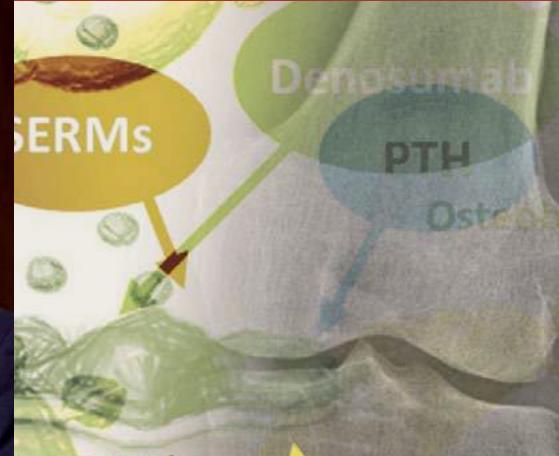
8-week Family Medicine rotation that includes stints at polyclinics, GP clinics, as well as sub-acute, rehab and palliative care units.

We also have a robust postgraduate Masters of Medicine residency programme in Family Medicine. In addition, the Graduate Diploma in Family Medicine and Programme B, both run by the College of Family Physicians Singapore, provide opportunities for practising GPs to upskill themselves in Family Medicine. Fellows of the College have since 2014 been inducted to the Chapter of Family Medicine Physicians, Academy of Medicine Singapore - an endorsement of the discipline.

These strides were only possible because many family physician leaders had played an active role shaping Family Medicine education and practice since the early days. Among them are the late Dr Wong Heck Sing as well as other family medicine leaders including Dr Lee Suan Yew, Dr Alfred Loh, Associate Professor Goh Lee Gan, Associate Professor Cheong Pak Yean and

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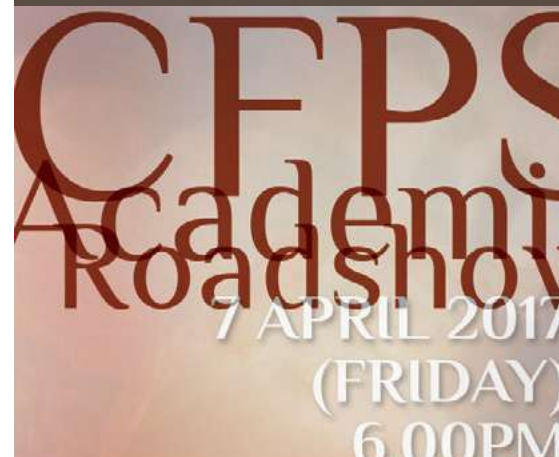
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**ON NUMBERS:**  
**“60% of the doctors in polyclinics and GP clinics are accredited as family physicians ... about 1,700 today... We need to double this to 3,500 by 2030...”**

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(continued from Cover Page: Our Numbers, Settings and Teamwork in Family Medicine)

Associate Professor Lim Lean Huat. Some of them are amongst us this evening. May I ask you to join me in recognising their immense contributions.

## Three Elements Shaping Family Medicine Education

Family Medicine has come a long way - as an academic discipline and as an integral part of healthcare delivery. Today, about 60% of the doctors in polyclinics and GP clinics are accredited as family physicians. As we look ahead to meet our future healthcare needs, there are a few elements which I think Family Medicine education and practice will have to take into account – Numbers; Settings; and Teams.

## More Family Physicians Needed

Let me first talk about Numbers. To put it simply, we need to train more family physicians. All of us know of our rapidly ageing demographics, increased chronic disease burden and case complexity. We also know that a hospital-centric healthcare system is unsustainable. We must therefore put more focus on person-centred primary and community care, to enable Singaporeans to be comprehensively cared for, through their life journey, in the community. I believe this is in line with the principles of good Family Medicine.

We have about 1,700 family physicians today. Based on MOH's preliminary projections, we need to double this to 3,500 by 2030, particularly in primary care in GP clinics and polyclinics. These are where most patients will, and should, turn to as their first and continuous line of care.

Our education and training pipelines must be able to respond to meet these needs. This is why MOH has set up a workgroup to review how the Family Medicine residency programme's training pipeline can be enlarged, while maintaining standards. We are also working with the College of Family Physicians Singapore to strengthen its GDFM in chronic disease management, geriatrics and mental health.

(continued on the next page)

(continued from Page 3: Our Numbers, Settings and Teamwork in Family Medicine)



Standing (from left): A/Prof Lim Fong Seng, A/Prof Yeoh Khay Guan, Dr Tan See Leng, A/Prof Chen Fun Gee, A/Prof Quek Swee Chye, A/Prof Kenneth Mak, Mr Chua Song Khim  
Seated (from left): Mr Chan Heng Kee, Dr Lee Suan Yew, A/Prof Benjamin Ong



Standing (from left): A/Prof Cheong Pak Yean, A/Prof Lau Tang Ching, A/Prof Aymeric Lim, A/Prof Dan Yock Young, A/Prof Lee Kheng Hock, Prof Lawrence Ho  
Seated (from left): A/Prof Lim Lean Huat, Prof Lee Hin Peng, A/Prof Goh Lee Gan

**ON SETTINGS:**

*“By 2030 ...we expect 10% of family physicians to be practising in community hospitals.”*

**Working in Different Settings**

Second, Settings. Today, close to 90% of our family physicians practise in GP clinics and polyclinics. Only about 2% practise in community hospitals. The rest work in acute hospitals and other settings.

While GP clinics and polyclinics will continue to anchor care in the community, the need and role of Family Medicine beyond these traditional primary care settings will grow, especially in intermediate and long-term care. By 2030 for example, we expect 10% of family physicians to be practising in community hospitals.

Training programmes must therefore expose Family Medicine trainees to different settings. More exposure in less-traditional areas such as palliative care, community hospitals, transitional care and home care, are needed for trainees. For those whose practice is based in community

hospitals, a more targeted training approach might have to be developed. MOH has thus started discussions with the College of Family Physicians Singapore to explore how Family Medicine training can better support care in community hospital practice.

**Working Together in Teams**

Third, Teams. The family physician of the future, regardless of his work setting, will increasingly work within a team of providers. This is inevitable; driven by the increasingly complex case mix and fast pace of medical advancements. Given smaller families and diminishing family support, family physicians will also find themselves having to do more to coordinate care for patients. Even the most well-trained ones will need the support and collaboration of other members in the healthcare family.

The importance of team-based care in chronic disease management is a key reason we developed Family Medicine Clinics and Community Health Centres. It is also why we are working to strengthen links between primary and specialist care, such as through direct access to specialist outpatient clinics for selected conditions based on established protocols.



From left: A/Prof Lim Fong Seng, Mr Chua Song Khim, A/Prof Benjamin Ong, Mr Chan Heng Kee, A/Prof Yeoh Khay Guan, A/Prof Quek Swee Chye, A/Prof Dan Yock Young, A/Prof Goh Lee Gan

Teamwork is also relevant in the context of GP clinics. MOH is developing the Primary Care Networks concept to bring solo GPs together in networks. We hope that this will enable them to share administrative and clinical resources, and explore opportunities for collaboration. We have also developed GPCoconnect, an IT solution for GPs, to strengthen links across the sector and with Regional Health Systems.

#### ON TEAMS:

*“The most important element for team-based care ... is not structure and systems, but people.”*

The most important element for team-based care to succeed is however not structure and systems, but people. Beyond the acquisition of clinical knowledge, emphasis will need to be placed during the education and training of young family physicians, on practical skills in team-based practice. We hope that family physicians and Family Medicine educators can embrace this philosophy of inter-professional

collaboration in their practice, learning, as well as teaching of junior doctors.

#### Conclusion

Ladies and Gentlemen, the NUS Yong Loo Lin School of Medicine has made commendable efforts to nurture the growth of Family Medicine in Singapore over the past three decades. We know that it will continue to play a leading role in Family Medicine. I am confident it will evolve its education and training system and methods to meet the challenges ahead, including the three elements which I just spoke about.

To all family physicians with us this evening, thank you for your dedicated service. We believe the future holds exciting prospects for primary care and Family Medicine. We look forward to your continued contributions in shaping our healthcare system for the future, so that Singaporean can enjoy better health, better care and a better life.

*Images courtesy of NUS Division of Family Medicine*

■ CM

## A Tale of 3 Clusters

Interviewed by Dr Phua Cheng Pau Kelvin, FCFP(S), Editorial Board Member

The six regional health systems in Singapore will be reorganised into three healthcare clusters for the central, eastern and western regions. Polyclinics will also be reorganised, in line with the geographical reach of the three new clusters.

- **Central:** Alexandra Health System will merge with National Healthcare Group (NHG)
- **East:** Eastern Health Alliance will merge with Singapore Health Services (SingHealth)
- **West:** Jurong Health Services will merge with National University Health System (NUHS)

There are a few major challenges in healthcare for Singapore over the next few decades:

1. The increasing healthcare needs of an ageing population
2. Increased chronic disease burden
3. The need to manage future growth in healthcare manpower and spending (i.e. increase productivity and efficiency)

MOH stated that this reorganisation will enable Singapore to meet “future healthcare challenges” with the following improvements:

- Each cluster will have a fuller range of capabilities and facilities across different care settings
- Will be able to deliver more comprehensive care and person-centred health promotion.

- Able to implement changes more swiftly and decisively.

#### *Family Physicians: How will these changes affect patient care especially primary care?*

The editorial team sought to appreciate how the above changes will affect family physicians and the way they care for their patients. We interviewed a few family physicians practicing in different settings for their view on this matter. There were a few common themes voiced out:

1. They recognise that care coordination and case management are essential to care for patients in the community;
2. IT enablers are crucial for successful implementation of common platforms for communications between the various providers, including primary care;
3. The key to a healthier population starts with a strong primary care team.

We also spoke to a few family physicians who run their own clinics. They felt that these changes are unlikely to affect their practice in the near future. This is not surprising as this is a recent announcement and the Ministry and the clusters have yet to announce detailed plans on any changes to the current model of care or collaborations with GPs.

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# Editor's Words

by Dr Irwin Clement A. Chung Wai Hoong, MCFP(S), Editor

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Ms Patricia Cheok

Heraclitus, a Greek philosopher, is quoted as saying "change is the only constant in life." Indeed, in a fast-paced go-getter society like ours in Singapore, it is common day occurrence, and oft disguised by the cloak of improvement, innovation, adaptation and evolution. There is no constancy in this constant, to be sure.

Just across the vast Pacific Ocean, in the "land of the free", where not too long ago the echoes of "change" rang through the presidency of Barack Obama, we hear today from Donald Trump the resonance of "change back" – give us back the America we once knew. I reckon that many of us could have watched Donald Trump's election to the US presidency with a mix of amusement or outright incredulity. Surely, the American public could be trusted to know what it would take for their country to survive in these times, couldn't they? Looking back at its industrial heyday is not going to help its global position as the rest of the developing economies surge forward. Living in past is not going to help it face the future.

Fast forward a couple of months into the new year, we in the healthcare family come face to face with our own change of seismic proportions – public healthcare is being restructured again. Was it not too long ago when we sprouted 6 regional health systems from 2? Now we are being shrunk to 3 by merger more or less according to geographical divisions. And this time round, it has really hit home for some of us – the impact on primary care is more acutely felt with the redistribution of polyclinics, the bulwark of subsidised, open access public healthcare. Each of the resultant healthcare clusters will therefore be endowed with a ready suite of services spanning much of the healthcare spectrum. Taking a more geographically limited approach to service planning is supposed to also support better health and social care integration as well as population health management at large. Could we not do that with 6? Apparently not.

After the news of restructuring was released, I happened to chance upon an old acquaintance of mine, now a GP in private practice. He was quick to ask me "which side of the fence I was on", as if deciding where I pledged my allegiance (or rather, plied my trade) was an epic moral quandary. So I told him I was "happily stuck" in NHG. In turn I asked him if he had any concerns or saw any opportunity with this latest reform, from his position as a neighbourhood GP operating in the territory of the "NUPpies" – nope, it's life as usual regardless of whoever sits on the throne, or what kind of throne it is, for that matter. So perhaps the more enterprising of our kind out in the private sector take better to change, but I am tempted to think that the rationale behind this reform has failed to strike a nervous chord in the likes of him. And why is that so?

Unlike some of us who are inadvertently caught in the emotional, operational, legal, financial and even political dust storm of restructuring, folks on the ground are simply focused on their basis for existence – there are sick people out there and they need a doctor. If I look after them well, they will bring with them their father, mother, brother, sister, uncle, auntie, cousin, spouse, children and grandchildren who need my attention. I will care for them, soothe their ills and keep them healthy to the best of my ability. They will also help me pay my rent. You folks in the ivory tower can play your musical chairs; I will simply practice family medicine the way I know how. Simplistic though it may sound, perhaps it is also a good reminder to us who pride ourselves as stewards of an affordable, accessible and good value healthcare system that at the heart of change, there is truly a constant – a nexus of calm in the crosswinds of restructuring – we are here for our patients, and that sacrosanct relationship is something we can ill afford to change.

■ CM

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(continued from Page 5: A Tale of 3 Clusters)

## Dr David Tan Hsien Yung, Head, Pioneer Polyclinic, NUP

### College Mirror (CM):

What is your role in NUP?

### Dr David Tan (DT):

I am a Family Physician first of all, and still have very much of a clinical role in attending to patients and their health and psychosocial issues. I am also heading the new Pioneer Polyclinic development in Jurong West area, and am looking forward to the opening of the new clinic in the latter half of 2017.

Pioneer Polyclinic is unique in that we hope to empanel most of our patients to teamlets, such that patients have continuity of care with their providers, and the teamlets have a panel of patients whose outcomes they are ultimately responsible for. My role as clinic head is to also help develop the teamlets as this is a new care model which many doctors and nurses may not be too familiar with.

Apart from my clinical and administrative role, I continue to be involved in teaching and training matters for NUP.

### CM:

How will the larger cluster affect the delivery of care to the community in the western part of Singapore?

### DT:

The formation of NUP will better align the polyclinics in the West under one group and being part of NUHS will

also enable the entire healthcare cluster to deliver more integrated, patient-centric and comprehensive care.

As there will be a need for more capacity and capability in primary care, having an additional polyclinic group like NUP will help to support these needs, especially working closely with both NHGP and SingHealth Polyclinics as well as GP partners. NUP, which is part of the academic health system of NUHS, will also leverage on the research strengths and the hinterland of NUS to advance the practice of Family Medicine to better serve our population.

### CM:

What are the key areas of integration that will benefit the community?

### DT:

Our service to our patients will still continue amidst the integration that is occurring, but I foresee that all this should help to ensure continuity of care across the different care settings (i.e. primary, tertiary, ILTC) and cover the needs of the community from 'cradle to grave'.

To achieve this, we will need to continue to closely engage our patients and their caregivers, so that they are empowered to take better care of themselves and be more responsible for their own health. At the same time, we need to coordinate well with GP partners, other community health and social care providers to ensure the wellbeing of the community we serve.

## Dr Tan Kok Leong, Senior Consultant, TTSH

### College Mirror (CM):

What is your role in TTSH?

### Dr Tan Kok Leong (TKL):

I am a Family Physician, Senior Consultant, and Deputy Head of the Department of Continuing & Community Care, Tan Tock Seng Hospital (TTSH). I am also the Programme Director for the TTSH Transitional Care (TC) Programme.

The TC Programme was formed and became operational in July 2016. This followed the merger of 2 services, the Action Care & Coordination (CC) and the Virtual Hospital (VH). These 2 services were previously operating as separate entities in TTSH and focused on facilitating the transition of patients from the hospital back to the community. Action CC emphasised inpatient care coordination (i.e. prior to planned discharge), while VH focused on care coordination in the community.

In Jan 2017, the Post-Acute Care at Home (PACH) Service

was merged into the TC Programme. PACH managed post-hospital discharge patients who were home-bound/bed-bound with complex medical and nursing needs.

With the merger of the three services (Action CC, VH, & PACH) into one Transitional Care (TC) service, the care planning and coordination are better streamlined with each patient having one Transitional Care Specialist (TCS, registered nurse) to oversee care coordination from inpatient to the community and to be the point-of-contact (POC) in the community for patients, caregivers, and community partners who are involved in providing care.

The key objective of the TC Programme is to reduce avoidable hospital emergency service attendance and hospital admissions through:

- Empowering the patients and their caregivers to better manage and cope with their medical conditions, and
- Having a tripartite model of care collaboration with TC Service representing the hospital arm, collaborating with

primary care services, and community medical/nursing and social services to render a timely and responsive care to the patients in their home

**CM:**

With these new larger integrated clusters in place, what are the potential opportunities to improve patient care in the area of transitional care?

**TKL:**

The family physicians play a very important role in providing the medical care component to patients in the community. As described in the above on the tripartite care model, the family physicians are key to:

- Working with hospital SOC specialists in the provision of stabilisation and maintenance clinical care to patients with complex diseases, timely and accessible intervention in the early phase of disease exacerbation, and/or close monitoring and treatment titration to prevent disease progression or exacerbation
- Being the primary care physician for the patient by managing and coordinating clinical care and performing periodic medication reconciliation, to avoid adverse events arising from polypharmacy, and reduce stress on the patients and their caregivers on having to go for multiple SOC appointments and performing overlapping lab investigations
- Working with community partners in the management of identified frail elderly patients through preventive care, such as performing a comprehensive geriatric assessment, and making the appropriate referrals to various health and social care providers in order to better support patients in their home and community

**CM:**

What are the key areas that are crucial for this integration to work well?

**TKL:**

Crucial areas to ensure that the Care Integration can work

- A strong sense of collective ownership by members of the care team and both hospital and community providers
- Clarity in the roles and functions of the various stakeholders from the hospital and community in achieving a continuity of care using a trans-disciplinary approach involving various professionals
- Attainment of necessary knowledge and skill sets in managing patient with complex medical & social needs; these include clinical knowledge in disease management, case management, nursing procedures, etc.
- A common platform for timely sharing of information by the care team members; IT, regular case discussion sessions, multi-disciplinary rounds, etc.
- Use of IT in clinical monitoring that can be make critical information available in a timely manner to all members in the team
- Agreed upon work processes to facilitate care amongst the members in the care team
- Agreed upon common KPIs and outcome indicators to ensure alignment of care goals
- Funding from MOH and the regional clusters to support collaborating partners in the community

## Dr Chong Chin Kwang, Director (GP Clinic Network), Frontier Healthcare Group

**College Mirror (CM):**

Hello Dr Chong Chin Kwang, tell me about your role in Frontier Healthcare Group?

**Dr Chong Chin Kwang (CCK):**

I am the Director of the GP Clinic Network.

**CM:**

How will the new clusters affect patient care for Frontier Healthcare Group?

**CCK:**

While patient care at the individual level may not be affected, GPs do need to appreciate the potential systems-level implications as a result of the cluster integration. I am optimistic that with some of the latest developments in our healthcare scene, GPs will be better engaged and there will be better care integration.

**CM:**

How are the potential areas of improvement?

**CCK:**

Engagement is likely to develop more positively when there are common objectives and workflows between the two sides of the engagement. I would think that this is more likely to happen when both sides of the engagement are more consolidated - re-clustering into the 3 health clusters on one side and GPs coming together to form Primary Care Networks (PCNs) on the other side. For example, in our PCN, to align with the re-clustering, we have organised our PCN into 3 regions and each region is headed by two GP clinical leads to help in the engagement with our public healthcare sector colleagues.

*(continued on the next page)*

*(continued from Page 7: A Tale of 3 Clusters)***Dr Chua Chi Siong, Medical Director, Jurong Community Hospital****College Mirror (CM):****What is your role in Jurong Community Hospital?****Dr Chua Chi Siong (CCS):**

I am the Medical Director of Jurong Community Hospital (JCH) and together with my team of clinicians, nurses, operations, HR and finance personnel, oversee the running of the hospital. From the clinical viewpoint, apart from being responsible for the standards of clinical care at JCH, I worked very closely with the clinicians in Ng Teng Fong General Hospital (NTFGH) to ensure that patients who require post-acute and rehabilitative care are seamlessly and safely transferred across to receive the required care at JCH en-route to recovery. Knowing that many of the patients will require well-coordinated post-discharge care involving not just family physicians, but also other community health and social partners, I worked with different teams to ensure that discharge care plans are developed and communicated to relevant partners for good continuity of care.

**CM:****How will the larger cluster affect the delivery of care to community hospital patients in the western part of Singapore?****CCS:**

Prior to the latest reorganisation, there was already strong vertical integration between the restructured and the

community hospitals. With the larger cluster, we aim to build on the existing relationship and work arrangements to better integrate care from the community to the home. As a larger cluster, we will be able to leverage combined resources, expertise and greater opportunities to ensure patients receive well-coordinated care across both restructured and community hospitals. For example, one of the key changes in this reorganisation is that each of the new cluster now has a Polyclinic group so that post-discharge care can be further smoothed for better continuity of care.

**CM:****What are the opportunities the re-organisation present to a family physician in ILTC sector.****CCS:**

A well-trained family physician will have skill sets and ethos that allow him to contribute in a variety of healthcare setting. MOH has identified family physicians to play a crucial role in the further development of the ILTC sector. There is now greater opportunity in terms of training to realize the full potential of family physicians to contribute to patient care across setting and, for those who are interested, to participate in care in more than one setting (as well as involvement in teaching and research).

■ CM

## A Primary Care Doctor's Perspective of Public Healthcare Sector Restructuring

by Dr Ng Chee Chin David, FCFP(S)

From a macro perspective, restructuring our public healthcare system into 3 regional clusters is a move in the right direction. The perceptible duplication and fragmentation arising from having 6 fairly autonomous regional health systems will hopefully be reduced in time to come with the breakdown of boundaries and better interfacing between services. In the spirit of care integration, this reorganisation places the cluster HQ firmer in the driver's seat by overseeing a larger geographical area as well as crucial components of the public healthcare system from tertiary hospital to polyclinics. It however remains to be seen how well the mergers will drive the clusters to focus more on community and primary care, an objective clearly desired by the Ministry of Health.

The shift of care into the community has always been the intention of Ministry in the face of an increasingly aged

population. Care provision in the community necessitates the building of meaningful and mutually beneficial relationships with community healthcare elements like the GPs, ILTC providers and also social organisations as well as other government or grassroots agencies like the Police, schools, People's Association. That network of relationships built on trust undergirds every collaboration that true integration within each region will ensue.

Thus, it is important that the clusters take on the mantle of managing the health of a population by going beyond traditional institutional barriers, bridging the public-private divide and looking hard at what will really benefit the health of the population they serve.

Some potentially thorny issues, however, need further in-depth exploration:

(continued from Page 7: A Tale of 3 Clusters)

**Dr Chua Chi Siong, Medical Director, Jurong Community Hospital****College Mirror (CM):**

What is your role in Jurong Community Hospital?

**Dr Chua Chi Siong (CCS):**

I am the Medical Director of Jurong Community Hospital (JCH) and together with my team of clinicians, nurses, operations, HR and finance personnel, oversee the running of the hospital. From the clinical viewpoint, apart from being responsible for the standards of clinical care at JCH, I worked very closely with the clinicians in Ng Teng Fong General Hospital (NTFGH) to ensure that patients who require post-acute and rehabilitative care are seamlessly and safely transferred across to receive the required care at JCH en-route to recovery. Knowing that many of the patients will require well-coordinated post-discharge care involving not just family physicians, but also other community health and social partners, I worked with different teams to ensure that discharge care plans are developed and communicated to relevant partners for good continuity of care.

**CM:**

How will the larger cluster affect the delivery of care to community hospital patients in the western part of Singapore?

**CCS:**

Prior to the latest reorganisation, there was already strong vertical integration between the restructured and the

community hospitals. With the larger cluster, we aim to build on the existing relationship and work arrangements to better integrate care from the community to the home. As a larger cluster, we will be able to leverage combined resources, expertise and greater opportunities to ensure patients receive well-coordinated care across both restructured and community hospitals. For example, one of the key changes in this reorganisation is that each of the new cluster now has a Polyclinic group so that post-discharge care can be further smoothed for better continuity of care.

**CM:**

What are the opportunities the re-organisation present to a family physician in ILTC sector.

**CCS:**

A well-trained family physician will have skill sets and ethos that allow him to contribute in a variety of healthcare setting. MOH has identified family physicians to play a crucial role in the further development of the ILTC sector. There is now greater opportunity in terms of training to realize the full potential of family physicians to contribute to patient care across setting and, for those who are interested, to participate in care in more than one setting (as well as involvement in teaching and research).

■ CM

## A Primary Care Doctor's Perspective of Public Healthcare Sector Restructuring

by Dr Ng Chee Chin David, FCFP(S)

From a macro perspective, restructuring our public healthcare system into 3 regional clusters is a move in the right direction. The perceptible duplication and fragmentation arising from having 6 fairly autonomous regional health systems will hopefully be reduced in time to come with the breakdown of boundaries and better interfacing between services. In the spirit of care integration, this reorganisation places the cluster HQ firmer in the driver's seat by overseeing a larger geographical area as well as crucial components of the public healthcare system from tertiary hospital to polyclinics. It however remains to be seen how well the mergers will drive the clusters to focus more on community and primary care, an objective clearly desired by the Ministry of Health.

The shift of care into the community has always been the intention of Ministry in the face of an increasingly aged

population. Care provision in the community necessitates the building of meaningful and mutually beneficial relationships with community healthcare elements like the GPs, ILTC providers and also social organisations as well as other government or grassroots agencies like the Police, schools, People's Association. That network of relationships built on trust undergirds every collaboration that true integration within each region will ensue.

Thus, it is important that the clusters take on the mantle of managing the health of a population by going beyond traditional institutional barriers, bridging the public-private divide and looking hard at what will really benefit the health of the population they serve.

Some potentially thorny issues, however, need further in-depth exploration:

**1. Accountability vs. porosity**

Accountability is demanded from regional population management to the individual physician/GP in the heartlands. However, the population and private providers alike are not beholden to the care of their geographical cluster. How does the Ministry intend to hold accountability in the midst of porosity? Unlike other geographically larger countries where regional health organisations are physically far apart from each other or their patients are bound to their services through insurance contracts, our 3 regions (and their patients) are packed in a small island of no more than 600 square kilometres. That some of our patients will cross regions when seeking healthcare is a given, and it is very unlikely that the ability of patients to cherry-pick services across cluster boundaries will be curtailed. So accountability for care outcomes and population health may need to be limited to certain sub-populations or omit those who venture out of the cluster, or are identified as obligate cluster-hoppers.

**2. Value Proposition**

Value = Outcomes/Cost

What outcomes are we looking for in this restructuring exercise? How do we measure cost or the constituent costs of long-term care? In primary care where the focus is on prevention and early diagnosis, how do we measure complications delayed and costs avoided downstream? Value is notoriously hard to show. The job is made harder when there is no available data, difficult data collection, potentially unreliable subjective/qualitative data or red tape. Porosity, as mentioned above, makes the job even more challenging. And that is exactly why we need to think through these carefully before jumping on the bandwagon of change. The user may be convinced of value by a conglomeration of success anecdotes, but will the stakeholders be convinced likewise? It is therefore vital that system enablers like IT be built to pervade the entire healthcare cluster, with the aim to make information more accessible to instigate regular review and improvement. To continue driving in darkness risks ruin by ignorance.

At the meso level, the polyclinic clusters have been impacted the most in the restructuring exercise with the creation of a third polyclinic cluster from the existing two. Whilst not seismic, this move is major enough to generate activity for the 3 polyclinic HQs for the next few years to come. Capacities are going to be stretched, to say the least as a whole new leadership team shapes up under the NUHS cluster.

Over the years, our polyclinics have morphed into centres for chronic care delivered in a team-based model. With this restructuring and desired closer linkage with hospitals

and cluster at large, this trend will likely continue as polyclinics transform further to care for the growing number of complex chronic, geriatric patients and other patients specifically decanted from specialist services. There will be increasing cross-institutional accountability for these groups of patients as well as the call to extend care beyond the walls of the polyclinic into the community and home. Transformation of this nature will take time and the polyclinics will have to grapple with both external reorganisation and internal transformation despite an overt struggle with adequate resourcing.

The private GP community carries 80% of primary care and almost 50% of chronic care in Singapore. This renewed emphasis on population health management in the public sector could afford the opportunity for GPs to band together for greater collaboration with the public clusters. I suspect the same issues of accountability and value proposition to both users and stakeholders whilst keeping an eye on bottom line will emerge, and both the public sector and private providers need to work hand in hand to ensure they share a common vision for the region. College also plays an important role in facilitating such conversations and advocating on their behalf to relevant agencies.

On a personal level, having worked for many years in one of the clinics affected by restructuring, it really isn't easy letting go of the clinic and staff. Thinking about the people I worked with, the memories and conversations that took place in the corridors, jokes shared at the spine of the consult rooms, patients seen, friendships forged. It is hard realising that they will soon leave and be part of another organisation. And for some staff, the anxieties and uncertainties are palpable. Yet others are more positive and hopeful for the future. The way restructuring impacts individual staffs is sometimes unanticipated, even if at all carefully and comprehensively engineered. A nurse told me that as a result of moving to another cluster, she will face a lot more hassle claiming medical benefits for her son – might just be a hygiene factor to consider for the effectors of change, but a host of unintended and unexpected consequences for others.

Beyond the issues mentioned above, I would argue that there needs to be an articulation of what the healthcare system as a whole is or is not, to be, where different healthcare elements sit in the overall scheme of things, their mandate, roles and responsibilities. This also needs to be coupled with intentional engagement of the public, and of staff as well. Public mind-set and expectations need restructuring in tandem with the organisational restructuring that is taking place. Indeed, the social compact between the healthcare system and members of the public needs to be renegotiated. Only then will the painful throes of restructuring truly bear fruit for both providers and recipients.

■ CM

# Getting to Know the Medical Protection Society

Interviewed by Dr Tan Tze Lee, Vice-President and Dr Subramaniam Surajkumar, Honorary Assistant Secretary, College of Family Physicians Singapore

**m**embers of the College 25<sup>th</sup> Council, Dr Tan Tze Lee and Dr Subramaniam Surajkumar, recently met with Dr Alison Metcalfe and Ms Allison Newell of the Medical Protection Society (MPS) to clarify recent developments in medical indemnity coverage in Singapore. College would like to thank MPS for contributing to this article, as well as their continuing support for healthcare professionals in Singapore.

## College of Family Physicians Singapore (CFPS):

Can you give us some history of MPS?

## Medical Protection Society (MPS):

MPS was founded in 1892 by a group of doctors and dentists, whose aim was to defend and support fellow healthcare professionals.

Today, we stand as the leading international provider of protection for doctors, dentists and other healthcare professionals - with 300,000 members in countries worldwide, including Singapore, where we have proudly provided protection for the last 45 years.

The healthcare landscape has changed dramatically over the years, but our grounding principle remains the same – we are a member-owned, mutual organisation that is run exclusively for the benefit of members, with no shareholders seeking a profit.

We are the leading experts in clinical negligence, with years of international experience and expertise – and as fellow healthcare professionals, we understand better than anyone, the issues facing the profession today.

## CFPS:

How is MPS governance structured?

## MPS:

MPS is run entirely for the benefit of members, and is governed by the MPS Council. This is our board of directors, the majority of which are elected by fellow members, and is chaired by Professor Kay-Tee Khaw.

The Council are supported by the Executive Committee, which is tasked with assisting and advising the Chief Executive in the day-to-day running of the organisation, and is made up of the Chief Executive, five Executive Directors and MPS's General Counsel.

## CFPS:

How long has MPS been in Singapore and what has that meant for doctors there?

## MPS:

MPS has been the leading provider of protection and support for healthcare professionals in Singapore since 1972. Today, we are proud to protect and support the professional interests of thousands of members in Singapore.

We have decades of experience in dealing with highly specialist and complex clinical negligence cases in Singapore and have the best lawyers, medicolegal and dentolegal advisers in the field.

## CFPS:

What services does MPS provide for its Singapore members?

## MPS:

Where others may only provide indemnity for claims, we offer assistance with patient complaints, disciplinary procedures, medical council hearings, inquests and media advice.

Members can talk doctor-to-doctor to our team of experts, who will guide members through a situation and explain what they can do to stop it escalating. We also offer access to a 24-hour independent counselling service and members.

Perhaps most importantly of all, we offer a wide range of education. We believe prevention is better than cure, and we want to prevent problems from occurring in the first place.

## CFPS:

What is MPS's commitment to Singapore?

## MPS:

We're proud to have supported thousands of healthcare professionals in Singapore with claims, complaints and other issues since 1972 and we will continue to support the profession for many years to come.

We have a programme of events and education workshops planned throughout the year, and we have also listened to members who tell us that they want MPS to be more local. As a result, we will be opening a regional office in South East Asia in the near future.

As a member-owned organisation, we operate solely for the benefit of members. Unlike insurance companies we have no shareholders looking to make a profit, and no short-term requirement to generate profits. What we do have however, is a long-term commitment to supporting doctors in Singapore throughout their career.

## CFPS:

There has been some speculation on the financial health of the MPS. Can you enlighten us on this?

## MPS:

We are confident of our financial position and publish our Annual Report each year on our website. We are proud to have more than 300,000 members around the world and to help individual doctors and dentists every day.

We're about to celebrate our 125<sup>th</sup> anniversary and we have every intention of being here for another 125 years.

## CFPS:

What sort of medical indemnity coverage do MPS members enjoy?

## MPS:

We offer two types of protection: occurrence-based protection and claims-made protection.

Occurrence-based protection allows members to access the benefits of membership and request assistance for any claim or complaint that arises from an adverse incident that occurs during the period of membership, regardless of when it was reported and the claim or complaint is received, so long as the incident occurred while the individual was a member and in the appropriate category of membership with MPS.

Claims-made protection for obstetricians also allows members to access the benefits of membership and request assistance for any claim or complaint that arises from an adverse incident that occurs during their membership, so long as they were a member at the time of the incident, and had continuous membership (or had purchased extended reporting benefits) for the period between the incident occurring and the time it was reported. The incident also needs to be reported to us as soon as is reasonably practicable after the member becomes aware of it.

## CFPS:

In recent months there have been some changes with MPS's coverage of doctors employed in the public sector. Can you elaborate on these changes?

## MPS:

Ministry of Health Holdings' (MOHH) has introduced a new scheme for the provision of indemnity for public sector healthcare professionals, which means that these healthcare professionals will have their indemnity provided by an alternative indemnifier.

In response, we have provided access to both a full membership and non-claims membership option for those

healthcare professionals who wish to remain with MPS, which they would have in addition to the MOHH indemnity scheme.

The non-claims membership means that these healthcare professionals will continue receiving access to the specialist advice and impartial support from fellow doctors. In addition, they can continue requesting support with a Singapore Medical Council (SMC) investigation or patient complaint, together with support in preparing for inquests and writing reports, amongst other things.

However, non-claims membership as such would not be entitled to request help with a clinical negligence claim.

## CFPS:

What does this mean for these public sector doctors and what is MPS doing to manage these changes?

## MPS:

Members in the public sector will have their indemnity provided by the new arrangements that have been put in place by MOHH, and will automatically move to the new provider as their current MPS membership expires in 2017.

However, if any doctors in the public sector wish to continue with individual membership with MPS, in addition to the new MOHH arrangement, they are welcome to do so, on either a full membership or non-claims membership basis.

## CFPS:

What advice would you offer the public sector doctors with regards to these changes?

## MPS:

Our commitment to doctors in Singapore remains as strong as ever. We have been proudly supporting members in Singapore for 45 years, and we will continue to offer the same high quality service that we always have.

Public sector healthcare professionals have the option to remain with MPS if they wish, with membership options that can be tailored to meet their needs.

Those members, who do choose to stay, will benefit not only from our world class expertise and years of experience when it comes to clinical negligence, but will also have access to the best lawyers, medico-legal and dento-legal advisers in the field.

There will also be educational and risk management workshops available throughout the year, and following member feedback, we will be opening a regional office in South-East Asia later this year.

# How should we teach our children?

## *The zealot, the bigot and the pragmatist*

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

By our children, I mean our professional children. The students and doctors who are still wet behind ears, and will take notes when the grey-haired ones speak. As a furtive member of the planned parenthood of such doctors, I see a parallel between teaching a young doctor and bringing up a child. I had spent many hours arguing with my fellow parents on how we should teach the next generation of family physicians. I noticed that we fall broadly into 3 categories.

### The zealot

There are those with fixed ideas on what is family medicine. They are obsessed with doctrines that were canonised by the high priest equivalents of the profession. For them, training is the pursuit of ideological purity. Almost inevitably, it degenerates into inflexible and impractical enforcements of doctrines that is out of sync with the changing needs of the patients and the reality of the community that we serve. Just like religious intolerance, reaction to the non-conformist is to impose inquisition and persecution. It might sound a little harsh but they really go around pontificating what is pure family medicine and what is heresy. Like the Pharisees in biblical times they will quote chapter and verse from definitions written by academics on what constitutes true faith. The problem is that family medicine for all the good that it brings is not a religion nor is it a divine revelation. If we go a little into the history, we will remember that it is an evolving movement to revive generalism in response to a call to restore a fragmented healthcare system brought on by unrestrained specialisation.<sup>1</sup>

### The bigot

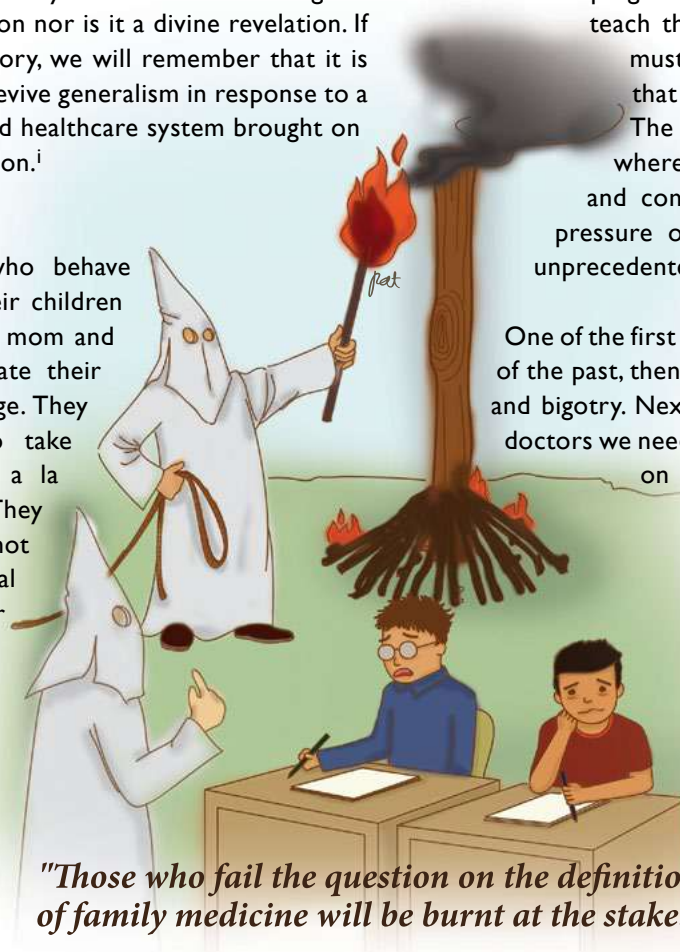
Then there are those who behave like parents who want their children to grow up to be just like mom and dad. They seek to re-create their children in their own image. They expect their trainees to take over the family business a la The Godfather movie. They define family medicine not by doctrines but by tribal loyalties. While the former treat non-conformists as heretics, this version of the dysfunctional parent treat those that reject their way as traitors. In short, they confuse family medicine with family business.

To be fair we all have traits of such parents in us, myself included. The rational educator must rise above these negative tendencies to become the pragmatic parent. The champion of this mode of parent-educator is John Dewey. Dewey was an American education reformer and one of the key personalities in the philosophy of pragmatism. Many of our so called new ideas in medical education are really rehash of Dewey's philosophy on education, re-introduced with varying degrees of recidivism to the old maladies of zealotry and bigotry. Dewey sees education as a process of socialisation that must be rooted in the real world. When educators say "experiential learning" or "learner centeredness", we are quoting Dewey unknowingly. What is conventional wisdom now, was not during the time of Dewey. We have him to thank for many of the progressive ideas of education that we have today. Dewey and the pragmatists believe that theory is useless and cannot be assumed to be true until they can be successfully applied. Essentially all dogmas that we teach are suspect unless we can apply them and their application result in improvements to the system.

### The pragmatist

So what is the pragmatist to do when we ponder what to teach the next generation of doctors who must practice in a healthcare system that is changing even as you read this? The new world is likely to be one where people are older, have multiple and complicated chronic diseases and the pressure on healthcare resources will reach unprecedented levels.

One of the first things to do is to discard the dogmas of the past, then restrain our tendencies to zealotry and bigotry. Next, we should consider what kind of doctors we need for the new environment and focus on this as we revamp our curriculum. Essentially the task at hand is not to train an idealised doctor but to develop a healthcare workforce that is fit for practice in the new reality that is already upon us.



*"Those who fail the question on the definition of family medicine will be burnt at the stake!"*

<sup>1</sup> Lee KH. A historical perspective of the barriers to generalism. Aust Fam Physician. 2015 Mar;44(3):154-8. Available at <http://www.racgp.org.au/afp/2015/march/a-historical-perspective-of-the-barriers-to-generalism/>

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# Examining the Literature on Organisational Structure and Success

by Dr Lim Khong Jin Michael, Editorial Board Member

Organisations in the twenty-first century need to be efficient, flexible, innovative and caring in order to achieve a sustainable competitive advantage. If innovation, flexibility and a caring culture are part of the requirements of a successful organisation in the twenty-first century, then organisations should not simply have a hierarchical structure that tends to favour efficiency at the expense of innovation, flexibility and a caring culture. In this article, we will explore three alternative views to a hierarchical organisational structure, namely the community model, the ambidextrous model and the phenotype model.

## I. The Community Model

Arguing against hierarchy and scientific management in 1961, Likert pointed out that while it is capable of increasing production, it may have problems of inconsistent quality, excessive waste, absenteeism and increased worker turnover in the long term, due to the lack of a caring culture at the workplace resulting in workers' dissatisfaction. He described a new organisational structure, communal in nature, consisting of a tightly knitted, effectively functioning social system made up of interlocking work groups with a high degree of group loyalty among the members and favourable attitudes and trust between superiors and subordinates. His choice of co-ordinating mechanism for such an organisational structure is that of supportive relationships in a caring culture contributing to the sense of personal worth and importance of the individuals involved.

In the 1960s, Burns and Stalker conducted a study of the electronics industry in Britain. They suggested that the mechanistic (bureaucratic) organisational structure of the electronic firms was only appropriate for stable conditions

and therefore not suitable for the electronics industry in the twentieth century with its rapid changes. They observed three problems that surfaced in the companies that they were studying as a result of this mismatch. In some companies, they noted the development of an alternative clandestine or open hierarchy which was ambiguous. In other companies, they observed a proliferation of more branches to the bureaucratic hierarchy. And in still other companies, there was an emergence of multiple committees to supplement the mechanistic organisational structure. They recommended that companies in a rapidly changing environment should change their organisational structure from mechanistic to organismic (community), because the latter is more appropriate for changing conditions. They described the organismic (community) organisational structure as a network of control, authority, and communication which was more horizontal than vertical, existing as a continual redefinition of the individual's responsibilities, functions, methods and powers through interaction with one another in the company.

Since the latter half of the twentieth century, it has generally been accepted by Organisation Theory researchers that the initiation of innovations flourish better in an organisational structure consisting of less hierarchy and less formal rules. Researching eight new biotechnology firms in the United States in 1997, Judge and his fellow researchers found that a goal-directed community type of organisational structure is more conducive for innovation as compared to traditional hierarchies. Their idea of a community was a group of individuals who have learned how to communicate honestly with each other, whose relationships go deeper than their masks of composure, and who have developed

some significant commitment to make others' conditions their own. They pointed out that creativity emerges in the safe place of working in a community as the members of the group learn and innovate together in a circle of trust and care.

## II. The Ambidextrous Model

Some researchers in the late twentieth and early twenty-first centuries believed that it was necessary for organisations to be ambidextrous in order to achieve sustainable competitive advantage and be successful over the long term. Organisational ambidexterity refers to the ability to both exploit old certainties and explore new possibilities; to be efficient with today's business demands and yet to be capable of adapting to a changing environment or to change its environment through its innovations. Levinthal and March (1991) pointed out that an organisation needs to engage in sufficient exploitation to ensure its current viability and, at the same time, devote enough energy to exploration to ensure its future viability. They observed that exploitation is associated with activities such as refinement, selection and implementation, and that exploration on the other hand is associated with search, experimentation, and discovery.

They noted that there is a general tendency for firms to favour exploitation over exploration activities as the former tends to generate more positive returns in the near term and therefore garner more positive feedback.

## III. The Phenotype Model

Dougherty (2001) noted that the hierarchical organisational structure was still the prevalent structure in large firms today despite its many incompatibilities to the new expectations of the twenty-first century, because the concepts of alternative organisational structures were not yet fully viable. As pointed out by Drucker in 1999, in large organisations, we cannot simply abandon the hierarchical structure – there has to be a final authority, someone who can make the final decision and who can expect them to be complied with.

Therefore a competitive organisational structure for a changing environment should be one which contains both a hierarchy and a community structure. Current models that incorporate this idea have generally utilised project teams, committees or specialised departments which have more community-like features to supplement the overall hierarchical infrastructure. The weakness of such an

approach is that the work of the community-like units are usually considered by the other workers to be of secondary significance to the activities of the main hierarchy, and these units are at times isolated from the main hierarchical structure in form and function.

The third model we will discuss here is the Phenotype Model which was created by Lim, Griffiths and Sambrook in 2010 (Figure 1). It is an effective tool for helping managers make the paradigm shift towards understanding their organisations' intertwined hierarchical and community structures. This model was derived by transposing the understanding of genetics to organisational structure. In genetics, phenotype refers to the observable characteristics of an organism which comes about from the expression of an organism's genes and the influence of the environment. In the Phenotype Model of organisational structure, each worker's formal, hierarchical participation and informal, community participation within the organisation, as influenced by his or her environment, contribute to the overall observable characteristics (phenotype) of the organisation. In other words, just as each pair of alleles within the genetic material of an organism contributes to

the physical characteristics of the organism, the combined expressions of all the workers' formal hierarchical and informal community participation within an organisation give rise to the organisational structure. Due to potentially different combinations of the workers' formal hierarchical and informal community participation, each organisation is therefore a unique phenotype along a spectrum between a pure hierarchy and a pure community organisational structure.

The Hierarchy-Community Phenotype Model of Organisational Structure views an organisation as having both a hierarchy and a community structure, both equally well established and occurring extensively throughout the organisation. On the practical level, it utilises the organizational chart to study the hierarchical structure which brings across individuals' roles and formal authority within their designated space at the workplace, and social network analysis to map out the community structure within the organisation, identifying individuals' informal influences which usually do not respect workplace boundaries and at many times extend beyond the workplace. By acknowledging the presence of the "hidden" community within an

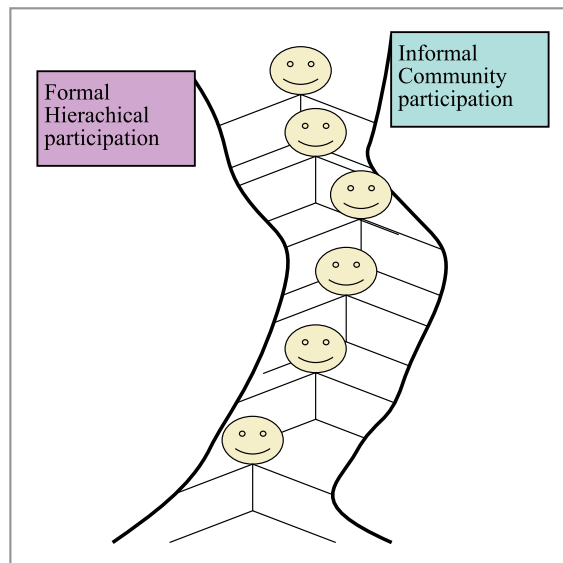


Figure 1.  
The Hierarchy-Community Phenotype Model of Organisational Structure

(continued on Page 18)

(continued from Page 15: Examining the Literature on Organisational Structure and Success)

organisation, managers truly understand and better steer their organisations toward not just being efficient, but also caring, flexible and innovative.

### Conclusion

As pointed out by Butler (1986), in today's understanding of organisational structures, even though most, if not all, organisations are not of a pure hierarchical structure, many managers are still blind-sided to the existence of the community structure within their organisations. In other words, the community structure is present within the organisations but they are usually ignored, either consciously or sub-consciously, by the management. Frequently, management regards the community structure within the organisation as simply "the informal organisation" and consequently leaves it alone. This blindness towards the organisation's informal community structure is one reason why top-down initiatives are frequently met with resistance from informal groups and their leaders that have not been identified, understood and won over. Inherent in

every organisation is the Hierarchy-Community structure which, when acknowledged, understood, appreciated and developed, could bring about not just a successful organisation but also a caring and sustainable one.

With more than 100 years of theoretical and empirical studies on formal hierarchical organisational structure, we have made considerable progress in our understanding of its contribution to the exploitation of existing capabilities. Perhaps the challenge today is to consider how the informal community structure of an organisation can be delicately activated to help the organisation meet the social and innovative expectations of its workers and the customers of the twenty-first century, while preserving the integrity of the hierarchy and its purpose, bearing in mind that the informal community and the formal hierarchy of the organisation are inter-twined as one, held together by all the individuals within the organisation who have a sense of personal worth, need and voice, and a desire to be acknowledged as such.

### Application

In mergers and reconfiguration of organisational structures, such as in the recent restructuring of the public healthcare sector in Singapore from six regional health systems to three integrated clusters, it may be useful for the management to recall the Phenotype Model and bear in mind that other than the altering of the formal hierarchical organisational structure, the informal community organisational structures have also been affected. Staffs within each previous regional health system have developed trust, camaraderie and loyalty as they work together, and at times even compete together against other regional health systems so as to improve on their own standards. Each previous regional health system was able to motivate and care for its staff and stay flexible and innovative, delivering excellent healthcare services to the public largely through the strength of the relationships within their community (community organisational structure) and the commitment of their leaders (hierarchical organisational structure).

For those of us familiar with change management, we know that it takes one to two years to get the buy-in to any major change within an organisation. How then can we exercise care and concern to help the staffs who are affected by this restructuring? Some suggestions include firstly mapping out how different groups of people are affected by the restructuring; secondly, giving individuals and groups the opportunity to voice their concerns through town hall meetings and small group discussions akin to the SG50 Conversations; and finally, keeping an open channel with the concerned individuals and helping them to adjust, giving those who are still not able to adjust after a reasonable period of time the option to transit to another cluster without penalty. We need to appreciate that organisations are made up of communities of people who desire to be heard, understood and given a choice to respond when faced with major changes in their lives even when those changes are as a result of decisions already made by managers higher up in the organisational hierarchy.

■ CM

## FAMILY PRACTICE SKILLS COURSE

### Cardiovascular Disorders 2

The College of Family Physicians Singapore would like to thank the Expert Panel for their contribution to the Family Practice Skills Course #68 on "Cardiovascular Disorders 2", held on 07 – 08 January 2017.

#### Expert Panel:

Dr Tan Chee Eng  
Dr Peter Ting  
Dr Titus Lau  
Dr Ng Tsun Gan  
Dr Tang Kok Foo

A/P Leong Keng Hong

Dr Bernard Lee  
Dr Colin Teo  
Dr Leslie Leong  
Dr Lui Nai Lee

#### Chairperson:

Dr Lawrence Ng Chee Lian  
A/P Goh Lee Gan

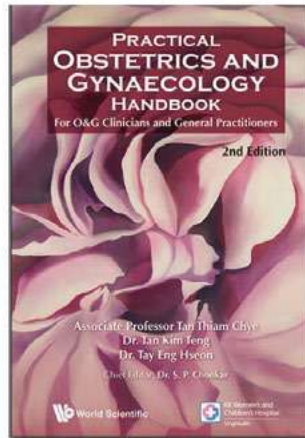
# Practical Obstetrics and Gynaecology Handbook: for O&G Clinicians and General Practitioners 2<sup>nd</sup> Ed (2014)

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

“Practical Obstetrics and Gynaecology Handbook: for O&G Clinicians and General Practitioners 2<sup>nd</sup> Ed (2014)” is one of those books that residents love. It provides up-to-date, concise, comprehensive and information in a handy pocket size that you can carry everywhere for revision and quick reference.

This mini textbook has 74 very short chapters, each filled with succinct key points supplemented by flowcharts, algorithms, and practical vignette. The book sticks to fundamental principles and key management points and puts everything in a very readable format. Complex topics are distilled into practical bite size portions. It is ideal for quick read and goes straight to the important points.

The book is written specifically for family physicians and clinicians in the primary health care setting, focusing on problems that are likely to be encountered by family physicians. It also advises on first hand management, referral criteria guidelines and additional information on the probable actions by OBGYN after referral. Experienced



obstetricians and gynaecologists might even find it useful to reaffirm and compare their practices with those advocated by the authors/contributors who are well known in their respective areas in O&G.

It is noteworthy that the book won the British Medical Award (BMA) Book Awards in 2015. Previous awardees included residents' favorites like Kumar and Clark's Clinical Medicine, Macleod's Clinical Diagnosis, Thalange's essentials of Paediatrics and Netter's Anatomy. So this book is in good company. Residents, especially those preparing

for family medicine exams will probably find this book very helpful.

The authors include well-known local specialists such as A/Prof Tan Thiam Chye, Dr Tan Kim Teng, Dr Tay Eng-Hseon and Dr Sonali Chonkar. The content is therefore very practical and reflects local practice. Besides those who are preparing for family medicine exams, this book is also a good resource for practicing family doctors, medical students and even OBGYN specialists.

■ CM

## Photo Quiz

Contributed by Dr Nicholas Foo Siang Sern, Editorial Board Member

### QUIZ #1

A 30-year-old lady presents with throat pain and fever of 2 days' duration. The pain is worse on the right.

#### QUESTION

Describe the findings seen on examination of her oral cavity/oropharynx.

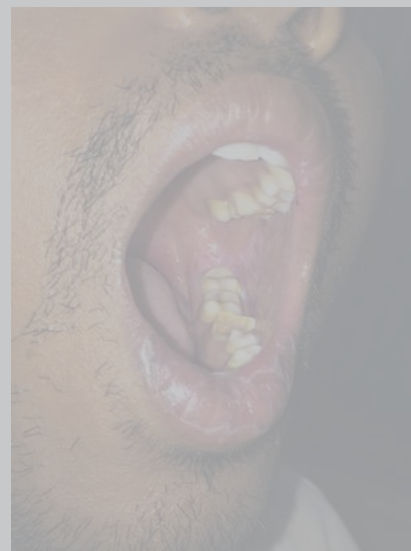


### QUIZ #2

A 32-year-old man presents with a pruritic rash over his limbs of 3 months' duration. He has also noted some changes to his lips and buccal mucosa.

#### QUESTION

Describe the findings seen on examination of his oral cavity and limbs



◀ Oral cavity

(continued on the next page)

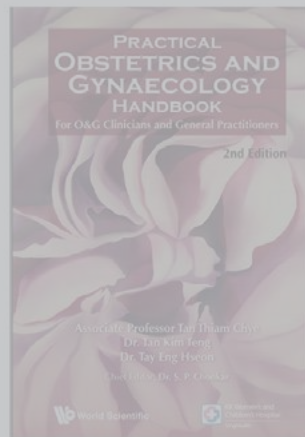
# Practical Obstetrics and Gynaecology Handbook: for O&G Clinicians and General Practitioners 2<sup>nd</sup> Ed (2014)

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

“Practical Obstetrics and Gynaecology Handbook: for O&G Clinicians and General Practitioners 2<sup>nd</sup> Ed (2014)” is one of those books that residents love. It provides up-to-date, concise, comprehensive and information in a handy pocket size that you can carry everywhere for revision and quick reference.

This mini textbook has 74 very short chapters, each filled with succinct key points supplemented by flowcharts, algorithms, and practical vignette. The book sticks to fundamental principles and key management points and puts everything in a very readable format. Complex topics are distilled into practical bite size portions. It is ideal for quick read and goes straight to the important points.

The book is written specifically for family physicians and clinicians in the primary health care setting, focusing on problems that are likely to be encountered by family physicians. It also advises on first hand management, referral criteria guidelines and additional information on the probable actions by OBGYN after referral. Experienced



obstetricians and gynaecologists might even find it useful to reaffirm and compare their practices with those advocated by the authors/contributors who are well known in their respective areas in O&G.

It is noteworthy that the book won the British Medical Award (BMA) Book Awards in 2015. Previous awardees included residents' favorites like Kumar and Clark's Clinical Medicine, Macleod's Clinical Diagnosis, Thalange's essentials of Paediatrics and Netter's Anatomy. So this book is in good company. Residents, especially those preparing

for family medicine exams will probably find this book very helpful.

The authors include well-known local specialists such as A/Prof Tan Thiam Chye, Dr Tan Kim Teng, Dr Tay Eng Hseon and Dr Sonali Chonkar. The content is therefore very practical and reflects local practice. Besides those who are preparing for family medicine exams, this book is also a good resource for practicing family doctors, medical students and even OBGYN specialists.

■ CM

## Photo Quiz

Contributed by Dr Nicholas Foo Siang Sern, Editorial Board Member

### QUIZ #1

A 30-year-old lady presents with throat pain and fever of 2 days' duration. The pain is worse on the right.

#### QUESTION

Describe the findings seen on examination of her oral cavity/ oropharynx.



### QUIZ #2

A 32-year-old man presents with a pruritic rash over his limbs of 3 months' duration. He has also noted some changes to his lips and buccal mucosa.

#### QUESTION

Describe the findings seen on examination of his oral cavity and limbs



◀ Oral cavity

(continued on the next page)

(continued from Page 19: Photo Quiz)

**ANSWER**

The following findings are seen:

- Asymmetrical appearance of the soft palate, with erythema and oedema on the right side
- Collection of pus at the right peritonsillar area
- Uvula is displaced to the left

**WHAT IS THE DIAGNOSIS?**

Right Peritonsillar Abscess

**LEARNING POINTS**

- A Peritonsillar abscess (PTA), or Quinsy, is a localised accumulation of pus in the peritonsillar tissues.
- The most widely accepted etiologic theory involves the progression of an episode of exudative tonsillitis first into peritonsillitis and then into frank abscess formation. PTA has also been documented to arise de novo without any prior history of recurrent or chronic tonsillitis.
- The nidus of infection is located between the capsule of the palatine tonsils and the constrictor muscles of the pharynx. The anterior and posterior pillars, torus tubarius (superior), and pyriform sinus (inferior) form the boundaries of this potential peritonsillar space. Because this area is composed of loose connective tissue, severe infection may rapidly lead to formation and accumulation of purulent material. Progressive inflammation and suppuration may extend to directly involve the soft palate, the lateral wall of the pharynx, and, occasionally, the base of the tongue.
- Transoral incision and drainage (I&D) is recommended. This is usually done under local anaesthesia in adults.
- Most patients treated with antibiotics and adequate drainage of their abscess cavity recover within a few days. A small number present with another abscess later, requiring tonsillectomy. If patients continue to report recurring or chronic sore throats after proper incision and drainage (I&D), a tonsillectomy may be indicated.
- Patients with peritonsillar cellulitis or those who are still symptomatic after I&D can be admitted for intravenous antibiotics and hydration, particularly if oral intake is significantly hampered.

References:  
 1. Medscape  
 2. ENT for Family Practice  
 (Editor: Dr Luke Tan Kim Siang, 2005)



Flexor surface of right forearm ▶

◀ Extensor surface of right leg

**ANSWER**

The following findings are seen:

- White striations forming a reticular pattern on the lips and white plaques on the buccal mucosa are present
- Violaceous, shiny and polygonal papules are seen on the forearm
- Violaceous, scaly, hyperkeratotic plaques are seen on the leg

**WHAT IS THE DIAGNOSIS?**

Lichen Planus

**LEARNING POINTS**

- Lichen Planus (LP) is a pruritic eruption
- The lesions are characteristically papular, purple (violaceous), polygonal and peripherally located (4Ps)
- LP may also affect the genitalia and mucous membranes
- It is a cell-mediated immune response of unknown origin
- It is commonly associated with Hepatitis C and may be found with other conditions of altered immunity such as ulcerative colitis, alopecia areata, vitiligo, dermatomyositis, morphea, lichen sclerosis and myasthenia gravis

(continued on the next page)

- Lesions develop initially on flexural surfaces of limbs with maximal spreading within 2 to 16 weeks
- Pruritus is common in LP with hypertrophic lesions being extremely pruritic
- Oral lesions may be asymptomatic or have a burning sensation. They may be painful if erosions develop
- LP is a self-limited disease that usually resolves in 8 to 12 months. Mild cases may be treated with fluorinated topical steroids. More severe cases, especially if involving the scalp, nails and mucous membranes, may require more intensive therapy

References: Medscape

■ CM



**FAMILY MEDICINE  
COMMENCEMENT  
CEREMONY 2017**

COLLEGE  
46<sup>TH</sup> AGM

**29 July 2017 (Saturday)  
2.00pm**

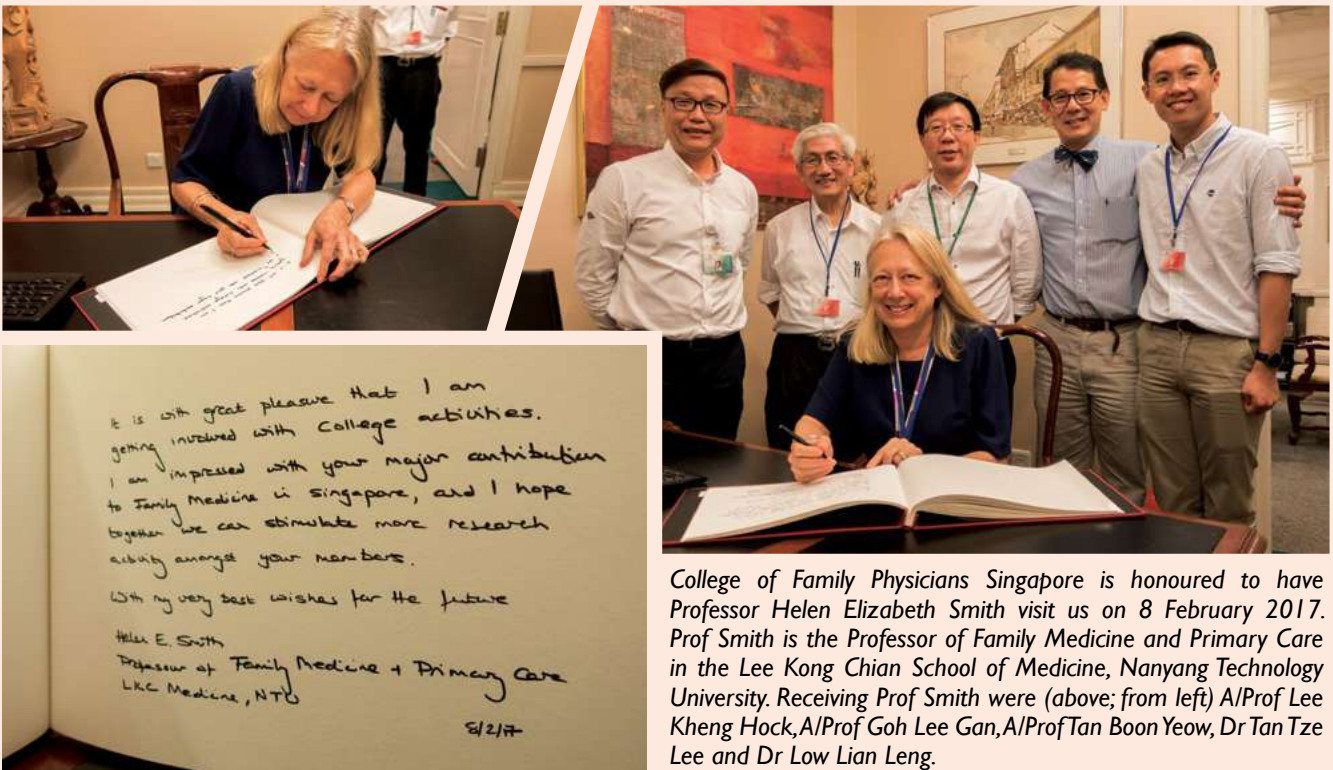
College of Medicine Building  
Auditorium (Level 2)  
16 College Road Singapore 169854

**Family Medicine  
Commencement Ceremony 2017**  
2.00 - 3.30pm ♦ Auditorium (Level 2)

**Tea Reception**  
3.30 - 4.00pm ♦ Function Room (Level 1)

**College 46<sup>th</sup> AGM**  
4.00 - 6.00pm ♦ Auditorium (Level 2)

## Professor Helen Elizabeth Smith visits CFPS ~ 8 February 2017



College of Family Physicians Singapore is honoured to have Professor Helen Elizabeth Smith visit us on 8 February 2017. Prof Smith is the Professor of Family Medicine and Primary Care in the Lee Kong Chian School of Medicine, Nanyang Technology University. Receiving Prof Smith were (above; from left) A/Prof Lee Kheng Hock, A/Prof Goh Lee Gan, A/Prof Tan Boon Yeow, Dr Tan Tze Lee and Dr Low Lian Leng.

# The insightful talk at College on “The future of Family Medicine from a NHS perspective”, by HMDP visiting expert Prof Jeremy Dale

by Dr Farhad Vasanwala, BSc (Hons), FCFP(S), FRCP, HOD FM, SengKang Health

On the 18<sup>th</sup> of January 2017 evening, the College of Family Physicians Singapore had the pleasure of hosting a talk by Professor Jeremy Dale on “The Future of Family Medicine from a NHS perspective”. He was here in Singapore as a Health Manpower Development Plan (HMDP) visiting expert in Integrated Diabetes Care hosted by both Changi General Hospital and Sengkang Health @ Alexandra Hospital Family Medicine Department from the 16<sup>th</sup> to the 20<sup>th</sup> of January 2017.

Indeed as an eminent academic and researcher from the University of Warwick, where he holds the position of Professor of Primary Care at Warwick, he is well qualified to share his experience on this issue. He is also a part-time GP with the Engleton House Surgery in Coventry which is the busiest practice in that city, and hence he is well aware of the ground situation. He shared how NHS was facing up to the tough budgetary constraints by utilising various innovations and programmes to overcome these financial challenges, as well as some of the key messages below.



Professor Jeremy Dale at College

The role of Family Physicians in the hospital and community interface and how they can pick up the mantle for:

- a) Strengthened foundation of integrated, community based generalist care.
- b) Integration of generalist and specialist in the both the community and hospital settings.
- c) Assuming roles that were previously performed by their specialist colleagues through enhanced and extended training opportunities.
- d) Management of patients in the emergency department and facilitating discharge planning in the hospitals. (Figure 1)

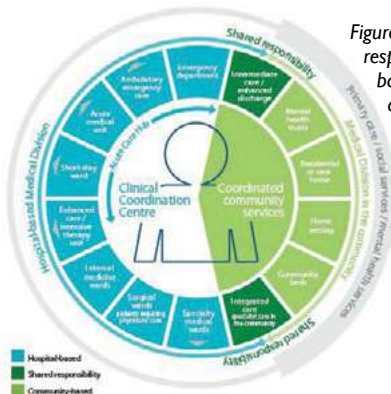


Figure 1: The future of care – shared responsibility between hospital-based and community-based care and services<sup>1</sup>

He also discussed on the use of technology to help patients in the community. A fascinating example was an app “Sensely” devised by Prof Dale and his team where patients could ask questions about their health through an NHS Nurse Avatar named Molly. However, the programme was risk averse so patients would always be counselled to seek medical help if there were any red flags. This will help patients to better understand their health conditions through symptomatology and incentivises the patient to seek help earlier, hence retarding disease progression and reducing morbidity and mortality of the patient.



Figure 2: Molly the NHS Avatar<sup>2</sup>

NHS is in the process of having an approved smartphone App Library for their patients in the hospital and community. It would be exciting to see if their choice would be applicable to our local setting.

Following that there was a lively Q&A session, where we realised the challenges that primary care faced by the public, policy and press were universal and that the solutions in various countries were similar e.g. the role of Family Physicians in the General and community hospitals to improve on care coordination between the hospitals and community.

It is simultaneously ironic yet comforting to hear that NHS General Practitioners and Policy Makers realised how care integration and transition is vital to prevent fragmentation and escalation of costs, which is the path that we in Singapore are pursuing too, as evidenced by increasing number of Family Medicine Departments in Singapore. Such strong affirmation from Prof Dale has certainly helped to reassure our hospital family medicine departments that we are indeed on the right path.

CM

References:

1) The Future Hospital Commission, Royal College of Physicians 2013  
<https://www.pinterest.com/pin/508414245410737545/>

2) Meet Molly the Avatar Nurse is found at:  
<http://adigaskell.org/2015/03/20/meet-molly-the-virtual-nurse/>  
The Horizons Tracker, March 20<sup>th</sup>, 2015.

# The Journey to the Fellowship

*The College academic year begins this year on 29<sup>th</sup> July with the FM Commencement 2017. Many family doctors enrol in one of the training routes offered by the College viz. the GDFM programme, the College Masters programme or the Fellowship programme. This issue of the Mirror interviewed Dr Tan Tze Lee, Vice President of the College, who shared his own journey to finally taking the fellowship..*



## College Mirror (CM):

You obtained your post-graduate MRCP from the Royal College of Physicians, United Kingdom in 1992 and have practised as a family doctor in the heartlands for over 20 years. Yet you saw the need to sign up for the GDFM programme in 2010, why so?

## Dr Tan Tze Lee (TTL):

It has been a long, challenging but most satisfying journey!

It began in 2009 when I joined the council as a council member. At the first council meeting, I was appointed Honorary Editor and given the responsibility of taking care of the College's Journal the Singapore Family Physician (SFP). The SFP was undergoing a revamp at the time, and my first task then was to prepare it for admission to the Western Pacific Region Index Medicus. I had also much to learn about how the SFP was published. My mentor was none other than Prof Goh Lee Gan, who spent much time showing me the scholastic ropes of FM. When I look back, it is clear to me that Prof Goh was gently nudging me towards formal family medicine (FM) training.

*"I was told that internal medicine (IM) was only a component of FM. I had to jump some hoops."*

Many of my colleagues in the College Council had already attained the Masters and the Fellowship in FM. Even though I had already the MRCP, I was told that internal medicine (IM) formed only a component of FM, and in order to qualify for the Fellowship programme, I had to jump some hoops. These were first the GDFM (Graduate Diploma of Family Medicine), and after that the Collegiate Membership of the College of Family Physicians Singapore [MCFP(S)] by assessment.

## CM:

A year after you registered for the GDFM in 2010, you were admitted to the Family Physician Register. Yet you continued to complete the 2-year GDFM course to qualify to sit for the examination...

## TTL:

At the time the Ministry of Health had also just instituted the Accredited Modular Course (AMC), where senior family doctors like myself with many years of experience could

qualify for inclusion in the Family Physician Register (FPR) after attending the required modules. Having already done many of the modules, I applied and was admitted to the FPR in November 2011.

By then I was already in the GDFM training programme and pleasantly surprised that the curriculum and course were indeed very useful for family practice. Though I practiced in Choa Chu Kang for over 20 years, the refreshed knowledge helped in my continuing professional development. The tutorial group discussions held at the end of each module were an excellent platform to discuss the simulated cases and practice the OSCE (Objective Structured Clinical Examination). The GDFM course comprises 4 weekends of FM lectures each quarter. That meant a commitment of 32 weekends over 2 years for the 8 modules! This was on top of running my clinic and the College activities. The long road ahead was sufficiently onerous to make me re-think many times about continuing the journey but by God's grace I persevered.

## CM:

And you took the GDFM examination in 2014 ...

## TTL:

By the end of the 2-year programme, I was reluctant to sit for the GDFM exam as I was swamped with clinical work and other organisational responsibilities. Not only that, I was already registered in the FPR via the AMC route. Was it necessary for me to clear this hurdle? After some humming and hawing, I finally relented and signed up for the GDFM exam in 2014. It was much more challenging than I had anticipated. The theory paper was very difficult. Thankfully, I managed to pass that. The OSCE component was the real challenge. A dinosaur like me had never taken a real OSCE examination before and even though I had some practice it did not really prepare me for the actual thing. I failed this attempt and felt rather let down. Honestly by then I felt like giving up. However, my friends and colleagues at the

*"A dinosaur like me had never taken a real OSCE examination before. I failed the 2014 GDFM examination.. I swallowed my pride and applied to take the GDFM examination again in June 2015. I passed."*

college were of great support and encouraged me to carry on the journey. So, I swallowed my pride and applied to take the GDFM again in June 2015. For this attempt I was better prepared, with help from friends like Suraj and Soo Kiang who helped me fine hone my deficient OSCE skills. This time round, I passed!

## CM:

And next stop was Collegiate Membership..

## TTL:

With the GDFM under my belt, and the MRCP, I was able to apply to take the MCFP by assessment in February 2016. There are two components to the assessment. I had to write up 40 cases and face two very senior fellows of the college for a robust discussion! The clinical component consisted of two cases that I had to clerk and present. In this component, they observed my interviewing and examination of the patients, after which I was subjected to a viva. I passed muster and in March 2016, was conferred the Collegiate membership, MCFP(S) by assessment.

## CM:

And at last you qualify for the fellowship programme. Tell us about your experience.

## TTL:

There were around 30 doctors in my fellowship batch - many younger doctors from the polyclinic clusters, the SAF and public hospitals. Some like us were in private practice. There were five of us in the 'senior' group, having been in practice for over 20 years; the others in this group had gone through the MMed(FM) route. I was the odd one out.

The programme was rigorous! We were introduced to the world of research, and learnt how to appraise the quality of research evidence. We had a mini-course on medical pedagogy, and had separate programmes on OSCE question setting, as well as methodologies on setting multiple-choice questions. Prof Goh Lee Gan and Dr David Ng were my tutors for the OSCE segment and they were excellent teachers - giving us insight and advice on how best to set the OSCEs and avoid pitfalls. For the MCQ setting component, we had none other than Dr Ong Chooi Peng, who is simply amazing! Never could I have imagined the rigor and discipline required to set an MCQ, and Dr Ong's excellent guidance got us through.

## CM:

How was the training?

## TTL:

We had regular monthly meetings, where we gathered to present our cases, research findings, review papers. All these presentations were critiqued by the group. We also worked

*"What stands out (in the fellowship class) is the friendship and camaraderie that was so fantastic to behold"*

together to organise the medical pedagogy workshop in 2015. This was a supreme effort where everyone contributed. It was a great success. What stands out is the friendship and camaraderie that was and still is so fantastic to behold.

Every 6 months we had a review by our supervisors on our progress. Prof Cheong Pak Yean and Dr Chng Shih Kiat supervised the senior group and they were most encouraging and kept us on track.

Towards the end of the 2 years, there was the usual mad scramble to complete the logbook which is an integral part of the final assessment. Many of us were sharing tips on how to put it together; some of us were very efficient and had the final logbook ready weeks before. People like me managed to get it in just before the deadline!

## CM:

And the summative fellowship examination came ...

## TTL:

No one enjoys taking exams, and neither do I. I was all nerves on the day. During the final assessment, we had to make a vigorous defence of my logbook. I was not confident of the outcome. So it came as a bit of a shock and surprise to me when I found out that I passed!

People ask me whether the fellowship course was worth taking; indeed it was. The skills that I acquired during the 2 years are quite frankly incredible. Is it useful for a normal FP like myself in private practice? Yes it is. I can now look at clinical papers and spot the flaws. I can do research. I have better knowledge on ethical issues.

## CM:

Your road was indeed rocky but you arrived.

## TTL:

We learnt so much. Yet what stands out is the camaraderie and unity that was imbued in all of us. We had gone through thick and thin, supporting each other as we struggled with our research and logbooks. We were all amazed at the dedication of our tutors, all of whom went the extra mile to help us get ready for our exit viva. Words cannot fully describe our gratitude to them! Having now been conferred the fellowship, it's time to give back to our fraternity by teaching and I hope to see many family doctors joining the College programmes this year.