

COLLEGE OF FAMILY PHYSICIANS  
SINGAPORE

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## CFPS Convocation Ceremony 2025

*Speech by Professor Kenneth Mak, Director-General of Health,  
Ministry of Health*

**D**r Wong Tien Hua, President,  
College of Family Physicians  
Singapore,  
Distinguished colleagues and esteemed  
guests,

A very good evening to all of you. It is my  
privilege to join all of you at the College  
of Family Physicians Singapore's Family  
Medicine Convocation Ceremony and  
Dinner. This is a momentous occasion  
for the doctors this evening who are  
new FCFP, MMed(FM), and GDFM  
recipients. Tonight, we celebrate not just  
individual achievements, but a collective  
milestone that will shape the future of  
healthcare in Singapore.

To the primary care doctors who are new  
FCFP, MMed(FM), and GDFM recipients,  
I extend my warmest congratulations  
on reaching this significant milestone  
in your professional journey. Your  
dedication, perseverance, and  
unwavering commitment to advancing  
the noble discipline of Family Medicine  
have brought you to this remarkable  
accomplishment and achievement. In

our profession, learning never stops.  
Hence, today is a joyous celebration  
of your lifelong commitment to  
professional development. I also want to  
acknowledge the family members, loving  
spouses and children, and mentors who  
have supported your journey—their  
patience, encouragement, and guidance  
have been instrumental in your success.

*... a historic moment  
for Family Medicine in  
Singapore ... officially  
recognised as a specialty  
by the Specialists  
Accreditation Board  
(SAB), marking a pivotal  
transformation in the  
discipline.*

(continued on Page 2)

(continued from Cover page: CFPS Convocation Ceremony—Speech by Guest-of-Honour Prof Kenneth Mak)

*As of 1 November this year, more than 1,100 GP clinics have joined Healthier SG in partnership with MOH to embrace this vision.*



But as Tien Hua shared, tonight marks more than a personal celebration. We are also witnessing a historic moment for Family Medicine in Singapore. Family Medicine has recently been officially recognised as a specialty by the Specialists Accreditation Board (SAB), marking a pivotal transformation in the discipline. This recognition places Singapore alongside other nations such as the United States of America, United Kingdom, and Australia, formally acknowledging Family Medicine as a specialty. The SAB had earlier announced the accreditation criteria for existing and incoming Fellows to become accredited Family Medicine specialists. Therefore, I encourage all eligible practitioners to submit your applications as soon as possible to meet the stipulated timelines. This is your moment to be part of this historic milestone in the progress of medicine in Singapore.

The role of Family Physicians in Singapore's healthcare transformation continues to evolve. You have built upon your foundational role as trusted healthcare partners to deliver comprehensive, holistic care that strengthens the doctor-patient relationship. Much of what we are doing for Family Medicine—the training, the recognition as a specialty—is fundamentally about addressing the needs of our population and ensuring that our patients receive the appropriate care.

Through Healthier SG, the relationship with your patients will evolve to become more meaningful and personal. As their doctor of choice, you will journey through their life milestones and be entrusted with providing preventive, acute, and chronic care for them and their families. As of 1 November this year, more than 1,100 GP clinics have joined Healthier SG in partnership with MOH to embrace this vision. This is a testament to the profession's commitment to transformation, and I want to thank you for coming on board with the vision for better primary care. Family Physicians serve as the cornerstone of our healthcare system—the trusted first point of contact who guide Singaporeans towards better health.

The scope and complexity of Family Medicine practice continues to expand. Family Physicians are increasingly managing complex chronic diseases as our population rapidly ages; mental health conditions, end-of-life and palliative care, and advanced care planning all take stage. Family Physicians will also be increasingly involved in shared care models with hospital-based specialists as we aim to keep our patients anchored in the community. Today, shared care models for Chronic Kidney Disease Stage 3b, breast, and colorectal cancer survivorship are ongoing.

Our commitment to quality-focused primary care infrastructure development is evident in our pilot of Price Quality Method tenders for GP clinics in HDB estates, prioritising quality care delivery over price alone. Delivering quality care will increasingly require multidisciplinary team-based care, with larger clinic spaces to accommodate comprehensive services including nurse counselling, diabetic foot, and eye screening programmes.

The importance of structured postgraduate Family Medicine training cannot be overstated as we manage the breadth of patients from cradle to grave. CFPS has played a critical role in supporting training and development through its GDFM, MMed(FM), and Fellowship programmes. I want to acknowledge that CFPS has played a key role in pushing through the proposal to recognise Family Medicine as a specialty.

Looking ahead, we must focus on strengthening the Family Medicine workforce and building a foundation of trust. Well-trained family physicians are essential in delivering coordinated and evidence-based care. You will often be the first and most trusted point of healthcare contact for our communities. MOH is committed to strengthening Family Medicine by expanding our comprehensive training programmes, nurturing the next generation of family physicians who will serve as the cornerstone of Singapore's healthcare system.


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# Editor's Words

by Dr Lim Khong Jin Michael, Editor, College Mirror Team B

In “The Healing Power of Gratitude”, Dr Eugene Chua writes that “Family Medicine is meaningful work—but it is demanding work. Many of us carry emotional burdens quietly: the worry for a frail patient, the weight of a difficult conversation, the exhaustion that follows a relentless week. Gratitude does not erase these realities, but it gives us a different way to hold them.”

As doctors, we often carry heavy responsibilities. For many of us, this calling to be a doctor—while heavy—is also deeply meaningful. It is one of a few vocations that blends knowledge and practice with an understanding of our own humanity and gives us a sense of purpose beyond ourselves.

## Gratitude for the Calling

Studying medicine, developing clinical judgement, and using our hands and minds to heal is a privilege, not a right. On difficult days, remembering medicine as a calling rather than just a job to make ends meet can bring perspective and strength. Gratitude shifts our focus from the burdens of work to the honour of serving in it.

Dr Charity Low shares a touching story: she sang for a patient, Tat, during his difficult moments. Gradually, he joined in with his harmonica, slept better, moved more, and even returned to gardening. After nine months, he was walking into the clinic again.

Gratitude does not deny the reality of stress or emotional fatigue. Instead, it offers a way to see work as stewardship. As A/Prof Gan Wee Hoe noted, leadership as a doctor encompasses humility as well as accountability and faithfulness to the responsibilities entrusted to us. As good doctors, we need to motivate colleagues and patients during hard times, establish genuine caring relationships when opportunities arise, and build trust through character and integrity at all times.

## Gratitude in the Patient Encounter

Daily interactions with patients offer some of the most profound moments of gratitude. Dr Lois Hong recalls Isa, a patient in one of the world's poorest capitals, whose joy and

appreciation for life reminded Dr Hong to reflect on her own habitual grumbling and negativity within a comparatively comfortable lifestyle. Isa inspired her to move through life with more gratitude and grace.

Even difficult encounters are opportunities for gratitude. They teach patience and empathy—essential qualities for compassionate care. As Dr Alfred Lye notes, gratitude in the doctor-patient relationship recognises our shared humanity in the face of suffering.

## Gratitude Through Trials

Medical life involves sleepless nights, cases that linger in one's memory, and dealing with complaints of unsatisfactory medical practice. Gratitude in these seasons does not mean pretending everything is fine. Rather, it is the practice of acknowledging what is meaningful, even in difficulty, and setting aside time for self-care. Reflecting on mental wellness in medicine, Dr Ng Li Ling writes, “Gratitude doesn't dismiss the challenges we face in our practice; rather, it allows us to see both the difficulties and the grace in every situation.” Trials reveal our humanness, our dependence on God, family, and friends, and it births the resilience needed to endure and overcome.

## Gratitude for Growth and Progress

A doctor's journey is one of lifelong learning. As Dr Kenneth Tan reflects: pursuing further education as a busy practitioner is challenging, yet it reflects the desire to grow and stay true to the ideal of improving as a physician.

Dr Ng Li Ling emphasises that gratitude for growth also includes appreciating colleagues who support, challenge, mentor, and stand with us through every season of medical life.

## A Life Shaped by Gratitude

Gratitude transforms a medical career into a journey of reflection, humility, and purpose. It renews compassion, strengthens resilience, and reminds us that even amid busyness or moments of injustice, our work is God-given, profoundly human, and deeply meaningful.

(continued from Page 2: CFPS Convocation Ceremony—Speech by Guest-of-Honour Prof Kenneth Mak)

*Family Physicians serve as the cornerstone of our healthcare system—the trusted first point of contact who guide Singaporeans towards better health.*

Together, we are advancing the Healthier SG vision of one doctor for every family who truly knows and cares for their patient's complete health journey. In a system with finite resources, we must continue to emphasise appropriate and cost-effective solutions as we tackle the growing healthcare needs of our population. Primary care must deliver the right care, for the right patient, at the right time and the right place.

Tonight's celebration represents more than individual achievement. It represents our collective commitment to excellence in Family Medicine and our shared vision for a healthier Singapore. I encourage all of you to continue engaging actively with one another, sharing your knowledge, and fostering a culture of continuous learning and innovation in primary care.

Tien Hua shared a bit about what it is to be a specialist, a Family Medicine specialist, and this issue of whether or not prices and salaries will rise. I think that is not necessarily the most important thing that we need to ask ourselves. What we need to ask ourselves is: what is the value proposition that we give to our patients and their families? Through the establishment of a new tier of Family Medicine specialists, it is my hope that each and every one of you will become, or are now, a Family Medicine specialist. That you will set the stage for high quality care, ensuring the best of outcomes for our patients who increasingly will be moving out from hospitals to home, receiving the best of care for their chronic diseases where they are, and you will establish amongst your community what those best practice standards are in raising the quality of care in primary care settings.



*The importance of structured postgraduate Family Medicine training cannot be overstated as we manage the breadth of patients from cradle to grave.*

Congratulations once again to all our new FCFP, MMed(FM), and GDFM graduands. I wish you continued success as you embark on this next chapter of your professional journey, serving our communities with distinction and compassion. And I look forward to interacting with each and every one of you as a family physician, Family Medicine specialist, and a friend and colleague, wanting the best of care for our patients.

Thank you very much.

*Primary care must deliver the right care, for the right patient, at the right time and the right place.*

# CFPS Convocation Speech 2025

## Recognition of Family Medicine as a Specialty

Speech by Dr Wong Tien Hua, President, CFPS

**P**rofessor Kenneth Mak, Director General of Health, A/Prof Lee Kheng Hock, Our Sreenivasan orator for this evening,

Our guests from overseas—Prof Wang Zhong and Prof Wang Zhiyi from Tsinghua Medicine, both of whom kindly hosted me in Beijing two weeks ago,

Distinguished guests, esteemed colleagues and fellows, our Graduands and families, ladies and gentlemen.

Welcome to the 2025 Convocation of the College of Family Physicians Singapore. It is my great pleasure and privilege to welcome you as we come together to celebrate the achievements of those who have made the cut in their respective College programmes in the field of Family Medicine. We are here also to recognise the effort, discipline, and commitment that has brought each of you to this point, together with the support of your families, teachers, and supervisors.

We extend our heartiest congratulations to our Graduate Diploma in Family Medicine and Master of Medicine (Family Medicine) graduands, Collegiate Members, and Fellows of the College for their tremendous achievement.

This evening, we will be seeing:

- 21 graduates from the Fellowship cohort;
- 23 who are elected to Collegiate Membership;
- 18 graduates from the College programme MMed(FM); and
- 163 from the Graduate Diploma in Family Medicine cohort.

This year's Convocation also takes place at a meaningful time for our profession: Family Medicine has now been formally recognised as the 36th medical specialty in Singapore.

Since 1 November, The Specialist Accreditation Board (SAB) has begun accepting the first batch of applications for specialist accreditation in Family Medicine. The pioneer group invited to apply will be our Fellows of the College who have completed Fellowship by Assessment, and who fulfil practice hours to show currency of practice.

I would like to now address some of the concerns that were raised from our feedback and engagement with the public and our own fraternity.



The first concern is about fees and charges—some have asked if this will lead to higher consultation fees, and whether it will be more expensive to see a Family Medicine specialist.

I reposted Minister of Health Ong Ye Kung's Facebook announcement of the good news on 31 October—and the first comment I got when I reposted that on my feed was from a specialist friend. He asked "Can increase the charge?"

On that same afternoon the announcement was made, I had an interesting encounter with the first patient that came to my clinic when I opened for my afternoon session. It was for follow-up of a skin rash that I had earlier suspected could be herpes zoster. After an assessment, I determined that there was no progression of the painless unilateral patch of skin dermatitis. I reassured her that no medication was required. As she stood up to leave, she paused at the doorway and turned around to ask, "So, doctor, you won't be charging me today?" I had to spend some time convincing her that the follow-up consultation fee was well worth the reassurance that I provided.

I think this reflects the reality that we Family Physicians work in. Patients are price-sensitive, and the private sector responds strongly to market forces. No Family Physician can simply decide to raise fees; the current market would not support it.

Thus I can say that specialty recognition should not automatically lead to an increase in healthcare costs. In the private sector, pricing is tightly shaped by market forces; in the public sector, subsidy structures continue to ensure affordability.

However, I do see a future where Family Physicians and FM specialists will be spending more time dealing with complexity and managing patients with multiple conditions—and that eventually the fees charged will reflect the time, the responsibility, and the professional expertise involved.

In this area, I also hope that the government will take the lead and help establish a fair remuneration structure and promotion pathway for Family Medicine specialists in the public sector.

The second concern is about fragmentation. A common concern is that recognising Family Medicine as a specialty might separate doctors into “specialists” and “non-specialists.”

I can say that it is not the intent of this recognition to create any divisions within primary care. The aim is not to create hierarchy, but to raise the professional standing of all Family Physicians.

Family Medicine being seen as a specialty increases public trust by reassuring patients that FPs meet training benchmarks. Recognition will also clarify training pathways and professional expectations, ensuring younger doctors have clear progression routes and mentorship opportunities.

It is also important to emphasise that specialty recognition will not exclude or disadvantage existing practitioners. There will be no new barriers imposed on doctors currently practising in primary care, whether in private or public settings. Those who are already providing Family Medicine services will continue to do so as before. The intent is not to restrict or ringfence practice to a select few, but to create a pathway for professional advancement through training and formal recognition.

Third, recognition is about standards and quality, not cost. I would point out that Family Medicine training already requires very high standards. Anyone who completes the GDFM and passes the Family Medicine Applied Knowledge Test (AKT)—a four-hour “marathon” consisting of 180 single best-answer questions—must already possess and demonstrate strong foundation knowledge.

The upcoming Advanced Family Medicine (AFM) programme, leading to FCFP and specialty recognition, builds on this foundation and extends training into broader clinical exposure, leadership development, ethics, and professionalism. Specialty recognition therefore represents structured capability, and accountability.

## “Family Medicine being seen as a specialty increases public trust”

The route to establishing Family Medicine as a recognised specialty has not been straightforward. Family Medicine training in Singapore developed independently through the vision of our College leaders. It is unique in that it includes a private practice pathway, and historically the oversight, examination, and accreditation structures existed outside the specialist accreditation system.

We had to carefully map our “Family Medicine universe”—our curriculum, examinations, and working committees—and align them with the specialist accreditation framework. This required detailed and patient work across agencies and institutions.

I would therefore like to acknowledge and recognise the many colleagues who contributed to this development.

The original proposal paper submitted in 2021 was chaired by: A/Prof Lee Kheng Hock (Chair), A/Prof Tan Tze Lee (Co-Chair), and A/Prof Tan Boon Yeow (Co-Chair).

A revised proposal was submitted by the Joint CFPS-AMS Family Medicine workgroup in 2024. It comprised Censor-in-Chief Dr Darren Seah, CFPS Vice-President Dr Suraj Kumar, Dr Sabrina Wong, Dr Sally Ho, A/Prof Tan Boon Yeow, and myself.

We are very grateful for strong support from: A/Prof Tan Woon Teck Clement (Director, DGMS), Dr Wong Chiang Yin (Master, AMS), Prof Teo Eng Kiong, and A/Prof Alan Ng (Past Master, AMS).

Our appreciation also goes to MOH and the Primary and Community Care Division (PCC)—especially Dr Ruth Lim, former Director of PCC, and Dr David Tan, current Director of PCC.

And finally, our sincere appreciation to our Guest-of-Honour this evening, Prof Kenneth Mak, Director-General of Health, for his steady leadership and guidance. He is one of the few who possesses a detailed and almost encyclopaedic understanding of our Family Medicine training system, and he was able to guide and steer both the FPAB and the SAB towards today’s outcome.

Thank you.

# Citation for Adjunct Associate Professor Tan Tze Lee

## *Albert and Mary Lim Award 2025*

### *College of Family Physicians Singapore*

Speech by Dr Suraj Kumar, Vice President, College of Family Physicians Singapore

**P**rofessor Kenneth Mak, Director-General of Health, President and Council of the College of Family Physicians,  
Distinguished Guests, Friends and Colleagues,

Good evening.

I am both honoured and delighted to deliver the citation for the conferment of the Albert and Mary Lim Award for 2025 to my very good friend and colleague, Adjunct Associate Professor Tan Tze Lee.

This prestigious award was first presented in 1974 as the Albert Lim Award and was re-named the Albert and Mary Lim Award in 1999, in memory of the late Dr Albert Lim and his wife Mrs Mary Lim.

The Albert and Mary Lim Award is the highest honour that the College can bestow on distinguished individuals and celebrates those who have made significant contributions to the college and demonstrated outstanding commitment, leadership, and service in the field of family medicine. Prof Tan's career exemplifies these qualities in every respect.

#### **Leadership and Service**

It is difficult to know where to begin and compress all that Prof Tan has done for the FM fraternity and the College in just 10 minutes, so I hope that I can do him justice.

Prof Tan graduated from University of Edinburgh in 1987 and obtained his MRCP (UK) in 1992. He was also admitted to the Royal College of Physicians, Edinburgh in 2010. He was conferred his Fellowship by CFPS in 2016 and joined the chapter of Family Medicine Physicians in the Academy of Medicine in 2017.

As a Family Physician in private practice, he has been running his practice, the Edinburgh Clinic, with his wife, Kee Loo, for more than 30 years.

He has a special interest in respiratory medicine and has been active in research, having co-authored many papers, published abstracts, and presented posters in numerous international conferences and meetings.



Prof Tan has also been an active member of the council of the Singapore Medical Association from 2013 to 2023, serving as its Vice President from 2017 to 2018.

But his greatest contributions have been to the CFPS.

Prof Tan joined the College in 1992 and has served in the council since 2009 in almost every position, from Editor, Treasurer, Honorary Secretary, Vice President, and finally President, the latter from 2017–2023.

Prof Tan has been a central figure in advancing Family Medicine in Singapore. His unwavering dedication to the discipline is evident through his many years of service as President of the College of Family Physicians Singapore, where he has championed the importance of primary care and driven key initiatives to strengthen the profession. Under his guidance, the College has grown in stature and influence, elevating the standards of care for countless patients across the nation.

### Educational Contributions

Prof Tan's passion for medical education is reflected in his role as an adjunct associate professor, where he has inspired generations of medical students, residents, and fellow practitioners. His commitment to nurturing future leaders in Family Medicine is seen not only in his teaching but also in his mentorship, fostering an environment of continuous learning and professional growth.

### Advocacy and Professional Excellence

Throughout his career, Prof Tan has been a tireless advocate for family physicians and primary care. His contributions extend beyond clinical practice to shaping policy, promoting research, and driving innovation in healthcare delivery. He is widely respected for his integrity, vision, and ability to bring together diverse stakeholders for the betterment of patient care and the profession.

### Conclusion

Adjunct Associate Professor Tan Tze Lee's exemplary service, dedication, and leadership have made an indelible impact on the College of Family Physicians Singapore and the wider medical community. In recognition of his outstanding achievements and lasting legacy, he is most deserving of the Albert and Mary Lim Award.



CM

## Long Service Award (CFPS Secretariat)

*The College would like to congratulate and thank our staff Ms Anica Goh, Mr Choo Guorong, and Mr Chester Kwan for their dedicated and untiring service. Ad multos annos!*



# The Rise, the Fall, and the Reincarnation of Family Medicine

*Sreenivasan Oration 2025, College of Family Physicians Singapore*

by A/Prof Lee Kheng Hock, Senior Consultant at the Department of Family Medicine and Continuing Care in Singapore General Hospital

It is a particular honour to speak at this Sreenivasan Oration, a lecture series named for Dr Baratham Ramaswamy Sreenivasan. He was the first in a long line of College leaders who have worked tirelessly to restore the values of Family Medicine to our healthcare system and our people. This oration was established to keep his legacy alive, and in doing so, it asks us each year to adopt a Janus-like gaze: one face looking to the past, the other to the possibilities of the future. It is this dual perspective that I wish to explore with you tonight.

My address is titled “The Rise, the Fall, and the Reincarnation of Family Medicine”. This story is evolutionary, yet it is anything but linear. It is a tale woven from many threads: dedication to service, the triumph of science, the failure of wisdom, institutional inertia, the passion of our professional grassroots, and ultimately, the vindication of a collective vision. It is a global narrative spanning more than half a century, one in which Singapore has been carried on a tide of international progress while simultaneously steering its own distinct path, guided by the discipline and pragmatism for which our nation is known.

## Global Origins, Local Beginnings: The Rise of Generalism

At the start of the 20th century, the physician was a generalist by design. Medicine’s great early advances were made by people who think holistically in terms of families, households, communities, and population. Patients were seen in the context of their family and communities.

At the turn of the 20th century, medicine entered a period of astonishing scientific and technological progress. Discoveries in bacteriology, radiology, pharmacology, and surgical technique reshaped the very foundations of medical knowledge. New tools such as X-rays, laboratory testing, and emerging therapeutic innovations created entire domains of information that no single physician could fully master. Universities and hospitals responded by organising themselves around increasingly narrow fields of expertise, each with its own methods, instruments, and intellectual culture. Specialisation soon became both inevitable and celebrated. In this new landscape, the traditional generalist who once cared for the whole person across the journey of life gradually lost prominence as the expanding universe of medical knowledge displaced the centre of gravity away



from broad-based practice and toward focused disciplines. Specialisation was a moral and intellectual good. But, like every powerful advantage, it had costs. Fragmentation of care followed. The patient became, in effect, a set of problems and malfunctioning organs.

In the United States during the 1960s, the tension between an increasingly specialised medical system and the need for whole-person continuity of care became both visible and urgent. Two landmark national reviews gave voice to this concern. The Millis Report of 1966, commissioned to examine graduate medical education, concluded that modern healthcare required physicians who could integrate care across settings and disciplines. It introduced the idea of the primary physician, a doctor who would assume ongoing responsibility for coordinating comprehensive care for individuals and families. The Folsom Report of 1967, produced by a distinguished committee under the American Medical Association, went further by articulating the vision

*At the start of the 20th century, the physician was a generalist by design. Medicine's great early advances were made by people who think holistically in terms of families, households, communities, and population.*

of a personal physician for every American community. It emphasised that health could not be understood apart from family and social context and that the country needed doctors rooted in the everyday realities of people's lives. Together, these reports warned that their nation had slipped into a downward spiral where no one was responsible for the whole patient. Their recommendations created the momentum for change. In 1969, the American Board of Family Practice was established, formally recognising Family Medicine as a specialty and signalling the rebirth of the generalist tradition that had nearly disappeared. It marked the return of a physician who cared first for the person, not only the disease.

While the United States was wrestling with the consequences of fragmentation in the 1960s, the United Kingdom was experiencing its own reckoning with the role of the general practitioner. The National Health Service, created in 1948, had originally placed the general practitioner at the front door of care. Yet by the mid-20th century, British general practice faced declining morale, outdated facilities, uneven standards, and widening gaps between hospital specialties and community medicine. These concerns prompted a series of influential inquiries and reforms. The 1950 Collings Report revealed the poor working conditions and variable quality of general practice, which galvanised efforts to modernise training and improve professional standards. This momentum eventually led to the formation of the Royal College of General Practitioners in 1952, an institution that became the intellectual and professional champion for a revitalised general practice. By the early 1970s, the RCGP had established vocational training, strengthened examinations, and redefined the general practitioner as a specialist clinician responsible for comprehensive, continuous, and family-centred care. These reforms elevated general practice from a default career choice to a respected discipline with a clear academic foundation. In many ways, the British revival of general practice paralleled the American rebirth of Family Medicine.

As movements in the United States and the United Kingdom gained momentum, a parallel current was rising across continents. Countries as diverse as Canada, Australia, the Netherlands, and the Scandinavian nations were reflecting on the limits of fragmented care and the growing need for physicians who could hold continuity, context, and community at the centre of practice. By the late 1960s, it was clear that this was not a local adjustment but a worldwide reorientation in thinking about what modern healthcare required. This convergence found its culmination in 1972, when national colleges and academic bodies from around the world came together to establish the World Organisation of National Colleges, Academies, and Academic Associations of General Practitioners and Family Physicians, better known as WONCA. WONCA also affirmed that Family Medicine was not a fallback career or an interim stage before specialisation. It was a specialty in its own right, grounded in mastery of the whole person and committed to the health of communities. Singapore was among the early members of this new international family, aligning itself with a global movement that understood the value of relational, continuous, and context-rich care.

### **Singapore's Parallel: Organising, Legitimation, and Persistence**

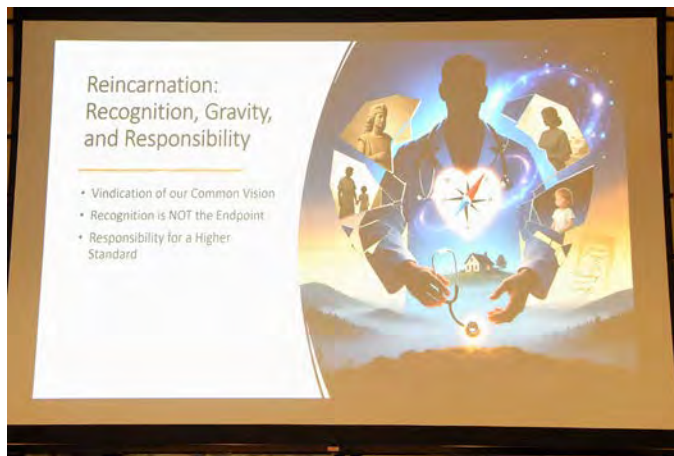
While the world was debating identity in the 1960s and early 1970s, a different kind of conversation was starting here. Singapore in the 1970s was remaking itself through nation-building, system-building, and institution-building. Health policy and hospital development were central to that national project. Into that climate a small group of committed clinicians planted something audacious: the College of General Practitioners Singapore, founded on 30 June 1971. From the outset they asked not for ceremony but for standards: examinations, journals, a professional home. Within a year the College ran its first Membership (MCGP) examination, and within a few years the MCGP diploma was recognised by the Singapore Medical Council as a registrable postgraduate qualification.

Through the 1980s and 1990s, Singapore's Family Medicine community deepened its academic roots. NUS recognised Family Medicine as an academic discipline; structured postgraduate training matured with the MMed(FM); the College itself evolved into the College of Family Physicians Singapore. The slow architecture of training and assessment was deliberate, focused on an unshakable insistence that community-based care demanded its own rigour.

The formation of the Department of Family Medicine and Continuing Care (FMCC) at Singapore General Hospital (SGH) in 2006 was a seminal moment in the development of Singapore's health system, representing the first clinical department of its kind within a restructured public hospital and marking a deliberate strategic shift in care delivery. Its significance lay in actively moving the generalist perspective

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of Family Medicine “upstream” from the traditional community setting into the tertiary hospital environment, a necessary response to the immense pressures of an ageing population presenting with complex, multi-morbid chronic conditions that challenged the acute, specialised care model. The department was fundamentally a mechanism for care integration, established to bridge the historical divide between hospital and community, with its primary function being to ensure continuity of care—from coordinating services for complex patients within the hospital (inpatient consultative services) to managing the critical transitional phase upon discharge. By pioneering services like transitional care and home medical care for sub-acute patients, the FMCC laid the groundwork for a more holistic, person-centred, and continuous care model, setting a national precedent for how tertiary institutions could actively engage in population health and seamlessly link acute episodes with long-term recovery and maintenance in the community.

Meanwhile, FPs in polyclinics are advancing new care models for of chronic diseases, leading multi-disciplinary teams (including nurses, dieticians, and health educators) that run structured programmes for complex conditions like diabetes and hypertension. Simultaneously, the private sector has been galvanised through the Primary Care Network (PCN) scheme, a core component of the Regional Health System (RHS) strategy. Under the PCN model, private General Practitioners (GPs), often led by an FP, band together into virtual networks to receive government funding and administrative support. This structure allows solo GPs to provide team-based chronic care. This strategic partnership ensures that the majority of Singaporeans, who rely on private GPs for primary care, receive holistic and coordinated management for their chronic conditions closer to home. Finally, FPs are crucial in the intermediate care sector, often serving as the primary doctors in community hospitals. In this role, FPs manage patients’ sub-acute medical needs, focusing on rehabilitation, care planning, and the final transition back to the community, ensuring that the generalist and community centredness guides long-term recovery and prevents fragmentation of care.

## Reincarnation: Recognition, Gravity, and Responsibility

What a decade of determined work can yield is not merely respect—it is structural gravity.

On 31 October 2025, the Specialists Accreditation Board announced that Family Medicine would be recognised as Singapore’s 36th specialty, effective 1 November 2025. This moment is more than an institutional milestone; it is the vindication of a vision held and tirelessly advanced by our College leaders for over half a century. The announcement from the Specialists Accreditation Board is the structural culmination of that vision. It is the proof that decades of determined work of forging formal pathways, establishing rigorous credentialing, championing fellowship standards, and building indispensable hospital partnerships, can yield not merely respect, but what we might call structural gravity. This is the force that now pulls training pipelines, resources, and the very conversation about healthcare towards the central, indispensable role of the family physician.

Our founders and the leaders who followed did not labour for a medal or a title. They built for this very outcome: a future where the discipline they championed would be unequivocally recognised for its critical function. This specialist status is the ultimate affirmation of their conviction that community-based care demands its own unique rigour and expertise.

But let us be clear. This recognition is not an endpoint. It is a threshold that they have brought us to. With this new status comes the profound responsibility they modelled for us. That is to steward a discipline that must remain nimble, humane, and outward-looking. The fact that our fellowship-holders will form the first cohort of accredited specialists is the final,

“... a parallel current was rising across continents. Countries ... were reflecting on the limits of fragmented care and the growing need for physicians who could hold continuity, context, and community at the centre of practice.”

*... the College of General Practitioners Singapore, founded on 30 June 1971. From the outset they asked not for ceremony but for standards: examinations, journals, a professional home. Within a year the College ran its first Membership (MCGP) examination, and within a few years the MCGP diploma was recognised by the Singapore Medical Council as a registrable postgraduate qualification.*

undeniable evidence that our leaders were right all along. They envisioned a physician who integrates care, coordinates complexity, and takes responsibility for whole lives. Today, that physician is not just an ideal; they are a certified specialist, their practice now the validated standard.

This is their legacy, made manifest. Our task is to honour it not with complacency, but with the same unwavering commitment to the work ahead.

#### **Memento Mori: The Quiet Warning in an Age of VUCA and AI**

If our task tonight were only to celebrate, we would be repeating the complacency that once led to our decline. For triumph invites not rest, but vigilance.

In Rome, the triumphant general was accompanied by a slave who whispered, memento mori—remember you are mortal. That whisper is not fatalism; it is prudence. It is the attitude that keeps leadership honest.

We enter an era of VUCA: volatile, uncertain, complex, ambiguous. It is shaped by demographic ageing, multimorbidity, constrained resources, and new forms of inequality. Against this backdrop, the most disruptive force is not merely demographic: it is technological. Artificial intelligence will reconfigure knowledge flows, triage, diagnostics, and patient access to information. AI will reduce some work and magnify others. It will make some doctors more efficient—and make other roles obsolete if we allow it. The choice is not to accept or reject AI. The choice is whether we design AI to serve the ethic of primary care—continuity, context, shared goals—or whether we let opaque systems optimise for throughput and narrow metrics.

We need only look to our own history to understand this moment. The rise of specialisation, for all its brilliance, carried a hidden cost: it fragmented care, reducing the person to a collection of malfunctioning organs. The generalist, the steward of the whole person, was nearly lost. Today, we stand at a similar crossroads, not with a new discipline, but with a new force: Artificial Intelligence.

AI presents a risk of fragmentation as profound as any we have faced. Left unguided, it promises to optimise for efficiency and narrow metrics, potentially creating a new, digital-driven fall. A system where algorithms, not relationships, dictate care, and where the patient's story is lost in a sea of data. This is not a future we can accept.

But the lesson of our past is not to reject progress, but to master it. The choice is not whether to accept AI, but whether we will imbue it with our values. We must embrace AI not as a replacement for the family physician, but as the most powerful tool we have ever had to actualise the full vision of our practice.

*On 31 October 2025, the Specialists Accreditation Board announced that Family Medicine would be recognised as Singapore's 36th specialty, effective 1 November 2025.*

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We must ensure AI serves the core ethic of Family Medicine: continuity, context, and shared goals. We must be in the rooms where algorithms are built, insisting they reflect the messy realities of multimorbidity, social determinants, and human uncertainty. Let us build tools that augment relational care and free our attention for listening and deepen our understanding.

Just as we reclaimed the generalist tradition and reincarnated it as a respected specialty, we must now seize AI. By combining this formidable technology with our timeless values, we can not only avoid a new fall but advance towards a future where the promise of whole-person, continuous, and deeply human care is finally, fully realised.

### **Closing: Stewardship and the Work Ahead**

So where do we go from here? This hard-won recognition is not our final destination, but the starting point for the next phase of our journey. Our path is clear.

First, we must treat our specialist status as a mandate, not a medal. This new standing confers a duty to lead in medical education, to define quality standards, and to provide policy advice. Our teaching must emphasise not only knowledge, but also the ability to make sense of uncertainty, to negotiate patient priorities, and to excel in interprofessional collaboration.

Second, we must claim artificial intelligence as a profound design opportunity. We will build, co-develop, and govern tools that augment relational care. This means creating triage systems that preserve continuity, predictive models that suggest rather than instruct, and summarisation tools that free our attention for the essential art of listening.

Third, we must steward the entire health system towards greater integration. We will advocate for payment and organisational models that reward continuity of care and outcomes that truly matter to patients. We must champion team-based care that extends the reach of family physicians without breaking apart the integrity of responsibility.

Our founders, Dr Sreenivasan, Dr Wong Heck Sing, and Dr Koh Eng Kheng did not build for applause. They built standards, examinations, journals, and mentorship programmes. They understood that a professional home is constructed through practice, pedagogy, and professionalism.

Now we inherit that house. We have the honour of living within the walls they raised. Let us use this shelter not for complacency, but for the work that remains: education, research, policy, and partnership with technology, all in service of enhancing the moral project of medicine.

Let us be the discipline that insists on the person behind every record, the family behind every history, and the community that sustains health.



*They envisioned a physician who integrates care, coordinates complexity, and takes responsibility for whole lives. Today, that physician is not just an ideal; they are a certified specialist, their practice now the validated standard.*

And as we celebrate this reincarnation, let the slave's whisper guide us: memento mori. Remember the fragility of achievement, the responsibility of status, and the moral seriousness of the work we do.

Thank you.

■ CM

# Becoming More Grateful

by Dr Hong Yinghui Lois, Family Physician, Editorial Team Member (Team B)

I got to know Isa while working in the capital city of one of the poorest countries in the world. Isa lives on a dusty street in an obscure suburb with her two adopted toddlers. She's a foreigner, single, in her 40s. Her boy has got phocomelia and learning disabilities.

Isa is the happiest person I have ever met.

It's not easy being a single, older, working mum in a foreign country. But if you sat down with Isa for a drink and a chat, what you would notice is the gratitude with which she speaks of her children, her work, her life. The way she goes about the tasks of daily living in a city where drinkable water must be hauled home in 15 kg jerrycans. You don't buy too much perishable food lest it spoil when the inevitable four-day power outages happen. You do keep extra water supplies and a shelf of tinned food in case of floods, civil unrest, or other unscheduled disasters.

Meeting Isa changed my perspective of the basic conditions needed for gratitude.

I went home that day and reflected on my habitual grumbling and my negativity in the midst of my affluent, comfortable lifestyle. I resolved I would henceforth become a person who moved through life with that kind of gratitude.

That was almost ten years ago. I'm not yet that person.

## How Grumpy Bear Learnt to Smile

Gratitude is like a set of muscles I have had to train over the years (as a child, my favourite Care Bear was Grumpy Bear). People who study positive emotions describe gratitude not just as an emotional state, but a habit. Emmons and McCullough wrote that gratitude is what happens when you recognise you've got a good thing—and you recognise that it came from someone else. Other researchers, like Watkins (2003), have shown that people who practise gratitude experience more positive emotions and greater resilience.

Gratitude is good for you.

## Why Doctors are Grumpy

I suspect gratitude doesn't come naturally to medics. Perhaps it's because we're trained to look for pathophysiology—to suspect EVERYTHING. We're trained to anticipate complications, side effects, risk factors. We get socialised into narratives of suffering. As third-year students we listen slack-jawed to horror on-call stories ("Last night I admitted 67 patients and had two cardiac arrests in the ward"). As HOs we add our own ("One evening I walked past a patient and the dialysis machine exploded.").



*Despite apparent lack of effort, my cat routinely makes it onto my gratitude list.*

We callow 19-year-olds watched patients get cancer diagnoses, wake up paralysed, or just... die. We met people on the worst days of their lives. Quite often, we graduated into a health system that—like most—makes up for resource constraints by drawing on the inexhaustible sense of duty of their healthcare workers. We carry our private griefs and burdens along with caring for others.

Sometimes, to be a healthcare worker is to see suffering, and to suffer.

And, if we're honest, we kind of like complaining about that.

So we run the gamut from burned-out moroseness to a sophisticated cynicism: about our patients, our leaders, our colleagues, our system, our world.

*Gratitude is like a set of muscles I have had to train over the years*

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*People who study positive emotions describe gratitude not just as an emotional state, but a habit.*

### Why Should We Consider Gratitude?

Caragol (2021) trialled a short, daily gratitude exercise with clinicians—just a few minutes a day—and found it reduced stress and led to greater professional satisfaction. Paulson (2016) wrote that while chasing pleasure doesn't make us happier, gratitude reliably increases wellbeing. Gratitude works even in tough settings. Especially in tough settings.

I've now spent half of my working life in low-resourced health systems. I've become convinced that gratitude is not a luxury to reserve for a someday when things get better. It's essential if we're to keep on keeping on in the work that we do today.

### The Limits of Gratitude

There's a growing body of research on "gratitude interventions"—simple things you can do to invite moments of gratitude into your life. But there are, crucially, a couple of limits to gratitude:

1) It shouldn't be used to silence people. Philosopher Terrance McConnell (2016) calls this "inapt gratitude". The child in an abusive home or the medical student facing racial discrimination—none of them should be told to "just be grateful for what you do have."

2) You have to mean it. When gratitude is genuine, both giver and receiver benefit. But we all know the hollowness of a passive-aggressive "thanks". Forced gratitude lists don't work; a 2023 meta-analysis by Kirca suggests that "excessive" gratitude exercises lose their positive effect. Also, if you're clinically depressed (medics are at three times population risk) gratitude alone won't fix that; please get help!

### Rx Gratitude: Some Ideas From a Lifelong Grumpy Bear

So how can we as doctors cultivate gratitude? Here are some exercises to do (because you want to, not because you have to):

1) Ask: who sets the tone for gratitude in your life? Do outings or dinners or WhatsApp groups turn into complainfests? If so, is that a dynamic that can change?

2) In a busy clinic, look out for small moments where you can affirm the good—a patient's trusting you with a heavy story, their patience while waiting outside your room, their efforts to manage their chronic disease.

3) Every evening, write (or voice note, or text) three things that you enjoyed that day.

4) Once a week, think of one colleague who made your life better. Tell them. Be specific: "Thanks for helping with my case that day", not just "Thanks for everything".

5) Once a month, write a short note of appreciation to someone important to you.

### Small, Everyday Gratitude

For a long time, I thought gratitude required a big life shift, that I'd have to become a different sort of person altogether. But increasingly I have begun to think that gratitude doesn't begin in the extraordinary. It starts by noticing each day's small, steady signals of grace—the kind Isa taught me to notice, even in a city with four-day power outages. Gratitude doesn't demand new conditions. It invites us to see what's already here.

And maybe that's enough to start.

*I suspect gratitude doesn't come naturally to medics. Perhaps it's because we're trained to look for pathophysiology—to suspect EVERYTHING.*

# The Healing Power of Gratitude

by Dr Eugene Chua, Family Physician, Editorial Team Member (Team B)

As the year draws to a close, it invites us into a moment of reflection—on the people we journeyed with, the challenges we encountered, and the moments that kept us going. In that pause, one powerful theme often comes to mind: Gratitude.

## What Gratitude Truly Is

Gratitude is more than politeness or optimism. It is not about denying hardship, nor forcing ourselves to “look on the bright side”. Instead, it is the gentle discipline of recognising what is still good, still meaningful, and still sustaining us—even in the midst of difficulty.

It is a posture rather than a performance; a way of seeing rather than a way of escaping.

## Why Gratitude Matters in Healing

Over the past decade, research has increasingly affirmed that gratitude can shift the emotional landscape for those who practise it. A randomised controlled trial by Wong et al (2018) showed that clients who engaged in gratitude writing during psychotherapy experienced sustained improvements in wellbeing for up to 12 weeks beyond the intervention. A 2023 systematic review of 64 trials by Diniz et al found that gratitude interventions consistently improved mental health and reduced symptoms of anxiety and depression.

What is striking is how small acts—a brief written reflection, a gratitude list, a thank-you letter—can unlock meaningful psychological benefits. These practices appear to increase positive emotions, broaden perspective, and reduce the weight of negative thoughts.

## A Gift for Physicians Too

The healing power of gratitude is not only for patients. It is also, deeply, for us.

Family Medicine is meaningful work—but it is demanding work. Many of us carry emotional burdens quietly: the worry for a frail patient, the weight of a difficult conversation, the exhaustion that follows a relentless week. Gratitude does not erase these realities, but it gives us a different way to hold them.

When we pause to celebrate a small breakthrough with a patient, reflect on a colleague’s quiet support, or acknowledge the privilege of being trusted by those we care, something shifts internally. Gratitude grounds us and reminds us that we are held by more than just our own strength. It recentres us. It reminds us that what we do every day matters.

*... it is the gentle discipline of recognising what is still good, still meaningful, and still sustaining us—even in the midst of difficulty.*

Simple practices—a short end-of-day reflection, a note of thanks to a colleague, or recalling one meaningful moment from clinic—can create pockets of emotional breathing space. Over time, these small acts accumulate into a habit of noticing goodness, even in the busiest weeks.

## Being Grateful

As we wrap up the year, perhaps gratitude offers us not just comfort, but renewal. In practising it ourselves, may we become more grounded, more present, and more generous in extending compassion—to patients, to colleagues, and to ourselves.

May gratitude be both the compass and the companion that carries us into the year ahead.

*The healing power of gratitude is not only for patients. It is also, deeply, for us.*

■ CM

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# FAMILY MEDICINE CONVOCAT



## 30th Council (2025 – 2027) College of Family Physicians Singapore

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Seated (from left): Adj A/Prof Tan Tze Lee, Dr S Suraj Kumar (Vice-President), Prof Kenneth Mak (GOH, Director-General of Health, Ministry of Health), A/Prof Lee Kheng Hock (Deputy Chief Executive Officer (Education and Community Partnerships)), Dr Wong Tien Hua (President), Dr Seah Ee-Jin Darren (Censor-in-Chief), Dr Wee Wei Chieh Nelson

Not in photo: A/Prof Low Lian Leng, Dr Shen Fengli Sharon



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Seated (from left): Dr Fanniyah Anis, Dr Singh Jyoti, Dr Dodangodage Don Naveena Dinushika Weerasinghe, Dr Chu Mei Yin, Dr Tay Zhi Yan Clare, Dr S Suraj Kumar (Vice-President), Dr Wong Tien Hua (President), Dr Seah Ee-Jin Darren (Censor-in Chief), Dr Udugamasooriya Soorige Dona Imalka Jayamali, Dr Poh Su Ern, Dr Kuah Poh Kah, Dr Nicole Soh Wei Ying\*, Dr Lai Hsuan (Lai Xuan)

\*2025 GDFM Book Prize Winner

# ION CEREMONY & DINNER 2025



## 2025 MMed(FM) College Programme Graduates

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Seated (from left): Dr Sze Kai Ping (Associate Programme Director), Dr Ong Ai Li (Associate Programme Director), Dr S Suraj Kumar (Vice-President), Dr Wong Tien Hua (President), Dr Seah Ee-Jin Darren (Censor-in Chief), Dr Wee Wei Chieh Nelson (Programme Director)



## Graduates of Collegiate Programme – MCFP(S) Recipients

Standing (3rd row; from left): Dr Wayne Han Lee, Dr Lim Han Wei, Dr Han Xiao, Dr Benjamin Wong Jiann Shuenn, Dr Jonathan Tung Gak Wah

Standing (2nd row; from left): Dr Tui Ze Yuan, Dr Goh Jun Heng, Dr He Cong En Jeremy, Dr Liew Siew Lee, Dr Ho Chien Hui, Daphne, Dr Loh Yi Bing, Dr Lim Shi Min Eunice, Dr Sheila Koh Anthony, Dr Shen Xiao You

Seated (from left): Dr Nurul Azyan Binte Mohd Sidik, Dr Tan Juanmin, Dr Ong Ai Li, Dr Gan Yuan Ying, Dr S Suraj Kumar (Vice-President), Dr Wong Tien Hua (President), Dr Seah Ee-Jin Darren (Censor-in Chief), Dr Kuang Silin, Dr Crystal Lim, Dr Kwek Sock Yuen Cassandra, Dr Thio Si Min



## Graduates of Fellowship Programme – FCFP(S) Recipients

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Seated (from left): Dr Chiong Xiao-Ying, Cleo, Dr Ee Runhua, Michelle (Yu Runhua), Dr Tsang Li Ping, Marianne, Dr Lee Jun Hwee, Benjamin\*, Dr S Suraj Kumar (Vice-President), Dr Wong Tien Hua (President), Dr Seah Ee-Jin Darren (Censor-in Chief), Dr Wee Wei Chieh Nelson, Dr Tan Kian Wee Kenneth, Dr Ng Li Yan, Dr Tan Mui Ling Donna

\*Dr Koh Eng Kheng Gold Medal for Best Fellowship Graduand 2025



## FAMILY PRACTICE SKILLS COURSES

### **Basic Obesity Management Accreditation 5**

The College of Family Physicians Singapore would like to thank the Expert Panel for their contribution to the Family Practice Skills Course #129 on “Basic Obesity Management Accreditation 5”, held on 11-12 Oct 2025.

**Expert Panel:**

Dr Lee Yingshan  
Dr Tham Kwang Wei  
Dr Benjamin Lam  
Mr Adrian Toh  
Ms Jessica Ong  
Dr Kim Guowei  
Dr Elaine Chew  
Dr Dawn Chong  
Dr Natalie Koh  
Dr Lee Phong Ching  
Ms Pauline Xie  
Dr Tan Kok Kuan  
Dr Leong Choon Kit  
Dr Donna Tan  
Dr Suraj Kumar

### **COVID-19 and Respiratory Virus Vaccination Strategies for Family Physicians, 2025 Update**

The College of Family Physicians Singapore would like to thank the Expert Panel for their contribution to the Family Practice Skills Course #130 on “COVID-19 and Respiratory Virus Vaccination Strategies for Family Physicians, 2025 Update”, held on 18 October 2025.

**Expert Panel:**

Dr Ian Wee  
Dr Leong Hoe Nam  
Dr Kenneth Tan  
Dr Gabriel Yee  
Dr Suraj Kumar

# A Beautiful Story of Gratitude

by Charity Low Cheng Hong, Family Physician, Editorial Team Member (Team B)

In the midst of this busy clinic in the countryside, Perth, Australia, a familiar figure steps in: an old, wrinkled face, taking his stride steadily, though slowly, with an upright posture, which could be considered admirable for a 94-year-old. As befitting his manner, Tat inconspicuously places the vase of beautiful roses onto the counter, adjusting each of their postures with a touch of master-skill in flower arrangement. That done, he quietly slips out of the clinic, back to his cozy cottage across the road, with his small garden in full blossom. He does this routine, almost weekly, having recovered strength from his previous debilitated condition, filling the clinic with the aroma of gratitude.

About a year ago, Tat was wheeled into the same clinic by his daughter, his tall posture crumbled up, eyes dimmed. He was quite new to me. His regular GP had gone on long leave, and he presented to me a few times for minor acute illnesses. His words stunned me: "Dr Low, I was previously so active and energetic, enjoying gardening daily. Now, I feel weak like a kitten, for a year or two already. I have lived many good years and now have opted for euthanasia. I come to say goodbye." He had apparently submitted application to the Euthanasia team and expected to have his life terminated within a few weeks. Limited by the short consultation duration of 10 minutes, I could only respectfully acknowledge his feelings and decision, checking that he was not in pain and there was no probable source of infection. I sent him off, informing him that I hoped to visit him at home and make him more comfortable.

At the end of that day, with a heavy heart, I ploughed vigilantly through all his case records, investigations, and specialist letters over the past years, hoping to leave no stone unturned. While respecting his decision, I felt it my responsibility to find out what could have been the factors leading to his deconditioning these past two years. Ex-police officer and construction worker, married with two daughters, six grandchildren, gastric ulcers five years ago diagnosed on OGD, Hb trend reducing gradually over time, low ferritin/saturation, angioplasty with stent done half a year ago with no improvement in effort tolerance, aortic stenosis unfit for surgery due to age, declined TAVI; AF on anticoagulant, depression on medication, insomnia, chronic backache, subclinical hypothyroidism despite thyroxine replacement... I rounded up the search, patched up the jigsaw puzzle, and made arrangements to visit Tat the following week.

I found Tat lying on his sofa, staring into the ceiling. However, he made an effort to stand up and greet me. I took all his vital signs, including SpO<sub>2</sub> at rest, on standing 5 min, on walking to the toilet and back. I could observe his breathlessness on exertion, something that he attributed to his old age. He was then resistant to any specialist referral or invasive procedures.



*Our flowers of gratitude for this week*

I discussed with him conservative treatment, to help him feel more comfortable, changed his depression medication, arranged for home oxygen, booked for iron infusion, resumed his PPI to reduce dyspepsia, increased his pain medication, allowed him to have adequate medication to have a good rest at night, increased his levothyroxine in miniature amount (to balance with risk of worsening AF); discussed with Tat and his wife usage of medications, frequency, and duration, recruiting her help to prepare all the meals he liked, adding nutritional value to them ... I ended with the presentation of a common, warm folk song to him: "You are my sunshine, my only sunshine, you make me happy when skies are grey. You'll never know, dear, how much I miss you. Please don't take my sunshine away!" My croaky voice brought tears to his eyes as he waved farewell.

I visited him a few more times, each time after contemplation, considering his multiple co-morbidities holistically, revising health plans for him, making adjustments and improvements to make each visit count. It turned out that Tat enjoyed my singing. By and by, he took out his harmonica to try and play along as I sang. He enjoyed good sleep and less backache; his bloatedness went down; food became more tasteful; his mood was elevated. Over several months, he slowly started light gardening and enjoyed his sunbathing. Hard work and patience paid off. After about nine months, he started walking into the clinic again!

Though Tat acknowledges that he would not be able to return to his full function, being 94 years old, he is immensely thankful for the lease of life given to him and appreciates the level of energy that he has regained. The doctors from the euthanasia team assessed him once, twice, three times. They finally concluded that he is yet to reach the terminal state for euthanasia and informed him to withdraw his application.

As the gloomy winter passes, the grateful, sparkling vase of roses at the counter reminds us constantly of the spring of life—highlighting the vital role of family physicians in the holistic management of patients!

■ CM

## Nurturing Mental Wellness Through Gratitude

by Dr Ng Liling, Family Physician, Editorial Team Member (Team B)

**A**s Family Physicians, we pour much of our energy into caring for others—listening, diagnosing, advocating—for the well-being of our patients. In doing so, however, we often neglect our own mental health. The demands of our work, from busy clinic schedules to emotionally challenging cases, can leave us feeling drained, disconnected, and overwhelmed. The toll is real: studies show that approximately one in three physicians experience burnout at any given time.

And it's no surprise that those on the front lines of care, such as Family Medicine, are most at risk.

In these seasons of exhaustion, it's crucial to recognise that nurturing our mental wellness is not a luxury, but a professional necessity. As caregivers, our ability to offer compassionate, high-quality care is directly linked to our own emotional and psychological health. This is where gratitude can play a pivotal role in our resilience and overall well-being.



Thankful for the colleagues who have been part of my journey as a Family Physician

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## Mental Wellness in Family Medicine: Beyond Burnout

Mental wellness encompasses more than just the absence of burnout or distress. It's about resilience—the ability to cope with adversity—and flourishing in all aspects of life: mental, emotional, social, and psychological. For healthcare providers, fostering mental wellness allows us to show up not just as practitioners, but as whole, thriving individuals.

### The Power of Gratitude

Gratitude is a simple yet powerful practice that can help strengthen our inner resilience. Research shows that gratitude can reduce stress hormones, improve emotional regulation, and even enhance the relationships we share with our colleagues. It's a tool that allows us to recognise and appreciate the small yet meaningful moments of our work—moments that can often go unnoticed in the rush of daily tasks.

Gratitude doesn't dismiss the challenges we face in our practice; rather, it allows us to see both the difficulties and the grace in every situation. A difficult consultation, a patient's heartfelt thank you, or the quiet teamwork during a busy day can all become grounding moments if we take time to pause and appreciate them. Expressing gratitude not only strengthens our relationships but also fosters a culture of mutual support, encouraging prosocial behaviours and motivating us to continue helping each other.

### Practical Ways to Cultivate Gratitude in Daily Practice

Dr Robert Emmons, a leading researcher in the field of gratitude, outlines three stages to this practice:

1. Recognising what you're grateful for.
2. Acknowledging it—taking a moment to notice and reflect.
3. Appreciating it—expressing gratitude in ways that reinforce its significance.

Here are a few simple ways to incorporate gratitude into your daily routine:

#### Start the Day with Intention

Before you open your clinic or dive into messages, take a slow breath and recall one thing you're grateful for—whether it's the support of a colleague, the trust you've built with a patient, or simply the privilege of being able to serve others.

#### End with Reflection

Before leaving work, mentally list three moments from the day that you appreciated. These could be small victories, moments of teamwork, or personal milestones. Reflecting on these helps you close the day with balance and reduces emotional carryover into your home life.

... approximately one in three physicians experience burnout at any given time.

### Express Appreciation Openly

Make it a point to thank someone—a nurse, a receptionist, or a fellow doctor—for something specific they did. Verbalising gratitude not only uplifts others but also reinforces a culture of mutual care and support. A handwritten thank you note or an appreciation letter can have a lasting positive impact.

### Reframe Difficult Encounters

After a particularly challenging case, ask yourself: What did I learn from this? or What values guided me in this moment? This shift in perspective can turn frustration into growth, helping you maintain resilience.

### Keep a Gratitude Journal

Spend a few minutes each week noting things that went well—whether in the clinic or outside of work. Over time, this practice can serve as a mirror of meaning, reminding you of the positive aspects of your work and life.

### A Culture of Support and Well-Being

As family practitioners, we often remind our patients to care for their minds and hearts. Practising gratitude allows us to do the same—to reconnect with purpose, soften the hard edges of fatigue, and see the beauty still present in our work every day.

While gratitude won't erase the pressures of healthcare, it can help steady us, nurturing the quiet resilience that is essential for healing—both for our patients and ourselves. By taking time to appreciate the small moments, express thanks, and reflect on the positives, we can build a more sustainable, fulfilling practice.

As we continue to navigate the demands of Family Medicine, let's remember that mental wellness isn't just about avoiding burnout—it's about actively cultivating the resilience to thrive, even in the toughest of times. Gratitude can be a key part of that journey.

Gratitude is a simple yet powerful practice that can help strengthen our inner resilience.

# A Philosophical Discussion of Gratitude in Healthcare

by Dr Lye Tong Fong, Family Physician, Editorial Team Member (Team B)

For the physician, gratitude should be a disposition that acknowledges the privilege of participating in a patient's most vulnerable moments. This is not gratitude for payment or prestige, but a profound respect for the trust bestowed upon the physician. It fosters humility, countering the god-complex that can fester in the face of medical expertise and authority.

For the patient, the capacity to feel and express gratitude can be a powerful component of the healing process itself. It represents an affirmation of life and care, a psychological shift from passive victimhood to active engagement. It strengthens the relational bond, making the clinical encounter less a transaction and more a covenant. In this light, gratitude is the moral and emotional substrate without which medicine risks becoming a cold, mechanistic exercise in applied biology.

## Arguments Against Inappropriate Ideas of Gratitude

The rosy view of an all-good gratitude is sharply contested by a more cynical, yet equally compelling, philosophical argument. The philosopher Immanuel Kant was deeply suspicious of gratitude, warning that it creates a moral debt that can never be fully discharged, placing the beneficiary in a position of permanent inferiority to the benefactor. In the context of healthcare, this is not a relationship between equals. The patient is inherently vulnerable—fearful, undressed, and often uninformed. The physician holds the power of knowledge, authority, and access to treatment.

Second, we consider the tensions between justice (social good), charity, and cost when discussing healthcare and gratitude. Should a cancer patient feel grateful for a life-saving chemotherapy that bankrupts their family? Should an individual from a marginalised community be expected to express profound gratitude for receiving a standard of care that is their basic right? Framing healthcare as a “benefit” for which gratitude is the appropriate response can obscure the reality that it is a fundamental social good. It risks shifting discourse from one of rights and justice to one of charity and benevolence.

Third, we examine the appropriate appreciation of healthcare workers. The recent phenomenon of public “gratitude” for healthcare workers during the COVID-19 pandemic, while often well-intentioned, serves as a potent case study. The clapping, the banners, the free pizzas—these symbolic gestures of thanks were lauded by some as a morale boost. Yet, for many within the profession, this public performance rang hollow. It was a substitute for the substantive gratitude

that could be better demonstrated through adequate pay, safe staffing ratios, mental health support, and functional protective equipment. This “cheap gratitude” allowed society and policymakers to feel they had discharged their moral duty without addressing the underlying, systemic failures that were burning out the workforce. It transformed a crisis of labour and justice into a narrative of heroic sacrifice, placing the onus on the individual worker to be resilient and grateful for the praise, rather than on the system to be accountable for their well-being.

## Appropriate Gratitude

Finding a balance in this philosophical stalemate requires careful recalibration of what gratitude in medicine should mean. The conclusion is not to banish gratitude, but to refine it. Authentic gratitude in medicine must be decoupled from power and obligation. For the patient, it should be a voluntary, internal emotion, never an expected performance. It is the quiet thankfulness for a life restored, felt on their own terms, without any fear of consequence for its absence.

For the physician and the healthcare system, the primary object of a doctor's gratitude should not be the patient's thanks, but the patient's trust and the opportunity to serve. This is a gratitude that manifests as professional integrity, relentless curiosity, and a commitment to justice.

Systemic gratitude for healthcare workers must be actionable, moving beyond symbolic applause to tangible investments in their welfare and professional dignity.

Ultimately, a philosophically sound practice of gratitude in medicine is one that strengthens autonomy rather than undermines it, and that demands justice rather than obscuring its absence. It is a gratitude that exists not as a debt to be repaid, but as a mutual recognition of shared humanity in the face of suffering. In this refined form, gratitude ceases to be a double-edged scalpel and becomes instead a steadying hand, guiding both healer and patient through the ethical labyrinth of care, reminding them that while curing is a science, healing remains, profoundly, an art rooted in a balanced and conscious reciprocity.

# Journey to Fellowship

by Dr Aziz Noordin, Family Physician, Editorial Team Member (Team B)

**Dr Aziz:** Hi Kenneth, thank for taking the time to speak with the College Mirror. Tell us a bit about yourself. What keeps you busy these days?

**Dr Kenneth:** Hi everyone, I'm Kenneth. I'm a family physician working at a solo GP practice in Punggol, and I have just recently opened a second branch. It is busy, but I'm very thankful to have colleagues and friends to help me juggle it all.

**Dr Aziz:** That's great to hear. And congratulations on your Fellowship! Take us back to the beginning. What first drew you to Family Medicine?

**Dr Kenneth:** Family Medicine has always been something I was very interested in since my Phase 3 clinical posting at NUS. I was attached to a Family Physician who told me something very precious: "You know, only in a GP clinic can you really see your patient's smile." That message really stuck with me.

When you work in a hospital setting, patients are more sick, whereas in primary care, you take care of them when they are well and possibly throughout their life. I was actually considering orthopaedic residency at the time. I was posted to SGH and was part of the team that performed an amputation for a patient due to poor diabetic control. After the amputation, the patient was very thankful to the team, but in my mind, I had the thought that if the primary care system had helped him control his diabetes, he would not have needed such a drastic, invasive surgery.

That planted the seed of me wanting to become a Family Physician.

**Dr Aziz:** Every journey has its rough patches. What were some of the moments when you questioned whether it was all worth it?

**Dr Kenneth:** There were many moments where I doubted the purpose of this exercise. First, many people questioned why a solo GP and private practitioner would pursue further education and training. Second, when time was taken away from the clinic to attend courses, not only my patients but my staff also questioned me. They wondered why I was closing my clinic to attend these courses when we had such a busy practice.

As a result, we actually lost some patients and staff along the way, either because they found my opening hours erratic, or because they felt they could earn more in other clinics. But what helped me stay the course was the support of mentors



*Dr Kenneth Tan  
at his new clinic*

like Dr Leong Choon Kit, my coach in the Fellowship course, and my close friends in GP+ cooperative, PCN, and other groups who really supported me with my research and deliverables needed for Fellowship.

**Dr Aziz:** Looking back at yourself before and after this training, how has it transformed the way you practise medicine?

**Dr Kenneth:** Through the course, I now feel that I have received similar training to my specialist colleagues. In a sense, it gave me the confidence to manage patients of greater complexity.

**Dr Aziz:** We all have those pivotal moments that change everything. What's one conversation or gesture from your support network that still resonates with you today?

**Dr Kenneth:** I was not planning to take the Fellowship exam this year. At a Family Medicine dinner, some of my Fellowship colleagues asked me why I wasn't taking the exam and encouraged me to give it a go. I did, I took the exams, and I made it. Their words really made a difference.

**Dr Aziz:** If you could sit down with a younger Family Physician just starting out, what wisdom would you want to pass on?

**Dr Kenneth:** Carry on the training. Believe in yourself, and believe in the system that will form up around you as long as you try.

**Dr Aziz:** Finally, if a single word or phrase could define your Fellowship journey, what would it be?

**Dr Kenneth:** I think it would be idealism. To better yourself is a noble thought, but not many of us are able to achieve it or devote time and attention to it because we're busy with work and family. To take on a further education journey as a private practitioner really has to do with staying true to that ideal of wanting to better yourself as a physician.

■ CM

# Certificate Course in Community Child Health

by Dr Tan Kee Tung, Family Physician, Editorial Team Member (Team B)

The Certificate Course in Community Child Health is a 1-year part-time course organised by the Department of Paediatrics at KK Women's and Children's hospital. This course aims to enhance the knowledge of practising clinicians in order to provide integrated, holistic care to children to improve long-term health; be empowered with the soft skills needed to work in partnership with the community and community agencies; and value-add and enhance current practices of healthcare providers in the community. I am glad to have attended this course in 2024.

The curriculum is taught over fortnightly weekdays afternoons that consist of:

1. Interprofessional Collaborative Practice
2. Advocacy
3. Mental Health
4. Anticipatory Care

Course participants include family physicians, community paediatricians, and paediatrician nurses. We learnt through case studies, didactic lectures, and sharing sessions with community paediatricians, child psychiatrists, social workers, dietitians, and healthcare policy planners.

As the African proverb states: "it takes a village to raise a child". It is apt to apply a holistic approach in the care of a child, bearing in mind the social determinants of child health: built environment, healthcare, economic stability, social and community context, and education, which may shape clinical presentation and management.

The course ended with a home visit to a family comprising at-risk vulnerable children where we had the opportunity to apply the knowledge gleaned from the course. Our classmates were divided into two groups and conducted two home visits accompanied by our lead social worker. My team visited a single mother family of four children (ages six months, three, seven, and nine years respectively) living in a 1-room rented flat. Our team identified psychosocial issues and applied anticipatory care and advocacy to issues identified. What impressed me is the resilience of this family's mother. Despite financial and social difficulties, she remained resourceful and committed to the care of her children. Our team also learnt tremendously from the experiences of the other team's home visit.

Has this course changed my practice in the polyclinic? Yes, very much so! In bread-and-butter paediatric case like neonatal jaundice and development assessments, I spend a little time to know the psychosocial dynamics of the family. In teenagers consult, I apply the HEADSS framework to build rapport and enquire psychosocial contributors to the medical presentation. I also learnt about community children initiative like Kidstart and Family Nexus, and important social agencies like Family service centres and Montfort care.

I am grateful to our teachers and instructors, as well as my course mates, for providing me this community child health lens in my paediatrics consults! Do sign up for this certificate course if you want to brush up your paediatric consult and be equipped with this new community child health approach!

■ CM



Dr Tan Kee Tung with Community Child Health faculty and course mates

# Interview with A/Prof Gan Wee Hoe: Gratitude, Humility and Leadership

by Dr Lim Khong Jin Michael, Family Physician, Editor (Team B)

**CM:** Hi Wee Hoe, thank you for agreeing to this interview. Please share with us some things about your life and work and what you like to do on your days off.

**GWH:** Like many Singaporeans growing up in the 1970s and 1980s, I had a front-row seat witnessing our nation's growth and transformation from third world to first within one generation. This very much shaped my world view and life philosophy.

I believe that the courage to start and act triumphs over the incessant pursuit of the perfect plan. I embrace the virtues of integrity and kindness because they anchor us to others who journey with us. I know that discipline and hard work are foundational to what we want to achieve in life.

I had a very meaningful 24-year career with the Singapore Armed Forces (SAF), where I learnt a lot about leadership, systems thinking and organisational competencies. But above all, my SAF career enabled me to forge strong bonds with many lifelong friends from diverse backgrounds.

I transited to Singapore Health Services (SingHealth) eight years ago, where I now practice Occupational Medicine and have management roles in both SingHealth Community Hospitals and the future Eastern General Hospital.

On my days off, I love to “jio” friends for a game of table tennis or pickleball, or simply watch random movies on Netflix.

**CM:** What are three most important things about leadership you learnt while serving in the military?

**GWH:** First, leadership is deeply personal and there is no one-size-fits-all formula. While you can seek to emulate a leader whom you respect, you will ultimately need to find your own landing point and be comfortable carrying that leadership ethos and style across different situations.

Second, leadership starts from self. Before a leader is able to influence others, he must first be able to lead himself. In



*A/Prof Gan Wee Hoe and his friends enjoying a game of pickleball together*

the SAF, we have a saying: “Rank is what you wear. Respect is what you earn”. At the very core, leadership is less about the position or authority that one holds. Rather, it is defined more by the strength of character, the clarity of purpose, and one's integrity.

Last but not least, leadership is all about people. I learnt this from a senior leader whom I deeply respect. Be it large organisations or small teams, they run on trust, motivation, and relationships. A leader therefore needs to be able to uplift, empower, and mobilise. People make culture, and culture drives performance.

**CM:** Do you have any advice for others transiting from military to civilian leadership?

**GWH:** Many of us who transited from the military have learnt valuable lessons on the differences in leadership style in the civilian setting. Generally, civilian leadership emphasises less on position and more on influence; places preference on collaboration over command; and incorporates an element of flexibility in decision-making, such as negotiation and stakeholder engagement. Hence, those who are moving from the military sphere into the civilian arena will do well to cultivate adaptability and embrace partnership-building without necessarily relying on formal authority.

## ANNOUNCEMENTS

# Upcoming Changes to College MMED (FM) Programme Admission Criteria in 2027



CFPS would like to formally announce the upcoming changes to the admission criteria for the College MMED (FM) Programme as well as the concurrent launch of a new Pre-MMED (FM) 1-year Condensed GDFM Programme in 2027.

From 2027 onwards, admission to CFPS MMED (FM) Programme will be via a valid GDFM Certificate. To encourage other prospective applicants to enter the CFPS MMED (FM) Programme in lieu of the current route of repeating the 2-year GDFM, CFPS will be launching a new Pre-MMED (FM) 1-year Condensed GDFM Programme in 2027. The following applicants will be eligible for this new expedited programme:

- (a) GDFM Applicants whose GDFM Certificate have exceeded the 5-years validity period
- (b) Applicants with SMC FPAB Category C [i.e. MRCGP (UK), DABFM (USE), FRACGP (Aus), FRNZCGP, FHKCGP]
- (c) Former FM Residents who have completed residency and obtained a "pass" grade in AKT or ABFM but did not successfully obtain the MMED (FM) despite maximum attempts at the clinical examinations [i.e. lapse of candidature]

Note:

- Applicant in (a) will be eligible for admission to College MMED (FM) Programme if they successfully pass the AKT during the candidature period of the new programme.
- Applicants in (b) and (c) will also be eligible for conferment of GDFM if they successfully passed the AKT and GDFM clinical examinations during the candidature period of the new programme.

Please watch the recording of the CFPS Academic Roadshow for MMED (FM) College Programme 2026-2027 for more details.



**CM:** Please share with us some things you are most grateful for in your life and how these influence your leadership style.

**GWH:** I am immensely grateful to have grown up in Singapore, where we have a Government that builds world class healthcare, education, public transport, and other systems, contributing to a high standard of living for its citizenry.

As we celebrate Christmas, which is right around the corner, I am forever grateful for the message of love, the promise of hope, and the gift of life. The Bible taught me that leadership is not about status or recognition, but about serving others (Mark 10:42-45). It also exhorts the courage to always do what is right and not what is popular (1 Corinthians 16:13-14). Lastly, we lead teams and manage resources as stewards, not owners (1 Corinthians 4:1-2). To me, this highlights the leadership posture of humility and emphasises the accountability and faithfulness to the responsibilities entrusted to me.

**CM:** What are you looking forward to doing together with your family, colleagues, and friends in the next five years?

**GWH:** In the next five years, I look forward to the successful opening of Eastern General Hospital. The privilege of being involved in the design, planning, and opening of EGH is a once-in-a-lifetime opportunity. This milestone will certainly be the collective achievement of the pioneering team, and we are all working concertedly towards this common goal.

On the personal front, I hope to grow steadfastly in my spiritual journey. I also sometimes jokingly tell my friends that I will work towards competing in a veterans' table tennis league competition one day...with a podium finish. 😊

**CM:** Thanks much Wee Hoe for sharing with us your journey and insights in leadership. Wishing you and your team much success in creating a positive work culture that builds and mends lives and relationships.

*Leadership [...] is defined more by the strength of character, the clarity of purpose, and one's integrity.*

■ CM

# More than Medicine

The care that connects; more than you expected

During my tenure as a Staff Registrar at Sengkang Community Hospital (SKCH), one of the operating sites of SingHealth Community Hospitals (SCH), I played an active role in enhancing clinical workflows to optimise patient outcomes and care quality. I developed several key processes, including the osteoporosis care pathway, advanced care planning referral process, and hypoglycaemia prevention workflow. Additionally, I had the valuable opportunity to participate in departmental quality improvement initiatives, collaborating with multi-disciplinary teams to devise innovative solutions that streamlined daily operations and enhanced patient care delivery.



## NURTURING PROFESSIONAL GROWTH

At SCH, I've found an environment that truly nurtures professional growth and supports my clinical passion. My deep interest in palliative care found fertile ground here, leading to my pursuit for the Graduate Diploma in Palliative Medicine in 2024. This academic endeavour, combined with hands-on experience in our inpatient hospice ward, has significantly enriched my expertise in end-of-life care. The organisation's commitment to physician development extends further, with my supervisors actively championing my participation in the Fellowship program. This advanced training pathway has been instrumental in honing my clinical acumen and critical thinking capabilities, enabling me to make more meaningful contributions both as a family physician and as a member of the broader healthcare team.



Featuring: Dr Audrie Foo  
Associate Consultant



# COLLABORATIVE SPIRIT

Our department has a strong team spirit where everyone's voice is valued. What sets us apart is our shared commitment to patient safety and clinical excellence, creating a culture where senior physicians regularly engage in open, candid discussions about frontline challenges. This organisational structure has proven invaluable during demanding periods, as we collectively brainstorm and implement innovative solutions to overcome obstacles. The strength of our team lies in this mutual support system, where experienced doctors readily share their expertise and work shoulder-to-shoulder to navigate complex situations, ultimately ensuring the highest standards of patient care are maintained even during challenging times.



## TEAM-BASED APPROACH

Nothing brings me greater professional satisfaction than witnessing the seamless coordination between doctors, nurses, therapists, and social workers as we unite to help patients return home safely. This intricate dance of collaborative care goes beyond mere discharge planning - it's about crafting sustainable solutions that enable our patients to maintain their health and independence in familiar surroundings. When we successfully prevent readmissions through thoughtful intervention and family education, it reinforces the power of our team-based approach and reminds me why I chose this path in healthcare. The joy of seeing patients flourish in their community settings, supported by our comprehensive care strategies, exemplifies the true impact of integrated healthcare delivery.



SingHealth Community Hospitals (SCH) - a place where compassion, innovation, and community care come together. Scan the QR code to watch this video!

Email to [schrecruitment@singhealthch.com.sg](mailto:schrecruitment@singhealthch.com.sg) for more information on career opportunities!

# FPSC 131 – The Art and Science of Prescribing Lifestyle Changes in Primary Care

## Implementing Lifestyle Medicine in Your Daily Practice

24 - 25 JANUARY 2026 (SAT-SUN)

2pm - 5pm [Via ZOOM]

### Introducing Lifestyle Medicine

Lifestyle Medicine is an evidence-based clinical discipline that empowers physicians to treat and potentially reverse chronic conditions by addressing their underlying causes. It is not functional medicine nor aesthetic medicine. It does not involve expensive testing. It is evidence-based, patient-centered, and deeply practical. Using the six pillars of Lifestyle Medicine, you'll learn to prescribe lifestyle habits as first-line therapy, not as an afterthought:

- Whole-food plant-predominant nutrition
- Regular physical activity
- Restorative sleep
- Stress management
- Avoidance of risky substances
- Positive social connections

### REGISTER HERE

This FPSC [Seminars, Workshops and MCQs] will be accredited for a total of 12 Core CME points (Family Medicine) - pending SMC approval.

Note: The accredited Core CME points will meet the requirements for both Family Physicians and Family Medicine Specialists.

Scan the QR code or access the link below to register online.

<https://www.cognitofirms.com/cfps/fpsc131>



### DAY 1 TOPICS

#### Lifestyle Medicine - An introduction: What is it? Why do we need it?

[Speaker: Dr Ng Lee Beng]

Senior Consultant, Department of Family Medicine and Continuing Care, Singapore General Hospital]

#### Dousing the fire - Managing chronic inflammation through Lifestyle Changes

[Speaker: Dr Koh Li Wearn]

Senior Consultant, Department of Rheumatology, Allergy and Immunology, Tan Tock Seng Hospital]

#### Lifestyle medicine in General Practice - Case studies

[Speakers: Dr Leonard Leng, Family Physician]

Dr Shariffa Syahidah Chishty, Family Physician]

#### Behavioural Health in Primary Care - Effective communications and health coaching to facilitate change (Workshop)

[Speaker: Ms Susan Tan]

Founder of social enterprise ECI Consulting Holdings Pte Ltd]

#### Q & A and Panel Discussion

Moderator: Dr Suraj Kumar

Vice President, College of Family Physicians Singapore



### DAY 2 TOPICS

#### Thrive, Not Survive: Maintaining Physician Wellness through the Lens of Lifestyle Medicine

[Speaker: Dr David Teo]

Senior Consultant, Psychiatrist, Deputy Medical Director, Connections MindHealth]

#### The Insomnia Trap - Breaking the Rhythm of Insomnia

[Speaker: Dr Leonard Eng]

Consultant, Department of Psychiatry, Singapore General Hospital and the SingHealth Duke-NUS Sleep Centre]

#### Social Prescribing - How to Make it Work for the Busy Family Physician?

[Speaker: A/Prof Lee Kheng Hock]

Senior Consultant, Department of Family Medicine and Continuing Care, Singapore General Hospital]

#### Social Prescribing Tools: How to apply Positive Psychology in co-designing prescriptions? (Workshop)

[Speaker: A/Prof Lee Kheng Hock]

#### Q & A and Panel Discussion



Organised by:

COLLEGE OF FAMILY PHYSICIANS SINGAPORE

# Bringing Purpose to Every Day

How the Cognitive Intervention Programme Supports Community Living with Dementia

by the Agency for Integrated Care (AIC)



For families navigating the challenges of dementia, each day can feel like a repetition of the last, marked by uncertainty, isolation and emotional strain. Such can be said for Mdm Grace Puah after her husband, Mr Vijaya Raghavan, was diagnosed with the condition.

"I think our lives were quite boring," Mdm Puah shares. "We would do the usual – morning walks when the weather permits, lunch, and then watch television. Nothing spectacular. There was nothing to look forward to."

However, that changed when Mr Vijaya joined the Cognitive Intervention Programme (CIP) upon the referral of his family doctor. On programme days, three guided hours of movement, conversation and tailored cognitive activities now give structure and purpose.

## Bridging dementia care within the community

Beyond medication management and safety planning, there have been limited structured, evidence-based interventions available within the community for persons living with dementia and their families. Currently, they may choose Dementia Day Care, a full-day custodial service typically used to complement care at home.

For those who retain many independent abilities and prefer not to spend their time in a day care setting, CIP offers an answer to meaningful cognitive and social engagement. The programme provides structured activity that aims to maintain cognitive function or delay decline, whilst easing caregiver strain.



Participants exercising with staff during a CIP session.  
Photo credit: Dementia Singapore.

## Why cognitive stimulation works

Cognitive stimulation is a form of "mental exercise" developed specifically for persons living with dementia, including a variety of activities to stimulate thinking and memory. A Cochrane review of 34 randomised controlled trials demonstrates that cognitive stimulation interventions show consistent improvements in cognition, with twice-weekly frequency associated with clinically meaningful gains (Woods et al., 2023).

Multi-domain interventions that combine physical activity with cognitive tasks demonstrate synergistic effects and prove feasible in community settings (Ahn et al., 2022). Beyond clinical scores and objective outcomes, this approach supports intangible benefits that families value: maintaining autonomy, preserving sense of self, and creating meaningful time spent with loved ones.

## What CIP offers

Currently running island-wide until July 2028, CIP delivers 14 sessions over seven weeks. Adapted from the United Kingdom's Cognitive Stimulation Therapy (implemented there as the most evidence-based non-pharmacological intervention for dementia (NICE, 2018)), CIP follows this model and contextualises it within Singapore's community setting. The programme operates across seven sites, with small groups enabling optimal engagement.

Beyond participation, caregiver support is embedded throughout. Through regular engagements, service providers update caregivers on the progress of their loved ones and offer a channel for caregivers to share their challenges and obtain necessary resources for support. Transport is available for clients who require it, and means-tested subsidies help manage out-of-pocket costs.

## The caregiver's perspective

Mdm Puah describes the programme as bringing enjoyment and renewed engagement to Mr Vijaya's daily life. "This programme sparked something in my husband. He looks forward to it. He wants to go."

The benefits reach beyond programme days. Some afternoons after sessions, Mr Vijaya would share with Mdm Puah what happened: discussions or activities that caught his interest. These moments create natural opportunities for engagement at home.

Beyond this meaningful impact, Mdm Puah also highlights practical considerations that other families may recognise.

The programme's phased approach helps families adapt. During the initial seven weeks, Mdm Puah managed the twice-weekly schedule by handling drop-offs and pick-ups herself, working around weather and traffic. Once Mr Vijaya transitioned to the maintenance phase, the once-weekly schedule offered more flexibility whilst sustaining benefits.

Her advice to other caregivers considering the programme is straightforward: "Go and try it out with an open mind even if you are doubtful or suspicious. You have got nothing to lose and may be pleasantly surprised."

The couple has already recommended CIP to another family, whose loved one has similarly enjoyed the experience.

### CIP at a glance

- Running island-wide until July 2028
- Programme structure:
  - 14 sessions over 7 weeks (twice weekly, 3 hours per session)
  - Optional 26-week maintenance phase (once weekly)
  - Small group setting
  - Difficulty-appropriate multimodal activities: physical exercise, cognitive tasks, social engagement
  - Overseen by dementia practitioners
  - Monthly caregiver engagement platforms with resources
- Financial support:
  - Means-tested subsidies available
  - Transport subsidies are available for Singapore citizens and permanent residents within 5km of CIP venues

**REFERENCES:** [1] Woods, B., Rai, H.K., Elliott, E., Aguirre, E., Orrell, M., & Spector, A. (2023). Cognitive stimulation to improve cognitive functioning in people with dementia. *Cochrane Database of Systematic Reviews* 2023(1). <https://doi.org/10.1002/14651858.CD005562.pub2> [2] Ahn, S., Chung, J.W., Crane, M.K., Bassett, D.R., & Anderson, J.G. (2022). The Effects of Multi-Domain Interventions on Cognition: A Systematic Review. *Western Journal of Nursing Research*, 44(12), 1154-1154. <https://doi.org/10.1177/01939459211032272> [3] National Institute for Health and Care Excellence. (2018, June 20). Dementia: assessment, management and support for people living with dementia and their carers (NG97). NICE. <https://www.nice.org.uk/guidance/ng97/chapter/Recommendations#interventions-to-promote-cognition-independence-and-wellbeing>

## A practical step forward

Looking back at life before CIP, the contrast is clear. Days that once felt repetitive now have rhythm and purpose. The three-hour sessions provide structure, and the once-weekly maintenance phase proves sustainable for families managing other commitments.

While the programme does not promise to reverse decline, it offers something valuable: sustained function, preserved dignity, and meaningful time together.

For GPs, this represents a tangible intervention to recommend when families ask what comes next. CIP complements conventional management, fits alongside existing routines, and supports both cognitive function and caregiver wellbeing. Early referral, as part of the initial management plan, maximises benefit for both persons living with dementia and caregivers.

### How to refer participants

#### Who is eligible?

Individuals with mild to moderate dementia diagnosis can be referred. Upon referral, service providers assess participants' suitability to join the programme. If a participant's condition changes or the programme proves unsuitable, service providers facilitate connection to other relevant programmes and services.

#### • For referrals by GPs



Submit referrals via FormSG:  
<https://for.sg/cip-referrals>

#### • For referrals by public healthcare institutions

For referrals through BRIGHT, please reach out to [contact.cip@aic.sg](mailto:contact.cip@aic.sg) for more information

#### • For self-referrals

Individuals may contact their preferred service provider directly when ready.

**NTUC Health (Bukit Batok West, Jurong Central, Chai Chee, Kampung Admiralty, Marsiling)**  
[Care@ntuhealth.sg](mailto:Care@ntuhealth.sg) | 6715 6715

**Dementia Singapore (Bendemeer)**  
[eunice.tan@dementia.org.sg](mailto:eunice.tan@dementia.org.sg) | 8333 4080 / 6389 5385

**Yong En Care Centre (Chinatown)**  
[shirkhim-go@yong-en.org.sg](mailto:shirkhim-go@yong-en.org.sg) | 9851 8501 / 6225 1002



For more information on CIP, visit [for.sg/aicsays-CIP](https://for.sg/aicsays-CIP) or scan the QR code.

# FPSC 132: Persons with Intellectual Disabilities 4



31 JAN - 1 FEB 2026 (SAT-SUN)  
2:00pm - 5:15pm [In-Person]

Venue:  
National Trades Union Congress (NTUC) Centre  
Level 7, Room 701  
One Marina Boulevard, Singapore 018989

## DAY 1 TOPICS

Common Physical Health and Ageing Issues in Persons with Intellectual Disability

[Speaker: Dr Chen Shiling  
Founder & Executive Director, Happee Hearts Movement]

Approach to Mental Health Conditions in Persons with Intellectual Disability

[Speaker: Dr Wei Ker-Chiah  
Chief, East and West Region, Institute of Mental Health, NHG Health]

Bridging Communication Gaps: Practical Tools for Everyday Consults

[Speaker: Ms Deborah Quek  
Speech and Language Therapist, Happee Hearts Movement]

Case Studies (Workshop)

[Facilitator-led]

Q & A and Panel Discussion

## DAY 2 TOPICS

Overview on Autism and Health-related Issues

[Speaker: Dr Vivien Lee  
Family Physician, Happee Hearts Movement]

Reasonable Adjustments in Clinic: What can GPs do?

[Speaker: Dr Chew Bao Li  
Family Physician, Associate Consultant, NHG Polyclinics - Ang Mo Kio]

Healthcare and Disability Service Landscape for Persons with Intellectual Disability

[Speaker: Ms Joy Teo  
Head, Community Building and Enablement, Happee Hearts Movement]

Case Studies (Workshop)

[Facilitator-led]

Q & A and Panel Discussion

This FPSC [Seminars, Workshops and MCQs] will be accredited for a total of 12 Core CME points (Family Medicine) - pending SMC approval.

*Note: The accredited Core CME points will meet the requirements for both Family Physicians and Family Medicine Specialists.*

Scan the QR code or access the link below to register online.

<https://www.cognitofrms.com/cfps/fpsc132>

Please note that this FPSC will be conducted as an IN-PERSON SESSION. There will be limited seats. Please register early.

**REGISTER HERE**



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