



COLLEGE OF FAMILY PHYSICIANS  
SINGAPORE

# THE College Mirror

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Guest-of-Honour Dr Tan See Leng  
addressing the guests of WFDD  
Dinner 2026.

*WORLD FAMILY DOCTOR DAY  
DINNER 2026*

**Speech by  
Guest-of-Honour  
Dr Tan See Leng**

*“There is a special  
satisfaction when a patient  
comes back not because  
they are unwell, but  
because they trust you.”*

**D**r Wong Tien Hua, President, College of Family Physicians Singapore,

Distinguished guests,

Ladies and gentlemen,

Every time I attend a College of Family Physicians event, it feels a little like coming home. I see so many familiar faces—colleagues, mentors, classmates, and friends whom I have known throughout my medical journey. Looking around the room tonight, I am reminded of the many years we have spent together in medicine, and of the shared experiences that continue to connect us. The long clinic days, the difficult conversations, and the patients who arrive with one concern and, just as they are about to leave, remember three more things they want to ask about.

What stays with us most, however, is the privilege of caring for people over time.

There is a special satisfaction when a patient comes back not because they are unwell, but because they trust you. Over the years, that patient becomes a lifelong patient. Then their spouse comes, their children come, their siblings come. Before long, you are caring for entire families, sometimes across generations.

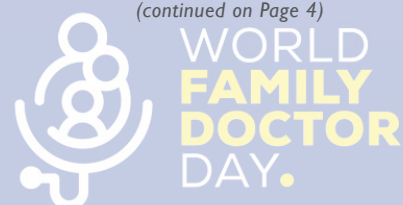
That is a privilege unique to Family Medicine.

Even today, I still receive messages from some of my former patients. Some ask for referrals. Others want advice.

These experiences stay with us. They shape our instincts, our judgements, and our understanding of what it means to care for people.

That is why World Family Doctor Day is not just an occasion to celebrate a profession. It is also an opportunity to reflect on how profoundly Family Medicine is evolving.

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*Editor's Words*

by Dr Yee Wenjun Gabriel Gerard, Editor, College Mirror Team C

It brings me immense joy to welcome you to the June 2026 edition of the *College Mirror*. As we celebrate World Family Doctor Day 2026, our focus is on the fundamental **Unity of Family Medicine** across our clinical landscapes regardless of how the world around us changes, especially with the AI revolution.

Whether we practise in acute hospitals, community wards, polyclinics, private practices, or directly in the patient's home, we are bound by a shared generalist identity that views the patient as a whole person, and we as Family Physicians are resources to the defined populations we serve.

Minister for Manpower Dr Tan See Leng, our Guest-of-Honour at our World Family Doctors' Day celebrations, reminded us that Family Medicine's core values remain the bedrock of preventive and chronic care, helping patients add life to their years. While AI will transform healthcare, it will never replace the Family Physician. Our nuanced clinical reasoning --exemplified by the ICEKAPs framework --remains superior to AI's pattern recognition. He challenged us to envision agentic AI augmenting rather than competing with us, managing operational burdens while we jealously guard our clinical reasoning. The future lies in AI-enhanced reasoning combined with shared decision-making, deeper rapport, and our irreplaceable humanity.

Our President, Dr Wong Tien Hua, sets the stage in his opening address, reminding us that good technology must always clear the path for compassionate care. Grounded by the principles of ethical AI discussed during our CFPS Masterclasses and the Family Medicine Review Course, as well as future MMEs, our fraternity continues to ensure that innovation strengthens clinical judgement without compromising compassion, empathy, and trust.

The essence of family medicine lies in breaking down barriers, and this issue beautifully captures how our peers act as bridges across disparate settings:

- **Caring Beyond Borders:** Dr Patricia Lee takes us on a moving journey with the Singapore Emergency Medical Team (SGEMT) deployment to Myanmar. It is a stark, inspiring reminder that Family Medicine's core strengths—versatility and holistic and comfort with diagnostic uncertainty—are vital during crises, where treating acute-on-chronic conditions and managing

psychological trauma are just as critical as handling acute disaster injuries.

- **Finding Purpose in the Time We Give:** Dr Gan Yuan Ying shares a heartwarming perspective from SingHealth Community Hospitals. She illustrates how stepping away from the rapid-fire pace of acute wards allows us the luxury of time to build deeper relationships, partnering with an interdependent, multidisciplinary team to restore dignity to patients during prolonged recovery journeys.

- **An Interview with Our New Nominated Member of Parliament:** It was my absolute privilege to catch up with Dr Haresh Singaraju, a consummate clinician-leader and a former fellowship trainee of mine! We explore how Family Physicians are uniquely positioned to spearhead social prescribing and champion health equity. He highlights the delicate balancing act of clinical administration, leadership, and guarding sacred family time. As we all note in Family Medicine, the Family comes before Medicine.

- **Bridging the Gap in Intellectual Disability:** In another engaging interview, Dr Chen Shiling sheds light on the critical role GPs play in treating adults with Intellectual Disabilities (ID). She offers invaluable pearls on overcoming diagnostic overshadowing and shares how her team is expanding various care pathways for the ID community.

- **An Interview with Our New Editor:** It was equally delightful to interview my peer and Changi General Hospital (CGH) colleague, Dr Yang Kaymond. Kaymond shares his enriching experiences in Mobile Inpatient Care at Home (MIC@Home), demonstrating how technology can bring hospital-level care seamlessly into the community, improving continuity of care across geographical settings for our patients—another key tenet of FM.

Beyond our clinics, we celebrate the diverse passions that keep our minds and bodies resilient. We hit the slopes in Hokkaido with Dr Julia Yuen, whose snowboarding bruises serve as a masterclass in embracing the discomfort of learning new skills. Dr Kenneth Tan shows us the patient art of second-hand grand piano regulation, reminding us that both

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music and medicine reward humility and ongoing stewardship. Finally, Clinical Assistant Professor Xu Bangyu challenges us to trade the treadmill for tyres, celebrating functional CrossFit movements that build real-life strength for our demanding clinical days.

As you flip through these pages, I hope you feel a deep sense of pride in our shared calling. We are the

■ CM

(continued from Cover Page: Speech by Guest-of-Honour Dr Tan See Leng)

### The Expanding Role of the Family Doctor

Many years ago, we learnt the phrase: "Cure seldom, relieve often, comfort always". It speaks to humanity and compassion. Most importantly, it speaks to the enduring human connection at the heart of medicine.

But today, this adage is evolving. The possibilities before us have expanded dramatically. Many of you have pursued further training and become Family Physician Specialists. Advances in science and technology are giving us new tools to diagnose earlier, intervene sooner, and achieve better outcomes for our patients. We are entering an era where we will cure more, we will prevent more, and through it all, we will continue to comfort.

Take genomics, for example. Today, genetic testing can identify an individual's pre-disposition to certain diseases, allowing preventive measures to be taken long before symptoms appear. This is why Singapore is investing in genomics as part of our broader effort to strengthen preventive care.

specialty that sees the person's life story—whether behind the desk, inside the ward, or within the (nursing) home (hospice). Happy reading, stay active, and keep finding joy in the magnificent, unified tapestry of care we weave together every day!

As healthcare becomes more predictive, the role of family doctors will become even more important. A genomic report cannot persuade someone to exercise more regularly. It cannot encourage someone to take their medication consistently. Only a trusted Family Physician can do that. Only a physician who has built a relationship with a patient over many years can guide them towards healthier choices and sustained behavioural change.

This is where Family Medicine becomes extraordinarily powerful. We are moving from a healthcare system that reacts to disease, to one that increasingly anticipates disease before it manifests. That is the promise of healthy longevity. And healthy longevity is not simply about adding years to life. What is the point of living longer if those additional years are spent in poor health? The real goal is to add life to years—to help people remain active, independent, and engaged for as long as possible.



Left to right: Dr Grace Chiang, Dr Low Lian Leng, Dr Wong Tien Hua, Dr Tan See Leng, Dr S Suraj Kumar, Dr Darren Seah, Dr Nelson Wee

### AI Will Transform Medicine, But Will Not Replace Doctors

No discussion about the future of healthcare is complete without talking about artificial intelligence. There has been much discussion about whether AI will replace doctors. My answer is simple: no.

In my capacity as the Minister for Manpower, we have been clear that Singapore's approach to AI adoption must remain human-centric. Technology should empower people, not displace them. I believe AI will transform healthcare significantly. In fact, it already has. But it will not replace Family Physicians.

Instead, it will amplify your capabilities. Today's AI models can process enormous amounts of information rapidly. In some areas, they demonstrate impressive diagnostic and analytical capabilities.

But medicine is not merely a pattern-recognition exercise. Diagnosis is not simply about matching symptoms to probabilities. The real art of medicine lies in taking a history, understanding a patient's circumstances, appreciating family dynamics, and recognising the subtle cues that may not appear in any dataset.

Every experienced Family Physician knows exactly what I mean. Sometimes it is a look. Sometimes it is something that simply does not feel right. Our patients are not isolated data points. You know their baseline personalities. You understand the stresses they face at home. You recognise the anxieties that might be affecting their health behaviours and treatment compliance. And over time, you develop something that no algorithm can replicate—clinical judgement.

That judgement allows you not only to recognise what is common, but also to identify what must not be missed. It is what prompts you to investigate further when something does not fit the usual pattern. It is what helps you manage uncertainty and assess risk responsibly.

AI can support that process. It can sharpen decision-making. It can help personalise advice, anticipate risks, and improve preventive care. But technology alone will never determine outcomes. It is the systems we build and, ultimately, the clinicians who use them that will determine whether patients benefit.

The question is no longer whether AI can support clinical reasoning. It can. The question is how we integrate these tools thoughtfully into real-world practice—with the right safeguards, governance, and accountability.

### The Human Core of Medicine

Amidst all this transformation, one thing remains central: the doctor-patient relationship. Patients do not come to us merely for information or treatment plans. They come because they trust us to guide them through uncertainty. That trust is built over time—through conversations, follow-ups, and countless small decisions made together. It is built in moments of reassurance, moments of doubt, and moments of vulnerability. And those relationships are irreplaceable.

As we celebrate World Family Doctor Day, I hope all of you will see yourselves not just as clinicians, but as architects of the future of healthcare. A future that is more predictive, more preventive, and more personalised. A future where technology continues to advance, but where the practice of medicine remains deeply human.

The future of medicine will not be shaped only in laboratories or research centres. It will be shaped every day in your clinics, through the trust you build with your patients and the care you provide to families and communities.

Thank you for your dedication, your commitment and your service to patients and families across Singapore.

Happy World Family Doctor Day!

“Over the years, that patient becomes a lifelong patient. Then their spouse comes, their children come, their siblings come. Before long, you are caring for entire families, sometimes across generations.”

■ CM

# WFDD 2026 Opening Address

by Dr Wong Tien Hua

President, CFPS

**D**r Tan See Leng,  
Minister for Manpower, Minister-in-charge of  
Energy and Science & Technology,  
Distinguished guests, Ladies and gentlemen,

Good evening and a warm welcome to all. Thank you very much for joining us tonight as we celebrate WONCA's World Family Doctor Day. We are very privileged to have with us tonight Dr Tan See Leng, Minister for Manpower, as our Guest-of-Honour.

Dr Tan is not only a respected national leader, but also a fellow Family Physician and a past Council member of the College of Family Physicians Singapore. We are grateful for his longstanding friendship with the College and for his warm and steadfast support of Family Medicine and primary care over the years. His continued encouragement and engagement with our fraternity mean a great deal to us, and we are truly honoured by his presence tonight.

WONCA is short for World Organization of National Colleges, Academies, and Academic Associations of General Practitioners/Family Physicians.

Our College has a long relationship with WONCA. We previously hosted two WONCA world conferences in Singapore, in 1983 and 2007, and we recently hosted the WONCA Asia Pacific Regional Conference in 2024 at Raffles City Convention Centre, in conjunction with the Singapore Primary Care conference.

World Family Doctor Day has become an annual celebration that recognises the central role of Family Doctors in delivering personal, comprehensive, and continuous healthcare to our patients.

World Family Doctor Day is also a day to acknowledge and appreciate the progress made in Family Medicine and the exceptional contributions of primary care teams globally. In Singapore, we also honour and celebrate the tireless efforts of our family doctors and healthcare professionals in improving healthcare through their contributions to teaching, research, and leadership in Primary Care.



The theme for this year is: "**Compassionate Care in a Digital World**".

The three core messages are

- Digital innovation must be driven by real needs —not by technology alone**
  - Our FamMed values must guide how digital tools and AI are designed and used in primary care.
- Digital tools and AI in primary care must be worthy of trust**
  - They must be safe, ethical, transparent, and evidence-based, with clear accountability, and strong data governance.
- Good technology clears the path for compassionate care**
  - Good tools should reduce administrative burden, fit real workflows, support clinical judgement, and leave more time for relational, compassionate care.
  - They should help coordinate care and not add to bureaucracy.

These principles have also been a theme of the College's work over the past year.

## SPCC 2026 and Family Medicine Core Values Workshop

The aforementioned principles were strongly reflected at the recent Singapore Primary Care Conference 2026, which was held just last week from 14–16 May 2026, where family physicians, nurses, and allied health professionals came together to discuss how we can build a more sustainable and resilient primary care system for the future.

Organised by SingHealth Polyclinics, NHG Polyclinics, National University Polyclinics, and the College, it was two years in the making and I would like to congratulate the organisers for a successful conference. The plenary sessions explored challenges facing healthcare today—from sustainable financing and future-ready care models, to AI, climate resilience, and population health.

This year's conference was significant as it was the first SPCC held following the formal recognition of Family Medicine as a medical specialty in Singapore.

One particularly meaningful component of SPCC 2026 was the workshop on Family Medicine Core Values, facilitated by Dr Sze Kai Ping with the support of Drs Fong Qi Wei, Tan Shu Yun, and Winnie Teo. It was a timely ground-up effort to examine what Family Medicine in Singapore stands for. Values such as compassion, continuity, comprehensiveness, coordination, community orientation, and person-centred care cannot be left implicit; they need to be deliberately articulated and translated into everyday practice. This work will continue through an upcoming Delphi consensus process, as we seek to define the core values of Family Medicine in Singapore.

The work on core values will be important as its principles will guide the College and stakeholders when we adopt digital technology and AI.

This theme on AI was further reinforced in the plenary by Prof Steven Lin on "Futureproofing Primary Care", which highlighted how emerging technologies such as AI can enable more efficiency and support effective primary care systems.

## CFPS AI Masterclass for Physician Leaders

Recognising the growing impact of artificial intelligence on healthcare, CFPS also conducted an AI Masterclass for our senior Family Medicine leaders and teachers on 17 January 2026 at our Neil Road Academic Training Centre.

Through this half-day workshop, we discussed how AI will reshape clinical practice and education, and we explored how Family Physicians, as well as the college as an organisation, can respond to these changes. There is no doubt that leadership in Family Medicine will be increasingly important in shaping how AI is implemented in primary care, and the College must therefore remain actively involved in these conversations.

Participants also highlighted the need for clear legislation, governance, and professional guidelines surrounding AI-assisted clinical decision-making.

There was strong agreement that, even as technology advances, we must preserve the human element in Family

Medicine practice—empathy, trust, professional identity, and relationship-centred care.

## FMRC MME on Ethical AI in Family Medicine

There were further discussions on AI at the Family Medicine Review Course 2026 held on 9 May, organised by our Fellowship trainees as part of their Medical Pedagogy training. This year's theme, "Primary Care for a Changing World", reflected the reality we face in practice today—where change is constant, and primary care continues to be shaped by evolving disease patterns and health needs. As Family Physicians, we do not get to decide what kinds of patients walk through our doors each day.

FMRC also featured a Medical Ethics session, "Beyond the Algorithm: Ethical AI in Family Medicine", which was delivered by Prof Valerie Teo. She highlighted several key ethical challenges surrounding AI in healthcare, including data governance and patient consent, clinical decisions influenced by non-transparent systems, potential bias and unequal performance across patient populations, as well as automation bias with the risk of over-reliance leading to deskilling. Her session was important in laying the groundwork for an ethical approach to the use of AI within the context of Family Medicine.

## ClinicalKey AI Rollout

Beyond discussions on leadership and ethics, CFPS recognises that our members need practical tools that can support day-to-day clinical work safely and effectively.

I am therefore pleased to announce the transition from UpToDate to ClinicalKey AI as our clinical decision support platform for members. CFPS will be offering 200 highly subsidised seats for ClinicalKey AI this year.

ClinicalKey AI is an advanced conversational search and clinical decision support tool developed by Elsevier, combining generative AI with a large library of medical references, journals, and clinical guidelines to provide fast, evidence-based answers at the point of care. The subscription will also include access to an extensive list of full-text reference books and journals that will be valuable not only for clinical practice, but also for teaching, training, and research.

The current annual subscription cost is listed at USD\$499 per user. Thanks to a generous subsidy, College members will pay only S\$90 inclusive of GST for a one-year subscription from 1 March 2026 to 15 February 2027.

This transition reflects our commitment to providing our

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members with innovative resources that support better care in an increasingly digital healthcare environment.

**Mount Sinai Leadership Observership**

Finally, beyond technology and clinical innovation, CFPS remains deeply committed to developing the next generation of Family Medicine leaders. Our third batch of five selected young Family Physicians attended the two-week CFPS-Mount Sinai Leadership Observership Programme at Mount Sinai Hospital in New York City from 9–20 March 2026.

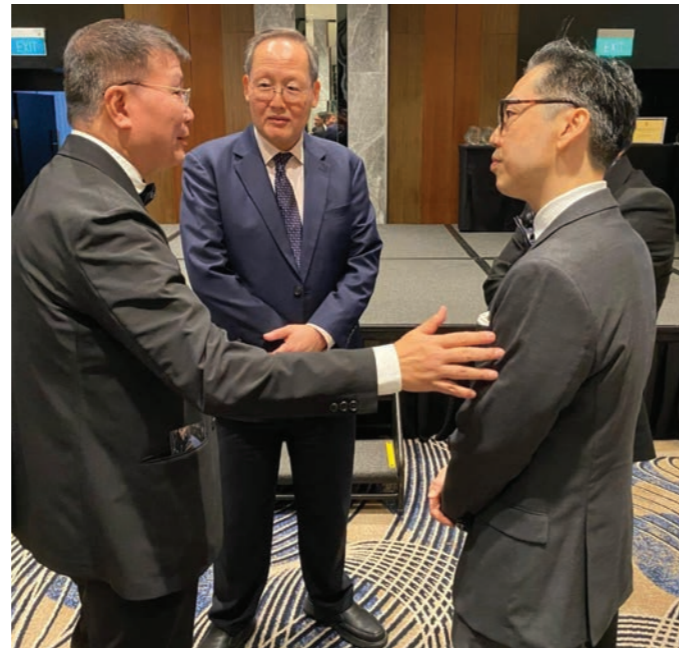
This year's participants were Dr Grace Chiang, who served as Council member and team lead, Drs Jonathan Yeo, Tricia Chang, Ngai Qian Yi, and Bryan Lim.

The programme offers a unique observership experience tailored specifically for Family Physicians in Singapore.

During the programme, participants were attached to clinicians across Hospital Internal Medicine, Outpatient Primary Care, and Home Care services, gaining valuable exposure to team-based practice and healthcare systems leadership.

They also had opportunities to engage directly with senior leaders and division chiefs within the Mount Sinai Health System to learn about leadership strategies, innovation, and organisational transformation.

Whether through strengthening our core values, engaging responsibly with AI, supporting lifelong learning, or developing future leaders, CFPS remains committed to ensuring that Family Medicine continues to grow with both excellence and compassion.



*... beyond technology and clinical innovation, CFPS remains deeply committed to developing the next generation of Family Medicine leaders.*

CM

**FAMILY MEDICINE INDUCTION CEREMONY 2026**  
**CFPS 55<sup>TH</sup> AGM**  
**25 July 2026 (Saturday)**  
 Ng Teng Fong Centre for Healthcare Innovation (CHI) Auditorium  
 18 Jalan Tan Tock Seng  
 Singapore 308443

**Family Medicine Induction Ceremony 2026**  
 2.00 - 3.30pm

**Tea Reception**  
 3.30 - 4.00pm

**CFPS 55<sup>th</sup> AGM**  
 4.00 - 6.00pm

# College Mirror Reflections for FMRC 2026

It was an honour to co-chair the FMRC 2026. I am thankful for the opportunity and trust placed in us to take on the responsibility of organising this annual event. Putting it together was no easy feat. We had to balance the planning work with our usual clinical duties, work commitments, and ongoing FCFP deliverables.

What made the journey especially meaningful was the strong teamwork within the committee and our fellowship cohort. Each member brought different strengths, skills, and networks to the table. I was heartened to see everyone stepping up, supporting one another, and going the extra mile when needed. I am grateful to all who contributed to making FMRC 2026 a success.

Dr Ong Poh Wei Paul  
 Family Physician  
 SKCH  
 FMRC 2026 Co-chairperson



The award recipients at the FMRC 2026



The speakers at the FMRC 2026

The process of organising the Family Medicine Review Course (FMRC) 2026 was both a long and deeply fulfilling journey. As many of us had limited experience managing an event of this scale, the learning curve was steep from the very beginning. Serving as one of the Co-Chairpersons, I felt a significant sense of responsibility to ensure that the event would not only run smoothly but also meet the expectations of both the participants and the College. This experience gave me a much deeper appreciation of the extensive work that takes place behind the scenes to lay a strong foundation for a successful conference. The whole team came together with each member bringing their strengths and ideas to the table. Looking back, I feel a strong sense of relief and accomplishment at the conclusion of the event. I would like to thank all the participants who attended the event, as well as all our team members. This event would not have been possible without everyone's collective effort and support. It was truly an honour to be part of such a wonderful team.

Dr Benjy Soh  
 Family Physician  
 CGH Family Medicine  
 FMRC 2026 Co-Chairperson

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Being part of the FMRC 2026 Sponsorship Committee was a meaningful and rewarding experience. Throughout the planning process, I learnt how to coordinate a team effectively, facilitate discussions on sponsorship tiers and agreement terms, and balance the expectations of sponsors, the organising committee, and the College. Working with sponsors also strengthened my communication, negotiation, and stakeholder management skills, particularly in ensuring smooth coordination of booth logistics and programme arrangements leading up to the event. Personally, it was encouraging to see the strong turnout and active engagement at both the conference sessions and sponsors' booths, which reflected the collective effort of the team. This experience gave me a deeper appreciation of the amount of behind-the-scenes planning, adaptability, and teamwork required to run a successful large-scale medical conference.



From left: Dr Teo Chen Rong, Dr Soh Yi Min Benjy and Dr Hwang Yung-Hsin Gwen

It has been an honour to co-lead the Scientific Committee for FMRC 2026. We carefully decided on the theme, "Primary Care for a Changing World: Addressing Global Trends in the Evolving Landscape of Family Medicine", to reflect the rapidly changing challenges and opportunities faced by family physicians today. In curating the programme, we sought to ensure that the topics remained relevant and practical. We were also proud that this was the first FMRC to feature an MME talk addressing the ethics of artificial intelligence in healthcare, recognising the increasing importance of AI in clinical practice and medical education. One of the key learning experiences was working closely with the Sponsorship and Logistics committees. This professional collaboration was essential in bringing together a meaningful and successful event.

Dr Adela Lua  
Family Physician  
SingHealth Polyclinics—Tampines  
FMRC 2026 Scientific Committee

Dr Chen Shiyun  
Associate Consultant  
Sengkang General Hospital, Family and Community Medicine  
FMRC 2026 Sponsorship Committee

Serving as Scientific Committee Co-lead for FMRC 2026 was an enriching experience. Designing a programme that was clinically relevant, practical, and intellectually stimulating required thoughtful reflection on the evolving needs of Family Physicians today. The process encompassed careful thematic curation, engagement of speakers, liaison with sponsors, and close coordination across multiple committees. This collaborative effort culminated in a successful course that was warmly received. It also fostered a strong sense of shared purpose, teamwork, and professional growth within the organising team.

Dr Ethel Chow  
Family Physician  
SGH FMCC  
FMRC 2026 Scientific Committee



Serving as Logistics Head for FMRC 2026 was a valuable experience in leadership, coordination, and problem-solving. Managing venue planning, food coordination, AV setup, and crowd flow required balancing operational needs with budget and attendance uncertainties. One of the most meaningful learning experiences was independently creating and managing the event website for registration, attendance, enquiries, and feedback collection. It was my first experience building and maintaining a fully functional website for a large-scale educational event, and it gave me greater appreciation of the planning, troubleshooting, and responsiveness required behind the scenes. The experience strengthened my confidence in taking the initiative, learning new technical skills independently, and coordinating multiple stakeholders to ensure smooth event execution.

Dr Lai Kah Ho  
Family Physician  
AE Medical Clinic (Beacon Medical Clinic Group)  
FMRC 2026 Logistics Committee

Organising the Family Medicine Review Course from a logistical standpoint was a valuable experience. We selected a smaller venue than past iterations of this event, guided by past attendance rates. However, when it was later decided that our event would be free to attend, registration became overwhelming and plans had to be made to cater for an overflow venue with livestreaming. This experience reinforced the importance of contingency planning and teamwork, as unexpected changes required flexibility and collaborative problem-solving. Designing the event poster was also an enriching experience for me, despite not having a background in graphic design. I learnt how to balance various operational requirements while maintaining visual appeal. Overall, planning this event strengthened my organisational and communication skills while giving me a greater appreciation of the effort required behind the scenes to run an effective educational programme.

Dr Tui Ze Yuan  
Family Physician  
Bukit Batok Polyclinic  
FMRC 2026 Logistics Committee



# An Interview with Our New Nominated Member of Parliament

by Dr Haresh Singaraju, Head Queenstown Polyclinic, Nominated Member of Parliament

Interviewed by: Dr Yee Wenjun Gabriel Gerard, Editor, College Mirror Team C

**CM: Hi Haresh! Nice catching up and here's formally congratulating you on both your Fellowship (in 2024) and being nominated as NMP! It feels like just a moment ago when you were sitting in my Philosophy/ Professionalism Ethics and Law (PEL) class in 2022 in our old College building! I remember your enthusiasm and maturity even then 😊 Proud that you have come so far and thanks for joining us and giving back as a PEL tutor for Fellowship!**

**HS:** Hi Gabriel, thanks man. Honestly, it still feels a little surreal yet daunting. That PEL class was formative for me. Sitting in that room, thinking through our

professionalism and the ethics of what we do, reminded me why I chose Family Medicine in the first place. It's the one discipline that insists on seeing the person as a whole before the diagnosis. The Fellowship and the NMP role both came from that same discipline: to keep asking whether the systems we build are actually serving the people and their families in front of us. And coming back as a PEL tutor? That's an easy yes, especially with the team we have (see Figure 1). I've always adored the three fields. I have also just completed an exec cert in Healthcare Law and Ethics from NUS; a joyous, practical course. I encourage all to consider it.



Figure 1: Dr Haresh with the Professionalism Ethics Law and Leadership faculty after conducting a successful mock exam for our ever-expanding FCFP batches

**CM: I'll start with the easy stuff. Is there anything you want to let our wider FM audience know about yourself? A fun fact maybe?**

**HS:** Haha, I've always loved sports. Football, swimming, tennis, basketball... more at a recreational level. Until I found something I was good at: Rock climbing. And I've recently leaned towards an Italian-inspired style of dressing up. I can't pull off their looks or build though. So besides their dress-up, I follow their espresso drinking styles haha. Anyway, I think there's something to it. How you present yourself (Figure 2) is a form of respect: to the people you serve, to the profession, and frankly, to yourself. It's the same principle behind a well-structured consultation: the details matter.

**CM: PEL tutor, Head of Queenstown Polyclinic, and now Nominated MP! How do you juggle all this?**

**HS:** The honest answer is: I don't do it alone. Not even close.

My wife is the pillar. She holds the family together in ways that don't make it onto any CV but probably should. Our parents are deeply involved too. It really is a village. Family friends who step in, grandparents who show up. I'd be a much less effective doctor and parliamentarian without them.

At work, I've been intentional about building strong teams and leaders of teams within Queenstown Polyclinic. I strongly believe in collective leadership. We're healthcare professionals! I'm fortunate to have strong support from NUP leadership too, who've given me room to serve in Parliament while ensuring the clinic never misses a beat.

And personally, I protect two things fiercely: early morning workouts and family time. The workouts are how I focus on the present. And family time is non-negotiable. I've learnt that work-life integration isn't about perfect balance every single day. Some days, work or Parliament take up more resources. Some days, a sick child takes up everything. And I honour the monthly dates with my beloved wife. Oh, and I call to check on two different loved ones daily on my long journeys back home. The key is that over a week, a month, the people who matter most never feel like they come second.

**CM: We were speaking recently about social prescribing and, more broadly, about social inclusion and health equity. I've always thought of social prescribing as a key enabler of these outcomes. In your view, are these areas we can explore as Family Physicians to improve population health in an equitable manner at that?**

**HS:** Absolutely, and I think Family Physicians are uniquely positioned here, perhaps more than any other specialty.



Figure 2: The consummate professional, Dr Haresh Singaraju

We already see the whole person. We know when a patient's loneliness is contributing as much to their decline as their diabetes. We notice when a caregiver is burning out before they do. The question isn't whether we can see it. It's whether the system lets us act on what we see.

In my Budget 2026 and MOH COS speeches, I raised specific examples: the culinary class at the Community Club five minutes from my clinic or the gardening group that mattered to a patient. It's exactly the kind of meaningful social activities that could benefit an isolated elderly patient. But it's not linked to Healthier SG. Neither is the e-sports interest group for seniors near my home. Not because these don't work but because no one has completed the bridge between health and community. That bridge is what social prescribing is about.

In May 2025, the World Health Assembly adopted its first resolution recognising social connection as a public health priority. Singapore is a member. If we already have the infrastructure, and we do as exemplified by SingHealth Community Hospitals via their Living Asset Map (LAMP), the question is why the connections remain incomplete.

For Family Physicians, I believe this is our space. We are the front door. We are trusted. If social prescribing is going to work in Singapore, it will be because an FM doctor looked up from the chronic disease management plan and asked: "Aunty, how are you coping at home?" That question is the beginning of a prescription no pharmacy can fill.

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(continued from previous page: An Interview with Our New Nominated Member of Parliament Dr Haresh Singaraju)

And on equity: social prescribing is inherently equalising. It doesn't require expensive interventions. It requires connection. The Community Club class costs a few dollars. What's expensive is the downstream cost when we don't act; the emergency department visit, the readmission, the fall that didn't need to happen.

**CM: That segues nicely into the meat of the interview. \*Drum roll\* What do you hope to achieve during your tour of duty as NMP as well as Head of Queenstown Polyclinic? And looking forward, knowing that leadership is truly a transient stewardship, how do you plan to hand over to your successor(s)?**

**HS:** As an NMP, I have one central thesis: we need to measure whether people's lives are actually improving, across health, housing, work, and family, not just whether the system is producing outputs efficiently.

In my Budget speech, I asked the Government to look into a wellbeing index, something some OECD countries are already doing. We could trial an integrated well-being report for two cohorts: Healthier SG enrollees aged 65 and above, and middle-income families with children under six. One proof of concept at each end of the life course. Because right now, each Ministry sees its slice. No one sees the whole person. That's a gap Family Physicians understand intuitively; it's literally what we're trained to do.

I also want to push for team-based care to be properly validated by outcomes, not throughput. Our nurses, pharmacists, allied health professionals are trained and ready. But the system hasn't given patients enough reason to familiarise with them, and we don't yet track their impact systematically. That needs to change.

At Queenstown Poly, I have a 5-pronged strategy, namely healthy communication, team-based care, integrative technology, F.A.I.L. Fridays (where I encourage in-house innovations), and integration with our social partners in Queenstown. All of these are works in progress.

On succession: I think the most important thing a leader can hand over is not a programme or a plan. It's a team that knows why they're doing what they're doing. If I've built strong leaders within Queenstown, people who believe in the mission and can carry it forward with their own style, then I've done my part. The best compliment would be if the clinic gets even better after I leave.

**CM: You've spoken a lot regarding the Health Information Bill, and the broader issues of ensuring care continuity, maintaining cybersecurity whilst ensuring adequate informational contribution to the NEHR. How do you view FM, the public, the**

**cybersecurity vendors, and how the government can continue navigating the continued advanced persistent threats (puns intended) that continue to plague us, whilst balancing all this? There has been feedback that even guidance on NEHR is still grey (at best).**

**HS:** Gabriel, you're right that this is where many of our colleagues feel the tension most acutely, and I want to validate that, because I feel it too.

On the ground, the day-to-day reality for Family Physicians is this: we want to contribute to a shared health record because we know it improves care continuity. When I see a patient at Queenstown who was just discharged from the hospital, I need to know what happened. The patient's safety depends on it. But the guidance around NEHR contribution has been, as you say, grey. Many GPs I speak with feel caught between wanting to do the right thing and not being sure what the rules actually require.

In Parliament, I've raised the need for clarity, not just on what data must be shared, but on the practical protections for clinicians who contribute in good faith. The Health Information Bill is an important step because it creates a legal framework. But legislation alone doesn't solve the problem if the people on the ground don't feel supported in operationalising it. It is reassuring to know they will continue to look into this arena.

On cybersecurity, I think we need to be honest about the asymmetry. Threats are evolving faster than many small practices can keep up with. We can't expect a solo GP to also be a cybersecurity expert. What we can do is push for practical, centrally-supported infrastructure: standardised security protocols that are easy to implement, clear guidance that doesn't require a law degree to interpret, and incident response support that doesn't leave practices alone when something goes wrong.

The broader principle is this: if we want FM doctors to contribute meaningfully to a national health information ecosystem, we owe them three things: clarity on what's expected, protection when they comply in good faith, and practical tools to do it safely. Right now, we're asking a lot and supporting a little. That gap is what I want to help close.

**CM: Are there any other areas that you are deeply passionate about and would like to share with our audience? Any initiatives you hope more FPs get on board with?**

**HS:** A few things I care deeply about, beyond what we've already covered.

*... reminded me why I chose Family Medicine in the first place. It's the one discipline that insists on seeing the person as a whole before the diagnosis. The Fellowship and the NMP role both came from that same discipline: to keep asking whether the systems we build are actually serving the people and their families ...*

First, the whole-person development of physicians themselves. We talk a lot about patient-centred care, but I wonder how often we turn that lens on ourselves. Mind, body, spirit, community: these aren't just dimensions of our patients' well-being. They're ours too. Each domain matters. A physician who takes care of themselves models something powerful for their patients.

Second, I'm passionate about workplaces that are made for families. In my COS PMO cut, I talked about a tiered certification to ensure workplaces function in the spirit of the Made for Families initiative. As a profession, we should be leading on this, not just for our patients but within our own clinics and institutions. Work-life integration should be a design principle, not an afterthought.

Third, support for vulnerable communities through a systems-based approach. Health and social integration isn't a slogan; it's a practical challenge. ComLink+, which pairs lower-income families with dedicated coaches across domains, is the closest model we have. But it's limited in scope. We have a few types of vulnerable populations. I want us to think about how primary care can be a platform for this kind of integration at scale.

And finally, staying grounded. I grew up in the heartlands. My parents worked hard. I barely saw my father because of his constant "over-times" to make ends meet. My very-scary informal tuition teacher was my own mother despite her not completing her O-Levels. Those roots matter to me. One of the risks of any leadership role is that you start to lose touch with the ground. I try very hard not to. The conversations I have with patients in my consultation room and various community groups are the most honest conversations. They keep me real. I hope other FPs feel that too. We have a front-row seat to how people actually live. That's not just a clinical privilege. It's a civic one.

**CM: With that, I truly thank you for your precious time Haresh! We unanimously nominate you (pun intended) for another round as Fellowship PEL tutor! 😊**

**HS:** Haha! Nomination accepted, gladly. Thank you, Gabriel. This was a genuinely warm conversation, and I'm grateful to the College Mirror for the space. To every FP, I hope we continue to feel that what we do matters more than most people realise. We are the doctors who see people as people; the whole person. That's not a small thing. Which is why we should not fear being replaced by AI. We might be the most important specialty in healthcare today. Keep going. I'm proud to be one of you.

■ CM

## FAMILY PRACTICE SKILLS COURSES

### Maybe it's Multiple Myeloma? The Role of Family Physicians in Improving Patient Outcomes

The College of Family Physicians Singapore would like to thank the Expert Panel for their contribution to the Family Practice Skills Course #134 on "Maybe it's Multiple Myeloma", held on 2 May 2026.

**Expert Panel:**  
Dr Cinnie Soekojo  
Dr Sanjay De Mel  
Prof Chng Wee Joo

# World Family 2026 Doctor Day Dinner

23 May 2026 • voco Orchard



# Caring Beyond Borders

## A Singapore EMT Mission in Myanmar

by Dr Patricia Lee



Setting up of Base of Operations

I have always enjoyed participating in medical missions. I love the outdoors and adventure, and I value the opportunity to use my medical skills to serve underserved communities. Prior to COVID-19, I had joined several medical missions to Nepal, China, Sri Lanka, Cambodia, and Thailand.

During a Family Medicine (FM) ACP meeting, there was a call for volunteers to join the newly formed Singapore Emergency Medical Team (SGEMT). I felt that I fit the criteria and was eager to be part of the team.

Soon, I found myself among a 34-member multidisciplinary team comprising doctors, nurses, a physiotherapist,

psychologist, technical and logistics personnel, and Ministry of Health (MOH) staff.

The SGEMT was established to strengthen SingHealth's emergency response capabilities and support regional disaster relief efforts. The team is equipped to provide rapid and comprehensive medical care during emergencies, including emergency services, primary care, and maternal and child health outpatient care.

Development of the SGEMT began in early 2023 and took 18 months to complete. During this period, team members underwent extensive training through online modules, in-person sessions, and a final ground deployment exercise. The training prepared us to meet the World Health

Organization's standards for a Type I Fixed Emergency Medical Team, with the capacity to manage up to 100 patients a day over a two-week period.

The preparation was far more demanding than I had expected. Beyond medical training, we learnt how to set up and dismantle tents, connect lighting systems, and function as a highly self-sufficient field hospital team. The tents were heavy and required coordinated teamwork to assemble. We trained under the hot sun, in the rain, and in muddy conditions. Despite the physical demands, everyone volunteered willingly, united by a shared goal of achieving WHO verification.

In September 2024, the SGEMT successfully attained WHO verification and was placed on standby for six months.

Shortly afterwards, on 28 March 2025, a 7.7-magnitude earthquake struck Mandalay, Myanmar's second-largest city. On 1 April, MOH received a request for assistance from the ASEAN Coordinating Centre for Humanitarian Assistance (AHA Centre). The SGEMT was activated and deployed on 3 April.

Due to damaged roads and multiple changes in deployment sites, it took more than a day to reach Mandalay. Our final mission site was Bahtoo Stadium, where we supported Mandalay General Hospital (MGH).

We spent an entire day setting up the field hospital, only to be hit by sudden strong winds that blew away eight of our twelve tents. We worked late into the night rebuilding the tents and restoring operations.

The conditions were challenging. Temperatures rose to 39° Celsius, and we worked long hours in sweltering heat. Over eight days, the team treated more than 1,800



Patients waiting areas

patients—exceeding the projected 1,400 patients expected over two weeks.

Another challenge came in the form of language barriers, but medical students and nurses from Mandalay General Hospital helped with translation. With support from the Singapore Red Cross, the Myanmar Red Cross deployed two ambulances to improve patient transfers between the field hospital and MGH. We also implemented a queue management system to better handle the large patient load.

Despite the difficult conditions, team morale remained high. The training we underwent helped us work seamlessly together, supporting one another and filling gaps where needed. There were no complaints from anyone.

Many of the patients we saw were overflow cases from the overstretched general hospital. They ranged from infants to elderly patients in their eighties. Interestingly, only 16.4 percent of cases were directly related to earthquake injuries, while the majority were due to chronic medical conditions exacerbated by the disaster and disruption of healthcare services.

We treated fractures, infected wounds, sprains, and contusions related to the earthquake. We also cared for patients who had lost access to their medications after their homes or clinics were destroyed. Many had poorly controlled hypertension or diabetes. Others were struggling with psychological trauma after witnessing the collapse of buildings and the loss of loved ones.



Restoring tents after strong winds

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*(continued from previous page: Caring Beyond Borders)**Treatment of earthquake and non-earthquake related injuries*

One particularly heartbreaking encounter was with a woman who lost her two children and niece when their house collapsed during lunch. She happened to be outside the house and survived. As she shared her story, all I could do was hold her hand and comfort her as she cried.

I also remember an elderly man who came to our field hospital with dangerously high blood pressure of over 200 mmHg and complaints of giddiness. After treatment and observation, his blood pressure gradually improved. Although he declined admission to the hospital, he returned regularly for follow-up reviews. He was staying in a tent beside our field hospital and became visibly happier as his symptoms improved. Eventually, his blood pressure stabilised at 120/80 mmHg. He later visited us daily just to say hello and even invited us to visit his tent. Moments like these reminded me that beyond medical treatment, providing comfort and reassurance is equally important.

What struck me most was the resilience of the Myanmar people. One medical student continued volunteering despite losing a family member in the earthquake. Her determination to serve her community despite personal tragedy was deeply inspiring.

I am grateful to have been part of this mission and to contribute, even in a small way, to helping those affected by the disaster. The experience gave me new friendships, valuable insights, and a deeper appreciation of how fortunate we are.

Above all, the mission reminded me that compassion and care can transcend borders. It was one of the most meaningful experiences of my life, and I would volunteer again if the opportunity arose.

*Our SGEMT team and Base of Operations at Bahtoo Stadium, Mandalay City, Myanmar*

■ CM

# Bridging the Gap

## The Role of the GP in Intellectual Disability

by Dr Chen Shiling (SL), Founder and Executive Director, Happee Hearts IDHealth Clinic

Interviewed by Dr Yee Wenjun Gabriel Gerard (CM), Editor, College Mirror Team C

**CM:** Hi Shiling! Thanks for agreeing to be interviewed by the *College Mirror*! We are truly happy (pun intended) to have you share with us about your journey to bridge the gaps in the care of those with Intellectual Disability (ID). Perhaps you could share with us a little about yourself, and how you got into the care of those with ID? Was there any particular encounter or moment that made you realise the status quo was no longer an option?

**SL:** I started volunteering with people with intellectual disability when I was 17 years old, and that opened my eyes to a very different world. Later, as a medical officer, I started organising health screening events for this population and witnessed the myriad challenges they faced accessing healthcare.

I remember a particularly sad moment during one of these events. When I was volunteering as a student, I spent many memorable Sunday afternoons with a little boy, Xiaofeng, who has autism and is non-verbal. During one of these health screening events years later, I saw Xiaofeng again, and so much had happened. He had been repeatedly admitted to the hospital, was on multiple psychotropics, was increasingly homebound, and his parents were feeling so helpless. That day, as I looked at Xiaofeng and saw his distress, I asked myself, how did the incredible little boy I know end up in this state today? That was an important moment that made me realise there were real gaps that had to be addressed.

**CM:** Prior to IDHealth, what did the typical patient journey for an adult with ID look like across primary and tertiary care? Where did you see the biggest gaps or breakdowns?

**SL:** Adults with ID and high support needs autism were expected to seek healthcare in the same way as our general population. This means that they go to primary care providers as their first touch points and then get referred to emergency departments and tertiary specialists when needed.

There were three very clear gaps. First, healthcare professionals have inadequate knowledge and skillsets

about this population and their distinct healthcare needs. Second, there was no healthcare provider who was able to understand and manage their healthcare needs in a holistic manner. Third, this population sits right in the gap between health and social sectors, as they spend many years of their lives supported by disability service providers. There was no one bridging this gap and supporting the families in navigating the complex systems.

**CM:** It is often difficult for GPs to distinguish between medical issues and the underlying ID-related behaviours. Some have termed this diagnostic overshadowing; would you have any tips for us on how to approach this? Especially given that many of your patients are less able to express themselves?

**SL:** Diagnostic overshadowing refers to the phenomenon where healthcare professionals attribute presenting symptoms and complaints, for example, agitation, to the underlying ID and autism. The most important thing is to be aware of this tendency, and always remember that the symptom, atypical as it may be, is often caused by a health condition. Therefore, we must always ask ourselves, "Why is this happening? What could be causing it?"

**CM:** We note how you have built up a network of primary care partners who receive your referrals! Are there any practical changes that a regular GP clinic could make to its environment to be more inclusive for patients with ID?

**SL:** Patients with ID need time and flexibility. Therefore, setting aside quieter periods in the day to allow more time to see a patient with ID will help tremendously. Patients may also be in discomfort or stressed, resulting in them being restless or agitated. Flexibility can take different forms, such as doctors seeing them first even if other patients came before them. Conversely, flexibility may involve allowing them time and space to calm down first.

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Dr Chen and the IDHealth team

Another simple addition to the clinic is to have available materials that can aid communication, such as visual supports. We have some of these on our website <https://happeeheart.com/resources/>. Feel free to download them for your use and reach out to us if you need any support!

**CM:** We note IDHealth has served over 500 people with ID and 1,000 caregivers. In Family Medicine, we treat the person in the context of their family. How do you manage ageing caregivers who are terrified of what happens to their child when they are gone?

**SL:** Parents are their children's greatest supporters and fiercest protectors. Therefore, their fear stems from the worry of who will take on this role when they are no longer around.

First, we need to acknowledge these fears as being very valid and very real. Thereafter, we need knowledge and skills to be able to guide and facilitate the process of what we call future care planning. This involves understanding who the person truly is, together with thinking through their health, social, residential, and financial needs, as well as who would be a suitable caregiver when their ageing parents are no longer

around. This is a process that takes time. We often need to facilitate family conversations, as well as take appropriate legal steps to safeguard the plans.

**CM:** Could you share your journey to getting here, how you built your team, and any advice for how GPs could access such services to wrap the care around the patients without having to maintain all the services in-house? If they do however decide to do so, would you have any tips on how to keep this sustainable?

**SL:** The service model that we've developed is one that is designed to address the health needs of this population while overcoming the barriers they face in accessing healthcare. However, we see ourselves as merely one part of the ecosystem. In the long run, we hope to focus on taking on the complex patients who require more intensive and customised care, while supporting other clinicians in seeing the less complex ones. To this end, our team has embarked on capability building for both health and social sector professionals.

**CM:** You've mentioned that health problems in patients with ID could be better addressed. Could you share some key areas of learning that our College's FM training programmes might consider utilising?

**SL:** Some key areas will include the distinct healthcare needs in this population, the approach to behaviours of concern, overcoming communication barriers and sensory processing difficulties, particularly in the ones with autism and future care planning.

**CM:** FM is truly a discipline from womb to tomb, and we are heartened you are launching new services in palliative care and dementia for the ID community this year. What will be the key thrusts of your team in these areas? How can our wider GP community support this?

**SL:** Persons with ID and autism have different health profiles from the general population. An example of this is how they develop dementia earlier in life, particularly in those with Down Syndrome, with different presentations and trajectories. The assessment tools used in the general population will also not be suitable for this group. Therefore, our dementia service will focus on validating assessment tools suitable for this population and implementing interventions that are tailored to their needs. Similarly, clinicians often face difficulties identifying palliative needs in persons with ID and autism. They also struggle with helping them cope with grief, loss, and the concept of dying. As we develop these services and support strategies, we would love to partner GPs in early identification and support of patients in the community.

**CM:** Founding a charity and a clinic is a marathon. What has been your greatest source of professional fulfilment when the administrative or financial hurdles seemed insurmountable?

**SL:** Without a doubt, it is seeing patients and their families thrive. Often, when they come to us, they are very distressed and on the verge of giving up. When we see our patients with ID improve and see the immense impact this has on their families who love them so dearly, it makes all the challenges worthwhile.



Dr Chen with her patient Xiaofeng and his mother

**CM:** Do you have any final words for our GP community with regards to the care of those with ID?

**SL:** I've worked with people with ID and their families for close to three decades now. They never cease to inspire and amaze me. I urge you to take the step, use your skills, and enter their lives. I am confident you will find your life enriched in ways you never imagined.

**CM:** Thank you Shiling for your kind time! We are truly happy (pun intended again) to have had you and have learnt so much.

CM

# An Interview with Our New Editor

by Dr Yang Kaymond [YK], Registrar, CGH Department of Family Medicine

Interviewed by: Dr Yee Wenjun Gabriel Gerard [CM], Consultant, CGH Department of Family Medicine

**CM: Hi YK! It's so nice to be interviewing you in this setting as our fellow editor and my peer! It seems like just a moment ago we were co-teaching during Family Medicine residency on lymphedema, lipoedema, cellulitis, and their overlaps in 2021. The case you presented together with the discussions it sparked remain relevant even till this year's Peer Review Learning!**

**YK:** Hi Gabriel! Thank you for the invitation. That lymphedema session has followed me longer than expected. I now see enough swollen legs at work that I occasionally wonder whether the topic chose me, rather than the other way around.

**CM: I'll start with the easy stuff. Anything you want to let our wider FM audience know about yourself? A fun fact maybe? Or what you've been up to since graduating from residency to chief residency? 😊**

**YK:** Talking about graduations, my daughter recently graduated from infancy to toddlerhood six months ago. She is quite a character—she has a massive attitude, rocks out to EDM (electronic dance music), and recently started addressing me by my first name. Basically, she is a smaller, louder version of me—and I treasure every moment with her.

**CM: A father (of soon to be two), GDFM and LKC medicine tutor, chief resident, Fellowship! How do you do it?**

**YK:** I'm still figuring it out. I've moved away from the traditional idea of "work-life balance" and instead adopted work-life integration, a concept I picked up from my SCRP programme director. I look for synergies in everything I do. I try to find overlap between the things I do—teaching sharpens how I communicate, clinical work grounds my leadership, and stewardship reminds me why service matters. At home, I'm also very fortunate to have a supportive wife who is just as busy but shares the same commitment to raising our children with intention and effort.

**CM: I'm sure the audience is interested in Family Medicine practice in the acute hospital setting, which I must say is a leap of faith you took after residency. What does a day in your life look like?**

**YK:** My day typically revolves around providing hospital-level care to patients in their own homes through Mobile



Dr Kaymond Yang with his family

Inpatient Care (MIC@Home). To do this effectively, we tap on technology like remote patient monitoring and video consultations, alongside a dedicated schedule of home visits conducted by nurses and doctors. What I find meaningful is how care at home supports patient empowerment. Patients and families take a more active role in recovery—from monitoring vital signs to understanding the illness and building confidence in self-care at home.

What I enjoy most when visiting patients is seeing them in their own environment, witnessing the social determinants of health. The patient's home is not merely a location, but a therapeutic tool. It helps soothe a delirious patient. It can bridge the gap to functional independence, like an elderly patient relearning to navigate their actual kitchen or gradually taking charge of their medications.

It does have its challenges. We manage acute conditions requiring intravenous treatments and close monitoring in a home setting. It has really taught me humility; we are part of a much wider multidisciplinary team. Delivering good care at home relies on learning from and working through our colleagues to co-manage these patients safely.

**CM: You've been very passionate about many areas of FM. List a passion at present.**

**YK:** I'm interested in how Family Medicine can remain truly generalist even as our practice settings become more distinct. Many of us now find our niche within specific spaces—GP clinics, polyclinics, community hospital, mobile inpatient care (MIC), transitional care, nursing homes, and hospices. These settings are the functional anchors of our healthcare system, allowing us to build the skills needed to deliver individualised and patient-centred care for the patients we see most often.

But the upcoming challenge is making sure these environments do not become structural silos. When care becomes fragmented, we risk losing sight of the patient's journey as one continuous story.

My hope is that we continue building better clinical and informational bridges across these settings. It is less about expecting Family Physicians to constantly move across different jobs, and more about designing the systems and communication pathways that close these structural gaps. By strengthening these links, we can enhance the continuity of care for all our patients.

**CM: Are there any other areas that you are deeply passionate about and would like to share with our audience? Any initiatives you hope more FPs get on board with?**

**YK:** I've been increasingly interested in Point-of-Care Ultrasound (POCUS) as a practical adjunct for Family Physicians, especially in community and home-based settings. There was a recent SFP article on this that I found very timely.

That said, I think we need to develop this carefully. POCUS has real potential, but it must be supported by proper training, accreditation, governance, and a clear understanding of its limits. I am currently working on obtaining local institutional accreditation. Used well, it can strengthen clinical assessment without replacing sound clinical judgement.

**CM: With so many burning passions, how do you not burn out? What do you do to decompress?**

**YK:** I enjoy simple things—nice meals with family, bringing my daughter to new places, and the occasional jog with her in a running stroller. These runs are usually interrupted by important toddler discoveries, such as birds, dogs, or random leaves. I've learnt to count those as part of the workout.

**CM: Well, we certainly look to hearing how these, and you, have evolved in future editions again! The Dreyfuss journey to mastery is truly long and winding, but it helps to have friends along the way 😊 Thanks so much YK for your precious time and see you again (tomorrow, at work).**

**YK:** Thank you for the opportunity to share! It has been a privilege to grow alongside colleagues and friends in Family Medicine, and I look forward to continuing that journey together.

CM

# A Rookie's Sharing of a Snowboarding Experience and Lessons from The Bunny Hill

by Dr Yuen Sok Wei Julia

I was never good at activities that involve navigating surfaces on wheels or blades. Ice skating, rollerblading, skateboarding... Managing momentum and speed on a slippery or smooth surface always caused apprehension as it made me feel like I was out of control. Thus I thought that was the end of my exploration of such activities.



That is until one day when I got asked this question: "Do you want to go snowboarding?"

Snowboarding: no wheels, no blades, just a board bound to both feet, with no obvious brakes and having to glide down a snow slope.

The physician in me immediately zoomed in to the health hazards associated with snowboarding, the most common being upper extremity injuries, specifically wrist fractures and sprains due to falling on outstretched hands. Other common injuries include shoulder dislocations or fractures, concussions, ankle injuries... the list goes on. And unsurprisingly, most of these injuries happen to beginners. That doesn't include other hazards such as risks associated with icy conditions, collisions with others on the slopes, hitting fixed objects like trees, etc.

Somehow or other, I agreed.



Dr Julia Yuen

The day finally came. I remember it was a cold snowy day in Hokkaido. I was in a quaint little shop getting my rental gear, trying on the snowboard boots and watching as the staff attached the bindings to my snowboard. We loaded up the drive to the slopes. Unexpectedly, due to the sudden change in weather conditions and strong winds, the ski lifts were closed. "Could this be a sign?" I thought to myself.

Undeterred, we woke up bright and early the next day, geared up and once again drove to the slopes. I threw on the rest of my protective gear and snowboard boots, grabbed my snowboard, and began trudging in the snow, following my instructor. He taught me the basics of stance and balance, how to manoeuvre with one foot strapped in, how to skate around, and how to fall safely. I recall thinking there was no way I could fall safely as taught, especially when there was no way to accurately anticipate a fall. It wasn't an exaggeration that I immediately experienced the fear of falling and loss of control when my both feet were strapped in to the snowboard. Not to mention it was way more slippery than I had expected. After a while, the instructor said, "Ok, let's take the ski lift up the beginner's slope." The helmet and goggles must have concealed the fear written all over my face. The ski lift? It's where every beginner snowboarder falls. When getting off... I thought, recalling all the videos I had seen.

The instructor ran through the techniques on how to get off the ski lift. All I recall was his voice shouting out instructions as I attempted to stand up from the ski lift, only to last a few seconds before hitting the ground. And then, the class started proper. He taught me about snowboarding on the heel-side and toe-side, asking me to attempt the heel-side and do a falling leaf, shifting my weight between my front and back foot to move horizontally across the slope. He emphasised to look where I wanted to go and shared tips how to avoid catching an edge. We went down and up the slope a few times. Somehow I couldn't get it and didn't manage to accomplish much before the class ended.

As I sat on the snow frustrated at the lack of my progress and watching others snowboarding with such ease and grace, I thought, what was it that was different between them and I? Especially the little ones; snowboarding, falling, and getting up again, laughing and continuing. Then it clicked. That was it. Fear was holding me back.

Recognising that, I tried challenging my irrational fear. What was the worst-case scenario given that I was travelling at a snail's pace and wearing head-to-toe protective gear in an area with soft snow? Slowly but surely, I started to get the hang of it and I started to see how snowboarding could be enjoyable. I took the ski lift many more times, with mixed success at staying on my feet. I became more comfortable with falling. I went up and down the slope many times practising the techniques and tips the instructor had shared. Bit by bit, my confidence grew.

As I reflected on the four days of snowboarding, I realised that it turned out to be a masterclass in developing myself both professionally and personally.

It taught me that fear can be a major factor holding someone back from their full potential, that falling isn't failing but the inability to try again is, that it's important to have your eyes set in the desired direction and outcome, that leaning into discomfort like leaning downhill feels counterintuitive but helps with the greatest growth, that commitment to the turn makes one less likely to fall while hesitation usually causes it, and that it's important to remain engaged and balance between a toe or a heel to avoid catching an edge.

In medicine, we don't usually leave much room for being "bad" at things. We're conditioned to value precision and expertise. But snowboarding reminds us that growth is rarely a graceful process. It forces us to accept that mastery is preceded by a thousand undignified falls. As we return to our various primary care practice settings, perhaps we can give ourselves a little more credit for the bruises we pick up along the way. Even the most seasoned family physician must occasionally lean into the discomfort of a new or challenging situation, trusting that the only way to find our flow is to risk the occasional bruise.



# Fixing Up Old Things

## What a second-hand grand piano taught me about the practice of medicine

by Dr Kenneth Tan



space for a large, loud, expensive instrument that is hard to move. Our humidity is unkind to acoustic pianos, and tuning adds recurring cost. I thus satisfied myself with a digital piano.

Each reason against an acoustic piano was, well, reasonable, and together they formed a consensus that now was not the right time. Adequacy, in its quiet way, is one of the strongest arguments against changing anything. But if not now, then when?

### Bringing Home a Second-Hand Grand

Upon completion of my Family Medicine training, I bought a second-hand grand piano. A new instrument definitely has its appeal, arriving according to factory specifications, but I had to be honest about who I am as a player. My skill is modest, and my repertoire does not demand a high level of precision. A new piano's finely tuned mechanisms are for someone at that level of proficiency, and I am not that someone.

A well-maintained second-hand piano, I decided, would suit me better, being capable of more than I would ever ask of it. I called in a professional; watching him work at the piano, I realised that what I had thought of as a single instrument was a system of several thousand moving parts, each contributing to a sound produced without any electricity at all, perfected over the decades.

### Regulation: Making 88 Keys Feel Like One Instrument

I wanted more control, so I bought my own tools and attempted a solo tuning. It was not as good as professional work, but it kept the piano sounding right for longer between visits.

### A Musical Childhood

Like many Singaporean children of my generation, I benefitted from music and art classes at my local Community Centre. My parents found those weekend courses a useful way for me to learn a new skill, and to be out of their hair. I was not particularly talented, but those years created an appreciation for music that I have carried with me ever since.

Yet I never owned a grand piano. Families in Singapore aspire to move up the property ladder, and it was already a challenge to give each child a bedroom, much less find

Tuning is only part of what a piano needs. A piano can be in tune and still feel wrong; keys can be uneven in weight or sluggish on the return, pedals can lifting the dampers a little too late or too early. This is where regulation comes in. Over the years, felts compress, wooden parts lose their tolerances, and friction creeps in where the action once moved cleanly. Regulation is the patient process of working through the action; adjusting, lubricating, restoring each part to where it ought to be.

The discipline of regulation is that you have to do it for all 88 keys. The instrument needs to feel cohesive, like a single machine, so that the pianist does not have to think about the keyboard. A piano is never as good as the day it was made, but with steady, careful work, we can slow the decline.

People sometimes ask, why bother with an old instrument when you could buy a new one? But a well-built piano can last a hundred years; if a little ongoing care keeps it working well, that feels like good stewardship.

Regulation is never finished. You get closer to perfection but never quite reach it; and even if you did, the changing climate and the playing itself would shift things again.

### What the Piano Teaches

I see the same in my daily work as a Family Physician. Like a piano technician, I am asked to look after something that already exists. Patients have histories, age with time, and are held together by habits both good and bad. We pay attention to the small problems, looking not only at numbers on a blood test but at the wear and tear of the years. We listen carefully, identify what is out of true, and try to bring the system back into working harmony.

Medicine, like piano maintenance, rewards humility, and neither craft is ever finished. Just as the piano drifts with the seasons, a patient's health drifts with time. In Singapore, humidity does its quiet work on wood, metal, and felt just as surely as stress, sleep, and work do theirs on a human body.

Maintenance and change are not signs of failure; they arise as a result of physical existence. I find this a comforting thought when working with a particularly complex patient.

### Practice, and the Wisdom of Returning

The other discipline the piano demands is practice. I have no illusions of performing one day. The enjoyment of playing simple tunes on a well-maintained instrument is its own prize. I can hear an acoustic instrument in my own home and appreciate the gifts of friends who come over and share their music.

This is not so different from Continuing Medical Education, where doctors come together to maintain and develop our skills. The real value is in the sharing and learning from each other.

There is something quietly beautiful about returning to a piece assigned to you many years ago. You realise your approach has changed—you have more wisdom now to appreciate what you were doing then, and to find beauty in notes you used to merely play.

### A Private, Unpressured Joy

So much of our professional life is measured. Now, measurement is not bad in and of itself. It can motivate change. But over time, we might end up valuing only what can be counted. The piano is one of the few domains in my life where nobody is keeping score. I play because I want to. I tune because the instrument requires it. I learn new pieces because I want to progress. This joy belongs only to me.

The best parts of our practice are also the ones that cannot be counted: the conversation with a long-term patient about what is going on in their life; the change we knew we made, slowly, over time.



# Breaking the Mould: Why This Family Physician Traded the Treadmill for Tyres

by Cl Asst Prof Xu Bangyu

## How CrossFit Is Revolutionising Fitness for Healthcare Professionals

After another gruelling 12-hour shift at work, the last thing most of us want to see is a gym. The thought of monotonous treadmill sessions or isolated bicep curls feels about as appealing as reviewing lab results. But what if exercise could be different? What if it could be engaging, practical, and—dare I say it—actually fun?



Enter CrossFit, the fitness methodology that's turning traditional gym routines on their heads. Instead of counting endless reps on machines, imagine flipping massive tyres across a car park, carrying weighted kettlebells like you're hauling medical equipment, or pulling sleds loaded with plates as if you're moving a patient bed through hospital corridors.

## Real Movement for Real Life

The beauty of CrossFit lies in its functional movements—exercises that mirror activities we do in daily life and work. Take the Romanian deadlift, for instance. This isn't just about building stronger hamstrings; it's about training the proper hip-hinge movement pattern we use every time we bend down to examine a patient or lift something from the floor. After years of hunching over examination tables and computer screens, this movement helps counteract the postural damage we accumulate during long clinical days.



Cl Asst Prof Xu Bangyu

The farmer's walk—simply carrying heavy weights while walking—might look deceptively simple, but it's incredibly relevant for healthcare workers. It strengthens our grip, improves our posture, and builds the kind of functional strength we need when carrying medical bags, moving equipment, or supporting patients during transfers.

## Beyond Physical Fitness

What sets CrossFit apart isn't just the varied movements; it's the community aspect that addresses something many healthcare professionals struggle with— isolation. After spending days caring for others, we often neglect our own wellbeing. The group dynamic of CrossFit

creates accountability and camaraderie that's often missing from solo gym sessions.

The sled push and pull exercises shown in these photos aren't just about building leg strength; they're metaphors for the daily grind we face in healthcare. Sometimes we're pushing through resistance, sometimes we're pulling our weight, but we're always moving forward. There's something deeply satisfying about physically manifesting the mental resilience we need in our profession.

## Scalable and Sustainable

One common misconception about CrossFit is that it's only for ultra-fit athletes. The reality is quite different. Every movement can be scaled to match your current fitness level. Can't flip a massive tyre? Start with a smaller one. The Romanian deadlift can be performed with just a broomstick until you build up strength and perfect your form.

This scalability makes CrossFit particularly appealing for busy healthcare professionals who might be starting their fitness journey later in life or returning after years of inactivity due to demanding work schedules.

## The Mental Health Connection

Perhaps most importantly, CrossFit provides an outlet for the stress and emotional weight we carry as healthcare providers. There's something cathartic about flipping a tyre after a particularly challenging day—it's a physical release that traditional cardio simply can't match. The varied nature of workouts keeps your mind engaged, providing a mental break from the clinical decision-making that dominates our professional lives.

## Getting Started

If you're intrigued but intimidated, start small. Many CrossFit gyms offer beginner classes or "on-ramp" programmes designed to teach proper form and gradually build fitness. Look for certified trainers who understand the importance of injury prevention—the last thing any of us needs is to be sidelined by a preventable injury.

Remember, the goal isn't to become a competitive athlete overnight. It's about building a sustainable fitness routine that enhances your ability to serve your patients while taking care of your own physical and mental health.

## The Prescription for Change

As Family Physicians, we regularly counsel patients about the importance of regular exercise. Perhaps it's time we took our own advice—not with boring, repetitive routines that feel like another chore, but with engaging, functional fitness that prepares us for the physical and mental demands of our profession.



The next time someone asks about your exercise routine, you might just find yourself saying, "Well, yesterday I flipped a tyre and pulled a sled." Trust me, it's a lot more interesting than "I did 30 minutes on the elliptical."

After all, if we're going to preach the benefits of an active lifestyle, shouldn't we be living proof that exercise can be both effective and enjoyable?

Ready to flip your fitness routine? Consider visiting a local CrossFit gym for a trial class. Your back, your stress levels, and your patients will thank you.



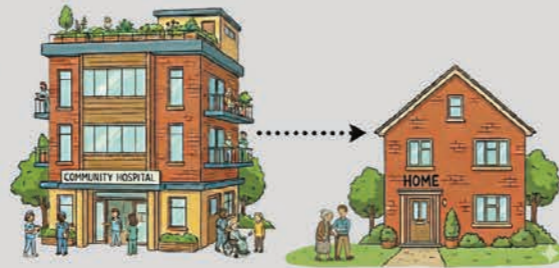
# FINDING PURPOSE IN THE TIME WE GIVE

Before joining SCH, Dr Yuan Ying's journey spanned across acute wards, emergency departments and polyclinics settings shaped by urgency, efficiency and rapid decision-making. Yet, it was during a posting here, in her family medicine training, that everything changed.

At SCH, patients stay for weeks, not hours or days. They come to heal, rebuild, and often, to rediscover parts of themselves lost to illnesses.

**"During their recovery, I walk alongside them, not just as a doctor but a partner in their journey,"** said Dr Gan Yuan Ying, Associate Consultant, Post-Acute & Continuing Care (PACC) at SKCH.

Together with nurses, therapists and medical social workers, Dr Yuan Ying forms a care team that is beautifully interdependent.



Care here, is not doctor-centric but person-centric.

## The Turning Point

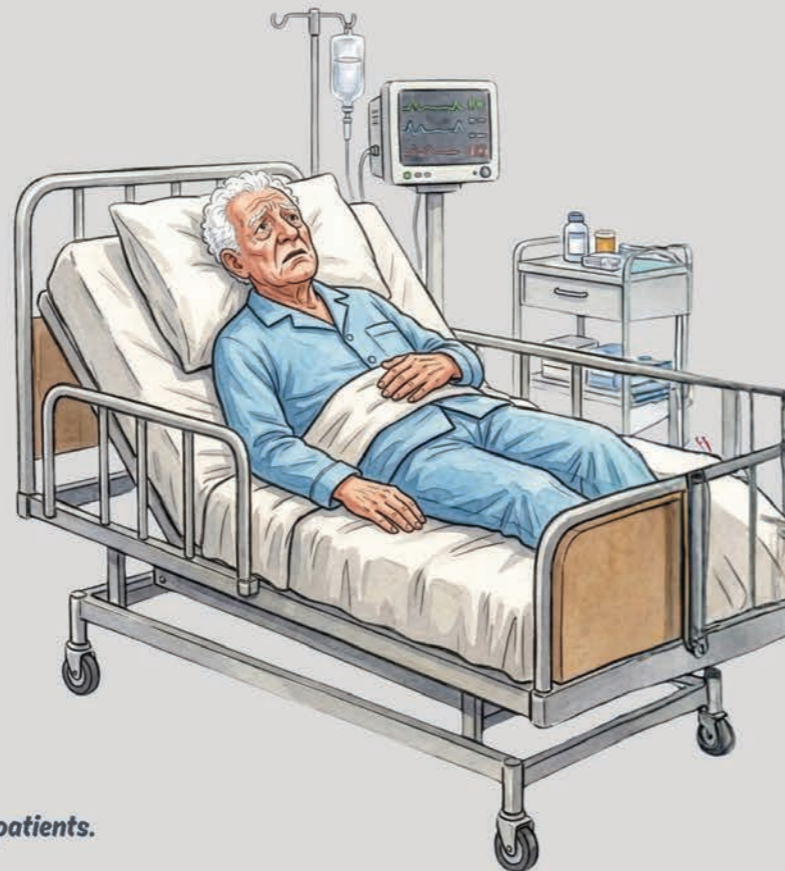
But this was not always how she imagined it.

Before her family medicine training, Dr Yuan Ying had assumed community hospital work would mirror acute care. But a one-month posting changed everything.

She saw how every discipline brings a vital piece to the puzzle where a nurse's attentive wound care, a therapist's encouragement during rehabilitation or a social worker's guidance for families can shape a patient's journey.

**"It was in the quieter and steadier rhythm of the community hospital that I found something deeper, which is time,"** she said.

She has time to listen, understand and truly connect with her patients.



## Building Deeper Relationships with Patients

What makes her work meaningful are the stories that unfold along the way. Often, a patient's struggle goes beyond what she initially sees.

A poorly controlled condition may not be a matter of neglect but of discomfort, fear, or unseen barriers. With time and trust, patients begin to share.

**"Sometimes, a small discovery like a side effect or difficulty in chewing can transform a patient care entirely,"** shared Dr Yuan Ying.

She remembers one patient who was admitted to SCH after his cancer surgery and whose recovery was complicated by pneumonia and severe weakness.

Once independent, he was now bedbound, reliant on a feeding tube and filled with regret. Rehabilitation was slow and hope often fragile. Eating mattered deeply to him, yet it was not safe.

Together, Dr Yuan Ying and the care team navigated that delicate balance between risk and quality of life.

With the dedication of the therapists, the patient regained enough strength to sit in a chair. The care team then cautiously reintroduced oral intake, guided by careful assessment and teamwork.

The day Dr Yuan Ying saw him sitting in the therapy gym, upright, present and eating again felt like a quiet triumph. Not a return to who he once was, but a step toward who he could still become.

Moments like these remind Dr Yuan Ying why her work matters.

Through the highs and the lows of the journey to recovery, it is a privilege to stand beside them, to offer guidance, compassion and dignity.

## Reflections and Impact

**"In the community hospital, healing is not just about medicine. It is about seeing the whole person through their resilience, fears and stories,"** shared Dr Yuan Ying.

It is about weaving together care that honours not only the body, but the life behind it.

And in doing so, she has found that while we help our patients heal, they in turn, teach her how to care.



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# Ethics CME

Mandatory Medical Ethics CME (MME CME) is required for Practising Certificate (PC) renewal. Doctors renewing their PCs on a two-year basis must obtain 5 ethics core points, while those renewing for one year are required to obtain 3 ethics core points.

To facilitate the accumulation of these points, CFPS will be organising the following medical ethics CME activities:

Date	Activity & Topic	MME points	Fees		Registration
			Member	Non-Member	
4 July 2026	Webinar (Zoom)  (Medical Certification: Duties, Risks and Legal Pitfalls for Family Physicians)	2 points	Free	\$196.20	Member and Non-Member registration link: <a href="https://www.cognitoforms.com/cfps/ethicscme">https://www.cognitoforms.com/cfps/ethicscme</a>
5 and 12 September 2026	<u>Professionalism, Ethics and Law (PEL)</u>  TBC	TBC	Free	TBC	Registration will open in August 2026
24 October 2026	Webinar (Zoom)  (Between Care and Code – Ethical Tensions in AI in Family Medicine)	2 points	Free	\$196.20	Registration will open in September 2026
November 2026	Online discussion & MCQs  (Ethical Responsibilities of Family Physicians in Public Health Practice)	1 point	Free	\$98.10	MCQs – Open for submission in November 2026 <a href="https://lms.wizlearn.com/cfps/">https://lms.wizlearn.com/cfps/</a>

All prices stated are inclusive of 9% GST.

# FACT

**INSURERS CAN  
USE POLICY TERMS  
TO SAY NO.**

**WE USE  
DISCRETION  
TO SEE HOW WE  
CAN SAY YES.**

We use people, not contracts, to decide how to help members through challenging times.

Rather than using policy terms to make our decisions, when a member is faced with a case or claim, our experienced healthcare experts review each case individually. This allows us to say yes to requests for support – even in unique circumstances.



**GET THE FACTS**



## GRADUATE DIPLOMA IN MENTAL HEALTH

Enhancing Mental Health Competencies of General Practitioners and Family Physicians

As Singapore's healthcare landscape evolves under Healthier SG and the National Mental Health and Well-being Strategy, General Practitioners (GPs) and Family Physicians (FPs) are increasingly becoming the crucial first point of contact for mental health support across the nation.

To better support GPs and FPs in this expanded role of recognising, diagnosing, and managing mental health conditions in their communities, there is a critical need for specialist knowledge in recognising early symptoms and delivering appropriate treatment.

The **Graduate Diploma in Mental Health (GDMH)** programme has been shaping the mental health competencies of GPs and FPs for 16 years.

Jointly offered by the Institute of Mental Health and the Division of Graduate Medical Studies, National University of Singapore, GDMH has shown remarkable success in building clinical confidence and competency amongst primary care providers, with 97% of Cohort 13's respondents reporting increased confidence in diagnosing and managing mental health conditions six months after programme completion.

**Early Bird Rate ending on 1 June**  
Registration period:  
**23 March - 30 June 2026**  
Course Duration:  
**September 2026 - October 2027**

Course information



Hear from a GDMH graduate



imh.GDMH@nhghealth.com.sg 6389 2263/2239

Organised by:



Division of Graduate Medical Studies  
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CME eligibility: **50 CME points** will be awarded upon successful course completion  
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Academic Roadshow	4 September 2026, 5.30pm via Zoom  
Application Window	5-27 September 2026
Clinic Inspection	1-15 October 2026
Selection Interview	20, 22, 23 October 2026, 6pm via Zoom

*The MMed(FM) 2027-2028 intake will be the last intake for which applicants with MRCGP(UK) will be accepted. Future applicants with MRCGP(UK) will need to undertake the new upcoming 1-year Accelerated GDFM prior to admission to the MMed(FM) College Programme.*

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