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NUS Commencement 2026

Dr Wong Tien Hua, President, College of Family Physicians Singapore,
Guest Speaker for NUS Commencement 2026, Ceremony 27

Good afternoon, Professor Aaron Thean, NUS Deputy President (Academic Affairs) and Provost; Distinguished Guests, Graduates, Parents, and Friends; Ladies and Gentlemen,

My heartiest congratulations to all of you who will shortly be conferred the NUS Master of Medicine degrees. Today marks an important milestone in your professional journey. For some of you, the MMed represents the completion of specialist training and entry into independent practice. For others, it is an important step within a longer training pathway. Regardless of where you are in that journey, this achievement reflects your commitment to professional excellence and lifelong learning.

Very soon, your juniors will be turning to you for guidance, and at the same time, your own teachers and consultants will expect you to think more independently, make sound judgements, and shoulder greater clinical responsibility.

It is at this stage of one's professional journey that many doctors begin to realise an important truth about Medicine—it is both a science and an uncertain art.

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College of Medicine Building
16 College Road #01-02, Singapore 169854
Tel: (65) 6223 0606 Fax: (65) 6222 0204
GST Registration Number: M90367025C
E-mail: information@cfps.org.sg
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Editor's Words

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

The neighbourhood GP knew your children by name, and your mum listens only to him regarding her diabetes and diet control. This was medicine as a caring relationship. That world is fast disappearing.

In “Interview with Dr Desmond Wai: The Changing Landscape of Private Specialist Practice”, we see a gastroenterologist whose foreign patient load has dropped 80 percent and whose local volume has fallen 30 percent. His income declines while overheads rise. He represents a growing cohort caught between shrinking patient pools and rising costs. The changes to insurance riders are redirecting patients to restructured hospitals.

This is closely linked to “Insurance Provider Panels in Singapore: Balancing Cost, Patient Choice, and Procedural Fairness”. Insurance panels are understandable tools for controlling costs, but insurance providers are increasingly determining unilaterally which doctors can join a panel, and which doctors patients can see and at what cost. A patient who has developed a therapeutic relationship with a specialist over many years may face substantially higher out-of-pocket costs if that doctor is removed from a panel. There is no formal mechanism for doctors to challenge such decisions or for patients to appeal them. The process lacks transparency, and the consequences can be profound.

For general practitioners, the pressures are different but equally acute. “The Changing Guard: A Clinical and Economic Reality Check on Primary Care in Singapore” describes how third-party administrators (TPA) now function as gatekeepers, dictating which investigations and medications are permitted and which fees are acceptable. GPs spend precious time justifying standard procedures to TPA, insurance administrators, or their Artificial Intelligence (AI).

“AI Is Not One Thing” reminds us that clinicians need to understand both AI’s capabilities and its limitations in the consultation process. Patient-identifiable information mistakenly entered into AI systems may be used to train models and potentially be leaked. “AI in Healthcare—A User’s Perspective” acknowledges the benefits—summarising guidelines, drafting documents, identifying patterns—but warns that hallucinations and omissions require clinicians to verify every output. The clinician remains accountable.

“Mandatory National Electronic Health Records: Clinical Benefits, Practical Challenges, Ethical Considerations, and International Perspectives” describes obvious benefits of a mandatory National Electronic Health Record: better continuity of care, fewer duplicated investigations, and safer medication management. Yet the larger the database and system, the greater the risk of a cyberattack and leak. Patients, even if they are concerned, cannot opt out; they can only restrict certain access. This autonomy and privacy implication is significant, and compliance burdens fall heaviest on small practices.

“Responding to Insurer and Third-Party Administrators’ Requests: A Guide for Doctors” reminds us that Insurers and TPAs have legitimate reasons to request clinical information, but doctors must consider relevance and necessity, disclosing only what is appropriate for the stated purpose.

Singapore healthcare needs cost control and appropriate use of technology. But these tools should serve medicine, not redefine it in a different trajectory. Efficiency should not come at the expense of patient autonomy. Insurance oversight should not become clinical control. AI should not replace the human touch. Healthcare policy must recognise that doctors are not simply providers operating within an administrative system. They are humans, albeit professionals, relating with a fellow human being—to care, to empathise, and to bring comfort to their patients.

Within the current landscape, consolidation might be the inevitable response, akin to a mass production factory—large groups have greater bargaining power and can afford the administrative support and compliance costs. But what are we sacrificing? The GP who takes time to chat, who notices subtle changes in your mother’s demeanour, and who smiles and gives sweets and stickers to your children might not thrive in large networks. If we value that relationship in a small practice, we must ensure the economic structures supporting it are sustainable. This means regulating TPA and Insurance practices in Singapore healthcare, and ensuring compliance costs do not cripple them. The doctor will see you now—but who is it this time?

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Science searches for certainty, but the Art of Medicine enables us to deal with the uncertainty.

Science provides us with clinical guidelines, evidence-based medicine, advanced tools for diagnostics and treatment, and of course, artificial intelligence integrated into healthcare systems. These advances are no doubt important. Clinical guidelines and protocols help to standardise care, improve outcomes, reduce variation, and enhance patient safety.

Despite all this, clinical medicine remains deeply human and often uncertain.

Patients rarely present exactly as they do in textbooks. Symptoms may be vague, incomplete, or evolving. Different diseases may present in similar ways. Some patients come with multiple problems, while others struggle to even describe what they are feeling. Each person brings different ideas, concerns, and expectations into the consultation room.

This is where clinical judgement and intuition become important.

Intuition is the ability to rapidly assess a situation, recognise patterns, identify what matters, and arrive at a provisional judgement. Doctors often describe this as a “gut feel”—that ability to tell that something either fits or does not fit an expected pattern.

As a family physician, I deal with this daily in Primary Care. We see patients at the earliest stages of illness, often before diseases develop. Over thousands of patient encounters, we learn to develop a sharp sense of observation. From the moment a patient enters the consultation room, we observe the way the patient looks, walks, breathes, and behaves.

Intuition is therefore born from experience, observation, and reflection, and then compressed into rapid decision-making.

The psychologist Daniel Kahneman (*Thinking, Fast and Slow* (2011)) described two modes of thinking—a fast, intuitive system and a slower, analytical one.

In medicine, we constantly move between both. Intuition allows us to function efficiently in busy clinical environments, but analytical thinking helps us question assumptions, reconsider diagnoses, and avoid error.

There is a fine line between making a good clinical call and jumping to the wrong conclusion.



As such, how can we sharpen our clinical intuition? The first is to have humility.

Being a better doctor is not simply about accumulating more information, but rather through a process of refining judgement. You refine judgement through broad clinical exposure. Through those days with overwhelming caseloads, overflowing wards, and sleepless calls, through mistakes that humble you, and through your patients who teach you lessons no textbook can provide.

Secondly, you refine judgement through reflection.

Take time to think about your cases. Ask yourself: Was my first impression correct? What did I miss? What could I have done differently? Reflection transforms experience into wisdom.

Finally, good clinical decision-making depends on a good doctor-patient relationship.

Patients are not simply diagnoses to be solved. They are people navigating fear, uncertainty, and vulnerability. Shared decision-making is not merely presenting treatment options but helping patients journey through uncertainty with honesty and empathy.

Technology will continue to transform medicine in the years ahead. Artificial intelligence will become more deeply embedded into healthcare. But we are not a profession that will go extinct, because patients will still look for the human connection and seek doctors for their wisdom, judgement, and compassion.

So, continue to learn the science behind your individual speciality, but develop your intuition that will apply to individual patients.

Learn widely, stay humble, reflect deeply. And never lose sight of the privilege of caring for another human being.

Congratulations once again to the Class of 2026, and I wish all of you a meaningful and fulfilling journey ahead.

Family Medicine Induction Ceremony 2026

Speech by Guest-of-Honour, A/Prof David Tan

Dr Wong Tien Hua, President of the College of Family Physicians Singapore; College Council; Programme Directors; Colleagues; and most importantly, our incoming Family Medicine trainees,

Good afternoon, and welcome.

It is a privilege to be here today as your Guest-of-Honour, and I want to begin by saying something simple but sincere: congratulations. For those who are embarking on the Graduate Diploma in Family Medicine, congratulations on starting your journey in Family Medicine. For those embarking on the Masters of Medicine and Fellowship programme, you have taken a big step towards being recognised as someone who is proficient or specialist in Family Medicine. You all have chosen one of the most meaningful paths in medicine. That choice deserves to be celebrated.

When I look at where Family Medicine in Singapore stands today, I feel a genuine sense of pride—and I hope you will too, because you are entering a profession that has been fundamentally transformed over the past decades.

Not too long ago, Family Medicine was sometimes seen as the quieter cousin of the hospital specialties. A general practitioner was the doctor you visited for cough and colds, or for a subsidised referral. That perception has changed, and it has changed because of deliberate, sustained efforts by the College, by the Ministry of Health, by the medical schools, and by thousands of family physicians who believed that primary care deserved better.

Let me briefly take you through some of that journey. Over the years, we have put in place a range of schemes to support primary care—from the Chronic Disease Management Programme, which brought structured, subsidised care for conditions like diabetes and hypertension into the community, to the Primary Care Networks, which gave private GPs a framework to collaborate, share resources, and care for patients more comprehensively. These were not small administrative changes. They represented a shift in how Singapore thinks about healthcare—that good care should begin in the community, close to where people live, and that the family physician is central to that vision.



Then came HealthierSG—perhaps the most significant transformation in primary care in a generation. For the first time, we are asking Singaporeans to enrol with a regular family physician, to build a longitudinal relationship with someone who knows them, their history, their family, and their circumstances. This is not just a policy shift; it is a philosophical one. It says that healthcare is not just about treating illness—it is about knowing people.

Our polyclinics have grown in tandem, expanding their capacity and capabilities, and increasingly working alongside private GP partners rather than in parallel. Our modern polyclinics are well-equipped and well-run, and often a destination for visitors both overseas and locally looking to improve their own systems and processes. For some of us perhaps in private practice who have not had the opportunity to visit a modern polyclinic, I'm sure your journey in your courses will open up opportunities to have a tutorial in a polyclinic.

The recognition of Family Medicine as a specialty in its own right has given the profession the standing it deserves—our Family Medicine Specialists who have completed their advanced training in Family Medicine, be it the Fellowship programme or in future the advanced FM programme, are not generalists by default, but specialists by choice, with a distinct and sophisticated body of knowledge and skill.

(continued on next page)

(continued from previous page: Speech by Guest-of-Honour)

This recognition of additional training does not just apply to our Family Medicine Specialists. By 2030, all Healthier SG clinics will be required to have at least one unique GP who is practising in the clinic registered with the SMC as a family physician in the Register of Family Physicians. This gives recognition to the additional training that our FPs on the register have gone through, whether through the GDFM or MMed(FM) programmes, and gives assurance to our patients that their GPs are adequately skilled to manage their health holistically under Healthier SG.

Indeed, the most exciting chapters may still be ahead of us.

We are working on the next evolution of Primary Care, which will deepen support for GPs, strengthen care teams, and make it easier for family physicians in private practice to deliver the kind of comprehensive, coordinated care that their patients need. We want to make sure that choosing to practise in the community is not just professionally fulfilling, but practically sustainable.

We are also expanding Medisave limits to give patients greater ability to use their savings for outpatient care, and broadening the list of conditions under the Chronic Disease Management Programme. These changes are designed to reduce the financial barriers that sometimes stand between patients and the care they need—and to ensure that your work as a family physician is appropriately recognised and supported.

Beyond the clinic walls, we are investing in stronger connections between family physicians and community partners—social service agencies, community health teams, and voluntary welfare organisations. This is because we know that health is shaped by far more than what happens in a consultation room. Housing, loneliness, financial stress, caregiver burden—these are the realities your patients live with, and the family physician of tomorrow will need to navigate these with skill and compassion.

In addition, technology will play an increasingly important role. From digital health records to AI-assisted decision support, the tools available to you will continue to evolve. I encourage you to embrace these not as replacements for the human relationship at the heart of Family Medicine, but as instruments that free you to do what only you can do—to listen, to understand, and to care.

I want to take a moment to speak honestly to those of you who are considering, or have already decided, to enter private practice.

Private practice can be deeply rewarding. The autonomy, the continuity of care, the relationships you build with families over years and decades—these are gifts that few other careers can offer. I have met GPs who have cared for three generations of the same family, who were present at births

and at deaths, who were the first call in a crisis, and the steady hand through chronic illnesses. That kind of medicine is profound.

But I would be doing you a disservice if I did not also say this: private practice is not without its difficulties. Running a clinic is running a business. There are operational pressures, administrative burdens, and financial uncertainties that your training will not fully prepare you for. The landscape is competitive, and the expectations of patients are rising. Decisions best made for patients, such as using subsidised drugs, may not always be the best for your business, and tough choices will need to be made.

I am not saying this to discourage you. I am saying it because I want you to go in with your eyes wide open. Seek mentors who have walked this path. Ask the hard questions before you sign a lease. Build your networks early. And know that the Ministry, the College, and the broader primary care community are working hard to make the environment more supportive—but that support works best when you are prepared to receive it.

Whichever path you take—polyclinic, private practice, academia, or some combination—I want to spend a moment on something that I think deserves more attention than it often gets.

You will hear a great deal, in the years ahead, about value-based care. It is the language of health systems and health economists—care that is measured by outcomes, that rewards quality over quantity, that aligns incentives with what actually makes patients healthier. It is an important idea, and we in the Ministry think about it a great deal.

But today, I want to talk to you about something slightly different. I want to talk about **values-based care**—and yes, the pun is very much intended.

Because, before you can deliver value to your patients, you need to be anchored in your values. And I worry that in the busyness of training, in the pressure to pass examinations and accumulate competencies, with the pressures of hitting KPIs or balancing your books, the deeper question of who you are as a physician can sometimes get lost.

Let me name some of those values explicitly.

Professionalism. This is more than turning up on time and dressing appropriately. Professionalism is the commitment to hold your patients' interests above your own convenience, above commercial pressures, above the fatigue of a long day. It is the willingness to say "I don't know" and to find out. It is the discipline to keep learning long after your examinations are done. In Family Medicine, where you will often be working without the immediate safety net of a specialist colleague down the corridor, professionalism is not a soft skill—it is a clinical one.

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Family Medicine ...* ”

Patient-centred care. Again, this phrase gets used so often that it risks becoming lip service. But think about what it actually means. It means that when a patient sits across you, the consultation is not organised around your workflow, your template, or your time pressure. It is organised around their story, their concerns, their values, and their goals. It means asking not just “What is wrong with you?” but “What matters to you?” It means recognising that the patient in front of you is the expert on their own life, and that your clinical expertise is most powerful when it is placed in service of their priorities, not substituted for them. Be mindful, however, that this does not mean giving patients everything that they want or demand, but giving the patients what is best for them, according to your clinical assessment.

This is harder than it sounds. It requires you to slow down when the system is pushing you to speed up. It requires genuine curiosity about people—not just their symptoms, but their circumstances, their fears, their relationships. It requires, frankly, a kind of humility that medicine does not always cultivate.

Continuity of care. This is perhaps the value most distinctive to Family Medicine, and the one most at risk of being eroded by the pressures of modern practice. Continuity is not just about seeing the same patient twice. It is about the accumulation of trust over time—the kind of trust that allows a patient to tell you something they have never told anyone else, that allows you to notice a change that no algorithm would flag, that allows you to have the difficult conversation that needs to be had. Research consistently shows that continuity of care is associated with better outcomes, fewer hospitalisations, and higher patient satisfaction. But beyond the data, continuity is simply what makes Family Medicine

family medicine. It is the thread that connects you to your patients across the seasons of their lives.

And underpinning all of these is something harder to name but no less real—a **genuine care for people**. Not patients as cases, not patients as data points, but patients as human beings who are vulnerable and trusting and deserving of your very best. That orientation—that fundamental disposition towards the person in front of you—is what will sustain you through the difficult days, and what will make the good days genuinely meaningful.

So, as you build your clinical skills, as you master the guidelines and the protocols and the prescribing, do not let the values get crowded out. They are not the soft backdrop to the real work of medicine. They *are* the real work of medicine. They are what will make you not just a competent, proficient, or expert physician, but a **GOOD** one.

Finally, I want you to know this: you are not alone.

You are joining a community—the College of Family Physicians Singapore, your fellow trainees, your programme directors, your future colleagues in PCNs and polyclinics and private clinics, and community hospitals across this island. This community has your back. It will challenge you, support you, and grow with you.

The College of Family Physicians and the Ministry of Health are committed to primary care. We are committed to you. The investments we are making—in infrastructure, in policy, in technology, in training—are investments in your future and in the future of your patients.

So as you begin, or continue on, this journey of Family Medicine training, carry with you the knowledge that what you are doing matters. That the patients who will walk through your door—sometimes frightened, sometimes confused, sometimes just needing someone to listen—will be better for having you as their doctor.

Welcome to Family Medicine. Welcome to one of the most important professions in Singapore’s healthcare system, and I look forward to seeing what each of you will go on to achieve.

Thank you.

■ CM

Interview with Dr Desmond Wai

The Changing Landscape of Private Specialist Practice

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

CM: Hi Desmond, thanks for agreeing to this interview. Please provide some background on your specialty and your years of experience in both restructured and private hospital practice. What were your key concerns and considerations when deciding to transition from restructured to private practice?

DW: I got my MBBS from NUS in 1994. I completed my internal medicine training in 1999 and my gastroenterology specialisation in 2002. I worked at NUH until 2006. During that time, I also worked with a liver transplant group. In 2006, I left to start my own private practice.

I left due to a combination of push and pull factors. I won't speak too much about the push factors. Suffice to say, the private group offered me a better package, so I decided to give private practice a try.

CM: How would you describe the current patient demand for your specialty in private practice compared with about 10 years ago?

DW: My foreign patient load has dropped significantly, by more than 80 percent compared with 10 years ago. I used to have a sizable number of patients from Myanmar, Vietnam, Indonesia, Bangladesh, and Malaysia. Over the last 10 years, there has been considerable political and economic instability in our region, and I think that has affected patient load. The Singapore dollar has also become much stronger over the last decade, making it more expensive for foreigners to come here for medical care. At the same time, our neighbours—Malaysia, Thailand, Indonesia, and China—have improved their medical capabilities and can provide a cheaper alternative to medical care in Singapore.

We saw a significant increase in Singaporean patients in private practice following the introduction and subsequent adoption of “as-charged” insurance plans beginning in 2005. This coincided with the withdrawal of the Singapore Medical Association’s (SMA) Guidelines on Fees in 2007, after the SMA was advised that the guidelines could contravene the Competition Act, following concerns raised by the Competition Commission of Singapore. This combination gave doctors considerably more latitude in setting their fees. I think some of us went overboard, which led to many



people, including our Minister of Health, feeling that private specialists had exploited the system. This has been referred to as the “Buffett Syndrome”.

Over the last five years, MOH has realised that private insurance premiums have risen so much that private health insurance has become unsustainable. The changes to private health insurance riders suddenly shifted many privately insured patients back to the restructured hospitals. Personally, I think my clinic patient load and procedure volume have dropped by about 30 percent over the last few years.

CM: Are there other contributions to the drop in private patient volume?

DW: I think two events have contributed to a drop in private patient volume. The first was the implementation of the cancer drug list, which led to cancer patients returning to the restructured hospitals. Cancer patients often present with many digestive problems and some used to be referred to me, such as gastrointestinal bleeding, abnormal liver profiles, viral hepatitis flares, and liver toxicity from medications.

The second was the change in insurance riders, which resulted in significant co-payments for patients, even if they had the best Integrated Shield Plan with riders. This shifted more patients towards the restructured hospitals.

CM: How significant have recent changes in private medical insurance and Integrated Shield Plan riders been in influencing patients' healthcare decisions?

DW: Patients in their 60s have told me that their annual premiums are more than S\$10,000, while some patients in their 80s have told me that their annual premiums exceed S\$20,000. So, many retirees downgrade their plans when they reach 60 years of age. I hope they return to the restructured hospitals. I am worried that some might stop consulting doctors altogether and self-medicate with medications purchased from Johor Bahru.

CM: Have insurance panels and increasing requests from insurance administrators for medical memos affected your practice?

DW: About 10 years ago, when insurance companies launched the panel programme, they said that panel specialists must charge within the panel fees, while non-panel doctors had no such restrictions. Panel specialists could also be audited by insurers. These factors led many private specialists to reject panel membership.

Back then, we did not anticipate the introduction of the MOH fee benchmarks, which subsequently placed limits on doctors' fees anyway.

Later, patients also faced disincentives when consulting non-panel doctors, such as higher co-payments and shorter follow-up periods.

Yes, Integrated Shield Plan insurers and Third Party Administrators (TPA) ask for a lot of clarifications and medical memos. In a way, this is not necessarily a bad thing, because we do have doctors who may overtreat and overprescribe. Some degree of oversight is therefore a good thing.

CM: Have referral patterns changed?

DW: I am sad to say that I have observed that fewer patients are asking their General Practitioners (GP) for specialist referrals. Nowadays, the first person a patient asks is often their insurance agent. They then choose a panel specialist.

Of course, word-of-mouth remains a good source of referrals. However, even if a specialist is excellent, has a good reputation, and comes highly recommended by family physicians, patients will only see them if their insurance allows it.

CM: What are some other factors causing a drop in income in private practice?

DW: I also see a new trend where local patients consult their specialists and GPs in Singapore but do their investigations and treatment in Malaysia. They consult Singapore doctors to be sure that their Malaysian doctors are following standard treatment. Many local patients have also told me that they purchase their chronic medications, such as statins or diabetic medications, in Johor Bahru.

CM: What are the key concerns for high clinic overheads despite the lower clinic income?

DW: My patient load has dropped, while the fees I charge have remained stagnant, so my revenue is slowly declining. At the same time, rental, manpower, and other overhead costs continue to go up. With the implementation of NEHR, there are also additional IT and compliance costs. Overall, my take-home income has declined.

CM: Do you think the current lower patient load is temporary, or do you see it as a longer-term structural change in Singapore's private healthcare market?

DW: I don't see any improvement in private healthcare patient load in the horizon. Several major restructured hospitals will be completed over the next 10 years, allowing the Government to take care of more patients. At the same time, changes to insurance make it harder for patients to consult private specialists.

(continued on next page)

(continued from previous page: Interview with Dr Desmond Wai)

CM: How are private specialists responding to the lower patient volume?

DW: I see many specialists consolidating their practices. Five years ago, many specialists had several clinics in different hospitals. Nowadays, I see many of them closing clinics and consolidating into just one clinic.

I have heard of some specialists rewarding their nurses with more than six months' bonus in the past. Those "good old days" are gone.

I have concierge and referral agents approaching me for collaboration. They ask me to pay them a portion of my professional fees in return for bringing in new patients. I don't collaborate with them, as I do not want to cross the red line set by the Singapore Medical Council (SMC).

CM: Looking ahead 2–5 years, which specialties or types of private practices do you think will remain strong, and which might face the greatest pressure?

DW: Clinics that depend heavily on foreign patients will gradually find it more difficult to do well. Solo practices may also find it increasingly difficult to survive.

Nowadays, a new private specialist may have difficulty joining insurance or TPA panels. As a result, many new

specialists are joining larger medical groups, which have greater bargaining power with insurers.

I heard recently that one major Integrated Shield Plan provider signed up several new specialists from a large medical group onto its panel, while many solo specialists are being turned away.

CM: If you were advising a specialist who is considering joining or starting a private practice in Singapore today, what would you tell them to consider before making that decision?

DW: Talk to me, or to any private specialist, for a realistic picture.

Private practice is becoming increasingly difficult for newcomers. Don't burn bridges with your restructured institutions, as you may need to return if private practice becomes non-viable. In fact, I have seen several gastroenterologists return to restructured hospitals after a short stint in private practice. Times are tough, and there is nothing wrong with that.

CM: Thanks much Desmond.

■ CM

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OR

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Insurance Specialist Panels in Singapore

Balancing Cost, Patient Choice, and Procedural Fairness

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

Insurance specialist panels have become an important feature of private healthcare financing in Singapore. Integrated Shield Plan (IP) insurers use panels of private specialists to manage healthcare costs, negotiate fees, and provide policyholders with enhanced benefits such as lower co-payment and pre-authorisation.

A specialist's inclusion, exclusion, or removal from an insurer's panel can materially affect the specialist's practice and, more importantly, the choices available to existing patients. A patient who has developed a longstanding therapeutic relationship with a specialist may face substantially higher out-of-pocket costs if that specialist ceases to be a panel provider.

Singapore has recognised these competing interests for some time. The Ministry of Health (MOH) has acknowledged concerns regarding panel size, transparency, patient choice, continuity of care, and the potential ethical implications of insurer-controlled panels. MOH has stated that insurers independently determine their panels with specialists based on mutually agreed terms, while encouraging insurers to make their panel-selection criteria more transparent. More recently, MOH has expressly recognised the need to balance insurers' legitimate interest in removing specialists whose fees are significantly above panel ranges or who make inappropriate claims against the need for reasonable patient access, choice, and continuity of care.

The issue, therefore, is not whether insurers should be permitted to maintain panels. The more difficult governance question is what procedural safeguards should apply when an insurer makes an adverse decision about an individual specialist's empanelment.

Why Insurers Use Specialist Panels

MOH has explained that panels allow insurers to manage claims costs by ensuring that panel doctors adhere to negotiated fee ranges. Policyholders who use panel specialists may receive more favourable co-payment arrangements.

The Singapore Position: Substantial Insurer Discretion

MOH has stated that individual insurers determine their panels independently with specialists, based on mutually agreed and acceptable terms. This approach is commercially understandable. An insurer must be able to decide which specialists it wishes to contract with, what fees it is prepared to reimburse, and what claims-management arrangements it considers appropriate. Specialists likewise remain free to decide whether to participate in a panel.

For a specialist, panel status may determine access to a substantial group of insured patients. For a patient, panel status may determine whether treatment with a particular specialist attracts enhanced insurance benefits or significantly greater out-of-pocket expenditure.

Cost Concerns Should Not Be Confused with Clinical Misconduct

An insurer may legitimately wish to remove a specialist whose claims are fraudulent, whose billing practices are inappropriate, or whose conduct repeatedly results in claims that fall outside the intended use of the policy. Such circumstances may justify strong action, including suspension or removal.

The position is less straightforward where the disagreement concerns fees alone. A specialist whose average fees exceed an insurer's preferred range may be treating unusually complex patients. A higher-than-average claim does not necessarily establish overcharging. MOH has recognised that fee benchmarks are reference ranges rather than absolute ceilings and that legitimate clinical circumstances may justify fees above those ranges.

This distinction matters because removal from a panel may carry reputational implications. If a specialist is removed following an insurer's assessment of claims or fees, patients may interpret the removal as suggesting poor clinical practice even though the underlying disagreement is purely contractual or financial.

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(continued from previous page: Insurance Provider Panels in Singapore)

Panel Turnover and Continuity of Care

Insurers may need to refresh panels, respond to changing claims patterns, renegotiate fees, or remove providers who no longer meet contractual requirements. The concern arises when changes occur frequently or without adequate consideration of patients already undergoing treatment.

A patient may have been treated by the same specialist for years and may have developed confidence in that specialist's clinical judgement. This is particularly significant in oncology, chronic disease, complex surgery, rare disorders, and other conditions where continuity of care may have clinical importance.

If the specialist is removed from the patient's insurer panel, the patient faces a difficult choice: continue treatment with the existing specialist and bear higher out-of-pocket costs, or transfer care to another specialist in order to retain enhanced insurance benefits. MOH has expressly recognised this concern.

A fair system should distinguish between: routine changes to panel composition; removal for serious concerns requiring immediate action; and disputed contractual or financial disagreements.

Where a patient is undergoing substantial or clinically sensitive treatment, a reasonable transition period could allow the patient and treating specialist to plan appropriately. This need not require an insurer to maintain a specialist indefinitely on its panel. Rather, it recognises that continuity of care may justify transitional arrangements.

Is the Current Framework Sufficient?

Singapore has several layers of oversight concerning private health insurance. MOH oversees healthcare-policy aspects of Integrated Shield Plans, while the Monetary Authority of Singapore (MAS) exercises financial-sector regulatory oversight over insurers. Competition issues may also fall within the Competition Act.

An insurer's decision to remove a specialist may not amount to an abuse of dominance or other competition-law infringement. Yet the process may still raise legitimate questions about transparency, notice, reasons, and the opportunity to challenge an adverse decision.

Existing Dispute-Resolution Mechanisms

Singapore has developed mechanisms for resolving certain insurance and healthcare disputes. The Clinical Claims Resolution Process (CCRP), for example, provides a mechanism for addressing clinical disputes involving

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of insured patients.*

Integrated Shield Plans. Such mechanisms are valuable, but they should not automatically be regarded as substitutes for a process governing panel empanelment and removal.

A dispute concerning whether a particular treatment is medically appropriate is different from a dispute concerning whether a specialist should remain on an insurer's preferred panel. The latter may involve contractual fees, claims patterns, administrative requirements, or other commercial considerations. An independent mechanism specifically addressing contested panel decisions would therefore serve a different function.

Towards Procedural Fairness in Panel Decisions

A more balanced framework would not prevent insurers from exercising commercial judgement. Instead, it would establish minimum procedural safeguards.

First, insurers should have clear and reasonably transparent panel-selection criteria. Specialists should know, at least in general terms, the factors that determine inclusion and continued participation.

Second, where a specialist is removed for reasons other than urgent concerns involving fraud, patient safety, or serious claims misconduct, the specialist should ordinarily receive reasonable notice.

Third, specialists should be given reasons for an adverse decision, subject to legitimate exceptions such as confidential investigations or fraud-related concerns.

Fourth, where practicable, specialists should have an opportunity to respond to allegations or concerns before permanent removal. This would allow a specialist to explain unusual claims, complex cases, coding issues, or exceptional clinical circumstances that may not be apparent from claims data alone.

Fifth, where appropriate, there should be an independent or suitably impartial review mechanism for disputed panel decisions. This need not involve a court or statutory

tribunal. A structured review process involving an independent medical or industry body could provide a proportionate alternative.

Finally, there should be continuity-of-care protections for patients already undergoing significant treatment. Transitional arrangements could be considered where immediate transfer of care would be clinically undesirable.

Multilateral Healthcare Insurance Committee

The timing of this discussion is particularly relevant as MOH has established a multilateral approach to the wider problems affecting private healthcare insurance.

The Multilateral Healthcare Insurance Committee (MHIC) brings together healthcare professionals, providers, insurers, consumer representatives, and government stakeholders. MOH has stated that panel-related issues and pre-authorisation are among the areas being examined collaboratively.

This provides an appropriate forum for considering whether panel governance should evolve beyond the existing focus on panel size and overall access.

Questions for consideration could include:

- Should insurers publish minimum panel-selection criteria?
- Should specialists receive reasons for removal, subject to appropriate exceptions?
- Should there be minimum notice periods?
- Should specialists have an opportunity to respond to disputed claims data?
- Should patients undergoing significant treatment receive transitional protection?
- Should there be an independent review process for contested removals?
- Should panel turnover be monitored not merely quantitatively but also by specialty and continuity-of-care impact?

Conclusion

Insurance provider panels are a legitimate and increasingly important mechanism for managing private healthcare costs in Singapore. They allow insurers to negotiate fees, manage claims, and offer policyholders enhanced benefits while supporting efforts to contain rising healthcare expenditure.

The issue is not whether insurers should be permitted to maintain panels or remove specialists. Insurers should be able to remove specialists on legitimate commercial, claims-management, clinical, or integrity grounds. The more important question is how that power should be

exercised when a decision materially affects a specialist and their existing patients.

Singapore has already recognised the importance of transparency, reasonable patient access, patient choice, and avoiding excessive panel churn. MOH's recent statements demonstrate that the policy debate has moved beyond whether panels are appropriate and towards how they should operate within a sustainable healthcare system.

What appears less developed is a formal framework of procedural safeguards for individual specialists facing adverse empanelment decisions. Competition-law principles do not necessarily address this issue, and existing clinical claims-dispute mechanisms are not necessarily designed to function as appeals against panel removal.

A mature panel system should therefore preserve insurer discretion while introducing proportionate safeguards: transparent criteria, reasonable notice, reasons for adverse decisions, an opportunity to respond, continuity-of-care protection, and an appropriate avenue for independent review.

Such an approach would not place specialists' commercial interests above those of insurers or patients. It would recognise that all three stakeholders have legitimate interests and that a sustainable healthcare-insurance system must balance cost containment, patient choice, clinical independence, and procedural fairness.

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The Changing Guard

A Clinical and Economic Reality Check on Primary Care in Singapore

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

For generations, the cornerstone of the healthcare ecosystem has been the sacred, unencumbered relationship between a patient and their General Practitioner (GP). We were the traditional guardians of health, journeying with families across decades. We managed the acute crises, meticulously guided the chronic disease trajectories, and intimately understood the socioeconomic nuances that influence a patient's wellbeing—nuances that a specialist in a tertiary hospital, operating on a fifteen-minute consultation block, simply cannot capture.

Today, however, the Singaporean primary care landscape is undergoing a profound and, at times, agonising metamorphosis. Standing between the physician and the patient is an increasingly dense thicket of third-party administrators (TPAs), complex financing mechanisms, and national health policy frameworks that, despite being well-intentioned, may have structural limitations. As we stand at this crossroads, we must critically evaluate the competitive healthcare market mechanics against public health frameworks to understand not just the clinical future of our profession, but our very economic survival.

The TPA Stranglehold and the Financialisation of Care

To understand our current predicament, we must first look at the cautionary tales of healthcare financing globally. The ultimate system failure occurs when insurance ceases to be a safety net for the catastrophic and instead mutates into a pervasive financing tool that dictates daily clinical pathways. The American model serves as a glaring warning: a system where corporate profits, astronomical administrative friction, and payer mandates frequently override clinical necessity, leaving populations underinsured and practitioners burnt out.

While Singapore has avoided the extremes of the US system, the creeping influence of TPAs has introduced a toxic friction into our neighbourhood clinics. What began as a mechanism to streamline corporate HR benefits has evolved into a system that actively erodes the trust between practitioners and patients.

TPAs currently operate as gatekeepers, frequently intervening in clinical management in ways that are far from

optimal for the patient in a GP setting. We see this daily: the dictation of which basic investigations are permitted, the restriction of specialist referrals to preferred “panel” networks, and the suppression of consultation fees to artificially low rates. When a GP is forced to spend vital clinical time justifying a standard blood panel to an administrator, or explaining to a frustrated patient why their necessary medication is excluded from their corporate tier, the sanctity of the consultation room is compromised.

For years, the medical community's calls to regulate these middlemen have largely gone unheard. The result is a dual survival crisis for independent practices. First, our margins are aggressively squeezed by exorbitant TPA administrative fees. Second, we face severe patient pool drainage; if a clinic refuses to accept predatory TPA terms, corporate insurance mandates force long-standing patients to seek care elsewhere.

Healthier SG: A Philosophical Triumph, but a Financial Strain for GPs

It is within this high-pressure environment that the Ministry of Health introduced Healthier SG (HSG). From a purely epidemiological and clinical standpoint, HSG is a masterstroke. It represents a long-overdue systemic recognition of what GPs have been arguing for decades: preventative, community-based care is vastly superior—and ultimately more economical—than reactive, hospital-based “sick care”.

By attempting to anchor every resident to a single primary care physician, HSG theoretically restores the GP to their rightful place as the coordinator of longitudinal care. It prioritises chronic disease prevention, lifestyle intervention, and continuity of care.

However, a philosophical triumph does not automatically translate into a sustainable business model. When we analyse the P&L (Profit and Loss) realities on the ground, the budget allocation for HSG reveals a stark disconnect between policy intent and private practice viability.

When the initiative was debated, the government announced a macro budget of \$1 billion for setup and \$400 million annually for recurrent costs. Recently, it

was highlighted that funds flowing to GP clinics through schemes like CHAS and HSG rose from \$230 million to nearly \$350 million. On paper, an average allocation increase of over \$140,000 per clinic sounds like a massive injection of capital into the private sector.

The reality in our ledger books tells a different story.

“Pass-Through Subsidies”

The fundamental issue is that the vast majority of this budget does not go to the GP's bottom line. It is deployed as “pass-through subsidies”.

Consider the Healthier SG Chronic Tier. To make private GPs competitive with polyclinics, patients now receive massive subsidies (up to 87.5%) for a whitelisted set of chronic medications. The government funding pays for the drug subsidy, bridging the gap between our cost and the polyclinic price. The funds pass from the state, through our clinic accounts, directly to the pharmaceutical distributors.

Similarly, the fully subsidised national screenings and vaccinations are high-volume, low-margin activities. We serve our vital public health role by administering them, but the compensation barely covers the logistical overhead of cold-chain storage, inventory management, and the clinical time taken to administer and document them.

The Capitation Squeeze and the Cost of Compliance

The direct financial reward for the GP taking on the heavy lifting of population health is the Annual Service Fee—a capitation-style payment meant to cover the ongoing management of an enrolled patient. Let us be candid: compared to the immense responsibility and administrative burden required, this payout is peanuts.

Co-financing is undoubtedly the correct macroeconomic model for a sustainable national healthcare system. However, the current model asks the private GP to absorb a staggering increase in compliance and audit costs.

To participate in HSG, clinics have been forced to overhaul their digital infrastructure. We must integrate with the National Electronic Health Record (NEHR), upgrade to highly specific Clinic Management Systems (CMS), ensure rigorous cybersecurity standards, and maintain meticulous, audit-ready patient data trails. The initial government IT grants were a fraction of the actual implementation costs, and they do nothing to cover the recurrent software licensing fees, the increased bandwidth requirements, or the extra hours our clinic assistants spend on data entry rather than patient care.



Dr Lye Tong Fong Alfred

We are managing our patients on razor-thin margins for medications and investigations, only to see our operational profits consumed by the administrative friction of compliance. The promised financial upside of HSG is heavily skewed towards centralised administrative setups and IT vendors, leaving the independent physician holding the bag.

Structural Asymmetries Between Private Practice and Polyclinics

The financial strain is compounded by the fact that, under HSG, private GPs are effectively serving the same pool of patients with chronic diseases as polyclinics, but within a profoundly uneven playing field.

While HSG attempts to level the cost of medications for the patient, it does nothing to level the structural costs for the provider. Polyclinics benefit from structural and institutional advantages that are not similarly available to private general practitioners, including:

- **Real Estate:** They are housed in purpose-built state infrastructure, immune to the ruthless commercial rental hikes that plague heartland GP clinics.
- **Capital Expenditure:** They receive block grants for expensive diagnostic equipment, from advanced imaging to in-house laboratories.
- **Manpower:** They are supported by a vast, centrally funded allied health network of dietitians, physiotherapists, and specialised nurses.

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Private GPs must cover commercial rent, rising utility costs, and a fiercely competitive wage market for locums and clinic staff entirely from our own suppressed margins. Expecting a solo practitioner to match the multidisciplinary output of a polyclinic, while suffocated by TPA caps and compliance costs, is an exercise in magical thinking.

The Necessary Evolution: Scaling and Ecosystem Growth

It brings no joy to say this, but the convergence of these forces—TPA margin compression, aggressive compliance demands, and unequal institutional competition—has triggered an unavoidable Darwinian shift in our profession.

We are witnessing the tragic but perhaps necessary evolution of the landscape. Older GPs, who have served their communities faithfully for decades, are looking at the NEHR mandates and the sheer bureaucratic weight of HSG and choosing to close their doors. The era of the solo, independent neighbourhood doctor operating a low-overhead, high-touch practice is rapidly drawing to a close.

To survive and thrive in this new era, private practitioners must ruthlessly rethink their operating models. Survival now dictates the construction of an ecosystem growth strategy.

1. Consolidation and Economies of Scale

The fixed costs of modern medical practice—cybersecurity, CMS licensing, audit compliance, and real estate—are simply too high for a single doctor to bear efficiently. The future belongs to multi-location clinic networks. By scaling operations, clinic groups can spread these heavy administrative overheads across a larger revenue baseline. Consolidation allows for centralised procurement, better negotiating power with pharmaceutical vendors, and the ability to afford dedicated administrative staff to handle the bureaucratic demands of HSG and TPAs, freeing the doctors to actually practise medicine.

2. Embracing Digital Health Architecture

We can no longer afford to restrict our care to the physical consultation room. If we are to manage chronic diseases effectively on thin margins, we must leverage technology to capture the patient lifecycle efficiently.

This means integrating proprietary, customised digital frameworks into our practices. The deployment of 24-hour telemedicine triage, digital health concierge mobile applications, and automated biometric tracking are no longer luxury add-ons for elite clinics; they are baseline necessities. By linking immediate online consultations with

long-term lifestyle management apps, we can maintain patient engagement, monitor chronic metrics remotely, and reserve in-person clinical time for complex interventions. This digital ecosystem approach allows a clinic network to scale its patient base exponentially without a proportional increase in physical footprint.

3. Redefining Value Beyond the Panel

Finally, we must critically evaluate our reliance on TPA networks. While breaking away entirely is daunting, clinic networks must begin to carve out bespoke value propositions that compel patients to stay, even if it means stepping outside their corporate panel. Whether it is through hyper-personalised preventative screening packages, advanced longevity medicine, or seamless digital convenience, we must build a brand of care that transcends the lowest-common-denominator approach of corporate insurance.

Conclusion: Reclaiming Our Profession

The introduction of Healthier SG represents a paradigm shift, placing the GP back at the centre of the patient's health journey. However, the economics of this shift are currently broken, heavily favouring state institutions and administrative middlemen while starving the private practitioners expected to execute the vision.

As a profession, we cannot passively wait for funding models to catch up to clinical realities. We must take aggressive ownership of our operational structures. By consolidating our practices, implementing strategic digital health ecosystems, and refusing to let our clinical judgement be compromised by financial gatekeepers, we can build a resilient, scalable model for the future.

The transition is undoubtedly painful, and we will lose many esteemed solo colleagues along the way. But if we adapt to these market mechanics with the same rigour we apply to clinical science, we can ensure that the private GP remains not just a surviving entity, but the thriving, indispensable guardian of our nation's health.

■ CM

Editor's note: The views and opinions expressed in this article are those of the author and do not necessarily reflect the official policy or position of The College Mirror. Any feedback or responses should be directed entirely to the author.

AI Is Not One Thing

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

Artificial intelligence is already in the consult room, regardless of whether a clinic has purchased or downloaded anything. *The College Mirror* presents this interview with Dr Dinesh Visva Gunasekeran, who has completed a PhD in AI, on what doctors get wrong about it, what should never go into a chatbot, and what stays ours.

CM: With AI arriving in practice, what do doctors most often get wrong?

DVG: One of the key things we get wrong as clinicians is our understanding of AI as a homogeneous form of software, when it is actually quite heterogeneous. There are generations of AI very different from what ChatGPT and other generative tools have popularised. Preceding generations of AI such as machine learning (ML) and deep learning (DL) have a completely different set of constraints, strengths, and benefits, and they present different opportunities as well as different risks.

CM: Vendors are knocking on clinic doors. What should never go into one of these tools?

DVG: Avoid any patient-identifiable information going into these systems: names, contact details, addresses. Such information is generally unnecessary for most applications of these systems and should be removed or appropriately de-identified before use. But we need to be careful, because it can be embedded in our notes in places we may not expect, such as in a lab report header. Or, more innocently, in a free-text note where we recorded a dependent or minor's parent's name and contact details to affirm consent or as part of updating their guardian. Pasted into an AI system, that carries identifiable information that introduces potential privacy risks down the road.

CM: If we pay for the model, is it safer?

DVG: Not necessarily. It really depends on the terms of use. Some AI providers actively use the prompts that are entered into the system by users such as clinicians to develop and retrain their models. If it is generative AI, that can introduce the risk of identifiable information that was put into the model leaking into someone else's later use of it, whether innocently or purposefully, during adversarial attacks.

CM: The AI in Healthcare Guidelines 2.0 makes the clinician an accountable user. What does that ask of a GP?

DVG: If we are considering deploying one of these tools in our practice, it is critical to read and digest it, because

it spells out what is good practice, what is potentially unsafe, and what we need to consider as end users. These tools may be useful for summarising, but they may have hallucinations or omit something clinically important that results in wrong recommendations. We always need to verify its outputs and provide our own clinical opinion, particularly in long conversations with many exchanges of prompts, where the tool's attention to the initial information about the patient can degrade.

CM: A tool says this patient has a 75 percent risk of diabetes in three years. Do I just pass that on?

DVG: We need to humanise any recommendation from an AI system, because it can only act on the restricted data it has, both in its training data and in its context on the patient in front of us. Contextualising that risk, and communicating it in a way the patient understands, in terms of both health literacy and technology literacy, remains our responsibility. So is helping them navigate what it means: what is actionable in screening intervals, what is actionable in lifestyle, and how that information is used in the journey of behaviour change.

CM: Complete this sentence: The thing I would never let AI do is ...

DVG: Become a replacement for the social ecosystem or the social support my patients have. Generative AI chatbots can be sycophantic, with a propensity to agree, and may reinforce misconceptions people might have. Even highly educated individuals might not realise, through repeated conversations, that they are starting to internalise false or distorted beliefs. I would be very cautious with younger adults who claim that AI is a friend and would encourage them to develop their relationships with parents, family, and peers instead.

CM: So do these tools belong in the consult room?

DVG: Most of the general-purpose frontier models are good for pattern recognition, for summarisation, and for pointing you to resources, and I use them actively when I am reading or revising. But their role in the consult room should be carefully defined and evaluated. They cannot see the nonverbal cues we see. Even with access to the record, they do not have the full context of our patient, and they have no feedback loop. We can see immediately how open a patient is to a recommendation and prioritise a quick win so that they feel empowered to make greater changes in their health journey. That is very much the responsibility of us clinicians. I think the most useful application of AI in primary care is for it to help assemble

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Dr Dinesh Visva Gunasekeran and Family Medicine colleagues from Singapore at the inaugural "Innovation in Primary Care to Support Communities" in Beijing, China in 2025

the information we need to make clinical decisions well. Today, the clinician often acts as the integration engine across the medical record, laboratory results, guidelines, administrative rules, and the patient's own history. A useful test is whether AI genuinely supports some of that cognitive work. Simply moving work elsewhere, e.g., from writing a case note to checking an AI-generated transcription for errors, might not provide much value in primary care. Moreover, not every problem requires AI. Sometimes the right answer is better care transformation or simply better software design.

CM: Not as a clinician or a data scientist, but as a parent of two young children, what do you guide them towards?

DVG: I am still thinking about this. I do not have answers, but I do have opinions. As much as these tools make knowledge easily available, learning is still very much dependent on the individual and requires practice. Answers might be more accessible, but knowing how to arrive at those answers is critical. Another thing I focus on in raising my kids is agency. Our education system tends to drive students towards structured paths and confined areas of knowledge work, which might not be viable in a future where these models are embedded in organisations and economies. Hence I want to encourage my kids to build their own agency, apply these tools to their own interests, learn to think out of the box in problem solving, start their own projects, and develop their own sense of satisfaction in what they do.

Sidebar: Before you paste anything clinical into a chatbot

- Remove all names, contact details, addresses, IC numbers, and dates of birth. The system does not need them.
- Check the places where identifiers hide: lab report headers, copied documents, and free-text notes where a caregiver's name or number was recorded for consent or documentation of communication.
- Paying for the model does not make it safe. Safety depends on the design and evaluation, and privacy depends on the terms of use, and whether prompts are used to train the model.
- Ask any vendor to demonstrate their compliance with the AI in Healthcare Guidelines 2.0 (AiHGE 2.0), whether the tool falls under HSA regulation with software as a medical device (SaMD) registration completed, and whether they hold relevant certification such as ISO 13485.
- Treat every output as needing a clinical opinion of your own, especially late in a long continuous conversation with AI on a given topic.

■ CM

AI in Healthcare

A User's Perspective

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

Artificial intelligence (AI) has rapidly entered healthcare. For many clinicians, the first encounter with AI was through tools like ChatGPT or Gemini. What initially seemed like an interesting technological innovation has quickly become a practical tool for daily workflows, whether for searching information, summarising clinical guidelines, drafting documents, or generating patient education materials. As AI continues to be integrated into healthcare, understanding how it works and how it influences patient care will help us prepare for upcoming shifts.

Traditional computer programmes follow rules and instructions explicitly programmed by humans. AI differs by learning patterns from large amounts of data to generate predictions, recommendations, or responses. Rather than being told every possible scenario, AI identifies relationships within data and applies what it has learnt to new situations.

AI can broadly be divided into three categories:

- **Predictive AI:** Analyses existing data to estimate future outcomes. In healthcare, it can identify patients at risk of chronic diseases, predict hospital readmissions, or detect early clinical deterioration.
- **Generative AI:** Creates new content such as text, images, audio, or computer code. It is useful for drafting reports, summarising literature, and creating educational materials.
- **Agentic AI:** The newest development, where AI systems plan and perform a series of tasks with minimal human intervention to achieve a defined objective. While still evolving, agentic AI may eventually coordinate appointments, retrieve clinical information, and assist with complex workflows.

Most generative AI applications today are powered by Large Language Models (LLMs). These models are trained using enormous amounts of text collected from books, journals, websites, and other public sources. During training, they learn relationships between words, phrases, and concepts, encoding this knowledge into billions of parameters. When a user enters a prompt, the model predicts the most likely next word based on these learnt patterns, repeating this process until a complete response is generated.

Although this appears conversational, AI is fundamentally predicting language rather than reasoning like a human expert. This explains why the quality of the response depends heavily on the prompt provided. Clear, specific prompts produce more useful answers, while vague prompts may result in incomplete or less relevant responses. Asking follow-up questions or refining the prompt often leads to significantly better outputs.

Many clinicians already use AI in their daily work, often without realising how diverse these tools have become. ChatGPT and Gemini are commonly used to answer questions, search for knowledge, summarise lengthy articles, and generate written content. Gemini also powers conversational chatbots that interact naturally with users. NotebookLM allows users to upload selected references or guidelines to create an AI assistant that answers questions based only on those sources, making it particularly useful for education and project work. Claude has demonstrated strengths in generating structured documents, developing forms, and assisting with workflow design.

Beyond text generation, AI tools can create presentation slides from a simple prompt, generate speaker notes, and transform reports into polished PowerPoint presentations, reducing the time required to prepare lectures or conference presentations. AI can also generate educational videos complete with narration, subtitles, and animations, making it easier to produce teaching materials and patient education resources. For researchers, AI can summarise scientific papers, identify key themes across multiple publications, organise literature for reviews, and assist in drafting research proposals or manuscripts. These examples illustrate that AI is increasingly supporting productivity across clinical care, education, research, and administrative work.

Beyond improving productivity, AI has the potential to transform healthcare delivery. Predictive AI may facilitate earlier disease detection and better patient risk stratification, enabling clinicians to intervene before complications occur. AI may support personalised treatment recommendations by integrating clinical data, investigation results, and evidence from published literature. Healthcare organisations are also exploring

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AI to optimise staffing, appointment scheduling, and workflows, improving operational efficiency while reducing administrative burdens.

In diagnostics, AI-assisted interpretation of medical imaging, electrocardiograms, and retinal photographs supports clinicians by improving efficiency and highlighting abnormalities requiring closer review. Telehealth platforms increasingly incorporate AI-powered virtual assistants that guide patients, answer common questions, and facilitate follow-up care. Administrative processes such as clinical documentation, referral letters, and insurance claims may also become increasingly streamlined. For patients with complex medical conditions, AI can synthesise information from multiple guidelines, providing clinicians with decision support while leaving the final judgement to the healthcare professional.

As users of AI, it is equally important to understand its limitations. AI can generate “hallucinations” or inaccurate information or omit important details. The information

it produces should therefore be verified against reliable clinical references and should never replace professional judgement. Patient confidentiality must remain paramount. Healthcare professionals should exercise caution when entering identifiable patient information into public AI platforms and ensure compliance with institutional policies and data protection regulations.

Ultimately, AI should be viewed as an assistant rather than a replacement for healthcare professionals. Its greatest strength lies in augmenting human capabilities by reducing repetitive administrative work, improving access to information, and supporting clinical decision-making. The core values of Family Medicine—listening to patients, understanding their personal circumstances, and building long-term therapeutic relationships—remain uniquely human. Learning to use AI thoughtfully, responsibly, and ethically will enable us to harness its benefits while continuing to deliver safe, evidence-based, and patient-centred care.

■ CM



AI usage in a consultation setting (image generated using AI!)

Mandatory National Electronic Health Records

Clinical Benefits, Practical Challenges, Ethical Considerations, and International Perspectives

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

A mandatory national electronic health record (EHR) system represents a major transformation in healthcare information governance. By requiring healthcare providers to contribute defined clinical information to a shared national platform, such systems aim to improve continuity of care, reduce duplication, enhance medication safety, and facilitate coordinated healthcare delivery. However, mandatory participation also raises important concerns regarding privacy, cybersecurity, professional workload, data quality, cost, and patient autonomy.

In Singapore, the **Health Information Act (HIA) 2026** provides the statutory framework for the contribution, access, sharing, and protection of health information and will progressively expand participation in the **National Electronic Health Record (NEHR)**. The NEHR is a national repository containing selected health information contributed by healthcare providers, including medications, laboratory results, diagnoses, vaccinations, radiological images, and discharge summaries. The HIA 2026 will require specified licensed healthcare providers to contribute prescribed key health information to the NEHR, with the contribution requirements being implemented progressively from 2027.

International Experience

International experience demonstrates that countries have adopted different approaches to national health information, ranging from the absence of a single national EHR, to patient opt-out models, to mandatory provider participation and mandatory components of health information. Examples include:

Australia: My Health Record moved from an opt-in to an opt-out model in 2018, resulting in substantially broader population coverage.

Austria: The electronic vaccination record (elmpfpass) provides an example of a mandatory national health-information component, requiring healthcare providers to record specified vaccination information in the central vaccination register.

China: China does not have a single, centralised national EHR system; instead, it has a combination of national,

provincial, and local electronic health-record and health-information systems.

Denmark: Denmark has been developing a digital health infrastructure since the 1990s, culminating in the 2003 introduction of the national health portal and the establishment of mandatory provider obligations. Patients retain the explicit right to object to data collection.

England: The Summary Care Record (SCR) was implemented nationally as an opt-out system, with patients automatically included unless they chose not to participate.

Estonia: Estonia's national EHR system, launched in 2008, operates on an opt-out model. Patients retain control over their data, with the ability to restrict access to specific records or individual doctors.

Finland: Finland's Kanta system is mandatory for healthcare providers, with Kanta Services launched in 2010 and the national Patient Data Repository introduced progressively from 2014. Healthcare professionals can access patients' electronic health records, while patients can use MyKanta to view their information and manage consent and restrictions on data sharing.

Germany: Since 2025, Germany has progressively introduced the electronic patient record (ePA) on an opt-out basis, with patients able to object to the creation or use of their record. Healthcare providers have defined obligations concerning the electronic patient record and the electronic transmission of health information.

Taiwan: Taiwan's NHI MediCloud system operates on a mandatory, default-participation basis, as it is integrated into the compulsory National Health Insurance system, although patients can restrict access to their medical information.

United States of America: The United States does not have a single national electronic health record (EHR) system; instead, healthcare providers use multiple EHR systems that are increasingly required to meet federal interoperability and information-sharing standards. The federal HITECH Act (2009) accelerated the nationwide adoption of electronic health records through financial incentives and subsequently supported regulatory requirements for certified EHR technology and information sharing.

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Family Medicine Induction Ceremony & AGM 2026





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Advantages of a Mandatory National Electronic Health Record

1. Improved Continuity and Coordination of Care

The strongest argument for a mandatory national EHR is improved continuity of care. When clinically relevant information follows patients across healthcare settings, clinicians are less dependent on patients recalling previous diagnoses, medications, and investigations. This is particularly important during hospital admissions, discharge, specialist referrals, and transitions between acute, primary, and community care.

2. Reduction in Duplicate Investigations

Fragmented health information can result in unnecessary repetition of laboratory tests and imaging when previous results are inaccessible or difficult to verify. Health-information exchange has the potential to reduce such duplication, saving both healthcare resources and patients' time.

3. Improved Medication Safety

Medication reconciliation is an important patient-safety issue, particularly for older patients and those receiving care from multiple providers. Access to medication information can help clinicians identify potentially conflicting medications, allergies, and previous treatments.

4. Better Population-Health Management

National health-information systems can support disease surveillance, healthcare planning, quality improvement, and population-health management. Large datasets can facilitate the identification of disease patterns, assessment of healthcare utilisation, and evaluation of health policies. However, secondary use requires clear governance. Information collected primarily for patient care may have significant ethical implications when subsequently used for research, policy, or other purposes.

Disadvantages and Risks of a Mandatory National Electronic Health Record

1. Privacy, Confidentiality, and Cybersecurity

The principal concern surrounding a national EHR is the protection of highly sensitive health information. Centralising information creates a potentially valuable target for unauthorised access and cyberattacks.

Cybersecurity should therefore be regarded as part of patient safety, rather than simply an information-technology function. The Australian experience demonstrates that cybersecurity responsibility extends

beyond the central government-operated system to healthcare providers, technology vendors, and other stakeholders.

Australia also provides an important example of the tension between accessibility and confidentiality. In their paper "Evaluating the Contextual Integrity of Australia's My Health Record", Kariotis et al (2019) argued that the shift from sharing health information within individual clinical encounters to a longitudinal national health record fundamentally changed the context of information sharing and raised significant privacy concerns.

2. Threats to Patient Autonomy

Mandatory contribution raises a fundamental ethical question: should patients have the right to refuse inclusion of their health information in a national system? Under Singapore's HIA 2026, patients cannot generally opt out of the statutory contribution of prescribed health information to the NEHR. They can exercise a degree of control over subsequent access through Access Restrictions, but this does not prevent a healthcare provider from contributing information that the HIA 2026 requires to be submitted. This creates an important distinction between refusal of contribution and restriction of access.

Can doctors refuse to contribute information to the NEHR? The position of doctors is similarly constrained. The HIA 2026 places contribution obligations on doctors and does not provide an individual doctor with a general personal opt-out from those statutory obligations. However, healthcare institutions should provide appropriate governance channels for doctors to seek clarification where they believe that specific information falls outside the prescribed contribution requirements or where compliance raises a genuine clinical or legal concern.

The HIA 2026 provides patients with mechanisms to control access to their NEHR information. Patients can monitor access through HealthHub and report suspected inappropriate access. The framework also allows patients to impose Access Restrictions at the healthcare-institution level. This reflects the team-based nature of healthcare but limits the patient's ability to distinguish between individual professionals within the same institution.

Patient autonomy is further qualified by emergency access provisions. Where access to restricted information is necessary in a life-threatening emergency, healthcare professionals may be permitted to override an Access Restriction under specified safeguards. Such access is subject to authentication, declaration of the emergency, and audit requirements.

3. Clinician Workload and Workflow Disruption

Implementation of an EHR can initially increase workload. Clinicians and clinic staff may need to enter structured data, navigate multiple screens, reconcile information, and respond to electronic communications. International experience demonstrates that these challenges can persist after implementation. A technically functioning system may still fail to deliver its intended clinical benefits if it increases the time required for common tasks or does not fit existing workflows. Implementation should therefore include formal usability testing with clinicians, adequate training, and continuous post-implementation monitoring.

4. Data Quality and Information Overload

More information does not necessarily mean better information or better patient care. A national record containing inaccurate, duplicated, outdated, or poorly structured information can create new clinical risks. During time-constrained consultations, excessive or irrelevant information may make it more difficult for clinicians to identify the information that is most relevant to immediate patient care.

5. Financial and Organisational Costs

National EHR implementation requires substantial investment in infrastructure, interoperability, cybersecurity, technical support, training, and ongoing system maintenance. England provides an important example of the financial and organisational complexity of national implementation. The English experience demonstrates that large-scale national programmes can struggle when implementation timelines are unrealistic, local clinical requirements are insufficiently incorporated, and contractual or technical arrangements become overly complex.

6. Risk of Unrestricted Surveillance

The central ethical challenge is to ensure that mandatory participation does not become synonymous with unrestricted surveillance. The HIA 2026's restrictions on the use of NEHR information are important safeguards. NEHR information is intended primarily for patient care, and access for employment or insurance purposes is prohibited except where specifically permitted by written law. Access is restricted to authorised healthcare professionals and subject to audit and security controls.

The HIA 2026 will require specified licensed healthcare providers to contribute prescribed key health information to the NEHR, with the contribution requirements being implemented progressively from 2027.

Conclusion

The success of a national EHR should not be measured simply by the number of healthcare providers connected to the system. More meaningful measures include improvements in patient safety, continuity of care, healthcare efficiency, data quality, and patient experience, together with preservation of confidentiality and public trust. Singapore's decision to mandate contribution makes public trust particularly important, as patients do not have the option of opting out as a means of addressing their privacy concerns.

The HIA 2026 can be viewed as seeking a defensible balance between individual autonomy and collective patient safety, but it should not be regarded as the final resolution of the autonomy question. The legitimacy of the HIA 2026 will ultimately depend not merely on whether it produces a comprehensive national database, but on whether patients and clinicians regard that database as a trustworthy instrument of patient care.

Governance should therefore include meaningful representation from clinicians and patients, supported by regular review of patient experience, clinical outcomes, privacy concerns and system performance. As the NEHR expands, the ethical adequacy of the framework should be continuously assessed, particularly in relation to vulnerable patients, highly sensitive information, inappropriate access, public understanding and the practical effectiveness of Access Restrictions. Ultimately, a mandatory national health record can offer important benefits for patient care and healthcare planning, but its long-term success will depend on whether these benefits can be achieved without compromising the privacy, autonomy, and trust on which the healthcare system depends.

Responding to Insurer and Third-Party Administrators' Requests

A Guide for Doctors

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

Private medical insurance is an important component of Singapore's healthcare financing system. Doctors are increasingly requested to provide medical reports, clinical summaries, diagnoses, treatment details, and in some cases, prognosis to Private Insurers and Third-Party Administrators (TPA). Insurers and TPAs have legitimate administrative functions, including verifying diagnoses and treatment, assessing claims, determining policy coverage, and administering employer medical benefits. However, these functions must be balanced against patient confidentiality, consent, and the doctor's professional judgement.

Patient Consent

Patients should be notified and their explicit consent obtained before their health information is sent to insurers. This does not require a fresh signature for every request. A valid patient authorisation accompanying the request may provide the necessary basis, provided the consent covers the proposed disclosure and the information is appropriate for the stated purpose. If there is any doubt as to the validity or scope of consent, the doctor should discuss these with the patient.

Consent to disclosure is not consent to unrestricted disclosure. A broad consent form should not be regarded as authorisation to release everything in the medical record. Consent establishes that disclosure is authorised; it does not remove the doctor's responsibility to consider relevance and necessity. For example, an insurer assessing a knee injury claim may reasonably require information about the diagnosis, treatment, prognosis, and functional consequences of that injury. It does not justify disclosing unrelated psychiatric or gynaecological treatment.

What Information May Insurers and TPAs Request?

Insurers and TPAs have legitimate reasons for requesting medical information. Depending on the circumstances,

these may include:

- the patient's diagnosis;
- the date and circumstances of an illness or injury;
- relevant symptoms and clinical findings;
- investigations performed and their results;
- treatment provided;
- dates of admission, surgery, or treatment;
- relevant previous medical history;
- prognosis or functional impairment;
- whether a condition is related to a pre-existing condition; and
- whether treatment is clinically related to the condition being claimed.

Clarifying Unclear or Overly Broad Requests

A common difficulty arises when an insurer requests "medical records" or "all medical information" without identifying the claim being assessed. Where the purpose is unclear, clinicians should seek clarification.

A doctor may respond: "The request does not identify the claim, condition, or assessment for which the information is required. Please provide sufficient context so that relevant information can be provided."

A request for clarification should not be regarded as an unreasonable refusal. Without knowing the purpose, the doctor cannot determine what information is relevant. This remains true even where the patient has signed a broad consent form.

Medical Reports Versus Raw Medical Records

The Ministry of Health's (MOH) guidance favours the preparation of separate medical reports or clinical summaries rather than routine disclosure of raw medical records.

A medical record is created primarily to facilitate patient care and may contain extensive information unrelated

to the insurance claim. An insurance report, in contrast, is prepared for a specific administrative purpose. Doctors should provide information supported by their records, relevant to the stated purpose and within their professional competence. Where information cannot reliably be established, the appropriate response is to state that it is unavailable rather than speculate.

What May a Doctor Decline or Defer?

Doctors have a professional responsibility to limit disclosure to information that is appropriately authorised, relevant, necessary, and lawfully disclosable.

A doctor may appropriately decline, defer, or seek clarification where:

- appropriate patient authorisation is absent;
- the validity or scope of consent is genuinely uncertain;
- the purpose is unclear;
- the information is unrelated to the claim;
- the request is unnecessarily broad;
- disclosure would reveal unrelated confidential information;
- the doctor is asked for an opinion outside his or her competence;
- the information cannot reliably be established; or
- compliance would require prohibited access to the NEHR.

In many situations, the appropriate response is to narrow or clarify the request rather than refuse it entirely.

Clinical Opinions and Insurance Determinations

Doctors should distinguish between providing clinical information and making contractual determinations. If an insurer asks whether a condition falls within a policy exclusion, the doctor can provide the diagnosis, clinical history, and relevant professional opinion. Whether those facts satisfy a contractual definition is ordinarily a matter for the insurer.

Where an insurer asks whether a condition was “caused by stress” or seeks another conclusion that cannot be established from available evidence, the doctor should avoid unsupported speculation and clarify where uncertainty remains.

Outside One’s Knowledge or Competence

Doctors should not provide opinions outside their competence. A General Practitioner (GP) who has referred a patient with a complex orthopaedic injury to an orthopaedic surgeon can provide information from the GP’s own records. If the insurer asks whether the patient has permanent impairment, the GP can explain that

the particular question is more appropriately answered by the specialist. This reflects appropriate professional boundaries rather than a refusal to cooperate.

TPAs and Contractual Audit Provisions

The fact that a request comes from a TPA rather than directly from an insurer does not change the principles governing disclosure. The doctor should establish who the TPA is acting for, the purpose, and the specific information required.

Similar considerations apply to panel-doctor contracts containing “right to inspect and audit” provisions. Such clauses should not automatically be interpreted as giving unrestricted access. MOH has reminded insurers that contractual arrangements must not compromise doctors’ legal obligations. Insurers should not ordinarily receive raw medical records merely because an audit clause exists. In exceptional circumstances, appropriately redacted records may be provided where necessary and relevant.

Commercial relationships with TPAs must not compromise clinical independence. Singapore Medical Council (SMC) guidance aims to prevent financial arrangements from influencing clinical judgement.

The NEHR: A Separate Statutory Boundary

The Health Information Act (HIA) 2026 creates an important distinction between a doctor’s own clinical records and the NEHR. Insurers do not have access to the NEHR, and healthcare professionals are prohibited from accessing the NEHR for insurance purposes except in specified circumstances authorised by law.

A doctor cannot respond to an insurer’s request by logging into the NEHR. Patient consent does not provide a general exception to this prohibition. Doctors should rely on their own clinical records, history-taking, and examination when preparing insurance reports.

A Practical Approach for Doctors

When an insurer or TPA request is received, doctors should:

1. **Identify the requester.** Determine whether the request comes from the insurer, TPA, employer, or another intermediary.
2. **Establish the purpose.** Identify the claim, condition, treatment, pre-authorisation request, or underwriting issue being assessed.
3. **Confirm authority.** Check that appropriate patient authorisation or another lawful basis for disclosure exists.

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4. **Assess relevance and necessity.** Determine what clinical information is actually required to answer the stated questions.
5. **Consider competence.** Provide information and opinions supported by the records and within the doctor's expertise. Refer specialist questions where appropriate.
6. **Disclose selectively.** Prepare a focused medical report or clinical summary rather than routinely releasing the entire medical record.
7. **Not access the NEHR for insurance purposes.**
8. **Document the process.** Record the request, authority for disclosure, clarification sought, response received, and information ultimately disclosed.

When Should Medical Protection or Legal Advice Be Sought?

Routine reports generally do not require legal advice. Assistance from a medical protection organisation, professional indemnity insurer, or solicitor may nevertheless be appropriate where:

- an insurer demands the entire medical record;
- an audit clause is invoked; consent is absent or disputed;
- the insurer refuses to clarify its purpose;
- unrelated sensitive information may be disclosed;
- contractual sanctions are threatened;
- the doctor is asked to access the NEHR;

- the requested opinion falls outside expertise; or
- litigation is threatened.

Where there is uncertainty, the doctor should first seek clarification. If the dispute persists, professional or legal advice should be obtained before disclosure.

Conclusion

The relationship between doctors, TPAs, and insurers requires a balance between legitimate insurance administration and the doctor's obligations of confidentiality and professional independence. The doctor is not simply an administrative intermediary. The doctor retains professional responsibility for determining what confidential medical information can appropriately be disclosed, in what form, and for what purpose.

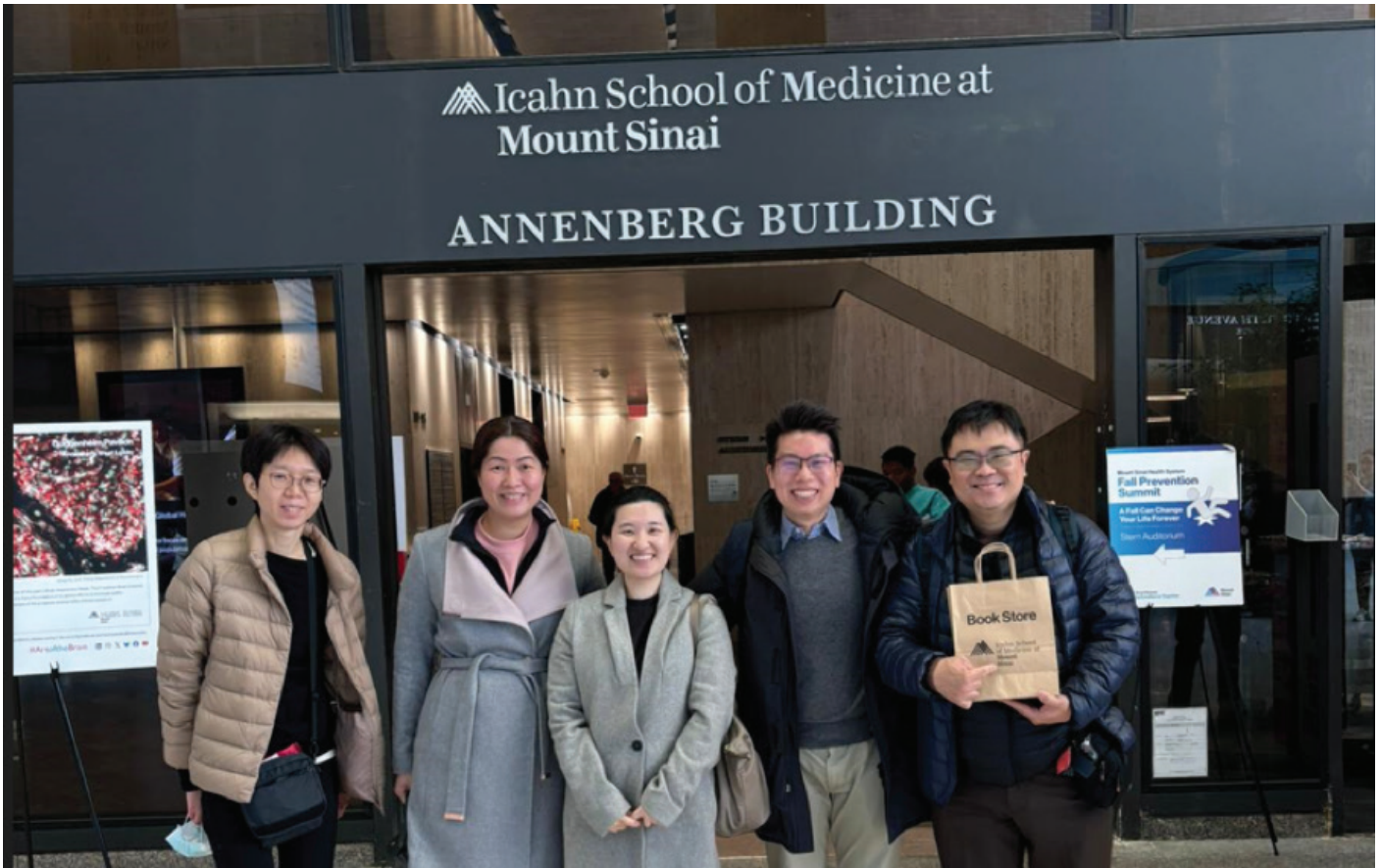
The appropriate response depends on the circumstances. A clear, authorised, and relevant request should be met with disclosure; an unclear, overly broad, or unauthorised request should be clarified or declined. When seeking clarification, the response may be: "Please clarify the purpose and specific information required, and I will provide the clinically relevant information that I am professionally and legally able to disclose." This balances legitimate insurer functions with patient confidentiality and professional independence.

Suggested responses to Insurer/TPA requests

Insurer/TPA request	Suggested response
TPA requests information without clear authority or purpose	Verify the requester, authority, and purpose before disclosure.
"Please provide the entire medical record"	Do not automatically release it; clarify the purpose and consider a targeted report.
Request does not identify the claim or purpose	Seek clarification before disclosure.
"Diagnosis relevant to the claim"	Provide the diagnosis based on clinical records.
"Treatment provided"	Provide relevant treatment information.
"Relevant investigation results"	Provide results relevant to the claim or assessment.
Opinion is requested outside the GP's expertise	Provide information within the GP's competence only.
"Prognosis or functional impairment"	Provide an opinion within professional competence only.
"Previous medical history relevant to the claim"	Provide it only where clinically relevant.
Request for unrelated medical history	Clarify or decline/defer disclosure where it is not relevant.
Information cannot be established reliably	State that it is unavailable or cannot be determined; do not speculate.
Request to access the NEHR for insurance purposes	Do not access the NEHR for that purpose.
Patient asks the doctor to obtain information from the NEHR for an insurer	Patient consent does not circumvent the statutory restriction.
Insurer asks doctor to determine whether a policy exclusion applies	Provide relevant clinical facts and professional opinion; avoid unsupported contractual conclusions.

CFPS-Mount Sinai Family Medicine Leadership Programme

by Dr Grace Chiang, Dr Bryan Lim, Dr Jonathan Yeo, Dr Tricia Chang, and Dr Ngai Qian Yi



Left to Right: Dr Ngai Qian Yi, Dr Tricia Chang, Dr Grace Chiang, Dr Bryan Lim, Dr Jonathan Yeo

Our two-week attachment at Mount Sinai Hospital was an enriching and multifaceted experience that offered the five of us, each with varied interests, roles, and areas of practice, a unique opportunity to learn from one another while gaining insight into a different healthcare system and environment. The programme was thoughtfully designed to combine didactic learning with immersive clinical experiences, allowing us to explore not only advances in medicine, but also the broader forces shaping the future of healthcare.

The didactic component featured engaging sessions on leadership, artificial intelligence, and medical education, providing perspectives that extended beyond traditional clinical practice. Discussions on leadership highlighted the importance of adaptability, collaboration,

and purposeful change in navigating an increasingly complex healthcare landscape. The sessions on artificial intelligence offered a glimpse into how emerging technologies might transform clinical decision-making, healthcare delivery, and the way clinicians work. Equally thought-provoking were the discussions on education, which explored how we can better prepare healthcare professionals and learners for a rapidly changing world.

The clinical programme complemented these sessions with full-day inpatient and outpatient postings across a diverse range of services such as longevity medicine, hospital medicine, Hospital at Home, home care, and concierge care.

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Perhaps the most valuable aspect of this attachment was the opportunity to view healthcare through multiple lenses. Across the various settings, we saw how innovation, technology, clinical expertise, and patient-centredness can intersect to shape new models of care. For the five of us, the attachment was not simply an opportunity to observe another healthcare system, but a chance to reflect on our own practices, challenge existing assumptions, and consider how lessons from Mount Sinai Hospital could inspire meaningful improvements in our respective areas of work.



Leadership Programme Talk with Dr Andrew Dunn

Concierge Medicine: Lessons for Primary Care

One of the more thought-provoking components of the CFPS-Mount Sinai Family Medicine Leadership Programme was the visit to Mount Sinai's Hudson Yards practice. The concierge model operates within a very different healthcare and financing environment from Singapore, but it provides an interesting perspective on how primary care can be organised around continuity, accessibility, and coordination.

With more time allocated to each patient, consultations can extend beyond addressing an immediate complaint to consider the patient's broader medical needs and priorities. Greater continuity also allows the primary care physician to maintain oversight when several specialists are involved. These principles are familiar to Family Medicine, but the Hudson Yards model demonstrates what they can look like when the surrounding service is deliberately structured to support them.

There are clear limitations to direct comparison. Concierge medicine serves a particular patient population and is relatively resource-intensive. Replicating such a model across Singapore's primary care system would therefore neither be straightforward nor necessarily appropriate.

The more relevant consideration is whether selected principles can be applied more broadly. Longer consultations for patients with greater medical complexity, stronger continuity with a regular family physician, and better coordination across healthcare providers may offer value without requiring adoption of the concierge model itself.

The Hudson Yards experience therefore offers a useful service-design perspective. High-quality primary care depends not only on the capabilities of individual physicians, but also on whether healthcare systems provide sufficient time, continuity, and supporting structures for comprehensive care.



With the Hudson Yard's team

Mental Health: For Both Patients and Providers

Primary care physicians are often the first point of contact for patients with mental health issues and help to coordinate care to support these patients. Mount Sinai has a new Behavioural Health Centre that has integrated outpatient clinics and an inpatient psychiatric ward within a building. This serves as a one-stop service for community psychiatry patients.



Mount Sinai Behavioral Health Center

An interesting part of this hospital is that there is a section called “Intensive Crisis Residence”. One of the first to be offered in New York State, the Intensive Crisis Residence is a short-term alternative to psychiatric hospitalisation. Patients are taken care of by peer counsellors, social workers, nurses, and doctors, but in a home-like environment. This programme is a safe alternative to going directly home after an inpatient psychiatric hospitalisation, so that patients can have more time to safely adjust to being in the community.



A room at the Intensive Crisis Residence



White noise machine

We also learnt that they take patient privacy and confidentiality very seriously. White noise machines are placed outside every consultation room to ensure privacy and confidentiality.

There is also a strong support for staff and employees. The Centre for Stress, resilience, and personal growth (started during Covid-19) offers confidential and individualised support to staff and eligible dependents. Using proven strategies, they help individuals build resilience and navigate life’s challenges with confidence. Throughout Mount Sinai’s sites in New York City, there are “Wellness spaces and Recharge rooms” for staff and employees to rest and practise self-care. Resources like the Louis Armstrong Centre for Music and Medicine, and Mount Sinai Calm, are also available for activities related to music, art, meditation etc. Music therapy for anxiety, pain management, and singing groups for stroke patients are some of the services available.

The Office of Wellbeing and Resilience conducts leadership workshops, mindfulness sessions, and coaching sessions to empower team members to build on their inherent strengths, finding meaning and cultivating realistic optimism.

Our main takeaways from this behavioural health observership were that Mount Sinai places a large emphasis on mental health among employees and shows commitment to their community partners by offering extended hours, having the Intensive Crisis residence available for anyone who needs it no matter where they are referred from. We also note that they have a specialised clinic and department just for substance

use, which shows the multi-faceted burden of substance abuse on society—it affects health, economics, and social cohesion, not to mention it being the leading cause of preventable death. Singapore is fortunate that we have very strict drug laws, which is a cornerstone of our public safety strategy designed to keep the country relatively drug-free.

Home-Based Care: Same-same but Different

We had the pleasure of visiting the home-based programmes at Mount Sinai, Hospital at Home and Visiting Doctors. This is akin to our Mobile Inpatient Care@ Home and chronic home care services respectively. Underpinning their programmes was a strong belief that being at home is best for patients as well as a desire to reduce the load on overcrowded hospitals.

We were impressed by the range of services that could be offered, including radiological investigations and intravenous infusions. We reflected that widespread use of point-of-care ultrasound at home can improve our ability to diagnose and manage within the home setting. This would reduce the need for homebound patients to return to the hospital for care.

However, one striking difference was a lack of a multidisciplinary team within their Visiting Doctors programme. Allied health services such as nursing procedures and home therapy had to be outsourced to external procedures. The advantage of having a multidisciplinary team to manage patients holistically cannot be overstated. We in Singapore are able to systematically develop comprehensive care plans using a biopsychosocial approach via regular multidisciplinary team meetings and can easily communicate with one another when the patient’s condition changes. Additionally, home care being largely nurse-led in Singapore, compared to a physician-led service at Mount Sinai, promotes coordinated and value-based care.

Nevertheless, physicians at Mount Sinai do their best to work around limitations, such as reaching out to external providers to discuss patient care. It is heartening to know that regardless of location, home-based doctors share the same ethos of providing patient-centred care.



A day with a Home Care Doctor

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A day with the Hospital at Home Team

Longevity Medicine: Reimagining the Future of Healthcare

Our attachment at the Mount Sinai Hospital offered a unique opportunity to step beyond the traditional disease-focused model of healthcare and explore a more proactive approach to healthspan and healthy ageing.

A key highlight was gaining insight into the hospital's longevity research initiatives, such as its DigiTwin project, which seeks to harness advanced technologies and personalised data to better understand and influence the trajectory of ageing. It uses big data modelling to answer novel clinical questions, and research into novel AI-driven models of human health by pioneering the development of a Digital Twin Model. This model is powered by AI and real-time health monitoring to provide personalised insights to extend healthspan.

We were also introduced to a range of assessments and devices used in longevity medicine to evaluate physiological function and biological health, providing a more comprehensive picture of an individual's health beyond conventional clinical measures. Experiencing these assessments first-hand, including undergoing a cardiopulmonary exercise test (CPET), was particularly memorable. It provided a practical appreciation of how objective measures of cardiorespiratory fitness and physiological reserve can contribute to a more personalised approach to preventive healthcare.

The attachment also demonstrated that medicine extends well beyond the walls of the clinic. The rehabilitation department—which also looks into longevity medicine in terms of how it might affect athlete healthspan and performance—works together with external partners to offer cold plunge and sauna therapies. This provided an opportunity to explore emerging approaches to recovery,

resilience, and metabolic health, while considering their potential role alongside established preventive strategies.

What stood out was the hospital's emphasis on bringing together research, technology, clinical assessment, and lifestyle interventions to create a more individualised model of care. The experience provided not only an introduction to the science and tools shaping the future of longevity medicine, but also a thought-provoking perspective on how healthcare can evolve from treating disease to proactively preserving function, optimising wellbeing, and ultimately helping individuals live healthier, more fulfilling lives for longer.



Dr Tricia Chang undergoing a cardiopulmonary exercise test (CPET)



With Christopher Miller, Performance and Reconditioning Specialist at Mount Sinai Hospital

Value-Based Care: The Mount Sinai Approach vs Singapore's Focus

Our team had several opportunities to learn from Mount Sinai administrators and senior ambulatory care physicians on how value-based care (VBC) has been embraced and established within their healthcare system, as opposed to the usual fee-for-service model that many other institutions still adopt.

In 2015, Sinai launched VBC as a population health initiative to compensate their primary care providers for their team-based care and coordination whilst optimising patient care outcomes. They largely showcased VBC as a healthcare delivery and payment model that ties provider compensation to the health outcomes achieved for patients, relative to the cost of care. One example of this delivery method was through the Hospital at Home model, which we described earlier.

In the ambulatory setting, several quality indicators were identified and tracked annually as process improvement metrics, e.g., hypertension and diabetic patients treated

to target; diabetic patients who performed their annual retinal photography and screened for proteinuria; patients who were screened for breast & colorectal cancers and depression; and appropriate use of statins amongst high cardiovascular risk patients. These same patients were also tracked to see if the outcomes translated to lower emergency room visits and hospitalisations.

Besides having a robust electronic medical records system (EPIC) that could track these metrics longitudinally, we noted that the system also incorporated comprehensive measures to ensure that only appropriate measurements were tabulated. For example, patients who would not benefit from statin use (such as those with terminal illness) or were statin intolerant were appropriately coded and excluded from the count.

Whilst incentivisation appears to be the main lever that drives this approach, it is merely a means to an end. Back home, we note that the Ministry of Health, Singapore, has similarly begun systemically embracing this concept, albeit in a more wholistic manner, named as the Appropriate and Value Based Care (AVBC) approach, since 2025.

This movement ensures that every patient receives care that is both clinically-effective and personally meaningful to their health journey, by focusing on evidence-based care, patient-centred care, and preventative care. This is achieved through ensuring that care is right-sited, integrated, and coordinated, yet cost-effective and sustainable. For the primary care sector in Singapore, we see this largely being achieved through Healthier SG objectives, although the system is still treading cautiously to fine-tune the approach.

Closing Thoughts

Beyond the knowledge and insights gained, perhaps one of the most memorable aspects of our two-week attachment was the camaraderie that developed among the five of us. Although we came from different roles, backgrounds and areas of interest, the shared experience created many opportunities to learn from one another, exchange perspectives and discover common ground. From navigating a new hospital environment and moving between different clinical services to sharing meals, conversations and reflections at the end of each day, these moments strengthened our bond and made the experience more meaningful.

As we look back on our observership at Mount Sinai Hospital, we leave with more than new knowledge and ideas. We return with a broader perspective of what healthcare can be—more connected, innovative, personalised, and responsive to the changing needs of

patients and communities. The observership challenged us to think beyond our individual practices and consider how leadership, technology, education, and new models of care can come together to shape the future of healthcare. Most importantly, it reminded us that while professional development may bring us together, it is the relationships, shared experiences, and friendships formed along the way that often leave the most enduring impression. Our two weeks at Mount Sinai Hospital may have come to an end, but the lessons, inspiration, and bonds forged during this journey will undoubtedly stay with us well beyond the observership.



Lunch with the Mount Sinai Team



Team bonding

Basic Obesity Management Accreditation (BOMA) 6

Building Confidence in Obesity Care

An Interview with Dr Tham Kwang Wei and Dr Benjamin Lam

Q1. The BOMA course is now in its sixth year. What have we achieved?

The Basic Obesity Management Accreditation, or BOMA, was first launched in 2021 as an annual online Family Practice Skills Course. It is conducted over two afternoons during a weekend.

The first afternoon covers the core essentials of obesity care, providing participants with a practical foundation in understanding obesity as a chronic disease, assessing patients appropriately, and initiating evidence-based management. The second afternoon focuses on new developments, prevailing issues in obesity care, and interactive case discussions. While the core curriculum remains largely constant, the second-day programme is refreshed each year to keep participants up-to-date in this rapidly evolving field.

Participants who attend the course and achieve at least 60 percent in the multiple-choice assessment receive BOMA accreditation, which is valid for two years. For reaccreditation, participants need only attend the second afternoon, allowing them to update their knowledge before completing the assessment.

Over the past five editions, participation has grown from 332 participants in 2021 to 354 participants at BOMA 5 in 2025. The course has also expanded beyond local family physicians to include allied health professionals, specialists involved in obesity care, and healthcare professionals from around the region. In 2025, 6 percent of participants were from outside Singapore.

Feedback has generally been very positive, with 96 percent of participants rating the course as at least useful or most useful in the most recent edition. More importantly, we are encouraged that BOMA has helped many healthcare professionals become more confident and competent in discussing and managing obesity.

This is important because obesity, or excess adiposity, is not simply a matter of body weight. It is a chronic disease characterised by adipose tissue dysfunction and systemic disturbances such as inflammation and insulin

resistance, which can damage multiple organs, impair quality of life, and contribute to premature mortality.

BOMA's main achievement has therefore been both its reach and its practical impact: developing a growing community of healthcare professionals who are better equipped to recognise obesity early, communicate about it sensitively, and provide evidence-based care.

Q2. What are the highlights of the coming BOMA 6 course?

BOMA 6 will be held online on 3 and 4 October 2026.

As usual, the first afternoon will cover the core curriculum and practical essentials of obesity management, while the second afternoon will focus on emerging developments and rapidly evolving areas in obesity care.

One major highlight will be obesity pharmacotherapy, which is evolving at an extraordinary pace. We have moved from medications with relatively modest efficacy to much more effective therapies, including single-, dual-, and potentially triple-receptor agonists. The field is also progressing from injectable to oral treatments, and from daily dosing to weekly, monthly, or potentially even less frequent dosing.

Another important area of development is the preservation of muscle mass during weight loss. Future treatments might not only help people lose excess fat but also help preserve, or potentially improve, muscle mass and physical function. This is particularly relevant for older adults and people at risk of sarcopenia.

We will also cover metabolic dysfunction-associated steatotic liver disease, or MASLD, as well as the relationship between obesity and kidney disease.

These topics reflect a broader understanding of obesity as a condition that affects the heart, kidneys, liver, and metabolic system together. Excess adiposity, especially central adiposity, can drive dysfunction across these organs and increase cardiovascular risk. Managing obesity early might therefore help prevent or delay

multiple complications, rather than treating each one only after it develops.

The timing is especially relevant as the first comprehensive AHA/ACC/ADA/ASN guideline on cardiovascular-kidney-metabolic syndrome was released in June 2026. It highlights staged assessment, earlier intervention, and coordinated multidisciplinary care to reduce cardiovascular and kidney complications. (professional.heart.org)

Through lectures, updates and case discussions, BOMA 6 aims to translate these developments into practical approaches that participants can apply in everyday clinical care.

Q3. Is there anything else you would like to tell us?

The growing recognition of cardiovascular-renal-hepatic-metabolic syndrome, and the close interconnections between the heart, kidneys, liver, and metabolic system, have important implications for family physicians.

This framework describes a continuum ranging from the prevention of risk factors, through excess adiposity and other metabolic abnormalities, to tissue and organ dysfunction, and eventually established cardiovascular disease. It encourages earlier risk assessment, appropriate staging, and coordinated treatment before serious complications occur. (professional.heart.org)

Obesity, particularly central adiposity, is a major upstream driver within this continuum. This means that obesity care should not be viewed as optional or cosmetic. Excess adiposity can lead to adipose

“One major highlight will be obesity pharmacotherapy, which is evolving at an extraordinary pace. We have moved from medications with relatively modest efficacy to much more effective therapies ...”

tissue dysfunction, systemic inflammation, insulin resistance, and other metabolic disturbances. These pathophysiological changes can then result in obesity-induced dysfunction across multiple tissues and organs, including the cardiovascular system, kidneys, liver, and pancreas, ultimately contributing to diabetes, kidney disease, liver disease, and cardiovascular events.

Primary care has a central role as family physicians see patients across the life course and are often the first to identify increasing weight, central adiposity, hypertension, abnormal glucose, dyslipidaemia, liver abnormalities, or declining kidney function. They are well placed to assess the person holistically, initiate conversations about weight without stigma, support behavioural change, start appropriate treatment, and coordinate referrals when more specialised care is required.

This is particularly relevant in Singapore, where cardiovascular disease remains a leading cause of mortality. We therefore hope that more family physicians and other healthcare professionals will join BOMA 6.

By improving our ability to recognise and manage obesity early, we have an opportunity not only to help people lose weight, but also to address the underlying pathophysiology, prevent progressive tissue and organ dysfunction, and protect cardiovascular, kidney, liver, and metabolic health.

Ultimately, effective obesity management is an important part of preventing cardiovascular disease and reducing premature mortality.

“Future treatments might not only help people lose excess fat but also help preserve, or potentially improve, muscle mass and physical function.”

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(continued from previous page: Basic Obesity Management Accreditation (BOMA) 6)

FPSC BOMA 6 programme outline

Session 1: Laying the Foundation (Saturday, 3 October 2026)

Moderator: Lee Yingshan (SASO)

Duration	Timings	Topic	Speakers
10 mins	2:00 - 2.10pm	Opening by SASO & CFPS Representatives	(CFPS) (SASO)
25 mins	2:10 - 2:35pm	Understanding Obesity: How and Why? Understanding Obesity as a disease, the etiology and causative factors of obesity	Lee Yingshan (SASO, TTSH)
25 mins	2:35 – 3:00pm	Approach to the Patient with Obesity - History, assessment and overall approach to management - Presentation and Case overview by speaker: video demo	Benjamin Lam (CFPS, SASO, CGH)
25 mins	3:00 - 3:25pm	Moving it for the Weight Loss and Health Gain in Obesity - Exercise and health benefits and role in obesity management - Exercise prescription for the primary care physician	Jazimin Haron (SASO, KTPH)
15 mins	3:25 – 3:40pm	Combined Q&A	All
15 mins	3:40 - 3:55pm	BREAK	
25 mins	3:55 – 4:20pm	Dietary Interventions in Obesity Management	Ang Siew Min (SASO)
25 mins	4:20 – 4:45pm	Intensifying Treatment with Metabolic Bariatric Surgical Interventions	Shanker Pasupathy (OMSSS, Gleneagles)
30 mins	4:45 - 5:15pm	Approach to Childhood and Adolescent Obesity	Elaine Chew (SASO, HKH)
15 mins	5:15 – 5:30pm	Combined Q & A	All
	5:30pm	CLOSE	

Session 2: Diving Deeper into Obesity Management (Sunday, 4 October 2026)

Moderator: Benjamin Lam

Duration	Timing	Topic	Speaker
5mins	2:00 - 2.05pm	Opening and Recap	Benjamin Lam (SASO, CGH)
30 mins	2:05 - 2:35pm	Update in MASLD Management	Mark Muthiah (NUH)
30 mins	2:35 – 3:05pm	Obesity and the Kidneys	Jean-Paul Kovalik (SGH)
15 mins	3:05 - 3:20pm	Q & A and Panel Discussion	All
15 mins	3:20 – 3:35pm	BREAK	
35 mins	3:35 – 4:10pm	Pharmacotherapy in Obesity Management	Tham Kwang Wei (SASO, WH)
40 mins	4:10 – 4:50pm	Case Discussion: 2 cases x 20 mins each - One involving lifestyle medicine (involving diff diet intervention) - Long-term: case weaving all interventions – lifestyle -> OMM -> MBS -> OMM + MBS	Moderator: Lee Yingshan - Dr Eva-Leina Yoosuff & Ang Siew Min - Caron Sak (Curie) & Sarah Tan (SASO, SGH)
30 mins	4:50 – 5:20pm	Q&A with Panel Discussion (30 mins)	Panellists: All speakers Leong Choon Kit, Suraj Kumar, Donna Tan
10 mins	5:20 - 5:30pm	Closing	Prof Goh (CFPS) & Tham Kwang Wei (SASO)

The *College Mirror* is pleased to recognise the winner of the College of Family Physicians Singapore Prize by publishing the essay, "**Not the Diabetes. You.**" for our readers.

Not the Diabetes. You.

by Nevin Chua Yi Meng, a Year 5 student at the Lee Kong Chian School of Medicine (LKCMedicine)

Seeing the Whole Person

The elderly gentleman sitting across the desk had a problem list that stretched the length of a page: hypertension, diabetes mellitus, osteoarthritis, chronic heart failure—ten diagnoses in all, each with its own medication, its own specialist, its own follow-up. He had come in that morning for a follow-up on his blood glucose.

He did not expect to discuss anything else.

Buried near the bottom of his record, nestled almost apologetically between cardiac and orthopaedic entries, was a single line: Generalised Anxiety Disorder. My Family Medicine supervisor paused at it, almost as if he was contemplating what to say next. He looked up from the screen, turned to the patient, and asked: "How have you been feeling lately? Not the diabetes. You."

It was, on the surface, a simple question. What it unlocked was anything but.

What my supervisor uncovered that morning was not a case of GAD at all. As the elderly gentleman spoke—haltingly at first, then with the quiet urgency of someone who had been waiting too long to be heard—it emerged that his anxiety had nothing to do with a psychiatric disorder. His wife had suffered a stroke a year prior and was now bedridden at home. He was her sole caregiver, managing her medications, her turning schedule, her meals, all the while attending his own appointments and quietly carrying a weight that no one had thought to ask about. A previous clinician had labelled him with GAD, and that label had propagated silently through every consultation note since. No one, until that day, had looked past the diagnosis to find the man behind it.

After that encounter, my supervisor said something to me that I will never forget: "For many patients, there is more beneath the surface." He did not mean it merely as a clinical tip. He meant it as a philosophy: that the reason for the visit is rarely the whole story, and that the family physician's task is to make room for what the patient truly needs to say. Sometimes it is a cry for help. Sometimes it is simply the need to be seen as a full human being, not a cluster of conditions.

Family Medicine is not, as I once assumed, simply a waypoint before the real specialists take over. It is one of the most demanding and irreplaceable disciplines in healthcare, one that holds the whole person together when every other part of the system is trained to see only a fragment. For individual patients, it offers a breadth of care that no subspecialty can replicate. For Singapore as a nation, it is the structural backbone upon which a sustainable and future-ready health system depends. To underestimate Family Medicine is to misunderstand medicine itself.

This is the essence of what family physicians practice. George Engel's biopsychosocial model, now foundational to medical education, finds its most complete expression not in the subspecialty clinic but in the Family Medicine consultation room, where illness is approached not as an isolated physiological derangement but as the convergence of biology, psychology, and social circumstance. Managing multimorbidity means holding 10 conditions in mind while never losing sight of the one person they belong to.

The significance of this approach is borne out by evidence. A landmark 2017 evidence synthesis¹ found that, across 11 studies examining relational continuity of care, every single one demonstrated a reduction in mortality; across 61 of 64 studies assessing healthcare utilisation, good continuity led to lower hospitalisation rates. The physician who knows a patient is not merely a convenience. He is a clinical resource with measurable, life-prolonging impact. Barbara Starfield's foundational work² on primary care demonstrated that health systems characterised by her Four Cs—first contact, continuity, comprehensiveness, and coordination—consistently produce better outcomes, more appropriate specialist use, and lower costs.

That morning, we could not resolve our patient's financial pressures or lift the weight of caregiving from his shoulders. But we listened, acknowledged what he was carrying, and facilitated referrals to a medical social worker and a financial counsellor. As he left the room, I understood something I would never have learnt in any ward or textbook: the therapeutic relationship is itself a

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(continued from previous page: *Not The Diabetes. You.*)

clinical instrument and Family Medicine as a specialty has mastered its use.

The Architecture of Singapore's Health System

Beyond the individual patient, Family Medicine is structurally indispensable to Singapore's healthcare system. Singapore's epidemiological reality is unsparing: a rapidly ageing population with rising multimorbidity and a chronic disease burden that compounds year on year. Against this backdrop, Singapore's network³ of approximately 2,400 private GP clinics and polyclinics forms the first and most frequent point of contact between the population and its health system. Polyclinics alone record millions of attendances annually, with hyperlipidaemia, diabetes, and hypertension accounting for a significant proportion of all diagnoses.⁴ These are not conditions that resolve between specialist appointments, but live with patients at home, at the workplace, and in the difficult hours of a sleepless night.

The indispensability of this architecture becomes vivid when compared to a country without it. During my elective in China, I realised there is no formal referral system there requiring patients to first consult a primary care physician. Two in five older patients bypass primary health centres entirely, attending secondary or tertiary hospitals even for conditions that community care could manage.⁵ This is not simply a preference. It reflects a deeply entrenched distrust in primary care quality, shaped by decades of under-investment in the workforce and continuity of care at the community level. Between 2010 and 2018, the share of outpatient visits handled by primary care institutions in China declined from 62 percent to 53 percent, despite sustained government investment intended to reverse that trend.⁶ The downstream effects are well-documented: China's hospital admission rate for hypertension stands at 490 per 100,000 population, more than five times the OECD average of 95 per 100,000, reflecting the preventable burden that falls on tertiary hospitals when primary care fails to manage chronic disease upstream. This is not a failure of hospital medicine but a failure of the nationwide architecture.

Singapore has deliberately built differently. The 3M framework—Medisave, MediShield Life, and Medifund—ensures that primary care remains financially accessible across all income strata. Healthier SG, launched in July 2023, marks a generational shift in health policy: from reactive, episodic care to proactive, preventive, relationship-based care anchored at the level of the family physician. The programme asks every Singaporean to enrol with a regular GP or polyclinic, not merely to

register, but to build a sustained clinical relationship over the years.

Honest critique, however, demands we acknowledge the challenges. Enrolment data shows that as of early 2024, a significant proportion of CHAS cardholders aged 40 and above had yet to enrol.⁷ GP capacity constraints, additional administrative burdens of chronic disease management, and fee structures that some practitioners find inadequate for the complexity of longitudinal care are some reasons that risk diluting the programme's goals.⁸ The architecture itself is sound. Whether enough physicians will choose to practise within it, and whether the system will adequately support them, remains the defining question.

What the Posting Taught Me

I arrived at my Family Medicine SIP carrying, I recognise now, a quietly condescending assumption: that Family Medicine managed the straightforward cases, and that the genuine intellectual and technical demands of medicine resided elsewhere—in the operating theatres, the ICUs, the subspecialty wards. That assumption did not survive my first week.

What I witnessed was not simplicity. It was breadth of an entirely different and more demanding kind. Within the same morning session, my supervisors would navigate a psychiatric presentation, a dermatological complaint, a gynaecological concern, and a patient needing an immediate visit to the emergency department. They held clinical recall for conditions I had studied only months prior and could not fully reconstruct on the spot. They knew, with quiet confidence, which patient needed an ambulance and which needed reassurance. And through all of it, they gave every patient the time they deserved. There was no residual category of “easy cases”. There was only the full, unsorted complexity of human illness presenting at the door.

My supervisor's phrase “there is always more beneath the surface” captured something I had not fully grasped prior to that posting: that Family Medicine's intellectual challenge is not the rarity of the conditions it sees, but the depth with which it must see them. A subspecialist might know more about one organ system than any GP ever will but only the family physician stands in a position to hold the patient's whole life in view—to recognise that the person presenting with poorly controlled blood glucose might actually be struggling with grief, caregiver exhaustion, or financial precarity that no endocrinologist has ever thought to ask about.

This is the intellectual and moral heart of Family Medicine: the willingness to remain a generalist in a

culture that rewards specialisation, to sit with uncertainty, and to be the doctor a patient returns to—not because their specialist appointment fell through, but because this is the physician who knows them.

The Road Not Yet Taken

Despite all of this, Family Medicine in Singapore faces a recruitment problem that has yet to be resolved. The prestige gradient between hospital specialties and primary care remains steep—not just in medical culture, but in compensation structures, career visibility, and prevailing assumptions about intellectual challenge. My own intended specialty is surgical, and I admit that I am not exempt from this mindset. Yet, the most technically skilled surgeon operates most effectively when the system around them functions smoothly: when the disease is identified early, when comorbidities are managed, and when the right patients arrive for the right procedures. Family Medicine is not the alternative to specialised excellence; it is its necessary precondition.

The College of Family Physicians Singapore, the Ministry of Health, and medical schools like ours must continue to act on this gap—through curricula that celebrate the complexity of generalism, remuneration frameworks that reflect the true labour of longitudinal care, and postgraduate training cultures that position the family physician not as a default assignment but as a deliberate and aspirational vocation.

Closing

The elderly gentleman left our clinic that morning without a new medication, without a fresh investigation, without a specialist referral for anxiety. What changed was that someone had finally looked past the 10 diagnoses and found a man carrying grief and exhaustion that no ICD code could classify. His family physician had done what Family Medicine does best: seen the whole person, asked the question no one else had thought to ask, and made him feel that he was not invisible.

That is why Family Medicine matters. Not as a stepping stone, not as a safety net, but as a discipline with a philosophy at its centre: the irreplaceable conviction that medicine's purpose is not to treat diseases in isolation, but to care for people in their entirety. In a city-state confronting an ageing population, a growing chronic disease burden, and a healthcare system that must perform across the full arc of a patient's life, that conviction is not merely admirable. It is essential.

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Turning “stay active” into a prescription

by the Agency for Integrated Care (AIC)

In 2024, ischaemic heart diseases (IHD) accounted for 19.6% of all deaths in Singapore, making them the country’s third leading cause of death, followed by cerebrovascular and hypertensive diseases.

For patients with stable IHD, the Healthier SG care protocol for Stable IHD / Chronic Coronary Syndrome emphasises early intervention through lifestyle modification and appropriate medical therapy to prevent disease progression and cardiovascular events.

Physical activity is a key component of care but prescribing it safely and effectively may not always be straightforward. In this article, we spoke with Dr Tham Tat Yean and Dr Wang Mingchang to better understand the principles behind exercise prescription and how general practitioners (GPs) can apply them in practice.

Their joint written responses have been lightly edited for length and clarity.



? Why was physical activity emphasised as one of the core management strategies in the care protocol?

All-cause mortality, cardiovascular mortality and hospital readmissions have been shown to be reduced among patients with cardiac conditions who exercise. When GPs become familiar with evidence in this area, it can give them greater confidence to encourage and “prescribe” exercise as a core pillar of disease management.

? Although physical activity is core in secondary prevention against IHD, why do you think exercise is often described as an underutilised therapy in practice?

Primary care physicians may worry that exercise could trigger angina or cardiac events. They may also be unsure how to prescribe exercise safely for patients with IHD. Plus, patients themselves may be concerned about their fitness level and safety, which can make the conversation more difficult.

? How can GPs reassure patients who fear another cardiac event?

GPs can explain that aerobic exercise may improve oxygen supply to the heart through remodelling of the coronary vessels and enhanced collateral formation around existing coronary stenosis.

? What might a practical prescription look like?

Ideally, patients with stable, chronic cardiac disease should undergo exercise testing to establish their ischemic threshold (heart rate at which ischemic symptoms occur) to aid exercise prescription and monitoring. Exercise intensity should be at most 10 beats per minute below the threshold.

At a glance: Prescribing exercise in stable IHD

			COMPONENT	PRACTICAL GUIDANCE
STAGE	Test		Ischaemic threshold	The maximum intensity of prescribed exercise should be at most 10 beats per minute below the established threshold
	Start	Activity type	Aerobic activity such as walking or cycling	
		Frequency	At least 3 days per week	
		Duration	15 to 20 minutes per session	
		For deconditioned patients	Accumulate shorter bouts of 1 to 10 minutes	
		Initial intensity	Approximately 20 to 30 beats per minute above baseline heart rate	
	Monitor	Heart rate	Measure the radial or carotid pulse, or use a suitable wrist-worn heart-rate monitor	
	Progress	Sequence	Increase frequency, followed by duration and then intensity; do not increase all three at once	
		Longer-term aim	150 minutes of aerobic exercise per week	
	Stop	Warning symptoms	Stop exercising and seek medical attention for giddiness, chest pain or significant shortness of breath	
	Seek specialist input	Pacemaker or transplanted heart	Exercise recommendations should be determined by the patient's cardiologist	

- 2 Stable IHD patients often have multiple comorbidities to address. How can exercise counselling be made a systematic part of routine chronic disease reviews, rather than an afterthought?

Today, lifestyle and non-drug strategies form a core component of our management approach to every chronic disease patient. This is heavily emphasised in the training approach for our GP colleagues in the community. There should be adequate emphasis to various approaches like exercise, diet, patient education and empowerment when we manage chronic diseases.

Exercise counselling can be done over multiple visits. An appointment can also be made specially for exercise counselling.

- 2 What resources can GPs leverage to help patients with stable IHD stay active between visits?

The Healthier SG Stable IHD and Body Mass Index (BMI) Control Care Protocols provide guidance on physical activity, to support GPs in making recommendations for patients.

Where appropriate, GPs may consider referring patients with well-controlled IHD or multiple comorbidities to Active Health Labs – run by Sport Singapore – which offer fitness assessments and personalised exercise programmes while factoring in patients' chronic diseases.



Dr Tham Tat Yean

CEO & Family Physician
Frontier Healthcare Group



Dr Wang Mingchang

Sports and Family
Medicine Specialist

Resources for GPs on management of Stable IHD



Stable IHD / Chronic
Coronary Syndrome
Healthier SG
Care Protocol



Body Mass Index
Control Healthier SG
Care Protocol



Active Health
Programmes
Referral Form

FPSC 135 — Basic Obesity Management Accreditation 6

3 - 4 October 2026 (SAT-SUN)

2pm - 5:30pm [Via ZOOM]

REGISTER

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.cognitoforms.com/cfps/fpsc135>



DAY 1 TOPICS

Understanding Obesity: How and Why?

Speaker: Dr Lee Yingshan

Senior Consultant, Department of Endocrinology, Tan Tock Seng Hospital
Vice-President, Singapore Association for the Study of Obesity

Approach to the Patient with Obesity

Speaker: Dr Benjamin Lam

Senior Consultant, Department of Family Medicine, Changi General Hospital

Moving it for the Weight Loss and Health Gain in Obesity

Speaker: Mr Jazimin Haron

Principal Physiotherapist, Khoo Teck Puat Hospital

Dietary Interventions in Obesity Management

Speaker: Ms Neo Wen Joo

Senior Dietitian

VLCD Accredited Healthcare Professionals

Intensifying Treatment with Metabolic Bariatric Surgical Interventions

Speaker: Dr Shanker Pasupathy

Medical Director, Digestive Centre, Mount Elizabeth Medical Centre

Approach to Childhood and Adolescent Obesity

Speaker: Dr Elaine Chew

Adolescent Medicine Service, Department of Paediatrics Medicine, KK Women's and Children's Hospital

Combined Q&A

All Speakers

DAY 2 TOPICS

Update in MASLD Management

Speaker: Adj Prof Mark Dhinesh Muthiah

Senior Consultant, Division of Gastroenterology and Hepatology, Department of Medicine, National University Hospital

Obesity and the Kidneys

Speaker: Dr Kovalik Jean-Paul

Associate Consultant, Department of Endocrinology, Singapore General Hospital

Pharmacotherapy in Obesity Management

Speaker: Dr Tham Kwang Wei

Senior Consultant Endocrinologist, Woodlands Hospital, President, Singapore Association for the Study of Obesity

Case Discussion of 2 cases with Q&A and Panel Discussion

Moderator: Dr Lee Yingshan

Case presenter:

- Dr Eva-Leina Yoosuff
Medical Director, Morrow Medical, Family Physicians, Certified Health & Wellness Coach
- Ms Neo Wen Joo
- Dr Caron Sak
Family Physician, Curie Genetics
- Dr Sarah Tan
Consultant, Department of Endocrinology, Singapore General Hospital

Panellists:

- Dr Leong Choon Kit
Family Medicine Specialist, Family Medicine Department, National University of Singapore
- Dr Suraj Kumar
Vice-President, College of Family Physicians Singapore
- Dr Donna Tan
Family Medicine Specialist & Deputy Director, Clinical Services, National Healthcare Group Polyclinics



Dr Tham Kwang Wei



Dr Benjamin Lam



Dr Lee Yingshan



Mr Jazimin Haron



Ms Neo Wen Joo



Dr Shanker Pasupathy



Dr Elaine Chew



Adj Prof Mark D Muthiah



Dr Kovalik Jean-Paul

Course Director: Dr Tham Kwang Wei

Moderators: Dr Lee Yingshan
Dr Benjamin Lam

Sponsored by:



(For avoidance of doubt, Novo Nordisk shall have no direct influence over the contents of the topics discussed / presentation materials.)

Organised by:



COLLEGE OF FAMILY PHYSICIANS
SINGAPORE



FPSC 136: Optimising Healthspan: Tackling Drivers of Aging

Singaporeans are living longer lives, but does this translate into healthier life-years?

Join us for an engaging session that explores how addressing the biological drivers of ageing can preserve function, maintain independence, and improve quality of life for older adults.

Gain valuable insights into the intricate relationship between infection, frailty, and sarcopenia, and examine how vaccine-preventable diseases can accelerate functional decline, increase healthcare utilisation, and compromise healthy ageing.

The session will be followed by an interactive workshop where participants will explore how global best practices in adult vaccination can be translated into practical, locally relevant solutions. Through case-based discussions and peer learning, uncover effective strategies to improve vaccine uptake, identify opportunities to strengthen preventive care within primary care settings, and develop scalable approaches that support value-based healthcare.

Leave with actionable insights to optimise healthy ageing and better support your patients.

17 October 2026 (SAT)

2:00pm - 5:15pm [via ZOOM]

Dr Hong Liyue



Dr Daphne Yang



Dr Leong Hoe Nam



TOPICS

From Lifespan to Healthspan

[Speaker: Dr Hong Liyue

Consultant Geriatrician, Alexandra Hospital]

Frailty and Sarcopenia: Clinical Consequences and Windows for Prevention

[Speaker: Dr Daphne Yang

Consultant Geriatrician, Tan Tock Seng Hospital]

Vaccination as a Key Enabler of Preventive Care in Older Adults

[Speaker: Dr Leong Hoe Nam

Medical Director, Rophi Clinic

Senior Consultant Infectious Diseases Physician]

Panel Discussion (Workshop)

All Speakers

This FPSC [Seminar, Workshop and MCQs] will be accredited for a total of 3 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.cognitoforms.com/cfps/fpsc136>

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Family Medicine Specialist
Kenneth Tan Medical Clinic
Dr Tang Xin Er
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