THE
College Mirror
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National Electronic Health Records (NEHR)
THE "WHATS" AND "HOWS"

THE UPCOMING HEALTHCARE SERVICES (HCS) BILL, TARGETTED FOR ENACTMENT IN 2019, MANDATES HOW FAMILY DOCTORS CAN CONTRIBUTE THEIR PATIENT'S DATA INTO THE NEHR DATA DEPOSITORY. WITH THE AIM TOWARDS SEAMLESS CARE, IT IS HOPED THAT PATIENT INFORMATION CAN BE ACCESSED OVER A WIDER HEALTHCARE LANDACAPE SUCH THAT FLOW OF INFORMATION CAN BENEFIT ANOTHER INSTITUTION OR CLINIC.

BUT THE "WHATS" AND "HOWS" WILL DETERMINE HOW FAMILY DOCTORS VIEW SUCH A MOVE. COLLEGE MIRROR POLLS HER READERS AND THIS IS WHAT SOME HAVE TO SAY...

REASONS FOR CONCERN
It is good that NEHR is made mandatory so that data contribution is done for benefit of patients, as long as patient retains control over who views his/her data.

PROPOSED SOLUTIONS
Patient needs to retain control over who views his/her data, and it will be good for patients to specify which doctor can see by entering the doctor's MCR number and allowing that doctor to be on the viewing list.

REASONS FOR CONCERN
Medico-legal safeguards are skewed against doctors. Whether we submit, don't submit, check or don't check, all are prone to error. How protected are doctors or is this just another stone that we will stumble over?

PROPOSED SOLUTIONS
Legal assurance that use / non-use will not constitute medical negligence.

(continued on Page 3)

IN THIS ISSUE:

Changing Healthcare Changing Needs

by Dr Fok Wai Yee Rose, MCFP(S), Editor (Team A)

In November 2017, our Minister for Health Mr Gan Kim Yong's launched the Healthcare Industry Transformation Map (ITM). It involved an enhancement to the National Electronic Health Records System to include key medical information to empower clinicians to make better-informed diagnoses and treatment decisions. And with Singapore's population ageing, more patients may be consulting multiple doctors for varying needs, so having an extensive database of patients' medical history can help make care safer, said the authorities. It will also help doctors seeing patients who are unable to articulate their conditions comprehensively and help them cut duplicate tests. Currently, only about 3 per cent of private healthcare licensees, including general practitioners, private hospitals and nursing homes, are contributing to the national repository. About one in five GPs today still do not have an IT system, according to a survey by the Integrated Health Information Systems (IHiS), the MOH's IT arm[1].

We invite our primary care fraternity to share their perspectives on this initiative and proposed solutions to its implementation.

Following the successful pilot project of Frontier Primary Care Network (PCN) in 2012, PCN received Ministry of Health's endorsement and funding support in 2015 and launched PCN as a mainstream model in 2018. Dr Chong Chin Kwang and Dr Derek Leong share on their challenges and memorable moments in this journey.

Our reorganisation of Western region healthcare cluster culminates in the inauguration of National University Polyclinics (NUP) and Dr Lew Yii Jen, Chief Executive Officer endorses the positive re-clustering experience and importance of team based care to promote holistic delivery, integration and navigation of primary care. Dr David Tan, head of Pioneer Polyclinic promotes empanelment and benefits of teamlet-based care, a new model of care for better outcomes and continuity of care. Prof Doris Young, head of the newly set up department of Family Medicine, shares her vision in advancing Academic Family Medicine in NUHS and her excitement to bring every family doctor together to enhance teaching, improve services and skill up to do world class research that we can be proud of, driven and led by Family Medicine academics.

Another role for primary care physicians is to lead a multi-disciplinary team to provide community cancer survivorship and Prof Soo Khee Chee, founding director of NCCS recognizes this pressing need in view of the sharp rise in many cancers as a result of aging population, sedentary lifestyle and obesity.

On a lighter moment, we have our lifestyle corner on tips on building a guitar.

Finally, how do we as a Family Medicine fraternity position ourselves to stay relevant in a fast changing landscape? Are we narrowing the divide between specialists and generalists? Do we adopt a paternalistic approach or should we lend our ear to the voices on the ground.

At the end, we often have to reflect on whether we have remained true to the 1st principle of Family Medicine (according to McWhinney), of being committed to the person rather than to a particular body of knowledge, group of diseases, or special technique. In simple words, our patients should always be at the heart of all we do.

1. https://www.todayonline.com/singapore/moh-compel-private-doctors-submit-info-national-healthcare-database

CM

CONTENTS

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(continued from Cover Page: National Electronic Health Records (NEHR) The "Whats" and "Hows"))

REASONS FOR CONCERN

Our clinic is concerned that the IT infrastructure for seamless upload of electronic medical information is not ready for private clinics.

Therefore the clinic workflow for patients will be slowed down or affected.

On the ground, there are quite a number of feedback that CMS GP connect still has quite a number of bugs that need to be fixed. The system often has downtime that affects the clinic operations.

PROPOSED SOLUTIONS

The government need to work with the other private CMS IT providers to develop solutions for seamless uploading of information.

Either that, the government has to develop the IT solution or programme that will allow the above before implementing the new NEHR law.

(continued on the next page)

- Erratum -

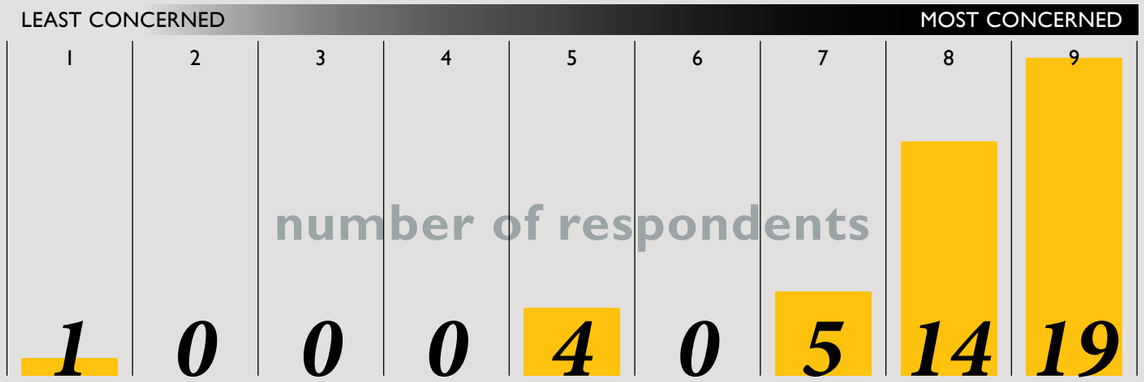
College Mirror Vol. 43 No. 4 December 2017 Event Photos - Family Medicine Convocation 2017

On Page 13 of the original article, under the group photo for GDFM Graduands - Standing (middle row from left) - *Dr Phua Hui Ling Michelle* was left out.

The online version of the article has been corrected to reflect the change.
We apologise for the error.

(continued from Page 3: National Electronic Health Records (NEHR) The "Whats" and "Hows")

ON A SCALE OF 1 (LEAST CONCERNED) TO 9 (MOST CONCERNED), HOW CONCERNED ARE YOU?



REASONS FOR CONCERN
I provide sexual health screening and treatment services for my patients who understandably want discretion first and foremost.

PROPOSED SOLUTIONS
Important details to general continuation of care that other physicians may find useful should be submitted but sensitive topics could be omitted.

REASONS FOR CONCERN
Medico-legal safeguards are skewed against doctors. Whether we submit, don't submit, check or don't check, all are prone to error. How protected are doctors or is this just another stone that we will stumble over?

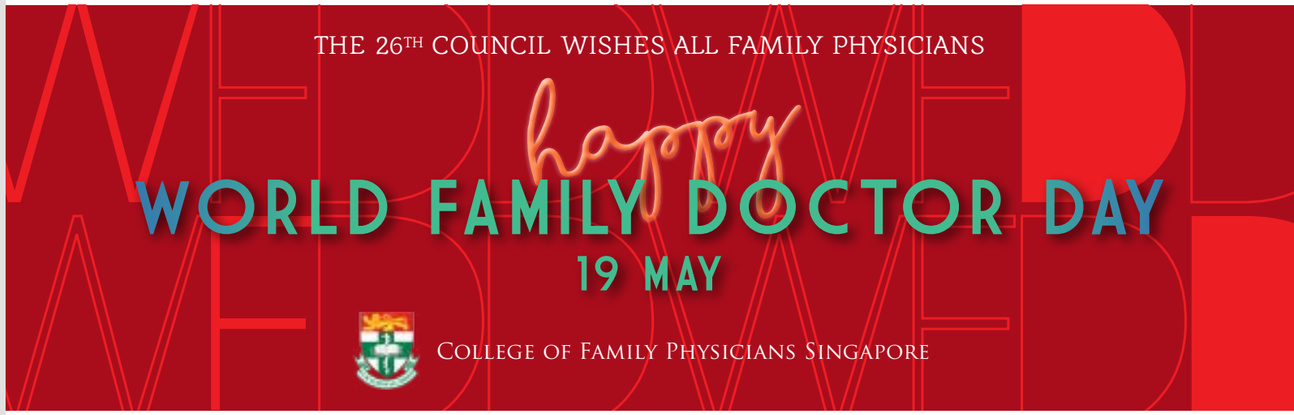
PROPOSED SOLUTIONS
Legal assurance that use / non-use will not constitute medical negligence.

REASONS FOR CONCERN
The medicolegal implication a medical practitioner may be liable for should he/she didn't go through all the patient records when patient consulted him/her for a simple ailment such as URTI and missed a CXR reporting a mediastinal mass. This CxR is not ordered by this doctor but ordered by another doctor from another clinic.

REASONS FOR CONCERN
- Will a doctor be liable if he fails to offer a patient the option to opt out of NEHR and the patient finds out after the consult that some information which he wishes to keep confidential is now accessible by other medical practitioners?
- Tying in with scenario 1, if the physician is deemed liable, does it mean we have to counsel the patient with regards to NEHR everytime he/she comes in for a possibly sensitive consultation?
- Will the current driving license form be still relevant? Will physicians be obliged to go through NEHR to look at the patient's past history before certifying him fit to renew his license or will the current signed declaration by the patient stand?

PROPOSED SOLUTIONS
We can enforce physicians to put in place IT systems that are capable of submitting information to the NEHR.

However, to uphold autonomy and confidentiality, shouldn't we give patients the chance to decide? Will it be more ethical to have an opt in system for the patient versus an opt out system.



REASONS FOR CONCERN
- Increase administrative work.
- Compelled to sign onto only two approved clinic software.
- Increase cost. Need to enhance clinic software and employ more assistance for data entry.
- But may not translate to better care as doctors will be too pre-occupied to type than to look at patient.
- Some older doctors are excellent family doctors who have great difficulty to adjust and adapt and forced into earlier retirement because of all these regulations.

There should be some space for these small groups of doctors and adequate time to help them to come on board.

PROPOSED SOLUTIONS
Progressive implementation with adequate funding. Use PCN resources to help and lead. Using carrot rather than stick will be better approach instead of legislation. Make it financially so attractive for doctor to change rather than a high handed approach. If you don't win the hearts of the people on the ground, the policy however sound will not succeed.

REASONS FOR CONCERN
Singhealth IT system requires additional time consuming steps to access NEHR for each patient. This discouraged checking it. Thus, integrating the information on one platform is desperately needed.

PROPOSED SOLUTIONS
We need to come together to create a new platform that is user friendly

REASONS FOR CONCERN
- Additional "administrative' duty and time taken implies increased screen time and reduced patient contact time.
- Differing interface would need some form of integration or painful enforced adaptation.
- Medicolegal implications eg insurance companies request for past history and management.

PROPOSED SOLUTIONS
- National integration and automation of data extraction with financial support I to bridge the multiple IT interface.
- Authorities to have a better understanding and feel of the ground, eg. insurance practices and having guidelines on request of information and some sort of standardization of medical request forms.

(continued on Page 7)

Closer Care in the Community:
PRIMARY CARE NETWORKS

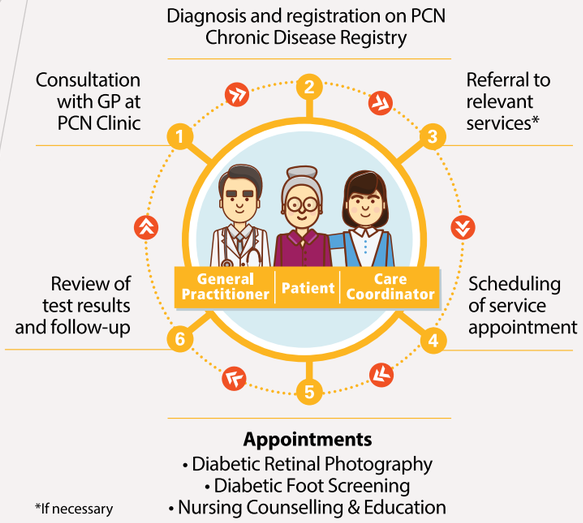
By Agency for Integrated Care

There has been much buzz about the Primary Care Networks (PCN) scheme since it was launched on 1 January 2018. Under the PCN scheme, General Practitioners (GPs) from private clinics can form virtual networks to share resources and provide more holistic chronic disease management for their chronic patients in a team-based manner. Patients are also able to access additional ancillary and support services provided by the PCN. Currently, there are 10 PCNs with about 340 participating GP clinics.

To join a PCN, GP clinics must be on Ministry of Health's (MOH's) core schemes such as the Chronic Disease Management Programme (CDMP), Community Health Assist Scheme (CHAS) and Public Health Preparedness Clinic (PHPC) scheme. Participating GP clinics on the PCN scheme will retain their business autonomy in their clinic operations. For instance, they can continue to use their existing Clinic Management System. Through the scheme, administrative support and manpower resources, such as nurses for chronic disease counselling, would be provided to GPs in the network. Each PCN would also set up and administer its own Chronic Disease Registry.

On 30 January 2018, a Welcome Dinner for PCN Leaders was held to commemorate the launch of the PCN Scheme. A PCN Leaders Orientation Programme was held in January 2018 to share with the PCN Leaders the experience and key learning points from the existing Frontier and NUHS PCNs related to their PCN journey, as well as other topics such as Quality and Improvement in Healthcare.

How PCN Works?



Role of PCN Leaders

Overall PCN Leader

- PCN Leader must be a Family Physician (in private practice) on the Register of Family Physicians
- Provides strategic guidance for the overall development of the PCN, including partnering the PCN GPs closely to drive clinical development and improvement to the PCN workflow and outcomes

Administrative Leader

- Administrative Leader supports the PCN Leader in the administrative and finance-related aspects of the PCN operations
- He/she does not need to be a doctor

Dr Chong Chin Kwang, PCN Leader of Frontier PCN, sharing pointers at the PCN Leaders Orientation Programme in January 2018

Chronic Disease Registry under the PCN Scheme

What is a Chronic Disease Registry (CDR)?

A database that contains the personal and medical information of patients that allows tracking and monitoring of patients for better care management and follow up.

How does it help with chronic disease patient management?

Enables the doctors or clinics to track and monitor care outcomes of their own patients with chronic conditions such as Diabetes Mellitus (DM), Hypertension and Hyperlipidemia systematically.

To find out more about PCN or how you can join one, please visit **https://www.primarycarepages.sg/PCN**. You may also write to AIC at **gp@aic.sg** or call **6632 1199**.

(continued from Page 5: National Electronic Health Records (NEHR) The "Whats" and "Hows")

Dear Colleagues

I am glad that College is seeking feedback from our members.

This is a very important feedback as it affects all doctors in Singapore and once Parliament approves the drastic changes there will hardly be any turning back.

Although the changes proposed by the MOH are useful, there are certain concerns:

1. CONFIDENTIALITY

It is unacceptable that a patient's record can be sourced electronically by any doctor, who may or may not be attending to the patient's illness.

Experts or even amateurs can hack into their medical records. Just recently, a young amateur in the USA hacked into the email of the Secretary State of Defence in the US, including the confidential records of the the Ministry of Defence.

MOH allows patients to opt out of the NEHR system. So, if the majority of our patients opt out of the system, will the system achieve its target?

How can the MOH reassure our patients of the confidentiality? Many patients do not wish other doctors to know of their sensitive medical history.

2. TIME CONSUMING

For the younger generation of doctors who are electronically trained since young and who can type without looking at the key board, the new changes are in keeping the the new era.

However, for the older generation of doctors who are not able to key in data as fast as writing into case notes, it will be laborious and will lose the important eye contact with their patients.

May I suggest that if the electronic system is approved, kindly allow such senior doctors to opt out of the electronic system for a minimum of two or three years from the time of the legislation. This will allow very senior doctors (eg 70 years and older) who are about to retire to continue working as their patients are so used to their personal doctors.

To provide patients who are treated at A & E of various hospitals with instant information of their medical conditions, we can allow them or their relatives to photograph their case notes with their phones. This would include all the relevant data that is being sorted by the emergency doctor attending to the patient.

The photo should include the all the relevant data and the latest treatment,and any allergies or side-effects of any drug.

In case the patient is not educated, a face and thumb print code will allow the doctor to access into such date. Even the next of kin can access such data.

This method will allow the doctor attending to the patient to access into the important data that is being sought.

Besides, it will allow the senior doctors to continue serving their patients instead of retiring earlier than planned. Society still needs such experienced doctors. Those who wish to keep on working after a designated period will then have to follow the latest electronic system if approved.

I sincerely hope that the MOH will consider a grace period for senior doctors. The cut off age can be decided by the relevant authorities.

Thank you for allowing me the express my views.

Dr. Lee Suan Yew

Past President of the College of Family Physicians
Past President of the Singapore Medical Council
Past Director of the SGH Board of Directors
Past Chairman of the Singapore Ethics Committee

Primary Care Network: *A holistic team-based model for Chronic care at GP clinics in Singapore*

by Dr Tan Eng Chun, MCFP(S), Editorial Board Member

In April 2017, the Ministry of Health made an official announcement to invite General Practitioners (GPs) to participate in the Primary Care Network (PCN) scheme. As of January this year, it was encouraging to see a total of 340 GP clinics has joined the PCN scheme, and organised themselves under the 10 Primary Care Networks that were formed.

Under the PCN scheme, participating GP clinics will receive MOH funded support of nurse counsellors and care coordinators to provide holistic team-based care for their patients with chronic diseases. This is an important milestone to improve the chronic care model of private GP clinics.

College Mirror and AIC interviewed the representative GP of Frontier PCN and Class PCN, to share their insights and views on the progress and challenges in setting up the network.

From left: Dr Wong Tien Hua, Raymond Lim, Dr Chong Chin Kwang, Dr Lam Pin Min (Senior Minister of State for Health, Serene Ang, Justina Khoo, Marine Chioh, See Chue Win

Image courtesy of Frontier PCN

Dr Chong Chin Kwang (Clinical Lead of Frontier PCN)

Qn1: Frontier PCN is the pioneer PCN that started in Singapore. Can you share some history on how it started?

As practising family doctors, we have always felt that GPs have the capability and capacity to take on more chronic disease caseload to help manage our nation's rising chronic disease burden. We think what is hindering the GPs from doing so is the lack of support and resources to provide team-based care. A typical GP practice is not likely to able to afford or would want to invest in such resources. But if a number of GP practices are able to come together to share such resources, and the resources are funded, then it be would be possible for team-based care to be delivered at GP clinics. This is the concept of PCN, which is already an established model of care in countries like Canada and New Zealand.

When the Primary Care Master Plan was first announced in 2011, FMC (Family Medicine Clinic), and CHC (Community Health Centre) were the endorsed models of care. We thought PCN could potentially be another model in the Primary Care Master Plan. In April 2012, Frontier Healthcare Group, under the leadership of its visionary CEO, Dr Tham Tat Yean, decided to start a pilot PCN project. The idea was supported by the Agency for Integrated Care (AIC) and the pilot took off as a joint collaboration between two parties.

Qn2: What were some of the challenges and mile stones during the journey?

We started the pilot PCN project with the 9 Frontier GP clinics in April 2012. We decided to put in place a framework of clinical governance and in order to operationalise this, we had to set up a Chronic Disease Registry (CDR) for every clinic. The CDR will be used to systematically track the clinical process indicators and care outcomes of the clinic's chronic patients. The data would then be manually populated from the case-notes into the CDR template Obviously, it was a tedious manual process. There was some initial inertia. To overcome this, we took efforts to explain and demonstrate that the data collection is not merely for the purpose of reporting but is necessary for the clinics to manage their patients better and more holistically. Today, the data collection process has become part and parcel of the clinics' routine work.

The clinic doctors and staff also had to get used to having a mobile team of Nurse Counsellors (NCs) and Primary Care Coordinators (PCCs) participating in the care of their chronic patients. This meant having to give the team access to their case-notes and space in the clinic to carry out their duties. It posed some inconvenience and some may felt it as intrusion into their clinical practice. We took great efforts to convince the doctors and clinic staff on the merits of team-based care and to reassure them that the involvement of the NCs and PCCs is more to complement their efforts to care for their patients.

Subsequently, other independent and solo GP clinics joined the network. The doctors of these clinics are like-minded GPs who shared our PCN vision. The pilot PCN project showed encouraging results in terms of clinical indicators and satisfaction from patients and doctors.

In October 2015, the PCN project received MOH's endorsement and funding support. It was renamed the RHS-PCN programme. At that point, we had a total of 21 GP clinics.

On 1st January 2018, MOH launched PCN as a mainstream model. This saw a total of 10 PCNs, including our PCN, embarking on the PCN scheme. We became officially known as Frontier PCN. There were 38 GP clinics in our PCN.

As our network gets larger, it becomes increasingly difficult to cope with differences. But we continue to accommodate as many voices and to forge consensus as far as possible as we value the "ground-up" philosophy. The forging of consensus has to be over a period of time and this has to some extent, hampered operational and administrative efficiencies in the short term. We are not deterred by this as we take a long term view of our working relationships with the GPs.

Qn3: How did MOH, AIC support you in this journey?

AIC provided us administrative and nursing headcount support to kickstart the pilot PCN project. They helped us consolidate the results of the project and presented them to MOH. This eventually resulted in MOH giving its endorsement and funding support to the PCN scheme.

Qn4: Can you share with us some of the benefits that the PCN have brought to your group and GP clinics?

PCN has helped our clinics provide better and more holistic care to our patients. Tracking of our patients' chronic care components has become more systematic. The support provided by the primary care team increases patient care time and yet frees up time for the doctor to focus on the more complex medical issues.

Our clinics now have visibility of their overall standard of care delivery and within the PCN, they are able to benchmark their clinic's results with those of their peers. There are sharing of best practices, consensus building and co-development of workflows.

The provision of Nurse Counselling, Diabetic Foot Screening and mobile Diabetic Retinal Photography services within the clinic's vicinity also confers "one-stop" convenience to the patients.

Qn5: Can you share some perspectives and insights on the future of PCN in Singapore?

MOH has set aside a budget to support the PCN scheme over the next 5 years. Currently, there are 340 GP clinics participating in the PCN scheme and the numbers are likely to grow with time. I understand that more schemes are likely to be rolled out through the PCN programme and this will mean more support to GP clinics.

A strong primary care sector is important to help our nation cope with its rising chronic disease burden. As a GP community, it is important to show our support for the PCN scheme and to demonstrate that more effective and holistic care can be delivered through the PCN scheme. This will then give MOH the confidence to continue its support or even enhance its support to the PCN scheme.

(continued on the next page)

(continued from Page 9: Primary Care Network: A holistic team for Chronic care at GP clinics in Singapore)

Dr Derek Leong (GP Member of Class PCN)

Qn1: When did you hear of PCN, and what made you decide to join one?

I first heard of this in April 2017 when MOH launched its first application call for General Practitioners (GPs) to join the Primary Care Networks (PCN) scheme. I decided to join one as participating GPs would be able to tap on funding and administrative support to implement team-based care to better monitor and manage their patients' healthcare needs.

Qn2: What were some challenges and/or resistance (or fears) that you had to overcome to join the PCN?

As a partner in Healthmark Group anchoring a relatively newer clinic, my concern was that if there would be any additional fees or excess administrative paperwork required to join a PCN.

Another area of concern was with regards to business operating confidentiality. In the initial stages of PCN development, there was no clarity on how much or what information clinics would be required to collate and submit.

Qn3: How did you overcome them in the end?

All my concerns were addressed once the concept and vision of the PCN scheme became more apparent over the ensuing few months, and discussion with various other fellow GPs and my group partner doctors.

Qn4: How did AIC and PCN HQ support you through this journey thus far?

AIC has supported me through this journey thus far through timely provision of information to my PCN HQ (Class PCN). My PCN HQ formed a chat group and Dr Leong Choon Kit and Dr Paul Ang Teng Soon have provided up to date and relevant information with regards to the PCN set up, requirements, and running. Information regarding funding and expenditure have also been made very transparent. A PCN meeting date for all the participating clinics has also been set already for all of us to meet up face to face.

Qn5: Could you share with us a specific example where your patients were able to enjoy better chronic care in the community thanks to the PCN scheme?

With the shared resources of the PCN, my chronic disease patients will be able to enjoy easier access to services such as diabetic retinopathy screening, nutrition advice, and nurse counselling etc.

Qn6: What are your thoughts or any tips to help your fellow GP peers who are interested to join a PCN?

Speak to your fellow GPs who are already part of a PCN and make the decision to come on board. A single twig breaks, but the bundle of twigs is strong.

CM

Building Guitars In Okinawa

Interviewed by Dr Tan Li Wen Terence, Editorial Board Member

Joji Yoshida is a talented Japanese luthier making a splash in the world of hand crafted instruments. Joji trained under reknown builder, Sergei de Jonge in Canada and is now based in Naha, Okinawa, where he handcrafts a limited number of masterpieces each year. I caught up with Joji for some inside information on his work.

College Mirror (CM):
Thanks for speaking with us, Joji! Can we start by asking how you got starting building instruments?

Joji Yoshida (JY):
In 2010, I quit my job and was planning to move from Yokohama to Okinawa. I have been playing guitar since I was 12 and always dreamed if I could build it by myself. I found it was the perfect timing to jump in, so I took Sergei de Jonge's guitar making course and became a guitar builder.

(continued on Page 12)

March 2018 Column

by Adj Asst Prof Tan Tze Lee, President, 26th Council, College of Family Physicians Singapore

Medical fee benchmarking, the Healthcare Services Act (HCSA) and regulation changes to submissions to the National Electronic Health Record (NEHR), enhancement to the Graduate Diploma of Family Medicine (GDFM), Primary Care Networks (PCNs), Family Medicine as a clinical specialty….These are just some of the many agenda items that the College has been addressing in the past few months. Each one has their own demands, and like every child, each is unique and very important in its own right.

Yet, with so many individual projects calling out for our undivided attention, we must not lose sight of the fact that we are doing all this for one singular reason: to better serve our patients, who have entrusted their health needs to us, their family doctors, their family physicians. It could be in the heartland GP clinics, town practices, the polyclinics, community hospitals, nursing homes… All of us are unified in one purpose, to provide the best care for those we serve.

This was brought home to me when I had the privilege to visit the Hong Kong College of Family Physicians (HKCFP) in December last year, to attend their HKCFP/FRACP Conjoint Fellowship conferment and 40th Anniversary commemoration dinner, which was held at the Hong Kong Academy of Medicine. It was a grand affair, with many of the senior stalwarts of the Hong Kong Family Medicine fraternity intermingling freely with the many proud young doctors who had successfully completed family medicine training in Hong Kong. What impressed me was the bright eyed enthusiasm and camaraderie amongst all who attended. The atmosphere was electric, and there was a real buzz to the festivities. Yet, this was a formal affair, with all the regalia fitting for the occasion. I recall an email to our Secretariat, gently reminding me to bring my academic gown for the occasion!

When I entered the main hall, I was most impressed to see the coats of arms for the various colleges of the Hong Kong Academy of Medicine, with that of the HKCFP right in the centre. Seated on the podium with the other invited guests, I could see the many expectant, radiant faces of the graduands who had made the grade. After the conferment, we were regaled by Past President, Dr Stephen KS Foo, who shared his personal reflection of the 40 year history of the HKCFP.

I had the privilege to meet with the HKCFP Young doctors committee and their head Dr Loretta Chan, together with Prof Doris Young, as well as the Censor in Chief of the Royal Australian College of General Practitioners, Dr Mark Miller. We had the most enjoyable discussion on their hopes and aspirations for Family Medicine in Hong Kong, and it was a great inspiration to see their energy and verve! This is something we should take note of and emulate.

The commemorative dinner that evening was most memorable, with the Hong Kong SAR Secretary for Food and Health, Professor Sophia Chan as Guest of Honour.

(continued on Page 13)

(continued from Page 10: Building Guitars In Okinawa)

Joji Yoshida's favourite guitar built - looks great and sounds great

All images courtesy of Joji Yoshida

CM:
So what is it like being a guitar builder?

JY:
Guitar building is the only job I never feel I waste my time. All the other jobs I have experienced, I always feel I was doing it for money, to live. But guitar making, it is not only for money. It is fun. I love it. People love it and respect me. People wait for the weekend and hate Monday. But as a guitar builder, working is fun. Day doesn't matter.

CM:
What's a typical day like for you?

JY:
Work until night, then my private time (play guitar, watch movie, etc). Since I am self-employed and do whatever I want to do, there is no fixed schedule actually.

CM:
How long does it take to make a guitar? Maybe you could give us a rough idea of the construction of a guitar?

JY:
About a month. If I rush, 20 days. Depending on how many options a guitar has though.

CM:
That's a long time! Let's talk about the guitars you've built! What's your favourite guitar you have built?

JY:
This one. http://www.jojiyoshidaguitars.com/048.html. It is not only looks great but sounds great too! Many times the best looking guitar does not sound as good as it looks. But this one was different. Also, maple guitars usually lacks bass but this one has full sound. Guitar is made of wood. Product of nature. There is no same thing. Every piece is different. In this guitar, I guess all the planets are aligned!

CM:
Thanks Joji, before I let you go, can I ask what advice you would give us if we were thinking of a custom made guitar?

JY:
Work hard and save money, because it is expensive! Seriously, designing a guitar in your mind won't cost you any money. Do it as long as you can. People ask me to build a copy of famous maker. Be yourself and find your own voice, look, and let me build a true original one for you, not a copy of someone else.

CM

(continued from Page 11: March 2018 Column)

In the first part of the evening, past president Dr Stephen Foo shared more of the HKCFP's 40-year history, this time in Cantonese. Without doubt, the memories shared were more intimate and heartfelt, and revealed much about how the college had grown, with the networks and friendships between fellow family physicians. I was struck by the warmth between the various sectors, public and private; they were all unified by a common goal, of improving the standards and stature of family medicine in Hong Kong. And always, with the aim of providing best care for patients. All through the evening, we were entertained by a very talented band, whose members were made up of Fellows of the College!

This month's issue of the Mirror focuses on the newly formed National University Polyclinics (NUP), with interviews of Dr David Tan on the newly opened Pioneer Polyclinic and their new models of care, and Dr Lew Yii Jen on the journey of the newly formed NUP. Professor Soo Khee Chee shares on cancer survivorship in patients in the National Cancer Centre, and how family medicine principles are key to cancer management and survival in the community.

Our Assistant Honorary Secretary Dr Lim Hui Ling is the College representative on the Medical Fee Benchmark Committee, and she is our advocate for the primary care sector. We will be sending out a survey to poll our GP members on the costs of their services in order to better represent you. Please keep a sharp lookout for it, and a reply would be a great plus for our fraternity!

Our College programme directors have all been working very hard, upgrading the courses to meet the needs of our members and young doctors. In this issue Dr Surajkumar will share with us the revamp of the College's MMed programme.

Last, but not least, Dr Rose Fok interviews the inaugural head of the nearly formed Department of Family Medicine, Yong Loo Lin School of Medicine. Read on to find out who it is and the new direction and initiatives for the new Family Medicine Department! Let's hope that such developments allow us to continue working towards enhancing the standing of family medicine, and earn the right to be finally recognised as a specialty in our fair nation.

All images courtesy of Adj Asst Prof Tan Tze Lee

CM

Forging Ahead — *Family Medicine Mission in NUP*

Interviewed by Dr Fok Wai Yee Rose, MCFP(S), Editor (Team A)

Dr Lew Yii Jen is Chief Executive Officer of the National University Polyclinics. A practicing family physician, Dr Lew obtained his Masters of Medicine, Family Medicine from the National University of Singapore and is a Fellow of the College of Family Physicians, Singapore, FCFP(S).

Dr Lew previously served as the Senior Director of Clinical Services at National Healthcare Group Polyclinics (NHGP) where he oversaw the clinical quality and patient safety matters of the nine polyclinics. He worked closely with the nurses, Care Managers, Allied Health Professionals and the operations staff in the team based comprehensive care of chronic patients, as well as coordinated with the regional hospitals in the integration of care of patients across different institutions. Dr Lew was also responsible for the overall coordination of the emergency preparedness of the polyclinics under NHGP in the areas of civil and national emergencies including pandemic situations.

He has served as a member of the Ministry of Health (MOH) Expert Committee on Immunisation, the MOH Inter-Agency Committee on Mental Health Integration, and the Agency of Integrated Care GP Advisory Panel.

Dr Lew is active in providing important medical covers for international events, the most recent being the setting up of medical centres for the SEA Games and Para Games in 2015. He is currently involved in the MOH Chronic Disease Management Programme Clinical Advisory Committee which advises on the latest medical condition to be CDP Medisave claimable.

RESTRUCTURING: AN OPPORTUNITY TO EFFECT INTEGRATED CARE

College Mirror (CM):
Thank you for taking time to share your thoughts with us in College Mirror. With current National healthcare transformation, what are the benefits and challenges you could see from the on-going re-clustering exercise?

Dr Lew Yii Jen (LYJ):
The key opportunities lie in being able to develop and strengthen primary care to enable our population in the West to receive quality, integrated and seamless care in the community and closer to their homes.

Dr Lew Yii Jen

Image courtesy of Dr Lew Yii Jen

With this re-clustering, NUP is in a good position to leverage on the combined strengths of the clinicians and management staff who come from the different institutions in NUHS. I am working on the cross-sharing of ideas and best practices, and developing NUP into an integrated and relationship-based primary care network that plays a key role in the community.

My focus will be on ensuring NUP is aligned with the push for primary care in Singapore; both private and public, to strengthen, grow and better integrate as "One Primary Care System".

I would like all NUP staff to continue to follow the time tested fundamental principles of Family Medicine and be committed to providing primary care that is accessible, comprehensive and coordinated.

POSITIVE RE-CLUSTERING EXPERIENCE

CM:
How would the re-clustering exercise bring about positive patient experience and outcome?

LYJ:
Over the years of working as a Family Physician at NHGP, I have come to realise the importance of delivering care on a team-based approach. This approach is especially effective in the care of chronic patients as regular and consistent follow-ups can be done by our family physicians, care managers and allied health professionals according to the specific needs of this group of patients.

Currently, I am getting more of our chronic patients empanelled into care teams. With this, it means that the same group of family physicians are able to follow through with the patients and become familiar with their health conditions. This enables the care teams to build stronger relationships with their patients and enhance patient engagement.

I will continue to drive and improve this team-based approach at NUP and patients can be assured of receiving care that is coordinated and seamless, thereby improving their health outcomes and satisfaction.

PREVENTIVE HEALTH & COMMUNITY WELL-BEING

CM:
With greater focus on preventive health and community well-being, what are the current gaps that you see as priority to address?

LYJ:
Singapore faces the challenges in meeting the needs of an ageing population, rising chronic disease burden, and fragmentation of care across the health system. Primary care has always been and will continue to be the first line of care for the public. As a result, the demands on primary care in terms of volume and complexity will correspondingly grow in the coming years. We will therefore need to transform the way we organise and manage primary care so that we can better meet these emerging needs.

With an aging population, it is also timely that NUP works together with MOH, AIC as well as other institutions within the NUHS to look into mental health and dementia. We aim to adopt a specialist-led multi-disciplinary team approach when caring for patients with mental health conditions.

We will also be looking to see how to better partner our community partners. By developing care beyond polyclinic walls, our patients will enjoy greater convenience and access to more healthcare options. NUP will be partnering neighbouring GPs and FMCs (eg. Keat Hong and Frontier FMC), as well as the Primary Care Networks (in Bukit Panjang) to drive community outreach programmes on chronic management and health screening initiatives.

INTEGRATING COMMUNITY PARTNERS

CM:
In your Integrative & Community Care Programs working with partners of the Regional Health System, what are the value propositions that would incentivize your partners to make the necessary change? Can you share learning points on Primary Care Network and other programs?

LYJ:
The focal point of such partnerships is about harnessing each other's strength to bring about better care for our patients. With like-minded partners, it will not be difficult to discuss the necessary changes that we as healthcare providers will need to make in order to provide patient-centric care. Having clear objectives and outcomes that are beneficial to the system as a whole and patients are essential in the process of discussion.

Through our journey of engaging patients to refer them to our PCN or FMC partners, we have learnt that familiarity with a healthcare provider is an important contributing factor towards patients' willingness to be referred. As such, by increasing patients' knowledge and correcting misconceptions about PCN/FMC partners it can help patients be more willing to be referred. Having PCN/FMC care facilitators located in our polyclinics to explain and facilitate the referral and even having their doctors in our clinics to see patients' helps in increasing the overall number of referral cases.

NAVIGATION OF CARE

CM:
How could the re-clustering exercise help rationalize and simplify complex care processes to facilitate a more seamless patient care journey?

LYJ:
All the polyclinics in NUP are already working closely with the respective departments in National University Hospital and Ng Teng Fong General Hospital for the coordinated process of patient referrals from the polyclinics to the hospitals, and from the hospitals back to the polyclinics for follow-up. Being part of NUHS will also enable the entire healthcare cluster to deliver more integrated, patient-centric and comprehensive care to the patient.

For example, the use of common IT platforms such as the National Electronic Health Records, where information such as patients' discharge summaries from hospitals, their blood test results and medications, are stored and shared, allows doctors to better understand what the patient has gone through in different institutions. Looking ahead, we will work even closer with the various healthcare partners in the new NUHS for better integration of care across primary care to tertiary care. By developing care beyond polyclinic walls, our patients enjoy greater convenience and access to more healthcare options.

TRAINING & EDUCATION: ARE OUR COMMUNITY PARTNERS READY TO PROVIDE ENHANCED PRIMARY CARE?

The College of Family Physicians have called on GPs and Primary Care to level up their knowledge and sharpen their clinical skills. This will ensure the quality of the trusted Family Physician.

CM:
What additional training and advance medical education are needed to help the family physicians to be better equipped for this new role?

LYJ:
NUP strives to be a training centre for future-ready family physicians for the community. As the population ages, areas

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(continued from Page 15: Forging Ahead - Family Medicine Mission in NUP)

such as cardiovascular risks, geriatrics and mental health become increasingly important. NUP is planning to train more family physicians in the assessment and screening of mental conditions for the community. We are working closely with the three local medical schools to train the undergraduates. Likewise, we are preparing for the development of more post-graduate doctors to become proficient Family Physicians for the community.

PATIENTS' DEMAND FOR HIGHER LEVEL OF SERVICES

CM:
With the evolving integrated healthcare services, how could we work to improve the health literacy of the population and optimize health service utilization?

LYJ:
As a key member of Singapore's primary care sector, polyclinics play a crucial role in meeting the growing and changing health care needs of the population. We want to work with our patients and caregivers towards self-care, monitoring and management of their medical conditions. Health literacy is an important topic to enable patient empowerment and engagement. We have been working with Health Promotion Board, community services and the NUHS institutions to derive simple and user friendly health education materials for our patients.
We will also need to continue to closely engage our patients and their caregivers, so that they are empowered to take better care of themselves and be more responsible for their own health.

At the same time, we need to coordinate well with GP partners as well as other community health and social care providers to ensure the wellbeing of the community we serve. We can do so by working through the cluster RHS' to further review and enhance current health screen programmes and refer at-risk or diagnosed patients for follow-up and also by partnering GPs, FMCs and PCNs to drive community outreach programmes on chronic management and health screening initiatives to the residents in the areas we serve.

CM

Pioneering Primary Care *in the West*

by Dr David Tan, Head of Pioneer Polyclinic
Interviewed by Dr Fok Wai Yee Rose, MCFP(S), Editor (Team A)

Dr David Tan

College Mirror (CM):
We understand that Pioneer Polyclinic is embarking on a new model of care - "Teamlet based care": can you share what it involves?

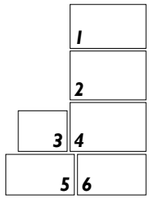
Dr David Tan (DT):
Actually, team-based care is just one of the components of this new model of care that we have gone into. Borrowing from the 10 building blocks of high-performing primary care by Bodenheimer et al *(http://www.annfammed.org/content/12/2/166.full)*, there are quite a few steps that we have embarked on over the years including empanelment of our patients into teamlets which comprise doctors, nurses and care coordinators, supported by non-clinicians such as pharmacists, dieticians, psychologists, financial counsellors and medical social workers. Together, these teamlets use data-driven improvement to track their panels' clinical and operational indicators. Through this, the hope is that we can better achieve some of the other building blocks such as patient-team partnership, population management and continuity of care.

CM:
How does it differ from our usual care at the polyclinics? What are the benefits and limitations? Does this model require more resources?

DT:
Many of the polyclinics are already going into this new model of care, with all the NUP clinics previously under NHGP having started at least a teamlet in each clinic. What's different in Pioneer is that all our chronic patients and patients who require continuity of care will be empanelled into a teamlet.

The benefits of this teamlet based care are aplenty, including:
- building of relationships within teamlet members, and with their patients
- better continuity of care
- support for non-clinicians to practice at the top of their license

CM:
Are there any particular target groups like the elderly?



1 *- The ribbon cutting ceremony at the official opening of Pioneer Polyclinic. (From left) Dr Lew Yii Jen, Mr Cedric Foo, Prof John Eu-Li Wong, Minister for Health Gan Kim Yong, Mr Richard Lim, Mr Patrick Tay, Mr Chua Song Khim, Dr David Tan*

2 *- Unveiling the community art mural in the background (From left) Dr Lew Yii Jen, Mr Cedric Foo, Minister for Health Gan Kim Yong, Mr Patrick Tay, Dr David Tan*

3 *- Allowing kids to participate in work experiences like that of a dietician, pharmacist or doctor.*

4, 5, 6 *- Community groups - (from top: Pioneer Constituency, Boon Lay Constituency and Jurong West Primary School) - coming together to mould personalised clay pieces for the wall mural.*

All images courtesy of Dr David Tan

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(continued from Page 17: Pioneering Primary Care in the West)

DT:
We are empanelling all patients who require continuity of care, such as those with chronic conditions such as Diabetes, Hypertension, Asthma and COPD.

CM:
Do you have previous experiences in other Polyclinics? What are the results?

DT:
Yes, we have been analysing results of patients being followed up by the teamlets compared to those that were not, and have found improvement in their clinical indicators (such as HbA1c) and uptake of preventive health screening (such as DRP/DFS uptake, MMG, Pap).

CM:
Does Pioneer Polyclinic engage surrounding healthcare providers like GPs, FMC, Medical Groups, nursing homes etc? Any plans like GP nearby, CMEs, engagement like "meet-the-GPs sessions" etc?

DT:
Yes. The management team of Pioneer Polyclinic has been engaging the GPs around the area early on from the stage of the clinic design and will continue to do so in the coming years.

CM:
How does Pioneer Polyclinic intend to integrate care with the acute hospitals so as to facilitate right siting of patients from hospital to community?

DT:
Being part of the NUHS family, this provides more opportunities to collaborate with the hospitals to better manage our patients together.

CM:
The Pioneer Polyclinic is impressive with colour codes, can you share what they mean?

DT:
Being the first polyclinic in Singapore to go beyond 4 levels (we're 7 storeys high!), the team designed the clinic with the patient in mind, hoping to reduce patient movement as much as possible. Hence, services such as phlebotomy services have been decentralised to the teamlet floors, meaning that patients should be able to receive most of their care on the same floor. The floors have been colour-coded according to different nature themes, so that patients can identify with their own floor colour over time. This also allows the staff to have a sense of belonging to their 'floor'.

CM

Advancing Academic Family Medicine *in NUHS and Beyond ...*

Interviewed by Dr Fok Wai Yee Rose, MCFP(S), Editor (Team A)

Professor Doris Young
MBBS (Melb) MD (Melb) FRACGP

Doris Young graduated from Faculty of Medicine, University of Melbourne and completed Family Medicine training in Australia. Over the last 35 years, Doris has been involved extensively in educating and training medical students, registrars, general practitioners and other health professionals in adolescent medicine, general practice and primary care research. Over the last 10 years, she has been actively building General Practice /Family Medicine education and research capacity in Hong Kong and in China.

Doris Young has published widely in the area of General Practice integration models with the wider health care system and her research focussed on trialling innovative models of care in the primary care setting to improve health outcomes for people with chronic diseases in culturally and linguistically diverse and disadvantaged communities.

Doris moved to Singapore in January 2015 and in 2016 took up a part time role as research advisor to National Healthcare Group Polyclinics. She joined National University of Singapore January 2017 as Professor in the Division of Family Medicine.

On 1 Feb 2018, she was appointed the inaugural Head of a new Department of Family Medicine at NUHS.

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College Mirror (CM):
Can you share on the development of Family Medicine (FM) in other countries and "what works" and "what doesn't"?

Prof Doris Young (DY):
<u>What works?</u>
From my experience looking at countries where they have good health outcomes, good accessibility, good equity, those countries have a strong primary care system. This means that their patient's first port of call is the General Practitioner (GP) who is properly remunerated to provide evidence-based care to the community. These countries invest money in primary care and the community value their family doctor and they have trust their GPs to provide value-added care. In addition, their FM academic fraternity is a strong discipline that work together to deliver care strategically that is well aligned and this may take quite a lot of time to develop.

The most cost-effective healthcare system is where the majority of care is delivered in the community that is co-ordinated by well-trained Family doctors / GPs working with a multidisciplinary team and where the primary care system is well integrated with secondary and tertiary hospital care.

<u>What does not work?</u>
This is when family doctors don't look after a family/ population providing only episodic care that is not well integrated with the rest of the healthcare system. This encourages 'doctor-shopping' behaviour resulting in fragmented care. FM development also doesn't work in those countries where Family Medicine is not perceived as a specialty in its own right and not valued by their community including their government.

CM:
What is the funding model of primary care in Australia?

DY:
A. Paying GPs to manage patients
Currently, most primary care services like GP visits are funded through Medicare. GPs receive most of their remuneration through fee-for-service (FFS) payments, which is where the GP bills an amount for the provision of an individual service. Around 82% of GP services are bulk billed, meaning the GP directly bills Medicare for the patient visit rather than billing the patient.

But not all GP services are paid for in this way. A growing number involve 'blended payments', where as well as FFS, the GP receives an incentive payment as a 'reward' for providing an improved level of service. Practice incentive payments (PIP) are currently paid for a wide range of enhanced services such as the provision of after-hours care; teaching medical students managing patients with chronic conditions such as asthma or diabetes.

FFS and incentive payments make up the bulk of GP remuneration in Australia. But the rise of chronic diseases like diabetes has led to calls to reform this blended payment system in order to support more multidisciplinary team care, with alternative models such as capitation[2].

B. Paying GPs to train students
It took a 10-year journey from an honorary system "begging GPs to teach" to the current system whereby GPs receive remuneration for teaching students. It is never money making but to compensate them for time and income lost. In return these designated "teaching-GP clinics" have to undergo training and meet accreditation guidelines which raise the status of the GP clinic as a quality practice involved in student teaching.

Thus "teaching money" must follow the "teachers and the learners" and now in Australia, there are many very passionate GPs teachers who provide good role models and competent training for our residents and students.

CM:
How does the College of Family Physicians play a role to advance Family Medicine?

DY:
We need to see the "end product" then work backwards. The end product is to have a highly regarded GP who is respected by the community and recognised as a specialist in their own right, who receive proper remuneration and have good work life balance. The respect from the public is very important, that every person or family should have a family doctor. In Australia, 90% of the people have a general practitioner. In the UK, it is 100%[1]. Everyone should have a good GP who looks after them and their family members.

In order to produce high quality GPs/FPs, we need to expose the students early to Family Medicine, provide good role models and mentors, craft an interesting curriculum which will make family medicine residency attractive. We need every player to play their part to encourage more quality residents to choose family medicine as a speciality. The College of Family Physicians has a big role to raise the status and standards of FM as a specialist discipline, make it financially attractive and have a strong voice in the relevant healthcare decision making bodies to promote the value of having a robust primary care system in Singapore.

CM:
Is there any fundamental similarity and difference between Family Medicine and Specialist training and education?

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(continued from Page 19: Advancing Academic Family Medicine in NUHS and Beyond ...)

DY:
What is similar?
Family medicine is a speciality in its own right, just like cardiology or neurology etc. We also have our own core curriculum and skillsets that require training to reach competencies. CME is also crucial to maintain knowledge and skills adopting evidence based practices to improve health outcomes.

What is different?
Breadth and not depth of scope of practice is the focus of FM. In order to acquire skillsets in various disciplines, across multiple settings (e.g. GP, polyclinics, home care) FM doctors need to receive relevant training for their practice needs. The core curriculum cannot be too diffuse, but sets the standard to what is required to train family doctors to provide safe and unsupervised medical practice in the community.

CM:
Can you share on your experiences in teaching Family Medicine to under and post graduates?

DY:
From my experience working at University of Melbourne for the past 30 years teaching General Practice to medical students and residents, we need to expose undergraduates to General Practice early and also throughout the medical course so that they have an understanding of the role of GPs in the healthcare system. We need a defined curriculum to develop knowledge, skills and attitudes unique to general practice and these must then continue into residency training.

CM:
How can Family Medicine in NUHS develop as an academic Clinical Program?

DY:
It is very exciting for NUHS to have a stand-alone department of FM whose mission is to raise the academic standing of FM. To do this well we need to have more FM curriculum time throughout the five years of the course, recruit passionate teachers to deliver education using innovative technologies. We will also need to integrate undergraduates with post graduate residency training and develop continuing medical education so that everything we do has an evidence base to them.

The academic standing of FM is also measured by its success in research. I plan to set up a primary care research unit and bring together collaborators to develop research themes and answering research questions that arise from primary care perspectives. I hope to instil a research culture amongst the staff, the medical students, residents, and GPs and provide training for them to engage in research. Finally, in order to move towards delivering world class research I want to link up our GP researchers with FM / GP colleagues internationally as well as exposing our younger doctors to other primary care research experts.

CM:
What roles can Family Medicine play in a Specialist-centric restructured hospital?

DY:
In Singapore, some FM doctors already provide high quality clinical services in the areas of aged care and rehabilitation, especially in community hospitals. However, I see the added value of FM doctors in hospitals to focus on providing ambulatory care and establish a unique role in facilitating transitional and home care from hospital to the community. Ultimately FM doctors can also help to navigate care back to the patient's GP.

CM:
We are now at an exciting time for development of Family Medicine in Singapore. Our Minister of Health, Mr Gan Kim Yong explained that in the Healthcare 2020 Master Plan, we need to:

(i) move beyond hospital to the community;
(ii) move beyond quality to value; and
(iii) move beyond healthcare to health.

These 3 moves are critical in preparing us to meet our long-term healthcare needs in a sustainable manner. What do you think of these Singapore initiatives?

DY:
I think the move is timely, in particular the move from hospital care to the community.

Hospital to community
The most important criteria for the successful implementation is to select the right type of patients that can be appropriately shifted to the community. Many people after receiving acute and subacute care in hospitals and are now stable, can go back to the community to receive care. These can be shared medical care or social and community support care.

Quality to value
When a government invest so much money into the healthcare system, they want to know whether there is "value for money". I think this is important to quantify to avoid too much spending to get "quality" and yet you might not get the value of the dollar spent. Measuring this is important for an effective affordable healthcare system.

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Healthcare to health
Finally, this is obvious that we should not treat the sick too late or when they develop multiple advanced complications. We need to emphasize the importance of health promotion, self-management and staying healthy. This shift of the mind-set of the community to be more self-reliant and responsible to maintain their own health rather than merely depending on doctors and nurses to fix their problems. This revamped healthcare with a broad base in the community will then truly be good value for money!

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2. Explainer: Paying for GP Services
http://theconversation.com/new-funding-models-are-a-long-term-alternative-to-medicare-co-payments-35382

CM

Advocating Community Cancer Survivorship in NCCS

An interview on 26 October 2017 with Professor Soo Khee Chee, Senior Consultant and Director* of National Cancer Centre Singapore
Interviewed by Dr Fok Wai Yee Rose, MCFP(S), Editor (Team A)

DEFINING CANCER SURVIVORSHIP

College Mirror (CM):
What is Cancer Survivorship?

Prof Soo Khee Chee (PS):
As the cancer survivor transits from active treatment to recovery and wellness, care need changes and the care model should give priority to health promotion, disease prevention and management of chronic diseases.

This new model should be patient-centric and holistic, best sited in the community closer to patient's home, with our preferred partner being the primary care physician (PCP).

Professor Soo Khee Chee
Images courtesy of National Cancer Centre Singapore (NCCS)

CANCER AS A CHRONIC DISEASE

CM:
Being diagnosed with cancer is a life-changing experience and the survivor has to live with the fear of recurrence for the rest of their lives. Do you have advice for cancer survivors?

PS:
Accepting cancer to be a chronic disease is the cornerstone of transition from fear to temperance and they should be encouraged to optimise control of this new chronic disease. We need to reassure survivors of our commitments to train a wider base of PCP to better manage their cancer survivorship issues at the community level and this would increase patients' confidence in community cancer survivorship to take charge of their health.

NEED FOR COMMUNITY CANCER CARE

CM:
Why do we need Community Cancer Survivorship?

PS:
Headlines in Straits Times recently announced a sharp rise in breast and prostate cancers as a result of aging population, sedentary lifestyle and obesity. With more cancers, there are now more survivors as a result of better healthcare and improved supportive care.

Survivors are living longer and developing more comorbidities and remaining susceptible to treatment complications.

MODEL of NCCS COMMUNITY CANCER CARE

CM:
What model of community cancer care will NCCS adopt?

PS:
The American Society of Clinical Oncology recommends a shared care model, where the general practitioner co-manages with the oncologist on cancer survivor's post-treatment issues and this level of follow-up care should be dependent on provider and survivor preferences, and also the resources available in that country.

And why a shared care model is because randomized control trials conducted in the West have found that GP-based survivorship care was not inferior to oncologist-based care.

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(continued from Page 21: Advocating Community Cancer Survivorship in NCCS)

LEADING A MULTIDISCIPLINARY TEAM

CM:

Who should lead this Community Cancer Team?

PS:

The primary care physician with the broad-based training and skillsets of comprehensive, preventive and continuing care for individuals and families is well placed to lead the team. Their accessibility and long-term relationships with patients and families give them the advantage to influence health-seeking behaviours. However, they cannot do this alone and need strong support from community nursing, allied health partners and the expertise of tertiary care.

EDUCATION & TRAINING

CM:

How do you think NCCS should prepare for community cancer survivorship?

PS:

NCCS can initiate certified training to develop skill sets as well as partner with community PCP to engage and co-develop cancer survivorship care guidelines, care models, and new services. We need to recognize PCP as a designated care physician for cancer after completing a certificate of "competence" through post-graduate qualifications. Our training should be formalized by an academic centre and should be modular addressing oncologic emergencies, treatment-related toxicities and side effects, tumour specific relapse patterns, surveillance protocols, cancer genetics, preventive care, evidence-based screening and psychosocial needs.

With certified training, we hope to recognize our primary care partners as visiting specialists with privileges, easy access to labs and imaging, fast-track referrals back, and a care coordinator to ensure timely communication and seamless transition of care.

Figure 1. Proposed survivorship care model and required elements

COLLABORATION

CM:

Which community partners does NCCS plan to collaborate with to advance community cancer survivorship?

PS:

We hope to engage with the community PCP themselves (both private and polyclinics) and the education and training arms of both the College of Family Physicians Singapore as well as the Family Medicine Residency Faculty to better understand training needs and see how best to collaborate and support them.

SUSTAINABLE FUNDING

CM:

Cancer survivors need to cope with "out-of-pocket" payment to manage their surveillance and survivorship side effects and long-term toxicities of treatment. Is there a sustainable funding available to assist them?

PS:

We understand this important barrier and will work with stakeholders and initiate discussions to propose the inclusion of "Cancer as a Chronic Disease" in order to attract funding in CHAS portable health benefit card as well as other varieties of funding models.

FUTURE DIRECTIONS

CM:

What is the future for cancer survivorship?

PS:

The increasing burden of cancer will greatly impact the country's resources and healthcare needs thus the urgency to support community engagements, partnerships and collaborations, new models of care and sustainable funding. NCCS will provide the leadership to advance cancer survivorship in the community.

** Professor Soo has relinquished the appointment as Director of NCCS with effect from 26 November 2017, and is currently a Visiting Senior Consultant at NCCS.*

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Figure 1. Loh, W.J.K., Ng, T., Choo, S.P., … , Yee, A., Chan, A., Soo, K.C. Cancer Supportive and Survivorship Care in Singapore: Current Challenges and Future Outlook. Journal of Global Oncology, 2018

CM

Overcoming all odds and executing the impossible with College Secretariat…

all part and parcel of being the Executive Director

Interviewed by Dr Low Sher Guan Luke, FCFP(S), Hon. Treasurer, Chief Editor

Appreciation dinner for Dr Tham Tat Yean (third from left), together with the ExCo and immediate past president of CFPS, A/Prof Lee Kheng Hock (fourth from left).

President of CFPS, Adj Asst Prof Tan Tze Lee (left) presents a gift of appreciation to Dr Tham Tat Yean.

The success of College and her achievements were never achieved overnight, but over many generations of executive directors (ED) who have done good work, with strong support from the Secretariat! 2018 sees the hand over from Dr Tham Tat Yean (TTY) to Dr Jonathan Pang (JP). College Mirror (CM) goes undercover to uncover what makes both our good men tick, and what we can look forward to with this handing over of the baton!

CM touches base with Dr Tham first to know more about the man who served his term from 2014 – 2017.

College Mirror (CM):

Hi Dr Tham, you have done a lot for College during your term of office as executive director! Can we get you to share some of your contributions for the benefit of our readers?

Dr Tham Tat Yean (TTY):

I was ED for 4 years, from 1st January 2014 to 31st December 2017. I am humbled by the fact that my contribution as ED pales in comparison to my predecessors over the years – they are Lee Kheng Hock, Cheng Heng Lee and Jonathan Pang. I therefore do not think that I have done a lot.

In reality, I was merely building upon the good work and foundation that my predecessors had laid down. One of the key areas that I focused during my tenure was to revamp the human resources policy and staff career planning of our College Secretariat. Although College has a small secretariat, my view has always been that their role is particularly crucial in ensuring College's vision and mission are executed properly. College Council is made up of dedicated individuals who volunteer their time while the ED position is a part-time appointment. This means the success of College's operations depend greatly on how the Secretariat implements its tasks and activities with limited supervision. I believed strongly we needed a good core Secretariat team that is loyal, well trained and empowered to carry out College's mission. The other area that I spent some time reviewing was the policies and procedures in our Secretariat. As our operations grew in scale, these policies and procedures had to evolve to meet the changing business environment and needs of our organisation.

CM:

What were some of the challenges that you faced?

TTY:

The main challenge is that the Secretariat can be better led and managed by a full-time ED. Historically, our College EDs have been part-time appointments and that causes some constraints on the oversight and leadership of the Secretariat by the ED. Nevertheless, College has been able to mitigate this to a certain extent with a relatively well-organised Secretariat team.

CM:

Who were some of your better allies and how have they helped?

TTY:

College had a foundation of good working relationship with the Singapore Medical Association and the Academy of Medicine Singapore. This has led to a healthy collegiality between the Councils of the 3 professional bodies. During my tenure, I am also grateful that College had very fruitful and collaborative relationships with the Ministry of Health (MOH) and the Agency for Integrated Care (AIC).

(continued on Page 30)

Revisions in the MMed(FM) College Programme

by Dr S Suraj Kumar, FCFP(S), Honorary Secretary, 26th Council, College of Family Physicians Singapore

MMed Family Medicine (FM) College Programme is a structured training programme that trains an echelon of family physicians to be on par with specialists in other disciplines and to prepare them as future leaders in Family Medicine. This course is approved by the Ministry of Health, and is run by the College of Family Physicians Singapore.

The MMed(FM) College Programme will undergo some changes that will come into effect with the next course. The changes will enhance the programme structure making it more robust, enabling it to keep pace with the evolving changes in the MMed(FM) examination format.

Programme Extension

The current 12-month programme will be extended to 16 months and structured in the following manner:

- Academic Programme - July 2018 to June 2019
- Examination Preparatory Programme (New Extension) - July 2019 to October 2019

The extension was added in response to feedback from previous trainees and trainers that the structure was too short and compressed. There also appeared to be a 'let off' in intensity for trainees after the course ended officially in May for previous batches. The extension will hopefully address these issues. It will now allow a more sustained but yet gradual build-up of intensity in the preparation for the MMed examinations in November, with the Theory (MCQ) portion of the exam being conducted in July.

Changes in the Structure

The academic course itself is largely unchanged. It is designed for working doctors wishing to pursue further higher training in FM

(continued on the next page)

FAMILY PRACTICE SKILLS COURSE

The Extended Consultation

The College of Family Physicians Singapore would like to thank the Expert Panel for their contribution to the Family Practice Skills Course #72 on "The Extended Consultation", held on 20 & 21 January 2018.

Expert Panel:
A/Prof Cheong Pak Yean
A/Prof Goh Lee Gan

Chairperson:
Dr Jonathan Pang
Dr Wong Ming

(GDFM). The teaching sessions are conducted weekly in the evenings comprising tutorials, workshops, clinical bedside teaching and mock sessions with role play. These can be either centralised large group sessions or decentralised small group teaching with discussions and case based learning (see the table below). The log book of 40 cases examined during the viva examination and audit project are also unchanged. The only enhancement in the academic component will be additional mock sessions for the Theory (MCQ) portion of the MMed(FM) examination which be conducted in July. The rest of the main changes will be in the new extension preparatory programme but the progression from the academic component into the extension portion will be seamless.

	Components	Special Remarks
1.	Centralised large group teaching	• Tutorials, Workshops, Clinical and Mock Sessions • At least 75% attendance required
2.	Decentralised small group teaching	• Discussions, Mock Sessions • At least 75% attendance required
3.	Skills Courses	• To improve competence in various clinical skills • To enhance clinical and patient clerking skills • At least 75% attendance required
4.	Self-directed learning	• Learning through practice, homework assignments and on-line reading • Portfolio - based learning recorded in a logbook • The logbook forms part of the formative assessment
5.	Written Work	• 40 Cases – Submitted for the MMed examination • Audit Project – Assessed as part of the final formative assessment
6.	Preceptorship Sessions	• Observation of consultation by supervisors in the trainee's own practice setting • Two Sessions – Second session will be combined with the practice audit (below)
7.	Practice audit	• To assess the trainee's practice management standard

The MMed(FM) examination is now mainly consultation based. To better prepare for the MMed(FM) examination, the preparatory programme will focus on drilling and sharpening the trainees' approach for all stations in the examination, which are:

- Consultation
- Physical examination
- Viva – 40 cases
- Ethics
- OSCE slides

This segment will not only enable trainees to consolidate and review their knowledge and skills, thereby becoming better family physicians, it will have the added focus which is to prepare for the MMed examinations. The increase in mock sessions was also at the request of trainees and from consistent feedback. These sessions will serve to simulate examination conditions, which are not only important in the final honing of clinical skills but also in the mental preparation of trainees taking an intensive and demanding examination such as the Masters (FM). All in all, there will be more than a doubling of all such simulation sessions for the entire 16-month programme.

More than Just Examination Preparation

Although it may appear that the College Programme through its intensity, is primarily designed just to prepare for the MMed(FM) examinations, it is more than that. The MMed(Family Medicine) Examination in its current form mirrors what a family physician actually does and with diligent blue printing based on what the community needs, ensures that the relevant competencies are assessed objectively. If the examination is appropriate and rigorous, appropriate and rigorous training training would naturally follow.

In addition, trainees passing through the programme, become better trained family physicians, learning new skills and enhancing their existing ones. There is great emphasis on upholding the principles and practice of family medicine encompassing proper duty of care, ethics and professionalism and treating patients holistically with empathy and compassion. Through the long hours of learning, practice and preparation, these skills become ingrained in our trainees such that they become lifelong traits that are never lost long after the examinations are over.

CM

CFPS ACADEMIC ROADSHOW 2018

6 APRIL 2018 (FRIDAY) | 6.00PM
SGH ACADEMIA L2S3

REGISTRATION CLOSES ON
11 MAY 2018

VISIT **CFPS.ORG.SG**
FOR MORE DETAILS

GRADUATE DIPLOMA IN FAMILY MEDICINE - *Enhanced!*

GDFM

GDFM is a structured training certification programme jointly organised by College of Family Physicians Singapore (CFPS) and The Division of Graduate Medical Studies (DGMS), National University of Singapore (NUS).

GDFM is a 2-year comprehensive and structured training programme for primary care doctors. It consists of 8 Family Medicine Modular Courses (FMMC), 1 elective and 3 compulsory Family Practice Skills Course (FPSC), 3 Practice Management Courses and Clinical Revision Course (Mock Exam).

The aim is to train primary care doctors to practise family medicine at an enhanced level to meet the needs of the child, adolescent, adults and elderly.

Eligibility

Candidates must possess the following in order to be eligible to register for the GDFM programme:

1. A basic degree of the MBBS or equivalent qualification registered with the Singapore Medical Council (SMC)
2. Full or Conditional registration with SMC; temporary registered practitioners must support their applications with a letter of recommendation from their HOD. Provisional registration doctors are not eligible to apply.
3. Must have 1 full year of working experience in Singapore at point of course application.
4. Must fulfil CME requirements
5. Must hold a current and valid practicing certificate.
6. Must have 20 active clinical hours per week either at point of application or throughout the training before the GDFM examination. 2 years validity applied to the clinical hours. The relevant clinical postings are:
   a. General Medicine
   b. Emergency Medicine
   c. Polyclinics
   d. Community Hospital
   e. Paediatrics
   f. Geriatrics
   g. Primary Care

*For enquiries or details, please contact College Secretariat at **6223 0606** or email **gdfm@cfps.org.sg***

CERTIFICATE OF COMMUNITY HOSPITAL PRACTICE - *New!*

CHP

Certificate of Community Hospital Practice (CHP) is a new programme organised by College of Family Physicians Singapore (CFPS).

It is a structured training designed to train doctors to be able to provide care to patients in the community hospital at an enhanced level. The training consists of:

1. 80 clinical hours
2. Compulsory FPSC on Complex Care
3. Formative assessments
4. Summative assessments

Eligibility

Candidates must possess the following in order to be eligible to register for the CH programme:

1. Present trainees currently under GDFM programme or GDFM certificate holders
2. Full *or* conditional registration with the Singapore Medical Council (SMC). Temporary registered doctors must support their application with letter of recommendation from their Head of Department (HOD). Provisional registration doctors are not eligible to apply.
3. Must hold a current and valid practising license issued by Singapore Medical Council (SMC)
4. Must fulfill CME requirements.

*For enquiries or details, please contact College Secretariat at **6223 0606** or email **gdfm_ch@cfps.org.sg***

MASTER OF MEDICINE IN FAMILY MEDICINE

MMed(FM) College Programme

The MMed (FM) College Programme is a 16-month structured training programme tailored for GDFM graduates who wish to proceed to Masters level training. The course will consist of weekly evening sessions that comprise tutorials, workshops, clinical beside teaching and mock sessions with role play. This will involve both centralised large group and decentralised small group teaching. There will also be a preceptorship component and a practice audit. Trainees will find the practice audit useful in helping them formulate quality improvement processes to enhance patient care outcomes.

Clinical attachments for various specialties are designed to provide the breadth of exposure for trainees to acquire the requisite competencies to practise as FPs in the local context. Each trainee is attached to a supervisor assigned by CFPS.

Aims & Objectives

The aim of this course is to provide a comprehensive and structured training programme for doctors with at least 6 years' experience after graduation and have completed the 8 modules of the Family Medicine Modular Course (FMMC) to prepare them to sit for the MMed(FM) Examinations.

MASTER OF MEDICINE IN FAMILY MEDICINE (cont'd)

Eligibility

Registration with SMC	To have full or conditional registration with the Singapore Medical Council (SMC)
Training	The satisfactory completion of all 8 modules of the Family Medicine Modular Course not more than 5 years prior to completion OR Have attained MRCGP(UK)
Work Experience	At least six years of experience after graduation of which at least one year must be in a Family Medicine setting. Make up attachments may be required to make up for the shortfall in this experience
Clinical Work during Training	The trainee is required to be in current practice of 24 clinical hours per week, of which 8 must be in an approved Family Medicine setting
Clinical Inspection & Interview	This may be conducted when required to assess the suitability of the practice and candidate for MMed(FM) training

*For enquiries or details, please contact College Secretariat at **6223 0606** or email **mmed@cfps.org.sg***

FAMILY MEDICINE FELLOWSHIP PROGRAMME (ADVANCED SPECIALTY TRAINING IN FAMILY MEDICINE)

Fellowship [FCFP(S)] by Assessment

The Fellowship [FCFP(S)] by Assessment is awarded to candidates who successfully completes the 24-month Advanced Specialty Training (AST) programme in Family Medicine conducted by the College and passes the Fellowship Summative Exit Examination. The programme is offered to doctors who have successfully completed basic structured family medicine training in an approved training programme, namely the Master of Medicine (Family Medicine) [MMed(FM)] at the National University of Singapore or its equivalent.

The structured programme serves to enhance and complement the trainee's own sphere of clinical experience and practice. It consists of didactic lectures, small group discussion and presentations, workshops and seminars, direct supervision and self-directed learning.

Aims

The aims of the programme are to:

- Provide structured advanced directed and self-initiated learning
- Provide supervision and mentorship for the advanced clinical practice of family/community medicine
- Provide a framework for the education and research in the practice of family medicine

On attaining the Fellowship (FCFPS) by Assessment, the candidate will be able to function as a consultant in the following essential roles of a family physician:

1. Family Medicine Expert
2. Communicator
3. Collaborator
4. Manager
5. Health advocate
6. Scholar
7. Professional

Eligibility

Applicants must be an Associate or Ordinary Member of the College of Family Physicians Singapore.[1]

The trainee must fulfil the following entry requirements:

1) Professional
   - *Be a Collegiate Member of the College of Family Physicians Singapore.[2]*

2) Academic

   Route 1
   - Possess the MMed (Family Medicine), the MCGP (Singapore) or equivalent qualifications.

   OR

   Route 2
   - Possess MMed (Internal Medicine) or MRCP (UK) or equivalent internal medicine training and qualification, and GDFM with at least 6 months experience working in a family medicine practice setting of which at least 3 months must be in primary care within the last 3 years

   OR

   Route 3
   - Possess MRCGP(UK) or equivalent overseas family medicine training and qualification and GDFM.

Trainees going through Route 2 and Route 3 may enrol into the Fellowship programme during their final year of GDFM programme. They must obtain their GDFM certificate and must attain the award of Collegiate Membership by Assessment before they are qualified for the Fellowship Summative Assessment.

3) Clinical Practice
   - Currently in active clinical practice i.e. 24 clinical hours per week, of which 8 hours must be in a family medicine setting as defined by the College Constitution.
   a) Ambulatory care in the community
   b) Intermediate care in the community hospitals and rehabilitation centres
   c) Long term care in the nursing homes, residential care and home based care
   d) Hospice and home based end-stage diseases care
   e) Interface care which is care within acute hospitals in the interface with the other settings

4) Letter of Good standing
   - Submit a letter of good standing from a Fellow of the College of Family Physicians, Singapore together with the application form.

[1] Existing Non-Members can apply to be an Associate or Ordinary Member of the College of Family Physicians Singapore at the point of the programme application. Enrolment into the programme is subjected to the approval of the College Membership.

[2] The trainee will need to be a Collegiate Member of the College of Family Physicians Singapore before they are allowed to sit for the Summative Exit Examination.

Please refer to **http://cfps.org.sg/programmes/fellowship-programme-fcfps/** for the requirements for the Summative Exit Examination.

The trainee must apply and sit for the Summative Exit Assessment after completing the advanced specialty training programme and not later than 4 years from the year of enrolment into the programme. If the trainee does not successfully pass the Summative Exit Examination by then, he/she is expected to re-apply and restart the AST programme.

*For enquiries or details, please contact College Secretariat at **6223 0606** or email **programmes@cfps.org.sg***

Family Medicine Review Course 2018

Organised by:
Academy of Medicine, Chapter of Family Medicine Physicians &
College of Family Physicians Singapore

The Chapter of Family Medicine Physicians (FMP) of the Academy of Medicine Singapore (AMS), together with the College of Family Physicians Singapore, have co-organized the Family Medicine Review Course since its inception in 2016. The Course has been warmly received by participants, and we are proud to organize our third Course in 2018 as part of our celebration of World Family Doctors' Day.

Family doctors will play an ever-increasing role in our shift "Beyond Hospital to the Community" as our population ages. In line with MOH's vision of "One Singaporean, One Family Doctor", it is our desire to continue to support one another with the latest clinical updates and essential skills to cope complex scenarios in primary care. Experienced Family Physicians and Family Medicine trainees will find the plenary lectures in our 3rd Course to be highly relevant and useful.

We strongly encourage you to sign up for this 3rd Course. Join us in our journey as we continue to serve in our many different roles in the community!

A/Prof Lee Kheng Hock
Chairman
Family Medicine Chapter
Academy of Medicine

Adj Asst Prof Tan Tze Lee
President
College of Family
Physicians Singapore

Organising Committee:
Dr Wong Peng Yong, Andrew
Dr Boo Ying Ying, Alicia
Dr Aw Junjie
Dr Bansal Vivek
Dr Jiang Song'En, Jeffrey
Dr Kwan Shuyi, Charmaine
Dr Chong Wern Siew, Christopher
Dr Tan Wee Lit

Advisors:
A/Prof Lee Kheng Hock
Dr Chng Shih Kiat
Dr Lee Kwang How
Dr Kong Jing Wen
Dr Ng Lee Beng

We are delighted to invite you to the 3rd Family Medicine Review Course, jointly organised by the Chapter of Family Medicine Physicians (Academy of Medicine) and the College of Family Physicians Singapore, to be held on the afternoon of **19 May 2018 (Saturday)** at the **Health Promotion Board.**

This year, we aim to deliver the latest updates of evidence based practices in clinical medicine & patient-centred approaches in difficult ethical scenarios, and boost confidence in the management of various specialty domains in primary care.

The Family Medicine Review Course is designed to cater to help keep the experienced Family Physician abreast with the latest developments in Family Medicine practice, as well as assist the aspiring Family Medicine trainee or medical student learning and preparing for examinations.

We are honoured to have a line-up of eminent and distinguished faculty who are both locally and regionally renowned. They will deliver 2 plenary lectures as well as 4 parallel clinical tracks relevant to the practice of Family Medicine in Singapore today. These tracks include Ethics, Metabolic Medicine, Paediatrics, Gynaecology, Palliative Care & Dentistry.

The course coincides with World Family Doctor's Day (WFDD), and we look forward to seeing you at these important events on the Family Medicine calendar.

FM Review Course Organising Committee, FCFP(S) Batch 2017-2019

FAMILY MEDICINE REVIEW COURSE 2018

19 May 2018, Saturday 1.00pm – 5.30pm

Health Promotion Board (HPB)

3 Second Hospital Avenue, Singapore 168937

Registration slots are limited to the first **140** applicants

Categories & Fees	Early Bird Fees (before 28th Feb 2018)	Standard Fees
College Members / FAMS	S$25.00	S$35.00
Non-College Members / Non-FAMS	S$45.00	S$65.00

All prices stated are inclusive of 7% GST. Registration fees includes lunch & tea-break.
Cheque payment must be made payable to **College of Family Physicians Singapore**.

Closing date for registration is **15 April 2018** (Registration may close earlier once slots are full)
Track allocations are on a first come first served basis. CME points pending.

Venue	Auditorium/Function Room, HPB	
Time	Programme	
1300 to 1400	Lunch & Registration & Pharma-sponsored talk	
1400 to 1410	Opening address by President, College of Family Physicians Singapore Welcome address by Chairman, Chapter of Family Medicine Physicians, AMS	
Track	Plenary sessions	
Venue	Auditorium, HPB	
Time	Topic	
1410 to 1450	Ethical Dilemmas in Primary Care *Dr T Thirumoorthy*	
1450 to 1530	Approach to transaminitis and management of non-alcoholic fatty liver disease (NAFLD) *Dr George Goh*	
1530 to 1600	Tea Break	
Track	Gynecology & Dental	Paediatrics & Palliative
Venue	Auditorium/Lecture Room	Auditorium/Lecture Room
Time	Topic	Topic
1600 to 1640	Managing Menopause In Primary Care *Dr Ang Seng Bin*	Screen Time in Kids *Asst Prof Jennifer Kiing*
1640 to 1720	Common dental & oral mucosal issues in primary healthcare *A/Prof Catherine Hong*	Managing End-of-Life Symptoms In Primary Care *Dr Victoria Wong*
1720 to 1730	End	End

Family Medicine Review Course 2018

Name: Dr _____

MCR No.: _____ Email: _____

Contact: (HP) _____ Office: _____

I am a ☐ College Member
☐ Fellow, Academy of Medicine
I'd like to attend the following session:
☐ Gynecology & Dental
OR
☐ Pediatrics & Palliative

Please mail the completed form & cheque payment by **15 April 2018** to:
College of Family Physicians Singapore, 16 College Road #01-02, College of Medicine Building, Singapore 169854.
For further enquiries, please contact College Secretariat at 62230606 or **Fax**: 6222 0204.

(continued from Page 23: Overcoming all odds and executing the impossible with College Secretariat...)

With such a foundation, I am optimistic that the stage is set for more meaningful and collaborative discussions at the leadership and working level between College and the other stakeholders.

CM:
In your opinion, what will you like the incoming executive director to be able to achieve during his term of office?

TTY:
I have always believed that alignment and unity in vision of the professional bodies, policy makers and our public healthcare agencies are crucial in healthcare transformation. Moving forward, as primary care transformation takes on an even more crucial role in our country, the new ED would need to work closely with College Council and support its strategic initiatives. Besides implementing education courses and academic programmes for GPs and FPs, College is increasingly consulted by various stakeholders on a variety of primary care issues beyond education and training. As College Council respond to these issues and needs, the ED and secretariat will need to provide timely support and implementation behind the scenes.

I am confident that Dr Jonathan Pang, the incoming ED will do a great job. Jonathan was previously a College Council Member and Honorary Secretary and in fact has also served as ED as I had mentioned earlier. He is therefore well-equipped to lead the College Secretariat.

CM:
After your term as executive director, how else will you be contributing to College?

TTY:
Currently, I continue to serve in the College's FM CME Assessors' Board and her Administration and Human Resources Committee.

My ties with the Council leadership remain very strong. I will continue to provide feedback to its leadership on a variety of primary care issues. In my other professional and related roles, I am involved in primary care transformation planning activities. This means I will continue to look to College for its guidance and position on primary care matters.

CM:
College thanks you for all your efforts as ED, Dr Tham!

CM also spoke to Dr Pang as the new incoming ED.

CM:
Hi Dr Pang, you have been the executive director for College before, and are now back for another term of office. How is it like to step back into your old role? Does it feel the same as it did back then, or different?

Dr Jonathan Pang (JP):
It feels good to be back and being in a familiar environment. I also have a sense of deep responsibility to fulfil the expectations of the President and the new Council. Only 3 of the staff are still around when I last left. Quite a few new faces! But the office is still the same!

CM:
What do you hope to achieve during your term of office?

JP:
I hope to get to know the rest of the staff better and build on the good work done by Dr Tham. We are adding a new staff and hope everyone can get along and build up a good team spirit to ensure the work needed can be delivered across smoothly and effectively. I also hope that we can be of use and benefit all our members!

CM:
Who do you have to work closely with, as executive director?

JP:
The people that I need to work closely are Prof Goh as IFM Director and also Jennifer, Asst GM, to ensure all our staff are able to work well to deliver our courses and regular programmes without any hiccups, if possible.

CM:
Do you foresee any challenges ahead?

JP:
The main challenge are to maintain and develop further the team spirit and cohesiveness of the secretariat. The other main challenge is to help IFM develop the enhanced GDFM programme and get more suitable people on board to helm the various programmes and keep it sustainable. We must, of course, remain relevant and useful to our members to help them maintain their professional development as well as get enough CME points to renew their practising certificates.

CM:
Lastly on a personal note and not related to business, what is your hobby? Do surprise us a bit!

JP:
No real hobbies other than watching a little bit of serials, Korean or American on iPad before sleep. Have started doing some cycling on those shared bikes (e.g. Mobike) recently as a form of exercise, with my wife and son, late at night.

CM:
CM wishes you all the best in your new portfolio, Dr Pang!

■ CM

Family Practice Skills Course #73

Vaccinations in Adults

Sat, 26 May 2018: 2.00pm - 5.30pm
Sun, 27 May 2018: 2.00pm - 5.30pm

Health Promotion Board, Auditorium Level 7,
3 Second Hospital Avenue, Singapore 168937

TOPICS
Unit 1: Vaccination for Elderly
Unit 2: Pneumococcal Vaccination for Adults
Unit 3: Meningococcal and Travellers Vaccination
Unit 4: Adult Immunisation: Translating theory to practice
Unit 5: Dengue management in primary care and the role of vaccination in Singapore
Unit 6: Medical Ethics in the context of Vaccinations

WORKSHOPS
Day 1: 1. Pneumococcal Vaccination, in light of the new NAIS
2. Travellers Vaccination to Middle East
Day 2: 1. Travel Vaccines: A-Z of travel medicine in primary care
2. Adult Immunisation

SPEAKERS
Dr Wong Sin Yew
A/Prof Helen Oh
Dr Leong Hoe Nam
Dr Limin WiJaya
Prof Paul Tambyah
Dr Leong Choon Kit
A/Prof Goh Lee Gan

■ SEMINARS (2 Core FM CME points)
Seminar 1• Unit 1 - 3: Sat, 26 May (2.00pm - 4.00pm)
Seminar 2• Unit 4 - 6: Sun, 27 May (2.00pm - 4.00pm)

■ WORKSHOPS (1 Core FM CME point)
DAY 1, Sat, 26 May (4.30pm - 5.30pm)
DAY 2, Sun, 27 May (4.30pm - 5.30pm)

*Registration is on first-come-first-served basis.
Seats are limited.
Please register by 21 May 2018 to avoid disappointment.

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

This Family Practice Skills Course is sponsored by **Pfizer Pte Ltd. Singapore (Day 1)** and **Sanofi Aventis Singapore Pte Ltd. (Day 2)**, organised by **College of Family Physicians Singapore.**

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

REGISTRATION

FREE REGISTRATION for College Members!

Vaccinations in Adults
Please tick (✓) the appropriate boxes

	College Member	Non-Member
Seminar 1 (Sat)	☐ ~~$32.10~~ FREE	☐ $32.10
Seminar 2 (Sun)	☐ ~~$32.10~~ FREE	☐ $32.10
Workshop 1 (Sat)	☐ ~~$32.10~~ FREE	☐ $32.10
Workshop 2 (Sun)	☐ ~~$32.10~~ FREE	☐ $32.10
Distance Learning (MCQ Assessment)	☐ ~~$85.60~~ FREE	☐ $85.60

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

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

Cheque number: _____

Signature: _____

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

Name: Dr_____

MCR No: _____

(For GDFM Trainee only) Please indicate: _____ intake

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

_____

_____

_____ E-mail: _____

Tel: _____ Fax: _____

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

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

Or fax your registration form to: 6222 0204

Not all symptoms are physical

As a General Practitioner (GP), you are often the first point of contact for those who are unwell. Are you able to identify possible mental health issues and detect the early signs?

The Graduate Diploma in Mental Health (GDMH), jointly offered by IMH and the Division of Graduate Medical Studies, National University of Singapore, provides comprehensive and structured training in community psychiatry and counselling. It equips GPs and doctors with the knowledge and skills required to assess, identify and manage various psychiatric conditions and provide more holistic care to their patients.

At the end of the 12-month course, participants would be able to:

- Identify the various types of psychiatric disorders
- Be familiar with the principles of treatment approach for different psychiatric cases
- Apply assessment methodology to different mental health disorders
- Learn management skills and how to prescribe basic psychiatric medications

Graduate Diploma in Mental Health

Open for registration from 26th March to 2nd July 2018

Government subsidy is available (subject to terms and conditions)

For more information, please visit www.imh.com.sg/education. You may also contact:
Nirhana Binte Japar: 6389 2831 / nirhana_japar@imh.com.sg
Sharifah: 6389 2246 / sh_syed_zainuddin@imh.com.sg

Organised by:

INSTITUTE of MENTAL HEALTH
National Healthcare Group

NUS National University of Singapore