College of Family Physicians Singapore

The Singapore Family Physician

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Special Commemorative Issue

College of Family Physicians Singapore 50th Anniversary

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College of Family Physicians Singapore

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Foreword

Fifty Years On

Adj Assoc Prof Tan Tze Lee
President, 28th Council
College of Family Physicians Singapore

Fifty years ago, the College, under its previous name of College of General Practitioners Singapore, was inaugurated on 30 June 1971. In 2021, we will be celebrating the 50th anniversary of the College.

In the early days of Singapore's modern history, a group of determined general practitioners had a vision to advance the practice of Family Medicine. Formal training in Family Medicine (FM) leading to the membership of the College of General Practitioners Singapore (MCGP) diplomate examination commenced the following year, and in 1974, the Diploma was recognised by the Singapore Medical Council as an additional qualification. Over the past 50 years, the College has developed numerous postgraduate programmes to address the needs of our family doctors. Our mission is to ensure that Family Physicians in Singapore are well trained, so as to be empowered to provide good medical care for their patients in the context of the person, the family, and the community that they live in. Our trained family doctors can now be found serving in various settings, in primary care, in community hospitals, and even in general hospitals. Many are in leadership positions in our healthcare system, and all have played crucial roles in our fight against the COVID-19 pandemic, providing surveillance, early detection, and timely treatment.

We are indeed proud of the achievements of our family doctors over the past 50 years, and as a fraternity, the College looks forward to making even greater contributions to our healthcare services.

On 3 December 2021, the College held an event to celebrate our 50th anniversary. We were privileged to have Prime Minister Mr Lee Hsien Loong as our Guest-of-Honour. It was indeed a great honour for the College, and we are immensely grateful for his support.

The year 2021 also marks a year since the start of the COVID-19 pandemic, a year that has shaken the world to its core and pushed societies to their breaking point. During this crisis, the importance and central role of general practitioners and family physicians have been highlighted as never before. The public health preparedness clinics (PHPCs) have played and continue to play a pivotal role in surveillance, and are at the forefront of detecting potential cases of COVID-19.

As we celebrate this momentous occasion of the College's 50th Anniversary, let us also commemorate the important roles family doctors perform in Singapore, especially during these COVID times. May the College always stand united as one fraternity, helping each other to run the good race as we continue to contribute to Singapore's healthcare system.

Editorial

The Fifth Decade

Dr Chiang Shu Hui Grace
Honorary Editor, 28th Council
College of Family Physicians Singapore

2021 marks the 50th anniversary of the College of Family Physicians Singapore. Much has been achieved since the early pioneers in Family Medicine had the foresight to establish the College. Today, Family Medicine plays a prominent role in Singapore's healthcare system. Family Medicine has been recognised as the first and continuous line of care in the healthcare system.

With the developments and technological advances in medicine, the past five decades of Family Medicine have undergone an evolution largely in part due to the following: i) an ageing population; ii) increasing recognition of family medicine; iii) the practice of one discipline, many settings; iv) funding in primary care; and v) the evolution of medical communications. These will be briefly discussed in this article and expanded upon in subsequent articles in this issue.

AN AGEING POPULATION

An average Singaporean's life expectancy currently stands at 83.1 years; this is among the highest in the world.[1] This number is expected to increase further. By 2030, the percentage of Singaporeans aged 65 and above is expected to increase by 20 percent.[2] This increased lifespan implies that more Singaporeans will be living longer, increasing the chances of contracting chronic medical conditions, thus significantly increasing the healthcare needs of Singapore. To address these growing healthcare needs, the Ministry of Health implemented a Healthcare 2020 Masterplan to expand the healthcare infrastructure.[3] The Healthcare 2020 Masterplan aims to enhance the accessibility, affordability, and quality of healthcare to better meet the needs of Singaporeans. This calls for a greater emphasis on primary care. Family physicians will welcome the opportunity to serve the community.

FAMILY MEDICINE AT THE FOREFRONT – ONE DISCIPLINE, MANY SETTINGS

As Singapore's population ages and with an increasing prevalence of chronic diseases, family physicians are positioned and equipped to support a sustainable healthcare system. Family physicians can be the building blocks of the healthcare system. Anchored within the community, they are strategically placed to better monitor and manage their patient's medical condition before it escalates or develops complications. Family physicians provide affordable, accessible and quality care within the community, which in turn eases the pressure on hospital resources.[3] Trained family physicians effectively manage chronic diseases and practice across multiple settings: primary care settings (i.e., general practitioner clinics, polyclinics); intermediate care settings (i.e., community hospitals); and long-term care settings (i.e., nursing homes). In the decades to come, family physicians will continue to be a key and integral pillar of an integrated and sustainable healthcare system.

FUNDING IN PRIMARY CARE

With an increased emphasis on Primary Care, measures have been introduced to provide for more affordable primary care for Singaporeans.[3] For instance, the qualifying criteria of the Community Health Assist Scheme (CHAS) have been relaxed to increase the eligibility of Singaporeans to seek treatment at CHAS-registered general practitioners in the community. CHAS offers varying subsidy tiers to meet the needs of patients with different financial circumstances. Increased access to subsidised care may translate to early detection and better management of chronic disease, and avoidance of complications.

MEDICAL COMMUNICATIONS IN FAMILY MEDICINE

The ability to communicate effectively with patients and their families is foundational to family medicine. Skilful communication is key to providing good patient care. Prior to the 21st century, the doctor-patient relationship was predominantly paternalistic. Communication practices now actively seek to bridge the gap between the world of medicine and the personal experiences and needs of patients.[4] Skilful family physician communication characterised by partnership building, collaboration, social conversation, positive talk, and empathy for patients and family members are key influences on patient health beliefs, treatment adherence, and satisfaction with care.[5-7]

BEYOND 2021

Singapore and the world are changing, and family physicians are part of this change. Family physicians should be proud of their professional discipline. Just like the forefathers of the College, each family physician has an integral part to play in the fabric of Singapore's healthcare system and has an opportunity to create value. Family physicians can be effective advocates about key health issues and be change agents within the healthcare system. Through commitment to quality care and willingness to innovate, family physicians

ensure the health and well-being of their patients and communities.

May the discipline of family medicine in Singapore continue to be one that emphasises continuing and comprehensive care that spans across the life-course, encompassing all ages and disease entities, whilst integrating biological, clinical, and behavioural sciences.

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Congratulatory Messages

WONCA President, Professor Donald Li

Dear Prof Tan Tze Lee,

On behalf of the World Organization of Family Doctors (WONCA), as President, it gives me great pleasure to extend my heartfelt congratulations to the College of Family Physicians Singapore on your 50th Anniversary.

Over the past 50 years, the College of Family Physicians Singapore has moved from strength to strength since its inception. I am delighted to have witnessed its achievements over the past 30 years. Sharing the same vision as WONCA, the College is committed to providing training to future generations of family doctors, maintaining the highest standard of patient care in Singapore. The practice of Family Medicine is the best assurance of quality primary care. The College of Family Physicians Singapore has ensured strict adherence to clinical and administrative standards demanded of the speciality and has provided continuous medical education and professional development as well as increased awareness about family medicine to the public.

I wish to take this opportunity to commend the important work done in training family doctors and propagating the speciality by the founders, forefathers, leaders, and all the fellows and members of the College of Family Physicians Singapore.

Once again, may I congratulate the College on its remarkable accomplishment. On this auspicious occasion, I wish the College continued success in the years ahead. Congratulations and Happy Anniversary!

With warmest regards,

Prof Donald Li
President of World Organization of Family Doctors (WONCA)

Congratulatory Messages

WONCA Europe

Dear Colleagues,

On behalf of WONCA Europe, please accept our heartiest congratulations on the occasion of 50 years of foundation of the College of Family Physicians Singapore and our wishes of great success to the academic society of your esteemed institution.

We warmly congratulate the staff and physicians at College of Family Physicians Singapore for reaching 50 years of patient-centred care in the community. We understand the value and importance of family medicine and this milestone is a wonderful opportunity to highlight the impact that community-based family medicine can have on its population.

We appreciate and feel with you in the current difficult situation, being faced with a pandemic and we wish you strength to overcome these difficult times.

Once again, we send our congratulations on this important anniversary and our well-wishes to continue for many more decades to come.

Sincerely,

Prof Dr Shlomo Vinker
WONCA Europe President

Prof Dr Eva Hummers
WONCA Europe
Honorary Secretary

Congratulatory Messages

WONCA APR President, Professor Meng-Chih Li

Dear President Tan and Colleagues of CFPS,

On behalf of Wonca Asia Pacific Region, I would like to congratulate you warmly on the occasion of the 50th Anniversary of the College of Family Physicians Singapore. The College, which was established in 1971, has dedicated itself to promoting and implementing the values, ideals, and services of medicine for Singaporeans for half a century, and has become one of the role models in education and service in family medicine internationally.

The past year has been a challenging time for family physicians the world over. However, in spite of COVID-19, CFPS colleagues have stepped up to the challenges of the pandemic, and have continued to work tirelessly to play a central role in the delivery of personal, comprehensive, and continuing healthcare for all. We admire and respect Singapore's achievements in controlling the pandemic, and recognise the great contributions made by CFPS colleagues along with other healthcare providers.

Happy Anniversary and keep well.

Sincerely yours,

Prof Meng-Chih Lee
MD, PhD, MPH
President, 2016-2021, Wonca APR
Taichung, Taiwan

Congratulatory Messages

Member Organisations from WONCA APR

RACGP

Royal Australian College *of* General Practitioners

Dear Adj Assoc Prof Tan Tze Lee and CFPS Board Members,

On the Occasion of the Singapore College of Family Physicians 50th anniversary

The Royal Australian College of General Practitioners its Board and Members, Council of Censors and RACGP International passes on its congratulations as 2021 commemorates the 50th Anniversary of the establishment of the Singapore College of Family Physicians. On this auspicious occasion it is appropriate to reflect on the initial group of family physicians in Singapore who formed the institution to enshrine and promote the values and ideals of family medicine. These visionary family physicians who set the initial Colleges Mission to advance the Art and Science of Medicine, put teaching and learning first for those doctors who seek to establish themselves in high quality Family Practice. This vision continues to support and benefit the Singaporean communities in which Family Physicians work. The SCFP and the RACGP have had close ties over many decades and there has been a fertile history of leaders of both Colleges meeting to further the ideals of Family Medicine and exchange ideas about quality Family Practice and the future developments that our colleges aspire to within our region and globally through WONCA.

The significance of celebrating anniversaries and reviewing history is a tradition of reflection and quality improvement. For instance, it is very difficult to forge a path forward without knowing what journeys have already been undertaken. As an example, by 2003 the SCFP as part of its Family Physician training and certification, was already putting together online video based clinical encounters. This activity is something that demonstrates the progressive nature of its Board and Council of education. Sometimes, the past is the only light with which to truly illuminate the future. In this era of increasing technological learning and pandemic enforced social distancing these skills are truly adaptable to the future.

The RACGP hopes that our educational and collegiate ties will enhance and continue well into the future as we support the ideal of Family Medicine, General Practice. We welcome and congratulate the continued support of our connected communities as we move through this difficult time on our small planet. As we are both currently residing under the same mid-autumn full moon it would be fitting to close with a suitable mid-autumn greeting.

Wishing both our colleges a long life to share the graceful moonlight, though hundreds of miles apart.

Yours sincerely

Dr Karen Price
President, RACGP

Dr Tess van Duuren
Censor in Chief, RACGP

Dr Mark Miller
Chairman International, RACGP

Congratulatory Messages

Member Organisations from WONCA APR

香港家庭醫學學院
The Hong Kong College of Family Physicians

On behalf of the Hong Kong College of Family Physicians, I would like to send our warmest congratulations to the College of Family Physicians Singapore in celebrating the 50th Anniversary of establishment.

Over the past 50 years, the College of Family Physicians Singapore has made many significant contributions to advance Family Medicine in Singapore through her mission to advance the Art and Science of medical practice by upgrading and up-skilling doctors through the setting of standards as well as through education and advocacy.

We look forward to closer association and collaboration between the College of Family Physicians Singapore and the Hong Kong College of Family Physicians in the ongoing promotion and enhancement of Family Medicine training, postgraduate medical education, research and development in the Asia Pacific Region.

Many congratulations once again to the College of Family Physicians Singapore for your 50th Anniversary and wishing you many prosperous and successful years ahead!

Dr David VK Chao
President
The Hong Kong College of Family Physicians

一般社団法人
日本プライマリ・ケア連合学会
Japan Primary Care Association

Dear President-Professor Tan Tze Lee and respected colleagues in Singapore

In celebration of the 50th anniversary of The College of Family Physicians Singapore (SFP), I would like to send you my heartiest congratulations on behalf of Japan Primary Care Association.

The great advancement of family medicine in Singapore is the solid proof of SFP's constant and assiduous efforts in this field.

We express our respect for Singaporean family physicians who are doing their best to maintain the people's health through their practice and vaccination, even within the coronavirus crisis.

Moreover, SFP has been making an unselfish contribution to family medicine in the Asia and Pacific region all these years.

I appreciated giving me the opportunity to observe your OSCE examinations in 2019, it was very systematic and very impressed.

We would like to thank the academic exchanges at WONCA APR and hope that we can continue to learn together, even though it is a difficult time due to the outbreak of COVID-19.

I wish you all the best in your another 50 years' endeavors.

With warmest regards,

Tesshu Kusaba, MD
President
Japan Primary Care Association

Congratulatory Messages

Member Organisations from WONCA APR

Dear Prof. Lee,

Greetings!

Here is the message as promised on the occasion of your organization's anniversary.

Congratulations and more power!

Dr. Marivic,

Family Medicine of the Future: "The Next 50 Years"

Family physicians are both at the forefront of health care delivery and will continue to do so with the shift to Universal Health Care. We all have the responsibility to retool ourselves to keep up with the swift changes in the healthcare ecosystem, including adapting to the challenges from unexpected and unprecedented situations like the COVID pandemic.

Our organizations' efforts will be central and vital to shaping the future of Family Medicine. We must intensify our efforts to encourage the most promising medical students to choose careers in Family Medicine. Family Medicine residencies must reinvent and innovate programs to meet people's needs and the changes in an evolving health system. Family Physicians are called upon to lead this change. We will continue to be the largest and most widely distributed group of physicians while working in teams with patients and other allied health professionals.These collaborative engagements will equip family physicians and our allies in and outside of medicine who care about building a robust and diverse primary care workforce to inspire, support and encourage advocacies for policies and standards that will advance primary care.

On behalf of the Philippine Academy of Family Physicians National Board of Trustees and the entire membership of Filipino Family Physicians, I extend our best wishes for a successful convention. I am certain that this gathering will be an opportunity to foster solidarity among Family Physicians apart from providing the latest updates in our discipline. May you continue to be prime movers in promoting, protecting, and enhancing the health and well-being of patients, their families, and the communities under your care. After this pandemic, we hope to forge together robust partnerships for a healthier region in this part of the world.

Congratulations to the College of Family Physicians Singapore!

Maria Victoria Concepcion P Cruz, MD, DFM, FPAFP
National President
Philippine Academy of Family Physicians, Inc.

College of Family Physicians Singapore – 50th Anniversary Celebration

Dr Chiang Shu Hui Grace
Honorary Editor, 28th Council
College of Family Physicians Singapore

Dr Wee Wei Chieh Nelson
Council Member, 28th Council
College of Family Physicians Singapore

On 3rd December 2021, the College of Family Physicians Singapore (CFPS) celebrated its 50th Anniversary. The College's anniversary celebration was one for the history books. Not only was it the College's Golden Anniversary, due to the COVID-19 pandemic, it was the first time the College's anniversary celebration was held virtually over Zoom.

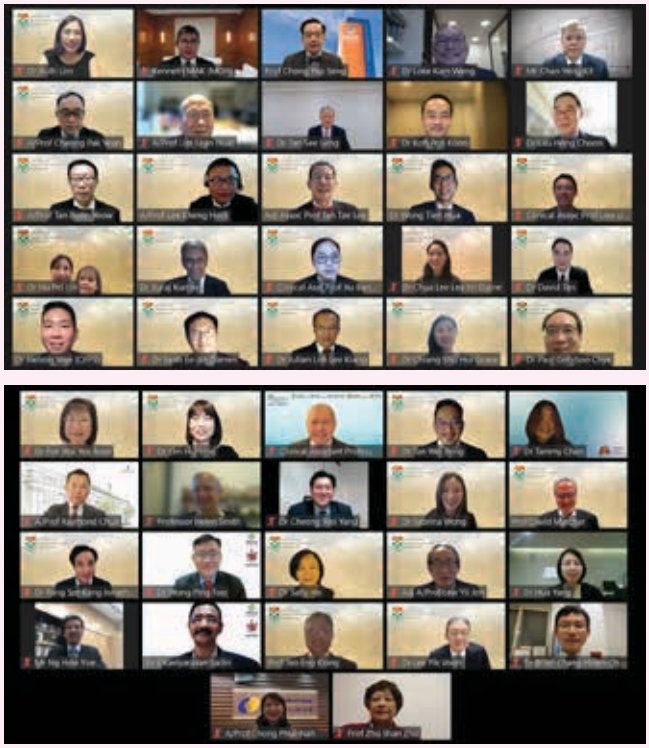
The evening's celebration saw myriad honoured guests from WONCA Asia Pacific Region (Malaysia, Taiwan, and China), the Ministry of Health, Singapore Medical Council, Academy of Medicine Singapore, Singapore's three medical schools (Duke-NUS, Lee Kong Chian School of Medicine, and NUS) and healthcare clusters (National University Polyclinics, National Healthcare Group Polyclinics, and SingHealth Polyclinics), and members of the fraternity gathered to celebrate the history and achievements of the College and appreciate the contributions of the many family physicians past and present. The event commenced with a welcome address by CFPS President, Adjunct Associate Professor Tan Tze Lee.

The College was extremely privileged to have Prime Minister Lee Hsien Loong grace the event as the Guest-of-Honour. To commemorate this momentous occasion, the College presented PM Lee with a calligraphy scroll at the Istana. Though PM Lee was unable to join the celebrations in person, he prepared a video message for the event wherein he highlighted the commitment and professionalism that family physicians have displayed during the COVID-19 pandemic. PM Lee thanked family physicians for their services beyond the pandemic in helping to keep hospitalisation rates low. He also addressed the need for Singapore to continue to build up primary care as the foundation of its healthcare system.

The College was also honoured to have immediate Past President of CFPS, Associate Professor Lee Kheng Hock deliver a speech on "A Short History of CFPS". He aptly described the history of the College as the history of family medicine in Singapore. As A/Prof Lee revisited the College's rich history, he called for College members to learn from the trends of the College's history and their consequences, so as to continue to improve upon the standards and practice of family medicine.

The evening's highlight also marked the delivery of the Sreenivasan Oration entitled "Family Medicine for the Next 50 years", by Dr Tan See Leng, Minister for Manpower and Second Minister for Trade and Industry. CPFS Honorary Secretary, Dr S Suraj Kumar delivered the citation for the Sreenivasan Orator. In his oration, Minister Tan See Leng articulated the need for the community of family physicians to respond to the healthcare challenges of the next 50 years and how the fraternity would be able to do so. He urged family physicians to transform care to meet the demands of Singapore's rapidly changing demographics, embrace technology to augment care, prepare ahead to better meet the threat of future pandemics, and redesign family medicine education and training as the role of family physicians evolves.

The evening's celebration concluded with a closing address by Dr Wong Tien Hua, Vice President of CFPS. The College would like to thank all who have contributed towards making the College's 50th Anniversary celebration a truly meaningful and memorable one.



College of Family Physicians Singapore, 28th Council and Distinguished Guests

Keynote Address

50th Anniversary Celebration

Adjunct Associate Professor Tan Tze Lee
President, 28th Council
College of Family Physicians Singapore

Good evening!

Prime Minister Mr Lee Hsien Loong, Minister of Manpower Dr Tan See Leng, distinguished guests and members, ladies and gentlemen,

It is my greatest honour to welcome you to our 50th anniversary celebration! We are very privileged to have PM Lee grace our event this evening, and have Minister of Manpower Dr Tan See Leng delivering the Sreenivasan Oration for 2021.

2021 has been a year that we will remember for generations to come. This is the second year of the COVID-19 pandemic, and our community has had a roller coaster ride as we continue to battle the virus. We have been blessed by a government that has helped steer the good ship Singapore through these stormy unknown seas, and as we plumb the depths of these waters, we can be confident that our leadership has always planned first and foremost with the welfare of the people in mind. We have achieved vaccination rates of more than 85 percent! If we account for children under the age of 12 who are at present ineligible for vaccination, this represents in excess of 95 percent of the eligible population! Do the people of Singapore trust the government and their doctors? Absolutely!

2021 marks the 50th year since the College was inaugurated in 1971. Fifty years is a significant achievement. A half-century, two score and ten years, golden anniversaries; such momentous events are celebrated the world over. They mark a waypoint in an organisation's journey and give us an opportunity to reflect on the achievements of the past while looking forward to the future.

2021 is the second year of our fight against COVID-19. In the early days of the pandemic in January 2020, the College stepped up and provided much-needed support with a hotline for our general practitioners (GPs) on the frontline. This was manned by our council members over the Chinese New Year weekend and proved to be a godsend for many of our GP colleagues who needed advice and a listening ear. The activation of Public Health Preparedness Clinics (PHPCs) was timely in getting the PHPCs the backup and equipment they needed, and the College was strongly supportive of this. The College organised a good number of town halls and webinars for our GPs who were thirsty for information regarding this new disease, as well as resilience webinars to help our colleagues weather the storms of working in pandemic times. These resilience webinars proved to be very popular and attracted both GPs and specialists alike. To this day, the College is committed to supporting our members and GPs through this crisis.

This 50th anniversary has been an opportunity to showcase what our doctors have been able to achieve over the years. Through the efforts of our council member Dr Tan Wei Beng, the College was able to work closely with SingPost on a series of stamps that showcase the contributions and achievements of our family doctors over the last 50 years. This series of six stamps depict our family doctors in various settings; in acute medicine, chronic disease management, community hospital care, pandemic response, medical education, and research and health promotion, and show the breadth and depth of family medicine. We are indeed very proud of these milestones and achievements and look forward to making even more contributions to the development of our healthcare services.

Just six years after Singapore was founded in 1965, the College was inaugurated on 30 June 1971. This was the culmination of the efforts of a determined group of visionary general practitioners (GPs), who foresaw the need for Singapore to better train GPs to address the healthcare needs of the nation. Looking back, the form and direction the College took was in many ways serendipitous. A chance meeting in a Sydney backyard with Dr Richard Geeves of the RACGP and Dr Wong Heck Sing resulted in a series of meetings that led to the "founding of our College."[1] Our fledgling College received much advice and goodwill from the Royal Australian College of General Practitioners, and this close relationship continues to this day. These first steps eventually led to the "recognition of general practice as a separate discipline".[2]

The College organised the first local postgraduate qualification in general practice, with the inaugural College Diplomate examination being held in 1972.[2] The external examiners were Professor Wes Fabb and Dr Richard Bank Geeves of the RACGP.[1] In those early days, candidates' own

practices were their "training ground" and examination preparations were run by specialist colleagues.

In 1988, a structured vocational training for family doctors, which was a tripartite collaboration between the Ministry of Health, the College, and the National University of Singapore,[3] was mooted. Monthly rotations in different hospital postings for junior medical officers were introduced to train new FM trainees under the new Masters of Medicine (Family Medicine) [MMed(FM)] traineeship programme (A).[3] In 1995, in order to cater to the needs of doctors who were already in independent practice but were still keen to undergo training and accreditation in the MMed(FM), the College introduced an alternative programme that became known as "Programme B".[3]

The Graduate Diploma in Family Medicine (GDFM) was later introduced in 2000 to meet the needs of GPs who wished to receive training and accreditation in Family Medicine but were unable to invest the time and commitment required by the MMed(FM) programme. This course, consisting of distance learning programmes and small group tutorials, has proven to be very popular amongst practitioners.[3]

In that same year, the College introduced the Fellowship by assessment programme,[4] which is a 24-month Advanced Specialty Training (AST) programme in Family Medicine conducted by the College.[5] Candidates who complete the AST successfully and pass the Fellowship Summative Exit Examination are conferred the FCFP(S). The programme is offered to doctors who have successfully completed basic structured family medicine training in an approved training programme, such as the Master of Medicine (Family Medicine) [MMed(FM)] at the National University of Singapore or its equivalent.

The Fellowship programme is rigorous, and successful candidates can register their FCFP(S) with the Singapore Medical Council as a postgraduate medical degree. Fellows are recognised by the College and various institutions as having been trained to practise the medical speciality of Family Medicine at the level of a consultant family physician. Consultant family physicians are able to provide a wide range of services, such as comprehensive care, continuing care, preventive care, and personal care, as well as coordinating care needs, such as advice and referrals to tertiary centres, and liaising with other family physicians for primary care at other settings. The fellows have achieved the highest level of FM training, and with this comes great responsibility. We are grateful for our fellows who have stepped forward to be leaders in their work settings and contributed to the fraternity in the areas of training and leadership. In this way, we will be able to pay it forward for future generations.

Since 2011, when the Primary Care Masterplan was first mooted, there have been many initiatives to transform primary care in order to better right-site healthcare resources in the community, such as the Community Health Assistance Scheme (CHAS), Pioneer Generation, Merdeka Generation, family medicine clinics, and primary care networks. These initiatives have made primary care the focus of healthcare delivery in Singapore. In each and every step, the College was consulted and involved, with family physicians instrumental in helping with the conceptualisation, setting up, and delivery of these services.

In the past five years, it became apparent that we needed to look at the health of our nation from a different perspective. Our healthcare system is highly skilled and well-trained to treat disease. We needed to go one step further and find novel ways to nip illness and disease in the bud. In 2016, the Ministry of Health adopted the 3 "Beyonds" strategy to future proof our healthcare system: 1) to move beyond hospital to the community; 2) beyond quality to value; and 3) beyond healthcare to health. These goals resonate with the College, and we strive to continue training and upgrading our FPs to fulfil the nation's health needs well into the future.

Today, family physicians play an increasingly pivotal role in our healthcare system. They are found in GP clinics across the island (over 2,000 to date), in our polyclinics, community hospitals, transitional care, intermediate and long-term care facilities, community psychiatric services, the list goes on. We serve in countless settings, but one thing that binds us is the holistic and patient-centred care that is at the core of family medicine. We develop deep and trusting relationships with patients over many years. What if they were in a position to freely choose a primary care doctor of their choice, who is able to help them to navigate their complicated healthcare journey? The late Professor Barbara Starfield of Johns Hopkins University famously said, "There are lots of evidence that a good relationship with a freely chosen primary-care doctor, is associated with better care, more appropriate care, better health, and much lower health costs."

Family doctors do work very hard, and during this pandemic we have certainly been working much harder than during "peacetime". What we are experiencing now is in fact a war against a virus. Some of our older patients have quipped that it feels just like how Singapore was during the Second World War!

We have to make clinical judgements that have lifesaving consequences. We are our community's medical Sherlock Holmes, searching for the clinical truth. Our patients are now well-equipped and educated by the University of the Search Engine, and oftentimes they have already done copious research as to their symptoms. They then come for consultations to discuss the research that they have conducted. They often ask very pertinent questions and may have consulted several doctors before they arrive

in our consultation room. We may find these encounters challenging, but when done well can be very enriching to the doctor-patient relationship.

Patients seek care that is friendly, accessible, and affordable; care that is holistic; care that is able to treat the whole person in all its complexities and life experiences. They are often perplexed by the many appointments in hospitals to see various specialists. They often wish they could just see one clinician who is able to take care of all their problems. As family physicians, we are in the best position to coordinate their care and be the key person to deliver this continuity of care. We are ideally suited to be the guardian and guide of a patient's healthcare needs: overseeing the many treatments, watching out for drug interactions and contraindications, and working out the best and most appropriate regime for them.

The College has been working hard to advocate and support family medicine for the last 50 years. One of our aims is to achieve specialist recognition of Family Medicine as a discipline. We are very glad for the strong support from the Ministry of Health for this and for the affirmation from our Permanent Secretary, Mr Chan Yeng Kit during our convocation ceremony in November. We have made much progress here and I am happy to announce that our proposal for Family Medicine Specialist recognition has been approved at the Family Physician Accreditation Board (FPAB). This has been the culmination of a massive effort by all at the FPAB, and we are especially grateful for the support and leadership of our chair, Director of Medical Services, Associate Professor Kenneth Mak.

We are grateful to all who have contributed over the years to family medicine, and we thank all who have worked so hard to make family medicine what it is today. I am confident that being accorded this recognition will further spur the FM fraternity to continue the accelerated evolution of our primary care services.

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Prime Minister's Message

Transcript of Pre-Recorded Message by Prime Minister Lee Hsien Loong at the College of Family Physicians Singapore's Virtual 50th Anniversary Dinner on Friday, 3 December 2021

Guest-of-Honour, Prime Minister Lee Hsien Loong with calligraphy scroll gifted by the College of Family Physicians Singapore to commemorate the College's 50th Anniversary.
Photo credit: MCI

Adjunct Associate Professor Tan Tze Lee, President, College of Family Physicians Singapore,

Distinguished Guests,

Ladies and Gentlemen,

Good Evening.

I congratulate the College of Family Physicians Singapore on your 50th Anniversary. This is a significant milestone. I am glad that many past Presidents of the College, the Councils and Family Physicians members are present today. The College's many achievements would not have been possible without your efforts and contributions.

Over the past 50 years, the College has played an important role in Singapore's healthcare system. It has raised the professionalism of our primary care practitioners, and helped to establish primary care as an indispensable pillar of our healthcare system.

COMBATING THE COVID-19 PANDEMIC

The importance of primary care is most apparent in our nation's ongoing battle against COVID-19. Primary care providers play critical roles at the frontline, identifying and treating patients with acute respiratory infections, administering swab tests and vaccinations, taking care of COVID-19 positive patients under the Home Recovery Programme. These are demanding tasks, but you displayed commitment and professionalism at every step of the way. Your efforts have contributed to the early detection, treatment, and isolation of cases, which is all the more important now as we deal with the uncertainty of the Omicron variant.

You have made a key difference to keep our COVID-19 situation under control, prevent our healthcare system from being overwhelmed, and hold deaths from COVID-19 down.

Thank you for your service.

PRIMARY CARE AS BACKBONE OF HEALTHCARE

COVID-19 or not, one of the key goals of our healthcare system is to keep as many patients out of hospitals as possible. We do this first by preventing people from falling sick, and if they do fall sick, we want to intervene early, before their conditions worsen. And where possible, look after them within the community.

This is what primary care does best. As family physicians, you are specialists in your own right. Hospital specialists see patients for a specific condition, but you see patients holistically, as a person, across their range of conditions. You are their first point of contact for healthcare matters; you know their medical history, habits, lifestyle, even social environment; you build trust and develop relationships with patients over the long term, and often also with their family members. You thus deliver key health outcomes for your patients, including by encouraging them to go for regular screening, and to adjust lifestyles to avoid complications. And during COVID-19, this also meant wearing masks and going for vaccination. You diagnose their condition or illness accurately when they present with complaints. You provide comprehensive care throughout the person's life cycle, and within the comfort of their community.

We must continue to build up primary care as the foundation of our healthcare system. This is especially important as our population is ageing.

Two broad areas we should work on.

Prime Minister's Message

First, to strengthen the relationships between family physicians and patients. Today, people see different doctors on each visit to the polyclinics, and it is the same for some of the bigger GP clinics too. It would be more effective if patients are always seen by the same care team. The National Healthcare Group has piloted a team-based care model across its polyclinics. Patients are assigned to a regular team of doctors for their primary care needs. The results from this pilot have been encouraging. More of the patients have good control of sugar, cholesterol, and blood pressure levels. Hence, we are keen to explore ways to expand this pilot across all healthcare clusters, and not just in the polyclinics, but also within the wider GP community. This will get us closer to the vision of Family Medicine: "One Singaporean, One Family Doctor".

Second, we need to shift our mindset on how primary care services are provided. Instead of just providing healthcare services that are available in the clinic, we should tap on the expertise and resources available in the broader community to expand the range of support that family physicians can provide, particularly for chronic conditions and complex care needs. This means forging relationships with a wider network of partners and professionals, even beyond the healthcare sector. For example, with social service agencies to better support vulnerable families. This is not so easy for GPs who operate in small solo practices to do this, but we will support you in doing so. Under the Primary Care Network scheme, more than 600 clinics have organised themselves into 10 networks to share resources and operate in teams. We will expand these networks, and build closer partnerships between GPs and healthcare clusters. This will allow more GPs to make use of the full range of clinical capabilities and assets of the healthcare clusters, thus bringing high quality community healthcare to every individual.

ROLE OF COLLEGE

What is the role of the College in all this?

It is to raise the standard of Family Medicine to provide continuing professional education, including postgraduate training, to our practitioners; to keep family physicians up-to-date with developments in the ever-advancing field of healthcare. Also, just as importantly, to nurture the next generation of family medicine practitioners.

The College can also lead efforts to bring primary care to the fore. Partner our regional healthcare systems, shape a national healthcare system that is primary care-centric and anchors care within the community.

CONCLUSION

The College has done well over the past five decades to build the foundation of Family Medicine so Singaporeans can enjoy better primary care.

I look forward to your continued leadership to strengthen the practice of primary care to better meet the needs of our population in the decades ahead.

Thank you all once again, and happy 50th anniversary!

Sreenivasan Oration

Sreenivasan Oration by Dr Tan See Leng, Minister for Manpower and Second Minister for Trade and Industry, at the College of Family Physicians Singapore's Virtual 50th Anniversary Dinner on Friday, 3 December 2021

Adjunct Associate Professor Tan Tze Lee, President, College of Family Physicians Singapore (CFPS),

Council Members,

Distinguished Guests,

Ladies and Gentlemen,

Good evening.

INTRODUCTION

Thank you for this privilege to deliver the Sreenivasan Oration, in commemoration of the late Dr B R Sreenivasan's immense contribution to Family Medicine, medical education, and the health of countless Singaporeans.

Modern Day Family Medicine began due to growing concerns over care fragmentation and impersonal care.

This was brought about by the rapid advancement in medicine and in medical specialisation. Drs B R Sreenivasan, Wong Heck Sing, Koh Eng Kheng, Lee Suan Yew and Victor L Fernandez saw the need for the formation of the College as the first step that would lead to the establishment and recognition of general practice as a separate discipline to bring back the essence of medicine and to put the patient at the heart of all we do.

This was achieved through a prescribed curriculum of training, a rigorous assessment process, and research.

Indeed, these were men of great foresight and we today are the beneficiaries of their determination and advocacy.

I am truly honoured and privileged to be part of this fraternity of family physicians. 2021 marks the 50th Anniversary of the College of Family Physicians Singapore.

It is therefore timely that the topic given to me is "Family Medicine for the Next 50 Years", to discuss the critical challenges that we face for the next 50 years and ask ourselves: "How should we, as family medicine practitioners and as a College approach these challenges?"

How we as a community of family physicians respond to four key challenges will define us in the next 50 years.

Let me elaborate.

TRANSFORMING CARE TO MEET DEMANDS OF RAPIDLY CHANGING DEMOGRAPHICS

First, our population is ageing rapidly.

By 2030, one in four Singaporeans will be aged 65 years and above.

A rapidly ageing population will lead to an increased demand on our healthcare system and our shrinking local workforce will make it doubly challenging to support these needs.

As much as there are ongoing efforts to support our seniors in ageing healthily, gracefully, and with dignity, many of our seniors will face a myriad of chronic diseases as well as problems related to frailty and disabilities in their silver years. This will require multiple complex interventions to support their care needs.

Afflictions can be both mental and physical in an ageing, lonely, difficult world.

This is why we should shift towards Population Health, which takes an inter-disciplinary and multi-stakeholder approach towards improving health outcomes across a population.

What does this mean for family physicians?

We should then move beyond being gatekeepers to specialist care and become effective team players and leaders within the care ecosystem.

We should move upstream in preventive care, collectively make evidence-based care decisions as part of a clinical team, and walk together with the patients as well as their families in their care journey while ensuring the best health

outcomes. The more we work together as a team, the better we will be able to manage a more diverse and complex array of issues, resulting in better clinical outcomes and service excellence for our patients.

Take for instance, the Primary Care Network (PCN) scheme, where private GP clinics come together and self-organise into networks to provide team-based care for more effective chronic disease management.

They share resources with fellow clinics in the same network, which provides their patients with easier access to ancillary services such as diabetic foot screening (DFS), diabetic retinal photography (DRP) and nurse counselling.

As of October 2021, there are 10 primary care networks (PCNs), comprising over 600 GP clinics islandwide, which many of you are part of.

This model of GP-led networks has been powerful in providing peer leadership on clinical care, and the Ministry of Health will do more to leverage them when developing regional and local programmes to improve the health of our communities.

At the Ministry of Manpower, we are also transforming how primary care should be delivered for our migrant workers.

Instead of fragmented and episodic care, we have taken bold steps to adopt a population health approach where migrant workers would be enrolled into dedicated medical providers who will provide accessible, affordable, and culturally attuned medical services.

This would build stronger doctor-patient relationships and bring about better continuity of care.

Ultimately, this will improve health outcomes of our migrant workers.

This new integrated primary healthcare system will operate like a "Hub-and-Spoke" model of care, where each sector will be anchored by a "Hub" Medical Centre for Migrant Workers, providing a suite of primary care services near migrant workers' place of residence, coupled with smaller "Spoke" Onsite Medical Centres at selected large dormitories, alongside Mobile Clinical Teams for rapid health response towards emerging clusters, and 24/7 telemedicine services. This is complemented by designated GP clinics in the community that have stepped up to provide care for migrant workers.

The clinics are also equipped with multilingual translation capabilities in English, Mandarin, Tamil and Bengali.

Clinical teams may also be augmented by healthcare workers who can speak the native language of migrant workers to provide culturally attuned care while maintaining public health surveillance to mitigate the risks of future outbreaks.

EMBRACING TECHNOLOGY TO AUGMENT CARE

Second, technology has been said to disrupt the patient-doctor relationship. An increasing amount of paperwork bogs down the daily work of a GP and reduces time to engage with the patient meaningfully.

The COVID-19 pandemic has brought about transformational changes in the way we adopt technology to deliver care.

In particular, the use of telemedicine has been brought to the forefront and its adoption was accelerated by the COVID-19 pandemic.

This has enabled physicians to continue to deliver healthcare remotely and in fact make care even more accessible.

Family physicians have stepped up to provide telemedicine consultations for their patients who have been placed on home recovery.

Family physicians who have built strong relationships with their patients can help allay their fears, offer more targeted medical advice based on the understanding of the patient's medical history, and ensure right siting of care.

We are at an inflection point in healthcare's digital transformation.

As purveyors of change, family physicians must take the lead in defining how technology can provide patient-centred care and better health outcomes.

Besides these, there is an immense potential in harnessing technology to also improve work processes as well as care experience for our patients.

An example is Project THRUST (Tackling Hypertension Right, Unifying Strengthening Trust) developed by GPs in partnership with a local start-up to deliver a more comprehensive care model for hypertensive patients.

The project employs a range of technology tools, including remote vital sign monitoring devices (such as blood pressure machines and lifestyle trackers) and both patient-facing and clinician-facing apps for care delivery and communication.

This project is funded under the GP Innovation Initiative (GPII) by the MOH Office for Healthcare Transformation (MOHT). GPII is a programme that provides funding support to GPs with innovative solutions that helps in achieving good disease control and are financially sustainable and scalable.

Led by Dr Lee Yik Voon (Lee & Tan Family Clinic and Surgery), the Project involves 10 GP clinics and their Technology and Care Services Partner, Witz-U.

Since the launch of the programme in December 2020, the programme has recruited close to 200 fee-paying patients. Each patient is monitored and coached on various aspects of his/her behaviour and lifestyle, such as medication, blood pressure monitoring, diet, exercise, and mindfulness by a multi-disciplinary team comprising the GP, a health coach/ nutritionist, a care coordinator, and a mindfulness coach.

The programme has shown encouraging improvements in patients' blood pressure, as well as the care experience for both GPs and patients.

True to the innovative spirit of the College, GPs like Dr Lee Yik Voon are much needed to embrace innovative solutions with a critical eye.

This is done through testing and validation of technologies and marrying them with patient-centric care as well as sustainable models at the clinics.

PREPARING AHEAD IN MEETING THE THREAT OF FUTURE PANDEMICS

Third, the next pandemic is not a question of if but when. In the past two decades alone, the world has experienced several notable outbreaks, including the 2003 Severe Acute Respiratory Syndrome (SARS) epidemic, the 2009 H1N1 pandemic, the 2012 Middle East respiratory syndrome (MERS) epidemic, the 2014 Ebola epidemic, and the current coronavirus disease 2019 (COVID-19) pandemic.

Even as we celebrate this 50th anniversary, governments and healthcare systems all over the world are now grappling with the Omicron variant.

These challenges remind us that Singapore must continue to strengthen our healthcare system capabilities and capacities, as well as remain vigilant against these threats.

Primary care remains the cornerstone of pandemic response and has shown itself to be highly adaptable in meeting the unique demands of the pandemic.

On this note, I would like to thank all of you in leading the frontline efforts in our fight against COVID-19 in the past two years. GP clinics have been the first port of call for patients suffering from symptomatic COVID-19.

In doing so you have taken on new IT systems, adapted to dynamic testing strategies and pivoted along with the country from elimination, stabilisation to endemic strategies. However, beyond the public health response, you have kept your patients close to your heart. You have built trust over time and this has provided much comfort and reassurance by addressing any misinformation or fake news that has been widely circulated.

Through physical or virtual means, you have also cheered your patients on through their recovery.

To this end, **rapid and potentially irreversible climate change would only further breed fertile conditions suitable for disease transmission, and family physicians will have to be prepared for the next pandemic.**

As the first line of defence, family physicians will need to remain vigilant in performing both public health functions such as early detection and testing, and primary care functions such as triaging and managing suspected cases of infectious diseases.

A good example would be the astute family physicians of Sims Drive Medical Clinic, who alerted the Ministry of Health to a sudden spike in cases of fever, rashes, and joint pain at their clinic, which led to the discovery of the first Zika cluster in Singapore in 2016.

THE EVOLVING FAMILY MEDICINE IDENTITY – REDESIGNING EDUCATION AND TRAINING

With the three critical shifts, the demand on the family physician will only be greater.

This brings me to the last challenge.

New competencies will need to be developed to meet the evolving and expanding role of family physicians.

Family physicians of the future will need a good mix of communication skills to connect with both patients and colleagues from a myriad of disciplines and be familiar with the local health and social care services landscape to help patients navigate and transit across the various care systems. They will need to develop leadership and influencing capabilities to be effective team leaders and team players in multi-disciplinary healthcare teams.

They will also need to leverage on behavioural science strategies and deeper communication strategies to better build trust and nudge their patients to take ownership of their own health.

Just like Dr B R Sreenivasan and the pioneers, the College will need to ride the winds of uncertainty and disruption and continue supporting our family physicians in meeting these new demands through its strengths in providing professional education and training.

This will involve a shift in the emphasis of the undergraduate and postgraduate education and training from hospital to community Medicine, and from a traditional biomedical curriculum to one that incorporates social and behavioural sciences.

Some may argue that family physicians are redundant in this increasingly specialised world.

But it is exactly because of the increasingly volatile, uncertain, complex and ambiguous (VUCA) world we live in that family physicians are even more valuable.

For this, I am reminded of the aphorism "to cure sometimes, to relieve often, to comfort always", which originated in the 1800s with Dr Edward Trudeau, founder of a tuberculosis sanatorium.

Today, more and more diseases can be treated successfully, with, even more diseases being relegated into chronic illnesses.

Our mindset shifts have to be targeted toward upstream preservation of health and prevention of infirmity.

As a community, we must lead alongside with academia, international organisations and associations and contribute as opinion leaders on the world stage.

Locally, as we shift towards Population Health and take up a multi-stakeholder approach, family physicians can continue to look at each patient as a whole and provide comfort always, through meaningful conversations with our patients.

Success in my humble opinion may mean a family physician who is able to constantly keep abreast of the latest developments and advances in care, be an active advocate and clinician to his patients and their families, connected to the academia both locally and internationally actively participating in Research and Development, contributing in evolving models of holistic care, and being a leader in his or her respective communities.

CONCLUSION

Even as the practice of Family Medicine changes over the next 50 years, primary care will be evergreen and continue to be the foundation of any healthcare system.

There can be no better moment than this for the community of Family Medicine practitioners to reflect and re-double our efforts to transform family medicine to meet the challenges in the next 50 years.

I am confident that family physicians will see challenges as opportunities and seize them to further strengthen this bedrock of the healthcare system.

Best wishes to all family physicians as you continue to transform Singapore's healthcare landscape for better health and better care for all Singaporeans.

Thank you.

Closing Address

Dr Wong Tien Hua
Vice President, 28th Council
College of Family Physicians Singapore

Thank you, Minister Tan, for delivering the Sreenivasan Oration.

I am so pleased to see Minister Tan carry the torch for our fraternity in his current role in shaping public policy. He has done so much for primary care in Singapore, and we are very fortunate to have him as a friend of our College.

As we come to the end of this evening's programme, I acknowledge that it has been a very tough two years for primary care, but we can look forward to the closing weeks of 2021 with a good dose of optimism. The majority of our population has been vaccinated and many have received their booster shot. Our COVID mortality rates remain low and our healthcare system has so far not been overwhelmed. We have returned to dining in for five persons and we can once again interact socially with our friends. In addition, quarantine-free travel via land route to Malaysia is now possible, allowing many of our Malaysian workers to return home to loved ones and vice versa, and more travel lanes are being opened. Larger scale events such as concerts are also around the corner. It seems as if we will finally able to move from the pandemic stage to an endemic one.

WHAT DOES THIS MEAN FOR PRIMARY CARE?

As CFPS President Adj Assoc Prof Tan Tze Lee has said in his speech, primary care is now at "war" against COVID-19. Primary care workers are working under extraordinary pandemic conditions, they are stretched to their limits with many working long hours, dealing with staff shortages, and having little respite from their daily rigours. Many have not had the chance to take leave or go on vacation.

We understand that these sacrifices are necessary given the great demand for healthcare services, and that most frontline workers are committed to playing their part in helping the nation through this pandemic by working longer hours. But a wartime footing has its costs as resources are diverted to fighting COVID-19, which detracts from the usual business of primary care.

Because of the pandemic, GPs and primary care frontliners have had to bear the burden of screening of acute cases, testing for suspect cases, and providing vaccination for the community.

This means that there is:

- less time for our chronic patients, many of whom are elderly with multiple needs. We in primary care have had to reduce routine patient visits by providing a longer period between follow-up visits.
- less time to look after mental health, with many of our patients facing extreme hardships from job loss or deaths in their family.
- less time for building a good doctor-patient relationship, which is critical in changing healthcare behaviour. Patient communication, which we hold so dear, is lost when our faces are hidden behind a mask.

It is therefore my sincere hope that we will soon be able to return to the regular "business" of primary care.

As Minister Tan has said in his oration, primary care will need to undergo significant transformation to meet the demands of our rapidly changing demographics – namely our ageing population. In the coming months, we will hear more about the concept of population health, which takes an inter-disciplinary and multi-stakeholder approach towards improving healthcare outcomes in Singapore.

If population health is to work, we will require a core of well-trained family physicians to take up the role of care coordinators and to manage more complex diseases at the primary care level.

This is where the College has a role to play in the training and skills development of our GPs. Attaining the GDFM, then the MMed(FM), and eventually fellowship of the College has to mean something, not just self-actualisation. I believe that well-trained FPs will have a central role to play in population health in the near future, by being the experts of care of our population across the entire disease spectrum.

Population health also means that we will need to consolidate primary care into one seamless system in terms of healthcare delivery. As mentioned by Minister Tan, we need to be able to work in clinical teams to manage increasingly diverse and complex cases.

Closing Address

One other area we can explore is having more public-private sector cooperation. The pandemic has shown that a partnership between MOH and GPs works wonders and is an efficient and powerful way to deliver care.

During the pandemic, we have seen how PHPC clinics assist in the national effort by keeping patients away from A&E, thus preventing hospitals from being overwhelmed. The clinics provide screening and triage, SASH and testing services, vaccinations, and help monitor patients during home recovery.

This public-private sector cooperation will likely take on a bigger role in the near future. It will be expanded and enhanced when population health comes into play, to make primary care a seamless experience for the public.

In summary, as COVID-19 shifts to endemicity, I hope to see primary care capabilities freed up so that we can refocus our resources towards looking after the needs of our ageing population, continue upgrading our skills to meet these needs, and explore new models of care that can integrate and enhance our limited resources.

To conclude this evening's 50th anniversary celebration, I would like to leave you with this quote from Minister Tan's Sreenivasan Oration.

"Even as the practice of Family Medicine changes over the next 50 years, primary care will be evergreen and continue to be the foundation of any healthcare system."

Speech has been edited for clarity.

A BRIEF HISTORY OF THE COLLEGE OF FAMILY PHYSICIANS SINGAPORE AND FAMILY MEDICINE IN SINGAPORE

Associate Professor Lee Kheng Hock
Immediate Past President
College of Family Physicians Singapore

Dear Mr Lee Hsien Loong, Prime Minister and Guest-of-Honour,

Dr Tan See Leng, Minister for Manpower and Second Minister for Trade and Industry,

Professor Tan Tze Lee, President of the College,

Council Members,

Distinguished Guests, Ladies and Gentlemen,

Where do we begin?

It is often said that history repeats itself and that one must learn from history. However, it is unclear how we should do that. The most practical advice that I have come across was from our founding Prime Minister, Mr Lee Kuan Yew. He said the following: "History does not repeat itself in the same way each time, but certain trends and consequences are constants. If you do not know history, you think short-term. If you know history, you think medium- and long-term." We should therefore look for recurring trends in history and their consequences. This will be help us to not be reactionary but instead think of building a better future.

The history of the College is the history of family medicine in Singapore. This history took place against the backdrop of a larger world movement that was trying to restore balance in medicine and overcome the fragmentation brought on by the excessive specialisation of medicine. Let us explore the trends and consequences of medicine and let them help to guide our thinking.

THE CHANGING WORLD OF MEDICAL TRAINING

The rise of organ and disease specific specialisation began in the years after World War II. This was driven by the rapid advancement of science and technology in medicine. While this enabled rapid advancements in medicine, it soon became apparent that it was attained at a price. Doctors who continued to provide generalist care became neglected both in resourcing and training. Consequently, the rapid improvement of skills and knowledge was accompanied by the adverse effects of depersonalisation of care, rising costs, and the inefficiency of managing problems in their respective parts.

In 1964, the World Health Organisation was sufficiently concerned to convene an Expert Committee to make recommendations on the role of general practitioners in relation to the community and the healthcare system. The committee applauded the establishment of Colleges and Academies to support professionalism and to raise the standard of practice among general practitioners. It also called for the integration of general practice with hospitals to conduct comparative studies of outcome, when hospitalised patients are managed by either specialists or general practitioners.

In 1966, the American Medical Association (AMA) was so concerned about the negative impact on the training of physicians that it formed the Citizens' Commission on Graduate Medical Education – also known as the Millis Commission – to study the issue and make recommendations to ensure that the training of doctors would continue to be relevant to the needs of the community. It raised the alarm that we were training too many specialists and neglecting the training of those who chose to work in general practice, which the community has greater need of.

Independently and in the same year, the Folsom Report developed by the US National Commission on Community Health Services was published. The report advocated that "the planning, organization, and delivery of community health services by both official and voluntary agencies must be based on the concept of a 'community of solution'." It called for the provision of high-quality comprehensive personal health services to all people. Most poignantly, the report asserted that every individual should have a personal physician who would be the central point for integration and continuity of all medical and related services. That was in 1966; those words still resonate to this very day.

A Brief History of CFPS

In 1969, the AMA's Council on Medical Education and the American Board of Medical Specialties granted approval to form a certifying board in family medicine. Family Practice came to be recognised as a specialty and the first batch of family medicine specialists graduated in 1971.

In the United Kingdom, specialists are recognised through the system of Royal Colleges of each specialty. Whilst the Royal College of General Practitioners (RCGP) was formed as early as 1952, it was only in 1965 that a call for special training in General Practice was made. A document on postgraduate training entitled "Special Vocational Training for General Practice" was published calling for equal recognition and reward for general practitioners who had completed postgraduate training in general practice. In 1968, it was supported by the Royal Commission on Medical Education (The Todd Report), which recommended postgraduate vocational training and admission to the RCGP upon successful completion of such training. Specialised training in general practice thus gained recognition and admission to the RCGP.

THE TIDE OF CHANGE REACHES SINGAPORE

The 1960s also saw the global movement advocating for specialised training in general practice as a counterbalance to disease or organ-specific specialisation reaching the shores of Singapore.

The Academy of Medicine Singapore (AMS) was formed in 1957 as the body representing all specialists in Singapore. The vision of the organisation was to advocate for postgraduate training of all specialists. It was modelled after the Royal Colleges; however, instead of having multiple institutions, all the recognised specialties come under one national body.

In 1966, the AMS began to form Chapters of Specialists to support and recognise the specialised training of doctors following their graduation from medical school. The earliest were the Chapter of Physicians (1966), the Chapter of Surgeons (1966), and the Chapter of Obstetricians and Gynaecologists (1968).

As early as 1962, a Society of General Practice (subsequently renamed the Society of Private Practitioners) was formed under the Singapore Medical Association. However, this was not an academic body but functioned as an association of private practitioners who were mainly general practitioners at that time. (In those days, many specialists became general practitioners when they left government service.)

In 1969, the Singapore Medical Association formed a committee to look into the feasibility of creating an academic body for general practitioners and how it might be structured. The committee was chaired by Dr Koh Eng Kheng (Past President, CFPS) with Dr Lee Suan Yew (Past President, CFPS) as one of the committee members. The momentum gained ground when Dr John Hunt, President of the RCGP, visited Singapore and joined the call for the formation of an academic body representing general practice. There were extensive discussions with the leaders of the professional bodies.

The committee eventually came up with three options. The first was to form a Chapter of General Practitioners under the AMS. The second was to form a faculty under either the RCGP or the Royal Australian College of General Practitioners (RACGP). The third was to form an independent College of General Practitioners. The second option was rejected as it was considered unacceptable for an independent country, and the first option was preferred. However, the Master of the Academy at that time rejected the idea of a Chapter of General Practitioners within the Academy. The only option then was to go it alone. In February 1970, a pro tem Committee chaired by Dr Wong Heck Sing (Past President, CFPS) with the inclusion of Dr Koh Eng Kheng was created to work on the formation of the College of General Practitioners Singapore.

Dr Wong Heck Sing made a private visit to the RACGP to seek technical advice on the establishment of a College and to learn about their system of training and assessment for general practitioners. Upon his return, he conferred with the leaders of the professional bodies. The consensus was that a Singapore College of General Practice was of critical importance and that such a College should focus on raising standards of practice and the academic development of general practice. Matters such as GP welfare should be delegated to the Society of Private Practitioners and the SMA. Membership should be open to all GPs but only those who had passed examinations could be recognised as Collegiate members.

On 29 March 1971, the inaugural meeting of the College was held. The first Council of the College was appointed, with Dr B R Sreenivasan as President, Dr Wong Heck Sing as Vice-President, and Dr Koh Eng Kheng as one of the five Council Members. The constitution was approved by the Registrar of Societies and the College was officially registered on 30 June 1971.

The first Censor-in-Chief Dr Wong Kum Hoong and his team immediately started work on the MCGP examinations, which were benchmarked to the examinations of the Royal Colleges of United Kingdom and Australia. The first MCGP examinations were held on 5 November 1972. Dr Richard Geeves and Dr Wes Fab, censors from the RACGP examinations, were invited as external examiners to ensure that the candidates met the highest standards of general practice at that time. The MCGP was recognised by the SMC as a registrable postgraduate qualification in 1974.

A Brief History of CFPS

Concurrently, work was done to publish an academic journal for the College titled *The GP*, which was later renamed as the *Singapore Family Physician* in 1975. The first issue was launched on 1 March, 1973.

Guided by the clear vision laid down by our founding members, successive councils rallied our members who donated resources and volunteered their time to fulfil our mission. Over the next 50 years, our College succeeded in placing the Singapore brand of family medicine on the world map and elevated the standard to training of family medicine to parity with other specialties in Singapore. Let us take a quick look at what happened on these two fronts.

PUTTING SINGAPORE FAMILY MEDICINE ON THE WORLD MAP

The effort to place Singapore Family Medicine on the world map started in the 70s. In 1972, Academies and Colleges of Family Medicine around the world came together to form The World Organisation of Family Doctors (WONCA) and our College was actively involved in promoting family medicine on the world stage from its inception.

On 20 May 1983, the College hosted the 10th WONCA conference. At that time, it was largest international medical conference ever held in Singapore. Delegates from around the world came to Singapore and were impressed by the quality of a world conference delivered by a small, young College. Financially it generated a good surplus that was able to fund College activities for the next decade.

15 August 1987, the College premises were moved to the College of Medicine Building. It was officially opened by the former Minister of Health, Mr Howe Yoon Chong. The facilities included a mock consultation room for training, a computer lab, and a library of family medicine books and journals. This allowed our College to host the Office of the Secretariat of WONCA in 2001.

On 24 July 2007, the College hosted the 18th WONCA World Conference. Colleges around the world vied to host the world conference, which only takes place once every three years. The team led by Dr Tan See Leng pressed on against great odds and setbacks over the 10 years to secure the bid. It was the first time that an Asian College had been given the privilege of hosting the World Conference twice within such a short period of time. The conference, attended by more than 2,000 delegates from 50 countries, was a resounding success. Financially it was also one of the most successful WONCA conferences. It contributed $1.59 million dollars to our College Funds and enabled the College to continue to expand our training programmes.

In 2010, 2012, and 2017, the College hosted the 2nd, 4th, and 6th Asia Pacific Primary Care Research Conference (APPCRC) respectively. This was part of the concerted effort of the College to promote research in family medicine. A good number of family physicians who participated in these conferences are now accomplished and respected researchers in family medicine.

ADVANCING STANDARDS IN TRAINING AND PRACTICE OF FAMILY MEDICINE

Advancing standards and advocacy for recognised training in Family Medicine was an even harder journey. In those days, it was still a widely held belief that there was no need for special training for a doctor to go into general practice. Medical school training alone was deemed to be more than adequate.

On 11 December 1986, the College and the Department of Social Medicine and Public Health submitted a "Joint Memorandum on the Academic Recognition of the Discipline of Family Medicine in the Faculty of Medicine, National University of Singapore". This was well received. On 13 February 1987, Family Medicine was recognised as a distinct academic discipline in medicine after much persistence and hard work by College members. The Department of Community, Occupational and Family Medicine was formed in the National University of Singapore.

In 1988, the Steering Committee on Family Medicine Training was formed. This was a tripartite body comprising the College, the Ministry of Health, and the university. The need for specialised training in family medicine was recognised and came into effect after almost 20 years of perseverance by the College. In February 1991, a Memorandum proposing the institution of a Master's degree in family medicine was submitted to the School of Postgraduate Medical Studies and accepted.

In 1992, the 15th and final MCGP examination and conferment was held. This programme became the Master of Medicine (Family Medicine) programme. A traineeship programme similar to the basic specialist training programme of the other specialties was initiated. On 12 July 1993, the first Master of Medicine (Family Medicine) examination was held.

Following that, on 26 November 1992, a memorandum proposing an advanced training programme for family medicine was presented to the Singapore Medical Council and the School of Postgraduate Medical Studies. It called for the recognition of specialist status for candidates who successfully completed such an advanced specialist training (AST) programme that would follow on from the MMed(FM). Unfortunately, this did not receive support and the effort to establish the AST was unsuccessful despite the advocacy efforts in the years that followed.

A Brief History of CFPS

In 1995, the College started the Private Practitioners Stream, also known affectionately as "Programme B" of the Master of Medicine (Family Medicine) programme. This programme enabled family physicians who were already in private practice to re-enter the training system. The initiative grew out of the concern that the training capacity of the public health institutions were very limited and the numbers required by our healthcare system would not reach critical mass. There were also large numbers of highly effective GPs already in private practice who aspired to improve their competency and practice standards through structured training and formal assessment. It is worth noting that our current Minister of Manpower, Dr Tan See Leng is a distinguished alumnus of this programme.

In 1998, the College started a 2-year Fellowship by Assessment programme, which became the de facto equivalent of advanced specialist training. The first cohort of successful candidates graduated in 2000. Many of this first and subsequent cohorts went on to serve in leadership roles in the College, academia, and public health institutions. Graduates of the programme were recognised as consultant clinicians.

On 1 July 2000, the College launched the first course in the Graduate Diploma in Family Medicine. This was to fulfil the vision of the College that all medical practitioners who work in the settings of family medicine should receive formal training and assessment. In addition, it marked the completion of the College's work of creating a training path for a young medical graduate to progress on to the MMed(FM) Programme and finally to the Fellowship by Assessment Programme.

In 2006, with the advice and support of the College, the Singapore General Hospital established the first hospital-based clinical department of family medicine in our region. The Department of Family Medicine and Continuing Care was given the mission to provide inpatient, outpatient, and transitional home care to patients with a view to providing care continuity, integrated care, and supporting patients in the community. Since then, large numbers of family physicians have taken on leadership and consultant physician roles in community hospitals and long-term care facilities in addition to the traditional primary care clinics. Well-trained family physicians are now able to practise at the top of their licence and bring the benefits of family medicine training to patients across the entire spectrum of our healthcare system.

In 2011, the family physician register was established after extensive rounds of public consultation, giving recognition to doctors who had received training in family medicine. The idea had first been proposed by the College in 2005.

On 14 June 2014, the AMS formed a Chapter of Family Medicine Physicians in response to the need to recognise highly skilled family physicians. It was also to recognise the rigours of the five years of training in family medicine culminating in the FCFP as equivalent to all other specialist training.

On 30 October 2015, a dinner was held to show appreciation to the pioneer GPs in conjunction with the celebration of the 50th Anniversary of our Nation. At that event, former Minister of Health Mr Gan Kim Yong urged GPs to become highly competent, preferably with home care and transitional care training and experience, as well as equipping themselves with the skills to work with other healthcare professionals across an integrated healthcare system. This was a necessary response to the changing needs of our population.

In 2016, the College commissioned a visioning project entitled "FAmily Medicine for Our Singapore" (FAMOUS) to understand and respond to future trends for Family Medicine in Singapore. It was comprehensive study involving a survey of 985 members – a Delphi study of 22 key opinion leaders in Singapore's healthcare system and multiple focus groups involving 63 family physicians, residents, and medical students. It revealed interesting trends for the future that are still relevant today.

For family physicians working in the polyclinics, concerns included:

- the challenges of brief contact time, complex patients, and high volume.
- issues in care transitions between polyclinics and hospitals.
- the need to improve continuity of care through teams and ownership of patients.

For family physicians working in private practice, concerns included:

- the value of teaching and training not being given recognition for FPs' private practice.
- the need to challenge the current mindset of peers and policymakers towards FPs in private practice. FPPPs must be seen as an integral part of primary care and the health systems.
- Better recognition for FPPP with postgrad training and participation in research and teaching.

For family physicians working in community hospitals and long-term care settings, concerns for the future included:

- deficiencies in the continuity of care within hospitals and between hospitals and community.

- care fragmentation, which continues to be a serious problem for the healthcare system and a new challenge for family medicine.
- the need for one responsible generalist to follow up care of patients.

For residents and medical students, concerns for the future included:

- the need for more well-trained FPs to manage complex patients, training for which should start in medical school.
- a perceived lack of clarity, resources, or completeness in FM training.
- the need to promote FM as a specialty to raise prestige and attract students and young doctors into the field.

With regards to the future, one particularly worrying concern stood out. Residents and medical students sensed that there was a lack of recognition for specialised training for family medicine. Family medicine training appeared incomplete and hence less attractive as a career.

At the 2016 Sreenivasan Oration, A/Prof Kenneth Mak urged the family medicine community to accept the wider role that family physicians have in our healthcare system and move beyond our comfort zones of what is considered traditional primary care.

True to its nature, history sometimes returns to its starting point, but never in the same way it initially begun.

This year (2021), the College and the AMS (Chapter of Family Medicine Physicians) presented a joint proposal to the Family Physician Accreditation Board calling for the acceptance of the College's FCFP programme as the equivalent of AST (Senior Residency) and the recognition of Family Medicine as a specialty under the Specialist Accreditation Board (SAB). This received in-principle approval of the FPAB on 23 November 2021 and the proposal will be formally submitted to the SAB in January 2022.

LEARNING FROM THE PAST AND SHAPING THE FUTURE

Family medicine began with doctors who saw the trend of over-specialisation and its negative consequences on the practice of medicine. They believed that the heart of medicine should be based on the principles of care being personal, primary, preventive, comprehensive, continuing, and community-based.

As members of this College that is now half a century old, we should learn from the trends of our history and the consequences, both good and bad, that come with such trends. This will help us to move away from short-term thinking both as individuals of this specialty and as a community of leaders trying to improve the standard and practice of family medicine, for the sake of our people and our nation.

Our founding leaders and members did not ask "What is in it for me?" when they set up our College 50 years ago, struggling against the odds. For them, it was never about the present or short-term self-interest. It was not about profits for those who are in the private sector or promotions for those who are in the public sector. The focus was always on creating a better future, a legacy that they would leave behind for future generations of family physicians and Singaporeans. As we reap the benefits of their hard work now, surely we should pay it forward. Members of the College, I urge you to continue focussing on their vision – our vision – as we stand on the threshold of perhaps the greatest milestone in the history of our College. This is a good time for us to learn from our past and continue on our journey to create a better history for family medicine. Ladies and gentlemen, thank you for the privilege and opportunity for me to share my understanding of the history of the College of Family Physicians Singapore.

College Councils

College Councils – Present and Past (1971-2021)

28th Council (2021–Present)

President Adjunct	Associate Prof Tan Tze Lee
Vice President	Dr Wong Tien Hua
Censor–in–Chief	Dr Seah Ee-Jin Darren
Honorary Secretary	Dr S Suraj Kumar
Honorary Treasurer	Clinical Asst Prof Xu Bang Yu
Honorary Editor	Dr Chiang Shu Hui Grace
Honorary Assistant Secretary	Dr Lim Hui Ling
Honorary Assistant Treasurer	Clinical Assoc Prof Low Lian Leng
Council Members	Dr Chua Lee Lea Im Elaine
Council Members	Dr David Tan Hsien Yung
Council Members	Dr Fok Wai Yee Rose
Council Members	Dr Hu Pei Lin
Council Members	Dr Julian Lim Lee Kiang
Council Members	Dr Paul Goh Soo Chye
Council Members	Dr Tan Wei Beng
Council Members	Dr Wee Wei Chieh Nelson

27th Council (2019–2021)

President	Adj Assoc Prof Tan Tze Lee
Vice President	Dr Wong Tien Hua
Censor-in-Chief	Dr Paul Goh Soo Chye
Honorary Secretary	Dr S Suraj Kumar
Honorary Treasurer	Dr Xu Bang Yu
Honorary Assistant Secretary	Dr Lim Hui Ling
Honorary Assistant Treasurer	Dr Lim Ang Tee
Honorary Editor	Cl Assoc Prof Low Lian Leng
Council Member	Dr Chua Lee Lea Im Elaine
Council Member	Dr Fok Wai Yee Rose
Council Member	Dr Koong Ying Leng Agnes
Council Member	Dr Lim Lee Kiang Julian
Council Member	Dr Seah Ee-Jin Darren
Council Member	Dr Tan Hsien Yung David
Council Member	Dr Tan Wei Beng
Council Member	Dr Wee Wei Chieh Nelson

26th Council (2017–2019)

President	Adj Asst Prof Tan Tze Lee
Vice President	A/Prof Lim Fong Seng
Censor-in-Chief	Dr Paul Goh Soo Chye
Honorary Secretary	Dr S Suraj Kumar
Honorary Treasurer	Adj Asst Prof Low Sher Guan Luke
Honorary Assistant Secretary	Dr Lim Hui Ling
Honorary Assistant Treasurer	Dr Ng Lee Beng
Honorary Editor	Dr Low Lian Leng
Council Member	Dr Chan Hian Hui Vincent
Council Member	Dr Goh Lay Hoon
Council Member	Dr Koong Ying Leng Agnes
Council Member	Dr Lim Ang Tee
Council Member	Dr Seah Ee-Jin Darren
Council Member	Dr Tan Hsien Yung David
Council Member	Dr Wong Tien Hua
Council Member	Dr Xu Bang Yu

25th Council (2015–2017)

President	A/Prof Lee Kheng Hock
Vice President	Dr Tan Tze Lee
Censor-in-Chief	Dr Paul Goh Soo Chye
Honorary Secretary	A/Prof Tan Boon Yeow
Honorary Treasurer	A/Prof Lim Fong Seng
Honorary Assistant Secretary	Dr S Suraj Kumar
Honorary Assistant Treasurer	Dr Ng Lee Beng
Honorary Editor	Dr Low Lian Leng
Council Member	Dr Chan Hian Hui Vincent
Council Member	Dr Doraisamy Gowri
Council Member	Dr Goh Lay Hoon
Council Member	Dr Lim Hui Ling
Council Member	Dr Low Sher Guan Luke
Council Member	Dr Ong Cong Wei Alvin
Council Member	Dr Pang Sze Kang Jonathan
Council Member	Dr Teo Hui Ying Valerie

24th Council (2013–2015)

President	A/Prof Lee Kheng Hock
Vice President	Dr Tham Tat Yean
Censor-in-Chief	A/Prof Tan Boon Yeow
Honorary Secretary	Dr Tan Tze Lee
Honorary Treasurer	Dr Lim Fong Seng
Assistant Honorary Secretary	Dr Ng Chee Lian Lawrence
Assistant Honorary Treasurer	Dr S Suraj Kumar
Honorary Editor	Dr Tan Ngiap Chuan
Council Member	Dr Eng Soo Kiang
Council Member	Dr Farhad Fakhrudin Vasanwala
Council Member	Dr Leong Choon Kit
Council Member	Dr Low Sher Guan Luke
Council Member	Dr Ng Lee Beng
Council Member	Dr Pang Sze Kang Jonathan
Council Member	Dr Tan Hsien Yung David
Council Member	Dr Yee Jenn Jet Michael

23rd Council (2011–2013)

President	A/Prof Lee Kheng Hock
Vice President	Dr Tan See Leng
Censor-in-Chief	A/Prof Tan Boon Yeow
Honorary Secretary	Dr Pang Sze Kang Jonathan
Honorary Treasurer	Dr Tan Tze Lee
Assistant Honorary Secretary	Dr Leong Choon Kit
Assistant Honorary Treasurer	Dr Rukshini Puvanendran
Honorary Editor	Dr Tan Ngiap Chuan
Council Member	Dr Ang Choon Kiat Alvin
Council Member	Dr Chng Shih Kiat
Council Member	Dr Eu Tieng Juoh Wilson
Council Member	A/Prof Koh Choon Huat Gerald
Council Member	Dr Lim Fong Seng
Council Member	Dr Siew Chee Weng
Council Member	Dr Tham Tat Yean
Council Member	Dr Yee Jenn Jet Michael

College Councils

22nd Council (2009–2011)

President	A/Prof Goh Lee Gan
Vice President	A/Prof Lee Kheng Hock
Censor-in-Chief	A/Prof Tan Boon Yeow
Honorary Secretary	Dr Pang Sze Kang Jonathan
Honorary Treasurer	Dr Lim Fong Seng
Honorary Editor	Dr Tan Tze Lee
Council Member	Dr Chow Mun Hong
Council Member	Dr Eu Tieng Juoh Wilson
Council Member	Dr Goh Choon Kee Shirley
Council Member	Dr Leong Choon Kit
Council Member	Dr Rukshini Puvanendran
Council Member	Dr Tham Tat Yean
Council Member	Dr Wong Tack Keong Michael

21st Council (2007–2009)

President	A/Prof Goh Lee Gan
Vice President	A/Prof Cheong Pak Yean
Censor-in-Chief	Dr Lee Kheng Hock
Honorary Secretary	Dr Cheng Heng Lee
Honorary Treasurer	Dr Lim Fong Seng
Honorary Editor	Dr Ng Chee Lian Lawrence
Council Member	Dr Chow Mun Hong
Council Member	Dr Ee Guan Liang Adrian
Council Member	Dr Eu Tieng Juoh Wilson
Council Member	Dr Lew Yii Jen
Council Member	Dr Pang Sze Kang Jonathan
Council Member	Dr Rukshini Puvanendran
Council Member	Dr Wong Tack Keong Michael

20th Council (2005–2007)

President	A/Prof Goh Lee Gan
Vice President	A/Prof Cheong Pak Yean
Censor-in-Chief	Dr Lee Kheng Hock
Honorary Secretary	Dr Cheng Heng Lee
Honorary Treasurer	Dr Tan Chin Lock Arthur
Honorary Editor	Dr Ng Joo Ming Matthew
Council Member	Dr Ong Chooi Peng
Council Member	Dr Tham Tat Yean
Council Member	Dr Lim Fong Seng
Council Member	Dr Ho Han Kwee
Council Member	Dr Pang Sze Kang Jonathan
Council Member	Dr Tan See Leng
Council Member	Dr Yii Hee Seng

19th Council (2003–2005)

President	A/Prof Cheong Pak Yean
Vice President	Dr Tan Chin Lock Arthur
Censor-in-Chief	A/Prof Goh Lee Gan
Honorary Secretary	Dr Lee Kheng Hock
Honorary Treasurer	Dr Yii Hee Seng
Honorary Editor	Dr Ng Joo Ming Matthew
Council Member	Dr Cheng Heng Lee
Council Member	Dr Goh Jin Hian
Council Member	Dr Lim Fong Seng
Council Member	Dr Wong Weng Hong
Council Member	Dr Pang Sze Kang Jonathan
Council Member	Dr Tan See Leng
Council Member	Dr Tan Yew Seng

18th Council (2001–2003)

President	A/Prof Cheong Pak Yean
Vice President	Dr Tan Chin Lock Arthur
Censor-in-Chief	Dr Lau Hong Choon
Honorary Secretary	Dr Lee Kheng Hock
Honorary Treasurer	Dr Tan See Leng
Honorary Editor	Dr Ng Joo Ming Matthew
Council Member	A/Prof Goh Lee Gan
Council Member	A/Prof Lim Lean Huat
Council Member	Dr Kwan Yew Seng
Council Member	Dr Ng Mong Hoo Richard
Council Member	Dr Tan Chee Beng
Council Member	Dr Tay Ee Guan
Council Member	Dr Yii Hee Seng

17th Council (1999–2001)

President	A/Prof Lim Lean Huat
Vice President	Dr Tan Chin Lock Arthur
Censor-in-Chief	Dr Lau Hong Choon
Honorary Secretary	Dr Lee Kheng Hock
Honorary Treasurer	Dr Ng Mong Hoo Richard
Honorary Editor	Dr Tan Chee Beng
Council Member	Dr Loh Wee Tiong Alfred
Council Member	A/Prof Goh Lee Gan
Council Member	Dr Lim Hock Kuang David
Council Member	Dr Tan See Leng
Council Member	Dr Kwan Yew Seng
Council Member	Dr Ng Chee Lian Lawrence
Council Member	Dr Ng Joo Ming Matthew

College Councils

16th Council (1997–1999)

President	Dr Loh Wee Tiong Alfred
Vice President	Dr Lim Lean Huat
Censor-in-Chief	A/Prof Goh Lee Gan
Honorary Secretary	Dr Yii Hee Seng (till May 1997)
Honorary Secretary	Dr Ng Mong Hoo Richard (from Jul 1997)
Honorary Treasurer	Dr Tan Chin Lock Arthur
Honorary Editor	Dr Lau Hong Choon
Council Member	Dr Soh Cheow Beng
Council Member	Dr Lim Hock Kuang David
Council Member	Dr Lee Kheng Hock
Council Member	Dr Tan Chee Beng
Council Member	Dr Tan See Leng
Council Member	Dr Kwan Yew Seng (co-opted Feb 1998)

15th Council (1995–1997)

President	Dr Loh Wee Tiong Alfred
Vice President	Dr Lim Lean Huat
Censor-in-Chief	A/Prof Goh Lee Gan
Honorary Secretary	Dr Tan Chin Lock Arthur
Honorary Treasurer	Dr Ng Mong Hoo Richard
Honorary Editor	Dr Hong Ching Ye
Council Member	Dr Bina Kurup
Council Member	Dr Lau Hong Choon
Council Member	Dr Lee Kheng Hock
Council Member	Dr Lim Hock Kuang David
Council Member	Dr Soh Cheow Beng
Council Member	Dr Wong Song Ung
Council Member	Dr Yii Hee Seng

14th Council (1993–1995)

President	Dr Loh Wee Tiong Alfred
Vice President	Dr Lim Lean Huat
Censor-in-Chief	A/Prof Goh Lee Gan
Honorary Secretary	Dr Soh Cheow Beng
Honorary Treasurer	Dr Tan Chin Lock Arthur
Honorary Editor	Dr Moti H Vaswani
Council Member	Dr Bina Kurup
Council Member	Dr Lee Kheng Hock
Council Member	Dr Lim Hock Kuang David
Council Member	Dr Deirdre Murugasu
Council Member	Dr Ng Mong Hoo Richard
Council Member	Dr Wong Song Ung
Council Member	Dr Yeo Khee Hong

13th Council (1991–1993)

President	Dr Koh Eng Kheng (resigned Oct 1991)
President	Dr Loh Wee Tiong Alfred (from Jul 1992)
Vice President	Dr Loh Wee Tiong Alfred
Vice President	Dr Lim Lean Huat (from Aug 1992)
Censor-in-Chief	Dr Goh Lee Gan
Honorary Secretary	Dr Tan Chin Lock Arthur
Honorary Treasurer	Dr Soh Cheow Beng
Honorary Editor	Dr Moti H Vaswani
Council Member	Dr Choo Kay Wee
Council Member	Dr Huan Meng Wah
Council Member	Dr Lim Lean Huat
Council Member	Dr Ng Mong Hoo Richard
Council Member	Dr Wong Song Ung

12th Council (1989–1991)

President	Dr Koh Eng Kheng
Vice President	Dr Loh Wee Tiong Alfred
Censor-in-Chief	Dr Lim Kim Leong
Honorary Secretary	Dr Soh Cheow Beng
Honorary Treasurer	Dr Lim Lean Huat
Honorary Editor	Dr Goh Lee Gan
Council Member	Dr Chan Cheow Ju
Council Member	Dr Huan Meng Wah
Council Member	Dr Lim Khai Liang John
Council Member	Dr Ng Mong Hoo Richard
Council Member	Dr Tan Chin Lock Arthur

11th Council (1987–1989)

President	Dr Lee Suan Yew
Vice President	Dr Koh Eng Kheng
Censor-in-Chief	Dr Lim Kim Leong
Honorary Secretary	Dr Soh Cheow Beng
Honorary Treasurer	Dr Loh Wee Tiong Alfred
Honorary Editor	Dr Goh Lee Gan
Council Member	Dr Chan Cheow Ju
Council Member	Dr Chan Swee Mong Paul
Council Member	Dr Cheong Pak Yean
Council Member	Dr Yeo Peng Hock Henry
Council Member	Dr Yeo Siam Yam (resigned Jun 1988)
Council Member	Dr Leong Vie Chung (co-opted Jul 1988)

College Councils

10th Council (1985–1987)

President	Dr Victor L Fernandez (till Oct 1985)
President	Dr Lee Suan Yew (from Dec 1985)
Vice President	Dr Loh Wee Tiong Alfred
Censor-in-Chief	Dr Lee Suan Yew (till Nov 1985)
Censor-in-Chief	Dr Lim Kim Leong (from Dec 1985)
Honorary Secretary	Dr Goh Lee Gan
Honorary Treasurer	Dr Chan Swee Mong Paul
Honorary Editor	Dr Moti H Vaswani
Council Member	Dr Sivakami Devi (till Feb 1987)
Council Member	Dr Omar bin Saleh Talib
Council Member	Dr Soh Cheow Beng
Council Member	Dr Tan Kok Yong (till Dec 1986)
Council Member	Dr Yeo Peng Hock Henry
Council Member	Dr Koh Eng Kheng (from Feb 1987)
Council Member	Dr Cheong Pak Yean (from Feb 1987)

9th Council (1983–1985)

President	Dr Wong Heck Sing
Vice President	Dr Victor L Fernandez
Censor-in-Chief	Dr Chang Ming Yu James
Honorary Secretary	Dr Loh Wee Tiong Alfred
Honorary Treasurer	Dr Lim Kim Leong
Honorary Editor	Dr Leong Vie Chung
Council Member	Dr Chan Swee Mong Paul
Council Member	Dr Goh Lee Gan
Council Member	Dr Michael Loh Peng Yam
Council Member	Dr Moti H Vaswani
Council Member	Dr Yeo Peng Hock Henry

8th Council (1981–1983)

President	Dr Victor L Fernandez
Vice President	Dr Frederick Samuel
Censor-in-Chief	Dr Chang Ming Yu James
Honorary Secretary	Dr Lim Kim Leong
Honorary Treasurer	Dr Chin S S Philbert
Honorary Editor	Dr Leong Vie Chung
Council Member	Dr Chan Swee Mong Paul
Council Member	Dr Chiong Peck Koon Gabriel
Council Member	Dr Hia Kwee Yang
Council Member	Dr Loh Wee Tiong Alfred
Council Member	Dr Moti H Vaswani

7th Council (1979–1981)

President	Dr Victor L Fernandez
Vice President	Dr Frederick Samuel
Censor-in-Chief	Dr Chang Ming Yu James
Honorary Secretary	Dr Lim Kim Leong
Honorary Treasurer	Dr Chiong Peck Koon Gabriel
Honorary Editor	Dr Leong Vie Chung
Council Member	Dr Chan Swee Mong Paul
Council Member	Dr Loh Wee Tiong Alfred
Council Member	Dr Tan Tian Cho
Council Member	Dr Moti H Vaswani
Council Member	Dr Wong Heck Sing

6th Council (1977–1979)

President	Dr Victor L Fernandez
Vice President	Dr Frederick Samuel
Censor-in-Chief	Dr Evelyn Hanam
Honorary Secretary	Dr Moti H Vaswani
Honorary Treasurer	Dr Lim Lean Huat
Honorary Editor	Dr Gordon O Horne
Council Member	Dr S Devi
Council Member	Dr Lim Kim Leong
Council Member	Dr Ng Ban Cheong
Council Member	Dr Wee Sip Leong Victor (till Aug 1977)
Council Member	Dr Tan Cheng Bock Adrian (till Dec 1977)
Council Member	Dr Wong Heck Sing

5th Council (1976–1977)

President	Dr Wong Heck Sing
Vice President	Dr Liok Yew Hee Timothy
Censor-in-Chief	Dr Evelyn Hanam
Honorary Secretary	Dr Lim Boon Keng
Honorary Treasurer	Dr Victor L Fernandez
Council Member	Dr Chang Ming Yu James
Council Member	Dr S Devi
Council Member	Dr Gordon O Horne
Council Member	Dr Lim Lean Huat
Council Member	Dr Frederick Samuel

5th Council (1975–1976)

President	Dr Wong Heck Sing
Vice President	Dr Chen Chi Nan
Censor-in-Chief	Dr Evelyn Hanam
Honorary Secretary	Dr Lim Boon Keng
Honorary Treasurer	Dr Victor L Fernandez
Council Member	Dr Chang Ming Yu James
Council Member	Dr Foo Choong Khean
Council Member	Dr Gordon O Horne
Council Member	Dr Liok Yew Hee Timothy
Council Member	Dr Tay Leng Kong Moses

College Councils

4th Council (1974–1975)

President	Dr Wong Heck Sing
Vice President	Dr Chen Chi Nan
Censor-in-Chief	Dr Evelyn Hanam
Honorary Secretary	Dr Koh Eng Kheng
Honorary Treasurer	Dr Chang Ming Yu James
Council Member	Dr Gordon O Horne
Council Member	Dr Leong Vie Chung
Council Member	Dr Liok Yew Hee Timothy
Council Member	Dr Colin Marcus
Council Member	Dr Frederick Samuel

3rd Council (1973–1974)

President	Dr Wong Heck Sing
Vice President	Dr Chen Chi Nan
Censor-in-Chief	Dr Wong Kum Hoong
Honorary Secretary	Dr Koh Eng Kheng
Honorary Treasurer	Dr Liok Yew Hee
Council Member	Dr Chang Ming Yu James
Council Member	Dr Chin Keng Huat Richard
Council Member	Dr Foo Choong Khean
Council Member	Dr Gordon O Horne
Council Member	Dr Colin Marcus

2nd Council (1972–1973)

President	Dr B R Sreenivasan
Vice President	Dr Wong Heck Sing
Censor-in-Chief	Dr Wong Kum Hoong
Honorary Secretary	Dr Foo Choong Khean
Honorary Treasurer	Dr Chen Chi Nan
Council Member	Dr Chin Keng Huat Richard
Council Member	Dr Koh Eng Kheng
Council Member	Dr Lim Boon Keng
Council Member	Dr Colin Marcus
Council Member	Dr Ted Wong Hoption

1st Council (1971–1972)

President	Dr B R Sreenivasan
Vice President	Dr Wong Heck Sing
Censor-in-Chief	Dr Wong Kum Hoong
Honorary Secretary	Dr Foo Choong Khean
Honorary Treasurer	Dr Leow On Chu
Council Member	Dr Chen Chi Nan
Council Member	Dr Koh Eng Kheng
Council Member	Dr Lim Boon Keng
Council Member	Dr Colin Marcus
Council Member	Dr Ted Wong Hoption

College Mission

1. To advance the Art and Science of Medicine.
2. To discuss Medical and Scientific problems.
3. To assist in providing postgraduate study courses for family physicians, and to encourage and assist practising family physicians in participating in such training.
4. To arrange for and/or provide instruction by members of the College or other persons for undergraduate or postgraduate students in family practice.
5. To promote and maintain high standards of family practice of Medicine.
6. To encourage and assist young men and women in preparing, qualifying, and establishing themselves in family practice.
7. To preserve the right of the family physician to engage in medical and surgical procedures for which he/she is qualified by training and experience.
8. To provide, endow or support scholarships, lectureships, readerships, and professorships in subjects appertaining to or associated with family practice.
9. To give, grant, issue, or bestow diplomas, certificates, and other tokens and distinctions in recognition of proficiency or attainment in family practice or in any subject cognate to family practice; any such tokens or distinctions may be awarded upon examination or thesis or *honoris causa*.
10. The College may acquire by purchase, hire, lease, or grant, or sell any movable or immovable properties in furtherance of the objects of the College.
11. To receive, borrow, or invest money for any of the objects of the College.
12. To do all such things as are incidental or conducive to the attainment of the foregoing objects or any of them.

Historical Milestones

OUR HISTORY – THE COLLEGE MILESTONES (1971-2021)

1971
- 18 March: The First Council of the College was formed and presided over by the late Dr B R Sreenivasan. The College was housed at the old Alumni Medical Centre at 4A College Road.
- 30 June: The College of General Practitioners Singapore was officially inaugurated.

1972
- 5 November: The first examination for diplomate membership, the MCGP(S), was held. This was the first postgraduate examination for family medicine to be conducted in Singapore.

1973
- 1 March: The first issue of *The GP* was published. This was the journal of the College. The name of the publication was changed to *The Singapore Family Physician* in 1975.

1974
- 1 July: Dr Benjamin A Sheares, the then President of Singapore, became the Patron of the College. The MCGP was recognised by the Singapore Medical Council (SMC) as a registrable postgraduate medical qualification.

1978
- The Sreenivasan Oration was established to honour the memory of the founding President and his contributions to the College.

1983
- 20 May: The College hosted the Tenth WONCA World Conference on Family Medicine in Singapore.

1985
- 9 December: A memorandum was submitted by the College to the Ministry of Health proposing a vocational training programme for doctors intending to pursue a career in Family Medicine.

1987
- 13 February: Family Medicine was recognised as a distinct academic discipline in medicine after much persistence and hard work by College members. The Department of Community, Occupational and Family Medicine (COFM) was formed in the National University of Singapore. The Undergraduate Teaching Committee of the College would work closely with the Department in the teaching of Family Medicine in the University.
- 15 August: The College premises were moved to the College of Medicine Building. It was officially opened by the former Minister of Health, Mr Howe Yoon Chong.
- 19 October: The Postgraduate Medical Library, which was jointly set up with the Academy of Medicine, was officially opened.

1988
- 12 November: The First Annual Scientific Conference and Meditech Exhibition was organised by the College.
- The Steering Committee on Family Medicine Training was formed. This was a tripartite body comprising the College, the Ministry of Health, and the Department of Community, Occupational and Family Medicine (COFM).

1991
- February: A memorandum proposing the institution of a Masters Degree in Family Medicine was submitted to the School of Postgraduate Medical Studies by the Steering Committee on Family Medicine Training.

1992
- 26 November: A memorandum proposing an advanced training programme for Family Medicine was submitted to the Singapore Medical Council and the School of Postgraduate Medical Studies.
- The 15th and final MCGP examination and conferment was held.

1993
- The College was appointed by SMC to administer the Singapore Medical Council-Continuing Medical Education (SMC-CME) Programme.
- 12 July: The first Master of Medicine (Family Medicine) [MMed(FM)] examination was held.
- 17 November: The name of the College of General Practitioners Singapore was officially changed to "College of Family Physicians Singapore".

1995
- A 2-year Private Practitioner Stream (PPS) leading to the Master of Medicine (Family Medicine) [MMed(FM)] was inaugurated.

1998
- The First Batch of College Fellowship by Assessment was started. There were eight participants. All completed the programme in 2000.
- A postgraduate FM training centre was officially opened: the Graduate Family Medicine Centre, which has been used for the PPS training since 1995.

Historical Milestones

1999
- The College Internet Project was launched.

2000
- The first intake of 48 doctors in the Graduate Diploma in Family Medicine commenced in July 2000.

2001
- The World and Asia-Pacific office of WONCA was sited in the College. The College also won the bid to host the World Congress in 2007.
- 23 June: The first launch of the Family Medicine Year for the Diploma, Masters, and Fellowship programmes were held. The ceremony also included the inception of two new programmes — the FM Fellowship Programme in Aged Care and the Structured Modular CME.

2002
- August: The Institute of Family Medicine (IFM) was formed to develop the academic programmes of the College.

2003
- The compulsory Continuing Medical Education (CME) Programme was introduced. The College was represented in the SMC-CME Coordinating Committee and worked closely with SMC to ensure the quality of CME events was acceptable.
- July: The first module for the E-Learning programme was launched.

2005
- Announcement of the Ministry of Health (MOH) Public Consultation Paper on the Proposed Establishment of the Family Physicians (FP) Register.

2006
- May: The Family Medicine Continuing Care (FMCC) department in Singapore General Hospital (SGH), the first family medicine department in a hospital, was formed. The College was involved in this initiative through its representation in the Steering Committee of Family Medicine Continuing Care, Singapore General Hospital.

2007
- 24-27 July: The College hosted the 18th WONCA World Conference on Genomics and Family Medicine at Suntec Singapore. The Guest-of-Honour was Mr Khaw Boon Wan, the Minister for Health.
- 4 November: College Convocation and Dinner. Ms Yong Ying-I, Permanent Secretary, Ministry of Health, was the Guest-of-Honour.

2008
- 23 November: College Convocation & Dinner. The Guest-of-Honour was Mr Khaw Boon Wan, Minister for Health.
- 23 November: Dr Lee Suan Yew received the Albert & Mary Lim Award at the College Convocation & Dinner.

2009
- 28 November: College Convocation & Dinner.
- 5-6 December: The Inaugural Asia Pacific Primary Care Research Conference (APPCRC) was held in Melaka.

2010
- 19-23 May: The 19th World Conference held in Cancun, Mexico.
- July: *The College Digest*, a quarterly electronic newsletter, was launched.
- 28 November: College Convocation & Dinner. The Guest-of-Honour was Prof Satku, Director of Medical Services, Ministry of Health.
- 6 October: A memorandum on the reciprocal recognition of the FRACGP and the FCFP(S) was signed at Cairns Convention Centre between The Royal Australian College of General Practitioners (RACGP) and the College. This signing ceremony celebrated the decision of reciprocal recognition of the fellowships of the two Colleges and led to the award of the FRACGP by Fellowship *ad eundum gradum* to those with FCFP(S) who wish to apply and are working in Australia.
- 28 November: Special invited guests to the Convocation & Dinner were Prof Claire Jackson (President, RACGP), Dr Jennifer Kendrick (Censor-in-Chief, RACGP), Prof Jan Radford (Immediate Past Censor-in-Chief RACGP). They witnessed the adoption of the Memorandum on reciprocal recognition of the FRACGP and the FCFP(S) between the RACGP and CFPS.
- 28 November: A/Prof Cheong Pak Yean and Dr Cheng Heng Lee received the Albert & Mary Lim Awards at the College Convocation & Dinner.
- 4-5 December: The College hosted the 2nd Asia Pacific Primary Care Research Conference (APPCRC) at Gallery Hotel, Singapore. It was well attended with 116 paid delegates from Australia, Bangladesh, Hong Kong, India, Japan, Malaysia, Myanmar, Singapore, and Thailand.

Historical Milestones

2011

- 3-4 December: The 3rd Asia Pacific Primary Care Research Conference (APPCRC) was held in Kuala Lumpur.
- 27 November: 40th Anniversary Dinner of the College. The Guest-of-Honour was the Minister for Health, Mr Gan Kim Yong.
- 27 November: Dr James Chang Ming Yu received the Albert & Mary Lim Award.

2012

- 18 November: The Guest-of-Honour for the College Convocation & Dinner was the Minister for Health, Mr Gan Kim Yong.
- 18 November: A/Prof Goh Lee Gan received the Albert & Mary Lim Award.
- 1-2 December: The College hosted the 4th Asia Pacific Primary Care Research Conference (APPCRC) at the Centre for Translational Medicine (Block MD6) in Yong Loo Lin School of Medicine, National University of Singapore (NUS), with participants coming from 16 countries, representing 42 organisations. The pre-conference, Research Championship workshop, was held on 30 November.

2013

- 23 November: The Guest-of-Honour for the Family Medicine Convocation Ceremony & Dinner was Ms Tan Ching Yee, Permanent Secretary (Health), Ministry of Health Singapore.
- 23 November: The recipient of the Albert & Mary Lim Award was Dr Julian Lim Lee Kiang.
- 23 November: The recipients of the Long Service Award were Dr Lim Fong Seng and Dr Jonathan Pang.

2014

- 17 May: The World Family Doctors' Day Gala Dinner was held at Marina Bay Sands & Convention Centre (Begonia Ballroom, Level 3). The Guest-of-Honour was Mr Gan Kim Yong, Minister of Health.
- 22 November: The Guest-of-Honour for the Family Medicine Convocation Ceremony was A/Prof Benjamin Ong, Director of Medical Services (DMS).
- 22 November: The recipient of the Albert & Mary Lim Award was Dr Moti H Vaswani.
- 22 November: The recipient of CFPS Honorary Membership was Mr Lek Siang Pheng.

2015

- 23 May: The Family Medicine Teachers' Conference was held at NUS-Shaw Foundation Alumni House.
- 23 May: The World Family Doctors' Day Gala Dinner was held at NUSS Kent Ridge Guild House.
- 28 November: The Guest-of-Honour for the Family Medicine Convocation Ceremony was Dr Lam Pin Min, Minister of State for Health.
- 28 November: The recipient of the Albert & Mary Lim Award was Prof Chew Chin Hin.
- 28 November: The recipient of CFPS Honorary Membership was Prof Chew Chin Hin.

2016

- 14 May: The Family Medicine Review Course was held at the Academia, SGH.
- 14 May: The World Family Doctors' Day Dinner was held at the Academia, SGH.
- 19 November: The Guest-of-Honour for the Family Medicine Convocation Ceremony was Dr Lam Pin Min, Minister of State for Health.
- 19 November: The recipient of the Albert & Mary Lim Award was Dr Kwong Kum Hoong.

2017

- 20 May: The Family Medicine Review Course was held at the Academia.
- 20 May: The World Family Doctor Day Dinner was held at the Grand Copthorne Waterfront.
- 18 November: The Guest-of-Honour for the Family Medicine Convocation Ceremony was Mr Ng How Yue, Second Permanent Secretary, Ministry of Health.
- 18 November: The recipient of the Koh Eng Kheng Gold Medal for Best Fellowship Graduand was Dr Loo Yuxian.

2018

- 19 May: The Family Medicine Review Course was held at the Health Promotion Board (HPB).
- 19 May: The World Family Doctor Day Dinner was held at the Park Royal on Pickering.
- 17 November: The Guest-of-Honour for the Family Medicine Convocation Ceremony was A/Prof Benjamin Ong, Director of Medical Services, Ministry of Health.
- 18 November: The recipient of the Albert & Mary Lim Award was A/Prof Lee Kheng Hock.
- 18 November: The recipient of the Koh Eng Kheng Gold Medal for Best Fellowship Graduand was Dr Xu Bang Yu.

Historical Milestones

2019

- 25 May: The Family Medicine Review Course was held at the Health Promotion Board (HPB).
- 25 May: The World Family Doctor Day Dinner was held at the Park Royal on Pickering.
- 23 November: The Guest-of-Honour for the Family Medicine Convocation Ceremony was Mr Edwin Tong, Senior Minister of State, Ministry of Law and Health.
- 23 November: The recipient of the Koh Eng Kheng Gold Medal for Best Fellowship Graduand was Dr Chong Wern Siew Christopher.

2020

- The Family Medicine Review Course, World Family Doctor Day Dinner, and Convocation Ceremony were not held due to COVID-19 restrictions.

2021

- 15 May: The Family Medicine Review Course was held via Zoom.
- 20 November: The Guest-of-Honour for the Family Medicine Convocation Ceremony was Mr Chan Yeng Kit, Permanent Secretary (Health), Ministry of Health.
- 20 November: The recipients of the Koh Eng Kheng Gold Medal for Best Fellowship Graduand 2020 were Dr Chiang Shu Hui Grace and Dr Yuen Sok Wei Julia.
- 20 November: The recipients of the Koh Eng Kheng Gold Medal for Best Fellowship Graduand 2021 was Dr Koh Zhong Wei Jeremy.
- 3 December: 50th Anniversary of the College. The Guest-of-Honour was Prime Minister Lee Hsien Loong.

Reflections

Reflecting and Learning from Past Presidents – 50 Years On

Dr Chiang Shu Hui Grace
Honorary Editor, 28th Council
College of Family Physicians Singapore

In the five decades since the inauguration of the College of Family Physicians Singapore, CFPS has been humbled to have been led by numerous visionary leaders: Dr B R Sreenivasan (1971-1973); Dr Wong Heck Sing (1973-1977, 1983-1985); Dr Victor L Fernandez (1977-1983, 1985); Dr Lee Suan Yew (1985-1989); Dr Koh Eng Kheng (1989-1991); Dr Alfred Loh (1992-1999); A/Prof Lim Lean Huat (1999-2001); A/Prof Cheong Pak Yean (2001-2007); A/Prof Goh Lee Gan (2007-2011); A/Prof Lee Kheng Hock (2011-2017); and A/Prof Tan Tze Lee (2017-current). The College is honoured to receive the well-wishes, words of wisdom, and hopes for the future from our past presidents.

We have much to learn from the words of our past presidents. Lessons to take away include that of perseverance in the face of challenges, the importance of collaboration, and continued education, innovation, and growth.

In spite of naysayers, our forefathers of the College showed both tremendous fortitude and foresight in the formation of the College. Being a young College, our pioneers initially collaborated with more mature colleges such as the Royal College of General Practitioners (RCGP) and Royal Australian College of General Practitioners (RACGP). This openness to collaboration with other institutions/bodies has continued through the decades not only locally but overseas, contributing to the growth of the College. The College has been privileged to host two WONCA World Conferences in 1983 and 2007, and will have the privilege of hosting the upcoming WONCA Asia Pacific Conference in 2023. The College is also working closely together with other professional bodies such as the Academy of Medicine, Singapore to recognise Family Medicine as a speciality in Singapore.

The College continues to nurture future and current family physicians through training and education. Since its inauguration, the College has worked tirelessly to promote and maintain high standards of family medicine practice, from evening lectures in the early days of the College to formal postgraduate training. In 1972, the first examination for diplomate membership, the MCGP, was held. This was the first postgraduate examination for family medicine to be conducted in Singapore. In 1985, a memorandum was submitted by the College to the Ministry of Health proposing a vocational training programme for doctors intending to pursue a career in family medicine. In 1987, Family Medicine was finally recognised as a distinct academic discipline in medicine after much persistence and efforts from College members. Today, postgraduate training in Family Medicine has evolved into the Graduate Diploma of Family Medicine, Master of Medicine (Family Medicine), and the Fellowship programme, enabling trained family physicians to practise at varied settings including general practitioner clinics, polyclinics, nursing homes, community hospitals, and hospitals.

As we move forward into the future, our hope for the College is that it continues to be an institution that enshrines and promotes the values and ideals of Family Medicine. May the College continue to lead Family Medicine in improving the health of all Singaporeans just as our pioneers envisioned, by setting standards for education through innovation, certifying and supporting family physicians through championing advocacy and training, and most importantly honouring the sacred relationship between the patient and the physician.

Plaque of names of the past presidents of the College of Family Physicians Singapore

Reflections

Reflections from Past Presidents

[First published in The College Mirror, *September 2021 Vol 47(3)]*

Dr Lee Suan Yew
President (1985-1989)
College of Family Physicians Singapore

50TH ANNIVERSARY WISHES

May I congratulate our College of Family Physicians' President, Adj Associate Prof Tan Tze Lee and his 27th Council Members for keeping up and even improving the high standard of our College's teaching and professional achievements and reputation.

We started humbly in 1971, 50 years ago, as a College of General Practitioners and we changed our College's name to College of Family Physicians to stress the medical care of Family ethos focused by our College members.

In the early years, the College used to arrange lectures in the evening. Who would believe that over the years the College arranges the lectures, training, and examinations for postgraduate doctors who are planning to take different examinations. For example, the GDFM, MMed(FM), and FCFP(S).

I must congratulate all the doctors who are helping the College in the planning, teaching, and examining all our postgraduate candidates for the different examinations. Their dedication is outstanding.

We also have to thank the Academy of Medicine leaders for inviting the Fellows of our College to form a Chapter of Family Physicians in the Academy. Our current Academy leaders, led by Dr Teo Eng Kiong, are even supporting the Fellows of FP to be classified as specialists. Discussions are ongoing and it is our hope that the Ministry of Health and the Specialist Accreditation Board will accept the Fellows of Family Physicians as specialists. Apparently, the Hong Kong and Malaysian Ministries of Health have already done so. It is not the prestige that matters but it is the recognition that is important. This will attract more young doctors to undergo the FP postgraduate training and examinations and exit examinations. As our population gets older, we need more Family Physicians with specialist training to manage this important aspect.

MOH need not fear about the Family Physicians raising their fees. ALL doctors must remember Sir William Osler's wise words:

> *"The practice of medicine is an art, not a trade; a calling, not a business, a calling in which your heart will be exercised equally with your head."*

These words were edged on a stand at the entrance of our College. It was my Council and I who felt that those words are important throughout our career. We must practise medicine with compassion, integrity, humility, professionalism, and lifelong learning for the good of our patients.

Reflections

Dr Alfred Loh Wee Tiong
President (1993-1999)
College of Family Physicians Singapore

Fifty years ago, a group of farsighted family doctors got together to form the College of General Practitioners, Singapore (CGPS) with the assistance of more mature colleges overseas in the UK and Australia. Our pioneers had to contend with rather negative sentiments from their colleagues in the public service and even the university in those early years. Despite these naysayers, the early Singapore College Councils pursued the policy of continuing medical education and practice upgrading for its members.

All these early efforts began to pay off in these last two decades. With increasing awareness and acceptance of the important role the family doctor plays in the holistic care of the individual and the community as well as in adopting increasingly higher standards of postgraduate courses and examinations, the discipline of Family Medicine is now widely accepted here. The recognition by the Singapore Medical Council of the Graduate Diploma in Family Medicine (GDFM) and the Master of Medicine in Family Medicine [MMed(FM)] bears testimony to this. The College of Family Physicians Singapore has achieved much especially these last two decades.

In his recent 50th Anniversary Message, the College President Adj Assoc Prof Tan Tze Lee mentioned the hosting of two WONCA World Conferences by the Singapore College in 1983 and 2007. These reflect the standing the College of Family Physicians Singapore enjoyed in the global family medicine fraternity during those earlier years. Perhaps it is now timely for the College to extend its vision further afield by working in collaboration with the sister Colleges of Family Medicine, especially in the ASEAN Region. Working with the Office of the Asia-Pacific Regional President of WONCA (World Organisation of Family Doctors) may be a suitable approach. The collaboration may take the form of joint research in family medicine, exchange of training materials, conduct of conjoint examinations, exchange of teaching fraternity, and even joint college conferences in family medicine.

In doing so, the College of Family Physicians Singapore will contribute to the universality and acceptance of the discipline of Family Medicine in ASEAN and the Asia-Pacific Region. This is something I would urge the College to seriously consider as one of its future endeavours.

Reflections

Dr Lim Lean Huat
President (1999-2001)
College of Family Physicians Singapore

I was elected President of the 17th Council (1999-2001) of the College of Family Physicians, Singapore. The outgoing President before me was Dr Alfred Loh. During my term of office, my Vice President was Dr Arthur Tan Chin Lock, and Dr (now A/Prof) Lee Kheng Hock was the Honorary Secretary.

There were several College activities in my term of office that have continued to be important to this day. These were the launch of the College Website, the graduation of the First Cohort of the College Fellowship Programme, and the launch of the Graduate Diploma in Family Medicine programme.

LAUNCH OF THE COLLEGE WEBSITE[1]

The College Website was first set up in 1994 and relaunched on 22 May 1999, and the Website is now active and well today. It has presently information on College programmes, CME programmes, Events, Publications, Membership, and Links.

GRADUATION OF THE FIRST COHORT OF COLLEGE FELLOWSHIP PROGRAMME[2]

The First Cohort of eight Fellows of the College successfully passed their Exit Interview on 16 September 2000. They received their conferment during the College's 30th Anniversary Celebrations Scientific Meeting in 2001. Today as of 2021, we have 155 Fellows.

LAUNCH OF THE GRADUATE DIPLOMA IN FAMILY MEDICINE PROGRAMME IN 2000[3]

The objective of the course is "to train FPs/GPs to practise Family Medicine at an enhanced level [that] is able to meet the needs of the young child, the adult, and the elderly, with emphasis on diagnostic and management skills in the various clinical disciplines." As of 31 March 2021, we have 1,463 doctors with the GDFM qualification.

COLLEGE ACTIVITIES IN THE SOUTHEAST ASIA REGION DURING THE EARLY 2000S[4]

The Singapore College was active in its work in "helping neighbouring countries such as Myanmar and Indonesia develop the discipline of Family Medicine in their respective countries".

WE WON THE BID TO HOST WONCA WORLD CONFERENCE 2007[5]

2001 was also a lucky year for us. We bid for the WONCA World Conference of 2007 in Orlando and we won the bid by just one vote, beating Australia to it. Dr Tan See Leng led the bid. The rest is history.

THE FUTURE

The is one more milestone to be reached: that FM is recognised as a specialty. It will come.

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Reflections

Associate Professor Cheong Pak Yean
President (2001-2007)
College of Family Physicians Singapore

INNOVATIONS IN FM TRAINING

The College championed Family Medicine (FM) training in Singapore as its *raison d'etre* and thus accepted the challenges of having to develop generalist physicians grounded both in the science and the art of medicine and skilled in handling a plethora of illnesses that span various medical disciplines in breadth as well. Two aspects of the training are highlighted: namely, in the teaching of medical communication and humanities (MCH), using a transdisciplinary approach; and providing clinical case-based training across the breadth of disciplines.

MEDICAL COMMUNICATION & HUMANITIES (MCH) FOR THE GENERALIST PHYSICIAN

This challenge of medical education and understanding of man himself was highlighted by Dr Wong Heck Sing (WHS) in 1978 in the College's inaugural Sreenivasan lecture[1] titled "The Future of Singapore General Practitioner". Dr Wong quoted Dr Sreenivasan, our founding president, to reiterate "that the most difficult part in the study of medicine was the study of man himself" and bemoaned the eclipse of the generalist physician (GP) and the fragmentation of care by body systems from specialisation and sub-specialisation.

Dr Wong, who succeeded Dr Sreenivasan as President of the College, noted that "education today is essentially a study of the human body per se … (The GP) needs a broad education and should not concentrate mainly on the physical and biological sciences to the exclusion of the humanities and the arts … His understanding of people may be drawn from the reading of novels, biographies, poetry and plays and from the visual arts and this understanding will heighten his sensitivity to the feelings of his fellow men in later life." Dr Wong observed that "Those that do go into general practice have to learn by trial and error."

These words are prescient. When I started community practice in 1980 after completing my clinical training in Internal Medicine, I was recruited by my good friend A/Prof Goh Lee Gan into the nascent FM teaching fraternity though I had no formal FM training. I realised the gaps in my clinical skills – that I have to be equally adept at engaging the mind, which every patient has (sic), and caring in the context of his/her family in the community. I taught FM as best as I could from what I learnt from patients and picked up from observing my FM colleagues.

I felt inadequate. So, in 2005, I decided to learn from the psychotherapy fraternity in Singapore about mind matters, did a Masters, then practised and taught psychotherapy. My mission is to develop methods to train the family physicians into the generalists envisaged by our forefathers.

Together with A/Prof Goh and Prof Kua Ee Heok, a doyen of the psychiatric community, we developed a counselling method for doctors we termed "Brief Integrative Psychological Therapy" (BIPT)[2] as documented in a book in 2015. Though BIPT provided basic elements of counselling, we found that most doctors steeped in the biomedical paradigm of Evidence-Based Medicine (EBM) of the body are not able to parallel process EBM and NBM (Narrative-Based Medicine) and therefore still choose to refer patients with psychosocial problems to professional counsellors as they feel that they do not have enough counselling skills and training. Moreover, the limited consultation time does not allow the incorporation of BIPT routinely.

A/Prof Goh and I had the opportunity to teach the BIPT system we developed to medical students in their FM posting in concert with a team of counsellors in the Counselling and Care Centre. We have been doing so since the 2011s, for about a decade now. We shifted the consultation paradigm of actuating both the rational and intuitive mind together to extend only parts of the usual consultation methods when needed and if needed while keeping the usual flow as default. Together with Dr Ong Chooi Peng, we wrote a second book, *The Extended Consultation: Talk Matters!*[3] We found this approach valuable for both students and doctors. We exposed FM residents and doctors in workshops, in the Family Practice Skills Course (FPSC). We had the opportunity to present our experience and lessons learnt at the Asian Pacific WONCA Conference in Kyoto, May 2019.

Dr Ong and I then wrote a third book[3] going beyond NBM to encompass Illness Experience as pictures drawn by medical students with reflections and commentaries by experienced doctors. These Illness narratives expressed in prose is used in the practice of Illness-Based Medicine (IBM). Other channels of human communication to express the illness experience are poetry, pictures, and even performance. We have recently integrated the tools of the extended consultation with the Kolb's experiential learning cycle for reflective observation (extended history, examination, and investigation), abstract conceptualisation (Formulation), and experimentation (Psycho-social interventions).

We believe we now have the tools to actuate Dr Wong Heck Sing's clarion call made in 1978 to have a system to teach the family physicians to go beyond the body to care for the whole person and "not have to learn by trial and error".

CLINICAL FM TEACHING

The other challenge in FM training is teaching using a good case-mix and real patients. GP postings for medical students started soon after the College was formed and the training was structured in 1987 when the FM was taught in NUS. Postgraduate chair-side teaching started with the MMed(FM) traineeship programme in the early 1990s. The postings included a three-week full-time attachment to private general practices. These attachments provided a vista of how community practices function and more importantly learning and catching FM precepts from experienced physicians. These clinical attachments were soon discontinued after a few years due to administrative and financial reasons.

The need to provide clinical case-based experience[4] for private practitioners in a two-year part-time programme that commenced in 1995 led Dr Julian Lim, Dr Chan Nan Fong, and I to develop the ambulatory care round tutorials based on the trainees' own portfolio of patients. The use of portfolio-based learning provided valuable clinical experience and contextual learning.

The advent of the FM residency programme in 2011 was another fillip. Clinical postings were arranged to both private and public FM clinics and hospital departments. Experienced FM physicians were attached chair-side as perceptors. Convivial interactions of young residents and matured FM physicians were documented and published.[5]

The College was founded in 1971. 50 years thence, the College has geared FM training to produce doctors who practise with both Art and Science and to span the breadth of clinical specialties as well.

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Reflections

Associate Professor Goh Lee Gan
President (2007-2011)
College of Family Physicians Singapore

Congratulations to you, Tze Lee, and your Council for being at the helm as we celebrate the Fiftieth Anniversary of the formation of the College of Family Physicians Singapore. On an occasion like this, it is nice to reflect on the events of the day that were and may be still significant. I will like to share the experience of hosting the two WONCA World Conferences that Singapore was privileged to be given the honour to host.

WONCA WORLD CONFERENCE SINGAPORE 2007

I was President for the period of 2007 to 2011. The year 2007 was the year that the Singapore College hosted the WONCA World Conference for the second time. Dr Tan See Leng was the Host Organising Chairman and he was interviewed in *The College Mirror* of the day by Dr Shiau Ee Leng (refer to Figure 1). It was a journey of ten years, recounted Dr Tan. Nevertheless, it was a successful Conference and thanks are due to him and his Team. We initially bid in 1997 to host the World Conference but lost to the Americans, who went on to host the 2004 World Conference in Orlando. We bid again in 2001 in Durban and this round we beat Australia to host the 2007 World Conference by just one vote. In the 2007 World Conference, we also had a Trade Exhibition organised and this time the late Dr Paul Chan Swee Mong was the Chairman of Exhibition Committee.


THE College Mirror

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PRESIDENT'S FORUM

Welcome to Wonca World Conference 2007

Source: CFPS, 2007

FIGURE 1. *College Mirror* Welcoming Participants to the Singapore Wonca Conference in 2007

WONCA WORLD CONFERENCE SINGAPORE 1983

The 1983 World Conference was Singapore's first foray into hosting a World Conference in General Practice/Family Medicine and I look back at the event with a fair bit of nostalgia. I was relatively young then, in my late 30s, and the people at the helm were Drs Alfred Loh, who was Chair of the Host Organising Committee, and Lim Kim Leong, Moti Vaswani, Paul Chan (deceased), Victor Fernandez (deceased), and Fred Samuel (deceased) who filled the various posts. I was given two tasks as a newly enlisted member of the Host Organising Committee. The first was to help Dr Paul Chan in setting up the Trade Exhibition in Hotel Mandarin Car Park, which turned out to be a huge success; we occupied all four storeys. The second task was to run the Publications Committee. We made a special impression of being the first WONCA Conference to have the Proceedings ready at the start of the Conference. The Proceedings were edited by Drs Patrick Kee, Lim Kim Leong, and myself, with help from other members of the Host Organising Committee.

The 1983 Conference was important to Singapore in introducing ourselves to the world of Family Medicine and that marked the beginning of the journey culminating in the Family Medicine postgraduate training programmes we know today. At the 1983 Conference, Dr Lee Suan Yew was our Singapore speaker in one of the Plenary sessions and he spoke on "Challenge of Family Medicine in Southeast Asia", a pertinent topic of the day. The rest is history: we met the challenge in Singapore and so have the other countries in Southeast Asia.

MMED(FM) 1993, FELLOWSHIP 2000, GDFM 2002

With the WONCA Conference of 1983, General Practice/Family Medicine as a discipline began to attract attention and in 1987, the discipline became a subject in the Undergraduate MBBS Programme. The Master of Medicine in Family Medicine was set up in 1993, Fellowship in 2000, and GDFM in 2002. The details and progression have been covered in Dr Lee Suan Yew's write-up.

INTO THE FUTURE

The recognition of Family Medicine as a specialty will be the next milestone.

Reflections

Associate Professor Lee Kheng Hock
President (2011-2017)
College of Family Physicians Singapore

50 YEARS OF NURTURING TALENTS FOR FAMILY MEDICINE

Why Do You Choose Family Medicine?

I remember the bad old days when we always had more vacancies than applicants in Family Medicine. Sitting in the "selection" panel was often a humbling experience. I remember interviewing one particular candidate more than a decade ago.

You know we always ask the standard obligatory question during selection interviews. "Why do you choose Family Medicine?" Then we wait for the recorder to click and the standard well-rehearsed answers to play.

"I want to take up a traineeship. Oh…I like the office hours with no night calls. I want to go home in the evening to cook for my family."

No other reasons were given when we probed. She didn't know Family Medicine from *Family Guy*.

I kid you not. She didn't mince her words with euphemisms like "a better opportunity for work-life balance" or a more "humanistic career".

The moment she left the room we looked at each other in amusement tinged with sadness. She was one of the last few to be interviewed and we are still about 30 percent short of our quota. Everyone in the panel was shocked when I differed and voted to accept her into the traineeship. I told them that I respected her honesty and also pointed to the obvious fact that we need to train more family physicians and that at this rate we would never reach critical mass. Any willing candidate is precious to me at that time.

The rest of the selection panel were flabbergasted and protested, citing the usual things like the need to maintain high standards and more basic virtues like self-respect for our discipline. I dug my heels in and refused to budge. It was late in the afternoon and they were too tired to prolong the argument with me. They relented and she got in. I followed her career. She was not brilliant but she was diligent. There were a few close calls but she persevered. Today she is an outstanding clinician leader in a public institution and is a good teacher. I am glad I decided to be disagreeable at that moment so many years ago.

The Tide Has Turned

These days, the tide has turned and we have overwhelmingly more candidates than training positions. Notwithstanding that the need for well-trained family physicians has gone up, I hear that we are still leaving vacancies unfilled. Now it is my turn to be flabbergasted. I hear the same old argument about having to maintain standards and our self-respect as a discipline. I personally know some of these candidates who were rejected. They may not be blessed with Winstonian oratorical skills or impressive grades. But I know that they are good doctors and if given even half a chance, will turn out to be excellent family physicians. Almost all of them were as good, if not better than the candidate that I insisted on accepting more than a decade ago.

Human Capitalisation Rate

Recently, I came to learn about the concept of human capitalisation rate and suddenly I understood what had been bugging me all these years. According to my favourite thinker and author, Malcolm Gladwell, human capitalisation rate is the "the percentage of people in any given situation who have the ability to make the most of their potential." If you look at it this way, you can see that the human capitalisation rate for family medicine is dismal. Year after year we see large numbers of doctors with good potential to become excellent family physicians drift into the practice of Family Medicine or other undifferentiated fields without reaching their full potential. Malcolm went on to explain that there are three reasons that may explain poor human capitalisation rate.

Firstly, we wrongly assume that talent is scarce. Essentially, we search with a deficit lens on and cannot see the talent that is right under our nose. We need to adopt a more optimistic, strength-based approach and look for half-full glasses rather than half-empty ones. Secondly, finding talent alone is not enough. You need to put in the proverbial "10,000 hours" to become excellent. Finally, people may not have the talents that you are looking for but they have their strengths. This is the human potential that needs to be optimally capitalised. More often than not, their strengths can overcome their weaknesses with the right amount of support and training. Innate talent is overrated.

This is not a criticism of the system of training but a commentary on our natural tendency to overlook talent. We also fail to understand that talent is not everything when

it comes to human capitalisation. It is about maximising potential as they are found. My take on what the College has been doing for the past 50 years is about helping Family Physicians train to the highest level that they wish to and practise at the top of their licence. This in turn has made tremendous contributions to our healthcare system and our nation. I shudder to think what would have happened in an alternate universe 50 years ago when the men and women of vision had not gone against the tide and created our College. Family Medicine would probably still be a non-entity and we would be stuck in the 1970s mode of hardworking but untrained GPs trying their best but being totally neglected.

Today, we have a better system in place thanks to the visionary leaders and passionate members of our College. The Government Outpatient Service has evolved into Polyclinics that provide state-of-the-art care in chronic disease management. GP clinics are better organised in networks and are making critical contributions to the public sector through many government subsidy schemes that are inclusive of FPs in private practice. Community hospitals have sprung up that are staffed by Family Physicians providing inpatient care to patients with complex health and social care needs. Even acute hospitals have Family Medicine units that work on transitional care and population health initiatives. We have Family Medicine departments in all our medical schools where we find increasing numbers of academic Family Physicians who are making cutting edge contributions in research and education. We have gained the respect and recognition of our specialist colleagues in the Academy of Medicine Singapore.

Family Medicine as a Specialty in Singapore

In 2017, the College of Family Physicians Singapore was invited to assist in the formation of a Chapter of Family Medicine Physicians. We are now at the threshold of being officially recognised as a specialty. A joint workgroup of the CFPS and AMS will be presenting a formal proposal to the Specialist Accreditation Board to recognise Family Medicine as a Specialty in Singapore. This may yet be the most fitting accolade to the 50 years of contribution made by the College of Family Physicians Singapore.

WORK OF THE COLLEGE 1971-2021

A/Prof Cheong Pak Yean
Past President (2001-2007)
College of Family Physicians Singapore

A/Prof Goh Lee Gan
Past President (2007-2011)
College of Family Physicians Singapore

INTRODUCTION

This review on the work of the College from 1971 to 2021 focuses on the College's role in the training of Family Medicine (FM) practitioners to serve our people.

UNDERGRADUATE FAMILY MEDICINE EDUCATION

Ever since the clinical attachment programme was started in 1970, clinical attachments of medical students to general practitioner clinics have been arranged by the College.

In 1987, FM was accepted as an academic discipline in the National University of Singapore (NUS). The Department of Social Medicine and Public Health (SMPH) was given the responsibility of teaching the discipline in the undergraduate Bachelor of Medicine, Bachelor of Surgery (MBBS) programme. To reflect this role, the name of the Department was changed to Department of Community, Occupational, and Family Medicine (COFM). In 2008, undergraduate FM shifted to being taught by the Division of FM in the Department of Medicine, and from 2018, via the Department of FM in the Yong Loo Lin School of Medicine (YLLSOM). Academic undergraduate programmes were also started in Duke-NUS Medical School and Lee Kong Chian School of Medicine (LKCMedicine) in 2005 and 2013 respectively.

Numerous members of the College of Family Physicians serve as Clinical Tutors in the Undergraduate Family Medicine Clinical Postings Programme. The success and sustainability of the Undergraduate Family Clinical Postings Programme are due to the efforts of our FM practitioners. The College is indeed grateful for their years of contribution over the last five decades.

POSTGRADUATE FAMILY MEDICINE EDUCATION

Table 1 lists the chronology of the four stages of the Postgraduate Family Medicine education development in Singapore. Postgraduate programmes evolved with the establishment of training programmes for the Master of Medicine in Family Medicine [MMed(FM)], the Fellowship programme (FCFPS), and the Graduate Diploma in Family Medicine (GDFM) in chronological order. The development of these Postgraduate FM training programmes traverse four stages in the past five decades.

First stage. In the first 20 years starting from 1972, the College conducted courses and examinations leading to Diplomate Membership (MCGP). Fellowships were then awarded by election for service. Other family doctors joined the College as ordinary members.

Second stage. In its second stage of development from 1991 to 1998, the Masters programmes in FM were set up to replace the MCGP. In 1993, the College changed its name from College of General Practitioners (CGP) to College of Family Physicians Singapore (CFPS).

Third stage. The third stage from 1998 to 2004 saw the development and consolidation of the existing training structures that we are familiar with today. The Fellowship programme by assessment was started in 1998 to replace the Fellowship by election. The Graduate Diploma in Family Medicine (GDFM) was started in July 2000.

Fourth stage. In the fourth stage of postgraduate FM training development, which now has a decade of history from 2011, the Ministry of Health (MOH) Residency programmes replaced the MOH traineeship programme, and the MMed(FM) College programme replaced the MMed(FM) Programme B. The Institute of Family Medicine, set up in 2002, continues to develop the FM Postgraduate programmes under the administration of the Censors' board of the College.

Table 1: Chronology of postgraduate FM training programmes in Singapore

Start Year	Conferred from	MILESTONES	Remarks
1st Stage: The Diplomate Membership			
1972	1972	Diplomate Membership (MCGP) by assessment	Last examination, the 15th conducted in 1992
1972	1973	FCGP/FCFP (1) by election	Last fellows elected in 2003
1987		Undergraduate Academic FM (2)	Steering committee for FM formed
2nd Stage: The Master of Medicine (FM)			
1991	1993	MMed(FM) MOH traineeship	Replaced by MOH residency programmes in 2011
1995	1997	MMed(FM) Private Practitioners Stream (PPS)	Replaced by Programme B in 1998
1998		MMed(FM) Programme B	Replaced by the College programme in 2011
3rd Stage: Academic FM structures			
1998		MCFP by election	For those with MMed(FM)
1998	2001	FCFP by assessment (Fellowship programme)	Advanced Specialist Training (AST) in FM for those with MCFP
1999	2002	Graduate Diploma in FM (GDFM)	For those with MBBS
2002		Institute of FM established	
2004	2006	MCFP by assessment	For those with GDFM and additional course work
4th Stage: Residency & Register			
2011		Residency programmes	Masters later made an "exit" benchmark
2011		MMed(FM) College Programme	
2012		Family Physicians Register	MOH plans to set up this register by 2007. It was first announced on 22 Dec 2004
2014		Chapter of FM Physicians, Academy of Medicine	

MAINTAINING STANDARDS

There was only one academic standard for family medicine training in Singapore 50 years ago – that of the Diplomate examination for the MCGP. The training programme and examination were set up with the assistance of the Royal Australasian College of General Practitioners (RACGP) as well as prominent local specialists and general practitioners.

Dr James Chang, who was in the first batch of MCGP who passed the examination, recalled being coached to conduct examinations by Prof Seah Cheng Siang and other local doctors, as well as Australian examiners in Melbourne in 1973. Dr Chang subsequently became the censor-in-chief for the diplomate examination. These standards were elaborated upon by Dr Wong Heck Sing in 1978 in the first Sreenivasan Oration, "The Future of the Singapore General Practitioner".[1]

Twenty years later in 1991, FM training was transferred from the College to a tripartite body, the Joint Committee of Advanced Specialty Training (JCAST), and a university Masters degree replaced the Diploma awarded by the College (MCFP). A training and examination format following that of other specialities that was developed. FM traineeships were awarded for those in public service who had completed three years of training with two years spent in hospital specialist departments. The development subsequently devolved from JCAST to another committee, the Joint FM Committee.

In 1994, a number of doctors who had completed their training but left service were allowed to take the MMed(FM) examination. A new training programme called the "Private Practitioners' Stream" (PPS) was approved. Soon, other doctors who were in private practice as well as non-trainees in public service also joined this two-year part-time

programme. As this PPS programme took in an increasing number of doctors from institutions, its name was changed to "Programme B" in 1998 to distinguish it from "Programme A", the MOH FM traineeship programme. Those enrolled in Programme B (as opposed to trainees in Programme A) were not funded by MOH.

1998 was a watershed year. The FM leaders reviewed the numbers of Masters trainees trained in both streams A & B, and concluded that we were far from the critical mass that would uplift the practice of FM. The small numbers were due to there being only one high academic standard. The decision was made by the College leadership to develop another new training programme, the GDFM, for those with MBBS. The programme took off in 2000. In March 2002, MOH gave the College a grant of SGD 382,000 to develop and build up capacity for the GDFM Course.

An advanced specialist training (AST) programme to fellowship replacing awards of fellowship by election was also set up in 1998. The key objective of the FM AST programme was to train leaders and teachers for the larger numbers in training at the GDFM, Masters, and Fellowship levels entering the respective programmes.

TABLE OF FM SKILLS ACQUISITION

By 2014, all different levels of FM training were in place.[2] See Table 2.

Table 2. Table of Skills Acquisition

Skills sets	Skills acquisition (after Dreyfus)
Novice	Undergraduate education
Advanced Beginner	MBBS
Competent	GDFM
Proficient	MCFP, MMed(FM)
Expert	Fellowship
Mastery	Practice
Source: Goh LG, Ong CP, 2014.[2]	

As of 31 March 2021, there are 1,463 doctors with GDFM, 741 doctors with MMed(FM), and 210 doctors with FCFPS.

ENSURING SUSTAINABILITY

The Institute of Family Medicine inaugurated in 2002, embarked on training FM trainers to teach the various postgraduate FM programmes. A learning community for the whole teaching cascade from training FM specialist fellows, Masters, and graduate FM Diplomates has been in place for some years now. We need to continue to develop these pools of training talents.

FAMILY MEDICINE AS ONE DISCIPLINE IN MANY SETTINGS OF CARE

It is clear that besides FM in the community setting, the discipline of FM is also necessary in the care of patients in many other settings from acute tertiary care to intermediate and long-term care, as well as palliative care. Trained family physicians who are in leadership positions in these settings have been trained in the shared ethos and skills of the above-mentioned integrated training structures.

FM as one discipline in many settings is now established in Singapore. We need to continue to develop it as a discipline that will help to provide the quality of care to "beyond hospital to the community", "from quality to value", and "from healthcare to health".

CONCLUSIONS

Together, the FM fraternity in the various healthcare clusters working synergistically with the College have developed FM to what it is today. We need to continue to develop it to serve our people. The paradigm of practice of Singapore Family Medicine is "one discipline in many settings".

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1. Wong HS. The First Sreenivasan Oration, 1978 The Future of Singapore General Practitioner. Singapore Family Physician. Singapore Family Physician 1978, 4:3&4. URL: https://www.cfps.org.sg/assets/Sreenivasan-Oration/1978-Sreenivasan-Oration-Dr-Wong-Heck-Sing.pdf. Accessed: 1 Dec 2021.
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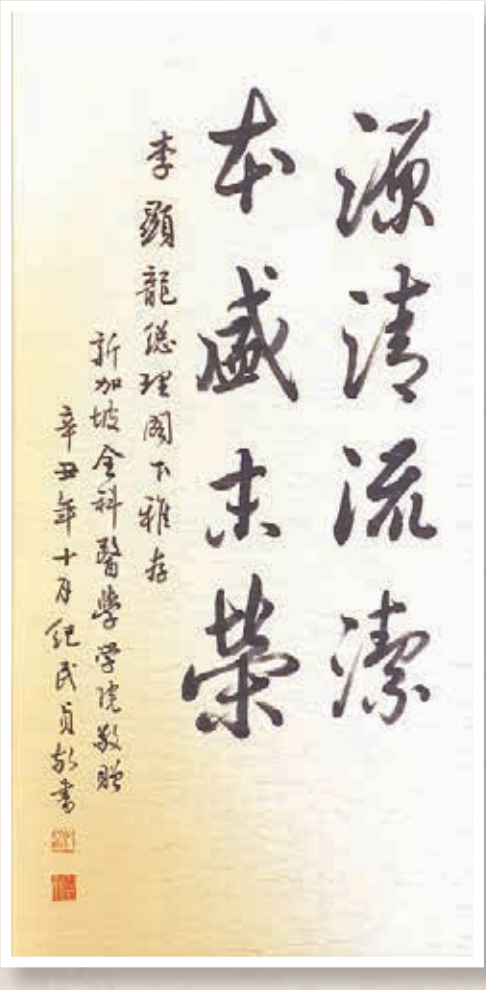
Pictorial Story of The College

50th Anniversary Calligraphy Scroll



Calligraphy scroll gifted by the College of Family Physicians Singapore to Prime Minister Lee Hsien Loong to commemorate the College's 50th Anniversary.

CALLIGRAPHY COUPLET

源 清 流 洁， 本 盛 末 荣
Yuán qīng liú jié , běn shèng mò róng

The author, Ban Gu (AD 39-92), was a Chinese historian, politician, and poet during the eastern Han Dynasty, and was best known for his part in compiling the Book of Han, the second of China's 24 dynastic histories.

The couplet, consisting of four words each, is taken from a work by Ban Gu to memorialise the life and achievement of Liu Bang, the first Emperor of the Han Dynasty. The couplet is inscribed on a stone tablet placed in Sishuiting, Pei County, where Liu Bang served for many years as a low-ranking official before leading the rebellion that saw him eventually crowned as the inaugural Emperor of the Han Dynasty.

The Meaning of the Couplet

Streams with clean water at the source will have clean water flowing downstream. Trees with deep roots will have flourishing leaves growing from it.

They:

- congratulate a leader or organisation who has laid down a good beginning and a solid foundation for the success that follows. This success will depend on its foundation and roots; and
- also refer to leaders who set a good example of being untainted and incorruptible, thereby ensuring that their subordinates and followers will also espouse similar values.

东汉 班固（泗水亭碑铭）

意思: 源头的水清，流出的水也是清洁的，树根札得深，树叶必定茂盛多姿，常以此言作祝词，愿其开头正当，结局也好！

【源清流洁】水的源头清了，下面的水流自然干净。比喻事物因果相关，有好的起头，就会有好的结果。也比喻领导廉明，下属也就廉洁。◆也作“源清流清” “源清流净” 。《荀子· 君道》 : “源清则流清，源浊则流浊。”

【本盛末荣】本：草木的根。末：梢端。荣：茂盛。草木根部发达，就能枝繁叶茂。比喻事物的兴盛取决于根本。

【释义】比喻因果相关，事物的源头、根本好了，其发展、结果自然就好。

Pictorial Story of The College

WORLD CONFERENCES HELD IN SINGAPORE

10TH WONCA WORLD CONFERENCE ON FAMILY MEDICINE
20-24th MAY 1983

Singapore hosted the 10th Wonca World Conference in 1983. It was anchored by a Host Organising Committee consisting of seven members, who were joined by three secretariat staff.

Picture 1. Host Organising Committee of 10th Wonca World Conference

Seated from left to right: *Dr Lim Kim Leong (Organising Secretary), Dr Alfred Loh (Chairman), Dr Victor Fernandez (Deputy Chairman & Treasurer)*

Standing from left to right: *Dr Moti Vaswani (Chairman, Publicity Sub-Committee), Dr Goh Lee Gan (Chairman, Publications Sub-Committee), Miss Teo Siew Gek (Administrative Assistant), Miss Janet Ho (Administrative Secretary), Miss Theresa Loh (Administrative Assistant), Dr Paul Chan (Chairman, Exhibitions Sub-Committee)*

Not in picture: Dr Fredrick Samuel (Chairman, Scientific Sub-Committee)

The Conference was opened by then President Devan Nair. Picture 2 shows President Nair with then Wonca President Dr Arthur Hoffmans, and then President of the College Dr Victor Fernandez.

Picture 2. President Devan Nair flanked by Dr Arthur Hoffmans and Dr Victor Fernandez (20 May 1983)

Picture 3. Audience at the Opening Ceremony

The Opening Ceremony was held at the World Trade Centre. Wonca then had 31 member countries compared to 119 member orgnaisations from 93 countries. There was an attendance of 1,000 in 1983 including some 250 accompanying persons. The 2007 conference had more than 2,000 delegates.

Pictorial Story of The College

1983 WONCA World Conference

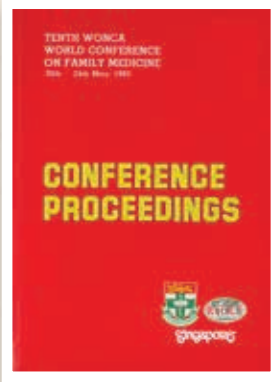
Picture 4. WONCA Conference Plenary Speaker: Dr Lee Suan Yew

The Conference had five segments: the Keynote address, Plenary sessions, WONCA Open Forums, Free Papers Sessions, and Workshop Seminars. Dr Lee Suan Yew was a Plenary Speaker. His topic was "Challenges of Family Medicine in South East Asia".

Picture 5. International delegates at the 10th Wonca World Conference on Family Medicine in 1983.

A Conference Proceedings was available at the Conference. In it were the full text of the Keynote Address, 13 Plenary Papers, 25 Open Forum Papers from the Wonca Standing Committees, and a selection of 96 Free Standing Papers.One of the features of the 10th Wonca Confernce was a Daily Bulletin. The full-sized cover page of the five daily bulletins are reproduced on the subsequent pages.

Picture 6. Souvenir Programme



Picture 7. Conference Proceedings

Picture 8. Abstract Book

Picture 9. Conference Satchel

Pictorial Story of The College

WONCA Taipei 1999

VIPs at 1999 WONCA Taipei Conference

Conference forum

Conference dinner

Pictorial Story of The College

18th WONCA World Conference 2007

[First published in The College Mirror, *September 2007:Vol 33(3)]*

Wonca World Council Meeting

Conducted on the 21-23 July 2007, the Wonca World Council Meeting saw the movers and shakers of the primary healthcare realm.

Opening Ceremony - 24 July 2007

Mr Khaw Boon Wan, Minister for Health Singapore, with Dr Tan See Leng, Prof Bruce Sparks, and A/Prof Goh Lee Gan in the opening ceremony of the 18th Wonca World Conference 2007

Pictorial Story of The College

18th WONCA World Conference 2007

[First published in The College Mirror, *September 2007:Vol 33(3)]*

Keynote Lectures and Plenary Lectures

World renowned speakers - Dr Shigeru Omi, Prof Edison Liu, Dr Francis Collins, Dr Spencer Wells, Prof David B. Goldstein, Prof Yvonne Carter, and many others - delivered practical lectures and updates that brought family medicine in Singapore to a higher level.

Host Organising Committee Dinner - 25 July 2007

A relaxing and warm hospitality dinner organised by the HOC of 18th Wonca World Conference to welcome our international peers and colleagues.

Pictorial Story of The College

WONCA Asia Pacific 2023 Bid

[First published in The College Mirror, *September 2019:Vol 45(3)]*

CFPS *wins* WONCA Asia Pacific 2023 bid

by Dr Xu Bang Yu, FCFP(S), Hon. Treasurer, 27th Council, College of Family Physicians Singapore

An introduction – What is WONCA?

To know the significance of winning such a bid, we must first know what WONCA is about. The World Organization of Family Doctors (WONCA), as it is known, is a global non-profit professional organisation that represents Family Physicians from all regions of the world. But then, shouldn't the acronym be WOFD? The acronym WONCA was originally derived from the initials of the **W**orld **O**rganization of **N**ational **C**olleges, **A**cademies and Academic Associations of General Practitioners/Family Physicians. The name WONCA is therefore the short form of that very long name. WONCA's mission is to improve the quality of life of people around the world through high standards of care in Family Medicine.

Presently, WONCA has seven regions: Africa, Asia Pacific (AP), Eastern Mediterranean, Europe, Iberoamericana-CIMF, North America and South Asia. Each region is represented by a Regional President and Regional Council. The Asia Pacific region is one of the largest regions of WONCA, comprising member organisations from Singapore, Australia, New Zealand, Hong Kong, Japan, Korea, Taiwan, Thailand, Malaysia, Myanmar, Mongolia, Philippines, China, Fiji and Vietnam.

Singapore bids for WONCA Asia Pacific 2023

The College of Family Physicians Singapore (CFPS) sent a team to WONCA Asia Pacific (AP) Conference 2019 in Kyoto to bid for Singapore to host WONCA AP Conference 2023. The team comprised of CFPS President, Adjunct Assistant Professor Tan Tze Lee, Honorary Secretary Dr S Suraj Kumar, Honorary Editor Dr Low Lian Leng and Council Members Dr Wong Tien Hua and myself, with support from College Secretariat's Assistant General Manager Ms Jennifer Lau. CFPS's bid was also supported by the Singapore Tourism Board (STB), and they provided our team with a promotional video of Singapore which we incorporated into our bid presentation.

Support from College Elders, (from left) Dr Alfred Loh (immediate past CEO WONCA); A/Prof Goh Lee Gan (Past Asia Pacific Wonca Regional President 2001-2007), Dr Ryuki Kassai (Scientific Chair, Kyoto Conference), A/Prof Cheong Pak Yean (Past President CFPS, 2001-2007.

Image courtesy of A/Prof Goh Lee Gan

A bid supported by College Elders

A/Prof Goh Lee Gan, A/Prof Cheong Pak Yean and Dr Alfred Loh attended the Kyoto 2019 conference with our CFPS delegation. College seniors might remember that A/Prof Goh was a past regional vice-president of WONCA Asia Pacific region and Dr Loh a past CEO of WONCA. Their presence no doubt lent weight to our bid. Besides going up to Kyoto for the bid, these seniors also gave our team valuable insights from their past experience. A/Prof Cheong Pak Yean lent his support by providing free copies of his new book "Being Human: Stories from Family Medicine". This book was very well received by various members of the WONCA Asia Pacific Council and many were left disappointed due to limited stock!

(continued on the next page)

‹ Catching up with old friends and also making new friends at the networking dinner.

Strengthening CFPS through networking

CFPS arranged for a networking dinner with the various member organizations of the WONCA Asia Pacific region. The evening is filled with lots of catching up with old friends and also making new friends. The progression of Family Medicine, the challenges and new horizons for each member organisations were discussed over a traditional kaiseki dinner. Many new insights and ideas were gained, as this was one way to bond the leadership of Family Medicine across the Asia Pacific region.

CFPS Singapore wins the bid

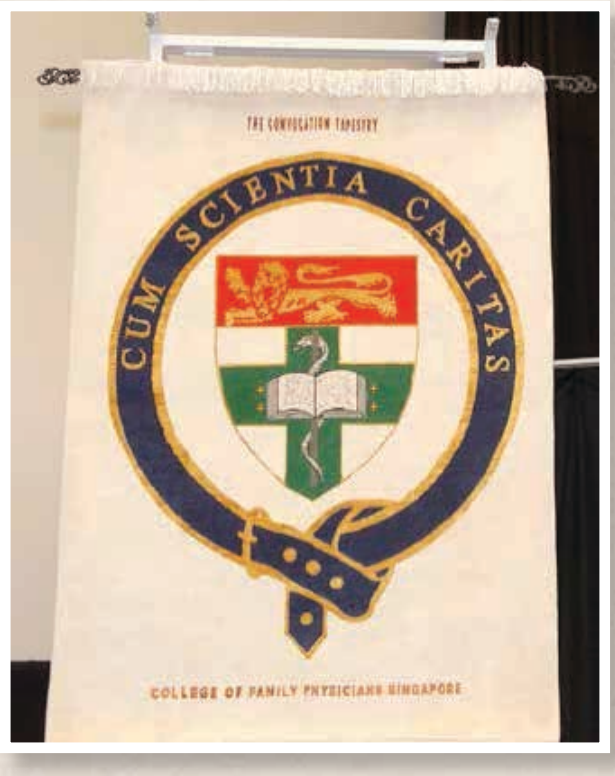
The bidding process was held on the 15th May 2019 during the WONCA Asia Pacific Council Meeting. Dr Low Lian Leng and I had spearheaded the bid, with strong support from College President and Council. Prior to the actual bid, both of us had done much preparatory work, from budgeting, to looking for conference venues to exploring various possible conference themes. And that of course included the all-important power point presentation for that bid day. We were so delighted to have hit the "bull's eye" with unanimous support from all members of the WONCA Asia Pacific Council. With the initial elation from CFPS's victorious bid, we soon realised that we have much work to do in preparation for WONCA Singapore 2023! And yes, College will put up a great show!

CM

Pictorial Story of The College

College Regalia

The College of Family Physicians Singapore has an unique set of regalia for use in ceremonial occasions. The College crest bears the motto *"Cum Scientia Caritas"*, which means scientific knowledge applied with compassion.



College Convocation Tapestry

The College Convocation Tapestry was unveiled on 1 October 2005 by Prof K Satkunantham. It consists of the Academic Crest of the College with the words "The College Convocation Tapestry" and College of Family Physicians Singapore. It was woven using wool and silk threads on a base of silk and measures 1.45m by 1m.

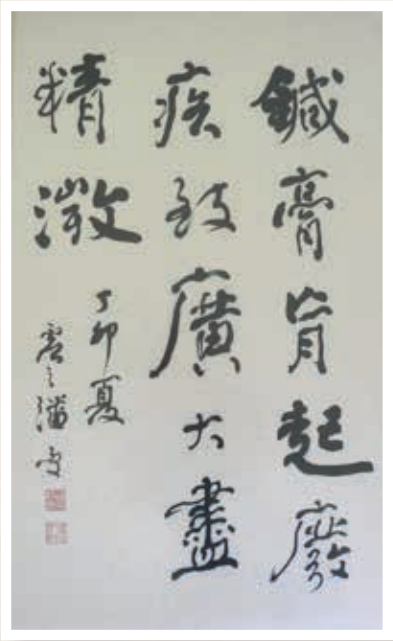
College Mace

The College Mace was installed on 4 November 2007 in memory of Dr Wong Heck Sing. It was presented to the College by the Host Organising Committee of the Wonca 2007 World Conference.

Pictorial Story of The College

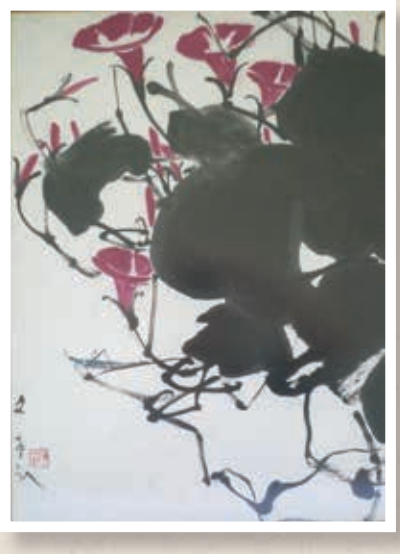
A Selection of College Paintings and Pottery

The majority of these paintings and pottery were either purchased or donated in 1987. Each council member from the 11th Council (1987-1989) contributed $1,000 to purchase these works of art from famous local artists.



Gifted by Pan Shou (June 1987). The famous calligraphist wrote and gifted this meaningful calligraphy scroll specially to the College.

"To cure the incurable, To make the lame walk, To use your skills widely, to strive for excellence."



Morning Glory. Chinese Ink & Brush
Chen Wen Hsi

Gifted by LTC (Dr) Earl Lu, FRCS (June 1987), surgeon and artist.

After a Day's Work. Watercolour
Tay Bak Koi (June 1987)

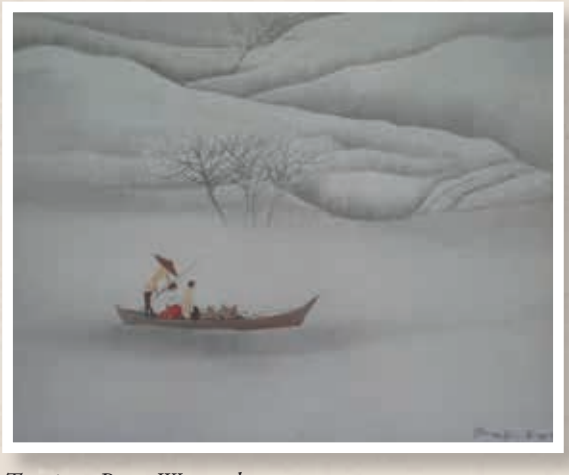
In the Evening. Watercolour
Tay Bak Koi (June 1987)

Fishing. Watercolour
Tay Bak Koi (June 1987)

Pictorial Story of The College

Fishing Alone. Watercolour
Tay Bak Koi (June 1987)

Gifted by LTC (Dr) Earl Lu, FRCS (June 1987), surgeon and artist.



Two in a Boat. Watercolour
Tay Bak Koi (June 1987)

Movement in Silver/Gold
Gifted to the College of Family Physicians by Thomas Yeo (June 1987)

Lotus Study. Chinese Ink & Colour
Henri Chen (June 1987)

Pictorial Story of The College

In Search of Atlantis. Lithography
Lu Kuo Shiang (June 1987)

Chinatown Street Scene. Watercolour
Ong Kim Seng (June 1987)

Coleman Bridge. Watercolour
Peh Eng Seng (July 1987)

Presented by Academy of Medicine, Singapore

Singapore River. Watercolour
Goh Chye Khee (June 1987)

Lotus, Chinese Ink & Brush
Chen Wen Hsi
Presented by LTC. (Dr) Earl Lu FRCS (June 1987)

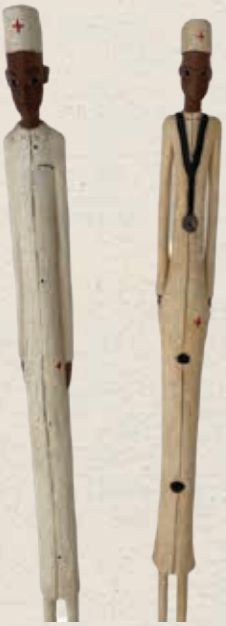
Pictorial Story of The College

Tang Dynasty (618–907)
Phosphatic Splash Stoneware Jar

Balinese Carving. Satin Wood.

Significance: Just like this intricate Balinese carving originated from a "simple" piece of wood, Family Medicine was also seen as "simple" to many in the 1970s and 1980s, but the art of Family Medicine can also enrich the lives of many patients through the practice of holistic medicine.

Gifted by Dr & Mrs Lee Suan Yew (June 1987)



African statues gifted to the College of Family Physicians Singapore by overseas delegates.

Qing Dynasty (1644–1912)
Ox-Blood Vases & Brush Washer

A Green Glazed "Hu".
The body decorated with "taotie" mask. Mock ring handles and the glaze frosted overall with a silvery iridescence.

Han Dynasty
BC 220–AD 206

Cliosonne Vase gifted to the College of Family Physicians Singapore

Pictorial Story of The College

Commemorative Stamps

2021 marks the 50th anniversary of the College of Family Physicians Singapore.

To celebrate the College's 50th anniversary, CFPS has collaborated with SingPost to release an inaugural set of commemorative stamps showcasing the contributions of family doctors in Singapore, and to mark the beginning of the next chapter of Family Medicine in Singapore. This set of stamps depicts the diverse roles of family doctors in Singapore and the varied settings in which they practise. These six stamps showcase the areas of: health promotion, acute medical services, chronic disease management, community hospital care, pandemic response, and continuous medical education and research.

Pictorial Story of The College

Reciprocal Recognition Between the Royal Australian College of General Practitioners and the College of Family Physicians Singapore

On 6 October 2010, a memorandum on the reciprocal recognition of the FRACGP and the FCFP(S) was signed at Cairns Convention Centre between RACGP and the College in Cairns, Australia. This signing ceremony celebrates the decision of reciprocal recognition of the fellowships of the two Colleges and leads to the award of the FRACGP by Fellowship *ad eundum gradum* to those with FCFP(S) who wish to apply and are working in Australia.

Memorandum on the reciprocal recognition between the FRACGP and the FCFP(S) on 6 October 2010.

A/Prof Goh Lee Gan, immediate Past College President, signing the memorandum with RACGP immediate Past President, Dr Chris Mitchell on 6 October 2010.

Gift of wine decanter from RACGP to commemorate the reciprocal recognition of the FRACGP and the FCFP(S).

Pictorial Story of The College

Five Decades

In The 1970s

SINGAPORE MEDICAL ASSOCIATION

MEDICAL Newsletter

A BI-MONTHLY PUBLICATION OF THE SINGAPORE MEDICAL ASSOCIATION

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E. K. KOH
LIM SIEW MING
TAN KHENG KHOO

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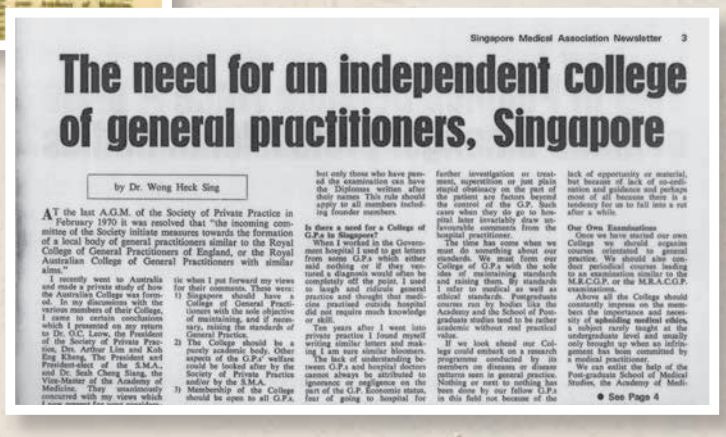
AN ACADEMIC BODY FOR G.P.s IN SINGAPORE

by
John H. Hunt, O.M., F.R.C.P., F.R.C.S.
President, Royal College of General Practitioners

Editorial The Speech

An SMA News Report on a speech by Lord Hunt of Fawley from the British College on the setting up of a GP College for Singapore.



Singapore Medical Association Newsletter 3

The need for an independent college of general practitioners, Singapore

by Dr. Wong Heck Sing

AT the last A.G.M. of the Society of Private Practice in February 1970 it was resolved that "the incoming committee of the Society initiate measures towards the formation of a local body of general practitioners similar to the Royal College of General Practitioners of England, or the Royal Australian College of General Practitioners with similar aims."

I recently went to Australia and made a private study of how the Australian College was formed. In my discussions with the various members of their College, I came to certain conclusions which I presented on my return to Dr. D.C. Louw, the President of the Society of Private Practice, Drs. Arthur Lim and Koh Eng Kheng, The President and President-elect of the S.M.A., and Dr. Soah Cheng Siang, the Vice-Master of the Academy of Medicine. They unanimously concurred with my views which

tic when I put forward my views for their comments. These were:
1) Singapore should have a College of General Practitioners with the sole objective of maintaining, and if necessary, raising the standards of General Practice.
2) The College should be a purely academic body. Other aspects of the G.P.s' welfare could be looked after by the Society of Private Practice and/or by the S.M.A.
3) Membership of the College should be open to all G.P.s

but only those who have passed the examination can have the Diplomas written after their names. This rule should apply to all members including founder members.

Is there a need for a College of G.P.s in Singapore?

When I worked in the Government hospital I used to get letters from some G.P.s which either said nothing or if they ventured a diagnosis would often be completely off the point. I used to laugh and ridicule general practice and thought that medicine practised outside hospital did not require much knowledge or skill.

Ten years after I went into private practice I found myself writing similar letters and making I am sure similar blunders.

The lack of understanding between G.P.s and hospital doctors cannot always be attributed to ignorance or negligence on the part of the G.P. Economic status, fear of going to hospital for

further investigation or treatment, superstition or just plain stupid obstinacy on the part of the patient are factors beyond the control of the G.P. Such cases when they do go to hospital later invariably draw unfavourable comments from the hospital practitioner.

The time has come when we must do something about our standards. We must form our College of G.P.s with the sole idea of maintaining standards and raising them. By standards I refer to medical as well as ethical standards. Postgraduate courses run by bodies like the Academy and the School of Postgraduate studies tend to be rather academic without real practical value.

If we look ahead our College could embark on a research programme conducted by its members on diseases or disease patterns seen in general practice. Nothing or next to nothing has been done by our fellow G.P.s in this field not because of the

lack of opportunity or material, but because of lack of co-ordination and guidance and perhaps most of all because there is a tendency for us to fall into a rut after a while.

Our Own Examinations

Once we have started our own College we should organise courses orientated to general practice. We should also conduct periodical courses leading to an examination similar to the M.R.C.G.P. or the M.R.A.C.G.P. examinations.

Above all the College should constantly impress on the members the importance and necessity of upholding medical ethics, a subject rarely taught at the undergraduate level and usually only brought up when an infringement has been committed by a medical practitioner.

We can enlist the help of the Post-graduate School of Medical Studies, the Academy of Medi-

See Page 4

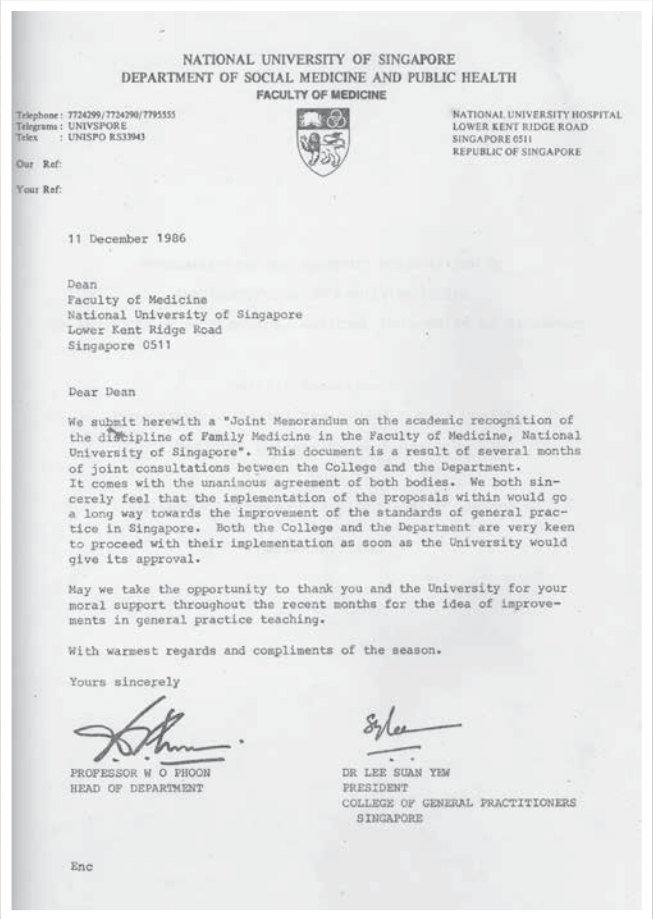
This article was written by Dr Wong Heck Sing of the encouragement and support given by the Australian College for GPs in Singapore. It was published in the SMA Newsletter and it served as the manifesto for the formation of the College of General Practitioners Singapore.

The First Council of the Singapore College. The College was officially registered with the Registrar of Societies on 30th June 1971.

From left to right: Dr Ted Wong Hoption, Dr Colin Marcus, Dr Koh Eng Kheng, Dr Lim Boon Keng, Dr Foo Choong Khean, Dr Wong Heck Sing, Dr BR Sreenivasan, Dr Wong Kum Hoong, Dr Leow On Chu. Absent: Dr Chen Chi Nan

Pictorial Story of The College

In The 1980s



NATIONAL UNIVERSITY OF SINGAPORE
DEPARTMENT OF SOCIAL MEDICINE AND PUBLIC HEALTH
FACULTY OF MEDICINE

Telephone : 7724299/7724290/7795555
Telegrams : UNIVSPORE
Telex : UNISPO RS33943

NATIONAL UNIVERSITY HOSPITAL
LOWER KENT RIDGE ROAD
SINGAPORE 0511
REPUBLIC OF SINGAPORE

Our Ref:
Your Ref:

11 December 1986

Dean
Faculty of Medicine
National University of Singapore
Lower Kent Ridge Road
Singapore 0511

Dear Dean

We submit herewith a "Joint Memorandum on the academic recognition of the discipline of Family Medicine in the Faculty of Medicine, National University of Singapore". This document is a result of several months of joint consultations between the College and the Department. It comes with the unanimous agreement of both bodies. We both sincerely feel that the implementation of the proposals within would go a long way towards the improvement of the standards of general practice in Singapore. Both the College and the Department are very keen to proceed with their implementation as soon as the University would give its approval.

May we take the opportunity to thank you and the University for your moral support throughout the recent months for the idea of improvements in general practice teaching.

With warmest regards and compliments of the season.

Yours sincerely

PROFESSOR W O PHOON
HEAD OF DEPARTMENT

DR LEE SUAN YEW
PRESIDENT
COLLEGE OF GENERAL PRACTITIONERS
SINGAPORE

Enc

The Joint Memorandum on the academic recognition of the discipline of Family Medicine in the Faculty of Medicine, NUS submitted on 11 December 1986. On 13 February 1987, the Department of COFM was formed.

Opening of the new College Premises. Our present premises at the College of Medicine Building was officially opened by Mr Howe Yoon Chong on 15 August 1987.

College Examiners. From left to right: Drs Lee Suan Yew, Lim Kim Leong, Prof Wesley Fabb and Dr Tan Yean Tin. Prof Fabb from the Royal Australian College of General Practitioners and an Honorary Fellow of our College was the first of the external examiners of our MCGP examination. Together with Dr Richard Banks Geeves, he was sent to Singapore by the RACGP to help us set up our first examinations. Prof Fabb was also the first HMDP expert in Family Medicine in 1988.

Pictorial Story of The College

In The 1990s

One important milestone in the 1990s was the development of formal vocational training Programme in Family Medicine. The Diplomate Programme of the College (MCGPS) provided the foundation for an MMed Family Medicine Programme. The last batch of the MCGPS graduated in 1992.

Graduands of 15th MCGPS in 1992

The MMed Family Medicine Programme was approved by the Senate of the National University of Singapore in 1991 and the first Examination was conducted in 1993. In 1995, a Private Practitioner Stream was started with a programme of 40 tutorials a year for two years, and a clinical refresher course lasting one week. A Graduate Medical Centre was set up on the floor above Dr Cheong Pak Yean's Clinic. For several years, this Centre was the training centre for the Private Practitioner Stream. The course participants sat for the same MMed FM Examination. The Graduate Medical Centre also became the training ground for the first College Fellowship Programme in 1998.

The Graduate Centre was "officially" opened in 1998, with Prof John Murtagh and Prof Lewis Ritchie as the Guests-of-Honour. They were Visiting Lecturers in the MMed FM Advanced Course being conducted at that time.

Opening of the Graduate Medical Centre with Dr Cheong Pak Yean giving his address.

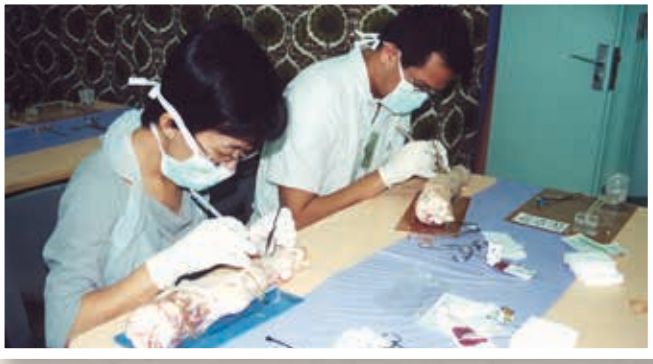
Group photograph at the official opening of the Graduate Medical Centre. The First Batch of Fellows in training are in the back row.

Pictorial Story of The College

In The 2000s

The 2000s marked a period of consolidation of Family Medicine training and development. The first batch of the Fellowship of the College of Family Physicians (FCFPS) by Assessment, which started in 1998, had their Exit Examination in 2000. There were eight graduands. Another educational activity was the minor surgical procedures course conducted by our surgical colleagues. This course introduced an alternate use for pig trotters as material for learning stitching skills.

Inaugural FCFP Exit Interview 2000



Minor Surgical Procedures Course 2001 `17-18 – Stitching pig trotters

In the second half of the 2000s, family medicine research began to be a focal point of interest as the spinoff of a 2003 Wonca Research Conference in Canada. This led to the Asia Pacific Research Workshop in Phuket in 2005, and eventually to the Inaugural Asia Pacific Conference on Primary Care Research (APCPCR) in Malacca in 2009 and the Second Asia Pacific Conference on Primary Care Research (APCPCR) in Singapore in 2010. Prof John Rush from the Primary Care Research Network (PCRN) Singapore and Prof Jan Radford, Censor-in-Chief from the Royal College of General Practitioners of Australia, were speakers at the Conference in Singapore. The Research Conferences aimed at teaching and coaching participants in research skills. Attractive prizes were awarded for the best research efforts.

Group photograph of the 2nd APPCR Conference Participants on 5 December 2010

Speakers of the 2nd APPCR Conference Participants on 5 December 2010: Prof John Rush and Prof Jan Radford

Research awards given at the APPCR Conference

Pictorial Story of The College

Shifting to the College Building (Present Premises)

Opening of the College at MOH, 1987

Family Medicine in 2021 and Beyond

The 28th Council (2021-2023)
College of Family Physicians Singapore, December 2021

BACKGROUND

Family Medicine is an academic and clinical discipline focused on the provision of person-centred, continuing, comprehensive, and coordinated care for an individual across their life cycle in the context of their families, communities, and environment. Family medicine addresses the needs of an ageing population and the increase of non-communicable diseases at the primary care level by incorporating health education and prevention within clinical care.[1,2] Strong primary care is an essential cornerstone to achieving health equity as the practice of family medicine considers the biological, psychological, social, economic, cultural, and spiritual parameters, and is not limited by age, race, gender, organ, system, or disease.[3,4]

Family physicians form the bedrock of the healthcare system and are usually the patients' first contact with healthcare services. Primary care serves as an important point of entry into the rest of the healthcare system[4] and Family Physicians are largely sought by patients to navigate the increasingly complex healthcare system of today.

In Singapore, primary care is gaining recognition as playing an important role in the future of Singapore's healthcare. A strong primary healthcare translates to a cost-effective healthcare system, better health equity, and a healthier population.[3,4]

As Singapore continues to strengthen the role of primary care in Singapore's healthcare system to achieve the vision of "One Singaporean, One Family Doctor", the discipline of family medicine must continue to adapt to best meet the needs of patients in a changing healthcare environment.

VISION AND MISSION

The vision and mission of the College of Family Physicians Singapore is to promote and maintain the high standards of the practice of family medicine through advancing the art and science of medicine, continually redesigning and improving upon the training and education of family physicians, and advocating for family physicians.

BUILDING UPON THE CORE COMPETENCIES OF A FAMILY PHYSICIAN

The College of Family Physicians Singapore defines a family physician as a registered medical practitioner who has acquired core competencies in the following areas after successfully completing a structured and comprehensive training program that is accredited by a recognised professional body or institution that provides for such training.[5]

The six core competencies of a Family Physician include[5]:

1. Clinical care
2. Person-centred care
3. Comprehensive and continuing care
4. Collaborative and integrated care
5. Community-orientated care
6. Professionalism

A family physician is required to maintain competence through dedicated and rigorous participation in continued professional development activities that include ongoing medical education, audit, quality improvement, and research and teaching in the discipline of family medicine.[5]

Family physicians are highly skilled generalists who deal with undifferentiated clinical problems presenting at an early stage. Family physicians not only deal with acute illnesses that might be life-threatening, but also regularly treat chronic diseases, psychological or emotional problems, and transient illnesses.

Central to the practice of family medicine is a strong patient-doctor relationship. Family physicians are their patient's champions and healthcare advocates. They get to know their patients, and tailor care and advice to meet their patients' changing needs and stages of life. Family physicians collaborate with specialists and other healthcare professionals to deliver coordinated, holistic, comprehensive, and patient-centred care.

Family physicians often take on various roles in multiple and varying practice environments that require a high level of adaptability.[6] Family physicians are generalist clinicians, friends, servants, helpers, facilitators, advisors, communicators, teachers, mentors, leaders, advocates, and researchers.[6] Although all health professions provide valuable services to their patients and the healthcare system, family physicians fill a unique central leadership role not replicable by other healthcare professions.

Family Medicine Perspectives

FAMILY MEDICINE EDUCATION

The College of Family Physicians Singapore is dedicated to advancing family medicine in Singapore through its mission to upgrade and up-skill doctors through education, research, and advocacy.

Family medicine education plays an important role in training a culturally diverse family physician workforce that meets the needs of the community in an evolving healthcare landscape. In addition to clinical practice and medical knowledge, family physicians must also be trained in cultural proficiency, quality improvement, health informatics, evidence-based medicine, practice-based research, and the biopsychosocial model of care. Such training develops family physicians who are committed to excellence, embody the core values of the family medicine discipline, are experts in providing primary care, are skilled at adapting to varying patient and community needs, and are prepared to embrace new evidence-based technologies and innovations.

LIFELONG LEARNING

Medical practice constantly evolves as new information supplants old.[7] As professionals, family physicians are obliged to keep abreast of advances and trends in medicine and healthcare delivery so that they can continue to adapt to the changing ecology of the medical environment.[7] Lifelong learning is also a process of continuously scrutinising and building on one's practice to be the best family physician one can be.[8]

In today's healthcare environment, family physicians are being held to unprecedented levels of accountability to patients, families, communities, society, and payers. A greater emphasis is being placed on measuring and improving the clinical and fiscal outcomes of medical care. Hence, lifelong learning should involve both the acquisition of knowledge and process of decision-making such that family physicians are better able to use their knowledge as they make clinical judgements. In fact, maintenance of professional competence remains an exercise of lifelong learning and an essential requirement for evidence-based medical practice.

ENHANCING THE ART AND SCIENCE OF FAMILY MEDICINE

To lead and facilitate change in healthcare, a wide base of knowledge is essential. Family physicians should participate in the generation of new knowledge that will be integral to the activities of all family physicians.

Family Medicine research in Singapore can enhance the quality of healthcare by improving our understanding and practice of family medicine in various settings. Translating research findings into clinical practices can benefit patients through evidence-based primary healthcare and enrich family medicine as an evolving and critically important medical discipline in Singapore.[9] A strong culture of family medicine knowledge is needed to strengthen the discipline's ability to improve the health of individuals, families, and communities.

FAMILY MEDICINE AND PUBLIC HEALTH

Positioning family physicians at the frontline of primary care through focusing on creating integrated and high-value healthcare can invigorate the healthcare system. Family physicians serve as the first point-of-contact with health services and facilitate entry to the rest of the healthcare system.[10] With the rise of chronic diseases, the pendulum has shifted in the direction of integrated, comprehensive, and person-centred primary care. These chronic diseases are affected by social, environmental, and community determinants of health. Family physicians with their ability to recognise patient risk factors and intervene are the backbone of a strong primary care infrastructure that can prevent and manage these diseases. As an indispensable pillar of the healthcare system, primary care has been shown to be associated with enhanced access to healthcare services, better health outcomes, and a decrease in hospitalisation rates and emergency department visits.[11] Effective primary care can also help counteract the negative impact of poor economic conditions on health.[11]

The COVID-19 pandemic has highlighted the critical roles family physicians play at the front line. As the first point-of-contact in the healthcare system, family physicians have a crucial role to play in the identification and surveillance of early clusters. Family physicians' close physical proximity to patients' homes and the knowledge that family physicians have of their patients is also pertinent to the effective rollout of the home recovery programme of patients and vaccine promotion.

By integrating family medicine and public health, family medicine can meet the goals of promoting population health, which results in improving the health of the nation.

FAMILY MEDICINE AND POPULATION HEALTH

Family physicians work to improve the health of the communities they serve. Family medicine is a specialty that views and manages every patient in the context of family, and every family in the context of community, and is thus uniquely positioned to lead population health efforts through the integration and coordination of care.[12]

Complex care has to be integrated not just along and across disciplines and settings, but also within the community. Family physicians can start by shifting more effectively from reactive to proactive care. Moving forward, increased collaboration and teamwork between stakeholders within the healthcare landscape (i.e., primary care, tertiary care, long-term care), community engagement, patient empowerment, and relational leadership is needed to address the healthcare needs of the population.

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Evolution of Consultation Models in Family Medicine Practice in Singapore Over the Last 50 Years

Dr Chiang Shu Hui Grace
Honorary Editor, 28th Council
College of Family Physicians Singapore

A/Prof Goh Lee Gan
Past President (2007-2011)
College of Family Physicians Singapore

INTRODUCTION

Within the consultation model, the ability to communicate effectively with patients and their families is foundational to family medicine. Skilful communication is key to providing good patient care. Family physicians who are skilled communicators are better able to establish and strengthen relationships, solicit and provide relevant and accurate information, and engage with patients, families, and the public.[1]

Studies have shown that physicians' communication skills are linked to increased patient and physician satisfaction, improved physical and psychological well-being, higher levels of adherence to therapeutic recommendations, better physiological indicators of disease control, and improved physical and mental well-being.[2,3]

Within the clinical consultation, medical communication can be a complex and dynamic process. Prior to the 21st century, the doctor-patient relationship was predominantly paternalistic. This has now evolved to a relationship that is patient-centred. Likewise, the ways in which family physicians communicate with their patients have similarly evolved.[4] Communication practices now actively seek to bridge the gap between the world of medicine and the personal experiences and needs of patients.[4]

Patients seek relationships with family physicians that are built on trust, empathy, expertise, and the right balance between autonomy and support.[1] Communication now takes on an interactive approach, wherein family physicians adopt a patient-centred approach and utilise communication behavioural techniques to engage patients, while patients adopt an active role (interactive). Communication is also proactively initiated with family members who possess valuable and unique information about patients. Medical knowledge alone is unable to guarantee a positive outcome. Family physicians should possess the ability to navigate complex dynamic interactions. Skilful family physician communication characterised by partnership building, collaboration, social conversation, positive talk, and empathy for patients and family members is a key influence on patient health beliefs, treatment adherence, and satisfaction with care.[5-7]

This article discusses seven consultation models that have been introduced to the practice of family medicine over the past 50 years.

EVOLUTION OF EFFECTIVE PATIENT-CENTRED CONSULTATION METHODS

1. Physical, Psychological, and Social Circumstances, 1972[8]

The Royal College of General Practitioners model released in 1972 encourages the practitioner to extend his/her thoughts on the patient's problems beyond the purely organic realm of said problems. This model advocates the need to include the patient's emotional, family, social, and environmental circumstances.

2. Stott and Davis, 1979[9]

This model on consultation tasks is a four-point framework that can be used to realise the full practical potential of each doctor-patient contact. These four areas can be systematically explored to achieve greater breadth in each patient consultation:

a. Management of presenting problems
b. Modification of help-seeking behaviour
c. Management of continuing problems
d. Opportunistic health promotion

3. The "BATHE" Technique, 2018[10]

The "BATHE" technique is a biopsychosocial approach to treating patients. Family physicians can adopt this technique to incorporate the principal features of psychosocial medicine into patient care. Recognising that a multitude of factors affect a person's mental and physical well-being, this technique, comprising of five components, looks at the whole person. The questions seek to delve into the social concerns, stressors, and other life events that might be affecting the patient.[10,11]

Evolution of Medical Communications in FM

Studies have shown that an enhanced understanding of a patient's life experience is linked to better outcomes in patient care, satisfaction, and empowerment, compared to a sole reliance on treating physical symptoms.[12,13]

Table 1: "BATHE" technique[10,11]

Background	What is going on your life?
Affect	How do you feel about that?
Trouble	What troubles you the most?
Handling	How are you handling that?
Empathy	That must be very difficult for you.

4. Neighbour (*The Inner Consultation*), 1987[14]

The Inner Consultation is a practical consultation model that aims to bridge the critical gap between patients and family physicians on the side of the family physician. This model characterises the patient consultation as a journey, punctuated by five checkpoints: connecting, summarising, handing over, safety-netting, and housekeeping, alongside an awareness of "minimal cues" (verbal and non-verbal) to help uncover the patient's unspoken agenda. Patient consultations are complex interactions with its own dynamics. Table 2 shows the interactions and dynamics in each of the five checkpoints.

Table 2: Neighbour's five checkpoints: "Where shall we make for next and how shall we get there?"

Checkpoint	Interactions
1-Connecting	Establishing rapport with the patient
2-Summarising	Getting to the point of why the patient has come, using eliciting skills to discover their ideas, concerns, and expectations, and summarising back to the patient
3-Handing over	Doctors' and patients' agendas are agreed. Negotiating, influencing, and gift wrapping
4-Safety net	"What if?": Consider what the doctor might do in each case
5-Housekeeping	"Am I in good enough shape for the next patient?"

This model helps family physicians develop the skills required to listen, think, ask, talk, negotiate, and plan simultaneously. Applying *The Inner Consultation* model allows the patient's unadulterated narrative to be heard, guides the physician to formulate hypotheses, and embellishes the symbiotic doctor-patient relationship.

5. Pendleton's Seven Tasks in the Consultation, 1984[15]

This seven-task patient-centred model seeks to meet the patient's consultation needs by introducing the concept of eliciting the patient's ideas, concerns, and expectations (ICE) and establishing the reason for encounter as the starting point. The questions that family physicians can ask to elicit the patient's ICE include: "Was there anything else you were hoping to discuss today?", "What is your main fear/worry/concern about this problem?" and "What were you hoping to get out of today?".

Pendleton's model is useful for family physicians when managing patients with multiple problems or who have difficulties in terms of motivations for change of lifestyle and behaviour.[16,17]

Table 3: Pendleton's Seven Tasks in the Consultation[15]

Find out why the patient has come. Also called the reason for encounter and from there take a history that covers the following: the nature and history of the problem, the patient's ideas, concerns and expectations, and the effects of the problem on the patient and significant others
Consider the other problems that the patient may have, such as continuing problems, risk factors
Decide with the patient on an appropriate action for each problem. In general practice, there is a need to prioritise the action to take if the patient has more than one problem
Achieve a shared understanding of the problems with the patient
Involve the patient in the management and encourage him/her to accept appropriate responsibility
Use time and resources to good advantage
Establish or maintain a relationship with the patient that helps to achieve other tasks
Footnotes: *Steps (1) and (2) together correspond to the approach to the problem. Steps (3) to (7) correspond to the management of the patient and the patient's problem. Steps (3), (4) and (5) are crucial steps that form the cornerstone of the patient's compliance to the doctors' management plan.*

6. Impact of Telemedicine on Communication, 2019

Telemedicine provides the tools for connectivity when family physicians and patients are unable to be in the same place and time. Telemedicine offers family physicians an opportunity to stay current in a cradle-to-grave speciality by delivering timely healthcare in long-term chronic disease management. Family physicians can be better positioned to

care for their patients with physical or functional disabilities who have difficulties coming down for on-site consults. Telemedicine can support family physicians in journeying and providing their chronic patients with medical care through their life course.

7. Impact of the COVID-19 Pandemic on Communication, 2020

The COVID-19 pandemic has had a detrimental effect on the traditional physician clinic consult and has brought about significant changes in patient consultations. While the essence of patient consults remains unchanged, the pandemic has transformed patient care. Wearing personal protective equipment, maintaining a safe distance, and the use of telemedicine are now the norm. These changes might negatively affect physician-patient communication.[18] Non-verbal communication guides the emotional aspect of the doctor-patient relationship. Studies have shown that patients have a negative perception of doctors' empathy when the latter wear face masks.[18,19] This was attributed to the "masking effect" on non-verbal communications. During this pandemic, physicians face a higher risk of burnout whilst patients might be more stressed or sensitive. Hence, physicians should continually practise essential communication elements such as shared decision making and a patient-centred approach.

CONCLUSION

Over the last 50 years, within the consultation, there is an evolution towards a patient-centred focus in dealing with the complex and dynamic processes. In this evolution, seven models have contributed to what is now regarded as the routine family medicine consultation model. How family physicians communicate with their patients in the consultation will continue to evolve with the increasing use of telemedicine as a mode of consultation and the COVID-19 pandemic.

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THE MOH 2020 VISION OF "ONE SINGAPOREAN, ONE FAMILY DOCTOR"

Associate Professor Goh Lee Gan
Past President (2007-2011)
College of Family Physicians Singapore

Dr Chiang Shu Hui Grace
Honorary Editor, 28th Council
College of Family Physicians Singapore

INTRODUCTION

The standard of patient care in Family Medicine/General Practice (FMGP) has steadily improved over the last fifty years to what it is today. This improvement has been the result of the personal endeavours of senior family physicians and various postgraduate training programmes under the tripartite collaboration of the College of General Practitioners, Ministry of Health (MOH), and universities (NUS since 1987, Duke-NUS since 2005, and LKC since 2013).

Since 2012, MOH has been working towards fulfilling the Healthcare 2020 Masterplan. One of Healthcare 2020 Masterplan's aim is to realise the vision of "One Singaporean, One Family Doctor".[1]

In this article, we will describe the development of the "One Singapore, One Family Doctor" vision based on published speeches.

THE LAST 50 YEARS OF FAMILY MEDICINE/ GENERAL PRACTICE (FMGP)

FMGP as a clinical discipline started in Singapore fifty years ago, in tandem with the global counterculture to the increasing fragmentation of medical care around organ systems in the 1950s and 1960s. One significant consequence was the formation of the College of General Practitioners Singapore in June 1971. The events leading to its formation are nicely articulated by Associate Professor Lee Kheng Hock in his speech "A Short History of CFPS".[2]

Over the last fifty years, the College of General Practitioners Singapore (later renamed the College of Family Physicians Singapore in 1992) has played a pivotal role in the training of various levels of postgraduate Family Medicine. College members have also participated in the teaching of medical undergraduates and hosted clinical attachments in their practices since 1987, when Family Medicine was formally taught to medical undergraduates.

The development of FM training programmes in Singapore owes its success to the close and continuing tripartite collaboration of the College, universities, and MOH, beginning with the MMed(FM) training programme from 1992, the College Fellowship (FCFP) programme from 1998, and the Graduate Diploma in Family Medicine (GDFM) programme from 2000.[3]

MOH'S 2020 HEALTHCARE VISION

The vision of "One Singaporean, One Family Doctor" is part of MOH's Healthcare 2020 Masterplan, which was first introduced in 2012. In the Addendum to President Dr Tony Tan's Address in 2016, Mr Gan Kim Yong, then Minister for Health, spoke of MOH's vision for all Singaporeans "to live well, live long and with peace of mind". He elaborated on the MOH's Masterplan, which had six components[1]:

- Enabling Singaporeans to lead healthy and fulfilling lives
- Making healthcare more convenient and accessible for our people – through achieving the vision of "One Singaporean, One Family Doctor"
- Reshaping healthcare delivery to provide high quality and seamless care
- Investing in the future through healthcare research and innovations
- Enhancing accessibility and affordability
- Health for all

1. Affordable, Good Quality Care for Singaporeans

In the context of making healthcare more convenient and accessible to our people, Minister Gan elaborated: "Our vision is to achieve 'One Singaporean, One Family Doctor', where more Singaporeans will establish a long-term partnership with a regular family doctor. Over time, the family doctor, being the first stop of care, will develop a more holistic understanding of each family member's health needs. This will enable them to provide care that is most appropriate for the patient. We will continue to engage and work closely with the primary care community to strengthen the sector and provide convenient, affordable and good quality care to Singaporeans."[1]

2. Capabilities and Capacity Building for the Future

In 2018, Dr Lam Pin Min, then Senior Minister of State for Health, spoke at the MOH Committee of Supply Debate. He added the concepts of "capabilities and capacity building for the future, ensuring that Singaporean have access to good care, close to their homes" to Minister Gan's concepts of accessible, affordable, and good quality care.[4]

The Primary Care Network (PCN) Scheme was introduced in January 2018 with 10 PCNs. By October 2018, more than 300 GP clinics were involved. The PCN scheme enables patients who have chronic diseases to receive continuing and coordinated care through the PCN coordinator and his/her team. The number of participating clinics has risen to more than 600 as of 2021.

An example was given by Dr Lam in his 2018 speech to illustrate the PCN Scheme. A patient who had hypertension and obesity was advised to screen for other chronic conditions, e.g., Type 2 DM, which indeed, turned out to be present. The patient received advice on her diet and lifestyle activities from the PCN nurse. She also went for diabetic foot and eye screenings provided by the PCN team. Continuity of care within the same team of caregivers was achieved, with better results than if there were no PCN Schemes.[4]

3. The Future of FM

At the CFPS 50th Anniversary celebration held on 3 Dec 2021, Dr Tan See Leng, Minister for Manpower and Second Minister for Trade and Industry, delivered the 2021 Sreenivasan Oration titled "Family Medicine for the Next 50 Years". How FM practitioners respond to four key challenges will define the practice of FM in the next fifty years. He elaborated on the following in his oration[5]:

- Transforming care to meet demands of rapidly changing demographics
- Embracing technology to augment care
- Preparing ahead in meeting the threat of future pandemics
- The evolving Family Medicine identity – redesigning education and training

4. Continuing the Role of CFPS: Raising the Standard of FM, Advancing Healthcare, and Nurturing the Next Generation

In his address to CFPS, Prime Minister Lee Hsien Loong spoke of two broad issues we should work on[6]:

- Strengthening the relationships between family physicians and patients
- Shifting our mindset on how primary care services are provided

DISCUSSION

Both Prime Minister Lee Hsien Loong and Dr Tan See Leng have added additional concepts to the initial concept of "One Singaporean, One Family Doctor" described by Mr Gan Kim Yong and Dr Lam Pin Min in 2016 and 2018 respectively. The way ahead lies in the development of implementation details and operational guidelines based on these concepts.

TAKE-HOME MESSAGES

- The vision of "One Singaporean, One Family Doctor" is for each FM practitioner to provide care that is affordable, and good, with capabilities and capacity for the future
- The CFPS has two broad areas to work on: strengthening the relationships between family physicians and patients; and providing continuing professional education and nurturing the next generation of family physicians
- The community of family physicians needs to respond to the following four key challenges in the years to come: 1) transforming care to meet the demands of rapidly changing demographics; 2) embracing technology to augment care; 3) preparing ahead in meeting the threat of future pandemics; and 4) managing the evolving FM identity through redesigning education and training.

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POSTGRADUATE FAMILY MEDICINE EDUCATION

THE GRADUATE DIPLOMA IN FAMILY MEDICINE (GDFM) PROGRAMME

Dr Wong Tien Hua
Current Programme Director, GDFM

Dr Kwong Kum Hoong
Immediate Past Programme Director, GDFM

The Graduate Diploma in Family Medicine (GDFM) is a structured training programme for Family Physicians (FP) in Singapore. It is jointly organised by the College of Family Physicians Singapore (CFPS) and the Division of Graduate Medical Studies (DGMS), National University of Singapore (NUS). Introduced in July 2000, it was the first vocational postgraduate diploma course in Family Medicine for medical practitioners. Successful candidates who pass the GDFM are awarded a certificate from NUS and are eligible for admission into the Family Physician Register.

The GDFM programme aims to provide a comprehensive vocational training in Family Medicine, with the goal of cultivating competent family physicians in Singapore. This vocational training focuses on providing real-world, practical and professional skills that are applicable to the work of a family physician. In addition, it places a special emphasis on the training of an FP practising in the context of Singapore, and is therefore subject to the local laws, ethical codes, and standards of care expected of the doctor. The GDFM programme therefore aims to ensure that the FP is proficient in independent practice whilst being familiar with caring for patients in a local context.

The quality of the GDFM programme has grown year-on-year courtesy of the dedication and leadership of our predecessors. The core content undergoes constant review and updates to reflect the changing healthcare landscape and practice of medicine in primary care. Our inhouse team from the Institute of Family Medicine provides these updates and reviews the academic literature on a regular basis. The IFM not only reviews the eight core modules in the GDFM programme and three practice management courses but also organises the numerous family practice skills courses (FPSC) throughout the year. In 2018, the GDFM programme added three compulsory FPSCs covering chronic disease management, mental health, and geriatric care.

The strength of the programme also draws from the many dedicated doctors who volunteer their time as tutors in the programme. Small group teaching in tutorial groups enable students to interact and discuss cases after each module, as well as share experiences and knowledge with each other. In addition, tutorial groups act as informal support groups beyond the prescribed tutorial subjects and allow participants to share clinical cases as they encounter them in practice.

The GDFM programme was launched on 1 July 2000, and the enrolment for the programme has steadily increased over the years with a proportional increase in the graduands adding to the pool of qualified FPs in the country. In 2002, following the completion of the two-year course, the pioneer batch of GDFM students saw only 40 graduates. In 2020, there were 137 graduates.

The GDFM programme has stood the test of time and continues to prepare itself to train our future FPs. The challenge in the coming years is to align the various components of FM training so that there is a continuum, from diploma to Master of Medicine, Family Medicine [MMed(FM)] and Fellowship. The GDFM must remain relevant and be an attainable route for practitioners in both the private and public healthcare institutions, with better recognition as the basic standard and requirement for clinical practice in Singapore.

Invited Papers

MMED(FM) – COLLEGE PROGRAMME

Dr Julian Lim
Immediate Past Programme Director, Master of Medicine (Family Medicine), College Programme

Dr S Suraj Kumar
Current Programme Director, Master of Medicine (Family Medicine), College Programme

Dr Wee Wei Chieh Nelson
Current Associate Programme Director, Master of Medicine (Family Medicine), College Programme

EVOLUTION AND INNOVATIONS THROUGH THE YEARS

1993 – Start of MMed Training

The Master of Medicine (MMed) in Family Medicine (FM) training programme started in 1991[1] with the first MMed examination held in 1993. At that time, there was only one training programme offered to all Ministry of Health (MOH) Family Medicine (FM) trainees. That was a three-year programme with a two-year relevant hospital rotation and a one-year primary care posting together with attendance of the eight modules of the Family Medicine Training Programme (FMTP).

1994 – Start of the College Programme

The college programme started informally on 29 March 1994 when a small group of doctors, who had left the traineeship programme for private practice, wanted to continue training in postgraduate FM. This was carried out under the supervision of Adj A/Prof Cheong Pak Yean. The doctors met at Adj A/Prof Cheong's clinic – Cheong Medical Clinic – during their Tuesday lunch breaks. Formal teaching sessions were based on the "hospital" model of case presentations. Literature and topic reviews were also conducted.

These sessions soon attracted a good number of general practitioners who were also interested in continuing their postgraduate education. As the lunch breaks were too short, the sessions were shifted to dinner breaks in July 1994 and then subsequently to Friday evenings in February 1995. This allowed for more time as most of the participating doctors did not work on Friday nights.

Dr Julian Lim was the first to successfully obtain his Masters in 1995. Other candidates during this period of informal training subsequently obtained their Masters degree in 1996 and 1998. We refer to this period as the "Pre-PPS" days

1995 – PPS, Structured Programme and GFMC

As the number of candidates from the private sector grew, the two-year Private Practitioners' Stream (PPS) was officially launched on 14 July 1995 under the supervision of Adj A/Prof Cheong Pak Yean and Adj A/Prof Chan Nan Fong. The meeting place at Jalan Jurong Kechil was the upper level of the shophouse above Cheong Medical Clinic, which Adj A/Prof Cheong aptly named the Graduate Family Medicine Centre (GFMC).

That same year, the GFMC was officially recognised by the NUS FM Committee as a training centre for the PPS. During this time, the programme was structured as follows[2]:

1. Family Medicine Clinics were held on every first Friday with senior Family Physicians, and Consultant Rounds with invited specialists on every third Friday.

2. Individual group tutorials were held on the second, fourth, and fifth Fridays. These comprised two parts:

    a. Portfolio-based learning

    This was a new innovation then and was presented as the *"Innovations in the teaching of Ambulatory Care in Family Medicine"* by Adj A/Prof Cheong Pak Yean and A/Prof Goh Lee Gan for the Postgraduate Clinical Teachers Workshop on 23 Aug 1995.[3] The portfolio-based record (PBR) and Clinical Encounter Form (CEF) were developed to enable:

    - Teaching to be centred around patient encounters with trainees
    - Opportunity for trainees' preparation and tutors' reflection
    - Protected time for interaction and discussion
    - Quality Assessment to be linked with education

A paper was subsequently published in the Singapore Medical Journal (SMJ) in 1998 titled "Experience with portfolio-based learning in family medicine for the FM MMed degree" by Drs Julian Lim, Chan Nang Fong, and Cheong Pak Yean describing the two-year (1995-1997) experience with portfolio-based learning.[4]

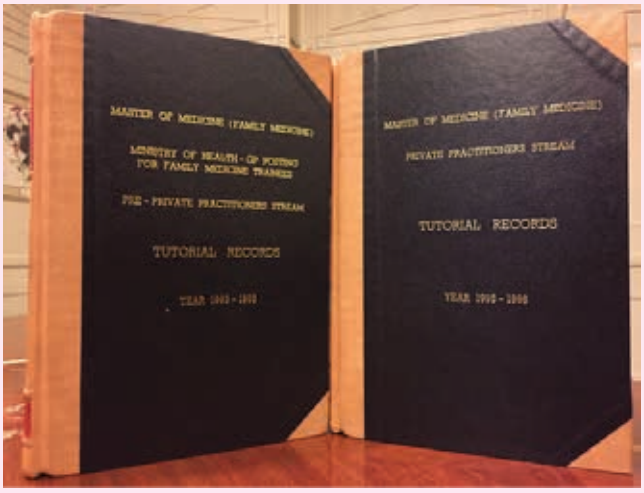
    b. Structured learning

    This was based on the themes of the previous FMTP module and was usually graced by an invited visiting consultant specialist.[5]

Invited Papers

1996 – Establishment of Second Centre at NUS

Due to the increasing class size, a new FM centre, the National University Centre (NUSC), was erected at NUS in July 1996, with Adj A/Prof Chan Nan Fong and Adj A/Prof Lim Lean Huat supervising the two groups there. The GFMC groups under Adj A/Prof Cheong Pak Yean and Dr Henry Yeo met on Friday evenings whilst the NUSC groups met on Wednesday evenings. During this period, the first week of the month saw the two groups from GFMC and NUSC coming together for combined teaching. Graphic templates were introduced as an aide memoir and there was an increased focus on clinical teaching with the teaching in the fourth week of the month being held at the hospital wards for clinical sessions.

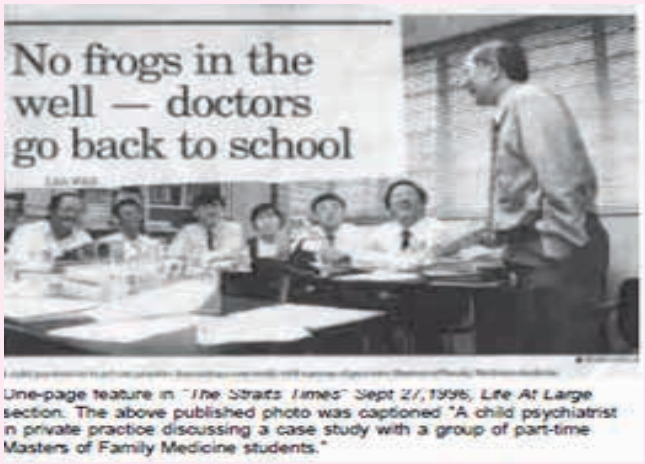


The two volumes of Tutorial Records covering the Pre-PPS period from 1993-1995 and Volume 2 covering the PPS period from 1995-1998.

1997 – Post-examination Celebration and Sharing

The activity of the groups in GFMC was reported in the *Straits Times* on 27 Sep 1997 and was observed by a group of trainers from Myanmar on 22 May 1997.[6] The first official batch of PPS trainees sat for the examinations in 1997.

As the PPS was a two-year programme, there were two concurrent cohorts consisting of first- and second-year trainees. Thus the post-examination celebratory sessions were a sharing of joy, "pearls" of wisdom, and mutual inspiration. This mutual sharing is still carried out in the present day and is a very powerful motivation tool.


No frogs in the well — doctors go back to school

One-page feature in "The Straits Times" Sept 27, 1996, Life At Large section. The above published photo was captioned "A child psychiatrist in private practice discussing a case study with a group of part-time Masters of Family Medicine students."

One page feature in the Straits Times, 27 Sep 1996, Life At Large section captioned "A child psychiatrist in private practice discussing a case study with a group of part-time Masters of Family Medicine students". From left to right: Drs Tan See Leng, Lawrence Soh, Matthew Ng, Moira Goh, Julian Lim, A/P Goh Lee Gan, Prof Wong Tze Tai (child psychiatrist).

Tradition of mutual sharing conducted by successful candidates. The session included the sharing of tips and passing on of notes, books and equipment. This particular session was held at Alexandra Hospital in 2017.

Invited Papers

The two boards with the names of successful trainees during the pre-PPS and PPS days. To date, there have been a total of 53 successful trainees across the two boards.

The two rocks with the names of successful trainees during the Programme B days.

1998 – Refurbishment and Official Opening of the GFMC

The GFMC was refurbished by Adj A/Prof Cheong Pak Yean and 9 October 1998 saw the official opening of the GFMC by Dr Alfred Loh, then President of the College of Family Physicians Singapore (CFPS). On the same day, the Inaugural Lecture of Family Medicine Fellowship Programme was delivered by Professor John Murtagh, Professor of General Practice, Head, Department of Community Medicine, Monash University, Melbourne.[7]

There was an emphasis on problem-solving skills and the introduction of mock examinations based on the case commentaries written by the trainees in preparation for the oral part of the MMed examination.[8]

Our guests, Professors John Murtagh and Lewis Ritchie, with our primary care leaders at the official opening of the GFMC by Dr Alfred Loh and inaugural lecture of the FM Fellowship Programme by Prof John Murtagh.

Standing (L-R); Dr Swah Tech Sin, Dr Siaw Tung Yeng, Dr Paul Goh, A/Prof Shanta Emmanuel, Dr Julian Lim, Dr Kwan Yew Seng, Dr Tan Chee Beng, Dr Lim Kim Leong & A/Prof Cheong Pak Yean.

Seated (L-R); Dr Lam Sian Lian, Prof Lewis Ritchie, Dr Alfred Loh, Prof John Murtagh & A/Prof Goh Lee Gan.

1999 – Email Communication and Clinic Audits

The email was introduced as the primary mode of communication, replacing the previously used facsimile. The audit visit to the trainees' practice was also introduced as a means of assessing the suitability of the clinic as a learning environment.[9]

Online learning enabled the face-to-face sessions per quarterly FMTP module to be reduced from eight to four. There was greater focus on clinical teaching with the new structure comprising:

- Week 1 – Combined sessions
- Week 2 – Short cases
- Week 3 – Long cases
- Week 4 – Meet-the-expert sessions[10]

There was even an MOH-PPS debate organised during the combined sessions. This was before MOH split the hospitals and polyclinics into two clusters.

The old slide projector and old overhead head projector (OHP) was replaced by a projector connected directly to the computer.

The Goh Lee Gan Challenge Trophy for the Family Medicine Debate.

2000 – FM Grand Round

The MMed(FM) working group was formed and MOH trainees from the healthcare clusters (SingHealth and National Healthcare Group) participated in the PPS programme through combined sessions, which were renamed as the Family Medicine Grand Rounds. These were held every first Wednesday of the month with each cluster and the PPS taking turns to organise the session.[11]

A five-day clinical skills refresher course was organised traditionally in the hospitals for the trainees as part of their training. This year saw the clinical skills refresher course being conducted in Myanmar where they were shown cases with signs not commonly seen in Singapore.[12]

2002 – FM Commencement Ceremony

This year saw the beginning of a new landmark tradition – the initiation of the Family Medicine Commencement Ceremony. The formal induction of PPS trainees following the ceremony was also introduced along with the publication of a handbook for MMed(FM) trainees.[13] NUSC held their clinical sessions in the restructured hospitals, namely National University Hospital (NUH) and Alexandra Hospital (AH), whereas GFMC held their clinical sessions at Ang Mo Kio Community Hospital (AMKCH).

2003 – SARS and the Simulated Patient (SP)

This was the very significant year of the Severe Acute Respiratory Syndrome (SARS) with the curtailment of clinical sessions. This led to the introduction of the electronic stethoscope in the teaching of cardiology and the novel method of case presentation where a trainee took history from another trainee (who had previously seen the patient) while the class observed the consultation process in the long case format. This new method was opposed to the traditional case presentation by the trainee to the tutor and is very similar to the current use of the "Simulated Patient" (SP) for training and examinations.

2004 – Merged Training Sessions at CFPS

Dr Cheong decided that the Jalan Jurong Kechil venue would be devoted to the College Professional Development Programme (CPDP) leading to the Collegiate Membership of the College (MCFP) and requested that Dr Julian Lim prepare his own clinic, Newlife Family Clinic & Surgery at Teban Gardens, to take over the role of the GFMC. Fortuitously, the intake for PPS declined and the GFMC and NUSC merged, with many of the now combined sessions then being held at CFPS, which graciously allowed the sessions to be conducted at no cost.

2005 – Formation of JCFMT

The Training Coordination Committee (TCC) was formed under the Joint Committee for Family Medicine Training (JCFMT)[14] to set up a one-year programme with the understanding that the applicants should have completed all eight modules of the FMTP and a minimum of five years' posting experience in addition to other qualifying criteria. This was thus aimed at those who had completed their GDFM and wished to further their studies. It was decided that direct entry would not be allowed.

2006 – One-year Programme B and FMCC

The MOH FM traineeship programme was called programme "A" and was the forerunner of the present-day FM residency programmes. The college one-year programme was thus known as Programme "B" and officially commenced in 2006. The change in name from PPS to Programme B also served to reflect the change in the profile of the trainees as there was now an increasing proportion of doctors from the polyclinic taking up this programme.

Dr Julian Lim became the first programme director (PD) of Programme B. The programme was hosted by the newly formed Department of Family Medicine and Continuing Care (FMCC) at the Singapore General Hospital (SGH)

and the venue of the teaching shifted to the lecture room at the CFPS at College Road. At this point, the structure of the programme was:

- Week 1 – Joint sessions with the Programme A trainees held at CFPS
- Week 2 – Clinical tutorials at FMCC
- Week 3 – Professorial/clinical skills sessions held on the 3rd week
- Week 4 – Clinical tutorials at FMCC

2008 – Live Telecast of Consultation

From its inception, during the pre-PPS and PPS days, the programme was conducted without any financial assistance. The trainees and supervisors somehow managed to keep the programme running by being frugal, resourceful, and often using their own personal funds. When there was a dire need for a photocopier, one of the trainees, Dr Tan See Leng, generously used $1,500 of his own money to buy one so that the class could photocopy transparencies and notes when needed. When the borrowed overhead projector (OHP) had to be returned, a second-hand OHP was purchased for $100 after a frantic but fruitful checking of the *Straits Times* classifieds. In 1998, the GFMC was refurbished entirely out Adj A/Prof Cheong Pak Yean's own pocket.

In the same spirit of generosity and self-sacrifice, after the handover in 2004, the centre at Newlife Family Clinic & Surgery was finally refurbished entirely at Dr Julian Lim's own cost. It then hosted its first clinical tutorial on 19 Mar 2008 with the clerking being done in the consultation and the proceedings transmitted "live" to the whole class seated at the patient waiting area. This area was transformed into a "lecture room" with round-the-table seating, with a projection screen at one end and a whiteboard at the other.

Clerking being done in the consultation room beamed "live" to the rest of the class in the waiting area.

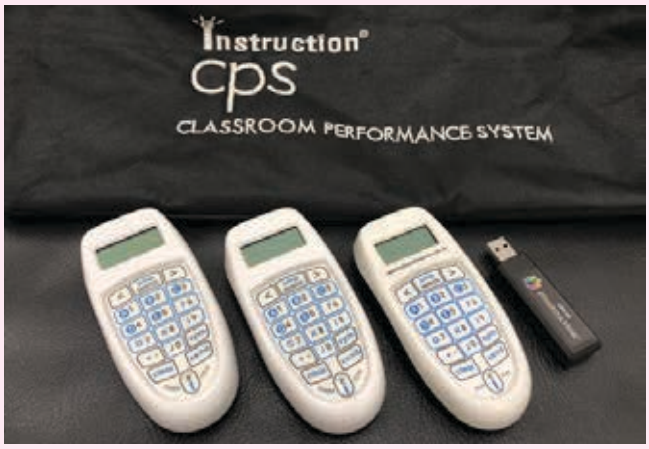
2009 – "Clickers"

An Audience Response System (ARS) with 60 "clickers" purchased by Dr Julian Lim was introduced into the training with the aim of encouraging better trainee participation and obliging the trainees to commit to a definite answer in order to promote deeper learning.

The running of Programme B was transferred to CFPS. The joint sessions with the programme A trainees were discontinued due to changes in the posting policy of not having the trainees complete their one-year primary care rotation as a whole block. The structure was then reorganised as:

- Approach to systems
- Long case clinical sessions
- Theory – including how to do the clinical audit and 50 cases record
- Short case clinical sessions

A system of paying out honoraria to resource persons was instituted and the training was held at various locations.



The Audience Response System or "Clickers"

2010 – The 50-case Logbook

There was a change in the format of the written submissions for the MMed examination. The five case commentaries and the one-week practice profile gave way to a logbook of 50 cases. This was later shortened to 40 cases in 2014, which remains the current format. The logbook consisted of single-page case writeups or shorter, reflecting the cases seen and managed by the trainees. The trainees' logbooks were examined during the viva section of the MMed examination. Since assessment drives instruction. emphasis then shifted to focus on the SOAP (Subjective; Objective; Assessment; Plan) format of written medical recording of the consultation.

2011 – Residency Programmes

The year saw the first intake of new residency programmes by the two Sponsoring Institutions (SIs), namely the National Healthcare Group and SingHealth. These residency programmes replaced the previous Programme A.

The MMed(FM) Programme B then became the College Programme and was deemed the alternative route towards the attainment of the MMed(FM), with CFPS becoming the unofficial third SI in 2015.

2015 – ABMS MCQs

The American Board of Medical Specialties (ABMS) multiple choice questions (MCQs) became the sole written component of the MMed examination. The ARS proved to be a very useful tool in the training for the MCQs as it allowed for instant marking and immediate feedback. MCQ training sessions were also held at intervals during the training programme in College Premises to in preparation for the written component of the MMED examination. During these training sessions, trainees were taught to analyse and de-construct the MCQ questions. Slide-based training sessions were also subsequently added and expanded to allow for broad coverage of up-to-date topics in Family Medicine. Discussions and debates were often a key part of the training sessions so as to help trainees develop critical thinking skills and expand their horizons beyond rote learning.

MCQ training sessions were routinely conducted in College premises prior to the COVID-19 pandemic and subsequent introduction of IT and Zoom based learning platforms.

Slide-based training sessions were developed to complement in the MCQ training sessions. These interactive sessions require the trainees discuss on various key family medicine topics.

2015 – College MMed Family Medicine Programme B

Programme A became the Family Medicine Residency Programme in 2011. Programme B was officially renamed the College MMed Family Medicine Programme during the College Convocation in Dec 2015.[15]

2015 – Consultation Stations

The clinical component of multi-station MMed examination underwent a major restructuring with the introduction of the new consultation stations, which were designed to resemble an actual consultation process in primary care. This represented was a major departure from the previous short- and long-case format. The college training programme accordingly evolved in tandem to include stronger emphasis on the integration of various skills required for an effective consultation in primary care. Clinical training sessions were regularly held in collaboration with the various polyclinics and government restructured hospitals. Standalone physical examination tutorials were also conducted for the various systems to ensure that the trainees continue to hone their skills in preparation for the MMED examination.

Dr Low Lian Leng submitted an abstract on the "Evaluation of a novel Single-case Multi-role format in the Teaching of Consultation and Communication skills" to the Asia Pacific Medical Education Conference (APMEC) in 2017. The trainer plays the patient in the first round for the first trainee. The first trainee then remains in the same room for the second round to play the examiner while observing the trainer play the patient for the second time. For the third round, the first trainee then plays the patient and the second trainee now plays the examiner with the trainer now observing the proceedings. This method allows the trainee to experience the process first as a candidate, then as a simulated patient, and finally as an examiner. This also allows the trainee to observe how other trainees approach the same case. The abstract was presented as an e-poster during the conference by Dr Julian Lim on behalf of Dr Low Lian Leng.

Adapting to the changes in the format of MMED examination, more consultation-based clinical tutorials were organised in collaboration with the various polyclinics.

Invited Papers

Clinical training on physical examination skills remains a core aspect of the training programme and is regularly held in various government restructured hospitals.

A key feature of the clinical tutorials is the debrief session that allows trainees to receive feedback and clarify their doubts.

2016 – Report to ESME

The PD, Dr Julian Lim, submitted a written report to "Essential Skills in Medical Education" (ESME) to document the rationale and considerations behind the latest college training programme.

2018 – New PD and Programme Extension

Dr Suraj Kumar took over as the Programme Director, while Dr Julian Lim remained as the advisor.

The college programme was extended to 16 months in response to feedback from the trainees and faculty that the current structure was too compressed. Decentralised small group teachings were also introduced early into the programme to allow for better engagement between the trainees and tutors. With each trainee also being assigned to a supervisor, the trainee's progression would be closely tracked and referred to during the Formative Assessment conducted by the Programme Director.

2019 – IT Platform and iHeed

The programme started using a new IT learning management platform called iHeed, which allows the trainees to submit assignments and the trainers to mark and keep track of the progress made by the trainees. It also allows MCQs to be attempted at the trainee's convenience and marked by the system before the actual face-to-face tutorial to discuss the answers and debriefing.

The college is currently in the process of reviewing the IT platform and will make a suitable decision on a long-term system that would best benefit our programme.

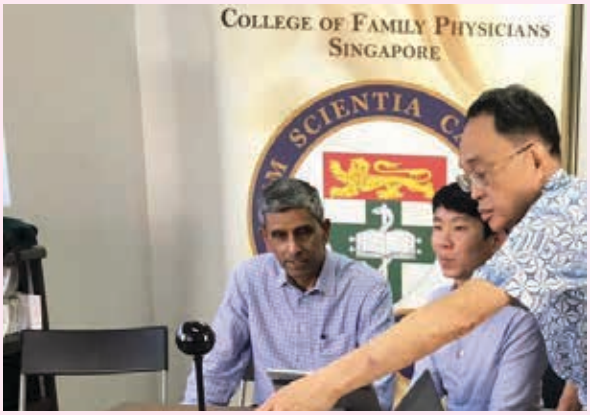
Introduction of iHEED to the faculty at Mandarin Hotel as part of the tradition of thanking the trainers in advance with a dinner.

2020 – COVID-19 and Zoom

On 23 January 2020, the first confirmed case of COVID-19 in Singapore was announced by the Ministry of Health, and the country was put on DORSCON Yellow footing. The very next day, Dr Julian Lim purchased a Zoom e-conferencing plan to evaluate the software for possible use for the MMed (Family Medicine) programme.[16]

A trial was conducted on 5 February 2020 for an MMed(FM) tutorial with the lesson beamed to tutors not involved in the session. That was the first time the college used Zoom in an actual tutorial for its training programme.

The use of Zoom was further refined by Dr Nelson Wee and Dr Eng Soo Kiang for the conduct of a "hybrid" consultation station with Dr Nelson simulating a patient for the history taking and the physical examination being carried out on PEM-LA (see below). Dr Eng Soo Kiang demonstrated how to be a co-trainer over Zoom by encouraging observations and comments in the chat box and – more effectively – firing specific questions to specific students who were then required to provide specific answers related to the case to deepen and broaden the learning for everyone.



First inaugural Zoom-based tutorial for MMED trainees in early February 2020 before the introduction of mask-mandates and other restrictions.

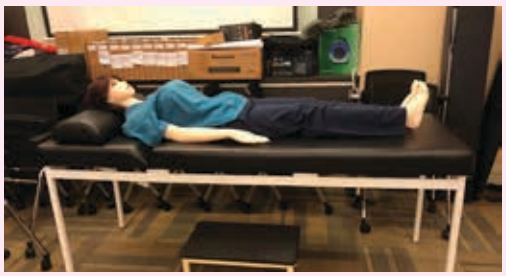
THE PROGRAMME IN OUR 50TH YEAR AND BEYOND

2021 – Programme Changes and New Teaching Methods

The pandemic has continued into our 50th year with many ups and downs. As the nation moves into the uncharted waters of endemicity and living with COVID-19, the programme has also continued to innovate and adapt to the changing conditions.

Teaching through the Zoom platform continues to be the default at the moment, although there is a likelihood of limited face-to-face sessions in the near future. To overcome the problem of physical contact, Dr Julian Lim purchased a lifelike mannequin for the training of physical examination skills. The examination couch, step, and head rest were donated by Dr Julian Lim, while Dr Nelson Wee contributed the apparel. To overcome the lack of paediatric training materials during the pandemic, various mannequins were also utilised to bridge the gap.

For the programme itself, we continue to adapt to the changing needs of our trainees by taking in feedback from both trainees and trainers alike. We also constantly look into learning from other institutions both locally and overseas. The programme has now been extended to two years and will be aligned to the calendar year. The course will conclude just before the MMed examinations at the end of the year.



PEM-LA: The Physical Examination Mannequin – Learning Aid

Mannequins were also employed during the pandemic to facilitate clinical training in paediatrics during the pandemic.

We have focused our efforts on three major initiatives:

- The development and strengthening of our teaching faculties.
- The consolidation and digitalisation of teaching methods and resources.
- The customisation of training for our trainees.

The teaching staff have also been re-grouped into faculties, or rather what we would like to term small communities. Each of these communities focuses on their areas of interest, which cover a major aspect of family medicine training. This allows for better faculty retention and development of their respective special skill sets.

In terms of teaching resource management, we hope to move ahead with the times and utilise more new technologies to update and consolidate our teaching resources. We are currently digitalising our teaching resources and exploring the use of mobile-based applications in selected classes. We aim to balance didactic teaching with more interactive and experiential learning through the use of technology and innovative teaching methods.

Finally, we recognise that our trainees work in diverse environments and have different skillsets, strengths, and weaknesses. We are currently implementing a system that enables us to monitor the progress of our trainees more closely, both individually and as a cohort, and allows for adjustments and refinements in the training programme. We have also identified the need for our trainees to develop the soft skills that would prepare them to be future leaders and will incorporate these elements into their training.

Camaraderie and Collegiality

Although all those involved with the programme come from different clinical settings, one of the major strengths of the college programme is the great camaraderie and strong sense of "family" among our trainers and trainees who are private sector practitioners, public institution (polyclinic) doctors, community hospital physicians, and many more. Regardless of where they come from, there is a common sense of identity and purpose under the college banner. This bonding and collegiality play a huge part in helping the trainees get through the challenges faced during the course.

For trainers, all of whom are essentially volunteers who give much of their time and effort to the cause, the programme ensures that there is time to meet and interact as a teaching fraternity, be it the pre-course briefing or get-together "*makan*". There is always a rich exchange of ideas and knowledge that drives innovation in teaching and training. The well-being of our trainers is especially important as we ramp up the training and will need many hands on deck to step up to help.

We also do not forget the administrative and operational support from the college secretariat who are also considered as part of the family and are included in all our activities, be it work or social.

The tradition of thanking the trainers in advance with a dinner-cum-pre-course briefing before the start of a course. Standing left to right: Drs S Suraj Kumar, Lim Ang Tee, Luke Low, Julian Lim, Nelson Wee. Seated left to right: Drs Farhad Vasanwala, Chong Tsung Wei, Jean Jasmin Lee, June Tan, Lai Yirong, Rose Fok, Ms Patricia Cheok (Programme Executive)

And a mid-course catch-up with a dinner at Samy's!

Goals and Aspirations – The Future Looks Bright

Doctors that come through the programme not only pass the examinations but also become better trained doctors, equipped with the skills to rise up to the challenges brought on by Singapore's ageing population and the increasing complexity of care.

We are very much encouraged by the major improvements in passing rates for both trainees of the College Programme and the candidates re-attempting the examination in both the written and clinical components of the recent MMed(FM) Examination. We are also heartened by the fact that many of our graduates have moved on to leadership roles in the family medicine community and are contributing to the development of the next generation of doctors.

As with everything in life, nothing remains static. The course will have to evolve as FM itself evolves. The College will also have to strategise and prepare for a ramping up in numbers to meet the needs of the community. We are actively planning for an expansion of training facilities that will bring us into the next phase of the development of the programme. For that, we will not only need more trainers and operational support, but we hope to get the fresh graduands to return as trainers to "give back" to the college programme. These new trainers will be able to use their recent experiences to better help the trainees by providing new perspectives and ideas on training.

Therefore, going forwards, we hope the programme continues to grow into one big community of trainers and trainees who work together regardless of the FM settings they come from to provide a positive learning experience and foster strong lasting bonds among our graduates. This will help to increase the visibility and awareness of what FM is about among our undergraduates and postgraduates such that more doctors will choose this as their career path, with the college doing its part in the helping them achieve their goals and aspirations.

It is the hope of the authors of this article that we can all meet and celebrate in the post-pandemic future!

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NUHS FAMILY MEDICINE RESIDENCY: A STORY OF CHANGE

A/Prof Tan Boon Yeow
Founding Programme Director, NUHS Family Medicine Residency

Dr David Tan Hsien Yung
Current Programme Director, NUHS Family Medicine Residency

THE WILD WEST YEARS

Family Medicine has a proud tradition within the National University Health System. We initially started out as part of the Community, Occupational and Family Medicine Department of the National University of Singapore in 1987. In 2008, we became the Division of Family Medicine within the University Medicine Cluster. Finally, in 2018, the Department of Family Medicine was incorporated into NUHS. Through our various iterations, we have been involved in undergraduate and postgraduate Family Medicine training and examinations.

Our postgraduate story begins in earnest in 2011, when Singapore first adopted the American-style residency programme. The NUHS leadership felt that the time was ripe to establish a Family Medicine residency programme to meet the increasingly complex needs of patients and the healthcare system. At the same time, the postgraduate residency was also seen to complement and complete the suite of undergraduate programmes already offered.

In 2011, NUHS did not have any primary healthcare entity in its fold. We had to innovatively co-create a Family Medicine residency by partnering Frontier Healthcare and Raffles Medical Group, together with St Luke's Hospital, to form the core Family Medicine training sites. Frontier and Raffles are private general practitioner group practices, whilst St Luke's Hospital is a family physician-led not-for-profit community hospital.

The residency faculty was formed from NUHS Family Medicine staff as well as staff from the various partner institutions. Together, we forged a new compact for the fledgeling programme, with a vision to transform Family Medicine in Singapore.

The early years are memorable for our failing to pass the first Accreditation Council for Graduate Medical Education – International (ACGME-I) accreditation. The stringent ACGME-I requirements, coupled with our nascent primary care facilities, meant that we had to engineer a wide-ranging makeover to meet their requirements. This we did, with herculean efforts by faculty and senior NUHS management, and supported by our long-suffering pioneer residents. The updated programme went on to pass re-accreditation and subsequent accreditations.

TRANSFORMING FAMILY MEDICINE

The healthcare landscape is rapidly changing as Singapore braces itself to cope with the silver tsunami. Keeping our nation healthy hinges on a nimble system built upon appropriate preventive healthcare, prompt and cost-effective intervention for acute medical conditions, and good chronic disease control.

The NUHS Family Medicine programme seeks to produce generalists who are trained to practise confidently in diverse settings. We seek to equip ourselves with sound clinical judgement, a scholastic attitude, and a heart to serve patients and society. We have an aspiration to be holistic generalists to balance the subspecialisation such that fragmentation is minimised and care is co-ordinated and patient-centric. We have an additional aspiration to see generalists practise as widely and as excellently as they have been trained to do.

The aspiration to change mindsets and practice will need active contribution from family physicians from the public, private, and the not-for-profit sectors. This is a tenet we recognise and have built our programme upon. Indeed, we unabashedly believe that the NUHS residency programme is an example of how the national healthcare system can leverage on partners from the three sectors to deliver not only comprehensive and holistic care, but education for the next generation of family physicians.

GROWING THE PROGRAMME

With the regional health systems reorganisation in 2017, NUHS was partnered with a new polyclinic cluster, the National University Polyclinics. This meant an overnight increase in primary care resources, which allowed for a substantial increase in the size of the resident cohorts from six to thirty annually.

The opportunity to expand has brought its own challenges. We have had to suddenly recruit for an expanded faculty to support the needs of an increased number of learners. Along with this, we have had to build and refine a new residency culture, as well as strive to maintain academic and clinical standards. We have also had to renegotiate training compacts with hospital speciality departments.

The challenges notwithstanding, we have been heartened by the support we have received. Our specialist colleagues have stepped up to volunteer teaching sessions for our residents. They have valiantly and painstakingly worked with us to fit increased numbers of residents into their departments. Our Family Medicine fraternity has not failed us. New family physicians have joined us as teaching faculty. At the same time, our residency alumni have returned as enthusiastic and valued new faculty to pay it forward to new generations of residents.

PANDEMIC PAINS

COVID-19 has been a great disruptor and we have not been spared. When Singapore moved from DORSCON Yellow to Orange in the first half of 2020, we scrambled to relook our residents' rotations in the light of new movement restrictions, be they inter-departmental or inter-institutional constraints. At this time, some Family Medicine programmes decided to reassign all their residents from the hospitals to the polyclinics for the duration of the heightened measures. We chose to keep to our residents' planned rotations as much as possible, to minimise the impact on their training. At the height of the movement restrictions, it was almost like trying to quickly solve a puzzle with a rapidly changing picture! Our programme coordinators took on the burden of adjusting the rotations within the ambit of allowed movements for healthcare workers.

COVID-19 has also affected how we deliver our teaching sessions. We had to rapidly learn to deliver effective teaching virtually using the Zoom platform. This has had the benefit of increasing accessibility for residents caught in last-minute work or in distant locations from NUHS, and many fortunate residents and faculty obviously do not need to travel home at the end of the sessions. Unfortunately, Zoom and social distancing mandates have meant that our programme has not met as a group for the past year-and-a-half. The disadvantages that accompany this situation are grievous and dreadful indeed.

LOOKING AHEAD

We believe family physicians are the foundation of any high-performing healthcare system. The NUHS Family Medicine residency endeavours to develop well-trained family physicians to serve, teach, and lead in the community. As our residents graduate to take up different positions in the healthcare system, we hope that we have done our part faithfully and innovatively. Many of us trust that the best is yet to be and that this bodes well for the greater ***healthcare*** landscape!

THE SINGHEALTH FAMILY MEDICINE RESIDENCY PROGRAMME: THE FIRST DECADE (2011-2021)

Dr Joanne Hui Min Quah
Current Programme Director, SingHealth Family Medicine Residency

Dr Sally Chih Wei Ho
Founding Programme Director, SingHealth Family Medicine Residency

INTRODUCTION AND AIMS

The SingHealth Family Medicine (FM) Residency, begun in 2011, is a rigorous three-year postgraduate training programme nurturing doctors as compassionate and excellent well-rounded Family Physicians (FPs) who become future leaders in the discipline. Residency continued the training of proficient Family Physicians towards the Master of Medicine (MMed) FM awarded by the National University of Singapore (NUS), from the Basic Specialist Training (BST) established in 1991 and the vocational training offered by the College of Family Physicians Singapore (CFPS) and its predecessor, the College of General Practitioners Singapore, from the 1970s.[1] With the advent of the Accreditation Council for Graduate Medical Education – International (ACGME-I) residency training in Singapore, SingHealth became one of the sponsoring institutions for FM training. It adopted the recommendations of a workgroup set up by the Ministry of Health (MOH) and retained the strengths of broad-based training with hospital rotations and added FM exposure in the early training years and adopted a structured formative assessment framework.[2] Over the years, the programme has innovated in developing e-learning modules, comprehensive exam preparation, and electives in global health, public health, research, and education.

SingHealth, our sponsoring institution (SI), is the leading and largest public healthcare cluster in Singapore. The SingHealth Duke-NUS Academic Medical Centre with its network of four major hospitals, five national speciality centres, three community hospitals, eight polyclinics, and Duke-NUS Medical School converges clinical care, education and research. It is united by our common purpose "Patients. At the Heart of all we do" to transform healthcare and deliver affordable, accessible and quality care to our patients. The SingHealth Duke-NUS Family Medicine Academic Clinical Programme, launched in 2017, is unique within our healthcare clusters in uniting Family Physicians practising across the care continuum from hospital to community within SingHealth to advance FM as an academic discipline and establishing thought leadership. Our residents benefit from the case mix and caseload as well as the diverse strengths of our specialists and FPs across the network.

The structured three-year training programme comprises four aspects: (i) workplace-based training; (ii) structured learning sessions; (iii) a formative assessment programme; and (iv) scholarly opportunities.

WORKPLACE-BASED TRAINING

The workplace-based training consists of block rotations in hospitals in the first two years and primary care clinics in the third year, with our signature longitudinal Residency Continuity Clinic (RCC) throughout the three years. Figure 1 shows a sample rotation plan. Residents rotate through relevant clinical postings including internal medicine, geriatric medicine, general surgery, orthopaedic surgery, urology, community hospital, paediatric medicine, children's emergency, adult emergency, and obstetrics and gynaecology. FM residents are integrated into the teams with speciality residents in ward work with a special emphasis on ambulatory clinics, which are more relevant to their learning where possible. Short attachments are arranged to provide relevant experiences not available in the block rotations, e.g., community geriatrics, nursing home, home care, palliative medicine, neonatology, paediatric orthopaedics, and adolescent medicine. Residents can opt for electives in areas of interest, including a valuable exposure to public health and primary care policy through a posting with the Primary and Community Care Division of the Ministry of Health. In the final year of training, residents are based in primary care in the polyclinic, while being engaged in teaching discussions and having attachments to specialities such as cardiology, respiratory, gastroenterology, renal, neurology, endocrinology, dermatology, rheumatology, infectious disease, sports medicine, child development, otorhinolaryngology, ophthalmology, and occupational medicine, as well as the primary care-based GeRiAtric ServiCE (GRACE) memory and cognition clinic, private general practice clinics, and Family Medicine Centres.

For the longitudinal curriculum, residents return for RCC at the Academic Family Medicine Centre weekly throughout the three years of residency, as well as the Health Wellness Clinic (HWC) weekly for six months in the third year. The RCC is a directly-supervised clinic where a faculty is blocked from clinical duties and is solely responsible for the clinical supervision and provision of feedback to three to four

residents, resulting in a consistently high degree of quality supervision and learning. Each clinic session is followed by small group case-based discussion of the cases seen as well as structured learning activities. The HWC has evolved and is anchored by a Family Physician who supervises one to two residents together with a Psychiatrist, and this gives our residents exposure to the community mental health clinic in primary care.

The workplace-based training provides situated authentic learning experiences, supported by experiential, constructivist, and social learning theories.[3] The RCC also situates the residents' learning in primary care communities of practice with shared learning goals.[3] The faculty's close supervision and feedback provide coaching while their assistance in complex or unfamiliar consultations provide modelling for residents, promoting the development of expertise as articulated by Collins' cognitive apprenticeship model.[4]

STRUCTURED LEARNING SESSIONS

Structured learning activities include monthly big group academic Saturday core teachings, monthly small group academic topic teachings, grand rounds, journal clubs, workshops, and sessions on clinical quality and patient safety, evidence-based medicine, wellness tools including mindfulness, and exam preparation. The academic Saturday core teachings involve specialist speakers facilitated by FM faculty in a flipped classroom format with pre-reading and group discussions at the start of each session, followed by interactive teaching on topics relevant to primary care. FM Grand Rounds are held monthly at our four campuses including Singapore General Hospital, Changi General Hospital, Sengkang General Hospital and KK Women's and Children's Hospital, with our hospital-based FM faculty engaging our residents and supporting their clinical learning.

FORMATIVE ASSESSMENT PROGRAMME

The formative assessments were developed based on the principles of programmatic assessment using a variety of assessment tools to inform different competencies, including both knowledge tests such as the In-Training Exam (ITE) and workplace-based assessments such as the directly observed Mini Clinical Examination (mini-CEX), chart recalls, case logs and case write-ups for case-based discussion, and multi-source feedback and patient satisfaction surveys.[5] There was a focus on multiple assessments over time to increase reliability and track progress and, where feasible, different assessors. To help learners improve, emphasis was placed on timely qualitative feedback rather than numerical ratings.

SCHOLARLY OPPORTUNITIES

All residents participate in topic teaching, journal club, or other presentations to peers. Residents also partake in quality improvement projects, typically in a multi-disciplinary team, while some may opt to take on research projects. Residents have opportunities to present their work at local and overseas conferences (refer to Figure 2).

ACHIEVEMENTS

SingHealth Family Medicine Residency was the first local Family Medicine programme to be accredited under ACGME-I in 2011. It was the largest FM residency programme as it rapidly ramped up its intake in quick succession, from an initial batch of 10 residents (Figure 3), to 20 in 2012, 24 in 2015, and then 29 in 2017. The programme has seen 153 residents graduate from 2014-2021 and currently has 80 active residents. Continually making improvements through monitoring outcome indicators as well as reviewing resident and faculty feedback through Programme Evaluation Committee (PEC) meetings and Annual Programme Evaluation and Improvement (APEI) exercises, it achieved the accolade of Most Improved Residency Programme at the Residency in the SingHealth Excels (RiSE) Awards in 2016 and 2021. Annually, our residents' and faculty's successes are celebrated through RiSE Outstanding Resident Awards and Outstanding Faculty Awards. Our programme has had one to two Chief Residents each year and to date we have a total of 15 , of which eleven were selected for the Singapore Chief Residency Programme, and the other four selected for the SingHealth Residency Leadership Programme.

Compared to BST, the SingHealth FM residency programme greatly reduced attrition from postgraduate FM training. Attrition for BST ranged from 24 percent to 54 percent for the 2006-2010 cohorts, while attrition for SingHealth FM residency ranged from 0 to 8 percent for 2011-2021.[6]

One of the key factors contributing to the achievements of the programme is our dedicated faculty with a passion for education. The residency framework of faculty funding and management support was instrumental in the programme, institutionalising weekly faculty administrative time and monthly faculty meetings, which enabled faculty to devote time to developing educational materials, assessments and educational projects. The programme is supported by our proactive administrative team who smoothen our residents' learning journey, assist our faculty and facilitate programme accreditation.

INNOVATIONS AND EVOLUTION

The face-to-face teachings in big and small groups run on a fixed cycle, while on the ground there is a need for residents to be equipped with adequate knowledge for daily work, which may be compounded by challenges in receiving adequate supervision in some high workload hospital rotations. To support just-in-time learning and ensure learning outcomes are achieved, the programme curated posting-specific e-learning resources, pre- and post-posting MCQs, and mid-point reviews and discussions with faculty to support asynchronous learning. In addition, it obtained a SingHealth Duke-NUS Education grant and completed development of 30 interactive e-learning modules covering a wide range of topics relevant for primary care learning.

Exam preparation has been strengthened to better support our residents towards this summative exam. With evidence of deeper learning and retention from repeated testing and feedback, we have introduced pre- and post-posting MCQs, individual Readiness Assurance Tests (iRAT) and team Readiness Assurance Test (tRAT) at the academic Saturday core teaching, quarterly mini-ITE to complement the annual ITE, as well as the MCQ learning plan for residents who require enhanced support.[7] To support the clinical exams, our programme has also introduced mock consults, mock slides, mock vivas, and the FM Ethics workshop, as well as collaborations with Singapore General Hospital for the rheumatology workshop, National Heart Centre for the cardiology workshop, KK Women's and Children's Hospital for the paediatric workshop, and Sengkang General Hospital dermatology and Changi General Hospital emergency for slides teaching. While exam preparation is introduced in years 1 and 2, this is intensified in year 3, and continued seamlessly post-residency in collaboration with SingHealth Polyclinics (SHP) and SingHealth Community Hospitals.

Scholarly activity for residents has been enhanced to include core and special interest tracks. For learning on Quality Improvement, all residents participate in the SHP Introduction to Quality and Safety workshop, complete online modules by Institute of Healthcare Improvement (IHI) on patient safety and quality improvement, and form multi-disciplinary teams to conduct audit and quality improvement projects, culminating in a poster presentation to share their learning journey and reflections. Residents have opportunities to learn about Pedagogy through the Centre for Resident and Faculty Development (CRAFD) workshops on bedside teaching and giving effective feedback, as well as presentations at the FM Grand Rounds. All residents receive training in evidence-based medicine through faculty-led workshops, as well as fundamentals in research through the Basic research workshop, Collaborative Institutional Training Initiative (CITI) certification, and Human Biomedical Research Act (HBRA) Essentials training.

The Community Health Research Project (CHRP) has given residents the opportunity conduct clinical research in teams, from formulating the research question and obtaining centralised institutional review board (CIRB) ethics approval to data collection, analysis, and research writing. In 2021, this culminated in the CHRP championship where resident groups presented their research methodology and findings, assessed by a panel of judges. The CHRP, which used to be core, is now a scholarly interest track, and residents keen on a career in research can embark on the FM Clinician-Researcher Development Programme, which supports one towards becoming a Clinician Scientist.

Scholarly special interest tracks also include education pedagogy, education research, and topic review. Interested residents are mentored and provided resources and suitable training to support them towards starting educational initiatives or medical writing, with opportunities to attend and present at relevant conferences as well as publish. SingHealth Graduate Medical Education has started the Junior Educator Development Initiative (JEDI) program, bringing together budding clinical educators from across SingHealth to build their foundation of medical education concepts, with one FM resident in the first batch in 2021.

The Global Health Scholarly special interest track was introduced in 2019 (Figure 4), with support from the SingHealth International Collaboration Office, as well as our partners in New Canipo, Palawan, Philippines. Our team including two residents, three faculty and two nurses, together with a dentist and a collaborator from Philippines, participated in our inaugural trip providing clinical care for the community, teach-the-trainer workshops for healthcare workers and barangay leaders, as well as discussions with the mayor. We plan to continue with this initiative once COVID-19 travel restrictions are lifted.

The Mentorship and Buddy framework was introduced in 2019 for resident wellness and to facilitate career guidance, enhanced networking, and scholarly opportunities for personal and professional growth of our residents. Each R2 and R3 is given the choice to be matched with a Family Physician to journey with, while each R1 is matched with an R2 to facilitate his on-boarding onto the programme and the FM community.

The COVID-19 pandemic has been a spark to transform learning. Although restrictions were imposed on residents in terms of posting changes and movement for RCC and hospital Specialist Outpatient Clinic (SOC) attachments, it did not dampen FM learning. Our residents also rose to meet the call to support COVID wards, dormitory operations, and Intensive Care Unit (ICU) coverage. We received excellent feedback when the academic Saturday core teaching went online, and RCC was adapted to virtual RCC teaching, with residents learning from the comfort of their own home. Year 3 residents who were initially scheduled

for hospital SOC attachments had their learning objectives achieved through FM faculty-led topic discussions with a primary care focus, and this received even better feedback than the original sessions.

Faculty development included internal programme sharing of best practices, SingHealth Academic Medicine Education Institute (AMEI) workshops, and educational conferences such as the SingHealth Duke-NUS Education Congress, Asia-Pacific Medical Education Conference (APMEC), and the International Association of Medical Education (AMEE) conference. COVID-19 was a blessing in disguise, as these virtual educational conferences were made more accessible and affordable, with more faculty able to attend and benefit from (Figure 5).

SingHealth has implemented the ACGME Clinical Learning Environment Review (CLER) pathways to excellence, and this addresses the following six areas: patient safety; healthcare quality; care transitions; supervision; professionalism; and resident wellness. Our programme underwent an internal review in April 2021 to ensure programme quality and to identify areas for improvement moving ahead.

FUTURE DIRECTIONS

Postgraduate Family Medicine training towards the Master of Medicine Family Medicine has evolved from Basic Specialist Training (BST) to Residency Training. ACGME-I accreditation from 2011-2021 has introduced a more structured training framework with a focus on competencies and formative assessments. Moving forward, to better serve the needs of the community and to allow training to be more contextualised, FM has exited ACGME-I accreditation to come under Joint Committee on Specialist Training (JCST) accreditation since July 2021. While the six ACGME core competencies of medical knowledge, patient care, professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice continue to be key, entrustable professional activities will be introduced to further enhance Residency training.

SingHealth Family Medicine Residency: Sample Rotation Chart

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Year 1	Internal Medicine (ICU attachment)			Geriatrics (Community Geriatrics attachment)			General Surgery		Urology	Comm Hosp	Orthopaedic Surgery (1 week KKH Paediatric Orthopaedic attachment)	
RCC	1/2 day PM per week: Resident Continuity Clinic, RCC											
Year 2	Paediatric A&E (1 week Neonatology attachment)			Paediatric Medicine (1 week Ambulatory attachment)	Adult A&E		O&G (Adolescent Health attachment)			Elective: Dermatology / ENT / Eye / FMCC / Occupational Med / BVH Palliative Med&Comm Hosp / SK Comm Hosp/ Psychiatry / MOH Health Policy / Sports Med (1 week Psychiatry attachment*)		
RCC	1/2 day PM per week: Resident Continuity Clinic, RCC											
Year 3	Polyclinic (General Clinic)											
RCC	1 day per week: Resident Continuity Clinic, RCC											
Attachments	Psychiatry (Health Wellness Clinic, HWC)						Child Development	ENT	Eye	GP Clinic, FMC & Physiotherapy	Occupational Medicine	Sports Medicine
	Internal Medicine [Cardiology, Dermatology, Endocrinology, FMCC, Gastroenterology, Infectious Diseases, Neurology, SHP GRACE clinic (HWC and Dementia Clinic), Palliative Medicine, Renal, Rheumatology]											

* Residents opting for Psychiatry elective may opt to do the 1-week attachment in another specialty.

Figure 1: Sample Rotation Plan

Figure 2: Resident and Faculty at WONCA Kyoto Japan, 2019

Figure 3: First batch of SingHealth FM Residents at their Community Health Project, 2013

Figure 4: Global Health trip to New Canipo, Palawan, Philippines, 2019

Figure 5: The SingHealth FM Family at SingHealth Duke-NUS Scientific Congress, 2019

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FAMILY MEDICINE EDUCATION: A TEN-YEAR PERSPECTIVE FROM NATIONAL HEALTHCARE GROUP POLYCLINICS

Dr Darren Seah Ee-Jin
Immediate Past Programme Director, NHG Family Medicine Residency

Dr Tan Kim Kiat
Founding Programme Director, NHG Family Medicine Residency

Dr Jason Chan Meng Huey
Current Programme Director, NHG Family Medicine Residency

In 2010, National Healthcare Group Polyclinics (NHGP) was tasked by its parent cluster, National Healthcare Group (NHG), to set up a Family Medicine Residency Programme. This would eventually replace the existing MOH Basic Speciality Training in Family Medicine and run directly under the auspice of the NHG Graduate Medical Education Committee (GMEC). This was an arduous task as the polyclinics had never fully administered the training programme on its own and the running of the programme would be new to everyone involved.

THE EARLY YEARS: BUILDING FOUNDATIONS

The founding programme director was Dr Tan Kim Kiat, who was pivotal in establishing and guiding the programme through its initial stormy years of accreditation with the Accreditation Council of Graduate Medical Education-International (ACGME-I). Before the programme could begin, newly minted core faculty members had to be trained in the structure and format of residency training. This was a completely new universe of educational terminology and process for everyone. Terms such as "programme evaluation" and "clinical competency" committee were foreign and the concept of an education improvement process was novel to say the least in Singapore. Yet, we could already see how such a system would bring value and improvement to family medicine training in Singapore. Many months were spent working on written agreements with speciality host departments on the posting curriculum and formative assessments, and many meetings were spent debating on what would be the best curriculum to produce family physicians who are mission fit for the healthcare challenges of tomorrow.

Our first attempt at ACGME-I accreditation left us vaguely disheartened as we received a conditional accreditation for a mere six months and the ACGME-I requested another site visit six months later for the numerous citations that we had received. However, true to the Singapore "Can-Do" spirit, changes were made, citations were addressed, and pedagogy was sharpened to ensure that our curriculum met the requisite standards and we could clear the next accreditation with flying colours. Our second accreditation site visit proved that we could adapt to the demands of the ACGME-I curriculum.

The NHG Family Medicine Residency Programme finally commenced in July 2011 with 10 residents based in four polyclinics: Toa Payoh Polyclinic, Bukit Batok Polyclinic, Chua Chu Kang Polyclinic, and Hougang Polyclinic. In its initial years, repeated changes to the curriculum were made to ensure that training needs and clinical service requirements were well balanced. Our pioneer batch of residents often received new instructions on a monthly basis with regard to changes in didactic teaching schedules and new arrangements for continuity clinic sessions at the Polyclinics.

Figure 1: Early residents

The ACGME-I standards proved pivotal in ensuring that family medicine training was firmly embedded in the primary care setting with the provision of weekly continuity clinics that allowed residents to appreciate the application of applying the principles of family medicine and the nuances of managing clinical problems in the primary care setting. The weekly continuity clinics instituted from the first year of residency training by the NHG Family Medicine Residency Programme was a vital component.

THE MIDDLE AGES: EXPANSION

In 2013, the baton of Programme Director was passed on to Dr Darren Seah, who had been involved as the Associate Programme Director since the Programme's inception. The Programme continued to build on its initial foundations and incrementally added new posting sites and new base polyclinics to increase its cohort sizes progressively.

From 2013 to 2014, two further rounds of site visits took place with initial accreditation citations that had to be reviewed and corrected to align specifically with ACGME-I requirements. The repeated citations revealed a philosophical disjoint between the way Singapore and America viewed the discipline of family medicine. Even against such a backdrop of events, the programme focused on increasing cohort sizes as there were Ministry mandates to increase the number of family medicine residency positions in order to ensure a healthy pipeline for fuelling the expansion of primary care which we see today. Such an expansion of the programme required strong support from NHGP Senior Management to allocate sufficient training space and medical manpower so as to ensure adequate training facilities and teaching faculty. The NHG Family Medicine Residency was indeed fortunate to have many supportive senior leaders both within NHGP and the broader GMEC community in NHG.

The programme was on a steady keel at this stage of evolution. The didactic teaching schedule was well established, with biannual (i.e., twice a year) seminars that provided lectures to dovetail with the clinical postings as well as regularly fortnightly family medicine-focused sessions covering the range of topics vital for primary care practice. The programme incorporated innovative experiential sessions such as "Dialogue in the Dark", which allowed our residents to better appreciate blindness as a disability and to reflect and think of better care processes for such patients in their future practice. To encourage residents to take a keener interest in family medicine research, a quarterly research forum was established for senior family medicine research faculty to teach the fundamentals of practice-based research to our residents. Several residents who were keen on research were enrolled into the NHG Clinician Scientist Preparatory Programme over the course of their residency, which furthered their knowledge and exposure to research.

Figure 2: Combined teaching sessions

One of the key fundamental features of residency training was the annual programme evaluation process, which NHG Family Medicine Residency Programme took a serious view of to that ensure constant adjustments were made to improve the programme for both residents and faculty. This annual cycle of improvement resulted not only in greater satisfaction scores from residents but better learning experiences in the clinical postings, which translated to the graduates being more confident about independent practice upon their graduation from the programme. In the NHG Programme Evaluation Committee, evaluation data was grouped according to Miller's Pyramid of Assessment, hence we could pay more attention to data from the top of the triangle. Another key feature was the involvement of residents in training and recently exited residents in the committee that truly allowed the committee to have a firm sensing of the issues affecting resident learning and well-being.

Another key component of the NHG Family Medicine Residency Programme was the deep scrutiny that the Clinical Competency Committee conducted for all the residents every three months. These were highly charged meetings where faculty would debate at length regarding which residents would progress in training and which residents had to have academic remediation plans due to a failure to meet targets and milestones. Faculty had to screen formative assessment results from both the resident's hospital posting as well as continuity clinic assessment to decide on the residents' current performance and whether it was up to the mark. Those who fell short of expectations were highlighted and extensive remediation plans were discussed. This was also emotionally demanding on faculty who also served as mentors and supervisors to these residents. Having to make the decision of resident non-progression – or worse, dismissal – was thankfully a rare event for the faculty over the years. These discussions helped developed faculty and improved their acumen of holistic judgement and remediation planning.

Figure 3: Graduation celebration in 2017

The Programme saw its first cohort of residents graduate and obtain their Master of Medicine (Family Medicine) in 2014. A sense of relief was perhaps felt when eight out of ten exam candidates were successful at the first attempt of the exam. Many in the faculty gained a sense of validation that the Programme was on the right track in implementing many of the new educational processes adopted from the American residency system. With the fine-tuning of curriculum, zeroing-in of evaluation, and refinement of feedback, the programme enjoyed successive 100 percent Master of Medicine pass rates in 2017 and 2018. More importantly, graduates of the programme were demonstrating deep clinical expertise in the manner they cared for patients in primary care. Several excelled in their post-residency career and were appointed to junior leadership positions in NHGP. Even within the residency programme, it was heartening to see several graduates taking on core faculty roles.

In 2017, however, re-clustering of the Singapore Public Healthcare Institutions occurred. With this announcement, the NHG Family Medicine Residency Programme would lose four clinics to National University Polyclinics. This meant a temporary reduction in training space availability and thus programme expansion plans had to be put on the backburner. Besides training space, the programme would also part ways with key faculty, including our founding programme director, Dr Tan Kim Kiat.

THE NEXT LAP: REINVENTION

Leadership renewal was a clear agenda from 2018 onwards given the impact of the re-clustering. Dr Jason Chan, who joined NHGP as a result of the re-clustering was appointed as the Associate Programme Director. Prior graduates of the programme: Dr Kee Kok Wai, Dr Teh Kailin and Dr Jeremy Koh were appointed to key positions within the residency programme to ensure a healthy pipeline of potential future leaders of the programme.

Figure 4: Dr Tan Kim Kiat's (left) farewell

The pace of primary care expansion plans were also increasing. The Ministry of Health had announced a whole slew of new clinics that were to be completed by 2030. The Programme had to work with GMEC and NHGP Human Resources to have a clear 10-year plan for the manpower build-up required to staff these future clinics while balancing ongoing clinical staffing requirements. Given the limited training capacity as NHGP had downsized to six clinics due to the re-clustering, the difficult decision was made to reduce first-year continuity clinic sessions to just half a day while maintaining full-day continuity clinics in the second and third years of training.

By now, new pedagogical trends were being introduced to the medical education community. Entrustable Professional Activities and Programmatic Assessment were heavily discussed with a view to implementation in the near future. With a potential reaccreditation site visit to be erected, the Ministry of Health decided that specialities that had very fundamental differences with ACGME-I requirements were to adopt local accreditation standards instead. Family Medicine was chosen as one of two specialties to adopt local Singapore Speciality Training Standards in 2022.

In 2020, the impact of COVID-19 on the NHG Family Medicine Residency Programme was severe. FM residents were deployed to the National Centre for Infectious Disease to aid with ongoing COVID-19 ward duties whenever there was a surge in inpatient cases. Throughout the year, multiple curriculum changes were made to comply with the regulations for healthcare staff movement of the day. Continuity Clinic sessions for residents were frequently cancelled in order to support COVID-19 efforts in hospital. The balance between service needs and educational mission became more tensioned. From DORSCON Orange to

Figure 5: Dr Darren's (second row, 3rd from right) farewell

Heightened Alert, the running of the NHG Family Medicine Programme became an operational animal that required swift decision-making on resident posting whenever staff movement limits were upgraded. During the midst of the pandemic, Dr Jason Chan took over the reins as Programme Director while Dr Darren Seah continued his involvement as a core faculty member.

The programme has continued to evolve under the leadership of Dr Jason Chan. Faculty meetings are now conducted with the aid of digital tools such as Trello Boards to keep track of outstanding issues. Thankfully, due to the adaptability of faculty and residents alike, online teaching sessions were created in the early part of 2021, and many hospital specialists from Tan Tock Seng and Khoo Teck Puat Hospital contributed their time to provide additional tutorial sessions for the residents.

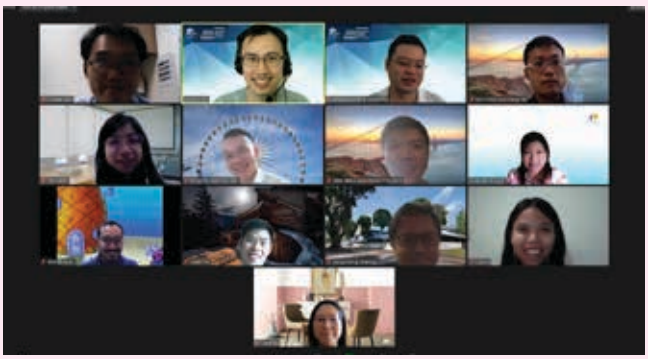

Figure 6: Faculty meetings

Resident-led committees looking into Education, Wellness and Outreach were initiated to deepen the involvement of residents in fundamental areas of the programme. The NHG FM Residents themselves have stepped up and used social media tools to promote educational activities of the programme and crafted online well-being sessions in the form of Titbit rounds. Many of these activities continue to bond the FM residents together. In these uncertain times of the pandemic, the sense of unity, family, and camaraderie have proven invaluable. The curriculum of the programme has also evolved rapidly to meet new clinical needs. Residents are involved in video-consultation services as part of routine clinical service provision. They are guided and supervised by faculty on the nuances of providing care and counselling on the video consult platform.

Figure 7: Video consultations

CONCLUSION

This 10-year lookback has demonstrated that the experience gained from adopting the ACGME-I accreditation standards have strengthened the educational rigour and quality of family medicine training standards in NHG. Educational processes such as programme evaluation, formative assessment with feedback, and academic remediation planning will continue to be embedded as core components of the residency programme as we move to adopting local training standards. With the pandemic in the backdrop at the time of writing this article, further shifts, adjustments, and changes will continue to be made as the training curriculum evolves to keep abreast of new technologies and trends in the healthcare landscape of the future.

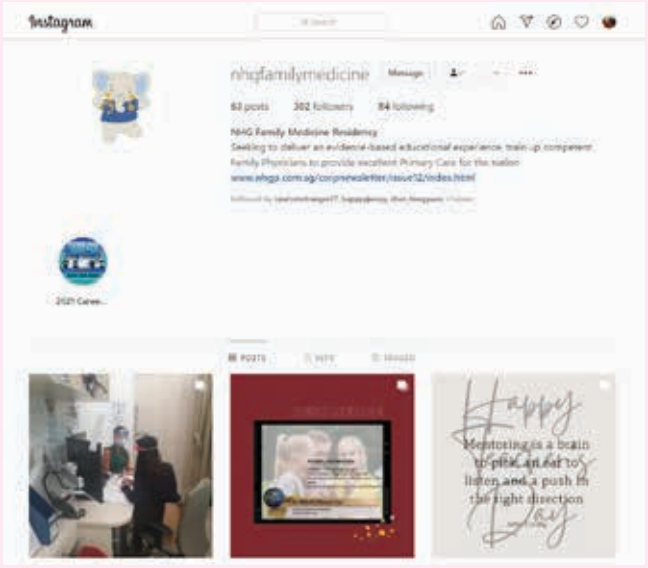

Figure 8: Resident-led outreach on Instagram

Figure 9: NHG FM mascot printed on a tote bag

SUMMITING THE PEAK OF FAMILY MEDICINE TRAINING

Dr Ng Lee Beng
Immediate Past Programme Director, FCFP(S)

Dr Low Sher Guan Luke
Current Programme Director, FCFP(S)

The Fellowship Exit programme, which is Family Medicine Advanced Speciality Training, is the pinnacle of family medicine training in Singapore.

AIMS

The curriculum and scope of training builds upon the Master of Medicine (Family Medicine) programme and aims to equip a post-MMed(FM)-proficient Family Physician (FP) to take up seven essential roles: Family Medicine Expert; Communicator; Collaborator; Health Advocate; Manager; Scholar; and Professional.

Its rigorous contents ensure that those who complete the programme are well on their way to being an Expert Clinician in the increasingly complex care required by our ageing population, handling the interplay of biomedical and psychosocial issues that influence patients' healthcare journeys and health outcomes. They are also ready to pay it forward by becoming Educators and training juniors to join their ranks. They have the basic Research skills to initiate or collaborate with others on robust research. They are ready to be Managers of multidisciplinary teams and limited resources in the midst of competing needs.

The training framework ensures that the other roles of effective Communicator, Scholar, Health Advocate, and Professional are also simultaneously nurtured so that those who complete the Fellowship journey are ready to take up active and leadership roles in whichever setting they practise in, be it in ambulatory care in the polyclinic and general practice arenas; subacute and transitional care in acute and community hospitals; or intermediate and long-term care in nursing homes and other chronic care institutions.

ITS EVOLUTION

The first cohort of the Fellowship by Assessment was started in 1998 with 10 trainees, all of whom passed. This was a two-year training programme.

In 2012, the Fellowship Programme underwent a major restructuring in its curriculum and training format to meet the increasing needs of the population, the increasing trainee cohort size, and to match the rigour of other advanced speciality programmes. The trainees embark on three major parallel training routes simultaneously – Clinical Practice, Research Skills, and Pedagogy. Large group case presentations, small group tutorials, hands-on pedagogical training to produce evaluation tools, and research skills workshops populate the journey. The journey culminates in an Exit examination. Many will attest that it is no walk in the park.

Since its inauguration, the Fellowship programme has made much progress. A steady conduit of trainers and examiners have come off the Fellowship train to hold the standard of excellence in Family Medicine training across all three clusters and in the three medical schools. Most, if not all, FM undergraduate and postgraduate training programmes are helmed and staffed by Fellows. Many sit in the Standard Setting Committee for Family Medicine at the Ministry of Health.

Many Fellows have gone on to provide leadership across the healthcare landscape. Presently they lead the family medicine departments in several acute hospitals and run the community hospitals and polyclinic clusters.

As the only national programme for advanced FM training, the Fellowship programme brings together trainees and trainers from all three clusters as well as the private sector. This has allowed the forging of personal relationships, better communications, and a greater understanding of the practices and work scope of the different family medicine settings.

The greatest achievement of the programme was its recognition by the Academy of Medicine of its provision of rigorous postgraduate training, thus meeting the academy's requirement for entry into its hallowed ranks. This paved the way for the creation of the Chapter of Family Medicine Physicians in 2015.

THE WAY AHEAD

We would like to encourage FM trainers to continue to train well. Firstly, the population needs well-trained family physicians (FPs) everywhere. Secondly, it is hoped that when FPs everywhere continue to excellently (a) transit patients successfully out of the hospital and back into the community, and (b) handle the complex care required in the community resulting in reduced readmissions and hospital utilisation, the legal recognition of Family Medicine as a speciality by the Ministry of Health will become a reality.

THE ROLE OF FAMILY PHYSICIANS IN THE COVID-19 PANDEMIC – THE SINGAPORE EXPERIENCE

Dr Chiang Shu Hui Grace
Honorary Editor, 28th Council
College of Family Physicians Singapore

A/Prof Goh Lee Gan
Past President (2007-2011)
College of Family Physicians Singapore

INTRODUCTION

Family medicine serves as the cornerstone of a strong healthcare system and family physicians are the foundation of a high-functioning healthcare system. The effective delivery of family medicine is associated with enhanced access to healthcare services, better health outcomes, and a decrease in hospitalisation and use of emergency department visits. Family physicians are skilled clinicians, patient advocates, and healthcare leaders. The diverse knowledge, unique skill set, and long-term relationships that family physicians have with their patients make them vital to the healthcare ecosystem.

The practice of family medicine embodies several unique attributes.[1] Family medicine is community-based and places a strong emphasis on continuity of care and comprehensive whole-person care. Family physicians are usually the first point-of-contact for patients and play a unique role in healthcare delivery and coordination. Due to these distinctive characteristics, family physicians in Singapore are favourably positioned to play a vital role in the pandemic response. During the COVID-19 pandemic, family physicians have been at the frontlines of the pandemic response playing a critical role in surveillance, triaging, vaccination, providing non-emergency are, and caring for vulnerable populations.

SURVEILLANCE

Family physicians play an essential role before and during a pandemic. They are a key component of surveillance systems. As the patient's first port of call, family physicians are able to identify early trends or "clusters" and report this to public health professionals. A network of clinics that consolidate the primary care clinic response to public health emergencies known as Public Health Preparedness Clinics (PHPCs) have played a significant role in the COVID-19 pandemic response by performing sentinel surveillance swabs and collecting data on community transmission.

TRIAGE AND TREATMENT

COVID-19, being a novel virus, has resulted in an overwhelming cascade of new and changing information. Family physicians have learnt how to deliver care in the midst of this pandemic whilst keeping up with flood of new information, adapting their practices rapidly and safely to meet patient needs. The majority of patients with COVID-19 experience only mild to moderate symptoms and can be treated at home, while a small subset require hospitalisation.[2,3] The role of family physicians in the community is critical in triaging high-risk patients, empowering patients and their families with the right information, support and resources to make an informed personal decision, act at the right time, and not present to the emergency department unnecessarily. Family physicians help to prevent unwarranted emergency department visits and hospitalisations, thus conserving hospital resources and preventing institutional outbreaks.

Family physicians have had to decide which patient care services should be conducted in-person and which could be conducted via telemedicine, as well as balancing the benefits and risks of providing in-person or virtual care, based on patient needs, the presenting concern, and their respective clinical judgement. Family physicians have also continued to treat COVID-19 patients in numerous settings, from clinics to community care facilities, homes to hospitals, emergency departments to long-term care facilities.

PREVENTIVE CARE AND PUBLIC EDUCATION

Due to the longstanding relationship between patients and their family physicians, some patients may consider their family physicians to be more credible sources of information than public health organisations.[4,5] Family physicians are thus uniquely positioned to educate patients especially when misinformation about COVID-19 is rife. Family physicians have a responsibility to provide patients with advice on preventative measures and counter detrimental misinformation.

Many family physicians in Singapore have taken up this mantle. They are encouraging COVID-19 vaccination in their clinics, vaccination centres, and mobile vaccination teams. They are helping to educate the general population by explaining the evolving evidence about COVID-19, its prevention, treatment and vaccine development, countering conspiracy theories, and reiterating public health messages at the individual, community, and national level.

COVID-19 has also transformed family physicians into mental health therapists as patients turn to them for help regarding their mental health issues. The isolation wrought from the COVID-19 pandemic has resulted in an increased number of patients suffering from sleep issues, psychological issues, and worsening chronic conditions.[6] Family physicians are in the best position to offer emotional support, guidance, and counselling to these patients.

CONTINUING CARE

During the COVID-19 pandemic, family physicians continued and continue to provide care for patients with chronic diseases and non-COVID-related issues. As resources in hospitals were diverted to care for COVID-related issues, family physicians had to provide care in the community to an increased number of patients through both old and new modes of practice, such as telemedicine. Family physicians have been able to reach more patients through innovative avenues of practice such as telemonitoring and virtual visits. This has been especially useful when patients are quarantined or want to limit risk of exposure to infection.

SUPPORTING FAMILY PHYSICIANS AS A FRATERNITY

During this period of increased stress and uncertainty, it is more important than ever for family physicians to look after themselves. Continued well-being is crucial for family physicians to continue the good fight for their patients. Consulting and sharing information within the healthcare community is important in preventing siloed practice, which might exacerbate a sense of isolation from the medical fraternity. Family physicians are coordinators of primary care teams. Through their consultations and engagement with government and leaders, they can help connect professional bodies with the public through effective communication. The College of Family Physicians has continued to support the family medicine fraternity through COVID-19 resilience seminars and COVID-19 education sessions held together with other professional bodies such as the Ministry of Health, Singapore Medical Association, and Academy of Medicine.

BEYOND THE COVID-19 PANDEMIC

The COVID-19 pandemic has highlighted the integral role of family medicine in the healthcare system. Family medicine's comprehensive scope of practice, together with the long-term relationships built with patients and their families, allows family physicians to act as their patient's healthcare advocates especially during tumultuous times. Beyond the pandemic, the family medicine fraternity must continue to train and mentor future family physicians, participate in research and quality improvement, and provide leadership at the practice, community, hospital, and system levels.

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HEALING FROM A DISTANCE: THE RISE OF TELEHEALTH AND TELEMEDICINE

Dr Wong Sin Yew
Infectious Disease Physician, Infectious Disease Specialists

Dr Yii Hee Seng
Executive Chairman, WhiteCoat

INTRODUCTION

Telehealth and telemedicine are not new concepts. The American College of Family Physicians describes telemedicine as:

> *"The practice of medicine using technology to deliver care at a distance."*

The Singapore Medical Council's Handbook of Medical Ethics defines telemedicine as:

> *"The systematic, structured use of telecommunications and information technology to deliver medical services or information over distances, across geographical and legal borders, with or without an intervening or intermediary healthcare professional."*

The use of telemedicine has been steadily gaining in popularity in recent years.[1] With the COVID-19 pandemic, there has been a rapid adoption and surge in the use of remote consulting.[2,3,4] The escalation of telehealth since early 2020 has also prompted numerous publications on the various aspects of telehealth that have been adopted.[4] In addition, the use of telehealth has been actively encouraged by governments and third-party payors.[5,6] Certainly, in many countries, the reimbursement of telehealth has also driven a change in practice.[5]

In the early stages of its development, telehealth focussed on how to improve access and enhance healthcare for patients with chronic medical conditions living in remote areas, such as those in rural environments. It subsequently expanded to the management of acutely ill patients onboard ships and in military conflict areas. The terms "telehealth" and "telemedicine" were often used interchangeably.

WHO introduced a standardised definition of telemedicine:

> *"The delivery of healthcare services, where distance is a critical factor, by all healthcare professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation and for the education of healthcare workers in the interests of advancing the health of individuals and their communities".*[4]

Others have used "telehealth" to mean healthcare services provided by all healthcare professionals, including the provision of education, while using "telemedicine" to refer to services provided by physicians and surgeons. In this review, the focus will be on the latter.

Provision of telemedicine covers the following areas:

1. Management of chronic diseases
2. Diagnosis and treatment of acute diseases
3. Provision of preventive care

Usually, the physician-patient "teleconsulting" will be done via videoconferencing or telephone. With improved technology and access, "real-time" videoconferencing has become the modality of choice. Video calls are also preferred as they allow the observation of visual cues of the patient's condition and appreciation of his/her physical and social environment.

In lieu of a skilled physical examination, there will be a need for the patient to perform self-monitoring and provide the following parameters to the physician: weight and physiological variables such as body temperature, blood pressure, heart rate, and oxygen saturation. After the initial teleconsult, regular transmission of physiologic parameters and symptom tracking may be required as part of continued care and follow-up.

The role of telehealth in the management of chronic diseases is discussed thoroughly in the section on family medicine and will not be elaborated upon further here as there is considerable overlap with specialists managing chronic diseases.

TELEHEALTH STATISTICS

The Physician Benchmark Survey on Telehealth in 2020 was conducted by the American Medical Association (AMA). The survey results, which were released in September 2021, demonstrated a large increase in the use of telehealth from 2018 to 2020.[7] The percentage of physicians whose practice used videoconferencing with patients increased from 14.3 percent to 70.3 percent between 2018 and 2020. Fifty

percent of physicians used telehealth to provide care for patients with acute disease and 34.3 percent used telehealth to provide preventive care.

The lack of skilled physical examination in telemedicine has not been an obstacle to the practice of psychiatry. In the AMA survey,[7] psychiatry was the speciality that had the highest use of telehealth in 2020. Eighty-five percent of psychiatrists in the survey served their patients through video or telephone consultations. Eighty-three percent used it to diagnose and treat patients and to manage chronic disease. Seventy-three percent reported that telehealth was used to treat patients with acute diseases and 44.4 percent used it to provide preventive care.

Besides psychiatry, other medical specialities that had a high rate of telehealth utilisation included endocrinology/diabetes and haematology/medical oncology. In this survey, paediatricians were less likely than family physicians and general internists to provide visits by phone.

Compared with medical specialists, surgeons were relatively unlikely to report the use of videoconference or telephone visits with patients. The exceptions were urologists; a reported 87 percent of them worked in practices that used telehealth.[7] In a more detailed analysis, Chao et al[8] reported on the use of telehealth by surgical specialities in Michigan in the first nine months of 2020. Of the 4,405 surgeons in the study cohort, 58.8 percent performed telehealth during this study period and 26.8 percent were for new patient visits. In contrast, less than 1 percent of new patient visits in 2019 were conducted by telehealth. There was a significant variation in the nine surgical disciplines in the provision of telehealth. The highest rates were for urology/neurosurgery and the lowest were for ophthalmology/ENT. Telehealth conversion rates decreased over time, presumably after the first wave of infection in the United States. Patients and surgeons may have viewed the use of telehealth as a temporary means to meet the needs of the pandemic.[8] In a separate study,[9] telehealth facilitated 30.4 percent of all outpatient visits.

Digital health has been used in cardiology even before the COVID-19 pandemic.[10] In the past, face-to-face consultation was the default and teleconsultation and remote monitoring was the exception. With the COVID-19 pandemic, tertiary cardiac units began utilising telehealth in heart failure patients and focused not just on teleconsultation but also on other applications such as remote monitoring using apps, wearable devices, and telerehabilitation.[11]

REMOTE PATIENT MONITORING

In the AMA survey, 33 percent of medical specialists used remote patient monitoring and were driven mainly by cardiologists (63.3 percent) and endocrinologist/diabetes physicians (41.6 percent).[7] With today's advancing technology, what has been described in this article regarding teleconferencing, remote monitoring using apps, and wearable devices is only the tip of future capabilities. Other forthcoming monitoring may include ingestible and injectable devices.[1] Technological advances in digital health that involve the application of artificial intelligence and machine-learning algorithms that could transform the way health and disease are analysed and managed is beyond the scope of this article and will not be covered here.

TELEMEDICINE IN FAMILY MEDICINE: LOCALLY AND OVERSEAS

Telemedicine increases accessibility to healthcare services, especially for patients living in remote areas. The widespread use of smartphones enables video consultations with doctors, which enhances the value of telemedicine. Doctors are now able to examine and advise if there might be an urgent condition that requires immediate evaluation, or a non-urgent medical issue. For minor dermatological conditions such as atopic dermatitis, the doctor can prescribe a cream. Amazingly, most small towns have chemists. If the medicine, e.g., a tube of hydrocortisone, is available at the chemist's store, the doctor can attach a prescription to be filled at the chemist's shop.

Prior to COVID-19, the main reason for an increase in adoption of telemedicine was convenience, due to the vast distance between doctor and patient. However, the advent of the pandemic ramped up the demand for telemedicine due to lockdowns across the globe, effectively entrenching it as a necessity. The need for such services for those who live and work in remote areas continues, but telemedicine has also now been widely adopted in big and dense cities such as New York, Boston, Melbourne, and Singapore.

Software development plays a big part in telemedicine, especially the case notes. Almost all of them will allow doctors who follow the teaching to document history first followed by physical examination, diagnosis, and order investigations or treatment. Blood pressure and temperature can be measured by the patient and reported to the doctor. Unfortunately, physical examination beyond that is limited to observing rash, deformities, and any limitations in movement. This is probably the weakest link in telemedicine consultation today. Doctors using telemedicine for consultation must have a high index of suspicion. If a patient reports minor symptoms but appears unwell, he/she must advise the patient to proceed to the nearest clinic or even to the A&E for further evaluation. Attending to children below two years of age can be treacherous as the infant is unable to inform the doctor of what is wrong. This is thus a double-edged sword.

Telemedicine offers family physicians an opportunity to stay current in a cradle-to-grave speciality by delivering timely healthcare in long-term chronic disease management during and beyond the COVID-19 pandemic. Family physicians can be better positioned to care for their patients with physical or functional disabilities who have difficulties coming down for on-site consults. Telemedicine can support family physicians in journeying and providing their chronic patients with medical care throughout their life.

In Singapore, most, if not all, medicine prescribed via telemedicine are delivered to the patient's designated address, usually within the same day, with the exception of two scenarios: 1) The clinic does not stock the item the patient wants and is reluctant to use another, equivalent, medicine for various reasons; and 2) for medicine that is known to be abused or where frequent use is known to lead to dependence/addiction. This includes medicine with codeine, especially cough syrups with codeine, and hypnotics and sedatives.

For patients who genuinely need any of the above medicine (with proper medical documentation and certification by his/her doctor), a handful of telemedicine providers have arrangements with pharmacy chains, usually Watson's and Guardian's, which are the two biggest chains in Singapore. For these patients, doctors will issue electronic prescriptions that are embedded in their app. Often, a QR code is generated. The pharmacist scans the QR code and can see it reflected in their system. The patient will be asked to verify his/her identity, be it via NRIC, FIN or passport, which must match the information embedded in the app and which is made available in the e-prescription, just like it would have been for a hardcopy prescription.

Before dispensation, the app will show that item as "not fulfilled" or "not purchased". Once the prescription for that item has been fulfilled, the app will be updated almost immediately to show that it has been "fulfilled" or "purchased".

If the patient opts for partial fulfilment, the app will reflect the quantity prescribed, quantity fulfilled, and quantity not fulfilled yet, which allows the patient to return and purchase the balance at a later time if need be.

This feedback loop is very important to prevent abuse. As long as the app shows that the prescription has not been fulfilled, or is partially fulfilled, the patient could run to another store with the same app and purchase the same item several times before the system is updated and the status is reflected in the app.

TELEMEDICINE IN TIMES OF CRISIS

In many countries, telehealth has become a central piece in patient healthcare delivery during the COVID-19 pandemic.[3,4] With telemedicine, healthcare providers are able to allocate more resources towards pandemic concerns while at the same time continuing to care for patients with non-COVID-19 conditions. As patients were urged to stay home at various times during the COVID-19 pandemic, telehealth capabilities were quickly expanded and broadened to allow for delivery of healthcare services to the patients' homes. Clinicians, some initially reluctant, began expanding their knowledge of telehealth capabilities.

The distance/remote element in telemedicine has become a relative rather than actual physical measurement. With patients advised to avoid public places and practise physical distancing, teleconsulting has become an alternative means of continued healthcare. For those who have been diagnosed with COVID-19 and asked to continue with home monitoring and recovery, telemedicine has been useful as a "forward triage" in selecting the appropriate patients to be sent to the Emergency Department for inpatient care.[2,6,12]

A huge benefit of telemedicine is evident in unforeseen circumstances, such as when patients are stuck in foreign countries for an extended period of time. In 2020, a group of people came to Singapore to visit their children and grandchildren who were living and working here, but the outbreak of COVID-19 meant that they but could not return when borders were shut. Their plan for a one-month visit was thus extended to at least six months. In such scenarios, patients who can present electronic records of their existing medicine and dosage are able to obtain a prescription from local doctors. The attending doctor in Singapore can take a look at patient's level of control and advise if doses should be changed, tiding the patients over until they are able to revisit their respective doctors at home.

THE BENEFITS OF TELEMEDICINE

As with many industries, telemedicine has proliferated in healthcare in large part due to the rapid developments in the IT sector. One such development is the mobile phone. The role of this tiny device in our daily life can never be overstated. Ever since Steve Jobs unveiled the very first iPhone back in 2007, the mobile phone has evolved into an all-in-one machine, performing tasks ranging from surfing the internet and receiving and sending emails to taking pictures and making payments. Video capabilities on mobile phones allow patients to book appointments with their physicians and hold said appointments through their phones simply by tapping on the screen. This boom in technology combined with the COVID-19 pandemic has greatly boosted the profile of telemedicine, courtesy of enforced lockdowns in many areas around the globe.

For office workers, telemedicine is a huge boon. With telemedicine, they can get themselves in the queue while continuing with their work. When it reaches their turn, the

doctor will ping the patient and the consultation begins. At the end of the consultation, the patient can see the medicine prescribed by the doctor through their screen. The doctor will advise what each medicine is for, their dose, possible side effects, and provide advice on non-medicinal ways to manage the condition. A careful doctor will also advise the patient about possible complications and what the patient should look out for, e.g., for a patient presenting with epigastric pain, the patient should be advised to observe for pain shifting to the right iliac fossa, which may be accompanied by fever, nausea, or vomiting. The patient should then be advised to proceed to the Emergency department if this happens. Most telemedicine platforms allow the attending doctor to provide free text advice for the patient.

Seemingly trivial matters that are of benefits to both patients and physicians cannot be overlooked either. For example, there will be significant cost savings for the patient who does not have to travel to a clinic, wait to consult a doctor, wait for his or her medicine, the medical certificate, returning home, and so on. Likewise for employees who have to take time off work to consult a doctor, which could result in an hour or more before the employee returns to work.

OBSTACLES IN TELEHEALTH AND TELEMEDICINE

There are both benefits and costs to everything in life, and telemedicine is no exception. Main obstacles may be broadly defined as stakeholder resistance to digital health adoption, legal/technical and ethical issues, and lack of reimbursement. Telemedicine consultations require the same amount of time, as in-person consultations and rigorous and astute attention to details to accurately meet and maintain the standards of care.

Full data and medical histories may be incomplete as they are reliant on a patient's (and sometime caregiver's) interpretation of symptoms and clinical problems. A limitation of telemedicine includes the lack of expert physical examination to corroborate the symptoms. Patients with mental disabilities or cognitive impairments might not be candidates for teleconsultations.

Another challenge is the patient's perspective on telehealth. The main considerations can broadly cover:

1. Patient autonomy
2. Value attribution
3. Equity and trustworthiness

An oft-cited obstacle to telehealth for the patient is technology access, as telemedicine does not reach all patient groups equally, especially the marginalised sections of the population such as the elderly, the poor, and those with physical and cognitive disabilities. In the retrospective study by Aziz et al[15] at the Massachusetts Eye and Ear Infirmary, decreased participation in video-based consultations was associated with older age groups, lower educational level, being unemployed or retired, or having a disability. One would argue that the proliferation of telemedicine could exacerbate healthcare inequality for the target group most likely to benefit from such endeavours.[16]

In technologically-advanced Singapore, this is likely to affect only the minority of patients. The basic infrastructure required for telemedicine such as electronic medical records, data privacy, and cloud storage (for large data requirements) is not demanding for most healthcare institutions and clinics in Singapore. Access to remote monitoring technology such as communication devices, wearables, etc are not difficult to configure in a technology-driven economy such as Singapore's. However, this issue is much more relevant in other countries where broadband access may be limited. And every patient affected is one patient too many.

Despite Singapore's top-notch connectivity, internet and connectivity issues cannot be overlooked as an obstacle to telemedicine, as blind spots can pop up when moving between areas, interfering with connectivity. Such blind spots include underground car parks, driving between tall buildings, travelling through tunnels, and certain multistorey car parks. These blind spots interfere with consultations and could result in misunderstandings and patients missing out on important information. In worst-case scenarios, the consultation might have to be cancelled and postponed, resulting in an unwanted inconvenience. Even without these blind spots, internet connectivity can be notoriously spotty at the most inopportune of times, and there have been several occasions of network outages by internet providers.

Another major obstacle is the lack of skilled physical examinations, which often results in increased laboratory and radiological investigations. Access to laboratories and radiology proved to be challenging at the height of the COVID-19 pandemic and continues to remain so in a remote setting.

Trust is a fundamental value in healthcare and thus also essential in telehealth. Trust might be harder to establish in a virtual consultation than in person, due to a lack of opportunities to observe and interpret body language. Most experts agree that 70 to 93 percent of communication is nonverbal, and virtual meetups deprive parties of the opportunity to convey this nonverbal communication. This deprivation can lead to a lack of establishment of competence, logic, empathy, and reliability.

This naturally leads to a point that bears repeating: for all its numerous benefits, Telemedicine will never truly replace the tried-and-tested face-to-face consultation_between doctor

and patient. In the same manner that gatherings such as office meetings, educational classes, worship services, and even a simple meetup at a cafeteria will always be preferable in person, so too is the consultation between doctor and patient. There are just some things that technology will never be able to replicate, and one of those things is the physical human experience and connection.

TELEMEDICINE IN SINGAPORE

For corporate clients, telemedicine is a value-added service in the competitive corporate client market. This includes larger medical groups such as Raffles Medical Group, Shenton Medical Group, Fullerton Healthcare, etc.

Many telemedicine companies own and operate brick-and-mortar clinics. This gives doctors and patients an alternative, should there be an inability to examine patients via telemedicine. Patients are given the option to consult at these brick-and-mortar clinics or be referred to another GP, to specialists, or to the A&E department. One of the earliest companies providing telemedicine services in Singapore is MyDoc, which was established in 2012.

In 2018, the Ministry of Health (MOH) launched the Licensing Experimentation and Adaptation Programme (LEAP), a regulatory sandbox initiative to better understand new innovative services by partnering early with industries. The intention was to establish Telemedicine as a separate category of service when MOH migrated from the Public Hospitals and Private Clinics (PHPC) Act to the new Healthcare Services Act (HCSA). This business model marries brick-and-mortar healthcare with digital efficiency.

PRACTICAL TIPS FOR TELECONSULTING

Pre-consultation preparation is especially important for new patients and for existing patients with new acute conditions. This allows the appropriate selection of the patient for the teleconsultation and to ensure a smooth flow of the video consultation process.

New patients need to understand and consent to the limitations of teleconsults as mentioned earlier. The specialist needs to ensure that past and recent investigations are forwarded and reviewed before teleconsult. It may also happen at this stage that the specialist might determine he/she is not the appropriate specialist for this particular patient or that an in-person clinic consultation is required.

Additional useful tips for and instructions to the patient include the following:

1. Ensure that the communications equipment being used (desktop computer, laptop computer, tablet computer, smartphone) has a functioning video camera, speakers, and microphone.
2. Ensure good cellular or Wi-Fi connection.
3. Ensure a quiet and private environment.
4. Select and include other family members/caregivers in the videoconferencing as appropriate. Such individuals may be asked to participate in the examination as well as in the subsequent care plan that will be formulated.

It is worth highlighting to all doctors that certain medical professional indemnity insurers do not cover Telemedicine. Doctors intending to sign up with a telemedicine platform to provide such services are advised to speak to their professional indemnity insurer to make sure they are covered before they commence.

THE FUTURE OF TELEMEDICINE

Better research has to be conducted, and quality measures need to be implemented, into telemedicine.[17]

Telemedicine has to take into account the shifting landscape on a large scale: it not only has to cater to patients' expectations, it also has to follow regulatory and licensing requirements.[9]

From a sustainability angle, the COVID-19 pandemic has disrupted our healthcare system and has forced us to relook how healthcare should be delivered. With vaccination rates of more than 70 percent in their respective resident populations, many countries are eager to "open up their economies" in order to avoid financial ruin. In some countries, the uptake of telehealth has plateaued or started to decrease.[18] Nevertheless, there will not be a return to the pre-COVID-19 scenario. As the population becomes increasingly digitally empowered, it is likely that patients will use technology to manage their heath and diseases. Reimbursement issues will need to be taken into consideration and will likely be the key driver and enabler for the long-term adoption of telehealth.

For those who have started telemedicine using the regulatory sandbox outlined by MOH, it is important to reflect on their experiences and focus on how to increase "value", improve quality, and enhance patient safety.

Overall, there is compelling evidence that telehealth has been a positive addition to and transformation of healthcare and is likely to have a significant effect on the advance of

healthcare in the future. We are well in the next phase of development of telehealth. For those who have not started, they will inevitably experience hurdles, but as they go along, such obstacles will be overcome with relative ease, and it will become second nature.

The capabilities to help and treat patients have never been greater and it is an exciting time for healthcare using telemedicine. While we do not have all the answers, solutions will continue to present themselves with ongoing interest and investments in telemedicine.

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THE MEDICAL CONSULTATION – A CORNERSTONE OF FAMILY MEDICINE PRACTICE

Dr Lee Eng Sing
Family Physician, Senior Consultant
National Healthcare Group

Clinician Scientist, Lee Kong Chian School of Medicine
Nanyang Technological University of Singapore

SUMMARY/ABSTRACT

The role of the family physician is to provide comprehensive and individualised care for each patient. Therefore, it is necessary to foster clear and responsive communication between both parties. This article is a reminder of the importance of the medical consultation by breaking it down into its different components. In this article, we outline the stages involved in medical consultations and provide guiding principles to consider in order to build effective patient-physician communication at each consultation stage.

Keywords: communication, consultation, physician-patient relations

INTRODUCTION

The medical consultation is an important feature of family medicine. It is not just a meeting of the family physician and the patient but also an exchange of ideas between the medical profession and the society at large.

The medical consultation can be divided into five different components involving four order gates of communication (two by the patient and two by the physician) as follows:

1. Reason for encounter (*first-order of communication*)
2. History-taking (*Second and third-order of communication*)
3. Examination and investigation
4. Synthesis of all the information collected
5. Closure and follow-up (*Fourth-order of communication*)

MEDICAL CONSULTATION

1. Reason for Encounter

Before a patient turns up at the family physician's office, he/she has to be wary of the information garnered by signals of deviations from the norm experienced by the body, resulting in an impetus to seek a physician's help. This first-order gate of communication is often heavily influenced by personal, family, and social circumstances.

It is commonly assumed that illness and disease come together, but that is not the case as they are different.[1] Illness is what a person experiences; disease is the categorisation and interpretation of that illness in scientific terms. It is possible to have illness without a disease or a disease without illness. Suffering is the common denominator for all patients with either illness or disease.[2] The "suffering" needs to be addressed or patients would feel that they are being put down. Therefore, it is important to ascertain the "reason for encounter" by the patient because if this is not done properly, the patient will leave the consultation room unsatisfied.

2. History-Taking

Oftentimes, a patient does not present and explain his/her problems with strong degrees of certainty. This depends on the familiarity of the "illness" experienced and the language used to describe it. The eventual message presented to the physician may be directly or indirectly shrouded with emotions of fear, guilt, or anxiety and be misconstrued by the listener. This constitutes the second gate of communication that the patient has to cross.[1]

Finding out a patient's ideas, concerns, and functions in everyday life, as well as their expectation of the consultation, is crucial in improving communication in a medical consultation. The family physician creates the right environment for the patient to speak comfortably, listens responsively, understands the context of the patient, and looks out attentively for the body language of the patient. This is the third-order gate of communication. Awareness of transference from the patient and self-reflection on possible countertransference of the physician will also help to minimise miscommunication during the medical consultation.

3. Examination and Investigation

Sufficient physical examination should be performed in order to confirm the clinical impression and rule out

surprise findings. The more undifferentiated the problem, the more extensive a physical examination to be carried out. A physical examination done with a respectful demeanour can further enhance the patient-physician relationship and healing. This has been described by Cassell as the tenderness phenomenon.[3] Note that not every consultation requires an investigation. Wilson suggests good old common sense and a more thorough look through the medical notes.[4]

4. Synthesis of All the Information Collected

While it is important to look at the diseased organ that a patient presents, it is also important to look at the patient holistically. The options of treatment and management will have to take into account the interplay of the two views. An alteration of analysis and integration leads progressively to an ever deeper understanding of a comprehensive entity.[5] Subsidiary and focal awareness bring about the understanding of the "whole" and the "parts" to a higher level.

On top of all the information garnered from the history, examination, and investigation results, the physician also needs to reach a common ground with the patient during the closure and follow-up. This act of integrating all the information gathered is the know-how (tacit knowledge) that is developed with time and experience.

5. Closure and Follow-up

Many symptoms are not medically explainable in family practice. Classifying them into physical, psychological, or social problems is not accurate because it worsens the mind-body-environment divide. Moreover, giving a medical explanation to legitimise a patient's suffering would result in over-medicalisation and create a pseudo-reality that science and medicine can explain all phenomena experienced in this living world. There is more to life than medicine can diagnose, and medicine should not put itself on a pedestal.

A problem that cannot be properly defined needs to be recognised as such. Using time as a diagnostic tool with watchful waiting and/or frequent reviews may need to be considered. How good the closure is done will depend on the patient-physician relationship and the fourth-order gate of communication — the physician must be mindful to use the appropriate language at the right level to reframe the patient's perspective of the expected role of a physician and of the dimensions of healing for the symptom(s) reported. This is compounded when the patient is not sure of what he/she wants. It is very common for patients to change their minds with regards to what is important to them and what they want.

Ultimately, a myriad of things must occur outside the consultation room in order to make the medical consultation a successful encounter. Along with the know-how (tacit knowledge), the know-what (facts) and know-why (science) from the biomedical model, good family physicians should also possess the know-who (networking) to connect the patient with the most appropriate healthcare providers or technology in the whole healthcare system.

CONCLUSION

Family medicine is rooted in the historical generalist tradition. It is a profession grounded in science and enhanced by the central role of the patient-physician relationship. This relationship is built over time and the little glimpses at each visit help to build the personalised care that will eventually be useful for future consultations. With the challenges of consumerism, technology, and easier access to information, it is even more pertinent that the medical consultation is the cornerstone of good healthcare delivery.[6]

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A RESIILIENCE ROADMAP FOR PRIMARY CARE PHYSICIANS

Dr Goh Jun Heng
Family Physician, Yishun Polyclinic

Dr Angelia Chua Hwee Ling
Consultant Family Physician, Yishun Polyclinic

ABSTRACT

The COVID-19 pandemic has resulted in an increase in perceived stress levels amongst healthcare workers, leading to concerns about burnout. Burnout is linked to an increase in medical errors and can be prevented by encouraging resilience. In light of the above factors, a programme to foster resilience was introduced in Yishun Polyclinic, adopting the principles of the self-determination theory. Elements of the initiative included birthday celebrations, a buddy support system, and a monthly facilitated sharing session that sought to fulfil the needs of relatedness, autonomy, and competence. In an uncertain future with an accelerated pace of change, a resilience roadmap can pave the way to a better future.

Keywords: COVID-19 pandemic, healthcare workers, burnout, medical errors, self-determination theory

PATIENT'S REVELATION: WHAT HAPPENED?

Doctors are humans before heroes. While it is usually doctors seeing patients, there are times where the roles are reversed, and doctors find themselves on the other side of the stethoscope. This is especially relevant in current times due to the crushing effects of the COVID-19 pandemic, which has translated to an increase in mental health issues amongst primary care providers. In a cross-sectional study of 257 General Practitioners in Singapore conducted between April and September 2020, it was demonstrated that 21.4 percent met the criteria for anxiety based on the Generalised Anxiety Disorder-7 scale, 82.1 percent for burnout based on the Oldenburg Burnout Inventory, 26.6 percent for depression based on the Patient Health Questionnaire-9 scale, and 8.9 percent for post-traumatic stress disorder based on the Impact of Event Scale-Revised.[1]

While the spotlight has been focused on the mobilisation of personal protective equipment, vaccination drives, and contact tracing, it is equally vital to care for our carers' mental health as a physician workforce plagued with high rates of mental health problems will have significant downstream impacts such as suboptimum quality of patient care. In a survey conducted on 115 internal medicine residents in a university-based residency programme in Seattle, Washington, burnout was strongly associated with reports of one or more suboptimal patient care practices at least monthly (odds ratio of 8.3 [95 percent CI, 2.6 to 26.5; P<0.001]). Examples of suboptimal patient care practices listed in the study included discharging patients to make the service manageable because the team was too busy, not fully discussing the treatment options or answering a patient's questions, making treatment or medication errors that were not due to a lack of knowledge or inexperience, ordering restraints or medication to an agitated patient without evaluating him/her, and not performing a diagnostic test due to a desire to discharge a patient.[2] In a similar vein, a meta-analysis of 47 studies on 42,473 physicians found that burnout is associated with a twofold increase in odds for unsafe care, unprofessional behaviours, and low patient satisfaction.[3]

Another cross-sectional study titled the PROTECT (Psychological Readiness and Occupational Training Enhancement during COVID-19 Time) study conducted at the National Healthcare Group Polyclinics in March 2020 concluded that all healthcare workers at the time of the survey during the COVID-19 pandemic, regardless of scope of work, had higher levels of stress compared to general population before the COVID-19 pandemic.[4] The outcome was scored on the Perceived Stress Scale (PSS), which is a 10-item scale that measures the degree to which situations in one's life are viewed as demanding and stressful. Perceived stress level of healthcare workers in various departments ranged from 17.2 to 20.3 compared to the baseline PSS level of between 16.0 and 17.0 of the general Singapore population prior to the COVID-19 pandemic.

Possible factors contributing to this increased stress level included ensuring adequate infection control, new workflows to manage patients remotely, frequent changes in workflows in response to the growing spread of COVID-19, requirements for rapid data submission, dealing with logistic challenges, and working in split teams.

The findings from these studies are a clarion call to those involved in primary care to design a resilience roadmap towards a burnout-free future where doctors seeking help do not feel silenced by stigma and where it is recognised that it is okay to not be okay,

GAINING INSIGHT: WHAT ARE THE ISSUES?

Burnout has been described by Maslach as a prolonged response to chronic emotional and interpersonal stressors on the job and comprises three domains: emotional exhaustion; depersonalisation; and the lack of personal accomplishment.[5] A cross-sectional study conducted on 446 residents from Singhealth Residency found that 80.7 percent of residents had burnout in at least one of the three domains.[6]

High levels of burnout is a major problem and has been associated with increased risk of medical errors. This is demonstrated by a study published by the Department of Internal Medicine, Division of Hematology, Mayo Clinic, Rochester, USA, which showed that each one-point increase on a Maslach Burnout Inventory-Depersonalisation metric scale range of 0-33 was associated with an 11 percent increase in the likelihood of reporting an error. Alongside that, each one-point increase on a Maslach Burnout Inventory-Emotional Exhaustion metric scale range of 0-54 was associated with a 5 percent increase in the likelihood of reporting an error.[7]

A study by the Betsy Lehman Center for Patient Safety investigators identified 62,000 preventable harm events and calculated excess claim costs due to medical errors of more than $617 million over a 12-month period.[8] In the watershed report "To Err is Human" by the US Institute of Medicine, it was revealed that more than 1 million preventable errors occur every year within the US. Of these, between 44,000 and 98,000 result in death.[9]

In light of the above findings, it is evident that nipping the problem of burnout in the bud can help to avert the disastrous financial and humanitarian cost of medical misadventures and is a worthy pursuit for the medical profession.

STUDY THE MANAGEMENT: HOW DO WE APPLY IN OUR CLINICAL PRACTICE?

Literature Review on Resilience and Primary Care Providers

Data on interventional studies on relieving burnout has pointed the way forward in the quest towards a lofty aspiration of a burnout-free medical ecosystem. In a study conducted by West, 19 biweekly facilitated physician discussion groups stretched across nine months with an hour of protected paid time every other week for participants demonstrated a decrease of 15.5 percent in rates of high depersonalisation three months after the study versus a 0.8 percent increase in the control arm (P=0.004).[10] This single-centre randomised clinical trial involved 37 intervention arm participants who were enrolled into facilitated small-group curricula. Topics addressed during the sessions included internal resources such as mindfulness and resiliency skills training and links to external resources such as community, friendships, and spirituality.

In an article that explored the concept of resilience and its potential relevance to medicine titled "Towards an understanding of resilience and its relevance to medical training", resilience was defined as a dynamic capability that allows people to thrive on challenges given appropriate social and personal contexts. The dimensions of resilience identified included self-efficacy, self-control, self-care, ability to engage support and help, learning from difficulties, and persistence despite roadblocks to progress.[11]

In a systematic review on resilience in medical doctors, it was noted that the myriad of influences on the resilience levels of doctors span from personality factors, organisational factors, and social support (both from peers and on a personal level), to outside interest and overcoming previous adversity.[12] A study by Waddimba et al of New York physicians further highlighted that social support of colleagues was an important determinant of doctors' resilience and emphasised the importance of building support networks to improve workplace resilience among clinicians.[13]

Overview of the Resilience Programme Implemented in Yishun Polyclinic

In March 2021, the Yishun Polyclinic leadership team initiated a programme to foster a journey towards building resilience amongst clinicians. This initiative adopted a three-pronged approach that comprised celebration of birthdays, the formation of a buddy support system, and a monthly facilitated sharing session.

In a large public institution, it is easy for individuals to feel like small cogs in a large machine and lose their intrinsic self-motivation to produce. The key to unlocking this conundrum requires understanding the self-determination theory, which suggests that people are motivated to grow when their three innate psychological needs – namely, the need for relatedness, autonomy, and competence – are fulfilled.[14] Self-determined behaviour is intrinsically driven and done for its own sake as it is inherently satisfying or engaging. In order to promote the tendency to be proactive, it is important to leverage on the self-determination theory to optimise the workplace in a manner that fosters the growth of these three crucial elements.

The first element of relatedness was promoted by bringing together a whole community of doctors to celebrate each and every individual physician's birthday so as to create a sense of belonging and attachment. Funds were raised on a voluntary basis in the spirit of autonomy and were used

to purchase memorable gifts for each valued member of the medical team. The importance of birthday celebrations cannot be overstated and have been shown to help with a better understanding of oneself, make the person feel unique and valuable, and provide support in tough times.[15]

The second element of autonomy was incorporated into a buddy support system, whereby clinicians form intimate teams of two or three of their own volition. Buddies were tasked with providing a pillar of support by checking in with each other regularly, sharing their reactions to stressors, validating their experiences, and escalating to clinic-designated peer support leaders when they determined that their buddies required a higher level of mental support. In order to give members as much options as possible, there was no mandate on the specifics of how each buddy should help each other. This flexibility afforded the clinicians the freedom to decide the best form of support their buddies required.

Looking abroad, this coping mechanism of a buddy system has already been rolled out in a healthcare setting to maintain optimal mental resilience in face of the daunting challenges posed by the pandemic. A case in point would be a rapidly deployable psychological resilience intervention developed jointly by the Department of Anesthesiology and the Department of Psychiatry and Behavioural Sciences at the University of Minnesota Medical Center to preserve the psychological health of the medical frontliners working in conditions that engender high levels of fear and anxiety.[16] The intervention founded on a peer-support model developed by the United States Army was organised into three levels of support, the first level being peer support, the second level being that of a unit level support, and the third level being that of a one-on-one support by mental health consultants.

Last but not least, competence is also important for individuals to feel intrinsically motivated. Competence can be supported by providing optimal challenges and opportunities that match an individual's skill set and by providing relevant feedback. Facilitated physician discussions conducted monthly over Zoom aims to provide a platform to build on individual's skill set through the collective sharing of the team's wisdom garnered through past experiences so as to better prepare the team to overcome future obstacles and build self-efficacy. Positive feedback provided spontaneously by peers, juniors, and seniors further enhance intrinsic motivation for clinicians to go beyond the extra mile and contribute to the growth and development of the clinic. An example would a recent sharing session on Teacher's Day, whereby the contributions of different mentors in the clinic were highlighted and the defining characteristics of what makes a good teacher in the minds of the tutees were discussed. This session generated a sense of collective appreciation for the teaching culture in Yishun Polyclinic and provided a source of motivation for those in the education track to continue with the noble pursuit of grooming the next generation.

The implementation of the aforementioned programme was complicated by the limitations of social interaction consequent to the introduction of social distancing. It was highlighted in the article "Resilience in Times of COVID-19: Isolation and Loneliness in Family Medicine" that family physicians are no longer able to rely on traditional communicative practices as the COVID-19 crisis continues, resulting in disconnection breeding deficient collaboration, lack of mentorship, and a feeling of isolation from one's work community.17 However, with crisis comes opportunity and there are ways to humanise online sharing and learning in this age of disruption. A short welcome and check-in video, keeping it real by allowing for pets or kids to make a surprise appearance, getting personal through usage of first names, referring to comments made in previous discussions, providing opportunities for interaction through Q&A sessions, being compassionate by following up on how others are doing, and how we can help through personal messages are some suggestions that served to build rapport and meaningful personal connections that bridged the digital divide.[18]

CONCLUSION

In an unpredictable future with an accelerated pace of change, it is important for family physicians to be equipped with the resilience to ride out the storms ahead. The resilience roadmap implemented by Yishun Polyclinic is one example whereby the current generation can aspire to build towards a better future.

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Guidelines and Information for Authors
The Singapore Family Physician

Authors are invited to submit articles for publication in *The Singapore Family Physician* on the understanding that the work is original and that it has not been submitted or published elsewhere. Your original article will be considered for publication on the understanding that they have to be approved by the Editorial Board via a double-blinded peer-review process and *subject to revision*. Authors are encouraged to consult the recommendations in the *Uniform Requirements for Manuscripts Submitted to Biomedical Journals* (http://www.icmje.org/index.html), which the SFP is in accord with.

The following types of articles may be suitable for publication: case reports/study, original research works, audits of patient care, protocols for patient or practice management and letters to the Editor. The CME and review articles will be published under the prerogative of the Institute of Family Medicine (IFM) in the College of Family Physicians Singapore. The article has no word limit and should be written in British English. This must be submitted in an electronic form and of a format that is compatible with major word processor applications. Submissions in Microsoft Word format is preferred.

RECOMMENDED FORMAT FOR THE MANUSCRIPT

The submission should comprise of the following:

1. Title Page
2. Summary/Abstract
3. Key Words
4. Text/Manuscript
5. Tables
6. Illustrations
7. Learning Points

Authors are advised to ensure the anonymity of study subjects and patients by removing any and all information that could compromise their privacy from the submission.

The text should be typed in Arial font, 12-point size with a 1.5 line space.

The Title Page

- The title should be concise and highlight the key elements of the article.
- Include on the title page first name, qualifications, present appointments, type and place of practice of each contributor.
- Include name, address, handphone number and email address of the first author to whom correspondence should be sent.
- Insert at the bottom: name and address of institution or practice from which the work originated.

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- The summary should describe why the article was written and present the main argument or findings.
- Limit words as follows: 250 words for major articles; 200 words for case reports.
- All Original articles (examples: randomised controlled trials, cohort studies, observational studies, and review articles) must be accompanied by a structured abstract while all other categories of manuscripts (examples: PRISM and Case Records of Family Medicine) should have unstructured abstracts.

- **Structured** – Organise the abstract according to the following headings:

1. **Introduction** – states the purposes/aims of the study/ investigation
2. **Methods** – describes the selection of study subjects/ experimental animals, observational and analytical methods
3. **Results** – provides specific data and its statistical significance, if possible
4. **Conclusion** – succinct emphasis of new and important aspects of the study or observations

Key Words

- Add, at the end of summary in alphabetical listing, **keywords** of up to 5 in number, which will be used for article indexing and retrieval under Medical Subject Headings or MeSH. MeSH is the NLM controlled vocabulary thesaurus used for indexing articles for WPRIM and PubMed. Please refer to www.nlm.nih.gov/mesh/ for details.

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The text should have the following sequence:

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- **Methods (whenever applicable, e.g., original article, review article):** Specify the study's main and secondary objectives–usually identified as primary and secondary outcomes. Identify methods, equipment (give the manufacturer's name and address in parentheses), and procedures in sufficient detail to allow others to reproduce the results. Give references to established methods, including statistical methods; provide references and brief descriptions of methods that have been published but are not well known. Describe new or substantially modified methods, giving reasons for using them and evaluate their limitations. Include numbers of observations and the statistical significance of the findings where appropriate.

- **Selection and Description of Participants (under methods)**
  Describe the selection of the subjects clearly, including eligibility and exclusion criteria and a description of the source population. If the study was done involving an exclusive population, for example in only one sex, authors should justify why, except in obvious cases, (e.g., prostate cancer). Authors should define how they determined race or ethnicity and justify their relevance.

- **Technical Information (under methods)**
  Identify precisely all drugs and chemicals used, including generic name(s), dose(s), and route(s) of administration. Identify appropriate scientific names and gene names.

  - Drugs must be referred to generically; all the usual trade names may be included in parentheses.
  - Dosages should be quoted in metric units.

- Laboratory values should be in SI units with traditional unit in parentheses.
- Do not use patients' names, initials or hospital numbers to ensure anonymity.

Statistics (if applicable): Describe statistical methods which can be easily understood and verified by the reader. Use technical terms in its proper place, and where possible quantify readings and indicate errors of uncertainty and confidence intervals.

Discuss eligibility of experimental subjects. Give details about randomisation. Describe the methods for and success by any blinding of observations. Report treatment complications. Give number of observations. Report losses to observation (such as dropouts from a clinical trial). Avoid non-technical uses of technical terms in statistics, such as "random" (which implies a randomising device), "normal", "significant", "correlations", and "sample". Define statistical terms, abbreviations, and symbols.

Results (whenever applicable, e.g., original article, review article): Present results in logical sequence in the text, table and illustrations. Do not repeat in the text all the data in the Tables or Illustrations. Emphasise or summarise only important observations.

Provide data on all primary and secondary outcomes identified in the Methods Section. Extra or supplementary materials and technical details can be placed in an appendix where they will be accessible but will not interrupt the flow of the text, or they can be published solely in the electronic version of the journal.

Give numeric results not only as derivatives (for example, percentages) but also as the absolute numbers from which the derivatives were calculated, and specify the statistical significance attached to them, if any. Restrict tables and figures to those needed to explain the argument of the paper and to assess supporting data. Use graphs as an alternative to tables with many entries; do not duplicate data in graphs and tables. Avoid nontechnical uses of technical terms in statistics, such as "random" (which implies a randomising device), "normal," "significant," "correlations," and "sample."

Separate reporting of data by demographic variables, such as age and sex, facilitate pooling of data for subgroups across studies and should be routine, unless there are compelling reasons not to stratify reporting, which should be explained.

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  The author(s) is/are responsible for the accuracy and completeness of the references, which should be identified in the text by superscript Arabic numerals in the order of first citation and noted in numerical order at the end of the text.

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  Tan and Ho. Treat-to-target approach in managing modifiable risk factors of patients with coronary heart disease in primary care in Singapore: What are the issues? Asia Pacific Family Medicine, 2011;10:12. doi:10.1186/1447-056X-10-12.

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The Case Records of Family Medicine is newly created series to encourage submissions from family medicine teaching programs, family medicine departments to submit cases of learning value to the Singapore Family Physician. Cases discussed during peer review learning, family medicine grand ward round teachings are just some examples that are suitable for this series. Authors planning to submit their case studies to the Case Records of Family Medicine section should structure their article according to these headings:

Title
- The title should define the key focus of the case study.

Case Presentation:
- The author(s) will provide a pertinent summary of the medical and/or psychosocial issue pertaining to the health or disease management of the case. It should cover the situation and relevant background of the case. Author(s) should conceal the identity of the subject and/or related or accompanying personnel: abbreviation should be used instead, if necessary.

Diagnoses/Problems identified
- The assessment of the diagnoses/problems identified will constitute a problem list and will serve as a focus for the management of the case. If the case was a diagnostic dilemma, the author(s) should showcase the diagnostic challenges and their work in narrowing to the correct diagnosis and/or differential diagnoses.

Management of the case
- This section covers the approach to the management of the case by the author(s).

Literature review on latest evidence/guidelines (related to diagnosis and/or management)
- The author(s) should provide a literature review of current evidence/guidelines, if any, of the basis of the case's diagnosis/management, or to highlight the gaps of knowledge if such evidence is lacking.
- The author(s) will provide a concise summary of the lessons learnt from this case study.

Clinical Practice pointers (up to 3)
- The author(s) will suggest ways to apply the new knowledge in clinical practice or to highlight the limitations of its applications, if any.

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Authors planning to submit their case studies to the PRISM section should structure their article according to these headings:

Title
- The title should be framed into a question to define the key focus of the case study.

Patient's revelation: What happened?
- The author(s) will provide a concise description of the setting on which the subject raised his/her medical or psychosocial issue pertaining to their health or disease management. It should cover the background, encounter and interaction of patient with the healthcare professional (doctor, nurse or allied healthcare professional).

Author(s) should conceal the identity of the subject and/or related or accompanying personnel: abbreviation should be used instead, if necessary.

Gaining insight: What are the issues?
- The issue(s) raised by the patient should be framed into question(s). The question(s) will constitute a problem list and will serve as a focus for the management of this subject.

Study the management: How do we apply in our clinical practice?
- This section covers the approach to the management of the subject by the author(s). The author(s) should provide a literature review of current evidence, if any, of the basis of the subject's management, or to highlight the gaps of knowledge if such evidence is lacking. The author(s) will suggest ways to apply the new knowledge in clinical practice or to highlight the limitations of its applications, if any.

Conclusion
- The author(s) will provide a concise summary of the lessons learnt from this case study.

The article submitted to the PRISM section should be written by not more than three authors. Each article should not exceed 2000 words. Photographs or charts may be included but should conform to the specific instructions for any other articles submitted to *The Singapore Family Physician*.

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