PROPOSED ESTABLISHMENT
OF THE
FAMILY PHYSICIAN REGISTER

PUBLIC CONSULTATION PAPER

MINISTRY OF HEALTH
SINGAPORE

OCTOBER 2005
The Ministry of Health seeks the public’s views, comments and feedback on the proposed establishment of the Family Physician Register.

All feedback and comments should be addressed to:

“Feedback on FP Register”
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EXECUTIVE SUMMARY

1. Responding to calls from the College of Family Physicians Singapore and the Transforming Primary Care Committee appointed by Ministry of Health (MOH) to establish minimum training requirements for family physicians, MOH proposes to establish a Family Physician Register. This Register will list the names of family physicians who have undergone a recognised formal training programme in family medicine.

AIM OF ESTABLISHING THE REGISTER

2. The aim of the Family Physician Register is to raise the overall standard of family medicine practice in Singapore. Formal training in family medicine will be a pre-requisite for entry into the Register.

THE DESIRED OUTCOMES

3. The desired outcomes of the Family Physician Register are:

   (a) Improved management of chronic diseases and, consequently, reduced national burden of disease.

   (b) Reduced avoidable hospitalisation of chronic diseases through emphasis on early treatment and prevention.

   (c) More appropriate siting of care at family clinics in the community instead of at specialist outpatient clinics in hospitals.

   (d) Increased public confidence in the skills and knowledge of family physicians.
An effective and sustained doctor-patient partnership, to realize the vision of “A family physician for every Singaporean”.

4. With the above outcomes, we would be able to improve patient care at primary care level, contain overall healthcare cost and enhance professional fulfilment for both family physicians and specialists.

SITUATIONS IN OTHER COUNTRIES

5. Many developed countries require family physicians to undergo a formal training programme. For example:

   (a) **Australia**: 2-year training programme followed by the Fellowship examination conducted by the Royal Australian College of General Practitioners which is the requirement since 1996 for doctors to practise as the primary physician in a family medicine clinic.

   (b) **Canada**: 2-year residency training followed by a certification examination to practise as family physicians.

   (c) **UK**: 3-year residency training programme and an assessment before they can practise independently.

   (d) **USA**: 3-year residency training followed by an examination conducted by American Board of Family physicians.

CRITERIA FOR REGISTRATION IN THE FAMILY PHYSICIAN REGISTER

6. Criteria for registration in the Family Physician Register will vary depending on the doctor’s qualifications and practice experience. Details are as shown in Table 1.
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<td></td>
<td>At least 2 years of approved medical practice experience(^1) in family medicine</td>
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<td><strong>Practice Route</strong></td>
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<td></td>
<td>At least 8 years of approved medical practice experience(^1) (of which at least 5 years should be in family medicine)</td>
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Notes:

1: This includes both private and polyclinic practice in Singapore. For part-time doctors, full-time equivalent of a polyclinic doctor (42 hours/week) will be used as basis for calculation.

2: This degree is no longer available. The last examination for this degree was in 1992.

3: MOH has appointed an Interim Joint Committee for Family Medicine Training, which will recommend the relevant qualifications.

4: Maintenance of Proficiency is a modular programme for experienced doctors. There are 8 modules conducted over a 2-year cycle and doctors can select any 4 relevant modules to attend. Each module is conducted over 4 sessions in 1 quarter. Four modules can be completed between 1 to 2 years. There will be no examination and a certificate will be awarded upon completion of the modules.
7. Currently, doctors have to accumulate 50 Continuing Medical Education points every 2 years to renew their practising certificate. The Maintenance of Proficiency programme for experienced doctors will be a structured CME programme that will allow these doctors to accumulate the necessary points and at the same time complete 4 modules on chronic care to gain entry to the Register.

**CLINIC LICENSEE AND CLINIC MANAGER**

8. To set the standard of primary care delivered, we plan to issue new licences to run family medicine clinics only to those on the Register. New family medicine clinic managers\(^1\) will also be required to be on the Register.

9. Existing clinic licensees and clinic managers will **NOT** be affected by this new requirement. However, various routes are available, depending on practice experience, to attain the necessary qualifications for entry to the Family Physician Register (see section on criteria for registration in the Register) and existing clinic licensees and clinic managers are encouraged to take up one of these training routes to enter the Register.

**CONCLUSION**

10. MOH envisages a larger role for family physicians in our healthcare system. While there are other practice-related issues that need to be addressed, setting training standards is a necessary step that has to be taken. With family physicians enabled through appropriate training, the stage will be set for many more positive changes that will allow the family physicians to play a pivotal role in our healthcare system and realise our vision of “One family physician for every Singaporean”. This will bring about a higher level of primary care for Singaporeans.

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\(^1\) This refers to clinic manager as defined in Public Hospital Medical Clinic Act (1979), rather than “manager” of a medical clinic. According to the Act, only registered medical practitioners can be clinic managers.
11. MOH would like to seek the views and feedback of the public and healthcare professionals on the proposed Family Physician Register. Specifically, we are asking for feedback on:

- The criteria for registration in the Register.
- The proposed plan to require future family medicine clinic licensee and clinic managers to be on the Register.

12. A copy of the public consultation booklet has been sent to all registered medical practitioners and made available to all medical students to seek their feedback. The public is welcomed to post their feedback on the e-consultation page at the Ministry's website. All feedback should reach the Ministry by 14 Nov 2005.
PROPOSED ESTABLISHMENT OF A
FAMILY PHYSICIAN REGISTER

I. INTRODUCTION

1. Responding to calls from the College of Family Physicians Singapore and the Transforming Primary Care Committee to establish minimum training requirements for family physicians, MOH proposes to establish a Family Physician Register.

2. In June 2004, the College of Family Physicians Singapore had put forth a proposal to MOH to implement a minimum training standard for family physicians (see Annex). This is in line with the College’s position that maintaining standards and raising the level of professionalism for family physicians are essential pre-requisites to achieve the goals of managing patients holistically.

3. In Aug 2003, a workgroup on Transforming Primary Care was appointed by MOH to make recommendations to transform primary care and manage patients more holistically. Managing patients holistically is one of MOH’s 8 priorities. The workgroup consists of a panel of healthcare professionals from both private and public sector. Amongst other recommendations, the workgroup has proposed to enable family physicians with the appropriate training as an essential step forward.

4. MOH has carefully studied the recommendation and consulted various professional bodies before proposing the establishment of a Family Physician Register. The Family Physician Register will list the names of family physicians who have undergone a recognised formal training programme in family medicine.
5. MOH would like to seek the views and feedback of the public and healthcare professionals on the proposed Family Physician Register.

II. CURRENT SITUATION

6. Chronic diseases like diabetes, high blood pressure, heart disease, stroke, chronic lung disease and cancer are now the major causes of death and disability worldwide. In Singapore, chronic diseases account for more than 60% of deaths in Singapore².

7. Patients with these chronic diseases are in many instances, managed by specialists in a hospital setting. However, with increasing number of patients with chronic disease, it is not desirable, or indeed possible in the long term, for this situation to continue. Current data suggests that attendance at specialist outpatient clinics in public hospitals is steadily increasing³. With a high patient load, specialist outpatient clinics are often not a conducive environment for specialists to explore issues beyond the patient’s presenting symptoms. If this trend continues, the quality of care delivered may be compromised and healthcare costs will escalate.

8. As most chronic diseases affect many body systems, many specialists are usually involved in the care of these patients. It is common for a patient with diabetes or stroke to be followed up concurrently by the various specialists in their respective fields. Often, situations arise where no one doctor understands patients’ problem in a holistic manner.

9. Patients with general or vague presenting symptoms like giddiness may sometimes be referred from one specialist to another as such symptoms may be due to disorder of one of a few possible body systems. Occasionally, the patient's symptoms may not even improve after seeing various specialists as the symptoms could be related to psychosocial issues like work stress or

² MOH, Singapore
³ MOH, Singapore
family problems. Many of these problems can be minimised if a well-trained family physician who knows the patient and family well could work through the patient’s problems.

10. The strategy to contain increasing prevalence of chronic disease is in prevention, early detection and early treatment as well as sustained lifestyle changes. There is a need for continuity in management (e.g. sustaining changes in lifestyle habits) and treatment needs to be individualised (e.g. identify patients with increased risk for screening tests). However, specialist outpatient visits are often too short or focused on the presenting symptoms to address continuing care issues or issues related to prevention. In addition, resources are not used efficiently if specialists are asked to treat simple cases, especially those that are outside their respective specialties.

11. Many patients and medical professionals are not fully satisfied with this current arrangement of care delivery. Currently, patients often have to make frequent trips to hospitals due to multiple specialists’ appointments and have to pay higher fees at these tertiary institutions.

III. FAMILY PHYSICIANS TO PLAY A BIGGER ROLE

12. A significant proportion of patients with these chronic diseases can ideally be managed holistically in the community. The family physician can take on the role of the new generalist and help coordinate care for the patient and his family in a competent and cost-effective manner.

13. Management of chronic diseases and their risk factors requires medical knowledge that crosses specialties and good counselling skills. A well-trained family physician is equipped to take on this responsibility, with a much larger scope compared to what he is currently doing.

14. The availability of timely, appropriate and effective primary care has generally been recognised as an important factor in avoiding hospitalizations
for undesirable outcomes of chronic diseases. A local study\textsuperscript{4} had shown that 41% of admissions due to asthma were potentially avoidable if proper care was administered in the primary care setting. Whilst multiple factors contribute to hospitalisation rates, emphasis on prevention and treatment can help reduce avoidable hospitalizations of chronic diseases.

15. The preliminary results in one of the pilot polyclinics of the recently launched Singapore National Asthma Programme have been promising. There was a 30% decline in the number of patients with acute asthma attacks. The number of asthma referrals to the hospitals also decreased from 3 cases a month to none.

16. Prevention of chronic diseases should ideally begin even before the patient has the disease. Patients who are, for example obese or have strong family history of certain cancers, can be proactively screened or encouraged to modify their lifestyle before the disease sets in. The best place for such preventive effort is at the family medicine clinics. Screening and health education can take place even when the patient presents with other acute illnesses.

17. However, the skills required to manage these chronic conditions and to retain care in the community is currently not widely available in the community. Medical school training equips the graduates with general basic skills. Doctors who choose not to specialise, practise as general practitioners. There is a gap between this and the additional skills that family physicians require to better manage these chronic conditions. These skills are more effectively acquired through additional, structured and directed training programmes at the post-graduate level. Steps must be taken to ensure that more family physicians are appropriately trained to take on this bigger role.

18. In Singapore, voluntary postgraduate training in family medicine has been available since 1972. However, the take-up rates of these programmes have been low. Currently, only an estimated 15% of the doctors in family medicine clinics have formal training in family medicine.

19. While many doctors have acquired various skills through years of practice and are delivering good quality primary care to the people of Singapore, a system needs to be in place to ensure that newer generations of family physicians will acquire the necessary skills much earlier in their professional career.

20. Family physicians will be able to manage a wider spectrum of patients at greater depth and enjoy long-term doctor-patient relationships with them. Specialists’ skills will also be more appropriately utilised through discharging patients to family physicians or co-managing patients with family physicians. In this way, specialists can concentrate on managing more complicated medical problems.

21. It is probable that better trained doctors who spend more time with the patient and provide better service may charge a higher fee. Currently, trained family physicians are not charging higher fees. However, it is more important to look at overall healthcare cost to the patient, which is not expected to increase as more care is retained in the community rather than at hospitals, instead of fees per visit to the doctor.

22. MOH is aware that setting training standards alone without addressing other practice related issue may prevent us from achieving the desired outcomes. However, setting training standards is the first and necessary step. MOH is committed to work continuously to address other related issues in order to arrive at the desired outcomes.
IV. AIM AND DESIRED OUTCOMES OF ESTABLISHING THE REGISTER

23. The aim of the Family Physician Register is to raise the overall standard of family medicine practice in Singapore. Formal training in family medicine will be a pre-requisite for entry into the Register.

24. The desired outcomes of the Family Physician Register are:

   (a) Improved management of chronic diseases and, consequently, reduced national burden of disease.

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   (c) More appropriate siting of care at family clinics in the community instead of specialist outpatient clinics in hospitals.

   (d) Increased public confidence in the skills and knowledge of the family physicians.

   (e) An effective and sustained doctor-patient partnership, to realise the vision of “A family physician for every Singaporean”.

25. With the above outcomes, we would be able to improve patient care at primary care level, contain overall healthcare cost and enhance professional fulfilment for both family physicians and specialists.

V. SITUATIONS IN OTHER COUNTRIES

26. In recent years, there has been a growing focus globally on family medicine as studies have shown that family physicians can improve health
outcomes. In the USA, a study\(^5\) has shown that one more family physician per 10 000 people is associated with 70 fewer deaths per 100 000. Other studies\(^6,7\) have demonstrated that each additional family physician per 10 000 populations increased the odds of early diagnosis and survival of some cancers like cervical and skin cancer.

27 Many developed countries require family physicians to undergo a formal training programme. For example:

- **Australia**: 2-year training programme followed by the Fellowship examination conducted by the Royal Australian College of General Practitioners, which is the requirement since 1996 for doctors to practise as the primary physician in a family medicine clinic.

- **Canada**: 2-year residency training followed by a certification examination to practise as family physicians.

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<td></td>
<td>□ Graduate Diploma in Family Medicine (GDFM), Singapore</td>
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<td></td>
<td>□ Member of College of General Practitioner, Singapore² (MCGPS)</td>
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<td>□ Overseas equivalent qualifications (to be finalised):</td>
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<td></td>
<td>– Member of Royal College of General Practitioners, MRCGP(UK)</td>
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<tr>
<td></td>
<td>– Fellow of the Royal Australian College of General Practitioners, FRACGP</td>
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<td>– American Board Certification in Family Medicine, USA</td>
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<td>– Certificant of College of Family Physicians (CCFP), Canada</td>
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<td></td>
<td>– Other qualifications to be determined on a case-by-case basis</td>
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<tr>
<td><strong>Practice Route</strong></td>
<td>□ A relevant postgraduate qualification / diploma relevant to family medicine³ that can be registered with the Singapore Medical Council</td>
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<tr>
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<td>□ Maintenance of Proficiency⁴ Certificate</td>
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Currently, doctors have to accumulate 50 Continuing Medical Education points every 2 years to renew their practising certificate. The Maintenance of Proficiency programme for experienced doctors will be a structured CME programme that will allow these doctors to accumulate the necessary points and at the same time complete 4 modules on chronic care to gain entry to the Register.

If the Family Physician Register were established today, some 15-20% of current primary care doctors would be able to gain entry to the Register. By 2007, this figure would rise to about 25%. The target is to reach 75% by 2010.

VII. IMPLEMENTATION PLANS

To support the Family Physician Register, a Family Physician Accreditation Board will be set up together with a Joint Committee for Family Medicine Training. This structure will oversee the Family Physician Register as well as training issues related to family medicine.

The Family Physician Accreditation Board will be responsible for setting the standards for family medicine training while the Joint Committee for Family Medicine Training will ensure proper implementation of the training programmes. Representatives from National University of Singapore (Division of Graduate Medical Studies), College of Family Physicians Singapore, healthcare clusters, private family physicians as well as MOH will be represented in the Family Physician Accreditation Board and Joint Committee for Family Medicine Training.

While awaiting the amendment to MRA to include the Family Physician Register, an interim Joint Committee for Family Medicine Training has been set up to recommend the necessary changes to the family medicine training programme to meet the future challenges. This includes reviewing the current training programme and examination structure leading to the Master of Medicine (Family Medicine) degree.
34 All doctors, regardless of their year of registration, will have opportunities to further train themselves. The programmes will be tailored according to their needs. For example, the programmes, which incorporate online modules, will be flexible so as to accommodate the doctors’ busy schedules.

VIII. LICENSEC AND CLINIC MANAGER OF FAMILY MEDICINE CLINICS

35 Under the current system, licences to run clinics can be issued to medical or non-medical persons or enterprises. In turn, the clinic licensee can appoint any doctor to be the clinic manager\(^8\) to look after the daily management of the clinic. The clinic manager may or may not be the clinic’s licensee. Whilst the clinic licensee has to account for all the clinic’s affairs, the clinic manager is responsible for the day to day running of the clinic and is involved in the direct delivery of care to the patients.

36 This system can be further strengthened to protect the public’s interests. To ensure greater professional accountability to the public, we plan to issue new licence to run a Family Medicine clinic only to those on the Family Physician Register. Other doctors who are not on the Family Physician Register, as well as non-medical persons or enterprises who intend to run family medicine clinics can be co-licensee of clinics. If the licensee is not the owner of the family medicine clinic, the owner will be the co-licensee.

37 In practice, as a doctor can be licensees of more than one clinic, requiring the licensee to be from Family Physician Register may not necessarily translate to better care to the patients. Thus, MOH plans to also require future family medicine clinic manager to be on the Register. Doctors

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\(^8\) This refers to clinic manager as defined in Public Hospital Medical Clinic Act (1979), rather than “manager” of a medical clinic. According to the Act, only registered medical practitioners can be clinic managers.
who are not on the Family Physician Register can work under the supervision of the clinic manager.

38 Amendments to the Private Hospital and Medical Clinic (PHMC) Act regulations will be made to reflect these proposed changes to the requirement for clinic licensee and clinic manager.

39 Existing clinic licensees and clinic managers who are not family physicians will NOT be affected by this new requirement. Existing clinic licensees can continue to hold clinic licences even if they have to relocate or rename their clinics. However, they will not be granted licences for additional new clinics. They also cannot add new co-licensees who are not family physicians.

40 There are many routes available to attain the necessary qualifications for entry to the Family Physician Register (see section on criteria for registration in the Register) and existing clinic licensees and clinic managers are encouraged to take up one of these training routes to enter the Register.

IX. CONCLUSION

41 With the various routes available to attain the necessary qualifications for entry to the Family Physician Register, MOH encourages all doctors to do so in order to play the larger role envisaged for family physicians. While there are other practice-related issues that need to be addressed, setting training standards is a necessary step that has to be taken. With family physicians enabled through appropriate training, the stage will be set for many more positive changes that allow the family physicians to play a pivotal role in our healthcare system and realise our vision of “One family physician for every Singaporean”. This will bring about a higher level of primary care for Singaporeans.
MOH would like to seek the views and feedback of the public and healthcare professionals on the proposed Family Physician Register. Specifically, we are asking for feedback on:

- The criteria for registration in the Register.
- The proposed plan to require future family medicine clinic licensee and clinic managers to be on the Register.

A copy of the public consultation booklet has been sent to all registered medical practitioners and made available to all medical students to seek their feedback. The public is welcomed to post their feedback on the e-consultation page at the Ministry's website. All feedback should reach the Ministry by 14 Nov 2005.
ANNEX

PROPOSAL FOR THE GRADUATE DIPLOMA IN FAMILY MEDICINE (GDFM) AS THE NATIONAL STANDARD FOR FAMILY DOCTORS IN SINGAPORE

Presented to the Ministry of Health from the College of Family Physicians Singapore on 3rd June 2004

1 INTRODUCTION

1.1 The Ministry of Health has set several objectives for primary care in Singapore. The role of the family doctor should be to promote healthy living focused on health promotion and disease prevention and to provide more than just episodic outpatient care. It is a national goal that every Singaporean should have a good family doctor.

1.2 The College proposes that a minimum vocational standard for family doctors to be the Graduate Diploma in Family Medicine (GDFM). The College perceives that maintaining vocational standards and raising the level of professionalism in family doctors are essential pre-requisites to the achievement of the stated goals. The GDFM is developed and conducted by the College with examinations by the National University of Singapore. This programme has been benchmarked against the Australian and United Kingdom national standards of primary care. Since its launch in 2000, it has proven to be relevant and of a standard achievable by practicing doctors.

1.3 The vision is to train at least 90% of family doctors to reach the level of the GDFM in 8 to 10 years. Presently only 20% of doctors in Singapore have received some form of vocational training in primary care (See Annex A).

2 WHY IS TRAINING IN FAMILY MEDICINE NECESSARY?

2.1 Undergraduate education is not enough. In the United Kingdom, a vocational certificate of training is required to be a principal in general practice. In the US, primary care doctors are board certified in family medicine or general internal medicine. In Australia, they must hold the FRACGP to be principals (See Annex B). In Singapore, a registered medical practitioner presently does not need any vocational training in family medicine/general practice to practice as a GP. This is an anomaly that must be urgently addressed.

2.2 The increasing numbers of chronic medical problems and geriatric patients in developed countries require a model for patient-centred and community based continuing care. The present community based care in Singapore is more episodic and acute in nature. Vocational training is needed to empower family doctors to focus on continuing and elderly care.

2.3 Medical specialisation and sub-specialisation have created the need for community based, generalist doctors who are able to fill in the gaps of care and to integrate the management of the patient. Vocationally trained family doctors are the community based, generalist doctors needed in Singapore.

3 WHAT ARE THE BENEFITS OF BETTER TRAINING OF FAMILY DOCTORS?

3.1 Freeing up costly resources. Well-trained primary care doctors will be able to manage conditions without wasteful and unnecessary referrals to hospitals thereby freeing up the costly resources to provide better care to patients managed in the wards and in the specialist outpatient clinics (SOC). The national emphasis on prevention and management of risk factors will also help to keep people healthy and minimize the use of expensive interventional care.

3.2 Implementing national health care policies and quality assurance initiatives. A primary care that is staffed by well-trained doctors who are committed to the values of family medicine will be more effective in carrying out national health policies and quality assurance initiatives.
3.3 Imparting principles and values of family medicine. Besides skills and knowledge, vocational training imparts the principles and values of family medicine. The emphasis on communication, preventive care, continuing care and patient centeredness will promote personalized primary care.

3.4 Nurturing functional groups and teamwork. A national training structure will provide opportunities to form functional groups and encourage co-operation and peer interaction. This builds social capital and enables quality improvement activities that require peer review and peer support. It will also promote co-operation between clusters and between sectors.

4. ARE THERE POSSIBLE NEGATIVE EFFECTS?

4.1 Would cost of primary care go up? Fees are unlikely to go up as these are determined primarily by market forces and not FM degrees or training. Family physicians with MMed. or GDMF now in practice are not charging higher or significantly higher in giving better service. In fact having more vocationally trained family doctors will bring down the overall cost of healthcare with better and more expert care.

4.2 Would better training necessarily translate to better care? The strategy is to have training that emphasizes practical application of skills, knowledge and promote evidence based, cost-effective interventions for better care. This strategy is found in the Graduate Diploma in Family Medicine as it emphasizes practical skills and knowledge.

4.3 Would the training disrupt service delivery? The GDFM program allows practicing doctors to work and study at the same time. Training is held outside normal office hours. It is IT-enabled distance learning, augmented by face-to-face workshops, skills courses and small group tutorials. The present cohorts working in hospitals, polyclinics and GP clinics have been able to complete training without any disruption in service delivery.

5 WHAT RESOURCES WILL BE REQUIRED FOR TRAINING 150 TO 200 DOCTORS PER YEAR TO GDFM LEVEL?

5.1 We will need greater and more sustainable training resources to meet the training of 150 to 200 doctors per year. To meet this challenge we must pool together all available primary care training resources and co-ordinate all the training activities in family medicine. So far, the College managed to put together the resources needed to train up to 50 to 80 doctors a year. The College will have to work with the clusters for effective implementation as most non-trainee doctors who end up as GPs will serve their 5-year bond in the clusters. Hence, the clusters will need to be mandated to channel the training of such doctors into the approved Family Medicine training programme, which is the proposed GDFM programme. The programme is not onerous and is benchmarked to the Australian and UK Family Medicine training.

5.2 Some indication of the resources needed are listed below:

- Small group teaching. Five trainees to each trainer, for 200-300 trainees for two years' cohort (100 x 2), we would require 80 trainers.
- Big group teaching. These workshops are held quarterly. We need 4-8 venues with class size of 50 each class for the two cohorts at any one time.
- OSCE Examination held once a year. We need 40 examiners for every 50 candidates for each cohort.

6 ACTIONS REQUIRED

6.1 We propose that the Ministry of Health adopt the GDFM as the minimum required vocational standard for independent primary care practice. The Ministry of Health can specify an achievable time frame and to exempt some groups of doctor who are already in practice.

6.2 We propose that a Joint Committee of Family Medicine Training be set up to mobilise all the available training resources. This will have representation from MCH, NUS and CFPS. The Committee will be given the clout to ensure that the objectives are met.
6.2 We propose that MOH mandate non-specialist trainee doctors be trained in Family Medicine so that in effect a young doctor chooses either to be a specialist trainee or a Family Medicine trainee. Family Medicine traineeship will not be onerous as the aim is to equip the doctor to practise good Family Medicine. Hence, they will be trainees at the ODFM level. The few who wish to do the MMed (FM) can do so after ODFM as the ODFM is an entry criterion.

Submitted on behalf of Council, College of Family Physicians, Singapore

Dr Lee Kheng Hook  A/Prof Goh Lee Gan  A/Prof Cheong Pak Yean
Hon Gen Sec CFPs  Censor-in-Chief CFPs  President, CFPs