



Part 4

Reflections and Stories



Life is short, Art is long

(Quoted from *The Hong Kong Practitioner* 2006; 28:266-271)



Family medicine is different from the other medical disciplines in how it expresses the science of medicine in the care of a person who is ill and not just to treat a disease. Different people need to be treated differently even if they have the same disease, the same person with the same disease may need different care at different stages of the illness or in a different context. In order to make a lasting difference with the art of family medicine, we need to be passionate for our work, keep practicing, use our imagination and preserve our uniqueness.

Cindy L K Lam



The Hong Kong College and I



Dr David A Game

Hon Secretary-Treasurer,
WONCA, 1972-80

President, RACGP, 1974-76

President, WONCA, 1983-86

Honorary Life Direct Fellow,
WONCA, 1989

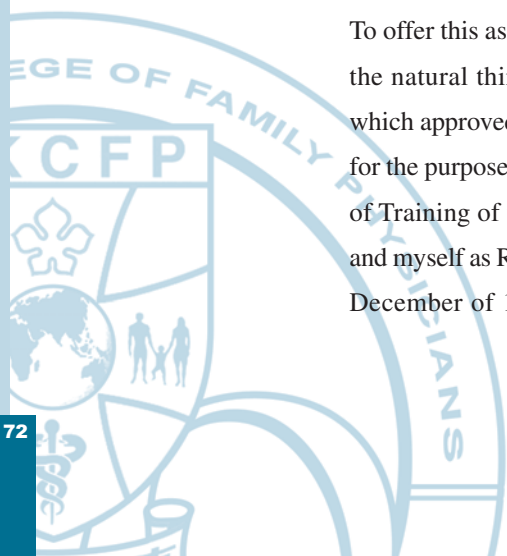
Patron, the Australian
Postgraduate Federation in
Medicine, 2003

*I*n 1975, on my return from China where I had been visiting as a member of the first official Australian medical delegation to the Peoples' Republic of China, I stopped over in Hong Kong and met up again with my old friend, Peter Lee. We had met previously in Switzerland, England, etc., through our mutual involvement with WONCA, the World Organization of Family Physicians. At this time, I was Hon Secretary/ Treasurer of WONCA in addition to being the President of the Royal Australian College of General Practitioners (RACGP).

During my visit to Hong Kong in 1975, Peter introduced me to those dedicated medical practitioners who were keen to develop a college in Hong Kong in line with international trends of the establishment of academic organizations with the aim of improving the education and status of general practitioners in their own countries. I also met other influential people, most of whom were not yet at that time fully convinced of the significance of general practice in the provision of first-class medical care.

On my return to Australia, wearing both my RACGP 'hat' and WONCA 'hat', I encouraged my own College to offer to assist Hong Kong in these endeavours. The RACGP at this time was in an advanced stage of development, particularly in the aspects of education, assessment, and examination. It was also playing a very significant role in the early development of WONCA. Amongst the stated objectives of WONCA is the proviso to assist in the promotion and development of general practice as the preferred method of providing health care to the community, particularly where this was not recognized; and, subsequent to this, stimulating the development of academic organizations to support the educational, assessment, and examination processes to legitimize, bolster, and enhance the evolving discipline of general practice.

To offer this assistance to our friends in South-east Asia, including Hong Kong, seemed to be the natural thing to do. Fortunately, this challenge was taken up by the RACGP Council which approved the dispatch to Hong Kong of three senior members of the Australian College for the purpose. Dr Frank Farrar, Secretary-General of RACGP, Dr Robert Harbison, Director of Training of the Family Medicine Programme (the Vocational Training Wing of RACGP) and myself as RACGP President, made a special trip to Hong Kong for one week in November-December of 1975 to advise the HKMA Council on the process of establishing a 'Hong



Kong College of General Practitioners'. I am particularly happy and pleased to place on record that this visit was funded and financed in its entirety by the RACGP as a gesture of goodwill in offering encouragement and practical assistance to our Hong Kong colleagues.

For this reason we, in the Royal Australian College of General Practitioners, were most gratified that our Hong Kong colleagues in the Hong Kong Medical Association made good use of our initiative and active support by appointing a few of their Council members to found an 'Interim Council of the Hong Kong College of General Practitioners' in December 1975. This led to the establishment of the 'Hong Kong College of General Practitioners', which held its first annual general meeting in 1977, and subsequently its most impressive formal Inauguration Ceremony at the Hong Kong City Hall in 1979. It was befitting that representatives of the RACGP should be prominently featured amongst the galaxy of local luminaries and foreign dignitaries in the 1979 Inaugural Ceremony. The Ceremony was highlighted by the presentation by RACGP President, Dr W D Jackson, to the newly installed President of HKCGP, Dr Peter C Y Lee, a symbolic insignia of office – a gavel.

These happenings gave rise to a close working relationship between the two colleges, which culminated in the inauguration of the Conjoint HKCFP/ RACGP Fellowship Examination in 1987. The Conjoint Fellowship Examinations are held annually and successful candidates are conferred the double Fellowship Degrees of FHKCFP/ FRACGP. The 2007 Conjoint Fellowship Examination will be held in November 2007 and is the 21st in the Series. The RACGP is proud to be so intimately associated with the HKCFP and is delighted that this close liaison proved to be mutually beneficial, particularly in the fields of education and assessment of competence for the enhancement of the concept of general practice/ family medicine as the preferred method of providing health care to the community.

How The Hong Kong College of General Practitioners (now HKCFP) became one of the Owners of

The Duke of Windsor Social Service Building



Dr Peter C Y Lee

Founding President, the Hong Kong College of Family Physicians, 1976-1988

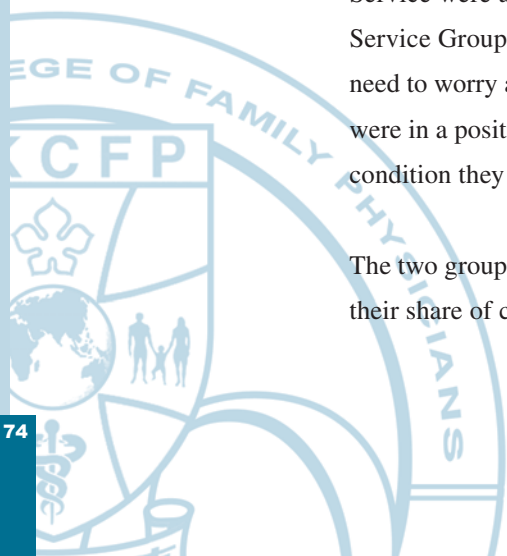
President, World Organization of Family Doctors (WONCA), 1992-1995

In telling the story of how the Hong Kong College of General Practitioners (HKCGP) became one of the owners of the Duke of Windsor Social Service Building, I must remind readers that the HKCGP was born out of the Hong Kong Medical Association (HKMA); and that, in its infant years, the affairs of the College were closely intertwined with those of the Association. For this reason, it is imperative that I also give you a case history of how the HKMA acquired its own premises.

In 1955, when I was first elected a member of the Council of the then Hong Kong Chinese Medical Association (HKCMA), all HKCMA meetings and social functions were held in the premises of the Hong Kong University Alumni Association (HKUAA). It was only around 1960 that a 'Permanent Premises Committee', headed by Dr Philip Mao and Dr Raymond Yang, was formed to raise funds to acquire premises for the medical association. The response was enthusiastic, and by 1962, over \$100,000 was raised. The Association utilized \$80,000 to purchase a 980-sq.ft. office at 33 Wyndham Street. This became the official address and premises of HKCMA (name changed to HKMA after 1970) until October 1975, when it moved to the Duke of Windsor Social Service Building.

When the Federation of Medical Societies was incorporated in 1965, Dr the Hon Sir Albert Rodrigues, President of the Federation, Dr Harry Fang, President of the Hong Kong Chinese Medical Association, and Professor Elaine Fields, President of the British Medical Association (Hong Kong Branch), joined forces to make strong representations to Government for a land grant for a custom-built headquarters for the medical profession. However, it soon became apparent that even if the grant of land was free, the government would never pay for the construction costs. This placed the Medical Group in a quandary because it could never finance the project if operating on its own. Coincidentally, members of the Council of Social Service were also looking for permanent premises. Since voluntary societies in the Social Service Group enjoyed full government subvention (including capital outlay), they did not need to worry about finances. By pooling resources, the Medical and Social Service Groups were in a position in 1975 to accept the government's offer of a piece of land in Wanchai on condition they built a 12-storey building on it.

The two groups agreed that each would have six storeys apiece, and each be responsible for their share of construction costs; and, at their own request, the Social Service Group would



pay for an extra floor to provide housing for its Executive Director. On a pro-rata basis, the construction cost of a floor-unit of 4,000 sq. ft. came to about \$800,000. As far as the Medical Group was concerned, the six 'medical' floor-units in the proposed building were provisionally allotted to the original parties which took part in the initial negotiations, in the following manner:-

The Federation of Medical Societies	2 floors
The Hong Kong Medical Association	1 floor
The British Medical Association (Hong Kong Branch)	1 floor
The Hong Kong United Nations Organization (chaired by Dr P H Teng, the D.M.H.S.)	1 floor
The Hong Kong Nurses Association	1 floor

Regrettably, by the time occupation permit of the new building was granted in 1975, only the Federation and the Medical Association of the Medical Group had enough financial resources to pay for construction costs of their respective floors; but even then, the Federation could afford only one of the two floors assigned. With the tacit agreement of the Social Service Group, the Federation's unpaid floor was left vacant and unoccupied and 'held in abeyance' to await the outcome of its on-going fund-raising campaigns. *Believe it or not, the Federation's unpaid floor was left vacant and unoccupied for a period of ten years.*

It was around 1984-85 that Sir Harry Fang, President of the Federation of Medical Societies, approached me in my capacity as President of the Hong Kong College of General Practitioners as well as a personal friend. He divulged to me in confidence that the Federation could not

raise the necessary money to meet its commitment, despite all his efforts over the past ten years. Sir Harry was in an awkward position. Having stalled the Social Service Group for ten years, he ran out of pretexts for further delays, but could not countenance handing over yet another floor of the building to the Council of Social Service. He emphasized that the dilemma was much more than the mere loss of one floor, but that the 'breach of commitment' by the Federation



Dr M K Rajakumar, Dr the Hon K L Thong and Dr Peter C Y Lee unveil the plaque on the 8/F Duke of Windsor Social Service Building in Hong Kong on 18 May 1985

would mean a tremendous 'loss of face' to the whole medical profession. His last hope rested with the Hong Kong College of General Practitioners because, even though rigid land-grant conditions prohibited 'sub-lease' of the unpaid floor to any third party other than members of the Federation, he was confident that no one would object to the College acquiring a floor by virtue of it being a non-profit academic medical college. He therefore appealed to the College officially and to me personally for help.

Lamentably, I had to tell Sir Harry that not only had the College no money at all, but also the College had no immediate need for permanent premises of its own. Nevertheless, in order to help him out and to ease a critical situation, I volunteered to use my own money to pay for half a floor and to offer it as a gift to the College, provided that he could persuade the Hong Kong Dental Association to pay for the other half. Since the Dental Association was already a member of the Federation, Sir Harry was delighted, and a deal was struck. And so it came to pass that I donated \$500,000 to the College – \$400,000 to pay for half a floor and \$100,000 for renovation and equipment. The College thus became owner of half a floor on the 8th floor of the Duke of Windsor Social Service Building – *a full ten years* after I, as HKMA President, declared open the premises of the Hong Kong Medical Association in 1975 on the 5th floor of the same building.



Left to right: Professor John Leong, Dr M K Rajakumar, Dr the Hon K L Thong, Dr Peter Lee, Dr Henry Lee and Dr Peter Wu at the unveiling of HKCGP premises in the 8/F Duke of Windsor Social Service Building in Hong Kong on 18 May 1985

The Practice of Family Medicine

*B*efore studying at medical school, I had the idea that a doctor was a problem fixer. Our job is to locate the part with problems, then fix the part accordingly. However, experience with patients told me that human beings are not that simple. We sometimes cannot even define 'normality' from 'abnormality'. A human is not just a body, but a being with complex structure, mind, psyche, and spirit. The practice of family medicine has given me further insights into that.

Although in school we learned the concept of 'one patient, one disease', and 'common things occur commonly', it is interesting to see that some patients do have several different problems at the same time, with types of presentation not mentioned in textbooks nor encountered in hospitals. This is particularly true in family medicine. During my early time in community-based training, failure to make a definitive 'diagnosis' often caused much frustration and anxiety. With guidance from trainers and exposure to different patient groups, I learned the principle of the bio-psycho-social model of problem formulation and management. Another quality to develop is tolerance of uncertainty, with the ability to use time as a diagnostic tool. To communicate our uncertainty to our patients with confidence is an active process, in which we are expected to put down our pride, learn to be humble, and admit that we don't know, yet adopt a positive attitude of watchful waiting, consulting others, searching for literature, and even generating questions for future research.

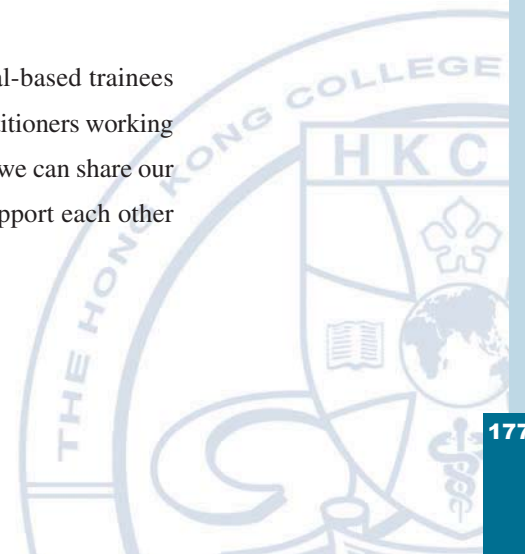
A doctor is often thought to be knowledgeable and skilful, and consciously and subconsciously we expect ourselves to be the boss. Therefore we are quite intolerant of patients who are 'non-compliant', feeling loss of control if patients do not accept our advice. Family medicine tells me that doctors and patients are not opponents in a game, but are partners in a project. We know each other more when we work together. That's why learning about patients' ideas, concerns and expectations are so important in our daily practice.

The Hong Kong College of Family Physicians is like a big family. Hospital-based trainees may feel lonely with their short rotation to different specialties. General practitioners working in solo practice may lack support. Our College provides a good place where we can share our problems, challenges and visions, so that we can learn from each other, support each other and grow as better doctors and even better people.



Dr Catherine S W Ng

Higher Trainee



Our College plays an important role in the vocational training of family physicians. A great step forward was the beginning of hospital-based training in 1996, with FM trainees being given the opportunity to acquire hands-on experience of working in different specialties, so that specific knowledge and skills could be learned directly and effectively. It is never easy to collaborate with so many specialties to ensure that our training needs are met. The College is putting great effort, through the hard work of cluster coordinators, into improving the standard of hospital-based training. Thanks to continued discussions and negotiations, progress has been positive. Community-based training is a process of assimilation, integration, and application. Government Outpatient Clinics, Staff Clinics, and Family Medicine Specialty Clinics provide adequate patient flow for that purpose. The tremendous patient-load has posed a great challenge to trainees in applying family medicine principles to daily practice. However, our College is working hard on that. It receives feedback from trainees on trainers and the training centres, so as to attain a better balance of training with service delivery.

We are never short of opportunities to update our knowledge and widen our scope. Our College has organized a wide variety of courses, lectures, seminars, and workshops conducted on weekdays, weekends and Sundays, so as to accommodate the needs of members working in different sectors. I especially appreciate the efforts made by the College to invite colleagues from different specialties as speakers. This is not only educational, but also forms a basis for communication and collaboration with other specialties.

It is encouraging to see that health-care professionals and the public are increasingly aware of the role of family physicians in the health-care system. As primary-care providers, we are not limited to serving our patients at the first encounter, but can and do offer comprehensive and continuous care. As gate-keepers, we ensure that patients can get early access to secondary and tertiary care if necessary. Apart from improving our publicity through clinical consultation, health talks, public programmes and mass media, it is also important for us to differentiate ourselves. As my trainer, Dr Daniel W S Chu, said, family medicine is not just about being 'kind' to our patients. We should develop our uniqueness, and an important aspect to work on is family issues.

Time flies. Our college will celebrate its 30th birthday soon. The age of 30 is a golden age, not fresh like greenies, but with great potential of further advancement. Now with more trainers and trainees, our College is rapidly expanding. I am looking forward to witnessing our 40th, 50th, 60th anniversaries..., even the 100th anniversary, as everything will be far beyond my imagination by that time.

Family Medicine

*F*amily medicine. There is a standard definition of family medicine in the examination which we are all very familiar with. But for some of us, there might be different answers in mind.

For me, 'family medicine' can be further broken down into 'family' and 'medicine', which are my life and career respectively.

People may have different missions at different stages of life. The feeling and the understanding of family medicine may also change with experience, both good and bad. As for many other trainees, after my internship I started my hospital-based training in the Hospital Authority (HA) setting (at Tseung Kwan O Hospital). Being different from most other trainees, I continued my community-based training in a non-governmental organization, the United Christian Nethersole Community Health Service. I worked in this organization for about three-and-a-half years. Since then I have been employed again by the Hospital Authority. I have chosen this career path mainly because different opportunities arose and because of different personal missions which developed during my vocational training period. Changing one's mission over time according to one's experience and situation is a norm, but one must also know one's mission at a particular stage of life.

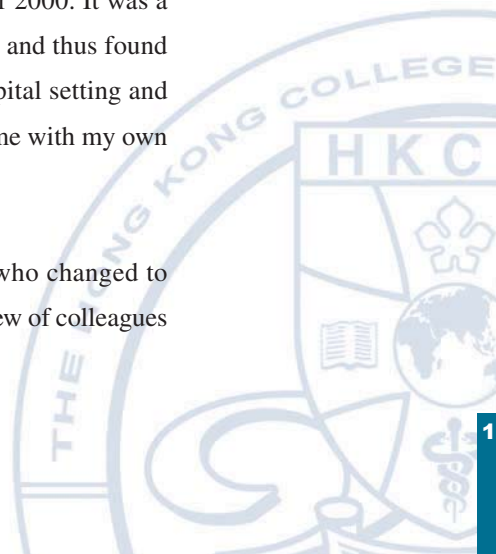
Towards the end of my internship, I again needed to decide on my career path. There are many different specialties in the medical field. As an intern, I could only rotate through four specialties. I did not really know which ones were suitable for me. Even if you think you have experienced the working style of the specialty during your internship, it may be very different when you actually become a resident in that specialty.

I started my hospital-based training at Tseung Kwan O Hospital in the year 2000. It was a new start in my career. I rotated different specialties during those two years and thus found out my real career interest. The final answer was that I did not like the hospital setting and the very frequent night duty. I enjoyed family medicine, and also enjoyed time with my own family.

Different people have different interests. Indeed there were FM trainees who changed to other specialties in the first two years of rotation. On the other hand, I also knew of colleagues



Dr Lawrence C L Wong
Higher Trainee



who changed their careers in medicine, surgery or paediatrics to family medicine. Choosing a suitable specialty according to individual mission, personality and interest in the first few years is very important because we usually stay in that particular specialty for the rest of our careers after that early period.

During my two years of hospital-based training, I learnt a lot from different specialists. But the most important thing, as an adult learner, is that we should know what and how deep we need to learn. There are many subjects in different specialties. We need to learn what is useful for our future general practice. This is the learning objective of rotating in different specialties. Otherwise we waste a good opportunity for learning. Three to six months' rotation in each specialty is actually very short. How can we prepare for it? I suggest one draft out one's own learning plan and topics in each specialty before the rotation starts. We can do this by asking the opinions of senior colleagues, by researching common diseases in different specialties in the general-practice textbooks, and, last but not least, by attending the weekly structural seminar in family medicine. This may also differ according to different personal interests but should be related to future general practice. For me, the two missions of hospital-based training helped confirm my career plan, interests and study and were really useful to me in my future general practice.

I left the Hospital Authority and joined a non-government organization (NGO) with a lower salary for the two-year community-based training. The trainer at the NGO, Dr Joyce Tang, promised I could continue my two-year training without interruption. And the practice environment was more similar to the private setting, which was also different from the GOPC. The working hours were also very good, so that I had time with my family and the energy to study for the conjoint examination. Once again I would like to express my appreciation here to my trainer, Dr Joyce Tang. She taught me a lot and, even now, she is still my trainer for higher training. Over the last three-and-a-half years, I have passed the Conjoint Fellowship Examination and obtained three different diplomas, in child health, geriatrics, and family medicine respectively.

There is currently a trend towards studying for various postgraduate diplomas or master's degrees in different specialties, not limited to family medicine. I have some friends in anaesthesia, psychiatry and O&G who have studied for various quotable qualifications, including the Diploma in Family Medicine, Advances in Medicine (CUHK), and the Diploma in Practical Dermatology. There is a real need for continuous professional development and higher postgraduate qualifications, and to meet this need many different new courses have been introduced over the past few years. But I think the single most important mission in community-based training is to become a Fellow of the Hong Kong College of Family

Physicians. The other diploma is just a bonus. Don't waste all the effort of training without getting a fellowship!

There are different needs at different stages of life and career. For financial reasons, I came back to the Hospital Authority again as it offers higher pay. However, I do not go into the 'real' private sector because I prefer to have a better quality of life, namely better working hours so that I can spend more time with my family members. Now, my mission is the exit examination.

I now need to attend the structural seminar once again. The topics in different clusters are similar and also repeated every two years. But the feeling, understanding and even the role are quite different at different stages of training. During hospital-based training, the topics were novel and some concepts were difficult to understand without some real general-practice experience. During the community-based training, although the topics were repeated, there was a deeper understanding. Now, I need to give comments and opinions on the topics. And I find it is also a time for me to update my medical knowledge and learn from other colleagues. Medicine is developing very quickly. No one can know everything. But, most importantly, one has to know one's own limitations and continue to learn and upgrade oneself.

Medicine is the combination of science and art. With ongoing training, I feel the focus of my learning has shifted from science to art. During my hospital-based training, I focused on acquiring basic knowledge of different diseases. Now I am focusing more on the consultation process, communication skills and doctor-patient relationships. I feel this is very common among family-medicine trainees. I am not saying the 'art of medicine' is not important in hospital-based training, but this is my experience and I would like to share it here. Actually, I think the art of medicine should be learnt and appreciated earlier in one's career so as to avoid adopting a doctor-centric approach in consultations. However, sad to say, the 'art of consultation' was not always emphasized in the early training period. And the reality is that sometimes it is difficult to practice 'art' in a very busy clinic. I hope that future trainees can learn from my experience and can try to appreciate the 'art of family medicine' much earlier on.

Different stages of 'training' involve different missions. The feeling and the understanding of the 'training' may also change with time. The above consists only of my personal experience and corresponding feeling for family medicine. With different career paths and different principal missions in life, trainees will come to acquire their own feelings and understanding of 'family medicine'.

Family Medicine Training in Hong Kong: Past, Present and Future

Interview with Dr Aylwin Chan and Dr Daniel Chu



Dr Wendy W S Tsui

FM Trainer, HKW Cluster

Both the health-care delivery system and family medicine education in Hong Kong have undergone tremendous changes over the last ten years.

In the 1990s, the Hong Kong health-care delivery system was criticized as being hospital-based and specialist-centred. Anyone could walk in any clinic, either public or private, and demanded a referral to see a specialist. However, since the publication of Harvard Report (1999) and the health-care reform consultation document 'Lifelong Investment in Health' (2000), greater emphasis has been placed on: 'Training of Family Medicine physicians to strengthen the gate-keeping function and to reduce unnecessary referrals to the Specialist Service.'

At the same time, the Government's move echoed the change in family medicine (FM), and in 1997 the Hospital Authority (HA) started to collaborate with the Hong Kong College of Family Physicians (HKCFP) on providing basic vocational training programme through expanding training centres in the public sector.

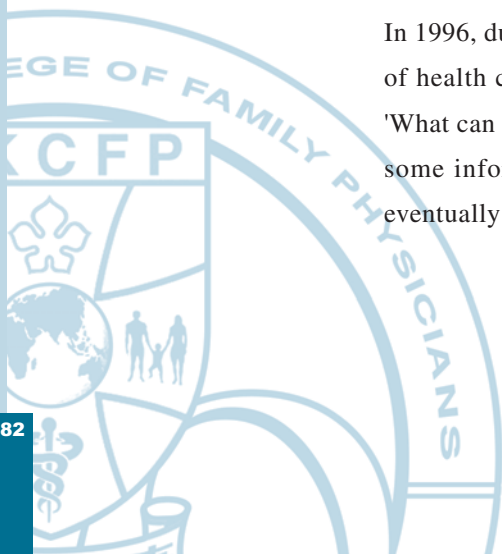
We are privileged to have this opportunity to talk to two FM veterans, who have witnessed, participated in, and are still exerting their influence over FM development in the HA:

- Dr Aylwin Chan, Senior Executive Manager (Professional Services and Primary Care), Hospital Authority
- Dr Daniel Chu, Consultant and Cluster Co-ordinator in Family Medicine, HKE and HKW Cluster

Q1. Please share with us the recent developments in family medicine in Hong Kong.

Dr Chan:

In 1996, during a meeting with Dr E K Yeoh, I volunteered to develop co-ordination of health care provided by both the public and private sectors. So I asked myself, 'What can the HA do to promote this?' In summer 1996, Dr Daniel Chu and I started some informal contacts with the Hong Kong College of Family Physicians, and eventually reached an agreement on the provision of FM training under the HA.



Dr Chu:

Dr York Chow, Hospital Chief Executive of Queen Elizabeth Hospital at that time, agreed to create two posts for hospital-based FM training with its own funding, after discussion with Dr Stephen K S Foo, the president of HKCFP at that time.

Dr Chan:

And in 1997, we recruited 20 doctors as the second generation of trainees. Things were still at the preliminary stage: we developed the training handbook to meet the College's requirements, and we held informal assemblies as the 'family medicine committee' to discuss our future direction. But despite our inadequacies, we hoped the HA could lead the primary-care training, and the HA could take over all the GOPCs from the Department of Health (DH).



Dr Aylwin Chan, Senior Executive Manager (Professional Services and Primary Care), Hospital Authority

Soon we faced the problem of a lack of community-based training venues. In 1998, the waiting time at SOPDs was getting much longer, which gave us the chance to develop 'step-down'/ 'fast-track' clinics to accommodate stable patients from different SOPDs, which were later renamed as 'integrated clinics'.

In 1999, with the surge in medical graduates, the HA needed to employ 300 doctors each year. Thus FM, as the specialty with the shortest training period (four years), was required to take up 80 to 100 graduates per year. This was not a healthy development. The initial two to three years was a hard time for us. We intentionally remained low-profile since, as a new specialty, we needed support from other well-established specialties, and any controversial gestures should be avoided. The problems we faced at this juncture were the low morale of trainees, and the too-frequent change of rotations during the hospital-based training period. We asked the College to allow six-month rotations for certain large specialties (e.g., medical, surgical).

In 2000, community-based training was rapidly developing, with the establishment of more integrated clinics, staff clinics, and GOPCs. Then another problem arose: inadequate trainers. We therefore got permission for our trainees to train at elderly health centres and DH staff clinics.

Dr Chu:

In 2001, we began to discuss the take-over of the GOPCs. Five pilot clinics were set up. The timing was good as GOPCs could help to accommodate the large number of community-based trainees. Then a plan was formulated to take over the GOPCs in July

2003. At that time, the biggest challenge was to enhance co-operation among the 2,000 staff, including those from DH. After all these clinics were set up, the base for family medicine was established.

Dr Chan:

'With a crisis comes an opportunity.' The SARS period proved that our trainees were really 'versatile' and could assist in different specialties and settings. In June 2005, media exposure of the queues at GOPCs facilitated an improvement to the booking system, so that all chronic patients got appointments with longer follow-up periods, which allowed more contact time per patient-consultation and thus improved the quality of care.

Q2. What do you find encouraging?

Dr Chan:

I have been impressed by the following developments:

- 1) The recognition of our FM trainees by our specialist colleagues
- 2) The success of triage clinics at the NTW cluster
- 3) The up-surge in FM enrolment over the recent years.

Dr Chu:

So far trainees who have finished formal training in our cluster are all good doctors, delivering good-quality care to patients, wherever they are working.

Q3. What changes need to be made?

Dr Chu:

The threat to FM is that we lack unique skills. 'Just being good to patients' is not enough as other specialties begin to change. If the health-care structure changes so that specialists don't need to rush patients, we may find ourselves replaceable if we rely on our attitude alone.

We can easily refer patients to colleagues in other specialties for all problems except one, the family issue. However, we are weak in this respect. Society expects us to be good at family issues, but actually not many family doctors have a basic grip in this area. It would be good if all community-based trainees were to follow two families over the long term as part of their training. They could also attend training in handling family issues, such as the Family Therapy basic course.

We should also be good diagnosticians. This is important as we are gate-keepers, not only avoiding unnecessary referrals, but also picking up those in need of referral to other services without delay.

Hong Kong is lacking mental and psychosocial care services. Only tertiary mental care is provided here. People with emotional problems are either placed at the very front end or referred to the tertiary mental service. In Hong Kong, family doctors play an important role in this field as they are in the front line. Since an individual's social circle can be small, the doctor may be the person with whom the patient has most frequent contact. Family doctors should play a part, especially regarding those with only mild social or psychological problems.

Another aspect is training. There is still room for improvement. FM training is difficult as people are affected by their attitude. Every trainee is different. The training is not only about training a person to have better medical knowledge as a doctor, but also about training how to be a person, which is difficult.



Dr Daniel Chu singing at the Christmas Party of his Family Medicine and Primary Health Care Team (HKE & W)

Q4. What are the differences between trainees now and ten years ago?

Dr Chan:

Trainees ten years ago were unclear about their future, but they had a pioneer attitude and were not afraid of failure. Trainees nowadays have a clearer and brighter future, but still they need a pioneer attitude, especially when they set up their own clinics. They need a public-health point of view and should be willing to develop new things.

Q5. What advice would you give to trainees?

Dr Chu:

Every trainee should aim at becoming a good doctor. Don't give up clinical stuff. Many tasks are interesting, but we should not allow ourselves to be simply managers. We should be good clinicians too.

Dr Chan:

Relationship-building is of the utmost importance in FM, no matter whether with colleagues within the same clinic, DH colleagues or other specialists. Moreover, we need to gain trust from our patients. This can be achieved by wholeheartedly helping patients, and through a willingness to listen to them and to solve their problems.

Q6. More Health Maintenance Organizations (HMOs) are now in operation and we will practise in the private sector eventually. Do you have any advice for us?

Dr Chu:

It is not important whether you practise in the private sector or not. The most important thing is how to be a doctor. Our ability should not be subject to the environment.

Q7. What are the next developments in FM?

Dr Chan:

As regards training, the trend is to provide at least six years of training. Different modules will be considered to enrich the content of FM and provide the basis for further self-development.

In the long run, we should focus more on mental illnesses, chronic diseases and health maintenance. In promoting mental health, we need more positive publicity to minimize stigma.

Dr Chu:

Our next direction will be assisting China to develop a well-established primary-care system. Although there is training available now, they lack experience. All trainers are coming from other specialties, so there is a problem regarding execution.

Interviewers:

- Dr Bryan Chan, Community based trainee, HKW Cluster
- Dr Catherine Ng, Community based trainee, HKW Cluster
- Dr Desmond Ho, Community based trainee, HKW Cluster

Interview Coordinator:

Dr Wendy W S Tsui, FM Trainer, HKW Cluster



Left to right: Dr Wendy Tsui, Dr Desmond Ho, Dr Catherine Ng

A Memoir for the Thirtieth Anniversary of The Hong Kong College of Family Physicians

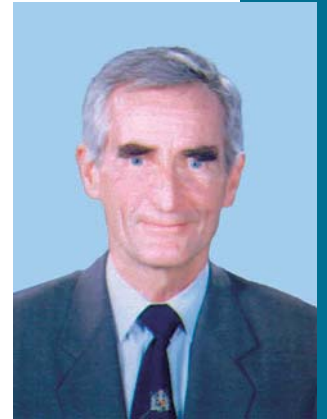
When the Hong Kong College of General Practitioners was founded in 1977, I was delighted to be elected as a Full Member. By then I had been practicing medicine in Hong Kong for 14 years. I had joined a group medical practice in 1963 and had passed a Membership examination in Medicine at the Royal College of Physicians and Surgeons of Glasgow in 1967.

Although much of my time was spent seeing referrals as a general physician, I was also seeing many patients as a doctor of first contact. It was clear to me that my hospital-based training as a student and subsequent hospital experience, without any significant exposure to General Practice, had in no way prepared me for the skills needed to handle primary contact with patients. So in 1971, I became an Associate Member of the Royal College of General Practitioners, and following appropriate preparation I sat and passed the newly-created Membership examination in 1973, becoming one of the first in Hong Kong to do so.

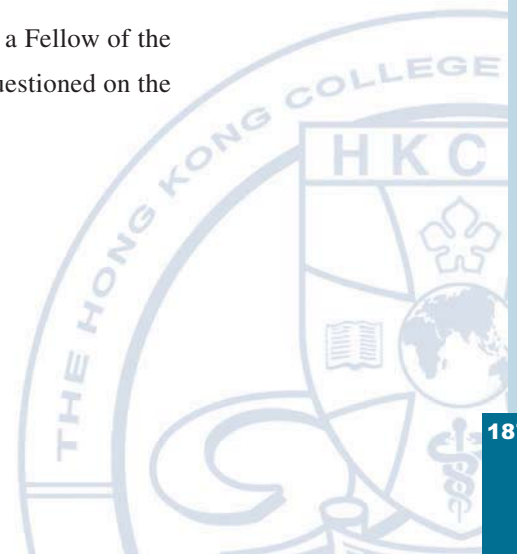
I still possess some of the books that helped me at that time: Dr Michael Balint's *The Doctor, his Patient & the Illness*, which opened up a whole new area of knowledge regarding the relationship between the doctor and patient; and Dr Keith Hodgkin's *Towards Earlier Diagnosis*, based on a lifetime of careful analysis of his work as a General Practitioner (I had a most informative meeting with him around this time at his practice in northern England), and the classic book, *Epidemiology of a County Practice* by Dr William Pickles, who became the first President of the Royal College of General Practitioners in 1952.

Meanwhile in Hong Kong a dedicated group of doctors was doing the groundwork preparatory to the inauguration of the Hong Kong College of General Practitioners. Happily, many of them are to this day still active in College affairs.

I was elected a Full Member of the College in October 1976, and became a Fellow of the College some years later on examination. I still remember being keenly questioned on the treatment of gall bladder disease by Dr Peter C Y Lee.



Dr John F Mackay
Editorial Board Member,
1993-2005



Since 1977 the College has grown steadily in stature and accomplishment. I have made my own small contributions, as an Honorary Clinical Tutor in General Practice for the Chinese University from 1986 to 1991; as an examiner for the Conjoint Fellowship from 1987 to 1991; as a member of the Editorial Board of *The Hong Kong Practitioner* from 1993 to 2005; as a contributor of several articles to *The Hong Kong Practitioner*; and as a contributor to the 14th World WONCA conference in 1995.

Memories from those times regarding the College that stand out were the first meetings with our colleagues and mentors from the Royal Australian College of General Practitioners, Dr David Game, Dr Wesley Fabb, and Dr Clarke Munro, all outstanding teachers and with a missionary zeal to establish more firmly the discipline of Family Medicine/ General Practice; the stimulation of tutoring students; the tension of conducting clinical and oral examinations; the seminar given by Richard Smith, the editor of the *British Medical Journal*, to the Board of *The Hong Kong Practitioner*; the sight of John T N Chung striding onto the stage carrying his guitar at the closing ceremony of the World WONCA Conference; the pomp and ceremony at the inauguration in 1993 of the Hong Kong Academy of Medicine, with speeches by Professor David Todd and the Governor, the Rt Hon Christopher Patton, at which 79 Foundation Fellows represented the College of General Practitioners.

Memories arising out of my clinical work are rich with contrasts. They range from treating a film star who had been blown up by an exploding machine-gun during filming at Clearwater Bay; to visiting ships in the harbour to administer smallpox, typhoid, and cholera inoculations; and once to take off a captain whose jaw had been broken in a fight with his first officer; and to dealing with immigrants, legal ones like the Russian 'True Believers' from north China who arrived with the help of the United Nations High Commission for Refugees (UNHCR), and the illegal ones like the thousands who arrived from Vietnam in 1979 after the end of the war, one shipload of hundreds of 'Boat People' were held under guard at my clinic while they all had chest X-ray screening for TB.

Family practice was never boring. Every day in the office was full of variety, but whether the patient was an international jet-setter, or a local businessman, or his or her employee, the problems were unique to that individual and warranted the application of the same Family Practice skills. Both the doctors and their patients in Hong Kong have much for which to thank the College.

Hong Kong continues to be a place where 'interesting times' are always with us, both in the sense of personal experience and in the development of the College.

The Hong Kong College of Family Physicians is a success thanks to the initiative and dedication of a few outstanding individuals who were prepared to contribute their time and energy to launch the project, and who in turn have inspired others to take up the challenge of continuing and improving it.

There was a time when western medicine was so enthralled with the concepts of medicine as a *science* that the *art* of medicine was being neglected: the primary care doctor was seen merely as a stepping-stone towards a visit to a specialist. Medical students regarded general practice as the worst-case option.

Those days are past. The young doctor setting out on his or her career now has a good knowledge and appreciation of the worthwhile challenge of primary care thanks to an appropriate university education, inspired and aided by the training advocated and supplied by the Hong Kong College of Family Physicians and other colleges like it around the world.

Postgraduate Educational Activities

Dr Freddie Y T Lau

Council Member
1980 - 1992

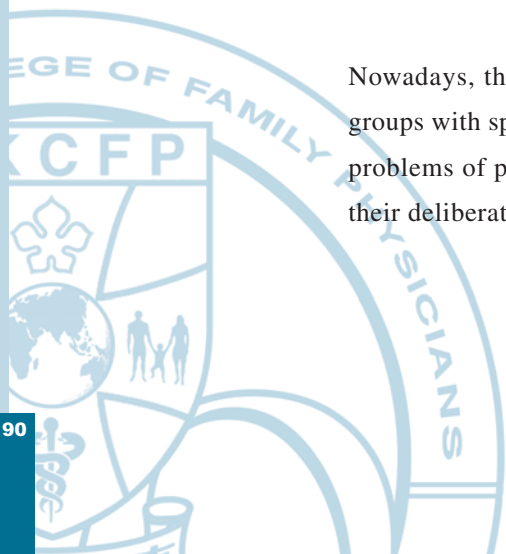
*I*n 1984, the HKCFP was the first medical institution in Hong Kong to start large-scale postgraduate educational activities.

These activities took the form of symposiums, workshops, seminars, and lectures, with selection of the topics for each activity being based on suggestions from members of the Board of Education. It was the College's intention to adhere to the true Hippocratic spirit in that all lectures would be given freely and at no cost to members. Our first refresher course was conducted over a period of two weeks, the speaker being Professor H Barber of the University of Glasgow. He gave eight lectures and conducted two workshops; and the entire event was a complete success. I was able to find appropriate sponsorship for all events and this refresher course became a highlight on the calendar for both its educational and social nature.

These were the mainstay of the College's activities and they were well received. As time passed, other activities were introduced, including clinical attachments. The ongoing clinical attachment is conducted in association with the ENT Department of the Chinese University of Hong Kong.

During these Education Committee deliberations, it was recognized that small-group educational activities could significantly enhance members' learning skills. Such small-group activities could also provide a more intimate learning environment, thus avoiding the intimidating atmosphere of the large symposium, and providing a forum where personal questions could be addressed without the presence of the hundreds of other people in the audience. The Kowloon Tong group was the first to be established and is still going strong to this day. However this format and even other formats do have their drawbacks: there may be members who are too passive.

Nowadays, these activities in their various forms are still in use and, recently, small groups with special interests have been active, for example the small group looking into problems of psychosis. It would be very interesting if we could obtain an insight into their deliberations, and if other groups could follow suit.



However, the didactic lectures we have been providing are only tools of our trade – it is the application that is important and relevant.

Family physicians are like good painters. They should know their pigments, their canvas, and their brushes and should have an insight into their objectives. Thus equipped, they can paint a full picture of their patients' problems leading to the appropriate remedy and the proposal of appropriate preventative measures.

If we could apply these tools to the principles of family medicine, then the objectives of the College will have been fulfilled.

Those were the days....



Dr Ho-yin Choi

Council Member
1977 - 1984

About thirty years ago, I was among a group of still young and energetic doctors who shared the view that general practice in Hong Kong should be organized into a medical discipline that would set and maintain standards both locally and internationally. With the encouragement of Dr Natalis C L Yuen and inspired by Dr Peter C Y Lee, I joined the college council in 1977.

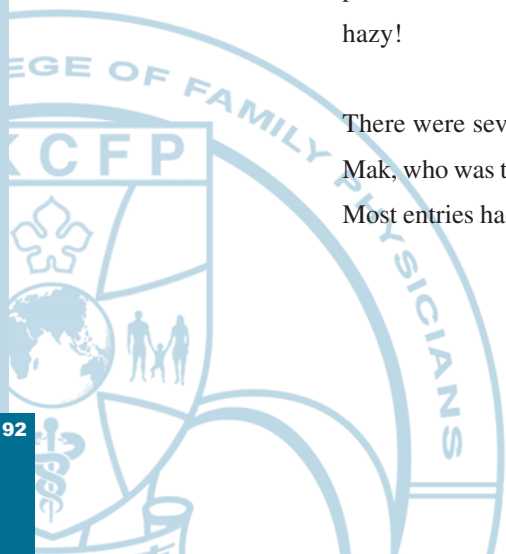
At the time, there was plenty of council work for every member, even for those who were not actively looking for it. Anyone who happened to suggest something good or useful for the College during meetings would land himself a committee either as its convener, committee member, or chairman!

As chairman of the Education Committee and editor of the Journal at one time, I needed to solicit articles regularly for the Journal. These articles were sourced mainly from university lecturers, professors, and other private specialists. But these articles were not easy to come by and their supply was sporadic. Contributions of original articles from general practitioners were even more scarce! I was lucky to have help from other council members and, together, we were able to meet deadlines and get the Journal going on a regular basis. As computers were not in common use at that time, proofreading was invariably time consuming and a real pain in the neck!

In those days, our shrewd business manager, Dr Freddie Y T Lau, was friendly with all the pharmaceutical firms, and his ability to get sponsors for the Journal and other educational activities just ahead of the deadline never ceased to amaze me.

In particular, the story of the College logo needs to be told for two reasons: first, it is now a permanent feature of the College and second, I need to record it before my memory gets too hazy!

There were seven or eight entries in the logo competition. For some reason, Dr Hing-kwok Mak, who was then the chairman of the Education Committee, asked me to make a submission. Most entries had junks floating about Victoria Harbour, and my entry had most of the existing



components, but also a sword passing through the two poles of the earth, signifying medicine eradicating global diseases. The Council voted in my favour but the Vice President, Dr Hing-kwong Chiu, thought the sword was bad *fengshui* and asked if that could be modified. I was happy to oblige.

I spent the next few weeks with an artist, a Mr Pak, getting all the components into the right scale, proportion, and perspective. The final design was presented and was accepted unanimously by the Council as the official logo for the College. The wording in Chinese was the work of Dr Hing-kwok Mak and it was chosen from a number of other entries. Thus, in summary:

- *Background Colour*: gold or yellow, an imperial colour that signifies wealth and authority
- *Green Landmass*: the concept of global reforestation, an environmental idea developed before the present 'Greenies'
- *Bauhinia*: the flower of Hong Kong
- *Humankind*: the family unit, an idea adopted from Carl Sagan's SETI programme, a plaque on board the spaceship Pioneer
- *Staff and Serpent*: traditional symbols for medicine and disease
- *The Open Book*: knowledge, wisdom, and teaching
- *Spinning Globe*: advancing with time

All the above symbols are embedded inside a Red Cross, the universal symbol for medical care and assistance.

Now you have the story of the College logo first hand, straight from the horse's mouth, so to speak! Looking back, those were fun years and, during those five years, I made many lifelong friends. The College is now a full-fledged entity with world recognition, what we set out to do thirty years ago has now been accomplished and more.

The irony for me now is that I am on the other side of the fence struggling hard every year to earn enough points to qualify for my CME certificate!

But never mind. Whenever I see that little logo on the cover of the Journal, I know I have contributed something worthwhile!

My 30 years as a GP



Dr Kwok-wai Chan

Council Member,
1986-1987, 1999-2004

Censor, since 2006

Congratulations! The Hong Kong College of Family Physicians is celebrating its 30th anniversary in 2007. Coincidentally, the year 2007 will also be my 30th year working as a GP. Thirty years is not a short time, and I would like to take this opportunity to share with you the ups and downs of my career, which can be roughly divided into three phases, each lasting for about a decade.

The years of Alice in Wonderland

These were the first decade of my general practice. It started off in 1977 when I opened a small private practice in Kwai Chung on the outskirts of the Kowloon peninsula. There was no particular reason why I took up general practice. It just happened that the Our Lady of Mary Hospital, where I worked at the time, had a lot of renowned general practitioners. Naturally, I was influenced and inspired by them to join the big family of GPs. Those eight to nine years were my 'Alice in Wonderland' years. Every patient to me was a new encounter and every disease entity a new experience. I was bewildered with curiosity and new experiences. On the other hand, getting married, buying the first flat and the arrival of my daughter, Louiza, brought me so much satisfaction and happiness, that I felt I owned the whole world. Things were too good to be true – until one evening, at a reunion dinner, when classmates and spouses were exchanging gossip and working experiences. 'My husband was an ENT specialist', said wife A. 'I will fly to the UK next month with my spouse for his further surgical training', wife B joined in. My wife and I just sat there saying nothing as my heart began to sink, giving way to my inferiority complex of being just a GP. I began to find my job boring with just cough and colds, and I started to lose enthusiasm for my work. What else could I do...

The price of being proud

Spotting an advertisement that CUHK was going to start its first diploma course in family medicine was my saviour. I sent in my application almost immediately. Enrolling in the DFM course kicked off the second decade of my GP career. That was the year 1985, ten years after my graduation, but it was never too late to learn. The course has widened the scope of my practice, given me the theoretical background to support my daily work and, most important of all, given me the chance to learn from Dr Natalis Yuen and Dr Paul Lam who were pioneers in the field of family medicine.

The course had provided me with two very important assets. Firstly, I was able to apply what I had learned into my daily practice and was able to see my practice growing as a result.

Secondly, I began to appreciate more about the real nature of a GP's work. These gave me back my confidence and pride in working as a GP. On the professional front, I passed my MRCP in 1986 and the Conjoint FRACGP/ FHKCGP Fellowship Examination in 1987. I felt proud and contented with my achievements.

Next to my office was a Belgian Bank, which was later taken over by the Hong Kong branch of the Bank of Credit and Commerce International (BCCI). Not equipped with risk management, I put all my eggs in one basket with the bank next door. 'Get all the money out of the bank', I told my wife on 5 July 1991, the Friday afternoon when I heard from the radio that the Bank of England had shut down BCCI in United Kingdom a few hours previously. 'The Hong Kong Government reassures us that BCCI Hong Kong is OK and besides, cash withdrawal may be difficult', said my wife. We trusted the Government, only to find the debacle of BCCI Hong Kong on our plates the next morning.

God has made me humble again. Suffering a substantial financial loss had blessed me with one thing...the feeling of loss, the understanding of suffering and, most important of all, the power of empathy. This enriched my communication skills with patients and enabled me to recover from the trauma and eventually from my financial loss. God has His plan. What appeared to be a loss may be a blessing in future. Learn from the loss and do not give up.

The rewards of having a special interest

Frustrated with the Hong Kong Government, I said goodbye to Hong Kong in 1994 and landed in Sydney. In order to be able to work in Australia, I struggled through the Australian Medical Council examination and embarked on a year of internship in Hornsby Hospital, a peripheral hospital on the outskirts of Sydney. Although taxing both physically and psychologically for a man of over forty, it gave me the opportunity to re-visit the hospital system and brush up my clinical skills. It happened that my last few months of hospital work were in a rehabilitation unit, overloaded with patients with long-term musculoskeletal problems. Finding that Australian patients had a very strong trust in musculoskeletal medicine sparked off my interest in the discipline. The next three years were hard work studying musculoskeletal medicine in the University of Sydney and also attending almost every available musculoskeletal workshop, seminar and training course all over Australia. I returned Hong Kong in 1998 and started my present practice in Tsuen Wan as a GP with special interest in musculoskeletal medicine. This idea has been well rewarded.

Looking back, I consider my career to be successful, but only after 30 years of ups and downs in the path of professional development. It took me 20 years to find a special interest. Do you have one yet?

Reminiscences



Dr Andy K Y Cheung

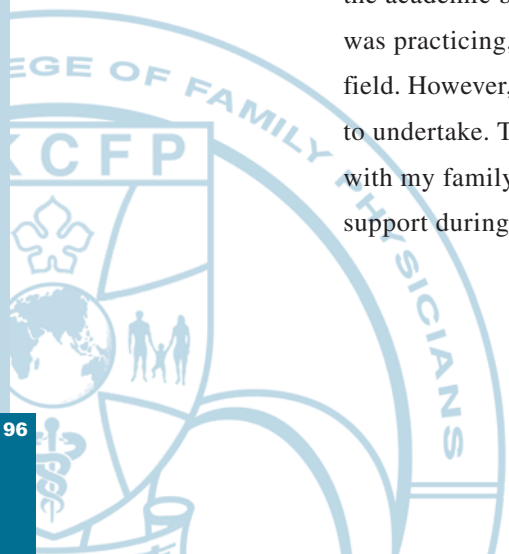
Council Member,
1992-1995

The inauguration of the Hong Kong College of Family Physicians (formerly the Hong Kong College of General Practitioners) was held on 22 July 1977. This particular date has a very special meaning for me, as it is also my eldest son's date of birth. So, as the College celebrates its anniversary, I am also celebrating my first child's birthday at the same time. My wish is that both may continue to grow, mature, and flourish. Whilst the birth of a child brings about joy, satisfaction, and gratification, there then follow the responsibilities and dedication that are needed to nurture the 'newborn'. I would therefore like to take this opportunity to pay my respects to the founding members of our College for their wholehearted contributions and dedication.

Just as I watched my son growing tall and strong, I have also witnessed our College expanding with an increasing number of members and activities targeted at upgrading the standard of practice of its members and at the advancement of family medicine practice in Hong Kong.

We are living in a rapidly changing world and many things have changed during the past 30 years. General practitioners have long been mistakenly regarded as doctors who treat only coughs and colds or other minor ailments. Many of their important attributes and contributions are overlooked or undermined. Thanks to the unfailing efforts of college members, the important concepts and functions of family medicine have been brought into high-quality practice, although this may not have been fully appreciated by the public at large.

When I was in medical school more than thirty years ago, 'family medicine' was non-existent in the medical curriculum. The term 'family medicine' was new to me and it was out of curiosity that I applied for the Diploma in Family Medicine course at The Chinese University of Hong Kong in the year 1989-90. I found that I was very much in tune with the academic basis and concepts of family medicine since it was very relevant to what I was practicing, and the course teachers motivated me to pursue my career further in this field. However, as a Category II candidate, and as a mother of two, it was not an easy task to undertake. The level of attainment gained was at the expense of leisure time and time with my family. I am fortunate, and extremely grateful to my family who gave me much support during that period of time.



The concept of family medicine is indeed very important and relevant to medical practice no matter which specialty a doctor may enter. I am very concerned for those who had no chance and who may have no further chance to enter into formal and proper training in family medicine. Therefore I am particularly keen to share my experience, especially with those who are not offered such opportunities to learn through informal sharing sessions or formal teaching courses.

As for my practice, the more I take the patient's context into consideration when looking into their presenting problem, the more I find myself in need of further improvement especially in cases when psychosocial issues play a more important part in association with their manifested illness. Take the problem of insomnia as an example: It is common for patients to approach us for a prescription for sleeping pills. There could be various contributing causes for their insomnia, namely, loss of job, financial hardship, relational problems, children's behaviour problems, bereavement, and so on. Do I, as a family physician, take it for granted that prescribing drugs is all I can do for my patients and leave the other causes to be handled by people of other disciplines, such as a counsellor? In that case, would my patients feel comfortable consulting somebody else and repeating the whole story again to a total stranger? If not, what more can a family physician offer in such a situation? Do I feel comfortable and am I competent enough to handle these issues? These are the relevant issues that we family physicians have to take into account in our daily practice.

Time and again, many of my friends and colleagues ask me why I have a special interest in counselling. My answer is two-fold. Firstly, I respond to my patients' needs. Managing patients' symptoms may sometimes appear to be simple. However, from time to time, some doctors may find it difficult to treat their illness and the associated problems that may arise as a result of the illness. Attaining more and better skills in counselling enables me to be more competent in handling these problems and at the same time makes my patient feel more at ease and relieved when we touch on issues such as bereavement, terminal and debilitating illnesses, psychosomatic problems, and so on. Secondly, I feel more helpful when I am still able to assist my patients, even when conventional medicine and surgery can do little for them. Some may argue that patients with such issues could and should be referred to other professionals such as counsellors, psychotherapists, or psychiatrists. However, for practical reasons this may not be feasible. Counsellors may not be readily available and, even if available, the patient may not have the confidence to tell the whole story again to a total stranger and it may take a counsellor much longer to establish a therapeutic relationship. Often, when patients tell me about important events in their life, I can anticipate potential

problems. Being more alert and equipped with appropriate counselling skills, I may be able to prevent problems from happening and this is much more cost-effective and efficient than when serious issues have eventually developed into full-blown problems. Surely, the preventive role of a family physician can be extended to the mental-health aspect as well as to family problems such as family violence too.

However, I do not mean that all family physicians should spend years in counseling-skills training, as each doctor has his/ her own special interests and potential in different fields. I think it is a good idea, especially for those who have obtained their fellowship, to develop their interests in special fields such as psychological medicine, musculoskeletal medicine, men's health, child's health, women's health, and elderly health for example, so that they can handle more complicated and difficult cases and relieve the specialists' burden in their respective fields. In this way, health care can be delivered more cost-effectively when a team of family physicians, each with their different special interests, is practicing in the same location. This would generate beneficial synergies for the entire medical system.

Growth and improvement are always possible. While we, as members of the College, have every reason to celebrate our success and validate our achievements, it is hoped that we can join hands, from every corner of family practice, to move forward towards more achievements in and contributions to the medical profession.

*Finally, borrowing Virginia Satir's idea, I wish that all of us could attain:
'Peace within': when we know that we are practicing family medicine in good faith;
'Peace between': when we can truly enjoy our relationships with our patients and colleagues; and 'Peace among': when we are collaborating well with other professionals within the health-care system.*

Congratulations!

Congratulations to the Hong Kong College of Family Physicians on its 30th anniversary! As I reflect on the past 20 years working with fellow colleagues in Hong Kong, many precious memories come to mind.

I am most privileged to have witnessed the following, just to name a few examples:

1. The vision and dedication of the pioneers who founded the College.
2. The good work throughout the years of the Council members, who have worked hard to establish the specialty of family medicine in Hong Kong.
3. The pioneer teachers of family medicine for their being true to their calling to teach, love, and serve students and patients.
4. The eager learning spirit of the mature doctor 'students' who took time away from their busy practices to learn and to sit for the Chinese University Diploma and the HKCFP Fellowship Examination, even before they became quotable.
5. The many Diploma graduates who were stimulated to make changes to their practice, and then went on to pursue further postgraduate studies, sit for the fellowship examination, and become active members and office bearers of the College, and full or part-time teachers of family medicine.
6. The many young aspiring medical students and graduates who have a better appreciation and understanding of the holistic care rendered by doctors in the community.

Dr Cynthia S Y Chan

Council Member,
1992-1997

Chief Examiner,
1996-1999



7. The friendship and support of the many examiners who meet yearly to diligently prepare the conjoint examination to maintain its high standards.
8. The examples and wisdom of the many doctors who helped to teach medical students and postgraduate students.
9. The dedication to duty by trainees and fellow colleagues during the SARS epidemic and the imminent threat of avian influenza.
10. The challenging but fruitful years of linking up primary care with secondary care, with implementation of various changes to the health-care system, and
11. The gracious understanding and support from colleagues from other specialties and disciplines in the training and provision of seamless holistic care throughout the continuum of hospital to community.

Yes, there are plenty of good and conscientious family doctors in the community who are keen to update their knowledge and skills and practise good medicine. Our numbers and 'converts' have grown slowly but surely in the early phases. We need to be more inclusive rather than exclusive, to enable those who did not have the opportunity for formal training to participate in the movement of building better primary care for our patients.

We have now gained a critical mass and reached the exponential growth phase. There are new challenges with training and examination of large numbers of trainees. Let us look forward to a new generation of family doctors who treasure the golden opportunities for learning that they now have, and who will aim to excel in knowledge, practice, and research, and are dedicated to their patients, society, and the specialty. The College needs enthusiastic young doctors who will join their forerunners and heed the calling of their vocation.

The Path from General Practice to Family Medicine

– a Middle-aged Fellow's Reflections

I assume this only occurs to fellows with a Category II background, but I find it impossible to separate my reminiscences on the not-so-many years with the college fellowship from the many more years of doctoring without the fellowship. What exactly does a fellowship mean to a doctor? Or, rather, what exactly does the process of achieving a fellowship mean to a doctor, in this case, me? Category II candidates refer to those that were not trained *ab initio* in an organized institutional programme, thus mostly are older in age, of more diverse clinical backgrounds, and with fixed ideas about doctoring.

In the Beginning

In the beginning, all doctors were general practitioners. All doctors – Western, Traditional Chinese, Korean or Tibetan – looked after the births of babies, diagnosed syphilis, removed teeth, amputated gangrenous legs and prescribed St John's Wort or 24-tastes herbal remedies to cure internal dry heat.

Then, not long ago, doctors began to differentiate themselves. Why was this? I guess the academics could argue about the consequences of urbanization, if not provide other more sophisticated social theories. Whatever the reasons, we see some classmates claiming an interest in particular organs, and becoming hepatologists or spine surgeons, some assuming a kind of divine hierarchy of the brain and the heart over the piles and toenail specialists. Some happened to acquire certain techniques and are good at taking beautiful images, while some render patients unconscious and then revive them. Their knowledge and techniques dictate the scope of patients they see and the functions expected from them.

Ask any leader, president, celebrity or any of your peers, and they will all say that family is the most important thing in their lives. None would say the kidney is the most important (assuming they don't have renal failure), so, by such an argument, family doctors should be the most important doctor. We should all be proud of being the doctor who looks after the most important thing in a human being's life.

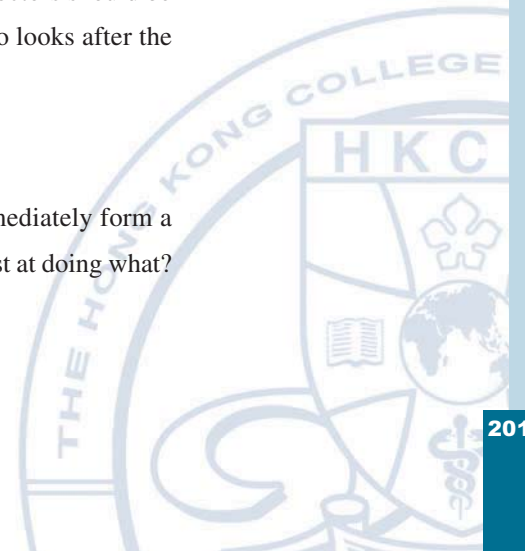
Family Medicine or General Practice?

How should we describe a doctor – so that people (or colleagues) can immediately form a vivid picture of what the doctor looks like, behaves like, does what and is best at doing what?



Dr Mark S H Chan

Council Member,
since 2006



That is the problem or the challenge in defining what a family physician is. And, in this regard, the Hong Kong College of Family Physicians (and its many international counterparts) certainly had very real reasons and philosophy for changing its name and defining its scope of work. But interestingly, if not confusingly, many respectable institutions still opt to call themselves a college of general practitioners (for example, Australia and the UK). I do not mind either way, but the question remains: What is the difference between current family practice compared with the former general practice, say thirty if not a hundred years ago (when the notion of family medicine did not yet exist)?

Reminiscence: What is family medicine and what happened to the doctor?

As one gets older, I (I guess most others too) take less stock of words from their surface meaning, but more by related behaviours and deeds. My initial understanding of family medicine is from the people I know who practice family medicine. My first contact with family medicine was through Dr Jonathan K C Lau, who was one of my classmates in Australia. At the end of the first year we had the rare opportunity of an attachment at Clonclurry, where the then non-profit Flying Doctor general practice was based. Where was Clonclurry? Right in the middle of nowhere in central Queensland. We got to visit farms and outback stations in remote areas using small planes. The town's GP, and in fact the only doctor, was Dr Harvey Sutton, whose father was a professor of medicine. What about him? He was also the chief surgeon, injecting varicose veins, removing appendixes and, as the chief obstetrician, delivering babies and doing caesarians. This was general practice in reality, but was it family medicine? Looking back, what was being practiced was undoubtedly family medicine. Dr Sutton would co-ordinate all care, whether calling for radio help from thousands of miles away in Townsville or Brisbane, or evaluating the bio-psycho-social impact on an alcoholic aboriginal patient ranching on a cattle station with no other social facilities apart from the pub and post office. He was on call 24 hours a day for all matters trivial or acute. He also presided over the local Rotary Club and remained vitally important to members of the community for a good 30 years continuously. I guess one may criticize his practice for not being very evidence-based, nor did he have any CPD certification. You could also argue that he did not receive any formal training or handed in any log book (who had one 30 years ago anyway?).

Getting back to Jonathan, he did his training in New Zealand and taught Tai Chi in his innovative local preventive-medicine programme. At one time he tried to enlighten me on family medicine while working with the refugees at Whitehead. I was cramming my Simpson Wright and Goodman Gillman for a science-based fellowship examination. It was easy for young doctors to be fascinated by the world of expensive high-tech, and perhaps better organized, institutional medicine.

The next important family medicine encounter came 14 years later. Somehow having enough of hospital medicine, I ventured into solo private practice. Since I was aware that I did not know much about family medicine, I paid the money and enrolled in the Monash University Diploma programme. One day the postman delivered a huge, heavy parcel. There was a lot of reading to do. Being a slow reader, I painfully caught up on the required readings by Ian McWhinney, Richard Hetzel, and interviews by Professor Piterman on live tape recordings. It sounded as if I too was at the recording, listening to their conversation on the principles of family medicine. Here they brought in the new concept (to me) of reflection, of healer, of holistic medicine, of the doctor as medicine and many more. I never thought reflection was important before. No, no other specialty would place such a value on such a concept.



Left to right: Dr Albert Y F Kong, Dr Mark S H Chan, Dr Wai-chi Lam, Dr Hon-ming Chan, Dr Partick H Y Kwan, Dr Anthony W L Lam and Dr Mark W W Lai at the Conjoint Fellowship Conferment Ceremony in 2005

The Fellowship

I took up The Chinese University of Hong Kong Diploma of Family Medicine course in 2000 and made many treasured friendships as a result. Of most impact was that with Dr Albert Y F Kong, a renowned pediatrician who humbly acknowledged his inadequacy in family medicine and acted as a key role model for all of us in overcoming our naive arrogance. Dr Anthony Lam was practical, perseverant, and optimistic, and Dr Sam Tsoi was a perfectionist in his studies and serious about even the most minute details. Dr Wing-wo Lam was unassuming, organized, and talented. And there were others, like Dr Andrew Tsang, a surgeon-turned-GP, Dr Tak-hung Lam, who has collected three master's degrees, and Dr David Wong who was sincere and determined, and many who are already 'successful' GPs in their practice locality but are still willing to pursue more. We were lucky to have Dr Yuk-tsan Wun and Professor Albert Lee, who enlightened us in evidence-based medicine, and treated the mature students with the appropriate level of care.

And so with the book by Sackett, a new horizon of EBM is being opened; Dr Cynthia S Y Chan introduced us to the world of family dynamics, family trees, and the use of role-plays; Dr Natalis C L Yuen brought us the Satir Model, and Dr Andy Cheung introduced family counselling. Concepts many would take for granted in a formal training scheme became totally new learning and practical experience for working GPs. A more personal influence on me was Dr Kwok-wai Chan, who repeatedly challenged us to go for the fellowship examination. Dr Chan went on to help us set up a study group and over the next three years

encouraged and guided it. Our inept performance in examinations improved with the selfless assistance from, again, remarkable young colleagues like Dr Kam-wing Ching, who also dedicated his leisure time to suicide prevention, and Dr Allen H Y Ngai and Dr Stanley K H Lam, both talented doctors with high aspirations. The resulting friendships and the common group experience would last throughout my life. This 'encounter' process encapsulates the meaning of my fellowship.

What is doctoring after all?

I teach students. As I do, I always think, 'What is medicine?' To be more down to earth, 'What is doctoring?' Really I was trying to ask myself, what sort of doctoring life am I leading and, given the chance, how could I transform students into being the sort of doctor I would like to receive care from. The challenge of a lung transplant would be handled by those well trained and well prepared at the right time and place. Likewise, the caring for thousands of people (yes, we are responsible for the thousands of patients and families who voted with their feet to register with us) throughout their lives would be our challenge. The fellowship examination prepares us and assesses our commitment to the practice of patient care along family-medicine principles, and this is what differentiates a family physician from a general practitioner.

Doctoring is about healing, about reflection, about relationships, about helping patients, about seeing, showing, and managing illness by interacting with patients, about making a living, about our very own life interfering with our many patients in their journey through sickness and health.

On the day we stepped out of institutional medicine, we were all Category II candidates, setting our own life-long education in doctoring.

In the end, there are in fact no such things as Category II fellows. There is only one fellowship, the one that one has gone through.

Family Medicine from A Specialist's Point of View

*T*rained as an endocrinologist, and specializing in diabetology, I had once been obsessed with science, the evidence-based approach, precision, proof, and so on. Having been absorbed so much into the processes of learning, knowing, and researching more into diseases, I had almost forgotten about the patients who actually harboured the various diseases. It is only when I came across the philosophy of family-medicine practice, summarized in the mnemonic 'ICE', that my approach towards managing patients has been enlightened.

With the decline in the role of the generalist in the first half of the 20th century, development of a new specialty defined in terms of the family (family practice) and established as the 20th medical specialty board in the United States in 1969, had been based on the original notion of identifying the family as the basic unit for the provision of medical care.

Specializing in managing certain kinds of disease by a selected group of medical doctors (so-called specialists) helps to advance knowledge in the relevant field on the one hand, and, on the other, generate efficiency in handling sizeable service demand volume in a consistent manner. To me, the uniqueness of family medicine, involving patients as partners, better communication, and so on, could be generic to all practicing clinicians, specialists, and non-specialists alike. There should be no conflict between wanting to be mainstream (to fit in) and wanting to be distinctive, and at the same time, between the family doctor (the new breed of specialist) and the general practitioner (the old guard).

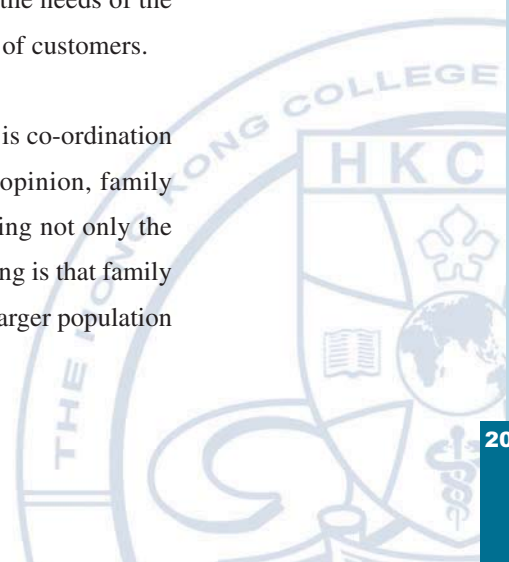
In the business arena, there is a concept known as 'disruptive innovation'.¹ Upstart companies can pose threats by introducing disruptive innovations (cheaper, simpler, more convenient products or services aimed at the lower end of the market) to dominant market players, whose sustaining innovations on improving products and services to meet the needs of the profitable high-end customers have overshoot the needs of the vast majority of customers.

What is needed on top of specialization in 21st-century health-care delivery is co-ordination in the form of quality-assured disease-management programmes. In my opinion, family practice will serve the role of bridging the gaps between specialties; treating not only the disease processes *per se*, but also the patient as a whole. What I am suggesting is that family physicians could consider bringing in disruptive innovations by enabling a larger population



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of not as 'specialized' family physicians to take over the management (in a more convenient, less expensive setting) of medical problems that historically could be performed only by expensive specialists in centralized, inconvenient locations.

In order to be a competent family physician, most people believe that one has to undergo proper training.

In managing a newly admitted acute myocardial infarction patient, a junior doctor in training talked to the patient's son, 'Sir, how would you like your mother to be treated?' The patient's son answered back in an annoyed manner, 'If I knew what to do, I would have been in your position, working as a doctor instead.'

What is the problem here? Had the trainee not been exposed enough to cases of acute myocardial infarction (clinical competence)? Or, had the trainee not been oriented in how bad news should be broken to patients or their relatives (communication skills)? Or, had the trainee not been equipped with the concepts and philosophy of family medicine?

As a family doctor, being sympathetic to, reassuring, and understanding the patient's concerns and expectations alone is not enough. The timely exercise of relevant clinical skills and knowledge is crucial. Clinical competence cannot simply be replaced by clinical enthusiasm. In my opinion, training in clinical competence does not necessarily have to enable one to know how to do everything (to actually manage the disease processes technically; knowing how to manage), but to know or be aware what others in the 'management team' are, or would be, doing (to manage the patient holistically; knowing the management plan).

Equipped with technical knowledge generated from previous scientific work of others, doctors are in a position to work with the patient, instead of working on the patient.

May I share with you the blog of one of my second-year medical students, who had participated in a special summer module in June 2006, learning about how to be a good medical doctor?

'...What actually have we learnt about communication? Well, it's about our patients.

Yes, patients. It's about making patients feel good; it's about making patients do what you want them to do willingly or even enthusiastically; it's about actively avoiding arguments (not ignoring or neglecting demands).

What determines the quality of service of a doctor? The ability to cure? Nope, doctors don't cure, they help patients cure, patients who without the doctors' help may cure themselves anyway. The breadth of knowledge? Knowledge is certainly important but patients, in most circumstances, don't recognize this and they take our knowledge for granted (knowledge may not make you good but lack of knowledge does make you bad). We have to accept that quality is a subjective feeling of patients. Patients determine quality, and we doctors' responsibility is to deliver the best feeling possible within (or even without) the limitation of resources.

Doctors don't cure, good feelings do.

How do you make patients with diabetes feel good about insulin injection? How do you make cancer patients feel good about prognosis (even when it's bad) and maintain their enthusiasm towards life? How do you make family members feel comfortable about their loved ones dying? We can make huge differences, even in the context of a three-minute consultation or a five-minute meeting with family members.

We have to accumulate skills and experience to generate good feelings (or at least not to make the patient feel bad). How do you accumulate? There is only one ingredient in the recipe: ATTITUDE. What kind of skills? It's all about communication.

And what makes good attitude? Just remember that our role is to SERVE.

DOCTOR+ATTITUDE+COMMUNICATION>SERVICE>PATIENTS>FEELINGS

It is simple, isn't it'

In conclusion, there should be no distinction between clinical specialists as long as each and every one of them caters for patient care as a whole. We only speak one language, namely to deliver the highest possible standard of care to our patients in a holistic manner. Specialization, a way to facilitate development of individual clinical specialties, has resulted in compartmentalization, which can only be alleviated through enhanced communications between individual specialties, with patient care as a common ground.

Reference

1. Christensen CM, Bohmer R, Kenagy J. Will disruptive innovations cure health care? Harv Bus Rev 2000;78:102-12.