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The President's Message

Dr. Harbaksh Singh

I am privileged to have been elected as President this year and I wish to extend my gratitude to the immediate Past President and all the council members for the work carried out last year. This year we have a good mixture of doctors from other GP and Family Medicine associations and hope that we will work together for the betterment of all our societies.

It has been more than 3 months since the election and the Conjoint exams are around the corner again. The Chief examiner Dr Tan Chow Wei, Dean of studies Datuk Dr Sheikh Amin, Censor in chief Dr Emma Zulkifli along with the Board of examiners are the pillars of our examination syndicate and are doing an excellent job. The Chapter of teachers, Malaysian Primary Care Research Group and Editorial board are doing an excellent job behind the scenes.

With the new government of the day, we can expect new policies and the AFPM and members have to be prepared for eventualities and opportunities for GP's to be involved in the Primary Healthcare system where public and private sector cooperation is required. For this to occur, GP's have to and must be clinically well equipped eg. GCFM(formally DFM) as a government requirement to be able to participate in the scheme if and when it materialises.

Our property has been purchased and it is in the final stages of completion as per the S&P agreement. We have also looked at various parcels of land for our new building which will house our AFPM as well as the Academies Of Medicine. A joint committee has been formed to look into this.

I look forward in working with all the council members and members in taking AFPM forward.

Dr. Harbaksh Singh
President

The Chairman's Message

A/Prof. Dr. Chandramani Thuraisingham

Allow me to thank you for having chosen me to serve the Academy once again. I am happy to announce that the Council for 2018-2019 has a good representation of active general practitioners and together we hope to serve the GPs better.

In our effort to serve our members and elevate the standard of general practice in Malaysia the Academy of Family Physicians will continue to have discussions with the Ministry of Health Malaysia and we welcome constructive suggestions from each one of you.

Please feel free to drop by at our office to get acquainted with us, and to allow us serve you better this term.

A/Prof. Dr. Chandramani Thuraisingham
Chairman of Council

The Honorary Secretary's Message

Dr. Kaviyarasan Sailin

Season's greetings to all of you. By the time this issue is printed most of us would have returned from the long Hari Raya and school holidays and started with our quotidian tasks.

Congratulations to the newly elected council members. This time around the council is well represented by general practitioners and we hope to work together to uplift the primary health care system of the nation.

The GP College has morphed from a humble beginning with few visionary founding members into a centre of excellence in training, educating and enhancing the skills of primary care providers. The well-structured GCFM and ATFM programs is seeing an increase in enrolment with over 300 students registering for 2018 academic year. Primary care Dermatology is another popular course among the general practitioners.

The MAFP/FRACGP part two exam will be held on 14-15thTh July 2018. Best wishes to all the students taking the exam. However the number of general practitioners are still comparatively low. It's our vision to train all the general practitioner in the country so that standard of primary care delivery is excellent across the nation.

Hopefully with abolishment of GST and KWSP withdrawal facility for our GCFM program, more general practitioners will enrol into our courses.

The general practitioners are at a crossroad facing immense pressures and challenges from various agencies. The mushrooming community clinics formerly known as one Malaysia clinic with extended hours, dwindling patients, medico-legal issues, and third party agencies who dictate unreasonable terms need to be addressed. Hence all the general practitioners need to work hand in hand to face these and other future challenges.

On the lighter note, AFPM has acquired a three storey freehold shop lot at USJ Subang Jaya. The documentations are being carried out by our appointed lawyers. The AFPM foundation is also taking shape and once ready it will provide grants for research in primary care, assistance to needy students and charity to the community.

MPCRG is the research arm of AFPM and those interested in primary care research can contact our office for further details. MPCRG is also planning to have the Asia Pacific Primary Care Research Conference in 2019.

The staffs have settled in the new office and they are working tirelessly supporting the smooth running of the online courses, workshops, seminars and conferences. We are going green and soon will implement online application forms for all courses.

Congratulatory messages has been sent to our newly elected Prime Minister Tun Dr Mahathir bin Mohamad and to our new health minister Dr Dzulkefly Ahmad.

Let's hope the new health minister will further enhance the primary healthcare delivery system of the nation by integrating public-private sectors and invest more in primary care to reduce healthcare expenditure.

By
Dr Kaviyarasan Sailin
Honorary Treasurer

The Family Physician and the GPwSI
(General Practitioner with Special Interest)

By A/Prof Dr Chandran Rajagopal

The Malaysian Academy of Family Physicians (AFFPM) defines a Family physician as one who is trained and educated to provide comprehensive medical care, health maintenance and preventive medicine services to all members of the family regardless of age, sex and the type of problem - i.e. biologic, behavioral or social.

As the name suggests, the emphasis of a Family physician is on the Family and not just disease process or pathophysiology. Family Medicine requires it's practitioner to be not just a clinician, but also an advocate, coordinator, counselor, information resource and at times support for their patients.

By breaking free from the limitations of age, sex and type of problem in defining their scope of practice, Family physicians are in an unique position to understand and treat the variable manifestations of clinical, behavioral and psychosocial problems across the entire frame of a lifetime. The clinical settings in which Family Physicians work are as varied as the scope of their practice. Most often, Family physicians work as solo or group practitioners with mostly office and clinic care of their patients. They also work in emergency departments, hospitals, nursing homes, sports fields, occupational health sites and industry and the family home! Family physicians who develop a special interest in certain fields also work in substance abuse and detox programs; assist surgical procedures in dermatological, outpatient or office procedures and also work in O&G and emergency medicine. Some physicians choose career paths in administration, public health or teaching. Family physicians have work schedules that vary considerably. On an average, Family physicians work 53 hours per week with about 80% of this time spent in direct patient care.

Family medicine training is a structured four (4) years training program, that provides future family physicians an integrated learning experience. At the Academy of Family Physicians of Malaysia, the training consists of first 2 years as a Diploma in Family medicine, and the next 2 years as an Advanced training program, the four (4) years of training teaches trainees how to comprehensively manage the multiple problems of patients and their families. It also emphasizes the need to build long term relationships with patients and their families, over time. Efficiency with regards to time and cost management are emphasized. On looking at the wide spectrum of disease entities and psychosocial issues that are dealt by a Family physician, it is understandable to ask - How will I ever know all of that?

The truth is, Family medicine is based on continuity of care. The patient-physician relationship is central to this process. The Family physician focuses on treating the patient rather than just a disease entity and such treatment is uniquely affected by the individual circumstances of each patient.

Most Family physicians find a very comfortable balance between the knowledge of clinical medicine and knowledge about their patients. The AFPM encourages continuing medical education (CME) activities to keep abreast of the new developments in both principles and practice.

I feel that the time has come for Family physicians to go on to developing a special interest in any of the areas in their field. Structured Training programs are available to develop a particular area of interest. Types of programs that are available include Dermatology, Aesthetic medicine, Occupational medicine, Sports medicine, Geriatrics, reproductive medicine, Adolescent medicine, Preventive medicine, Faculty development, Substance abuse, Rural medicine and research. Many Family physicians also develop interest in areas of alternative or complementary medicine. Family physicians within AFPM should become comfortable with the idea of developing special interest alongside the practice of Family Medicine Managed care organizations consider Family physicians to be the specialist of choice in practice, because of their breadth of skills, quality of care provided and their skills in preventive care.

The Royal College of General Practitoners was commissioned by the British department of health to produce the general practitioner with special interest (GPwSI). This framework guidance was established in conjunction with The Department of Health and Royal College of General Practitioners with Special Interests in April 2002, along with the NHS Modernisation agency's practitioner with special interest. This feature is also practiced by RACGP.

As a practitioner with special interest in Dermatology, I will try to rationalize for the GPwSI In Dermatology, I have been criticized for practicing dermatology with general practice and I hope family physicians can rationalize the needs especially in rural areas. The demand for dermatology services has increased steadily over the last decade and will continue to rise the varying availability of service provisions and needs of public and private specialist dermatologist opinion for such management. We must be realistic that there are insufficient Consultant Dermatologists to cope with the current and future demands of such services that only such Consultants can do.

In such a scenario there is an increasing role for other health care professionals to increase this capacity options including the GPwSI in dermatology. Such developments should only happen when GP's are sufficiently trained to practice primary care clinical dermatology and a series of integrated options with all those concerned are negotiated within the local framework. When there are sufficient number of GPwSI in dermatology they should emulate the British counterparts in developing a Primary Care Dermatology Society with particular aims in providing Care for skin diseases in Primary Care. In UK there are more than 600 practitioners, who are members of the Primary Care Dermatology Society.

I think that the time has come for this expertise to be recognized, harnessed and formalized within the national frame work to provide such care to all citizens across the nation which could not be availed due to various logistic reasons; whilst providing an opportunity for continuing professional development. The GPwSI should make arrangement with the trainers and consultants through MOH for continuing training and support on a regular basis. They can collaborate with other members of the local health community to develop and implement management guidance for primary care practitioners in the care of common medical conditions.

It should be recommended that regular audits should be carried out to monitor such service deliveries
Which incorporates the following:

- Clinical outcome and quality
- Follow up dates
- Referral rates of patients to specialists by GPwSI and other general practitioners.
- Access to GPwSI service
- Patient satisfaction questionaires

Most surveys show as GPwSI to be amongst the most contented in their professional and personal lives. Not being dependent on a hospital for treating the majority of their patients gives these physicians far greater flexibility and control of their time. Being Family and community oriented in their practice, most Family physicians practicing with special interest find a satisfying balance between personal and professional life. With the profession of medicine changing ever so rapidly, it appears that Family physicians are faring better than most physicians in the evolving medical environment.

The increase in demand for Family physicians is certainly linked to their cost effective care, their ability to coordinate care and their wise and effective use of resources. Opportunities and challenges for Family physicians are perhaps more than for any other specialty. Family physicians are suited for practice in the smallest and largest of communities. Their challenge is to ensure that all Malaysians have access to effective primary care for all common ailments.

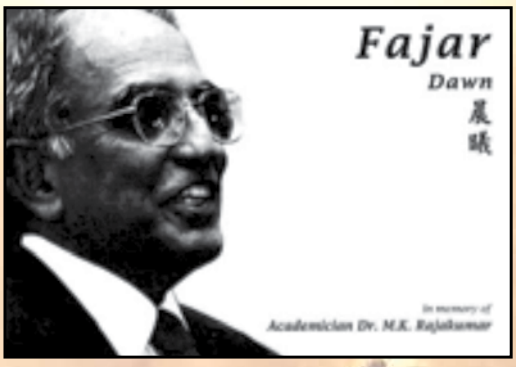
Reference

Department of Health. Guidelines for the appointment of general
practitioners with special interests – dermatology.
www.doh.gov.uk/pricare/gp-specialinterests/index.htm
www.doh.gov.uk/pricare/g-specialinterest
www.bad.orguk-British association of dermatology

MK Rajakumar Oration

Delivered by:
Professor Dato Dr Sivalingam Nalliah, FRCOG

21st April 2018



YB Tan Sri Ali Hamza, Chief Secretary to the Government of Malaysia, The President of the Academy of Medicine, Dr J.P Kamalanathan, YB Dato Seri Dr Jeiyandran Sinnadurai, Deputy Director-General, Ministry of Health Malaysia, Dr Mark Miller, Chief Censor, Royal Australian College of General Practitioners, Distinguished Guests, Ladies and Gentleman.

It is indeed an honor to deliver this year's Oration in memory of a great visionary and Father of Family Practice in Malaysia Dr M.K. Rajakumar. I wish to thank the President and Organizing Committee of the Academy for this invitation.

When I was approached to give this oration I was reminded that the Theme for the Annual Meeting of the Academy, 2018 was 'Current Challenges in Family Medicine' and that I should not exceed 20 minutes! I thought it would be appropriate to reflect on many of the strategies that Dr M.K. Rajakumar had articulated at various fora throughout his life as a Founder President and Leader in Family Practice and to include some specific areas that perhaps the Academy may want to focus to further enhance the training of F Family Medicine Physicians in the country.

To this end I would like to reflect on the following areas viz.

- Historical perspectives
- Relevance of Family Practice
- Curriculum- undergraduate and postgraduate
- Quality
- Personalized medicine
- Big Data
- Health Analytics
- Customization of Family Practice

Historical Perspectives:

The Dawson Report of Oct 1920 refers to a "white paper," where mention is made of "primary health care Centres," intended to become the hub of regionalized services in the UK. In this report there is a statement of 'Practitioners being identified for preventive work' and that state health services be managed, at least part time by local GPs. The role of the practitioner is extended to provide prenatal care, medical inspection and treatment of school children, physical culture and examination of TB and occupational disease which were referred to as communal disease. The current services provided by the Primary Health Care through the MCH and Health Centres under the Ministry of Health are designed and based on this model.

Ref: Dawson Report http://www.publichealthjrnl.com/article/S0033-3506(20)80029-8/abstract

Experiences in disease and disease patterns following the Second World War led to the development of emergency medical service as an integral part of communal service. The National Health Service of UK evolved over the years to be totally run by the state with clear roles of GPs and local authorities as distinct from specialist care provided in regional hospitals. Included in the socialist model of ambulatory care were the management of mentally ill people and the care of the older population. Local health authorities firmed up the maternal and child health services and immunization.

In the US, General Practice is drawn from the time medical education became an institutionalized venture.

(AMA, 1846). The aim then was to 'purify the medical profession from quackery, establish conventional medical education based on natural sciences, improve standards of care in public health and standardize medical education'. This led to the Flexner Report (Carnegie Foundation for Advancement of Teaching) when full time faculty were recruited to teach in medical schools attached to universities. When medical education was institutionalized in 1935, cost of medical education increased exponentially with specialization in medicine becoming a reality. This led to 'animosity' between specialist and GPs who were ranked lower. GPs were prevented from hospital work and procedures.

The shortage of physicians in the 1960s led to much public dissatisfaction. Healthcare became inaccessible to those in rural areas and inner cities with increasing 'depersonalization of medicine and fragmentation of care.' The Millis Commission on Graduate Medical Education requested the AMA to re-look at Family Practice urging that a physician 'does not focus on individual organ and system but upon the whole man……'The Folsom Report made recommendations that are attuned to what Dr. M.K. Rajakumar has been professing all his life; 'every individual should have a personal physician who will be the point for integration and continuity of all medical services to his patient … would practice preventive medicine and provide holistic care addressing social, emotional and environment factors affecting the health of the patient and family, continually.'

As Family Practice became more acceptable because of its holistic care of person and community, the American Board approved Family Practice as a specialty in 1969. The first certification examination was conducted in 1970. In Malaysia, comprehensive Primary Care is provided by the government in Health Centres and Public Health. General Practitioners who work in group practice or individually provide an alternative healthcare largely to fee paying clients. Current primary care practice , especially in the latter is faced with new challenges in the form of managed care, financial constraints of consumers and other factors like social and cultural factors apart from complementary medicine coming into the plethora of available health services. Apart from competition within the GP fraternity, competition in urban areas is also rife from specialists and private hospitals who provide direct care of clients which could be affordably rendered by primary care physicians.

Other challenge that are current seen in the local setting are a lack of continuity of care because of 'doctor hoping' and inefficient practice / institute centered record keeping. With rapid technological advances patients are now better informed and are more demanding which require practitioners to be up-to date in current evidence based practice.

Ref:
https://www.aafpfoundation.org/content/dam/foundation/documents/who-we-are/cfhm/FMImpactGutierrezScheid.pdf

It is timely to remind ourselves of the Four Main Features of Primary Care Services:

- *first-contact access for each need*
- *long-term person- (not disease) focused care*
- *comprehensive care for most health needs*
- *coordinated care when it must be sought elsewhere*
- *Primary care is assessed as "good" according to how well these four features are fulfilled.*
- *For some purposes, an orientation toward family and community is included*

Relevance of Family Practice

Starfield B et al (2005) in their review highlight the value of Primary Care Physicians in reducing morbidity and mortality. Their study between 1980-1995 showed that health outcomes improved especially in all-cause mortality, heart disease, stroke mortality, infant mortality , low birth weight , life expectancy and self-rated health largely related to increase in primary care physicians (1:10000). This was further substantiated by reduction in mortality in the US with increase in number if primary care physicians by Macinko et al (2005).

Ref: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/

Susan Thomas and colleagues (2011), in their review of the Malaysian Health Delivery System: Changes, Challenges and Champions, reiterated the fears expressed by Dr Rajakumar in 1974 (essays) that the explosion of tertiary care Centres to meet the needs of the population clearly is not the answer to health care needs of the country. Tertiary care models focus on curative models, far from the ideals Primary Care objectives. It is both doctor and illness focused, expensive, fragmented into organ specific care and institutional focused. Health care in developing country like Malaysia is changing to wellness service as opposed to illness service with a lifetime health plan for all in the population. The Academy and Primary Care Providers in Malaysia will need to send the correct signals through advocacy and effective statements so that health funding will not be disproportionate. Primary care physicians will need to provide high quality evidence based services to fend off direct tertiary care consultation apart from educating the population the useful role primary care physicians play in providing holistic and realistic care for the whole community in a continuing and comprehensive way.

Positive moves away from current disease oriented clinic based health care are necessary to remain relevant and will lend to Family Practice being person and community oriented covering all health related conditions and in wellness so as to be comprehensive and coordinated i.e. . The same physician caring for the same patient and family over a long period. Continuous, coordinated and collaborative care requires a system that would permit access to records across the board between colleagues and between systems (private and public) improving quality of care and reducing cost of health care. Confidentiality issues should not pose a problem with well-informed patients and an effective IT infrastructure and excellent ethical and professional practice.

Such progressive steps in electronic health records will uphold the four main features of primary care i.e.

- first-contact access for each need
- long-term person- (not disease) focused care
- comprehensive care for most health needs
- coordinated care when it must be sought elsewhere (referrals when appropriate considering socio-cultural and economic factors)

Continuing care from womb to tomb including emergency care, child and maternal care, rehabilitation and care of those completing their life at home (dying) was emphasized in many of M.K.Rajakumar's essays since 1974.

Medical Curriculum Development

Primary care has evolved as a speciality and a survey conducted in 25 countries in Asia-Pacific medical schools showed that 20/25 schools have included Primary Care in their undergraduate curriculum with dedicated faculty to teach students in their departments. This is also the practice in Malaysia. Certainly, this is a positive step in the right direction in sensitizing undergraduates to careers in primary care. I have often reminded my own university that we should adopt the Lancet Commission Report 2010 which emphasizes the need to train undergraduates in the community and not in hospitals so as to reflect on the ideals of holistic care in a work based environment focusing on promotion of health and prevention of disease. Hospital based undergraduate learning is more illness based with a slant to specific disciplines sustain the concept of curative medicine.

Commendably, the father of primary health care, Rajakumar with the pioneering GPs in Malaysia went on to set up the Malaysian Academy of Primary Health Care Physicians (College of General Practitioners). This was a far sighted move which now has become a center for learning outside the formal university education model. The Academy of Family Physicians of Malaysia today will always cherish this initiative by Rajakumar and his colleagues back in the 1970s. His outstanding contributions to the primary health care sector was recognized by the World Organization of Family Doctors (WONCA) to which he served as President. The Rajakumar Movement founded in 2008 is testimony to the vision Rajakumar had and clearly shows that Family Practice is relevant and here to stay.

Challenges in Curriculum Development

In line with his thoughts the Academy has evolved and played an active role in training Primary Care Physicians in both private and public sectors so as to be able to take the Fellowship of the Academy and also the Australian College of General Practitioners. In order to fulfill Raja Kumar's vision of 'appropriate to Malaysia,' curriculum design will need to focus on local health behavior and disease trends to remain relevant as a speciality. I refer to mass customization later in my talk, but unless Academy makes moves to include a transformation program adopting the Lancet Commission 2010 on 'Reforms for a Second Century' we may be left behind with an archaic curriculum. In order to make the curriculum dynamic Academy has to invest in robust data that reflects on health seeking behavior and disease trends in all parts of the country. Vocational training using set curriculum based on overseas models could be largely accepted but

will not meet (entirely) the needs of select population peculiar to Malaysia especially the marginalized groups, immigrant workers, refugees, new emerging disease, occupational hazards related to evolving technology and resources development in urban and rural areas. This is why customization of the curriculum is required.

Undergraduate Curriculum Development

Chirk Jenn, Ng et al (2016), writing in the Society of Teachers of Family Medicine on the status of FM Training Programs in Asia Pacific showed that 71/75 medical schools surveyed had a unit teaching FM in their universities and in 20/25 countries surveyed showed that FM was recognized as speciality in their respective countries. In the same survey 7/11 universities who responded had a department of FM delivering the undergraduate curriculum with 4/7 providing postgraduate training.

The authors expressed concerns of a lack of comprehensive and systematic documentation on the status of FM training in the Asia-Pacific region. Primary care is integral to national health, as stated in the Alma Ata in 1978 and the WHO defined primary care as key to achieving health for all.

Ref: http://www.stfm.org/FamilyMedicine/Vol48Issue3/Ng194

I have alluded to the positive steps taken in introducing Primary Care in undergraduate curriculum in Malaysia above but I am not sure how much input the Academy has, in the curriculum development of MBBS programs in Malaysia. In my opinion more hours need to be given for primary care programs and the delivery methods will need improvement so as expose undergraduates to the real world of primary care through community based learning rather than hospital base training. Primary care physicians should take leadership in undergraduate training so as consolidate holistic learning with reduced emphasis on technology enhanced clinical training. Androgogic principles need to adopt patient centric approaches so as to see a transformation. Transformative learning together with interdependence education will propel; primary care teachers in taking a leading role in undergraduate learning; eventually leading to a population based person centered learning outcomes. Such transformation is expected to provide equity in health care in Malaysia.

Postgraduate Curriculum:

Two pathways are available in Malaysia for speciality training in FM i.e. the public universities running a structured 4 year program and that available through the Academy of Medicine which eventually leads to the Fellowship (including the Fellow of the Australian College of General Practitioners). The founders of the College of GPs, Malaysia lead by Dr. M.K Rajakumar were pivitol in making this alternative pathway a reality. I am happy that the latter program has evolved into an enviable one as it attracts a large number of GPs in Malaysia enabling them to pursue postgraduate training in a paced manner suitable to their time and practice. The close ties the Academy has developed with the Australian College is admirable and indicates the value of networking with regional Centres. Returning specialists from UK and US are increasing, which may require the Academy to put in place criteria which would enable such specialist to adapt to the local setting rapidly. I am not sure how much has been done in this area.

Quality Practice and Professionalism

M.K Rajakumar addressed Quality and Empathy in his keynote address at the 12th WONCA meeting in KL as these had been close to his heart and practice. He reiterated that 'Quality is not the good intention to better BUT the process of measurement of behavioral changes against set targets'. Aspects of quality that need to be addressed are: effective delivery of services with efficiency, patient satisfaction, and having community interests with regards to health policies and health investment. The practitioner needs to show that that he will respond to the needs of patient and society.

To this end, we need to re-look at postgraduate training with regards to structure, process and output and not be satisfied with number of graduating specialists. Malaysia is a small country and yet we have two pathways for postgraduate education. One should be mindful of the patient and society in need of FM services. I would urge the Academy to move up the progress ladder to look at the quality of both programs and evaluate if they are aligned to the changing demography in the country; if there is a need for inclusion of specific skills not available in the formal curriculum and how satisfied the public are with members of the Academy and that in public service.

Ref: http://bmjopen.bmj.com/content/bmjopen/6/1/e009375.full.pdf

Boon-How, Chew et al (2016) conducted a national survey of public health care provider's impression of FM specialists (FMS) in Malaysia where 780/1345 responded. The results of this survey showed that FMS were providing safe and effective treatment in line with standards of care professionally and ethically. While most of the domains

evaluated were outstanding there were deficiencies in certain areas especially in 'clinical performance, personal attributes and professionalism'. More studies of this nature will need to be considered by the Academy to uphold quality and safety among out graduates both trained locally and those joining after being trained overseas.

Human resource is a factor to consider and the Academy may make a move to optimize human capital for training through novels means. I could suggest one way would be to re-look at the postgraduate curriculum of the two postgraduate pathways and look for commonness. It would not be difficult to foster closer relationship between the two faculties (private and public) so as design a curriculum adept to Malaysian needs. Specific modules may be incorporated so as to develop competencies in specific areas of need e.g. Retrieval Medicine, Care of Displaced people, Rehabilitation Medicine, Occupational Medicine, rural medicine etc.

We are mindful that 'one size fits all' slogan no longer is applicable in this world and clearly customization of a dynamic curriculum would be the way to go.

Summarizing the development of a postgraduate curriculum fit to Malaysia we need more negotiations between public and private providers of medical education for development of a curriculum in postgraduate education in FM which is flexible, dynamic and current which addresses global and local population needs and that which is work based. Such a move would be in line with the Transformation in Education which I have addressed above. Clearly the Academy will need directions based on Big Data and local morbidity and mortality studies. Leadership in medical education in FM has been strong in the Academy but more can be done for producing quality service through well prepared graduates and specialists.

Quality Assurance and Leadership:

M.K Rajakumar had his early education in Malacca where he showed his leadership in both curricular and extra-curricular activities. Though he began clinical practice he was best known as a leftist intellectual in his early working years as he rose in ranks in the political circle in the Labour Party and the Barisan Socialis. He worked well with great leaders like Tan Sri Dr Tan Chee Koon, V.David and Karam Singh. His political career waned after he spent 1966-1969 in detention. After his release Professor Emeritus Tan Sri Khoo KL said that Rajakumar focused not only on his medical practice but with the overall improvement of standard of health care. He was a founder of the College of General Practitioners Malaysia and its President. I remember at that time I had spent 2 years in Tangkak and Segamat District Hospitals. I was keen on O&G as a speciality but always had an interest in General Practice because of its holistic approach to medical care. The College was offering the Diplomate Examination in collaboration with the Australian Royal College of General Practitioners. I wrote to him pleading for my case to sit for the first examination in 1980. I told him that I have been running the outpatient departments in both these district hospitals apart from doing rota call at the Emergency Department, delivering babies, performing appendectomies and hernia repairs, overseeing the children's ward and the male wards apart from attending to Trauma and Fractures. He wrote back to me that the censors had approved my application because what I had been doing is what the College was looking for in an ideal GP! Fortunately I was one of the 10 candidates who were successful in the examination. I was looking forward to award of both the MCGP and the FRACGP but I was disappointed as I was told that the conjoint exam would only become operational the following year and had to be contented with the MCGP!

MKR showed his leadership in medial politics by becoming: MMA President (1979-80); Malaysian Scientific Association President (1981-83); World Organization of National Colleges, Academics and Acad Assoc of FP President (1986-89); and the list goes on. Nandini Balakrishnan (2016) included MKR as one of the nine 'Unsung Heroes who should have a spot in history books. When the Rajakumar Movement was founded in 208, he accepted it with humility and added:

'Let us form collaborative bilateral links for a pooling of experience and expertise that will have a beneficial multiplier effect on both partners. Experience in vastly different cultures and environments will make us better doctors and better human beings…' –unquote

Beyond leadership, M.K Rajakumar highlighted quality with respect to reviewing one's on practice and also reviewing the practice of colleagues and staff. The Academy of FM Malaysia may want to initiate specific steps to look at the quality of care and if standard of care is followed by members. Peer review is a powerful tool but there are challenges in operationalization. Documentation and extensive adoption of evidence based practice will contribute to quality and also lend to evaluation by external bodies and colleagues.

Customization and Patient Centered Care

Personalized medicine is focused care based on biological and genetic markers that dictate how disease is managed. This is still in its infancy and would not be in the realm of family practice in developing countries in the near future. However, it is evident that Family Practice is and has always been patient centered. Patient centered care (PCC) was first introduced as a health care strategy by the Picker/Commonwealth Program in 1988 so as to be patient and family-centric. This shift from clinician and health system based to the client and society best fits the role of modern family practice as it goes beyond healing a disease to a value based approach incorporating respect for culture and beliefs of patients together with meeting their needs and preferences. In order to provide such value based care pathways family medicine practitioners require appropriate training through a dynamic curriculum of learning lending to the concept that 'one model fits all' is no longer applicable. A model curriculum would include specific electives that would best suit sites of practice based on demography and community characteristics. The popular TV series 'Doc Martin' is a classic example of how a country doctor struggles to adapt to a rural community in south England.

Equity in Healthcare

Equitable health care has been an issue worldwide, Malaysia included. The Ministry of Health Facts (2009) showed a huge difference in the doctor-patient ratio in the country. There were 500 people per doctor in Kuala Lumpur but only 4000 per doctor in Terengganu and East Malaysia. This ratio has been reduced over the years with 1:927 in 2009. How does the Academy contribute to equity in health care; do we have accurate data as how health delivery is sorted out in Malaysia, what role can the Academy play in addressing this issue? These are questions that we may have to answer apart from the established objectives of the Academy as a national organization. The Minister of Health in 2008 (YB Liow T.L.) said that despite Malaysia's continuing effort in socio-economic development plans, there continues to exist issues in equity and accessibility especially for the indigenous groups, rural population and the hard-core poor. Clearly there is a need for special modules in medicine for these marginalized groups so as to equip desiring medical practitioners to serve in such areas. How do we plan to encourage doctors to move to serve in areas where there is a need; is this a role for the government or could the Academy of Family Physicians play a role in this endeavor. I shall leave you to ponder over h these questions. Such noble moves will address M.K.Rajakumar's call to provide quality and value based medical care which goes beyond disease treatment. There is a need to make the shift from the conventional restrictive health care system dictated by a well carved out government led management system to a collective value based system which will provide a superior patient centered caring system.

The Lancet Commission 2010 (Health Systems in an Interdependent World) urged health providers to reform the vision, programs and system of educational institutions to train health professional who CAN MEET the people's needs. The ultimate aim is to empower communities with knowledge about wellness, promotion of wellness and avoiding illness through lifestyle changes and good health behaviors. Health providers are knowledge brokers and can drive healthcare but care must be socially driven.

The ball is in your court , so to say as Dr Margaret Chan (Director General of WHO) said in her address on the 'Rising Importance of Family Medicine' at the 2013 World Congress of the World Organization of Family Doctors that when management is left to tertiary care health cost rises excessively. Current estimates are that health cost will rise at about 5-6 % annually (in the US). Referring to cancer alone, Chan mentioned that wealthy nations operate in a culture of excess: excessive diagnostic tests, excessive interventions, and excessive promises that 'create unrealistic expectations for patients and families'. I see the same trend today in our hospitals, this may largely be due to a paternalistic approach we adopt against 'unrealistic expectations by patients and family'. Clearly a value driven evidence based management plan rendered to a well-informed client /clients will lead to reduction in cost and better decision making.

Under the 10th Malaysia Plan four initiatives have been drawn viz,

1. Transformation of the health system
2. Increasing quality, equity and accessibility of the health system
3. Shifting the focus on to prevention rather than curative
4. Increasing quality of health human resource.

I see an ideal platform for the Academy to explore its own resources and work with the Ministry of Health so that these initiatives are not left to the MOH alone. If we can develop a novel primary health care system that is population based rather than private and public, we could make huge strides to better and more efficient primary healthcare.

Big Data and Health Analytics

Need for Integration in the Digital World

Technology is here to stay and the use of computerized health records has merits and improves quality of health care. Being patient centric is the mantra word to be adopted so as to provide continuing care in an integrated health care system, Malaysia would need to close the divide between private and public so as to be productive and avoid delay in care and duplication of services. Duplicating health history for each provider is an example; this extends to the performance of investigations without access to previous health care details. Such unproductive practices can be avoided by both empowering patient with health information and getting access to patient records easily using electronic documentation.

In the Digital Age rich data insights are the most efficient tools for organizations and practices to analyze and determine patients' and community needs which would eventually lead to more effective and productive clinical decision making. There are challenges in such an approach but with Academy, adopting a policy of using common templates to capture patient information and improving its centralization of record keeping would be a workable means of sharing of data which eventually will contribute immensely to Big Data. Democratization of data capture for health analytics is the way forwards which will reflect on health behavior, disease trends, immunization uptake and many other aspects that will contribute to the very elements of primary care in promoting wellness, preventing disease and caring for chronic illness. Training in self-care and empowering the patient in matters related to chronic disease are essential paradigm shifts that will lead to comprehensive and continuing care and needs to be adopted as a means of quality family practice in Malaysia.

Advancing technology and the digital age are s changing the way we practice medicine. Family practice in Malaysia cannot stay away from the positive impact Big Data will have in customized decision making. The Academy can play a huge role in influencing its members and all primary care practitioners in a uniform way of data collection derived from patient care and its generation to draw disease patterns and care pathways. One of the weakest point in healthcare in Malaysia is collection of accurate data on healthcare because of a lack of uniformity in such data generation. Perhaps the Academy can play a leading role in this aspect so as to contribute to useful information to Big Data.

Undeniably, data sharing will influence the way we practice medicine in the future. IBM Watson and Faltiron Health illustrate how taking data, cleaning it up will lead to using such data to identify potential interventions which are cost saving. Look at the huge amount of information that is derived by each practitioner related to each patient:

- Individual biology
- Health history
- Well-being information
- Sleep disorders and rest patterns
- Lab tests, medical imaging
- Genetic profiles
- Biopsies and ECG
- Waiting time
- Generic data: derived from medical reports and medical claims, prescriptions, clinical trials and academic research.

Such information needs to be put to good use. Better data capture and analytics will lead to thorough patient records, improved patient care and evidence based decision making. Overall one will get a better and more efficient business model. Telehealth has been in vogue for more than 2 decades and will continue to be a means of consultation especially in Primary Care. Digital innovations using electronic medical records will enable seamless referrals.

Big Data is changing the way we manage patients in all aspects. There is evidence to show that Healthcare Analytics potentially can reduce treatment costs through application of best evidence in a climate of best practice. The overuse of antibiotics is well known worldwide and this is often due to a lack of adherence to best practice, for example. Analyzing Big Data assists in promoting wellness and predicting epidemics.

Areas in healthcare in Primary Care where Big Data is hugely helpful are in Electronic Health Records and access to such which can provide access to information rapidly for better management of patients and family. Current issues in Malaysia are the lack of data sharing between institutes and practitioners for the betterment of patient care due to confidentiality. The Academy may want to explore how this can be overcome in the interest of patient wellness and avoiding duplication of data generation. Preventing medical errors with red flags has been effectively employed by one software innovation in Israel, (MedAware). Medical devices and electronic wearables are now in vogue and have been effectively employed for remote monitoring

of patients with asthma and hypertension. Wait time reduction has been yet another application generated by use of Big Data in health institutes and clinical practice.

The Academy may want to engage in running courses in Big Data in Health Analytics so as to be aligned to current clinical management trends. Stewardship and leadership will be essential for practitioners to believe in the value of Big Data as paving the way to more patient centric quality care. This is because of several challenges Big Data utilization presents. Capturing data which is clean, accurate and correctly formatted are integral to electronic health records. Clearly standardization of data collection is vital. A poor understanding on how Big Data will contribute to cost effective quality healthcare can be a stumbling block. Storage of data and effective retrieval will require a dynamic IT infrastructure. Data security will always be an issue as hacking and phising are well known threats in modern IT models. Issues of how data is to be employed locally and how sharing will be operationalized will always be areas to content with in use of electronic health records.

Conclusion:

The Eight Millennium Development Goals address human misery through an integrated comprehensive care platform for best outcome which should reach out to Academy members. The ultimate aim is to provide lowest cost greatest user satisfaction i.e. 5% health cost for 95% health burden. I am not sure how much of these initiatives have been discussed by the Academy. I am fully aware of the efforts made by the MOH in reducing maternal mortality and infant mortality in this country. Despite these great efforts more needs to be done. Of great import to us are the need to address the following disorders/diseases squarely:

i. Ageing
ii. Obesity
iii. Non-communicable disease
iv. Adolescent health and pregnancy
v. TB, Malaria, HIV/AIDS
vi. Obesity

There is a need for global effort in combating these ailments and much of this is related to knowledge based approaches and socially driven activities. Glocalization is not a catchword but a reality. The World Economic Forum looked at the Health Delivery System today from a broader perspective which very much reflects how Primary Care should be practiced. Access to health care is a human right and I feel that is the responsibility of the state, value based health care is essential and much be reflected in effective health policies drawn to meet community needs; human capital needs to deployed to areas in need to overcome inequity of healthcare using technology and data , hence requiring efficient health records.

How can Primary Care and the Academy move forward as the legend Dr. M.K Rajakumar would have wanted? I leave you with the following messages based on what I have said so far:

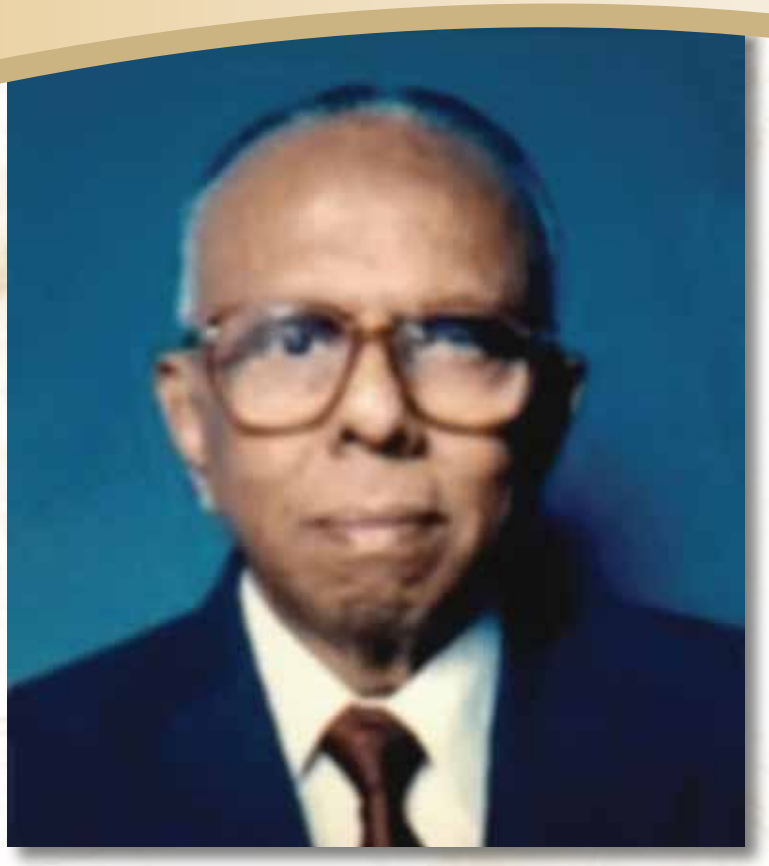
- Universal health coverage is a right and mass customization is the way to go
- How do we do that? Customized, standardized approaches in healthcare in meeting local need are essential.
- One size fit all concept does not hold and training needs to be customized based on health needs and disease trends through a flexible and scalable curriculum and evidence based practice
- Technology and Big Data will be the future for improved health care
- Seamless quality care is the mantra for all members

Once again, I wish to thank the President and the Organizing Committee to give this oration in honor of our beloved Father of Family Physicians Malaysia, Dr. M.k/ Rajakumar.

Thank you.

Professor Dato Dr Sivalingam Nalliah
KMN, PMP, DPMP
MBBS (Mal), MCGP, FICS, MRCOG, FRCOG, Master in Education

OBITUARY



Dato Dr P T Arasu
4th October 1922 - 12th Mac 2018

"My greatest joy in my work in the field of Family Medicine is getting to know the patient, their family and their children, through their joys and sorrows, you share their happiness and pain. In that way you become part of their family"

By Prof Datuk Dr D.M. Thuraiappah

Thirunavukarasu Ponnambalam (P T Arasu) also know as "Peter" to some, was born in Kajang on the 4th October 1922 to Mr V S Ponnampalam and Mrs Muthupillai. He attended the Kajang High School with well known Tan Chee Khoon. They later attended Victoria Institution to complete their Cambridge School Certificate and entered the King Edward the VII School of Medicine in Singapore in 1940.

He came from a very conservative family which was the basis for his continued achievements in his later life. His life was an epitome of leadership and innovations in many aspects of both his family, social, professional and political life.

In his 2nd year of Medical school, the 2nd World War broke out while he was in Singapore. He was witness to the death of 10 of his friends outside the hostel, the sinking of the Prince of Wales and the Repulse warships, which were anchored in Singapore Harbour on the 10th December, 1941. He witnessed many other horrific incidents during the war. Not to be deterred by these events, he volunteered for the Medical Auxiliary Service(MAS) at Tan Tock Seng Hospital. When the Japanese Officers found out that he had been a medical student, they sent him to be the Junior Assistant at the Kajang Hospial,, his home town till the war was over in 1946.

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After the war, he rejoined the Medical School and qualified with MBBS in 1951. Professor Ransome stated in his testimonial that Dr Arasu was commended by the Examiner. He was the auditor for the Students' Union. He and Dr Tan Chee Khoon completed their housemanship at the General Hospital Kuala Lumpur, after which he continued his work at the Malacca General Hospital, during which time he was commended by Mr Hassett the Surgeon for his dedication and high quality of work, with a delightful sense of humour.

In 1956, he went into general practice at No: 234, Jalan Ipoh, Arasu Dispensary, which became very famous in the community. Dr Tan Chee Khoon opened his practice on "Batu Road" now known as Jalan Tuanku Abdul Rahman. Both were involved in society and politics, but in opposite camps.

He was involved in St Johns, where he was awarded the Knight Commander of St John by the Queen. The MMA Meritorious Award, a Gold Medal. He was conferred the KMN, DPMS and the JSM for his services to the government.

His most rewarding contribution, he claims, was that he was able to persuade the Minister of Health to transfer land on which Bangunan MMA stands today and as Chairman of the Building Committee, to put up the building. He was also able to persuade the Menteri Besar, Dato Harun Idris provide the land for the three Colleges at the corner of "Circular Road" now called Jalan Tun Razak. Dr Arasu won the Sentul constituency against Mrs P.G.Lim and appointed a State Assemblyman to chair the Public Accounts Committee. He was able to use his position KPNS and KPS, to help many distraught individuals for scholarships, allocations and licenses during that time.

As a general practitioner, he was a founder member of the College of General Practitioners, Malaysia and fought hard to get the three Colleges gazetted in parliament in 1973. It passed the first reading with the help of Tun Dr Ismail Abdul Rahman, 2nd Deputy Prime Minister who died soon after. He was awarded the MCGP by Datuk Paduka Dr Ruby Abdul Majeed in 1994. He remained a Trustee of the three Colleges land till recently. He was always interested in the affairs of the AFPM and used to ask if his name was on our membership list, jokingly. He was proud to be one of our senior members and attended our functions when able. He passed away on the 12th March 2018. He will be sadly missed by the medical fraternity.

I would like to thank his family for the above information


Academy of Family Physicians of Malaysia
45th ANNUAL GENERAL MEETING
21st April 2018, Saturday
Sheraton Petaling Jaya Hotel, Selangor


45th ANNUAL GENERAL MEETING


45th AN

CONVOCATION

21st April 2018

Sheraton Petaling Jaya Hotel, Selangor

Annual Dinner

21st April 2018

Sheraton Petaling Jaya Hotel, Selangor

Calendar of Events 2018

1 JANUARY

Practice Skills Workshop
Intake 16, 17, 18 & 19
Date: 6th – 7th January 2018, Saturday & Sunday
8.30am – 5.00pm
Venue: Grand Season Hotel & Seri Pacific Hotel, Kuala Lumpur

EXCO Meeting
Date: 13th January 2018, Saturday, 2.00pm – 5.00pm
Venue: AFPM Conference Room, Bukit Jalil

Eligibility Exam ATFM Intake 6 & Repeats
Date: 14th January 2018, Sunday, 9.00am – 5.00pm
Venue: Hotel Armada, Petaling Jaya

Public Holiday – New Year's Day
1st January 2018, Monday

Public Holiday - Thaipusam
31th January 2018, Wednesday

2 FEBRUARY

EXCO Meeting
Date: 9th January 2018, Saturday, 4.00pm – 7.00pm
Venue: AFPM Conference Room, Bukit Jalil

Conjoint MAFP / FRACGP Part 1 Exam
Date: 24th – 25th February 2018, Saturday & Sunday, 9.00pm – 5.00pm
Venue: Hotel Armada, Petaling Jaya

Public Holiday – Federal Territory Day
1st February 2018, Thursday

Public Holiday - Chinese New Year
16th – 17th February 2018, Friday & Saturday

3 MARCH

1st Weekend Workshop Dermatology
Date: 9th – 11th March 2018, Saturday & Sunday, 8.30am – 5.00pm
Venue: Grand Season Hotel, Kuala Lumpur

EXCO / COUNCIL MEETING
Date: 10th March 2018, Saturday
Time: 10.00am – 1.00pm – EXCO
2.00pm – 5.00pm – Council
Venue: AFPM Conference Room, Bukit Jalil

2nd Centralized Practice Workshop ATFM Intake 7
Date: 24th March 2018, Saturday 9.00am – 5.00pm
Venue: Hotel Armada, Petaling Jaya

IMU OSCE Skills Workshop ATFM Intake 7
Date: 25th March 2018, Sunday, 9.00am – 5.00pm
Venue: IMU, Bukit Jalil Campus

4 APRIL

ATFM Research Mentor Workshop
Date: 7th April 2018, Friday, 9.00am – 5.00pm
Venue: Hotel Armada, Petaling Jaya

EXCO Meeting
Date: 14th April 2018, Saturday, 10.00am – 12.00pm
Venue: AFPM Conference Room, Bukit Jalil

AGM / Convocation / Annual Dinner
Date: 21st – 22nd April 2018, Saturday & Sunday, 9.00am – 10.00pm
Venue: Sheraton Petaling Jaya Hotel

5 MAY

MOCK Examination Part 2 Conjoint MAFP/ FRACGP
Date: 6th May 2018, Saturday, 9.00pm – 5.00pm
Venue: TBA

EXCO Meeting
Date: 12th May 2018, Saturday, 2.00pm – 5.00pm
Venue: AFPM Conference Room, Bukit Jalil

Module Workshop
Intake 16, 17, 18 & 19
Date: 26th – 27th May 2018, Saturday & Sunday, 8.30am – 5.00pm
Venue: TBA

Public Holiday – Labour Day
1st May 2018, Tuesday

Public Holiday - Wesak Day
29th May 2018, Tuesday

6 JUNE

EXCO Meeting
Date: 9th June 2018, Saturday, 10.00am – 1.00pm
Venue: AFPM Conference Room, Bukit Jalil

2nd Weekend Workshop Dermatology
Date: 29th – 30th June 2018, Saturday & Sunday, 8.30am – 5.00pm
Venue: Grand Season Hotel, Kuala Lumpur

Public Holiday – Nurul Al-Quran
2nd June 2018, Saturday

Public Holiday - Hari Raya Aidilfitri
15th – 16th June 2018, Friday& Saturday

7 JULY

Practice Skills Workshop
Intake 17, 18, 19 & 20
Date: 7th – 8th July 2018, Saturday & Sunday, 8.30am – 5.00pm
Venue: TBA

EXCO / Council Meeting
Date: 21th July 2018, Saturday
Time: 10.00am – 1.00pm – EXCO
2.00pm – 5.00pm – Council
Venue: AFPM Conference Room, Bukit Jalil

Part 2 Conjoint MAFP/FRACGP Examination
Date: 14th – 15th July 2018, Saturday & Sunday, 9.00am – 5.00pm
Venue: TBA

Research Workshop 3 (Mentoring 2)
Date: 21st July 2018, Saturday, 9.00am – 5.00pm
Venue: Hotel Armada, Petaling Jaya

3rd Centralized Practice Workshop
Date: 22nd July 2018, Sunday, 9.00am – 5.00pm
Venue: Hotel Armada, Petaling Jaya

8 AUGUST

EXCO Meeting
Date: 10th August 2018, Saturday, 2.00pm – 5.00pm
Venue: AFPM Conference Room, Bukit Jalil

Public Holiday – Hari Raya Haji Qurban
22nd September 2018, Wednesday

Public Holiday - Merdeka Day
31st August 2018, Friday

9 SEPTEMBER

3rd Weekend Workshop Dermatology
Date: 7th – 9th September 2018, Friday, Saturday & Sunday, 8.30am – 5.00pm
Venue: Grand Season Hotel, Kuala Lumpur

EXCO Meeting
Date: 8th September 2018, Saturday, 2.00pm – 5.00pm
Venue: AFPM Conference Room, Bukit Jalil

Public Holiday – Agong Birthday
9th – 10th September 2018, Sunday & Monday

Public Holiday - Awal Muharram
11th September 2018, Tuesday

Public Holiday - Hari Malaysia
16th – 17th September 2018, Sunday & Monday

10 OCTOBER

EXCO Meeting
Date: 13th October 2018, Saturday, 2.00am – 5.00pm
Venue: AFPM Conference Room, Bukit Jalil

11 NOVEMBER

EXCO / Council Meeting
Date: 10th November 2018, Saturday
Time: 10.00am – 1.00pm – EXCO
2.00pm – 5.00pm – Council
Venue: AFPM Conference Room, Bukit Jalil

Module Workshop
Intake 17, 18, 19 & 20
Date: 17th – 18th November 2018, Saturday & Sunday, 8.30am – 5.00pm
Venue: TBA

Public Holiday – Deepavali
6th November 2018, Tuesday

Public Holiday - Prophet Mohd Birthday
20th November 2018, Tuesday

12 DECEMBER

EXCO Meeting
Date: 8th December 2018, Saturday, 2.00pm – 5.00pm
Venue: AFPM Conference Room, Bukit Jalil

Public Holiday – Christmas Day
25th December 2018, Tuesday

Academy of Family Physicians of Malaysia
Akademi Kedoktoran Keluarga Malaysia

Graduate Certificate In Family Medicine (GCFM) 2018

The Academy of Family Physicians, Malaysia recognizes the need for training all General Practitioners to a level of competence in Good Medical Practice to meet the national healthcare delivery standards. AFPM has developed a two year (four semesters) distance learning program for Graduate Certificate in Family Medicine.

The objective of this Online Learning Programme is to provide flexibility in learning for all General Practitioners who meet the entry requirement.

The course delivers high level teaching materials covering all subject areas of interest to General Practitioners. With the Online tutorial support, Online assignment and MCQ test system, the student will be exposed to information technology and update their professional skills via the cyberspace community.

Upon completion of the GCFM programme, the candidate may continue studying by enrolling on the Advance Training in Family Medicine (ATFM) for two years to prepare for the Membership Examination of the AFPM and the Fellowship Examination of The Royal Australian College of General Practitioners. (MAFP/FRACGP)

The first semester will commence with the first four modules, which are to be completed each month. The first workshop will be held on the first week of the semester.

The one and half day workshop will consist of a half day E-Learning session, and followed with one day of Principle of Family Practices, Management of General Practice, Economics of General Practice and Quality Improvement Program.

Application form can be downloaded from http://www.afpm.org.my

For further details, please contact:
Academy of Family Physicians of Malaysia
Unit 1-5, Level 1 Enterprise 3B, Technology Park Malaysia (TPM)
Jalan Innovasi 1, Lebuhraya Puchong-Sungai Besi
Bukit Jalil, 57000 Kuala Lumpur.
Tel: +603-8993 9176 / 9177 Fax: +603-8993 9187

Academy of Family Physicians of Malaysia

GRADUATE CERTIFICATE IN FAMILY MEDICINE (GCFM)

The Academy of Family Physicians of Malaysia

Applications are now open for the GCFM Intake 21 (Jan 2019). Candidates must have satisfactorily completed Housemanship/ Internship and possess a current Annual Practicing Certificate (APC). The 2-year Diploma consists of 16 modules, online MCQs, workshops, assignments, logbook and a final examination.

(Candidates must have at least two (2) years of General Practice or Primary Care experience in the last five (5) years before a candidate is allowed to sit for the GCFM Final Professional Examination)

Please contact secretariat at (603) 8993 9175 / 8993 9177 or email afpm@po.jaring.asia or go to www.afpm.org.my for further information.

(Closing Date to receive application: 30th Sept 2018)

Advanced Training In Family Medicine (ATFM)

The Academy of Family Physicians of Malaysia

The Advanced Training in Family Medicine (ATFM) Programme has been designed to train candidates who wish to acquire the qualification of Member of the Academy Family Physicians of Malaysia (MAFP) which is jointly awarded with the Fellowship of the Royal Australian College of General Practitioners (FRACGP). This qualification is an entry qualification for gazettement to practice as a Family Medicine Specialist.

In this programme trainees will be required to build on their clinical knowledge and skills to ensure that they are applicable in family practice. While guided readings and supervision from mentors will be available, much of the learning of the trainees will be through self-study. Eligibility to sit for the ATFM Examination will be based on the successful completion of all sectors of the ATFM programme.

AIM OF ATFM:

To provide training to medical practitioners for competent, unsupervised general practice

GENERAl OBJECTIVES

- To provide continuing, comprehensive and personalised care to individual patients and their families
- To detect and manage illness early in the community setting
- To provide health promotion and prevention of disease
- To equip general practitioners with the required knowledge, skills and attitude for delivery of the best possible care to patients in the general practice setting, and, to only refer patients if further secondary or tertiary care is needed
- To understand research and/or audit process

CONTENT OF CURRICULUM

- Principles of General Practice
- Chronic Illnesses
- Clinical Management
- Emergency Medicine
- Mental Health
- Aged Care
- Children's Health
- Adolescent Health
- Men's Health
- Women"s Health
- Sexual Health
- Care for Groups with Special Needs
- Palliative Care
- Rehabilitative Medicine
- Practice Management
- Health Promotion & Disease Prevention
- Research

At the end of the Programme, ATFM graduates are expected to have acquired the following competencies:

1. Diagnosis & management
2. Evidence-based practice
3. Communication Skills
4. Health promotion, disease prevention
5. Demonstrate commitment through provision of personalised, holistic, comprehensive, continuous and coordinated care to patients and their family
6. Demonstrate adherence to principles of confidentiality, scientific/academic integrity, informed consent, and ethical practice
7. Demonstrate understanding of basic research methodology and be able to develop a quality assurance project within family practice

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