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Pandemic Preparedness Clinics (PPC)

Revised Primary Care Flu Pandemic Response Framework

A new enemy

The tremendous surge of Influenza A (H1N1) infection since mid-April 2009, originating from Mexico before spreading successively to America, Canada and to the rest of the world, continues to be a persistent threat to both affected and unaffected countries, serving as a stark reminder of how globally interconnected the world has become. As of current (26 May 2009), 46 countries have officially reported 12,954 cases of Influenza A (H1N1) infection including 92 deaths.

The spread of this virus to our shore has even been described as 'inevitable'. As events are rapidly unfolding before our eyes, there is a need to revise our previous Primary Care Flu Pandemic Response Framework (which was initially designed based on Avian Influenza - H5N1 and past pandemic scenarios) in our battle against the current Influenza A (H1N1-2009) threat in our local setting.

A new strategy - revised flu pandemic framework

GPs who had participated in past flu pandemic workshops organised by SMA, CFPS and MOH realised that the clustering concept of group GPs under a particular region and led by a polyclinic or large medical group forms the fundamental basis for MOH to support them with PPEs and anti-viral supplies.

However, as we know more about the characteristics of the H1N1 virus and its associated morbidity and mortality rate, as well as the efficiency of its transmission, MOH released a circular (MOH 49/2009 dated 12th of May 2009) informing GPs that the revised framework will comprise of clinics which will be known as the Pandemic Preparedness Clinics (PPC). In the event of a pandemic, MOH will spearhead the entire operation planning and logistic supply to GPs. Together with polyclinics, it is imperative that GPs who provide the bulk of primary care treatment be roped in to help treat such cases and mitigate the spread of the H1N1 virus in the community.

In order to better equip PPC clinics, MOH will supply them with PPEs and Tamiflu for staff prophylaxis and for the treatment of patients based on prevailing guidelines. Nevertheless, the supply of Tamiflu to PPC clinics for

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Managing Influenza A (H1N1-2009): Our roles and responsibilities

by Dr Wilson Eu, Editor

On 30 April 09, Singapore declared DORSCON Orange in tandem with the stepping up by WHO to Pandemic Alert Phase 5- this declaration was a strong signal that a pandemic is imminent though not inevitable. Since 11 May 09 Singapore has stepped down to DORSCON Yellow. Developments in other countries have shown that Influenza A H1N1-2009 is characterised by lower Case Fatality Rate than previously thought, but with greater potential for community spread.

New developments are occurring rapidly. MOH press releases and updates via MOH_conversations @moh.gov.sg are a daily occurrence. As information becomes available it is swiftly disseminated throughout the world and national authorities often need to re-assess and re-calibrate their existing plans and measures. MOH has revised the Primary Care Flu Pandemic Response Plan for Influenza A (H1N1-2009) and this forms the lead article in this edition of the College Mirror.

The spread of a novel influenza virus would test the response of the best laid plans. As of 10 Jun 09, there are over 25,000 cases with 139 deaths worldwide. Besides North America and Mexico, evidence of person to person can be found in Australia, Chile, Spain and Japan. Locally, Singapore recorded its first case on 26 May 09. As of 10 Jun 09, Singapore has 18 confirmed cases, all except 1 was contracted whilst the patients were overseas. In this editorial, we reflect on the events of the last few weeks.

Doing our job

The GP fraternity has continued to care for their patients throughout this period of uncertainty. As far as we know, no GP has reduced service provision during the last 4 weeks. This despite the fact that initial MOH circulars (MOH circular 17/2009) were telling us of 854 cases of severe atypical pneumonia, including 59 deaths in MEXICO. Those affected included healthcare workers and their family members with close contact.

This is a testament to the commitment of our frontline healthcare staff. There had been some difficulty in securing N95 masks in the week of April 26 and commercially available stocks nationwide were depleted.

An understanding of the behaviour of influenza illnesses in general and previous experience with the SARS virus and the continuing participation by various GPs in the Flu Pandemic Response exercises, contributed to the resilience amongst the frontline doctors.

Responding to a potential pandemic influenza situation is complex and involves many unknowns. In spite of the wealth of information from previous outbreaks, it is not possible to cover all eventualities. At a national level, Singapore's response to the virus has evolved with updated information regarding it's virulence and infectivity. Locally, each GP needs to determine the most sensible way to protect his/her patients, staff, immediate family members and his/her own well being; and, in the context of limited resources. The practising GP is in the best position to make these important decisions. A practice at the airport or one that sees many expatriate patients would have a different risk profile, when compared with one where the majority are local Singaporeans.

The degree of risk is dynamic, changing as more information becomes available. Different organisations look at the problem from a defined perspective. The WHO alert levels refer to risk of spread not the severity of the illness. Singapore has a detailed preparedness for flu plan that adheres to WHO guidelines. This is essential. However, GPs then must translate all these guidelines into sensible, implementable measures and find and allocate resources to carry out the strategy in a timely manner.

Unhelpful New Paper article

The recent New Paper article was unhelpful. It ran a story of GPs who are non-compliant of MOH guidelines. GPs have not been complacent. On May 2 a seminar was organised by MOH, SMA and CFPS for all primary care practitioners. The response was overwhelming with standing room only for many who came to listen and be informed. Our Primary Care colleagues are certainly concerned with the global outbreak of H1N1 Influenza A. Many doctors have provided feedback and suggestions to the relevant organisations on the problems that have been encountered as the measures are implemented. All are cognisant that there is a potential risk in every patient encounter.

Improving our responses

This episode should give the medical profession and Ministry of Health policy makers an opportunity to stress test our plans in real life.

(1) More secure supply of PPEs
Going forward, planners need to help frontline doctors have a more secure supply of these PPE items in order that GPs can continue to practice when outbreaks of infectious diseases occur. PPE requirements vary a great deal between different practices as the staffing levels and sources of staff (locum, full time, part-time and job-sharing arrangements) mean a wide range of PPE consumption rates. There is also a need to look at measures to prevent hoarding of these vital safety equipment which puts lives of healthcare workers at risk. Opportunists who use the increased demand to make a quick profit must be investigated.

(2) Robust IT system
Another lesson we can learn from this H1N1 episode is the importance of a robust IT system which can disseminate and receive information rapidly and reliably. An infectious disease outbreak in the age of global air travel often requires rapid information updates and protocol changes. Desktop PCs and handheld devices with broadband internet access are essential tools in a clinic, just as important as a stethoscope or a glucometer.

A Responsibility

The question arises as to why we need to prepare at all? Maureen Baker Honorary Secretary RCGP in an article in General Practice Update March 2009 (http://www.rcgp.org.uk/pdf/GPU_March_56-59_baker_final.pdf) describes it succinctly when she wrote that general practice is an essential service just like transport, fuel, food and energy supply. As citizens, we expect these services to continue during a pandemic period, so will fellow citizens expect us to provide our services to the best of our ability. Further, there is also an ethical dimension: 'The precautionary principle states that where there is a significant chance of serious harm to human health or well-being, there is a moral imperative to take action in advance of the treatment, rather than to wait for harm to be inflicted'.

Singapore is a major regional air hub. Eight to ten million tourists arrivals every year, and many of our patients travel for business and pleasure. We have to accept that delivering care safely during a period of infectious disease outbreak is part of our job. It is our responsibility to keep our staff protected and informed to the best of our ability.

Preparing for the pandemic is a little like deciding which form of car insurance to get whenever we renew our road tax. Should we get the cover we want to use or the one we want to pay? Let us not tarry and drag out feet. If we fail to plan the consequences may not fall on us alone.

Need to recognise continuing efforts of all GPs

College applauds the continuing efforts of all GPs to serve their patients whilst keeping a wary eye for the ongoing H1N1 Influenza infection. College will continue to support measures that will enhance the safety of patients, clinic staff and doctors.

CFPS will continue to work in synergy with MOH and SMA to prepare clinics. It is challenging as circumstances are changing rapidly. Prof K Satku, Director of Medical Services in a letter to GPs dated 14 May 2009 says emphatically, "The Influenza A H1N1-2009 virus can only be contained if everyone works together. The Ministry recognises that GPs play a very significant role in containing this disease and will endeavour to provide its fullest support to all frontline primary care providers to prevent and mitigate any community transmission."

Also in this edition of the College Mirror, we will present a flu-kit containing information from various sources that may be useful tools to help us be more prepared. Besides keeping a wary eye on developments regarding Influenza A (H1N1-2009), normal clinic work needs to continue. Dr Michael Yee writes on the upcoming Mental Capacity Act and the possible roles for the Family physician.

Looking after ourselves is often neglected. A/Prof Cheong Pak Yean and A/Prof Goh Lee Gan have contributed a very useful article on building a undefeated and undefeatable mental defence.

As this edition goes into print, WHO Pandemic Alert 6 was declared on 11 June 2009. It means the coming days will see us all coming into daily contact with patients having H1N1-2009. Attention is directed towards MOH Circular 65/2009 which sets out Singapore's strategy in the containment phase (current) and mitigation phase. WHO's declaration of the first global influenza pandemic also signals acceleration of pandemic flu vaccine production. The availability of the pandemic vaccine should arrest this global scourge.

CM

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Teamwork, Solidarity, and Stars

by A/Prof Goh Lee Gan, President, 21st Council, College of Family Physicians Singapore

Judging by the last few weeks' response since DORSCON Orange was declared on 30 April 2009 and moved to DORSCON yellow on 11 May 2009, Singapore is doing fine. It is good to know that the majority of people - public, press, policy makers, and profession are rallying to keep the H1N1 virus out of Singapore. The consensus is that we should not be laissez-faire and welcome the infection.

Managing uncertainty

The wisdom lies in managing uncertainty such that we are all together. As Minister said a while ago, it is a matter of time that we have a H1N1 case in Singapore. Today we have more than 40 imported cases. It is still uncertain how the new human H1N1 virus will behave. Certainly, the present can be *deja vu* of March 1918 as a prelude to a fierce people killing second wave of October 1918 (See Figure 1). Or it may not be and the new H1N1 virus joins the ranks of benign influenza infections. Only time will tell. But life has got to go on.

Good sense and social responsibility

I believe that there is good sense and social responsibility in our people and this is in taking action to keep out the virus. From GPs' feedback at the frontline, patients who have come back from infected areas and have symptoms tell their doctors upfront, and the patient concerned puts on surgical mask to prevent infecting their loved ones and the public in case they have the real McCoy. They also comply with the arrangements made for them to be tested in TTSH to rule out influenza infection as the cause of the ILI (influenza like illness), and if it is an influenza infection, to make sure it is a seasonal one.

Teamwork and social support

I see good synergy and support between MOH and the grassroots. As usual SMA being the big professional brother has rallied to organise the talks, and get the PPE for the frontline doctors. College has played a supporting role of manning the hotline, answering queries, and working with the consortium of MOH, HPB, and SMA to create the information material, advisories, and push out timely information.

It was gratifying to see the MOH auditorium filled to capacity and with doctors covering the every inch of space between the blocks of seats, up the stage, and even behind the screen in the GP Forum of 2nd May 2009. It was the first time in Singapore to see such a big audience. And DMS Prof Satku's pronouncement that MOH was there to help the frontline doctors was perhaps the most important piece of information communicated that afternoon.

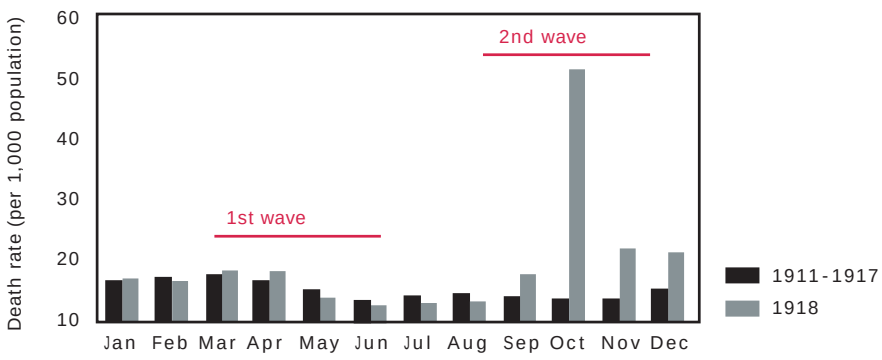
Well, many weeks have passed since 2 May 2009. Many more frontline doctors have signed up to join the pandemic flu preparedness network. A GP Forum to update frontline doctors and share questions and answers was held on 23 May 2009. Further updating is ongoing through the MOH MedAlert system.

Talk about the stars

The press plays an important people stabilising role. It can choose to talk about black holes or it can choose to talk about the stars. It is better to tell the preferred story in such time and circumstances instead of the problem saturated one. We can feature doctors and nurses and triage points with the PPE doing their work at the frontline. This would be elevating to the frontline doctors who are literally sweating it out; and it will create public confidence that the frontline doctors are doing their part to ensure that we are all safe. Let us do better. Talk about the stars and not the black holes.

It was good to see the newspaper reporting on the first H1N1-2009 case in Singapore on 26 May 2009 being done positively. This is the way forward. CM

TABLE 1 : **Death Rate in the U.S. by Month** (per 1,000 population)



(from page 1)

treatment will be monitored through an online real time system called the Health Check System (HCS).

PPC clinics will be activated when there is evidence of sustained community transmission even if we are in DORSCON Yellow. The public can recognise PPC clinics through a decal which will be put up in front of the clinic or they may check from the list of participating PPC clinics near their area on MOH website (to be posted soon).

Stocks of PPE will be supplied to PPC-registered clinics from the week starting June 1. PPCs currently (3 June 2009) have not been activated.

Fighting the battle together

Participation of GPs in these PPC clinics will come from two categories. Those who have signed up with MOH under the former framework and attended its corresponding flu pandemic workshop would have received a PPC form for PPC registration through their email. This is to verify and to update their clinic details with MOH in addition to confirm its readiness in the event of a pandemic.

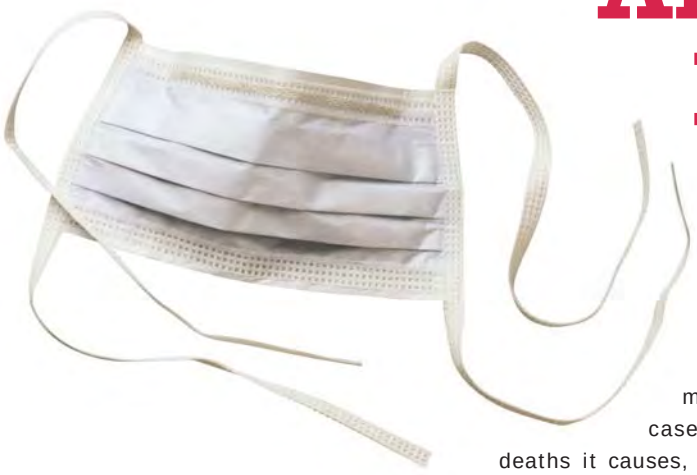
Those who have not previously signed up and interested to do so can contact SMA to attend the next available flu pandemic workshop (the last being held on 23 May 2009). After they have attended the workshop, they will receive the above mentioned email containing a PPC form for PPC registration.

The workshop on 23rd May attracted a full house of over 200 participants despite the short notice. Representatives from CDC, MOH, SMA and CFPS gave presentations on the latest H1N1 updates, pointers on how to deal with suspected cases, tips on how to organise a PPC clinic, and explanation of the logistics supply chain and Health Check System. There was also on-site mask fitting by N95 suppliers.

It is hoped that with the successful implementation of the PPC framework through the support of its participating GPs, Influenza A's (H1N1) pandemic assault in Singapore can be mitigated to a large extent. The cooperation of both the private and public wing of the country's primary care sector will go a long way to help safeguard our national healthcare system in times of such crisis. CM

PPC clinics will be activated when there is evidence of sustained community transmission even if we are in DORSCON Yellow.

Assessing the Severity of An Influenza Pandemic



11 May 2009

The major determinant of the severity of an influenza pandemic, as measured by the number of cases of severe illness and deaths it causes, is the inherent virulence of the virus. However, many other factors influence the overall severity of a pandemic's impact.

Even a pandemic virus that initially causes mild symptoms in otherwise healthy people can be disruptive, especially under the conditions of today's highly mobile and closely interdependent societies. Moreover, the same virus that causes mild illness in one country can result in much higher morbidity and mortality in another. In addition, the inherent virulence of the virus can change over time as the pandemic goes through subsequent waves of national and international spread.

Properties of the virus

An influenza pandemic is caused by a virus that is either entirely new or has not circulated recently and widely in the human population. This creates an almost universal vulnerability to infection. While not all people ever become infected during a pandemic, nearly all people are susceptible to infection.

The occurrence of large numbers of people falling ill at or around the same time is one reason why pandemics are socially and economically disruptive, with a potential to temporarily overburden health services.

The contagiousness of the virus also influences the severity of a pandemic's impact, as it can increase the number of people falling ill and needing care within a short timeframe in a given geographical area. On the positive side, not all parts of the world, or all parts of a country, are affected at the same time.

The contagiousness of the virus will influence the speed of spread, both within countries and internationally. This, too, can influence severity, as very rapid spread can undermine the capacity of governments and health services to cope.

Pandemics usually have a concentrated adverse impact in specific age groups. Concentrated illnesses and deaths in a young, economically productive age group will be more disruptive to societies and economies than when the very young or very old are most severely affected, as seen during epidemics of seasonal influenza.

Population vulnerability

The overall vulnerability of the population can play a major role. For example, people with underlying chronic conditions, such as cardiovascular disease, hypertension, asthma, diabetes,

An influenza pandemic is caused by a virus that is either entirely new or has not circulated recently and widely in the human population.

rheumatoid arthritis, and several others, are more likely to experience severe or lethal infections. The prevalence of these conditions, combined with other factors such as nutritional status, can influence the severity of a pandemic in a significant way.

Subsequent waves of spread

The overall severity of a pandemic is further influenced by the tendency of pandemics to encircle the globe in at least two, sometimes three, waves. For many reasons, the severity of subsequent waves can differ dramatically in some or even most countries.

A distinctive feature of influenza viruses is that mutations occur frequently and unpredictably in the eight gene segments, and especially in the haemagglutinin gene. The emergence of an inherently more virulent virus during the course of a pandemic can never be ruled out.

Different patterns of spread can also influence the severity of subsequent waves. For example, if schoolchildren are mainly affected in the first wave, the elderly can bear the brunt of illness during the second wave, with higher mortality seen because of the greater vulnerability of elderly people.

During the previous century, the 1918 pandemic began mild and returned, within six months, in a much more lethal form. The pandemic that began in 1957 started mild, and returned in a somewhat more severe form, though significantly less devastating than seen in 1918. The 1968 pandemic began relatively mild, with sporadic cases prior to the first wave, and remained mild in its second wave in most, but not all, countries.

Capacity to respond

Finally, the quality of health services influences the impact of any pandemic. The same virus that causes only mild symptoms in countries with strong health systems can be devastating in other countries where health systems are weak, supplies of medicines, including antibiotics, are limited or frequently interrupted, and hospitals are crowded, poorly equipped, and under-staffed.

Assessment of the current situation

To date, the following observations can be made, specifically about the H1N1 virus, and more generally about the vulnerability of the world population. Observations specific to H1N1 are preliminary, based on limited data in only a few countries.

The H1N1 virus strain causing the current outbreaks is a new virus that has not been seen previously in either humans or animals. Although firm conclusions cannot be reached at present, scientists anticipate that pre-existing immunity to the virus will be low or non-existent, or largely confined to older population groups.

H1N1 appears to be more contagious than seasonal influenza. The secondary attack rate of seasonal influenza ranges from 5% to 15%. Current estimates of the secondary attack rate of H1N1 range from 22% to 33%.

With the exception of the outbreak in Mexico, which is still not fully understood, the H1N1 virus tends to cause very mild illness in otherwise healthy people. Outside Mexico, nearly all cases of illness, and all deaths, have been detected in people with underlying chronic conditions.

In the two largest and best documented outbreaks to date, in Mexico and the United States of America, a younger age group has been affected than seen during seasonal epidemics of influenza. Though cases have been confirmed in all age groups, from infants to the elderly, the youth of patients with severe or lethal infections is a striking feature of these early outbreaks.

In terms of population vulnerability, the tendency of the H1N1 virus to cause more severe and lethal infections in people with underlying conditions is of particular concern.

For several reasons, the prevalence of chronic diseases has risen dramatically since 1968, when the last pandemic of the previous century occurred. The geographical distribution of these diseases, once considered the close companions of affluent societies, has likewise shifted dramatically. Today, WHO estimates that 85% of the burden of chronic diseases is now concentrated in low- and middle-income countries. In these countries, chronic diseases show an earlier average age of onset than seen in more affluent parts of the world.

In these early days of the outbreaks, some scientists speculate that the full clinical spectrum of disease caused by H1N1 will not become apparent until the virus is more widespread. This, too, could alter the current disease picture, which is overwhelmingly mild outside Mexico.

Apart from the intrinsic mutability of influenza viruses, other factors could alter the severity of current disease patterns, though in completely unknowable ways, if the virus continues to spread.

Scientists are concerned about possible changes that could take place as the virus spreads to the southern hemisphere and encounters currently circulating human viruses as the normal influenza season in that hemisphere begins.

The fact that the H5N1 avian influenza virus is firmly established in poultry in some parts of the world is another cause for concern. No one can predict how the H5N1 virus will behave under the pressure of a pandemic. At present, H5N1 is an animal virus that does not spread easily to humans and only very rarely transmits directly from one person to another. ■CM

This article was published online in the following website: http://www.who.int/csr/disease/swineflu/assess/disease_swineflu_assess_20090511/en/index.html

The Influenza A (H1N1-2009) Experience Thus Far...

- From a solo GP practice

by Dr See Toh Kwok Yee, MCFP(S), Editorial Board Member

"I recall receiving a MOH Medalert on my cell phone on 26 April 2009, a Sunday, prompting me to check my email for the attachment. There was none.

Fortunately, my doctor wife was able to receive the same notice on her Blackberry. The technical glitch had originally affected many GPs and I received my first MOH Circular the following day. It was to be my introduction to the Swine Influenza and the start of a flurry of events. That the outbreak had occurred just two months after the "Out of Sight but Not Out of Mind" Influenza Pandemic Planning seminar was uncanny.

Curiously, my first reaction was not one of fright or panic. But rather one of resignedness; my thoughts lingered on the extra work, preparations and time that I would have to put in as a one-doctor outfit the coming week to turn the clinic into full battle mode should this unfold into another SARS-like episode.

My initial confidence had stemmed from what I had understood or rather misunderstood from the FLU Pandemic seminar mentioned previously. This newfound buoyant feeling did not last long as the events quickly unfolded.

Three days after the first Medalert, MOH had, in tandem with WHO situational review, raised the DORSCON level from Green to Yellow. At this alert status GPs and their staff were required to wear full PPE when managing patients. This was spelled out clearly in the sector-specific advisories that followed. And before I could fully grasp the situation, the alert level was raised another rung to Orange within the next forty-eight hours.

My nightmare had started.

My foremost problem was that my PPE stock, excess from the SARS crisis, was very limited. This had prompted me to send an SOS email to all three help-lines (CFPS, SMA and MOH) enquiring at what stage of this outbreak would the PPE stock be released to the clinics participating in the FLU Pandemic Framework. I had also made known the urgency of my situation as my 'ammunition' was running out fast and the usual suppliers were at that point out of stock. I could not sustain clinic operations at this level of preparedness for long.

Dr. Lee Yik Voon (SMA) had replied that we had to wait till DORSCON RED before the PPE could be distributed. Both Dr. Lee Kheng Hock and A/Prof Goh Lee Gan had answered for the College with words of encouragement and assurance that the problem will be conveyed to MOH.

(My appreciation and gratefulness to our fellow colleagues from both SMA and CFPS who were there for the GPs during the SARS episode and who have once again avail themselves to all GPs irrespective of membership).

It was some relief during the GP Forum on 2 May to discover that the PPE supply problem was also shared by the majority of the GPs.

As I had mentioned earlier that my initial confidence had arisen from my misunderstanding that the PPE will be made available the moment PPE was required. I had not realised that DORSCON levels below RED, that is, YELLOW and ORANGE would also require the use of PPE! I am not certain how many fellow GPs were likewise caught flat-footed.

My next challenge was convincing my clinic assistants the need to put on full PPE when registering and screening the patients. Of all the PPE items, wearing the N95 mask for a prolonged period was the most daunting task as all of us who had weathered the SARS crisis would attest. The breathing discomfort under that the mask had rendered my clinic assistants noticeably more impatient and more irritable when dealing with patients. This was especially so with the elderly patients for whom they had to raise their voices through the masks. The gown with the outer impervious plastic layer also added on to the general discomfort.

The compliance of my clinic assistants to wearing PPE was further complicated by their casual observations that many clinics had not similarly stepped up their infection control measures. Pharmaceutical sale reps doing their rounds had also concurred with them on this. My rejoinder to their protest would be that we had to do our utmost and what was necessary to protect ourselves, our families and our patients.

I did lament to the three help-lines about fellow GPs who continue to practice without any PPE. They are doing a disservice to the rest of us who are trying

"And before I could fully grasp the situation, the alert level was raised another rung to Orange within the next forty-eight hours. My nightmare had started."

our best to cope with the situation and, more importantly, to their patients.

Some form of respite came when the DORSCON level was reverted to YELLOW on 11 May. The renewed supply of PPE and Tamiflu from the commercial operators also contributed to the much needed reprieve.

This lull has given me time to manage stress, that of my staff and I, restore any depleted supply and simplify some clinic SOPs to render the practice during the outbreak more sustainable.

A positive note from the ongoing predicament is that, my regular patients have not complained about the additional screening and procedures they are made to go through.

Some returned travelers had to be isolated in another room while the febrile ones had waited patiently outside the clinic. I believe the media had played a pivotal role in informing, educating and preparing the population.

I have, to date, called 993 twice for two patients who had developed fever and flu symptoms upon recently returning from areas with confirmed cases of H1N1 infections. Thankfully, both were negative and had not begrudged my action.

From the daily updates, it is obvious that we are not out of the woods yet. The storm clouds are still looming in the horizon. Hopefully, they will dissipate without incident.

Should they unleash their full fury upon us, would history remember the Singapore GPs in their finest hour or would we be found wanting?" CM

The Influenza A (H1N1-2009) Flu KIT

A. Characteristics of Influenza A(H1N1-2009)

The following is taken from slides by Dr Jeffery Cutter. Talk given during Flu Preparation Seminar on 23 May 2009.

- ❑ Most cases present mild illness similar to seasonal flu
- ❑ No deaths outside Americas (CFR ~ 0.1%)
- ❑ A(H1N1-2009) appears to be more contagious than seasonal flu. The secondary attack rate of seasonal influenza is 5 to15%.Current estimates of secondary attack rate of A/H1N1 22% to 33%.
- ❑ Outside Mexico, nearly all deaths had pre-existing conditions
- ❑ In Mexico, about half of deaths in previously healthy people and another half in people with pre-existing conditions.
- ❑ The virus causes diseases in all age groups
- ❑ Higher attack rates for younger people and lower for older groups.
  - The older age groups have some immunity due to previous exposure to similar viruses
  - The virus is currently circulating among the children and young adults and is just a matter of time that the older age group becomes more exposed

  Or other reasons, more research is needed.

Antiviral use for influenza A/H1N1-2009

European and Asian countries

- ❑ Mainly importing their cases
- ❑ Use antivirals very aggressively as precautionary measures to prevent the virus from spreading from infected travelers to others.

Mexico and the US

- ❑ The virus is circulating in the community
- ❑ Provide treatment for patients with underlying conditions and patients who are at high risk, such as pregnant women, people with chronic medical conditions.

B. Checklist for General Practice Clinics

The following is a checklist that I have used to set up my clinic to respond locally to an influenza outbreak.

- ❑ Broadband internet access in clinic. Multiple terminals preferred.
- ❑ Obtain necessary password to access Health Professionals Portal.
- ❑ Ensure staff have Singpass.
- ❑ Read Guide to Organising a Primary care clinic. http://www.moh.gov.sg/mohcorp/uploadedFiles/News/Current_Issues/2007/Flu%20Primarycare%20Clinic%20 Guide%20-%20Version1-8%20_18Jul07.pdf
- ❑ Draw up a Service Continuity Plan for your clinic from reading the Guide above and taking into account local factors. Patient safety is paramount. Segregate flu from non-flu.
- ❑ Staff have been briefed on pandemic phases and the practice's response.
- ❑ Staff are aware of the 'red-flags' (influenza-like

illness (ILI) + travel history/contact with probable or confirmed case) that alert them to a suspected case.
- ❑ Triage clinic assistant knows what to do if a patient with ILI with recent travel history is identified.
- ❑ Staff understand role of good hygiene and infection control - hand washing, social distancing methods (more-than-1m rule).
- ❑ Staff understands the rationale for requesting a patient to wear a surgical mask and how to instruct patient's correct way to wear a mask.
- ❑ Stocks of PPE, handrubs, cleaning agents, paper towels are available. Review stocks every 3-4 days.
- ❑ Vendors list on SMA website.
- ❑ Staff are competent to put on, remove and dispose of PPE.
- ❑ Staff are aware of important contact phone numbers. Refer MOH circular 32/2009 Annex A. Include also local Neighbourhood Police Post.

- ❑ Staff are aware of the clinical management protocols - suspect case, anti-virals, seasonal influenza vaccinations.
- ❑ Staff are aware of the practice cleaning policy and where cleaning solutions are kept.
- ❑ Posters and signage's are in place to reinforce practice protocols and public health messages.
- ❑ Counsel staff and acknowledge feelings of anxiety amongst staff.
- ❑ Staff are briefed to deal with anxious patients.
- ❑ Make plans to deal in event of staff absenteeism.
- ❑ Review with staff working hours and flexibility-note staff members' other commitments - young children, effect of school closures, part-time work in other clinics, etc.
- ❑ Review techniques of taking temperature, advising patients why and how to wear surgical masks with clinic staff regularly.

C. Some useful websites for Influenza A (H1N1-2009)

General-public information, FAQ on travel

1. http://www.crisis.gov.sg/FLU - Official Singapore Flu site, YouTube of MOH press conferences, pamphlets for public, MOE notes to parents
2. http://www.crisis.gov.sg/FLU/InfluenzaA/FAQ - useful FAQ covering general topics
3. http://www.moh.gov.sg/mohcorp/influenzah1n1/default.aspx - useful FAQ with respect to health care: definitions of suspect, probable and confirmed cases; correct way to wear a surgical mask
4. http://www.cdc.gov - US Centre for Disease Control
5. http://www.who.int/csr/disease/swineflu/en/index.html - WHO website

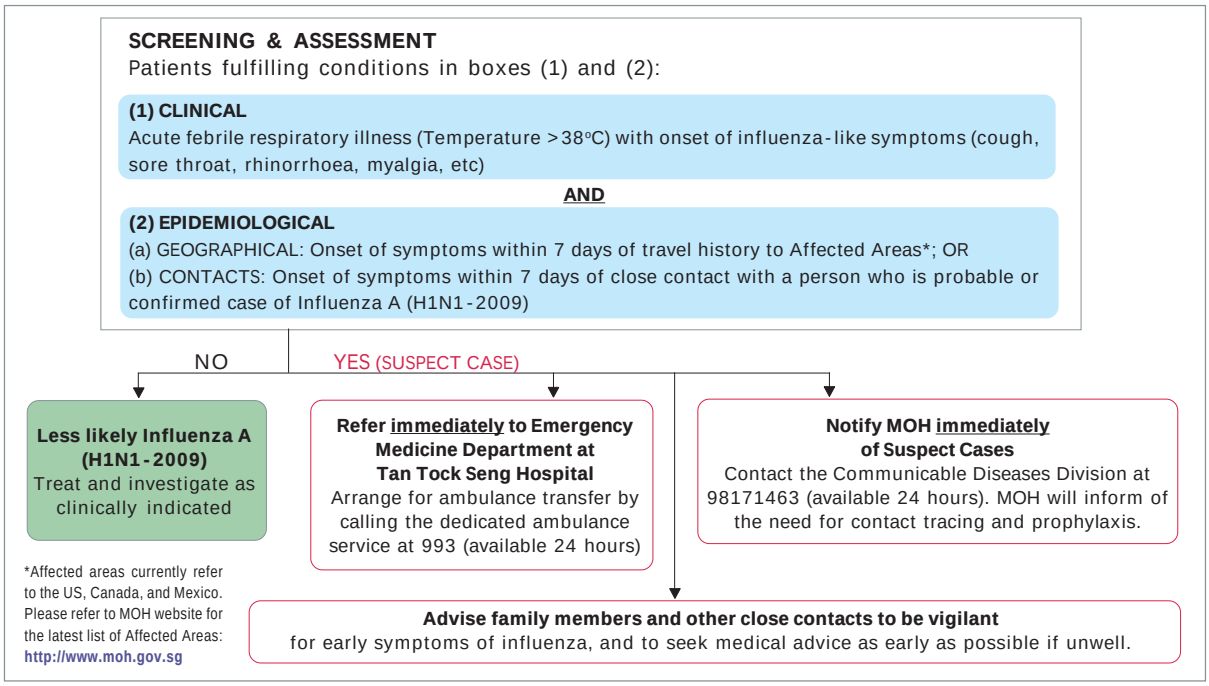
Medical

1. http://www.crisis.gov.sg/FLU/MOH+Influenza+Pandemic+Readiness+and+Response+Plan+(updated+Jan+2009).htm
2. http://www.hpp.moh.gov.sg/HPP/DOCTORS_Home.html - MOH circulars, notification requirements, and MedAlert
3. http://www.sma.org.sg/references/Influenza_A_H1N1.html - very useful, concise webpage with various MOH Circulars to doctors, licensees; Standard Operation Procedures; PPE vendors
4. http://www.cfps.org.sg - CFPS' site with useful downloadable posters and Advisory for GPs

Worldwide

1. http://news.bbc.co.uk/2/hi/americas/8021547.stm - Tracking the Influenza A (H1N1-2009) across time and space (BBC News website)

D. Management of patients presenting with influenza-like symptoms



E. Healthcare Institutions' Response Plans

Further details for Healthcare Practitioners are available through the Health Professionals Portal.

1. Hospitals

Enhanced Infection Control Measures

- Healthcare workers in high risk areas (e.g. Intensive Care Units, Operating Theatres/Rooms, Emergency Departments) will be required to use full personal protective equipment (PPE, e.g. N95 mask, disposable gloves, eye protection and gowns).
- Healthcare workers should continue to use the appropriate PPE in all other clinical areas.

Enhanced Screening & Visitation Measures

- Enhanced triage and screening measures (such as temperature screening, screening for symptoms of flu-like illness) of visitors to clinical areas.
- Hospitals will enforce visiting hours and limit the number of visitors to 2 visitors per patient at any one time
- Hospitals will record the contact particulars of all visitors to clinical to help facilitate contact tracing.

Hospital Operations and Patient Care

- Inter-hospital movement of patients restricted to medically indicated transfers only.
- Inter-hospital movement of doctors and healthcare workers restricted to essential services.
- Elective admissions have been reduced to increase hospital capacity.
- All patients with symptoms of influenza and travel history to affected areas will be isolated and managed appropriately.

2. Primary Care Clinics

- Triage of patients at reception to separate flu/febrile patients from other patients by checking symptoms & taking body temperature.
- Patients to declare symptoms, contact and travel history in Patient Declaration Form
- Flu/febrile patients to wear surgical masks and separated from other patients while in clinic
- Exercise strict infection control precautions by staff (temperature screening for all staff; triage staff to don full PPE; doctors to don PPE while attending to high risk patients)

3. Border Screening

Temperature Screening

- Temperature screening at air, sea and land checkpoints
- Passengers with fever symptoms will undergo a more thorough onsite medical assessment by the medical teams.

4. Travel Health Alert

Voluntary Self-Monitoring

If you have been to affected areas (Mexico*,USA and Canada) in the last 7 days, please continue to monitor your health and:

a. If you are unwell with fever (temperature >38C), and cough/ sore throat/runny nose, please call 993* and provide the person receiving your call accurate information regarding: your symptoms; where you travelled; if you have had contact with any persons suspected of having flu; [*Such patient will be referred to the Communicable Disease Centre for a thorough assessment via a dedicated ambulance service (tel 993) which will convey such patients to TTSH Emergency Department.]

b. If you remain well, you can continue with your normal activities. *Home Quarantine Order (HQO) for travellers to Singapore with a recent Mexican travel history has been lifted with effect from 16 May 09.

Public Travel Advisory

- Members of the public are advised to avoid non-essential travel to affected areas
- If you have to travel to such areas, be vigilant and maintain a high standard of personal hygiene at all times.
- Should you fall ill while overseas, do see a doctor as soon as possible and refrain from travelling until you are certifed by the doctor.

4a. MOH Advisory to all travellers (LATEST-16 Jun 09)

In view of recent cases of travelling though unwell, MOH would like to **remind travellers from infected areas to consult a doctor there as soon as possible if they feel unwell and to refrain from travelling if they have symptoms within 24 hours of their planned departure**. This is to avoid infecting other passengers and putting them to great inconvenience if they have to be quarantined.

For travellers who have been to the eight countries identified by WHO as having community spread (ie. USA, Mexico, Canada, UK, Spain, Chile, Australia, Japan), they should immediately call 993 for an ambulance to bring them to CDC2 for assessment if they develop symptoms within seven days of their return. **If unwell, they should not go about their usual activities such as going to school, shopping or work**. This will significantly reduce the likelihood of their transmitting any infection to their family members, friends and the community.

For people who are planning to travel, they should check the MOH website for the latest update on the list of countries most affected by H1N1 in terms of numbers of cases, deaths and known exported cases. Several groups have been found to be at a higher risk of developing complications from H1N1 Influenza A.

They include those who are: pregnant, undergoing chemotherapy, being treated on steroids, have underlying medical conditions such as asthma, chronic lung disease or heart disease, young children below 2 years of age. MOH advises that these people carefully review their travel plans to affected countries and take the necessary precautions.

5. Community Measures

Public education to raise personal & public hygiene standards

- Strengthen and maintain public education on good personal and public hygiene habits, healthy living.

F. Affected Areas

Please refer to MOH website for the current list of "Affected Countries" CM

Personal Perspectives in Leadership

by Dr Lee Suan Yew

"I am very honoured to have been invited to address you on this interesting but subjective topic, "Personal Perspective in Leadership". To my knowledge there is no medical textbook which has a chapter on medical leadership. There are many books written on Political and Religious leadership. However, we know that medical leadership is extremely important in a progressive society.

With good medical leaders we can progress in a right direction and at a correct pace. With wrong leadership we not only remain stagnant but we may put our own people onto a wrong path which affects our healthcare programme.

In Singapore, our leaders in the medical field would include policy makers in the Ministry of Health and office-bearers of the various medical organizations namely, the Singapore Medical Council (SMC), Singapore Medical Association (SMA), the Singapore Alumni Association, the Academy of Medicine, the College of Family Physicians, and other numerous medical societies in Singapore.

What are the qualities we wish our leaders to possess? There are many! Our wish list is long. It is difficult to find all these qualities in a single leader but collectively, if the office bearers possess a good number of these qualities, then that society should succeed and progress.

I wish to give a rating of 1-10 in terms of importance. The most important quality in a leader is:

1. Integrity (10)

He or she must have integrity. He or she must be trusted; otherwise, the organization will not thrive. There is a saying: If you have lost some money, you have lost "NOTHING"; If you have lost health, you have lost "SOMETHING"; If you have lost integrity, you have lost "EVERYTHING"

2. Passion (8)

He/she must be passionate in what he/she is doing. He will not count the time spent in the organization. He will not count the cost either i.e. loss of earnings. With passion, it follows that the leader will also be dedicated. A half-hearted leader is usually ineffective.

3. Decisive (7)

He must be decisive and not waver on certain issues. On important issues a leader must be decisive and take a stand.

4. Intelligent or wise (7)

He must be intelligent or wise. Otherwise, wrong decisions may be made. Wrong decisions made in good faith is understandable but not through stupidity.

5. Vision (10)

A leader must have a vision. He must lead with a clear vision. Otherwise, the organization is directionless. He must lead his organization to another level so that successive leaders will bring the organization to a higher plane. His vision must have width and depth, e.g. Obama - has that vision. He must act based on his vision.

Annual General Meeting 2009

College of Family Physicians Singapore

The 38th Annual General Meeting of the College of Family Physicians Singapore will be held on 27th June 2009 (Saturday) starting at 4.00pm at Health Promotion Board, Level 7 Auditorium, 3 Second Hospital Avenue, Singapore 168937.

The Family Medicine Commencement Ceremony 2009 will be held on the same day and venue, starting at 2.00pm.

6. Good speaker or eloquence (8)
It is important for a leader to spell out his policies clearly to his audience. Poor speeches often lead to deaf ears! Obama again is a good orator with substance. Do not be an empty vessel. It sounds awful!

7. Good listener (7)
A good leader must listen to his committee, associates or critics, much like a good doctor who listens carefully to the patients' history or complaints. At committee meetings, do not conduct a monologue. Try to get all the members to voice their opinion. Listen for sound suggestions. If they are on a wrong track, re-focus on the issue at hand. Be fair and objective.

8. Interactive (6)
Be approachable and interact with people. He must be a good net-worker and be able to influence others for the benefit of the organization. If he is a loner and dislikes mixing with people then he should do research work. A quiet leader may be good but he needs to interact with people to get things done.

9. Humble (7)
Must not be arrogant.
The more famous he is the more humble he should be. Have you ever met an arrogant doctor, e.g. a plastic surgeon who shows off his skill? How did you feel? I get put off by arrogant people! I have met very famous people and they are usually humble, e.g. the Emperor and Empress of Japan, Dr Debaky, Dr Gwee Ah Leng, Queen's Scholar, Prof Wong Hock Boon, Father of our Paediatric medicine in Singapore, and Dr Yeo Ghim Seng, excellent surgeon and speaker of Parliament.

10. "Character" (8)
You see one and you know he has a "good character". He can be seen a mile away. It is the behaviour, body language, life-style, etc. Hard to evaluate complex character, but it is very important.

"A good leader must listen to his committee, associates or critics, much like a good doctor who listens carefully to the patients' history or complaints."

11. Charisma (5)
Useful but not very important. John F. Kennedy, Winston Churchill, M. Ghandi, Mr Nehru, Nelson Mandela. They all have charisma. It helps in politics. Less so in medical leadership.

12. Team Player (7)
Essential in any organization to be a team player. All pulling in the same direction. Argue and debate by all means but at the end of the day or meeting, we all must pull our weight together. Politics - "Nationalism", gave way to majority views.

13. Serve (8)
"Called to serve".
Service to his organization or the MOH. Must not count any loss of income or time spent in servicing a committee or organization. The reward in serving a committee or organization is to see that the objectives are met for the benefit of many people, e.g. Churchill, Obama, many preachers, Martin Luther King.

14. Must Inspire and Encourage others (8)
Must have a "Winning Attitude"

15. Good Track Record (9)
Background - not quarrelsome, honest, progressive, and direct. Known to get things done. Efficient & progressive.

16. Good Mentor (6)
Training others for future leadership role, e.g. Dr Albert Schweizzer - Triple PhD, Lamberene Africa. Set up a simple hospital for the poor. Many European doctors and nurses followed him.

17. Share Your Dreams (7)
Dream concrete dreams but do not be a "Dreamer". Be somewhat prophetic. What your wishes are for the future. E.g. Dr Martin Luther King's famous speech, "I Have a Dream"

18. Leadership is Colour Blind (10) & Spiritually Neutral (10)
Must not have prejudices. Must be based on meritocracy. The world is changing. Many countries have multi-ethnicity, e.g. USA, again Obama is a fine example. Singapore is also in this category.

19. Renewal
"Time to step down". Do not tarry too long. Must have a succession plan. Do not wait to be asked to leave. Plan to leave.

Conclusion

As you can see, there are so many facets that go to make a good leader. You need not have all these attributes, but you should have several of these in order that you prepare yourselves for leadership roles.

Some are born leaders.
Some are made or groomed to be leaders.
Some are reluctant leaders.
Many have leadership thrust upon them.

On that note, I thank you for your attention." CM

Leading the Future of Family Medicine

by Dr Raymond Ng

"Vision is seeing the future in the present, built on the past."
"Vision is seeing the invisible and making it visible."
"Vision is an informed bridge from the present to the future."

These impassioned words were spoken by Mr Peter Tan, Principal Anglo-Chinese School (Barker Road) who shared on leadership and visioning at the leadership seminar themed "Leading the Future of Family Medicine" co-organised by my fellowship group and the College of Family Physicians.

Over two days on 4th and 11th April 2009, various eminent speakers and physician leaders spoke on lessons in leadership and on how Family Medicine can rise further in the areas of practice, teaching and research. Why is good medical leadership important? What makes a good leader? What is in store for Family Medicine in the next 5 to 10 years? Pearls of wisdom and stories of exemplary leadership shared captured the minds and hearts of the audience.

This year, the audience had the privilege of having two speakers from outside of the medical fraternity to share different perspectives on leadership.

Mr Peter Tan opened the seminar with his talk on the importance of vision in leadership which he defines as "A clear mental picture of a better tomorrow, given by God, which moves a person to believe that it not only could be done, but it should be done." He subsequently shared that leadership is about relationships, that people are an organisation's most appreciable asset and that a leader's most important asset is people skills.

The second non medical speaker on 4th April was Mr John Chu, Chief Financial Officer Korn/Ferry International for Asia Pacific, who provided a fascinating insight into the difference between "high performers" and "high potentials" and the science of selecting the person with the right fit for the job.

The third speaker, Professor Low Cheng Hock, President, NHG College National Healthcare Group, shared passionately and in his inimitable fashion, the 10 Pillars of highly effective living, ginseng soup for the family physician's soul.

Professor Satku, the Director of Medical Services at the Ministry of Health, spoke of the Ministry's vision for Family Medicine in Singapore: a family physician for every Singaporean. In his talk, he exhorted the audience to put "patient before self; and society before the profession," defining his take on leadership as "...first about having an informed vision... working with others to develop a collective vision and and then striving towards it".

Dr Lee Suan Yew, a veteran Family Physician leader, capped the first session of the seminar with his heartfelt sharing on the qualities that make a good physician leader, rating highly traits such as integrity and passion.

The second session of the seminar held on the 11th of April did not dissapoint with the line up of four impassioned speakers.

Dr Lee Kheng Hock, Censor-in-Chief of the College of Family Physicians, gazed through the crystal ball and shared perspectives of Family Medicine training in the future.

Professor David Matchar, Professor and Director of Health Services Research, Duke-NUS Graduate Medical School (Singapore), touched on major research challenges in family medicine, including those related to the management of chronic and complex conditions in the outpatient setting.

Dr Lau Hong Choon, Director of the Manpower, Standards and Development Division of the Ministry of Health spoke of the important roles Family Medicine leaders hold in the community as well as the challenges that we face.

Last but not least, Dr Lim Lean Huat inspired with his speech on how today's family physician has emerged like a butterfly. He exhorted the audience to continue to maintain high standards, to know who we are and where we stand and to groom future leaders.

The leadership seminar was an enriching experience for the audience who undoubtedly, were motivated and inspired. The Family Physician leader will continue to evolve and adapt to ever changing needs and challenges. However, his heart will remain strong and compassionate , and beat for those whom he is called to serve. To quote from Prof Satku's talk, "Success is not for any one individual alone... with good leadership, all should experience success". CM

Mental Capacity Act

and the Registered General Practitioners

The Mental Capacity Act covers actions and decisions made on behalf of persons **over 21 years old** who lack mental capacity to make those particular actions or decisions themselves. It sets out 5 statutory principles which should be borne in mind by all, including medical practioners, when dealing with persons with mental capacity issues:

1. Assumption of Capacity unless established otherwise
2. Take all steps to help in decision making
3. Unwise decision does not mean lacking in mental capacity
4. Decisions made for person lacking mental capacity must be in the person's best interest
5. The decision made for person lacking mental capacity must be a less restrictive option.

The Mental Capacity Act allows persons (donors) who have mental capacity to voluntarily appoint one or more persons (donees) to act and make decisions on their behalf in the future if and when they lack mental capacity, through a document called a **Lasting Power of Attorney (LPA)**. It also allows the Court to appoint a **deputy** to act and make decisions on behalf of a person who lacks mental capacity where that person has not made a Lasting Power of Attorney. For parents of children (below the age of 21 years) with intellectual disabilities, besides applying to the Court to have themselves appointed as their child's deputy, it allows the parents to have the Court appoint a sucessor deputy to make decisions for their child if the parent(s) pass(es) away or loses mental capacity.

The Mental Capacity Act provides **safeguards**: Makes ill-treatment, including wilful neglect, of persons who lack mental capacity a criminal offence and covers certain decisions that cannot be made on behalf of the person lacking mental capacity, for example: (i) Making or cancelling an Advance Medical Directive; (ii) Registering and withdrawing an objection to the Human Organ Transplant Act; or (iii) Refusing life-sustaining treatment or treatment required to prevent a serious deterioration in the condition of the person who lacks mental capacity.

The Mental Capacity Act provides **statutory protection** (except for negligence) to care-givers, including registered medical practitioners, who carry out acts in connection with care and treatment as long as he or she takes reasonable steps to ascertain the person's capacity to consent to the specific act; and he or she reasonably believes that: (i) the person lacks mental capacity with regards to a matter, and (ii) the act is done in the person's best interests.

Some of the key functions of the Public Guardian and his Office include: (i) Establishing and maintaining a register of LPAs; (ii) Supervising deputies appointed by the court; and (iii) Investigating any contravention or alleged contravention to the Act.

What is Mental Capacity?

Mental Capacity is the ability of the person to make a specific decision at a particular time for himself.

How to Assess Capacity?

The Act provides a 2-stage test for assessing capacity.

Step 1: Is the person suffering from an impairment of, or disturbance in the functioning of the mind or brain?

Step 2: If yes, does the impairment or disturbance cause the person to be unable to make the decision for himself / herself when he / she needs to?

The Mental Capacity Act states that a person is unable to make a decision if he or she cannot do one or more of the following things:

- Understand the information relevant to that decision
- Remember that information
- Use or weigh that information as part of the decision-making process
- Communicate that decision by any means; e.g. talking, using sign language, drawing, etc.

Therefore, assessments must be time and decision specific. So, a person may have the capacity to shop for groceries but not be able to manage his or her investments. Others may lack capacity for a short time or their capacity may change from time to time, so assessments must relate to the specific decision to be made at the time.

Who Can Assess Mental Capacity?

Different individuals may be involved in assessing a person's capacity for different decisions. The assessment can be informal or formal dependent on the time the decision needs to be made as well its importance.

Informal Assessment is appropriate for most day-to-day decisions and is usually made by the person's care-giver. For decisions concerning medical treatment, the healthcare professional will assess the patient's capacity to consent or refuse treatment, but if the healthcare professional is uncertain, he may request a formal assessment of capacity to be made.

Formal Assessment, which is made by specialists or accredited medical practitioners in mental health, may be requested by a professional, e.g. a lawyer, or by the donee of an LPA where they have doubts about the person's capacity and the decision is that of an important one, e.g. selling the house, transferring assets from the person's account to another account.

Can a General Practitioner Make an Assessment of Capacity for His Patient?

Currently, formal assessments of mental capacity are carried out by specialists, e.g. psychiatrists. This is going to change once the Mental Capacity Act comes into effect.

Together with the existing specialists, General Practitioners (GPs), who have gone through the requisite training and passed the tests jointly organised by Ministry of Community Development, Youth and Sports (MCYS) and the College of Family Physicians (CFPS), can be considered by OPG and CFPS to be on the panel of accredited GPs who are able to make mental capacity assessments.

Such accredited GPs will be able to carry out formal assessments of mental capacity alone or working together with a multi-disciplinary team of medical professionals, e.g. psychiatrists.

In this instance, a patient of the GP may come to him for capacity assessment to certify that the patient has the capacity to make an LPA. Similarly, the family or an interested party may bring the patient to the GP to have an assessment of the patient's capacity prior to making an application to court for a deputy to be appointed for the patient, or prior to donee having to make an important decision on behalf of the patient.

The Code of Practice

When the Mental Capacity Act comes into force, a Code of Practice would be published. This Code provides guidance and information about how the provisions in the Mental Capacity Act should be put into practice and also provides scenarios for illustrations. Everyone involved in the care of a person with mental incapacity, including registered GPs should have due regard to the Code of Practice. ■CM

For more information on the Mental Capacity Act, please contact:

Office of the Public Guardian (OPG)
Enquiry Line: 1800 226 6222
Fax: 6258 3512
E-mail: MCYS_OPG@mcys.gov.sg
Website: http://www.mcys.gov.sg/mca2008

Mental Capacity Act :
What's in it for me?

by Dr Michael Yee, FCFP(S), Editorial Board Member

A woman's $8.8m bank account was frozen last year as OCBC says the elderly woman does not have mental capacity to make financial decisions. Losing one's mental capacity is a disturbing prospect yet a real possibility, especially for those who are advancing in age. Consider the hypothetical case of Mr JK:

JK is an 80-year-old man suffering from advanced dementia. He is a resident at the Sunny View Nursing Home. JK made a Lasting Power of Attorney (LPA) for his personal welfare and property and affairs before he lost capacity. He appointed his son, JI, as his donee. He had put aside $50,000 for his care in a nursing home should the need arise. Unfortunately, JI died last month. There is still some $40,000 left to cover JK's nursing home fees at Sunny View. In the LPA, JK appointed his nephew, JH, as the replacement donee for JI. JH has removed JK from Sunny View and placed him in a rented flat. The flat is in a very poor condition. The ceiling leaks and there is mould in the bathroom. JK has been left to fend for himself.

It is clear that the elderly JK represents a growing group of vulnerable ordinary folk, in today's fast ageing population in a society struggling to find our moral compass. We exist in a truly diversified multi-racial and multi-religious environment of dynamic mix of individualism and collectivism. Leaving such issues to the collective moral conscience of our society might be ideal, but far from practical, in the fast changing ethical circumstances. Turning a blind eye to such problems is simply not feasible. The proposed draft bills are thus both courageous and timely.

What is the Mental Capacity Act that we have heard so much about recently? The Mental Capacity Act is a proposed draft bill which:

1. Addresses the need to make decisions for persons, when they lack mental capacity to make those decisions for themselves.

2. Allow persons who have mental capacity (donors) to voluntarily appoint one or more persons (donees) to act and make decisions on their behalf if and when they lack mental capacity to do so in the future, through a Lasting Power of Attorney (LPA).

3. Allows the court to appoint a deputy to act and make decisions on behalf of a person who lacks mental capacity.

4. Allows parents of offspring with intellectual disabilities who are below the age of 21 years of age to apply to the court to appoint a deputy to ensure that their child's future care is arranged if the parents pass away or lose their mental capacity.

5. Gives legal protection for acts done, by caregivers of a person who lacks mental capacity, are done in the best interests of that person being cared for.

6. Creates a new office called the Public Guardian whose functions include maintaining a register of LPAs and a register of court orders appointing deputies, supervising deputies and dealing with allegations of abuse by donees and deputies.

7. Provides safeguards to protect persons lacking capacity through empowering the Public Guardian with supervisory and investigative powers. The Act makes ill-treatment of persons who lack capacity by caregivers and decision-makers a criminal offence.

There are built in prohibitions on certain decisions from being made on behalf of a person who lacks capacity. For example consenting to marriage and adopting or renouncing a religion and other listed decisions.

These are indeed relevant issues that need to be tackled on an urgent basis, but lets look a little closer, take the hypothetical example of Mdm SS:

SS is a 66-year-old divorcee who lives alone in a walk-up apartment. Her children were tragically killed in a road traffic accident six months ago. SS used to be active in the community, taking part in local activities and volunteering at Resident Committee activities. Since the accident, she does not speak to anyone and points at items in the market to purchase them. Her friends and neighbours are very concerned about her.

Is Mdm SS suffering from dementia with diminished mental capacity or is she merely psychologically depressed? Has she suffered a mild stroke in her grieve that has rendered her with a speech or language disability, but still able to decide with clarity? A detailed biopsychosocial assessment by a trained professional with reasonably standardized elements is obviously required. The quintessential question to be answered is has she lost her mental capacity to make decisions in her context? Who should assess if she has lost her mental capacity, and what if she refused formal assessment? Without a proper assessment, dementia does seem like a possible differential diagnosis. But again, has the mental state deteriorated to the extent where decisions need to be made on her behalf? She might not be able to make some decisions, but are there some decisions that she could make on her own? Does making an unwise decision mean that the person is mentally incapacitated? There are many ethical questions to be answered and all has to be addressed in the proposed draft bill.

What is the significance of the Mental Capacity Act that requires the attention of the Family Medicine fraternity? The GP, who has a sound long-term professional relationship with his patient and his family in the context of the community, in which the patient is functioning, is most qualified to assess people with such needs. Our knowledge, skills and attitude on mental state examinations and assessments is a valuable asset for straight forward cases, but other input and further training is required for more complex cases as well as for calibration of standards. Under the proposed Mental Capacity Act, formal assessments can only be performed by accredited GPs who have been specially trained to conduct mental capacity assessments and specialists in mental health, such as psychiatrists. The College with other authorities and bodies has been looking into various aspects of the training and accreditation process.

Understandably, the Family Medicine fraternity views these potential new responsibilities with suspicion, due to past experience with the courts and other authorities especially on the issue of statutory examinations. As a fraternity, we need to safeguard our interest as we endeavour to do what is required of us. Politics and crushed egos aside, there is a pressing need for community based primary care physicians to step up and take on the responsibilities that we have been called to. We can deal with the issues along the way, and it is in acting honourably that we shall take back the respect due to us. This might be a good opportunity for GPs to continue to widen our skills and at the same time take the initiative to continue in narrowing the rift that has formed from past injustices.

"Does making an unwise decision mean that the person is mentally incapacitated?"

Definitions

Lasting Power of Attorney (LPA)
A legal document that a person (donor) signs which allows him to choose one or more persons called donees to make decisions about his personal welfare and/or property and affairs on his behalf when he lacks mental capacity. Anyone above 21 years old can be a donee except an undischarged bankrupt

Deputy
A deputy is a person appointed by the court to make certain decisions on behalf of a person who lacks mental capacity when the person has not made an LPA or has no donee to decide on his behalf in respect of those decisions.

Best Interests
Decision-makers have a duty to consider many factors, which focuses on what is best for the person lacking capacity.

References

1. Draft: Code of Practice Mental Capacity Act 2008, 20 April 2009.
2. Selina Lum, Woman's 8.8M Frozen, The Straits Times, 20 November 2008 http://www.straitstimes.com/Breaking%2BNews/Singapore/Story/STIStory_304699.html (Last accessed 22/5/2009)

CM

Developing An **Undefeated Mind**

Tools for Mental Resilience

by A/Prof Cheong Pak Yean & A/Prof Goh Lee Gan

CM invited A/Profs Goh & Cheong to contribute a report of the lunch-time symposium of the above title that was held on 30th April 2009 in the National University of Singapore (NUS). Mental resilience is important in this challenging time when the threat of a novel flu pandemic looms during this economic downturn. The two professors have spoken on a topic of practical interest.

The NUS Lunchtime Symposium series is organized by the Development Office & Department of Psychological Medicine of the National University of Singapore (NUS) Video recordings of the seminar are now published by NUS on-line in Youtube. Readers may listen to the talks via the computer links listed at the end of this article or via the links returned by searching within Youtube using the speakers' names as keywords. As the slides referred to in the talks are not included in the Youtube video clips, a selection of the key ones are included in this report.

Introduction

Do you have an undefeated mind? The acid test of the undefeated mind is this - at the moment of truth is there personal resilience? Personal resilience has been defined as 'the capacity to cope with adversity and to avoid breakdown when confronted by stressors' (Couser, 2008; M Rutter, 1985) - failure or loss, threat or real. The non-fall doll is the essence of personal resilience - as defined by Sir Michael Rutter.

One proposed model to develop personal resilience is to develop our centering skills and balancing it with the 3Ps (Fig. 1) namely, working on the patterns, problems and psychological processes of our mind. In that way, we can quickly centre ourselves when we get out of balance or out of centre as the result of stressors in life. This unified model is put together from the various established schools of psychological therapy by Prof Kua Ee Heok, Prof Frank Voon, Wee Sin Tho, Vice-President of development of NUS and both the speakers.

Centering

Centering is a term that "refers to a series of processes that strive simultaneously to increase an awareness of the body center and to promote the discovery of the true self that is beyond the mask of ego". Centering is the "integration of body, mind, and spirit into a harmonious whole." (Banet, 1980, p. 175). Centering skills include relaxation, imagery, meditation, and the tenets of positive mental health and psychology.

The image of centering comes from pottery. It has been described as "that act which precedes all others on the potter's wheel i.e. the bringing of the clay into a spinning, un-wobbling pivot, which will then be free to take innumerable shapes as potter and clay press against each other." (Richards, 1962, p. 9) Centering in pottery is often described as the most difficult and crucial step in the art.

As in pottery, centering is an excellent image to use for the process individuals use to find balance in their lives; to integrate what is within them in their work and to help them direct their energy effectively to allow their work to take the shape they want.

To develop the high end centering skills, there are three areas to consider namely,
1. Exposure to destabilizing forces;
2. Positive mental health development; and
3. Positive psychology development

Just as physiological systems in the body are constantly kept in homeostatic balance, the processes of the mental milieu must also be ordered to create an orderly reference point- a metaphorical center to create the sense of reality, self, valueing and agency. Besides physical and positive mental centering processes, three types of psychological work viz. pattern, problem and process work to be described can be used to anchor the mind and to center it when it is thrown out of balance. Exposure to minor changes and resulting righting reactions help create mental resilience against major destabilizing forces.

Positive mental health is having emotional well-being, psychological well-being, and social well being. The presence can be measured by agreement to statements that reflect well-being viz.

- o **Emotional well-being** -"I am satisfied with life"
- o **Psychological well-being** -"I have direction & meaning"
- o **Social well-being** -"We are in it together"

Positive psychology is living the 3 lives of happiness - the pleasant life, the engaged life and the meaningful life. The attributes are reflected in the following statements viz.

- o **The pleasant life** - I give thanks each day for the nice things in my life."
- o **The engaged life** - I contribute to make things happen"; "Count on me"; "I use my signature strengths for the good of others."
- o **The meaningful life** - I am glad I can contribute"; "I find fulfillment."

We invite you to make a start. Everything that we do starts with a thought. For those who have started, we encourage you to reflect on moving towards positive mental health by counting the positive things in your life and be mentally well - emotionally, psychologically and socially. Positive mental health is not difficult to achieve.

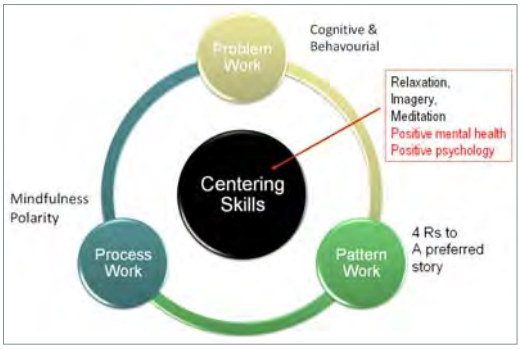


Fig. 1: Model to Develop Mental Resilience

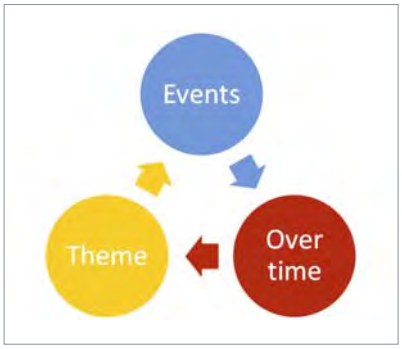


Fig. 2: How life stories (narratives) are created

Fig. 3: Positive (Bright Stars) & Negative (Dark Holes) Life Events

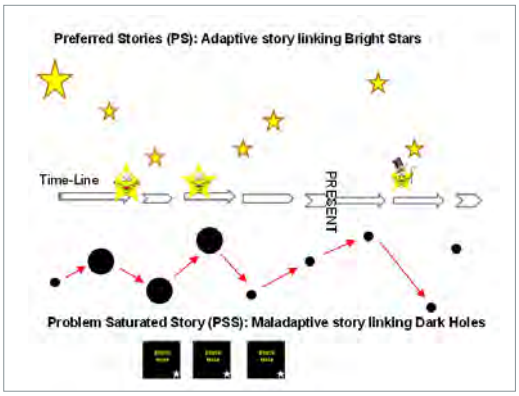
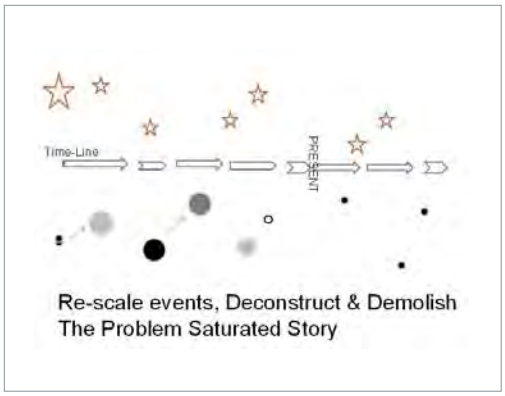


Fig. 4: Re-scale events, Deconstruct & Demolish The Problem Saturated Story



We can also make a start towards positive psychology by being happy. Each day we can choose to be pleasant, be engaged, and do meaningful things. You may wish to consider being part of the campus mental health network to develop undefeated minds.

Pattern Work

What is pattern work? It is about working on the many unique stories that we each defined ourselves with - happy stories, sad stories; big stories, small stories; stories we project to our friends and other stories we share with our loved ones (Fig. 2)? Pattern of life can also be termed life narrative or schema.

Each of our stories is derived from salient events that happened in our life. These stories we tell ourselves in self-talk and to others, define who we are and influence how we feel, act and react to past, present and even future events. How are these stories created? A story has 3 defining features - viz an account of unfolding events, that occurred over time and all linked with a theme that convey meaning, motive, causality.

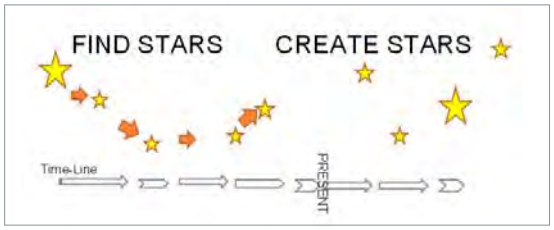
Besides routine events, many salient events do happen in each of our life. If we represent perceived 'good events' as stars and 'bad events' as black holes in a time-line of our life, we would indeed get a very messy and busy picture (Fig. 3), as is life. Positive and negative events do occur all the time. Rick Warren, the author of Purpose Driven Life said in an interview with Paul Bradshaw 2009 "Rather than life being hills and valleys, I believe that it's kind of like 2 rails on a railway track, and at all times you have something good and something bad in your life'.

Negative life events however stand out more to many of us because they are emotionally laden with pain. Perhaps it is evolutionally protective as in the saying 'the burned child fears the fire'. We do learn life lessons from it. However, certain negative stories become so dominant that it adversely affect our present and future life. These stories are called 'Problem Saturated Stories' or PSS (Fig. 3). The stars that also existed were ignored. The PSS is often triggered inappropriately and has a life of its own, taking up materials on its way.

The challenge now is to look at these dark holes to rescale them - some are actually not so black, and some only appear to be black; to deconstruct the links and; demolish the negative story (Fig. 4).

The next task is to search for over-looked stars that have been missed in the past (Fig. 5) - not from a point of regret, but from a point of learning. These stars will be the materials you can use to

Fig. 5: Find Stars - Create Stars to construct the preferred story



create a preferred story of the past. Psychotherapists term this exercise as eliciting exceptions - when the bad outcome did not ensue even when the antecedent situations or circumstances are the same. The 'Miracle Question' can also be used to evoke imagery in a leap of faith to imagine that all the problematic issues and mental state suddenly disappear.

Lessons can also be drawn from the validated interventions from positive psychology viz.

- **Good things:** Write down each day '3 good things in life'- things that went well for day. This talk may be one of them.
- **Thanksgiving:** Make a gratitude visit/exercise and practice thanksgiving. Thank your colleague for favour he extends to you.
- **Visible positive responding:** Start by thanking the lady who serves you tea this afternoon.
- **Signature strength:** Think of one of your strength and how to use it in a new way. Remember a time when you were at your best and reflect on your strength at that particular time. Identify your signature strength and start using it in a new way.

('Positive Psychology Progress: Empirical Validation of Interventions' Seligman et al 2005 American Psychologist)

These exercises create a swell of positive feelings and help create a positive story for you and also for others. Using these positive stars as psychological materials, we can then begin the PATTERN work which can easily be remember as the 4 Rs. Re-author, Re-member, Re-frame, and Re-tell (Fig. 6).

1. Re-author

Author the Preferred Story from the multi-stories of your life with **author**-ity.

- Identify problem saturated story
- Externalise DARK HOLES and demolish negative theme
- Identify overlooked STARS
- Find positive theme linking STARS
- Celebrate the Preferred Story

2. Re-member

These are the steps to Re-member the people or things in your "Club of Life":

- o Identify someone or something (the old member) that caused the pain, distress, dark holes (in the past) and still affecting you.
- o Examine how it continues to enslave you and how it continues to cause the distress now.
- o Moving to "REMOVE" the member from your present "Club of Life".
- o Re-membering the persons or things in your present "Club" for the preferred story of the present and future.

3. Re-frame

George Lakoff, professor of linguistic at UCB University of California at Berkeley, wrote in his book 'Metaphor We Live By' that "Metaphor is not an ornamental flourish of language but an essential part of thought. Our ordinary conceptual system, in terms of which we both think and act, is fundamentally metaphorical in nature."

Reframing is illustrated visually by this bistable picture (Fig. 7). What do you see? A vase or the silhouettes of two persons? The mental exercise illustrates cognitive reframing of a bistable picture as in cognitively reframing themes. A clinical case can illustrate the act of reframing. A student presented to me as her world was in shambles. Her parents were on the verge of divorce and she was failing all her examinations. I found out that she saw herself as the GLUE of the family and tried frantically to keep her parents together. The GLUE metaphor was dysfunctional, as she felt stuck in the fray. She was worried that if her parents divorce, it would be her fault as the GLUE failed. I helped her to reframe her role from GLUE to OIL - The oil that lubricate the family wheels and yet not enmeshed and totally responsible for the outcome.

4. Re-tell

We have to work to Tell, Retell, Tell, Retell. Re-telling stories integrate thoughts, emotions and actions until the Preferred Positive Story lives (Fig. 8).

Problem Work

A SITUATION is a situation. It is the cognitive perception of the situation that creates emotions, behaviour, and thoughts (Fig. 9). At times, negative automatic thoughts (NATs), which are not conscious at the time of reaction are responsible for maladaptive responses. NATs are produced by cognitive distortions that habitually cause problems. The aim is to work to defeat these thoughts by the mental discipline of thought testing. This is illustrated by the following example.

Situation:
I greeted my boss this morning and he just walked past me as if I did not exist.
Consequence:
I felt lousy and angry.
Reflection:
What was in my mind when I felt that? Automatic Negative thoughts - He did it on purpose to belittle me. (Cognitive distortion of emotional reasoning)
Evidence for the thought being true:
He dislikes me. He thinks I am not up to mark.
Evidence for thought being untrue or not totally true:
I just saw him in this audience and he would not be here if he thinks so poorly of me.
Alternative explanations for situation:
Maybe he just was too absorbed in his thoughts this morning. Maybe he quarreled with his wife last night.
Outcome:
If I always think negatively, then I would feel bad for nothing (like this morning) and my relationship with my boss would never improve.
Action:
After this talk, I am going down to thank him for coming to listen to me and improve my relationship with him.

To sum up the case example, PROBLEM work is Cognitive Behaviour Therapy (CBT) which include the following steps:

- o Reflect on problem emotions/behaviour.
- o Identify negative habitual/automatic thoughts to situation.
- o Thought testing: evidences for thought being true and untrue.
- o Examine alternative explanations for situation.
- o Outcome scenarios for habitual cognitive distortions.
- o Action that can be taken to overcome the negative thoughts.

Process Work

Process work involves Mindfulness and Managing Polarities. Mindfulness is the ability to focus our attention in the here-and-now, free from the tyranny of the past or anxiety for

Fig. 6: Pattern Work for Preferred Stories

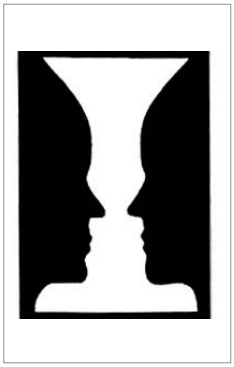


Fig. 7: The bistable picture

Fig. 8: Re-tell to thicken preferred story

Fig. 9: Problem Work - Situation triggered emotions, behaviour, and thoughts

the future. Some examples of exercises that center our mind are:

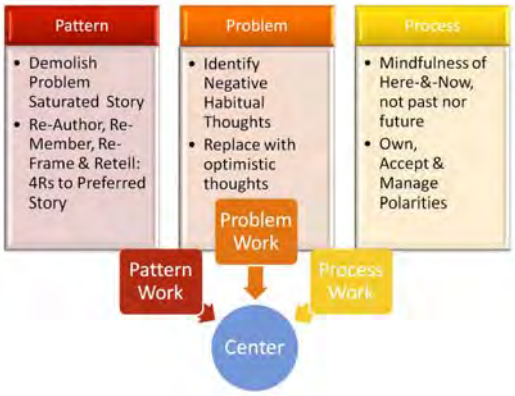
- o Movement: Breathing exercise, tai-chi
- o Balance: Muscle relaxation, Meditation, quiet time
- o Engagement in work, intimate relations or leisure
- o Time flows. Self is lost in the present.

Managing polarities is the process of discovering, owning and managing the disparate even antithetical parts of self. We all have psychological polarities. We may generally be kind but there may be a part of us that is cruel. Knowing, understanding and managing these polarities are important for psychological balance.

Conclusion

We can work to psychologically center ourselves by engaging in positive centering exercises as well as working on the patterns, problems and psychological processes of life.

CM



Internet Resources

NUS Youtube video clips

Centering by A/Prof Goh:
http://www.youtube.com/watch?v=hxFpTu-cwS8
The 3 Ps by A/Prof Cheong:
http://www.youtube.com/watch?v=p15ZKwKUPUs
Role Play:
http://www.youtube.com/watch?v=NM_PU39Hp00

Pattern Work

Narrative Therapy:
http://www.dulwichcentre.com.au
Solution Focused Brief Therapy:
http://www.sfbta.org

Problem Work

Beck Institute for Cognitive Therapy:
www.beckinstitute.org
Schema Therapy:
www.schematherapy.com

Common Words Doctors not Uncommonly Mispronounce!

by Dr Gabriel Seow, FCFP(S), Editorial Board Member

I can never forget that day when my pathology tutor asked for the name of the diagnostic test for tuberculosis and I proudly answered "I know, sir: It's the Mann-Tocks test". "I don't know what that is but I know one thing: Mantoux will most certainly turn in his grave!" he mused. I remember dying and wondering why the French never learnt to spell... And remember the good ol' PAS test for glycogen is per-iodic acid-Schiff & not periodic acid-Schiff? It gave many a hearty chortle at my expense.

Anyway, not being a phoneticist, I'm in no position to correct anyone's pronunciations. However, in the course of listening to so many talks, I've observed that there are favorite terms (medical and otherwise) which appear problematic and trip up the best of us. Here's a sample list:

(Just for the fun of it, you may wish to cover the leftmost column and test (and enjoy!)yourself. No CME point for this one though!)

The Word	Commonly pronounced	Correct pronunciation
Acumen	AK-yoo mən	əKYOOmən
Bacillus	BA-silus	bə SILəs
Chiropodist	KYE-rɒpədist	Ki ROPədist
cerumen	SAIR-roomən	si ROOmən
cephalic	KEFəlic / SEFəlic	sə FALik
-cephalo-	-keFALo- / -seFALo-	-SEF əlo-
corpuscle	kor PUS əl	KOR pə səl
chimera	kyMAIR ra / chim MAIR ra	ki MEER ə
dyspnea	DIP sneer	disp NEE ə
gonorrhea	gon NOOREa / GONəREEə	gon ə REE ə
Mittelschmerz	mittle SMERz	MIT tel shmehrTZ
marche a petit pas	(whatever you can think of)	marsh ah pətee pah
neologism	NEO lo jizəm / neoloJIZəm	nee OL ə jizəm
organism	or GANizəm	OR' gə NIZəm
opH-thalmology	OP tell mol ə jee	OF thəl MOL' ə jee
paroxysm	pair ROK siz əm	PAR' ək SIZ əm
papilloedema	PAP pilo edema	PAPleeDEEMə
purulent	pye RUL ant	PYUUR ə lant
quiescent	KWYE e sent	kwee ES ənt
respite	ree SPYTE	RES pit
reciprocal	REH see pro cal	ri SIP rəkəl
torsades de pointes	(whatever you can think of)	tor SAHD də pwahnt
umbilicus	um be LYE kes	um BIL i kəs
vertigo/vertiginous	vur TYE goh/ VUR ti jin es	VUR' ti GOH/ vur TIJ ə nəs
Behçet's		BAY setz
Gilbert's		zhel BAIRz
Guillian-Barrè		gə YAN- bar RAY
Roentgen		RENT gen
Virchow		FIR ko

Getting to Know the New Editor

Dr Wilson Eu

CM: Tell us something about yourselves.

Dr Wilson Eu: I came to Singapore in 1993, did my undergraduate degree in Melbourne, married in 1996 and have 2 kids. That sums up the major milestones in my life thus far. I practice in the eastern suburbs of Singapore. We started the clinic in 1999.

CM: Are there any significant role models that have made an impacted on your life as a doctor?

Dr Wilson Eu: I think my father who is a retired social worker and lay preacher continues to have a significant impact. His persona is that of the traditional father - strict,serious, no nonsense. Yet I have seen him counsel people who were grieving or been abused or sick over the years. I never underestimate the power of a kind word or emphatic gesture. Hope is a powerful tool. The second person who has influenced me is my landlady whom I stayed with during my undergraduate days. She taught me not to be insular in my world view and be more tolerant and kind.

CM: If there is one thing you want to change in family medicine, what would it be?

Dr Wilson Eu: I feel that there is a 'disconnect' between those in private GP practice and those who are in the hospitals and administration. In Singapore, GPs in private practice are free to practice will relatively minimal interrogation and intervention. This has been positive as it gives us great latitude. However, the flip side is that the GP land scape becomes very diverse and fragmented with everyone doing what they think they are good in, building a niche. There is often a lack of incentive to invest time and and effort to build up further capabilities and capacity, as short term returns often take precedence over long term potential deficits. Overtime, getting GPs to talk amongst themselves becomes more difficult and, for GPs to come together as a body to engage with administrators even more challenging.

There is an article in a past issue of the College Mirror by Dr Tan Yew Seng (Vol 30 No 3, 2004 available on-line at College website) which I find illuminating. Dr Tan uses the analogy of the 'neglected child' to help describe some of the shortcomings and (mal-adaptive) responses.

A great deal has changed in the last ten years and Family medicine in Singapore has taken giant steps viz. GDFM, MMed, FCFM and setting up of hospital FM departments; more funding for patient care in private practice through various initiatives like Medisave use in CDMP. These are big changes that our present leaders have promulgated. I hope that more in the medical fraternity would realise that we are moving on, that we have jettisoned the unhelpful behaviors and mindsets and are focusing on being better doctors to our patients; and in a broader context our patients could see this too. So, I wish a deeper conversation can occur between all of us whose job it is to help our patients look after their health.

CM: Do you think that GPs should take up the GDFM? Why is it important for GPs to constantly upgrade our training?

Dr Wilson Eu: For the first question, you are speaking to a convert, so, yes GDFM is a very important first step. I also feel it is more than just keeping current as far as knowledge is concerned. When I took up GDFM, the part that I found more interesting was the monthly tutorials. Here one gets to talk to fellow practitioners at different levels of seniority/experience and how each would apply the knowledge. Translating book knowledge to practice, how to make the 'guidelines' real in Singapore is what I found most rewarding.

"More and more diseases will be managed outside of the traditional institutions and so the pie will grow if we are ready to partake in it."

Family Practice Skills Course #31

Allergy in Respiratory Airway Disease

The College of Family Physicians Singapore would like to thank **AstraZeneca** and the Expert Panel for their contributions to the College on the Family Practice Skills Course held on 6-7 June 2009.

EXPERT PANEL:

Prof Lim Tow Keang, Chair - Workgroup, Singapore National Asthma Program, Head - Respiratory & Critical Care Medicine, NUHS

Dr Lee Pyng, Sr Consultant, Dept of Respiratory & Critical Care Medicine, Singapore General Hospital

Prof Hugo van Bever, Head, Paediatric Allergy, Immunology & Rheumatology Services, Dept of Paediatrics, NUHS

A/Prof Christopher Goh, Head & Sr Consultant, Dept of Otolaryngology, Singapore General Hospital

Dr Tan Keng Leong, Sr Consultant, Dept of Respiratory & Critical Care Medicine, and Director, Allergy Clinic, Singapore General Hospital

Clin A/Prof John Abisheganaden, Sr Consultant, Dept of Respiratory Medicine, Tan Tock Seng Hospital

Sr Nora Bte Said, Asthma Care Nurse, National University Hospital

Chairpersons: **Dr Charity Low, Dr Chow Mun Hong**

CM: What in your opinion is the next 10 years of Family Medicine going to be like?

Dr Wilson Eu: I think we are really looking at very exciting times ahead. More and more diseases will be managed outside of the traditional institutions and so the pie will grow if we are ready to partake in it- Management of lifestyle risk behaviours, counselling for genetic risks, palliative care are some examples. We all need to look at our present situation, the present work processes, business and subvention models to make sure that we can be a participant and not merely a spectator when these opportunities come.

CM: What needs to be done to keep the College Mirror relevant to its readers?

Dr Wilson Eu: I hope more private GPs will take some time to think through the challenges and blessings that they have gone through and come forward to contribute in whatever way they can to the life and workings of the College. The College Mirror is one such avenue. The College Mirror will remain relevant so long the members come forward with their point of view. CM

Family Practice Skills Course #32

Mental Capacity Act

26 & 27 September 2009 | 2.00pm - 6.45pm

Singapore Management University

Ngee Ann Kongsi Auditorium Lvl 2

School of Accountancy, 60 Stamford Road, Singapore 178900

Unit 1: **Overview of Mental Capacity Act**
Unit 2: **Mental Capacity Act's Legal Implications**
Unit 3: **Code of Practice - Implications for General Practitioners**
Unit 4: **Mental Capacity in Financial Matters**
Unit 5: **Psychiatry and Geriatrics**
Unit 6: **The Ethical Issues**

SPEAKERS

Prof Kua Ee Heok, Professor and Senior Consultant Psychiatrist, Dept of Psychological Medicine, National University Health System

A/Prof Chin Jing Jih, Senior Consultant, Dept of Geriatric Medicine, Tan Tock Seng Hospital

Ms Sumytra Menon, Legal Analysis, Wrtg & Res Instructor, Faculty of Law, National University of Singapore

Mr Lek Siang Pheng, Partner, Rodyk & Davidson LLP's Litigation & Arbitration Practice Group, Honorary Legal Advisor, College of Family Physicians Singapore

Ms Cynthia Chan, Assistant Director, Office of the Public Guardian

☐ SEMINARS

(2 Core FM CME Points for each seminar)
Seminar 1 • Unit 1-3: Sat, 26 Sept 2009 (2.00pm - 4.15pm)
Seminar 2 • Unit 4-6: Sun, 27 Sept 2009 (2.00pm - 4.15pm)

☐ WORKSHOP (2 Core FM CME Points)

Workshops:
Sat, 26 Sept 2009 (4.30pm - 6.45pm)
Sun, 27 Sept 2009 (4.30pm - 6.45pm)
Part 1 • Case Studies & Skills 1-2
Part 2 • Assessment for Accreditation

*Registration of workshop is on first come first served basis. Seats are limited. Please register by 20 Sept 2009 to avoid disappointment.

☐ DISTANCE LEARNING MODULE

(6 Core FM CME Points upon completing the MCQ Assessment)
• Read 6 Units of study materials in the Singapore Family Physician Journal and pass the MCQ Assessment.

This Family Practice Skills Course is conducted jointly by the College of Family Physicians Singapore and **Ministry of Community Development, Youth and Sports (MCYS)**

MCYS
Ministry of Community Development, Youth and Sports

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FREE REGISTRATION for College Members!

MENTAL CAPACITY ACT

Please tick (✓) the appropriate boxes

	College Member	Non Member
Seminars (26-27 Sep) & Workshops (26-27 Sep)	☐ FREE	☐ $ 120.00
Assessment Fee	☐ $ 20.00	☐ $ 20.00
Distance Learning (Journal)	☐ FREE	☐ $ 40.00
TOTAL		

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

Cheque number: _____

Signature: _____

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

Name: Dr _____

MCR No: _____

(For GDFM Trainee only) *Please indicate:* ○ 2007 Intake ○ 2008 Intake

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

_____

_____

_____ **E-mail:** _____

Tel: _____ **Fax:** _____

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

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

Or fax your registration form to: **6222 0204**