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Establishing a Register of Family Physicians

by Dr Wong Tien Hua, MCFP(S), Editor

The Medical Registration Act (MRA) governs the registration of medical practitioners and regulates the conduct and ethics of doctors in Singapore. It was last amended in December 2002. Since then, new issues in professional conduct and standards of healthcare have arisen. The Ministry of Health (MOH) and the Singapore Medical Council (SMC) proposed some amendments to the MRA to ensure that the MRA is relevant to new developments in the practice of medicine.

A 6-week public consultation was conducted from 14 January to 25 February 2009.

One of the proposed key revisions was to establish a Register of Family Physicians, along with the setting up of a Family Physicians Accreditation Board.

By establishing the register, MOH hopes that more doctors will be encouraged to voluntarily upgrade themselves so as to be recognised and be included in the list. This will have the effect of raising the overall standard in primary healthcare. The move is seen to be timely as more doctors have now been trained in Family Medicine and a register will recognise these doctors for their additional skills and knowledge as Family Physicians (FP).

The idea of a FP register is not new. The first public consultation on the establishment of FP register was conducted in 2005. For this current proposal, it was specified that Family Physician Registration will not be a prerequisite for the issuance of medical clinic licences under the Private Hospitals and Medical Clinics (PHMC) Act.

The FP register put simply, is a list of General Practitioners (GP) who have met a defined minimum standard of competence, be it in experience or training. How will this serve to raise the standard of Family Medicine in Singapore, and in so doing, serve the public by protecting its health and improving its safety?

In the past, any doctor with a basic degree could set up a private clinic and start his practice. There was very little post graduate training in Family Medicine and not much recognition for GPs within the medical profession. Family Medicine was itself not well defined. Over the past few decades, Family Medicine is being increasingly recognised and well established. This movement was led by the United

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Tough Times are Here Again

by Dr Wong Tien Hua, MCFP(S), Editor

If you haven't already noticed, there is now a persistent and pervasive atmosphere of doom and gloom in Singapore, and the haze is not even here yet. Everyday we hear news of job cuts, belt tightening and pleas for more handouts. Another alarming trend is the increasing number of high profile thefts, white collar crime, and the number of people being scammed by well dressed businessmen (no, I'm not talking about the bankers). Certainly when funding is in short supply, such scams will inevitably surface because they operate on the basis of easy access to excess cash. If the Pollutant Standards Index keeps track of the haze, perhaps a Ponzi Scam Index may be a good measure of the thickness of the financial conflagration engulfing the nation.



will no doubt be more cases of stress related illnesses, deferment of chronic treatment due to financial difficulty, and family and social tensions that underpin the hidden agenda in each patient's visit. As caring and empathetic doctors in the front line of this crisis, I am sure many of us will not hesitate to extend a hand of help; many of us may waive our consultations to help the needy or allow patients to repay their debts later, when they are in a better financial state.

Which brings me back to a discussion I overheard recently when someone quipped, "It's a good time to be a doctor again". Many of us may share this feeling. It was less than a year ago when property prices were at such stratospheric levels that buying a landed property might as well be on the moon. Stories of quick and easy money at the stock markets, fat cat bonuses, and flashy cars in the streets, left many GPs feeling a bit left out of the game. There we were, doing good work and trying hard to make ends meet. Income was steady but no one was going to offer us a 12-month bonus at the end of the year. Many of us were wondering if it was even worthwhile being a GP. The core competencies of the family physician in managing chronic diseases and practicing community based medicine were under assault from the generous profits promised by switching to aesthetic procedures.

Today, the global market is suddenly very different. For those of us who had been prudent and living wisely, healthcare is still a relatively stable industry. GPs who had been earning a decent and steady stream of income now see abundant investment opportunities. But we must also not forget the support that our patients gave us during our difficult times as well (the 2003 SARS epidemic comes to mind). During such tough times, there

Will the GP market be affected by the financial crisis? The answer is undoubtedly a yes. However Dr Loke Wai Chiong's timely article (p12) shows that healthcare seems to be the best place to be to weather the storms. The important thing we must all do now is to develop a clear strategy for the way forward. Now is the time to cut down wasteful practices and procedures, now is the time to retain our best staff and invest in team building, and now is also the best time to increase our own professional standards and training. After all, diseases and illnesses are independent of financial cycles.

Mental Capacity

An interesting case was reported in the press recently (The Straits Times, Thu 11/12/2008, page B6). A 92 year old woman had sued her local bank for freezing her account of \$8.9M. The case came about because the bank had doubts about her mental capacity and had refused her access to her own money. The woman had gone to the bank earlier to open a joint account together with her 43 year old daughter. The bank had sufficient doubts to deny that request and they also denied a subsequent request when the two women wanted to close their account. According to the bank, they had good reasons to believe that the account holder was not mentally capable of handling her finances. The bank said that it was acting prudently to protect the woman's best interests.

The woman and her daughter are now suing the bank to have her locked funds released, but before so doing the court has ordered her to undergo an

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independent psychiatric test to assess her mental capacity.

Why is this case of interest to the General Practitioner? Picture this, in the near future, your patients may come to you to have their mental capacity assessed before they are deemed suitable to make decisions on a variety of legal transactions. These include opening, closing and operating bank accounts, dealing in

The Mental Capacity Act enables Singaporeans to make advanced plans for themselves in the event that they lose mental capacity. It also sets out a code of practice to provide guidance to caregivers and doctors on how to make decisions on behalf of patients who lose mental capacity.

Feelings amongst GPs will undoubtedly be mixed. On the one hand many will dread the additional burden of responsibility that the GP has now to shoulder. Such assessments carry legal implications and no GP in his right mind would fancy being hauled to court to stand up and be cross examined as to whether his decision about his patient's

assessment form will minimise this uncertainty. Borderline and difficult cases can be referred for specialist opinion.

On the other hand, many GPs will also welcome this additional role that has been bestowed on the Family Physician. If you think about it, who is in a better position to determine the mental capacity of the patient? The GP who has intimate knowledge of his patients and who follows them up through a period of many years, or a psychiatrist who often can only depend on a few hours of interview and interaction? But the point is, GPs are encouraged to sign on to this scheme on an entirely voluntary basis. You don't have to do it if you don't want to. At the very least, you should understand the new Act and its implications as it affects every one.

The College together with the support of the Ministry of Community Development, Youth, and Sports (MCYS) will be organising the Family Practice Skills Course on Mental Capacity in July 2009. CFPS and MCYS hopes to see a strong show of support from the primary healthcare community, and hopes that many GPs will take the assessment test to be part of the approved panel of assessors. ■CM

Woman, 92, ordered to take mental test

She challenged bank's call to assess her ability to handle \$8.9m account

By SELINA LUM

A 92-YEAR-OLD woman who sued OCBC Bank for freezing her \$8.9 million account has been ordered by the High Court to undergo an independent psychi-

Last month, a lower court granted OCBC's application for Madam Hwang to be examined by an independent psychiatrist to evaluate whether she was mentally fit to handle her finances. Madam Hwang then challenged

On Tuesday, Justice Tan Lee Meng dismissed her appeal on the summary judgment issue. Her lawyer Andrew Ee then withdrew the appeal against the issue of appointing a psychiatrist.

At the hearing, OCBC's lawyer questioned if Madam Hwang was the one driving the lawsuit.

Why is she vigorously resisting being examined by a court-appointed expert if she is indeed mentally fit to handle her financial affairs, asked Mr Adrian Wong.

investment products, buying and selling of property, and any business transactions where their decision making processes may be questioned in a future date.

All these will be specified in the Mental Capacity Act, a new law which will come into effect from the second half of this year.

mental capacity was made rightly or wrongly. Such fears are understandable but illogical. As it is, the GP is already responsible for all those professional decisions that he makes on a daily basis. On face value, the process of assessment of mental capacity sounds difficult and subjective, so hopefully the design of the

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Family Medicine Training for New and Existing Careers

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

In this issue of the College Mirror, the focus is on family medicine training and careers in family medicine.

Existing careers

First, what about existing careers? This refers to family medicine in the community. We have our frontline force of family doctors in the private clinics and in the Polyclinics. What vocational training is needed? The patient into the future will be clearly more educated, more knowledgeable about his or her medical problems, and also the options for dealing with the problems. So, the family doctor sitting in the consultation room will definitely be more prepared and confident if he or she has gone through a vocational training programme in family medicine either at the graduate diploma level namely the Graduate Diploma in Family Medicine or the masters level namely the MMed (Family Medicine).

Then there is a small band of family doctors who will grow in numbers into the future to man the community hospitals, rehabilitation centres, and palliative care. There is much meaningful work being done in caring for such patients.

New careers

What are new careers in Family Medicine? There are now careers for family physicians in the hospital where the scope of work is to provide the interface care and to connect the patient across different providers and also to right site the patient. This kind of work is described in the setting of the Division of Family Medicine in NUHS in this issue. Another hospital with a department doing this nature of work is the Department of Family Medicine and Continuing Care (FMCC) in Singapore General Hospital.

Training routes

There are also different routes of progression of the MMed(Family Medicine). First there is the "through train" programme; a family medicine training scheme for medical officers working in restructured hospitals where the three year programme is made up of two years of hospital rotation postings and one year in primary care setting. For those who have the GDFM, the next step will be the one year Programme B training to attain the MMed(Family Medicine). There is now a third route that will be

made available shortly, consisting of 18-month programme for doctors with several years of hospital experience. These doctors would soon be able to sign up for a Programme C training to go through a 12-month structured teaching programme involving big group and small group learning, as well as a 6-month posting in primary care. Find out more at the lunch time seminar on Family Medicine Careers that will happen on 4 April 2009. **ICM**

“There is now a third route that will be made available shortly, consisting of a 18-month programme for doctors with several years of hospital experience.”

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Kingdom and USA. There are now many post graduate courses available both in Singapore and overseas for the Family Physician to improve his or her professional skills. The College has been offering its GDFM and MMed(FM) courses for some years, and there is now an ever increasing group of Family Physicians with advanced training.

A better trained FP such as these are better equipped to handle not only more complex problems such as those with chronic diseases, but is also trained to recognise other factors at play that may affect the patient's overall health. The FP is able to treat his patients based on his intimate knowledge of the patient's illness in the context of his social, occupational and psychological background.

Does our healthcare system really need a register of Family Physicians in order to incentivise doctors to be better trained and more qualified? By separating the FP register from clinic license requirements; its legal edge has been removed. Whereas the previous proposal would see a massive surge in FP registration, as one would need it in order to open a medical clinic, the new proposal now is based on a purely voluntary scheme to encourage GPs to go for further training. This is both a laudable and a welcome relief.

GPs do not need any more barriers in order to set up practice. The FP register also recognises experienced GPs who had been practicing independently for a number of years. These doctors do not need to have the GDFM to qualify; they only need to go through the accredited modular course in order to be included in the FP register.

The question now would be whether there is any incentive for a GP to be included in the register. A GP who has been practicing for many years and who has gathered his own pool of loyal patients may not see the need to obtain a paper qualification. Being listed on the register could reassure his patients that he is keeping up to date, but the GP may see little else of immediate benefit. Being

A better trained FP such as these are better equipped to handle not only more complex problems such as those with chronic diseases, but is also trained to recognise other factors at play that may affect the patient's overall health.



on the register does not guarantee more patients, it does not entitle him to extra funding, and it does not allow him to charge a higher fee.

There may therefore be a risk of creating two groups of doctors, one so called "better trained" group of Family Physicians, and another group who may not have the necessary qualifications, but will have the advantage of years of clinical practice experience. This scenario is a possibility if not enough GPs are convinced of the benefits of the FP register and not enough sign up in the first wave of registrants. The other consideration is whether being listed on the FP register matters at all to patients (see following article). Patients traditionally visit their GPs based on

convenience and familiarity. Not many patients may take the time to look up the FP register list to see if their GPs are included.

The FP register aims to increase the standard of GPs in Singapore but whether it can achieve this goal has yet to be seen. It is not a panacea for the differing and varied standards in primary healthcare today. Much depends on how many of us share a common vision of achieving a higher level of competence as Family Physicians. The College will need to work hard in the coming months to maintain the high standard of training as seen in the GDFM programme. The College will also need to prepare itself to meet the demands of a pool of potential participants as it rolls out the Accredited Modular Courses.

Establishing a Register of Family Physicians

A Perspective from a Heartland GP Practice

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

It has been three years since the idea of The Family Physician Register was first mooted and lauded by many prominent members of the medical fraternity.

The objectives were noble; to raise the overall standard of Family Medicine practice in Singapore with formal training in this field being a prerequisite for entry into the register.



Many have, with self belief and determination, resolved to improve ourselves to stay relevant and true to our calling. The Family Physician Register is seen by many as our validation and vindication.



Among ourselves, many GPs had agreed in principles and had viewed the new standard as an endorsement and the fruition of our hard work.

Instead of resigning to the fate of being disrespectfully oft-labeled as cough and cold doctors and surrendering to tabloid-like mistreatment, the Singapore GPs have refused to go quietly into the night.

Many have, with self belief and determination, resolved to improve ourselves to stay relevant and true to our calling.

The Family Physician Register is seen by many as our validation and vindication.

Notwithstanding the register carries with it the aspiration of the GPs, does it resonate with the same significance among the average patients in an average heartland neighbourhood GP clinic?

The question came up when I bumped into a GP friend during a seminar recently.

He had read the recent news article about the register and, amidst the revived interest on the issue, was a little concerned about his qualification; his post-graduate certification being from Australia.

After reassuring him that he would in all likelihood be eligible for the register given his more than a decade of practice and an advanced training, he had wondered if his patients would really give a damn if he was in the register or not.

Would they defect en masse next door just because he was not in the register?

With this in mind, I had decided to poll my own regular patients over two very busy Saturday morning clinics.

I had managed to obtain the following interesting and some rather surprising responses from them:

Q1: Are you aware of the proposed Family Doctor Register?

The respondents were more or less split down the middle in term of their awareness of the register.

Those that knew had learned about it from the local newspapers.

Those that didn't also included the educated who had access to the newspapers.

Q2: Do you think the purpose of the Register is good?

I had explained that in order to qualify for the register, their GP would have to go for courses to upgrade himself and even, perhaps, study for exams.

All those polled agreed unanimously that the idea of the register with its obligatory vocational upgrade was good.

The reason was they would appreciate their Family Doctors' competency to be at least on par with the latest knowledge and medical developments so that their treatment and advice would continue to be sound and current.

One particular respondent fearing that I might not make it onto the register had vouched to continue to see me come what may and had empathised with me the long clinic hours and now the need to spend even more time for courses and exams.

She had also prudently added that the many years of GP experience should put him in good stead and the experience was as equally important as any advanced training.

Another, while having her foot excision wound dressed with AQUACEL.Ag dressing, must have noticed my harried looks when she gave a motherly encouragement that those doctors (thinking me) that had not make it onto



The purpose of the Family Physician Register, as had been expounded many times before, was not meant to divide the haves from the have-nots.

Family Practice Skills Course #30

Gastrointestinal Diseases

The College of Family Physicians Singapore thanks **AstraZeneca** and the Expert Panel for the contribution rendered to the Family Practice Skills Course on **Gastrointestinal Diseases**, 7-8 March 2009.

EXPERT PANEL:

Dr Fock Kwong Ming, Senior Consultant Gastroenterologist, Changi General Hospital

Dr Richard Guan, Consultant Gastroenterologist and Hepatologist, Mount Elizabeth Medical Centre

Prof Lawrence Ho, Chief, Dept of Medicine and Senior Consultant Gastroenterologist, National University Hospital

Prof Teo Eng Kiong, Chief of Medicine & Head, Div of Gastroenterology, Changi General Hospital

Dr Yim Heng Boon, Senior Consultant Gastroenterologist, Tan Tock Seng Hospital

A/Prof Gwee Kok Ann, Consultant Gastroenterologist, Gleneagles Hospital

Chairpersons: **Dr Jason Yap Soo Kor**, **Dr Marie Stella P Cruz**

the register should not give up trying.

I suspect that these might be some of the typical responses from our regular patients who have been taken care of competently and compassionately through the years by their faithful GPs and all of us can take heart in this.

But I do not think this should be justification for inaction. On the contrary, we should reciprocate our patients' trust and loyalty and endeavor to better ourselves and put our names on the register.

Q3: If the Register is only published on the internet, would you look for your doctor's name in it?

The respondents that had internet access said they would and those that didn't would not be bothered to. Some in the latter group had wondered if the register could be made available in other mediums like clinic brochures and newspapers.

The purpose of the Family Physician Register, as had been expounded many times before, was not meant to divide the haves from the have-nots. In my opinion, it does not give bragging rights to the former, neither does it seek to ostracise the latter. The criteria and entrance requirements for the register are attainable by every GP with a little sacrifice.

Since we are all in the same boat, why not cross the river together and enjoy the ride! **ICM**

Family Practice Skills Course #17 (Repeat)

Dementia Update

The College of Family Physicians Singapore thanks the Expert Panel for the contribution rendered to the Family Practice Skills Course on **Dementia Update**, 10-11 January 2009.

EXPERT PANEL:

Dr Kandiah Nagaendran, Associate Consultant, Dept of Neurology, National Neuroscience Institute

Dr Chong Mei Sian, Consultant Geriatrician, Dept of Geriatric Medicine, Tan Tock Seng Hospital

Dr Joshua Kua, Consultant Psychiatrist, Dept of Geriatric Psychiatry, Institute of Mental Health

Dr Tan Boon Yeow, Consultant Family Physician, Head, Medical Services, St Luke's Hospital

Dr Lim Wee Shiong, Consultant Geriatrician, Dept of Geriatric Medicine, Tan Tock Seng Hospital

Dr Ng Li-Ling, Senior Consultant, Dept of Psychological Medicine, Changi General Hospital

Dr Dennis Seow, Consultant Geriatrician, Dept of Geriatric Medicine, Alexandra Hospital

Mrs Theresa Lee, Executive Director, Alzheimer's Disease Assoc.

A/Prof Goh Lee Gan on the Division of Family Medicine, NUHS

Connecting Care to Result



Interviewed by Dr Wong Tien Hua, MCFP(S), Editor

A new Division of Family Medicine is now formed within the University Medicine Cluster (UMC) of the National University Health System (NUHS). NUHS comprises the NUS Yong Loo Lin School of Medicine, the NUS Dental Faculty and the National University Hospital (NUH). There are now thus two independent FM entities in tertiary medical institutions in Singapore - the other being the Department of Family Medicine & Continuing Care in the Singapore General Hospital.

This newly formed division is headed by A/Prof Goh Lee Gan, President of the College's 21st Council. It also appointed Dr Wong Teck Yee and Dr Cheong Seng Kwing as Consultant Family Physicians. The former NUS Community Occupational & Family Medicine (COFM) Department is now renamed to the Department of Epidemiology & Public Health (EPH) of the NUS Yong Loo Lin School of Medicine. The College Mirror met A/Prof Goh to get to know more about the new establishment.

CM: Can you tell us a bit more about the newly formed Division of Family Medicine and how it fits into the functions of the Department of Medicine at NUH, of which it is under?

A/Prof Goh (GLG): Thank you, Tien Hua. The Division of Family Medicine, in line with the Department of Medicine in NUH, has the three missions of service, teaching, and research.

In relation to service, the current deliverable of the the Division is the Family Medicine Specialist Outpatient Clinic (FMSOC). The FMSOC has, conceptually, three categories of patients: (1) those who are stable and can be transitioned to our GP colleagues in the private clinics, and to some extent in the Government Polyclinics for those patients who want to see only the Polyclinic doctors; (2) those who have several hospital specialists for whom we could try to optimise the number of specialists they need to see; and (3) in the future, those who need to be

“The way forward will be to prioritise and to build capacity to achieve the overall missions of the Department of Medicine of excellence in service, teaching, and research.”

reviewed to be sure that they are well to go home, e.g. patients from A&E Department who need a further review.

As a first task, working with the hospital specialists to enable transition of stable patients to our colleagues in the clinics will be the current pre-occupation.

With regards to the teaching mission, the Division of Family Medicine co-ordinates the undergraduate family medicine posting which presently consists of two-week attachment to our GP tutors and two-week attachment to our Polyclinic doctors. We are now preparing to extend the undergraduate Family Medicine posting to six weeks to include one week of community hospital attachment and one week of palliative care.

Together with the clusters, MOH, and the Graduate School, the full-time and adjunct academic staff are involved in organising the MMed(Family Medicine) Examination and the GDFM Examination, which are both postgraduate examinations leading to a Masters degree and Graduate Diploma respectively awarded by the Yong Loo Lin School of Medicine, NUS.

There is also the research mission of finding answers to health care issues and effective health care delivery. Some of the research will be in collaboration with doctors in the community, some in collaboration with our hospital specialists and some as individual investigative efforts.

Hence, there is a lot that we could do. The way forward will be to prioritise and to build capacity to achieve the overall missions of the Department of Medicine of excellence in service, teaching, and research.

CM: In the overall structure of healthcare delivery, how or where would a hospital based team of trained Family Physicians fit in?

GLG: This is a good question. I see the hospital based trained Family Physicians to be providing a pathfinding role and service in connecting the care of the hospital based specialists on the one hand, and the care of the GPs, FPs,

“The central mission of the Division of Family Medicine is to meet the service needs of our people, both by ourselves and also in collaboration with our hospital based health care providers...”

polyclinic doctors in the community on the other. This type of care is called by various names: hospitalist care, transitional care, and right siting care. It is hoped that the development of this kind of care will enable transition of care from hospital to the community more seamlessly. In a longer run, this kind of care will be taught to all doctors so that there is good confidence in managing patients in transition from hospital and the community clinic and vice versa. With an ageing population, this kind of expertise in the GPs, FPs, and polyclinic doctors will become valuable and indispensable as we grapple with patients who are more aged, have multiple comorbidities, and more frail.

CM: Can you tell us what is the Mission of the Division of Family Medicine? What is your vision for its growth and future development?

GLG: The central mission of the Division of Family Medicine is to meet the service needs of our people, both by ourselves and also in collaboration with our hospital based health care providers, and also in collaboration of the community hospital and related health care providers. This central service mission is supported by the two missions of teaching and research. The vision of family medicine is connecting care to result in more effective care outcomes.

CM: Integration of Care and Right Siting are currently hot topics in the primary healthcare scene in Singapore. Can you explain to our readers what this means? Do you see these as major functions of your new unit? If so how will you see this happen?

GLG: Yes. Integration of care and right siting are descriptive terms of efforts in connecting care in some way to make it more effective and seamless. Integration

of care is the connecting of care across different providers. Right siting is efforts to place the patient in the most appropriate setting as for example, a stable patient can be looked after by the doctor in the community, instead of continuing to be looked after in the hospital specialist outpatient clinic.

CM: There will be many GPs reading about this new unit and many may wonder what relevance it has for GP practice in Singapore. Will the Division of Family Medicine have an impact on GP practice in the near future?

GLG: Oh yes. There is no doubt that the creation of hospital based family physicians is a paradigm shift. To succeed, the paradigm shift needs a buy-in from early adopters. Once the idea catches on because we have resolved the teething problems of organisation, structure, and function, I have no doubt the movement will grow.

The Department of Family Medicine and Continuing Care (FMCC) in the Singapore General Hospital is the trail blazer in our country in setting up a department of this nature. The Division of Family Medicine in NUH is the second Family Medicine entity to have the service, teaching, and research missions. Other entities are fast being set up in the other restructured hospitals. There will be opportunities for careers in family medicine that are new and challenging.

So, for family physicians who look forward to more challenging careers of providing care that could be in the community, in the FM specialist outpatient clinic in the hospital, or in the community hospital or in combination of these settings, I would say: "Come onboard. We need more of such family physicians."

CM: Thank you, Prof Goh. ■CM

Mental Capacity Act

WHAT EVERY REGISTERED MEDICAL PRACTITIONER WHO CARES FOR & TREATS ADULTS WHO LACK MENTAL CAPACITY NEEDS TO KNOW

- Raising awareness amongst Registered Medical Practitioners

THE MENTAL CAPACITY ACT - BALANCING EMPOWERMENT & PROTECTION

OVERVIEW

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.
- 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, by executing a legal instrument called a Lasting Power of Attorney (LPA).
- 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.
- Allows parents of children (below the age of 21 years) with intellectual disabilities to apply to the Court to appoint a deputy to make decisions for their child if the parent(s) pass(es) away or loses mental capacity.
- 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:
 - Making or cancelling an Advance Medical Directive
 - Registering and withdrawing an objection to the Human Organ Transplant Act
 - Refuse life-sustaining treatment or treatment required to prevent a serious deterioration in the condition of the person who lacks mental capacity.

WHAT IS MENTAL CAPACITY?

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

The Mental Capacity Act states that a person lacks mental capacity 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.

ASSESSING 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?

Therefore, assessments must be time and decision specific, i.e. a functional test of capacity. 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.

FORMAL ASSESSMENTS

- Formal assessments of mental capacity can be carried out by a registered medical practitioner alone or working together with a multi-disciplinary team of medical professionals, e.g. psychiatrists and geriatricians.
- Registered medical practitioners who wish to offer mental capacity assessments must attend a formal training course conducted by the College of Family Physicians Singapore and pass a test to be on MCYS' panel of medical practitioners qualified to carry out mental capacity assessment. Registered medical practitioners may choose to not offer these assessments.
- An Assessment of Mental Capacity Form must be filled out by both the person seeking assessment and the registered medical practitioner carrying out the assessment. Only medical practitioners on MCYS' panel of medical practitioners qualified to carry out mental capacity assessment can certify whether a person lacks capacity.
- The donee of a Lasting Power of Attorney can only act on behalf of the donor when the donor lacks mental capacity.
- Formal assessments of capacity are not required for every decision. However, a formal assessment would be needed for important decisions, for example transferring assets.

HOW THIS ACT AFFECTS YOU

1. Registered Medical Practitioners must ensure that when caring or treating adults over 21 years old to make their own decisions, they follow the statutory principles listed in the Act. They must also apply these statutory principles when carrying out mental capacity assessments. The principles are listed below.
2. The Act provides statutory protection (except for negligence) to 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
 - He or she reasonably believes that:
 - o the person lacks mental capacity to consent, and
 - o the act is done in the person's best interests.

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

Office of the Public Guardian (OPG)*

Enquiry Line : (Pending)

E-mail : MCYS_OPG@mcys.gov.sg

Fax : 6258 3512

Website : (Pending)

THE STATUTORY PRINCIPLES

There are 5 statutory principles which should be borne in mind by all, including medical practitioners, when dealing with persons with mental capacity issues.

1. Presumption of Capacity

When dealing with any person, the assumption will be that he or she has mental capacity unless it is established otherwise.

2. To Take All Steps to Help in Decision-Making

Registered Medical Practitioners cannot treat a person as though he or she is unable to make a decision unless all practicable steps have first been taken to help him or her to do so without success.

3. Unwise Decisions

Just because a person makes an unwise decision does not mean that he or she lacks mental capacity.

4. Best Interests

Any act or decision made on behalf of a person who lacks mental capacity must be done or made in his or her best interests.

5. Less Restrictive Option

Before an act is taken or decision made on behalf of a person who lacks capacity, the attending registered medical practitioner must check if there is a better alternative that is less restrictive of the person's freedom and rights.

THE CODE OF PRACTICE (Coming Soon!)

The Code of Practice provides guidance and information about how the Mental Capacity Act works in practice. It contains case studies as illustrations of certain principles.

Registered Medical Practitioners are expected to have due regard to the Code of Practice.





The Economic Crisis and the Family Physicians

by Dr Loke Wai Chiong, FCFP(S), Editorial Board Member

Much has been written, discussed and bemoaned about the economic crisis, and I will not attempt to repeat it all here. Suffice to say that a truly toxic mix of sub-prime loan defaults, collateralised debt obligations and similar bundled securities, land price bubbles, excessive risk taking by banks and bankers, moral hazard, fall of some of the biggest banks pulling others with them, credit crunch, business closures, retrenchments, loss of consumer confidence, collapse of the real economy leading into a vicious cycle - have all worked together to sink us into what many call the worst recession since the Great Depression.

In the midst of doom and gloom, many believe that healthcare remains recession-proof. Indeed, people will still need to look after their health, with or without a job or money; but is this really true? What does the recession mean for the GP? How about the patient?

Lessons from previous recessions

It is helpful to study previous recessions, and try to draw parallels with our current one, in order to forecast what may happen in the coming months.

Jiang et al recently studied the four most recent recessions in the US (Nov '73 - Mar '75, Jan '80 - Nov '82, July '90 - Mar '91, Mar '02 - Nov '02) and their impact across 10 sectors. They found that the Healthcare sector was among the first to decline in the first, lagged in the second, and was subsequently unaffected in the last two recessions. Only Utilities and Consumer Staples were more resilient to recession. When the economy recovered, Healthcare led

the way in recovery. The same study compared peak-to-trough change in sector EBITAs (earnings before interest, taxes and amortisation). In the first two recessions, it was ranked 5th and 6th (out of 10) in terms of size of contraction, but in the last two recessions, it actually showed 2% and 21% growth instead. What is more amazing was that the 1990 recession saw Healthcare as one of only two, and in 2001 the only sector out of ten showing growth in EBITA.

Bohlen & Weaver studied consumer spending during recessions, and found that consumers tended to change priorities rather than make across-the-board cuts. Healthcare spending actually increased, and was 4th highest after spending on education, reading (newspapers and magazines), and personal insurance. More was also spent on food at home. Consumer spending decreased significantly (in decreasing order of magnitude) for food away from home, personal care products and services, transportation, apparel, tobacco, housing, and entertainment.

So history does seem to show that healthcare has been relatively resilient to recessions. However, our current one that is turning the world on its head is sure to still impact us.

Strategy in a Different World

The origin and magnitude of this recession has led scholars to believe that it will be significantly different from previous ones. Many think there will be a "structural break" with the past, a dramatic change to the underlying structures of industries. It has become hard to imagine that we can go back to the heady days of rapid expansion in financial services, ever-rising

consumption and uncontrolled bubbles in housing prices. Demand patterns will fundamentally change, and some organizations and even industries will (unfortunately) be wiped out in the process.

Professor Rumelt of UCLA's Anderson School of Management in a recent commentary proposed some survival tips for business owners (including GPs):

1. In hard times, save the core at expense of periphery (we should first ask: what is our core competency? Chronic disease care? Aesthetics?)
2. Cut waste, overhead, clutter, cross-subsidies wherever you can.
3. It may be a good opportunity to cut expenses and find new efficiencies.
4. Focus and strengthen your competitive advantage - defined as when you can take away business from a competitor at a profit, and when your cash costs of doing business are low enough to survive.
5. Find opportunity in hard times to buy assets of distressed competitors, such as buying over clinics. Choose those with competitive advantages unencumbered with debt and clutter.
6. Re-negotiate terms with suppliers, landlords, etc. Don't be shy.
7. Focus on employees and communities, relationships and networks. These will be repaid many times over when good times return. Gaining and retaining the right staff during these times will make a difference.
8. If you can't survive the hard times, sell out early. Once you are in financial distress, you will have no bargaining power at all.

The challenge would be to use the crisis as an opportunity, to acquire assets to build a base for future growth. Actions you might need to consider can be:

1. Operational actions, short and long term impact

Short-term operational moves include preservation of cash and assets, and making sure that your core business continues and your regular clientele is preserved. Longer-term, major assets or inputs must be preserved, redeployed or expanded. Group practices may take this chance to hire top talent, or retain them with fresh challenges and engagement.

2. Strategic actions, short and long term

Short-term strategic actions include selling off assets selectively to raise money for business survival. Longer-term actions are aimed at enhancing and sustaining performance, like careful expansion when the cost of starting business falls.

Back To Our Real Business

Though we have spent much column space on business impact and decision making, we must not forget the impact the recession has and will continue to have on our patients and our clinical practice.

Many doctors will notice a change in Demand, or in more familiar terms, the Health Seeking Behaviour of patients. With tightening personal budgets, there will be decrease in discretionary

“Even in mainstream family medicine practice, there may be decrease in attendance for chronic disease monitoring, follow up, and even for acute illnesses, when patients are forced to tighten their belts due to unemployment or pay cuts.”

spending on products and services perceived as a luxury or non-essential. These may include aesthetic procedures, health screening, and lifestyle programmes like weight loss and fitness. GPs who depend upon these for revenue may be badly hit.

Even in mainstream family medicine practice, there may be decrease in attendance for chronic disease monitoring, follow up, and even for acute illnesses, when patients are forced to tighten their belts due to unemployment or pay cuts. It has been said that people are more concerned about their financial health than physical health, and may not be able to appreciate the longer-term costs of untreated or uncontrolled disease.

Consequently, GPs may see late presentations of acute and chronic ailments, as patients endure symptoms until these become severe or intolerable. There may also be higher incidence of complications related to delayed treatment or poor control. Infectious diseases may present late, and may have already spread to others in contact with the patients.

Diagnosis and timely notification of these, recognising outbreaks and epidemics will become even more important.

To cut costs, patients may increase self medication and the use of over-the-counter drugs, hoping to save on doctor consultations. If mis-used (or abused), there

may be higher risks of adverse drug effects presenting to the GP.

What about the type of medical conditions? The recession will have definite psychological impact. As the old joke goes, "A recession is when your neighbour loses his job, a depression is when you lose yours." The wise GP will raise his antenna and be on the look-out for signs and symptoms of stress, anxiety and depression. Timely diagnosis and management will go a long way to help the troubled patient cope with his problems of living.

And so, as we step into the uncertainty of a likely drawn-out recession, it is with hope, resilience and a clear strategy that we can survive, thrive, and continue to provide the care that our patients need and deserve. **■CM**

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Dr Loke Wai Chiong, MMed (FM), FCFP(S) is a member of The College Mirror Editorial Board. Currently, he is also pursuing his Executive MBA at UCLA-NUS.



Getting to Know the New Editorial Board Member

Dr Kiran Kashyap

The College Mirror recently welcomed a new member of the Editorial Board, Dr Kiran Kashyap. In this issue, we share with you the privilege of learning about her passion in Family Medicine and her role models.

CM: Tell us something about yourselves. What was your journey as a doctor? What influenced you to become a Family Physician?

I graduated in 1992 from NUS, and knew as a medical student that Family Medicine was the right line for me. Family Medicine is the only discipline that allows me to enjoy interaction with patients to a level where I can look after 3 - 4 generations at the same time. I thoroughly enjoy dealing with such a wide range of patients and problems. Following the MMed Exam in 1998, I joined a small group practice and have been running the same family practice in Meyer Road since then.

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

I have had the pleasure of meeting two inspiring Family Physicians during training - Dr Lim Kim Leong, whom I met during my third year medical student attachment, and Dr Moti Vaswani, whom I met during my MMed training attachment. Both had impressed me with their dedication to their patients, and I felt that this is what medicine and being a good doctor is all about. These attachments afforded a rare opportunity to witness directly the impact a good doctor has on his patient.

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



I would like greater recognition for the humble family doctor, who has to keep up with changes in medicine across all fields, and handles such diverse problems, stemming them at the root without any fanfare. Give us the respect we deserve. I would like to do away with payment schemes that undervalue the consultation process by the family physician.

I would prefer a system where we are recognised and paid fairly for the consultative process, so we don't have to rely on other sources of revenue like sales of pharmaceuticals.

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

Absolutely. The training and knowledge incorporated in the Family Medicine programs sets us apart in how we manage patients. It is medicine practised at a totally different level, in terms of knowledge and holistic attitude and confidence when compared to a young graduate with MBBS only. Of

course, experience over the years plays a big role, but one has to keep up with the rapidly changing medical world. Patients now have easy access to a lot of medical information. It is unnerving to have a patient quote various internet-sourced data, unless we have kept our knowledge and skills updated.

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

In the US, there is definitely a rising unhappiness with the compensation system for primary physicians to the extent of a tremendous drop in numbers of primary healthcare providers. In Singapore, MOH has made changes in the right direction, in guiding the focus back on primary healthcare as the right site to control many chronic illnesses, and in encouraging preventive health care. I am optimistic for us in Singapore, although I think more needs to be done to address the managed healthcare system, which currently squeezes the family physician to the point of ridiculously low consultation fees. By concentrating on achieving and maintaining updated knowledge through the GDFM, MMED, Family Practice Skills Courses and various CME events, we can achieve a higher level of service in Family Medicine.

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

Since we family physicians are a scattered lot, the College Mirror serves as a source of reference to update us on events or changes in our systems, including CME events. It also can inspire fellow family physicians with articles that cover the work of many unsung heroes. ■CM

In line with this issue's highlight on Family Medicine training and career, the College Mirror had the privilege of meeting Dr Tan Chee Beng, one of the key leaders of today's Family Medicine training. Dr Tan shared about his thoughts on the future of Family Medicine training programmes and its career pathways.

CM: Dr Tan, what is the potential of Family Medicine Training in the near future? Why is it important for more doctors to take up the Family Medicine Training Programme (MMed(FM) and GDFM)?

Dr Tan Chee Beng (TCB): In the near future there is going to be the establishment of the Family Physician Register in Singapore. This is a clear recognition of the important roles family physicians play in the healthcare scene of tomorrow. With a rapidly ageing population and increasing healthcare burden of chronic diseases, Singapore will need a strong primary care with good family physicians so that we can provide good healthcare at the primary care level.

The patients of the future are going to be more educated and more discerning. They are going to live longer, have more chronic conditions and higher complexity. They will value good health and look for good family physician to be their regular family doctor. They will be able to differentiate and appreciate which doctor provides good patient care.

Likewise, to cater to increasing complexity, our healthcare system is going to be more integrated. As a system, we will need more well trained family physicians so that they can play a pivotal role in preventive care and chronic disease management at the community level.

I believe doctors will realise the importance of the need to move up the healthcare value chain. The Family Medicine training will continue to grow

Dr Tan Chee Beng on FM Training Family Physicians of Tomorrow

and expand as more and more doctors will opt to equip themselves with necessary skills and knowledge to become good family physicians.

CM: What are the possible career pathways for someone who has attained the MMed(FM)?

TCB: A doctor who has attained the MMed(FM) can be described as someone who has reached a multi-road junction with many career options and opportunities. At the primary care level, there are well established career tracks in the polyclinics. Likewise some GP groups are also paying MMed(FM) graduates more. Some of the public hospitals have also begin to set up Departments of Family Medicine & Continuing Care and are looking for family physicians. There are also MMed(FM) graduates working in community hospitals, palliative care centres.

Recently, the MMed(FM) is also recognised as the BST (basic specialty traineeship) level for subspecialties like

“The patients of the future... will be able to differentiate and appreciate which doctor provides good patient care.”

Sports Medicine, Palliative Care, and Geriatric Medicine. There is also a dual Public Health / Family Medicine traineeship to train healthcare administrators.

Increasingly doctors are going to recognise the intrinsic value of MMed(FM) and the opportunities it can offer to allow the MMed(FM) graduate to pursue his/her area of interest whether it is at the primary care level or in institutional practice.

CM: The GDFM can be described as the Basic Building Block of Family Physician training, how does GDFM fit into the overall structure of FM training in Singapore?

TCB: Both the GDFM and MMed(FM) training programmes are good structured programmes that cater to the professional development needs of primary care doctors. Both programmes have different rigor and levels of competencies.

The MMed(FM) programme is more intense and rigorous but provide greater opportunities. The GDFM is comprehensive and allows the GDFM holders the option to consider taking up the MMed(FM) programme at a later date.

Both are good programmes, and I would encourage doctors to make investment in these programmes to become good family physicians. The patients of the future will look for good family physicians. ■ **CM**

Feedback on the Proposed Amendments to the Medical Registration Act (MRA)

From: Council of the College of Family Physicians Singapore
To: Director of Medical Services, Ministry of Health
Submitted: 10 March 2009

FEEDBACK ON THE PROPOSED AMENDMENTS TO THE MEDICAL REGISTRATION ACT (MRA)

1. Stating Objectives of the Act

It is good that the objectives of the Act have been explicitly stated in the proposed amendments.

2. Enhancing Constitution of Medical Council

In view of the possibility of more medical schools being set up in Singapore, the wording of the text should accommodate such changes with regards to SMC representation.

3A. Establishing Register of Family Physicians

The College wholeheartedly supports the establishment of the Register of Family Physicians (FPR) as it will enhance the practice of family medicine.

The College is concerned that the proposed FP Register allows overseas trained doctors from for example Australia and UK with their FRACGP or MRCGP to gain entry onto the register and practice independently. Notwithstanding their clinical skills these overseas trained doctors may not be able to practice effectively in the local cultural context, with the potential risk of adverse outcome. Such factors are extremely important in the specialty of family medicine where the ability to understand and treat the patient as a whole person is critical. Thus, an initial period of practice under supervision for these overseas trained doctors to familiarize themselves with the local conditions should be mandated before they are allowed to practise independently.

The College would like to be represented in the FP Accreditation Board to give inputs on the accreditation of family physicians and also play a role in the verification and approval process in granting equivalency of foreign qualifications to our GDFM. The Australian RACGP has power to give input on the credentials for entering the Vocational Register of Australia (VR) which is the equivalent of the FPR of Singapore. In fact, only the FRACGP is recognised for entry into the VR.

3B. Title of Family Physician regulated

Page 50 of the Bill "Amendment of section 65", states that the title of "Family Physician" will be regulated just like the title of "Specialist". Anyone who is "not registered under section 22A which is the FPR cannot advertise or hold himself

out as being registered as family physician." We support this move.

Whilst the family physicians provide the base for the practice of family medicine in the community, it is a fact that Family Medicine is also practised as a specialty focussed on integrative and continuing care in various institutions even at tertiary hospitals. The Master of Medicine (Family Medicine) is de facto being used as the Basic Specialty Training (BST) for entry into training for specialties such as geriatrics and for subspecialties such as palliative care and sports medicine. Beyond the FPR, de jure recognition in the Specialist Register should be accorded to those doctors who are de facto practising as Family Medicine Specialists (FMS) having the higher qualification of MMed (FM) and who have undergone the requisite advanced training to be professional clinical FM leaders and who play the pivotal interface role with other medical specialists.

4. Developing Sub-specialties

We are in agreement to the proposal to amend Section 35 to allow the Specialties Accreditation Board to define subspecialties in medicine.

5. Improving medical registration

We are in agreement with the provisions to empower the SMC to specify requirements and impose restrictions on conditionally registered doctors and where this is necessary to safeguard the public.

6. Power of the SMC Investigator

With regards to the proposal to allow the SMC's Complaints Committees to appoint officers who will be empowered to investigate complaints, our concern is such persons have powers that appear to exceed police or court officials namely, the power to enter without warrant, inspect, search, make copies of notes, take photos, test chemicals or remove any substance or container.

7. Lay people in SMC

We have reservations for the provision of the option of appointing a judge, legal officer or senior lawyer as chairperson of the Disciplinary Tribunal to overcome the deficiency in knowledge of complex legal issues of the medical practitioner. The downside to this arrangement is that the layperson may not be conversant with the issues related to medical practice and this is a worse trade off. Suffice to have a competent legal officer as a member of the DT to advise the medical practitioner chairman on technical legal issues of the case.



The College wholeheartedly supports the establishment of the Register of Family Physicians (FPR) as it will enhance the practice of family medicine. (Photo: Council Meeting at the College Conference Room)

8. Fines raised to \$100,000

With regards to the proposal to allow the Disciplinary Tribunal to impose a penalty of up to \$100,000 our view is that the quantum may be excessive and a quantum of \$20,000 to \$40,000 would more appropriate.

It was explained to some of us that the figure of up to \$100,000 was proposed so that the period of suspension can be reduced or avoided, if the quantum can be raised to match the severity of the offence. This would be good as it means less disruption to the doctor and his practice. The concern some of us have is into the future, the original spirit of the law is forgotten and doctors are punished with hefty fines as well as long periods of suspension. Hence, on balance we would choose an increase of quantum to \$20,000 to \$40,000.

Another point against increasing the penalty to \$100,000 is that this may create a situation where the doctor feels the fine is high, choose not to plead guilty, and contest the charge. This could lead to an increase in defence costs which are paid for by medical defence organisations.

9. Restriction of practice

Currently, after being struck off for 3 years, a doctor affected

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“The concern some of us have is into the future, the original spirit of the law is forgotten and doctors are punished with hefty fines as well as long periods of suspension.”

can re-apply. The new law will effectively stop the struck-off doctor from re-entering the register for up to 10 years. This is unfair for doctors who have truly repented and deserve a second chance.

10. Appeal to the High Court

Under the current MRA, only the doctor may appeal to the High Court when the decision of the Disciplinary Committee is against him. The

complainant does not have this recourse. The proposal to also allow the aggrieved complainant to appeal to the High Court should be re-considered. Some of the council members are concerned that this is unfair to the doctors since the complainant already has recourse to bring the case to the civil court.

11. Performance or Fitness Assessment (pg 22)

A doctor facing a SMC enquiry may be required to undergo performance or fitness assessment tests. We like to seek clarification on this process and whether there is a proposed role for the CFPS.

12. Health Committee can suspend a doctor for medical conditions

It is only right that when there is doubt about the mental or physical health of a doctor vis a vis his ability to practice safely it should be investigated.

13. Mentally or Physically unfit to practise (Amendment of Sect 28) & Health Committee

We agree that SMC should have the powers to stop doctors who are unfit mentally or physically from practicing based on a medical or psychiatric report from an independent doctor or Health Committee.

14. Interim Orders

Interim orders (IO) can stop the doctor immediately from practicing if the IO committee thinks fit. Whilst, this is a very powerful tool to stop a dangerous doctor, it can also be unjust if the doctor is later found not guilty. We would therefore request further thoughts on the due processes and the implementation of the necessary check and balance to protect an innocent doctor.

15. Notify SMC of change of address. Failure to notify means a fine

We feel that an imposition of a fine for such a minor and often honest mistake is excessive. **ICM**

Influenza Pandemic Planning Seminar 2009

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

The first Influenza Pandemic Planning Seminar for the new year was held at SAFRA Mount Faber on the 7-8 February. The target audience were the perennial GPs and, for the first time, the Community Paediatricians.

The seminar was organised by MOH in collaboration with SMA. It was fittingly entitled "Out of Sight but Not Out of Mind", a timely reminder to everyone lest we were so preoccupied by the cares of the current economic debacle that a pandemic might overtake us like a thief in the night. The opening address was given by Dr Chong Yeh Woei of SMA.

Influenza Pandemic Response

Dr Chong reviewed the five levels of colour-coded risk management approach adopted by MOH; the DORSCON Alert Codes.

The codes, progressing from green through yellow, orange, red to black provide a guide for planning and execution in the event of the influenza pandemic. (DORSCON abbreviates for Disease Outbreak Response System Condition. The Alert Codes may be found on the website, www.flu.gov.sg which also updates the Singapore current alert level)

The goals of the response strategy are to minimise illness, deaths and overall socio-economic impact through treatment, containment of spread, maintenance of essential services and mass vaccination when pandemic vaccine becomes available.

The two-prong Healthcare response of outpatient management (involving polyclinics and private primary care clinics) and inpatient management (involving ALL hospitals for more severe cases of flu and non-flu patients) was highlighted and explained leaving no

doubt that every doctor has a role in a pandemic.

The Primary Care Framework

Dr Chong underscored the importance of heartland primary care clinics in the pandemic strategy. Without the participation of GPs during a influenza crisis, the 18 polyclinics will be overwhelmed and overcrowded which may in turn fuel the viral spread.

The accessibility of the GPs in each locality would also translate into less likelihood of cross-infection as patients need not have to travel outside their community for treatment.

The MOH concept of the Primary Care Framework is, upon activation of DORSCON RED, (1) maintain normalcy and accessibility of primary care, (2) support the private clinics to enable them to continue to manage the ill including the pandemic flu and (3) cluster the clinics around polyclinics for coordination.

To date, about 63% of private primary care clinics including the large GP groups had been recruited into the framework through letters of invitation and outreach briefings.

Dr Chong next detailed the support that would be available to all participating private primary clinics.

The assurance is that they will receive staff protection IDENTICAL to the public Healthcare Workers. This includes PPE (gloves, N95 masks and gowns), antiviral prophylaxis and surgical masks for patients. In addition, antiviral drugs for treatment of influenza cases will be provided.

On activation of DORSCON RED, all participating clinics will receive six weeks supply of PPE and antiviral prophylaxis and 1 week supply of antiviral drugs. Thereafter, the antiviral drugs will be topped up weekly.

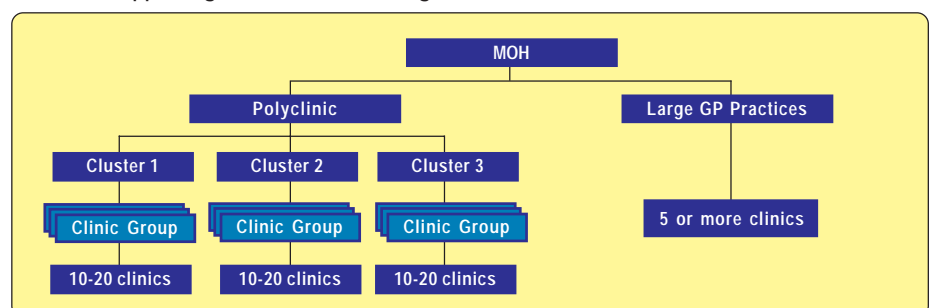
The clustering framework around the 18 polyclinics based on geographical location will provide coordinated support, dissemination of information and allocation of resources (Figure 1).

Dr Chong concluded by reminding the participants the Amendment to the Private Hospitals and Medical Clinics Regulations, 9 Jun 2008. The added new regulation 56B states " The Licensee of a ... medical clinic... shall ensure that the clinic:

A) Participates in such planning, design and conduct of national medical emergency preparedness exercises as may be required, and,

B) has drawn up and put in place

FIGURE 1: Supporting the Clinics: Clustering Framework



emergency infection control measures, including isolation strategies, isolation facilities and infection control equipment to control and prevent the spread of infectious disease.

Dr Chong's exhortation was for the entire healthcare system to work together to prepare for the influenza threat.

Following Dr Chong's address, Dr Jeffery Cutter of MOH presented the latest updates and developments on avian influenza in the world.

Global Avian Influenza (AI) situation

As at 27 Jan 2009, there were a cumulative of 403 cases and 254 deaths giving a case fatality of 63%.

The countries most affected were Indonesia (141 cases), Vietnam (107), Egypt (53), China (37) and Thailand (25).

Countries affected in 2009, as at 27 Jan, were China (6cases) and Egypt (2 cases).

Countries with Highly Pathogenic Avian Influenza (HPAI) with recent or ongoing risk of human infections are Indonesia, China, Vietnam, Cambodia, Lao PDR, Thailand, Egypt, Bangladesh and India.

As such doctors were advised to be vigilant of patients with flu symptoms from these countries.

The Virus

Thus far, there is no major change in the characteristics with regards to the efficiency of transmission from human to human. The case fatality, however, has



The seminar ended with a mask fitting demonstration and a mask fitting exercise and each participant was given a bag of PPE items.

remained very high among human patients.

Treatment

The Neuraminidase inhibitors, Oseltamivir (Tamiflu) and Zanamivir (Relenza), are still the drugs of choice. The newer Peramivir is unavailable. Resistance to Oseltamivir (Tamiflu) is still not a worry.

National Stockpile

Singapore has stockpiled Oseltamivir to treat 25% of the population that is expected to be infected in the influenza pandemic. The stockpile may also be used for both pre- and post- exposure prophylaxis.

Vaccines

The pandemic flu vaccine can only be expected to be available six months into the pandemic as the exact viral strain has to be determined first for it to be effective. Hence, the main purpose of this vaccine when available is to ameliorate the impact of the second wave of infection. The vaccine when ready will be made available to the whole population.

Presently, Singapore will stockpile the H5N1 vaccine to be given to essential personnel, children up to 12 years of age and persons at higher risk of complications at the first warning of an increase human to human transmission.

Non-pharmaceuticals Measures

In a pandemic, the general public will be advised to wear masks in crowded places if going to such places cannot be avoided. Any ill person will be advised to stay at home and

household contacts should observe voluntary home quarantine to avoid silent transmission.

Following the two informative presentations, the participants (who were seated according to their OPD cluster groups) met their respective OPD leader who guided them through the Flu pandemic planning exercise. The exercise included customising the individual GP clinics for flu and non-flu cases.

All patients are to be screened and strictly segregated into flu and non-flu cases and directed to different waiting areas to prevent transmission. There will be a designated consultation room for flu patients and another for non-flu cases. The solo GP is expected to rotate between the two consultation rooms.

The participants were also taught how to customise manpower calculations and PPE requirements. The seminar ended with a mask fitting demonstration and a mask fitting exercise and each participant was given an appreciation bag with PPE items.

It was a thoroughly enjoyable and instructive afternoon and the prevailing theme was that the private GPs had an indispensable role to play in a flu pandemic.

A couple of interesting and thought-provoking questions were raised during the Q&A segment.

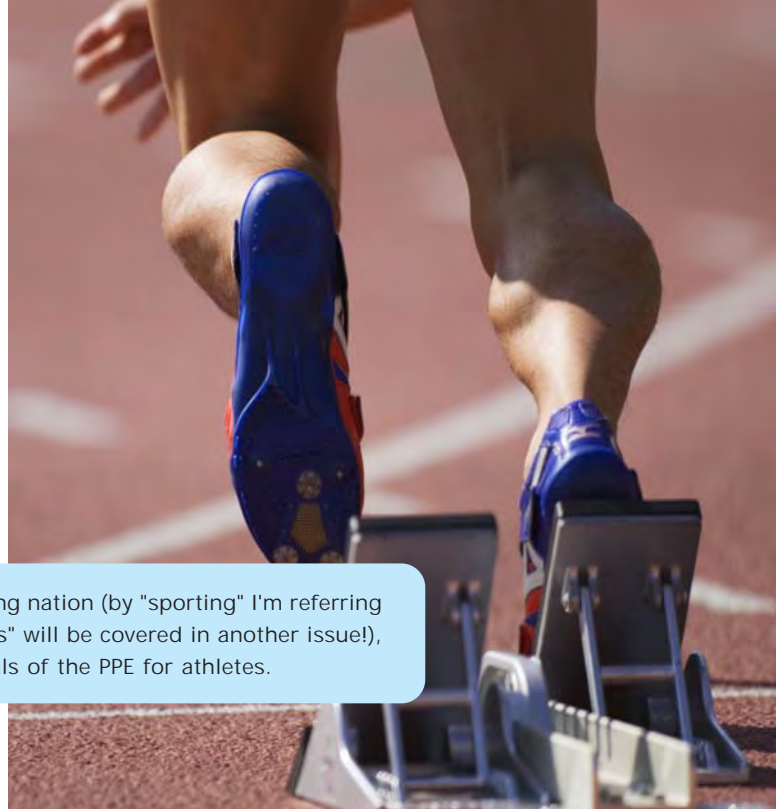
One participant had lamented about the support or lack of rendered to GPs during the SARS crisis and had wondered aloud to the agreement of many others present whether the same would befall us in the pandemic.

Another participant had suggested trying out a different concept of having GPs in the same cluster coming together in a common venue sharing consultation times and resources to look after patients during a pandemic.

The organisers agreed that they were indeed pertinent questions and concerns that deserved considerations. ■ CM



Influenza Pandemic Planning Seminar held at SAFRA Mount Faber, 7-8 February 2009.



A Primer on the Preparticipation Physical Evaluation (PPE)

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

With all that hype about Singapore becoming a sporting nation (by "sporting" I'm referring to athletics of course; the topic on "gentlemanliness" will be covered in another issue!), it's good to know some "short cuts" to the essentials of the PPE for athletes.

What is a PPE?

This is a screening tool used to evaluate athletes (or potential athletes) for injuries, illness and other factors prior to practice and competition that might place themselves or others at risk during sports.

When should the PPE be conducted?

Ideally PPE should be done 6 weeks before participation to allow for rehabilitation, consultation, additional tests

Which are the 2 main areas of focus?

1. Cardio-respiratory system
2. Musculo-skeletal system

Which are the 5 key historical components?

History	Look out for	Why?
Exertional symptoms	Dizziness, chest pain, palpitations, syncope, cough or wheeze	CVS and EIB/EIA screen (Exercise-induced bronchospasm/asthma)
Concussion	Confusion, amnesia exertional headache	Recent concussion increases risk of recurrence
Skin problems	Infestations, impetigo, herpes, molluscum	Contagion in direct contact sports
Family	Sudden cardiac death < 55 yr	HOCM is AD
Medical	Visual/ Hearing/musculoskeletal impairment or injury; Convalescence from recent illness; Missing organs; Head injury	Eligibility for certain sports

Which are the 8 key components of the PE?

System	Look out for
Anthropometrics	BMI, body composition, Marfanoid habitus
Eye	Acuity, retinal problems, prosthesis, anisocoria
CVS	BP, pulses, ESM>3/6, any diastolic murmur,
Respiratory	Chest wall deformity, breath sounds, diaphragmatic excursion
Abdominal	Organomegaly
Skin/nails	Contagious skin conditions
Musculo-skeletal	Power, ROM, flexibility, gait, scars (previous injuries)
Genitalia (male only)	Testes, hernia, Tanner staging

What are contra-indications to participation in high-contact sports?

1. Atlanto-axial instability
2. Hepatomegaly; splenomegaly (NB sports avoided for 4 weeks following IMS)
3. Solitary functioning kidney
4. poorly controlled epilepsy

What are examples of contact sports?

Direct/collision:	Limited/impact:
i. boxing, wrestling, martial arts	i. ball-games (basket, base, volley, hand, soft)
ii. hockey	ii. gymnastics
iii. soccer, rugby	iii. diving
	iv. bicycling, skating, skiing
	v. field (high jump, pole vault)
	vi. horseback riding

What is the 90 sec orthopedic screening examination?

Instructions	Observation
Stand facing examiner	General habitus: AC joints
Look at ceiling, floor, over both shoulders, touch ears to shoulders	Cervical spine motion
Shrug shoulders (vs. resistance)	Trapezius
Abduct shoulders 90° (vs. resistance)	Deltoid
Full ext rotation of arms	Shoulder motion
Flex & extend elbows	Elbow motion
Arms at sides, elbows at 90° flexed; pronate & supinate wrists	Elbow & wrists motion
Spread fingers; make a fist	Hand or finger motion & deformities
Contract & relax quadriceps	Symmetry, knee effusions; ankle effusions
"duck walk" 4 steps (away from examiner)	Hip, knee & ankle motion
Back to examiner	Shoulder symmetry, scoliosis
Knees straight, touch toes	Scoliosis, hip motion, hamstring tightness
Stand on toes; stand on heels	Calf symmetry, leg strength

In the absence of clinically significant historical or clinic findings, there are no recommendations for routine diagnostic testing (Although the Italians, who include a resting ECG in the PPE, boast of one of the lowest rates of SCD among professional athletes). Any positive findings, however, should alert us to initiate appropriate investigation on the system involved. E.g. if history and physical examination are suggestive of structural heart disease, the standard evaluation will generally include a 12-lead ECG, stress echocardiography and graded exercise testing.

Finally:

Although there is no solid evidence that it will reliably identify all athletes at risk, a comprehensive PPE offers us the best opportunity to help make the sporting arena a little safer for our patients. **ICM**

In recent years and months, we have seen Family Medicine (FM) increase in scope and relevance. Beyond playing their traditional GP and polyclinic roles, we have today well trained and qualified Family Physicians (FPs) providing care and serving across the whole continuum of our healthcare system - from preventive to palliative, from acute hospitals to community hospitals and nursing homes, holding clinical to key administrative and policy-making positions, helping to shape the future for our profession and the system as a whole. These changes underline the important role primary care and FM must play as we strive to improve the health of everyone.

The most recent development in this direction is the opening of Advanced Specialist Training (AST) in Geriatric Medicine to local MMed (FM) graduates.

An information session was held at the Ministry of Health on 10 February 2009 to introduce this new opportunity, and also highlight the other possible career paths available to our Family Physicians today - be it Sports Medicine, Palliative Medicine, Public Health or, now, Geriatric Medicine.

A/Prof Pang Weng Sun, Chairman of Geriatric Specialist Training Committee (STC) shared the history and the decision making process that led to the opening of this door.

Back in the 1990s, community geriatrics grew in relevance. Restructured hospitals were increasingly sub-specialised and focused on acute care. Community hospitals (CHs) evolved as step-down care facilities predominantly for the elderly. CHs, nursing homes (NHs) and elderly home care services tapped on family doctors in the community to provide care and coverage. However, among this group of well-intentioned GPs, there was wide variation in the levels of commitment and prior training to do the task.

In 1997, the Graduate Diploma in Geriatric Medicine (GDGM) was started, targeting at CH doctors, FM doctors and GPs with a special interest to learn more

“The study and care of the elderly is very satisfying and rewarding... it can help you discover or rediscover the inevitable ageing process in your own life. By enriching the lives of those you care for, you have the opportunity to enrich your own life and grow old gracefully too.”

about managing the elderly. In 2008 the GDGM (HC/ILTC) was developed to train non-traditional source doctors to serve in this under-provided sector.

With our rapidly ageing population, the need for more doctors to be involved with the aged will grow more pressing. The latest decision is therefore to allow the MMed (FM) as an alternative entry criterion into Geriatric AST, when in the past only MMed (Internal Medicine) or MRCP would have been allowed. An FP

completing AST will then be fully recognised as a Geriatric Medicine specialist under the Chapter of Geriatricians, College of Physicians, Academy of Medicine Singapore. He would enjoy equal status as a specialist, and able to work in both acute and community settings, depending on his inclination and interest.

To enter this track, the MMed (FM) graduate must have relevant postings during his FM training years, and add

Specialist Training in Geriatrics for MMed (FM) Graduates

Reported by Dr Loke Wai Chiong, FCFP(S), Editorial Board Member



on some additional months of rotations under the MO Specialist conversion scheme (as few as six months if the postings during the MMed years were relevant). Thereafter will be the three years of geriatric AST, and upon exit, progression to associate consultant, consultant and senior consultant similar to any hospital specialist.

Geriatrics has been defined as "that branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness in older people... (which calls for) for special medical skills. The purpose is to restore an ill and disabled person to a level of maximum ability and wherever possible return the person to an independent life at home."

This very much matches Family

Medicine's basic tenets of holistic, continuing and comprehensive care. What an MMed (FM) graduate in AST will learn includes geriatric assessment, care management planning, the geriatric "syndromes", rehabilitation, leading a multidisciplinary team, geriatric pharmacology, psychogeriatrics, geriatric orthopaedics, end-of-life care, bioethical and medicolegal issues, gerontology, and medicine in old age (across organ systems and conditions). As geriatric specialists, some may subsequently develop specific "subspecialty" interest, such as incontinence, geriatric palliative care or community geriatrics.

Current FM trainees and those already graduated, though interested, may be worried about returning into acute medicine, medical ward work, and

inevitably doing calls as a medical registrar (or higher). The correct mental attitude and passion to learn will be important. Those who have graduated more recently will find it less severe an adjustment.

Prof Pang has these words of encouragement for those considering the pursuit of Geriatrics specialisation after their MMed (FM), "The study and care of the elderly is very satisfying and rewarding. If nothing else, it can help you discover or rediscover the inevitable ageing process in your own life. By enriching the lives of those you care for, you have the opportunity to enrich your own life and grow old gracefully too." ■ CM



Dealing with Paediatric Patients in Family Practice

by Dr Kiran Kashyap, MCFP(S), Editorial Board Member



Handling paediatric patients can be a challenging experience, but is often most enjoyable. I particularly enjoy seeing young children and find them so refreshingly honest and open in their opinions. The biggest challenge I find is dealing with the parents, who may be overly anxious or overbearing.

If you have a significant paediatric patient population, it is worth organising your clinic to be child and family friendly. For instance having children's toys (washable) and books or videos at the waiting area can keep them busy.

The consultation room also should not have too many explicit diagrams (e.g. skin diseases) that might scare children. Have toys that are easily accessed by the kids directly. However, you need to watch for any toys that go into the mouth - should be taken out for cleaning.

History taking

With infants and children below 5 years of age, we have to rely on the caregivers - usually parents or grandparents (or

“The biggest challenge I find is dealing with the parents, who may be overly anxious or overbearing.”

“Observation of the child's behaviour and interaction with the caregiver gives valuable clues. Distractions are very useful in alleviating the anxiety of your young patient while you examine them.”

often the maid!) - for the history. I like to point the children to a drawer full of toys that they can entertain themselves with while I talk to the caregiver.

School-going children are often a joy to talk to. They are often very talkative, and will be put at ease very quickly if you first engage them with questions about their interests, e.g. school, pets, cartoons. They can answer questions directly, and are often fascinated by explanations accompanied by pictorial diagrams.

Adolescents respond to a simple and honest approach, and will appreciate being treated as individuals with their own opinions.

Examination

Remember to check the growth parameters regularly - may be necessary to instruct the clinic staff to check height and weight recording at every visit. It is important to prescribe safely, using the child's weight as a guide.

Observation of the child's behaviour and interaction with the caregiver gives valuable clues. Distractions are very useful in alleviating the anxiety of your young patient while you examine them. Give them a toy to hold, preferably something in tune with current cartoon or television trends. We all know it is impossible to hear anything when the child is screaming his lungs out, and the parent sits by helplessly, while you get increasingly annoyed. My preferred position is to have the young child sitting in the lap of the adult, who sits on the chair or the couch, and the parent puts one arm over both the child's arms, with the other hand used to stabilise the head. It is relatively easy to examine the child's ears and throat this way.

Older children may appreciate the privacy of a drawn curtain. They are often more reluctant to undress, and have to be reassured.

Procedures

Venepuncture

When it comes to venepuncture in children, you have only one attempt! Ensure the tourniquet is applied while the patient's arm is hanging straight down, rather than with the patient holding the arm upwards. This ensures bulging veins! Have an experienced staff member hold the arm of the child steady while you withdraw blood, with the parent holding the child. Never rely on the parent alone, as they will invariably flinch, or not anticipate the child's strength when in pain, and then you have an impossible situation. Have something on hand to distract the child immediately after, like a sweet, stickers or small toy. Distraction seems to be the key in calming tears quickly.

Vaccinations

Besides the routine vaccinations that are on the MOH schedules and health booklets, there are a myriad of optional vaccines. Also, we are seeing more expatriates amongst our midst, who often have confusing records from many countries.

The optional vaccinations include Pneumococcal, Rotavirus, Chicken Pox, Meningococcus, Japanese encephalitis, HPV. With increasing globalisation and travel, it is necessary for us to be up to date with recommendations. Some good websites include: US CDC: www.cdc.gov/vaccines/Australian: www.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook-home (has very detailed information and pictures).

The preferred anatomical site for intramuscular injections in infants below 12 months is the anterolateral thigh, and in children above 12 months is the deltoid. Use 23 or 25 Gauge needles of 25 mm length for intramuscular, and 25 or 26 G needles of 16mm length for subcutaneous injections. I always change to a fresh needle if a rubber bung has been pierced to keep it sharp.

I always end the consultation on a positive note - usually with stickers (widely available and inexpensive) and hand stamps. Parents often report that the child looks forward to coming to the clinic because of the anticipated stickers. I also restrict sweets to visits with needlepricks only, so as not to encourage the sweet tooth. ■CM



Graduate Diploma in Family Medicine

Direct Route to FP Register!

The Graduate Diploma in Family Medicine (GDFM) is a vocational training certification for primary care doctors. The aim of this 2-year part-time trainee programme is to train primary care doctors to practise Family Medicine at an enhanced level to meet the needs of the child, the adolescent, the adult and the elderly. The courses emphasise on basic clinical diagnostic and management skills essential to general practice.

The programme is planned to accommodate the busy doctor's schedule as almost all courses which require in-person attendance are conducted outside regular office hours. The courses consist of the following:

- 8 modules of Family Medicine Modular Course (FMMC) with each comprising of 4 workshops (2½ hrs each), 1 tutorial (1 hr each), online case studies and multiple choice assessments
- 4 Practice Management Courses (9 hrs in all) and 1 elective Family Practice Skills Course (6 hrs)

Invitation for Application 2009-2011 Intake

Eligibility

You are eligible to enroll in the GDFM programme if you are :

- Registered with Singapore Medical Council and possess MBBS degree or an equivalent qualification.
- A registered doctor who is about to complete housemanship or becoming a Medical Officer in April/May 2009.

Join us on the following day to find out more about GDFM and MMed (FM) Programme B:

CAREER SEMINAR IN FAMILY MEDICINE

Date/Time: 4 Apr, 1.00 - 2.00pm*

Venue: Postgraduate Medical Institute (PGMI), Block 6 Level 1, Singapore General Hospital

*Lunch is provided. Please RSVP via email to gdfm@cfps.org.sg by 31st March 2009.

GDFM Components

To qualify for GDFM Examination, trainees are required to complete the following components:

8 FMMC Modules

Each FMMC module consists of 4 workshops conducted over 4 Saturday afternoons, with online case study, multiple choice assessment, and 1 small group tutorial based on the theme of the FMMC module of that particular quarter. One module would be covered per quarter. Attendance in tutorials and at least 3 of the 4 workshops, and completing online case study and multiple choice assessments are mandatory for the trainees to be certified of having completed the FMMC module.

3 Practice Management Courses

- Principles & Practice of Family Medicine (P&P)
- Consultation, Communication & Counselling (CCC)
- Professionalism, Ethics & Law Skills Course (PEL)

1 Elective Family Practice Skills Course

Trainees can choose to complete any one of the several Family Practice Skills Courses conducted by the College before the GDFM Examination

1 GDFM Clinical Revision Course

1 BCLS competency certification

Trainees are to make their own arrangement to attend a BCLS and obtain a valid competency certification.

Fees

Registration and course fees are payable to 'College of Family Physicians Singapore'.

Course fees (inclusive of Registration fees)

- College member: S\$4,284.00
- Non-College member: S\$4,716.00

Fees do not include the elective skills course (Family Practice Skills Course), BCLS, tutorials, and examination. (Examination fees are payable to 'National University of Singapore', when applying for examinations in 2011).

GDFM Examination

The examination is conducted by DGMS, NUS, in June/July 2011, and consists of:

- Written paper - Applied Knowledge Test paper (MCQ), (2 hrs); Key Features Problems paper (2 hrs)
- Skills Assessment in the Objective Structured Clinical Examination (OSCE), (2 hrs)



Registration

GDFM is open for registration until **22 May 2009**

MMed(FM) Programme B is open for registration until **8 May 2009**.

For more details and application forms, please visit our website

www.cfps.org.sg,

or contact us at:

Tel: **6223 0606**

Fax: **6222 0204**

E-mail: gdfm@cfps.org.sg

Address:

**16 College Road, #01-02
College of Medicine Building
Singapore 169854**

Allergy in Respiratory Airway Disease and Beyond



6 & 7 June 2009

2.00pm - 6.45pm

Health Promotion Board, 3 Second Hospital Ave

- Unit 1 Updates in Asthma Guidelines (GINA)
- Unit 2 COPD
- Unit 3 Food Allergy in Children
- Unit 4 Allergic Rhinitis
- Unit 5 Allergen Avoidance
- Unit 6 Pharmacology of Drugs in Airway Disease

SPEAKERS

Prof Lim Tow Keang, Senior Consultant, Respiratory & Critical Care Medicine, Dept of Medicine, National University Hospital

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

Prof Hugo van Bever, Head, Paediatric Allergy, Immunology & Rheumatology Services, National University Hospital

A/Prof Christopher Goh, Head and Senior Consultant, Dept of Otolaryngology, Singapore General Hospital

Dr Tan Keng Leong, Senior Consultant, Dept of Respiratory & Critical Care Medicine, Singapore General Hospital

A/Prof John Abisheganaden, Senior Consultant Respiratory Physician, Dept of Respiratory Medicine, Tan Tock Seng Hospital

- SEMINARS** (2 Core FM CME Points for each seminar)
 - Seminar 1** • Unit 1-3: Sat, 6 June 2009 (2.00pm - 4.15pm)
 - Seminar 2** • Unit 4-6: Sun, 7 June 2009 (2.00pm - 4.15pm)

- WORKSHOP** (2 Core FM CME Points)
 - Workshop:** Sat, 6 June 2009 (4.30pm - 6.45pm)
 - Part 1** • Case Studies: Food allergy, RAST Testing, etc.
 - Part 2** • Demonstration/Practical Skills:
 - Written Asthma action plan, inhalation techniques

*Workshop is held only on Day 1 (Saturday). Registration of workshop is on first come first served basis. Seats are limited. Please register by 1 June 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.

The development of this Family Practice Skills Course is supported by an educational grant from **AstraZeneca**.



REGISTRATION

ALLERGY IN RESPIRATORY

Please tick (✓) the appropriate boxes



	College Member	Non Member
Seminar 1 (Sat)	<input type="checkbox"/> FREE	<input type="checkbox"/> \$ 20.00
Seminar 2 (Sun)	<input type="checkbox"/> FREE	<input type="checkbox"/> \$ 20.00
Workshop (Sat)	<input type="checkbox"/> FREE	<input type="checkbox"/> \$ 40.00
Distance Learning (Journal)	FREE	<input type="checkbox"/> \$ 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 made 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**