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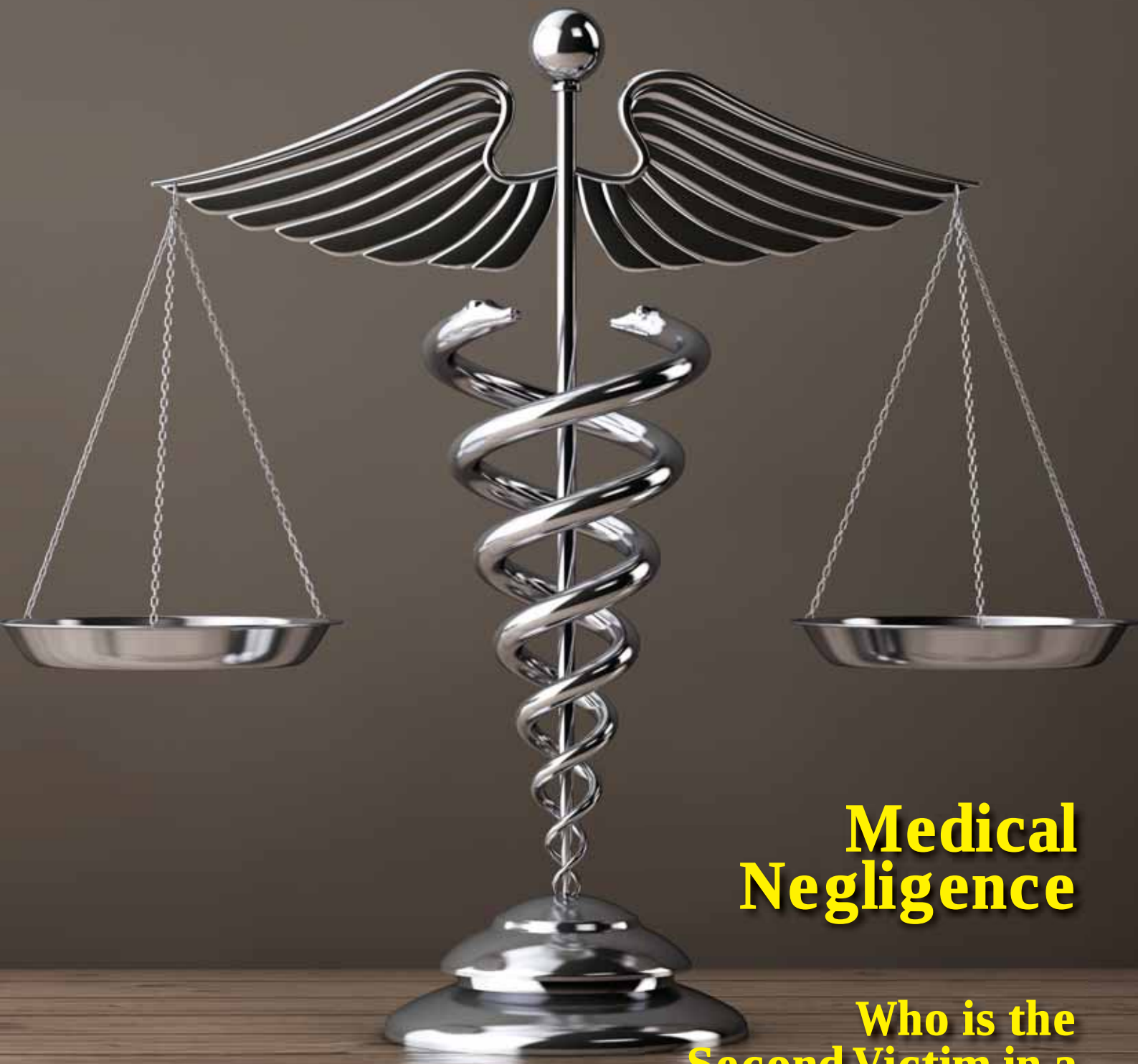
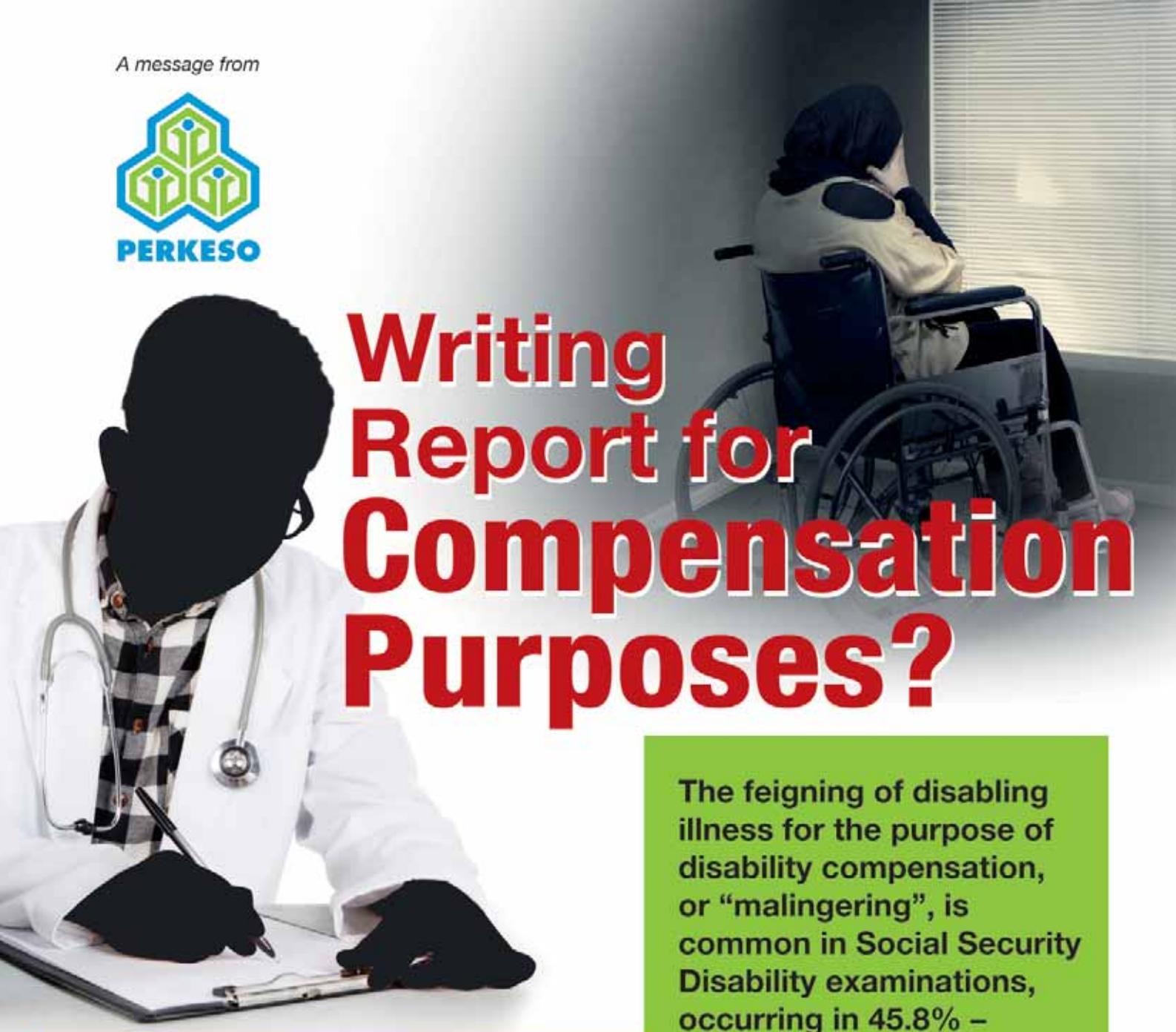


Medical Negligence

Who is the Second Victim in a Medico-Legal Case?

A message from

PERKESO



Writing Report for Compensation Purposes?

The feigning of disabling illness for the purpose of disability compensation, or "malingering", is common in Social Security Disability examinations, occurring in 45.8% – 59.7% of adult cases

– Estimated Costs of Malingered Disability , Michael Chafetz James Underhill, Archives of Clinical Neuropsychology, Volume 28, Issue 7, 1 November 2013, Pages 633-639

Writing a fraudulent report is a crime. We will not hesitate to prosecute offenders in the court of law.

The cost to the Social Security Fund from claims approved based on fraudulent medical report runs into millions of ringgit each year.

Be our partner in safeguarding the workers' contributions against malingerers and syndicated fraudsters.

Write an accurate report.
Help the truly ill & flush out the fakes.

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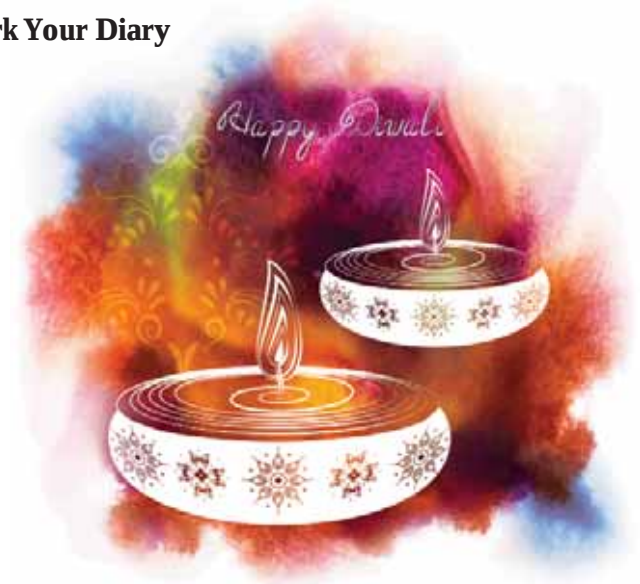

Assoc Prof Dr Jayakumar Gurusamy
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Recipe for Medical Negligence Communication Gaffe

I was recently at a hospital as a visitor to hold the hand of a relative of mine who was about to undergo a lumpectomy for breast carcinoma. During my visit, a house officer walked into the room to obtain consent for lumpectomy from the patient. Ironically, in a span of about 30 minutes, the house officer visited the patient thrice, each time to make amendments to the consent form. My relative was so distraught that she remarked, "Will the surgeon operate on the correct breast"?

The Oxford dictionary defines communications as the imparting or exchanging of information by speaking, writing, or using some other medium. A recent study in the United States of America indicated 30% of medical negligence cases were attributed to poor communication. Your guess is as good as mine when it comes to Malaysia! Statistics regarding annual medical negligence claims in Malaysia are not systematically collated. However, all indications from various sources indicate an upward trend and poor communication is ubiquitous.

It cannot be denied that as doctors, we sometimes take communication with our patients for granted. Some patients may frown upon us for our paternalistic behaviour. Traditionally, the doctor's position has been that of the "all-knowing" physician and one of benevolent superiority (as parent, decision-maker). Quite often, doctors do more talking than listening (Korsch et al, 1998).

A study published in the Journal of the American Medical Association found that 72% of doctors interrupted the patient's opening statement after an average of 23 seconds. Patients who were allowed to state their concerns without interruption used only an average of 6 more seconds. Doctors underestimate the amount of information patients want and overestimate how much they actually give. Doctors who communicate poorly are more likely to end up in court. With regards to a doctor's liability, the burden of proof of successful patient-physician communication often lies with the physicians.

Times have changed now. In this era, the approach is more towards a patient-centred consultation style and less of an authoritative style. According to the American Association of Orthopaedic Surgeons, physicians who practice patient-focused communication show empathy and respect, listen attentively, elicit patients' concerns and calm fears, answer questions honestly, inform and educate patients about treatment options, involve patients in medical care decisions, and demonstrate sensitivity to patients' cultural and ethnic diversity.

The well-known principle is that good communication is the cornerstone of the physician-patient relationship. Patients are more likely to comply with treatment instructions thereby improving patient satisfaction. Overall quality of care may be improved by taking patients' views and wishes, thereby reducing medical error. Realistically looking, patients do not sue physicians they like and trust.

In one of my clinical practice sessions, a patient with a long standing diabetic foot ulcer sought treatment from my colleague. The patient started ranting about the frequent hospital visits with seemingly little improvement to his ulcer. My colleague in a humorous manner remarked, "*Lebih senang dan cepat, kalau kaki awak dipotong penuh*". The patient obviously was unhappy with the statement. The next day, he made a formal complain to the Member of Parliament of the area who sought immediate explanation from the hospital director. In addition, the news was splashed in the vernacular newsprint.

Being witty or humorous may assist to build rapport with patients. However, there is a fine line between a joke and a damning statement. Communication with our patients should be professional and non-judgemental. Sometimes, we encounter colleagues who like to be the moral compass to the patients with their unwelcomed advice.

Studies have shown that failure to be honest with patients is a frequent cause of medical litigation. Patients were more likely to sue when they view the lines of communication are hazy, a probable "cover-up" is imminent or when they want more information. The only way they could get it is to file a lawsuit.

Another aspect which contributes to poor communication among some physicians is the habit of working in silos and shuttling patients to a

myriad of departments or sub-specialties. Patients sometimes endure disjointed experience, with healthcare professionals working in a world of their own towards different management plans; cobbling together disparate pieces of data, and sometimes offering treatment or operating with missing pieces of information.

An article in the New England Journal of Medicine (N Engl J Med 2013) described an unfortunate but all too common situation in hospitals. A patient was very sick in the intensive care unit with respiratory failure and with an unusual skin rash. 40 doctors with more allied healthcare professionals were involved in the patient's care. So many people, in fact, that nobody knew who was in charge and except for ordering more and more tests nobody did anything. The NEJM article sites the "Bystander Effect" which is the tendency for everyone in a big group to assume someone else will act. Finally, the patient was saved by an acute problem which forced a doctor on the spot to actually do something.

It is vital for clinicians to reduce "tunnel vision" where doctors focus only on their area of specialty and ignore providing a continuum of care and managing the patient holistically. It is difficult to pinpoint who is responsible for following up when things fall through the cracks and results in the blame game when things get sour, to the extent of a law suit for medical negligence.

Listening, truth telling, displaying empathy and caring are the hallmarks of patients' expectation in the clinical practice. However, these obligations can be challenging for us to meet at times with the scarce resources, time, complexity of illnesses, conflicting cultural expectations coupled with idiosyncrasies of some patients and caregivers. Often, our high-stakes hospital setting is a recipe for disaster. Factors like extended working hours, sardine-packed outpatient clinic settings, administrative burden, and life-or-death situations all lead to communication faux pas among physicians. Developing strategies to address these challenges should assist to close the gap of communication between patients and physicians resulting in better care.

I dread the time in the near future if I am required to train my medical students to add on one more component to their medical history clerking template of their patients –

Medical Suit History: Have you ever sued your doctor in the past?

"The biggest communication problem is we do not listen to understand. We listen to reply." – Stephen R. Covey.

SUNWAY
MEDICAL CENTRE

Screening for Lung Cancer – Why, How and Who?

By Dr Anand Sachithanandan,
Consultant Cardiothoracic Surgeon

This November, in conjunction with global Lung Cancer Awareness Month, cardiothoracic surgeon Dr Anand Sachithanandan provides a brief update on lung cancer screening.

Why?

Contemporary data from our National Cancer Registry (NCR) (5-year report published October 2016) for the years 2007-2011 reaffirms lung cancer as a relatively common and deadly disease here. It is the leading cancer to afflict Malaysian males accounting for 15.8% of all cancers in men, only marginally surpassed by colon cancer (16.3%). In women, lung cancer is the 5th commonest tumour accounting for 5.6% of all cancers, surpassed by breast (32%), colon, ovarian and uterine tumours. Nevertheless lung cancer kills more men than any other cancer. Approximately 25% of all cancer related deaths in Malaysian men is from lung cancer. In women only breast cancer claims more lives in women than lung cancer which accounts for 13% of all cancer deaths in Malaysian females.

The lifetime risk for any Malaysian to develop a cancer of any sort before 75 years of age is approximately 1 in 10 for men and 1 in 9 for women. The overall lifetime risk for lung cancer is 1 in 55 for all males; 1 in 62 for Malays, 1 in 103 for Indians and highest in ethnic Chinese males (1 in 43). A similar trend is observed in women with the age-standardized risk for a Chinese female approaching twice that of an Indian or Malay lady.

Survival from lung cancer is largely stage dependent although other important considerations include tumour biology and resection margins.

Global data suggests surgically treated early stage IA cancers have an excellent 5-yr survival of approximately 90%. In contrast, survival is grossly diminished for advanced stage IV disease with a dismal 5-yr survival of less than 5-10%. Despite tremendous recent advances in chemotherapy, targeted therapy and immunotherapy, treatment for advanced disease still remains non-curative. The goal of treatment is to palliate symptoms and sometimes confer improvement in disease progression free survival.

Alarmingly, between 89-91% of Malaysians diagnosed with a lung cancer have locally advanced disease or distant metastatic spread at their initial presentation. NCR data confirms only 4% had early stage I disease; stage II (7%), stage III (23%) and stage IV (66%). This immediately precludes a curative therapy for the overwhelming majority (90%). The Health Ministry's inaugural Malaysian Study on Cancer Survival (1st MySCan 2018 Report) confirms that lung cancer has by far the worst survival of all local cancers with a 5-year relative survival of just 11 months and a median survival time of only 6.8 months.

In short, lung cancer is being diagnosed too late in the vast majority of Malaysians with the disease as evinced by the dismal prognosis reported by MySCan. Once symptomatic the disease is often but not always at an advanced stage.

Primary care physicians must not ignore common albeit non-specific symptoms in both smokers and non-smokers, and have a low threshold to promptly further investigate a persistent cough (> 2 weeks duration) or recurrent or unresolving chest infections.

Anatomical lung resection surgery remains the unequivocal gold standard treatment for early (stages I and II) lung cancer after meticulous work up to assess resectability and operability. For medically unfit patients with resectable disease options include a sublobar resection, radical radiotherapy including SBRT or percutaneous radiofrequency ablation. There remains no consensus on the optimal treatment for heterogeneous stage IIIA disease due to ipsilateral mediastinal (N2) nodal disease. In selected cases, there is a promising role for surgical resection in the context of multi modality therapy usually preceeded by neoadjuvant chemoradiotherapy and appropriate re-staging often with endoscopic EUS or EBUS. There is little role for surgery in stage IV disease with the exception of oligometastatic disease from a solitary cerebral or adrenal lesion in a young patient.

How?

Two major landmark trials provide compelling unequivocal evidence on the survival benefits of screening for lung cancer in 'at risk' individuals with the use of a low dose CT (LDCT) scan. The National Lung Screening Trial, USA (published New Engl J Med 2011) targeted American male smokers and ex-smokers (aged 55-74 years) who were randomized to either three annual LDCT scans or conventional chest x-rays. NLST data demonstrated a 20% mortality risk reduction from lung cancer with LDCT screening and an overall 6.7% reduction in death from any cause.

The Dutch-Belgian NELSON trial just announced their much awaited results at the recent World Conference on Lung Cancer (Toronto, September 2018) demonstrating even more impressive statistically significant health benefits. LDCT screening of high risk asymptomatic individuals reduced lung cancer deaths by 26% at 10 years in men. Their researchers suggest 'a significant and even larger reduction' in lung cancer deaths in high risk women albeit in a smaller subset. This European study targeted individuals aged 50-74 years of age who were screened at 1,3 and 5.5 years from randomization. In contrast to the NLST data, there was an acceptably low false-positive scan rate, reflecting advances in imaging technology including volumetric analysis to better characterize suspicious lung nodules.

Concerns of LDCT include false positives, unnecessary invasive biopsies, radiation and patient anxiety. This can be mitigated by application of rigorous investigative algorithms with a multi disciplinary approach based on clinical profile and nodule characteristics.

The LDCT is a quick, single-breath scan that requires no prior preparation or fasting with minimal radiation, as no contrast is required unlike a conventional CT scan. Furthermore recent advances in LDCT imaging has significantly improved specificity and drastically reduced the radiation dose. Having said that it is important to remember that screening for lung cancer is a process and not an isolated test.

Who?

Useful guidelines exist for whom LDCT screening should target but no consensus exists regarding the optimal duration and frequency of surveillance. Based on American/European data and taking into consideration local epidemiology, life expectancy and smoking prevalence it seems not unreasonable to offer screening here for male and female chronic smokers and ex-smokers aged 45-75 years. Others who may benefit include individuals with a family history of lung cancer, a personal history of any cancer, those with chronic lung diseases like COPD, previous pulmonary tuberculosis and chronic exposure to environmental pollutants like second hand smoking, asbestos and radon gas.
Traditionally lung cancer has been a male smokers' disease but alarmingly an increasing number of non or never smokers are now being diagnosed particularly Chinese women, many with tumour expression of a genetic (eg. EGFR, ALK or ROS) driver mutation. Genes aside, chronic exposure to cooking or diesel fumes, and second or third hand smoke (passive smoking) may be a factor. Presently there is a paucity of evidence to recommend screening for non smokers hence early detection in this unfortunate subgroup remains elusive.

Smoking including passive smoking remains the single most preventable and modifiable risk factor in the pathogenesis of lung cancer. LDCT screening for lung cancer does not contradict or compete with smoking bans or efforts to promote smoking cessation. The recent announcement by our new government to ban outdoor smoking at open-air eateries nationwide as of 1st January 2019 is most timely. Legislation to create more smoke free zones and efforts to promote smoking cessation including increased tobacco taxation must be sustained. Political will aside, implementation and monitoring such bans may prove challenging but regulatory authorities must be meticulous and enforcement fair and consistent.

Serum tumour markers (eg. CEA, NSE, Cyfra-21, ProGRP etc.) currently utilized primarily as a research tool and for disease surveillance post therapy may hopefully soon be incorporated into the risk stratification of high-risk individuals who may benefit from screening. If carefully instituted LDCT screening has the potential to save lives with detection of earlier stage disease amenable for curative surgery.

President's Message

Dr Mohamed Namazie Ibrahim
President
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WMA General Assembly in session

Another month has gone and as anticipated, it has been very busy. October is the month for the Annual General Assembly (GA) of the World Medical Association (WMA). This year it was held in Reykjavik, Iceland from 3-6 October.

Delegates from more than 50 national medical associations (NMA) attended the GA. As a constituent national medical association, MMA is represented by the President as the official delegate to the GA, together with the President-Elect as the alternate delegate. Additional members were admitted as observers. Dr Ashok Philip was also present as the Chair of the Advocacy Committee.

The Malaysian delegation at the WMA General Assembly

In the last few years, WMA has allowed the delegates and observers to attend the deliberations of the various major committees and the meeting of the Council of WMA prior to the General Assembly. The non-committee and Council members were also given the privilege of speaking on the matters that were discussed, giving an opportunity for the smaller national medical associations to voice their concerns or to give their input to influence the final outcome of the position papers.

Several policies and position papers were adopted during the GA. Among the issues discussed and adopted include:

Clinical Independence

The original paper on clinical independence is called the Declaration of Seoul on Professional Autonomy and Clinical Independence, which was adopted at the WMA GA, Seoul, Korea in October 2008.

This document was amended this year and reaffirmed that professional autonomy and clinical independence are essential components of high-quality medical care and that the patient-physician relationship must be preserved. Medical professionalism requires these two components, without which the delivery of medical care can be compromised. The Assembly also warned that unreasonable restraints on physicians' clinical independence imposed by governments and administrators were not in the best interests of patients, because they might not be evidence-based and risked undermining the trust between patients and physicians. To this, I would add the restrictions imposed by the managed care organisations/ third party administrators and the insurance companies.

Capital Punishment

The delegates, including MMA, once again reaffirmed that physicians should not participate in any form of capital punishment as it is anathema to the very fibre of medical ethics and is incompatible with the physicians' role as a healer. The Council and GA took note of MMA's stance of being against capital punishment, and acknowledged the dilemma that our physicians face as they are by law, required to certify the fitness of death penalty convicts and to be present during the execution of the convicted prisoners. The Secretary-General of WMA offered to write to the Malaysian government raising the ethical concerns

of physicians in Malaysia. Fortunately, there would not be a need for this as a few days after the GA ended, the Malaysian government announced that the death penalty will be abolished and there will be a moratorium on all executions until then. MMA welcomes this progressive and bold outlook of our government.

Medical Tourism

The statement on medical tourism is important to us as Malaysia is one of the leading medical tourism destinations. Our specialists have contributed significantly to this sector, which is one of the economic driving factors for the country.

The paper was brought to our attention at the Council Meeting of WMA in Riga, Latvia in April 2018. This was the first time that I came to know about it and I had requested for deferment on the discussion on this paper till we had studied it. However, the request was not accepted in spite of the Chairman of the Socio-Medical Affairs Committee asking for a working committee to look into further studying the paper, which was initially proposed by the Israel Medical Association. The Council decided to table the paper at the General Assembly in Reykjavik in October 2018. This paper was subsequently adopted by the General Assembly recently and has become the official statement of WMA.

Among the recommendations in the paper is the one calling on the governments involved in medical tourism to ensure that the health care delivery to their own citizens are not compromised and do not have a negative impact to the country's health care system. Medical tourism should not affect the proper use of limited resources negatively to the residents of the hosting country. There is also a warning on unethical or illegal practices such as organ trafficking. The authorities, including the governments, should be able to stop elective medical tourism where it is endangering the ability to treat the local population. The full statement can be accessed through this QR code.

Telemedicine

The original statement on the ethics of telemedicine was adopted at the WMA GA, Copenhagen, Denmark in October 2007. This policy was reviewed this year in Reykjavik, Iceland.

Telemedicine has been defined as the "practice of medicine over a distance, in which interventions, diagnoses, therapeutic decisions, and subsequent treatment recommendations are based on patient data, documents and other information transmitted through telecommunication systems."

"Telemedicine can take place between a physician and a patient or between two or more physicians including other healthcare professionals."

The statement gives the general principles of telemedicine and emphasises the autonomy and the responsibility of the physician, and quality of care. The recommendations include the adaptation of technology to the local regulatory framework, development of ethical norms, practice guidelines, national guidelines, national legislation and international agreements on subjects related to the practice of telemedicine while protecting the patient-doctor relationship.

An important point to be taken into consideration is that telemedicine should not be viewed as equal to face-to-face healthcare and should not be introduced solely to cut costs or as a perverse incentive to over-service and increase earnings for physicians. There is also the emphasis on the need for the profession to explicitly identify and manage adverse consequences on collegial relationships and referral patterns, besides the need for new guidelines and standards for the practice integration.

The recommendations also include the involvement of the local national medical associations where appropriate. I am happy to note that our Ministry of Health has included two representatives from MMA in the MOH Telemedicine Development Group.

Biosimilar Medicinal Products

This is an important policy paper by WMA which has an impact in developing countries. Following the expiry of patents for original biotherapeutics, there has been an increase in the development and approval of copies called "similar biological medicinal products or "biosimilars", that are highly similar to a previously approved biological product known as the originator or reference product. The biosimilars are not the same as generics. The difference is that a generic drug must contain the 'same active ingredients as the original formulation'. A biosimilar is a different product with a similar but not identical structure that elicits a similar clinical response. These biosimilar products have changed the management of patients chronic and debilitating conditions by providing a cheaper alternative that can achieve a similar efficacy as the originator.

A recommendation in this policy statement warns of the risk of insurers and health care providers resorting to favour biosimilars instead of originators even when the use of the originators may be more appropriate.

The national medical associations are encouraged to be part of the government initiatives to develop national guidelines on the safety of biosimilars.

Development and Promotion of Maternal and Child Health Handbook

The Millennium Development Goals (MDGs) 2015 objective was to reduce the maternal mortality ratio and infant deaths. The Sustainable Development Goals (SDGs) 2030 have set further reductions of maternal mortality ratio, neonatal mortality and the under-five mortality rate as important targets to be achieved.

As early as 1948, Japan was the first country in the world to create and distribute a maternal and child health (MCH) handbook. This was used successfully to protect and improve the health and wellbeing of the mother and the child. There are currently 40 versions of the MCH

handbook throughout the world, each adapted to their local context and need. The use of MCH handbook has been shown to help improve the knowledge of mothers on maternal and child health issues and has contributed to changing behaviour during pregnancy and peripartum period.

WMA recommends the national medical associations to promote the use of MCH handbook adapted to the local needs, promote local research to evaluate the usage and to make recommendations to improve the quality of care in the local setting.

Other Statements

A total of seven new and seven revised policy statements were adopted during the GA. One other policy statement and two resolutions with minor revisions were also adopted. Those interested can access these through this QR code.

Installation of New President

Dr Leonid Eidelman, the Past President of Israel Medical Association was installed as the new President of the WMA for 2018/19 term. He is also the head of anaesthesiology department at the Rabin Medical Center in Israel. The day after his installation the Canadian Medical Association tabled a motion at the General Assembly for Dr Eidelman to resign for plagiarising his inaugural speech from the speech given by a past president of the Canadian Medical Association.

The matter was referred to the Council as per the by-laws of WMA. After deliberation, the Council decided that Dr Eidelman could continue as President as he had given a satisfactory explanation and had apologised for the part that was allegedly plagiarised stating that the speechwriter had done that and he had no knowledge that it was taken from another speech. The Canadian Medical Association was not satisfied and left the Assembly and later sent an email to the Secretary-General and informed him that they are withdrawing from the membership in WMA. This episode, unfortunately, has weakened the WMA as several other national medical associations were also not satisfied with the action taken by the WMA Council.

Election

Dr Miguel Roberto Jorge was elected the President-Elect for the term 2018/19 and will be installed as President in Santiago, Chile in October 2019. He is an Associate Professor of Psychiatry and Chair of the Research Ethics Committee of the Federal University of Sao Paulo in Brazil. He had served as Treasurer of the Brazilian Medical Association. Dr Jorge came to Penang as an observer at the 33rd CMAAO (Confederation of Medical Associations in Asia and Oceania) General Assembly in September 2018.

Social Functions

The four-day General Assembly of WMA was not all work. Iceland is an island created by seismic activity and multiple volcanic eruptions over several eons, which is still continuing. There are on an average of two or three minor earthquake activities every day.

Time was set aside for social functions which included a half-day tour of the Thingvellir National Park. The ancient Viking parliament site is situated in this park. This park is also where the American and Eurasian tectonic plates pull apart, creating a beautiful and scenic rift valley. You can cross over from the Americas into Eurasia within minutes. This area is also well known for its geothermal activity which is used for heating and generating electricity without burning fossil fuels. A visit to an old church was followed by a very sumptuous informal dinner held in a replica of the ancient wooden Viking home covered by turf. This gave an opportunity for all delegates to mingle around and exchange pleasantries as well as for networking.

The host, Iceland Medical Association, were very gracious and generous and since it was a perfect evening with a star-studded sky, they "turned on the Northern Lights" after the dinner – it was a spectacular 'performance' by nature that was an experience of a lifetime for those of us from the equatorial region. Shooting pictures of the dance of the lights in the sky with a DSLR camera was a challenge in itself. It was an opportunity to fall back on the old skills of using manual settings with long exposure to capture the lights while working with freezing fingers against high winds blowing across to destabilise the camera. It was an unforgettable experience that will be cherished by many who witnessed the phenomenon which is frequently seen in Iceland during the winter months.

The spectacular Aurora Borealis, the Northern lights.

Local Affairs – Special Night with YAB Tun Dr Mahathir Mohamed and Tun Siti Hasmah

A dinner function has been organised for the two Tuns in appreciation of their contributions to the nation. MMA Council decided to honour Tun Mahathir, who is a founding member of MMA, with the MMA Life Time Achievement Award and Tun Siti Hasmah with an Honorary Membership of MMA. The Life Time Achievement Award is a newly created award that will be bestowed on members of MMA who have made exceptional contributions to the profession and the nation. Tun Mahathir is one such candidate who rightfully deserves this honour from our Association.

The dinner function will be held on 30 November 2018, at the Shangri La Hotel, Kuala Lumpur. All arrangements are being made and we hope that it will be an event of grandeur befitting the award being bestowed. Please ensure your presence at the dinner and the tickets may be purchased through your branches or from the MMA Secretariat in Kuala Lumpur.

Berita MMA Editorial Board Policy

Berita MMA is an official publication of Malaysian Medical Association. The purpose of Berita MMA is to disseminate timely information of members' views, reports, news and leisure articles that interest a broad spectrum of readership. The bulletin is also intended to be a conduit for discussion of issues facing the medical fraternity or highlight thought-provoking articles. Personal attacks, political statements or innuendos are unwelcome.

Any reports of activities like MMA branch events are encouraged to have more insight on a certain topic held; rather than the mundane line of just reporting the date of event, venue, number of participants or chief guest present.

All articles are in English Language. Contributors of articles should make an effort to vet through their articles or seek assistance from their colleagues to have a minimum standard of language that is acceptable for publication. Plagiarism is frowned upon.

Submitted articles are subject to revisions and minimum language corrections by the editor. We envisage having a diverse range of both articles and contributors. The right to publish is at the sole discretion of the Editorial Board of Berita MMA.

The policy was approved by the Berita MMA Editorial Board on 22 April 2015.

From the Desk of the Hon. General Secretary

Dr Gunasagaran Ramanathan
Hon. General Secretary
secretary@mma.org.my

A good secretariat is very important for any organisation to function smoothly.

MMA, being a premier Medical Association and the largest in this country needs a well-organised Secretariat.

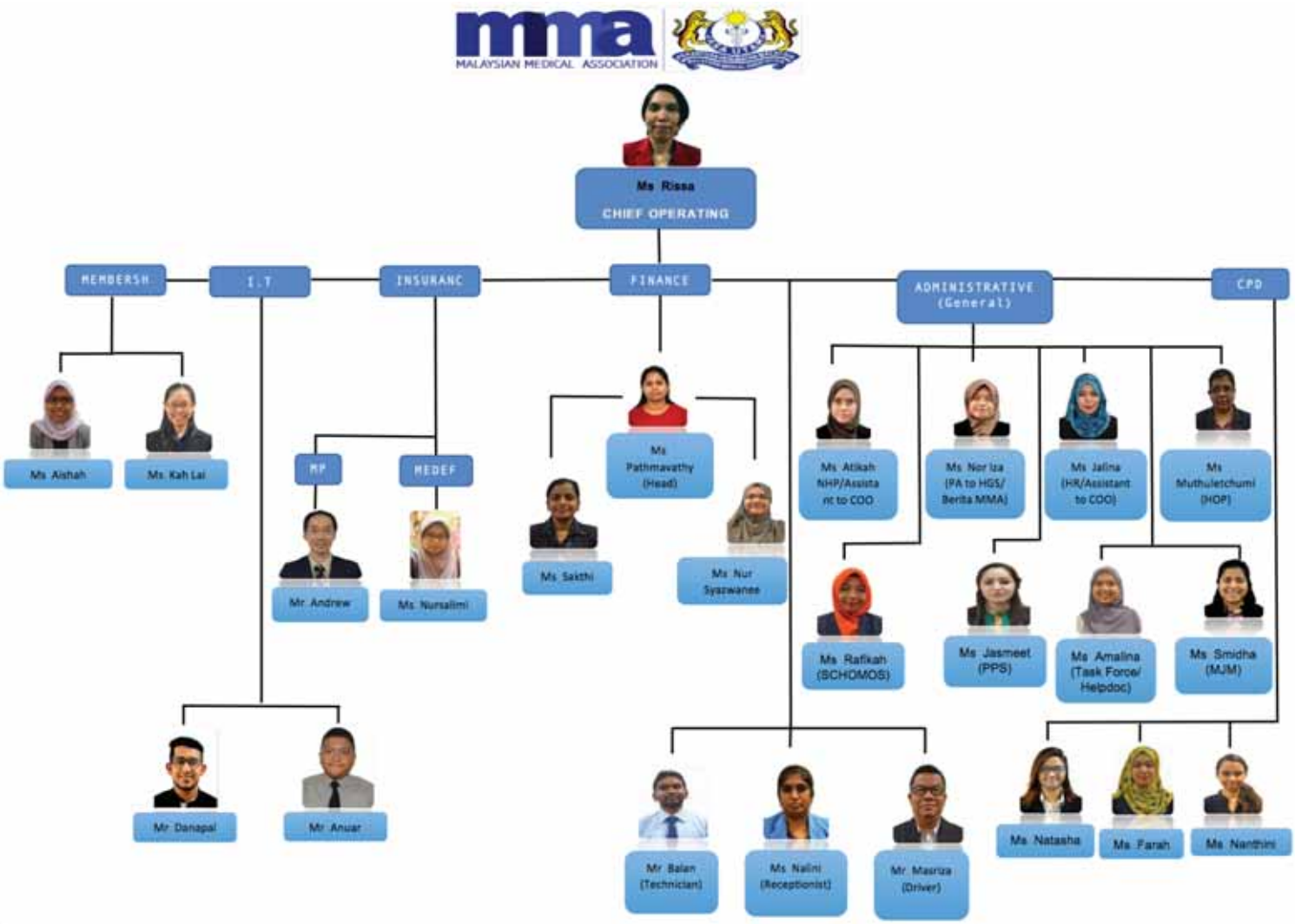
Currently, the MMA Secretariat has 24 full time staffs. While a few are given charge of a single portfolio, the majority of the staff have a number of portfolios under their charge.

Ms Rissa is the Chief Operating Officer (COO) and is in charge of the Secretariat. She plays an important role in ensuring the smooth functioning of the Secretariat.

It is proud to note that some of the staff have been serving MMA since 1995.

KPI standards are strictly adhered to in order to ensure discipline and maximum productivity.

I have attached the organisation chart so that members are familiar with the designations of our staff.



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There will be new committees that will be established soon, e.g. Committee for International Relations and Women and Child Health. Therefore, the need for employing extra staff will arise. Moreover, some staff are tasked with too many portfolios. While some Committees may not be very active, it may become difficult for a staff when more than one committee has programmes that run simultaneously. However, the Secretariat room is also becoming congested and will not be able to fit in any more furniture for new staffs. Serious consideration need to be given to expanding the Secretariat space by occupying vacant rooms on the 5th floor.

In the past, there was a high staff turnout. This has reduced with better salary and incentives. We need to always keep the welfare of our staff as our top priority.

Medical Negligence

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Being the subject of a medical negligence lawsuit is a nightmare for any physician. Not only is the court process laborious and time consuming, but it also impacts the physician's mental health and confidence to practice. There have been numerous cases where physicians have reported feelings of isolation, shame and guilt when a case is brought against them. Data from the United Kingdom (UK) also reveals that there is an increased rate of self-harm among these physicians due to stress exacerbated by 'overly legal' correspondences and confusing processes. It is also a well-known fact that it leads to a change in the affected physician's clinical practices, which oftentimes lead to an increase of defensive medicine.

Much as we may try to avoid being involved in a medical negligence claim, the truth is that by virtue of all of us being human, we will be bound to make mistakes, albeit some more grave than others. There is bound to be some patient who will be unsatisfied with our services despite our best efforts. The statistics on medical negligence claims in Malaysia reveal a rise in cases, corresponding to a similar global trend. Not only are the amounts of cases increasing, but also the amount of monetary compensation awarded by the courts. One of the highest awards made in 2017 was in the case of Rohgetana vs. Dr Navin Kumar & Ors where the court awarded more than RM6 million! As such, it would be prudent for medical practitioners to have some knowledge about medical negligence so that they can be prepared if they are faced with a medical negligence claim.

Why do patients decide to sue their doctors? The common myth regarding this is that to gain compensation. However, most studies

show that this is true in only about 18% of cases. These studies also reveal that most patients sue to correct the deficient standards of care, to find out what happened and why it happened, also to enforce a sense of accountability within the healthcare system. It has also been reported that up to 70% of litigation cases are related to poor communication after an adverse outcome where patients felt that they have been deserted, devalued or have had a lack of information conveyed to them about their illness. This also means that a majority of cases can be avoided by having good and effective communication skills!

Medical Negligence

The word 'negligence' in the context of medical negligence means something more than just carelessness. It implies the "complex concept of duty, breach and damage thereby suffered by the person to whom the duty was owing". Generally, there are three criteria that need to be fulfilled in order for a complainant or plaintiff to succeed in proving that a doctor had been negligent. The first criterion is the establishment of a duty of care. Patients usually have no problems proving that the doctor owed a duty of care to them. In October 2018, the UK Supreme Court extended this duty to the hospital receptionist! The second criterion is that there was a breach in the standard of care of the patient or a dereliction of duty. In the court of law, this standard differs depending on whether the duty of the doctor was related to making a diagnosis, giving information or providing treatment to the patient. The third criterion that needs to be proven is that the patient suffered some damage or harm, and that this damage or harm was directly caused by the breach of the standard of care. This does not need to be limited to only something physical, but it needs to be of significance to the patient.

The Bolam Test

The Bolam test comes from the UK case of Bolam vs. Friern Hospital Management Committee that was decided in 1957. This case involved John Hector Bolam, a patient who was suffering from a depressive illness. He was advised by a psychiatrist for electro-convulsive therapy (ECT) for which he duly consented to despite not being warned of a 1 in 10,000 risk of fracture. Bolam was not given any muscle relaxants prior to the ECT being conducted and neither was his body manually restrained. There was a mixed opinion on use of muscle relaxants as well as restraints for ECT therapy at the time. Unfortunately, Bolam sustained bilateral hip dislocations and pelvic fractures.

He decided to file a suit of negligence against the hospital management for allowing the doctor to perform the ECT without administering any muscle relaxants prior to the procedure or providing some form of manual restraint, and also for failing to inform him of the risks involved. However, the trial judge at the time, Justice McNair, found that neither the doctor nor the hospital was liable for negligence. He decided that "a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art." In other words, the judge decided that a doctor is not negligent if he has acted in accordance with an approved practice just because there is a contrary or different view of management. This pronouncement is famously known as the Bolam test.

The importance of the Bolam test is the fact that while the law imposes a duty of care to the doctor, the standard of care that a doctor owes to the patient and therefore whether there was negligence or not is decided by the medical fraternity themselves and not the courts.

Bolitho Qualification

The Bolam test was further qualified by the case of Bolitho vs City & Hackney Health Authority. In this case, Patrick Bolitho was a 2 year-old boy who was admitted for croup. He developed respiratory distress in the ward for which the nurse made an urgent call to the senior pediatric registrar. However, Bolitho's condition improved despite the doctor not attending to see him. About 2 hours later, Bolitho had another episode of respiratory distress for which the nurse contacted the same doctor again. The doctor was busy in the clinic and instead contacted her house officer to attend but this attempt failed as the house officer's beeper was not working. Bolitho condition improved

again without both doctors attending to him, but deteriorated again just 30 minutes later. This episode resulted in Bolitho collapsing and suffering a cardiac arrest. Resuscitation was commenced, but unfortunately Bolitho suffered severe brain damage and subsequently died.

Bolitho's mother claimed that the failure of the pediatric registrar to attend to her child whilst he was suffering from breathing difficulties amounted to negligence. It was argued by the defendants that even if the doctor had attended to him earlier, she would not have intubated him and therefore avoided the injury. Hence, causation for the damage could not be established. The court chose to accept the defendants' expert evidence, which held that they would not intubated Bolitho had they attended resulting in the health authority winning this case.

In this case, the court decided to retain the use of the Bolam test, but made it subject to a condition that the 'body of medical opinion' would need to withstand logical analysis. What this means is that in the event that the expert opinion does not withstand logical analysis, then the court can choose not accept this opinion. This is important because if we recall the Bolam test that states that a doctor is not negligent just because there is a contrary view, the Bolitho qualification provides an additional condition that these practices need to be a logical one.

Rogers vs. Whitaker

Another case of interest is the Australian case of Rogers vs. Whitaker. In this case, Ms Whitaker's right eye was almost completely blind since she was a child while her left eye was normal. She consulted an ophthalmic surgeon, Dr Rogers, who advised her to undergo an operation to remove some scar tissue in her right eye. She was informed that it would improve the appearance of her right eye and could also probably improve its vision. Ms Whitaker agreed to the procedure. Unfortunately, the surgery did not result in any improvement of the right eye and instead caused a rare complication to her left eye that is known as 'sympathetic ophthalmia'. The occurrence of sympathetic ophthalmic was approximately 1 in 14,000 and it resulted in Ms. Whitaker's left eye becoming totally blind, thus making her literally totally blind and being unable to lead the life she had before the operation.

Ms Whitaker made many allegations about Dr Rogers in this case for negligence but the only claim that was considered by the High Court was if Dr Rogers was negligent in failing to inform Ms Whitaken about the risk of becoming blind after the procedure. The High Court decided that to reject the Bolam test when considering a doctors duty to advice and instead stated that "the law should recognise that a doctor has a duty to warn a patient of the material risk inherent in the proposed treatment". It further decided that the courts, and not a body of respected medical men, should be the decider of the 'materiality' of a risk. This case in essence decided that the decision of whether a doctor is negligent or not with regards to information giving (and thus consent taking) laid with the court rather than the medical profession.

Malaysian Context

These three cases so far are important to us because the main source of medical negligence law in Malaysia is derived from the common law by virtue of Section 3 of the Malaysian Civil Law Act 1956. Hence, the Bolam test was used as the standard to judge if a medical practitioner in Malaysia was guilty of medical negligence or not. However, the decision of the Federal Court in the case of Foo Fio Na vs. Dr Soo Fook Mun & Anor in 2007 determined that the test that should be applied in Malaysia should be that of Rogers v Whitaker instead of the Bolam test. It stated that "the Bolam test has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent and material risks of the proposed treatment".

However, because this case was also concerned with negligent treatment, there was a question as to whether the Bolam test ceased to be totally relevant in Malaysian Law. Since this decision was made, two inconsistent lines arose in the courts' decisions on the standard to be applied in medical negligence cases in Malaysia. One believed that the Bolam test no longer applicable and it was now for the court to decide whether there had been a breach

of the standard of care by a medical practitioner while the other believed that the test in Foo Fio Na and Rogers vs. Whitakers related only to a medical practitioner's duty to advice or provide information to a patient and did not apply to the standard of care expected in respect of the duty to diagnose and to treat.

Zulhasnimar & Anor vs. Dr Kuppu & Ors

The debate of using the Bolam test or the standard of Rogers v Whitaker in Malaysia was decided recently in 2017 by the Federal Court in the case of Zulhasnimar & Anor vs Dr Kuppu & Ors and is currently the landmark case for Malaysian medical negligence law. This case revolved around the occurrence of a rare incidence of placenta percreta(chorionic villi invade through the uterine serosa) at the uterine fundus of Madam Zulhasnimar and the subsequent delivery of her child that was complicated with cerebral palsy. The facts of the case were that a 36-week pregnant lady had presented to the hospital in the early hours of the morning with a complaint of abdominal pain. She had chosen to present to that specific hospital because Dr Kuppu, a consultant Obstetrician and Gynaecologist at that hospital, had previously delivered her first child. She was found to be tachycardic but not in labor at the time of presentation, and was given analgesics, which subsequently reduced her pulse rate to 80 beats per minute. She was then seen by Dr Kuppu during morning rounds and was deemed to be well, but suddenly collapsed at around 11am. She was immediately resuscitated and brought to the operation theater for an emergency caesarian section and subsequently required an emergency hysterectomy. The intraoperative findings found that she had placenta percreta and her baby was delivered with severe cerebral injury due to birth asphyxia.

The patient was unhappy with the outcome and decided to sue the doctors involved and the hospital for negligence, arguing that she was indeed in labor when she presented and that this resulted in bleeding that led to her collapse. She alleged that her child suffered from severe prenatal asphyxia because of a delay in performing the caesarian section. In the High Court, it was found that Madam Zulhasnimar failed to prove that the doctors breached their duty and standard of care. This decision was affirmed by the Court of Appeal resulting in a further appeal to the Federal Court for clarification on the question of which standard of care to determine medical negligence was applicable in Malaysia. The Federal Court decided that in cases of medical negligence, the Bolam test should apply to diagnosis and treatment, while the test applied in Rogers vs. Whitaken should apply to the duty to advice.

Conclusion

We have tried to provide a simple overview of the evolution of medical negligence in Malaysia. The latest Federal Court decision is consistent with the trends observed in other common law countries as is evident from the UK case of Montgomery vs. Lanarkshire Health Board and the Singaporean case of Hii Chii Kok vs Ooi Peng Jin London Lucien. Many doctors have also been worried with a tendency of negligence to involve criminal negligence with the recent events of the Bawa Garba case in the UK. However, doctors should rest assured that if they practice medicine with good ethics, sound knowledge and skills, they should have no cause for worry as the law will be on their side.

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Who is the Second Victim in a Medico-Legal Case?

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In a Medico-Legal case, the victim is always the patient and the party at fault will be the healthcare provider. Whether such cases are disputed within the court system or settled outside, the statistics show that the healthcare provider is usually the party at fault and due justice will prevail most often in favour of the plaintiff [the patient]. After months to years of legal arguments, the defendant [the healthcare provider] will have to pay the plaintiff accordingly, once found guilty after exhausting all avenues of appeal.

The victim or the next of kin who may have suffered from the act of negligence or misconduct of the healthcare provider, will get some measure of satisfaction once the verdict is passed by the court, even though the suffering of the patient could be beyond what can be compensated by financial means alone.

But then who is the second victim? This is often not thought of and most societies around the world would rather not address this group who do also suffer in the process of serving good justice to the main victim.

Second victims are the health care providers who carry the blame of the entire medical mishap. It could be the treating doctor, nurse, pharmacist or any health care provider. The psychological trauma of facing the complaint and then the various levels of investigations and repeated questioning from hospitals to ministerial committees. The mental agony becomes even more unbearable while facing medical council hearings which could last for months and years without accounting for the constant postponements.

Medical care providers will suffer further in silence when these cases are presented in court and names are published in the media. The agony of facing the judgement passed by the media and these days by social media could have lasting effects.

Doctors and nurses who still have to make a living are forced to face the criticism of colleagues within hospitals and the fraternity.

There will only be negative assumptions and everyone will choose to be judgmental on the case.

We know that no medical care provider in most instances will 'plan' to be negligent or make an error. Medical errors are mostly committed unintentionally and are largely un-avoidable. There are two victims in Medico-Legal – the patient and the second victim, the healthcare provider – and we have to deal with both the victims.

What Should We Do with the Second Victim?

The main victim [patient] has many avenues to get medical and legal assistance. The courts will dictate the course of action and it has to be complied with. Medico-legally the case will be deemed to have been settled and depending on their circumstances patients will move on, although there may be times when the traumatic thoughts and /or physical damage would remain.

Will it be the same for the 'convicted' health care provider as the case closes? Can he or she continue to practice in the same frame of mind? Will the guilt and shame persist forever? Will it ever be forgotten? Do we leave this group of 'wrong doers' alone and say 'serve you right'? A health care provider may have had an impeccable success record and the best results treating patients but just one incident ruins the entire success story he or she had.

Many second victims may just move on to another life and leave clinical medicine. They would just accept it as fate and unfortunate. To have an excellent healthcare provider leave everything because of one case, would be very unfair. We know these second victims suffer a great psychological trauma and many have gone into depression and a few resorted to suicide. Some may pick themselves up and get going into their practice and ignoring the incident but accepting it as a lesson learnt provided they were not barred from practice by the authorities.

Whilst not condoning the medico-legal errors, we in the healthcare fraternity should have support groups to help second victims. Let's leave the mistakes aside and give these second victims space to get back to life. The mental anguish and self-blame will reduce if their peers could encourage these second victims to get back to work and move on.

Justice to the patient must be served in accordance to the law, but the processes should be done quicker as lengthy trials and enquiries will frustrate the healthcare provider and the patient. A prolonged time to reach a verdict is damaging and frustrating to all parties as everyone wants a quick closure.

Medical colleagues should have empathy and be supportive of the second victim. No one in the medical world can be immune to the potential risk of a medico-legal battle. Patients and their lawyers will use all avenues to be compensated should there be an error, and the healthcare provider has an equal opportunity to defend legally. But the social and emotional trauma should not be aggravated, particularly by the same profession. We must remember that anyone within the profession could be the next victim.

Hospitals should have policies to govern remedial actions to address the grievances of patients, and this is usually done well. However, at the same time, due consideration should be given to the second victim without compromising the rights of the patient.

In conclusion, the second victim is a victim like the patient in the entire incident and moving forward, it's imperative that we do not ignore them.

SCHOMOS Updates

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The team with Dr Mohd Fikri

Meeting with Medical Development Division, MOH

Regular meetings and the further communication with higher authorities have been a part of the ongoing efforts to continuously bring up important issues for the betterment of conditions for our government doctors. On 6 September 2018, SCHOMOS EXCO together with National EXCO had an important meeting with Medical Development Division (MDD), Ministry of Health (MOH) to discuss and highlight these vital issues. Dr Mohd Fikri bin Ujang who is the Deputy Director of MDD and his team listened to us and the mood was positive for working together to handle the matters.

The main issues that were discussed were as follows:

1. **Workplace Bullying and Harassment**
   Recently, there has been increase in the number of complaints regarding workplace bullying and harassment. This has brought attention of the many cases and the urgent need for intervention to solve these matters. MMA has initiated the move with the introduction of HELPDOC, subsequently championed by SCHOMOS, which will serve as a portal for doctors to channel their complaints. MOH has agreed that complaints can be directed to them. This joint collaboration has so far seen a positive response, with the majority of complaints and issues related to SCHOMOS being solved within 2 weeks.

SCHOMOS also invited Dr Fikri to be the chief guest of the JDN (Junior Doctors Network) Conference, which will involve doctors from several countries around the world including Japan, India, Singapore, Myanmar and many more. The theme for the event would be *Leading the Way towards Mutual Respect – The Role of Junior Doctors in Preventing Workplace Bullying.* A declaration would also be signed in conjunction to the event. Dr Fikri also advised us to inform our doctors that any form of bullying or harassment, be it physically, sexually, or mentally, should be reported immediately – they may use various channels such as HELPDOC, hospital administrators or directly to MOH. He also mentioned that before this it had been difficult for Ministry to investigate further in view that complainants do not prefer their details to be known. He urged that without those details, it becomes difficult to make the necessary investigations pertaining to the matter.

SCHOMOS had also made a courtesy visit to the Occupational Safety and Health Unit on 8 August 2018 to discuss on how we could work together in coming up with guidelines in handling bullying and harassment amongst healthcare workers especially between doctor to doctor. The team

was also happy to share how HELPDOC had been progressing. SCHOMOS also mentioned that a permanent slot will be given to OSH Unit for a talk during the Rights and Responsibility Seminars in the future. A recent survey was conducted online and more than 2300 respondents gave their views. This data is being analysed and will be presented during the JDN Conference in Penang.

2. **House Officer Placement and Waiting Times**
The number of medical graduates in our country has been on a rising trend recently and placement issues have been a major concern to the ministry. This has caused the waiting time to increase before they can be offered contract posts. The second reason why there has been a delay is that 30% of them do not finish the Housemanship Training program within the stipulated time, leaving no more extra places for new housemen to be absorbed in. SCHOMOS strongly supports the idea of the Ministry to place these officers under a contract post and they would need to go through proper assessments and training before being offered the permanent posts as Medical Officers. Ministry is also looking into upgrading eight more hospitals in the next two years to ensure they would be prepared to receive House Officers. The hospitals are Hospital Langkawi, Hospital Slim River, Hospital Labuan, Hospital Port Dickson, Hospital Lahad Datu, Hospital Keningau and Hospital Sarikei. A pre-requisite is that each department must have two gazetted specialists. From 44 hospitals we shall have 52 hospitals which will accommodate House Officer postings within the next two years.

3. **UD56 Posts for Senior Medical Officers**
Ministry has agreed to collaborate with SCHOMOS to come up with a criterion of selection for senior officers entitled for the UD56 posts. There was a concern from SCHOMOS that since recently senior teachers have been granted the Grade 56, doctors should also be given the privilege. As a matter of fact, this matter has already been brought forward to Ministry of Health during the meetings in November 2017 by SCHOMOS Exco but it proved unfruitful.

4. **Medical Officer Contracts and Criteria for Conversion to Permanent Posts**
A serious concern was raised whereby approximately 3000 doctors will not be able to get permanent posts. Considering the fact that private GP market is currently saturated, where will these doctors look to for the career? Ministry is in discussion to come up with a criteria for selection into permanent posts and it will be made transparent to all House Officers joining the system. However, if there is a need for the services of the doctors, but a lack of permanent posts, their contracts may be extended further. District postings and primary care postings may be an important criteria for selection process as well. Besides that, Ministry also encourages those doctors interested in pre-clinical studies to take up Post Graduate Studies in these fields as there seems to be a lack of expertise nowadays amongst our local doctors. Research and Development is another field that may attract these doctors to pursue their career. These new career opportunities can be options for the doctors.

5. **Sub Specialists Allowance**
SCHOMOS suggested that the training allowance to be given to sub-specialists who give training. Ministry understands the concerns and will look into the matter and provide us with feedback on the progress of the matter. There was a recent concern that many sub-specialists are leaving (to private sector) in view of lack of these incentives in the government sector, Ministry will look into this matter seriously and update us. Since 2016, SCHOMOS has been advocating for these senior doctors who are sub-specialists to be given special allowances for their services and a good acknowledgement from Ministry has been achieved whereby they would look into special allowances for Trainers involved in the Sub-Specialist Training Programmes.

The meeting was fruitful and reinforces the close relationship with MOH and MMA. We are grateful that Dr Mohd Fikri for taking the time to see us and hear us out. SCHOMOS will continue to follow-up on these issues and engage in discussion for the betterment of the doctors. SCHOMOS will continue to engage with the Ministry with more meetings for the betterment of conditions for our doctors in the public sector.

PPSMMA Updates

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Legal Frame Work for Online Healthcare Services (OHS)

Planning Division, Ministry of Health (MOH) headed by Datuk Dr Hj Rohaizat B Hj Yon, took the initiative to develop the Legal Frame Work to regulate OHS, based on the five principles of Healthcare Services:

1. Patient safety.
2. Quality of care.
3. Assurance of data privacy, security and confidentiality.
4. Accountability.
5. Traceability.

A total of 17 stakeholders were invited from MOH, regulatory bodies and profession. MOH is planning to roll out the legal frame work by Dec 2019. MMA attended the workshop representing the profession which was held on the 3 – 4 Oct 2018.

MMA expressed its stand based on the above five principles:

1. OHS must be regulated.
2. OHS on the first instance should be for calling in the doctor for F2F consultations.
3. OHS should be for provider to provider platform.
4. Home visit by registered doctors.
5. OHS should strictly comply with the Code of Professional Conduct by MMC, PHFSA and its regulations and various other regulations.
6. The legal frame work should address key areas and principles:
   a) Clinical standards & outcomes.
   b) Human resources.
   c) Organisational.
   d) Technology & equipment.

MMA also expressed its concern on:

1. Over-commercialisation of healthcare by certain business models currently being used by OHS.
2. Transactional Consultations.
3. Certain Vendor Driven Policies rather than Vendor Compliant Policies.
4. Doctors “contracted” by certain OHS have clearly breached CPC of MMC and, MMC & ministry should not be waiting till the framework is out.

MMA thanked Datuk Dr Hj Rohaizat B Hj Yon, *Pengarah Unit Perancang*, MOH and his team for the good work, research and the professionalism in conducting the workshop. We are also happy with *Unit Perancang’s* reassurance that MMA’s view, stand and concerns will be addressed. We have also requested for the draft before it is send to the next level.

Private Healthcare Productivity Nexus

This workshop is an initiative under the Malaysian Productivity Corporation which reports directly to the prime minister. It is focused more on the private hospital but managed to push in the Private Primary Care as well. It is being championed by Dato’ Dr Jacob Thomas, former president of APHM.

They had three work streams:

1. Regulatory compliance.
2. Innovation & technology to increase productivity.
3. Workforce management.

MMA attended work stream two which discussed:

1. ICT as enabler in delivering care.

2. Integration of care.
3. Regulatory compliance / Uberisation of Healthcare.
4. Private-Public Partnership / Private-Private Partnership.

Managed to place some of the current ongoing discussion/study/proposal by MMA on:

1. MMA-IJN GP collaboration (Private-Private Partnership).
2. The ongoing study of Public-Private Partnership with Skim Peduli Sihat.

Dato' Dr Jacob Thomas agreed and supported MMA, on the need for Private Primary Care (GPs) to be included in any talks concerning Private Healthcare in Malaysia.

Fee Schedule/Third Party Administrators/FOMEMA/ GP enhancing meeting with Legal Officer, Medical Practice Division, MOH, and YB Dato' Seri Dr Dzulkefly Ahmad.

The earlier stand to march has been put on hold for the time being, as we have achieved what we wanted in our recent meeting with *Bahagian Amalan Perubatan* and MOH on the 15 October 2018.

1. **Harmonisation of the 7th Fee Schedule** is progressing well, and will hopefully be gazetted in the next 2-4 weeks. The delay is due to the processes that involves other agencies and ministries.

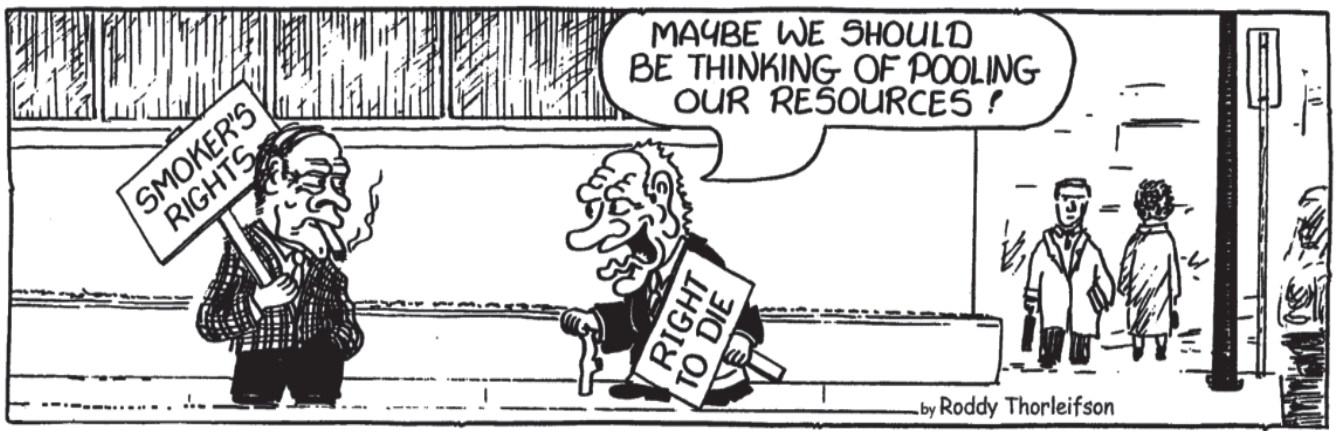
2. **Third Party Administrators** – Dr Ahmad Razid B Salleh, *Pengarah Bahagian Amalan Perubatan*, MOH, reassured us that the regulatory issues with Third Party Administrators will be resolved by December 2018. MMA has already submitted to Bahagian Amalan Perubatan the Common Agreement between Registered Medical Practitioners and Third Party Administrators that complies to the acts, regulations & MMC code of ethics for vetting.

3. **FOMEMA** – The Minister of Health, YB Dato' Seri Dr Dzulkefly Ahmad, has instructed his officers to take seriously the issues on transparency in allocation of laboratories and X-ray facilities, monopoly of transmission system and also placing the concessionaire agreement under OSA. The bundle system proposed as an interim solution while awaiting the proposed fee revision was welcomed by the Minister.

4. **General Practitioner Enhancing.** MMA has urged a Task Force under the MOH to enhance private primary care as the gatekeeper and reduce the overall ballooning healthcare cost by focusing in preventive care via Digital Health. To assist MMA's initiative for a study, prepare a report and proposal on early detections of NCDs and its complications by GPs via a PPP model. Assistance from Family Health and eHealth, Ministry of Health.

- MMA-IJN GP collaborations.
- *Skim Peduli Sihat* model for NCDs

YB Dato' Seri Dr Dzulkefly Ahmad is not only in support of, but also welcomes the initiative and will get relevant agencies within MOH to support it as well. Need to wait for details.



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Elective Experience

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After completing my fourth year in medical school, I had seven weeks of semester break left before recommencing my final year in September. During that period, I decided to proceed with a four-week elective posting at the Department of Anesthesiology and Critical Care, University of Malaya Medical Centre (UMMC) and then, a short stint at the International Volunteers Headquarters (IVHQ) Medical Volunteer Program at 1A Hospital Orthopedics and Rehabilitation, Ho Chi Minh City, Vietnam for the next two weeks. My experiences of doing these attachments in both places were absolutely wonderful – without a doubt. I got to learn a lot of things in the medical field and met some of the most amazing personalities from different parts of the globe. At UMMC, I had the privilege of seeing a wide range of cases from medical, surgery and others along with the experience of managing patients in ways that were very efficient and with a minimal risk of infection. On the other hand, the hospital that I was attached to in Vietnam was an Orthopedics and Rehabilitation centre and most of the patients there suffered from motorcycle accidents, work-related injuries, stroke and as well as Agent Orange exposure from the American-Vietnam War.

With the team in Vietnam

Agent Orange is an herbicide and defoliant chemical and it is widely known for its use previously by the United States military as part of its herbicidal warfare program; Operation Ranch Hand during the American-Vietnam War from 1961 to 1971 and from the records, over three million people in Vietnam were exposed to this agent. Its effects also include damaging environmental issues, in which over 3.1 million hectares of forest in Vietnam were defoliated and the traces of dioxin was found in the mixture. It caused major health problems in Vietnam such as leukaemia, Hodgkin's lymphoma and various kinds of cancer for many individuals who were exposed and the chemical is also capable of damaging genes resulting in deformities among the offspring of exposed victims.

These electives also gave me a perfect opportunity to explore areas of medicine such as anaesthesiology, critical care, orthopedics and rehabilitation medicine, as well as some parts of surgery in greater depth and I also had the opportunity to find out more about the career opportunities in these fields. It also provided me a good chance to get an insight of what are expected of doctors in this area of medicine by their patients. The reasons I had chosen Vietnam was because I wanted to experience a new culture, while developing my medical knowledge by gaining an insight into the Vietnamese healthcare system. This was a unique opportunity to gain a greater understanding of differences and to compare the medical systems between Malaysia and Vietnam, along with contributing what I could in terms of clinical skills to the Vietnamese. The best part of both elective placements was actually being able to do various procedures and to assist the doctors and nurses in their daily activities. The nurses and other hospital staffs taught me and other elective students the proper way of doing things; to have an overview of their medical practices and some of their own guidelines. Coming from Malaysia, there was a huge culture shock when I first entered into the Vietnamese hospital. It was quite an eye-opening experience to see how very little resources could be used efficiently to yield the maximum care for the patients.

Medical volunteers from United Kingdom, Morocco, Spain, Hong Kong and Malaysia.

At UMMC, I had an opportunity to learn about basic anaesthetic management and skills along with attachment at the critical care unit. It gave me a chance to understand infection control, management of high-risk patients and as well as the importance of mobilisation

of bed-ridden patients. While monitoring the delivery of anaesthetic drugs during a surgery, I also managed to observe many surgeries such as carpal tunnel surgery, reconstructive urology surgery, transurethral resection of prostate (TURP) for benign prostatic hyperplasia, total abdominal hysterectomy and bilateral salphingo-oophorectomy (TAHBSO) for infected ovarian tumour and many more other interesting surgeries. I also learnt about the importance of reviewing the patients in anaesthesia clinic prior to their surgeries, which is very vital in order to reduce the risks and complications of surgeries as well as the importance of post-surgery pain management care for the patients, which is also known as acute pain service (APS).

APS provides timely application of appropriate pain relieving methods, which improves the overall postoperative pain management and patient's hospital experience. I also learnt the importance of taking relevant investigations for certain cases and not wasting the hospital resources as some investigations can be very expensive and must be done if there are only important indications.

In Vietnam, we would check and change the patients' intravenous lines, fluids, and administer intravenous tube therapy as a daily routine every morning and afternoon. Then as the day continued, I would help to clean some of the extremely severe wounds in the Trauma Ward. The wounds that we encountered varied from open to close wounds, and wounds with internal and external fixations. Subsequently, we would check their blood pressures. It was not unusual if the family of the patients would also ask for their blood pressure to be checked. They would then ask if the results are normal and I would use the Google Translate app to show them the results since most of them cannot understand English language. After showing them the results, I will say 'good' with a 'okay' hand gesture and eventually they would have a huge smile on their face. On some days, the routine work was to assist or observe the doctors in either at the occupational therapy room, acupuncture department, wound care clinic or the surgical clinic. I also managed to shadow the work of the surgeons in the operating room. On one occasion, I witnessed more than three surgeries in a day. The surgeons showed my friend and I the methods of skin grafting, internal fixation of broken bones and proper wound care cleaning during surgery. When compared to the hospitals I had been attached to previously, there was a vast difference with their operation theatre. The Vietnamese's operation theatre was small, some had fans instead of air conditioners and some surgical utensils were re-used without autoclaving but just by washing with normal saline fluids. The Vietnamese hospital that I was attached had no house officers or interns because it was operating as a specialised hospital. Therefore, most of the immediate care for the patients was done by the nurses and then followed by the doctors. If it was in Malaysia, the house officers would have done the immediate management with the supervision of a medical officer or senior doctor and the nurses would just aid the junior doctors. It was indeed remarkable to see something different.

Attachment at University of Malaya Medical Centre (UMMC)

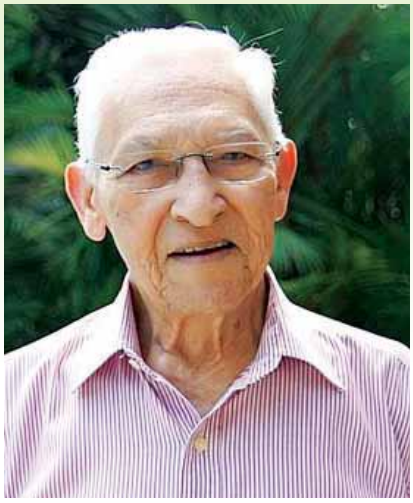
To reflect back on my experiences during the whole period of my electives, I can conclude that I had learnt much more on how to be more flexible and adapt to the changing situation as well as to always have a back-up plan as things sometimes could derail from the initial plan at any moment. Additionally, I also had learnt to be more opportunistic (in a good way), to learn as much as possible from the house officers and senior doctors. At UMMC, I was always attached with the house officers, thus I felt that I could roughly know and be aware of on how house officers work, how to prepare for each patient, ward rounds and proceed in obtaining the necessary investigations. I am sure that I am almost capable to do the task of a house officer in the future but more importantly at this moment, I have to be better equipped with the knowledge and experience so that I can be trained to be a safe doctor when the time arrives so. I cherished every minute that I spent at both hospitals, soaking up the miles of information that was available out there, even if some were just by merely observation.

Night view at Ho Chi Minh City, Vietnam from the Saigon River Cruise.

Founding Member of ICAN Nobel Peace Prize Winner

Datuk Seri Dr Ronald S McCoy

This article is about a sterling Malaysian medical professional who believes that all the babies he has delivered deserve to live in a world free of nuclear weapons.



The Nobel Peace Prize 2017

On 6 October 2017 the Nobel Peace Prize 2017 was awarded to International Campaign To Abolish Nuclear Weapons (ICAN). The award was given because of its "work to draw attention to the catastrophic humanitarian consequences of any use of nuclear weapons" and its "ground-breaking efforts to achieve a treaty-based prohibition of such weapons".

The idea to form ICAN was initiated by Dr Ronald McCoy and eventually achieved in 2007, with very significant contribution from the *Medical Association for Prevention of War Australia* (MAPW) an affiliate of *International Physicians for the Prevention of Nuclear War* (IPPNW). MAPW's Tilman Ruff became the founding chairman of ICAN. ICAN is now a global coalition of more than 450 civil society groups from 101 countries. Its untiring efforts resulted in the adoption of the United Nations Treaty on the Prohibition of Nuclear Weapons on 7 July 2017.

Career before Retirement from Medical Practice

Dr Ronald McCoy, a Malaysian of Anglo-Indian descent, was born in 1930 in Seremban. He received his secondary education in Victoria Institution Kuala Lumpur and entered University of Malaya in Singapore as its first batch of medical students in 1949. During his housemanship in Kuala Lumpur General Hospital (KLGH) two significant events occurred. First he did obstetrics and gynaecology (O&G) under Dr Derek Llewellyn-Jones, whose professionalism so impressed him that he subsequently specialised in O&G.

He later became the secretary of the Medical Alumni Association (the MMA did not exist then) under the chairmanship of the late Dr Tan Chee Khoon. Encouraged by Dr Tan, he wrote an expose of KLGH which was published in the Malay Mail. Although this made him persona non grata with the government, Dr McCoy was awarded two years of study leave to specialise in O&G. When he came back with the MRCOG, he was posted back to work with Dr Llewellyn-Jones. However, when he continued to be critical of the administration of KLGH, he was transferred to the GH in Seremban. As his wife was working in Kuala Lumpur, he decided to resign from government service despite his initial intention to work in government service till retirement. He then worked at Assunta Hospital, and later Pantai Medical Centre of which he was one of its founding members. Dr McCoy decided to retire in 1996 in order to fully pursue nuclear disarmament when he was appointed to the Canberra Commission on the Elimination of Nuclear Weapons by then Australian Prime Minister Paul Keating.

Founding ICAN

Dr McCoy began his involvement with IPPNW in 1986, after reading about the award of the 1985 Nobel Peace Prize to IPPNW. In 1987 he founded Malaysian Physicians for the Prevention of Nuclear War (MPPNW) which then became affiliated with IPPNW. He fully shared IPPNW's stance that as it would be impossible for doctors to make any meaningful response in a nuclear war, doctors therefore had a responsibility to work for the elimination of nuclear weapons. Dr McCoy served IPPNW as co-president for eight years.

36th MMA Council 1994 – 1995

At the annual general meeting of the Victoria Institution Old Boys Association in Singapore on 18 January 2018, Dr McCoy gave a talk titled "Banning Nuclear Weapons". He warned that "any detonation of nuclear weapons will produce incinerating heat, powerful blast effects, ionising radiation, and massive amounts of smoke and soot which will blot out the sun, cause severe climate disruption and a nuclear winter, leading to crop failure and famine, and possibly human extinction."

During an interview in year 2000 he stated "We will keep working to eliminate nuclear weapons. It's a long struggle….. Maybe not in my lifetime, but maybe in the next generation, we will get down to zero nuclear weapons with a bit of luck."

When the 2005 Nuclear Non-Proliferation Treaty (NPT) review conference failed to advance nuclear disarmament, Dr McCoy proposed a change in strategy to IPPNW. He commented, "It felt like barking up the wrong tree… So, let's take nuclear disarmament out of the NPT process, which was not working, and let's form an international campaign to abolish nuclear weapons. That is how we got ICAN."

The Doer and Mentor

Believing that we should all work for the betterment of the society and the world we live in, Dr McCoy has played a number of other roles. He is a pioneer member and past president of the Malaysian Medical Association (MMA) and chaired the MMA National Health Plan Committee which proposed universal coverage and equitable access to health care for all. He was also a member of the Aliran Board of Trustees.

On the personal level, he is committed to the individual development of others, especially when his own personal and career development has been enriched by a number of mentors.

Awards

Dr McCoy was awarded the Datuk Paduka Mahkota Perak (DPMP) by HRH Sultan Raja Azlan Shah of Perak in the early 2000s. On 14 January 2018 HRH Tuanku Muhriz ibni Almarhum Tuanku Munawir of Negeri Sembilan awarded him the Darjah Seri Setia Negri Sembilan Yang Amat Cemerlang (SSNS) with the title "Datuk Seri" for his role as a world peace activist in the founding of ICAN and in the adoption of the Treaty on the Prohibition of Nuclear Weapons.

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Are We Ready for Geriatrics?

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It was my great pleasure to speak in two highly prestigious conferences across the nation in the month of August 2018. The 1st Malaysian Congress of Geriatric Medicine (MCGM) was held from 2-4 August 2018 in Alor Setar, Kedah. The congress was run by a team of dedicated geriatricians with the theme of "Together We Care" where 40 speakers were invited to contribute their knowledge, comments, experiences, thoughts and most importantly, their enthusiasm towards elderly care. It was a fantastic event involving more than 500 delegates from different entities ranging from healthcare professionals, NGO and layperson. Network building and sharing of thoughts were emphasised to be the most imperial among the topics.

MCGM was followed by Emergency Medicine Annual Scientific Meeting (EMAS), from 6-8 August 2018 in Putrajaya. This meeting attracted 70 speakers around the world and it focused on "Art & Science in Emergency Medicine – Putting Evidence into Practice". Emergency physicians have expressed their interests in critical care, clinical toxicology, pre-hospital care, trauma, medical education, administration, paediatrics and geriatrics. The great momentum of this very fraternity event was witnessed by more than 700 emergency medicine enthusiasts.

The World Health Organization (WHO) defines the elderly as those who were more than 65 years of age. Numerous figures and data around the world has precisely pointed out the population is ageing, which has been spotted as a global population issue. Global population ageing emerged as the utmost challenge to all the countries. The focus and demands of healthcare systems will need to consider and accommodate the upcoming issues and requirements for the ageing population while still prioritising other health care issues such as communicable diseases, child and maternal health and many others. It is definitely a valid issue to be dealt with, as it is forecasted to have a great impact on social and financial responsibilities.

The service industry has conquered the past two decades due to the quality, value, maintenance and its outcome which progressively drawing the attention of various categories of consumers. Those were the days when money was only spent on the availability of the service whilst quality of service may be the aim. Back in the 1970's, accessibility to doctors or a healthcare facility posed great difficulties. In contrast, currently many new emerging medical schools have been founded and multiple healthcare facilities, including clinics, are available along the street.

Are We Treating Our Elderly Well?

Malaysia is currently gifted with 36 dedicated geriatricians serving in government, private and universities to take care of nearly 3 million of elderly citizens. This enormously insensible figure reflects the duty of family doctors or general practitioners in dealing with the elderly's problems in the community. There are various groups of warm-hearted people who contribute in various ways to provide services regardless of government or private sectors. However, their efforts have not been fully optimised as not all the elderly individuals benefit from their programmes. There are nursing homes, old folks' homes, day care centres and others across the country aiming to serve the elderly population. However the human resources, financial implications, knowledge and skills sometimes appear to be limited due to several reasons.

Overcrowding is an upcoming issue as the population is overwhelming and the service is not readily available to cope with it. Nowadays, emergency departments (ED) are pathetically playing the role of a main treatment modality or destination for elderly patients. Apart from attending the critical cases, ED is also occasionally used as a "dumping" ground for dependent patients or those who lack family support.

A reminder to everyone, "geriatrics" is a medical term which allows us to stratify the number of people over a certain age. The more important point would be the functional status, individual's ability, capacity and health status. Hence, there is always a good discussion on the biological age versus chronological age. Education and training uphold a very essential role in making elderly care into a huge success and not limited in terms of healthcare or allied health groups. This is supposed to be a concern for the whole nation, as everyone is getting older every day, day by day, without fail. It will be such a graceful scene to start appreciating and understanding the elderly from primary education.

Hence, the author would wish to remind everyone that the elderly group have sacrificed their younger days in building their families and the nation, for the forthcoming generations and they in no doubt deserve a better care from any system. In terms of health care systems, geriatric care requires interdisciplinary approaches. Physiotherapists, occupational therapists, pharmacists, rehabilitation physicians, family medicine specialists, emergency physicians, social welfare officers, hospital administrators and others are important in promoting elderly care. WHO serves as an untiring advocate of geriatric care reformation. It seeds the awareness for training all future medical doctors in the care of the older person and encourages the adoption of life-course approach in the education and training of doctors.

The low expectations of the older generations and ignorance from current generations have caused the importance of elderly health awareness to lag behind. Those were the days where it was considered crass if you spend time, cash and effort on the elderly as they had never fallen sick and would not want to get themselves treated. Just imagine the two extreme age groups in our lives, namely the paediatrics and geriatrics. We have special regulations, guidelines, check-ups, plans, protocols, policies and etc. even before the babies were born. We are fighting hard for our children and the next generations. How about those who have touched the magic figure of 65? We still have similar guides for them but with loose practice. What have we fought for ourselves when we reach 65? Honestly, nothing much that we can actually recall, DIL (death in line) and DNR (do not resuscitate) are definitely not specifically tailored-made for elderly population.

Back to my emergency medicine business, where we never fail to be a busy and happening spot in any hospital. There is a yearly increment of elderly visits to all emergency departments across the nation. However, the conventional way of training medical staffs may need further modification or enhancement. Previously, there was no proper geriatric rotation in medical schools for medical students and paramedics have limited exposure on geriatric approaches. It is not surprising that elderly are treated as "another adult". While it is not wrong to do so, they definitely deserve more precise care and better quality of treatment pertaining to their pathophysiological needs.

Resuscitations, diagnoses, uncertainties, mixture of feelings, happiness, emotions, cries and deaths are all the elements of this unique spot. We wish to provide the elderly a better approach of care and hence a better future. The International Day of Older Persons is observed on 1 October of each year. The theme for 2018 was "Celebrating Older Human Rights Champions".

Mental Anguish of Non-Psychiatrists Treating Mental Anguish

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On Monday, 1 October 2018, a 15-year old student of SMJK Heng Ee, Penang, jumped to her death from her 11th floor apartment unit in Jelutong, George Town. She was supposed to have taken her PT3 examination that day. She left behind 4 notes – one each to her parents, friends, classmates and teachers.

As of July 2018 there are 381 psychiatrists on the National Specialists Registry. They have to serve a Malaysian population of more than 30 million. Singapore has a population of 5.6 million and they have more than 300 psychiatrists. The latest National Health and Morbidity Survey 2015 revealed that the prevalence of mental health issues among Malaysians age 16 and above was 29.2% or about 4.2 million. It is obviously impossible for a psychiatrist to treat more than 10,000 patients at any one time. You do not need a rocket scientist to tell you that this gap in service can only be fulfilled if non-psychiatric physicians and general practitioners (GP) step up and step in as gate-keeper. Yet non-psychiatrists who treat patients with mental health issues face many challenges which result in mental anguish.

Mental Anguish of Missing Physical Ailments, Like Cancers

The medical training is skewed towards identifying symptoms and eliciting physical signs. We are trained to look for abnormalities in investigations. But there are many diseases where abnormalities are functional rather than structural.

With their skewed training, doctors feel 'dis-eased' when patients are unwell but have no physical signs or when investigations draw a blank. These situations often lead to over-diagnosis when minor insignificant abnormalities picked up during investigations are blamed as the cause of the patients' symptoms. "Am I missing a cancer?" is the question often asked by the doctor. This mental anguish could be overcome by regular follow-up of the said patient and keeping a watchful eye out for "red flags" or alarm features.

Mental Anguish from Employers of Patients

Employers take care of their employees when they are physically ill but mental health issues are often considered a character weakness, not realising that the latter reduces productivity. It leads to absenteeism, i.e. throwing in medical certificates, and presenteeism, i.e. the employee is present at work in body but not in spirit.

When it comes to mental health of their employees, employers tend to be reactive rather than proactive. It took the suicide of an employee to spur a major multi-national company, the biggest private sector employer in Melaka, to organise a depression workshop for its workers. Recently, Tenaga Nasional

Berhad came out with the directive that only psychiatrists could initiate antidepressants for its employees. This directive has caused much mental anguish among its panel doctors – many patients with psychosomatic symptoms but mild anxiety and depressive symptoms only do not like the stigma of visiting psychiatrists. Yet the panel doctors' hands are tied when it comes to initiating antidepressants for them.

Mental Anguish from Insurance Companies

Employers often pay their employees' medical expenses through group insurance purchased for them. It is well-known that insurance companies do not cover psychiatric illnesses. So what happens when investigations for a symptomatic patient draw a blank after admission? As pointed out earlier, this situation may prompt the doctor to over-diagnose, otherwise a diagnosis of one of the myriad of functional disorders will be made.

While some functional disorders like irritable bowel syndrome, functional dyspepsia, non-erosive reflux disease, fibromyalgia and tension headache have diagnostic criteria, others like non-cardiac chest pain, chronic backache and functional pain syndrome are more nebulous. In order to facilitate insurance claims, doctors often hide behind these medical euphemisms instead of directly making the diagnosis of depression or anxiety disorder. Insurance companies and employers alike should also realise that mental illnesses predispose a person to physical ailments through suppression of the immune system. Employees who are psychologically healthy are also more likely to be physically healthy, hence less likely to require subsequent pay-outs for physical illnesses.

Mental Anguish from Disciplinary Actions

On 31 October 2014, Singapore Medical Council (SMC) handed down a 4-month suspension on Dr Ng Teck Keng, 50, a GP "for inappropriately prescribing sedative medication to a patient for more than seven years."

Details of the case reported in The Straits Times, Singapore on Friday, 26 December 2014 revealed:

1. Dr Ng had over-prescribed Dormicum, a high-dependency drug, to his patient for sleep-related issues from March 2005 to July 2012.
2. SMC was "taken aback" that Dr Ng had prescribed his patient 80 tablets of the drug over eight occasions in a five month period in 2012.
3. The drugs were prescribed in spite of the fact that the patient's father had written a letter to Dr Ng in March 2011, requesting that he refrain from prescribing his son the drug as he was addicted to it.
4. As a result, the male patient was warded in the intensive care unit at a hospital for an overdose.

With this sword of Damocles hanging over doctors' heads, no wonder non-psychiatrists are unwilling to step up and step in to fill the gap in psychiatric services. I would like to propose the following safeguards to overcome this mental anguish:

1. Use anxiolytics at the lowest dose for the shortest duration only while waiting for the effects of SSRI's (Selective Serotonin Reuptake Inhibitor), SNRI's (Serotonin Noradrenaline Reuptake Inhibitor), Mirtazapine, Agomelatine and tricyclics to kick in.
2. Periodically offer to refer or even encourage your anxious or depressed patients to see a psychiatrist. Document these even if they are reluctant because of the stigma or for whatever reasons.
3. Make known to your anxious or depressed patients that you are treating him in your capacity as their GP or physician and that you are not a psychiatrist.
4. Do not give repeat prescriptions of anxiolytics to your anxious or depressed patients without first taking a look at them, even if it is just to say "hello".

Concluding Remarks

Malaysia still has a long way to go when it comes to mental health services. Greater acceptance by employers and insurance companies will certainly help to de-stigmatise psychiatric illnesses. Baby steps taken should include empowering non-psychiatric physicians and general practitioners to diagnose and treat depression and anxiety disorders. Do not hinder them until such time there are enough psychiatrists to serve the whole population.

APMHE 2018

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Surgeon Generals from various nations with United States Indo – Asia Pacific Surgeon Command, Rear Admiral Louis Tripoli (First row 11th from left) and Lieutenant General Dato' (Dr) Yaa'kob Koming, Malaysia's Surgeon General (5th from left).

The Asia Pacific Military Health Exchange (APMHE) is a platform for military healthcare professionals across the Asia Pacific region to discuss issues related to military medical services, clinical research, education, prevention and improvement which may benefit military medicine holistically.

This annual event of APMHE 2018 was recently held from 17-21 September 2018 at the Wyndham Grand Xi' South Hotel in Xi'an, China and was co-hosted by the Directorate of Medical Services of the People's Liberation of Army of China and the United States Pacific Command Surgeon. The theme of APMHE 2018 meeting was "Challenges and Solutions: Strengthening Global Health" and this was a forum for networking among delegates of participant countries in sharing information on a wide range of topics which included infectious diseases, mental and behavioural health, nursing, humanitarian assistance and disaster relief, and clinical as well as field medicine.

This event received almost 600 delegates from 29 countries and international organisations from the Indo–Asia–Pacific region such as Australia, Bangladesh, Brunei, Cambodia, Fiji, India, Indonesia, Japan, Laos, Maldives, Mongolia, Myanmar, Nepal, New Zealand, Pakistan, Philippines, Singapore, South Korea, Sri Lanka, Thailand, Timor Leste, Tonga, United Kingdom, Vietnam, the United Nation (UN), the International Committee of the Red Cross (ICRS), the ASEAN Centre of Military Medicine, as well as Malaysia.

The Royal Medical and Dental Corps of Malaysian Armed Forces has been a regular participant for Asia Pacific Military Health Exchange (APMHE) since it began in 2015 in Da Nong, Vietnam and played host for APMHE in 2016, where it was held in Kuantan, Pahang. The Malaysian delegate this year was headed by Lieutenant General Dato' (Dr) Ya'akob Koming, the Surgeon General of Malaysian Armed Forces, and was accompanied by an Obstetrician and Gynaecologist, two Public Health Physicians, an Emergency Physician, a Psychiatrist, a Dental Specialist and two Medical Officers. The Field

Malaysia's Surgeon General with Malaysian delegates. From left Major (Dr) Mehrun Nissa Sarfraz, Major (Dr) Mohd Zamri Derahman, Colonel (Dr) Mohd Asri Din, Brigadier General (Dr) Rozali Ahmad, Lieutenant General Dato' (Dr) Yaa'kob Koming, Brigadier General Dato' (Dr) T. Thavachelvi, Colonel (Dr) Mohd Arshil Moideen, Colonel (Dr) Nik Mohd Noor, Lieutenant Colonel (Dr) Izwan Hussin and Lieutenant Colonel (Dr) Faizul Islam

Bilateral talks between Malaysia's Surgeon General and Surgeon General of United States Indo – Asia Pacific Surgeon Command

Medical Commander of the Malaysian Field Hospital in Cox's Bazar Refugee Camp, Bangladesh was also invited and flew from Dhaka to attend and present at this event.

The APMHE 2018 was officiated by Rear Admiral, Louis Tripoli, United States Indo–Pacific Command Surgeon who welcomed Surgeon Generals and their delegates from nations all over the world to this exceptional event. The keynote speech by Major General Li Qingjie, Vice Director of the Logistics Support Department under China's Central Military Commission, emphasised that military medical service forces of all countries should work

together to safeguard the UN peace keeping operations, strengthen cooperation and exchanges, and jointly promote the Asia – Pacific and global health governance.

This was then followed by plenary speeches from several renowned international speakers from China, United States, Thailand and Australia. These included various topics ranging from infectious diseases such as H1N1 and H5N1 outbreaks to the Ebola vaccination development by the Chinese Military Medical Research Hospital, Humanitarian Aid and Disaster Relief – The Ark Ship and ASEAN Council of Military Medicine (ACMM) on joint military exercises providing health support internationally and among ASEAN countries.

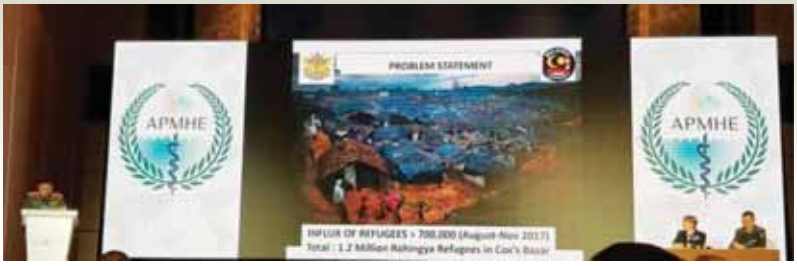
The medical symposium then continued with several breakout sessions at various ballrooms and meeting rooms at the prestigious Wyndham Hotel. Bilateral talks were also conducted by the People Liberation Army of China, United States of America, United Kingdom and Australia with Malaysia in enhancing the relationship as well as to plan for the future cooperation in military medicine by sharing information and training field exercise. The bilateral talks, which were attended by the Surgeon Generals of each country, were also held to discuss medical aid and assistance needed for current situations around the world.

The Malaysian delegates were also given the opportunity to present several oral presentations as well as poster presentation at this remarkable event. The commander of the Malaysian Field Hospital in Cox's Bazar, shared his experiences in managing the Malaysian Field Hospital and their recent achievements in the medical and health aspects from water treatment supply and abled surgical interventions performed at the make-shift Level 3 field hospital in the Cox's Bazar Refugee Camp. The work of multilevel healthcare providers at this field hospital was applauded and praised as Malaysia was the only ASEAN nation to provide expertise in a field hospital.

APMHE 2018 was made even more meaningful with the Medical Support Display at the Air Force Medical University of Xi'an, where medical equipment, its field hospital and field ambulance were displayed. A visit to the Air Force Hospital, which serves as a teaching hospital, was proof of China's medical advancement in medicine with the display of several mannequin simulators in the surgical field.

Towards the end of the week-long health exchange, a well organised visit to the UNESCO world heritage site, the magnificent Terracotta Warrior excavation site was planned by the organisers. This was then followed by a dinner at the ancient Xi'an City Wall, the oldest, largest and well preserved of all Chinese city walls continued with a beautiful Gala Show to end the night!

Over 200 presentations and multilateral talks were held at this unforgettable event. APMHE 2018 drew to a close on Day 5, with closing speeches from the two host countries, emphasising needs of multilateral medical health support nations across the world with the current changes due to varied reasons such as natural disasters. APMHE 2018, a successful symposium, held in Xi'an, the centre of Eastern Ancient Silk road, proved itself in this millennium as an effective choice for regional multinational medical exchange.



Commander of Malaysian Field Hospital in Cox's Bazar, Colonel (Dr) Mohd Arshil Moideen, sharing his experiences at APMHE 2018

A display of field hospital at the Air Force Medical University, Xi'an

A medical staff from the Air Force Medical University Hospital briefing Malaysia's Surgeon General on the simulators

Malaysia's Surgeon General viewing the medical support on display at the Air Force Medical University, Xi'an

Malaysian delegates at the Terracotta excavation site

Gala Night Show with Xi'an City Wall at the background

Leadership
Do you have what it takes?

Dr Gayathri K Kumarasuriar
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"The ultimate measure of a man is not where he stands in moments of comfort, but where he stands at times of challenge and controversy."
– Martin Luther King, Jr.

Every leader in history has used his or her power for greater good, some for their country and mankind, some for themselves. In a recent newspaper article, a member of royalty advised our country's leaders that "they were entrusted to protect the nation and citizens and as a result must fulfil this trust". This is a concept that should be mirrored in every organisation. Good leaders should inspire, motivate, mentor, guide and direct the people they lead. A big component about being a good leader is being an ethical one.

According to members of the Forbes Coaches Council when a company or its leaders do not adhere to a moral code, the result would be unethical actions. This will eventually bring about the downfall of the leader and the organisation itself. Ethical leaders respect the employees under their care and treat them fairly without showing any favouritism. They lead by being good examples, have integrity and act without any ulterior motive for their own benefit. They are brave to face challenges and accept the consequences of their actions.

While the majority of our heads of departments do fit in the above categories, there are some who do not. These are the few who can make the lives of the people working under them, a literal hell. They lack leadership skills and are given the post because of their seniority or rank. Some are unshakable in their position because they know people in the right places. The patriarchal nature of our setting makes the situation worse when leaders of poor calibre head a department. Some lower the morale of their staff by continuously badmouthing them and focusing on the negativity. We have also heard of leaders who focus on monetary gains rather than their core duties. There are some who harass their staff for not sharing the same opinions as them, citing disloyalty, or feel that a difference of opinion is a personal attack against them. The inert personalities of these people do not fit the bill either. Some cover their cowardice by hiding under a thick cloak of self-defence and blaming the others who work with them, while others can be downright domineering. There are those who are bullies and some who dish out different forms of harassment causing mental anguish to the employees working with them. The leadership courses they attend do not seem to have any influence on them as most of them lack the insight.

Lodging a complaint against one's leader is not an easy task. Verbal complaints alone are not enough. Administrative rules require proper evidence which must be documented. This means that on top of being bogged down by the daily work routine, one is also supposed to monitor one's leader and document all their wrong doings. Not many are brave to do so as they fear the backlash as their identity would be known. Employees, who are in fact internal clients, are also advised not to go beyond the organisation to the higher authorities because there might be

repercussions to them. Either way, their hands are tied. Complicated by too much red tape, the avenues to express ones dissatisfaction leaves an unhappy employee stonewalled. This is a fact in both the private and government sectors. Some continue to work in anguish silently, some eventually throw in the towel and resign while the rest just request for transfers. Some are transferred out if they appear to be a 'threat' to said leader. Meanwhile, these leaders continue with their nonsensical attitudes to the day they retire or until someone breaks the unfriendly set of protocols and takes his or her grievance higher up. This person will have to face a risk of being chastised, or worse still, 'marked' (a famous term used in the government sector).

The American Management Association mentions five components for ethical leaders which apply in every setting where there is a leader:

- **Communication** – Ethical communication by being truthful and having integrity. Upholding truthfulness and walking the talk, gets the leader respect of all the people working with him or her.

- **Quality** – Ethical quality to ensure quality services and delivery. This in return will reduce the potential risks of medical negligence and lawsuits.

- **Collaboration** – Need to collaborate and get consensus from the most astute of advisors. "Wise leaders collaborate to incorporate best practices, solve problems, and address the issues facing their organisations." It is believed that a leader who collaborates ethically makes better decisions for their organisation.

- **Succession planning** – Not being afraid to let go but recognising the potential leader in one's organisation and training them to one day take over.

- **Tenure** – How long should one lead? Here the conduct of the leader is important. The mission of an ethical leader is to serve the organization and not themselves.

The Becker's Healthcare review states that in the medical sector, to be a good leader, there are five inherent qualities.

Communication skills is a two way process. Effective communication is more about listening than talking. Good leaders listen and engage the people working under them. The team feels appreciated, respected and in turn, learn to respect their leader. Good leaders have realistic visions for the future. Challenges and setbacks will not deter them. They continue to work with their team to ensure that the challenges are faced together. A leader who can see what is ultimately best for not only ones patients, but also staff and organisation, is more likely to steer everyone in the right path. Having the integrity and holding on to the moral compass of putting others before oneself. By leading with this example, many healthcare lawsuits can be avoided.

Many medical leaders do not demonstrate the empathy they show their patients to their co-workers. Like respect, empathy that is given to someone will often be reciprocated. Leaders who empathise with their staff are more likely to forge strong bonds with their employees.

In an industry facing death, sickness and lawsuits on a daily basis, being optimistic can sometimes be a challenge. Good leaders are the ones who are able to motivate their employees and remain optimistic despite the hard times.

Absurdum est ut alios regat, qui seipsum regere nescit.

(It is absurd that a man should rule others,
who cannot rule himself.)
Latin Proverb

FIFA World Cup Russia 2018

"from Russia with love & awe!" – an unforgettable experience!

By
Dato' Dr Gurcharan Singh s/o Amar Singh
Member, FIFA Medical Committee
Consultant Sports Medicine Physician
Life Member, Wilayah Branch
datodrguru@gmail.com

It was an honour, as well as a humbling experience, to be the first Malaysian doctor and member of the FIFA Medical Committee. I was on assignment to my 5th FIFA World Cup Russia 2018 and found it to be both exhilarating and challenging, more so knowing that I had to function in a different environment of medical and cultural practices. I discovered that medical practice, which is different from standard practice – not necessarily better or worse, just different.

Attending all the FIFA/LOC pre-competition inspections, training workshops and ensuring standards of care met FIFA requirements paid off. Members of FIFA medical delegation had some reservations yet were excited travelling to the World Cup. However, Russia put in place one of the best medical services, meeting international standards compared to all previous FIFA World Cups. On duty were 6,455 accredited health care personnel (4,000 at stadiums); 172 medical stations at various venues (155 at stadiums) and 314 ambulances (205 ambulances at stadiums) covering all 12 venues.

Emergency response time was under three minutes for any emergency, with 13 medical evacuation helicopters on stand-by at special locations near the stadium. Medical services are free in Russia and a total of 14,293 medical contacts at all 12 venues were reported during the month-long event. Surprisingly, a paediatrician was on duty at the stadium during every match to cater to the needs of children – it was exceptional and not seen at previous World Cups.

As a member of the FIFA delegation to the World Cup Russia 2018, I was asked to take charge of all medical and anti-doping related matters at the Nizhny Novgorod Venue. This city was known for manufacturing heavy military equipment, especially tanks, and was subjected to intense bombing by allied forces during World War II. The ultra-modern newly built stadium located at the confluence of two rivers, namely Volga and Oka, was a sight to behold, especially at sunset. Security was very tight, but visitors were not harassed and there were no incidents. Transportation both intra- and inter-city, as well as visa into Russia, was free for all valid World Cup ticket holders.

As a FIFA Medical Officer, my scope of responsibility was to attend all organisational meetings, inspect the stadium, EMS medical stations at the stadium

Anti-doping: blood sample collection

Paediatrician at N. Novgorod Stadium match day

and referral hospitals, coordinate the needs of team physicians cum team officials of participating teams and the FIFA Delegation including the spectators, and finally, to carry out all anti-doping controls both in and out-of-competition testing. Additionally, I had to report daily (electronically) to FIFA HQ regarding all injuries and illness of players on and off match days, FIFA Delegation and third parties (spectators, international media etc.). However, the collaboration of the LOC Medical Team and FIFA Medical Officer was excellent, professional and friendly.

The LOC medical personnel, medical equipment and supplies met international standards as well as FIFA requirements. No margin of compliant, yet there was time for sight-seeing and parties getting to know the local culture and people and a great atmosphere at the "Fun Fest" where large screens showed live matches, lots to eat, drink and dance. Russians ensured all visitors are warmly received within a festive atmosphere and leave with fond memories of Russia.

The introduction of VAR (video assisted referee) for the first time at a FIFA World Cup proved successful. Team medical staff could instantly replay an on-field foul or serious injury, especially head injuries (e.g. concussion) to the Team Physician for appropriate treatment and action.

Given the adverse international publicity that the Russian Government was a party to doping practices of athletes in the past and the subsequent suspension of the Russian Anti-Doping Agency (RUSADA), the anti-doping programme during the World Cup Russia was the largest ever, compared to any past FIFA World Cup. All anti-doping controls were strictly conducted by FIFA Medical Officers. No Russian citizens were involved. A total of 2,761 samples (blood and urine) were taken both in and out-of-competition. Ninety percent of players were targeted for testing based on intelligence information. Players from teams that advanced to the semi-finals were tested at an average of four times during the tournament. No adverse analytical finding or positive test was reported by the laboratory in Lausanne, Switzerland.

Without a degree of doubt, FIFA World Cup Russia was indeed a fantastic magical sports spectacle in the World of Sports and football.

Early Cancer Detection

Dr Murallitharan Munisamy
Secretary
MMA Public Health Society (MMA PHS)
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The MMA Public Health Society (MMA PHS) joins hands with the National Cancer Society of Malaysia (NCSM) to provide education and training on the early detection of cancer for Malaysian primary care professionals all across the country.

The training programme will be rolled out at 40 workshops held throughout Malaysia over a period of one year and will be run across eight regions; including Sabah and Sarawak. The workshops will be conducted by experienced and qualified healthcare experts in Malaysia to enhance the management of cancer among primary care physicians, especially MMA members.

These workshops are intended to address the prevailing gap in various aspects of cancer control such as prevention, screening and early detection and patient management as well as other critical areas.

MMA PHS, MMA and NCSM formalised their collaboration at a signing ceremony held today on the side-lines of the World Cancer Congress (WCC) hosted by NCSM at the Kuala Lumpur Convention Centre from 1 – 4 October 2018.

Presiding over the signing was Deputy Health Minister Dr Lee Boon Chye, while representing MMA was General Secretary Dr Gunasagaran Ramanathan and Immediate Past President Dr Ravindran Naidu. MMA PHS was represented by its Chairman, Professor Dr Sanjay Rampal while NCSM was represented by its President, Dr Saunthari Somasundram.

The MMA PHS is one of the societies under the aegis of the MMA and has continuously worked, albeit a little quietly in the background, to further grow and improve the sector of public health medicine in Malaysia while the National Cancer Society of Malaysia is the country's oldest cancer control organisation, being founded by Malaysia's first oncologist and MMA member Datuk Dr S.K. Dharmalingam since 1966.

"Primary care physicians are on the frontlines of healthcare. It is critical for them to be involved in early detection of cancer when the odds of successful treatment are so much higher as compared against the current situation in Malaysia where many new cases are detected only at the late stage," said Dr Saunthari.

The MMA is also continuously engaged in efforts to reduce the burden of non-communicable diseases (NCD) which includes cancer. "Providing training on early detection through workshops such as these will further empower the skills of primary care doctors throughout Malaysia and we are sure, will translate into benefits to patients in terms of earlier detection and better care," said Prof Sanjay Rampal.

The structured workshop series is expected to begin from the end of the year, and CME points will be awarded. Further details will be disseminated to MMA members via Berita MMA as well as through the respective MMA state branches.

The team with the Deputy Minister of Health Malaysia, Dr Lee Boon Chye

The Star – 20 October 2018

MMA Supports Ban on Smoking in Parliament, Restaurants

KUALA LUMPUR (Oct 19): It is estimated that about 20,000 people in Malaysia die each year from diseases linked to the smoking habit while the number of smokers is believed to be increasing, according to the Malaysian Medical Association (MMA).

In this regard, it welcomed and was in full support of the recent Health Ministry's directive to ban smoking at Parliament House and in restaurants nationwide.

In a statement today, MMA noted that as Malaysia faced an increasing burden in non-communicable diseases, there was no doubt that serious diseases related to smoking such as lung cancer, respiratory disease and heart disease were major contributory factors to the public health burden.

"We are ever ready to work hand in hand with the ministry towards the elimination of all tobacco products," it said.

It was reported that the smoking ban in Parliament took effect on Oct 15 while eateries such as restaurants and hawker stalls will be made no-smoking zones next year.

An afternoon with Dr Andrew Choo

Interviewed and written by,
Donald Wee
Publisher, Berita MMA

As a young boy, Dr Andrew Choo, who was second in a family with seven siblings, studied at St George's School Balik Pulau (a church-run school), where he studied until standard 4. At that time in the late 1940s, education was a luxury for most people in small villages, and the education level for most children was just up to Standard 4.

"I was lucky to have a dedicated and passionate teacher, Mr Dass, who was concerned that I did not plan to continue my studies. The only available option at the time was to study in Georgetown which was about 20 km away from my home that would require a trip of about an hour by bus," says Andrew.

His teacher went out of his way to find a solution as he wanted Andrew to continue studying. Mr Dass got in touch with the social welfare department, which at the time was running a home for the aged at Batu Lanchang Lane off Green Lane where the present Lam Wah Ee Hospital is located.

A Home Away from Home

At that time, the home housed 150-200 inmates, and was big with different sections such as quarters, dining areas, and so on. Mr Dass contacted the welfare officer, a European named FH Cook. "Mr Cook was sympathetic to my plight and offered me free room and board. Mr Dass even went on to make arrangements for me to study at St Xavier's Institution Branch School in Pulau Tikus," he states.

However, due to the Japanese occupation, Andrew had to take a short hiatus from school and was only able to return to his studies later. He reminisces how another fellow student, who was the number 2 boy, was fast-tracked to Standard 6. Since Andrew was the number 1 student, he thought it odd that he was passed over and went to talk to the school's sub-director. As a result of his action, he was also fast-tracked to Standard 6.

> **"Sometimes in life, you are helped along, so take advantage of your opportunities."**

After some time, the Sub-Director of the school, Brother John Edward, was surprised to learn that Andrew was staying at the home for the aged. When asked about this, Andrew explained his circumstances and Brother John was generous enough to make arrangements for him to stay at the boarding school for free until he completed his higher school certificate. When he was in Standard 8 (the equivalent of Form Four today), he had appendicitis and was hospitalised in Penang General Hospital. The quality of care that he received from the surgeon and staff nurses made such a lasting impression that it planted the seed that later germinated into the desire to become a doctor.

From One Island to Another

After successfully finishing his studies at St Xavier's, Andrew wanted to further his studies at a Singapore university and successfully applied for a scholarship. He even briefly met with Tan Sri Dato' Loh Boon Siew who gave him RM1,000 as a reward for being the first Balik Pulau boy to go to university in Singapore.

His teacher, Mr Dass, helped arranged for passage to Singapore by ship. Here, he met another boy, Chuah Kee Chiang, who was also heading to the same university to further his studies. Andrew got to know him and upon arriving at their destination, they were both met by the boy's uncle. "His uncle drove a small Morris Minor, and I can still recall how we had to stuff both our over-sized bags into the car and somehow still cram ourselves into it!" he laughingly quips.

Ragging in the Old Days

Back then, ragging was very much a part and parcel of university tradition and Andrew recalls how he enjoyed himself and got to know a lot of the seniors. The main purpose behind ragging back then was to force the new students to mix with the seniors and to get both groups to know each other better. As it was more in the spirit of good-natured fun rather than bullying in nature, there was plenty of fun to be had. In fact, some of the seniors

even went as far as to pass their notes and books to him when they graduated.

Andrew later joined the university's Catholic Student Society (CSS) after they approached him and helped him to get settled in by showing him around campus. The chaplain of CSS also conducted a retreat for all new students to help break the ice and make them feel at home. "It was also around this time that I had the misfortune of being a victim of infective hepatitis. I was pleasantly surprised when my parents were able to find their way from their village in Balik Pulau Penang to see me in Singapore while I was hospitalised as they had never left their village before," he lightly remarks. His family was not well-to-do and his parents were smallholders who farmed a small plot of land in Balik Pulau, Penang.

Serving His Bond

Upon graduating in 1960, Andrew returned to Penang to serve out his bond period. He recalls an unforgettable incident in the fourth month of his housemanship, when he went for a movie on a Saturday. The movie was "Teacher's Pet" and halfway through the movie, there was an urgent message at the bottom of the cinema screen stating "Dr Choo wanted in the hospital. Emergency. Ambulance waiting at the entrance."

He left immediately and was whisked off to the paediatric ward, where a nurse and 'new' paediatrician who had just finished his specialty training in UK were struggling to do a tracheostomy of a baby suffering from diphtheria. "As it was an emergency and the baby was turning blue, so I didn't have time to scrub or make any other preparations. I just grabbed the scalpel from the paediatrician and quickly made an incision to insert the tube," he recollects.

From Public to Private

Once he had completed the bond, he decided to work in the private sector in order to sponsor his younger brother for veterinarian science in Pakistan. Andrew took up a post with a private hospital at a plantation in Sungai Petani, Kedah where he worked for the Malayan-American Plantation. It was also here that he met his wife, Josephine Tan, who was a teacher.

He enjoyed working there and even had time to play golf at a nearby golf course. In fact, it was golf every day. "My golf handicap was down to nine after two years, and I was the Harward Golf Club champion in Sungai Petani. I was the envy of many senior European plantation employees who said that they had been playing golf all their lives and still had a handicap of 24!" he states.

Family photo, 1974

Weekends were full of activities such as wild boar hunting or pigeon shooting. However, after having children, Andrew felt it was time to get back to the city as he wanted them to have more options when it came to studies. He made some enquiries and joined a friend, Dr Sim Wong Pin, to work as a partner in his clinic. "Nowadays, I'm semi-retired and only work three days a week," he jokes.

Foray into Politics

Andrew has always been interested in human affairs even since his school days and was very active socially in university. "That's probably why I was elected as head boy and captain of St Xavier's in 1953 and President of the CSS in university. I was one of the doctors from the Catholic Doctors Association of Malaysia (CDAM) who volunteered for refuge service for one week after the 26 December 2004 Acheh Tsunami in Indonesia – the disaster had to be seen to believe. I was also very actively involved with the church near my home in Setapak where I was the parish council chairman for 12 years," he divulges.

Initially, his political leaning was toward DAP (Democratic Action Party) because he felt that MCA (Malaysian Chinese Association) was just playing second fiddle to UMNO (United Malays National Organisation). However, he decided to try to make a change by joining MCA after the 13 May 1969 riots, as he hoped to prevent such tragedies from happening again in future.

On that day, it was work as usual in his clinic but due to the declaration of emergency and the imposed curfew, he was could not leave the clinic's premises. He was touched as the people living in the surrounding area would bring food to the back door of the clinic. The following day, he was able to get in touch with the police in Jinjang and they arranged for an escort to take him home. On his way back, they passed through the 'hot' areas and he felt incredibly sad at seeing the terrible aftermath, with many areas still looking like a warzone.

Getting into politics was also something that he felt was necessary because he felt that there was too much injustice and corruption happening. At that time, he was the only professional who was in politics – the other members were mostly businessmen or those who were not well-educated, so the top MCA people were very keen to push him to become an exco member. However, as Andrew still wanted to focus on his own clinic (which

A more recent family photo

he had just started not long ago), he declined their offer. Finally, after a year with MCA, he was appointed as a Senator for one term.

Man of Many Responsibilities

At the same time, he was also busy with CDAM where he served as President for two terms, President of the Fui Chiu Association (FCA) for one term, and after that President of the Pan Malaysian Fui Chiu Association. He organised the very successful 4th World Fui Chiu Community Convention at Genting Highlands in 2001, which was declared open by Tun Dr Mahathir Mohamad.

4th World Fui Chiu Conference Opening Ceremony, 2001

Volunteer refugee service @ Banda Acheh, Indonesia, 2005

"Having everything lined up made things easy for me and being in politics was an eye opener for me. I thought the establishment would always be welcoming toward someone with integrity and principles, but sadly, the real situation was very different," he remarks, pointing out that he faced a lot of opposition from within and had many difficulties in trying to meet his obligations.

"Although I just couldn't help wanting to get in to do something about it, the reality was that there were numerous obstructions, especially from the people who were opportunistic and who resisted change. No matter what, we want genuine people who have integrity and principles to be leaders. It is a sad thing to see our country with so much potential going into such dire straits," he relates.

"Dealing with this was next to impossible. We're talking about making changes to an establishment that has evolved over years and years. Someone new turning up wanting to do things the right and proper way faced opposition from all levels," he discloses. The unending stream of challenges was severe enough that Andrew decided enough was enough – he did not want to rock the boat too hard.

"Politics is full of opportunistic fellows who are more than willing to go to extremes in achieving their goals."

Looking Ahead

Now, Andrew believes that ideally, more doctors should go into politics. If the elites choose to stay away, then the positions would fall to the opportunists. Of course, there will be numerous obstacles which can be very frustrating to deal with.

However, he believes that if more principled people (e.g. doctors, professionals), go into politics, there would be less temptation as they do not need to depend on politics for monetary gains. "The results of GE14 should not make us complacent. If not for Tun Dr Mahathir, who was brave enough to stand up and be heard, things would not have changed," he advises.

Another item that Andrew finds worrying is the quality of doctors. "In my time, the ratio was two doctors to one specialist, so housemen really got a lot of chances to learn. Nowadays, the ratio is as high as 25 housemen to 1 specialist! I did my first appendicectomy after one week as a houseman. Today's houseman may finish a year of housemanship without getting any hands-on experience!" he informs.

Learn to Deal with Stress

As the medical line can be a stressful one, Andrew pointed out the importance of finding ways to deal with one's stress. Golf and cooking are two of his favourite pastimes. Golf is a great way to get fresh air and some exercise. Cooking is an experiment that he finds very interesting – you can get so many different tastes.

Humour

compiled from here & there.

Mind Your Language!

* Wonder why the word funeral starts with FUN?
* Why isn't a Fireman called a Water-man?
* If money doesn't grow on trees, why do banks have branches?
* If a Vegetarian eats vegetables, what does a Humanitarian eat?
* How do you get off a non-stop flight?
* Why are goods sent by ship called CARGO and those sent by truck SHIPMENT?
* Why is it called 'Rush Hour' when traffic moves at its slowest then?
* How come noses run and feet smell?
* What are you vacating when you go on a vacation?

Points to Ponder...

The difference between in-laws and outlaws:
Outlaws are wanted.

Alcohol is a perfect solvent:
It dissolves marriages, families and careers.

A fine is a tax for doing wrong.
A tax is a fine for doing well.

Archaeologist: Someone whose career lies in ruins.

There are two kinds of people who don't say much:
Those who are quiet and those who talk a lot.

Alcohol and calculus don't mix:
Never drink and derive

The nice fact about egotists:
They don't talk about other people!

Penang Teaching Conference for GPs

Dr Hooi Lai Ngoh
Vice-Chairman
MMA Penang Branch
drhooi.hooi@gmai.com

Basic Life Support (CPR) Workshop

The 21st Penang Teaching Conference for General Practitioners was held from 13-16 September 2018 at the Bayview Hotel Georgetown, Penang.

This meeting has been run consecutively every year for the past 20 years and the topics are specially selected to be of interest to those in primary care medicine. There were two full-day pre-conference workshops – Ultrasound in Obstetrics and Basic Life Support on 13 September 2018.

The conference proper was held during the next 2½ days ending on Sunday 16 September at lunchtime. This year there were topics on cardiology, dermatology, paediatrics, respiratory medicine, emergency medicine, neurology, contraception, dengue and medico-legal issues. Participants were treated to a dermatology quiz and also an x-ray quiz – prizes were awarded to participants with the highest marks. The pre-conference workshops on 13 September 2018 were attended by over 50 participants and there were more than 300 delegates for the conference proper from 14-16 September 2018.

This was the 21st conference of the series and this coming of age saw the largest number of delegates ever recorded over the years. The Organising Committee would like to thank all participants for joining us to celebrate the longest running annual GP conference in Malaysia. Delegates came from all the states of Malaysia and from as far away as Brunei and Singapore.

The proposed dates for the next Penang Teaching Conference for General Practitioners are 12–15 September 2019; MMA Penang Branch hopes that support will be maintained for this meeting, so do keep the dates free.

Speakers for the symposium on heart failure

Packed conference venue on first day of conference

ECOU 2018

Organising Committee

Opening speech by Prof Dato Dr Ahmad Sukari

Dr Long Tuan Mastazamin bin Long Tuan Kechik
MMA Kelantan EXCO 2018/19
Life Member, Kelantan Branch
jizurimin@yahoo.com

The road to organising the biennial National Conference East Coast Oncology Update 2018 (ECOU 2018) was filled with many hardships for the executive committee, even under the watchful eyes of the charismatic leadership of Hospital Universiti Sains Malaysia Nuclear Medicine Specialist, Dr Syed Ejaz Shamim.

However, with the help of the hardworking members and good support from the Pusat Pengajian Sains Perubatan Universiti Sains Malaysia (PPSP USM), under Prof Dr Saiful Bahari, and Jabatan kesihatan Negeri Kelantan, under the new director Dr Zaini Hussin, the event was a success.

This was the second joint collaboration between the Nuclear Medicine, Oncology and Radiotherapy Department USM (JPNRO USM), under the honourable Dr Ahmad Lutfi, and Malaysia Medical Association Kelantan Branch (MMA Kelantan), under the diligent chairman Dr Mohd Rahimie.

The objective was in line with the goals of both MMA and MOH, which is for healthcare professionals (including medical students, nurses, and radiotherapists) to keep up to date with current information on disease management, including cancer. The theme "Multi-Dimensional Cancer Care" was unanimously picked to stress the importance of co-operation between multiple levels of patient care, starting from the first encounter at GPs or local clinics, up to the end of life intervention.

Various speakers from local and national institutions were carefully selected to attract the interest and to bring depth to the subject matter. Topics were well arranged to cater to all aspects of cancer management, ranging from managing cancer patients in Kelantan by Kelantan's Health Director, clinical management of cancers, the new role of technologies available in this era, and even the care of the patient at home.

The result was about 200 satisfied participants, including some from East Malaysia, who spent two days in the culture-rich capital of Kota Bharu. The event also fulfilled the aims of our chairman, Dr Syed Ejaz Shamim, to create more researchers who can give their ideas and findings to the mainstream population. There were 12 researchers who presented topics such as cancer prevention and futile cost management. Congratulations to the 1st winner of the ECOU Oral Presentation Competition, Dr Nur Jihan Anwar Tan from UITM! We hope more researchers with more interesting topics will join us in ECOU 2020.

Oral Presentation Judges

Participants

24 November 2018

MMA SELANGOR FELLOWSHIP NIGHT

Venue : The Lake View Club (next to Holiday Villa Subang Jaya)
Contact : +6012-227 2754 (Dr Arulnathan)

14 December 2018

MLSM END OF YEAR GATHERING

Venue : Perdana Room, Royal Lake Club Kuala Lumpur
Organiser : Medico Legal Society of Malaysia (MLSM)
Contact : Dato' Dr Venugopal / Charlaine (03-2694 9999 ext 1102)
Email : mlsmsecretariat@gmail.com/ venubal60@gmail.com / charlaine@rdl.com.my

15 December 2018

COMMON CLINICAL PROBLEMS AND HOW TO HANDLE THEM

Venue : Taman Desa Medical Centre
Contact : +603-7982 6500 (Ext. 3316 / 8036 / 8037)

18 – 20 January 2019

MALAYSIAN SOCIETY OF HYPERTENSION 16TH ANNUAL CONGRESS 2019

Venue : Shangri-La Hotel, Kuala Lumpur
Contact : + 6 012 – 212 1328
Email : msh.asm.secretariat@gmail.com

14 – 15 February 2018

THE 2ND INTERNATIONAL CONFERENCE ON GLOBAL PUBLIC HEALTH CONFERENCE 2019

Theme : Enhancing Global Health Development towards Sustainable Healthy Communities
Venue : Colombo, Sri Lanka
Organiser : The International Institute of Knowledge Management
Contact : chandana@tiikm.com

5 – 7 April 2019

PENANG RESPIRATORY CONFERENCE

Venue : Bayview Hotel, Georgetown, Penang
Organiser : Malaysian Medical Association (Penang Branch) in collaboration with Malaysian Thoracic Society
Contact : +604-226 6699 or +604-227 0376 (Dr Hooi Lai Ngoh) / +604-222 9188 (Mr S P Palaniappan)
Email : drhooi.hooi@gmail.com / pgrespiratory@gmail.com

27 – 29 June 2019

59TH NATIONAL MMA CONVENTION & SCIENTIFIC CONGRESS 2019

Venue : Putrajaya Marriot Hotel

22 – 25 July 2019

6TH ASIA-PACIFIC CONFERENCE ON PUBLIC HEALTH

Theme : Urbanisation Challenge for Health
Venue : Penang Island
Organiser : College of Public Health Medicine, Malaysian Armed Forces Health Services and Penang State Health Department

22 – 24 October 2019

OHHW – 11TH INTERNATIONAL JOINT CONFERENCE ON OCCUPATIONAL HEALTH FOR HEALTH WORKERS

Venue : Hamburg, Germany
Organiser : Centre for Epidemiology and Health Service Research in Care Proessions (CVcare), University Clinics Hamburg-Eppendorf
Email : albert.nienhaus@bgw-online.de

RAMSAY SIME DARBY HEALTH CARE

Ara Damansara Medical Centre

ARTHRITIS IN PRIMARY CARE

4th NOVEMBER 2018 | 10.00 AM - 12.30 PM

ARA DAMANSARA MEDICAL CENTRE

SPEAKERS :

Dr Ainon Mokhtar

Consultant Physician & Rheumatologist

Dr Ling How Tieng

Consultant Orthopaedic Surgeon

TOPICS :

"Early Rheumatoid Arthritis - Diagnosis & Management"

"Update on Knee Osteoarthritis"

FOR REGISTRATION, kindly email your:

Full name, NRIC number, MMC number, Practicing Clinic & area, email address and contact number to Liana at **norliana.mahussin@ramsaysimedarbyhealth.com** or **Ms Nabihah Yusof (Roche)** at **013 - 222 3914**

DEADLINE FOR REGISTRATION - **1 NOVEMBER 2018**

CPD POINTS AWARDED

LIMITED SEATS AVAILABLE

ARA DAMANSARA MEDICAL CENTRE

Lot 2, Jalan Lapangan Terbang Subang
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VIP Vaccination Is Protection

GIVE YOUR PATIENTS A GOOD SHOT AT BEATING THE FLU

SEASONAL INFLUENZA

An acute viral infection with considerable disease burden

Together, influenza type A and B viruses are responsible for the **SEASONAL FLU EPIDEMICS** that occur each year.[1,2]

In tropical and sub-tropical countries, both type A and B influenza viruses **CIRCULATE YEAR-ROUND**.[3]

EVERY YEAR:

3-5 million
cases of severe illness[2]

290K-650K
deaths[2]

FluQuadri™
4 strains for broader protection

provides broader protection as it includes both co-circulating B lineages[4,5]

- Best fits current influenza epidemiology[4,5]
- Offers broader influenza protection
- Demonstrated safety and immunogenicity[6-8]
- Indicated from 6 months of age and older[9]
- Benefits from Sanofi Pasteur's expertise[10]
  - Over 3.5 billion influenza vaccines distributed worldwide
  - Provides high quality influenza vaccines in more than 150 countries

Vaccination is the best defence against influenza.

PREVENTION STARTS WITH YOU!

REFERENCES: 1. Centers for Disease Control and Prevention. Types of Influenza Viruses. Available at http://www.cdc.gov/flu/about/viruses/types.htm. Last accessed Dec 2017. **2.** World Health Organization. Influenza (Seasonal). Fact Sheet, December 2017. Available at http://www.who.int/mediacentre/factsheets/fs211/en/. Last accessed Dec 2017. **3.** Saha S, *et al. Bull World Health Organ* 2014;**92**:318-30. **4.** Belshe RB. The need for quadrivalent vaccine against seasonal influenza. *Vaccine* 2010;**28S**:D45-D53. **5.** Ambrose CS, Levin MJ. The rationale for quadrivalent influenza vaccines. *Hum Vaccin Immunother* 2012;**8**(1):81-8. **6.** Greenberg DP, *et al.* Safety and Immunogenicity of an Inactivated Quadrivalent Influenza Vaccine in Children 6 Months through 8 Years of Age. *Pediatr Infect Dis J* 2014;**33**(6):630-36. **7.** Greenberg DP, *et al.* Safety and immunogenicity of a quadrivalent inactivated influenza vaccine compared to a licensed trivalent inactivated influenza vaccine in adults. *Vaccine* 2013;**31**(5):770-6. **8.** Greenberg DP, *et al.* Final Clinical Study Report (QIV03 – NCT01218646). 2011. **9.** Sanofi Pasteur. FluQuadri™ Product Prescribing Information. **10.** Sanofi Pasteur, Leading Provider of Seasonal Influenza Vaccines. Fact Sheet. Press Release, October 2017. Available at http://www.sanofipasteur.com/en/Documents/PDF/Sanofi_Pasteur_leading_provider_of_seasonal_influenza_vaccines_2017_10_12.pdf. Last accessed Dec 2017.

ABBREVIATED PRODUCT INFORMATION (API): 1. TRADE NAME: FluQuadri™ quadrivalent influenza vaccine. Active Ingredient: Four split influenza virus, inactivated strains. **2. THERAPEUTIC INDICATION:** FluQuadri™ is indicated for the prevention of influenza disease caused by influenza type A and B viruses contained in the vaccine. **3. DOSAGE AND INSTRUCTIONS FOR USE:** For intramuscular use only. Children from 6 months to 35 months receive one 0.25 mL dose. Children from 36 months to 8 years receive one 0.5 mL dose. If the child has not been previously vaccinated against flu, a second dose should be given after at least 1 month apart. Individuals 9 years and older receive one 0.5 mL dose. FluQuadri™ should not be combined through reconstitution or mixed with any other vaccine. **4. CONTRAINDICATIONS:** History of severe allergic reaction to any component of the vaccine, including egg protein or after previous administration of the vaccine or a vaccine containing the same components or constituents. **5. SPECIAL WARNINGS AND PRECAUTIONS:** Guillain-Barré Syndrome; Preventing and Managing Allergic Reactions; Altered Immunocompetence; Limitations of Vaccine Effectiveness. **6. PREGNANCY AND LACTATION:** No animal reproduction studies have been conducted with FluQuadri™. It is not known whether this vaccine is excreted in human milk. **7. UNDESIRABLE EFFECTS:** The most frequently reported reactions include injection-site pain, tiredness, feeling unwell, headache, muscular pain and irritability. **8. INTERACTIONS:** Data evaluating the concomitant administration of FluQuadri™ with other vaccines are not available. **9. OVERDOSE:** No cases of overdose have been reported. **10. REVISION DATE:** July 2014. **11. FULL PRESCRIBING INFORMATION AVAILABLE ON REQUEST FROM:** Sanofi Pasteur, vaccines division of sanofi-aventis (Malaysia) Sdn. Bhd., Unit TB-18-1, Level 18, Plaza 33, No. 1 Jalan Kemajuan, Seksyen 13, 46200 Petaling Jaya, Selangor Darul Ehsan, Malaysia. Ref. No. MYFLU001/0714

SANOFI PASTEUR

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