OCTOBER 2021
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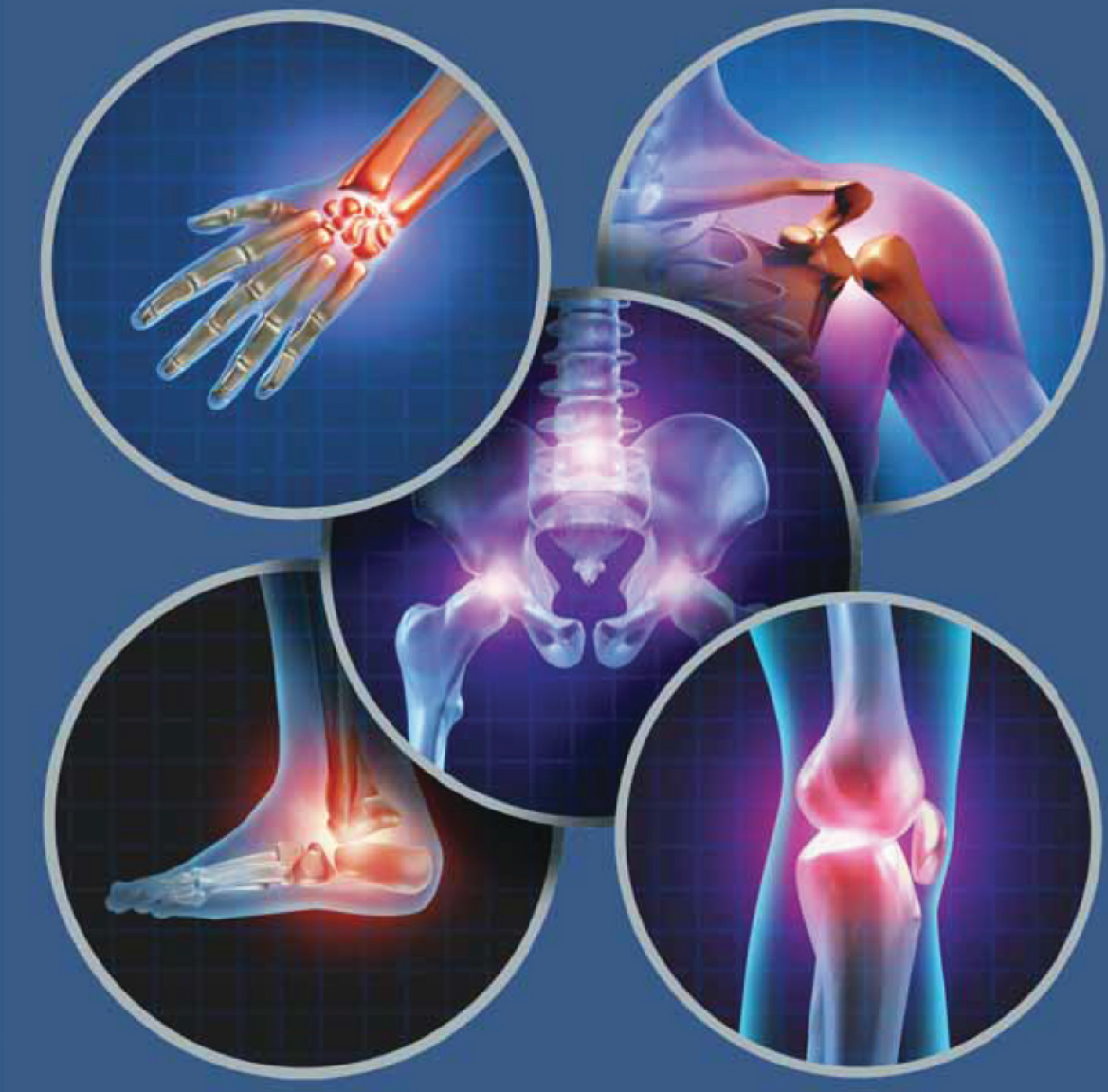
BERITA MMA NEWS
MALAYSIAN MEDICAL ASSOCIATION



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New Resident Doctor

DR. MOHD FAIRUZ SUHAIMI

Resident Consultant Orthopaedic, Arthroplasty and Knee Surgery

MBBS (MMMC), Doct. Ortho & Trauma (UKM),
Fellowship in Knee Surgery (SYDNEY)

Prince Court Medical Centre - Level 2A (Orthopaedic Clinic)

Monday	: 9am -1pm / 2pm - 5pm
Tuesday	: 2pm-5pm
Wednesday	: 9am -1pm / 2pm - 4pm
Friday	: 9am -12pm
Saturday	: 9am -1pm

03 2160 0000 ext: 2125

Dr. Fairuz Suhaimi is a certified Orthopaedic Surgeon who specialise in knee and lower limb surgeries.

Dr. Fairuz Suhaimi completed his undergraduate studies in 2004 from Melaka-Manipal Medical College. He completed his housemanship and continued on his clinical service as a medical officer in the Department of Orthopaedic & Traumatology, Hospital Selayang before continuing with his postgraduate studies in the field of orthopaedic and trauma surgery in 2008.

After obtaining his Doctor in Orthopaedics & Traumatology from Universiti Kebangsaan Malaysia in 2012, he then joined the Faculty of Medicine, Universiti Teknologi MARA (UiTM) as a clinical lecturer. He continued his clinical service in Hospital Selayang, managing mainly musculoskeletal trauma patients, sports injuries and arthritis. He furthered his training at the Sydney Orthopaedic Research Institute under the watchful eye of internationally renowned surgeons, David Parker and Myles Coolican.

He completed the fellowship in knee reconstruction, arthroplasty, arthroscopy and trauma in 2017. Apart from his clinical practice, he conducts many research and academic work at the national level. He was the co-chairperson for the Selection of the Postgraduate Orthopaedic Training (SPOT) Malaysia 2020 and a syllabus contributor to the recently launched Malaysian Postgraduate Orthopaedic Training Syllabus. He is also active in organisational work in the field of orthopaedics, and previously was a council member of the Malaysian Orthopaedic Association. He brings to Prince Court Medical Centre more than 10 years of experience in managing orthopaedic patients mainly with arthritis, knee injury, sports medicine and trauma using the latest technologies and clinical practise.

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The Changing of the Guard

Our Annual General Meeting was held online on 11 September 2021 via Zoom. It looks like most people are getting quite accustomed to this mode of meeting, and the whole meeting went quite smoothly. I would like to congratulate Dr Koh Kar Chai, our incoming President for 2021/22. Congratulations also go to the new ExCo. Particular thanks are owed to our Immediate Past President Datuk Dr M. Subramaniam. His term has certainly not been easy, but he was able, with the assistance of ExCo and Council, to handle all the problems and queries that came his way, while also making sure that the MMA gave assistance to those in need wherever possible.

While the AGM went smoothly, it is my belief that we must, as an association, debate policies more. We pride ourselves in being the largest doctors' organisation in the country. Certainly this is true, and we are growing every year. However, our growth is not as fast as the growth in the number of doctors. This means that every year we represent a smaller proportion of the doctors in the country.

There are many reasons why doctors choose not to join the MMA. For example, if we fight for improved conditions for our members in the government service, non-members will also benefit from our efforts. Similarly, if we successfully engage with Managed Care Organisations and Third Party Administrators to improve remuneration for private practitioners, the benefits will go to everyone, not just PPSMMA members.

However, one reason may be that our AGMs are perceived as "talk shops" where a few members talk (and talk and talk) about rather petty matters from the minutes and reports. Rarely if ever do any discussions about policy matters occur. Nobody raises such issues, so nobody discusses them.

I can understand why ordinary members rarely do so. There are constitutional guidelines about when matters for discussion must be submitted. Most members do not have the time, or may miss the deadline for submission. Some members might wish to submit resolutions for discussion but feel hesitant. Most resolutions submitted are related to the Association and not matters of national importance, so anyone wanting to submit something different might hesitate.

While these may be valid concerns, and there may be real obstacles, we should not accept that AGMs

Dr Ashok Philip
Editor
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The presence of those seeking the truth is infinitely to be preferred to the presence of those who think they've found it. *– Terry Pratchett*

> "The simplest way to insert policy debates into the AGM is for the Council, SCHOMOS and PPS to take the lead."

will continue without significant policy debates forever. A little effort will be needed, but I believe the benefits will be real and varied – better visibility to the public, more credibility with the policy-makers, improved opportunities for members to influence policy, and perhaps an improved image for the MMA in the eyes of non-members.

As I have suggested before, the simplest way to insert policy debates into the AGM is for the Council, SCHOMOS and PPS to take the lead. They deal constantly with the real problems our doctors face. MMA is often reactive rather than proactive. Problems arise and we grapple with them. To a limited extent, though, we do know what is likely to need addressing before trouble starts. This is because people in PPS NWC, SCHOMOS NWC and the Council are often there for several years in succession, and become familiar with the problems. They also become familiar with the many proposed solutions, and may have ideas of their own about where things need to go.

It would be fairly straightforward, I think, for Council, SCHOMOS and PPS to each identify an area of particular concern and prepare a position paper on it. This should be circulated with the other items for the AGM such as the Annual Report and Amendments to the Constitution. Members can then read about the issues and debate them at the AGM.

Under the current Constitution, these papers would have to be submitted as resolutions and debated and voted on in the usual manner. Any resolution, obviously, can be amended during debate if the proposers agree. If the final version is accepted by the majority of those present and voting at the AGM, it will become official MMA policy. Having gone through an open and rigorous debate will give it added weight and credibility.

There are many things that need to be done to put MMA on a firm professional footing. Debating policies is, I strongly believe, one of the most important. We are a large professional organisation. There should be no argument about it – we should be putting forward our own stand on the important issues of the day, not just reacting to the initiatives of others. I hope the new Council and NWCs will look into this suggestion as just one measure to take us to the next level. **BMMA**

Editor's Note

To streamline the process of article submissions, members should adhere to the following guidelines:

- spotlight articles <1000 words, <3 photos/charts/tables.
- MMA convention & scientific conference (<700 words, <3 photos)
- SCHOMOS. PPSMMA, SMMAMS (<700 words, <3 photos)
- MMA society/committee (<700 words, <3 photos)
- general & all other articles (<700 words, <3 photos)
- branch news (<200 words, <5 photos)

In tandem with the Editorial Policy, the Editorial Board reserves the right to edit, enhance or reject articles to maintain the overall flow of the content and style.

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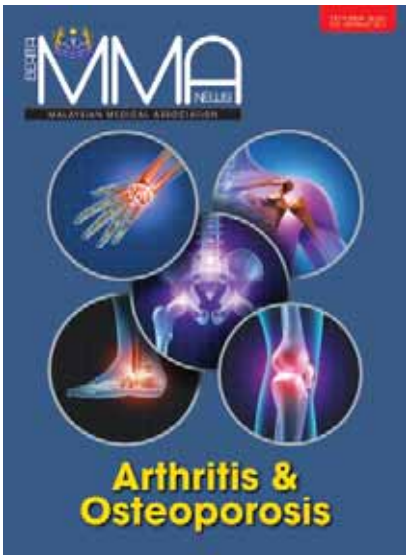

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Snoring Is Not The New Norm

The role of sleep in health

Most people know that they have to get enough sleep. But with the busy lifestyles, erratic work schedules or even new children (and pets) can keep someone from getting the sleep they need.

Sleep is a basic human need, and people cannot survive without sleep, just as they cannot live without food, drink, or oxygen. Over 45% of the world's population suffers from sleep disorders, and it's a worldwide epidemic that endangers public health and quality of life. A good quality sleep should constitute the three elements: **Duration, Depth and Continuity**.

- **Duration:** Sleep should be long enough to allow you to feel refreshed and alert the next day.
- **Depth:** You will need *deep sleep* for restoration.
- **Continuity:** Sleep period should be *sustainable* without disruption.

Sleep and Health

A good quality and restorative sleep are essential for day-to-day functioning. Studies suggest that sleep quality is rather important that quantity as it has a greater impact on quality of life and daytime functioning. Sleep keeps the body immune systems in shape by production of hormones in our bloodstream to regulate metabolic processes and detoxify the toxins in the body.

When you don't get enough sleep and are sleep deprived, you're more likely to develop chronic diseases including obesity, Type 2 diabetes, cardiovascular disease, depression, and other disorders like decreased immunity, social isolation, general well-being, mortality, and even suicide.

Snoring and Sleep

Snoring comes in a variety of forms, from soft snuffles to loud rasps and snorts. An estimated 45% of adults' snores occasionally, while 25% snore regularly – often disturbing their bed partner's slumber and possibly their own, too. Snoring can be found in both men and women, including all age groups, 40% of men snore regularly versus only 24% of women. You're more likely to snore if you're overweight, are a middle-aged or older man or are a postmenopausal woman. These snoring issues also seem to worsen with age.

Why do people snore?

Snoring is defined as a rumbling sound of the obstructed breathing, which can be caused by some basic factors, such as poor muscle tone, bulky throat tissue, or long uvula and narrow soft palate. It may also be a red flag that you have a treatable health problem that is interfering with breathing while you sleep, for instance, nasal congestion caused by sinus infection or allergies, nasal polyps (non-cancerous growths in the nose), or a deviated nose bone.

Snoring – An Alarming Sign?

- Snoring that occurs three or more times per week
- Your average snore rings in approximately 38 decibels, but the loudest snore can go up to 120 decibels. Very loud and bothersome snoring
- Snoring isn't just bad for the snorer, but it is terrible for their bed partner's rest.
- When your bed partner noticed that you snore with gasping, choking or snorting sounds.
- People who snore have an increased risk of insulin resistance. This means snoring is a risk factor for Type 2 Diabetes as insulin resistance is a prediabetes state.
- Regular snorers face an increased risk of heart disease that is five times higher than people who snore occasionally. As a result, habitual snorers have a greater chance of getting high blood pressure, stroke and high cholesterol.
- Sleeping position play a role in snoring. Back sleepers have a risk of snoring, thanks to the partially closed airway by the gravity where the tongue ad soft palate falling to the back of the throat.
- Genetic factors play some role in contribution to snoring regarding the size and structure of the airway, for example, you can have a long uvula or soft palate or enlarged tonsils and adenoids.
- Lifestyle factors such as taking alcohol or sedative medications etc. These can relax the throat muscles and result in potential collapse and closing of the airway.
- When you catch a 'cold', allergies or nasal congestion, this can lead to snoring because of the blockage of the airway
- When you snore and have daytime sleepiness and fatigability leading to trouble concentrating and thinking clearly.

Self-Assessment Questionnaire: Risk of developing Sleep Apnea

I am over age 40	Yes/No
I am overweight	Yes/No
I snore	Yes/No
I often awake with a morning headache	Yes/No
I have woken up gasping or choking in the night	Yes/No
I have been told I stop breathing at night	Yes/No
I often wake up feeling tired and unrefreshed	Yes/No
I take naps to try and refresh my daytime sleepiness	Yes/No
I have other chronic medical illnesses such as diabetes, hypertension	Yes/No
I wake up always feeling throat dryness or discomfort	Yes/No

If you answered "Yes" to four or more of these questions, you are at risk of developing/living with sleep apnea.

What should you do about it?

The next step toward a healthy sleep is to contact your sleep doctor for further information and advice. There are various treatments and therapies to either reduce snoring or treat the underlying cause, such as sleep apnea. As snoring is an initial beginning symptom of risk factor of sleep apnea, it is highly recommended to talk with a healthcare provider about your sleep health.

The first and most important step is to figure out what's causing your snoring so you can receive the right treatment for you. An otolaryngologist can use endoscopy to inspect the upper airway begin from the nasal passages down to the larynx for any obstructions. You may be recommended to do a sleep test in your bed, which is then evaluated and diagnosed by a board-certified sleep specialist.

How would you be treated if you were diagnosed with Sleep Apnea?

Treatment varies for each individual diagnosed with Sleep Apnea. The factors depend on the body mass index (BMI), site of obstruction in the upper airway, and the severity of the obstruction. There are five categories of main treatment for Sleep Apnea.

- Lifestyle modification
  - maintaining a healthy weight with exercise and healthy eating
  - good sleep hygiene
  - limiting use of alcohol and sedatives
  - adjusting sleeping positions
  - raising the head of your bed
  - reducing nasal congestion
- Oral appliance therapy (OAT) – also known as anti-snoring mouthpiece. The mechanism works by holding the tongue and jaw in a stable position so that it will not block the airway while asleep. There are two types called as; Mandibular Advancement Device (MAD) and Tongue Retaining Device (TRD)
- Continuous positive airway pressure (CPAP) – one of the most common treatment for the sleep apnea in adults. The mechanism works by giving a positive airway pressure through a hose and mask into the airway, preventing it from being obstructed.
- Surgery – an option depending on the anatomical site of obstruction in the upper airway that can be corrected surgically, such as uvulopalatopharyngoplasty (widens the airway by removing the tissues in the pharyngeal regions), addressing the nasal polyps, a deviated nasal bone, or other blockages of the nasal passages.
- Myofunctional therapy – a combination of physical therapy exercises to improve breathing and facial posture. Poor muscle tone around the upper airway makes it more likely for a person to snore. Thus, exercises to strengthen the mouth, tongue and throat can beneficial to a certain extent.

Dr Tan Shi Nee
Consultant ENT, Head & Neck, Snoring and Sleep Surgeon
KPJ Rawang Specialist Hospital

President's Acceptance Speech

Dr Koh Kar Chai
President
president@mma.org.my

Dear members of the Malaysian Medical Association, a token of appreciation goes out to all of you for the confidence shown for me to lead this august association.

As indicated to all of you in the run up to me being elected as the President of MMA, it is not about me but about the association and its members. I am here to serve and I humbly pledge to serve the association to the best of my abilities.

When I was elected President Elect, none of us imagined that the current pandemic will last for so long. The issues facing us as healthcare professionals are unprecedented. COVID-19 has shown us that the healthcare system that many of us had praised is not as healthy as we would like it to be.

The pandemic had exposed many cracks in the system. Though we see a similar situation in many healthcare systems around the world, we should not just put the blame on the pandemic and move along as we are. We need to take a long hard look at healthcare reforms that are much needed for our country.

We should not just pay lip service but embark on it. The process will take quite a few years to say the least, but I believe that MMA, being the responsible medical association it is, should take the bull by its horns. We should engage more regularly and purposefully with the government on the need for reforms in our healthcare system that are in the best interest of the health and well-being of the population whose healthcare we as medical professionals, are responsible for.

There is a multitude of issues to look at, and it will involve both the public sector and private sector. I believe that MMA, with its SCHOMOS (Section Concerning House Officers, Medical Officers and Specialists) and PPS (Private Practitioner Section) is well prepared to forge ahead and tackle all the obstacles encountered and to be encountered in the reformation of healthcare in this country, be it about Contract Medical Officers; lack of medical personnel or rather misplaced medical personnel in the public sector; Dispensing separation; Medicine Price Control; unequal access to secondary and tertiary care and all other aspects related to the need to transform our healthcare system.

We have with us a seasoned Director General of Health, Tan Sri Dr Noor Hisham Abdullah, and a dynamic new Hon. Health Minister Khairy

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MEDICAL TOURISM HOSPITAL OF THE YEAR IN ASIA PACIFIC
with Bumrungrad International Hospital, Thailand
• BEST ONCOLOGY SERVICE PROVIDER

MALAYSIA HEALTHCARE BRAND AWARDS 2019
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CANCER CENTRE OF THE YEAR 2019

BUSINESS EXCELLENCE AWARDS 2019
WINNER:
UK-MALAYSIA PARTNERSHIP AWARD 2019

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International Real Estate Federation
WINNER:
MALAYSIA PROPERTY AWARD PURPOSE-BUILT CATEGORY 2019

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Jamaluddin Abu Bakar, whom we need to work with towards our common aspirations of a healthcare system that truly leaves no one behind, that is efficient and sustainable – one that will be the pride of us doctors and our patients.

With this, I look forward to engaging and working closely with the Ministry of Health, State Health Departments, the media, our current Exco and Council, the various committees and of course our erstwhile members.

Once again, I thank all of you for your support and encouragement.

Dear colleagues, reformation is a strong word to use but it is what is needed to put our healthcare system on a better footing than before. Not that the system was in a poor state as we have received accolades before. But the current pandemic has shown that there is room for improvement. It is now timely to look at a reformed healthcare system that is responsive and which provides equal access to healthcare of good quality to all in this country of ours.

> "I believe that MMA should take the bull by its horns."

Piecemeal adjustments of scattered issues should no longer be the practice. Let us look at the system as a whole and identify all the areas that need improvement or a total reform. Of course it is easier said than done, but we need to start somewhere.

It is an opportune time now to start, especially when the nation is embarking on a recovery process after the ravages of the pandemic and we are entering into an endemic phase. Though COVID-19 is still with us and we are still counting the losses in terms of life and livelihood, there is the need to create a robust healthcare system to ensure that we overcome the current loss and are able to withstand further strain on our healthcare system.

More and more of our people are descending into the rungs of a lower income group with even the middle income group hard pressed to sustain their healthcare spending and we need to recognize this before it is too late.

Whether in public or private sector, our healthcare professionals need to unite together and not remain in the silos of their own practice. Our colleagues in academia and such need to be cognizant of the fact that every one of us will be affected.

As a single example, the issue of contract doctors and how we manage it will have an impact on all of us, from there being no proper career pathway for those in the public sector to an overflow of fresh junior doctors in the private sector. Those in academia will not be spared too with their own job prospects at stake depending on how the tides turn.

With that, I will just like to reiterate that a reform of our healthcare system is needed, and all of us in healthcare must remain united and focused for it to happen. All that is currently good within your silo may not remain in status quo. **BMMA**

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From the Desk of the Hon. General Secretary

Dr Thirunavukarasu Rajoo
Hon. General Secretary
secretary@mma.org.my

Thank you for the trust and confidence in re-electing me as the Hon. General Secretary for the third year (2021/22).

For this new term, I shall be focusing on making the MMA brand more active in social media like Twitter, Instagram and even Tik-Tok – making the delivery of services to our members more accessible. As one of the biggest National Medical Associations, we shall continue to highlight and speak up on issues concerning policy, regulatory and even trade; ultimately ensuring the quality in patient care.

The MMA office bearers met the Hon. Health Minister YB Tuan Khairy Jamaluddin and the Director General of Health, Tan Sri Dato' Dr Noor Hisham Abdullah on 27 September 2021 and discussed nine major issues that are currently affecting the medical fraternity in both public and private sectors.

The nine issues are contract doctors, pay grades and on call payment, public holiday leaves for government doctors, public private partnership, pandemic preparedness of GP clinics, regulating the third-party administrators, 7th Fee Schedule, a new entity as a one stop centre for the private practice and formation of Health Commission. The details of the presentation can be accessed via the QR code:

CPD Updates

For the GPs who have difficulty acquiring CPD points during the CPD year due to MCO, MMA has ensured the availability of online modules and webinars. Most of these services were provided by MMA free of charge. Approximately 2,201 webinars and 42 online modules have been organised.

As of 31 August 2021, the total number of MMA mobile applications users was at 50,090. The MMA mobile application is currently linked with the Ministry of Health's myCPD system. MMA is in discussion with Academy of Medicine (AMM) to link the MMA CPD System with the AMM CPD system.

All providers need to submit the events at least 30 days prior to the CPD activities. The MMA CPD system has so far received 26,892 CPD event applications for accreditation of CPD points from 1 July 2017 to 30 July 2021. These events were submitted for accreditation by a total of 535 approved CPD providers.

Furthermore, doctors who attended events overseas or have completed overseas online CPD modules submitted total of 18,394 for accreditation of CPD Points by manual submission via the MMA Mobile Application.

The first MMC-CPD Grading Schedule for CPD points was approved during the MMC meeting on 21 April 2015 and further revised in May 2016. The CPD points were awarded under nine categories (A1 to A9). The MMC CPD Grading System was further revised on 4 April 2018 and endorsed by the MMC Council at their meeting on 17 April 2018. Effective 1 July 2020 the MMC CPD Committee has revised the MMC Grading Schedule into eight categories (A1-A8) making it more appropriate and effective for all registered medical practitioners. For details, refer to the QR code:

Refer below for statistic on the current CPD point cycle (1 July 2021 to 31 August 2021)

- Total number of doctors that has achieved 20 CPD points: 3,257

DYSPHAGIA AFTER STROKE DOES IT MATTER?

Dr. Nor Azira Ismail
MBBS (Adelaide), MRehabMed (Malaya), CMIA (NIOSH)
Medical Director &
Consultant Rehabilitation Physician
Daehan Rehabilitation Hospital Putrajaya

"Her area of interest include Neurorehabilitation, Paediatric Rehabilitation and Oncology Rehabilitation. Other than that she also provides consultation for any illnesses resulting in temporary or permanent disabilities, chronic pain management and musculoskeletal injuries."

Most studies reported that dysphagia occurs in more than 50% of people following stroke. For those with minor swallowing abnormalities, the recovery of swallowing function usually occurs within 7 days. Unfortunately, about 11-13% of stroke survivors remain dysphagic after 6 months[1].

Cerebral, cerebellar, or brain stem strokes can impair swallowing physiology leading to dysphagia. The presence of dysphagia, at the time of admission to hospital, is independently associated with poor outcome, including poor functional ability, institutionalisation and increased mortality.

The complications of dysphagia include aspiration pneumonia, recurrent cough, and choking. Moreover, some stroke survivors need modifications to dietary and fluid intake, have compromised nutrition and hydration, reduced quality of life, and social isolation as the result of dysphagia.

Swallowing is a complex task. The process starts after food ingestion and can be divided into four stages defined by the location of the food bolus:

1. Oral preparatory stage: prepare bolus for propulsion into pharynx
2. Oral propulsive stage: tongue pushes bolus through the fauces into the pharynx
3. Pharyngeal phase: pharyngeal structures move bolus through the upper esophageal sphincter.
4. Esophageal phase: esophageal peristalsis and gravity move the bolus through the lower esophageal sphincter into the stomach.

The control of swallowing during eating involves the activation of neural network in the cerebral cortex that includes the insula, cingulate gyrus, prefrontal gyrus, somatosensory cortex, and precuneus regions; and the brain stem. Any neurologic or muscular damage along the deglutitive axes can cause dysphagia[2].

Swallowing abnormalities can develop when these damages result in malfunction, discoordination, or lack of function of the neuromuscular apparatus. When a system, particularly the one that involves striated muscles, is not used, the apparatus becomes weak and begins to atrophy. Although the ability to swallow may return without therapy, the swallowing muscle will become weaker and weaker during this waiting period. Therefore, physicians should not postpone treatment in the hopes of a spontaneous recovery. Dysphagia rehabilitation therapy is particularly important in this patient population, as the swallowing muscle must be kept strong.

Dysphagia rehabilitation comprised of both rehabilitative and compensatory approaches with rehabilitative approaches designed to improve swallowing physiology and improve swallowing safety and tolerance, while compensatory strategies are used to reduce symptoms of dysphagia. Apart from these approaches, dysphagia rehabilitation also involves the use of dysphagia evaluation tools such as imaging (Ultrasound, Videofluroscopy, Fiberoptic endoscopic evaluation of swallowing, and Fiberoptic endoscopic evaluation of swallowing with sensory testing) and non-imaging (beside assessment tools, and pharyngeal manometry) in the evaluation and monitoring the process and progress of dysphagia rehabilitation.

An interdisciplinary dysphagia rehabilitation team includes rehabilitation medicine physician, speech and language therapist, rehabilitation nurses, occupational therapists, physiotherapist, respiratory therapist, dietician and dentist to ensure holistic approach in the evaluation and treatment of swallowing disorders.

Eating and drinking are basic human needs. Dysphagia does not only increases morbidity and mortality after stroke but also significantly affects quality of life when it is not possible to share meals with family and friends. Dysphagia rehabilitation is important to help prevent complications from dysphagia, ensure adequate nutrient and hydration in order to maintain proper functions of the body and foster prompt reintegration into society.

References:
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Shaker R & Geeren J. Management of Dysphagia in Stroke Patients. Gastroenterology & Hepatology Volume 7, Issue 5 May 2011
Cohen et al. Post-stroke dysphagia: A review and design considerations for future trials. International Journal of Stroke 2016, Vol. 11(4) 399–411

- Total number of doctors that has achieved more than 20 CPD points: 8,607
- Total number of doctors that has achieved less than 20 CPD points: 15,401
- Total number of doctors that has 0 CPD points: 22,834

IT Updates

1) CPD Membership System Revamp – Completed Test Run for CPD Membership portal and Test Run fo r MMA Mobile Apps on 20 Sept/2020.
2) CPD Membership System hasn't launched yet and will be launching soon as we are still waiting for Mobile Apps Patching. We can't launch CPD Membership System without mobile apps. We will notify all users during the launch time.
3) MMA CPD system has been successfully integrated with the MYCPD system effective January 2021 onwards. Therefore, CPD Points captured via MMA APP will be transferred to the MYCPD system automatically. Kindly take note that this point integration is only for government doctors.
   - Point migration issue for MYCPD User – Still ongoing.
   - CPD points issue for users – Still ongoing, especially for IOS users.
   - Points not capturing in merits – Still ongoing.
   - Points captured twice issue – Ongoing and will be resolved soon after CPD has migrated to a new server.
4) Successfully carried out MMA 61st AGM at Dewan Bunga Raya.
5) MMA website Revamp – Have some amendments that need to be completed before launching.

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Stay tuned to announcement from MMA on MEDEFEND's monthly "Breakfast Talk" webinars.

For further information, please reach out to Ms Fadzlin (03-2723 3237) or Ms Shalini (03-2786 2431) or email Medefend.my@marsh.com.

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MMA WhatsApp

As of end of 19 September 2021, the total number of WhatsApp queries is 27.

The breakdown is as follows:-

Queries	Total	Resolved	Pending
COVID-19 vaccine	2		2
CPD Points	5	5	
Emedasia	1	1	
Hazard Leave	1	1	
Job Advertisement	1	1	
Mailing List	1	1	
MMA AGM	1	1	
MMA App	4	4	
Membership Number	1	1	
MMA Web	3	3	
MPS	1	1	
Patient Information Leaflets	1		1
Penang GP Course	1	1	
Standard for clinical thermometer	1		1
Swab Test Training	1	1	
Transfer Request	1	1	
Webinar	1	1	
Total	**27**	**23**	**4**

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From the Desk of the

Hon. General Treasurer

Dr Vasu Pillai Letchumanan
Hon. General Treasurer
treasurer@mma.org.my

Finance-Related Resolutions Passed in AGM 2021

I would like to thank all delegates and observers that attended the AGM and take this opportunity to highlight a few resolutions related to finance.

One of the resolutions on bereavement payment has been passed and this will be an added benefit for MMA members. The MMA Exco has considered the Hon. Auditors' recommendation that deceased MMA Members be given a small contribution by MMA.

The House resolved that a contribution of RM5,000 be given to the family of deceased MMA Life Members and a contribution of RM2,000 be given to the family of deceased of MMA Members. This resolution will be reviewed in three years. We are in the process of formulating the SOP for the claim process involved. Meantime, we hope the members or state MMA informs MMA on the details of deceased members.

The second resolution passed was regarding standardising the mileage claim for travelling nationwide. This ensures all members treated equally and subjected to similar financial guidelines.

The third resolution in relevant to finance that was passed was regarding KPI for state grants. The idea of KPI was brought by one of the council members during the last term and it was accepted by EXCO after deliberation. We are still in the midst of drawing the guidelines on the KPI which is expected to be implemented for the term of 2022/23.

Accounts and Taxation for 2020

As another extension has been given till end of September, tax computations were distributed to all the states to all the states and payment has been done. As doctors, as we are not experts in tax related matters, thus the finance department is in the process of arranging dialogue session with council members and

> Cloud accounting will be implemented in 2022 and the process to will start before year's end.

state treasurers with the tax agent on the topic of tax treatment for the society. This will be a useful session for better understanding of tax treatment and tax submission, to help in future submissions.

As agreed by council, cloud accounting will be implemented in 2022, and the process to engage the vendor and training of the users will be started before end of year.

Property Issues:

Regarding purchase of Melaka property, MMA Foundation has obtained approval from the land office but is still in the process of getting approval from Minister of Domestic Trade and Consumer Affairs Malaysia. This action is pending and MMA Foundation has been following it up.

For the property purchased by MMA HQ at Plaza Sentral, the Redemption Statement for both units has been settled and UOB Bank Berhad have duly executed the Receipt and Reassignment. Our lawyer has forwarded the Receipt and Reassignment and Deed of Assignment for the Developer to endorse their consent on both the documents. This is expected to be completed soon. Then we will settle the final payment.

The purchase of second property at Plaza Sentral, we have signed the sales and purchase agreement. The investment in these properties expected to increase revenue of MMA in coming years.

For Selangor property, the Deed of Assignment was forwarded for Developer's endorsement then need to submit for assessment of stamp duty.

With all the proper steps followed; we are assisting with the purchase of the property.

Kenanga Fund Investment:

As reported previously, MMA has invested RM250,000 into Kenanga's MoneyEXTRA Fund. As this is still short period post investment, the profit at the moment still stands at less than 1%. I shall update periodically on the performance of the fund.

Group Personal Accident Insurance (GPA)

MMA has purchased GPA for its members, and there have been three claims so far. Claimants need to provide adequate information and documents as required by insurer within a time period, we sincerely hope for the kind cooperation of claimants on this matter.

The coverage for death/permanent disablement from accident is RM50,000. Following a covered accident, if the insured is required to undergo outpatient or inpatient treatment or surgical interventions, the policy will cover the medical expenses up to RM2,500 per annum.

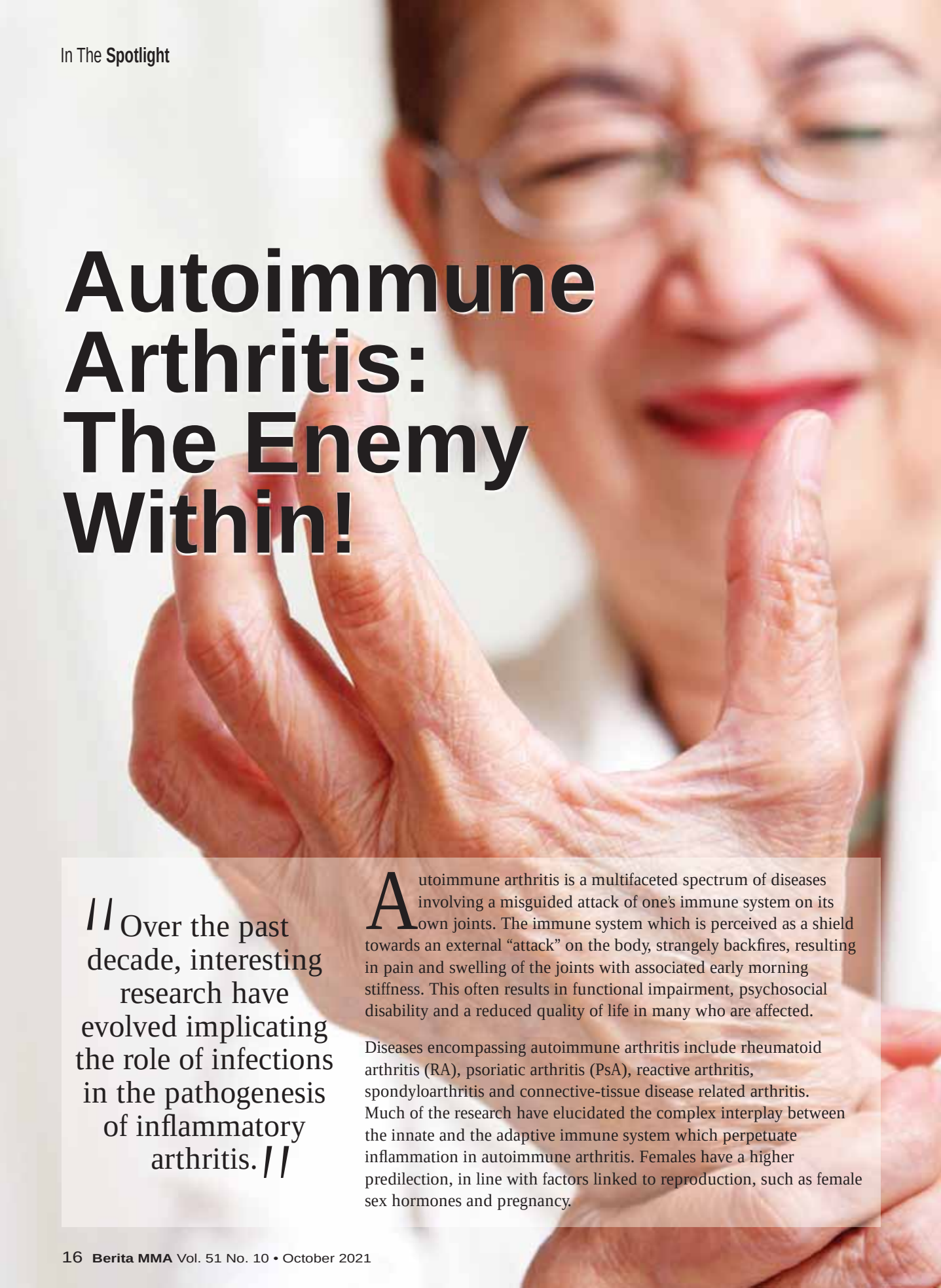
For any queries on claim purposes, please contact: BrokingEB@bsompo.com.my

MMA Congress 2022

MMA successfully organised MMAC 2021 in May 2021. We will be organising MMAC 2022 as well and hopefully it can be organised either physical or hybrid. We will update regarding the details once finalised.

As usual, the income and expenditures being monitored closely, strictly adhering to financial guidelines. I would like to thank my finance team headed by Ms Pathma for the great work being done in keeping good financial records for MMA. Please do contact us at treasurer@mma.org.my if any queries or suggestions. BMMA

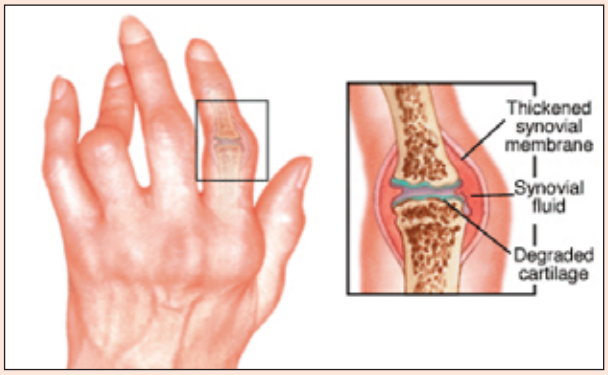
Autoimmune Arthritis: The Enemy Within!



> // Over the past decade, interesting research have evolved implicating the role of infections in the pathogenesis of inflammatory arthritis. //

Autoimmune arthritis is a multifaceted spectrum of diseases involving a misguided attack of one's immune system on its own joints. The immune system which is perceived as a shield towards an external "attack" on the body, strangely backfires, resulting in pain and swelling of the joints with associated early morning stiffness. This often results in functional impairment, psychosocial disability and a reduced quality of life in many who are affected.

Diseases encompassing autoimmune arthritis include rheumatoid arthritis (RA), psoriatic arthritis (PsA), reactive arthritis, spondyloarthritis and connective-tissue disease related arthritis. Much of the research have elucidated the complex interplay between the innate and the adaptive immune system which perpetuate inflammation in autoimmune arthritis. Females have a higher predilection, in line with factors linked to reproduction, such as female sex hormones and pregnancy.



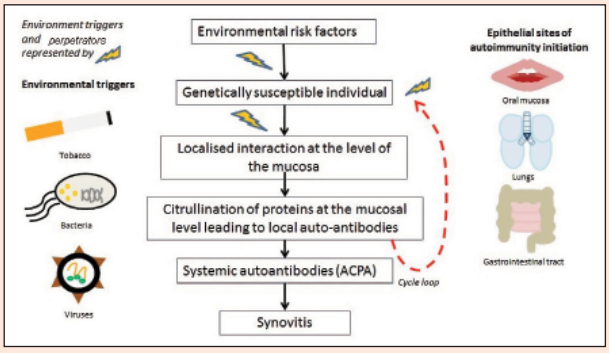
The Triggers

Genetic risk factors play a prominent role in the autoimmune pathogenesis; for example, the role of HLADRB1 increases RA risk and the presence of HLA-B27 augments the risk of spondylarthritis. By far, the most prominent environmental trigger factor is cigarette smoking. The citrullination process that occurs in the lungs of RA patients is triggered by smoking; resulting in the generation of highly pathogenic anti-citrullinated peptide antibodies (ACPA).

ACPA positivity has been proven to promote disease severity with poor clinical outcomes and progressive radiographic joint damage. Having this in mind, ACPA testing in susceptible individuals with inflammatory arthritis will help prognosticate disease severity at onset; hence, helping decide appropriate therapy at baseline.

Over the past decade, interesting research have evolved implicating the role of infections in the pathogenesis of inflammatory arthritis. Porphyromonas gingivalis causing periodontal disease have gained interest as a microbial candidate involved in RA pathogenesis.

Pathogenesis of autoimmune arthritis



Similarly, chlamydia infection plays a major role in the induction of reactive arthritis. Eliminating this triggering bacteria and microbial antigens are challenging due to their tendency to persist in the joints leading to chronic disease.

Autoimmunity and the Gut

There is an exponential increase of evidence that links the gut microbiome to the development of autoimmunity in RA, PsA, SLE and spondyloarthritis. The composition of the gut microbiota is hugely influenced by diet, smoking and infections. Having co-evolved with our gut commensals, the human gut microflora is essential in maintaining homeostasis in the gut and the immune system.

Mice models have proven that the presence of Bifidobacterium commensal have a dominant protective effect against development of arthritis by reduced TH17 expression in the gut. Hence, demonstration of gut-microbiome dysbiosis causing intestinal mucosal inflammation could modulate immune responses that trigger autoimmune arthritis. Understanding the impact of this altered microbiome has promoted improved hygiene practices, consumption of healthy diet and the prudent use of antibiotics.

Tainted Understanding

The knowledge around autoimmune-related arthritis is rather scarce amongst medical practitioners and the general public. Few are aware of the true nature of the systemic manifestations of autoimmune diseases.

Much emphasis is often given to diabetes mellitus, hypertension as well as early cancer detection. The truth is, many Malaysians, especially those within the age group of 20-50 years, suffer in silence with joint-related pain and disability.

While there is no cure for the disease, early testing, diagnosis and treatment can lead to life-changing outcomes and improved functionality. It's the lack of awareness that drives the public to indulge in fast-selling immunity booster products which have extraordinary yet questionable claims.

The idea of boosting your immune system does sound appealing. However, the idea of too much boosters can

sometimes backfire, leaving the immune system in an unbalanced, volatile state. In lieu of this, early referral to the rheumatologist for treatment will help such patients before disability sets in.

Time is of essence in initiating early treatment with much emphasis given to the new conceptualised term – "Treat-to-Target (T2T)" strategy in inflammatory arthritis. These guiding principles of treatment have helped thousands of patients to achieve disease remission owing to the progress in treatment strategies that have evolved considerably over the decades.

The greatest myth about autoimmune arthritis etched in our minds is that steroids is the crux of treatment with otherwise, very little choice of therapies. Fortunately, we are in an era where the treatment armamentarium for RA, PsA and spondyloarthritis have remarkably advanced leaving steroids to be used only as a bridging therapy.

The strategy of therapy has evolved merely from providing symptomatic relief with NSAIDS and COX-2 inhibitors to the use of disease modifying anti-rheumatic drugs (DMARDS). Methotrexate remains the anchor drug with effective data on inducing clinical remission and arresting structural joint damage. Salazopyrine, leflunomide and hydroxycholoroquine are often used in combination with methotrexate to achieve a steroid-free remission.

The initial algorithmic approach was largely pyramidal. It was initiated with a base of NSAIDs, steroids and ultimately DMARDS. This approach only led to improvement in some patients. More clinical research and new outcome measures have navigated the practice of early initiation of methotrexate and adopting treat-to-target use of combination DMARD therapy to mitigate the burden of inflammation. This approach has been deemed safe, effective and reasonable in early treatment of autoimmune arthritis.

The Wave of Change with Biologics

Biologic therapies revolutionised the treatment of inflammatory arthritis in the late 1990's, dictated largely by the research and understanding of the molecular mediators of synovial inflammation in the joint. The development of monoclonal antibodies and genetically engineered proteins directed towards cytokines were principally aimed at targeting the components of the immune system responsible for initiating the inflammatory cascade.

Tumour necrosis factor (TNF) inhibitors (infliximab, adalimumab, golimumab), Interleukin-6 inhibitor (tocilizumab), Janus kinase inhibitors (tofacitinib, baricitinib, upadacitinib), interleukin 17A inhibitor (secukinumab) and anti CD20 (rituximab) are the array of biological targets and therapies that are available for use. These treatment halt disease progression and many are able to gain their functionality and lead a normal life. Hence, the myriad of drug options should be discussed in length with patients to give them a more individualised approach to treatment that suits them best.

Conclusion

Most arthritis patients suffer in silence and envision a bleak future ahead of them. The pain is real, but so is hope! With this understanding, greater awareness should be emphasised on autoimmune-related arthritis in order to render a more meaningful hope for a better tomorrow. **BMMA**

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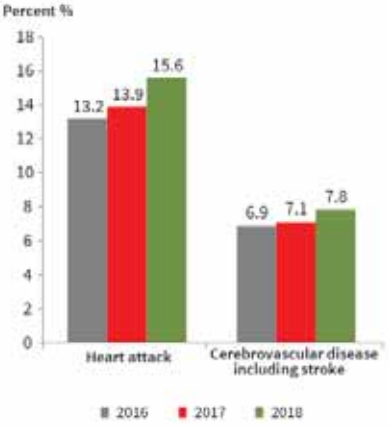
Healthy Blood Flow for Healthy Cardiovascular System

Cardiovascular diseases (CVDs) have been the leading cause of mortality in Malaysia over the years, accounting for approximately 35% of total deaths[1,2] with heart attack and stroke being the top 2 killers. According to the Department of Statistics Malaysia, the mortality rate caused by heart attack and stroke demonstrated an increasing trend from year 2016 to 2018 as shown in Figure 1[3,4,5].



Generally, the risks of heart attack and stroke increase with age; however, both can strike anyone at any time as the risk factors of both diseases being addressed at young age as well[6,7,8]. Fortunately, up to 80% of heart attacks and strokes are preventable[9]. Hence, understanding the prevention of heart attack and stroke is the key in reducing the risk of developing them.

Most people understand the importance to monitor blood pressure and cholesterol levels regularly. Yet, blood flow is regarded as the third pillar of cardiovascular health. A healthy cardiovascular system is known to allow blood to flow freely without any obstructions through the blood vessels. Keeping blood circulating efficiently is essential to overall physical well-being.

There are a range of factors that can result in poor blood circulation with the primary cause often being the clumping together of platelets in the blood. Platelets play a central role in haemostasis. When the endothelial surface (lining) of a blood vessel is injured, the structure of platelets will change from discs (smooth platelets) to spiny spheres (spiky and sticky platelets) causing them to aggregate at the site of injury and plug up the wound. However, platelets can become spiky and sticky without any injury or vessel laceration due to several risk factors, including:

- Age (>40 years old)
- Poor lifestyle and diet
- Menopause
- Health complications such as metabolic syndrome, chronic inflammation and deep vein thrombosis (DVT).

The above risk factors may lead to excessive platelet aggregation and unwanted blood clot formation which consequently can cause life-threatening diseases such as ischemic stroke which accounts for almost 80% of the total cases of strokes.

Aspirin is commonly prescribed for secondary prevention to reduce the risk of recurrent cardiovascular event and it is not recommended to be used as primary prevention as studies have showed that the risk of bleeding from daily use of low-dose Aspirin outweighs the benefits. This is in light with the advice from US Food and Drug Administration (FDA) where Aspirin should not be routinely used for primary prevention of cardiovascular diseases as the benefits of Aspirin for primary prevention has not been established[10].

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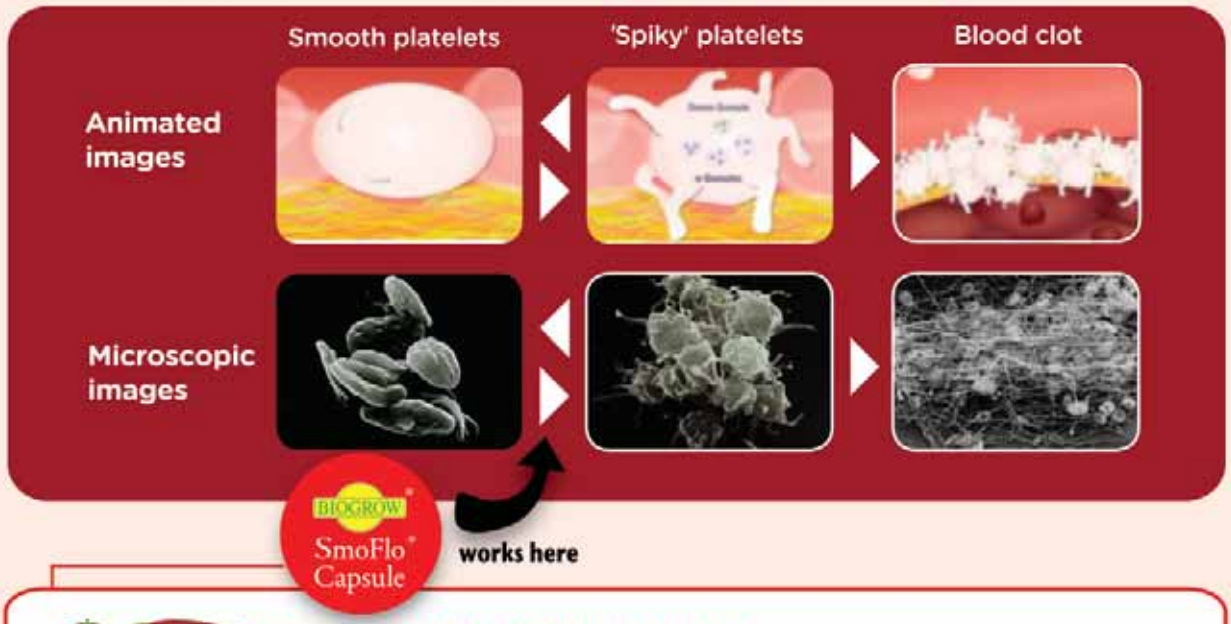
As compared to Aspirin, fruitflow® **natural water-soluble tomato extract** in **Biogrow® SmoFlo® Capsule** acts reversibly and gives healthier effect by suppressing the reaction of platelets but letting them to clot normally if they receive a strong stress signal from the body such as injury. Therefore, it is not associated with excessive bleeding, gastrointestinal bleeding and hemorrhagic stroke like Aspirin does.

How does Biogrow® SmoFlo® Capsule work?



fruitflow® **natural water-soluble tomato extract** in **Biogrow® SmoFlo® Capsule** works by keeping the platelet smooth to avoid aggregation and unwanted blood clot formation in the blood vessels.

It does not disrupt the rest of the blood clotting process so clotting will still take place as usual after injury.

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- Middle-aged to older adults (aged >40)
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- Individuals with high blood pressure
- Pre-diabetic/diabetic patients
- Individuals with overweight / obese
- Individuals practicing unhealthy diet
- Individuals who lead an unhealthy lifestyle
- Individuals with high stress level
- Individuals aiming to improve/maintain blood circulation without medication

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Looking Back, Forging Ahead!

The 41st National SCHOMOS AGM was held via Zoom (virtual platform) on 10 September 2021. This has been the second time that our AGM was conducted virtually (due to the COVID-19 pandemic).

The election of office bearers saw a healthy mix of the young and the seasoned being elected into the Executive Committee. Dr Vijay Ganasan was re-elected as Chairman. He is serving in Sarawak. Vice-Chairman is Mej (B) Dr Ahmad Filza Ismail (Kelantan), Hon. Secretary is Dr Sivabala Selvaratnam (Penang), Hon. Treasurer is Dr Goh Zhong Ning, Leonard (Sarawak), and Assistant Hon. Secretaries are Dr Lynette Sheena Dewa Rajo (Kuala Lumpur) and Dr Timothy Cheng Tsin Jien (Sabah). I believe this line-up would ensure continuity as well as bring onboard relevant new ideas.

There were two firsts @ this AGM:

- 50% of the Exco currently serve in East Malaysia thus making our 58th Malaysia Day celebrations a wee bit more meaningful with rock solid representation from the east!
- Dr Leonard Goh is the first contract doctor with the Ministry of Health to get elected into the National SCHOMOS Exco.

It is said that the past informs our future. This term, the National SCHOMOS Exco intends to raise the bar on what needs to be accomplished, while keeping an eye on what was done well in the last term. Our efforts would only come to fruition with the unwavering support of our National Working Committee (NWC) in various states. Top in our list is to get at least 2,000 doctors to become MMA members! Last term we managed to get about 1,500+ doctors to sign-up.

SMMAMS (Society of MMA Medical Students) would be empowered to better engage with medical students at the 30+ medical colleges in Malaysia while the JDN (Junior Doctors Network) would play a more active role in championing issues faced by our contract doctors.

We now have three seats at the MBK (Majlis Bersama Kebangsaan) P&P (Pengurusan & Profesional) – one more than the previous years. MBK is the platform to safeguard the welfare of civil servants and SCHOMOS is the sole representative of government doctors here. Numerous perks enjoyed by government doctors today are thanks to the papers presented by SCHOMOS at the MBK meetings. Two papers are currently awaiting approval, with the first concerning 'Approved Permits' for senior doctors with 20 years of civil service, and the second on the extension of special medical leave for contract doctors. We urge all MMA members to come forth and channel your ideas through SCHOMOS. The 'Approved Permits' idea had its origins from a Life Member in Perak!

We would like to thank our members for giving the SCHOMOS Exco and the NWC the mandate to serve. With a dynamic new Health Minister (YB Khairy Jamaluddin), our work cut out, and the team all set to hit the ground running, it'll be onwards and upwards for team SCHOMOS! BMMA

Dr Sivabala Selvaratnam
SCHOMOS Hon. Secretary 2021/22
sivabala.schomos@gmail.com

The Intersection of Medicine, Business and Ethics

"First do no harm" or the Latin phrase " Primum Non Nocere" is an ethical guideline that every trained doctor should adhere meticulously in their daily Professional practice. All doctors take cognisance of the fact that their lifetime work is all for their patients' healthcare and to try to heal if possible and comfort always.

When medicine turned into business and the complexity of medical technology, treatment or healthcare related activities are associated with financial returns – sometimes, the intersection between business and medicine becomes blurred.

Ethical guidelines to some are no longer sharp and clear demarcation; but rather, the guidelines are hazy bands and different shades of black or white.

The challenge for every doctor involved in the business of Medicine is to have the moral compass to act, advice and offer treatment that is appropriate. It is pertinent to always do what's best for the patient and not what's best for himself or herself.

The challenge is for every doctor to put the best interest of the patient above all else even to the extent of making less returns or none at all at times. It's an inescapable fact that at times the business of Medicine cannot be totally separated from the practice of medicine but every act that a doctor perform must result in protecting the patients' health or healing sickness and at the same time not harming or denying treatment to others and the wider community.

Sometimes when there are multiple treatment options or the need to ration healthcare in situation of low resource or supplies, the tendency to choose those options that yield the greatest returns or supply to the highest bidder must be actively resisted.

> "The challenge is for every doctor to put the best interest of the patient above all else."

Sometimes the justifications to offer certain treatments or to recommend certain health prevention procedures may not be for the patient's or public's best interest but yet there are some who are repeatedly able to find enough reasons to do so just because these treatments or procedures offer high returns.

The difference between business and medicine is that business puts profits above all else and medicine put the best interest of the patients and public health above all else. A doctor involved in the business of medicine should never confuse between those objectives and what separates a doctor as a Professional is the trust patients and public place on them.

The moment those trust is broken and the day a doctor operates contrary to what is expected of him or her is the time he or she should quit medicine for he or she is no longer practicing medicine. When non established treatments become gold standard, when questionable procedures become usual practice, when pushing the boundaries becomes habit and when patients' safety are no longer the utmost priority, professionalism will surely be lost forever.

Hippocrates would never ever imagine in his days what are the challenges modern doctors have to negotiate in the business of medicine, yet it is possible to keep his core ideals if we all are adamant that a doctor must always be a doctor first and foremost and business of medicine is always second rather that the other way round.

Only by doing that will a doctor be a true professional and to be respected as one. **BMMA**

Dr John Teo Beng Ho
Vice Chairman PPSMMA 2021/22
jbhteo@gmail.com

Blindfolded

It's been about two years since the start of the pandemic, which has affected most sectors of our economy, welfare, and particularly our education in one way or another. Before I begin, I would like to introduce myself, I am a fourth-year private medical student who has been staying at home for the past year. I am just an average student just like most of my friends and batch-mates. Before the pandemic, we used to go to the hospitals for our clinical postings as it was part of the curriculum.

Everything was fine as the doctors and professors were trying their very best to educate us students. However, the clinical exposure we get now (due to the pandemic) is abysmal – practical knowledge such as "history taking" has been lackluster due to the nature of the current model of teaching.

When they first introduced us to emergency remote teaching, it was fine and comfortable as we get to wear any clothes and eat during a lecture class. It was easy to pander and lose focus for most of the lectures. Unfortunately, I could not comprehend these new methods, which gave us a better reason to play truant.

I cannot speak for the rest of my peers, but I can't comprehend much of what they were teaching and didn't bring it up with a belief that the pandemic would end soon. As days go by, our Faculty of Medicine tried their best to bring us back to campus. Online classes have covered most of our clinical postings.

Meanwhile, students from other universities (especially government universities) got their vaccinations, even there was a case where the medical student refused to vaccinate. At this point, I panicked as we didn't get to go to the hospital even though our Faculty tried hard to bring us back.

I can't comprehend online classes as well as face-to-face classes. Professors normally will notice our facial expressions, e.g. whether students understand topics or are exhausted due to long classes. Online classes have totally ruined that! We now have long class hours, reaching even up till dusk when we still have classes.

With the emergence of online classes, student's cognition towards the topics became increasingly excluded. Instead, the timetable and teaching schedules took precedence with emphasis being placed on finishing our classes in time and according to these schedules.

"You are a 4th-year medical student, you should know this" – these comments and others in a similar vein are daunting, particularly as we haven't been able to go to the hospital for more than one year. I am not a smart student, but with the correct guidance, I can still understand the topics, and most importantly, if I have any doubts I am able to clarify it immediately.

When I was staying in a hostel, my focus would be primarily on my studies. But home is a non-conducive environment to study in, as I can barely focus because of various distractions and other 'technical' difficulties.

Finally, addressing our batch as Year 4 medical students is absurd as we barely went to the hospital. I firmly believe that clinical teaching in situ far surpasses classroom (and especially online) teaching. I can't speak for my other batch-mates, but I for one am anxious and worried. I don't have the same exposure as my seniors before the pandemic. I also believe that there is a significant amount of procrastination that we should acknowledge when it comes to private universities compared to government universities. **BMMA**

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Innovations in Medical Education

It is often said that change is the only constant, and being able to change is integral to survival.

In March 2019, the world faced a disruption that has changed the way we conduct ourselves; it would be fair to say that all spheres of public and private activity were affected, and the way we deliver education was no exception.

For years, medicine has largely been taught face-to-face, in lecture theaters, laboratories and in hospitals by the bedside of patients. This has been the tried-and-tested method of educating doctors the world over and in the years preceding the pandemic, doctors, academics, and students had all become comfortable with the status quo.

While in many educators had embraced the internet and had begun to introduce these tools into the teaching, learning and assessment processes, the medical fraternity being conservative by nature was slow in embracing change. It would not be wrong to say that the pandemic that began early last year was a game changer that has forced all of us to change and innovate in the way we deliver teaching and learning activities as well as assess students.

Innovation is a process by which a domain, a product, or a service is renewed and brought up to date by applying new processes, introducing new techniques, or establishing successful ideas to create new value. Innovation is generally important because it promotes creativity, develops leadership, and ensures relevance and competitiveness in any sphere of activity.

> // Innovation promotes creativity, develops leadership, and ensures relevance and competitiveness in any sphere of activity. //

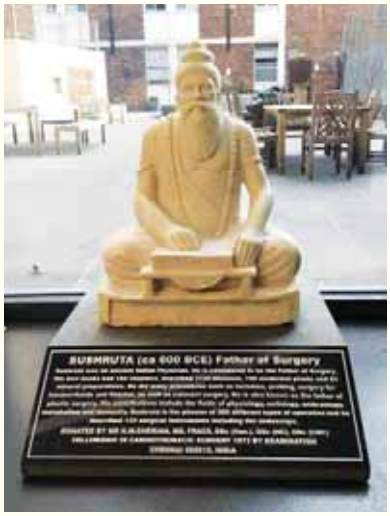
This is more significant in education as innovation makes us move outside the confines of our comfort zones as educators and challenges our methods and strategies of delivery and assessment to support the success of students as well as ourselves. This transformation may be small or a complete overhaul, but it is done with purpose and supports the whole system. This can be an uncomfortable process as we must move from an area of familiarity to one that is more uncertain and challenging, requiring new skill sets and attitudes.

Innovation requires us to break the rules, challenge convention, explore new paths off the beaten track, and also to collect ideas everywhere to overcome obstacles, change concepts, and optimise strategies. We also need to believe in the changes planned and put together a team who will bring different perspectives and styles to drive the changes that need to be implemented.

While we all believe that some of the newer concepts in medical education such as simulation, are new a glimpse back in time will show us that we have been innovating ever since medicine began and many aspects of medical education and training have a long history.

The Indian Sage Sushrutha, widely regarded as the “father of plastic surgery” who lived in the 6th century BCE developed a system of surgical apprenticeship that encompassed

- A 6-year period of study before training.
- An oath taking ceremony.
- The use of vegetables and wormwood to practice incisions and probing.
- The dissection of cadavers sans knives, by immersion in water to



A statue of the Indian Sage Sushrutha


Sir William Osler (1849-1919)


Dr Abraham Flexner (1866-1959)

allow study of the decomposing body.

Many of these are still very much a part of our curriculum today, but delivery has changed due to the developments in technology and the availability of newer techniques in teaching and learning.

Taught medicine as we know it is largely attributable to the ground-breaking work of Sir William Osler and Dr Abraham Flexner.

Sir William Osler recognised that physicians should learn from the bedside, listening to and examining patients. He is attributed with recognising the need for doctor-patient relationship and the concept of respect and dignity for patients based on of empathy, compassion and devotion to the profession.

Dr Abraham Flexner authored the ground-breaking Flexner report on medical education in the USA and Canada that:

- Set standards on admission to, and graduation from medical schools.
- Adhered to protocols of science in teaching and research.
- Allowed medical schools to control instruction in hospitals.
- Strengthened medical licensure.
- Allowed appointment of full-time professors in medicine.

The work of both these giants still resonates, and quite rightly so in the way we train doctors today.

So how do we innovate in an area that is so dependent on human contact to deliver outcomes?

In the basic sciences the use of prosected and plastinated anatomy specimens and models allow anatomy to be taught without cadavers which are a scarce commodity. AI and virtual reality allow us to take this a step further to teach anatomy using modelling and 3D printing technologies. Progress in imaging and radiology allows cross sectional anatomy to be taught by anatomists and radiologists, just as keyhole surgery has allowed anatomy to be taught using life images by surgeons.

These innovations bring clinical sciences into the classroom, thus allowing a fledgling medical student to appreciate the relevance of the sciences taught in the early years to practice further down the line. The availability of the internet allows immersive learning and review of material asynchronously for students.

In the clinical years the use of high-fidelity manikins to practice clinical procedures has allowed students to make mistakes and learn in a sheltered environment. This gives students the time to develop skills and confidence in carrying out these procedures before real life encounters in the wards. This practice will improve safety and reduce error as well as possible litigation while possibly reducing supervision time of young doctors.

While innovations are important, as educators and practitioners we must be sure that any innovation is based on the needs of the learner and the context. Technology is not necessarily better or worse, they

are different and are driven by the needs of the student and instructor as well as the context of the curriculum and its outcome.

A recent study in the delivery of the medical curriculum found that medical students valued the human interface highly and rated live patient encounters much higher in terms of instructional value when compared to technologically novel learning strategies. Medicine is a deeply human discipline that is based on science but can be emotive and technology will aid delivery but will probably never replace the life patient encounter. This underlines the need to use technology appropriately and emphasises the need for "the human factor" in delivery.

To innovate appropriately requires sound knowledge, critical thinking, and the ability to recognise a cause and effect, many before him had observed the protection afforded by exposure to cow pox to smallpox but the association required an Edward Jenner to develop the science of inoculation and vaccines. An innovator must also be able to persist in the face of adversity, as new ideas are seldom welcomed with open arms.

Disruption, thus inevitably drives innovation and planning must consider

- Appropriateness
- Value-add to the curriculum
- Resources and Expertise
- Staff and student readiness
- Resources
- Costing.

The innovation must be planned and once implemented, be assessed, and evaluated with feedback from all stake holders so that the necessary modifications are made to ensure they are fit for purpose. The final impact of any innovation is in the quality of the product in the field and in the case of medical education this will be the performance of the junior doctors we graduate to the work force.

In conclusion

- Innovations have always been a part of education.
- Disruptions drive innovation.
- Innovations must not be enamoured by technology.
- Innovations must have a human interphase in medical education.
- Innovations must be fit for purpose. **BMMA**

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He is a clinician turned medical educator, trying to make sense of technology while nurturing soft skills in medical students. A good book and a pet dog keep him sane.

Errata:
There was an error in the figures used to show the intragastric balloon procedure shown on page 33 of Berita MMA September 2021; the error is regretted. The correct figures are as follows.

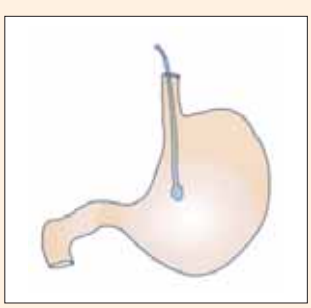


Figure 1: The balloon in its pre-inflated form is swallowed

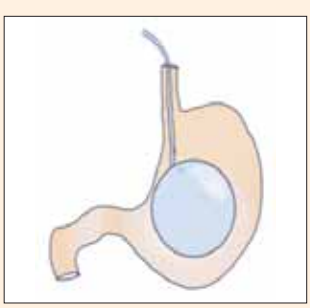


Figure 2: Once the position confirmed using fluoroscopy, specialised solution is infused through the catheter.

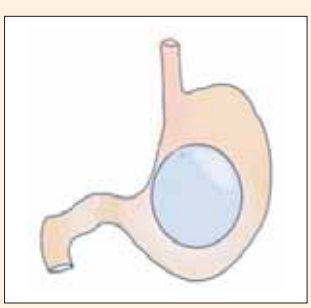


Figure 3: Once fully inflated and position reconfirmed, the catheter is removed.

Stay Protected Against Influenza & COVID-19

> // It is possible for a person to be infected with both influenza and COVID-19 at the same time. //

Similar yet Different[i]

Although both influenza and COVID-19 are contagious respiratory diseases, they are caused by different viruses. They share a similar yet wide-ranging disease presentation from asymptomatic or mild up to severe disease and even death. The way that they are spread is also similar, i.e. via contact, droplets and fomites.

The incubation period of influenza is 1-4 days compared to 1-14 days of the original COVID-19 strain. Both influenza and COVID-19 can spread even in the absence of symptoms.

The Delta Variant of Concern is able to ramp up the viral load within the first few days, thus making it more transmissible and contagious than the original Wuhan strain.[ii]

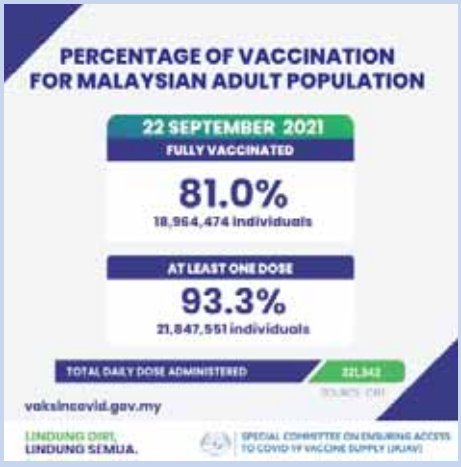
Unlike COVID-19, influenza commonly affects young children causing complications like acute viral bronchiolitis, pneumonia, secondary infection with the pneumococcus, myocarditis and encephalitis.

Other groups at high risk for severe influenza include pregnant women, the elderly, persons with chronic medical conditions, those who are immunosuppressed, travellers and healthcare workers. As a comparison, the risk for the pregnant lady with influenza is much worse than with COVID-19.

During the 2009 influenza pandemic, the mortality rate for the pregnant women was 5% of the total population, even though they only made up 1% of the population.[iii] And the risk of ICU admission was 7-fold.

Co-infection & Vaccination

It is possible for a person to be infected with both influenza and COVID-19 at the same time. Since both diseases share similar symptoms, it is highly likely that only COVID-19 will be diagnosed and testing for influenza may be forgotten. There remains a worrying potential for an influenza outbreak to occur, so COVID-19 patients should also be screened for influenza. This is where prevention comes into the picture.



Announcement from the Special Committee on COVID-19 Vaccine Supply (JKJAV) on twitter as of 22 September 2021[iv]

At this point, it is safe to say that the majority of people would not hesitate to get their COVID-19 vaccinations. Unfortunately, the same does not hold true for influenza vaccinations as many people tend to ignore it, especially in light of COVID-19. Vaccinating against both can be a crucial factor in preventing both influenza and COVID-19, and at the very least, it will help in reducing the risk of severity if one is infected with COVID-19.

The Importance of the Influenza Vaccine

There are several studies showing that influenza vaccination can reduce the severity (and even mortality) of COVID-19 patients.

A recent large study in patients with COVID-19, showed that the annual influenza vaccine reduced the risk of strokes, infection, blood clots in the legs, (DVT), visits to the ER and ICU admissions.[v]

An earlier study involving 27,201 patients, with an influenza uptake of 47.8% reported 4.5% who tested positive for COVID-19. The flu-vaccinated patients who tested positive for COVID-19 were less likely to be hospitalised, require mechanical ventilation, and required a shorter hospital stay.[vi]

Another study suggested that influenza vaccination was linked to a reduction in the mortality of COVID-19 patients, but further studies would be needed to confirm this.[vii]

Doctors should encourage their patients, especially those who have pre-existing illnesses, to get their influenza vaccines. You may refer to current recommendations and guidelines from the Ministry of Health (MOH) or the Malaysian Society of Infectious Diseases & Chemotherapy (MSIDC) for up-to-date information on the administration of influenza vaccines with other COVID-19 vaccines.

Doctors, nurses, and anyone who works in the healthcare setting or is in close contact with healthcare personnel should also be vaccinated against influenza due to their increased risk of infection. Don't underestimate the importance the influenza vaccine. It is just as important as getting the COVID-19 vaccination. **BMMA**

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DON'T TAKE THE FLU LIGHTLY!

"For the 2021 – 2022 influenza season, influenza vaccination will be paramount to reduce the impact of respiratory illnesses attributed to influenza and resulting burdens on the healthcare system during the COVID-19 pandemic."

– Centers for Disease Control and Prevention (CDC)[1]

What is the impact of flu?

About **290,000** to **650,000 DEATHS** worldwide every year[2]

HIGH MEDICAL COSTS to treat complications of flu[3]

Days or weeks of **MISSED WORK** or **SCHOOL**[2]

The **Clinical Guidelines of COVID-19 Vaccination in Malaysia** recommends immunisation with any other vaccines to be scheduled at least **2 weeks BEFORE** or **AFTER the COVID-19 vaccine**[4] – including the flu vaccine.

The flu vaccine is recommended for everyone aged 6 months and above.[1]

An **effective way to reduce the risk of flu and its serious complications** is to **get vaccinated annually**.[2,5]

The persons depicted are models used for illustrative purposes only.

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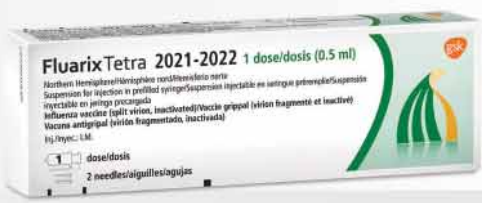

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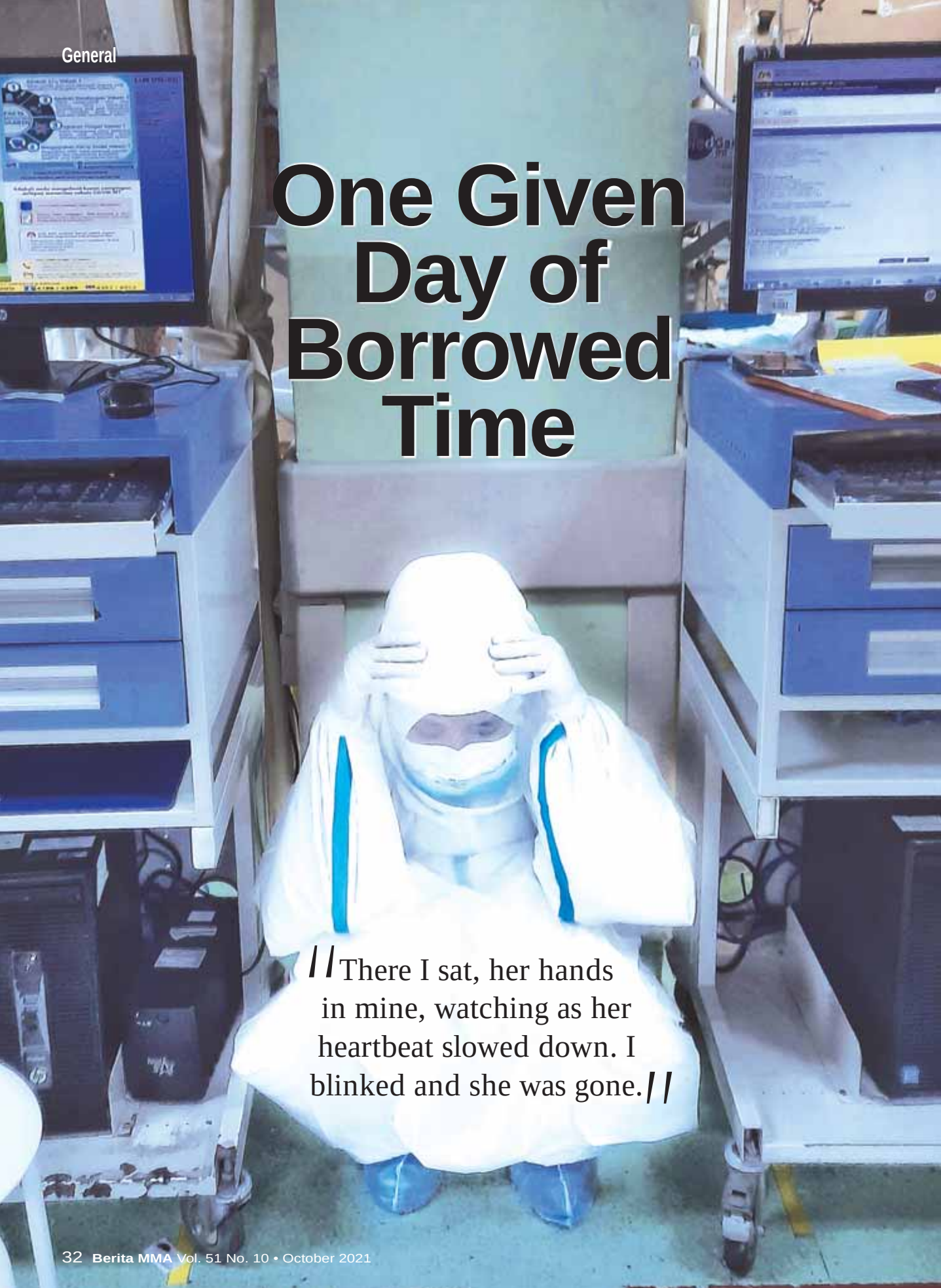
One Given Day of Borrowed Time



//There I sat, her hands in mine, watching as her heartbeat slowed down. I blinked and she was gone.//

The alarm rang and I woke up. I looked outside. Dawn is breaking. Slowly, I prepared myself for work. I stood in front of the mirror. The same reflection looked back at me – red eyes, paired with eyebags, chapped lips and skin that has seen better days. I kissed my family goodbye and drove to the hospital.

After nearly two years in the battle against COVID-19, instead of being motivated, the will to fight has depleted, replaced by muted despair. That dreaded feeling increased with each step I took toward the common room, as I changed into hospital scrubs before entering the COVID-19 ICU unit.

Adorned in our arsenal, the PPEs, the PAPRs, I started my review of the patients. This one was dying, my patient in Bed 14. After updating the family, only one request was within my capability to grant, the rest were whimsical expectations, only to be crushed by the harsh reality. There I sat, her hands in mine, watching as her heartbeat slowed down.

"It's okay now. Time to rest. You've done the best that you can." I blinked and she was gone. Words that have been uttered over and over again. Repeatedly, frustratingly, regretfully – more so during the 4th wave when the delta variant hit us hard.

Oh look, a new case. It was a pregnant mother of three, breathing too fast to my liking. The only option to save her was intubation. "Will I be okay? Will my baby be okay? Will I be able to see my husband and kids again?" she asked.

I stood there dumbfounded. The previous death was still raw, resonating within my being, but her eyes were pleading, begging. "For now, this is the best course of action. Pray that you will be able to wake up again." The moment I spoke those words, I can feel the universe whispered back, "Lies." I shook my head to clear the tangling cobwebs of guilt that was at the back of my subconscious mind.

After intubation, she was sent for EMLSCS and returned, only to be prone for the next 16-20 hours. I glanced at her vitals. My heart felt like lead. "Another one battle, between life and death. Which one will emerge superior this time?"

Finally ended my shift and showered at the common area. Physically and emotionally drained, I drove back home. It was during these times that I allow grief to wash over me. Tears streamed down as I let go of the pent-up anguish inside. I parked my car and walked straight to the toilet to shower again. I stood in front of the mirror. That same reflection looked back at me. Inhale, exhale. Lifting the corner of my lips with my fingers, a smile formed in the reflection. Not a glimpse of who I am inside. A better façade to face the family.

How do I do it, you ponder? I start by appreciating the days that are given to us. Including days like this, when the world feels so bleak; when I begin to question our existence, that despite our best efforts, we keep on losing them one by one, the elderly and the young ones; when even our maternal mothers are not spared.

But what is grief, if it's not love persevering? A battered heart that shows that I have cared, a bruised spirit that shows I have breathed, a shattered soul in the husk of the living, a valiant effort in playing the tug of war with God, only to be humbled by His power.

Embracing the good days is a much more wonderful feeling. The lightness in our steps, feeling the warmth of the sun, and that radiant glow inside when seeing your patients being discharged from ICU, thus knowing they will make it home where their families are waiting.

How do I hold on, you ask? From the start, I have seen people in financial crisis, yet doing their best to maintain SOP. Now, when the vaccination shows the critical case numbers are improving.

When hope exists, when it fills your lungs with air, no matter how deep the struggle is. When joy trumps sadness, when flowers grow from hard spaces in your heart – that's when I hold on. **BMMA**

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Coronavirus: Building My Deadly Nest

I'm an omnipotent ghoul, unwelcome guest,
Here to build my deadly nest;
Am I messenger or leveller at devil's behest,
Wreaking carnage and grief, at best?

My army deployed with devastating energy,
Constantly remodelled with infinite strategy;
My cavalry raging on land, water and air,
With unfettered abandon and infinite flair.

No Fat Man mushroom nor far-flung missile
Can annihilate me or render less vile,
For, I am omnipresent and indiscernible,
Possessing powers humanly incomputable.

Man toiling relentless, solutions in search,
Delving deep into genomic research;
Remedies old revisited, new ones trialled,
Chinks in my armour desperately drilled.

Vaccines concocted at feverish pace,
Conflicting issues clouding the race;
Material benefit or moral dysfunction?
People hand-wringing in abject frustration.

Remember: I've come my deadly nest to build,
Surrender not nor flee desire unfulfilled;
Remember too: I act as messenger,
Risking my longevity in looming danger.

For my apocalyptic flights to be stalled,
Powers and prowess to be mauled.

Man:
Imperative to change behaviour,
Practise safety, cleanliness your saviour;
Shelve fun, frolic and fraternity,
Stay on course for vital immunity;
Adopt ways for kith and kin health,
Rein in penchant for power and wealth,
Take leap of faith for life's symphony.
Re-learn tenets for universal harmony.

Seeking refuge from my sanctum verdant,
Decimated by avaricious human penchant;
I've come to build my deadly nest,
But do halt me thriving as eternal pest.

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This third poem in my Coronavirus Trilogy was composed in August 2021, with pandemic cases and deaths spiralling, and desperation in all aspects of life and the systems of our nation. It is a tangible, painful reality, and everyone is seeking divine resolution with human endeavour. Living with the virus controlled and attenuated may be our ultimate future destiny.

The Darkness of The Rose

These words, they splatter,
staining this parchment.
Teardrops flow down freely,
as I'm stunned beyond words.

We were the ever so perfect couple,
Love made in heaven, they said.
You were my sunshine,
that lighted my life, throughout the day.

You were the bright moon,
that lighted up my dark nights.
You were the shimmering stars,
that glimmered, oh so bright.

You were the blood,
that coursed through my veins.
You were my heart,
that beats, every second.

You were the oxygen,
that kept me breathing.
You were the man,
with the perfect voice,
singing, like a mockingbird.

You were my man,
my soulmate.
We had planned our future together,
without the slightest clue,
of what the future holds for us.

Now, what's left are just memories,
the sweetest of all.
You were strong,
until you breath your last.

That Cancer,
it took its aim and shot.
Took its aim and shot,
without a second thought.

Without a care in the world.
It has no feelings.
It never has, indeed.
It doesn't care if you are young or old.
Evil or kind.
It doesn't care.
It just rips us apart.

It is like a ferocious dragon of fire,
that opens its mouth wide and bites with vengeance.

It is as ruthless,
as it seems.
Dear Cancer, I LOATH you.

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GP: Why I Need to Know About Breast Cancer Treatments?

Breast cancer is the commonest cancer in Malaysia with more than 4,300 new breast cancer cases being diagnosed every year. In my previous article (*The Importance of Primary Healthcare in Cancer Screening – Berita MMA August 2021*), I have shared the role of primary healthcare in breast cancer management particularly in breast cancer screening and prevention.

Here I will like to share a case and why it is important for GP to know about breast cancer treatment as well.

A 45 years old premenopausal lady with underlying breast cancer and no other comorbidity presented to a GP clinic with complaint of diarrhoea for 3 days duration. It was noted that her random blood sugar was 13 mmol/L. She was treated as acute gastroenteritis and possibly diabetes (She was advised for dietary and lifestyle modification). One week later she presented again with the same symptoms and the blood sugar was 15.6 mmol/L.

Is this a case of gastroenteritis and undiagnosed diabetes? Or these symptoms could be side effects from anticancer therapy?

Under normal circumstances, cancer patients on treatment will be monitored and follow-up with their treating physician. However due to COVID-19 pandemic, many patients are reluctant to go hospital or trying to reduce the visits.

> "Therefore, what happens when they encounter problems or developed symptoms?"

Therefore, what happens when they encounter problems or developed symptoms?

They will visit their trusted GP, which is nearer and more accessible to them.

Over the years, we have learnt that breast cancer is not a single entity and gone were the days where breast cancer treatment only consists of chemotherapy, radiotherapy and tamoxifen (hormonal therapy for breast cancer). Side effects from anti-cancer therapies are no longer just hair loss, nausea or vomiting.

As we move towards precision medicine, more molecular studies are being conducted to guide us on cancer treatment. Besides the treatment options mentioned above, targeted therapy and immunotherapy are also being used to treat breast cancer as well. These drugs have different side effect profiles than conventional chemotherapy.

Let's us briefly go through some of the breast cancer treatments and its side effects. For easier understanding, the breast cancer treatments discussed below will be based on 3 main subtypes of breast cancer; HER2 positive, hormone positive, and triple negative breast cancer.

HER2 Positive Breast Cancer:

1. **Anti-HER2 therapy:** Example such as trastuzumab, pertuzumab, ado-trastuzumab emtansine, lapatinib, and neratinib.
   Common side effects: Diarrhoea, rash, and cardio toxicity such as heart failure (Less common, and majority reversible. Recommendation: 3-monthly ECHO assessment).

Hormone Positive Breast Cancer:

1. **Hormonal therapy:** Example such as tamoxifen, anastrozole, letrozole, exemestane, and fulvestrant.
   Common side effects: Menopausal symptoms such as hot flushes, arthralgia, osteoporosis, thromboembolism, and endometrial hyperplasia/ cancer.

2. **CDK 4/6 inhibitors (targeted therapy):** Example such as abemaciclib, palbociclib and ribociclib.
   Common side effects: Neutropaenia (febrile neutropaenia rare), leukopaenia, diarrhoea, fatigue, and nausea.

3. **PIK3CA inhibitor:** Example such as alpelisib.
   Common side effects: Diarrhoea, hyperglycaemia, and skin rashes.

Triple Negative Breast Cancer:

1. **Immunotherapy:** Example such as pembrolizumab.
   Common side effects: skin rashes, thyroiditis, hypothyroidism, pneumonitis and other immune related side effects.

2. **PARP Inhibitor:** Example such as Olaparib.
   Common side effects: Anaemia, neutropaenia, nausea, vomiting and fatigue.

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The list of adverse events above is not an exhaustive list and only covers some of the common side effects and those of interest. Likewise, the treatment of breast cancer is not just limited to the list above; but may include chemotherapy, radiotherapy or a combination of these options or others.

Back to the case above, the patient was diagnosed with advanced hormone positive breast cancer and is currently on second line treatment with alpelisib and fulvestrant. The diarrhoea and hyperglycaemia were known side effects of the treatment. It is always good to speak to the treating physician as the presenting symptoms could be due to side effects of anticancer therapy or unrelated at all. This is to ensure optimal care can be provided to the patient, as some drug's side effects may requires specific management and medications.

More than one fifth of breast cancer patients in Malaysia presents at stage IV on diagnosis, and this is affecting their outcomes and survival. GP play a major role in breast cancer screening and prevention, which could downstage more patients and thus improving the outcomes and survival. Now, we can also work together in providing optimal care for our breast cancer patients, especially those who are on anticancer treatment. **BMMA**

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The Chair

October, the Breast Cancer Awareness Month, was back. Pink buntings adorned the entrance area and an air of excitement, even gaiety seemed to prevail. About five hundred people were expected to attend the annual breast cancer symposium which was to be held in the Medical School's main lecture hall.

Staff, students and patients had worked hard to organise various events in conjunction with the Breast Cancer Awareness Month. The highlight this year was a fund-raising concert cum dinner. Nurses and cancer survivors had trained with professional performing artists for weeks in preparation to entertain the guests at tonight's gala.

As she walked towards the lecture hall, the Chair of the Breast Surgery Unit looked around with guarded satisfaction. Many people were wearing pink ribbon badges. Exhibition space adjacent to the lecture hall had the usual booths, promoting treatment related paraphernalia, bras, wigs, scarves and hats, lifestyle improving goods and services and the miscellaneous. Free drinks were available.

Fluffy, pink, stuffed animals and pink balloons were being given away. Several stylishly dressed women were leisurely walking about the booths sporting short, newly sprouted crop of hair, while others had concealed their baldness with scarves and caps. Among the cheerful faces, there were the sad and lost ones. The agile and the robust mingled with the emaciated, the frail and the wheelchair-bound.

Years of involvement with internationally acclaimed research and pioneering of the breast cancer awareness program had made the Chair of the Breast Surgery Unit a national icon. She was a champion of early diagnosis and felt that not enough was being done. Patients had continued to present at advanced stages and there was an alarming increase of breast cancer among younger women. Five mobile mammography and ultrasonography units were flagged off earlier by the Hospital Director to launch the Breast Cancer Awareness Month.

Emanating music and announcing their mission on loudspeakers, these sleek pink vehicles were roaming about the selected areas of the city and its outskirts. On the very first day, three new cases were detected and referred to the hospital's breast cancer unit for further investigation.

The institution had come a long way in improving the diagnosis and management of breast cancer and was a leading centre for the training of breast surgeons and oncologists. State-of-the-art diagnostic and imaging facilities and latest treatment modalities were provided. The Chair hoped to do much more and today's symposium reflected her aspirations.

It was opened by the Dean of the Medical School with a short and inspiring speech. The lecture hall was packed with breast cancer survivors and family members, representative of pharmaceutical companies, charitable and non-governmental organisations, academic staff, students and the local press.

In her lecture, the Chair emphasised the importance of early diagnosis and highlighted the measures required to achieve that. Several other speakers elaborated on various aspects of prevention and treatment.

Lastly, a breast cancer survivor addressed the gathering, tracing her ordeal and recovery from advanced disease. She had undergone double mastectomy, chemotherapy and radiotherapy nearly five years ago and was still disease-free. Her inspiring narrative was much applauded.

The gala dinner took place at a nearby hotel. As expected, pink was the dominant colour of flowers and décor in the banquet hall. Guests were clad in myriad shades of pink, from soft to bold and deep to bright, while hospital staff wore pink scarves and pink ties. Donated by a celebrity fashion designer, the scarves and ties were on sale outside the banquet hall.

Performing artists, especially cancer survivors took the hall by storm. Audience participated whole heartedly, singing and clapping and breaking into dance around their tables. Towards the end, the Chair was pleasantly surprised to learn that she was selected as the

first recipient of the National Breast Cancer Society's newly established award. She went up to the stage and received it from the society's President for her outstanding contribution to breast cancer awareness and research. It was a most moving experience and she was given a standing ovation.

The fund-raising dinner was a big success and when it ended, the Chair rushed home for a much-needed rest. She had a busy clinic next morning. As she stood soaping herself in the comfort of a warm shower, she gazed at herself in the full-length mirror.

How would it feel to lose a breast or worse still, both breasts? She had seen patients going hysterical and crying bitter tears when they were told that may require a mastectomy. Some had stormed out of her office and were not seen again. What happened to them? Where did they go?

It was quite a while since she had examined her own breasts, and that is exactly what she did. No, this was not happening. It could not be. No. She was imagining this. Her left breast felt unusually lumpy. Was there a growth? A closer look in the mirror showed that her left breast appeared slightly bigger, even firmer.

What was going on? Afraid to proceed but knowing that it had to be done, she examined her axilla. There it was, a hard and discrete little thing, also on the left side. Her experienced fingers recognized it as a lymph node and not a good one. More search revealed yet another similar but smaller lump. Startled by her discovery, she wrapped herself in her bathrobe and sank into the sofa. It was past midnight.

A feeling of guilt overwhelmed her, as if she had committed a criminal offence. No, she could not go to her own unit for help. No, she could not ask one of her colleagues there to examine her. She blanked out and fell asleep.

Early next morning the Chair was on the telephone with Sara, a former colleague. An excellent breast surgeon, Sara had opted to work at an exclusive private medical facility which catered to the needs of foreigners and the rich and famous. By 9.00 am the Chair was sitting in Sara's elegant office, feeling numb and dazed. Was this really happening?

Palpable lesions spreading in her left breast, palpable lymph nodes, bearers of evil tiding lurking in her left axilla. Thinking back over the happenings of a year or so, she began to recollect. There were times when she had felt unusually tired, experienced low stamina. She had had herpes involving scalp, face and neck, and a sudden episode of fungal infection of her toenails.

All these had pointed towards a challenged immune system and were ignored. Her cells had turned against her, silently and sneakily, damaging the very tissues they belonged to.

By mid-morning, the Chair had had a mammogram and undergone an ultrasound guided biopsy. The attending radiologist, Mia, wanted to make a comparison of the current images with the previous ones. Mia offered to call her counterpart at the hospital where the Chair was working to trace the Chair's past imaging records.

When was her previous mammogram or breast ultrasound examination done? How long ago? Mia wanted to know. The Chair could not be sure. Perhaps four or five years ago, or maybe much longer? She had no recollection of undergoing the screening in recent years.

Mia stared at her in disbelief, speechless. The local daily was lying on Mia's table, a special issue on breast cancer. The front page carried a photograph of an elegantly attired and smiling Chair. She was receiving the Breast Cancer Society's special award for her contribution to early diagnosis of Breast Cancer. Included in the following pages was a glowing description of the previous day's activities and the gala dinner.

In the following days, a PET CT supported the initial findings and demonstrated suspicious spots on the Chair's left clavicle. Mastectomy was performed which was uneventful and was to be followed with chemotherapy and radiotherapy. Histopathology report had described the tumour as a poorly differentiated, triple negative carcinoma in-situ of the left breast, with lympho-vascular infiltration. BMMA

Author's Note:
The above short story is a work of fiction.

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Selayang Hospital Receives HFNC

One unit of High Flow Nasal Cannula (HFNC) was donated to Selayang Hospital after our Wilayah Branch Committee decided on a donation drive and initiated this project in the month of July 2021. Donations came in from Committee members, Wilayah members, few other State members, friends and few organisations.

We managed to collect enough funds to procure and contribute one unit of HFNC, which was subsequently handed over to the hospital on 27 August 2021 for their use.

During this trying period of the COVID-19 pandemic, there are many lives gasping for breath in the ICUs throughout our country. Not every patient who is in dire need of a ventilator or similar equipment is able to have access to it simply because demand exceeds supply. This has placed doctors in a dire situation where they are forced to prioritise which patient to ventilate.

After talking to several intensive care consultants in government hospitals in our country who are treating COVID-19 patients, we have been advised that there is an urgent need for Fisher and Paykel Airvo2 High Flow Nasal Cannula (HFNC) apparatus.

This apparatus can be used in the ward for COVID-19 patients who

Datuk Dr Kathiresan (L) with Dr Saravanan and Dr Ravi

Dr Nik Nor Aniza (Timbalan Pengarah (Perubatan II) Hospital Selayang) presenting a certificate of appreciation

Contribution of HFNC with consumables to Selayang Hospital

are in late stage 3 or stage 4, to increase the oxygen percentage to safe level. Since there is an acute shortage of ICU beds in most of the hospitals, the HFNC oxygen apparatus is a very useful machine and its usage may avoid the need for an ICU bed.

By providing this lifesaving equipment we are confident that some preventable deaths can be avoided. We do not know the colour or creed of the patient saved. Even in the future we may not meet him. But imagine the smile on his face generated by our little act. Our conscience whispers "You have done something great for humanity".

Special note of thanks to our Wilayah Persekutuan Member Datuk Dr Kathiresan who helped us with the logistics of arrangements for handover at Selayang Hospital.

On behalf of our Chairman Dr Saravanan, our Committee Members and I would like to thank all the generous donors who came forward to help in this donation drive to make this contribution of HFNC to Selayang Hospital a huge success. **BMMA**

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MMA Wilayah Persekutuan Branch
Life Member, Wilayah Persekutuan Branch
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A doctor brings a red pen to work every day, so his nurse asked him," Doc, I wonder why you get bring that red pen to work every day." The doctor replied," Well, I need it to draw blood."

Mr Rasul consulted his doctor for dizziness. "Good morning Mr Rasul, what seems to trouble you," the doctor inquired.

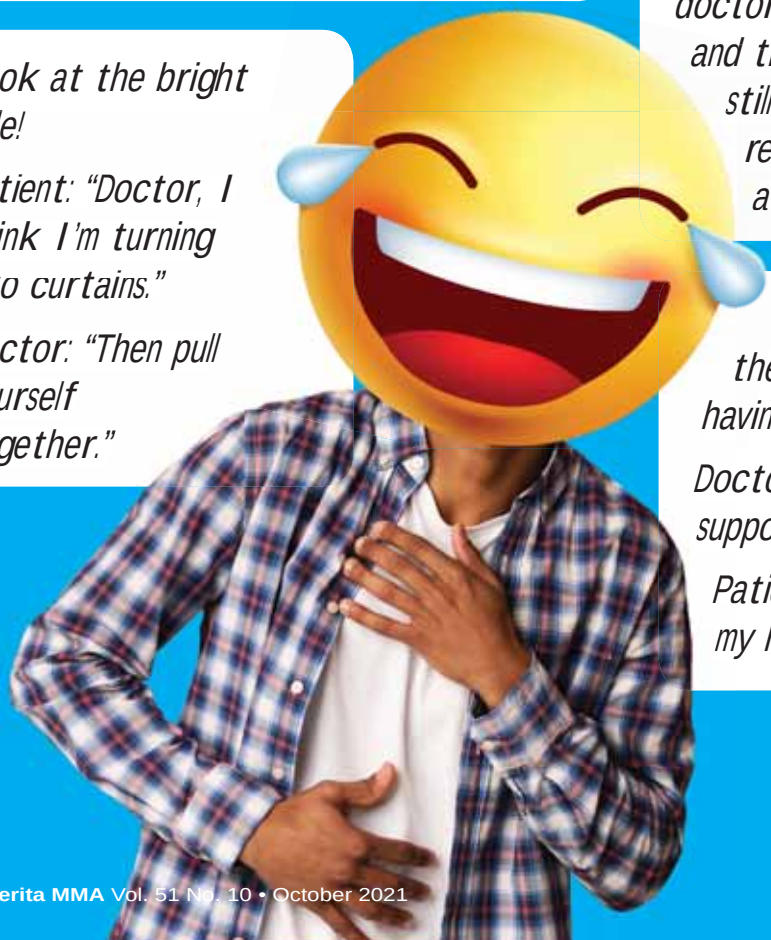
The patient replied, "Well, I feel dizzy upon getting up."

The doctor immediately replied," Oh, then try getting up one hour later."

Look at the bright side!

Patient: "Doctor, I think I'm turning into curtains."

Doctor: "Then pull yourself together."



The doctor stood next to a very ill patient and said:

Doctor: "I'm so sorry to inform you that I cannot hide. Is there anyone you would like to see?"

Mr Steve: "Yes, doc (replied faintly), maybe another doctor."

A doctor mistakenly prescribes a laxative instead of cough syrup. The patient returned to the doctor about one week later, and the doctor asked," Are you still coughing? "The patient replied, "No, doctor I'm afraid."

An older man attended the doctor's office for having his hearing checked.

Doctor: "Uncle, you have a suppository in your ear!"

Patient: "Now I know where my hearing aid went."

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New Straits Times – 11 September 2021

Dr Koh Kar Chai is new MMA president

KUALA LUMPUR: Dr Koh Kar Chai has assumed the role of Malaysian Medical Association (MMA) president for the 2021-2022 term following its 61st National Annual General Meeting held virtually today.

Dr Koh takes over the reins from Prof Datuk M. Subramaniam who completed his 2020-2021 term and now hold the role of immediate past president.

In his acceptance speech, Dr Koh said healthcare reforms would be a top priority during his term.

"We need to take a long hard look at healthcare reforms that are much needed for our country.

MORE NEWS

MMA calls for long-term solution to contract medical personnel issues

MMA takes serious view of threats against HDK participants

MMA urges cops to stop harassing docs who took part in Code Black, Black Monday campaigns

Vaccinate the unvaccinated first, says MMA

"The process will take quite a few years to say the least, but I believe that MMA, being the responsible medical association it is, should take the bull by its horns," he said in a statement today.

Dr Koh also emphasised the need to continue to engage with the government on various issues concerning the healthcare system, saying that doctors should take the lead.

MMA, he said, should engage more regularly and purposefully with the government on the need for reforms in the country's healthcare system that are in the best interest of the health and well-being of the population.

He further said there are a multitude of issues to look at, which involve both the public and private sector.

"I believe that MMA, with its Section Concerning House Officers, Medical Officers and Specialists (SCHOMOS) and Private Practitioner Section (PPS) is well prepared to forge ahead and tackle all the obstacles encountered and to be encountered in the reformation of healthcare in this country.

"(This could be) about Contract Medical Officers; lack of medical personnel or rather misplaced medical personnel in the public sector; Dispensing separation; Medicine Price Control; unequal access to secondary and tertiary care and all other aspects related to the need to transform our healthcare system."

Dr Koh also expressed confidence in the health ministry under a new leadership supported by experienced top officials.

"We have with us a seasoned Health Director-General, Tan Sri Dr Noor Hisham Abdullah, and a dynamic new Honourable Health Minister Khairy Jamaluddin Abu Bakar, who we need to work with towards our common aspirations of a healthcare system that truly leaves no one behind, that is efficient and sustainable – one that will be the pride of us doctors and our patients.

"I look forward to engaging and working closely with the Health Ministry, State Health Departments, the media, our current Exco and Council, the various committees and of course our erstwhile members."

Dr Koh graduated from Kasturba Medical College, Manipal, India.

Upon completion of his M.B.B.S. degree in 1991 he served in public healthcare under the Health Ministry and upon completion of his public service, he ventured into private general practice from the year 1994 till present day.

He has been an active member of the MMA for almost two decades and is involved in many policy discussions and decisions on healthcare issues.

Dr Koh is an advocate for equal access to quality, safe and affordable healthcare services for all. He is also a firm believer in vaccination as a way forward in the prevention of communicable diseases.

Those in the new line-up for the new term are Dr Muruga Raj Rajathurai (president-elect), Dr Thirunavukarasu Rajoo (Honourary General Secretary), Dr Vasu Pillai Letchumanan (Honourary General Treasurer), Dr Arvindran Alaga (Honorary Deputy Secretary), Dr Sivanaesan Letchumanan (Honorary Deputy Secretary), Dr Vijay Ganasan (SCHOMOS Chairman), and Dr Balachandran S Krishnan (PPS Chairman).

MMA Official Facebook

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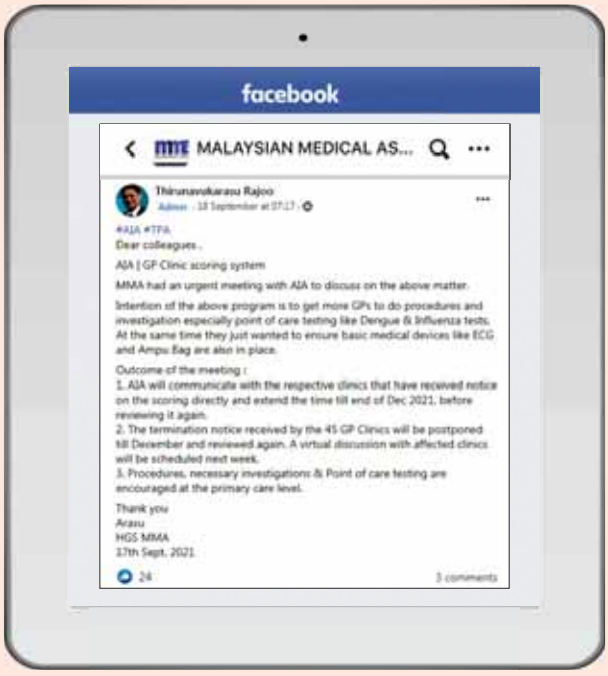

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ORGANIC FOODS

Oregano

Oregano is an herb from the mint or Lamiaceae family used for thousands of years to add flavour to dishes and treat health conditions. It is featured in the Mediterranean diet and is commonly associated with joy and happiness by Greeks and Romans, i.e. "oros" means mountain and "ganos" means fun.

The most common type is Oregano Vulgare, also known as Spanish thyme and wild marjoram. The herb flavour and scent are enriched with antioxidants such as thymol, carvacrol, limonene, terpinene, ocimene and caryophyllene. The fresh leaves of oregano are peppery and assertive, sometimes bitter or astringent.

Oregano is usually used in the diet as a supplement and as an aromatic oil. In cooking, people use the dry leaves or fresh to add a "Mediterranean" flavour to a range of dishes that pair well with tomato and often feature in pizzas and pasta sauces. Thus it goes exceptionally well with baked goods, vegetable dishes, legumes, fish and chilli dishes.

However, oregano also serves herbal needs for good health; to treat ailments such as skin sores, muscle sores, asthma, cramping, diarrhoea, indigestion and colds. Some studies mentioned that this beautiful herbal acts as antioxidants, relieves inflammation, regulates blood sugar, and fights cancer, but further evidence is required.

Do you know?

- It is best to avoid oregano products for two weeks before surgery because it can increase the risk of bleeding
- Dilute essential oils with olive oil or water before using because the concentration of oregano oil of more than 1% may result in skin irritation
- Oregano tea is generally safe, but consuming more than 4 cups a day may cause stomach upset
- Overcooked fresh oregano run the risk of having a bitter taste, and also large quantities of dried oregano usage in cooking may impart a medicine-like a flavour rather than a pleasant herbal taste
- Not all oregano plants are edible; some are used for medicinal and decorative uses only

Reference:
1. Medical News Today: What are the health benefits of oregano?
2. Medically reviewed by Natalie Butler, R.D., L.D. — Written by Yvette Brazier on January 17, 2020

Prepared by
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Venue : Online
Organiser : Malaysia Association For Bronchology & Interventional Pulmonology (MABIP)
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Website : http://www.apcb2021.com/

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Venue : The Vertical, Bangsar South Kuala Lumpur
Organiser : The Private Medical Practitioner's Association Of Selangor and Kuala Lumpur
Email : secretariat@acadmed.my
Website : www.pmpaskl.org

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Oct 16

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Organiser : MMA Sabah Branch and Persatuan Ortopedik Sandakan

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Oct 23

Venue : Online
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