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For those patients whose lives are still impacted by AD symptoms, help give them sustained improvement that starts fast[1,2]

olumiant® (baricitinib) tablets

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References: 1. Olumiant 2mg_4mg PI_EUSPC 04 May 2021. **2.** Genovese MC, Smolen JS, Takeuchi T, et al. Safety profile of baricitinib for the treatment of rheumatoid arthritis up to 7 years: an updated integrated safety analysis. Ann Rheum Dis. 2019;78:308-309.

Abbreviated Prescribing Information

Contents: 2mg or 4mg Baricitinib per film-coated tablet. **Indications: Rheumatoid arthritis**: treatment of moderate to severe active rheumatoid arthritis in adult patients who have responded inadequately to, or who are intolerant to one or more disease-modifying anti-rheumatic drugs. Olumiant may be used as monotherapy or in combination with methotrexate. **Atopic Dermatitis:** treatment of moderate to severe atopic dermatitis in adult patients who are candidates for systemic therapy. **Dosage:** 4mg once daily. A dose of 2mg once daily may be used in patients aged ≥ 75 years, patients with a history of chronic or recurrent infections, patients who have achieved sustained control of disease activity with 4mg once daily and are eligible for dose tapering, patients with creatinine clearance between 30 and 60mL/min, and patients taking Organic Anion Transport 3 (OAT3) inhibitors. For atopic dermatitis, Olumiant can be used with or without topical corticosteroids. The efficacy of Olumiant can be enhanced when given with topical corticosteroids. Topical calcineurin inhibitors may be used, but should be reserved for sensitive areas only, such as the face, neck, intertriginous and genital areas. Consideration should be given to discontinuing treatment in patients who show no evidence of therapeutic benefit after 8 weeks of treatment. **Administration:** Take orally, with or without food, at any time of the day. **Contraindications:** Pregnancy. Hypersensitivity to the active substance or to any of the excipients. **Special warnings and precautions:** • Not recommended for use in creatinine clearance < 30mL/min and severe hepatic impairment. • Not recommended to use live, attenuated vaccines during or immediately prior to Olumiant therapy. • Do not give Olumiant to patients with active tuberculosis and breastfeeding patients. • Do not initiate and temporarily interrupt Olumiant treatment in patients with an ANC < 1 x 10^9 cells/L, ALC < 0.5 x 109 cells/L or haemoglobin < 8 g/dL. • Use with caution in patients with risk factors for DVT/PE and Olumiant treatment should be discontinued, and patients should be evaluated promptly when patients present with DVT/PE clinical features. • Temporarily interrupt Olumiant treatment and resume only when infection resolves, herpes zoster episode resolves, or diagnosis of drug-induced liver injury is excluded. • Treat patients with latent tuberculosis with standard anti-mycobacterial therapy before administering Olumiant. • If any serious allergic or anaphylactic reaction occurs, baricitinib should be discontinued immediately. **Adverse reactions:** Very common (≥1/10): Hypercholesterolaemia and upper respiratory tract infection. Common (≥1/100 to <1/10): headache, nausea, abdominal pain, rash, acne herpes zoster, herpes simplex, gastroenteritis, urinary tract infections, pneumonia, thrombocytosis >600 x 109 cells/L, ALT increased ≥ 3 x ULN **Drug interactions:** Probenecid increases baricitinib exposure. Leflunomide, teriflunomide, ibuprofen and diclofenac may increase baricitinib exposure. No clinically significant interactions with ciclosporin, methotrexate, ketoconazole, fluconazole, omeprazole, digoxin, simvastatin, ethinyl oestradiol, levonorgestrel. Presentation: Blister strip cold form aluminium foil sealed with aluminium foil lidding, in carton of 7 and 28 film-coated tablets. **Date of revision:** 26 July 2021. **Reference:** Olumiant 2mg_4mg PI_EUSPC_19 Oct 2020_04 May 2021.

Malaysia: Adverse events should be reported to zpmypv@zuelligpharma.com

Before prescribing, please refer to the full prescribing information, which is available upon request.

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3 December

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Dr. Arnil Sirimanne received his MB BCh BAO from the National University of Ireland, Dublin and was conferred the degree in Master of Clinical Oncology (MCO) from University Malaya.

Since 2008, he has worked in various Radiotherapy & Oncology Departments at Hospital Kuala Lumpur (HKL), Pusat Perubatan Universiti Malaya (PPUM), Hospital Universiti Kebangsaan Malaysia (HUKM), Hospital Umum Sarawak and Institut Kanser Negara (IKN).

He spent about two and a half years at Hospital Umum Sarawak as a Clinical Oncologist until February 2020. Subsequently, he proceed to practice at the Institut Kanser Negara (IKN), Putrajaya.

Dr. Arnil has a special interest in brain and urological malignancies as well as radiosurgery. He was formerly a trainer for the Masters of Clinical Oncology. Apart from his clinical work, he is also actively involved as one of the key speakers for cancer topics and conferences.

Currently, he is a member of the Malaysian Oncological Society (MOS), South East Asia Radiation Oncology Group (SEOROG), Federation of Asian Organization for Radiation Oncology (FARO) and European Society for Medical Oncology (ESMO).

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Learning from Adversity: Reforming Malaysian Healthcare

Dr Ashok Philip
Editor
ashokphilip17@gmail.com

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*

We have swiftly reached the end of an extremely unusual year. If anyone had told us at the beginning of 2020 that the end of 2021 would see significant pandemic restrictions still with us, he would have been laughed at – and yet here we are.

It hasn't all been bad, though. No doubt we had political shenanigans which fuelled the rise in COVID-19 cases, and many people who should have known better became anti-vaxxers. On the plus side, though, the administration of vaccines nationwide showed that logistically speaking our health system is really very good – especially when the efforts of the private and public sectors can be combined and coordinated. I must also say that the Health Ministry has been unusually agile in responding to changing data about vaccine efficacy, waning protection and the need for boosters. The Minister has also been a breath of fresh air – he is unusually engaged and responsive to public views and feedback.

However, the underlying problems with our healthcare system remain – indeed, the pandemic has highlighted and probably induced major weaknesses. We should therefore be thinking ahead about ways to deal with these problems in a comprehensive and lasting fashion.

During the height of the pandemic, there was a danger of running out of wards and beds to manage cases. These logistic problems were handled fairly well. Large facilities were converted to quarantine centres for low risk or mild cases. Wards were refitted to function as high-dependency and intensive care units. Ventilators and other necessaries were purchased. Private hospitals stepped in to help manage COVID-19 cases, even though many such patients were not able to use private insurance to pay for their treatment.

As vaccination rates rose, case numbers (and especially serious cases and deaths) dropped, and we were able to reduce the proportion of resources devoted to COVID-19 management. However, one aspect of the public healthcare system which showed glaring weaknesses was manpower.

For more than a decade, the medical fraternity has been warning various Ministers of Health about the overproduction of doctors without a corresponding increase in hospitals, beds and posts. Our jeremiads fell on deaf ears. Very little was done to restrict the production of doctors. The moratorium on new private medical colleges did little more than prevent further increases in production of doctors.

> "The Health Ministry has been unusually agile in responding to changing data about vaccine efficacy, waning protection and the need for boosters."

Finally, faced with an unmanageable number of graduates seeking housemanship posts, the Ministry started employing them on a contract basis. While understandable, this does not seem to me to be (to put it mildly) an optimal solution. In practice, very few contract officers have been offered permanent posts. As things stand, without getting such a post, there is no way to specialise via the Masters pathway. The parallel pathways are probably too expensive, and may also require special posting or training. Thus, if nothing is done, within 5-8 years, the Ministry of Health will begin to suffer from a serious shortage of specialists.

Some junior doctors have formed a movement to demand permanent posts, threatening to go on strikes or walkouts if their demands are not met. Their threats and actions have drawn nationwide attention – generally sympathetic. Some civil servants responded in the time-honoured tradition of the Malaysian Civil Service – with heavy-handed threats of disciplinary action, even deregistration. As MMA Past President Dr Milton Lum has pointed out, a pure trade or employment dispute does not fall under MMC's purview, and they are the only people who can deregister a doctor. However, cooler heads seem to have prevailed, and some discussion seems to be going on. I would only advice the Hartal movement to find allies. Not everyone needs to agree with you 100% to be considered an ally.

What can MMA do to help the young doctors? As I have mentioned before, it is necessary to have a comprehensive review of the Malaysian healthcare system. Patchwork or piecemeal reform will end up putting undue strain on the unreconstructed or unreformed areas of the system. Unfortunately, any proposed reform is likely to provide political ammunition to the opposition, so any government will be hesitant to move, despite seeing what needs to be done. They resemble deer in the headlights, standing frozen as danger bears down on them. The only way to progress is to bring both sides together to craft reform. If everyone takes ownership of the proposals, no one can use it as political ammunition.

Very soon, the MMA Health Policy Committee will hold a seminar to put forward some modest proposals to an audience of technocrats, bureaucrats, politicians and concerned citizens. Here's hoping that this will not turn out to be yet another flash in the pan. **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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President's Message

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

A big shout-out to the General Practitioners (GP) who have signed up for the National Covid-19 Immunisation Programme (or PICK), especially for the booster doses and the roll-out for adolescents. It had a sluggish start but eventually picked up and the GPs are contributing to the increasing number of vaccinated individuals in the country, who have completed their second dose as well as those who have received their boosters.

Judging from comments given by the public, many find it more convenient to access GPs for vaccination and there is an additional element of trust in the family doctor which is most crucial in addressing widespread vaccine hesitancy in our population.

The Ministry of Health needs to take a leaf from this and work on future Public Private Partnership projects for the benefit of the population. There is a lay out cost to such projects which have been a hindering factor, but it is proven to have a good cost benefit outcome if we are to formulate such public private partnership in sincerity.

The Malaysian Medical Association has always been charitable at heart. In this instance, on 3 November 2021, the Malaysian Medical Association (represented by Dr Koh Kar Chai, President of MMA and Mr Chris Lee, Chief Executive Officer of NeoScience Sdn Bhd) handed over medical devices worth RM500,000 to Ybhg Dato' Mohd Shafiq Abdullah, Chief Secretary to the Ministry of Health, via the COVID-19 Quarantine and Treatment Centre (PKRC Bersepadu MAEPS 2.0). The items comprised three units of Philips Respironic V60 Ventilator, 10 sets Bullard PAPR and 25 units Philips Oxygen Concentrator.

Another thing that we have learnt from this pandemic is that working in silos will be detrimental for the future of healthcare in this country. During a recent meeting on 11 November 2021 with Lt Gen Dato' (Dr) Zulkefli Bin Mat Jusoh, the Director General of Health Services Division, Malaysian Armed Forces, he alluded to the fact that it was a combined effort of the various ministries that we were able to manage the COVID-19 situation in the Klang Valley. It would have been extremely challenging for the Ministry of Health to have gone it alone given the intensity of the pandemic.

At a recent Health Technology Council meeting held on 15 November 2021 which was chaired by Ybhg Tan Sri Dato' Seri Dr Noor Hisham Bin Abdullah, Director General of Health, we broached the subject of the high cost of drugs for those with rare as well as terminal diseases. The cost of managing terminal diseases may be exorbitant with the expenses for the treatment for rare diseases paling in comparison. But upon taking in the fact that treatment for the rare diseases are likely to be life long, it is indeed sobering to know that the expenses here are indeed towering.

The DG of Health suggested that there should be a pooling of the purchasing power of both the public and private sectors which will then enable us to have a bargaining chip to negotiate for lower pricing. We will now need to look at how to tackle this issue by the horns and to do it soon, as the number of patients suffering from the related financial burden needed to maintain a decent quality of life (QOL) is high and increasing all the time.

At the Selangor International Health Conference which had its maiden appearance during the 7th Selangor International Expo 2021 at Kuala Lumpur Convention

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Centre, the President of MMA was invited to give a keynote address entitled, **'Effective Primary Care for our Ageing Population.'**

Dr Koh giving a speech

Following is an excerpt from the keynote address.

"Are we doing enough? We need to start with the young to ensure that they will grow to be a future population of seniors who are healthy. Engage them now in a healthy lifestyle which will bode them well when they age.

Inculcate the healthy aging concept. Look at reducing age associated morbidity and disability and the effects of multi-morbidity. Work with the elderly and involve them even before they start showing symptoms of aging. Ensure a good doctor patient relationship to build up trust.

It is essential to provide funding to the private primary care sector for health promotional services. Elderly care is specific and the primary care providers need to be trained and equipped to manage this group with high incidence of comorbidities and in many cases unable to afford reasonable healthcare."

The address ended with an invitation to the government of Selangor, being the developed and industrialised state that it is, to spearhead the way for strengthening primary healthcare services for the aging citizens of Selangor.

As for the contract doctors' dilemma, we had hoped that there will be a viable solution at hand after all the efforts put in by MMA. A proposal for a contract extension of up to 10 years was given in order to allow our junior doctors to complete their specialisation so as to fill up the dearth in specialists. We were rather disappointed that an extension from 2-4 years only was given. Though it was also mentioned that grants would be given for the contract doctors to go into a master's programme, not much details have been forthcoming. We do hope for transparency in the management of the welfare of the contract doctors. On a whole, this group of doctors have indeed sacrificed themselves for the salvage of this nation at the peak of the pandemic.

At a Twitter Spaces session held on 26 November 2021 organised by SCHOMOS for the contract doctors, a question posed was, 'What will the future be for the contract doctors if they don't get a permanent position?' My reply was, 'What type of a future are you looking at?'

If it is the fear of not being able to specialise, this is exactly what MMA has been seeking a solution for. We had proposed an extended contract for this very reason and the Ministry of Health (MOH) has agreed in principle to this extension. MMA is continuing its engagement with the MOH and the government to come out with a framework on this.

But if it is job stability that is desired from the offer of a permanent position, I would say that everyone desires to have a stable career position and that MMA will endeavour to secure more permanent positions for our junior doctors as we will need to strengthen our current healthcare system to be more robust as we face an uncertain future with the current pandemic.

It is however very competitive in the job market where every other person desires to have a stable appointment and we can only hope that a significant number of permanent positions can be offered to our contract doctors by the end of this year.

That said, the junior doctors should not lose hope but should come together under the umbrella of MMA so that we can act with a single strong voice. **BMMA**

Dr Koh presenting a souvenir to Lt Gen Dato' (Dr) Zulkefli Bin Mat Jusoh with the MMA

After the meeting with Director General of Health Services Division, Malaysian Armed Forces

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Dr Thirunavukarasu Rajoo
Hon. General Secretary
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From the Desk of the
Hon. General Secretary

Antimicrobial Resistance:
Importance of Antibiotic Stewardship in the Private Sector

Antibiotics are the cornerstone of basic and modern medicine. Since the first successful use of penicillin in the 1940s, the chances of survival among patients with fatal infections increased significantly. Over the years, the range of antibiotic uses has expanded, from the treatment of infectious diseases to chemotherapy and as a prophylaxis in invasive surgeries, like caesarean sections, colorectal surgery etc.

The indispensable role of antibiotics and other antimicrobials in improving patient outcomes underlines the need to ensure proper mitigation of antimicrobial resistance (AMR). As described by the World Health Organization (WHO), AMR is *a serious threat to global health and development*.

The AMR rate has doubled in the last 20 years, resulting in 700,000 AMR-related deaths per year on a global scale. At this rate, the death toll from drug-resistant infections is projected to rise further to 10 million per year in 2050 – which means one AMR-related death every three seconds. The economic burden caused by these antimicrobial resistant infections is also a cause for concern especially in low and middle-income countries like Malaysia. With the incidence of antibiotic-resistant infections increasing worldwide, experts believe it may cause the next pandemic, for which the medical line needs to be prepared for.

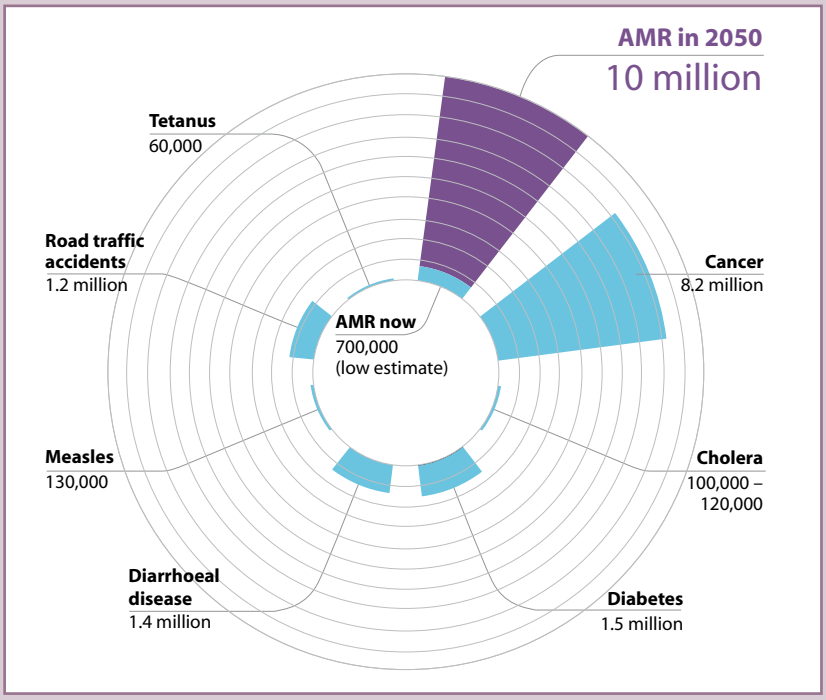

Figure 1: Comparative deaths (Source: https://amr-review.org/infographics.html)

Although resistance towards antimicrobials is a naturally occurring phenomenon that is bound to happen, healthcare practitioners and the public can play a part in delaying the process through the proper use of antimicrobials. With modern medical care being heavily reliant on antibiotics as a means of prophylaxis and treatment, a joint effort needs to be made by public and private healthcare practitioners to prioritise antibiotic stewardship when prescribing.

Antibiotic stewardship refers to the practice of prescribing the most appropriate antibiotics, only when indicated, and with the right dosage and appropriate duration in order to optimise clinical conditions, avoid adverse drug events and delay antibiotic resistance. According to data published in 2019 by the Medical Practice Division, Ministry of Health Malaysia, the ratio of private health clinics to public health clinics in Malaysia is almost 3:1.

With private clinics being more widely available and the preferred choice for some in terms of convenience, private practitioners hold the obligation to view AMR seriously and be more judicious when making the decision to prescribe antibiotics. National Medical Care Statistics (NMCS) 2014 showed that 1 in 5 clinic encounters in Malaysia resulted in an antibiotic prescription with the rate of antibiotic prescriptions being almost 5 times higher in private clinics than public clinics (30.8% vs 6.8%). It was found that private clinics contributed to an astounding 87% of overall antibiotic prescription in primary care. The URTI antibiotic prescription rate was the highest at 46.2% vs the Netherlands' 17% and Hong Kong's 5%.

> "The economic burden caused by these antimicrobial resistant infections is also a cause for concern."

In 2017, MOH Malaysia along with the Ministry of Agriculture and Agro-Based Industry Malaysia published the *Malaysian Action Plan on Antimicrobial Resistance* (MyAP-AMR) to tackle the rise of AMR in Malaysia affecting both humans and animals7, which is also represented by MMA. However, due to insufficient data, the implementation and subsequent effectiveness of this programme remains a grey area. However, there are numerous studies on the benefits of antibiotic stewardship programmes implemented in other countries.

A systematic review that included 16 studies on the influence of Antibiotic Stewardship Programmes (ASP) saw a reduction in overall antibiotic consumption accompanied by cost savings in antibiotic therapy. ASPs were also associated with reduced incidence of infections and colonisation with antibiotic-resistant bacteria and *Clostridium difficile* infections in hospital inpatients. Apart from combatting antibiotic resistance, antibiotic stewardship can also protect patients from harms caused by unnecessary antibiotic use.

A study done in the United States found that 1 in 5 patients experienced at least one antibiotic-associated adverse drug event (ADE) when given antibiotics over a day. Out of this, 20% of the ADEs were attributable to unnecessary antibiotic prescriptions (conditions for which antibiotics were not indicated). Among the ADEs reported include, allergic reactions, end-organ toxic effects, subsequent infection with antibiotic-resistant organisms and *Clostridium Difficile* infections.

From an economic standpoint, antibiotic stewardship can help alleviate the financial burden caused by increased antibiotic resistance. It is estimated that, at this rate, antimicrobial resistance will end up costing a cumulative of USD100 trillion by the year 2050. This is because drug-resistant infections necessitate prolonged hospital stays and intensive care for patients. An antibiotic stewardship programme implemented in the United States saved a total of USD17 million over eight years. After the programme got discontinued however, the cost of antibiotics had skyrocketed to one million after just a year. Aside from practicing antibiotic stewardship, private practitioners can also engage in interventions to educate their patients on the proper use of antibiotics. A number

of local studies have demonstrated generally poor antibiotic-related knowledge among the Malaysian public, with the most common misconception being that antibiotics are able to treat viral infections too.

Attitudes and behaviours towards antibiotic use is also questionable with a considerable proportion of people reporting non-adherence to prescribed doses and many being unaware of the term *drug resistance*. This is especially true among those in the low socio-economic group. Patients need to be made aware of how antibiotics work and the importance of completing their course of antibiotics within the stipulated duration.

The rise in antimicrobial resistance coupled with the slow-moving development of new antimicrobial classes is a slow-growing but very real threat to public health. Having a drug-resistant infection means that you can spread this infection to those around you, making this a shared dilemma. Although multiple factors have led to the recent acceleration of this phenomenon, over-prescription of antibiotics by healthcare practitioners remain the leading contributor. As such, relevant stakeholders must commit towards implementing preventative measures like strict antibiotic stewardship and educational interventions for the public to ensure the future generations are able to reap the virtues of antibiotics and other antimicrobials that have proven crucial in treating infectious diseases.

MEDEFEND Updates

Marsh MEDEFEND team has been keeping busy during the lockdown this year. They continued with their Annual Risk Management Series D and introduced two new virtual programmes to their clients:

- Breakfast Talk
- Talk to Us

Breakfast Talk
[1 CPD point]

MEDEFEND's Legal Claims Manager, Ms Christine Ellis spoke on issues that are important for doctors to take note especially when it comes to managing risks in their medical practice; also the importance of knowing when to call your Marsh Brokers representative when faced with a claim or a potential claim. The topics that were covered this year:

1. Provision of Advice & Consent Taking
2. Effective Engagement & Complaint Management
3. MEDEFEND: How, What & When
4. MEDEFEND: To Tell or Not To Tell

Talk to Us

This virtual booth via Zoom was done monthly where MEDEFEND Doctors get to talk freely with Marsh Brokers for one hour from 4 – 5pm. Some of the queries raised during this open session:

1. Medico-legal issues as addressed during the Breakfast Talk
2. Defence cost in addition to the Limit of Indemnity
3. Free Run-Off cover when a doctor permanently ceases practicing
4. Full Retroactive cover

Risk Management Series D Webinar: Consent after Montgomery
[1 CPD point]

Prof James Badenoch was the guest speaker for this year's MEDEFEND Webinar Series D. He was the Queen's Counsel who presented the Montgomery appeal to the UK Supreme Court, and how he overturned the 60-year old Bolam Standard.

Marsh will continue offering doctors with more Risk Management events for 2022 including the Breakfast Talk and Talk to Us. For any enquiries 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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"Study the past if you want to define the future."
– Confucius

REHABILITATION APPROACH IN DISABILITY MANAGEMENT

Disability refers to a condition or function judged to be significantly impaired in comparison to the usual standard of an individual group. Persons with Disabilities (PWDs) are those who suffer from long term physical, mental, intellectual or sensory impairments, preventing them from effective participation in society when they are faced with challenges. It is estimated that there are about 4.86 million PWDs living in Malaysia albeit in 2019, only 500,000 were registered under the Department of Social Welfare Malaysia (JKM).

Rehabilitation is defined by WHO as "**a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment**". Rehabilitation care includes a comprehensive range of inpatient and outpatient services and complex continuing care for those who experience debilitating illness or injury.

The ultimate aim of rehabilitation medicine is to provide PWDs with opportunities for full and effective participation and inclusion in society, including studying, working and access to all services on the same basis as others without disability.

Rehabilitation medicine team-based approach starts from acute phase, to rehabilitation phase to community phase. Rehabilitation team members are usually formed based on the illness or condition of the patient and team composition may change at different phases of rehabilitation. Frequent multidirectional team communications are done to ensure issues are addressed and goals are met accordingly.

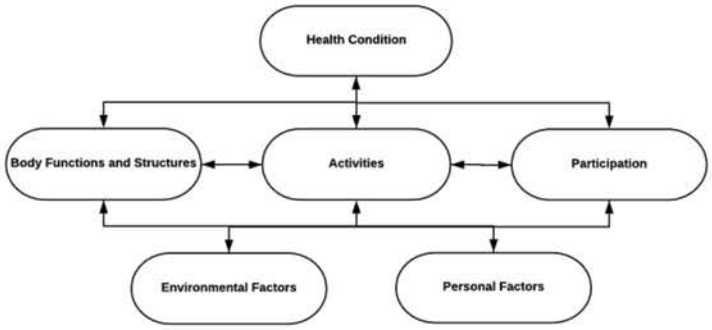


Figure 1: International Classification of Functioning, Disability and Health framework (ICF), WHO 2001.

Utilizing the bio-psycho-social model such the International Classification of Functioning, Disability and Health framework (Figure 1), the 'patient centric' rehabilitation care aim to help PWDs to learn how to care for a body that now works differently. By focusing on their abilities, rehabilitation care helps empower them to maintain a high level of health and reintegrate oneself into the community.

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."

About Daehan Rehabilitation Hospital Putrajaya

Daehan Rehabilitation Hospital Putrajaya is focused on the delivery of rehabilitative clinical care and comfort, as well as assisted living with the primary purpose of improving physical, mental and social well-being through a broad range of premium support services. Daehan's expertise lies in the creation of customized medical hospitality environment that combines both medical and after-care service excellence to ensure an exceptional experience for all patients. Forming the cornerstone of Daehan's rehabilitative care is a refined and systematic approach built on Korean rehabilitation practices complemented by advanced rehab technology and state-of-the-art facilities.

From the Desk of the

Hon. General Treasurer

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

Update on Resolutions Related to Finance Passed in AGM

I wrote about the resolutions in the last two articles. There will be guidelines drawn on the bereavement payment that was passed as resolution. It is important for members to inform MMA regarding their nominee.

We request the kind consideration and cooperation from members in providing us with the necessary details – the latest update for giving details is being incorporated into the MMA mobile app. This is one of the important benefits for the members and MMA is obliged to take necessary action in the implementation of resolution.

Meanwhile, we hope the members or state MMA informs MMA on the details of deceased members. Option of filling up form manually was given as well through email blast.

Accounts and Taxation for 2020

The state representatives will be having dialogue session with tax agent in December 2021 and we hope state MMA branches will actively participate in clarifying issues on tax treatment for the society and get explanation on branch-related tax issues. 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, the process to engage the vendor and training of the users will be started before end of year. Majority of the states has agreed and chosen the appropriate package suitable for them. The training for the state representative will start in December according to the schedule.

Property Issues:

Regarding purchase of Melaka property, MMA Foundation has obtained approval from land office but approval from the Minister of Domestic Trade and Consumer Affairs Malaysia is still pending. MMA Foundation has been following up on this as it is long overdue. MMA is monitoring closely the progress.

For the property purchased by MMA HQ at Plaza Sentral (the first two units), as all the documentations completed, we have made the final payment. The property is now ours officially. We are also looking for new tenant for these two units starting from January 2022.

We have signed the sales and purchase agreement for the second property at Plaza Sentral (3rd unit),. The lawyer is proceeding with further documentations. 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; next is to submit for assessment of stamp duty.

Wilayah has completed the purchase of the building and the title grant has been passed to MMA HQ for safekeeping according to the constitution.

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

Kenanga Fund Investment:

As written in previously, MMA has invested RM 250,000 into Kenanga's MoneyEXTRA Fund. As this is still a short period post investment, the profit at the moment still stands at slightly more than 1%. I shall update periodically on the performance of the fund. MMA also in the midst of forming an investment committee to look into other investment opportunities.

Group Personal Accident Insurance (GPA)

MMA has purchased GPA for members, 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, policy will cover the medical expenses up to RM2,500 per annum..

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

> "Cloud accounting will be implemented in 2022."

MMA Congress 2022

MMA successfully organised MMAC 2021 in May 2021. We will be organizing MMAC 2022 from 27-29 May 2022 and it will be a hybrid event as per allowed SOPs and if it is feasible. This will be another new experience in organising a hybrid event. 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**

The World Medical Association

The World Medical Association (WMA), founded in 1947, was part of the wave of international institution building that followed the horrors of the Second World War. It is basically an association of associations. The members are National Medical Associations (NMAs). There are also Associate Members, who are individuals. Associate Members are active in debate and policy making, but do not have votes.

NMAs have to be open to all members of the profession and independent – they cannot be under government control. The Malaysian Medical Association has been a member of WMA for many years, though our level of activity and influence has fluctuated considerably. The high point of our involvement undoubtedly was when MMA Past President Datuk Dr N Arumugam, was elected WMA President-Elect in 2005.

Since then, there has been some turbulence, which saw the MMA leave the WMA for a short while, then rejoin. I venture to say that the MMA has been more involved and active in the Association since 2015, and we have been able to effect some changes in the way the WMA functions. These changes will allow us to be more active and influential in an association often dominated by the bigger associations.

The question that arises, of course, is "Why bother?"

The WMA is active in formulating policies and declarations relevant to the profession. It has a prominent presence internationally, and partners many organisations, including the WHO. It speaks out when physicians are in danger or under compulsion. All these actions are initiated and developed mostly by the Council of the WMA, which is influenced even more by the large nations than the General Assembly.

All the policies of WMA are freely available on their website.

If anyone wishes to know more about physician-assisted dying, abortion, telehealth and many other topics, the WMA website is a goldmine. However, the voice of smaller NMAs is not heard as well as it should be. The changes I mentioned earlier may help to change that, and thus make WMA more relevant to smaller countries.

I strongly recommend going to taking a look at the WMA website if you need some insight into ethical and other issues as they affect the profession. Happy browsing! **BMMA**

https://www.wma.net/policy/

Prepared by
Dr Ashok Philip
Editor
ashokphilip17@gmail.com

KPJ HEALTHCARE

KPJ RAWANG
SPECIALIST HOSPITAL

Sleep Screening Packages

SNORING & SLEEP SCREENING PACKAGE — RM750*

- Sleep Diagnostic Test

ITEMS INCLUDED:

- One (1) night stay in single standard room
- One (1) night of sleep apnea diagnostic test
- Sleep diagnostic report interpretation by clinician
- Initial Continuous positive airway pressure (CPAP) trial subject to the doctor's advice

ITEMS EXCLUDED:

- Medications and surgical treatment
- Covid-19 test (PCR)

*Terms & conditions apply

COMPREHENSIVE ENT SLEEP SCREENING PACKAGE — RM1688*

- Sleep Diagnostic Test
- Blood Test
- ENT Consultation
- Upper Airway Evaluation

*Patient are required to fasting at least for 8 hours before lab test

ITEMS INCLUDED:

- One (1) night stay in single standard room
- One (1) night of sleep apnea diagnostic test
- Executive Profile (GP59G)
- ENT evaluation
- Sleep diagnostic report interpretation by clinician
- Initial Continuous positive airway pressure (CPAP) trial subject to the doctor's advice
- The price include one (1) time follow up for sleep & blood report

ITEMS EXCLUDED:

- Medications and surgical treatment
- Covid-19 test (PCR)

KKLIU : 3084/2021

Otorhinolaryngology (ENT)

DR DIPAK BANARSI DASS
Otorhinolarygologist (ENT)
Level 1, Suite 6

DR NAZLI ZAINUDDIN
Otorhinolarygologist (ENT)
Level 1, Suite 2

DR TAN SHI NEE
Otorhinolarygologist (ENT), Head & Neck Surgeon
Level 1, Suite 2

olumiant® (baricitinib) tablets

Improving Atopic Dermatitis Treatment Options with Baricitinib

The advent of JAK-inhibitors for the treatment of moderate-to-severe atopic dermatitis

Baricitinib is a once-daily, oral, reversible, selective JAK1 and JAK2 inhibitor that has recently (September 2021) obtained approval from NPRA for treating moderate-to-severe AD in adult patients.[1] This new indication for Baricitinib is exciting as it adds to the dermatologists' armamentarium when managing moderate-to-severe AD.

In October this year, Professor Dr Thomas Werfel (Department of Dermatology and Allergy, Hannover Medical School, Germany) shared to a group of experts the rationale of using JAK-inhibitors in AD and the efficacy and safety data of three pivotal studies from the BREEZE-AD (**B**aricitinib in moderate to s**E**vere atopic **E**c**ZE**ma – **A**topic **D**ermatitis) clinical program.

AD is a complex immune-mediated disease that is primarily Th2 driven and involves different inflammatory pathways, such as the modulation of IL via the JAK pathway.[2] JAK-inhibitors block these pathways and the array of ILs produced, such as IL-4, IL-5, IL-13, IL-22 and IL-23, resulting in the reduction of AD symptoms.[1]

Prof Thomas' presentation focused on three pivotal global studies, i.e. BREEZE-AD1, -AD2[3] and -AD7.[4] The objectives of AD1 and AD2 were to determine the efficacy and safety of **Baricitinib monotherapy** in moderate-to-severe AD in patients with inadequate response to topical therapies whilst AD7 evaluated **Baricitinib in combination with TCS**. All three studies were compared to a placebo arm. The efficacy and safety data of the **recommended 4 mg Baricitinib** vs placebo arms are presented here.

Efficacy of Baricitinib 4 mg

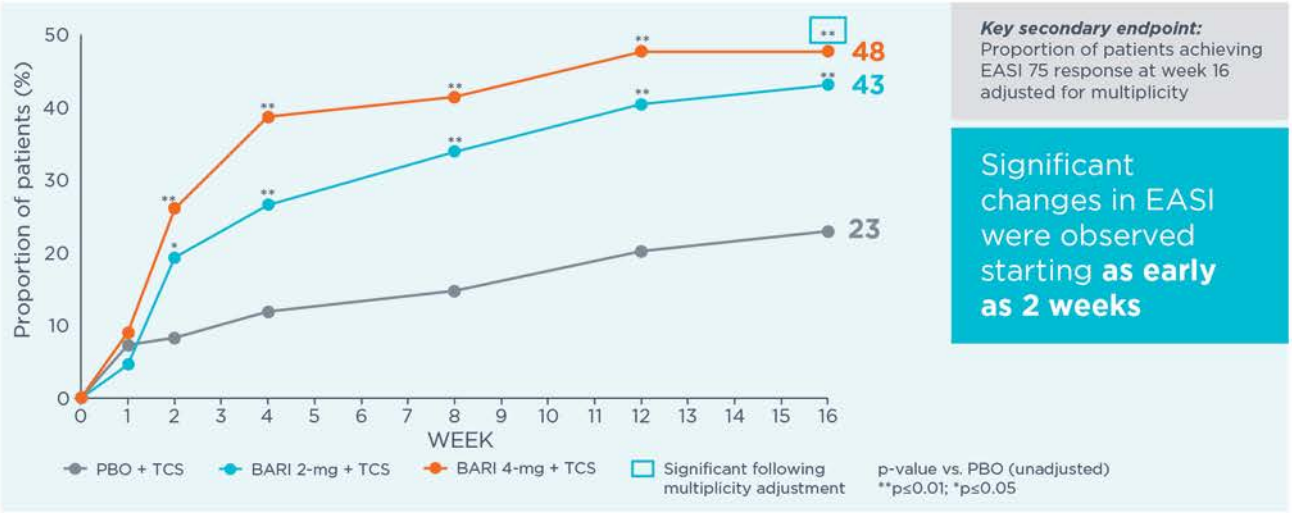
Baricitinib 4 mg monotherapy demonstrated a significant proportion of patients with moderate-to-severe AD achieving clearance of skin lesions (vIGA-AD 0,1) starting as early as two weeks. The proportion of patients achieving EASI 75 (i.e. a reduction of ≥75% from baseline scores) and improvement of itch scores (i.e. ≥4-point change from baseline score, which is considered clinically meaningful) were also significant and observed as early as one week.[3]

The study design of AD7,[4] evaluating Baricitinib in combination with the background and on-demand utilisation of moderate- and low-potency TCS, **reflects real-world clinical practice**. Significantly more patients achieved vIGA-AD 0,1 (≥2-point improvement) and itch NRS (≥4-point improvement) scores from baseline at week 16 (31% vs 15%, p≤0.001 and 44% vs 20%, p≤ 0.05, respectively). The improvements were observed as early as 4 and 2 weeks for each. Figure 1 shows the earliest observed improvements in the itch NRS whilst Figure 2 illustrates the EASI 75 outcomes.

LS Mean percent change in itch NRS from baseline by day, MMRM

Figure 1. Data are presented for the ITT population with MMRM estimates for data after TCS rescue; Percentage change from baseline values were calculated as the LS mean change from baseline divided by the mean at baseline. BARI=baricitinib; ITT=intent to treat; LS=least squares; MMRM=mixed model repeated measures; NRS=numeric rating scale; PBO=placebo; TCS=topical corticosteroid. *Adapted from Reich K ey al. JAMA Dermatol 2020[4] and Buhl T et al. 29th EADV 2020.[5]*

Proportion of patients achieving EASI 75 response, NRI



Key secondary endpoint: Proportion of patients achieving EASI 75 response at week 16 adjusted for multiplicity

Significant changes in EASI were observed starting **as early as 2 weeks**

Figure 2. Data are presented for the ITT population. BARI=baricitinib; EASI 75=Eczema Area Severity Index ≥75% reduction; ITT=intent to treat; NRI=non-responder imputation; PBO=placebo; TCS=topical corticosteroid. *Adapted from Reich K, et al. JAMA Dermatol. 2020*[4]

Baricitinib **increased the proportion of TCS free days** over the 16 weeks versus placebo (29% vs 13%, p≤ 0.001).[4] All three studies significantly **reduced skin inflammation, skin pain, and sleep disturbance due to itching**.[3,4]

Safety of Baricitinib 4 mg[1,6]

A total of 1060 patients had ≥ 1-year exposure to Baricitinib during the BREEZE-AD clinical program. **Most AEs were mild or moderate in severity**, and **the discontinuation rate due to AEs was low** (4.6% at 105 weeks). The occurrence of infections (serious and opportunistic), including herpes simplex and oral herpes were low, and similar between treatment groups. There were also no serious herpes zoster events and none that led to permanent study discontinuation. Treatment-emergent AEs of interest such as major adverse cardiac events, venous thromboembolic events and non-melanoma skin cancer were very low.

Conclusion

Baricitinib is an effective and tolerable JAK-inhibitor and its promising outcomes have begun a new era in AD management by expanding the treatment options available to individuals with moderate-to-severe AD.

Abbreviations: AD, atopic dermatitis; AE; adverse events; DLQI, Dermatology Life Quality Index; EASI, Eczema Area Severity Index; IL, interleukin; JAK, Janus kinase; NPRA, National Pharmaceutical Regulatory Agency; NRS, numeric rating scale; TCS, topical corticosteroids; Th, T helper cells; vIGA-AD, validated Investigator's Global Assessment for atopic dermatitis.

References: 1. Olumiant 4 mg Film-Coated Tablets. Summary of Product Characteristics. Available at https://www.medicines.org.uk/emc/product/7486/smpc. Accessed Nov 2021. **2.** He H, Guttman-Yassky E. *Am J Clin Dermatol* 2019;20(2):181-192. **3.** Simpson EL, *et al. Br J Dermatol* 2020;182 (2):242-255. **4.** Reich K, *et al. JAMA Dermatol* 2020;156(12):1333-1343 (with Suppl data). **5.** Buhl T *et al.* 29th European Academy of Dermatology and Venereology (EADV) Congress; October 28–November 1, 2020. **6.** Bieber. T, *et al. J Eur Acad Dermatol Venerol* 2021;35(2):476-485.

Abbreviated Prescribing Information
Contents: 2mg or 4mg Baricitinib per film-coated tablet. **Indications: Rheumatoid arthritis:** treatment of moderate to severe active rheumatoid arthritis in adult patients who have responded inadequately to, or who are intolerant to one or more disease-modifying anti-rheumatic drugs. Olumiant may be used as monotherapy or in combination with methotrexate. **Atopic Dermatitis:** treatment of moderate to severe atopic dermatitis in adult patients who are candidates for systemic therapy. **Dosage:** 4mg once daily. A dose of 2mg once daily may be used in patients aged ≥ 75 years, patients with a history of chronic or recurrent infections, patients who have achieved sustained control of disease activity with 4mg once daily and are eligible for dose tapering, patients with creatinine clearance between 30 and 60mL/min, and patients taking Organic Anion Transport 3 (OAT3) inhibitors. For atopic dermatitis, Olumiant can be used with or without topical corticosteroids. The efficacy of Olumiant can be enhanced when given with topical corticosteroids. Topical calcineurin inhibitors may be used, but should be reserved for sensitive areas only, such as the face, neck, intertriginous and genital areas. Consideration should be given to discontinuing treatment in patients who show no evidence of therapeutic benefit after 8 weeks of treatment. **Administration:** Take orally, with or without food, at any time of the day. **Contraindications:** Pregnancy. Hypersensitivity to the active substance or to any of the excipients. **Special warnings and precautions:** • Not recommended for use in creatinine clearance < 30mL/min and severe hepatic impairment. • Not recommended to use live, attenuated vaccines during or immediately prior to Olumiant therapy. • Do not give Olumiant to patients with active tuberculosis and breastfeeding patients. • Do not initiate and temporarily interrupt Olumiant treatment in patients with an ANC < 1 x 10^9 cells/L, ALC < 0.5 x 10^9 cells/L or haemoglobin < 8 g/dL. • Use with caution in patients with risk factors for DVT/PE and Olumiant treatment should be discontinued, and patients should be evaluated promptly when patients present with DVT/PE clinical features. • Temporarily interrupt Olumiant treatment and resume only when infection resolves, herpes zoster episode resolves, or diagnosis of drug-induced liver injury is excluded. • Treat patients with latent tuberculosis with standard anti-mycobacterial therapy before administering Olumiant. • If any serious allergic or anaphylactic reaction occurs, baricitinib should be discontinued immediately. **Adverse reactions:** Very common (≥ 1/10): Hypercholesterolaemia and upper respiratory tract infection. Common (≥1/100 to <1/10): headache, nausea, abdominal pain, rash, acne herpes zoster, herpes simplex, gastroenteritis, urinary tract infections, pneumonia, thrombocytosis >600 x 10^9 cells/L, ALT increased ≥ 3 x ULN **Drug interactions:** Probenecid increases baricitinib exposure. Leflunomide, teriflunomide, ibuprofen and diclofenac may increase baricitinib exposure. No clinically significant interactions with ciclosporin, methotrexate, ketoconazole, fluconazole, omeprazole, digoxin, simvastatin, ethinyl oestradiol, levonorgestrel. **Presentation:** Blister strip cold form aluminium foil sealed with aluminium foil lidding, in carton of 7 and 28 film-coated tablets. **Date of revision:** 26 July 2021. **Reference:** Olumiant 2mg_4mg PI_EUSPC_19 Oct 2020_04 May 2021.

Malaysia: Adverse events should be reported to zpmypv@zuelligpharma.com **Before prescribing, please refer to the full prescribing information, which is available upon request.**

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Dr Felicia Chang:

Beating Poliomyelitis with Resilience and Determination

International Day of Persons with Disabilities (IDPD) is celebrated every year on 3 December and this annual recognition was proclaimed in 1992 by the United Nations General Assembly. The theme for IDPD 2021 is "Leadership and participation of persons with disabilities toward an inclusive, accessible and sustainable post-COVID-19 world."

Berita MMA joins this annual observance this year by highlighting and recognising the dedication and contribution of Dr Felicia Chang to the field of medicine. She is an accomplished palliative care physician who consults in Beacon Hospital, Petaling Jaya and provides home visits around Klang Valley area for patients who are unable to travel to the hospital. She is well liked by her patients as she is passionate, caring and devoted to helping terminally ill patients have dignified, peaceful and comfortable final days.

Diagnosed with polio when she was one, Dr Felicia has suffered severe nerve injury which resulted in permanent paralysis of her right lower limb. She walks with a limp as her right leg is shorter, smaller and weaker than her left leg. Due to this, in her growing years, she was overcome with low self-esteem and became very timid. However, at a turning point in life during her late adolescence, she decided to step out of the box, dream big and pursue her ambition of becoming a doctor. Her decision was met with lots of criticisms and doubts on whether she could be a doctor due to her disability. She decided to challenge that notion with "Why not?" and soon after, she packed her bags and was off to India.

Medicine was a natural attraction and progression for her. Due to polio, she spent many years as a patient herself and was awed by the doctors who treated her and helped her parents. Her dad used to put her on his shoulders, get on a bus and seek treatments from various practitioners of alternative medicine (including bomohs, sinsehs, Ayurvedic, acupuncture and moxibustion).

> "Palliative medicine was a perfect vocation and attraction"

She aspired to be like the doctors and practitioners, as that tender age, being a doctor was equivalent to helping fellow human beings. Palliative medicine was a perfect vocation and attraction for Dr Felicia as it encompasses holistic, comprehensive, and individualised approach to patient care.

She completed her MBBS in Kasturba Medical College, Mangalore, India and remembers the struggles that she went through. As there were frequent power disruptions that left lifts lifeless, she had to struggle to climb five flights of stairs to get to her classes. Her grit ensured that she persevered through all the challenges that came her way. On the day of her medical graduation, she received a standing audition from the audience for being the epitome of perseverance and determination and it remains as one of the proudest moments in her life.

She started her housemanship at Hospital Teluk Intan and completed her compulsory services at Hospital Manjung. After serving at Hospital Selayang as a palliative care doctor for a year in 2004, she transitioned to serve at Hospis Malaysia. Dr Felicia devoted seven years of her career here, serving patients, teaching, and training volunteers. In 2012, she moved on to Assunta Palliative Care Centre and assumed the role of Medical Director and was instrumental in starting a home care service.

She made a big leap in 2015 and became an independent palliative care practitioner. She is now a

palliative care physician at Beacon Hospital, Petaling Jaya. Her services here include clinic consultations, wards consult, Grief and Bereavement Clinic and homecare services.

Dr Felicia always gets asked on her choice of choosing palliative medicine as her career, which she is passionate about and believes that palliative care is a basic human right. Witnessing a friend's mom, diagnosed with breast cancer with brain metastasis, screaming in pain at her hometown in Manjung, Perak and being helpless about it that time motivated her to pursue a career in palliative medicine.

She vowed that she would do her very best to ensure that terminally ill patients will have a more dignified and peaceful death. This determination was further cemented after she listened to a lecture by Dr Rosaline Shaw, a palliative care physician from Australia, who remains a great inspiration and guide. She subsequently went on to set up homecare services around Manjung, Beruas and Pantai Remis. She has always believed that palliative medicine chose her, and she has been called the "Healing Angel "by fellow colleagues.

She believes in the holistic approach in the management of her patient and attends to their physical, emotional, and spiritual wellbeing. Inclusion of caregivers and family members of patients are part of her comprehensive managements as it is vital that they understand and can empathise with the patient to improve the quality of life. Her job also encompasses dealing with the final journeys of terminally ill patients by making them as comfortable as possible during their last moments of life.

On the other hand, she is also a jovial and fun-loving doctor who has taken her paediatric patients on grocery shopping trips and to Genting Highlands! While at Hospis Malaysia, she was also involved in delivering lectures and doing bedside teaching for both undergraduate and postgraduate medical students.

Fiercely independent, she drives and tends to most daily activities on her own. She has great support from her mother and three siblings. Dr Felicia has gone on to do many things that most of us would not dare to do. She has received her diving certificate from Pulau Perhentian. A trip to Australia has seen her jumping off the plane (she will do this again, though).

Undersea adventures and mid-air shenanigans

She is known to be a successful fundraiser and actively fundraises for children with cancer via The Malaysian Association of Paediatric Palliative Care (MAPPAC), Kiwanis Bukit Bandaraya and for charities related to the Orang Asli.

For her contribution and dedication in palliative care, Dr Felicia was the only female recipient to be awarded the Ten Outstanding Young Malaysian Award (Humanitarian & Voluntary Service category) by Junior Chamber International Malaysia in 2015. She also received the "Most Inspiring Women 2015" award from readers of The Malaysian Women's Weekly (as voted via SMS). In the same year, she was also the "Women's Weekly Winner of Category Health, Sport & Wellness Award 2015 and The Star Paper "Person of the Year 2015".

Dr Felicia after receiving the Ten Outstanding Young Malaysian Award

Dr Felicia wants to see equal opportunities for the disabled community and wants to inspire them to get out of the box that society has put them in. She wants them to grow wings and achieve their dreams. Being in the space outside of her box, she has never and will never allow her disability to stop her from achieving her goals. **BMMA**

"Each time a woman stands up for herself, without knowing it possibly, without claiming it, she stands up for all women."

– Maya Angelou

Interviewed and written by:
Dr Punithavathy Shanmuganathan
Editorial Board Committee Member
punithavathy.s@taylors.edu.my

I Am Differently Able (Part 1):

Disability is a Matter of Perception

Good health is crucial to be able to work, learn and be engaged within a community. But this does not mean having a disability is the biggest pitfall on someone's quality of life and future because it is part of being human. Disability can be a temporary or permanent experience at some point in life for almost everyone.

Disability is often linked to the interactions between individuals with a health condition such as cerebral palsy, stroke, limb amputation, hearing loss and many others. However, the term is often misunderstood with impairments and handicaps, which are distinctively different. The World Health Organization (WHO 1976) draws on a three-fold distinction between disability, impairment and handicap:

- **Disability:** Restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within or within the range considered normal for a human being
- **Impairment:** Loss or abnormality o psychological, physiological or anatomical structure or function
- **Handicap:** Disadvantage for a given individual, resulting from an impairment or a disability, which prevents the fulfilment of a role that is considered normal (depending on age, sex, social and cultural factors) for that individual

WHO reported over 1 billion people are estimated to live with some form of disability which corresponds to about 15% of the world population, with up to 190 million(3.8%) people above 15 years old and having significant difficulties in functioning, often requiring healthcare assistance.

However, the data on disabled people in Malaysia is understated, so only 1.6 % of the Malaysian population or 537,000 people with disabilities were registered in 2019 as per the United Nations (UN) human rights expert. These individuals denial or perception about their disability contributed to this number rather than the government's insufficient access or registration efforts.

Classifications of Disability

Disability is linked with physical impairment, sensory impairment, cognitive impairment, intellectual impairment, mental illness, and various chronic diseases. The disablement process proceeds from the acquisition of pathology (disease, injuries) to impairments (anatomical, physiological or mental abnormalities), which generate functional limitations in fundamental physical and mental actions; ultimately leading to disability (cessation or restriction in carrying out the activity of daily living and other social roles.

To simplify, disability is actualised as being a multidimensional experience for the person involved. The types of disability outlined in Figure 1 are practised in Malaysia. Perhaps the category mentioned in the Borang Pemohonan & Pendaftaran OKU-application forms is used to register the disabled person, which is ultimately helpful in providing their need, protecting their rights, and data registry.

According to ICF, nine broad domains of functioning can be affected. ICF classifies functioning and disability associated with health conditions used to create a more meaningful picture of the experience of the health of individuals and populations as outlined in Figure 2.

Children Grow with their Disabilities

"Children with disabilities have a right to be seen, valued and included" is how UNICEF spotlighted the disabled child. It is not easy for a child to thrive with their disability, especially those born with a disability. Policies and services are needed to support their families and communities to nurture, care and protect them. There are many types of disabilties

Types of Disability

The types of disabilities vary and depend on how it is categorised. This classification was adapted from Borang Pemohonan Pendaftaran Orang Kurang Upaya (OKU) from Jabatan Kebajikan Masyarakat (JKM) which was revised in 2019. This classification loosely categorised disability into hearing loss, vision loss, mental, speech and language problems, learning disabilities and physical. The physician is required to assess an individual's disabilities and categorise them accordingly because this is essential to apply for the OKU card and also allow the registry of cases.

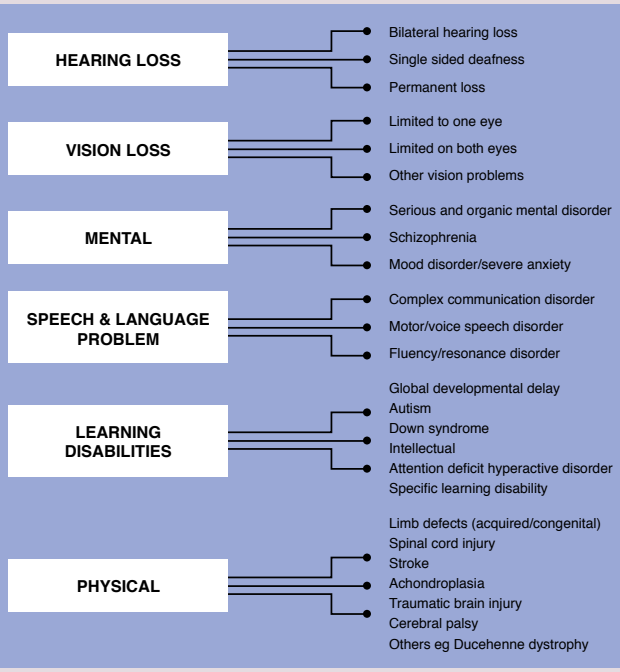

Figure 1: types of disability as categorised in Borang Pemohonan & Pendaftaraan OKU

in children, but the most common is developmental or congenital trauma and illness.

Down syndrome, cerebral palsy, autism and intellectual disability are commonly seen disabilities by the paediatricians office. The complications of their diseases coexist; for instance, a child with cerebral palsy is complicated with hip subluxation, contractures, dystonia, hearing impairment and many others, which further impose physical limitations requiring extensive treatment and closer care from the healthcare professionals. This consequently results in developmental delay, although the term is different from disability.

A child with developmental delay exhibits slower developing skills, namely gross motor, fine motor, speech and communication, and social and behaviour. Sadly, disability in childhood results in a lifelong impact on the child's physical, mental and social wellbeing. They constantly needed special care and assistance, especially in the area of health and education.

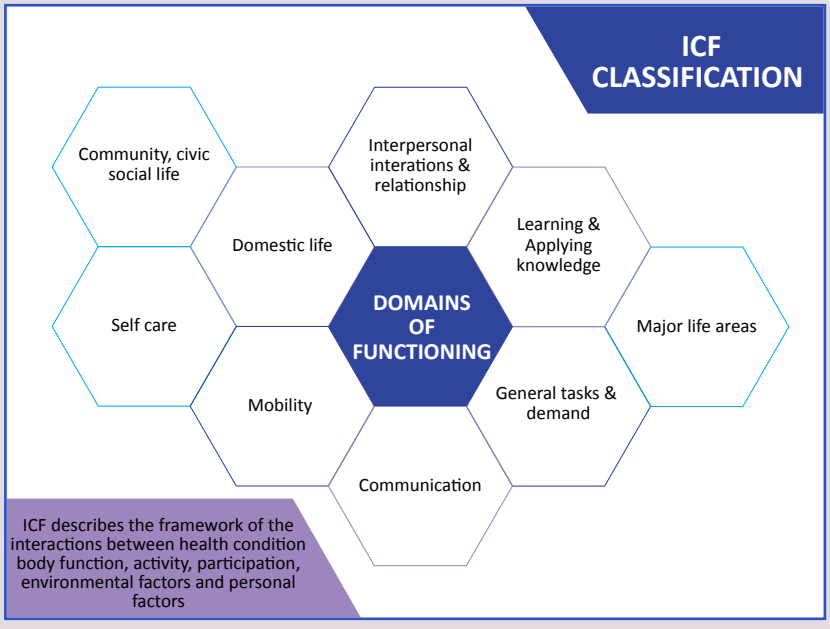

Figure 2: concepts on domains of functioning as elucidated by ICF

Being a parent to a disabled child is difficult. They continuously need to wrestle with an unfortunate situation because of their child's care. This is highly impossible for working parents who need to

balance their work, family,y and personal needs. Even more, worse when financial or social issues ensue.

Disability during Adulthood

Adulthood mainly revolves around studying and working, which interplay with other psychosocial factors. However, it is very distressful to face disability and lose the quality of life amidst this catastrophic situation. The disabilities in adulthood are multidimensional, ranging from the neurological, spinal cord, musculoskeletal, complications from diseases and traumatic sequelae. In addition, underlying comorbidities such as diabetes, hypertension, peripheral vascular disease, chronic renal failure, and others are essential in determining disabilities.

Gender, age, ethnicity, mental health problem, smoking status and socio-economical state are the governing factors for disabilities based on the National Health and Morbidity Survey (NHMS) 2015. The quality of life paradigm can be challenging, especially when inflicted with disabilities when considering or planning to make up their future.

Coping mechanisms can be arduous because great efforts are required to make a massive shift in their daily life, and sailing within the social stigma also can be an issue of concern. However, people can overcome their disabilities smoothly due to a sound support system such as health care and government providence, family member's care, and society's assistance.

Disability in Elderly

Health and disability are closely tied to the elderly population because physical and cognitive health are expected to decline with ageing. Disability in advanced age may cause serious consequences such as fall and injury, poor nutritional status and severe dependency. This increases the risk of immediate home care, hospitalisation, nursing home admission and death. This consequently increases the economic burden.

Because of the multifaceted and complex nature of the disability, many approaches and interventions aim to prevent disability in old age. The disability in old age is regarded as a dynamic social phenomenon related to individual physiological, psychological and medical conditions, socio-economic position, cultural norms, and environment.

Comprehensive geriatric assessment and care, early screening, management of chronic diseases, medications, counselling and creating an accessible environment are some modalities to assist comprehensive care for elderlies with disabilities.

Disability & Quality of Life

Disabilities do not define an individual's capabilities because it is often perceived in a very negative manner. They experienced more psychosocial front restrictions, which ultimately led to poor quality of life (QoL). Societal barriers limit their freedom to carry out regular social roles and daily life. The QoL is a great public health concern involving complex multidimensional concepts, including physical health, psychological and social wellbeing features.

QoL is very subjective because intrinsic and extrinsic factors influence it, so it is also challenging to optimize without predicting such determinants as anxiety, depression, self-efficacy, and physical activities. Most importantly, self-efficacy is perceived by the person about fulfilling the task to enhance confidence in their abilities. Because self-efficacy has a mediating role between stress and depression, which protect the person from pain and fatigue.

In addition, physical activity is crucial to prevent chronic and secondary complications among disabled people. Studies confirmed that QoL and health status measures are largely subjective concepts that can be evaluated through the judgement of people about their health and life status. Therefore, disability limits a health problem and mirrors the individual's concern in interacting with society and physical movements.

A Growing Need

Demand for rehabilitation care in Malaysia is rising due to the increasing number of non-communicable diseases(NCD) associated with disability. Rehabilitation is observed as part of the universal health coverage and the continuum of care for everyone. The two primary roles of rehabilitation are restoring the ability of the patient with disability to function and helping him/her achieve maximum function and independence.

It is coordinated using medical, social, educational and vocational factors to train individuals to the highest functional capabilities. The lack of good rehabilitation care will cause an extreme burden of support for disabled people and their families or caregivers. Thus, rehabilitation is crucial to enhance the quality of life and manage chronic diseases, impairment, and disability without undue hardship for the family or caregivers.

The primary role of rehabilitation care is to optimise daily living activities, including managing basic but essential skills such as communication, ambulation, and independence. However, its benefit may go beyond basics such as education, employment and driving. Unfortunately, the momentum for rehabilitation care in Malaysia is not well established compared to other developing countries.

Public awareness or understanding about rehabilitation care are still below satisfaction because they adapt and are comfortable with their disabilities rather than expanding their potentials by seeking rehabilitation care. Rehabilitation care is usually provided in the healthcare centre by a dedicated team consisting of doctors, nurses, physiotherapists, occupational therapists, speech therapists, dieticians, social workers, and equipment providers. This multidisciplinary team approach for rehabilitative care is the basis of the treatment because the different disciplines work together towards a common goal, including optimizing the maintenance and ensuring the rehabilitation needs are met.

Caregivers' Perspective

Being a caregiver for a disabled person can be rewarding, but it is very stressful and often comes at a personal cost. The common challenges are managing their time, especially working or studying, because they find it difficult to spend time on their individual needs. This consequently leads to emotional and physical stress.

Poor mood or emotional management results in psychological illness, including depression, anxiety and insomnia. Sometimes communication with their care one can be challenging because they see many changes over them and may not understand the whole situation well. For instance, stroke person care includes ambulation, skin care, toileting, transferring and fulfilling their daily needs, but the caregiver may struggle to comply with all the necessary care, especially when they need to balance their working life or personal life.

In the long run, such a scenario may cause burnout and emotional exhaustion. Some of the signs of caregiver stress are easily becoming irritable, losing or gaining too much weight, feeling lethargic, insufficient sleep, losing interest in daily activities, low mood, and feeling overwhelmed or constantly worried.

Another worst-case scenario being a caregiver are the financial burden because they had to source out for additional income to support their carer to assist better support. Caregiver often owns undeserved guilt, believing that they are not doing or helping their loved one well. They tend to compare themselves with another caregiver and determine their care.

Disability can be a negative or unpleasant experience to many. However, they're still disabled warriors looking at life in a very encouraging way, including achieving in their career, achieving higher in their education, driving super cars, striking in their favourite sports and having a perfect life with an ideal family despite social stigma remains and their rights often drawn back. This will be discussed more in the next part of "I Am Differently Able" in the upcoming edition. **BMMA**

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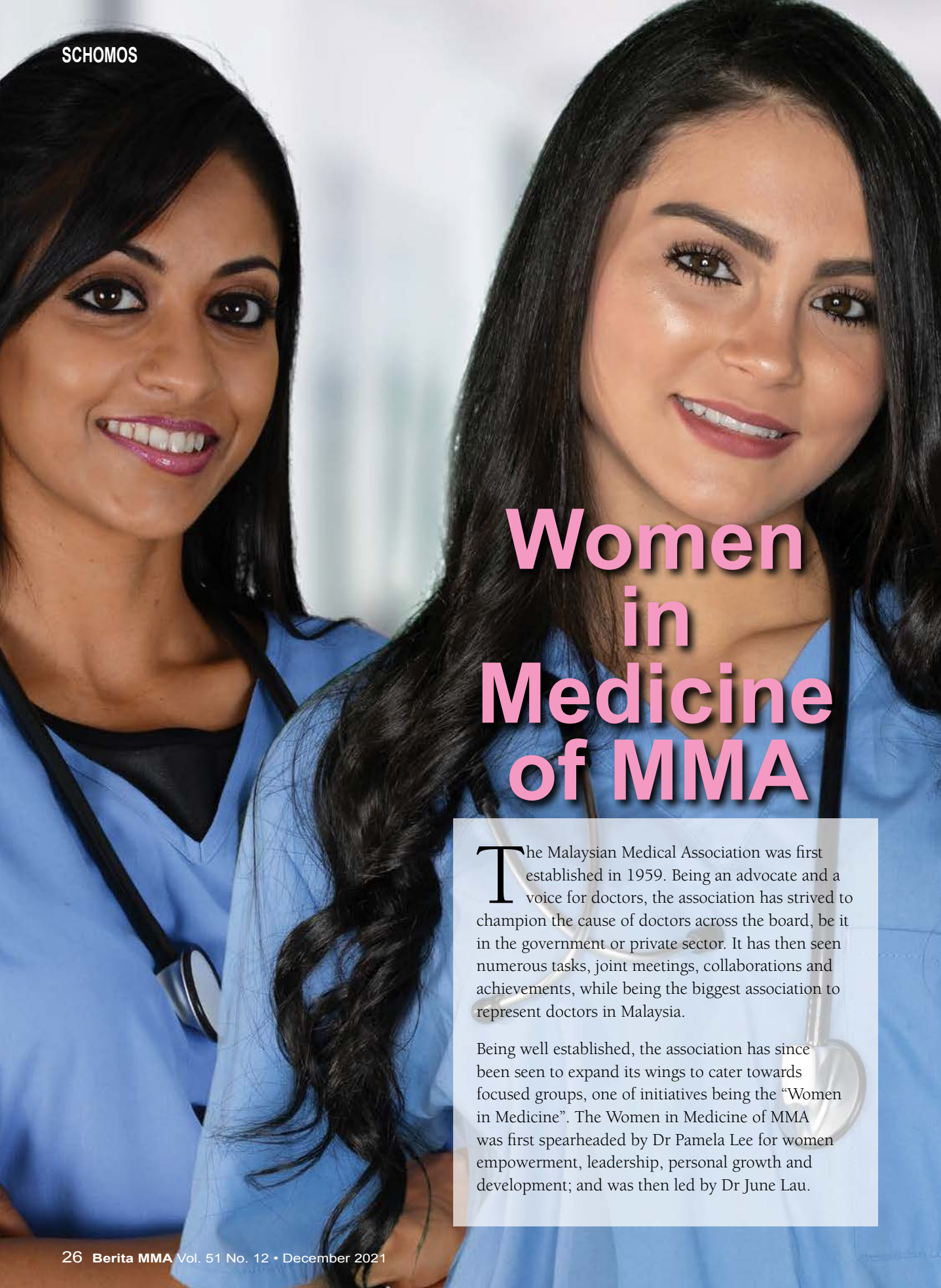

Women in Medicine of MMA

The Malaysian Medical Association was first established in 1959. Being an advocate and a voice for doctors, the association has strived to champion the cause of doctors across the board, be it in the government or private sector. It has then seen numerous tasks, joint meetings, collaborations and achievements, while being the biggest association to represent doctors in Malaysia.

Being well established, the association has since been seen to expand its wings to cater towards focused groups, one of initiatives being the "Women in Medicine". The Women in Medicine of MMA was first spearheaded by Dr Pamela Lee for women empowerment, leadership, personal growth and development; and was then led by Dr June Lau.

The missions instituted by the Women in Medicine focus on providing opportunities to acquire relevant skills for personal and professional development; forming a network alliance with local and international female physicians and organisations; promoting health and wellness among female doctors; and fostering mentorship between early career women doctors with mid to high level women doctor leaders.

Various surveys and infographics have been done and published in the past under the banner of Women in Medicine of MMA. Today, the Women in Medicine continue to keep abreast with issues related to health and the community to include addresses on issues such as workplace harassment, taboos of women's health, and breast cancer awareness in the times of COVID-19.

Collaborations are also in the works towards forums and discussions with other academies and associations, along with working with the National Health Policy Committee towards uplifting women's health and welfare, be it among healthcare professionals or the general population.

While working towards achieving our goals, we would like to take this opportunity to introduce the current working committee of the Women in Medicine for Year 2021/22.

Dr Lynette Sheena Dewa Rajo
Chairperson
Honorary Assistant Secretary, SCHOMOS 2021/22
Currently pursuing her Masters in Surgery degree with the University of Malaya

Dr Lam Mynn Dee
Subcommittee Member
Currently working at the Medical Research and Ethics Committee, National Institute of Health

Dr May Lau Fei Cheng
Subcommittee Member
Currently working as the Regional Medical Advisor of the Asia Region with Bayer Pharmaceutical

Dr Merlinda Shazellenne
Subcommittee Member
JDN Chairperson, Malaysia
Secretary of MMA Negeri Sembilan 2021/22
Currently working as Senior Medical Officer with Ministry of Health

The Women in Medicine can be approached whether for advice, suggestions or collaborations. Do feel free to get in touch with the Chairperson or subcommittee members through:

- Instagram @women.med.mma
- Facebook @MMA SCHOMOS (cc Women in Medicine)

Alternatively, you can reach out via Helpdoc by dialing +603-4041 1140/ +6013-831 1140 or email to Helpdoc@mma.org.my (cc Women in Medicine). BMMA

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Digitalisation in Primary Healthcare

Recently, I had the benefit of attending the Selangor Healthcare Conference. During the three day seminar, we, the participants, had the grand opportunity of listening to a myriad of gifted speakers.

The session that struck me most, surprisingly, was the presentation done by our very own Hon. General Secretary and my long term friend, Dr Thirunavukarasu Rajoo. His presentation focused on the wave of Digitalisation in Primary Healthcare. Many things he had said are worthy of a revisit and deeper contemplation. With his kind permission, I am using his materials herein for such a purpose.

I believe that he has grabbed the bull by the horn by highlighting the various benefits of digitalisation in healthcare that will be delivered upon the patient as the ultimate user of healthcare services but the impact on private GPs has to be carefully elicited.

The overhaul and introduction of vertical engagements in healthcare services were listed to encompass the following:

1. Responsive & sustainable healthcare.
2. Advocation and enablement of prevention.
3. The remodelling of the patient-doctor relationship.
4. Expanding the reach of healthcare professionals.
5. The levelling of platforms between doctors and patient relationships.

Responsive & Sustainable Healthcare

Solutions for a health problem has always been the province of personal affordability or cost assignment to an enrolled insurance scheme. The role of the GP needs to encompass a sustainable healthcare solution with the ability of directing the patient to potential strategic partners or even to manage a second or third medical opinion before undertaking a major surgical procedure. None of this will be humanly possible for an owner operated clinic if technology and digitalisation is not being embraced as part of their operational workflow.

Advocation and Enablement of Prevention

We have known both from personal experience and through various studies that a significant portion of a clinic's revenue mix is derived from the sales of prescription medicine. Over prescribing is a common global phenomenon. Many control measures are set in place and the response to regulate this has led to the emergence of the Managed Care Organisation or MCO which serves the role of policing "rogue" clinics.

The control mechanism placed is always digital. The opportunity and incentive due to this aspect of digitalization is in the realm of practicing preventive medicine. With the emergence of IOT gadgets i.e. Fitbits, the GP has the ability to interpret streamed data to evaluate potential risk factors over the patient's health horizon. Is it not surprising if GPS using digital technology can actually get more visits from healthy patients seeking to remain healthy rather than sick patients seeking to get better?

Remodelling the Patient-doctor Relationship

The patient has always treated doctors as the subject matter expert when it comes to their ailments. Today, with a handy handphone and an agile app the patient can traverse a plethora of medical information and data to arrive at some basic information on their affliction.

Thus, patients recounting their history while the doctor conducts a one-sided discourse belong to a bygone era. The doctor has to by default ascribe that the patient might know more about their conditions than meets the eye. Digitalisation redefines the status quo of the patient doctor relationship.

Expanding the Reach of Healthcare Professionals

We have seen the government embrace medical tourism as a catch phrase for improving our country's trade balance. Patients are flocking in from our neighbouring countries to access our medical services. Imagine the doors of opportunity that can be thrown open by tele-medicine for our local GPs.

Our country is recognised for its quality healthcare services. It is not too far-fetched to see our GPs being able to deliver medical consultation to patients as far away as Indonesia, Vietnam or Cambodia. Even language is no longer a barrier because of apps like Google Translate.

The Levelling of Platforms between Doctors and Patient Relationships

The status quo of GPs rests on the fact that they are ascribed to be the subject matter experts and the first point of call for diagnosing a disease. This pre-established stereotype will be the first thing to crumble from the onslaught of the disruptive wave that is being unleashed by the Digitalisation in Primary Healthcare.

As the patients become empowered the crude constraints of the traditional GPs roles will be challenged and many aspects of his roles will either become obsolete or redundant. The benefits a patient will derive from the digitisation process is not a matter of dispute. What I am disputing is that what benefits the patient from digitalisation will automatically benefit the common GP as well. This is a dangerous fallacy.

For the GP to remain relevant and pertinent to his patient base when the patients themselves are becoming empowered in all aspects of their personal health, the practising GP MUST adapt and evolve as well. Sitting back and thinking that it will be business as usual with all the tectonic changes happening around them from tele-consultations to online symptom checkers to borderless consultation, the common GP is being too lackadaisical in identifying the threats to his very existence.

There are still many who are resistant to embrace changes. They do not believe in electronic record keeping much less personal digital health records. The domain of the GPs roles are slowly being eroded with paramedical players such as radiographers, ultrasonographers, phlebotomists, midwives are being provided larger roles in the health landscape which has been the privy of the general practitioner (GP).

Knowing this potential for disruption in the lives of our GP fraternity, MMA has embarked in the last five years to remain abreast and relevant by initiating the following programs and discourse. It must be used as a springboard to set and tamper the impact from digitalisation. We believe that it will buy GPs both the time needed to upskill and re-purpose themselves in the digital healthcare age. This is not a strategy of attrition but rather a hard won respite for GPs to embrace and move towards implementing a digital dimension in their workplace and practice.

1. Introducing the need for Clinical Governance
2. Good Medical Practice
3. Focusing on Patient Welfare
4. MMA Code for Professional Conduct
5. Digitalisation Handbook & Guide for the GP

Let me leave this as food for thought. BMMA

"Change is the law of life. And those who look only to the past or present are certain to miss the future."
– John F. Kennedy

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The Pilot DREAM Project

Drowning Risk Evaluation and Management (DREAM)

Drowning is a major health problem throughout the world, especially in the Western Pacific Region of WHO. Drowning occurs in a variety of locations (e.g. sea, lakes, rivers, pools) and under a variety of circumstances (e.g. recreation, occupation, transport). Any water body is often used for recreational swimming/bathing and is a "death trap".

The government has set up the National Water Activity Safety Council in the Ministry of Housing and Local Government to coordinate and promote all activities pertaining to drowning prevention. The Council consists of representatives from both government and non-governmental agencies and bodies. The Council has identified many "hot spots" of drowning cases. The public need to be made aware of these hot spots and drowning risks therein. The relevant authorities, such as local municipalities, need to undertake interventions to remove/overcome the risks identified in these locations.

With funding from RCSI & UCD Malaysia Campus (RUMC), the authors identified two sites for drowning risk assessment. The first was Sungai Gabai Waterfalls, Selangor, a site identified as "hot spot" by the Water Activity Safety Council. The local community, MISAR, Department of Drainage and Irrigation, Selangor were invited to discuss the implementation of the project. Selected team members were briefed on the methods /procedures.

Captain Bala (MISAR) briefing the survey teams before the survey

The risk survey protocol was adapted from the document entitled "Water Safety Essentials for Local Governments" developed by the Australian Water Safety Council and Department of Health and Aging.

The team identified the following in the designated area:

a. Risk:
   - Water body – the full length, extent and boundary
   - Risks to the public – access to the water, extent of the risk (depth etc.), presence of other dangers such as rocks
   - Prior action taken by authorities (if any) and its adequacy – barriers (fences, walls, etc.), signage and breaks in barriers, signage or lack of it, resources for rescue if relevant (floats, etc.)

Teams surveying the waterfalls site for risks

b. Assessment of site as low, medium and high risk depending on ease of accessibility to public, hazard of site (depth of water, lack of barriers, etc.)
c. Other risks for injury such as falls, etc. at the site of waterfalls
d. Recommendations to prevent drowning

The teams recorded the findings on a prepared form, took detailed photographs and met to discuss their findings and recommendations to overcome risks at identified sites (such as barriers, signage, etc.). Their final report was sent to the relevant local authorities for implementing risk mitigation measures. The authorities took relevant action to mitigate the risks identified at the site and the results were presented at the Council's meeting.

The second site chosen for drowning risk assessment was Port Dickson. The authors met with local community leaders, staff of Hospital Port Dickson and representatives of relevant government agencies such as Municipality, Fire & Rescue, Marine, etc. Data from the hospital showed that almost half of the cases of drowning occurred in swimming pools in the hotels in the area. This finding was reported to the Council and Ministry of Housing and Local Government.

The Department of Local Government organised a meeting for representatives of the hotel industry to discuss efforts at prevention. A seminar for hotel owners in Port Dickson to educate them on appropriate drowning risk prevention interventions is being planned.

The project is a classic example of inter-sectoral cooperation involving the community, NGOs such as MISAR & MMA, academic institutions (RUMC) and government agencies to solve a health problem at the community level using a health systems approach. BMMA

> "The project is a classic example of inter-sectoral cooperation involving the community."

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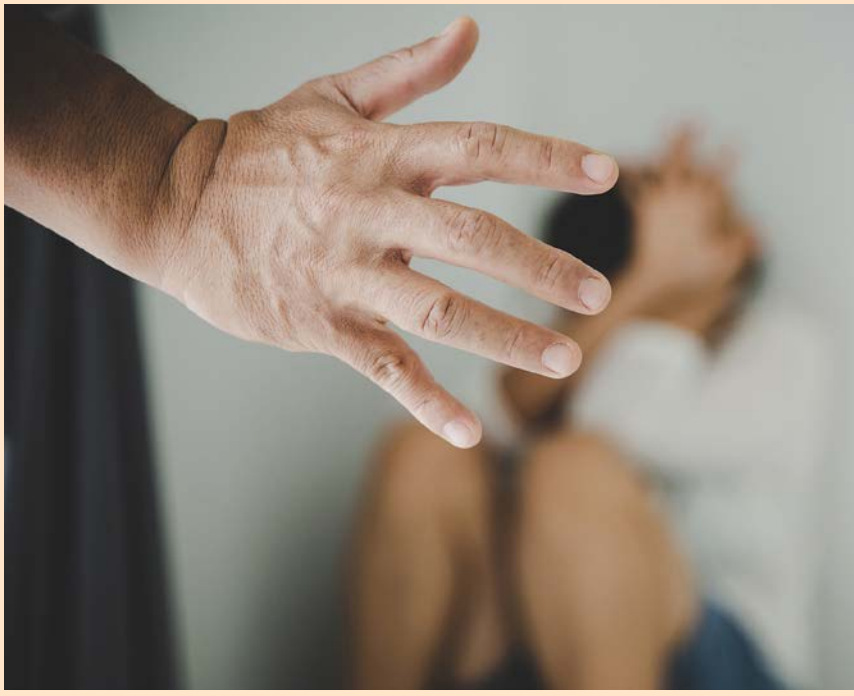
Violence Against Women



Gender based violence (GBV) is any act done against a person's will based on gender norms and unequal power relationships that result in physical, sexual or mental harm to anyone. These acts include threats of such acts, coercion, and arbitrary deprivation of freedoms of individuals. Violence against women (VAW) manifest in many forms. Globally, it is estimated that 1 in 3 women will experience physical or sexual abuse in their lifetime.

It has been repeatedly observed that a root cause of VAW lies in a combination of power, privilege and permission that is reinforced by patriarchy, which is a social system that privileges the gender of men. Toxic masculinity and various expressions of these result in targeted violence against women in the forms of domestic violence/ intimate partner violence, sexual assault, psychological and financial abuse, sexual harassment, and various other harmful behaviors. In the digital space, online abuse targeting women, stalking, and cyberbullying are new forms of VAW.

It is important for healthcare professionals to be aware of the epidemic of violence against women as only 40% of women seek help of any sort after experiencing violence, especially for those who are already experiencing multiple facets of discriminations. The American Academy of Family Physicians recommends that all women of reproductive age be screened for intimate partner violence and provided of referred screen-positive women to ongoing support services.

VAW clinically may present connected to injuries, disabilities, chronic health problems, sexual and reproductive health issues, unintended pregnancies, homicide or even suicide/para-suicide. Psychological effects of VAW may be direct or indirect. Anxiety, fear, depression, inability of concentration, and PTSD (Post-Traumatic Stress Disorder) are examples of direct effects of VAW.

Psychosomatic illnesses, withdrawal, and substance abuse (and other coping mechanisms) may be categorised as indirect effects. These physical and psychological factors prevent survivors of VAW from thriving in their community, restrict relationships outside abusive environments and limit opportunities for employment, education, and other meaningful social connections in a person's life.

VAW also impacts society and affects their families, neighbours, friends, healthcare workers, legal and security personnel, and the wider community. The cost to society is also impacted by greater strain on healthcare to legal service and losses in productivity in the workforce.

Crisis situations such as natural disasters, political conflict and public health emergencies have been shown to increase rates of gender-based

violence. The Women, Family and Community Development Ministry noted that more than 9,000 domestic violence cases were recorded since the start of the movement control orders as a response to the COVID-19 pandemic until August 2021.

It has to be emphasised that a large majority of cases of VAW go unreported. Data from the Women's Aid Organisation based in Kuala Lumpur showed that there was a 57% increase in reported cases last year. As the pandemic situation worsened throughout 2021, its economic impact also made matters worse.

The One Stop Crisis Centres (OSCCs) that were supposed to handle survivors of sexual and family violence were overwhelmed as hospitals and emergency rooms were overburdened with COVID-19 cases. Cases of VAW hence were frequently not reported and perpetrators not punished.

The Malaysian Domestic Violence Act is in force but has many limitations in practice. The act covers a wide range of harmful acts including causing physical injury, compelling a victim by force or threat against the victim's will and causing psychological abuse and emotional injury. The act protects spouses, former spouses, children, family members (adult sons and daughters, fathers and mothers, brothers and sisters, and any other relatives), and "incapacitated adults" who are living as members of the family. It also covers "de facto spouses" for couples who have not registered the marriage but have gone through a customary marriage ceremony. The act, however, does not cover non-married couples. This is a significant barrier to justice for many couples in new forms of relationships who may be co-habitating, or experience intimate partner violence outside the home. Challenges remain in enforcing these laws and not enough is being done to prevent violence.

Malaysian law defines rape as sexual intercourse with a woman without her consent or against her will. In addition, sex with a girl below 16 years of age is statutory rape, regardless if she consents or not. Fundamentally, rape is sex without consent, or if the person is unable to give consent. Consent should be freely given, reversible, informed, enthusiastic and specific. Sexual assault is any sexual contact without consent. While the law does not define sexual assault, various forms of sexual assault are criminalized in various forms such as molestation, penetration of the anus or vagina with an object without the person's consent, among others. In clinical practice, many survivors of sexual violence may visit a healthcare provider, yet not want to pursue police reports or legal avenues. The role of clinicians here is important in supporting the client to ensure her best health and safety, to provide her all options of counselling and support, and to refer her to social workers or OSCCs as needed.

Violence against women needs to be handled with compassion, sensitivity, and dignity to ensure that the survivor is supported in the most effective and empowering way. Many civil society organisations such as WAO, AWAM and WCC are working towards ending violence against women in Malaysia. Advocacy and research are important to provide a better understanding of the nature, magnitude and impact of violence against women and girls. Data collection and gender-sensitive policy analysis is also paramount to understanding the scope of what works and what doesn't in addressing the epidemic of gender-based violence. Healthcare professionals can and should play a more effective role in supporting survivors in the best holistic way possible.

Individuals in need of assistance or support for VAW can call the following Hotlines for assistance:

WAO Hotline (03 3000 8858) and SMS/WhatsApp line TINA (018 988 8058)

AWAM Telenita Helpline (016 237 4221) telenita@awam.org.my

WCC Penang Hotline (011-3108 4001)

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International Men's Day

On 19 November, we celebrate the annual International Men's Day, to acknowledge and appreciate the responsibility of men as husbands, fathers, brothers, sons and colleagues. Different activities have been organised worldwide to celebrate this day.

In Malaysia, health clinics all over the Malaysia are encouraged to organise activities to raise the awareness among the public on the importance of men's health. This is in accordance with *Pelan Tindakan Kesihatan Lelaki 2018-2023* to make sure the quality of healthcare service provided for men can be monitored and improve it from time to time.

Data from Department of Statistics Malaysia on 29 July 2021 showed that the life expectancy of male citizens was 72.8 years while for female citizens, it was 78.2 years. The life expectancy for men has always been shorter than the women. There are several reasons; reports showed that men have poorer health and suffer higher mortality and morbidity across various diseases compared to women. Therefore, it is important to educate the public especially the men population for them to pay more attention to their health.

In addition, studies have shown that men are less likely to undergo health screening than women due to poor health-seeking behaviour, lack of health knowledge and masculine attitudes. On the other hand, men engage in riskier behaviours than women, such as criminal activities and high risk occupations. As for mental health, even though women have more psychiatric illnesses like major depressive disorder, but men were more prone to committing suicide, abusing illegal drugs and becoming aggressive.

In celebration of International Men's Day, we set up a public talk for patients who were coming for their usual appointment to Klinik Kesihatan Kepala Batas (located in Seberang Perai Utara, Penang). While waiting for their consultation in our outpatient

A wide range of topics was covered

Sharing information on men's health with patients

department, they were provided with the latest updates regarding the health information among the Malaysian especially for men.

In the talk, different topics were presented, including cardiovascular, smoking, alcohol, drug abuse, benign prostatic hyperplasia, prostatic cancer, erectile dysfunction and depression. They were enlightened with the statistics of the diseases, the common clinical features and what can they do to reduce their risks of getting the illnesses.

In our health clinic, we provide screening tests and treatment for certain diseases. We took the opportunity during this International Men's Day to let the public knows that they can get screening for diabetes, hypertension, dyslipidaemia, erectile dysfunction, malignancies, depression and many other topics. At the end of the presentation, we opened the floor for questions and answers session.

The patients asked many different types of questions for themselves and on behalf of their family members. We can see that some of the patients were aware of the common health issues faced by the men population. Furthermore, we prepared a QR code for them to scan to setup an appointment for further in-depth consultation with the family medicine specialist in the health clinic.

At the health clinic level in Malaysia, we play an essential role in promoting better health awareness among the public especially for the men since there are only limited healthcare services that cater specifically to the health needs of men at the moment. In future, hopefully our male patients will be offered a better healthcare service. **BMMA**

> "Studies have shown that men are less likely to undergo health screening than women."

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A Rare Case

There are only twenty such cases reported in literature
This is our first
Initial diagnosis was different
Then, some suspicion
Radiologists were surprised
Such unusual scans!
Pathologists questioned
Sample from a five-year-old?
Parents were told
They agreed to the biopsy
Knowing there was little hope
But autopsy?
Will they permit?
Unlikely
Although it would be confirmatory
Still, good material for teaching
Case-report writing
Just wait till it is presented at the meeting
Bound to be a lengthy discussion
Lots of questions
Explanations
And surely
If written well
This case will make it to a good journal

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Insurance Puns

What kind of insurance would a transformer need?
Life and car insurance!

What insurance can't an insurance agent sell to a ghoul?
Life insurance!

What is the similarity between parachutes and insurance?

If it doesn't work the first time you need it, it's useless.

A horoscopist visited her GP to review her blood result. Before the doctor could say anything, the horoscopist began the conversation:

Horoscopist: Doc, what is your zodiac sign?

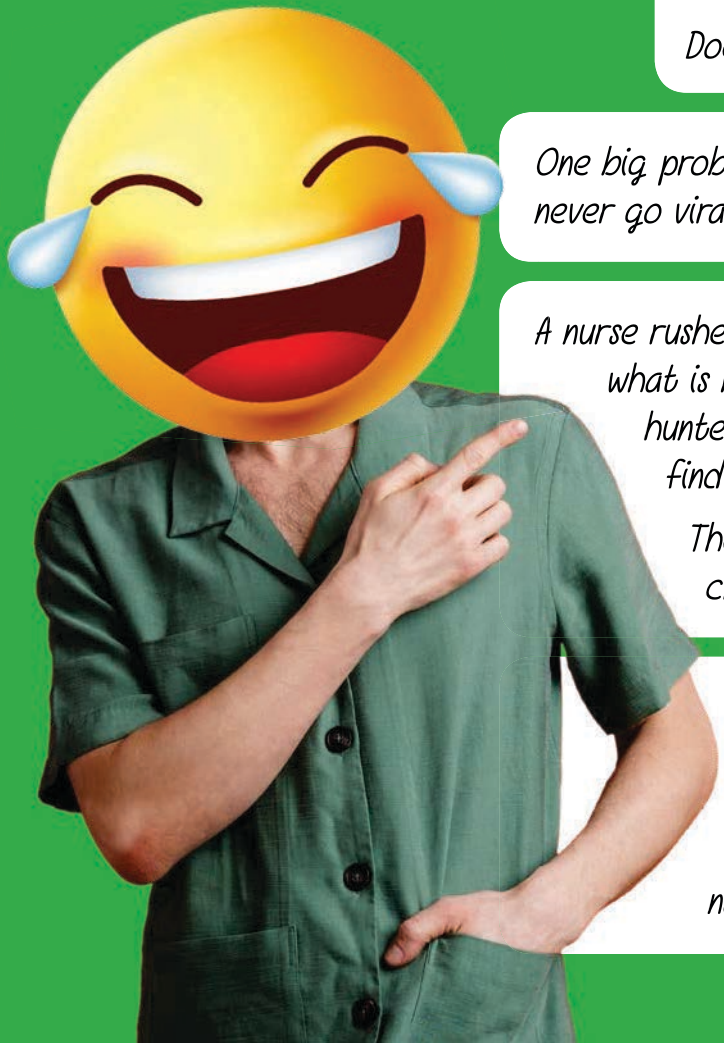
Doctor: Well, mine is Gemini.What about it?

Horoscopist: I knew it; Gemini is the most studious sign among others.

Doctor: What is your zodiac sign?

Horoscopist: Cancer

Doctor: What a coincidence!



One big problem with antibiotics is that they will never go viral no matter how popular it gets.

A nurse rushed to her doctor and asked," Doc, what is medication in the prescription? I hunted over 50 pharmacies but couldn't find one!"

The doctor replied, "I was just checking if my pen is working."

Two twin girls are born; one is named Skye after her perfect blue eyes. Unfortunately, the other girl had cataracts, so she was named Claudia.

The SCHOMOS Selangor Webinar Series

The World Health Organization defines Health as a state of complete physical, mental, and social well-being, and not merely the absence of disease. This was reflected in the call of the Minister of Health Khairy Jamaluddin that the centrality of both mental and physical health is very important, and that no one should be left behind.

According to the Lancet, there has been a significant increase in the prevalence and burden of depression and anxiety following the COVID-19 pandemic. Indeed, experts have suggested that a "silent" mental health pandemic is emerging. It is important to note that mental health conditions affect not only the general public, but also healthcare professionals.

This was evident as the prevalence of burnout among healthcare professionals had ranged from 40% to 62% at the height of this pandemic. Both the authors had served for various amounts of time at the COVID-19 wards, and can therefore bear testament to reports of burnout, stress, and anxiety associated during the pandemic.

We cannot, should not, and must not take this mental health burden lightly as the consequences are dire to healthcare professionals, patients, and the healthcare system itself. First, the healthcare professionals might experience burnout from this pandemic, which will lead to suboptimal care and treatment for the patient. Not only that, healthcare professionals who are facing burnout are 5-20% more likely to retire, fracturing our healthcare system, which has been severely affected by the pandemic.

As such, in conjunction with the World Mental Health Day 2021, MMA Selangor held the first episode of our webinar series entitled Medics & Mental Health: the Pandemic's Burden towards Healthcare Workers.

We were fortunate to invite Dr Juliet Mathew, the vice chairperson of MMA Selangor who concurrently serves as a lecturer at the International Medical University, as well as a registered counsellor. The session also involved Miss Nur Ajirah Abdul Manaf, a clinical psychologist at Hospital Pengajar Universiti Putra Malaysia (HPUPM) with a special interest in Child and Adolescent Psychology. Dr Sean Thum, the acting SCHOMOS representative for MMA Selangor who himself is a Psychiatry trainee, moderated the session.

Dr Juliet provided an excellent perspective on the mental health effects the COVID-19 pandemic had on our population, and gave us an idea on what we can do to seek help. Miss Ajirah provided an insight into the increased workload mental health practitioners are facing, besides enlightening us about the work clinical psychologists carry out. Both ladies echoed Khairy's call to destigmatize mental health, and normalize conversations so those in need can seek help, counseling and treatment.

All in all, we hope the session gets to serve its purpose by raising awareness of the medical fraternity on mental health conditions. We in the medical field must look out for one another, and this goes for one's well-being during the pandemic too.

This episode is the first of a series of webinars that aim to draw attention to important and relevant topics that will allow strong healthcare professionals in the process of nation-building. We hope this can be a springboard to more success in our subsequent episodes. Should you feel that you may be interested in participating in our webinar series as a speaker, please do not hesitate to contact the authors at schomosselangoractivties@gmail.com. We would love to include your perspectives in our programme! **BMMA**

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House Officer

Immune-enhancing Potential of Palm Tocotrienols

The immune system plays an important role in helping us to remain healthy as the cells of the immune system help us fight and recover from infections and diseases such as cancer, as well as to heal from injuries. Vitamin E tocotrienols have been proven to have anti-cancer effects and provides immune enhancement. [1-3] Prof. Ammu K. Radhakrishnan, an expert in immunology, answers questions related to the clinical outcomes of palm-derived tocotrienol in its immune-enhancing potential.

Prof. Dr. Ammu K. Radhakrishnan
Jeffrey Cheah School of Medicine and Health Sciences,
Monash University, Malaysia

1 What are the factors that can cripple our immune system?

Some of the factors that can cripple our immune system include poor nutrition, stress, not having adequate rest and sleep, as well as living a sedentary lifestyle. Nutrition, in particular micronutrients, is a major factor that can affect host immune system. Several clinical studies have shown that supplementation with vitamins (A, C and E) can play an important role in activating the immune response. Fatigue or lack of sleep can also affect the proper functioning of the immune, thus, we must have adequate rest. A sedentary lifestyle will have negative impact on the immune system. Hence, moderate exercise is recommended but very strenuous exercise should be avoided. Stress is not good for the immune system as it can induce production of substances that can have a negative impact on the immune system.

2 How does palm tocotrienols affect the immune system in general?

A clinical study showed that daily consumption of tocotrienol-rich fraction (TRF), which is vitamin E from palm oil enhanced the immune response to tetanus toxoid vaccine. [4] Subjects who were given the TRF supplementation (400 mg daily) had significantly higher levels of antibodies to the vaccine, when compared to placebo. These findings suggest that TRF supplementation improves the immune response to the vaccine, which can increase its protective effect.

3 What is the recommended dosage of palm tocotrienol supplementation that can affect cancer cells?

Recently, we reported that daily supplementation of gamma-tocotrienols (1 mg per day) caused a marked reduction in the number of T-regulatory cells in peripheral blood and tumour microenvironment in tumour-induced mice[5] and this was also accompanied by the promotion of cell-mediated immune responses. It has been proposed that the proportion of T-regulatory can be used to predict the clinical outcome in soft tissue sarcoma, breast cancer and colon cancer patients. [6-9] Hence, the findings show that tocotrienols can regulate host immune response to produce anti-cancer effects. In addition, we recently also reported that supplementation of gamma-tocotrienols may modulate T-regulatory cells through DNA methylation. [10]

4 Tocotrienols have shown effectiveness in animal studies such as mice, implying that they can help boost the immune system. Does this, however, apply to humans as well?

To date, there are numerous papers in the literature that strongly support the anticancer properties of tocotrienols in various types of human and animal cancer cell lines as well as animal models of cancer. [5, 10-14] In contrast, there are only a handful of papers reporting on the effects of TRF supplementation on cancer in clinical trials. Hence, there is a need to carry out studies to evaluate the anticancer effects of tocotrienols in clinical trial setting.

We have previously reported that it is not possible to observe significant changes to the host immune system following daily TRF supplementation in the absence on an immunological challenge. [15] However, a significant enhancement of immune response to the tetanus toxoid vaccine was observed when healthy volunteers who were supplemented daily with 400 mg of TRF was challenged with a booster dose of tetanus toxoid vaccine. [4] These findings suggest that supplementing daily with TRF can help to ensure that the host immune system remain healthy and will be able to respond readily in the face of an immunological challenge such as a vaccine or infection.

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MPOC

MONASH University

Keeping Up With COVID-19

A pandemic strikes, leaving us with movement restrictions and a void of medical talks, conferences and meetings. When times are tough, the tough gets going. MMA Wilayah Persekutuan (WP) introduced the MMA Wilayah Webinar Series in mid-2021 during the peak of Movement Control Order (MCO) 3.0.

It was targeted to healthcare professionals from private and public sectors. Topics were based on popular demand. How do we do a webinar that is free of charge with no expenses? Well the MMA WP simply utilised its readily available talent. Speakers were selected from MMA WP members, and they possessed vast experiences and specialities within their respective niche. To date, MMA WP has successfully hosted two webinars. They are:

MMA Wilayah Webinar Series 1:

Celebrating Diversity in Medical Practice (Saturday, 10 July 2021) via Zoom

Diversity in medical practice does not only mean having healthcare professionals of various backgrounds or ethnicity, but entails a wide range of experiences . This webinar was aimed at introducing younger healthcare professionals to various different opportunities and working environments in healthcare. It could not have been a better time when the nation and MMA was battling with house officers' contract renewals in the midst of a pandemic.

Dr Balachandran Krishnan spoke about the doctor being an entrepreneur. Col (Dr) Gnanamalar Gnanasundram gave us an insight on the life of a doctor in an army uniform. Dr Varatharaja Thirugnanasambatham who is a trained medical repatriation services spoke about the joys of travelling while transporting patients around the globe. Professor Dr Victor Hoe enlightened us about the vast opportunities in medical education, research and the need to pursue masters or PhD.

Medicine and healthcare is indeed colourful with diversity!

MMA Wilayah Webinar Series 2:

Corporate Medicine (Saturday, 25 September 2021) via Zoom

Healthcare governance has evolved over the years with corporate medicine. Although the term corporate medicine is widely used, it is still alien to many within the profession. It entails the way we package healthcare from managed care organisations to hospital based organisations, encompassing the way we structure, plan and deliver healthcare to the people. Corporate medicine has been a thing in the 20th century. Even the Ministry of Health Malaysia introduced a corporate culture or budaya korporat to ensure an improved delivery of healthcare.

Datuk Dr Kuljit Singh spoke about hospital management in the public and private sectors. Retired Major General Dato' Pahlawan (Dr) Mohanadass Ramasamy enlightened us on the role of healthcare corporatisation within the academic setting. Dr Ravi Venkatachalam enlightened us about the benefits of both public and private healthcare institutions. Dato' Dr Krishnamoorthy Appalanaidu touched upon the benefits of group practice in primary care which allows patients to seek various treatments under one roof.

The webinars successfully elicited conversations on medical diversity and corporate medicine via panel discussions. If you missed the webinar, it is available for viewing via MMA Central and MMA WP Facebook pages. Our gratitude goes to the MMA IT team for their assistance with the platform of the webinar. **BMMA**

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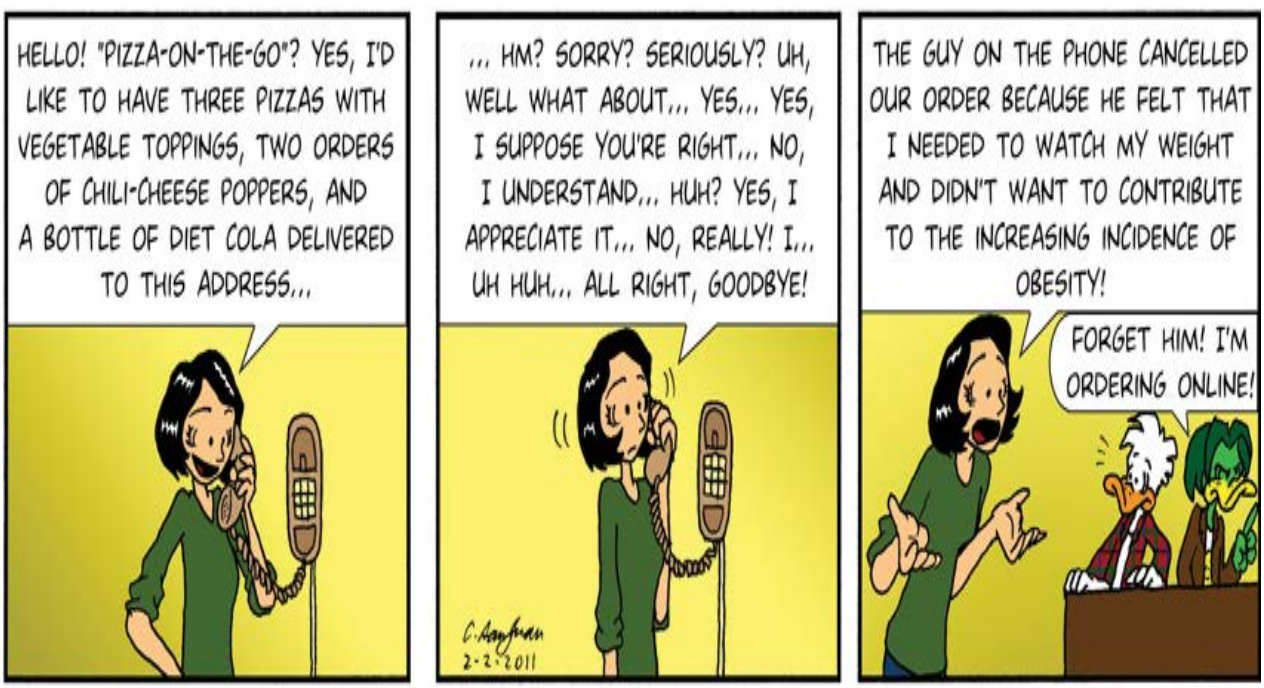

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ORGANIC FOODS

Saffron

With the nickname "sunshine spice", Saffron is harvested from the Crocus Sativus flower, also known as the saffron crocus. It is one of the most expensive spices globally due to its labour-intensive harvesting method, thus making production costly. Also, it takes between 15,000- 16,000 flowers to produce 1 kg of saffron spice, which leads to it costing upwards of RM50 per gramme of pure Saffron.

This heftily priced spice originated from Greece, where it was revered for its medicinal properties, and was commonly consumed to enhance libido, boost mood and improve memory. However, Saffron only grows well in countries with four seasons or Mediterranean climates such as Western Asia, India, Spain and Iran.

Low temperatures coupled with high humidity during flowering season affects the flowering of the Saffron crop, and spring rains boost the production of new corms (i.e. the underground bulb of a plant). The vivid crimson stigma and styles, called threads, are collected and dried as a seasoning and colouring agent in food. Saffron tastes like iodoform, with a hay-like fragrance due to the phytochemicals picrocrocin and safranal. It also contains a carotenoid pigment, crocin which gives a rich golden yellow hue.

As an antioxidant, Saffron helps protect cells against oxidative stress, and is linked to health benefits such as reduced inflammation, anticancer properties and antidepressant activity. In a review of five studies, saffron supplements were significantly more effective than placebos at treating mild to moderate depression symptoms.

Interestingly, eating and smelling Saffron appears to help treat Premenstrual Syndromes (PMS) such as irritability, headache, cravings, pain and anxiety. In addition, Saffron acts as an aphrodisiac and boosts libido, especially in men and women suffering from sexual dysfunction due to antidepressants.

There's good news for weight watchers too, because Saffron has been shown to reduce snacking and curb appetite thus it may help one to lose weight. Recently, Saffron has become commonly used in skincare routines as it helps brighten skin and prevents premature skin ageing.

Reference:
1. 11 Impressive Health Benefits of Saffron (https://www.healthline.com/nutrition/saffron)
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Did you know?
- Consumption of Saffron greater than 5g (about one teaspoon) have uterine stimulant and abortifacient effects
- Drinking saffron water every morning is suitable for a caffeine fix and also improves skin texture and treatment of skin blemishes
- The best way to consume Saffron is by soaking them in warm water or milk to maximise the flavour and colour of food
- It is best to avoid refrigerating Saffron because Saffron loses its properties when exposed to high levels of moisture and humidity
- Possible side effects of Saffron are dry mouth, anxiety, agitation, drowsiness, low mood, sweating, nausea or vomiting, constipation or diarrhoea

Organic foods like Saffron is safer, more nutritious and better-tasting. In addition, those organic foods are an environmentally friendly method of production. As a result, the awareness increases to opt for better health choices.

"Eating organic isn't a trend, it's a return to tradition."

Prepared by
Dr Nalini Munisamy,
Editorial Board Committee Member
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Jan 12-16

Venue : Virtual
Organiser : Universiti Malaya (UM) and National University of Singapore (NUS)
Email : apmec2022@um.edu.my
Website : https://medicine.nus.edu.sg/cenmed/apmec2022/index.html
Tel : +603 8996 0700, +603 8996 1700, +603 8996 2700

1ST EAST COAST HYBRID REGIONAL CONFERENCE 2022

Jan 22

Venue : Dewan Seminar, Paya Bunga Hotel, Terengganu
Organiser : College of Physicians Malaysia
Email : admin@cpamm.asc.org.my
Secretariat : Academy of Medicine of Malaysia
Tel : +603-8996 0700, +603-8996 1700, +603 8996 2700
Fax : +603-8996 4700

WORLD CONGRESS OF NEPHROLOGY 2022

Feb 24-27

Venue : Kuala Lumpur Convention Centre (KLCC), Kuala Lumpur, Malaysia
Organiser : The International Society of Nephrology (ISN). Hosted by Asian Pacific Society of Nephrology (APSN) & Malaysian Society of Nephrology (MSN)
Email : admin@cpamm.asc.org.my
Contact person : Paolo (Organiser); Munchees Chong (Local PCO)
Tel : +6014-621 1491
Email : pzavalloni@theisn.org / wcn2022@anderesfourdy.events
Website : https://www.theisn.org/wcn/

COLOPROCTOLOGY 2022

Mac 4-6

Venue : Virtual
Organiser : Malaysian Society of Colorectal Surgeons
Email : secretariat@colorectalmy.org
Tel : +603-8996 0700, +603-8996 1700, +603-8996 2700
Website : http://www.colorectalmy.org/downloads/Coloproctology 2022.pdf

CPAMM REGIONAL CONFERENCE 2022

Mac 25-27

Venue : Bayview Hotel Georgetown, Penang
Organiser : College of Physicians, Academy of Medicine of Malaysia
Secretariat : College of Physicians, AMM
Email : admin@cpamm.asc.org.my
Tel: : +603-8996 0700, +603-8996 1700, +603-8996 2700 / Mobile +6017-8571503 (Mr Afiq)
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ADACEL® ABBREVIATED PRODUCT INFORMATION

1. TRADE NAME: Adacel® Suspension for Injection **Pharmacotherapeutic class:** Bacterial and viral vaccines, combined **Dosage forms and strengths:** 0.5ml vial single dose. Each dose (0.5 mL) contains tetanus toxoid 5 Lf, diphtheria toxoid 2 Lf, Pertussis Toxoid 2.5 µg, Filamentous Haemagglutinin 5 µg, Fimbriae Types 2 and 3 (FIM) 5 µg, Pertactin 3 µg **2. THERAPEUTIC INDICATION** ADACEL® is indicated for active booster immunization for the prevention of tetanus, diphtheria and pertussis in persons 4 years of age and older. ADACEL® is not to be used for the treatment of disease caused by B. pertussis, C. diphtheriae or C. tetani infections. **3. DOSAGE AND INSTRUCTIONS FOR USE** ADACEL® (0.5 ml) should be administered as a booster dose by the intramuscular route. The preferred site is into the deltoid muscle. **4. CONTRAINDICATIONS** Known systemic hypersensitivity to any component of ADACEL® or a life-threatening reaction after previous administration of the vaccine or a vaccine containing one or more of the same components are contraindications to vaccination. Encephalopathy within 7 days of a previous dose of a pertussis-containing vaccine not attributable to another identifiable cause is a contraindication to vaccination with any pertussis-containing vaccine. **5. SPECIAL WARNINGS AND PRECAUTIONS** Intramuscular injections should be given with care in patients suffering from coagulation disorders or on anticoagulant therapy. ADACEL® should not be administered into the buttocks, nor by the intradermal or subcutaneous route. Do not administer by intravascular injection, ensure that the needle does not penetrate a blood vessel. Vaccination should be postponed in cases of an acute or febrile disease. However, a disease with low-grade fever should not usually be a reason to postpone vaccination. The possibility of allergic reactions in persons sensitive to components of the vaccine should be evaluated. Allergic reactions may occur following the use of ADACEL® even in persons with no prior history of hypersensitivity to the product components. If Guillain-Barré syndrome has occurred within 6 weeks of receipt of prior vaccine containing tetanus toxoid, the decision to give any vaccine containing tetanus toxoid should be based on careful consideration of the potential benefits and possible risks. Immunocompromised persons (whether from disease or treatment) may not achieve the expected immune response. If possible, consideration should be given to delaying vaccination until after the completion of any immunosuppressive treatment. Nevertheless, vaccination of subjects with chronic immunodeficiency such as HIV infection is recommended even if the immune response might be limited. **6. PREGNANCY AND LACTATION:** The effect of ADACEL™ on the development of the embryo and fetus has not been assessed. The effect of administration of ADACEL™ during lactation has not been assessed. **7. UNDESIRABLE EFFECTS** Pain at the injection site was the most common local adverse event. Most injection site reactions occurred within 3 days following vaccination and their mean duration was less than 3 days. The most frequent systemic adverse event was tiredness in children and headache in adolescents and adults. Fever was reported in less than 10%. These adverse events were usually transient and of mild to moderate intensity. The following adverse events were included based on severity, frequency of reporting and the strength of causal association to ADACEL®. *Immune System disorder* -hypersensitivity reaction *Nervous System Disorders* -Paraesthesia, hypoesthesia, Guillain-Barré syndrome, brachial neuritis, facial palsy, convulsion, syncope, myelitis *Cardiac Disorders* -Myocarditis *Skin and Subcutaneous Tissue Disorders* -Pruritus, urticarial *Musculoskeletal and Connective Tissue Disorders* -Myositis, muscle spasm *General disorders and administration site conditions*: - Large injection site reactions (>50 mm) and extensive limb swelling from the injection site beyond one or both joints have been reported after administration of ADACEL® in adolescents and adults. These reactions usually start within 24 – 72 hours after vaccination, may be associated with erythema, warmth, tenderness or pain at the injection site and resolve spontaneously within 3 – 5 days. The risk appears to be dependent on the number of prior doses of acellular pertussis containing vaccine. **8. INTERACTIONS** ADACEL® may be administered concurrently with a dose of inactivated influenza vaccine at separate sites with separate syringes. ADACEL® may be administered concurrently with a dose of Hepatitis B vaccine in 11 and 12 year-olds at separate sites with separate syringes. ADACEL® should not be mixed in the same syringe with other parenterals. **9. OVERDOSE:** No information **10. REVISION DATE** March 2015 **11. Full prescribing information available on request from** Sanofi Pasteur, vaccines division of sanofi-aventis (M) Sdn. Bhd., Unit TB-18-1, Level 18, Plaza 33, No 1 Jalan Kemajuan, Seksyen 13, 46200 Petaling Jaya, Selangor Darul Ehsan, Malaysia. **Ref No.** MYADA003/0315

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