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* Red Dot Design Award 2011

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Published by
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Email: info@mma.org.my / publications@mma.org.my
Facebook: https://www.facebook.com/malaysianmedicalassociation
Website: www.mma.org.my
© Copyright Reserved
ISSN 0216-7140 PP 1285/02/2013 (031328) MITA (P) 123/1/91

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At the end of each year, we all say the year has passed so quickly and there is so much more to be done! I am sure this is no different for the year 2014 as well! Much has been achieved at MMA, some issues making progress steadily, some slowly, all the same, we have to move on.

In the Private Sector, solo General Practitioners (GPs) have been feeling the pinch in their practices, reduced patient numbers, competition from group practices, laboratories and pharmacies, rising cost of professional indemnity, and costlier maintenance of overall operations. The GPs are hoping to provide follow-up services for patients with non-communicable diseases who have been discharged from Government Hospitals and Outpatient Clinics.

Whilst terms and conditions in the Government Sector have been regularly improved over the years, the demands of Government Doctors will continue, seeking new areas of recognition and revision of existing benefits. There will be no finish line to this, and resignations from Government to Private Sector will continue. There is news of about at least 10 new Private Hospitals to be completed in the next two years.

Back to the Berita MMA, we thank all contributors for their support. We now receive materials from members who are submitting to the Berita for the first time. This is encouraging, and the Editorial Board ends up carrying forward articles to the following month! Advertisers have also been forthcoming, and we make reasonable profits, though our objective is to ensure a newsletter befitting the profession with no financial loss!

The Book on the 55 Year History of the MMA is progressing, though I must admit, it is a mammoth task. Interviews are still going on with Past Presidents and other important personalities who have served the MMA, reports of Branches and Societies are being edited currently, and suitable photographs are being selected from thousands at the Secretariat – this alone is not an easy task! The Editorial Board of this Publication hopes to capture all major milestones of the MMA, and the persons who have made it happen. We have to be proud of our heritage, and this publication of 250 pages will hopefully document our development. The greatest concern of the Editors is to ensure there are no gaps in the history, and all effort is being undertaken to assure that the book is as complete and comprehensive as possible. We are confident that the Book would be published early next year, ready to be launched at the 55th MMA AGM.

This issue of the Berita carries the first announcement from the MMA Elections Committee for nominations of posts that will be contested at the next AGM. The selection of leadership of the Association is a democratic process, and it is hoped that members who meet the requisite will come forward to offer themselves to be elected for various posts. A healthy competition is always desirable!

The 55th MMA AGM will be held in Kota Bharu, Kelantan from 29 to 31 May 2015 at the Grand Riverview Hotel. The Kelantan Branch, though with a small membership of 200, is hosting the AGM after a span of 34 years (the last in Kota Bharu was held in 1977). As a curtain raiser to the AGM, the Organising Committee is introducing Kelantan through its history and pictures in this issue of the Berita. This AGM will be a great opportunity for members who do not normally consider Kelantan for a holiday, let us drive up along the East Coast and enjoy the scenic east!

On another note, we sadly lost two stalwarts of the MMA this month. Dato’ Dr K. Saravananthan on 2nd November and Dato’ Dr Khoo Kah Lin on 7th November due to illness. Both were icons of the medical profession and had contributed significantly to the healthcare of our nation. Dato’ Sarva was President of MMA in 1984 and Dato’ Khoo from 2007-2009. We pray their souls RIP.

As this is the final issue of the Berita for 2014, we wish to thank all readers for their support and feedback. We wish all our fellow members, friends and families, Merry Christmas and A Very Happy, Prosperous and Peaceful Year ahead!
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It has been a busy month. There have been many meetings and many strides have been taken. We hope to achieve our objectives in resolving issues for doctors, immaterial of the ministry or party that it involves.

Meeting with the Minister of Health
The ExCo met the Minister of Health and his team at the end of October. We sent eight pages of issues to be discussed and the meeting spanned across three hours. The Minister and Director General of Health were part of a large team representing the Ministry of Health (MoH). Each issue was deliberated extensively. The summary of the meeting is attached in another article in the Berita (page 10).

Meeting with the Secretary General (KSU) of MoH
The ExCo met the KSU in early November. Mainly issues with regards to administration were discussed. The Hon. General Secretary (HGS) has attached a report on the meeting in this Berita issue as well.

Goods & Services Tax (GST)
GST has created a lot of confusion among doctors and private hospitals. The Customs Department and the Ministry of Finance have failed to answer many questions. We continue to engage with both parties to verify the procedures in GST and all related issues.

Firstly, let me assure the General Practitioners. You do not need to register unless your annual turnover is more than RM500,000 for sales of medication outside the exempt list in GST, supplements and non-allopathic treatments, including aesthetics. If you exceed RM500,000 annually for these, please register.

I identified several problems with the Custom's circular dated 25th October. I have explained that the doctor's fees are controlled by the Private Healthcare Facilities & Services Act (PHFA) and hence by charging GST on those mentioned services, we will be breaching the Act. I also noted that FAQ 5 is encouraging the breaching of Medical Ethics and the Medical Act. I approached the Custom Officers in several meetings and they were unable to resolve this problem.

I subsequently met the Deputy Minister of Finance twice with the help of a fellow member, and have finally managed to convince him of these irregularities. He has requested me to write a letter; in it I have proposed that all fees for consultation and procedures under the PHFA be exempted from GST. If this is considered, it will resolve

As the Year Draws to a Close ...

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– Hal Borland
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*National Health & Morbidity Survey (NHMS), 2011.
** FSIO. MOH. Guide to Nutrition Labeling & Claims (as of Dec 2016).
most issues. This will be brought to the Prime Minister for
a final decision.

Trans-Pacific Partnership Agreement
(TPPA)
There are many rumours spreading, citing that several
areas have agreed and signed the TPPA. We have been
assured by the Minister of Health that the rights of
doctors and patients will be protected.

I have met the negotiators from the Ministry of
International Trade & Industry (MITI) and the MoH
separately after that meeting. They too, have assured
me that the Minister is fully aware of the meetings and is
guiding them on all issues related to health which have
already been negotiated. They have assured us that they
are ready to brief us on any health-related issues that are
being or have been discussed in the agreement.

Kedah Annual Dinner
The Kedah branch successfully conducted their annual
dinner. YB Dato’ Dr Leong Yong Kong from the ExCo
of Kesihatan Kerajaan Negeri Kedah, was the guest of
honour. About 200 members attended the successful
dinner and had a good time. During the dinner, I managed
to brief the members on the latest updates through my
speech.

Healthcare Financing
I attended a two-day international conference organised
by University Kebangsaan Malaysia. During the
conference, the university’s company had gone out
internationally to set up Casemix and social insurance
systems in several countries, including Indonesia and
Iran. The question which arose was, when will Malaysia
start? Nobody from the MoH could answer.

However, a discussion among the speakers had revealed
that restructuring had been aborted at least five times
over the last 20 years. It is therefore logical to assume
that some planning is still being done by the MoH,
though we are left to guess at what stage and when it will
be implemented.

Health Tourism
I was invited by the MITI to give a 10-minute presentation
on Health Tourism. I was asked to speak on what doctors
wanted, the opportunities and challenges. During the
meeting, several agencies also gave presentations. It
was revealed in this meeting that Malaysia is the second
highest destination for Medical Tourism after Thailand,
even beating out Singapore. It was a very happy
revelation. One of the main reasons noted would be the
cost of private healthcare; this is mainly due to the
limitation imposed on doctors’ fees by the PHFA. This
has made us a very competitive destination.

There are many hospitals opening up to partake in
this new opportunity. In the Iskandar region alone, it is
expected that 25 new hospitals will be built to cater to
the expected needs and expansion. My simple question
is, where will they get the specialists from? Look at the
advertising section of the weekend papers and you will
figure what I mean.

Meeting the UN Rapporteur
Under the Committee on Health & Human Rights, we met
the UN Special Rapporteur who was visiting the country
for two weeks. His name is Dr Dainius Puras, a Lithuanian
Professor of Psychiatry who has been contracted for
a period of three years as a volunteer. We combined
ourselves with three other medical organisations to
provide all concerned doctors with a platform for unity.

We highlighted that Malaysia has one of the best
healthcare systems in the world. It is primary care focused
and has universal coverage with very good accessibility.
However, there are cracks in the system that need to be
addressed.

The issues brought forward included the access to certain
marginalised groups which are the refugees and asylum
seekers, prisoners, sexual minorities, foreign workers,
illegal immigrants, and sufferers of mental disorders and
their carers.

We also mentioned issues on rights to health that are
being threatened by law enforcement agencies. There
has also been a conflict of interest among doctors with
reference to certain policies and legislations. These
include the whipping of children and capital punishment
in both the conventional and religious law.

National Working Committee (NWC), PPS
The PPS conducted their second NWC meeting. It was
well-attended by most of the branches. Several issues
were discussed and some were resolved. I have to
congratulate the PPS Chairman for initiating and guiding
the PPS in many projects. Hopefully, they can do even
more before the term is over.

New Constitution
I want to inform the members that our new constitution
has been approved by the Registry of Societies (RoS)
since September. Though the information had been
shared via the HGS’s column, some members have not
read it. I would like to note here that there were errors
in the software system, eROSES, that did not allow us to
submit part of the new constitution.

The parts that have not been put in have been forwarded
to the Constitution Committee for discussion and will
also be resubmitted again to RoS with an acceptable
format of the Annual General Meeting (AGM). We hope
to finally resolve that issue by the next AGM.

I hope this brief summary of the issues currently
happening and affecting doctors will keep members
abreast. We, the ExCo and Council, will try to address
and resolve as many issues as possible. We will also try to
inform the general body at full tilt.
PAEDIATRIC EPILEPSY SYMPOSIUM
“Getting It Right”

Date: 10 January 2015 (Saturday)
Time: 8.00 am - 4.00 pm
Venue: Ara Damansara Medical Centre
5th Floor, Conference Room
Lot 2, Jalan Lapangan Terbang Subang
Seksyen U2, 40150 Shah Alam, Selangor, Malaysia

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PROGRAMME

<table>
<thead>
<tr>
<th>TIME</th>
<th>TOPIC</th>
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</thead>
<tbody>
<tr>
<td>6.00 am</td>
<td>Registration</td>
</tr>
</tbody>
</table>
| 8.30 am | Welcome speech
by CEO Yeyasan Sime Darby, Pn Yatea Zainal Abidin                  |
| 8.40 am | Opening Speech
by YBhg Datuk Dr S. Jeyamohan, Ministry of Health, Malaysia         |
| 8.50 am | End of officiating ceremony                                          |
| 9.00 am | Seizures in children and their mimics                                |
|        | Associate Professor Dr Choong Yi Fong, University Malaya Medical Centre |
| 9.30 am | Which drugs do I choose?                                             |
|        | Dr Vigneiswari Ganasean, Hospital Pulau Pinang                       |
| 10.00 am | Epilepsy in young adults - special considerations                   |
|        | Associate Professor Kheng Seang Lim, University Malaya Medical Centre |

<table>
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<tr>
<th>TIME</th>
<th>TOPIC</th>
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<tbody>
<tr>
<td>10.30 am</td>
<td>Pitfalls in managing children and young adults with epilepsy</td>
</tr>
<tr>
<td></td>
<td>Dr Simon Harvey, Royal Children’s Hospital, Melbourne</td>
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<tr>
<td>11.00 am</td>
<td>BREAK</td>
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<tr>
<td>11.30 am</td>
<td>What to do when seizures are not controlled</td>
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<td></td>
<td>Dr Simon Harvey, Royal Children’s Hospital, Melbourne</td>
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<tr>
<td>12.00 pm</td>
<td>Surgery for epilepsy - efficacy and safety</td>
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<tr>
<td></td>
<td>Professor Dr Ben Seladurai, Ara Damansara Medical Centre</td>
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<tr>
<td>12.30 pm</td>
<td>Role of ketogenic diet in epilepsy</td>
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<tr>
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<td>Dr Khoo Teik Beng, Hospital Kuala Lumpur</td>
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<tr>
<td>12.50 pm</td>
<td>My story (presentation by a parent / patient who has undergone epilepsy surgery)</td>
</tr>
<tr>
<td>2.00 pm to 4.00 pm</td>
<td>Epilepsy Surgery Case Conference (Limited Seats) (first come first serve)</td>
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REGISTRATION FORM

Name: ____________________________ Name of Hospital / Clinic: ____________________________

IC / Passport: ____________________________ Name of Hospital / Clinic: ____________________________

Address: ____________________________ Tel: ____________________________ Fax: ____________________________

Mobile: ____________________________ Email: ____________________________

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Private Sector

- Non-Communicable Diseases
There was a planned pilot study of services that could be outsourced to the private General Practitioners (GPs) but was aborted. We know that there are more than 6,000 GPs in the community that may help improve the situation if there was a mechanism to outsource these services. The mechanism can be discussed to ensure the highest quality of service and that the patients receive the best treatment at their convenience.

Response
This involves policy changes and cannot be done overnight. The issue will be discussed with the Ministry of Finance (MoF). The Ministry of Health (MoH) will try to put this issue into the 11th Malaysia Plan.

- Domiciliary Care
We hope that the MoH can train some of these interested general practitioners and outsource these domiciliary care services to them.

Response
As above.

- Personal Data Protection Act (PDPA)
The PDPA has created a grave concern in the medical community including MMA and the Malaysian Medical Council (MMC).

Response
The Minister fully agrees with MMA. He has already explained to the Minister of Multimedia who has agreed in principle, and we were advised to write in for an exemption. We are awaiting the official written reply from the Ministry of Multimedia.

- Continuing Professional Development (CPD)
CPD is another issue that has been made compulsory in the new Medical Act. We sincerely hope that it can be initiated slowly for doctors to adjust to this new system (lower points that would be increased gradually over the years to the predetermined target). We also hope that since medical professionals are required to obtain the Annual Practicing Certificate (APC), the cost of attending these activities should be tax-exempt.

Response
The Minister stated that all the programmes from the three providers will be standardised. All doctors will have to achieve the points required to obtain their APC. It is anticipated that the Rules and Regulations for the Act will be ready in August 2015. Therefore the doctors should be prepared to collect the necessary points by 2016.

- FOMEMA, PERKESO, EMGS
Issues concerning medical examinations have been plaguing doctors for some time now. We would like to take this opportunity to thank PERKESO in reviewing their rates for medical examinations at this current time. However, there have been problems with equal opportunities for all doctors with EMGS. FOMEMA fees for examination of foreign workers have not increased for more than 17 years. There has been an impasse and we hope that the Government can increase these examination fees and seriously consider standardising them.

Response
The Minister has stated that the digital X-ray is voluntary and not compulsory; doctors need to get their own radiographers or pool together and employ a radiographer. They could even arrange zonal coverage. Even though this ruling has come into effect this August after many delays, the actual enforcement has not taken
place. He further stated that, if the MoH did not enforce these measures, the Atomic Board would take over. This is because the Atomic Act 304 causes a clash between the MoH authorities with the Atomic Commission, and there needs to be enforcement. Otherwise, the Atomic Board will take the power of enforcement away from the MoH.

He also advised MMA to write an official letter to the Minister for a detailed explanation. After this has been done, the issue will then be brought to the Prime Minister's attention.

**Medical Indemnity**

Medical indemnity premiums are increasing annually at a very high rate. This is also being made compulsory by the new Medical Act. We hope that the Government can allow these premiums and payouts to be tax-exempt.

**Response**

The Minister will discuss the issue with the MoF. He also suggested that the best way in solving the hike, is to limit the payouts by the court, hence capping payments which would increase indemnity premiums.

**No Fault Compensation**

As an alternative to the current situation, we are proposing a system that is beneficial to the public as well as to the medical profession and Government. The public gets a shorter turnaround time for their claims. The doctors do not have to stress about going to court. Furthermore, the claims are fixed beforehand by an independent board and are usually lower than the court claims.

**Response**

The Minister stated that every system has its benefits and disadvantages. He suggested that the MMA set up a Committee to look at this issue, examine all aspects and come up with the pros and cons of all recommendations put forward.

**Maternity Centres**

There are also new rules for the registration of clinics and "private hospitals" which apparently have been formed to create a cost-saving alternative in healthcare expenses. With the ruling of having resident paediatricians and anaesthetists, these maternity centres may have to shut down and patients in smaller towns would lose this service. The license renewal process has also become more complex. We hope that the MoH could make it easier by setting the renewal at every five years instead of annually.

**Response**

These centres are classified as hospitals under the act. The problem highlighted by Bahagian Amalan is the procedures and SOPs in these centres. The Minister agreed for these centres to pool their anaesthetists and paediatricians if the volume is inadequate. However, they must make sure all the centers are listed in their APC system. They also have to ensure that there is coverage during all emergencies and this should not be only on paper but in practice.

**Fee Schedule**

We would like to thank the Government for the new fee schedule that was released at the end of last year. Even though it appears to have made a significant jump, it has only been upgraded after many years. The newly approved fee schedule is actually the fee schedule proposed by MMA about 12 years ago and not the current recommendation. There is also no increment based on the annual rise in cost of living as well as the cost of medical indemnity. GST and other laws will further impact the fees. We hope that this issue can be addressed.

**Response**

This request was rejected.

- **Goods & Services Tax (GST)**

GST will be effective in April. Private specialists practise differently in the private sector. Most private specialists are independent contractors to the private hospital. They may be a limited company or function as individuals. The patients usually do not pay GST. However, the doctors as third party suppliers, will charge the hospital GST. The commission is taken by the hospital and it will be charged GST. The doctors then have to register for GST if their income is more than RM500,000 per year.

Justice as mentioned in the previous month's column, there is a query that has not been answered. Doctor's fees are limited by the Private Healthcare Act, and with these factors inserted, there will be an added amount. Will that contravene the act? Finally the public will have to be the party who bears the brunt of higher healthcare cost.

**Response**

The Minister agreed with the sentiment and also stated that the MoF did not understand how doctors conducted their practice. He suggested for MMA to meet with the Customs and MoF.

- **Third Party Agreements (TPA)**

With the two laws mentioned above, working with the current TPA will change. We have been voicing our concern that they have never been regulated and have been strangling doctors with their one-sided agreements.

**Response**

There will be a new act governing the TPA. MMA will be invited for the preparation of this Act and modifications to the PHFA.

- **Malaysian Medical Council (MMC)**

The new Medical Act has been passed in 2013. We are still awaiting the Rules and Regulations. We have noted that the MMC will be corporatised and there is a plan to increase the fees for all forms of registration, including the Annual Practicing Certificate (APC). We hope that these fees are not increased too much too fast. We also hope that all new regulations are discussed with the stakeholders before they are implemented.

**Response**

The Minister has not agreed to any change in the charges. The Rules and Regulations governing the new Act will be out around August 2015.

**Government Sector**

- **Overproduction of Doctors**

We are concerned about the increasing production of doctors in the country as there are currently more than 38,000 registered doctors. The MoH can only employ 5,000 new house officers annually.
Response
The Minister stated that this is a complex issue and many issues are intertwined. He has suggested that the best solution would be to raise the minimum SPM requirement to 5As. This would automatically reduce the number of entrants to universities, both local and abroad.

Currently, new doctors will have to wait six months before being employed. It is expected that this waiting time will increase. The Minister stated that we cannot have an exam that restricts employment but the Moratorium for new universities can be extended.

Training & Distribution
The training of these doctors has also been compromised. Due to the poor quality of production, it takes a longer time to train doctors during their housemanship. We keep hearing that there are too many doctors but shortages continue to occur on ground. This is caused by the maldistribution of medical officers. We need to address this by rewarding incentives to the unpopular postings. We also need to redistribute posts based on work needs. There is a need to allocate more training-only posts which does not affect service.

We hope that the MoH, being the largest trainer of medical officers in the country, will be able to emphasise on the alternative pathways to specialise. The opportunities for training should be clearly known.

Promotions
There has been a dearth of promotions in the MoH over the last two years especially for JUSA C and the grades above it. The Public Health specialists, Occupational Health specialists, administrators, and Family Physicians feel left out. They feel that they have been excluded or delayed in their promotions compared to their other colleagues. We hope this issue can be addressed and resolved.

Response
The Minister is aware that the MoH is very short of specialists and agrees with all the above. MoH is supportive of the Masters and parallel pathways. They will also look at the Board’s certification mode when making MoH the main trainers.

Response
The Minister announced that there will be a major promotion exercise in November with over 100 promotions. This will address the groups that were previously missed out, including the Family Physicians and the Public Health specialists.

Response
The Minister announced that another six hospitals will be included in this system come January 2015. He hopes that other hospitals will be included later.

Response
The Minister stated that this is a complex issue and many issues are intertwined. He has suggested that the best solution would be to raise the minimum SPM requirement to 5As. This would automatically reduce the number of entrants to universities, both local and abroad.

Currently, new doctors will have to wait six months before being employed. It is expected that this waiting time will increase. The Minister stated that we cannot have an exam that restricts employment but the Moratorium for new universities can be extended.

Alliances
There has been a proposal by SCHOMOS to increase the allowance for specialists. This allowance has not been changed. SCHOMOS has also proposed a sub-specialist allowance.

Response
This was rejected.

Research
Research has been earmarked as an added requirement for specialists. There are many that are keen but are bogged down by the immense workload. We hope that the MoH would consider providing assistance through the provisions of protected time for research, research assistants and grants in order for this to be carried out.

Response
The problem will be looked into.

Overseas Leave
Currently, doctors especially senior specialists, have difficulty in obtaining leave for their presentations overseas. We hope the process of obtaining leave to attend, lecture and present at conferences abroad can be simplified and accelerated. With the introduction of leave application through the Human Resource Management Information System (HRMIS), we hope that leaves could be applied, submitted and approved online. This would greatly hasten the process.

Response
The HRMIS online system is unstable and it cannot be ensured that the speed required can be matched. The process has however been shortened whereby non-J USA specialists and agreements would only have to be obtained from the Head of Department, Hospital Director, Head of Service, and the KSU. This process should take less than two months.

Response
The LPP was introduced as a pilot project in Putrajaya Hospital and Selayang Hospital by our former Prime Minister, YABhg Tun Dr Mahathir Mohamad. There has been a change of two Prime Ministers and we are still awaiting the expansion of that practice to the other hospitals. We hope that the MoH will be able to expand these services to all major hospitals and not just another six in order to help retain more specialists within.

Limited Private Practice (LPP)
The LPP was introduced as a pilot project in Putrajaya Hospital and Selayang Hospital by our former Prime Minister, YABhg Tun Dr Mahathir Mohamad. There has been a change of two Prime Ministers and we are still awaiting the expansion of that practice to the other hospitals. We hope that the MoH will be able to expand these services to all major hospitals and not just another six in order to help retain more specialists within.

Response
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Flexi System for Consultants
There has been a proposal by some consultants to work part time in Government Service. This is being practised in several western countries. In this system, they will work on a sessional basis in the Government Sector and the rest in the Private Sector. This will allow for better retention of specialists in Government Service and also allow job-sharing (which may be a good principle for female staff who may want to work part time as they also have family commitments).

Response
He said this is a new modality. This requires Policy decision and discussion with jäbanan Perkhidmatan Awam. They will need to study this method and look at its advantages and disadvantages.
28 October 2014

The MMA ExCo had a meeting with the Minister of Health, YB Datuk Seri Dr S. Subramaniam. Several important issues were discussed.

- We have appealed to the Minister that the Medical Sector should be exempted from the Personal Data Protection Act (PDPA). He agreed with us and will try to resolve this issue with his counterpart at the Ministry of Multimedia and Communication. However, as of now it is compulsory for all General Practitioners (GPs) to register for the PDPA.

- Continuing Professional Development (CPD) has been made compulsory in the new Medical Act. MMA and the CPD Committee of MMA are in the process of meeting the Ministry of Health (MoH) and Malaysian Medical Council Officials to finalise the details like number of CPD points required to renew the Annual Practicing Certificate (APC). According to the Minister of Health, the New Medical Act will probably be implemented by August 2016. The CPD Committee Chairman and members of the CPD Committee are requesting for MMA to provide the CPD points required for the renewal of the APC for all its members, which include the GPs or specialists.

- We have proposed to the Minister of Health that all costs incurred for attending CPD courses be tax-exempt.

- FOMEMA - the Minister has asked MMA to prepare a comprehensive letter regarding fees for medical examination and X-rays for foreign workers which has not increased or been reviewed since its implementation 17 years ago.

Many other issues were discussed and was highlighted by the President in his report of the meeting.

30 October 2014

The 43rd Annual General Meeting of MMA Terengganu was held. The meeting and election of Office Bearers was conducted by President-Elect Dr Ashok Philip, Immediate Past President Dato’ Dr N.K.S. Tharmaseelan, and Hon. General Secretary Dr Ravindran Naidu. The MMA Terengganu Branch was considered null and void due to certain irregularities earlier in the year at their AGM. The meeting went on very well with many junior members in the Committee. The Chairman of Terengganu Branch is Dr Dayal Krishnan.
5 November 2014
Meeting with Secretary General (KSU) from MoH. Issues discussed were:

1. Private Sector
   - Non communicable diseases – like Diabetes Mellitus and Hypertension are being poorly managed, making Malaysia one of the countries with the highest ratio of chronic renal failure and renal diseases. There was a pilot study of services that was to be outsourced to the private GPs but was suddenly aborted due to reasons only known to the MoH. The MMA is requesting that the outsourcing of these services to the 6,000 GPs or more, be reconsidered. We can ensure the highest quality and best treatment for patients.
   - Domiciliary Care
   - FOMEMA, PERKESO, EMGS

2. Public Sector
   - Promotions in Government Service – there has been a reduction of promotions in the MoH over the last two years especially for JUSA C and grades above that. If this continues there will be a migration of specialists to the more lucrative private sector. Specialists from the area of Public Health, Occupational Medicine and Family Medicine feel left out as there has been a delay in their promotions.
   - Overseas Leave – senior specialist have difficulty in leave approvals for presentations overseas. MMA has requested for this process to be simplified and applications to be submitted and approved online.
   - Limited Private Practice (LPP) – we are still waiting for the expansion of this to other hospitals in the country, as such services will help retain specialists.
   - Flexi System for Consultants – the introduction of this system will encourage specialists to remain in Government Service.

8 November 2014
A historic meeting was held between MMA, the Medical Practitioners Coalition of Malaysia (MPCAM) and the Islamic Medical Association of Malaysia (IMAM) at MMA House. It was a “get to know each other” meeting and several issues of common interest were discussed. All agreed that we should form a united front. This meeting was then followed by a discussion with the Malaysian Pharmaceutical Society and Malaysian Community Pharmacy Guild. Basically the discussion was about good dispensing principles and why dispensing should be done by the pharmacists. There was no mutual agreement or decision on anything.

18 November 2014
Attended the 55th MMA AGM Organising Committee meeting in Kota Bharu, Kelantan. MMA was represented by the President-Elect and HGS. A final decision was made to have the AGM on 29 May 2015 (Friday) to 31 May 2015 (Sunday). As official functions cannot be held on Thursdays in Kelantan as per the State Government Law, the ExCo decided to have it on Friday, Saturday and Sunday. I believe this is the first time we are holding the National AGM on those days. The venue decided by the Organising Committee is The Grand Riverview Hotel, Kota Bharu, Kelantan. The hotel is very nice and has been recently refurbished with several meeting rooms and a large grand ballroom. I am sure members will not be disappointed with this venue.
21 November 2014

SCHOMOS Kedah organised a Stress Management Workshop at Darulaman Golf Resort for two days (21 & 22 November 2014). There were more than 60 participants and mostly were junior doctors from Kedah, Perlis, Penang, and Perak. It was a very interesting workshop and I felt the privilege of being able to participate with the others. I was given a time slot along with SCHOMOS Kedah Chairman, Dr Arvindran Alaga. There were many questions and what was supposed to be 20-minute session expanded into an hour instead.

The Kedah Branch Annual Dinner was held that same night at Starcity Hotel, Alor Setar. MMA was represented by the President, President-Elect, HGS, and Hon. General Treasurer Dr Gunasagaran Ramanathan. This is MMA Kedah Chairman Dr Vasu Pillai’s second term in office. The chief guest was Kedah State Executive Council member, YB Dato’ Dr Leong Yong Kong. In his speech he mentioned that he is a Life Member of MMA. That was nice to know. It was encouraging to note that he is willing to work with MMA Kedah on the state’s healthcare issues. I wish to congratulate Dr Vasu Nair and his team for organising an excellent Annual Dinner; a very big thank you for inviting us!

Wishing You a Merry Christmas & a Happy New Year!

PUTRA MEDICAL CENTRE
PUSAT PAKAR PERUBATAN PUTRA

PUTRA MEDICAL CENTRE is a 150 bedded hospital strategically located in the centre of Alor Setar. We are expanding and growing with an 8th Level New Wing. In line of our expansion, we would like to invite applications for the following Resident positions:

SPECIALISTS
- Ophthalmologist
- Dentist
- Nephrologist
- Neurosurgeon
- Geriatrician
- Neurologist
- Intervention Radiologist
- Orthodontics
- Oncologist
- Obstetrician and Gynaecologist
- Rheumatologist
- Physician
- Endocrinologist

HOSPITAL POSITIONS
- Pharmacist
- Medical Officers
- Nursing Manager (With Post Basic Qualification Dialysis and Accident & Emergency)
- Staff Nurse (With Post Basic Midwifery, Dialysis, Icu And Etc)

Please send CV, certificates, testimonials and photo (n.r.) to:
Human Resources Department
Putra Medical Centre
888, Jalan Sekera, Off Jalan Putra, 05100 Alor Setar, Kedah Darul Aman
Website: www.putramedicentre.com.my Email: hr@putramedicentre.com.my

For enquiries contact:
Dr Lim (016-440 8666)
Mdm Gan (012-582 0528)
Tel: 04-734 2888 Fax: 04-734 8882
ELECTION COMMITTEE

TO: ALL MEMBERS OF THE MALAYSIAN MEDICAL ASSOCIATION

Dear Member,

NOMINATION FOR THE POST OF PRESIDENT-ELECT, HONORARY GENERAL SECRETARY, HONORARY GENERAL TREASURER AND TWO HONORARY DEPUTY SECRETARIES (2015-2016) OF MMA

The Election Committee of the Malaysian Medical Association hereby calls for nominations for the post of President-Elect, Honorary General Secretary, Honorary General Treasurer and two Honorary Deputy Secretaries of the Malaysian Medical Association for the year (2015-2016).

In compliance with Clause 7 (8), (9), (10) and (11) of the MMA Constitution, nominations are called herewith for the above posts.

No member may offer themself / herself as a candidate for more than one of the following posts of office bearers: President-Elect, Honorary General Secretary, Honorary General Treasurer and Honorary Deputy Secretary.

Please note that the candidate for the post of President-Elect for 2015-2016 shall be a MMA member in benefit from EASTERN REGION. Candidates for President-Elect must be Life or Ordinary Members of MMA of at least five (5) years' standing and who shall have served in Council or in a Branch Committee for at least two (2) years.

The candidates for Honorary General Secretary, Honorary General Treasurer and two Honorary Deputy Secretaries can be a life member or ordinary member in benefit from ANY Branch of the MMA.

ALL NOMINATIONS FOR THE POSTS OF PRESIDENT-ELECT, HONORARY GENERAL SECRETARY, HONORARY GENERAL TREASURER AND TWO HONORARY DEPUTY SECRETARIES (2015-2016) MUST BE RECEIVED BY THE MMA ELECTION COMMITTEE BY 5.00 PM ON FRIDAY, 13 MARCH 2015 CANDIDATE, PROPOSER AND SECONDER MUST BE MEMBERS IN BENEFIT.

(Candidates wishing to withdraw the nominations can do so by Friday, 20 March 2015 by 5.00 pm).

Nomination papers are available from the MMA Secretariat at the above address. Nomination papers should be addressed to:

THE HONORARY SECRETARY, MMA ELECTION COMMITTEE
4TH FLOOR, MMA HOUSE, NO: 124, JALAN PAHANG
53000 KUALA LUMPUR

Please take care to fill the Nomination Forms correctly and legibly as improper or incorrect filling may lead to disqualification. Submission of nomination forms by fax will not be accepted.

Yours sincerely,

DATO' DR P. VIJAYA SINGHAM
Honorary Secretary
Election Committee
Malaysian Medical Association
J USA “P”!

When the going gets tough, the tough get going. Heard that before? Popularly meant to mean “when the situation becomes difficult, the strong will work harder to meet the challenge”. Mind you, it also can mean “when the situation becomes almost impossible, those who are truly strong will be wise enough to pull out, rather than be totally decimated.”

Jump ship you may say. Maybe that is the smartest thing to do. After all you are still serving the same public, same country and even now the same employer! Yes my friends, you will be potentially serving the same master as the private sector is very much Government-linked now. It has been a busy time as usual, shaking hands and taking photos over the last few months. I wish I was shaking your J USA appointment letter but I am sorry that will not be the case for a while. In a direct one-on-one conversation with the Ministry of Health (MoH), we would probably see 100 or so J USA posts being announced soon but they will specifically be for our brothers and sisters in the family medicine side. They too have waited long and hard and I am happy at least some of them will finally be rewarded. There may be a few sporadic J USA posts for our friends in hospitals but I suspect it will likely be a conversion of existing temporary posts to permanent ones. For the other few hundred (maybe bordering 1,000) who have applied, just hang in there a little more! As for those who do not want to rough it out, you may consider joining the master employers more lucrative form of service to the rakyat (some say Indonesia) via the private sector. That is the only J USA I can guarantee will generate more profit by the end of the month. It is called the J USA Private. Being a urologist I suddenly have this intense desire to say, “J ust ‘P’ it”!

This J USA I believe, is the sole way to generate more income. However, if you really do not mind spending little time at home and would be happy to spend your weekends away from your family and passions, then feel free to use the great trump card from the ministry which would allow you to work after office hours on weekdays and weekends. Yes, you can greatly improve the bank balance with that and I wish you well. Though, in my personal opinion, that it not a very sensible definition for ‘quality of life’.

There needs to be a proper balance in everything. Be honest to yourselves about how much control you can have on the time you spend making the extra money. You will work and once again you will sacrifice!

Maybe we need a new approach, paradigm shift or a simple reality check. Yes, we have fought for the house officers, medical officers and specialists in the past, but remember, they are in the group with fewer choices in terms of employment. It is the consultants and senior specialists who have no real incentive to actually serve the public sector unless driven by some personal belief and satisfaction on an academic or professional basis. MoH will lose these people. That is the truth. Maybe they are not really bothered because as I told you the MoH is not about free service versus paid service; it is about service to its people and delivering the best it can. So if you are a top notch physician and leave to work with a private hospital with a Government-Linked Company connection, you are still serving the same master and community. Yes, if you decide to leave the country then it is a concern and they have a talented organisation to cajole you back. They offer both private and public services. They just want you back to serve your people and country.

So let us stop whining and decide what you or your family need and want.

SCHOMOS has taken upon itself to respect the fact that young doctors need seniors who can teach. Medical students need clinicians who can guide. Trainees in subspecialties need trainers. Poor and middle class people, including myself, will find it impossible to afford the exorbitant private medical costs and will succumb to public services only to be ‘unserved’. Thus I believe that if we adopt a new employment scheme, just like what they have in a few countries around the world, there may still be hope.

My suggestion is simple. I am due for my J USA C for the past two years. I currently earn about RM12,000 and should be earning RM18,000 plus the car! So in essence I am an employee who is working for RM6,000 less than my worth. What about not giving me the J USA at all and just allowing me now to work the RM12,000 in value? In other words I should now only work three days a week. Then I would have two full days to do a private session. Potentially that may be better than the pay rise and a rebadged vehicle. This is not new. This is called the session system. It exists in the universities and I understand they are allowed three sessions a week to do something else during office hours. I am suggesting two full days off. I still wish to get my J USA at some stage because it will affect my pension and status in the ministry’s hierarchy. Now with the prospect of getting a pension, having a connection with the public hospitals and freedom to work almost half the time in private, I believe many will not leave.

This has been presented to the Minister and I will officially submit a proposal to see if it will be considered. I recently attended a meeting with the Malaysian Board of Urology and have ran this through them. As a subspecialty board, they too are extremely concerned about the haemorrhage in the public sector and seemed positive with the system we recommended. I have thought about this long and hard.

Another great hurdle to cross. But SCHOMOS has and will also do its best for you. Best wishes for the holidays and do not wait another year to go for a holiday with your friends and family. Do it now and if necessary get the J USA “P”!
It was an honour for the 54th National MMA AGM delegates to give Kelantan a chance at hosting the 55th National MMA AGM since 1977. We are currently in the early stages of planning the AGM activities, therefore information will only be furnished later on.

As a start, President-Elect Dr Ashok Philip and Hon. General Secretary Dr Ravindran Naidu attended the fourth meeting for the 55th National MMA AGM on 18 November 2014 and advised me to first introduce Kelantan and its history. Well, my state was first referred to in the notes of Ptolemy as “Kalantan”. It was said that it came from a dialect from North India describing the city of Koli, where Gautama Buddha’s mother was born. The word “Thana” was added to the name of the city, thus forming “Kolithana” or “Kolamtanah” which was finally changed to Kelantan. Some historians believed that the name Kelantan originated from “Kilatan” due to the frequent thunder strikes around the land. In the Ma Duanlin encyclopaedia, a place called “Ko-Lo” was mentioned, while other Chinese manuscripts describe a place called “Ho-Lan-Tan” or “Kou-Lo-Tan”. The etymology may vary, but many locals believe that Kelantan was a corruption of the word “Gelam Hutan”, also known as the swamp tea tree (Melaleuca leucadendron).

History showed that Kelantan survived many invaders from Funan and Khmer in the early 12th century to the official coronation of Long Yunus, a Malay ruler from Pattani in Southern Thailand, as the first ruler of Kelantan around 1760. Significant historical sites to explore would be Kota Bharu (especially Pantai Bachok), the first area invaded by the Japanese Army exactly after midnight on 8 December 1941, which subsequently lead to the fall of British power in Peninsular Malaysia within three days’ time. The remnants from this war have been well-preserved at the War Memorial Museum of Kota Bharu which was originally called “Bank Kerapu” (it was built by Mercantile Bank in 1912, on a land that apparently belongs to Nik Yusof, a renowned local chief.tain). During the invasion, the location was used by the Japanese as the kempetai’s military base, a secret police station for war coordination. Upon the fall of Japan and return of the British, Bank Kerapu continued to function as a bank until 1992, when it was turned into a war memorial by the Kelantan Museum Corporation. It houses more than a thousand exhibits relating to the war, including a mixt ure of tools used during the occupation such as the Japanese bicycle.

Kelantan is blessed with many tourist attractions. One of my favourites would be Istana Jabar (Jabar Palace) which has luxurious woodcarvings that showcase the excellent craftsmanship of the Kelantanese. It was built by Sultan Muhammad ii in 1887 for his grandson Long Kundur, but today it has been converted to a museum in order to share the uniqueness and beauty of this architecture with the world. There
is also a Malay Weapon Gallery which houses many unique weapons such as the ‘keris’ (dagger) and ‘pisau’ (knife). The name Jahar was taken from the tree that stands at the entrance, also known as “Flame of the Forest”. For more handicraft displays, you can visit the Handicraft Village and Craft Museum or “Balai Getam Guri” located within the culture zone. It has a variety of handicrafts, silverwares, and other traditional handmade items such as the ‘songket’ (brocade fabric). Demonstration of the making of songket and batik painting is also available. Do not forget to try the ‘nasi ulam’ with traditional ‘budu’ sauce when you are at Restoran Cikgu! The price and taste of food will surely prompt you to visit Kelantan more often. However, to truly understand the culture and roots of a Kelantanese, Muzium Islam or Dewan Syurga (Islamic Museum) is a must-visit museum. It was once known to be the Veranda of Mecca or ‘Serambi Mekah’. From there you will be able to see many artifacts and understand how the Islamic religion arrived at Kelantan and maintained a strong influence in the lives of its followers till today. Never forget to drop by Pasar Besar Siti Khadijah (Siti Khadijah Market), famously known for its vast variety of fresh seafood and fresh vegetables. It is mostly run by women. Apart from the usual fresh goodies like seafood, vegetables and a wide variety of fruits, you can also find ready-to-eat food like ‘ayam percik’, ‘nasi dagang’ and a variety of soup-based noodles, all tinged with the unique taste of Kelantan. Do not forget to also try the local desserts such as ‘kuih-muih’ (assorted cakes and pastries), ‘tempeh’ and a glass of hot milk tea, which is the staple drink for Kelantanese.

The sightseeing will not seem complete if you do not visit the Muzium Diraja Istana Batu (The Royal Museum). It was built in 1939 under the reign of Sultan Ismail I of Kelantan (1920-1944), as a wedding gift for his nephew Yahya Petra (1960-1979) who was the eventual successor of Kelantan. It has a pale yellow structure and served as the palace for the crown prince. It was then donated to the state and is now open for public viewing. The richly-furnished rooms will allow you a glimpse into the past royal life.

Yet, the best is still well-preserved and kept as a mystery; this is with reference to Istana Balai Besar (The Grand Palace), which is a single storey palace built by Sultan Muhammad II over 170 years ago, as the official residence of past sultans. It is believed that bullfights used to be held in the palace for official royal ceremonies until the mid-1900s. The palace is now used for official state functions and is not open to public. Only a few lucky men and women can enter the sacred place, but most will be satisfied to take a picture with the famous gates.

I personally hope that all MMA members can come and experience Kota Bharu. One of our family activities will include a sightseeing tour around Kota Bharu, where all the aforementioned places will be visited. So book your dates, 29 to 31 May 2015 for a fun-filled time in Kota Bharu!
The decisions in the recent High Court of Malaya cases of Abdul Razak Datuk Abu Samah v. Raja Badrul Hisham Raja Zezeman Shah & Ors [2013] 10 MLJ 34 and Gurmit Kaur a/p Jaswant Singh v. Tung Shin Hospital & Anor [2012] 4 MLRH 465 have caused some ripples within the medical fraternity. Casual conversations with colleagues about the subject, and mention of the two cases, show clear consternation: “Is it really true? That’s ridiculous!”

In the opinion of this writer the earlier decision (Gurmit Kaur) seems to suggest that in certain cases doctors will be liable if they fail to obtain the consent of the spouse, above and beyond obtaining the consent of the patient. The latter decision (Abdul Razak) appears to make spousal consent mandatory in other cases.

The purpose of this short article is to examine the impact of the above decisions and the effect they may eventually have on the liability of a surgeon to his patient in relation to the administration of proper advice.

**Gurmit Kaur Case**

Facts of the case (as gleaned from the judgement of the case)

Gurmit Kaur was informed by the Gynaecologist at Tung Shin Hospital that she had a large uterine fibroid. She planned to have more children and thought she was being admitted for myomectomy but the surgeon instead performed a hysterectomy. During the follow-up, she inquired as to when she could get pregnant again, and was shocked to find a hysterectomy had been done.

It is noteworthy that Tung Shin Hospital, where the operation was done, had a special consent form which was entitled “AGREEMENT BY HUSBAND/WIFE (For operations that may result in sterility)” and necessitated the signature of the spouse. This special consent form also specifically states that “THIS FORM SHOULD BE USED IN CERTAIN MAJOR GYNAELOGICAL OPERATIONS E.g., HYSTERECTOMY AND OOPHORECTOMY IF THE PATIENT IS MARRIED AND LIVING WITH HER HUSBAND”.

Abdul Razak Case

Facts of the case

The plaintiff in this case was Abdul Razak Datuk Abu Samah, the patient's husband.

The patient aged 71, who complained of abdominal pain and vomiting, was initially admitted to the Government Hospital in Temerloh, Pahang. At the Temerloh Hospital the patient was diagnosed with adhesion colic and treated conservatively with medication and intravenous fluids.

Medical Negligence: Is Spousal Consent Necessary?

Dato' Dr Sarjeet Singh Sidhu
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UniKL-Royal College of Medicine Perak
Member Ethics Committee
Life Member MMA, Perak

The decisions in the recent High Court of Malaya cases of Abdul Razak Datuk Abu Samah v. Raja Badrul Hisham Raja Zezeman Shah & Ors [2013] 10 MLJ 34 and Gurmit Kaur a/p Jaswant Singh v. Tung Shin Hospital & Anor [2012] 4 MLRH 465 have caused some ripples within the medical fraternity. Casual conversations with colleagues about the subject, and mention of the two cases, show clear consternation: “Is it really true? That’s ridiculous!”

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The patient in this case was Abdul Razak Datuk Abu Samah, the patient's husband.

The patient aged 71, who complained of abdominal pain and vomiting, was initially admitted to the Government Hospital in Temerloh, Pahang. At the Temerloh Hospital the patient was diagnosed with adhesion colic and treated conservatively with medication and intravenous fluids.
Throughout the patient's stay at Temerloh Hospital, the 1st Defendant Dr Raja Badrul Hisham, who was actually based in Hospital Kuala Lumpur (HKL), had kept track of the patient's condition by speaking to her doctors at Temerloh Hospital. Abdul Razak knew Dr Raja Badrul Hisham personally as he himself had previously been treated by the doctor.

When there appeared to be no improvement in the patient's condition, Abdul Razak rang Dr Raja Badrul Hisham and sought a transfer to HKL in order to place the patient under his care.

By the time the patient arrived at HKL, Dr Raja Badrul Hisham had left for a conference in another state. He left the patient under the care of his assistant, Dr Leong. At HKL, Dr Leong wanted to insert a Ryle's tube but the patient refused.

Whilst at the conference, Dr Raja Badrul Hisham kept track of the patient and eventually instructed Dr Leong to seek the consent of the patient and prepare for operation.

On the morning of the surgery, Dr Raja Badrul Hisham informed the patient of the need for surgery. He also spoke to the plaintiff (Abdul Razak) on the telephone about the surgery and got his (verbal) consent to proceed.

"Despite being strongly advised by the surgical team that she had to have the Ryle's tube inserted before anaesthesia was administered to prevent stomach fluid which entered into her lungs, the patient adamantly refused the tube."

The team finally decided to administer anaesthesia and insert the tube after induction of anaesthesia.

However, during induction of anaesthesia the patient regurgitated and aspirated a large volume of stomach fluid which entered into her lungs, causing respiratory failure that led to her death from aspiration pneumonia the following day.

The issues before the court were:
1. Whether defendants were negligent for performing surgery on the patient without the insertion of the Ryle's tube.
2. Whether the defendants' failure in preventing aspiration meant that the defendants had fallen below necessary and acceptable standard of professional care.
3. Whether the defendants breached their duties by failing to inform the patient of risks associated with surgery.
4. Whether the defendants owed the plaintiff (the patient's husband) a duty of care and that the defendants had breached this duty of care owed to him by failing to obtain the necessary prior consent from the plaintiff to proceed with the proposed surgery (this was alleged by the plaintiff).

On the first two issues the court appears to have found no negligence on the part of the defendants.

There was no necessity in resorting to the highly controversial point of seeking spousal consent just because, in the court's view, the factual matrix appeared to suggest that the husband was the decision-maker.

As to whether the defendants breached their duties by failing to inform the patient of risks associated with the surgery, the court noted:

"The... defendants failed to inform the patient of the risk of death from aspiration. In fact the increased risk of death because of her full stomach meant that the patient had not been informed of a critical risk factor that would have been necessary for her to take into consideration in making her decision to proceed with general anaesthesia and surgery... failed to discharge their duty of care owed to the patient to duly inform and advise the patient adequately and sufficiently of the inherent and material risks of proceeding with the surgery and anaesthesia without the insertion of a Ryle's tube. The... defendants had deprived the patient of such material information and caused her to consent to the surgery and anaesthesia without having her appreciate the grave risks involved in the same." (para 44) [Emphasis added].

It is submitted that the court's findings on this critical point alone were grounds enough to have found for the plaintiff, and nothing further need have been necessary. As in the Gurmit Kaur case, the end result in Abdul Razak could justifiably have been achieved without resort to the need for spousal consent. But the court went further.

The court went on to take special notice of the plaintiff's allegation (see Note 1 below) that by failing to get his consent to the proposed surgery the defendants had in fact breached their duty of care.

The court stated that, "In this case, even though the consent form did not require the consent of the plaintiff, the factual matrix of the case indicated that the 1st Defendant owed a duty to inform the plaintiff of the nature of the surgery and the inherent and material risk of the procedure, especially in light of the patient's refusal to have the Ryle's tube inserted. The involvement of the plaintiff in the patient's decision-making was obvious from the evidence. In the circumstance, it would have been prudent for the 1st Defendant to discuss the patient's medical condition and the proposed treatment and its material and inherent risk with the plaintiff before the surgery. In this regard, the 1st Defendant admitted that he could have done better." (para 46) [Emphasis added].

The court contended that the factual matrix of the case was such that it was clear that the plaintiff was the
decision-maker, and so this made it necessary to seek spousal consent; of course, with the need for spousal consent would come all its attendant ramifications.

Conclusion

Gurmit Kaur may have been rightly decided on the facts peculiar to that case; it is possible to argue that the case did not make the seeking of spousal consent mandatory in all, or even most, cases.

The decision in Abdul Razak may equally be justified and right, but it is humbly submitted that there was no necessity in resorting to the highly controversial point of seeking spousal consent just because, in the court's view, the factual matrix appeared to suggest that the husband was the decision-maker. This was an unnecessary extension of the law.

This paper has been an attempt, by a doctor, in arguing that the courts now appear to have made it a mandatory duty of care owed by a doctor to his patient to obtain spousal consent in certain cases and that in doing so the courts erred by unnecessarily creating new duties of care and extending the law.

Note:
1. Bear in mind the fact that the plaintiff is not the patient or her estate but is the patient's husband, Abdul Razak.
2. A detailed argument on this writer's point of view is presented in his article Spousal Consent and Medical Negligence: A Bridge too far? Which appears in the Malayan Law Journal of Aug 2014 (2014) 4 MLJ 2014 Reports i-xviii, wherein this writer, as a doctor, makes an attempt in arguing that the courts now appear to have made it a mandatory duty of care owed by a doctor to his patient to obtain spousal consent in certain cases and that in doing so the courts erred by unnecessarily creating new duties of care and extending the law.
3. For the sake of brevity and simplicity the facts as presented here will be meagre and so may appear inaccurate. For greater precision the interested reader is referred to the MLJ article alluded to on Note 2 above.

References:
1. Involve your spouses in medical decisions: Malaysian doctors. http://yourhealth.asiaone.com/content/involve-your-spouses-medical-decisions-malaysian-doctors#sthash.Siurqwcx.dpuf

Congratulations

The MMA congratulates:

Datuk Dr A.T. Kumararajah a/l Tambyraja

On the award of
Darjah Pangkuan Seri Melaka (D.P.S.M.)

By Yang di-Pertua Negeri of Melaka
Tuan Yang Terutama Tun Dato' Seri Utama Mohd Khalid Bin Yaakob

On the occasion of
TYT 's 76th Birthday

Datuk Dr Mohamad Ruslan Mohamad Amin

On the award of
Datuk Panglima Gemilang Darjah Kinabalu (P.G.D.K)

By Yang di-Pertua Negeri of Sabah
Tuan Yang Terutama Tun Datuk Seri Panglima Haji Juhar Bin Haji Mahiruddin

On the occasion of
TYT's 61st Birthday
Two recent events in Malaysia have brought to the fore the issue of drugs in sports. These are the disqualification of a Wushu Gold Medalist at the recently concluded Incheon Asian Games and the “breaking news” that a highly ranked badminton player had failed a doping control test at a world event.

Doping and its control is certainly not a new phenomenon in the current landscape of global sports and it is given prominence even to the extent that a sizeable portion of the hallowed Olympic oath, that a selected athlete takes on behalf of all the participants, is dedicated to the need to stay clear of drugs.

Doping control, initially spawned by the sports associations, now finds itself overseen by an independent global body, the World Anti-Doping Agency or WADA, headquartered in Montreal and funded by contributions from the International Olympic Committee and from signatory governments. Its underlying instrument of authority and enabling instrument is the WADA Code, first introduced in 2004, revised in 2009 and awaiting implementation of the 2015 version come January. All stakeholders in sport, including The International Olympic Committee, its continental organisations, National Olympic Committees, international federations of the different sports, national federations reflecting these sports, and major event organisers are obliged to be signatories of the Code and have to demonstrate compliance in its tenets to maintain their place in the sporting matrix. The Code implements its programmes through its Prohibited List, International Standards (for testing, laboratories and Therapeutic Use Exemptions), Technical Documents and Guidelines.

The anti-doping programme is dependent on four pillars — education, prevention, testing and sanctions. Whilst Education and Preventive measures are going on quietly, what takes centre stage in media and community is the testing and the sanctions that arise from them. Testing is done on urine and/or blood depending on what is being looked for in a particular athlete and the needs of his sport. This takes the form of either in competition-testing or random, unannounced out-of-competition testing. Samples are taken under strict conditions and sealed (tamper-proofed) and dispatched through an unbroken chain of custody to a WADA accredited laboratory, of which there are 33 in the world. In Asia, there is one each in Tokyo, Beijing, Seoul, Bangkok, New Delhi, and Almaty. Malaysia also used to pride itself with the one at Universiti Sains Malaysia, Penang, but unfortunately this laboratory lost its accreditation about a year ago.

The prohibited list is the key to the testing and sanctions programme. WADA issues an amended list every year which is fine-tuned yearly based on feedback, experience, consultation, and consensus before it is finalised by WADA’s List Committee each September in preparation for the following year’s new list.
The list contains substances and methods which are prohibited in sports according to their classes of pharmacological activity. For a substance to be included in the list it must satisfy any two of the following criteria:

- It is performance enhancing
- It is injurious to the health of the athlete
- It is against the true spirit of sports

Many in the list are medicines that are used in medical practice. If an athlete needs to use one of them for a genuine medical purpose he has to obtain a ‘Therapeutic Use Exemption’ or TUE approval which is issued by special committees based on applications from the attendant physicians. Therefore, medical practitioners must be fully conversant not only with the list (so that they know if they are prescribing a banned substance) but also with the process to apply for a TUE should they still need to prescribe this substance in the interest of their patient. Generally TUEs or even retrospective TUEs in an emergency will only be approved if the athlete needs the substance for his medical treatment and there is no equivalent or suitable alternatives which are not prohibited.

Samples taken from athletes are divided at the point of collection into two separate bottles named the A and B samples and sent securely to the laboratory. The Laboratory will test the A sample and keep the B for analysis should there be a contest on its results on the A sample. If the laboratory comes up with evidence of a banned drug, they will call it an adverse analytical finding (AAF) and send the report to the responsible authority. The latter will conduct an initial review to see if it is satisfied with the analytical evidence and will also perform due diligence to ascertain if the athlete has a valid TUE for the substance concerned or if there have been any substantial departure from the recommended procedures for the sample collection and dispatch. If there are none of these circumstances, the authority will scale the AAF to an ADRV (anti-doping rule violation). At this point the authority will initiate the process of informing the athlete, explaining his rights and calling for a hearing before a disciplinary panel to determine the sanction to be applied. One right the athlete can exercise is to have the B sample tested at his own cost. He could also elect to be present at the opening of the B sample. If he exercises this option, further action will be withheld until these results are known (in reality it is an extremely rare event for any dissimilarity between the A and B sample analysis).

Once these are all done, the athlete will be sanctioned in two Acts. Act 1 will be by the organiser of the event who will have the authority to disqualify the athlete from the event, withdraw medals and prize money. During this process, the “strict liability” rule applies and the athlete will pay the price even if his positive result was due to ignorance, innocence or if he was a victim of administration by one his entourage. Following this, the documents and evidence will be passed on for Act 2 to take place by the body which has the authority over the athlete in terms of his sport (international federation) or his country (national anti-doping agency). This is where a decision will be made as to how long the athlete will be suspended. There are rules and procedures for this and depending on the substance and the circumstances, there is room during a hearing for the athlete to seek and perhaps receive a level of mitigation on the recommended period of eligibility. In some instances the authority for both Acts are one and the same. During the period of ineligibility the athlete is not allowed to play any role in the sport whatsoever.

In Malaysia, doping control activities are led and coordinated by the Anti-Doping Agency of Malaysia (ADAMAS) which comes under the purview of the Ministry of Sports, and the National Anti-Doping Organization (NADO). These agencies conduct tests and education programmes for our national athletes and also assist sports organisers who wish to conduct tests during their events.

Whilst the dictum is “zero tolerance” to doping, it will be difficult to achieve a dope-free environment but efforts cannot be slackened to keep this to a minimum. Prevention, education, testing, and sanctions all have to play their part.

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**Briefing sports officials**
Abortion & Reproductive Health

I refer to the article entitled “Unintended Pregnancies, Contraceptive Usage and Maternal Health” written by Dr John Teo, published in Berita MMA July 2014. A similar article was also published in the OGSM Bulletin, a publication of the Obstetrical and Gynaecological Society of Malaysia (OGSM). The author and the professional associations must be congratulated for focusing on the vital message of the low use of contraception by the Malaysian population in the effort to curb unintended pregnancies.

Oral contraception was introduced a few years after Malaysia gained its independence. After more than five decades of independence and the availability of modern methods of contraception, we cannot claim success in the area of contraception utilisation. Since 1984 to 2004, the contraceptive prevalence rate has remained unchanged at around 52% among married women, while the total fertility rate continues to decline from 3.0 in the year 2000 to 2.3 in 2010. This suggests that abortion may be on the rise, although the abortion rate for Malaysia has not been systematically documented. Traditional methods of contraception account for more than 20% of the contraceptive usage, so clearly much more needs to be done by the medical profession in the education of the public and improving access to contraception.

The articles by Dr Teo focused our minds on the following facts:

- Unintended pregnancy can only have three sequelae i.e. abortion, miscarriage or live births.
- Abortions are a global problem; 48% of unintended pregnancies have ended up in abortion.
- In Malaysia: If 8 million women are in the reproductive age group, the estimated number of abortions in Malaysia per annum will be 224,000. This may be an overestimation but the bottom line is that there is very little reliable data on abortions in Malaysia.
- The number of Malaysian women dying from abortion-related complications is 5 to 8 per year under the Confidential Enquiries into Maternal Deaths data.

Therefore, abortions do occur in Malaysia but there are very few maternal deaths due to abortion-related complications.

Dr Teo’s article makes very little mention of the provision of safe abortion services. The medical professionals cannot afford to ignore this area of care if we want to do the best for our women in the reproductive age group.

There are another two inevitable facts we need to remember:

- Only women can get pregnant although a male is required for her to get pregnant! (Let us ignore artificial insemination for the purpose of this discussion).
- The difficult decisions about what to do with an unintended pregnancy have to be handled by women! (I have not heard a male being charged with baby-dumping)
Let us get another fact clear: abortions are not illegal in this country. The two professional associations (the MMA and the OGSM) together with the National Council of Women's Organizations (NCWO) were in the forefront of the movement that resulted in the amendment of the Penal Code relating to abortions in 1989.

It would be illustrative to quote in verbatim Section 312 of the Penal Code titled “Causing miscarriage: Whoever voluntarily causes a woman with child to miscarry shall be punished with imprisonment for a term which may extend to three years or with fine or with both; and if the woman is quick with child, shall be punished with imprisonment for a term which may extend to seven years, and shall be liable to fine”.

This section carries an explanation as follows: “A woman who causes herself to miscarry is within the meaning of this section”. This is self-explanatory. I last saw a woman who had intended to procure an abortion by inserting lalang (weed) leaves into the cervix and vagina almost 20 years ago. She died from sepsis despite prolonged treatment. If she had survived, she would have had the burden of being charged (but only if the doctor had reported it to the police!)

More importantly, doctors should recognise the impact of the exception clause that is stated after Section 312. It was this exception that was inserted after the amendment of the Penal Code relating to abortion in 1989 – “This section does not extend to a medical practitioner registered under the Medical Act 1971 [Act 50] who terminates the pregnancy of a woman if such medical practitioner is of the opinion, formed in good faith, that the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to the mental or physical health of the pregnant woman greater than if the pregnancy were terminated.”

The impact of this exception grants the power to a doctor (registered medical practitioner) and not necessarily a specialist to make the decision regarding termination of pregnancy. For this purpose, he must form an opinion in good faith that on the balance of probabilities her life is in greater danger from continuing the pregnancy. The other view that the doctor could hold is that she may have an injury to her mental or physical health. This is a very liberal definition and does not place the burden of being charged (but only if the doctor had reported it to the police) on the patient.

This exception does not obviate a doctor from conforming to good medical practice in ensuring that there is good documentation of the case and his opinions, appropriate consent and conformance to all other regulations from licensing authorities. One should also not use drugs that are not licensed in this country or use existing drugs for off-label indications. There are many private abortion services available but they often operate in a secretive manner in this country. This sometimes leads to overcharging and less than sympathetic, or in some cases, downright rude comments to patients. That should not be the case if we want the quality of the service to improve. In fact there are exemplary practices that provide safe abortion services together with pre- and post-abortion counselling, as well as contraception advice.

Under the Syariah (Islamic) laws, the Fatwa (a ruling on a point of Islamic Law given by a recognised authority) allows for abortion to be carried out for foetus under 120 days of gestation, if the mother’s life is under threat or the foetus is abnormal. The civil laws are applicable to all Malaysians but the Syariah laws are only applicable to Muslims.

The professional bodies should be in the forefront of developing good practices and educating doctors regarding safe abortion services within the ambit of the law. To the credit of the Ministry of Health, a clinical practice guideline on “Termination of Pregnancy” has been issued in 2012 but the implementation and practice is still patchy and very much dependent on individual opinions.

Malaysia is a member of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the International Conference for Population and Development (ICPD) Programme for Action which upholds women’s equality and rights to universal access to family planning as well as sexual and reproductive health services including contraception and abortion.

The management of family planning in Malaysia is in the context of maternal healthcare by the Malaysian Government. Prior to 2011, only married women were able to obtain contraceptive services from the public health sector. Single women who are usually young and not financially independent may face problems in accessing the services. Even though contraceptives may be available to all in the private healthcare sector, this is at a higher cost and may not be affordable to those who are poor.

In addition, many national demographic and health surveys conducted to gather sexual and reproductive health data involved only married women. The exclusion of young unmarried women who may be sexually active may have led to a lack of comprehensive evidence for development of sexual and reproductive health programmes that may benefit all women regardless of marital status.

Three studies were carried out in Malaysia on the issue of abortions with funding from the World Health Organization. I was part of the team that conducted these studies which have now been published in various peer-reviewed journals.

These were:

1. Survey on knowledge and perception of medical students on abortion.
2. Study on medical officers’ knowledge, attitude, and willingness to provide abortion-related services as a reproductive right of women.
3. Study on reproductive rights and choice: insights from women on pregnancy termination.
The Findings

Survey on medical students:
- About 70% of medical students (respondents) were aware on what was a safe abortion procedure, but less than one quarter were aware that the contraceptive prevalence rate (CPR) for modern methods in Malaysia is less than 40%.
- Generally students from the private university had a higher level of awareness on abortion issues and contraception as compared to those from the public universities.
- About 35% of them reported correctly that the first trimester is the gestation period beyond which menstrual regulation should not be performed.
- About 54% of them knew the definition of abortion (i.e. terminating a pregnancy before the foetus is viable, and viability of a foetus is taken as when the pregnancy is 22 weeks).
- 60% of them were aware that abortion is permissible under certain conditions, while 22% were of the view that abortion is illegal under all circumstances in Malaysia.
- More than 80% were of the view that foetus has the right to live (pro-life).
- About 22% approved of pre-marital sex, majority stated that sex education (including contraceptive information) should be introduced in schools.
- About 64% felt that contraceptive services should be provided to the unmarried.
- Over 80% stated that they would provide contraceptive information to unmarried persons, and pre- and post-abortion counselling in their future practice, but less than 20% would provide medical or surgical abortion services.
- About 90% agreed that there should be more training in general knowledge and legal aspects of abortion, including counselling.

Study on medical officers:
- Over 80% of doctors (respondents) have some understanding of abortion including what is a safe medical procedure, but have limited knowledge on CPR, abortion methods and their associated risks of complications.
- Slightly more than one third of the doctors were able to identify the preferred methods for first-trimester and second trimester abortion.
- Over 80% of doctors knew that abortion is legal under certain circumstances, but majority of them either did not know or were unsure about whether abortion is allowed in case of rape or foetal abnormalities.
- Most of the medical officers were conventional and “pro-life” in their attitudes towards sexuality and abortion.
- Majority of them either remained neutral (33%) or would resist (41%) in carrying out abortion under any circumstances when it is against their personal religious beliefs.
- Over 80% of them were comfortable in giving pre- and post-abortion counselling including contraceptive use; about half of them indicated that they would refer the women for safe abortion services.
- Almost all of them indicated that some training in abortion-related issues should be included in the existing medical curriculum.

Study on women who had undergone abortion:
- Majority of the respondents have poor knowledge of sexual and reproductive health (SRH): inadequate contraception information (OC pills and IUCD are most commonly known), unaware of the early signs of pregnancy, not knowing complications of abortion, access to related knowledge, and service provision was lacking.
- Most of them viewed abortion as a sin and religiously unacceptable and that abortion is illegal - there are mixed reactions of post-abortion emotions (relief or regret).
- Financial constraints and large family size were cited as the main reasons leading to abortion, and medical abortion (MA) is preferred as compared to dilatation & curettage (D&C) and manual vacuum aspiration.
- Most of them tended to make their own decisions to abort although joint decisions were made for some (particularly those who were married).
- The expressed needs include: more information on MA, better understanding of SRH issues relating to unintended pregnancies and abortion related concerns, information on shelter facilities, and setting-up of mutual agreement between pregnant women and prospective adopters.

The researchers suggested the following as an action plan:
- The Ministry of Health (MoH) as the lead agency in the provision of care as well as in setting standards for the provision of such care should take the lead in developing a guideline on the provision of safe abortion services which takes cognisance of the current medical and surgical developments in this area as well as various international commitments by the nation in improving the care of the pregnant woman and the child. All stakeholders should be involved in the development and implementation of this guideline. This has now been accomplished.
- There is a need for the Government to implement a comprehensive reproductive health policy to build on previous advances in this area which have currently stagnated and unlikely achieve the Millennium Development Goals without fresh strategies and greater political commitment.
• Appropriate training in abortion such as general knowledge, legal aspects, pre- and post-abortion counselling and abortion procedures, as well as safe abortion care should be included and well integrated into the existing medical curriculum.

• Medical students should be given (and encouraged to acquire) good knowledge of reproductive health including family planning. This must not be derailed by the personal preferences and prejudices, if any, of the teachers.

• There should be continuing professional development (CPD) programmes for all healthcare professionals which inculcate contemporary reproductive health issues.

• The use of appropriate abortion technology and the availability of equipment, supplies, standards or technical guidelines and referral mechanisms should be made known to medical practitioners.

• Policy changes are needed to address weaknesses in our schools’ sex education programme, provision and promotion of comprehensive contraceptive services. The MoH and other agencies should reinvigorate the previous existing mechanisms of coordination and provision of contraception to women at ground level. Managers of health should use contraceptive prevalence rates as their key performance indicators.

• Women as well as current and future healthcare providers should be educated on the current status of the laws with regards to abortions in Malaysia.

• There should be a review of the Ethical Codes of the regulatory professional bodies and national medical associations with regards to abortions so that current international frameworks on human rights and medical ethics are reflected in the guidance provided to registered medical practitioners in this country. Ethics will have to take into account the boundaries set by religious bodies of various faiths while at the same time reflecting the need to provide for individual patients needs and requirements after informed consent.

Work should be ongoing in these areas by committed caregivers with the interests of women in mind. The law should form the framework of whatever we do in Malaysia. It is clear that the law is moderately permissive although abortion on demand is not indicated if there is no risk to life or injury to the mother. This is where doctors need to play their role by being fully informed about the law and performing their tasks ethically. If a doctor has religious objections to the procedure of abortion, he is ethically obliged to refer to a colleague who may perform it within the ambit of the law and not impose his own convictions upon the patient who may not subscribe to it.

I look forward to the day when our professional bodies take a leadership role in advocating the rights of women as they did in 1989. Much more can be done than what is being done presently. For one they could be in the forefront in providing clarity of thought and education when there are sensationalist headlines about abortions, baby dumping, and the provision of contraception to those in need.

Reference:

A woman finds Aladdin’s magic lamp. She starts rubbing it and a Genie comes out as usual. The woman looks at the Genie and asks him to grant her the following wishes:

• I want my husband to have eyes only for me
• I want to be the only one in his life
• I want that when he gets up in the morning I’m the first thing he grabs and takes me everywhere he goes.

The Genie turned THE LADY into an iPhone 6

Humour
Remembering Aceh: 10 Years after the tsunami

A decade ago on Boxing Day, 26 December 2004, the tsunami struck a devastating blow to many countries. The worst hit were Indonesia (Aceh), Sri Lanka and India. As a young psychiatrist at Hospital Kuala Lumpur, my first instinct was to volunteer on the MERCY Malaysia mission to Sri Lanka with the added benefit to the mission of being a native Tamil speaker.

But the need for psychiatrists at home was too great, and I was not allowed to go. However as the devastating effects of the tsunami became more and more apparent, I could not ignore the desire to make a difference. I persisted and was granted six months’ unpaid leave by the Ministry of Health (MoH), to provide humanitarian services to the tsunami survivors in Aceh.

Getting Down to It

I began working with the International Medical Corps (IMC), a leading international NGO and was based in Banda Aceh. I started psychiatric and psychosocial rehabilitation projects in the districts of Banda Aceh and the surrounding areas. Starting with a small team of one doctor, one psychologist and four nurses, I set up mobile clinic services for traumatised survivors with a special focus on patients who had pre-existing mental illnesses and who were further marginalised and traumatised survivors with a special focus on patients who had pre-existing mental illnesses and who were further marginalised and neglected after the tsunami. The large numbers of displaced people living in makeshift barracks lead to the further separation of family members and the breakdown of the hitherto closely-knit family support systems. This made the job even more challenging.

In a matter of six months, my team had treated more than 1,200 patients in the two districts alone. Many of them suffered from Post Traumatic Stress Disorder (PTSD), depression and psychosis. Along with purely clinical services, we also organised psychosocial activities which included recreational, sports and religious activities that helped restore normalcy to the lives of those psychologically affected by the disaster. “Tahilian” or mourning ceremonies were organised in the camps and these were deeply appreciated by the displaced people in the camps who did not have the means to mourn the dead in a culturally appropriate manner.

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Perdana University
Member MMA Wilayah

I was entrusted to provide leadership to the psychosocial working group, comprising a consortium of NGOs, International agencies and Government bodies including the provincial health office.
Cultural Awareness Brings Success

One significant psychosocial project that we designed was the erection of two “Quiet Houses” at the site of the mass gravesites in Aceh Besar. One of these gravesites near Banda Aceh contained approximately 45,000 bodies, buried there unceremoniously and in haste.

The “Quiet House” served to act as a place of rest and prayer for families who had otherwise had to line up by the roadside to do the same. It was built and the surroundings landscaped with the help of the local community in the spirit of gotong-royong. This “Quiet House” was later visited by the President of Indonesia who expressed his appreciation and indeed was visibly moved by what he saw.

I also volunteered to run the psychiatric clinic once a week at the only mental hospital in the province, the Rumah Sakit Jiwa at Banda Aceh. Despite the obvious need, Aceh continued to have only three psychiatrists to serve a population of 4.2 million people in the whole province and my weekly clinic was deeply appreciated by the hospital authorities who were tremendously short staffed.

Six months went by quickly and there was still much to be done. In the meantime I faced a dilemma as to whether I should return to Government Service in Malaysia or continue my work in Aceh.

The decision that I took changed my career pathway forever. I took the bold step of resigning from MoH to stay on in Aceh. The IMC expanded my scope to provide leadership in psychosocial and mental health services to all their operational districts in the whole of Aceh. I lead a province wide team which included Dr Pamela Smith, an Assistant Professor of Psychiatry from UCLA.

We also reached out to the traditional healers (dukun) in Aceh. We conducted regular workshops with the healers to explain issues of mental illness and together plan the rehabilitation of the mentally ill without undermining the cultural and spiritual components of their treatment. The workshops resulted in increased numbers of referrals to the more formal service as well as cross referrals to the traditional healers. This resulted in the dukuns playing a valuable role in ensuring patients complied with the rehabilitation therapy and they in fact often provided the spiritual support that was much needed in the healing process of the mentally ill.

Recognising that the issue was a far-reaching one, my team also organised community awareness programmes in all our operational districts in Aceh. These programmes involved religious leaders, community leaders, teachers, police personnel and women groups to discuss mental health issues with the aim of overcoming the stigma attached to the mentally ill.

These programmes were the starting point of a campaign to “unchain” an estimated 800 so-called “mad” patients all over Aceh. Many of these were literally in cages, locked rooms or simply chained to a pole!

Our team managed to unchain a total of only 120 patients over a period of three years as clearly the process not only involved closely monitored treatment modalities but also winning support from the families and communities that often were not forthcoming.

Local Knowledge Transfer to Ensure Progress

It soon became clear that parallel services had to cease, to be replaced by a more coordinated effort to ensure a sustained and long term clinical and psychosocial programme in Aceh. I was entrusted to provide leadership to the psychosocial working group, comprising a consortium of NGOs, International agencies and Government bodies including the provincial health office.

I provided technical input to start community mental health services in Aceh by instituting a province-wide training programme in mental health for nurses who had until then, like their counterparts in the rest of the country, no training whatsoever in mental health.

Kick-starting the programme was an uphill task as it involved a great deal of advocacy to convince local authorities of the need to make budgetary allocation for mental health training and in particular community mental health services.

Despite the challenges, I did not want to lose that golden opportunity to initiate a change that would align Aceh with the worldwide paradigm shift; away from custodial
institutionalised care of the mentally ill towards a more humane, community-based approach.

Ultimately we succeeded and now community mental health service is firmly established in the whole province of Aceh. I also started campaigning for the training of doctors in mental health, with funding from the European Union. With the community mental health team comprising of trained doctors, nurses and village volunteers, my dream of providing dignity to the mentally ill by establishing a community-based approach was finally realised.

Compounding the difficulty in treating the mentally ill was the fact that Aceh and the rest of Indonesia did not have proper guidelines for providing community mental health services. I initiated negotiations with the Royal College of Psychiatrists, UK, to have the world famous book “Where There Is No Psychiatrist” to be printed and distributed to all the primary health centres throughout Aceh. I edited the original version and made it suitable for the Indonesian situation; hence the birth of “Ketika Tidak Ada Psikiater”. This book is now being used as a standard guideline for community mental health services in Aceh.

I also authored the book “Guidelines for Psychiatric Nursing Care” (2005) which had been distributed to nursing schools throughout Aceh. Dr Pamela Smith (UCLA) and I also authored the “Pocket Book of Psychotropic Drugs” (2006) in Bahasa Indonesia.

In October 2007, I joined another organisation, CBM International, with consultative status to the World Health Organization, and started a new project called “Aceh Psychosocial Rehabilitation Programme”. The activities of this programme were an extension of the programmes I handled whilst with IMC.

Later, I moved on to be based in Jakarta, where I advised the Ministry of Health Indonesia while still overseeing the development in post-tsunami Aceh.

My main aim was to ensure that the most vulnerable and inaccessible populations with mental health problems be reached and helped, therefore, I also spearheaded the creation of the mental health law for Aceh, which was the first and even today is the only province in Indonesia to have such a law. This law or Qanun, aims to ensure respect and dignity to the mentally ill and guarantee that they have access to acceptable standards of care.

Moving on Beyond Aceh

I went on to set up similar services in Padang Sumatera after the Earthquake (2007) and the Volcanic eruption of Gunung Merapi in Jawa (2009) – always using the disaster as an entry point to set up long term sustainable services.

Beyond Indonesia I also worked in community developments and in setting up mental health services at post-typhoon areas in Philippines. I am also involved in establishing services in Southern Philippines as part of trauma counselling in the implementation of the peace accord.

Currently, I am engaged in the capacity building of psychosocial rehabilitation counsellors for ravaged Timor Leste which obtained independence after a bloody and deeply traumatic 30-year war with Indonesia. I obtained European Union funding to set up psychosocial services in the capital city of Dili which is up and running now.

Indeed the crises of disasters provided opportunities for long term sustainable development of community mental health services in not only Aceh but other countries in the region as well.

As I look back, I am pleased to see much has changed in Aceh. Today, 10 years after the unimaginable destruction caused by the tsunami, the people of Aceh have demonstrated to the outside world that with strong commitment and faith, such a fractured society can again stand up and be counted.
2014 was not one of our best years. As the saying goes: there will be ups and downs. This time around we in Malaysia had some amount of ‘downs’ but we did survive them pretty well. Almost all events that placed a mark in our history had some medical relevance, thus as doctors we were invariably affected.

The year 2014 started with one of the longest period of low water levels in the major dams in the Klang Valley due to a long-standing draught. Most experts could not explain the rare phenomenon in a tropical country like Malaysia where a good rainfall would be expected throughout. From a medical perspective, it would mean a higher rate of some infectious disease and the potential consumption of polluted water.

We had low levels of water in the tanks and no water in the pipes but somehow there seems to be enough water for the Aedes mosquitoes to multiply in greater numbers, thus causing a record high number of dengue cases amongst our population. This was another cause for concern among the medical care providers as there were hardly any beds left, both in public and private hospitals, during the critical months of the epidemic.

March 2014 was definitely a tragic month as we have since lost MH370, with no traces of it till now. What was more shocking but comparably saddening, was MH17’s downing in Ukraine which simply added on to our nation’s grief. We were plain unlucky, and never in our wildest imagination would we see ourselves being hit by two catastrophes within the same year. Medical personnel from psychological experts to forensic specialists had their list of duties overflowing when these two unfortunate events occurred within months of each other.

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We were not spared from the issue of drug doping and two of our athletes/sportsmen-women were tested positive for restricted or prohibited drug types, thus causing undue stress to the governing bodies. Medical doctors involved are busy defending the athletes concerned, but turning the reports around have proven a difficult task.

In the medical fraternity we had so many issues that left doctors wondering (perhaps still wondering) on the final conclusion of GST and Personal Data Protection Act. Both of these issues have a great value to the nation but the details need to be worked out for the doctors and patients. This may not be bad news for us but we are still worried about its final impact on our patients.

The year 2014 also marked the passing of two prominent and well-known Past Presidents: Datuk Dr Kanapathipillay Sarvananthan and Dato’ Dr Khoo Kah Lin. Both of these men had served MMA for long periods of time before holding office as President, and the two physicians had made significant contributions to the area of healthcare in Malaysia. May their souls rest in peace.

I hope we will not see another 2014 and shall be blessed with a fresh start in 2015. We will face challenges but the worst is to face catastrophes. Medical doctors will be involved in most instances, and that will be in our line of duty. We must be prepared - mentally, physically and financially - to respond to changing circumstances whether for the better or worse.

Best wishes for 2015!
At What Cost, Healthcare in Malaysia?

DR H. KRISHNA KUMAR

What’s driving the increase in healthcare costs in our country? The cost of healthcare in Malaysia has been on an upward trajectory in recent years.

Such increase in costs are the inevitable consequence of the country’s aspiration to reach the status of a developed nation by 2020, which requires numerous standards to be fulfilled.

Many issues are in play when you talk about the increase in costs. The increase in minimum wages has increased the cost of employment of clinic staff, with wage bills increasing by more than double.

The Private Healthcare Act 1996 has brought more new regulations, which require clinics and doctors to modify their premises to comply with these standards. However, it has to be said that such standards improve the safety of care given to patients.

In recent years, clinics need to renew the registration of their clinics at a regular basis, which has a cost attached to it, especially as they need to be inspected prior to registration.

The professional fees of doctors are controlled by the Private Healthcare Act 1996. These fees have already been given a maximum ceiling. However, unfortunately, the cost of hospital care is not controlled, and continues to increase.

This dichotomy in fees should be addressed. Either both fees should be controlled, or both be allowed to be determined by market forces.

The cost of drugs is increasing, although the availability of generic drugs has somewhat circumvented some of this increase. However, even some generic drugs are now more expensive.

Personal Data Protection Act (PDPA) 2010

We are one of the very few countries (compared to most Western countries) who are mandating the healthcare sector to comply with this.

We already have the Malaysian Medical Council monitoring the actions of doctors, especially in their professional handling of patients and patient information.

Further laws can complicate matters, what with other parties involved. Also, there’s a cost factor in the form of an annual registration fee.

The Trans-Pacific Partnership Agreement (TPPA)

The Trade and Industry Ministry is embarking on a discussion with 11 other countries to sign this agreement. It may look good for trade, but the implications are immense for the healthcare sector.

First, patented drugs will cost more. In addition, these drugs will see their patent period extended, making such drugs more expensive for a longer time.

“Patent linkage” further delays the introduction of generics for up to two years.

“Data exclusivity” would also cause companies planning to produce generics to delay their production. This is because they would need to create their own clinical studies to prove the efficacy of their generic, or pay royalties to the original company to produce the generics. This would further increase the price.

Goods and Services Tax (GST)

Healthcare may appear to be tax-exempt, but there will be increased costs.

Yes, professional fees are regulated and fixed, and hence, will not have a GST tax as they are tax-exempt.

However, other hospital and clinic costs are not tax-exempt. The other services provided will now need to be documented and charged. These will usually have a GST. Only then, can clinics and hospitals be able to claim back the GST that they are paying for the purchases they are making.

In the end, it is the consumer who will have to pay for all these costs.

I do not wish to be the bearer of gloomy news, but as things go, it’s not looking too bright.

We, the people of Malaysia, should make an effort to have a say in this matter, in order to safeguard our future.

Dr H. Krishna Kumar is president of the Malaysian Medical Association (MMA). For further information, email starhealth@thestar.com.my. The information provided is for educational and communication purposes only and it should not be construed as personal medical advice. Information published in this article is not intended to replace, supplant or augment a consultation with a health professional regarding the reader’s own medical care.
MMA Proposes ‘No-Fault’ Compensation System for Quick Payout

BY ANNIE FREEDA CRUEZ

PETALING JAYA: The Malaysian Medical Association (MMA) will submit a proposal to the Government to introduce a “no-fault” compensation system for those who suffer personal injury through medical mishap or clinical negligence. MMA President Dr H. Krishna Kumar said the time has come for Malaysia to have such a system, under which a fixed award structure will be drawn up to provide appropriate compensation to those affected by medical mishaps.

The “no-fault” system refers to a compensation scheme based on the principle that injured persons are entitled to receive compensation for their injuries, without having to prove fault against any other party, be it a doctor or hospital.

“The authors may highlight issues like the need for recommendations and remedies. Some people prefer the anonymity of the Internet, but nothing should prevent a patient from asking their doctor questions face to face.”

He said while patients feel they were better informed these days because of forums and blogs, they should seek clarification and answers from their doctor first before becoming “Google doctors”.

“It will also save doctors and courts a lot of time, while contributing to patients’ safety,” he said.

The no-fault compensation scheme, which has been implemented in six countries including New Zealand, Sweden and Finland, is now being considered by policy-makers in many other countries.

Krishna said the implementation of such a scheme will be a win-win situation for both patients and doctors.

In June this year, a nine-year-old girl was awarded RM2.78 million in damages by the Kuala Lumpur High Court in a suit against the Government, a hospital and 28 others for medical negligence which allegedly caused her to suffer brain damage.

In another case in 2009, a 54-year-old housewife sued the Government for RM7.5 million in damages for a wrong cancer diagnosis, which lead to the unnecessary removal of her left breast.

Kris hna said the implementation of GST will also increase costs for outsourcing of medical services in the laboratory and radiology sections.

With patients bearing the increase, he expressed hope that the government will look into increasing “sin taxes” for items such as alcohol and tobacco, as well as to encourage membership in health clubs and gyms to promote exercise.

It should also consider increasing the taxes or remove subsidies for salt, sugar and oil to discourage people from consuming too much of such items, which can adversely affect health.

‘Google Doctors’ are Not the Real Thing

THE Internet has brought loads of medical information to people’s doorsteps. While some may be helpful, there are many from dubious sources, said former president of the Malaysian Medical Association Datuk Dr N.K.S. Tharmaseelan.

“The authors may highlight their personal experiences and symptoms, but these can be misinterpreted by those reading them. Signs and symptoms may be the same for different diseases. There needs to be individual examination and lab tests, before treatment.”

He said while patients feel they were better informed these days because of forums and blogs, they should seek clarification and answers from their doctor first before becoming “Google doctors”.

“It’s essential that patients form a bond with their family doctor. The doctor can refer the patient to a specialist if needed. An interactive and satisfying relationship is essential in developing good doctor-patient relationship. Communication is important in overcoming this barrier. This is more effective than running to the Internet for recommendations and remedies.

Some people prefer the anonymity of the Internet, but nothing should prevent a patient from asking their doctor questions face to face.”

It serves no purpose to complain about a doctor on social media. Dr Tharmaseelan said.

“If the intention is to seek redress after a consultation or treatment, there are many avenues to seek assistance and advice. Venting on social media without knowing the facts shows malice, ulterior motive and ill intention.”

Under the Private Healthcare Facilities Services Act Amendment Order 2013, patients can request for a report from doctors and the hospital, if they are not happy. They have to be given a written report within two weeks, failing which, the patient can lodge a complaint with the Health Ministry.

“Hospitals are obliged by law to investigate complaints and explain to the patient, the results of the investigation. Patients can complain if they feel that charges are exorbitant. While doctors’ fees are fixed by the Government, hospital charges are not regulated. If the patient is still unhappy, he or she can proceed to the Malaysian Medical Council which has disciplinary and punitive powers to take action against the doctor and the hospital.”

Furthermore, the patient can file a civil suit for negligence, if he or she feels there was negligence or mismanagement.

A patient who chose to make unsubstantiated allegations against a doctor on social media would place himself or herself in a compromising position, he said, adding that defamation suits could be costly and the patient might end up paying a heavy price.
Seborrhoeic Dermatitis vs Scalp Psoriasis

Seborrhoeic Dermatitis (also known as seborrhoea/seborrhoeic eczema/scalp eczema, and in infants known as cradle cap) and Scalp Psoriasis are two common skin conditions that affect the scalp. It may be difficult to distinguish between the two, and even worse, both conditions share some similar symptoms. However, a simple visual examination of the scalp can help you make a clear diagnosis.

Briefly, Seborrhoeic Dermatitis is a common chronic relapsing form of eczema that predominantly affects the scalp and face. It is associated with proliferation of the various species of the skin commensal Malassezia in its yeast form where its metabolites cause an inflammatory reaction.

Scalp Psoriasis is a chronic subtype of psoriasis that may occur in isolation or with any other forms of psoriasis. It is characterised by thick silvery-white scales over well-defined red patches. It can spread to other areas such as the forehead, back of neck and behind the ears.

<table>
<thead>
<tr>
<th>Seborrhoeic Dermatitis</th>
<th>Scalp Psoriasis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occasional redness of the skin</td>
<td>Visible red patches</td>
</tr>
<tr>
<td>Oily scalp</td>
<td>Non-oily scalp</td>
</tr>
<tr>
<td>Itching of scalp</td>
<td>Soreness of scalp</td>
</tr>
<tr>
<td>Ill-defined diffuse localised scalp patches or thick yellowish crust</td>
<td>Occasional itching</td>
</tr>
<tr>
<td>Superficial folliculitis over the hairline, forehead and cheeks</td>
<td>Bleeding may occur when scales are scrapped off (Auspitz Sign)</td>
</tr>
<tr>
<td>Scales may be attached to the hair shaft</td>
<td>Affects typically the hairline, however it may extend beyond affecting the entire scalp</td>
</tr>
<tr>
<td>Can affect other areas such as face, back and chest that have increased sebaceous glands as well as eyelid margins (Blepharitis)</td>
<td>Severe cases with a lot of scratching, picking on scales and stress can lead to temporary hair loss</td>
</tr>
<tr>
<td></td>
<td>May have nail changes (commonly, pitting)</td>
</tr>
</tbody>
</table>

The key characteristics and features are outlined above to help differentiate and plan effective treatment measures, though both conditions do share some similar treatment.

Scalp Psoriasis

Shampoo:
- Coal Tar Shampoo
- Clobetasol Prorionate shampoo/scalp applicator
- Calcipotriol + Betamethasone Dipropionate scalp applicator

Topicals:
- Salicylic Acid, Anthralin, Corticosteroids
- Tazarotene, a Vitamin A derivative

Phototherapy:
- UVB combs

Oral medication:
- Methotrexate, Acitretin, Cyclosporin

Biologics

Seborrhoeic Dermatitis

Topicals:
- Keratolytic agents such as salicylic acid.
- Mild corticosteroids to reduce inflammation in acute flare.
- Calcineurin inhibitors such as tacrolimus or pimecrolimus.

Shampoo:
- Containing ketoconazole, selenium sulfide, coal tar or salicylic acid.
- Steroid scalp applicators.

Face, ears, chest and back:
- Cleanse using non-soap (non-lather) cleanser.
- Topical hydrocortisone – increase potency depending on severity and location.
- Topical calcineurin inhibitors.
On a wet Saturday morning, I headed to the home of Dr Sivanantharajah Kandiah. As I got out of my car in the compound of his home in the enclave of Taman Titiwangsa at the heart of Kuala Lumpur, I was awed by the rustic ambience as well as the rustle of the numerous coconut, jackfruit and mango trees. The aromatic holy basil plant and other plants were nestled in between the trees at his house compound. A pleasant but unusual sight to spot in the bustling city centre where the sight of the Petronas Twin Towers stand proudly!

Dr Kandiah was fondly known as Plastic Kandiah on the corridors of the hospitals during his heydays. This was to distinguish him from his younger brother, Dato’ Dr S. Kandiah, an Otorhinolaryngologist.

I was led to the living room by his current lady in hand, his gorgeous daughter, Dr Meena. There was a sparkle in his eyes and warm demeanour as Dr Kandiah received me. I was awed by his simplicity and frankly by his physical well-being and mobility. I had a heads-up of the series of serious personal health-related events over the last two decades that he had endured and the manner he had moved on in life in a dramatic manner.

As I tried to gauge his readiness to open up, my opening question to Dr Kandiah was whether he was willing to share his numerous life threatening ailments with me and the rest. In an energized manner, he remarked, “My experiences and challenges I endured whilst I was ill is more worthy to share than my professional career and success”!

He was born in Telok Intan (known then as Teluk Anson). He did his lower primary education in Taiping King Edward VII School. The Second World War created chaos to his schooling. He subsequently continued his upper primary and secondary education as well as his senior Cambridge at the Central College at Jaffna, in Ceylon (now Sri Lanka). Later, he moved over to Kandy and completed his Higher School Certificate (HSC) at Trinity College, Kandy. He fulfilled his ambition when he enrolled into the fame University of Colombo in Ceylon and obtained his MBBS in 1960.

As Dr Kandiah chatted with me, my eyes darted away with glances at his comfortable home, well-furnished with antique furniture and walls adorned with old photos in his living room. The photographs related an awesome storyline beginning with his parents, his late wife who was an Ophthalmologist, children and goddess that he professes to. I was immersed listening to this grandly man who related his life and career. Upon his return from Ceylon as a young enthusiastic doctor in 1960, he commenced his career as a houseman at J ohor Bahru. In between his hectic houseman days compared to the current era where loads of housemen are posted in each discipline, he went across the causeway to attend academic sessions and passed his Part 1 of the FRACS examination in 1962. He subsequently managed to get a posting as a surgical medical officer under Dato’ Dr Syed Mohammad bin Alwi (SMA) Alhady, the then Senior Consultant Surgeon at KL General Hospital. Dr Kandiah’s voice turned enthusiastic and appreciative when he spoke about Dr Alhady whom he looked up to as his mentor. Dr Alhady was a well-respected and an experienced surgeon. His foresight and efforts created a fertile milieu whereby young impressionable surgical trainees were given invaluable exposure. At that point of time, the Medicare Foundation from the United States would provide doctors with various specialities that were not developed locally like Urology and Plastic Surgery. These doctors would come to Malaysia and provide services for short stints. Dr Kandiah was given the task to assist them. This provided him a nidus to sharpen his knowledge and skills. He accompanied the surgeons during their stint in Malaysia. He started off as an apprentice, a point of contact to procure cases for them and later as a reliable as well as a capable assistant to them in the surgical field.
He eventually caught the attention of his local superiors and the foreign experts.

His perseverance paid off. He managed to secure a local Federal scholarship for a duration of two years and headed to United Kingdom to hone his skills and pursue his fellowship dreams. In addition to his Federal Scholarship grant he also obtained a stipend while working in United Kingdom. He managed his finances well and responsibly, and was able to send some money to his parents and siblings in Malaysia to sustain their livelihood. He was fortunate to have worked at St James and St Bartholomew hospitals at London. His pupillage stint under House Surgeon Sir Norman Tanner, the Consultant Gastroenterologist Surgeon motivated him and added dimension to the young surgeon in the making. He completed his FRCS Part 2 examinations (London and Edinburgh) in a remarkable time frame of 11 months. Dr Kandiah mischievously remarked he made the mistake to inform the Federal Scholarship authorities in Malaysia of his achievement. He was summoned home immediately before the two year tenure to serve in Malaysia!

He developed an interest in Plastic Surgery. This was as a result of his earlier involvement with Medicare Foundation Plastic Surgeons who worked in Malaysia. At that time, Dr Bernard L. Morgan, a Plastic Surgeon from Jacksonvile, Florida who made numerous visits to Malasya for work and Dr SMA Alhady recognised the immense potential and need for Plastic Surgery in Malaysia. Lo and behold, Dr Kandiah was offered a job as a Registrar in Plastic Surgery in Jacksonvillle Florida by Dr Bernard Morgan.

Dr Kandiah had to fulfill a ‘pre-requisite criteria’ to pursue his career in United States. He quipped his late father requested him to get married before his trip. His father was jittery to the fact that the dashing young man might get himself hitched to an American lass. Hence in 1966, he married Dr Sarojinidevi, an enchanting lady who also graduated from University of Colombo. Both of them went off happily to United States to pursue their postgraduate studies. Dr Kandiah obtained a Fulbright scholarship in addition to a local Federal Scholarship to undertake a subspecialty course in Plastic Surgery for four and a half years. He sat and completed the American Board of Plastic Surgery examination. He continued his stay in the United States to research in keloids for a year. His two children Meena and Sivakshanthy were born in US. He returned to Malaysia in 1970 with a handful of instruments he purchased for keloid and cleft lip surgery. He had the distinction of being the second trained plastic surgeon in the country and the first within the Ministry of Health. Dr V. Sivaloganathan, a medical lecturer from University of Malaya was the first trained plastic surgeon of the country having been sent to United States six months prior to Dr Kandiah’s departure.

Upon his return to Malaysia as a young doctor with fanciful thoughts, he wanted to purchase a Mercedes Benz car. His father discouraged him and advised him to purchase a house close to Kuala Lumpur General Hospital instead. The same house remains his one and only shelter all these years.

The era in the aftermath of the May 13 (1969) riots threw a spanner to his plans to set up a plastic surgery unit. There was also a notion during the era, plastic surgery was not an important discipline. Grudgingly, he worked as a General Surgeon initially. He voiced his frustration to his previous Chief of Surgery and his mentor, Dr SMA Alhady who had then retired. His persistence paid off. He caught the attention of the Director of Development and later the Director General of Medical Services, Tan Sri Dato’ Seri Dr Haji Majid Ismail. He was given a nurse, one hospital attendant and a garage under the roof of the Orthopaedic Department on 13 July 1970 to conduct his first plastic surgery. It conceived initially with one operative session and two beds for males and another two beds for the females. It subsequently increased to two operative sessions.

As time went by, the load of patients took a strain on the physical space of his workplace. Dr Kandiah organised a party (cost RM2,000.00!) at his home with Mr Charles Abraham, a photographer who meticulously kept records of photos of pre-and post-operative procedures. He invited the powers-that-be to his party. The adage “A picture says a thousand words” holds water here. After viewing all his operative photos, seeing his conviction for his speciality and hearing his loud cry “I want a plastic surgery ward”, the Department of Plastic Surgery was born in 1974 fathered by no less than Tan Sri Majid Ismail who accepted the proposal and gave a roof to sow the seed for a new specialty. With it, came an old but dedicated plastic surgery ward in association with Orthopaedic Surgery. Two medical officers were posted in the new department. He also had his own operating theatre time. The Department of Medical Photography came by too and Mr Charles Abraham helmed it.

Dr Kandiah was fortunate to have Tan Sri Majid Ismail as his a master (as he calls him!), an Orthopaedic Surgeon who himself made medical strides in the watershed of the history of Malaya during the period
of transition between the colonial years and the new nation.

In line with the Ministry of Health’s aim of providing coverage of plastic surgery services for the entire nation, Dr Kandiah in his “Operasi Pembedahan Plastik” frequently went around the country with one medical officer and one nurse every two months for one week duration between Ipoh, Penang, Kuantan, Kota Bahru. He developed interest in burn reconstruction, congenital deformities like cleft lip and palate. He was involved in the reconstructive surgeries at the Sungai Buloh Leprosarium with Dr KM Bhojwani who had the distinction of being a Surgeon (FRCS) and Physician (MRCP).

I could not help but stare and admire in awe at Dr Kandiah as he revealed historical events in a chronological order. At 81 years of age, he was witty and immaculate in his conversation. With a tinge of desolate, he mentioned he quit the Government Service in 1978 as he had financial commitments. He attended his wife’s funeral post operatively. Pneumonia set in and to make matters more precarious, he later developed encephalopathy. A six weeks stay in the intensive care unit with total parenteral nutrition (TPN) followed by another three months stay at the normal ward turned him into skin and bones as well as immobile. “You are unlikely to walk,” voices of the caregivers echoed in his ears. Beating all odds, he fought back gallantly. With a team of dedicated doctors, physiotherapist, other healthcare professionals as well as strong family support, he recovered well. He professes to mind over matter to overcome incredible obstacles.

His contribution to the profession extended beyond the doors of the hospitals. Tan Sri Majid Ismail, Dr SMA Alhady, Prof Balasegaran, Dr KA Menon, Tan Sri Dr Sinnadurai, Datuk Dr RP Pillai, Dr Lim Kee Jin, Dr Majid, and Dr Kandiah played a pivotal role in the setting up of The Academy of Medicine of Malaysia. On 10 June 2005, he was invited by the College of Surgeons, Academy of Medicine of Malaysia to present the 32nd Ismail Oration.

Dr Kandiah believes in the care of human sufferings; a surgeon needs technical skills, scientific knowledge and human understanding. Technical skills and scientific knowledge can be taught but human understanding cannot be taught, but rather inculcated. One who uses these with courage, humility and wisdom will provide a unique service for his fellow men and will build an enduring edifice of character within himself. He believes there is still enough turf for all to work harmoniously even though there is a remarkable rise in the population of doctors. A patient will be the best ambassador.
for the doctor as the good words of each patient to others will raise the profile of the caregiver. Patients are more enlightened (thanks to Google!) and empowered these days. Love your work, treat each patient as your family member and refrain from living in the ivory tower are the mantras of this incredible man. He chuckled as he said even house officers may have great ideas or may be able to pick up a near miss symptom or sign from a patient that will keep a patient going.

Malaysian Medical Association holds good memories for him. He has been a member of MMA for more than four decades. He thinks the organisation is growing at a steady pace and the members have more to contribute to propel the association and raise the stature of the medical fraternity ahead.

As we chatted into lunch hour, I excused myself. However, Dr Kandiah persisted to invite me to join him for lunch as he sat beside me. Hunger was not thought of that day for dinner as he served me with spoonful of the dishes! It was a coincidence to know that he loves to cook. Mutton paratel, fish curry and rasam remain his favourite dishes. He enjoys and indulges in marketing in the wet market by nudging the fish with his fingers to ascertain the texture and freshness. As much as he cooks, he enjoys relishing on good food. He and his colleagues who called themselves the ‘The Hard Up Millionaires Club’ used to manage a kitty to collect funds and indulge in their passion of eating.

A rather philosophical man with a hand that loves to hand out aid, he believes you receive more than what you give in life. The nature of what you get may be in cash, happiness or good health. We are commonly advised to save for the rainy. However, he joked that rainy days come only when you keep the money!

A word of advice from him to the young doctors of today is for them to try and have a mentor and master for them to succeed. For the surgeons out there; as fine dining is being challenged by fast food, fine microvascular surgery by laparoscopic laser and robotic surgery, coronary surgery by laser angiolysis – the classical “face lift” has gone to the museum, with the advent of suspension thread and syringes! So, we have to come to the inevitable conclusion that the only constant thing in this world is change. Unless a surgeon is determined never to change, he or she will have to consider adapting new techniques to improve results.

The octogenarian stands out as a pearl in our medical fraternity. As much as he has used the scalpel to remodel his patients, he incidentally went under the knife himself in a dramatic fashion. Dr Kandiah remains an enigma. His professional experiences and contribution as well as his personal life threatening battles are invigorating to all. He is a shining example of the aphorism “when the going gets tough, the tough gets going”!

As a parting question, I enquired from Dr Kandiah whether he had ever fulfilled his dream of 1970 of purchasing a Mercedes Benz. His sheepish answer was a firm “No”!

As I drove out of his house, I could not help reflect to the pleasant morning and the chronicle of life of the doyen of Plastic Surgery in Malaysia. The excerpts of the tune of the song “We are the Champions” by the British band group Queen and written by Freddie Mercury rang in my ears:

I’ve paid my dues; time after time,
I’ve done my sentence; But committed no crime,
And bad mistakes; I’ve made a few
I’ve had my share of sand kicked in my face; But I’ve come through.

We are the champions, my friends,
And we’ll keep on fighting till the end,
We are the champions, we are the champions,
No time for losers, cause we are the champions.
MMA Melaka's 32nd Annual Dinner (as there was no installation of new Chairman) was held on the 11 October 2014 at Equatorial Hotel, Melaka. This event, which was eagerly anticipated by the medical fraternity and friends, drew a large number of doctors and others who were ready to dine and dance the night away. It was attended by 350 doctors and guests.

The Melaka branch annual dinner this year was completely different from the ones held in previous years. This dinner event, which had Datuk Dr S. Pandurangan as the Organising Chairman, was in the form of an informal poolside dinner with the theme ‘Hawaiian Night’. There were no VIPs, no official speeches, no eight course dinner (but buffet style with a wide range of cuisine) and for the first time children of all ages were allowed at the occasion. Though no guest of honour was invited, the event was graced by eminent personnel such as President-Elect Dr Ashok Philip (who also represented President Dr Krishna Kumar), Past President Dato’ Dr N.K.S.Tharmaseelan, Hon. General Secretary Dr Ravindran Naidu, Hon. General Treasurer Dr Gunasagaran Ramanathan, and Hon. Deputy Secretary Dr Rajan John.

Upon arrival, garlands were slipped onto all the guests (including children) by attractive girls dressed in Hawaiian dresses. There was a cocktail session before the programme began.

During this Annual Dinner, Dr M. Swamenathan who continues for another year as Chairman of MMA Melaka, made a brief speech and introduced his Committee Members for the year 2014-2015.

The programme went on smoothly with no formalities and during the course of event there was excitement, entertainment, delicious food, and fellowship throughout. The entertainment was provided by the music machine operated by Edward Kanadi, a fire dance troop, a magician, and a clown who enhanced the children’s joy. Mention must be made of Datuk Dr N. Rajagopal who added merriment to the environment with his humorous gestures. Towards the end, guests took to the floor and danced the night away.

The whole event was well conducted by Dr Ignatius Joseph who was the Master of Ceremonies.
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- Paraplegia
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- Walking stick
- Ankle, knee, back, wrist support
- Cervical collar

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Infertility is defined as a couple not able to conceive after 12 months of regular unprotected sexual intercourse. Infertility affects 1 in every 7 couples. This makes it one of the most common problems faced for people between the ages of 20 and 45. The good news for couples struggling to conceive is that most people are now able to achieve their dream of starting a family through the huge advances made in fertility treatment. Investigations and treatment methods used to achieve pregnancy artificially or partially artificial are called Assisted Reproductive Techniques (ART) which includes the following:

Semen Analysis
A common test for males, the semen analysis evaluates certain characteristics of men and determines the number and quality of the sperm.

Sperm Freezing / Banking
It is a procedure to preserve the sperm cells for future use. Sperm can be used successfully after cryopreservation. It is advisable as a “back up” semen sample for specific situations such as difficulty in producing a sample on the day, male partner away for employment, or declining semen quality. Sperm freezing is also available for men before they go through chemo or radiotherapy and before a vasectomy and prostate surgery.

Surgical Sperm Retrieval
This treatment is suitable for:
- An obstruction preventing sperm release, due to injury or infection
- Congenital absence of the vas deferens (men born without the tube that drains the sperm from the testicle)
- Vasectomy
- Non-obstructive azoospermia - the testicles are producing such low numbers of sperm that they don't reach the vas deferens.

In Vitro Fertilization (IVF)
IVF is the most common kind of ART. It is done by joining the sperm and eggs outside a woman’s body in a small dish in the laboratory to allow fertilisation to occur. One or more embryos are then put into the woman’s uterus. Patient will need to undergo a hyperstimulation with a combination of a few drugs to stimulate the ovaries to produce more follicles or eggs.
**Intra Cytoplasmic Sperm Injection (ICSI)**
ICSI is a procedure whereby a single healthy sperm is injected into the centre of the egg using a delicate microneedle. This method is used when the sperm have difficulty penetrating the egg or when the sperm count is very low. The wife will still need to undergo a hyperstimulation with a combination of a few drugs to stimulate the ovaries to produce more follicles or eggs.

**Embryo Freezing / Banking**
Embryo freezing is useful for storing surplus embryos after a cycle of IVF, as patients who fail to conceive may become pregnant using such embryos without having to go through a full IVF cycle again. Or, if pregnancy occurred, they could return later for another pregnancy. Embryo freezing is also an alternative to couples that might not want to transfer too many embryos and risk a multiple pregnancy.

**Blastocyst Transfer**
It is an extended embryo culturing to provide high quality embryos which are capable of continued development and result in higher live birth rate. This is particularly useful for younger women with good prognosis for pregnancy from IVF. However, only about 25 to 60% of the human embryos progress to the blastocyst stage after 5 days of culture and there will be fewer embryos for freezing.

**Frozen Embryo Transfer (FET)**
A FET cycle is for women with wish to use their frozen embryos in the future, e.g. after delivery of a child, after an unsuccessful stimulated ICF cycle. FET is also a good option when the endometrium lining or hormone is showing signs of not suitable for a fresh embryo transfer during a stimulated IVF cycle.

**Oocyte Freezing / Banking**
Oocyte cryopreservation is aimed at three particular groups of women:
- Those diagnosed with cancer who have not yet begun chemotherapy or radiotherapy
- Women with a family history of early menopause
- Those who would like to preserve their future ability to have children, either because they do not yet have a partner, or because of work commitment

**Embryo Biopsy**
Woman of an advanced age (> 35 years old) is at an increased risk for chromosomal abnormalities. An embryo biopsy can be done to rule out the chromosomal abnormalities and genetic diseases in pregnancies. The biopsy is performed by taking a small sample of cells from the embryo using a micromanipulator and micropipette and the cells will be sent out for genetic screening.

**Laser Assisted Hatching (LAH)**
It is a laboratory procedure performed mostly on cleavage stage embryos before being transferred back to the patient’s womb. During the procedure, a small opening is made on the outer shell of the embryo LAH can assist the embryo in breaking out of this shell to facilitate the implantation process.

**Another infertility treatment which is a component of assisted conception is Intrauterine Insenmination (IUI)**
IUI is a simple procedure where the doctor uses a small catheter to put the washed sperm into the uterus after minimal stimulation with medications or injections.

This community message is brought to you by SunMed’s Fertility Centre, one of the latest additions to our Centres of Excellence. For more information on our fertility services, please call 03 7491 9191.
Royal College of Surgeons in Ireland  
Intercollegiate Basic Surgical Skills Course - Penang / Kuching 2015

<table>
<thead>
<tr>
<th>Month</th>
<th>Date</th>
<th>Venue</th>
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<tbody>
<tr>
<td>March</td>
<td>4th – 6th</td>
<td>Penang Medical College</td>
</tr>
<tr>
<td>March</td>
<td>11th – 13th</td>
<td>University of Malaysia in Sarawak</td>
</tr>
<tr>
<td>September</td>
<td>2nd – 4th</td>
<td>Penang Medical College</td>
</tr>
</tbody>
</table>

**Intercollegiate Basic Surgical Skills Course**
**THREE DAY TECHNICAL TEACHING COURSE**

**Aimed at:** Surgical trainees who are starting Basic Training in their first year.

- **Course Objectives:**
  To train participants in basic techniques for all types of surgery.

- **Course Content:**
  The emphasis of the course is on:-
  - basic knot tying techniques
  - suturing techniques
  - percutaneous biopsies
  - gastrointestinal/vascular anastomosis
  - repair of nerve and tendons
  - introduction to safe laparoscopy
  - endoscopic procedures

- **Closing Date:**
  One month (exactly) before course date commencement.

- **Fee:**
  - EURO 350.00 for Malaysians Nationals (attached to MOH)
  - EURO 750.00 for all others

  Bank Draft to: The Royal College of Surgeons in Ireland

- **How to apply:**
  Please note that there are only sixteen places available on each course. These are awarded on a first come, first served basis on receipt of completed application and fee. Please keep this Surgical Training Office advised of any changes to your contact details.

To enrol, please return completed application form (available at www.rcsi-star.com) and fee to:-

Prof N. Premnath  
Director of Surgical Training  
Royal College of Surgeons in Ireland  
Penang Medical College  
4, Jalan Sepoy Lines  
10450, Penang  
Malaysia

Email: prem@pmc.edu.my

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in conjunction with

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&
HOSPITAL PULAU PINANG, MINISTRY OF HEALTH MALAYSIA

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Intercollegiate MRCS PART A (MCQ) Examination

<table>
<thead>
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<td>January</td>
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<td>31/10/2014</td>
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<td>21/04/2015</td>
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<td>September</td>
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Intercollegiate MRCS PART B (OSCE) Examination

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<td>February</td>
<td>01/02/2015</td>
<td>07/12/2014</td>
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<tr>
<td>August</td>
<td>16/08/2015</td>
<td>21/06/2015</td>
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</table>

Location: PENANG MEDICAL COLLEGE
4 Jalan Seboy Lines
10450 Pulau Pinang

Venue: Multipurpose Hall

Fees for examination payable by bank draft to: The Royal College of Surgeons in Ireland

Details:
Ms Paulina Bany
Penang Medical College
4, Jalan Seboy Lines
10450 Penang, Malaysia
Tel No.: 604 – 228 7171
Fax No.: 604 – 228 7272
Email: paulina@pmc.edu.my

Mr Martin Cunningham
The Royal College of Surgeons in Ireland
123 St. Stephen’s Green
Dublin 2, Ireland
Tel No.: 00 353 1402 2366
Fax no.: 00 353 1402 2454
Email: martin cunningham@rcsi.ie

Candidates must send their completed application forms to RCSI, Dublin.
Application forms are available from the RCSI Website www.rcsi.ie

Enquires: Prof N. Premnath - RCSI Director of Surgical Training, PMC. www.rcsistar.com
YEAR 2014

DECEMBER

DRUG-RESISTANT TUBERCULOSIS (DR TB) UPDATE 2014

THME : CHALLENGES & MOVING FORWARD

Date : 4 – 5 December 2014
Venue : Institut Perubatan Respiratori, Kuala Lumpur
Contact : Dr Zamzurina / Ms Hafiza
Tel : +603-4023 2966
Fax : +603-4021 8807
Email : hafizashamsuddin@yahoo.com

MMA SEMINAR ON AIDS

Date : 6 December 2014
Venue : Main Auditorium, Hospital Kuala Lumpur
Contact : Ms Saira
Tel : +603-4041 1375 (ext 127)
Fax : +603-4041 8187/4041 9929
Email : pps2@mma.org.my

2ND INTENSIVE COURSE IN OBSTETRIC EMERGENCIES

Date : 6 – 7 December 2014
Venue : Medical Academies of Malaysia, Kuala Lumpur
Contact : Mr Chong, Secretariat OGSM
Tel : +603-6201 3009
Fax : +603-6201 7009
Email : ogsm@myjaring.net

CPD ON UPDATES IN OCCUPATIONAL MEDICINE

Date : 20 December 2014
Venue : Kota Kinabalu, Sabah
Contact : Ms Jennifer Edward Jenner
Tel : +603-4041 1375 (ext 102)
Fax : +603-4041 8187/4041 9929
Email : soem@mma.org.my

MARCH

MMA 3RD SEMINAR ON POSTGRADUATE MEDICAL EDUCATION

Date : 28 March 2015
Venue : Grand Seasons Hotel, Kuala Lumpur
Contact : MMA Secretariat
Tel : +603-4042 0617/4041 1375
Fax : +603-4041 8187/4041 9929

MAY

12TH MALAYSIAN CONFERENCE AND EXHIBITION ON ANTI-Aging, Aesthetic AND REGENERATIVE MEDICINE & 5TH INTERNATIONAL CONGRESS ON ANTI-AGING, AESTHETIC AND REGENERATIVE MEDICINE

Date : 1 – 3 May 2015
Venue : Nusantara Ballroom, Sheraton Imperial Kuala Lumpur
Contact : SAAARM Secretariat
Tel : +603-4041 0992/4041 6336
Fax : +603-4042 6970/4041 4990
Email : info@saaarm.org
Website : www.saaarm.org

55TH MMA ANNUAL GENERAL MEETING (AGM)

Date : 29 – 31 May 2015
Venue : The Grand Riverview Hotel, Kota Bharu, Kelantan
Contact : Dr Long Tuan Mastazamin
Email : jizurimin@yahoo.com

SEPTEMBER

4TH ASIA PACIFIC CONFERENCE ON PUBLIC HEALTH

Date : 7 – 9 September 2015
Venue : Kuala Lumpur
Organizer : College of Public Health Medicine, Academy of Medicine of Malaysia

9TH INTERNATIONAL CONGRESS OF THE INTERNATIONAL SOCIETY FOR HEMODIALYSIS 2015 (ISHD 2015)

Date : 13 – 16 September 2015
Venue : Kuala Lumpur Convention Centre (KLCC)
Contact : ISHD Congress Secretariat
Tel : +603-2162 0566
Fax : +603-2161 6560
Email : ishd2015@console.com.my
Salam Sejahtera,

Dear Members of The Malaysian Medical Association,

The financial solution that takes care of you...

Your career profession is a highly noble profession and respected by the community.

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Thank you.

Yours sincerely,
for Bank Islam Malaysia Berhad

MUJIBBURRAHMAN ABD RASHID
Head
Consumer Banking Division

<table>
<thead>
<tr>
<th>BANK ISLAM PERSONAL FINANCING-i MONTHLY REPAYMENT SCHEDULE</th>
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*Current Base Financing Rate (BFR) is 6.85% per annum
For terms and conditions, log on to www.bankislam.com.my

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Agfa HealthCare (M) Sdn Bhd (791257-M)
Address: Unit 704, Block B, 7th Floor, Kelana Business Centre, 97 Jalan SS 7/2, 47301, Kelana Jaya, Selangor, Malaysia
Tel: +603-7682 7300 Fax: +603-7604 7400 Email: mytechnology@agfa.com Website: www.agfahealthcare.com

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