Wishing You
A Blessed Ramadhan
&
Hari Raya Aidilfitri
University College Shahputra (UCSA) aims to become an international institution of higher learning which is able to produce professionals who can excel in both challenging local and global markets.

UCSA seeks to provide a supportive, helpful and friendly environment that is essential to achieve academic excellence in line with the Vision and Mission of the Institution.

UCSA enjoys a reputation for being excellent, helpful and friendly. It has a longstanding record for its excellence in academics while providing highly experienced academician and friendly management team for quality higher education learning.

UCSA’s history
Established in 1997, UCSA started with the name Institut Fitra and later was renamed as Shahputra College. In 2011 Shahputra was upgraded to University College status.

UCSA has been strengthened by a series of successful collaborations with strong partners, each of whom has contributed significantly to our character and approach.

Currently UCSA concentrates with a dedicated focus in offering Medical Programmes that is strongly supported by Allied Sciences and other high impact Programmes.

UCSA’s Faculty of Medicine
Since the faculty was established in 2012, faculty members have strived to improve the quality of education with new teaching strategies, a new curriculum to address emerging needs in health care. The goal to produce leaders and compassionate caregivers has been the primary focus.

The Bachelor of Medicine and Bachelor of Surgery (MBBS) UCSA programme is a 5 year programme which consists of 2 years of Basic Medical Sciences and 3 years in Clinical Placement. The Faculty of Medicine UCSA has affiliation agreements with 5 hospitals in Pahang that provide clinical care and training.

With its vast reservoir of talent, extensive network of affiliates and commitment to problem solving, the Faculty of Medicine UCSA hope to steer education and research in health care directions that will benefit local, national and global communities.

A five-star university
UCSA was awarded a 5-star rating by the Ministry of Higher Education in MyQuest Rating. The rating indicates that the university is considered to have a broad range of areas, has cutting-edge facilities and complies with regulatory agencies.

UCSA has also been awarded with Excellence Toward Community – Private Sector by Majlis Perbandaran Kuantan.

UCSA has achieved success in extra-curricular activities such as sports and drama.

UCSA at a Glance 2014
UCSA today has produced over 34,000 graduates at various levels and qualifications.

UCSA has more than 250 individuals working to advance the boundaries of knowledge in laboratories, classrooms, workshops, wards and clinics.

We invite Medical Professionals to join the UCSA Medical Faculty. Lecturers/Associate Professors/Professors in the following specialisations are invited to apply via email:

1. Internal Medicine
2. General Surgery
3. Obstetrics & Gynaecology
4. Paediatrics
5. Community Medicine

Requirements:
(a) Registered with the Malaysian Medical Council
(b) Possess a current AFC
(c) Registered in the National Specialist Register

Please submit your full resume with recent photo to hrcshahputra.edu.my by 30th July 2014.
Website: www.universitycollegeshahputra.edu.my
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Firstly I would like to welcome the members of the Editorial Board for the year 2014-15: Dr Gayathri, Dato’ Dr N.K.S. Tharmaseelan, Datuk Dr Kuljit Singh, Assoc Prof Dr J ayakumar, and ex-officio Dr Ravindran Naidu. With such a formidable team, and with the support of all members, I am sure the Berita MMA will continue to progress and remain an interesting and readable publication. The response from members to serve the Editorial Board was very encouraging, but we had to keep the Board to an effective five only! To those interested members that we could not accommodate, please do contribute - your suggestions and writings are welcome.

The one good news at the Editorial Board is, we are not short of articles each month. The Berita has maintained its 48 pages every month. We are getting more contributors, and that is encouraging. For the CPD/CME column, we are thankful to Dr Chin Pik Kee, for agreeing to submit a series of five articles on Ophthalmology for non-Ophthalmologists. Dr Chin is the Vice-President of the Malaysian Society of Ophthalmology. The Board also wishes to put on record its appreciation to the National Clinical Research Centre, whose Director Dr Goh Pik Pin and its Head of Healthcare Statistics Unit Dr Sheamini Sivasampanu have together shared their work with our members over eight consecutive issues of the Berita.

The June issue of the Berita was delayed as we needed to cover the National AGM held over the last three days of May. In the coming months, we hope to target for printing to be completed by the 10th of each month. The softcopy of the Berita is uploaded, soon after completion, on the MMA website. Click on Publications, followed by Berita MMA. Your User ID and Password is your MyKad number without the hyphen. If you have any difficulties, call the MMA Secretariat for assistance and the staff will reset your password.

On Medical Education: The medical profession has been most critical of the current quality of undergraduate medical education, and the issues related to it - training, overcrowding, and dropout during and after graduating. The Editorial Board is now inviting members directly involved in Medical Education to contribute to the Medical Education column. Share with concerned colleagues that not all is wrong, or what is still good!

The media ‘audit’ on Private Practitioners issuing medical certificates seems to be cyclical, like once every three to four years. It has happened again! This time new stakeholders were discovered in the game. Middlemen selling MCs for a fee, stolen MCs from Government Medical Facilities, and of course the few private clinics where MCs are obtained at ease from our very compassionate and generous colleagues! Whoever the players that result in a MC being issued, the perception in the minds of the public is, ‘doctors are selling MCs’, simply because doctors are the only authorised persons to issue MCs. That is indeed a bad reflection on the profession. I recently attended a one day forum: “Medical Absenteeism - Whose Responsibility?” It was attended by some 300 Human Resource Practitioners and some Private Medical Practitioners working with industry. The forum was officiated by the Deputy Minister of Health YB Datuk Seri Dr Hilmi Yahaya. Amongst the many speakers were Dato’ Dr Tharmaseelan and Dr Koh Kar Chai of the MMA. The message that was sent to the participants is, yes, there are some bad apples in any profession, but one cannot generalise as a result. The difficulties and responsibilities faced by Medical Practitioners in a doctor patient-care relationship were highlighted, and participants were asked to look introspectively as to the causes of sickness absence in their own organisations. Our colleagues are reminded to issue MCs after careful medical examination to entitled patients, to record the MCs given, not to backdate, to ensure that they sign and write legibly, and to include the MMC record the MCs given, not to backdate, to ensure that it is the month of Ramadhan again. The MMA and the Editorial Board would like to wish all its Members, Families and Friends A Blessed Ramadhan & Selamat Hari Raya Aidilfitri. May we all continue to live in peace and harmony.
Solutions For Your Practice

Welch Allyn products are designed to meet your need for simplicity and efficiency. See more patients, perform more procedures, and provide more complete on-site care.

In today's healthcare environment, frontline caregivers are treating more patients, with more acute conditions, and have fewer resources to help them. That's where we come in. We work each and every day to deliver products and solutions that are innovative, yet easy to use, helping caregivers focus on seeing more patients, perform more diagnosis, and provide better on-site care.

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Our success depends on our ability to adapt to the changing world of the frontline caregiver.

And now, Welch Allyn has a broad range of connected device solutions that can improve your office workflow by quickly, accurately and electronically capturing, saving and storing patient diagnostic information to your electronic health record (EHR) system.

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It has been a challenging and rewarding experience to lead the largest Medical Association in the country. Even though after serving the association in different positions over many years, it is really different when you have to wear the shoes and bear the responsibilities. I hope that I will be able to live up to the expectations placed on me.

We, the Executive Committee and the Council, are just finding our feet and setting processes in place. We hope that this will make us more efficient in serving our members.

**Personal Data Protection Act**

A meeting was held between the officials of the Personal Data Protection Act, the Executive Committee of MMA, and some invited members of the Medical Practitioners Coalition Association of Malaysia (MPCN/MPCAM). We vehemently addressed our concerns about the Act and its impact on doctors and their practice. I will highlight some points.

The Act 709 was passed in 2010 and implemented in 2013. It was explained that the Malaysian Medical Council (MMC) would lead the regulation requirements and a committee would be set up.

We requested that the doctors be excluded from this act. However, we were notified that the Minister of Communications and Multimedia had officially written to the Minister of Health on 23 May 2014, stating that this cannot be done and that his request had been rejected. We then requested that the doctors be exempted from making the registration payments and again we were politely rejected.

Visit www.pdp.gov.my to read on the 7 Principles.
Cultivate Healthy Eating Habits with Oat Cereal Fiber

It should come as no surprise that breakfast is the most important meal of the day. A recent British survey has revealed that far from enjoying a traditional English breakfast each morning, over 40 percent of the nation’s adults are skipping breakfast at least once a week due to lack of time.

Most people think skipping breakfast is the way to lose weight. However, according to the Journal of Epidemiology, breakfast skippers have a higher risk of obesity, which is one of the known risk factors for heart disease and Type 2 diabetes.

Most breakfast choices in Malaysia tend to be extremely deficient in fiber but high in calories due to their high sugar and fat content. For example, one plate of nasi lemak with a cup of ten tarik contains about 500 – 600 Calories (kcal), and is highly-packed with energy but very deficient in fiber. Therefore, choosing a healthy breakfast cereal or snack food rich in cereal fiber (oat beta-glucan) and with a reduced sugar and fat content (less calories) is key to slashing your risk of obesity, heart disease and Type 2 diabetes.

According to a nine-year research project, increasing consumption of cereal fiber after a heart attack may improve long-term survival rates!

A US-based study found that a higher cereal fiber intake was most strongly associated with positive survival outcomes, compared to fruit and vegetable fiber. The results also suggested that for every daily 10g increase in fiber intake, the risk of dying over the nine-year follow-up period decreased by 15 percent.

One of the most abundant types of soluble fiber found in cereals for instance, oats is beta-glucan. According to many years of research, 3g of oat beta-glucan from cereal products has been shown to actively reduce blood cholesterol when consumed on a daily basis. In order to live up to its claim of “help reduce cholesterol”, a food product should provide at least 1g of oat beta-glucan in a single serving.

Biogrow Oat BG22™ Crispy Cereal – the functional oat bran cereal that your heart loves!

Basics in the form of oat bran powder, now 3g oat beta-glucan is available in ready-to-eat crispy cereal form! Biogrow Oat BG22™ Crispy Cereal is delicious, crunchy heart-shaped crisps made from Swedish oat bran and is fully made in Germany using sophisticated processing technology. A single packet (30g) provides 3g oat beta-glucan.

Unlike conventional breakfast cereals, just one packet delivers 3g oat beta-glucan in a much smaller daily serving size. Taking 3g of oat beta-glucan daily will help reduce cholesterol. It is also rich in total dietary fiber (6.6g each packet), and high in protein, iron and magnesium.

In order to achieve better weight management, calorie restriction is crucial. In terms of energy, one packet provides only 102 Calories (or kcal), which constitutes only 4 to 5 percent of the average adult’s daily energy requirement (2000 – 2500 Calories per day).

When & How to Consume Biogrow Oat BG22™ Crispy Cereal?

It can be eaten straight from the packet as a convenient snack in between meals or whenever you need something crispy to munch on. It also tastes great with cold beverages such as low fat milk, soy milk, chocolate milk and yogurt. High fiber consumption requires you to drink plenty of water as this will improve gel formation in the stomach and intestines for better cholesterol-lowering effect.

Just add one packet of Biogrow Oat BG22™ Crispy Cereal to your dietary routine or make it your breakfast to kick start your morning and while enjoying the heart-healthy goodness of 3g oat beta-glucan at the same time!

References:

This article is contributed by Legosan (Malaysia) Sdn. Bhd.
For more enquiries, please call 03-7956 2220 (Mon – Fri; 9am - 5pm) or email info@biogrow.com.my. Like our Facebook page at fb.biogrow.com.my.
Please note that the fees are charged for a 2 yearly duration with:

- Category A (individuals at RM 100/year)
- Category B (partners at RM 200/year)
- Category C (limited companies at RM 300/year)
- Category D (public companies at RM 400/year)

Please also note that all branches or subsidiaries are charged at RM 10 each.

We also highlighted that most doctors are unaware of the Act and may not have registered. The PDPA registration section informed us that they have received more than 16,000 registrations of which 2,209 clinics have registered (these include dental and other clinics).

We have also requested for a roadshow to promote awareness and provide information on registration to the medical fraternity. They agreed. They will be writing a short article to be published in the Berita and are willing to run awareness workshops in any selected states. We have requested that they videotape it and set up a podcast or YouTube clip for easier access and wider coverage.

Due to the poor understanding and dissemination of information to the medical fraternity, they have extended the time of registration under the Act. Even though they have not specified a deadline, I am requesting that all doctors register as soon as possible to avoid getting into trouble.

At the end of the meeting, we stated that we would be writing to the Minister of Communications and Multimedia on a few issues. As he is the only person authorised to give exemptions, we will be requesting his good office to exclude the medical profession from the registration of this Act or to exempt the charges required. We will continue to address this issue.

Personal Injury in the Courts

The Attorney General’s Chambers (AGC) has requested that the Ministry of Finance hold a sub-committee meeting among stakeholders to discuss changes to the Act governing personal injury. I have been invited as the President of MMA to this meeting.

Initially the meeting was only addressing the personal injury mostly from road traffic accidents. I however highlighted the medico-legal aspect of this discussion which was rather skewed previously. As I was the only doctor, it was a challenge expressing it to a committee filled with lawyers and actuaries.

There will be more meetings before the recommendations can be made. I am requesting that the payouts (including for medico-legal cases) be restricted to a range and all personal injuries to be classed together. This will help reduce payouts during court cases and reduce the premiums for medical indemnity that would become compulsory for all doctors when the New Medical Act is being enforced. We hope that this input would be taken into serious consideration.

Facebook

I just took over the administration of the MMA Facebook less than a week ago. I have not been very active but have started updating some posts there. I hope members will fully utilise this page as a means to interact or exchange information with the association, or with one another.

I have uploaded the single press report that has been published thus far. Even though I am regularly on the phone with the press, most interviews have not seen the light of day as I try to make my comments very practical with reference to the principles of MMA.

Trans-Pacific Partnership Agreement (TPPA)

We have appointed Dato’ N.K.S. Tharmaseelan, our Immediate Past President, as the Chairman for this Committee. He will be organising a conference next month and will be inviting all medical organisations. We will also prepare a paper for the Government and work with all similar parties to achieve the common good.

I will keep updates regular so members can stay abreast with the current issues being addressed by MMA. We hope by doing this, MMA would become more relevant, and we would be able to increase our membership numbers.

Thank you everyone for showing your support to me, the ExCo, Council and the Association.
VACANCIES - ACADEMIC POSITIONS

1) HEAD OF DEPARTMENT of PSYCHIATRY (Clinical)
   - Possess an MBBS or medical qualifications recognised by the Malaysian Medical Council and Postgraduate qualification in the respective discipline or equivalent.
   - Proven track record in undergraduate and postgraduate teaching and research.
   - The successful applicant will be appointed at the level of Associate Professor or Professor commensurate with his/her postgraduate qualifications and experience.
   - Attractive international remuneration package is available for expatriates.

2) LECTURER/SENIOR LECTURER in MEDICINE / SURGERY / PSYCHIATRY (Clinical)
   - Possess an MBBS or medical qualification recognised by the Malaysian Medical Council.
   - A minimum of 3 years working experience in related disciplines.
   - Preferably be engaged in, or already have, a recognised postgraduate qualification or equivalent.

3) LECTURER/SENIOR LECTURER in PUBLIC HEALTH
   - Possess an MBBS or medical qualification recognised by the Malaysian Medical Council.
   - Preferably be engaged in, or already have, a recognised postgraduate qualification or equivalent in related disciplines.

Malaysian applicants must have valid MMC and APC registrations when applying for clinical positions.

Formal application with curriculum vitae including contact details, expected salary, two (2) passport size photographs, and testimonials from three (3) referees and copies of educational certificates and other supporting documents should be addressed to:

THE REGISTRAR
Penang Medical College
4, Jalan Sepoy Lines, 10450 Penang, Malaysia.
Tel: 604-226 3459  Fax: 604-227 6529
E-mail: registrar@pmc.edu.my

Closing date: 10th August 2014. Only short listed candidates will be notified.
I would like to thank all those who voted at the recently concluded AGM in Johor Bahru, to allow me to serve the MMA. It is a real privilege and pleasure to be able to represent your interests in such a remarkable Association. Please do get in touch with me should you require any help. I will do whatever within my power to enhance the services for the benefit of the members.

I would like to take this opportunity to thank the Organising Chairman, Dr Muruga Raj and his team who organised the 54th National AGM. It was one of the best AGMs ever, and future organisers may have a difficult time matching up to Johor Bahru. Congratulations to the Organising Committee for a job well-done.

We will face serious challenges over the coming years that I am sure we will overcome. I would however like to take this opportunity to encourage more of you to get involved and join as members of MMA.

We have had several meetings so far in June. The first meeting was with representatives from Medical Protection Society UK. Several issues were discussed with emphasis on enhancement of services for the members of MPS. We shall strive to give the best to all the members of MPS and MMI.

On 13 June 2014, the Medicine Advertisements Board (Lembaga Iklan Ubat) held a meeting at Putrajaya, which was chaired by the Director General of Health, YBhg Datuk Dr Noor Hisham Bin Abdullah. The DG of Health has requested the MAB, Bahagian Amalan of the Ministry of Health and the Malaysian Medical Council to meet and decide on certain grey areas (loopholes) that exist in these regulations.

We held the first staff meeting on 13 June 2014. This was attended by the Hon. General Treasurer Dr Gunasagaran, the Hon. General Secretary Dr Ravindran R. Naidu, Hon. Deputy Secretaries Dr Koh Kar Chai and Dr Rajan John, and all the staff of MMA. Several matters were discussed and finally a cake was cut by staff who celebrated their birthdays in June, followed by high tea for all.

The PPS ExCo met on 14 June 2014 followed by the PPS NWC on 15 June 2014. Much was discussed and all these issues will be mentioned by the PPS Chairman in his article. Among the issues discussed were:

- Fee Increase for FOMEMA
- Third Party Administrators Regulations
- Pathology Act
- TCM Regulations

The Personal Data Protection Act (PDPA) has become another issue for the general practitioners. Despite doctors being regulated by the Private Healthcare and Facilities Services Act by the Ministry of Health regarding Personal Data Protection of our patients, another law has come about duplicating the same regulation but this time by the Kementerian Komunikasi dan Multimedia Malaysia (KKMM). Is this never going to end - regulation after regulation governing doctors? Not only do we have to register but we need to pay an annual fee to the PDP Department – RM100.00 for solo practices, RM200.00 for group practices and RM300.00 for sendirian berhad. Another financial burden for all general practitioners. We had a meeting with the Timbalan Ketua Pengarah and his officers on 18 June 2014. Much was not achieved in this dialogue. We hope to pursue this matter further, if necessary, with the Prime Minister.

All members who attended the 54th National AGM in JB, kindly be informed that MMA is reimbursing the RM100.00 paid as registration fees. Please fill-up the claim form, attach the receipt and forward to Finance Department, MMA Kuala Lumpur.
Sunway Medical Centre continues to be committed to providing quality patient care. Celebrating its 15th Anniversary this year with the theme "Committed to You", Sunway Medical Centre (SunMed), has embarked on several initiatives in 2014 with the aim of increasing the quality of care and achieving its vision of becoming one of the leading private hospitals in the ASEAN region. Some of SunMed’s key initiatives in 2014 include becoming the 1st hospital in Southeast Asia to achieve accreditation from the Australian Council of Healthcare Standards, building more Centres of Excellence with the recruitment of more sub-specialist consultants, as well as plans for a future new block which will house the new integrated cancer centre and nuclear medicine department.

SunMed is the first hospital in Southeast Asia to receive the Australian Council on Healthcare Standards (ACHS), awarded on 27 April 2014, in recognition of its commitment to deliver the highest quality of care to Malaysians, based on international evidence-based standards of healthcare assessment of SunMed’s world-class multi-speciality medical care. SunMed chose to partner with ACHS as it most closely aligns with its expansion strategy in healthcare research and education with the Jeffrey Cheah School of Medicine and Health Sciences at Monash University Malaysia. This collaboration provides a platform for mutual development on both fields to spur research and continuous improvement in healthcare.

New Consultants on Board

With the increased trend of sub-specialisation of medical care, SunMed is focusing on building new Centres of Excellence to provide niche services by sub-specialist consultants. To date we have welcomed new doctors including Dr Ng Char Hong, Consultant Breast Surgeon, Dr Lim Bee Chian, Consultant Cardiologist, Dr Sree Kumar Palani, Consultant Ophthalmologist and Oculoplastic Surgeon, Dr Syed Abdullah Al-Haddad, Consultant Neurosurgeon and Dr Khoo Yee Laim, Consultant Psychiatrist. Our new Centres of Excellence include the Breast Care Centre, Foot and Ankle Centre, Spine Centre and Ear, Nose & Throat Centre.

Proposed New Medical Centre Block and Two New Hospitals

To achieve its vision of becoming one of the leading private medical centres in ASEAN, SunMed is embarking on a clear expansion strategy with a proposed new medical centre block in Bandar Sunway and two new hospitals, one in Penang and another in Sunway Velocity Kuala Lumpur.
I would like to thank all those who helped me contest and win the President-Elect’s post at the National AGM in Johor Bahru recently. It was not an easy task, and yet in comparison to the work that lies ahead, it seems simple.

As those of you who know me (or have read my manifesto) will be aware, I am seriously concerned at the direction in which MMA has been moving recently. In any association, there will inevitably be differences of philosophy and opinion. I strongly believe that open debate based on evidence and facts is the way to reach agreement and consensus. Since we are often discussing complex matters, it will rarely be the case that any one person or group will be completely correct. We must have open minds and listen sincerely to other parties and points of view, and we must be prepared to compromise.

Unfortunately a trend has developed of running to the Registrar of Societies whenever someone is displeased with the result of an election or decision. The complaint to the RoS is usually of some breach of the constitution. After that, we go through the now familiar (but still loathed) cycle of show-cause letters and threats of deregistration. Usually everything gets worked out, but in the meantime a lot of time and effort is directed at resolving these manufactured crises; it could be better directed towards identifying and tackling the burgeoning problems facing the profession. What I cannot really understand is why members who profess loyalty to the association would want to go down the path which may lead to its dissolution and destruction. Is it really so intolerable to them that their point of view has not prevailed? Remember, there is an internal dispute resolution mechanism. Use it. If you feel you are being blocked or stonewalled by the people in office, remember you have it in your power to call for an SGM – if you can persuade 100 members to sign-up for your cause, you should have a good chance of getting a hearing, and maybe even of getting your way – in whole or in part.

The other points I want to raise are about the weaknesses in our constitution and our unrealistic approach to constitutional interpretation. Many members are aware that the quorum for an AGM is 50 members, but we do not usually proceed to the logical corollary – that 34 members can change the constitution. For an association with more than 10,000 members, this is a serious shortcoming. Another weak point is that often the constitution does not specify what is to be done in case some provision fails to be followed. A case in point can be found in the recently concluded State AGMs. Some states, through oversight, allowed lapsed members to participate in their AGM. They were advised to hold their AGMs again. This was an ad hoc solution, because the constitution does not specify what needs to be done. Unfortunately, this solution brought up new problems – State AGMs are supposed to be completed two months before the National AGM. Four weeks’ notice is needed before calling an AGM. Due to time constraint, it was not possible to fulfill all these requirements. If the constitution contained provisions for what to do in such eventualities, much confusion could be avoided.

Part of the confusion is due to doctors not being lawyers! We tend to look at what happened, see what the constitution says, notice a discrepancy and loudly proclaim that the constitution has been breached. Some of us then rush off to the Registrar of Societies. Lawyers, however, would look more at the purpose of the constitution. The reason the AGM is held is to allow members to have a voice in the running of the association. If, due to poor framing or mistakes, we are in a position where there is no way to follow exactly the dictates of the constitution, we must look to fulfill the underlying reason. So the meeting must be held, even if with shorter notice and closer to the National AGM than mandated, because it is more important to give the members a voice than it is to be literalists.

The long term solution to these issues will be to strengthen and stabilise the constitution, but it will never be perfect, because we are not all-knowing and because circumstances change. Thus we must always remember that a purposive and not a literalist interpretation of the constitution should be aimed for – think what the aim of the clause is, then consider the language it is couched in, poor framing or mistakes, we are tendency to look at what happened, see what the constitution says, notice a discrepancy and loudly proclaim that the constitution has been breached. Some of us then rush off to the Registrar of Societies. Lawyers, however, would look more at the purpose of the constitution. The reason the AGM is held is to allow members to have a voice in the running of the association. If, due to poor framing or mistakes, we are in a position where there is no way to follow exactly the dictates of the constitution, we must look to fulfill the underlying reason. So the meeting must be held, even if with shorter notice and closer to the National AGM than mandated, because it is more important to give the members a voice than it is to be literalists.

Of course, many other issues of importance also face us. Among these are amendments to the PHFSA Regulations, the implementation of the Personal Data Protection Act, the “oversupply” of doctors, the quality of housemen’s training, the TPPA, and no doubt many more. If members have thoughts or need assistance on any issues please contact us. The MMA wants to be relevant to members, but it is a two-way street. If you do not tell us what is troubling you, we may not realise that you need help. You can always reach us through the MMA website or Facebook page, and of course directly through any Council member.

I hope to write regularly on issues of importance to the profession and association. In deference to any readers with hippopodagophobia, oresquipedalophobia, I will try to avoid polysyllabism, except in the interests of precision or just for fun. So until next time, keep going strong!

Dr Ashok Zachariah Philip
ashokphilip17@gmail.com
President-Elect
What ails the Malaysian Health System?
What ails the Medical Profession?

First I would like to thank the Annual Oration Committee and the current MMA Council for bestowing on me the singular honour of allowing me to present this prestigious lecture at this MMA AGM, in my own hometown, Johor Bahru. I last worked here at HBJB from the 1979 to 1982, some 32 years ago! Ribuan Terima Kasih!

Annual Lectures Review – Common Recurring Theme

When I reviewed the titles and content of the past annual orations that began in 1997, I was struck with one startling fact, one undercurrent theme. Almost all the lecturers have seen fit, beginning with Dato' Dr Lim Kee Jin’s “Mission and Vision in the Medical Profession” to the last but one lecture by Tan Sri Dr Ismail Merican in 2012, to discuss in effect the medical profession itself, our professional issues and practices, ending with that ominous “Medicine at the Crossroads—the Malaysian Dilemma”. Almost all revolve around what the profession has been doing, its problems, changing trends, its challenges, as well as its future prospects, our future or current relevance as a profession and/or as an association. Underlying these variations about one common theme, ethical concerns or lack of direction or professionalism seem to resonate out loud!

So this means that we haven’t really changed much. Every generation of doctors always feel they have unique problems, but they are really just different expressions around the same themes. Our medical profession has been slowly shuffling along, evolving sluggishly in terms of policy shift, but reacting sporadically sometimes vehemently to testy confrontations that affect our livelihood. But our problems and our challenges remain the same, recurring if only under different cloaks and guises of variable perceptions.

In this regard I would like to commend our current President Dato’ Dr Tharmaseelan for having been one of the most effective and outspoken spokespersons for the medical profession for a long time! Thank you for a great year as President! Syabas for daring to be different!

Notwithstanding our occasional bluster, most times the medical profession appears to be pliant, self-absorbed, and quite content to leaving our fortunes to the policy makers and shakers, then decrying that we have not been consulted, our voices not heard, or our interests not protected!

Therefore, it appears that we need to constantly remind ourselves that we need to be more than simply knee-jerk reactive. We need to be retrospective, introspective as well as prospective when we look at ourselves as physicians, and at the medical profession as a whole. Of course I had earlier stated when I took over as President of the MMA in 2009 that we should not be bogg ed down by constantly looking over our shoulders, into the rear mirror. We have to move forward too!

So, we do have to ask ourselves: Have we lost our ethos, our underlying ideals, our character, our narrative, and our direction?
Thus, my talk will touch on two inextricably linked components: “What ails the Medical Profession?” and “What ails the Malaysian Healthcare System”?

What ails the Medical Profession?
Looking within Ourselves

I would like to start by quoting Islamic philosopher Prof Tariq Ramadan, who had said:

“Instead of looking outside of ourselves and counting potential enemies... turn our glance inward, and... take the measure of our greatest challenge: the self, the ego, in our own eyes and as others see us.”

Indeed, I would urge all of us to especially remember the latter: what and how do “others see us”?

As medical practitioners, we all experience a bewildering array of problems. We have fewer self-paying patients but bigger and bigger numbers of patients who are governed by third party payers. We have to deal with arrogant, troublesome and sometimes delinquent insurers, third party payers, MCOs/HMOs, concessionaires and regulatory authorities, which make our lives as independent healthcare practitioners so much harder.

Our regulated fee structure has been frozen for more than 10 years, yet when the 14.4% upward revision was finally passed by the Health Minister in mid-December 2013, (but gazetted only in April this year!) cries of insensitive greed and cost-escalation thundered against us!

So, while we worry about these never-ending nitty-gritty practice issues, we must also consider how the public is watching, following and scrutinising our responses and our ‘demands’. We cannot expect them to understand our rationale for more wages or fees, because in the eyes of many, most doctors already belong to the upper middle-income strata of society. We’ve become seen as too greedy, having lost or surrendered our integrity and our altruism to the God of Mammon!

So we need to be more media savvy and maybe more politically-correct! We need to communicate our concerns, our legitimate yearning to be paid better, and yet remember to reinforce to our detractors out there, that we promise to perform better, that their interests are what it is all about ultimately. We need to turn our focus onto the patient and his or her needs and welfare! We need to gauge and temper our public engagement much better and resonate more in sync with the public’s expectations and concerns.

Quo Vadis the Medical Profession?

That is why, we must step aside once in a while and re-examine how our remit as healthcare providers have changed and how we are being perceived: whether we are seen as benign altruistic ‘demigods’ of hope and cure, or as venally complicit merchants: purveyors and sellers of increasingly abstruse wares of false hope, or short-term salves and balms.

I will be blunt here. With all the lure of quicker profits from innocuous but seemingly powerful injectable vitamins, from multilevel functional or nutraceutical supplements, to aesthetic beauty or anti-ageing hypes, stem cell rejuvenation supplements, we might not necessarily be much better or more professional than our much-maligned snake-oil hawkers, traditional mumbo-jumbo sinsehs or bomohs or complementary-alternative medical practitioners! Whither then is our medical profession heading?

It would appear that many a modern medical practitioner would choose the easier path forward, parking our ethical moral principles to the remotest reaches of our subconscious, suppressing our already diminishing superego or conscience that was formerly anchored on our Hippocratic Oath and our esteemed code of professional conduct. Of course, I hope to be proven mistaken every now and again:

“There are ultimately only two possible adjustments to life; one is to suit our lives to principles; the other is to suit principles to our lives. If we do not live as we think, we soon begin to think as we live. The method of adjusting moral principles to the way men live is just a perversion of the order of things.”

~ Fulton J. Sheen, Archbishop and Theologian-Philosopher

In other words, we need to live by principles, not fit or change ethical principles to our liking or how we’d like to live.

Reigniting Our Oslerian Ideal: The Doctor’s Role

Sir William Osler, Regius Professor of Medicine at Oxford defines what the doctor’s role should be:

“To acquire facility in the art of diagnosis... to grow in clinical judgment... to appreciate the relative value of symptoms and the physical signs... to give to the patient and his friends a forecast or prognosis... and to conduct the treatment that the patient may be restored to health... or, failing that, be given the greatest possible measure of relief.”
Let’s reignite our Oslerian ideals, let us conduct our treatment so that our patients may be restored to health or failing that, be given the greatest possible measure of relief!

Let’s return to where medicine was in its purest form, that which is patient-centred. We’ve certainly advanced stupendously over the past few decades. We’ve become much better technicians capable of diagnosing more accurately, imaging better, cutting better, miniaturising our surgeries, dishing out poly-pharmacies of hope and prevention. But the converse of over-reliance on just new drugs, newfangled tools and investigations is now thought to be foolhardy sometimes, especially when divorced from patient’s aspirations. In fact some of these over-treatment strategies have been shown to seriously endanger patients’ safety and lives, too.

Stanford University and many others have made a determined return to the art of the clinical bedside teaching and examination. At least in Malaysia, our usual local medical schools have remained focused on the clinical aspects of medical teaching and training. So we might be doing some things right, if only we had fewer medical students, more teachers, more patients, more teaching hospitals, and more responsible policy makers!

It’s Harder to be a Good Doctor...

The modern doctor’s roles now include more than just being a medical expert and healer. We must be seen to be professional by our peers and the regulatory authorities; we must be capable yet financially-savvy managers, be up-to-date scholars keeping abreast of rapidly changing medical advances all the time; we must be willing collaborators and advocates for health systems policies, research and improvement. We must also be patient advocates and be great communicators to boot!

Tall order indeed for someone who’s increasingly left on our own to learn and to adapt in this changing landscape of ‘self-guided’ learning medical schools, hospital wards with too many medical students and overflowing young graduate house officers, yet too few teachers and mentors to guide us, and even fewer patients to learn from!

It has been said that as we grow older, we become more cynical and streetwise, our hearts for compassion and altruism shrinks. Instead increasingly, we are seen as being too obsessed with fees, remuneration and money. Doctors are envied and seen to be showy owners of bigger cars and bigger houses. Somehow this derisory image does not gel with the public perception. It is not befitting our persona of being that benign benevolent healer, who should perhaps eschew such luxuries, such finer things in life, and be more in sync with the socially-minded middling rakyat. Once in a while of course we have an exemplary icon to show-off in the likes of Dr Michael Jeyakumar. But how many of us are so socialist or social-minded?

Negative Public Perception

Generally, the public expects doctors to be paid relatively well, but most can’t accept that docs should earn megabucks via crass profiteering! Such expectations that the doctor should be above the fray of being too business-minded are not without foundation. So more patients than not routinely seek second or third opinions, because that trust is no longer given! But sadly this is the growing depiction of what the modern doctor is perceived of today. I think no one really begrudges the professional who has spent so much time, effort, so many years and so much money, to train to become a doctor. That said, the lure of money and personal lucre is a dizzying deflector and obscurer of conscience, integrity and professional altruism.

Many among the public, the mass media and many health economists and academic health policy makers now think that most doctors have lost their moral compass. We’ve become too obsessed with our perceived self-importance and indispensability, our physician autonomy and pride run amuck, our palpable greed!

Our professional underpinning, our raison d’être of being a physician seems lost in translation, so much so that more and more health economists and policy makers are challenging the way we pay our doctors. Fee-for-services may become a thing of the past, if many health economists and policy-planning authorities have their way. There’s just too much conflict of interest and moral hazard involved in the fee-for-service model of reimbursement. The future beckons with salaries, global budgets and DRGs and profit sharing, including reimbursements or bonuses based on pay for performance.
There's also increasing talk about caveat venditor over and above caveat emptor. It's not just buyer beware for our patients, it's also physician beware for the services that you deliver. Should or could doctors provide guarantees for services rendered against defective or bad outcomes? Poor delivery or untoward outcomes might be challenged as expected goods and services or premise unfulfilled. Non-delivery of contracted services or bad outcomes and complications might become litigated to the fullest extent of the negligence or even grievous assault and battery laws (including manslaughter!).

Currently, our courts have been quite loathe to enforce higher standards of care negligence ... but the tide is changing with the Rogers vs Whitaker and our own Fiona vs Soo judgments. Even public sector medical directors, who have failed to ensure adequate systems and protocols for safe patient management or timely triaging, have now been found to be vicariously liable for negligence!

**What Do Our Patients Expect?**

So yes, times have changed. Public expectations have risen and the public is increasingly knowledge-empowered.

Patients have developed a notional mindset that all doctors and all medical care should achieve standards and outcomes of the very best and the very predictable, that the doctor should do no harm. They have come to expect doctors to be unerring well-trained super-skilful technocrats, surgeons or physicians. They cannot accept that technical lapses, mistakes and mishaps might happen, and when they do occur, then someone has to be blamed, and where possible to be punished and also to pay back, especially when they feel they have been shortchanged or when there have been perceived gross miscommunication as to the doctor-patient encounter or promise.

Physicians and surgeons must climb off the pedestal of thinking that they are demigods, that's no longer so themselves, even when mishaps or negligence occur, as to whether doctors tend to protect or cover-up over themselves, even when mishaps or negligence occur, over and above the safety or interests of their patients!

To some extent the intrusive massmedia has contributed to this greater public scrutiny, creating some public doubt as to whether what we do as doctors are truly in the patients’ best interests! There are also questions as to whether doctors tend to protect or cover-up over themselves, even when mishaps or negligence occur, over and above the safety or interests of their patients!

Are doctors' lips sealed like some fraternity-mandated, mafia-like code of silence or omertà? Or do doctors have a duty of care to report on their less capable peers, who endanger or harm patients, not necessarily through wilful neglect, but of failure to ensure or maintain a higher standard of care expected? Will there soon be some new mandatory black box technology to monitor and ensure patient safety particularly around surgical or anaesthetic procedures?

Are we over-treating our patient? Is there too much medicine, too much medicalisation for hitherto ageing processes? Are we too absorbed with providing medicaments for every complaint no matter how trivial? Is conservative management now considered under-treatment fraught with self-doubt, inadequacy, inferiority, or obsolescence?

Do defensive medical practices lower medico-legal risk, or do they increase instead potential iatrogenic harms? Do we remember the IOM report of 1999, “To Err is Human”? Do we have a duty of care and responsibility to inform upon our less scrupulous members, who over-utilise unnecessary tests and procedures, who game the system for personal profit or callous disregard of our trust benevolence?

Will whistle-blowing be the next big ‘bad’ thing to take place in this country? Our Whistle-Blowing Act has already been passed, so we should be prepared for some possible backlash soon. Will audit and fraud oversight now be the thing of the future, as is happening in the USA, where there is now a dedicated FBI Unit looking into medical fraud? Many errant doctors and hospitals including some of the famous affiliated Cleveland clinics have been fined tens of millions of dollars, forced restitution and penalty of deregistration and jail time!

Singapore has started greater official oversight mechanisms and has established a special board into looking at fraudulent medical practices and billing, after the sensational case pertaining to a renowned surgeon overreaching her compounding (yes fraudulent) billing for the management of a Brunei royalty.

**Refocusing on Our Medical Practice**

We need to do this in earnest and more consciously. Why because we are facing more and more challenges.

- Medico-Legal Challenges, not just Negligence claims but also MMC complaints;
Embrace Social Media Networking Groups

We are having more and more physician interest groups, all purportedly trying to represent and speak for the profession, many have their niche interests, and despite urging for unity, we are increasingly divided and disparate. Many of us are trying to reinvent the wheel, but with due respect, some like MCPN have not been truly tested yet for bigger numbers or diversity of membership, unity of purpose and concepts, despite its impressive virtual membership size. But MCPN has taught us the old ‘foggies’ that the internet and social media network is the space to develop the most relevance, with the best exposure, of reaching most members, if members so choose to embrace this technology!

However, it is useful to note that any society's institutional structures, constitutional constructs and tradition take time to build and develop. But that is not to say that these out-crops of independent alternative groups are irrelevant. Indeed, they must be engaged with as they challenge us the MMA, for leadership position. We ignore them at our own peril. So our MMA has to be more alert, more assertive and more inclusive, to rejuvenate our style and our purpose. We mustn’t be seen to be laggard and tired, worst if we’re seen to be obsolete and replaceable!

Ignoring like-minded colleagues and groups and working together with them, would be akin to burying one’s head in the sand like an ostrich! Of course, our divergent interests may still be different, but we’ll have to try and find confluence of purpose and share our collective voices all the more! We’re no longer just the biggest association with the biggest membership numbers, we need to stay relevant and in touch! Perhaps we can still lead the pack, so to speak! But it is imperative that we be magnanimous by becoming more inclusive and not exclusive!

So What ails our Healthcare System?

Too Many Doctors, Too Few Patients ...

Glut of Doctors

Our public service doctors too have many challenges. Our public hospitals have to contend with too many junior house officers, medical students, all vying for attention to be taught, to be mentored, to be given due attention. Many more trainees are suffering from psychological distress and work-coping failures. As many as 2 to 3 in 10 house officers had to repeat a posting or more, because of some failure to adapt or because of psychological reasons. Through 2012-2013, some 1800+ HOs had to be extended, some withdrew or vanished, and a few were terminated. Our medical officers are swamped with too much work, with little or not enough supervision; our consultants...
are too tired from the rigors of paperwork, reports and other ‘official’ duties. And physician remuneration, promotion and relocation issues continue to rankle everyone. So SCHOMOS do have their hands full!

At least the Medical Review Panels and Fitness to Practice Committees of the MMC had to work doubly hard to address these mounting issues. So having more medical graduates at such an unprecedented scale and rate, carries more problems than just the sheer numbers. Our physician quality has suffered, and our training capacities have been stretched to the limits and have been found wanting!

While we might think that only we have a glut of doctors, we are facing a glut of other allied healthcare providers, too! There are now some 30,000 fully registered medical practitioners with the MMC. At any one time, because of the two-year housemanship period, some 8,000 HOs (4,086 and 4,472 for 2012 and 2013 respectively) are provisionally registered. Some 250+ have been extended, annually, with more undergoing psychological or psychiatric treatment or evaluation. Our doctor-population ratio now stands at 1:700.

The MoH planning division is aiming for 1:400 by 2020, when our numbers would then double to around 87,000! But more seriously, we would face a serious surplus of medical graduates by 2016, when most preregistered housemen might have to wait for their turn because of lack of space and facility to train them for the rotations! To continue on as employed medical officers might be even harder still, as our public sector posts are being filled so quickly.

So yes we are facing a deep crisis due to poor planning and projection on the part of our health ministry. We should not have embarked purely on a numbers game, so now we are facing the brunt of capacity failure. Yet some local medical colleges are still asking to recruit more medical students, and more want to open more programmes! So how then can we absorb such excess?

That is why, we have to seriously contemplate and agree to some form of national licensing examination and only those who pass would qualify to work as houseman. We have to seriously contemplate and agree to some form of national licensing examination and only those who pass would qualify to work as houseman.

medical schools should not be the ‘sinecure’ homes for post-retirement academics or senior public sector officers! Our system simply cannot sustain the increased number so soon, so fast!

And we’ll soon be having a glut of pharmacists as well. The total number of pharmacists as of 2013, now stands at 11,372 with 59% being in the public sector, many waiting to leave for the private sector. Some 30% are in the private sector, while another 11% are either overseas or not practicing! The pharmacist-population ratio is now 1: 2947 and it is projected that by 2016, this ratio would have achieved the WHO target of 1:2000! So we should expect even greater calls for separation of dispensing duties very soon. Ultimately we have to consider this reality; it is a question of when, not if. Of course, we already know of the nursing glut. Some excess unemployed 8 to 12,000 state registered nurses are now forcibly absorbed by both the public and private sector to re-train so as to help them repay their PTPTN loans!

Competing Interests & Shifting Regulations

Even as we get bogged down by our own practice issues, outside forces continue to circle the bandwagon around us. Our livelihood is under threat. We face multitudes of competition from poorly regulated third party ‘health’ service industries: community pharmacies and pathology laboratories posing as legitimate physicians, beauty and slimming wellness centres, complementary-alternative health practitioners and snake-oil merchants, etc. These seem to flourish as they like with hardly any overt oversight or constraints.

Yet, ironically we appear singled-out to face more and more regulatory restrictions. We experience greater and greater loss of autonomy and freedom to practice as we like. We feel we’re unfairly overburdened with bureaucratic regulatory straitjackets, and even more from fee restriction and financial oversight. In brief, we loathe having any Leviathan to serve as an overlord master over us, but the constricting forces of regulations and more regulations, SOPs and guidelines continue to strangle our independence! Why is this so? Why are we so unjustly penalised?

But alas, we have to start asking ourselves, and look within ourselves. Might there be some amongst us who have triggered such reactive oversight? Are we all benevolent practitioners, all the time? Probably not because most if not all of us are never 100% selfless and/or altruistic; we can never be because we are fallible human beings.
I am reminded of what Swedish philosopher Soren Kierkegaard had said, that “A man who as a physical being is always turned toward the outside, thinking that his happiness lies outside him, finally turns inward and discovers that the source is within him.”

The reality is that we all have to contend with our own demons, that undercurrent of entangled conflict of interests that cannot be separated from us and our baser instincts—that we sometimes exploit that patient-physician information asymmetry to subtly coerce our less informed patients toward more services and treatments than they might not truly need or benefit, or steer them toward our own vested interests or profits.

That is not to say that we are all always criminally-inclined or fraudulent, but that we need to re-assess ourselves sometimes, to re-orientate our true motives, our ethos, our professional direction! We need to know that ethical conduct can be learnt and be reinforced, likewise for the converse! Bad or unethical behaviour, on the other hand, is very hard to change, but easily reinforced because of pecuniary incentives! So perhaps, we do need this increased oversight to keep us all in check!

Global Healthcare Crisis: Escalating Costs

Indeed, globally it would appear that healthcare and its systems are in crisis. Healthcare appears to have grown by leaps and bounds, with stupendous advances and technology, new cures or alleviators of pain and suffering.

But costs have escalated to such unrealistic peaks, that healthcare payers - the majority of whom are from Government coffers or tax-generated public purse, and other third party payers have been left reeling. Many co-paying or uninsured individuals have been left impoverished and ultimately neglected! The public is increasingly feeling the pinch. Private sector hospitalisation bills have been escalating, and many a retiree finds it very hard to afford private care, with inadequate pension savings. Many are resorting back to the public sector amenities for continuity of care, particularly for chronic disease management.

Costs of catastrophic illness, of dying and end-of-life care are now horrendously expensive and are increasingly impoverishing many an unsuspecting family. Everyone chooses to have the best care, even futile care, when our loved ones are concerned. But costs have exploded in the private sector beyond the norms of inflation, when every glove, tissue, gauze, pill or even oxygen gas that is used are counted! Allied or nursing services are not cheap either, and staff remuneration forms a sizeable 40-60% of almost all private sector facilities. Maintenance costs for expensive state of the art equipment runs into an aggregate of around 8% to 12% of the Capex cost per annum! Thus, there have been cost surges in cross-subsidising mark-ups for medications and other disposables, etc! Currently in the Klang Valley, a night in an ICU can set some patient back some thousands or tens of thousands of ringgit a day!

To make matters worse, there has been a steady over-utilisation of resources. When you have expensive equipment available, more doctors than not tend to utilise them more, thus leading to more overuse and increased costs. Sometimes it is the patient who demands for these services, just in case he or she wishes not to miss some diagnosis or other! Of course, most doctors are happy to comply with these wishes, in this era of defensive medical practices!

In the Klang Valley there are now some 20 catheterization laboratories, and some 15 MRI scanners! More often than not, however, doctors are complicit in raking up too many procedures without evidence-based needs or indications, but perhaps driven by pure lucre alone. Of course, the institutions that invest in such high tech amenities indirectly reward greater utilisation of these tests and procedures. So the indications for these diagnostic or therapeutic measures are usually lowered.

As I have pointed out earlier, more and more third party payers, insurers and MCOs however, are instituting measures for more rigorous audit of such services as their healthcare billings skyrocket. Denial of payments or partial payments now dot the landscape in contentious reimbursement disputes, with the patient finally feeling the brunt of such costs, when hospitals demand full payment. Personal bankruptcies are now noted among ill patients who have overspent their savings or credit. This impoverishment rate is currently thought to be less than 5% in this country, but rising!

Our ailing Healthcare System: Is There a Better Way Forward?

Is the fee for service model sustainable or efficient? Probably not. Then, is the single payer system necessary or the best option for the future? Almost certainly so, if we ask most of the world’s health economists, and the WHO. But local and regional issues do play very critical roles in ensuring that such health reimbursement transformation is carried out only when the majority of the public and the institutions are ready to allow this to take place,
seamlessly. There should be infrastructural strengths to ensure that there will be the least disruptions to the health service, as possible. But most importantly, there must be bipartisan political will to do so, that must be matched with public expectations that the money is well spent. Currently we have a serious problem with public trust.

Just 47% of the population voted in a minority Government perceived to have been too entrenched with corruption, patronage, and wasteful profligacy. We live in an increasingly toxic sociopolitical climate, where racial and religious taunts and extremisms have been bandied about with impunity, thereby seriously undermining the ethnic harmony and unity that has long been the strength of this country.

Competing patronage for funding such as BR1M, expedient poll handouts, and ugly and bitter fights for smaller and smaller fraternities of bigots and extremists are not uniting the people of this country. We are indeed derailing the common aspirations and direction of the nation's collective citizens. Can we trust this Government to do all the right stuff for our people without any overlay of wanton corruption or wastages? It is becoming increasingly difficult to believe this to be so. All this infighting has caused us to suffer a serious loss in belief in our institutions and our governance structure.

Costly Alternatives, but Public Sector Reprieve for Some

While there have been several upgrading of secondary and tertiary health services in the public sector, these still lag behind the rising demands of the public. Some facilities are built with insufficient planning and are understaffed and therefore underused. Some like the 10 public sector specialised heart centres are doing extremely well catering to the burgeoning poor with heart ailments. Some like the Serdang Hospital Heart Centre, and other Heart Centres in Johor Bahru, Kuching and Kota Kinabalu, are now providing much needed if hugely-subsidised surgeries for tens of thousands of cardiac patients per year, greatly offsetting the delays and long wait times previously accustomed to.

So clearly these measures are necessary and welcome developments, and do enhance the capacity and prestige of our public sector health services. I believe that this type of transformation to enhance and improve the capacity and expertise of the public sector services would be the better way forward. Indirectly if these services are done well, they can then even compete with the private sector to attract private buy-ins into these services at more competitive pricing. Although some may be uneasy about these services being offered on a full-payment scheme, this is one mechanism to check against the escalating prices of the private sector—what some economists have described as a price bulwark for competitive costing.

Unfortunately though, these health establishments are built too expensively. It is arguable that if formal tendering were carried out more diligently, many of these hospitals could have been constructed and commissioned at a fraction of the costs, thereby benefiting more people with more prudent use of our finite health ringgit! Worse unfortunately, the reputation of some of these establishments have been tarnished by their higher attendant shares of structural inadequacies and failures—roof collapse, leaking pipes and air-conditioning, ceiling leaks and failure, mouldy infestation of walls and ceilings, germ-infested operating theatres. Our maintenance culture is appalling although we have beautiful structural designs at first glance.

What about Health Reform à la 1Care?

While the vision and the goals of the previously named 1Care health reform are laudable, implementation worries have already scuttled the initial acceptance of this proposed major transformation. Worse, the public has now been taxed with rising petrol prices and utility charges, with another 6% GST to be rolled out by next April 2015.

Any talk of more payout for say the social health insurance premium by the public will almost certainly be rejected. Thus, the setting up of what was earlier known as the National Health Insurance/Financing Authority has been met with scathing skepticism that some cronies or concessionaries would be rewarded unfairly for this multibillion ringgit scheme! Already this form of patronage divestment of Government projects has been seen through some of the concessionaires like NFC, Syabas, Remedi, Pharmaniaga, Faber Medivest, etc. Thus, the confidence that this scheme will be fairly implemented and the money well-spent, is extremely doubtful.

But as I delve deeper into the complex areas and spheres of health costs and reform globally, I have to acknowledge that our increasingly dichotomised private-public system might not be sustainable in the longer term. But sadly, our now entrenched and flourishing private health sector has probably grown too big to fail or to be amalgamated into a single stream healthcare system, alongside our public sector.

Private Sector Entrenchment & GLC-Control

Our private sector is now curiously driven by GLC-owned conglomerates (Khazanah's IHH Healthcare, Johor Corp KPJ Healthcare, Ramsay Hunt-Sime Darby Healthcare, Columbia Asia group) which all seem at contrasting odds with the pledges of the Government to provide best value healthcare through the single payer system for all Malaysians.
With these for-profit entities driving higher healthcare costs these last few years, it would be highly improbable that our limited health resources could cover any full-fledged private schemes. Just based on price efficiencies alone, these private entities will not be ‘affordable’, competitive, or prudent. There are real possibilities that large chunks of whatever national health funds might be siphoned at exorbitant costs away from the ordinary Malaysian, in effect creating possibly paradoxical deficits, this time not only from public coffers but also from hard-earned premium collection from citizens, too!

How to marry such a profit-orientated sector with huge investments and expected double digit returns on investments (ROIs) versus a hugely subsidised public sector predominantly financed by Government allocated tax ringgit is mind-boggling. I do not foresee these GLC-owned health facilities (with sizeable private foreign investors) taking much of a haircut, if or when the proposed integration of services are targeted to occur with the touted health reforms!

Yet the difficulties and Government’s two-faced approach are enigmatic but perhaps consistent with some managed competition model: to ensconce a free-market model for healthcare, to boost mutual productivity and comparative excellence, with the public amenities competing with quality and cost-efficiencies vs the other private sector quality with luxury approach, as described by some.

Unfortunately, under this current Government approaches, more of these GLCs, and patronage-based private concessionaire entities, are expected to be encouraged and developed. This has led to these big corporations acquiring and swallowing up smaller medical centres, much to the chagrin of smaller more mobile lower cost facilities that offer a different pitch and niche to another sector of the public. Monopolies must be tempered carefully and regulated more!

Already, pharmacy chains have been set up in anticipation of and to tap into the possible dispensing rights separation from doctors in the near future, as our growing number of pharmacists claims their professional voice. Just how much stake the Government or GLCs have in partaking of this sort of policy moves remain to be seen. Until and unless greater common public good and decisive will overcomes and supervenes skewed political purpose, or motives, it will be difficult to trust this current Government to implement a fair and equitable health reform system, any time soon.

Public Sector Rejuvenation & Rebranding

But in the interim, the public sector must take the lead and improve their bottom-line services, including some much needed tertiary specialist care as a mandatory social safety net. The public sector needs to provide greater access and quality to finally compete with the private sector for cost efficiency, quality and safety. This has already begun, as I have alluded to earlier with some specialised services in the country, e.g. Heart Care Centres have now been set up in nearly every state in the country, with great efficiencies at tackling much needed expert care for the poor and the middle income citizens. Tens of thousands of patients/citizens have benefited from this exercise, where costs have been kept to a minimum, and with wait times being made tolerable.

Yes the luxury aspects are not quite there, but the goals here are to provide timely services for those in need. It is true that the infrastructure construction costing of these facilities have been high, perhaps too high, but ultimately, the service they provide has far made up for the shortfall.

Of course public sector maintenance problems are legend, and episodic structural failures only worry us some more as to the safety for patients and public alike. All these need to be improved upon to garner greater public confidence. If only we can also improve on this model of good service quality and patient safety, build quality, more transparency and tender processes for the best values, then we will attain world-class productivity and standards!

What is clear is that our health system needs far greater direction and focus. It certainly needs more tweaking and safeguards before any such transformation plans can be rolled out

Status Quo Expected

Thus, our disparate and inequitable healthcare system is probably here to stay for some years yet, unless the Government embarks on some drastic draconian reform by imposing a nationalisation of the private sector concerns. But this scenario seems extremely unlikely, given the fact that in the past the Government has been more keen to divest the public sector services either through direct privatisation or corporatisation exercises. What is clear is that our health system needs far greater direction and focus. It certainly needs more tweaking and safeguards before any such transformation plans can be rolled out, whether in staggered stages or in one revolutionary paradigm shifting putsch. We need more sturdy
blue prints and economic studies as well as stout institutional bulwarks to ensure that all the allocated public purse is truly channelled correctly.

At this current time, the single-payer system (community-rated) national health scheme while aspired too is fraught with too many difficulties and intangibles. This proposal is so entangled with so many potential implementation irregularities, that there is that grand potential to inflate even more crony-based patronage and corrupt practices.

I’d like to end with this quote from Bishop Fulton Sheen: “The refusal to take sides on great moral issues is itself a decision. It is a silent acquiescence to evil. The Tragedy of our time is that those who still believe in honesty lack fire and conviction, while those who believe in dishonesty are full of passionate conviction.”

“Some day a politician will arise who will be so devoted to truth that he will follow it, knowing that by doing so, he will go down in defeat. That day will be the restoration of politics as principles; it will also be the rebirth of a nation.”

We must all wait with bated breaths! But I remain cynically hopeful!
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JOHOR BAHRU
29TH-31ST MAY 2014
WHY can’t all doctors registered with the MMC and especially those working in Malaysia become members of the MMA?

This question has been on my mind for a very long time. It started when I became a Life Member of the MMA as a House Officer back in Ipoh a long time ago. I became a member because, being a professional I wanted to belong to a professional body, which represented me and would potentially look after my professional interest apart from my employer. A body which brought all of us together in crucial ‘medicine’ changing times and also provided an avenue for fellowship, professional development and unbiased discourse.

Over the years I have no doubt that MMA has tiptoed towards this ambition successfully and will continue to do so hopefully with a sprint now.

My first task as the new Chairman was to go on a membership drive at Hospital Angkatan Tentera Mizan, Wangsa Maju, Kuala Lumpur. We did not have a big turnout, as I truly anticipated, but the hour-long round table discussion certainly brought SCHOMOS a lot closer to our brothers and sisters in uniform. Dr Siva and myself fielded questions on our relevance, our track record and why we needed to represent doctors in the Government service irrespective of ministry. I must mention that Dr Siva ‘sealed the deal’ when he concluded by saying that SCHOMOS could use some ‘AK47’ to push its cause! Jokes aside, it is my belief that representing these doctors in uniform is an honour for us and we could use their wisdom and immense sense of service to the community which had been inculcated in them from the very start. These are men and women who will stand in the front line treating our wounded without a blink of an eye and they certainly deserve to be taken care!

Their firm belief in the famous words ‘servitium ante sui’ is embodied in their persona. This needs to be shared and it needs to be forged in the younger generation. We left the meeting extremely pleased with our small breakthrough and look forward to sharing their ideas, vision and bringing them into our association in a big way!

I truly believe that in unity, we have strength. We represent all and will continue to strive to do so. Godspeed and thank you all for giving me this chance to serve.
An Eventful Past Year
Looking forward to another!

Let me first congratulate the MMA Johor team under the able leadership of Dr Muruga Raj. They did a fabulous job of organising our recent MMA Annual General Meeting in Johor Bahru after a lapse of 20 years. I am really proud of this Organising Committee from Johor, which happens to be my home state. Well done my friends!

My sincere thanks to the 134 PPS members who attended the PPS Annual General Meeting and for re-electing me as your PPS Chairman, and the rest of our PPS ExCo members. Dr K. Mohan from Johor has replaced Dr Muruga Raj as one of our new Honorary Assistant Secretaries (the new PPS ExCo Committee list is enclosed for your attention).

My dear friends, last year was an eventful year for PPS. We managed to address every one of the issues that we GPs are faced with, and though we have not been able to resolve all of them, we have succeeded in submitting and getting our proposal approved on the revision of SOCSO fees for panel doctors (after nearly 11 years since the last revision in 2003). I take this opportunity to thank the CEO of SOCSO Datuk K. Selvarajah, the Deputy CEO Dato’ Dr Azman, the GM Datin Dr Amsharija, the rest of their Senior Management team and the SOCSO Board for their kind consideration and approval. We hope an announcement on the new fee schedule will be made soon.

Our GP Seminar held last year was a great success and made a nett profit of around RM 100,000 for MMA.

As far the EMGS issue is concerned, we have brought it to the attention and discussed with all the parties including MoE, and right now the total number of clinics approved to conduct the student medical examinations are 105 as of May 2014 (which was 42 back in May 2013) of which 55 are Qualitas and 50 are non-Qualitas clinics. For your kind information, only 115 GPs have applied to EMGS to be their panel clinics as of April 2014.

For this year, our main focus will be to take up the rest of the pending issues, especially TPPA, FOMEMA and the new ones like the Data Protection Act and GST. To be really effective in resolving these problems we have allocated a particular issue to each of our PPS ExCo members. We believe the PPS Committee in every state should be active and effective. We have informed all our NWC Committee members at our last committee meeting held on 15 June 2014 that every state should submit their PPS Committee Members’ list immediately and have regular PPS activities to promote the relevance of MMA to our private doctors, and encourage them to join as members and to strengthen this August organisation.
We have repeatedly requested for our members, who are owed money by Medijaring, to write to us with the full details and documents so that we can take joint action - including legal - against them to recover the outstanding monies. I have taken charge of this issue and I am appealing to all of you who are facing this problem to write to me immediately with the full facts and documents.

To resolve our FOMEMA issue where our fees have not been reviewed for the last 17 years we have requested our President and HGS to write to our Prime Minister who is also the Finance Minister, under whom is the UKAS (Unit Kerjasama Awam Swasta).

We know the future is in our hands and will succeed as long as we are united and sincere in doing whatever we do.

Should you have anything urgent to discuss or highlight with regards to any PPS issue, please do not hesitate to contact my ExCo members, in particular our Secretary Dr Muhammad Gowdh or yours truly.

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We, the PPS ExCo,

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Dr Muhammad Gowdh  
Honorary Secretary

Brig Gen Prof Datuk Dr N. Rajagopal  
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Honorary Assistant Secretary

Dr K. Mohan  
Honorary Assistant Secretary

—

Source: PhD Comic © 2013 www.phdcomics.com
Stigma in Mental Health

Stigma is a term that is widely used today. In medicine, it is often used alongside the words cancer, HIV and mental health. We can argue which has the lion’s share but it is fair to say that it is a serious concern regardless of the disease or condition that it is associated with. The definition of stigma can be varied, as the problem is a multidimensional one. Goffman\(^1\) states that stigma is a ‘deeply discrediting attribute that disqualifies one from full social acceptance’ while Scambler\(^2\) divides it into two, enacted stigma and felt stigma. Enacted stigma is said to be a stigma that arises ‘due to actual discrimination or unacceptability by other parties’ while felt stigma is ‘the fear of such a discrimination’. Both of these definitions are apt in that they identify the problem succinctly, and illustrate the depth of stigma. If left alone, stigma will halt all the good work that has gone into other aspects of patient care, like policies, education and interventions. It is a major hindrance in delivering healthcare to those in need and is very much a public health problem in any case.

A victory over stigma is when a patient is able to seek help confidently without shame, and to have a doctor who is able to deliver the service without blame, complemented by a supportive and non-judgemental society, which sees a person beyond an illness. Policy makers, NGOs and leaders all have their respective role to play in this model.

In order to effectively tackle stigma towards mental health patients, we must identify and address the many different forces that are at play. The following are my thoughts on the ways we can address these factors, derived from experiences and observations following an eight-week undergraduate psychiatry posting.

Attitudes among Healthcare Workers

Current evidence on attitudes of health workers towards mental health appears to be mixed. In a study done by Anthony\(^3\), health professionals were found to have higher mean scores for negative attitudes towards psychiatric patients than the general public. In the Malaysian setting, it was found\(^4\) that general staff are likely to provide differing levels of care if the patient was a ‘known psychiatric patient’. However,
studies elsewhere\(^5\) indicate a shift towards a more positive attitude among health professionals. Based on this data, the evidence of an overwhelmingly positive attitude among healthcare workers is not strong enough, and hence further improvements should be made in this regard.

The stepped care model identifies primary care as the key player in detecting and managing mental health in the community. Thus, it is very important that general practitioners and primary care physicians, among others, are keeping a lookout for psychiatric illness. More importantly, they must be willing to address it. One way of improving attitudes and commitment towards mental health is to make sure sufficient emphasis and exposure is made during their undergraduate course. Several studies have been done in this regard\(^6,7\) in the local setting and the consensus is that students with good quality exposure show better recognition and acceptance of mental illness as an illness like any other. A well-drafted posting hence, is vital in overturning the years of stereotypical representation portrayed in the media. A shift in thinking is necessary, as Tan et al.\(^6\) put it,

“The student needs to accept cognitively, socially and emotionally that the ‘orang gila’ (mad man) his parents taught him to fear as a child, has a brain disorder - a mental illness that manifests in disordered thinking, emotion and behaviour, and that this fear-inducing illness can be understood and treated successfully.”

It also goes without saying, that with better appreciation for mental health, GPs-to-be will be more motivated to constantly attend CMEs and update their knowledge in the field of psychiatry, as it expands and improves. Keeping up with the latest developments allows for greater understanding of plights of patients besides encouraging active exchange of opinions. This will be a great improvement for a topic that used to be only brought out during ‘water cooler conversations’.

**Correcting Faulty Perceptions**

A lot of people seem to have the wrong idea about psychiatry. A study in the local setting\(^8\) found ethnic background, religion, educational level and residential location to be key factors in determining attitudes towards mental health. Popular media has not been very helpful in addressing this misrepresentation, if any, it has only made it worse; depictions of people being caged, communication with ghosts and witchcraft is just some of the examples we have today. Bad representation such as these, combined with little knowledge of the real world scenario leads to faulty perceptions and stigmatisation. It is vital to make an attempt to correct these perceptions in the public so as to create awareness and alleviate stigma.

One way to remedy this is to readjust patient’s expectations (Table 1). By addressing the lack of knowledge, misconceptions and unrealistic expectations, we can shift ignorance to acceptance. Once a person has accepted the mental illness in question, slowly but surely, respect and tolerance will build. The tipping point is when they choose to complete the cycle by educating another person. This is a self-sustaining model, one that takes advantage of the core of humanity; leveraging on ‘peer education’ as a form of creating and sustaining awareness.

**Representation in the Community**

Outpatient mental health service in Malaysia is delivered through health clinics, hospitals, clinical psychologists and private practitioners\(^9\). The health clinic is the least financially burdened approach. The quality of care in this setting has been proven by a number of studies\(^10,11\), which pegs customer satisfaction between 78.8-92.3\%. However, there has not been any research done on the prevalence of stigma in this regard. Patient load is generally high in Government-funded services and this can lead to less contact time and poor privacy to patients, both factors which are important to good mental health consultations. Such a situation allows for misconstrued ideas of mental illness to be formed, by patients, family members and health staff alike. One way around this is to relook at the idea of Community Mental Health Centres (CMHC). These centres can provide a more conducive environment for proper delivery of mental health services. In fact, provisions are already in place\(^12\) in the legislation and operational policy to establish a greater number of CMHCs.

With access to a dedicated community multidisciplinary team, medications, and provisions for walk-in patients, CMHC allows for better interactions between patient and health professionals, and thus has maximum potential to address stigma head on. Just as rural clinics (Klinik Desa) play an auxiliary role in supporting maternal health service, CMHCs can function as a proper adjunct to health clinics, offloading patients and freeing resources, in the process. The proposition for a more aggressive establishment of CMHCs can be made attractive by perhaps positioning them alongside rehabilitative medicine. In a study...
Conducted by Mazlina13, the state of rehabilitative medicine in Malaysia is said to be in its infancy; hence, the notion of offering mental health and rehabilitative service in a combined, dedicated environment can be mutually beneficial to all. The comorbidities between these fields are often overlapping and have been well documented in popular literature. Placing them side-by-side can encourage a new level of participation from the public. CMHCs in the Government setting currently are named Mentari or Pusat Kesihatan Mental, the latter, of which is highly polarising and should be replaced. A more appropriate name should be adopted, to reflect the more inclusive approach. Rehabilitative & Wellness Centre, or Pusat Rehabilitasi & Kesihatan is one suggestion, while Klinik Rehabilitasi is a more simplistic term, comparable to the existing term Klinik Desa.

From Illness to Wellbeing

A different way of tackling stigma towards mental health patients is to shift part of the attention away from debilitating diseases to mental health wellbeing. The term wellness and wellbeing are interchangeable, with the meaning being a more holistic, all-inclusive approach to health. Cobin and Welk discuss the concept of health and wellbeing extensively in the first chapter of their book14; of note is the notion that illness does not define health, but merely causes an effect on health. This is a profound message, one that argues for (mentally or physically) ill patients to still have a reasonable quality of life. To me, this would include a life without any form of shame or discrimination, both key components in stigma. I believe that wellness can be an easier concept to engage in, especially with the uninhibited public. It can act as a vital catalyst to convey deeper messages and education on the plights of chronic mental health patients and the unfair treatment of society towards them. Currently, mental health promotion in the country is done thorough campaigns, school-based programmes and web portals9. Under the brand of ‘MySihat’, a specially formed Health Promotion Board oversees health promotion initiatives in the country with grants and endorsements for NGOs and corporate entities. Although mental health is listed as a priority area, almost all the activities that were organised in 2013 were not aimed at mental health15. Thus, even with provisions and funding in place, little is being utilized to promote mental health. In the mental health promotion sub-chapter of the operational policy, the Ministry of Health too has identified age-appropriate themes to develop programmes for; however, no clear results have been obtained thus far. In my opinion, instead of prolonged school-based programmes, shorter and more intensive programmes will be more useful. Rather than nudging the proverbial mountain inch by inch over time, why don’t we consolidate our efforts, and give it a more sizeable thrust in a week’s time? An annual national mental health week, with participation from all parts of the society might deliver more impact in creating awareness than long forgotten and often outdated programmes. School children can be engaged in a variety of ways, with immediate targets and objectives being the aim. Of course, a curriculum infused with a carefully drafted, long-term education of mental health is always welcomed too. Parents should be targeted at workplace, with particular attention made in illustrating the significance of a balanced life. Recognising the need for a healthy social and psychological life cannot be understated. If we can successfully impart this understanding unto parents, I believe that it will create a butterfly effect, allowing for strides to be made on new fronts. Ignored, this will only allow for society to continue to ridicule and set aside sufferers of mental illnesses.

Conclusion

The points that have been put forward thus far are not distinct from one another but have considerable overlap between them. This illustrates the wide interactions between the many elements of stigma. Ultimately, reducing stigma has a lot to do with changing the ways of thinking of people, and society at large. It might not be the easiest thing to do, but this is not a reason to put it aside. Policy-makers, doctors, NGOs must be committed to combating stigma. Ideas in this essay are intentionally so to introduce different ways of looking at the same problem. Stigma is not a new problem, and novel ways of combating it must be constantly evaluated and tried. Targeting key areas, and improving them as best as possible, can lead to a steady reduction in stigma. Just as the notch at the right angle allows a tree to fall, we need to make changes at the correct areas to bring down the ‘tree of stigma’.

References

Greetings from Sao Paulo, Brazil

Warm and fraternal greetings from Sao Paulo, Brazil.

As a member of the FIFA Delegation to my fourth FIFA World Cup, Brazil is special – a place where football is religion, is breathed, unites people in difficult times, and flows in every Brazilian vein. Brazil’s success in the opening match against Croatia brought much needed healing to the political unrest in the country. The country is in samba mood. I am based in Sao Paulo, third largest city in the World with traffic jams being a daily feature.

Apart from enjoying the festive mood of this prestigious sporting event, as a FIFA Medical Officer, it is an appointment with a high degree of professional responsibility addressing all medical, anti-doping, research and related issues. At this level, the job is both demanding and complex but with experience it becomes routine. Decisions need to be made during trying situations, especially when handling professional players supported by a specialised team of medical experts. Often one has to be alert for those (team officials, players and team physicians) who try to outsmart situations to gain advantage during the tournament.

Emergency Medical Services

Upon arrival at the venue, the FIFA Medical Officer (FMO) needs to contact the Local Organising Committee to ensure that infrastructure for emergency medical services and specialised hospital facilities meet international standards and FIFA requirements. A visit to the stadium is also made, to inspect the medical room (for players and VIP), medical supplies and equipment for medical emergencies during a match. In view of the number of on-field sudden cardiac emergencies, FIFA regulations ensure mandatory presence of an Automated External Defibrillator (AED) at the fourth official bench (referee). No match will start if an AED is not available on the ground. In addition, FIFA has provided all participating teams with an AED and an emergency bag equipped with emergency medical supplies. In addition to the four ambulances at the stadium, there is a helipad outside the stadium if the need arises to airlift a player or official to hospital.

The FMO needs to monitor and ensure that the sideline medical teams (stretcher bearers) respond effectively to on-field emergencies during a match as per tournament guidelines.

The FMO has to monitor all medical investigations both elective as well as emergencies/surgical cases and hospitalisation of players, officials and FIFA delegation both on match and non-match days. Sometimes medical decisions need to be made after consultations between the participating team physician, the club doctor (player’s home club) and the FIFA Medical Officer.

Heat Stress Monitoring

The FMO will record the Wet Bulb Globe Thermometer (WBGT) readings at 90 and 60 minutes prior to the start of each match. If the reading is 32 degrees Celsius and above as well as taking other factors into account, the FMO will recommend three-minute cooling breaks at 30 and 75 minutes into the start of each half of the match. This is to prevent heat related injuries especially heat stroke. The LOC must supply cool drinks and towels soaked in ice buckets to
each team during the three-minute breaks. Heat has drawn much media attention in this tournament.

**Anti-Doping Matters**

Upon arrival at the venue, the FMO needs to ensure the Anti-Doping Infrastructure at the stadium meets FIFA Anti-Doping Regulations.

The FMO will conduct out-of-competition doping controls on all players of each team prior to the start of the FIFA World Cup 2014 Competition, and 800 doping controls have been completed till date. All samples are negative. In competition, during each match the FMO is responsible for the entire doping controls i.e. selection of players by random draw (two players per team); collection of biological samples and transportation of the samples to the doping laboratory. All players participating in the FIFA World Cup Brazil 2014 are subjected to both urine and blood controls.

As a member of the FIFA TUE Advisory Group, I have to evaluate and approve all applications for Therapeutic Use Exemption as per the World Anti-Doping Agency International Standards for TUE guidelines. A player on a drug/medication (due to his medical condition) that appears on the World Anti-Doping Agency banned list of medications/methods needs to apply for exemption. Treatment patterns for medical conditions may vary among physicians and this can pose a challenge for the TUE Advisory Group; though it is to ensure best evidence-based medical practice, to prevent abuse, curtail performance enhancing drugs, as well as protect the health of player.

In the event that the doping laboratory reports a sample as an adverse analytical finding, the FMO will initiate case management proceedings. Once an Anti-Doping Rule Violation is established, the next step would involve the Chairman, Organising Committee for FIFA World Cup Brazil 2014, FIFA Legal Office, FIFA Disciplinary Office and the responsible team – head of delegation and player. This process is carried out confidentially.

**Other Related Medical Matters**

The FMO will ensure that all players participating at the FIFA World Cup Brazil 2014 has undergone a pre-competition medical assessment. Team physicians need to supply documentary evidence (FIFA Declaration Form for PCMA) to the FMO. If a player has not undergone a PCMA, he is ineligible to participate in the FIFA World Cup.

The FMO is responsible for data collection of all injuries and illnesses during the match from the team physicians. This is an ongoing research project since 1998 and it is compulsory for team physicians to comply. The results are published for the benefit of team physicians, coaches, trainers, researchers. This is in addition to the collection of data from all medical contacts involving teams, spectators, VIP/members of the FIFA Delegation, media, sponsors and LOC workforce.

It is gratifying and humble to be the sole Asian Physician on the FIFA Medical Team to the FIFA World Cup Brazil.
Anti-Aging Medicine

The field of Anti-Aging Medicine is fast growing and has received very positive attention. It is a model of healthcare for living a long healthy life in this fast-paced world. It promotes innovative science and research to prolong the healthy lifespan in humans. It uses advanced scientific and medical technologies for the purpose of early detection, prevention, treatment and reversal of age-related diseases.

Regenerative Medicine

Over the years, related disciplines of regenerative medicine and aesthetic medicine were included for the holistic approach for the overall wellbeing of patients. Regenerative medicine includes the use of new evolving technologies such as gene therapy, stem cell therapy and nano technology.

Aesthetic Medicine

Aesthetic Medicine has recently received its approval last year from the Ministry of Health with the Letter of Privileging and Credentialing to interested doctors of all specialties, and guidelines in the practice was formalised.

It all started in 2011, with the Government setting up a committee for the wellness industry under the Performance Management and Delivery Unit (PEMANDU). Three centers of excellence in this field of which the SAAARMM was invited and we initiated the fast forward of acceptance by showing the statistics in this field that can contribute enormously to our economy. It was then agreed that doctors have a role to play in this industry with a market size of one billion ringgit.

Subsequently, SAAARMM was part of the consultative body in the recommendation for the MoH guidelines. This area of medical practice embraces multidisciplinary modalities dedicated to create a harmonious physical and psychological balance through non-invasive, minimally invasive and invasive treatment modalities which are evidence-based. These modalities focus on the anatomy, physiology of the skin and its underlying structures, to modify the otherwise normal (non-pathological) appearance, in order to satisfy the goals of the patient. These are carried out by registered medical practitioners.

Moving forward in the field of aesthetic medicine, SAAARMM decided at our last board meeting to embark on the teaching and certification of aesthetic medicine to all our members and this was put forward as per our discussion with the Ministry of Health representatives during our recent congress. We will be launching our education programme in October 2014.

Congresses and Platform for Our Homegrown Malaysian Speakers

To raise SAAARMM’s profile internationally, annual conferences have been held around the early part of May since 2004 with the first international congress being held in conjunction with the 8th Malaysian Conference and Exhibition on Anti-Aging, Aesthetic and Regenerative Medicine in 2011 which attracted participation by speakers and delegates from over 20 countries.

With the international exposure of our society, our society members were chosen as speakers to give their expert opinions in countries ranging from the USA, Spain, Britain, Singapore, Thailand, China, Japan, Indonesia, India, Slovakia, USA, and Dubai.
In recent years, we have seen close ties with the USA, India and Indonesia of which we were consulted and our model of a society was used in the forming of the Indian society with similar aspirations.

International Model of a Society
In recent years, we have seen close ties with the USA, India and Indonesia of which we were consulted and our model of a society was used in the forming of the Indian society with similar aspirations.

Masters Degree in Anti-Aging, Aesthetic and Regenerative Medicine
One of my initiatives was with UCSI University, where we sought to move up a level with a Master's degree in this field, in 2010.

I headed the write-up and submission to the Malaysian Quality Assurance for higher learning and the first ever Master of Science in Anti-Aging, Aesthetic and Regenerative Medicine at UCSI University was approved the following year. The President Dato' Dr Peter Ng of UCSI University was very supportive in our society's effort in education. This was the biggest contribution of SAAARMM in education at tertiary level and it must also be stated that Dato' Dr S. Harnam and Dr Ng Kwong Fai were team players in this MSc programme's success.

Joint Symposia
I had the opportunity to bridge and build good relationships with other medical societies. Over the past four years, we had joint symposiums with the Society of Sports and Exercise Medicine Malaysia (SSEMM) in 2010, the Penang Medical Practitioners' Society (PMPS) in 2012, the Perak Medical Practitioners' Society (PMPS) 2013 and the assistance of Melaka Manipal Medical College with the Indian Nutritional Medical Association (INMA) 2012. Our future recognition would come from Malaysians in the form of research which we are very much in support of.

Upcoming Symposium and Congress
We are organising our next symposium on Anti-Aging, Aesthetic and Regenerative Medicine at Avillion Port Dickson on 20 September 2014.

The 12th Malaysian Conference and Exhibition on Anti-Aging, Aesthetic and Regenerative Medicine and 5th International Congress on Anti-Aging, Aesthetic and Regenerative Medicine to be held at the Sheraton Imperial Hotel Kuala Lumpur from 1 to 3 May 2015. We would like to announce that our Royal Patron His Royal Highness Sultan Muhammad V, The Sultan of Kelantan, would be officiating our event.

**About Infertility**
- 15% of reproductive age couples have infertility issue
- 25% of infertility is due to the male factors
- Male factor infertility can be resulted from:
  - Impaired sperm quantity
  - Impaired sperm quality (motility and morphology)
  - Both of above
MoH: Allopurinol – Start Right, Stay Safe

The Malaysian Adverse Drug Reactions Advisory Committee (MADRAC) would like to remind all prescribers that allopurinol should not be used for acute gout or other unapproved indications. This drug should be prescribed only for the approved indications as listed below. All patients on allopurinol should be counselled and monitored closely for serious adverse cutaneous drug reactions such as SJS, TEN and DRESS*.

The indications of allopurinol which are approved by the Drug Control Authority (DCA), Malaysia are as follow:
- Chronic gouty/gouty arthritis
- Uric acid nephropathy
- Calcium oxalate renal calculi/ uric acid renal calculi
- Hyperuricemia secondary to:
  - cancer chemotherapy/ radiation therapy
  - blood dyscrasias
  - enzyme disorders

The number of adverse drug reaction (ADR) reports related to allopurinol received in Malaysia showed an increase from the year 2000 to 2011 (Graph 1). The number of ADRs involving use in asymptomatic hyperuricaemia also showed an alarming increase, beginning in the year 2002 with a peak in 2007. This resulted in several risk minimisation steps being taken between 2004 until now, to ensure rational use of this drug and reduce the incidence of ADRs (Table 1).

Graph 1: Allopurinol Adverse Drug Reaction Reports in Malaysia (2000-2013)
Between 20-47% of the ADRs reported for allopurinol each year involved serious skin reactions (Graph 1). In order to reduce or prevent these, patients must be counselled to stop the drug and consult their doctor immediately if they develop any of the following signs or symptoms: fever, sore throat, fatigue, eye irritation, cough, rash, itching, swelling or joint pain. Increased vigilance and dosage adjustment may be required in patients with renal impairment, hepatic impairment, and those on diuretic therapy.

The risk minimisation measures taken below have shown some promising results, with a 21% decrease in the total number of allopurinol ADR reports from 2011-2013, as well as a reduction in ADRs related to use in asymptomatic hyperuricaemia. However, the number of serious skin reactions remains high, making up almost 40% of the total reports in 2013. The NPCB continues to monitor this safety issue closely and will take further steps to ensure the safe and rational use of allopurinol.

<table>
<thead>
<tr>
<th>Year / Date</th>
<th>Risk Minimisation Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>Advisory distributed to prescribers on approved indications of allopurinol</td>
</tr>
<tr>
<td>2007</td>
<td>MADRAC discusses allopurinol safety issue of increasing ADR reports, use in asymptomatic hyperuricaemia, and cases of serious skin reactions</td>
</tr>
<tr>
<td>2008 Dec</td>
<td>Circular from the Director General of Health regarding allopurinol ADRs and information for prescribers – KKM87/P1/19/1/0(12)</td>
</tr>
<tr>
<td>2010 Apr</td>
<td>Article in MADRAC Bulletin: “SJS and TEN Associated With The Use of Allopurinol”</td>
</tr>
<tr>
<td>2011 2 Feb</td>
<td>Letter from NPCB to the Pharmacy Practice and Development Division on the suggestion by MADRAC to restrict usage and tighten the indication of allopurinol</td>
</tr>
<tr>
<td>2012 12 Apr</td>
<td>MADRAC decision to issue reminder letters to prescribers who use allopurinol outside the approved indications, resulting in ADRs.</td>
</tr>
<tr>
<td>19 Aug</td>
<td>Circular from the Director General of Health to remove uric acid analysis from routine renal profile results – KKM87/P1/19/1/0(25)</td>
</tr>
<tr>
<td>25 Aug</td>
<td>Circular regarding the amendment of the FUKKM raising the allopurinol prescribing category from ‘B’ to ‘A/KK’ and tightening the indication of allopurinol - KKM-55/BPF/103/001/09Jd.13(55)</td>
</tr>
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*Abbreviations: SJS= Stevens-Johnson syndrome; TEN= toxic epidermal necrolysis; DRESS= drug reaction with eosinophilia and systemic symptoms*
Unintended Pregnancies
Contraceptive Usage and
Maternal Health

lobally, latest data published in 2008 shows that 41% of pregnancies were unintended. The unintended pregnancies rate for Asia was 38%. The reasons for unintended pregnancies were substantial unmet need for family planning services in many areas of the world, poverty, education, non-use, incorrect use or contraceptive method failure. Socio-economic, regulatory and religious conditions also play an important part in the incidence of unintended pregnancies. It has also been found globally that the three main reasons for non-use of contraception were opposition to contraception, perceived side effects of contraception and infrequent sex or no sex. However, it has also been noted that more than 50% of women who cite infrequent sex or no sex as reason for non-use actually had sex in the last three months prior. Unintended pregnancy can only have three sequelae, i.e. abortion, miscarriage or live birth. All three sequelae can be associated with maternal injuries and deaths. Globally, in 2008, 48% of unintended pregnancies ended up in abortion, 38% as unplanned birth and 13% as miscarriages. The global abortion rate was 35 per 1,000 women in the reproductive age group in 1995 and stalled at 28 per 1,000 since 2003.

The Malaysian Context
Extrapolating these figures into the Malaysian context with a current population of 30 million in March 2014 and an estimated 8 million women in the reproductive age group, the estimated number of abortions in Malaysia per annum will be 224,000. This is equivalent to 600 abortions per day and 25 abortions every hour. Malaysia’s maternal mortality rate was 41 per 100,000 live births in 1995 and the latest data was at 28 per 100,000 in 2006 to 2008. This is a reduction of 31%, falling way short of the Millenium Development Goal set by the World Health Organization (WHO) of 75% reduction by 2015. The ever users of contraception in those mothers who have died during pregnancy stands at an average of 20% only with no improvements for the past 15 to 20 years that the series of Malaysian Confidential Enquiry into Maternal Deaths were reported. It has been repeatedly stressed by our Ministry of Health that better family planning can reduce Maternal Mortality significantly.

With approximately 40% of pregnancies being unintended and preventable by contraception, it follows that many Malaysian women need not die from pregnancies that they never intend to have in the first place. The Malaysian contraceptive prevalence rate since 1988 till date has never shown any improvement, hovering between 50 to 55%.

This is equivalent to the contraceptive prevalence rate of Philippines for example, a country where the bulk of the population are Catholics and have very strong objections to the use of most contraceptive methods. In comparison, our neighbouring countries of Thailand, Vietnam, Singapore and Indonesia have higher contraceptive prevalence rates of 72%, 78%, 62% and 61% respectively in 2008. The unmet contraceptive needs of married Malaysian women have widen over the years, signifying that more women are not using contraception despite their intention was not to get pregnant. It was reported that the unmet needs was 16% in 1988 and 24% in 2004. The unmet contraceptive needs for unmarried women would have been even more.

The data from teenage pregnancy was indeed alarming as well, recording a 300% increase from approximately 6,000 cases in 2010 to 18,000 cases in 2012. Baby-dumping statistics were significant with the Royal Malaysian Police recording 407 cases from 2005 to 2010 with Selangor on top of the list. We recognised as a fact that the recorded figures are the tip of the iceberg with many other cases that may have gone unrecorded or undetected.

Tackling the Problem
We know from global data up to 2010 that the stalling of the incidence of abortion coincides with the plateau of the contraceptive prevalence rate. Data from large studies in the United States have shown that contraception definitely prevents unintended pregnancies. One important study looking at women at risk of unintended pregnancies had shown that 65% of women who use contraception consistently were responsible for only 5% of unintended pregnancies, whereby 16% of women who do not use contraception at all were responsible for 52% of unintended pregnancies.

Better acceptance and uptake of contraceptive practices/methods are critical in reducing unintended pregnancies, abortion and maternal deaths. Indeed, serving the contraceptive needs of women will also reduce miscarriages as well as infant deaths. Long-Acting Reversible Contraception, in particular hormonal implants and intrauterine devices are particularly effective in decreasing the incidence of unintended pregnancies. It has been advocated by the World Health Organization and the National Institute of Clinical Excellence in the United Kingdom. The American College of Obstetricians and Gynaecologists have stated in 2012 that these methods are the best reversible methods in preventing rapid repeat pregnancies, unintended pregnancies and abortions.
they should be offered as a first-line contraceptive option to all women. Unfortunately, the availability, accessibility and usage of such methods globally are low and similarly in Malaysia, such methods are used by less than 5% of women who use contraception.

**Status of Contraceptive Provision and Services in Malaysia**

Contraceptive services are provided by Ministry of Health, National Population and Family Development Board (LPPKN), as well as the Federation of Reproductive Health Association, Malaysia (FRHAM). In addition, contraception are available in private hospitals, pharmacies as well as private clinics. Most of the contraceptive methods are available in all four major service providers although the provision ranges from free to subsidised and full payments. In practice, there were difficulties noted in many areas of contraceptive provision that posed a challenge to the Malaysian women when accessing contraception:

- Long-acting reversible contraception in particular hormonal Implants are only available in Ministry of Health Hospitals for selected high-risk patients. This method currently is unavailable for women in Government primary care clinics such as Klinik Kesihatan.
- Not all methods are available in all the service providers most of the time due to disruption in supply of the methods, availability of trained healthcare providers in fitting the devices, and the differing costs of different methods. Choice and continuous availability of methods are integral components in making sure women can continue to use contraception to avoid pregnancy.
- Contraceptive knowledge and training for healthcare providers are not uniform and thus differing advices and management of contraceptive cases may be offered by differing healthcare providers and thus may at times be not the most appropriate or even correct advice and management. This creates a misuse, resulting in a decrease of efficacy in the method applied, and increasing rate of unintended pregnancies.
- The “Fear Factor” is very much prevalent among Malaysian women in terms of myths and misconceptions about the side effects of contraceptive methods.
- Socio-economic and religious constraints are also important factors that pose difficulties for women in accessing contraception. Commonly, the rural women may not have the economic ability to access highly effective methods such as long-acting reversible methods due to cost constraints as well as non-availability of trained personnel in a nearby clinic. Religious groups may impose their own views and beliefs about contraceptive practices which may not be in the best interest of the women concerned.
- Malaysia’s Law is also not clearly defined as to the provision of contraception to adolescents, thus limiting access to this vulnerable group and exposing them to a high incidence of teen pregnancy.

**The Challenge for Malaysian Women’s Reproductive Health**

Among the women:

We need to correct the myths, misconceptions and opposition towards contraception. We need to raise the socio-economic status of women as it has been shown that much higher incidence of unintended pregnancies occur in the lower and middle-income group.

We need to raise the education level of all girls and women as education is the key to understanding and better family planning.

Among the healthcare professionals:

We need to continuously train all healthcare professionals and equip them with the most accurate and up-to-date contraceptive information and management skills. We need to increase contraceptive methods and ensure that supplies are available (in particular long-acting reversible contraceptives), continuous and uninterrupted.

Among the Governments and Non-Governmental Agencies:

We need to have the political will to recognise that contraception is the key to nation building and a healthier and productive population. We also need to ensure greater coordination between all agencies and stakeholders in maximising our resources towards this very important agenda.

**The Story**

On Independence Day, 31 August 2012, a newborn baby girl was still alive when she was flung out of the window from one of the upper floor of the Desa Mentari flats in Kuala Lumpur. Post-mortem results revealed the baby died of severe head injuries. The mother was a 20-year-old unmarried woman who gave birth on her own while alone that Sunday in the third-floor flat. She was subsequently arrested and remanded by the police. A resident of the same flat said when he heard the noise, he came out to inspect and saw that the baby still had an umbilical cord attached and there was blood all over her body. She looked like a cute girl.

This story is typical of many other similar stories that are published, unfortunately too frequently, by the Malaysian press and underlies the tragedies that continue to befall Malaysian women and girls. It is a tragedy that no girls should deserve to endure, and no babies deserve to die the day they were born. It is a tragedy that is totally preventable only when society decides that their lives are worth saving, by entitling them to proper reproductive healthcare and the choice of when to get pregnant, rather than leaving it to chance. We have the tools and the knowledge to prevent such tragedies if only we empower women and girls and allow them to access such preventive methods unhindered.

Malaysia signed the Convention of Elimination to Discrimination Against Women on 1 July 1995 joining 188 nations in the world to date in affirming the rights of women and girls to reproductive health and the freedom to choose in reproductive needs. It is a promise by all nations who signed the declaration that we will do all we can to uphold the rights of women and girls in their reproductive choice and to choose when to get pregnant and when not to.

“The fact that we are meeting at this Fourth World Conference affirms our commitment and preparedness to change. The Platform for Action is a means for us to operationalise the commitment to lead to a fundamental change. The Malaysian Government is committed to equal rights and responsibilities, equal opportunities and equal participation of men and women” – Tun Dr Siti Hasmah Binti Hj Mohd Ali, Head of Malaysian Delegation to the Fourth World Conference on Women in Beijing, 1995.

Why are we not doing more?
"My doctor asked me whether I needed a 7- or 14-day duration medical certificate (MC) for the surgery he performed for my carpal tunnel syndrome," a colleague of mine chuckled as she related to few of us over lunch. She was bemused as much as the rest of us with the manner the doctor had given her options. Medical absenteeism has been a contentious issue globally and in Malaysia. Polarised views on causes and management are frequently obtained. In recent times, it has made media headlines with various scandals ranging from selling of MCs' by a doctor and agents to syndicates selling faked MCs' from Government Hospitals. This is further compounded with the football World Cup samba!

As medical practitioners, patients often request MCs from us. The reasons vary from serious illnesses to seemingly trivial headache, food poisoning or malingering. We are caught between ethical practices versus pressure from some patients for MCs for non-genuine cases or medical conditions blurred with diagnostic dilemma. The Employment Act 1955 stipulates that ‘an employee shall, after examination at the expense of the employer by a registered medical practitioner duly appointed by the employer; or if no such medical practitioner is appointed or, if having regard to the nature or circumstances of the illness, the services of the medical practitioner so appointed are not obtainable within a reasonable time or distance, by any other registered medical practitioner or by a medical officer shall be entitled to paid sick leave’. The employee is obliged to inform the employer within 48 hours of the commencement of the sick leave under this Act.

The Act by and large with few exceptions covers any person who has entered into a contract with an employer whose wages do not exceed RM2,000.00 per month under a contract of service with an employer. However, many companies adopt the same principle as per the Employment Act for employees earning more than RM2000.00 on sick leave provision. In the event of an industrial dispute, the Industrial Court tends to fall back to The Employment Act 1955 as a guideline. Hence, employers have the obligation to accept medical leaves issued by doctors when the MC is given within the ambit of the rule of law. Acceptance of medical certificates by employers given by assistant medical officers at 1Malaysia clinics or from Klinik Kesihatan remains solely as a goodwill gesture by employers.

A nationwide survey conducted by Malaysian Employers Federation2 (MEF) revealed that employers cumulatively pay out an estimated RM 8.12 billion for the medical problems of the 6.5 million private sector workers nationwide. According to MEF3, Malaysia has the highest medical leave rate in the region. They are proposing the idea of setting up a Central Repository Database (CRD) to monitor employee absenteeism. If the concept is found to be viable, all employers will be required to report to CRD each time an employee takes medical leave with particulars of the staff and the concerned doctor. This raises issues with regards to protection of personal data, patient doctor confidentiality and probable abuse by some unscrupulous employers. Companies instead should take the initiative to monitor their own sickness absenteeism rate as well as trends and take measures to rectify the situation and counsel their employees.

As for doctors, an area of concern is regarding patient confidentiality. Some medical certificates carry the
patient’s diagnosis which is against ethical practice as well as Malaysian Medical Council’s (MMC) guidelines. We need to be mindful of this when we are occasionally queried by human resource personnel for the patient’s diagnosis. Medical certificates should ideally be signed and the doctor’s full name together with the MMC registration number be stamped. Any of this information will enable employers to counter check the authenticity of the concerned doctor from the MMC website. It is ideal to indicate the time of issuance in the MC. Occasionally, Government doctors are requested to countersign blindly for civil servant patients especially teachers who had sought treatment from private clinics or hospitals. This should not be condoned as a Government doctor cannot function ethically or professionally as a rubber stamp for a case that he or she had not attended to personally. Secondly, there has already been an amendment to the Government Order (GO) for the acceptance of medical certificates for civil servants from Government or private doctors. Backdating of MCs is also unacceptable. There have been previous instances where doctors have been hauled-up for this act.

As doctors, we sometimes issue light duty slips to patients; another contentious issue. Light duty slips are not legally binding. Acceptances of these slips are at the discretion of the company. They do not carry much weightage and often discarded by employers or leaves them in a predicament if the nature of the job the patient is able or not able to undertake is not stated by the doctor in the light duty slip. Light duty remains subjective for interpretation from one to another. What is light to one person may be heavy to another!

There has occasionally been mudslinging at the medical profession with regards to medical absenteeism. The reality is there are many stakeholders involved to overcome this problem. There is a higher probability of unhappy and demoralised employees to take leave than the rest. Virtually all major reviews of the literature have demonstrated a consistent relationship between job satisfaction and absenteeism. Health promotion efforts at the workplace result in reduction of healthcare and compensation costs, increase productivity and worker morale, reduction in staff turnover, absenteeism and disability. Workplaces should institute wellness programmes and they should be viewed as investment rather than a liability as the adage goes ‘Prevention is better than cure!’ ‘Return to work’ interviews conducted by companies have been found to be effective to curtail medical absenteeism. This may range from ‘hope you’re better, we missed you’ message to the employee as well as trying to understand the underlying problems. This indirectly deters malingers. Long-term sickness and employees with light duty slips may be referred to occupational physicians to ascertain how they can fit into the workplace as part of the ‘Fitness to Return’ programme.

Self-regulation is warranted, failing which we can expect fundamental changes to the whole mechanism of medical certificate issuance. It remains challenging to handle the vague cases and it is understandable to give the benefit of doubt to the patient. The next time when a seemingly healthy patient walks into your clinic and says, “Doc, can I have a MC?”, be wary! Have we reached a stage where we will have to examine the stools of the patient who presents with severe diarrhoea (well-hydrated with soft abdomen on palpation and sluggish bowel sounds on auscultation); or examine the sanitary pad of the patient who presents repeatedly for dysmenorrhoea?

References:
1. Employment Act 1955 (Act 265) and Regulations.
3. MCs in Malaysia among highest in the region, says MEF; The Star, Sunday December 5, 2010.
Place MMC Registration Number on Documents, Doctors Advised

BY DANIAL DZULKIFLY

KUALA LUMPUR, June 14 — The Health Ministry is recommending that doctors place their Malaysian Medical Council (MMC) registration number on all official documents, including medical certificates (MCs). Deputy Director General Datuk Dr Jeyaindran Sinnadurai said this would ensure more transparency across the board.

“At the moment, only medical practitioners working in the government sector are required to attach or place their MMC registration number on any document. However, those in the private sector are not required to do so,” he said.

“It would be great for all doctors to adopt the practice so that it is easy for the public to verify their credentials,” he said.

Dr Kumar said the move could be implemented gradually by the MMC, which would inform all doctors of the requirement especially when renewing their Annual Practicing Certificate.

“Only regulatory data that is required by law is handed to the necessary Government offices,” he said.

Dr Kumar said the move was not to breach medical ethics and would protect both the doctor and patient. “I agree if such regulations are made by and enforced by the Malaysian Medical Council,” he said.

“Such a measure does not breach any professional ethics or confidentiality. If any person is interested in finding a doctor and their qualifications and place of practice, it is freely available on the MMC website.

“Most documents released by the doctors will have the patient’s consent and the patient is usually the recipient of the documents. Only regulatory data that is required by law is handed to the necessary Government offices,” he said.

Dr Kumar said the move could be implemented gradually by the MMC, which would inform all doctors of the requirement especially when renewing their Annual Practicing Certificate.

“We have submitted our findings to the MMC for further action,” he said.

The department’s private medical practice control unit director Dr Faizal Mat Arifin, who led the raiding team, said the doctor who operated the clinic had abused his authority in issuing medical certificates.

“We have submitted our findings to the MMC for further action,” he said.

Those involved in the raid provided their statements and handed over the purchased certificates to help with the investigation.

The department questioned the doctor and his staff when it raided the clinic on May 18 and seized several documents, including an MC booklet.

The MMC has received a report and said the council would act accordingly.

The council may in the exercise of its disciplinary jurisdiction, impose any punishment as in the Act under Section 30 of the Medical Act 1971.”

Malay Mail was called in by the state Health Department yesterday to assist with the case.

WANTED

Female Aesthetic Doctors

Female aesthetic doctors are needed as ‘person in charge’ for private aesthetic clinics. Letter of credentialing and privileging would be an advantage.

Those interested kindly contact RANI at ranivij@hotmail.com
PETALING JAYA: Patients will soon have the option to choose between getting their medication from doctors as they do now, or to insist on the doctor giving them a prescription to buy the required drugs from a pharmacy.

It is learnt that the Health Ministry is working with the Malaysian Medical Association (MMA) and the Malaysian Pharmaceutical Society (MPS) to have this choice in place by next April.

However, some issues are still to be ironed out to ensure that it is a favourable solution for doctors and pharmacists, as well as patients.

The issue of separating drug prescribing and dispensing of medication between doctors and pharmacists, has been a bone of contention for a long time, as there are pros and cons to both arguments.

“Most importantly, we need to ensure that separating these functions do not burden patients financially,” said a ministry official, who declined to be identified.

“We also have to ensure there are enough pharmacists in both urban and rural areas nationwide for this system to be effective,” he added.

MPS President Datuk Nancy Ho told theSun a special committee has been set up with the relevant authorities to draw up a mechanism which will ensure all parties including patients, are not shortchanged by the move.

In recent years, calls to separate the prescribing and dispensing functions have been growing.

Pharmacists argue that separation of the functions can avoid the conflicting roles of doctors who have the potential to profit from the prescription and sale of drugs, and be part of a check-and-balance system to prevent over-prescribing practices.

In many Asian countries, including Malaysia, doctors dispense drugs directly to patients, earning profits that vary with the types and amount of drugs given.

However, profits from this practice helps doctors to offset clinic costs and allow them to charge lower consultation fees.

Commenting on the proposed move, MMA President Dr H. Krishna Kumar told theSun that doctors have no objection to the separation as long as all parties, including Managed Care Organisations, agree to let them charge consultation fees (without medication) of between RM30-RM125 as per the revised rate under the 13th Schedule of the Private Healthcare Facilities and Services Act 1998 announced last March.

He added that while doctors are fully aware the separation of functions will happen eventually, it has to take into account certain factors.

For example, he said, if the suggestion to stop doctors dispensing is adopted, there must be no double standards and it should be across the board for all doctors, irrespective of whether they are in the urban or rural areas.

“That means there must also be pharmacies and pharmacists in rural or remote areas to cater to this system. Otherwise, it will create unnecessary complications as to the fees to be charged by doctors if they have to dispense medicines, especially in areas with no pharmacies,” he added.

He pointed out that patients may incur extra expenses if the pharmacies are situated far from the clinics.

“The move should not inconvenience patients,” said Dr Krishna.
These are 2 retinal photographs that have been merged into a composite picture (right eye).

**Questions**
1. Is there diabetic retinopathy?
2. Is the optic disc normal?
3. Is the macula normal?

**Answers**
1. There are no red dots, blots or yellow dots seen in all quadrants. This indicates the absence of retinal haemorrhages and exudates. The blood vessels are of normal calibre and no abnormal vessels are seen – there is no apparent diabetic retinopathy.
2. The optic cup is significantly larger than average. Arrow a, vertical diameter of the optic cup; Arrow b, vertical diameter of the optic disc. The average “normal” ratio of a/b is 0.3. Here, it is 0.7; the patient needs further evaluation to exclude glaucoma.
3. The macula has no yellow or red dots seen. The slight red hue seen is the normal reflex at the fovea. The macula therefore appears normal.

Arrows c show the partially-obscured rim of the photograph; this is caused by a small pupil or poor photographic technique, and is of no significance.

The Malaysian Society of Ophthalmology runs a not-for-profit retinal photography service to help doctors screen their patients for diabetic retinopathy.

Website: http://mso.org.my/eyephotoproject.html, Email: msoeyephoto@gmail.com, Tel: 03-7960 6728
MMA Pahang has spread its wings and landed in Jerantut, where the National Park is situated. A programme was planned to promote healthy living, educate on cancer, perform health screening, and of course, to promote MMA’s long presence in a large state such as Pahang.

A unique combination of activities were articulated and themed 3Cs, “Cycle for Cancer, Colour for Cancer, Cook for Cancer” in order to cover all age groups. Hence, the National Cancer Council (MAKNA) was roped in as the main co-organisers of the event, along with the working committee from Jerantut District Hospital who hosted it, under the leadership of Dr Hj Muhd Siv Azhar Merican, who is also a Life Member of MMA.

The programme was officiated by the Member of Parliament of Jerantut, YB Tn Hj Ahmad Nazlan with flagging-off of 155 cyclists from various age groups on various types of bicycle for a 25 km challenge. He then visited the colouring contest where 100 preschool children took part colouring a picture. Also running concurrently was the cooking competition where five pairs took the challenge to prepare a healthy meal using appropriate calories and a slice of chicken as the main dish. Judges for both events were from agencies such as Pejabat Pendidikan Daerah, Pejabat Kesihatan Daerah, Bank Rakyat, and Jabatan Perpaduan.

Two trailers that were parked at the compound of the hospital also attracted the public. The MAKNA mobile mammogram trailer conducted 173 tests (exceeding their target of 150 cases!) and 87 breast clinical examinations, while the hearing assessment mobile unit from Universiti Islam Antarabangsa Malaysia (UIAM) conducted tests, which also exceeded their target. A special thanks to ENT specialist Dr Ailin Razali, MMA Life Member, for bringing her team over.

Other activities that were carried out during the day were dental examinations, blood donations, PAP smears (37 cases), organ donor pledging (8 new registrations), lucky draws, Hepatitis B screening (the cost of test was borne by MMA Pahang), and health screening / medical consultations with our MMA team including the Chairman himself Dato’ Dr K. Paramanathan, Secretary Dr Prem Kumar, Physician Dr Rena Menon, and Ophthalmologist Dr Carmen Chew. A total of 148 patients were seen that morning (a standard Government outpatient clinic attendance!). The public was very pleased with the presence of specialists examining them and they hoped such activities would be organised again in future.

The event was indeed a blast for both the organisers and the local community. It is hoped such an activity will be held in another district in Pahang to promote MMA Pahang. We serve ...

Prizes were given away during the closing ceremony. The colouring contest was sponsored by Bank Rakyat and cooking competition by ADABI. Fifty lucky numbers were drawn for prizes for cycling participants and public attendees, with a mountain bike worth RM 2,000.00 being the main prize. The event was indeed a blast for both the organisers and the local community. It is hoped such an activity will be held in another district in Pahang to promote MMA Pahang. We serve ...

The public was very pleased with the presence of specialists examining them and they hoped such activities would be organised again in future.

Dr Prem Kumar giving away prizes.

MMA Pahang Team.

Dato’ Dr Paramanathan with Dr Shiv Azhar and YB Tn Hj Ahmad.
I am happy Dr Helmy Haja Mydin highlighted the issue of the need for doctors to practise what they have learned in his article “Too Much Vomit” (New Straits Times, 7 June 2014). As he stated, a study published in the Journal of Archives of Internal Medicine showed that combining history, physical examination and basic tests led to a correct diagnosis in three out of four patients.

I would like to share my experiences as a practising doctor for 32 years. I have found patients being undertreated or wrongly managed in many instances because many a time, doctors just carry on managing cases “status quo” be it in the wards, and more so in busy clinics in Government and private practice.

An unfortunate blind middle-aged lady who was unable to walk for a few months was just given painkillers and vitamins by general practitioners. The family who knew me then brought her over instead. I conducted an examination after obtaining her full medical history. I made a provisional diagnosis of Potts Disease (TB Spine) and she was admitted. She was subsequently confirmed to have TB Spine and was treated, after which she could get up and walk again.

Another gentleman of similar age had been coming to an Emergency Unit due to abdominal pain. His pain was so intense that they needed to give him narcotics (pethidine or morphine). After more than a dozen visits, he was then labelled a drug addict by the emergency staff. However, when I went through his history including those in his outpatient notes, I found that he had Hepatitis B and an enlarged liver. He was never referred to a specialist and that was after umpteen visits to OPD and the Emergency. He died shortly before his appointment with a specialist.

A 64-year old lady was admitted to ICU with the diagnosis of Tetanus because she kept jerking and her blood pressure was labile. She was also unconscious, however, her presentations were very much like tetanus, so she was managed as one. After about a month of being managed in ICU, she did not recover. She continued to have body spasms though her blood pressure was stabilised. Our Chief Anaesthetist, the late Datuk Dr S. Radha Krishna did a full physical examination on her and found she had a bruise and lump on her scalp underneath her hair. She was sent for brain scan and we found she had an extradural hematoma and her daughters then stated she had a fall. She was soon put up for craniotomy and the clot was removed. Almost magically she woke up and walked home. Datuk Dr Radha was a great boss and clinician.

In the ward, again when there were not enough doctors, I did the rounds. At the end of the ward was a male patient who had been in the ward for daily dressing due to the month-old ulcer on his leg. I noticed how pale he looked and conducted further investigation. Indeed his haemoglobin level was so low, he needed blood transfusion.

Another man whose family I knew, called me to say that his father was delirious and they had brought him to the Emergency Unit but was discharged by the medical assistant. I told them to come over and upon a full examination on his medical history and current condition, he was found to be suffering from haematuria. His haemoglobin had become so low that he became delirious. After a blood transfusion he became himself again and was later referred for operative treatment of kidney.

A distant cousin, a male in his 30s, complained of abdominal pain at OPD. The doctor who saw him thought he was a malingerer and just wanted a medical leave as he had been seen several times at OPD. He came to see me and I found a palpable mass in his left hypochondrium. He was then diagnosed to have Ca descending colon stage 11. Luckily, he is now a cancer survivor.

A 19-year old male patient at emergency department was treated for diarrhoea and discharged. His mother came to complain to me. He was actually having melena and needed massive blood transfusion - we had to manage him in ICU. I prayed very hard hoping he would not suffer from any blood-borne infectious diseases (even though our blood is screened, a possibility of blood borne transmission can still occur due to the window period and irresponsible donors).

Can you believe this? A 27-year old lady came in with appendicitis and was operated on. Intra-peritoneum, the surgical doctors found a catheter. They were all puzzled including the
anaesthetic MO and they just decided to remove the catheter. Post-operative, they only realised this lady had a VP shunt due to hydrocephalus. How unfortunate for her! She was managed by doctors who were “cincai” from the surgical as well as the anaesthetic side. If only they had taken her past medical and surgical history, they would have known.

Another anaesthetic blunder was when a difficult intubation case was missed in a mute and deaf patient. It became an early morning fiasco when the usual 30-minute appendicectomy operation took several hours because she could not be intubated and a spinal had to be done which was also equally difficult and exhausting because she was also a known case of severe arthritis. Less than a week before, she had an elective knee surgery and the difficult intubation case was already noted in her anaesthetic chart which was still in her notes, as she was not discharged yet.

When I was managing a small district hospital, we had a maternal mortality case and during the discussion I realised I had seen the patient before at OPD (filling in the job of my MO), when she was five months pregnant with her fifth child. I noticed she had petechiae and sent her for a Full Blood Picture. The results came back normal. In this district hospital I worked in, there was no haematology analyser and the blood count was done manually. I decided to send off a sample of her blood to the Institute of Medical Research (IMR) but the results would only come back after a week. I never saw her after that. However, when I went through her notes for the maternal death meeting, the IMR result was there and she actually had low platelet count and it was noted that she should have a bone marrow biopsy done. Several doctors who saw her after that did not flip through her results even when she had presented with haematuria, and she died due to postpartum haemorrhage after her delivery. She had idiopathic thrombocytic purpura.

Shocking but true! I am just a simple doctor, but because I was thorough in managing the cases as taught in basic medical training (by checking the patient’s medical history in detail and conducting proper physical examinations), I managed to help many go home treated, healthy, and happy.

It is sad that in this era, a proper diagnosis could still be missed, all because some doctors opt to take shortcuts in managing their cases. When I was managing hospitals as a Director, doctors were hard to come by. Mistakes and cases of missing diagnosis were unavoidable as each doctor had about 2 minutes or so per patient. However, that did not hinder me from being thorough in my work. There was even a time when I had to close the clinic myself because I took so long with every case.

In this modern technological era, I have come across doctors who do not lay a finger on their patient and have not bothered to take note on any past medical history, what more occupational and family history. In some cases, blood pressure and pulse were not examined as well, when this should have been the basic care that doctors are required to provide. I have picked up a number of hypertension cases this way, especially young hypertensives who needed to be worked.

Recently I correctly diagnosed a patient who had hyperthyroidism because I found her to be tachycardic. When going through her records, it was noted that she had actually visited our clinic several times, and her heart rate was usually charted to be around 130 by the nurses. She did not have the full features of hyperthyroidism, but blood investigation confirmed it.

There is no shortcut in medicine. When we take the effort to fully examine a patient and his/her medical background, it reaffirms our position as concerned doctors; by doing so, we will be able to reduce mistakes, the ordering of unnecessary investigations, wastage, and the cost of managing a case. Ultimately we will be more efficient in cutting cost and saving time of all parties involved. I tell the young doctors that ordering all kinds of investigations just shows one’s deficiency in deriving the right diagnosis. By doing this, they increase the workload of the lab and ward staff, which creates a vicious cycle.

These cases that I share with you are just a portion of the disasters I have seen, managed, and rectified with damage control. We are lucky or maybe actually unlucky that our patients are still naïve, or that they are too nice to take legal action against us. By allocating ample time for each case, not only are we able to correctly diagnose a patient, we would gain their confidence too. Any form of healthy lifestyle counselling that we wish to impart would also be better accepted. I truly hope that our doctors will go back to the basics and treat each case with TLC, as if he/she is managing their own family member.

Dr Zorina Khalid
drzorina@yahoo.com.my
Life Member MMA
Sabah
YEAR 2014

AUGUST

1ST GLOBAL MANIPAL ALUMNI HEALTH SCIENCES CONVENTION 2014
Date : 7 – 8 August 2014
Venue : Royale Chulan Hotel, Kuala Lumpur
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Email : manipalghsc@gmail.com/manipalmaam@gmail.com
Website : www.manipal.org.my

6TH SABAH MMA PRIMARY CARE CONFERENCE
THEME : PRIMARY CARE, EMBRACING NEW FRONTIERS, ENRICHING LIVES
Date : 16 – 17 August 2014
Venue : Le Meridien Hotel, Kota Kinabalu
Contact : Ms Paulyn
Tel : +6012-805 5009
Fax : +6088-538 804
Email : mma_sbh@yahoo.com.my

3RD REGIONAL CONFERENCE – NUTRITION IN OBSTETRICS & GYNAECOLOGY 2014
THEME : NUTRITION & WOMEN’S HEALTH
Date : 22 – 24 August 2014
Venue : Hotel Istanza, Kuala Lumpur, Malaysia
Tel : +603-6201 3009
Fax : +603-6201 7009
Email : administrator@ogsm.org.my
Website : www.ogsm.org.my

SEPTEMBER

ASIA-PACIFIC GLOBAL HEALTH CONFERENCE 2014
Date : 4 – 7 September 2014
Venue : AIMST University Kedah
Contact : +6010-225 7067 (Mr Puventhiran)
          +604-421 8157
Fax : +604-429 8157
Email : apghc2014@aimst.edu.my
Website : apghc2014@aimst.edu.my

IMU NATIONAL CLINICAL SKILLS CONFERENCE
Date : 5 – 27 September 2014
Venue : International Medical School, Clinical School Seremban
        and The Royale Bintang Resort & Spa Seremban
Contact : Ms Liong Siao Lin @ +603-2731 7669
          Ms Inthirah @ +606-767 7795 ext 105
Fax : +603-865 6018/+606-763 0652
Email : icl@imu.edu.my & inthirah_narayanan@imu.edu.my
Website : www.imu.edu.my/icl

17TH PENANG TEACHING CONFERENCE FOR GENERAL PRACTITIONERS ORGANISED BY MMA PENANG BRANCH
Venue : Bayview Hotel Georgetown, Lebuh Farquhar, Penang
Dates : 11 September 2014 ~ Pre-conference Workshops
        12 – 14 September 2014 ~ Conference
Secretariat : Mr SP Palaniappan
Email : 17gpcourse@gmail.com
Tel : +604-222 9188
Fax : +604 222 9188/+604-226 2994
Chairman : Dr Segaran Xavier
Tel : +6012-397 4633/ +603-7955 7000
Fax : +604-324 3227
Organisation : Dr Hooi Lai Ngoh
Email : drhooi@hooi.pmc.my
Tel : +604-226 6699
Fax : +604-229 2379

39TH ANNUAL GENERAL MEETING AND DERMATOLOGY CONGRESS
Dates : 15 – 18 September 2014
Venue : G Hotel, Penang
Theme : Challenges in Skin, Hair and Nail Disorders
Contact : Anthony Choong, Menarini Asia Pacific
Tel : +603-7985 7000/7000
Mobile : +6012-345 2536
Fax : +603-7955 3530
Email : anthony.choong@menariniapac.com
Website : www.dermatology.org.my

OCTOBER

46TH APACPH CONFERENCE KUALA LUMPUR “EVOLUTION OF PUBLIC HEALTH IN THE ASIA PACIFIC REGION”
Date : 16 October 2014 ~ Pre-Conference
        17 – 19 October 2014 ~ Conference
Venue : Faculty of Medicine, Universiti of Malaya
        (Pre-Conference) Hilton, Kuala Lumpur (Conference)
Contact : Mdm Hamizwanis Hamid
Tel : +603-7967 7457
Fax : +603-7967 4975
Email : apacph@um.edu.my
Website : www.apacph2014.org

INTERNATIONAL CONFERENCE ON HEALTHY AGEING 2014
Date : 20 – 21 October 2014
Venue : International Medical School, Bukit Jalil Kuala Lumpur
Contact : Ms Liong Siao Lin / Ms Michelle Chow
Tel : +603-2731 7669 / +609-2731 7029
Fax : +603-865 68018
Email : icl@imu.edu.my
Website : http://imu.edu.my/healthy-ageing/

NOVEMBER

15TH ANNUAL CONGRESS OF THE ASIA-PACIFIC ASSOCIATION FOR GYNECOLOGIC ENDOSCOPY & MINIMALLY INVASIVE THERAPY (APAGE) 2014
Date : 27 – 29 November 2014
Venue : Shangri-La Hotel, Kuala Lumpur, Malaysia
Tel : +603-6201 3009
Fax : +603-6201 7009
Email : info@apage2014.com
Website : www.apage2014.com
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- Cardiothoracic Surgery
- Paediatric Cardio
- Physician
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- Respiratory Medicine
- Gastroenterology
- Psychiatry
- Psychology
- Endocrinology
- Immunologist
- Dermatology
- Oncology
- Haematology
- Plastic & Dental
- Plastic & Reconstructive Surgery
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- Geriatric
- Hand & Microsurgery
- Maxillofacial Surgery
- Nephrology
- Paediatric Surgery
- Rheumatology
- Vascular Surgery
- Hepatobiliary

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- Registered with the Malaysian Medical Council
- Valid Annual Practicing Certificate

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- Valid Annual Practicing Certificate
- Registered with the Malaysian Medical Council
- Registered with the National Specialist Register of Malaysia

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Email: doctors@pantai.com.my
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