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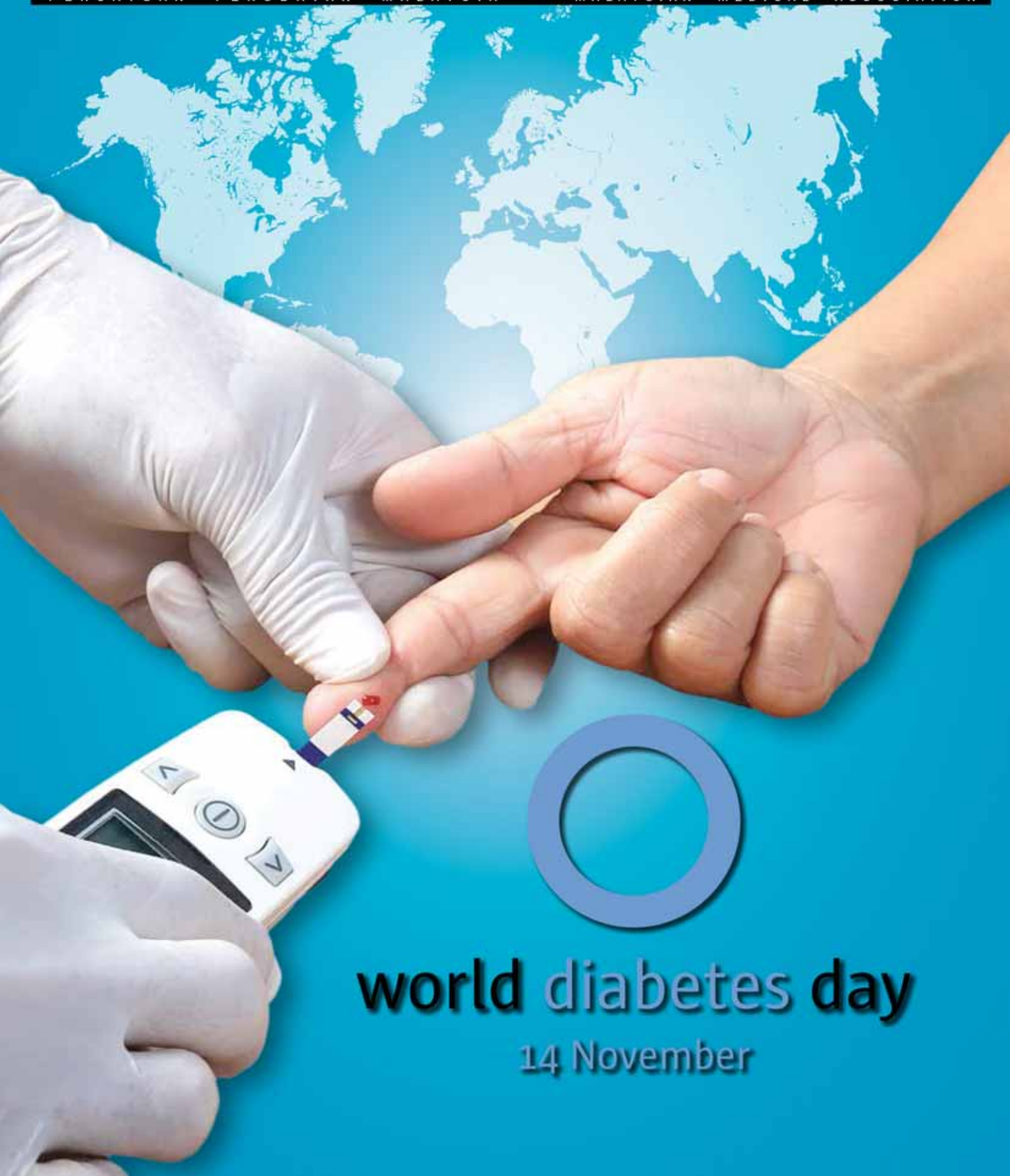
berita MMA news

PERSATUAN PERUBATAN MALAYSIA • MALAYSIAN MEDICAL ASSOCIATION



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Contents

Keep Well, Keep Fit!

Dato' Pahlawan Dr R. Mohanadas
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Editor

As Medical Practitioners are we keeping ourselves healthy and fit? Do we use the knowledge we have obtained in keeping ourselves in good shape, healthwise, and why not literally too! Do we practise what we advise our patients? Are we good role models for the family and the community?

These questions come to my mind as I hear of my contemporaries in the profession, diagnosed with complications of lifestyle diseases and cancer, some at late stages, inoperable, and their untimely deaths that have been announced in the papers. MMA Secretariat records about 20 members passing away each year, have not checked their ages though!

How many of us are serious in getting our regular medical check-ups done? Do we do a comprehensive medical check for our respective ages? I know of several friends who would just send off their blood for an occasional package of tests, then continue smoking and enjoying the physical inactivity, what with that many channels on television and the all addictive smartphones! The blood results will be back from the laboratory in the evening, and well, I am fine! A usual occurrence, and I guess we need to advise our own colleagues or harass them sometimes.

The one part is, individual responsibility for one's own health, ensuring we identify the risk factors early and have that managed. If an illness is diagnosed, ensure that we seek appropriate treatment early rather than self-treat, and avoid complications.

The second will be improving and maintaining our levels of fitness for optimum health. The WHO in its document **Global Recommendations on Physical Activity for Health** advises at least 150 minutes of moderately intense aerobic physical activity in a week. That would be like 30 minutes a day for 5 days. Alternatively, at least 75 minutes of vigorous aerobic physical activity per week. Let us take a simple formula of 45 to 60 minutes per session, 3 to 5 times per week, 30 minutes on the treadmill, 15 minutes of simple weights and floor exercises, and if a sauna is available, 15 minutes in it. You will feel and look younger for your age, besides of course the more important health benefits that are intended like cardiovascular, respiratory and muscle strength.

The world renowned, Dr Kenneth Cooper, the father of aerobics, is an American Board Certified Preventive Medicine Physician, and a former Colonel in the US Army and Air Force. He is now 83 years old and still an active lead figure in fitness circles. He, together with his son Dr Tyler Cooper, also a Preventive Medicine Specialist at the internationally acclaimed *The Cooper Institute and Cooper Aerobics Centre* has this very simple prescription for health and fitness, and I would like to share this here for the benefit of our busy colleagues.It consists of 8 indicators, and is termed the *Cooperized Lifestyle*, and I quote in full:

- Maintain a healthy weight
- Eat healthy most of the time
- Exercise most days of the week
- Take the right supplements for you
- Stop Smoking
- Control Alcohol
- Manage Stress
- Get a regular Comprehensive Physical Examination

(Source: cooperaerobics.wordpass.com & www.cooperinstitute.org)

Is this not all so simple? We can all do it, spare some time for a better quality of life for ourselves and our loved ones, and simultaneously, create an image of a profession of healthy and moderate living individuals. The Cooper's 12 minute test of fitness will form a reliable benchmark for you to check your progress.

Keeping fit need not mean a compulsory membership to a Fitness Club, which may cost an average of RM200 to RM300 per month. The Fit Malaysia programme launched in September this year by the Youth and Sports Ministry, is a community-based programme designed to keep the population fit and healthy and thereby transforming Malaysia to be a sporting nation in the long haul. Jogging, cycling, martial arts and aerobic fitness form the core components. Could we as Medical Practitioners take lead roles in our own community when Fit Malaysia is launched in our localities?

The 2015 budget did not provide additional incentives in the promotion of health through sports and fitness, unless it slipped my reading. However, the RM300 per year that is tax deductible for the purchase of sports equipment remains, and hopefully you are utilising it. Keep well, keep fit my friends!

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2015: Healthcare

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President

It is now the month of November and we are edging closer towards the end of the year. Time may hang heavy on one's hands if there is little to do, but here at MMA that is far from the opposite. Time is of the essence in our strive to move forward and achieve what was planned. Again, I would like to emphasise, work and duties have to be executed diligently and no excuses can be accepted. We have finally managed to secure an appointment with the Minister of Health on 28th October. We will also meet the Secretary General of the Ministry of Health (MoH) on 5th November.

Redevelopment of the MMA House

We have placed an advertisement in the newspapers for any interested parties to participate in a joint venture with MMA in redeveloping MMA House. We have given them till the end of October to respond. We will then set a deadline of about two weeks for the proper presentations to roll in before we pick and decide from the lot.

In the recent ExCo meeting, we had two suggestions. The first was to refurbish the whole building. As we have done the electrical work, we will have to look at the piping, air-conditioning, fire safety, roofing, painting, and other miscellaneous expenses. We need to consider these costs and compare them to the overall cost of maintaining an old building annually.

The second proposal was to sell the building we currently own and buy a better building (condition-wise) further away from the centre of town. Even this proposal has its pros and cons.

We will collate all the three proposals and present them in detail at a special General Meeting. Once this is done, we will allow the house to vote on the choice which would best supplement our plans for MMA's future.

The Malaysian Budget

I received many calls from the press before and immediately after the budget was announced, as they wanted to know MMA's response to it. Since none of the press covered my views fully, I will place them here.

My wish list on behalf of the MMA includes these items:

- Reduce subsidy or increase tax on food that is unhealthy e.g. sugar, salt, and saturated cooking oil. Especially those bought in large quantities.
- Remove taxes on healthy food e.g. vegetables, fruits, oat bran, etc.
- Increase sin tax for cigarettes and alcohol. This extra revenue can be allocated for healthcare instead.
- Increase fine and jail terms for illegal smuggling of above items to prevent its cheap availability.
- Tighten law on sales of cigarettes to those below 18 years.
- Tax incentives for joining health clubs and gyms (tax deduction).
- Increase number of public parks, jogging tracks and gyms to promote health. This would also allow green lungs to sprout in the city centres and provide fresh air to the public.
- Tax incentives or exemption for those using medical insurance.
- Remove medical indemnity from GST, both premiums and payouts.
- Deductions in health costs, excluding supplements, for individuals and families.
- Promote healthy lifestyle programmes.
- Remove tax on exercise equipment and sports equipment.
- Increase deduction for pension/KWSP/health insurance for taking care of one's health in later life.

It was made known in Budget 2015 that the Government would be allocating RM23.3 billion for the healthcare sector, RM1.2 billion more than last year's budget of RM22.1 billion. The cost of staff salaries, maintenance and medicines will cover this increase.

Below are some of the highlights on the allocation for the healthcare sector:

- The National Essential Medicine, covering almost 2,900 medicine brands used to treat 30 types of diseases including heart failure, diabetes, hypertension, cancer and fertility treatment, would not be subjected to GST. We have to see the full list to ensure that all essential medications are covered
- Two hospitals will be built in Dungun and Seri Iskandar. Twenty (20) health clinics and four dental clinics will also be built. An additional 30 1Malaysia clinics would also be established, bringing the total to 290 clinics nationwide.
- More hospitals are required as the number of hospital beds are far lacking compared to most developed countries. However, we also need to find the staff to man these hospitals. RM30 million has been allocated

Healthy Diets as The First-line of Defense Against Heart Disease

The old adage ***"You are what you eat"*** holds true today. With increasing rates of people with high cholesterol (6.2 million) and a growing trend of obesity (3 million) and Type 2 diabetes (3.6 million), it's important to watch what you eat.

What Constitutes A *Heart-Healthy* Diet?

According to the American Heart Association (AHA), diet and lifestyle changes are usually the ***first*** step in lowering cholesterol before medications are added. Heart-healthy eating, together with regular physical activity can lower the risk for heart disease and stroke.

A heart-healthy diet is usually achieved by eating foods that are ***low in calories, saturated fat, total fat, cholesterol, sodium and high in soluble fiber such as oat beta-glucan***.

Therapeutic Lifestyle Changes (TLC) Diet is part of a three-step program endorsed by AHA as a heart-healthy regimen. The main focus of the TLC diet is cutting back on saturated fat, primarily from meat, whole-milk products and avoid trans-fat which could bump up bad cholesterol. The effects of the TLC diet are further enhanced with gradual weight reduction through regular exercise.

If you need to take a cholesterol-lowering drug, following the TLC diet & lifestyle approaches may, in some cases, enable you to take a lower dose of statins.

Key Recommendations for a *Heart-Healthy* Diet:

1. Eat more fruits, vegetables, whole grains or other cereal products which are high in soluble fibers (oat beta-glucan). Examples include oat bran powder & crispy oat cereals.
2. Choose foods that are low in saturated fat, trans fat and cholesterol.
3. Limit salt (sodium) intake.
4. Keep your body weight healthy by balancing the calories intake from food with regular exercise.
5. Eat more foods high in omega-3 fatty acids, such as flaxseeds and algae-derived oil.
6. Limit drinks and foods with added sugar.
7. Avoid alcohol or drink in moderation.

INFO-CHANNEL

Oat bran powder and crispy oat cereals are rich sources of fiber, protein and the heart-healthy ingredient – oat beta-glucan. Yayasan Jantung Malaysia (YJM) has approved and endorsed the following health claim: "Take 3g of oat beta-glucan from ***Biogrow Oat BG22***™ daily, as part of your low fat and low cholesterol diet, **helps reduce cholesterol.**"

Heart-Healthy Diet also leads to Weight Loss

If you are overweight or obese and have no idea which diet you should follow to lose weight, this might be your answer: A study published in The New England Journal of Medicine suggests that the wisest way to lose weight is to adopt a heart-healthy diet which is high in fiber and low in calories.

When it comes to a high-fiber, high-protein and low calories diet, ***Biogrow Oat BG22™ Crispy Cereal*** form the cornerstone within that category. Comprehensive studies worldwide have affirmed such cereals of its ability to exert cholesterol-lowering, weight-reducing, bowel-improving effects. The healthful combination of soluble fiber (oat beta-glucan) and insoluble fiber in ***Biogrow Oat BG22™ Oat Bran Powder*** is good news to control hunger - the Achilles heel in successful weight loss.

All in all, successful weight loss is a culmination of an active lifestyle which includes regular physical activity and healthy eating habits.

LOAD UP ON OAT FIBER & MAKE LIVING HEART-HEALTHILY YOUR PRIORITY TODAY!

**Disclaimer: The above is in no way meant as a substitute for sound medical advice whatsoever. In all circumstances, consult your doctor / physician prior to embarking on any diet regimes.*

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Message by **Yayasan Jantung Malaysia** (The Heart Foundation of Malaysia):

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1 packet (30 g) = 3 g beta-glucan

2 scoops (≈ 18 g) = more than 3 g beta-glucan

2 sachets (≈ 18 g) = more than 3 g beta-glucan

This article is contributed by
Legosan (Malaysia) Sdn. Bhd.
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to replace 635 units of haemodialysis machines in Government hospitals and clinics. To encourage the Private sector's participation, space will also be provided in Government hospitals and health clinics to place another 244 haemodialysis machines which will be contributed by the Private sector as part of their corporate social responsibility. This is a good initiative between the two bodies to improve and achieve better standards in healthcare.

The Government will also allocate RM45.4 million to provide medicine for patients undergoing chronic and acute haemodialysis treatment. This is already ongoing.

Expenses incurred for treatment of serious diseases such as cancer, kidney failure and heart attack are given tax relief up to RM6,000. Last year it was RM5,000. The relief is available to the taxpayer, the spouse and children. Those with catastrophic illnesses will obtain more relief but it may still be inadequate.

Dengue prevention efforts will be enhanced through community awareness programmes. RM30 million has been allocated for the purchase of dengue prevention equipment such as reagents, thermal fogging machines, mist blowers, and Ultra-Low Volume technologies. Apart from that, the Government will distribute 55,000 dengue test kits for free to private clinics to expedite the process of early dengue detection; this will help the virus to be identified quicker, resulting in less complications as treatment will be initiated earlier. This is another good partnership between the Government and Private sector, but bear in mind that we will need more than 55 kits per doctor for the continuity of care.

"Are you satisfied with the allocation, dear Dr? Did it fulfill your expectations?"

My answer was simply "*No*", as more is still needed for healthcare. The allocation needs to be based on Gross Domestic Product (GDP). The World Medical Association recommends a minimum of 5% GDP to be allocated for healthcare annually.

Goods & Services Tax (GST)

GST will be implemented April next year. Are we ready for it? Are the Ministry of Finance (MoF) and Customs ready for it? During my recent discussion with various MoF officials, it is clear that they do not understand us doctors and the way we practise. I tried to furnish them with pertinent information and data but they have not been able to answer all our queries.

Most General Practitioners do not have to fear. They are covered by the letter we published last month from the Royal Malaysian Customs. As the HGS pointed out in his article, all third party services incur a GST but you are not allowed to relay the charges to patients. The tax, along with the cost of your services, would just have to be added upwards on to the bill.

Private Specialists

Doctors practise differently in the Private sector. Most Private Specialists are independent contractors to the hospitals they work in. They may be part of a limited company or function as individuals. They provide the services directly to the patient. Payments are collected from patients or third party administrators (TPA) (which include insurance companies) by the hospital. Commission or service charges are taken by the hospital. Some are on guaranteed or shared income.

The patients usually do not pay GST. However, the doctors as third party suppliers will charge the hospital GST. Their commission will be taken by the hospital and it will be charged with GST as well. This total bill will then be issued to patients but they would not be taxed. Though it is implied that patients would not have to fork out more from their wallets when seeking healthcare services, we have already witnessed an increase in healthcare cost just by referring to the earlier charges imposed by third party suppliers.

Doctors would also have to register with the GST Department if their annual income exceeds RM500,000. If a doctor orders a test, refers to another doctor or the laboratory (another independent contractor), GST will be incurred and passed on to patients, but they will not have to pay GST at this stage.

All supplements and nutritional products are subjected to GST (as they are not medical drugs) and only certain drugs are exempted from GST. All medical indemnity insurance premiums (compulsory under the new Medical Act) will be subjected to GST. These charges will have to be passed on to patients eventually.

There is a query that has not been answered. Doctor's fees are limited by the Private Healthcare Act. However, with these factors being inserted, there will be an added amount. Will this contravene the act? But also note that the fee is collected by the hospital and the hospital fees are not restricted by any act. Will this loophole be utilised?

Will the implementation of GST also increase the premiums for medical cards and medical coverage? As insurance companies are third parties and will be subjected to GST at every transaction, they will probably pass on the cost to the public under the guise of raised premiums in order to cover these increased costs.

So finally the public will have to bear the brunt of rising healthcare costs.

World Medical Association (WMA)

I represented our august Association and country for their meeting. It was found that most members are not declaring their true membership as most of the national associations cannot afford the subscription fee. Therefore, WMA has decided on a fee reduction which in turn has managed to earn them more subscriptions as all countries are now paying their dues. They too have agreed to be flexible in order to collect more.

There were many resolutions passed and they will be available as links in our MMA website for all of you to access. We hope that you will be able to see the common problems faced by all nations in this small world.

Ebola has made us realise if that we do not cooperate with each other and help the poor and less developed countries, a small isolated endemic disease may become an international epidemic. We have to look at Nigeria for lessons on controlling the disease and our country has already embarked on its journey of preparation in order to combat the disease should it – unfortunately – hit our shores. For this, we wish the Government all the best in their efforts and hopefully this pandemic outbreak will not cross into our borders as it will affect us all.

ManipalHospitals
LIFE'S ON

Manipal Health Enterprises (MHE) is a part of globally known Manipal Education & Medical Group and is India's third largest healthcare provider with 10 corporate hospitals and 5 managed hospitals. MHE has acquired Arunamari Specialist Medical Center at Klang, renamed as **Manipal Hospitals, Klang (MHK).**

MHK is a private medical healthcare provider located in Bayu Perdana, Klang. We are soon expanding and growing to a 200+ bedded tertiary-care hospital in Bandar Bukit Tinggi, Klang.

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- Urology
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For enquiries, you may contact
Dr. Jeyanthi (012-233 7026) or
Ms. Tan Ai Hoom (03-3324 3288)

You may send in your detailed resumes to tan.aihoom@manipalhospitals.com or send us a hard copy, addressed to the **Head of HR.**

Manipal Hospitals Sdn Bhd (340797-H)
(Formerly known as Arunamari Specialist Medical Centre Sdn Bhd)
162A, Jalan Batu Unjur 1, Bayu Perdana, 41200 Klang. Selangor Darul Ehsan, Malaysia.

From the Desk of the Hon. General Secretary

Dr Ravindran R. Naidu
flynaidumma@gmail.com
Hon. General Secretary

Where There is Unity There is Always Victory

The amended and new version of the Constitution has been approved by the Registry of Societies (RoS) as of 22 September 2014. All Articles and By-Laws have been changed to Clause 1 – Clause 30. This change was instructed by the RoS as they are streamlining all constitutions of various organisations in the same format. Secondly, all submissions have to be done online (via eROSES) and manual submissions will not be allowed.

One of the amendments to the Constitution is *Clause 6 (3) (iv)* where the annual subscription payable for Student Members will be RM50.00 per annum. There has been some confusion with regards to the subscription of students. The new subscription rates will apply to any application received after the 22th September even though the forms are dated earlier.

The doctors in this country are facing numerous problems. Many General Practitioners have wound up due to lack of income. There are many laws and regulations governing the General Practitioners. Issues like too many medical schools resulting in overproduction of doctors, GST, PDPA, FOMEMA, increasing medical indemnity rates without tax-exemption, third party administrators/MCOs, the new Medical Act and Corporatisation of MMC, and many more issues are troubling all doctors, regardless General Practitioners or Private Specialists. Something has to be done about these issues that are plaguing the doctors in this country and the only way is to be UNITED.

It is time for all the doctors in this country to stand united and tackle all these issues. Only if we are united can we achieve the best for doctors in Malaysia. All the various organisations of doctors need to stand united in this country so that we can achieve what is fair for us.

Staff Meeting

Staff Birthday Celebration

The monthly staff meeting and birthday celebration for all October babies was held on 10th October. It was agreed that MMA will sponsor a Family Day outing for all the staff, their spouses and children. The staff have decided to go to I-City Shah Alam on 30th November.

We attended the Melaka Annual Dinner and Installation Night held at Hotel Equatorial on 11 October 2014. Attendance was good, and the dinner centred around a Hawaiian theme. As usual it was a very joyous night.

"THE MMA REQUIRES GENUINE RECONCILIATION AND ALL PARTIES MUST CLOSE RANKS FOR THE SAKE OF THE ASSOCIATION" *– Tan Sri Razali Ismail*

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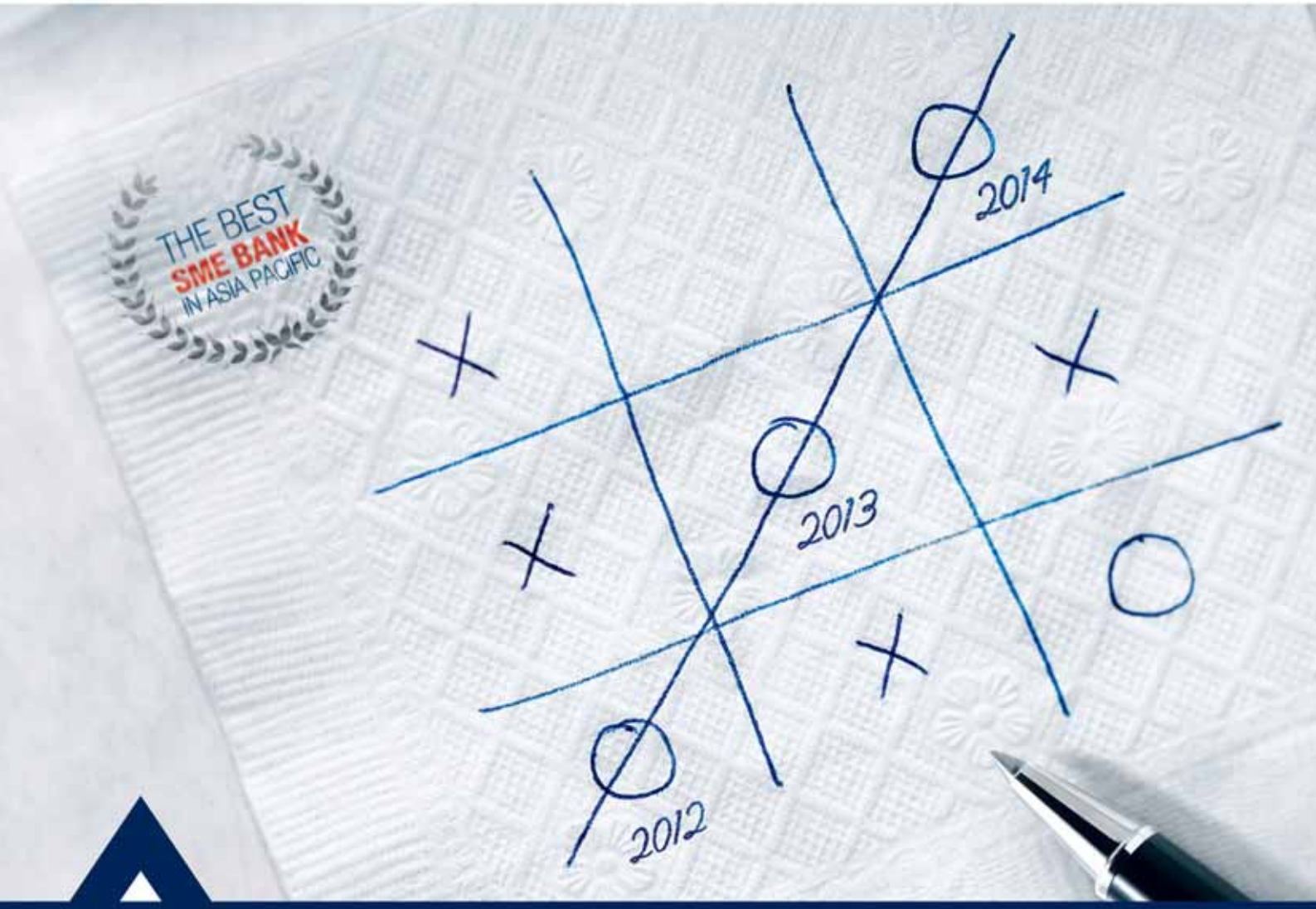

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Trigeminal Neuralgia

CONSULTANT NEUROSURGEON
Dr Syed Abdullah Al-Haddad
MB Bch, BaO, LRCSI, LRCPI, MRCS, MSc (Trauma), FRCS (Surgical Neurology), Certificate Completion of Training (CCT) in Neurosurgery (UK)

Trigeminal Neuralgia (TN), also known as prosopalgia or Fothergill's disease, is an extremely intense severe pain usually present as a lancinating or electric shock sensation on one side of the face affecting along the distribution of the trigeminal cranial nerve (Type 1) and occasionally with constant dull burning background pain, (Type II TN) . Both forms of pain may occur in the same person, sometimes at the same time. The intensity of pain can be physically and mentally incapacitating. It is universally acknowledged as the most painful affliction known to humankind.

This condition can occur at any age but more common in people from the age 40-60 with a slightly more female preponderance.

SYMPTOMS

Trigeminal Neuralgia symptoms may include one or more of these patterns:

- Occasional twinges of mild pain.
- Episodes of severe, shooting or jabbing pain that may feel like an electric shock.
- Spontaneous attacks of pain or attacks triggered by things such as touching the face, chewing, speaking and brushing teeth.
- Bouts of pain lasting from a few seconds to several minutes.
- Episodes of several attacks lasting days, weeks, months or longer — followed by a period of remission. Pain in areas supplied by the trigeminal nerve, including the cheek, jaw, teeth, gums, lips, or less often the eye and forehead.
- Pain affecting one side of your face at a time.
- Attacks becoming more frequent and intense over time.
- The presence of trigger point - whereby the pain can be triggered by touching this point usually on the affected cheek.

PATHOPHYSIOLOGY

TN is thought to be caused by a vascular compression on the trigeminal nerve, resulting in demyelination of the sensory nerve fibres especially at the root entry zone (REZ). As a result there is an abnormal transmission of action potentials to the adjacent nerve fibres (a process known as ephaptic transmission).

TN can occur in patients with multiple sclerosis (MS). A further cause of TN include demyelination by compression from a tumour. The cause can be unknown in some cases, where no vascular or other lesion is identified.

EXAMINATION AND TESTS

The diagnosis of this condition relies entirely on good history taking as patients with TN usually present with normal examination finding and furthermore, there is no specific blood or radiological test to confirm the diagnosis.

INVESTIGATION

MRI Brain (CISS - constructive interference in steady state sequence) is normally used to identify vascular compression of the affected trigeminal nerve. However, this vascular compression may not be visible in some cases. MRI is also used to rule out tumour compression at the petrous apex or multiple sclerosis.

TREATMENTS

Medical

Management of this condition must be tailored individually, based on the patient's age and general condition. The first line of treatment of this condition is usually pharmacology which seems to be effective in 75% of patients. Most patients respond very well initially to Carbamazepine (Tegretol) as a single agent. Over the years, however, they may require a second or third drug to control breakthrough episodes. Other drugs used to treat this condition include Oxcarbazepine, Pregabalin and Phenytoin. Over time, the drugs used for the treatment of trigeminal neuralgia (TN) often lose effectiveness as patients experience breakthrough pain. For patients in whom medical therapy has failed, surgery is a viable and effective option.

Surgery

Three operative strategies now prevail: microvascular decompression (MVD), percutaneous procedures and radiosurgery. Ninety percent of patients are pain-free immediately or soon after any of the operations, although the relief is much more long-lasting with microvascular decompression. Percutaneous surgeries make sense for older patients with medically unresponsive trigeminal neuralgia. Younger patients and those expected to do well under general anaesthesia should first consider microvascular decompression—presently, this is the most cost-effective surgery although it is also more invasive.

Percutaneous procedures usually can be performed on an outpatient basis under local or brief general anaesthesia at acceptable or minimal risk of morbidity. It is aimed at causing localised damage to the peripheral nerve at the level of trigeminal ganglion. Three types of procedures are commonly employed: percutaneous radiofrequency trigeminal gangliolysis (PRTG) - using heat to damage the nerve, percutaneous retrogasserian glycerol rhizotomy (PRGR) - using chemical, and percutaneous balloon microcompression (PBM) - using physical compression to cause damage to the trigeminal nerve. Patients are left with minor, local, residual facial numbness after PRTG; may occasionally lose sensation after PRGR; and rarely do so after PBM. In each procedure, the surgeon introduces a trocar or needle lateral to the corner of the mouth and, under fluoroscopic guidance, into the ipsilateral foramen ovale.

Microvascular decompression of trigeminal nerve requires general anaesthetic and a small opening size of 50 cent coin made behind the ear (retrosigmoid) on the symptomatic side of the patient. Once the offending loop of vessel is identified and mobilised, a small spongy-like material (e.g. teflon or fascia graft) is placed between vessels and the nerve to prevent the vessel from returning to its native position.

The timing for surgery is debatable, and no randomised study has addressed this question. However, the earlier a surgical technique is applied, it seems the better the outcome. At least two medication trials should be performed and carefully evaluated before more invasive techniques are instituted.

A community health message brought to you by

SUNWAY MEDICAL CENTRE

To Err and To Be Erred

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National SCHOMOS

Can this happen: To cause harm and be harmed in return? The obvious answer is, "Yes". An example will be when you cause a road traffic accident. The chances of you being hurt in return are high.

A very smart man once told us that, "For every action there is an equal and opposite reaction". This holds true as a law and it applies to everything we do. Over the years the awareness regarding medical errors has become more prevalent amongst healthcare providers and the general public. The media too has taken special interest in these events because there is no news like bad news that sells a paper!

In view of this situation, regulatory associations have set up investigation committees and other auditing avenues to keep track and investigate whenever necessary.

There is now an emphasis on keeping the patient and their family members informed or well-handled when an error occurs. Indeed a lot is being done to ensure the best healthcare practices are provided to the patients. In these financially difficult times we are often expected to provide for more than we are able to handle. Resources are limited, patients are unlimited and the desire to do more than you can actually cope with, is high amongst many. In all nobility, doctors are actually good people. So when you do more with less, mistakes can happen. We actually have a system to manage the 'victim' and his family. But what happens to the 'culprit'? Mistakes, inevitably, will take place and we have accepted that. But do we know that the 'culprit' is also a victim? This gives rise to the concept of the '**second victim**'.

Healthcare workers – who are often impacted by medical errors – as second victims, experience many of the same emotions and/or feelings that the first victims (patient and family members) face.[5] The signs and symptoms are similar to those in acute stress disorder, including initial numbness, detachment, depersonalisation, confusion, anxiety, grief, depression, withdrawal or agitation, and re-experiencing of the event.[1] There are other feelings related to medical errors which include shame, guilt, anger and self-doubt.[5] Lack of concentration and poor memory are also common, and the affected person may be significantly impaired in performing usual roles. These symptoms may last for days to weeks. A few go on to suffer long-term consequences, similar to post-traumatic stress disorder, that include re-experiencing the original trauma through flashbacks and nightmares, avoidance of situations associated with the trauma, increased arousal including sleep disturbance and irritability. These symptoms often result in significant functional impairment.[1]

Healthcare workers have been known to react to such events in drastic ways. We know of people who have decided to change their career paths forever, and also of those who have resorted to self-harm. The second victim phenomenon is a common problem for healthcare organisations. There has been a lot of work done in the West regarding this issue and it is about time that Asia also recognises the potential problem at hand, and tackle it with our own protocols. It was a blessing being able to attend the IAMRA (*International Association of Medical Regulatory Authorities*) Conference in London where I met a very interesting gentleman who shared his vast knowledge on the topic of second victims. He also shared some interesting papers with me and this one in particular was interesting:

Kronman and colleagues identified the need for training programmes to provide structured, meaningful ways for House Officers to discuss their errors, cope, and forestall negative emotional consequences. They identified that the ability to cope successfully with errors may be dependent on appropriate reassurance provided by colleagues and supervisors. The coping response is determined by additional factors, including the severity of the outcome. However, this kind of psychological first-aid may be necessary, if not sufficient, to allow optimal recovery for the second victim.[2]

Note that this is seriously lacking in our system. There is a need to move away from the 'blame' system to a more 'balm' system if I may say so myself. You never really forget the complication or 'hurt' you have caused a patient. This is especially true if you have had a long professional relationship with the patient's family and the patient itself. Generally the senior tier may spend the least amount of time with patients and it is the House Officers, Medical Officers and Nurses who actually do, thus making them the vulnerable group in this scenario. It does not help if you have unsympathetic colleagues who may mock you and make you relive the trauma constantly. Interaction with other medical colleagues can be critical to the coping process, and without them a clinician may feel isolated. After being involved in an adverse event, clinicians need both professional reaffirmation and personal reassurance.[3][4]

The thought of facing a lawsuit is probably one of the worst feelings a clinician could experience. It traumatises and leaves a scar like no other. What are the protocols and pathways for hospitals to support their clinician in such an event? Are there any? Should there not be a support system?

The problem is real and with the increasing number of doctors, the problem is growing. Awareness is needed at this point. We should all do what we can in our capacity to soothe, support and calm our colleagues who have become second victims. There will be a large group who will settle down with this level of intervention. There will be another group which may require counseling and physiotherapy etc. Systems need to be in place and we must accept that mistakes will happen and the blame culture usually leaves the clinician sore, resentful, depressed, unmotivated, and even suicidal.

The second victim phenomenon is a common problem for healthcare organisations. There has been a lot of work done in the West regarding this issue and it is about time that Asia also recognises the potential problem at hand

The next time your colleague has a complication, do not worry too much about the family and patient as there is a mechanism in place to handle that. Pay more attention to how your colleague is coping!

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TPPA and its Implications for Healthcare

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PPS

What Is TPPA?

TPPA stands for Trans-Pacific Partnership Agreement and was originally called the Trans-Pacific Strategic Economic Partnership (TPSEP). It is a multilateral agreement ostensibly to facilitate trade between the member countries but its chapters and regulations extend far beyond matters pertaining to trade and include broad and restrictive measures regarding patent laws, protection of intellectual property (IP), restriction of access to information (Data Exclusivity) and the opening of markets to facilitate the entry of foreign capital with severe restrictions on policy and regulatory powers of host governments. In addition, perhaps the most pernicious and perverse provision is the Investor-State Dispute Settlement (ISDS) provision which is a mechanism to enable multinational companies to sue signatory countries while these countries are not allowed to sue the same companies.

To date, 12 countries – New Zealand, Chile, Singapore, Brunei, Peru, Vietnam, Canada, Mexico, and the US are negotiating the proposed free trade pact. Malaysia joined the negotiations in 2010. The US joined in February 2008 and took charge of the negotiations with a stated aim of, 'participation in Trans Pacific Partnership (TPP) to position US business better to compete in Asia-Pacific area'. When the World Trade Organisation (WTO) talks in Cancun (2003) collapsed, the US Trade Representative Robert Zoellick warned that the US would not allow the way forward to be blocked by a group of 'won't do' countries.

Secrecy

The negotiations and the negotiating texts are shrouded in secrecy. The public and even lawmakers are denied access to discussions but about 600 corporate 'advisors' to the US delegation enjoy full access. What knowledge we have about TPPA is from leaked documents, much of which has been revealed by WikiLeaks. These reveal that TPPA, which is to be the model for a 21st century trade agreement, mandates a high degree of liberalisation which will allow unhindered opening of markets to foreign capital for exporters to penetrate signatory countries. This will impact local industries of particular interest to the medical profession and the pharmaceutical products manufacturers, and will result in large scale unemployment which is of no concern to the US. Host countries will also face severe restrictions in formulating policies.

New Patent Regulations

TPPA will allow new patents for existing drug modifications ('evergreening'), diagnostic, therapeutic and even surgical techniques. These go far beyond the restrictions of WTO's already severe Trade-Related Aspects of Intellectual Property Rights (TRIPS). This will in effect prolong patent protection and delay the manufacture of generic versions and deny consumer access to cheaper medicine. As can be expected, the developing countries will bear the cost of this inhumane restriction. In addition, TPPA prohibits pre-grant opposition to patent applications. This is a tool to combat weak patents. Challenging undeserved patents will become cumbersome and expensive. TPPA seeks to water down disclosure standards in the granting of patents. Higher standards of disclosure will help local manufacturers and researchers to enter the market with generics.

> For the ordinary citizen, healthcare will be more expensive as the availability of generics will be considerably delayed

An alarming aspect of patent protection is that biologicals, plants and animal will be patentable. Many drugs, it is foreseeable, will be extracted from particular plant species or sub-species and these too can enjoy patent protection. In fact the US Centers for Disease Control (CDC) has already obtained a patent for a particular type of the Ebola virus. This happily is not the same type of Ebola virus that is at present ravaging West African states and threatens to spread to other parts of the world as otherwise research efforts will be severely restricted by lack of access to intellectual property.

At present the granting of patents for a chemical entity does not automatically confer marketing approval by the relevant drug control authority but with TPPA these will be mandatorily linked. Patent period for pharmaceuticals which by international law is 20 years now can be granted extension. This will protect high-priced monopolies. The effect of this will be acutely felt when new and better remedies are discovered for existing treatable illnesses and for diseases that are currently untreatable.

Under TPPA, signatory companies will be responsible to enforce patent protection. Custom and regulatory bodies will be given wide ranging powers to seize medicines

on mere suspicion of patent infringement and factories can be closed and prevented form manufacturing all products if it is suspected that even a single pharmaceutical entity that still enjoys patent protection is being manufactured. It is incumbent on governments to enforce these punitive measures.

Higher Level of Intellectual Property (IP) Protection

Data exclusivity is an extreme level of protection of intellectual property. Data obtained by innovator companies such as the results of clinical trials will be the sole property of these companies and cannot be used by generic manufacturers without the permission and payment of copyright access fees to the holder of the intellectual property rights. In addition, clinical data relating to minor modifications such as route of administration of a drug will enjoy patent protection as if it were a new entity and data exclusivity will also apply. Access to affordable knowledge even for legitimate use of protected digital work including buffer copies made by computers will limit public access to digitised education, research and cultural knowledge. Generic medicine manufacturers will have to re-invent the wheel

As can be imagined all these provisions such as, evergreening, increased patent protection and data exclusivity will benefit the multinationals and give them the greatest returns. For the ordinary citizen, healthcare will be more expensive as the availability of generics will be considerably delayed.

State Owned Enterprises (SOE)

State Owned Enterprises (SOE) in Malaysia Government-Linked Corporations (GLCs) of host countries are often accorded preferential purchasing agreements and differential tax regulations in the interest of national development. A chapter in the TPPA seeks to remove this preferential treatment as the SOEs are viewed as impediments by the US. For Malaysia, the rights and privileges enjoyed by Bumiputra companies will likely have to be abolished. SOEs will have to compete under the same terms as multinationals and any attempt to restrict this can and will result in the host countries being sued.

Government Procurement

The Government Procurement chapter will restrict governments from helping their own small businesses. These small businesses will not be able to compete with big multinational corporations which will have unhindered access to bid for Government Development contracts. It will be strictly forbidden to impede investors to participate.

Investor-State Dispute Settlement (ISDS)

The ISDS provision in TPPA is a particularly obscene benefit available to investor companies. Under this provision these companies can sue signatory countries not only for any infringement of the rules enshrined in TPPA but also if they feel that profits or even perceived future profits will be affected. The dispute will be adjudicated by a supranational tribunal whose verdict cannot be appealed. These tribunals can override the laws and regulations and even the constitutions and parliamentary decrees of the nations sued. On the other hand, host countries do not enjoy the same right to sue an investor company. The adjudicating tribunals are monopolised by a small group of specialist lawyers who can be the judges in one case but attorneys in other cases. In cases that have been decided in the past, companies that sued host countries have won exorbitant award that have crippled the development of small developing nations. Cases that have come to these tribunals have almost always resulted in victories for the suing companies.

Adverse Effect on Healthcare and Health Policy

All these provisions in the TPPA will not only adversely affect the healthcare systems of developing signatory countries, as is obvious, but also severely restrict growth and development by prohibiting governments from making new laws to protect workers, e.g. by raising minimum wages, introducing measures to raise levels of workplace safety and introducing new health policies such as better maternity benefits for workers. These measures are sure to affect the profits of foreign investor companies and thus expose governments to lawsuits. TPPA will also destroy the environment by encouraging activities such as logging and mining by removing export taxes and by prohibiting measures to value add to raw materials and convert primary produce within the country. Foreign corporations can reap full benefits while being freed of any social, economic or human rights responsibilities. Governments on the other hand will be saddled with a laundry list of obligations.

MMA's Stand

At the 54th MMA AGM in Johor Bharu, we passed a resolution voicing concern about the negative impacts of TPPA on the medical profession and public health in the country. MMA felt that there would be restricted access to generic medicines caused by the much stricter implementation of IP rights. Liberalisation of healthcare under the proposals of the TPPA will give foreign corporations the same access to the Malaysian domestic market as Malaysian firms and lead to the proliferation of foreign owned private hospitals and managed care organisations (MCOs).

What Is To Be Done?

The Malaysian Government must halt all negotiations until Malaysia's proposals and position on all the chapters of the TPPA are presented to and discussed in Parliament and made known to the rakyat. Cost Benefit Analyses of the TPPA to the rakyat must be carried out and the findings made public. The Government must reveal how Malaysian's right to good health, food, livelihood (wages and standard of living) and a safe environment will be safeguarded.

It is a bizarre paradox that a treaty like TPPA which claims to be a "free trade" agreement is in its most economically important provisions of protectionist and the exact opposite of free trade.

world diabetes day 2014

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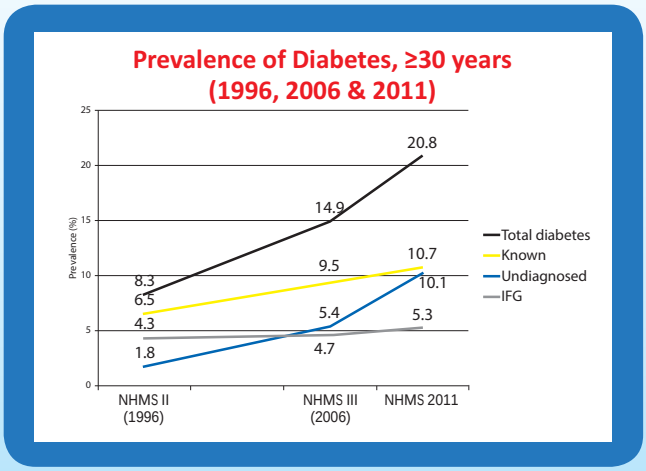
World Diabetes Day 2014 falls on 14 November which is the birthday of Frederick Banting, who together with Charles Best discovered insulin in 1921. This day began as an official United Nation Day in 2007. The campaign is led by the *International Diabetes Federation* (IDF). Its logo is the blue circle.

The theme of this year's celebration is "**Healthy Living & Diabetes**" and this will be the theme for the next three years. The focus of the campaign in 2014 will be on healthy eating which is important not only from the point of management of diabetes but also its prevention; hence the slogan, "**Diabetes: Protect Our Future**". The key message of the campaign includes:

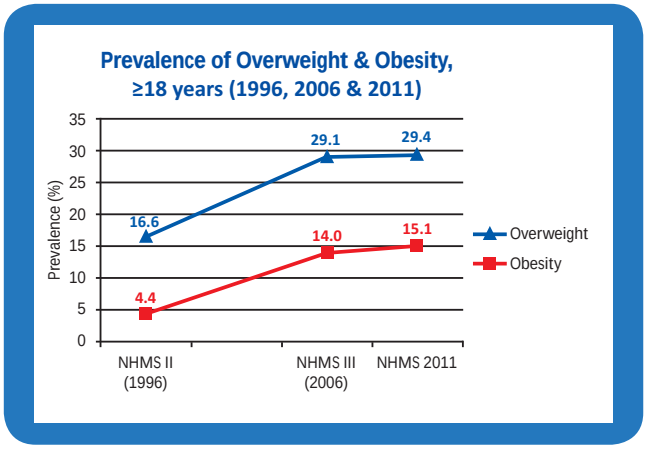
- Make healthy food the easy choice
- Healthy eating, make the right choice
- Healthy eating begins with breakfast

As doctors I believe we have two distinct roles in this campaign. The first as community leaders we need to take part or lead in local campaigns to create awareness that healthy food should be the choice for all and not just for people with diabetes. The 'all' include children as well. We need to do this because the Malaysian population has one of the highest rising rates of diabetes.



Source: National Health & Morbidity Survey (NHMS), MoH

In terms of food we are spoiled for choice. It is delicious and relatively cheap and very carbohydrate-centric. This combination is ripe for eating, putting on weight and ending up with diabetes. Our genetic make-up is such that we get diabetes at a lower BMI compared to Westerners.



Source: National Health & Morbidity Survey (NHMS), MoH

There have been numerous campaigns in the past to encourage people to eat healthy with little success in reducing obesity or diabetes. However there have been exceptions, for example, the Minnesota Diabetes Prevention and Control Prowgram (DPCP) developed a strategy focused on raising awareness of prediabetes and preventing Type 2 diabetes by having people lose weight. The participants lost an average 5.7% of their body weight.

Perhaps instead of advising our folks not to eat this and that, we should provide healthy choices. Despite the widespread notion that our food is diabetogenic, the reality is that healthy choices are available if sought for. It is not always necessary to forgo the delicious favourite dish. I advise my patients to eat anything they want but in relative portions and controlled amounts. The morning nasi lemak unites all Malaysians unequivocally. As customers, we could ask for reduced 'nasi' and increased 'kangkung' and 'timun' (vegetable sides). If there are more of such requests, it will become the standard packing portion in due time. Many complain that healthy food is not available but demand shapes what is supplied. There has to be a big 'movement' in the country to ask for healthy food. If we doctors do not lead this within our own localities, who will?

Wide selection of vegetable dishes in a Taiping restaurant

The plate method to decide the relative ratio of food portions is easy to follow i.e. half the plate should be vegetables, a quarter plate of carbohydrates and a quarter plate of meat.

Photo courtesy of Pn Noorhayati, Dietitian, Hospital Taiping

A patient can reduce his usual morning breakfast of two pieces of roti canai to a breakfast starting with an apple and followed by a piece of roti canai. Again starting with salad or fruits in a buffet has its advantages for several reasons. Usually if there is no queue at the salad section, we tend to consume less carbohydrates later, which is good for lower glucose excursion and less weight gain. There is no reason for us to begin our meals with carbohydrates. In fact, I understand in some religions, the advice is to start with fruits. All religions preach moderation in food intake. If we decide to eat at the fast food restaurant we can choose to have a salad (with chicken in it) first.

The following slides depict the glycemic surge in the same person, depending on the food taken:

Healthy plate concept

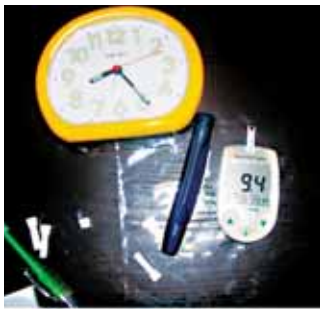
One hour later

Two hours later

The above illustrates how glucose should fluctuate in a normal person after food. When we take a mixed meal, the glycemic load of the meal is reduced. In other words the fibre part would reduce the rate of the glycemic surge of the carbohydrate portion. Furthermore the total calories consumed is also less when smaller portions of carbohydrates are eaten.

Now note the fluctuation below when the type of food is different even though the serving amount is less:

Instant noodles, an unhealthy but common favourite among Malaysians



One hour later

The above illustrates the concept of glycemic load. Highly processed food like noodles, white rice, white bread etc will increase the post prandial glucose substantially whenever the pancreas is unable to secrete sufficent insulin.

I also advise my patients not to skip meals – especially breakfast – because if we do, hunger would set in and initiate a craving for carbohydrates, which would probably result in more food consumption. Somehow we must learn to distance ourselves from the 'over-hospitable' practice we Malaysians are so familiar with: dishing out a plethora of food which your event guests are then subjected to finish in a bid to avoid wastage. Moderation should become the 'in-thing' because we care for each other's health.

As leaders we should encourage our local councils to make it mandatory for restaurants to provide information on the calorie value and glycemic load of the food served. Like in some developed countries, the local councils should ban sales and marketing gimmicks such as 'value' meal sets (which are usually accompanied by a high calorie drink and fries) at a lower price than the á la carte item alone. While engaging the local councils, do try to highlight the benefits of covered walkways and indoor playgrounds so as to encourage more physical activity in our population. Bicycle paths alike those in Penang would be a good example of the local council's commitment in supporting healthy lifestyles and safe choices.

Perhaps MMA could present an award to any MMA branch that has managed to coax its local council into developing an innovative facility which would prompt more interest for exercise. One step further would be to have a nationwide 'Healthy City' award.

In summary, as community leaders we need to engage the people and local authorities, and change their mindsets on food so they would:

- Demand healthy food choices
- Use the plate portion method for all meals
- Demand healthy facilities to stay active

Getting involved as above would produce repercussions on ourselves; we tend to embrace the advice we give.

Medical Negligence: Start of the Lawsuit

The plan is to have a series of short articles addressed to doctors even though the real players will be many non-doctors. The "story" of these articles will constitute a composite of several cases, all rolled into one, in an attempt to give it a flow; each scenario will be based on an actual case with names, places, etc. deliberately changed to maintain anonymity. Not all the issues raised in this story will be applicable to all cases. The storyline will generally deal with Obstetrics but much will be in harmony with other fields of medicine.

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Whenever faced with an unexpected adverse outcome, many doctors feel guilty, feel genuinely sorry for the patient, have moments of self-doubt, and certainly feel the dread of an impending lawsuit; all this without even being negligent

The Start of It All

When you first receive a letter from a lawyer or law firm making some allegations and/or seeking a medical report regarding one of your patients, your initial instinctive reaction is one of fear. This is not because you think (or know) that you have been negligent, but because you fear the adverse publicity that will likely ensue (no pun intended), and the sullying of your reputation (among other issues). That sick, depressive feeling in the pit of your stomach lingers for too long.

Your next reaction is to call your medical indemnity insurer (MII) and seek advice. The MII will then direct you to a particular law firm and ask you to seek advice from them.

In one case the doctor was asked by a law firm for a report about a particular patient the doctor had handled. He called his MII and was referred to a prominent Kuala Lumpur based law firm; in Malaysia they are almost always KL-based. The first bit of advice the doctor got was that he was not obliged to furnish any report, and he could say as much. The doctor, acting upon the advice, did not furnish a report. A few weeks thereafter he received another letter from the (potential plaintiff's) lawyer, and the doctor sent out a report, the legal advice notwithstanding; there was no reason to not send the report. Just two days after the report was sent out he received a letter from the Malaysian Medical Council (MMC) threatening to take action if a report was not immediately furnished. The doctor replied, explaining that the delay was on account of the so-called legal advice, but that the report had nevertheless been sent prior to his receiving the MMC's letter. Evidently the doctor's response was not as 'polite' as is narrated here. But given that the MMC's letter (threatening without making any reasonable enquiry) was not very polite or professional to begin with, such a reaction in not entirely unforgivable.

Notice how the lawsuit is called a "Medical Negligence" or "Medical Malpractice" suit, and there is no denying that on many occasions there is definite negligence. But even if it is not negligence, as understood by most people, calling it "Medical Negligence" or "Medical Malpractice" from the outset gives the impression that there is negligence, even if it is only alleged. You appear to start off as 'guilty' even though the law presumes you innocent until proven otherwise. Perhaps another name, such as 'Medical Adverse Outcome' may appear a little less innocuous and neutral, though the trauma that ensues will be no less or different.

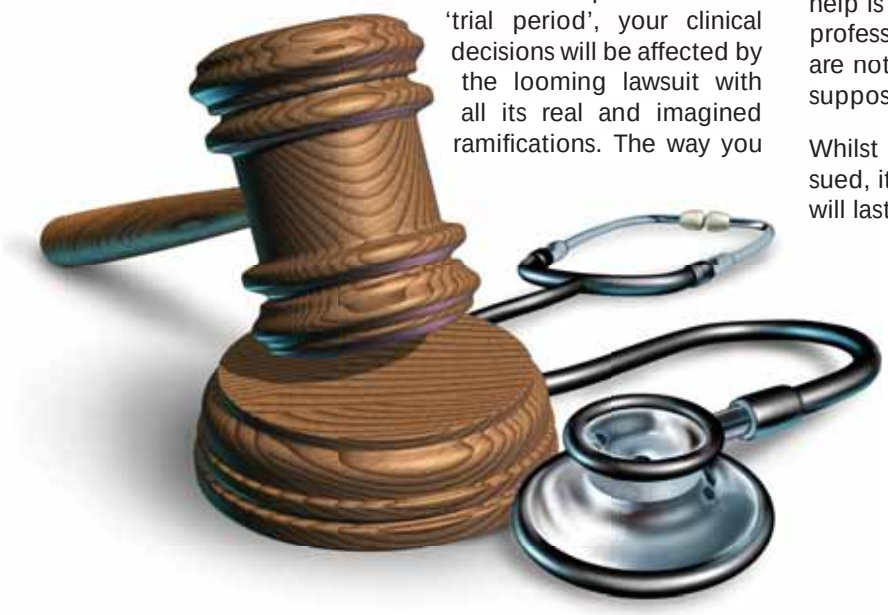
Once the process is underway you will communicate with your lawyers (appointed by your MII) to prepare for the case. Any further communication between the plaintiff and you will actually be a communication between your respective lawyers.

The Rollercoaster Ride

Your nightmare starts, and may last for years. In the past, some cases took more than a decade to resolve, though it is much faster now, with the speed possibly coming at the expense of justice (expediency over justice). The Foo Fio Na case took more than 25 years before some end came to it. This emotional distress will stay with you throughout the years, often exacerbated around the trial dates.

As it is by nature, whenever faced with an unexpected adverse outcome, many doctors feel guilty, feel genuinely sorry for the patient, have moments of self-doubt, and certainly feel the dread of an impending lawsuit; all this without even being negligent. Self-doubt and reflection are a norm even when there is no adverse outcome. For example, whenever I had to resort to a Caesarean section (CS), with a truly celebratory outcome I tended to reflect on the need for the CS. "Could I have waited a little longer to allow a chance for a normal delivery? Was it really necessary to resort to a CS?". At every juncture there was a need to question myself and I am sure others must have had similar feelings. This constant self-evaluation and obsession to hold yourself to the highest standards, tends to work against you when you get that first hint of a lawsuit. It depresses you.

But why do doctors feel this way? Medical negligence comes under Tort Law, which demands that a fault must be established before any compensation can be given. In other words the plaintiff (patient) must establish some fault if he/she is to get any compensation. What this means is that there is an allegation that you (the doctor) have failed to meet the standard of care expected of a 'good' doctor, that you are at fault. You will see this as an assault on your honour and integrity; you feel (know) you have done your best and, as every doctor knows, despite doing your best the outcome may be far from perfect. The initial reactions of shock and anger soon give way to continuous stress and insomnia, your psychological demeanour changes and its effects rub on to your family. These feelings or reactions will stay throughout the duration of the case. This is the start of your prolonged nightmare. However, given the long drawn-out nature of such lawsuits, time allows such stresses to eventually 'settle down' somewhat, only to resurface with a vengeance whenever you work with your lawyers in the preparation of the lawsuit and whenever the hearing dates approach. You may find yourself awake at all hours, playing the 'videotape' of the case in your head over and over again, rehearsing in your mind the explanations you will give in response to the allegations.



In the initial phases of this 'trial period', your clinical decisions will be affected by the looming lawsuit with all its real and imagined ramifications. The way you practise medicine will be affected. An Obstetrician, for example, may begin to have a higher rate of Caesarean sections (CS) than in the past or as might be reasonably expected. He will often 'jump the gun' and resort to a CS when the clinical scenario may have justified a 'wait and see' approach. Fortunately most doctors will quickly readjust and revert to making the right clinical decisions based on the actual clinical scenario and not allow the lawsuit to cloud their judgement, causing them to resort to unnecessary surgery or investigations.

The Emotional Cost

Much of what is written here vis-à-vis the emotional trauma will appear melodramatic to some readers, but you cannot really appreciate the emotions a doctor goes through when he is sued until you are eventually in that position, or have been through it. You will not be affected just emotionally, but mentally, physically, and financially. You will worry about the impact of the lawsuit on your future practice even if you are found non-negligent; the damage would already have been done.

The urge to 'settle' right at the beginning will be great, even if the case appears obviously defensible, especially if you are aware of the emotional trauma. You will tell your (defense) lawyer to seek an amicable settlement. But the demand made by the plaintiff will be so exorbitant that it will inevitably be turned down by the insurers.

And so the battle will begin, one from which the doctor will emerge a loser even if he wins the lawsuit itself. "And doctors who've been sued return to practice with considerably less joy than before. One even compares it to overcoming death."[1] Some even contemplate suicide: "Physicians who've been sued have a higher rate of suicide".[2] Conscientious medical practice is a heavy burden with a very heavy toll on the doctors. Dr Pamela Wible talks of physician suicides on a YouTube posting.[3] She talks of being a doctor for more than 20 years and says, "I've never lost a patient to suicide. I've lost only friends, colleagues, lovers, all male physicians. In the US we lose over 400 physicians per year to suicide, the equivalent of an entire medical school gone… a cry for help is a weakness… and a visit to a Psychiatrist may be professional suicide. We are not supposed to cry… we are not supposed to make mistakes… We are not really supposed to be human." [Emphasis added].

Whilst different doctors will react differently to being sued, it is an inalterable fact that the effect of the lawsuit will last a lifetime.

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29th General Assembly & 50th Council Meeting of CMAAO

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Hon. Deputy Secretary MMA

Influence, innovation and integration of eHealth Databases can promote the realisation of our post-millenial Sustainable Strategic Goals come 2015

The *Confederation of Medical Associations in Asia and Oceania* (CMAAO) held its 29th General Assembly and 50th Council Meeting in Manila, Philippines, from 24 – 26 Sept 2014.

CMAAO is the initiative of Dr Rolodolfo P. Gonzalez, Philippine Medical Association, in 1956. From its very inception in 1956, CMAAO has served as a major platform to exchange pertinent health issues and to strengthen ties among medical associations in the Asia and Oceania region. Now it has grown into an organisation with 18 member associations contributing to the promotion of public health.

They are:

1. Malaysian Medical Association
2. Medical Association of Thailand
3. Indonesian Medical Association
4. Philippine Medical Association
5. Taiwan Medical Association
6. Japan Medical Association
7. Hong Kong Medical Association
8. Indian Medical Association
9. Korean Medical Association
10. Singapore Medical Association
11. New Zealand Medical Association
12. Australian Medical Association
13. Bangladesh Medical Association
14. Cambodian Medical Association
15. Myanmar Medical Association
16. Macau Medical Association
17. Nepal Medical Association
18. Sri Lanka Medical Association

MMA was represented by President-Elect Dr Ashok Philip, Immediate Past President Dato' Dr N.K.S. Tharmaseelan, Hon. General Treasurer Dr Gunasagaran Ramanathan, Hon. Deputy Secretary Dr Koh Kar Chai, PPS Chairman Dr Ganabaskaran Nadason, SCHOMOS Chairman Dr Datesh Daneshwar, and myself.

This meeting was hosted by the Philippine Medical Association (PMA). National Medical Associations that were present include Bangladesh, Hong Kong, India, Indonesia, Korea, Japan, Myanmar, Nepal, Singapore, Taiwan, and Thailand. The Japan Medical Association had several observers who diligently participated throughout the whole meeting. We were honored to have Dr Margaret Mungherera, President of the World Medical Association, and Dr Robert M. Wah, President of the American Medical Association (First American Chinese to hold this office) as special guests for this event.

Dr Robert Wah (President American Medical Association), Dr Rajan John, Dr Margaret Mungherera (President World Medical Association), Dr Koh Kar Chai, and Dr Gunasagaran

MMA ExCo with newly-elected President of CMAAO, Dr Jose Asa Sabili

MMA ExCo listening attentively

The opening ceremony was by Prof Dong Chun Shin, Council Chairman of CMAAO. Dr Maria Minerva P. Calimag, President of Philippine Medical Association, followed next with a welcome address to greet all delegates of the 29th Council Meeting. In her message, she emphasised this year's topic "**Health Database In An Era of Information Technology** " which is relevant at present times, since we now address healthcare issues by using high-tech registries that serve as information systems and also as governance tools to disseminate, evaluate, assist, monitor and oversee all primary healthcare levels.

The time is indeed ripe for CMAAO and its member associations to share experiences about how the influence, innovation and integration of eHealth Databases can promote the realisation of our post-millenial Sustainable Strategic Goals come 2015 and beyond.

There were inspirational messages by the President of the World Medical Association and also by the President of the American Medical Association. Dr Jose Asa Sabili was officially inaugaurated as the 32nd President of CMAAO for 2014 – 2015.

The 12th Taro Takemi Memorial Oration was delivered by Prof Dr Jaime C. Montoya who spoke on the topic "Building and Sustaining a Health Research and Innovation Network in South – East Asia".

Dr Taro Takemi was the former President of the Japan Medical Association. In recognition of his ideas, the *Takemi Program in International Health* was established in 1983. Dr Takemi pointed out the global necessity of enhancing and improving health services and worldwide problems stemming from limited resources and he advocated the development of new, efficient health resources and the improvement in their methods of distribution.

This was followed by presentations from National Medical Associations (NMAs) on "Health Database In An Information Technology Society". Dr Ashok Philip presented for MMA. During the congress, all the participating associations presented their country reports.

CMAAO Resolution on Ethical Frameworks for Health Databases and Human Genetic Databases

This resolution aims to reaffirm the special characteristics involved in the collection and use (for both research and non-research purposes) of health and genetic information and to propose an ethical framework that reflects such special characteristics. The resolution's primary obejective is to propose principles that reflects the regional characteristics of Asia and Oceania in order to provide direction and guidelines to NMAs in this region in their efforts to play a leading role in related fields. Ultimately, CMAAO hopes to contribute to public health and human rights by encouraging the Government and all the related agencies to urgently develop statutes that clearly require protection of personal health information and explicitly stipulate the permitted scope of usage of such health information.

Recommendation for CMAAO Members

Member NMAs shall urge their governments to prepare the necessary legal systems and procedures so that the principles proclaimed in this resolution are shared and realised, and if necessary, are responsible for providing related advice as an expert group.

Also each NMA shall exert efforts in the development and distribution of education and training programmes not only for health database or human genetic database researchers, related personnel and physicians, but also the general public so that the principles proclaimed herein are widely communicated.

They shall support research activities on ethical approaches to this issue and also monitor whether such ethical principles are being well-followed. For this purpose, member NMAs shall build broad and close cooperative relationships with the governments, health authorities, academia and related organisations.

The Philippine Medical Association showered all the visiting delegates with warm hospitality and proved a gracious host. Arrangements were made to pick up and drop back the delegates from the airport at PMA's expense.

The 30th CMAAO General Assembly will be held in Myanmar from 23 – 25 September 2015. The 31st CMAAO General Assembly will be held in Bangkok, Thailand, September 2016.

Ophthalmology in Malaysia: A Reflection

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University Malaysia Sabah
& Consultant Ophthalmologist
Life Member MMA, Sabah

The standard of Ophthalmology in Malaysia is remarkably good. We owe this to many of our illustrious predecessors.

I started my training in the Eye Department of Kuala Lumpur General Hospital (HKL) around the 70's. I then went to the Princess Alexandra Eye Pavilion (PAEP) in Edinburgh, which was the second largest training center in UK for aspiring Ophthalmologists all over the world.

I was amazed to find that the Eye Department of HKL was almost on par with PAEP. When I applied for leave, the clerical staff gave me a form that was a facsimile of the one I used to fill in HKL! The operating microscope was the same and the Ophthalmologists there were also struggling to use the indirect ophthalmoscope.

Where does the standard of Ophthalmology lay now? It is undeniable that we have world-class facilities in the Government and Private sector. We are training most of our own Ophthalmologists locally and some of them are able to hold candles with ones trained at Harvard, John Hopkins, Moorefield's, and Shahkara Nethavalaya.

I have no doubts that the MS Ophthalmology Training Programme is excellent by international standards. However, at the moment, no other country recognises our MS as an equivalent to their postgraduate degree. This will become a problem when our Ophthalmologists intend to pursue subspecialty fellowships at reputable international centres. They have to compete for limited placements with foreign candidates. An option is to conduct all exams, from Basic Sciences, as a conjoined exam with one of the Royal Colleges in UK. A step in the right direction has been the formation of a conjoint board (universities and Ministry of Health) with standardised exams. Together, the board has been able to engage external examiners from reputable centres all over the world.

An ongoing improvement in our training programme, as is the case in most developed countries around the world, will reflect a better standard of healthcare to the public.

I have no doubts that the MS Ophthalmology Training Programme is excellent by international standards

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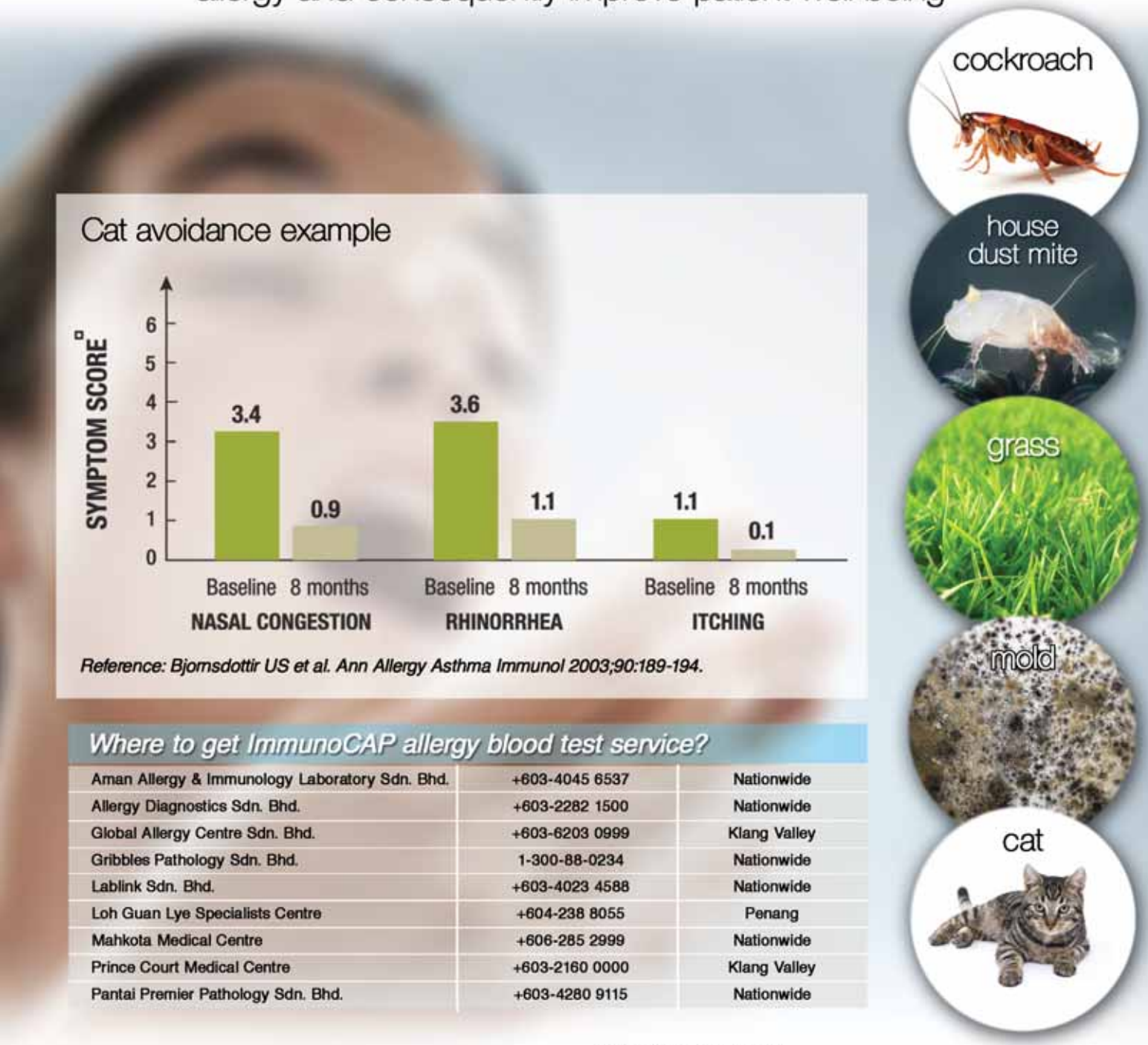

Cat avoidance example

Reference: Bjornsdottir US et al. Ann Allergy Asthma Immunol 2003;90:189-194.

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Communication Skills

Dato' Dr N.K.S. Tharmaseelan
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Immediate Past President

> Doctors need to adhere and observe patience. They can be in situations where patients may be easily provoked or irritated after a long and tiring day

Communicating skills are an essential part of human development and are not formed overnight. Some are born with the knack for talking while others need to learn. Some, rarely ever speak or listen. Those who have the 'gift of the gab' must have the patience to listen to others, to become good communicators.

Communication is a two-way mechanism; talking and listening. One who talks eloquently would not necessarily be a good communicator if he is not able to listen to the other party. He should give the other party time to talk and listen to what the other has to say. He cannot remain boisterous.

Early Communication Skills

Communication begins at home, right from the cradle. A child brought up in an environment with more communication opportunities will have a head start over others when it comes to communicating in adult life. We must learn to communicate with our children. We should not shout at or shut them up, as they will develop the same traits they have grown up in.

Most schools do not emphasise or promote communication skills. It does not form a part of their curriculum. These are formative years and they would certainly benefit if they are exposed to some form of communication skill.

Most institutions of higher learning, especially medical schools, have integrated communication skills as part of their curriculum. These skills are acquired or practised in classroom settings and may not necessarily be exercised immediately during real life situations. It has to be mastered over the years whilst at medical school itself, efforts must be continuously made by students throughout their course in order to enhance those skills.

Communication is Both Verbal and Non-Verbal

Communication does not depend entirely on verbal or spoken words. Non-verbal actions, like mannerism, body language, eye-contact, and tone of spoken words along with being empathetic are essential components.

Being aloof, speaking in a loud manner, inappropriate body language, poor eye-contact, inappropriate facial expressions and apathy towards another will certainly result in communication problems. There should be an expression of interest in communication even on minor issues.

For a doctor, these along with well-chosen, simple, easy to understand words will certainly help in a mutually beneficial consultation. In this multilingual society as ours, we must make sure that the doctor understands what the patient is saying and vice-versa.

When there is a problem in communicating with one another due to language barriers, a translator should be sought amongst the staff or the relatives of the patient. We must also pay attention to the sensitivities of others in our multiracial and multi-religious society, as this may result in serious misunderstandings. We should understand the connotations implied when addressing someone in another language, for example 'Thambi' and 'Ah Pek' are not necessarily terms of endearment if used by one of another denomination.

> All doctors must endeavour to attend CPD courses and workshops on communication skills ... and this must be included as part of the KPI for all doctors

Doctors need to adhere and observe patience. They can be in situations where patients may be easily provoked or irritated after a long and tiring day or because they have undergone a stressful episode before the consultation. Modern day living is prone to so much stress in our daily lives. This may create an atmosphere for miscommunication even before it starts.

When one is talking to deliver information across, one needs to listen to the other party and reflect on it before providing a proper response. Without listening fully to the complaints of the patient, the doctor may not be able to gather relevant information, give relevant answers or provide appropriate treatment. The lack of time places constraints on this process of communication during consultation and treatment; but this is inevitable, we have to give it time.

Assessing Communication Skills

Key Performance Index (KPI) can be used as a tool, to assess performance in communication. KPI may enhance the need to acquire communicating skills.

We can use complaints as a factor in assessment of KPI. If a certain doctor, clinic or hospital seems to be having too many complaints, it is an indicator that something is definitely wrong. An occasional letter of praise from a patient is a positive sign. Administrators should thus focus on areas and departments that are prone to many complaints.

Studies around the world have shown that in many medical negligence lawsuits, negligence was not the main factor in initiating the civil suit. In fact on investigation, 90% of the time these were a result of improper or inadequate communication. In many cases there was no negligence at all. Arrogance and speaking in a loud voice often resulted in patients filing complaints.

Good communicators and those who never have had complaints against them should be given incentives as a motivation to continue being good communicators with their patients; hopefully this would encourage the others to take the initiative as well. Those who have had complaints against them, should have the complaint investigated and if it reveals there was miscommunication, it should be addressed by encouraging them to participate in communication skills workshops.

All doctors must endeavour to attend CPD courses and workshops on communication skills. Those attending should be given additional CPD points and this must be included as part of the KPI for all doctors.

The Greatest Barrier to Improve Communication

There are too many doctors in some units, sometimes even up to 100 doctors undergoing internship at a time. They may not all receive the same quality training and exposure especially with regards to communication, and may thus lack the exposure to deal with patients. Coming into direct, 'one to one' dealing with patients is important but the opportunity to interact is limited and does not allow enhancement of communicating skills.

Too many patients. As hospitals become more crowded, the waiting time to see a doctor is lengthened. When they finally see the doctor, the time for consultation and communication is shortened so that the next patient can be hastened in.

Waiting. Nobody likes waiting for hours to see a doctor. Patients get irritated because of the waiting period, and when they are finally seen by their doctors, they are not granted a justifiable amount of consultation time. This is probably the major cause of communication breakdown and ensuing problems.

Dissatisfaction. When a doctor makes a hurried consultation, it may result in dissatisfaction by patients who would have expected the doctor to have spent more time talking to them. This disappointment then leads to a chain of events that results in complaints about treatment received without it being dependent on the outcome of treatment. The lack of communication definitely increases the number of complaints.

Lack of empathy. It is surprising that a few doctors are engaged on the phone, speaking to others, reading a newspaper or are on the internet during consultations. This will certainly create a lack of trust or reduce bonding opportunities, resulting in discontent and anger which may force the patient to lodge complaints.

Conclusion

Communication is important and plays a major role in our daily lives – in a relationship, a family home, in the office, and when we deal with another person. Love failures, divorces, domestic violence, and workplace problems all have their roots in the lack of communication skills. It probably plays a more visible role in the service sector, most prominently in the healthcare sector.

A Long Road Indeed

Dr Long Tuan Mastazamin Bin Long Tuan Kechik
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Chairman
MMA Kelantan

The sincerity and support I obtained from senior members and past chairmen – to make sure that my tenure will be without any glitch – were very heartfelt and exemplary

Last year, at the 53rd National MMA AGM in Negeri Sembilan (the third AGM I have attended so far), I promised myself that I would be present at the 54th AGM in Johor. But it suddenly dawned on me that the journey from Tumpat, Kelantan (my hometown, which is the northernmost area of the East Coast of Malaysia) to Johor Bharu was a very long drive. The GPS had stated 751 kilometres or 12 hours of drive! My mentor and Ex-Kelantan Chairman, Dr Seri Buana advised me to book a flight instead as it will only take less than an hour from Kota Bahru to Johor Bahru. However, I always brought my family along for a holiday during the MMA AGMs. It would not be practical for me to pay thousands of ringgit for more than 20 seats and the baggage-handling fee that would accompany. Therefore, my group which consisted of 4 nuclear families, decided to use our own transportation. We had planned to arrive a few days before the AGM, so I could join my family in some of their activities.

Our early journey began on 26 May 2014 right after *subuh* prayers. We prayed for a safe drive and with the warmth of the sunrise, our cars were on the road. The original plan was to drive along the seafront area but we later felt it was better to use the new East Coast Highway (LPT) as it would require less travel time due to better road conditions. We drove through Kota Bharu-Kuala Krai Expressway till we reached Setiu. We were fortunate as our entry into the new LPT was free as the toll booths were not operating yet. By lunch time, we arrived at Paka town and had some '*ikan bakar istimewa*' which was a local delicacy. The drive then continued along the Terengganu road till we reached Kuantan. Entering LPT again, we headed towards the North-South Highway (PLUS) that led us straight to Johor Bharu town.

When we reached our destination, we had a meal and quickly dozed-off. The first item on our itinerary for Day 1 was Legoland (why come so far if not to experience some fun time with my family?). During the night, we had a small family dinner where we recapped our experiences at the theme park and also discussed next day's itinerary. On Day 2, we organised our own sightseeing tour around JB town. We reached the State Museum and spent half a day in the town zoo next to it. I had my very first close encounter with the camel and was also lucky enough to meet Ruby, an adult tigress raised by the zookeeper since it was just a cub. In the evening, we went with the 'recreation of choice' by the ladies in our group: operation "shop till you drop".

On 29th June, I went to Persada Convention Centre to register and participate in the sports events. My favourite sport, bowling, had few participants this year but my goal was

to defend the championship title I obtained two years ago in Kedah. Unfortunately, there was no bowling event in Negeri Sembilan last year. Thank *Allah* for my luck as I was again crowned the MMA Bowling Tournament Champion for the second time (although it was the first time I had touched a bowling ball all year). After lunch, I headed for the SCHOMOS National AGM. This year, we lost a good Chairman, Dr Azhar Hamzah, who refused to carry on his position in order to pursue a bigger objective, which is to gain experience in a foreign land next year. However, we witnessed a good continuation with the Committee led by Dr Datesh Daneshwar. I was fortunate to be included in the Committee and I hope to contribute as much as I can to our fraternity. The State Dinner that night was well attended by participants, and we enjoyed an array of entertainment, good food and great company.

The National AGM commenced the following day. This year we only had to vote for the President and Honourable General Secretary post as all other posts were won uncontested. This year was also a special year for me as I was elected as the Kelantan MMA Chairman. At a glance, many may feel that there were more qualified and senior candidates. However, I am thankful for the faith the members had shown and also for the trust placed on my capability to lead a state of 300 members. Their sincere hope was for MMA Kelantan to rejuvenate and become more active than prior to my leadership. The sincerity and support I obtained from senior members and past chairmen – to make sure that my tenure will be without any glitch – were very heartfelt and exemplary.

Back to the AGM, we officiated the meeting with a traditional parade. The MMA Mace led upfront, followed by state flags which were carried proudly by the volunteers. I once had the honour of carrying Kelantan's state flag during the parade four years ago. The then-President, Dato' Dr Tharmaseelan, kick-started the meeting and followed through with the agenda. That night, the National MMA Dinner was held and we were graced with the presence of DYMM Tuanku Sultan Ibrahim Ismail, the Sultan of Johor. The dinner was a blast and I was lucky to personally meet the Sultan's acquaintance and thank him for coming.

As a Kelantanese, I am proud that the MMA members have selected Kota Bharu as the next AGM host. We will give our all to make it the best AGM

On the second day of the AGM, I completed my visits to all booths. I spent an average of 2 to 3 minutes in each booth, browsing at the new medical innovations the market had to offer, and obtaining information on the new drugs available.

The AGM came to an end at noon and as expected Kelantan got their chance of hosting the National MMA AGM for 2015. This was a good piece of news as the next election for the Presidency will only be open to East Coast members in 2015, therefore increasing the chances for a new President-Elect to be elected from this region. Yet, it is still early to say as nobody from the East Coast has expressed a willingness to take up the challenge of MMA's hot seat. Well, for the MMA Kelantan Committee, we were joyful and grateful that we were finally given the chance to organise the AGM again since the last one in 1977. A lot of work and effort is going to be required, but as quoted by our Immediate-Past Chairperson, Dr Selasawati, "Organising the National AGM in Kelantan is going to be hard work but if we work together, nothing is impossible". After the AGM came to an official close, I stayed on for my first Council Meeting. All the items on the agenda were covered in less than three hours.

The drive home was worse than the journey down to JB due to the fatigue and also the crammed space in the vehicle (the aftermath of operation "shop till you drop"!). At 11.00pm, I gave up the steering wheel and traded it for a comfortable bed at a hotel room in which I slept like a log. We finally reached our home-sweet-home at 4.00pm the following day. It was a great experience as it was my first attempt at driving such a long way from home.

As a Kelantanese, I am proud the MMA members have selected Kota Bharu as the next AGM host. We will give our all to make it the best AGM in our own way while keeping the great tradition of MMA alive. Hope to see you and your family in Kota Bharu next year, so please do mark your calendars (tentatively 29 – 31 May 2015).

Increasing Healthcare Cost in 2015: Time to Brace for It

Datuk Dr Kuljit Singh
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Editorial Board Member

Like most countries worldwide, healthcare cost is always a worry and not many can actually predict the real impact to the healthcare providers and patients. It is not cheap to fall sick and perhaps preventive steps towards good health will have to be the core thrust for the Government. I can speculate that the Government and public hospitals spend more when treating patients, in comparison to private hospitals. The capital expenditure in public healthcare is enormous with no real return of investment in ringgit and sen.

The common man's out-of-pocket expenditure on healthcare is known to be a main concern and based on various data available, it is also one of the common reasons for bankruptcy. We have a good public healthcare system but due to long waits and other concerns, the public would sometimes seek private healthcare services, which may be beyond their means. The thought of integrating public and private healthcare has always been on the table of discussion but it is not easily done.

Escalation of Healthcare Cost in 2015

Possible Reasons for Rise in Healthcare Cost 2015

1. GST: Exempted Supply
2. Separation of Dispensing Rights
3. Medical Indemnity

We have pressing issues in 2015 which include the hidden costs for healthcare. It may be both a global and regional issue for some time, but it will definitely be implemented next year. The introduction of GST (Goods & Services Tax) exempts patients from paying but every other cost within the private healthcare, from asset procurement to some medication or equipment, will be subjected to GST. Therefore, an indirect increase in cost will be inevitable; this would probably have to be absorbed by private hospitals or doctors.

> The overall cost for dispensing at a pharmacy and consultation at a clinic would mean a double increment in charges to a patient

The cost of medication will also increase for patients once the dispensing rights are separated from doctors. The overall cost for dispensing at a pharmacy and consulation at a clinic would mean a double increment in charges to a patient, sans consideration of inconvenience and the extra cost for travelling or parking. The argument will go on but the final solution would have to be determined by the Government.

Litigations in courts have not been spared from medico-legal cases. Doctors would exercise caution and perhaps keep referring difficult cases in order to avoid uncompromising situations. Medical indemnities regardless of which company or policy will increase further, thus impacting healthcare cost as well. The Malaysian courts are handling more medico-legal cases today as compared to 10 years ago.

Moving Forward

We need to look at every aspect of healthcare to contain the cost. The public will have to embrace the changes but we hope policymakers would also factor in some exceptions. Healthcare providers have always faced various difficulties in carrying out their duties but most of us have done our part well despite the restrictions. The impact of increased healthcare cost will have an effect on doctors too, and we should be prepared for it very soon.

We hope our nation will always have stability and healthcare will never be compromised.

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General Practitioner
Joint Life Member MMA, Selangor

All in a Day's Work

One of the many happy returns of being a doctor is the genuine gratitude obtained from sincere patients. Nothing pleases the heart more than a few good words for a job well-done from a satisfied client, a fulfilled customer, or in my profession, a healed human being. When I started working in Kota Kinabalu, Sabah in the late 90s as a fresh intern, I was taken aback by the simplicity exuded by the people there. Their gratefulness touched me to the core. They would reward me and my fellow colleagues with what I call "gifts from the heart". A sack of rice, a bag of local vegetables, a can of coco-cola, fresh fish with medicinal properties, etc. My husband once received a little puppy from a patient who overheard his complains about the missing shoes and flower pots from within our house compound.

Back in Manipal, India, where I did my medical studies, grateful patients would not hesitate to do the "nose dive"– my version of falling flat on the ground with arms stretched forward to worship a doctor who had saved them from an illness. The "*You are my GAWD*" drama, which is usually accompanied by a lot of crying and loud praises, is a norm there. Also, the thank you nod that comes with both palms in contact, as if saying a prayer. To me, these blessings meant a whole lot more than expensive gifts.

I suppose, it is understandable then, after all this conditioning early in my career, to expect a certain kind of positive attitude from patients in much civilised Kuala Lumpur. Not that I need a sack of potatoes or a kitten now. A mere thank you or a slight curve of a smile would not cost anything. In fact, it would definitely brighten a tired doctor's day. What I get here instead, is the Smart Alec type folks who get their information from the internet and try to dispute my plan of treatment. The "ARE YOU SURE?" and "but that's not what I found out from Google" group.

A patient walked into my room today demanding a referral letter to one of the established medical centers nearby. He seemed to be in a hurry as he uttered, "I am not really sick. I just want a letter from you to XYZ medical centre so that my medical insurance can cover the bill. Your nurses are making a BIG deal about this and insist that I see you. Can you prepare the letter for me? It is for my routine check-up. I usually see Dr ABC, he knows me well. I'll pick it up tomorrow?" He tried to walk out as fast as he walked in but my disapproving, famous half-smiling-half-frowning look stopped him. I sighed slowly and heavily, and proceeded to explain why I would not be able to do what he had demanded. "You see, Mr M, I need to examine you first before I decide whether you need to be referred," I nagged. "In any case, if I do discover something, I would like to treat you first with my humble knowledge and if that does not bring you the desired comfort, I will surely hand you over to the specialist, Okay?"

I have, over the years, had unpleasant experiences with many patients who treated me like a little girl who knew nothing. One burly and loud guy, who had waited for half an hour and did not get his addictive sleeping tablets from me had shouted, "After all you are only a bloody medical officer!" Another, who expressed his desire to slap me when I refused to give him a past dated medical certificate in view of escaping a court case, banged his fist on my table when I said, "You should slap me Mr N, with the cameras installed in here, I could happily put you behind bars for that! "

Hence, I was not surprised when this particular patient decided to throw a fury. I kept smiling as he rattled on, and as he ended his tirade with, "I'll report you to the medical association!" I gently took out my calling card from the drawer and shoved it towards him. "That is my full name, you will need it for your report." I then turned to my nurse and said, "Call the next patient, please."

No nose dives for me. All in a day's work! Sigh.

The Malay Mail Online – 22 September 2014

Shocked, Malaysian Doctors Remind 'Jihadist' Healer in Syria of Professional Code

KUALA LUMPUR, Sept 22: The story of an alleged Malaysian doctor who migrated to Syria to seek martyrdom has prompted the local medical fraternity to remind their colleague of the oath she had taken as a professional healer.

The "Hippocratic Oath", according to local doctors, is a moral code of conduct that medical professionals take to pledge their dedication to the practice of saving all lives, regardless their race, religion or beliefs.

The doctors expressed shock that the 26-year-old woman, who claims to be Malaysian, had left her home country for the purpose of helping the Islamic State (IS) militant movement's cause with her medical expertise.

"Aid should be given to not one particular group, but to all those who are victims, regardless of their religion nor political leaning," Malaysian Medical Association (MMA) President Dr H. Krishna Kumar told the Malay Mail Online when contacted last week.

"There are many conflicts all over the world, and Syria is just one of it.

Sharing Dr Krishna Kumar's sentiment, Dr Rashidah Zalani said that if helping people using her medical expertise is what the woman had intended, she should have volunteered to serve in war-torn countries, instead of becoming a militant herself.

"Resorting to militancy despite being a medical professional is not the way," Dr Rashidah added.

New Straits Times – 27 September 2014

'Budget Should Address Healthcare Issues'

By Elvina Fernandez

KUALA LUMPUR: THE medical fraternity and the public are hoping that Budget 2015 will address a number of shortcomings in the provision of healthcare services.

Malaysian Medical Association President Dr H. Krishna Kumar said despite being ranked as third best in the world in providing healthcare services, the amount of money allocated by the Government was still minimal.

"The Government should look into improving medical staff remunerations to avoid losing them to the private sector.

"Many doctors do not stay in the public service after serving the required years," he told the *New Straits Times* yesterday.

Dr Krishna said although Malaysia produced a large number of doctors, it did not have enough specialists.

"With a shortage of specialists, longer working hours are required from doctors," he said, adding that there should also be adequate trainers to train specialists.

He said there was no point in building more hospitals if there was an insufficient number of specialists.

"The Government must also make it compulsory for every university offering medical programmes to have their own hospitals."

Dr Krishna said the Government should raise certain taxes and lift sugar subsidies to check on the rising number of non-communicable diseases.

He said tax exemption be given for gym memberships to promote a healthy lifestyle.

Suthakar Govindan, 51, who frequently visits Government Hospitals, said they should reduce the waiting hours, especially for senior citizens. He suggested that hospitals come up with express lanes dedicated to senior citizens to collect their medications.

Suthakar said the government should increase the number of beds at Public Hospitals.

Pharmacist Nanthini Suriayanarayan, 24, said the Health Ministry should consider opening drive-through medication dispensing facilities for patients to collect their monthly medical supplies.

"This will help address the long waiting time at Public Hospitals."

Suthakala Govindan, 53, said she hoped poor families be spared from paying fees at Government Hospitals.

The Star – 9 October 2014

MMA Wants GST Removal on Medical Indemnity Insurance

PETALING JAYA: The Malaysian Medical Association (MMA) has expressed concern that doctors may have to pay more in premiums for their medical indemnity insurance once the Goods and Services Tax (GST) comes into effect.

Its President Dr H. Krishna Kumar said the association called on the Government to remove the GST imposed on medical indemnity insurance, both in premiums and payouts.

"Doctors will be burdened by the increased cost of medical indemnity insurance as a result of it being subjected to GST," he said.

Dr Krishna said while insurance would be subjected to GST, doctors could not pass it down to patients as healthcare had been exempted from it.

Doctors, he said, would have to bear the burden as doctors' fees were fixed and governed by the Private Healthcare Facilities and Services Act 1998.

Citing an example, he said, the premium cost for obstetrics and gynaecology could be as high as RM80,000 per annum and the additional RM4,800 for GST would increase the cost of healthcare.

"Doctors will then start charging for other services that are currently not charged and, eventually, patients will end up paying for it, increasing the cost of healthcare," he said.

Meanwhile, Association of Malaysian Medical Industries chairman Hitendra Joshi urged the Government to put medical devices in the same GST zero-rated category as pharmaceutical drugs.

He said medical devices should be categorised "zero-rated" on the GST because they save, improve and prolong lives.

"If a medical device is zero-rated, retailer or hospital will claim back GST (as output tax) and will not charge it to the consumer," he said.

On the other hand, "GST exempted" would mean retailer or hospital would have to "absorb" the GST and while there was no GST in the final bill to consumer, there could be a possibility that businesses might increase the price to cover the GST they paid, he said.

New Straits Times – 11 October 2014

2015 Budget: RM30mil Allocation For Dengue Prevention

By Lavanya Lingan

KUALALUMPUR: The RM30 million allocation for dengue prevention programmes and provisions for free dengue test kits to private clinics will allow for faster diagnosis of the disease.

Malaysian Medical Association (MMA) President Dr H. Krishna Kumar said the move would reduce the waiting time at public hospitals and clinics and help complications among sufferers as treatment could be initiated earlier.

"These initiatives is another good collaboration between the public and private sectors," he said when commenting on the allocations that were announced in the tabling of the 2015 Budget in Parliament today.

He also lauded the plan to provide space in public hospitals and health clinics to place 244 haemodialysis machines contributed by private sector, as part of the latter's corporate social responsibility.

Increased tax relief for treatment of serious diseases from RM5,000 to RM6,000 would also be a relief to those with serious illnesses, he said.

Dr Krishna said the Government's initiative to boost healthcare was generally good, but there was still room for improvement.

"These are good initiatives but they are still inadequate. Emphasis should be given on taking care of one's own health. The Government could promote exercising by giving tax exemption to gyms and exercise equipment," he said.

He said sin taxes on cigarettes and alcohol should also be increased, and channeled to fund healthcare.

Meanwhile, Federation of Private Medical Practitioners Association Malaysia President, Dr Steven Chow lauded the special allocations to address the rising number of dengue cases in the country.

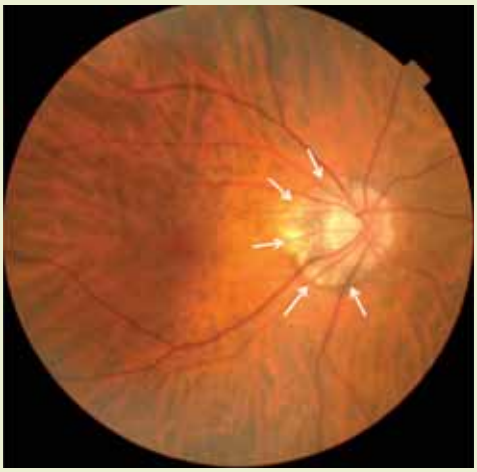
The emphasis on dengue is good in view of the seriousness of the problem,» he said, adding the allocation for non-governmental organisation was also a very good move to empower such groups.

However, he proposed that the allocation could be contributed directly to specific societies such as the St John's Ambulance. He also proposed for a 1Malaysia People's Aid (BR1M) specifically for healthcare needs.

Retinal Photo Quiz (Part 6)

By Dr Chin Pik Kee (Life Member MMA)
and Dr Tara George

Quiz 6 (of 6)



This is a retinal photograph of a 65-year old man who has had diabetes for 20 years (right eye).

Questions

1. Is there diabetic retinopathy?
2. Is there diabetic maculopathy?
3. Is the optic disc normal?

Answers

1. There are no red dots, red blots (haemorrhages) or yellow dots (deposits) seen in all four quadrants. No abnormal vessels are seen. Hence, there is no apparent diabetic retinopathy. (The striped or streaked appearance of the fundus is a common finding in the elderly and in highly myopic eyes).
2. There are no red dots, red spots or yellow spots at or near the macula. Hence, there is no apparent diabetic maculopathy.
3. The optic disc has a crescent of atrophy (white arrows) at the optic disc. This is also a common "normal" variation in myopia and in the elderly.

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, Tel: +603-7960 6728
Email: msoeyephoto@gmail.com/drchinpk@hotmail.com

Prof Dr M. Parameshvara Deva: A Passion for Psychiatry

Professor Dr M. Parameshvara Deva, a Life Member of MMA, continues to serve the medical community well past his retirement age. He is currently a Professor of Psychiatry with the Faculty of Medicine, University Tunku Abdul Rahman (UTAR) at their Sungai Long campus. He has been an educator for more than four decades and is a keen advocate of the need for innovation in the field of Psychiatry.

The Gálfi Béla Award

In 2002, Prof Deva received the Gálfi Béla Award from the *Hungarian Association for Psychosocial Rehabilitation* in recognition of his efforts to improve the psychiatric services in countries like Thailand, Philippines, Indonesia, and Singapore.

Fellowship of the Schizophrenia Research Foundation of India

In recognition of his work in improving mental health in Asia, SCARF of India awarded him their Fellowship in 1996.

Founder Patron AFPA 2005

He Founded the Asian Federation of Psychiatric Associations in 2005

A Man of Many Accomplishments

Prof Deva has not only been involved with many international organisations as a member and/or founder, such as the *ASEAN Federation of Psychiatry and Mental Health* (Founder-Member in 1981, Council Member from 1981-1991, President from 1989-1991), *World Psychiatric Association* (WPA) (Zone Representative for the South Asian Zone from 1989-2005), *World Association for Psychosocial Rehabilitation* (Founder-Member from 1986-1989, President from 1996-1998), *Malaysian Psychiatric Association* (MPA) which he was President of in 1988, Malaysian Medical Council (Member from 1988-1998), *WPA Section on Education in Psychiatry* (Chairman from 1995-1999), Asian Union *Against Depression* (Founder-Member from 2001-2004, Vice President from 1997-1998), *Global Network for Mental and Neurological Health* (Regional Coordinator from 2001- 2004), *Western Pacific International Division of the Royal College of Psychiatrists UK* (Secretary from 2004-2009 and Chair from 2009-2013), and the *Asian Federation of Psychiatric Associations* (AFPA; founded by Prof Deva in 2005 and he was subsequently honoured as AFPA's Founder and Patron by its Council). AFPA has World Congresses of Asian Psychiatry (WCAP) every two years and held its 5th Congress in 2013 in Colombo (previous Congresses were held in Goa, Taipei and Melbourne).

As a direct result of his involvement both locally and internationally, he has contributed to the development of Psychiatry not just in Malaysia, but also all over the world. Prof Deva has also served as an Editorial Board Member for the *Medical Journal of Malaysia* (MJM), *Medical Progress* (HK) and the *ASEAN Journal of Psychiatry* of which he was Editor in 1997. In fact, many of his later contributions in the West Pacific Region under the aegis of the *World Health Organization* (WHO) happened as a result of his involvement with WHO, where he authored 36 WHO reports during his attachment as a consultant to many countries in the Western Pacific Region in the 16 years since he retired from University of Malaya after 28 years of service and teaching of undergraduates, postgraduates, family physicians, and nurses.

In addition to this, he has also contributed to the medical community by publishing well over 200 works (including 24 books, 86 journal papers, 64 scientific reports) and authoring over 600 scientific presentations.

"It was a good opportunity to share, in part because we started the ASEAN Federation of Psychiatry and Mental Health. I did the similar things for them and would go to one country and stay for a week to look at their facilities, give their staff other key personnel lectures or provide them with training and so on" – Prof Deva

MP Deva cooking at a scout camp in Kuala Pilah

MP Deva with two other scouts on a 25-mile trek for their 'Venturer Badge' along the Kuala Pilah-Seremban road

His childhood was a relatively quiet period as he lived and studied in the quiet town of Kuala Pilah. He first started schooling at Tuanku Muhammad School which was named after the late Yang di Pertuan Besar of Negeri Sembilan who died in the 1930s. He started schooling in 1949. His earliest memories were of the Boy Scouts, which he first joined as a cub sometime in 1950 when he was about 8 to 9 years old.

He had a deep interest in scouting and greatly enjoyed the many opportunities it offered him to go camping and exploring, for he was drawn to adventure. He finally 'graduated' to become a full-fledged scout in secondary school and worked his way through all the badges to finally become a King Scout.

From King Scout to Medical Studies

MP Deva posing with several other fellow students at Calcutta National Medical College (1967)

Captain MP Deva at the 3rd Rangers Airport Camp, Sibu

After finishing his early education in 1958, he managed to get a place in National Medical College, Calcutta, India in 1960. He spent quite a few years in India as the country was in the grip of riots at that time which caused the university to postpone the exams several times. However, he persevered before finally graduating in 1967 and came back to work as a House Officer in Johor Bharu. Even then, he was drawn to become an educator and applied to join Universiti Malaya (UM) as a Medical Officer Trainee in Psychological Medicine.

Unfortunately, he had to postpone his plans as he was called up for National Service Training, and joined the Armed Forces as a Captain and Regimental Medical Officer in 1969. It was unfortunate when the May 1969 riots happened as his tenure was extended for an additional year, bringing his total tenure with the Armed Forces to almost 18 months.

> Back then, Psychiatry was a field of medicine that was constantly on the backburner. Conditions for psychiatric patients were deplorable. We formed the MPA with the purpose of working hand-in-hand with the Government

Although he did not serve in the Malaysian Armed Forces on National Service for a long time, his experience there was an eye-opener. He served in several locations with the 3rd Malaysia Rangers in Sarawak and Taiping. After serving in Taiping he was posted to Majidee Garrison in JB as Officer-in-Charge of the small Armed Forces Sick Quarters (AFSQ) he was given the choice to opt for a position as a Reservist which he immediately applied for so that he could start training in Psychiatry. It was then that he joined UM for two years as a Medical Officer, and then as a lecturer in 1973. After just over two years, he was sent to Edinburgh for training in the field of postgraduate Psychiatry.

May 1975: Prof Deva with his other colleagues in Ward 5, University Hospital

> I am thankful for my earlier experiences as a boy scout and being posted with the army as it enabled me to work well in the difficult circumstances in Mongolia

Filling a Niche

"In November 1976, I took the initiative to call for a meeting with the other Psychiatrists in Malaysia with the idea to establish the *Malaysian Psychiatric Association* (MPA). This meeting saw 17 out of 25 Psychiatrists attending and we successfully started MPA. Back then, Psychiatry was a field of medicine that was constantly on the backburner. Conditions for psychiatric patients were deplorable. We formed the MPA with the purpose of working hand-in-hand with the Government in the formation of the National Mental Health Policy for the betterment of conditions - both for the professionals and our patients," reveals Prof Deva.

An Unexpected Path

Despite his initial misgivings, he found himself drawn to Psychiatry. It began when he was still doing his housemanship in Johor Bahru. He was asked to look after the psychiatric ward, and it was a heart-wrenching experience to see the psychiatric patients housed in the Prisoners l's ward treated just like prisoners. Despite his initial plan of doing general medicine, he decided to opt for Psychiatry.

His work in Psychiatry in the years as an academic staff in UM and his involvement in many international bodies that dealt with mental health drew the attention of WHO, which was in the midst of trying to improve the state of mental health practices in countries of the West Pacific Region.

They were quick to head-hunt Prof Deva and offer him the opportunity to serve as the Acting Regional Advisor in Mental Health and Health Promotion for Western Pacific Region of WHO in 1998. The Western Pacific Region (WPRO) of WHO is by far the largest in area and population among the WHO's 6 Regions with over 1.6 billion people in 37 countries and territories – and many among the richest and poorest countries and the smallest and largest.

In retrospect, it is not a surprise that WHO wanted Prof Deva to take the helm for this project as he was not only involved with numerous organisations both at the national and international level, but he was also active as a participant and a speaker in numerous conferences around the globe.

In 1981, the *ASEAN Federation of Psychiatry and Mental Health* (AFPMH) was established and the MPA joined as a Founder-Member. It was Prof Deva who proposed the ASEAN Traveling Fellowship, which served two main purposes – to invite Psychiatrists from needy countries to explore Malaysia's progress in mental health and also to sponsor MPA members who are interested in going abroad to teach short courses on Psychiatry to nurses, GPs and even postgraduate trainees.

Busy as a Bee

Although his work in WPRO of WHO was a big change from Academia in UM, which was filled with clinical work and teaching, the change opened up his mind to the enormous needs of less developed countries of the vast region. This posting would involve covering numerous countries in the West Pacific Region which includes countries from Mongolia and China to most of the ASEAN Countries and the Pacific Islands.

Prof Deva in a follow-up visit to the Ger-based Rehabilitation Project he started in 2008 with help from WHO; this was in Ulaan Baatar, Mongolia and the temperature during the day was -28°C

"I learnt that many of these countries were poorly equipped to deal with psychiatric services. This was not just in terms of equipment, but also the training of

the professionals who were responsible for psychiatric services was lacking. That was the real challenge. In Mongolia I was asked to reform the old Soviet-style mental health system into a market-driven one with emphasis on community care and de-institutionalisation. The first Ger-based (or tented traditional house) Rehabilitation Centre was started by me in 1999 and today there are at least seven of them in the country," he enthuses.

Prof Deva went to Mongolia at least eight times in various weather conditions ranging from lovely summers to freezing winters which went as low as -30°C to ensure that the project succeeded despite the many limitations it faced. He first went with full WHO support, and later as a volunteer.

"I am thankful for my earlier experiences as a boy scout and being posted with the army as it enabled me to work well during this part of my life in the difficult circumstances in Mongolia. It made me more flexible in coping with challenges and moving around different remote places, regions, or countries as it hardly made any difference to me. I was able to concentrate on developing the psychiatric services wherever I was asked to go," he explains.

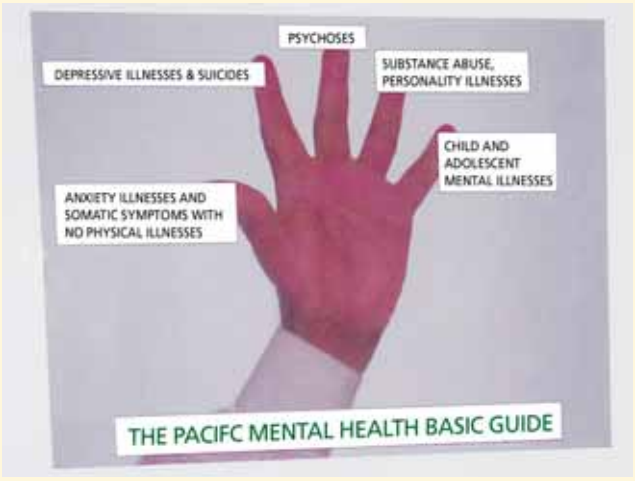
An Unforgettable Experience

It was during his fifth trip to Fiji that had the biggest impact on Prof Deva in recent years. He went there twice in the last five years, and the first time he was there, he saw that the conditions psychiatric patients had to endure had not improved. Although it was the norm in many poor countries for patients in mental wards to be locked-up and often physically restrained, in Fiji, he came across some instances where the patient was kept in chains with some showing severe muscle wasting and contracture due to the severity of their restraints.

He made it his mission to educate the people and train the nurses and doctors. Over time, the situation in Fiji changed for the better. Now they have a programme in place to handle new patients, in the first ever General Hospital Based Psychiatric Units for short term acute care. When the Minister of Health, Dr Neil Sharma, asked him to suggest an appropriate name for those psychiatric units, Prof Deva suggested naming them as Stress Management Wards. This was a paradigm shift for the staff who had been used to care of the mentally ill in locked wards of a 127 year old mental institution for psychiatric patients and derided with names like Lunatic Asylum or mental hospital. Most importantly, the doctors and nurses have been trained in not just what to expect in inpatient care but also in what they can do for the community as well through the formation of Day Centres for Stress Management.

Prof Deva was able to work with not just the Fiji National University at Suva (Visiting Professor at the Fiji School of Medicine in 2011), but also as a Consultant Psychiatrist for the Fiji Ministry of Health (Interim National Mental Health Adviser Fiji in 2012).

Prof Deva at the 2010 opening of the Te Kainga Stress Management Centre, Cook Island



Prof Deva at the 2010 opening of the Te Kainga Stress Management Centre

"One of the things that I have learnt from being a teacher for more than 40 years is that a good teacher is one who can make difficult things simple and easy to understand. It was with this philosophy in mind that I came up with the concept of 'Lima' while spreading the message about Psychiatry and its best practices in the Western Pacific Region. This concept basically simplifies the methodology emphasising Anxiety, Depression, Psychoses, Substance Abuse and Childhood stress illnesses and makes it easy for the doctors and nurses to use their knowledge as simply and as efficiently as possible," he explains. It strengthens Stress Management in Primary Care Settings without getting confused.

Prof Deva is happy that Malaysia has improved a lot in terms of psychiatric services. However, he expresses concern that while the postgraduate training programme in psychiatry was started in 1973 at UM and with currently about 300 psychiatrists (with good training for postgraduate students), the training for undergraduates may not be comprehensive enough with few psychiatrists going into Academic Psychiatry .

"When Malaysia is compared with other countries, how far ahead we are will depend on whether we are compared against the low-income or high-income countries. If you compare to other countries in this region, then we certainly have something to be proud of. However, if we compare ourselves to countries such as

> Giving to society can start at any age, so young people should start getting involved as early as possible, give more instead of taking

Japan, Taiwan, Hong Kong, or Korea, then we still have a long way to go," he adds. "Looking at Taiwan, Hong Kong, Singapore, these countries have a much higher ratio of Psychiatrists to population. Additionally, they also have better facilities and a bigger budget for psychiatric health."

Quality Begets Quality

Looking at the scenario nowadays, Prof Deva expresses grave concerns over the quality of the educators. One of the most fundamental problems faced is the lack of one to one time that students fail to be provided with. In order to have this, there needs to be a hospital attached to the university (or vice-versa), which is often lacking. Some medical schools also do not have full-fledged Psychiatrists to train their students so they let the already very busy hospital doctors do the teaching. This situation is unacceptable as hospital doctors are already overwhelmed with clinical work and thus will not have the time to guide them properly. Just as crucial would be the lack of teachers, which simply means that Malaysia's current methodology of teaching undergraduates would have to be reassessed.

Past and Present

Prof Deva is quick to point out that among all the developing countries, Malaysia fares far better than most all of them. Having seen the situation in China and India, he can say without a doubt that the quality of care is definitely better here.

"This is not to say that we have already reached the pinnacle," he cautions. "In terms of the availability of human resources, we are good, even though we do not have a large headcount. If we look at the numbers of Psychiatrists we have had since 44 years ago, we have increased the number of Psychiatrists by as much as 20 times."

Prof Deva believes that with sufficient budget, more Psychiatrists can easily be produced. However, the main factor that would influence the quality is the supervision during the training of these personnel. "We need to ensure that we have trainers with more practical experiences and enough people to supervise them. This way, I think we could do more." Prof Deva further elaborates that present standards should not be allowed to dwindle. One important thing, he stresses, is to have more psychiatric units available in every hospital or clinic. "Ideally, every state in Malaysia should have more such psychiatric units. Take Sarawak, which I am happy to say has progressed quite nicely – although it has more clinics now, it still has a long way to go."

There is also an important need for medical students and young doctors and specialists to recognise anxiety and depression wherever it occurs in primary care clinics and inpatients – and not just in psychiatric wards! Mental stress occurs everywhere in the healthcare services and all healthcare professionals need to have a paradigm shift in their understanding of psychiatric and psychosocial problems and leave all of Psychiatry to the 300 Psychiatrists in the country. Just as Diabetes occurs everywhere and all nurses and doctors are trained to deal with it at the primary care level – so is there the need for all healthcare personnel to understand the simple Lima Approach to psychiatric problems and to recognise and manage anxiety and depression related illnesses in their practices. This also requires better teaching at undergraduate level.

Right now, Prof Deva emphasizes the urgent need for more Psychiatrists in Malaysia. Although the ratio of Psychiatrists to our population is around the region of 1:50,000 he believes we still need another 600 Psychiatrists.

Passion is the Key

Prof Deva believes that in order to be successful, one must be passionate about their calling. "I feel that the younger generation should have more passion for their profession. It is not just about doing more; they should go beyond the call of duty. Enthusiasm is completely necessary if you want to improve. There is no way to succeed if you do not show your leadership or if your passion is not there," he claims.

Prof Deva's personal belief is that every doctor should do their part to improve their profession. This may include educating the public, but regardless of what it may be, they will definitely need to go above and beyond their professional duties. "There will be sacrifices that need to be made, so it is up to you how far you are willing to take things. Young people should contribute as much as they can, as they will have the physical strength for it. As you age, it becomes more and more difficult to give things a go due to physical limitations," he confides.

"For instance, do more volunteer work in mental health – go to rural areas and give the poor free consultations and where possible help colleagues in neighbouring countries by sharing our experiences in improving services. Nowadays there are many events where free blood pressure tests are given, so why not something similar in psychiatry, or better still Stress Management? With the advent of social media nowadays, you can do your bit to educate the public via your own Facebook. Giving to society can start at any age, so young people should start getting involved as early as possible, give more instead of taking," he advised.

42nd MMA Sarawak Annual Installation Dinner 2014

Group photo of Committee Members with the Assistant Minister of Public Health, Sarawak, Datuk Dr Jerip Susil

Dr Chin Saw Sian
sawsian@gmail.com
Hon. Secretary
MMA Sarawak

Speeches by the MMA Sarawak Chairman, MMA President and the guest of honour were captivating and well received

The Annual Installation Dinner of MMA's Sarawak Branch was held at Four Points Hotel, Kuching, 6 September 2014. Doctors from both the private and public sectors came together with their families and friends to witness the grand occasion of the installation of our in-coming Chairman, Assoc. Prof Haji Dr Kamarudin Kana. Leaders of the various professional organisations were also invited to the dinner.

YAB Datuk Patinggi Tan Sri Dr Haji Adenan Satem, Chief Minister of Sarawak, was the guest of honour but due to unforeseen circumstances, he was represented by YB Datuk Dr Jerip Susil, Assistant Minister of Public Health for Sarawak.

For this year's celebration, MMA Sarawak had the honour of welcoming MMA President Dr H. Krishna Kumar, President-Elect Dr Ashok Philip, Hon. General Secretary Dr Ravindran Naidu, Hon. General Treasurer Dr Gunasagaran Ramanathan, and Hon. Deputy Secretary Dr Rajan John.

Besides the delicious food that was served, we were also entertained by members of a musical group. "The Rhapsody" consisted of pianists, violinists and a soprano vocalist. Diners were treated to a selection of classical oldies from as far back as the 60's. The youngest member of the group, a five year-old girl stole the hearts of the audience with her amazing talent at playing the piano and violin.

During the function, the new Committee for 2014-2015 was introduced and appreciation certificates were given to members who had served in the previous Committee. Speeches by the MMA Sarawak Chairman, MMA President and the guest of honour were captivating and well received.

Incoming Chairman, Dr Kamarudin Kana with Outgoing Chairman, Dr Donald Liew, and President Dr Krishna Kumar

MMA President, Dr Krishna Kumar delivering his speech during the dinner

Group photo of MMA Sarawak Branch Committee Members for 2014-2015

As in previous years, awards were given to doctors who have made contributions to the medical field and to MMA. This year's MMA Sarawak Honours Award went to Dr Julian Wee Kiam Siak who has served in Sarawak since the 70's, initially as Medical Officer-in-Charge for Sarawak General Hospital and in 1975, established his own private practice till this day. The MMA Sarawak Public Service Award was presented to a very deserving and dedicated Paediatrician, Dr Toh Teck Hock from Sibu Hospital for his tremendous contributions to children with special needs.

The MMA Sarawak Best MD Gold Medal Award for UNIMAS students was awarded to Dr Chong Tze Huat. This memorable moment was witnessed by the UNIMAS Medical Faculty Dean, Prof Dr Haji Ahmad Haji Hata Rasit. Excellence Awards under the Kenyalang Medical Foundation were also presented to UNIMAS's best medical students from year one to five by the Vice Chairman, Dr Lim Joo Kiong.

The annual donations to charitable organisations were given to the Lions Nursing Home and Kenyalang Medical Foundation.

The dinner was preceded by a 'Meet-the-President' session where the local MMA members had the opportunity to meet the President and his team to voice out questions and their concerns. A hot discussion on GST was carried out, and MMA National has agreed to look into the matter with the relevant ministries for members' best interest.

As in years past, the MMA Sarawak Annual Dinner 2014 ended well with all present having had an enjoyable evening.

SAILOR IN PHARMACY

Humour

One day a sailor goes into a pharmacy - reaches into his pocket and takes out a small whiskey bottle and a teaspoon.

He pours from the bottle onto the teaspoon and offers it to the pharmacist.

"Could you taste this for me, please?"

The pharmacist takes the teaspoon, puts it in his mouth, swills the liquid around and swallows it.

"Does that taste sweet to you?" asks John.

"No, not at all," says the chemist.

"Oh that's a relief," says John, "The doctor told me to come here and get my urine tested for sugar."

Dr Gayathri K. Kumarasuriar
gsuriar@yahoo.com.sg
Vice Chairperson
MMA Kedah
& Editorial Board Member

A Ray of Light, A Glimmer of Hope

MMA Kedah members with Dr Solomon and some of the children

Children are God's gift to mankind, our hope, our future, the symbol of continuance of our survival as the human race. Yet, time and again we hear heart-wrenching and chilling tales of how children are subjected to inhumane treatment and torture.

Thankfully there are saviours amongst us who make it their mission in life to help as many of these children as they can. One such samaritan is Master Dr Solomon B.G. Rajanthran, a Psychologist and Hypnotherapist by profession who started the Batu Grace Children Home, Kulim, in 2008 with three children. As the number of children from one house increased, the number of houses increased as well. They were finally renting five houses to run this place which was eventually bought over and donated by another good samaritan, a year ago. Now the place has 89 children, several single mothers and aged citizens as well. Dr Solomon's training sessions help him finance the orphanage. Just like most private orphanages, the challenges and trials they go through to cater for these children are not easy. However, the concept of mindfulness that is practised by all of them, both carers and children, alike, have helped them sustain their anguish in times of difficulties. The children are inculcated with the principle of spirituality and prayers are conducted every night where the children play an active role.

Children waiting for dinner to be served

> We have so much because we give. We are in a position to give because we have been blessed with the opportunity to give

Dr Sureiin Krishnasamy, a MMA member from Hospital Kulim, made all the preliminary arrangements for MMA Kedah to help the children in this home enjoy the Festival of Lights in our small way. More members would have had attended the function if not for the torrential downpour and occurrence of flash floods along the way. Some of our members who were not able to attend contributed electrical goods and 'Ang Pow' to the children. MMA Kedah sponsored the dinner and contributed some cash.

We were greeted by Dr Solomon and several children who were hovering around him, looking at us curiously. Well, we did look a sight, like drowned rats, to borrow a cliché'.

As we were talking to him, this young chap approached us, with an air of confidence that astounded us. He is only six but displays wisdom beyond his age. His story was that he was found abandoned at birth by an immigrant who took care of him till he was about 6 months old. His room was a cardboard box. Instead of milk he was fed only black coffee for his carer had hardly any money to feed himself. He was so frail that no one thought he would have lived to see the next day, and yet he did. Lovingly called 'The King', he now controls the whole centre!

Another 11 year-old was rescued when she was brought to seek treatment for a laceration wound on her scalp in a hospital. She was made to work as a maid in a relative's house. Each time she failed to execute the chores instructed, she would be

struck! She was only five when these heinous incidents took place. That was about six years ago. There is still a remnant of the scar on her scalp where hair does not grow. As for the emotional and psychological scars, would they ever heal, I wonder? Yet, she offered us the most beautiful smile, her eyes sparking with joy. Many of these children have no birth certificates for the Registration Department wants some form of identification! The sad thing is that no amount of reasoning can make them see sense. We live in such a society!

The youngest is a little girl, about nine months old, a cherubic angel who greeted us with a shy smile and sleep laden eyes. Going through the phase of stranger anxiety, she clung to her carer, occasionally peeping at us with that lovely smile that tugged at all our heart strings. She was given away at birth by her mother. "Would her mother want her back, if she sees her now?" I wondered.

The challenges faced by those who run the centre are many yet one can see the love and care showered upon the children and the others staying there. From young, these children have been brought up using the reward system – a good method of encouragement. A few of the older children have already started polytechnic courses and some are attending local colleges. These children would never have had the opportunity to go this far in life had they been staying with their parents or relatives.

Like this orphanage, there are so many in our country that are in dire need of help both financially and otherwise. How much can we do to help change the lives of these children? A lot, actually.

This brings to mind what a good friend of mine said, "We have so much because we give." How true. We are in a position to give because we have been blessed with the opportunity to give. How many of us are that lucky? It is not just giving financial aid. These children are so starved of love and affection. Something for all of us to ponder …!

It is a known fact that one needs to be strong physically and mentally before one can help others. Bearing this in mind, MMA Kedah will be organising our annual Stress Management activity on the 21st and 22nd November in Jitra.

This event is opened to Specialists, Medical Officers and House Officers. We promise you nothing but fun and laughter, the best way to manage stress. For those interested to attend, please contact your state SCHOMOS representatives for details. The more, the merrier! See you soon!

Congratulations

The MMA congratulates

Datuk Dr Maheswaran a/l Sithampalam

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

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

On the occasion of
TYT's 76th Birthday

THE ROYAL COLLEGE OF SURGEONS IN IRELAND
Intercollegiate Basic Surgical Skills Course – Penang / Kuching 2015

Month	Date	Venue
March	4th – 6th	Penang Medical College
March	11th – 13th	University of Malaysia in Sarawak
September	2nd – 4th	Penang Medical College

Intercollegiate Basic Surgical Skills Course
THREE DAY TECHNICAL TEACHING COURSE

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

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

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

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

Fee:
EURO 350.00 for Malaysians Nationals (attached to MOH)
EURO 750.00 for all others
Bank Draft to: **The Royal College of Surgeons in Ireland**

- **How to apply:**

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

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

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

Email: prem@pmc.edu.my

THE ROYAL COLLEGE OF SURGEONS IN IRELAND
in conjunction with

PENANG MEDICAL COLLEGE
&
HOSPITAL PULAU PINANG, MINISTRY OF HEALTH MALAYSIA
are pleased to offer the

Intercollegiate MRCS PART A (MCQ) Examination

Month	Date of Exam(s)	Closing Date	Exam Fee
January	06/01/2015	31/10/2014	€ 645
April	21/04/2015	13/02/2015	€ 645
September	08/09/2015	19/06/2015	€ 645

Intercollegiate MRCS PART B (OSCE) Examination

Month	Date of Exam(s)	Closing Date	Exam Fee
February	01/02/2015	07/12/2014	€ 1195
August	16/08/2015	21/06/2015	€ 1195

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

Venue : Multipurpose Hall

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

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Details :

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

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

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

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

YEAR 2014

NOVEMBER

MMA WILAYAH 11TH PRIMARY CARE SYMPOSIUM

Date : 1 – 2 November 2014
Venue : Eastin Hotel, Petaling Jaya
Contact : Ms May (+6012-638 8128)
Dr Koh Kar Chai (+603-6253 1871)
Ms Jess (+6012-631 3436)
Website : www.mmawilayah.org.my

CPD ON UPDATES IN OCCUPATIONAL MEDICINE

Date : 8 November 2014
Venue : Grand Seasons Hotel, Kuala Lumpur
Contact : Ms Muthu / Ms Jeniffer
Tel : +603-4041 1375 (ext 102)
Fax : +603-4041 8187
Email : soem@mma.org.my

AOEMM Seminar

Date : 8 – 9 November 2014
Venue : Vistana Hotel, Kuala Lumpur
Contact : Ms Hema
Tel : +603-4050 8211
Fax : +603-4050 8211
Email : malaysia.aoem@gmail.com

COPD TALK AND SPIROMETRY WORKSHOP

Date : 26 November 2014
Venue : Institut Perubatan Respiratori, Kuala Lumpur
Contact : Dr Syakirin / Ms Hafiza
Tel : +603-4023 2966
Fax : +603-4021 8807
Email : hafizashamsuddin@yahoo.com

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
Tel : +603-6201 3009
Fax : +603-6201 7009
Email : info@apage2014.com
Website : www.apage2014.com

DECEMBER

DRUG-RESISTANT TUBERCULOSIS (DR TB) UPDATE 2014
THEME : CHALLENGES & MOVING FORWARD

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

2ND INTENSIVE COURSE IN OBSTETRIC EMERGENCIES

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

YEAR 2015

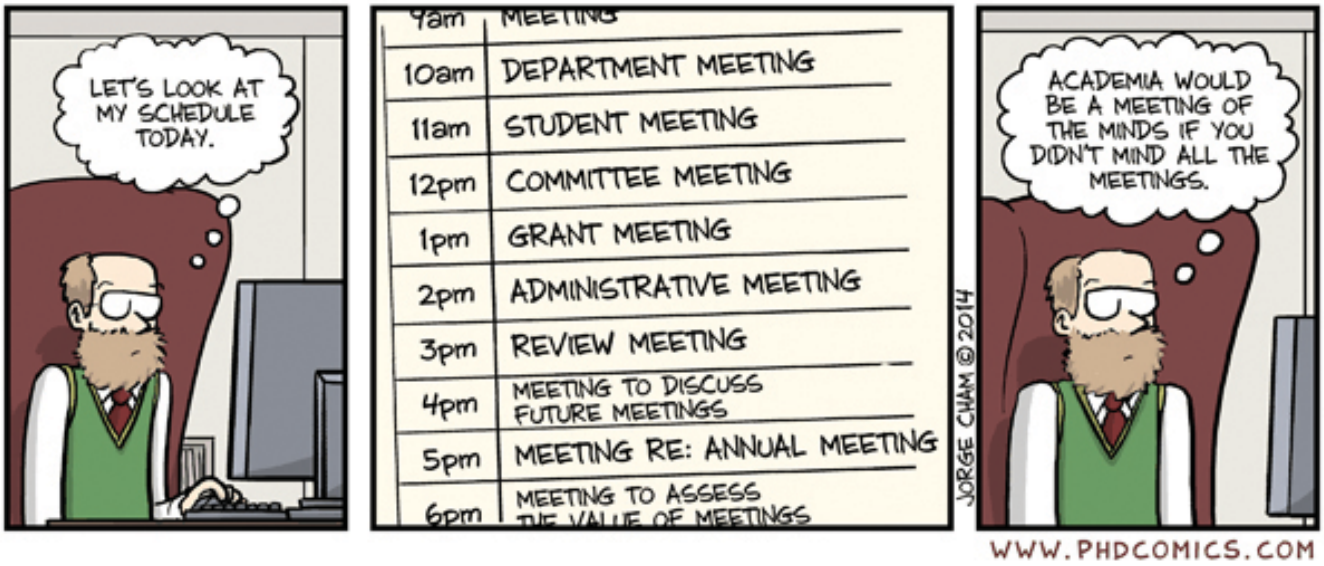
JANUARY

9TH ASIA PACIFIC CONFERENCE ON CLINICAL NUTRITION (APCCN)

Date : 26 – 29 January 2015
Venue : Shangri-La Hotel, Kuala Lumpur
Contact : APCCN Congress Secretariat
Tel : +603-2162 0566
Fax : +603-2161 6560
Email : apccn2015@console.com.my
Website : www.apccn2015.org.my

NHAM-SCIM 4TH BASIC ECHOCARDIOGRAPHY CERTIFICATION COURSE

Date : 30 January – 1 February 2015
Venue : Hospital Pulau Pinang, Penang
Contact : Secretariat, National Heart Association of Malaysia
Tel : +603-4023 1500
Fax : +603-4023 9400
Email : secretariat@malaysianheart.org
Website : www.malaysianheart.org



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Thank you.

Yours sincerely,
for Bank Islam Malaysia Berhad

MUJIBBURRAHMAN ABD RASHID
Head
Consumer Banking Division

BANK ISLAM PERSONAL FINANCING-i MONTHLY REPAYMENT SCHEDULE

FINANCING AMOUNT	FINANCING TENURE (YEAR)									
	*BFR - 1.65 % (5.20%)			*BFR -0.35% (6.50%)						
	1	2	3	4	5	6	7	8	9	10
10,000	856.99	439.61	300.61	237.15	195.66	168.10	148.49	133.86	122.55	113.55
50,000	4,284.96	2,198.05	1,503.04	1,185.75	978.31	840.50	742.47	669.31	612.73	567.74
100,000	8,569.92	4,396.10	3,006.08	2,371.50	1,956.61	1,680.99	1,484.94	1,338.62	1,225.45	1,135.48
150,000	12,854.87	6,594.15	4,509.12	3,557.24	2,934.92	2,521.49	2,227.42	2,007.93	1,838.18	1,703.22
200,000	17,139.83	8,792.20	6,012.16	4,742.99	3,913.23	3,361.99	2,969.89	2,677.25	2,450.90	2,270.96

*Current Base Financing Rate (BFR) is 6.85% per annum
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CR 10-X

CR 10-X : Computed Radiography
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Optimize workflow without cropping image manually when x-ray exposures are collimated

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For more information, please contact :
Agfa HealthCare (M) Sdn Bhd (791257-M)
Address: Unit 704, Block B, 7th Floor, Kelana Business Centre, 97 Jalan SS 7/2, 47301, Kelana Jaya, Selangor, Malaysia
Tel: +603-7882 7300 Fax: +603-7804 7400 Email: my.he.enquiry@agfa.com Website: www.agfahealthcare.com

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