Berita MMA news

December 2011

Berita MMA Vol. 41 No.12

(FOR MEMBERS ONLY)

PERSATUAN PERUBATAN MALAYSIA MALAYSIAN MEDICAL ASSOCIATION

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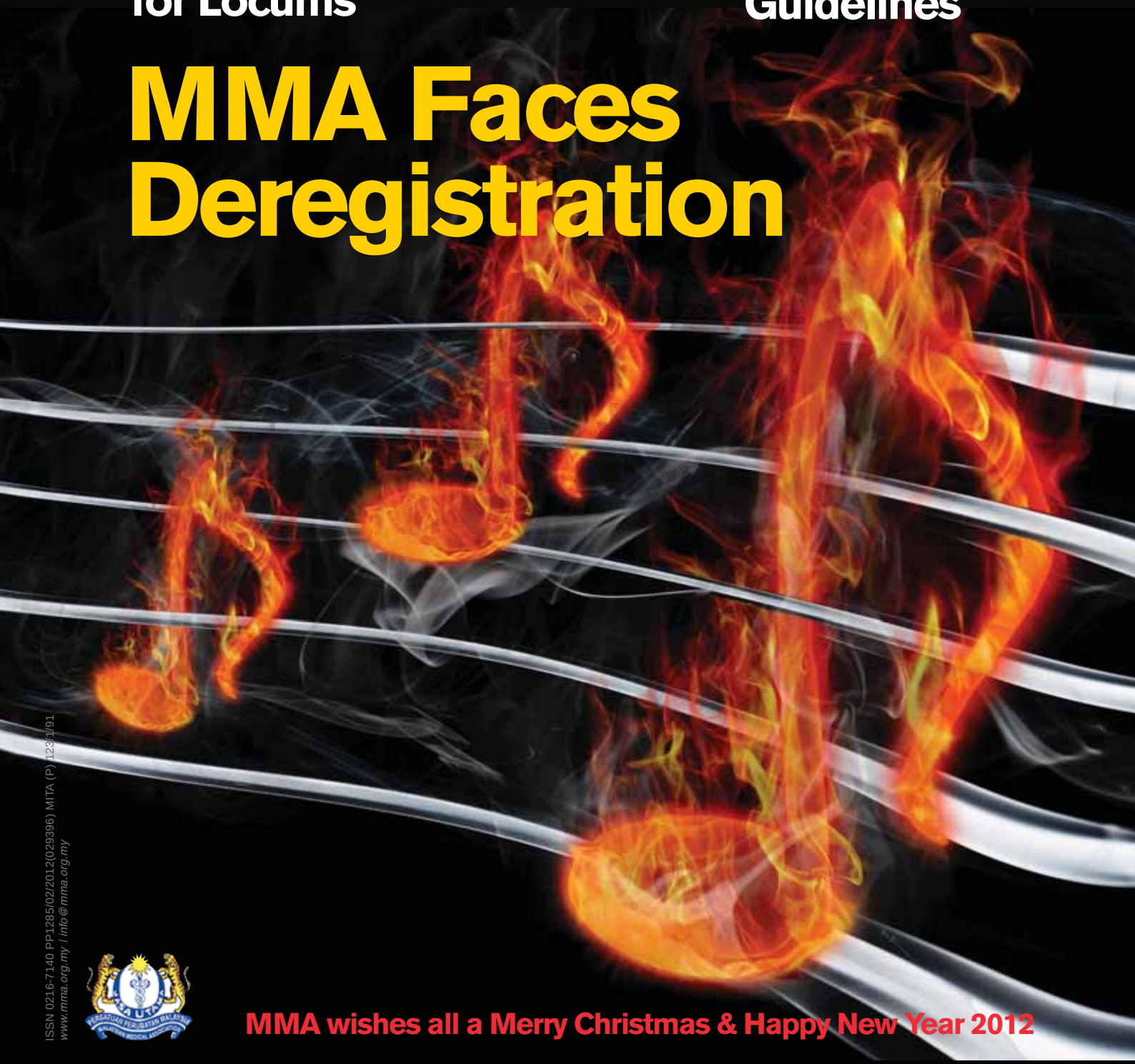

MMA wishes all a Merry Christmas & Happy New Year 2012

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References:

1. *J Sex Med 2008; 5: 946-953*
2. *Data on File – Phase I Clinical Trial in Convance, UK*

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Berita MMA news

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Malaysian Medical Association
4th Floor, MMA House, 124, Jalan Pahang, 53000 Kuala Lumpur
Tel: +603 4042 0617; Fax: +603 4041 8187, 4041 9929
Email: info@mma.org.my / publications@mma.org.my

Website: www.mma.org.my

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CONSULTANT
DeCalais Sdn Bhd
D-3-8 Plaza Damas, 60 Jalan Sri Hartamas 1, Sri Hartamas, 50480, Kuala Lumpur
Tel: +603 6201 8857; Fax: +603 6201 8850
Email: deepa@decalais.com
Website: www.decalais.com

PRINTER
Print Scope Sdn Bhd
No.38 & 40, Jalan PBS 14/3,
Taman Perindustrian Bukit Serdang,
43300 Seri Kembangan, Selangor
Tel: 03 8945 6409

Editor's Message

Datuk Dr Kuljit Singh
Editor

MMA Faces the Music… but is the music good for us?

After a great 50 years anniversary bash last year and being acknowledged as a well established medical association for half a century; we were slapped with a notice of deregistration in the month of November 2011. The notice resulted in tremendous anxiety and a great deal of emotional upheaval amongst the members of MMA and also its office bearers. It is an unfortunate mark in our history. I personally have had to take the brunt of it from working colleagues who are not members. Indeed I am sure that all of us associated with the MMA have had to do the same. And of course, there has been no shortage of cynical comments from members of the public.

We, doctors can sometimes be in the wrong type of limelight and this piece of news is not something we would like to cherish. The errors that led to the deregistration are technical in nature but the situation has been churned around so much that some would make it appear that the entire association is in a mess. Happily, the top management of the Association has sorted everything out to make sure that the Association's processes are now in order. Looking back at the facts, this is the best that can be done.

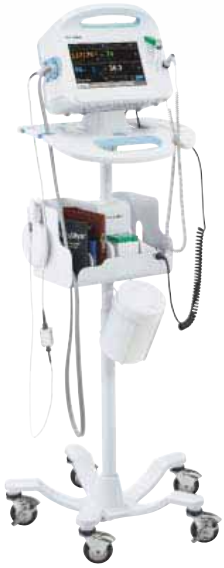
Acting in good faith and in the best interests of the association, however, can get tricky if for some, self-interest precedes the real love for the association. I am sure the members who complained had no personal agenda, no disgruntled feelings, no old scores to settle and they always had the association's best interests at heart when they took such drastic steps. We all work together for the best outcomes that everyone shares within the association. So, one can only conclude that self interest is the motivator for those who would bring such difficulties to bear on the association.

Most of us have sacrificed a lot of time working for MMA in the past and some are still dedicating their time to MMA. I am sure we must stand strong and get the house running well. Details can be sorted out among us and it is difficult to comprehend why some doctors can choose to divide us at such a critical time in our history, when the future does not bode well for us.

My hope is that everyone will close ranks and move on with our mission. It is best to eradicate members who have a selfish agenda. We should have members who can sit together to work out plans and strategy in overcoming our difficult issues regardless of who holds office. Let's not follow a culture of acrimony as this would definitely weaken us at critical times as our profession sets forth on an uncertain future.

My best wishes to everyone and lets turn a new leaf for 2012! M

H A P P Y N E W Y E A R



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The Silver Lining...

The events that took place over the past couple of weeks have seen the Exco as well as members on a real roller-coaster ride. I would like to take this opportunity to explain as much as possible to members the events that surrounded the deregistration and the reinstatement of the MMA.

I have already talked about the show-cause letter in last month's *Berita* ("Is the MMA in danger of being deregistered?"), and had informed members that we had replied by the stipulated deadline to that letter.

I had only mentioned in my previous message that there were allegations of digressions from the MMA Constitution which were all related to the 2011 election of office bearers. I would like to elaborate here so that you will see all the alleged "offences" were of a technical nature and there was no fraud or mismanagement of funds involved. There were four allegations in the show cause letter:

a. That we had wilfully contravened By-Law IX(5)(ii) of the MMA Constitution by not sending out the list of candidates for the elections to members seven weeks before the election.

b. That we had wilfully contravened By-Law X of the MMA Constitution by publishing in the *Berita MMA* of November and December the call for nominations for Hon. Deputy Secretaries (i.e. before the Registrar of Societies (ROS) approval for the amendment of the Constitution, passed at the 2010 AGM, was received on 17 January 2011).

c. That we had wilfully contravened By-Law IX (5) (ii) of the MMA Constitution by failing to announce the candidate for Hon. Gen. Treasurer for 2011.

d. That we had wilfully contravened Article X(1) (g), Article X (1) (h) and Article X (1) (i) of the MMA Constitution by sending to members the agenda for the AGM which was not according to the above articles.

MMA Exco members met with an ROS officer on 24 October 2011 and after the discussion, we sent our answer to the show-cause letter on 27 October 2011, addressing each of the allegations above:

a. The names of the candidates for election 2011 were announced in the *Berita MMA* April issue. The seven weeks may not have been met due to postal problems.

b. By-Law X (which referred to the nomination of two DHGS on the floor at the AGM) was superseded by the amended By-Law IX which called for nominations for all the posts including DHGS.

c. The name of the candidate for HGT for 2011 was not announced because there was only one candidate therefore, there was no election.

d. The agenda as stipulated in Article X(1)(g), (h) and (i) had been followed at the AGM after discussion with the members present at the AGM.

The letter ended stating that the MMA tried our best to follow the Constitution and any mistakes had not been done wilfully ("*bukan dengan sengaja*").

As mentioned earlier, during the course of several discussions with the ROS officers, we received verbal reassurances that this was just a "routine matter", as a complaint had been received by the ROS and they had to respond to it. Therefore, we were really taken by surprise when the "red letter" (deregistration notice), dated 15 November 2011, arrived at the MMA on 16 November 2011.

As I mentioned in my previous message, "To deregister an organisation which is more than 50 years old, with over 10,000 members is not a trivial matter." Not only were we (Exco) surprised and shocked by this, so was the Minister of Health (MOH), with whom I met on the 17 November. Even if the ROS did not accept our explanation in our answer to the show-cause letter, at the very least we should have been given a chance to

explain in person as well as be advised as to what remedial action should be taken – this was not done.

According to the Societies Act 1966, any society deregistered by the ROS has 30 days to appeal against the decision to the Minister of Home Affairs. We engaged a lawyer to assist us with drafting the appeal letter and this was duly sent to the Minister, via the ROS Putrajaya, on 22 November 2011. In the meantime, we were required to suspend all activities, so a notice was sent to council members and committee chairpersons and was also put up on the MMA website. A press statement was also issued to let the public know that MMA had to suspend our activities but that we hoped to be back in action soon.

Our appeal letter to the Minister of Home Affairs stated the following points:

a. That the action was too harsh and not commensurate with the alleged offences. Also that we were not given any chance to explain to the ROS in person, and that we had followed the verbal advice of the ROS officers throughout this episode.

b. That the MMA is a 50 year old association with over 10,000 members and we carry out a lot of important functions and therefore, this action has far reaching consequences not just for the medical profession but for the country.

c. That for the past 50 years we have conducted our elections without problems and this deregistration has resulted from a complaint made by an unsuccessful candidate in the elections.

d. The appeal letter also proposed two solutions, of which we stated that we preferred the first option.

    i. To reinstate the MMA with immediate effect together with an advisory that the next election (May 2012) be carried out adhering strictly to the Constitution.

    ii. To hold another election – but we pointed out that this would lead to needless expense and confusion as there would be an overlap of dates (the earliest another election can be called would be February 2012) and the new Exco would only function for three months.

On 25 November 2011, the HGS and I met with the Ketua Pengarah of ROS, Dato Abdul Rahman. He informed us that the reply to our appeal was ready and we were given a copy of the letter, dated 25 November 2011, but were told not to release it until the Minister of Home Affairs issued a press release on it. However, we were informed that we could resume all activities. This message was duly informed to our council members and committees, in a short note, without releasing the letter from the Ministry of Home Affairs.

Unfortunately for us, due to the long weekend and the UMNO General Assembly, the Ministry of Home Affairs only issued the press statement on Wednesday 30 November 2011. We then released the letter from the Ministry as well as our appeal letter, together with an announcement on the MMA website. The letter from the Ministry of Home Affairs states that by the powers given to the Minister under Section 18 of the Societies Act 1966, the Minister, *"telah memutuskan rayuan terhadap pembatalan MMA ditangguhkan selama enam bulan"* and went on to state, *"Namun yang demikian, jika pihak tuan gagal mamatuhi Undang-undang Berdaftar Persatuan dan Akta Pertubuhan 1966 dalam tempoh yang ditetapkan, pendaftaran pertubuhan tuan akan terbatal secara automatik"*.

Since then, a lot of people have made statements in the press, some giving incorrect information, e.g. that the MMA has "six months to get our house in order" and that "the MMA has to hold fresh elections in order to get re-instated". These are simply not true as the response from the Ministry of Home Affairs to our appeal letter states that the decision of the ROS is *"tangguhkan"* or "suspended" which means that the MMA can function normally again. The "warning" that was given to the MMA is that in the next six months, we have to follow our Constitution and the Societies Act strictly. While many of the reports were not "supportive" or "favourable" to the MMA, there were also a couple of letters and articles which presented a more accurate picture and which were more sympathetic to the MMA.

Since receiving the reply from the Minister of Home Affairs, the MMA has sought the advice of our lawyers and of the ROS. Our lawyers have advised us that Section 18 of the Societies Act gives the Minister of Home Affairs the power to "confirm, reject or vary" the decision of the ROS, and the reply to our appeal letter means that the Registrar's decision has not been confirmed but has been varied; with this varying of the Registrar's decision by the Minister, the status quo of the MMA was restored and all business and activities of the MMA may proceed as normal. Our lawyers further advised, "The Minister's decision also carries the notification that if MMA fails to adhere to its Constitution within the (next) six months, the registration (of MMA) will automatically be cancelled. The Minister's decision carries no other conditions or directives." And, concludes that "the current governing body of the MMA may carry on its duties and ensure that all activities and conduct is in compliance with the MMA's Constitution and By-Laws." As this is a reasonable opinion, we have decided to follow the advice of our lawyer, whilst awaiting the decision of the ROS.

The issue of having another election has been brought up by some members, who say that since all the

allegations are related to the elections, we should declare the 2011 AGM elections null and void and hold another election. However, there has not been any such order from the ROS or the Minister of Home Affairs at any point in time. Furthermore, there is no provision in our Constitution for holding an election other than at the AGM. There are also other problems due to the shortage for time, for example the earliest the re-election (for 2011/2102 Exco posts) can be held will be in February 2012 and yet by January 2012, we will have to send out the call for nominations for the 2012/2013 Exco posts – this will surely lead to even more confusion. Some say, never mind the inconvenience or the expense or the possible confusion – hold the elections to eliminate any doubt about the legitimacy of the current Exco. However, I feel that we have to be guided by the Minister's decision – while he chose to vary (and not to cancel) the deregistration notice by the ROS, he also chose not to order a re-election (which was offered, in our appeal letter, as one of the solutions to this situation).

I have tried to keep members and others informed by using the MMA website and updating council members by email throughout this period of time. One of the challenges that we have faced is that of members going to the press, who report inaccurate information as outlined above. Therefore, I am using the *Berita* to inform members about the whole sequence of events and what we have done in response. We have also called an emergency council meeting and I am trying to explain the situation to members whom I meet or those who call me up. Unfortunately, I cannot speak to everyone.

It is sad that some members chose to take their unhappiness and dissatisfaction and grouses to the Registrar of Societies instead of bringing it up within the Association itself; worse still, some have also expressed their opinions in the press without having any discussion with me or others in the Exco. To what avail? It has only brought dishonour and disrepute to not just the Association but the whole medical profession. I hope that this will not happen again in the future. We should be able to settle our differences and disputes internally. What is saddest is that no attempt was made to do this before taking things into the public domain.

To end on a higher note – whilst this whole event has brought a lot of sadness and angst, it has also brought good things – the "silver lining". While a lot of people have said not-too-nice things about the Association, there are many more members who have called to express their concern, and their support for the Association and the current office bearers, and offered to help in whatever way they can. Apart from current council members, these include past presidents and office bearers, currently or previously active members, as well as doctors who are members but are not very active, and also doctors who are not members (but who I hope will become members!!). I cannot name everyone, but I would like to thank every one of you who has shown your concern and your support for us in this difficult time, and I hope that people like you will come shining through and overshadow the "dark forces" who wish to bring disrepute to our Association and, by extension, our profession. M

Statistics according to State and Category of membership

as at 31 November 2011

No	State	Ordinary Members	Life Members	Total	Student Members
1	Johor	217	397	614	44
2	Kedah	181	197	378	303
3	Kelantan	74	105	179	227
4	Melaka	127	185	312	614
5	N. Sembilan	138	219	357	27
6	Penang	207	409	616	171
7	Pahang	122	153	275	9
8	Perak	641	550	1191	107
9	Perlis	55	21	76	1
10	Sabah	177	236	413	95
11	Sarawak	328	313	641	13
12	Selangor	588	854	1442	164
13	Terengganu	32	45	77	12
14	W.P	583	917	1500	96
15	W.P Labuan	3	6	9	0
	GRAND TOTAL	**3473**	**4607**	**8080**	**1883**

Overseas Members = 138 Exempt Members = 328 Honorary Members = 7 Associate Members = 2

Chronology of Events

Date	Event
May 2010	The method of electing the main office bearers was changed from postal ballot to voting at the AGM via a constitutional amendment passed by a 2/3 majority at the 50th MMA AGM in Melaka. The amendments to the Constitution were sent to the ROS for approval in July 2010, and approval was received on 17 January 2011.
November-December 2010	The Election Committee sent out the notice calling for nominations for the posts of PE, HGS, HGT and two Deputy HGS in the November and December issues of the *Berita MMA*. This was the routine every year (with postal ballot) except that this time, the call for nominations included the positions of Deputy HGS.
March 2011	By the close of nominations on 9 March 2011, the following nominations were received: two candidates for post of President elect: Dr Hooi Lai Ngoh and Dr SR Manalan, two candidates for post of HGS: Dato Dr Tharmaseelan and Dr Rajamohan, one candidate for the post of HGT: Dr Ravindran Naidu, and three candidates for post of DHGS: Dato Sarjeet Singh Sidhu, Dr Harvinder Singh and Dr N. Jeganathan.
April 2011	All the above candidates' manifestos were printed in the *Berita MMA* April issue; except for Dr Ravindran Naidu, who had won unopposed. In the same issue of the *Berita*, there was a notice by the Election Committee secretary on the "Procedures for election at the 51st AGM".
12 May 2011	A letter from Dr Hooi to Dr D Quek, President MMA, was received. There were two main complaints in her letter: (i) that the notice of the election had not been received by members seven weeks before the election, as provided for in the Constitution, and (ii) that the call for nominations had gone out before the approval from the ROS was obtained. She also informed the President that she had complained to the ROS. The HGS called the ROS to ask if we could carry on with the elections and the AGM and was informed (verbally) that we could.
27 May 2011 (AGM)	At the AGM, an objection was raised as soon as the meeting started regarding the agenda, which stated "to accept and declare as President-elect…" and similarly for HGS and HGT – this had been amended in the 2010 AGM to read "to elect the President-elect…" etc. There were calls not to carry out the election that day, and the issue of inadequate notice (point no. 5 (i) above) was also brought up. There was a long discussion and the floor voted to accept the amended agenda, and to proceed with the elections.
6 July 2011	The MMA had a visit from En Addzizul Osman from the ROS office, WP, to investigate complaints by a member. The HGS met with En Addzizul to provide the facts and documents requested.
29 September 2011	The MMA received a "show-cause" letter dated 28 September 2011, asking us to explain four allegations of breach of our Constitution.
24 October 2011	The President, President Elect, Hon. Gen. Secretary and Hon. Deputy General Secretary met with En Addzizul Osman, ROS office (WP) to discuss the show-cause letter.
16 November 2011	The deregistration notice, dated 15 November 2011, was received from the ROS (WP).
18 November 2011	Announcement was put on the MMA website stating that we had been deregistered and that all activities had to be suspended until further notice.
22 November 2011	Appeal letter to the Minister of Home Affairs was delivered personally by the President, via the ROS Putrajaya.
25 November 2011	The HGS and President met with the Ketua Pengarah of ROS, Dato Abdul Rahman after which we were given the reply from the Minister of Home Affairs, dated 25 November 2011.
1 December 2011	The Announcement on the MMA website was changed, stating that MMA activities are back to normal. A copy of the appeal letter and the reply from the Minister of Home Affairs was also put up on the MMA website.

Evolution of Berita MMA

The *BERITA MMA* Editorial Board is probably one of the only committees in MMA that meets every month. In fact, the Editorial Board meets more often than the MMA Exco. It is not an easy task to edit a newsletter for an association - particularly an association for doctors. However, I have had both an interesting time and a challenging time as editor of *Berita MMA*. I have been on the Editorial Board since the time of Dr David Quek and this has given me a solid background in terms of managing content.

Doctors today are more aware and vocal than ever before. The nature of their work sometimes leaves frustrations that can be difficult to control and they can easily flare up once you get onto the keyboard of the PC. It's tough for the Editorial Board to edit some of the content that is received and there are times when senior MMA members get annoyed if even a word is removed or replaced in their manuscript.

Although we have a disclaimer in *Berita* to the effect that the content of the *Berita* does not always reflect the opinions of the Association, Exco and the Board, this advisory is often forgotten and the content is mistakenly taken to be MMA's official view once it is published in *Berita*. We are concerned that at times some articles can be too abrasive thus they may not be published.

The Board has already transformed *Berita* into a modern concept magazine and it has been well received by all – even though at times it feels like a nightmare to satisfy all. We have even had a complaint from a member that the new *Berita* was too heavy for in-the-bed reading and one member complained that it cannot be folded and so it is not good!

Today, *Berita MMA* does not garner as much as profit as it used to and recent treasurers' reports and auditors' report have indicated losses. This is due to the ever increasing cost of printing and publishing which is universal with all printers and publishers. Somehow our advertisements have not risen in tandem with the cost of production. Pharma companies have a wider choice to channel their advertising these days than in the past as there are newsletters in many specialised societies. In the last 10 years, Malaysia has become a regular venue for medical conferences thus advertisements are printed in all the souvenir magazines. In fact, there are many new advertising channels and so the advertising yield for the *Berita* has been diluting.

2012 will see some facelift to the *Berita MMA*. I plan to have it more personalised and doctor friendly. We hope that *Berita* will be the main channel of information for doctors. I hope to lift the level of *Berita* so that it becomes a real reference point for members and at the same time a source of news and information.

My best wishes and Happy New Year! M

Datuk Dr Kuljit Singh
Editor

Honorary General Treasurer's Message

Dr Ravindran R. Naidu PJK
Hon. General Treasurer, MMA

Indemnity Insurance for Locums

A locum also known as locum tenens is a medical professional that temporarily holds a position at a hospital, clinic or private practice. The locum often holds the place of another medical professional, which is also what locum tenens refer to as a placeholder.

In layman's terms, the locum is a doctor or medical professional who freelances. Whether the person acts as a substitute or just to fill a position on a temporary basis, the role of the locum tenens is all important.

Medical indemnity insurance can provide:

- Help with legal problems that arise from your professional practice
- Legal advice and representation
- Underwriting in cases of negligence
- Expert advocacy
- Free run-off cover at retirement
- Educational risk management programmes

A phrase we often hear from doctors and locum doctors is: Why do I need medical Indemnity insurance? I thought the clinic or hospital provides the cover.

Most doctors are under the impression that their locums are indemnified by their indemnity providers. But this is not the case. Your personal indemnity cover does not cover your locum.

All locums will have to have their own indemnity insurance. Their employer's indemnity insurance will not cover them. If an employer has taken an indemnity cover for locum, it covers that particular locum doctor ONLY. An indemnity cover has to be taken separately for EACH locum. This does not cover all your locums except for the one insured.

MMI provides what is known as locum cover extension. But please be informed that it is not for your locum but for yourself only.

HOW DOES THE LOCUM COVER EXTENSION OPERATE?

Operating in consideration of the payment of an additional premium, indemnity is extended to include liability arising from the use of locum whilst working for the insured doctor, provided that:

- The locum is a Registered Medical Practitioner with a current Malaysian Annual Practicing Certificate.
- The locum must have similar qualifications/expertise as the insured doctor.
- The insured doctor wishing to avail himself of locum coverage will have to declare all places of practice which should include the timing of practice from Monday to Sunday.

Prior to working in a clinic or hospital, locums should seek advice of the current situation regarding indemnity. Locums should check what indemnity cover is provided by the clinic/hospital (in most situations locums working in public hospitals should expect to have government backed indemnity provided by the employer).

If you have not got any indemnity cover currently, you need to ask some important questions:

1. Is there any specific exclusion, which would affect your locum work?
2. Does your policy cover one specialty only e.g. general practice, and does it cover you if you work as a locum in the Emergency Department also?

Whenever you undertake a locum position, it is important that you confirm that you have your own indemnity cover or request for your cover to be arranged by your employer.

We strongly recommend that all doctors including locums obtain your own personal professional indemnity insurance. M

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Unity is Essential for the Future of Healthcare Delivery

Dr Koh Kar Chai
PPS Chairman

Disclaimer: Some members have alluded that the PPS Chairman is in support of 1Care for 1Malaysia based on the frequent articles in Berita. Please do note that the articles are objective in nature and are written in an effort to allow our members an understanding of what is taking place so that they can draw their own wise conclusions. 1Care for 1Malaysia may be idealistic to some of us at the present moment because there are too many factors which have to be taken into consideration before the system can even begin to see the light of day. The active engagement of the various stakeholders may be taken as a sign that the government of the day and the Ministry of Health (MOH) is going overtime in getting the blueprint drawn up.

Much has happened since my last report in *Berita* issue last month, not least of which is the deregistration of MMA by the ROS. However, PPS is focused on moving forward with the multitude of current issues facing our doctors. A massive change is set to take place soon in the healthcare scene and we have to be prepared to meet the new challenges ahead if we are to continue surviving as doctors in Malaysia.

The response to my call for MMA GPs to rally together has been encouraging with the first GP giving his support via email on the very day that the Berita November issue reached our doctors. The responses are still coming in at the point of writing this article. For those of you who missed the call for GPs to rally together for a common cause, join us by e mailing to *pps@mma.org.my* your name and current contact details. I do reiterate that this is not the formation of a body to oppose whatever some of us perceive as unfair practices against the GPs, but to ensure that GPs remain as a group with bargaining powers to ensure that we will be able to continue practising medicine as it was meant to be.

A bone of contention at the moment is the visits on some GP clinics by enforcement officers from the Pharmaceutical Services Division of MOH. Most of the calls coming in have been from Selangor. This is being looked into, but please do remember that in the event of a "raid", MMA can only offer you advice. Reason being is that a "raid" is brought about by specific complaints or abnormally high purchase of psychotropics by the clinic concerned. It then becomes a due process of law. Hence, legal advice should be sought. However, the channels of communication with MMA will remain open for such members so aggrieved as this is after all, their association.

Our DG of Health has written an article in the Star newspaper, dated 3 December 2011, entitled 'Better healthcare for all', which is about the 1Care for 1Malaysia plan. This is to be interpreted as an attempt to engage the public in the impending healthcare system which many are saying will not take place. He has, in a nutshell, spelt out what the MOH envisions on the 1Care for 1Malaysia health system.

2011 Malaysia Health Insurance Training Programme in Taiwan

I attended the training stint at the above mentioned programme as a consultant for the Joint Learning Network (which is supported financially by various Foundations as well as The World Bank) that largely

Renal Dialysis unit at Taipei Hospital

At Taiwan International Healthcare Training Centre

funded my attendance there along with some support from MMA. Assistance was not provided from the MOH as I am from the private sector.

Attendees of this programme included 20 other officials from the MOH who are actively involved in the formation of the blueprint for 1Care for 1Malaysia. It was a fruitful trip with lessons learnt, especially on the intricacies involved in the running of such a large scale health system.

The purpose of this trip was not to look at the adoption of the Taiwan healthcare system as alluded to by some, but as part of a comparative study of the healthcare systems of other countries. The health system of each country is unique, and whether they are successful or not, will each offer us valuable lessons to be learned. This is an important integral process as we strive to develop a healthcare system of our own. Everyone should pay heed of the complexity of the setting up of such a system in our multi-plural society which can never be done overnight.

Taiwan's healthcare system has received mention because of its extensive coverage to 99% of its population with the lowest administrative cost in the world. Its National Health Insurance (NHI) programme was launched in 1995 because of a determined political resolve to ensure equitable healthcare to the masses, which at that time had only a few healthcare insurers (Labour Insurance, Government Employee's Insurance and Farmer's Insurance) to cater to less than 60% of the population exposed to rising healthcare cost.

The characteristics of NHI are:

* Compulsory enrolment for all citizens and legal residents.
* Single payer system run by the government.
* Payroll based premium. Premium is shared by employee, employer and the government.
* Uniform package with co-payment.
* Healthcare providers are contract based with 92% of providers contracted. It is NOT mandatory for healthcare providers to be in the system.
* Uniform fee schedule under the global budget.
* Premium and co payment subsidies for the disadvantaged.

At the crux of this system is the smart card system, the function of which is to simplify managerial process; enable daily update of medical visit data; allow infectious disease tracing and monitoring; detection and management of heavy users. Every member of the population enrolled in the NHI will have a smart card which is to be presented at each visit to the healthcare provider.

With the Taiwan Minister of Health

Public satisfaction of this system is at a high level of almost 90% which is to be expected as there is a complete freedom to choose healthcare providers and there is no limitation on the rate of utilisation. What it means is that the public can see whichever doctor they want, visit any hospital they choose, and how many times they desire. However, it places a huge burden on healthcare expenditure with lots of wastage as there is over-utilisation of the healthcare services. There are reports of patients seeing multiple doctors in a day for the same illness.

What about satisfaction among the healthcare providers in view of the high utilisation rate? Does it mean that they end up seeing more patients and having an increase in income? There are no data to show the satisfaction level of the healthcare providers. But anecdotally, many are not happy with a system which constantly looks over their shoulder and controls the way they manage a patient as well as control their income.

It is interesting to note how they use incentives to ensure that healthcare providers toe the line. In other words, they dangle a carrot in front of you to ensure productivity instead of using the rod to control you.

A point to note is that there are hardly any doctors with basic medical qualifications. The doctors at private clinics are mostly specialists of some sort who see primary care cases as well as cases needing specialist care. It is not mandatory for doctors to have post graduate training including being a Family Medicine Specialist in order to see primary care cases. The doctors are driven to take up a specialty on the perception by the public that specialists are always better than mere GPs. However, specialists and GPs are paid the same at the private clinic level. M

ANNOUNCEMENT

Restriction on Practice of Ozone Therapy and Chelation Therapy by Registered Medical Practitioners

The Malaysian Medical Council had made the following determination at the meeting on 9 August 2011.

There have been various clarifications sought from several sources on the efficacy and benefit of the usage of Ozone and Chelation Therapy as a therapeutic regiment or option by registered medical practitioners.

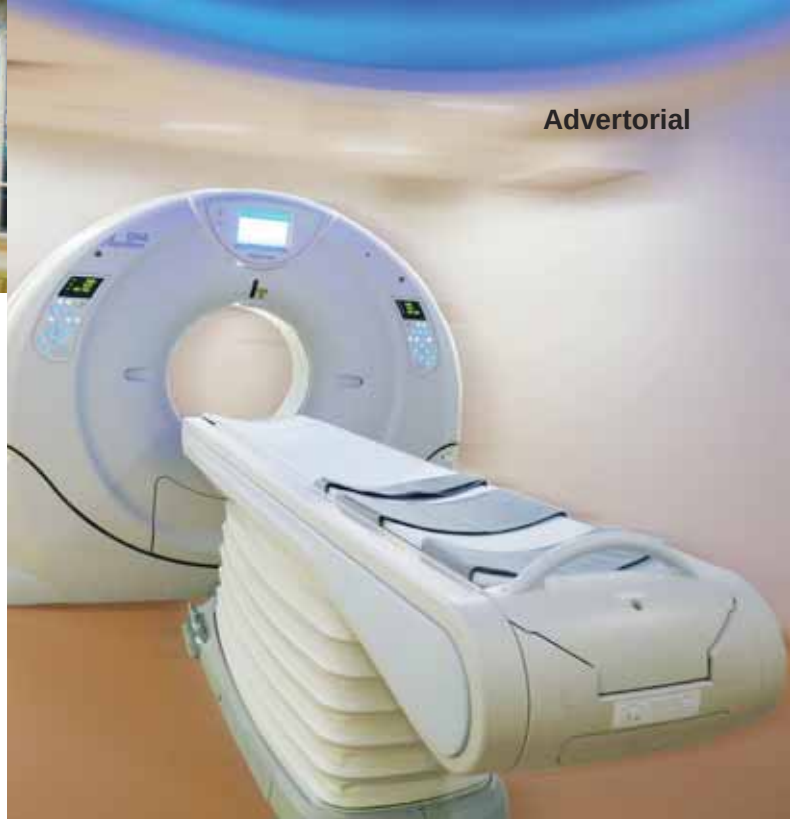
The Council, after extensive discussions and relaying on information obtained from local and overseas scientific databases, concluded that there is no evidence to support any therapeutic benefit from the usage of the above mentioned therapies for any illness.

Consequently, there is a need for further research on these two treatment modalities especially on the indications for their usage, their efficacy and safety.

As such registered medical practitioners are advised not to use and/or apply these two modalities as treatment for any medical conditions except for research purposes until conclusive evidence of definitive benefit can be ascertained or proven.

The public are hereby cautioned and advised that in the eventuality they submit themselves for such treatment then they will be doing this at their own risks. The Malaysian Medical Council and the Ministry of Health will not be responsible for any possible adverse outcomes.

Dato' Dr Hasan Bin Abdul Rahman
President, Malaysian Medical Council



One STOP Cardiac Centre

with the objective of Accuracy, Safety, Convenience And Value for Money

With an approximate RM 30 million invested into state-of-the-art medical equipment such as the world's most advanced and fastest CT Scanner, the Toshiba Aquilion ONE 640-Slice 4D MSCT, iHEAL has assembled a CARDIAC DREAM TEAM with the following core objectives.

ACCURACY

No guesswork, consistently high resolution images for accurate diagnosis using 640 slice MSCT. Combination of structural and functional assessment of coronary artery at iHEAL is unique and the only one in the market that reduce the probability of misdiagnosing coronary artery disease. Basic screening using less accurate technique such as exercise treadmill may cause false sense of assurance in false negative or unnecessary anxiety and invasive angiogram for those with false positive results.

SAFETY

Consistently low radiation dose and lower volume of contrast using 640 slice MSCT. The whole process including prescription of negative chronotropic drugs are supervised by cardiologist. Collaboration between cardiologist and radiologist ensure comprehensive assessment of cardiac and extra cardiac pathology. Certain screening test has its own inherent side effect. For example, CT Scanning using older technology and machines may expose patient to higher radiation dose and contrast.

CONVENIENCE

Fast 640-slice 4D MSCT produces high quality images of the heart in just 0.35 seconds. Shorten the waiting time of patients and delivering results within the same day. iHEAL is strategically located inside Mid Valley City with amenities that include hotels, shopping and entertainment paradise.

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Cost must be balance with accuracy. No benefit of doing cheap screening test if it is not accurate. We provide an all-in-package in a capitated sum to ensure that the patients are not surprised by additional hidden charges. iHEAL Screening packages are designed by specialist based on disease prevalence. E.g. the heart package at the cost of RM 3888 is complete and comprehensive to detect coronary artery blockages at any stage, congenital heart problem, valvular, myocardiaum, pericardial and risk of sudden cardiac death.

TEAMWORK

One stop centre with collaboration between cardiologist and cardiothoracic surgeon to choose the best, balanced, unbiased opinion, treatment options and management strategies for each unique patient. Decisions are made with patient's best interest in mind. Cost reduction as patients need not undergo similar procedure when seeking for second opinion.

LESS INVASIVE SURGERIES

Better result, higher safety, lower cost. Dr. David Khoo Sin Keat, a Consultant Cardiovascular and Thoracic Surgeon in Malaysia performs less invasive surgeries such as the CORONARY ARTERY BYPASS GRAFT (Offpump Bypass Surgery, Endoscopic Harvesting of Saphenous Vein and Left Thoracotomy) and the Sweaty Palms surgeries.

BENEFITS OF HEALTH SCREENING AT IHEAL

Early detection saves life. For example, Heart Attack or Sudden Cardiac death is the first presentation of heart disease in nearly 50% of all cases. But this can be avoided if detected earlier through an accurate heart screening programme. Modern medications with strong evidence base such as antihypertensive and statins have revolutionized the prevention of CAD. The key is to be able to stratify patient with early disease for aggressive lifestyle and medical intervention.

iHEAL
MEDICAL CENTRE
KUALA LUMPUR

Level 7 & 8, Annexe Block, Menara IGB, Mid Valley City,
Lingkaran Syed Putra, 59200 Kuala Lumpur, Malaysia.
t +603-2287 7398 www.ihealmedical.com

Implementation of Circulars

Dr Rosalind Simon
SCHOMOS Chairman

In this new term of SCHOMOS, two very important circulars were implemented that is the housemen flexi-hours and also the specialist allowance.

The housemen flexi-hours were implemented since September/October this year and the intention of our DG Dato' Seri Dr Hasan is indeed to be applauded. We cannot compare the work done by us when we were houseman as the number of housemen available was small and thus the large work load. We were also blessed with capable nurses who could do much of the mundane ward work which is currently done by housemen.

However, it has come under scrutiny by many sectors, even the parents, who are still not happy if you go by the newspaper reports. The most important issue for us doctors is sufficient training. Is the present system, where we take all newly qualified doctors for the housemanship training, correct? Should we not look into the number of housemen required for each unit and post them accordingly? What is the point of having many housemen in one unit and they are unable to do procedures? These are the most common queries raised by senior doctors. Of course, the housemen are happy with the system but only once they become medical officers will they realise the loss of clinical exposure during their housemanship. But is it their fault? Isn't it our duty to ensure that housemanship training is adequate? We should not just sign up the troublesome houseman so that we do not need to handle them and 'pass the buck' to someone else. The end result, it is the general public and parents of housemen that pay the price. Medical officers and specialists are very concerned about the attitude and lack of interest among the housemen in dealing with patients and this is a serious concern. Many have lost the sense of empathy and the profession has become a job! The bright side of flexi-hours is that the dedicated, hardworking housemen are doing very well and with better quality of life.

The problem also stems from the mushrooming of medical universities locally and the approval of many sub standard universities from overseas. The parents cannot be faulted for sending their children to these MMC approved universities. The newly qualified doctors also cannot be blamed for their lack of knowledge if these approved universities are not doing their job. However, housemen who show interest and are willing to learn should be encouraged and not be ridiculed during the training. It is always a two-way communication if we want to improve the health system. It is a collective responsibility. We, as physicians, should overcome our reluctance to extend sub-standard housemen. We find it problematic to adjust to new systems and more often than not, are forced to accommodate the requests of parents or those with 'connections'. We should not let parents decide how we train our young ones. At the end of the day, we want doctors with knowledge and a caring attitude, who will be able to take care of our loved ones.

The other circular about which I was often bombarded with phone calls and emails was regarding the specialist allowance circular implementation. The backdating of specialist allowance for six months was the issue. The issue was clarified with the Ministry of Health (MOH) and it was confirmed that the backdating will be as per the previous circular. However, different hospitals decided to implement the circular as and how they had interpreted. This present circular states that the specialist allowance is extended to our colleagues in public health and dental doctors; clinical specialist allowance is not modified. We had requested MOH to send an internal clarification letter and we are awaiting that. Stress among specialists in all grades has also gone up with the new letter stating that specialist will be posted to Sabah or Sarawak in rotation for a period of six months. There is nothing achieved by sending senior doctors to districts where they will not be able to function to their full capacity.

A recent letter in *Berita MMA* says that SCHOMOS has become a trade union which is partly true. We do look after doctors' welfare in civil service but we also act as mediators for many issues that doctors have on a one to one basis which is usually not publicised due to confidentiality issues. SCHOMOS also gets involved in health camps, informal nights and games which are organised by the state SCHOMOS chairpersons. MMA President has also suggested for us to have a seminar for doctors on how to deal with patient deaths and stress management as we often overlook our own well-being. Suggestions by members will be appreciated. We can be contacted via email *Schomos@mma.org.my* or via Facebook SCHOMOS group. M

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in conjunction with

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HOSPITAL PULAU PINANG, MINISTRY OF HEALTH MALAYSIA

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Location: Penang Medical College
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Dates: 20th – 21st February 2012
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Fee for Viva Examination: EURO 1,050

MRCS PART B (Clinical) Examination
IMRCS Irel (Clinical) Examination

Location: The Hospital Pulau Pinang
Jalan Residensi
10990 Pulau Pinang

Dates: 22nd, 23rd & 24th February 2012
15th, 16th & 17th August 2012

Fee for Clinical Examination: EURO 1,050

MRCS PART A (Written)

Available on the following dates: **10th January , 17th April and 11th September 2012**
Venue : Penang Medical College.
Fees: EURO 600
Fees for all exams and courses payable to **"Royal College of Surgeons in Ireland"**.
Application forms for examinations are available on RCSI Website *www.rcsi.ie*

Details:

Ms. Paulina Bany
RCSI Surgical Training Office
Penang Medical College
4 Jalan Sepoy Lines
10450 Penang, Malaysia
Tel No.: 604 – 226 3459
Fax No.: 604 –227 6529
Email: paulina@pmc.edu.my

Ms Siobhan Purcell
Examinations Office
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: siobhanpurcell@rcsi.ie

Candidates must send their completed application forms to *Ms Siobhan Purcell at RCSI, Dublin.*

RCSI INTERCOLLEGIATE BASIC SURGICAL SKILLS COURSE

Location: Penang Medical College
4 Jalan Sepoy Lines
10450 Penang

Dates: **7th , 8th & 9th March 2012**
12th, 13th 14th September 2012

Fee: EURO 250 (Malaysian), EURO 750 (Non Malaysians)

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

Assoc. Prof. N. Premnath, FRCSEd, FRCSI
RCSI Director of Surgical Training
Penang Medical College
Tel. No. 604-226 3459 Fax. No. 604-227 6529
Email: rcsistar@gmail.com prem@pmc.edu.my

52nd MMA AGM Timelines and Guidelines

Dato' Dr N.K.S. Tharmaseelan
Honorary General Secretary
secretary@mma.org.my;
nks.tharmaseelan@gmail.com

The Organising Committee of the MMA Annual General Meeting has finalised the dates for the 52nd MMA AGM to be held in Cinta Sayang Resort & Carnival, Sg Petani, Kedah between 24 – 27 May 2012.

I have attached some guidelines and timelines for the benefit of branches, committees and members as complaints to the Registrar of Societies are becoming a regular feature in the MMA. I urge all involved in the conduct of the branch and National AGM to adhere to these guidelines. Please refer to the Constitution when in doubt or please call / email the Honorary General Secretary for clarification.

1. COMPLIANCE OF ARTICLE X (ii), (iii), (iv): GENERAL MEETINGS OF THE ASSOCIATION

In accordance with the above Article, the Secretariat has set the following target dates and notices will be sent out accordingly.

a. Notice of AGM – by 1 March 2012 (12 weeks before AGM)

b. Last date for submission of resolutions – by 5.00 p.m. on 29 March 2012 (8 weeks before AGM)

c. Members to receive Annual Report 2011/2012 by 10 May 2012 (2 weeks before AGM)

2. PREPARATION OF ANNUAL REPORT

All Branches, Sections, Societies, Committees, Representatives to external organisations should submit their Annual Reports by 5 April 2012.

3. DUTIES OF BRANCHES

In accordance with By-Law V (9) the Branch AGM should be held two months prior to the National AGM, that is by 29 March 2012.

Notice of the Branch AGM should be sent out at least 4 weeks before the date of the AGM.

All resolutions to be tabled by members at the Branch AGM should reach the Branch Secretary at least 21 days before the AGM.

At least 14 days before the Branch AGM, the Branch Secretary should notify members of the Agenda and also circulate the following:

a. Annual Report

b. Audited Statement of Accounts

c. Minutes of previous AGM

d. All Resolutions submitted in accordance to By-Law 10(ii)

3.1 Post Branch AGM

Minutes of the Branch AGM should be prepared, and after being approved by the Branch Chairman should be circulated to all Branch members.

3.2 Submission to MMA Secretariat by 30 days

The following should be submitted to the MMA Secretariat by 30 days of the MMA Branch AGM:

1. Borang 9 (Peraturan 10) of the Societies Act 1966
2. 2 copies of the Minutes of the Branch AGM
3. 3 copies of the list of newly elected office bearers in the prescribed format
4. 2 copies Statement of Accounts

3.3 Election of Delegates

All Branches should submit the list of delegates attending the National AGM to the MMA Secretariat by 5 April 2012. This will then be forwarded to the Organising Committee of the MMA AGM. (Please note By-Law V (13)(I), (ii) & (iii).

4. DUTIES OF SOCIETIES WITHIN MMA

In accordance to the terms of reference of Societies within MMA, all Societies should hold their AGM by 29 March 2012.

Societies should adhere to By-Law V subsection 10(I), (ii), (iii) and (iv) of the MMA Constitution in preparation of the Annual General Meeting of the Society.

5. STAFF RESPONSIBLE FOR THE COMPILATION OF THE ANNUAL REPORT 2011/2012

a. Ms Rissa Soetama
   - Overall in charge of production of CD and printed Annual Report.
   - MMA Council Report
   - Coordination of MMA Branches' Reports
   - Coordination of MMA Committees' Reports
   - Coordination of Reports from Representatives to External Organisations
   - Coordination of Reports from Societies

b. Ms Matilda Cruz
   - Ethics Committee Report
   - Seminars / Workshops Reports
   - Reports of International Meetings

d. Ms Umaiyal Sethu
   - SCHOMOS MMA Report

e. Ms S. Muthuletchumi
   - PPSMMA Report

f. Ms Arcaana Nyanasegran
   - Financial Statement of Accounts M

VACANCY ANNOUNCEMENT

An International Organization is seeking qualified Nationals for the following position:

Medical Escorts (Nurse + Doctor)

General Functions

The incumbent will provide health assistance to the migrants during all phases of their journey under the IO care, which would include medical escort, operational support, pre-departure health checks and general assistance such as seating, help with meals and attending to personal hygiene.

The Medical Escort is expected to carry out his/her duties in accordance with strictest moral and ethical standards and with due respect for gender and socio-cultural differences of the migrants. The Medical Escort is likewise responsible for having a valid passport (validity of which should be not less than six months remaining).

Major Duties and Responsibilities

1. Receive the migrant(s) at the Receiving Point in the Country of Departure; provide the migrant(s) with escort services throughout the journey, and handover the migrant(s) to the designated Receiving Party at the designated place in the Country of Destination.
2. Reviews all files of refugees/migrants known to have significant medical conditions and communicating the findings with the IO physician.
3. Medical Escort (and/or the attending medical personnel) completes the airlines' MEDIF form in case in-flight special services are required. MEDIF forms are usually submitted at least 2 weeks in advance for review/approval by the Airlines' medical staff.
4. Responsible for bringing a medical escort kit, with additional medications and medical equipment related to specific needs of the travelling migrants. The escort is expected to return the kit upon completion of tasks and maintain an accurate inventory of supplies used during travel and inform IO at the base mission accordingly.
5. Ensures that the to-be-escorted individual and other IO passengers are fit for travel and do not pose any health threat to other passengers on the aircraft.
6. Reserves the right to cancel any persons from a flight after evaluating the clinical condition of the migrant in coordination with the IO physician. The medical escort should immediately notify the IO Migration Health Services Unit and the Operations staff of such events that may cause delays/alterations of the operation as planned.
7. Endorses the escorted migrant to his/her family, representative from the sponsoring volunteer agency, or the IO Operations staff, or appropriate health care personnel at the final destination and obtain written evidence of the hand-over.
8. Submits a completed Medical Flight Report Form and Migrant Handover Notification to the IO Mission and the relevant MHS Unit involved within 2 days after the completion of tasks.
9. Performs other duties as assigned.

Requirements:

1. Doctor: University degree in Medicine in any of the following specialties; Pediatrics, Psychiatry, Cardiology, Anesthesiology, Emergency Care.
2. Nurse: University degree in Nursing with at least 5 years of experience in Intensive Care Units, Minimum five years of medical practice, preferably with work experience in Intensive Care Units or with other emergencies.
3. Anesthesiology, Emergency Care, Pediatrics.
4. Ability and willingness to travel frequently.
5. Fluency in spoken and written English.
6. Individual candidates should be in good health.

Interested Candidates are requested to clearly specify the position applied and send application, CV with three reference and photograph to the following email: *iomkualalumpur@iom.int* or fax to: +60-3-9235 5551.

Only shortlisted candidates will be called for interview.

MMA 1009/5 1 December 2011

ELECTION COMMITTEE

TO: ALL MEMBERS OF THE MALAYSIAN MEDICAL ASSOCIATION

Dear Member,

NOMINATION FOR THE POST OF PRESIDENT-ELECT, HONORARY GENERAL SECRETARY, HONORARY GENERAL TREASURER AND TWO HONORARY DEPUTY SECRETARIES (2012-2013) OF MMA

The Election Committee of the Malaysian Medical Association hereby calls for nominations for the post of President-Elect, Honorary General Secretary, Honorary General Treasurer and two Honorary Deputy Secretaries of the Malaysian Medical Association for the year (2012-2013).

In compliance with BY-LAW IX (1) of the MMA Constitution, nominations are called herewith for the above posts.

Please note that the candidate for the post of President-Elect for 2012-2013 shall be a MMA member in benefit from ALL regions. Candidates for President-Elect must be Life or Ordinary Members of MMA of at least five (5) years' standing and who shall have served in Council or in a Branch Committee for at least two (2) years.

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

ALL NOMINATIONS FOR THE POSTS OF PRESIDENT-ELECT, HONORARY GENERAL SECRETARY, HONORARY GENERAL TREASURER AND TWO HONORARY DEPUTY SECRETARIES (2012-2013). MUST BE RECEIVED BY THE MMA ELECTION COMMITTEE BY 5.00 PM ON FRIDAY, 02 MARCH 2012 CANDIDATE, PROPOSER AND SECONDER MUST BE MEMBERS IN BENEFIT.

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

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

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

Yours Sincerely

DATO' DR MOHAN SINGH
Honorary Secretary
Election Committee
Malaysian Medical Association

ANNOUNCEMENT

MEMBER'S EMAIL ADDRESSES

Dear Members

Soon we would be able to update you by email on the latest news, send reminders for membership renewals, etc. using our new membership system. We need your correct email address for our **Membership Group Email Database** compilation.

You may email the information to our membership section: membership@mma.org.my

Your kind cooperation in this request is highly appreciated.

Thank you.

Dato' Dr N.K.S. Tharmaseelan
Honorary General Secretary
Malaysian Medical Association

Periodic Deworming with ZENTEL®

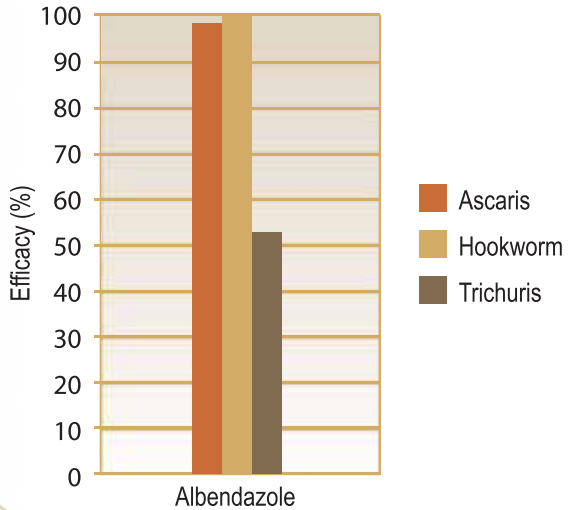
enhances Child Health & Development

BENEFITS of Deworming:[1]

- Weight gain in children
- Cognitive development
- Improvement of vitamin A status
- Reduction of anaemia

Albendazole is the preferred drug for the treatment of helminthic infections. Albendazole is a safe and highly effective broad-spectrum anthelminthic drug. Treatment with albendazole in every 6 months helps to reduce the transmission worms, malnutrition and incidence of diarrhoea.

Efficacy of albendazole treatment[2]



A single dosage of Zentel (which contains albendazole) once in 6 months will help eliminate common worms.

Zentel can be used in children over 12 months and is available in both syrup and chewable tablets.

Albendazole 400mg is listed in the World Health Organization (WHO) model list of essential medicines for children.

1. Harold A, Joseph K, Isaac S, *et al*. Effect on weight gain of routinely giving albendazole to preschool children during child health days in Uganda: cluster randomised controlled trial. BMJ. 2006;333:122
2. Controlling disease due to helminth infections. Crompton DWT, Montresor A, Nesheim MC, et al (eds). World Health Organization, Geneva, 2003.

For further product information, please contact:

GlaxoSmithKline Consumer Healthcare Sdn Bhd (3467-X)
Lot 89, Jalan Enggang, Ampang/Ulu Kelang, 54200 Selangor, Malaysia. GSK Toll Free No.: **1-800-88-3225**

Remembering the Legacy of a Past President & True Pioneer:

Dato' Dr T. Sachithanandan (1931-1981)

Consultant Anaesthesiologist M.B.B.S., F.F.A.R.C.S.I., F.F.A.R.A.C.S., DA, F.I.C.S., A.M., DPMJ, SMJ.

Dr Anand Sachithanandan

In 1981, the medical profession in this country and the local anaesthetic fraternity in particular, lost a true pioneering stalwart unexpectedly with the sudden demise of Dato' Dr T. Sachithanandan at only age 49. He underwent an elective coronary bypass operation at London's Harley Street Clinic under the knife of the world renowned leading British heart surgeon, Mr Donald Ross.

Dato' Dr T. Sachithanandan

Tragically, unlike our then Malaysian Prime Minister, Tun Hussein Onn whom Mr Ross had similarly operated on just several months earlier, Dr Sachithanandan did not survive the bypass procedure. Considerable advances have been made in the techniques and safety of both anaesthesia and cardiac surgery since this early era and coronary surgery today is widely performed throughout Malaysia with excellent outcomes obviating the need to seek specialist treatment overseas.

Awareness and an appreciation of the heritage of any organisation or specialty, and the sacrifices and pioneering effort of the doctors involved is fundamentally important to better understand and thus, improve contemporary practices as historically much progress in medicine is made standing on the shoulders of giants. This brief article is a poignant remembrance of the defining work of the pioneering anaesthesiologist, the late Dato' Dr T. Sachithanandan, 30 years since his untimely passing.

The First Intensive Care Unit (ICU)

As both Johor state Anaesthesiologist and President of the Johor Baru Junior Chamber International (JCI-Jaycees), a state level global charitable foundation, Dr T. Sachithanandan was highly instrumental in establishing the first intensive care

Dr T. Sachithanandan with anaesthesia residents on a postgraduate teaching ward round, Johor Bahru General Hospital 1969

unit (ICU) in a Ministry of Health (MOH) government hospital in 1969. This historic ICU was only just preceded by the unit at University Hospital, Kuala Lumpur*. Funding for the Johor Baru ICU was derived from three principal sources namely the MOH, Johor state government and charitable public donations via Jaycees fundraising. Dr Sachithanandan's vision and determination to set up this first public sector ICU was reflected in how he skilfully negotiated unprecedented government funding which matched 'dollar to dollar' the Jaycees charity funds. Fundraising commenced in 1965 and this pioneering ICU was built and finally declared open on 3 February 1969 by HRH Sultan Ismail of Johor. The ICU 'project' won the best project award at the National Jaycees Convention that year (1969) and received a personal commendation from then Prime Minister Tunku Abdul Rahman Putra as a benchmark for future NGO work. The monumental challenge and success of establishing this first ICU at Johor Baru General Hospital (GH) cannot be overstated as it became the template model on which subsequent ICU's were designed and built in virtually all the other state general hospitals in Malaysia.

Academic Training & Accreditation

The Faculty of Anaesthesiologists, College of Surgeons, Malaysia was established in April 1975. Over time, the faculty evolved into an independent College of Anaesthesiologists within the Academy of Medicine, Malaysia. As the inaugural Vice-Dean of the Faculty (1975/76) and subsequently, as Anaesthesia Dean in 1976/77, Dr Sachithanandan was a major driving force in the impetus to develop local academic training in the specialty. With fellow pioneering contemporaries, Prof AE Delilkan and Dr Lim Say Wan initially and later Prof Abdul Hamid bin Hj Abdul Rahman and Dr Antony Manavalan, Dr Sachithanandan was very involved in organising a curriculum, structured training programme and preparatory courses leading up to a local postgraduate certification in Anaesthesiology. This landmark effort from the Faculty of Anaesthesiologists formed the basis for the eventual curriculum and format used by University Kebangsaan Malaysia (UKM) (in 1985) and University Malaya (UM) (in 1987). To put this effort in perspective one should know that in 1976 there were a total of only 36 qualified anaesthesiologists in Malaysia. From the 1950s till 1965, aspiring anaesthetists went abroad for their final phase of training and fellowship exams. The Australasian Primary and Final fellowship exams were first held in

> Dr T. Sachithanandan was highly instrumental in establishing the first intensive care unit (ICU) in a Ministry of Health (MOH) government hospital in 1969.

** The University Hospital ICU (Prof A.Ganendran, University Malaya) opened just a fortnight earlier on 18th January 1969.*

KL in 1973 and 1975 respectively. As of 2008, 461 specialists have obtained a local Masters degree in anaesthesia from UKM, UM and University Sains Malaysia (USM) collectively. However, it is not only contemporary practicing anaesthesiogists in Malaysia who owe much to an earlier generation as most advances in Malaysian surgery too would not be sustainable without a sufficient pool of trained and competent anaesthesiologists.

The First Postgraduate Medical Centre

Further evidence of the late Dato' Dr Sachithanandan's commitment towards developing and raising standards of postgraduate training in Malaysia, not only for anaesthetists but all medical specialists was exemplified by his active involvement in establishing the first postgraduate medical centre in the country, again at Johor Baru GH in 1969, with two like minded colleagues; eminent pioneering physicians Dato' Dr Lim Kee Jin and the late Datuk Dr Sam Abraham (paediatrician). Their objective was to develop a comprehensive programme directed towards the continuing education of the doctor in an era long before CME was fashionable or deemed necessary. Dato' Dr T. Sachithanandan went on to further establish another such centre, the first in the state of Perak at Hospital Ipoh in 1977.

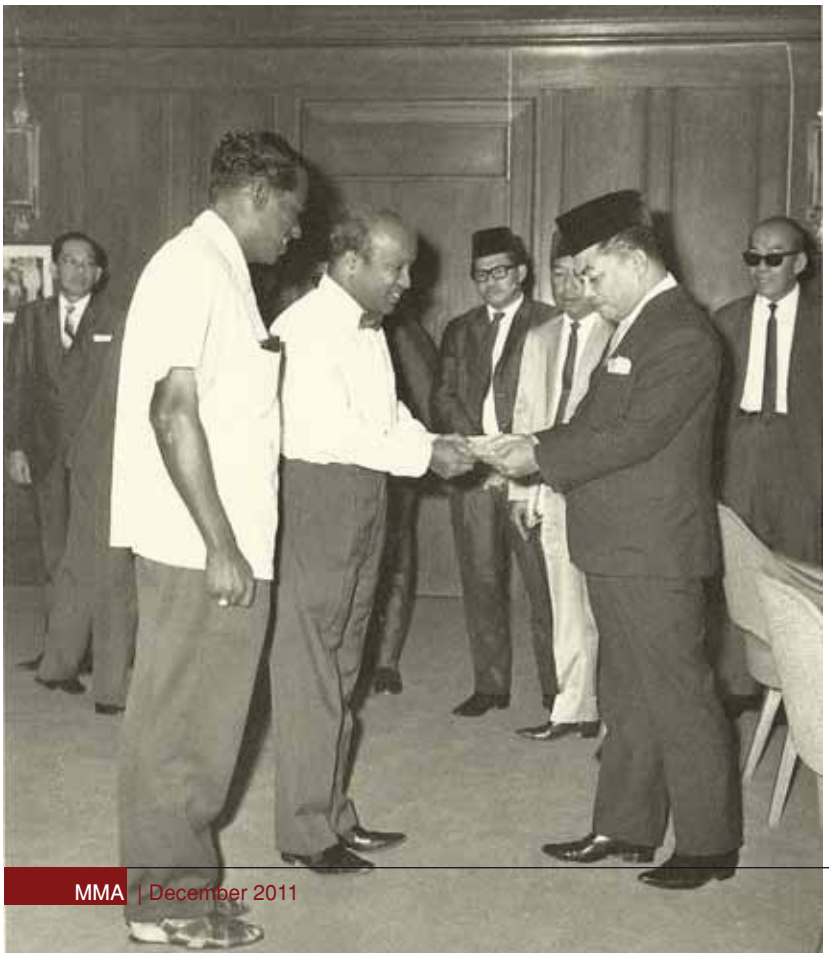
Malaysian Medical Association

Historically, anaesthesia as a specialty has often been in the shadows of surgery which perhaps was erroneously perceived to be more glamorous. Dato' Dr T Sachithanandan's election to the Presidency of the Malaysian Medical Association in 1972 brought prestige and prominence to the anaesthetic fraternity. He was the first anaesthesiologist to become MMA President, a feat only twice repeated in the subsequent 40 years (the late Dato' Dr Lim Say Wan in 1982/83 and our incumbent and first ever lady president Dr Mary Cardosa in 2011/13 have done so since).

As MMA President he authoritatively articulated concerns of the profession and challenged the political hierarchy and policy-makers of the day on a variety of wide ranging issues, from ensuring all doctors in general were appropriately and fairly remunerated by the SOSCO authorities, to bravely challenging (albeit unsuccessfully) the ministerial decision requiring public sector doctors at government hospitals to "clock in", a policy that showed little appreciation for the complex pattern and intensity of work undertaken by hospital specialists in contrast to the more predictable work practice of other civil servants.

Dr Sachithanandan and several MMA past presidents (the late Datuk Dr Keshmahinder Singh, Datuk Dr Syed Mohammed and Dato' Dr R. P. Pillay) were however, more successful in lobbying the then health minister to jettison the ministry's intention to register unqualified medical practitioners, an evidently retrograde and unsafe step, in the interests of public safety and quality assurance. His presidency also oversaw the establishment of the MMA House on Jalan Pahang where the MMA secretariat still actively functions today. Dr Sachithanandan was a champion of the 'young doctor' strongly advocating for the more junior MMA members be given a 'voice' and formal representation on the

State Government funding was vital in establishing the country's first ICU – Dr T. Sachithanandan receiving a cheque from thn Johor Menteri Besar Dato' Othman Saat in 1968



influential MMA council, and the opportunity to contribute as evinced by his valedictory address in 1973.

Malaysian Society of Anaesthesiology and Health Ministry Government Service

The late Dato' Dr Sachithanandan was one of the few founding members of the Malaysian Society of Anaesthesiology (MSA) in 1964 along with contemporary pioneers Drs Frank Bhupalan, Antony Manavalan, M. C. Poopathy and Law Ghim Teik. The MSA today boasts a healthy membership of approximately 600 specialists nationally and is undoubtly one of the more proactive and dynamic specialist organisations. Dr Sachithanandan became MSA president in 1968 and personally helped forge good relations with sister organisations in Australia and Singapore. His personal qualities of impeccable integrity, selfless ambition and visionary leadership coupled with a highly charismatic and naturally charming personality not surprisingly inspired many junior doctors to take up anaesthesia when it was perhaps then a less established and less desired specialty. However, first and foremost, Dato' Dr Sachithanandan should be remembered for the exceptionally competent and efficient anaesthesiologist he was, and for being largely responsible for the early development (including the training of many junior specialists) and provision of a first class anaesthesia service in the two large Malaysian states of Johor and Perak.

First Private KPJ Hospital

Three decades on, Dato' Dr T. Sachithanandan's contributions still remain impressive, relevant and undiminished. One of his final contributions was his active involvement in the clinical design of the Johor Specialist Hospital (JSH) in 1980, the state's first private hospital. This was the very first Kumpulan Perubatan Johor (KPJ) hospital in the country and yet again became a template for the establishment of many more future lucrative KPJ hospitals nationwide. Sadly, he never got the opportunity to work at the JSH.

In retrospect, his achievements were remarkably exceptional given that he did not even live to celebrate a 50th birthday. Heritage awareness facilitates an understanding and genuine appreciation of the pioneering works of our eminent predecessors. This is important for rarely do advances in medicine occur in isolation, more often progress is made by standing on the shoulders of giants. Dato' Dr T. Sachithanandan was one such individual.

Dato' Dr T. Sachithanandan is survived by his wife Datin Puni Sachithanandan who currently resides in Kuala Lumpur, daughter Dr Sharmila – consultant gastroenterologist at Hospital Selayang & Sime Darby Medical Centre, and son Dr Anand – consultant cardiothoracic surgeon at Hospital Serdang. M

Dr Lee Say Fatt

Mass Human Papilloma Virus (HPV) Vaccination of Women in the General Population

A Re-look at the Real Efficacy in Preventing Pre-cancerous and Cancerous Lesions of the Cervix

This article was written in response to the recent announcement by the Government of Malaysia regarding the allocation of RM50 million for the HPV immunisation programme in 2012. It was subsequently reported in The Sunday Star *(9 October 2012) headlines "Shot in the arm".*

The headlines mentioned that at least 350,000 unmarried women aged 18 and above are expected to benefit from the free HPV immunisation programme to protect women against cervical cancer. Women, Family and Community Development Minister Datuk Seri Shahrizat Abdul Jalil further mentioned that no age limit has been set for the HPV vaccination and those who would qualify would be determined later.

Introduction

Cervical cancer is the second most common malignant disease in women worldwide. Similarly, in Malaysia, it is also the second most common female cancer, constituting 12.9% of all female cancers. The Malaysian National Cancer Registry reported an average of 2,000-3,000 hospital admissions of cervical cancer per year in Malaysia, with the majority presenting at late stages of the disease.

It is now well established that human papillomaviruses (HPV) is the etiologic agent of almost all cervical cancers. Persistent viral infection with oncogenic types of HPV can lead to cancer of the cervix, anus, vagina, vulva, penis, mouth, and sinuses. In a study by the International Agency for Research on Cancer, HPV was detected in 99.7% of invasive cervical cancers from 22 countries. Although 15 high-risk HPV types have been shown to be associated with cancer, types 16 and 18 are responsible for two thirds to three quarters of cervical cancers worldwide.

The prevalence of genital HPV infection in the world is around 440 million. Epidemiological studies in the USA have reported that 75% of the 15–50 year-old population is infected with genital HPV over their lifetime. These are grouped into "high-risk" and "low-risk" types according to the degree of risk of development of cancer after infection with each genotype. Genital HPV infection is extremely common and most often causes no symptoms. A proportion of individuals infected with low-risk HPV types such as HPV-6 or HPV-11 will develop genital warts, whereas a subset of women infected with high-risk HPV such as HPV-16 or HPV-18 may develop cervical intraepithelial neoplasia (CIN), which can later lead to cervical cancer.

Epidemiological studies in the USA have reported that 75% of the 15–50 year-old population is infected with genital HPV over their lifetime[5].

Types of HPV Vaccine

There are currently two HPV vaccines available in Malaysia, the quadrivalent vaccine (Gardasil, from Merck) against types 6, 11, 16 and 18 and the bivalent vaccine (Cervarix, from GlaxoSmithKline), which protects against HPV types 16 and 18. The HPV vaccines consist of a recombinant HPV major capsid protein L1, which generate virus-like particles (VLP) resembling HPV virions, but which are non-infectious, immunogenic and subtype specific. The vaccine is able to stimulate a high antibody response that has been shown to persist for at least five years. The vaccine is generally safe and well tolerated.

Vaccine Efficacy and Target Groups

The HPV vaccine has been proven effective in almost all the clinical trials done so far. All the landmark studies showing such excellent results were done mainly in young women up to the age of 26. The excellent efficacy only applies to young women who are negative for HPV 16 and 18 (naïve group) at entry points at the trials. In this group of women, the efficacy in preventing CIN caused by the HPV 16 and 18 was more than 90%. It is important to note that the vaccine protect against only two (maybe a few more strains due to the cross protection) of the 15 other oncogenic HPV strains. It is not surprising therefore to find that the oncogenic HPV strains not targeted by the vaccine were responsible for a large number of CIN 2,3 and adenocarcinoma lesions in one of the trials. This explained the reduced efficacy of the vaccine against the reduction of CIN caused by any of the oncogenic HPV types.

The efficacy is even lower when analysing the intention to treat population which will include women even if they were already infected with HPV-6/11/16/18 at baseline, may acquire the infection before completion of the vaccination schedule, had HPV-associated disease, or violated the study protocol. The efficacy of the vaccine in reducing CIN caused by any strains of oncogenic HPV in this intention to treat population was only 17% to 33%. This group represents the general population of young women, including those that are sexually active and may have already been infected with the HPV at first vaccination.

In other words, the HPV vaccine is most effective in females who have not been exposed to any of the vaccine subtypes targeted. In the one of the quadrivalent trial (FUTURE I) involving 5455 young women who reported a lifetime history of four or fewer sexual partners, 27% of them already had either serological or molecular evidence of infection with either HPV 16 or 18. Similarly, about a third of women (33.2%) were positive to HPV 6, 11, 16 and 18 at baseline by serological or DNA testing (via PCR). Therefore, these data proved that one third of women who are sexually active are already infected with vaccine type HPV. All these underscores the importance of vaccinating women before they become infected, which, in most cases, means before the onset of sexual activity.

At the present moment, HPV testing before initiating vaccination, however, is not recommended because there are no good measures of past exposure; additionally current clinically available testing reflects only current viral shedding. This makes it difficult to

counsel a sexually active woman regarding the need to be given the vaccine. In contrast to the Center for Disease Control (CDC) guidelines which recommends vaccination of women up to 26 years old, the American Cancer Society (ACS) stated that there is currently insufficient data to recommend for or against universal vaccination of females aged 19 to 26 years in the general population. Furthermore, the ACS guidelines stated that the HPV vaccination for women over age 26 years is not currently recommended. A decision about whether a woman aged 19 to 26 years should receive the vaccine should be based on an informed discussion between the woman and her healthcare provider regarding her risk of previous HPV exposure and potential benefit from vaccination. This is especially so if the woman has been sexually active. They should be told that the efficacy is significantly reduced and the vaccine may not alter the natural course of the disease (still at risk of cervical cancer) if they are already infected with any of the oncogenic HPV strain. Therefore, women must continue to be screened for cervical lesions after being vaccinated. Efficacy would still be high in females aged 19 years and older who have not yet engaged in sexual intercourse and these women would still derive full benefit from HPV vaccination.

Conclusion

From a number of excellent trials, both vaccines have been shown to be highly successful in reducing the incidence of pre-cancerous cervical lesions (CIN) caused by HPV-16 and HPV-18, particularly in those who are HPV negative at the beginning. However, it is apparent that the vaccine may have much lower levels of efficacy in a "real world" setting, particularly in women above aged of 18 and already sexually active. One third of them may have already been infected with the oncogenic HPV strain that the vaccine is intended to protect against. The efficacy is only 17 to 33% for prevention of CIN caused by any of the oncogenic HPV strain. Therefore, proper counselling should be given to sexually active women above aged 18 seeking advise on vaccination. All these issues regarding reduced efficacy and the need to continue regular cervical cytology smear should be discussed to allow them to make an informed choice. So far, the cost effectiveness of mass vaccination in this group of women has not been proven. The criteria of being 18 years old and single do not mean that the woman has not been infected with the HPV. Mass vaccination like this may give them a false sense of security and yet may not provide any benefit in terms of the natural progression of the disease in those already infected. There is concern that vaccinated women may feel protected from cervical cancer and may be less likely than unvaccinated women to pursue screening. Vaccination of secondary target populations of older adolescent females or young women is recommended only if this is feasible, affordable, cost effective, does not divert resources from vaccinating the primary target population or effective cervical cancer screening programmes, and if a significant proportion of the secondary target population is likely to be naive to vaccine-related HPV types. With so many essential questions still unanswered, there is good reason to be cautious about introducing large-scale vaccination programmes. Instead, we should be more selective and focus on the groups where the benefit is maximal. In view of this, the Government of Malaysia and the relevant Ministries should re-look again into this programme of mass vaccination and evaluate whether the RM50 million is worth it. M

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9th – 11th March 2012

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Doctors Still Leaving Govt Service

Ili Liyana Mokhtar & Suganthi Suparmaniam
KUALA LUMPUR
news@nst.com.my

A total of 1,441 government doctors have quit the service between 2008 and August this year, citing a number of reasons.

Deputy Health Minister Datuk Rosnah Abdul Rashid Shirlin told the Dewan Rakyat yesterday that among the reasons were continuing their studies, serving as lecturers at public or private institutions of higher learning or because of personal problems.

Statistics showed that 452 doctors quit in 2008, 338 in 2009, 386 last year and 265 in the first eight months of this year.

Rosnah was replying to Mohd Nor Othman (BN-Hulu Terengganu), who wanted to know the number of government doctors who had resigned since 2008 and the reasons.

She said the ministry had set a target ratio of one doctor for every 400 patients by 2020, adding that it was possible to achieve this.

To achieve the target, 87,177 medical officers would be needed by 2020, when the country's population is projected to reach 35 million. It was reported earlier that there were some 30,000 doctors at present.

President of the recently de-registered Malaysian Medical Association (MMA), Dr Mary Suma Cardosa, felt that the numbers were not alarming for now.

"Assuming that the majority of doctors who left government service did go into private practice, what is of greater concern is whether a large number of those who resigned were specialists as the imbalance between the private and public sectors in terms of specialists will be made worse as a result," she told the New Straits Times.

MMA immediate past president Dr David Quek believed that the lack off a proper training structure and career path development were expected to compel more doctors to leave government service.

"Most of them, when they complete their compulsory service, will want to leave. Training and career path structure -- the ministry needs to seriously look into this."

He added that there were only 600 to 800 postgraduate training positions in the country, in stark contrast to the 3,000 to 5,000 medical students who graduate every year.

Source: New Straits Times, 22 November 2011

Shocking That MMA Has Been Deregistered

Dr K.H. SNG
KUALA LUMPUR
Sunday November 27, 2011

As a life member of the Malaysian Medical Association, it comes as a shock to me that my association has been deregistered. This is very tragic indeed, that a legally registered society of a noble profession in this country should be struck off so unceremoniously.

The MMA has done so much for society and for the profession, and many of its past presidents and leaders are leading members of society from various communities.

Whatever the slip or mistake, it must surely be an inadvertant administrative error, and certainly not a serious act of crime against any law of the country.

The Registrar of Societies (ROS) can give warnings and even fine societies that infringe the regulations.

It should reserve deregistration for the most serious crimes, e.g. involvement in illegal activities. Another point of note is the response of ROS to complaints by members.

Disgruntled members who do not get what they want often write in to complain against their own society.

Again, unless the infringement is criminal and involve illegal activities, perhaps many of these complaints can be directed back to the association by the ROS, to be dealt with at the next annual general meeting.

The ROS should protect society by ensuring legally registered bodies are protected from elements that look into ways and means to bring down societies and foundations that have been contributing so much to society.

Source: The Star, 27 November 2011

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* HPV - Human Papilloma Virus

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- Vaccination can help to reduce the risk of cervical cancer by offering protection against the most common strains of cancer-causing Human Papillomavirus (HPV).

Reference: 1. Malaysia Cancer Statistics 2006

Talk to your doctor today about the MMA HPV Vaccination Programme For Teens or call toll-free helpline 1-800-22-8688.

A community health service by :

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4th Floor, MMA House, 124, Jalan Pahang, 53000 Kuala Lumpur, Malaysia.
Tel: (603) 4041 1375 Fax: (603) 4041 8187, 4041 9929

Mark Your Diary

FEBRUARY 2012

Malaysian Medical Association Selangor Branch Organising Family Day

Organiser: MMA Selangor
Date : 24 – 26 February 2012 (Friday – Sunday)
Venue : Pangkor Island Beach Resort
Contact : Dr D K Bhanot
Tel : 012-329 1216

MARCH 2012

13th Malaysian Congress and Exhibition On Allergy and Immunology

Date : 9 -11 March 2012
Venue : The Ritz Carlton Kuala Lumpur
Contact : MSAI Secretariat
Tel : 03- 4041 0092 / 4041 6336
Fax : 03- 4042 6970 / 40427919
Email : dr_harnam@hotmail.com
Website : www.allergymsai.org

15th Ottawa Conference (On Assessment of Competence In Medicine and The Healthcare Professions)

Date : 9 -13 March 2012
Venue : Kuala Lumpur Convention Centre, Kuala Lumpur
Contact : Secretariat
Tel : 03- 4252 9100
Fax : 03- 4257 1133
Email : ottawa2012@aosconventions.com
Website : www.ottawaconference.org

1st World Congress on Healthy Ageing 2012

Date : 19 – 22 March 2012
Venue : Kuala Lumpur Convention Centre
Contact : Ms Siew Peng Keong / Mr J.C Lim
Tel : 03-2072 2600
Fax : 03-2072 5600
Email : wcha@healthyageing.org
Website : www.healthyageingcongress.org

APRIL 2012

9th Malaysian Conference and Exhibition On Anti-Aging, Aesthetic and Regenerative Medicineand 2nd International Congress On Anti-Aging, Aesthetic and Regenerative Medicine

Date : 27 – 29 April 2012
Venue : Shangri-La Hotel, KL
Contact : SAAARMMS Secretariat
Tel : 03- 4041 0092 / 4041 6336
Fax : 03- 4042 6970 / 4042 7919
Email : info@saamm.com
Website : www.saaarmm.org

MAY 2012

Attention All Members!!!
Keep these dates free!!!

52nd National Annual General Meeting & Scientific Meeting

23 May 2012 - Scientific Meeting
24-27 May 2012 - MMA AGM
27 May 2012 - Trip to Haadyai

Venue : Cinta Sayang Resort & Carnival, Sg Petani, Kedah
Contact : Dr Tharmalingam / Dr Rajan John
Tel : 012-494 7671 / 012-408 4914
Email : drtharma@yahoo.com / drrajan09@yahoo.com

JUNE 2012

4th National Early Childhood Intervention Conference (NECIC)

Theme : Family-centred practices — early childhood intervention and beyond
Date : 7 – 9 June 2012 (Thursday – Saturday)
Venue : Kingwood Hotel, 96000 Sibu, Sarawak, Malaysia
Secretariat : Association for Children with Special Needs Sibu
Tel : 084-217 912
Fax : 084-213 902
Email : necic2012@gmail.com
Website : www.agapesibu.org/about-us/necic2012

MMA Wilayah 8th Primary Care Symposium

Date : 23 - 24 June 2012
Venue : Eastin Hotel, PJ
Tel : Dr Koh Kar Chai 03-62531871
Ms Jess 012 6388128
Fax : 03 62531871
Email : mma_wp@yahoo.com
Website : www.mmawilayah.com

JULY 2012

1st Asia Pacific Clinical Epidemiology & Evidence-Based Medicine Conference (APCEEBM 2012)

Date : 6 – 8 July 2012
Venue : Kuala Lumpur, Federal Territory, Malaysia
Contact : Ms Devi Peramalah
Tel : 03-7967 3793 / 3797
Fax : 03-7967 4975
Email : apceebm1@um.edu.my
Website : http://apceebm.um.edu.my

SEPTEMBER 2012

14th Congress Of The International Society For Peritoneal Dialysis (ISPD 2012)

Date : 9 – 12 September 2012
Venue : KLCC Convention Centre
Contact : Ms Grace Chong
Tel : 03-2162 0566
Fax : 03-2161 6560
Email : ispd2012@console.com.my
Website : www.ispd2012.org.my

The entries for Mark Your Diary have been prepared in good faith and we apologise for any inadvertant error that may occur and the publisher nor the MMA, nor The consultant is responsible for any consequences of such errors.

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References:
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