

Academy of Medicine of Malaysia Council Members 2014 - 2015

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Message from the Master

Prof Dato' Dr P Kandasami



It is indeed a great honour and privilege for me to be elected as Master of this august organization. I accept the position with humility, consciously aware of the difficult task ahead. I pledge to follow in the footsteps of my predecessors, and to do my very best for the Academy. I sincerely look forward to the guidance and support of all members of the Academy and in particular the past Masters during my tenure as Master.

One of the great advantages of the Academy of Medicine is that it embraces all specialties and thus it is in a privileged position to articulate the vision of the profession. The Academy enjoys the confidence of the Ministry of Health, the Malaysian Medical Council and the public. I would like to acknowledge the hard work and visionary leadership of my predecessors who have given us this singular honour.

The Medical Act 1971 (Bill of the Medical (amendment) Act 2012), necessitates specialist intending to practice in Malaysia to be registered with the National Specialist Register. The amended law calls for the creation of a specialist registry under the Malaysian Medical Council. The Ministry of Health and Malaysian Medical Council entrusted the task of setting up the National Specialist Register to the Academy. The Academy has successfully established the NSR and is currently administering it on behalf of the Malaysian Medical Council. The National Specialist Register has become a reference point for private hospitals and the public to verify the status of a medical practitioner. The Academy will hand over the National Specialist Register to the MMC once the regulations of the amended Medical Act are ready.

The enormous advances in scientific and technological advances in recent years as resulted in major changes in the practice of medicine. Specialization and sub-specialization has become an integral part of this evolution. In Malaysia, specialty training is primarily provided by public Universities. It is a well-structured programme with good governance leading to a Master's Degree. The National Conjoint Board oversees all these Master programmes and Specialty Conjoint Boards oversee their respective discipline. On the other hand, the development of sub specialty (Fellowship) training programme has been less than uniform. The Fellowship training was initially a programme by the Ministry of Health.

continued on page 2

However, currently Universities and Specialty societies are also involved in training. Standards of training and assessment between the various institutions are inconsistent.

The Academy being a professional body will work closely with the Ministry of Health, Universities and Specialty Societies/Colleges to oversee the governance of this programme. The Academy will assist to establish a policy framework for 'Fellowship' training, and develop standards for accreditation of trainers and training centres. The Academy in collaboration with the Ministry of Health will award certificates upon completion of training. To facilitate the training programme, the Academy has planned to establish a Secretariat to provide administrative support to specialty bodies. The Academy is also seeking international collaboration and training opportunities with Royal colleges. A significant milestone was achieved by the Academy on the 27th August 2014 when it signed an MOU with the Royal College of Surgeons, Edinburgh for collaboration in Cardiothoracic and Plastic Surgery training. The Academy will sign a MoU with the Royal College of Paediatrics and Child Health, United Kingdom on the 14th of Oct 2014 for the conduct and administration of the MRCPCH examinations in Malaysia.

The challenge for medical practitioners is not only to perform at the end of the training programme but to remain competent throughout their working life. The well informed, knowledgeable public expects the doctor not only to remain up-to-date but to be professionally competent. In order for medical practitioners to provide quality care and meet consumer expectations, they must pursue lifelong learning.

Continuing professional development (CPD) has become an essential feature of modern medicine. The Malaysian Medical Association has been operating the CME system on a voluntary basis since 2002. Unfortunately, the participation by medical practitioners has been poor. Although the term CPD and CME are frequently used interchangeably, CPD incorporates a wide range of competencies including medical, managerial, ethical, social and personal skills while CME often refers to activities related to knowledge and skills. CPD is a systematic and ongoing process of education, in-service training, learning, and support activities that build on initial education and training. The amended Medical Act 2012 requires medical practitioners to acquire compulsory CPD points for the renewal of the Annual Practising Certificates (APCs) and revalidation of specialist registration. Three organisations have been identified for the provision of CPD points; the Malaysian Medical Association for private primary practitioners, the Academy of Medicine, Malaysia for private specialist and the Ministry of Health for all government doctors. It is anticipated that the systems will be merged in the future to a single system.

A new CPD Grading System has been formulated after consultation with stakeholders. The credit point system includes 'core' and 'non-core' activities. Core activities are essentially are a wide range of activities related to knowledge and skills relevant to the medical practitioner's practice. Non-core activities include activities related to personal development, leadership and management activities that help to improve the level of care of patients. Educational activities sponsored by Specialty Societies including regional and national scientific meetings, conferences and workshops will generate CPD points. All medical practitioners have a responsibility to develop their own development plan for the maintenance of professional competence.

The Academy in partnership with Ministry of Health has established an online system for doctors to record their CPD points. Colleges of the Academy will generate CPD activities and they have been asked to appoint an overall administrator and an evaluator for each specialty and subspecialty. All CPD events will be screened, accredited and credit points will be allocated. A list of CPD activities including scientific meetings, conferences and workshops will be uploaded on the website. The Malaysian Medical Council is in the process of establishing a CPD Secretariat in its complex at Jalan Cenderasari, Kuala Lumpur. The Academy will work with the MMC CPD secretariat when it is operational.

The amendment to Medical Act 2012 has made the profession conscious of the need to be lifelong learners. However, the mandatory requirement for medical practitioners to acquire the minimum number of credit points for recertification of their annual licence to practice and revalidation of the specialist registration may shift the purpose of the CPD activity. Specialist may attend courses unrelated to their professional development to simply meet the target credit points. CPD programmes not managed effectively and efficiently can be wasteful and detrimental. Practitioners must realise that continuing professional development is a personal responsibility. The Academy can help the practitioners meet the developmental related to their practice. It is hoped that CPD strengthen the relationship of the Academy with its members.



SIGNING OF MEMORANDUM OF UNDERSTANDING

MOU between the *College of Surgeons* and the **Royal College of Surgeons of Edinburgh** on **27th August 2014**



On 27th August 2014, the College of Surgeons, Academy of Medicine of Malaysia signed a Memorandum of Understanding with the Royal College of Surgeons of Edinburgh to set out joint activity in areas of Cardiothoracic, Plastic and Orthopaedic Surgery. The signing ceremony was held at the Ministry of Health Malaysia and was witnessed by Datuk Seri Dr S Subramaniam, Minister of Health Malaysia and Datuk Seri Dr Noor Hisham Abdullah, Director-General of Health Malaysia.



RCPCH and Academy signing MOU on **14TH OCTOBER 2014**

On 14th October 2014, the Academy of Medicine of Malaysia signed an Memorandum of Understanding with the Royal College of Paediatrics and Child Health, United Kingdom in relation to the examination of membership of the Royal College of Paediatrics to be held in Malaysia.



20th TUN DR ISMAIL ORATION

YB DATUK SERI DR S SUBRAMANIAM

Towards The “Ministry Of Health”

at the Opening Ceremony of the

**48th Malaysia-Singapore Congress Of Medicine and
2014 International Congress of Pathology & Laboratory Medicine (ICPaLM)**

26th August 2014 | Shangri-La Hotel, Kuala Lumpur, Malaysia



I would like to express my sincere appreciation at having being accorded the honour of delivering this auspicious speech to such a distinguished audience came from three different countries on this significant occasion of the prestigious Malaysia-Singapore Congress of Medicine. I will speak on my mission to make the Ministry of Health a ministry that is concerned with health and well-being. Be that as it may, we still find that many healthcare systems in the world are disease-oriented, despite the New Public Health having been around since the 1980s.



2. The goal of healthcare is that of health. The means to achieve health includes socio-economic change, medicine and public health.
3. Socio-economic conditions are important for the preservation and improvement of health and should surely enter into any broad scheme of healthcare.
4. Health might best and not simply be defined as an individual's experience of well-being and integrity of mind and body. It is characterized by an acceptable absence of malady and consequently, by a person's ability to pursue his or her vital goals and to function in the social and work context.
5. Healthcare is an organized attempt to promote the health of its members, encompassing the fields of public health and medicine.
6. Health policy will be the organization of this method into some overall financial and distributional structure designed to pursue the general goals of healthcare and ultimately, health.

7. Modern medicine is challenged between the dual needs of the human desire to avoid illness, suffering and death and on the other hand, by the capacity of medicine as a combination of science and clinical skills to do something within the boundaries of its professional competence and integrity to deal with such illness and suffering.
8. The Alma Ata Declaration of the World Health Organisation in 1978, reaffirmed the WHO definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The Ministry of Health Malaysia considers **health as a basic human right** in accordance with the WHO Constitution of 1946.

*“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”
(WHO Constitution 1946).*

Thus, every Malaysian should be able to attain “a level of health that will permit them to lead a socially and economically productive life” as per the Alma Ata Declaration.

9. The MOH also reaffirms its policy that **health is a major resource** that is critical to the success of the nation's economy. Health and health care are viewed as **investments and not as a “cost”** to the country.
10. It is an accepted fact that **health status** is determined by **multiple variables** or “determinants”:
a) genetics b) environment c) life-style and d) health care services.
11. This is the holistic view of health. Thus, to attain good health, all the 4 factors must be addressed, not only by Ministry of Health, but also by other Ministries whose policies and actions will have an impact on health. Thus, the need for multi-sector collaboration as well as public-private partnerships to attain good health status is essential.



continued on page 5

12. The Government of Malaysia has far-sightedly included health improvement as part of socio-economic development through its rolling 5 year **Malaysia Plans**, ever since Independence in 1957. This is also reaffirmed by the Alma Ata Declaration that *“Economic and social development, is of basic importance to the fullest attainment of health for all... The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace”* (adapted from Alma Ata Declaration).

Primary Prevention: Screening and Early Diagnosis

13. The emphasis of Ministry of Health is shifting from merely treating and managing diseases to health and well-being. This means that we are training our sights towards prevention and health promotion as well, healthy lifestyle and healthy environment. In the next few minutes, I will illustrate to you, how we are moving towards achieving that goal of being a Ministry that promotes health rather than just treating and managing diseases.
14. According to the Ottawa Charter, primary prevention involves “preventing the onset of disease; it aims to reduce the *incidence* of disease. It involves interventions that are applied before there is any evidence of disease or injury. Examples include protection against the effects of a disease agent, as with vaccination. It can also include changes to behaviors such as cigarette smoking or diet. The strategy is to remove causative risk factors (risk reduction), which protects health and so overlaps with health promotion.”
15. Primary prevention may be aimed at individuals or at whole communities. Individual approaches for example (encouraging young to stop smoking) have the advantages that the clinician’s personal contact could be motivational; the message can be tailored to the patient, and you can support him in actually making the decision to stop. But the limitation is that your advice does not tackle underlying forces driving his behaviour in the first place or the context in which his behaviour occurs such as government policies. Therefore, a community or population approach (e.g. via mass media advertising, increasing taxes, policies or banning smoking in public places) tries to change risk factors in the whole population. It is more radical and may produce cultural and behavioral contextual changes that may support individual efforts.
16. Examples of primary prevention apart from smoking cessation, preserving good nutritional status, physical fitness, immunization, improving roads, or fluoridation of the water supply as a way to prevent dental caries. These are the roles of health promotion and public health. A successful primary prevention programme requires that we know at least one modifiable risk factor, and have a way to modify it.”

In approaching this noble intention of the preservation of the state of health, I will try within the confines of the time limit today to highlight some of the examples the phenomenal successes and challenges which we face in this process.

Efficacy of Immunization Programmes

17. As the adage goes, prevention is better than cure. The Ministry of Health has embarked onto a comprehensive programme to eradicate vaccine-preventable diseases. This is an entirely cost-effective way of attaining health rather than treating patients who have developed debilitating diseases later.
18. In Malaysia, vaccination program was available in the 1950’s, even before independence but it was rather focused in urban areas. The National Immunisation Programme (NIP) started in 1972 with 5 targeted vaccine preventable diseases namely TB, diphtheria, pertussis, tetanus and polio. Later, many other vaccines were included in the NIP. Measles vaccination was introduced in 1982. Since then, the incidence has dropped dramatically. Supplementary immunisation activities were carried out whenever there is a resurgence or the coverage is noted to drop. Presently Malaysia is working towards eliminating measles.
19. A similar pattern is seen with neonatal tetanus. The incidence has been below 1 per 1,000 live births as recommended by WHO. Malaysia achieved maternal and neonatal tetanus elimination status in 1990 when the WHO announced the target goal during the World Summit for Children. Since then the incidence has been below 1.
20. Our HPV vaccination programme which is internationally accepted as an important effort to prevent cervical cancer has been running smoothly and has achieved remarkable results. 99.5% of all Malaysian female students in Form 1 have been given this vaccination since 2006 and will give them a 70% reduction in cervical cancer when they grow older.

Harm Reduction : HIV/AIDS

21. Since 1986 when the first HIV case was diagnosed in Malaysia, HIV has become one of the country’s most feared health and development challenges. At the beginning of the pandemic, injecting drug users was a key factor that drove the country’s responses which focused more on creating awareness and early detection.
22. The government through the Ministry of Health has embarked on a vigorous plan, programme and activities in tackling this disease in such a manner ranging from primary, secondary and tertiary prevention.
23. Based on the country’s Strategic Plans on AIDS, with vigorous interventions, we are aiming for the reduction of new HIV cases from 21.7 per 100,000 populations in the year 2000 to 11 per 100,000 populations in the

year 2015. As a result, there has been a significant reduction of new cases by more than half from 28.4 per 100,000 populations in 2002 to 11.42 cases per 100,000 populations in 2013.

We are confident that by 2015, we will be able to reach the target to reduce new HIV cases to 11 per 100,000 population.

By the end of 2013, Malaysia had reported a cumulative 101,672 HIV cases, 20,235 AIDS cases and 16,340 deaths related to HIV/AIDS, thus giving a reported PLHIV of 85,332 cases.

24. The two interventions are harm reduction initiatives involving Opiate Substitution Therapy (OST) and needle and syringe exchange programme (NSEP) have been part of Malaysia's response for several years. Together, these programmes are aimed at reaching out to at least 102,000 (60%) persons out of an estimated population of 170,000 PWIDs by 2015.

Initiated in February 2006 and now entering its sixth year of operation, the NSEP is mainly provided by the NGO which comprise of 79% and government health clinics which account for the remaining 21%. As of 2013, this programme has reached out to 72,686 IVD users with an average distribution of needle and syringe about 522 per PWID in a year.

25. The government has fully adopted the OST programme after the successful pilot project in 2005. As of 2013, this programme is currently provided mainly by government hospitals and clinics, private healthcare practitioners and has been extended to the National Anti-Drug Agency (NADA) service centres at 7%, and prisons at 2%; altogether making up 811 OST centres throughout the country. This programme has reached out to 65,249 drug users nationwide. Through harm reduction services, a total of 137,935, which is 79% of drug users have benefited. Malaysia can be proud that we have exceeded our target.

27. Another achievement in HIV and AIDS intervention in this country is the Prevention of HIV from mother to child – PMTCT. Moving towards eliminating MTCT of HIV, Malaysia has established a high quality PMTCT programme since 1997 which is available in all government and some of the private healthcare facilities. This programme provides services which include screening, provision of ART, care and support for pregnant women with HIV and their partners/spouses and not only to mothers attending antenatal care but also to those who had missed antenatal care i.e. in the labour room. Screening coverage at public facilities has improved substantially from 49.7% in 1998 to almost 100% in 2013. Beginning from 2011, the country has adopted treatment options B+ for all HIV positive pregnant mothers regardless of nationality and HIV exposed babies get free replacement feeding for 2 years beginning 2012.

29. In managing HIV and AIDS epidemic, financial resource is critical in assuring that the activities run smoothly. For the past several years, Malaysia has been among the few countries that are really committed in allocating adequate resources for this work in the Asia Pacific region.

30. We are proud that our government is funding approximately 95% of the total HIV and AIDS efforts. The remaining 5% originate from non-government, civil society and international agencies. In general, the total expenditure has increased every year and in 2013, the total expenditure was estimated at around RM181 million (USD56.5 million), an increase of 2.6% compared to the previous year.

Risk Factor Management in NCD & Cancer

31. Non-Communicable Diseases (NCDs) is now a global issue, which extends beyond the health sector. The United Nations Secretary-General, Mr Ban Ki-Moon had said that "NCDs in developing countries are hidden, misunderstood and under-recorded". In addition, he also described NCDs as "A rapidly rising epidemic in developed and developing countries... with serious socio-economic impacts, particularly in developing countries. Workable solutions exist to prevent most premature deaths from NCDs and mitigate the negative impact on development."

As to the way forward, he said that "These solutions need to be mainstreamed into socio-economic development programmes and poverty alleviation strategies".

32. In September 2011, NCD was discussed by Heads of Governments at the United Nations in New York, resulting in a Resolution, entitled "Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases." During the 65th World Health Assembly 2012, all Member States decided to adopt the "25 by 25" target i.e. a 25% reduction in premature mortality from NCD by year 2025. And at the recent 66th World Health Assembly in May 2013, the Assembly adopted the "Global Action Plan for the Prevention and Control of NCDs 2013-2020, including the 25 NCD indicators with 9 voluntary global targets. One of the main over-arching principles of the Global Action Plan is "**Multi-Sectoral Action**"

33. In terms of the way forward in strengthening the implementation of the National Strategic Plan for Non-Communicable Diseases or NSP-NCD in Malaysia; We have prioritized our plan of action in the coming years for policy and regulatory interventions based on **the Global Action Plan for the Prevention and Control of NCDs 2013-2020**, adopted at the recent 66th World Health Assembly in Geneva in

May 2013. For multi-sectoral action, in particular for the whole-of-government approach in addition to the NSP-NCD Cabinet Committee we would also be using other existing high-level inter-sectoral committees previously not used for health-related agenda. In addition to the top-down approach, we also need to start developing and strengthening the bottom-up approach. We have started the KOSPEN (or *Komuniti Sihat Perkasa Negara*) initiative early this year. We also need to increase the capacity of NGOs and civil society. This is where I see the Malaysian Health Promotion Board (or *MySihat*) can play a major role. As what I have mentioned before on various occasions, I stress the importance of public-private partnerships.

33(a) With regard to NCD risk factors, the statistic are worrying. Smoking has increased from 21.5% in 2006 to 23.1% in 2011 amongst adults aged 18 years. 43.7% of adults aged 18 and above were physically inactive in 2006 which has decreased slightly to 35.2% in the year 2011. The prevalence of hypertension was 29.9% in 1996 and has now increased to 32.2% in 2006 and 32.7% in 2011. As for diabetes, the prevalence has increased from 11.6% in the year 2006 to 15.2% in 2011.

34. KOSPEN, which is the acronym for *Komuniti Sihat Perkasa Negara*, is a collaboration between the Ministry of Health and other agencies. The main objective of KOSPEN is empowering individuals and communities in self-care to reduce the exposure to NCD risk factors. It is a Blue Ocean Strategy between MOH and other government departments and agencies which have existing programs and activities at the grassroots level, e.g. KEMAS (Department of Community Department), *Rukun Tetangga* (Neighbourhood Watch). We add value to the existing program and activities of these different departments and agencies, by incorporating elements of NCD risk factor screening and intervention

In the six months we have been 5,770 volunteers, 2,389 KEMAS personnel and 501 MOH personnel who have been trained under the KOSPEN activity. Within that time period also, 15,234 adults had undergone screening. Our target is to train 50,000 grassroots level and screen 1,000,000 people.

35. COMBI (Communication for Behavioural Impact) is a component of health promotion and an empowerment programme involving volunteers to mobilize the community members to take action to prevent and control dengue. Volunteers organize activities such as *gotong-royong* and promotion activities. Until June 2014, 2690 COMBI projects had been established and for localities with COMBI project most of the dengue problem can be controlled. Statitiscal evidence shows therer is a reduced prevalence of dengue in area with active COMBI area.

Environment Management in Health

As was mentioned before, the environment plays an important part in the country in determining the health status of its citizens.

36. The MOH is actively involved with the Department of Environment to promote Health Impact Assessment (HIA). Health impact assessment is defined as a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population. It is concerned with improving the health of populations and reducing health inequality. The intended outcome of the HIA is a series of recommendations to minimize or eliminate any potential negative impacts and to maximize any potential positive impacts. HIA considers which key determinants of health will be affected e.g. living and working conditions, social networks, lifestyles, and how these in turn will potentially impact on the health and wellbeing of the population and on health inequalities.

HIA is currently conducted on prescribed activities as described in the Environmental Quality (Prescribed Activities) (Environmental Impact Assessment) Order, 1987, which comes under the purview of the Environmental Quality Act, 1974.

37. On 5th December 2012, the Malaysian Cabinet decided that the **MOH** was responsible for strengthening collaboration between ministries, agencies and other stakeholders through the National Environmental Health Action Plan platform or NEHAP in short.

Amongst the Objectives of NEHAP are,

- to **develop** and **maintain** human health and sustainable development through the management of environmental health with **a systematic and holistic manner** in the country.
- to **strengthen collaborate and cooperate** between various sectors for **effective use of resources** in improving human health and sustainable development.
- to present **strategies on how to improve environmental health** within the country and to define the roles and responsibilities of various stakeholders.
- to be the *umbrella programme for Environmental and Health* for the country.
- to serve as the *catch-all-nets* in identifying the gaps for E&H.

Nutrition in Health

38. Nutrition is a key health determinant. To address nutrition and nutrition related health issues in the country, the National Food Safety and Nutrition Council chaired by the Honourable Minister of Health Malaysia was formed on 21 March 2001. Subsequently, the National Nutrition Policy of Malaysia was formulated and approved by the Cabinet on 17 December 2004. The goal of this policy is to achieve and maintain nutritional well-being of Malaysians to enable them to contribute to nation building in line with Vision 2020.
39. The first National Plan of Action for Malaysia (NPANM) was formulated in 1996 following the 1st International Conference in Rome in 1992 through concerted multi-sectoral effort and commitment of government and non-government organisations to eliminate or to reduce substantially under-nutrition and micronutrient deficiencies. To ensure the achievement of the aim of the National Nutrition Policy, the National Plan of Action for Nutrition of Malaysia (NPANM) 2006-2015 has been framed and implemented with the guiding principle of close multi-sectoral collaboration. A mid-term review of the NPANM was carried out on 2010.
40. The draft Rome Declaration on Nutrition, a collective commitment made at the coming 2nd International Congress on Nutrition (ICN2) 2014 has highlighted the multiple threats of malnutrition which are major challenges to sustainable development. It has also *“acknowledged that malnutrition, including under-nutrition, micronutrient deficiencies, overweight and obesity, as well as non-communicable diseases caused by unbalanced diet, has high socioeconomic and other costs for individuals and families, communities and states; threatens their health and wellbeing by impacting negatively on human physical and cognitive development; compromises the immune system; increases susceptibility to communicable and non-communicable diseases; and poses heavy burden on societies by restricting the attainment of human potential and reducing productivity”*. Thus, the NPANM II which will end in 2015 will be reviewed

accordingly based on the Framework of Action of the Rome Declaration on Nutrition 2014 it will be followed up in legislation changes.

42. With regard to Trans-Pacific Partnership Agreement (TPPA), the Ministry of Health Malaysia is among the 13 countries that stands firm in its commitment to ensure that tobacco and tobacco-products are carved out from the TPPA. It is intended to protect the health of Malaysians and to support the continuing efforts of the Ministry to reduce the number of smokers as well as its impact on health and premature mortality as well as exposure to second-hand smoke in this country. This is also in-line with the WHO Framework Convention for Tobacco Control (FCTC). This stand is also consistent with the stand of other NGOs in this country such as the Malaysian Council on Tobacco Control (MCTC) facing great challenges from other partners at the negotiation table.

CONCLUSION

Before I conclude, the overall picture... I presented just now, that health per se cuts across all elements of governance as such. And, in order to achieve a society that is built on the premises of health, it will be possible to predetermine an advanced or holistic approach, which will involve wholesome government policies, whether it is related to health or not related directly to health should have a health impact assessment to see how it is going to contribute to health. And we need to build an empowered community... a community which is aware and mobilized and including the empowerment to bring to us in request foreign environment is enabling for the provision of a healthy life.

We also need to nurture very active partnerships between the government, civil society and the community as a whole because this cooperation and assistance is a vital way to determine for the promotion of a healthy community and for the creation of a healthy nation.

So, that is the direction which the Ministry of Health has set forth. That is why I titled my speech as “Towards **the** Ministry of Health and NOT “Towards a Ministry of health”... underlying the very very important statement that the preservation of health is as important as the treatment of maladies. **e**



2ND T J DANARAJ ORATION

THE HIPPOCRATIC COMMITMENT TO PATIENTS: A DECLINING TREND IN MODERN MEDICINE



by

Tan Sri Dato' Dr Abu Bakar Suleiman

At the

**48TH Malaysia-Singapore Congress Of
Medicine and 2014 International Congress
of Pathology & Laboratory Medicine
(ICPaLM)**

27th August 2014

Shangri-La Hotel, Kuala Lumpur, Malaysia

As in many medical schools, the final year medical students at the International Medical University (IMU) formally and solemnly recite our version of the Hippocratic Code. The core premise of the Hippocratic Code has stood the test of time, more than 2000 years.

In ancient times, before Hippocrates, disease and illness were attributed as a sign of divine dismay, and the Gods needed to be appeased to achieve a cure. Hippocrates and his followers showed courage in breaking away from this paradigm. They moved away from the divine and supernatural, to focus on the biology of the body. In the process they put the patient at the centre of their focus. They collected detailed case histories, dismissed religious and supernatural explanations and developed remedies in the form of diets, exercise and mixed minerals and herbs based on their understanding of ill health.

It is proclaimed in the Oath, "In every house where I come, I will enter only for the good of my patients". This commitment to the patient without compromise, has become a global ideal, and has become fundamental to the core values held by the medical profession, and to patient's expectations of their doctors.

The Hippocratic Code has been accepted across the world, through the

ages. It was brought to the west by the Romans and to the east by the Muslim caliphates.

The Hippocratic commitment and devotion to the patient as a person in ancient times, enabled doctors then, to gain the patient's trust. Doctors were forbidden to have sex with patients, they attempted accurate prognosis and avoided making promises that could not be kept. They also emphasised the importance of privacy and the confidentiality of the doctor-patient relationship.

In the past the Hippocratic commitment to patients was in the context of medicine's limited ability to cure illnesses, and the absence of significant medical technology in medical practice. Public authorities, including the soldiers and police also had little interest in seeking the limited skills of doctors to either protect or oppress the citizens.

The Hippocratic Oath commonly viewed as the foundation of the medical profession, is really the prevailing ethos rather than a professional approach. Medicine in ancient Greece was influenced by the classical philosophy of Plato and Aristotle. Hippocrates was a doctor and also an outstanding philosopher of his times. The Hippocratic Oath was a concise statement of the moral code of ancient Greek medicine, and

points to the relationship of doctor, patient and illness. The dynamics of this triangle in modern times can be affected by so many factors, such as science and technology, the media, economic considerations of cost-benefit, effectiveness, and efficiency, with subsequent consequences.

THE CONCEPT OF MODERN MEDICAL ETHICS

In modern times, the shaping of the ethical concept of medicine as a profession, in the English language was done by the Scottish physician-ethicist John Gregory (1724-1773) and the English physician-ethicist, Thomas Percival (1740-1804). Medical practice in eighteenth century Britain and North America was entrepreneurial. There was a constant tension between the Hippocratic commitment to the sick on one hand, and entrepreneurial self-interest on the other.

The medical market place at the time was over supplied, and competition was fierce, as the outcome of failure was poverty. Doctors attempted to stand out from competitors by "peculiarities" of dress, speech and manners. There was also tension between doctors and the "Trustees" and managers who ran hospitals on behalf of the employers.

Gregory was concerned that the entrepreneurial, self-interested medical practice of the time,

continued on page 10

introduced biases that distorted clinical judgement and decision making. He was also concerned about the competence of medical practitioners.

Gregory set out to give the concept of a profession, intellectual and moral content, and proposed the ethical concept of medicine as a profession, which had three components.

Firstly, the doctor commits to being scientifically and clinically competent.

Secondly, the doctor commits to the protection and promotion of the patient's health-related interests as the doctor's primary concern and commitment, keeping self-interest systematically secondary.

Thirdly, doctors commit to maintaining and passing on medicine to future patients and doctors and society as a public trust, not as a merchant guild that protects the self-interests of its members as its primary concern and commitment.

The first two components of the ethical concept of medicine as a profession emphasises the core professional virtue of integrity and self-sacrifice respectively.

In the third component, Gregory had referred to the Royal Colleges of the time, which despite the Royal Charter existed only for the self-interests of its members.

Percival took up the direction of Gregory in the third component, and expressed it in clear, conceptual terms. He discussed and developed the ethics of when doctors should retire from practice. In his words,

“Let both the physician and surgeon never forget, that their professions are public trusts, properly rendered lucrative whilst they fulfil them, but which they are bound, by honour and priority, to relinquish, as soon as they find themselves unequal to their adequate and faithful execution.” (Percival, 1803)

In the history of western medical ethics, Gregory and Percival were the first to use the word 'patient' instead of 'the

sick'. This has important implications from the ethical concept of medicine as a profession. Fulfilling the three components required by the ethical concept of medicine as a profession, as proposed by Gregory, turns medical practitioners into professional doctors.

The reality of medicine as a profession is the function of the combination of the exercise of clinical skills, decision making and behaviours of doctors. External forces such as funders or governments do not create the profession nor can they affect or destroy it. Doctors as a group are in charge, and should hold themselves accountable to uphold the values of the ethical concept of medicine as a profession. From this is developed the doctor-patient relationship as a fiduciary relationship of protection and promotion of the patient's and research-subject's health related interests.

The ethical concept of medicine as a fiduciary profession, becomes the platform that influences the doctor's character and behaviour, and the ethical principles become a guide in clinical practice, research and teaching. It is also useful in guiding doctors in the face of economic and other conflicts of interests. The doctor's self-interest must always be subordinate to the patient's interest. This is a continuous and major challenge to all doctors so long as they practise medicine.

Medicine's limited capabilities in the past over 2000 years probably helped to sustain the Hippocratic commitment to patients. Medicine started to change dramatically in the nineteenth century as anaesthesia was introduced, hygiene became better understood and antiseptics were applied in surgery. This enabled operations to be performed into the abdomen, chest and brain. X-rays, electrocardiograms and lots of other innovations added to medicine's capability, and to mounting costs of care.

As medicine's capabilities grew, it moved from being a cottage industry to an industrial scale enterprise. It made economic sense to put operating rooms, equipment and gadgets into

the central setting of hospitals, which became increasingly complex and increasingly expensive.

Increasing public expectations pushed governments to provide medical care to all citizens. Germany was the first to do so in 1883 with a national health insurance covering their citizens. Other European countries followed Germany's example, which very much later was followed by Asian countries like Japan, Korea and Taiwan.

Healthcare spending 120 years ago was probably less than one percent of the Gross Domestic Product. In many countries this has now increased by ten-fold and in the USA probably twenty-fold. In these circumstances it is only to be expected that the State has become involved in setting priorities and imposing limits on resources allocated to healthcare.

The amazing advances in science and technology resulting in medicine's increasing capabilities is a double edged sword. The increasing capabilities to diagnose and treat comes with escalating costs. This then puts pressures on doctors and health professionals being caught in positions of budgetary constraints and may have to withhold life extending care to patients, breaking the promise of fidelity to patients.

Doctors are expected to balance care to individual patients with the need or priorities of the community, in terms of utilisation of resources. Doctors are expected to control costs to help manage health care spending. This inevitably results in some form of rationing, which tends not to be publicly acknowledged.

This rationing process tend to occur in a covert manner all over the world. Our political masters in government will claim that patients will not be deprived of treatment when needed despite budgetary constraints. In reality how can this be true? Waiting time for treatment of complex illnesses increases and the disease progresses. The current scandal of waiting time in the Veterans Administration health system in USA is

another example of attempts to ration care in a covert manner. In the 1970's in the United Kingdom, there were hardly any patients over the age of fifty years on long term dialysis. Yet it was claimed that no rationing occurred. It so happened apparently that the GPs' do not refer patients over the age of fifty for dialysis treatment.

The commercialisation and commoditisation of medicine and healthcare is inevitable in a market economy. The entrepreneurial bent of doctors who own healthcare facilities, expensive equipment and treatment modalities in a fee-for-service environment is rich with conflicts of interest. Similarly the interaction between doctors and the pharmaceutical and medical devices industry poses problems of conflicts of interest. Doctors who has contracts or arrangements with managed care organisations, third party administrators and insurance companies are often persuaded to avoid costly treatments or to limit care. A similar situation with managed care in the USA in the 1990's caused popular public outrage against managed care.

As medicine's capabilities have increased dramatically, society have come to depend on doctors to perform a broad range of functions that does not sit well with the Hippocratic commitment of looking after the patient's interest.

The advances in science of infectious diseases have resulted in laws that confine the sick against their will, and the practice of compulsory vaccination of the healthy population to stop disease outbreaks. Here the values of public health appears to be in conflict with medicine's fidelity to individual patients.

Would examining a prisoner to ensure fitness for execution be in the prisoner's interest?

Would resuscitating and treating a sick prisoner to ensure fitness for execution be in the patient's interest?

In the war on terror after nine eleven, doctors had been involved in the

process of interrogation. Torture was involved in the so called "enhanced interrogation" process, and doctors were involved not only in evaluating the prisoner's physical condition as part of the process, but doctors were also involved in planning the torture process in the so-called "enhanced interrogation".

Attempts to rationalise the involvement of doctors in torture by claiming that prisoners are not doctor's patients, further highlight the cynical and distorted view that has been taken of a doctor's role. In using clinical skills and practice in the assessment of the health of individuals, doctors are bound by our ethical code. Using legal gymnastics to redefine what constitute "torture" in the interrogation process is a cynical attempt to legalise what are actually criminal activities. It is difficult to see how the doctor's involvement in this can even be considered in the interest of the "patient".

In a similar view, it is difficult to see how the doctor's assessment of soldier's fitness to be involved in combat or assessing the mental state of murderer's accountability for crimes committed, can be viewed to be consistent with the Hippocratic tradition. In both cases, the clinical assessments put the "patients" at grave risk of being killed in combat or by execution.

THE SOCIAL PURPOSES OF MEDICINE

The community expects medicine to have various social purposes including healthcare cost containment, criminal justice, national security and support for common values. When these values clash or contradict each other, doctors are expected to choose between them.

It is important that the social purposes of medicine be openly discussed and debated by doctors and non-doctors. This can help clarify the roles doctors have to play for the greater good, beyond caring for individual patients. This will be helpful for doctors as well as for the public.

There is the need to understand the boundaries between acceptable and

improper exploitation of clinical relationships for public purposes. While the consideration may be the importance of the social purpose, there are implications for trust and trustworthiness in clinical relationships.

Increasingly medical technology are used for public purposes such as national security and criminal punishment. In this situation medicine's credibility as a caring entity is put at grave risk by pushing doctors to break with their pledge of fidelity to patients.

Increasingly we have seen economics come to dominate over medicine, science and technology, and medicine has become dependent on social institutions for economic viability. Cost containment have been imposed on doctors who then can no longer be exclusively committed to their patients.

That medicine has become deprofessionalised and transformed into a vast industry have caused concerns to many in the medical fraternity around the world. In an effort to reconsider medical professionalism, a collaboration of a number of medical societies in the USA and Europe developed the Physicians' Charter on Medical Professionalism in 2002. This Charters calls for a renewed sense of professionalism and seeked to ensure that all medical professionals and the healthcare system are committed to patient welfare and the basic tenets of social justice.

The Charter's emphasis on a duty-based ethics approach, focussed on competence is important in the modern complex settings of healthcare. This approach can be viewed as a necessary adaptation to the demands of the market place ethos, and the healthy competition that will occur. Doctors should be accountable to the public, and patients are empowered to manage their own health. Medicine can become more democratised. This can all be considered desirable. However medicine then becomes reduced to be an occupation like any other.

The ethics of medicine then becomes reduced to the minimalist ethics of

business and commerce.

Many doctors appeared to have accepted this view, and their main concern that the doctor's responsibility primarily focuses on technical competence, disclosure of interest, and a contractual relationship with patients. Many are concerned that they may be deprived of the rich rewards, their education and expertise entitle them to.

There are a minority among doctors who are concerned with the ethos of the market place, that commoditisation and commercialisation of medicine distorts the fiduciary relationship they have with their patients. They are the few that want to dedicate their lives to something other than their own self-interest. The values and ethics of this group of doctors conform to the traditional ideal of a profession with the emphasis on virtue ethics. To them medicine is a vocation, never merely a job. There are many capable, dedicated and sensitive doctors who feel that they are practising medicine in a dark world, lacking of a soul.

The majority of doctors exist between these two groups. They compromise to survive, and worry whether this compromise is defensible. They realise that they cannot be professionals in the pure and pristine ideal of the professional concept.

This is the group that long and yearn for a more ethically sensitive system and look for leadership from their professional societies. They hope for medical statesmanship that does not appear to exist anymore. Unwilling as they maybe, they adapt to the values imposed by the market and commercial model of healthcare.

THE GOALS OF MEDICINE

In considering the social purposes of medicine, we must be reminded of a report by the Hastings Centre, New York entitled "The Goals of Medicine: Setting New Priorities". This report was the result of an international

consultation conducted in several countries in four continents, over four years by the Hastings Centre, New York in 1996.

This report proposed the four goals of medicines, which represent the core values of medicine, namely

- The prevention of disease and injury and promotion and maintenance of health
- The relief of pain and suffering caused by maladies
- The care and cure of those with a malady, and the care of those who cannot be cured
- The avoidance of premature death and the pursuit of a peaceful death

A relook at the Goals of Medicines can be helpful for us to look at future priorities for the ways the health care systems are organised, how doctors should be trained and for development of thrust areas in biomedical research.

While we can expect medical knowledge and skills to be used for the good, it can also be used for evil or unacceptable purposes. While the goals of medicine may be open to various interpretations, we must apply it for the common good.

The report also emphasises that medicine should aspire:

- to be honourable and to direct its own professional life
- to be temperate and prudent
- to be affordable and economically sustainable
- to be just and equitable, and
- to respect human choice and dignity

The values and issues emphasised in this report are crucially important for the future of medicine.

THE IMPORTANCE OF TRUST

The late Stephen Covey in a lecture in New York in 2010, cited that 27% of

people trust healthcare leaders, and 28% of people trusted hospitals. Three or four decades previously 73% of people trusted doctors and hospitals. Apparently the situation is similar in Britain.

Stephen Covey had further stated that "... the ability to establish, grow, extend and restore trust with all stakeholders (patients, families, colleagues and communities) is the number one leadership competency in healthcare today."

The loss of trust of this scale is deeply disappointing, even as so many doctors and health professionals are dedicated and work so hard for patients, as so much more is spent on healthcare, and medicine has so much to offer. However this is the reality, and healthcare now is so exceedingly complex and so multifaceted.

Medicine exists to serve society and has to adapt to the priorities and values that shapes our contemporary and dynamic society. I believe that working for Health is a moral issue, and similarly in medicine we have to find a philosophy of medicine that explores the values that is at the core, and is internal to medicine. This can then be a moral philosophy, and the Hippocratic tradition and medical ethics can provide guidance in this process. The moral philosophy of medicine must be linked to a philosophy of medicine, which can be a foundation of the medical profession in facing the challenges of modern society. This is work that needs to be done, and leadership is urgently needed if medicine is to continue to claim its status as an esteemed profession that deserves the trust of patients and the community.

Will there be people of virtue, dedication and talent that can lead us in this process to uphold the values of medicine that is consistent with medicine's traditional values that can exist in our contemporary, dynamic society?



2014

INTERNATIONAL CONGRESS OF PATHOLOGY & LABORATORY MEDICINE (ICPaLM) and 48TH MALAYSIA-SINGAPORE CONGRESS OF MEDICINE

Report by **DR ARNI TALIB** (Chairperson, Organising Committee)

The joint conference of the 2014 International Congress on Pathology and Laboratory Medicine (ICPaLM) and the 48th Malaysia-Singapore Congress of Medicine was held on 26th to 28th August 2014 at the Shangri-La Hotel, Kuala Lumpur. The theme was on "Personalised Diagnostics: From Bench to Bedside". The World Association of Societies of Pathology and Laboratory Medicine (WASPaLM) also participated in the conference and contributed several plenary and symposium lectures.

Registration

There were a total of 608 registrants for the main conference (full delegates and day registrants). The speakers and delegates came from 28 countries.

Scientific Programme

The Scientific committee headed by Professor C F Leong had put together a very commendable scientific programme.

The programme started off with two pre-conference workshops on Cytology (24th & 25th August 2014) and Haematology (25th August 2014). Both workshops

were fully subscribed. The scientific programme started off on 26th August 2014 with the K Prathap Memorial Lecture delivered by Prof Dennis Lo on the topic of Molecular Diagnostics Using Plasma DNA: From Science to Clinical Reality. These were followed by plenary sessions and concurrent scientific sessions and the areas covered included anatomical pathology, chemical pathology, haematology, forensic pathology, microbiology and emergency medicine and the same format was used for the next two days.

On 27th August 2014, Tan Sri Dato' Dr Abu Bakar Suleiman delivered the 2nd T J Danaraj Oration on The Hippocratic Commitment and Patients: A Declining Trend in Modern Medicine.

All the scientific sessions were well attended and were packed till the last session. A Young Investigator Award was held at the conference and the award and prize money were given to two presenters:

- Thalassemia screening in newborns using dried cord blood spots: A preliminary observation by Dr Asral Wirda Ahmad Asnawai of University Sains Islam Malaysia.



continued on page 14



- Vascular malformation and neoplasms: An effort to reclassify the commonest soft tissue lesions in children and adolescents by Dr Siah Hui Hui of Hospital Kuala Lumpur.

A total of 108 posters were accepted for presentation in this conference. The poster presentation was well participated by pathologists, trainee pathologists and scientific officers from various institutions within the country. This time the posters were presented on digital platform and generally received good feed backs from delegates. Awards were given for the three best poster presentation.

Opening Ceremony

The official opening of the conference was officiated by Dato' Seri Dr S Subramaniam, Minister of Health Malaysia, on the afternoon of 26th August 2014. This was followed by the 20th Tun Dr Ismail Oration which was delivered by Dato' Seri Dr Subramaniam on "Towards the 'Ministry of Health". Professor Datuk Looi Lai Meng read the citation on him.

This was followed by the conferment of the Academy Fellowship on overseas presidents and special guests as well as on Academy members and the induction of members of the Academy.

A Welcome Reception was held after the Opening Ceremony.

Conference Dinner

A Conference Dinner was held on 27th August 2014. Overseas guests, invited faculty and delegates attended the dinner. The overseas guests enjoyed the cultural performance which was put up.

Support from Biomedical Industry

The conference received good support from the biomedical industry. There were three gold sponsors with satellite lunch symposia and also 28 exhibition booths taken up. 

