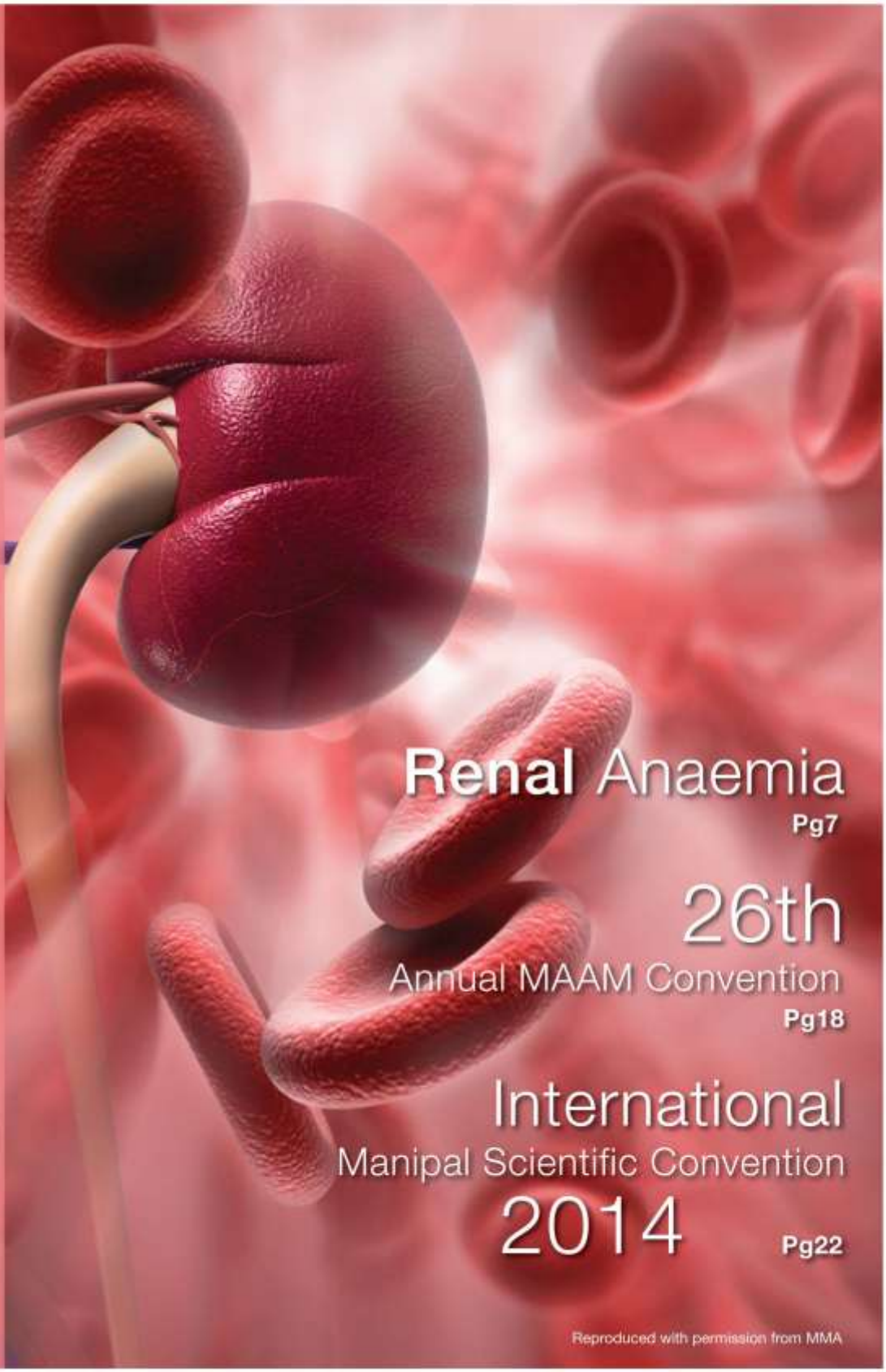
Vol XIX For members only

HOWZIT

Manipal Alumni Association Newsletter



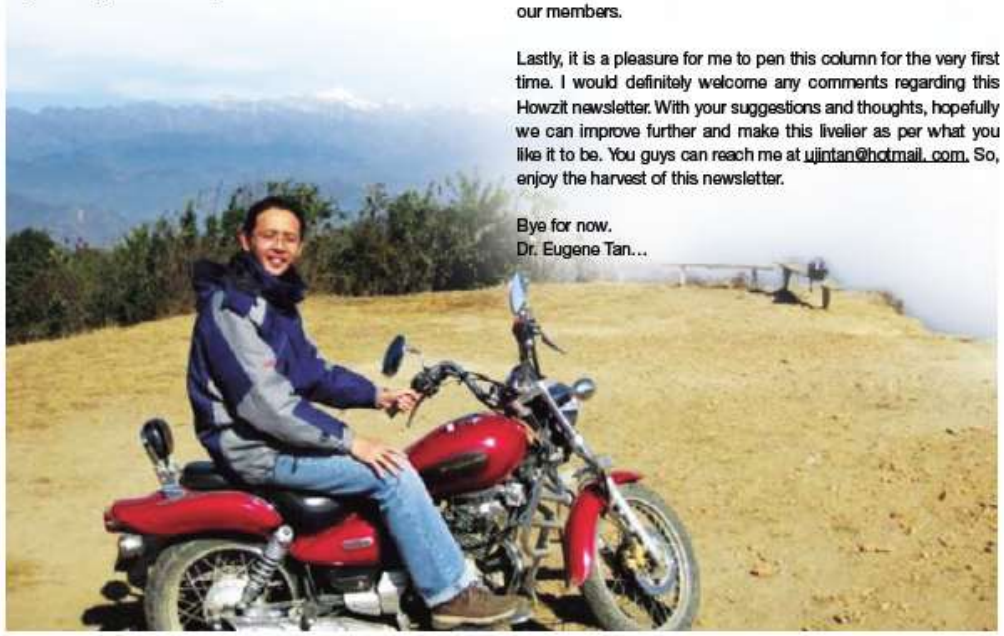
Hello to Manipalites out there,

The Editorial Team would like to wish all of you, a Merry Christmas and a Happy New Year! "Howzit" for the year 2013? Have you made your resolutions yet?

Chakadae? Hahaha…

Well, firstly let me introduce myself, as I am sure that many of you guys do not know me as yet. I am Dr. Eugene Tan, an ex-Melaka Manipal student (Batch 8 to be exact), currently doing my Masters in Internal Medicine in UMMC. I have been asked to stand in as Editor for Howzit Newsletter (whilst Dr. Simon Martin who is the present Editor is taking a break) by none other than Mr. President, Dr. Nirmal Singh. Wow, I cannot believe that I said "YES" on that very day in November 2012 and am now writing my very first editor's column. Mind you, I never had any experience in writing any of these before. So, in preparation for this big responsibility, I made a few internet searches, read the past newsletters and with some assistance by the experts, namely, Dr Koh Kar Chai, I am lettering my thoughts in this column like the fresh green vegetables in the market.

But, just to begin with, I am known as the youngster in the Alumni. After I graduated from MMMC in 2006, I knew of the existence of this Alumni but unfortunately did not attempt to join at that time due to work commitment, until Dr. Simon Martin introduced this to me sometime in 2009 via Facebook and then made my first physical appearance during the last 27th AGM at Royal Selangor Club in May 2012.



Since then, I had to change my thoughts and perceptions on you guys, as my initials thoughts was that this will be just another mundane association. Guess I was so wrong; this group of people is not like MMA or others, we manage to improve ourselves through CPD programs, we do charitable work via Community Services, we have reunions during the Convention, and we have fun from the sports activities and much more. With the great ideas and visions of the current Executive Committee, a young and dynamic team, I am very sure that our Alumni can reach even better heights.

Currently, the team under Dr. Philip George is taking on a mammoth duty to organize our very first International Manipal Alumni Health Sciences Convention planned to be held in August 2014 in our capital city, Kuala Lumpur. So far, we have been getting good vibes from the International Manipal Alumni community and we are expecting many delegates, (Ex-Manipalites/ Ex-College Mates) from all over the world to visit our home country, Malaysia, not only just for a proper Scientific Meeting but most importantly a Reunion, a long awaited event from those under-graduate years. I am sure you guys want to meet your old friends of which you have bitter sweet memories from your teenage time back in Manipal/Mangalore.

Well, going back to the Howzit, I am sure you would have noticed a difference in the appearance and contents as we feel the need of a change in order to flow with the new trend nowadays. The fresh look of the front page was done by Dr. Sivaroshan. Besides, I would like to give my sincere appreciation to all the contributors of the articles in here. I had to spend time reading all of your articles before publishing it and well I did learn some new things along the way. Thank you to our advert sponsors, without them I am sure we will not be able to circulate this to all our members.

Lastly, it is a pleasure for me to pen this column for the very first time. I would definitely welcome any comments regarding this Howzit newsletter. With your suggestions and thoughts, hopefully we can improve further and make this livelier as per what you like it to be. You guys can reach me at ujintan@hotmail. com. So, enjoy the harvest of this newsletter.

Bye for now.
Dr. Eugene Tan…

At the time of writing, it's a week before Diwali and it will be the week before Christmas as you read this. So, from the committee to you, Happy Diwali, Merry Christmas and a Happy and Healthy New Year.

Since the May 2012 AGM, a number of happenings have occurred. What has come to pass and their related events and issues are in the subheadings below.

Community Service

Our community work is slowly moving along. Kampong Aman in Sungai Buloh gets monthly visits with two doctors on Sunday mornings. We will be embarking to help another community in Sungei Siput, Perak on the 9th of December 2012. This will be a Stage-1 exploratory effort to identify medical problems and issues that are affecting the community. Stage-2 is to use the information gathered to craft a structured approach in assisting the community. Governmental support may be sought to bolster our efforts. We hope it will be forthcoming.

Before Perak however – on the 19th of November – we are meeting the Penang Welfare Department to discuss how we can throw our weight behind efforts to provide community work in the state. We are looking forward to this.

In summary, before the turn of the year, we will have charitable services running is three states. This is good news but I fear we are spreading the butter much too thinly across the bread. This brings me to the two critical issues we face:

- More medical manpower needed
- More accurate deployment of effort required (I will discuss this below)

Manpower

Currently the set up is rotating two doctors from a pool of volunteers for Kampong Aman. Sincere thanks to those volunteers. If we do not expand this pool we will face burnout from too many Sundays taken up from helping in three states. The bigger the pool, the rotations will come to you less often. And MAAM can help without feeling overburdened or too much of personal time taken. We are strongly appealing to more doctors to volunteer. To volunteer your services please contact any one of us and we will put you on the list. After all, is it not in our oath to help the underprivileged? This brings me to my next point.

Accurate Deployment

Our attempts so far, though well intentioned, have not truly been targeting the underprivileged. We unfortunately came to this realization after a few months of effort. I need to tread carefully here; I do not mean to say that the work was futile. The community work carried out has without doubt helped people. But can these people afford the treatment that was given? I say yes. The very definition of charity is "the voluntary giving of help to those in need". The key here is to find those in need, not want.

MMMC and Recruitment

Other than trying to expand the volunteer pool, we have also been at work expanding the membership base by liaising with Malacca Manipal Medical College (MMMC). At their mid-year convocation, MAAM gifted medals and free life memberships to the recipients of the excellence award. After the ceremony, we had the honor of meeting Dr Ramdas Pai, Professor Datuk Dr. Abdul Razzak the pro vice chancellor, Prof Dr Jaspal Singh Sahota the Dean of MMMC and other academic staff of the institution. The consensus was that we work closely with the student body and improve our member benefits.

In good faith, we will offer the MIMS Mobile app (further information below) free-of-charge to MMMC student members. MMMC has additionally requested routine career guidance talks from MAAM members for out-going students. Volunteers are needed here. Wouldn't you have loved some learned advice when you were studying?

To date, we delivered a talk to MMMC students during their Post-Graduate Fair on the 3rd of November. The purpose of the talk was to educate the attendees on the various courses available and the complexities of Post Graduate studies. Dr Rishya Manikam – HOD – ER – UMMC was the opening speaker with an overview of Post Graduate studies, held the audience in stitches with his entertaining delivery. He later spoke about Emergency Medicine. Dr Rishya is from the 1st batch of MMMC having swept all the gold medals available throughout his stay in MMMC. There were talks on Orthopaedics, Paediatrics, O & G, occupational Medicine and General Surgery. We put up a booth and yes, we managed to recruit new members.

During the induction for the twinning / returning students to MMMC (2.5 years in good old Manipal, India), we spoke to them about MAAM, our activities, and the importance of joining the alumni.

As you can see, recruitment is a critical issue to us as MAAM's life depends on numbers and young blood. We might require a youthful sub-committee for recruitment of MMMC students. I do not qualify for this I think. Maybe last year I would have been of age. Not this year I fear. Not this year.

Benefits for Members

Ah, the thing you have been waiting for. I had to insert this toward the end to get you to read the other topics.

MIMS Mobile App (iOS and Andriod)

The drug index as most of us know it is the MIMS. This is also available on line, which is FOC. It is also available as an "app" on the I-phone and the androids. This is called the "MIMS Mobile". It is an added advantage for young Doctors on the "go", post graduate students and the IT savy.

This "smartphone app" is currently available at the price of RM350 per year. Thanks to UBM Medica, it is now for sale to MAAM members at only RM50 per year. All you need to do is to inform our secretariat that you would like to purchase the MIMs Mobile and we will liaise the whole process for you. Shameless product endorsement ahead. Dr Philip George – our Assistant Secretary, psychiatrist and the Deputy Dean of International Medical University – is extremely impressed with it after purchase. He says it is an excellent on-the-move app for both the doctor and the medical student…

USMLE

A training course organized by MMMC for the USMLE examination is on the drawing table. Refer to the advertisement in this issue of Howzit.

Banking and Insurance

Alliance Bank has offered special privileges for members but due to red tape in the banking industry this is taking longer than initially expected. All that I can say at this juncture is if you need any banking facilities with Alliance Bank, call us and we will put you through to the correct persons. We do not need to know your bank balance – no fear.

Initial discussions are underway with insurance companies. In the near future, we hope to be able to give you great benefits.

Conventions and Conferences

2012 Annual Convention in Penang

The convention went very well. Despite a smaller crowd versus the 25th anniversary, the event was executed with clockwork precision. Kudos to the Organizing Chairman Dr Roshan (and his trusty iPhone sidekick). We employed the services of event management company to help with certain sectors of the event. This gave the organizing committee more time to deal with top-line issues like partying

2013 Upcoming Annual Convention

Might as well start working on this now that the last one is over. We are working on some new ideas. Keep logged on to our website and look out for our e flyers for updates. For a short in sight

The AGM in 2013 is a non election AGM and we plan to combine some interesting CPD and games with the AGM probably in April 2013.

For the 2013 convention…..Kuantan probably will be the site in June / July 2013.

What do you think? Put it to a vote. Log on to the MAAM website and post your comments and ideas. Put your yellow shirts away; this will be a clean, fair and transparent vote.

2014 Inaugural Global Manipal Scientific Health Sciences Conference

The conference is being organized for the 7th and 8th of August 2014. The 10th will see a Manipal-style dinner event take place. The Organizing Chair is our Assistant Secretary Dr. Philip. The Scientific Chairman is Dr. Jaspal Singh Sahota, an ENT surgeon who is the Dean of MMMC. The scientific committee has been formed. The working committee is for now made up of the main MAAM committee. It will soon expand in order to work this epic event.

As is the norm in this article, we need volunteers. Please come forward wherever you are. You can be of assistance whomever you are and whatever your skills. Send an email to manipalmaam@gmail.com

Venue is to be confirmed. It will probably be firmed up by the time you read this. Ideas are being bounced and getting hot and we hope to strike up a good working relationship with all concerned. Our target for this event – the first in our history is 500 delegates for the scientific conference and 1000 attendees for the dinner.

Goodbye for now.
Till the next time in 2013, yours truly,

Dr. Nirmal Singh

RENAL ANAEMIA IN

CKD-Practice Points for GPs

Practice points for GPs in the management of renal anaemia in chronic kidney disease. This is a project which was undertaken recently by the Malaysian Medical Association. Our alumni is proud that a sizeable number of the working group comprised of us Manipalites, no less than our own President, Dr Nirmal Singh. The Chairman of this working group, Dr S.R. Manalan, President of the Malaysian Medical Association is also a Manipalite himself.

This was made possible with an unrestricted educational grant from Roche (Malaysia) Sdn Bhd. The amount of hard work put in by all culminated in the launch of the Practice Points booklet by the Honorable Health Minister, Dato' Seri Liow Tiong Lai at the PJ Hilton on 2, November, 2012.

Chronic Kidney Disease is when there is an irreversible loss of kidney function over a period of at least three months. It is associated with multiple related medical problems either as it's cause or it's consequence thus becoming a major burden on the healthcare resources of this country.

Anaemia is a known complication of chronic kidney disease and it's severity is closely related to the residual renal function. Thus it is important for those who are in primary care to recognise and understand this common complication.

This Practice Points booklet is a worthwhile attempt to introduce the management of renal anaemia in chronic kidney disease to the general practitioner.

Dr Koh Kar Chai

Our first Community Camp for our 'adopted' village, Kg Sri Aman in Sungai Buloh, was held on March 25th 2012.

By: Dr. Thomas John

NGOs working in the area alerted us to the situation of the inhabitants of this village, who have to deal with poor living conditions; they also have difficulty in getting medical help as the nearest health centres (at Sungai Buloh and Ijok) are at least 12 – 15 km away. The executive committee therefore decided to adopt the village and make regular visits there every 1 – 2 months, in the hope of improving their general health by doing medical checkups and screening for any new ailments, on a more regular basis.

The village comprises 100 families, mostly Indians, who became economically displaced once the surrounding rubber and palm oil plantations were converted into housing schemes. They used to work in these estates; since the closure of the estates, they have had to fend for themselves. They have chosen to stay on in the area and manage as best they can, because buying homes in the new housing schemes is costly, and too far beyond their means. Each household consists of a minimum of 5 – 6 people.

On our first visit in March, we went with a team of 5 doctors, 1 orthopaedic doctor, 2 dentists and 2 pharmacists. We also had volunteers to help us with such tasks as registering the patients and recording their height and weight. Further assistance was provided by Gribbles Laboratory, who helped with taking the patients' blood to be checked for sugar, cholesterol, etc. We saw a total of 104 patients; among them, there were many new cases of DM and HPT, as well as many cases of Arthritis among the older folks. Almost all the children under the age of 12 years were also screened for dental hygiene.

On a lighter note, in order to foster a greater sense of community between our team and the villagers, our volunteers also organised a futsal game for the young kids in the village. They had a really great time, and in fact wanted to know when we would be back for the next game!

Our next visit to Kg Aman was on 5th August 2012. This time we had a smaller team of 2 doctors and 2 nurses, who helped us with registration as well as dispensing of medication. We managed to see around 50 patients during this visit.

On 23rd September 2012 we again visited with 2 doctors and 2 nurses, and saw a total of 59 patients. Our most recent visit was on 21st October 2012, when we managed to see 39 patients. Turnout was relatively low this time because there had been another medical camp in the area just one week prior to our visit there.

Overall, our visits there have been very encouraging, but we still need to make greater and more integrated efforts to help the villagers. They need not only medical help, but also encouragement and counselling in other areas, to help them take a more positive and proactive approach to their situation so that they can try to improve their lives. In order to be able to help them with this, we need more doctors to volunteer their services. Unfortunately, this has not been forthcoming so far. We urge you to consider your own good fortune, and try to help those far less fortunate than ourselves.

Combined CPD Program - Melaka

By: Dr Roshan

A Symposium on Anti-Aging, Aesthetic and Regenerative Medicine in collaboration with SAAARMM (Society for Anti- Aging, Aesthetics and Regenerative Medicine), MAAM (Manipal Alumni Association of Malaysia) and INMA (Indian Nutritional Medical Association) was conducted on the 22nd September 2012 at the Avillion Legacy in Melaka. It was a very successful event with more than 75 participants. The MAAM sponsored 20 students form the Melaka Manipal College as part of its program to nurture the next generation manipalites. It was a full day event with topics that were very different and interesting at the same time. The afternoon breakout session saw an introduction to Aesthetics by our fellow Manipalite, Dr. Kuljit Singh. I think the students really enjoyed this session. There were many more renowned speakers, Dr Rajbans Singh, Dr Selvarajah, Dr Lenny Da Costa, Dr Fernando Cortizo, Dr A Sreekumar, Dr Harnam Singh, Dr Kamalakaran, on of course our President Dr Nirmal Singh. The MAAM would like to thank all the participants that attend the event, SAAARMM and INMA for all the effort that went into organizing this event.

Cardiac-type Chest Pain Presenting in Primary Care

By: Dato' Dr Devan Pillay.

When GP's treat patients with chest pains, they have to decide whether there is a serious underlying pathology requiring urgent action or whether a 'wait and see' strategy can be applied. Chest pain can be caused by a wide range of different illnesses among which life-threatening cardiac disease is of the greatest concern. However, chest pain is caused by Coronary Heart Disease (CHD) in only around 15-20% of primary care patients. For most of patients with chest pains, the GP remains the main point of entry into the health care system. The effectiveness of the GP's gatekeeping role ie; identifying patients with CHD and protecting patients from over diagnosis and treatment depends on the accuracy of their provisional diagnosis after taking the patients' history and performing the basic clinical examination.

Assessment for possible acute coronary syndrome

- Consider the history of the pain, any cardiovascular risk factors, history of ischaemic heart disease and any previous treatment, and previous investigations for chest pain.
- Symptoms that may indicate acute coronary syndrome (ACS) include:
  - Pain in the chest and/or other areas (eg the arms, back or jaw) lasting longer than 15 minutes.
  - Chest pain with nausea and vomiting, marked sweating and/or breathlessness, or haemodynamic instability.
  - New-onset chest pain, or abrupt deterioration in stable angina, with recurrent pain occurring frequently with little or no exertion and often lasting longer than 15 minutes.
- The response to glyceryl trinitrate (GTN) should not be used to make a diagnosis and symptoms should not be assessed differently in men and women or among different ethnic groups.
- Patients with pre-existing angina should be advised that when an attack of angina occurs, they should:
  - Stop what they are doing and rest.
  - Use GTN spray or tablets as instructed.
  - Take a second dose of GTN after 5 minutes if the pain has not eased.
  - Take a third dose of GTN after a further 5 minutes if the pain has still not eased.
  - Call 999 for an ambulance if the pain has not eased after another 5 minutes (ie 15 minutes after onset of pain), or earlier if the pain is intensifying or the person is unwell.

Presentation

A full cardiovascular assessment is essential.

- Chest pain due to cardiac ischaemia typically tends to be retrosternal or epigastric, tight and crushing in quality, and may radiate to the arms, shoulders, neck or jaw.
- Aortic dissection tends to cause pain with a tearing quality; pericarditis and pulmonary pain tend to be worse on inspiration (pleuritic) and oesophageal reflux pain has a burning quality.
- Cardiac ischaemia pain tends to be retrosternal.
- Stable angina is likely if chest discomfort or breathlessness is associated with effort, emotion, food or cold weather, symptoms are relieved by rest and/or glyceryl trinitrate (GTN) and one or more risk factors for coronary artery disease are present.
- In patients with acute coronary syndrome:
  - Chest pain may be associated with sweating, nausea, vomiting, dyspnoea, fatigue, and/or palpitations.
  - Shortness of breath may be the main symptom of cardiac ischaemia, associated with angina pain, or a symptom of heart failure.
  - Atypical presentations are common (especially in women, older men, people with diabetes and people form ethnic minorities), eg abdominal discomfort or jaw pain; elderly patients may be present with altered mental state.
- The assessment of any patient with possible cardiac chest pain should include smoking history, past history of cardiovascular disease and comorbidities, especially diabetes, hypertension and hyperlipidaemia.

Examination

- Many patients will have entirely normal examination findings. However, a thorough cardiovascular examination is essential.
- Always check pulse rate and rhythm, blood pressure, auscultate heart sounds (ensure no murmurs, eg aortic stenosis can present with angina) and chest (to exclude signs of heart failure).
- Consider findings suggesting non-cardiac chest pain, eg tenderness of the chest wall, epigastric tenderness due to a peptic ulcer, and focal lung signs associated with pneumonia.

Differential diagnosis of chest pain

The main causes of chest pain include:

- Angina, acute coronary syndrome (ACS) (include myocardial infarction)
- Acute pericarditis.
- Pneumonia, pulmonary embolus, pneumothorax.
- Gastro-oesophageal reflux, oesophageal spasm.
- Peptic ulcer disease.
- Gallstones, cholecystitis
- Acute pancreatitis.
- Chest wall pain, eg Tietze's syndrome, trauma, shingles, rib secondaries, osteoporosis.
- Aortic dissection.
- Anxiety, depression.

Investigations

Depending on the clinical state of the patient and any suspicion of myocardial infarction, the patient may require immediate transfer to hospital before any investigations are performed.

- Investigations may be required to exclude non-cardiac causes of chest pain, eg chest X-ray (pneumonia), abdominal ultrasound (gallstones), serum amylase (acute pancreatitis).
- Initial blood investigations include cardiac enzymes, fasting lipids, fasting glucose and full blood count (to exclude anaemia, and high white cell count may suggest pneumonia).
- Resting ECG – a resting ECG is normal in over 90% of patients with recent symptoms of angina.
- Chest X-ray – this may be useful in evaluating the presence of heart failure or an alternative diagnosis, eg aortic aneurysm, pneumonia, rib fractures, rib secondaries or osteoporosis.
- Exercise ECG testing should not be used to diagnose or exclude stable angina for people without known coronary artery disease.
- Depending on the presentation, further investigations may incluse eechocardiogram, coronary angiography, V/Q scan or pulmonary angiography (pulmonary embolus), CT aortography (aortic dissection) or upper gastrointestinal endoscopy (gastro-oesophageal reflux disease, peptic ulcer).

Practice Points

- A detailed history is important to establish the likelihood of coronary disease and whether symptoms are compatible with angina. Patients with unstable symptoms should be identified at the outset.
- Electrocardiogram stress testing or stress imaging techniques may be used to determine the presence and extent of ischaemia.
- Additional laboratory or imaging tools may be required to exclude alternative diagnoses or detect associated conditions such as heart failure or valve disease.
- Optimal medical therapy, ideally with aspirin, statin beta-blockade, and angiotensin-converting enzyme inhibition, should be considered in all cases, with additional anti-anginal drugs as required for symptom control.
- Risk factors such as smoking, diabetes and hypertension should be identified and treated appropriately.
- Risk stratification should be performed by clinical evaluation response to stress testing and quantification of left ventricular function to establish the need for coronary angiography. Assessment of reversible ischaemia should be considered mandatory in most cases.
- The extent and location of coronary disease on angiography (if performed) should be incorporated into the risk assessment to determine whether revascularization is appropriate.
- The choice of revascularization method (percutaneous coronary intervention or coronary artery bypass graft) is determined by the extent and complexity of disease; presence of diabetes; co-morbidities which increase surgical risk; ability to take dual antiplatelet therapy; and patient preference.

* IF IN DOUBT, ALWAYS REFER TO A CARDIOLOGIST *

SHOCKING NEWS!!!
Diabetes DOES NOT cause BLINDNESS

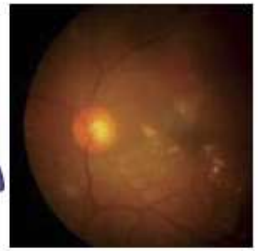
By: Dr. Kewaljit Singh

This was the shocking news that we found when Howzit interviewed ophthalmologist Dr Kewaljit Singh – a fellow Manipalite. When asked to explain this controversial statement , he said lets review some facts about Diabetes that we all know.

1) Prevalence of Diabetes in Malaysians aged 30 and above is about 15%.
2) Diabetic Retinopathy (DR) is the COMMONEST complication of diabetes and is the LEADING cause of Blindness among working ADULTS

How does Diabetic Retinopathy cause Blindness?

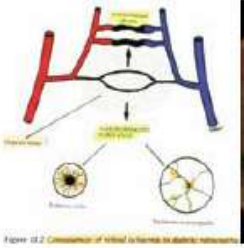
1) LEAKAGE

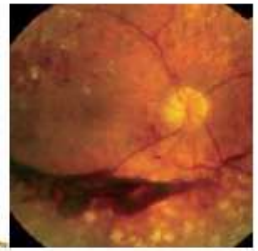


Leakage from blood vessels spread to macula causing macula oedema and resulting in vision loss. Early detection and treatment can prevent macula oedema and vision loss.

2) OCCLUSION

Occlusion of blood vessels causes hypoxia which results in new vessel formation. These new vessels bleed easily resulting in vitreous haemorrhage and blindness. Early detection of new vessels and laser treatment causes regression of new vessels preventing vitreous haemorrhage and blindness





MALAYSIAN STATISICS

Data from the Diabetic Eye Registry of Ministry of Health showed that 36.8% of Diabetic patients had DR and 14.7% had SIGHT THREATENING DR.

What does this mean to us doctors?

It means that if there are 20 diabetics under your care, 7 of them have Diabetic Retinopathy out of which 3 of them have SIGHT THREATENING DR. The question is which 3. How to identify these 3 out of 20 diabetics.

All diabetics should have a retinal examination every year. Early detection and treatment is the best way to prevent Blindness from Diabetic Retinopathy.

Malaysian NHMS(National Health & Morbidity Study) 2006 showed that 55% of patients with diabetes had never undergone eye examination.

Among the 45% who had eye examination previously only 32.8% or 1/3 had their examination in the last year. In summary only 15% Diabetics had their eye examined in 2005.

The 85% who did not have their eyes checked have a high risk of having sight threatening DR and go blind.

My Question is:

"Did Diabetes cause their blindness?"

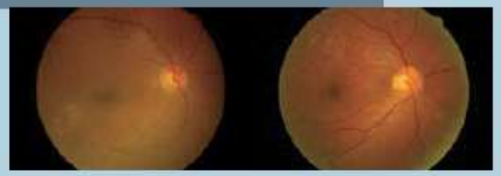
The answer once again is

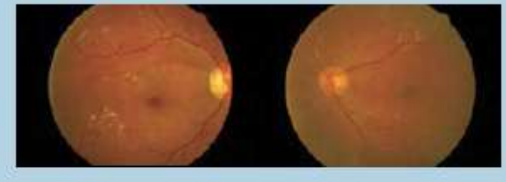
NO - DIABETES DOES NOT CAUSE BLINDNESS.

Diabetes can cause Diabetic Retinopathy.

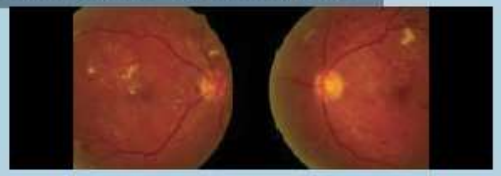
BLINDNESS is caused by FAILURE of the DIABETIC patient to have their YEARLY EYE EXAMINATION. Most Blindness caused by Diabetic Retinopathy is PREVENTABLE by early detection of DR and laser treatment if necessary.

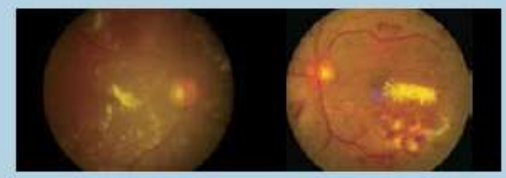
EARLY DETECTION – BEFORE VISION LOSS





LATE DETECTION – AFTER VISION LOSS





With the incidence of Diabetes rising, the number of patients with Sight threatening DR is going to increase and more diabetics are going to go blind. World Sight Day and World Diabetic Day have just gone past. Did we do anything for our patients to save their vision?

What can we do? In Part 2 we identify the problems and will give you tips that you can apply to prevent blindness in your diabetic patients.

PART 2 –

PREVENTING UNNECESSARY BLINDNESS

We have now agreed that Blindness in Diabetics is not caused by diabetes but by failure of regular yearly eye examination.

Why is it that 85 % did not have their eye checked in 2005 and 55% never had their eyes checked. According to Malaysian NHMS the low percentage of patients who had undergone eye examination may be due to:

1. lack of awareness among Health Care Providers regarding the need for diabetic retinopathy screening
2. Non-adherence to the CPG,
3. Patients defaulting on follow-up examinations
4. overcrowding at public health clinics
5. HCPs not being proficient in the use of direct ophthalmoscopes to examine the fundus.

Below(in italics) is my view regarding the NHMS reason

1) *Lack of awareness among Health Care Providers*
   This may be true among the paramedical staff but not the doctors. I believe all our doctors are aware of the need for diabetics to have their eye examination yearly. However there is a NEED to EMPHASIZE on the importance of a YEARLY EYE EXAMINATION. And to ENSURE that diabetic patients under our care have their eye examination.
2) *Non-adherence to the CPG*
   We need to adhere to the CPG – Yearly Eye Examination for ALL Diabetics.
3) *Patients defaulting.- Need to educate more.*
4) *Overcrowding in clinic –good problem for GP. Can afford to employ another doctor.*
5) *Not proficient in Direct ophthalmoscope – Attend Manipal Alumini - Ophthalmology made Easy for GPs Workshop*

Here are a couple of tips that may be helpful.

TIP 1: *Just check your Diabetic patients IC No. Whenever their birthday month just tell them to treat themselves to an eye check up.*

Tip 2: *The longer the Diabetes the higher the risk. Start today – make sure that EVERY Diabetic who has Diabetes for more than 10 years has their EYE EXAMINATION. Mark him HIGH RISK and "HOUND" him to have his eye examination every time you see him. We cannot do this to every Diabetic but for a start let us get the high risk patients. Once finished with this group, target the next batch who have Diabetes for more than 5 years.*

Tip 3: *Ask patient whether any blurring of vision.*
Check patients vision. If vision blur or decreased, advice to see eye specialist (a little late but might still be able to save some sight as we have seen many cases who come in very late)

TIP 4 : *If you can use your direct ophthalmoscope go ahead and dilate both eyes. Don't be afraid. Just ensure there is someone to take him back. Also advice that in the very very very very rare instance that he gets headache and vomiting when he goes home it could be a glaucoma attack and all he needs to do is go to Emergency Dept of any hospital and let them know he had dilatation done. Glaucoma attack can easily be treated especially if they go early.*

These are some simple things that we as doctors can do. Our statistics do not lie. We are just having too many diabetics who have unnecessarily become blind. Some of us are doing whatever needs to be done but what I believe is we all can do that little bit EXTRA. Once again DIABETES DOES NOT CAUSE BLINDNESS if we ENSURE that ALL the Diabetics under our care have their EYE Examination.

With the New Year just around the corner here is a great 2013 New Year Resolution for us:
I AM GOING TO MAKE SURE THAT ALL DIABETIC PATIENTS UNDER MY CARE HAVE THEIR EYE EXAMINED IN 2013.

Wishing all you Manipalites a HAPPY NEW YEAR and let us together make a difference and save the sight of our diabetics.

Levels of Prevention in Cancer

By: Dr D. Jayendran

Cancer is not a single disease but a group of related diseases. Many things in our genes, our lifestyle, and the environment around us may increase or decrease our risk of getting cancer. It is therefore not surprising that at least one-third of all cancer cases are preventable. Prevention offers the most cost-effective long-term strategy for the control of cancer and there are 3 levels at which preventive strategies can be expressed. The natural history of disease is closely linked to the appropriate level of prevention at each stage.

Primary Prevention

Primary prevention encompasses the elimination or reduction of exposure to recognized risk factors in susceptible populations to prevent a disease. Evidence of effective primary prevention measures in reducing cancer rates are, for example, the observed decrease in cases of male lung cancer from a fall in tobacco smoking, or reduced bladder cancer among dye workers after the elimination of aromatic amines' exposures. Primary prevention is an important means to improve public health, and it is by far the most cost-effective and sustainable intervention for reducing the burden of cancer globally. A WHO study found that at least 1.3 million cancer deaths annually could be prevented through healthy working and living environments.

Some primary prevention recommendations in accordance with personal habits and environment include:

- Consuming a low fat diet (no more than 30% of total daily calories) high fiber diet (20-30 grams/day)
- Eating five-nine servings of fruits and vegetables each day.
- Controlling one's calorie intake in order to maintaining or achieving ideal body weight.
- Not using tobacco products.
- Avoiding excessive sun exposure without protective clothing and sun screen.
- Avoiding alcohol or consuming only in moderation. This means no more than 1 drink/day for females and 2 drinks/day for males.
- Avoiding exposure to cancer causing chemicals and materials.
- Using protective clothing during exposure to hazardous substances.
- Checking one's home for cancer causing agents, such as asbestos and radon.
- Practicing safe sex

As such primary cancer prevention encompasses a healthy lifestyle and includes all measures to avoid carcinogen exposure and promote health. The focus of primary prevention is to prevent a cancer from ever developing or to delay the development of a malignancy. For individuals with a particularly high risk of a cancer (such as those with a known genetic predisposition), primary prevention may include the use of chemopreventive agents or prophylactic surgery to prevent or significantly reduce the risk of developing a malignancy.

Secondary Prevention

Secondary prevention refers to the early detection and swift treatment of subclinical, asymptomatic, or early disease in order to to cure disease, slow its progression, or reduce its impact on individuals or communities.The activities involve organized, direct screening efforts or education of the public to promote early case finding of an individual with disease so that prompt intervention can be instituted to halt pathologic processes and limit disability. Before starting on secondary prevention programmes, the available evidence should be analysed to estimate the effectiveness of the proposed activities.

The main aspects of secondary prevention include:

a. **Public education** to promote breast self-examination, use of home kits for detection of occult blood in stool specimens and familiarity with the seven cancer danger signals.
b. **Cancer registries** - hospital based or population based
c. **Early detection - Screening** may include physical examinations, self-examinations, radiologic procedures, laboratory tests, or other examinations. Below are screening tests/examinations available to you. Ask your doctor which tests are appropriate for you and how frequently you should have them performed.

Prostate - Digital rectal exam/ Prostate Specific Antigen (PSA)
Colon - Digital rectal exam/ Stool blood test/ Sigmoidoscopy or colonoscopy
Skin - Skin exam by a health care provider
Oral - Oral exam by dentist
Breast (female) - Breast exam by health care provider/ Mammogram
Cervical - Pelvic exam/ Pap test

Tertiary Prevention

involves monitoring for and preventing recurrence of the originally diagnosed cancer and screening for second primary cancers and long-term effects of treatment in cancer survivors. The focus of this form of prevention is aimed at detecting complications and second cancers in long-term survivors when treatment is most likely to be effective and ultimately improve their quality of life. "Tertiary prevention efforts have demonstrated that it is possible to slow the natural course of some progressive diseases and prevent or delay many of the complications associated with chronic diseases."

Tertiary prevention is conducted primarily by individuals and their health care practitioners (physicians, nurses and allied health professionals).

For people with cancer, tertiary prevention often includes measures to keep the patient comfortable and the disease in remission for as long as possible and in so doing, health care professionals may make use of rehabilitation programs, chronic pain management programs and patient support groups.

A number of factors can influence the effectiveness of a tertiary prevention programme; for instance people are more likely to follow through on personal lifestyle changes if they have been heavily endorsed by their health care providers.

Cancer Chemoprevention in the 21st Century: Genetics, Risk Modeling, and Molecular Targets

The remarkably consistent results of tamoxifen in preventing breast cancer (reduced invasive breastcancer rates by 49%) cover all three basic chemoprevention settings, which include primary prevention of breast cancer in healthy women at high risk for cancer development in the Breast Cancer Prevention Trial (BCPT), secondary prevention of breast cancer in patients with ductal carcinoma in situ (DCIS), and tertiary prevention of contralateral breast cancer in definitively treated breast cancer patients. Tamoxifen in breast cancer and Celecoxib in Colon cancer are the first definitive proof of principle for chemoprevention, and demonstrate that premalignancy can be reversed, and second primary cancers can be prevented through pharmacological means.

The results also provide a strong rationale for the use of mechanistic/molecular-targeting and translational studies in developing new chemopreventive agents. There are on going chemoprevention trials in cancers of the head and neck, lung, esophagus, colon, bladder, prostate, skin, and breast. These are being conducted in the belief that If certain molecular alterations (or panels of alterations) can be linked to cancer development, their reversal could be used as a surrogate end point for cancer prevention, just as the reversal of high cholesterol levels is accepted as a surrogate for heart disease prevention. With advances in molecular genetics, imaging, and novel screening tools, we are optimistic that it will be possible to detect premalignant disease and early-stage cancer in more and more people. We believe that patients diagnosed with premalignancy will become a growing subset of medical oncology practice, and chemopreventive approaches will be an effective therapeutic option for these individuals. Through molecular imaging techniques, it will be possible to identify abnormal clones and target specific agents to suppress or eradicate clones to make a significant impact on cancer prevention. Equally important, genetic polymorphism/ phenotypic marker studies will allow individual risk to be pinpointed in patients who have not yet developed cancer. The use of long-term chemopreventive therapy to delay cancer onset in high-risk patients could offer these individuals many more years of healthy, high quality life. We hope that this type of management will eventually allow cancer risk to be treated and monitored as a chronic disease, as is hyper -cholesteremia in the setting of heart disease.

Economic implications

The present financial crisis will affect cancer prevention through several avenues: personal lifestyle choices, exposure to environmental risk factors, decisions made in the private sector and public policy on cancer prevention. Whilst it is clearly problematic to reach solid conclusions on a direct connection between economic crises and cancer mortality, we can identify trends that provide guidance for further action. For some lifestyle choices such as smoking or diet, we argue that public policy may channel existing tendencies during times of crisis for clear added value. In other areas, including research and health system investments, we will make the case that the resources not used now for cancer prevention efforts will lead to increased costs (both financial and human) down the road. Policy makers face a clear choice: they can follow a cost contention strategy, which may reduce expenditure in the short-term only to increase it in the long-term, or they can use the financial crisis as an opportunity to make difficult choices in terms of health service rationalisation, whilst at the same time strengthening evidence-based prevention policies. In short, we argue that despite the scarcity of funds and the governmental priorities on economic recovery, cancer prevention is more relevant now than ever.

26th MAAM Convention @ PENANG

Penang has always been a beautiful island for rest, relaxation and convention. It was the Merdeka weekend, but we went ahead anyway and organized the 26th MAAM Convention.... the theme was Take it Easy. I have always liked the idea of a Hawaiian Luau Party, so my informal theme was decided. Nirmal gave me a free hand in organizing the event so with a strong and supportive committee behind me, I set out to work.

For those who attended, you can skip to the next article, for those who could not attend, all I can say is that you missed a great convention. We had a 3 day 2 nights Convention as usual, but had our CPD on Friday afternoon, there were a lot of free gifts and Lucky draws. The Ipad 3 for the Friday's session went to Dr. Nesa Mani.

The kids had a great time, all the gadgets and games kept them busy till late evening.

We started the Luau Party by 5pm, the Hawaiian dancers kept the crowd entertained till sunset, the ambience just kept getting better as night fell.... you had to be there to understand what I'm trying to put into words. We decided to have a transparent canopy this year and that simply added to the ambience. The night started with our Hawaiian dancers giving us a wonderful performance followed by some amazing fire dancers. We had a lovely spread of food, the hotel out did itself..... thank you Bayview. Supernova took over after dinner and rocked the night away.

Saturday morning was light, the ladies had a lingerie sale and the children had a telematch. We started the day with a Lunch symposium by Roche and a property talk by Property crown. Again there were lots of free gifts and luck draw. The 2nd ipad was snatched by Mr. Arasu and the Golf sets were auctioned off to Dr. Jayendran and Mr. Arasu.

After lunch a good lunch we opened the Hospitality suite on the beach, the kids enjoyed kite flying and some water games, the adults played futsal and the rest just lazed about under the canopies sipping a cold beer. As the sun set, everyone started getting ready for the Pre cocktails and the Gala dinner.

The foyer of the Grand ballroom was filled by Manipalites in their best, Hamid Khan entertained us with some lovely instrumental music. We were graced by the presence of the honorable Chief Minister of Penang, YB Lim Guan Eng. After our opening video presentation, our President Dr. Nirmal Singh gave his opening address; The Chief Minister gave an excellent speech. Dinner was served with entertainment by Touch Mahal Acoustica. The Chief Minister had to leave by 9.00pm but only did so much later as everyone wanted a photo with him. Please contact me if you want a copy of your photo @ poliklinikroshan@gmail.com.

After dinner we were entertained by Andrew Netto, by this time the children had finished their Disco night party and had joined us in the Grand ballroom, my kids were in stitches with Andrew's jokes. The night was getting livelier now. Touch Mahal Acoustica came back for their 2nd set. This year I wanted to start the dance with live music and the Shasha knew how to entertain the crowd. In fact they were so good that they played till 1.30am, my poor DJ didn't even get a chance to spin.

Supper was served at the foyer and the party continued on long after the music stopped. Eventually the crowd slowly thinned out, a few went straight for the Sunday morning breakfast.

On behalf of the MAAM committee, I would like to thank each and every member that joined us to make the 26th Convention a great success.

Thank you Manipalites... See you soon

Roshan
(Vice President & Organising Chairman)

Photo Gallery

Preliminary Announcement

1ST INTERNATIONAL MANIPAL ALUMNI HEALTH SCIENCES CONVENTION 2014

In conjunction with
28th Manipal Reunion

DATE: 7th to 10th of August, 2014

SUPPORTED BY
Manipal Melaka Medical College

Overall Event at a glance

DAY	EVENT	VENUE	INVOLVES
Thursday 7th Aug, 2014	Scientific Convention	Hotel ballroom	All registered delegates
Friday 8th Aug, 2014 Am to pm	Scientific Convention continues Evening night out in respective batches from Manipal	Same	All Registered delegates
Night		Various venues	All Manipal Alumni delegates
Saturday 9th Aug, 2014	Alumni and family games eg: cricket, futsal, tennis, squash, netball etc…	TBA	All Manipal Alumni & families
Am to pm			
Night	Gala Dinner	Hotel	All Manipal Alumni & families
Sunday 10th Aug, 2014	Breakfast and goodbyes	Hotel	Manipal Alumni & families

For more information please visit our website at: **www.manipal.org.my**

Oral Cancer

"The visible aero digestive tract cancer"

By: Dr M.Thomas Abraham, Consultant Maxillofacial and Oral Surgeon
Hospital Tengku Ampuan Rahimah Klang, President, Malaysian Association of Oral & Maxillofacial Surgeons

The term "Oral Cancer" has been used to describe any malignancy that arises from the oral tissues. Squamous cell carcinoma is the most common variety and it accounts for about 90- 95% of oral malignancies

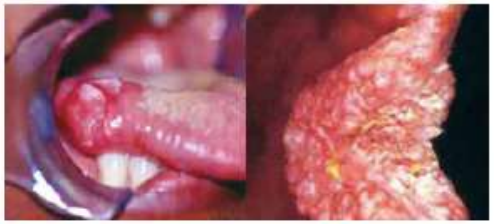
Oral Cancer is the 6th commonest form of cancer in the world. It accounts for half a million new cases diagnosed every year, and about quarter of a million deaths every year..

In any cancer the prognosis of the disease is measured in terms of 5 year survival rates, the 5 year survival rates for oral cancer is less than 50% and this figure has more or less remained static over the last three decades. The 5 year survival rates reported for oral cancer is poorer than colorectal , breast and cervix cancers. The reason for the poor prognosis has been attributed to :

a) Advanced stage of the disease when the diagnosis is made
b) Distant metastasis of the disease
c) Poor response to chemotherapy.

However at the same time we wish to highlight that the disease if diagnosed and treated early, the 5 year survival rate is over 80 %. It is important that we need to understand the reasons why oral cancer is been diagnosed late. To understand this it is important to recognize the varied presentations of oral cancers, It can present as a

a) Exophytic growth
b) Ulcerative or infiltrative growth.



Picture 1
Showing Cancer of the Tongue

Picture 2
Showing Cancer of the Corner of the mouth

The question then we need to ask ourselves is **Why are oral cancers being diagnosed late?**

Oral cavity due to its location is the most easily accessible part of the body and hence oral cancers logically can be detected at early stage without the need for any costly diagnostic aids and yet in the majority of cases, the diagnosis are made late. To give you an example 80% of the cases that we see in our hospitals are usually in stage 3 or stage 4. We all have experienced mouth ulcers at some time or the other and we all know how painful these ulcers can be. Those who had these ulcers know the pain they experience, when eating, speaking or swallowing etc. Because they are painful you seek medical treatment almost immediately. Unfortunately the cancerous or malignant ulcers in the early stages are painless or asymptomatic, and hence the delay in seeking medical help. It is evident from our interaction with the patients we see, when we ask them as to the reason for seeking medical treatment so late and the common reply we get is 'If it is not painful or asymptomatic then why do you need to go and see the doctor'. The other common reason is being ignorance. It is worrying that there are some professionals who have tertiary education are also ignorant about mouth cancers.

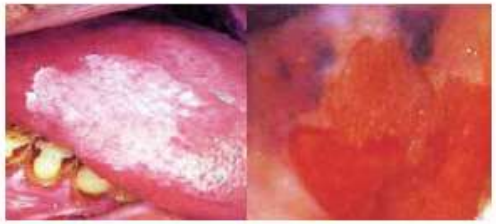
Warning signs to look for?

1. **Any ulcer or a lump which does not heal in two weeks.**

Those of us who have experienced mouth ulcers know that these ulcers usually heal within 10- 14 days. Hence it is important that we send the right message. Any ulcer which does not heal needs to be seen by a health care practitioner and a biopsy needs to be done to confirm the diagnosis.

2. **Lump or thickening of the oral soft tissues**
3. **Difficulty in chewing swallowing or eating**
4. **Difficulty in moving the jaw or tongue**
5. **Numbness of the tongue, lips or mouth**
6. **Radiating pain especially to the ear.**

Look for additional a warning signs like :



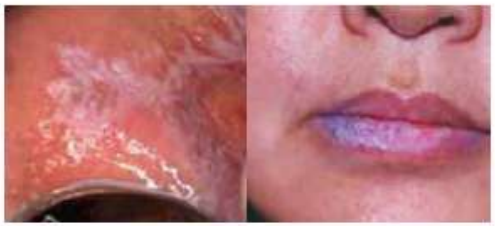
Picture 3
Showing Leukoplakia

Picture 4
Showing Erythroplakia

Leukoplakia – It means a white patch, as the name suggests it is a predominantly a white lesion of the oral mucosa that cannot be characterized as any other definable lesions. These lesions have a higher incidence of malignant transformations

Erythroplakia – This term is used to describe the lesion of the oral mucosa that present as red areas. These lesions have a highest potential for malignant transformation

Lichen Planus – This lesion has a white and red forms and they can exhibit different patterns which can appear as a lacy pattern or as a raised plaque or can have areas with in this pattern which is ulcerative and it is this variety carries the risk of turning into a cancerous growth.



Picture 5 & 6 showing Lichen Planus of the cheeks and lips

Oral submucous Fibrosis – They can affect any part of the oral mucosa characterized by mucosal rigidity and the normal feel of the pliable soft mucosal feeling is lost, this is clinically manifested by the patient as having difficulty in opening of the mouth

Are there any Risk Factors

These risk factors can be broadly classified into two:

Environmental : Betel quid use
Tobacco use
Alcohol use
Excessive exposure to sunlight in fair skinned people
Fungal and viral infections (Human Papilloma virus , Candia albicans)

Genetic : High risk population
Younger age groups
In individuals with a family history of mouth cancers

Other Contributing factors:

Age: Commonly occurs in the 4th to 6th decade of life, with the highest prevalence in the 6th decade of life

Gender: More commonly in men than women depending upon the extent of and the type of tobacco habits prevalent among them. But in the Malaysian scenario it is higher among the Indian women

Race / Ethincity: In the Malaysian scenario this is very obvious with more than 60% of the cases occurring in the Indian population followed by the other races. Cultural, Social and religious traditions is a very important contributing factors. For example The Malays who are predominantly Muslims do not take alcohol while they chew Betel quid and use tobacco. On the other hand the Chinese use Tobacco and alcohol, culturally, but do not use Betel quid, while the Indian use all the three, this explains why there is such a vast difference in the incidence among the Indian population followed by other indigenous groups such as Orang Asli, Dusuns, Kadazans etc.

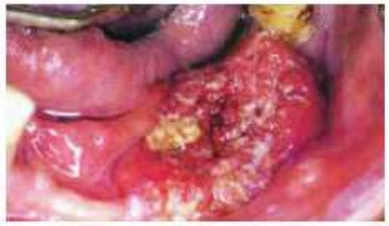
Race	Incidence
Indians	60%
Malays	10%
Chinese	10%
Others	20%

includes Orang Asli, Dusuns, Kadazans, etc.

Graph showing incidence of oral cancers among the different races in Malaysia

Diet: Scientific studies have shown that in a population with a diet rich in fresh fruits and vegetables and olive oil and curcumin (Turmeric) can lower the incidence in cancers. This is very evident from the studies emerging from the East European block of countries like Romania, Hungary Czechoslovakia etc. These East European countries over the last two decades have showed an increasing trend in the incidence of oral cancers while their counterparts in the Mediterranean countries have shown a decreasing trend. The only explanation to this trend is that the Mediterranean countries used a diet rich in Fresh fruits and vegetables with olive oil while the East European countries lacked this in their diet

What does oral Cancer look like?



Picture 7 Showing cancer of the jaws

It can present as an ulcer or as an exophytic growth, and can occur anywhere in the oral mucosa, which is not painful initially. It is usually occurs as single deep ulcer which does not heal even after two weeks, which bleeds on touch, with indurated or hard margins and the edges are usually raised. It is commonly associated with swollen lymph nodes

Oral cancer is conventionally treated by Surgery, Radiotherapy or chemotherapy or in a combination of the above three methods, it all depends upon the stage of the disease and the extent of spread of the disease and distant metastasis. Surgery and radiotherapy is usually the preferred choice of treatment, while chemotherapy is less effective in Oral cancers.But with the advent of newer Chemotherapeutic drugs, some of the lesions are showing good response to chemotherapeutic agent. The decision to treat by one or all the three methods depends upon the patients medical condition and the ability to withstand the treatment and the decision whether they are planning for a curative or palliative outcome.

In any form of cancer the outcome is usually stated as a 5 year survival rate. The 5 year survival rate for oral cancer is 80% in the early stages and in localized disease. Once the disease or cancer has spread to the lymph glands in the neck region, this 5 year survival rate drastically decreases to 40% and the 5 year survival becomes less than 20% once the disease has spread to other organs or what we call as metastasis of the disease. So it is very important that these lesions are picked up early and treated appropriately for better out comes or prognosis of the disease.

Like any other cancer there is a lot of research is being carried out globally as well as in Malaysia. The Oral Cancer Research coordinating Centre (OCRCC) and the Cancer Research Initiative Foundation (CARIF) are currently carrying out numerous researches in this field. Some of the work has been directed towards identifying tumor markers in oral cancer. By identifying the tumor markers in oral cancer it opens up a whole new phase in identifying the prognosis and managing the disease.

Like any other cancer there are a few things one can do to prevent the disease. First of all abstaining from the risk factors which was mentioned earlier like Betel quid. Tobacco, alcohol etc can play a big role in preventing the disease. The second thing one can do is **"Mouth Self Examination"** We normally take a minute or two to brush our teeth on a daily basis, but we would like to suggest that at least once in a fortnight take an additional two minutes to stand in front of the mirror and have a proper look in your mouth. Look for any lumps or bumps in the mouth, any ulcer or break in the continuity of the mucosa. Also look for any change in colour of the mucosa like a white patch or red patch or any white patterns. Seek medical treatment for any ulcer which has not healed with in two weeks

There are approximately 7 steps to systematically examine your mouth

1. Look at the lips with your mouth open and closed positions
2. Look at the inner aspect of your upper and lower lips by pulling your lips outwards
3. Look on the inner aspect of your cheeks on both sides
4. Examine the roof of your mouth including the soft palate
5. Protrude your tongue and take a look on the surface of the tongue and also on both the sides of the tongue
6. Lift your tongue up and look on the under surface of the tongue and on the inner aspect of your teeth
7. Feel for any swollen glands with in the Head and neck region

Lastly maintain a good oral hygiene and visit your dentist every six months ideally or at least once a year.

The Oral Health division of the Ministry of Health conducts out reach screening camps either individually or in conjunction with other NGO's , take time to visit one of these camps and get your mouth looked into to allay your fears. You can also visit your Dental health care practitioner s and they would be able to make appropriate specialist referrals.

To conclude if there is one message we wish to leave it is seek professional help if you have noticed any lump or an ulcer which has not healed with in two weeks. Remember that an if you seek professional help early, it will help in early diagnosis and early management of the problem which gives a better out come.

This article appeared in Star on the 25th of Novemebr 2012 in the column "Fit for Life"

Lastly is there anything I can do to prevent the disease?

Like any other cancer there are a few things one can do to prevent the disease. First of all abstaining from the risk factors as mentioned earlier like Betel quid. Tobacco, alcohol etc can play a big role in preventing the disease. The second thing one can do is "Mouth Self Examination" We normally take a minute to brush our teeth on a daily basis, but we would like to suggest that at least once a week take additional two minutes to stand in front of the mirror and have a proper look in your mouth. Look for any lumps or bumps in the mouth, any ulcer or break in continuity of the mucosa. Also look for any change in colour of the mucosa like a white patch or red patch or any white patterns. Seek medical treatment for any ulcer which has not healed with in two weeks.

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Legal Rules Relevant
To a Claim Based On Clinical Negligence

"In the airline industry, the evidence…. from scheduled airlines is the risk of death is one in 10 million. If you go into a hospital in the developed world, the risk of death from medical error is one in 300".[1]

Medical errors are and were common in the past. However, 20 years ago who would have thought of suing a doctor considering the high esteem in which they were held. The prevailing attitude of society has gradually changed and it is not uncommon now to find more and more claims brought against doctors for clinical negligence.

In a clinical negligence claim, the claimant has to overcome four hurdles for a successful claim. These include:

1. Duty of care
2. Breach of that duty of care (also referred to as standard of care)
3. Causation i.e. the link between breach and damage
4. Foreseeable damage.

The onus of proof is on the claimant and the standard of proof is on the balance of probabilities.[2]

1) Duty of care.

To bring clinical negligence claim, the claimant must first establish that a duty of care was owed to him by the defendant. The question that need to be answered will be, who owes the duty, when does the duty arise, what is the extend of the duty and is there one or more duties? The duty is owed by the health carer and or the health carer's employer. In English law there is only one duty but for simplicity it is divided into separate components e.g. the duty to diagnose, the duty to provide information (as defined by Bolam v Friern H CC)[3] and the duty to provide post-operative care etc. The duty will begin when treatment begins and will end when the treatment is completed or when the patient or the health carer dies. Defining when the duty begins is easy but defining when the treatment (and the duty ends) can be problematic.[4] Who owes the duty? The duty is owed by all persons involved in the care of the patient (doctors, nurses, physiotherapist etc.). Inexperience has no bearing on the nature of duty (inexperience is no defence).[5] Can a duty be owed to a third party? In English law the proposition is that A cannot be liable for harm caused by B to C except in very exceptional circumstances.[7] However in American law a doctor owes a duty to a third party in respect of the activities of his patient.[7]

2) Standard of Care

The second link in the clinical negligence claim is to show that the defendant's action fell below the standard of care expected of the particular health carer. In determining this question the courts apply the 'Bolam test' which originated from the case of Bolam v Friern where McNair J said:

> "The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established in law that it is sufficient if he exercises the ordinary skill of an ordinary man exercising that particular art"

It is an objective test – it is what a reasonable and responsible group of health carers with similar skill to the defendant would or would not have done. The standard remains constant no matter what the treatment and inexperience is no defence. The Bolam test demands that the doctor comply with all accepted medical practice and this practice must be current. How current will depend on the length of time the knowledge has been available and there is no absolute rule.

One area where the Bolam test has caused the most consternation is in relation to disclosure of risks. It has been argued that the patient should be told all the risks associated with the procedure and not just what the medical professional thinks the patient should know. The Australian courts have rejected Bolam in this area. The courts stand is that the patient should be told everything when he needs to make an informed choice about his treatment. In Roger v Whittaker[6] the Australian High Court found the defendants' were in breach of their duty of care for failing to disclose a 1/14,000 risk to the claimant, whereas the English court in Sidaway v Board of Governors of Bethlehem

Hospital[9] was not prepared to do the same where the risk was 1-2 %.

In 1997 the House of Lords in Bolitho v City and Hackney H.A[10] took an opportunity to re-explain the Bolam rule. The Lords commented that it was not enough to glibly rely on medical opinion and that the opinion itself must have a 'logical basis'. In Bolitho the area of risk disclosure was omitted in the judgement. However in Pearce v United Bristol Healthcare NHS Trust,[11] Lord Woolf said that 'where there is what can realistically be called a "significant risk", then in ordinary event... the patient is entitled to be informed of the risk'.

In 2008 the English courts further extended the doctors duty and standard of care in the area of risk disclosure. In Birch v University London Hospital NHS Trust[12] the court found neurosurgeons and neuroradiologists liable for not discussing alternative treatments with the claimant prior to taking consent. Had they done so the claimant would have declined catheter angiography and so avoided a stroke. Failure to adhere to clinical guidelines by National Bodies can also result in a verdict against the doctor.[13]

3) Causation

The most difficult obstacle for the claimant in a successful clinical negligence claim is to show that the defendant's lack of care caused his injuries. The claimant must proof this on a balance of probabilities and it cannot be assumed. Causation is usually proven by the "But For" test. The claimant says that but for the defendant's negligence he would not have suffered damage. This will be true if there is only one cause of the injury (i.e. the defendant's breach). However in clinical negligence cases there are often more than one cause of the damage.

In Gracia v East Lancashire Hospital NHS Trust[14] the claimant failed to proof that a breach of standard of care i.e. a delay in the delivery of the baby caused cerebral injury in the baby. It was shown in this case that the cerebral hypoxia caused by the delay in delivery was not the cause of cerebral injury but the cerebral injury was due to embolization which was not caused by the breach of standard of care.

In Barnett v Chelsea & Kensington Hospital Management Committee[15] there was a breach of duty in not attending to a patient with arsenic poisoning but the claimant failed to recover for damages. The court held that the patient would have died even if there was no breach of duty and that the breach was not the cause of the death.

Where there is more than one possible cause of damage but only one of which is the defendant's negligence then it sufficient for the claimant to show that the defendants conduct materially contributed to the damage[16] or that the negligent act materially increased the risk of damage.[17]

English law does not allow a loss of chance claim in medical negligence. In Hotson v East Berkshire H.A,[18] the health authority admitted negligence in delaying a diagnosis of a traumatic slipped femoral epiphysis and the claimant developed avascular necrosis of the femoral head (AVN). The claimant failed to claim for damages because AVN would have a 75% chance of developing from the fall anyway. Here the delay in diagnosis and treatment had not materially contributed to the developing AVN on the balance of probabilities (51/49). The final word on the subject of loss of chance was uttered in Gregg v Scott,[19] where the House of Lords did not allow the claimant to recover for damages from a delay in diagnosis of Non Hodgkin lymphoma, because on the balance of probabilities his chance of cure even if diagnosed early was less than 50%.

The English courts do not generally accept the doctrine of Res ipsa loquitur (Latin for 'the thing or situation speaks for itself') in clinical negligence cases. It would probably be appropriate in a situation where the patient is unconscious in the operation theatre and had no idea of events that took place to be able to prove causation. In such cases the onus would be on the defendant to explain why the damage occurred. If the defendant is unable to give a reasonable explanation he would be liable. Simple clear examples would be leaving swabs in the body or amputating the wrong limb. Such cases usually don't reach the courts and are settle anyway.

Departure from the traditional principles of causations has in recent years become common in cases of non-disclosure of risk. In Chester v Afshar[20] the claimant alleged that the defendant had negligently failed to inform her of a 0.9 to 2 % risk developing nerve root injury following a three level discectomy. Although the non-disclosure did not cause the damage which could have occurred anyway, the House of Lords found in favour of the claimant. In an Australian case of Chappal v Hart[21] the court found in favour of the claimant and it was sufficient for the claimant to say that she would not had the operation that day had she been properly advised of the risk of surgery. Although Chester did not establish a general causation rule, it is obvious that causation has been modified on policy grounds to afford remedy on grounds of justice. Current law as it stands requires that the health carer needs to advise the patient on all possible risks involved, so that the patient can make an informed decision about his treatment.

4) Damage

The last link in a clinical negligence claim is to show that the defendant's lack of care has injured the claimant and consequently he has sustained some form of damage. There is a need to identify the different heads of damage and the compensation to be awarded. This area of medical law will be of interest to the practicing lawyer and I will skip it for the sake of brevity.

Conclusion

I have briefly outlined the current legal rules that are relevant to a claim based in clinical negligence in English law. I am not familiar with Malaysian law but I gather that the legal rules are very similar. I am sure that this short article will give you sufficient information to help you in avoiding pitfalls in your practise. Generally it is essential for us to develop rapport with our patients for which good communication is necessary. Language is often a problem when we have to explain technical terms to our patients. There is no substitute for a good history and physical examination which must be clearly recorded in the patients file. We often see that the GP's do a better job of this than the specialist. Investigation such as MRI can't help us make a diagnosis without a proper history and examination. It is also pertinent that we do not record physical findings that do not exist just to fit them into the MRI diagnosis. This deceit can easily be picked up during record review by the expert witness. The need to spend more time with the patient when taking consent for elective surgery cannot be overemphasised. Introducing a system to address patient grievances in our practise and in the hospital where we work will go a long way in reducing litigations. When we are asked to prepare a medical report addressing grievances it is wise to make them short and factual and not give opinions especially when litigation is anticipated. Leave this to the expert witness who will be in a better position to do so. Last but not least we need to stay current especially for those of us who are in private practise. Knowledge is only click away.

Dr K S Dhillon
Orthopaedic Surgeon
Shah Alam, Selangor.

PS. This article is only for use for the Manipal Alumni Bulletin.

1. Sir Liam Donaldson speaking for the World Health Organization.
2. In criminal proceeding the standard of proof higher. It is proof beyond reasonable doubt.
3. Bolam v Friern H CC [1957] 2 ALL Er 118.
4. For example, does the GP's duty ends when he refers the patient to a consultant.
5. Wilsher v Essex AHA [1986] 3 ALL 801.
6. Home Office v Dosset Yacth [1970] 2 ALL ER 294.
7. Tarasoff v Regents of the university of California (1976) 551 P2d 334.Here a psychotherapist was held to owe a duty for his patient killing someone, where the patient had confided his intention to the therapist.
8. Roger v Whittaker (1993) 4 Med L R 79.
9. Sidaway v Board of Governors of Bethlehem Hospital [1984] 1 ALL ER 1018.
10. Bolitho v City and Hackney H.A [1997] 4 All 771.
11. Pearce v United Bristol Healthcare NHS Trust [1999] 48BMLR 118.
12. Birch v University London Hospital NHS Trust [2008] EWHE 2237.
13. Martin Adshead v Dr Sarah Tottle (unreported) (2008).
14. Gracia v East Lancashire Hospital NHS Trust [2006] EWHC 2060.
15. Barnett v Chelsea & Kensington Hospital Management Committee [1969] 1 QB 428.
16. Bonnington Casting Ltd v Wardlaw [1956] 1 All ER 615.
17. MaGhee v N.C.B [1972] 3 All 1008.
18. Hotson v East Berkshire H.A [1987] 2 All ER 90.
19. Gregg v Scott [2005] UHKL 2.
20. Chester v Afshar [2004] UHKL 41.

Dear All,

Below are the details of the meeting with the Penang State Govt today for the committee's consideration and decision

Time : 4.30pm
Date : 19/11/12
Venue : Office of YAB Lim Guan Eng

Present

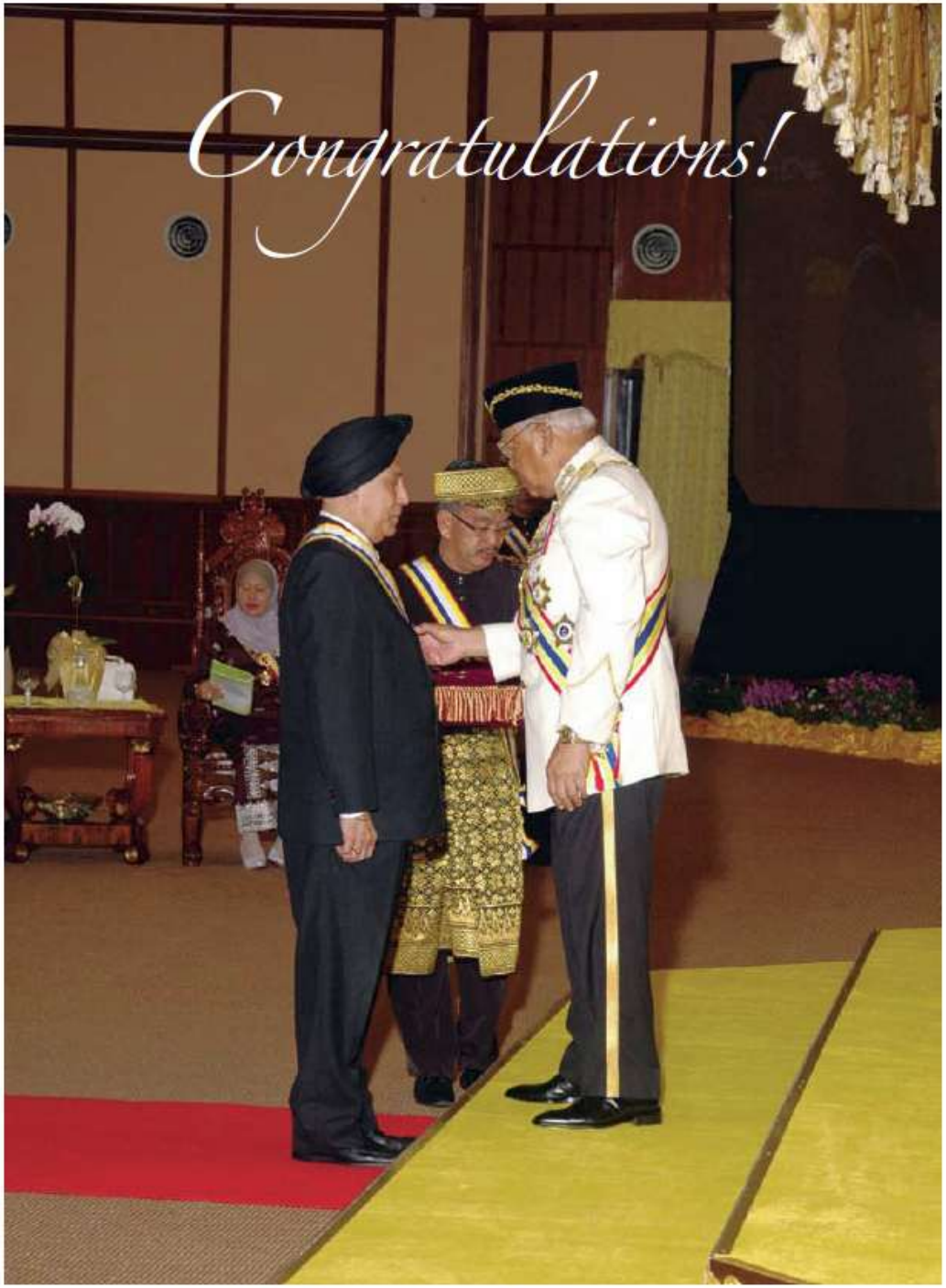
1. YB Phee Boon Poh, Penang State Exco in Charge of Health and Welfare
2. Mr. Theng Kah Nyean, Special Assistant to YB Jeff Ooi
3. Ms. Annie Choo, representative from House of Hope, Penang
4. Dr. Sham Kumar

I presented the proposal as per letter to YAB Lim Guan Eng from Dr. Nirmal and also shared information regarding Kampung Aman and work being done. I also highlighted that there is an exploratory meeting with Dr. Jeyakumar scheduled on the 9th of December. I voiced our concern that we needed to work with a genuine community of needy people to foster a long term relationship without any abuse from any party be it partners or patients who were not really needy. In response to this YB Phee requested us to work with the House of Hope and to adopt the community of families at the Rifle Range flats in Air Itam which represents a hardcore urban poor community of approximately 2000 families or approximately 4000 people. At the present the House of Hope is working with the State Govt to deliver monetary and food aid to the distressed in the area and there is a genuine need for medical back up. Currently there are a few doctors visiting fortnightly to examine and refer patients to the GH. He has requested Manipal Alumni to consider this community as a start and to see if we could garner the support of other organisations/NGOs and pharmaceutical companies to set up formal clinics, pharmacies and other services. He also hoped that based on this we could spearhead a system to expand our services into other poor communities in the state as a lead runner.

I responded by saying that it was a viable proposal but we would like to start off in a small way by firstly holding monthly clinics and then based on response and support to extend to fortnightly or weekly. This was also based on funding and pharma support. In the meantime I will liaise with Ms. Annie Choo to visit the area and give further feedback to the central committee. I was given to understand that the have a basic setup of community hall, office and helpers at the flats and that they can identify other facilities to move forward with registration and clinic space.

Meeting ended at 5.30pm.

Regards
Dr. ShamKumar



Datuk Dr. Jagjit Singh Hullon receiving the Darjah Pangkuan Seri Melaka (DPSM) award from the Governor of Malacca on 13/10/2012

Our President with the MMMC Student Council members

Dr. Jaspal, Dr. Rishya and Dr. Nirmal at the MMMC Post-Grad Fair 2012

MIMS Mobile (Malaysia)

Drug information on-the-go

The new MIMS Mobile (Malaysia) is comprehensive and easy-to-use app that allows doctors to search the extensive MIMS drug information databases anytime, anywhere, even if you are not connected to the internet.

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The MIMS Mobile (Malaysia) iPhone/iPod app advances MIMS' ongoing mission to empower physicians at every point of care. In collaboration with the Manipal Alumni Association Malaysia (MAAM), the app will be made available to all Alumni members at a special discount rate of RM50 for 1 year subscription, instead of RM300 for non-Alumni members.

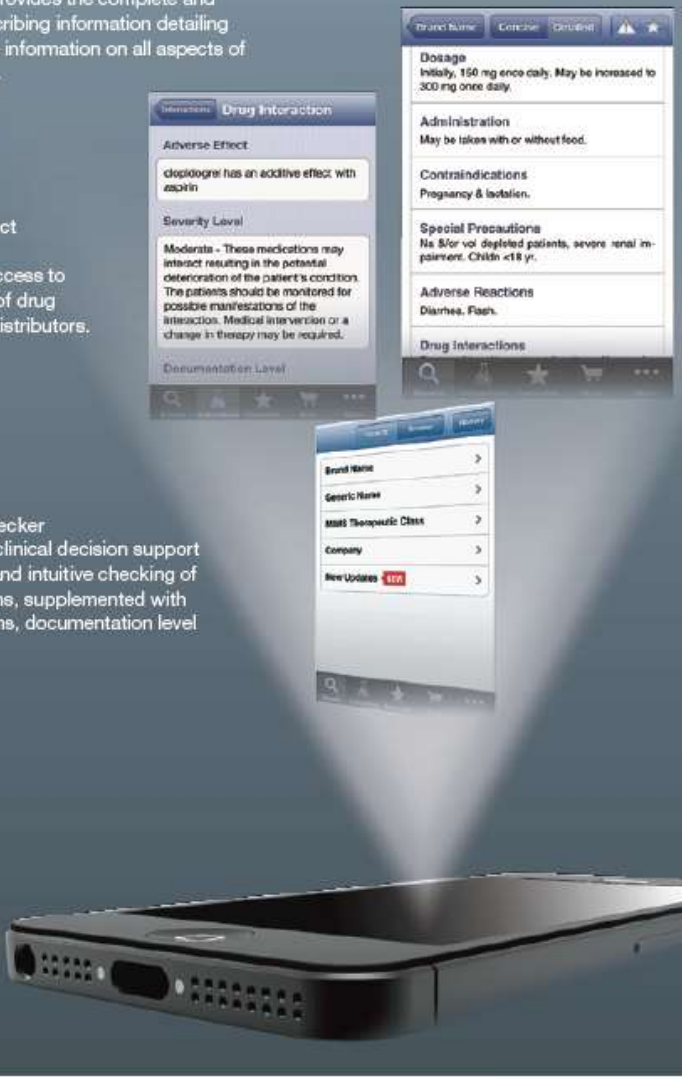
Some of the features are:

Concise Prescribing Information
Delivers concise summaries of key prescribing information to allow quick on-the-go referencing of drug indications, dosage, safety precautions, contraindications and packing information.

Detailed Prescribing Information
MIMS Mobile provides the complete and approved prescribing information detailing comprehensive information on all aspects of the medication.

Manufacturer Contact Information
Allows convenient access to contact information of drug manufacturers and distributors.

Drug Interaction Checker
An evidence-based clinical decision support tool enabling quick and intuitive checking of drug-drug interactions, supplemented with recommended actions, documentation level and references.



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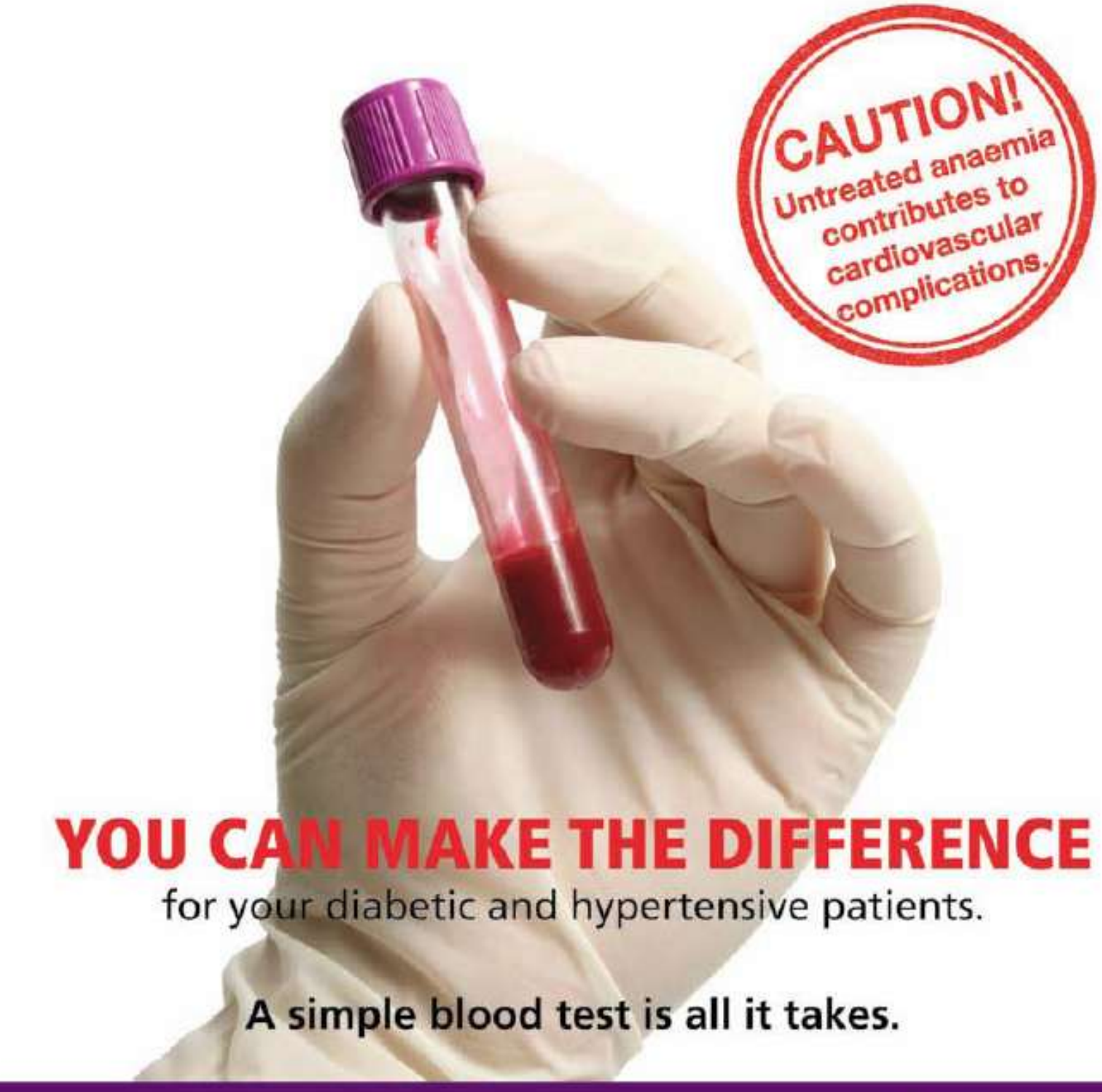

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