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Obstetrical and Gynaecological Society of Malaysia

2019/2020 Council Issue 4

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COVID-19 : The Effects of a Pandemic on Obstetric and Gynaecological Practice and Solutions for the Future

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A publication by the Obstetrical and Gynaecological Society of Malaysia

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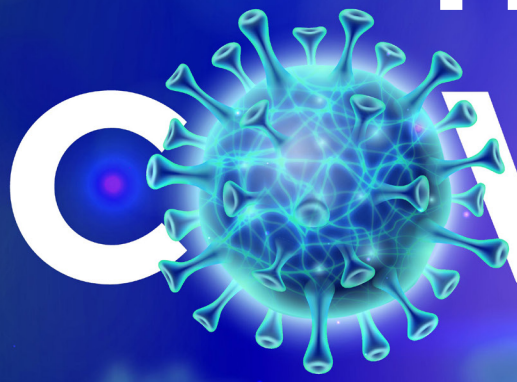
The COVID-19 Paradigm Shift Effect



Paradigm shift, a concept identified by the American physicist and philosopher Thomas Kuhn in his influential book The Structure of Scientific Revolutions in 1962, is used to describe a fundamental change in the basic concepts and experimental practices of a scientific discipline. It is probably one of the most overused phrase in medicine. Yet, the coronavirus pandemic may be one case where it applies succinctly.

The coronavirus does not just attack the respiratory system. Like the great tragedies in the history of the world such as the Spanish Flu epidemic in 1918, Great Depression and World War II, it has the potential to fundamentally transform the foundations of free society and the world we live in. The final impact of this pandemic in terms of human lives lost, directly or indirectly, the cost of a prolonged world economic recession or another potentially devastating depression like in the 1930s, and how every facet of life as we know it may change in the foreseeable future, are still unfolding and yet to be fully realised.

On an individual level, this pandemic has fundamentally changed the way we behave, socialise, communicate, eat, work and live. We now know that touching, crowded places or being close to other people and breathing the air in an enclosed space can be risky. Not wearing a mask in public may leave us feeling vulnerable. How quickly that awareness recedes may vary for different people, but it is unlikely to vanish completely for those who lived through this. We might all find that we cannot stop washing our hands.

Probably one of the most visible paradigm shift is in our healthcare delivery. Fundamental obsessives like changes in clinical practices relating to infection control which were far from the norm just a few months ago, has become almost mandatory. Perhaps out of necessity, the traditional-care setting of face to face consultation in close proximity may become less popular and is replaced by remote office visits or video call consultations. Medical insurance providers allowing billing for telemedicine would certainly facilitate the development of this modality. While there may be issues with regards to privacy

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(2019-2020)

and confidentiality, there are certainly containment-related benefits to this shift. Naturally, not all types of consultations can be performed through a video call. Furthermore, healthcare systems must surely undergo changes to be able to manage future pandemics better.

The coronavirus pandemic certainly affected almost everyone and everything one way or another, and our society is not naturally immune. It is certainly not business as usual at the OGSM office. The office staff have been working from home since the MCO began on the 18th of March and only recently started to operate from the office through a rota once the CMCO was announced on the 1st of May. Almost all activities in our usually packed educational calendar have practically grinded to a halt. We are still retaining some hope that MOM Scientific Congress 2020, which has been rescheduled to the 6th till the 8th of November, can still be held in the traditional way albeit with smaller number of participants and some modifications to reduce the risk of infection. The Council will closely monitor the development in the country and would only proceed if it is considered safe and when the Ministry of Health allows conferences to proceed. We are aware that mass gatherings may not be allowed anytime soon, possibly not until an effective vaccine is widely available, which by best estimate would be in 12-18 months.

Arguably, the biggest impact this pandemic has on society is the postponement of the 28th International Congress of the Obstetrical and Gynaecological Society of Malaysia which was planned on the 24th until the 26th of July, 2020. A cancellation of this year's Congress looks imminent, but the Council is hopeful that the 2021 OGSM Congress will be able to proceed, but in which format remains unclear. Apparently, the AOFOG Congress 2021 scheduled in March 2021 in Bali has also been postponed to the 23rd until the 26th of May 2022.

On the critical question of when and how to hold the OGSM AGM, which has traditionally been held in conjunction with the Congress, still remains unclear. The Council has officially written to the Registrar of Societies (ROS) requesting for an extension but at the time of writing this article, we have yet to receive a response or any guideline on how to proceed. The Council is currently exploring the possibility of conducting a virtual AGM, especially if the response from ROS is not forthcoming.

Facing these set of evolving unique and unprecedented challenges, the Council is actively looking at various options in trying to maintain the financial sustainability of the society by finding new sources of revenue, prudent spending and cost containment. At the same time, it's still trying to maintain the welfare of our valuable employees, and perhaps more importantly, staying relevant to our members and continue to strive to achieve our goals and objectives.

One example of continuing to remain relevant is illustrated by the ICOE Steering Committee who have been actively organising Facebook Live Broadcasts regularly in the past several weeks. I envisage this would be the new way for the society and various OGSM subcommittees to connect with our members, at least for the foreseeable future until some form of normalcy returns. The Council is also currently exploring the feasibility of organising virtual scientific conferences or congresses to deliver scientific updates.

The coronavirus pandemic has not run its course and will undoubtedly cause more significant disruptions, pain and suffering. It may force us to reflect and reconsider who we are and what we value, and perhaps in the process, rediscover the better version of ourselves and in the way we do things. However, I am confident the human spirit as well as OGSM will eventually prevail through these difficult times.

Any article relating to the battle against coronavirus would not be complete without acknowledging those in the frontlines. They are not conscripts, mercenaries or enlisted men and women; they are doctors, nurses, pharmacists, caregivers and utility workers, among others. The nation should recognise their sacrifices as true patriotism, saluting our doctors and nurses like they do a national hero. Kudos to our fellow brothers and sisters in the frontlines, hopefully they stay safe and receive all the accolades that they thoroughly deserve.

I would like to take this opportunity to wish all our Muslim members and their families "Selamat Hari Raya Aidilfitri! Dengan ingatan tulus ikhlas, maaf zahir batin".

Thank you and stay safe everyone!

Going Far Beyond the Call of Duty

Dr Hyzan Mohd Yusof a Consultant Orthopedic Surgeon is in the forefront of this very valiant endeavor. Dr. Eeson spoke to him recently to get a first hand account of what the real situation is.

From the twenty-sixth floor balcony, the unobstructed view of the distant horizon was truly majestic. The twin towers and their two new contenders are truly a sight to behold. Heavy dark clouds hung over the city just beyond, with obvious bolts of lightning to be seen. Thunder, however, was too distant to be heard. Despite the obvious, I still hoped the dark clouds would somehow get blown in a different direction. But they did not.

The Covid pandemic's arrival on our shores was somewhat similarly insidious. We hoped that this mysterious disease would somehow bypass us and yet a few short weeks later, we have all found ourselves in a lock-down. Strange and unprecedented times indeed!

While most of us lament the gross inconvenience, loss of income and possibly even the absence of common 'luxuries' like a haircut, we are also acutely aware that a sizeable proportion of our community have been (and still are) facing grave consequences of the sudden lock-down. While we still go to bed at night with a full stomach, many others out there do not.

For the longest time, there has been an underserved population in many areas. Urban Malaysia, more so in Klang Valley, has many individuals and families that have been dependent upon donated food and essential items from well-meaning NGOs. Very soon after the MCO was implemented, this marginalised group had exponentially grown. The daily wage earners, many of whom were already struggling, suddenly found themselves unable to feed their families. For many of them, this was a strange and frightening experience. Not surprising as most of us have never been in a predicament of these dimensions before!

To obtain a better understanding of the situation, we spoke to Dr Hyzan Mohd Yusof, an Orthopaedic Consultant at Sunway Medical Centre, who is actively involved in providing food aid to the needy. He was one of the founders of MRA – The Malaysian Relief Agency, an NGO that was established in 2010 by a few individuals, mostly doctors, all of whom already had some experience with humanitarian work.

MRA has, over the past 10 years, been able to build an extremely robust structure that intelligently amalgamates their inherent organisation skills and the spirit of volunteerism. Over the years, their network has grown throughout the country and beyond. They have not only achieved international recognition by the United Nations, but have also been successful in obtaining sizeable funding, using their track record as leverage.

Even before the MCO, MRA has been actively involved in food distribution to the needy in all parts of Malaysia. However, during the MCO, they became immediately aware of the sudden predicament of many individuals and families in our country. This led them to ramp-up their efforts in reaching out to the poor with food aid. Dr Hyzan informed us that during the MCO period alone, approximately RM5 million worth of food aid had been distributed throughout the country.

MRA is apolitical and believes that hunger knows no boundaries. Therefore, their aid is provided regardless of race, religion or nationality. Hence, in difficult times such as these, hungry illegal immigrants are also not denied the required food aid, leaving the politics for tomorrow.

Dr Hyzan cited some examples to illustrate the dire circumstances that have befallen some of us. He spoke of a family that was forced to boil nothing more than a tablespoon worth of rice grains, pretending that their porridge would be enough for all. The family also attempted to boil leftover 'pucuk ubi' even when there were no longer any leaves left on the stem. Yet another example was a single mother with a toddler, seen in Segamat, Johor, rummaging through a rubbish dump. When MRA volunteers approached and asked why she was out in the open during the MCO, her answer shocked them. She was hoping to find empty cans and bottles that she could sell as she only had two ringgits to her name.

It is plights such as this that keeps Dr Hyzan, his organisation and their volunteers motivated and perseverant despite the challenges. Certainly, the MCO posed unique difficulties to them as they were sometimes denied access to getting their aid to the needy. Fortunately, their vast experience in humanitarian work enabled them to deftly navigate the bureaucracy and get on with their mission.

In the final analysis, it would appear that the core challenges they face are likely two. The first would most certainly be funding, resources and volunteers (while they have done well thus far, the task is far from over), while the second would be more precise identification of their target group. For now, their database of the needy is purely built upon word of mouth. Obviously, one would not expect the needy to avail themselves to this vital assistance from MRA (and NGOs like them) by finding them on a mobile app! Therein lies a challenge in of itself.

OGSM hopes to create more awareness on the plight of the hungry, hoping that more will come forward to assist in this very noble cause. If you are involved in similar humanitarian programs in the country, we would like to hear your views too.

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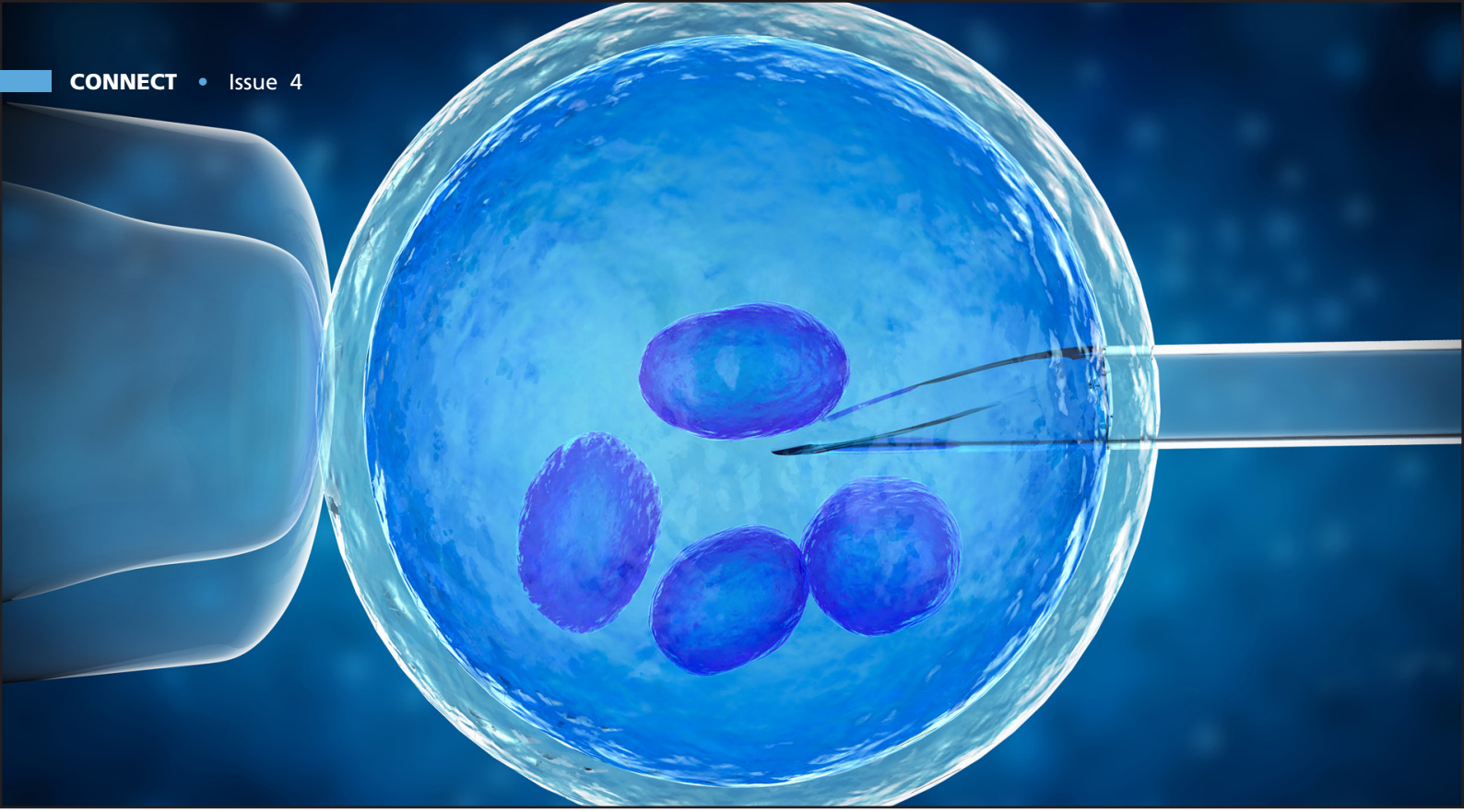

Ethical Dilemmas and Controversies in ART

Ms Diana Tain Chieh Xing
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Dr Eeson Sinthamoney
is a Fertility Specialist and Director at Sunfert International Fertility Center

While a comprehensive and robust local legislation to govern the practice of Assisted Reproductive Technology (ART) in Malaysia has long been the intention, it has yet to materialise. Those in the fraternity are acutely aware that some frameworks have been in the mill for years, yet nothing has come to fruition. Rumours were circulating as to the reasons. Fortunately, some months ago, under the able leadership of the chair, a large committee was convened on short notice and in three long days of extended discussions, an extensive policy document that examined the local practice of ART was constructed.

The larger private fertility centres in Malaysia had thus far taken the "self-regulation" path via The Reproductive Technology Accreditation Committee (RTAC) approval in an attempt to ensure that their ART practice remained within ethical bounds. However, the newly minted ART policy marks the beginning of a more well-defined and transparent era of clinical practice in this exhilarating and intriguing subspecialty field.

Many ask why such a policy (or indeed the ART Act itself) had taken so long to see the light of day? The answer most certainly lies in the inconvenient reality that there are only a very few other medical practice areas where clinical practice and medical ethics come into uncomfortable proximity and threaten to trample each other. Hence the inherent difficulties.

This short discourse will illustrate a few examples of these ethical dilemmas. Malaysia is a multiracial nation with a Muslim majority population. Therefore, understandably, religious beliefs dominate lifestyle and decision-making choices which are rather similar to Turkey (Urman & Yakin, 2010). While the standard ART-related treatments are allowed and well subscribed to, Muslims are prohibited from utilising donated gametes or donating gametes, embryos or blastocysts to other couples. If all efforts fail to result in a live birth, it is then left to fate and destiny with adoption still a distinct possibility.

That said, the needs and beliefs of minorities are given proportionate consideration and leeway. From a fertility treatment perspective, gamete donation is allowed provided certain criteria are fulfilled. Embryo donation is perhaps not as well subscribed to as one would want to expect – likely due to legislative issues that may not adequately address some potential consequences of embryo donation.

Our ethical dilemmas are certainly not unique. For example, in Italy, a country with strong Catholic beliefs, strict rules apply on the number of embryos allowed for transfer. There is also prohibition on screening of embryos prior to transfer, cryopreservation of supernumerary embryos as well as gamete donation (Rovei et al., 2010).

Conversely, the Human Fertilisation and Embryology Authority (HFEA) 2019 regulating laws in the United Kingdom allows non-anonymous gamete donation, while in some European countries like France and Denmark, the same is also allowed albeit anonymously (Firth, 2001).

Far more controversial is the awareness of the existence of the LGBTQIA+ community and their 'needs'. Malaysia however is still conservative. Therefore, homosexual females (or males) or unmarried singles wanting to get pregnant using ART treatment are usually told to get treatment abroad.

Surrogacy is yet another area of controversy. This will likely be allowed if medically indicated but again, may not be well supported due to the absence of good legislation that addresses all varied potential issues usually associated with this type of treatment. This is primarily because the law clearly dictates that the surrogate is the legal mother of the child. Surrogacy is not an option for Muslims. There are also several good examples of unethical utilization of surrogacy, such as in Nigeria, where a large proportion is purely for financial benefit. This unfortunate climate is said to be due to the absence of relevant stringent laws (Makinde et al., 2016). Cross-border surrogacy is a relatively new ethical issue whereby singles or couples previously denied ART treatment in their native countries are allowed treatment in a country with more primitive legislation. This can then sometimes lead to dire consequences, a prime example being the sudden banning of surrogacy in Thailand due to the abandonment of "baby Gammy" (a child with Down syndrome) by his Australian parents (Whittaker, 2016).

Gender selection will continue to be a huge ethical and social issue in many parts of the world. Whether for 'family balancing' or single-minded preference of a particular gender, this trait transcends borders (Colls et al., 2009). Hence, the service for pre-implantation genetic testing (PGT) sometimes caters to an affluent generation paying to identify a blastocyst with a preferred gender. This situation often presents unique ethical problems since identifying these couples can

sometimes be difficult as they often masquerade as being simply obsessive-compulsive, trying to minimise their risk of transferring a genetically impaired embryo. Patients in this category should be denied treatment but the high revenue from such cycles can often prove a significant sway factor.

The HFEA (2019) is strict on refusing gender selection treatment based on social reasons but does allow it if there is a risk history of a sex-linked genetic disorder. Perhaps a way forward to help resolve this issue would be a strict policy where gender information is not revealed.

It is abundantly clear that fertility treatment is closely entwined with various ethical dilemmas. As treatment options advance, so too the controversies. This is hardly surprising since news of the first IVF birth forty two years ago was received both positively and negatively depending on which side of the divide one stood. Here in Malaysia, it would appear that we now finally have a clearer path defined with the new ART Policy. Notice how much we can achieve with reasonable, level-headed and fair minded people at the helm.

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COVID-19:
The Effects of a Pandemic on Obstetric and Gynaecological Practice and Solutions for the Future

Dr Felicity Mishan Ng Yiwey is a recent graduate awaiting her house-officer posting. In the meantime, this young and talented writer has joined as an ad-hoc member of the Connect editorial board.

COVID-19 - Did you ever think an organism of such micro proportions would one day lead to a global catastrophe? What was brewing in late December 2019 in a place far from here has crossed borders at an unforeseeable pace and taken the world by storm. Although our history books have been painted red with past pandemics; the Plague, Cholera and more recently, the Influenza, the world was not quite ready for a pandemic like COVID-19. Every day, more people are dying, economies are crumbling and societies are protesting. Amidst all this chaos, it made me wonder, where do obstetricians and their clinical practice fall in this seemingly never ending cycle of cross-infectivity?

While not directly contributing to the fight against COVID-19, obstetricians particularly play crucial roles during this pandemic. Pregnant women are in an incredibly unique situation and presented with equally unique concerns about their health and the health of their unborn child. A practitioner is now responsible for ensuring that these concerns are dealt with, and more importantly, bear the responsibility of safeguarding the prenatal community. Given the current circumstances with movement restriction policies in place, upholding such duties can be a struggle. The key component to any medical practice, particularly concerning obstetrics and gynaecology (OBGYN), is that they require face to face encounters between the doctor and patient. Pregnant women are already in a state of physiological immunocompromise. This, including the higher than ever risk of infectivity from COVID-19, places them at a particularly delicate position leading to many unnecessary physical consultations being discouraged by national regulations. Under such directives, what is our new normal? With these questions looming over the OBGYN community, I set out to understand the changes surrounding OBGYN practice during a pandemic.

" Dr. Felicity spoke to a few ObGyn's to understand the impact of the pandemic on their practice"

The first and most remarkable adaptation in response to the pandemic was the implementation of better infection control techniques. Many frontliners have described a looming fear for their personal health during such challenging times. To further complicate matters, the possible burden of disease transmission to a pregnant mother and her unborn child will also lie in the hands of an obstetrician. Certainly, the pressure can be overwhelming. Dr Wong Choon Meng, from Yan Specialist Women's Clinic in Sri Petaling, described his new normal as seeing patients in a mask, a face shield and an apron. To him, Personal Protective Equipment (PPEs) are a necessity, not only for his safety, but also for the safety of his patients. Other measures that clinicians have taken include observing sanitary precautions. This is done by frequent hand washing and ensuring equipment and furniture are wiped down following patient contact. These measures are taken to ensure a minimal transmission risk even if it involves greater investment in time and money.

Social distancing measures are also largely enforced in clinic and hospital premises as means to flatten the curve. Other than the recommended measures of rearranging furniture and ensuring a 1 meter physical distance between patients and staff, additional actions include having practitioners space out their appointments and cancel non-essential face to face consultations. By reducing patient volume at any one time, the risk of disease transmission would proportionally decline. While it can be an arduous process, many have looked to alternatives to ensure that every patient is well accounted for. A senior obstetrician from Klang Valley has been using an online appointment booking application, which significantly reduced walk-in visits. Similarly, Dr Wong encourages telephone consultations for his stable patients, such as those requiring repeat prescriptions, and using facilities like 'Grab' to help deliver prescriptions.

In hospitals, Dr Corrine Young, a medical officer from Sarawak General Hospital, described being assigned into teams of four to six. Such arrangements were made to reduce the number of social encounters while maximising workforce potential. She also mentioned a new normal where elective surgical cases and procedures are being postponed to a later date and the number of outpatient cases are now managed by phone.

Next is the financial impact. The economy suffered a whopping US40 billion loss in markets during the 2003 SARS pandemic. Fast forward to 17 years later with this new and evolved virus, analysts are predicting that we could have already surpassed this figure. A crippling economic status is certainly no stranger to doctors and its impacts do affect private practitioners the most. Aggravating the situation is the need to comply with national directives by reducing operational hours and keeping staff and patient encounters to a minimum. Senior obstetricians from Klang Valley have reported a 30 to 50 percent decline in business revenues since the beginning of the Movement Control Order (MCO). While most have described this situation as stressful and frustrating, many are persevering and doing the best they can to provide for their patients.

As an alternative, many private clinics have looked into the possibility of adopting telemedicine, where they provide patients with online consultations which also doubles to help reduce physical appointments. While the OBGYN telemedicine scene in Malaysia has yet to take flight, recognising it as a useful tool is the first step forward. Not only does it have the ability to manage medications, provide postoperative care, discuss lab results and observe treatment plans, it also provides an extremely convenient platform for monitoring patient conditions such as gestational diabetes and preeclampsia where frequent and close monitoring is required. Despite the recognition, integration of such a system into real practice would take at least a few years, with a sustainable investment plan.

Having recognised these struggles, I asked the experts a question:

'What lessons have the pandemic taught you?'

The answer was simple: to always be prepared and be adaptable. While patient encounters remain part of our daily lives, the emphasis on infection control can sometimes be lost. For that reason, adapting a more mindful approach towards any form of patient interaction should be deemed extremely necessary during a pandemic like this. Minimising face to face contact with patients where possible by focusing on home care is what we must strive to deliver. Outcomes would not only include a reduced risk of transmission, but also a more convenient and affordable way to practice. Clinicians should look to cultivating the skills required to garner such outcomes for the greater good of public health as well as for the economy. Perhaps it would also be a good time to look into e-medicine as a more sustainable solution for the future.

Dr Felicity Mishan Ng Yiwey
10th May 2020

The COVID-19 Pandemic and its Impact on the 28th International Congress of the Obstetrical and Gynaecological Society of Malaysia

The widespread disruptions caused by the COVID-19 pandemic has forced the OGSM Council and the Organising Committee to make the difficult decision to postpone the 28th International Congress of the Obstetrical and Gynaecological Society of Malaysia. This key and unprecedented decision was made based on available information at the time of the declaration of the pandemic.

However, to decide the duration of postponement is a more onerous task. One must be able to predict the course of the pandemic, which is not easy. Though the evolution and spread of a pandemic is not completely random and follow a standard life cycle that consists of set phases, these phases are heavily influenced by the biology of the virus, attitude of society and the inherent risk factors within the society. They are also equally influenced by Government, capacity of the Health Care System and policy changes, especially those related to travel and assembly of people. This innate uncertainty of the complex, dynamic and global reach of the COVID-19 pandemic has made traditional predictions or forecasting methods misleading and unreliable.

Therefore, determining the new date for the 28th Congress is an immense challenge and one which would be prudent to err on the side of caution as it would have a huge impact on the registrants, exhibitors, speakers and contracts with event venues such as hotels and convention centres.

There are various mathematical models which aid us in predicting the standard life cycle of the COVID-19 pandemic, such as the SIR (susceptible-infected-recovered) mathematical-based model that predicts future infections of COVID-19 according to data from current confirmed cases and deaths. Based on the SIR model, the global end to the Covid-19 pandemic should be around the beginning of December 2020.

Therefore, although the exact date for the next Congress has not been finalised, it will need to take into consideration the end of the pandemic as well as various other factors that are equally important such as contracts with event venue and contracts with vendors of event-related services, such as providers of transportation, decoration, audio-visual services and exhibitors.

Conventionally, our annual Congress is meant to be a premier conference for the Obstetrics and Gynaecological fraternity. Aside from the educational content, the Congress has always been a great networking opportunity for both doctors as well as the healthcare industry. The Organising Committee remains committed to ensuring that the 28th Congress continues this tradition, if not setting an even higher benchmark!

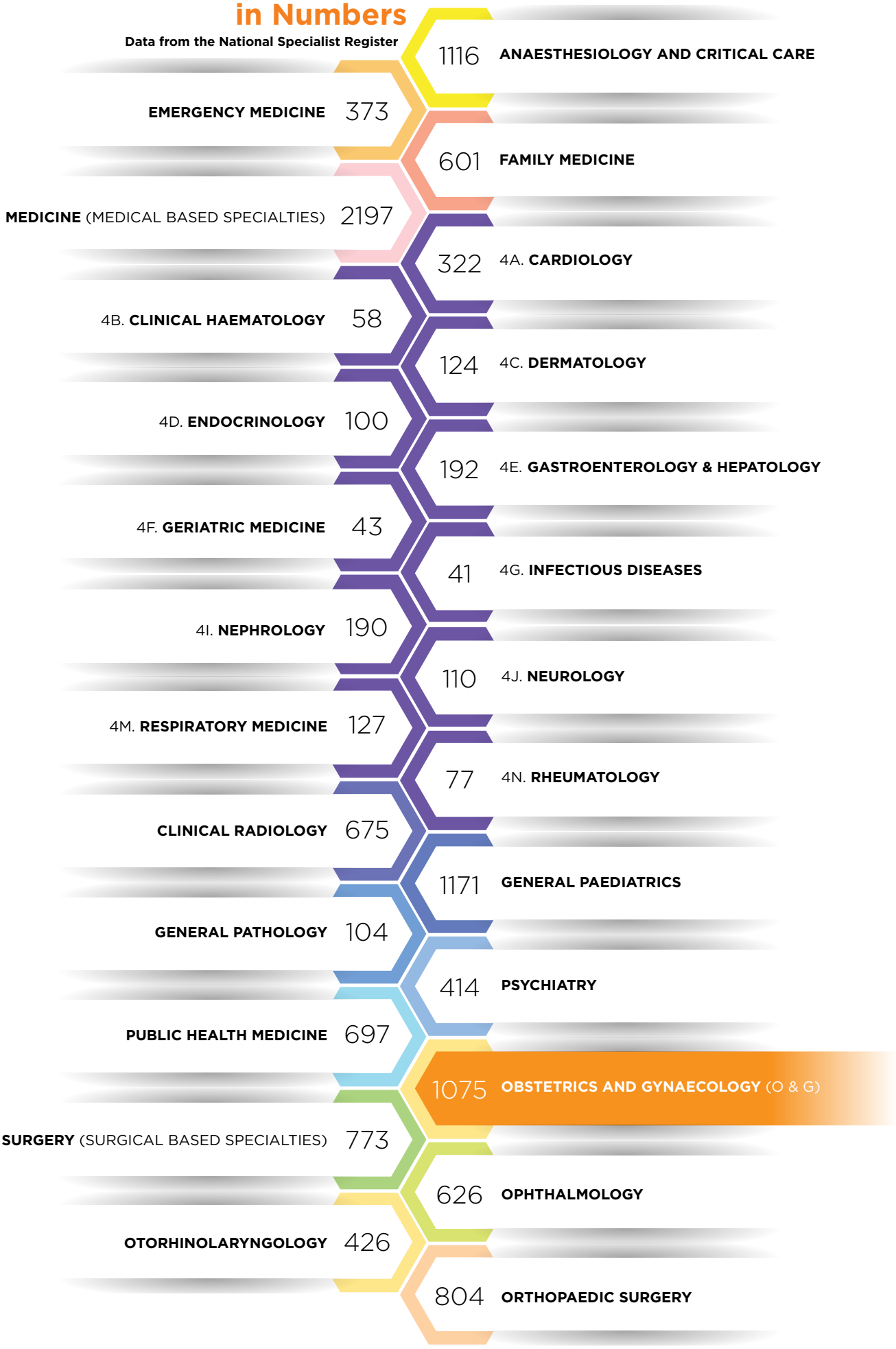
Best wishes, stay safe and a Selamat Hari Raya to all our Muslim members.

Dr Murali Ganesalingam
a Senior Obstetrician and Gynaecologist, is the President -Elect of OGSM and the Organizing Chairman of the 28th Congress

Specialities in Malaysia

in Numbers

Data from the National Specialist Register



Ethical Professional Practice

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A professional means a member of a profession. It denotes and defines the standards of education and training that prepare members of a profession with the particular skills, expertise and knowledge to perform the role of a professional. Those who are specialists will have to perform and be judged by the standards expected of them. As doctors and specialists, we are expected to not just perform within the set benchmarks, but also to adhere to acceptable ethical norms as well.

Ethics is a stem of philosophy dealing with values pertaining to human conduct which takes into consideration righteousness and wrongness of action. It also elucidates the goodness and badness of the motives and ends of such actions.

It is for the professional who is entering the practice to be invested with the responsibility of adhering to the standards of ethical practice and conduct, as set by the profession or the professional body. Some of these standards are codified. However, moral and ethical values may not be clearly defined or delineated. They may be obfuscated with many grey areas that must be traversed whilst managing patients. This ethical navigation may be subject to several sequences and numerous interpretations. Some even have their own set moral values which may not be in line with the thinking and belief of the rest. Each individual has his own vision and convictions regarding ethics or moral values in practicing medicine. Race, gender, cultural and religious values may sometimes impinge or encroach on the acceptable standards of ethical professional practice.

Professional ethics encompasses the personal, organisational and corporate standards of behaviour expected of professionals in the medical practice. Professionals exercise specialist knowledge and skills but medicine is not an exact science, so it is subject to many variables. Thus, medical professionals would exhibit various divergent ways in managing a specific case. This will sometimes abut into the red lines of ethical professional practice.

While the profession dictates the best mode of performing a certain procedure, ethics seek answers as to why that procedure or management was chosen as the best way. It will also scrutinise whether it was justifiable by moral and ethical standards of the society at large. Thus, many medical organisations, academies and associations have chosen to formulate ethical professional practice guidelines for their brethren to rely on. These guidelines crystallise the ideas, thoughts and beliefs into crafting the standards of practice. This is to pave the way for rational decision making by doctors for the benefit of all. However, these guidelines cannot be set in stone. They need to evolve with the times and changing attitudes of society which will certainly be influenced by transforming moral and ethical values.

The face of medicine is fast changing due to the rapid advances in research and treatment modalities which are enabled by enormous technological advances. Occasionally, market forces seem to influence how medicine is practised. As professionals, we sometimes sway away from the basics as we become more reliant on machines, gadgetry and wizardly diagnostic inventions. This is more so with sophisticated non-invasive interventions to manage patients. What one may ask on hindsight is whether these tests were required in a standardised manner to manage patients? Would it be fair for the patient to be pommelled with a battery of tests just to be on the safe side, which many refer to as defensive medicine? Some patients seek answers as to why simpler surgical procedures were not done when unexpected complications arise during highly sophisticated surgical interventions. Many ethical questions are posed by the patient when complications surface during these procedures or when the patient is faced with an assumed hefty bill?

As professionals, we need to keep patient interest above all. The primary obligation will be to cause no harm. When professionals provide specialist care, it must be governed by generally acceptable moral and ethical values according to universal expectations, most importantly by the patient.

Menopause Subcommittee Report (2019–2020)

Dr Premitha Damodaran
Menopause subcommittee Chair, OGSM
Consultant Obstetrician & Gynaecologist
Pantai Hospital Kuala Lumpur

The menopause subcommittee has just finished finalising the Clinical Practice Guidelines for Menopause Management in Malaysia. The CPG has been reviewed by 7 internal reviewers and 2 external reviewers, namely, Dr Delfin Tan from the Philippines and Prof Dr Rodney Baber from Australia. Corrections have been subsequently accomplished according to the recommendations.

We are presently awaiting KKM review. In view of the COVID situation, the CPG has not been submitted for review as of now.

The plan, as such, would be:

1. Submission to KKM in June/July 2020

2. Await their meeting which is usually held twice a year. The scheduled meeting is usually in September, however, with the present situation, we have to accept that COVID related matters may take precedence.

3. Corrections and approval will follow and then be put up on the Academy website once approved.

This CPG is aimed to treat all women who are approaching menopause, going through menopause and in the post menopause stage. It also targets women who have problems of premature menopause. We hope it will provide a very useful tool to all healthcare professionals.

Once these guidelines are up on the Academy of Medicine website, the work of implementing these guidelines will begin. We are aiming to work with the Malaysian Menopause Society with regards to public and medical forums and CME programmes.

I have indeed been honoured to chair this CPG and have had the delight to work with a wonderful group of colleagues and friends; **Dr Ho Choon Moy, Assoc Prof Ng Beng Kwang, Dr Raman Subramaniam, Prof Dr Jamiyah Hassan, Prof Dr Nik Hazlina Nik Hussain, Prof Emeritus Dato' Dr Nik Mohd Nasri and Dr SP Chan.**

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REFERENCES: 1. Kohler G, et al. A dose-ranging study to determine the efficacy and safety of 1,2 and 4 mg of dienogest daily for endometriosis. Int J Gynaecol Obstet. 2010 Jan;108(1):21-5. **2.** Strowitzki T, et al. Dienogest is as effective as leuprolide acetate in treating the painful symptoms of endometriosis: a 24-week, randomized, multicentre, open-label trial. Hum Reprod. 2010 Mar;25(3):633-41. **3.** Kitawaki J, et al. Eur J Obstet Gynecol Reprod Bio. 2011 Aug;157(2):212-6. **4.** Morotti M, et al. Eur J Obstet Gynecol Reprod Biol. 2014 Dec;183:188-92. **5.** Imai A, et al. in Endometriosis - Basic Concepts and Current Research Trends, Prof Koel Chaudhury (Ed.), ISBN:978-953-51-052404, InTech.

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Big Data and Health Analytics: Need for Integration in the Digital World

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Introduction

Accurate documentation of patient information and diagnosis are paramount in healthcare. Data forms the framework for the design and development of healthcare policies in any community, and I have often made reference to the need for the O&G fraternity to adhere to these conventional rules. A limp attempt at data collection by 14 hospitals in the Ministry of Health (National Obstetric Registry) had missed out on vital information, largely due to the variables compulsorily collected. The information is usually collected at the end point without much validation by dedicated personnel. I made reference to this weakness in a commentary I wrote in MJM[3] and compared it to the excellent data collection and analysis by Scandinavian countries. During my service in Ipoh Hospital, five nursing sisters with foresight acquired rudimentary knowledge in the use of Epi-Info and churned out details of disease burden in the Department of O&G. This formed the basis for budgeting and human resource allocation, apart from generating information for research materials for nearly 11 years that I had served there. When I was transferred to Kuala Lumpur Hospital in 2001, I was impressed by the dedicated team working on data collection in the department. However, after two years of 'harassing' the consultant-in-charge and people in-charge, I was unable to obtain an annual report of the state of affairs in my own department!

I often lament at the lack of commitment by the new generation of healthcare providers who do not find pride in determining disease pattern and disease burden within their own community despite the advances of computers and the birth of the digital age. Far often than not, vital information on disease and diagnosis is left to junior doctors to complete for submission to the record office. In hospitals (in MOH) where I have worked, specialists, sisters and doctors appear to follow a fixed routine based on which place of work they are assigned to and complete the day's work with little or no time to reflect on what went well and what did not. Unless we gather vital information on disease relating to disease and outcomes of care pathways, document such information on prescribed formats and regularly audit our results, we will not be able to improve the quality of service. To this end, I wrote a commentary in MJM[3] on one disorder in pregnancy and why there is so much more to be done in Gestational Diabetes which will provide windows of opportunity to prevent or delay the onset of T2DM in years to come[2]. I cannot comment on how such information is generated in the private sector and, if available, are they accessible to relevant authorities. The College of O&G (and to some extent OGSM) can initiate a simple survey to determine if what I have commented on is worth its salt.

The Digital Age and Technology

I made reference to this topic when I was invited to deliver the MK Rajakumar Oration at the College of Family Physicians Malaysia in April 2018. I make no apologies for taking large sections of this write up from that Oration, lending to some elements of 'self-plagiarism'. Digital technology has revolutionised data collection and documentation, and the use of computerised health records clearly has merits to improve the quality of healthcare rendered. Being patient-centric is the mantra word to be adopted so as to provide continuing care in an integrated healthcare system. After the Covid-19 pandemic, the new normal would be to have a comprehensive healthcare delivery based on disease burden and not on class and fees for service. Malaysia would need to close the divide between private and public sectors so as to be productive, provide equity in healthcare and avoid duplication of health care services. Distributive justice is an ethical phenomena to be applied when resources are scarce and healthcare is a scarce commodity worldwide; again, shown in this Covid-19 pandemic. Duplicating patient's health history for each provider is an example, seeing that integrated documentation services are lacking; this extends to the performance of investigations without access to previous healthcare details when the same patient is seen in multiple health facilities. Such unproductive practices can be avoided by both empowering patients with health information and easily acquiring access to patient records using electronic documentation. Initial efforts at introducing a personal health record in the Ministry of Health during the 1990s had not taken off.

In the digital Age, rich data insights are the most efficient tools for organisations and health practices – to analyse and determine patient and community needs, which would eventually lead to more effective and productive clinical decision making. There are clear challenges in such an approach but with organisations like the National Institute of Health, Ministry of Health Documentation Unit, COG and OGSM, adopting a policy of using common templates to capture patient information and improving its centralisation of record keeping will be a workable means of sharing data which will eventually contribute immensely to Big Data.

Documentation of diagnosis at the discharge of a patient is an example. In complicated obstetric of moderately obese patient G7P6 who has severe IUGR due to preeclampsia and is also diagnosed with the conditions shown below undergoing induction of labour ultimately developing shoulder dystocia and postpartum haemorrhage may be discharged as PPH following vaginal delivery. In order to collect accurate data, the diagnoses at discharge should be in three sections, to be completed as shown in the following example:

Antenatal Diagnosis:
1. Pre-existing type 2 Diabetes
2. Moderate preeclampsia
3. IUGR
4. Grandmultipara
5. Obesity
6. Rheumatoid arthritis

Intrapartum Diagnosis:
1. Failure to progress (after induction of labour with Foley catheter)
2. Vaginal birth
3. Postpartum haemorrhage
4. Shoulder dystocia with birth asphyxia

Postpartum Diagnosis:
1. Type 2 Diabetes Mellitus
2. Moderate anaemia
3. (Outcome of baby)
4. Obesity

Democratisation of data capture for health analytics is the way forward. This information will reflect on health behaviour, disease trends, counselling pointers on preventive measures and many other aspects that will contribute to the very elements of healthcare of women and children. The primary aim

is to promote wellness, prevent disease and care for chronic illness (which may be co-morbid) shall be developed in times to come. Training in self-care and empowering the patient in matters related to obesity, GDM, hypertension, anaemia in pregnancy, multiparity and their effects on health are essential paradigm shifts that will lead to comprehensive solutions. Hence, care has to be continuous and not cease at the postnatal visit; strategies are long term and they must be adopted as a means of quality practice in Malaysia.

Advancing technology and the digital age are rapidly transforming the way we practice medicine. OBGYN practice in Malaysia cannot stay away from the positive impact that Big Data can provide customised decision-making. The COG and OGSM can play a huge role in influencing its members and all intending O&G specialists and midwives in a uniform way of data collection derived from patient care and its generation, to draw disease patterns and care pathways. I have alluded to this weak point in the healthcare in Malaysia, i.e., the collection of accurate data on healthcare due to a lack of uniformity in such data generation.

What can the COG and OGSM do with the MOH, in stewardship, so as to contribute to useful information to Big Data?

Undeniably, data sharing will influence the way we practice medicine in future. IBM Watson and Faltiron Health illustrate how collecting data and cleaning it up will lead to using such data to identify potential interventions which are cost saving. Just look at how potentially vast amounts of information derived by each practitioner related to each patient can be usefully utilised for the development of strategies:

- Individual demography
- Health history
- Well-being information
- Depression, anxiety and sleep disorders
- Lab tests, medical imaging
- Genetic profiles
- Biopsies, CTG, ultrasound findings
- Waiting time
- Generic data: derived from medical reports and medical claims, prescriptions, clinical trials and academic research

Such information should be put to good use. Better data capture and analytics will lead to thorough patient records, improved patient care and evidence-based decision making. Overall, one will acquire a better and more efficient business model. Telehealth has been in vogue for more than 3 decades and will continue to be a means of consultation. Digital innovations using electronic medical records will enable seamless referrals. The private-public divide cannot continue to prevail as it is too expensive and a capitalist model.

Effect of Big Data

Big Data is changing the way we manage patients in all aspects. There is evidence to show that Healthcare Analytics can potentially reduce treatment costs through the application of best evidence in a climate of best practice. The overuse of antibiotics is well known worldwide, and this is often due to a lack of adherence to best practice. Analysing Big Data assists in promoting wellness and can be used to develop care pathways relevant to Malaysia in OBGYN. A simple example is 'indications for induction of labour' which varies a great deal in our practice but we have little national information as to the success of each method selected and consequent outcomes of the intervention.

Current issues in Malaysia include the lack of data sharing between institutes and practitioners for the betterment of patient care due to confidentiality. How do we explore this problem in the interest of patient wellness and avoid duplication of data generation? Preventing medical errors with red flags has been effectively employed by one software innovation in Israel (MedAware). Medical devices and electronic wearables are now in vogue and have been effectively employed for remote monitoring of patients with asthma and hypertension. Wait time reduction has been yet another application generated by the use of Big Data in health institutes and clinical practice.

OGSM and other trainers may want to run courses in Big Data in Health Analytics so as to be aligned to current clinical management trends. Stewardship and leadership will be essential for practitioners to believe in the value of Big Data as paving the way to more patient-centric quality care. This is due to several challenges Big Data utilisation presents. Capturing data that are clean, accurate and correctly formatted are integral to electronic health records. Clear standardisation of data collection is vital. A poor understanding on how Big Data will contribute to cost effective quality healthcare can be a stumbling block. Storage of data and effective retrieval will require a dynamic IT infrastructure. Data security will always be an issue as hacking and phishing are well known threats in modern IT models. Issues of how data is to be employed locally and how sharing will be operationalised will always be areas to contend with in the use of electronic health records.

Conclusion:

The Eight Millennium Development Goals address human misery through an integrated comprehensive care platform for best outcome which should reach out to all members of OGSM. The ultimate aim is to provide lowest-cost greatest-user satisfaction, i.e., 5% health cost for 95% health burden. I am not sure how much of these initiatives have been discussed by MOH or COG/OGSM. I am fully aware of the efforts made by the MOH in reducing maternal mortality and infant mortality in this country. Despite these great efforts, more needs to be done. What is greatly important to us include the need to squarely address the following disorders/diseases:

i. Ageing with relevance to women
ii. Obesity
iii. Non-communicable disease in pregnancy – progression of GDM and Preeclampsia to chronic disease states
iv. Adolescent health and pregnancy – psychological and physical ailment
v. TB, Malaria and HIV/AIDS, especially in pregnancy
vi. Screening for genital and breast cancer
vii. Contraception – state of affairs in Malaysia

Although there is a need for a global effort in combating these ailments, much of these are related to knowledge-based approaches and socially driven activities. Globalisation is not a catchword but a reality. The World Economic Forum looked at the Health Delivery System today from a broader perspective which very much reflects on how medicine should be practiced. Access to healthcare is a human right (WMA) and I feel that is the responsibility of the state. Value-based healthcare is essential and must be reflected in effective health policies drawn to meet community needs; human capital must be deployed to areas in need to overcome inequity of healthcare using technology and data, hence requiring efficient health records.

I referred to the far sighted thinking of the primary care Malaysian legend, Dr M.K. Rajakumar, in the numerous lectures he had given over the years as he was revolutionising Primary Care in the country. The following messages are based on what he would have loved to see and what I have said so far, which is worthy of repetition:

- Universal health coverage is a right and mass customisation is the way to go.
- How do we do that? Customised, standardised approaches in healthcare in meeting local needs are essential.
- One size fits all concept does not hold and training must be customised based on health needs and disease trends through a flexible and scalable curriculum and evidence-based practice.
- Technology and Big Data will be the future for improved healthcare.
- Seamless quality care is the mantra for all members.

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The "Malaysia Lecture": Say what?

Dr Ravi Chandran
Past President OGSM 2005/2006
Immediate Past President AOFOG
Consultant Obstetrician and Gynaecologist
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This is a common response elicited from many an OGSM member whenever the "Malaysia Lecture" is mentioned! So, what is this lecture and how did it all start?

In 2013, the OGSM Council under the Presidency of Dr Tang Boon Nee embarked on an ambitious path to elevate the status of our Society. For several years, we had an impressive track record of organising several successful national and international congresses. Be that as it may, we were numerically still a "small" Society and it was felt that OGSM needed greater recognition on regional and international platforms. During a fruitful brainstorming session, several ideas were mooted, and these were then incorporated into the OGSM Road Map.

The idea of having a "Malaysia Lecture" at the biannual AOFOG Congress was my brainchild but the seed was actually planted during the RCOG World Congress which we had successfully organised in 2012 in Kuching. As the Scientific Chair then, it struck me that the Singapore Lecture which was incarnated in 1991, was an annual lecture that generated interest and continued to keep "Singapore" and the "OGSS" in the minds of regional and international delegates attending the Congress. Since I was already on the AOFOG Executive Board at the time, I set about exploring how I could make the "Malaysia Lecture" a reality.

The AOFOG Congress is already top heavy with "named" lectures and those of us who have served on the AOFOG Council will readily attest to the uphill task of trying to include yet another "named" lecture into the Congress programme. It required meticulous planning and execution as well as unstinting support from the OGSM Council and members. But most of all, it needed lots of patience for the right opportunity to come along.

The AOFOG Congress in Kuching in 2015 finally provided this opportunity. The OGSM Council of 2014/2015 and the Local Organising Committee of the Congress worked very hard to ensure the success of this Congress and the just rewards came with a substantial financial gain to both OGSM and AOFOG. This then provided a good springboard to launch our attempt to include the "Malaysia Lecture" in the AOFOG Congress programme. Once our AGM of 2016 had sanctioned this move, I presented our case to the AOFOG Executive Board in the same year and the "Malaysia Lecture" was born!

The first "Malaysia Lecture" took flight at the 25th AOFOG Congress in Hong Kong in 2017. It was a very poignant moment, not only for OGSM, but also for me personally since the first "Malaysia Lecture" also coincided with my installation as the 27th President of AOFOG. I was simultaneously honoured and humbled to represent OGSM as only the 3rd Malaysian to hold this privileged position.

Professor Mats Brannstrom from the University of Gothenburg gave our "Malaysia Lecture" a rousing start by presenting a masterful lecture on "Uterus transplantation with live births and the future". The audience were captivated by the pioneering technological advances that have since made uterine transplantation a reality today with great potential for future application.

The momentum of the "Malaysia Lecture" was maintained by Professor Haywood Brown in its second iteration during the 26th AOFOG Congress in Manila in November last year. During his tenure as President of the ACOG in 2018, Professor Brown was instrumental in developing the concept of the 4th Trimester and advancing the role of the Obstetrician in ensuring a woman's healthy life-course. His lecture was aptly titled "Impact of pregnancy on Long-term Women's Health". Needless to say, his lecture was also well received and has encouraged many of us to seek out "teachable moments" and explore opportunities within our practice to enhance the overall health and well-being of our women.

Inevitably, my thoughts drifted back to that fateful night in 2013 when a group of us met to discuss the future direction of our Society. Has the "Malaysia Lecture" played its role in enhancing the prestige of our Society?

The "Malaysia Lecture" is now entrenched in the AOFOG Congress programme with well-known speakers delivering interesting and cutting-edge orations. Because we have managed to attract high calibre orators with high calibre lectures, the "Malaysia Lecture" is gaining traction and delegates are increasingly looking forward to them. In much the same way that the Singapore lecture is viewed, the "Malaysia Lecture" now shines a spot-light on Malaysia, and more specifically, on OGSM – something that we should all be proud of.

Paradoxically, while gaining recognition in regional and international arenas, why then is the OGSM membership at large not very familiar with the "Malaysia Lecture"?

This may partly be due to the fact that the lecture is held only once every 2 years but may also be due to lack of publicity. While impending AOFOG Congresses are well publicised in our Newsletters and Website, there needs to be special emphasis and greater promotion of the "Malaysia Lecture" so that our members are kept informed. Perhaps a section on our Website could be dedicated to the "Malaysia Lecture" so that its history and a record of orations can be maintained for posterity. Perhaps the time has also come for all OGSM Council members to lead by example and make a special effort to attend and support the "Malaysia Lecture". Nothing beats experiencing first-hand the fruits of our success and basking in the glory of the recognition accorded to our "small" Society at these Congresses.

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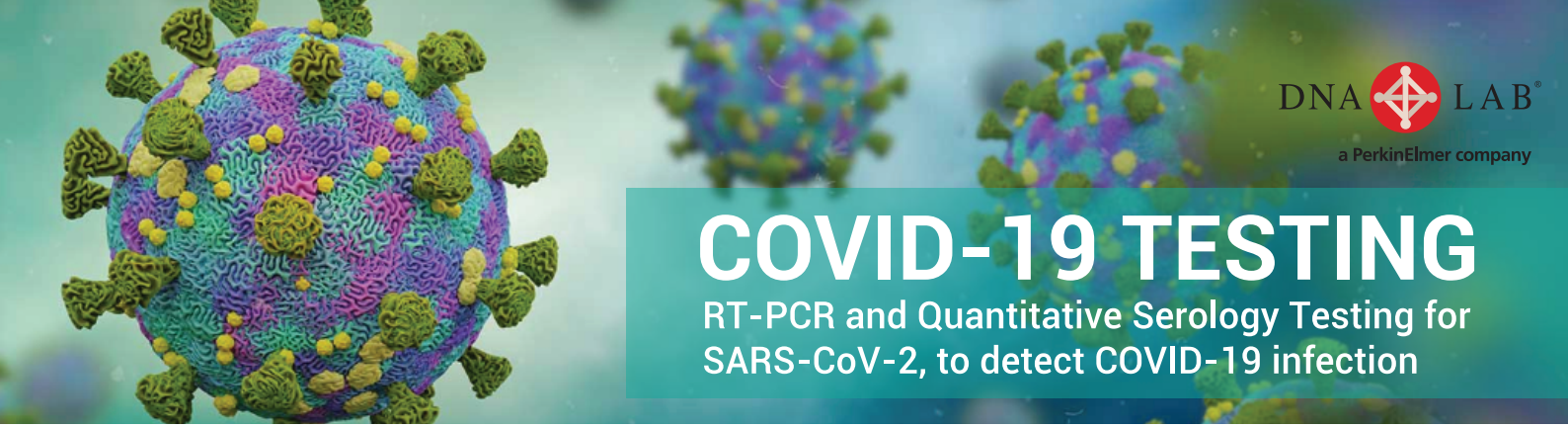

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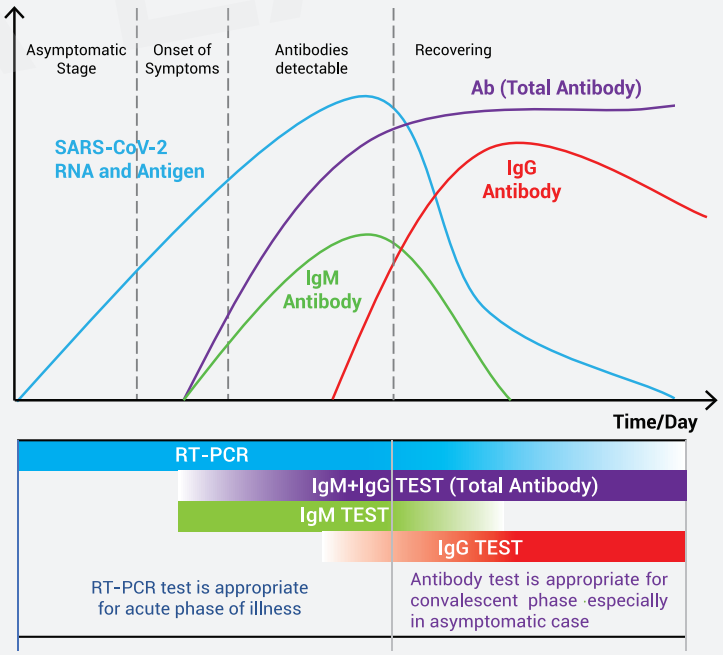
Variation of SARS-CoV-2 RNA and Antigen, IgM/IgG After Infection[1]



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