2013 / 2014 ISSUE 2

OGSM NEWSLETTER

Obstetrical & Gynaecological Society of Malaysia

FROM THE PRESIDENT'S DESK

Obstetricians, we are besieged from every side.

On one side, we have patients who file complaints, rightly or wrongly. Some end up with a complaint with the hospital management and resolved at that level, some of these complaints end up with a legal suit. The worst is probably the complaints that go to MMC, where we are judged by our peers.

Doctors in general are being increasingly scrutinized, not only by the patients, but also by our peers. On that note: MMC has produced a new guideline on consent taking; this governs the way we take consent from patients. I urge all members to take serious note of it. I am very certain that because of the way the guideline is written, it binds us, the doctors, in writing in what we ought to do in consent taking. This exposes us to disciplinary action by the MMC if consent is not taken according to the guidelines.

On another side, we have patients who say: we will reject your professional advice of safe delivery. I would like to 'DIY' delivery at home, it is more natural. After all childbirth should be a natural process, not over-medicalised, like how our grandmothers used to do. The Obstetrician says "but it is not safe". We end up being attacked for being too interventional. There are several 'patient education groups' in the community who are encouraging the patients to try DIY delivery at home. I strongly urge that if any of us should have patients who are considering this option, to try and dissuade the patient from an unassisted homebirth. Sometimes patients may even request for her obstetrician to attend to the labouring mother at home with the intent of a homebirth. I urge that you should not agree to such request.

On another front, we are paying higher and higher medicolegal indemnity fees. Medicolegal indemnity is fast becoming unaffordable. In many countries, there is little private obstetrics, precisely for this reason. It is economically not viable to practise private Obstetrics. Is Malaysia heading that way?

OGSM has been championing higher fees, for all O&G procedures. Despite our effort in the last 3 years, it has not come to fruition. The reasons for that are multi-factorial: economics, politics, supply. It must be highlighted though that one of the main reason is: the doctors from different specialties cannot agree on the quantum of increase. The Ministry of Health does not look at each specialty individually. It would like to apply the same quantum to all specialties, if one speciality says 'no' than the whole plan fails.

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SECRETARY'S REPORT

"Life is what happens while you are making other plans" - John Lennon

The Obstetrical and Gynaecological Society of Malaysia (OGSM) has been busy with a hectic schedule of activities accomplished, and others being planned for the future. The OGSM is recognised as being a reputable society by the Ministry of Health and other Non-Governmental Organisations as a result of its involvement in a wide range of activities, the scientific and social programmes it hosts and the fact that membership numbers have passed more than 1000.

The Ministry of Health has invited OGSM to participate in the Confidential Enquiries into Maternal Deaths (CEMD). Two of our members have been appointed to attend these meetings regularly. OGSM would like to thank Dr Gunasegaran PT Rajan and Dr Jaspal Singh Sachdev for agreeing to contribute their time and effort by representing our society in this worthy endeavour to reduce maternal deaths in Malaysia.

OGSM has also worked with the Ministry of Health in organising the 2nd National Lactation Conference which was held from the 12th to the 14th of September 2013 at the 1 Borneo Ballroom, Kota Kinabalu, Sabah. The conference was well attended by more than 350 delegates from Malaysia and Singapore. It was preceded by a half-day Pre-Congress Workshop attended by more than 100 delegates, which focused on exchanging experiences about breast feeding. This conference was inaugurated by the Honourable Minister of Health, Dato' Dr S. Subramaniam. Following the opening ceremony, a press conference was held during which a number of issues pertaining to breast feeding were raised and questions answered by the honourable minister and Dr Tang Boon Nee, the OGSM President.

The Ministry of Health has also requested that OGSM spearhead efforts to promote Sexual and Reproductive Health in Malaysia. OGSM has begun work on this project, starting first with plans to set up a dedicated website on sexual and reproductive health issues. Secondly, we are planning on creating a training programme for health professionals on these same issues. Any of our members who are interested in working on this project are encouraged to contact OGSM.

OGSM has been in existence for fifty years. Our past records are valuable and essential to guide our future generations of leaders. In recognition of this, we have embarked on a new project of archiving our records and have engaged a part-time staff for this very purpose. As part of the next phase, we will be writing to all past office bearers and council members and to the past presidents, requesting for them to submit old photos, letters and other memorabilia to OGSM. These will be useful for retrieval of essential elements in OGSM's history.

Two state OGSM representatives organised fellowship nights in their respective states on the 21st of September 2013. OGSM sponsored both events and would like to thank Dr Malini Mat Napes from Terengganu and Dr V. Jaya Balan from Perak for their efforts. Dr Tang Boon Nee and I attended the function in Perak and greatly appreciated the opportunity to interact with our members up north. OGSM is keen to support such events to promote fellowship among our members. Members from Kuala Lumpur and Selangor can look forward to the upcoming fellowship night on the 14th of December when Prof Philip Steer will be delivering a lecture at the OGSM office.

OGSM is deeply saddened by the news of the passing of Dato' Dr P. Boopalan, our Past President, Chairman of the I. S. Puvan OBGYN Foundation and Chair of MASEAN Chapter (O&G), on the 2nd of November 2013. We placed an obituary message in The Star newspaper on the 5th of November and would like to convey our heartfelt condolences to his family on behalf of the OGSM Council and all our members.

The OGSM Council is planning many new activities for the year 2014. I would like to wish all our members a Merry Christmas & Happy New Year 2014.

DR THANEEMALAI JEGANATHAN
HONORARY SECRETARY

10TH ANNUAL INTERNATIONAL SOCIETY OF ULTRASOUND IN OBSTETRICS AND GYNECOLOGY (ISUOG) OUTREACH COURSE

Raffles City Convention Centre Singapore
4th to 6th May 2014

The organizing committee of this course has offered our members a discounted 'Group Registration' rate. To enjoy this offer, please visit their website at www.isuog-or.com.sg and follow the steps below when registering:

1. Click Registration Form
2. Enter group registration code ORGRPREG
3. Enter OGSM as the name of the country

TREASURER'S REPORT

Dear colleagues,

As the year draws to a close and with council's term well into its second half, it seems entirely fitting to take cognisance of our financial foothold. This time around, we will draw attention to certain issues that should be of interest to members.

5th APCOC Congress 17-19th April 2014

The society is co-organizing this congress with the Asia-Pacific Council on Contraception (APCOC) under the very able leadership of Prof. Jamiyah, a past president. The decision to support this effort was made by the council of 2011-2012. We have agreed to provide RM10,000 as seed money and to share the profits (or losses) by 50%. Going by their previous track record, the congress is likely to make a profit. All factors considered, we feel this endeavour is a worthwhile pursuit.

AOCOG 2015

Preparations for this meeting are well underway and looking at the trajectory of its progress, AOCOG 2015 looks set to become the new benchmark, both from an organizational and scientific perspective. Financially, we have a separate account and are pleased to report that there has not been a need to dip into the seed money that was previously allocated by the society.

RCOG/OGSM annual travelling fellowship

A sum of RM200,000 was deposited into a special account with a 50% contribution from the society and the remaining from the Royal College. This was in part to commemorate the reverberating success of the RCOG 2012 meeting in Kuching and to keep up the momentum of our formidable rapport with the college. Professor Jane Norman was nominated the inaugural fellow and she visited us in April 2013. This time around, Dr. David Richmond, the new RCOG president himself will be travelling to Malaysia in February 2014 and Dr. Gunasegaran PT Rajan will certainly ensure that the RCOG president gets as a wide an audience as possible while in Malaysia.

Administrative costs

The issue of high administrative costs have been previously discussed. This has escalated further in the current term but for a very good cause. We have taken on board an additional staff on a part-time basis, and she has proven herself indispensable. She has been tasked specifically with collating and archiving all old documents, photographs and other such historical artefacts so that not only can we trace the roots of our society but more importantly, these important documents allow us to understand the fundamentals of how and why our society functions in the way it does!

Council teleconferencing

For many good reasons, council decided to invest in a cloud-based teleconferencing program that allows our council members in Penang to attend the monthly meetings without physically being in Mont Kiara. It was also envisioned that this facility would allow council to forge closer links with the state and sub-speciality representatives too. If all this works well, the natural next step would be to expand this facility in creative ways to promote fellowship and intellectual discourse within the fraternity. But alas, the program hasn't performed up to expectations and council is currently working closely with the vendor to find an amicable solution.

Purchase of another property

As discussed and resolved at the last AGM, the society has formed a subcommittee to look into the purchase of this new property. As agreed, a sum of RM2.5 million has been allocated. Ably led by our trustees, several properties have been assessed but no decision has been made yet. We will update you as the search continues.

Funds for regional initiatives

At the last AGM, a total of RM100,000 per year for 5 years has been allocated for regional initiatives to be directed primarily at activities in Myanmar and Cambodia. A well subscribed MRCOG course was recently carried out in Yangoon. Four of our members were despatched to run the course. The total cost to us was approximately RM3,400.00 as the society only funded the travel while all hospitality and accommodation costs were borne by the hosts. The feedback from participants was extremely encouraging. We have also drawn up some elementary guidelines on how this allocation can be spent and we hope that this will be helpful in our quest to remain financially accountable.

More guidelines

Since 2009, we have periodically formulated guidelines that allow us some consistency in the way we manage our finances. Over the last 5 terms, the number of these guidelines has increased, the most recent being one that categorizes the activities that the society involves itself in and its financial implications. While this approach may appear cumbersome to some, we are of the belief that these efforts are the bricks and mortar that builds the foundation of a strong organization, one that is robust, consistent, transparent, financially resilient and accountable.

We hope that this has provided some insights on the dynamics of our society's finances and we look forward to your constructive feedback at anytime.

Best wishes and a Happy New Year!

DR EESON SINTHAMONEY
HONORARY TREASURER

ONE DAY GYNAECOLOGY UPDATE

The One Day Gynecology Update organized by the Department of Obstetrics and Gynaecology, Hospital Sultanah Nur Zahirah was held at the auditorium of the Perpustakaan Awam Negeri on 21 September 2013. This seminar drew over 160 participants consisting of both medical officers and paramedics.

The objectives of this seminar were :

1. To update participants on recent advances in common gynecological diseases.
2. To optimize the referral process from primary to tertiary health care centres.
3. To stimulate dialogue and address difficulties in the diagnosis and treatment of common gynecological diseases in primary health care settings.

The participants were warmly welcomed by Dr Mohd Nasir Tak Abdullah, O&G consultant before the commencement of the seminar. Our speakers were the consultants and specialists from the Obstetrics and Gynaecology Department of Hospital Sultanah Nur Zahirah. We also invited Professor Anisah Jalaluddin from UPSI to speak.

Participants were also treated to light refreshments in between lectures to ensure they remain well nourished and attentive throughout the day. The seminar ended at 4.30pm with the participants bringing home goodie bags courtesy of our sponsor and as we hope, bountiful knowledge to share.

The organizing committee would like to take this opportunity to thank our generous sponsor; Abbott Laboratories (Malaysia) Sdn Bhd, OGSM, MMA (Terengganu Branch) and Post Graduate Medical Society (PGMES), our enthusiastic line of speakers, and above all, our wonderful participants.

DR MALINI MAT NAPES
OGSM TERENGGANU STATE REPRESENTATIVE

" Knowledge is power. Information is liberating. Education is the premise of progress, in every society, in every family."
- Kofi Annan

I LOVE ME CONFERENCE

The 4th annual I Love Me conference, organized as part of OGSM's CSR activities, was held this year on the 7th of September 2013 at the Cititel Hotel Mid Valley, Kuala Lumpur. The one-day conference consisted of two concurrent streams with 18 speakers delivering 20 presentations throughout the day on various topics about women's health and concerns. As in previous years, attendance was open to the public and free of charge. This year the event attracted 420 participants who ranged in age from 16 to 82 and received much positive feedback from the attendees who found the sessions useful and educational. Many were eager to know when the next I Love Me would be held!

OGSM would like to express our sincere gratitude and thanks to the 18 speakers and the team that AWT, our event organizers put together to run the show that day, all of whom gave up their time willingly and smilingly on a Saturday, for no renumeration, purely in the spirit of "giving back".

DR GOH HUAY-YEE
CSR CHAIRPERSON

I LOVE ME CONFERENCE 2013

"The doctors really gave us time to ask questions."
- Zai from PJ

"This is the first time I have attended the I LOVE ME conference. I heard about it through Facebook. It was very educational."

"We are glad the conference has returned this year. My friends and I always find it very interesting."
- Joyce Lim from Klang

"The doctors were very engaging and the topics were relevant. I will certainly come again next year."
- Cindy from Setiawangsa.

WOMEN'S CLINIC FOR THE POOR AT GRACE COMMUNITY CENTRE

As part of the CSR activities of the society, OGSM conducted a Women's Clinic For the Poor at Grace Community Centre off Masjid India on Sunday the 24th of November 2013 from 2 to 5.30 pm. Volunteering their time and services were retired MOH nurse Yim Key Lim, RN Liew Ching Shui and RN Tan Mei Yuen from Tropicana Medical Centre, Dr Lavitha Sivapatham, Dr Hoo Mei Lin and Dr Goh Huay-yee.

The clinic offered measurement of BMI, blood pressure and random blood sugar levels, and breast and pelvic examinations as well as pap smears. The response was overwhelming and the team saw over 60 patients in that afternoon and picked up a range of pathology including breast lumps, cervical polyps and one case of CIN 3 which was referred on to Ampang Hospital.

OGSM would like to thank all who sacrificed their Sunday afternoon to participate in this clinic. Your contributions were greatly appreciated.

(from left) Reverand Gurmit, AN Yim, Dr Goh HY, Dr Hoo ML, Dr Lavitha, RN Tan and RN Liew

LIFE SAVING SKILLS COURSE (LSSC) FEEDBACK

The Life Saving Skills Course has so far trained 600 medical personnel across Malaysia. A recent interview yielded the feedback below. It highlights the difference this course has brought to the practice of Obstetrics and Gynaecology. Congratulations to Dr Gunasegaran and his team.

Dr Guna and RN Vigneswary

Attending this workshop enabled my nurses and I to update ourselves and enable us to provide more effective care to mothers, recognize potential problems, keep track of mother's progress and be more involved in their labour. We were also given a detailed reference manual and counseling aids that provide more in depth information on common maternal issues and problems which we can use to refresh our memory and also share this information with our colleagues who have yet to attend this course. After undergoing this training, we are able to give a higher standard of patient care as we know and use the latest methods and skills especially when faced with obstetric emergencies.

RN Vigneswary
Nurse Supervisor
Labour And Delivery Ward
Tropicana Medical Centre

I had the priviledge to attend the Life Saving Skills Course. This course has improved my confidence in both identifying potential problems and initiating action for laboring patients in my hospital.

RN Atiah
Midwife

The OGSM course that I've attended at Selayang Hospital has given me more knowledge and upgraded my skills as a midwife. This course has exposed me to the many emergency situations we can potentially face. I now feel better equipped should I face these emergencies at work.

RN Avarine
Midwife

MRCOG PART 2 REVISION COURSE
CENTRAL WOMEN'S HOSPITAL, YANGON, MYANMAR
15TH – 16TH NOVEMBER 2013

The inaugural MRCOG Part 2 Revision Course was organised as an outreach initiative by OGSM after several discussions with the Obstetric and Gynaecology Society of Myanmar. It was designed as a complete Theory and OSCE course to cover the whole component of the MRCOG Part 2. We limited the number of participants to 24 to ensure that we were able to spend adequate time with each of them.

It was a successful endeavor and there were discussions to continue the training program as a joint effort of both the national societies and the RCOG Representatives of both countries. Organising a 'training the trainer 'course with the RCOG support was also considered as a future effort.

DR SHILPA NAMBIAR
COURSE COORDINATOR

Ed: OGSM would like to thank Dr Shilpa Nambiar and her team (Drs Lavitha Sivapatham, Nicholas Lim and Jerilee Mariam Khong Azhary) for donating their time and efforts in the running of this course. We congratulate them on their very successful and well received course.

PRESIDENT'S DESK (CONT.)

I believe, and this is my personal opinion, that the number of private Obstetricians will reduce, unless something drastic is being done about the fees or the way indemnity insurance is being offered in Malaysia.

Even if the fee schedule rises dramatically, are patients willing to pay more? As it is, patients are complaining about high private medical charges. I believe that market forces will eventually decide the correct fee.

As we are besieged from every side, it is more important than ever that we stand up for each other and for our specialty. Our specialty should be like a fortress, protected by sound and safe medical practice, fellowship and solidarity.

When a colleague has a complication, instead of pulling him/her down further by unnecessary comments, we should pull him/her up by offering understanding and emotional support. It is not easy being an Obstetrician. For those who have done it for a while will understand. Those who are new may feel that they are invincible. They will soon be reminded that they are not so. Another obstetrician will understand your predicament better than anyone else. If you feel that you need to speak to someone senior, you are most welcome to contact me or any of the council members and we will try to assist in any way possible.

Last weekend, some of our trainee members had the privilege of mingling with some senior Obstetricians during the Inaugural OGSM Teaching conference. This, I hope, will be the beginning of a strong foundation of support.

I was reminded as well that most patients still value the advice given by doctors. Patients complain not so much when something goes wrong, but more when communication breaks down. I believe a lot of the medicolegal problems can be resolved if we listened and communicated better.

I urge our members to be in touch with current changes in medical practice. Remember that judges/ lawyers/patients have access to a lot of information. On the occasion that something should go wrong, we will be judged against standards which are current. We cannot afford to be unfamiliar with terms like risk management, clinical practice guideline, audit, incident review.

Obstetrics is still enjoyable, especially if there is strong support and fellowship.

With that, Happy 2014 to all !

DR TANG BOON NEE
PRESIDENT

THIRD BIENNIAL MEETING OF THE ASIAN SOCIETY OF GYNECOLOGICAL ONCOLOGY, KYOTO, JAPAN, 2013

The Asian Society of Gynecological Oncology (ASGO) organised its 3rd Biennial meeting in Kyoto, Japan between 13/12/13 to 15/12/13. Over 1,300 delegates from 28 countries attended the meeting including five from Malaysia. Two doctors from Malaysia were awarded ASCO travel grants to attend the meeting. They were Drs Nirmala Kampan and Yulianty Arifuddin from University Kebangsaan Malaysia. These two doctors also submitted posters for the meeting. There were over 300 abstracts submitted. The majority of the participants were from Japan with large numbers of delegates coming from Indonesia, Korea, Taiwan and the Philippines.

The Society of Gynaecological Oncologists of the USA, The European Society of Gynaecological Oncology and the International Gynaecologic Cancer Society were represented at the meeting. The faculty comprised over 70 experts from various parts of the world. I was invited to be a member of the faculty and spoke on Pelvic & Paraortic Lymphadenectomy in Ovarian Cancer during the session on Gynaecological Oncology Surgery.

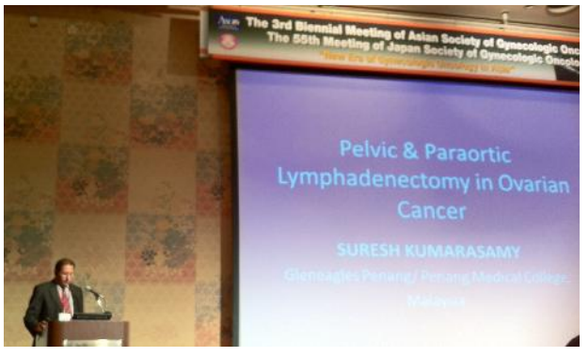
The scientific program was very interesting with presentations on cutting edge basic science research, as well as more practical clinical issues involving gynaecological cancer surgery, radiotherapy and chemotherapy. The entertaining social program included a welcome reception and tea ceremony. During the banquet an orchestra comprising of Japanese Obstetricians & Gynaecologists performed. The conference was very well organised.

Next year ASGO will be organising the 3rd International Workshop between 23rd to 24th August 2014 at the Asan Medical Centre, Seoul, Korea. The 4th Biennial Meeting will be held in Gangnam, Seoul, Korea from 12th to 14th November 2015. Travel grants are likely to be offered to young doctors (below 40 years) to attend the meeting, details of which will be announced in time. Recipients of Travel Grants are usually required to submit abstracts for presentation.

ASGO consists of individual members from Asian countries with a major professional interest, either as a clinician or as a scientist, in the prevention, treatment and study of gynaecologic cancer. The aim of ASGO is to contribute to the development of gynaecologic cancer science through research and exchange of information in medical science and friendship among members.

In the past, membership of the ASGO was free. The council of ASGO has recently decided that the membership fee for Malaysian doctors is US$ 50 per year. The new fee structure will be implemented in the near future. Further details will be announced in the ASGO website at www.asiansgo.org in time.

DR SURESH KUMARASAMY
IMMEDIATE PAST PRESIDENT OGSM
COUNCIL MEMBER
ASIAN SOCIETY OF GYNECOLOGICAL ONCOLOGY



Dr Suresh Kumarasamy delivering his lecture on Paraaortic & pelvic lymphadenectomy in Ovarian Cancer

Drs Nirmala Kampan and Yulianty Arifuddin, ASGO Travel Grant recipients being introduced in the presence of Dr Shahila Tayib

INAUGURAL OGSM TEACHING CONFERENCE

OGSM: 'At the OGSM AGM 2013, there was an overwhelming feeling that we really should be doing more for the trainees. One of the initiatives to address this matter is to conduct an educational conference specially catered to the needs of the trainees, hence the OGSM Teaching Conference was conceived. The OGSM Council hoped that this would not only provide a platform to address the concerns of our trainees but also to provide an opportunity for the O&G trainees in Malaysia to network, support each other, get to know the senior doctors in the fraternity and enhance their training with the educational sessions provided during the conference.'

Trainees: 'The Inaugural OGSM Teaching Conference (IOTC) was held on the 14th -15th December at the Boulevard Hotel, Midvalley. We had 70 participants from both the MOG and MRCOG pathways as well as a couple of senior house-officers and senior doctors. There were 15 speakers including the distinguished Professor Phillip Steer, consultants from the MOH/ private sectors and university professors. The scientific program was developed based on the needs of the trainees as indicated by the trainees themselves. Overall, the trainees that attended gave good feedback (4-5 out of 5 for all sessions) and the success is evident in the attendance, which was good till the end. The exam practice sessions and the interactive sessions on research were also much appreciated by the trainees. Overall, everyone who attended was positive and the resounding feedback was that this Teaching Conference should be made an annual one'

ASSOC PROF NAZIMAH IDRIS
ORGANIZING CHAIRMAN IOTC

Ed: OGSM would like to acknowledge to efforts of Assoc Prof Nazimah and her able Organising Committee. Congratulations on a job well done.

MASTERCLASS IN CLINICAL GOVERNANCE

After the success of our first “Masterclass in Medical Ethics”, OGSM organised their 2nd “Masterclass” on the 28th of September 2013. Malaysian trainees are often weak in matters pertaining to Clinical Governance. The Masterclass in Clinical Governance was held at the OGSM office and was attended by 28 trainees from hospitals from all over the country. Important exam orientated issues such as maternal mortality and audit were discussed. We were priviledged to have distinguished speakers Prof Dato' Dr Sivalingam Nalliah, Dr J Ravichandran and Dr Krishna Kumar amongst the faculty. Lectures were later reinforced by an OSCE session where common scenarios such as audit were discussed. As a candidate sitting for the MRCOG exams, I found these topics well taught and I felt that my queries were addressed.

DR LOH HUEY WEN
OGSM TRAINEE REPRESENTATIVE

CONGRATULATIONS

TO THE NEWEST MEMBERS OF OUR O+G FRATERNITY

MASTERS (MOG) NOVEMBER 2013

DR NAJIHAH ABDUL AZIZ
DR WAN FAIZAH MOHAMED
DR AISHATH SHIBNA AHMED
DR HANDOJO TJANDRA TJAHYANA
DR MASHARUDIN ABDUL WAHAB
DR NILAWATI ISHA
DR NURUL AZWA HASNY
DR RIDUAN MOHD TAHAR
DR MAIZATUL HASNIDA MOHD BASIR
DR NORLIZA MOHD IBRAHIM
DR SALMI DARAUP
DR PRAVIN A/L PERABA
DR SALINI SUHAILA NASIR
DR SITI AISHAH TAJUDIN
DR HATEEZA ZAKARIA
DR SYEDA NUREENA SYED JAFER HUSSAIN
DR ZATUL AKMAR BT AHMAD
DR NADZRATULAIMAN BINTI WAN NORDIN
DR ROSLIZA SHAFIE
DR NOR AZLINA ABD RAHMAN

MRCOG NOVEMBER 2013

DR KANDDY LOO CHIN YEE
DR CHAN JOE MEE
DR LI HIE ING
DR SIVANESWARAN JEYARASALINGGAM
DR HOO PEK SUNG

MALAYSIAN MEDICAL COUNCIL CONSENT FOR TREATMENT OF PATIENTS BY REGISTERED MEDICAL PRACTITIONERS

1. Definition

In general terms, CONSENT is the voluntary acquiescence by a person to the proposal of another; the act or result of reaching an accord; a concurrence of minds; actual willingness that an act or an infringement of an interest shall occur.

Consent is an act of reason and deliberation. A person who possesses and exercises sufficient mental capacity to make an intelligent decision demonstrates consent by performing an act recommended by another. Consent assumes a physical power to act and a reflective, determined, and unencumbered exertion of these powers[1].

Consent refers to the provision of approval or assent, particularly and especially after thoughtful consideration.

2. Necessity For Obtaining Consent

Generally, no procedure, surgery, treatment or examination may be undertaken on a patient without the consent of the patient, if he or she is a competent person. Such consent may be expressed or implied and may be verbal or in writing. Obtaining a patient's consent is an important component of good medical practice, and also carries specific legal requirements to do so. Except in an emergency where the need to save life is of paramount importance, the consent of the patient must be obtained before the proposed procedure, surgery, treatment or examination is undertaken. Failure to do so may result in legal action for assault and battery instituted against the medical practitioner.

3. Necessity To Warn Patients About Material Risks

Every patient as an individual has a choice whether or not to undergo a proposed procedure, surgery, treatment or examination.

A medical practitioner is obliged to disclose information to the patient and to warn the patient of material risks before taking consent. Failure to obtain a patient's consent or disclose material risks may be interpreted as a failure of the standard of care resulting in a disciplinary inquiry by the Medical Council or may even be construed as a breach of duty of care and legal action instituted.

While a patient might consent to a procedure after being informed in broad terms of the nature of the procedure, this consent will not amount to an exercise of choice unless it is made on the basis of relevant information and advice.

The medical practitioner must inform the patient, in a manner that the patient can understand, about the condition, investigation options, treatment options, benefits, all material risks, possible adverse effects or complications, the residual effects, if any, and the likely result if treatment is not undertaken, to enable the patient to make his own decision whether to undergo the proposed procedure, surgery, treatment or examination.

4. Explanatory Notes/Documents

It is recommended that practitioners provide additional information on risks and adverse effects of any procedure in a written explanatory document which the patient (or next-of-kin or legal guardian) can read, request further explanation where necessary, understand and append a signature to that effect.

These Explanatory Notes will be considered an annexure to the main consent form signed by the patient or next-of-kin or legal guardian.

Where such explanatory notes or document are not available or not in standard use, the practitioner may note down the risks and adverse effects, as explained to the patient (or next of kin or legal guardian) in the patient's case notes and duly signed/initialled by him, with the date.

5. Circumstances in Which Consent May Not Be Required

There are several exceptions to the rule that the consent of a patient must be obtained before commencing any procedure, surgery, treatment or examination, and they include the following:

A medical emergency is defined as an injury or illness that is acute and poses an immediate risk to a person's life or long term health. Consent is not required in emergencies where immediate treatment is necessary to save an adult person's life or to prevent serious injury to an adult person's immediate and long term health where the person is unable to consent, subject to there being no unequivocal written direction by the patient to the contrary, or where there is no relative or any legal guardian available or contactable during the critical period to give consent.

In such circumstances, a consensus of the primary surgeon (who is managing the patient) and another registered practitioner is obtained and the surgeon signs a statement stating that the delay is likely to endanger the life of the patient. The registered medical practitioner must co-sign the consent form.

Specific arrangements apply for the obtaining of consent from a third party such as a parent or guardian of a child patient (see infra, Part 6 et seq.).

Consent of the patient may not be required for any treatment that may be ordered by a court of law, for example, an order for the specific treatment of a minor, or a patient on life-support.

6. Patients Who Are Young Persons (Minors)

The Laws of Malaysia Act 21: Age of Maturity Act 1971 states under Age of majority: "The minority of all males and females shall cease and determine within Malaysia at the age of eighteen years and every such male and female attaining that age shall be of the age of majority"

Generally, whether a young person is sufficiently mature to provide a valid consent to medical treatment depends not only on his or her age but also on whether he or she has sufficient maturity and intelligence to understand the nature and implications of the proposed procedure, surgery, treatment or examination. This must be decided on a case-by-case basis, and whatever decisions made must be "in the best interest of the patient".

It is important to note that for the purposes of the Regulations, a patient who is unmarried and below 18 years of age does not have the capacity to give valid consent to any medical procedure or surgery.

If a minor presents with an adult other than a parent, the attending medical practitioner should attempt to ascertain the adult's relationship to the child and whether the adult is the child's guardian. Where the adult does not appear to be the child's guardian, but bears some relationship to the child, and confirms that the parent/guardian is aware that he/she is accompanying the child, it is reasonable to assume that the parent or guardian has delegated responsibility to that person, unless there is any indication to the contrary (i.e. a previous objection by the parent to that person exercising any authority in relation to the child).

Where the patient is an "infant" as defined under the Guardianship of Infants Act 1961, it would be prudent for the medical practitioner to consult or obtain the consent of the infant's legal guardian. Under the Guardianship of Infants Act 1961, the guardian of the person of an infant shall have the custody of the infant, and shall be responsible for his support, health and education[2].

The Law Reform (Marriage & Divorce) Act 1976 makes it clear that each parent has full responsibility for each of his/her children who is under 18 years of age. Parental responsibility is not affected by changes to relationships (i.e. if the parents separate). Each parent has the responsibility for his/her child's welfare, unless there is an agreement or a Court has made an order to the contrary[3].

This means that the consent of either parent to his/her child's medical treatment is usually sufficient. There are two circumstances where the consent of either parent may not be sufficient:

i. Where no formal court orders have been made, and one parent consents and the other refuses. The best way of handling this situation is by counselling the parents and trying to reach agreement on what is in the child's best interests.

ii. Where a Court of law has made an order to the contrary.

In recognising the evolving capacity of the child, the United Nations Convention on the Rights of the Child (commonly abbreviated as the CRC, CROC, or UNCRC) as a human rights treaty setting out the civil, political, economic, social, health and cultural rights of children, defines a child as any human being under the age of eighteen, unless the age of majority is attained earlier under a state's own domestic legislation[4].

7. Patients Who Are Incapable of, or Impaired With, Decision-Making Ability

Impairments to reasoning and judgment which may make it impossible for someone to give informed or valid consent include such factors as basic intellectual or emotional immaturity, high levels of stress such as Post Traumatic Stress Disorder (PTSD) or as severe mental retardation, severe mental illness, intoxication, severe sleep deprivation, Alzheimer's disease, or being in a coma.

In such circumstances, and in an emergency to save life, the procedure as outlined for emergency treatment or management should be followed.

When there is a relative, next-of-kin or legal guardian is available, the consent may be obtained from such a person if an elective or non-emergency operation is necessary from a medical practitioner's considered opinion.

Under the Mental Health Act 2001, consent is generally not required for conventional treatment apart from surgery, electroconvulsive therapy or clinical trials for patients with mental disorder as defined by the said Act[5].

In instances where consent is required it must first be obtained from:

i. The patient himself if he is capable of giving consent as assessed by a psychiatrist; or

ii. If the patient is incapable of giving consent, from his guardian in the case of a minor or a relative in the case of an adult, "guardian" and "relative" as defined in the Mental Health Act[5];

iii. Two psychiatrists, one of whom shall be the primary or attending psychiatrist, if the guardian or relative of the patient is unavailable or untraceable and when the patient himself is incapable of giving consent.

8. Types of Consent

In all instances or episodes of taking consent, whenever possible conducted in privacy, it must be ensured that the patient (or next-of-kin or legal guardian) is fully aware of the objective and process of giving consent, be comfortable and composed.

a. Implied consent is a form of consent which is not expressly granted by a person, but rather inferred from a person's actions and the facts and circumstances of a particular situation (or, in some cases, by a person's silence or inaction). This may become an issue if there is any dissent or disagreement arising from the patient's interpretation of the practitioner's actions or the outcome thereof.

b. Expressed consent may be in oral, nonverbal or written form and is clearly and unmistakably stated. Issues may arise when the consent is through oral communication, as stated under 'implied consent'.

c. Informed consent can be said to have been given based upon a clear appreciation and understanding of the facts, implications, and future consequences of an action. In order to give informed consent, the person concerned must have adequate reasoning capacity and be in possession of all relevant facts at the time consent is given. This term was first used in a 1957 medical malpractice case by Paul G. Gebhard in the USA[6,7.] Informed consent is a medico legal requirement or procedure to ensure that a patient knows all of the risks and costs involved in a treatment. The elements of informed consents include informing the patient of the nature of the proposed procedure, surgery, treatment or examination, possible alternative treatments, and the potential risks and benefits of the treatment.

d. Valid consent can be defined as the voluntary agreement by an individual to a proposed procedure, given after appropriate and reliable information about the procedure, including the potential risks and benefits, has been conveyed to the individual. It is generally accepted that consent to be "valid" should be "informed"; the requirements for obtaining valid consent are:

   i. It must be given by a person with legal capacity, and of sufficient intellectual capacity to understand the implications of undergoing the proposed procedure.

   ii. It must be taken in a language which the person understands.

   iii. It must be given freely and voluntarily, and not coerced or induced by fraud or deceit.

   iv. It must cover the procedure to be undertaken.

   v. The person must have an awareness and understanding of the proposed procedure and its known or potential risks.

   vi. The person must be given alternate options to the proposed treatment or procedure.

   vii. The person must have sufficient opportunity to seek further details or explanations about the proposed treatment or procedure.

   viii. There must be a witness/interpreter, who may be another registered medical practitioner or a nurse, who is not directly involved in the management of the patient nor related to the patient or the medical practitioner, or any such person who can speak the language of the patient, to attest to the process during taking of the consent.

e. Verbal consent is given by using verbal communication, and may be open to debate and as far as possible, should be avoided.

f. Nonverbal consent is given by using nonverbal communication, like nodding acquiescence or extending the arm for a procedure, which are also open to debate and should be avoided.

9. Written Consent

The Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006 states in Part VIII Consent under section 47 (3) "Consent obtained or caused to be obtained under this regulation shall be in writing."[8]

Without prejudice to the above, which relates to practice in private healthcare facilities and services, written consent when not taken in a standard consent form, should nevertheless be recorded in the patient's case notes/record that the patient had been informed and had consented to a particular stated procedure like setting up an IV line or giving rectal enema. This is to safeguard against any unexpected outcome.

10. Pre-requisites for Medical Practitioner Taking Consent

There are a few pre-requisites for the taking of consent by a practitioner from a patient (or the next of kin, or legal guardian as the case may be):

a. The doctor and the patient must have met or know each other in the context of doctor-patient professional relationship.

b. The doctor who is planning to operate or do an invasive procedure on a patient must establish personal contact with the patient, in other words the two must meet before the intended procedure.

c. The doctor must explain to the patient the nature of the procedure and its objective, and alternative procedures.

d. The doctor must explain possible complications, which may delay or affect the result of the procedure, as well as influence the duration of stay in the ward.

These pre-requisites are best satisfied when the person who is planning to perform the procedure personally and directly takes the consent from the patient. This would establish and uphold the tenets of good medical practice and pave the way for an accepted standard and quality of professional care.

11. Responsibility of Medical Practitioner Taking Consent

It is understood that by a particular practitioner undertaking the procedure he is competent, skilled and experienced (in the broadest senses of the words). Such an assurance is assumed to be so by the patient.

It is generally required that only fully registered medical practitioners may take consent for a procedure, surgery, treatment or examination from a patient, and also perform the procedure, surgery, treatment or examination for which that consent has been taken.

The primary responsibility and vicarious liability in the event of complaints rests on the practitioner who has taken the consent and who additionally has himself performed the procedure, surgery, treatment or examination. This is based on the requirement that the practitioner taking the consent and performing the procedure, surgery, treatment or examination will be able to explain to the patient all details of the proposed procedures as above, which would include possible unexpected findings and complications, and the remedial actions that will be taken.

In the event of the practitioner taking the consent and the practitioner performing the procedure, being two different registered medical practitioners, the final responsibility and liability will be on the practitioner who performs the procedure, who should, before performing the procedure, confirm the nature of the information given to the patient by the other practitioner in the course of taking the consent.

In a department with many practitioners of varying competence, skill and experience, the ultimate and direct responsibility rests upon the Head of Department for having allowed a junior practitioner (including trainees, medical officers and housemen as part of their training) to take consent and perform a specific procedure as described above, or for having delegated a specialist to make such decisions on his behalf.

It is not enough for the Head of that department to assume or to claim that a particular practitioner has the competence, skill and experience to perform a procedure, surgery, treatment or examination independently and without supervised assistance unless the Head of Department himself is so aware and convinced, and has reason to believe it to be so.

12. Standard Consent Form

A consent form is routinely being used by healthcare facilities and services in the country and contains various details.

A standard consent form should contain:

a. Patient identification data: Name, IC Number, Address, gender

b. Name of procedure/surgery to be performed in full

c. Type of anaesthesia

d. Name(s) of registered medical practitioner(s) performing the procedure/ surgery.

e. Permission to proceed with any additional procedure that may become necessary during the surgery and related to the procedure for which the original consent had been obtained.

f. A statement to the effect that the person who is performing the procedure has explained to the patient (or next-of-kin) the nature of the procedure and the potential material risks.

g. A statement to indicate that the Patient has received and read additional Explanatory Notes, if so provided by the practitioner.

h. Signature of Patient/next-of-kin (relationship) and IC Number and date

i. Signature of Practitioner and name stamp, and date

j. Signature & name of Witness (to the signing of the form) and date.

13. Prepared Material with Information about a Treatment

Prepared material such as brochures or standard forms (with translations where relevant) with information about a procedure, surgery, treatment or examination may be useful if given to the patient as a means of stimulating discussion and for guiding the medical practitioner when informing the patient about a proposed procedure, surgery or treatment. However pre-prepared material should not be used as a substitute for informing or making sure that a patient understands the nature of, and risks involved in, the procedure, surgery or treatment, as the provision of such material per se will not necessarily discharge the medical practitioner from his legal duty.

The medical practitioner should assist the patient to understand the material provided and, if required, explain to the patient any information that he or she finds unclear or does not understand. The medical practitioner must afford the patient the opportunity to read the material and raise any specific issues of concern either at the time the information is given to the patient or subsequently.

The medical practitioner must ensure that any pre-prepared material given to the patient is current, accurate and relevant to the patient.

If such pre-prepared information material does not disclose all "material risks" either in general terms or otherwise, the medical practitioner must provide supplementary information on such "material risks" as are not disclosed, verbally. The likelier the risk, the more specific the details should be.

An inadequate or inaccurate information sheet may have significant negative implications in subsequent litigation. It may give rise to an inference that the patient was not properly informed or ill-informed. In most cases in determining what "material risks" should be disclosed, an information sheet cannot be a substitute for a full and frank discussion with the patient.

Any additional information provided should be specifically noted on the information sheet or in the medical practitioner's case notes.

[Explanatory notes and documents prepared by the practitioner in Section 4 do not come under this category].

14. Faxed or Photocopy Of Consent Form

It is necessary for the patient, or next-of-kin or legal guardian to be physically present before a registered medical practitioner for purposes of giving consent for a procedure, surgery, treatment or examination. Such presence will provide the practitioner the opportunity to personally and directly explain the procedure to be undertaken as described above.

For the above specific reasons, faxed or photocopied consent form is not acceptable.

15. Additional Special Aspects on Consent

a. Period of validity of consent

It is generally believed that for an acceptable standard of care, the consent for an invasive procedure has to be taken a reasonable period before the procedure. A reasonable period would be not more than 24 hours. If during this period there is a change in the circumstances or condition of the patient requiring a review of the procedure initially planned, for which consent had been taken, then it is incumbent on the practitioner to obtain a fresh consent.

For any procedure not carried out within the 24 hours, or delayed for any period thereafter, for whatever reason, including requiring an in-patient to be discharged home, a new consent has to be taken before undertaking the procedure, surgery, treatment or examination as the circumstances or the disease condition may have changed during that period or the patient may have forgotten the details of the consent.

It sometimes is the practice of convenience in many healthcare facilities that consent is taken when the patient is being seen in the clinic by the practitioner, and while scheduling the intervention, which may be in a week's time or later. In such instances, when the patient is seen on admission at the time before the surgery, it is best to remind him/her about the proposed procedure, surgery, treatment or examination and salient points in the consent form previously signed by the patient. Nothing should be taken for granted.

b. Chronic conditions requiring periodic treatment, including transfusion of blood or blood products

Good standard of care requires that consent has to be specific in time and procedure for any invasive treatment. For example, for a patient requiring de-sloughing or related procedure (like digital ablative surgery) of a diabetic ulcer or a haemophiliac patient requiring periodic blood transfusion or chemotherapy, consent has to be taken on every occasion that the procedure is to be undertaken.

c. Consent for photographs and audio-visual recordings

Prior consent must be obtained if the practitioner is planning to take clinical photographs or to make audio-visual recordings before, during or after an invasive procedure. There may be medico-legal reasons for taking photographs, or audio-visual recordings, as in cosmetic surgery or ablative surgery involving upper or lower limbs. Such photographs and audio-visual recordings rightfully belong to the patient and if to be retained by the practitioner, further consent

must be obtained. If such photographs or audio-visual recordings are requested by the patient to be taken away, it is necessary to keep copies of such material in the patient's records, for future requirements, like medical reports. This information are available in the MMC Guideline on Audio and visual recordings in Medical Practice[9].

d. Consent on admission

Based on the principles that consent must be specific for a procedure, "blanket" consent on admission of a patient, either as an out-patient or in-patient, is not allowed. The reason that this will cover all treatments, including those which may be perceived to be minor, like giving injections or per vaginal examination, and which may be considered "implied", is not acceptable. Similarly, consent for release of information and details on diagnosis of diseases and/or management, to employers or third party payers (Managed Care Organizations or insurance firms) has to be specific and contemporaneous, and not "blanket" at time of commencement of employment. Similarly, too, consent for the release of results and/or reports on pre-employment medical examination to the prospective employer has to be obtained from the applicant.

e. Consent for Investigations for HIV

Because of the special implications to persons who may test positive for HIV, and the need for counselling and further management, specific consent has to be taken before the tests are carried out.

f. Consent for keeping (for teaching purposes) organs or tissues removed at surgery

Patients may request for specimens removed at surgery (limbs, spleen, gall bladder, etc.) to be ritually disposed and this should be complied with. In instances where such a request is not made, the surgeon may seek the consent of the patient or next-of-kin to retain the specimens for medical education or research purposes, but without having to reveal the identity of the patient. Under section 2 of the Human Tissues Act 1974, where the deceased during his lifetime has, either in writing or verbally in the presence of two or more witnesses during his last illness, expressed a request that his body or a specified tissue in his body be used after his death for therapeutic purposes, or for purposes of medical education or research, the person lawfully in possession of his body after his death may authorize the use of the deceased's body or removal of the organs, unless he has reason to believe that the request was withdrawn[10].

g. Consent for sterilisation and hysterectomy

Sterilisation procedures in a woman or man should be consented by the patient. Similarly, hysterectomy and orchidectomy should also normally involve consent by the patient.

h. Consent for release of patient data to another practitioner for treatment

Written consent must be given by a patient who is being transferred to another healthcare facility or medical practitioner for purposes of further treatment, for release of relevant parts of his medical records.

16. Refusal to Give Consent for Treatment

Generally, every individual is entitled to refuse medical treatment. A legally competent person has a right to choose what occurs with respect to his or her own person. For such persons, the right to refuse treatment exists, regardless of the reasons for making the choice whether they are rational, irrational, unknown or even non-existent. Forcing medical treatment on a competent patient who has validly refused such treatment could be tantamount to an assault or battery.

However, if the patient's circumstances change significantly, any prior refusal of medical treatment may not remain valid and may need to be reviewed with the patient.
Similar to consent to treatment, refusal of treatment may be expressed or implied and may be in writing or given verbally. The refusal of treatment by a patient should also be recorded in detail and in writing in the medical record or the medical practitioner's case notes, and where possible, signed and dated by the patient.

17. Advance Care Directives (or Living Wills)

A medical practitioner should refrain from providing treatment or performing any procedure where there is an unequivocal written directive by the patient that such treatment or procedure is not to be provided in the circumstances which now apply to the patient ("Advance Care Directive").

However, this does not apply where the patient's directive contains instructions for illegal activities, such as euthanasia or the termination of pregnancy.

Should there be an Advance Care Directive, the medical practitioner should consider whether it is sufficiently clear and specific to apply to the clinical circumstances which have arisen. The medical practitioner should also consider the currency of the directive, whether it can be said to be made in contemplation of the current circumstances (for example, whether the directive was made before or after the diagnosis of the current illness). Whether there is any reason to doubt the patient's competence at the time that the directive was made, or whether there was any undue pressure on the patient to make the directive, are factors that should be considered.

In an emergency, the medical practitioner can treat the patient in accordance with his or her professional judgment of the patient's best interests, until legal advice can be obtained on the validity or ambit of any Advance Care Directive that may have been given by the patient. Where there are concerns about the validity or ambit of an Advance Care Directive in a non-emergency situation, the medical practitioner should consult the patient's spouse or next of kin and the medical practitioner should also consider the need to seek legal advice and to discuss the issue with his or her colleagues, or other clinicians involved in the patient's care. Such discussions should be documented in the patient's medical case notes.

18. Consent for Other Procedures

Aspects of consent are also covered in MMC Guidelines on Assisted Reproduction, Organ Transplantation and Clinical Trials & Biomedical Research, Confidentiality, Good Medical Practice and Release of Medical Records and Reports, Audio and Visual Recordings in Medical Practice.

Adopted by the Malaysian Medical Council on 15 January 2013

Notes:

a. *The initial draft was prepared by the MMC Committee chaired by Datuk Dr. Mahmud Mohd Nor, with Mr. Darryl S.C. Goon, Dr. Eeson Sinthamoney, Dato' Dr. Abu Hassan Asaari, Dr. (Mr.) Zulkiflee Osman, Dr. (Mr.) Zainal Ariffin Azizi, Dr. Lim Wee Leong, Dr. David Quek Kwang Leng, Mdm. Narkunavathy Sundareson, Mr. Donald Joseph Franklin, Mr. Mohamad Fazin Bin Mahmud, Dr. Rosnah Binti Yahya and Dr. Nor Akma Binti Yusuf as members and submitted to the Council on 9 November 2010.*

b. *In view of various comments about the initial report by members of the Council, Dato' Dr. Abdul Hamid Abdul Kadir, Chairman of the MMC Ethics Committee was appointed to review the report.*

c. *The sentiments expressed by those present at a meeting convened to discuss the major issues in consent taking, held on 10 January 2012, have also been taken into consideration in the preparation of this draft, as well as at meetings of the MMC in March 2012 and few times at subsequent Council meetings.*

d. *Amendments to the draft suggested by some members of the Malaysian Medical Council (Dato Dr Megat Burhainudin bin Megat Abdul Rahman, Professor TA Lim, Professor Dr Zainul Rashid Mohd Razi and Dr Milton Lum), at various times, were considered at a meeting on 7 December 2012, at which were present Dato Dr Megat Burhainudin bin Megat Abdul Rahman, Professor TA Lim and Dr Milton Lum.*

e. *This draft on Consent in Medical Practice covers in great detail one section in the Code of Professional Conduct. Aspects of Consent are also covered in MMC Guidelines on Confidentiality, Good Medical Practice, Release of Medical Records and Reports, Assisted Reproduction, Organ Transplantation, Clinical Trials and Biomedical Research, Audio and Visual Recordings in Medical Practice.*

THE ROLE OF MINIMAL ACCESS SUGERY (MAS) IN GYNAECOLOGIC-ONCOLOGY

References

1. *Schlaerth A.C., Abu-Rustum N.R. Role of Minimally Invasive Surgery in Gynecologic Cancers. The Oncologist 2006, 11:895-901.*
2. *Querleu D., Martel P., Leblanc E., Laparoscopic surgery and gynaecological cancers. Cancer Bulletin 2007 ; 94 (12) : 1063-71.*
3. *Baillieres Clin Obstet Gynaecol. 1997 Mar;11(1):1-22. Hysterectomy: a historical perspective.*
4. *Joan L. et al. Laparoscopy Compared With Laparotomy for Comprehensive Surgical Staging of Uterine Cancer: Gynecologic Oncology Group Study LAP2.*
5. *Chung HH, Lee S, Sim JS, Kim JY, Seo SS, Park SY, et al. Pretreatment laparoscopic surgical staging in locally advanced cervical cancer : preliminary results in Korea. Gynecol Oncol 2005 ; 97 : 468-75.*

THE KL OGSM FELLOWSHIP NIGHT

The KL OGSM Fellowship Night was held at OGSM's Mont Kiara office on Saturday, the 14th of December 2013. We were honoured once again to host Professor Phillip Steer who spoke eloquently about the use of technology in the practice of O&G, highlighting a matter near and dear to most of us, that is the challenges of CTG monitoring, and the difficulties both medical and legal, that our UK colleagues have been facing in recent years. Retraining and updating the clinician were addressed and this may soon become a requirement even on our shores in the not too distant future.

Mr K. Navinderan from Shearn Delamore was also invited to update members regarding recent landmark legal cases that may change the way we practice. 2014 is going to be an interesting year indeed with 2 recent legal decisions being discussed at the Federal Courts which may change the face of medical litigation in Malaysia. Watch this space for more updates from our legal fraternity.
Overall, it was an eye opening evening and the fellowship that followed was as usual, a lot of fun.

DR HOO MEI LIN
OGSM NEWSLETTER EDITOR

ROLE OF MAS IN GYNAE ONCOLOGY

THE ROLE OF MINIMAL ACCESS SURGERY (MAS) IN GYNAECOLOGIC-ONCOLOGY

Minimal Access Surgery or laparoscopic surgery is a relatively new field in Malaysia. In Gynaecology however, the first laparoscopic hysterectomy was performed by Harry Reich in Kingston, Pennsylvania in 1988. Laparoscopic surgery is now commonly used in the treatment of benign masses and ectopic pregnancies. Increasing, MAS is being recognized as a viable modality in the management of gynaecological cancers.

Diagnostic Purposes (Obtaining Histological Diagnosis). The use of hysteroscopy and cystoscopy has been widely accepted in assisting clinical staging in gynaecological malignancies. We still have many patients who present with ascites and a pelvic mass with metastasis to the other organ as evident by CT-scan. If the cytology from ascitic fluid is repeatedly negative for malignant cells, there is a role for diagnostic laparoscopy to obtain tissue for histological diagnosis i.e. from peritoneal seedling, ovarian surface or even omental biopsy. In these cases, it is important to avoid rupturing the tumour or cyst.

Ovarian Cancer

Laparoscopic approach can be incorporated in many ways in managing ovarian cancer. It depends on the stage of disease and surgical goals of the procedure. In advanced stage disease, laparoscopy can be used to confirm histopathological diagnosis and determine resectability. In early-stage disease, patients can be comprehensively staged via the laparoscopic approach. There are also cases referred for completion of surgery after accidental malignant ovarian cystectomy. Complete staging can be done laparoscopically i.e. TLHBSO with infracolic omentectomy, appendicectomy and pelvic lymph nodes dissection.

Second look surgery is not common practice with the availability of CT-Scan. In selected patients, there is a role in using laparoscopy as a second-look procedure at completion of adjuvant chemotherapy. This will help determine further treatment in advanced ovarian cancer, either for primary debulking surgery (PDS) or interval debulking surgery (IDS) after neoadjuvant chemotherapy. A second look diagnostic laparoscopy helps avoid unsuccessful open surgery (open and close).

Endometrial Cancer

The use of laparoscopy in managing early endometrial cancer is not new in Malaysia. Laparoscopic hysterectomy is commonly done locally now and pelvic lymphadenectomy has started to become a routine procedure in some centers. The benefits of MAS in the management of early-stage endometrial cancer have been proven time and again in numerous studies. It is a safe option with lower hospital costs and comparable results to the abdominal approach. The laparoscopic staging procedure includes a total laparoscopic or assisted vaginal hysterectomy, pelvic and para-aortic lymph node dissection, peritoneal washings, and omentectomy in patients with clear cell carcinoma or serous malignancies of the endometrium. In terms of outcome, the recurrence free survival rate was not significantly different between the laparoscopy (97.3%) and laparotomy (93.3%) groups. Similarly, the overall survival rate was 86.3% versus 89.7%, respectively. These randomized, prospective data really recommend that laparoscopic procedures be included in the routine treatment options for patients with endometrial cancer.

Cervical Cancer

Another established procedure is laparoscopic radical hysterectomy. An extended series of 200 laparoscopic radical hysterectomies was published by French surgeons with reassuring results. Cervical cancer less than 2 cm without lymph node involvement are cured by minimally invasive surgery in 98% of case, but tumours over 4 cm are still have guarded outcome. These results were similar in a Korean study. Therefore, laparoscopic radical hysterectomy should be considered in cervical lesions of less than 2 cm.

Women with early-stage cervical carcinoma who wish to maintain fertility with preservation of the uterus may be offered laparoscopic radical trachelectomy. This procedure involves laparoscopic pelvic lymphadenectomy, tunneling of the ureters, resection of parametrium and then through vaginal approach, resection of the upper vagina, the affected cervix with an adequate margin, the cardinal and uterosacral ligaments can be accomplished. This is then followed by an endocervical and endometrial sampling above the radical trachelectomy specimen with intraoperative frozen section for pathologic evaluation of surgical margins.

With low recurrence rates and multiple successful pregnancies reported, laparoscopic radical trachelectomy is emerging as an acceptable alternative for treating patients with early-stage cervical cancer who desire fertility preservation.

Conclusion

Laparoscopy has multiple benefits for gynaecology oncology patients. The main advantage to the surgeon is improved visualization of operating field and therefore improves dissections in challenging areas such as the pararectal and obturator spaces. Improved visualization also helps in the resections of metastatic or recurrent disease. There is reduced bleeding from small vessels because of the pressure from pneumoperitoneum, decreased hospital stay, and rapid recovery. Postoperative chemotherapy or radiation can be initiated earlier, and radiation complications from bowel adhesions are minimized. Worldwide interest clearly demonstrates that laparoscopic techniques must now be part of the armamentarium of the gynaecology oncologist. In experienced hands, the operating time and outcome is almost similar as laparotomy. Minimal access surgery should not be taken as competitor to open surgery but should be regarded as a complimentary method in gynaecology-oncology surgery.

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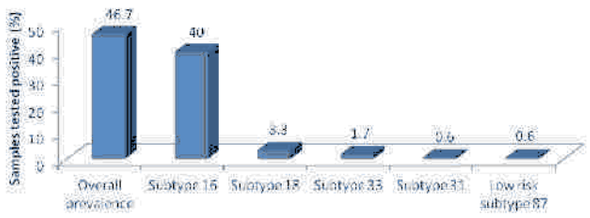
HOSPITAL AMPANG

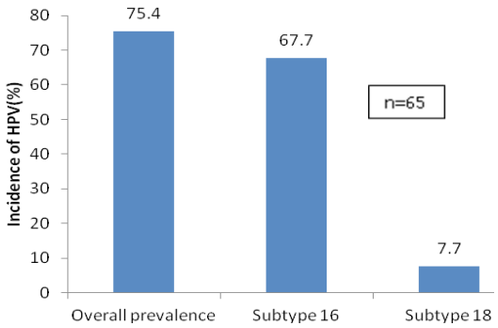
PREVALENCE OF HPV INFECTION IN MALAYSIA

Several studies have been carried out in Malaysian population to report the prevalence of HPV infection.

Chong et al., carried out a prevalence study in Southern Selangor which showed high prevalence of HPV in the sample studied (n=200). The high-risk oncogenic type 16 was the most common HPV subtype. In this study, nested polymerase chain reaction was used to detect HPV DNA. The method was found to be highly sensitive in detecting even low-risk patients[1].

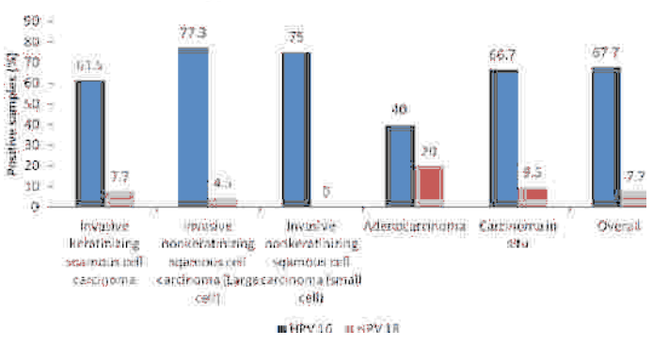


Padmanathan et al., carried out a study investigating the incidence of HPV in histologically confirmed cervical carcinoma (n=65)[2], The overall prevalence and subtypes are given in the figure below

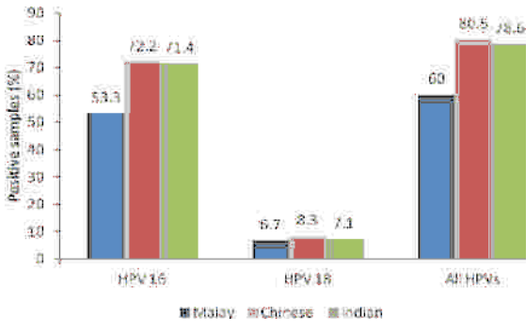


This was a comprehensive study, which also investigated the distribution of HPV types in the carcinoma types, frequency in the different races in Malaysia and prevalence of HPV in different age groups.

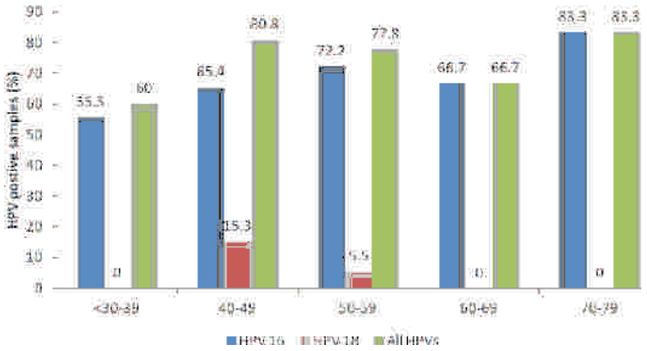
HPV types in different carcinomas



Frequency of HPV infection in different races in Malaysia



HPV prevalence in different age-groups

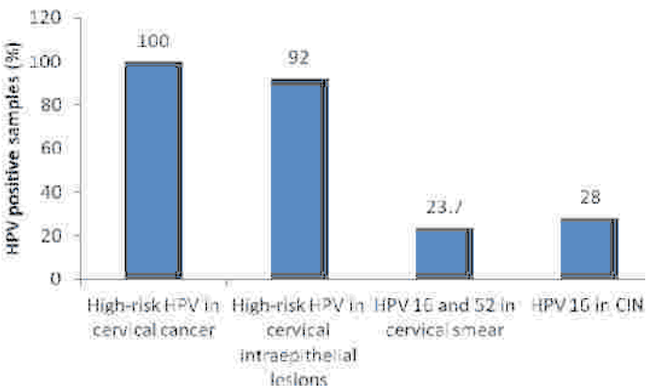


Sharifa et al. carried out a prevalence study for HPV infection in abnormal cervical smears in Malaysian patients. In the study, DNA was extracted from 38 abnormal smears which included 25 intraepithelial lesions, 13 cervical carcinomas and 10 normal smears using the polymerase chain reaction technique[3].

The key results of the study are as follows:

- The overall prevalence of high-risk HPV genotypes in abnormal smears was 95%.
- The high-risk oncogenic types identified were HPV types 16, 18, 31, 51, 52, 56, 58 and 66.

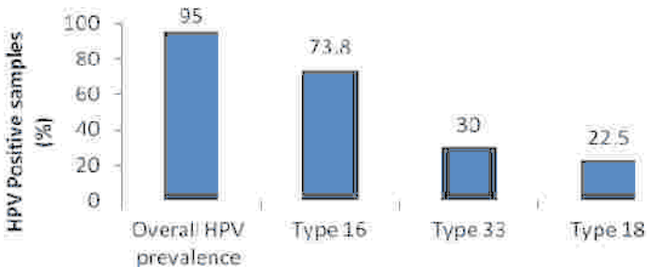
HPV prevalence in various abnormal smears



Sharifa et al., carried out a cross sectional study to determine the prevalence and distribution of HPV genotypes in pre-invasive (cervical intraepithelial neoplasia, grade 3 or CIN 3) and invasive cervical cancer (ICC). The study analysed paraffin-embedded tumour tissue blocks [n=80, comprising CIN 3 (n=20), invasive cancers (n=60)]. The study population was predominantly Chinese (66.3%) and the mean age was 52.0 ± 12.2 years.[4]

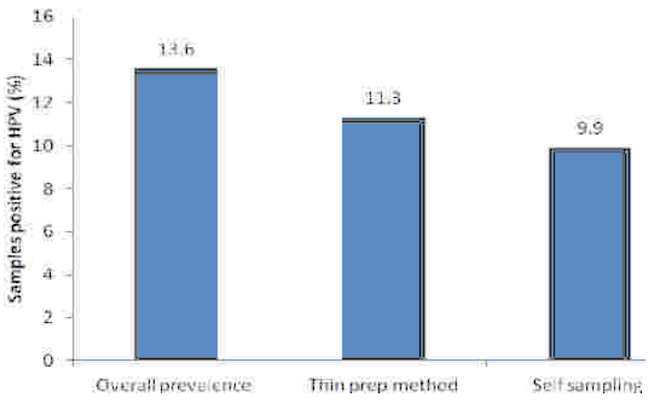
The key results of the study were:

- Twelve HPV genotypes were identified, namely, HPV 16, 33, 18, 39, 52, 45, 58, 59, 31, 35, 6 and 11. Single HPV genotype was observed in 38.8% and 53.8% of the cases showed two or more genotypes.



- Five commonly detected genotypes in ICC are HPV 16, 33, 18, 52 and 39.

Hamzah et al., carried out a cross sectional study that compared the efficacy of physician directed smear and vaginal self-sampling. Two samples (one each for directed smear and vaginal self-sampling) were taken from 345 patients and evaluated for HPV DNA and cytology.[5]



- The commonest high risk HPV DNA types detected were HPV 68 and 18, and for low risk type was HPV 42.

Cheah et al. carried out a retrospective analysis of large cell non-keratinising carcinoma of the uterine cervix (100 cases).[6] The key results of the study are as follows:

- The HPV type 16 and type 18 were prevalent in 47% and 41% of the cases, respectively.
- The overall detection rate of HPV type 16 and type 18 was 88%.

HPV Research Meeting

There is a scarcity of good data on HPV infection in Malaysia. Because of this, I organised a meeting aimed at stimulating HPV related research in Malaysia on the sidelines of the 22nd Malaysian International Congress of Obstetrics & Gynaecology on 2/6/13 at the Shangri-La hotel in Kuala Lumpur. Information on this meeting was circulated to members of OGSM.

Three presentations were made by Dr Jeffrey Tan (Australia), Professor Patti Gravitt (USA) and Prof Woo Yin Ling (Malaysia). The topics covered were: HPV testing in screening and clinical applications, Self-sampling in cervical screening with HPV testing and HPV research in Malaysia - opportunities and challenges. This was followed by a lively discussion among the participants.

HPV Website

To further educate Malaysian doctors on matters pertaining to HPV infection and also to act as a source for local data on HPV infection, I am working on developing a Malaysian HPV information website which will be linked to the OGSM website. This website will be available in a few months time. In addition to data, there will also be information on HPV related guidelines and educational material covering HPV testing, colposcopy and other related issues. Members of OGSM who have peer reviewed local data either published or presented in oral or poster form which may be suitable to be included in this website are requested to submit the data to Mr. Chong of the OGSM secretariat at: ogsm@myjaring.net

A new investigational 9 – Valent vaccine.

Results from a Phase III trial on a investigational 9-valent HPV vaccine called V503 covering HPV types 16, 18, 6, 11, 31, 33, 45, 52, and 58 were presented for the first time at a late-breaker session of the European Research Organisation on Genital Infection and Neoplasia (EUROGIN) Congress in November 2013 [6-9].

The seven cancer-causing HPV types in V503 (16, 18, 31, 33, 45, 52 and 58) cause approximately 90 percent of cervical cancer cases, approximately 80 percent of high-grade cervical dysplasias and approximately 50-60 percent of cases of low-grade cervical dysplasias. These seven HPV types also can cause vaginal, vulvar and anal cancers and pre-cancers. After HPV types 16 and 18, the five additional HPV types in V503 are the most common cervical cancer-causing types worldwide. HPV types 6 and 11 cause approximately 90 percent of genital warts cases

The Phase III study involving over 14,000 subjects evaluated the efficacy, safety and immunogenicity of V503 compared to the commercially available quadrivalent vaccine in 16-26-year old females. *(cont. pg 21)*

SS RATNAM YOUNG GYNAECOLOGIST AWARD (SSR – YGA)

The SSR – YGA is offered by the Asia & Oceania Federation of Obstetrics & Gynaecology (AOFOG) to promising, bright and upcoming Obstetricians & Gynaecologists from the Asia-Oceania region. In line with its aims of identifying and encouraging future leaders of the National O&G Societies and ultimately the AOFOG, this award is open to those below the age of 40 in the year of the award who have demonstrated leadership qualities and contributed to their own National Societies.

The award was first instituted in 1991 by the Japan Society of Obstetrics & Gynaecology but is now administered by the AOFOG Secretariat with grants from donor agencies and National Societies. In 2001, the award was renamed the SS Ratnam YGA in memory of Emeritus Professor SS Ratnam who passed away in that year when he was the President Elect. Prof Ratnam held the post of Secretary General of the AOFOG for 21 years and was the driving force behind the AOFOG in the early years of its development.

From 1991 till 2002, this award was restricted to only 7 developing and low resource countries. Since 2002 however, this award is now open to any member country of AOFOG. Competition is now stiff and a selection panel decides on who makes the final cut. Successful candidates can be proud of the award as they are readily acknowledged as the future of their own National Societies and the AOFOG. They can also be proud of being associated with one of the doyens of our profession – the late Professor Ratnam.

To date, only 4 Malaysians have received this award: Assoc Prof BK Lim (UHKL) and Dr Soon Ruey (Queen Elizabeth Hospital KK) in 2002, Dr Japaraj Robert Peter (Ipoh Hospital) in 2005 and most recently in October 2013, Dr Shilpa Nambiar (Hospital Ampang). The OGSM congratulates all of them and looks forward to many more successful applicants from among our aspiring young O&Gs in Malaysia.

The next AOCOG will be held in Kuching in 2015 so please look out for the advertisement for the SSR – YGA in our OGSM Newsletter.

DR RAVI CHANDRAN
AOCOG 2015 CONGRESS PRESIDENT

HUMAN PAPILLOMAVIRUS AND RELATED CANCERS

The primary efficacy analysis on the per protocol population showed that V503 was found to prevent approximately 97 percent of high-grade cervical, vulvar and vaginal diseases caused by five additional HPV types. The frequency of adverse events was comparable between V503 and the quadrivalent vaccine, except for a higher frequency of injection site adverse events. (90.8 percent in V503 vs. 85.1 percent in the quadrivalent vaccine).

Antibody levels generated against HPV 6, 11, 16 and 18 by V503 were similar to that of the quadrivalent vaccine.

Immunobridging studies were used for the adolescent population because adolescents are not likely to have been exposed to HPV, and therefore, efficacy against disease endpoints cannot be studied directly.

99.8-100 percent of adolescent females and 99.8-100 percent of adolescent males seroconverted against the nine HPV types at month 7 compared to 99.5-100 percent of 16-26-year old females. The safety profile of V503 was similar or slightly more favorable in adolescent males compared to adolescent females and females 16-26 years old.

DR SURESH KUMARASAMY
IMMEDIATE PAST PRESIDENT OGSM

1. Chong PP, Asyikin N, Rusinahayati M, et al. High Prevalence of Human Papillomavirus DNA Detected in Cervical Swabs from Women in Southern Selangor, Malaysia. Asian Pacific J Cancer Prev. 2010; 11:1645-1651.
2. Padmanathan A, Yadav M, Gregory ARA, et al. Detection by Polymerase Chain Reaction and Restriction Fragment Length Polymorphism of Human Papillomavirus in Archival Cervical Disease. Med J Malaysia. 1996; 51(2):255-263.
3. Sharifah NA, Seeni A, Prevalence of human papillomavirus in abnormal cervical smears in Malaysian patients. Asian Pac J Cancer Prev. 2009; 10(2):303-306.
4. Sharifa EWP, Sharifah NA, Sayyidi Hamzi AR, et al. Prevalence of human papillomavirus genotypes in preinvasive and invasive cervical cancer-A UKM Study. Med & Health 2010; 5(2):66-76.
5. Hamzah H, Aziz A, Lim BK, et al. Evaluation of human papillomavirus (HPV) infection among women in UMMC – comparison between thin prep and Fournier's self sampling. J Health Translational Med. 2013; 16(1):92.Cheah PL. Human papillomavirus related diseases in Malaysians. The Malaysian Journal of Pathology. 1994, 16(1):15-17.
6. Luxembourg, A. An Overview of the 9-Valent HPV L1 Virus –Like particle Vaccine Clinical Development Program Abstract SS 8-3 EUROGIN 2013 Congress, Florence, Nov 3-6, 2013
7. Joura, E. Efficacy and Immunogenicity of a novel 9-Valent HPV L1 Virus Like particle Vaccine Abstract SS 8-4 EUROGIN 2013 Congress, Florence, Nov 3-6, 2013
8. Van Damme, P Immunigenicity and safety of a Novel 9-Valent HPV L1 virus like particle in boys and girls 9 – 15 years; comparison to women 16-26 years old. Abstract SS 8-5 EUROGIN 2013 Congress, Florence, Nov 3-6, 2013
9. Van Damme P et al Immunogenicity and safety of a Novel 9-Valent HPV vaccine in Girls 9 – 15 years of age compared to the quadrivalent vaccine Abstract SS 8-6 EUROGIN 2013 Congress, Florence, Nov 3-6, 2013

CONQUERING MT FUJI

TOP VIEW FROM THE LAND OF THE RISING SUN

pic 1: Flying the OGSM flag

Mention "volcanos" and one would immediately picture a towering mountain with smoke and fire raging at the top. Well, not Mt. Fuji. It is a majestically beautiful dormant volcano with an almost perfect cone shape, often topped with snow and surrounded by lakes at the base. Mt. Fuji, standing at 3776meters, is the world recognized symbol of Japan and also its highest peak. Furthermore, it is located less than 3 hours away from downtown Tokyo and it is climbable. Mt. Fuji is a religious site with many Japanese making yearly pilgrimages. The climbing season starts from July until September where it was estimated up to 30000 people visited the mountain. It may get more crowded in the future as Mt. Fuji was recognized as an UNESCO World Heritage site this year. I have to confess; I succumbed to the call of Mt. Fuji and hence had to forego attending MICOG. Nevertheless, the presence of "OGSM" was with me all the way to the top as I brought the OGSM flag along *(pic1).*

Access to Mt. Fuji is so simple. I flew to Tokyo Haneda Airport and took a direct express bus from the airport itself to Kawaguchiko town, a starting point for most climbers. It is a picturesque town next to Lake Kawaguchiko. After soaking up the local sights and onsen (a must try!), I took a local shuttle bus to the 5th Station of Mt. Fuji where the road ends and my trekking adventure starts. It was 10pm. The trail was well marked but it was most easily navigated by following the headlamps of the other climbers ahead. Along the way, there were toilet stops and even resthouses where one can buy a cup of hot noodles and get some shuteye *(pic2)*. Although it was nighttime, the scenery was mesmerizing, contrasted by the starry Milky Way above and the dots of lights of surrounding towns below. Heaven and Earth. The megacity Tokyo was seen as a distant glow in the horizon. The sense of serenity from this experience was a reward itself.

pic 2: Food Stop

pic 3 & pic 4: Sunrise

pic 5: At the Summit

It took me about 7hours of huffs and puffs to reach the top. I summited just in time to be rewarded by a very beautiful sunrise peeking over the Pacific *(pic3)*. The vista of Five Lakes District surrounding the base of Mt. Fuji slowly revealed itself as the sun rises *(pic4)*. It was simply awesome and inspiring. Mind you, the air was thin and the wind blustery. Although it was 40degrees Celsius at Tokyo, there was still some snow at the top of Mt.Fuji. This is due to the altitude. Brrr! A thick wind-proof jacket and good boots is essential. The mountain itself is barren with moon-like landscape *(pic5)*. This land-scape feature is formed by millennia of volcanic activities, with the last eruption occurring in 1708. Fortunately there was no stench of sulphur. I thought I felt occasional tremor as I was trekking up but it could be fatigue (wobbly legs). The final highlight was the trek around the rim of the crater. The crater rim trek took about 1 hour to circum-navigate. As Mt.Fuji is a free standing volcanic mountain, a 360 degree panoramic view of the surrounding Japanese plains can be viewed. Alas, Tokyo is too polluted to be seen at all.

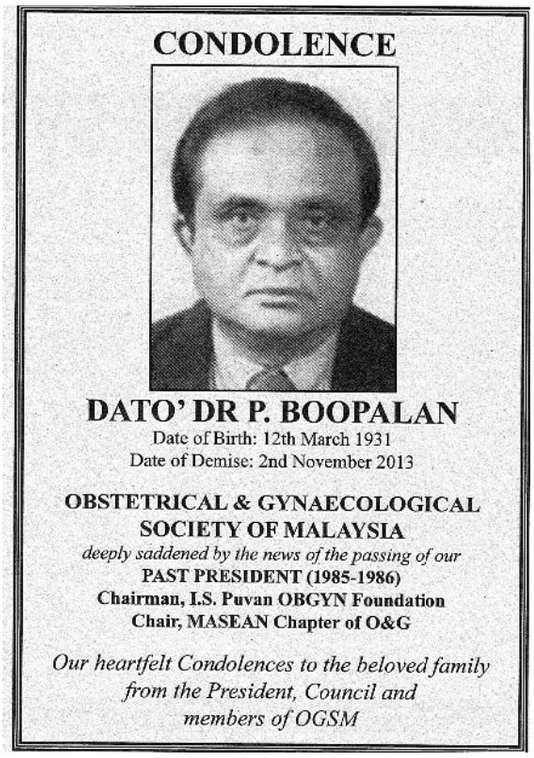
The route down is different from the way up. Certainly, it was much quicker going down. However it was very tiring trekking down due to the lack of sleep and the hot summer sun. Dehydration was a real problem. At my hotel in Kawaguchiko town, I celebrated by soaking away my aches in an outdoor onsen with a grand view of Mt. Fuji in the distance *(pic6)*. Ah! What an adventure.

DR WONG CHOON MENG

pic 6: Mt Fuji

DATO' DR P. BOOPALAN

Born: 12 March 1934
Died: 2 November 2013


CONDOLENCE

DATO' DR P. BOOPALAN
Date of Birth: 12th March 1931
Date of Demise: 2nd November 2013

OBSTETRICAL & GYNAECOLOGICAL SOCIETY OF MALAYSIA
deeply saddened by the news of the passing of our
PAST PRESIDENT (1985-1986)
Chairman, I.S. Puvan OBGYN Foundation
Chair, MASEAN Chapter of O&G

Our heartfelt Condolences to the beloved family from the President, Council and members of OGSM

The Star, 5 November 2013

Dr Boopalan was a family-man, a humane doctor, teacher, examiner and a friend to all who knew him. Besides his family he devoted almost all his time in the advancement of medical knowledge. During his time he held many major posts in the field of Obstetrics & Gynaecology in Malaysia.

He was President, Chairman or Secretary General of:

1. Obstetrical & Gynaecological Society of Malaysia
2. International College of Surgeons – Malaysian Section
3. Academy of Medicine – College of Obstetrics & Gynaecology
4. Asia Association of Obstetrics & Gynaecology
5. Malaysian Medical Association – Selangor Branch & P.P.S.

Dato' Dr Boopalan graduated from the University of Madras in 1961 and on his return joined the Malaysian Ministry of Health (MOH). He started to specialise in Obstetrics & Gynaecology (O&G), his chosen specialty very early in 1964, and was posted as Registrar to the New Maternity Hospital in Kuala Lumpur. It was there in 1966, on my return from the United Kingdom after obtaining my Membership with the Royal College of Obstetrics & Gynaecology (MRCOG) that I first met him. As a young doctor he was totally dedicated to his work, never complaining of overwork and always keen to learn. In fact he spent most of his time in the hospital! As expected he obtained his MRCOG in 1969.

On his return he was appointed as a Consultant with the MOH and served in Kuala Lumpur, Kuala Pilah and Klang General Hospitals. In 1982 he joined private practice at the Pantai Klang Specialist Medical Centre. In 1984 he returned to University Hospital (UMMC) where he taught and moulded young minds to become doctors of the highest standards. He has been an examiner not only in the University of Malaya and the National University but also at the Royal College of Obstetrics & Gynaecology. He was awarded his Fellowship with the Royal College of Surgeons (FRCS) in 1976 and with the RCOG (FRCOG) in 1981.

Dato' Dr Boopalan was a great organizer of National & International Congresses in Obstetrics & Gynaecology. He has published and presented papers at meetings and congresses both here and overseas. He also devoted his energy to the Red Cross Society, orphanages and societies for the mentally challenged children.

He was a great supporter of the Academy of Medicine Malaysia who honored him with a fellowship. It was at the last Annual General Meeting of the Academy on the 29th of September 2013 that I last met him. He was on a wheelchair but still came all the way from Klang to participate in its activities and do his share. We had a long chat about old times and about his achievements. During our meeting, I gathered that he was greatly content with his life of peace, harmony and fulfillment for himself, his family, but also with his fellow human beings.

He will be greatly missed by his wife and children but will be remembered most of all by his thousands of patients who under his care had safe comfortable deliveries.

We extend our condolences to his wife Datin Dr Noor Johan, children Rajan, Yashoda, Ruben and Neeza, grandchildren and family.

DATUK DR J. S. SAMBHI

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Location	:	Penang Medical College 4, Jalan Sepoy Lines 10450 Penang Malaysia
Exam Date	:	9th September, 2014
Opening Date for Applications	:	16th June, 2014
Closing Date for Applications	:	11th July, 2014
Fees	:	€650

Exemption:
The Royal College of Physicians of Ireland is pleased to grant an exemption from the MRCPI O&G Part 1 exam to holders of the Masters in Obstetrics and Gynaecology (Malaysia). Holders of the Masters may apply directly to sit for MRCPI O&G Part 2.

Full information regarding eligibility criteria, fees and the application procedure is available in the Examinations section of www.rcpi.ie
Candidates who are successful in the Theory examination will be required to appear for the Clinical examination in Dublin on 3rd November 2014.

For further details, please contact:
Dr Claire Lacey
Penang Medical College
4, Jalan Sepoy Lines, 10450 Penang
Email: claire.lacey@pmc.edu.my
Tel : (604) 2263459 ext 118

www.pmc.edu.my www.rcpi.ie