2013/2014 ISSUE 3

OGSM NEWSLETTER

Obstetrical & Gynaecological Society of Malaysia

FROM THE PRESIDENT'S DESK

Many of you are aware that there have been two recent maternal deaths from unassisted home delivery. OGSM, through its representation in the MOH Confidential Enquiry into Maternal Deaths and as a professional body, has been involved in some of the discussions involving this matter. It is fair to say that MOH is viewing this matter seriously and is taking steps to address this issue. I am confident from the discussions that MOH is aware of its role in protecting the patients as well as the staff who are looking after pregnant women. Several members have called me about this. As I was personally involved in some of these meetings, and having given extensive thought to the issue, I have penned my personal opinion here. This is not the official stance of the society. Hopefully this can provide some guidance to you who may face difficult discussions with patients about home birth (HB). I am reminded time and time again how much good antenatal and intrapartum care result from a firm and trusting partnership between the healthcare professional and the pregnant couple. The rapport and trust should be mutual. Many of the patients who choose to have a home birth against advice are opting out of this relationship. One possible reason is that they feel that the established ways of practicing medicine do not meet their need of a 'natural' delivery. Being in hospital does not give them autonomy over what they deem to be a natural process. They want to be in CONTROL, even if they are having their first baby. Some of these ideas are spurred on by persons or groups who promote 'natural delivery' methods. All these methods have the same theme: control, autonomy and natural delivery, possibly at all cost, with no intervention and no medication. Generally there is little emphasis about the risks of these methods.

Now WE, the obstetricians, sitting on the other side, may seem to be dismissive of these requests, such that these women are 'put off' by the idea of even discussing this with their doctor/midwife. These patients who are thinking of such delivery methods are generally well educated and not all are 'militant' regarding home birth. Many are just 'exploring' the idea-those with bad experiences with their prior deliveries-those who believe that natural delivery gives them a heightened sense of bonding with a calmer baby with heightened emotional wellbeing. Most would have attended some form of classes that promote alternative natural birth techniques. They usually are well informed of doctors or centres which are more 'pro natural birth' and will gravitate towards those centre/ doctors. Some will go doctor-hopping

(cont. pg 26)

Newsletter_April2014_V8.indd 1 9/5/2014 4:17:05 PM

SECRETARY'S REPORT

ARCHIVING ACTIVITIES

OGSM is currently undertaking the enormous task of archiving our rich history to preserve it for future generations. It has been a huge, challenging task but it has given all of us involved a unique perspective of how our society was conceived, how we have evolved, how we have grown and what we have become.

FOR EXAMPLE:

In April 1963; 14 gynaecologists met at the General Hospital, Johor Bahru and unanimously agreed to form the Obstetrical and Gynaecological Society of The Federation of Malaya. In 1963, we had 19 members registered. In April 2014, we stand strong at 1096 members.

Our membership fees started at RM10.00 in 1965. Our life membership fee stands at RM1,000.00 since its last increase in 1983.

One of our first achievements as a united group of Obstetricians and Gynaecologists in the acceptance of OGSM as a member of the Federation of International Obstetricians and Gynaecologists (FIGO) when its General Assembly of Federation met in Buenos Aires in September 1964.

We are in the process of converting our paper documents into electronic form. If any members would like to access this information, please contact the OGSM office. We are also at present looking for documents and information (photographs, letters etc) from 1994-1995. Should you have this or any other information, kindly pass us a copy to enable us to save all this interesting history for our future generation.

Participation in Future Congresses

OGSM has brought quite a few international and regional congresses to Malaysian shores; FIGO 2006, RCOG Scientific Meeting 2012 and AOCOG 2015. The OGSM council has decided to bid for the opportunity to host The International Gynecologic Cancer Society Meeting (IGCS 2020). Datuk Dr Abdul Aziz Yahya has been elected as the bidding committee chairman. He has accepted and is currently forming a bidding committee.

FIGO – SAFOG – SLCOG 2014 Conference is scheduled to be held from 30th Oct 2014 till 2nd November 2014 in Colombo. The theme of the conference is "Unmet needs in Women's Health". OGSM has been allotted 75 minutes for OGSM Symposium. OGSM is currently in the process of identifying and selecting speakers for this conference and the topics are open. Interested OGSM members can contact the OGSM office for further details.

GENTLE BIRTHING GROUP

Following 2 maternal deaths arising from unassisted homebirths, our Ministry of Health (MOH) invited advocates of 'natural births' for a meeting. The Gentle Birthing Group promotes birthing without any medical intervention and is an advocate for doulas and hypnobirth. This group is very active in the social media and conducts regular meetings. OGSM was also invited to participate in the meeting between MOH and this group where we had the opportunity to present our views on unassisted homebirths. Our views were also published in Sin Chew and New Straits Times.

LSSC

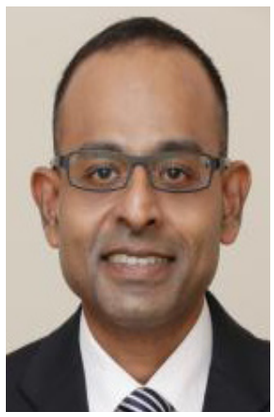
OGSM has to date, run 25 RCOG Life Saving Skills and the Newborn Care Course (LSSC). Our team has vast experience in teaching these emergency procedure skills to midwives and doctors practicing in both Malaysia and around the region. We are proud to announce that these experienced trainers have collaborated and revised, refreshed and restructured this course so it remains relevant and up to date. The new course module has been designed to be run over two days. The OGSM council would like to thank these trainers for their extraordinary contribution to this course. The notable OGSM Faculty are Drs Gunasegaran PT Rajan, Tang Boon Nee, Marcus Kang, Alvince Dev, Malar Kandasamy, Mohd Azam, Shilpa Nambiar, Muniswaran Ganesham, Si Lay Khaing and Tan Cheng.

We are looking for young vibrant junior specialists who are enthusiastic to become trainers in our new Obstetrics Emergencies Course. Please contact me or the OGSM office if you are interested. Finally, the present council term is ending. We would like to extend the invitation to the 23rd OGSM Annual Congress, at the One World Hotel, Petaling Jaya. I look forward to seeing all of there.

DR THANEEMALAI JEGANATHAN
SECRETARY
2013 / 2014

Newsletter_April2014_V8.indd 2 9/5/2014 4:17:05 PM

TREASURER'S REPORT



Dear colleagues,

The accounts for the financial year are closed and we are now undertaking the formidable task of tabulating the numbers, assessing the strengths and reflecting on our shortcomings. In the final analysis, we must ultimately determine if our resources have been pragmatically utilized. From a financial perspective, it has been a difficult year. The prophets of doom have been proven right. In our incessant discourse about how much reserves are 'adequate', they could always foresee that the good times would never last. Indeed, it appears that their argument has now been established.

There are several reasons for this.

Firstly, it is irrefutable that the pharmaceutical industry as a whole has been tormented by a financial crunch. This impediment cuts across all specialties. Many of our usual supporters have had to recalibrate their involvement. This has had an obvious impact on the income generated from our annual exhibition and will undoubtedly have implications on how we equilibrate our finances in the coming year. The math behind this isn't really difficult to comprehend as income generated from the congress is the cornerstone of the society's annual revenue.

Secondly, we will be having four large meetings in the same year. While each of these meetings serves different niche areas, there is always an element of overlap in industry support. Though it is veritable that the society may have a prominent role in organizing all these meetings, profit apportionment may differ. Add other fraternity conferences not linked to the society and the problem becomes even more pronounced. What this essentially means is that our revenue source is being rationed. Looking forward, it appears almost certain that this will be the new status quo.

The third reason is related to new guidelines from the Pharmaceutical Association of Malaysia (PhAMA). While the guideline is dated end 2012, there has been a recent impetus to ensure strict compliance from all its members. While the influence of this is wide and varied, one impact is very clearly where we can and cannot hold our congresses. There are several other trickle down effects including their unwillingness to participate in any society activity that may even remotely appear to contravene the code.

In the final analysis, it does appear certain that our traditional quintessential source of revenue has been curtailed and this new shift in our financial equilibrium looks permanent. Moving forward, we therefore need to be even more prudent and conservative in how we chose to utilize our resources as it is now abundantly obvious that nothing lasts forever.

Best wishes to all.

DR EESON SINTHAMONEY
TREASURER
2013 / 2014

TAN SRI DR JEMILAH MAHMOOD

Tan Sri Dr Jemilah Mahmood has been appointed to head the World Humanitarian Summit Secretariat at the United Nations headquarters in New York from Thursday the 8th of May. This is the latest in a long list of achievements for Dr Jemilah. In 1999, she founded the Medical Relief Society (MERCY Malaysia) and has successfully managed to bring people together to serve those in need, regardless of race, creed or religion. In 2013, she became the first recipient of Bahrain's Isa Award for Services to Humanity "for her efforts in disaster prevention and relief, education, community service, environment protection, climate change and poverty alleviation."

The World Humanitarian Summit, an initiative of the Secretary-General of the United Nations, is an opportunity for governments, UN and intergovernmental agencies, regional organisations, non-profits and civil society actors, the private sector, academia as well as people affected by crises to come together, take stock of humanitarian action, discuss the changing landscape, share knowledge and best practices, and chart a forward looking agenda.

Tan Sri Dr Jemilah was a former Treasurer of the OGSM Council for the 1995 / 1996 term. OGSM would like to extend its congratulations to her on being appointed to such a distinguished position.

Newsletter_April2014_V8.indd 3 9/5/2014 4:17:05 PM

RCOG-OGSM TRAVELLING FELLOW 2014: DR DAVID RICHMOND

Current President of RCOG 2013, Past Vice President for Clinical Quality (where he led RCOG's work on Clinical Standards and Guidelines), Dr David Richmond visited Malaysia and invited to speak at 5 different cities, Kuala Lumpur, Kuala Terengganu, Johor Bahru, Kuching and Kota Kinabalu. During his 5 day visit, OGSM members and Malaysian O&G trainees benefited from his 18 Lectures and 6 teaching ward rounds. Our O&G trainees had an opportunity to discuss issues about MRCOG training, changes with MRCOG examinations and problems with obtaining working attachments in the UK. In his report, Dr David Richmond extended his gratitude to all his hosts in Malaysia.

DR THANEEMALAI JEGANATHAN

AUSTRALIAN SOCIETY CONFERENCE OF GYNAECOLOGICAL ONCOLOGY

2015 ANNUAL CONFERENCE IN PENANG

The Australian Society of Gynaecological Oncology will be holding its 2015 annual meeting in Penang between Wednesday, 8.7.15 and Saturday, 11.7.15. This is only the second time in the history of the Society that their annual meeting is being held outside Australia. This meeting is being supported by the Obstetrical & Gynaecological Society of Malaysia.

It will be a three and a half day program with emphasis on prevention/newer technologies and innovations. The theme for the meeting is "Together We Eradicate Gynaecological Cancer: An Australasian Initiative".

The meeting will start at noon on Wednesday, 8.7.15 with teaching sessions for fellows in gynae-oncology followed by a welcome reception. The meeting proper will start on Thursday, 9.7.15 and will end with lunch on Saturday, 11.7.14.

The Asian Society of Gynaecological Oncology will be participating in the meeting. A number of experts in Gynaecological Oncology from Asia as well as Australia will be speaking at the meeting including Jim Nicklin, President of the Australian society.

American speakers who have confirmed participation include Richard Barakat from Memorial Sloan Kettering Cancer Centre, New York and David Cohn. Dr Richard Barakat will be attending the meeting in his capacity as the President of the International Gynaecologic Cancer Society at that time.

There will be an opportunity for gynaecological oncologists and trainees from Malaysia to present papers. The program is currently being developed and further details will be announced in time.

It is hoped that gynaecological oncologists as well as obstetricians & gynaecologists with an interest in gynaecological oncology from Malaysia will mark the dates in their calendars and attend this landmark conference in large numbers.

DR SURESH KUMARASAMY
IMMEDIATE PAST PRESIDENT
OBSTETRICAL & GYNAECOLOGICAL
SOCIETY OF MALAYSIA

Newsletter_April2014_V8.indd 4 9/5/2014 4:17:05 PM

GYNAECOLOGICAL UPDATE COURSE

GYNAECOLOGICAL ONCOLOGY UPDATE, PENANG, 25.1.15

The Obstetrical & Gynaecological Society of Malaysia in conjunction with the Malaysian Oncology Society (MOS) and the European Society of Medical Oncology (ESMO) will be organizing a one day Gynaecological Oncology update on Sunday 25.1.15 at the Bayview Beach Hotel, Penang. This will be held on the last day of the MOS-ESMO Best of ESMO South East Asia Summit. The faculty will include Professor Michael Quinn from Melbourne, Australia.

Gynaecological oncologists as well as obstetricians & gynaecologists with an interest in gynaecological oncology are advised to mark the dates in their calendars. Further details will be announced nearer to date.

DR SURESH KUMARASAMY
IMMEDIATE PAST PRESIDENT,
OBSTETRICAL & GYNAECOLOGICAL
SOCIETY OF MALAYSIA

WAO MEDICAL CAMP

The team from OGSM with WAO representatives

As part of the CSR programme for 2014, OGSM conducted an inaugural health education and screening session at the Women's Aid Organisation refuge on Saturday the 26th of April. OGSM was represented by Drs Lavitha Sivapatham, Emily Christine D'Silva, Hoo Mei Lin and Goh Huay-yee along with Miss Jenny Kaur. Dr Emily gave the first talk on pap smears and breast self examinations and Dr Lavitha followed on with a second talk on contraception. Both talks were delivered in three languages-Malay, English and Tamil with the help of Ms Yogasri one of WAO's social workers and Dr Goh Huay-yee, to cater to the various nationalities of the refuge's residents some of whom were from India, Iran, Afghanistan and Myanmar. Following that we conducted breast examinations and performed pap smears for all residents who wished to be examined. In total about 20 women were seen individually. As expressed below in an email from one of the refuge's social workers, Ms Jessie Ang, the residents found the session beneficial and appreciated OGSM's efforts greatly.

"The feedback from the residents were very good. Some of them expressed this is the first time they have access to information and medical examination. They are more aware of their health condition and will continue having follow up. For most of them, this is their first time they have their breast check and pap smear done. The doctors are very kind and very gentle to them. The doctors explained to them the procedure clearly before conducting the check-up which made them more comfortable. WAO is very much appreciate your time and support to our residents and ex-residents."

A second session is planned for October 2014. If any of OGSM's female members are interested in participating in this worthy effort, do contact Miss Jenny at the OGSM office. We would be delighted to have your assistance.

DR GOH HUAY-YEE
CSR CHAIRMAN

Newsletter_April2014_V8.indd 5 9/5/2014 4:17:06 PM

GREETINGS FROM OGSM 2014

Dear member

I hope by the time you read this newsletter you would have registered for our 23rd Congress of the Obstetrical and Gynaecological Society of Malaysia from 5th to 8th June 2014 at the One World Hotel PJ. If you have not let me enlighten you on what you will be missing.....

We start of with the 4 Precongresses namely a PPH Seminar and workshop in collaboration with the Obstetrical & Gynaecolgical Society of Hongkong, a half day Endometriosis Workshop and a Lactation Management workshop which will all be conducted in One World Hotel. We have not forgotten our trainees and the last workshop will be a MRCOG Part 2 OSCE circuit to be held in the IMU school Seremban. All the above events will be on the 5th June 2014.

Our congress proper starts on 6th June 2014 and the theme is 'Back to Basics'. In keeping with this, the scientific programme has 3 Master class sessions on Colpocopy, Ultrasound and CTG and I am positive these sessions wil be very refreshing and informative. We will have the usual plenaries and breakout sessions conducted by a very illustrious and varied faculty. The ever popular Debate session is back and I am looking forward to this segment of the programme which if history repeats itself will be a very entertaining!

No annual congress will be complete without a Gala Night and this will be in the One World Hotel Ballroom on the night of 7th June 2014. It will be a theme night so please dress up for the occasion and we have a couple of dance acts, not one but three comedians... yes three and a band in attendance for the dancers from the floor. Please don't miss out on the gala night lest you may regret it when you hear of all the fun we had on Sunday morning at the College of O&G Lecture.

Now I hope I have convinced you to be there so please register ASAP. Personally I love our annual congresses as it is that time of the year that I get to meet all my old buddies and teachers besides getting a good dose of updates. Hope to see you all on 5th June 2014 at the One World Hotel PJ.

DR SHANKAR SAMMANTHAMURTHY
ORGANISING CHAIRMAN, OGSM CONGRESS 2014

A FUN DAY OUT FOR THE KIDS

Saturday 7 June 2014
From 9am to 3pm

Kidzania Kuala Lumpur

To give back to our members for their unwavering support, OGSM has organised a trip to Kidzania for your kids.

We have a total of 50 free tickets to giveaway on a first come first serve basis. Transport and lunch will be provided. Please register with Jenny or Prema at 016 4843840 or email us at ogsm@myjaring.net to reserve your coupons to avoid disappointment.

What is KidZania Kuala Lumpur?

KidZania Kuala Lumpur is an indoor family edutainment centre which offers an interactive learning and entertainment experience for kids in a kid-sized city to deliver the first-of-its-kind edutainment fun. The KidZania experience is about real-life experiences, empowering, inspiring and educating kids through role-play. The visit is an educational and entertaining experience due to the many activities designed to support the comprehensive development of children. They are encouraged to learn through play, live out their ambitions and dreams with the added bonus of making new friends.

Terms & Conditions
For congress participants only
Limited to 2 coupons per congress participant
For Children aged 4-17 years
An adult (over 21 years) MUST accompany the child/children
There will only be ONE bus departing from One World Hotel and Kidzania. Please be punctual.
Accompanying adults entrance fee of RM35.00 is payable.

Disclaimer OGSM will not accept any liability in event of loss, damage or injury during the Kidzania outing.

Newsletter_April2014_V8.indd 6 9/5/2014 4:17:07 PM

ENRICHMENT LECTURE NIGHT
Thursday, 5th June 2014

INTRODUCING OUR SPEAKERS

DATO' AMBIGA SREENEVASAN

Dato' Ambiga Sreenevasan was the President of the Malaysian Bar from March 2007 to March 2009. She was called to the Malaysian Bar in 1982.

She was the Chairperson of Bersih 2.0, a civil society movement for free and fair elections from 2010 to January 2011 and Co-Chairman from January 2011 to November 2013. She was the Chairperson of the Bar Council Committee on Orang Asli Rights from 2010 - 2012. She was also member of executive committee of the Women's Aid Organisation from 2009 – 2011.

She was a Director of Securities Industry Dispute Resolution Center ("SIDREC") from 2010 to 2013.

Throughout the course of her career, Ambiga has been an advocate of human rights issues and the promotion of the rule of law. She is a recipient of the United States Secretary of State's International Women of Courage Awards 2009. She was conferred an Honorary Doctorate of Laws (Hon LL.D) by the University of Exeter in July 2011. Dato' Ambiga was also awarded the "Chevalier de la légion d'Honneur" (Knight of the Légion of Honour) by the Government of France in September 2011.

She is an Exco member of the Human Rights Organisation of Malaysia (HAKAM).

DR AMIR HAMZAH DATO' ABDUL LATIFF

HEALTH ECONOMIC STUDY, MALAYSIA: COST EFFECTIVENESS OF PARTIALLY HYDROLYSED FORMULA IN ATOPIC DERMATITIS PREVENTION

'Health Economics' is a branch of science that looks at the economic consequences of interventions on public health issues and health systems. It helps in choosing the most effective (outcome) and efficient (costs) health intervention that allows government and health providers to prioritize disease prevention programmes. Evidence has shown strong links between nutrition and health, thus making nutrition an intervention with high cost-benefit potential.

At least 7 Health Economic have been conducted to assess the economic impact of feeding high-risk infants with partially hydrolyzed formula as a nutritional intervention in the prevention of atopic dermatitis (AD). Results of the health economic study conducted in Malaysia in 2013 has shown that using a partially hydrolyzed formula instead of standard cow's milk formula in high-risk infants is expected to result in a reduction in the burden of AD and save RM1,175 per child over a 6 year period.

Dr Amir obtained his basic medical degree from the University of Malaya in 1989 and his Master of Medicine in Paediatrics in 1996. From 1998 to 2005, he did his Specialist Registrar training in Clinical Immunology & Allergy mainly at the Leeds General Infirmary and St James University Hospital in Leeds, UK.

He was a Clinical Associate Professor in Clinical Immunology and Paediatrics at the School of Medicine and Health Sciences of Monash University Malaysia, Sunway Campus in 2010; Head of the Paediatric Dept of Universiti Putra Malaysia (UPM) in 2009 and Head of the Paediatric Clinical Immunology Unit of UPM from 2007-2009.

He is currently a Consultant Paediatrician and Clinical Immunologist & Allergist at Pantai Hospital Kuala Lumpur. He's also a Visiting Consultant Clinical Immunologist & Allergist at three other private medical practices.

He is involved in numerous international professional organizations and currently the President of the Malaysian Society of Allergy and Immunology (MSAI).

Newsletter_April2014_V8.indd 7 9/5/2014 4:17:07 PM

ENRICHMENT LECTURE NIGHT
Thursday, 5th June 2014

DR LIEW FAH ONN

THE NEW ALLERGY GUIDELINES

There is a notable trend of increasing prevalence of allergic diseases affecting the world, including Malaysia. Preventing or reducing the risk of allergic diseases, especially in high-risk infants can reduce the disease burden.

With this in mind, two scientific societies including the Malaysian Society of Allergy and Immunology (MSAI) and the Obstetrical and Gynaecological Society of Malaysia (OGSM) have joined hands to develop recommendations for healthcare providers on the prevention of allergic diseases.

The recommendations are based on supportive data available in current literature and expert opinion

Dr. Liew is a senior Obstetrician and Gynaecologist who has been in practice since 1987. He is currently the Head of Obstetrics and Gynaecology at Assunta Hospital Petaling Jaya. He is a past president of the Malaysian Menopause Society and a Council Member, Asia-Pacific Menopause Federation. He was nominated by OGSM as its representative in the working committee towards allergy prevention.

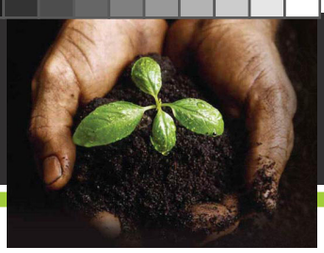
ENRICHMENT LECTURE NIGHT PROGRAMME

Date: Thursday 5th June 2014
Venue: Ruby Ballroom, One World Hotel, PJ

Time	Programme
5.30pm – 6.00pm	Registration & Pre-dinner Drinks and Canapes at Ruby Ballroom
6.00pm – 6.10pm	Introduction by Dr. Tang Boon Nee, President of Obstetrical and Gynaecological Society of Malaysia
6.10pm – 6.40pm	'Women at the Forefront of Change' by Dato' Ambiga Sreenevasan
6.40pm – 7.00pm	Q&A
7.00pm – 7.10pm	Introduction to 'Allergies and the Obstetrician Symposium' by Dr Eeson Sinthamoney, Consultant Obstetrician & Gynaecologist
7.10pm – 7.30pm	Health Economic Study, Malaysia: Cost Effectiveness of Partially Hydrolysed Formula in Atopic Dermatitis Prevention by Dr Amir Hamzah Dato' Abdul Latiff, Consultant Paediatrician & Consultant Clinical Immunologist/ Allergist (Adults & Paediatrics)
7.30pm – 7.50pm	Allergy Prevention Guidelines by Dr. Liew Fah Onn, Consultant Obstetrician & Gynaecologist
7.50pm – 8.00pm	Q&A
8.00pm – 8.15pm	Official Launch of the Allergy Risk Tracker
8.15pm – 9.30pm	Dinner in Topaz Ballroom

Kindly RSVP by 23 May with Ms Jenny 03-6201 3009 or email ogsm@myjaring.net to avoid disappointment

Newsletter_April2014_V8.indd 8 9/5/2014 4:17:08 PM



WHY ONE WORLD ?

The forthcoming congress is being held at One World Hotel Petaling Jaya. This may surprise many. The society has previously practised an appealing albeit unwritten policy of having the conference outside of Kuala Lumpur on alternate years and this would rightly be our 'year out'. In fact, council initially decided that the 2014 congress would be in Penang. That decided, the only venue that is capable of accommodating our traditionally colossal trade exhibition is Equatorial Hotel in Bukit Jambul. However, it was felt that since the Equatorial had only recently been utilized (in 2011), perhaps Rasa Sayang Resort by Feringgi beach would be a sensible better option. Great effort then went into assessing the space available and to even consider the option of placing a marquee in the car-park as well as in the lawn facing the open sea, to accommodate both the exhibition as well as the gala dinner as the hotel ballroom was rather too small for our needs.

Alas, as we were about to finalize our discussions with the hotel, news leaked out about a impulsion from within the Pharmaceutical Association of Malaysia (PhAMA) to compel its members to strictly comply with their code of ethics. Their most recent guidance is dated 2012 yet not many of us had heard of it, and those of us who had, thought little of it. Nonetheless, the rumblings were that there was a discreet push from within the organization to compel compliance and there were even rumours of a note that named hotels that certainly didn't comply with their code. A call to PhAMA to seek clarification was initially met with denial and later a defensive tone. The existence of the internal note was finally reluctantly admitted to, but puzzlement as to how it had leaked out and that is was 'only for internal training purposes'. While all this seemed like the ingredients of a James Bond sequel, the organizing committee got cold feet. What if indeed our sponsors decided that they could not support us because the venue did not comply with the code? What if we realized too late that half our usual industry friends were now told to distance themselves from us? All this doubt was too substantial a gamble to accept. Council therefore felt the judicious option would be to revert back to the Klang Valley as a preferred destination, despite the late hour.

Several options were assessed including Sunway Resort (in the code, the word 'resort' is an absolute no-no), KL Convention Centre, Shangri-La Hotel and even Putrajaya Mariott. Some of these venues were already taken up, others were deemed unsuitable. Finally it was a toss between the 'Shang' and One World Hotel. The former-tested, proven, efficient and familiar. To sum it up in one word – great.

But perhaps 'too' familiar?

We have had three congresses there before, this would be the forth. This year alone, two other meetings will be held there, APCOC and APAGE. Council therefore deliberated in great profundity on this concern and finally after a thorough analysis of the issues, took an open vote. A resounding majority (10 votes versus 0 to be exact!) decided to favour the underdog, the unproven, the unfamiliar but nonetheless the 'One' with awe-inspiring potential – One World Hotel.

So, while it would have been far easier and safer to side with the familiar, council decided to do the unthinkable and to take the unchartered course. We hope you enjoy this year's conference as we can promise you something rather different and perhaps a lot more excitement for the accompanying family.

Best wishes and see you in June.

DR EESON SINTHAMONEY
ON BEHALF OF THE ORGANIZING COMMITTEE
OGSM CONGRESS 2014

Newsletter_April2014_V8.indd 9 9/5/2014 4:17:08 PM

WHY ONE WORLD ?

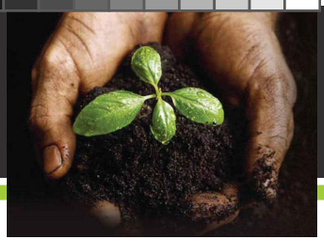
One World Hotel is adjoined to the award winning 1 Utama Shopping Centre, the fourth largest in the world. 1 Utama houses more than 700 retail outlets, 2 cinemas with 20 screens, a 36-lane bowling alley, rock climbing, food from almost all corners of the world; there are enough activities to cater to your whole family.

OGSM MRCOG OSCE COURSE

The OGSM is proud to present the MRCOG Part 2 OSCE Course as a one of the pre-congress workshop for the 23rd Congress of the OGSM, to be held in the International Medical University (IMU) Clinical School campus in Seremban. This intense half a day Course is run by experienced examiners and tutors from Singapore and Malaysia. The course is intended for trainees and postgraduates who are aiming to sit the OSCE component of the MRCOG Part 2 examination of the Royal College of Obstetricians and Gynaecologists of the United Kingdom. All the clinical situations are based on the United Kingdom code of practice. Candidates will be exposed to 2 sets of OSCE circuit questions (10 stations) which simulate real MRCOG Part 2 exam conditions using experienced examiners and professional role players. There will be individual feedback from examiners and role players after each station and an interactive session in the end on how to improve one's performance for the exam. Contact our secretariat now to secure your place.

DR NAZIMAH IDRIS

Newsletter_April2014_V8.indd 10 9/5/2014 4:17:10 PM



OGSM KIDS PARTY

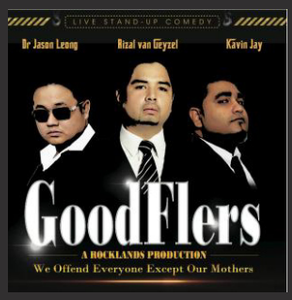
DATE : 7TH JUNE 2014, SATURDAY
TIME: 7.00PM - 10.00PM
VENUE: HAZEL & IVY ROOM, LEVEL 2M, ONE WORLD HOTEL
AGE: 3 TO 12 YEARS OLD
AGENDA: REGISTRATION
LIGHT REFRESHMENTS
CLOWN PERFORMANCE
BALLOON GIVE-AWAY
SAND PAINTING
MAGIC SHOW

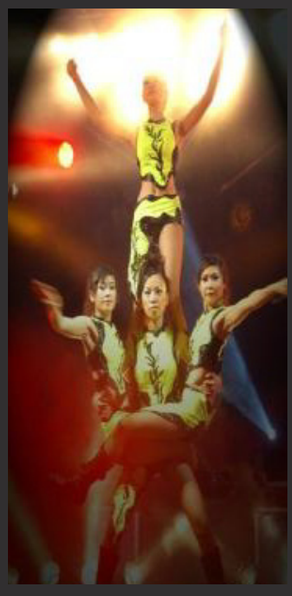
Kindly register your kids with us by ***Friday, 6th June 2014.***
Strictly limited to ***50 kids*** based on first-come-first-served basis.
No walk-ins will be entertained.

Contact Person: *Ms. Jenny (016-484 3840)*
ogsm@myjaring.net

Organised by:
Obstetrical and Gynaecological Society of Malaysia
Anmum Essential

GALA DINNER





2014 OGSM CONGRESS GALA DINNER BLACK AND GOLD EXTRAVAGANZA

Featuring the comedy geniuses of the Goodflers

Be mesmerised by the grooves and moves of the TraxImpact Dancers

All for **RM50** only

Book your tickets now with our congress secretariat as seats are limited

Newsletter_April2014_V8.indd 11 9/5/2014 4:17:31 PM

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.

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

2. NECESSITY FOR OBTAINING CONSENT

Generally, no procedure, examination, surgery or treatment - 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, examination, surgery, or treatment - is undertaken. Failure to do so may result in disciplinary inquiry for transgression of ethical professional codes and/or 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, examination or treatment.

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. Relevant information includes disclosure of possible risks which the patient ought to know and/or should know.

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, examination, surgery, or treatment.

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, examination or treatment, 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.

Newsletter_April2014_V8.indd 12 9/5/2014 4:17:31 PM

In such circumstances, a consensus of the primary surgeon/physician (who is managing the patient) and a second registered practitioner is obtained and the primary surgeon/physician signs a statement with the consent form stating that the delay is likely to endanger the life of the patient. The second 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, paragraphs 21 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, examination or treatment. This must be decided on a case-by-case basis, and whatever decisions made must be "in the best interest of the patient".

"Best Interest of the patient or child" is a single decision made by the medical practitioner(s), for management of a patient who is in a situation of helplessness, the decision so made being the most appropriate and fair to that patient or child under the circumstances.

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. - In instances where the attending medical practitioner is unable to adopt the above attempts in ascertaining the relationship of the accompanying adult to the child, he or she should defer the treatment unless it is an emergency life-threatening situation, or follow the procedures as for a medical emergency.

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.

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 reaching 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.

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.

Newsletter_April2014_V8.indd 13 9/5/2014 4:17:31 PM

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, and the relationship well established or confirmed, 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,[5] 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.

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;

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. 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. 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. 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].

d. 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.

e. Valid consent

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.

Newsletter_April2014_V8.indd 14 9/5/2014 4:17:31 PM

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.

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

g. Non-verbal consent is given by using non-verbal communication, like nodding acquiescence or extending the arm for a procedure, which are also open to debate. In such instances, it may be prudent to make an entry in the patient's notes that such consent was given.

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. This is to safeguard against any unexpected outcome and possible complaint.

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 practitioner and the patient must have met or know each other, through previous consultation or contact, in the context of doctor-patient professional relationship.

b. The practitioner 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, so that the patient is aware of the practitioner who will be performing such 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 risks and complications, which may delay or affect the result of the procedure, as well as influence the duration of stay in the ward or in intensive care.

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.

In public hospitals there is often an existing practice of group discussion/counselling of the anaesthetists or surgeons (and medical practitioners, generally) with patients prior to invasive procedures. It is best that the practitioner scheduled to perform the procedure is also in the group and signs the consent form with the patient. When the practitioner scheduled to perform the procedure is, for some reason, unable to be present in the group discussion, it is his duty to obtain the consent, or confirm with the patient, before performing the procedure.

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, examination, surgery, or treatment - from a patient, and

also perform the procedure, examination surgery, or treatment- 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, examination, surgery, or treatment - will be able to explain to the patient all details of the proposed procedures as above, which would include possible unexpected findings, risks and complications, and the remedial actions that will be taken.

Newsletter_April2014_V8.indd 15 9/5/2014 4:17:31 PM

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 rest 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.

12. RESPONSIBILITY OF HEAD OF DEPARTMENT IN ALLOWING CONSENT TAKING

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 post-graduate 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. In departments with sub-specialists, not of the same specialty as the Head of Department, it is still the responsibility of the Head of Department to confirm the status as stated above of all those specialists in his department in terms of taking consent from patients.

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 take consent and 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.

13. 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.

14. 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

Newsletter_April2014_V8.indd 16 9/5/2014 4:17:31 PM

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].

15. 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.

16. 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 7 days. 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.

In instance when a patient from whom consent had been taken for a particular procedure, and the procedure is delayed or postponed, including and especially when an in-patient is discharged home, a new consent has to be taken before undertaking the procedure, examination, surgery, or treatment, as the circumstances or the disease condition may have changed during that period or the patient may not remember 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 procedure or treatment, 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, or take a new consent. A new consent must be taken if the delay has been more than 30 days since the last consent. Nothing should be taken for granted.

b. Chronic conditions requiring periodic treatment

Good standard of care requires that consent has to be contemporaneous (specific in time) and procedure for any invasive treatment. This would apply in instances like patients requiring repeated de-sloughing or related procedure, chemotherapy or periodic blood transfusion.

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 is available in the MMC Guideline on Audio and visual recordings in Medical Practice.

d. Consent on admission and release of information

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, - =, 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

Newsletter_April2014_V8.indd 17 9/5/2014 4:17:31 PM

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. Human Tissues Act 1974 [10].

g. Consent for sterilisation, hysterectomy and orchidectomy

Consent for sterilisation procedures in a woman or man should be given by the patient concerned. Similarly, hysterectomy and orchidectomy should also involve consent by the patient. Any discussion between the spouses in this respect does not and should not deny the rights of the patient concerned in making the final decision and giving consent.

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.

17. 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.

In instances where patients refuse some life-saving procedures (like blood transfusion) on religious beliefs or native custom, and where the possibility of such emergency life-saving procedures becoming necessary are high in the course of treatment, the practitioner may seek a court's decision to protect himself from future action.

18. 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

Newsletter_April2014_V8.indd 18 9/5/2014 4:17:31 PM

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.

19. 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.

REFERENCES:

1. Gale Encyclopaedia of Public Health: Informed Consent, 2012.
2. Guardianship of Infants Act 1961.
3. The Law Reform (Marriage & Divorce) Act 1976.
4. United Nations Convention on the Rights of the Child, 1989.
5. Mental Health Act 2001.
6. Milwaukee Journal Sentinel on Paul G Gebhard, 1997.
7. Eric Pace, the New York Times, on P.G. Gebhard, 26 Aug 1997.
8. Private Healthcare Facilities and Services Regulations 2006.
9. The Malaysian Medical Council Ethical Guideline on Audio & Visual Recordings.
10. Human Tissues Act 1974.

Adopted by the Malaysian Medical Council on 26 November 2013

NOTES:

a. The initial draft was prepared by an 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. Further amendments have been incorporated following some issues raised by the Society of Anaesthetists and discussed at the MMC meeting on 19 November 2013.

f. 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 and in the Private Healthcare Facilities and Services Act 2006 and Regulations.

The MMC Consent Guidelines printed in the previous newsletter is an older version from January 2013. The newer version was adopted in November 2013. There are some changes but perhaps the most significant change is in item 16 (a) where the period of validity of consent has been extended from 24 hours to a maximum of 30 days. It is however still recommended by the guideline that if your procedure is delayed more than a week, a new consent should be considered. An electronic copy of the guidelines can also be found on the OGSM website.

Newsletter_April2014_V8.indd 19 9/5/2014 4:17:31 PM

RECENT TRENDS IN BIRTHING PRACTICES

The Egyptians used belly dancing as a laboring tool. The Zulu Indian birthing mother was silent during labour while the women in her family would cry out and groan in sympathy. The father of the baby was heavily involved during the birthing rituals of a Mexican tribe. He hung from the ceiling with each scrotum tied by strings held by the birthing mom. As she screamed in pain she pulled the strings, allowing him to understand the "pain" of labour.

The Ancient Birthing

Childbirth is considered as one of the most important events in a woman's life. Though the process of childbirth has remained the same over the generations, women's expectations of their birth experience have evolved over time.

The shift to birthing in hospitals came about in the 20th century. The belief that "doctors knew best" and the advent of painkillers in a safer setting encouraged more women to leave the comfort of their homes. Unfortunately the early painkillers brought about more sedated babies and a higher increase in instrumental deliveries. There was a higher incidence of respiratory problems and temporary specialized care.

Instrumental deliveries reduced morbidity and mortality, however many women started feeling that they were not given a choice in this matter especially when there were bad vaginal tears.

The concept of "high risk pregnancy" increased the incidence of inductions and caesarean sections. The number of repeat caesareans and its complications grew and we are now in the era of social inductions and caesareans by choice and at correct horoscope times.

In this generation, a woman can clearly expect that she and her baby have a healthy journey through pregnancy and birth. As women now have fewer babies, each pregnancy and baby generate intense focus and concentration. Many are beginning to believe that the "natural process" of labour is now being increasingly medicalized by pain management options (i.e. entonox/sedation/epidural), medical interventions (amniotomy, electronic fetal monitoring, induction, episiotomy, etc) and of course elective caesarean sections.

Thus the big movement towards "*humanization*" of childbirth which targets childbirth as a positive and satisfying experience for the birthing mom, her partner and the family as a whole. It serves to empower the woman allowing her to enjoy her birthing experience and at the same time giving her a sense of dignity and autonomy during childbirth.

Recent trends in birthing practices include freedom to choose different birthing positions, birthing at home, the use of hypnosis (hypnobirth), and water (waterbirth) as an alternative for pain relief along with having a totally unassisted birth without any medical interference. As obstetricians are now often being faced with these trends in their daily practice, a balanced view of what the "natural labour proponents" are requesting, becomes vital.

DIFFERENT BIRTHING POSITIONS

Staying up and moving around during the first stage of labour has been shown decrease the pain of labour and may shorten it. There would also be less need of epidural or opioid narcotics.

Women also find that having a comfortable position to labour makes them feel in control of the progress of their labour. Many of these positions also allow their partner to participate, increasing bonding towards the moment of birth.

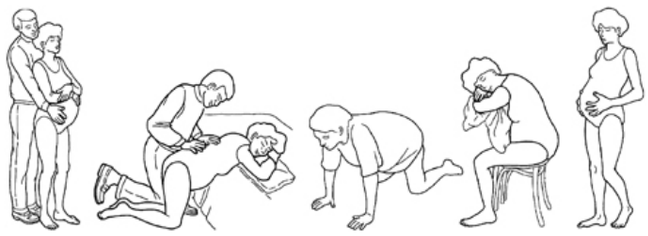
Whilst the ***traditional supine position*** gives the attending medical staff a good view of the perineum to support during crowning, it can disturb with the progress of labour especially in the occiput – posterior position. This position with the legs open and exposed sometimes demoralizes the woman and makes her feel her dignity is "lost".

The ***upright position***, which is when the woman is either standing or squatting, allows the pelvic outlet to be opened up by a further 28%. It allows pelvic mobility and aids fetal descent. There is reduced risk of aorta caval compression and allows for more efficient contractions.

Unfortunately the caregiver is unable to protect the perineum which leads to inadvertent perineal tearing and an increase in maternal blood loss.[1-3]

The ***sitting position*** on the other hand using the birthing stools has been shown to shorten the

Newsletter_April2014_V8.indd 20 9/5/2014 4:17:31 PM



second stage but unfortunately resulted in more second and third degree tears along with more blood loss.[3]

Many proponents of natural labour like the kneeling position because it takes the pressure of the spine and allows the baby to rotate. There is less pain, greater mobility of the pelvis and is an ideal position for delivery of big babies. The kneeling position also carries the lowest risk of episiotomies and bad perineal tears.

Lying on the side may slow down the baby's descent allowing the perineum more time to naturally stretch. However no changes in length of labour is noted when compared to the supine position.[2-3]

The position to labour may change frequently during the second stage until an ideal one is achieved. Both the laboring mother and attending obstetrician / trained birthing attendant should feel comfortable in the final position so as to optimize delivery and minimize perineal trauma.

HYPNOBIRTHING

Hypnobirthing is based on the theory that women need to understand the way their uterus functions as it goes into labour. It is a complete programme which focuses on a combination of visualisation, self hypnosis and deep relaxation to help achieve a pain free and comfortable birth.

It was first introduced in the book, Childbirth without Fear written by an English obstetrician Grantly Dick-Read and a French obstetrician Michel Odent in 1942.

The hypnobirthing proponents believe that childbirth and its three stages are a normal continuous process. The birthing mother and partner are taught hypnotic rapport which they use throughout labour. They are taught that pain is a necessary accompaniment in normal birthing and that fear is to be replaced with confidence and understanding.[4]

The first clinical trial on the effects of Hypnobirthing in labour is presently on going at the Central Lancashire University, United Kingdom. This is based on the preliminary data from Colchester Hospital, NHS Foundation Trust which showed that hypnobirthing methods reduced the need for any form pain relief by 50%, allowing 55% of mothers to have labours of 6 hours and less to achieve a 79% natural birth rate experience.

LAMAZE TECHNIQUE

Dr Fernand Lamaze, a French Obstetrician introduced this method in France in 1951 after a visit to Russia. It is based on the Pavlovian concept of conditioned reflex training which teaches the laboring mom to focus on breathing patterns. This serves to block pain messages to the brain and allows flow of oxygen to the baby and the muscles of the uterus.
Women are also taught to lead healthy lifestyles, to exercise, to move and to use the sense of touch (massage) during labour.[5] Only one study by Melzack6 showed a slight decrease in average pain scores, unfortunately not significantly different from the control group.

Many modifications of Lamaze are now available.

BRADLEY METHOD (Husband-Coached Childbirth)

In the Bradley method, the couple is taught to work as a team to concentrate and work through the pain. Deep relaxation and natural breathing methods are used. The husband / partner is the coach during labour.

LE BOYER METHOD

Frederic Leboyer introduced this method in his book "Birth without Violence" in 1974. This method focuses on delivery in a dim and quiet room. The serenity obtained raises the mother's pain threshold. It avoids overstimulation of the baby and fosters immediate parents / baby bonding as the mother massages the baby soon after birth, followed by the father who gives the baby a warm bath.[7]

WATERBIRTH

Many women now feel delivering in water is a gentler introduction of their baby to the world. Water can be used as pain relief with an option of coming out of the water at around 8 cms to deliver on bed in the conventional way (water immersion) or continue delivering the baby in water (water birth). Babies are born into an environment that is warm, wet and soft. Babies have been noted to be calmer, more alert and cry less after birth. Cord cutting is then delayed till pulsations stop.

Women who have had successful waterbirth have reported increased comfort and reduced pain. They feel relaxed in the buoyancy of the water

Newsletter_April2014_V8.indd 21 9/5/2014 4:17:31 PM

which in turn decreases adrenaline production allowing for shorter labour.

There is reduced pressure on the back allowing better blood circulation and better oxygenation to the baby. Partners take a more active role in delivery and may even get into the pool with them. Women feel more in control of their delivery and may sometimes guide the delivery of the baby with their hands.

Collaborative Studies have shown a statistically significant reduction in the use of pain medication (spinal, epidural, opioids) and other interventions such as instrumental deliveries and even caesarean sections. There were also no significant differences in the incidence of Apgar Scores less than 7 at 5 min, neonatal ICU admissions or neonatal infection rates.[8-9]

Strict criteria have to be followed in waterbirth i.e. pregnancies have to be strictly uncomplicated and of at least 37 weeks. The admission cardiotocograph should be reactive. The labour should be spontaneous or ongoing after induction and the laboring mother gets into water when she has good regular contractions or in active labour above 4 cms.

Intermittent monitoring of the fetal heart is done in water with a daptone and if there is any suspicion of abnormality, she is brought out of water for a conventional trace.

The delivery of a baby in water is ***not advisable in the inexperienced hands especially when carried out at home***. Many aspects have to be attended to such as keeping the water temperature at 37 ^{o}C and making sure that the laboring mother's pelvis is completely submerged in the water during the delivery. This aids in the complete delivery of the baby in water before bringing it out of the surface. Mothers have to be hydrated well and babies have to be monitored. As the water can disguise the amount of blood loss after delivery, it is usually advisable to deliver the placenta out of the water on bed. Episiotomies are not routinely given and vaginal tears are usually minimal in a waterbirth.

The Royal College of Obstetricians & Gynaecologists and The Royal College of Midwifes have endorsed the use of water in labour as a choice, provided that the attendants had appropriate skills and confidence to assist women who choose to labour or give birth in water.[9]

UNASSISTED CHILDBIRTH

Unassisted childbirth (UC) refers to the intentional delivery of the baby without the support of any medical staff or professional birth attendant. It is also called Freebirth, Unhindered Birth, DIY Birth, Unassisted Home Birth or Couples Birth.

Most Obstetrics & Gynaecology Societies around the world have issued public statements against this practice. It was first advocated by Moran (1972) who believed that childbirth is a deeply private and sexual experience that should only be shared between the couple.

Some women lean towards UC as they feel that childbirth should be regarded as a normal function of the female body and not a medical emergency. They believe that any medical intervention would only cause more harm and are willing to accept any consequences that labour may bring.

HOME BIRTHS

Unfortunately UC has been linked to high rates of neonatal morbidity. In 2011, the Australian Medical Association brought out a statement that a baby born via a planned home birth has 7 fold higher risk of an intrapartum death and a 27 fold higher risk of death due to intrapartum asphyxia.[10]

The American College of Obstetrician & Gynaecologists have shown that though the perinatal mortality rates were similar among planned homebirths and hospital births, neonatal deaths were two fold higher. They also showed that planned home births are associated with fewer maternal interventions including epidural analgesia, electronic fetal heart monitoring, operative vaginal delivery and caesarean deliveries. The rates for post partum haemorrhage and vaginal lacerations were shown to be similar with lesser incidence of infections and third and fourth degree tears at home.

Women keen to deliver at home should have an uncomplicated pregnancy with a trained birth practitioner in attendance during labour. There should be easy access to the nearest hospital in case of an emergency. These women should be informed that though the absolute risk may be low, planned home births is associated with a two to three fold increased risk of neonatal death when compared to a planned hospital birth.

Newsletter_April2014_V8.indd 22 9/5/2014 4:17:31 PM

MATERNAL AND NEONATAL OUTCOMES IN PLANNED HOME BIRTHS VERSUS PLANNED HOSPITAL BIRTHS [12]

	Planned Home Birth	Planned Hospital Birth	Odds Ratio	95% Confidence Interval
Neonatal Deaths – all newborns	2.0 / 1000	0.9 / 1000	2.0	1.2 - 3.3
Neonatal Deaths – non anomalous	1.5 / 1000	0.4 / 1000	2.9	1.3 - 6.2
Episiotomy	7%	10.4%	0.26	0.24 - 0.28
Operative Vaginal Delivery	3.5%	10.2%	0.26	0.24 - 0.28
Caesarean Delivery	5%	9.3%	0.42	0.39 - 0.45
Third & Fourth Degree Laceration	1.2%	2.5%	0.38	0.33 - 0.45
Maternal Infection	0.7%	2.6%	0.27	0.19 - 0.39

LOTUS BIRTHS

Delaying the clamping of the cord for at least a minute after birth allows more time for blood to move from the placenta to the baby. This significantly improves iron stores and hemoglobin levels in newborns, without any increased risk to mothers.[13]

Proponents of delayed cord clamping also believe that immediate clamping deprives the baby of the ability of moving from a liquid based environment towards an oxygen based environment.

In Lotus Birth, the umbilical cord is not clamped and the placenta is left to expel by itself. The baby that is still attached to the umbilical cord is believed to still obtain nutrients and oxygen from the placenta for the next few days. The placenta is cleaned and wrapped either in a special bag or with sand or salt to cut down the smell till the cord detaches itself.

The RCOG has advised caution as the baby is at risk of infection if the placenta is left attached. Once the umbilical cord stops pulsating, there is no circulation and is essentially a dead tissue. The placenta then becomes a source of infection as it is full of blood. The babies have to be monitored closely for infection, high blood counts and organ damage.[14]

DOULA

Many birthing mothers are now using doulas or birth companions to help them through labour. The Doula (Greek for a woman who serves) is someone who nurtures, protects the birthing mom at home or in the hospital.

Women with support throughout labour are less likely to have medical intervention such as an epidural or opioid analgesics, have an instrumental delivery, a caesarean section or have a baby with a low Apgar score.[15]

However doulas need to be experienced and registered within the area where they work. If delivering in the hospital, doulas should also not interfere with the medical management of the birthing mother but work with the medical staff towards a better outcome.

SKIN TO SKIN CONTACT

The conventional method of taking the baby away immediately to clear secretions have now given way to "skin to skin" contact soon after delivery. Babies are not wrapped up but placed directly on their mother's naked chest. A blanket or flannel is then placed over the baby and mother. Babies are happier, more alert, cry less and their temperatures are normal. Blood sugars are better and immediate skin to skin allows babies to be colonized by the same bacteria as the mother. Mothers were also likely to breastfeed longer.[16]

In natural childbirth having "skin to skin" contact becomes an important issue as mothers feel babies should not be separated from them soon after birth. Bonding starts immediately and babies tend to latch on easily. The Ministry of Health Of Malaysia has also advocated "Skin to Skin" as part of the breast feeding policies.

DESIGNER BABIES

On the flip side of natural childbirth is the choice of organizing a delivery according to time, day and mode (Designer Baby). Couples want babies born on certain dates and at certain times. Some try to achieve this by induction whilst others opt for a caesarean section.

The babies born at these auspicious times are said to have a head start in life. Their time of birth would not cause misfortune to other members of the family and the child is assured a smooth passage in life. There are couples who want their children born on dates that are popular such as 08.08.08 or 11.11.11. There are those who may want an induction or caesarean at particular times so that fathers could take planned leave, during school holidays or even planned to avoid panic or emergency situations. A planned delivery either by induction or an elective caesarean section should be carried out after 39 weeks, unless medically indicated. Babies born at 39 weeks have been shown to have less breathing problems, blood sugar variations, serious infections along with lesser admissions into neonatal care.[17]

Newsletter_April2014_V8.indd 23 9/5/2014 4:17:32 PM

CONCLUSION

These recent trends are clearly outside the conventional teachings taught to obstetricians. As these trends gain popularity, medical societies around the world are forced to reevaluate guidelines and statements, to bring about a balanced and evidence based perspective. While the wishes of the birthing mother is important in her management through labour, the expertise of her obstetrician in dealing with her pregnancy remains vital to ensure a smooth outcome to mother and baby.

Strict criteria should be carried before a home birth is considered and allowed only in an uncomplicated pregnancy. Home births should always be supervised by a properly trained medical personnel with quick assess available to a hospital. Mothers considering homebirths should be informed about the higher risk of perinatal morbidity.

As the pendulum swings towards a more natural childbirth, it would probably be only a matter of time that the old cultural rituals of childbirth mentioned in the beginning make a comeback.

DR PREMITHA DAMODARAN
CONSULTANT OBSTETRICIAN & GYNAECOLOGIST

REFERENCES

1. Gupta JK, Hofmeyr GJ, Smyth R. Position in the second stage of labour for women without epidural anaesthesia (Cochrane Review). The Cochrane Database of Systematic Reviews;2004, Issue 1.
2. Shallow H (2003) My rolling programme. The birth ball: ten years experience of using the physiotherapy ball for labouring women. MIDIRS Midwifery Digest 13: 28-30
3. The Royal College Of Midwives (RCM) (2011) Campaign for normal birth: Getting off the bed. London: RCM
4. Jones, L.; Othman, M.; Dowswell, T.; Alfirevic, Z.; Gates, S.; Newburn, M.; Jordan, S.; Lavender, T.; Neilson, J. P. (2012). Pain management for women in labour: an overview of systematic reviews. In Neilson, James P. "Cochrane Database of Systematic Reviews". Cochrane database of systematic reviews:
5. Using the official lamaze guide in childbirth education classes. Hotelling BA.J Perinat Educ. 2006 Summer; 15(3):47-9
6. Melzack R. The myth of painless childbirth. Pain (1984;) 19:: 321-37
7. Complementary and Alternative Approaches to Pain Relief During Labor. Michel Tournaire, Anne Theau-Yonneau. Evid Based Complement Alternat Med. 2007;4(4):409-417.
8. Cluett E, Nikodem V, McCandlish R, Burns E. Immersion in water in pregnancy, labour and birth. Cochrane Database Syst Rev (2004;) 2:: CCD000111
9. Immersion in Water During Labour and Birth (RCOG/Royal College of Midwives Joint Statement No. 1)
10. "Australia's mothers and babies 2006, Perinatal statistics series no. 22, Cat. no. PER 46". Sydney,: Australian Institute of Health and Welfare (AIHW) National Perinatal Statistics Unit. 2008
11. Planned Home Birth. Committee Opinion. American College of Obstetrician & Gynaecologist. No 476. Feb 2011. Committee on Obstetric Practice.
12. Wax JR, Lucas FL, Lamont M, Pinette MG, Cartin A, Blackstone DO. Maternal and Newborn Outcomes in Planned Home births versus Planned Hospital Births – a meta analysis. Am J Obstet Gynecol 2010; 203:243.e1-8
13. Effect of Timing of Umbilical Cord Clamping of term infants on maternal and neonatal outcomes. McDonald SJ, Middleton P, Dowsell T, Morris PS. Cochrane Pregnancy & Childbirth Group. Online July 2013. DOI: 10.1002/14651858.CD004074.pub3
14. RCOG Statement on Umbilical non Severance or Lotus Birth. 01.12.2008
15. Hodnett, E. D.; Gates, S.; Hofmeyr, G. J.; Sakala, C.; Weston, J. (2011). Continuous support for women during childbirth. In Hodnett, Ellen D. "Cochrane Database of Systematic Reviews". Cochrane database of systematic reviews (Online)(2): CD003766. doi:10.1002/14651858.CD003766.pub3. PMID 21328263
16. Early Skin to Skin Contact for Mothers and their Healthy Newborn Infants. Moore ER, Anderson GC, Bergman N, Dowsell T. Punlished on line May 16 2011
17. Elimination of Non Medically Indicated (Elective) Deliveries before 39 weeks gestation . The Collaborative Project. Elliott Main, MDa,b; Bryan Oshiro, MDc Brenda Chagolla, RN, MSN, CNSd et al. From California Maternal Quality Care Collaborative (CMQCC) a California Pacific Medical Center, Loma Linda University School of Medicine, Catholic Healthcare Westd California, Perinatal Quality Care Collaborative (CPQCC)e and March of Dimes

Newsletter_April2014_V8.indd 24 9/5/2014 4:17:32 PM

THE FIRST INTERNATIONAL CONFERENCE OF THE KURDISTAN-IRAQ SOCIETY OF O&G

When I received the invitation to speak and participate at the First Kurdistan-Iraq Conference of O&G, I was surprised. The invitation was from Dr Ariana Jawad, President of the Kurdistan-Iraq Society of O&G. I had met Dr Ariana during MICOG 2013 in KL. I remembered her as a dynamic lady, full of energy and enthusiasm.

Kurdistan-Iraq is a part of Iraq but yet distinctly different, has seen its fair share of war, torture and persecution. It is part of Iraq, but since the war in 2003, is generally independently governed and in peace. This part of Iraq (Kurdistan Iraq) had on purpose stayed away from the conflicts presently happening in the rest of Iraq. The Kurds are fiercely proud of their heritage; working hard to maintain peace in their country. Therefore this region of Iraq had seen tremendous growth and influx of investment.

As an example of the growth, currently in Erbil, capital of Kurdistan-Iraq, there are many new buildings. Double Tree Hilton hotel is currently being built. Security is still tight, with metal detectors at every entrance of a hotel and airport. It is a country at its renaissance of prosperity.

The Kurdistan is deservingly proud of their efforts. As a testament to this, both maternal and perinatal mortality is on the downward trend. New hospitals are being built, antenatal clinics have started in most parts of the country. Therefore all the more important and applaudable is this First International Conference; where many O&G doctors come from all over the region to learn, be encouraged and plan. To them this is more than just a conference, it is the beginning of a better future for the healthcare for women and newborns for Kurdistan-Iraq.

I arrived in Erbil International Airport on April 3rd after a stopover in Abu Dhabi. The whole journey, minus the stopover is about 10 hours. I was received at the airport by the congress organizing company and taken by limousine to the congress hotel, Rotana Erbil.

The delegates at the congress numbered about 400; enthusiastically attending every talk, with keen Q&A's after every session. The topics varied from threatened miscarriage, medical disorders in pregnancy, IVF, OHSS, laparoscopy, hysteroscopy to gynaecological cancers.

I delivered two lectures;' Teaching Obstetrics Emergencies, making it a Nation-Wide experience' and 'Engaging the Judiciary in O&G Medico-Legal cases'. Both were well received. I have also met other international speakers: from USA, UK, Jordan, Turkey and Egypt. Some have been to Erbil before, teaching at other courses and have seen the tremendous change this region of Iraq is experiencing.

I had stayed in Erbil for about 48 hours, arriving not knowing what to expect. When I left, I had the great satisfaction of knowing that OGSM had perhaps, contributed in a small way to the rebuilding of this part of the world. OGSM has also a new partner in global O&G. Above all, I am impressed by the commitment shown by the doctors and nurses who are committed to make healthcare better for the Kurdistan women and newborn.

DR TANG BOON NEE

Newsletter_April2014_V8.indd 25 9/5/2014 4:17:33 PM

(cont. pg 1) hoping to find one that will agree with their plan. They do see the safety of their babies as a priority.

So, how do we handle the situation when approached by patients contemplating unassisted homebirths or who wish to have a more 'natural' way of 'birth'?

Antenatal Period:-engage rather than confront, using words like 'nonsense', 'useless' will likely put these patients off. Once these patients are put off, they may be lost to the system and may then end up in an A&E with complications after a homebirth. Document clearly your conversation with the patient in your notes; what the patients wishes are: unassisted HB, birth with no medications, etc. Try to counsel them that HB, especially unassisted, has a mortality rate of 10X or more for both baby and mother. Try to dissuade them from an unassisted homebirth, perhaps a compromise on what they wish. Encourage them to have a birth plan. Go through the birth plan with them and come to a compromise, what you are ok with and what is not. File the birthplan in the notes. Do not agree to any part of the birth plan that you are not comfortable with; -explain that safe delivery involves MONITORING of both mother and baby. Educate the patient about safe delivery, even if the patient has fixed ideas of how their delivery should be Labour. DO NOT agree to attend a homebirth. BE EXTREMELY CAUTIOUS if the patient's husband calls and says there is a problem with the home delivery. Always ask them to get an ambulance or go to the nearest hospital. The MOH has a guideline as to what the Jururawat Masyarakat should do when called in this situation. NEVER agree to 'not monitoring' the delivery if the patient chooses a hospital delivery, above all maternal and fetal monitoring should not be compromised. If the patient refuses monitoring, document the conversation.

When CONFRONTED with a patient in advanced stage of labour, brought to hospital when it is obvious they have been trying a home delivery which did not go according to their 'plan': Try not to be angry, although as health care professional whose duty is to save life, you will naturally feel so.-Be calm and composed, deal with the situation at hand. Follow departmental protocol if there is one.-Usually at that time the couple is desperate: but they may still insist on no monitoring, lotus birth with the placenta not cut and still attached to the baby as they believe this gives their baby extra nutrients, no episiotomy even if the perineum is about to tear badly, no instrumentation even if the second stage is prolonged, no oxytocin for the third stage, no MRP even if the placenta is undelivered and worse still: no intervention even when there is evidence of fetal distress.-In that situation: explain as best as you can what safe delivery is. If they still refuse, explain that you cannot be responsible for what the outcome will be and take time to document that in the notes, preferably get the husband and/or the patient (if she is not too distress!) to sign in the notes. Explain that the mother or the baby may be damaged or die in that situation. Have a witness when counseling the couple and have them sign the documentation after the fact. Thereafter offer a second opinion of a colleague or a superior if available and even possibly offer to transfer care to another hospital. If the patient refuses or is too distressed to be transferred, you as the healthcare provider will have to handle the delivery as best as you can.

Post Delivery. DO NOT sign the birth certificate if you have not witnessed the delivery, even if you are confronted with a newborn baby with placenta attached, if you suspect that the patient had a homebirth on purpose. NEVER agree to signing the birth cert the NEXT day even if the patient is brought into hospital in the postnatal period. On occasions you may have the opportunity to speak to persons who conduct 'alternative birth practice' classes.

For some of these persons, the idea of natural birth is beyond just a theory or an idea, it is a strong belief and a fixed thought. In other words, YOU will NOT be able to convince them otherwise. Therefore do not try, you will likely be disappointed by your lack of success. Most will charge a fee for their classes. Some will charge a fee for 'accompanying' the patient in labour. The majority have no medical training. Some would have been certified by a doula agency. They form a 'sisterhood' type of bond with the patient. Therefore the patient will likely trust these educators more than the health care professional. Most are active online and are monitoring the internet realm very carefully.

What can we as healthcare professionals do better for the future?

Listen more. Understand that women generally want what is best for their baby and for themselves. Have ready statistics to show the high mortality rate of unassisted homebirth. Explain the difference between assisted and unassisted HB and that assisted HB is still not available in our system. Seek permission for 'common' obstetrics procedures eg: augmentation of labour, induction of labour, vaginal examination,

(cont. pg 27)

Newsletter_April2014_V8.indd 26 9/5/2014 4:17:33 PM

FROM THE PRESIDENT'S DESK (CONT.)

artificial rupture of membrane in an O&G department, follow protocols regarding these 'common' obstetrics procedures. Do not judge the women who come to you with such requests: they may have genuine reasons but you as a healthcare professional should insist on safe delivery. I do hope that the above will help you in your day to day interaction with pregnant mothers.

DR TANG BOON NEE
PRESIDENT
2013 / 2014

SUBSPECIALTY CHAIRMAN SELECTION PROCESS

Over the years, apart from an increase in membership of the OGSM, there has also been a trend towards members taking a keen interest in a subspeciality. Our special interest groups have represented these specialities admirably over the years, but as the needs of the membership increase, we are aware that some changes may be required.

In the past, your Council has nominated the subspecialty chairman to the post for a period of two years. Starting from 2014, we will request the membership to decide for themselves who they would wish to represent them.

At the forthcoming AGM, and during the subspecialty Meet The Expert session, an election process will be conducted to determine the Chairperson for the period 2014-2016. So please do attend the session that best represents your special interest, and have your voice heard.

DR PRASHANT NADKARNI

BELFAST RESEARCH FELLOWSHIP

CLINICAL RESEARCH FELLOWSHIP IN BELFAST, NORTHERN IRELAND

A Clinical Research Fellowship will be advertised in Belfast, Northern Ireland in August 2014 with a view to start in August 2015.

- 2 Year MD Clinical Research Fellowship with translational element OR
- 3 year PhD Clinical Research Fellowship (Optional)

Successful applicants would be expected to complete 2 smaller clinical projects per year in addition to their main MD/PhD thesis project. There would also be some clinical work built into the timetable.

The proposed MD/PhD project is an Algorithm for predicting patients suitable for complete debulking - to zero visible disease - in Serous Ovarian Cancer: reducing morbidity, improving Quality of life and survival. This would involve using current parameters - radiology, Ca125, clinical assessment - and molecular biomarkers, currently being identified.

.

Other possible projects are in development and the successful candidate may have a choice.

GMC registration is desirable, but not essential. It is a clinical research post, so patient contact would be desired. The Fellows will have an opportunity to get involved with operating if they wish, and also supplement their salaries with locum on-call work.

The post will be fully funded, £35,000 basic salary. Fellows will be allowed to engage in Locum work if they wish. Hence GMC registration desired.

MRCOG is not essential. An equivalent exam would be sufficient. Evidence of previous publications is also desirable.

Potential candidates who wish to express an interest are to inform the undersigned through the OGSM office at ogsm@myjaring.my

DR SURESH KUMARASAMY
IMMEDIATE PAST PRESIDENT,
OBSTETRICAL & GYNAECOLOGICAL SOCIETY OF MALAYSIA

Newsletter_April2014_V8.indd 27 9/5/2014 4:17:33 PM

Obstetrical & Gynaecological Society of Malaysia

23rd Congress

of the

Obstetrical & Gynaecological Society of Malaysia

Back to Basics

5 – 8 June 2014

One World Hotel, Petaling Jaya, Selangor

Final Announcement

SCIENTIFIC HIGHLIGHTS INCLUDE:

The Great Debate & Masterclasses including:

- Masterclass in Colposcopy by Dr Quek Swee Chong
- Masterclass in Antenatal Ultrasound by Prof S. Suresh
- Masterclass in CTG by Prof Emeritus Sir S. Arulkumaran

Newsletter_April2014_V8.indd 28 9/5/2014 4:17:33 PM