MPA's 31st Annual Scientific Congress this year will be on adolescent health. After successfully bidding for the 9th World (please note: WORLD) Congress of the International Association for Adolescent Health (IAAH) many years ago, the date has arrived and we are organising the congress with the Malaysian Association for Adolescent Health (MAAH), Ministry of Health Malaysia, the Federation of Family Planning Associations Malaysia and the National Population and Family Development Board Malaysia (LPPKN) on 28-30 October 2009. The theme is “Private Lives, Public Issues – a Global Perspective on Adolescent Sexual Health” and you can read all about it on the website www.iaah2009.com. The venue is Shangri-La Hotel in Kuala Lumpur.

Why adolescent health? We have not had any congress that tackles this issue from an international perspective and the paediatric community now has at least two paediatricians trained in adolescent medicine. It will give us paediatricians a strong foothold on this subspecialty and help us to claim our right to treat children up to the age of 18 as stipulated by the World Health Organisation (WHO). Although the theme is on sexual health, all other aspects of adolescent medicine will be discussed by the Faculty consisting of well-known international specialists and also regional and local speakers. For the first time too, teenagers will be invited to participate in some parts of the Congress. You can bet it will be exciting.

Shangri-La again? We shall not say KL Convention Centre is too expensive but it was and still is. There are not many venues that can take more than 500 delegates with about nine break-up rooms. Besides, the Shangri La Hotel has just recently been refurbished and all the carpets, furniture, lamps, plumbing, etc are new although they have kept to the conservative earth tones. Realising the need to be perpetually connected, all rooms come with complimentary Internet facilities. If you don’t bring your notebooks along, there will be enough booths with Internet connectivity in the Congress proper. The food served at the Shang is better than most other hotels with a wide selection for all meals.

Why October? This date was decided by the IAAH Board to coincide with holidays in the western world. As such, we had to defer our usual date in August to October. Other than its closeness with the Asia Pacific Congress of Pediatrics in Shanghai, the dates do not clash directly with any other congress or any foreseeable obstacles.

The IAAH2009 congress will give another opportunity for members to interact with colleagues from within the country and from the region and the world. The spectrum of topics for discussion will be wide and the scope limitless. Book the above dates for this annual reunion and renew our camaraderie. Free paper presentations on any topic are still welcome, with the deadline on 31 May 2009.
One cannot open the newspapers nowadays, nor access the internet, without being reminded of the catastrophic global economic situation we are now in. The only word that would do justice in describing the situation is ‘meltdown’. Only that word can accurately conjure the image of how presumably solid financial institutions can almost overnight liquefy and literally melt away.

Leading captains of industry failed to uphold the trust placed upon them, and some well placed and trusted financial doyens turned out to be outright crooks.

They flourished in a climate where an avuncular and fiscally irresponsible public allowed a situation to prevail where no one wanted to ask questions even as the signs of a crack in the Titanic were appearing; everyone busy enjoying the glory days trying to outspend each other, conveniently in denial that there will have to be a day of reckoning for such fiscal irresponsibility.

And thus the bubble burst, and burst it did, triggering a global financial crisis the likes of which no one has even seen in living memory.

We all now act surprised. Regulators wondered how it could have happened under their watch, and consumers wondered why nobody had ever warned under their watch, and consumers wondered why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody had ever warned why nobody has ever witnessed such a spectacle.

We in the medical sector will do well to learn lessons from this.

The delivery of medical services is fraught with intrinsic risks. Despite the best intentions of the medical caregiver, many things can, and do, go wrong. We very much need to practice Risk Management in order to ensure the best and safest outcomes for our patients, and where negative outcomes are unavoidable, to communicate and ensure the participation of the patient/family in understanding and evaluating the risks involved.

A study in the United States estimated that each year 98,000 Americans die and another 1,000,000 are injured due to preventable medical errors.

Risk management was perceived as pessimistic and negative, and largely downplayed. We now reap the harvest of this wholesale abandonment of caution and common sense.

And the overriding sentiment is ‘how can this have been allowed to happen’?

Besides the obvious greed and intertemporality of the population as the main factor, the other big contributory factor that abetted this crisis was the failure of the financial system to observe fundamental principles of something called ‘Risk Management’.

A ‘risk’ in simple terms is a hazard, the probability of a factor or event resulting in a negative outcome. ‘Risk Management’ is the process to identify and assess the intrinsic risks in any situation/organization/services, to institute measures to communicate the risks, and to control the negative impact of these risks on the achievement of the avowed objectives of the organization/services. That cyberspace sage of the ages called Wikipedia defines it as the “activity directed towards the assessing, mitigating (to an acceptable level) and monitoring of risks.”

During the halcyon days of seemingly endless, freely available credit, the public had chosen to believe that nothing bad could possibly happen. Risk management was perceived as pessimistic and negative, and largely downplayed. We now reap the harvest of this wholesale abandonment of caution and common sense.

The key question is how much risk do we accept, and how we contain that risk so as to minimise the negative outcome to our patients.

This is all the more pertinent with the increasingly medicolegally-conscious and litigious public (appropriately so as the public becomes more educated and aware of their rights).

It has also implications on cost containment, as the remedial measures for bad (avoidable) outcomes can be costly in financial terms, either to rectify/treat, or to compensate.

The NHS of UK states that “the integration of clinical risk management in the operations of medical institutions is in line with recent trends in clinical governance where traditional clinical governance based on individual professional responsibilities and liabilities is shifting towards the concept of an integrated system of clinical governance, …… safeguarding high standards of care, and creating an environment in which clinical excellence will flourish.”

Some elements of Risk Management are already incorporated into our system, such as Critical Incident Monitoring, Nosocomial Infection Surveillance, Adverse Drug Reactions Monitoring, and Mortality/Morbidity Audits. However the degree to which particular doctors or institutions pay heed to these strategies vary tremendously. It would not be inaccurate to say that the majority of doctors see these measures as a relative pain, or as something that ‘limits’ them rather than as tools to empower and improve their services.

It is timely that the Ministry of Health promote the philosophy of Risk Management in medical care, and inculcate in the new generation of doctors a work culture in which Risk Management is an integral part of their paradigm. It should strengthen the strategies involved and train the health personnel in using these tools to guide their day to day practice.

And hopefully with this, we doctors will remain relevant to a rapidly changing landscape of increasing transparency and accountability.

Soo Thian Lian
President 2007 – 2009
Dr Amin, a professional and a true friend in need

THE death of Dr Amin Tai Abdullah and Dr Haliza Mohd Shafie came as a shock to us, a group of friends who knew them well and had been climbing with them for years.

We were planning a trip to the Lost World of Malacca Basin in Sabah this May. Amin and I was making his preparations for the climb. He had reminded the team that the trek wouldn’t be easy, with a height of 1,500m to trek.

In the past when we were heading to places like Kilimanjaro, Annapurna and Everest base camps in Nepal, we would go for local preparation and trekking in Gunung Daruk, Gunung Nong and Gunung Ledang.

Klangate in Melanu is also a favourite place to train because the place is near and one could complete the trek up and down within two hours. We often joked that we could go up Kilangate to see the sunrise at 7am and be in Kuala Lumpur for our next trek at 9am. Some parts of Klangate hill has poor telephone reception so sometimes when we are not on call in the hospital, the phones would be left in the car.

One doesn’t need any climbing gear up Klangate hills. Some areas are steep but have ropes in place to help climbers. The most important part of the trek is to go with experienced trekkers and be physically fit. Amin had been in our trekking team for many years. He was always the organised, careful type with attention to details. He was the officer and always the pillar of the team; reminding every member of their training, clothing, climbing gears and vaccinations etc. The fittest quality of all is his caring attitude; always putting others before himself.

When we were up in Kilimanjaro in Tanzania many years ago, I advised all our team to avoid any mountain sickness and had inconstant vomiting. While many of us were tired, cold and weakened up in our tents, Amin walked out to her tent and hauled her a cup of warm tea and some medicine and kept her company and encouraged her. Dr Witi recovered, perspired and made the whole journey to Mount Kilimanjaro.

That was Amin. A member of Mercy Malaysia, he was the one who would do his private practice work at the Lions Eye Center and was a volunteer for any humanitarian aid missions locally and overseas.

He had served in Cambodia, Indonesia and Kosovo every time when his safety was in peril. To be able to achieve all these, he had a great wife and family who would support him all the way.

Not many people realised that Amin was one of the original surgeons in our surgical circle. When we encountered difficult cases, his help is sought after and he would, at any time of the day, offer his expertise; even for free. His expertise was well recognised and he was a member of the liver transplant based in Singapore.

Recently many of our universities were plagued with resignations of surgical specialists. The Department of Surgery in UPM was badly affected too. Amin volunteered his service as a locum or locum and had been actively teaching the medical students for the past two years.

Dr Haliza and her husband Bionawen trekked with us in Sigil Ten for four years ago. Despite her lack of treking experience, she was never one to give up easily. While I don’t know her that well, her caring attitude and bubbly temperament impressed me. I have to double check children and mothers would trust her and love her. The net is full of testimonies for her.

Dr Haliza Mohd Shafie & Dr Amin Tai Abdullah

28 March 2009 – today the country lost a senior paediatrician and a paediatric surgeon, MPA lost two members and I lost two good friends. We send our condolences to the families of Dr Haliza Mohd Shafie and Dr Amin Tai Abdullah over their sudden and tragic loss.

Dr Haliza and I worked together in Hospital Kuala Lumpur as UKM trainee lecturers where we were ‘conscripted’ into the M.Med (Paediatrics) training programme in 1984. Having returned from Australia and being more outspoken than the rest of us, she was obviously the one who shone during teaching sessions and ward rounds. She however decided to defer one year of the programme to devote her time to her newborn baby. She was a natural at neonatology and took an eventual interest in child abuse and neglect, becoming the chairperson of the SCAN (Suspected Child Abuse & Neglect) team. She managed to publish a paper on a collection of all babies admitted with intracranial haemorrhage and made an unofficial link with the use of the sarong cradle (buai). She was always sure of herself and would speak up when she thought something was not right. She became a specialist a year after me and took over the helm of the SCAN team soon after, working closely with Prof Datuk Dr Mohd Sham Kasim, the Welfare Department, the Police and various orphanages. It was a surprise when she submitted her letter of resignation to pursue private practice in Ampang Puteri Specialist Hospital (APSH).

Like Haliza, Dr Amin Tai enjoyed the outdoors, a legacy of their undergraduate training in Australia. Amin came to the scene slightly later and, as most paediatric surgeons, was very level-headed and thought like a paediatrician but cuts like a surgeon. We had many discussions during the course of managing common patients, the most memorable of which was a boy with a large haemangioma and arteriovenous malformation in the thigh in whom we tried steroid, interferon, coil embolisation and surgery to save the leg from amputation. Eventually, at age about fourteen, we decided together that we could no longer save the leg and Amin had the unpleasant task of amputating it. He subsequently related an incident when this same patient hobbled up to him in Melaka and asked why we did not amputate earlier! Amin was the sort of person who lived life to the full and always smiled at friends and even when called to see a patient at 3 am. As the founding Vice-President, he joined MERCY missions and was an adventurer of sorts. We all knew that he would not really be happy in private practice when he left UKM for APSH. This was proven true when he returned to help with service and teaching at HUKM for a few years and then UPM. He still managed to climb mountains, hike and do all the outdoor things that the rest of us got tired just thinking about.

Both will be missed by colleagues and friends as much as by their own families. Their sudden demise has left a gaping hole in our hearts as in those of their patients. May Allah bless their souls.

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The late Dr Amin Tai Abdullah

Dr Haliza Mohd Shafie
The 11th Western Pacific Congress on Chemotherapy and Infectious Diseases (WPCCID)

29 November – 3 December 2008, Taipei, Taiwan

The 11th Western Pacific Congress on Chemotherapy and Infectious Diseases (WPCCID) was held last year from 29 November until 3 December 2008 at the Taipei International Convention Center, Taiwan. This meeting was in conjunction with the 5th Asian UTI/STD Forum (AAUS 2008).

The host organisations of this Congress were the Infectious Diseases Society of Taiwan, Taiwan Society of Microbiology, Nosocomial Infection Control Society of Taiwan and the Taiwan Urologic Association whilst the collaborating organizations were the International Society of Chemotherapy, the Western Pacific Society of Chemotherapy (WPSC) and the Asian Association of UTI/STD.

The parent organization is the WPSC of which the new president is Dr Seto Wing-Hong from Hong Kong and the immediate past president our Professor Victor KE Lim. The WPCCID is held every two years. It is interesting to note with pride that the inaugural meeting was held in Kuala Lumpur in 1989.

Delegates minus the Thais

This Congress was said to have a participation of over 2000 delegates. Unfortunately, the Thai representatives were unable to attend due to political turbulence in their country.

Malaysia had a sizeable number of delegates, which included paediatricians, physicians, microbiologists and surgeons. Among the paediatricians who attended were Datuk Dr Zulkifli Ismail, Prof Koh MT, Dr Tan Kah Kee, Dr Fong Siew Moy and Dr Revathy Nallusamy.

Cultural Performances and Scientific Content

The opening ceremony was held on the 29 November at 6.00pm when Prof Victor Lim presented the first keynote lecture entitled Antibiotic Stewardship. We were treated to a welcome reception which included impressive stage performances by a famous Taiwanese sand painter who created well-known Taiwan landscapes with coloured sand, and the dazzling Diabolo dancers.
While there was no specific theme for this year’s Congress, updates on a wide range of topics and issues were presented and discussed. These included antimicrobial resistance, diagnostic testing for infectious diseases, vaccines and immunisation, tuberculosis diagnosis and treatment, infection control, specific microorganisms such as MRSA, Klebsiella pneumoniae, HIV and fungal infections and many others.

The highlights of this Congress were the keynote lectures which included David Ho speaking on the Challenges in addressing the HIV Pandemic, Donald Armstrong on Infections in Cancer Patients, Seto Wing-Hong on Infectious Disease Dashboard – Real Time Prediction for Prevalence of Infections. As in keeping with all Congresses, there were plenary lectures, symposia, oral presentations and poster sessions as well as meet the expert breakfast sessions.

World’s Tallest Building

There was much to learn and gain throughout the Congress. There was also opportunity to tour! The paediatricians as a group, had the opportunity to visit the famous world’s tallest building, the Taipei 101 and to travel in the world’s fastest elevator which took us up from the 5th to the 101st floor of Taipei 101 in 37 seconds! Some of us opted for a half day tour which took us to the well known National Palace Museum to view Chinese and other oriental artifacts and to the Chiang Kai-Shek Memorial.

Taiwan Hospitality

The hospitality in Taiwan was excellent, its staff at the hotel where we stayed and the convention centre were efficient. The weather was remarkably comfortable with cool temperatures between 18°C and 22°C. We were provided with plentiful food at the Convention and treated to Taiwanese delicacies such as its pineapple cakes.

The Congress was well worth the time and effort and provided excellent updates on numerous issues and concerns in infectious diseases and infection control. The Congress ended on the 3 December at 2.00pm which left us another half day for sightseeing before our departure the following morning. The 12th WPCCID will be held in 2010 in Singapore.

The Congress abstracts are available on CD and if anyone is interested, please contact the Berita editorial board.

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Wishing Well

A long married couple came upon a wishing well. The wife leaned over, made a wish and threw in a penny. The husband decided to make a wish too. But he leaned over too much, fell into the well, and drowned. The wife was stunned for a moment, but then smiled, ‘It really works!’
The Malaysian Association for Adolescent Health (MAAH), the adolescent health committee of the MMA together with Malaysian Paediatric Association (MPA), and Jabatan Kesihatan Negeri Pahang (JKNP), had an outreach programme targeting adolescents of Sekolah Menengah Kebangsaan Bukit Goh, Kuantan, Pahang.

The selected school was situated in a Felda scheme about 1 hour from Kuantan town. The easy accessibility of the school as well as a conveniently located government clinic in the vicinity makes SMK Bukit Goh ideal for our project. About 10 minutes from the school is a Felda Training Centre with accommodation available and that was where we stayed.

Fourteen committee members, six nurses, and ten university students from UITM and IIUM participated. We were joined by a few doctors and nurses from JKNP and a few lecturers from IIUM at the school itself.

The university students had attended our ‘training of trainers (TOT)’ sessions 2 weeks prior to the project and they were the facilitators whilst the committee members oversee and assisted them. They proved to be very capable, enthusiastic and communicated on the same level with the students.

**Objectives**

The objectives of the outreach program were to promote:

1) Public and professional interest in the comprehensive development of healthcare and well-being of adolescents.  
2) Encourage co-operation and collaboration between organizations and individuals interested in adolescent health, including adolescents themselves.  
3) To promote the concept of active youth participation in the activities of the association and in the care of their own health and that of their community.

In tandem with the above objectives, a one-day program was drawn which comprised of a short discussion of the topic followed by a workshop. The emphasis was on active-learning through workshops and discussions delivered in a fun, interactive and open environment.

The topics chosen were:

- **Healthy Lifestyle for Adolescents** by Dr Iskandar Firzada Osman an adolescent health specialist, family medicine specialist, Jaya Gading Hospital.
- **Smoking, Alcohol & Drugs – Should I Try?** Assoc Prof Dr M Haniki Nik Mohamed. Lecturer, International Islamic University Malaysia.
- **Teen Sex: Am I Ready?** Dr Mohd Farouk Abdullah, consultant obstetrician and gynaecologist, Hospital Klang.

**Student participation**

We requested the school to ‘choose’ 100 Form 2 (14 years old) students, a mixture of good students and problem students. Finally, there were 106 students, about 1/3 of whom were boys, and six teachers and counselors.
The students were divided into groups of 10 for each of the workshop sessions. Each was tasked to do activities relating to the topics of discussion. For healthy lifestyle they had to do a food pyramid, discuss the importance of too little or too much food and diseases that maybe related.

For the addiction workshop, they were asked to draw a body map detailing the ill effects and diseases caused by tobacco. They had a role play on how to refuse offers of addictive substance from peers.

**Teen sex group**

And for the teen sex, they had a group discussion on some of the myths about sex and again they had role plays on how to say “no” assertively and to avert from situations leading to sex. Groups were free to find their own place for discussion and fully utilize the materials provided. It was so much fun seeing them, spread out under the trees, at the school canteen, in the classrooms and even along the corridors! The groups had to make presentations in the main hall to all participants where active discussions took place. We had small gifts for best group presentations. Emphasis was on building a helping relationship, self-empowerment and making the right choices.

Bahasa Malaysia was used as the medium of instruction for all lectures and workshops. The main facilitators were the ten university students who were better accepted, as they were like older brothers and sisters to the adolescents. The student facilitators did a wonderful job and felt rewarded by the enthusiasm of the adolescents, and more than eager to participate in further outreach programmes.

**Overwhelming response**

The event was successfully organised and met with the set objectives. The response from students, in particular was overwhelming. All parties agreed on future workshops for other students at the school as well as other activities including health screening and continuous assessments for the effectiveness of such a program. We left tired, fun filled and fulfilled. We are looking forward to the next outreach programme with Orang Asli adolescents in Kuala Koh, Gua Musang, Kelantan. Please look out for the dates in our website: maahmalaysia.org.

In conclusion our first outreach programme targeting marginalised adolescents in the rural area had met with our objectives. It was an eye opener for our urban facilitators and committee members to interact with adolescents from a rural background. We hope this will be the beginning of more such projects.

**Nazeli Hamzah**

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“Standby to go to Gaza.”
Dr Lai Fui Boon, from Johor, shares her experiences, memories and thoughts after returning from a MERCY mission to the battle zone.

“Standby to go to Gaza.” I received the sms one Sunday whilst at Giant Hypermarket. Naturally, I thought it was a prank!

It was a frantic Monday morning to postpone surgeries and appointments. Some were permanently cancelled as parents were displeased. However, most of my patients had been very understanding for which I am very grateful.

There were six of us, a motley crew of two orthopaedic surgeons, a general surgeon, a paediatric surgeon and an anaesthetist. We had to write our last words for our loved ones which was left with MERCY’s safekeeping.

We arrived at Cairo on 18 January and drove to the border. The next morning, we were taken to Rafah gates, the border to enter Palestine. This was the first obstacle. Only journalists could enter that day but we persevered, waiting four hours and finally entered Rafah gate, only to spend another nail-biting two hours wait for immigration control to let us through.

Finally, we were in Gaza!

The first evening was at the local hospital, Al Nadesh (akin to a district hospital). We saw some children who had been injured in the war and some burns due to home accidents with kerosene.

We arrived at Cairo on 18 January and drove to the border. The next morning, we were taken to Rafah gates, the border to enter Palestine. This was the first obstacle. Only journalists could enter that day but we persevered, waiting four hours and finally entered Rafah gate, only to spend another nail-biting two hours wait for immigration control to let us through.

We worked at European Hospital (200+ beds) so named as it was built with European Union funds. I worked with the Paediatric Surgery Team consisting of eight surgeons. It was all elective work, running clinics and doing elective surgeries eg Hirschsprung, urology, oesophageal replacement, etc. The elective surgeries were cancelled during the 2-week war so there was a lot of work to be done.

Gaza Geo-Socio-Political background

Gaza is a long strip of land; to the north is Gaza City with Al Shifa Hospital, the largest tertiary hospital, in the centre is El Nasser Hospital, and 15 minutes further south is European Hospital. The southern most is El Nadesh Hospital. It takes 45 minutes by road to traverse south to north, not a big piece of land but divided from what is left of the rest of Palestine, the West Bank.

Gaza has been isolated from her neighbours for the past 3 years. The Israelis control the borders except for south where Rafah is under Egypt. No borders are opened. Thus, the Gazans lack the essential daily goods that we take for granted like flour, oil, cooking gas, meat, paper, medicine, etc. Hence, the 2000 tunnels into Egypt, to smuggle these essential goods mostly, I think.

There is little to no industry in Gaza. There are orchards, farms and olive groves, but only enough for local needs. The UN provides some of the needs including schools.
Forty percent of the population of Gaza are under 15 years old. Hence, during the recent war, 60% of the dead and injured were children and women. The fertility rate is high, usually 6-10 children per family. Life is tough with very little money on hand. Despite this the literacy rate in Gaza is more than 90%!

Most of the children are fairly well, but there are signs of malnutrition. The war had destroyed sanitation, rubbish is piling and piped water supply had just only resumed when we arrived in Gaza. There are still many power outages. Diarrhoea and infectious diseases eg measles as such will soon be more rampant.

The children play by the roadside. There is no playground. Therefore, road traffic accidents are not uncommon.

**Memorable and inspiring Gazans**

The most amazing and truly inspiring are the people of Gaza. They are so proud of their land, the will and determination to go on with life despite the tremendous hardship and uncertainties. They are incredibly charitable, very friendly and always have a smile for us strangers. They ask only for their story and plight to be known to the world. They have not given up on hope that Gaza will be “free”.

There are so many heart-breaking tales of families separated for years. Our hosts, the mother has not seen her daughter nor grandchildren, who are in West Bank. The host’s brother is exiled in Algeria for the past 18 years. Mohd has not seen his father, their correspondence is by phone or Internet. Another uncle is in an Israeli jail for the past 12 years with no news of him for the last two years! So many single parent families, but the extended family is incredible, all taking care of each other.

The Gazan doctors and medical teams had been very efficient during the 2-week war, so much so that when we arrived there was no acute war injuries to deal with, only complications.

**Paediatric war casualties**

Bombing started once the week-old ceasefire expired, mostly at night. The first three bombs were on the first day of Chinese New year, great fireworks! I felt the building shake but went back to sleep. The next team had an Israeli drone exploding in front of the El Nasser Hospital injuring scores of children on their way to school. The kids were very stoic, not shedding a tear. They had shrapnel injuries and superficial skin wounds which are painful.

There are many amputees, some single, some multiple. We met a 16-year old boy who lost both upper limbs and one leg. The only Rehabilitation Hospital, a world class facility 2km from the Israeli border, was hit by missiles, damaging a USD 6 million facility (donated by Kuwait). All police stations in Gaza are destroyed, along with the Parliament, some UN run schools, mosques, etc. Olive groves and orchards are not spared. One area, Jablya, was totally destroyed with nary a tree or house in sight. Yet despite the Israeli induced destruction, there is beautiful countryside and a gorgeous Mediterranean coastline to enjoy.

**Lasting impression**

My most lasting impression is not the destruction but the people of Gaza and the peace I found in Gaza despite the war. The Gazans inspired me, they have not lost hope, their will and determination to go on with life.

I hope to return to this beautiful place one day during this lifetime. We six are worried for the friends we have made, wondering whether they will be alive. I hope they are.

**Lai Fui Boon**

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This article is dedicated to the memory of Dr Amin Tai, Paediatric Surgeon extraordinaire, adventurer and a good friend. Au revoir buddy.
Trials, Tribulations and Frustrations of a Specialist in a Small (Peripheral) Hospital

When Prof Zul asked me to write a few words on the above title, little did he realise he approached the wrong person or rather the ‘very right person’.

I hope he does not regret it by the time he reads this piece. My intentions are only to picturise the natural situation and the rebels of life that a specialist in a small hospital goes through from my own personal perspective. Readers are free to agree or disagree with me. Judgement should be reserved till the end. But having said that, I don’t think even in my darkest dreams would any specialist working in a small hospital, especially in my state, disagree with me. I have used the abbreviation SSH in the rest of article to represent ‘specialists in small hospitals’.

Importance and privileges

I was trying to come up with a catchy opening phrase as, in a court of law, the opinion of the jury may entirely depend on a convincing opening statement, but my cerebral cortex diligently failed me; hence allow me to be blunt.

Why is the above title of importance?! Ah, I am pretty sure many would frown and some would even start to compare immediately; thus satisfying themselves by concluding that there is not an inch of difference between the SSHs and those doctors working in the multi-subspecialised and departmentalized, well equipped bigger and well staffed (or even surplus staffed) hospitals. My dearest colleagues, let me enlighten you on that, though I may sound a little bit biased on this but that makes me nothing more than human. I apologize to anyone who refuses to admit or agree with me but please feel free to challenge me and prove me wrong by coming here and working with me.

The pitch here is that we specialists in small hospitals (in my state at least) are understaffed, not well equipped, over-worked, inadequately supported and as a result deprived of many other simple satisfactions in life. And we are always disgruntled with the whole system. Why? There are many reasons, but not one good answer for them. This is an old problem, repeatedly surfing for many years, but no new solution has seen the light of day so far.

At the back of my mind, it is my hope that SSHs be given more importance and privileges for their (or rather my) unconditional devotion to their work (in an unfavourable environment) and more specialists be sent to lighten their burden.

Trials and Tribulations! Rounds, Doctor, Rounds!

Did you catch the latest news headlines? Did you see the latest news report? Did you watch football yesterday? Did you go for the opening ceremony? Did you attend his wedding? Did you go for holiday? How was the conference? All the above are part of a normal conversation that can take place when a staff meets another staff. But the answer for it, for a SSH, is probably
a difficult quiz to attempt. The reason being time is of the essence and we simply don’t have the privilege of time hanging by our side to spend that much in reading newspapers and watching tv news or a football match most of the time. The programmed SSH is only to do one thing, i.e, go to work, try to finish work, leave as little work for tomorrow, and go home to come back again the next day and continue the rest of the work. Even the word recreation sounds so foreign. Does it sound impossible? Yes it would for some, but let me assure you that it is as true as it can get if seen from where I am standing.

Blaming time for not waiting for me would be utterly foolish. Then who can I blame? Me, I guess. So it must be me, then! Too slow in rounds, too slow to see patients in clinic, poor time management and too slow that, too slow this, too slow, etc! But how fast can I see and examine and decide for a child who is lying on the bed helplessly and has obediently surrendered his fate to me. Can I just run from one bed to another, just listening to my faithful and junior MO’s impressions and opinion like in a marathon, without even touching the child? My answer with a clear conscience would definitely be ‘NO!’ Resorting to such a standard of work is a crime and an injustice to the child and neglecting responsibilities entrusted in me by the parents and the hospital. But, all said and done, do the SSHs have a choice, when he or she is running the whole show, it’s either a one man or two men show. I know guys the mere sound of the phrase ‘one man show’ immediately sends an interesting sense of importance down the spine. Eyes opened wider, most of us wake and sit straight. But for the SSHs, it’s not so different, they might sulk, mumble to themselves but at last smile cynically, knowing full well that that’s their fate to be, as most of us have pledged sincerely to be ethical specialists. Even a very highly motivated specialist, constantly challenged in this manner, gradually loses the very essence of service that had once greatly appealed to him. The question to be asked here is: ‘why is this happening?’

I know, I know, listening to the above, some would authentically assert that once one is thrown into such a position, then one should adopt and adapt. But the question to be answered here is it really fair when there are places in other parts of the country where some enjoy the luxury of more enjoyable environment and pace of work (probably with more specialists). If that is to be true then why was the Time Directive like the one that European Union have come up with was given such a high level of importance to the extent that the whole health care working system was reshuffled in UK. Something to think about seriously I guess.

**Frustration and Frailty**

I am quite sure by now most of you would have felt the heat of my frustration. And let me humbly assure you, my dear readers, that most of the SSHs like me have enough frustration concealed in them to match the wealth of Bill Gates! Most of us frequently do rely heavily on job satisfaction to distract and keep ourselves going despite the multitude of shortcomings. But how successful are we? Most of the time we are not. Some might ask, “Where do all these feelings of ‘frustration’ come from?” Its always not easy to point at a direction and grab an answer that everyone is contented with, so, I will let your own imaginative minds work out the math. I am sure all of you can.

Now some pessimists, or as some would like to call themselves “realists”, may regard what I am doing above as a sign of ‘weakness of mind’ or ‘just simple reasoning out a failure’ but to be truthful, most of us are just simple humans and we do have our limits and limitation, which make us frail. After all, we are made to be so.

**Unsung Heroes**

So there you have it, I have said it or rather, written what many specialists functioning in a small hospital or peripheral hospital have been wanting to put in words for such a long time. They suffer in silence, hiding their anguish, frustration, burn-out and anger, forcing themselves to work harder and harder till one day when they decide ‘enough is enough!’ The papers of resignation with their names imprinted, land silently on the busy and crowded desk of the Director. There goes another valiant unsung hero. His future looking rather murky (from his point of view), once what was his passion has become an aversion; his will waning like the early morning mist, the only light he sees now is the inevitable change of path. There goes the ‘valiant unsung hero’. These are the heroes who have persisted, despite the hardships and adversities, for many years till the day there was nothing left in them to give.

It was time to end. I bear neither grudge nor malice with this article. I sincerely hope that I have highlighted enough the plight, and in doing so, done justice to the work and hardships experienced by all the specialists like me working in a small or peripheral hospital.
Do You Know What DiCARE Is?

DiCARE stands for Diabetes in Children and Adolescents Registry (DiCARE) which is a MOH supported service to collect information about diabetes mellitus.

This registry started in April 2006 as a pilot project with the involvement of 4 hospitals (Putrajaya Hospital, Kuala Lumpur Hospital, HUKM and PPUM) and later became nationwide. This is an ongoing real time register of diabetic patients ≤ 20 years old via the e-DiCARE, an online case report forms (CRF). Currently, there are 17 hospitals registered under DiCARE. We have come up with our first report of 240 patients from April 2006 to December 2007. It was published in the Medical Journal of Malaysia (Vol 63, Supp C, Sept 2008, P 37-40).

The mean age of patients was 12.51 years (1.08 to 19.75 years old) and 46.4% were boys. The mean age at diagnosis was 8.31 ± 4.13 years old with an estimated duration of diabetes of 4.32 ± 3.55 years. A total of 166/240 (69.2%) have type 1 diabetes mellitus (T1DM), 42/240 (17.5%) have type 2 diabetes mellitus (T2DM) and 18/240 (7.5%) have other types of DM.

Majority of patients showed poor glycaemic control as evidenced by a mean HbA1c level of 10.0% ± 2.2 (range 5.2 to 17.0%). At the annual census in 2007, there were only 3/50 patients (6.0%) with T1DM and 4/20 patients (20.0%) with T2DM, who achieved target HbA1c of less than 7.5%. Most patients (80.4%) practiced home blood glucose monitoring. Patients were seen by dietitian (66.7%), diabetes educator (50.0%), and optometrist or ophthalmologist (45.0%). Only 10.8% attended diabetes camps. The early results of DiCARE served as a starting point to improve the standard of care of DM among the young in Malaysia.

With DiCARE, we are starting to understand about the standard of care and outcome of our children and adolescents with diabetes. This information is crucial for us to review the status and outcome of patients with the current management and to identify areas for improvement. Such information is useful in assisting the MOH, non-governmental organizations, private healthcare providers and industries in planning and evaluation, leading to diabetes prevention and control. In addition, it will help us to improve the future of children and adolescents with diabetes and thus reduce the burden on health cost of complications, morbidity and mortality. It is hoped that in the future, we shall know the incidence and prevalence of diabetes mellitus among children and adolescents in Malaysia.

The Objectives of DiCARE:
- To determine the number and the time trend of diabetes mellitus in the young in Malaysia.
- To determine the socio-demographic profiles of these patients to better identify the high-risk group in our Malaysian population.
- To determine the number, evaluate and monitor the outcomes of intervention in terms of metabolic control and complications.
- To stimulate and facilitate research using this database.

Benefits When You Participate in DiCARE:
- Access to database and therefore study the trend of diabetes among children and adolescents.
- Online data query and statistics of your institution anytime, anywhere.
- Online comparison of your institution data versus the country data anytime, anywhere.
- Data security and privacy are in compliance with regulatory requirement.
- Invitation to functions organized by DiCARE.
- Acknowledgement in publications of DiCARE.
- Complimentary personal copy of DiCARE publications.
- Free listing in the DiCARE website.
- Tap into a network of like-minded people from diverse professional disciplines and backgrounds.
More centres have begun to register in 2008 but we hope to invite and encourage more doctors to contribute to the community by becoming source data providers (SDP) to notify and report all diabetic cases. With our newly revised CRF that will be launched on 15 April 2009, we believe that the process of case notification will be easier. For DiCARE to become a success, ideally all doctors who care for diabetic patients ought to report to DiCARE.

For further information, you can contact:

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124 Jalan Pahang
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Fax: 03-40443080
Email: dicare@acrm.org.my
Website: www.acrm.org.my/dicare

We look forward to your continued support and collaboration that will enable DiCARE to develop and contribute significantly to the control of diabetes mellitus in Malaysia.

**Fuziah Md Zain, Janet Hong**
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**Doctors Around The Continent**

A Japanese doctor said, “Medicine in my country is so advanced that we can take a kidney out of one man, put it in another, and have him looking for work in six weeks.”

A German doctor said, “That’s nothing, we can take a lung out of one person, put it in another, and have him looking for work in four weeks.”

A British doctor said, “In my country, medicine is so advanced that we can take half of a heart out of one person, put it in another, and have them both looking for work in two weeks.”

A Texas doctor, not to be outdone said, “You guys are way behind. We took a man with no brains out of Texas, put him in the White House, and now half the country is looking for work.”

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**Hearing Problem**

An elderly gentleman had serious hearing problems for a number of years. He went to the doctor and the doctor was able to have him fitted for a set of hearing aids that allowed the gentleman to hear 100%.

The elderly gentleman went back in a month to the doctor and the doctor said, “Your hearing is perfect. Your family must be really pleased that you can hear again.”

The gentleman replied, “I haven’t told my family yet. I just sit around and listen to their conversations. I’ve changed my will three times!”
MMR Doctor Andrew Wakefield
Fixed Data on Autism

Brian Deer, The Sunday Times, UK
February 8, 2009

THE doctor who sparked the scare over the safety of the MMR vaccine for children changed and misreported results in his research, creating the appearance of a possible link with autism, a Sunday Times investigation has found.

Confidential medical documents and interviews with witnesses have established that Andrew Wakefield manipulated patients’ data, which triggered fears that the MMR triple vaccine to protect against measles, mumps and rubella was linked to the condition.

The research was published in February 1998 in an article in The Lancet medical journal. It claimed that the families of eight out of 12 children attending a routine clinic at the hospital had blamed MMR for their autism, and said that problems came on within days of the jab. The team also claimed to have discovered a new inflammatory bowel disease underlying the children’s conditions.

However, our investigation, confirmed by evidence presented to the General Medical Council (GMC), reveals that: In most of the 12 cases, the children’s ailments as described in The Lancet were different from their hospital and GP records. Although the research paper claimed that problems came on within days of the jab, in only one case did medical records suggest this was true, and in many of the cases medical concerns had been raised before the children were vaccinated. Hospital pathologists, looking for inflammatory bowel disease, reported in the majority of cases that the gut was normal. This was then reviewed and the Lancet paper showed them as abnormal.

Despite involving just a dozen children, the 1998 paper’s impact was extraordinary. After its publication, rates of inoculation fell from 92% to below 80%. Populations acquire “herd immunity” from measles when more than 95% of people have been vaccinated.

Last week official figures showed that 1,348 confirmed cases of measles in England and Wales were reported last year, compared with 56 in 1998. Two children have died of the disease.

With two professors, John Walker-Smith and Simon Murch, Wakefield is defending himself against allegations of serious professional misconduct brought by the GMC. The charges relate to ethical aspects of the project, not its findings. All three men deny any misconduct.

Excerpt from The Sunday Times, UK dated Feb 8, 2009
Announcements

World Vaccine Congress Asia 2009

Date : 8-11 June 2009
Venue : Marina Mandarin, Singapore
Secretariat : Terrapinn
Email : yeelim.tan@terrapinn.com
Website : http://www.terrapinn.com/2009/wvcaasia/index.stm

27th Annual Meeting of the European Society for Paediatric Infectious Disease (ESPID 2009)

Organised jointly by the ESPID Society and the ESPID Foundation

Date : 9-13 June 2009
Venue : Brussels, Belgium
Secretariat : Kenes International
PO Box 1726
CH-1211 Geneva 1 Switzerland
Tel : + 41 22 908 0488
Fax : + 41 22 732 2850
Email : espid@kenes.com
Website : http://www2.kenes.com/espid/Pages/home.aspx

Paediatric Respiratory Update
Understanding Respiratory Conditions in Children

Date : 20-21 June 2009
Venue : Paediatric Institute, Hospital Kuala Lumpur
Secretariat contact : Paediatric Institute / MPA Secretariat
Website : http://www2.kenes.com/espid/Pages/home.aspx

36th Annual International Conference on Global Health
New Technologies, Proven Strategies, Healthy Communities

Date : 26-30 May 2009
Venue : Omni Shoreham Hotel, Washington DC
Secretariat : Global Health Council
Email : conference@globalhealth.org
Website : http://www.globalhealth.org/

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Rotarix™: Broad and early protection with only two oral doses

Rotarix™ provides up to 100% efficacy against rotavirus gastroenteritis (RVGE) requiring hospitalisation, and high protection against most common strains. Importantly, Rotarix™ with its two-dose schedule, allows early immunisation that can be completed by the age of 10 weeks.

So now you can protect infants from severe RVGE before the age of highest risk (from 3-24 months).


Rotarix™: Inactivated rotavirus vaccine containing live attenuated human rotavirus MA104 strains.

Indications:
- Recommended for the prevention of gastroenteritis caused by Rotarix™.

Dosage and administration:
- Live oral vaccine in the form of a suspension containing live attenuated human rotavirus MA104 strains.
- The vaccine is administered in two doses: one after each of two alternate doses.
- The second dose should be administered at least 4 weeks after the first dose.

Contraindications:
- Rotarix™ is contraindicated in patients with known hypersensitivity to any component of the vaccine.

Warnings and Precautions:
- Vaccination should be preceded by a review of the medical history and physical examination.

Interactions:
- Rotarix™ is not recommended for patients who have been vaccinated with the same strain of vaccine in the past 12 months.

Pregnancy and lactation:
- Rotarix™ is not recommended for pregnant women or breastfeeding mothers.

Adverse reactions:
- Adverse reactions are typically mild and include fever, diarrhea, vomiting, abdominal pain, and rash.

Dosage and administration:
- The vaccine is administered in two doses: one after each of two alternate doses.
- The second dose should be administered at least 4 weeks after the first dose.

For more information, please visit www.Rotarix.com.