SUARA FPMPAM

Federation of Private Medical Practitioner's Associations, Malaysia

Message from President

Fellow Colleagues,

2014 once again has proved to be another challenging year in the making for the private medical fraternity.

Overproduction of doctors

Firstly was the confirmation that we are indeed over-producing doctors in Malaysia and the situation will get worse for many years to come before it becomes better. For those looking for cheap labour, this might be welcomed news but for the new young graduates, the future looks bleak. Even getting a training post for housemanship will no longer be guaranteed. The waiting list has already started. The Federation has been highlighting this for the past 10 years. Our stand was that quantity without regard to quality was a sure formula for disaster. We were constantly told that we were wrong. Finally the truth has surfaced.

Next year is expected to be further complicated with the full implementation of the Asean Framework Agreement on Services (AFAS) and the Mutual Recognition Agreement (MRA) for medical services. You will start seeing doctors from neighbouring countries seeking registration and work in Malaysia. The question is whether this will be a trickle or a flood as the gates begin to open.

PPDA and Confidentiality of Patient Data

Secondly, doctors in their daily practice must now conform to the provisions of a new law in the form of the Personal Data Protection Act 2010. Despite having no enabling regulations this law is now being enforced. The main issue here is confidentiality of patient data. For medical practitioners, this confidentiality of patient data is guarded even more stringently by the Medical Act (Amendment) 2012, the PHFS Act 1998/Regulations 2006 and the Code of Professional Conduct of the Malaysian Medical Council. The Federation is aware and is fully appreciative that the MMC has been vigorously working to have medical practitioners exempted from certain provisions of the PDPA. Without this exemption, our current format of doctor-patient communication and practice will be untenable. We look forward to an official confirmation from the Minister of Communication and Multi Media Malaysia.

The Pathology Laboratory Act 2007

It is now 7 years since the passage of this Act and we are yet to see it enforced with its enabling regulations.

In this lacuna, private laboratories and also pharmacies have taken upon themselves to cash in and provide all sorts of screening and diagnostic tests on walk-in patients and customers. We have been informed that some even send teams to factories, offices and homes to take blood for screening tests. Some proceed to provide treatment for patients without the necessary supporting proper medical evaluation by a registered and qualified medical practitioner. These improper practices are in clear breach of existing laws. The Federation strongly urges the authorities to take immediate action to curb these malpractices and to protect the health of the rakyat from being exploited by these businesses.

Doctors' Fees and Fee-Splitting

Thirdly, the rising cost of healthcare in Malaysia remains a major concern for our patients and the rakyat. Over the past 5 years, these increases have been particularly noticeable in

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total hospital bills. As usual, the knee-jerk responses have been to blame doctors for this increase. MCOs, TPAs and insurers take this opportunity to extract discounts on doctors' fees from doctors as well as hospitals/private healthcare facilities. Their usual modus operandi is that they would send patients only to doctors/private healthcare facilities that give discounts. If a doctor does not agree to the discount request, he is out. The Federation has opposed this and will continue to do so. Extracting discounts from doctors' professional fees in this manner is fee-splitting, which is illegal under the PHFSA. Since 2006, the Federation has had a standing Joint Integrated Health Care Committee (JIHC) that is specially dedicated to fight this issue, including taking legal action against the offending parties.

The fact of the matter is that doctors' professional fees are already capped by a government approved fee schedule and this has only been increased by 14.4% since the year 2000 working out to be a mere 1% per annum. Private practitioners have been quietly absorbing the yearly increase in cost of running a clinic.

Prescription and Dispensing

We have yet to see for ourselves the proposed Pharmacy Bill which is due for tabling in Parliament. We can expect this to be soon as the Dasar Ubat Nasional (DUNAS) is scheduled for full implementation in 2015. Central to the doctors' concern is the constant lobby for separation of prescription and dispensing. We hear this vigorously pushed by businesses out to monopolise the dispensing market.

However, it has been whispered on many occasions that even with the new Pharmacy Act, doctors will still continue to dispense but will have to comply with the same requirements as a dispensing pharmacist. The legal right of the doctor to dispense is clearly stated in the PHFS Act 1998/Regulations 2006 and also the Poisons Act.

It must be made clear that in a private clinic, the income from dispensing is essential for meeting the running cost of providing the service of the clinic. Historically private doctors have been previously providing a single package bill for their services and medicines. This has worked well to control the cost per visit for patients. The doctor's professional fee in these package bills was really very minimal.

The Federation will continue to champion the existing one-stop consultation, prescription and dispensing model for the convenience and cost-effectiveness for the patients. Indeed most of our patients, including those from other countries favor the one-stop facility.

Research done in the USA and UK has also clearly indicated that errors in dispensing by pharmacists are just as rampant in systems practising separation of roles. In the Memorandum presented to the UK Parliament by Professor Bryony Dean Franklin and Professor Nick Barber in 2009, dispensing errors was noted to account for 3.3% of all items dispensed and up to 9.8% of dispensed items in secondary care. Indeed in the UK, the government has found it fit to have criminal liability for dispensing errors. Studies in the USA have estimated that the rate of dispensing errors in ambulatory setting ranges from 1 to 24% of prescriptions. In 1999 an investigation done on 51 Massachusetts pharmacies in Boston, revealed that 4% of prescriptions dispensed by community pharmacist contained errors of which 88% of these involved wrong drug or strength.

Clearly there is no evidence to suggest that separation of roles in the Malaysian scenario will be any better than what we have existing now. A dichotomised system have also been shown to increase rather than decrease the cost of care and is inconvenient to the patient. It is thus, not in the rakyat's best interest. The choice of where to get his medications is the right of the patient. It is not in the patient's interest to take away this right.

Doctors' Day – 10th October 2014

With all the trials and tribulations, the Federation has decided that it is time that doctors and patients spend a moment to reflect on the future of Malaysian healthcare. It is also timely that doctors be appreciated for their services and sacrifices. We understand that the morale of doctors today, both young and old is at its lowest.

We call upon all doctors to take a day off from their usual routine on 10th October and join one another in a weekend of fellowship and celebration together with their families and friends. Get together, go for a trip or just chill out at your favourite haunt.

Your state private practitioners' society or other fellow medical associations are encouraged to organise their own separate events. You can also join the Federation who will be celebrating with our colleagues from the Perak Medical Practitioners' Society.

Doctors, you and your family deserve a treat.

Steven Chow
President, FPMPAM

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Note from the Editor

Dr Tan Poh Teng

In today's society, people are striving for a better healthy living conditions be it for themselves or for their loved ones. The sense of a secured health is the fundamental issues of medical care in the future. As health care systems change, as we improve our ability to avert death from acute diseases, and as the population ages, the care of individuals with chronic disease becomes more central to the mission or health care worldwide.

From the notion above, the Editor would then like to touch on issues with regard to maternal and child care, minimum wages of medical practitioners against the increment of medicine price, new requirements for clinic equipped with X-ray facilities, the emergence of 1Malaysia clinics and pharmacies, the intervention of Managed Care Organization (MCO) and also the separation of prescribing and dispensing of medication by medical practitioners. Generally, it seems to be a diverse topic to be addressed, yet it is a phenomenon that is rapidly occurring in today's global medical society.

When we talk about maternal and childcare, we cannot run away from the mortality rate that is constantly being reported by the World Health Organization (WHO). From 1990 to 2012, the number of deaths in children under 5 fell from 12.6 million to 6.6 million, Despite this admirable accomplishment, progress must be accelerated to meet Millennium Development Goal (MDG) number (4) that is reducing child mortality. Going beyond the MDG deadline, the momentum to improve child survival must be sustained in all regions. Since 1990, the lives of an estimated 90 million children under age 5 have been saved, but much work remains. If current trands continue, the world will not meet the MDG target until 2028, and another 35 million children will die unnecessarily.

If we look at the worldwide rate, the under-five mortality rate has dropped 47 per cent - well short of the two-thirds reduction required by the MDG target. The number of deaths per 1,000 live births dropped from 90 deaths in 1990 to 48 in 2012. However, stepped-up progress is needed to reach the target of 30 deaths per 1,000 live births by 2015. Accelerating progress in child survival requires urgent attention to ending preventable deaths in sub-Saharan Africa and South Asia, which together account for more than 80 per cent of deaths in children under the age of five (5) globally. South Asia has made strong progress in reducing preventable deaths, more than halving the number or deaths in under-fives since 1990. Sub-Saharan Africa, however, continues to lag behind, with a decrease in under-five mortality of 45 per cent over the same time period. However, along with the Middle East and North Africa, it is one of only two regions that have experienced a consistent acceleration in the pace of progress since 1990. As such, we see that the importance of child care is important even before childbirth.

Secondly, the Editor would like to touch against the minimum wages issue against the price hike of medicine in Malaysia. The National Minimum Wages initiative for Malaysia was announced by the Prime Minister in his Budget Speech on 15th October 2010. It is one of the Government's policy instruments vide New Economic Model (NEM) to ensure inclusiveness by transforming the economy from a middle-income to a hig-income economy by the year 2020. The policy is meant to ensure workers can meet their basic needs and create the necessary environment for industries to move up their value chain. Minimum wages is basic wages, excluding any allowances or other payments.

A World Bank study concluded that a minimum wages rate of less than RM1,000.00 per month or RM4.88 per hour would not significantly affect firms, employment, foreign direct investment or migrant flow into the country. More money in the hands of private consumers should boost private consumption. However, we as medical practitioners are aware that the prices of medicine are Increasing yearly. What should we do or steps to be taken by medical practitioners in Malaysia to overcome this issue?

The professionalism issue is being brought up in clinics equipped with X-ray facilities. From radiographers to biometric system, the issue has been the talk of town about operating and safety procedures for x-ray offices developed by the person responsible for the radiation safety in each facility. The model procedures in this regulatory guide are generalized. Each facility must write procedures that are specific for their facility. By using the sections of this guide that apply, the facility may create a unique set of operating and safety procedures. Although other formats are acceptable, information contained in this guide must be included in the operating and safety procedures. This guide is prepared for medical offices that have not developed their own radiation safety procedure manual. Larger medical clinics have already developed safety manuals and should check the content of their manuals to make certain they contain all the necessary information. We should take it as a challenge to improve ourselves in terms of services. Are we ready to answer the challenge?

The emergence of 1Malaysia clinics and pharmacies has been a challenge for private medical practitioners nationwide. Patients are flocking the 1Malaysia clinics and pharmacies, as they tend to provide affordable services and medicine for patients whom are in need of treatment but with minimum wage or the less fortunate. Ideally, it is an effort by the Government to ensure everyone has the equal opportunities to have a better and healthy living, but how do we managed our expenses if the number of patients are dwindling as the focus shifts to the 1Malaysia clinics and pharmacies. What solutions and course of action to be taken by private medical practitioners to ensure longevity in our practices?

In today's era, Managed Care Organization (MCO), introduces medical cards and panel for their clients. The big player, such as insurance companies are lending their expertise in health management to assist clients to have better medical services without spending a single cent during their visits

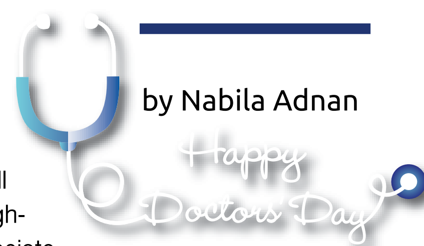
to the medical practitioners. We felt the pang, as at times, the payment for such services is long overdue. We are well aware that the dollars and cents involved are our bread and butter. Can we negotiate and come to term where both parties; MCO and private medical practitioner gain benefits from such partnerships? We urge you to give us your feedback on the issue at hand for the good of all.

Finally, the Editor believed that a "One-Stop Centre" on prescribing and dispensing medicine should be maintained at the clinic or hospital itself. We should play a part to ensure that our patients are comfortable and ensure the conveniences are being taken care off. The Editor would like to note that when a patient has to search on his or her own self, the medications prescribed to him or her, it would be an inconvenience for them and they might even have the wrong diagnosis. What would happen next, would be a domino effect! The inconveniences caused would lead to the patients to move to other medical practitioners who could provide them with a single solution to their problems! We would not like them to have a negative perception on us! Please do take care of your patients as how you care for yourself and your family!

On that note, thank you for spending your time to read and digest the note for the Editor! We hope that this issue will be an eye-opener and also a platform to start a new chapter and to improve and enhance our short-comings for a better future for all in the health industry! E

Doctors' Day – Ten out of Ten

by Nabila Adnan



Marcus Tullius Cicero, a Roman philosopher, politician, lawyer, orator, political theorist, consul and constitutionalist once said, "In nothing do men more nearly approach the gods, than in giving health to men".

So what exactly is a doctor? From a patient's perspective, a doctor is simply a person who fixes a person back to original state. According to Wikipedia, the word 'doctor' originates from the Latin word of the same spelling and meaning. The word is originally an agentive noun, a word that is derived from another word denoting an action, of the Latin verb *docére* meaning 'to teach'. However, the meaning of a doctor today has been somewhat diluted and less respected with the growth of self-medication and the internet.

Therein lies the need for the introduction of Doctors' Day. The special day is celebrated on various different dates around the world. The history of the day dates back to the 1800s when an American, Dr Crawford W Long became the first physician to use anesthesia in an operation that he performed on March 30, 1842. To commemorate this unprecedented event, March 30 was declared as a National Doctors Day in the United States.

Interestingly, the story of Doctors' Day in Malaysia is quite different. The date 10 October was chosen as it represents precision – ten out of ten or rather, full marks. As a doctor, you have to give your ten out of ten every second, minute, day, week and year after year – it is a duty you owe to your patients. Aside from this, in Malaysia, the personalized relationship between patient and doctor is increasingly under siege by commercial elements now being introduced by the owners of the business of medicine. With all the trials and tribulations, the Federation had decided that it is time doctors, families and their patients take time to reflect on this

Doctors' Day is an ideal opportunity to remind people of the imminent role doctor's play in our lives. Being a doctor is not just a 'job'; it is a challenging commitment to serve, which requires a high level of skill and precision. Aside from this, doctors have to deal with the reality that even a small professional mistake could drastically affect a patient's life. With this, Doctors' Day is the perfect time for all to acknowledge the high-pressured job and appreciate their doctor's dedication to always comfort, sometimes to heal but never to harm.

Also, we understand that the morale of doctors today, both young and old, is at its lowest. The basic social contract of the patient-doctor relationship itself is now under re-examination.

With the easy availability of medical information on the internet, patients are now more informed. Unfortunately, many are also becoming more misinformed as well. Doctors are seeing increasing cases of wrong self-diagnosis and self-medication. A doctor's good advice can easily get clouded when the patient is bombarded with too much unprocessed raw data and information on the net.

The detractors paint doctors as money making machines, rather than those who care for the wellbeing of the community. This has always been used as the basis for "doctor-bashing" in the media. It is true that the medical profession carries with it, a heavy responsibility, but behind the white coat and stethoscope is a human being. When an error occurs and there is death or harm done, it is indeed quite difficult to be forgiven. This is the unfortunate burden practicing doctors have to carry throughout their working lives. However, like all professionals, when things turn out well, doctors too need appreciation for their work and effort.

With the inauguration of Doctors' Day, this year, do make an effort to take the day off from your usual routine on 10th October. Join one another in a weekend of celebration with other doctors, family and friends. Get together, go somewhere, reward yourself or just chill out.

The Federation will be celebrating Doctors' Day with the Perak Medical Practitioners Society and the MMA (Perak). Come and join us.

For more information, visit www.fpmpam.org or www.facebook/fpmpam. E

GST – THE POTENTIAL EFFECTS ON HEALTHCARE IN MALAYSIA

Dr Ng Swee Choon

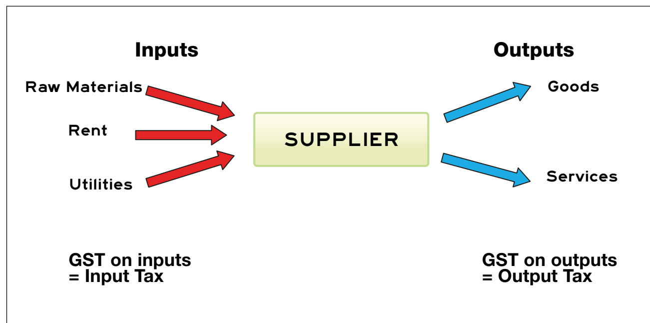
Introduction

On the 25th of October 2013, Malaysian Finance Minister (who is also the Prime Minister) Datuk Seri Najib Razak announced the introduction of the Goods and Services Tax (GST) in Budget 2014 to replace the current sales and services tax, GST will be effective on April, 2015.

Of course following the budget announcement, there was a flurry of activities in the mainstream Malaysian media. There were some pro-GST comments mainly from the government and their supporters claiming that "it will not burden the people" and some anti-GST comments mainly from the opposition political parties crying foul saying that government ministers do not even understand the proposed GST. Of special interest, was the honorable Minister of Health who had to retract his statement after being challenged by the DAP MP.

WHAT IS GST MALAYSIA?

Goods and Services Tax (GST) is a multi-stage consumption tax on goods and services whereby each point of supply in a production chain is potentially taxable up to the retail stage of distribution. At the same time suppliers are entitled to refunds of GST incurred on business inputs. The basic fundamental of GST Malaysia is its self-policing features which allow the businesses to claim their Input tax credit by way of automatic deduction in their accounting system. With the introduction of GST, the previous sales and services tax will be removed, and we also hope that personal income tax will also be reduced.



What we know?

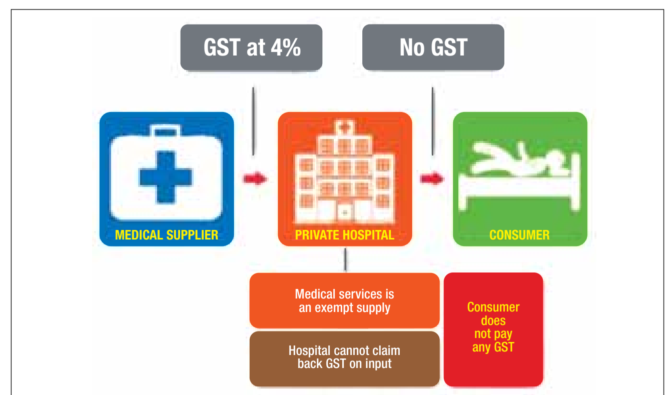
Following the definition, the goods and services are categorised by the government into 3 categories, viz,

1. The zero rated goods and services. So goods and services in this category has no GST, government does not collect from you and you do not collect from consumers.
   - Essential items such as: Rice, sugar, salt, flour, cooking oil among others
   - Public transport (LRT, KTM, Buses)
   - Sale and Rental of property
   - Electricity consumption up to 200kwH (about RM50), presumably per month

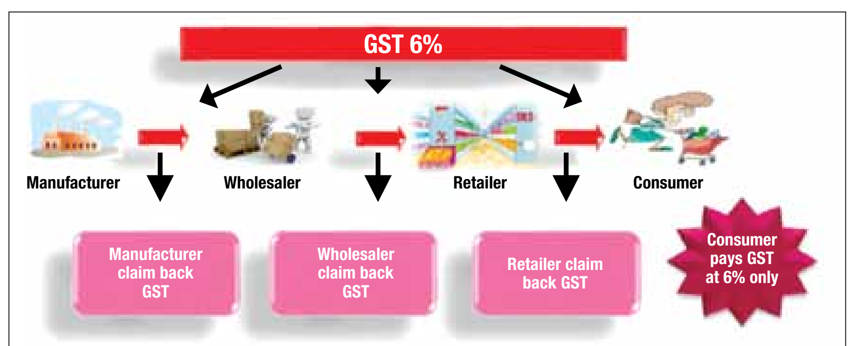
Although this list has been published, I think that this list is still not cast in stone and there is still room for negotiation and manipulation.

2. GST exempt goods and services. Goods and services in this category are exempted from GST. This means that in this category, government collects from you but you cannot collect from the consumers.
   - o Financial services (including life insurance and family takaful)
   - o Sale and lease of residential property
   - o Toll highway
   - o Private health and education
   - o Domestic transportation of passengers for mass public transport by rail (KTM, LRT, ERL, Monorail, ships, boats, ferries, express bus, state bus, worked bus, school bus, feeder bus and taxi)
   - o Land for agricultural purposes and land for general use (Government building and buried ground)

   Note that Healthcare belongs in this category.



3. The GST standard rated category. All the other goods and services not in the above two category.



The Deputy Minister of Finance announced in May 2014, that 689 goods and services are in the standard rated category.

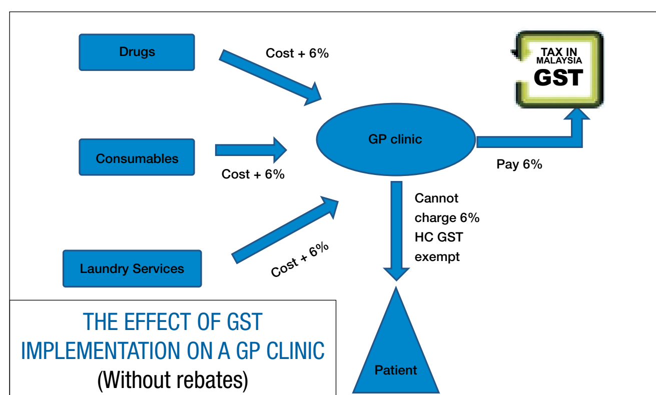
How will it work?

Doctors who run facilities with annual turnover exceeding RM 500,000 must register. The penalty for not registering is severe. Other medical facilities whose annual turnover does not exceed RM 500,000 may register voluntarily. Once you are register, you are subjected to the terms and conditions of GST legislations. If you do not pay the GST in time to the Customs department, you will be penalised.

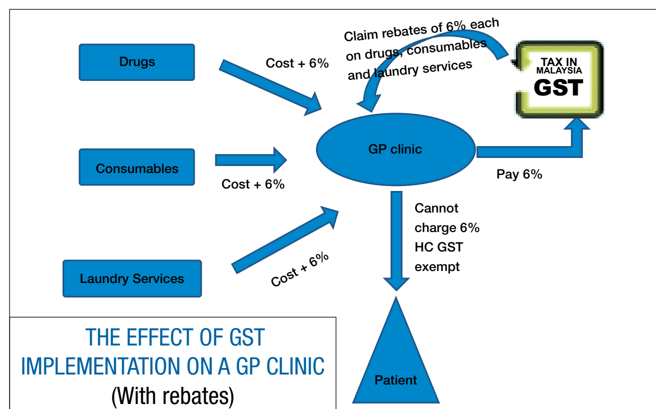
If a GP wishes to register voluntarily, there is additional paper work and you would have to stay registered for 2 years at least. You will of course be bound by the GST legislation, which also means that you can claim GST rebates on GST goods and services supplied to your clinic.

An example – A GP running a clinic.

It is my impression (I may be wrong), that most solo GP practices have an annual turnover not exceeding RM 500,000. In that case, the GP does not need to register with the Custom's Department under the GST regulations.



THE EFFECT OF GST IMPLEMENTATION ON A GP CLINIC
(Without rebates)



THE EFFECT OF GST IMPLEMENTATION ON A GP CLINIC
(With rebates)

NB

To claim rebates you must register with Customs Department, and face a ton of paperwork and customs department scrutiny.

Comments.

Currently only about 10% of working adults in Malaysia pay taxes. 90% do not and the government knows why and who they are who do not pay taxes. In this scenario then, consumption taxes would mean that all Malaysians who consume will be tax, and there is no escape for individuals by race or religion. The other point to make is that unless the leakages in the system is plugged, no amount of taxation will be enough for the government to use. The more you collect, the more is leaked. Soon we will be back to square one and the GST 6% tax rate will slowly creep up to 10% then 15% and soon 20%. I am very afraid of this, because this GST tax has the potential if creating social disharmony and increase crime rates. What is a father with 3 kids, earning RM2, 000 a month supposed to do, when his kids have no money to go to school, to buy uniform and stationary, and no money for the tuck shop? The young one is crying because there is no milk left and no food to eat? He sees his nearby neighborhood of middle income wage earners passing by every day. What do you think he will do?

Leaving social issues aside, Let us take a look at Healthcare. Of course Public Healthcare is NOT affected as there is NO GST on public goods and services. They are all zero rated. In Private healthcare, there is the Healthcare facilities (medical centers, ambulatory centers and also hemodialysis units). Cost will sure go up, no matter how the Minister of Health wishes to spin it. The whole supply chain to the private healthcare facilities are NOT GST zero rated, so GST will be collected and rebated. At the last link it the chain (healthcare facilities to patients), this step is GST exempt but the medical center has to pay the Custom Department GST, so they will surely be raising their cost, as started by their spokesman lately. They cannot absorb the increase. They will pass it on to the patient. In a very surprising way, imported drugs which at the moment are subjected to a 10% sales tax, will now be theoretically cheaper as the 10% sales tax is removed and replaced by a 6% GST although I personal do not see that happening.

As for the private GP, his practice will now cost more, as all his consumables, and other services like laundry, will cost more. If he registers with GST, he will face a ton of paperwork. If he does not, he will have to absorb the cost and pass it on. The 6% GST that he has to pay to Customs must also be factored in. As for drugs, the drugs from multinational companies may be cheaper (10 % less for no sales tax, but 6$ more for GST), while for locally manufactured drugs (currently no sales tax) will see an increase in price because of the 6% GST. Basically, I see the cost of running a GP clinic going up and so I can see that the cost of healthcare will go up. But the GPs cannot also simply increase cost as market forces dictates the cost of GP care. So the GPs are badly squash between the MCOs / TPAs and their terms, PHCFS Act, market forces and now GST. God help us all.

The government keeps telling us that this GST 6% initial rate is supposed to be revenue neutral. I just do not see it. Some goods will be, but the majority will not be, so overall things will go up. What I fear is that, after making a start in April 2015, they will slowly increase GST over the years so that before I meet my maker, it may be 15% (if I am lucky). During the Dewan Negara sitting in May 2014, the Deputy minister of Finance said that GST will be imposed on 689 goods. He expects that the price of 73 items will go up, the price of 287 items will go down, and the price of 287 items would remain the same after GST. I find this statement irrational. To make sure that traders and business people do no profiteer with this new tax, there must be good monitoring and enforcement of the "Anti-Profiteering Act". Firstly, this Act is yet to be implemented. For GST to be effective, good monitoring and across-the-board enforcement has to be part of our public servants culture, failing which, I think profiteering will be rampant with this new GST in April 2015.

Anyway coming back to healthcare, I am certain that cost will rise.

What then can we do? Very little I am afraid. The porridge has already been cooked. Enjoy it as much as you can. Do not choke on the bones. Life is tough as a GP.

Post script

I would like to declare that I am one of those who supported the Tak Nak GST demonstration on 1st May 2014.

Dr Ng Swee Choon
FPMPAM

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Mediation in medical disputes

Dr Milton Lum

Adverse events in health care, in contrast to the complications of disease, are not uncommon. Studies from the United States, United Kingdom and Australia reveal that they constitute about 10% of all hospital admissions. There is no national data in Malaysia. The incidence in Health Ministry hospitals is about 6-15% of hospital admissions but there is no data from private hospitals.

Adverse events may be preventable or non-preventable. Some are incidental and some are due to negligence, which may be commissions or omissions. As the causes of adverse events are multiple, they will continue to occur despite the patient safety efforts of healthcare providers.

When things go wrong, some of those affected will complain to the Health Ministry and/or the Malaysian Medical Council (MMC); others will resort to litigation. The MMC is not ordinarily concerned with allegations of negligence unless there is an element of misconduct by the doctor.

Data from various countries indicate that about a fifth to a quarter of all adverse events may be due to negligence.

It has been reported in many studies that the majority of victims of medical accidents want an honest explanation for what went wrong, a genuine apology, reassurance that the same event will not happen again, and in some instances, compensation.

Vincent, Charles; Young, Magi; and Phillips, Angela in their landmark study "Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action" (Lancet 1994; 343: 1609-1613) concluded that the main reasons for litigation were:

- accountability - the wish to see staff disciplined and called to account;
- explanation - a combination of wanting an explanation and feeling ignored or neglected after the incident;
- standards of care - wishing to ensure that a similar incident does not happen; and
- compensation - wanting compensation and an admission of negligence.

Christopher B-Lynch, Adeyemi Coker and John Dua analysed 500 medico-legal claims and found that 46% were due to misguided allegations, 19% to incompetent care, 12% to error of judgement, 9% lack of expertise, 7% failure of communication, 6% poor supervision and 1% inadequate staffing. (RCOG 1996 Br J Obstet Gynaecol 103; 1236-1242) They concluded that "because of the high percentage (46%) of misguided allegations, an alternative course of dispute resolution must be a realistic way forward."

Many neutrals state that the legal process cannot provide what victims of medical accidents want. Litigation incurs expenditure and takes a long time to conclude. The process, which encourages secrecy and entrenched positions, does not result in an amicable, early or satisfactory resolution for many.

The guiding principle of Lord Woolf's report Access to Justice Report (HMSO London 1996) i.e. "Effective access to the enforcement of rights and the delivery of remedies depends on an accessible and effective system" identified the following principles as important for the delivery of justice:

- Just;
- Fair and be seen to be so by:
  - (a) ensuring that litigants have an equal opportunity, regardless of their resources, to assert or defend their legal rights;
  - (b) providing every litigant with an adequate opportunity to state his own case and answer his opponent's;
  - (c) treating like cases alike;
- Procedures and cost should be proportionate to the nature of the issues involved;
- Speedy;
- Understandable to those who use it;
- Responsive to the needs of those who use it; and
- It should provide as much certainty as the nature of particular cases allows.

Mediation, a mode of alternative dispute resolution, is increasingly used in many jurisdictions as an alternative to litigation.

The judge in a court hears the position taken by each party and then decides.

Mediators help in the definition and analysis of the differences between the parties and look at the underlying interests and needs of the parties. Mediation differs from litigation in two fundamental aspects viz:

- It is voluntary.
- It is without prejudice (i.e. it does not bind either party, who are not held to what has been said or has occurred during the process).

Mediation can take place at any time. It can be at the outset of a complaint, or at a later stage, when litigation is underway, but is not meeting the needs of the parties and/or when negotiations to settle the case have broken down.

Benefits

The benefits of mediation are:

1. Speed

Litigation usually takes a long time to conclude. In the case of Dominic Puthucheary & Ors v Dr Goon Siew Fong & Anor, it took about 23 years to reach a decision. Similarly, in Dr Chin Yoon Hiap vs Ng Eu Khion and others it took about 21 years. The considerable time it takes for the resolution of litigated cases does not do justice to all parties.

In countries where Pre-Action Protocols are adhered to strictly, there is more rapid movement of the cases in the courts. However, time is still needed to get through the whole process which takes a few years to conclude. Where there are no Pre-Action Protocols or, if there are, no strict adherence to it, the whole process takes an even longer.

Mediation can provide a speedier resolution and permits the parties to have an earlier mutual evaluation of the case. Even if there is no settlement or resolution, mediation may be helpful, if the case goes to trial, because, the parties would have a more focused view of the issues between them.

A sine qua non for mediation, however, is the availability of all medical records and medical reports.

2. Confidentiality

Mediation allows parties to state their grievances and discuss areas of concern in private rather than in court, where it is public and which may be reported in the media.

3. Less stress

It is well documented that litigation is stressful to both parties. Mediation can help avoid this with early settlement of complaints and may be healing for both parties. The claimant has say in a setting where he or she is listened to. Many mediated cases addressed the emotional aspects of the complaint rather than monetary compensation. There is greater likelihood of a continuation and a healing of the patient-doctor relationship unlike in litigation, where it is destroyed in because of its adversarial nature.

4. Control

Mediation allows both parties to feel that they are in control of the proceedings instead of being under the control of lawyers and the courts. There is no feeling that a third party's view is imposed on them. This leads to no one feeling that they have lost out. It may also be less confrontational. This is, however, dependent on the parties involved.

5. Flexibility

There is greater flexibility in mediation because the remedies are more varied. Settlements in litigation are monetary. However, mediation permits more customised settlements which are not just monetary e.g. explanation, apology, dissemination of lessons from the case to other doctors.

6. Cost

The cost of litigation is increasing as evidenced by the marked increase in the premiums of medical indemnity organisations in the past two decades. Legal costs, rather than the compensation awarded to the injured party, constitute an increasingly significant proportion of the court payments. Sometimes, the legal costs exceed the court award.

The lower costs of mediation i.e. more rapid conclusion, informality and the non-requirement for the exchange of all the evidence can make it possible for more aggrieved patients to address their complaints.

7. Equity and ethics

The high cost of litigation has made it very difficult for patients without means to commence proceedings. Furthermore, there are allegations of cases being taken on contingency basis, a practice that is not considered ethical by the legal fraternity.

8. Results

It is reported that settlements result in as many as 80% of mediations. For example, court directed resolution (CDR) is offered to all who file law suits in Singapore. It is not mandatory as it takes place with the consent of both parties to the lawsuit. The implementation of CDR in its Subordinate Courts has contributed significantly to the early and amicable resolution of large number of lawsuits prior to trial, including medical negligence claims.

As of 1 April 2009, more than 1,400 matters have been referred to the Singapore Mediation Centre. Of those mediated, about 75% were settled. There are various types of cases which include contractual and employment disputes, medical negligence claims, partnership disputes and personal injury claims. Of the settled cases, more than 90% were settled within one working day. Of the disputants who participated in, and provided feedback on, the mediations conducted at the SMC, 84% reported costs savings, 88% reported time savings and 94% would recommend the process to other persons in the same conflict situation. (http://www.mediation.com.sg Accessed 13th August 2009). It was reported by the Singapore media that, of the 79 medical negligence suits filed in its Subordinate Courts from 1998 to 2006, only two went to trial.

Risks

As with all things there are risks, which include:

1. Sub-optimal outcome

It is possible that the patient may be disadvantaged by the settlement, either in monetary or accountability terms. There may be pressure to reach a conclusion on the mediation date, as everyone is expected to arrive at an agreement. There may be a feeling of failure for everyone involved if this does not occur.

2. No changes in medical practice

It is believed by some that litigation has led to a corresponding increase in risk management in medical practice and greater awareness of patients' communication needs. It is unclear if unreported mediated cases behind

closed doors will create the same impetus for patient safety measures to be undertaken.

3. **Lower damages**

   It is possible that mediation will result in lower payouts for damages in some cases because it is often the threat of the court action that provides the impetus for respondents into offering realistic damages.

4. **Lack of control**

   As in any informal process, there is less control of processes, as they are not controlled by the claimant, health care providers, or the usual procedures of the litigation process or the court.

5. **Cost**

   If a case is mediated after initial investigations, then the costs of mediation may exceed negotiation. A negotiated settlement often occurs at this stage and well before litigation.

6. **Stress**

   It can be stressful for some claimants to have to meet health care providers and the mediator face to face. On the other hand, lawyers can obviate direct contact with the other side and also act as a buffer in some circumstances.

Conclusion

At a time when the litigation is long and inequitable in many respects, the benefits of mediation far outweigh its risks. Mediation can provide benefits, both monetary and otherwise, for victims of medical accidents.

Few medical cases in Malaysia have actually been through the mediation process for various reasons. As such, it is not yet possible to determine its utility in the resolution of issues for victims of medical accidents.

Mediation will not work in all disputes. However, a better understanding of its benefits will certainly increase its uptake by claimants, lawyers, doctors, medical defence organisations, health care facilities and society in general. Those who believe in mediation will need to organise their collective strength and energy to promote it so that society can realise its benefits.

In summary, it would be helpful for all potential disputants to take heed of Richard Lamb's statement "No nation in history has ever sued its way to greatness."

Dr Milton Lum is member of the board of Medical Defence Malaysia. This article is not intended to replace, dictate or define evaluation by a qualified doctor. The views expressed do not represent that of any organisation the writer is associated with.

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AUTOMATED EXTERNAL DEFIBRILLATOR (AED)

Dr Chang Keng Wee

Ischaemic heart disease and sudden cardiac arrest is the number one cause of death in Malaysia. Most sudden cardiac arrests result from ventricular fibrillation. Every minute a normal heartbeat is not restored, the victim's chance of survival drops by 7-10 percent.

WHAT IS AN AED

An automated external defibrillator is a lightweight battery operated portable device that can send an electric shock to the heart to try to restore sinus rhythm. Sticky pads with electrodes are attached to the person's chest and the computer in the AED can analyse the heart rhythm. If a shock is needed, the AED has a voice prompt to tell the first aider when to give the shock.

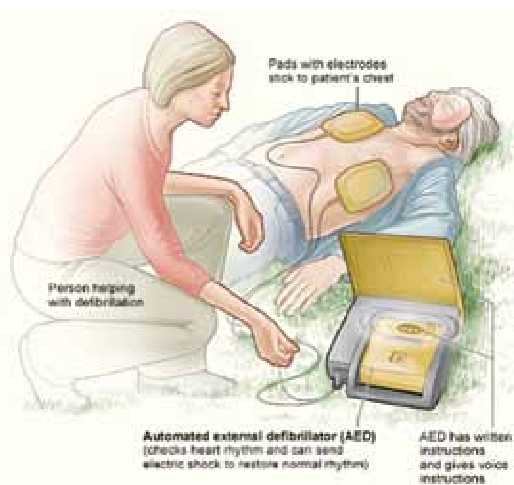
Nowadays, AEDs can be found in shopping malls, airports, sports centres, hotels, convention centres, golf courses, schools and airplanes.

HOW TO USE AN AUTOMATED EXTERNAL DEFIBRILLATOR

Before using an AED on someone who you think had a sudden cardiac arrest, check him/her to ensure that the person is really unconscious; confirm that the person cannot respond.

Call for help and immediately provide CPR (cardiopulmonary resuscitation). If two rescuers are present, one can provide CPR while the other gets the AED.

Check the person's breathing and pulse; if both are absent, prepare to use the AED as soon as possible.



Before using the AED, ensure the person who is unconscious is in a dry area. Expose the person's chest and apply the sticky pads with the electrodes to the Right upper chest above the nipple, and the other to the Left lower chest below the nipple. Press the analyse button and the machine will check the person's heart rhythm. If a shock is needed, the machine will prompt you when to deliver the shock.

Resume CPR until emergency medical help arrives.

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GOING THE EXTRA MILE -

DATO' DR LEE HOO TEONG

Dr Dato Lee Hoo Teong has always been intrigued by two things: the way the human body operates and by the prospect of being able to help somebody. These reasons are why he took up the study of medicine. Since working in the medical field since 1976 in various capacities, Dr Lee has been a blessing to his patients and to the public. As Dr Lee recalls, "the most rewarding experiences of being a doctor are when so many patients recovered after a correct and early diagnosis of their illnesses." Dr Lee has had a fulfilling career as a doctor in various roles starting out in government service as a medical officer; moving on to the Seremban General Hospital as a Surgical Registrar and venturing into private practice as a general practitioner.

But even while Dr Lee was just beginning his medical career in 1976, he found an additional calling to be involved in the St John's Ambulance, Malaysia (SJAM). Always looking to be helpful to others, Dr Lee began by conducting classes for SJAM. But seeing the good work that SJAM was doing for the community, Dr Lee felt a calling to be more involved in the organisation and sought more responsibility. He was soon promoted to Divisional Surgeon of Wilayah Persekutuan (WP); in 1988 he was promoted to Regional Staff Officer Training and in 1996 Dr Lee was made Regional Commander of SJAM WP. Since 2006 Dr Lee has served as the Chief of Staff Training at National level. In this capacity, Dr Lee is charged with planning, organising, and implementing SJAM's various training programmes.

Since assuming the role of Chief of Staff Training for SJAM, Dr Lee has been instrumental in revolutionising the reach and depth of medical outreach programmes in Malaysia. He personally introduced a series of structured training programmes such as

Basic and Advanced First Aid - giving knowledge skill and competency for members to operate as ambulance officers; Training the Trainers – enabling SJAM officers to be efficient teachers of advanced first aid classes; courses on Automated External Defibrillator (AED); Emergency Medical Technician Course – basic training in pre hospital care for SJAM officers; Aquatic Trauma care – a sea/water rescue course and the Emergency Medical Air Rescue Course - to enable SJAM officers to understand preparation of helicopter operations during rescue.

In addition, under Dr Lee's vision, SJAM was the first NGO to introduce and use AED in ambulance services in 2000 and the first in St Johns worldwide to establish a Simulation Lab and Training Academy using fully computerised mannequins. Under Dr Lee's leadership, SJAM, in collaboration with the Federation of Private Medical Practitioner's Associations, Malaysia, formed CARE (Citizen's Action in Response to Emergencies), an outreach programme to produce more first responders to save lives during emergencies.

While instrumental in transforming Malaysia healthcare's training landscape, Dr Lee counts a personal experience as his most memorable in SJAM. Dr Lee recalls when a parent called twice in two days to thank SJAM for the efficient and effective treatment of his children when they were involved in a car accident along the North South Highway on the way to Ipoh. He was surprised and grateful by the quick response time, within 5 minutes of the accident.

Despite being involved in SJAM for 38 years, Dr Lee is showing no signs of letting up. He is still as passionate as before to be a positive force to society. Moving forward, his key objective is to ensure continued upgrading of the competency, skills and knowledge of SJAM members in first aid, pre-hospital care and home nursing. With courses that already cover all aspects of emergencies, the next programme Dr Lee will introduce is a Disaster Preparedness and Management Seminar for SJAM officers in November 2014.

Dr Lee hopes more and more doctors give their time to volunteer for community services, like SJAM. SJAM accepts volunteers of all ages and many start in SJAM as students members. For more information, please call the SJAM Head Quarters at 03-92851576 or refer to the SJAM website www.sjam.org.my. E